Australian Government
Australian Institute of
Health and Welfare

Australia's welfare
2009

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

Australian Institute of Health and Welfare
Canberra

The Australian Institute of Health and Welfare is Australia's national health and welfare statistics and information agency. The Institute's mission is *better information and statistics for better health and wellbeing*.

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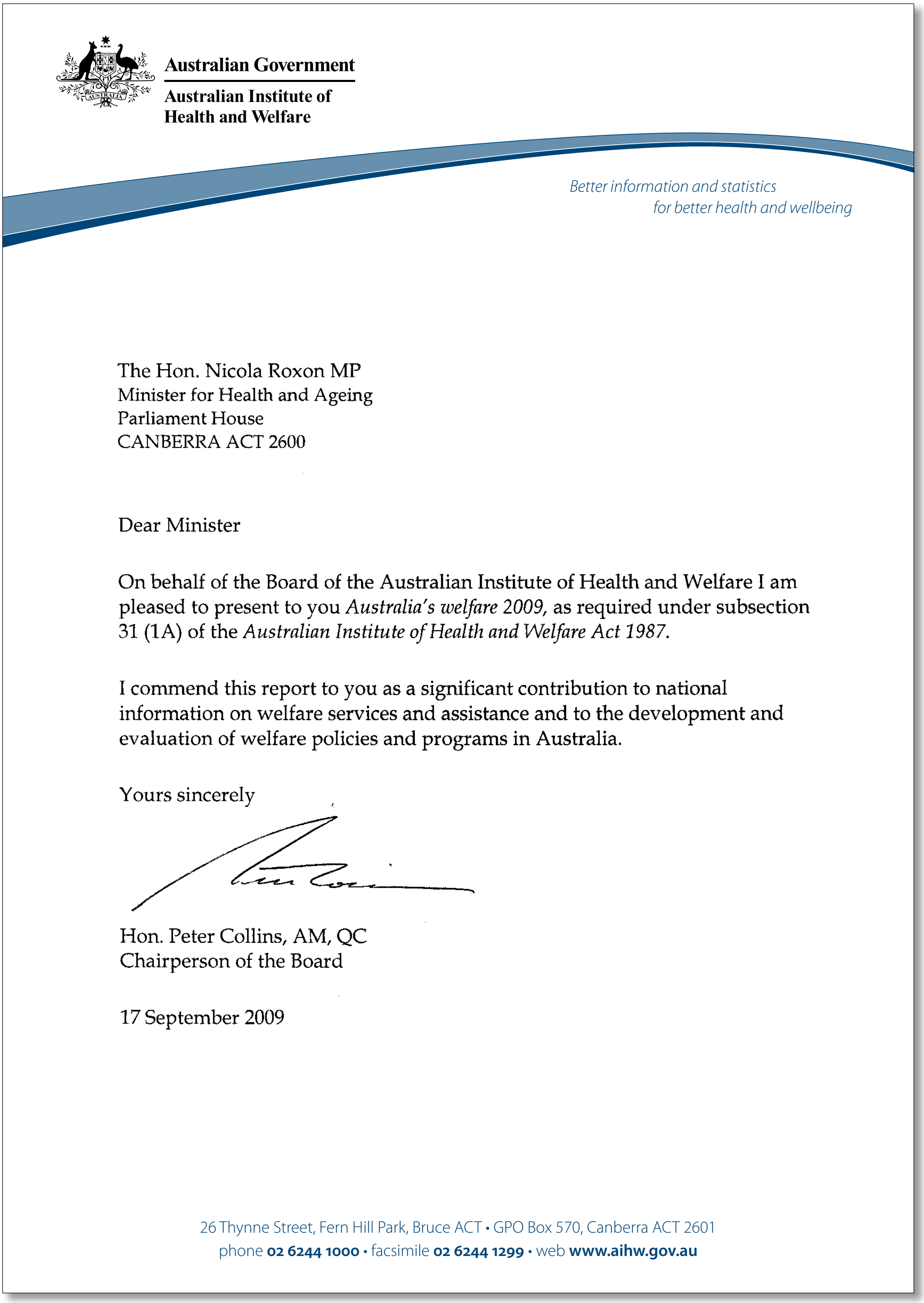

Australian Government
Australian Institute of Health and Welfare

Better information and statistics for better health and wellbeing

The Hon. Nicola Roxon 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 2009*, 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

Hon. Peter Collins, AM, QC
Chairperson of the Board

17 September 2009

26 Thynne Street, Fern Hill Park, Bruce ACT • GPO Box 570, Canberra ACT 2601
phone **02 6244 1000** • facsimile **02 6244 1299** • web **www.aihw.gov.au**

Foreword

I am pleased to introduce *Australia's welfare 2009*, the ninth edition of this comprehensive and influential report on the state of the welfare services provided to Australians. Reflecting the Australian Government's 2007 commitment to pursuing a Social Inclusion Agenda, this edition presents information on the provision of welfare services to Australians with a focus on social inclusion in Australia.

The Australian Social Inclusion Board was established in May 2008 to advise the Australian Government on ways to achieve better outcomes for the most disadvantaged in our community. This advice has focused on three priority areas: locational approaches to disadvantage, children at greatest risk of long term disadvantage, and jobless families with children.

Despite most Australians having a comparatively good standard of living, many Australians still face disadvantages which exclude them from community and civic engagement, and prevent them from sharing in the benefits of a wealthy nation. Although most often associated with poor labour market attachment and low education and skills resources, social exclusion can be further entrenched by mental illness, disability, family violence and homelessness. An inability to access services—one of the primary structural barriers to social and economic participation—is reflected in this report's discussion on unmet demand and need.

The persistence of social exclusion in Australia (even during the extended period of growth that Australia experienced until very recently) demonstrates the need for a different policy approach. Conventional policy responses have tended to focus only on individuals, with limited reference to family or community context. Further, conventional models generally employed a limited list of policy levers to address individual drivers of disadvantage with inadequate recognition of the interconnectedness of those drivers and little cross-disciplinary coordination.

A social inclusion response recognises that to address the needs of socially excluded groups, policy and delivery need to address the intertwining mix of resource, capability and opportunity gaps that drive disadvantage. Further, it recognises the context in which people live, addressing the interdependency between individuals, families and communities.

Social exclusion not only imposes a cost on individuals but also entails a significant cost to Australia if people are unable to contribute to their communities and to the broader productivity of the nation. The global financial crisis can be expected to exacerbate social exclusion. The crisis is likely to disproportionately affect young people and the low skilled, and create additional strain for the not-for-profit sector. The challenge for practitioners and policymakers will be to ensure Australia emerges from the downturn without disadvantaged groups being further excluded from economic and community participation.

The key to developing and delivering the Government's Social Inclusion Agenda is a comprehensive evidence base on how welfare services are being delivered to Australians, where services are effective and where the unmet demand and need remains. As it has done for 16 years, *Australia's welfare* will again be a vital tool for practitioners and policy makers in addressing the social policy challenges we face.

Patricia Faulkner
Chair, Social Inclusion Board

Contents

Note: All population and appendix tables can be found online at www.aihw.gov.au and are also available on the CD accompanying the printed book.

Preface

Welcome to *Australia's welfare 2009*. This major work is the latest of the AIHW's 2-yearly reports that provides statistics and related information on the provision of welfare services to the Australian people.

Welfare is of course an out-dated word. The *AIHW Act* expands on its meaning to require that the 'welfare' report covers community services including aged care, child care, disabilities, housing assistance, child protection and substitute care.

To achieve this, the AIHW draws on the 'welfare-related' information and statistics it collects from service providers and governments as well as other relevant information that provides transparency and allows analysis of trends and issues.

All of the specific subject matters are covered in this biennial report. In addition, this year, there is a special chapter on carers which draws on information from administrative data to highlight the role that carers, mostly women, play in complementing and underpinning the services provided by governments and the community.

It has not been possible in this edition to include information on welfare expenditure or to update the chapter on welfare indicators produced in previous versions. The Institute's welfare expenditure collection has been reviewed and is being re-developed with the aim of publishing a report in 2010. We plan to publish the welfare indicators in a separate report early next year.

The collections managed by the AIHW continue to be improved in their national consistency, comprehensiveness and usefulness. In each chapter of this report, we have included a discussion of data gaps and areas where the data need to be improved—some improvements are soon to be realised, some still a distant vision.

Statistics can both drive and serve policy. They also provide a key resource for the community, to increase our understanding of the society we are building, to provide the evidence base we often so badly need, and so to inform debate about the options. I hope that this comprehensive compilation of information will serve both purposes well.

Dr Penny Allbon
Director

Acknowledgments

Authors and contributors to this report were:

Chapter 1: Alison Verhoeven, Fadwa Al-Yaman, Moira Hewitt

Chapter 2: Sushma Mathur, Liz Berryman, Rebecca Rodgers, Tim Beard, Rachel Aalders

Chapter 3: Ann Peut, Joanna Gilham

Chapter 4: Louise O'Rance, Cathy Hales, Garth Brigden, Kirsten Trunk

Chapter 5: Clara Jellie

Chapter 6: Melinda Petrie, Simon Arnold

Chapter 7: Sean Ackland, Felicity Murdoch, Michael Navaratnam, Lynda Carney

The editorial and publication team included: Moira Hewitt, Alison Verhoeven, Fadwa Al-Yaman, Alison Heycox, Cecilia Burke, Peter Nolan, John Steggall and Judith Abercromby.

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Symbols

$	Australian dollars, unless another country is specified
%	per cent
’000	thousands
n.a.	when used in a table: not available
n.f.d.	not further defined
. .	when used in a table: not applicable
—	when used in a table: nil or rounded to zero (including null cells)
*	when next to a numerical value in a table: estimate has a relative standard error of 25% to 50% and should be used with caution
**	when next to a numerical value in a table: estimate has a relative standard error greater than 50% and is considered too unreliable for general use

Key points—*Australia's welfare 2009*

This section presents selected findings from the report. Each chapter from 2 to 7 also begins with its own list of key points. Please refer to the index for more detail on these topics.

Children, youth and families

- Over half a million Australian children (15%) lived in jobless families in 2006.
- Almost three-in-four (72%) children aged 3–6 years not in school usually attended preschool or a preschool program in long day care in 2008. Attendance was lower in families where parents were not employed.
- Aboriginal and Torres Strait Islander children and young people continue to be disadvantaged across a number of areas—less likely to attend preschool and school, meet minimum standards for literacy and numeracy and to continue their schooling to Year 12, are over-represented in the child protection system, and are more likely to be under juvenile justice supervision.

Ageing and aged care

- The planning of the allocation of places in Australian Government programs for residential and community care is under review, with the programs continuing to grow and reflect the structural changes in the ageing population.
- Home and Community Care (HACC) continues to reach the largest number of older clients in community care.
- Deeper understanding of how clients interact with the programs and services in the aged care system is being aided by data linkage between programs. The study of pathways in aged care (PIAC study) has led to a linked dataset which enables a study into patterns and dynamics in aged care service use.

Disability and disability services

- The number of people with disability doubled between 1981 and 2003, to reach an estimated 3.9 million Australians.
- The rate of growth in the number of people with profound or severe core activity limitation, that is, people who need help with core daily activities, was even higher (173% increase). Estimated to be around 1.5 million Australians by 2010, the number of people with this high level of disability is projected to increase to almost 2.3 million by 2030—roughly equivalent to the entire population of Western Australia in 2009.
- Aboriginal and Torres Strait Islander people are more than twice as likely as non-Indigenous Australians to need help with core daily activities because of disability.
- Disability shows an uneven geographic distribution, not always linked to remoteness. Census data on capital cities show that higher levels of disability tend to be more prevalent in areas of relative economic disadvantage.

Carers and informal care

- Most informal carers are women, aged between 25 and 54 years, and live with the person for whom they care. They are the main source of assistance for most people with disability and other long-term conditions, and the aged.
- Respite care is the major service type that specifically supports carers, yet few carers report that they have used respite services. Many carers who had used respite care previously (but not recently) said that they did not need it, they preferred not to use it or that their care recipient did not want it. For some carers this may indicate a lack of appropriate respite services.
- Many carers do not find the caring role satisfying, and many experience lower health and wellbeing than non-carers as well as considerable social disadvantage. Many carers also experience financial disadvantage, which for some (and particularly female carers) is related to their reduced capacity to participate in paid work as a result of their caring responsibilities.
- Support services in the future will have to meet increased demand but may also need to adopt new approaches to service delivery (including the need to close service gaps) and support shared-care responsibilities. This includes care that is shared more widely within informal care networks, but also a stronger shared-care approach between informal carers and formal support services.

Housing and housing assistance

- Current demand for affordable housing exceeds supply and the continued decline in affordability in the private rental market may further increase the demand for social housing.
- The largest ever single investment in social housing, and a new national housing agreement, will bring about significant changes in the supply and delivery of housing assistance to low-income households.

Homelessness

- Although homelessness is widely regarded as a metropolitan issue and inner city areas do have high rates of homelessness, there are also high rates of homelessness in regional and remote areas.
- Aboriginal and Torres Strait Islander peoples are over-represented in the homeless population, particularly in the Supported Accommodation Assistance Program (SAAP). On Census night 2006, Indigenous peoples were around 2% of Australians, but were 9% of homeless people. In 2007–08, 18% of SAAP clients and 26% of accompanying children were Indigenous.
- Family homelessness is an issue of growing concern. Of homeless people in Australia on Census night 2006, over a quarter (26%) were members of homeless families with children (up 17% from 2001). Families with children received over half (51%) of the total periods of support provided by SAAP in 2007–08 (up 45% from 2001–02).

Introduction

1

The Australian Institute of Health and Welfare (AIHW) has produced a biennial report on Australia's welfare since 1993, focusing on welfare services specified in the *Australian Institute of Health and Welfare Act 1987*, that is, aged care services, child care services, child welfare services, services for people with disabilities, housing assistance, and other community services. *Australia's welfare 2009* is the ninth report in the series. It provides statistics and related information concerning these services, as well as an outline of the development of welfare-related information and statistics during the 2-year period to June 2009.

Australia's welfare is complemented by the AIHW's other flagship publication, *Australia's health*, which reports on patterns and determinants of health and illness, health across the life stages, the supply and use of health services, health expenditure, the health workforce and health sector performance.

1.1 Welfare, wellbeing and social inclusion

Previous editions of *Australia's welfare* have identified a range of definitions for the term 'welfare' and the related concept of 'wellbeing'. *Australia's welfare* has generally defined welfare in terms of services, assistance, community, need, wellbeing, self-sufficiency, self-reliance, social and economic engagement, and participation.

In *Australia's welfare 2009*, wellbeing is defined using the conceptual framework presented in Figure 1.1. Services and interventions, such as the welfare services and informal care described in this report, contribute to wellbeing and are interrelated with socioeconomic, environmental, biological, behavioural and geographic factors, and human, financial and information resources. The components of wellbeing, including healthy living (shelter and housing, and disability), autonomy and participation (economic resources, employment and labour force participation, and recreation and leisure), and social cohesion (family formation, social support and networks, and community and civic engagement) are dealt with in *Australia's welfare 2009* through chapters focusing on children, youth and families; ageing and aged care; disability and disability services; carers and informal care; housing and housing assistance; and homelessness.

Health as a component of wellbeing is the subject of *Australia's health*, the most recent edition of which was published in 2008. A similar conceptual framework was used in that report to demonstrate the complex interplay between influential factors, services and interventions, and resources.

Reflecting the Australian Government's policy commitment to social inclusion, *Australia's welfare 2009* has a particular focus on social inclusion and its counterpart, social exclusion.

The Australian Government's Social Inclusion Agenda aligns with the conceptual framework for wellbeing used in this report. The Social Inclusion Agenda confronts social and economic disadvantage in Australia to create a society in which all Australians have the opportunity to participate fully in social and economic life. In order to achieve this, all Australians should have the resources (skills and assets), opportunities and capability to:

- learn—participate in education and training
- work—participate in employment or unpaid or voluntary work including family and carer responsibilities
- engage—connect with people, use local services and participate in local cultural, civic and recreational activities
- have a voice—influence decisions that affect them.

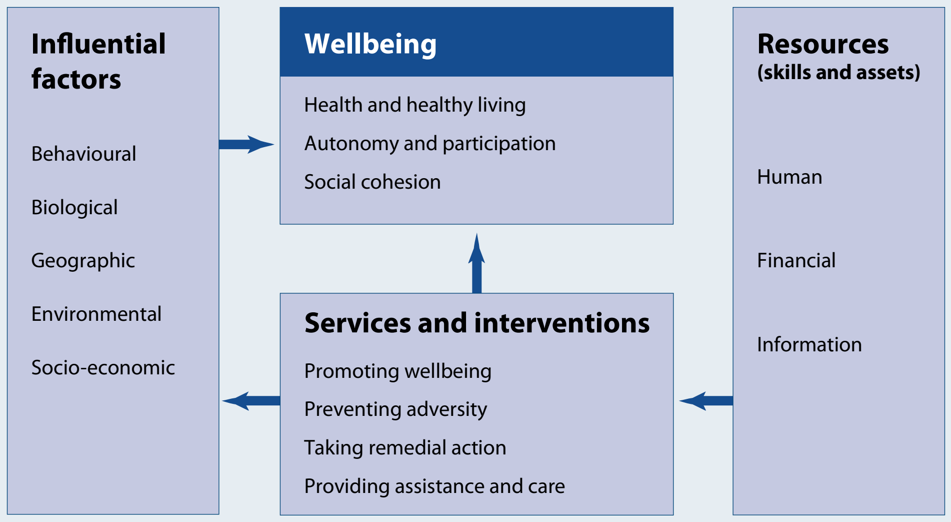


Figure 1.1: Conceptual framework for *Australia's welfare 2009*

Social exclusion is seen as arising from a mix of resource, opportunity and capability gaps that lead to a disconnection from key social, cultural, political and economic activities in society. Compared with traditional definitions of socio-economic disadvantage, the concept of social inclusion is broader and more multidimensional, and embraces a wider variety of reasons why people may be denied full participation in society. For example, social inclusion focuses not just on resources and assets but also on less tangible factors such as having a voice in decision making.

Disadvantage and social exclusion in Australia tend to be more prevalent among some population groups, which may also overlap. The most socially excluded Australians are those who experience complex and multiple forms of disadvantage relating to income, work, health, education, safety and support. Multiple disadvantage can affect individuals, families and communities.

The overarching aspirational principles of social inclusion, developed with advice from the Social Inclusion Board (Australian Government 2008), guide an inclusive approach to policy, programs and services. They include:

- reducing disadvantage
- increasing social, civil and economic participation
- giving people a greater voice, combined with greater responsibility.

These are guided by principles of approach that encourage building on individual and community strengths and partnerships with key stakeholders. These principles recognise that people experiencing, or at risk of, significant exclusion require services and interventions at particular points in the life-cycle such as transitions from childhood through adolescence to adulthood or at retirement.

In July 2009 the Government committed to developing a national statement on social inclusion by the end of 2009. It will set out a long term, whole-of-government strategy that encompasses social inclusion agenda measures. These include many that are already underway that relate to homelessness, the closing the gap agenda, the creation of jobs and skills in areas of concentrated unemployment and disadvantage.

A national compact between the Australian Government and the non-profit sector, outlining how both will work together to improve and strengthen their relationship now and into the future, is also being developed.

In the context of these developments, *Australia's welfare 2009* provides information and analysis about:

- need and demand, and associated unmet need and demand, where it can be identified
- how government welfare services and assistance contribute to individual and societal wellbeing in Australia
- the people who receive welfare services and assistance
- the distribution of welfare services and wellbeing across the population
- reforms in the provision of services that have occurred since the last report
- goals for change in the Council of Australian Governments (COAG) reform work and the Social Inclusion Agenda which will have an impact on the provision of services, their contribution to wellbeing, and how these are able to be measured and reported
- data and information gaps.

The report also considers priorities identified in the Social Inclusion Agenda that pertain to the specific areas examined in *Australia's welfare 2009,* including: the incidence and needs of children at greatest risk of long-term disadvantage and jobless families with children, the geographic distribution of programs and services, homelessness, employment for people living with a disability, and closing the gap for Indigenous Australians.

Australia's welfare 2009 also considers evidence of a social gradient and its relationship with the provision of services and interventions to promote wellbeing. The social inclusion principles refer to evidence that disadvantage can be concentrated in particular geographic locations. This is explored in detail in several areas of this report. For example, Chapter 2 notes that, compared to those in metropolitan areas, students in remote and very remote areas have a poorer record of academic achievement, which reduces their opportunities for further education and employment. Chapter 3 describes the uneven distribution of disability among older people across Australia, with the burden of disability for this age group being greatest in remote areas. The uneven geographic distribution of disability for the total population is also described, with findings presented in Chapter 4 showing that higher levels of disability tend to be more prevalent in areas of relative economic disadvantage. Chapter 7 describes patterns of homelessness across cities, regional and remote areas, and finds that while inner city areas have the highest rate of homelessness, the incidence of homelessness in regional and remote areas is also considerable.

1.2 Whose needs? How well met?

This edition of *Australia's welfare* focuses on the theme 'Whose needs? How well met?' When a person's wellbeing is compromised and they are unable to achieve a particular outcome or activity without assistance, their need may be expressed as a demand for services or assistance or it may remain unexpressed. In some cases, for example in the child protection sector, need may not be expressed but individuals may be assessed by welfare authorities as being in need of assistance. Need is subjective, and relative to individual and social expectations which may change over time.

The availability of welfare services is limited by available resources. To ensure services are allocated to those most in need and on an equitable basis, service providers may undertake an assessment process to confirm and sometimes prioritise the person's eligibility when a request for assistance is made. Once eligibility is confirmed, services are either provided and demand is met, or demand remains unmet because there is inadequate or inappropriate service provision. The relationship between need and demand is shown in Figure 1.2.

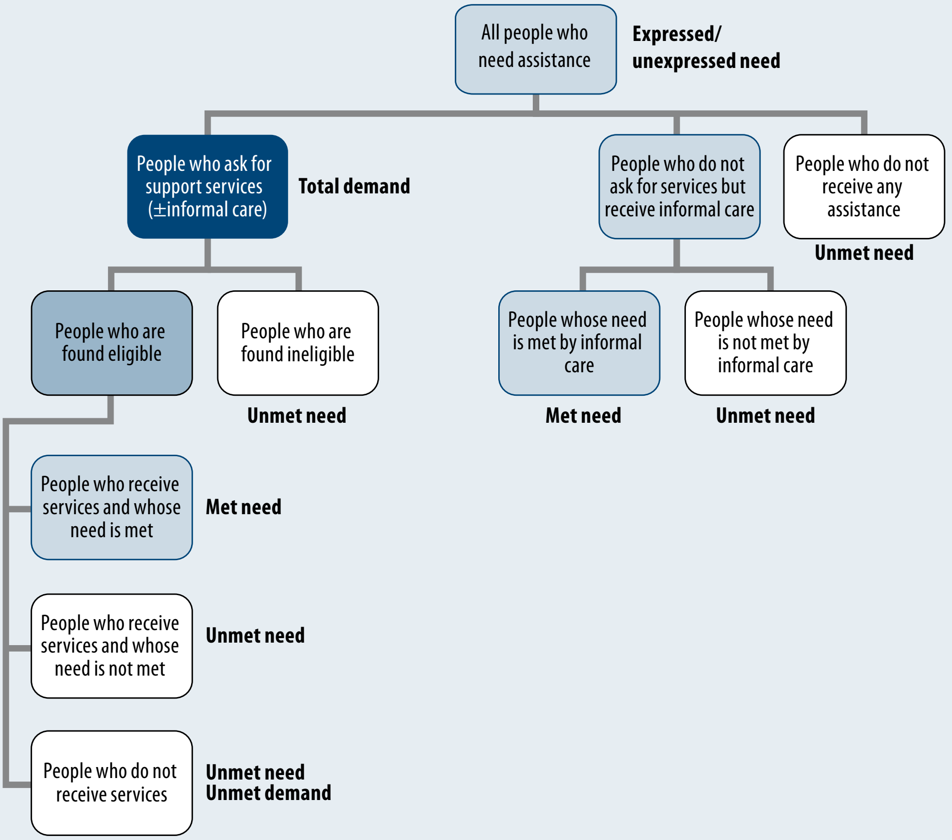


Figure 1.2: The components of need and demand

Need may also be met by informal assistance, or it may remain unmet, even where the person has been assessed as being eligible for services. An example is the waiting list system for social housing, where people are assessed as eligible but dwellings are not available.

Many people with disability or poor health rely on a mix of formal services and assistance, and the informal care provided by family, friends and neighbours. For some, the need for assistance will be met, either fully or partially, by informal care. Others will need and possibly receive both informal care and formal assistance (either government funded or privately funded). The availability of informal care is an influential factor in the total demand for formal assistance.

Obtaining a precise understanding of the level of need and demand, both met and unmet, across the various services and programs is difficult, because the availability of data is variable and data usually relate to assessed need or demand. However, where relevant data exist, *Australia's welfare 2009* attempts to describe the level of need and demand for services, identify population groups with particular needs and demands, and provide insights into how well need and demand is met.

Australia's welfare 2009 highlights areas where there is likely to be increasing demand for government services and assistance, particularly in a climate of financial and economic uncertainty. For example, Chapter 2 notes that over half a million children (15%) live in jobless families, and that these families have particular requirements for support, for example financial support.

Families with working parents may also have unmet demand for services. Access to child care is critical for many working parents with young children but one in 10 parents experiences difficulty obtaining formal child care.

It is difficult to quantify children at risk who may need child protection services. The Australian Government National Framework for Protecting Australia's Children, which includes a monitoring framework, will help to resolve this important information gap. The work underlying the framework should help to shift the focus of services for children at risk to early prevention and support services, with the aim of reducing the need for services in the longer term.

The ageing of Australia's population and the increasing rate of disability that ensues are likely to increase demand for aged care services. While aged care data give useful information about the services provided for Australia's ageing population including on the quality of care, there is a paucity of data about how well the needs of individuals are met and their associated quality of life, including for those who live in residential aged care facilities. The perspective of individuals, for example their satisfaction with government services and assistance, is also important in understanding how well needs are met.

Informal carers often provide care for older people and those with disability where there is an unmet need or no expressed demand for formal assistance and services. Informal carers play a critical role in the welfare system by providing support to people with disability and long-term health conditions that restrict their daily activity. Informal carers may also have unmet needs—while some financial assistance is available for carers, many experience economic disadvantage as a result of their carer role. While there is some evidence that carers have considerable unmet need for respite care, data gaps make it difficult for the level of unmet need to be quantified.

Housing plays a major role in the health and wellbeing of Australians, and facilitates social, community and economic participation. Unmet need for housing encompasses homelessness, a lack of conventional or adequate housing including poor dwelling conditions, overcrowded housing, a lack of affordable housing and extreme financial stress caused by unaffordable housing costs.

The challenges in housing affordability in recent years, both for renters and home buyers, have contributed to increases in the number of people experiencing homelessness, particularly in families with children, many of whom have an unmet need for assistance. Chapter 7 notes that families with children have more difficulty than people without children in securing some of the services they need to resolve their homelessness.

1.3 Australia at a glance

Almost 70% of Australia's 21.5 million people live in metropolitan areas, mostly near the coast, and concentrated in the south-east corner. Population density varies greatly across Australia, ranging from very low population density in remote areas to very high population density in some major cities. This report uses the ABS Australian Standard Geographical Classification, which classifies areas as *Major cities*, *Inner regional*, *Outer regional*, *Remote* and *Very remote*.

Life expectancy in Australia is among the highest in the world. In 2003–05, the life expectancy at birth for Australian males was 78.5 years, exceeded only by a 79-year life expectancy for males in Iceland and Hong Kong. Australian females had a life expectancy at birth of 83.3 years, exceeded only by an 85-year life expectancy for females in Japan and Hong Kong (ABS 2008a).

Like that of most developed countries, Australia's population is ageing. The median age has increased by more than 5 years over the past two decades to almost 37 years in 2008. The proportion of Australians aged 0 to 14 years has fallen from 22.4% in 1988 to 19.3% in 2008. Over the same 20-year period, the proportion of Australians aged 65 and over has risen from 10.8% to 13.3%. The working age population (15 to 64 years) has remained relatively steady over the past two decades, representing 67.5% in 2008, compared with 66.8% in 1988 (ABS 2008b).

In 2006, the estimated Indigenous population of Australia was 517,000—about 2.4% of the total population (ABS 2008c). One-quarter of the population was born overseas, with migration being the major contributor to population growth (ABS 2008d). Figure 1.3 shows the age and sex distribution of Indigenous Australian and non-Indigenous Australian populations. The age structure of the Indigenous population is much younger than that of the non-Indigenous population. This reflects both the higher mortality among Indigenous Australians in the middle adult age groups (35–54 years) and the higher birth rate among Indigenous women compared with all women (2.1 births compared with 1.9) (AIHW 2009).

About five million families were counted in the 2006 Census. Couples with dependent children, representing 37% of all families, are no longer the most common family type (down from 45% in 1986). Couple-only families also account for 37% of families, while one-parent families account for 11% (ABS 2007).

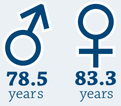
Australia at a glance

21.5 million people

Population was 21.5 million at June 2008, an increase of 0.5 million from June 2007 (ABS 2008b).

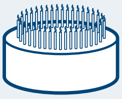
2.7 people per square kilometre

Population density was 2.7 people per square kilometre at June 2007 (ABS 2008b) but varied greatly from very low density in remote areas to very high density in inner city areas.



78.5 years (males), 83.3 years(females)—life expectancy

Life expectancy at birth in Australia is amongst the highest in the world at 78.5 years for males and 83.3 years for females (ABS 2008a).

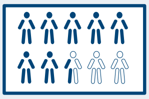


36.9 years old—median age

The median age of Australians was 36.9 years in 2008 (ABS 2008b), an increase of 5.3 years since 1988.

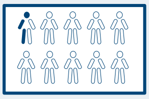
0.5 million Indigenous people

The estimated Indigenous population was 0.5 million at June 2006—about 2.4% of the total population (ABS 2008c). The age structure of the Indigenous population is younger than that of the non-Indigenous population.



75% born in Australia

Almost 75% of people living in Australia were born here. (ABS 2008a). Of people born overseas, the most common countries of birth were, in descending order, England, New Zealand, China, Italy and Vietnam (ABS 2007).



5.6% unemployment

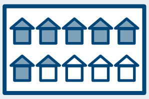
Unemployment was 5.6% in May 2009 (ABS 2009).

$1,027 weekly household income

Median gross household income was $1,027 a week and median gross family income was $1,171 in 2006 (ABS 2007).

$52,287 per capita gross domestic product

Per capita annual gross domestic product (GDP) was $52,287 with Australia ranked 10th among OECD countries in 2006 (OECD 2008).



65% of homes owner-occupied

There is a high proportion of home ownership, with almost 65% of privately occupied dwellings being purchased or owned outright (ABS 2007).

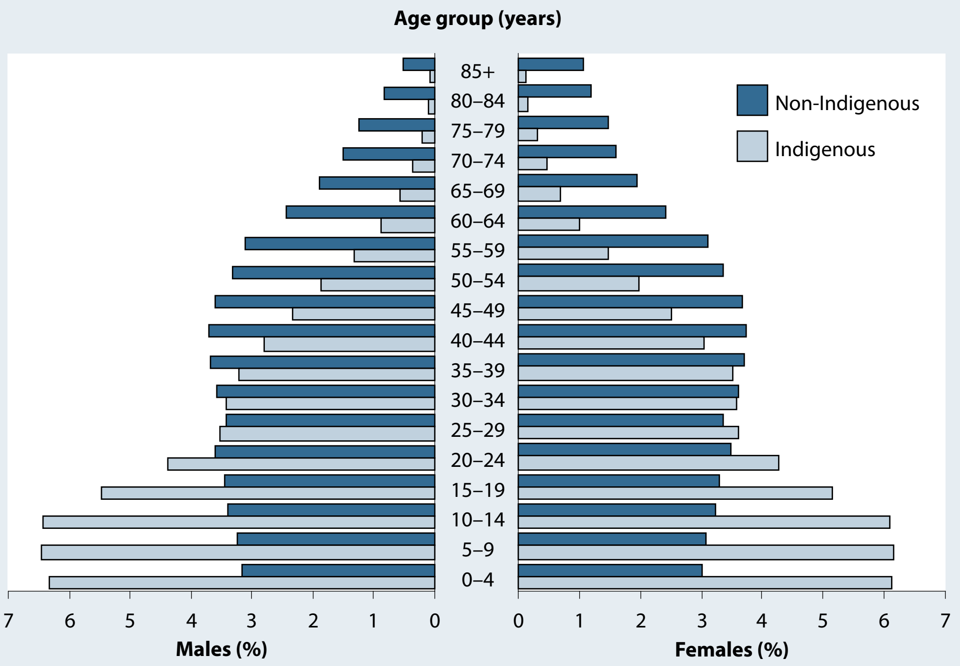


Figure 1.3: Age and sex distribution of Indigenous Australian and non-Indigenous Australian populations, 2006

The number of people with disability doubled between 1981 and 2003, to reach an estimated 3.9 million Australians (ABS 2004). By 2010, it is projected that 1.5 million people will experience severe or profound core activity limitation and will require help with core daily activities.

Care for people of all ages with disability and poor health is often delivered in the community, where informal carers play an important role. In 2003 an estimated 2.4 million informal carers provided assistance to almost 2 million people. Most carers were aged between 25 and 54 years, and were close family members of the person for whom they provided care. Females accounted for 54% of all carers and 71% of carers who were the main carer for someone with a severe or profound core activity limitation (ABS 2004).

The majority of the 7.5 million private dwellings counted in the 2006 Census were being purchased (32.2% in 2006) or were owned outright (32.6%). Rented dwellings comprised 27.2% of occupied private dwellings. Tenure type was not stated for 7.1% of dwellings, while 0.9% were recorded as ‘other tenure type’. Compared with 2001, there was a large decrease in the proportion of private dwellings that were owned outright, falling 7.1 percentage points in the 5 years to 2006. Conversely, the proportion of private occupied dwellings that were mortgaged increased by 5.7 percentage points (ABS 2007).

In 2006, the number of homeless people in Australia was estimated at 105,000. The highest numbers of homeless people were recorded in inner city areas, but some regional and remote areas, notably in northern Australia, also experienced high rates of homelessness. In 2007–08, just over 200,000 people accessed Supported Accommodation Assistance Program services, with almost 77,000 being accompanying children.

Box 1.1: Why some statistics appear dated

The most recent data available at the time of writing are used in this report. While the report is published in 2009 and includes statistics up to June 2009, many statistics refer to 2006, the date of the last Australian Census, or earlier. This is because some data, such as population-based surveys, are collected every 3 or 5 years, or even less frequently. Where more recent data have been collected, the process of preparing data, including quality assurance and publication lead times, has in some cases meant that more recent data were not available for this report.

1.4 A changing society

Through the nine editions of *Australia's welfare*, the AIHW has reported on changes in government services and programs aimed at meeting the needs of Australians in a society that has undergone significant social, economic and demographic changes over recent decades. These changes, which are key drivers of the need for services and assistance, include changed patterns of marriage and family formation, an ageing population, greater workforce participation by women, differing economic aspirations and conditions, and shifts in immigration policy. The various chapters of this report discuss some of these changed conditions, and the corresponding effects on the demand for, and provision of, government services and assistance.

Consideration is given in this report to the changing patterns of need over an individual's life course. While most children and young people in Australia experience positive life outcomes, for those who experience difficulties, key transition points at major developmental phases in life provide information that may guide the development of policy responses. The need for early prevention of disadvantage and social exclusion is informed by evidence of the potential for negative outcomes. Chapter 2 of *Australia's welfare 2009* considers the various stages in the development and learning process, from early learning and child care, through to schooling, vocational training and higher education. It notes the critical role that families play in a young person's life, and considers the impact of changes in family formation.

Changing community standards in relation to child safety and the increasing complexity of family situations are among the factors that may have contributed to the large increases in children on care and protection orders and in out-of-home care (up 37% and 32% respectively between 2005 and 2007). Greater awareness may also have led to greater measurement of the issue.

Chapter 3 of this report describes an ageing Australia. Ageing affects all aspects of life, from social and economic participation to housing, health, family relationships and work. One hundred years ago, the Age Pension was introduced to provide financial assistance to older people. It continues to be an essential component of the Australian retirement income system.

Since 2001 there has been a general increase in the proportion of older Australians who describe their health as excellent or very good (ABS 2009b). Nevertheless, rates of poor health and disability increase with age and older people experience a greater share of the burden of disease than other age groups. Dementia is the greatest single contributor to disability at older ages, responsible for more than half the burden of disease. Population ageing will continue to be an important driver of demand for health, aged care and disability support services.

During the second half of the 20th century, the typical housing life-cycle moved from renting in early adulthood, to home purchase and mortgages as partnerships were formed and children born, to outright home ownership in older age. Today, declining marriage and fertility rates, dissolution of households through separation and divorce, an ageing population, increased life expectancy and challenges in housing affordability are altering this cycle.

Adult children also remain at home longer. In the decade to 2006–07, there was a 19% increase in the number and proportion of non-dependent adult children aged 25 years or older remaining in the parental home. When they do leave home, they may rent for longer periods before purchasing. Once a home has been purchased, it may remain mortgaged for many years. Outright home ownership is increasingly deferred because of the high cost of home purchase and the wider use of housing equity to finance other lifestyle options.

Since the 2007 edition of *Australia's welfare*, there has been a significant shift in housing policy with a new national focus on measuring, monitoring and improving housing supply through the National Housing Supply Council, and strategies aimed at enhancing the supply of, and access to, secure affordable housing through a new National Housing Affordability Agreement. While the outcomes of this policy shift are yet to be measurable, *Australia's welfare 2009* describes the changed policy environment and the areas that these policies will affect.

Likewise, the new National Disability Agreement will contribute to a changing policy environment for the provision of disability services and assistance. While outcomes will not be measurable or reportable until the next biennial edition of *Australia's welfare* at the earliest, consideration is given in this report to areas and findings that are likely to be significantly affected by policy changes over the medium and long term.

1.5 Closing the gap on Indigenous disadvantage

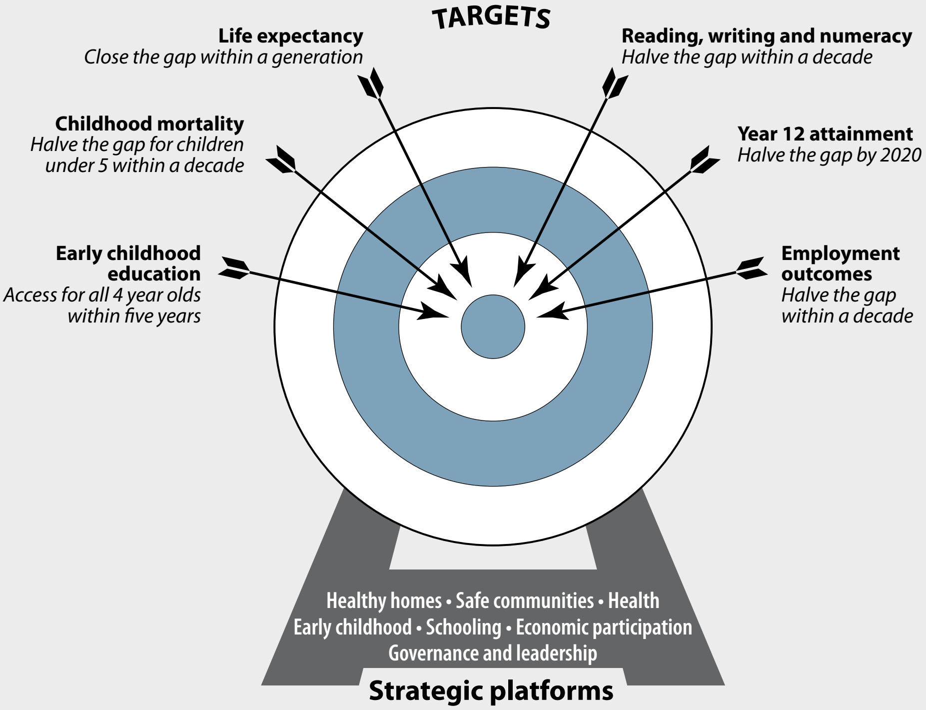
The welfare of Indigenous Australians continues to differ markedly from that of non-Indigenous Australians in many areas described in this report. For example, Aboriginal and Torres Strait Islander children and young people are less likely to meet minimum literacy and numeracy standards or continue their schooling to Year 12. They are more than 6 times as likely to be in the child protection system and 14 times as likely to be under juvenile justice supervision as non-Indigenous children and young people.

Indigenous Australians are more than twice as likely as non-Indigenous Australians to need help with core daily activities because of disability. The most marked difference between Indigenous and non-Indigenous Australians with disability is the prevalence of disability in Indigenous people aged 45–54 years. They are almost 3 times as likely to need assistance with core activities as non-Indigenous people of the same age.

Aboriginal and Torres Strait Islander people are over-represented in the homeless population, making up 10% of homeless people but only around 2.5% of the total Australian population. They are also more likely to live in overcrowded dwellings, particularly in remote areas where, in 2006, 19% of Indigenous households required two or more additional bedrooms. Around 7% of the dwellings managed by Indigenous community housing organisations, the majority located in remote areas, required replacement. A lack of secure housing, or housing that is poorly constructed and inadequately maintained, may contribute negatively to people's health and wellbeing.

The Australian Government has committed significant resources over 5 years to assist in closing the gap on Indigenous disadvantage. A set of targets and seven strategic platforms have been identified and formally adopted by COAG to tackle the current state of disadvantage (see Box 1.2).

Box 1.2: Closing the gap



The Closing the Gap initiatives and the 2009 National Indigenous Reform Agreement provide a new policy context for welfare services and assistance to Indigenous Australians. Five National Partnership Agreements support the National Indigenous Reform Agreement, providing for reform in the areas of Indigenous health (Closing the Gap in Indigenous health outcomes), Indigenous economic participation, remote Indigenous housing, Indigenous early childhood development, and remote service delivery. Each of these partnership agreements has a set of objectives and key priorities, as well as a set of expected outcomes for monitoring.

In addition, the National Health Care Agreement, the National Affordable Housing Agreement, the National Disability Agreement and the National Preventative Health Partnership Agreement will allow monitoring of Indigenous outcomes using key indicators.

Although some reform initiatives are producing immediate changes, it will not be until subsequent editions of *Australia's welfare* that broader changes will be measurable and reported. Data on Indigenous Australians are included in the relevant chapters of this report.

1.6 The evidence base for socially inclusive policy

Evidence and integrated data are used to inform policy and to provide information for the design and evaluation of welfare services and interventions. Likewise, the need for welfare services and interventions, particularly when this results in unmet need, is a critical indicator of social inclusion.

Achieving progress in social inclusion requires change in how government policies and programs are designed, developed, coordinated and delivered. The change must occur across major policy areas of government from health and education through to infrastructure, law and justice, financial services and other portfolios. It requires a greater focus on the needs of disadvantaged groups and places, on prevention and early intervention, and on the building of individual and community strengths. Adopting a whole-of-government approach, planning for sustainability, using locational approaches, developing tailored and 'joined-up' services, and monitoring and evaluating the effects of these policies and services on the wellbeing of disadvantaged groups are critical elements in achieving and measuring progress.

Using evidence and integrated data to inform policy is one of the 11 social inclusion principles outlined by the Australian Government (2008). Better information, faster learning and better use of knowledge are described as key factors in the improvement of outcomes, which should be evaluated alongside existing evaluations of processes. The measurement and evaluation of outcomes form a substantial part of the data requirements that underpin the COAG's national reform agenda, the National Indigenous Reform Agenda and agreements on health, education, housing and disability.

A range of measurement frameworks are being developed in Australia and internationally to identify the extent of social exclusion and its underlying causes. Evaluation and assessment using robust performance indicators will provide a strong evidence base to inform policy and develop new solutions.

Measurement frameworks used by agencies in the United Kingdom and Europe, such as the Joseph Rowntree Foundation, the New Policy Institute and the European Commission for Cross Country Comparison, employ a battery of objective measures of aspects of disadvantage. The battery approach has the advantage of using existing data collections, providing cost efficiencies and allowing time series to be produced. However, its reliance on existing concepts and definitions may limit data collection to what is currently feasible, rather than promoting data development to meet contemporary information requirements (Levitas et al 2007).

The European Commission has instigated the Peer Review and Assessment in Social Inclusion Program, which monitors, evaluates and promotes good practice in selected policies and institutional arrangements across its member countries.

In Australia, the Social Policy Research Centre at the University of New South Wales has developed measures of social inclusion based on indicators that relate poverty (based on income) with measures of deprivation (economic exclusion) and service exclusion. This work also measures the experience of multiple exclusions. The Melbourne Institute of Applied Economic and Social Research at the University of Melbourne uses multidimensional measures of low capabilities, functioning and wellbeing to describe poverty and disadvantage.

The social inclusion principles note that government needs to report regularly on progress in social inclusion, with several layers of disaggregation from the community level through to neighbourhoods, families and individuals. Long-term sustainable improvement in social inclusion is being built on established benchmarks and formal quantified targets that are attainable, measurable and time specific (Australian Government 2008).

There is a particular focus on geographic disaggregation in the social inclusion principles. Hayes and colleagues note that data from the Australian Bureau of Statistics (ABS) Census of Population and Housing and from AIHW administrative data sources can be used to produce estimates for small geographic areas, and to identify localities where social exclusion is prevalent (Hayes et al. 2008).

Longitudinal data are also a key component in measuring progress towards achieving social inclusion goals because of the long-term, cyclical aspects of social exclusion. Disadvantage is often the culmination of life-time experiences and is transmitted across generations. Hayes and colleagues suggest that 'because longitudinal data provide information on the sequence in which events occur, they can help in understanding the processes and experiences that lead to social exclusion and to the socially excluded becoming included' (Hayes et al. 2008).

The evidence base for socially inclusive policy development must therefore take into account the processes and interconnectedness of disadvantage. This has significant implications for the data collections that underpin policy development. In the past, data collections have been sector-specific and often based on single programs. In order to establish an effective evidence base to support research, policy development, planning and delivery of services with a socially inclusive focus, there is an increasing expectation that data will be linked across related sectors to give a more complete understanding.

Data linkage projects may also facilitate better understanding of 'joined-up' service provision, and the improvements in outcomes that may be achieved as the result of connected services. For example, linking data on aged care service provision, as described in Chapter 3 of this report, enhances the ability to report on transitions, pathways and outcomes from the service system as a whole as well as individual programs. Similar methodological approaches might be useful in measuring progress towards achieving social inclusion.

1.7 Gaps in the data

Australia's welfare 2009 identifies a range of data gaps and constraints in the topics examined that limit the ability to determine who needs welfare assistance or services, and how well their needs are being met. It examines data development activities currently underway or potentially required and makes recommendations about data development work that could address these information gaps. Many of the data gaps will need to be dealt with as a priority to help in reporting progress against the COAG reform and social inclusion agendas, and in providing an evidence base for policy development.

Early childhood education and child protection are notable areas that have significant national data gaps. The National Framework for Protecting Australia's Children will assist in identifying children at risk of multiple disadvantages. AIHW, in collaboration with the Australian Government and state and territory governments, has undertaken work to develop a draft national minimum data set for the National Child Protection Data Collection, which will help in better informing child protection policy. Similarly, initiatives such as the Australian Early Development Index, the development of nationally consistent data on early childhood education and care, and the Children's Headline Indicators are building new evidence bases on the wellbeing of children and youth to facilitate effective policy development.

At the other end of the life course, data are available to describe family and community participation for older people living in private households, but there are no data about similar social contacts for people living in residential aged care. The move from one's own home to an aged care facility may provoke a disconnection from the broader community and lead to social isolation. Conversely, for others, particularly the 27% of older people who live alone, a move to cared accommodation may expand social contact. Without data, it is difficult to gain a clear picture of this element of social inclusion for older people.

While there is an array of clinical and system indicators that help in measuring the standard and quality of aged care services, the concept of quality of life is more difficult to measure. Data development work in this area, particularly incorporating consumer perspectives, would enable a better understanding of the outcomes that contribute to maintaining or improving quality of life for older people.

Although Australia is well advanced in the measurement and monitoring of disability prevalence and the need for assistance, there are gaps in data and knowledge that are being highlighted by the move towards person-centred service provision. Much of the existing data relate to the number and amount of different types of services and the number of people who receive them. There is only limited information about whether the services offered or accessed are those needed or chosen by people with disability, and whether the services are effective in meeting people's needs. Priority work under the National Disability Agreement (NDA) will help address these gaps.

Data about carers are inconsistent and not comprehensive. Some enhancements to the primary data source (the 2009 ABS Survey of Disability, Ageing and Carers) will help deal with some data gaps. These changes include revised survey protocols to ensure better identification of primary carers, improved questions relating to unmet need, and an increased sample size to facilitate better analysis of groups of special interest, including those in remote areas.

The implementation of the National Affordable Housing Agreement, which forms part of the COAG reform agenda, has focused the reporting of progress against priority housing reform areas with the specification of associated outcomes and performance indicators. Reporting against these outcomes and performance indicators will require enhancements to existing data collections as well as the development of new data collections to provide information about the private housing market. Improving Indigenous identification, collecting unit record-level data, measuring components of need and linking records are important data development requirements.

The White Paper on Homelessness identified a need for improvements in homelessness data (FaHCSIA 2008). Chapter 7 discusses the limitations of current homelessness data, in particular the difficulties in defining what constitutes homelessness, enumerating the homeless population, identifying the various interactions that homeless people have with a range of support services, understanding how well their need for support services is met, and understanding the support required for homeless people to make the transition from homelessness to secure housing. The chapter describes some plans and options for data development in these critical areas.

The National Indigenous Reform Agreement includes key indicators to monitor progress in closing the gap on Indigenous disadvantage. Deficiencies in the quality and timeliness of existing data collections are a major challenge. The varying level of identification of Indigenous Australians in administrative data collections, by data set, by state and territory, by remoteness and over time are key barriers to the comparability of existing data sets. Survey data, on the other hand, suffer from sample sizes too limited to allow meaningful disaggregation, and sometimes are not conducted frequently enough for annual reporting.

Indigenous identification in key administrative data sets (the births, deaths, hospital, and perinatal data sets) and registers (infectious diseases notifications and surveillance system, and end-stage renal disease, diabetes and cancer registers) is improving. At a jurisdictional level, further improvement in Indigenous identification is still needed, but is particularly an issue for the south-eastern jurisdictions. It should be noted that small numbers in Tasmania and the Australian Capital Territory will always limit reporting for these jurisdictions.

The AIHW and the ABS in their respective areas of responsibility are working with the relevant government departments and ministerial councils to improve the quality and availability of existing data. Key strategies include implementing best practice guidelines to collect Indigenous information in all relevant data sets, assessing the level of under-identification in key data sets in order to adjust existing data to enhance comparability, improving the comprehensiveness of data collections, and using data linkage to enhance statistical reporting against some of the COAG targets, in particular those relating to mortality and life expectancy.

1.8 How this report is presented

Each of the chapters in this report begins with key points, summarising significant information within the chapter. There is an overview of the environment and population relevant to the particular topic, and detailed discussion of data about services and outcomes. Where available, regional and Indigenous data are disaggregated and analysed. Data gaps are identified and recommendations are made about data development needs.

Chapter 2 provides an overview of the wellbeing of children, youth and families. It discusses the substantial reforms that have occurred in the areas of early childhood development, schooling and skills training. Early intervention and prevention programs for families and children at risk are described. Information on children in the child protection system and out-of-home care, and those in the juvenile justice system is presented in this chapter. The incidence and needs of jobless and homeless families with children are also covered.

Chapter 3 reports on the provision and use of aged care services relative to the needs of older people, as well as the economic wellbeing and social inclusion of older Australians (defined as those aged 65 or over). Where possible, it compares the situation of older people in 2009 with that of 1999, the International Year of Older Persons. The chapter challenges two persistent myths about older Australians—that they are a homogenous group and that they are a burden on the community—through data that describe the diversity of the older population, and their community and civic participation.

Chapter 4 covers disability and disability services. It describes policy initiatives to support respite care and ageing carers, the National Disability Strategy, amendments to the Disability Discrimination Act, and the National Inquiry into Employment and Disability.

Chapter 5 focuses on informal care, the characteristics of carers, and the trends in levels of informal care provision as evidenced within existing community care programs for the elderly and the disabled. In particular, the chapter describes the impact that informal caring can have on the lives of carers, especially for those who provide care over the long term, and for women who frequently combine other roles with that of a carer.

Chapter 6 discusses housing and housing assistance. It reflects the contemporary national agenda by focusing on issues of supply and demand. The chapter examines the role social housing and other forms of government housing assistance play in meeting that demand. The effects and outcomes of this assistance are considered.

Chapter 7 describes program responses and service delivery to tackle homelessness, particularly those that support families and children. It includes a focus on locations where the incidence of homelessness is most significant.

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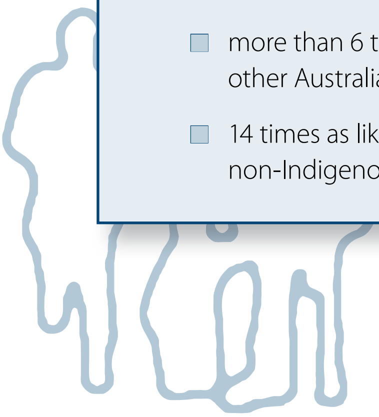
Children, youth and families

2

Key points

- Families play a vital role in ensuring that children and young people are supported as they make the transition from one stage of life to the next. A number of significant social changes have taken place in recent decades that have direct effects on families—the increasing trend in cohabitation before marriage, delaying marriage and childbirth until later in life, having smaller families, and increases in shared-care arrangements between resident and non-resident parents.
- In 2006–07 most children lived in couple families (83%) and of these, most lived in intact families (90%), with smaller numbers in blended families (6%) or step families (3%). A further 17% lived in one-parent families.
- In 2006 over half a million Australian children (15%) lived in jobless families.
- In 2008, 72% of children aged 3–6 years not in school usually attended preschool or a preschool program in long day care. Attendance was lower in families where parents were not employed. Increasing preschool attendance is a priority of the Australian Government.
- One in fourteen (7%) children not in school had a current need for formal care or preschool in 2008, and over half a million (39%) had parents who indicated a future need for formal care or preschool.
- Nine in 10 young people were engaged in either study or work in 2008, but almost one-third were doing more than a full-time load of either full-time study with additional work, or full-time work with additional study.
- Too many children are subject to violence and abuse—around 34,300 children were on care and protection orders in 2007–08, up 37% from 2005.
- Aboriginal and Torres Strait Islander children and young people continue to be disadvantaged across a number of areas. They are:
  - less likely to meet minimum standards for literacy and numeracy and to continue their schooling to Year 12
  - more than 6 times as likely to be in the child protection system than other Australian children
  - 14 times as likely to be under juvenile justice supervision as non-Indigenous young people.



2.1 Introduction

The health and wellbeing of Australia’s children and young people are at the forefront of policy making in Australia today, as it is recognised that the benefits of investing in children and young people flow through to the entire population and beyond one generation.

In recent years, the Australian Government has adopted a set of priorities and principles for children and young people that are central to its health, social inclusion and productivity agendas. Principles such as early intervention and prevention, reducing disadvantage and delivering effective support to children at greatest risk of long-term disadvantage are fundamental to promoting the health and wellbeing of all children and young people in Australia, and in promoting stronger families and safer and more connected communities (see Box 2.1 for further information on new policies).

This chapter presents a profile of Australia’s children and young people. It is broadly structured around their key stages in life, and includes the critical role that families play in a young person’s life. It also examines the poorer outcomes experienced by some children, young people and families, as well as the services they need.

While most children and young people in Australia are doing well, those who are unable to make a smooth transition may face significant difficulties and barriers in the short and long terms, and be in need of additional support. A lack of access, support or opportunities in education, for example, may have a cumulative effect on children and young people, and can affect future generations. Children from low-income families are also more likely to have lower educational attainment and a higher rate of teenage pregnancy and adult social disadvantage (Hobcraft & Kiernan 2001). Therefore, information on children and young people with poorer outcomes or those experiencing disadvantage is presented throughout the chapter where possible.

This chapter does not aim to present a picture of all children at risk of disadvantage. It instead focuses on key areas with available data related to Australian Government priorities and principles of social inclusion. Section 2.7, for example, focuses on children at greatest risk, in particular children and young people in the child protection or juvenile justice systems and those at risk of or experiencing homelessness. These children and young people may experience multiple levels of disadvantage, such as poverty, domestic violence, parental substance abuse, parental mental illness or long-term trauma.

In keeping with the theme of *Australia’s welfare 2009*, ‘Whose needs? How well met?’, this chapter presents information on the use of services, as well as the demand for services and unmet needs. However, information on unmet need for services is not always available. For example, there is no national information on the number of children who did not enrol in quality early childhood education programs or school, or the number of children who required but did not receive child protection services. Moreover, the impact of services on the outcomes for children who use them can be difficult to know in the absence of good data. Effective policies require the support of good data to track progress and inform future service delivery and planning.

Scope of the chapter

The chapter begins with a demographic profile of the 0–24 year age group, as demographic composition and change are drivers of the need for services and assistance. The characteristics and needs of families are discussed next, exploring the critical role that families play in bringing up children and young people. A primary focus of the chapter is the needs of children, young people and their families as they progress through different stages of their lives, for example, the importance of early learning and the need for child care in infancy and childhood, the need for education from early childhood to early adulthood, and the need for employment once young people leave education and training. These are covered in sections 2.4, 2.5 and 2.6. Children at greatest risk are discussed in Section 2.7, and Section 2.8 concludes the chapter with an overview of the gaps in the available data and the work being done to improve data quality and collection.

Children with disability, while not covered in this chapter, are included in Chapter 4 of this report. Health as a component of wellbeing is the subject of other Australian Institute of Health and Welfare (AIHW) publications, including *Australia's health* and *A picture of Australia's children*, and is not featured in this chapter.

Box 2.1: Broad policy frameworks for children, young people and families

At the national level, the most important policies for early childhood and family support developed in the last few years are the National Agenda for Early Childhood, the Council of Australian Government's (COAG) National Reform Agenda on Human Capital, and the Stronger Families and Communities Strategy (2004–2009). The Australian Government has worked with state and territory governments to develop a national early childhood development strategy, to provide the framework to guide the actions of government in improving child outcomes to 2020 (COAG 2009b).

The current policy environment has a strong focus on early childhood development and care, education and participation, and child protection. The Social Inclusion Agenda and the Closing the Gap on Indigenous Disadvantage initiative cover a number of these areas.

Early childhood:

- introducing a paid parental leave scheme of 18 weeks' postnatal leave for new parents, paid at the minimum national wage
- improving access to, and quality of, early childhood education programs and early learning experiences in child care, as part of a series of reforms to early childhood development through
  - improving the affordability of child care by increasing the child care tax rebate from 30% to 50%
  - establishing new early learning and care centres
  - providing universal access to early childhood education programs for all 4 year olds for 15 hours a week, for a minimum of 40 weeks a year, by 2013, with a particular focus on Indigenous 4 year olds in remote communities
  - developing a national quality standard and quality rating system
  - developing a National Early Years Learning Framework
- implementing the Australian Early Development Index nationally in 2009

(COAG 2008a; DEEWR 2009c; FaHCSIA 2009a; RCH 2009)

Education:

- developing and implementing a national curriculum in key learning areas by 2011
- lifting the Year 12 or equivalent retention rates to 90% by 2015
- expanding vocational and technical education through the creation of up to 711,000 additional training places over 5 years.

(ACARA 2009; COAG 2009a; DEEWR 2009b)

Child protection:

- implementing the National Framework for Protecting Australia's Children 2009–2020, which was endorsed by the COAG on 30 April 2009. This long-term approach to ensuring the safety and wellbeing of Australian children aims to improve coordination between governments and non-government organisations to reduce child abuse and neglect. It focuses on improving child protection through prevention, early intervention and best practice strategies (COAG 2009a).

Family Support Program:

- bringing together a number of existing family, children and parenting services that share a common interest. The program, announced in February 2009, will be implemented over 2 years. It will allow families accessing services to enter and move between services more easily (FaHCSIA 2009b).

Closing the Gap on Indigenous Disadvantage initiative:

- halving the gap in mortality rates for children under 5 within a decade
- establishing children and family centres to provide early learning, child care, and parent and family support services to Indigenous children and families. This will provide increased access to antenatal care services, sexual and reproductive health services for Indigenous teenagers, and maternal and child health services for Indigenous children and their mothers (through the National Partnership on Indigenous Early Childhood Development)
- ensuring access to early childhood education for all Indigenous 4 year olds within 5 years, including those living in remote areas
- halving the gap in reading, writing and numeracy achievements for children within a decade
- halving the gap for Year 12 attainment or equivalent by 2020
- halving the gap in employment outcomes, such as being employed and obtaining the skills to obtain and maintain employment, within a decade (COAG 2008a).

Social Inclusion Agenda:

- ensuring that all Australians are able to play a full role in all aspects of Australian life. Priorities of particular relevance to children and families include reducing the incidence and meeting the needs of jobless and homeless families with children, delivering effective support to children at greatest risk of long-term disadvantage and closing the gap in disadvantage for Indigenous children and youth (Australian Government 2008).

2.2 Australia's children and young people

This section describes Australia's child and youth population in terms of its size, composition, growth, regional distribution and cultural diversity. Understanding the size and composition of this population group, including its changing demographic trends, contributes to good policy decisions about the services required by children and young people.

There are different ways of defining 'children' and 'young people', depending on particular data collections or legal requirements. In this chapter, 'children' are generally defined as persons aged 0–14 years and 'young people' as those aged 15–24 years. However, this may vary depending on the topic and data source.

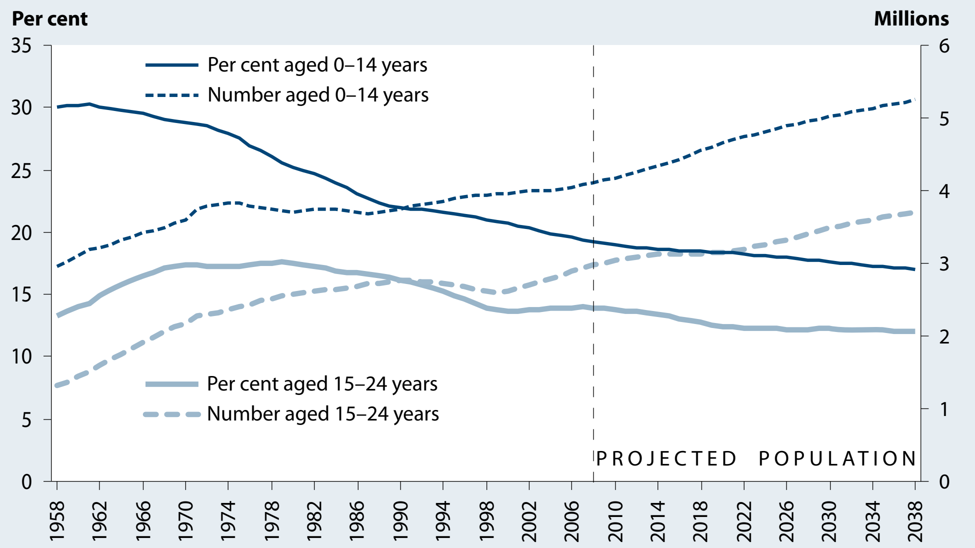
One in three Australians is under 25 years, but the proportion is falling

At 30 June 2008, children and young people accounted for one-third of the Australian population—7.1 million children and young people, of which 4.1 million (19%) were aged 0–14 years and 3 million (14%) were aged 15–24 years. Although Australia's population is ageing (see Chapter 3), the proportion of children and young people in the population is more than twice that of the population aged 65 years and over (Table P2). The number of males in the child and youth population (3.7 million) was slightly higher than the number of females (3.5 million). This is a reflection of more males being born than females (106 males born per 100 females in 2007) (ABS 2008c).

The number of children in the population is affected by fertility patterns. Australia's total fertility rate (see Glossary for definition) reached a peak of 3.5 births per woman at the height of the baby boom in 1961, but declined sharply with the introduction of the oral contraceptive pill in the early 1960s. The total fertility rate reached replacement level in 1976 of 2.1 births per woman, and gradually declined to a low of 1.7 babies per woman in 2001. Since then the total fertility rate has increased to 1.9 births per woman in 2007—the highest rate since 1981 (ABS 2008c).

Over the last four decades, the proportion of the child and youth population relative to the total Australian population has been steadily declining due to lower fertility rates and increased life expectancy. As a result, the proportion of children in the population has fallen from a peak of 30% in 1961 to 19% in 2008, and is projected to fall even further to 17% in 2038 (Figure 2.1). For young people, the proportion has similarly fallen, from a high of 18% in 1979 to 14% in 2008, and is projected to fall to 12% in 2038. Despite this, the number of children and young people in Australia is projected to continue to grow from 4.1 million to 5.2 million children and from 3.0 million to 3.7 million young people between 2008 and 2038. These demographic projections are based on a total fertility rate of 1.8.

Note: All population and appendix tables can be found online at www.aihw.gov.au and are also available on the CD accompanying the printed book.



Notes

1. Population projections (2008 onwards) are based on ABS Projection Series B. See ABS 2008a for the assumptions on which Projection Series B is based.
2. Per cent refers to the child and youth population as a proportion of the total Australian population.

Source: ABS 2008a, 2008n.

Figure 2.1: Number and proportion of children and young people in the Australian population, 1958–2038

Indigenous children and young people

In 2006, there were an estimated 194,249 Indigenous children aged 0–14 years and 99,722 Indigenous young people aged 15–24 years, accounting for 4.8% of all children and 3.5% of all young people in Australia (ABS 2008g).

The Indigenous population has a much younger age structure than the non-Indigenous population (see Figure 1.3). This reflects the higher birth rate among Indigenous women compared with all women (2.4 births per woman compared with 1.9 in 2007), as well as the shorter life expectancy among Indigenous Australians (ABS 2008c). Although Indigenous children comprise a relatively small proportion of the total Australian child population, they represent more than one-third of the Indigenous population (38%)—almost twice the proportion for non-Indigenous children (19%). For young people the differences are not as marked, but Indigenous young people still account for a higher proportion of the Indigenous population than non-Indigenous young Australians (19% compared with 14% respectively). Conversely, those aged 65 years and over comprise only 3% of the Indigenous population, compared with 13% for the non-Indigenous Australian population (see Chapter 3).

In 2006, the majority of Indigenous children and young people lived in *Major cities* and *Inner and outer regional* areas—76% or 224,845 children and young people (Table 2.1). However, Indigenous children and young people were 14 times as likely to live in *Remote* or *Very remote* areas as their non-Indigenous counterparts. Over one-third (38%) of children and young people living in *Remote and very remote* areas were Indigenous.

Over half (58%) of all Indigenous children and young people live in New South Wales or Queensland (Table P1).

Table 2.1: Distribution of Indigenous and non-Indigenous children and young people aged 0–24 years by remoteness, June 2006

	Indigenous children and youth		Non-Indigenous children and youth	
	Number	**Per cent**	**Number**	**Per cent**
Major cities	94,913	32.3	4,637,076	69.8
Inner regional	65,547	22.3	1,303,023	19.6
Outer regional	64,385	21.9	591,243	8.9
Remote	26,026	8.9	85,712	1.3
Very remote	43,100	14.7	26,483	0.4
Australia[(a)]	**293,971**	**100.0**	**6,643,537**	**100.0**

(a) Includes migratory and 'Other Territories'.

Source: ABS 2008g.

Geographical distribution of children and young people

The distribution of children and young people aged 0–24 years is similar across each of the states and the Australian Capital Territory—between 32% and 34% of the population in each jurisdiction in 2008 (Table 2.2). However, the Northern Territory has a younger population than the other jurisdictions, with children and young people comprising 39% of the Northern Territory's population. The relatively high proportion of children and young people in the Northern Territory is largely explained by the younger age profile of the Indigenous population—42% of the child and youth population in the Northern Territory were Indigenous (ABS 2008g).

Three-quarters of the child and youth population live in the three most populous states—in 2008 one-third lived in New South Wales, one-quarter in Victoria and one-fifth in Queensland (Table 2.2). In 2007, two-thirds (68%) of children and young people lived in *Major cities*, 29% lived in *Inner and outer regional* areas, and 3% lived in *Remote and very remote* areas (ABS, unpublished data). Young people were more likely to live in *Major cities* than children (71% compared with 66%), and less likely to live in *Regional and remote* areas, reflecting perhaps the greater availability of employment, education and training opportunities for young people in urban areas.

Table 2.2: Distribution of children and young people across the states and territories, June 2008

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Australia[a]
					Number				
0–14 years	1,331,854	997,501	864,548	427,853	289,920	97,119	64,155	52,299	4,125,776
15–24 years	961,318	747,553	609,133	311,050	218,471	65,301	54,326	34,289	3,001,739
0–24 years	*2,293,172*	*1,745,054*	*1,473,681*	*738,903*	*508,391*	*162,420*	*118,481*	*86,588*	*7,127,515*
All ages	6,984,172	5,313,823	4,293,915	2,171,197	1,603,361	497,529	345,551	219,818	21,431,781
					Proportion of state or territory population[b] (%)				
0–14 years	19.1	18.8	20.1	19.7	18.1	19.5	18.6	23.8	19.3
15–24 years	13.8	14.1	14.2	14.3	13.6	13.1	15.7	15.6	14.0
0–24 years	*32.8*	*32.8*	*34.3*	*34.0*	*31.7*	*32.6*	*34.3*	*39.4*	*33.3*
					Proportion of Australian population of that age group (%)				
0–14 years	32.3	24.2	21.0	10.4	7.0	2.4	1.6	1.3	100.0
15–24 years	32.0	24.9	20.3	10.4	7.3	2.2	1.8	1.1	100.0
0–24 years	*32.2*	*24.5*	*20.7*	*10.4*	*7.1*	*2.3*	*1.7*	*1.2*	*100.0*

(a) Includes 'Other Territories' comprising Jervis Bay Territory, Christmas Island and the Cocos (Keeling) Islands.

(b) The denominator is the relevant total state/territory population.

Source: ABS 2009a.

Children and young people born overseas

Australia is one of the most culturally diverse countries in the world, with one-quarter of the population born overseas. While most children and young people were born in Australia (88% or 6.2 million at 30 June 2007), around 268,400 (4%) were born in other English-speaking countries (the United Kingdom, New Zealand, the Republic of Ireland, Canada, the United States and South Africa) and over half a million (8% or 567,000) born in all other countries (ABS 2008l). However, according to the ABS Census of Population and Housing, the proportion of children and young people with one or both parents born overseas is higher—in 2006 nearly 1 in 5 (19%) dependent children and young people aged 0-24 years had both parents born overseas and a further 16% had one parent born overseas (the father for 9% and the mother for 7%) (ABS 2007a).

Between 1996 and 2006 there were substantial increases in the proportion of children and young people born in Sudan, Kenya, Afghanistan and Iraq (AIHW 2007a). These changes in migration trends, as well as Australia's diverse cultural and linguistic backgrounds, have implications for the provision of culturally sensitive and accessible services.

Refugee children and young people

The challenges in resettlement for those born overseas are perhaps greatest for those who have arrived in Australia under humanitarian programs, initially as displaced persons and more recently as refugees. While refugees face similar issues to other new migrants, they may also have particular needs distinct from other migrants in settling into Australia. Migrants have greater choice of when to leave their country and where to go, while refugees flee their country for their own safety and cannot return unless the situation that forced them to leave improves (HREOC 2003). Many young refugees may have experienced armed conflict and long periods in refugee camps, which can disrupt access to education, employment and health care. This may affect their capacity to learn a new language, develop vocational skills and gain access to well-paid work. Uncertainty about permanent residency in Australia and the anxiety of having family still living in danger may be additional burdens for refugees (Taylor & Stanovic 2005).

Australia has humanitarian and legal obligations to accept refugees, and a critical component of this is ensuring that the level of need and range of services required are appropriately met in order to facilitate a smooth and successful transition into Australian society. Many refugee young people have family and community links to help them with the challenge of settling in Australia, but this is not always the case. Research indicates that the risk of homelessness for young refugees is higher than for other young people of school age (Coventry et al. 2003). Supporting refugees is one of the priorities of the government's Social Inclusion Agenda.

At 30 June 2008, there were 31,200 children and 40,900 young people living in Australia who had arrived under the Humanitarian Program for refugees and others in refugee-like situations since 1993–94. Of these children and young people, almost one in five were Sudanese (around 13,000), while one in ten each were African (not further defined) or Iraqi (Table A2.1).

In 2007–08, approximately 6,300 children and young people arrived in Australia under the Humanitarian Program (around 3,800 children and 2,500 young people). Since 1998–99 the number of refugee children and young people ranged from a low of 4,400 in 1999–00 to a high of 8,900 in 2004–05 (Table A2.2).

At present, there are no national data available on the need or demand for services for refugee children and young people.

Children adopted from overseas

Children adopted from overseas (an intercountry adoption; see Glossary for the definition of this term) have become the dominant category of adoptions in recent years. In 2007–08, there were 270 intercountry adoptions, representing 61% of all adoptions in Australia (AIHW 2009a). The number of intercountry adoptions has fluctuated over the last 25 years (from 188 in 1982–83 to a high of 434 in 2004–05), while the total number of adoptions of all kinds has fallen considerably, from 3,072 in 1982–83 (6% intercountry) to 440 in 2007–08 (61% intercountry).

Of all children adopted from overseas since 1998–99, 25% came from South Korea, 20% from China and 14% from Ethiopia. Over the last two decades the key countries of origin for intercountry adoptions have varied, although adoptions from Asia have remained consistently high (between 62% and 88% of intercountry adoptions between 1990–91 and 2007–08). The proportion of adoptions from South and Central American countries show considerable variation and declined from a high of 26% in 1992–93 to 2% in 2007–08. The proportion of intercountry adoptions from African countries increased sharply from 1% to 15% between 1994–95 and 1997–98, and has since fluctuated between 12% and 17% (13% in 2007–08). This change was driven by a rise in children adopted from Ethiopia (AIHW2009a).

When children migrate to another country, a variety of factors influence their adaptation. Many children adopted from overseas have spent time in institutional environments, such as orphanages. In addition to adjusting to new family environments, adopted children usually need to adjust to a new cultural environment with a different language, food and customs.

2.3 Australian families

Families play a crucial role in the lives of most Australian children and young people, as they provide the environment in which children are cared for. Research has shown that children brought up in stimulating and nurturing environments have better outcomes throughout life (McCain & Mustard 2002; Zubrick et al. 2000). The relationships that children have with their family, particularly their parents, are among the most important influences on child development and psychological wellbeing (Shonkoff & Phillips 2000). The level of functioning within a family can be affected by changes in family circumstances, relationships between individual family members, the balance between parental employment and family life, and other external stressors that may affect the home environment (Silberberg 2001).

Social, economic and technological changes in society directly affect families, and Australian families have changed markedly over the last 20 years as a result. Changing social attitudes towards marriage and fertility have led to fewer Australians entering a registered marriage and, for those who do, a tendency to marry at an older age. Between 1988 and 2007 the crude marriage rate fell from 7.1 to 5.5 per 1,000 population while the median age of first marriage has increased by almost 4 years over the same period (ABS 2008k). The decline in the marriage rate is in part associated with the increase in de facto relationships, which more than doubled between 1986 and 2006, from 6% to 15% (PM&C 2008).

While there has been a general decline in marriage rates over the last two decades, divorce rates have fluctuated somewhat over this period—the crude divorce rate increased from 2.5 to 2.9 divorces per 1,000 people between 1988 and 2001 and has since declined to 2.3 in 2007. The divorce rate peaked at 4.5 divorces per 1,000 people in 1975, following the implementation of the *Family Law Act 1975* which made it easier for couples to divorce (PM&C 2008). Research suggests that relationship breakdown is more common today, partly due to the increase in de facto relationships, which are associated with a higher rate of relationship breakdown (Qu & Weston 2008).

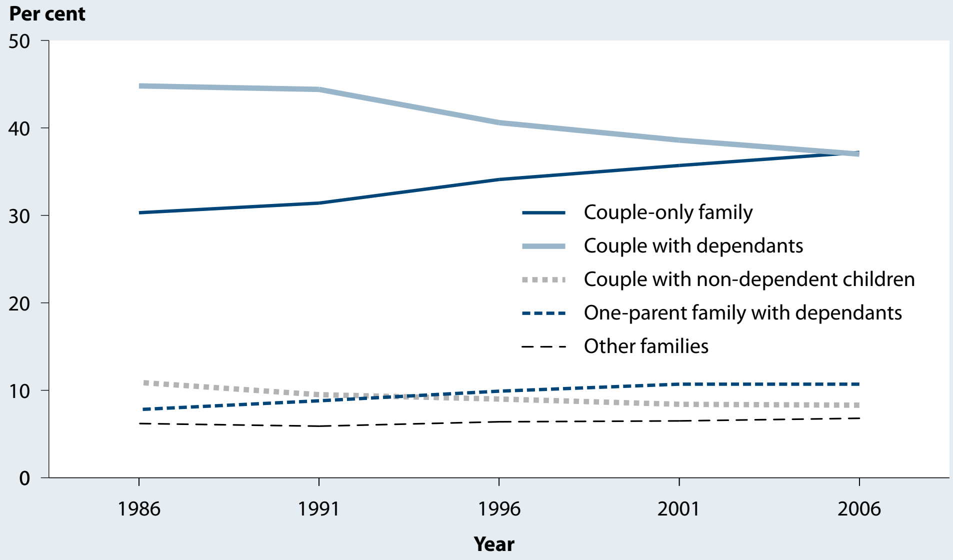
Supporting families, particularly early intervention and prevention strategies for those most in need, has positive social and economic benefits, including higher rates of employment and skill levels in mothers, better school performance, decreased welfare dependency, lower rates of criminality within families, reductions in child abuse and neglect, and a decreased need for services (Fish 2002). Priorities of the Australian Government's Social Inclusion Agenda are to address the incidence and needs of jobless families with children, and to support neighbourhoods and communities most at risk of disadvantage (Australian Government 2008).

This section describes the characteristics of Australian families in terms of composition, living arrangements and the employment patterns of parents. It also looks at household income and financial stress. Government financial assistance to support families with children is also discussed.

Families with children

The proportion of couple families with dependent children is declining

The composition of Australian families has changed over the last 20 years. Couple families with dependent children have long been the most common family type in Australia, however, their proportion has gradually declined from 45% of all families in 1986 to 37% in 2006. Coinciding with this decline has been an increase in the proportion of couple-only families, increasing from 30% to 37% of all families. This increase is partly due to population ageing, with more empty-nesters (older couples whose children have grown up and left home), but also reflects younger couples delaying having children or not having children at all (PM&C 2008). There has also been an increase in the proportion of one-parent families from 8% to 11% of all families over this period (Figure 2.2).



Note: Per cent refers to the family type as a proportion of all families in Australia.
Source: PM&C 2008.

Figure 2.2: Family composition, 1986–2006

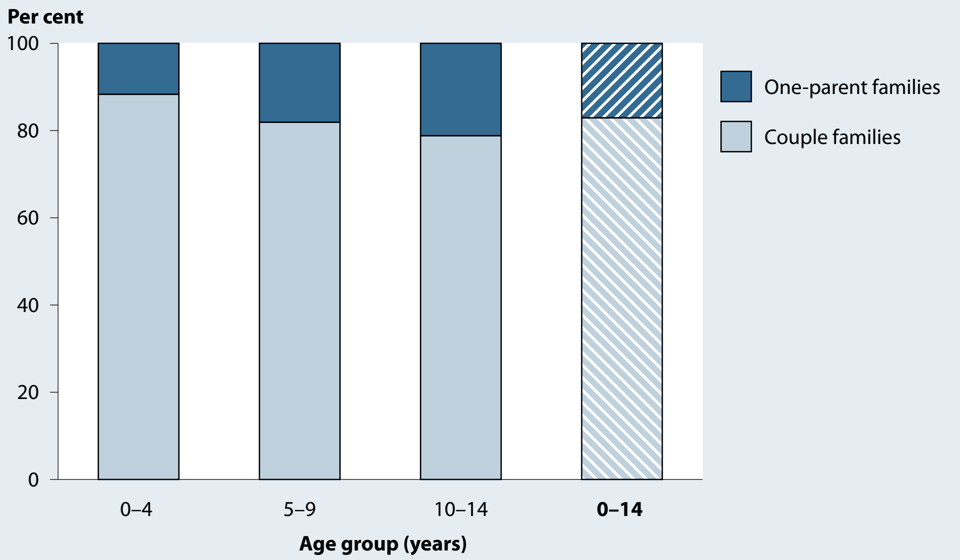
These trends in the composition of Australian families are likely to continue. By 2026, couple families without children are projected to be the most common family type and couple families with children are projected to decline as a proportion of all families. The proportion of one-parent families is projected to remain fairly stable (ABS 2004b). These changes will have implications for the provision and demand for services across the age and life spectrum.

Most children still live in intact two-parent families

Children today grow up in a variety of family types, including couple families (intact, step- or blended families), one-parent families, non-parental care, or shared-care arrangements. Most children experience a stable family environment. However, some children experience family dissolution or the re-partnering of parents while they are growing up. These children may face disruptions to family life, a change in socioeconomic status, adjustments to new parent–child and sibling relationships or changes in parenting styles and discipline (Wise 2003). Research suggests some children may encounter difficulties making these adjustments and are at an increased risk of poor mental health and overall wellbeing (Sawyer et al. 2000; Silburn et al. 1996; Vimpani et al. 2002). However, changes in family structures do not always have negative outcomes for children. Factors such as the quality of parent–child relationships, parenting style, supervision and care, and the level of family discord may affect children's vulnerability or resilience to family transitions. Children who were in a family environment of conflict or abuse may experience positive outcomes following a transition to a new family environment.

According to the ABS Family Characteristics and Transitions Survey, in 2006–07 most children aged 0–14 years (83%) lived in couple families, and of these most lived in intact families (90%), with smaller proportions living in blended families or stepfamilies (6% and 3%, respectively). Less than 1% of children in couple families lived in other arrangements, such as with grandparents or foster families. Around one in six children lived in one-parent families (17%), most (87%) of whom lived with their mother.

Of all Australian children, a higher proportion of infants and young children (0–4 years) lived in couple families (88%) compared with 5–9 and 10–14 year olds (82% and 79%, respectively). Conversely, in one-parent families a higher proportion of children were aged 10–14 years than 0–4 years (21% and 12% respectively) (Figure 2.3).



Note: Children in couple families include children of same-sex couples.

Source: ABS 2008h.

Figure 2.3: Children aged 0–14 years by family type, 2006–07

Living arrangements for Indigenous children

Living arrangements differ for Indigenous children. Indigenous households are more likely to be larger, non-nuclear and more fluid in composition than other Australian households (ABS & AIHW 2008). For example, the ABS Census of Population and Housing showed that, in 2006, 12% of Indigenous children aged 0–14 years living in family households lived in households with more than one family, compared with 3% of non-Indigenous children. Indigenous children were also less likely to be living in couple intact families (43% compared with 76%) and more likely to live in one-parent families (40% compared with 17%) than non-Indigenous children. Around 7% of Indigenous children were living with step-parents, 5% with grandparents and 4% with otherwise related adults (ABS 2009f). However, the ABS has acknowledged that the household and family structures used in the 2006 Census may not ‘always fully reflect the richness and complexity of household and family relationships relevant to the Indigenous population’ (ABS 2008m). Despite these limitations, the Census is the only national source of information on the living arrangements of Indigenous families.

Nearly 19,000 children are cared for by their grandparents

For some children, grandparents take on the role of primary carers because parents are unable to fulfil their parental responsibilities. Children living with grandparents may have been exposed to parental substance abuse, child abuse or neglect, or family violence, which can have implications for their physical, cognitive and psychosocial development. For grandparents, responsibility for caring for their grandchildren has legal, financial, lifestyle and health consequences that can adversely affect their own health and wellbeing. However, many grandparents take on this role to give their grandchildren the best chance of leading happy and healthy lives (COTA 2003).

Grandparents with day to day caring responsibilities for grandchildren can access financial assistance on the same basis as other families. As such they may be eligible for Family Tax Benefit, Parenting Payment, Child Care Benefit and for those on income support, the Grandparent Child Care Benefit (see Box 2.2 for information on these) (FaHCSIA 2009c). Grandparents whose grandchildren are placed with them through care and protection orders, where State authorities retain legal responsibility for decisions relating to the children, may also access non-taxable, non-means tested payments from respective State or Territory Governments, as well as support services assessed as necessary by the relevant child protection authority. However, grandparents with more informal care arrangements may not receive the same types or levels of support (COTA 2003).

According to the ABS Family Characteristics and Transitions Survey, in 2006–07, there were an estimated 14,000 grandparent families caring for 18,900 children aged 0–17 years (around 0.5% of all families with children and 0.4% of all children). The number of grandparent families has declined since 2003 from 22,500 to 14,000. While this decline is statistically significant the relatively large confidence intervals associated with these estimates mean that the size of this decline cannot be determined accurately (ABS 2008h; AIHW analysis of ABS 2006–07 Family Characteristics and Transitions Survey confidentialised unit record file) (for more information on this issue see AIHW 2009d).

Information on grandparent families was also collected in the 2006 ABS Census of Population and Housing for the first time. The Census is not as accurate as the ABS Family Characteristics and Transitions Survey at establishing the child–guardian connection in a household. However, bearing this limitation in mind, information from the Census indicates that children living in grandparent families were twice as likely to be living in a household with a low or very low income compared with children living with their parents. Rates of home ownership were also considerably lower among grandparents caring for children than among other older Australians. Indigenous children accounted for almost one-third of all children living with their grandparents (32%). While these children may be disadvantaged in terms of household income and housing, they may benefit culturally. A relatively high proportion of Indigenous children living with their grandparents spoke an Indigenous language at home (22%), compared with those living with a natural or adoptive family (9%) (ABS 2009f).

One in five children has a parent living elsewhere

Although most children live in intact families, some no longer live full time with both their natural parents—they may live full time with one parent or spend some time living with each parent in a shared-care arrangement.

In 2006–07, over 1 million (22%) children and young people aged 0–17 years had a natural parent—mostly fathers (82%)—living elsewhere. Of those with a natural parent living elsewhere, 43% saw their non-resident parent at least once a fortnight, but over a quarter

(28%) saw their non-resident parent less than once a year or never. Less than half (45%) of children with non-resident parents had overnight stays with their non-resident parent. This was higher for children aged 5–14 years (51%) than for younger children aged 0–4 years (33%) or older children aged 15–17 years (38%). Of those children who did have overnight stays, around three-quarters (73%) spent on average fewer than 3 nights per fortnight with their non-resident parent (ABS 2008h).

Non-resident parents are required to make a financial contribution towards the cost of raising their children through child support payments. Non-resident parents may also provide other forms of informal support. According to the ABS 2006 General Social Survey, parents with children aged 0–17 years living elsewhere commonly provided informal financial support—for example, providing or paying for clothing (46%), providing an allowance or pocket money (39%) and paying for education costs (32%) (ABS 2007b).

Over 700,000 parents provide child support for over 1.1 million children

The Child Support System has undergone substantial reforms since 1 July 2006, as a result of the *Family Law Amendment (Shared Parental Responsibility) Act 2006*, which introduced a presumption of equal shared parental responsibility, except where there is domestic violence or child abuse by one of the parents. This essentially creates an obligation for both parents to consult with each other and reach agreement on long-term issues, and recognises the benefit to the child of having a meaningful relationship with both parents (Attorney-Generals 2006). As part of these reforms, changes were made to the method used to calculate child support payments. Since 1 July 2008, the child support formula considers each parent's income more equally, payments are adjusted depending on the number and age of children, and the costs associated with children of second families are better taken into account (CSA 2009). Data presented in this section, however reflect arrangements under the previous child support system.

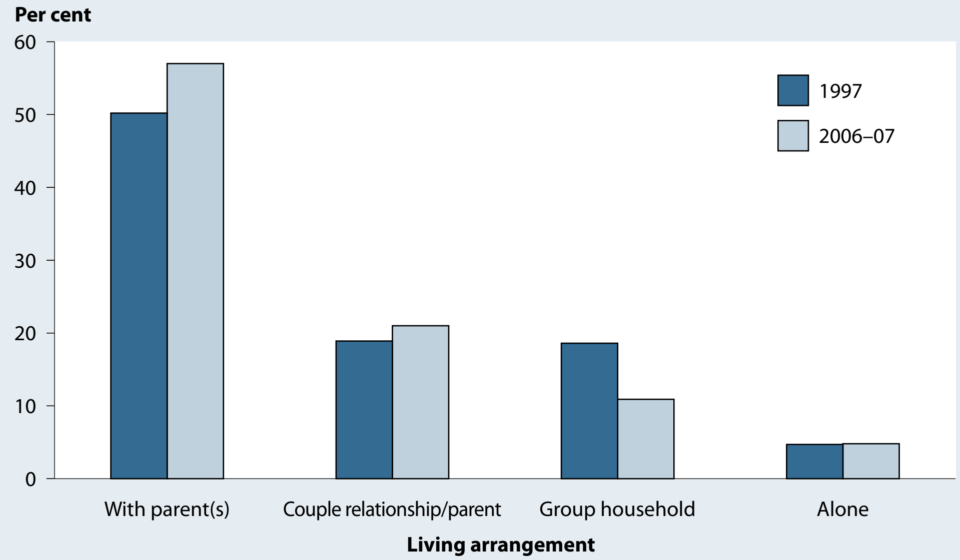
The Child Support Agency has around 1.5 million customers and transfers child support payments for more than 1.1 million children. At 30 June 2008, there were over 730,000 paying parents—an increase of around 20% since 2002. Around 61% of cases involved only one child, 29% of cases involved two children and the remaining 10% involved three or more children. In most cases the payers were male (88%), and in around 8% of cases the payers had subsequent families with dependent children for whom they were a major or principal provider of care (CSA 2002; CSA unpublished data).

At 30 June 2008, the average amount of child support payable (per case) was $4,256 per year. The amount of child support paid is calculated based on the income of both parents. The low levels of child support paid reflect the relatively low incomes of both paying and receiving parents. The median annual taxable income of payers was $38,660, around 50% higher than the median income of recipients ($25,281) (CSA unpublished data). The income of recipients does however, exclude benefits paid by Centrelink to the resident carer.

Living arrangements of young adults

Many young adults undergo a number of life transitions that affect their living arrangements. In 2006–07, over half of young adults aged 18–24 years were living with one or both parents (57% or 1.1 million young adults), one in five (21% or 412,000) were themselves parents or partners in a family, 11% were living in group households and 5% lived alone (Figure 2.4). Young men were more likely to live with their parents than young women (62% compared with 51%).

Between 1997 and 2006–07 there was an increase in the proportion of young adults living with one or both parents from 50% to 57%. A trend towards staying in education for longer, delayed marriage and parenthood, and the rising cost of housing may explain this increase. Coinciding with this increase has been a decline in the proportion of young adults living in group households.



Note: Only selected household relationships are presented, so percentages will not equal 100.

Sources: ABS 2004a; ABS 2006–07 Family Characteristics and Transitions Survey confidentialised unit record file.

Figure 2.4: Living arrangements of young adults aged 18–24 years, 1997 and 2006–07

For many young adults, moving out of the parental home is an important transition. According to the 2006–07 ABS Family Characteristics and Transitions Survey, just over half of young adults aged 18–24 years (an estimated 53%, or around 1 million people) had moved out of the parental home at some stage, with the proportion slightly higher for females than males (55% compared with 51%). Of those aged 18–24 years who had moved out at some stage, females were more likely to have done so before turning 18 (39% of females compared with 28% of males).

Independence and study were the most common reasons given by 18–24 year olds for first moving out (28% and 23%, respectively). Males were more likely to cite employment as the main reason for moving out, while females were more likely to cite family conflict, to live with their partner or to get married. The most common living arrangements after first moving out were group households (for 45% of males and 35% of females), or living with a partner as part of a couple (for 15% of males and 31% of females). Nearly two in five young people who had moved out returned to the parental home at least once, and this was similar for both males and females (ABS 2006–07 Family Characteristics and Transitions Survey confidentialised unit record file).

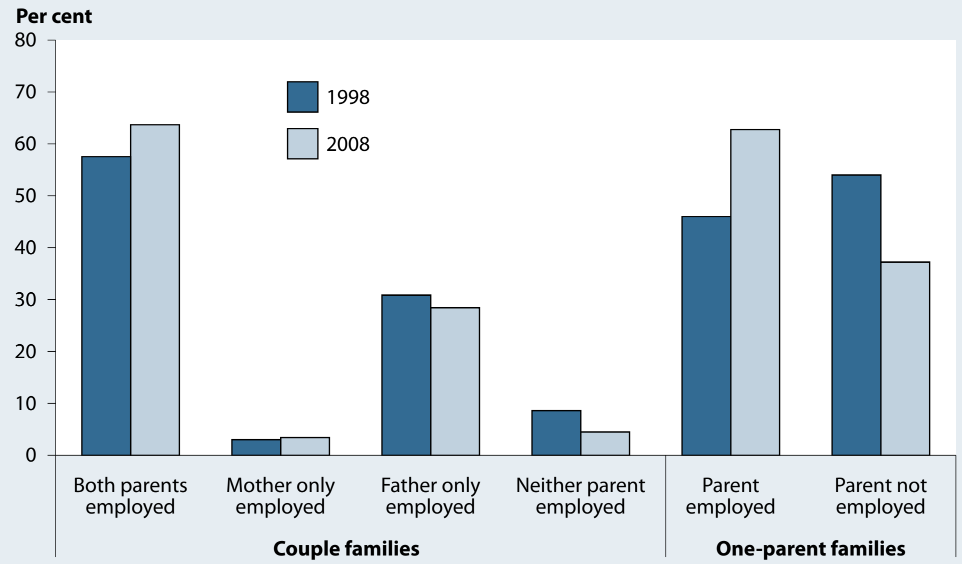
For the 47% or 900,000 young adults aged 18–24 years who had not moved out of home, the most common reason given for remaining at home was financial (41%), followed by the convenience or enjoyment of living at home (36%) (ABS 2008h).

Employment patterns of parents

Parents' employment patterns have a significant impact on the financial wellbeing of the family. Parental employment increases the economic resources available to families and protects against social exclusion and inter-generational disadvantage, as well as providing a positive role model for children in terms of work ethics and social responsibility.

Results from Wave 2.5 of Growing up in Australia: the Longitudinal Study of Australian Children showed that most working mothers of children aged 7–8 years agreed that having work and family responsibilities gave their life more variety (80%) and improved their competency (67%), and over half (57%) felt that working had a positive effect on their children (AIFS 2008). Labour force participation by parents nevertheless carries challenges in terms of balancing work and family responsibilities. Just under one-third (29%) of working mothers perceived their family time as less enjoyable and more pressured due to their work responsibilities (AIFS 2008). Despite the challenges associated with paid work, children of parents who are not working are at greater risk of economic disadvantage.

Between 1998 and 2008 the proportion of all families with dependent children aged 0–24 years that had at least one parent employed increased from 82% to 88%, according to ABS Labour Force surveys. This increase was greater among one-parent families (from 46% to 63%) than among couple families with at least one parent employed (91% to 96%). Despite this increase, employment rates were still lower among one-parent families—in 2008 around two-thirds (63%) of lone parents were employed. In 2008 the most common working arrangement for couple families with children were both parents employed (64%), with a further 28% having the traditional 'male breadwinner' arrangement (Figure 2.5).



Note: Includes children aged under 15 years, and young people aged 15–24 years who are full-time students.

Source: ABS 2009e.

Figure 2.5: Employment status of parents with dependent children aged 0–24 years by family type, June 1998 and June 2008

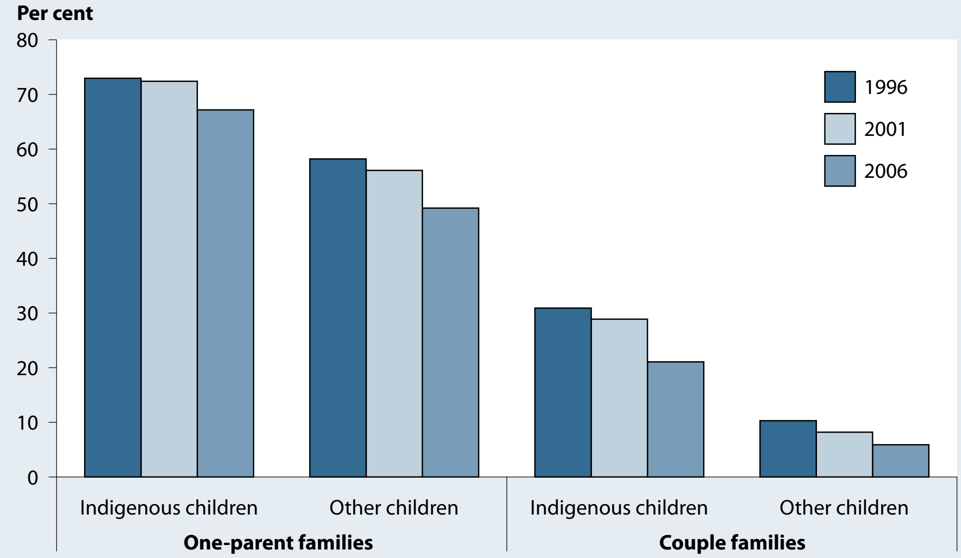
Motherhood and family responsibilities are major factors influencing the employment patterns of women of child-bearing age. In 2008 similar proportions of mothers in couple and one-parent families were working full time when their youngest child was aged 4 years or under (16% and 14% respectively). The proportion of mothers with children aged 0–14 years working full time increased slightly over the last decade (from 22% to 26%), reflecting in part the greater availability of child care and outside-school-hours care (ABS 2009e).

Over half a million children are living in jobless families

Secure employment provides financial stability, self-confidence and social contact for parents, with positive effects flowing on to their children. Conversely, members of households where no-one is employed report worse physical and mental health and lower life satisfaction than members of households where someone is employed (Headey & Verick 2006). Jobless families are disproportionately likely to be reliant on welfare, have low incomes and experience financial stress, and parental unemployment may also create tension and hostility in relationships and reduce warmth and supportiveness in the home (Shonkoff & Phillips 2000). Studies on the effects of unemployment on other family members have identified relationships between parental joblessness and family conflict, family breakdown and child abuse (McClelland 2000).

