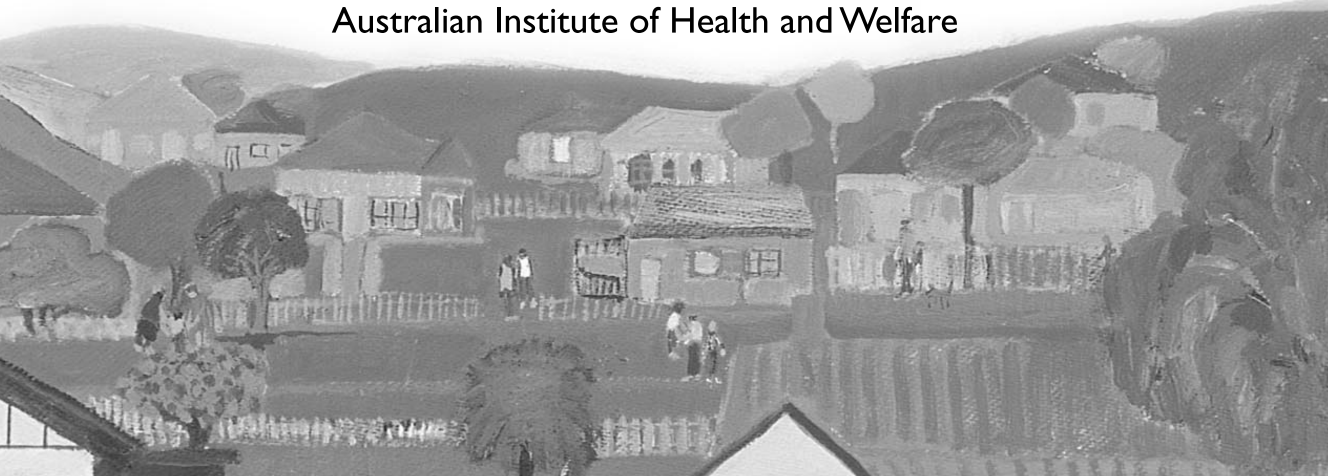
AUSTRALIA'S Welfare 2001

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



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Senator the Hon Kay Patterson
Minister for Health and Ageing
Parliament House
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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 2001*, as required under Subsection 31(1A) of the *Australian Institute of Health and Welfare Act 1987*.

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

Yours sincerely

Dr Sandra Hacker
Chairperson of the Board

23 November 2001

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Preface

Australia’s welfare services assist people across Australian society, but especially older people, people with disabilities, children and homeless people. The welfare services sector is significant in the nation’s economy with $13.7 billion being spent annually on paid services, and over 340,000 people employed in community services activities. A vast amount of unpaid assistance is provided by families, carers and volunteers double the value of the paid services.

Australia’s Welfare 2001 provides an account of these services and assistance, focusing on the nature of services provided, the people who receive and provide them and the outcomes achieved. The report as a whole provides an overview across the welfare and housing assistance fields in Australia, as well as a wealth of reference information and statistics.

This fifth edition of our biennial welfare report contains additions and enhancements that strengthen and enrich our understanding of welfare services in Australia. The chapters relating to specific service programs now include more information on changes over time, income support programs, service delivery in the different regions of Australia, and access to services by Aboriginal and Torres Strait Islander people. The chapter on welfare services resources, in addition to presenting and analysing information on welfare services expenditure, now profiles the community services workforce.

Australian policies are now increasingly framed in terms of outcomes for people and the community. The Commonwealth Government’s focus on stronger families, stronger communities and economic and social participation is a prime example. Such high level goals require the integration of services, for instance housing and community services, or aged care and disability services, and the provision of flexible, people-oriented services.

The challenge for an organisation such as the AIHW is to develop and provide information across program boundaries. The two special chapters in this report are geared to more integrated analysis and development of welfare-related information. One of the chapters examines the trend away from institutional services and towards community care in a number of areas aged care, disability services, mental health, substitute care for children and acute hospitals. The second special chapter outlines suggested measurement frameworks that allow welfare service provision to be seen in the broader context of the welfare of the population.

My thanks go to the many people both within and outside the Institute who have contributed to this report, which continues to be the nation’s premier source of statistical and other information on welfare services. As such, *Australia’s Welfare 2001* is a valuable and reliable reference for all people interested in welfare services and assistance in Australia, including service recipients, policymakers, administrators, educators, planners, analysts and students.

Richard Madden
Director

Symbols

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

1 Introduction

Australia's Welfare 2001 is the fifth biennial report on Australia's welfare. It builds on the previous four editions, and again contains separate chapters on welfare expenditure, aged care, disability services, children's and family services (including services for children in need of protection), housing assistance, and services for homeless persons.