According to the ABS Census of Population and Housing, in 2006, 15% of all children aged 0–14 years (543,600) lived in jobless families, with the proportion substantially higher for children in one-parent families (52%) (Figure 2.6). Longitudinal data from the Household Income and Labour Dynamics survey suggests that joblessness is more persistent for one-parent households, compared with couple households where joblessness is usually transient or short term. In 2001–03, around half (50%) of children in lone-mother households were jobless each year, and 30% were jobless for 3 years running. Nearly three-quarters (73%) of jobless households for 3 years running were one-parent households (Headey & Verick 2006). This is perhaps not surprising given that lone parents do not have a co-resident parent available to care for their children while they work. Children living in one-parent jobless families, may have however, an employed parent living elsewhere who provides social and financial support (PM&C 2008).

Between 1996 and 2006, the proportion of children living in jobless families declined from 19% to 15%. Indigenous children fare worse than other children in terms of living in jobless families—45% of Indigenous children aged 0–14 years (67,600) compared to 14% (476,000) of other children (ABS 2006 Census, unpublished data). However, as for other children, there has been a decline in the proportion of Indigenous children living without an employed parent (Figure 2.6).



Sources: ABS 1996, 2001 and 2006 Census of Population and Housing, unpublished data.

Figure 2.6: Children aged 0–14 years living in jobless families by family type and Indigenous status, 1996–2006

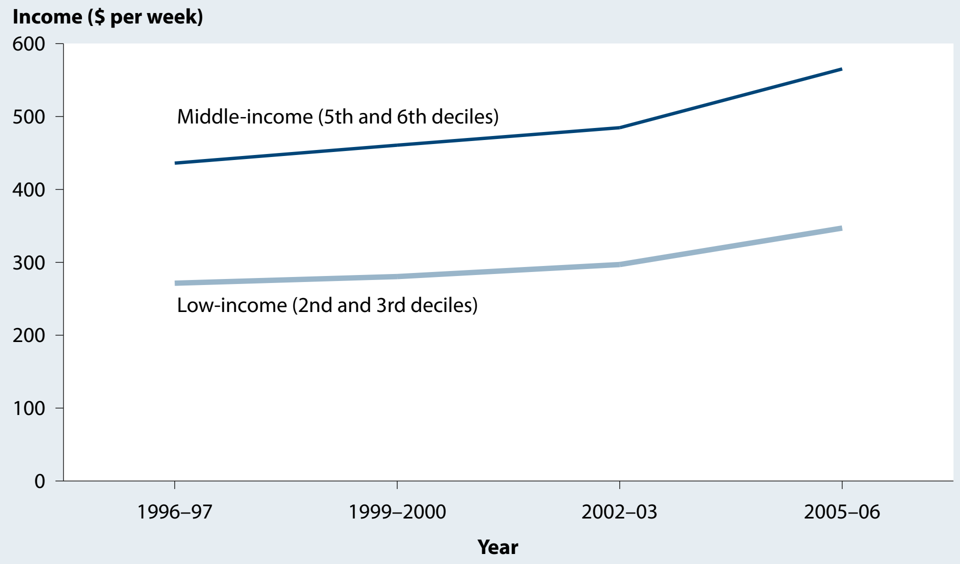
Family income and financial stress

For most families, regular income is the single most important determinant of their economic situation. Research has shown that children from low-income families may be more likely to have psychological or social difficulties, behavioural problems, lower self-regulation and elevated physiological markers of stress (Barnett 2008). Economically disadvantaged children risk being excluded from activities that other children take for granted, which can adversely affect their health, education and self-esteem as well as their social interactions with other children.

Income is usually received by individuals but shared among family members. In this section, family income is presented using a household's equivalised income (see Glossary for definition), which takes into account the size and structure of the household.

In 2005–06, there were an estimated 421,300 low-income households with children aged 0–12 years, with an average disposable income of $347 a week. Weekly disposable income for these households was on average $218 a week less than medium-income households with children (Figure 2.7). Between 1996–97 and 2005–06 the average income of low-income households with children aged 0–12 years increased in real terms by 28%. This was slightly less than the increase recorded by middle-income households (30%).

Income is not the only economic resource available to households. Households with higher levels of wealth can use these assets to support a higher standard of living. Outright ownership of a dwelling, for example, can substantially reduce living costs. There is a relationship between low income and low total economic resources for families with children, many of whom live in private rental and public housing. This is particularly the case for children living in one-parent families. One-parent families are more likely than couple families with dependent children to rely on a government pension or allowance as their principal source of household income (51% compared with 7% in 2005–06) and have far fewer assets (mean total assets of $280,300 compared with $845,500). As a result, one-parent families had a mean household net worth of $227,800, compared with $667,300 for couple families with dependent children in 2005–06 (ABS 2007c).



Notes

1. The low-income group is defined as the 20% of the population in the second and third income deciles—the population has been ranked in terms of income from lowest to highest into ten equal sized groups. The lowest (first) decile is not used because household income in this decile is not always a good indicator of the total economic resources available to many people with incomes close to nil or negative.
2. Data for all years are expressed in 2005–06 dollars.

Source: ABS surveys of Income and Housing, unpublished data.

Figure 2.7: Mean equivalised disposable income for households with children aged 0–12 years, 1996–97 to 2005–06

Low-income families are far more likely to experience financial stress

Financial stress is not limited to households with low incomes, nor does being on a low income necessarily imply that a person experiences financial stress. However, people in lower household income quintiles are more likely to report a range of financial stressors. According to the ABS 2006 General Social Survey, around half (49%) of households with children aged 0–14 years in the lowest income quintile (see Glossary for definition) reported at least one cash flow problem in the previous year, almost half (47%) reported being unable to raise $2,000 within a week for something important, and more than a quarter (28%) took at least one dissaving action (such as reducing home loan repayments, drawing on savings, increasing the amount owing on credit cards, taking out a loan or borrowing money from family or friends, or selling assets) in the previous year. This compares with just 5%, 3% and 12% for those in the highest income quintile (Table A2.3).

One-parent families with children aged 0–14 years were more likely to experience financial stress than couple families with children—half (50%) of one-parent families had experienced at least one cash flow problem in the previous year, 42% reported they could not raise $2,000 within a week for something important, and one-third (34%) took at least one dissaving action in the previous year. These proportions were much lower among couple families with children at 19%, 12%, and 22% respectively (Table A2.3).

Costs of raising children can be high

Having sufficient economic resources to meet the costs of raising children is crucial to the wellbeing of families. However, there is no fixed or absolute cost of raising a child. Research suggests that the costs of raising children increase with household income and tend to increase as children get older, especially if they attend private school and go on to university. Estimated costs have also been shown to be greater for the first child and less for each subsequent child (Henman 2005).

Different methods have been used to measure the costs of raising children in Australia. Some cost estimates are expenditure- or behaviour-based estimates based on the expenditure patterns of Australian households. The National Centre for Social and Economic Modelling, for example, in 2007 estimated the cost of raising two children to 21 years for a typical middle-income family to be $537,000 or 23% of household income. This estimate was lower for low-income families ($303,000), and much higher for high-income families ($759,000) (AMP & NATSEM 2007). Other cost estimates use a 'budget' standards approach. This involves identifying the goods and services needed to achieve a certain standard of living. This method produces cost estimates based on what is needed to be spent on children to meet community standards, rather than what is actually spent (Henman 2005). Based on a budget standards approach, a University of Queensland study estimated the cost of raising one child from birth to age 18 at between $128,200 and $187,200 (for low income earners on a low-cost budget) to between $236,100 and $306,200 (middle-income earners on a modest but adequate budget) (Henman 2009).

Another method questions the traditional basis for measuring the costs of children to their parents and instead compares the net wealth of couples with and without children over a 4-year period. This results in an estimated cost of raising a child to be as low as $1,300 a year (Dockery 2009).

Financial assistance for families

The Australian Government provides support for families in the form of family assistance payments and income support payments (see Box 2.2 for information on these). Family assistance is designed to help families with the costs of raising children, with higher assistance targeted to families with low incomes. The Australian Government has made a number of changes to family assistance payments in 2008–09 to target assistance where it is needed most, and to improve the administration and delivery of payments.

Box 2.2: Family assistance payments

Family Tax Benefit Part A is paid to low- and middle-income families with dependent children under 21 years and/or dependent full-time students aged 21–24 years. It is paid for each dependent child in the family and is subject to an income test.

Family Tax Benefit Part B provides extra assistance to one-parent families and families with one main income with dependent children under 16 years, or 16–18 years studying full-time. An additional income test was introduced in July 2008 so the benefit is now only available to families where the principal earner does not exceed $150,000 per year. Previously the benefit was income tested only on the lower earner's income.

Baby Bonus is a payment to help with the extra costs of a new baby or adopted child. Since January 2009 the payment has been delivered in 13 fortnightly instalments. A family income test was introduced at that time, so the bonus is now only available to families with a combined adjusted taxable income of $75,000 or less in the 6 months following the birth or adoption of a child. Eligibility was also extended to parents who adopt children under 16 years of age. Previously the bonus was a lump sum payment that was not means tested, and was only paid for new babies and adopted children under 2 years of age. Similar payments have previously been known as the Maternity Allowance and Maternity Payment.

Maternity Immunisation Allowance has been paid as two payments since January 2009. The first payment is for children who have received the immunisations recommended for an 18 month old and the second for children who have received the immunisations recommended for a four year old. Previously the allowance was a single payment for children immunised to the level recommended for an 18 month old.

Child care The Australian Government has increased the amount parents can claim for out-of-pocket expenses through the Child Care Benefit and Child Care Tax Rebate:

- **Child Care Benefit** is a payment to help with the cost of approved or registered care and is dependent on family income, the number of children in care, the number of hours per week and the type of care used. It is either provided as a fee reduction at the time of purchasing services, or as a quarterly lump sum payment. Since July 2008 there has no longer been a minimum rate of Child Care Benefit. The rate now reduces until the family's rate is zero. The family income level at which the payment ceases is dependent on the number of children using approved child care in the family.
- **Child Care Tax Rebate** is a payment to help working families with the cost of child care. To be eligible a family must have used approved child care, been eligible for the Child Care Benefit and have worked at some time during the financial year. For 2008–09 the Child Care Tax Rebate covers 50% of out-of-pocket child care expenses for approved child care, with a rebate of up to $7,500 per child per year, paid quarterly. Previously the rebate was 30% of out-of- pocket expenses, capped at $4,354 per child and paid annually.
- **Grandparent Child Care Benefit** helps grandparents who are the primary carers for their grandchildren and receive an income support payment. It pays the full cost of child care fees for up to 50 hours a week.
- **Jobs, Education and Training Child Care Fee Assistance** is additional funding to encourage parents on income support to enter or re-enter the workforce through the use of subsidised child care places.

- **Special Child Care Benefit** can pay up to the full cost of child care for a limited time, where there is a child at risk of abuse or neglect, or a family has an exceptional case of short-term financial hardship that has reduced their capacity to pay child care fees.

Paid parental leave A paid parental leave scheme will be introduced for children born or adopted after 1 January 2011 for new parents who are the primary carers of a child and have worked for at least 10 of the 13 months before the birth of their child. They will be entitled to 18 weeks postnatal leave at the minimum national wage. New mothers not eligible for paid parental leave will continue to receive, if eligible, current types of family assistance (including the Baby Bonus). Families electing to participate in the scheme will not receive the Baby Bonus.

Parenting Payment is a payment made only to the primary caregiver of a child, such as a parent, grandparent or foster carer. Single caregivers with at least one child under 8 years or couples with a child under 6 years are eligible for the payment provided they pass an income and asset test.

Sources: Centrelink 2009; FaHCSIA 2008b; Family Assistance Office 2009.

In 2007–08 over 1.7 million families received Family Tax Benefit Part A and 1.4 million received Family Tax Benefit Part B (Table 2.3; see Box 2.2 for payment details). While the number of families receiving Family Tax Benefit Part A has shown a general decline over the last 3 years, the number of Family Tax Benefit Part B recipients has fluctuated. There were more one-parent families receiving the maximum rate of Family Tax Benefit Part B (588,000 one-parent families) than couple families (328,000) in 2007–08. There were also 443,000 couple families receiving a reduced rate of Family Tax Benefit Part B in 2007–08. These figures do not include families that received the payment through the tax system, however in recent years the majority (90%) of families received the payments fortnightly, and are therefore included in the above figures (FaHCSIA 2007, 2008a).

Between 2005 and 2008, the number of recipients of the Maternity Immunisation Allowance increased by 30%, from 200,300 to 260,000. The use of legislated financial immunisation incentives, such as the Maternity Immunisation Allowance, and the Child Care Benefit appears to have had a positive effect on immunisation uptake (Lawrence et al. 2004). In September 2008, immunisation coverage for 1, 2 and 6 year olds was 91%, 93% and 88% respectively. While immunisation coverage between September 2005 and 2008 was stable for 1 and 2 year olds, at around 91% and 92%, it has increased for 6 year olds by 5% (Australian Childhood Immunisation Register, unpublished data).

In 2008, almost half a million families were receiving the Parenting Payment (single or partnered), with the number of families receiving this payment declining by 17% for single Parenting Payment and 21% for partnered Parenting Payment since 2006. These declines coincide with the introduction of Welfare to Work reforms starting on 1 July 2006.

The cost of child care can be a source of financial stress for families with young children (PM&C 2008) (see Section 2.4). However, according to the ABS September 2008 consumer price index, net child care costs for households fell by 23% compared with the previous quarter. This occurred in the quarter after the Child Care Tax Rebate was increased from 30% to 50% of out-of-pocket child care costs (ABS 2008d). Since 2003 the number of families receiving the Child Care Benefit, a payment to help with the cost of approved or registered care, has increased by 14%, from 697,900 to 798,100 in 2008 (Table 2.3).

Table 2.3: Number of families receiving family assistance, 2003–2008 ('000)

Type of payment	2003	2004	2005	2006	2007	2008
Family Tax Benefit Part A(a)	1,783.3	1,807.7	1,828.3	1,811.8	1,769.0	1,734.0
Family Tax Benefit Part B(a)	1,223.6	1,205.6	1,396.5	1,372.7	1,376.9	1,359.0
Maternity Allowance(b)(c)	207.0	209.2	22.3	. .	. .	. .
Baby Bonus(b)(c)			235.4	268.8	286.8	285.0
Maternity Immunisation Allowance(b)	203.9	203.7	200.3	223.1	242.5	260.0
Parenting Payment (single)(d)	437.0	449.3	449.0	433.4	395.5	360.6
Parenting Payment (partnered)(d)	181.4	177.2	167.0	159.7	144.4	125.9
Child Care Benefit(b)	697.9	704 .0	725.0	734.6	749.5	798.1
Child Care Tax Rebate(b)(e)	. .	. .	. .	. .	604.4	455.0(f)

(a) The number of families who received fortnightly payments as at 30 June.

(b) The number of families who received a payment during the financial year (1 July to 30 June).

(c) The Maternity Allowance was replaced with the Maternity Payment from 1 July 2004, which in turn became the Baby Bonus from 1 July 2007. The Baby Bonus figures for 2005 and 2006 represent the Maternity Payment.

(d) The number of families who received a payment in June.

(e) Before 2006–07, the Child Care Tax Rebate was paid by the Australian Taxation Office.

(f) Number of reconciled customers as at 30 November 2008 (that is, data are not available for the full calendar year).

Sources: AIHW 2007a; DEEWR 2008b; DEEWR unpublished data; FaHCSIA 2007, 2008a.

The Australian Government also makes payments such as ABSTUDY and Youth Allowance directly to some young people. Youth Allowance is the most frequently paid of these, and is usually a payment for young people aged 16–24 years who are full-time students or apprentices, or those under 21 years looking for work (Centrelink 2009). In May 2009, around 348,000 young people received Youth Allowance. The majority of recipients were full-time students (76%), a small proportion (1%) were apprentices and 23% were classified as 'other' recipients—this includes those looking for work, undertaking other approved activities or who were exempted from activity test requirements (DEEWR 2009a).

2.4 Early childhood and school entry

The importance of the early years in laying the foundations for future health and wellbeing is well recognised. Child development and experiences early in life determine the biological pathways that affect cognition, behaviour, capacity to learn, memory, and physical and mental health throughout life (Mustard 2006). The early years are a period of rapid brain development, and the provision of a stable, nurturing environment provides a strong base for early learning. It has been shown that children benefit from play-based learning, and that this is most effective when educators take part, stimulating children's thinking and enriching their experiences. Literacy and numeracy concepts can also be introduced in this way, which may improve children's transition to school (Edwards et al. 2008).

The term 'early childhood education and care' is used to refer to the interwoven nature of education and care in early childhood (OECD 2006). In recent years, the focus of early childhood policies has shifted from child care as a service industry to one with an education focus, reflecting the importance of early childhood education and care in enhancing learning and development outcomes for children. High-quality early childhood education and care has been shown to be a particularly effective intervention for children from socio-economically disadvantaged backgrounds, and reduces school drop-out, welfare dependency, unemployment, and future social problems such as crime and teenage pregnancies (Gorey 2001; Heckman & Masterov 2004; Vinson 2009).

Early childhood development is one of the priorities of the Australian Government. The key elements of the early childhood education commitments are set out in Box 2.3. In July 2009 the COAG endorsed *Investing in the early years—a national early childhood development strategy*, which provides a framework to guide the actions of governments to improve child outcomes to 2020. It aims to build a better coordinated and more effective early childhood development system (COAG 2009b). High quality and integrated early childhood education and care services are seen as critical to increasing the proportion of children entering school with the basic skills for life and learning (COAG 2006).

This section examines early learning and the use of formal child care and preschool services. It also discusses issues around the need for formal care and preschool, and affordability. Formal care is regulated care away from a child's home and includes long day care, family day care, outside-school-hours care, occasional and other formal care (ABS 2009c) (see Glossary for definitions of these types of care). Preschool is a planned education and developmental program for children in the year (or sometimes 2 years) before they begin full-time primary education, with the program planned and delivered by a university qualified early childhood teacher.

Box 2.3: The Council of Australian Governments' Early Childhood Education Initiatives

Under the National Partnership Agreement on Early Childhood Education, the COAG has committed to:

- providing universal access to quality early childhood education programs for all children by 2013, delivered by a university qualified early childhood teacher, for 15 hours a week, for a minimum of 40 weeks a year, in the year before formal schooling
- ensuring all Indigenous 4 year olds have access to quality early childhood education within 5 years, including those living in remote areas
- developing a National Quality Framework—including national quality standards for child care and preschool, and a rating system
- delivering early childhood education programs in a range of settings including child care, in order to meet the needs of working parents
- professionalising the early learning and care workforce, through increasing the number of early childhood teachers and carers through training, and retaining a professional early childhood education and care workforce.

Sources: COAG 2008b; DEEWR 2009c.

Informal early learning

Learning and development in the early years may take place in informal settings such as the home, and more formal settings such as playgroups, child care centres and preschools. Informal learning takes place in everyday life, is often unstructured and occurs in non-institutionalised settings (ABS 2009c). According to the ABS Childhood Education and

Care survey, in 2008, most children aged 0–2 years (92%) were involved in an informal learning activity with their parents in the survey reference week—80% were read to or told a story, 79% participated in musical activities, 70% played games or watched TV, videos or DVDs with their parents and nearly a quarter attended a playgroup (23%). However, nearly 1 in 10 children (8%) did none of these activities with their parents (ABS 2009c).

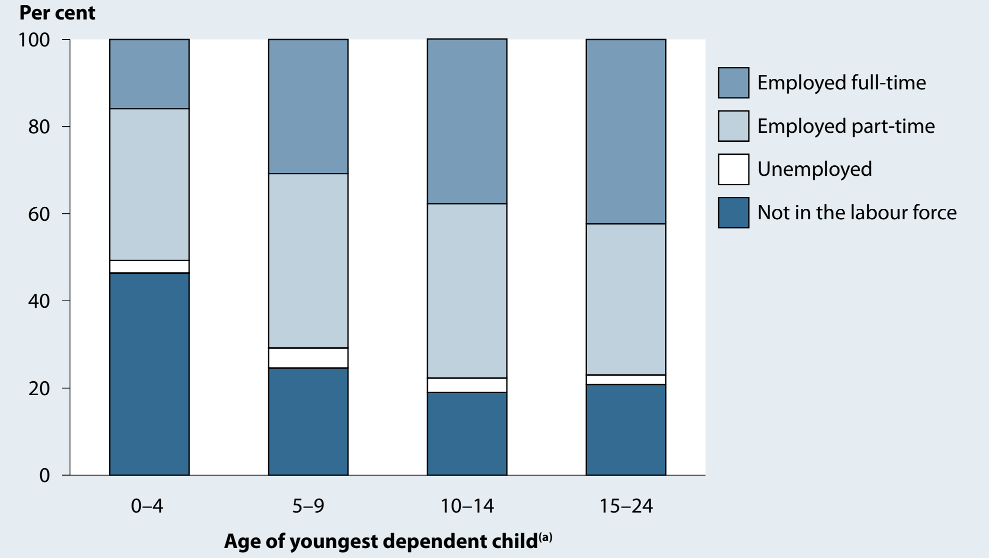
Children aged 0–2 years in families with at least one employed parent, were more likely (93%) to have parental involvement in a learning activity than those without an employed parent (86%). For example, 83% of children with an employed parent(s) were read a book or told a story compared with 68% of children without an employed parent (ABS 2009c).

Shared book reading contributes to the development of literacy skills and is important for eventual success in reading (Huebner & Meltzoff 2005). The frequency of reading sessions is an important factor in language development. In 2008, half (51%) of all children aged 0–2 years were read to or told a story every day, however one in five (20%) were not read to or told a story in the survey reference week. Children in couple families were more likely to be engaged in a reading activity every day (52%) than children in one-parent families (40%), while children in one-parent families were more likely to be read to on 1–3 days per week (20% compared with 14%) or not at all (24% compared with 19%) (ABS 2009c).

Formal care and preschool as transition points

The first major transition in life for an increasing number of Australian children is their entry into formal care or preschool. Parents may use formal child care and preschool services for a variety of reasons—to enter or re-enter the workforce, to pursue study, for personal reasons, or for perceived benefits for the child, for example to help them prepare for school. In 2008, the parents of nearly two-thirds of children not attending school gave work-related reasons as the main reason for using formal care (61%), nearly a quarter considered it beneficial for their child (24%), and 14% used it for personal reasons (ABS 2009c).

The working patterns of parents, particularly mothers, are influenced by the age of the youngest child in the family. According to ABS Labour Force surveys, while the proportion of mothers who work full time increases as the age of the youngest child increases, part-time work is still the most common form of employment for women until the youngest child reaches the 15–24 year age group. In June 2008, just under half (46%) of women whose youngest child was aged 0–4 years were not in the labour force. This proportion decreases to 22% for women whose youngest child was of school age (5 years and above) (Figure 2.8).



(a) Includes children aged under 15 years, and young people aged 15–24 years who are full-time students.

Source: ABS 2009e.

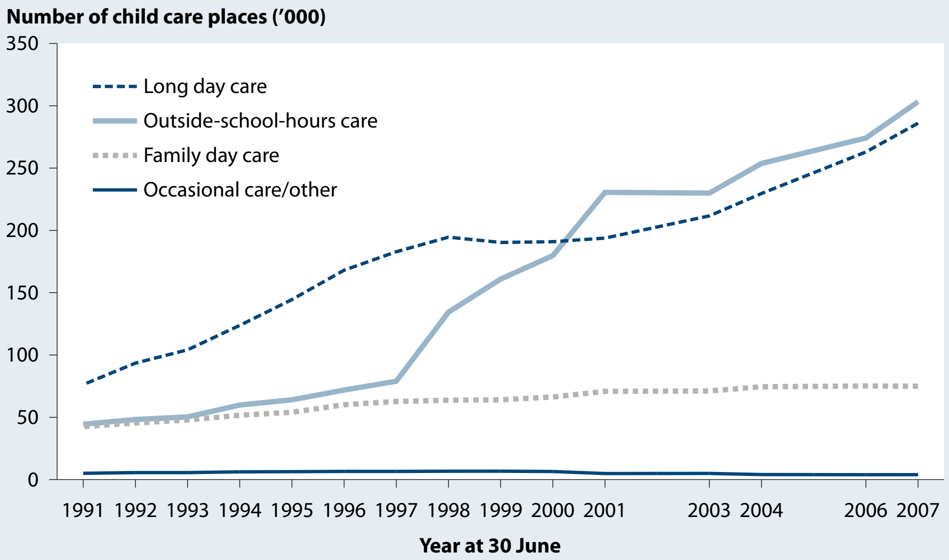
Figure 2.8: Employment status of mothers by age of youngest dependent child, June 2008

Government-supported child care places

A major social change of the past 30 years was the introduction and expansion of child care services. The Australian Government first entered the child care field in 1972 with the introduction of the *Child Care Act*. Child care services developed slowly throughout the 1970s and early 1980s, but have expanded rapidly over the last two decades, partly in response to the increasing labour force participation among women with young children.

At 30 June 2008, there were 713,200 Australian Government-supported child care places and 760,800 children aged 0–12 years using these places—54% used long day care centres, 22% outside school hours care, and 10% family day care (DEEWR unpublished data; SCRGSP 2009). The number of children using child care services is different to the number of places available, as multiple children are able to use a single place over the course of a week if they do not require full-time care and one child might use two places—for example one in before-school care and one in after-school care.

The number of government-supported child care places increased rapidly between 1991 and 2007. According to the Department of Education, Employment and Workplace Relations (DEEWR) administrative data, the number of child care places increased from around 168,300 to 665,900 over this period, with places for outside school hours care increasing nearly sevenfold and places at long-day care centres increasing nearly fourfold (Figure 2.9).



Note: No data were available for 2002 and 2005.

Sources: AIHW 2007a; DEEWR unpublished data.

Figure 2.9: Australian Government-supported child care places, 1991–2007

Formal early learning programs

The substantial and positive effects of quality early childhood education and care on children's social and cognitive development are well established, and attendance at an early childhood education program has been endorsed by the Ministerial Councils for Health, Community Services and Disability, and Education as a Headline Indicator priority area for children's health, development and wellbeing.

There is, however, currently no national data that measures the quality of early childhood education and care, due to difficulties in identifying and measuring the essential elements of high quality education and care. The Australian Government is developing a national quality framework for early childhood education and care to examine this issue (see Box 2.3). The development of a national early childhood education and care information agreement to underpin progress towards national data is also underway.

It is also difficult to estimate the number of children participating in early childhood education programs delivered by a university qualified teacher in the years before formal schooling. This is due to the varied nature of children's services across Australia and differences in data collections and methodologies across the states and territories. Data collections may vary in respect to their scope, collection methodology, timeframes and the type of data collected.

The ABS 2008 Childhood Education and Care survey collected information on children attending early childhood education programs across Australia. One aim of the survey was to improve identification of children attending early childhood education programs—particularly in long day care settings. Data from this survey are based on information reported by parents or guardians and not the centre a child attended. The survey did not collect information on whether the program a child attended was a quality program delivered by a university qualified teacher, as this was not seen as a question parents could necessarily answer. This may lead to differences in attendance counts compared with those derived from administrative data sources.

Most children attend preschool programs

Participation in formal early childhood education programs usually occurs in the year before children start school. Programs are generally for 4 year olds, although they may be open to 3 year olds in some jurisdictions and may also include 5 or 6 year olds depending on when they start school. Most Australian children access formal early childhood education programs through attendance at preschool or a preschool program in long day care. However, not all long day care centres offer a preschool program—in 2006 around half (48%) of all Australian Government-approved and supported long day care centres offered access to a preschool program (either in-house or at another location), and less than one-third (29%) of 4 year olds attending long day care centres participated in a preschool program in long day care (DEEWR 2008a; DEEWR unpublished data).

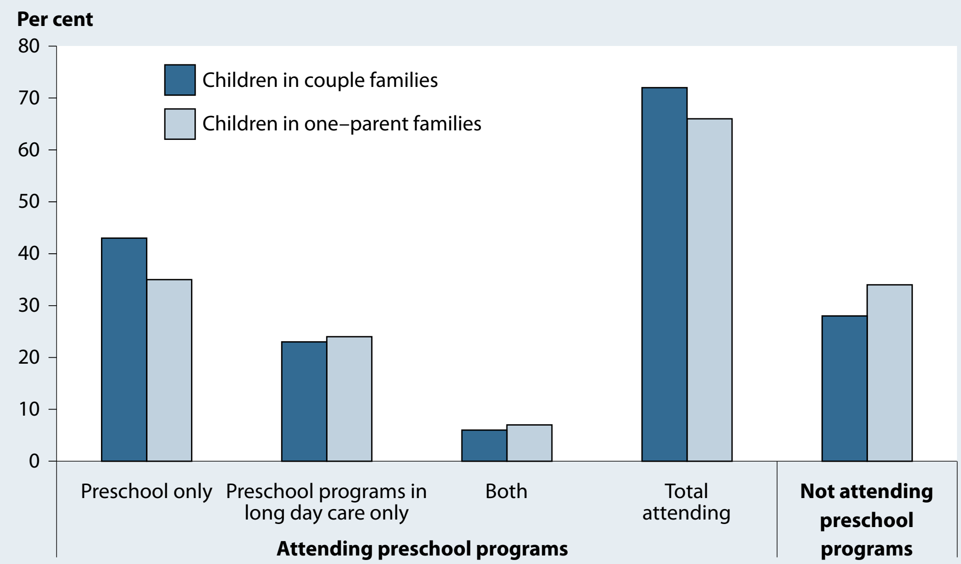
There are different ways of measuring preschool program attendance, for example retrospectively for children who are now attending primary school, or currently for children who have not yet started school. The ABS 2008 Childhood Education and Care survey collects information on preschool program attendance in both ways. It found that in June 2008, of the 1 million children aged 4–8 years attending school, 82% had attended a preschool or preschool program in long day care in the year prior to school (ABS 2009c). It also found that an estimated 395,000 (72%) of children aged 3–6 years not yet in school usually attended preschool or a preschool program in long day care (Figure 2.10). Not surprisingly, the attendance rate was higher for 4 and 5 year olds not attending school (85% and 92% respectively) than for 3 year olds (57%). Of those children aged 3–6 years not in school who usually attended preschool programs, most (59%) attended preschool only, around one-third (32%) a preschool program through long day care only, and almost one in ten (9%) both preschool and a preschool program in long day care.

Just over one quarter of children aged 3–6 years not in school (28%) did not attend preschool or a preschool program—8% attended long day care only and 21% did not attend either preschool or long day care. The proportion not attending preschool or a preschool program was considerably lower for 4 year olds (15%) than 3 year olds (43%) (ABS 2009c; ABS unpublished data).

Preschool program attendance is lower for children in one-parent and jobless families

Children aged 3–6 years in couple families were more likely to usually attend a preschool program than children in one-parent families (72% compared to 66%). This is driven by the higher proportion of children in couple families attending preschool only (43% compared with 35% in one-parent families). Similar proportions of children in couple and one-parent families attended a preschool program in long day care only (around 23%) (Figure 2.10).

Preschool program attendance was lowest for children in families where parents were unemployed—in couple families with both parents unemployed or just one parent employed part time, just over half (57%) of children usually attended a preschool program, while in unemployed one-parent families the proportion was 61% (ABS 2009c).



Source: ABS 2009c.

Figure 2.10: Usual attendance at preschool programs by family type, for children aged 3–6 years not at school, June 2008

Children in one parent families living in *Outer regional* and *remote* areas combined, were more likely to usually attend a preschool program (78%) than those living in *Major cities* (66%) or *Inner regional* areas (64%). This was not the case for children living in couple families however, where usual attendance was highest in *Major cities and Inner regional* areas (around 72%). The survey excludes families living in very remote areas, so does not provide a full picture of children accessing programs in very remote Australia.

Preschool program participation for Indigenous children

Increasing access to preschool programs for Indigenous 4 year olds, including those living in remote areas is a priority of the Closing the Gap on Indigenous disadvantage initiative. It is difficult however, to get reliable estimates on the proportion of Indigenous children attending preschool in the year prior to school. The main national data sources on Indigenous children accessing preschool are the ABS Census of Population and Housing, and the DEEWR National Preschool Census. The ABS Census collects preschool information based on a single question, so would not produce estimates as reliable as a survey focusing on early childhood education. However, Indigenous estimates are not available from the ABS 2008 Childhood Education and Care survey.

According to parental reported data on Census night, in 2006, half (5,400) of Indigenous 4 year olds attended preschool, compared to almost two-thirds (64% or 141,300) of non-Indigenous 4 year olds (ABS 2008m). For both Indigenous and non-Indigenous 4 year olds, preschool attendance was lower in very remote areas—34% of Indigenous children in *Very remote* areas attended preschool compared with 57% in *Major cities*, the corresponding proportions for non-Indigenous children were 53% and 66%, respectively. For children living in very remote communities, access to preschools may be limited by the availability of a service in the area, the distance to the nearest preschool or a lack of transport options.

The National Preschool Census provides information on Indigenous enrolments in preschool. In 2007, there were 9,627 Indigenous children enrolled in preschool programs in Australia. Of these, most were aged 4 years (6,264 or 65% of Indigenous children enrolled), but nearly a quarter were 3 years or under (22%) and a smaller proportion were aged 5 years or over (13%). Indigenous 4 year olds represented 5% of all 4 year old preschool enrolments and this has increased by 13% since 2004 (DEEWR 2008d).

Need for formal care and preschool

Access to affordable, high-quality child care services is a major concern for both parents and governments. Current trends in labour force participation, particularly among women, suggest there may be an expanding need for formal child care and preschool services. Assessing the level of need for child care services, and reasons for this need are important factors in service provision planning.

The ABS 2008 Childhood Education and Care survey collected information on the perceived need for formal care and preschool services, by asking parents whether any or additional formal care or preschool was required now or in the future. According to parents, in June 2008 over half (54%) of all children not attending school did not require any or additional formal care or preschool, either now or in the future. Over half a million (542,000 or 39%) children not attending school required formal care or preschool in the future only, 74,000 (5%) currently required formal care or preschool, and 17,000 (1%) required it currently and in the future. Of the children currently requiring formal care or preschool, 43% needed long day care, 40% preschool and 17% occasional or family day care. The proportion of children with a current need was higher for those not attending school (7%) than for those attending school (2%) (ABS 2009c).

Of those children not attending school with a current need for formal care or preschool, 45% required 1 day or less, 43% required 2 or 3 days, and 11% required 4 or 5 days of formal care or preschool. Over half (52%) of children with a current need for formal care or preschool would attend a service if it became available in the next 4 weeks. Around 17% would not attend a service if it became available, due to the cost of the care.

Child care and preschool affordability

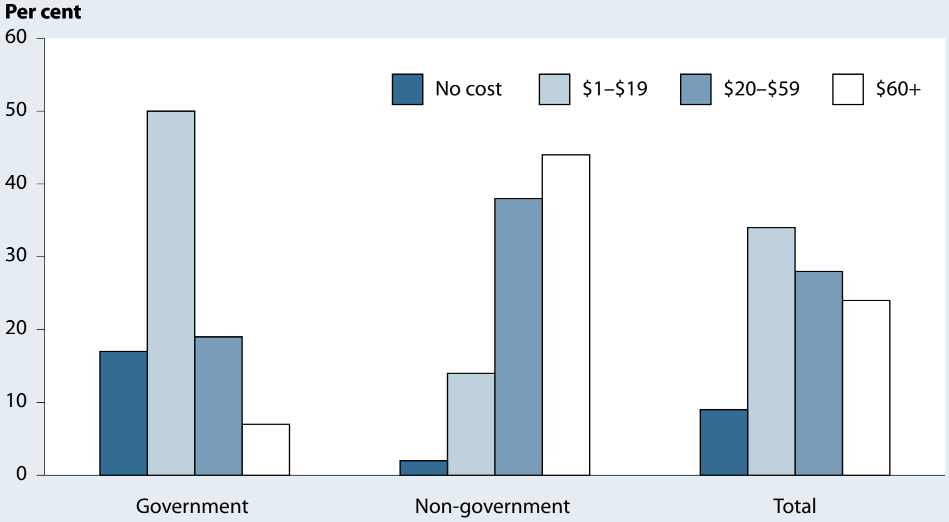
The cost of child care may be a source of financial stress for families with young children. Changes in the level of government funding and assistance to families influence the affordability of child care services. In recent years the Australian Government has provided additional support to families in meeting the costs of child care by increasing the amount they can claim for their out-of-pocket expenses through the Child Care Benefit and Child Care Tax Rebate. Families can now also have their Child Care Tax Rebate paid quarterly, rather than annually to provide more timely assistance. According to the ABS September 2008 Consumer Price Index, in the quarter after the Child Care Tax Rebate was increased from 30% to 50% of out-of-pocket child care costs, net child care costs for households fell by 23% compared to the previous quarter (ABS 2008d). This suggests that recent policy initiatives have provided additional assistance with the cost of child care for working families.

In June 2008, the median weekly out-of-pocket costs (after Child Care Benefit and the 30% Child Care Tax Rebate) of formal care for families with children aged 0–12 years was $35, according to the ABS Childhood Education and Care survey. The median cost of care was highest for children attending long day care ($53) and family day care ($25) (ABS 2009c).

However, for one in six families, the usual weekly cost of formal care was between $60 and $99, and for one in five families the cost was $100 or more.

For children aged 3–6 years who usually attended preschool (excluding preschool programs in long day care centres), nearly one in ten had no cost associated with their attendance. Around one-third had a usual weekly cost of between $1–$19, and just over one-quarter each a cost of $20–$59 or $60 or more (Figure 2.11). Costs were higher for children attending non-government preschools than government preschools—82% of children attending non-government preschools had costs of $20 or more per week compared to 26% for government preschools. This reflects that state-provided or funded preschools are generally cheaper than non-government preschools. It may also partly reflect differences in hours of attendance. Children usually attending non-government preschools were more likely to attend preschool for 15 or more hours per week than those attending government preschools (34% and 11% respectively). Children usually attending preschool in NSW were much more likely to have a cost of $60 or more per week (49%) than children in other jurisdictions, although they were also more likely to attend preschool for 15 hours per week or more (33% compared to 23% for all children) (ABS 2009c).

Children usually attending preschool in *Major cities* were also more likely to have costs of $60 or more (31%) than children in other regions combined (13%). Again, this difference may relate to the type and hours of preschool attended. Children in *Major cities* were more likely to attend preschool for 15 hours or more a week (28%) than children in other regions combined (13%).



Note: The usual weekly cost of preschool does not include costs for children attending preschool programs in long day care.

Source: ABS 2009c.

Figure 2.11: Weekly cost of preschool by type of preschool attended, for children aged 3–6 years not at school who usually attend preschool, June 2008

2.5 Education

A young person's learning and development is integral to their overall health and wellbeing as well as their future productivity and contribution to society. The importance of early childhood education and starting school 'ready to learn' has been well established (Duncan et al. 2007). In the long term, learning is essential to securing a job, and participating in and connecting with the wider community. There is a link between intergenerational poverty and educational attainment—inadequate education and training is a common factor in Australia's most disadvantaged communities and may increase their risk of social exclusion (Vinson et al. 2007).

Primary school provides the first compulsory educational experience for Australian children. Children in Australia are required to attend school from age 6 to 15 or 16 years, depending on the state or territory of attendance. Further schooling beyond these years is optional. Compulsory schooling ensures children receive a minimum amount of schooling in which they can acquire the essential knowledge and skills that will allow them to participate fully and productively in the community. Successful educational outcomes during the primary school years and beyond are affected by a number of factors, including successful transition to primary school, school attendance and the successful acquisition of literacy and numeracy skills.

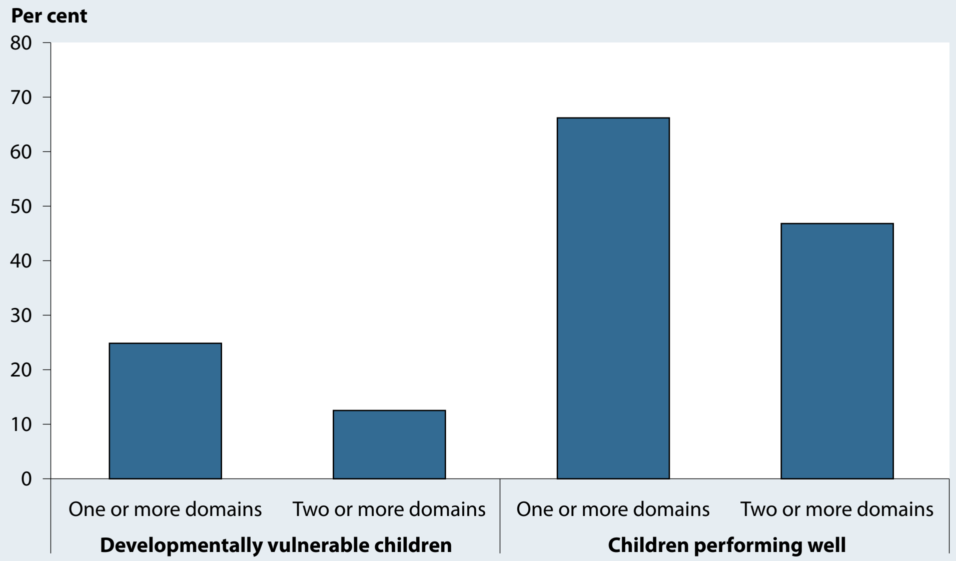
This section presents an overview of student achievement at different points in their education. This includes the transition to primary school, attendance at primary school, literacy and numeracy outcomes, retention to year 12 and school completion, and participation in further education. It also looks at young people's transition from education to employment.

Transition to primary school

Children entering school with basic skills for life and learning are more likely to experience a successful transition to primary school. Schooling transition issues relate to emotional competence, capacity for engagement with others and resilience in meeting the demands of schooling. Children who make a successful transition to school have higher levels of social competence and academic achievement compared with those who experience difficulty making this transition (Farrar et al. 2007). Transition to primary school has been endorsed by the Ministerial Councils for Health, Community Services and Disability, and Education as a Headline Indicator priority area for children's health, development and wellbeing.

There is currently no nationally consistent system for assessing children's readiness for a successful transition to school. However, the Australian Government has committed to the national implementation of the Australian Early Development Index (AEDI), starting in 2009. The COAG has also endorsed the AEDI as a national progress measure of early childhood development in Australia. The AEDI—a population measure of children's development, collects information on five developmental domains at school entry: physical health and wellbeing, social competence, emotional maturity, language and cognitive skills, and communication skills and general knowledge.

Between 2004 and 2007 the AEDI was implemented in 60 communities across Australia (with 37,420 children surveyed). Based on these data the majority of children (two-thirds) were performing well on one or more of the domains, and almost half (47%) were performing well on two or more domains. However, one-quarter of children surveyed were developmentally vulnerable on one or more developmental domains, which suggests they may have difficulty making a successful transition to school. A further 13% of children were developmentally vulnerable on two or more developmental domains and these children are considered to be at particularly high risk developmentally (Figure 2.12). Children in the lowest socioeconomic status areas were twice as likely to be developmentally vulnerable on one or more domains as those in the highest areas (38% compared with 16%).



Note: Weighted to Socio-Economic Indexes for Areas (SEIFA).

Source: AEDI Communities data 2004–2007, CCCH and the Telethon Institute for Child Health Research, unpublished data.

Figure 2.12: Children developmentally vulnerable and performing well on the Australian Early Development Index (AEDI) domains, 2004–2007

Research from Growing up in Australia: The Longitudinal Survey of Australia's Children (AIFS 2006, 2008) looked at the effect of child, parental, family and community factors on school readiness in children. It suggests a range of risk and protective factors are linked to school readiness—the more risk factors a child is exposed to, the greater the likelihood of poorer cognitive, behavioural and social outcomes. The research showed that children from financially disadvantaged backgrounds (family income in the lowest 15%) were more at risk of poor school readiness because they were more likely to have more of the risk factors associated with this. However, most children from financially disadvantaged backgrounds did not have low school readiness and most children with low school readiness were not from financially disadvantaged backgrounds. The research also showed that school readiness is a strong predictor of school adjustment and achievement in the following two years, and that financial disadvantage compounded the problem of school progress for those with poor school readiness (Smart et al. 2008).

Attendance at primary school

Regular school attendance is critical to successful student outcomes. It helps children develop the basic building blocks for learning and educational attainment, and social skills such as friendship building, teamwork, communication skills and healthy self-esteem.

Children who are regularly absent from school are at risk of missing out on these critical stages of educational development and may experience long-term difficulties with their learning, which may result in fewer educational and employment opportunities. Attendance at primary school is a key national education goal and has been endorsed by the Ministerial Councils for Health, Community Services and Disability, and Education as a Headline Indicator priority area for children's health, development and wellbeing.

Most children in Australia regularly attend school. In 2007, attendance rates across the states and the Australian Capital Territory, and across the three school sectors (government, Catholic and independent), were 89% or above for all year levels (years 1 to 6). In the Northern Territory, however, attendance rates were substantially lower (between 82% and 93%). This is likely to be related to the high proportion of Indigenous students in the Northern Territory, who have lower rates of school attendance (between 71% and 87% for Indigenous students compared with between 89% and 95% for non-Indigenous students). Across the three school sectors and the states and territories attendance rates were generally lower for Indigenous students (MCEETYA 2009).

Increasing attendance at primary school for Indigenous children will help to reduce the considerable gap that exists in academic achievement between these groups in Australia.

Literacy and numeracy

Literacy and numeracy skills acquired in the primary school years are essential for further educational attainment, social development and employment. Children's literacy and numeracy skills are affected by a number of factors such as their home environment, their engagement with the school environment, the quality of their educational experience and their attitudes to reading, mathematics and writing. In the home, the number of books available, the amount of time parents spend discussing books with their child, the presence of study aids (such as a desk, computer and dictionary) and the educational attainment of parents have been found to be associated with literacy and numeracy levels (Thomson & De Bortoli 2008; Zammit et al. 2002).

A national education goal for every child leaving primary school is that they have attained numeracy and literacy skills at an appropriate level. Literacy and numeracy have been endorsed by the Ministerial Councils for Health, Community Services and Disability, and Education as a Headline Indicator priority area for children's health, development and wellbeing. There has been substantial investment in literacy and numeracy education by all levels of government over the past decade. In the 2007–08 Budget, the Australian Government committed significant funding for a National Action Plan on Literacy and Numeracy, which aims to incorporate an evidence-based approach to literacy and numeracy programs and teachers' professional development (DEEWR 2008c; Gillard 2008).

Most students are meeting minimum standards for literacy and numeracy

National minimum standards have been developed for reading, writing, language conventions (spelling, grammar and punctuation) and numeracy for students in years 3, 5, 7 and 9. Students who achieve at or above the minimum standards have demonstrated at least the basic understanding required for their year level. In 2008, the first National Assessment Program—Literacy and Numeracy tests were conducted. These tests allow consistent assessment of all students in years 3, 5, 7 and 9 across Australia and provide considerably more information about student achievement than was previously available (MCEETYA 2008a).

Most students in Australia in years 3, 5, 7 and 9 are achieving at or above the minimum standards for reading, writing, language conventions and numeracy (between 82% and 95% for boys and 93% and 96% for girls in 2008). While the proportions of students meeting the standards are generally similar across year levels for each of the tests, for writing the proportions decline with increasing years of schooling. For example, in 2008 among boys, 94% of Year 3 students met the minimum standard for writing compared with 89% of Year 7 students and 82% of Year 9 students (Table 2.4).

Higher proportions of girls than boys were achieving at or above the national minimum standard for reading, writing and language conventions. The poorer performance of boys in reading has been attributed to a tendency for boys to be less interested and engaged in reading activities (Malloy & Botzakis 2005). There was no statistically significant difference in the proportions of boys and girls who met the minimum standard for numeracy.

Data from the national literacy and numeracy tests are not directly comparable with data from previous state- and territory-based tests. For the period 2001–2007, the proportion of students meeting the literacy and numeracy benchmarks remained much the same from year to year (MCEETYA 2008b).

Table 2.4: Students in years 3, 5, 7 and 9 achieving at or above the national minimum standards, 2008 (per cent)

	Boys				Girls			
	Year 3	**Year 5**	**Year 7**	**Year 9**	**Year 3**	**Year 5**	**Year 7**	**Year 9**
Reading	90.3	89.3	92.8	91.5	94.1	92.8	95.6	94.4
Writing	93.7	89.8	88.6	82.2	97.1	95.5	95.3	92.5
Spelling	90.3	89.1	90.1	86.7	94.8	94.5	95.0	92.9
Grammar and punctuation	89.5	89.6	88.7	86.7	94.0	94.4	94.6	93.2
Numeracy	94.6	92.8	95.4	93.7	95.5	92.5	95.3	93.6

Source: MCEETYA 2008a.

Some groups of students do not perform as well against the minimum standards for literacy and numeracy as other Australian children. This includes Aboriginal and Torres Strait Islander children, children living in remote areas and children whose parents had lower levels of educational attainment (Table A2.4).

In Australia in 2008, between 60% and 79% of Indigenous students in years 3, 5, 7 and 9 met the national minimum standards for reading, writing, spelling, grammar and punctuation, and numeracy, compared with between 89% and 96% of non-Indigenous students. Students in remote or very remote areas were less likely to achieve the minimum standards than students in metropolitan areas (7–16 percentage points lower in remote areas and 31–53 percentage points lower in very remote areas). As Indigenous children make up 62% of 0–14 year olds in *Very remote* areas (ABS 2008g), it is likely the lower proportion of Indigenous children achieving the minimum standards had a significant effect on the proportion for all students meeting the standard in very remote areas.

Students of parents with the lowest levels of educational attainment (Year 11 or lower) were less likely to achieve the minimum standards than students of parents with the highest level of educational attainment (bachelor's degree or above)—scoring 7–17 percentage points lower.

Australia compares well internationally, but not for Indigenous students

According to the Programme for International Student Assessment (PISA), which compares students in OECD and non-OECD countries (57 participating countries in total), Australia performs well internationally on reading, mathematical and scientific literacy measures. In 2006, among 15 year old students, Australia's mean scores for reading (513), mathematics (520) and science (527) were significantly higher than the PISA-reported OECD averages (492, 498 and 500 respectively). However, Australia was statistically significantly outperformed by five countries for reading (the two top-performing countries were Korea and Finland), eight countries for mathematics (Chinese-Taipei and Finland were the two top-performing countries) and three countries for science (Finland, Hong Kong and Canada) (Thomson & De Bortoli 2007).

Results from the PISA highlighted some areas of concern for Australia. Consistent with the results of the 2008 literacy and numeracy tests, the 2006 PISA results showed a wide gap in academic achievement between Australia's Indigenous and non-Indigenous students, with very little improvement since PISA was first conducted in 2000. In 2006, the average performance of Australia's Indigenous students placed them two and a half years behind Australia's non-Indigenous students (Thomson & De Bortoli 2008). Australian students in remote areas and from the lowest socioeconomic quartile also did less well than other Australian students.

Apparent retention rates

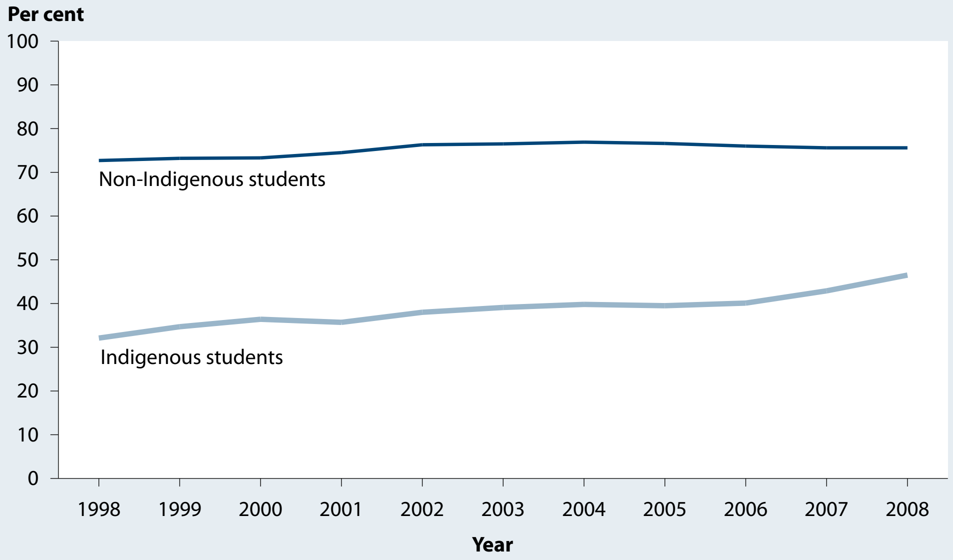
As the number of low-skilled jobs in the employment market decreases, the importance of trade and higher education qualifications increases. Students who fail to complete Year 12 may have fewer employment opportunities and are more likely to experience extended periods of unemployment than Year 12 graduates (Lamb et al. 2000). In May 2006, 50% of school leavers from the previous year who completed Year 10 or below were not fully participating in either study or work compared with 45% of those who had completed Year 11 and 20% of those who had completed Year 12 (Dusseldorp Skills Forum 2007). To address this issue the COAG has committed to lifting the Year 12 or equivalent attainment rate to 90% by 2015 (COAG 2009a). The states and territories have also agreed to introduce a youth participation requirement from 1 January 2010 that requires young people to be in school until they complete Year 10 and then to participate in full time education, training or employment until they turn 17. Anyone under the age of 20 without a Year 12 equivalent qualification will need to be in education or training to receive the Youth Allowance or for their parents to receive Family Tax Benefit A (Rudd 2009).

Three in four students remain in school to Year 12, but this is lower for Indigenous students

One measure of Year 12 attainment is the apparent retention rate to Year 12, defined as the percentage of full-time students who remain in secondary education from the start of secondary school (Year 7/8) to Year 12. The apparent retention rate almost doubled during the 1980s, increasing from 35% in 1980 to 64% in 1990 and peaking at 77% in 1992. The rate was 75% in 2008 and has remained fairly steady since 2003 (between 74–76%). Rates have been consistently higher for females—in 2008 the rate for females was 12 percentage points higher than the male rate (81% compared to 69%) (ABS 2009h).

The apparent retention rate to Year 12 is lower for Aboriginal and Torres Strait Islander students than for non-Indigenous students, with Indigenous students less likely to stay in school in 2008 (47% and 76%, respectively) (ABS 2009h). The gap in apparent retention rates between Indigenous and non-Indigenous students has narrowed over the last decade, from 41 percentage points in 1998 to 29 percentage points in 2008 (Figure 2.13).

Apparent progression rates are another way of looking at student retention. They refer to the proportion of full-time students who continue their high school education by progressing to a higher grade. In 2008, students were less likely to progress to higher grades after reaching Year 10. While almost all students progressed from Year 9 to Year 10 (97%), a considerably lower proportion (87%) progressed from Year 10 to Year 11 and from Year 11 to Year 12 (83%). Males were less likely to progress from Year 11 to Year 12 than females (80% compared with 85% respectively) (ABS 2009g).



Note: Apparent retention rate is defined as the percentage of full-time students who remain in secondary education from the start of secondary school (Year 7/8) to Year 12.

Source: ABS 2009h; AIHW 2007a.

Figure 2.13: Apparent retention rate by Indigenous status, 1998–2008

Completion of Year 12 or equivalent

Factors such as family and community support, information, guidance and learning options are important in keeping young people in school. A range of factors influence a young person's decision to leave school early. According to an Australian National Training Authority report, more than half of early school leavers leave school with the intention of getting a job or an apprenticeship. Others experience difficulties achieving at school, do not like school or leave for financial reasons (ANTA 2001).

Young people not in full-time education, training or employment once they finish compulsory education are disadvantaged, as they may not be in employment long enough to access on-the-job training and are at a greater risk of being unemployed later in life (ANTA 2001). While the apparent retention rate gives an estimate of the proportion of young people who stay in school, it is not a measure of successful completion of Year 12, nor does it reflect post-school educational participation of those not completing Year 12. Staying on at school is not the only option for young people after they complete Year 10. Some start an apprenticeship or commence studies at technical and further education. In 2008, 84% of 20–24 year olds had received a Year 12 Certificate or a Certificate level II or higher qualification—an increase from 79% in 2001 (ABS 2008f).

Participation in further education

Increasingly, young people are continuing their studies beyond compulsory schooling. The 2008–09 Federal Budget included several new measures to facilitate educational participation, including additional training places and apprenticeships in industries suffering skills shortages, trade training centres in schools, phasing out full-fee-paying undergraduate places in public universities for domestic students, an increase in the number of Commonwealth Scholarships for higher education for young people who are socioeconomically disadvantaged, and financial assistance (education and accommodation costs) for Indigenous students and those from regional and remote areas accessing higher education away from home.

The education participation rate measures participation in school and post-secondary school studies for young people aged 15–24 years and includes full- and part-time studies at school, technical and further education, colleges and tertiary institutions. In 2008, the education participation rate for 15–19 year olds was 78%, an increase from 73% in 1996. Since 1998 the rate has remained steady at around 76–78% (Table 2.5). Of the 15–19 year olds enrolled in a course of study leading to a qualification, two-thirds were studying for a Year 12 qualification or below. A further 17% were studying for a bachelor's degree, 10% for a Certificate level III or IV and 4% for a diploma or advanced diploma (ABS 2008e).

The education participation rate was considerably lower among 20–24 year olds reflecting the fact that young adults are more likely to be in full-time employment than 15–19 year olds. The education participation rate for 20–24 year olds gradually increased from 30% to 39% between 1996 and 2008 (Table 2.5). Most 20–24 year olds enrolled in a course leading to a qualification were studying towards a bachelor's degree (58%). A further 15% were studying for a Certificate level III or IV, 12% for a diploma or advanced diploma and 6% were undertaking postgraduate studies (ABS 2008e).

Table 2.5: Education participation rates for young people, 1996–2008 (per cent)

Age	1996	1998	2000	2002	2004	2005	2006	2008
15–19 years	73.3	76.4	76.7	76.7	75.8	75.5	76.6	78.3
20–24 years	30.2	31.2	33.0	36.5	36.9	37.9	35.6	38.9

Source: ABS 2008e.

Nine in ten young people are engaged in either study or work

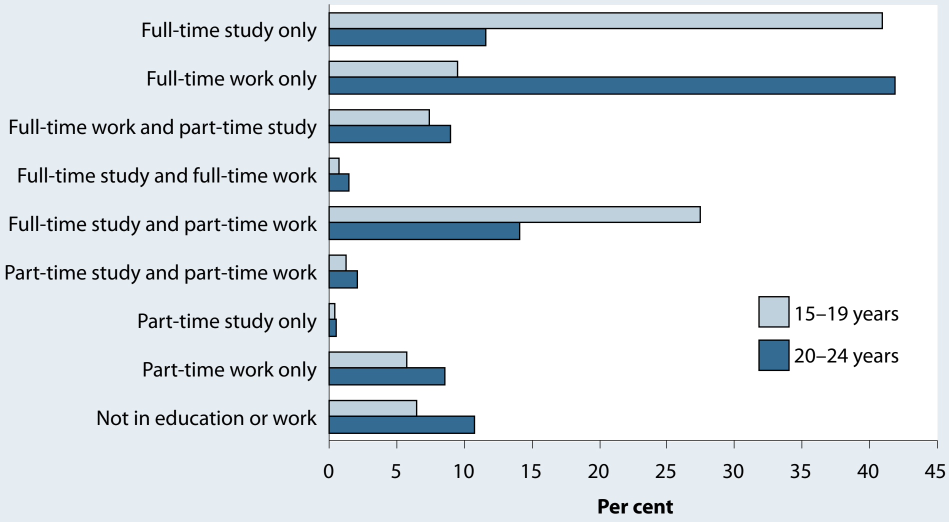
In 2008, 86% of young people aged 15–19 years and 78% of young people aged 20–24 years were participating full time in education or work (Figure 2.14). School leavers are taking varied pathways from school to full-time work. Between 1998 and 2008 there was a 27% increase in young people aged 15–24 years combining study with work (Table A2.5). The overall proportion of young people participating in education and/or employment has increased from 87% to 91% over this period.

In 2008, just under one in three young people (30%) had more than a full-time load, either full-time study with additional work or full-time work with additional study, with 15–19 year olds more likely to have more than a full-time load (36%) than 20–24 year olds (25%). Over two-thirds of 15–19 year olds (69%) were in full-time study (including 28% who combined full-time study with full- or part-time work). This pattern changes as young people leave school. Among 20–24 year olds, full-time employment is the dominant category, with half (51%) in full-time work (including 10% who combined full-time work with full- or part-time study). In total 27% of 20–24 year olds were engaged in full-time study (Figure 2.14).

According to the ABS 2006 Census of Population and Housing, one-third (33%) of Indigenous young people aged 18–24 years were participating full time in work or study—half the proportion of non-Indigenous young people (71%) (ABS & AIHW 2008).

Young people not involved in education, training or employment may have less opportunities to participate fully in society, are considered more at risk of personal and social stresses and social exclusion, and may have poorer long-term labour market outcomes than other young people (Long 2006). Youth unemployment or educational inactivity has been linked to a dependence on parents or social welfare, family problems, substance abuse, physical abuse, violence and crime (UN 2007; Clifford 2002).

In 2008, almost one in ten young people aged 15–24 years was neither working nor studying. This proportion declined from 13% in 1998 to 9% in 2008 (Table A2.5). In 2006, Australia ranked 16th out of 25 OECD countries in the proportion of 15–19 year olds not engaged in education or employment, indicating the potential for further improvements in youth participation rates in Australia (OECD 2008).



Source: ABS 2008e.

Figure 2.14: Participation in study and work, May 2008

In 2005 the ABS Education and Training Experiences survey suggested that around 397,000 or 20% of young people aged 15–24 years not at school, wanted to do more study for an educational qualification in the previous 12 months, but did not do so (ABS 2006). Nearly a quarter (24%) of these young people gave financial reasons for not doing so, and one in five said they did not have the time (19%). Other reasons included work-related (15%), course or qualification-related (15%), and personal or family reasons (12%).

2.6 Employment

Secure and satisfactory employment offers young people not only financial independence but also a sense of control, self-confidence and social contact. In contrast, unemployment, insecure employment and unfavourable working conditions have all been associated with low self-esteem and poor physical and mental health (Morrell et al. 1994; Morrell et al. 1998).

Youth unemployment rate is double the overall rate

The unemployment rate for young people is twice as high as the overall rate—in July 2008, the youth unemployment rate was 7.9 (11.1 for 15–19 year olds and 5.7 for 20–24 year olds) compared with 3.9 overall (Table A2.6). Over one-fifth (22%) of the unemployed population were aged 15–19 years and a further 16% were aged 20–24 years. Many unemployed young people however are engaged in either full- or part-time study—59% of unemployed 15–19 year olds and 30% of unemployed 20–24 year olds were enrolled in full- or part-time education in May 2008 (ABS 2008e). While students who are unemployed are not considered to be inactive, many rely on work for a source of income and so face significant financial pressures as a result of being unemployed.

Between July 2001 and July 2008 the unemployment rate fell considerably for both young people and those aged 25–64 years (around 37%). However, over this period, the youth unemployment rate remained consistently higher than for those aged 25–64 years, declining from 12.7% to 7.9%, compared with 4.9% to 3.1% for 25–64 year olds (Table A2.6). The recent economic downturn in Australia has resulted in a reversal of this trend, with unemployment rates starting to rise. In May 2009 the unemployment rate for 15–24 year olds reached 12.1%—an increase of 53% since July 2008, and the rate for 25–64 year olds reached 4.6% (48% increase) (ABS 2009d).

Poorer employment outcomes for Indigenous young people

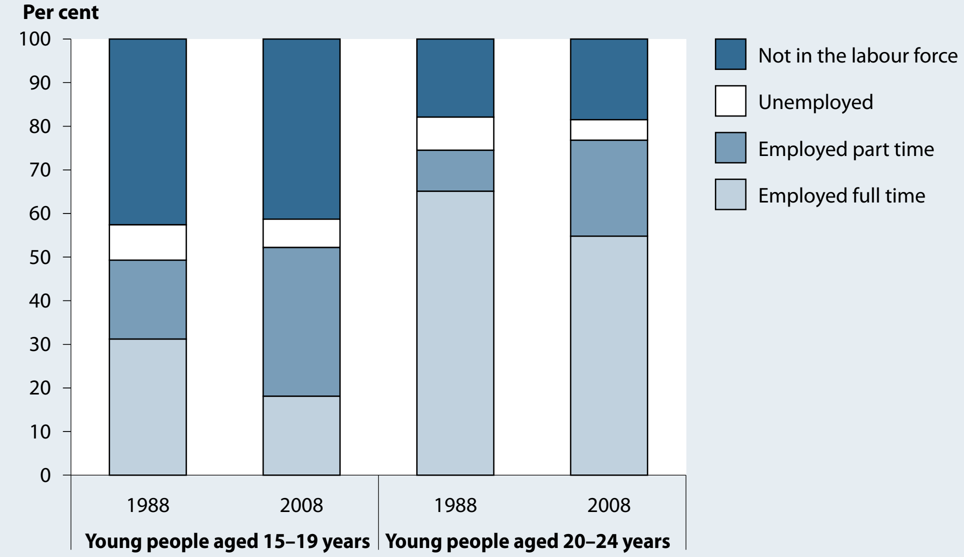
The unemployment rate for Aboriginal and Torres Strait Islander young people (15–24 years) was more than twice as high as for other young people in 2007—21% compared with 9%, respectively (ABS 2008i). Halving the gap in employment outcomes between Indigenous and non-Indigenous Australians is a key priority of the Closing the Gap on Indigenous disadvantage initiative.

Labour force participation of young people

Part-time work increasing, full-time work declining for young people

Between July 1988 and July 2008 the proportion of young people in part-time employment increased from 18% to 34% for 15–19 year olds and from 9% to 22% for 20–24 year olds (Figure 2.15). Coinciding with this increase has been a large decline in the proportion of 15–19 year olds in full-time employment (from 31% to 18%) and a smaller decline for 20–24 year olds (from 65% to 55%). Despite these changes, the proportion of young people not in the labour force has remained constant over the last decade—between 41% and 43% for 15–19 year olds and 18% and 19% for 20–24 year olds.

The increase in part-time work among young people may reflect an increase in participation in education and a deferral of entry into the full-time, long-term labour market.

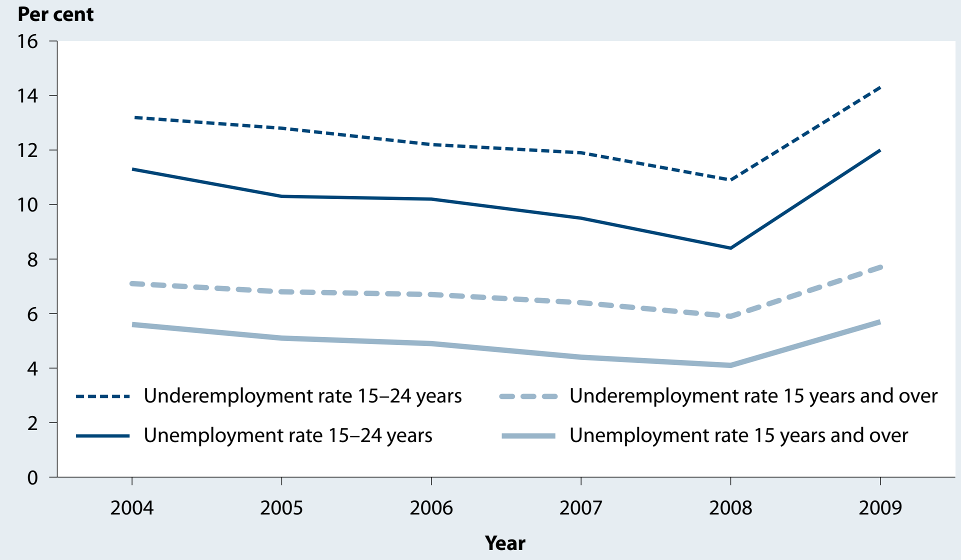


Source: ABS 2008j.

Figure 2.15: Labour force participation of young people, July 1988 and July 2008

Young people are twice as likely to be underemployed

Many young people are underemployed—that is, they are employed but would like more work than they currently have and are available to do more work. Underemployment can have a significant detrimental effect on the financial, personal and social lives of young people. Underemployed workers may also be at risk of low self-esteem or alcohol abuse (Friedland & Price 2003). In May 2009 the youth underemployment rate for 15–24 year olds (14.3%) was higher than for any other age group, and almost twice that for the overall labour force (7.7%). The youth underemployment rate declined between 2004 and 2008 (13.2% to 10.9%), however as the economic downturn progressed, the youth underemployment rate increased to 14.3% by May 2009 (Figure 2.16).



Notes

1. Data are trend series for May each year.
2. The underemployment rate includes those employed part time who want and are available for more hours of work, and those employed full time who worked part time hours for economic reasons, as a percentage of the labour force.
3. The unemployment rate is the number of unemployed persons as a percentage of the labour force (those who were employed or unemployed).

Source: ABS 2009b.

Figure 2.16: Unemployment and underemployment rates, 2004–2009

2.7 Children and young people at risk

There is a demonstrated relationship between the health and wellbeing of children and young people and the environment in which they grow up (McCain & Mustard 1999, 2002; Stanley et al. 2003). Children who are raised in supportive, nurturing environments are more likely to have better social, behavioural and health outcomes. There are a range of factors that expose children and young people to a greater risk of disadvantage. These include family stressors like financial difficulties, social isolation, domestic violence, mental health problems, disability, alcohol and/or substance abuse, and the lack of, or uninhabitable, housing.

Evidence from Growing up in Australia: the Longitudinal Study of Australian Children reveals a direct link between poorer parenting quality (such as parental hostility, lack of emotional warmth and low parental self-efficacy) and poorer development outcomes for infants and children (AIFS 2006). There is also a well-acknowledged relationship between the welfare of a child, parental neglect and criminal offending later in life (Weatherburn 2001). There is also a view that increasing levels of materialism and individualism may affect the mental health of children and young people (The Children's Society 2009; Eckersley 2008).

This may create dissatisfaction and weaken social bonds for some children and young people and make it harder for them to develop a strong sense of identity, purpose and belonging (Eckersley 2008).

The interrelationship of risk factors may place children at higher risk of abuse and neglect, and serious harm or injury. In particular, parental risk factors commonly associated with child abuse and neglect include domestic violence, parental alcohol and drug abuse, and parental mental health problems (COAG 2009c). Children who have been abused or neglected may experience lower social competence, poor school performance, impaired language ability, a higher likelihood of criminal offending and mental health issues (Chartier et al. 2007; Gupta 2008; Zolotor et al. 1999).

Reported levels of child abuse and neglect in Australia have steadily increased over recent years. In response to this, in April 2009 the COAG endorsed the National Framework for Protecting Australia's Children 2009–2020, which aims to reduce child abuse and neglect. This framework supports the broader Social Inclusion Agenda and suggests that the protection of children needs to change from not simply a response to abuse or neglect to one that promotes the safety and wellbeing of all children under a public health model (COAG 2009c).

This section focuses on at-risk children and young people involved in the child protection system, the juvenile justice system and those at risk of or experiencing homelessness.

Child protection and out-of-home care services

In Australia, statutory child protection systems are the responsibility of the state and territory governments, and child protection services in each state and territory provide assistance for some of the more vulnerable children in society. Children's need for assistance may be due to abuse or neglect, or the parent's inability to care for the child. Services may include the provision of advice, family support and/or out-of-home care.

Treatment and support services play a critical role in supporting families and minimising or complementing statutory intervention from departments responsible for child protection (Bromfield & Holzer 2008; Tominson 2002; Wise 2001). This is because child abuse and neglect are often symptoms of underlying problems within the family (for example poverty, unemployment or parental mental health issues), and treatment and support services may help deal with these issues. Despite recognition of the importance of treatment and support services there is currently a lack of consistency in the data collected across services and among states and territories. This makes presenting a coherent national picture of treatment and support services difficult.

This section examines patterns and trends in child protection services, using data collected by the AIHW from state and territory departments responsible for child protection. Data are collected on child protection notifications, investigations and substantiations, where substantiations refer to the determination, after investigation, that a child has been, is being or is likely to be abused or neglected or otherwise harmed (see Box 2.4 for definitions of these terms). Information is also collected for children on care and protection orders and in out-of-home care. While the broad processes in state and territory child protection systems are similar, child protection legislation, policies and practices vary. Variations between jurisdictions in recorded cases of abuse or neglect may reflect these differences in each jurisdiction, rather than a true variation in the levels of child abuse and neglect (see Bromfield & Higgins 2005). It should be noted that child protection data are particularly sensitive to changes in child protection legislation and departmental policies, practices, resources and data systems. For more information about child protection processes, see *Child protection Australia 2007–08* (AIHW 2009b) and *Report on Government Services 2009* (SCRGSP 2009).

There are data gaps and other quality issues in the national child protection data. Data development activities currently underway are briefly described in Box 2.5.

Box 2.4: Definitions of notifications, investigations and substantiations

Notifications are contacts made to an authorised department by a person or other body making an allegation of child abuse or neglect, child maltreatment or harm to a child. Notifications should not include reports regarding wider concerns about a child or family, which are classified as child concern reports. A notification involves one child only. Where it is claimed two children have been abused, neglected or harmed, for example from the one family, this is counted as two notifications. More than one notification about the same event is counted as one notification.

Investigation is where a community services department seeks to obtain more detailed information about a child who is the subject of a notification, and makes an assessment about the harm or degree of harm to the child and their protective needs. This includes interviewing or sighting the child where it is practicable to do so. Investigations relate to child protection notifications of children aged under 18 years, made to an authorised department between 1 July 2007 and 30 June 2008, and were subsequently investigated. Note that Table 2.6 refers to finalised investigations as at 30 June 2008—some investigations were not finalised by this date and as such not recorded in this category until the following financial year.

Substantiation of a notification is where it is concluded after investigation that the child has been, is being or is likely to be abused, neglected or otherwise harmed. A decision would then be made regarding an appropriate level of continued involvement by the state or territory child protection and support services. This generally includes the provision of support services to the child and family and, in situations where further intervention is required, the child may be placed on a care and protection order or in out-of-home care.

Source: AIHW 2009b.

Box 2.5: Data gaps and data developments in National Child Protection Data

Apart from the intensive family support services data, there are no other data at the national level on the support services used by children in need of protection and their families. Work is currently underway to broaden the scope of the national data collection in child protection and to improve comparability.

The AIHW, in collaboration with the states and territories, has undertaken developmental work on a draft national minimum data set for the National Child Protection Data Collection, with the aim of improving analytic potential and national reporting on children and young people in the child protection system. The AIHW will be working with the jurisdictions in developing and implementing a National Child Protection Unit Record Collection.

Work is also underway on a national collection of aggregate data on foster carers.

(continued)

One of the goals of the National Framework for Protecting Australia's Children is to improve information sharing, data collection and reporting by government and non-government organisations to better identify children at risk. This includes, for example, an Information Sharing Protocol between the Commonwealth and Child Protection Agencies, the development of a unit record data collection for Child Protection, and the development of indicators to measure progress on the six supporting outcomes of the national framework (COAG 2009c).

Notifications, investigations and substantiations

In 2007–08, 195,387 children aged 0–17 years across Australia were the subjects of one or more child protection notifications—a rate of 39 notifications per 1,000 children (Table 2.6). In the same year, 93,834 children were the subjects of one or more finalised investigations (nationally 19 per 1,000 children) and 32,098 children were the subjects of one or more substantiations (nationally 7 children per 1,000).

Table 2.6: Number of children aged 0–17 years(a) subject to a notification, finalised investigation or substantiation, 2007–08

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total
					Number of children				
Notifications	103,355	32,375	22,333	7,942	14,033	7,629	4,725	2,995	195,387
Investigations(b)	56,548	9,566	16,214	3,492	4,006	1,577	922	1,509	93,834
Substantiations(c)	13,202	6,164	7,331	1,393	1,830	924	545	709	32,098
					Number per 1,000 children				
Notifications	64.0	27.0	21.6	15.6	39.9	64.9	61.3	48.3	39.3
Investigations(b)	35.0	8.0	15.7	6.8	11.4	13.4	12.0	24.3	18.9
Substantiations(c) (d)	8.2	5.1	7.1	2.7	5.2	7.9	7.1	11.4	6.5

(a) Includes children of unknown age.

(b) Investigations refer only to children who are the subjects of finalised investigations for notifications received during 2007–08. Some investigations will therefore not be finalised until the following financial year. See Box 2.4 and AIHW 2009b for more information.

(c) Substantiations refer only to children who are the subjects of substantiations for notifications received during 2007–08.

Notes

1. Data refer to the number of children who were subject to a child protection notification, investigation or substantiation, therefore each child is counted once.
2. Definitions of notifications, finalised investigations and substantiations are given in Box 2.4.
3. For further explanation about the calculation of rates, refer to Appendix 2 of AIHW 2009b.
4. Data may include unborn children, except in Tasmania.

Source: AIHW Child Protection Data Collection.

Over recent years the rates of children subject to notifications and finalised investigations have generally increased nationally (Table A2.7). However, the rate of children in substantiated notifications has declined from 7.2 per 1,000 children in 2005–06 to 6.5 in 2007–08. The observed decline in substantiation rates may be an indication of the success of family support services offered in jurisdictions as an alternative response for less serious incidents. Data in future years will show if this trend continues.

While substantiation rates have fallen at the national level, the rate of children subject to a child protection notification has continued to rise, increasing from 34 per 1,000 children in 2004–05 to 39 in 2007–08. This increase could be attributed to a broadening of the definition of child abuse and neglect, more children requiring protection, and a greater community awareness of and willingness to report child abuse and neglect to state and territory child protection services (see AIHW 2009b for further details).

Substantiations are classified into one of four categories (physical, sexual or emotional abuse, or neglect) depending on the main type of abuse or neglect that has occurred. In 2007–08, the most common type of maltreatment was emotional abuse (37% of all children subject to substantiations nationally), followed by neglect (27%), physical abuse (25%) and sexual abuse (11%). These proportions have remained relatively stable over the last 4 years. Before 2004–05, physical abuse, emotional abuse and neglect each accounted for roughly one-third of children subject to substantiations nationally (AIHW 2003). By 2005–06 emotional abuse had become the most prominent form of abuse identified in substantiations, accounting for 40% of all children subject to substantiations nationally (AIHW 2007b). The increasing number of substantiations being classified as emotional abuse may in part be due to the broadening legislative definitions of emotional abuse, and a wider range of circumstances covered under mandatory reporting legislation.

Large increases in children on care and protection orders and in out-of-home care

Although departments responsible for child protection can apply to a court to place a child on a care and protection order at any point in the child protection process, such action is usually taken as a last resort. 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.

In 2007–08, 34,279 children were on care and protection orders and a majority of these children (26,425 or 77%) were also in out-of-home care (AIHW 2009b). In the years from 30 June 2005 to 30 June 2008, the number of children on care and protection orders increased by 37%, from 25,065 to 34,279. A similar increase (32%) was observed for children using out-of-home care services, from 23,695 to 31,166.

There are several possible reasons for this increase. While it may reflect increasing numbers of families considered to be unable to adequately care for their children, it may also reflect changing community standards in relation to child safety. Some of the increases may also be a flow-on effect from the increased number of cases being substantiated in recent years, or may be due to the growing number in out-of-home care placements as children remain on orders or in out-of-home care for longer periods of time.

Nearly all children are placed with either foster carers or relative/kinship carers

Out-of-home care provides alternative accommodation to children and young people who are unable to live with their parents. These arrangements can include foster care, relative/kinship care, residential or facility-based care, family group homes, and independent living arrangements (see Glossary under ‘Out-of-home care’ for definitions).

Of the 31,166 children in out-of-home care across Australia at 30 June 2008, 48% were placed in foster care, 45% in relative/kinship care, 5% in residential care and 2% in other care arrangements. Residential care is mainly used for children with complex needs or for those who need to be placed with a group of siblings. Children aged 0–4 years were more likely to be placed in foster care than any other type of care. Children aged 10–14 years and 15–17 years were more likely to be placed in residential care (Table 2.7).

Table 2.7: Children aged 0–17 years in out-of-home care by type of care, 30 June 2008

	Foster care		Relatives/kin		Residential care		Other[a]		Total[b]	
Age (years)	No.	Per cent	No.	Per cent	No.	Per cent	No.	Per cent	No.	Per cent
<1 year	701	64.7	356	32.9	20	1.8	6	0.6	1,083	100.0
1–4	3,542	53.5	2,950	44.5	46	0.7	86	1.3	6,624	100.0
5–9	4,488	48.4	4,490	48.4	123	1.3	172	1.9	9,273	100.0
10–14	4,404	45.2	4,465	45.9	656	6.7	212	2.2	9,737	100.0
15–17	1,742	39.2	1,754	39.4	665	15.0	287	6.5	4,448	100.0
0–17	**14,878**	**47.7**	**14,015**	**45.0**	**1,510**	**4.8**	**763**	**2.4**	**31,166**	**100.0**

(a) This category includes 'unknown' living arrangements, other home-based care, family group homes and independent living arrangements.

(b) Total includes one child of unknown age.

Note: Percentages may not add to 100 due to rounding.

Source: AIHW Child Protection Data Collection.

The Aboriginal Child Placement Principle outlines preferences for the placement of Aboriginal and Torres Strait Islander children when they are placed outside their immediate family (Lock 1997). All jurisdictions have adopted the Aboriginal Child Placement Principle in legislation and policy. The effects of the principle are reflected in the relatively high proportions (ranging from 85% in New South Wales to 35% in Tasmania) of Indigenous children placed with Indigenous relatives or kin, with other Indigenous caregivers or in Indigenous residential care at 30 June 2008 (AIHW 2009b). It is important to note that the Aboriginal Child Placement Principle is just one of the many considerations taken into account when making the decision on placements for Aboriginal and Torres Strait Islander children.

Characteristics of children in the child protection system

The child protection data indicate that some groups of children are over-represented in the child protection system. However, the complexity surrounding the interpretation of the data means it is often not possible to determine the reasons behind the over-representation.

Substantiation rates are highest among infants

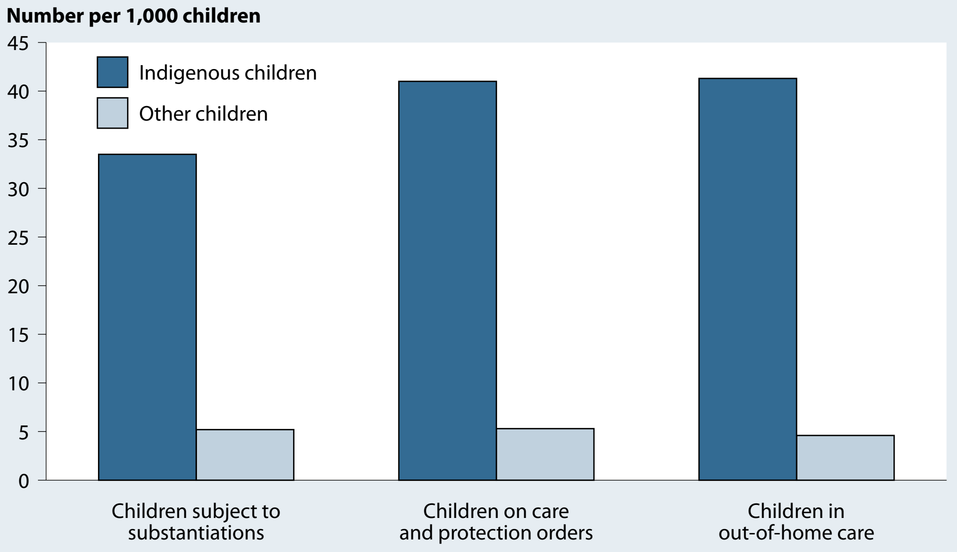
In 2007–08, children aged less than 1 year accounted for 14% of children subject to substantiations nationally—a rate of 16 substantiations per 1,000 children in this age group (AIHW 2009b). This rate is higher than for other combined age groups, for example, 8 substantiations per 1,000 children aged 1–4 years, 7 for 5–9 year olds and 6 for 10–14 year olds.

The high substantiation rate among infants may reflect the view that infants are a vulnerable population group needing extra care and protection. This could lead to an increased focus on early intervention (for example, see Vic DHS 1999).

Indigenous children are over-represented in child protection system

Aboriginal and Torres Strait Islander children are over-represented in the child protection system. Overall, Indigenous children aged 0–17 years were 6 times as likely to be the subjects of substantiations than other children in 2007–08, and were around 7 times as likely to be on care and protection orders or in out-of-home care at 30 June 2008 (Figure 2.17) (AIHW 2009b). This pattern is consistent with previous years. However, it should be noted that the quality of Indigenous data varies across jurisdictions and over time.

The prevalence of domestic violence and the generally lower socioeconomic status of Indigenous families are some of the factors in the over-representation of Indigenous children (Stanley et al. 2003). The legacy of past policies of forced removal of children, intergenerational effects of previous separations and cultural differences in child-rearing practices may also contribute to this over-representation (HREOC 1997).



Note: Data for children on care and protection orders and children in out-of-home care are at 30 June 2008. Data for children subject to substantiations are for the 2007–08 financial year.

Source: AIHW 2009b.

Figure 2.17: Children aged 0–17 years in the child protection system, 2007–08

Children living in one-parent families are over-represented in substantiations

A relatively high proportion of substantiations involve children living in one-parent families, compared with children living in two-parent intact families. For example, in 2007, of all families with children aged under 15 years, 19% were lone-mother households, 3% were lone-father households and 78% were couple households (ABS 2008b). In 2007–08, across the states and territories between 29% and 48% of substantiations involved children living in lone-mother households and a further 3%–10% involved children living in lone-father households (AIHW 2009b). This compares with between 37% and 57% of substantiations involving children from couple households.

There are a number of reasons for the over-representation of one-parent families in substantiations. For example, lone parents are more likely to have low incomes and be financially stressed and suffer from social isolation (Loman 2006; Saunders & Adelman 2006)—all factors that have been associated with child abuse and neglect.

Juvenile justice

For most young people who have an encounter with the juvenile justice system, their involvement does not progress beyond the police. One study found that 17% of the 1984 South Australian birth cohort had at least one formal police apprehension while aged 10–17 years, and this proportion was much higher for Indigenous males (63%) (Skrzypiec & Wundersitz 2005). Few young people, however, progress to the courts and fewer still are found guilty and receive supervised sentences. For example, a study in Queensland found around 1% of all young people aged 10–16 years were charged with offences and appear in court each year, but less than half of those appearing in court in 1994–95 were sentenced to a supervised order (Lynch et al. 2003). Of those young people who are sentenced to a supervised order, a high proportion re-offend and nearly 80% progress to the adult correctional system and receive either a community corrections order or a sentence of imprisonment (Lynch et al. 2003).

Throughout Australia, 10 years is the youngest age at which a child may enter the juvenile justice system and, in most states and territories, the relevant juvenile justice legislation encompasses all young people who commit (or are alleged to have committed) a crime before the age of 18 years (AIHW 2008a).

A major feature of the juvenile justice system is the diversion of children away from the formal system. If the young person is not diverted and is found guilty of the offence, the court may sentence the young person to an unsupervised sentence (such as a good behaviour bond), a community-based supervised sentence (such as probation or suspended detention) or to a period of detention. Young people may also be supervised in the community or held in detention while awaiting the outcome of the court hearing (AIHW 2008a).

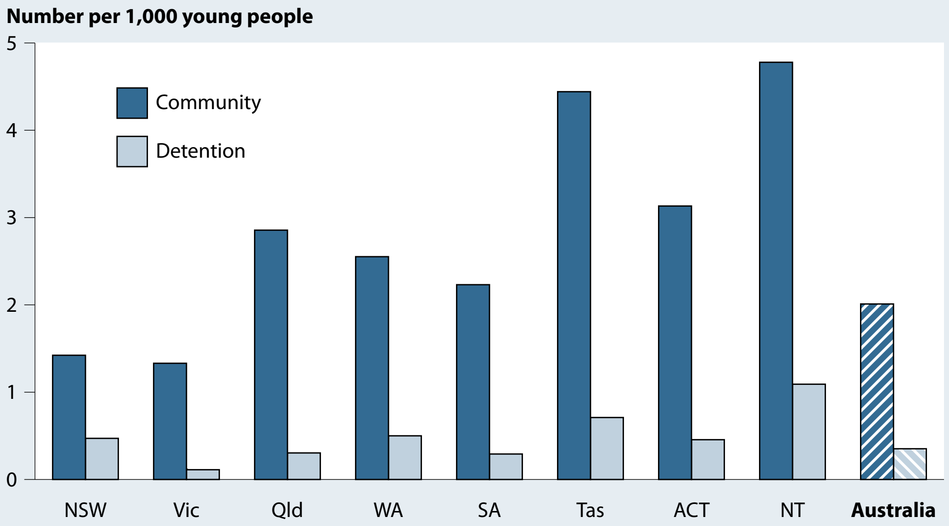
Young people under juvenile justice supervision

Young people under juvenile justice supervision are at significant risk of social exclusion. Many have disadvantaged backgrounds, low levels of educational achievement and a history of drug and alcohol use, and a considerable number have experienced childhood maltreatment, which is a strong predictor of future offending (Kenny et al. 2006; NSW DJJ 2003; Prichard & Payne 2005; Stewart et al. 2002; Stewart et al. 2005). Young people in supervision, both community-based and detention, have poor physical and mental health compared with those not under supervision (Kenny et al. 2006; NSW DJJ 2003).

To further investigate the pathways between child maltreatment, homelessness and juvenile offending, the AIHW is undertaking a project to link the Juvenile Justice National Minimum Data Set, the Supported Accommodation Assistance Program (SAAP) data collection and available child protection data. The linked data will enable analysis of the characteristics of young people who are involved in more than one of these sectors, which will help inform the development of early intervention and social inclusion polices and programs (AIHW 2008b).

In Australia, 12,765 young people were under juvenile justice supervision at some time during 2006–07 (AIHW 2008a). Most (84% or 10,675 young people) were aged 10–17 years, equating to 5 young people for every 1,000 aged 10–17 years. A minority (16%) were aged 18 years or older. Most (84%) young people under juvenile justice supervision had community-based supervision, but nearly half (43%) were detained at some time during the year. Nearly one-third (27%) were both detained and supervised in the community during 2006–07 (see Glossary for definition of these terms). Young people in the juvenile justice system who are unsupervised or who are supervised by other agencies, such as police, are not included in these data.

On an average day during 2006–07, around 6,000 young people were under supervision: 84% in the community and 16% in detention (AIHW 2008a). Most were male (84% of those in the community and 92% of those in detention) and most were aged under 18 years (90% in the community and 85% in detention). Nationally, 4,554 young people aged 10–17 years, or 2 out of every 1,000 young people, were under community-based supervision on an average day while 797 young people aged 10–17 years, or fewer than 1 young person per 1,000, was in detention, although this varied across the states and territories (Figure 2.18). The Northern Territory had the highest rate of young people aged 10–17 years in community-based supervision on an average day, with nearly 5 young people per 1,000 compared with around 1.5 in Victoria and New South Wales. The Northern Territory also had the highest rate of young people in detention (1.1 per 1,000) while Victoria had the lowest (0.1 per 1,000).



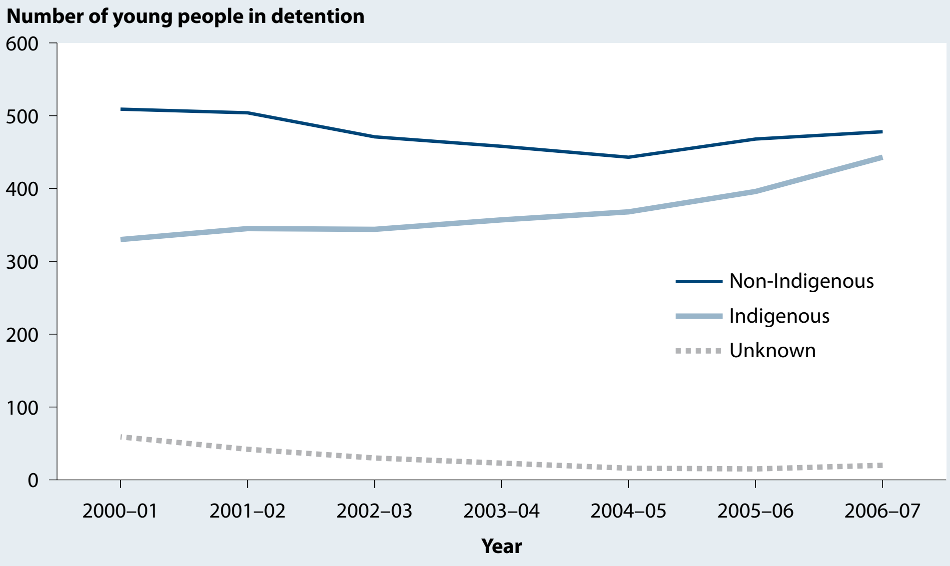
Note: Rates based on average daily numbers of young people under supervision.
Source: AIHW 2008a.

Figure 2.18: Young people aged 10–17 years under community-based supervision and in detention, 2006–07

Indigenous youth are over-represented in juvenile justice supervision

Aboriginal and Torres Strait Islander young people are over-represented in juvenile justice supervision—they were 14 times as likely to be under supervision as non-Indigenous young people in 2006–07 (AIHW 2008a). The levels of over-representation vary considerably across the states and territories, with Indigenous youth 4 to 25 times as likely to be in supervision as non-Indigenous youth. Overall and in most jurisdictions, the level of over-representation changed little over the 4 years from 2003–04 however, in some jurisdictions it increased, most notably in the Northern Territory.

The over-representation of Indigenous young people in detention has become particularly prominent in recent years. In 2000–01 on an average day, there were 1.5 times as many non-Indigenous young people in detention as Indigenous young people. By 2006–07, there were nearly as many Indigenous young people in detention as non-Indigenous young people (Figure 2.19). This is alarming, given that only 5% of Australians aged 10–17 years are Indigenous.



Source: AIHW 2008a.

Figure 2.19: Average daily number of young people in detention by Indigenous status, 2000–01 to 2006–07

Homelessness

Children who are homeless, whether as part of a family unit or on their own, experience significant negative social and health consequences including high rates of mental health problems, behavioural disorders and disrupted schooling (Karim et al. 2006; Yu et al. 2008). The instability and insecurity of temporary housing further contributes to fear and distress (Moore et al. 2007). Young people who become homeless face increased risk of exposure to assault, poor diet and inadequate shelter, and are more likely than other youth to engage in risky behaviours. The effects of homelessness often persist beyond the period of homelessness (Karim et al. 2006; Moore et al. 2007). Parents in homeless families are also likely to be suffering from depression or stress, which may mean they are unable to give their children adequate attention or affection. Dealing with homelessness has been identified as one of the priorities of Australia's Social Inclusion Agenda (see Chapter 7 for further information).

Obtaining an accurate count of the homeless population is difficult as some people move in and out of homelessness and may never be counted in official statistics, while some may never seek emergency assistance or are turned away from services. On Census night in 2006, 44,600 children and young people aged 0–24 years were homeless (43% of the homeless population). Children accounted for a higher proportion of the homeless population in 2006 than in 2001 (12% compared with 10%—a 22% increase), while the proportion of homeless teenagers aged 12–18 years declined by 21% (Chamberlain & MacKenzie 2008) (see Chapter 7 for further details).

Turn-away rates for immediate accommodation are higher for those with children

The major government response available to those who are homeless or at risk of homelessness is the Supported Accommodation Assistance Program (SAAP). SAAP provides a range of assistance including emergency accommodation, meals and showers, counselling and advocacy. In 2007–08, 45,200 clients aged less than 25 years and 76,900 accompanying children aged 0–17 years received services or assistance from a SAAP agency. This represents 1 in every 64 Australian children aged 0–17 years. Certain population groups are overrepresented in SAAP, in particular Indigenous accompanying children (7 times as likely to access SAAP services) and children living outside *Major cities* (see Chapter 7 for further details).

In 2007–08, the turn-away rates for couples and individuals with children as a proportion of those wanting to continue in or gain SAAP accommodation was 2.2% and 2.6% respectively, compared with a rate of 2.6% overall. However, the turn-away rate for new, immediate SAAP accommodation was higher for couples with children (77%) and individuals with children (66%) than for people presenting alone (49%). One reason for this higher turn-away rate is that, once accommodated, family groups tended to stay longer in SAAP accommodation than individuals, resulting in fewer places becoming available in agencies targeting family groups on any given day. Couples and individuals with children had average stays of 169 and 71 days respectively, while people presenting alone had an average stay of 44 days (AIHW 2009c).

2.8 Data developments and further information

This chapter has presented a profile of Australia's children and young people and their families, broadly structured around key stages in life. While it shows that most children and young people are doing well during these transitions, it also shows that some children and young people and their families experience poorer outcomes.

Policy initiatives require good data to help in the development of policy agendas and to track progress. There have been considerable data developments in recent years to support this. For example, in 2006 the Ministerial Councils for Health, Community Services and Disability, and Education endorsed a set of 19 Headline Indicator priority areas for children's health, development and wellbeing, to facilitate data development and collection in these areas. These indicators are reported on for the first time in the AIHW publication *A picture of Australia's children 2009*. In addition to reporting on these indicators, this publication also covers indicators of health status, risk and protective factors, early learning and education, family and community environments, safety and security, and system performance (AIHW 2009d). The development of large scale longitudinal studies such as Growing up in Australia: the Longitudinal Study of Australian Children and the Household Income and Labour Dynamics in Australia survey, as well as the national implementation of the Australian Early Development Index (AEDI) may also help in improving the evidence base on the wellbeing of children and young people in an Australian context.

While there are good data in a number of areas relating to children, young people and their families, there are also areas where data quality limits our ability to provide a comprehensive picture of the wellbeing of Australia's children and youth. In particular, there are two critical areas where significant data improvements could be made—early childhood development and child protection. These have been key items on government agendas in recent years. At present we cannot accurately estimate the number of service providers delivering quality early childhood education programs, or the number of children participating in these. There are also difficulties in obtaining consistent information on child protection and treatment and support services in the states and territories. In terms of the broader issues around social inclusion, it is difficult to get good measures of multiple levels of socioeconomic disadvantage, intergenerational disadvantage for Australian children and young people, and the extent of Indigenous disadvantage in some areas.

The AIHW is undertaking specific work to address some of these issues. This includes the linking of juvenile justice, supported accommodation and child protection data to better understand the movements of young people between these sectors, and the development of a national unit record level data collection for child protection to produce more comprehensive, accurate and comparable data in this area. The AIHW is also working with the ABS to develop a set of national data standards and protocols for reporting against the performance indicators in the National Partnership Agreement on Early Childhood Education.

Work is also underway to improve the quality of data available on Indigenous children by adding Indigenous status of the father to the AIHW National Perinatal Minimum Data set, resulting in a greater capture of Indigenous infants (by around 30%). The addition of father's Indigenous status will enable more accurate reporting against performance indicators such as low birth-weight and perinatal mortality. Data linkage is also being used to enhance the quality of Indigenous mortality data to more accurately estimate Indigenous mortality rates. This development work will contribute to the evidence base for the government's commitments on closing the gap between Indigenous and non-Indigenous Australians.

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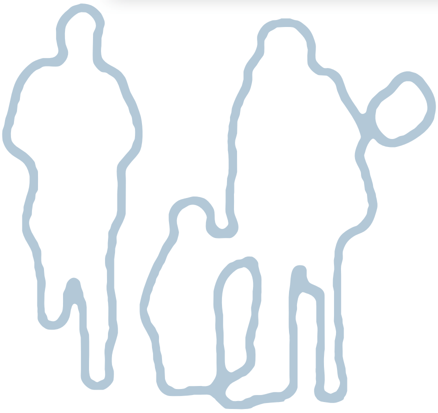
Ageing and aged care

3

Key points

- ☐ In 2008 there were 2.8 million people aged 65 and over, accounting for 13% of the Australian population.
- ☐ The 16,000 Indigenous people aged 65 and over made up only 3% of the Aboriginal and Torres Strait Islander population.
- ☐ Around 70% of people aged 85 and over lived in a private household in 2006 and almost half of them (47%) lived alone.
- ☐ Around 90% of older people living in private households had some form of weekly contact with friends and family members living elsewhere, but there are no data about similar types of social contact for people living in residential aged care.
- ☐ The means-tested Age Pension or a pension from the Department of Veterans' Affairs was received by over three-quarters (78%) of people of qualifying age in 2008.
- ☐ The Home and Community Care program is the largest source of formal community care. It assisted over 638,200 people aged 65 and over during 2007–08.
- ☐ In June 2008 there were about 150,500 permanent residents of aged care facilities aged 65 and over, of whom 29% were aged 90 and over.
- ☐ Personal care is the type of assistance received by the highest proportion of care recipients on high-level community care packages (Extended Aged Care at Home), while domestic assistance is the type of service received by most recipients of a low-level Community Aged Care Package.
- ☐ Over 10,000 older people received assistance during 2007–08 from the Transition Care Program following a hospital stay. The program achieved improvements in the functioning of older people through the provision of short-term therapy.



3.1 Introduction

In 2008, the Australian Government adopted a set of social inclusion principles that recognise that people must be given the opportunity to connect with family, friends, work, personal interests and their local community, and they must be able to access services (Australian Government 2008). This chapter discusses the characteristics of Australia's older population and the services and assistance they receive. It also briefly examines the participation of older Australians in their families, communities and broader society—available data about such participation were more extensively reported in *Older Australia at a glance* (AIHW 2007c) and the 2007 edition of *Australia's welfare* (AIHW 2007a).

One hundred years ago (1909), Australia recognised older people's need for support and assistance by introducing the payment of the Age Pension (FaHCSIA 2008b). At that time the pension was paid to men and women of 'good character' when they reached age 65, at a time when men had a life expectancy of 55 and women 59. Aboriginal and Torres Strait Islander people only became eligible for the Age Pension in 1966 (FaHCSIA 2008b). The Age Pension (along with pensions for war veterans and their spouses and widows) continues to be a major pillar in the Australian retirement income system and is discussed in this chapter.

The chapter also reports on the supply and use of aged care services in Australia. These services are the other main type of formal assistance that is either targeted to, or primarily used by, older people. Aged care services have a more recent history in Australia, mostly being developed after World War II in response to the housing needs of low-income older people and the nursing care needs of frail older people. Ten years ago (1999), the International Year of Older Persons highlighted the need for an appropriate caregiving mix for frail older persons, encompassing family, community and institutional care systems (United Nations 1999). In its policy response to the International Year of Older Persons (the National Strategy for an Ageing Australia), the Australian Government articulated its goal to develop a world-class, high-quality aged care system (Andrews 2001).

The primary focus of this chapter is on people aged 65 years and over, the current qualifying age for the Age Pension. It should be noted that the age group 65 years and over is not used by government as a planning or funding tool for aged care programs. Potential need for care and support services is not a function of age but of poor health and disability. Younger people can and do access some of these services (see Chapter 4). It is also important to note that at any point in time the majority of older people do not use formal services. Indeed, many older people are providers of care and support to others, including spouses, family members with disability and grandchildren (AIHW 2007a,c).

Among the factors that influence an individual's need for formal assistance are the availability of informal care networks (see Chapter 5), environmental factors, the availability of aids and technology to support independent living, isolation and loneliness, social participation and physical activity. Older people are also eligible for a range of benefits and services that are available to the general population and some of these are discussed elsewhere in this report (for example housing assistance in Chapter 6) or in other publications (for example hospital care, medical care and pharmaceuticals in AIHW 2007c and AIHW 2008).

The experience of ageing affects all aspects of life, from housing and income to health, family relationships and further education (see AIHW 2007c for statistical reporting covering a wide range of these issues). Of direct relevance to policy development for older people is the establishment of the Ministerial Conference on Ageing in 2008. This Ministerial Conference provides a forum for all levels of government to work together and respond to such issues as housing for older people, the need for 'active ageing' and more cohesive and efficient aged care services across Australia (DoHA 2008b).

3.2 Australia's older population

Australia's older population comes from diverse social and cultural backgrounds and has a wide range of health needs, family arrangements, physical abilities, economic circumstances and service needs. In part this diversity arises from the wide age range included in the population aged 65 and over (a range of around 40 years). The needs of an average 65 year old are generally very different from those of an average 90 year old. Wherever possible, this chapter presents information relevant to different age groups. As well as diversity of ages, the population of older people in Australia includes Aboriginal and Torres Strait Islanders, people born overseas, and people living in very different geographic locations. This section describes Australia's older population in terms of its size, composition and growth, as well as its regional distribution and cultural diversity. It provides a context for examining the social and economic situation of older people and their use of income support and aged care services. In particular, understanding the extent of future growth provides essential information for making good policy decisions and service planning.

Characteristics of the older population

Older population is growing and ageing

Life expectancy in Australia has been increasing almost continually throughout the last century and into this century, including for those in older age groups (AIHW 2008). At age 65, Australia's men can expect to live for a further 18.5 years and women for another 21.6 years. This is between 7 and 9 years more than their counterparts at the beginning of the 20th century (ABS 2008c), and has resulted in growing numbers of older people who may need aged care services and financial support during retirement.

On 30 June 2008 an estimated 2.8 million Australian residents were aged 65 years and over, the age from which most people can currently access the Age Pension. More than half were aged between 65 and 74 years (Table 3.1). This age group has high proportions of people providing active assistance to their families and communities, including as carers and volunteers (AIHW 2007c). For those whose primary concern is aged care services, an important guide to likely need for services is the population aged 75 and over, and indeed 85 and over. This is because rates of use of aged care services, particularly residential aged care, rise steeply at more advanced ages. There is a substantial minority of older people (about 362,000) who are aged 85 and over.

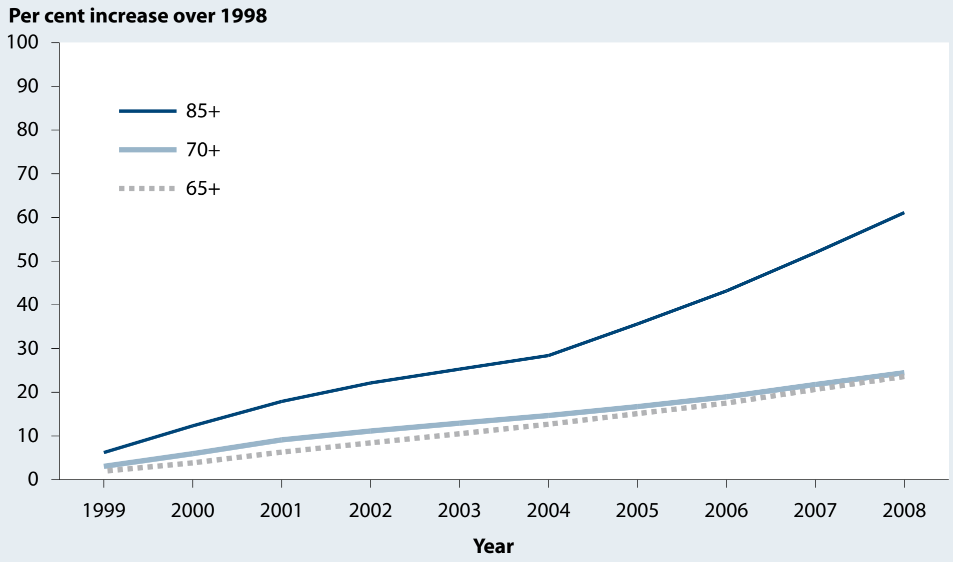
In the last decade, the growth rate in the population aged 65 years and over has been fairly constant at about 2% per year (Figure 3.1). Among the population who are most likely to need and use aged care services (those aged 85 years and over), the rate of growth has been considerably higher (between 3% and 7% per year). Between 1998 and 2008, the number of people in this age group increased by 61%. Growth in the very old population will be a major influence on government spending on aged care in the future, with the number of people aged 85 years and over projected to increase in the next 50 years to 1.8 million people, or 5% of the total population (ABS 2008k).

Table 3.1: Persons aged 65 years or over, 30 June 2008

Age	Males	Females	Persons	Males	Females	Persons	Per cent of Australian population
	Number			Per cent			
65–69	412,038	420,058	832,096	32.0	27.2	29.4	3.9
70–74	319,681	343,766	663,447	24.9	22.2	23.4	3.1
75–79	253,654	296,495	550,149	19.7	19.2	19.4	2.6
80–84	178,488	245,372	423,860	13.9	15.9	15.0	2.0
85 or over	121,954	240,491	362,445	9.5	15.6	12.8	1.7
Total 65 or over	**1,285,815**	**1,546,182**	**2,831,997**	**100.0**	**100.0**	**100.0**	**13.2**

Source: ABS 2008h.

Women of all cultural backgrounds in Australia tend to live longer than men (AIHW 2007c). Women accounted for 51% of people aged 65–74 in 2008, but comprised a larger share of the very old (66% of people aged 85 years and over, down from 67% in 2006) (Table 3.1) (AIHW 2007c:Table 1.1). The predominance of women in older age groups is diminishing as the life expectancy of men is increasing faster than that of women. The sex composition of the older population has implications for social and health policy—as a result of lifetime differences in earnings and workforce participation, older women are more likely to have lower incomes (ABS 2008a), while their survival to more advanced ages means they have high rates of severe disability (AIHW 2007c:Table A17.1).



Source: Table A3.1.

Figure 3.1: Increase in number of people aged 65 years and over, 70 years and over, and 85 years and over since 1998

Number of older Aboriginal and Torres Strait Islander people is small but growing

The Aboriginal and Torres Strait Islander population in Australia has a younger age structure than other Australians, partly as a consequence of lower life expectancy (see Figure 1.2). Much of the current Indigenous policy and research focus concerns interventions that target children, young people, families and people with chronic disease. In the face of the large and challenging problems in these areas, it is easy to overlook the needs of the comparatively small but growing numbers of older Aboriginal and Torres Strait Islander people.

The most recently published data estimated that life expectancy at birth was 67.2 years for Indigenous males and 72.9 years for Indigenous females, compared with 78.7 years for non-Indigenous males and 82.6 years for non-Indigenous females for the period 2005–2007—a difference of 11.5 and 9.7 years for males and females respectively (ABS 2009a). At the age of 65, however, the life expectancy 'gap' between the Indigenous and non-Indigenous Australians was less than at birth, at 4.5 years for men and 4.7 for women (ABS 2009a).

Estimates from the Census of Population and Housing show there were almost 16,000 Aboriginal and Torres Strait Islander people aged 65 years and over in 2006 (making up 3% of the Indigenous population) (Table 3.2). Indigenous people have poorer health and higher rates of disability than non-Indigenous people, which may result in the need for care services at comparatively younger ages (see ABS & AIHW 2008). For this reason, the number of Aboriginal and Torres Strait Islander peoples aged 50 years and over is used for aged care planning purposes. In 2006, there were almost 60,000 Indigenous people aged 50 years and over (12% of the Indigenous population) (Table 3.2).

The distribution of Aboriginal and Torres Strait Islander people aged 50 years and over is similar to that of the Indigenous population as a whole. In 2006, New South Wales and Queensland had the largest numbers of older Indigenous people (20,300 and 17,000 respectively), while the highest proportion of the population aged 50 and over who were Indigenous was in the Northern Territory (12%) (ABS 2008e). Aboriginal and Torres Strait Islander people in this age group, like the Indigenous population generally, were more likely than the non-Indigenous population to live in a remote area. About a third (30%) of Aboriginal and Torres Strait Islander people aged 50 years and over lived in *Major cities*, with 44% living in *Inner* and *Outer regional* areas combined, and 26% in *Remote* and *Very remote* areas. In contrast, around two-thirds (69%) of non-Indigenous Australians aged 50 and over live in *Major cities*, while almost a third (29%) live in *Inner* and *Outer regional* areas, and only 2% live in *Remote* and *Very remote* areas (ABS 2008i).

The diversity of Aboriginal and Torres Strait Islander people is reflected in the variety of Indigenous languages, with the Australian Standard Classification of Languages listing over 150 distinct Indigenous languages (ABS 2005). In 2006, Aboriginal and Torres Strait Islander people aged 45 and over, and those aged 25–44 years, were slightly more likely to speak an Indigenous language at home (13% and 14% respectively) than Indigenous children and young people (10–12%) (ABS 2008j). The most commonly spoken Aboriginal and Torres Strait Islander languages across the total Indigenous population were Torres Strait Creole, Kriol, Arrernte, Djambarrpuyngu and Pitjantjatjara (ABS 2008j). Older Aboriginal and Torres Strait Islander people who spoke an Indigenous language at home were more likely to be living in *Remote* and *Very remote* areas (87%) than in *Inner* and *Outer regional* areas (9%), or *Major cities* (4%) (ABS 2008j).

Providing care in culturally sensitive and appropriate ways to older Indigenous people is a key challenge, given the diversity of circumstances, language groups and geographic locations of a relatively small population group.

Table 3.2: Indigenous Australians aged 50 years or over, 2006

	Males	Females	Persons	Males	Females	Persons	Per cent of Indigenous population
Age		**Number**			**Per cent**		
50–54	9,616	10,196	19,812	34.6	31.8	33.1	3.8
55–59	6,869	7,554	14,423	24.7	23.6	24.1	2.7
60–64	4,574	5,115	9,689	16.5	16.0	16.2	1.9
65–69	2,901	3,576	6,477	10.4	11.2	10.8	1.3
70–74	1,861	2,430	4,291	6.7	7.6	7.2	0.8
75 and over	1,974	3,173	5,147	7.1	9.9	8.6	1.0
Total 50 and over	**27,795**	**32,044**	**59,839**	**100.0**	**100.0**	**100.0**	**11.6**

Source: ABS 2008h.

Highest proportions of older people live in south-eastern Australia

The population of older people is not evenly distributed throughout Australia. This has implications for the planning and delivery of health and aged care services as well as the design of appropriate transport and housing to support the social engagement of older people. The proportion of people aged 65 years and over varies by state and territory. In 2008, it was highest in South Australia and Tasmania (each 15% of the total population), and lowest in the Northern Territory (5%) and the Australian Capital Territory (10%). In other states, the proportion varied between 12% and 14% (ABS 2008h).

The highest proportions of people aged 65 years and over lived mainly in the coastal areas of south-eastern Australia. At 30 June 2007, more than a quarter of residents were aged 65 years and over in the Local Government Areas (LGAs) of Victor Harbor, South Australia (32%), Queenscliffe, Victoria (32%) and Great Lakes, New South Wales (28%). Other LGAs with a high proportion of older residents included Yorke Peninsula and Orroroo/Carrieton, both in South Australia (25% and 24% respectively); and Hindmarsh and Yarriambiack, both in Victoria (each 24%). There were 44 LGAs in Australia with 20% or more of the population aged 65 years and over (ABS 2008i).

In regional areas the demographic profile is more affected by the proportion and age structure of people entering or leaving an area than by influences such as fertility and mortality, which underlie population ageing in Australia as a whole. A region's population will age if a relatively large number of older people move into an area. A region will also age if relatively large numbers of young people leave the area.

Over one-third of older people were born overseas

At 30 June 2007, around one-quarter of Australia's population (5.3 million people) were born overseas. The median age of overseas-born residents was 13 years higher than their Australian-born counterparts (46 years and 33 years respectively). Major birthplace countries of origin with high median age were Italy (66 years), Greece (64 years), Germany (60 years) and the United Kingdom (53 years) (ABS 2008g).

Numbering close to one million, overseas-born people accounted for 35% of Australian residents aged 65 years and over on 30 June 2007 (ABS 2008g). The birthplace with the largest numbers of older overseas-born Australians is the United Kingdom (over 300,000). However, almost two-thirds (62%) of older overseas-born Australians come from non-English-speaking countries. In all, 22% of older Australians were born in a non-English-speaking country. Italy is the major country of birth for older immigrants from non-English-speaking countries (117,000 people, or 4% of all people aged 65 years and over), followed by Greece (63,000 people, or 2%), the Netherlands, China, Croatia and Poland (all 1%) (ABS 2008g).

Older people are present among all birthplace groups, often in very small numbers. The diversity of cultural and linguistic backgrounds within Australia has implications for the provision of services in terms of bilingual support and culturally sensitive service provision. The challenge is perhaps greatest for those groups that are small in number.

Fewer are widowed, more divorced or married

The increasing life expectancy of men is resulting in a gradual decline in the proportion of older people who are widowed. For example, the proportion of people aged 65 and over who were widowed decreased from 33% in 1996 to 29% in 2006 (AIHW 2007c:Table A3.1). Conversely, the proportion in couple relationships increased over this period from 55% to 57%. These trends are currently most evident among those aged 75–84 where the proportion that was married increased 6 percentage points during the decade to reach 52% in 2006 while the proportion that was widowed dropped 8 percentage points to 36%.

In addition, this period witnessed growth in the proportion of older people who were divorced, reflecting changes over the last 30 years in the stability and length of marital relationships. This is mostly evident among the younger cohort (those aged 65–74): in 2006, 10% of this age group were divorced compared with 6% in 1996 (AIHW 2007c:Table A3.1). Overall, 8% of people aged 65 and over in 2006 were divorced.

The marital status profile of men differed from that of women. In 2006, the proportion of older people who had never married was higher for men (6%) than for women (4%) (AIHW 2007c). Partly reflecting their greater longevity, older women were less likely to be married (45%) than older men (71%), and more likely to be widowed (42% compared with 12%). In addition, older men were more than twice as likely to remarry (1.5 remarriages per 1,000 men aged 65 and over in 2007, compared with 0.6 per 1,000 women) (derived from ABS 2008b). Among those aged 85 years and older, 78% of women were widowed compared with 37% of men.

These changes have consequences for the social and economic wellbeing of older people. On the one hand, increasing proportions of married couples may be accompanied by reductions in the proportions living alone and at risk of social isolation, an increase in the availability of spousal care giving for older people with disability, and more secure financial and housing circumstances. On the other hand, the considerable numbers of widows and older people entering retirement as divorcees may face higher risks of social, financial and emotional vulnerability.

Almost half of people aged 85 and over live alone

Despite a common myth that most older people live in some type of cared accommodation, the majority of older Australians in 2006 (92%) lived in private dwellings as members of family, group or lone-person households (see Table A3.2). Only 8% were usual residents in non-private dwellings, which include hotels, motels, guest houses, and cared accommodation such as hospitals, aged care homes and supported accommodation offered by some retirement villages. Although the proportion of older people living in non-private dwellings increased with age, most people in each age group—65–74 years, 75–84 years and 85 years and over—lived in private dwellings.

Over one-quarter (27%) of older people in private dwellings lived alone, and two-thirds (66%) lived in family households, with nearly all of these being single family households. The likelihood of living alone increases with age, with almost half (47%) of those aged 85 years and over living in lone-person households. Almost 4% of older Australians in private dwellings live in either multi-family or group households, and it is likely that many of these people are living with an informal carer. Informal care arrangements are discussed in detail in Chapter 5.

The use of cared accommodation increases with age. Cared accommodation mostly consists of, but is not limited to, Australian government-accredited aged care homes. In 2003, although only around 5% of all older people lived in cared accommodation, this increased to 31% among those aged 85 years and over (1% of people 65–74 years, 7% of people 75–84 years, 31% of people aged 85 or over) (AIHW analysis of ABS Survey of Disability, Ageing and Carers Confidentialised Unit Record File). On 30 June 2008, 150,481 people aged 65 and over were permanent residents in aged care homes, nearly 60% of whom were aged 85 years or older (AIHW 2009c).

Health and disability among the older population

Rates of poor health and disability increase with age

Good health is crucial for older people being able to enjoy a good quality of life, stay independent and participate fully in the community. It helps to moderate the demand for health and aged care services, which is important as Australia's population ages. In response to population ageing, the Australian Government has made the improvement of older people's health a national research priority. One area of special interest is the maintenance of a healthy lifestyle at older ages because benefits include the prevention of disease and functional decline, longevity and enhanced quality of life (WHO 2002).

The majority of older people in private households consider themselves to be in excellent, very good or good health (68%), although the proportion reporting fair or poor health increases with age. Even though older age may be generally associated with increasing levels of disability and illness, since 2001 there has been a general increase in the proportion of older Australians reporting their health as excellent or very good (ABS 2009b). It should be noted that self-reported health assessment data are not available for people in residential aged care, thus excluding a significant proportion of people who are more likely to have poor health.

Despite this generally positive view, older people experience a disproportionate share of the 'burden of disease' in Australia. A measure called disability-adjusted life years has been developed under the auspices of the World Bank and the World Health Organization to summarise the burden of disease, combining data on both fatal and non-fatal disease outcomes. This has been adapted by the AIHW for the Australian context. Measured by disability-adjusted life years, the burden of disease is the years of healthy life lost through living with a disability owing to illness or injury, or through premature death (AIHW: Begg et al. 2007). The measure has the advantage of identifying those health problems that cause much illness and disability even if they are not often fatal (such as dementia).

Adults aged 65–74 made up 7% of the population in 2003 but experienced 16% of the total burden of disease and injury in Australia. People aged 75 and over made up 6% of the total population and experienced 25% of the total burden in Australia in 2003

(AIHW: Begg et al. 2007:Table 3.5). Cardiovascular diseases and cancer accounted for over half of the total burden in both age groups (AIHW 2007c; AIHW: Begg et al. 2007). Overall, 60% of the burden among those aged 65–74 was due to premature death: for those aged 75 and over, the figure was 68%. The remainder of the burden is due to disability arising from illness, injury or age-related frailty.

The ABS Survey of Disability, Ageing and Carers identifies people with disability as those with a long-term condition (lasting or expected to last at least 6 months) who experience activity limitations or participation restrictions. Disability is therefore not defined only in terms of health conditions or body impairments: disability results from the interaction between a person with impairment and their environment (WHO 2001). A narrower measure used by the ABS survey identifies people with the most severe disability. This group are defined as people with 'severe or profound core activity limitation', meaning that they sometimes or always need help with at least one of the core activities of daily living: mobility, self-care and communication (see Chapter 4). The presence of core activity limitations is a useful indicator of the extent to which people may need some form of support in their daily life.

In 2003, over half of all people aged 65 years and over (56% or 1.4 million) had at least one form of disability lasting (or expected to last) at least 6 months and which restricted everyday activities (AIHW 2007c:Table A17.1). Disability rates increase with age group from 39% of those aged 60–64 years to 82% of those aged 85 years and over (AIHW 2005:Table A5.2). Although disability rates are high among older people, this does not always mean that the individual needs personal assistance or formal services.

Among older people with disability, less than half (40%) had a profound or severe limitation (derived from AIHW 2007c:Table A17.1). A small proportion had no core activity limitation (10%). The remainder may experience difficulty with these activities, or use aids and equipment, but needed no assistance. They may, however, also experience difficulty or need help with different activities such as housework. Profound or severe core activity limitation is strongly age-related, affecting around 12% of 65–74 year olds and increasing to 58% of people aged 85 years and over in 2003 (AIHW 2007c:Table A17.1).

Dementia—which can be broadly described as a general and increasing impairment of brain functions such as memory, comprehension and reasoning—is a major health problem among older people although it affects only 4% of people aged 65 and older (AIHW 2007b:Table 5.25). In older people, dementia is more likely than other health conditions to be associated with severe or profound limitations in self-care, mobility and communication, and is very likely to be associated with multiple health conditions (AIHW 2007b:Table 5.25). It is the greatest single contributor to the burden of disability at older ages—although not often fatal it causes so much disability that in 2003 it contributed to more than half the burden of disease among older people and was ranked fifth as a specific cause of the burden of disease among women (AIHW: Begg et al. 2007: 62–3).

Assuming constant age-specific disability rates, the number of people aged 65 years and over with a profound or severe limitation is projected to almost double in the 20 years to 2023, to over a million people (Table 3.3). The projected increase is most marked among people 85 years and over (a 132% increase in numbers by 2023, to over 390,000 people). The number of men aged 65 years and over with a severe or profound limitation is projected to increase at a higher rate (114%) than the number of women (84%), reflecting a more rapid rate of increase in male life expectancy. Among the very old, the number of men with severe or profound disability is projected to triple while the number of women will more than double.

Table 3.3: Projected number of people aged 65 years and over with severe or profound core activity limitation(a), 2003–2023

	2003	2008	2013	2018	2023
Male					
65–74	68,012	77,054	96,728	117,119	128,905
75–84	84,811	96,920	106,868	126,270	163,937
85 and over	40,269	55,455	75,924	95,940	120,862
Total 65 years and over	*193,092*	*229,429*	*279,520*	*339,330*	*413,705*
Female					
65–74	94,774	104,216	128,149	159,877	180,001
75–84	154,081	165,689	172,754	194,807	244,240
85 and over	129,130	162,973	201,373	233,435	272,562
Total 65 years and over	*377,985*	*432,879*	*502,276*	*588,120*	*696,802*
Persons					
65–74	162,786	181,270	224,877	276,997	308,905
75–84	238,892	262,610	279,622	321,077	408,177
85 and over	169,399	218,428	277,297	329,375	393,424
Total 65 years and over	**571,077**	**662,308**	**781,796**	**927,449**	**1,110,507**

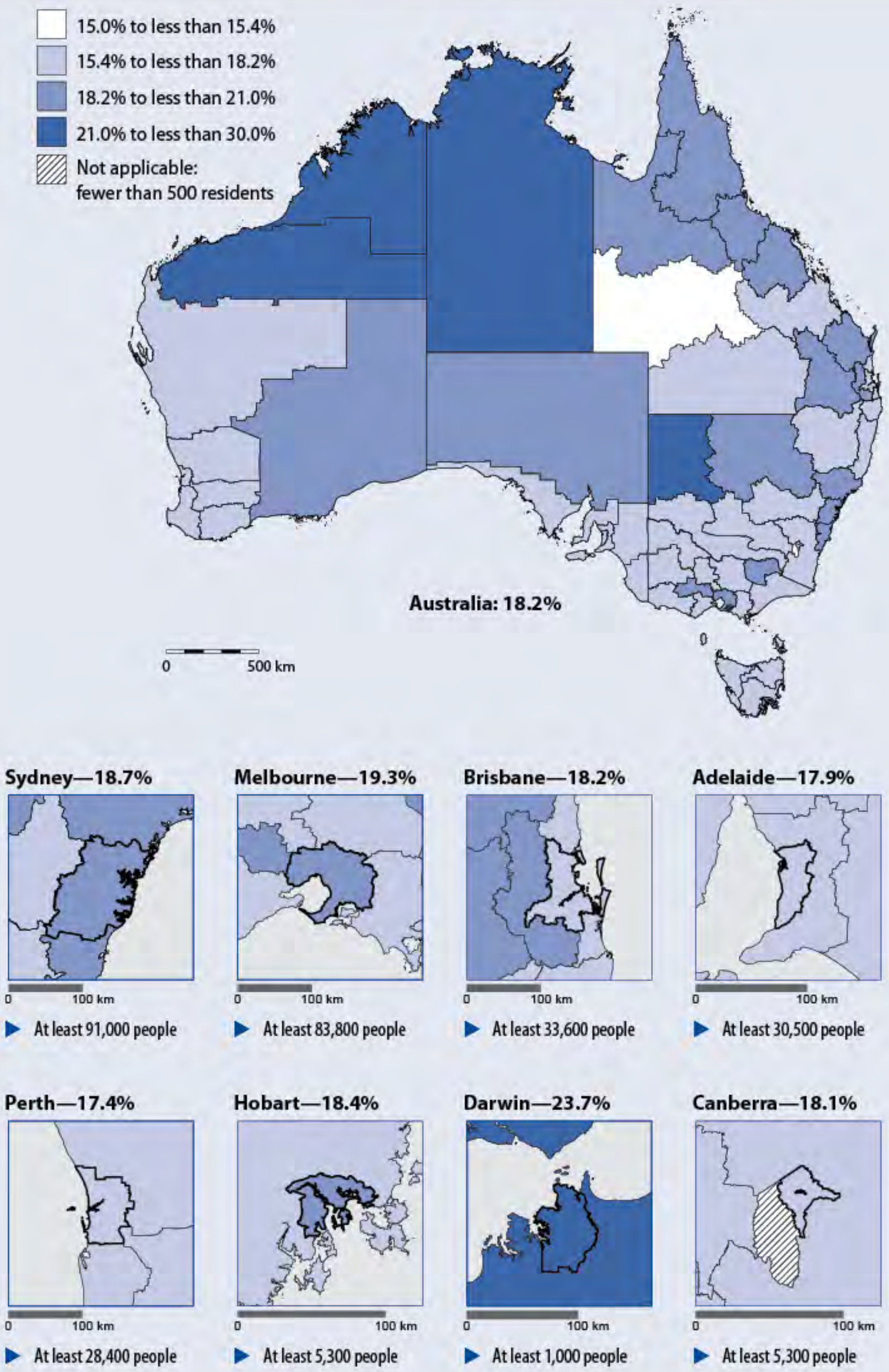
(a) ABS 2003 Survey of Disability, Ageing and Carers (SDAC) rates applied to ABS population projections (series B).

Sources: AIHW analysis of ABS 2003 SDAC confidentialised unit record file (CURF); ABS 2008k. Estimates based on the CURF may not exactly match those of ABS published reports as some potentially identifiable records are not included in the CURF.

Need for assistance is distributed unevenly

The 2006 Census of Population and Housing was the first Australian census to collect data about disability (see Chapter 4): specifically, data on the need for assistance with self-care, mobility and communication. Census data on this topic are less suited to determining prevalence estimates of disability than the Survey of Disability, Ageing and Carers (ABS 2006), but are particularly valuable for examining disability in small geographical areas and among small population groups.

According to the Census, disability among older people is distributed unevenly across Australia. The standardised rate of reported need for assistance with core activities among older people (including Aboriginal and Torres Strait Islanders aged 50–64) varies from 15.6% in the Midlands division of Western Australia to 29.5% in the Pilbara. The burden of disability among older people is greatest in remote areas, particularly the Pilbara (29.5%), Kimberley (27.6%), Northern Territory (27.8%) and Far West New South Wales (21.6%). Other areas with a high rate of need are concentrated in northern areas of Queensland, northern South Australia and on the east coast, particularly in Queensland and New South Wales (Figure 3.2) (see Chapter 4 for discussion about younger people with disability).



Source: Table A3.3.

Figure 3.2: Standardised rate of need for assistance with core activities, people aged 65 years and over by Statistical Division, 2006

Among capital cities, Darwin had the highest reported rate of need for assistance among people aged 65 years and over (24%), followed by Melbourne (19%) and Sydney (19%), while Perth had the lowest reported rate (17%). The largest numbers of people requiring assistance reflect the overall population of the cities: Sydney and Melbourne (at least 91,000 and 83,800 people respectively) had the largest numbers, while Darwin and Canberra (at least 1,000 and 5,300 people respectively) had the fewest people (Figure 3.2).

Among those aged 65 years and over, higher proportions of older Indigenous people needed assistance (26%) than non-Indigenous people (18%). Compared with Australian-born residents, overseas-born people aged 55 years or over were 10–20% less likely to need assistance if they were born in English-speaking countries, but 20–40% more likely to need assistance if they were born in non-English-speaking countries (see Chapter 4 for more detail).

3.3 Social and community participation

The Australian Government's social inclusion principles, developed with advice from the Australian Social Inclusion Board, recognise the importance of building and maintaining social connections for individual and societal wellbeing. Comparatively high rates of widowhood and disability may result in large numbers of older people being at risk of social isolation. Retirement from paid work may also increase this risk for older people due to the potential loss of social interaction with colleagues.

Current data sources about community and social participation such as the ABS 2006 General Social Survey and the 2006 Time Use Survey include older people living in the community but exclude people in residential aged care facilities. This is a major data gap, especially since some research suggests that moving to an aged care facility is a risk factor for social isolation (see Findlay & Cartwright 2002). There are also data gaps about the social connectedness of people receiving aged care services and whether (and how well) these services are meeting the social support needs of their clients.

Patterns of social contact

Retirement from paid work provides increased opportunities to spend time with a partner (where there is one). In 2006, average hours per week spent with a partner increased from 69 hours per week for men under 65 years to 115 hours for men aged 65 years and over; the difference for women was less marked (71 hours for women aged less than 65 and 74 hours for older women) (ABS 2008f). The average hours per week for women aged 65 years and over is affected by the sharp decline among those aged 75 years and over, due to the higher number of widows in this age group. High rates of widowhood among older women mean that, on average, women aged 65 years and over spend more than twice as many hours per week alone (61 hours) than men of the same age (30 hours) (ABS 2008f).

Contact with friends and family members who live elsewhere is particularly important for older people. In 2006, around 80% of people aged 65 and over had face-to-face contact with friends and/or family members in the previous week (ABS 2007; AIHW 2007c). The majority of older people (around 90%) had other forms of contact at least weekly, primarily via a fixed telephone.

Patterns of contact across age groups differed for men and women. For example, compared with their younger counterparts, a lower proportion of men aged 85 and over had some form of contact with family or friends (89% compared with 95% for men aged 65–74), but a higher proportion had face-to-face contact (83% compared with 70%) (AIHW 2007c:Table 10.1). The pattern for women was broadly similar across age groups for each type of contact.

In terms of participation in informal social activities such as visiting friends, available data suggest that this declines with age. In 2006, around 93% of people aged 65 years and over had engaged in a social activity within the last 3 months, declining from 94% among those aged 65–74 to 89% among those aged 85 and over (AIHW 2007c:Table A10.1). This decline was particularly marked for social activities that involved going out with friends (from 65% to 48% for indoor activities and from 63% to 41% for outdoor activities).

While high proportions of older people participate in these forms of social contact and participation, there also appears to be a small proportion with limited or no contact with family or friends, some of whom may be at risk of social isolation and in need of social support services. Extent of participation, however, may be a poor indicator of social opportunity as it encompasses personal choice (some people may prefer their own company or wish to avoid potentially difficult social situations).

Self-reported levels of satisfaction give a useful insight into whether older people believe they have adequate opportunity to participate. One such measure was collected by the 2003 ABS Survey of Disability, Ageing and Carers which found that one-fifth of older people living in private dwellings were not able to go out as often as they liked (AIHW 2007a:Table 3.21). Disability and poor health was the most common reason cited for not being able to go out, and older people with a profound or severe core activity limitation were more dissatisfied with social participation opportunities (53%) than those without these levels of limitation (14%).

Older people are an important source of volunteers and care givers

Older people make valuable contributions to their families and communities through unpaid household, volunteer and community work (De Vaus et al. 2003) as well as providing care to grandchildren and spouses or relatives with disability. This is particularly true among the younger age groups.

According to the ABS 2006 General Social Survey, 48% of people aged 65–74 provided unpaid assistance to people living outside their household, such as help with transport and errands, child care and emotional support (AIHW 2007c:Table A8.1). About one-third (33%) of people aged 65–74 years had undertaken voluntary work in the previous year (ABS 2007:Table 1). On average, people in the age groups 55–64 and 65–74 spend more time in voluntary work and care than other age groups (33 and 32 minutes per day respectively in 2006) (ABS 2008f).

Participation in voluntary work decreased in older age groups, partly reflecting high rates of ill health and disability. About 29% of people aged 75–84 and 17% of those aged 85 and over provided unpaid assistance to people outside their household in 2006 (AIHW 2007c:Table A8.1). Similarly, participation in volunteering declined to 22% of 75–84 year olds and 14% of those aged 85 and over (ABS 2007:Table 1). Time spent in volunteer work and care declined to an average of 25 minutes a day among those aged 75 and over, still higher than for age groups under 55 years (ABS 2008f).

3.4 Financial resources of older people

The majority of people aged 65 years and over were retired from the workforce in 2007 (85%). As people enter the older age groups and retire, income from wages, salaries and business activities tends to be replaced by income from superannuation, investments and/or government pensions. For all retired people aged 45 years and over in 2007, the main sources of income were government pensions and allowances (66%), 'other' sources including income from dividends, rental property, workers compensation, maintenance and other regular sources (12%), and superannuation (11%) (ABS 2008d).

The longer people had been retired, the more likely they were to have government pensions as their principal source of income. Government pensions and benefits were the main source of income for 74% of those who had been retired for 20 years or more. In part, this reflects generational differences in superannuation coverage. Older Australians are much less likely to have superannuation coverage than younger people, who have benefited more from the compulsory superannuation guarantee contributions instituted in 1992. In 2007, less than half (46%) of people aged 65–69 years and only 21% of people aged 70 years and over had superannuation coverage compared with 87% of people aged 25–54 (ABS 2008d).

A small proportion (5%) of people aged 65 years and over were employed full time in 2007, and the same proportion worked part time (ABS 2008d). This represents an increase of 2.6 percentage points compared with employment rates in 1996 (AIHW 2007c:Table 6.1). The remaining 5% were not in the labour force—either intending to work in the future or having never worked—or had an undetermined retirement status. Over one-quarter (29%) of those aged 65 years and over and employed in 2007 did not intend to retire from the labour force (ABS 2008d). AIHW calculations based on 2006 Census data show that in 2006 the average weekly income for employed people aged 65 years and over was just under $740, compared with just under $320 for those who were unemployed or not in the labour force (derived from ABS 2008b). Labour force and transition to retirement are discussed in detail in *Older Australia at a glance* (AIHW 2007c).

Government pensions

In June 2008, around 78% of the Australian population over the qualifying age for the Age Pension received this, or a similar means-tested income support payment from the Department of Veterans' Affairs (DVA) (Table 3.4). Eligibility for the Age Pension in June 2008 was 63.5 years (increasing to 65 by 2014) for women, and 65 years for men. The 2009 Budget measures include a decision to increase the qualifying age beginning in 2017 to reach age 67 by 2023 (FaHCSIA 2009).

Since its introduction on 1 July 1909, the Age Pension has grown into a major income support program with expenses totalling around $25 billion in 2007–08 (FaHCSIA 2008a). Over 2 million Australians aged 65 years and over received a full or part Age Pension at June 2008. More than half (56%) of age pensioners received a full-rate pension (Table A3.4). Currently, around 58% of pension recipients are women. A higher proportion of women (58%) receive a full pension than men (54%). In January 2009, the maximum single pension rate was $562.10 a fortnight and the maximum partnered rate was $469.50 for each member of a couple.

Table 3.4: Recipients of the Age Pension and the Department of Veterans' Affairs Pension, 2008[a]

	Age group (years)						
	60–64[b]	**65–69**	**70–74**	**75–79**	**80–84**	**85+**	**Total**
				Per cent of age pensioners[c]			
Males	. .	12.0	12.0	10.0	5.8	2.7	42.5
Females	3.9	14.3	13.2	11.0	7.5	7.4	57.5
Persons	**3.9**	**26.3**	**25.2**	**21.0**	**13.4**	**10.2**	**100.0**
Persons (number)	*79,973*	*535,011*	*512,095*	*427,140*	*271,908*	*207,318*	*2,033,445*
Per cent of age group population	*7.1*	*64.3*	*77.2*	*77.8*	*64.2*	*56.8*	*[d]69.0*
				Per cent of DVA pensioners[c]			
Males	5.6	2.4	1.9	2.3	9.7	13.7	35.5
Females	3.9	3.2	4.3	10.8	21.6	20.7	64.5
Persons	**9.5**	**5.5**	**6.3**	**13.1**	**31.2**	**34.4**	**100.0**
Persons (number)	*28,037*	*16,293*	*18,511*	*38,610*	*92,156*	*101,498*	*295,105*
Per cent of age group population	*2.5*	*2.0*	*2.8*	*7.0*	*21.8*	*27.8*	*[d]9.4*
Total as per cent of age group population	**9.6**	**66.3**	**80.0**	**84.8**	**86.0**	**84.6**	**[d]78.4**

(a) Age pensioners as at 6 June 2008; DVA pensioners as at 28 June 2008; estimated resident population as at 30 June 2008.

(b) Eligibility for the Age Pension in June 2008 was 63.5 years (increasing to 65 by 2014) for women, and 65 years for men.

(c) Age pensions administered by DVA are included in the 'DVA pensioner' figures.

(d) Per cent of people aged 65 and over.

Notes

1. Table includes full- and part-pension recipients (see Table A3.4 for a breakdown of recipients of part and full Age Pensions).
2. DVA pensioners include persons in receipt of a Service Pension, Disability Pension or War Widow's Pension.
3. Components may not add to total due to rounding.

Sources: Centrelink pensions database; DVA unpublished data.

In addition, in 2008 around 295,100 people aged 60 years and over received a pension from DVA (Age Pension, Service Pension or War Widow's/Widower's Pension) (Table 3.4). Currently almost two-thirds (65%) of DVA pensioners are women—over half of female DVA pensioners receive War Widow's pension (DVA unpublished data). By contrast, 96% of male DVA pensioners receive a Service Pension (DVA unpublished data). DVA pensions are particularly important for the cohort of older Australians aged 80 and over, many of whom served in World War II or are widows of those who served in the war.

Age Pension recipients have relatively modest levels of assessable assets and income. The average value of assessable assets was just over $32,000 for people receiving the full-rate pension and almost $133,000 for those receiving less than the full rate (FaHCSIA 2008a). Similarly, the average assessable income was lower for those receiving the full Age Pension than for those receiving a part-pension ($983 per year compared with $9,988).

Of those over Age Pension qualifying age and working, 27% received Age Pension payments and another 21% were registered in the Pension Bonus Scheme (FaHCSIA 2008a). This scheme (to be closed to new entrants from 20 September 2009) is intended to encourage older Australians to defer claiming the Age Pension, and continue working beyond the qualifying age. It provides a one-off tax-free lump sum to eligible registered people when they later claim and receive the Age Pension. As at 30 June 2008, over 150,000 people had registered in the scheme since it began in July 1998 (FaHCSIA 2008a).

Box 3.1: Financial support arrangements for older people, 2007–2009

From **20 March 2008,** the implementation of measures included in the Helping Seniors Make Ends Meet election commitments resulted in increases to Seniors Concession Allowance, Telephone Allowance, and Utilities Allowance; and Australian Government funding to state and territory governments to allow the provision of reciprocal public transport concessions to holders of Seniors Cards issued by those governments.

2008–09 Budget measures included a one-off bonus payment of $500 to older Australians who received Utilities Allowance or Seniors Concession Allowance.

December 2008: Economic Security Strategy payments to Age Pensioners and holders of the Commonwealth Seniors Health Card ($1,400 to single persons and $2,100 to couples).

2009–10 Budget measures included:

- maximum pension rate increases of $32.49 per week for singles and $10.14 per week combined for couples.
- the introduction of a Pension Supplement to incorporate the GST pension supplement, Pharmaceutical Allowance, Utilities Allowance and Telephone Allowance.
- a gradual increase in the qualifying age for the Age Pension from 65 in 2017 to 67 by 2023. The qualifying age for the Veterans' Service Pension will remain at 60.
- the development of a new Pensioner and Beneficiary Living Cost Index (PBLCI) designed to reflect changes in the cost of living experienced by pensioner and beneficiary households.
- tighter targeting of the Age Pension by changing the income test taper. Under the new rules, the pension will be paid to new pensioners with private income of up to $38,693 for singles and $59,228 for couples combined.
- the introduction of a Work Bonus which will treat pensioners' earned income more generously under the income test. Up to $250 of earnings a fortnight will be excluded from means testing.
- for 2009–10, the minimum amount self-funded retirees have to draw down from their account-based pensions will be halved.

Sources: FaHCSIA 2008a,c, 2009.

The financial wellbeing of older Australians was a major focus of government activity over the last 2 years. The principal response to these concerns was delivered in the 2009 Budget in response to the Pension Review (Harmer 2008). The Pension Review was directed to consider appropriate levels of income support and allowances and the efficacy of lump sum versus ongoing support. During 2008, pensioners and holders of the Commonwealth Seniors Health Card had received increases in a number of allowances as well as one-off payments as part of the economic stimulus package. In addition to the decision to raise the qualifying age for the Age Pension, the 2009 Budget measures included an increase in pension rates, streamlining of pensioner allowances and the development of a new Pensioner and Beneficiary Living Cost Index (Box 3.1).

Further changes to the retirement income system may take place following the final report of Australia's Future Tax System Review Panel due in December 2009. The Review Panel's interim report into the retirement income system was released in May 2009 and recommended that the three-pillar architecture of the system (the Age Pension, compulsory saving through the superannuation guarantee and voluntary superannuation saving) be retained (Australia's Future Tax System Review Panel 2009). The panel also recommended gradually aligning superannuation preservation ages with the increased Age Pension age, improving incentives to work beyond current retirement age, and introducing measures to reduce complexity and improve fairness in pension means tests, superannuation concessions and the interactions between the tax-transfer system and the aged care sector.

3.5 Provision of aged care

Most of the care of older people with long-term health conditions and disability is provided on an unpaid basis by relatives and friends. Carers may provide assistance with a broad range of activities, including core activities (self-care, mobility and communication) and non-core activities (for example transportation, shopping, meal preparation, household chores and paperwork). Informal care underpins Australia's community services system, not least of all in aged care. Informal care is discussed in more detail in Chapter 5.

Government-funded aged care is a feature of the care arrangements for significant numbers of frail older people, either supplementing informal care or providing a substitute for those without access to practical assistance from family and friends or for whom family care is no longer able to meet their needs. Funding and regulation of aged care services are predominantly the role of the Australian Government, which aims to 'ensure that older people receive a choice of high quality, accessible and affordable care; and that carers get the support they need to look after frail older people living at home. The Government also aims to encourage older people to live active and independent lives' (DoHA 2009b:147).

A number of information, referral and assessment services are in place to help people access aged care services. These include the Commonwealth Carelink Centres that operate across Australia (see <www9.health.gov.au/ccsd/> for more details) and the Aged Care Australia website (<www.agedcareaustralia.gov.au>).

Assessment of the care needs of potential aged care recipients is an integral part of accessing formal aged care services. In addition to testing eligibility for formal aged care services, assessment attempts to ensure that the services recommended will be appropriate for the individual care recipient. Assessment and approval by a multidisciplinary Aged Care Assessment Team (ACAT) is required for accessing services provided under the *Aged Care Act 1997*: Community Aged Care Packages (CACPs), Extended Aged Care at Home (EACH) and EACH Dementia (EACHD) packages, Transition Care and residential aged care programs (both permanent and respite care).

ACAT assessments are not required for the Home and Community Care (HACC) Program, the National Respite for Carers Program, Veterans' Home Care (VHC) or DVA Community Nursing; however, ACATs can refer clients to these programs. Several different assessment tools are used by HACC service providers. Two tools are being developed for use as nationally consistent assessment instruments for use in HACC: the Australian Community Care Needs Assessment–Revised and the Carer Eligibility and Needs Assessment–Revised. These will also be used by the National Carers for Respite Program. These tools are currently being refined and evaluated (DoHA 2009a).

The previous volume of *Australia's welfare* outlined major changes in aged care policy over the last decade (AIHW 2007a:Boxes 3.2–3.4). Significant developments in aged care policy, delivery and data development since the 2007 volume are outlined in Box 3.2.

Box 3.2: Developments in aged care policy, programs and data 2007–2009

2007

Survey of residential and community based aged care workforce conducted (Martin & King 2008).

2008

In March 2008 a new funding framework for Commonwealth–state financial relations was announced by the Council of Australian Governments (COAG). Funding arrangements for the Aged Care Assessment Program and the Home and Community Care Program changed from February 2009.

A Community Care Census, conducted by the Department of Health and Ageing, gathered data about recipients of CACPs, EACH, EACHD and the National Respite for Carers Program. The census updated and expanded an earlier census conducted in 2002 of CACPs and EACH packages. Both census collections include data about the care needs and services received by care recipients and carers that is not available through routine administrative data.

The Aged Care Funding Instrument was introduced from March 2008. See Box 3.7 for more detail.

All states and territories completed the transition to reporting version 2 of the HACC Minimum Data Set. All data for 2007–08 is in version 2.

The Indigenous Aged Care plan was announced. This aims to raise the standards of Indigenous and remote aged care services.

The 2008 Loans Round of the Zero Real Interest Loan initiative was completed. Loans were offered to 36 approved aged care providers for construction or extension of residential aged care facilities in areas of high need.

2009

From 1 July 2009 all current ACAT approvals for the following care types will not lapse if a person has not received the following types of care: residential respite care (high and low care), high-level residential care, EACH and EACHD packages. This means that all approvals made for these care types on or after 1 July 2008, which are not time limited so that they expire before 1 July 2009, will not lapse.

The *Aged Care Act 1997* now includes homeless older people as a 'special needs' group to formally recognise their unique requirements.

The 2009 Budget included the following measures:

- amendment of the *Aged Care Act 1997* to reset the basic daily care fee from 85% to 84% of the single age pension base rate so that pensioners in aged care homes can retain some of the Age Pension increase
- increased funding to aged care providers flowing from the continuation of the Conditional Adjustment Payment and increases to pension levels.

Sources: Health and ageing portfolio 2009; Health and ageing portfolio 2008.

Aged Care Assessment Program

The Australian Government and state and territory governments jointly fund the Aged Care Assessment Program (ACAP) under which ACATs conduct client assessments in relation to five dimensions of care need: physical, psychological, medical, cultural and social (DoHA 2002). The target population for services approved by ACATs is all people aged 70 years and over and Indigenous people aged 50 years and over. Young people with disability may receive an ACAT assessment if their care needs cannot be met by other sources.

This section reports ACAP data for 2006–07, the most recent available at the time of writing. During this period, most ACAT approvals remained valid for 12 months (see Box 3.2 for change from 1 July 2009). In 2006–07, ACATs accepted referrals to assess 179,858 clients with known age and Indigenous status, and assessments were completed for 161,389 clients (Table 3.5). At assessment, 92% of clients were living in the community, including 73% in private residences. Only 8% were living in institutional settings including residential aged care.

Permanent residential aged care was recommended for just under half of older ACAP clients with a completed assessment (45%), mostly for high care, with 50% recommended to live in a private residence (see Box 3.3 for a description of the relationship between ACAT recommendations and approvals).

Box 3.3: ACAT recommendations and approvals for care and support

A completed ACAT assessment results in recommendations for long-term care and program support as part of a care plan. Recommendations may include care in the community with support from programs such as HACC or VHC, or in support from an aged care program which requires an ACAT approval. Only one long-term care setting can be recommended (either community or residential), but clients can be approved for use of more than one type of care. For example, a client may receive a recommendation for high-level residential care, and be approved to use high-level permanent residential care as well as an EACH package and/or residential respite care.

Differences between recommendations and approvals may arise because:

- some approvals are 'just in case', where a client may be recommended to live in the community but is eligible for low-level residential care and approved for this care in case it is required
- some approvals are for support that is 'interim until entry to residential care', such as for the client in the example above who is recommended to live in residential care but packaged care and residential respite care may be provided in the interim.

In cases where the assessor and the client do not agree on the outcome of the assessment, approvals may reflect the client's views, whereas the recommendation reflects the assessor's view.

Once approval is granted, the client's receipt of services is subject to the availability of places and other considerations. Clients can be reassessed within the 12-month period if their care needs or attitudes change to the extent that a different level or type of care is required or desired.

Sources: ACAP NDR 2006; AIHW 2007a.

Around two-thirds (66%) of older ACAT clients with a recommendation for care services in the community were receiving formal assistance at the time of assessment (Table 3.6). In terms of ongoing program support, HACC was the most commonly used program (43%), followed by CACPs (10%) and VHC (9%). Following assessment, ACATs recommended a CACP for 37% and EACH or EACHD for 7% of older clients.

Table 3.5: ACAT clients, accommodation at assessment and as recommended, Australia, 2006–07[(a)]

	Usual accommodation at assessment for clients referred to ACAT[(b)]			Recommended long-term care setting for clients with completed assessment[(c)]		
	Age <65 or Indigenous <50	Age 65+ or Indigenous 50+	Total	Age <65 or Indigenous <50	Age 65+ or Indigenous 50+	Total
Community setting						
Private residence	75.5	73.1	73.2	54.5	49.7	49.9
Independent living in a retirement village	1.8	8.6	8.3	0.9	3.3	3.2
Supported community accommodation	3.6	1.3	1.4	3.4	0.7	0.8
Other	12.8	8.7	8.9	1.6	0.7	0.7
Total	*93.6*	*91.7*	*91.8*	*60.3*	*54.4*	*54.7*
Institutional setting						
Residential aged care service— low care	3.0	6.9	6.7	12.1	18.9	18.6
Residential aged care service—high care	1.5	1.0	1.0	26.6	26.2	26.2
Hospital	0.9	0.2	0.2	0.4	0.4	0.4
Other institutional care	1.0	0.3	0.3	0.6	0.1	0.1
Total	*6.4*	*8.3*	*8.2*	*39.7*	*45.6*	*45.3*
Total (per cent)	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**
Not stated or inadequately described (number)	786	9,825	10,611	. .	. .	. .
Total (number)	**8,080**	**171,778**	**179,858**	**6,828**	**154,561**	**161,389**

(a) Table includes only results from the last assessment for clients assessed more than once in the financial year.

(b) Usual accommodation at assessment includes incomplete assessments, i.e. those whose referral has been accepted by ACAT.

(c) Recommended long-term care setting includes only completed assessments for those who received a recommendation for long-term care.

Notes

1. Usual accommodation at assessment excludes 109 cases with missing, unknown or inadequately described information on non-Indigenous age and 5,451 cases on Indigenous status (in MDS v2).
2. Recommended support at assessment excludes 105 cases with missing, unknown or inadequately described information on non-Indigenous age and 3,390 on Indigenous status (in MDS v2).
3. Percentages based on numbers of clients, cases with known age, Indigenous status and accommodation setting.
4. Components may not add to total due to rounding.

Sources: Aged Care Assessment Program National Data Repository; AIHW analysis of ACAP MDS v2.

ACAT assessments serve a key role in identifying the need for respite care. Before assessment only about 10% of older ACAP clients who were recommended to live in the community had used residential respite care and 5% had used services through the National Respite for Carers Program (NRCP) (Table 3.6). Following assessment, ACATs recommended residential respite care for 67% and NRCP services for 22% of clients.

Table 3.6: ACAT clients with a recommendation to live in the community: program support at assessment and as recommended after assessment, Australia, 2006–07(per cent)[(a)(b)]

	Clients with a recommendation to live in the community					
	Program support received at time of assessment			**Program support recommended by ACAT after assessment**		
	Age <65 or Indigenous <50	**Age 65+ or Indigenous 50+**	**Total**	**Age <65 or Indigenous <50**	**Age 65+ or Indigenous 50+**	**Total**
CACP	5.7	9.6	9.5	20.5	37.0	36.3
EACH/EACHD	2.0	1.1	1.2	9.4	6.7	6.8
HACC	41.5	42.5	42.4	41.4	41.4	41.4
Veterans' Home Care	0.7	8.6	8.3	0.6	7.9	7.5
Day Therapy Centre	2.8	1.9	1.9	4.0	3.9	3.9
National Respite for Carers Program	8.0	4.7	4.9	21.5	21.7	21.7
Transition Care	0.3	0.3	0.3	1.2	2.3	2.2
Residential respite care	13.4	9.6	9.8	52.4	66.9	66.2
Other	13.2	7.0	7.3	13.0	7.3	7.5
None	39.2	34.1	34.3	21.4	10.7	11.2
Total (number)	**3,917**	**83,109**	**87,026**	**4,082**	**86,221**	**90,303**

(a) Table includes only results from the last assessment for clients assessed more than once in the financial year.

(b) Clients who receive or are recommended to receive support from multiple programs are counted separately under each applicable program.

Notes

1. Table excludes 1,774 cases of unknown Indigenous status, and 75 cases of non-Indigenous unknown age.
2. For 'Program support at time of assessment' table excludes 32,187 cases with unknown, inadequately described or missing information.
3. For 'Program support recommended' table excludes 2,322 cases with unknown, inadequately described or missing information.

Sources: Aged Care Assessment Program National Data Repository; AIHW analysis of ACAP MDS v2.

A considerable number of community-based clients were receiving informal and/or formal assistance with activities of daily living at the time of assessment, with informal assistance more common for all types of activities, especially in relation to communication, mobility and transport (see Table A3.5). For example, 85% received assistance with domestic chores and 48% with self-care activities.

Recommendations of formal care for ACAP clients living in the community were highest for domestic assistance (73%), transport (52%), and social support (51%) (ACAP NDR unpublished data). A higher proportion of ACAP clients aged 85 and over was recommended to receive formal domestic assistance (77%) and assistance with meals (52%) than the proportion of those aged 65–74 (67% and 42% respectively). Similar proportions were recommended for formal assistance with social support (52% of those aged 85 and over and 50% of those aged 65–74).

The majority (72%) of ACAT assessments in 2006–07 were performed in a non-hospital setting, with just over a quarter (28%) performed in a hospital setting (Table A3.6). There is a marked difference in relation to recommended long-term care arrangements depending on the assessment settings. Overall, hospital-based assessments were most likely (51%) to result in recommendations for high-level residential care, with only about a quarter (27%) resulting in recommendations for community care. In contrast, only 14% of assessments carried out in a non-hospital setting resulted in recommendations for high-level residential care, with over two-thirds (68%) for community care. Possible reasons for this difference in recommendation patterns include a change in health status experienced by clients assessed in hospitals and local ACAT data reporting practices (ACAP NDR 2007:142).

Overall, dementia was the most frequently recorded health condition that contributed to the ACAP client's need for care, accounting for one in five of all assessments (see Table A3.6). It was more prevalent as a main condition among people assessed by ACATs in non-hospital settings in 2006–07 (21%) than among those assessed in hospitals (16%). Over half (54%) of assessments performed in a non-hospital setting for clients with a main health condition of dementia resulted in recommendations for community care, with only a quarter (25%) resulting in recommendations for high-level residential care. Common main health conditions among people assessed in hospitals were cerebrovascular disease/ stroke, fracture and cancers, while for those assessed in non-hospital settings they were arthritis, heart conditions and cerebrovascular disease/stroke.

Reassessment and use of programs after ACAT assessment

ACAT data do not show what care programs are accessed following assessments. In addition, since ACAT approvals are generally only valid for 12 months, there has long been interest in the extent to which people had multiple assessments within a 12-month period and whether all of these assessments were necessary. Aged care administrative data have been recently linked for the Pathways in Aged Care (PIAC) cohort study (described in Box 3.4 and AIHW 2009b) and were used to explore this issue.

During the period covered by the study (2003–2006), approvals for all programs remained valid for 12 months. Reassessment within the 12-month period may have occurred for a number of reasons. Until 30 June 2004, all permanent residents required an ACAT assessment to change from low to high care—not just those who were changing care facilities, as was the case from 1 July 2004 (ACAP NDR 2005:173). Changes in client attitude and circumstances may also result in a new ACAT assessment within a 12-month period.

Nearly one-third of the PIAC new-pathways cohort had a reassessment within 12 months of their original completed assessment (the ACAT reference assessment) (AIHW 2009b:Table 1). The majority of these had only one additional assessment, but about 1,000 cohort members (or slightly more than 1%) had three or more assessments within the 12-month period. Nearly 15% of the cohort's reassessments ended without completion (reasons for this may include death of a client, changes in client health status or client concerns about the implications for their care). One in 10 reassessments was for a person already in permanent residential care.

For almost half of those who had a reassessment within 12 months, the first event in their care pathway after the reference assessment was a further ACAT assessment (49%) (Table 3.7), suggesting either a change in circumstances or attitude since their earlier assessment. Use of HACC or VHC services was the most common event after assessment for those who had not previously used these programs (43%). Another relatively common event was the use of residential respite care (13%), reflecting the 12-month limit on the currency of an ACAT approval.

Box 3.4: Pathways in Aged Care (PIAC) Cohort Study

As people's care needs change they may use support from different programs, or they may use support from more than one program at a time. Until recently, it has not been possible to examine people's pathways through the aged care system as a whole. Nor has it been possible to examine whether people act on the ACAT recommendation and approvals they have received (see Box 3.3 for discussion of ACAT recommendations and approvals).

In 2008–09, as part of the PIAC cohort study, a research team centred at the AIHW constructed a linked dataset that allows investigation into patterns and dynamics in aged care service use (AIHW 2009b).

The PIAC project linked data from the ACAP Minimum Data Set version 2 for clients' first completed ACAT assessment in 2003–04 (the reference assessment for the study) to other data sets detailing use of aged care programs for the years 2002–03 to 2005–06. These programs included HACC, VHC, CACP and EACH packages and residential aged care. The project also linked data for other ACAT assessments over 2003–04 and 2004–05. Deaths data were also linked to identify completed pathways.

The full PIAC cohort contains 105,077 people with a completed ACAT assessment during 2003–04 (ACAP NDR 2005). The PIAC new-pathways cohort consists of 77,437 people who had not previously used services requiring an ACAT approval. This group can be considered to be starting out on their care pathway. The cohort excludes clients from services that had not made the transition to reporting ACAP Minimum Data Set version 2 data during 2003–04. This mainly involved clients living in Queensland and northern New South Wales. In 2003–04, 70% of all ACAT assessments were reported using version 2 of the ACAP Minimum Data Set.

Table 3.7: First care pathway event for PIAC new-pathways cohort members with reassessments within 12 months of the end of the ACAT reference assessment (per cent)

First program event	With HACC/VHC before ACAT assessment	Without HACC/VHC before ACAT assessment	Total
Incomplete ACAT assessment	8.1	5.7	7.1
Completed ACAT assessment	47.1	33.5	41.6
HACC	12.2	40.8	23.7
VHC	1.8	1.9	1.8
CACP	8.4	4.1	6.7
EACHD	0.2	0.1	0.2
Residential respite care	16.3	9.1	13.4
Permanent residential care	5.9	4.9	5.5
Total	**100.0**	**100.0**	**100.0**
Total clients (number)	**15,135**	**10,152**	**25,287**

Notes

1. Table excludes 89 records with a pathway that indicated death before receipt of care, as this implies linkage errors.
2. The reference assessment is the first completed ACAT assessment in 2003–04.
3. An ACAT assessment may end before completion due to a number of reasons, including client withdrawal, changes in medical condition and death. As this table includes people with at least one reassessment, the category 'death' does not appear.

Source: AIHW analysis of PIAC cohort database.

In order to improve the efficiency of the ACAT assessment process and increase access to assessments by older people, from 1 July 2009 approvals for residential respite care, high-level residential care, EACH and EACHD will no longer lapse unless specified as time limited by the ACAT (Box 3.2).

Care services in the community

Community care programs are designed to support older people in their own home. In terms of client numbers, HACC, administered under the *Home and Community Care Act 1985*, is the largest of these programs. The HACC program provides 'a comprehensive coordinated and integrated range of basic maintenance and support services for frail aged people, people with disability and their carers' (DoHA 2008c).

Assistance available through HACC includes domestic assistance, personal care, transport, home maintenance, nursing and allied health care. The Australian Government provides around 60% of funding for the program and maintains a broad strategic policy role. The state and territory governments provide around 40% of government funding and are responsible for program management, including the approval and funding of individual HACC services in their jurisdictions.

As at 30 June 2008, there were about 3,300 active agencies registered in the HACC Minimum Data Set Agency Register. During 2007–08, an average of 91% of registered agencies reported data for each quarter (DoHA 2009a). Over this period, these agencies provided services and assistance to about 638,200 people aged 65 and over (Table 3.12). Older people made up 77% of the total HACC client population, slightly more than in 2004–05 (76%). Use of HACC services by older people increased since 2004–05, from 211 per 1,000 to 225 per 1,000 persons aged 65 and over in 2007–08 (Table A3.10) (see also AIHW 2007a).

Eligible veterans, war widows and widowers can receive assistance from a number of DVA-funded community care programs. Veterans' Home Care (VHC) delivers in-home support services including domestic assistance, personal care, home and garden services, and respite care. VHC is the second largest provider of community aged care services after HACC, providing services to almost 80,000 clients in 2007–08 (Table 3.16). Eligible people needing more than 1.5 hours per week of personal care or nursing may be referred to the DVA Community Nursing program, which served over 30,000 clients in 2007–08 (Table 3.16).

Other DVA programs that provide support to older people include the DVA Rehabilitation Appliances Program for the supply of aids and equipment; HomeFront, a falls and accident prevention program; and the Home Maintenance Line, a telephone service for advice with property maintenance and emergency repairs. Clients of DVA programs may also be eligible for assistance through other programs, on the basis of an assessment of care needs.

Smaller community and flexible care programs are administered under the *Aged Care Act 1997* by the Department of Health and Ageing, particularly CACP, EACH, EACHD packages, Transition Care Program and Innovative Care.

The CACP program delivers care packages, offering a mix of types of assistance according to a client's need together with case management and coordination by the service provider. The CACP program was introduced in 1992 to provide support in community settings for people who may otherwise qualify for low-level residential care. Services available through a CACP include personal care, home help, transport, meal preparation and gardening. Nursing and allied health are not available through CACP. Since 1998, the number of operational packages has increased fourfold. At 30 June 2008, 1,100 mainstream service outlets managed nearly 40,000 packages and delivered CACP services to almost 37,000 clients (Table 3.8), 95% of whom were aged 65 years and over. During 2007–08, over 53,000 clients received a CACP package.

EACH packages are designed as a community-based alternative to high-level residential care. In addition to the services available through CACP, EACH clients are able to receive specialist nursing care and allied health care. While still relatively small in size, the growth in this program since its pilot phase in 2002 has been rapid. At 30 June 2008, EACH was providing assistance to almost 4,000 clients compared with only 82 in 2002 and 700 in 2004 (Table 3.8). During 2007–08, around 5,900 individuals received an EACH package.

In 2006, EACH Dementia (EACHD) was implemented, providing ongoing care packages to older people with dementia-related high-care needs. At 30 June 2008, EACHD was providing assistance to 1,615 clients (Table 3.8). 2,600 clients were assisted during 2007–08.

Table 3.8: Care package programs, number of operational packages, provision ratio, number of services and clients, 1998 to 2008 (as at 30 June)

Program/year	Operational places/packages	Provision ratio[(a)]	Service outlets	Clients
CACP				
1998	10,046	6.3	480	9,583
2000	18,308	10.8	720	16,617
2002	26,425	14.7	916	24,585
2004	29,063	15.6	959	27,657
2006	35,383	18.2	1,011	31,803
2008	40,280	20.1	1,100	36,914
EACH				
2002	171	0.1	6	[(b)]82
2004	860	0.5	54	707
2006	2,580	1.3	157	2,131
2008	4,244	2.1	266	3,889
EACHD				
2006	601	0.3	49	279
2008	1,996	1.0	187	1,615
Transition Care[(c)]				
2006	595	0.3	25	296
2008	1,963	1.0	76	10,368

(a) Number of operational packages per 1,000 persons aged 70 years and over.

(b) Excludes 202 clients receiving assistance in the pilot phase.

(c) May be provided in either a home-like residential setting or in the community.

Note: From 1999 the number of places includes those provided by Multi-Purpose Services and services receiving flexible care subsidy under the National Aboriginal and Torres Strait Islander Aged Care Program.

Sources: ABS 2008; AIHW analysis of DoHA ACCMIS database as at October 2008.

The planning framework for services provided under the *Aged Care Act* aims to achieve a national provision level of 113 operational residential places and community aged care packages per 1,000 persons aged 70 years and over, by June 2011. Within this overall target ratio, 25 places should be community care places (of which 4 will be for EACH or EACHD packages). The provision ratio of community care packages has increased consistently over the last decade: at 30 June 2008, the provision of operational packages was 23.2 per 1,000 people aged 70 and over (20.1 CACPs and 3.1 EACH and EACHD packages) (Table 3.8).

More detailed data on community care programs, including information for states and territories, is available from the HACC Minimum Data Set annual bulletin (available from <www.health.gov.au>) and annual reports about aged care packages in the community (most recently AIHW 2009a).

Transition Care

The Transition Care Program was introduced in 2006, under joint funding arrangements between the Australian Government and state and territory governments. Transition care is goal-oriented, time-limited and therapy-focused—the program delivers a package of services including low-intensity therapy, nursing support and/or personal care to older people following a stay in hospital.

The aim of the program is to help older people who are leaving hospital to return home rather than prematurely enter residential care, improve the functional capacity and independence of those discharged from the program, and reduce extended hospital stays by older people. It optimises their independent functioning and gives them, their families and carers time to make longer term plans. The program is therefore for older people who would otherwise be eligible for residential care. To enter the program, clients must be assessed by an ACAT while they are still in hospital, and the client can only enter transition care directly upon discharge from hospital. Data about the effectiveness of the program in terms of improved functional outcomes for clients are reported in Section 3.7.

At June 2008, there were 76 service outlets with almost 2,000 operational places (Table 3.8). Transition care may be provided in either a home-like residential setting or in the community. The average duration of care is 7 weeks, with a maximum duration of 12 weeks that may, in some circumstances, be extended by a further 6 weeks. In 2007–08, over 10,000 individual clients used the program (Table 3.8). Including people who used the program more than once, there were over 11,000 admissions. Since its introduction, the Transition Care Program has assisted over 18,000 individual clients.

Further information about the program may be found at <www.health.gov.au>.

Respite care

Respite care serves a mixture of functions in the aged care service sector. Carers may require a break from providing assistance, sometimes on a regular basis. Frail older people without a carer (including those receiving formal care services) may also require a level of care for short periods of time outside their usual accommodation setting, to provide them with a break from the demands of caring for themselves or to provide them with opportunities for social interaction. Respite care can be provided in the person's home, in a day centre, in community-based overnight respite units and in residential aged care homes.

Programs that deliver care services typically offer respite care services in the community and may also help clients to access residential respite care. For example, HACC provides respite care in the form of a substitute carer in the home, centre-based respite, host-family respite and peer-support respite. VHC provides in-home respite care, while DVA separately funds residential respite care for eligible clients.

The National Respite for Carers Program is dedicated to the provision of respite care and other forms of support for carers. The program provides direct respite care in a number of settings, as well as indirect respite such as domestic assistance, social support and personal care for the care recipient, intended to relieve carers of some of the tasks of daily living (see AIHW 2007a:Box 3.5 for more detail). During a 1-week census in 2008, around 8,500 carers received a total of 97,000 hours of program-funded respite care (DoHA unpublished data).

Residential respite care provides emergency or planned care in a residential aged care home on a short-term basis. An ACAT approval is required to access residential respite care, and, up until 1 July 2009, an approval remained valid for 12 months (see Box 3.2). A person with a valid approval may use up to 63 days of respite care in a financial year, which may be taken in 'blocks'. Extensions of residential respite care for periods of 21 days can be approved by an ACAT. The numbers of people using residential respite care are small at any point in time (almost 3,200 people, or 2% of aged care residents at 30 June 2008) (AIHW 2009c). The short length of stay (an average of 3.3 weeks) means that the total number of people using respite care during the year is much higher. In 2007–08, there were about 51,300 admissions to residential respite care, which accounted for 49% of all residential care admissions.

Among the PIAC new-pathways cohort of 77,437 people (see Box 3.4), 41% received an ACAT approval for residential respite care at least once during 2003–04. This included 17,104 people who were recommended by ACAT to live in the community and to access residential respite care. Despite the ACAT recommendation, which implies that the older person (and the carer if available) would benefit from residential respite care, almost three-quarters of this group (73%) did not use residential respite care in the year following the ACAT assessment (Table 3.9). Some of these may have died before they could access residential respite care. The majority of those who took up this option within the year did so in the first 3 months. Thereafter take-up of residential respite care slowed down considerably.

Possible reasons for the low rates of take-up of residential respite care are indicated by carer submissions to the recent parliamentary inquiry into better support for carers. While carers indicated that respite care was of critical importance to them, they also cited issues such as a shortage of respite places in their local area, affordability (especially for those reliant on government pensions), insufficient flexibility in respite care options, and difficulties in understanding and accessing available services (HRSCFCHY 2009:167–176).

A group within this cohort who had an approval for residential respite care were recommended for permanent residential aged care or some other institutional care (13,651 people). Over one-quarter of this group (27%) used residential respite care within 12 months of their first completed ACAT assessment (Table 3.9). About one-quarter (25%) of those who entered permanent residential care within the 12-month period had used respite care in the first 3 months after the end of their ACAT assessment. In general, the more time that elapsed before a person moved into permanent residential care, the more likely it was that the person had first used respite care. This may suggest that some people used respite care to delay entry to permanent care, either because of problems with the availability of suitable permanent care or because of client preferences about their long-term care setting. It may also indicate that some people use residential respite care as an introduction to permanent residential care, which becomes more acceptable to them and/or their carers after these shorter term experiences.

Table 3.9: People with a recommendation[(a)] for residential respite care: time to first use of residential respite care after the first completed ACAT assessment in 2003–04, PIAC cohort[(b)] with an approval for residential respite care.

Time to take-up of residential respite care[(c)]	Per cent	Number
0–91 days	14.1	2,412
92–183 days	6.2	1,052
184–274 days	3.8	653
275–365 days	2.9	504
Within the year	*27.0*	*4,621*
Within 1–2 years	9.1	1,558
Not within 2 years	63.9	10,925
Total	**100.0**	**. .**
Total (number)	**. .**	**17,104**

(a) A person cannot be recommended for residential respite if their recommended long term care setting is residential aged care, hospital or other institutional care. Hence this table includes only clients recommended to live long-term in the community.

(b) The PIAC (Pathways in Aged Care) new-pathways cohort is 77,437 people with a completed ACAT assessment in 2003–04 reported on the ACAP NMDS V2, and who had not previously used programs which required an ACAT assessment. Note that in 2003–04 Queensland and parts of New South Wales were not covered by the MDS v2 (see Box 3.4).

(c) The reference date is the end-date of the first completed ACAT assessment in 2003–04 with an approval for residential respite care.

Notes

1. Table excludes 17 records with a care pathway that indicated death before receipt of care as this implies linkage errors.
2. A person may die before they can take up approved residential respite.

Source: Pathways in Aged Care (PIAC) cohort database.

Table 3.10: People who were recommended to live in long-term permanent residential care: time to residential respite by time to permanent care, PIAC new-pathways cohort[(a)] with an approval for residential respite care (per cent)

	Time to permanent care							
Time to respite	0–91 days	92–183 days	184–274 days	275–365 days	Total within 1 year	Within 1–2 years	Not within 2 years	Total
0–91 days	23.6	31.8	21.3	18.3	24.5	15.0	12.4	19.3
92–183 days	0.2	10.7	17.3	12.2	5.0	6.6	2.9	4.4
184–274 days	0.1	0.1	8.5	12.4	2.0	5.0	2.0	2.3
275–365 days	0.1	0.1	—	8.7	0.8	7.6	1.1	1.5
Within the year	*23.9*	*42.6*	*47.2*	*51.6*	*32.3*	*34.2*	*18.4*	*27.5*
Within 1–2 years	0.4	0.1	0.1	0.2	0.3	18.6	4.3	3.5
Not within 2 years	75.7	57.2	52.7	48.2	67.4	47.2	77.2	69.1
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**
Total (number)	**4,604**	**1,450**	**797**	**597**	**7,448**	**1,278**	**4,925**	**13,651**
Per cent of total	**33.7**	**10.6**	**5.8**	**4.4**	**54.6**	**9.4**	**36.1**	**100.0**

(a) The PIAC (Pathways in Aged Care) new-pathways cohort is 77,437 people with a completed ACAT assessment in 2003–04 reported on the ACAP MDS v2, and who had not previously used programs which required an ACAT assessment. Note that in 2003–04 Queensland and parts of New South Wales were not covered by the MDS v2.

Notes

1. Table excludes those who were recommended for residential respite care as a person cannot be recommended for residential respite if they are recommended to live long term in permanent residential care.
2. Table excludes 13 records with a care pathway that indicated death before receipt of care as this implies linkage errors.
3. The reference date for time periods is the date of the end of the first completed ACAT assessment in 2003–04 with an approval for residential respite care.
4. A person may die before they can take up approved residential respite.

Source: Pathways in Aged Care (PIAC) cohort database.

Residential care

Residential aged care is the largest program of formal care delivery for frail or disabled older people administered by the Department of Health and Ageing under the *Aged Care Act 1997*. It provides support and care for older people who are no longer able to remain living in the community (permanent care) as well as short-term respite care. Permanent residential aged care provides accommodation and care services to older people who can no longer live at home. The Australian Government makes a substantial financial contribution to residential aged care for qualifying residents in accredited aged care homes, and entry to residential care requires assessment and approval from an ACAT.

At 30 June 2008, there were 160,250 permanent and respite residents in Australian Government-funded aged care homes (Table 3.11). Over 150,000 people aged 65 years and over were permanent residents, with 52,650 new admissions during 2007–08 (AIHW 2009c).

On 30 June 2008, there were 175,472 residential aged care places, operated by 2,830 service providers. The majority (61%) of providers were in the not-for-profit sector, such as religious and community organisations (AIHW 2009c). A further 28% of providers were private for-profit establishments, while the remaining 11% were state and local government facilities. The average size of services has grown from 46 places in 1998 to 61 in 2008.

Each year, the Australian Government makes available new residential and community care places for allocation in each state and territory. The number of new places relates to a comparison of the planning benchmarks with the number of people aged 70 years and over in the general population. The current national planning benchmark is to provide 88 operational residential places per 1,000 people aged 70 years and over, to be achieved by 2011 (DoHA 2008a). Operational places are those which are ready to be occupied by a resident. Increases in the number of operational places will lag behind increases in allocations to allow for building or renovations that may be required.

Table 3.11: Residential aged care, number of operational places, provision ratio, number of services and residents, 1998 to 2008 (as at 30 June)

Year	Operational places	Provision ratio[(a)]	Service outlets	All residents
1998	139,917	87.1	3,015	133,807
2000	142,342	83.6	3,005	135,991
2002	146,268	81.9	2,961	138,929
2004	161,765	85.0	2,932	147,640
2006	166,291	87.0	2,931	154,872
2008	175,472	87.7	2,830	160,250

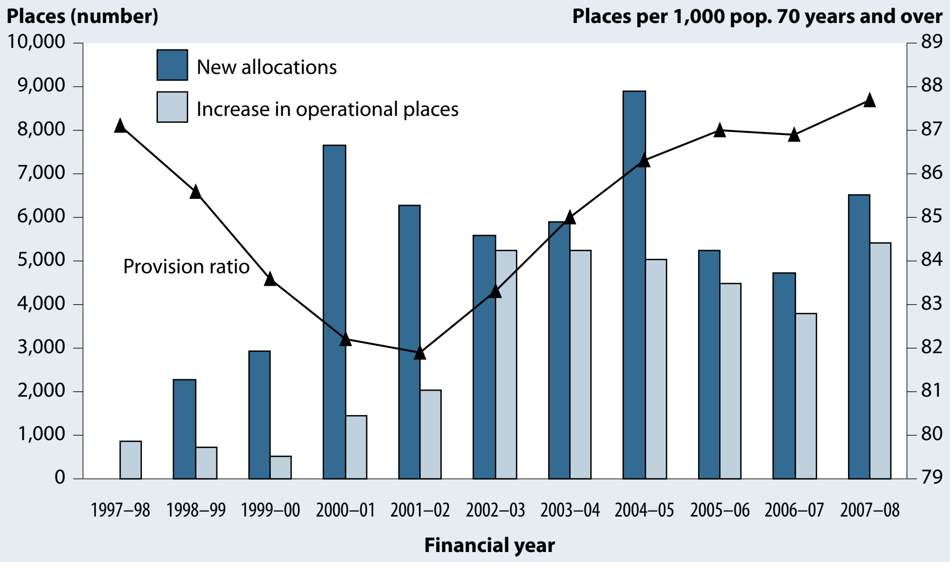
(a) Number of operational packages per 1,000 persons aged 70 years and over.

Note: From 1999 the number of places includes those provided by Multi-Purpose Services and services receiving flexible care subsidy under the National Aboriginal and Torres Strait Islander Aged Care Program.

Sources: AIHW 2008i; analysis of DoHA ACCMIS database as at October 2008.

During the late 1990s, allocations of new residential places by the Australian Government were very low (Figure 3.3). This changed during the 2000s, reaching a peak in 2004–05 when about 8,900 new residential places were made available (Table A3.7). New allocations in 2007–08 (6,525) were similar to those provided in 2001–02 (6,286).

The high number of allocations since 2000–01 is still to be reflected in the number of operational places. However, the planning target was close to being reached by 30 June 2008 when the provision ratio was 87.7 operational places. In 2007, the target ratio was rebalanced to increase the provision of high-care places. Previously the target ratio consisted of 48 low-care places and 40 high-care places for every 1,000 people aged 70 years and over—this has now changed to 44 low-care places and 44 high-care. As a result, almost 68% of all new residential aged care places allocated in 2007 were for the provision of high care (AIHW 2009c).



Source: Table A3.7.

Figure 3.3: New residential aged care allocations and operational places, 1997–98 to 2007–08

3.6 Aged care service use and client characteristics

This section examines the care needs of aged care program clients, and the services they receive to meet those needs. Selected characteristics of clients of aged care programs are presented and compared. Due to limitations of existing data collections, not all characteristics can be reported for all programs. This section also examines patterns of service use, including how long clients receive assistance from individual programs and movement patterns between different programs.

Use of aged care services

Most aged care clients are women

Across the programs, older aged care clients are predominantly women. In 2008, the proportion of female clients ranged from just over 50% in DVA programs to 72% of older people in residential care (Table 3.12). Although the majority of clients are women, the proportion of men is higher in DVA programs than in other aged care programs due to the cohort of World War II veterans now receiving assistance. The predominance of female clients in aged care services increases with age, reflecting the demographic profile of the population. The profile of permanent residential care clients also reflects this pattern, with women accounting for 48% of residents aged 65–69 years, rising to 81% of residents aged 90 years and over.

Table 3.12: Clients (aged 65 years and over) of aged care programs by age and sex, 2006–07 or 2007–08 (per cent)

	ACAP	HACC	VHC	DVA Community Nursing	Residential respite care	CACP	EACH	EACHD	Permanent residential care
	2006–07	2007–08				At 30 June 2008			
Males									
65–69	2.2	3.7	0.7	0.6	2.5	2.2	3.8	2.7	1.7
70–74	3.7	5.2	1.0	0.9	4.1	3.0	6.4	4.7	2.7
75–79	6.9	7.5	1.8	1.8	6.7	5.0	7.4	9.2	4.5
80–84	9.9	8.4	13.0	14.9	9.9	7.3	8.3	8.7	6.7
85–89	8.8	5.8	22.5	22.3	8.9	6.8	5.8	8.0	6.9
90 and over	5.4	2.8	7.3	8.3	5.3	4.2	4.2	3.4	5.4
Total males	*36.9*	*33.2*	*46.2*	*48.9*	*37.4*	*28.5*	*36.0*	*36.6*	*27.9*
Females									
65–69	2.2	6.4	0.5	0.3	2.1	3.5	5.1	3.0	1.6
70–74	4.5	9.6	1.4	1.0	3.8	6.1	7.8	5.5	3.0
75–79	9.8	14.0	6.0	5.1	8.6	11.4	10.0	11.2	7.3
80–84	16.6	16.4	19.3	17.1	15.8	18.9	14.1	16.4	15.4
85–89	17.1	12.7	19.2	18.6	18.3	19.2	14.0	16.3	21.6
90 and over	12.8	6.8	7.3	9.1	14.1	12.5	13.0	11.0	23.2
Total females	*63.0*	*65.8*	*53.8*	*51.1*	*62.6*	*71.5*	*64.0*	*63.4*	*72.1*
Persons									
65–69	4.4	10.1	1.2	1.0	4.6	5.6	8.9	5.6	3.3
70–74	8.1	14.9	2.4	1.9	7.9	9.1	14.2	10.2	5.7
75–79	16.7	21.8	7.8	6.9	15.2	16.4	17.4	20.4	11.8
80–84	26.6	25.0	32.3	32.0	25.7	26.2	22.5	25.1	22.1
85–89	25.9	18.6	41.7	40.9	27.2	26.0	19.8	24.3	28.5
90 and over	18.3	9.6	14.6	17.4	19.5	16.7	17.2	14.4	28.5
Total persons 65 and over	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**
Total persons 65 and over (number)	**174,733**	**635,238**	**77,274**	**32,625**	**48,881**	**35,092**	**3,623**	**1,545**	**150,481**
Persons aged less than 65 (number)	**8,159**	**193,254**	**1,923**	**704**	**2,412**	**1,822**	**266**	**70**	**6,606**
Persons aged less than 65 as % of all clients	**4.5**	**23.5**	**2.4**	**2.1**	**4.7**	**4.9**	**6.8**	**4.3**	**4.2**

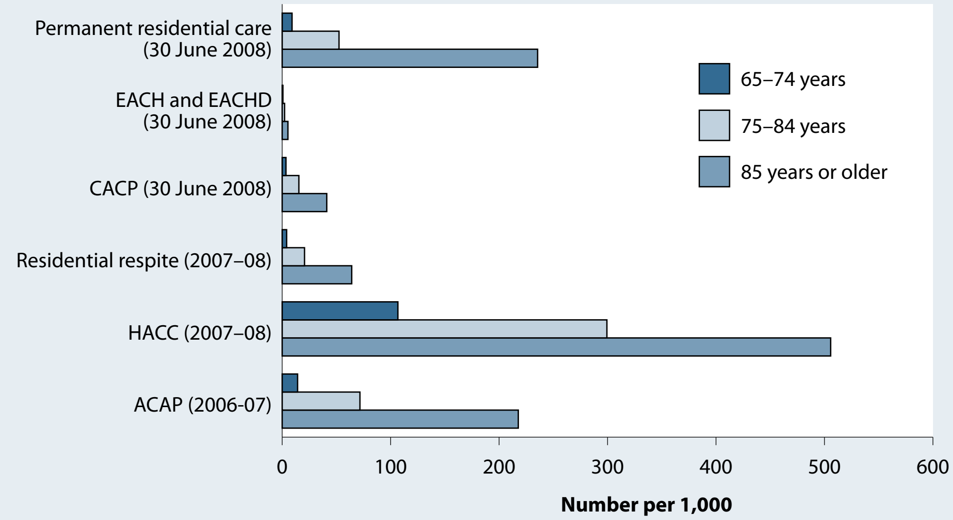
Notes

1. For figures as at 30 June, age is as at that date. For ACAP clients, age is at the time of the last assessment in the financial year. For residential respite, age is as at the end of the last admission. For VHC age is as at last service date. For DVA Community Nursing age is as at 30 June 2008. For residential respite care clients, age is as at first admission in the financial year.
2. For ACAP, 112 clients with missing age have been excluded and 136 people with missing sex are included in total persons. For HACC, 2,980 clients with missing age have been excluded and 9,313 people with missing sex are included in total persons. For residential aged care, VHC, CACP, EACH, EACHD and DVA Community Nursing, no missing ages were present.

Sources: Aged Care Assessment Program National Data Repository; AIHW analysis of HACC MDS; AIHW analysis of DoHA ACCMIS database as at October 2008; DVA unpublished data.

With the exception of DVA programs, people aged 85 years and over made up a higher proportion of people in residential care than in community care (Table 3.12). Over half (57%) of older permanent residents and 47% of older residential respite care clients in 2007–08 were aged 85 years and over. The proportion of DVA clients aged 85 years and over was comparable to residential aged care services, at 58% for Community Nursing and 56% for Veterans' Home Care. For other community care programs, the percentage of clients aged 85 years and over ranged from 28% of HACC clients to 43% of CACP clients.

Of the community care programs reported in this chapter, total usage rates were highest for the HACC program, and increased from 107 per 1,000 people aged 65–74 years to 299 per 1,000 aged 75–84 and 506 per 1,000 aged 85 years and over (Figure 3.4). The pattern of increased use with age was apparent for all community care programs, as well as ACAP and permanent residential care. At 30 June 2008, the rates of permanent residence in Australian Government-accredited aged care homes for age groups 65–74 years, 75–84 years and 85 years and over were 9 per 1,000 people, 52 per 1,000 and 236 per 1,000 respectively.



Source: Table 3.14.

Figure 3.4: Age-specific use of selected aged care programs, 2006–07 or 2007–08

High usage among Aboriginal and Torres Strait Islander people

Some qualification needs to be placed on the data reported in this section, due to quality issues relating to the identification of Indigenous clients of aged care services and Indigenous identification in the Census.

Usage rates for both Indigenous and non-Indigenous people increase with age. Indigenous people have relatively high usage rates for all aged care programs compared with non-Indigenous people. For example, Indigenous people aged 65–74 years use residential aged care at a rate of 22 per 1,000 compared with 9 per 1,000 for non-Indigenous Australians, and CACPs at a rate of 42 per 1,000 compared with 4 per 1,000 (Table 3.13). To some extent this reflects the poorer health of Indigenous people compared with their non-Indigenous counterparts of the same age. However, the comparison is affected significantly by the different age structures of the two populations, particularly the relatively lower proportion of Aboriginal and Torres Strait Islander people aged 75 years and over (Figure 1.2).

Table 3.13: Use of selected aged care programs by Indigenous status of clients

Age	ACAP 2006–07	Residential respite care 2007–08	CACP 30 June 2008	EACH/ EACHD 30 June 2008	Permanent residential care 30 June 2008
		Clients per 1,000 population			
Indigenous persons					
50–64	16.8	2.1	9.2	0.4	4.4
65–74	59.7	12.4	42.0	2.2	21.5
75 and over	201.4	55.4	90.4	4.6	110.2
Non-Indigenous persons					
50–64	1.8	0.5	0.4	0.1	1.5
65–74	15.0	4.1	4.0	0.7	9.0
75 and over	115.9	32.2	27.6	3.1	102.3

Notes

1. See notes to Table A3.9 concerning derivation of statistics and caveats, including allowance for missing values.
2. HACC usage rates in the Indigenous population are considered too unreliable to report. Table A3.9 shows Indigenous people as a proportion of older HACC clients and other key statistics relating to Indigenous HACC clients.

Sources: ABS 2008i; Aged Care Assessment Program National Data Repository; AIHW analysis of DoHA ACCMIS database as at October 2008.

Relatively high proportions of CACP recipients aged 50 and over are Indigenous: 3% at 30 June 2008, compared with around 1% of EACH, residential respite and permanent residential care clients and 2% of HACC clients (Table A3.9). The median age of Indigenous clients of aged care services is between 11 and 17 years younger than their non-Indigenous counterparts.

Overseas-born people use more community care services

People born overseas are increasing as a share of the older population and certain overseas-born groups are ageing more rapidly than the population as a whole (AIHW 2007c). Community care programs have a higher proportion of clients born in non-English-speaking countries than residential services. Between 22% and 26% of older clients of community care programs were born in non-English-speaking countries, compared with 15% of older permanent residents and 22% of all people aged 65 years and over (Table A3.10).

People born in non-English-speaking countries record relatively low use of residential care services compared with Australian-born people, but make relatively high use of HACC and CACP services at ages 75 years and over (Table 3.14).

Table 3.14: Usage rates of selected aged care programs by country of birth (per 1,000 people)

Age	ACAP 2006–07	HACC 2007–08	Residential respite 2007–08	CACP 30 June 2008	EACH/ EACHD 30 June 2008	Permanent residential care 30 June 2008
Australian-born						
65–74	17.0	113.1	4.8	3.8	0.7	10.5
75–84	80.7	301.5	21.8	14.7	2.0	55.6
85 and over	237.8	490.6	65.5	39.2	4.7	242.3
Overseas-born: main English-speaking countries						
65–74	12.0	75.6	3.5	2.2	0.6	6.8
75–84	67.5	256.0	20.1	13.6	2.0	47.8
85 and over	220.9	455.4	69.3	41.3	5.2	236.9
Overseas-born: non-English-speaking countries						
65–74	10.0	108.8	2.8	3.2	0.8	6.8
75–84	52.6	316.0	17.2	18.7	3.1	45.1
85 and over	148.1	603.7	52.9	50.0	8.3	201.5
All						
65–74	14.2	106.7	4.1	3.5	0.7	9.1
75–84	71.7	299.4	20.6	15.4	2.2	52.4
85 and over	217.7	505.7	64.1	41.1	5.3	235.5

Note: See notes to Table A3.10 concerning derivation of statistics and caveats, including allowance for missing values.

Sources: ABS 2007b; Aged Care Assessment Program National Data Repository; AIHW analysis of DoHA ACCMIS database as at October 2008; AIHW analysis of HACC MDS.

Needs of clients of aged care programs

The measurement and reporting of client needs and dependency for formal aged care programs may involve the use of generic tools and special-purpose administrative instruments, such as the Resident Classification Scale (RCS) and its replacement, the Aged Care Funding Instrument (ACFI) (Box 3.7). In some cases, data about clients' needs are not routinely reported, even where assessment is carried out before services are provided.

Due to such variations, it is not possible to directly compare client needs across all aged care programs. This section reports client needs in terms of data from ACAT assessments, administrative instruments used in residential care, the new HACC functional screen and data from the recent Community Care Census. Previously reported dependency data for DVA Community Nursing clients (AIHW 2007a) were not available for 2007–08.

High proportions of community-living ACAT clients need assistance with activities of daily living

ACAT assessments record the care needs of clients across a range of areas in order to recommend appropriate assistance. In 2006–07, the largest area of need for clients living in the community at assessment was for domestic assistance (92% of clients) (ACAP NDR unpublished data). High proportions of clients also needed assistance with transport (87%), meals (81%), social support (78%) and home maintenance (68%). Unsupported needs for assistance in these areas may jeopardise the ability of older people to remain living in the community as well as their social participation. Almost three-quarters of community-living ACAT clients needed assistance with health care (73%), nearly two-thirds needed assistance with personal care (64%) and over half (57%) needed assistance with mobility.

Care needs of community care recipients

Data about the activities with which HACC clients need assistance are becoming available following implementation of HACC Minimum Data Set version 2. Nine items which are mandatory under some circumstances (see Box 3.5) are reported, comprising seven self-assessed items recording the extent to which a client 'needs other people to enable them to carry out normal activities of daily living' (DoHA 2006), and a further two HACC-worker assessed items relating to memory and behavioural problems. Five optional self-assessed items may be reported for clients in some jurisdictions, describing communication, dressing, eating, toileting and mobility.

Box 3.5: HACC Functional Screen

Functional status data are required to be collected as part of the assessment process. The data record the extent to which the care recipient is able to perform selected activities of daily living, and whether they have memory or behavioural problems. The data are intended to identify areas in which a person requires assistance with activities of daily living and quantify the extent to which the person needs assistance from others to enable them to carry out normal activities of daily living in their home and in the community.

The collection of functional status data items is not meant to limit the screening and assessment tools used by agencies, and other tools may be used in addition to the functional screen.

It is recommended that the care recipient's functional status be rated at the start of a service episode, either at intake or following initial assessment, and reassessed when the client's circumstances change or when there is some reason to believe the person's need for assistance has changed.

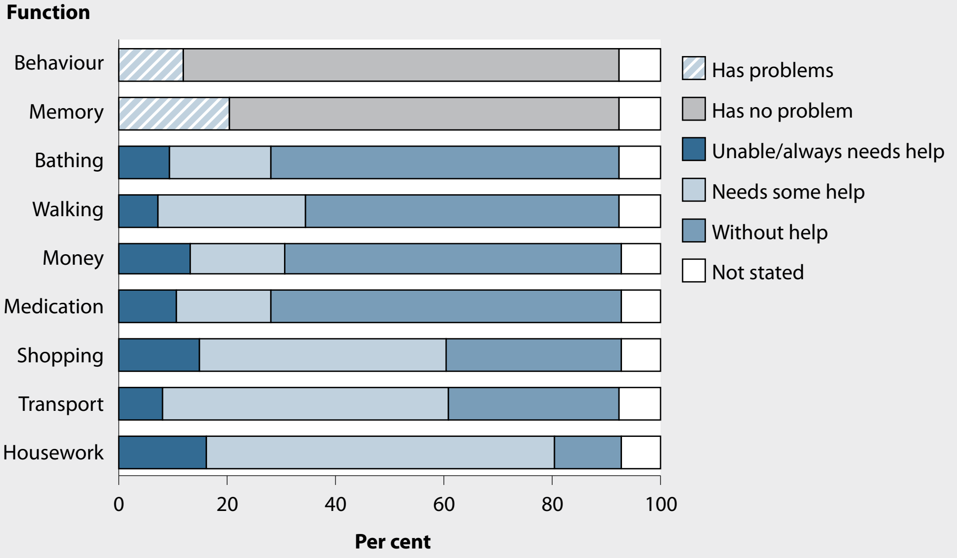
Source: DoHA 2006.

There are reservations about the quality of this data. In 2007–08 no jurisdiction reported the functional needs of all HACC clients—information on at least one functional item was reported for 466,000 clients, or 56% of clients (including those aged 65 or less). Coverage differs between jurisdictions (ranging from 28% to 91% in the final quarter of 2007–08), and the type of client being assessed may also vary; for example, in Victoria reporting of functional needs is only compulsory for endorsed assessment agencies. Current reporting of functional needs is most often associated with the provision of assessment, case management, care coordination and counselling, in line with the recommendation that the care recipient's functional status be rated at the start of a service episode or when there is reason to believe care needs have changed.

The four jurisdictions with the highest level of reporting for at least one functional item in the final quarter of 2007–08 were Western Australia (91%), the Northern Territory (86%), the Australian Capital Territory (76%), and Queensland (61%). Similar patterns in relation to assistance needs are evident across each of these jurisdictions. Data for Western Australia are shown in Box 3.6 to illustrate the pattern of reported and observed need in a jurisdiction with a relatively high reporting rate.

Box 3.6: Need for assistance among HACC clients in Western Australia 2007–08

Assistance with housework was the most commonly reported need (80% of clients in Western Australia), followed by shopping (61%) and transport (61%). Personal care assistance such as with bathing and showering were needed by over one-quarter of clients (28%). HACC workers observed memory problems or confusion in 20% of older HACC clients, while behaviour problems were recorded for 12% of clients.



Notes

1. Problems with behaviour and memory are assessed by the service provider, while assessment of capacity to carry out other activities is based on information from the client, carer, family and service providers.
2. Analysis uses the most recent assessment in relation to each type of functional need for each client.

Source: Table A3.8.

Routine administrative data for CACP, EACH and EACHD do not currently include a measure of client dependency; however, in 2008, the Department of Health and Ageing conducted a census of community care programs which included client care needs. Almost all EACH and EACHD clients (high-level packaged care) aged 65 years and over required assistance with at least one of the following activities: self-care, mobility, communication and/or behaviour (96% and 99% respectively) (Table 3.15). Just over three-quarters (77%) of CACP (low-level packaged care) clients aged 65 and over required assistance with at least one of these activities.

Almost all aged care package recipients required assistance with daily living activities such as housework, shopping, transport and handling money. Compared with CACP recipients, higher proportions of EACH and EACHD recipients needed assistance with core activities of self-care, mobility and communication. Consistent with the program's target population, 97% of EACHD recipients needed help with aspects of memory and behaviour compared with only 39% of CACP recipients and 59% of EACH package recipients, and with communication (75% compared with 20% and 41% respectively) (Table 3.15).

Table 3.15: Type of care needs among aged care package recipients aged 65 and over, 2008 (per cent)

	CACP recipients	EACH package recipients	EACHD package recipients
Self-care[(a)]	55.6	95.2	96.8
Mobility[(b)]	42.6	84.0	75.6
Communication[(c)]	20.3	41.3	74.6
Memory/Behaviour[(d)]	38.9	58.6	96.5
At least one of the above	*77.4*	*96.4*	*98.6*
None of the above	*22.6*	*3.6*	*1.4*
Other[(e)]	99.8	97.1	98.9
Total (number)	**32,695**	**3,354**	**1,313**

(a) Recipient sometimes or always needs assistance with eating, bathing/showering, dressing, toileting or managing incontinence.

(b) Recipient sometimes or always needs assistance with walking, getting out of bed or moving around.

(c) Recipient sometimes or always needs assistance with understanding others or making oneself understood by others.

(d) Recipient sometimes or always needs assistance with tasks requiring memory and/or organisational skills, or managing behaviour such as aggression, wandering or agitation.

(e) Recipient sometimes or always needs assistance with housework, getting to places out of walking distance, shopping for groceries or clothes, taking medicine or handling money.

Notes

1. Excludes 63 CACP recipients whose date of birth was unstated or invalid and 2 CACP recipients whose activities of daily living and date of birth was not stated or invalid.
2. Excludes 11 EACH package recipients and 6 EACHD package recipients whose date of birth was not stated or invalid.

Source: DoHA Community Care Census 2008.

Services received by clients of community care programs

Most community and flexible care programs offer services that can be received over variable periods of time. Services such as domestic assistance and personal care may be provided on an ongoing basis, whereas other services such as home maintenance may be required less often.

In 2007–08, the major types of assistance received by HACC program clients were domestic assistance (33% of clients), meals (20% of clients), home or garden maintenance (18%) and transport (17%) (Table 3.16). This profile of services received is broadly consistent with the functional needs reported by HACC clients in Western Australia (Box 3.6). Specialist services such as nursing (received by 21% of clients) and allied health or therapy (20%) were also used by a high proportion of clients.

Domestic assistance and home and garden maintenance feature among the services provided to high proportions of VHC clients (93% and 19% respectively in 2007–08) (Table 3.16). Eligible DVA clients with higher care needs may receive assistance from the DVA Community Nursing program, including nursing services and higher levels of personal care assistance. In 2007–08, the majority of these clients (79%) received specialist nursing care and 31% received assistance with personal care.

The DVA Rehabilitation Appliances Program meets clinically assessed needs for aids and appliances prescribed by professionals in nominated health disciplines. Mobility and functional support items and continence products account for approximately 80% of expenditure on aids and appliances under the program. In 2007–08, the DVA HomeFront (falls and accident prevention) program assisted 13,778 DVA clients, and 9,305 used the home maintenance and repairs telephone referral service.

The 2008 census of community care programs collected data about the services received by CACP, EACH and EACHD care recipients (Table 3.16). A large majority of CACP clients (82%) received domestic assistance. Assistance with personal care (39%) and social support (36%) were also commonly received. Personal care assistance was the most frequently received type of assistance by EACH and EACHD clients (83% and 74% respectively), reflecting their higher care needs, followed by domestic assistance (68% and 62% respectively). Specialist nursing services are not available through CACPs, although these clients may receive nursing through the HACC program if eligible. Around one-fifth (22%) of EACH package recipients and 17% of EACHD clients received nursing care.

Respite care featured prominently among the services received by EACH and EACHD clients (32% and 44% respectively). Much smaller proportions of VHC and CACP clients received respite care (8% and 4% respectively). The seemingly low level of respite care use by older HACC clients (2.2%) is an artefact of reporting, where respite care is recorded against the carer.

Some clients use more than one community care program at the same time

The array of service types available through community and flexible care programs varies (see Table 3.18). For example, specialist nursing and allied health services are available through HACC but not a CACP: if a CACP care recipient needs access to these types of services (perhaps after having a fall) they may be able to access them through HACC. It is therefore possible for some people to receive services from more than one program at the same time.

Program-based data sources do not always provide data on the extent to which aged care clients use services from more than one program at a time. The PIAC cohort study (described in Box 3.4) linked data about ACAT assessments in 2003–04 to data sets detailing the use of aged care programs for the years 2002–03 to 2005–06 (AIHW 2009b), thus providing a view of concurrent service use.

Six months after the reference assessment, nearly 8% of the 77,437 PIAC new-pathways cohort members who were still alive were receiving a CACP (Table 3.19). Of these, 28% were also accessing HACC services. A similar pattern was seen at 24 months. Reflecting the more limited nature of VHC services, overlap between VHC and HACC was also common, with around 40% of VHC clients also using HACC services. A relatively small proportion of people using the HACC program (13% at the 6-month point) were also accessing services from other programs (VHC, a care package and/or residential respite care).

Because of its short-term nature, few people at both the 6-month and 24-month points were in residential respite care (1.2% and 0.8%, respectively). At both times, more than half were accessing a community care program when they were at home.

Table 3.16: Community and flexible care programs: services provided to clients aged 65 years and over, 2007–08 (per cent of clients in program)

		DVA programs(a)		Care packages		
Service type	**HACC 2007–08**	**Veterans' Home Care(a) 2007–08**	**Community Nursing(a) 2007–08**	**CACP Dec 2008**	**EACH Dec 2008**	**EACHD Dec 2008**
Non-specialist care services						
Domestic assistance	32.6	93.1	X	81.5	68.3	61.6
Meals at home or a centre(b)	19.5	X	X	13.7	7.4	8.1
Other food services	0.6	X	X	21.4	35.3	34.6
Transport services	17.0	X	X	20.8	9.9	14.2
Home or garden maintenance	17.8	18.7	X	11.6	11.4	11.2
Activity programs (home or centre-based)	10.9	X	X	3.1	9.8	9.8
Social support	12.0	X	✓	36.4	26.4	34.4
Personal care	10.0	4.3	(c)31.2	39.3	83.3	74.2
Counselling (care recipient)	6.8	X	✓	✓	11.7	18.0
Counselling (carer)	1.3	X	X	X	X	X
Goods and equipment(b)	3.1	X	X	✓	✓	✓
Home modifications	4.3	X	X	✓	✓	✓
Respite care	2.2	(d)8.3	X	4.4	32.2	44.0
Linen services	0.3	X	X	0.7	2.0	2.6
Accommodation and related services	X	X	X	X	X	X
Specialist services						
Nursing (home and centre-based)	21.1	X	78.7	X	21.9	16.9
Allied health/therapy (at home or at a centre)	19.5	X	X	X	7.1	6.4
Total clients (number)	**638,218**	**77,284**	**32,625**	**33,411**	**3,354**	**1,314**

✓ Service type provided but data not available to report.

X Service type not provided.

(a) Different DVA programs from VHC and Community Nursing are used for assessment and to deliver services including minor home modifications, goods and equipment, transport, residential respite, counselling and allied health care to eligible DVA clients. VHC data are independent from Community Nursing data. Clients who received VHC services may have received Community Nursing services at the same time. Data on simultaneous receipt of VHC and Community Nursing services are not provided in the table.

(b) Includes more than one related type of assistance.

(c) Indicates personal assistance provided without any general and/or technical nursing care.

(d) Figure relates to provision of in-home respite care and emergency respite care only. VHC can approve in-home, emergency and residential respite services; however, payments for residential respite services are managed through a separate appropriation. Respite care figures under VHC exclude DVA clients who used residential respite but not other types of respite care funded by VHC.

Notes

1. HACC care recipients with missing or unreliable age are assumed to be over 65 and included in the 65 and over subtotals. Client numbers may therefore differ from those published in the HACC MDS Annual Bulletin (DoHA 2009a).
2. The number of HACC clients receiving each service type is identified by using the Statistical Linkage Key only. Numbers will differ from those published in the HACC MDS Annual Bulletin (DoHA 2009a), which counts HACC clients using a combination of Agency ID and Statistical Linkage Key.
3. Figures relate to the percentage of clients in each program who received each type of assistance at any time in the specified reporting period.
4. A person may receive more than one service type therefore percentages may not sum to 100.

Sources: AIHW analysis of DoHA ACCMIS database as at October 2008; AIHW analysis of HACC MDS; DoHA 2009a; DVA unpublished Community Nursing data; DVA unpublished Veterans' Home Care data.

Care needs of permanent aged care residents

Until March 2008, the Resident Classification Scale (RCS) produced a measure of dependency of people in residential aged care based on an appraisal of care needs carried out by the provider. The RCS comprised eight levels of dependency, with RCS 1 representing the highest need for care and RCS 8 representing the lowest. RCS levels 1–4 were collectively grouped as 'high care', while RCS 5–8 were grouped as 'low care'.

Phasing in of the ACFI to replace the RCS began in 2008. The ACFI provides a different measure of client dependency (Box 3.7). From 20 March 2008 all new admissions were appraised using the ACFI. Consequently, in 2007–08 both scales were in use at different times, with about one-third of residents assessed under the ACFI at 30 June 2008. Previous RCS results show a trend of rising dependency levels, which has been evident for some time (AIHW 2007a), while the ACFI results are reported here for the first time.

At 30 June 2008, the majority of permanent aged care residents with an RCS appraisal (70%) had high-care needs, and little variation in proportion was evident between men and women (Table 3.17). The proportion of residents classified as RCS 1–4 (high-care needs) increased steadily from 62% in 2000 (AIHW 2007a), perhaps reflecting the growing availability of community care options and a tendency for older Australians to use community care for longer periods before entering permanent residential care.

Box 3.7: Measuring dependency of permanent residents in aged care homes

Resident dependency levels were determined by the Resident Classification Scale (RCS) up to 20 March 2008. The RCS has eight categories that represent eight levels of care in descending order of need from 1 to 8. The level of Australian Government care subsidy is based on the level of care need indicated by each RCS category. No basic subsidy is paid for residents in category RCS 8. Categories 1 to 4 represent high-care status and categories 5 to 8 represent low-care status.

From 20 March 2008, the Aged Care Funding Instrument (ACFI) was introduced as a new funding model for residential aged care. A description of this new model may be found at <www.health.gov.au/acfi> and it is also briefly discussed in the *Report on the Operations of the Aged Care Act 1997 (1 July 2007 to 30 June 2008),* which may be viewed at <www.health.gov.au/internet/main/publishing.nsf/Content/ageing-reports-acarep-2008.htm>.

The ACFI attempts to separate and measure only those care elements that most contribute to the cost of care. Each resident is appraised in respect of three domains: Activities of Daily Living, Behaviour Characteristics and Complex Health Care Needs. Scores in each of these domains determine the level of care required (high, medium or low) for that domain, and the overall level of resident subsidy is derived from this. The concepts of ACFI high care and ACFI low care are defined through various combinations of scores in the three domains, and this enables an approximate comparison with RCS high care and RCS low care.

All new permanent admissions after 20 March 2008 are appraised using the ACFI. Existing residents from 20 March 2008 will be appraised by the ACFI if and when they require a review of their current classification.

Table 3.17: Level of dependency of permanent aged care residents aged 65 years and over with RCS appraisal, at 30 June 2008

	High care					**Low care**					
	RCS 1	**RCS 2**	**RCS 3**	**RCS 4**	**RCS 1–4**	**RCS 5**	**RCS 6**	**RCS 7**	**RCS 8**	**RCS 5–8**	**Total**
Number											
Males	6,535	6,763	4,601	1,643	19,542	3,397	2,668	2,326	123	8,514	28,056
Females	17,261	17,740	12,247	4,781	52,029	9,852	7,081	5,154	221	22,308	74,337
Total	**23,796**	**24,503**	**16,848**	**6,424**	**71,571**	**13,249**	**9,749**	**7,480**	**344**	**30,822**	**102,393**
Per cent											
Males	23.3	24.1	16.4	5.9	69.7	12.1	9.5	8.3	0.4	30.3	100.0
Females	23.2	23.9	16.5	6.4	70.0	13.3	9.5	6.9	0.3	30.0	100.0
Total	**23.2**	**23.9**	**16.5**	**6.3**	**69.9**	**12.9**	**9.5**	**7.3**	**0.3**	**30.1**	**100.0**

Note: Table does not include clients of Multi-purpose and flexible services.

Source: AIHW analysis of DoHA ACCMIS database as at October 2008.

At 30 June 2008, over a third of residents with an ACFI appraisal had a high level of dependency in activities of daily living (34%) and/or behaviour (35%), while 14% were assessed with high-dependency levels for complex health care. The high and medium categories combined accounted for 63% of those assessed for activities of daily living, 61% for behaviour and 42% for complex health (Table 3.18). Overall, 76% of permanent residents were classified with high care needs under ACFI, and 24% with low care needs.

Table 3.18: Level of dependency of permanent aged care residents aged 65 years and over with ACFI appraisal, at 30 June 2008

	High	**Medium**	**Low**	**Nil**	**Total**
Number					
Activities of daily living	15,377	13,077	12,714	4,216	45,384
Behaviour	15,888	11,574	10,563	7,359	45,384
Complex health care	6,108	13,128	17,801	8,347	45,384
Per cent					
Activities of daily living	33.9	28.8	28.0	9.3	100.0
Behaviour	35.0	25.5	23.3	16.2	100.0
Complex health care	13.5	28.9	39.2	18.4	100.0

Source: AIHW analysis of DoHA ACCMIS database as at October 2008.

Changes in program use over time

The type of support required by older people may change over time as their need for assistance varies, or their circumstances change (such as through the death of a spouse). This change may be permanent, or may be the result of an event such as hospitalisation, so that, for a short time, the older person needs additional assistance or different types of assistance.

Among the PIAC new-pathways cohort, program use increased over time, with the move to permanent residential care particularly noticeable: 23% of this cohort who were still alive at 6 months were in permanent residential care compared with 38% at 24 months (Table 3.19).

Table 3.19: PIAC new-pathways cohort: concurrent use of care programs at specified dates after ACAT reference assessment (per cent of clients alive at the time)

Programs being used	**6 months after assessment**	**24 months after assessment**
Not using a care program	33.3	28.0
HACC only	29.7	19.8
VHC only	2.8	2.1
HACC and VHC only	1.8	1.2
CACP only	5.7	6.6
CACP and HACC/VHC only	2.2	2.6
EACH/EACHD only	0.2	0.5
EACH/EACHD and HACC/VHC only	—	0.1
Residential respite care only	0.5	0.3
Residential respite care and HACC/VHC only	0.6	0.4
Residential respite care and CACP/EACH/EACHD only	0.1	0.1
Residential respite care, CACP/EACH/EACHD and HACC/VHC	—	0.1
Permanent residential care	22.9	38.2
Total	**100.0**	**100.0**
Number alive in group at time	**67,968**	**54,386**
Subtotals		
HACC and/or VHC only	*34.3*	*23.2*
Any HACC	*34.3*	*24.0*
Any VHC	*4.7*	*3.5*
Any HACC/VHC	*37.2*	*26.3*
Any CACP	*8.0*	*9.3*
Any EACH/EACHD	*0.3*	*0.6*
Any residential respite care	*1.2*	*0.8*
Deaths up until time	**9,380**	**22,962**
Group total at start or reference assessment	**77,348**	**77,348**

Notes

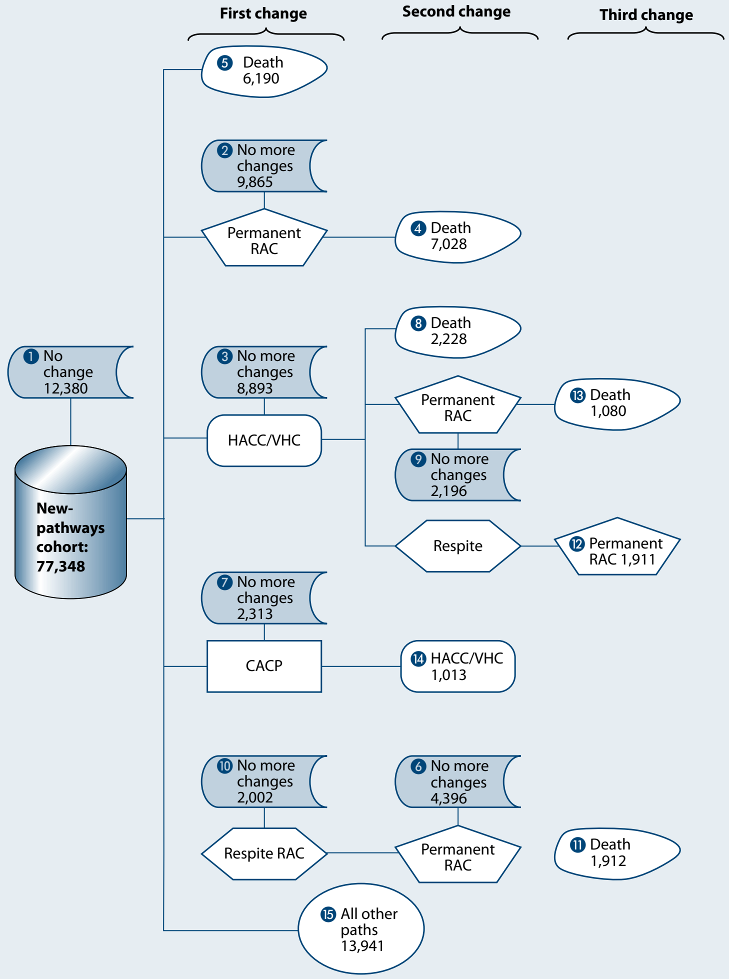
1. Table excludes 89 records with a pathway that indicated death before receipt of care as this implies linkage errors.
2. HACC/VHC indicates that these services are grouped, noting that VHC delivers a subset of the HACC service types.
3. EACH/EACHD indicates that these services are grouped for this table because of the small numbers of clients using these programs in the study period. A very small number of people were also identified as using the nascent Transition Care Program 2 years after the reference assessment.
4. The reference date is the date of the end of the first completed ACAT assessment in 2003–04.
5. Use of community care services (HACC/VHC) while on social leave from permanent residential care is not included in the analysis. HACC services that can be accessed while on a CACP include nursing and centre-based day care. Only the latter can be accessed by recipients of EACH/EACHD packages. HACC use data have been edited to reflect these access rules.
6. Percentages are based on clients alive at the time of measuring care status. Percentages may not sum to 100 due to rounding.

Source: Pathways in Aged Care (PIAC) cohort database.

Among those still alive at 6 months, one-third were not using a care program; this dropped to 28% at 24 months. The move into permanent residential care was accompanied by decreases in cohort use of residential respite care, VHC and HACC. By contrast, the proportion who received a CACP or EACH package increased with time, possibly reflecting growth in these programs during these years and a tendency to move onto packaged care.

There are many thousands of potential care pathways through the aged care system, reflecting the variety of care programs available and the diversity of individual circumstances. For example, by simply examining the order in which the PIAC new-pathways cohort accessed different care programs and whether the cohort member died, it is possible to identify just over 1,000 distinct care pathways over a 2-year period.

However, it is possible to identify a smaller set of care pathways that were used by a large proportion of the cohort. Looking at the first three events after the ACAT reference assessment, 14 paths were used by 82% of cohort members (Figure 3.5 and Table A3.11).



Source: Table A3.11. Numbers in bold refer to path number in Table A3.11.

Figure 3.5: PIAC new-pathways cohort: common care pathways showing first three changes over 2 years after the ACAT reference assessment

Nearly one-quarter of the cohort (24%) did not commence (or recommence) any new care programs in the 2-year period after the ACAT reference assessment—8% died without commencing any new programs while 16% of the cohort were still alive 2 years after the ACAT reference assessment and had not accessed any care programs in that time. Almost half (48%) of this latter group had used HACC or VHC services before their reference assessment. For a slightly smaller proportion (22%), entry to permanent residential care was the first program accessed after the reference ACAT assessment. Just over 40% of this group had died within 2 years.

Use of either HACC or VHC was the first step in five of the 14 most common pathways, and these five programs were used by 21% of the cohort. Residential respite care is also an integral part of the aged care system, and appears in four of the top 14 pathways (used by 13% of the cohort). Pathways incorporating residential respite care were more common among those who had accessed HACC or VHC before assessment (15%) than among those who had not (10%). Use of such care was often followed at a later date by admission into permanent residential care.

Almost half of clients ceasing community care enter residential care

People typically remain on a care package/program until they can no longer benefit from the type of assistance offered, they need another type of assistance or they die. The main reasons clients ceased receiving CACP services in 2007–08 were to enter residential aged care (46%) or death (17%) (AIHW 2009a). Smaller proportions of separations were due to hospitalisation or transfer to other forms of community care.

Death or entry to residential care were also the most common reasons for separations for EACH and EACHD clients—45% and 65% respectively went to residential aged care. The proportion of separations due to death was higher than for CACP (34% of EACH separations and 21% of EACHD separations). The proportion of EACH and EACHD clients transferring to other community care programs was low, while the proportion transferring to hospital was 8% for EACH and 6% for EACHD compared with 4% for CACP.

Death is the predominant reason for people leaving permanent residential aged care, accounting for 89% of separations in 2007–08 (AIHW 2009c).

In 2007–08, the median duration of support was between 1 and 2 years for CACPs and permanent residential care; however, one-quarter (26%) of separations from residential care were for people who had been in care for 4 years or more and 18% were for people who had been in residential care for less than 13 weeks (Table 3.20). Median duration of support was lower for EACH and EACHD. However, these are relatively new programs and have not yet established as many long-term clients. Data describing the length of stay to date for residents still in permanent residential aged care are published annually by AIHW (see, for example, in AIHW 2009c).

Table 3.20: Length of support or stay for CACP, EACH, EACHD and residential aged care, separations during 2007–08 (per cent)

	CACP	EACH	EACHD	Permanent residential care
Less than 4 weeks	4.1	7.4	8.3	7.9
4–< 8 weeks	5.7	9.1	13.1	5.4
8–< 13 weeks	6.8	9.8	13.0	4.8
13–< 26 weeks	14.5	18.0	25.4	8.6
26–< 52 weeks	18.9	22.4	23.8	10.9
1–< 2 years	22.5	21.8	15.8	15.6
2–< 3 years	10.2	7.6	0.7	11.8
3–< 4 years	6.1	2.7	. .	9.4
4–< 5 years	3.9	0.8	. .	7.1
5 or more years	7.3	0.3	. .	18.5
Total	**100.0**	**100.0**	**100.0**	**100.0**
Total (separations)	**17,816**	**2,067**	**1,073**	**53,819**

Notes

1. Table does not include clients of Multi-purpose and flexible services.
2. Residential age care figures exclude transfers between service providers for care of the same type (that is, respite or permanent care).
3. Components may not add to total due to rounding.

Source: AIHW analysis of DoHA ACCMIS database as at October 2008.

3.7 Service-related outcomes

The measurement of outcomes for aged care services is important for examining the delivery and quality of the services. 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 diverse client mix, combining a range of chronic and acute conditions, receiving varied formal services and supported by many informal activities—does not readily lend itself to specific outcome measures. In care contexts where successful management may nevertheless be followed by death or deterioration in health status, such measures are problematic.

Nevertheless, it is still possible to report on some measures relevant to program achievements, and this section presents data on the accessibility and quality of aged care services. In addition, for the first time, it is possible to report on changes in functioning among clients of the Transition Care Program as a result of the short-term therapy-based interventions provided through that program.

Accessibility

Timely access to appropriate aged care services can be critical for the health and wellbeing of older people and is an important component of a socially inclusive society.

How long does it take to access care services?

Accessing care services involves a number of processes including assessment, finding suitable care providers and making necessary arrangements to receive care. In 2006–07 the median time from referral to 'first face-to-face contact' with an ACAT was 9 days, ranging from a low of 6 days in South Australia to a high of 18 days in the Australian Capital Territory (ACAP NDR 2006). These times changed little over the 3-year period from 2003–04 to 2006–07.

The period of time between the ACAT approval and use of care services (elapsed time) may be affected by factors including the death of the potential client, the availability of services, perceptions and concerns about quality of care that influence client choice of preferred service, and unwillingness to accept particular residential placement offers (SCRGSP 2009:boxes 13.12 and 3.13). Elapsed time is different from waiting time—ideally, a measure of waiting time would exclude such factors and measure the time between a client's dedicated intention to obtain a service and receipt of the service. However, the practical problems of measuring this concept of waiting time at a population level are still being addressed.

One measure of 'elapsed time' between ACAT approval and entry to high-level residential care or receipt of a CACP appears in the *Report on government services* (SCRGSP 2009). This measure reveals that 23% of people entering high-level residential care during 2007–08 did so within 7 days of their ACAT approval and 52% within 1 month (SCRGSP 2009:Table 13A.37). The comparable figures for starting a CACP were 12% and 40%.

Table 3.21: PIAC new-pathways cohort: Time to death or entry into permanent residential care within 2 years after ACAT reference assessment (per cent)

Time after completion of ACAT reference assessment	Started on a CACP	Admitted into permanent RAC
Within 91 days	6.2	19.1
92–183 days	2.3	6.4
184–274 days	1.3	4.4
275–365 days	0.9	3.5
Within 1 year	*10.8*	*33.4*
1–2 years	2.3	9.9
Within 2 years	*13.1*	*43.3*
No event	86.9	56.7
Total	**100.0**	**100.0**
Total (people)	**77,348**	**77,348**

Notes

1. Table excludes 89 records with a pathway that indicated death before receipt of care as this implies linkage errors.
2. The reference date is the date of the end of the first completed ACAT assessment in 2003–04.

Source: Pathways in Aged Care (PIAC) database.

This measure of elapsed time only considers those people who actually received care services following ACAT approval—it excludes people with an ACAT approval who did not subsequently receive care. Data from the PIAC new-pathways cohort offers a different measure since the data are based on the population with a completed ACAT assessment in 2003–04 and examine when (or if) clients subsequently used care services. In this approach, the period of interest is the time from initial assessment to take-up of particular services for all assessed persons. Consequently, it measures the time taken by clients for their ‘care journey’. The data reported here are not comparable to the data in the *Report on government services* (SCRGSP 2009) since they include clients who did not access services for which they were approved and clients who may not have originally been given approvals for some services.

Almost one-fifth of the PIAC cohort (19%) were admitted to permanent residential care (including low-level care) within 91 days of their reference ACAT assessment and one-third (33%) within 1 year, including some who may not have been approved for such care at that time but who were later reassessed (Table 3.21). Just over 10% of the cohort had accessed a CACP within 1 year of their reference ACAT assessment, with the majority of these beginning their CACP within 91 days.

How has the supply of residential aged care places and packages changed?

The supply of aged care places is influenced by government planning and allocation processes, which determine the number of places available, as well as take-up of place allocations by service providers. The level of supply in turn affects consumers’ ability to access services. Examining the number of aged care places relative to the population at risk of needing care provides a useful indirect measure of accessibility for individuals. For the purposes of reporting on provision outcomes, aged care places and packages include CACP, EACH, EACHD, Transition Care and residential aged care. Operational packages or places in these programs can be measured against planning targets. It is not possible to provide a similar analysis for HACC or VHC as discrete packages and places do not exist.

Usage patterns have been an important consideration in establishing the planning target for the supply of aged care places and packages. The planning ratio for residential care places and community care packages represents the desired number of these places relative to the size of the population likely to need formal aged care. The MacLeay Report in 1982 (House of Representatives Standing Committee on Expenditure 1982) recommended that the population at risk of needing residential care be defined in terms of the number of people aged 70 years and over (it had previously been 65 years and over) reflecting age-specific usage patterns. Age is used as a proxy for care needs in the population, reflecting the relationship between age and disability, and the absence of regional-level data required for planning purposes.

This population is still used for planning purposes, although the actual planning benchmark has been increased. In 2008–09 the national planning benchmark, to be achieved by June 2011, was 113 operational packages or places per 1,000 people aged 70 years and over, consisting of 88 residential care places and 25 community-based packages (see also Section 3.5). The Australian Government has recognised a need to review the current planning ratio to take better account of demographic changes and changing patterns of use of aged care services (DoHA 2008d:94). The recent Senate Inquiry into Residential and Community Aged Care has also recommended a review of the ratio in the context of a broader review of aged care service planning and funding (SSCFPA 2009); and the National Health and Hospitals Reform Commission (NHHRC 2009) has proposed that the population aged 85 and over be used for planning, on the basis that this better reflects usage patterns.

Table 3.22 illustrates the historical pattern of provision relative to potential need according to the current and proposed age-based definitions of the ‘at risk’ population. As noted above, this analysis excludes the provision of HACC and VHC.

Table 3.22: Operational residential aged care places, CACP, EACHD packages, and Transition Care places at 30 June, 1998–2008

		Places/packages per 1,000 persons	
	Number of places/packages	**Aged 70 years and over**	**Aged 85 years and over**
1998	149,963	93.3	666.6
2000	160,650	94.4	635.8
2002	172,983	96.9	629.6
2004	186,503	101.2	645.6
2006	205,450	107.5	637.8
2008	223,955	111.9	617.9

Note: From 1999 the number of places includes those provided by Multi-Purpose Services and services receiving flexible care subsidy under the National Aboriginal and Torres Strait Islander Aged Care Program.

Source: AIHW analysis of ACCMIS database as at October 2008.

Occupancy rates are declining

Occupancy rates are another possible measure of the adequacy of supply of aged care service provision. Occupancy levels in residential aged care were high over the period 1998–2004 (mostly around 95–96%) (Table 3.23). They have declined since then, reflecting higher annual allocations of new places (Table A3.7), and averaged 94% in 2007–08. Occupancy rates remain higher in South Australia and Tasmania than in other jurisdictions, and evidence to the Senate Inquiry into Residential and Community Aged Care suggests there may be considerable variability in occupancy rates at local and regional levels (Senate Standing Committee on Finance and Public Administration 2009). High occupancy rates may create lengthy waiting times for entry to care in some parts of the country and for some groups of people (Hogan 2004; Productivity Commission 2008). Conversely, low occupancy rates may affect the financial viability of services with flow-on effects for service availability over time (Senate Standing Committee on Finance and Public Administration 2009).

Table 3.23: Average occupancy in residential aged care, 1998–99 to 2006–07

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Australia
1998–99	95.9	94.5	96.3	94.8	96.4	97.8	94.8	94.7	95.7
1999–00	95.6	94.4	95.9	95.1	97.3	97.8	93.2	95.1	95.5
2000–01	95.9	94.8	96.6	94.7	97.6	97.5	95.6	93.5	95.9
2001–02	95.3	94.9	96.4	92.9	97.7	97.7	97.7	91.9	95.5
2002–03	96.4	94.7	96.4	95.6	97.3	97.8	97.7	94.7	96.0
2003–04	96.1	94.4	96.5	95.7	97.2	97.5	98.0	90.9	95.9
2004–05	95.2	94.1	96.2	94.8	97.5	96.9	98.3	93.9	95.3
2005–06	95.4	93.0	96.0	94.9	97.6	96.0	97.9	95.1	95.1
2006–07	94.3	92.5	94.9	94.6	97.6	95.9	96.3	94.9	94.3
2007–08	93.4	92.2	93.5	94.2	96.8	95.1	93.2	92.2	93.5

Note: The average occupancy over a year is calculated by dividing total occupied resident days over the year by total available place days over the year. This gives an underestimate of true occupancy because some places may be offline for upgrading etc. over the period.

Source: AIHW 2009c.

Standard and quality of care

A main objective of aged care assistance is improvement or maintenance of an individual's physical and psychosocial functioning to enhance their quality of life. Currently available data collection processes are heavily focused on measures relating to quality of care, and hence rely on clinical and system indicators. Quality of care is essential to ensuring that aged care clients are not neglected or abused, have access to the best available health and care services to meet their needs, and are able to live with dignity and pain-free comfort.

A more complex concept is that of quality of life. Measurement in this field is not a straightforward matter: observable and measurable outcomes do not always match the older consumer's perceived quality of life. Older consumers' perspectives on their quality of life are less visible in the literature to date (Hambleton et al. 2009) and can be challenging to collect. For example, obtaining reliable data from cognitively impaired people can be difficult, and consumers may be reluctant to comment adversely on services they rely on. The Dementia Initiative's emphasis on outcomes to improve the quality of life for people with dementia and their carers provides a stimulus to further work on quality of life from consumer perspectives.

Compliance with residential aged care standards is high

The *Aged Care Act 1997* sets out a process of accreditation of residential aged care homes as an eligibility requirement for Australian Government funding. Accreditation by an independent authority, the Aged Care Standards and Accreditation Agency, is designed to assure both the government and the community that services provided to consumers meet recognised standards. The agency assesses homes against standards in four areas: management systems, staffing and organisational development; health and personal care; resident lifestyle; and physical environment and safe systems. At 30 June 2008, 92% of homes were accredited for at least 3 years and over 98% of all homes were compliant with all 44 Accreditation Standards Outcomes (DoHA 2008e).

In addition, the Aged Care Standards and Accreditation Agency undertakes a program of unannounced visits to ensure proper care of residents, including nutrition and hydration. In 2007–08, the agency conducted 5,244 visits to homes and all homes received at least one unannounced visit during this period (DoHA 2008e). A further 1,796 unannounced visits were made during the period 1 July 2008 to 15 December 2008.

High levels of compliance with accreditation standards have been evident over the period since national data have been available. For example, at 31 December 2000, around one in 10 aged care homes were rated as 'commendable' in relation to each of the four accreditation areas, and the large majority of homes (86–88%) received a rating of 'satisfactory' (AIHW 2001). A recent evaluation of the impact of accreditation on the delivery of quality of care and quality of life to residents concluded that accreditation promotes continuous quality improvement and has been the most influential factor in driving quality improvement in the sector (Campbell Research and Consulting 2007). The same report also notes that current accreditation is limited in its capacity to measure quality, in part because the standards are not sensitive to improvement in performance over time, particularly for homes already performing to a high standard.

All residential aged care services were required to meet the requirements of the 1999 Certification Instrument for building standards by 31 December 2005. Fire and safety requirements were met by 99% of services at 30 June 2008; the remaining homes have major works underway and are expected to achieve the targets in the near future (DoHA 2008e). In addition, space and privacy targets for aged care homes apply from 31 December 2008:

- For services that existed before July 1999, there should be no more than four residents accommodated in any room, no more than six residents sharing each toilet and no more than seven residents sharing each shower.
- For new buildings constructed since July 1999, there is to be an average for the whole residential aged care service of no more than 1.5 residents per room, no room may accommodate more than two residents, and there is a mandatory standard of no more than three residents per toilet, including those accessed from common areas, and no more than four residents per shower or bath.

As at 30 June 2008, 94% of services met the targets relevant to their situation (DoHA 2008e).

Most agencies have high standards of care in community-based programs

Since 1 July 2005, Quality Reporting has been the process for encouraging community care providers to continuously improve their service delivery and the systems and processes in place to ensure service quality. The 3-year cycle concluded on 30 June 2008. This program applies to CACP, EACH and the National Respite for Carers Program and, from 1 July 2008, EACHD. Service providers complete a Quality Report about how they meet program standards. The Department of Health and Ageing reviews the Quality Report, undertakes a site visit and advises on the outcome of the assessment, including any remedial action required. Around 1,500 service outlets were involved in the review process over the 3-year cycle 2005–2008 (DoHA 2008e).

HACC services are subject to appraisal against the HACC National Service standards. These standards are included in all service contracts and provide agencies with a common reference point for internal quality control by defining aspects of service quality and expected outcomes for consumers. In the first evaluation cycle from July 2001 to June 2004, 2,709 out of 3,335 HACC agencies were appraised (AIHW 2005). The second appraisal cycle took place over 2004–05 to 2007–08 (the Australian Capital Territory completed this cycle in 2008–09). A total of 2,915 HACC agencies (83%) were appraised over the second cycle (SCRGSP 2009). The national average score for these agencies was 17.5 (a high score is 17.5–20). A large majority of agencies received a high score (70%) and a further 19% received a 'good' score (15–17.4). A small number of agencies (101) were rated 'poor'.

Individual functioning improves after transition care

The Transition Care Program is designed to provide short-term therapy for older people after hospitalisation (see Section 3.5 for more detail). One of its aims is to improve the functional capacity of those discharged from the program to residential care, thereby lowering the level of care required. The functional capacity of program clients is assessed on entry to and exit from the program using the Barthel Index. The Barthel Index is a tool for assessing areas of need in mobility and activities of daily living. The maximum score is 100, with low scores in specific areas highlighting areas of greatest need. Changes in average entry and exit scores can be used as a proxy measure of the effectiveness of the program in meeting its aims (Table A3.12).

People aged 65 years and over had an average entry score of 70 in 2007–08, while the average exit score was 79—an average improvement during the program of 9 points. Both entry and exit scores declined with age, but the degree of improvement showed little variation by age (10 points for those aged 65–74 years and 75–84 years, and 9 points for people aged 85 and over). Entry and exit scores and the degree of improvement were slightly higher for men than for women. The average entry score for men aged 65 years and over was 70, while the average exit score was 80. For women, the respective entry and exit scores were 69 and 77.

These results indicate that the functioning of older people can improve following an acute episode of hospital care, provided they are given sufficient time and appropriate treatment and therapy. Results also suggest that the provision of appropriate short-term allied health and nursing services may be helpful to older people receiving a CACP or in low-level residential care following illness or injury. The provision of such services may assist in reducing demand for high-care services.

3.8 Ageing and aged care data

In the 10 years since the International Year of Older Persons, there has been substantial progress in terms of collecting and reporting data about older Australians. Sampling and reporting of ABS population survey data means that it is increasingly possible to disaggregate data by age groups to at least 85 years and over, thus permitting improved reporting about the diversity of needs and circumstances among Australia's older people.

The last 10 years have also seen considerable improvement in the amount and quality of data about aged care provision and use. This has been particularly notable in the community care sector with the development of the HACC Minimum Data Set (now in its second version) and in improvements to the ACAP Minimum Data Set. The newly implemented ACFI will provide enriched information about permanent aged care residents, particularly in relation to their physical and cognitive health. Current developments using data linkage methods are also increasing our ability to report on the operation of the aged care system as a whole rather than only on a program basis.

There remain some key data gaps and limitations. The only ABS survey that includes data about people living in residential aged care is the ABS Survey of Disability, Ageing and Carers. Almost one-quarter of the very oldest age group are therefore excluded from all other national surveys about health, social participation, income and wealth.

Routine data collection about CACPs, EACH and EACHD packages does not include information about the care needs of clients or the types of assistance they receive. This data has been collected through two special purpose data collections in 2002 and 2008. The implementation of the HACC Functional Screen holds the promise of data about the care needs of HACC clients once reporting coverage and data quality improves. While there is considerable effort being devoted to appraising the quality of care provided to aged care clients in the community and residential care sector, there are limited data currently available for reporting about these processes or outcomes for clients.

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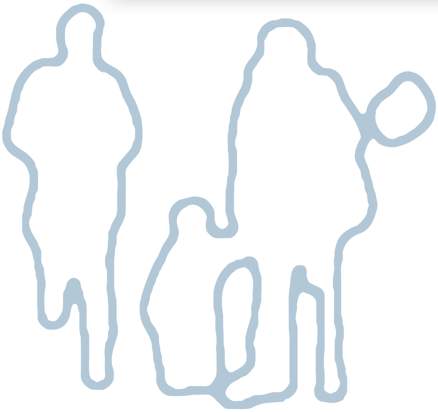
Disability and disability services

4

Key points

- According to the Australian Bureau of Statistics, the number of people with disability doubled between 1981 and 2003, to reach an estimated 3.9 million Australians.
- The rate of growth in the number of people with profound or severe core activity limitation, that is, people who need help with core daily activities, was even higher (173% increase). Estimated to be around 1.5 million Australians by 2010, the number of people with this high level of disability is projected to increase to almost 2.3 million by 2030—roughly equivalent to the entire population of Western Australia in 2009.
- Aboriginal and Torres Strait Islander people are more than twice as likely as non-Indigenous Australians to need help with core daily activities because of disability.
- Disability shows an uneven geographic distribution, not always linked to remoteness. Census data on capital cities show that higher levels of disability tend to be more prevalent in areas of relative economic disadvantage.
- Many people with disability rely on government income support as a sole or main source of income. In 2006, almost one in three people aged 18 to 64 years with specific activity limitations or participation restrictions lived in jobless households, compared with one in 13 people without limitations or restrictions.
- Respite services registered the highest rate of growth of any of the six broad service groups funded under the Commonwealth State/Territory Disability Agreement: from 96 service users per 1,000 people in the target population in 2003–04 to 137 per 1,000 in 2007–08.
- Within generic employment assistance programs, people with disability have been less likely than average jobseekers to achieve positive employment or training outcomes.



4.1 Introduction

One in five Australians experiences an activity limitation or participation restriction that can be broadly classified as disability. Some will identify themselves as a person with disability; others might say they are old, injured or unwell without explicitly acknowledging that they have disability. Disability can be evident from a very young age as the built and social environments place increasing demands on the developing child. For other people, disability develops initially as a result of illness or injury, with gradual or sudden, early or late onset. But disability is not defined simply in terms of diagnosis or cause: disability results from the interaction between a person with impairment and their environment. As Oliver (1990) contends, disability is a social, not an individual, problem (see also AIHW 1993, 2001). This explains why the prevailing philosophy emphasises the multidimensional nature of disability in a social context.

Discussions about disability are therefore strongly related to the principles of social inclusion in Australia. These principles include reducing disadvantage; increasing social, civic and economic participation; building on individual and community strengths; giving high priority to early intervention and prevention; 'joining up' services; and whole-of-government solutions. They are central to the conceptualisation of disability, the aspirations of people with disability, their carers and families.

Three developments seem certain to shape future responses to disability in Australia: the ratification of the United Nations Convention on the Rights of Persons with Disabilities, the National Disability Strategy; and the new National Disability Agreement.

In 2008, Australia became the 28th signatory to the United Nations Convention on the Rights of Persons with Disabilities. This Convention gives currency to the rights of people with disabilities as citizens and the importance of 'mainstreaming' disability issues (Box 4.1). It assigns collective responsibility for removing discrimination. 'Mainstreaming' means that all levels and areas of government and services infrastructure need to be concerned that people with disability can access their environment. Transportation, health and education systems, public facilities and services, information and communication technologies have a role alongside disability services.

Box 4.1: Principles of the United Nations Convention on the Rights of Persons with Disabilities

(a) Respect for inherent dignity, individual autonomy including the freedom to make one's own choices, and independence of persons.

(b) Non-discrimination.

(c) Full and effective participation and inclusion in society.

(d) Respect for difference and acceptance of persons with disabilities as part of human diversity and humanity.

(e) Equality of opportunity.

(f) Accessibility.

(g) Equality between men and women.

(h) Respect for the evolving capacities of children with disabilities and respect for the right of children with disabilities to preserve their identities.

Source: United Nations General Assembly, 6 December 2006.

A National Disability Strategy was a key recommendation of the 2007 Senate Inquiry into the funding and operation of the Commonwealth State/Territory Disability Agreement (SSCCA 2007). Release of a discussion paper and public consultation during 2008 marked the development of a strategy to ensure that principles enshrined in the United Nations Convention on the Rights of Persons with Disabilities are integrated into policies and programs in Australia (National People with Disabilities and Carer Council 2009). The National Disability Strategy is planned for release in 2010.

A third important milestone was the introduction on 1 January 2009 of the new National Disability Agreement. The National Disability Agreement provides the national framework, and outlines key areas of reform for the provision of government support services for people with disabilities. The National Disability Agreement replaced the 2002–2007 Commonwealth State Territory/Disability Agreement (CSTDA), which had been extended to 31 December 2008 to enable negotiations for the new agreement to be finalised. Similar to the CSTDA, the focus of the National Disability Agreement is specialist disability services, access to which is governed by state and territory disability legislation. The National Disability Agreement highlights the importance of coordinated effort across the whole of government to enable people with disability to access services and participate as valued members of society (Box 4.2). Ten reform priorities are named in the agreement, including better measurement of need and service planning and strategies to simplify access, and the agreement places emphasis on person-centred approaches to planning and delivery (see Section 4.4).

Together, the United Nations Convention on the Rights of Persons with Disabilities, the National Disability Strategy and the National Disability Agreement will set the broad context for policy and service planning and delivery. Several recent inquiries will also contribute to the national disability agenda, including the National Inquiry into Employment and Disability (HREOC 2005) and the House of Representatives Inquiry into Better Support for Carers (HRSCFCHY 2009).

Box 4.2: National Disability Agreement objective and outcomes

The National Disability Agreement, which came into effect on 1 January 2009, is an agreement between the Australian Government and state and territory governments to provide funding of $5.3 billion over 5 years for specialist disability services.

The National Disability Agreement is subject to the provisions of the Intergovernmental Agreement on Federal Financial Relations. A state or territory share of the total amount for the National Disability Agreement in a financial year is its population share as at 31 December of that year. The growth factor is calculated as a 5-year rolling average of nominal year-on-year growth in gross domestic product.

Through this agreement, the parties committed to the following objective as the long-term, overarching aspiration that governments should strive for in the provision of disability support services. All aspects of the National Disability Agreement contribute to, or measure progress towards this objective: 'People with disability and their carers have an enhanced quality of life and participate as valued members of the community'.

To meet this objective, the agreement contributes to the following outcomes:

(a) people with disability achieve economic participation and social inclusion

(b) people with disability enjoy choice, wellbeing and the opportunity to live as independently as possible

(c) families and carers are well supported.

The agreement identifies 10 priority areas for reform in the disability service system: better measurement of need; population benchmarking for disability services; making older carers a priority; quality improvement systems based on disability standards; service planning and strategies to simplify access; early intervention and prevention, lifelong planning, and increasing independence and social participation strategies; increased workforce capacity; increased access for Indigenous Australians; access to aids and equipment; and improved access to disability care.

The specialist disability services that are the focus of the agreement are complemented by mainstream services. All governments recognise that achieving improved outcomes for people with disability, their families and their carers, is contingent upon the effective coordination of efforts across government services (Clause 12).

Source: National Disability Agreement and Intergovernmental Agreement on Federal Financial Relations (<www.coag.gov.au>).

Person-centred services

Compared to the CSTDA, the National Disability Agreement more explicitly articulates consumer participation and choice, referring to 'person-centred' services.

Governments have traditionally funded disability services through block funding arrangements with service providers. Under this type of arrangement eligible people are able to access disability support services within the range offered to them by government-approved providers. Australia is following a trend towards 'individualised funding', similar to consumer-directed care in the United Kingdom and some other OECD (Organisation for Economic Co-operation and Development) countries.

In a truly individualised funding situation the person with disability, or a nominated person on their behalf, is allocated an amount of funding determined by direct reference to their needs. The person determines how funds are used to meet those needs assessed as eligible for funding (Stainton 2009). Other individual support arrangements in place in Australia are loosely referred to as individualised funding without adhering strictly to this definition. Individualised funding is one vehicle for increasing individual choice and control but the idea is not to leave people 'on their own'; person-centred service is about enabling people to choose from a range of service types and settings and different funding arrangements, including individualised funding and more traditional funding models, to best meet individual needs and aspirations (Bigby & Fyffe 2009). Spicker notes that the opportunity to exercise choice may aggravate existing disadvantages but concludes, 'the real aim is not to obstruct choices and opportunities, but to ensure that those who are poorest and most disadvantaged will be able to exercise such opportunities' (Spicker 2008:190).

The potential for individualised funding and other individual support arrangements to achieve person-centred service is not without concerns. Factors that contribute to success include funding levels in relation to need, community attitudes, and the ability of people with disability to access infrastructure and mainstream services such as housing and transport (Vizel 2009). Viewed from this perspective, individualised funding addresses the 'choice' criterion of person-centred service; five other criteria for person-centeredness relate to information, representation and participation, access, accountability and redress (Deakin & Wright 1990:12).

Needs and outcomes—what we do and do not know

This chapter reports on need for and receipt of formal assistance among people with disability. It uses measures of need from the ABS Survey of Disability, Ageing and Carers and the 2006 Census, the first Census to collect core activity need for assistance data. Conceptually equivalent measures of support needs of people who use disability services are also collected and reported annually (see for example AIHW forthcoming).

By comparison with many other countries, Australia is well advanced in the measurement and monitoring of disability prevalence and need for assistance. However, the theme of this edition of *Australia's welfare*, 'Whose needs—how well met?' exposes some gaps in data and knowledge. One such gap is the limited national picture of whether services offered or accessed are those needed or chosen by people with disability. The drive towards person-centred service provision has the potential not only to change the way that services are delivered but also to place greater emphasis on data that describe the processes behind service delivery.

Existing data on disability support services have an output focus, that is, the number and amount of different types of services received and the number of people who receive them. Person-centred service—'services are person centred and provide timely access to supports based on assessed needs' (Council of Australian Governments 2008)—describes a *way* of delivering services. Different or mixed funding arrangements can be involved but a common element is the tailoring of supports to a person's individual needs with the active involvement of the person with disability, their carer and family. Any examination of the effectiveness of systems in achieving this service-related outcome would therefore require insight into who assesses needs and how, and the extent to which the person with disability is able to decide how their needs should be addressed. Capturing this type of information would require significant systems and data development effort nationally.

Godfrey and Callaghan's (2000) exploration of 'user-centred' responses to unmet need openly acknowledges that 'ideas of need are centrally bound up with resource allocation and prioritisation'. This is certainly true in Australia because the disability service system is not an entitlement system. A further complexity is the role that generic services play alongside disability support services in the lived experience of disability. As in other areas of welfare assistance, we are a long way from tracing the path from need to service intervention and person-level outcomes. The attribution of outcomes to person-centred service is still the domain of local innovation rather than large-scale demonstration and national data.

The data and knowledge gaps about the effectiveness of services in meeting peoples' disability support needs, particularly on the *practice* of person-centred service provision, highlights the importance of work under the new National Disability Agreement on agreed definitions and improved measures of need, and related measures of demand and unmet demand.

Scope of the chapter

This chapter presents a picture of disability in the Australian population and a national overview of disability service provision. It is a largely retrospective picture, with the latest available data reflecting patterns of disability in the populations of 2003 and 2006 and the service system of 2007–08. While there is no evidence of significant change in age-specific rates of profound or severe core activity limitation, the total number of people with this severe level of disability is rising as a result of increasing numbers of people growing older and reaching the age groups where profound or severe core activity limitation is more prevalent. The average age of users of disability services is similarly increasing (AIHW 2008b). Population ageing will continue to be a main driver of demand for disability support services but other factors, such as changing social and policy perspectives, are likely to influence how services evolve to meet the needs of people with disability and their families.

Population disability analysis has traditionally focused on people aged less than 65 years, as this is the target age group for specialist disability services. Older people (that is, those aged 65 years and over) who need assistance receive services through the aged care system. This chapter focuses on people with disability aged 0–64 years, while Chapter 3 presents data about need for assistance among older people.

Support for people with disability encompasses a range of formal and informal arrangements. The major informal source of support, informal care, is addressed in Chapter 5. This chapter largely focuses on formal government-funded or provided services and income support provided to people with disability.

4.2 Disability in the Australian population

The ABS conducts a number of surveys that provide data on disability at the population level. The most comprehensive is the Survey of Disability, Ageing and Carers (SDAC), which collects information about a wide range of impairments, activity limitations and participation restrictions, and their effects on the everyday lives of people with disability, older people and their carers. Less detailed but conceptually similar disability data are available in other data sources used in this chapter, including the 2006 Census of Population and Housing and the 2006 General Social Survey (GSS).

The chapter refers to two measures of disability in the Australian population. The broadest measure, 'all people with disability', refers to all people with a long-term condition (lasting or expected to last at least 6 months) who experience impairments, activity limitations or participation restrictions. The second measure, referred to as 'severe or profound core activity limitation' encapsulates those people who sometimes or always need help with at least one of the core activities of daily living: mobility, self-care and communication (for details of all levels of core activity limitation, see ABS 2004). People with severe or profound core activity limitations are at the most severe end of the disability spectrum. Specialist disability services have tended to target this group.

Data from the Survey of Disability, Ageing and Carers

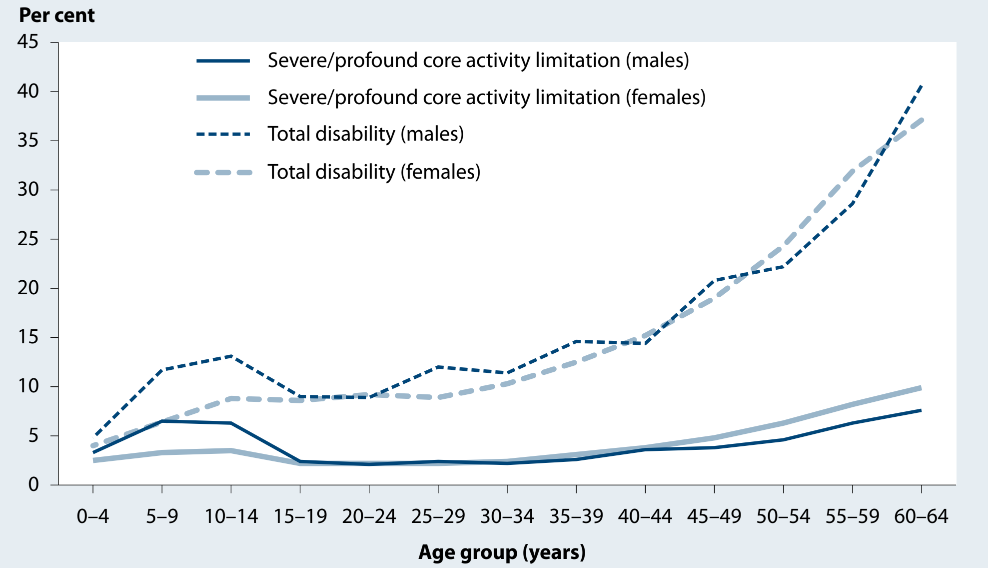
Disability rates vary with age

According to the ABS SDAC, in 2003 about 3.9 million people (20% of the population) had disability. This includes around 1.2 million people (6.3% of the population) with severe or profound core activity limitation (AIHW 2007c). When considering people aged 0–64 years (Table A4.1):

- about 15% had disability (2.6 million people)
- 3.9% had severe or profound core activity limitation (0.7 million people).

Generally speaking, disability rates increase with age throughout adulthood, from one in 10 people in their 20s and early 30s to one in three people in their late 50s and early 60s (Figure 4.1). Similarly, the prevalence of severe or profound limitation varies from around 2% of young adults to almost 9% of people aged 60–64 years. These patterns reflect the accumulation of risks to health and functioning over the lifespan, including the long-term effects of injury and chronic health conditions.

Patterns of disability are somewhat different in childhood and adolescence. The percentage of the population with severe or profound limitation, and disability more generally, is relatively high among school-aged children and lower in adolescence and early adulthood. This is particularly pronounced among boys: 6.5% of boys aged 5–9 years had severe or profound core activity limitation, compared to 3.3% of girls the same age. The effects of early intervention services and the school environment, as well as the way the survey collects information about children and young people, may contribute to increased identification of disability among children compared to teenagers and young adults.



Source: Table A4.1.

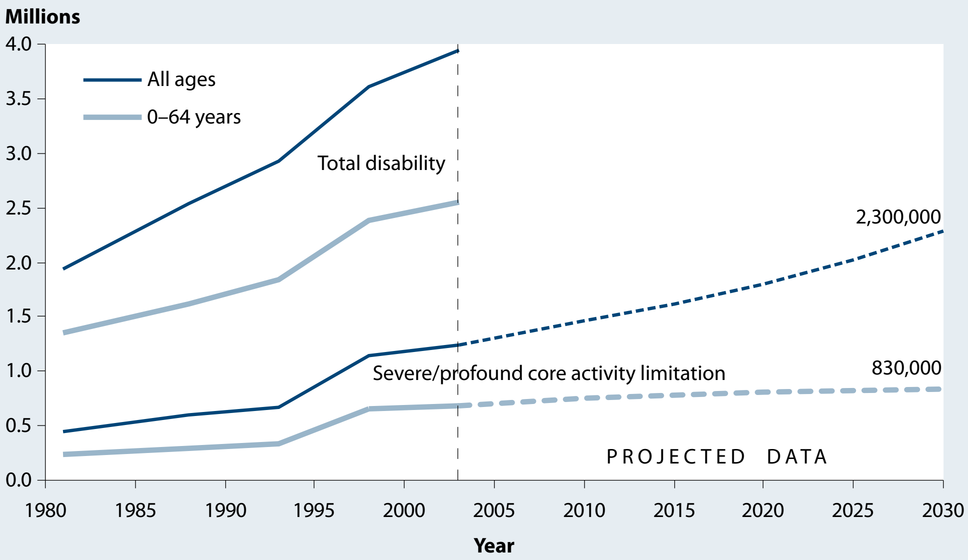
Figure 4.1: Persons aged 0–64 years with disability by age and sex, 2003 (per cent)

More than 2 million people with severe or profound disability by 2030

Including older people, there were more than 3.9 million people with disability in 2003. Around 1.2 million of these had severe or profound core activity limitations. According to ABS surveys conducted over the previous two decades (Figure 4.2; Table A4.2), between 1981 and 2003:

- the total number of people with disability doubled
- the total number of people with severe or profound core activity limitations rose 173%, or by around 790,000 people
- the number of people aged 0–64 years with severe or profound core activity limitations rose 183%, or by almost 440,000 people
- the number of people aged 0–64 years with disability increased by 90%, or 1.2 million people.

Some of the increase in the number of people with disability can be attributed to population growth, particularly the growth in the proportion of the population aged 65 years or over. Methodological changes to the SDAC also contributed to a large increase in disability prevalence as reported in the 1998 and 2003 surveys, compared with previous surveys. Improved diagnosis and heightened awareness of certain disabling conditions, especially attention deficit hyperactivity disorder and autism-spectrum disorders, have increased the reported rates of disability among children. However, there have been no significant changes in the underlying age-specific rate of severe or profound core activity limitation since 1981 (AIHW 2006a).



Notes

1. Children aged 0–4 years were not included in prevalence estimates of severe or profound core activity limitations in 1981, 1988 and 1993.
2. Projections are based on age- and sex-specific rates from the 2003 SDAC, applied to ABS projected population (series 8).

Source: Table A4.2.

Figure 4.2: Trends and projections in the number of people with disability, 1981–2030

Assuming that underlying rates of severe or profound core activity limitation remain stable, population growth and ageing could result in 1.5 million people with this level of disability in 2010, rising to 2.3 million by 2030—an increase of 85% on the 2003 figures. Most of the projected growth is expected to occur among older people. For people aged 0–64 years, the number with profound or severe core activity limitation is projected to rise by 23%, to around 830,000 people (see Table A4.2).

Physical disability is most common

Disabilities are often grouped into broad categories based on similarities in the underlying health condition, impairment, activity limitations, participation restrictions, environmental factors and support needs. Information about disability groups has been used by the disability sector and in legislative and administrative contexts in Australia, for example the CSTDA (see Section 4.4). The data presented here are based on the SDAC and are classified into five groups:

- intellectual
- psychiatric
- sensory/speech
- acquired brain injury (ABI)
- physical/diverse disability.

Physical/diverse disability was the most commonly reported disability among people aged under 65 years (12% of the population), followed by psychiatric and sensory/speech disabilities (4% each) (AIHW 2007c).

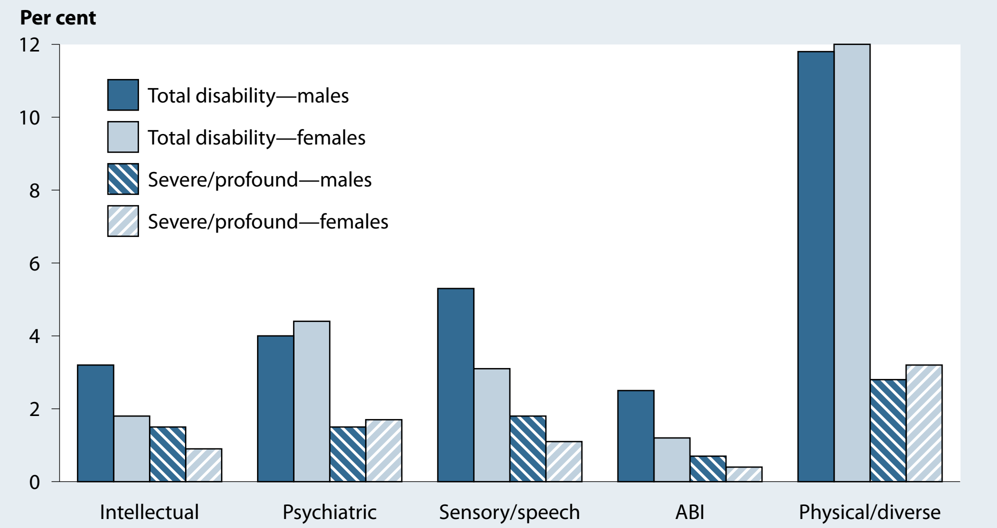
The prevalence of some disability groups varied considerably between the sexes (Figure 4.3). Males were more likely than females to have intellectual, sensory/speech disability or ABI. A slightly higher percentage of females than males had physical/diverse or psychiatric disability, but these differences were not statistically significant.

Around a quarter of people with physical/diverse disability had severe or profound core activity limitation. By comparison, half of all people with intellectual disability experienced severe or profound limitation (Figure 4.3).

Some people have more than one type of disability. In 2003, almost half of all people aged less than 65 years with disability reported two or more disability groups (AIHW 2009a). When a person has multiple disabling conditions, the one they nominate as causing the most problems is referred to as the 'main condition'. A person's main condition can change if they acquire additional disabling conditions, the severity of a condition changes or variations in environmental factors change the disability experience.

Most people aged 0–64 years with physical/diverse disability reported that it was their main disabling condition (88%; Table 4.1). By comparison, relatively fewer people with psychiatric (45%), intellectual (37%) or sensory/speech disability (34%) nominated these disabilities as their main condition.

Only 9% of people with ABI reported that it was their main disabling condition. This reflects the fact that people with ABI were much more likely to experience multiple disabilities compared with people with disability generally. For example, 26% of all people with ABI aged less than 65 years had four or more disability groups, compared with 5% of people aged 0–64 years with disability generally (AIHW 2007a).



Note: Based on all disabling conditions.

Source: AIHW 2007c:Table 4.2.

Figure 4.3: Disability groups of persons aged 0–64 years by sex, 2003 (per cent of the population aged 0–64 years)

Table 4.1: Disability groups of people aged 0–64 years, 2003

	All disabling conditions	Main condition	
	Number ('000)	Number ('000)	% of all conditions
Intellectual	436.2	162.7	37.3
Psychiatric	722.1	326.0	45.1
Sensory/speech	728.3	247.1	33.9
ABI	317.4	27.3	8.6
Physical/diverse	2,043.4	1,792.8	87.7

Note: Includes people with only one disabling condition.

Source: AIHW analysis of ABS 2003 Survey of Disability, Ageing and Carers confidentialised unit record file.

Disability data from the Census

The 2006 Census of Population and Housing was the first Australian Census to publish data on disability.

The Census form asked respondents whether they needed help with mobility, self-care or communication due to a disability or long-term health condition (ABS 2006b). The Census data item 'core activity need for assistance' is conceptually comparable to 'severe or profound core activity limitation' in the SDAC. However, the Census estimate of disability is based on a smaller number of questions than other ABS surveys, and relies on self-report rather than using trained interviewers. Therefore prevalence estimates of disability from the Census are considered less reliable than estimates derived from the SDAC.

The major benefit the Census brings to disability data analysis in Australia is the ability to pinpoint small geographical areas and specific population groups, including people living in remote areas and people born outside Australia.

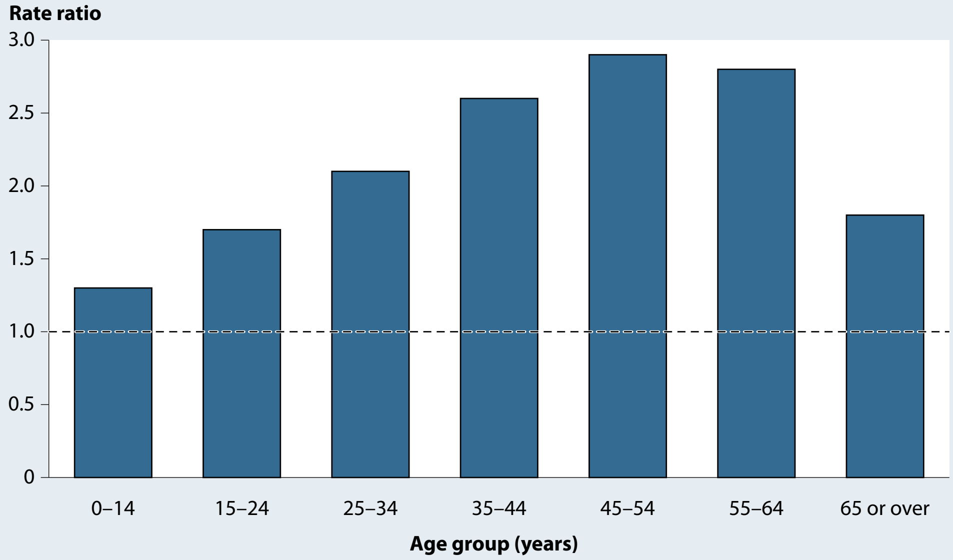
The following pages present Census data about the relative need for assistance with core activities among Aboriginal and Torres Strait Islander peoples, migrants, and people living in different parts of Australia.

Disability is more common among Indigenous Australians

According to the 2006 Census, 3.6% of Aboriginal and Torres Strait Islander people and 2.2% of non-Indigenous people aged 0–64 years reported needing assistance with core activities of daily living. After accounting for differences in the age structure and response rates of the two groups, Indigenous people aged 0–64 years were 2.4 times more likely to need assistance with core activities than non-Indigenous people.

Performance indicators of population access to CSTDA-funded disability services have employed an 'Indigenous factor' of 2.4 in calculations to account for the higher prevalence of severe or profound core activity limitations among Aboriginal and Torres Strait Islander peoples (AIHW 2006b; SCRGSP 2009). The Census results support the size of this factor.

Among those aged 65 years or over, 26% of Indigenous people and 18% of non-Indigenous people reported needing assistance. This equates to a rate ratio (Indigenous divided by non-Indigenous) of 1.8, after accounting for age structure and response rates (Figure 4.4).



Notes

1. Based on rates standardised to the age and sex- distribution of the Australian population.
2. Excludes people who did not respond to the Census questions about disability.
3. A rate ratio greater than 1.0 means that Indigenous Australians were more likely than non-Indigenous Australians of the same age to need assistance with core activities. Higher rate ratios mean larger differences.

Source: AIHW analysis of ABS 2006 Census of Population and Housing.

Figure 4.4: Need for assistance with core activities by Aboriginal and Torres Strait Islander people: rate compared with non-Indigenous Australians, 2006

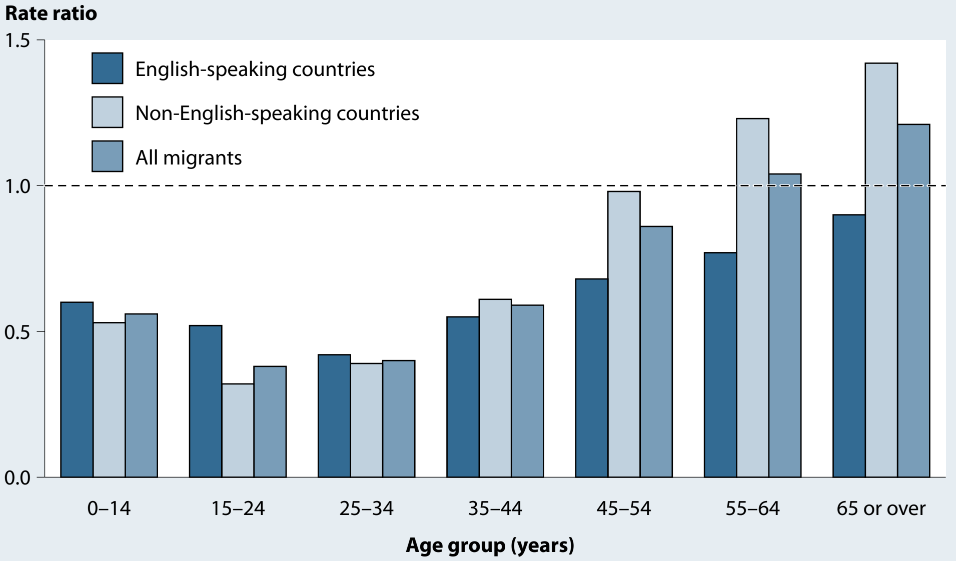
The difference between Indigenous and non-Indigenous Australians was most extreme in middle age—Indigenous people aged 45–54 years were almost 3 times as likely to need assistance with core activities as their non-Indigenous counterparts.

While aged care services are predominantly (although not exclusively) delivered to people aged 65 years or over, for planning purposes services for older Aboriginal and Torres Strait Islander people are targeted at those aged 50 years or over. This reflects the shorter average life expectancy of Indigenous Australians compared with non-Indigenous Australians, as well as the relative burden of disability and chronic health conditions in middle and later age (ABS & AIHW 2005).

Disability is less common among younger migrants

Rates of need for assistance with core activities also varied according to country of birth. Just over 5% of migrants and almost 4% of Australian-born residents reported needing assistance with core activities in 2006. After accounting for differences in response rates and population age structures, no overall difference was found between rates for people born in other countries and those for people born in Australia. However, the relative burden of severe disability varied considerably between different age groups.

Migrants aged under 55 years were less likely to need assistance than people born in Australia (Figure 4.5). The difference was particularly marked among younger adults.



Notes

1. Based on rates standardised to the age and sex- distribution of the Australian population.
2. Excludes people who did not respond to the Census questions about disability.
3. A rate ratio less than 1.0 means that people in the given population group were less likely to need assistance than people of the same age born in Australia; a rate ratio greater than 1.0 means that they were more likely to need assistance.

Source: AIHW analysis of ABS 2006 Census of Population and Housing.

Figure 4.5: Migrants' need for assistance with core activities: rate compared with Australian-born residents, 2006

For example, migrants aged 25–34 years were less than half as likely to need assistance as Australian-born people in the same age group. This pattern reflects the health requirement specified in the Migration Regulations, which is designed to minimise public health and safety risks, contain public expenditure on health and community services, including social security benefits, and maintain residents' access to health and community services (DIaC 2007).

Among older people, the relative percentage of people needing assistance with core activities diverges, depending on whether people were born in mainly English-speaking or mainly non-English-speaking countries. Compared with Australian-born residents, people aged 55 years or over were 10–20% less likely to need assistance if they were born in English-speaking countries, but 20–40% more likely to need assistance if they were born in non-English-speaking countries. This reinforces the importance of cultural considerations in delivering services to older people with disability.

Disability is distributed unevenly across Australia

According to the SDAC, rates of disability are generally higher in regional areas than in major cities (AIHW 2005a). However, the survey does not cover remote areas, or distinguish between small areas in different parts of the country with the same index of remoteness. The 2006 Census has made information about disability in small populations available for the first time.

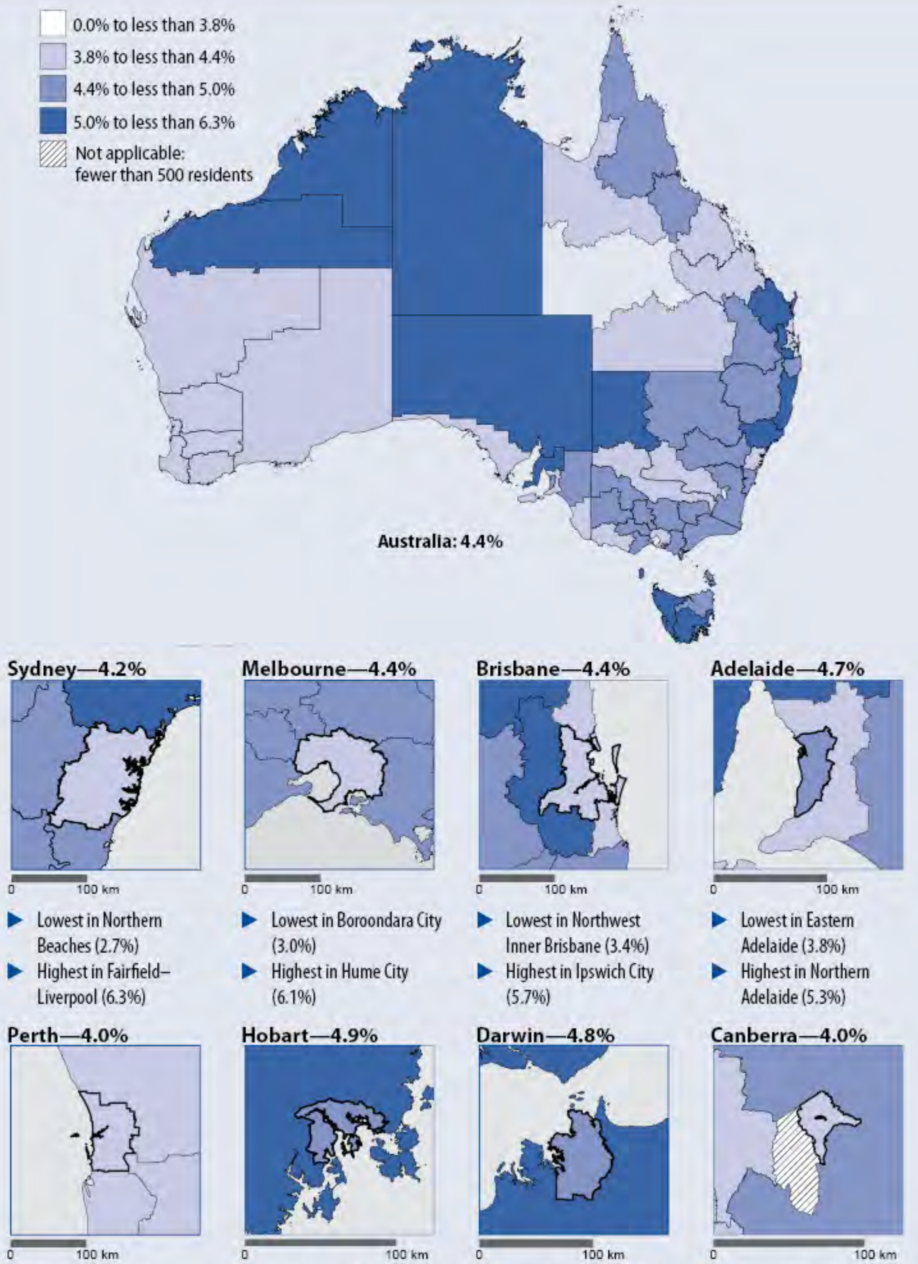
On average, 4.4% of all Australians reported a need for assistance with core activities in the 2006 Census (excluding those who didn't respond to the Census questions on need for assistance). However, this was not spread evenly throughout the population. The age-standardised proportion of people needing assistance ranged from 3.5% in the Central West Statistical Division of Queensland to 6.2% in Wide Bay–Burnett, north of Brisbane (Figure 4.6). Other areas with high rates (5% or greater) were clustered around remote areas in the Northern Territory and South Australia, the north of Western Australia and far western New South Wales, as well as the coastal regions north of Sydney, the areas surrounding Brisbane and western Tasmania.

The Census shows that the proportion of people needing assistance was not always lower in major cities and higher in regional areas. For example, Adelaide (4.7%) had a higher rate than the national average. By contrast, some regional areas, such as the south of Western Australia, south-west Queensland and the area north of the New South Wales and Victoria border had relatively low rates.

Figure 4.7 compares the age-standardised rates of need for assistance with core activities among 'younger people' in different Statistical Divisions. To account for premature ageing of Indigenous Australians, who make up a relatively high proportion of the population in some remote areas, it limits the analysis to Indigenous people aged 0–49 years and non-Indigenous Australians aged 0–64 years.

Among people aged less than 65 years, the national age-standardised rate of core activity need for assistance was 2.3%. This ranged from 1.4% in the Pilbara region of Western Australia to 4.2% in Wide Bay–Burnett (Figure 4.7).

Inner regional areas on the coasts of south-east Queensland, north-east New South Wales and eastern Victoria, as well as Tasmania, remote South Australia and far-western New South Wales, had the highest reported rates of need for assistance with core activities.



Sydney—4.2%

- ▶ Lowest in Northern Beaches (2.7%)
- ▶ Highest in Fairfield–Liverpool (6.3%)

Melbourne—4.4%

- ▶ Lowest in Boroondara City (3.0%)
- ▶ Highest in Hume City (6.1%)

Brisbane—4.4%

- ▶ Lowest in Northwest Inner Brisbane (3.4%)
- ▶ Highest in Ipswich City (5.7%)

Adelaide—4.7%

- ▶ Lowest in Eastern Adelaide (3.8%)
- ▶ Highest in Northern Adelaide (5.3%)

Perth—4.0%

- ▶ Lowest in Central Metropolitan (3.4%)
- ▶ Highest in East Metropolitan (4.3%)

Hobart—4.9%

- ▶ Lowest in Hobart—remainder (1.7%)
- ▶ Highest in Brighton (5.1%)

Darwin—4.8%

- ▶ Lowest in Litchfield Shire (3.6%)
- ▶ Highest in Palmerston–East Arm (5.8%)

Canberra—4.0%

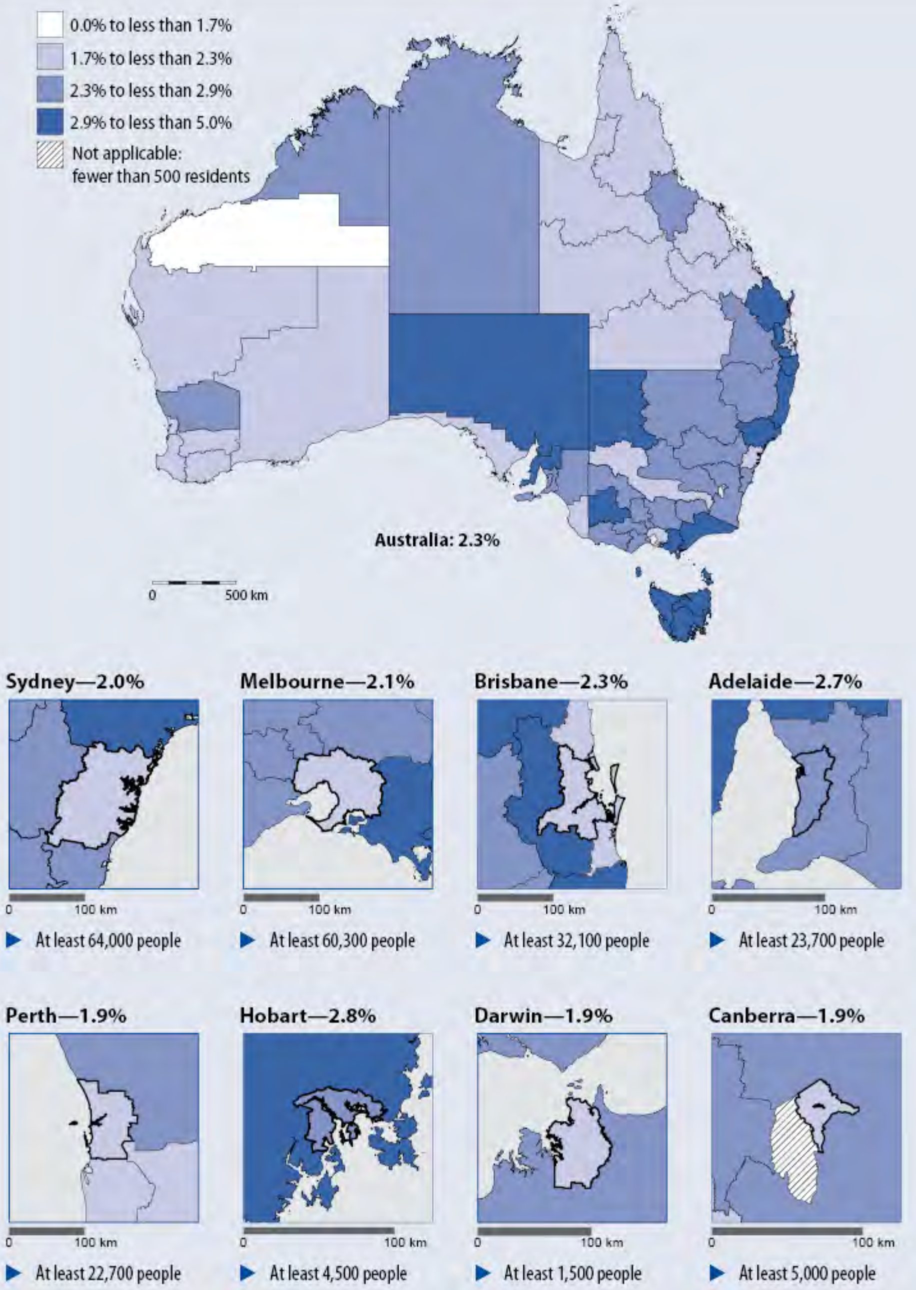
- ▶ Lowest in Woden Valley (3.6%)
- ▶ Highest in Belconnen (4.3%)

Notes

1. Based on rates standardised to the age and sex- distribution of the Australian population.
2. Excludes people who did not respond to the Census questions about disability.

Source: Table A4.3.

Figure 4.6: Need for assistance with core activities (all ages) by Statistical Division of usual residence, 2006 (per cent)



Notes

1. Based on rates standardised to the age and sex- distribution of the Australian population.
2. Excludes Aboriginal and Torres Strait Islander persons aged 50–64 years.
3. Excludes people who did not respond to the Census questions about disability.

Source: Table A4.3.

Figure 4.7: Need for assistance with core activities by persons aged 0–64 years by Statistical Division of usual residence, 2006 (per cent)

The percentage of people needing assistance with core activities was lower than average in all capitals except Hobart and Adelaide, most remote parts of Western Australia and Queensland, and the northern side of the New South Wales and Victoria border.

The Census data clearly show that the heterogeneous distribution of severe disability in Australia is not solely due to differences in remoteness. In particular, some regional areas have lower percentages of people with need for assistance with core activities than some cities. This variability has important implications for service planning.

Figures 4.6 and 4.7 tell a similar story: there is a relatively high percentage of people needing assistance with core activities in much of Tasmania, remote parts of South Australia, and on the eastern coastal fringe. The differences between the two figures suggest, however, that there is a particularly high burden of severe disability among older people in north-western and central Australia (see Chapter 3).

Disability is more common in relatively disadvantaged areas

In most capital cities, the percentage of people aged 0–64 years who needed assistance with core activities in 2006 was less than the national average of 2.3% (Figure 4.7). However, there was considerable variation in the distribution of severe disability within capital cities, with some metropolitan areas exhibiting relatively high rates of people needing assistance with core activities. Severe disability was more common in areas of relative economic disadvantage and less common in areas of relative economic advantage. When Statistical Local Areas were ranked according to their score on the Index of Economic Resources, people living in the bottom 20% of Statistical Local Areas within capital cities were more than twice as likely to need assistance with core activities as people living in the top 20% (3.1% and 1.3%, respectively; Figure 4.8), after adjusting for differences in age structure.

The direction of causality between disability and economic disadvantage is not clear, and it may be more helpful to consider it a symbiotic relationship. The relationship may be driven by disability-related factors to some extent. For example:

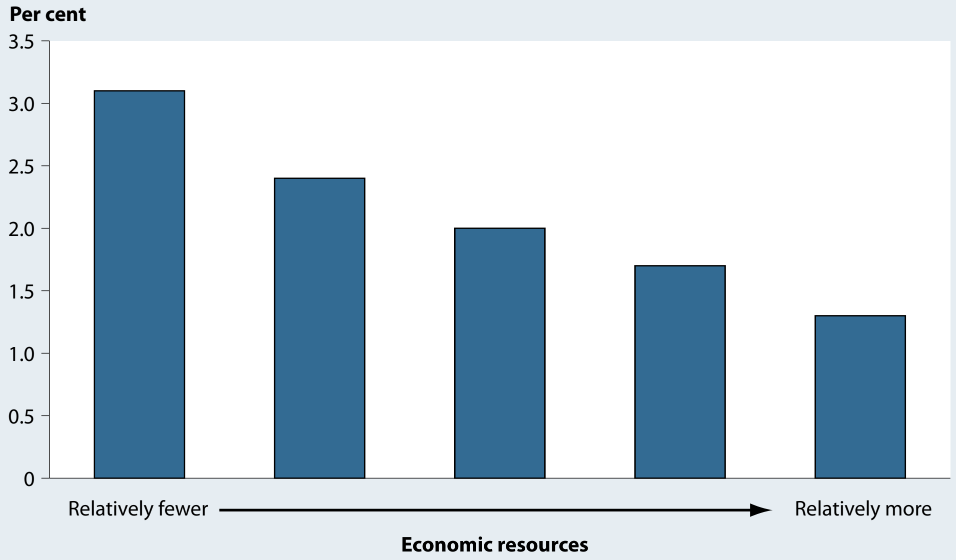
- Disability can reduce a person's ability to earn income and accumulate wealth, so disability can be a direct cause of economic disadvantage at the individual level. Family members of people with disability may also reduce or cease employment in order to care for them (ABS 2008c).
- At the population level, people or households whose income is reduced by disability may move to more disadvantaged areas in order to access low-cost housing.
- People with severe disability may cluster in more disadvantaged areas if disability-related services or accessible transport are located nearby, even though they may not necessarily experience high socioeconomic disadvantage on a personal level.

Conversely, socioeconomic disadvantage may cause or exacerbate disability (Lustig & Strauser 2007). Some specific examples of the mechanisms by which this can occur are:

- Various risk factors to health, such as smoking, sedentary or low exercise levels, little or no fruit intake and overweight or obesity, are more common among people living in more disadvantaged areas. These contribute to a higher burden of disabling chronic disease among socioeconomically disadvantaged people (AIHW 2008c:65).
- Occupational risk factors to health are often higher for people in lower status jobs (Niedhammer et al. 2008).

- People living in some geographical areas may be exposed to higher than average environmental risks to their health, such as industrial pollution or high ambient noise, which can contribute to the development or exacerbation of disability (Evans & Kantrowitz 2002). Further, subjective neighbourhood factors including perceptions of safety, social networks and traffic have been shown to affect self-rated mental health (Leslie & Cerin 2008).
- Psychological stress associated with poverty and social exclusion can contribute to a higher burden of mental illness among disadvantaged groups (ABS 2008a; Kuruvilla & Jacob 2007; Reijneveld & Schene 1998).

Finally, the association may be driven by a combination of both factors, or by a third factor common to disability and socioeconomic status. For example, disability is common among public housing tenants (AIHW 2007c:Table A5.6). If the public housing stock in a given city is clustered rather than spread throughout the city, there will be areas with a higher than average rate of disability as well as higher rates of other socioeconomically disadvantaged groups, such as people who are unemployed, low-income households and one-parent families.



Notes

1. Excludes Statistical Local Areas with fewer than 500 residents aged 0–64 years.
2. Percentages have been age-standardised to the Australian population on Census night 2006.
3. Statistical Local Areas are divided into quintiles based on their rank on the ABS Index of Economic Resources.

Source: AIHW 2009b.

Figure 4.8: Percentage of people aged 0–64 years living in capital cities needing assistance with core activities by quintile of disadvantage of area of usual residence, 2006

4.3 Financial resources of people with disability

Financial barriers can impede participation in many aspects of society. This is particularly the case for people with disability who, on the one hand, often have fewer financial resources than other members of society, while on the other hand may have to bear additional costs due to their disability. Understanding the relationship between disability and personal and household financial resources is therefore critical to reducing disadvantage associated with disability and enabling people with disability to participate as valued members of society. This is recognised in the National Disability Agreement, which aims to enhance the opportunities for people with disability to participate in economic as well as social and community activities.

This section provides a background to the discussion on economic participation, by examining the relative financial resources of people with disability, and their households, at the population level. It presents an analysis of the ABS 2006 GSS (Box 4.3), focusing on four areas:

- the distribution of different income sources among working-age adults with disability
- the relative household incomes of people with and without disability
- the types of wealth held by households of people with and without disability
- the extent to which people with and without disability experience certain types of financial stress
- The major policy responses to this issue—services to increase participation in employment and income support payments—are discussed in sections 4.5 and 4.6, respectively.

Disability data from the General Social Survey

Box 4.3: The General Social Survey

The 2006 ABS GSS is a household survey of adults aged 18 years and over that explores multiple aspects of life including social networks, community involvement, health and disability, personal stressors, financial stress and income. The survey identifies people who have a 'disability or long-term health condition', who are further classified by whether or not they experience specific limitations or restrictions (ABS 2007b).

While there are considerable methodological differences between the GSS and SDAC, particularly regarding the level of detail used to identify disability, the groups described below are conceptually comparable. One key difference is that the SDAC includes people living in cared accommodation, while the scope of the GSS is limited to people living in private dwellings. Neither survey covers remote areas.

This section presents GSS data for three groups of people:

- people with severe or profound core activity limitations—that is, people who sometimes or always need help with mobility, self-care or communication. This group is related conceptually to the group of people with a severe or profound core activity limitation in the SDAC

- people with specific limitations or restrictions—this refers to people with disability or long-term health conditions who have core activity limitations and/or schooling or employment restrictions. In some places in this section, this is shortened to 'people with restrictions'
- people without specific limitations or restrictions—this refers to people with neither core activity limitations nor schooling or employment restrictions. This group includes people who may have a long-term health condition or disability without specific restrictions.

ABS reporting of GSS data uses more detailed categories to classify disability and long-term health conditions (ABS 2007b) than are used in this section of the chapter. The focus here is on people with disability who experience specific limitations or restrictions in order to present a conservative estimate of the financial disadvantage experienced by many people with disability.

In addition to the financial data presented here, the GSS shows that many people with disability face barriers to social and community participation. For example, compared with all people aged 18–64 years, people with restrictions in core activities, schooling or employment were:

- less likely to have daily contact with friends or family outside their immediate household
- more likely to have difficulties with transport
- more likely to have difficulties accessing service providers
- less likely to have used a computer or accessed the Internet at home (ABS 2007c).

Greater reliance on income support

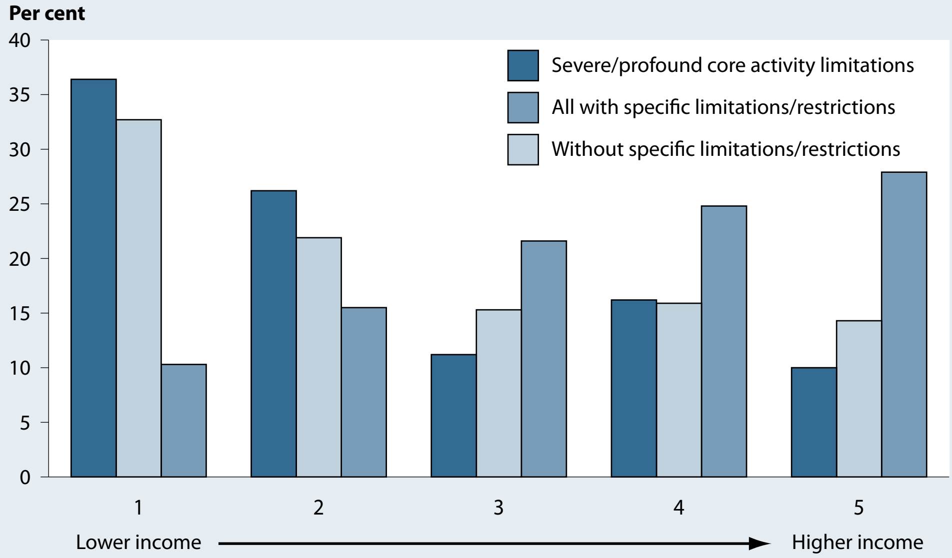
National surveys conducted regularly since 1981 show that people with disability have markedly lower labour force participation rates, and higher unemployment rates, than people without disability. The differences are starkest for people with severe or profound core activity limitations (AIHW 2007c, 2008a). Among people who are employed, those with disability are more likely than average to work part time (ABS 2004). Consequently, many people with disability rely on income support payments as their sole, main, or supplementary source of income. In 2006:

- half (51%) of all people aged 18–64 years with specific limitations or restrictions, and almost two-thirds (64%) of those with severe or profound core activity limitations, received income from government pensions or allowances, compared with one in five (20%) without specific limitations or restrictions
- government pensions and allowances were the principal income source for 57% of working-age people with severe or profound core activity limitations, 42% of people with specific limitations or restrictions of any severity, and 11% of people without limitations or restrictions
- In 2006, almost one in three (31%) people aged 18–64 years with specific limitations or restrictions, and one in 13 (8%) without, lived in jobless households. Disability can also affect the earning potential of those who don't have disability themselves, but who are connected with a person with disability, such as a carer.

Lower household incomes

People with specific limitations or restrictions were much more likely than people without limitations or restrictions to live in lower income households. Almost one in three (33%) people aged 18–64 years with specific limitations or restrictions, and one in ten (10%) without, lived in households in the lowest 20% of the income distribution (Figure 4.9). Equivalised household income varied according to disability group, with as many as 40% of those with intellectual disability living in low-income households (AIHW analysis of ABS 2006 GSS confidentialised unit record file). People with severe or profound core activity limitations were even more likely to live in low-income households (36%) than people with limitations or restrictions generally. At the other end of the income distribution, people with limitations or restrictions were about half as likely as those without to live in high-income households.

As this analysis takes into account the income earned by all household members, it means that people who live with an adult with disability, such as their family and carers, were also more likely than average to live in lower income households.



Note: Excludes people whose income was not stated.

Source: Table A4.4.

Figure 4.9: Equivalised gross household income quintiles of persons aged 18–64 years by disability status, 2006 (per cent)

Less household wealth

In addition to differences in income, people with disability were more likely than people without disability to live in low-wealth households. As with income, the benefits of individual wealth may be shared with other members of the household. For example, the security of tenure and housing quality enjoyed by home owners is shared, at least to some extent, by the rest of the household. Therefore household wealth is a useful concept when considering a person's economic wellbeing.

Household wealth refers to the balance of assets and liabilities held by members of a household. It includes investments and other asset classes, housing equity and consumer debt.

Compared with people without specific limitations or restrictions, people with core activity limitations or schooling or employment restrictions were more likely to live in an owner-occupied house without a mortgage—that is, a home that had been fully paid off (Table 4.2). This reflects both living arrangements and life-cycle effects. Home ownership rates increase with age, with more than half of all people aged 55 years or older living in an owner-occupied dwelling without a mortgage. Consequently, the relative likelihood of people with limitations or restrictions living in owner-occupied households without a mortgage varies considerably with age (AIHW analysis of ABS 2006 GSS confidentialised unit record file):

- similar proportions of people aged 18–34 years with (15%) and without specific limitations or restrictions (16%) lived in mortgage-free owned households
- adults aged 34–54 years with limitations or restrictions were more likely than their age counterparts without limitations or restrictions to live in an owner-occupied home without a mortgage (27% and 23% respectively). However, people in this age group with limitations or restrictions were 3 times as likely as those without to live with their parent(s), so this pattern may reflect home ownership of ageing parent carers
- people aged 55–64 years with specific limitations or restrictions were *less* likely than people of the same age without limitations or restrictions to live in a fully-paid off home (54% and 63% respectively).

Table 4.2: Household assets and liabilities of people aged 18–64 years by disability status, 2006 (per cent)

	With specific limitations or restrictions		Without specific limitations or restrictions
	Severe/profound	Total	
Home ownership			
Owner-occupied without a mortgage	34.5	31.8	26.3
Owner-occupied with a mortgage	26.2	30.8	44.3
Does not own home	39.2	37.4	29.5
Other asset classes			
Over $1,000 in cash or deposited in financial institutions	49.3	53.6	68.5
Shares, stocks and bonds	20.3	22.8	33.2
Investment property	14.4	15.7	24.2
Own incorporated business	3.5	5.6	10.9
Not known or not stated	2.0	2.3	1.6
None of these investments	39.2	35.3	21.0
Consumer debt			
Has consumer debt	43.0	45.2	47.5
Not known or not stated	1.5	1.3	1.8
Does not have consumer debt	55.4	53.5	50.7

Note: 'Household asset and liabilities' means that the asset or liability belongs to any member(s) of the household, not necessarily a person with disability.

Source: AIHW analysis of ABS 2006 General Social Survey confidentialised unit record file.

People with specific limitations or restrictions (31%) were much less likely than people without (44%) to live in mortgaged homes. Considering mortgaged and mortgage-free households together, people with limitations or restrictions were less likely than people without to live in owner-occupied housing. This means that people with disability, and those who live with them, were less likely to have access to housing equity to draw on if needed in the future.

Households with a member with disability were less likely than other households to have other types of assets. More than a third (35%) of people aged 18–64 years with specific limitations or restrictions, and almost two in five (39%) with severe or profound core activity limitations, lived in households where no-one had significant cash deposits, shares, stock or bonds, investment property or incorporated business. By contrast, only one in five (21%) people without limitations or restrictions lived in asset-free households. In particular:

- around half of people with specific limitations or restrictions lived in households where no one in the household had $1,000 or more in cash or deposits
- more than three-quarters of people with specific limitations or restrictions lived in households where no-one owned shares, stocks or bonds (including superannuation).

Greater financial stress

People with relatively few economic resources may be more susceptible to financial stress. One commonly used measure of financial stress is the ability to raise $2,000 in one week for something important. According to the 2006 GSS, people with specific limitations or restrictions (26%) were more than twice as likely as people without limitations or restrictions (11%) to report that they or other members of their household could not raise $2,000 in a week. This means that many people with disability may struggle to meet emergency costs such as unexpected medical expenses or replacement of essential household items.

Another measure of financial stress is whether a person experiences different types of cash flow problems, such as being unable to pay a bill on time, being unable to heat their home, going without meals, pawning or selling something for cash, or seeking financial assistance. In 2006, more than a third (34%) of people aged 18–64 years with specific limitations or restrictions had experienced a cash flow problem in the previous 12 months, compared with 18% of those without limitations or restrictions. Further, around 14% of people with specific limitations or restrictions reported having experienced three or more different kinds of cash flow problem in the past 12 months compared with 5% of people without limitations or restrictions. People with limitations or restrictions (7.1%) were 4 times as likely as people without limitations or restrictions (1.7%) to report having sought financial assistance from welfare or community organisations.

While financial stress is a function of spending and money management habits as well as available income, experiencing multiple types of financial difficulty is an indication of how having few economic resources can manifest in everyday life.

4.4 Support services for people with disability

This section gives an overview of government-funded support services for people with disability, including disability-specific programs, and mainstream education and employment services. The reference year is 2007–08.

For almost two decades, disability services have been provided primarily under either the CSTDA (before 2002, the Commonwealth State Disability Agreement) or the Home and Community Care Program (HACC). CSTDA-funded services are often referred to as 'specialist' disability services. This does not mean that the services are clinical in nature; the term reflects targeting under the CSTDA and is a legacy of the evolution of Australia's disability support system (Box 4.4) (for an historical account see AIHW 1993).

Box 4.4: Scope of disability support services under the Commonwealth State/Territory Disability Agreement and Home and Community Care

CSTDA

Services funded under the CSTDA Multilateral Agreement were to benefit people with disabilities. This was defined as people with disability that is attributable to intellectual, psychiatric, sensory, physical or neurological impairment, or ABI, where the disability is manifest before the age of 65 years, is likely to be permanent and results in substantially reduced capacity in self-care or management, mobility or communication and for which significant ongoing and/or long-term episodic support is required.

CSTDA services fall into eight broad categories: accommodation support, community support, community access, respite, employment, advocacy, information and print disability, as defined in the agreement.

The CSTDA specifically excludes services with a specialist clinical focus.

Source: Commonwealth State/Territory Disability Agreement 2002–2007.

HACC

The HACC target population is people who, without the basic maintenance and support services that the HACC Program provides, would be at risk of premature or inappropriate long-term residential care. This includes older and frail people with moderate, severe or profound disabilities; younger people with moderate, severe or profound disabilities and other groups who are agreed upon by Ministers. The HACC program also seeks to provide services to the unpaid carers of those people assessed as being in the target population. The HACC target population also includes people who might not have access to long-term residential care for cultural or geographical reasons, or other special needs.

Some of the services funded through the HACC Program include nursing care, allied health care, meals and other food services, domestic assistance, personal care, home modification and maintenance.

Source: DoHA 2008. Home and Community Care. Canberra: DoHA. Viewed 27 March 2009, <www.aodgp.gov.au/internet/main/publishing.nsf/Content/hacc-index>.

The HACC target population includes people with high levels of need for support; however, unlike the CSTDA, HACC does not link eligibility to disability type or age of onset. The origins of the two service systems—CSTDA firmly rooted in the paradigm of disability support and HACC showing a greater influence of an aged and community care philosophy—can be seen in the distinct profiles of specialist and non-specialist service user groups. A relatively new initiative, Younger People with Disability in Residential Aged Care (YPIRAC), caters to a subset of people with disability whose needs are not well met by the two larger disability service systems. Both traditional specialist services and the YPIRAC initiative come under the National Disability Agreement signed on 1 January 2009.

CSTDA-funded disability support services

The Australian Government and state and territory governments collect data for the CSTDA National Minimum Data Set. Full-year data have now been collected for 5 years and this section uses the data to summarise key trends in the specialist disability service system over the period 1 July 2003 to 30 June 2008. For more details see the annual reports on the CSTDA National Minimum Data Set, the most recent of which is *Disability support services 2007–08* (AIHW forthcoming).

Under the CSTDA, specialist disability services in eight categories were the responsibility of two levels of government. The Australian Government was responsible for the planning, policy setting and management of employment services for people with disability. State and territory governments were responsible for accommodation support, community access, community support and respite services. Some major state and territory differences exist within this overall arrangement whereby certain services, for example, early intervention services for children with disability, fall within the specialist disability system in some states but are administered under the education portfolio in others. Responsibility for advocacy, information and print disability services was shared between the two levels of government. Similar roles and responsibilities exist under the current National Disability Agreement.

Almost a quarter of a million service users

Almost one-quarter of a million people (245,746) used CSTDA-funded, or specialist, disability services in 2007–08. This represented an increase of close to one-third (31%) on 2003–04, or an annual growth rate of around 7%. The Australian Capital Territory recorded the highest growth (176% over 5 years), followed by the Northern Territory (97%).

Another perspective is the number of service users relative to the number of people who need assistance. The conventional measure of the population at risk of using specialist services is the number of people aged less than 65 years who need assistance with self-care, mobility and/or communication, commonly referred to as 'potential population'. Potential population so defined relates to targeting under the CSTDA (Box 4.4) (see also SCRGSP 2009). Where the number of service users per 1,000 potential population increases, a greater proportion of the target population is using services. This is an indicator of the proportion of the target population who are 'in the system'; it is not a measure of whether the services received are appropriate or sufficient to meet the needs of those who receive them.

In 2007–08, nationally around 335 people per 1,000 potential population received specialist disability services of one type or another. The increase from 273 per 1,000 potential population in 2003–04 has been driven mainly by greater numbers of people using respite, community support and open employment services (see 'Strong growth in respite and employment services', below).

Victoria registered the highest share of CSTDA service users, at around 37% of service users each year between 2003–04 and 2007–08, despite being less populous than New South Wales with around one-quarter of service users. This is at least partly attributable to differences between the specialist service systems in the two largest states that exemplify a lack of comparability between service systems nationwide. For example, there are different balances between what are termed residential and in-home accommodation support across states and territories; differences also exist in the coverage of community support and specialist psychiatric services (community support includes therapy support for individuals and early childhood intervention that may be delivered by varying service systems across the states and territories).

Some characteristics of CSTDA service users were similar from year to year (Table 4.3) (AIHW forthcoming). Using data for 2007–08 as typical:

- around 7% of service users lived in a CSTDA-funded institution, hostel or group home (17,400 people); the majority lived in private residences
- less than 40% of service users aged 15–64 years were employed, compared with 64% of the entire working age population (ABS 2008b)
- most working-age service users reported the Disability Support Pension as their main source of income
- just over half lived with family; a sizeable proportion (around 15%) lived alone
- around half had an unpaid carer—a relative or friend—who provided regular and sustained care and assistance; 65% of carers were the service users' mothers
- the proportion of Indigenous service users (4.5%) was higher than the proportion of Indigenous persons in the wider Australian population aged 0–64 years (2.8% in 2006) (ABS 2007a).

Service users are getting older, more culturally diverse

Over the life of the third CSTDA the median age of service users rose from 30.4 years to 32.6 years (Table 4.3). This was due to growth in the 45–64 years age group, which accounted for 1 in 4 service users in 2007–08 compared to 1 in 5 in 2003–04. At the same time, the proportion of service users born outside Australia increased from 8% to 11%, although this was still well below the overseas-born proportion of the general population (21% in 2006) (ABS 2007a).

Table 4.3: Selected characteristics of CSTDA-funded service users, 2003–04 to 2007–08 (per cent)

	2003–04	2004–05	2005–06	2006–07	2007–08	Per cent change
Male	59.0	56.4	58.1	59.0	59.1	—
Median age (years)	30.4	30.9	31.4	31.5	32.6	7.2
Indigenous	3.5	3.1	3.3	3.8	4.5	28.6
Born outside Australia	7.5	8.0	8.1	10.1	11.3	50.7
Needs help with core activities(a)(b)	54.5	59.4	59.1	59.4	50.8	−6.8
Has an informal carer(a)	52.1	53.3	55.8	49.2	50.2	−3.6
Employed (15–64 years)(a)	37.6	38.3	35.8	38.2	38.5	2.4
Unemployed (15–64 years)(a)	20.8	25.0	27.9	27.1	27.5	32.2
Not in the labour force(a)	41.6	36.7	36.4	34.6	34.0	−18.3

(a) Excludes missing data.

(b) Core activities include self care, mobility and communication. The rate of not stated' responses decreased over the 5 years from 26.4% in 2003–04 to 17.0% in 2007–08.

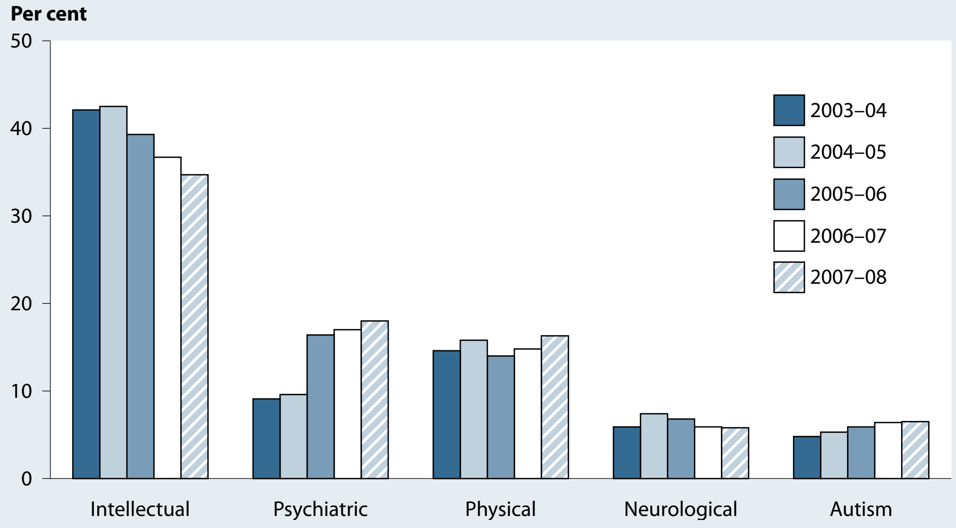
Sources: AIHW 2005b, 2006d, 2007b, 2008b, AIHW forthcoming.

Another notable trend was the proportion of service users aged 15–64 years who were unemployed, which rose from almost 21% to over 27%. This may be associated with a parallel decline in the proportion of service users not in the labour force.

Intellectual disability is the most common primary disability of service users

Historically, people with a primary disability of intellectual disability have made up the largest disability group of CSTDA service users, accounting for more than one-third from year to year (Figure 4.10). However, intellectual disability is only the fourth most common disability group among the wider population of people aged 0–64 years with severe or profound core activity limitation (Figure 4.3). This reflects in part a service system that has evolved from one focused on replacing institutional care for people with intellectual and psychiatric disability.

Over time, the expansion in services has been accompanied by a shift in the disability profile of the service user population. Most notably, the proportion of service users with a primary intellectual disability fell over the 5 years to 2007–08, while the proportion with psychiatric disability rose, overtaking physical disability as the second most common primary disability group. An administrative change implemented in Victoria from 2005–06, whereby all users of psychiatric services were coded as having a primary psychiatric disability, has contributed to this change.



Notes

1. Excludes missing data.
2. Victoria changed the coding practice of psychiatric disability from 2005–06, resulting in a larger proportion of service users reported as having a psychiatric disability.

Sources: AIHW 2008b, forthcoming.

Figure 4.10: The five most common primary disability groups among CSTDA-funded service users, 2003–04 to 2007–08 (per cent)

Dual diagnosis is common: around 2 in 5 service users in 2007–08 reported two or more disability groups. Although only 1% reported speech problems as a primary disability, this was a significant disability for 10% of service users. Taking into consideration all disability groups that a service user may have, there were substantial increases in the reporting of some disabilities, including:

- psychiatric conditions (135% increase between 2003–04 and 2007–08)
- autism (58% increase)
- specific learning or attention deficit disorder (56%).

Strong growth in respite and employment services

Broad groups of CSTDA-funded services included accommodation support, community support, community access, respite, employment, advocacy, information and print disability. This section summarises data on those services recorded in the 2007–08 CSTDA National Minimum Data Set (see AIHW forthcoming for more details).

Community support, which includes case management, was the most commonly accessed service group. Some 100,000 people (42% of service users) received community support in 2007–08. This was followed by specialist open and supported employment services, which were used by more than one-third of all service users, about 90,000 people. More than 20% of service users accessed more than one service group—common combinations were accommodation support together with community access, and community support together with community access.

Use of respite services grew from a relatively low base of about 20,500 service users in 2003–04 to 31,500 in 2007–08, registering the highest rate of growth over the period for any service group—a 53% increase overall and an average annual growth of around 11% (Figure 4.11). Various policy initiatives would have contributed to this increase, such as bilateral agreements for increased access to respite for older parent carers (FaHCSIA 2008a). Accommodation support and community access services registered the lowest increases in service user numbers (14% each).

Respite, community support and open employment services registered marked increases in access since 2003–04:

- respite—from 96 service users per 1,000 potential population to 137 per 1,000 in 2007–08
- community support—from 114 to 141 per 1,000 potential population
- open employment—from 143 to 167 per 1,000 potential population (in 2006–07[1]).

However, there was little growth in accommodation support (from 48 service users per 1,000 potential population in 2003–04 to 51 per 1,000 in 2007–08) and a decline in supported employment relative to potential population (from 69 per 1,000 potential population in 2003–04 to 60 per 1,000 in 2006–07[1]).

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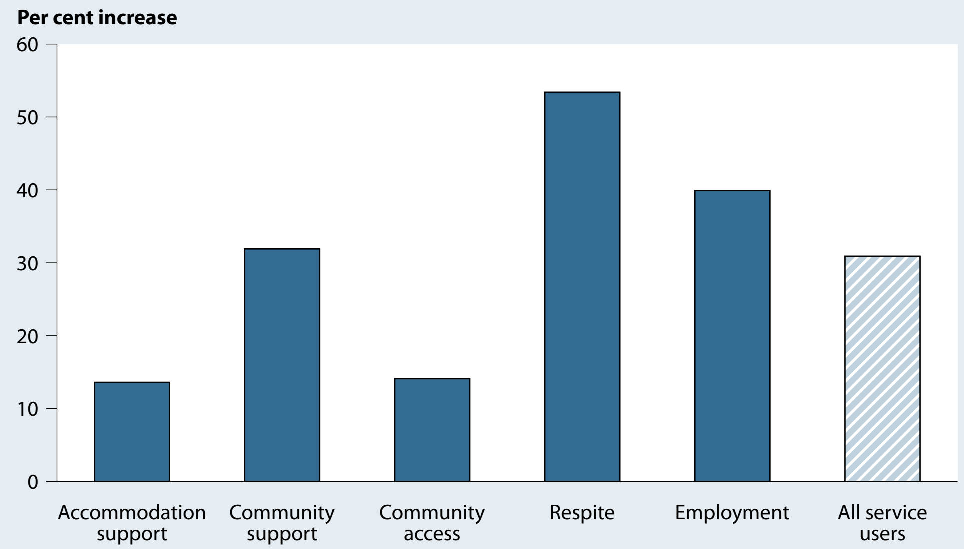
[1] 2006–07 is used as the reference year for employment service users per 1,000 potential population because of a subsequent change to the formula for potential population for employment services (SCRGSP 2009).



Source: AIHW forthcoming.

Figure 4.11: Increase in number of users of CSTDA-funded services, 2003–04 to 2007–08 (per cent)

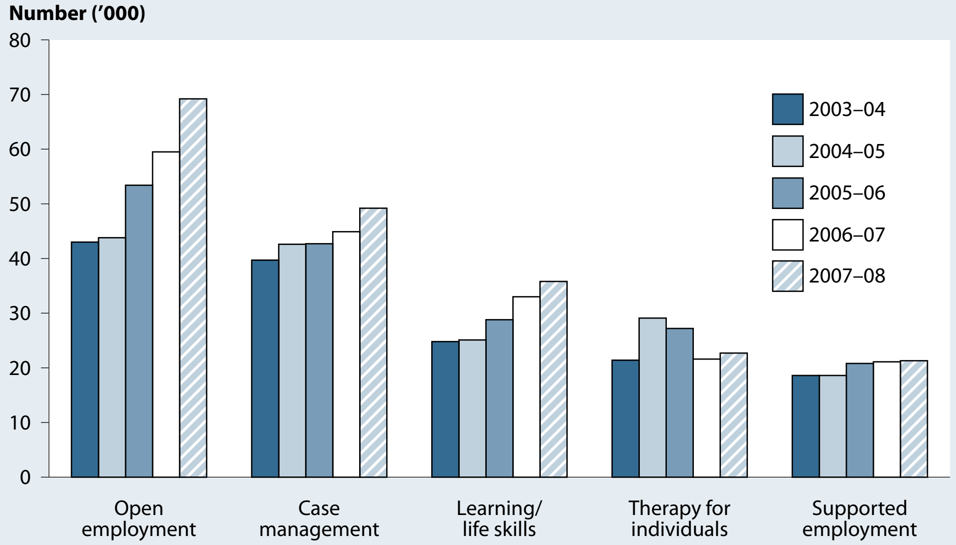
The broad service groups can each be broken down into a number of 'service types' (see AIHW 2008b). Between 2003–04 and 2007–08, the service type with the largest number of service users was open employment (open employment services help people with disability to participate in the open employment market), followed by case management, local coordination and development (Figure 4.12). Much of the growth in open employment services can be attributed to the move to full case-based funding in 2005–06 that opened up a large number of new open employment places. Other service types have also seen relatively large increases in the number of service users:

- regional and resource support teams—103%
- flexible/combination respite—95%
- own home respite—53%
- learning and life skills development—44%
- early childhood intervention—4%.

Several service types registered a decline in service users, most notably, recreation and holiday programs decreased by almost one-third (from 13,631 to 9,237 service users). Alternative family placement decreased by 29% (from 346 to 246 service users) and large residential/institutional accommodation services decreased by 21% (3,939 to 3,126).

Most specialist disability services are run by non-government organisations

Both government and non-government organisations deliver CSTDA-funded services. Open and supported employment services are run almost entirely by non-government organisations. Services administered by state and territory governments—accommodation support, community support, community access, and respite—are more often than not run by non-government organisations (71% overall) (AIHW 2008b).



Sources: AIHW 2008b, forthcoming.

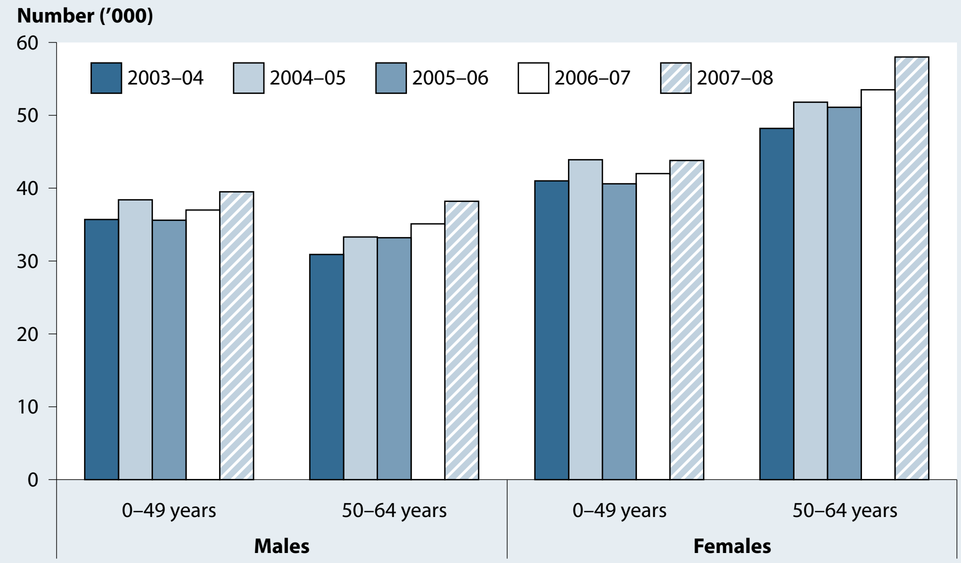
Figure 4.12: The five most common CSTDA-funded service types used, 2003–04 to 2007–08 ('000)

Support services funded by Home and Community Care

HACC is a program funded by the Australian Government and state and territory governments aimed at facilitating independent living and preventing admission to residential care (DoHA 2004). It provides a range of services to people with disability, the frail aged and their carers.

Some types of assistance funded through HACC, such as nursing care, allied health, and the provision of aids and equipment, were not available under the CSTDA. CSTDA-funded services were intended to complement and enable access to other formal services and support, including those available through HACC. The way that specialist and non-specialist services interact is critical to many people with disability being able to access the support they need and some tensions existed at the interface between HACC and the CSTDA. In practice, if a person receives support from specialist disability services, that may preclude them from receiving other types of assistance through HACC (AIHW 2006c). This would be the case, for example, where the provision of aids and equipment under HACC is considered to be a substitute for personal assistance for self-care or mobility assistance already received through CSTDA-funded services. Improved access to aids and equipment (and 'joined up services' generally) is a reform priority under the National Disability Agreement.

This section focuses on patterns and trends in service delivery to people with disability aged less than 65 years. For information about HACC recipients aged 65 years or over, see Chapter 3. While HACC also provides assistance to carers (such as respite and counselling services), these clients are not included in the information presented here.



Sources: AIHW 2008b, forthcoming; Table A4.5

Notes

1. Excludes 1–3% of service users aged 0–64 years whose sex was not stated.
2. Excludes service users aged 0–64 years who received carer services only.

Figure 4.13: HACC clients with disability aged 0–64 years, 2003–04 to 2007–08 ('000)

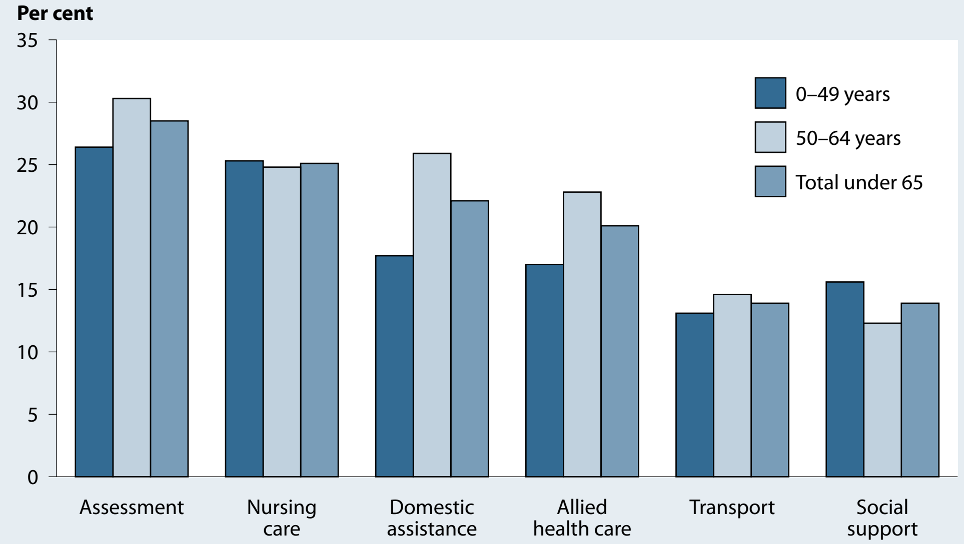
Around 182,000 people with disability aged 0–64 years reported that they received HACC services in 2007–08, representing 22% of all HACC clients. Female clients tended to be older, with a majority aged 50–64 years, while roughly equal numbers of males were in the 0–49 and 50–64 years age groups.

Between 2003–04 and 2007–08 the number of clients aged less than 65 years grew by 25,000 people, or 16%. Growth was strongest in the 50–64 years age group for both males and females (Figure 4.13).

Younger HACC clients with disability received a wide range of services. The most commonly accessed services in 2007–08 are shown in Figure 4.14. Access to some service types varied according to age, for example:

- people aged 50–64 years were more likely than those aged 0–49 years to receive domestic assistance or allied health care
- people aged 0–49 years were more likely to receive social support.

On average, people with disability aged less than 65 received 57.5 hours of assistance per year (in addition to types of assistance not counted in hours, such as provision of goods and equipment). Within the group of clients aged 0–64 years, people at the younger end of the spectrum received more hours of support, on average (63.2 hours per year for clients aged 0–49 years, compared with 52.4 for clients aged 50–64 years). This may be due to the different service usage patterns of the two groups, with younger people being more likely to receive more labour-intensive types of assistance.



Note: Excludes service users aged 0–64 years who received carer services only.

Source: Table A4.6.

Figure 4.14: The most common types of HACC assistance accessed by people with disability aged 0–64 years, 2007–08 (per cent)

One of the types of assistance funded by the HACC program is the hire or purchase of essential aids and appliances. However, the provision of goods and equipment through HACC is not coordinated nationally; rather, each state and territory determines its own funding priority for each HACC service type, including the provision of goods and equipment. As a result, the number of items supplied varies greatly between jurisdictions (Table 4.4).

Table 4.4: Number of goods or equipment provided to HACC clients aged 0–64 years, 2007–08

	NSW	Vic	Qld	SA	WA	Tas	NT	ACT	Australia
Self-care aids	3,066	. .	450	2,470	607	122	. .	20	6,736
Support and mobility aids	3,169	. .	84	3,176	1,260	—	. .	740	8,432
Communication aids	818	. .	284	n.p.	370	n.p.	. .	—	1,479
Aids for reading	26	. .	—	—	—	—	. .	110	136
Medical care aids	10,079	. .	13	109	n.p.	—	. .	100	10,330
Car modifications	103	. .	—	n.p.	n.p.	—	. .	150	257
Other goods/equipment	7,252	. .	53	598	—	53	. .	70	8,028

n.p. Not published due to small cell size, but included in totals.

Notes

1. Excludes service users aged 0–64 years who received carer services only.
2. Based on state or territory of agency. Victoria and the Northern Territory do not report on provision of goods/equipment by HACC providers.
3. Data should be interpreted with caution due to uneven quality of reporting of goods/equipment provision between jurisdictions.

Source: AIHW analysis of the HACC MDS.

Younger people in residential aged care

Some younger people with disability are supported in residential aged care. Most of these people have very high support needs, for example, a need for 24-hour or specialist nursing care or heavy lifting. Younger people, particularly those under 50 years of age, tend to enter residential aged care with very high support needs compared with people in the older age groups (AIHW 2007c:Figure 3.5).

Residential aged care is generally regarded as less than ideal for younger people with disability. While it may offer otherwise inaccessible instrumental assistance, a residential community with an average age of 85 years is unlikely to meet the social needs of a small minority of young people whose tastes in activities, food and surroundings are not always well catered for. Furthermore, the lack of interface between disability support and aged care services means that it can be difficult to access disability-specific supports. Younger people are not part of the target group of the Aged Care Assessment Program so a decision to approve a younger person for residential aged care is made only when no other more appropriate service is available (DoHA 2002). Therefore, young people in residential aged care represent an area of unmet need for disability services.

As at 30 June 2008, 6,606 younger people (under 65 years of age) lived in residential aged care (Table 4.5). Almost 2,000 younger people entered residential aged care in 2007–08 as permanent residents; close to 90% of these new admissions were aged between 50 and 64 years. New admissions peaked in 2004–05 and have fallen each year since. However, there has been an upward trend in the total number of younger people living in residential aged care facilities. All of the growth in permanent resident numbers in the decade 1999–2008 was among people aged 50–64 years.

Table 4.5: Permanent residents of residential aged care aged 0–64 years, 1999–2008

Age group	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	Per cent change 1999–2008
New admissions in financial year to 30 June[(a)]											
0–49 years	422	359	362	326	314	331	362	301	269	219	–48.1
50–64 years	1,746	1,731	1,629	1,629	1,719	1,768	1,890	1,864	1,743	1,771	1.4
0–64 years	**2,168**	**2,090**	**1,991**	**1,955**	**2,033**	**2,099**	**2,252**	**2,165**	**2,012**	**1,990**	**–8.2**
Permanent residents as at 30 June[(b)]											
0–49 years	1,197	1,152	1,094	1,077	1,009	997	1,019	1,007	926	858	–28.3
50–64 years	4,751	4,853	4,848	4,910	5,068	5,248	5,457	5,552	5,540	5,748	21.0
0–64 years	**5,948**	**6,005**	**5,942**	**5,987**	**6,077**	**6,245**	**6,476**	**6,559**	**6,466**	**6,606**	**11.1**

(a) New admissions refer to people admitted between 1 July the previous year and 30 June in the year shown.

(b) The total number of permanent residents at 30 June each year, including those admitted in the previous 12 months.

Note: Excludes transfers (a move under 2 days) from one service to another.

Source: AIHW analysis of Department of Health and Ageing Aged and Community Care Management Information System November 2008.

Younger people with disabilities may also use residential aged care services for respite. In 2007–08, there were around 2,400 respite admissions of people aged 0–64 years. This was 400 fewer admissions than the 2004–05 peak and around the same number as in 1999–2000 (AIHW analysis of DoHA Aged and Community Care Management Information System).

The Younger People with Disability in Residential Aged Care program

In 2006, the Council of Australian Governments signed a 5-year agreement aimed at reducing the number of young people living in residential aged care. The YPIRAC program began operating in July 2006 with funding of up to $122 million from the Australian Government to be matched by state and territory governments. Initial priority was to be given to people under 50 years of age living in or at risk of entering residential aged care.

In 2007–08, 580 people received support under the program, including some who had joined the year before and the majority (65%) who joined in 2007–08 (AIHW 2009c). Most (83%) were under 50 years of age. Consistent with the philosophy of choice, the YPIRAC program makes it possible to move out of residential aged care or to stay and receive additional support through the disability system. The program also provides additional home and community-based supports to people who are at imminent risk of entering residential aged care. YPIRAC service users in 2007–08 included:

- 296 people living in residential aged care who wanted to move to other accommodation
- 125 people living in the community but at risk of entering residential aged care
- 134 people living in residential aged care who remained there with additional services to be provided through the YPIRAC program.

A further 13 people chose to remain in residential aged care without additional support services.

As at 30 June 2008, 79 people had received alternative accommodation, including 33 who had been living in residential aged care and another 46 who were at risk of admission. Most of the people who wanted to move out of residential aged care were waiting for appropriate alternative accommodation to be found or built.

Not all the people contacted wanted to participate and not all of those who participated wanted to relocate from residential aged care. Around 11% of YPIRAC service users who were living in residential aged care on 30 June 2008 said that they were satisfied with their accommodation but needed additional services; another 7% said that they were satisfied with their accommodation, without qualification. One-third said that they were in residential aged care because more appropriate accommodation was not available. No explanation was given by more than one-third (37%) of the YPIRAC service users in residential aged care.

A support package was delivered to 265 people (46% of all YPIRAC service users), including 174 people living in residential aged care and 90 people at risk of admission (one not stated). Services provided through support packages commonly included attendant care or personal care (20% of service users), community access other than day programs (18%), assistive products and technology (17%) and individual therapy support (16%).

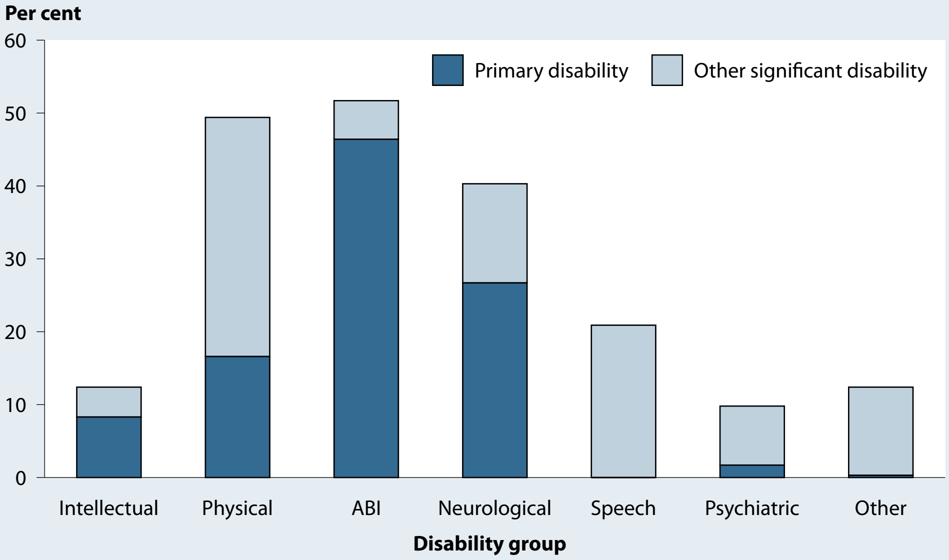
Within 2 years the YPIRAC program approached the threshold number of people in the priority age group who wanted to leave their familiar residential environment. High demand was recorded from the second target group—younger people with disability who need extra support to avoid admission to residential aged care. People in this 'at risk' group were the most likely to receive a support package (72%) and alternative accommodation (37%), reflecting a tendency towards early intervention and diverting younger people from aged care facilities.

Whose needs are not well met by conventional services?

In view of the YPIRAC program being a response to unmet need, it is instructive to compare the disability profile of YPIRAC service users with CSTDA service users.

ABI was the primary disability group of close to half (46%) of all YPIRAC service users in 2007–08 (Figure 4.15). This compares with 4% of CSTDA service users with ABI as a primary disability group. Taking into account both primary and other significant disability groups, around half of all YPIRAC service users had ABI (52%) and/or physical disability (49%).

Two in five YPIRAC service users (40%) had neurological disability with or without another type of disability. This compares with 13% of CSTDA service users with neurological disability.



Note: Other significant disability groups not separately identified were autism, deaf/blind, vision and hearing. One person reported autism as their primary disability group and one person did not state a primary disability group.

Source: AIHW 2009c.

Figure 4.15: Disability groups of Younger People with Disability in Residential Aged Care service users, 2007–08

These differences may reflect a traditional CSTDA service model geared around people with intellectual and psychiatric disability, many of whom are highly mobile. Before the YPIRAC program, the specialist disability system was clearly not meeting the needs of many people with complex nursing needs and limited mobility, as can be caused by ABI or multiple sclerosis, for example.

4.5 Education and employment

As well as specialist disability services, people with disability use the same services that all members of the community require and use, for example, schools, health services, transport services and so on. In fact, a primary aim of specialist disability services is to assist people with disability to access and benefit from generic services. This section looks at two important generic service systems that recognise people with disability as a special needs group and assist them to participate as valued members of society—education and employment. It examines the numbers of primary and secondary school students with disability and the use of employment services by people with special needs, including disability-related vocational needs. These are additional and complementary to specialist disability employment services provided under the CSTDA 2002–2007 and, now, the National Disability Agreement.

Education

The Disability Standards for Education, derived from the *Disability Discrimination Act 1992*, were first brought into effect in August 2005. These standards clarify the obligations of education and training providers, ensuring that students with disabilities are able to access and participate in the educational setting without experiencing discrimination. The standards are binding on both government and non-government providers in all education sectors: pre-school, school, vocational education and training, higher education, and adult and community education, as well as organisations whose purpose is to develop and accredit curriculums and courses.

Decisions about admission, enrolment or participation are the responsibility of the education provider, considering that reasonable adjustments are made where necessary so the student with disability is treated on the same basis as a student without disability. Providers are required to make ‘reasonable adjustments’ only. An adjustment is not mandatory if it causes ‘unjustifiable hardship’ to the provider (Ruddock 2005).

Assistance provided in schools

Generally, a student with disability must be formally assessed by an appropriate professional to be eligible for additional specialised assistance. Family members and school staff also play a role in deciding what outcomes and action are appropriate for the student. Central to the assessment is the consideration of how, and to what extent, the student’s disability affects their ability to function and learn in the school environment. The amount of funding and arrangements for its provision differ by jurisdiction. Funds are often provided directly to the school, rather than being allocated to a specific student.

Program funding and definitions of disability differ somewhat between jurisdictions; however, most adopt a model identifying the following broad disability groups:

- intellectual/learning disability
- physical disability
- psychiatric disability
- hearing or sight loss/impairment
- autism spectrum disorder.

More than 150,000 students with disability in Australian schools

In Australia, most school students with disability attend mainstream rather than special schools—82% of public and 94% of private school students with disability attended mainstream schools in 2008 (Table 4.6). This reflects the special funding arrangements that states and territories have in place to assist students with disability with high or special needs to remain in mainstream schools. However, policies vary between jurisdictions.

In New South Wales, South Australia, Tasmania and the Northern Territory, more than 90% of students with disability in government schools attended mainstream schools. In contrast, fewer than three in five students with disability in government schools in Victoria (55%) and Western Australia (59%) attended a mainstream school.

On average, 5.1% of government school students and 2.8% of non-government school students were recorded as having disability in 2008 (Table 4.6). There was considerable variation between jurisdictions in the proportion of schools students with disability, particularly in the government school system. It should be noted that these data do not take into account any differences in the prevalence of disability in primary versus secondary school, or the percentage of students at each level of education attending government versus non-government schools.

In total, there were more than 150,000 school students with disability in 2008, equating to 4.6% of all children and young people enrolled in Australian schools.

Table 4.6: Students with disability attending government and non-government schools, 2008 (FTE)[(a)]

	NSW	Vic	Qld	WA	SA	Tas	ACT[(b)]	NT	Total
					Government schools				
Mainstream schools	43,080	9,901	17,680	4,751	13,860	2,840	1,348	3,819	97,279
Special schools	4,754	7,970	3,021	3,259	1,030	156	355	331	20,876
Total	*47,834*	*17,871*	*20,701*	*8,010*	*14,890*	*2,996*	*1,703*	*4,150*	*118,155*
Per cent attending mainstream schools	90.1	55.4	85.4	59.3	93.1	94.8	79.2	92.0	82.3
Per cent of all students	6.5	3.3	4.3	3.1	9.0	5.1	4.9	12.7	5.1
					Non-government schools				
Mainstream schools	11,581	8,392	4,500	2,263	2,598	402	437	278	30,451
Special schools	1,459	158	179	71	144	24	0	0	2,035
Total	*13,040*	*8,550*	*4,679*	*2,334*	*2,742*	*426*	*437*	*278*	*32,486*
Per cent attending mainstream schools	88.8	98.2	96.2	97.0	94.7	94.4	100.0	100.0	93.7
Per cent of all students	3.5	2.8	2.0	1.9	3.0	1.8	1.7	2.8	2.8
					Total				
Students with disability	**60,874**	**26,421**	**25,380**	**10,344**	**17,632**	**3,422**	**2,140**	**4,428**	**150,641**
All students ('000)	1,121.4	790.3	619.5	327.2	246.4	71.7	47.3	40.8	3,264.7
Per cent with disability	5.4	3.3	4.1	3.2	7.2	4.8	4.5	10.9	4.6

(a) FTE (full-time equivalent) is not the same as the number of students attending school. For example, a student attending for half the normal school hours is counted as half an FTE. The total number of enrolled students will normally be greater than the number of FTE.

(b) ACT data exclude children attending preschools, which are included in the ACT Schools Census. Data will therefore differ from that published by the ACT Department of Education. The numbers provided above include students aged up to 20 years. In some years there may be significant numbers in the age 18–20 cohort and this may produce some volatility in numbers from year to year.

Sources: DEEWR unpublished data; data provided to AIHW by state and territory education authorities.

Support for students with disability in higher education

There is also support available for students with disability who continue into higher education in Australia. The Higher Education Disability Support Program grants funding to eligible higher education providers to assist with resources, training and specialised staff who assist in removing barriers to access for students with disabilities. The three components of the program are:

- *Additional Support for Students with Disabilities*, which provides funding to assist with costs incurred in providing educational support and/or equipment to students with disabilities with high cost needs. It also encourages efficient and effective use of equipment and resources for students with a disability
- funding to maintain the Australian Disability Clearinghouse on Education and Training website, which is a comprehensive website providing information and resources designed to promote inclusive practices for people with a disability
- *Performance-based Disability Support Funding*, which aims to encourage higher education providers to implement strategies to attract and support students with disabilities. In 2008, this initiative saw $1.3 million in funding distributed across 38 higher education providers throughout Australia (DEEWR 2009b).

Employment assistance programs

According to the 2003 SDAC, more than two-thirds of people with disability of working age experienced one or more employment restrictions (ABS 2004:Table 10). Some were permanently unable to work, while others could work with special assistance or were restricted in the type of job or number of hours they could work. The funding of services to help people with disability secure employment is one of the major avenues through which governments aim to increase the economic participation of people with disability. The Australian Government is developing the National Mental Health and Disability Employment Strategy in recognition of the barriers to employment faced by people with disability, and the importance of employment of people with disability to the Social Inclusion Agenda (Box 4.5).

While some people with disability receive CSTDA-funded services to help them look for and remain in work, many others access mainstream services through Centrelink. This section presents statistics on the major government-funded labour market assistance programs accessed by people with disability. As the data relate to the year to 30 June 2008, these programs were delivered under the Welfare to Work reforms, which have now been superseded. The data presented in the following sections therefore do not reflect the current service system, but provide a recent historical context to discussions about the use of government-funded employment services by people with disability.

Box 4.5: National Mental Health and Disability Employment Strategy

Development of the National Mental Health and Disability Employment Strategy is a key part of the Australian Government's Social Inclusion Agenda. It aims to address the barriers to finding and keeping work faced by people with disability and/or mental illness. The Strategy is due for release in 2009, with a directions paper released in December 2008. Initiatives include:

- changes to disability employment services, including the provision of services based on demand rather than on a capped number of places
- changes to Disability Support Pension rules to allow recipients to receive employment assistance without risking their pension eligibility
- additional supported employment places for people who are unlikely to achieve employment in the open labour market
- the Productivity Places program, which sets aside 711,000 training places over 5 years for jobseekers and existing workers, including people with disability
- engagement with business to encourage employment of people with disability
- promotion of the employment of people with disability within the Australian Public Service.

Source: DEEWR 2009c.

What services are available to help people with disability find work?

Labour market assistance programs can be divided into those specifically designed to help people with disability and those available to jobseekers regardless of their disability status. The major disability-specific programs funded under the CSTDA were:

- the Disability Employment Network (DEN), which provides open employment services to people with moderate to severe disability
- Australian Disability Enterprises (formerly known as Business Services), which enables people with high support needs to work in a supported employment environment.

These are included in CSTDA-funded disability support services (see Section 4.4).

Another employment assistance program provided specifically to people with disability is Vocational Rehabilitation Services, a program that helps people with disability, injury or long-term health conditions build work capacity and find or retain work. This program is separate from disability employment services funded under the CSTDA.

Mainstream programs also available to people with disability include:

- Job Search Support, the most widely accessible service offered by Job Network members. Under Job Search Support, Job Network members advise job seekers on job search techniques and employment programs, and provide access to job search facilities
- Job Placement Services, which matches job seekers' skills to vacancies, refers people to suitable vacancies and places successful applicants in jobs
- the New Enterprise Incentive Scheme, which helps unemployed people start up and run a small business
- Work for the Dole, work experience placements that are a Mutual Obligation requirement for some unemployed people

- Intensive Support, one-to-one assistance provided to job seekers who remain unemployed after 3 months. People who are classified as 'highly disadvantaged' or who are still unemployed after 12 months qualify for additional support, known as customised assistance
- the Personal Support Programme, which provides support to highly disadvantaged jobseekers who face multiple non-vocational barriers to employment, such as disability, mental illness, homelessness, drug and alcohol problems, and domestic violence. The Personal Support Programme aims to help people achieve economic outcomes, such as participation in employment, study or training, as well as social outcomes, including stable accommodation, improved life skills and community engagement. While the program is not a specialist disability service, a high proportion of people in the program have disability (Table 4.7).

The Welfare to Work reforms—an initiative of the former Australian Government designed to assist people to move off income support payments and into work—came into effect on 1 July 2006. For people with disability, the most significant parts of the package were changes in eligibility for the Disability Support Pension (DSP) (see Box 4.6) and the provision of additional employment services to promote workforce participation.

Changes to employment services were introduced in the 2009–10 financial year. These include the introduction of an integrated disability employment program to replace the Disability Employment Network and Vocational Rehabilitation Services, and the replacement of mainstream employment programs under Job Network with Job Services Australia.

What has changed since Welfare to Work was introduced?

As discussed in Section 4.4, one of the significant recent trends in specialist disability services funded under the CSTDA is the increase in use of open employment services. Between the 2005–06 and 2007–08 financial years the number of people accessing open employment rose by 29% (AIHW forthcoming). The period since the introduction of Welfare to Work has also seen considerable growth in the use of non-CSTDA labour market assistance services targeted at people with disability. The number of people commencing with Vocational Rehabilitation Services increased by 69% between June 2006 and June 2008, while new entrants to the Personal Support Programme rose by 75% (Table 4.7).

While some programs have grown considerably since Welfare to Work was introduced, use of other mainstream employment services has fallen. The total number of commencements with Job Search Support and Job Placement Services has fallen (by 31% and 10% respectively), as has the percentage of people accessing these programs who have disability (Table 4.7). The number of people commencing Intensive Support and the New Enterprise Incentive Scheme has been fairly stable, although in 2008 relatively fewer people in these programs had disability than in 2006.

Almost 20% fewer people were engaged in Work for the Dole in 2008, which reflects the general reduction in unemployment between 2006 and 2008. Over the same period there was no real change in the number of people with disability in this program, even though people with disability increased as a percentage of all Work for the Dole recipients (Table 4.7).

Table 4.7: Number of people starting labour market assistance programs, and per cent with disability, 2006 to 2008

	2006	2007	2008	Per cent change	2006	2007	2008
	Number of commencements				Per cent with disability		
Vocational Rehabilitation Services	25,482	32,444	43,115	69.2	100.0	100.0	100.0
Job Search Support	491,635	420,794	337,622	–31.3	6.5	5.4	5.0
Job Placement Services	638,212	645,569	577,868	–9.5	8.8	7.6	7.8
Intensive Support	366,259	372,190	360,130	–1.7	11.9	13.8	8.1
New Enterprise Incentive Scheme	6,546	6,332	6,429	–1.8	10.8	8.2	8.7
Work for the Dole	87,073	92,712	69,769	–19.9	6.9	7.3	8.5
Personal Support Programme	28,359	42,224	49,699	75.2	41.2	33.2	38

Note: Data relate to all people who commenced the program in the year to June 30.

Source: DEEWR 2009a; data supplied to AIHW by Department of Education, Employment and Workplace Relations.

How successful are employment services for people with disability?

Two in five jobseekers who exited Vocational Rehabilitation Services between 1 April 2007 and 31 March 2008 had achieved a positive outcome (employment or training outcomes) 3 months later (Table 4.8). Outcomes were lower for people with disability who were also Indigenous or from a non-English speaking background.

Of the generic employment assistance programs shown in Table 4.8, the New Enterprise Incentive Scheme and Job Placement Services had the highest proportion of people achieving positive outcomes (90% and 76%, respectively). In contrast, around three in five (60%) people exiting Intensive Support, just over two in five (43%) exiting Work for the Dole and one-quarter exiting the Personal Support Programme achieved positive outcomes within 3 months. Within each program, people with disability were less likely than the average jobseeker to achieve positive outcomes. They also had lower success rates than some other equity groups, namely sole parents and people from culturally and linguistically diverse backgrounds.

Table 4.8: Percentage of jobseekers achieving positive outcomes after exiting Job Network programs, year to 30 June 2008

	Equity groups(a)				All jobseekers
	Disability	Indigenous	CALD(b)	Sole parents	
Vocational Rehabilitation Services(c)	41.2	39.2	34.0	43.8	41.2
Intensive Support	49.7	46.2	60.2	67.7	60.1
New Enterprise Incentive Scheme	83.8	n.a.	89.5	91.1	89.9
Job Placement Services	62.9	60.6	71.3	77.1	76.0
Work for the Dole	33.2	31.4	47.0	49.7	43.3
Personal Support Programme	21.2	19.4	25.2	34.1	25.1

n.a. Not available as the estimate is based on a small number of known outcomes.

(a) Equity groups are not mutually exclusive.

(b) People from culturally and linguistically diverse backgrounds other than those born in English-speaking countries.

(c) All job seekers in Vocational Rehabilitation Services had disability. People in other equity groups therefore had disability and were also Indigenous, or had disability and were also sole parents, etc.

Note: Post-assistance outcomes are measured 3 months after jobseekers cease assistance. Positive outcomes include employment and education or training outcomes.

Source: DEEWR 2009a.

What don't we know?

Analysis of how well specialist and mainstream employment services are reaching their target population depends on the availability of accurate, up-to-date population data about the labour force status of people with disability. This is because changes in the labour force can occur over a relatively short period of time, so the number of people with disability potentially in need of employment assistance may vary significantly from one year to the next. However, current estimates of the 'potential population' for specialist disability employment services, and detailed analyses of labour force differentials between people with and without disability, are based on the 5–6-yearly SDAC. The lack of more regular data on the labour force status of people with disability diminishes the ability for government to respond from a solid evidence base to sudden changes, such as those anticipated due to the global financial crisis. There is now a plan for a biennial supplement to the ABS Monthly Population Survey to collect data on employment and labour force participation by people with disability.

4.6 Income support

Disability Support Pension

The DSP is a targeted payment intended to ensure that people with disability have adequate income and opportunities to participate in society (DEEWR 2009d). It is made to people who have a physical, intellectual or psychiatric impairment that limits their capacity to work (see Box 4.6) and to people who are permanently blind. To be eligible to receive this payment, people must be aged between 16 years and Age Pension age, and meet certain residency and other requirements.

The DSP is a source of income for many people who use specialist disability services. Of the 245,746 CSTDA-funded service users in 2007–08, close to three-quarters (72%) reported that the DSP was their main source of income (AIHW forthcoming).

In June 2008, more than 732,000 people were receiving the DSP, an increase from around 714,000 in June 2007 (Table A4.7).

Box 4.6: Changes to eligibility for the Disability Support Pension

DSP eligibility rules were changed as part of the 2006 Welfare to Work reforms (DEWR 2006). Before the introduction of these reforms, people who were assessed as being unable to work for at least 30 hours a week due to their disability were entitled to receive the DSP. With the changes as applied from 1 July 2006, applicants who are assessed as being able to work for at least 15 hours a week or be re-skilled for any work within the next 2 years are instead placed onto Newstart Allowance.

The changes to the DSP were accompanied by extra employment services to help ineligible people with disability find work (see 'Employment Assistance Programs' in Section 4.5).

Is the underlying recipient rate growing?

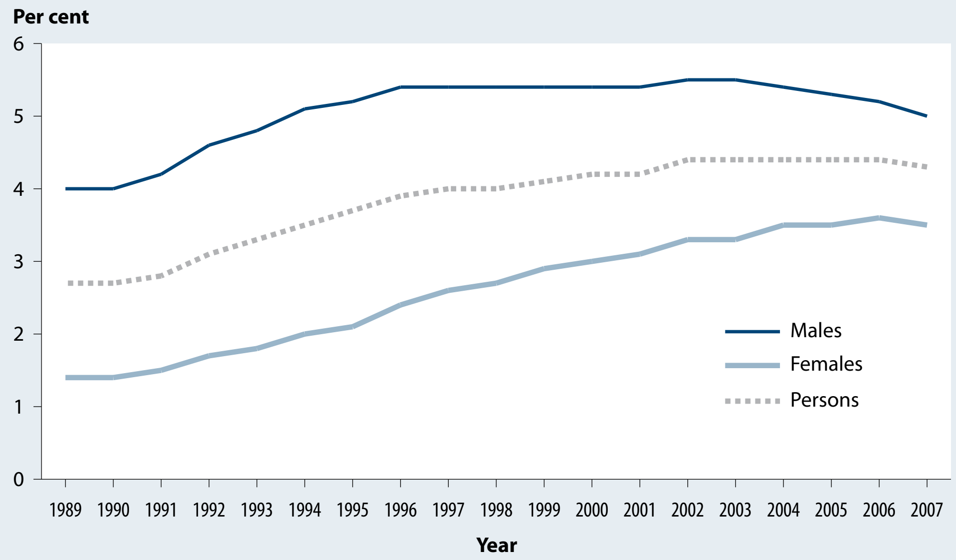
As the proportion of the population receiving the DSP is higher at older ages within the eligibility age range (FaHCSIA 2008b), it can be expected that population ageing leads to growth in recipient numbers. Indeed, the number of people receiving the DSP has more than doubled over the past two decades (and there has been an increase of around 75% in the number of people aged 50–64 years). After taking into account the changing age structure of the Australian population, the proportion of people aged 16 years or over receiving the DSP grew from 2.7% in 1989 to 4.4% in 2002, then levelled off until 2006 and declined slightly to 4.3% in 2007 and 2008 (Figure 4.16).

Women aged 60–64 years are recording the largest year-on-year increases in number of DSP recipients of any 5-year age group. In 2008 there were 11,320 more women aged 60–64 receiving the DSP than in 2007 (a 21% increase). The year 2008 also corresponded to an increase in the Age Pension qualifying age for women from 63 to 63.5 years. A biennial pattern of step increases in female DSP recipients can be traced to increases in female Age Pension qualifying age which began in the mid-1990s.

Trends in DSP payments over the past two decades in fact reflect a number of significant reforms to social security, including:

- introduction of the Disability Reform Package. Among the changes was the elimination of the Invalid Pension and Sheltered Employment Allowance in November 1991, to be replaced by the DSP (FaCS 1991). The 12 months to June 1992 saw the biggest annual increase in the number of DSP recipients (13%)
- phasing-out of other income support payments, particularly for older women
  - The Wife Pension, a payment for female partners of Disability Support Pensioners and Age Pensioners, has been closed to new applicants from June 1995. In the following 12 months the number of female DSP recipients aged 60–64 years rose from 653 to 3,434.
  - The Widow B Pension, paid to older women with limited financial support who were widowed, divorced or separated, was phased out from March 1997. The number of women aged 60–64 years receiving the DSP more than doubled between 1997 and 1998 (AIHW 2001:Table A7.8).
  - The Mature Age Allowance, paid to both men and women aged between 60 years and Age Pension age with no recent workforce experience, has been closed to new entrants since September 2003.
  - The Widow Allowance, paid to older widowed, divorced or separated women without recent workforce experience, is in the process of being phased out, beginning 2005.
  - The phased increase in female Age Pension qualifying age by six months every two years commencing on 1 July 1995 when it was increased to 60.5 years.
- Welfare to Work reforms, introduced on 1 July 2006 (see Box 4.6).

Research suggests that the number of people receiving the DSP is also affected by labour market factors, including the reduced availability of unskilled jobs (Cai et al. 2006; Lattimore 2007).



Notes

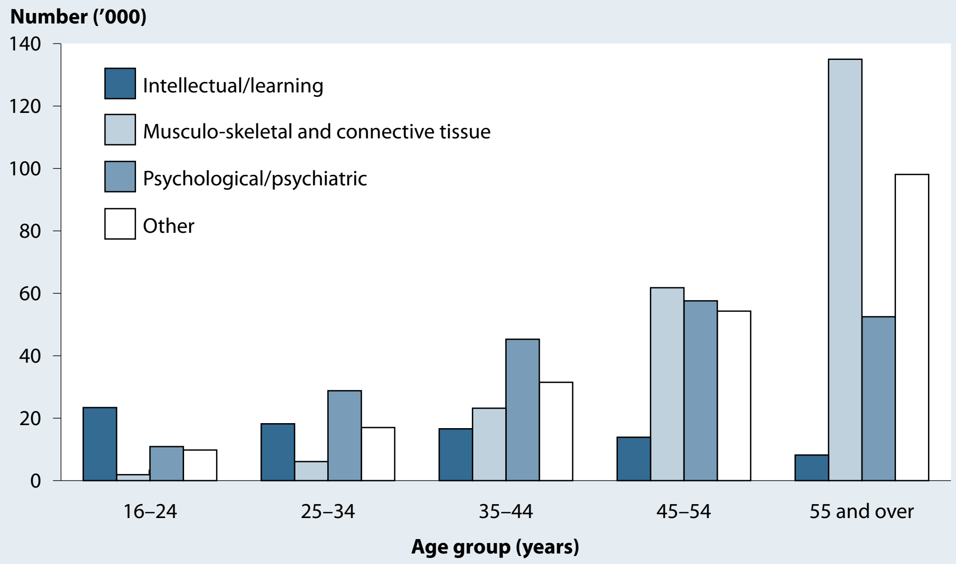
1. Percentages have been age-standardised to the Australian population.
2. As at June each year.

Source: Table A4.7.

Figure 4.16: Disability Support Pension recipients as a percentage of the population aged 16 years or over, 1989–2008

Different disability types among younger and older recipients

DSP recipients have a wide range of impairments. However, 70% of recipients in 2007 identified one of three groups as their primary condition: physical disability resulting from musculoskeletal and connective tissue disorders (32% or around 228,000 people); psychological or psychiatric conditions (27% or around 195,000 people) and intellectual or learning disability (11% or around 80,000 people) (FaHCSIA 2008b). Intellectual or learning disability was the most common disability type for recipients aged 16–24 years, while those aged 25–44 years were most likely to identify psychological or psychiatric conditions (Figure 4.17). Physical disability resulting from musculoskeletal and connective tissue disorders was the most common primary condition of DSP recipients aged 45 years or over. Of other conditions reported, each accounted for fewer than 5% of DSP recipients. These included diseases of the circulatory, nervous and respiratory system, sensory disorders and ABI.



Source: FaHCSIA 2008b.

Figure 4.17: Disability Support Pension recipients by age and primary condition, June 2007 ('000)

Other disability-related payments

Other disability-related payments include Mobility Allowance, Sickness Allowance, Wife Pension (DSP), Newstart Allowance (incapacitated) and Youth Allowance (incapacitated).

Mobility Allowance provides assistance to people with disability who are involved in employment, job seeking, voluntary work or training, and who cannot use public transport permanently or for an extended period without substantial assistance. Sickness Allowance is a payment for employees and some full-time students who are temporarily unable to work due to an incapacitating condition. The equivalent payment for people aged 16–21 years is Youth Allowance: incapacitated. Unemployed people aged 21 years or over who are unable to look for work, or undertake training or rehabilitation due to temporary incapacity or illness receive Newstart Allowance: incapacitated and are exempt from the usual activity test requirements (Centrelink 2009).

Sickness Allowance, Youth Allowance (incapacitated) and Newstart Allowance (incapacitated) are all temporary payments. Recipients with an incapacitating condition that causes them to be unfit for work over the long term will have their case reviewed and may qualify for the DSP if the incapacity to work is considered likely to be permanent. On the other hand, an individual may receive Mobility Allowance for a number of years. The former three payments are subject to income and assets tests, while Mobility Allowance is not means-tested (Centrelink 2009).

Wife Pension (DSP) is paid to female partners of men receiving the DSP. It was closed to new entrants on July 1995; consequently the number of people receiving Wife Pension (DSP) has fallen by three-quarters over the past decade (Table 4.9).

Over the period 1999–2008, the number of people receiving Mobility Allowance rose by almost 80%. Most people (87%) receiving Mobility Allowance also received the DSP; the growth in this payment coincided with the growth in DSP (DEWR 2005a).

By contrast, Sickness Allowance recipient numbers fell by one-third between June 1999 and June 2008. A Centrelink review of Sickness Allowance, which ensured that people who remained on the benefit had employment or training to return to, was reflected in a single-year fall of 13% in recipient numbers in 2001–02 (DEWR 2005b). The number of people being paid Newstart Allowance (incapacitated) and Youth Allowance (incapacitated) also fell over the past decade, by 44% and 29% respectively. Factors affecting these payments include changes to activity test exemption rules in 2002–03, resulting in one-third fewer recipients (FACS 2003), and the strengthening labour market throughout the period.

Table 4.9: Recipients of disability-related payments and allowances, 1999 to 2008

	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008
Mobility Allowance[(a)]	31,001	35,154	37,574	41,997	44,562	47,402	49,215	51,669	54,942	55,300
Sickness Allowance[(b)]	11,181	10,733	10,942	9,522	8,755	8,478	8,367	7,510	7,624	7,400
Wife Pension (DSP)[(c)]	68,526	59,935	51,225	44,238	37,880	33,183	28,144	24,627	21,228	18,555
Newstart Allowance: incapacitated	59,670	68,016	76,850	76,882	54,243	51,171	47,751	40,535	37,977	33,426
Youth Allowance: incapacitated	3,929	5,883	5,959	5,792	3,941	3,861	3,633	3,203	3,159	2,808

(a) Data for 2005 reflect the number of recipients as at June 10 2005.

(b) Data for 2005 reflect the number of current customers (excluding zero paid) as at 17 June 2005.

(c) Closed to new entrants as at 1 July 1995.

Note: All data as at 30 June each year except where indicated above.

Sources: AIHW 2007c; DEEWR 2008.

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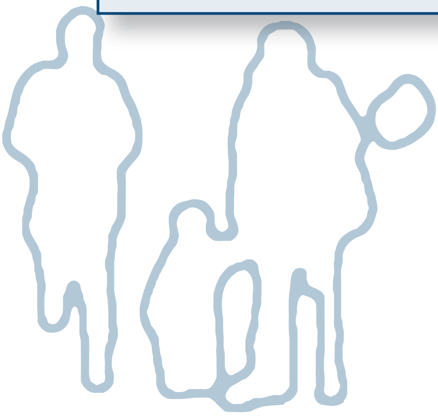
Carers and informal care

5

Key points

- Informal carers, most of whom are women, are the main source of assistance for most people with disability and other long-term conditions, and the aged, and enable many people to remain living at home.
- Most primary carers are close family members, live with the person for whom they care, and are aged between 25 and 54 years. Many spend significant amounts of time providing care.
- Carers are supported directly and indirectly by a range of services including financial benefits, respite services and community care services that provide in-home support and related assistance. Although many carers access these services, it is difficult to gauge how many may be missing out on services altogether, or how many need more help.
- Respite care is the major service type that specifically supports carers, yet few carers report that they have used these services. For some carers this may indicate a lack of appropriate respite services.
- Many carers do not find the caring role satisfying, and many experience lower health and wellbeing than non-carers as well as considerable social disadvantage. Many carers are also financially disadvantaged, which for some (and particularly females) is related to their reduced capacity to participate in paid work because of their caring responsibilities.
- Policy makers face an ongoing challenge to ensure that suitable support is available to help carers to continue to provide care, but also to help them fulfil other life roles. This is necessary to ensure an adequate supply of carers in an environment where there is likely to be an increasing demand for informal carers, but fewer people available to provide care.
- Support services in the future will have to meet increased demand but may also need to close service gaps and adopt new approaches to service delivery, such as the need recognise care that is shared more widely across informal care networks.



5.1 Introduction

Informal carers play a critical role in the welfare system by providing home-based support over a sustained period of time to people with disability, age-related frailty and long-term health conditions that restrict their daily activities. In 2003, an estimated 1.1 million people living in households with had a severe or profound limitation in one of the core activities of communication, mobility or self-care, and needed assistance with at least one of a number of specified activities. Of these, 61% received help from a formal service provider, but 95% received help from an informal carer (ABS 2004a). It has been estimated that the value of services provided by all informal carers exceeded $27 billion in 2005–06 (AIHW 2008).

Informal carers (hereafter referred to as ‘carers’) commonly help with a range of tasks including self-care, health care, mobility, transport, housework and property maintenance. But carers also play a significant role in supervising and providing a sense of security for people who need assistance with day-to-day activities (including communication and social interactions), supporting the social inclusion of people with disability and the aged, coordinating and managing their care recipients’ formal care services and advocating on their behalf. Carers are mostly female and mostly live with the person for whom they care. They may provide care for relatively short or long periods of time, and for more than one person concurrently (including the care of children without disability). And despite the important help they provide to another person, not all carers identify themselves as a ‘carer’.

For some people with disability, the assistance provided by informal carers means that they do not need further support from formal services, although, for most, informal care is supplemented by the use of formal services. Formal services are those services provided by government or non-government agencies that mostly rely on paid staff and are usually subject to regulation. Formal services may be funded by governments, purchased privately, or a mix of both. By contrast, informal care is largely provided on an unpaid basis although carers may receive financial assistance from the Australian Government. Carers might also have private arrangements for some payment or payment-in-kind from the person for whom they care, for example, a grandchild living with an elderly grandparent might receive free board in return for household help and meal preparation.

A greater focus on carers

While family members have long played a role in providing care for the aged and for people with disability and long-term health conditions, this care was historically largely a private matter managed within families, with little support from formal services. As a result, long-term data on the extent to which care has been provided in the home are scarce. The formal services that were available emphasised ‘institutional’ care in a range of areas across the welfare sector (including aged care, care for people with disability and out-of-home care for children). These services were provided by governments and private organisations (including not-for-profit organisations), and, by the middle of the twentieth century, institutional care was the dominant service model in these sectors (AIHW 2001).

However, in more recent times and particularly since the 1970s, service delivery reforms have been rolled out across the welfare sector, such that community-based care models are now preferred. These models, which have seen a shift away from institutional to home-based or smaller scale residential care, also emphasise choice for people who have ongoing care needs and offer increased flexibility of service provision. This was recognised as conferring benefits both to governments and to those who require care. It was also recognised that, to a large extent, these community-based care models were only effective because of the availability of informal carers, who substituted for, and supplemented, formal care services. As a result, the role of informal carers in the welfare system was formally recognised, and support programs and benefits specifically for carers became available (AIHW 2001).

Sustaining the supply of carers

Questions have been raised, however, about the sustainability of these community care models in the face of expected demographic changes. In particular, structural ageing of the population—the increase in the number and proportion of older people in the population—is expected to increase the amount of age-related disability in the community, and to drive demand for health and welfare services and an associated demand for informal carers. This will also occur in an environment where (proportionally) there will be fewer people of workforce age. This will place stress on young and middle-aged carers, who are likely to experience significant pressure to remain in the workforce, and which may compromise their ability to provide significant levels of care to ageing parents and other relatives (see AIHW 2004a for more information on structural ageing of the population). Additionally, governments will face decreased taxation revenue and increased costs associated with aged care, and may, therefore, increasingly rely on informal care sources to support ageing Australians and others with disability.

In addition to these demographic changes, other social changes have been identified that may threaten the supply of informal carers into the future. These include changes to family structures and dynamics such as an increased proportion of people living alone, increased childlessness, and continuing high rates of divorce and relationship breakdown. As a result of these changes people may have fewer close family members available to provide care if required. The increased mobility of family members may also mean that children are less likely to be living near ageing parents, and therefore less able to provide regular care (see AIHW 2004a and NATSEM 2004 for further discussion about demographic and social changes that may affect the supply of carers).

The changing role of women may also affect the future supply of carers. Traditionally, women have taken on the bulk of caring responsibilities, but as women are increasingly better educated and earning higher salaries than in the past, and households are increasingly relying on the income generated by adult females (AIHW 2004a), it remains to be seen whether women will be able to continue to fulfil these caring roles to the same degree, or whether caring responsibilities will continue to be layered on top of existing responsibilities.

Purpose of this chapter

Given the importance of informal carers and concerns about the availability of informal carers both now and in the future, it is relevant to look at the current circumstances of carers in Australia and consider the question of support provided to carers. This chapter describes carers in Australia and the support services available to them, and presents data on carers supported by these services. The chapter also outlines recent evidence about the potential costs of caring. These costs, which can be financial, social and personal, can be significant for many carers and are particularly relevant given broad interest in social inclusion for all Australians. The chapter also discusses the quality of current data sources about carers.

Discussion in this chapter is limited to carers who assist people with disability or other conditions (including age-related frailty) (see Glossary for definition of informal carer used in this chapter). This is consistent with most definitions of 'informal care', which exclude parental care provided to children *without* disability, although some definitions of 'informal care' do include the non-parental care of children (for example foster care, kinship care or the care of a child by grandparents). Non-parental care provided to children is not included in the scope of this chapter, although some information about informal substitute care of children can be found in Chapter 2.

5.2 Characteristics of carers and care recipients

The main source of information about carers and the people for whom they care is the ABS Survey of Disability, Ageing and Carers (SDAC) (see Box 5.1). In 2003 it was estimated that there were 2,455,400 carers in Australia aged 15 years or over who provided regular or sustained care to another person; this represented 16% of the Australian population aged 15 years or over (ABS 2004a). These carers helped 1,975,000 people who needed assistance with activities because of disability. Almost a fifth of these carers (19%, 474,600 people) were 'primary carers', that is, they provided the most care to another person with a severe or profound core activity limitation (see Box 5.1 for a full definition). The SDAC also estimated that there were 101,600 carers aged less than 15 years, though as only limited data are reported about these carers, and these carers cannot be classified as primary carers (according to the SDAC survey protocol), all ABS data presented in this chapter relate to carers aged 15 years or over only.

Box 5.1: The Survey of Disability, Ageing and Carers

The major source of detailed information about carers and the people for whom they care is the SDAC conducted by the ABS. Survey data are collected through the use of a structured series of questions and use trained interviewers to collect the data. Survey data are then used to derive estimates for states and territories, and the Australian population as a whole. The latest survey for which data are available was conducted in 2003. Data from the 2009 survey are expected to be available in 2010.

The SDAC distinguishes between carers and primary carers:

Carers are defined as '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 older persons (that is, aged 60 years and over). This assistance has to be ongoing, or likely to be ongoing, for at least 6 months' (ABS 2004a).

Primary carers are defined as 'a person who provides the most informal assistance, in terms of help or supervision, to a person with one or more disabilities. The assistance has to be ongoing, or likely to be ongoing, for at least 6 months and be provided for one or more core activities (communication, mobility and self-care)' (ABS 2004a). In the 2003 SDAC only carers aged 15 years or over for whom a personal interview was conducted could be considered a primary carer.

Some information about carers is also available through the 2006 Census of Population and Housing and the 2006 General Social Survey. But because carers are identified in different ways in these collections, the numbers of carers estimated by these data collections (which vary considerably from that produced by the SDAC) are not considered as reliable as the SDAC.

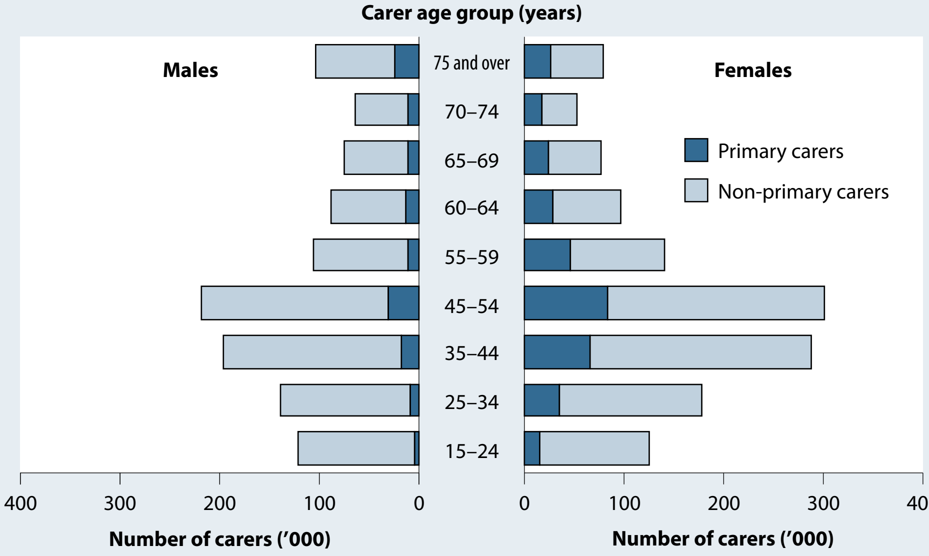
(continued)

The ABS regards the SDAC as the best source of detailed data about carers and the people for whom they care (ABS 2007) and the AIHW places most confidence in the estimates produced by the SDAC (AIHW 2008). Accordingly, most data analyses presented in this chapter are derived from the SDAC. Unless otherwise noted, all SDAC data presented in this chapter have been extracted by the AIHW from the SDAC confidentialised unit record file. When releasing data to research organisations, the ABS amends details of some records (such as age or sex of the person) or excludes records where there is a possibility that a person could be identified. Because of these changes, data extracted from the confidentialised unit record file can differ slightly from figures published by the ABS.

Section 5.7 of this report discusses some of the limitations of the SDAC data.

The circumstances and the characteristics of carers are diverse, and the responsibility of providing significant care to another is one that may be faced by people at any stage of life. However, the responsibility of caring does not fall equally on all population groups. Caring responsibilities are related to age: in 2003, most carers (54%) were aged between 25 and 54 years—and 40% of all carers were aged between 35 and 54 years (Figure 5.1). Primary carers tended to be slightly older—most (54%) primary carers were aged 35–59 years, and again, over 40% of primary carers were aged 35–54 years (ABS 2008).

Caring responsibilities are also related to gender: overall, females accounted for 54% of all carers and 71% of all primary carers. In 2003, there were more female carers than males in all age groups up to 70 years, after which there were more male carers than females. Among primary carers, however, female carers were more common than male carers in all age groups. The differences between the numbers of male and female primary carers were most pronounced in the younger age groups and became less pronounced with the increasing age of the carer.



Source: ABS 2008:Table 1.1.

Figure 5.1: Estimated number of carers by age group, carer status and sex, 2003 ('000)

When carer numbers are considered in relation to the total numbers of people in each age group, however, SDAC data show that the likelihood of being a carer increased in each successive age group until the 60–64 year age group, after which the proportion of carers in the population declined slightly (ABS 2008). A similar pattern occurred when looking at primary carers only. But, again, the patterns were not the same for males and females. Because most carers are female, the likelihood of a female being a carer (and a primary carer) was broadly similar to the pattern for carers overall, although the carer rate for females peaked earlier (in the 55–59 year age group) than for both male and female carers combined. For males, however, the proportion of male carers (and male primary carers) in the population continued to rise with each successive age group and peaked in the 75–79 year age group. The differences in carer rates between males and females are best understood by looking at the familial (or other) relationships that exist between carers and the persons for whom they care.

Carer’s relationship to recipient of care

Relationships are important in the context of informal care because it is these pre-existing relationships that give rise to caregiving relationships. The relationship between the carer and the person with disability can also, in part, affect the experience of the carer in terms of expected duration of caring, the likely demands of caring, and the disadvantage that a carer may experience as a result of the care they provide.

Over 90% of primary carers are close family members of the person for whom they care: 41% are a spouse or partner, 26% are a son or daughter and 23% are a parent (Table 5.1). But within each relationship category, it is females who are most likely to be identified as primary carers. This is particularly so for care provided by parents (where mothers account for 91% of parental primary carers) and care provided by sons and daughters (where daughters account for 71% of primary carers who are sons or daughters). But care provided by spouses or partners is more evenly divided between husbands or male partners (41% of spousal primary carers) and wives or female partners (59%).

Table 5.1: Primary carers, by sex and age group and relationship to main care recipient, 2003 (’000)

	Primary carers								
	15–44 years		45–64 years		65 years and over				
Relationship to care recipient	**Male**	**Female**	**Male**	**Female**	**Male**	**Female**	**Total male**	**Total female**	**Total primary carers**
Spouse/partner	*9.5	19.8	27.6	45.0	43.9	49.7	81.0	114.6	195.5
Parent	*2.7	57.2	*6.0	38.3	**1.0	*5.4	*9.7	100.8	110.5
Son/daughter	14.2	29.9	20.0	53.4	**0.6	*3.6	34.9	87.0	121.9
Other	*4.1	*7.2	*3.5	20.7	*2.2	*6.8	*9.9	34.7	44.6
Total	**30.5**	**114.2**	**57.2**	**157.5**	**47.7**	**65.4**	**135.4**	**337.1**	**472.5**

* estimate has a relative standard error of 25% to 50% and should be used with caution

** estimate has a relative standard error greater than 50% and is considered too unreliable for general use

Source: AIHW analysis of ABS 2003 Survey of Disability, Ageing and Carers confidentialised unit record file.

The nature of the familial relationship is also related to the age of the carer. Older carers predominantly cared for a spouse or partner (83% of primary carers aged 65 years or over). Carers in the middle years (those aged 45–65 years) were equally likely to be a son or daughter or a spouse or partner (34% each), with a further 21% being a parent. Younger carers were most likely to be a parent (41%), with smaller percentages being a son or daughter (31%) or a spouse or partner (20%).

The picture that emerges is one where females' caring responsibilities are more dispersed than that of males. Women are more likely than men to take on caring responsibilities for children and parents with disability (in addition to already being more likely to have existing caring responsibilities for children without disability). These intergenerational responsibilities have led female carers in these middle years to be labelled the 'sandwich generation'.

Although there is little data available that explores how decisions are made within families about who will provide care, the data presented above suggest that, within many families, females are frequently the default carers where there is more than one potential carer available. This is evident in the extent to which females are predominantly the main carers for children with disability (where, in many cases, there will be both a mother and father available to provide care) and for parents (where there may be both sons and daughters potentially available to provide care). This is consistent with the 'caring hierarchy' that has been described as existing in aged care in western societies (Shanas 1979). Within this hierarchy, a person with disability will be firstly cared for by a spouse if there is a willing and able partner available. But if there is no spouse or partner, or the spouse or partner is unable to provide care, caring responsibilities most often fall to other close relatives, and particularly female relatives.

This hierarchy of caregiving relationships, and the reliance on female family members to provide care, has been previously observed in at least one Australian study that investigated how decisions to provide care to ageing parents are made within families (Braithwaite 1990). The main reasons proposed for women's greater adoption of these responsibilities are women's lower workforce participation and/or incomes, and that the role of a carer to a relative with disability is a natural extension of the primary nurturing role usually undertaken by females within families (Edwards et al. 2008; Morse & Lau 2007).

Males, on the other hand, are most likely to be become carers at older ages to care for an ageing spouse. While the number of female carers aged 65 years and over caring for a spouse is higher, the rate among men in this age group is higher. This is because the population of males in this age group is smaller due to their lower life-expectancy and also because men tend to be older than their wives. As a result, females in these older age groups are more likely to be widowed, and therefore less likely to have a spouse who may need care.

These differences are confirmed to some extent by SDAC data that explored the reasons why individuals took on the caring role. In 2003, males were more likely than females to report taking on the role of a primary carer because no one else was available to fulfil this role (32% of males compared with 20% of females), because alternative care was thought to be too costly (28% of males compared with 13% of females) or because they 'had no other choice' (25% of males compared with 16% of females) (ABS 2004a). These findings suggest that males are more likely than females to become a primary carer when there are no other potential carers or alternative care arrangements available. Similar proportions of male and female carers, however, reported that they took on the role of primary carer because of family responsibility (58% of all primary carers), because they could provide better care (39%) or because of emotional obligation (35%) (ABS 2004).

Duration of caring

The experience of each carer is unique and will, in part, be influenced by the length of time they may be called on to provide care. In 2003, over half of all primary carers had been providing care for between 5 and 24 years (26% for 5–9 years and 28% for 10–24 years) (Table 5.2). Thirty-nine per cent of primary carers had been providing care to their main care recipient for less than 5 years, and 6% of carers (representing about 29,800 carers) had been providing care for 25 years or more.

Again, duration of caregiving is associated with the familial relationship between the primary carer and their main care recipient. Those providing very long term care (25 years or more) were most likely to be a parent (44%). A considerable proportion (35%) provided care to a spouse or partner. For carers who had been providing care for 10–24 years, 40% cared for a spouse or partner, a further 32% were a parent, and 23% were a son or daughter. Those who had been providing care for less than 10 years were most likely to be caring for a spouse or partner (42%).

Table 5.2: Primary carers by duration of caring, sex and relationship to main care recipient, 2003 ('000)

	Years in caring role								
	Less than 5 years		5–9 years		10–24 years		25 years and over		
Relationship to care recipient	Male	Female	Male	Female	Male	Female	Male	Female	Total[a]
Spouse/partner	32.2	46.4	18.8	31.6	22.8	27.8	*3.2	*7.3	195.5
Parent	**2.0	26.2	*2.6	24.9	*5.1	35.8	**0.0	13.0	110.5
Son/daughter	17.1	36.5	*8.3	23.8	*9.0	19.8	**0.0	*4.3	121.9
Other	*5.8	16.4	*3.2	*9.5	**0.9	*6.7	**0.0	**2.1	44.6
Total	**57.1**	**125.5**	**32.9**	**89.8**	**37.8**	**90.2**	***3.2**	**26.6**	**472.5**

* estimate has a relative standard error of 25% to 50% and should be used with caution

** estimate has a relative standard error greater than 50% and is considered too unreliable for general use

(a) Includes carers for whom years in caring role was not reported.

Source: AIHW analysis of ABS 2003 Survey of Disability, Ageing and Carers confidentialised unit record file.

Although there were more females in all categories when looked at by relationship to care recipient and duration of caring, the proportions of male and female primary carers who had provided care for between 5 and 24 years were equal (each 54%). But females were more likely to have been providing care over the very long term (8% of female primary carers had provided care for 25 years or more compared with 2% of male primary carers).

Who do carers care for?

In large part, the need for care is related to age—just over half (52%) of all people with a primary carer were aged 65 years or over, and about one-third were aged 75 years or over (35%) (Table 5.3). Care recipients who do not live with their carer tend to be older than those who do live with a co-resident carer—78% of non-resident care recipients were aged 65 years or over, compared with 44% of those who live with their primary carer. Overall, most primary carers (78%) live with the person for whom they care.

Table 5.3: Primary carer in households by age group and age of main recipient of care, 2003 ('000)

	Age of primary carer			
Care recipient characteristics	**15–44 years**	**45–64 years**	**65 or over**	**Total[(a)]**
Has a co-resident carer				
Under 15 years	49.0	*8.8	**0.0	57.8
15–24 years	7.1	15.3	**0.6	23.0
25–44 years	21.1	*9.3	*3.0	33.4
45–64 years	18.3	57.8	11.7	87.8
65 years or over	14.9	53.9	89.7	158.5
All with a co-resident carer	*110.4*	*145.1*	*105.0*	*360.5*
Has a non-resident carer				
Under 65 years	12.21	*8.1	*2.2	22.5
65 years or over	17.0	58.0	*5.9	80.9
All with a non-resident carer	*29.1*	*66.1*	**8.2*	*103.4*
Total	**139.6**	**211.2**	**113.2**	**463.9**

* estimate has a relative standard error of 25% to 50% and should be used with caution

** estimate has a relative standard error greater than 50% and is considered too unreliable for general use

(a) Excludes primary carers who are also recipients of care.

Source: AIHW analysis of ABS 2003 Survey of Disability, Ageing and Carers confidentialised unit record file.

Most people living in the community who identified that they had a primary carer had a physical/diverse disability (85%), and nearly half (48%) had a sensory/speech disability (Table 5.4). Those aged under 65 years were more likely to have psychiatric and intellectual disabilities than those aged 65 years or over, although physical/diverse disability was still the most common disability grouping reported for people aged under 65 years and those aged 65 years and over.

Table 5.4: People with disability living in households with a co-resident primary carer[(a)] by disability groups and age of care recipient, 2003

	Age of care recipient					
	Under 65 years		**65 years or over**		**All ages**	
Disabling condition	**Number ('000)**	**Per cent**	**Number ('000)**	**Per cent**	**Number ('000)**	**Per cent**
Physical/diverse	175.5	76.0	163.4	96.9	338.9	84.9
Sensory/speech	101.5	44.0	91.7	54.4	193.3	48.4
Psychiatric	109.1	47.3	44.2	26.2	153.3	38.4
Intellectual	85.7	37.1	20.8	12.3	106.5	26.7
Acquired brain injury	38.1	16.5	18.2	10.8	56.2	14.1
Any of the above	230.8	*100.0*	*168.6*	*100.0*	*399.4*	*100.0*

(a) Includes co-resident primary carers who were identified by the person with disability only.

Source: AIHW analysis of ABS 2003 Survey of Disability, Ageing and Carers confidentialised unit record file.

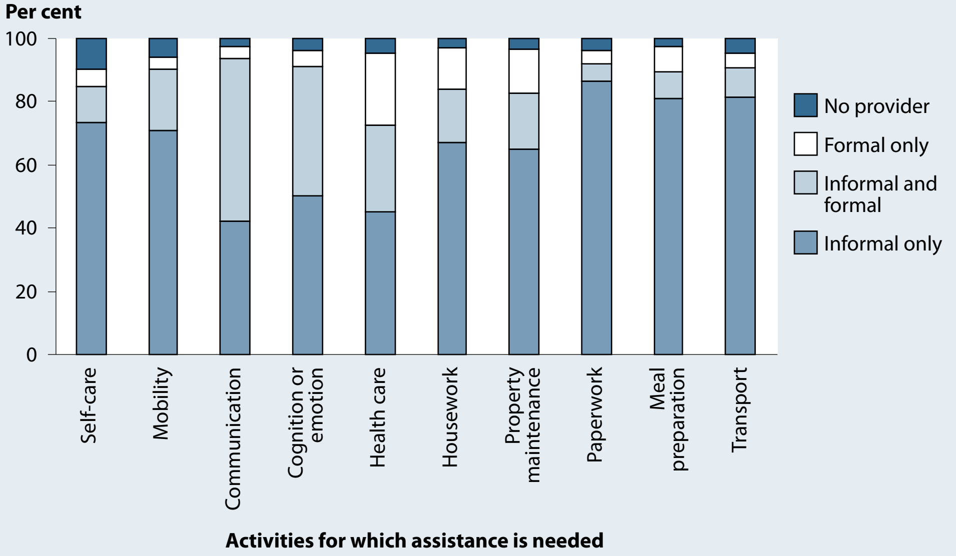
The type of disability experienced by the person requiring care can affect the demands placed on the carer and their experiences as a carer. Although it is by no means straightforward, there is some evidence that the burden of care tends to be greater when the person requiring care has an intellectual disability or disturbed behaviour (see, for example, Schofield et al.

1998). One recent study found, however, that the extent of care needs (rather than the type of disability) was more strongly related to mental health problems among carers (Edwards & Higgins 2009). Findings in this area can be complicated by the fact that many people with disability experience more than one type of disability.

5.3 How do carers help?

Carers help people with disability or long-term conditions in a wide range of areas. Most people with a need for assistance with a specific activity are likely to get at least some help with that activity from an informal carer. Based on ABS data from the 2003 SDAC, carers of people with a severe or profound core activity limitation (that is, someone who sometimes or always needs the help of another person with self-care, communication and/or mobility) were most likely to help with mobility, transport, property maintenance, housework and self-care (ABS 2004a).

Data on the needs of people with disability and the sources of assistance that they receive for these activities (if any) suggest that the help provided by carers is likely to be critical for many people with disability—for many people it may be the only help they get for some activities. For all of the day-to-day activities investigated by the ABS in the 2003 SDAC, more people with disability used informal, rather than formal, sources of help. Indeed, for people with a severe or profound core activity limitation, for all major activities for which assistance was needed, most received help from informal carers only, with the exception of communication and health care (Figure 5.2). The areas in which informal carers were most likely to be the only providers of assistance were paperwork (86% of those with a need in this area relied solely on informal assistance), transport (82%), meal preparation (81%), self-care (74%) and mobility (71%).



Source: Table A5.1 (AIHW analysis of ABS 2003 Survey of Disability, Ageing and Carers confidentialised unit record file).

Figure 5.2: Sources of assistance for people with a severe or profound core activity limitation living in households, 2003 (per cent)

For all activities, between 6% and 52% of people with a severe or profound core activity limitation who needed assistance with a specific activity received help from both informal sources and formal service providers.

'Health care tasks' was the one area where a substantial proportion of people with a disability received help from formal sources only (23% of those with a severe or profound core activity limitation). This most likely reflects the more specialised nature of many health care tasks, although even in that area, over two-thirds (73%) of people needing help received at least some help from informal carers.

5.4 Assistance and support for carers

A range of mainstream and specialist services are offered by the Australian Government and others to assist carers. These services are provided either directly to carers or indirectly to carers by helping the person with the care need that would otherwise have to be provided (or supervised) by the carer. Examples of mainstream services for people with disability that may benefit carers are appropriate public housing and appropriate schooling; specialist services for people with disability that may assist carers include the provision of personal care, or aids and equipment.

The main types of assistance provided to carers are financial assistance, respite care and community care support (such as household help, personal care and transport for the care recipient). This section describes the major national programs that provide these types of assistance, and presents data that describe carers who receive assistance through these programs and the people for whom they care. Carers can also receive information services and counselling, although these services are not covered in this section as information about them is limited.

This chapter does not provide a comprehensive description of all programs that are available to assist carers—state and territory governments, local governments and other organisations also provide programs and resources that help carers and people with disability living in the community. The Australian Government also funds other programs that fall outside the scope of the programs being examined, such as the Helping Children with Autism package, Special Disability Trusts, Family Relationships Services for Carers, and MyTime Peer Support.

A range of data sources are used to present data in the following sections. Some data have been obtained from routine administrative data sets that report information on all clients assisted in an annual reporting period, while other data are snapshot data and only describe clients assisted at a specific time. Information about the data sources used is provided in Box 5.2. It should be noted that carers are identified in different ways in these data collections. For some programs carers are identified through explicit eligibility criteria (for example, as applied to carers who receive financial benefits). But in other programs carers are self-identified or identified by the person with care needs in the course of assessing their needs for formal assistance. In these situations, no specific criteria are used to identify carers, and detailed information about the assistance the carer provides to the care recipient is not necessarily collected, and services are not required to report this information when they do collect it. Some further discussion of the quality of these data sets is provided later in this chapter (Section 5.6).

Where appropriate in these analyses, data about carers and the people for whom they care are compared to the nationwide profile of carers (and the people for whom they care) as identified by the SDAC. Both the program-based data and the SDAC provide information about carers and about the people for whom they care, but before any comparison is made between the two sources of data, some limitations must be noted and judgements made.

First, the data refer to different time periods. SDAC estimates were based on data collected in 2003, and, in this section, these data are being compared against information collected in later periods (as outlined in Box 5.2). As a result, the carers who appear in program-based statistics are not necessarily drawn from the same population on which SDAC estimates are based.

Box 5.2: Data sources analysed in this section

Carer Allowance and Carer Payment

Data on carers in receipt of these benefits were provided by the Australian Government Department of Families, Housing, Community Services and Indigenous Affairs. The data are sourced from Centrelink's administrative database, and the data extracted are snapshot data as at 6 June 2008.

National Respite for Carers Program, Community Aged Care Packages (CACPs), Extended Aged Care at Home (EACH) and EACH Dementia (EACHD)

Comprehensive information about the care recipients and carers assisted by these programs (and the services received by these client groups) is not routinely reported, but this information is available from a 1-week Community Care Census that was conducted by the Australian Government Department of Health and Ageing in early 2008. A similar census was conducted for the CACP and EACH programs in 2002.

Commonwealth State/Territory Disability Agreement (CSTDA) services, Home and Community Care Program (HACC) and Aged Care Assessment Program (ACAP)

Information on clients of these programs, their carers and the assistance received is collected for all clients on an ongoing basis as part of their respective (national) minimum data set reporting agreements.

- CSTDA data have been extracted for the period 2007–08 and exclude clients who were living in certain types of supported accommodation (large residential/institution accommodation, small residential/institution accommodation, hostels and group homes). These clients were excluded to improve comparability of the data with the other programs, which mostly provide care to people living in households. Data reported about carers includes both primary and non-primary carers identified in this collection. This was done, again, to improve comparability with the other programs—none of which distinguish between these carer types.
- HACC data relate to 2007–08. Analysis of this data set was undertaken by the AIHW, and, as a result, some figures presented in this chapter for the HACC program may differ from figures published elsewhere as different assumptions may have been made.
- ACAP data relate to 2006–07 and include information only on those clients living in the community. Clients living in non-community settings were, again, excluded to improve comparability of the data with the other programs. ACAP data have been provided by the ACAP National Data Repository at La Trobe University.

Second, carers identified in the program-based data sets are not usually further disaggregated into primary and non-primary carers (as defined by the ABS for the SDAC). It might be expected, however, that most carers assisted through these programs would have caring responsibilities broadly equivalent to those undertaken by primary carers. The CSTDA data set is the one program-based data set that does distinguish between primary and non-primary carers in a way that aligns conceptually with SDAC definitions; 88% of carers of CSTDA clients included in these analyses were primary carers. For these reasons, the judgement has been made that where, in this chapter, a comparison is made between carers who receive services and carers identified in SDAC, that comparison will refer to the population of primary carers, rather than to all carers.

Third, while these differences preclude useful comparisons between program-based and SDAC estimates of the *numbers* of carers and of people for whom they care, some insight can be afforded by selected comparisons of the *characteristics* of people as revealed by the two data sources.

It should also be noted that, although information on these assistance and support programs is presented separately by service-type, the populations they describe are not discrete populations. Carers can receive more than one type of assistance concurrently or at different times in their caring career. For example, a carer who is receiving financial assistance may also receive services, directly or indirectly, through any of the other programs.

Financial assistance for carers

There is a range of financial benefits available to carers. Many of these are mainstream benefits that are available to eligible carers and non-carers alike (such as the Age Pension, Disability Support Pension, Rent Assistance and Utilities Allowance). Two financial benefits are specifically available to carers: Carer Allowance and Carer Payment (see Box 5.3). Carer Allowance is not means tested and is received by more carers than Carer Payment, but carers can receive both benefits if they meet the applicable eligibility requirements for both types of assistance.

Box 5.3: Carer Allowance and Carer Payment

Carer Allowance is an income supplement that is available to people who provide daily care to a person with a disability or long-term health condition. The payment is not means tested, and recipients can receive other income benefits (such as Carer Payment or the Age Pension) at the same time as Carer Allowance. In certain circumstances a person can receive Carer Allowance in respect of more than one care recipient. Carer Allowance recipients who are caring for a person aged under 16 years also receive a Health Care Card in the child's name which entitles them to reduced pharmaceutical and medical costs.

Carer Payment is an income support payment available to carers who are unable to participate to a significant extent in paid employment because of their caring duties. Eligible recipients are those who provide constant care to a person with a substantial disability or medical condition or who is frail aged in that person's own home. In some cases a person may qualify for payment if they are caring for two or more children who together require care that is equivalent to that required by a person with a substantial disability.

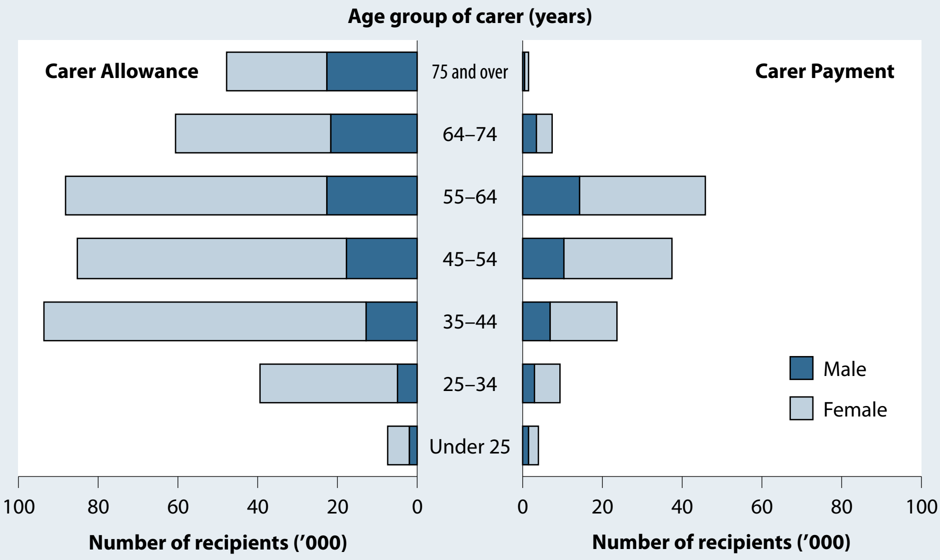
Carer Payment is means tested and provided on a scale of payment that is equivalent to the Age Pension and other pension payments. As a result, many people who might otherwise be eligible to receive Carer Payment may, for a variety of reasons, elect to receive an alternative benefit. Carer Payment recipients also receive a Pensioner Concession card, which entitles them to pharmaceutical and health care concessions and concessions on other services.

Both payments are administered under two streams: child (which applies if the care recipient is aged under 16 years) and adult (which applies if the care recipient is aged 16 years or over). Both streams have different application and eligibility requirements but, in general, assessment of eligibility is based on the level of care required by the care recipient and the level of care provided by the carer.

Who receives financial assistance?

In June 2008, 422,900 people were receiving Carer Allowance and 130,700 people were receiving Carer Payment. These carers were caring for 454,900 and 130,900 people respectively. Most people who receive Carer Payment (91%) also receive Carer Allowance.

The profiles of the carer populations receiving these payments differ by payment type, and reflect the different purposes and eligibility criteria for the payments (Figure 5.3). The age profile of carers receiving Carer Allowance was comparable to the age profile of primary carers as identified by the SDAC. Most carers receiving Carer Allowance were aged between 35 and 64 years (63%, the same as the proportion identified by the SDAC) and around one-quarter (26%) were aged over 65 years (compared to 24% of total primary carers identified by the SDAC).



Source: Table A5.2 (Australian Government Department of Families, Housing, Community Services and Indigenous Affairs).

Figure 5.3: Carers in receipt of Carer Allowance or Carer Payment by age group and sex, June 2008

For those receiving Carer Payment, the age profile is somewhat different. For carers in age groups below 55 years, the age profile is very similar to that for SDAC primary carers as a whole—58% of Carer Payment recipients were aged less than 55 years compared to 55% of all primary carers. Carer Payment recipients were more likely to be aged 55–64 years than in the general carer population (35% of Carer Payment recipients compared to 21% of primary carers). But Carer Payment recipients were much less likely than the broader population of primary carers to be aged 65 years or over—only a small proportion (7%) of people receiving Carer Payment were aged 65 years or over, compared to 24% of all primary carers.

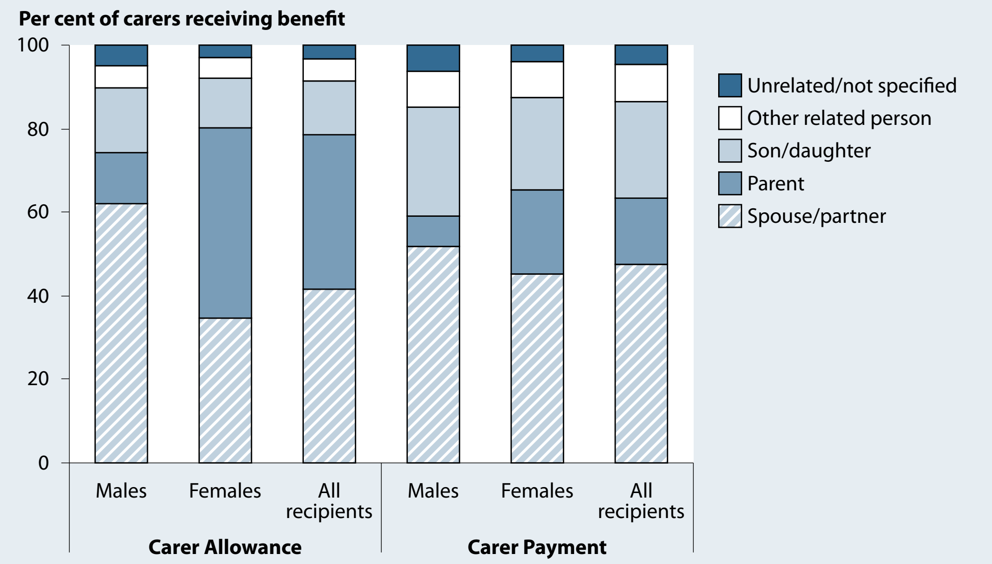
This pattern reflects the stated purpose of the Carer Payment, which is to support carers who are unable to participate to a significant extent in the paid workforce because of their caring duties, and therefore is mainly taken up by people aged under 65 years of age. It is also because carers aged over 65 years who are eligible for Carer Payment may also be eligible for the Age Pension, and will commonly take up (or continue receiving) that payment or other equivalent social support payments. Some information about carers' use of alternative benefits is evident for Carer Allowance recipients: Carer Allowance recipients who also receive another pension or benefit most commonly receive Carer Payment (120,300), but 82,500 receive the Age Pension, 39,500 receive a Parenting Payment and 23,900 receive the Disability Support Pension.

The number of females receiving Carer Allowance exceeds the number of males receiving this benefit in all age groups. As with the pattern of carers in the general community, there are differences between males and females in the patterns of receipt of Carer Allowance. Among males, 64% of males receiving Carer Allowance were aged 55 years and over. Females, on the whole, tended to be younger, with two-thirds (67%) of all females who receive Carer Allowance being aged between 35 and 64 years. Forty-three per cent of male Carer Allowance recipients were aged 65 years and over compared with 20% of female Carer Allowance recipients.

The age profiles of male and female recipients of Carer Payment were similar, although, again, more females received Carer Payment than males in all age groups. For this payment, 78% of males were aged 35–64 years compared with 84% of female Carer Payment recipients.

Overall, recipients of Carer Allowance and Carer Payment were most likely to be caring for a spouse or partner (42% of Carer Allowance recipients and 47% of Carer Payment recipients) (Figure 5.4). This is similar to the proportion of all primary carers who cared for a spouse or partner estimated by the SDAC (41%). Compared with the SDAC (where 23% of primary carers were parents), parental carers comprised a higher proportion of Carer Allowance recipients (37%) but a lower proportion of Carer Payment recipients (16%). Recipients of these benefits were less likely to be a son or daughter caring for a parent than the SDAC population (where 26% of primary carers were estimated to be caring for a parent compared with 13% of Carer Allowance recipients and 23% of Carer Payment recipients).

Male and female recipients of Carer Payment showed a similar profile in terms of relationship to the care recipient. The largest differences were seen among parental carers, where female recipients of Carer Payment were more likely than male recipients to be parental carers (20% of female recipients were mothers compared to 7% of male recipients who were fathers). For recipients of Carer Allowance, female carers were also more likely than male carers to be parental carers (45% compared with 12%) and male carers were much more likely to be caring for a spouse or partner (62% compared with 35%).



Source: Table A5.3 (Australian Government Department of Families, Housing, Community Services and Indigenous Affairs).

Figure 5.4: Relationship to care recipients of carers in receipt of Carer Allowance or Carer Payment by sex, 2008 (per cent)

Fifty-five per cent of Carer Allowance recipients and 48% of Carer Payment recipients owned their own home (with or without a mortgage)—lower than the 70% of primary carers and the 65% of the non-carer population who own their home (ABS 2008). The relatively low rates of home ownership by Carer Payment recipients is to be expected since this payment is subject to income and asset limits, and because recipients of Carer Payment are predominantly aged under 65 years of age (whereas, in general, home ownership rates are highest among those aged 65 years and over).

Who do they care for?

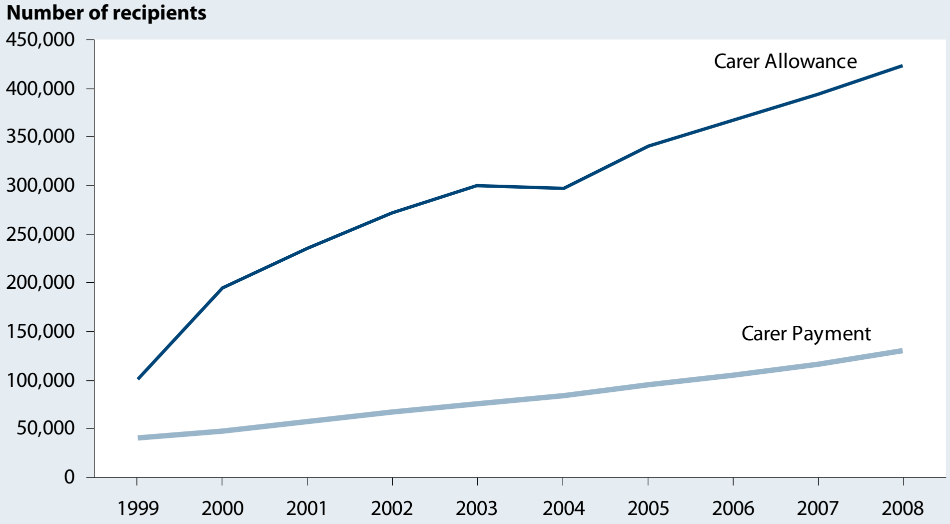
Around one-third (35%) of the people cared for by recipients of Carer Allowance were aged under 25 years of age (and 30% aged under 16 years), and 37% were aged 65 years or over. By contrast, most of the people cared for by Carer Payment recipients were aged 45 years or over (73%), although a similar proportion (36%) of care recipients were aged 65 years or over. Only a small proportion of the people cared for by Carer Payment recipients were aged under 16 years (5%). A review of the Carer Payment (child) benefit (for carers where the care recipient is aged under 16 years) found that the eligibility requirements for this income support payment were overly restrictive and the payment was difficult for carers to access (CP(c)RT 2007). Recent changes to the application process and eligibility criteria for carers seeking Carer Payment (child) are expected to result in a considerable increase in Carer Payment (child) payments in the short term (FaHCSIA 2009a).

On the whole, the age profiles of care recipients cared for by carers in receipt of financial benefits are younger in comparison with the age profiles of the main recipients of care of primary carers identified through the SDAC. While around half (48%) of care recipients identified through the SDAC were aged under 65 years, around two-thirds of Carer Allowance and Carer Payment recipients were aged under 65 years.

The most common condition experienced by a person aged 16 years or over who had a carer in receipt of a carer benefit was osteoarthritis—14% of care recipients whose carers received Carer Allowance (adult) and 15% of care recipients whose carers received Carer Payment (adult) had osteoarthritis recorded as their first-listed condition. Among children aged under 16 years whose carers were in receipt of Carer Allowance (child), the most common first-listed condition was 'learning disability' (recorded for 16% of care recipients whose carer received Carer Allowance (child)), followed by 'autistic disorder' (15%) and 'attention deficit/hyperactivity disorder' (14%). For care recipients aged under 16 years whose carer was receiving Carer Payment (child), 'autistic disorder' and 'severe multiple disability—mobility' were the most common conditions reported (18% and 14% respectively).

The number of people receiving financial assistance is growing

The number of people receiving Carer Allowance and/or Carer Payment has grown considerably over the last decade (Figure 5.5). Carer Allowance, in particular, grew from 100,700 recipients in 1999 to 422,900 in June 2008. The growth in Carer Payment recipients has not been as dramatic but has increased steadily over the last decade, from 40,100 recipients in June 1999 to 130,700 in June 2008. The growth in both payments has been ascribed to increasing need (in large part due to population ageing but also as a result of the demand for home-based care), better awareness of these benefits and changes to eligibility criteria that have increased the population who qualify for payment (Edwards et al. 2008).



Source: Table A5.4 (Australian Government Department of Families, Housing, Community Services and Indigenous Affairs).

Figure 5.5: Carer Allowance and Carer Payment recipients, 1999–2008

The growth in the number of people who have begun receiving these payments in recent years partly explains why current recipients have been receiving these benefits for relatively short periods of time. Over half of Carer Allowance recipients had been receiving the allowance for less than 5 years (57%). Carer Allowance (child) recipients were more likely to have received the benefit for 5 years or more than Carer Allowance (adult) recipients (57% compared with 37%). Sixty-one per cent of all Carer Payment recipients had been receiving the benefit for less than 5 years. Around one-third (35%) of Carer Payment (adult) recipients had been receiving the payment for 5 years or more compared with 14% of Carer Payment (child) recipients.

What isn't known about financial assistance provided to carers?

Because of the specific eligibility requirements that apply to those who receive Carer Payment, and because carers who are eligible for Carer Payment can also access other income support payments, it is difficult to know whether there are carers who would be eligible for this payment who are not receiving it. The SDAC estimated that, in 2003, 90,600 primary carers (19%) were receiving Carer Payment, while administrative data relating to Carer Payment record that there were 75,900 recipients in June 2003. The overestimation by the SDAC of the number of carers receiving Carer Payment may reflect sampling or other error in the survey, but could also reflect confusion experienced by some carers about what benefits they do receive (and particularly confusion about the difference between Carer Allowance and Carer Payment). Aside from the estimation problems, confusion about these benefits has also been identified as a barrier for some carers in being able to access benefits to which they might be entitled (HRSCFCHY 2009).

The SDAC also investigated reasons why some carers were not receiving Carer Payment. Of primary carers who were not receiving Carer Payment, 12% did not qualify either because they did not meet eligibility criteria or because they already received an equivalent income support payment. A small percentage (2% of primary carers) did not need the payment, and a high proportion (56%) had not investigated their eligibility for Carer Payment. The proportion of carers who had not investigated their eligibility was highest among those who had been caring for less than 5 years and those caring for 25 years or more (59% of both groups), but was also high for those who had been caring for between 5–24 years (53%).

Finally, in general it could be expected that most carers who were eligible for Carer Payment would also qualify for Carer Allowance, but in 2008 9% of Carer Payment recipients did not receive Carer Allowance. In some instances this has been identified as differences in the current eligibility requirements for the payment types. Confusion among carers about payments that are available and their entitlements may also contribute to this difference. It is expected that recent changes, under which carers who are approved for Carer Payment (child) will automatically qualify for Carer Allowance (child), will reduce this gap to some extent (FaHCSIA 2009a).

Respite services

Respite services provide a break for carers from their regular caring duties on a regular or ad hoc basis, by providing a substitute carer or substitute accommodation or support activities for the person with care needs. Respite care can be for short periods (a few hours) or for longer periods (a few days or more), and can be planned in advance or delivered as an emergency measure.

This section describes respite services provided under the National Respite for Carers Program (NRCP), which provides funding to over 650 community-based respite services to provide respite to carers of all ages (see Box 5.4). The substitute care funded by this program can be provided in a range of settings including care provided in the home, in day centres or overnight accommodation centres, with host families or as recreational activities for the care recipient.

Box 5.4: National Respite for Carers Program

The NRCP contributes to the support and maintenance of caring relationships between carers and their dependent family members or friends by providing access to information, respite care and other flexible respite support appropriate to individual carer need and the needs of the people for whom they care. The NRCP provides information and support to carers of frail older people and carers of people with disability through the following:

- Commonwealth Respite and Carelink Centres, which provide a single point of contact for members of the community, carers, health professionals and others needing information about community care and other support services in local areas to assist people to live independently. This information can be provided over the phone (by using a Freecall 1800 number) or in person at one of the 54 centres around Australia. Centres have a pool of funding that can be used to purchase short-term or emergency respite for carers
- the provision of respite through community-based agencies which can be arranged by direct approach to the respite care provider, or can be coordinated by a Commonwealth Respite and Carelink Centre. The program also funds other support for carers (for example domestic assistance or personal care) where the primary purpose of the assistance is to provide some relief to the carer
- the delivery of professional counselling through the National Carer Counselling Program, and carer advisory and information services through the Carer Information and Support Program. The aim of the Counselling program is to provide short-term emotional and psychological support services to carers to help reduce the carer's stress, improve the carer's coping skills and facilitate, wherever possible, the continuation of the caring role. Counselling can be offered in different ways to suit the different needs of carers, with individual face-to-face sessions, telephone or group counselling sessions offered. The Carer Counselling Program, along with carer advisory and support services,is delivered through the Network of Carer Associations in each state and territory.

Source: Australian Government Department of Health and Ageing.

Respite services are also provided by a number of community care programs, but, as these programs primarily provide other community support services to people with disability or long-term health conditions, they are discussed separately in the following section. Respite care can also be accessed through smaller programs that often target specific population groups (for example, the Mental Health Respite, Older Carers Respite, and Respite and Support for Carers of Young People with Severe or Profound Disability programs that are funded by the Australian Government Department of Families, Housing, Community Services and Indigenous Affairs) and residential aged care facilities. Respite services offered in residential aged care facilities are legislated under the *Aged Care Act 1997* but are part of the continuum of community care. Aged Care Assessment Team approval is needed to access up to 63 days of residential respite care in any financial year, and further periods of respite care can be accessed with additional approval.

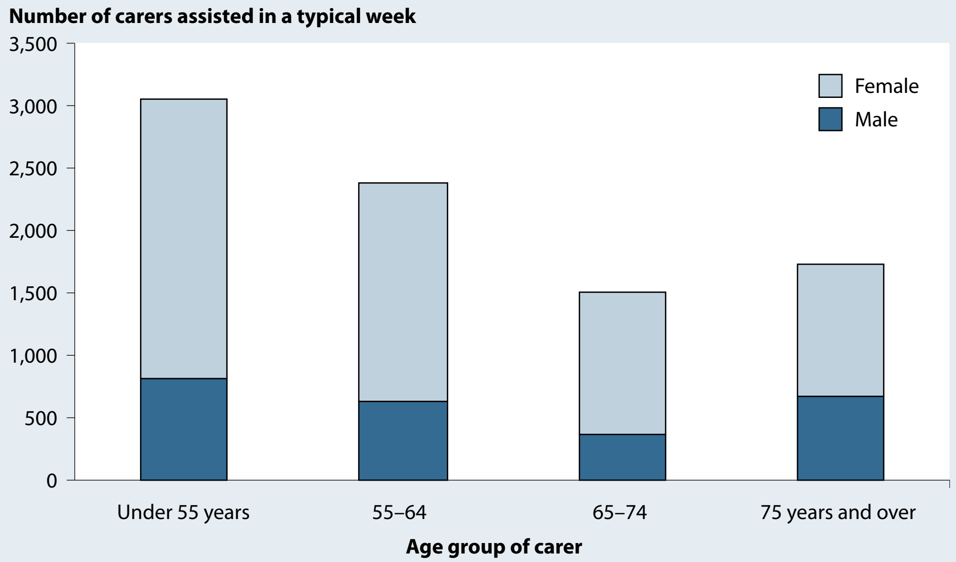
Who receives respite services under the National Respite for Carers Program?

In a typical week in 2008, the NRCP provided respite services to 8,673 carers who received 11,944 instances of respite. Most of the carers who received assistance were female (71%), most were aged under 65 years (63%) (Figure 5.6) and most lived with the person for whom they cared (75%). Most instances of respite (71%) were weekly scheduled services;

5% were considered 'one-off' instances of respite, and 4% were emergency measures. Of all instances of respite, 40% were provided in day centres and 38% were provided in the person's home (96% of which were same-day services). The remaining instances of respite care were individual or group recreational activities provided to the person with care needs, overnight respite in small-scale community facilities, or other arrangements.

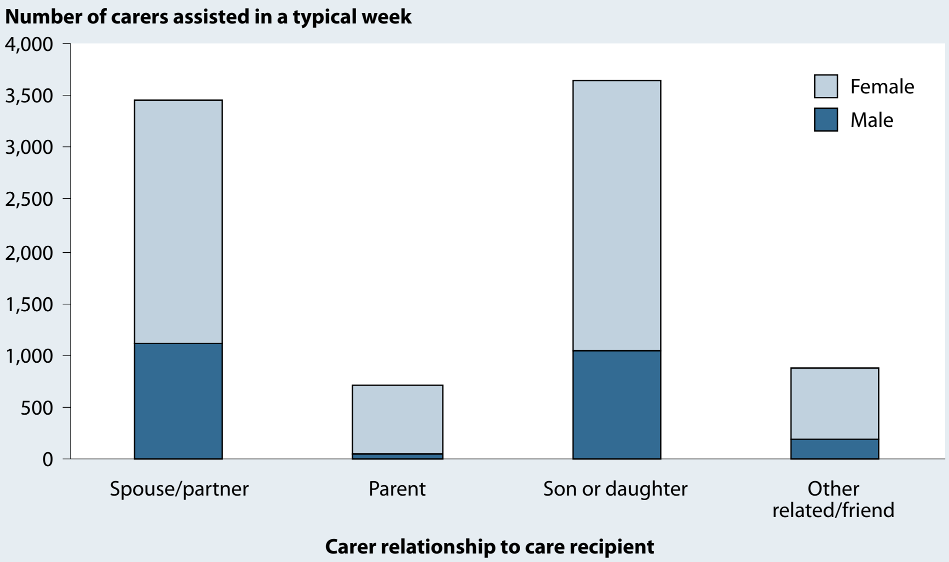
The NRCP is just one source of respite services but, as it is a national program that is available to all carers, it is relevant to consider how the carers who received respite care from the NRCP compare to the broader population of primary carers identified by the SDAC. Carers who received respite care from the NRCP tended to be older: 37% were aged 65 years or over compared with 24% of the SDAC-identified primary carer population; and carers aged under 55 years comprised 55% of the primary carer population but only 35% of those who received respite care through the NRCP in the relevant period.

Sons and daughters caring for a parent were the most common group of carers who received respite care from the NRCP (42% of carers who received assistance), closely followed by spouse/partner carers (40%) (Figure 5.7). Compared to the profile of carers established by the SDAC, sons and daughters caring for an ageing parent were over-represented as NRCP recipients (this group comprised only 26% of all primary carers). Conversely, parents were considerably under-represented—parents caring for a son or daughter with disability comprised 23% of all primary carers but only 8% of all NRCP recipients. These differences in carer profiles may reflect differing levels of demand for respite support by certain carer groups. They may also be because some groups have better access to respite services through other programs or because some carer groups find it easier to access respite care provided by the NRCP.



Source: Table A5.5 (Australian Government Department of Health and Ageing Community Care Census 2008).

Figure 5.6: Age and sex of carers who received NRCP respite services in a census week, 2008



Source: Table A5.6 (Australian Government Department of Health and Ageing Community Care Census 2008).

Figure 5.7: Relationship of carers who received NRCP respite services in a census week, 2008

One-quarter (25%) of carers assisted by the NRCP were responsible for caring for more than one care recipient. One-third (33%) of carers who received NRCP assistance and who cared for more than one care recipient were aged under 50 years, and a further 43% were aged between 50 and 64 years. Just over one-third of carers (35%) who received NRCP respite services were in paid employment, and were employed, on average, for 31 hours per week.

Overall, the main circumstance that carers reported that triggered their use of respite services was 'emotional stress and strain' (43% of all clients who received respite). But for carers who did not live with the person for whom they cared, the increasing needs of the care recipient were reported equally as often as emotional stress (30% of NRCP carers who did not live with the care recipient reported the main triggering circumstance as increasing needs; 29% reported the main circumstance was emotional stress and strain).

And who do they care for?

Carers who received respite support under the NRCP mostly cared for older people: 81% of care recipients were aged 65 years or over, and 65% were aged 75 years or over. By comparison, it was estimated by the SDAC that 52% of the main care recipients of primary carers were aged 65 years or over, and 35% were aged 75 years or over. This suggests that the NRCP mainly serves the respite care needs of carers of older care recipients, who are perhaps already clients of existing aged care programs. Again, this may reflect differing needs for respite care, but may also be because those already engaged with aged care programs find it easier to access NRCP services.

The care recipients of those carers who received respite services through the NRCP had high needs for care: three-quarters (75%) of care recipients could not be left alone to look after themselves for more than a few hours. Sixty-five per cent of care recipients sometimes or always needed assistance with tasks requiring memory or organisational skills, and 41% sometimes or always needed assistance managing their behaviour.

What isn't known about respite services provided to carers?

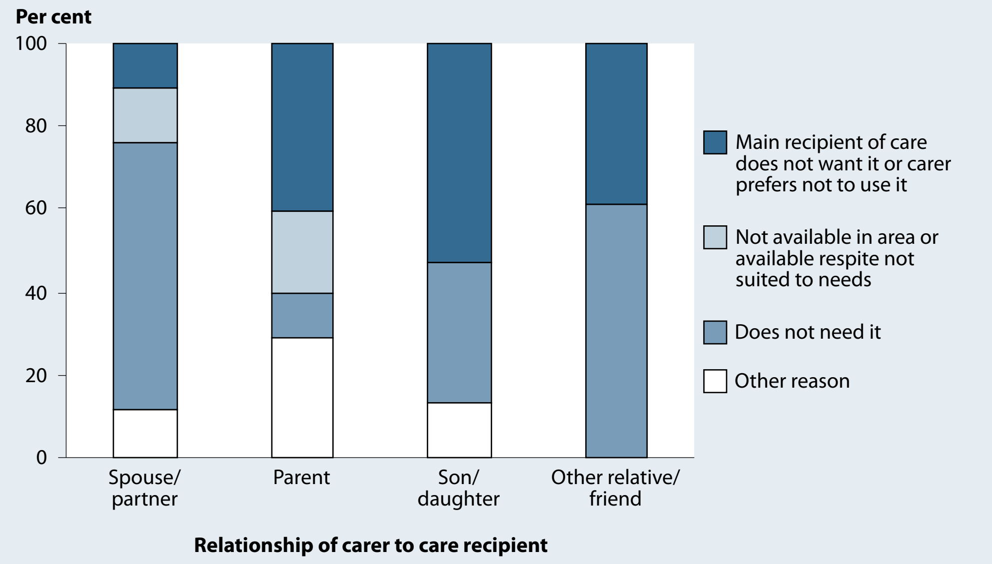
The NRCP is only one source of respite care, and so it is difficult to assess the unmet need of carers in relation to respite services by looking at the NRCP alone. The SDAC estimated, based on self-reported data, that only 13% of all primary carers (62,100 carers) had used respite care services at some point in their caring 'career' but over half (58%) of these had received respite assistance within the previous 3 months. When looked at in conjunction with the number of years that the carer had spent caring, the proportion of carers who had never used respite services was high across all carer groups, although carers were more likely to have used respite the longer they had been in the caring role—91% of those who had been caring for less than 5 years had never received respite care compared with 80% of those who had been a carer for 25 years or more.

Similarly, when looked at by the relationship of the carer to the care recipient, high proportions across all relationship groups had never used respite services. Parents (and particularly fathers) were most likely to have used respite care—28% of parents (and 38% of fathers) had used respite services at some time. Spouses and partners were least likely to have ever accessed respite services—6% had accessed respite care at some time. Previous use of respite services may be affected by the availability of substitute (informal) carers, the ability to cope with the caring role (including the ability to fulfil other responsibilities such as caring for children and working), and the level of engagement with other support services.

To better understand this low use of respite services, the SDAC asked primary carers who had used respite care in the past, but had not used it within the last 3 months, about the main reasons they had not used respite services recently. Overall, males were most likely to report that they had not needed respite care in the last 3 months, while females were most likely to report that they did not access respite services because they preferred not to use it or because the care recipient did not want it.

Spouses and partners were most likely to report that they did not need respite care (65% of those spouses and partners who had used respite services but not in the last 3 months). Carers who were sons or daughters or parents were more likely to report that the person for whom they cared did not want it or that they preferred not to use it (53% of sons and daughters and 40% of parents) (Figure 5.8). Carers who had been caring for less than 5 years were most likely to report that they did not need respite services, while carers who had been caring for longer periods (and particularly for between 5 and 9 years) were most likely to report that the main reason for not accessing respite services recently was related to the care recipient's reluctance for substitute care arrangements or because the carer preferred not to use it.

In terms of preferences for respite care, 19% of primary carers reported that they had an unmet need for respite services on weekdays, and 15% had an unmet need for respite services on the weekends.



Source: Table A5.7 (AIHW analysis of ABS 2003 Survey of Disability, Ageing and Carers confidentialised unit record file).

Figure 5.8: Primary carers who have used respite services previously by relationship to care recipient and main reason for not using respite services in the last 3 months, 2003 (per cent)

While these data appear to suggest that demand for respite services is relatively low (based on the number of carers who report that they do not need respite care), it should be noted that many carers gave as reasons for not accessing respite services recently that the services did not suit them as the carer, or that the alternative care was not wanted by the care recipient. These findings may indicate that the lack of appropriate respite services (in terms of meeting the needs of the carer and/or the person for whom they care) was a significant barrier to accessing respite care rather than that respite was not wanted by the carer.

This could explain apparent discrepancies with other sources of information, such as the Inquiry into Better Support for Carers, which concluded that there was considerable unmet need for respite care (HRSCFCHY 2009). This inquiry suggested that there was an urgent need for more respite services that were affordable, responsive to carers' and care recipients' needs, and accessible to people living outside metropolitan areas. Based largely on submissions and analysis of qualitative evidence, this inquiry has not quantified unmet need, but has assembled compelling evidence that there are carers who could be significantly supported by the availability of appropriate respite care services.

Because respite services are provided through a wide range of programs, and carers and their care recipients may access respite care through different programs on different occasions, it is not possible to assemble data that indicate the extent of unmet need for respite care among carers. Carers, as individuals, will have different needs for respite and will differ in their ability to access formal and informal support services that provide respite. A more detailed investigation of the actual provision of respite services in all these programs is needed, to identify specific groups of carers who may be facing difficulties in accessing respite assistance, and to better understand what types of respite care are most valued by carers.

Community care programs that support carers

The support programs discussed in this section mainly help people with disability and older Australians living in the community. They also support carers directly and indirectly by providing in-home assistance and related services as well as respite care, or, in the case of the Aged Care Assessment Program (ACAP), helping carers and the people for whom they care to access appropriate services. The ACAP, which mainly targets people aged 65 years or over, does not provide services to carers or care recipients directly. The program does, however, provide multidisciplinary assessments of the needs of people with disability or age-related frailty, provides referrals and approves eligibility for subsidised aged care services, such as community, flexible and respite care that help people stay at home longer, and residential aged care. As a result, the ACAP plays a crucial role in enabling older Australians with care needs to access appropriate services, and for this reason has been included in this section.

The programs discussed in this section are:

- Commonwealth State/Territory Disability Agreement (CSTDA) disability support services (this agreement is now known as the National Disability Agreement)
- the Home and Community Care (HACC) Program
- the Community Aged Care Package (CACP) Program
- Extended Aged Care at Home (EACH) and EACH Dementia (EACHD)
- the ACAP.

Further information about CSTDA services and HACC support provided to younger people is available in Section 4.4 , and further information about all of the other programs (including HACC support for the aged) is available in Section 3.5. Again, this is not a comprehensive listing of all programs that provide home help and related support. Nationally, the Australian Government Department of Veterans' Affairs also supports eligible veterans and widows through the Veterans' Home Care program, and other programs may operate in local areas.

How many clients of community care programs have carers?

The proportion of clients of community care programs who have a carer varies greatly across the programs considered in this section. While only one-third of clients of the HACC Program (34%) had a carer, most EACHD clients (87%) reported having a carer (Table 5.5).

Across the major aged care programs (HACC, CACP, EACH, EACHD), the proportion of clients with a carer increased progressively as the eligibility criteria increased. This is consistent with the target populations for these programs, as these programs reflect a 'continuum of care' in terms of the expected functional status of clients. Under this continuum, HACC provides a basic level of support to frail aged people and some younger people with disability, while CACP targets older people with disability who might otherwise receive low-level residential care, and the EACH programs target older people with more substantial activity limitations who might otherwise receive high-level care in a residential aged care facility.

Table 5.5: Community care program clients by carer availability

	Has a carer		Does not have a carer		
Community care program	**Number**	**Per cent**	**Number**	**Per cent**	**Total[(a)]**
CSTDA	110,923	50.4	109,117	49.6	241,817
HACC	245,754	33.5	486,992	66.5	831,472
CACP(b)	19,436	55.1	15,842	44.9	35,278
EACH(b)	2,857	78.9	766	21.1	3,623
EACHD(b)	1,197	86.6	186	13.4	1,383
ACAP	119,237	81.2	27,526	18.8	150,294

(a) Includes clients where carer availability was not reported.

(b) These figures are sourced from the 2008 Community Care Census, and therefore relate to clients of these programs in a 1-week data collection period only.

Note: The data obtained for each program apply to different reporting periods: CSTDA and HACC data are annual data for 2007–08; CACP, EACH and EACHD data were obtained from a 1-week census data collection in 2008; ACAP data are annual data for 2006–07. Further information about the data sources used can be found in Box 5.2.

Sources: ACAP National Data Repository; AIHW analysis of the HACC minimum data set; Australian Government Department of Health and Ageing Community Care Census 2008; CSTDA national minimum data set.

These findings are consistent with the view that carers are 'enablers' of community care (AIHW 2007:98), that is, for many older people with disability, the level of assistance provided by formal services is not sufficient to enable them to remain at home. But the presence of a carer who provides ongoing assistance (which is supplemented by community care services) can tip the balance in favour of home-based care.

This is also evident in data on the functional status of clients of the CSTDA, HACC and ACAP programs. In all these programs clients who had a severe or profound core activity limitation (that is, they sometimes or always needed assistance with at least one of the core activities of self-care, mobility or communication) were more likely to have a carer than clients who did not have a severe or profound core activity limitation (Table 5.6). Again, this suggests that the presence of a carer enables those with significant activity limitations to remain living at home.

Table 5.6: Community care program clients[(a)] by disability status and carer availability (per cent)[(b)]

	Has a carer			Does not have a carer		
Community care program	**Has a severe or profound core activity limitation**	**Does not have a severe or profound core activity limitation**	**Total**	**Has a severe or profound core activity limitation**	**Does not have a severe or profound core activity limitation**	**Total**
CSTDA	86.1	13.9	100.0	32.9	67.1	100.0
HACC (WA only)(c)	77.1	22.9	100.0	50.4	49.6	100.0
ACAP	79.5	20.5	100.0	60.0	40.0	100.0

(a) Data from the Community Care Census 2008 on activity limitations of clients of the CACP, EACH and EACHD programs were not available at time of publishing.

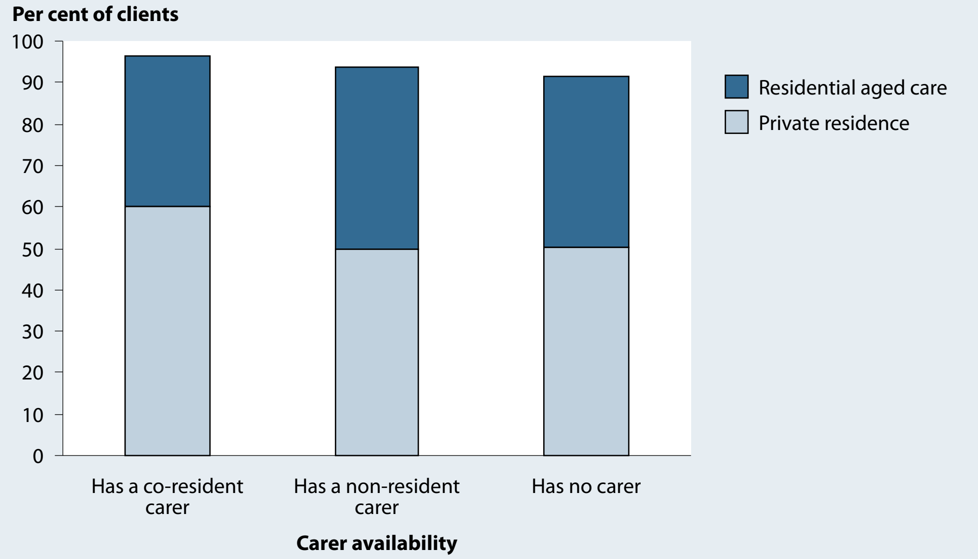
(b) Includes only records where both functional status (including core activity limitations) and carer availability were reported.

(c) Because of high levels of missing data relating to the functional needs of clients across many jurisdictions, the data presented here are based on results for Western Australia (WA) only, which had the most complete reporting of functional needs data in 2007–08. Further information on the quality of functional needs data is presented in Section 3.6.

Note: The data obtained for each program apply to different reporting periods: CSTDA and HACC data are annual data for 2007–08; ACAP data are annual data for 2006–07. Further information about the data sources used can be found in Box 5.2.

Sources: Table A5.8 (ACAP National Data Repository; AIHW analysis of the HACC minimum data set; CSTDA national minimum data set).

Further data from the ACAP confirm that the availability of carers can make a difference to the longer term care settings for the frail aged. As part of their multidisciplinary assessments of clients, Aged Care Assessment Teams record the most appropriate living environment for the client for their long-term care needs. Recent ACAP data indicate that, for all ACAP clients currently living in the community, the availability of a co-resident carer increases the likelihood that the client will be assessed as being able to remain living in the community with support services, if required (Figure 5.9). Overall, 60% of those living in the community with a co-resident carer were considered able to live at home (or in another private residential setting) in the long-term, compared with 50% of clients who did not have a carer. Clients living in the community who had a non-resident carer were equally as likely to be assessed as being able to live at home in the long-term as those with no carer (50% of clients with a non-resident carer were considered able to live at home in the long-term).

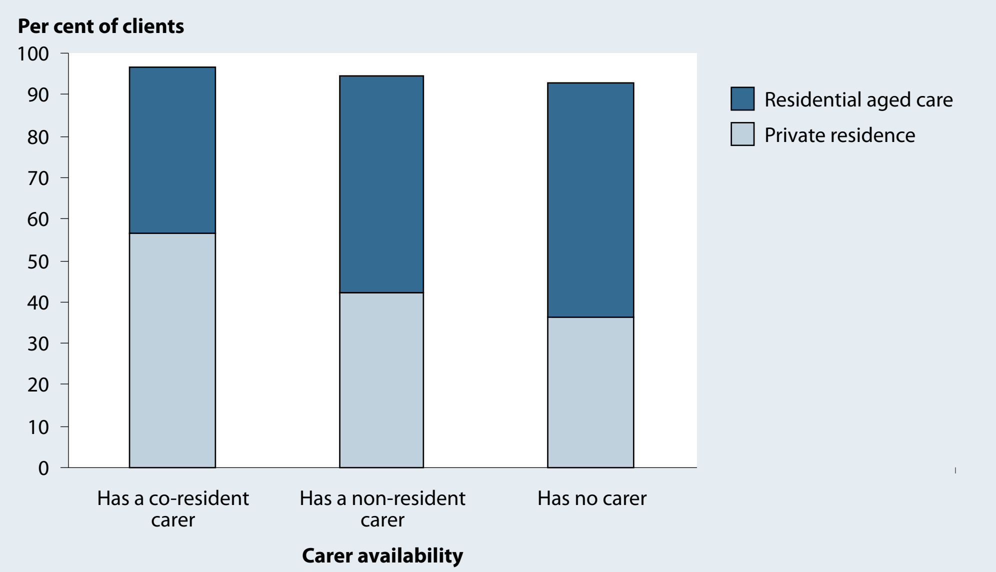


Source: Table A5.9 (ACAP National Data Repository).

Figure 5.9: Most appropriate living environment for the long-term care needs of ACAP clients currently living in the community, 2006–07

For ACAP clients with a severe or profound disability living in the community, the presence of a co-resident carer was particularly critical in terms of being able to remain living at home. While 36% of clients with a severe or profound core activity limitation and no carer were assessed as able to live at home in the long-term, 57% of those with a co-resident carer (and 42% with a non-resident carer) were recommended for long-term care at home (Figure 5.10). This suggests that the support provided by informal carers to people with disability can be crucial in terms of ensuring the wellbeing of the person for whom they care, but can also make a material difference in terms of their ability to remain living at home.

These data also suggest that it is the support provided by a co-resident carer that might be particularly critical in an aged care context. The importance of co-residency in caregiving relationships is likely to reflect the extent of care needs of these clients, and the constant nature of these care needs that are not likely to be well met by a non-resident carer. It may also indicate that the security and companionship provided by a co-resident carer may, for many care recipients, be as important as the practical assistance they provide.



Source: Table A 5.9 (ACAP National Data Repository).

Figure 5.10: Most appropriate living environment for the long-term care needs of ACAP clients with a severe or profound core activity restriction currently living in the community, 2006–07

In all community care programs, most clients who have a carer live with that carer (Table 5.7). But there is considerable variation within the programs. CSTDA clients with carers were most likely to live with their carer, although, in large part, this reflected the age of the clients—nearly one-third of CSTDA clients with a carer were aged under 15 years, and a further 20% were aged 15–24 years, that is, the clients fell in age groups where they would not have achieved independent living.

Table 5.7: Clients of community care programs by client age and carer availability (per cent)[(a)]

	Client has a co-resident carer		Client has a non-resident carer		Client has no carer		
Community care program	**Under 65**	**65 years or over**	**Under 65**	**65 years or over**	**Under 65**	**65 years or over**	**Total**
CSTDA	37.1	1.2	5.5	0.5	52.9	2.8	100.0
HACC	6.4	12.4	0.8	4.9	14.8	60.8	100.0
CACP	1.4	27.5	0.6	25.5	3.1	41.9	100.0
EACH	5.4	59.4	0.5	13.5	1.3	20.0	100.0
EACHD	3.4	67.6	0.4	15.0	0.7	12.8	100.0
ACAP	2.8	44.3	0.7	33.2	1.2	17.9	100.0

(a) Includes only records where client age, carer availability and carer co-residency status were reported.

Note: The data obtained for each program apply to different reporting periods: CSTDA and HACC data are annual data for 2007–08; CACP, EACH and EACHD data were obtained from a 1-week census data collection in 2008; ACAP data are annual data for 2006–07. Further information about the data sources used can be found in Box 5.2.

Sources: Table A5.10 (ACAP National Data Repository; AIHW analysis of the HACC minimum data set; Australian Government Department of Health and Ageing Community Care Census 2008; CSTDA national minimum data set).

Clients of EACH, EACHD and HACC were also very likely to have co-resident carers (over three-quarters of clients of these programs who had carers lived with their carer). Carers of ACAP clients and CACP clients were less likely to live with the person for whom they cared (58% of ACAP carers and 53% of CACP carers).

Who are the carers who are supported by these programs?

The profile of carers who are assisted through these community care programs differs across the programs, and also differs from the overall nationwide profile of primary carers to varying degrees across the programs. These differences are not surprising, given that community care programs target different groups of people with disability (based mainly around the age of the person with disability, that is, people aged under 65 years, and those aged 65 years and over).

Within CSTDA services, which mostly assist people with disability who are aged under 65 years, a high proportion of carers were clients' mothers (Table 5.8), most carers were aged under 65 years (87%—a higher proportion than that estimated by the SDAC in relation to primary carers) and, within this age group, were mostly aged under 45 years (Table 5.9). The relationship profile of carers assisted through HACC is the most similar to the SDAC primary carer population of all the programs considered in this section.

Table 5.8: Carers supported by community care programs by relationship to care recipient and sex (per cent)[(a)]

Community care program	Relationship to care recipient								
	Spouse/partner		Parent		Son/daughter		Other		
	Male	Female	Male	Female	Male	Female	Male	Female	Total
CSTDA	4.5	4.7	6.0	73.5	0.6	1.3	1.9	7.5	100.0
HACC	19.0	25.9	1.8	13.5	8.6	20.8	2.6	7.7	100.0
CACP	13.0	14.7	0.1	0.3	19.6	37.9	3.5	11.0	100.0
EACH	21.8	29.1	0.0	0.3	12.2	28.4	1.8	6.4	100.0
EACHD	23.0	28.1	0.0	0.4	11.4	29.5	2.2	5.5	100.0
ACAP	13.8	21.6	0.2	0.5	15.6	35.0	3.0	10.4	100.0

(a) Includes only records where both carer sex and their relationship to the care recipient were reported.

Note: The data obtained for each program apply to different reporting periods: CSTDA and HACC data are annual data for 2007–08; CACP, EACH and EACHD data were obtained from a 1-week census data collection in 2008; ACAP data are annual data for 2006–07. Further information about the data sources used can be found in Box 5.2.

Sources: Table A5.6 (ACAP National Data Repository; AIHW analysis of the HACC minimum data set; Australian Government Department of Health and Ageing Community Care Census 2008; CSTDA national minimum data set).

Within the programs that primarily assist the frail aged (HACC, CACP, EACH, EACHD and ACAP), the profile of carers is different than that seen for CSTDA services, but there are also notable differences within these programs. Carers of clients receiving assistance from EACH and EACHD (which target those at the more severe end of the spectrum of activity limitations) were mostly composed of spouses or partners of the clients (51% of carers for both programs) and sons or daughters (41% for both programs). About half of the carers of clients assisted through these programs were aged over 65 years. This makes carers assisted by these programs more likely to be aged 65 years or over than the general population of primary carers established by the SDAC.

Table 5.9: Carers supported by community care programs by age group and sex (per cent)(a)

	Carers aged under 65 years								
	Under 45 years		45–64 years		All aged under 65 years		65 years and over		
Community care program	Male	Female	Male	Female	Male	Female	Male	Female	Total
CSTDA	3.9	44.5	6.3	32.5	10.2	76.9	2.7	10.1	100.0
HACC	3.3	11.3	11.4	30.4	14.6	41.7	17.3	26.3	100.0
CACP	n.a.	n.a.	n.a.	n.a.	20.0	46.4	16.0	17.6	100.0
EACH	n.a.	n.a.	n.a.	n.a.	13.3	37.1	21.7	28.0	100.0
EACHD	n.a.	n.a.	n.a.	n.a.	12.0	36.9	24.6	26.6	100.0
ACAP(b)	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.

(a) Includes only records where both carer age and sex were reported.

(b) Information about the age and sex of carers of ACAP clients is not reported as part of the ACAP minimum data set.

Note: The data obtained for each program apply to different reporting periods: CSTDA and HACC data are annual data for 2007–08; CACP, EACH and EACHD data were obtained from a 1-week census data collection in 2008. Further information about the data sources used can be found in Box 5.2.

Sources: Table A5.11 (AIHW analysis of the HACC minimum data set; Australian Government Department of Health and Ageing Community Care Census 2008; CSTDA national minimum data set).

HACC clients were also most likely to be cared for by a spouse or partner (45% of HACC clients with a carer), with 29% cared for by a son or daughter, and 15% cared for by a parent. To some extent, this might reflect the younger age profile of HACC clients, who are more likely than clients of the other aged care programs to be aged under 65 years (Table 5.7).

Among CACP clients with a carer, the proportion cared for by a spouse or partner was lower—spouses or partners comprised 28% of all carers assisted indirectly by this program. A high proportion of carers assisted indirectly through this program were sons or daughters of the client (58%), and a notable proportion were other relatives or friends (15%).

Female carers of clients are more common in all groups, regardless of the program, the relationship type or the age group. Consistent with patterns of caregiving found in the broader carer population, within programs where spouses or partners are the major caregivers, the differences between the proportions of male and female carers tend to be smaller, although female spouses or partners are still more likely than male spouses or partners to be carers across all programs.

Changes in community care support provided to carers

This section describes changes in the availability of carers to people living in the community who receive community care support services, and the number of carers who may receive support through these services. Because data for some of these programs (CACP, EACH and EACHD) are only available from 1-week census collections undertaken in 2002 and 2008, the data for all programs sample just two points in time over comparable (but different) timeframes. It should be noted that these programs did not necessarily remain static over the time periods considered (for example, EACH was a pilot program in 2002 but was established as an ongoing program in 2004), data reporting rates may have changed (such as noted for ACAP) and data collection requirements may have changed. This latter change applies particularly to HACC, which introduced changes to its requirements for data collection in this period as it moved from version 1 of the data set to version 2. Because changes in data collection requirements and data reporting methods affect the number of carers identified, the figures provided here for HACC should be treated with some caution.

Table 5.10: Clients of major community care programs: changes in the number and proportion of clients with a carer over two points in time (around 2003 and 2007)

Community care program	Reporting period	No. of clients with a carer	Per cent of clients with a carer	Reporting period	No. of clients with a carer	Per cent of clients with a carer	Change	Change (percentage point)
CSTDA	2003–04	77,863	52.9	2007–08	110,923	50.4	+33,060	–2.5
HACC	2003–04	222,826	52.7	2007–08	245,754	33.5	(a)n.a.	–19.2
CACP(b)	2002	14,231	56.5	2008	19,436	55.1	+5,205	–1.4
EACH(b)(c)	2002	261	90.6	2008	2,857	78.9	+2,596	–11.7
EACHD(b)	2002	(d)n.a.	(d)n.a.	2008	1,197	86.6	n.a.	n.a.
ACAP	2003–04	74,258	78.9	2006–07	119,237	81.2	(e)+44,979	+2.3

(a) The HACC minimum data set moved from version 1 to version 2 over this time period. Differences in the versions, and particularly the change in practices around recording services provided directly to carers, and the level of missing data on client type in 2003–04, mean that direct comparison of numbers of clients assisted in these periods is considered unreliable.

(b) These data have been obtained from census data collections conducted over a 1-week period in 2002 and 2008. Therefore, the numbers of clients provided for these programs indicate the number of clients assisted in a typical week.

(c) The EACH program was a pilot program in 2002, and was established as an ongoing program in 2004.

(d) The EACHD program began in 2006 and therefore did not participate in the 2002 Community Care Census.

(e) Much of the increase in numbers of assessments conducted where the client had a carer has occurred because more Aged Care Assessment Teams are reporting national minimum data set data to the national repository. As a result, much of this change is thought to be attributable to improvements in participation rates for reporting rather than changes in numbers of assessments completed.

Sources: CSTDA national minimum data set, AIHW analysis of the HACC minimum data set, AIHW 2004b, AIHW 2004c, ACAP National Data Repository.

These recent data show that, for all programs for which data are available, the absolute numbers of carers who may be benefiting from these community care programs have increased although it is difficult to assess the extent of the increase as some of these changes may have been a result of improvements in reporting. These data show that, for most programs, there was little change in the proportion of clients with a carer in these programs over the time period analysed, although the data suggest a trend towards decreasing proportions of clients with carers (the ACAP being the only exception). The largest decreases in proportions of clients with carers were seen in the HACC and EACH programs. While changes in HACC data reporting requirements may have affected the proportion of care recipients identified as having a carer, there has been a continuing decrease in the proportion of clients of this program over a number of years that has been previously noted (DoHA 2008). The changes noted for the EACH program are considered less reliable as the EACH program was only a pilot program in 2002, and therefore only had a small number of clients at that point, and there are no equivalent data for the intervening periods. The availability of carers to EACH recipients will also have been affected by the introduction of the EACHD program in 2006, which is likely to have changed the profile of EACH recipients to some extent.

What gaps are there in the data about community care support for carers?

While the data presented in the previous sections represent the major community care programs that support people with disability and their carers, it is not possible to assess the coverage of these programs across the carer population for a number of reasons. The main reasons are that people with disability and their carers may access services through a number of different programs (either at the same time or at different times within a data collection reporting period), and data from the different programs are reported differently: some as annual figures for all clients assisted over the year, others based on clients assisted in a 1-week period only. It is therefore not possible to combine figures to get a picture of all carers being assisted through these programs.

The SDAC collected some information about carers' needs for community care-type services. Overall, the SDAC found that 8% of primary carers who wanted more support in their caring role (15,100 carers) reported that 'more physical assistance' was the main support they desired. This type of assistance was more likely to be most wanted by those who had been a long-term carer (14% of those who had been a carer for 25 years or more), which may, in turn, reflect the older age of long-term carers. As carers could only nominate one type of assistance that they most desired, this is likely to underestimate total desire for further support by community care programs. The Inquiry into Better Support for Carers found that in-home assistance of the type provided by these programs was highly valued by carers (HRSCFCHY 2009).

The SDAC also provides information on unmet needs of people with a disability who have co-resident carers. While needs for assistance with core activities of daily living (self-care, mobility and communication) were, on the whole, met, 31% of those with a need for assistance relating to communication reported that their needs were only partially met (or not met at all). For those with a need relating to mobility, 16% had a need that was not fully met, and for those with a need for assistance with self-care, 8% had a need that was not fully met. It is likely that this unmet need for assistance among people with disability places greater pressure on carers, and also suggests that there is unmet need for assistance of the type offered by community care programs.

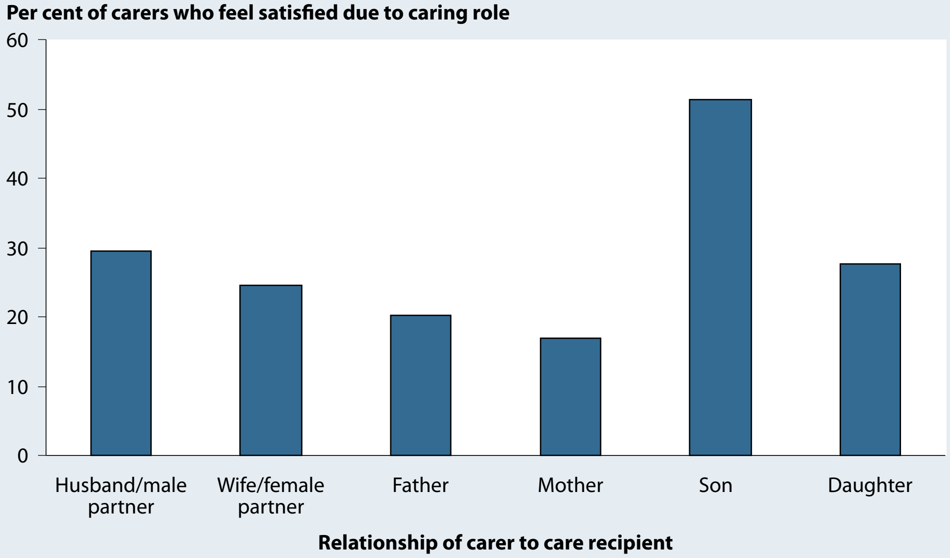
Finally, data presented here do not provide any indication of the extent, adequacy or appropriateness of the assistance provided. Future analyses to explore further the types and quantities of services received by clients with and without carers would be useful.

5.5 The costs of caring

For many carers the experience of looking after a relative or friend can be positive and rewarding, and many narrative descriptions of the experiences of carers highlight the rewards of caring, particularly for end-of-life care (see, for example, Hoole 2009, HRSCFCHY 2009). Based on ABS data, in 2003 one-third of all informal carers (34%) reported that the caring experience had brought them closer to the person for whom they cared, and 42% reported that their relationship was unaffected (ABS 2008). Carers were more likely to report that their relationship had become closer when they did not live with the person for whom they cared (45% compared with 31% of carers who lived with the person for whom they cared).

In terms of overall satisfaction with their caring role, however, only around one-quarter of primary carers (26%) reported that they felt satisfied as a result of their caring role. Male carers were more likely to report feeling satisfied than female carers (35% of males compared with 25% of females) (ABS 2008). The proportion of carers who reported feeling satisfied with the caring role was highest among those who had provided care for 25 years or more (38% of this group reported feeling satisfied), but was relatively constant for all groups who had provided care for less than 25 years. There were some interactions with carer gender evident: among carers who had cared for less than five years, males were considerably more likely to report feeling satisfied (39% of male carers compared to 22% of female carers), and among carers who had been caring for 25 years or more, female carers were considerably more likely to feel satisfied than males (41% of females compared with 10% of males).

Primary carers were most likely to report feeling satisfied if they were caring for a parent (34% of carers caring for a parent reported feeling satisfied). But within this group male carers were much more likely than female carers to report feeling satisfied (51% of sons caring for a parent compared with 28% of daughters) (Figure 5.11). Within all relationship groupings, female carers were less likely than male carers to report feeling satisfied as a result of their caring role.



Source: Table A5.12 (AIHW analysis of ABS 2003 Survey of Disability, Ageing and Carers confidentialised unit record file).

Figure 5.11: Proportion of primary carers who reported feeling satisfied due to the caring role by relationship to care recipient, 2003 (per cent)

These data suggest that, notwithstanding the potential rewards of caring and the availability of programs and benefits that support carers in their caring role, there are costs involved in being a carer, and these are not experienced uniformly by all carers. Costs, which can include economic costs and personal costs, are frequently related to gender and are also often related to the relationship between the carer and the care recipient. They can also be related to the life-stage of the carer, because the carer may also be combining the role of carer with other roles (as a spouse, parent or employee). They can also be related to the extent to which the carer has 'chosen' the role of carer, and the extent to which other potential carers are available.

The economic costs of caring

The economic costs incurred by carers include direct costs and opportunity costs.

Direct costs are those additional costs incurred by the carer that arise directly from their role as a carer. This includes the cost of specialised equipment or aids, home and vehicle modifications to accommodate the person with care needs, medicines or medical therapies, and increased household utility and transport costs (CP(c)RT 2007). While it is arguable these are costs of disability rather than the costs of caring, many of these costs are nevertheless borne by the carer or their household.

Although it is difficult to collect data on the direct costs borne by people with disability and/or their carers, and the actual costs incurred can vary greatly, the cost of disability has been estimated, on average, to be 29% of household income (adjusted to account for differing household compositions of households with a person with a disability). Costs are, on average, considerably higher where the person has a severe or profound core activity limitation, and households that include a person with disability are considerably more likely to be living in poverty (Saunders 2006). The Inquiry into Better Support for Carers (HRSCFCHY 2009) received numerous submissions from carers describing the costs they faced, particularly relating to specialised equipment or aids and home and vehicle modifications. In many cases these costs were significant despite some of these costs being paid or subsidised through programs or benefits that support carers and the people for whom they care or private fundraising efforts.

In considering the economic costs of caring, however, the more significant costs for most carers are the opportunity costs: lost income associated with reduced working hours or withdrawal from the workforce, and missed opportunities for career advancement or further education. These lost opportunities to generate income can affect retirement savings (for example, as a result of fewer opportunities to accumulate superannuation) and can be significant in households where there is both a person with disability and one or more people who provide significant care. This is particularly so where the person with disability was previously contributing income to the household and/or the exclusion of the carer from the workforce continues over an extended period of time.

How many carers are employed?

It is now well established that carers have reduced rates of participation in the workforce compared with non-carers. The SDAC found that 48% of primary carers aged 15–64 and 66% of non-primary carers aged 15–64 were employed at the time of the survey, compared with 73% of the non-carer population of working age (ABS 2008). Carers who were employed were more likely to work part time—54% of employed primary carers and 35% of employed non-primary carers worked part time (less than 35 hours per week), compared with 29% of employed non-carers. Female carers were both less likely than males to be in paid work (54% compared with 74%), and more likely to work part time (56% of employed female carers compared with 20% of employed male carers) (ABS 2008). Similar low rates of employment were found in a more recent survey of female recipients of Carer Allowance of working age—47% of women receiving Carer Allowance but not Carer Payment were employed (11% were employed full time and 36% employed part time) (Edwards et al. 2008).

Employment patterns also vary considerably when looked at by the relationship to the care recipient (Table 5.11). A high proportion of primary carers aged 15–64 years who were the spouse or partner of the care recipient were not in the labour force or were unemployed (62% of primary carers; 42% of male carers and 74% of female carers). This might reflect the generally older age of spousal carers, but may also reflect some unknown constraints on them.

To some extent, differences between employment rates and employment patterns among carers can be explained by the demographic profile of carers. As seen previously, most primary carers are female, and many are aged 45 years or over—groups that, even in the general population, tend to have lower employment rates and higher rates of part-time employment (Access Economics 2005). Nevertheless, even after taking into account the different sex and age structure of carers compared with the general population, full-time employment rates among carers (and particularly primary carers) were lower than those seen in the general population, and both primary carers and non-primary carers were still more likely to be in part-time work compared with the general population (Access Economics 2005).

Table 5.11: Primary carers aged 15–64 years by relationship to care recipient and employment status, 2003 ('000)

Labour force status	Relationship to care recipient								
	Spouse/partner		Parent		Son/daughter		Other		
	Male	Female	Male	Female	Male	Female	Male	Female	Total
Employed full time	14.6	7.6	*3.7	16.3	13.1	18.4	*2.5	*3.7	79.8
Employed part time	*7.0	*9.3	**1.2	30.8	*6.1	29.9	**0.9	*9.3	94.5
Unemployed or not in labour force	15.4	47.9	*3.9	48.3	15.1	35.0	*4.3	15.0	185.0

* estimate has a relative standard error of 25% to 50% and should be used with caution

** estimate has a relative standard error greater than 50% and is considered too unreliable for general use

Source: AIHW analysis of ABS 2003 Survey of Disability, Ageing and Carers confidentialised unit record file.

Decisions about who provides care within families might be affected by employment factors. That is, family members who are not in the labour force, unemployed or employed casually or intermittently might be the ones who take on the care of a family member with care needs (even though they may have other responsibilities, such as caring for children) (Edwards et al. 2008). While this may be the case for some carers, there is evidence that many carers have found caring responsibilities and workforce participation difficult roles to combine, and have had to withdraw from paid employment or change their work pattern to accommodate their caring responsibilities. Based on SDAC data, 31% who were not employed at the time of the survey worked just before taking on the caring role, and about half (51%) of those who left work just before taking on the caring role cited caring responsibilities as the main reason for withdrawing from paid employment. Females were more likely to leave the workforce to take on (or increase) caring responsibilities than males—55% of female primary carers who had left work just before commencing caring compared with 44% of male primary carers. Since becoming a carer, 23% of primary carers who were employed had reduced their working hours (ABS 2008).

Edwards and colleagues (2008) similarly found that a high proportion (45%) of female carers who were in receipt of Carer Allowance (but not Carer Payment) and were not employed at the time of the survey were employed before taking up caring responsibilities and stated that their caring responsibilities were the main reason they left their jobs (83%). Over one-third (39%) of currently employed females also reported that they had, at some stage, given up work because of their caring responsibilities. A high proportion (72%) also reported that they had changed jobs or work patterns (such as changing or reducing hours, or changing jobs) to better accommodate their caring responsibilities.

For many carers, employment is incompatible with their caring responsibilities because of the demands that their caring responsibilities place on them, and because of their need to take leave or re-arrange work hours around the needs of their care recipient. For many carers the absence of alternative care options for the person for whom they care may be a barrier to working, and, for others, the emotional and psychological demands of caring may also affect their ability to work. Nevertheless, many carers have stated their preference to work if they were supported in this role (Edwards et al. 2008; HRSCFCHY 2009).

For carers who want to work, paid employment can be important in ensuring their financial security, and also for the potential psychological and social benefits that participating in paid work can bring. Employment can provide an important opportunity for carers to focus on things other than caring, and to establish social networks outside the family and caring network. Participation in the workforce may also ensure that carers do not remain socially isolated once the caring role ceases.

Finding ways to enable carers to participate in the workforce is likely to be the focus of increased attention in the future, when population ageing makes it likely that there will be increased pressure on those of workforce age to remain in the workforce, and to work full time wherever possible. A number of changes to workplaces that would support carers to work have been identified. These include the provision of more flexible workplaces that can accommodate carers' needs to balance their work with their care recipients' needs, and legislative or other protections for carers to ensure that they are not discriminated against because of caring responsibilities (HRSCFCHY 2009).

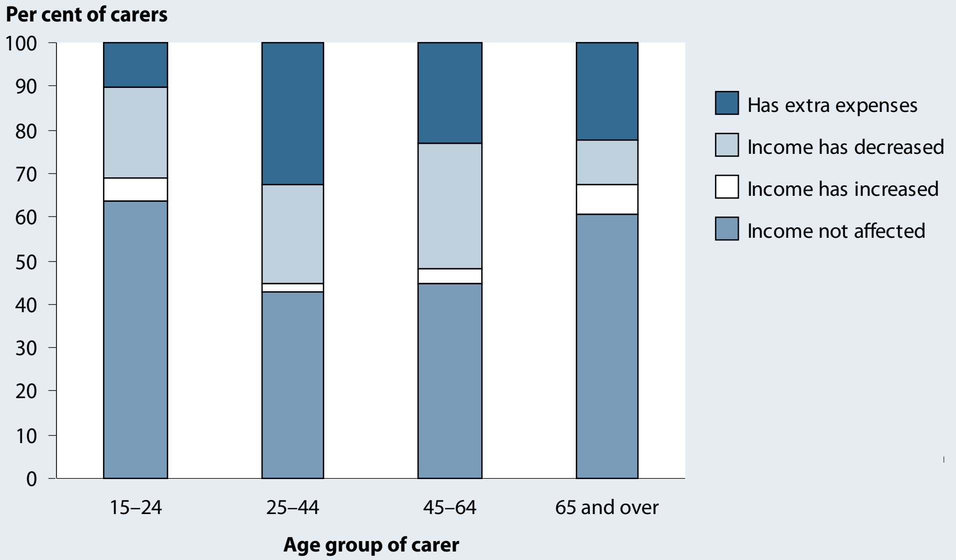
The role of support services for carers and people with disability is also important—support services need to be affordable and available in ways that are compatible with employment. For example, respite care needs to be available routinely to individuals rather than on an ad hoc basis and, for carers of school-aged children with disability, the availability of substitute care programs during school holidays is important (HRSCFCHY 2009). Supports provided to carers after their caring responsibilities have ceased may also be important in assisting carers back into the workforce after a period of absence (HRSCFCHY 2009).

Does caring cause financial stress?

Overall, in 2003, 48% of those primary carers who provided information about the main effect that the caring role had on their financial situation reported that their caring responsibilities had reduced their income or created additional expenses (25% said the main effect was additional expenses, and 23% said it was reduced income). Parents caring for a son or daughter with disability were more likely than other carers to report incurring additional expenses related to their caring role (38% of parental carers).

The proportion of primary carers who reported that their income had reduced as a result of caring increased (though only slightly) as age group increased up until age 65 (Figure 5.12). For carers aged 65 years or over, only 10% said that the main effect of caring on their financial situation was a reduction in income. This is likely to reflect the fact that most carers in this age group care for their spouses or partners and, for many, this caring role would have begun after retirement and therefore not affected their income. In this group, extra expenses were more often reported as the main effect of caring (22% of carers aged 65 years or over reported this as the main effect), although most carers in this age group (61%) reported that caring had not affected their income.

Young carers (aged 15–24 years), on the whole, were less likely than carers in the older age groups to report that income or expenses had changed for the worse as a result of their caring responsibilities: 64% reported that their income was not affected by their caring responsibilities and less than one-third reported that their income had decreased or that their expenses had increased (31% of young carers reported these as the main effect of caring on their financial situation). This is likely to be because many carers in this age group are caring for a parent (60% of carers aged 15–24) and therefore may not be directly responsible for expenses associated with the care of their mother or father. Also, young carers are generally not sufficiently established in the workforce to experience decreased income. For this group, however, the opportunity costs associated with their caring role are likely to be significant in terms of the loss of opportunities to work or study and to establish a career and begin to ensure their long-term financial security.



Source: Table A5.13 (AIHW analysis of ABS 2003 Survey of Disability, Ageing and Carers confidentialised unit record file).

Figure 5.12: Primary carers by age group and main effect of caring role on their financial situation, 2003 (per cent)

Whether as a result of reduced income, increased costs or other factors, many carers live in low-income households and experience financial stress. Based on SDAC data, in 2003 it was estimated that, after adjusting income to take account of differing household size and composition, 44% of primary carers who provided information about their household income and 29% of non-primary carers lived in 'low income households', compared with 18% of non-carers (ABS 2008, including for more information on the definition of low income households). Primary carers who were caring for a spouse were considerably more likely than other carers to be living in a low-income household (59% of carers caring for a spouse compared with 32% of carers caring for a son or daughter and 32% of carers caring for a parent). To a large extent this is because spousal carers tend to be older and older carers are also much more likely to be living in low-income households—69% of primary carers aged 65 year or over compared to 36% of primary carers aged under 65 years.

Similarly, over half (57%) of primary carers derive most of their income from a government pension or allowance (compared with 36% of non-primary carers and 24% of non-carers) (ABS 2008). Again, this is influenced by the age-structure of the carer population. While 31% of carers aged under 65 years who provided information about their main source of income mainly relied on a government pension or benefit for income, 79% of those aged 65 years or over were in this position. Female carers were also more likely to rely on government pensions and benefits (46% of female carers compared with 33% of male carers).

Despite indicators that many carers experience financial stress, carers, on the whole, do have relatively high rates of home ownership—72% of primary carers are home owners (with or without a mortgage) compared with 65% of the non-carer population. In large part, this is attributed to the fact that carers, on the whole, are older than the non-carer population, and home ownership is more likely in older age groups (ABS 2008). This may also reflect that fact that for many carers (especially those who provide care in late life for an ageing parent or spouse) home ownership is already established before caring responsibilities commence. Carers aged under 35 years were less likely than non-carers of a comparable age to be home owners (37% of carers in this age group owned their home compared with 44% of non-carers) (ABS 2008).

The personal costs of caring

There is a substantial body of evidence that describes the personal costs to carers—in terms of time, the effects on their health and wellbeing, and the effects on social aspects of their lives and social engagement. These costs can have a significant effect on the carer, but can also affect others, including the person with disability and other household or family members, although most data that are available are about the carer.

How much time is spent caring?

Providing ongoing assistance to a person with a disability can be time consuming, which can have an obvious impact on opportunities for carers to participate in paid employment, social activities and their community. According to the SDAC in 2003, 41% of primary carers spent less than 20 hours a week on average actively providing care and supervision, but another 40% of primary carers spent 40 hours or more a week providing care (Table 5.12). Female carers were more likely than male carers to spend significant amounts of time providing care (42% of female primary carers spent more than 40 hours a week providing care compared with 33% of male carers).

Carers who are a parent or a spouse (or partner) of the care recipient were most likely to spend significant amounts of time providing care—50% of parental carers and 44% of spousal carers provided care for 40 hours or more a week on average. Mothers and wives (or female partners) were, in particular, more likely to spend significant amounts of time providing care. Around half of mothers (52%) spent 40 hours or more providing care (compared with 30% of fathers), and 50% of wives or female partners spent 40 hours or more providing care (compared with 34% of husbands or male partners).

Table 5.12: Primary carers, by relationship to care recipient and average hours per week spent providing care, 2003 ('000)

Relationship to care recipient	Average hours per week spent providing care								
	Less than 20 hours			20–39 hours			40 hours or more		
	Male	Female	Total	Male	Female	Total	Male	Female	Total
Spouse/partner	30.9	34.2	65.1	17.0	19.8	36.9	25.0	53.7	78.8
Parent	*3.5	27.2	30.6	*2.7	18.2	21.0	*2.6	48.4	51.1
Son/daughter	20.4	40.9	61.2	**1.6	18.2	19.8	10.7	24.3	34.9
Other	*4.2	16.3	20.6	*2.6	*6.5	*9.1	*2.3	*7.2	*9.4
Total	**59.0**	**118.5**	**177.5**	**23.9**	**62.7**	**86.6**	**40.6**	**133.6**	**174.2**

* estimate has a relative standard error of 25% to 50% and should be used with caution

** estimate has a relative standard error greater than 50% and is considered too unreliable for general use

Source: AIHW analysis of ABS 2003 Survey of Disability, Ageing and Carers confidentialised unit record file.

In addition to the time spent directly assisting or supervising the person for whom they care, carers (and particularly female carers) spent more time undertaking housework and other domestic duties than non-carers (ABS 2008). This is likely to be due to both the demands of caring (including situations where carers might be contributing to housework in two households when they do not live with the care recipient) and because carers are more 'available' to undertake domestic duties because they are in the home with the person for whom they care for extended periods of time.

Are the wellbeing and health of carers affected by caring?

Based on SDAC survey data, one-third of all carers (34%) reported that they felt 'weary or lacking in energy' because of the care provided, 29% reported that they frequently felt 'worried or depressed', and 29% also reported that their wellbeing had 'changed' (ABS 2008). Overall, female carers were more likely than male carers to report feeling weary or lacking in energy (reported by 37% of females and 25% of males) or that their wellbeing had changed (reported by 33% of females and 20% of males) (ABS 2008).

Wellbeing was also related to the relationship between the carer and the care recipient—with parental carers most likely to self-report feeling weary or lacking energy (reported by 46% of parental carers). But within this group, it was mothers more than fathers who reported feeling weary and lacking energy (48% of mothers compared to 32% of fathers). And indeed, within all relationship groupings, female carers were more likely to report these negative effects of caring. The sex differences were most pronounced among parental carers (as indicated) and among sons and daughters caring for a parent with disability (where 39% of daughters caring for a parent reported feeling weary or lacking energy compared to 20% of sons caring for a parent).

Recent work by Edwards and colleagues (2008) that explored the effects of caring, compared data on carers receiving Carer Allowance and/or Carer Payment with equivalent data from the general population. This study found that, compared with the general population, carers reported significantly worse mental health and vitality. The findings in relation to mental health held true for both male and female carers, although the differences between the mental health scores of female carers and those of females in the general population were particularly noteworthy and does suggest that caring affects female carers' mental health more adversely than for male carers.

Female carers reported worse mental health (compared to females from the general population) at all age groups below 65 years, after which their scores were not significantly different from scores for females from the general population. Female carers also reported significantly lower vitality scores (when compared to the general population) at age groups below 51 years of age. Female carers aged 51–65 years reported vitality levels on par with the general population and female carers aged 65 years or more reported higher vitality scores than the general population. There were not sufficient numbers of male carers in the study sample to explore the relationship between mental health and age for male carers (Edwards et al. 2008).

Carers in this study also reported having experienced depressive symptoms for 6 months or more (since beginning caring) at much higher rates than reported by the general population—half of all female carers (51%) and nearly one-third (31%) of all male carers reported experiencing depression as a carer. Again, this held true for both male and female carers, and there was strong evidence that the risk of experiencing depressive symptoms was greatest in the first year of caring. It was also related to the level of care needs of the care recipient, with depression being more likely to have been experienced by those caring for people with high-care needs and those caring for more than one person with a disability (Edwards et al. 2008).

Edwards and colleagues (2008) also explored the self-reported physical health of carers and found that both male and female carers were more likely to report 'fair' or 'poor' health than the general population. Female carers were also significantly more likely to report poor health status at all age groups aged below 65 years than females of an equivalent age in the general population, although after age 65 years poor health was reported by similar proportions in both groups (there were too few male carers in the sample for this to be investigated among male carers). Poor physical health was associated with high 'demands' of caring—notably for carers who were caring for more than one person with a disability, or where the person being cared for had high-care needs.

According to ABS data, 40% of primary carers and 34% of non-primary carers reported having a disability themselves (compared with 20% of the non-carer population aged 15 years and over). The likelihood of carers having a disability is related to their age—20% of carers aged 15–34 years reported having a disability themselves, which increased to 61% of carers aged 65 years and over (ABS 2008).

It is likely that the reduced health and wellbeing status of carers has a number of causes. These could be an outcome of increased stress and distress experienced by carers, reduced opportunities to adopt health-promoting behaviours (such as exercise or visiting a doctor), and the physical strains and stresses of providing a level of constant care.

Does caring affect family relationships?

Edwards and colleagues (2008) also investigated the effects of caring on family relationships. Although they found that caring can create conflict within families, carers reported being more satisfied than the general population with their relationships with their children (even if a child was the care recipient). Carers were less satisfied than the general population, however, with the relationships between their children when one of the children is the care recipient. This supports other evidence that many carers report that siblings of a child with disability are frequently required to take on greater responsibility, spend less time with their parents and may resent the attention given to their brother or sister (ACD 2003; CP(c)RT 2007).

Again, the extent of problems with family functioning was related to the level of care required by the person with disability. Families caring for a person with high care needs were significantly more likely than families caring for a person with lower care needs to report family functioning problems. And families caring for a person with a psychiatric disability reported more family functioning problems than families caring for a person with another disabling condition (Edwards et al. 2008).

The SDAC found that 35% of carers who had other co-resident family members (apart from their main care recipient) believed that their relationships with other co-resident household members (excluding household members who were care recipients) were strained or lacked time. The remainder reported that their relationships were unaffected (44%) or had been brought closer together (8%) (ABS 2008). Female primary carers were more likely to report that their relationship with other co-resident family members was strained (37% of female carers compared to 27% of male carers); and carers who cared for a child aged under 15 years were more likely than other carers to report strained relationships or lack of time with other family members (52% of carers who cared for a child with disability aged under 15 years compared to 31% of other carers) (ABS 2008).

Caring responsibilities may also contribute to relationship breakdown. Although it is a difficult area to investigate, overseas studies indicate that couples who have a child with disability are more likely to experience relationship breakdown than those caring for children without disability (see discussion in Edwards et al. 2008). Edwards and colleagues (2008) found that around 30% of female carers aged 31–50 years (excluding those caring for a spouse or partner) had separated from their partner since they began caring.

Data from the SDAC indicate that one-third of all primary carers (34%) thought that their relationship with their spouse or partner (excluding cases where their spouse/partner was the care recipient) was 'strained' or that they lacked time together (37% of female carers and 24% of males). Edwards and colleagues (2008) found that carers were significantly more satisfied than the general population with their relationship with their partner (even when it was their partner who was the care recipient), although this finding only applies to 'surviving' caring relationships.

What about the impact on social activities?

Caring has also been found to affect the social lives of carers. In 2003, the SDAC found that 37% of carers who provided information about the effects of the caring role reported that they had lost touch with friends or that their circle of friends had changed since taking on the caring role. Primary carers caring for a parent were most likely to report that they had lost (or were losing) touch with friends (32% of those caring for a parent), and within this group, daughters were more likely than sons to report this effect on social circles (33% compared with 27%). Fathers caring for a child with disability also commonly reported that they had lost (or were losing) touch with friends (39% of fathers reported this effect, compared to 23% of mothers). Despite these changes in friendship circles, data from the ABS 2006 General Social Survey suggest that carers, on the whole, have equivalent patterns of social contact and social support to non-carers. This survey also found that carers were slightly more likely to have been involved in a range of social and community organisations than non-carers (ABS 2008).

Data reported by the ABS in this area are limited because questions are retrospective and because they do not take account of carers' perceptions of the adequacy of their current level of social contact. This issue was investigated in more detail by Edwards et al. (2007), who compared the social contacts of carers who were receiving Carer Allowance and/or

Carer Payment with data from the general population. This study found that carers were significantly more likely than the general population to have infrequent social contact outside their household (once or twice every 3 months), even after controlling for other variables that may affect social contacts. Carers who were aged over 35 years, experiencing financial hardship or caring for someone with high-care needs were all more likely to report low levels of social contact.

This study also investigated whether carers wanted more social contact outside the household. Carers with poor health status, carers caring for someone with medium- or high-level care needs, and carers experiencing financial hardship were all more likely to want more social contact. Interestingly, carers who were employed were also more likely than those not in the labour force to want further social contact with others outside their household (Edwards et al. 2007). This may suggest that carers have a strong preference to socialise with friends and family rather than incidental social contact arising from the workplace.

5.6 Quality of data about carers

The capture of data about carers can be complex: carers may care for more than one care recipient, care recipients may have more than one carer, carers may themselves be care recipients, and the experience and characteristics of carers and the people for whom they care are diverse. Additionally, snapshot data do not adequately provide a picture of how the care needs of care recipients and carers change over time; and programs vary in terms of whether they are primarily concerned with supporting carers or supporting the people with disability and/or the aged, which has implications for both the data collected about carers and the quality of the data.

As discussed, the SDAC is the main source of data about carers. This data collection has included questions about carers in surveys conducted since 1988, and since 2003 this survey is now conducted every 6 years. While the first of these surveys to collect information about carers included information about co-resident primary carers only, definitions of carers have since been broadened to recognise both primary carers and other informal carers (ABS 2004b), although in-depth information is only collected for primary carers, which has been identified as a limitation of this collection (AIHW: Gilham et al. 2009).

The main strength of this survey is that it is conducted as a population-based survey, and the identification of carers and primary carers is not based on self-identification but is instead derived from the care recipient’s need for assistance and information about the assistance provided by the carer. This should overcome, to a large extent, potential under-counting of carers who do not identify with the role of carer. But while the SDAC remains the most authoritative source of data about carers and the people for whom they care, problems have been identified. Some of these problems relate to the definitions used, while others relate to the operational protocols for the collection. Specific problems include:

- The definition of primary carer (as used in the ABS SDAC) excludes some care groups who may provide significant amounts of care to certain care recipient groups. For example, carers of people whose care needs are not continuous but episodic in nature, and carers who provide high-intensity care for periods of less than 6 months are not recognised as primary carers. This can include carers of people with significant mental illness or other long-term health conditions, and carers providing end-of-life care (AIHW 2008). The exclusion of these informal carer groups can mean that detailed information about these groups is not collected and does not feed in to the development of related policy.

- In 2003, the SDAC estimated that there were 474,600 primary carers in Australia who assist people with a severe or profound level of disability in the areas of self-care, mobility and/or communication. However, the survey also estimated that there were 756,000 people with a severe or profound core activity limitation who had a 'main informal provider of assistance'. The discrepancy between these figures suggests that the definitions or protocols for identifying 'primary carers' may be overlooking some groups who may be providing significant levels of assistance to support people with disability. Additionally, not all potential primary carers identified through the SDAC had their primary carer status confirmed by interview (as per the survey protocol). Therefore, the estimates of the number of primary carers should be regarded as a minimum (AIHW 2008).
- The operational protocol of the SDAC does not allow carers aged under 15 years to be classified as primary carers, and potential primary carers aged 15–17 years were only interviewed if parental permission was provided. This potentially undercounts the number of young carers who are providing significant levels of care to another person.
- The sampling of carers in regional and remote areas was not adequate to produce robust estimates of carers in these areas. In particular, this means that this data source does not provide comprehensive data about Indigenous carers.

For the 2009 SDAC, the ABS implemented a number of changes to the SDAC protocols. These include changes to procedures for identifying carers (see Box 5.5), enhanced questions relating to unmet need and an increased sample size to enable a sufficient sample to explore data relating to groups of special interest (including those in remote areas).

Box 5.5: Changes in carer definitions for the 2009 ABS Survey of Disability Ageing and Carers

The SDAC definition of a carer remained unchanged in the 2009 survey, but the process of identifying primary carers changed. In the 2003 SDAC, potential primary carers within a household were identified by a responsible adult who provided all the initial data about people in the household. A personal interview was then sought with any person identified as a potential primary carer. These people were then asked to confirm that they were a primary carer, that is, they provide the most care to the care recipient. If they said they did not provide the most care, no further questions were asked about the caring role that person performed and no primary carer was identified for that care recipient. While the care recipient was asked a set of questions that included identifying the person who provided them with the most care, no attempt was made to interview that person.

In the 2009 SDAC, where a care recipient identifies a different person as the main carer and, assuming they are a resident of the household, an attempt was made to ask that person to confirm their primary carer status and then to ask them the carer questions. This will lead to a greater pool of primary carers identified and thus more accurate data about primary carers. Output for primary carers will be available for both the 2003 and 2009 identification of primary carers.

Source: Australian Bureau of Statistics.

The data that are available about carers and their care recipients through routine program-level data sets have also improved greatly in recent years. The implementation of the HACC minimum data set in January 2001 required routine reporting of basic information about clients (including carer availability), the functional status of the client (care recipient) and information about services provided to all clients assisted by the program. This provided the first opportunity to investigate dynamics between client need, carer availability and assistance provided in a large national support program. This was followed soon afterwards by an ongoing data collection in CSTDA disability support services (which replaced an annual snapshot collection) and the ACAP minimum data set in 2002 and 2003 respectively.

It should be noted that the quality of data reported through these data sets can be variable. In most cases, implementation of these data sets follows a pattern whereby data quality and reporting rates can be patchy in the initial reporting periods, but each subsequent year of collection shows an improvement in data reporting as agencies adapt their information systems to the data requirements. This is usually evident in rates of missing data for individual data items and participation rates among services. As a result, these minimum data sets are now considered reliable sources of data about clients, their carers and the services they receive, although there can still be gaps in the information reported. For example, HACC version 2 has introduced new items to enable standard reporting on client functioning to be reported. This comprises items that are self-reported by clients, information that is assessed by HACC workers, and an optional module of items relating to specific needs for assistance. Complete reporting of these items has been variable across jurisdictions, across services and across client types. Further information about reporting of these items is included in Section 3.6.

Data about clients of the CACP, EACH, EACHD and the NRCP programs have become available as a result of week-long census collections undertaken in these programs. To date, two census collections have been conducted—one in 2002 and another in 2008. These are important programs in terms of supporting people with disability, the frail aged and carers, and so it is important that information about clients of these programs is regularly available. At the very least, this would mean continuing regular census collections, but could also mean the implementation of ongoing routine data collections on all clients assisted. The advantage of ongoing data collections is that they enable a more complete picture of assistance to be provided for these clients (including information such as how long clients receive assistance under these programs), and would make it easier to compare data on clients and assistance provided across programs. They may also provide a better picture of flows between related programs.

Despite the availability of data from relevant programs, the data sets have remained fragmented to a large extent, in part because of inconsistency in the way in which carers are identified. The agreed definition of an 'informal carer' for use in national health and welfare data collections is 'any person, such as a family member, friend or neighbour who is giving regular, ongoing assistance to another person' (AIHW 2009). However, this definition may be implemented in different ways. For example, the current HACC MDS guidelines (DoHA 2006) suggest the care recipient is asked 'Do you have someone who helps look after you?', although the guidelines do suggest that the help provided should be regular and sustained. Given that these programs are largely relying on identification of carers by care recipients, service providers and/or carers themselves, there is likely to be some variation in identification both across and within programs.

There is also inconsistency in the terms used. Many of the community care data sets refer to carers as 'primary carers' because of their interest in characteristics of the main caregiver. But the definition is not always the same as the 'primary carer' definition as defined in the SDAC. The CSTDA minimum data set is the only data set that distinguishes between 'primary' and other carers in a manner that is conceptually equivalent to the SDAC.

The data collected by Centrelink for the purposes of administering Carer Allowance and Carer Payment benefits have evolved independently, and are designed to meet the administrative needs of these programs, much of which is based in legislation. While the data collected are obviously constrained by these administrative and legislative requirements, it would be valuable if, wherever possible, the data collected reflected common data standards in use across the other programs that assist carers.

The AIHW recently investigated the feasibility of establishing a national data repository for data about carers. The purpose of this repository would be to bring together data about carers (in some form), and improve access to the data to enable routine analysis of data from the carers' perspective (AIHW: Gilham et al. 2009). While it was concluded that the establishment of such a repository was not viable in the short term, it was agreed that there would be considerable value in supporting a program of regular data analysis about carers based on data in these existing data sets, and establishing a committee to oversee the development of data definitions that relate to carers. This could be an important step in ensuring that data standards in these disparate collections converge, and in promoting data quality in relation to data on carers.

5.7 Support for carers into the future

This chapter has provided information about carers in Australia—who they are, who they care for, the support they receive, and the costs they face in providing that care. While the focus of some of this discussion has been on describing the major programs that support carers, it should be borne in mind that although carers may receive benefits and assistance from government-funded programs, carers should be seen as net providers of assistance by enabling people with care needs to remain living in their homes.

In recognition of the significant advantages of home-based care to governments and to people with a disability or age-related frailty, and of the (sometimes very significant) costs associated with caring, there has been considerable policy interest in supporting carers and sustaining caring relationships. Specific interest in carers from a policy perspective began in the mid-1980s with recognition of the role of carers in caring for older Australians and others with care needs. Around this time, the first payments specifically for carers were made available (Howe 1994; CP(c)RT 2007) and, more recently, continuing interest in mitigating the effects of population ageing and other related social changes on the demand for, and supply of, informal carers and a focus on social inclusion have also focused attention on the extent of caring that occurs within families and close social networks, and the wellbeing of these carers.

Recent policy- and program-related developments relating to carers have included a parliamentary inquiry into better support for carers (HRSCFCHY 2009), a review of the eligibility criteria and effectiveness of Carer Payment (child) benefits (CP(c)RT 2007), the payment of an annual 'carer supplement' to Carer Allowance, Carer Payment and Department of Veterans' Affairs Carer Service pension recipients (FaHCSIA 2009b), the more prominent focus on carers in the National Disability Agreement (which replaces the

Commonwealth State/Territory Disability Agreement), and the inclusion of carers in the newly-established National People with Disabilities and Carers Council.

Many state and territory governments have also enacted ‘carer recognition’ Acts (HRSCFCHY 2009). These Acts have various aims, but broadly aim to formally recognise the role of carers, confirm the right of carers to be involved in decision making related to the services provided to the person for whom they care, and require the involvement of carers in the development of policies and programs that might affect carers. Other state and territory governments have opted to embed carer rights in existing antidiscrimination and other related legislation. Many have also implemented action plans or similar frameworks that demonstrate a focus on the needs of carers. Similar legislation to protect the rights of carers has been suggested at the national level, along with other initiatives such as a national ‘carers card’ or a ‘companion card’, which could entitle carers to concessions and verify the carer’s right to act on behalf of the person for whom they care (HRSCFCHY 2009).

Many challenges lie ahead for governments in supporting a range of measures to assist carers and to ensure that carers continue to be supported into the future. However, this chapter will conclude by looking at just one area related to the delivery of services that support carers, and poses the questions: ‘Do carers need more services?’ and ‘Do carers need a different approach to service delivery?’.

Do carers need more services?

This chapter has already presented data indicating that many carers access services that are designed to support them and the person for whom they care. These services include financial assistance, respite care and community care programs that help in practical ways. Because of limitations in the data, and particularly the inability to link data across programs, the data are not able to tell us how many individuals are accessing these programs and how many are receiving no support from formal services. Establishing the level of unmet need is complicated by the fact that many carers receive support from other informal carers, and not all carers need or want support.

Nevertheless, in 2003, the SDAC found that over half (53%) of all primary carers do not receive support (from formal or informal sources) in their role as a carer and nearly one-quarter of all primary carers (24%; 115,200 carers) want more assistance (including 71,500 carers who already receive some help from formal or informal sources but who want more help). Carers who care for a child with disability aged under 15 years were more likely than carers of people of older ages to report that they need (more) assistance as a carer; and carers who do not live with the person for whom they care were more likely than co-resident carers to report wanting more assistance. Among both of these groups, most carers who wanted further assistance were already receiving at least some assistance (ABS 2008).

The type of assistance that carers most wanted (or most wanted more of) was financial assistance (16% of primary carers most wanted more financial assistance to assist them in their role as a carer), followed by respite care (10%) (Table 5.13). Interestingly, fewer than half of all primary carers (42%) who provided information on unmet needs wanted an improvement in their circumstances or more support of some kind to assist their role as a carer. This appears to contradict, to some extent, the findings of other studies that have suggested that many carers are at ‘breaking point’ and have an urgent need for better access to support services. The Inquiry into Better Support for Carers, in particular, made a number of recommendations relating to the need for the improved availability of respite care, in-home assistance of the type offered by community care programs, skills training for carers, aids and equipment that support carers, health services and counselling for carers, and care coordination and case management to ensure that carers receive the most appropriate mix of services for their circumstances.

Table 5.13: Primary carers by type of additional support most wanted, 2003 (per cent)

	Years in caring role				
	Less than 5 years	5–9 years	10–24 years	25 years or more	Total[(a)]
Additional support or improvement that was most wanted by the carer					
Respite care	8.3	12.0	12.9	*8.8	10.4
Financial assistance	16.1	16.7	14.7	*23.5	16.0
Physical assistance	*2.7	*4.6	*3.2	**5.8	3.5
Emotional support	*4.5	*3.4	*5.8	**2.5	4.6
Improvement in own health	*5.8	*5.2	*3.6	**0.0	4.6
Other support	*1.9	*3.9	*2.4	**0.0	2.4
Total who wanted an improvement or more support	*39.3*	*45.7*	*42.6*	*40.6*	*41.5*
Does not need an improvement or more support	60.7	54.3	57.4	59.4	58.5
Total (per cent)	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**
Total ('000)	**167.5**	**113.8**	**119.3**	**25.8**	**434.9**

* estimate has a relative standard error of 25% to 50% and should be used with caution

** estimate has a relative standard error greater than 50% and is considered too unreliable for general use

(a) Includes carers for whom years in caring role was not reported.

Source: AIHW analysis of ABS 2003 Survey of Disability, Ageing and Carers confidentialised unit record file.

As noted in the discussion on respite care, there could be two main reasons for these discrepancies. The first is that, while many carers receive support from some source, some groups of carers miss out, have greater needs for assistance, or have 'special' needs such that existing services do not adequately meet these needs. Parental carers of disabled children have been identified as one group who are likely to have unmet needs, particularly for carers who are themselves ageing, have been caring for decades (and may as a result face financial hardship), who are managing the behaviour of an adult with disability and who are concerned about the future welfare of their offspring (Bigby 2004). These parental carers have been described as 'dealing with the past, present and future' (Ryan 2008:22).

Second, carers' stated preferences about wanting further support will be influenced by their previous experience of services. In particular, if existing services do not meet needs well, it may be that carers do not require more of these services but instead need services that provide support in different ways.

Do carers need a different approach to service delivery?

In addition to finding an overall shortage of services that support carers, the Inquiry into Better Support for Carers concluded that, in many cases, existing services fail to meet the needs of some carers because gaps in services can reduce the usefulness of the available services. For example, while parents of school-aged children with disability may appear to have capacity to enter the workforce while their child is at school, the lack of respite services or alternative care programs during school holidays greatly undermines their ability to commit to paid employment (HRSCFCHY 2009).

Similarly, in the area of respite care, many services are perceived to be largely emergency responses to crisis situations. Respite services that are available on a regular basis to a carer may be more acceptable to both the carer (in terms of being able to take on other commitments on an ongoing basis) and to the person for whom they care. The carer would therefore be better able to sustain the caregiving relationship (HRSCFCHY 2009).

The Inquiry into Better Support for Carers also found evidence that access to carer support services is made difficult by the uncoordinated nature of the services (HRSCFCHY 2009). Therefore, accessing services frequently requires multiple assessments (often requiring assessment by medical professionals, which can entail considerable expense for carers), reviews and negotiations with a myriad of services. An active liaison point to coordinate services that are provided to the person with care needs as well as services provided to the carer has been proposed for those who require such assistance (AIHW 2008).

However, changes in approaches to service delivery alone will not overcome the potential problems associated with the expected shortage of carers that will occur as population ageing continues. In this context, it is likely that some fundamental changes are required in the way that Australians identify carers. In particular, it may be necessary to promote a more 'shared' approach within families and existing care networks to the provision of care for people with disability and the frail aged. In 2003, at least half (55%) of all primary carers had a fallback carer who could take their place when required—the remainder either did not have a fall-back carer (35%) or did not know if they had a fall-back carer (10%) (ABS 2008).

Shared approaches could also extend to care shared between formal and informal care networks. This would require services to build ongoing relationships with clients (as does happen within some service types), and to recognise the carer's role and needs associated with the care they provide to the care recipient.

While there is evidence that many people with disability receive help from more than one carer (see, for example, AIHW 2008), at present, shared approaches to caring may be disadvantaged by existing support services that often recognise only one main carer. Within existing services, eligibility for assistance is often based on the level of care provided by an individual over a period of time, and therefore provides disincentives for caring responsibilities to be shared to any significant extent with others. This has been identified as a particular issue in terms of assessment for eligibility for financial payments (CP(c)RT 2007; HRSCFCHY 2009).

Shared approaches to caring, in particular, could greatly benefit women who comprise the bulk of the carer population, frequently combine caring responsibilities with parenting and paid employment, and who may need to combine these roles more frequently in the future. Shared responsibility for caring would spread the burden of caring over a wider network, while still enabling all carers to continue to fulfil other life roles. Finding ways to help carers balance caring responsibilities and other roles may make the caregiving relationship more sustainable by enabling the carer to gain satisfaction from other aspects of life in addition to the satisfaction gained from caregiving.

To some extent, fulfilment of multiple roles (including that of an informal carer to a person with disability or age-related frailty) can be protective for carers. One investigation of female carers who cared for an ageing parent found that, while women who also cared for dependent children or worked had high levels of exhaustion, carers who were also raising children reported better psychological wellbeing than those without, and those with partners or who worked were more satisfied with their lives. Resentment about caring responsibilities was highest for those with fewer roles (outside their caring role) and especially those who had left the workforce because of their caring responsibilities. Those who worked but had experienced some conflict between their work role and their caring role also reported being significantly more exhausted or overloaded than those who did not work or did not experience such conflict in their work (Murphy et al. 1997). This suggests that caring can be satisfying, as long as it not the carer's only role, and as long as the carer is supported to provide this care.

Formal recognition of shared-caring responsibilities could also benefit Indigenous carers, as care within Indigenous communities is often shared within kinship networks. Under current arrangements, many of these carers do not qualify for financial benefits and other assistance based on their individual caring responsibilities, even though the person being cared for may have high-level care needs (CP(c)RT 2007).

Inevitably the development of services and policies relating to carers are inextricably linked with service and policy development that support people with disability and the aged. In that arena, suggested approaches to service funding, including the introduction of 'individualised funding models' (perhaps associated with a national disability insurance scheme) could provide benefits to some carers. Under models such as these, funds would be allocated to, or on behalf of, the person with care needs based on their level of need. Individualised funding would offer greater flexibility to people with disability and their families to manage caring responsibilities in the way that best suits them (HRSCFCHY 2009), and create a market for services that are valued by carers and the person for whom they care. Self-managed funds would also enable caring responsibilities to be shared between multiple carers, if appropriate.

It remains to be seen whether the 'crisis' in the supply of informal carers will eventuate, or whether carers in the future will be able to successfully combine caring responsibilities with other responsibilities (including employment). As has been seen, many carers do this already, but the costs may be high. Support services for carers in the future are likely to need to be more accessible, more effective in supporting carers by reducing the gaps in services, better coordinated, and to recognise shared-caring networks. Governments clearly play a role in providing services that support carers, but will also need to continue to play a significant role in influencing other domains that can make life easier for carers—measures that improve recognition of the role of informal carers and create a climate that promotes flexible workplaces that can accommodate the needs of those with caring responsibilities.

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Housing and housing assistance

6

Key points

- Key affordability challenges have focused the debate on the drivers of housing supply and demand, in which current housing demand exceeds supply.
- The supply and demand of housing may be influenced by government policies, building industry operations and other economic factors.
- The supply of social housing, in particular, has not kept up with demand while the continuing decline in affordability in the private rental market may further increase the demand for social housing.
- The largest ever single investment in social housing by an Australian government, and a new national housing agreement, will bring about significant changes over the coming years in the supply and delivery of housing assistance.
- Government assistance to encourage stability and security of tenure is targeted to home purchasers and low-income households in the private rental market.

6.1 Introduction

Housing plays a major role in the health and wellbeing of Australians and provides the security that allows people to participate in the social, economic and community aspects of their lives. The availability of affordable and appropriate housing also plays a significant role in addressing homelessness.

The rising cost of housing remains a significant issue that is heightened by an undersupply of affordable and appropriate housing and an increased demand for housing assistance. The past 2 years have seen the Australian Government and state and territory governments increase their commitments to providing affordable housing options for all Australians with significant changes in housing policy and initiatives in the delivery of housing assistance.

This chapter discusses:

- the current housing situation and policy environment in Australia
- current and emerging drivers of housing demand and supply
- the role that housing assistance programs play in addressing demand and supply issues, particularly in the context of the recent policy shift away from the highly targeted Commonwealth State Housing Agreement (CSHA) to the broader National Affordable Housing Agreement (NAHA)
- current and planned housing assistance programs, including details of those who are assisted and the effects and outcomes of this assistance.

The role of housing

A home for most Australians is a dwelling that provides shelter, safety, security and privacy. It is widely acknowledged that affordable, secure and appropriate housing is also essential for good health, education, employment and community safety outcomes, and that achievement of these outcomes contributes to people's ability to participate actively in their communities (Australian Government 2008c). In addition, dwellings and the neighbourhoods in which they exist influence the quality of the social environment, contributing to the wellbeing of society (ABS 2001). Housing, therefore, plays a major role in the living standards, health and wellbeing of Australians (AIHW 2008a). The absence of affordable, secure and appropriate housing can result in a number of negative consequences, including homelessness, poor health, and lower rates of employment and education participation, all of which can lead to social exclusion.

Housing is an important component in the national economy in terms of investment levels, building activity and employment (ABS 2007c). Dwellings are a major source of Australian wealth, accounting for two-thirds of net private sector wealth (Department of Treasury 2008a). Housing is also the major source of household debt, making up 87% of all household debt in December 2008 (Reserve Bank of Australia 2009). The tax system supports home ownership in Australia through capital gains tax exemptions on owner-occupied properties and negative gearing on investment property. These are considered in the Henry taxation review, amongst a range of taxation issues affecting the property market and the broader economy.

Why housing assistance is important

Housing assistance is a vital social safety net for various population groups (ABS 2008c). Those excluded from full participation in society have particular difficulty in securing appropriate and affordable housing due to their financial status, poor housing record or need for additional support. Within these groups there are often multiple factors of disadvantage, including combinations of various forms of disability, mental illness, poor health, substance dependency, and antisocial or behavioural issues (AIHW 2007a).

Housing assistance has become increasingly important due to the recent growing pressures on households, particularly those with low incomes. These pressures include a decline in housing affordability, increased living expenses and changes in the labour market.

Housing assistance is targeted to low-income households to both secure and maintain home ownership, and help establish and maintain their tenancies in the private rental market. Assistance is also available to those experiencing homelessness and can provide for emergency, short-term, medium-term and long-term housing needs (Box 6.1).

What is social housing?

'Social housing' is a fundamental component of housing assistance and encompasses all rental housing owned or managed by the government or a not-for-profit community organisation and let to eligible households. It includes public rental housing, state owned and managed Indigenous housing (SOMIH), community housing, Indigenous community housing and crisis accommodation. Social housing provides an affordable alternative to private rental and is targeted to low-income households that are unable to afford private market rents or secure private rental accommodation. Assistance is also provided to people in situations of actual or impending crisis or homelessness.

Box 6.1: Housing assistance programs

Assistance for renters

Public rental housing[1] is targeted to people on low incomes and people with special needs. Eligibility is determined by multi-faceted criteria designed to identify those most in need. State and territory governments provide and administer the dwellings.

State owned and managed Indigenous housing[1] is targeted to Indigenous people on low incomes and, like public rental housing, is provided and administered by state and territory governments.

Community housing[1] is targeted to low-income and special needs households managed by not-for-profit organisations such as local governments, and religious and charity groups. Supported housing options with links to other services including aged, disability and health services are available to those with special needs.

Indigenous community housing[2] is targeted to Indigenous people on low incomes and is managed by not-for-profit organisations.

Private rent assistance[1] is financial assistance provided by state and territory governments in the form of rental subsidies, bond loans and other assistance to low-income households experiencing financial difficulty in securing and maintaining tenancies in the private rental market.

Commonwealth Rent Assistance is a non-taxable income support supplement paid by the Australian Government to income support recipients or people who receive more than the base rate of the Family Tax Benefit Part A and who are renting in the private rental market (including community housing). See also Box 6.8.

Assistance for home purchasers

Home purchase assistance[1] is provided by state and territory governments to low income households to help with home purchase via direct lending and deposit assistance, mortgage relief and provision of advisory and counselling services.

First home owner schemes: The First Home Owner Grant is a national scheme administered by the states and territories but funded by the Australian Government, which offers a one-off grant of $7,000 to first home buyers regardless of their income.

The First Home Owners Boost was introduced in mid-October 2008. It offered an additional $7,000 to those receiving the First Home Owner Grant for established homes and an additional $14,000 to those building or purchasing a newly constructed home between 14 October 2008 and 30 June 2009. The First Home Owner Boost halved on October 1 2009 and will cease after 31 December 2009.

Assistance for homeless persons and those in crisis

The Crisis Accommodation Program[1] provides accommodation to help people who are homeless or in crisis. Support services are generally provided by non-government organisations and many are linked to those funded through the Supported Accommodation Assistance Program.

The Supported Accommodation Assistance Program[1] provides transitional supported accommodation and related support services to help homeless people achieve the maximum possible degree of self-reliance and independence.

1 Funded though the CSHA to 31 December 2008, thereafter through the NAHA.

2 Previously funded through the Community Housing Infrastructure Program and the Australian Remote Indigenous Accommodation program, and from 1 January 2009 funded under the National Partnership Agreement for remote Indigenous housing.

6.2 Housing in Australia

Today's housing

In 2006 there were approximately 7.6 million households living in private dwellings (normally a separate house, flat or bedsitter) in Australia. The majority of these households owned their own home with or without a mortgage (4.9 million or 68%) and a further 2 million were renting either private rental (23%) or social housing dwellings (5%) (Table A6.1) (ABS 2006).

The tenure of households varies across household composition, income categories and the life course. In 2005–06, over three-quarters (78%) of households were either couples with dependent children, couples only or lone-person households. Of those home owners with a mortgage, the most common family type was couple families with dependent children

(46%). Of those who own their home outright, couple-only households were the most common household type (38%). Households residing in social housing dwellings were more likely to be lone-person households (41%) or single-parent families with dependent children (22%). Those renting from a private landlord were predominantly lone-person households (31%) (Table A6.2).

Across household incomes, outright home ownership declined as income rose, while the number of home owners with a mortgage increased as income increased (Table 6.1). Although this may appear to be counterintuitive, it is largely explained by life course stages: as people enter old age they are more likely to have achieved home ownership, but their income is usually less than in peak working years. The proportion of households renting privately was consistent across the income levels varying between 21% and 26%. By contrast public rental housing was higher in lower income households (13% of the lowest quintile), largely because public rental housing is targeted to lower income households (Table 6.1) (ABS 2007c; AIHW 2008a).

Table 6.1: Income quintiles of households by tenure, 2006 (per cent)

Tenure and landlord type	1 (lowest)	2	3	4	5 (highest)	All households
Owner without a mortgage	47.6	39.9	28.6	24.6	26.7	34.3
Owner with a mortgage	13.8	27.6	41.9	47.3	50.3	35.0
State/territory housing authority	13.2	4.5	1.5	1.0	0.4	4.7
Renter with private landlord[(a)]	22.1	25.4	26.1	25.5	21.2	23.9
Other tenure type[(b)]	3.3	2.5	1.9	1.6	1.4	2.2
All households	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**

(a) Includes other landlord type: where the household pays rent to the owner/manager of a caravan park, an employer (including a government authority), a housing cooperative, a community or church group (i.e. community housing), or any other body not included elsewhere.

(b) Includes a household that is not an owner (with or without a mortgage) or a renter. Includes rent-free, life tenure, rent/buy and shared equity schemes.

Source: ABS 2007c.

The tenure of a household can be linked to life course stages, following a pattern of renting in early adulthood, moving to home purchase and mortgages as incomes rise and many form partnerships and families, and owning the home outright in older age. In 2005–06 only 3% of lone-person and couple-only households with the reference person aged under 35 years owned their home outright, compared with 74% of lone persons and 86% of couples with the reference person aged 65 years or over. Younger persons in a couple relationship were more likely to move into home ownership than younger single people, with 49% of younger couple households owning their home with or without a mortgage, compared with only 32% of younger singles. Likewise, when couples have children they are more likely than younger couple-only households to own their home (ABS 2007c).

In 2006, Indigenous households were more likely to be renting their home (63% compared with 28% of other households), than owning their home with or without a mortgage (36% compared with 71% of other households) (ABS 2008b).

The tenures of Indigenous Australians follow somewhat different patterns, with the major influences identified in urban areas as:

- long-term poverty, limiting tenure options essentially to social housing
- family and neighbourhood violence, narrowing the individual's focus to dealing only with crises and day-to-day necessities, leaving rent and bills unpaid
- conflict between Indigenous people and social housing providers related to housing accessibility and provider management practices (AHURI 2008).

According to the 2006 Census of Population and Housing, 67% of dwellings were in *Major cities*, 21% were in *Inner regional* areas, 10% in *Outer regional* areas and 3% in *Remote and very remote* areas. Tenure type varied by region, with the proportion of outright home ownership highest in *Inner regional* and *Outer regional* areas (39% in each area) and lowest in Very remote areas (31%). Conversely, a greater proportion of dwellings were rented in *Remote* and *Very remote* areas (39% and 56% respectively) (Table A6.3) (AIHW 2008a).

At 30 June 2008 households renting social housing dwellings largely lived in *Major cities* (67%). Larger proportions of those households in targeted Indigenous housing programs (SOMIH and Indigenous community housing) were living in *Regional and remote* areas, with 49% of SOMIH households in *Inner and outer regional* areas and 68% of Indigenous community housing households in *Remote and very remote* areas of Australia (Table A6.4).

Changes in housing

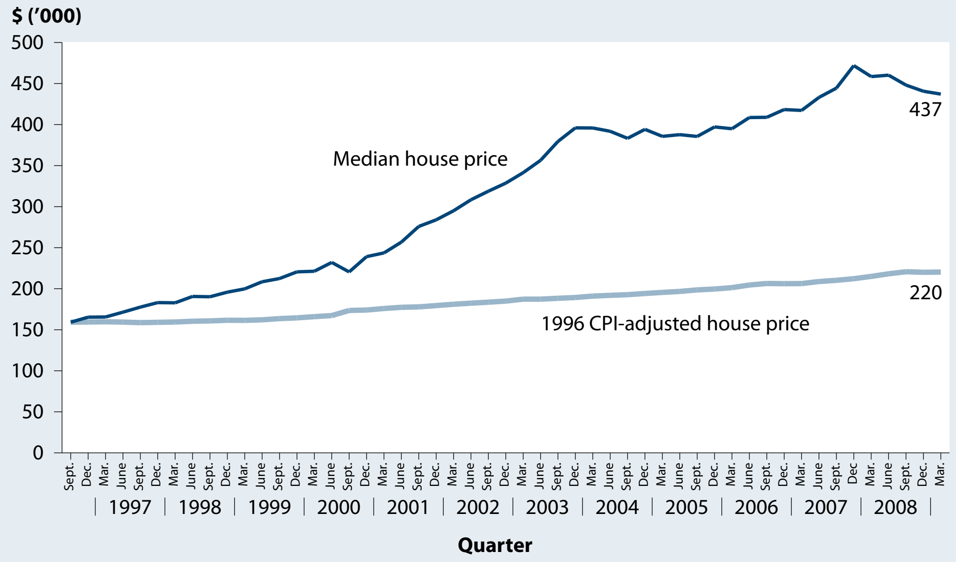
While the number of households continues to increase, from 5.3 million in 1986 to 7.6 million households in 2006, household size has decreased, with the average number of people per household falling from 2.8 in 1986 to 2.6 in 2006 (ABS 1988b, 2006, 2009f). Despite this decrease in household size, the size of dwellings has increased, with the proportion of dwellings with four or more bedrooms increasing from 15% in 1986 to 28% in 2006 (ABS 2009f). Indigenous households are larger than other households, with an average of 4.5 persons per household in 1986 and 3.3 persons per household in 2006 (ABS 1988a; ABS & AIHW 2008).

The composition of households saw a number of changes over the period from 1986 to 2006. Lone-person households and group households increased from 23% in 1986 to 28% in 2006, whereas households of couples with children under the age of 15 years have decreased from 31% to 22% (Table A6.5) (ABS 2009f).

Although the rate of home ownership has remained relatively stable over the years, the proportion of those who owned their home outright fell from 38% in 1986 to 35% in 2006 (ABS 1988b, 2009f). The proportion of those renting has remained at around 29% since 1986, with small changes in the proportions as a result of tenure classification changes from 1996 onwards (ABS 2009f).

Affordability of housing

The cost of buying a home has risen at a considerably faster rate than general price inflation. At March 2009, the weighted average median house price[1] was $437,121, almost twice the price if median house prices only increased in line with consumer price index (CPI) since 1996. Figure 6.1 illustrates the acceleration of house prices, particularly in the past decade.



Sources: ABS 2009d: tables 1 and 2; REIA Real Estate Market Facts.

Figure 6.1: Median house price versus 1996 CPI-adjusted median house price, September 1996 to March 2009

High demand for rental properties resulted in median rents continuing to rise as vacancy rates remain at record lows in most capital cities around Australia (REIA 2009c). The average of the eight capital cities' median rental costs has increased well above the CPI. At March 2009, the Australian weighted average median rent was $337 per week for a three-bedroom home, almost $100 per week more than if the average median rent increased only in line with CPI since 1996 (Figure 6.2).

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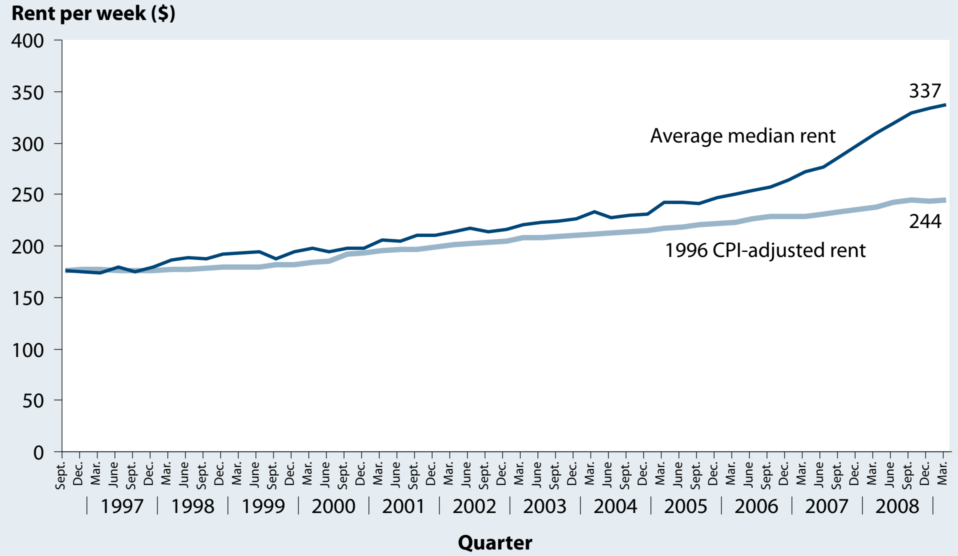
[1] Weighted average median house prices are derived from quarterly median prices from all capital cities, which are weighted according to the number of dwellings in each corresponding city. These dwelling numbers are sourced from the Australian Bureau of Statistics' 2006 Census (REIA 2009b, d).



Notes

1. Rental bonds data are used to determine median rents.
2. Includes private renters and renters in community housing.

Sources: ABS 2009d: tables 1 and 2; REIA Real Estate Market Facts.

Figure 6.2: Average median weekly rent for a three-bedroom house, September 1996 to March 2009

Over the 12-month period since March 2008, the median weekly family income increased by 6.2%. Over the same period, the average monthly home loan repayment decreased by 19.7% to $1,662, due to numerous cuts to interest rates (REIA 2009c). The proportion of family income required to meet average loan repayments fluctuated during 2008, peaking in the June quarter 2008 at 39.5% and dropping to 32.4% in the December 2008 quarter.[2] During the March 2009 quarter the proportion of family income required to meet average loan repayments dropped a further 3.8 percentage points to 28.6%. This compares to 37.8% in March 2008 (Figure 6.3) (REIA 2008a, 2009b, c).

Despite the recent improvement in affordability for home owners, the proportion of median weekly family income required to meet Australian weighted median rents in the private market continued to rise during 2008. At the March 2009 quarter the proportion of median weekly family income required to meet Australian weighted median rents[3] decreased by 0.2 percentage points to 25.1%. This compares with 24.7% in March 2008 (Figure 6.3) (REIA 2009c).

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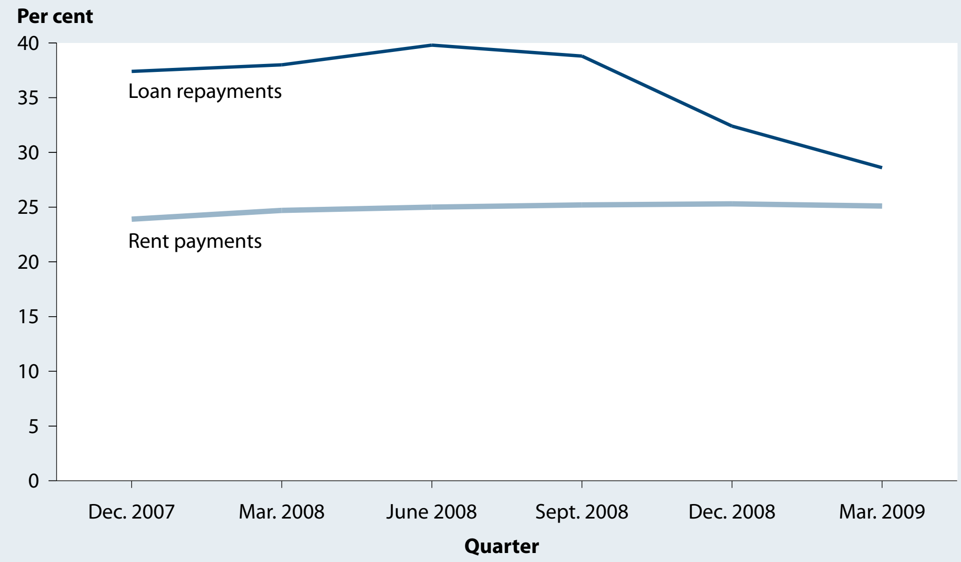
[2] The proportion of family income required to meet average loan repayments is calculated by dividing the average loan repayment by the median family income.

Average loan repayment: loan repayment figures are calculated from data provided by the ABS, Cannex Pollfax and financial institutions across Australia (REIA 2009b).

Median family income: a family is defined as a married couple with or without dependent children. The major part of family income is adult wages and salaries. Income data are sourced from ABS records and updated on the basis of movements in average weekly earnings.

[3] Rental affordability is expressed as the proportion of medial weekly family income required to meet weekly rent. The Australian weighted median rent for three bedroom houses is calculated using Census data, and median rents published in the Mortgage Choice–REIA publication, Real estate market facts (REIA 2009b).



Notes

1. Rental bonds data are used to determine rent payments.
2. Includes private renters and renters in community housing.
3. Excludes households who do not require a loan to purchase a property.

Sources: REIA 2008b, 2009b, c.

Figure 6.3: Proportion of family income needed to meet loan and rent payments, December 2007 to March 2009

Low-income earners are particularly vulnerable in an environment where rental and home loan affordability are deteriorating and the provision of social housing is one way of improving the situation. Both public rental housing and SOMIH, a component of social housing, provide affordable housing to low-income households through reduced rents. The difference between the rent paid and the full market rent of the dwelling is called the 'rebate amount'. This capping of a tenant's housing costs assists the household by allowing a greater level of spending on other goods and services, and is particularly important to low-income households (Bridge C et al. 2003).

In 2007–08, 88% of public rental households and 83% of SOMIH households paid an amount less than the market rent. Public rental households were paying a median of $73 per week in rent, and SOMIH households paying $96 per week. If those households were renting an equivalent house privately, public renters would have paid on average an extra $109 a week and SOMIH households an extra $112, not taking into account the possible receipt of Commonwealth Rent Assistance (CRA) (AIHW 2009g, h).

Australian governments have recently agreed on a range of initiatives to tackle the need for more affordable housing, including an increase in the number of social housing dwellings. Details of these initiatives are provided in the next section.

6.3 Housing policy and funding

There have recently been significant changes in housing policy and the delivery of housing assistance, particularly with the increased commitment to providing affordable housing options for all Australians.

Housing assistance in Australia is provided through a variety of programs funded through the NAHA and associated National Partnership Payments (social housing, remote Indigenous housing and homelessness), the First Home Owner Grant, CRA, and various state and territory specific programs. In addition, Reconnect and the Household Organisational Management Expenses advice programs help people who are homeless or at risk of homelessness by providing transitional supported accommodation and related support services.

Under the Intergovernmental Agreement of Federal Financial Relations, the NAHA replaced the CSHA on 1 January 2009 and will provide $6.2 billion over 5 years as well as over $3 billion in associated National Partnership Payments. In addition, in February 2009 the Australian Government announced a further investment of $6.4 billion from 2008–09 to 2011–12 for the construction of around 20,000 social housing units, and repairs and maintenance to around 47,000 existing social housing dwellings as part of the Nation Building—Economic Stimulus Plan (FaHCSIA 2009d). The objectives and reform and policy directions of the NAHA are detailed in Box 6.2.

The Australian Government has initiated a range of policies to improve housing affordability which will also contribute to the objectives of the NAHA, including:

- the National Rental Affordability Scheme
- the First Home Saver Accounts
- the National Housing Supply Council
- the Housing Affordability Fund
- an audit of surplus Commonwealth land that can be made available for new housing (FaHCSIA 2008e)
- a revamp of the Commonwealth Property Disposals Policy (Department of Finance and Deregulation 2009).

Further information about these initiatives is provided in Box 6.3.

Box 6.2: National Affordable Housing Agreement

The NAHA is an agreement between the Commonwealth of Australia and the states and territories effective from 1 January 2009. The objective of the NAHA is 'that all Australians have access to affordable, safe and sustainable housing that contributes to social and economic participation'.

Priority areas for reform identified in the NAHA are:

- improving integration between the homelessness service system and mainstream services
- setting up joint action and a national coordinated approach on homelessness
- creating mixed communities that promote social and economic opportunities by reducing concentrations of disadvantage that exist in some social housing estates
- improving access by Indigenous people to mainstream housing, including home ownership
- contributing to the achievement of Closing the Gap housing targets (Australian Government 2008b)
- establishing a nationally consistent approach to social housing to create a more transparent, accountable and efficient sector, including common costing and financial management reporting, practices and methodologies
- providing compulsory rent deductions and improved information exchange between the Commonwealth and the states and territories to improve the operational efficiency of public housing and to reduce evictions from public housing
- creating incentives for public housing tenants to take up employment opportunities within the broader employment framework
- enhancing the capacity and growth of the not-for-profit housing sector, supported by a nationally consistent provider and regulatory framework
- planning reform for greater efficiency in the supply of housing
- improving supply of land for new dwellings identified through audits of Commonwealth, state and territory surplus land
- increasing capacity to match new housing supply with underlying demand, including work undertaken by the National Housing Supply Council (COAG 2008).

Under the Intergovernmental Agreement of Federal Financial Relations there are also three national partnership agreements—social housing, homelessness and remote Indigenous housing—that will focus on increasing the supply of social housing, reforming the provision and supply of housing for Indigenous people in remote communities, and introducing reforms to reduce homelessness.

Box 6.3: Housing initiatives

National Rental Affordability Scheme: the scheme offers tax incentives to providers of affordable housing to build new rental homes for rent to low- and moderate-income households at 20% below market rates. The scheme is designed to increase the supply of affordable rentals by up to 50,000 dwellings by 2012. Up to 1.5 million households will be eligible to be tenants under the scheme (FaHCSIA 2008c).

First Home Saver Accounts: these Accounts help people saving for their first home through a combination of Australian Government contributions and preferential taxation. Those planning on buying their first home in 4 or more years time may be eligible to receive a 17% government contribution on the first $5,000 worth of savings in a financial year while paying a reduced (15%) tax rate on interest or earnings. First Home Saver Accounts have been offered by various banks, credit unions and building societies since 1 October 2008 (Department of Treasury 2008b).

National Housing Supply Council: the council will help the Government to assess current and future demand for housing across Australia and will publish an annual 'state of supply' report to analyse the adequacy of construction rates and land supply to meet demand and improve housing affordability for the next 20 years (FaHCSIA 2008d).

Housing Affordability Fund: the fund will invest up to $512 million over 5 years to lower the cost of building new homes. The fund's focus is on proposals that improve the supply of new housing and make housing more affordable for home buyers entering the market. It will reduce two significant barriers to the supply of housing:

- the holding costs incurred by developers as a result of long planning and approval waiting times
- infrastructure costs, such as water, sewerage, transport, and open space (FaHCSIA 2008b).

Commonwealth Property Disposals Policy: the guidelines for the release of surplus Commonwealth land have been revised and under the revamped policy Australian Government agencies are required to justify their land holdings annually, through the **Commonwealth land audit**. Surplus land assessed as suitable for housing and/or community use through the land audit will be disposed of under a site-specific strategy to optimise the Government's commitments to increasing housing supply without adversely affecting surrounding property prices, improve community amenity and create jobs (Department of Finance and Deregulation 2009).

Indigenous housing

The Australian Government has committed $1.2 billion over 5 years to help close the gap between Indigenous and non-Indigenous Australians. The Council of Australian Governments (COAG) has identified the following priority areas to remedy the current state of disadvantage:

- healthy homes
- safe communities
- health
- early childhood
- schooling
- economic participation
- governance and leadership.

The healthy homes priority area recognises 'a healthy home as a fundamental precondition of a healthy population…' (Australian Government 2008b, c). In line with this the Northern Territory Government has committed to improving housing standards to help close the gap on Indigenous disadvantage through the New Remote Housing System. The key elements of this new system are detailed in Box 6.4.

Box 6.4: New Remote Housing System in the Northern Territory

Under the partnership between the Northern Territory Government and the Australian Government, remote housing in the Northern Territory is being comprehensively evaluated and improved through four key strategies:

- increased construction investment through a capital works program that aims to deliver new houses, replace houses to be demolished, refurbish houses, improve infrastructure to support new houses and improve living conditions in town camps
- introduction of an improved housing management system
- appropriate land tenure agreements
- transfer of responsibility for the delivery of municipal and essential services to the Northern Territory Government (FaHCSIA 2009c).

Previous housing funding

The purpose of the CSHA was to provide funding for appropriate, affordable and secure housing assistance for those who most need it, for the duration of their need. Six housing assistance program areas operated under the CSHA:

- public rental housing
- Aboriginal Rental Housing Program (also referred to as SOMIH)
- community housing
- home purchase assistance
- private rent assistance
- the Crisis Accommodation Program (refer to Box 6.1 for details).

From 1 July 2007 to 31 December 2008, governments provided over $2 billion for housing assistance under the CSHA, of which the greatest proportion went to public rental housing (a component of the base funding grants) (Table 6.2).

Table 6.2: CSHA funding, 1 July 2003 to 31 December 2008 ($ million)

Funding arrangement	2003–04	2004–05	2005–06	2006–07	2007–08	1 July–31 Dec 2008
Base funding grants[(a)]	725.2	733.8	743.9	752.5	765.2	388.3
Aboriginal Rental Housing Program	100.7	102.1	93.3	94.4	96.0	48.7
Crisis Accommodation Program	39.7	40.1	40.7	41.2	41.8	21.2
Community Housing Program	64.0	64.7	65.6	66.4	67.5	34.3
State matching grants	355.0	359.2	364.1	368.4	374.6	190.0
Total	**1,284.5**	**1,299.9**	**1,307.6**	**1,323.0**	**1,345.2**	**682.5**

(a) Includes public rental housing, home purchase assistance and private rental assistance programs.

Sources: SCRGSP 2006, 2007, 2009.

The Australian Government funded some services for Indigenous community housing directly with Community Housing Infrastructure Program (CHIP) funds and other services with the states through pooled CHIP and CSHA funds. Over $1.1 billion in CHIP funding was provided over the 4 years to 30 June 2008, with $365.3 million provided in 2007–08, nearly a 50% increase on the $249 million provided in 2004–05 (FaHCSIA 2005, 2006, 2007, 2008a).

6.4 Drivers of housing demand

Housing demand is the total quantity of housing stock required to house all households and is driven by the needs and economic capacity of households, influenced by housing transitions, as well as by changes in population growth. It encompasses those people who have the capacity to meet their own housing needs, as well as those who do not.

Analysis by the National Housing Supply Council estimated the current demand for dwellings in Australia in 2008 at 8.3 million households (FaHCSIA 2009a).

Potential housing demand

There are a number of factors that influence the potential demand for housing, including both population growth and changes in demographic processes, in particular, household formation (ABS 2001).

The number of dwellings required nationally will grow more rapidly than the total population if the average number of people per household continues to fall. Based on Australian Bureau of Statistics' projections of growth of households, families and the population between 2001 and 2026, the number of households is expected to increase by 42% and the number of families by 31%, compared with population growth of 25% (AIHW 2007a).

Population growth can be measured by examining levels of international and internal migration, and trends in fertility and mortality. For particular areas, understanding what influences the movement of people from one area to another helps in assessing housing demand (ABS 2001). Each year Australia's population increases as a result of both natural increase (that is, births) and net overseas migration. Net overseas migration is more unpredictable than natural increase and in recent years has accounted for around half of the population growth at the national level (ABS 2008a).

In the 10 years to the end of 2008, Australia's population increased by 1.4% a year on average, with just under half of this growth resulting from natural increase and just over half from net overseas migration. In the last 3 years, Australia's population has grown by 1.8% a year on average, with net overseas migration contributing more to population growth than natural increases (58%, 59% and 62% respectively) (ABS 2009a:Tables 1 and 4).

All states and territories experienced positive population growth each year during the 10 years to the end of 2008 (with the exception of Tasmania in 1999 and 2000). During this period net overseas migration made a positive contribution to the populations of all states and territories, whereas net interstate migration was a major source of population loss for New South Wales and South Australia. Queensland consistently recorded the largest net population gain due to net interstate migration (ABS 2009a:Table 2).

The National Housing Supply Council's report presents projections of demand over the 20-year period from 2008 to 2028 based on estimates of the formation of different household types, using assumptions relating to migration and household transition. The council estimates that the net number of new dwellings required for Australia would be just over 3 million over 20 years. Demand was projected under a medium household growth scenario, which was considered to be the most likely scenario in the short term. This equates to 153,000 dwellings per year, corresponding to an increase in the number of households from 8.3 million in 2008 to 11.4 million in 2028 (FaHCSIA 2009a).

Movements of households through the housing market

Research by the Australian Housing and Urban Research Institute indicates that in recent years housing careers have diversified and as a result demand for housing may also be influenced by:

- changing household composition as a result of declining marriage and fertility rates, and dissolution of households as a result of divorce and separation
- the ageing population, the prevalence of disability and the associated increase in life expectancy
- movements in the housing market
- changing workforce and lifestyle patterns
- continued impediments to entry into home ownership, including Higher Education Contribution Scheme debts and the affordability of home loan repayments (AHURI 2009, REIA 2009a).

These factors may result in the tenures of households following somewhat different patterns from what has been seen in the past, and 'housing careers' may be better described as 'housing transitions', reflecting 'the movement of individuals and households through the housing market over time and across the life course…' (AHURI 2009:51).

Research also offers an alternative way of viewing housing transitions by focusing on housing decisions at any point in time, and suggests that 'housing decisions, and the ability to realise preferences within the housing system, reflect five dimensions:

- a lifecycle dimension
- a position within the labour market and economic resources dimension
- a health, disability and wellbeing dimension
- a tenure dimension
- a lifestyle values and aspirations dimension' (AHURI 2009:47).

Each dimension can influence housing decisions at any point and housing decisions can reflect the relative balance of the dimensions. For example, early in the life-cycle, demographic factors, such as marriage and the birth of a child, may be an important influence on housing decisions, but position in the labour market and the type and quality of housing will be important also. In mid-life, demographic factors may have relatively little influence, but tenure may have greater influence (AHURI 2009).

Future housing demand is influenced by many factors

A number of other factors have the potential to influence future housing demand. However, they are difficult to quantify and predict as no factor operates in isolation. In addition to the factors that influence demand for housing discussed previously, other factors include changes in:

- government policy, for example changes in taxation policy, or new housing policies or programs
- the economic environment, for example, interest rates, finance availability, house prices, rental affordability, investor sentiment, unemployment rates
- housing aspirations, for example demand for housing types and locations, demand for upgrading and downsizing.

Assessing the current need for housing assistance

To assess current levels of need for housing assistance, one way is to estimate the number of households whose capacity to access secure, affordable and adequate housing is compromised as a result of:

- homelessness
- living in overcrowded conditions
- low income and high housing costs (that is, extreme financial housing stress)
- poorly maintained housing.

These circumstances reflect unmet need for housing assistance. Details of how these estimates are measured are provided in Box 6.5.

Box 6.5: Measuring current levels of need

Homelessness: The estimates of homelessness include those households with no conventional accommodation, those living with friends or relatives on a temporary basis and those in Supported Accommodation Assistance Program accommodation (that is, primary and secondary homelessness).

Affordability: Housing affordability can be measured in terms of financial housing stress. The agreed measure under the NAHA is those households (in the lowest two quintiles) paying more than 30% of their income in mortgage or rent payments. However, for the purposes of estimating those in extreme financial housing stress the measure used is the number of income support recipients and low- income families in the private rental market in receipt of CRA paying more than 50% of their income in rent payments.

Overcrowding: To measure levels of overcrowding, the definition that is used is 'households that are renting and require two or more bedrooms to meet the Canadian National Occupancy Standard'. This standard assesses the bedroom requirements of a household based on the number, age, sex and relationships of household members.

Condition of existing housing stock: 'Dwelling condition' refers to the assessment of housing stock based on certain elements. One approach is to collect information on the condition of dwellings according to the extent of repairs required. This approach was used in the 2006 Australian Bureau of Statistics' Community Housing and Infrastructure Needs Survey, where the condition of permanent dwellings was categorised according to the cost of repairs and broken into three groups: minor or no repair, major repair and replacement.

Whose needs are unmet?

In 2006, over 83,000 people were homeless, that is, had no conventional accommodation, were living with friends or relatives or were in accommodation provided through the Supported Accommodation Assistance Program; nearly 40,000 households were living in overcrowded conditions; and nearly 84,000 income units were in extreme financial housing stress (Table 6.3).

Table 6.3: Estimated need for housing assistance, 2006

	Indigenous	Non-Indigenous	Total
Homeless people	8,277	74,803	**83,080**
Total population	517,200	20,701,500	**21,218,700**
Proportion that are homeless (per cent)	**1.6**	**0.4**	**0.4**
Overcrowded households	7,325	32,167	**39,490**
Total households[(a)]	151,927	6,519,947	**6,671,876**
Proportion that are overcrowded (per cent)	**4.8**	**0.5**	**0.6**
Income support recipients in extreme housing stress[(b)]	1,635	82,221	**83,856**
Total income support recipients[(b)]	29,450	906,879	**936,329**
Proportion in extreme housing stress (per cent)	**5.6**	**9.1**	**9.0**

(a) Excludes those households for which overcrowding could not be determined.

(b) Count as at June 2006.

Sources: ABS 2006; Australian Government Housing Data Set; Chamberlain & Mackenzie 2008.

Indigenous Australians experienced homelessness at a rate 4 times that of non-Indigenous Australians (1.6% and 0.4% respectively) and almost 10 times the rate of overcrowding (4.8% and 0.5% respectively). However, Indigenous Australians receiving income support were less likely to be in extreme housing stress compared with non-Indigenous Australians receiving income support (5.6% and 9.1% respectively) (Table 6.3).

Rates of overcrowding in 2006 were highest in remote areas of Australia, with 19% of Indigenous households identified as needing two or more bedrooms, compared with only 3% in non-remote areas. Rates also varied according to tenure, with the highest rates of overcrowding found among Indigenous households renting in community housing and lowest rates among home owners and purchasers (AIHW 2009e).

For those in extreme housing stress, rates were higher in non-remote areas, with 6% of Indigenous income support recipients and low-income families in the private rental market in receipt of CRA paying more than 50% of their income in rent payments, compared with only 3% in remote areas of Australia (Table A6.6).

Poorly constructed and inadequately maintained housing can affect people's health and wellbeing (AIHW 2007a). Details of the condition of dwellings are currently only available for discrete Indigenous communities using data from the 2006 Community Housing and Infrastructure Needs Survey, which relates only to the Indigenous population. In 2006, 7% of dwellings managed by Indigenous Community Housing organisations required replacement, with the majority of these dwellings located in remote areas of Australia (ABS 2007b).

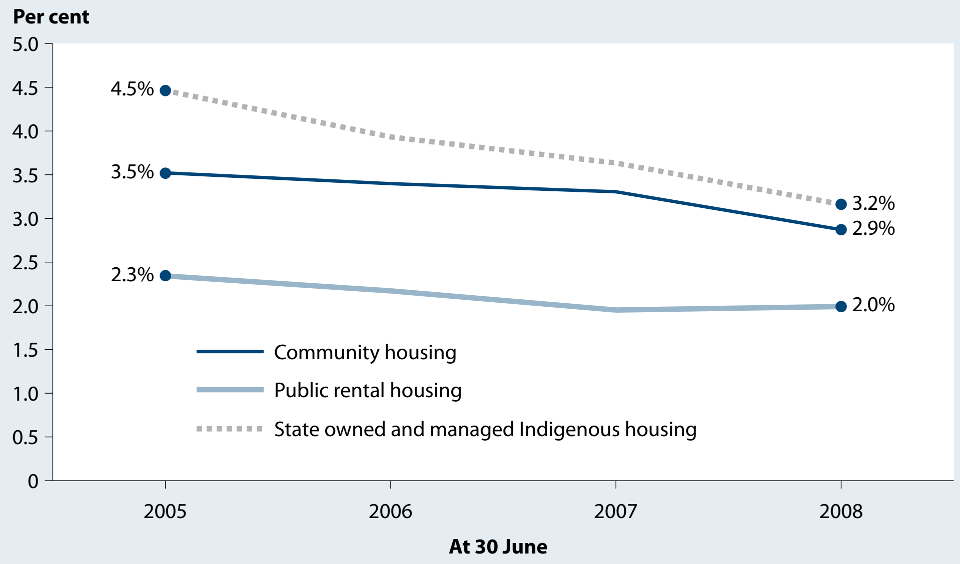
Demand for social housing is strong

The strengthening demand for social housing is evidenced by the declining vacancy rate. Since 2005, vacancy rates in SOMIH have fallen from 4.5% to 3.2% and in community housing from 3.5% to 2.9%. Public rental housing vacancies have remained low over the 4 years to 30 June 2008 (Figure 6.4). Fewer than 1.5% of Indigenous community housing dwellings were vacant at 30 June 2008 (AIHW 2009d).

A lower turnover of tenants in public rental housing compared with turnover in other social housing programs may be the result of the decline in public rental housing stock and longer tenures. This may contribute to the lower proportion of households that are able to be newly allocated and the lower vacancy rates compared with community housing. The growth of community housing may also contribute to this difference. Further analysis is required to understand what other factors influence the recent fall of social housing vacancy rates, but they may include increased efficiencies in property turnover and changes in stock configuration to better meet the demand profile.

Like social housing, the private rental market has experienced low vacancy rates since early 2005. On average, the private rental vacancy rate across all capital cities has been less than 3% since the March 2005 quarter. In the March 2009 quarter, the average vacancy rate was 2% (REIA 2009c).

In the private rental market, vacancy rates lower than 3% indicate strong demand for rental accommodation, while rates higher than 3% are generally considered to reflect an oversupply of rental accommodation (REIA 2008b).



Source: Table A6.7.

Figure 6.4: Vacancy rates of CSHA-funded social housing dwellings, 2005 to 2008 (per cent)

Unmet demand for social housing

Waiting lists can indicate where a need for social housing is not being met. At 30 June 2008, 177,652 households were on public rental housing waiting lists, 10,726 households were on SOMIH waiting lists and 36,946 households were waiting for allocation to community housing (AIHW 2009a, g, h), although it is possible that households may register on more than one waiting list. Traditionally in community housing, separate waiting lists are managed by individual community housing providers and the extent of double-counting of households across these and public rental housing waiting lists is unknown. However in some jurisdictions public rental and community housing waiting lists have been consolidated, meeting a key reform of the social housing initiative under the NAHA (COAG 2009).

Creating a central social housing waiting list in each jurisdiction will create a single point of entry for applicants and allow better measurement of the unmet demand for social housing. Centralised waiting lists will also benefit applicant households by ensuring that those with the highest level of need receive priority assistance and are matched to the most appropriate available dwelling and support services.

6.5 Housing supply

Housing supply is the quantity of housing stock available to house households at a point in time. It comprises existing housing stock, as well as additions to housing stock, using data on dwelling approvals and commencements.

Current supply of housing

In order to assess issues of housing supply, and the extent to which demand exceeds supply, a description of the current availability of stock is fundamental. Australia's existing housing stock is estimated to be 8.8 million dwellings, although factors, such as demolitions, that contribute to the loss of stock are not taken into account due to limited availability of data (Table 6.4).

Table 6.4: Estimated current housing supply, 2009

	Number	Per cent
Occupied private dwellings (August 2006)	7,596,182	86.1
Unoccupied private dwellings (August 2006)	830,378	9.4
Dwelling completions (September 2006 to March 2009)	393,825	4.5
Total	**8,820,385**	**100.0**

Sources: ABS 2006, 2009b.

The number of approvals issued for the construction of new dwellings also provides information about additions to housing stock. Although approvals do not necessarily relate directly to dwelling completions in the same time period, they do give an indication of future housing industry construction activity (REIA 2009a). Just over 130,000 approvals were issued for the construction of new dwellings during the 12 month period to May 2009 (ABS 2009c). During this period the number of dwelling approvals dropped by 22%.

Social housing supply

At 30 June 2008, there were nearly 420,000 government-funded social housing dwellings across Australia (Table 6.5), a marginal increase since 2004. Public rental housing stock has declined over the past few years, with the number of dwellings at 30 June 2008 nearly 7,500 fewer than in 2004, while the number of SOMIH dwellings remained steady. Complete dwelling information for community housing is only available from 2005 onwards, with an additional 7,000 dwellings added to the community housing portfolio over this time, representing a 22% increase. The number of dwellings funded under the Crisis Accommodation Program increased by 9% between 2004 and 2008, while the number of Indigenous community housing dwellings remained relatively stable with variances most likely a result of data quality issues.

Table 6.5: Number of social housing dwellings, 2004 to 2008

At 30 June	Public rental housing	State owned and managed Indigenous housing	Community housing(a)(b)	Crisis Accommodation Program	Indigenous community housing	Total
2004	345,335	12,725	26,753	6,916	21,717	413,446
2005	343,301	12,860	31,496	7,314	18,261	413,232
2006	341,378	12,893	32,349	7,350	22,192	416,162
2007	339,771	13,092	35,161	7,516	22,018	416,667
2008	337,866	12,778	38,519	7,567	23,279	418,100

(a) Community housing data for 2004 is subject to survey response rate.

(b) Community housing data for 2005 and 2006 is sourced from the trial collection of unit record level dwellings and organisation administrative data that excluded the Australian Capital Territory (ACT). ACT figures for these years has been included but sourced from CSHA national data reports.

Sources: AIHW 2005b, c, d, e, f, g, h, 2006a, b,d, e, 2007b, c, d, 2008a, c, f, g, 2009a, b, d, g, h, unpublished data.

Stock transfer programs have contributed to the shift in public rental housing and community housing figures. Housing New South Wales, in particular, aims to increase the capacity of community housing providers and has established a target to increase the community housing dwelling stock from 13,000 to 30,000 homes over a 10-year period from 30 June 2008 (Housing NSW 2007). Much of this growth is likely to be achieved through stock transfer, in which an average of 500 properties each year over the 2003–2008 CSHA were transferred from public to community housing (NSW Federation of Housing Associations Inc. 2007).

Stock transfer programs are likely to be developed in other jurisdictions and a proportion of the social housing dwellings constructed under stage two of the Nation Building—Economic Stimulus Plan may be transferred to community housing providers (FaHCSIA 2009d; Plibersek 2009).

Influences on supply

Housing supply is influenced by a number of factors relating to government policies, building industry operations and the economy (Figure 6.5). Combinations of these factors may act as impediments to the overall supply of housing.

Government policies

- Local, state and Commonwealth policies, e.g. housing, environmental, urban
- Land supply, land release and developmental approval processes
- Commonwealth and state taxes (e.g. property taxes) and other charges
- Infrastructure provision and charging
- New policies or programs

Building industry

- Costs and availability of labour and materials
- Private sector activity
- Workforce planning/trade education policies and practices
- Credit constraints on developers
- Investor expectations for property prices

Economy

- Uncertainty, e.g. global financial crisis, share market crash
- Interest rates
- Downturn in business investment
- Declining affordability
- Changes in investment sentiment

Sources: BIS Shrapnel 2009; REIA 2009a.

Figure 6.5: Factors influencing housing supply

With limited growth in social housing funding over the decade to 2008, the result has been fewer dwellings, out-of-date stock and increased maintenance costs. It is estimated that social housing stock has decreased from about 400,000 dwellings in 1996 to 390,000 in 2008. However, if social housing had maintained its share of total dwelling stock, there would currently be around 480,000 dwellings (FaHCSIA 2009a; Plibersek 2009). The cost of maintaining 30-year-old dwellings is more than twice that for dwellings less than 15 years old—the average public rental housing stock is between 20 and 29 years old, and 14% of stock is more than 50 years old (Plibersek 2009). The Australian Government has provided funds as part of the Nation Building—Economic Stimulus Plan for the construction of around 20,000 additional social housing units and the repairs and maintenance of around 47,000 existing public rental housing dwellings from 2008–09 to 2011–12 (FaHCSIA 2009d).

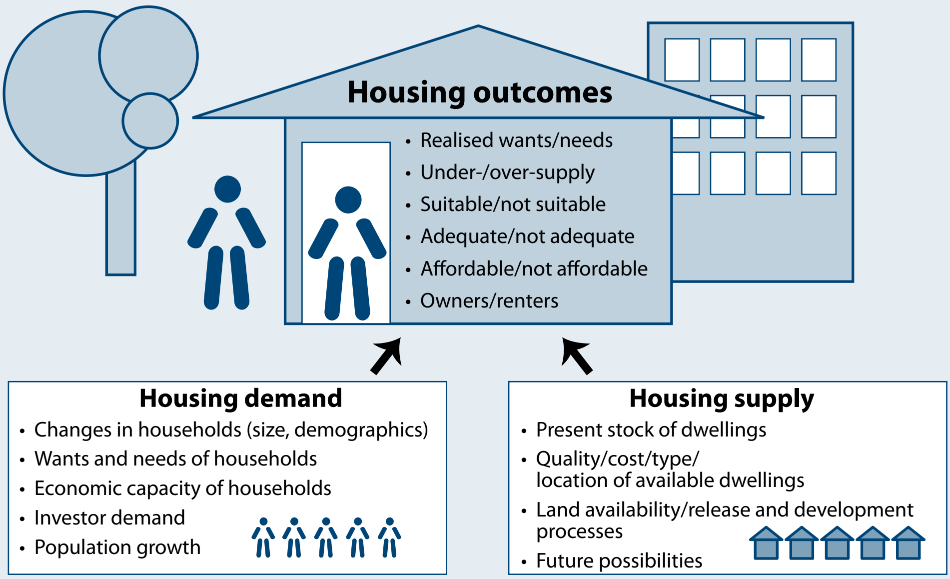
Projecting supply

Projecting supply is difficult, particularly due to the various factors that can influence it. The National Housing Supply Council has produced estimates based on the trend in the growth of aggregate housing supply (that is, total dwelling completions less demolitions, under the medium-supply projections) and information on capital city land supply for residential development. The council estimated the net annual growth of housing stock will be 130,000 in 2010, increasing to 142,000 a year to 2028, putting the total growth in the period 2008 to 2028 at 2.7 million dwellings (FaHCSIA 2009a).

Demand for housing exceeds supply

When housing demand exceeds supply, indicating a housing shortfall, a number of problems can arise (Figure 6.6), including:

- unmet needs and/or preferences of households
- inadequate levels of dwellings, in both type and location
- insufficient affordable housing options.



Sources: ABS 2001; BIS Shrapnel 2009; FaHCSIA 2009a.

Figure 6.6: Framework for assessing housing circumstances

In Australia, there is currently a housing shortfall, with housing demand exceeding supply. The National Housing Supply Council estimates this housing shortfall to be about 85,000 dwellings in 2008, based on the incidence of homelessness and low vacancy rates in the private rental market. It points out that the greater the gap between supply and demand, the greater the potential impact on housing availability and prices. The council notes two significant consequences of this. The first is that moderate-income households—which may have otherwise been able to access home ownership—are forced into private rental, pushing low-income households out of the private rental market or into unaffordable rents. The second consequence is the property market response, 'including increased attractiveness of investment in housing as rents increase, a consequently higher level of production…' and a reduction of the gap between housing demand and supply (FaHCSIA 2009a:xvi).

Although Australia's overall housing stock increased by 1.3 million dwelling units or 17% between 1996 and 2006, growth has not kept up with demand, particularly for affordable housing. Demand has increased as a result of decreasing social housing supply and high levels of demand for private rental accommodation (REIA 2009a).

The shortfall in housing stock is primarily in the bottom half of the housing market (FaHCSIA 2009a). The Australian Government has invested funding through a number of housing initiatives (Box 6.3) and the social housing initiative under the Nation Building—Economic Stimulus Plan, as a first step to increase the supply of affordable housing, in particular the supply of social housing.

Identifying locations of potential need for social housing

The gap between housing supply and demand will be lessened with the construction of up to 70,000 social housing dwellings under the National Rental Affordability Scheme and the Nation Building—Economic Stimulus Plan, particularly for low-income Australians. It is important to identify where there is a need for these new social housing dwellings to ensure that people have access to adequate housing. This should also complement a key Government reform of reducing concentrations of disadvantage to improve social inclusion.

The Australian Government is using location, among other criteria, to allocate National Rental Affordability Scheme incentives to successful organisations (FaHCSIA 2009b). Criteria used to determine priority locations of interest are:

- low rental vacancy rates
- unmet rental demand
- low proportion of affordable lettings and limited social housing
- high levels of housing stress
- high levels of expressed demand through social housing waiting lists
- high levels of relative socioeconomic disadvantage
- accessibility to transport, schools, shops, health services and employment opportunities.

Priority locations of interest may already have high concentrations of social housing. However, there may also be a need for redevelopment and government investment to create mixed communities that promote social and economic opportunities. Many households, particularly Indigenous households, in *Very remote* areas and discrete communities live in highly concentrated areas of disadvantage. More than one-third of dwellings in some *Very remote* areas are rented from government or Indigenous housing providers (Table A6.8). These areas have a significant level of need due to the poor condition of housing stock and high overcrowding rates (AIHW 2009e).

Other areas of relative high disadvantage may have a low concentration of social housing dwellings, indicating a potential need for additional social housing. It should be noted, however, that households not living in social housing in these areas may receive support through other forms of government assistance, such as CRA.

6.6 Housing assistance

Housing assistance is provided through a number of programs and is an important part of the Australian Government's social and economic policies and social inclusion agenda. Assistance is provided to those renting or purchasing their own home, or those who are homeless or in crisis (Figure 6.7). Much of the data presented in this section is about assistance funded under the now-expired CSHA, as data on assistance provided under the NAHA were not available at the time of preparing this report.

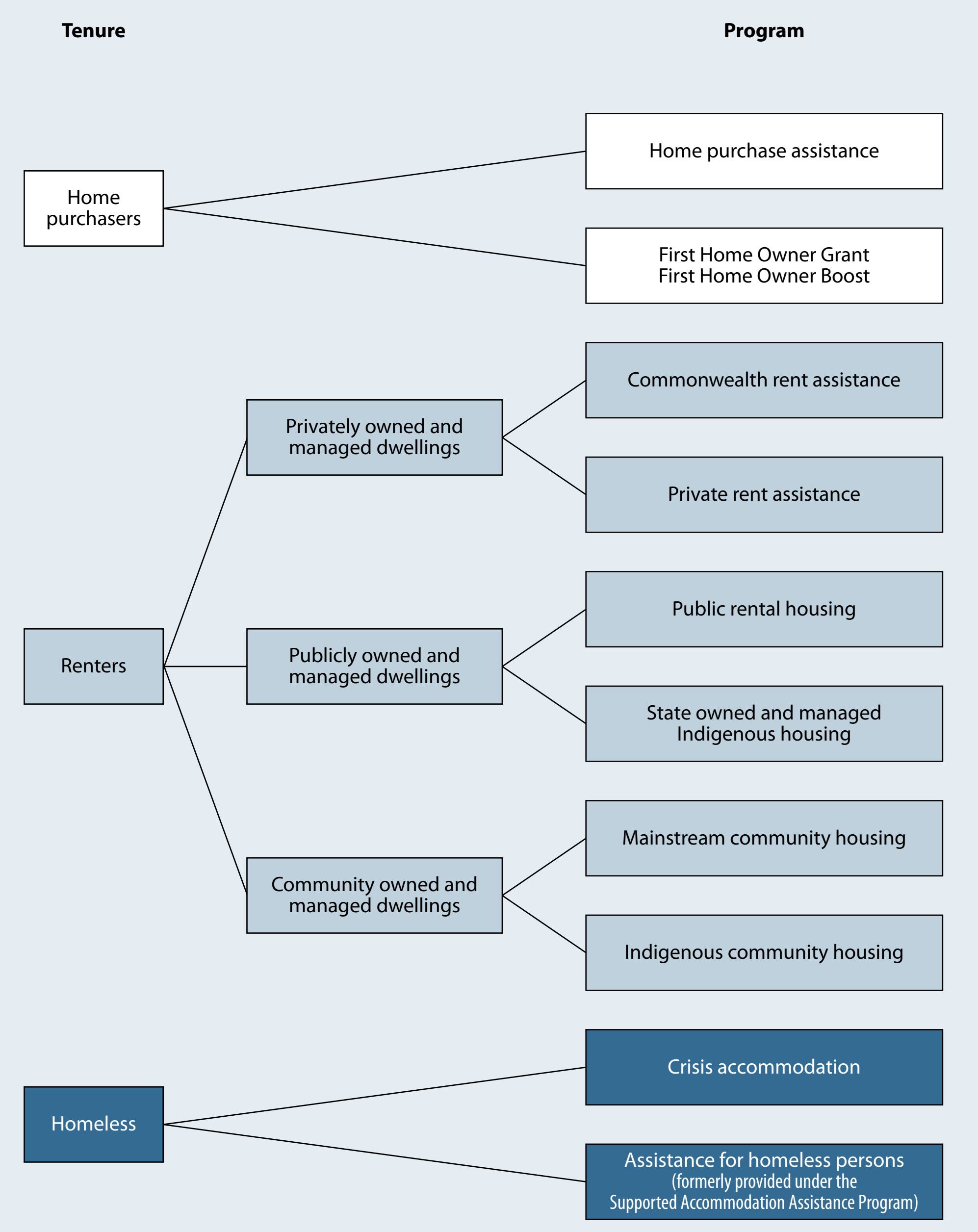


Figure 6.7: Housing assistance programs, 2008

Assistance for renters

Increased pressure on those in the private rental market due to a decline in housing affordability and low vacancy rates may result in many households seeking social housing or government financial assistance. The ability of households to be able to access such assistance is important, particularly low-income households and those with special needs.

New allocations to social housing are declining

Social housing is not only about putting an affordable roof over one's head. It can also provide flexible housing options linked with tailored support services, to enable tenants to deal with problems they may face now and in the future, to ensure the sustainability of their housing and to prevent them from becoming socially excluded.

Social housing assistance was provided to nearly 380,000 households in public rental housing, SOMIH and community housing funded under the CSHA at 30 June 2008, of which Indigenous households accounted for 10% of all households assisted (Table A6.9).

Of the 380,000 households assisted in social housing, over 33,000 households (9%) were newly allocated a social housing dwelling during the year (Table 6.6). The number of households newly assisted each year has been declining in both public rental housing and SOMIH, but increasing in community housing since 2004. In 2007–08, about 24,000 households were newly allocated to public rental housing, 23% fewer than in 2003–04. Similarly, nearly 22% fewer new SOMIH allocations were made in 2007–08 than 4 years before (AIHW 2005c, g, h).

Public rental housing offers life tenure to many households. It had the lowest proportion of households that were newly assisted (7%) during 2007–08, while almost 11% of households in SOMIH and nearly one-quarter in community housing respectively were newly allocated. The higher proportion of households newly assisted in community housing may be due to the inclusion of boarding/rooming housing programs, which are generally associated with shorter tenures and have a higher turnover of tenants (Table 6.6).

Table 6.6: Total and new households assisted, 2007–08

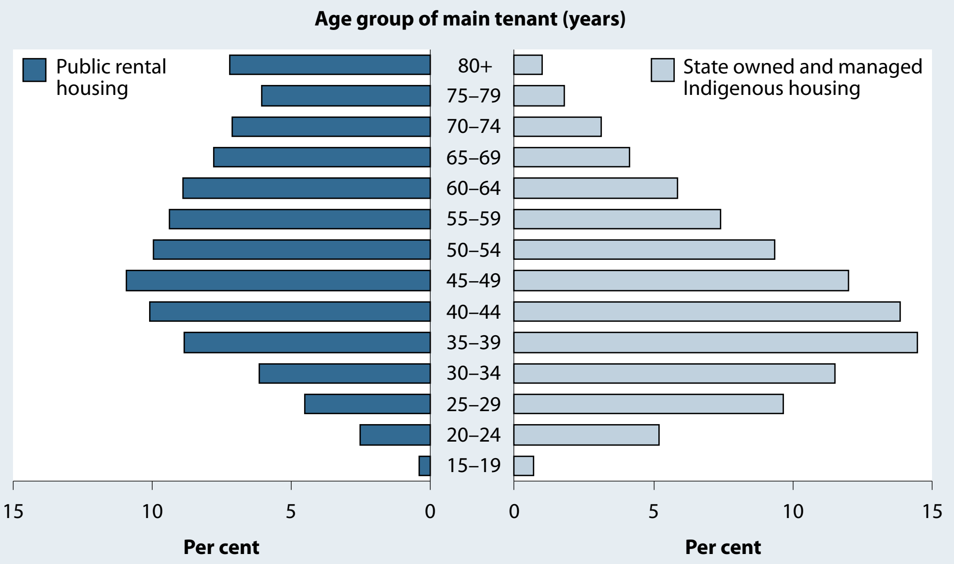
	Public rental housing	SOMIH	Community housing	Total
Total households	331,136	12,375	35,667	379,178
New households	23,731	1,294	8,728	33,753
Proportion of households newly allocated during 2007–08 (per cent)	7.2	10.5	24.5	8.9

Note: Household data for Indigenous community housing is limited and has been excluded from Table 6.6.

Sources: AIHW 2009a, g, h.

Who does social housing assist?

Females account for 63% of public rental housing main tenants and 75% of main tenants in SOMIH (Table A6.10). SOMIH main tenants are younger than those in public rental housing, with an average age of nearly 45 years compared with the main tenants in public rental housing with an average age of 54 years (Table A6.10). Six per cent of main tenants in SOMIH were aged less than 25 years compared with only 3% of main tenants in public rental housing. In contrast, 14% of main tenants in public rental housing and less than 3% of SOMIH main tenants were aged 75 years or over (Figure 6.8).



Notes

1. Public rental housing includes both Indigenous and non-Indigenous main tenants.
2. SOMIH is an Indigenous-specific program and therefore its age profile is skewed as a result of the younger age profile of the Indigenous population.

Source: National Housing Assistance Data Repository.

Figure 6.8: Main tenant age groups of public rental housing and SOMIH, 30 June 2008 (per cent)

Public rental and community housing households have a similar composition, with around half of all households being single adult households followed by around one-fifth of households containing a sole parent with children. SOMIH households are larger, with a higher proportion of those with children and group or mixed households (Table 6.7).

Table 6.7: Household composition of public rental housing, SOMIH and community housing households, 2007–08 (per cent)

Household composition	Public rental housing	SOMIH	Community housing
Single adult	50.2	21.7	50.7
Couple only	9.2	5.1	12.3
Sole parent with children	19.4	39.7	20.3
Couple with children	7.0	13.5	8.4
Group household and mixed composition	14.2	20.0	8.3
Total	**100.0**	**100.0**	**100.0**

Sources: Public rental housing and SOMIH data sourced from AIHW data repository; Community housing sourced from RMR 2008a.

Over 30% of all households in public rental housing, SOMIH or community housing contained a household member with a disability, a higher proportion than the national estimate of 20% of the total population (Table 6.8) (See Chapter 4). The types of disability and the extent of associated activity limitations are not currently captured in the social housing data collections.

Table 6.8: Social housing households with a member with a disability, 30 June 2008

Program type	Households with a member with a disability	Proportion of all households (per cent)
Public rental housing	102,877	31.1
State owned and managed Indigenous housing	2,554	20.6
Community housing	10,097	28.3
Total	**115,528**	**30.5**

Note: Disability information is not captured in the Indigenous community housing data collection. The Northern Territory cannot identify households with disability separately in the public rental housing data collection.

Sources: AIHW 2009a, AIHW housing data repository.

Who receives priority housing?

Priority housing is usually given to those in greatest need, though criteria may vary between jurisdictions (refer to Box 6.6). In many circumstances, homeless persons are housed in crisis accommodation until more suitable accommodation options are found. Over half (51%) of all new public rental housing allocations during 2007–08 were to those in greatest need, compared with 30% of priority allocations in SOMIH (Table 6.9). This may be explained by fewer new allocations to public rental housing as a proportion of total households, resulting in a greater need to allocate on the basis of priority.

About 7% of existing public rental housing households were Indigenous, and 15% of new allocations were made to Indigenous households (Table 6.9). Similarly, in community housing 11% of new allocations were to Indigenous households, despite only 6% of all community housing households being Indigenous. This higher rate may indicate that Indigenous persons are more likely to fall within one or more categories of greatest need and therefore receive priority allocation.

Box 6.6: Definition of greatest need

The term 'greatest need' is a national standard and is used to define low-income households that satisfied an eligibility test to receive CSHA-funded assistance and at the time of allocation were subject to one or more of the following circumstances:

- they were homeless
- their life or safety was at risk in their accommodation
- their health condition was aggravated by their housing
- their housing was inappropriate to their needs
- they had very high rental housing costs (AIHW 2006a).

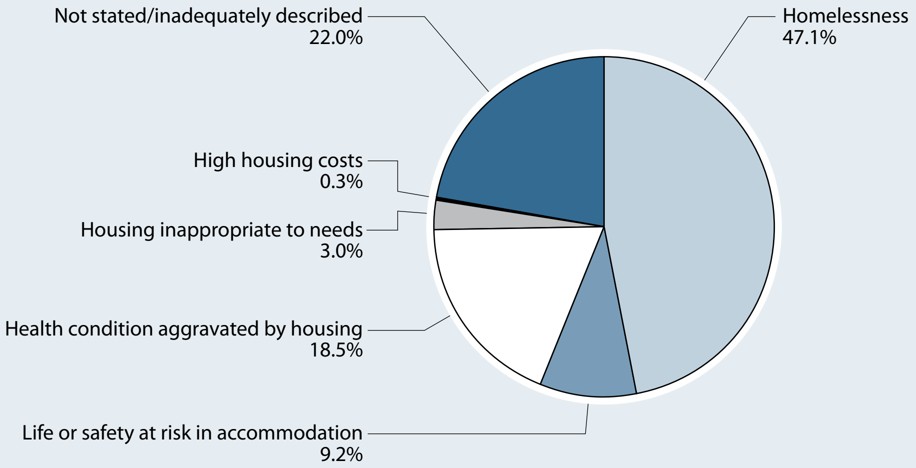
Table 6.9: New and Indigenous households, social housing, 2007–08

	Public rental housing	SOMIH	Community housing
Proportion of new allocations to households in greatest need, 2007–08 (per cent)	51.2	30.2	71.2
Proportion of households with an Indigenous person at 30 June 2008 (per cent)	7.2	100.0	6.4
Proportion of new allocations to Indigenous households, 2007–08 (per cent)	15.0	100.0	11.2

Sources: AIHW 2009a, g, h.

For both public rental housing and SOMIH, only the main reason for which households are classified as having 'greatest need' is reported. Of the main reason reported, 47% of greatest need allocations in these programs were due to homelessness, followed by 19% of those whose health condition was aggravated by their housing (Figure 6.9).

Those given priority allocation in community housing accounted for over 71% of new households assisted during 2007–08 (Table 6.9). Over half (51%) of those newly assisted who were in greatest need were homeless at the time. Data limitations currently prevent further analysis of priority allocations in community housing.

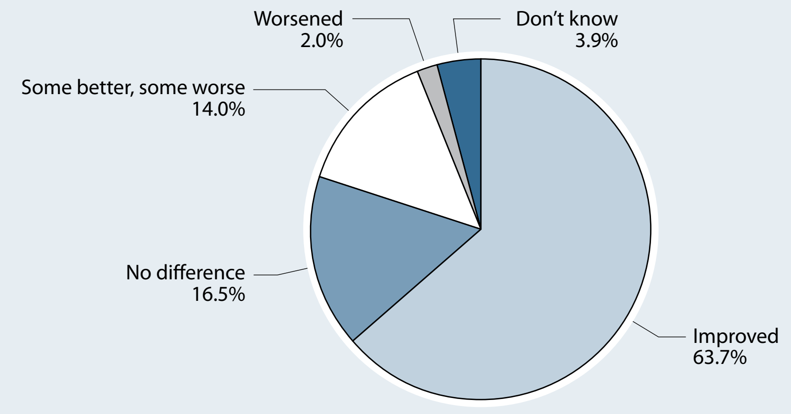


Source: National Housing Assistance Data Repository.

Figure 6.9: Reasons for priority allocation in public rental housing and SOMIH, 2007–08 (per cent)

Social housing improves tenants' lives

Given the high proportion of households in social housing with higher levels of need, such as those who are aged or with a disability, access to the necessary support services is essential to ensure that households do not become socially excluded. Nearly two-thirds (64%) of respondents to the 2007 National Social Housing Survey of public rental and community housing tenants said that their quality of life had improved since moving into social housing, with only 2% reporting that it had worsened (Figure 6.10). While the same question was not asked of SOMIH tenants, 86% of respondents said they had an improved family life (Roy Morgan 2008b).



Source: Roy Morgan Research 2007, 2008b

Figure 6.10: Change in overall quality of life of public rental and community housing households, March–April 2007

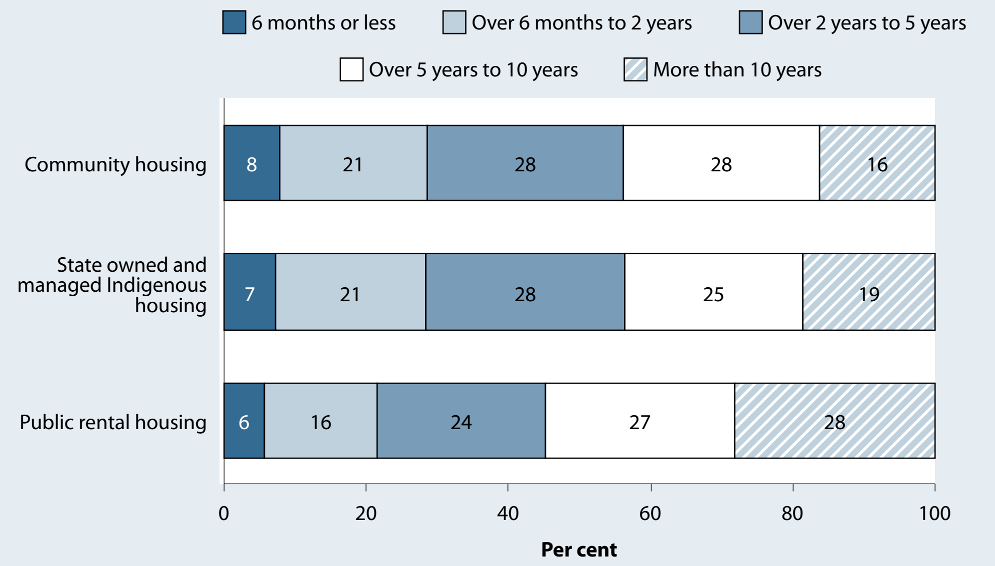
In the 2007 National Social Housing Survey, tenants were asked to rate their overall satisfaction with the service provided by their state housing authority or community housing organisation. Overall, community housing tenants showed a higher level of satisfaction than those in public rental housing and SOMIH, with 82% of tenants stating they were satisfied, compared with 71% of public rental housing tenants and 63% of SOMIH tenants. In addition, SOMIH tenants were more likely to be dissatisfied with the service provided, 23% compared with 16% for those in public rental housing and 11% community housing (Table A6.11).

Length of tenure is highest in public rental housing

Life tenures are generally associated with public rental housing. However, in recent years there has been a policy shift towards fixed-term leases for public rental housing tenants in some jurisdictions (Housing NSW 2008; SCRGSP 2009:Table 16.6). Tenants' needs and financial circumstances may change over time and this policy shift allows a greater number of people to be assisted.

Over 28% of those in public rental housing have resided in their current dwellings for more than 10 years—only 19% and 16% of tenants in SOMIH and community housing respectively had such lengthy tenures (Figure 6.11).

Flexible housing options in community housing may contribute to the higher proportion of shorter tenures of 6 months or less. These housing options are designed to meet tenants' short-term needs provided through transitional or boarding house accommodation. The increase of dwellings in the community housing sector may also be a contributing factor to the higher proportion of shorter tenures as new dwellings allow a greater number of new households to be assisted each year.



Notes

1. Length of tenure data is not collected for the Indigenous community housing program.
2. Community housing figures are sourced from the 2007 National Social Housing Survey.

Sources: AIHW analysis of the National Housing Assistance Data Repository; Roy Morgan Research 2008a.

Figure 6.11: Length of tenure in public rental housing, SOMIH and community housing, 30 June 2008 (per cent)

How are sustainable tenancies achieved?

The importance of sustainable tenancies is paramount given the higher level of need of many tenants in social housing. Increasing the sustainability of tenancies can be achieved by identifying the risk factors of tenancy failure and developing approaches for early intervention (Jones et al. 2003). Risk factors that can make a household vulnerable to tenancy failure include:

- prior ill health and disability
- cultural factors
- prior housing instability
- inappropriate housing.

Other risk factors where events may trigger household instability include:

- financial difficulty
- family and personal change or crisis
- neighbourhood conflict.

Policies, programs and practices of housing authorities aimed at preventing tenancy failure can be divided into three broad categories and include:

- proactive intervention—early identification, assessment and intervention, support programs, skills education, encouraging tenant participation

- reactive intervention—processes for managing breaches of tenancy and eviction
- remedial intervention—referral to other support agencies, reinstatement of housing (Jones et al. 2003).

One way to measure the sustainability of tenancies in public rental housing and SOMIH is to examine the number of tenancies that ended in the same year they were allocated. In 2007–08, 8% of all new allocations to public rental housing finished in the same period. A higher proportion of new Indigenous tenancies (10%) than non-Indigenous tenancies (7%) finished in that year (Table 6.10).

Although there has been a higher termination rate for Indigenous tenancies in both public rental housing and SOMIH compared with their non-Indigenous counterparts for all years shown in Table 6.10, the trend in the rate of short-term Indigenous tenancies has declined overall.

Table 6.10: New allocations that ended their tenancy in the same year, 2003–2008 (per cent)

	Public rental housing			SOMIH
Year	Indigenous	Non-Indigenous	All new allocations	Indigenous
2003–04	14.9	10.5	11.1	12.1
2004–05	13.6	9.2	9.6	11.0
2005–06	12.4	8.9	9.3	10.9
2006–07	11.4	8.4	8.8	9.7
2007–08	9.7	7.4	7.8	10.8

Note: All SOMIH allocations are to Indigenous households.

Source: AIHW analysis of housing data repository.

The 2007 National Social Housing Survey of community housing tenants found that tenant participation in the operation of the housing organisation tended to increase with length of tenancy. Only 42% of tenants of less than 6 months' duration compared with 60% of tenants of over 10 years' duration were involved in the operation of their housing organisation (Table A6.12). Most community housing tenants (70%) were satisfied with their level of involvement in the running and decision making of their housing organisation, while only 12% were dissatisfied to some extent (Roy Morgan 2008a).

The ability to be involved in the decision making and management of the organisation is an aspect that differentiates many community housing models from other forms of social housing. Tenant participation can help tenants build social and work-related skills, and can provide access to work experience, training or education and improved employment prospects (AIHW 2005a).

Low labour force participation in social housing

Only one-third of public rental and community housing tenants surveyed in 2007 were in the labour force (AIHW 2008b, e), the reverse of that found in the general population where over two-thirds (68%) of adults were in the labour force (ABS 2007a).

Of the public rental and community housing tenants who were not participating in the labour force, over three-quarters were not doing so because of illness, disability or age.

An over-representation of older people in social housing (28% aged 65 years or over) is a key contributor to the lower levels of workforce participation than the general population (13% aged 65 years or over) (AIHW 2007a:380).

Aside from the main labour force participation disincentives, such as the need for further education, work experience or training and the costs associated with child care, housing tenants stated that possible rent increases, a loss of benefits, or becoming ineligible for public or community housing were other reasons for not engaging in the workforce (AIHW 2008b).

Strengthening one's ability to participate actively in the workforce and community is a key principle of the Australian Government's Social Inclusion Agenda. Creating incentives for social housing tenants to take up employment is a policy reform direction under the NAHA.

To assist those living in areas of disadvantage and seeking work, projects funded through the Innovation Fund, which began on 1 July 2009, are designed to help the most disadvantaged job seekers to overcome workforce disincentives (Australian Government 2008a).

Other projects are also underway to encourage low-income households to either enter or remain in the labour force by improving the supply of affordable rental dwellings, along with ensuring that adequate links to transport, shopping, leisure and institutional infrastructure are in place (Box 6.7).

Box 6.7: Providing affordable housing while improving employment

The Docklands precinct has been identified as having the highest rental cost of all City of Melbourne precincts (Melbourne Affordable Housing 2008). Small businesses at Docklands, consisting of hospitality (53%), retail (19%) and cultural or recreation services (12%), have indicated that a lack of skilled staff has limited business growth. Staff shortages can be attributed to the lack of affordable housing, given the nature of the predominant casual or part-time employment that these industries offer.

To remedy the lack of affordable rental options in Docklands and the shortage of skilled workers in the area, the not-for-profit housing association Melbourne Affordable Housing has purchased 57 apartments in the Merchant housing development. These apartments are the first in Docklands to provide affordable rental housing. Applicants will be assessed on a number of criteria including:

- being employed in the inner metropolitan area of or seeking access to the inner Melbourne labour market, including connections with the community or local area
- having a single household income of around $38,000 or less, and around $64,000 or less for dual household incomes
- having the ability to pay rent while not spending more than 25–30% of their income on rent
- being able to be live independently and sustain their tenancy for the long term.

The project is expected to be completed in December 2009 (Vic Minister for Housing 2008).

How are private renters assisted?

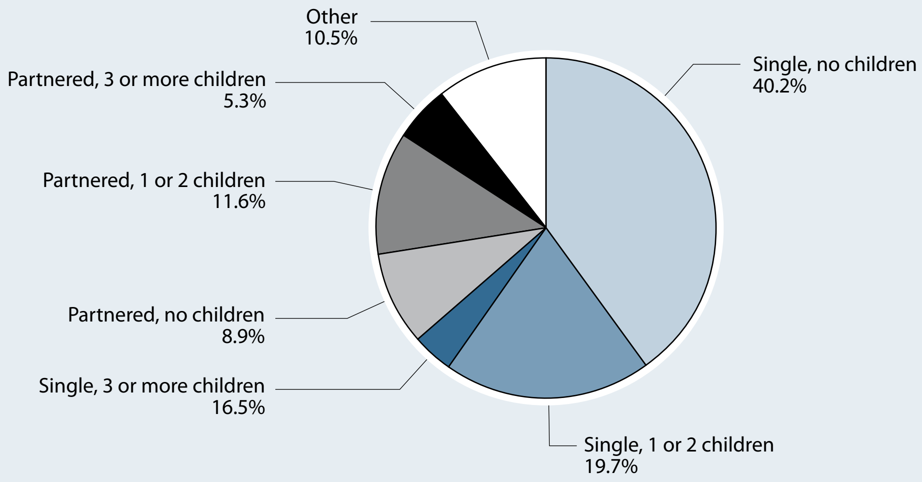
Households in private rental may be eligible for CRA and other state- and territory-based assistance based on their income and housing costs.

CRA is a non-taxable income supplement paid through Centrelink. It is also available to SOMIH tenants in New South Wales and community housing tenants who pay rents above specified threshold levels (refer to Box 6.8 for eligibility details). In 2007–08, the CRA program provided $2.3 billion of assistance to low-income renters (SCRGSP 2009). At 6 June 2008, there were nearly 930,000 income units receiving CRA (Table 6.11).

Box 6.8: Eligibility for Commonwealth Rent Assistance

Recipients of a Centrelink pension or allowance, or an amount of Family Tax Benefit over the base rate of Family Tax Benefit Part A, who are also paying private rent above minimum thresholds, may be eligible for CRA. It is generally not paid to home owners or purchasers, people living in public rental housing, or people living in residential aged care services with government-funded beds. More information on CRA eligibility rules, including minimum rent amounts and maximum amounts of CRA payable for various income unit types, can be obtained from Centrelink's website at <www.centrelink.gov.au>.

Singles and couples without children account for nearly half (49%) of all CRA recipients, while singles with children account for nearly one-quarter (24%) (Figure 6.12).



Source: Australian Government FaHCSIA housing data set.

Figure 6.12: Income unit type of CRA recipients, 6 June 2008

The effect of CRA on housing affordability can be examined by comparing the proportion of income that recipients would spend on rent both before and after CRA is received. CRA has been treated as a housing subsidy, and deducted from rent, to calculate affordability after CRA is received.

Before receiving CRA, two-thirds of all recipients were paying more than 30% of their income in rent, that is they were in financial housing stress. After receiving CRA, recipients paid a median rent of $109 per week, though over one-quarter (26%) of recipients were still paying between 30% and 50% of their income in rent and a further 10% were in extreme housing stress, paying more than 50% of their income in rent (Table 6.11). The proportion of CRA recipients paying between 30% and 50% of their income in rent has increased by 4% since June 2006 and by 1% for those recipients paying over 50% of their income in rent (AIHW 2007a).

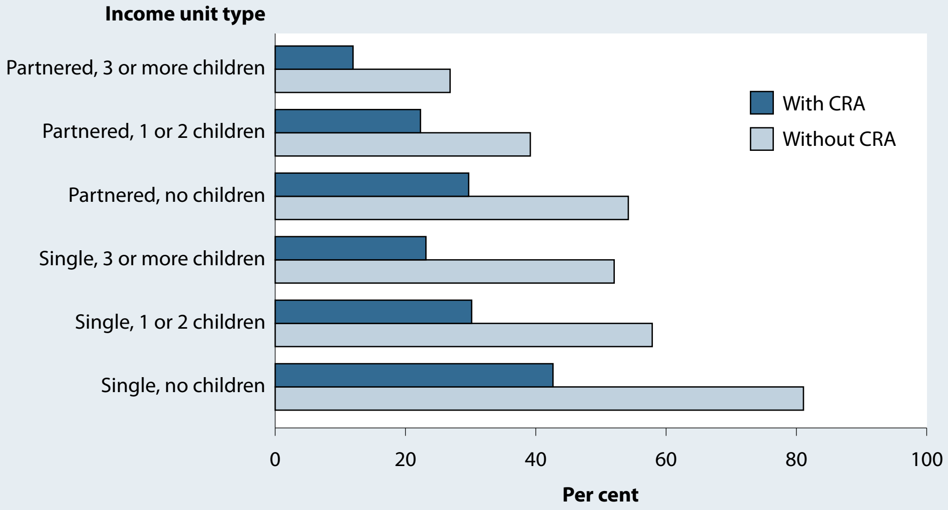
At 6 June 2008, a lower proportion of Indigenous recipients were in rental stress both before receiving CRA (57%) and after receiving CRA (27%). Indigenous recipients paid a median rent of $102 per week after receiving CRA.

Table 6.11: Recipients of Commonwealth Rent Assistance by proportion of income spent on rent with and without CRA payment, 6 June 2008

	Proportion of income spent on rent (per cent)				Total CRA recipients (number)	Median weekly rent ($)
	30% or less	Over 30% to 50%	Over 50%	Total		
All recipients						
Without CRA	34.5	39.1	26.4	100.0	927,364	160.0
With CRA	64.5	25.8	9.8	100.0	927,364	108.6
Indigenous recipients						
Without CRA	43.5	36.5	20.1	100.0	30,960	150.0
With CRA	73.1	20.3	6.6	100.0	30,960	101.6

Source: Australian Government FaHCSIA housing data set.

Figure 6.13 illustrates those recipients from Table 6.11 in rental stress both before and after CRA. Those without children are the most disadvantaged despite receiving CRA, with over 40% of singles and 30% of couples without children still in rental stress after CRA.



Source: Australian Government FaHCSIA housing data set.

Figure 6.13: CRA recipients in rental stress (paying more than 30% of income in rent) before and after CRA payment, 6 June 2008 (per cent)

States and territory assistance provided to private renters includes bond loans, rental grants or subsidies, relocation expenses and other one-off grants. Households receiving private rent assistance may also be in receipt of CRA, but the extent of this is unknown.

In 2007–08, $82 million worth of CSHA private rent assistance was provided to over 120,000 households in Australia. Since the last report, funding for private rent assistance has increased by $5 million, but the number of households assisted has fallen by about 14,000 (AIHW 2007b). This is most likely a result of the increased costs of providing assistance. Most funding ($47 million) was provided as bond loans that were offered to new clients in all states and territories, followed by $25 million in rental grants, subsidies and relief payments (Table 6.12).

Indigenous households accounted for over 11% of those who were newly assisted in 2007–08 across those jurisdictions where Indigenous status was known (AIHW 2009f). The number of newly assisted Indigenous households has grown by 4% since the last report. This may be due to the increased identification of the Indigenous status of households.

Table 6.12: CSHA private rent assistance program: households assisted, value of assistance and coverage, 2007–08

Program type	Households assisted (number)	Value of assistance ($'000)	Jurisdictions accepting new clients for the year ending 30 June 2008[a]
Bond loans	56,134	46,782	All jurisdictions
Rental grants/subsidies	50,100	24,723	NSW, Vic, Qld, SA, Tas, NT
Relocation expenses	2,440	587	Vic, Tas, ACT
Other one-off grants	13,457	9,894	NSW, Vic, Tas
Total for each program[b]	**122,131**	**81,986**	

(a) May include data from jurisdictions other than those listed here—that is, the program may not be current but jurisdictions are continuing to serve clients until the end of their contractual arrangements.

(b) A household may receive more than one form of assistance.

Source: AIHW 2009f.

Assistance for home purchasers

Various forms of government assistance and programs are targeted to low-income home purchasers who may have difficulty obtaining finance or meeting the ongoing costs of purchasing a home. In 2005–06, the average low-income first home buyer spent a greater proportion of their income on housing costs than other first home buyers (34% compared with 26%), demonstrating their need for assistance with home purchase (ABS 2007c).

Boost for first home owners

Government grants for first home buyers are not specifically targeted to low-income households, and home buyers receive the grant regardless of their income. These incentives may encourage those in the rental market to move into home ownership and achieve the stability and security of tenure, and long-term economic benefits that home ownership can offer. In 2007–08, over $1 billion of First Home Owner Grants were made to nearly 150,000 first home buyers (Table A6.13).

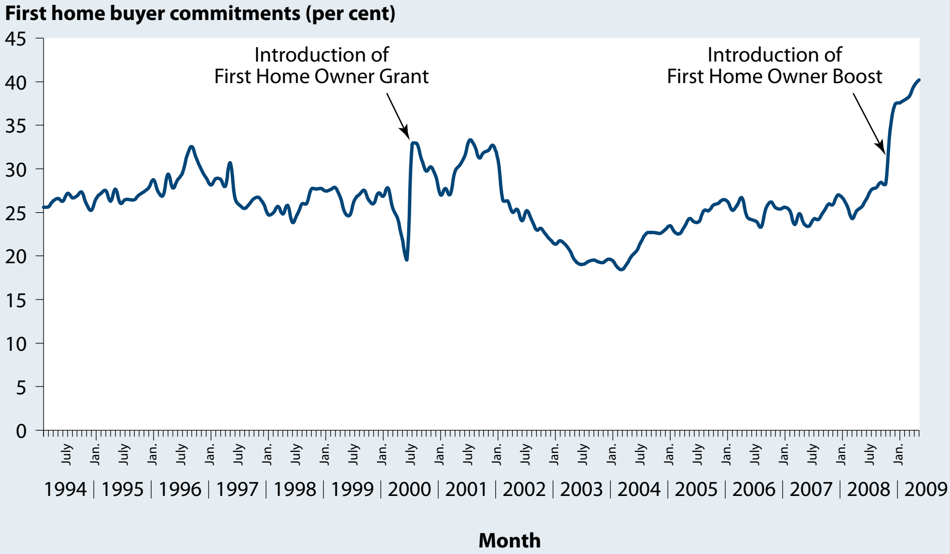
First home buyers may also be eligible for additional state-specific benefits for property purchases including stamp duty exemptions or concessions and bonus grants (Table 6.13). Other exemptions also apply to those purchasing land.

Table 6.13: Additional jurisdiction-specific first home buyer benefits, as at 1 March 2009

Jurisdiction	First home buyer exemptions
New South Wales	No stamp duty on properties up to $500,000. Stamp duty concession for properties between $500,000 and $600,000.
Victoria	$5,000 bonus grant for new properties. $3,000 bonus grant for established properties. $8,000 bonus grant for new properties in regional areas.
Queensland	No stamp duty on properties up to $500,000. Stamp duty concession for properties between $500,000 and $550,000.
Western Australia	No stamp duty on properties up to $500,000. Stamp duty concession for properties between $500,000 and $600,000.
South Australia	$4,000 bonus grant for properties up to $400,000. Phased grant for properties between $400,000 and $450,000.
Tasmania	–
Australian Capital Territory	No additional first home buyer-specific benefits though all home purchasers earning less than the specified threshold may be eligible for the following concessions: • $20 stamp duty on properties up to $340,000 • Stamp duty concession for properties between $340,000 and $422,000.
Northern Territory	No stamp duty on properties up to $385,000.

Sources: ACT Department of Treasury 2008; NSW Treasury 2008; NT Treasury 2009; Queensland Treasury 2008; SA Department of Treasury and Finance 2008; State Revenue Office Victoria 2008; Tas Department of Treasury and Finance 2008; WA Department of Treasury and Finance 2009.

Despite accelerating house prices, the proportion of home buyers entering the market for the first time is recovering. The proportion of dwelling finance commitments to first home buyers, excluding those refinancing, peaked at 33% in mid-2001 following the introduction of the First Home Owner Grant the previous year (Figure 6.14). This proportion dropped to only 18% at the start of 2004 but has slowly started to increase. The proportion of dwelling finance commitments to first home buyers reached record highs around 40% in the first half of 2009 following the introduction of the First Home Owner Boost on 14 October 2008.



Notes

1. Excludes refinancing of established dwellings and those households who do not require a loan to purchase a property.
2. A lending commitment is a firm offer of housing finance. It either has been, or is normally expected to be, accepted (ABS 2009e). However, not all commitments result in a purchase.

Source: ABS 2009e: tables 9A and 13A.

Figure 6.14: Proportion of dwelling finance commitments to first home buyers, February 1994 to May 2009 (per cent)

Other home purchase assistance

States and territories also provide various forms of home purchase assistance to low-income households, including direct lending, deposit assistance, interest rate assistance, home purchase advisory and counselling services' and mortgage relief. Improving access to home ownership through an array of support mechanisms for lower income households was the key objective of the home purchase assistance programs under the CSHA. Most of these programs will continue under the NAHA; however, new data are not yet available.

In 2007–08, nearly $1.2 billion worth of home purchase assistance was provided to over 32,000 households. Most funding ($1.1 billion) was provided as home loans (direct lending) followed by interest rate assistance ($16 million) and mortgage relief ($6 million) (Table 6.14).

Table 6.14: CSHA home purchase assistance: households assisted, value of assistance and coverage, 2007–08

Program type	Households assisted (number)	Value of assistance ($'000)	Jurisdictions accepting new clients for the year ending 30 June 2008
Direct lending	17,785	1,133,349	Vic, Qld, WA, SA, Tas, NT
Deposit assistance	19	110	Qld, Tas
Interest rate assistance	3,191	16,120	Qld, WA, SA, NT
Mortgage relief	347	5,974	NSW, Vic, Qld, WA, Tas(a), ACT
Home purchase advisory and counselling	10,685	184	NSW, WA
Other	265	744	Vic, Qld, WA
Total for each program(b)	**32,292**	**1,156,481**	

(a) Unable to provide household and value of assistance figures.

(b) A household may receive more than one form of assistance.

Source: AIHW 2009c.

Shared equity schemes

A number of state and territory governments offer shared home ownership schemes (a component of direct lending), usually referred to as rent/buy or shared equity schemes, whereby the tenant and the government both purchase a share of the property. Non-government owners are typically low-income households, which can buy as little as 20% of the property's total value. Home owners then have the option of buying additional shares or the government's entire share. This form of assistance not only provides an asset for the purchaser but also provides them with guaranteed security of tenure. An example of this is the Keystart program in Western Australia (Box 6.9).

Box 6.9: Shared equity schemes in Western Australia

Keystart was developed in 1989 and has assisted over 65,000 home purchasers in Western Australia by offering low-deposit loans to low- to moderate-income households. Keystart offers a range of schemes.

The **First Start Shared Equity Home Loan Scheme** reduces the initial cost of buying a home by sharing ownership with the Western Australian Department of Housing. Depending on household income and size, the Department of Housing and Works can co-own up to one-quarter of a property (before 14 October 2008, the Department could own up to 40% of a property). Home buyers are required to purchase more of the Department's share over time with concessions put in place if the entire share is bought within 10 years of the initial purchase. In 2007–08, 962 households were assisted under the First Start Shared Equity Scheme (WA Department of Housing 2008a, b; WA Department of Housing and Works 2008).

The **Goodstart Shared Equity Scheme** allows existing public rental housing tenants to purchase a share in either their current rental property or a property in the open market. In 2007–08, 80 tenants and applicants on the waiting list were assisted.

Other shared equity schemes were also offered in 2007–08, specifically targeting disabled, Indigenous or one-parent households (WA Department of Housing 2008a, b).

Assistance for people in crisis

Crisis support services are provided by governments, churches and other welfare organisations to help people in situations of actual or impending crisis or homelessness. Dwellings funded through the Crisis Accommodation Program (CAP) provide crisis accommodation to those in need and are supported by health and community organisation services that were formerly funded through the national Supported Accommodation Assistance Program and now under the NAHA.

Across Australia, there were 7,567 dwellings funded under CAP at 30 June 2008, a net increase of 51 dwellings on the previous year (AIHW 2009b). During 2007–08, 290 of these dwellings were constructed, purchased or leased and another 239 dwellings demolished, sold or disposed of.

Nationally, nearly $44 million was spent on capital throughout 2007–08 and an average of $1,786 was spent on maintenance per crisis accommodation dwelling. Information on those specifically housed in CAP dwellings is limited, though CAP stock is utilised by homelessness services to provide assistance to those in crisis or homeless. See Chapter 7 for further information on homelessness services and the clients assisted.

Housing assistance data

The implementation of the NAHA has provided the basis for increased options for the funding and provision of housing assistance, and has focused the reporting of progress against priority reform areas with the specification of associated outcomes and performance indicators. Reporting against these outcomes and performance indicators will require enhancements to existing housing assistance data collections, as well as the development of new data collections relating to the private housing market. Improving Indigenous identification, collecting unit record level data, measuring components of need and linking of records will be important areas of information development.

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Homelessness

7

Key points

- Although homelessness is widely regarded as a metropolitan issue and inner city areas have high rates of homelessness, there are also high rates of homelessness in regional and remote areas.
- Aboriginal and Torres Strait Islander peoples are over-represented in the homeless population, particularly in the Supported Accommodation Assistance Program (SAAP). On Census night 2006, Indigenous peoples were around 2% of Australians, but were 9% of homeless people. In 2007–08, 18% of SAAP clients and 26% of accompanying children were Indigenous.
- Family homelessness is an issue of growing concern. Of homeless people in Australia on Census night 2006, over a quarter (26%) were members of homeless families with children (up 17% from 2001). Families with children received over half (51%) of the total periods of support provided by SAAP in 2007–08 (up 45% from 2001–02).
- Interpersonal relationship issues, such as domestic violence and housing crisis are major factors in family homelessness.
- Families with children have more difficulty than people without children in securing some of the services they require to resolve their homelessness.

7.1 Introduction

Homelessness is generally understood to be more than just a lack of housing. It is a complex problem with multiple causes that can potentially affect anyone, at any time, as a result of particular circumstances. For some it is a once in a lifetime event; some cycle in and out of homelessness for a period of time; for others it is a chronic condition.

The social and economic costs of homelessness are significant. Being homeless makes it difficult for people to obtain or maintain employment or education and largely excludes them from full participation in the wider community. Further, the intergenerational effects of homelessness are now well known. Children who experience homelessness are more likely to perpetuate that state into adulthood and have an increased risk of long-term poverty, unemployment, chronic ill-health, and other forms of disadvantage and social exclusion (Chamberlain & MacKenzie 2003; MacKenzie & Chamberlain 2003; d'Addio 2007; FaHCSIA 2008a).

The interactions between homelessness and other forms of social exclusion are complex. Not only can being homeless often exclude people from full social and economic participation, experiencing other forms of social exclusion may increase the risk of a person becoming homeless (Bradshaw et al. 2004). Homelessness may also exacerbate any existing problems a person may have, such as mental illness, making those problems more difficult to live with or resolve. In this way, homelessness can be both a cause and a result of social exclusion.

A major focus of the Australian Government has been on improving social inclusion for all Australians. Addressing homelessness is an integral component of this agenda. *The road home: a national approach to reducing homelessness* (FaHCSIA 2008a) stresses the Australian Government's focus on the reduction and prevention of homelessness and the importance of information about the homeless, as well as those at risk of becoming homeless, in order to help understand this issue and to assist with service planning.

On 1 January 2009, the Supported Accommodation Assistance Program (SAAP) V Agreement between the Australian Government and the states and territories was replaced by the National Affordable Housing Agreement (NAHA) and a new National Partnership Agreement on Homelessness. Crucially, the new agreements further emphasise the ongoing importance of a sound evidence base for policy development and program management.

This chapter begins with an overview of homelessness in Australia before moving on to a case study of one of the growing groups of the homeless—families with children.

The chapter concludes by outlining the current government response to homelessness. As background to this, a summary of changes in government approaches to homelessness over time is presented.

7.2 Homelessness in Australia

At present, the main sources of information on homeless people in Australia are *Counting the homeless* (Chamberlain & MacKenzie 2008), which is based on data from the ABS Census of Population and Housing, and data from SAAP. This section uses these data to present an overview of homelessness in Australia.

Box 7.1: Cultural definition of 'homelessness'

This definition refers to the degree to which people's housing needs are met within conventional expectations or minimum community standards. In the Australian context this is described as having one room to sleep in, one to live in, and one's own kitchen and bathroom, and having security of tenure. The degree to which these housing needs are unmet provides a further level of categorisation as follows:

- **primary homelessness**—people without conventional accommodation, such as people living on the street, in parks, under bridges, in derelict buildings, improvised dwellings etc.
- **secondary homelessness**—people moving between various forms of temporary shelter including staying with friends, emergency accommodation, youth refuges, hostels and boarding houses
- **tertiary homelessness**—people living in single rooms in private boarding houses, without their own bathroom, kitchen or security of tenure.

In addition to producing estimates of the homeless based on the three categories described above, Chamberlain and MacKenzie also include estimates of those who are marginally housed, as described below:

- **marginally housed**—people in housing situations close to the minimum standard (for example marginal residents of caravan parks).

Source: Chamberlain & Mackenzie 2008.

How many homeless?

The ABS uses the 'cultural' definition of homelessness (Box 7.1) to count the homeless population on Census night. Using this as a base, Chamberlain and MacKenzie supplement the raw census data with information from the National Census of Homeless School Students and the SAAP Client Collection (see boxes 7.2 and 7.3) to provide an adjusted estimate of the homeless population. This estimate is produced every 5 years following the Census and is published in *Counting the homeless* (Chamberlain & MacKenzie 2008).

The intention is to give a more accurate picture of homelessness and to account for possible undercounting, particularly of certain groups (see Chamberlain & MacKenzie 2003, 2008, 2009a). The authors have continued to refine the methodology as they 'drill down' deeper into the subgroup numbers and discover new insights into how people manage their accommodation needs and what constitutes homelessness. Chamberlain and MacKenzie are working collaboratively with the ABS and the AIHW in continued refinements which will provide a better understanding of homelessness in Australia.

Chamberlain and MacKenzie estimated that, on Census night 2006, the number of people who were homeless in Australia was 104,676, or 53 per 10,000 people (tables 7.1 and 7.2; Chamberlain & MacKenzie 2008). The largest group in the homeless population were individual adults aged 19 years and over (57%), followed by families with children (26%), and young people aged 12–18 years (17%).

Table 7.1: Homeless population on Census night, 2001 and 2006 (number of people)

	2001	2006
Sector		
Boarding houses	22,877	21,596
SAAP accommodation	14,251	19,849
Friends and relatives	48,614	46,856
Improvised dwellings, sleepers out	14,158	16,375
Total	**99,900**	**104,676**
Group		
Families with children	22,944	26,790
Youth 12–18 years	22,600	17,891
Adults (singles and couple only)	54,356	59,995
Total	**99,900**	**104,676**

Source: Chamberlain & MacKenzie 2008.

While the overall numbers in 2006 were consistent with those recorded in 2001, there were variations in some sectors and groups of the homeless. For example, there was a significant increase in the number of homeless people using SAAP accommodation on Census night (up by 39%) (derived from Table 7.1). This increase was largely due to growth in the scope of the program over that period (see AIHW 2009a:Chapter 9).

The percentage of homeless people who identified as Indigenous also increased slightly from just under 9% in 2001 to just over 9% in 2006 (Chamberlain & MacKenzie 2003, 2008).

Families with children were identified as a growing group within the homeless population, increasing by 17% from 2001 to 2006. Data on homeless families with children are presented in more detail later in this chapter. In contrast, the numbers for youth aged 12–18 years declined by 21% in the same period.

Table 7.2: Number of homeless people per 10,000 population on Census night by state and territory, 2001 and 2006

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust
2001	42	44	70	64	52	52	40	288	53
2006	42	42	69	68	53	53	42	248	53

Sources: Chamberlain & MacKenzie 2009a, b, c, d, e, f, g, h.

Where are the homeless?

In this section, the geographical distribution of homelessness across Australia is examined. Two measures of homelessness are presented—a number and a rate. It is important to consider both. For example, an area could have a large number of homeless people but still have a low rate of homelessness if there is a large population in that area or, alternatively, have a low number of homeless people but a high rate of homelessness if the population in that area is small.

The figures presented below map the rates of homelessness (total, primary, secondary and tertiary) and of marginal residents of caravan parks per 10,000 people in the general Australian population on Census night 2006 by Statistical Subdivision (SSD).

Highest numbers of homeless people are in inner city areas

The SSDs with the highest numbers of homeless people were Inner Sydney (4,163 people), Inner Melbourne (3,490 people) and Inner Brisbane (2,070 people), comprising the inner city areas of Australia's largest capital cities (Chamberlain & MacKenzie 2009a, b, c, d, e, f, g, h).

The rate of homelessness in the inner city areas of capital cities was generally higher than in their middle and outer suburbs (Chamberlain & MacKenzie 2009a, b, c, d, e, f, g, h). This was the case in Sydney, Melbourne, Brisbane, Perth, Adelaide, Hobart and Canberra. This is not surprising as 'people often gravitate to the inner city, where services for homeless people have traditionally been located' (Chamberlain & MacKenzie 2009a).

Capital cities are not the only areas affected by homelessness

Capital cities, however, are not the only areas affected by homelessness. Figure 7.1 shows high rates of homelessness occurring in regional and remote areas, particularly in the northern and western areas of Australia. Interestingly, the homelessness rate in the capital cities was generally lower than in many of the regional and remote areas of their corresponding state or territory. This is illustrated by a comparison of Table 7.3, which presents the homelessness rate in capital cities, with Table 7.2, which shows the homelessness rate for each state and territory. In general, the homelessness rate in capital cities was lower than the corresponding state and territory average.

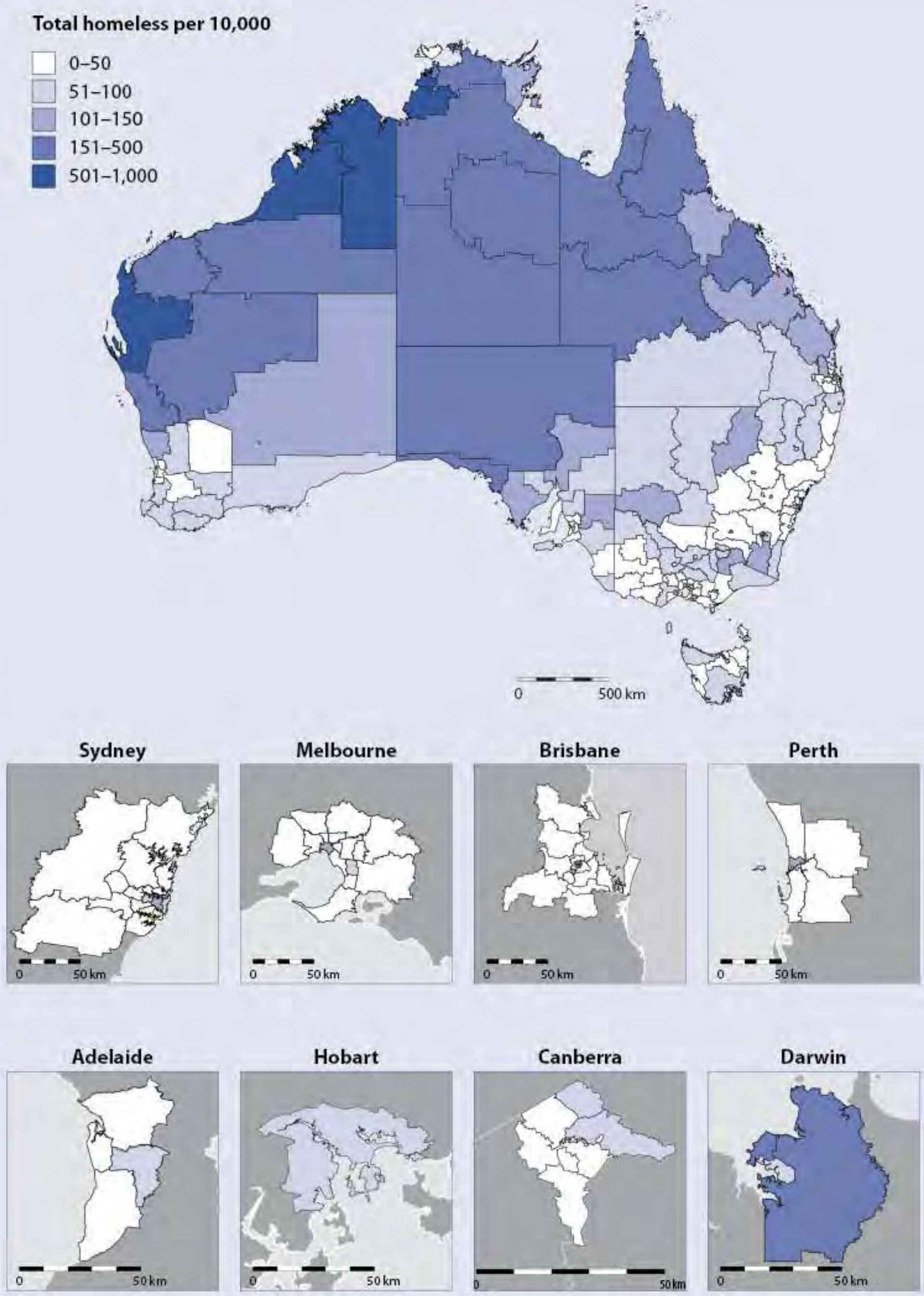
Table 7.3: Number of homeless people per 10,000 population on Census night 2006 by capital city

Sydney	Melbourne	Brisbane	Perth	Adelaide	Hobart	Canberra	Darwin
39	41	45	47	47	53	42	234

Sources: Chamberlain & MacKenzie 2009a, b, c, d, e, f, g, h.

Rates of homelessness higher in northern and western regions of Australia

Figure 7.1 shows that higher rates of homelessness occurred in the northern and western regions of Australia than in the south-eastern corner. The SSDs with the highest rates of homelessness were Finniss, in a remote area of the Northern Territory, and Ord, in the remote Kimberly region of Western Australia (911 and 873 per 10,000 people respectively) (Chamberlain & MacKenzie 2009a, b, c, d, e, f, g, h).



Sources: Chamberlain & MacKenzie 2009a, b, c, d, e, f, g, h.

Figure 7.1: Total homeless on Census night 2006 by SSD (per 10,000 people)

Primary homelessness higher in northern regions of Australia

The number of primary homeless recorded on Census night 2006 was 16,375—or 8 per 10,000 people (tables 7.1 and 7.4). Across Australia, the three SSDs with the highest numbers of primary homeless were all in Queensland—Wide Bay–Burnett (969 people), Far North (658) and Mackay (601) (Chamberlain & MacKenzie 2009a, b, c, d, e, f, g, h).

Table 7.4: Number of primary homeless people per 10,000 population on Census night 2006 by state and territory

NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust
6	4	13	12	6	8	2	82	8

Sources: Chamberlain & MacKenzie 2009a, b, c, d, e, f, g, h.

The distribution of primary homelessness rates across Australia (Figure 7.2) displayed a similar pattern to that of overall homelessness (Figure 7.1), with lower rates recorded in the south-eastern regions and higher rates in the northernmost regions. In particular, the Finniss and Daly SSDs in the remote northern tip of the Northern Territory recorded the highest primary homelessness rates (450 and 392 per 10,000 people respectively).

Distribution of rates of secondary homelessness similar to that of total homelessness

The number of secondary homeless recorded on Census night 2006 was 66,705—or 34 per 10,000 people (tables 7.1 and 7.5). The SSDs with the highest numbers of secondary homeless were Inner Sydney (1,611 people), Western Melbourne (1,436) and North Metropolitan in Western Australia (1,417) (Chamberlain & MacKenzie 2009a, b, c, d, e, f, g, h).

Table 7.5: Number of secondary homeless people per 10,000 population on Census night 2006 by state and territory

NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust
24	28	42	48	38	39	36	130	34

Sources: Chamberlain & MacKenzie 2009a, b, c, d, e, f, g, h.

The SSDs with the highest rates of secondary homelessness were Ord and Gascoyne in remote Western Australia (516 and 515 per 10,000 people respectively) (Chamberlain & MacKenzie 2009a, b, c, d, e, f, g, h).

The distribution of rates of secondary homelessness (Figure 7.3) followed a similar pattern to that of total homelessness (Figure 7.1), with higher rates in the northern and western regions of Australia, and lower rates in the south-eastern regions.

Tertiary homelessness higher in capital cities

The number of tertiary homeless recorded on Census night 2006 was 21,596—or 11 per 10,000 people (tables 7.1 and 7.6). The SSDs with the highest numbers of tertiary homelessness were Inner Sydney (2,164 people), Inner Melbourne (2,040) and Inner Brisbane (1,325) (Chamberlain & MacKenzie 2009a, b, c, d, e, f, g, h). This is not surprising as boarding houses are more common in capital cities and 70% of boarding house residents lived in capital cities (Chamberlain & MacKenzie 2008).

Table 7.6: Number of tertiary homeless people per 10,000 population on Census night 2006 by state and territory

NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust
12	9	14	8	9	5	3	36	11

Sources: Chamberlain & MacKenzie 2009a, b, c, d, e, f, g, h.

The rates of tertiary homelessness were also generally higher in the capital cities, particularly in the inner city areas (Figure 7.4; Chamberlain & MacKenzie 2009a, b, c, d, e, f, g, h). Of the SSDs, Inner Brisbane had by far the highest rate of tertiary homelessness (158 per 10,000 people). Inner Melbourne, Darwin City and Inner Sydney also reported relatively high rates of tertiary homelessness (75, 70 and 69 per 10,000 people).

Marginal residents of caravan parks higher outside of capital cities

Marginal residents of caravan parks are defined as those people who are renting a caravan, at their usual address, with no-one in the caravan having full-time employment. The number of marginal residents of caravan parks recorded on Census night 2006 was 17,497—or 9 per 10,000 people (Table 7.7; Chamberlain & MacKenzie 2008).

In contrast to the tertiary homeless living in boarding houses, 71% of marginal residents of caravan parks were living in regional and remote areas and 29% were in capital cities (Chamberlain & MacKenzie 2008).

Table 7.7: Number of marginal residents of caravan parks per 10,000 population on Census night 2006 by state and territory

NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust
8	6	16	10	5	3	1	14	9

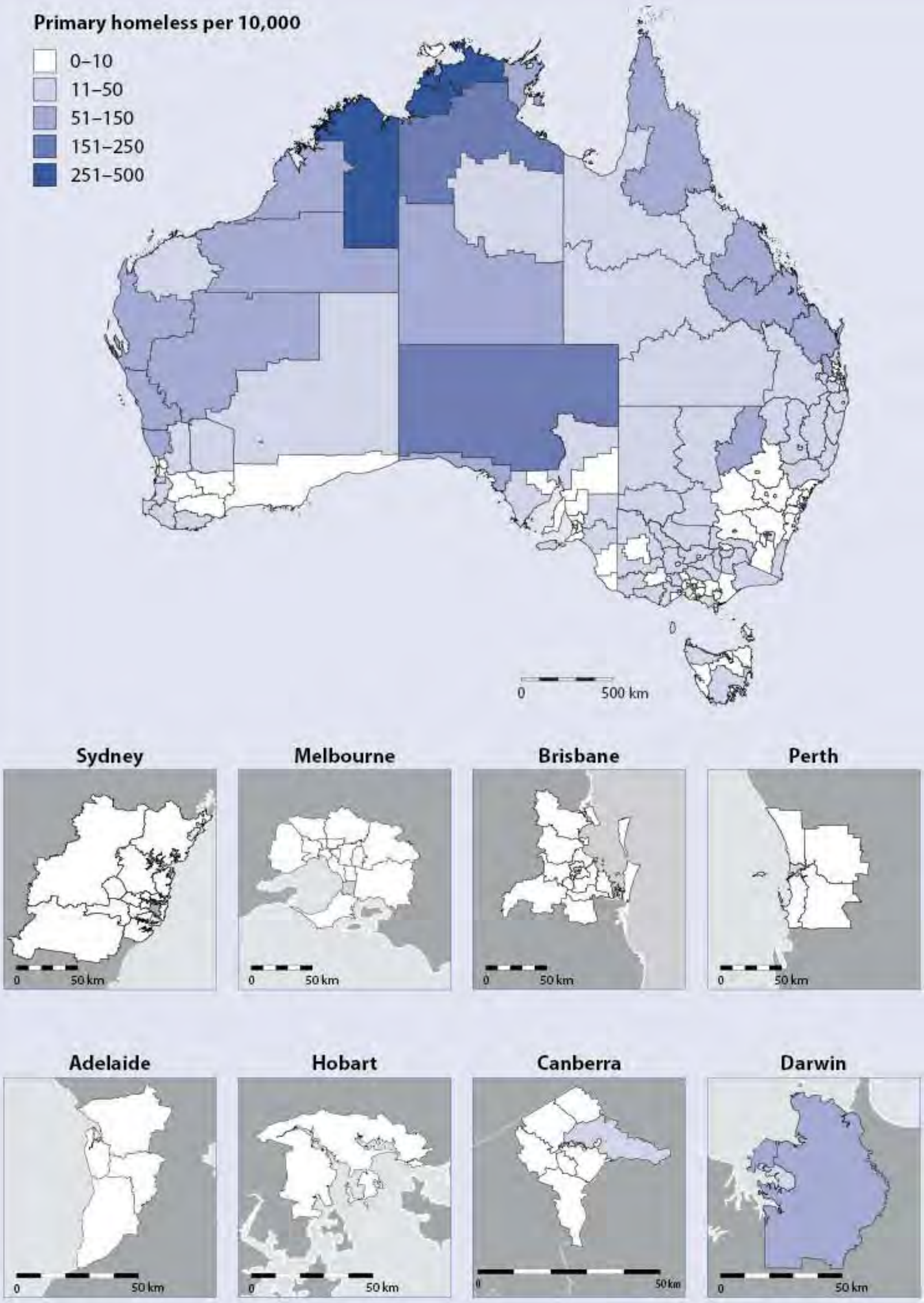
Sources: Chamberlain & MacKenzie 2009a, b, c, d, e, f, g, h.

Figure 7.5 shows the distribution of marginal residents of caravan parks. The map reveals lower rates of people living in caravans in capital cities, especially in the inner city areas, and higher rates living in regional and remote areas. This is particularly noticeable in coastal New South Wales, Queensland and Western Australia.

Marginal residents of caravan parks are excluded from the homelessness estimates presented earlier. This is because even those residents who are using this type of accommodation as an emergency or transient option are considered to fall under the category 'marginally housed' (see Box 7.1).

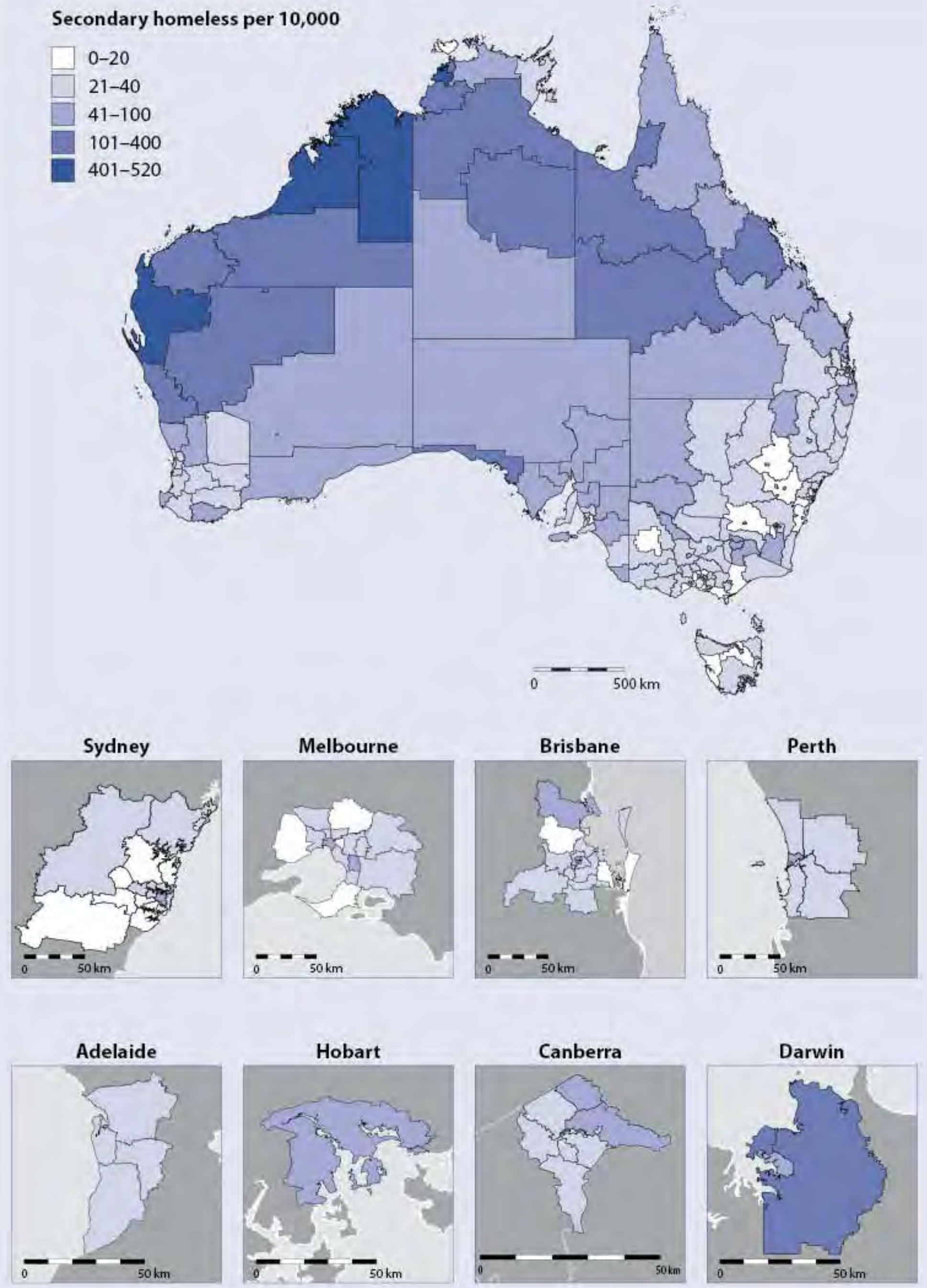
Because caravan parks may be used as an alternative mode of emergency accommodation to boarding houses, particularly outside of capital cities, there are likely to be some caravan park residents who should have been counted among the homeless. The appropriateness of excluding this group is discussed further in previous editions of *Australia's welfare* (see AIHW 2005a, 2007) and *Counting the homeless 2006* (Chamberlain & MacKenzie 2008, 2009a, b, c, d, e, f, g, h).

If marginal residents of caravan parks are included in estimates of the homeless population, the rates of homelessness increase the most for Queensland, New South Wales and Western Australia (tables 7.2 and 7.8). As the vast majority (93%) of marginal residents of caravan parks were in Queensland (6,385), New South Wales (5,104), Victoria (2,789) and Western Australia (1,994), the question of whether to include them as part of the homeless population is particularly an issue in those states (Chamberlain & MacKenzie 2009a, b, c, d, e, f, g, h).



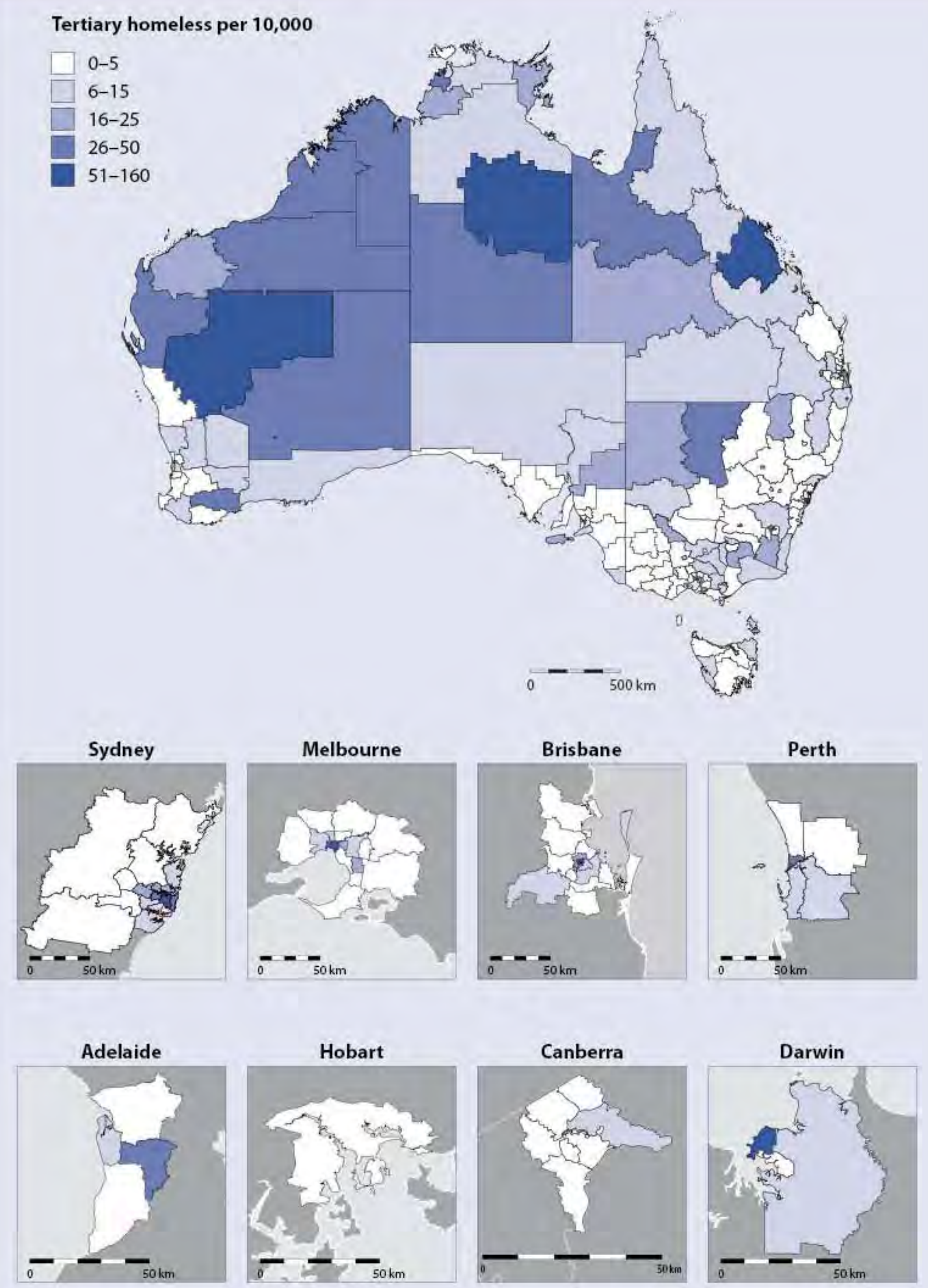
Sources: Chamberlain & MacKenzie 2009a, b, c, d, e, f, g, h.

Figure 7.2: Primary homeless on Census night 2006 by SSD (per 10,000 people)



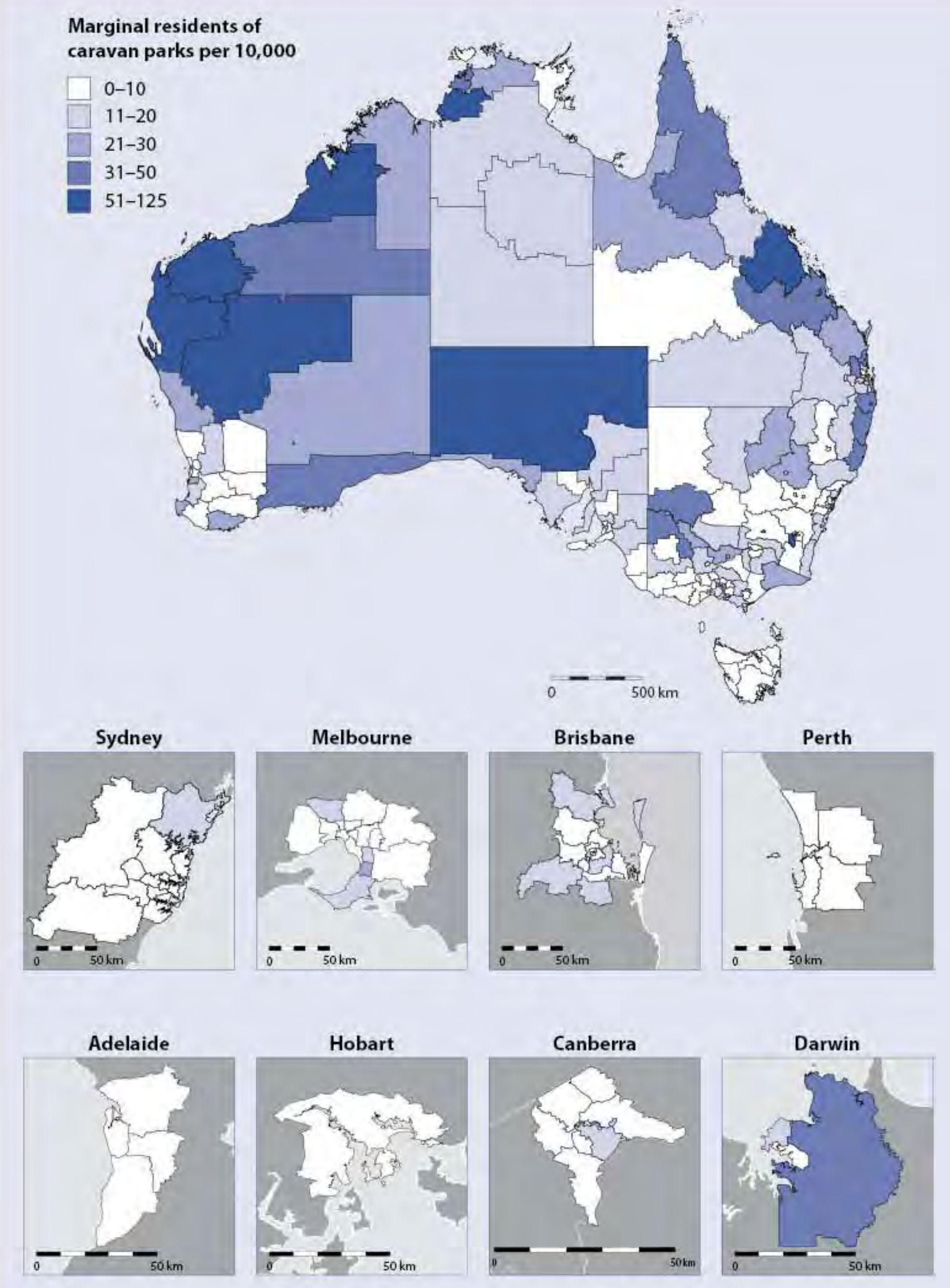
Sources: Chamberlain & MacKenzie 2009a, b, c, d, e, f, g, h.

Figure 7.3: Secondary homeless on Census night 2006 by SSD (per 10,000 people)



Sources: Chamberlain & MacKenzie 2009a, b, c, d, e, f, g, h.

Figure 7.4: Tertiary homeless on Census night 2006 by SSD (per 10,000 people)



Sources: Chamberlain & MacKenzie 2009a, b, c, d, e, f, g, h.

Figure 7.5: Marginal residents of caravan parks on Census night 2006 by SSD (per 10,000 people)

Table 7.8: Number of homeless people per 10,000 population including marginal residents of caravan parks by state and territory

NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust
50	47	85	79	58	56	43	262	62

Sources: Chamberlain & MacKenzie 2009a, b, c, d, e, f, g, h.

The Supported Accommodation Assistance Program

From 1985 to 2008, SAAP was the largest of the many government programs to support people experiencing or at risk of homelessness in Australia (see boxes 7.2 and 7.6). SAAP, which is now incorporated into the NAHA, was jointly funded by the Australian Government and state and territory governments. Support was provided by SAAP agencies. These agencies were administered by the states and territories and predominantly consisted of non-government organisations.

Box 7.2: *Supported Accommodation Assistance Act 1994*

The *Supported Accommodation Assistance Act 1994* described SAAP's overall aim as being 'to provide transitional supported accommodation and related support services, in order to help people who are homeless to achieve the maximum possible degree of self-reliance and independence'. It further defined its goals as being: to resolve crisis; to re-establish family links where appropriate; and to re-establish a capacity to live independently of SAAP.

Under the Act, a person was homeless if he or she did not have access to safe, secure and adequate housing. A person is considered not to have access to safe, secure and adequate housing if the only housing to which they have access:

- damages, or is likely to damage, their health
- threatens their safety
- marginalises them through failing to provide access to
  - adequate personal amenities, or
  - the economic and social supports that a home normally affords
- places them in circumstances that threaten or adversely affect the adequacy, safety, security and affordability of that housing
- has no security of tenure—that is, they have no legal right to continued occupation of their home.

A person was also considered homeless if he or she was living in accommodation provided by a SAAP agency or some other form of emergency accommodation, was in 'crisis and at imminent risk of becoming homeless', or was 'experiencing domestic violence and was at imminent risk of becoming homeless'.

This legislation was used to underpin the SAAP III (1995–1999), SAAP IV (2000–2004) and SAAP V (2005 – 31 December 2008) agreements.

Funding to SAAP agencies in 2007–08 totalled $400.4 million, of which $383.9 million was direct funding (AIHW 2009a). In real terms, total funding in 2007–08 was 28% greater than in 1996–97 and 1% greater than in 2006–07, while agency funding was 34% greater than in 1996–97 and 1% greater than in 2006–07. Funding for specialist homelessness services will continue under NAHA (see Section 7.4).

The number of SAAP agencies has expanded from around 500 at the program's inception in 1985 to 1,562 agencies in 2007–08. The establishment of particular SAAP agencies has in large part been the outcome of submission-based funding patterns influenced by various state- and territory-level policy directives, as each state and territory administered the agencies within their jurisdiction. Each agency varies in the services it provides, ranging from early intervention to prevent homelessness, through supported accommodation, to post-crisis support. Agencies also provide non-accommodation services for those who are marginally housed—such as showers, laundry facilities, meals and access to health professionals, such as general practitioners, psychiatrists, psychologists or podiatrists. In 2007–08, around one-third of client and accompanying child support periods involved a period of accommodation (AIHW 2009a), indicating that SAAP services have evolved far beyond the provision of just crisis accommodation (see Box 7.6).

Box 7.3: The SAAP National Data Collection

The SAAP National Data Collection has been providing information on the provision of assistance through SAAP since 1996–97. It consists of distinct components, each of which can be thought of as a separate collection. In 2007–08, three collections were run:

- **Client Collection**—run annually on the services provided to clients and their accompanying children. Upon gaining clients' consent to collect additional information, demographic data, the reason why a client sought assistance, and details of clients' circumstances before and after support can also be recorded. Data are recorded in terms of support periods—a discrete period of time in which a person is supported—which can range from less than 1 day, to several months and, in a very few cases, years.
- **Demand for Accommodation Collection**—run twice a year during two separate weeks. It is used to measure the levels of met and unmet demand for SAAP accommodation, including how many people were turned away. SAAP agencies were required to fill out a form per presenting unit (individual or group) each time accommodation was sought.
- **Administrative Data Collection**—provided annually by the state and territory departments that administer SAAP. It contains general information about the agencies providing SAAP services, including the client target group of each agency and details of funding.

Many SAAP agencies are funded to target quite specific client groups such as young people, single men, single women, women and children escaping domestic violence, or families. The remainder focus on supporting multiple or more general client groups. The largest group of agencies in SAAP, totalling 35% of agencies in 2007–08, was youth agencies. The next largest group of agencies was generalist agencies (24%), followed by agencies that catered for women and children escaping domestic violence (23%) (AIHW 2009a).

SAAP agencies often operate quite differently in response to the diverse needs of their client groups. Agencies targeting young people, for example, are often quite small and might have legal requirements to provide intensive 24-hour care to a relatively small number of clients, while those targeting single men often operate with a very high client turnover and less client contact. As a consequence, the proportion of support periods provided, as well as the types and lengths of support, varies significantly between types of agencies.

How many people use SAAP services?

In 2007–08, an estimated 1 in every 104 Australians, or about 202,500 people (125,600 clients and 76,900 accompanying children), were supported and/or accommodated by SAAP (AIHW 2009a:Chapter 3; derived from Table 7.9) (for definitions see Glossary and AIHW 2009a).

Clients

Around 125,600 clients were provided with 220,300 periods of support in 2007–08 (AIHW 2009a). The majority of clients (73%) had only one period of support, but the remainder had more than one, hence the greater number of support periods than clients. Nationally, 1 in every 147 people aged 10 years and over in the general population became a SAAP client.

Accompanying children

In 2007–08, 76,900 children accompanied clients of SAAP agencies, the equivalent of 1 in every 64 children in the general Australian population aged 17 years and under (AIHW 2009a). These accompanying children had 107,300 periods of support, and most (82%) had only one period of support during the year.

Who uses SAAP services?

Young people, especially young females, and children were the most likely to use SAAP services (AIHW 2009a). In 2007–08, 1 in every 63 people aged 15–19 years and 1 in every 49 females aged 15–19 years accessed SAAP. Children also had a high rate of use with 1 in 64 children overall and 1 in every 39 children aged 0–4 years accompanying a parent or guardian to a SAAP agency.

Females were more likely to use SAAP services than males: 1 in 120 females in the general Australian population used a SAAP service in 2007–08, compared with 1 in 192 males (AIHW 2009a). This may be due to the relatively large proportion of SAAP agencies that catered either exclusively or predominantly for women and children escaping domestic violence (23%).

Aboriginal and/or Torres Strait Islander peoples were over-represented in the SAAP population (AIHW 2009a). While they were estimated to account for around 2% of Australians aged 10 years and over at 30 June 2007, they represented 18% of all SAAP clients in 2007–08. A greater proportion of female than male clients identified as being an Indigenous Australian (21% of female clients, compared with 13% of male clients). At 26%, the proportion of Indigenous accompanying children in SAAP was also well in excess of their proportion of the Australian population (5%).

Why was support sought?

The most common reason cited by SAAP clients for seeking assistance was interpersonal relationship problems (44%) (tables 7.12 and A7.1) (AIHW 2009a: Table 5.4). This was followed by accommodation problems (19%) and financial issues (14%).

This varied when broken down by client group (AIHW 2009a:Table 5.5). For example, for females, interpersonal relationship problems were the most common reason for seeking support—53% for women aged 25 years and over; 58% for females aged under 25 years; and 68% for women with children. Within this broad category, domestic violence was the most prevalent reason for women aged 25 years and over (37%) and for those who presented with children (50%). For females aged under 25 years, family breakdown (22%) was cited as the most common reason in the interpersonal relationship category.

Interpersonal relationship problems were also common for males aged under 25 years (41%) and males with children (29%), with relationship or family breakdown the most common factor within this category (AIHW 2009a:Table 5.5). This differed for males aged over 25 years, who reported health issues (23%) and financial difficulties (22%) as the most common reasons for seeking assistance. The most common health issue reported for this group was problematic drug, alcohol, or substance use.

Couples, both with and without children, most commonly reported accommodation difficulties (45% and 31% respectively), particularly eviction or being asked to leave.

Were support needs met?

SAAP agencies were able to directly meet the needs of clients and accompanying children in the majority of cases (90% for clients, 92% for accompanying children) (AIHW 2009a:Chapter 7). Basic support services—such as meals, showers, recreation and transport—were the most likely type of service to be provided directly. Specialist services—such as health or medical services and specialist counselling—were the least likely services to be provided directly and the most likely services for which clients were referred on to other organisations.

Generally, SAAP client circumstances improved following support, particularly for those who required assistance with income, employment or housing, and for those supported for longer periods (AIHW 2009a:Chapter 8). Over half (60%) had a case management plan in place before the end of their support and, in most of these cases (93%), at least some of the goals specified in the plan were achieved.

Demand for SAAP accommodation

Although SAAP agencies supported and accommodated large numbers of people each day, they could not always meet all the requests for SAAP accommodation. In addition to the annual SAAP Client Collection data presented above, which show the service provision to clients of SAAP services, data are collected twice a year on people who request accommodation but do not receive it (are turned away) (see Box 7.3). Data collected during the 2007–08 Demand for Accommodation Collection period showed that people who required new and immediate SAAP accommodation were more often turned away (59%) than accommodated (41%) (AIHW 2009b:Chapter 9).

The most common reason that individuals or groups were turned away was because of a lack of accommodation (83% of valid unmet requests) (AIHW 2009b:Chapter 4). This was either because insufficient accommodation was available at the agency itself (59%) or because a referral agency was unable to refer the individual or group on because they had no vacancies on their books (24%).

Where are the SAAP clients?

This section combines the service provision information supplied by SAAP agencies with the postal addresses of those SAAP agencies to analyse the geographical distribution of SAAP clients and accompanying children across Australia.[1]

The following maps illustrate the size of the SAAP population relative to the Australian population. As with the maps presented earlier, both the number and the rate should be considered, as a region with a large number of SAAP clients and accompanying children might have a low rate of SAAP use if the size of the entire population in the region is large and vice versa.

SAAP clients and accompanying children

Figure 7.6 illustrates the distribution of SAAP clients and accompanying children in 2007–08 per 10,000 people in the general population by Statistical Division (SD), as well as by Statistical Subdivision (SSD) in the capital cities. This map indicates that, like the total homeless population presented in Figure 7.1, there were generally higher rates of SAAP use in regional and remote Australia than in metropolitan areas. For instance, apart from Darwin, Adelaide and Hobart, the capital cities had relatively low rates of SAAP clients and accompanying children per 10,000 people, as compared with the rest of their state or territory. A comparison of tables 7.9 and 7.10 shows that Adelaide and Hobart are the only capital cities where the rate of SAAP use was higher than in the rest of the corresponding state or territory.

Table 7.9: Number of SAAP clients and accompanying children per 10,000 population by state and territory, 2007–08

NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust
82	111	80	91	141	143	102	270	96

Notes

1. Location of client is based on the postal address of the SAAP agency attended.
2. State and territory estimates of SAAP clients and accompanying children are based on their first visit at the state and territory level in the reporting period. National estimates of SAAP clients and accompanying children are based on their first visit at the national level in the reporting period.

Sources: SAAP Client Collection; ABS 2008 (preliminary estimates).

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[1] Note that a limitation of this approach is the assumption that the postal address of an agency corresponds closely to its physical location, which may not necessarily be the case. For example, the postal address for an agency may be a regional office located some distance from where the agency is physically operating. The extent to which this happens is not known.

Table 7.10: Number of SAAP clients and accompanying children per 10,000 population by capital city, 2007–08

Sydney	Melbourne	Brisbane	Perth	Adelaide	Hobart	Canberra	Darwin
60	103	70	70	144	160	102	221

Notes

1. Location of client is based on the postal address of the SAAP agency attended.
2. Estimates of SAAP clients and accompanying children are based on their first visit at the state and territory level in the reporting period.

Sources: SAAP Client Collection; ABS 2008 (preliminary estimates).

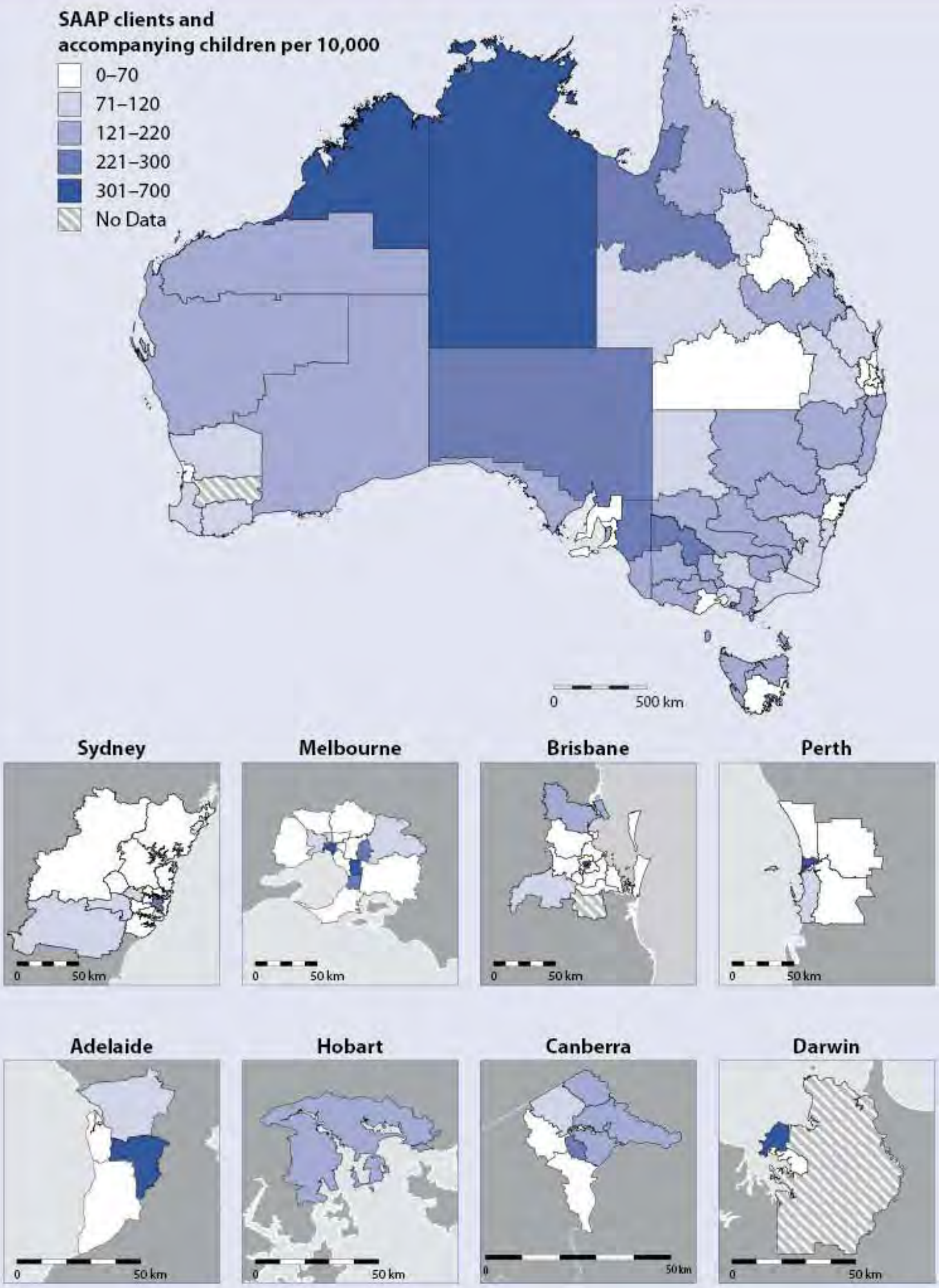
While the general pattern of SAAP use rates reflects the homelessness rates presented earlier, there are some exceptions. This is to be expected considering the different definitions of homelessness used by the two data sources. For example, the relatively high rate of SAAP clients and accompanying children in the Mid North Coast region of New South Wales contrasts with the relatively low rate of homelessness in the same region. One explanation for this is the region's high rate of individuals who are considered 'marginally housed' (Figure 7.5). This supports the premise that the cultural definition of homelessness, as currently applied by Chamberlain and MacKenzie, may lead to undercounting in regions where homeless people use caravan parks rather than boarding houses for emergency accommodation.

Aboriginal and Torres Strait Islander clients and accompanying children

The highest rates of SAAP use by Aboriginal and Torres Strait Islander peoples generally occurred in regional and remote areas rather than metropolitan areas (Figure 7.7).

Non-Indigenous clients and accompanying children

High rates of SAAP use by non-Indigenous people occurred in South Australia (particularly in regional and remote areas), northern Tasmania and western Victoria, while Western Australia and Queensland had comparatively lower rates (Figure 7.8).

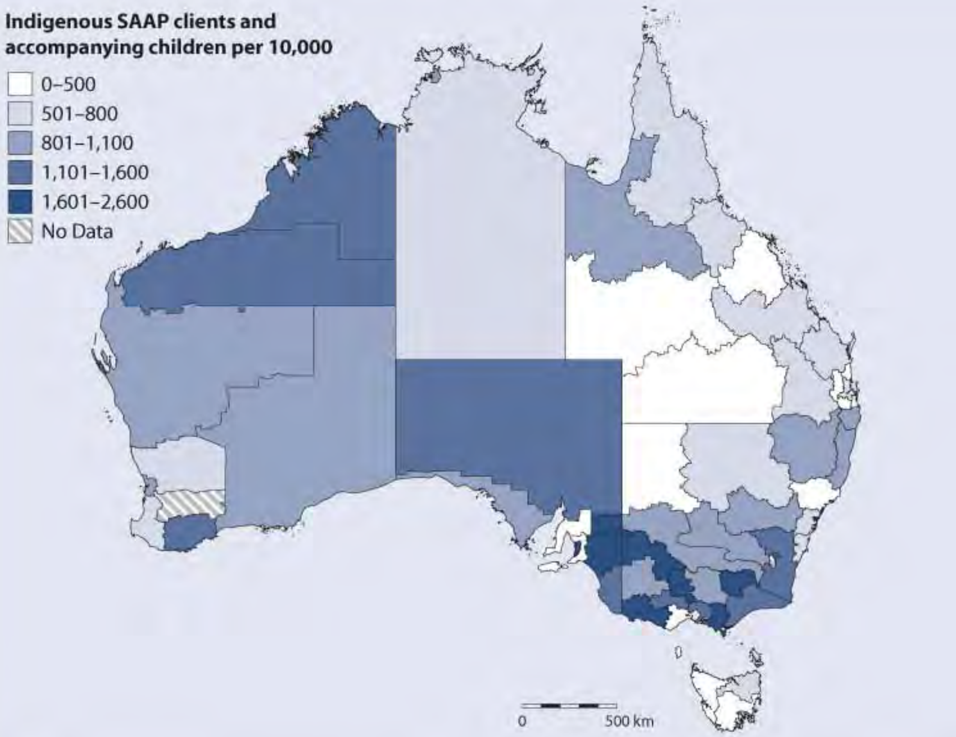


Notes

1. Location of client is based on the postal address of the SAAP agency attended. Some areas contain no SAAP agency postal addresses.
2. Estimates of SAAP clients and accompanying children are based on their first visit at the state and territory level in the reporting period.

Sources: ABS 2006, 2008 (preliminary estimates); SAAP Client Collection.

Figure 7.6: SAAP clients and accompanying children by SD (Australia) and SSD (capital cities), 2007–08 (per 10,000 people)

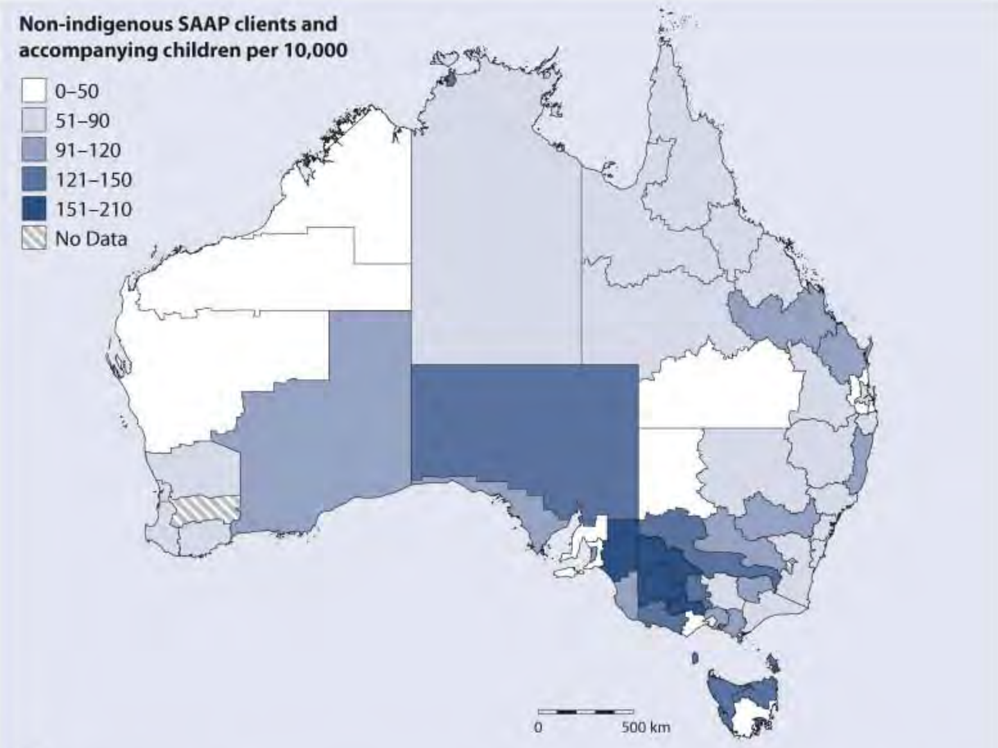


Notes

1. Location of client is based on the postal address of the SAAP agency attended. Some statistical divisions contain no SAAP agency postal addresses.
2. Estimates of SAAP clients and accompanying children are based on their first visit at the state and territory level in the reporting period.

Sources: ABS unpublished data; SAAP Client Collection.

Figure 7.7: Aboriginal and Torres Strait Islander SAAP clients and accompanying children by SD, 2007–08 (per 10,000 Aboriginal and Torres Strait Islander peoples)



Notes

1. Location of client is based on the postal address of the SAAP agency attended. Some statistical divisions contain no SAAP agency postal addresses.
2. Estimates of SAAP clients and accompanying children are based on their first visit at the state and territory level in the reporting period.

Sources: SAAP Client Collection; ABS unpublished data.

Figure 7.8: Non-Indigenous SAAP clients and accompanying children by SD, 2007–08 (per 10,000 non-Indigenous people)

7.3 A more detailed look: tough times for homeless families

Family homelessness is an issue of growing concern (Chamberlain & MacKenzie 2008; FaHCSIA 2008a). Difficult economic conditions as a result of the global financial crisis and a tight housing market have made circumstancess particularly hard for some families, with more likely to turn to support services for assistance.

Homeless families can experience multiple aspects of disadvantage, including unemployment, poverty and domestic violence, that contribute to their social exclusion. This is of particular concern in relation to children. Homelessness may have negative effects on children's development, education, health and wellbeing (AIHW 2005b). In addition, research has shown that the intergenerational impact of homelessness is considerable, and children who are homeless and disadvantaged are more likely to continue that state into adulthood (Chamberlain & MacKenzie 2003; MacKenzie & Chamberlain 2003; d'Addio 2007).

This section looks at the causes of family homelessness, service use by families, and the outcomes that homeless families experience after receiving a service response.

How many homeless families?

On Census night, 8 August 2006, there were an estimated 7,483 homeless families with children. They accounted for 10% of the 74,825 homeless 'households' in Australia (Chamberlain & MacKenzie 2008). In terms of the number of people making up these family groups, there were 26,790 people (10,608 adults and 16,182 children) accounting for over one-quarter (26%) of the total homeless population (104,676).

Family homelessness is increasing—up 17% from 22,944 in 2001 to 26,790 in 2006. Chamberlain and MacKenzie put this down to 'the increase in the number of families entering SAAP to escape domestic violence, combined with the shortage of affordable housing and the absence of early intervention initiatives' (Chamberlain & MacKenzie 2008:51).

Chamberlain and MacKenzie note that families often enter homelessness as a result of domestic violence or housing crisis (Chamberlain & MacKenzie 2008). They argue that early intervention strategies are effective for both these causes but acknowledge that providing early intervention for women escaping domestic violence may be difficult because assistance might only be sought after leaving the family home.

Homeless families with children in SAAP

SAAP has played an important role in securing accommodation and providing support for families and children who are homeless or at risk of homelessness. The SAAP National Data Collection contains valuable information on this group. It shows that difficulties in interpersonal relationships, mainly domestic or family violence, and housing crisis are major factors in family homelessness.

In the following analyses, SAAP client groups are broken down into people with or without children, and further disaggregated by sex and family composition where possible.

How many families with children used SAAP?

In 2007–08, clients with children accounted for over a quarter (27%) of the periods of support provided under SAAP (Table 7.11). The majority of these support periods were provided to females with children (80%).

When the periods of support provided to the children who accompanied clients are included in this figure, families with children accounted for just over half (51%) of the total support periods provided by SAAP in 2007–08 (Table 7.11). In terms of the number of people (as opposed to their periods of support), this equated to an estimated 117,700 individuals (40,800 clients and 76,900 accompanying children) (AIHW 2009a:Table 3.2, unpublished data).[2]

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[2] A client may present to SAAP multiple times and their 'family type' may vary with each period of support. For the purposes of estimating the number of people presenting as a family with children, clients are formed into two groups—those with children and those without—and their first presentation to a SAAP agency in each group is used. For this reason, the sum of clients with children and clients without children will not add to the total number of clients as presented in AIHW 2009a.

Support to families with children has increased over the years of the SAAP National Data Collection. In 2001–02, 46% of the total number of support periods were provided to families with children, increasing to 51% in 2007–08 (AIHW unpublished data). This represents an increase of 45% in the number of support periods provided to families between 2001–02 and 2007–08.

Table 7.11: Total SAAP support by client group, 2007–08

	With children					Without children					
	Female	**Male**	**Couple**	**Other/ unknown**	**Total**	**Female**	**Male**	**Couple**	**Other/ unknown**	**Total**	**Total**
Client support periods											
Per cent	21.6	1.3	4.0	0.2	27.1	31.1	34.9	2.7	4.1	72.9	100.0
Number	47,700	2,900	8,800	500	59,800	68,500	76,800	6,000	9,100	160,500	220,300
Accompanying child support periods											
Per cent	84.1	4.0	11.1	0.9	100.0	—	—	—	—	—	100.0
Number	90,200	4,200	11,900	900	107,300	—	—	—	—	—	107,300
Total support periods[(a)]											
Per cent	42.1	2.2	6.3	0.4	51.0	20.9	23.5	1.8	2.8	49.0	100.0
Number	137,900	7,100	20,700	1,400	167,100	68,500	76,800	6,000	9,100	160,500	327,600

(a) 'Total support periods' refers to client support periods plus accompanying child support periods.

Notes

1. Number excluded due to errors and omissions (weighted): 0.
2. 'Other/unknown with children' consists of records where the presenting unit was 'other' or missing or sex was missing, and the client recorded details of an accompanying child(ren). 'Other/unknown without children' consists of records where the presenting unit was 'other' or missing or sex was missing, and the client did not record details of an accompanying child(ren).
3. Cell numbers may not add due to rounding.
4. Figures have been weighted to adjust for agency non-participation.

Source: SAAP Client Collection.

Why do families with children seek support?

Families with children commonly reported either issues with interpersonal relationships (59%), such as domestic or family violence, or accommodation difficulties (21%), such as eviction, as their primary reason for seeking support (Table 7.12).

Box 7.4: Responses to homelessness—the 'Safe at Home' model

The Safe at Home model was identified as a key component of the Australian Government's commitment to reducing domestic and family violence (FaHCSIA 2008a). Traditionally, responses to domestic violence have focused on helping victims leave violent relationships. This usually meant leaving the family home and relocating. The Safe at Home model is aimed at keeping victims of violence in their family home, where it is safe to do so, while removing the perpetrator of the violence. It is an integrated approach that includes a range of services for victims and offenders, and children are recognised as victims of family violence in their own right. Importantly, the Safe at Home model recognises that this response will not suit all women and that other responses will be required, particularly for those at extreme risk of violence.

The prevalence and order of these reasons varied depending on the type of family unit. For example, females with children mostly reported issues with their interpersonal relationships (in 68% of support periods), predominantly domestic violence (50%) (tables 7.12 and A7.1). In contrast, males with children commonly cited accommodation issues (32%), such as eviction or being asked to leave (14%) and previous accommodation ending (10%), and interpersonal relationship issues (29%), such as family or relationship breakdown (16%), as the primary reasons they sought assistance from SAAP.

Table 7.12: SAAP support periods: main reason for seeking assistance by client group, 2007–08 (per cent)

Client group	Interpersonal relationships	Financial	Accommodation	Health	Other reasons	Total	Total (number)
With children	**58.7**	**9.9**	**21.4**	**2.2**	**7.8**	**100.0**	**58,300**
Female	67.8	7.7	16.3	1.8	6.3	100.0	46,800
Male	28.5	19.9	32.4	5.2	13.9	100.0	2,700
Couple	19.1	18.9	45.2	3.2	13.6	100.0	8,600
Other/unknown	48.0	5.3	30.1	2.1	14.4	100.0	100
Without children	**38.4**	**15.8**	**18.6**	**12.0**	**15.3**	**100.0**	**153,600**
Female alone	55.0	13.4	15.6	5.8	10.2	100.0	67,100
Male alone	24.0	18.1	20.2	18.2	19.6	100.0	76,000
Couple	26.8	17.2	31.2	5.5	19.3	100.0	6,000
Other/unknown	48.0	10.0	18.6	8.7	14.6	100.0	4,500
Total	**44.0**	**14.1**	**19.4**	**9.3**	**13.2**	**100.0**	**211,800**

Notes

1. Number excluded due to errors and omissions (weighted): 8,491.
2. 'Other/unknown with children' consists of records where the presenting unit was 'other' or missing and the client recorded details of an accompanying child(ren). 'Other/unknown without children' consists of records where the presenting unit was 'other' or missing and the client did not record details of an accompanying child(ren).
3. Figures have been weighted to adjust for agency non-participation and client non-consent.

Source: SAAP Client Collection.

The most common reason that couples with children presented to SAAP was to do with accommodation difficulties (45%)—particularly eviction or being asked to leave (21%), previous accommodation ending (11%), and overcrowding issues (11%) (tables 7.12 and A7.1). Couples with children were the family group most likely to cite accommodation difficulties as their main reason for presenting to the SAAP service.

For 'other' family groups with children (including multi-generational family groups), issues around interpersonal relationships (48%), such as domestic or family violence (36%), were commonly reported (tables 7.12 and A7.1).

For how long were families with children supported?

Once families with children were accepted into SAAP, they tended to be both supported and accommodated for longer periods than clients without children (Table 7.13). Families with children had a mean length of support of 78 days and a median length of support of 28 days (compared with 48 days and 7 days respectively for those without children) and a mean length of accommodation of 81 days and a median length of accommodation of 22 days (compared with 45 days and 10 days respectively for those without children). One of the reasons families stayed so long in SAAP might be that they had nowhere else to go.

Table 7.13: SAAP closed support periods: length of support by client group, 2007–08 (days)

	Length of support		Length of accommodation[(a)(b)]	
Client group	**Mean**	**Median**	**Mean**	**Median**
With children	**78**	**28**	**81**	**22**
Female	73	24	69	17
Male	86	35	135	84
Couple	105	45	169	94
Other/unknown	79	10	55	17
Without children	**48**	**7**	**45**	**10**
Female	52	7	47	9
Male	44	6	43	11
Couple	65	21	85	22
Other/unknown	47	7	36	8
Total	**56**	**10**	**54**	**12**

(a) Excludes accommodation that started or ended on the same day.

(b) A client may have no accommodation periods or one or more accommodation periods within a support period.

Notes

1. Number excluded due to errors and omissions (weighted): 0 support periods; 1,302 support periods with accommodation.
2. Figures have been weighted to adjust for agency non-participation.

Source: SAAP Client Collection.

Data on the availability and affordability of suitable accommodation for low-income families in the social and private housing sectors support the assertion that homeless families often had nowhere to go once they exit SAAP (see Chapter 6). In particular, the demand by low-income households has generally outstripped the availability of low-cost accommodation. Homeless people are, however, classified as one of the groups 'in greatest need' for priority housing allocation. Another priority group is those whose life or safety were at risk in their previous accommodation. This includes situations of domestic violence. Data on priority housing show that young people, mixed households and one-parent families are the most likely groups of people to be allocated priority housing due to homelessness (AIHW 2008). Women, especially those who were single parents, were more likely than men to get priority allocation because their life or safety was at risk. This supports data from SAAP which show that, of the family groups, women with children had the shortest lengths of support and accommodation and were also the most likely to exit to public or community housing (tables 7.13 and 7.16).

Were the needs of families with children met?

Around a third (32%) of support periods for families with children included a period of SAAP or Crisis Accommodation Program accommodation, while the remaining 68% were for support services only (AIHW 2009a). These proportions have changed over the last few years of the collection. For example, in 2005–06 the proportion of support periods in which families with children had a period of SAAP accommodation was 41%, decreasing to 37% in 2006–07, and again to 32% in 2007–08. This most likely reflects the increased emphasis on early intervention and post-crisis support under SAAP V, for which the data collection began on 1 July 2005.

Box 7.5: Responses to homelessness—the Household Organisational Management Expenses (HOME) Advice Program

The HOME Advice Program is designed to assist families who are at risk of homelessness. It was identified in the White Paper as a successful early intervention model for families (FaHCSIA 2008a). Most families present with a complexity of issues, such as a history of family violence or mental health issues, and with few social support networks. Community service workers adopt a holistic approach, working with all household members, often visiting them in their home. They assist with budgeting, parenting support, referrals to specialist services, public housing applications, and negotiate with real estate agents and housing authorities to maintain tenancies. Access to flexible brokerage money enables workers to intervene with timely financial assistance. The HOME Advice Program features a unique partnership between the Department of Families, Housing, Community Services and Indigenous Affairs, Centrelink and non-government service providers, with Centrelink HOME Advice social workers often being co-located at the community service agency.

In general, clients with children were slightly less likely than clients without children to have their requirement for housing or accommodation services provided directly by SAAP agencies in 2007–08 (Table 7.14). SAAP agencies were able to directly provide such services in 78% of cases for clients with children, compared with 84% of cases for clients without children. Clients with children experienced both a higher level of unmet demand for housing or accommodation services and a higher level of referral.

A slightly smaller proportion of clients with children than clients without children had their need for financial or employment services provided directly by the SAAP agency (81% compared with 86%). Clients with children were slightly more likely to receive a referral for such services (13% compared with 9%). These kinds of needs remained unmet in roughly equal proportions for both groups.

This data on service provision to homeless families with children, combined with data on the length of support and accommodation, indicate that there are some problems in securing the services families with children need to resolve their homelessness and to move to stable, long-term accommodation. Social inclusion initiatives, such as improved early intervention, enhanced tenancy support and better links with housing and wider community services, have an important role to play in improving this.

Table 7.14: Broad types of SAAP services required in closed support periods, client group by provision, 2007–08 (per cent distinct services required)

	Not provided			Provided					
Broad type of service	**Neither provided nor referred**	**Referred only**	**Total**	**Provided only**	**Provided and referred**	**Total**	**Total**	**Distinct services required (number)**	**Associated closed support periods (number)**
				With children					
Housing/ accommodation	9.4	12.6	22.0	62.0	16.0	78.0	100.0	46,200	30,900
Financial/ employment	5.5	13.4	18.9	61.9	19.3	81.2	100.0	29,400	20,300
Personal support	2.7	2.6	5.3	87.1	7.5	94.6	100.0	57,700	32,300
General support/ advocacy	2.2	2.7	4.9	85.6	9.5	95.1	100.0	75,600	37,700
Specialist services	7.6	25.6	33.2	45.1	21.7	66.8	100.0	22,700	13,800
Basic support/ other n.e.s.	1.5	1.8	3.3	93.6	3.1	96.7	100.0	43,100	19,400
Total (per cent)	**4.2**	**7.3**	**11.5**	**77.3**	**11.2**	**88.5**	**100.0**	**. .**	**. .**
Total (number)	**11,600**	**19,900**	**31,500**	**212,400**	**30,900**	**243,300**	**. .**	**274,700**	**45,900**
				Without children					
Housing/ accommodation	6.4	10.1	16.5	72.0	11.6	83.6	100.0	114,700	80,300
Financial/ employment	5.7	8.6	14.3	74.4	11.3	85.7	100.0	70,200	50,100
Personal support	3.5	2.5	6.0	89.1	4.9	94.0	100.0	100,200	66,800
General support/ advocacy	1.9	1.4	3.3	91.0	5.7	96.7	100.0	197,400	105,400
Specialist services	10.3	22.7	33.0	50.0	17.1	67.1	100.0	52,600	33,600
Basic support/ other n.e.s.	1.5	1.1	2.6	95.6	1.9	97.5	100.0	154,000	66,300
Total (per cent)	**3.8**	**5.3**	**9.1**	**83.8**	**7.1**	**90.9**	**100.0**	**. .**	**. .**
Total (number)	**26,300**	**36,500**	**62,800**	**577,100**	**49,200**	**626,300**	**. .**	**689,100**	**134,300**

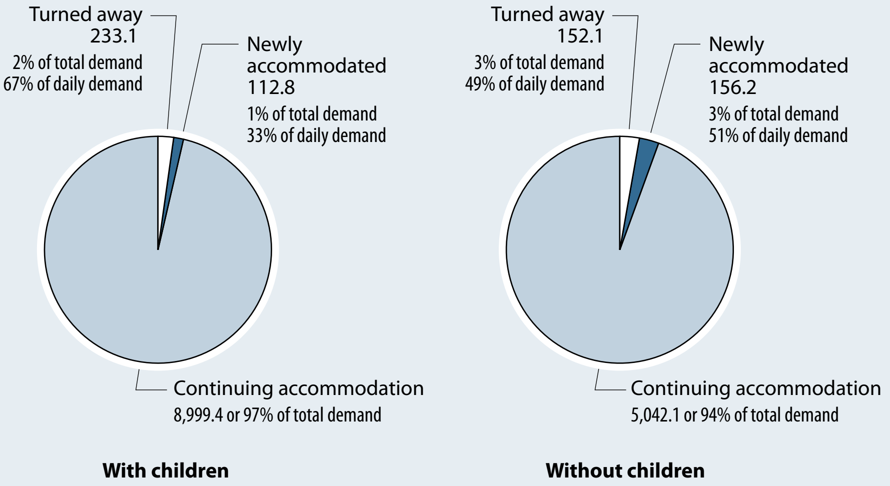
Notes

1. Number excluded due to errors and omissions (weighted): 5,945 (closed support periods with no information on service requirements or provision).
2. In groups of service types, a client may require more than one type of service within the group. Percentages for broad groups relate to all needs and not to support periods. For individual types of services, a need can be recorded only once within a support period, so percentages relate to support periods.
3. Figures have been weighted to adjust for agency non-participation.

Source: SAAP Client Collection.

It is harder for families with children to obtain SAAP accommodation

In 2007–08, data collected during the Demand for Accommodation Collection period indicated that families with children generally experienced more difficulty obtaining SAAP accommodation on an average day than people without children. Families with children were turned away in 67% of their new requests for immediate accommodation, compared with 49% of people without children (Figure 7.9; see also AIHW 2009b).[3]



Source: Derived from AIHW 2009b:Table 9.2.

Figure 7.9: Demand for immediate SAAP accommodation by requesting group, 21–27 November 2007 and 14–20 May 2008 (daily average number and per cent turned away)

Circumstances of families with children before and after SAAP support

Income, employment and housing are some of the essentials required for homeless families to overcome disadvantage and be socially included. For families with children, in particular, extended periods of instability and/or change in accommodation can have a detrimental effect on children's health, development and education (FaHCSIA 2008a).

Employment and income change little overall

In 2007–08, the majority of homeless families with children in SAAP were on a government payment as their main source of income and most, particularly women, were not in the labour force (Table 7.15). There was little change following support.

There was, however, significant variation in the proportions who were not in the labour force and those who were unemployed but actively seeking employment depending on the type of family unit. For example, females with children were far more likely than the other groups to not be in the labour force at all. In contrast, males with children were far more likely than females with children to be unemployed but actively seeking employment.

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[3] Measures of turn-away are only calculated for those who request immediate accommodation. Family groups were more likely than others to request accommodation in advance (AIHW 2009b). For this reason, estimates of turn-away may underestimate the demand from families with children.

Table 7.15: SAAP closed support periods for client groups with children: main source of income and employment status before and after support by family type, 2007–08 (per cent)

	Female		Male		Couple		Other/ unknown		Total	
	Before	**After**	**Before**	**After**	**Before**	**After**	**Before**	**After**	**Before**	**After**
Main income source										
No income	3.8	2.2	3.7	1.6	4.2	2.1	2.4	2.6	3.9	2.2
Government payments	86.1	88.4	86.3	86.5	83.2	83.4	83.2	83.4	85.7	87.6
Other	10.1	9.4	10.0	11.9	12.5	14.5	14.4	13.9	10.5	10.2
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**
Total (number)	**36,900**	**34,200**	**2,200**	**2,000**	**6,600**	**5,900**	**100**	**100**	**45,700**	**42,100**
Employment status										
Employed part time/ full time	11.1	12.4	13.0	16.3	12.6	15.6	11.0	9.9	11.4	13.0
Unemployed (looking for work)	6.6	6.3	26.5	25.2	18.1	16.4	16.0	14.3	9.2	8.6
Not in labour force	82.3	81.3	60.6	58.4	69.4	68.0	73.0	75.8	79.4	78.4
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**
Total (number)	**36,100**	**32,700**	**2,100**	**1,900**	**6,400**	**5,600**	**100**	**100**	**44,700**	**40,300**

Notes

1. Number excluded due to errors and omissions (weighted): 2,460 income source before, 6,032 after; 3,528 employment status before, 7,930 after.
2. Cell numbers may not add due to rounding.
3. Figures have been weighted to adjust for agency non-participation and client non-consent.

Source: SAAP Client Collection.

Housing situation is improved for some families

The most common housing situation for families on entry to and exit from SAAP was renting a house or flat in the private, public or community housing market (Table 7.16). A higher proportion of families were in this kind of housing after support, suggesting that SAAP generally assisted families with children to either maintain their existing tenancy or to acquire another after support.

Table 7.16: SAAP closed support periods for client groups with children: type of house/dwelling and type of tenure before and after support by family type, 2007–08 (per cent)

	Female		Male		Couple		Other/ unknown		Total	
	Before	After	Before	After	Before	After	Before	After	Before	After
Type of house/dwelling										
Improvised dwelling/sleeping rough	2.3	0.7	9.5	4.2	7.4	1.9	1.1	—	3.4	1.1
House/flat	87.5	90.6	69.2	78.0	76.6	85.3	74.5	89.5	85.0	89.3
Other house/ dwelling	8.7	7.1	19.3	16.1	15.1	11.8	23.3	10.5	10.2	8.2
Institutional setting	1.5	1.5	2.0	1.7	0.9	1.0	1.1	—	1.4	1.4
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**
Total (number)	**37,400**	**32,300**	**2,200**	**1,900**	**6,700**	**5,600**	**100**	**100**	**46,300**	**39,800**
Type of tenure										
SAAP/CAP funded	12.7	16.6	11.8	13.5	11.1	12.6	24.8	28.8	12.4	15.9
No tenure	3.8	1.8	10.4	4.0	8.2	2.9	4.7	1.8	4.7	2.0
Private rental	36.5	35.7	32.7	36.1	41.3	45.6	26.5	35.6	37.0	37.1
Public/community housing rental	22.0	27.8	14.0	25.2	12.2	23.6	8.5	14.0	20.1	27.0
Other tenure	25.1	18.2	31.1	21.2	27.1	15.3	35.6	19.8	25.7	17.9
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**
Total (number)	**35,000**	**30,500**	**2,000**	**1,800**	**6,300**	**5,400**	**100**	**100**	**43,500**	**37,700**

Notes

1. Number excluded due to errors and omissions (weighted): 1,867 type of house/dwelling before, 8,341 after; 4,711 tenure type before, 10,504 after.
2. Cell numbers may not add due to rounding.
3. Figures have been weighted to adjust for agency non-participation and client non-consent.

Source: SAAP Client Collection.

Living situation reflects family unit and reason for seeking assistance

Not surprisingly, the living situation of families before and after SAAP support generally reflected their type of family unit and their reasons for seeking assistance (Table 7.17). For example, the most common living situation for females with children before support was living alone with children (40%) or with a spouse or partner and children (27%). After support, females with children—who commonly presented because of domestic or family violence—were less likely to be living with a spouse or partner and their children (27% before support and 14% after). There was a corresponding increase in the proportion of females with children living alone with children (40% before and 58% after).

Table 7.17: SAAP closed support periods for client groups with children: living situation before and after support by family type, 2007–08 (per cent)

	Female		**Male**		**Couple**		**Other/ unknown**		**Total**	
Living situation	**Before**	**After**	**Before**	**After**	**Before**	**After**	**Before**	**After**	**Before**	**After**
With parent(s)	4.8	3.2	4.6	2.7	3.0	2.2	10.6	4.3	4.5	3.0
With relatives/friends	18.4	14.5	20.9	12.8	18.7	9.1	21.4	17.3	18.6	13.7
With spouse/partner	2.7	1.3	1.8	1.5	5.4	4.8	3.5	0.0	3.0	1.8
With spouse/partner and child(ren)	27.4	13.8	11.1	10.7	66.1	74.6	19.6	17.5	32.2	22.4
Alone	1.7	2.5	15.0	16.6	1.3	2.1	3.9	2.8	2.3	3.1
Alone with children	40.1	58.3	40.7	51.2	2.4	5.4	29.9	44.6	34.7	50.4
With other unrelated persons	3.8	4.5	5.2	3.8	2.3	1.4	4.9	7.3	3.7	4.0
Other	1.0	1.9	0.7	0.8	0.7	0.4	6.2	6.2	1.0	1.7
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**
Total (number)	**37,700**	**32,900**	**2,200**	**1,900**	**6,700**	**5,900**	**100**	**100**	**46,700**	**40,800**

Notes

1. Number excluded due to errors and omissions (weighted): 1,473 before, 7,379 after.
2. Cell numbers may not add due to rounding.
3. Figures have been weighted to adjust for agency non-participation and client non-consent.

Source: SAAP Client Collection.

7.4 Where to now?

This section outlines the government response to resolving homelessness in Australia. As background to this, the section begins with a synopsis of changes in government approaches to homelessness over time.

Evolution of government responses to homelessness

Over the past several decades, ideas on how to address homelessness have been evolving (see Box 7.6). Providing a crisis response, such as overnight accommodation and a meal, has gradually been supplemented with the acknowledgment that homeless people often require a more comprehensive, 'joined-up' and individualised response. This includes a focus on prevention, early intervention and breaking the cycle of homelessness.

The evolution of thinking on homelessness has been assisted by the growing volume of data available on homeless people, provided through such programs as SAAP (via the SAAP National Data Collection).

Box 7.6: History of government responses to homelessness in Australia, 1901–2008

1901 to 1973

- The predominant view was that homelessness was largely due to the absence of a roof and/or caused by the failure of the individual and that the vast majority of homeless people were transient middle-aged or older men with alcohol problems living on the streets of inner cities (Limbrick 2006). Assistance was primarily delivered by charitable and church groups.

1974 to 1984—Homeless Persons Assistance Program

- The first Federal Government homelessness legislation, *The Homeless Persons Assistance Act*, was passed in 1974. It was aimed at providing shelter, meals and showers, mostly in dormitory-style crisis accommodation in capital cities, and was delivered through the Homeless Persons Assistance Program.
- During this time, programs at the state, territory and national level were still separately funded and run, and different eligibility and funding conditions applied.

1985 to 2008—Supported Accommodation Assistance Program

- SAAP was a nationally coordinated initiative administered by the states and territories. SAAP agreements generally spanned 5 years, and new agreements set fresh objectives that emerged from an evaluation of the previous agreement.
- SAAP was originally 'conceived as a last resort safety net' for the homeless and the initial SAAP legislation, the *Supported Accommodation Assistance Act 1985*, and associated program (SAAP I 1985–1989) largely revolved around providing a crisis response, such as a bed and safe environment for the night, to the 'permanently' homeless or those who were 'temporarily homeless as a result of crisis' (FaHCSIA 2008b).
- SAAP II (1990–1994) was aimed at providing more assistance and support services, in addition to crisis accommodation, to help clients 'transition' to 'independent living' (FaHCSIA 2008b). The focus, however, was still largely on providing appropriate accommodation in order to resolve crisis.
- Early reviews of SAAP expressed concern that this type of response ended up perpetuating homelessness (Erebus Consulting Partners 2004; Lindsay 1993). To drive further reform, the *Supported Accommodation Assistance Act 1994* was introduced, along with a new agreement, SAAP III (1994–1999). Under SAAP III, the definition of homelessness now explicitly included those at risk of homelessness as well as those who were actually homeless (see Box 7.2). SAAP III also included the development of a research program and the establishment of the SAAP National Data Collection in 1995.
- The last two SAAP agreements (SAAP IV 2000–2005 and SAAP V 2005–2008) continued the evolution of SAAP. SAAP IV had four strategic themes: client-focused service delivery; integration and collaboration between SAAP and other service systems; increasing performance, knowledge and skills; and working together (Erebus Consulting Partners 2004). SAAP V had three strategic priorities: increasing involvement in early intervention and prevention activities; providing better assistance to people who have a number of support needs; and providing ongoing assistance to ensure stability for clients post-crisis (FaHCSIA 2008c).

The Supported Accommodation Assistance Program

From 1985 to 2008, SAAP was the major government response to homelessness in Australia. The move towards a social inclusion framework for addressing homelessness can be seen in the evolution of the program and its legislation over the years (Box 7.6).

SAAP represented a key step in a new national direction on homelessness service provision and data collection. It brought separate state, territory and national homelessness programs together for the first time, under consistent definitions and shared funding, and was instrumental in the move towards a comprehensive national response that recognised the importance of all levels of government working together to tackle homelessness. It was the first government approach to homelessness that acknowledged the significance of prevention and early intervention and recognised that the resolution of homelessness required more than simply a crisis approach.

Under SAAP, however, all states and territories had their own strategic responses to homelessness and these remained largely unconnected at a national level. Despite its good intentions and the generally good quality of services delivered, the success of the program in meeting its aims and objectives is debatable, primarily due to difficulties in achieving a more integrated response to clients' needs across the wider government and community service sector and the lack of exit points from SAAP. The evaluation of SAAP IV, for example, stated that 'SAAP can't be expected to do it all' and pointed to concerns about providing the 'joined-up services needed to both reduce homelessness occurring and providing appropriate pathways out of homelessness'. It also mentioned the 'lack of a coherent whole-of-government approach' (Erebus Consulting Partners 2004).

Importantly, from SAAP III onwards, the program had an associated data collection that was used both to monitor its success and to further research into understanding and addressing homelessness. The SAAP National Data Collection (Box 7.3) has made valuable contributions to the evolution of homelessness policy in Australia as well as raising the profile of homelessness as a significant social issue (Limbrick 2006). For example, data collected from the specialist homelessness services funded under SAAP have shown that it is unrealistic to expect specialist homelessness services to deliver the entire response to homelessness and that to completely meet the needs of homeless people, as well as achieve long-term reductions in homelessness, the response must be better integrated across government and the wider community services system (FaHCSIA 2008a).

SAAP data have also contributed to a greater understanding of the homeless population in Australia. At the start of SAAP, for instance, the prevailing view was that people experiencing homelessness in Australia were older men suffering from substance abuse living on the streets of the inner suburbs of major cities (Box 7.6) (Griffin & Limbrick 2004; Limbrick 2006). The SAAP National Data Collection has been instrumental in providing data that showed that, although these men were a significant group supported by the program, there were also large numbers of women, young people and families who were clients of SAAP services, that many of these clients did not live on the streets or in inner cities, and their reasons for presenting at SAAP agencies were diverse.

The way ahead

The current Australian Government has proposed a social inclusion framework to combat economic and social disadvantage in Australia. As part of this wider approach, it has initiated a detailed response to homelessness in *The road home: a national approach to reducing homelessness* (the White Paper) (FaHCSIA 2008a). Released in December 2008, the White Paper sets out the new national response to homelessness and outlines targets for the reduction of homelessness in Australia.

Supporting this, the Social Inclusion Agenda on homelessness will be administered through the NAHA and the National Partnership Agreement on Homelessness. The latter outlines the roles and responsibilities of the Australian Government and the state and territory governments specifically in reducing homelessness and is complemented by other partnership agreements including the National Partnership Agreement on Social Housing and the National Partnership Agreement on Remote Indigenous Housing. Separate state and territory implementation plans set out how the objectives will be achieved in the jurisdictions.

Importantly, all states and territories are able to specify the design of services in their jurisdictions (as outlined in their implementation plans), but the White Paper, NAHA and associated national partnerships provide an overarching strategy and accountability framework for the achievement of common goals to reduce homelessness in Australia.

National response to homelessness—the White Paper

The White Paper on homelessness (FaHCSIA 2008a) outlines three broad strategies to reduce homelessness and to increase economic and social participation. They are:

- turning off the tap—prevention and early intervention to stop people becoming homeless by tackling the structural drivers of homelessness
- improving and expanding services—improving and expanding service responses to homelessness to achieve sustainable housing, improve economic and social participation, and end homelessness
- breaking the cycle—moving people quickly through the crisis system to stable housing with the support they need so that homelessness does not recur.

There is an emphasis in the White Paper, in line with the principles for social inclusion, on improving the evidence on which the response to homelessness is based and measured. This involves an investment in improving the data available on homelessness. The importance of enhanced accountability and reporting is also emphasised in the new Intergovernmental Agreement on Federal Financial Relations (COAG 2009). It states that the Australian Government and the various states and territories need to move towards integrated, national reporting systems, which requires the improvement of national and state and territory data collection processes.

National Affordable Housing Agreement

The current government response to homelessness is administered under the NAHA. This agreement came into effect on 1 January 2009 and replaced programs such as SAAP and the Commonwealth State Housing Agreement. Unlike the previous SAAP agreements, the NAHA is ongoing in nature rather than time-limited.

The NAHA is designed to provide a framework for governments to work together to reduce homelessness, improve housing affordability and reduce Indigenous housing disadvantage. Under the NAHA the overall approach to homelessness is to better 'join-up' support for individuals and families across their full range of needs—including housing, employment, education, health and other community services—and to improve the way in which essential services work. It recognises that improving social inclusion and combating economic and social disadvantage require cooperation and integration between all levels of government as well as links across the wider community services.

The NAHA establishes a performance framework against which the objectives, outcomes and outputs of the agreement will be measured. The Agreement specifies that the role of the Australian Government is to coordinate homelessness data collection, with the states and territories responsible for the collection and publication of data. The Council of Australian Governments (COAG) Reform Council will report annually on the progress each jurisdiction has made against high-level performance indicators.

National Partnership Agreement on Homelessness

As part of the NAHA, the National Partnership Agreement on Homelessness between the states and territories and the Australian Government will run until 2013, subject to the completion of a review by COAG after 3 years.

The National Partnership Agreement on Homelessness states the shared goal of significantly reducing homelessness, and contributes to the NAHA outcome that 'people who are homeless or at risk of homelessness achieve sustainable housing and social inclusion'. It outlines specific performance benchmarks and indicators relating to people who are homeless or at risk of homelessness.

The National Partnership Agreement on Homelessness is complemented by other partnership agreements, including:

- the National Partnership Agreement on Social Housing, which is intended to support reforms to increase the supply of social housing, including funding specialist housing models, such as Common Ground, that are specifically for homeless people (see Box 7.7).
- the National Partnership Agreement on Indigenous Housing, which is aimed at improving the living standards of Indigenous Australians in remote areas by reducing overcrowding, homelessness, poor housing conditions and severe housing shortages.

Box 7.7: Government responses to homelessness—some examples

Presented below are a few examples of initiatives currently being delivered as part of the government's response to homelessness (see also boxes 7.4 and 7.5 and FaHCSIA 2008a).

Reconnect

Reconnect was mentioned in the White Paper as part of the Government's commitment to providing additional services for young people aged 12 to 18 years and described as 'an effective early intervention model' (FaHCSIA 2008a). Operating since 1999, Reconnect aims to break the homelessness cycle by intervening early to help young people aged 12 to 18 years to stabilise their living situation. Reconnect services are community based, providing support to the entire family, and catering to the individual needs of clients in a culturally appropriate manner. The services provided include counselling, mediation and access to other specialist services.

Foyer

The Foyer model is an initiative to assist young homeless people. It is a holistic response that provides safe and affordable accommodation along with support, guidance and mentoring to help young homeless people gain life skills, education, training and employment in order to enable them to live independently (FaHCSIA 2008a).

Street to Home

The Street to Home model is an 'assertive outreach' model that targets rough sleepers in order to stop the cycle of homelessness (FaHCSIA 2008a). It integrates health, housing, community services, mental health services, and drug and alcohol services and aims to help homeless people find stable and secure housing.

Common Ground

Common Ground is based on a successful New York housing model. The model seeks to provide inclusive and affordable rental housing for a socially mixed group of tenants with the intent to 'build the capacity of previously homeless people to become independent, productive members of society' (Common Ground Adelaide 2008).

7.5 Conclusion

The data on homelessness presented in this chapter show that, despite the popular perception of homelessness as a mainly metropolitan experience, cities are not the only areas affected. Homelessness is an issue in regional and remote Australia as well. The data also indicate that homelessness is a seriously disproportionate problem for Aboriginal and Torres Strait Islander peoples, particularly those living in regional and remote areas. It also points to family homelessness as an area of concern, suggesting that families are a growing group within the homeless population and that service providers appear to be struggling to meet their needs.

Homeless people are likely to face significant barriers to social inclusion. For example, a large proportion of the homeless are also jobless. They are often socially isolated—many having lost contact with family, friends and the wider community—and have difficulty exercising basic social rights, such as voting. A significant proportion have also been subjected to domestic violence or have mental health or substance abuse issues, and many experience difficulty accessing the full range of services that would address their multiple needs.

The Australian Government has made homelessness a key priority of its Social Inclusion Agenda and has made a commitment to reduce and prevent it. This Social Inclusion Agenda recognises the complex interplay between homelessness and other factors contributing to social exclusion, and conceptualises homelessness within a wider field of need. At the same time the Government has acknowledged the importance of having a robust evidence base. Such an evidence base is intended to support policy and inform the delivery of services to homeless people, as well as to measure progress in addressing homelessness and the interactions of homelessness with other causes of social exclusion. The development of a new homelessness data collection by the AIHW will contribute to an improved evidence base.

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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
ACFI	Aged Care Funding Instrument
AEDI	Australian Early Development Index
AIHW	Australian Institute of Health and Welfare
CACP	Community Aged Care Packages
CAP	Crisis Accommodation Program
CHIP	Community Housing Infrastructure Program
COAG	Council of Australian Governments
CPI	consumer price index
CRA	Commonwealth Rent Assistance
CSHA	Commonwealth State Housing Agreement
CSTDA	Commonwealth State/Territory Disability Agreement
DSP	Disability Support Pension
DVA	Australian Government Department of Veterans' Affairs
EACH	Extended Aged Care at Home
EACHD	Extended Aged Care at Home Dementia
FTE	full-time equivalent
GSS	General Social Survey
HACC	Home and Community Care
HOME	Household Organisational Management Expenses (Advice Program)
LGA	Local Government Area
MDS	Minimum data set
NAHA	National Affordable Housing Agreement
NRCP	National Respite for Carers Program
OECD	Organisation for Economic Co-operation and Development
PIAC	Pathways in Aged Care (Cohort Study)
PISA	Programme for International Student Assessment

RCS	Resident Classification Scale
SAAP	Supported Accommodation Assistance Program
SD	Statistical Division
SDAC	(ABS) Survey of Disability, Ageing and Carers
SOMIH	state owned and managed Indigenous housing
SSD	Statistical Subdivision
VHC	Veterans Home Care
YPIRAC	Younger People in Residential Aged Care

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

Note: All population and appendix tables can be found online at www.aihw.gov.au and are also available on the CD accompanying the printed book.

Glossary

Adoptions

There are three categories of adoptions:

> **Intercountry adoptions** Adoptions of children from countries other than Australia who are legally available and placed for adoption, but who generally have had no previous contact or relationship with the adoptive parents.
>
> **'Known' child adoptions** Adoptions of children who are Australian residents, 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.
>
> **Local adoptions** Adoptions of children who were born in Australia or who were permanent residents of Australia before the adoption, who are legally available for adoption but who generally have had no previous contact or relationship with the adoptive parents.

Aged care home An Australian government-accredited facility that provides supported aged care accommodation (low or high care or both).

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.

Apparent retention rate The ratio of the number of students in a given year to the number originally entering secondary school (Year 7or 8).

Blended family A couple family containing two or more children aged 0–17 years, of whom at least one is the biological or adopted child of both members of the couple and at least one is the stepchild of either member of the couple. Blended families may also include other children who are not the biological or adopted children of either parent.

Capital expenditure Expenditure on goods that have a life equal to or longer than a year.

Care and protection orders Legal or administrative orders or arrangements that give community services departments some 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.

Cared accommodation Accommodation that is defined by the Australian Bureau of Statistics to include hospitals, aged care accommodation such as nursing homes and aged care hostels, cared components of retirement villages and other 'homes' such as children's homes.

Community-based supervision Supervision of a young person in the community by a juvenile justice agency while the young person is either awaiting an initial court appearance for an alleged offence, waiting for a court hearing or outcome, or completing an order following the finalisation of a court case. Community–based supervision includes supervised bail, probation, community service orders, suspended detention and parole.

Community living The place of usual residence is a private or non-private dwelling as distinct from residential aged care, hospital or other type of institutional accommodation. Community settings include private dwellings (a person's own home or a home owned by a relative or friend) and certain types of non-private dwelling, for example, retirement village accommodation.

Constant prices Constant price estimates indicate what an expenditure would have been had a specific year's prices applied in all years, that is, it removes the effect of inflation. Changes in expenditure in constant prices reflect changes in volume only. An alternative term often used in text is 'real expenditure'. Constant price estimates for expenditure have been derived using the annually re-weighted chain price indexes of government final consumption expenditure produced by the Australian Bureau of Statistics.

Core activity limitation A person 'needing assistance or having difficulties with self-care, mobility and/or communication'.

Couple family A family based on two people who are in a registered or de facto marriage and who are usually resident in the same household. A couple family may be with or without children, and may or may not include other related individuals.

Deciles Groupings that result from ranking all households or persons in the population in ascending order according to some characteristics such as their household income and then dividing the population into 10 equal groups, each comprising 10% of the estimated population.

Dependent child A person who is either a child under 15 years of age or a dependent student (see *Dependent student*). To be regarded as a child the person can have no identified partner or child of his/her own usually resident in the household.

Dependent student A natural, adopted, step- or foster child who is 15–24 years of age and who attends a secondary or tertiary educational institution as a full-time student and for whom there is no identified partner or child of his/her own usually resident in the same household.

Detention-based supervision Supervision of a young person in a remand or detention centre by a juvenile justice agency while the young person is either awaiting an initial court appearance for an alleged offence, waiting for a court hearing or outcome, or completing an order following the finalisation of a court case. Detention-based supervision includes remand and sentenced detention.

Disability A term for any or all of an impairment of body structure or function, a limitation in activities, or a restriction in participation. Disability is a multidimensional concept and is conceived as an interaction between health conditions and the environment.

Disabling condition A disease or disorder that has lasted or is likely to last for at least 6 months; or a disease, disorder or event (for example stroke, poisoning, accident) that results in an impairment or restriction that has lasted or is likely to last at least 6 months.

Dwelling A structure or a discrete space within a structure intended for people to live in or where a person or group of people live. Thus a structure that people actually live in is a dwelling regardless of its intended purpose, but a vacant structure is only a dwelling if intended for human residence. A dwelling may include one or more rooms used as an office or workshop provided the dwelling is in residential use.

Family 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. Each separately identified couple relationship, lone parent child relationship or other blood relationship forms the basis of a family. Some households contain more than one family.

Family day care Comprises services provided in the carer's home. The care is largely aimed at 0–5 year olds, but primary school children may also receive care before and after school, and during school vacations. Central coordination units in all states and territories organise and support a network of carers, often with the help of local governments.

Family group homes See under *Out-of-home care*.

Formal aged care Regulated care delivered in either residential or community settings, including the person's own home. Most formal care is funded through government programs but may also be purchased privately.

Formal child care Regulated care away from the child's home. The main types of formal care are *outside-school-hours care*, *long day care*, *family day care* and *occasional care*.

Home-based care See under *Out-of-home care*.

Household A group of two or more related or unrelated people who usually reside in the same dwelling, and who make common provision for food or other essentials for living or a single person living in a dwelling who makes provision for his or her own food and other essentials for living, without combining with any other person.

Household equivalised income Equivalised income adjusts household income for household size and composition. For a household comprising more than one person, equivalised income shows how much income a person living alone would need to enjoy the same level of economic wellbeing as the household in question.

Indigenous A person of Aboriginal and/or Torres Strait Islander descent who identifies as an Aboriginal and/or Torres Strait Islander.

Indigenous household A household that includes one or more Indigenous persons.

Indigenous status Whether a person identifies as being of Aboriginal or Torres Strait Islander origin.

Informal carer A person, such as a family member, friend or neighbour, who provides regular and sustained care and assistance without payment for the care given to a person with disability or a long-term health condition, or an older person.

Informal child care Non-regulated care, arranged by a child's parent or guardian, either in the child's home or elsewhere. It comprises care by (step) brothers or sisters, care by grandparents, care by other relatives (including a parent living elsewhere) and care by other (unrelated) people such as friends, neighbours, nannies or babysitters. In the context of the Australian Bureau of Statistics Child Care Survey, it may be paid or unpaid.

Income unit One person or a group of related persons in a household, whose command over income is shared; or any person living in a non-private dwelling who is in receipt of personal income.

Independent living See under *Out-of-home care*

Intact family A couple family containing at least one child aged 0–17 years who is the natural or adopted child of both partners in the couple, and no child aged 0–17 years who is the stepchild of either partner of the couple. Intact families may also include other children who are not the natural or adopted children of either parent.

Labour force Persons who were *employed* or *unemployed* (not employed but actively looking for work) during the reference week of the Australian Bureau of Statistics Labour Force Survey.

> **Unemployed** Persons aged 15 years and over who were not employed during the reference week of the Labour Force Survey and had actively looked for full- or part-time work at any time in the previous 4 weeks, or were waiting to start a new job within 4 weeks of the end of the reference period.
>
> **Employed** Persons aged 15 years and over who, during the reference week of the Labour Force Survey worked for 1 hour or more for pay, profit, commission or payment in kind in a job, business or on a farm, or worked for 1 hour or more without pay in a family business or on a farm (that is, contributing family workers). This includes employees who had a job but were not at work and were away from work for less than 4 weeks up to the end of the reference week, or away from work for more than 4 weeks up to the end of the reference week and received pay for some or all of that 4 week period, those who were away from work as a standard work or shift arrangement, on strike or locked out, on workers compensation and expected to return to their job, or were employers or own account workers who had a job, business or farm but were not at work.
>
> **Full-time workers** Employed persons who usually worked 35 hours or more a week (in all jobs) and those who, although usually working less than 35 hours a week, worked 35 hours or more during the reference week of the Labour Force Survey
>
> **Part-time workers** Employed persons who usually worked less than 35 hours a week (in all jobs) and either did so during the reference week of the Labour Force Survey, or were not at work in the reference week.

Life expectancy An indication of how long a person can expect to live. Technically it is the average number of years of life remaining to a person at a particular age if death rates do not change.

Long day care Comprises services aimed primarily at 0–5 year olds that are provided in a centre usually by a mix of qualified and other staff. Educational, care and recreational programs are provided based on the developmental needs, interests and experience of each child. In some jurisdictions, primary school children may also receive care before and after school, and during school vacations. Centres typically operate for at least 8 hours a day on normal working days, for a minimum of 48 weeks a year.

Main disabling condition If multiple disabling conditions are reported in the Australian Bureau of Statistics Survey of Disability, Ageing and Carers, the main disabling condition is the one reported as causing the most problems. If only one disabling condition is reported, this is recorded as the main disabling condition.

Main tenant The tenant who is party to the residential tenancy agreement. Where this is not clear, it is the person who is responsible for rental payments.

Non-dependent child A natural, adopted, step- or foster child of a couple or lone parent usually resident in the household who is aged 15 years and over and is not a full-time student aged 15–24 years, and who has no identified partner or child of his/her own usually resident in the household.

Occasional care A type of formal care provided mainly for children who have not started school. These services cater mainly for the needs of families who require short-term care for their children.

One-parent family A family consisting of a lone parent with at least one dependent or non-dependent child (regardless of age) who is also usually resident in the household. Examples of one-parent families include a 25 year old parent with dependent children, and an 80 year old living with a 50 year old child.

Out-of-home care 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 child protection data collection:

> **Family group homes** These provide short-term care in government owned homes. These homes do not have salaried staff but are available rent-free to approved carers, who receive board payments to reimburse them for the cost of looking after the children in their care.
>
> **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 that 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.
>
> **Independent living** Where young people are living independently, such as those in private boarding arrangements.
>
> **Residential care** Where placement is in a residential building whose purpose is to provide placements for children and where there are paid staff. 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.

Outside-school-hours care Services provided for school-aged children (5–12 year olds) outside school hours during term and vacations. Care may be provided on student-free days and when school finishes early.

Primary carer A primary carer is defined by the Australian Bureau of Statistics as a person aged 15 years or over who provides the most informal assistance, in terms of help or supervision, to a person with one or more disabilities. The assistance has to 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 or self-care).

Private dwelling A private dwelling can be occupied or unoccupied. A private dwelling is normally a house, flat or even a room. It can also be a caravan, houseboat, tent, house attached to an office, or rooms above a shop. Occupied dwellings in caravan/residential parks are treated as occupied private dwellings.

Projection A projection is not a forecast but simply illustrates changes that would occur if the stated assumptions were to apply over the specified period.

Quartiles Groupings that result from ranking all households or persons in a population in ascending order according to some characteristic such as their household income and then dividing the population into four equal groups, each comprising 25% of the estimated population.

Quintiles Groupings that result from ranking all households or persons in a population in ascending order according to some characteristics such as their household income and then dividing the population into five equal groups, each comprising 20% of the estimated population.

Recurrent expenditure Expenditure incurred for services and goods with a life of less than a year.

Reference person In the Australian Bureau of Statistics Survey of Income and Housing the reference person for each household is chosen by applying, to all household members aged 15 years and over, the selection criteria below, in the order listed, until a single appropriate reference person is identified:

- one of the partners in a registered or de facto marriage, with dependent children
- one of the partners in a registered or de facto marriage, without dependent children
- a lone parent with dependent children
- the person with the highest income
- the eldest person.

For example, in a household containing a lone parent with a non-dependent child, the one with the higher income will become the reference person. However, if both individuals have the same income, the elder will become the reference person.

Residential care (children and young people in out-of-home care) See under *Out-of-home care*.

Residential aged care Low- and high-care services provided in Australian government-accredited aged care homes. Residential aged care includes accommodation-related services with personal care services (both low-and high-care services), plus nursing services and equipment (high-care services only).

Respite services Respite services support community living for people who receive assistance from informal providers by providing the carer with a break from the caring role. Respite services provide substitute care arrangements for short periods (a few hours) or for longer periods (a few days or more). Respite services may be delivered in a range of settings—most commonly the person's home, a day centre or community-based overnight respite unit, or in residential aged care homes.

SAAP accompanying child A person aged less than 18 years who has a parent or guardian who is a client of the Supported Accommodation Assistance Program, and accompanies that client to a SAAP agency any time during that client's support period, and/or receives assistance directly as a consequence of a parent or guardian's support period.

SAAP client A person who is homeless or at imminent risk of homelessness who is accommodated by a Supported Accommodation Assistance Program agency, enters into an ongoing support relationship with a SAAP agency, or receives support or assistance from a SAAP agency that generally entails 1 hour or more of a worker's time, either with that client directly or on behalf of that client, on a given day.

Severe or profound core activity limitation A person with severe or profound core activity limitation needs help or supervision – sometimes (severe) or always (profound) to perform activities that most people undertake at least daily, that is, the core activities of self-care, mobility and/or communication.

Social gradient Reflects the position in society of an individual or population group and their different access to and security of resources such as education, employment and housing, as well as different levels of participation in civic society and control over life.

Social housing Rental housing that is funded or partly funded by government and that is owned or managed by the government or a community organisation and let to eligible persons. This includes public rental housing, State owned and managed Indigenous housing, community housing, Indigenous community housing and the Crisis Accommodation Program.

Statistical Division (SD) Statistical Division is an Australian Standard Geographical Classification defined area which represents a large, general purpose, regional type geographic area. Statistical Divisions represent relatively homogeneous regions characterised by identifiable social and economic links between the inhabitants and between the economic units within the region, under the unifying influence of one or more major towns or cities. They consist of one or more Statistical Subdivisions and cover, in aggregate, the whole of Australia without gaps or overlaps. They do not cross state or territory boundaries and are the largest statistical building blocks of states and territories.

Statistical Subdivision (SSD) The Statistical Subdivision (SSD) is an Australian Standard Geographical Classification defined area which represents an intermediate level, general purpose, regional type geographic unit. SSDs consist of one or more Statistical Local Areas and cover, in aggregate, the whole of Australia without gaps or overlaps.

Stepfamily A couple family containing one or more children aged 0–17 years, none of whom is the natural or adopted child of both members of the couple, and at least one of whom is the stepchild of either member of the couple. A stepfamily may also include other children who are not the natural or adopted children of either parent.

Tenancy (rental) unit The unit of accommodation (dwelling or part of a dwelling) for which a rental agreement can be made.

Tenure The nature of a person or social group's legal right to occupy a dwelling.

Total fertility rate (TFR) The average number of babies that would be born over a lifetime to a hypothetical group of women if they experience the age-specific birth rates applying in a given year.

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