While the major focus is on welfare services and assistance, the coverage of the report has widened since 1993; for example, information on cash payments is now included in each chapter. Assistance to people in need may be provided through cash payments, direct services, or a mixture of both, and policy changes may replace one form of assistance with another. In the area of child care, for example, government assistance has shifted from direct service provision to payments to parents to assist in the purchase of child care services in the market.

Government programs are designed to meet the need for services and assistance. Understanding the level and type of need is therefore critical to the assessment of program performance. Analysis of the need for services and assistance has always been included in each of the service-specific chapters of the reports since 1993, and is continued here. To enable a better discussion on the assessment of social needs and program performance, this report contains a special chapter on indicator frameworks that have been developed in the field of welfare. The chapter reviews current efforts in developing indicators of need, performance measures, and broader welfare outcomes, and proposes a broad framework for further work in providing a context for the understanding of welfare service programs.

This report also contains a special chapter on the trend away from institution-based care and towards community-based care. Deinstitutionalisation is a policy focus common to many community services areas, but the history of this policy and the results of such initiatives vary between the different sectors. This chapter describes the broad trends in aged care, disability services, mental health services, substitute care for children, and acute hospital services.

Since 1999 there has been considerable national effort spent on data development. A general description of data development activities is presented in this chapter, and again details of sector-specific data developments are contained in each of the relevant chapters.

1.1 Government policy initiatives

Since the Institute's last biennial report in 1999, there have been important government policy changes at both the Commonwealth and the State and Territory levels that will have long-term implications for welfare service delivery.

The Commonwealth Government initiated a review of the welfare system and announced a series of changes to reform it. It has also developed a Stronger Families and Stronger Communities Strategy. The main features of these two initiatives are described below. Some of the main effects of the new tax system on welfare services, implemented in July 2000, are also described in this chapter.

Initiatives at the State and Territory level have emphasised early intervention, meeting the complex and multiple needs of clients, and a whole-of-government approach to service delivery. Some of these are also discussed here.

Welfare reform

In September 1999, the Commonwealth Government announced its intention to review the Australian welfare system and commissioned a reference group headed by Patrick McClure, Chief Executive Officer of Mission Australia. The main aim of the review was to develop options that encourage people in receipt of government assistance to participate in work and in the community. A major term of reference was to provide advice on options for the reduction of welfare dependency, while maintaining a sustainable safety net (Reference Group on Welfare Reform 2000:62).

The Reference Group reported in July 2000 and proposed a long-term vision of a Participation Support System that features individualised service delivery, a simpler income support structure, work incentives and financial assistance, mutual obligations, and social participation. The report offered a large number of recommendations for government action, ranging from medium- to long-term solutions and initial steps that could be adopted in the short term.

Responding to these recommendations, the Commonwealth Government announced, in the May 2001 national budget, a $1.7 billion package of changes: *Australians Working Together* (www.together.gov.au). The package offers improved personalised assessment, more opportunities for training and work experience, and better incentives to take up work. Measures include more assistance for parents, help for older people, better assessments and more employment assistance for people with disabilities, the introduction of a Working Credit, and new programs to assist people looking for paid work. The Working Credit is designed to encourage workforce-age people on income support to take up work by allowing them to keep more of their income support payment while working. New job search programs include the Personal Support Programme, which provides more intensive support to people whose personal problems make finding work difficult, and the Transition to Work Programme, which helps parents, carers and mature-age job seekers who are returning to the workforce. Mutual obligation arrangements are to be strengthened through more work for the dole places, greater support for voluntary community work, and the development of community—business partnerships.

The package will have a major impact on welfare service delivery, with Centrelink expected to provide more personal assistance and support to people to help them to find work. Details of changes that may have an impact on welfare service delivery in specific fields are included in the relevant chapters. The longer-term effects of these welfare reforms will be reported in later editions of *Australia's Welfare*.

Stronger families and stronger communities

The Commonwealth Government announced in April 2000 a long-term strategy to promote stronger families and stronger communities. The strategy re-states the fundamental importance of the family and the local community in the provision of help and assistance, and puts emphasis on prevention and early intervention. It stresses the importance of working with non-government partners and the provision of local solutions to local problems. For families, there are three focus areas: early childhood and the needs of families with young children, strengthening marriage and relationships, and balancing work and family. For communities, there are four areas of focus: strong leadership, skills and knowledge, expanding partnerships between public and private sector, and supporting volunteers (www.facs.gov.au).

Funds under this strategy were made available to initiate new programs of services and a range of family support services has been reviewed (AIHW 2001:86—94). Chapter 5 of this report contains further details about the strategy.

Taxation reform

The new tax system that came into effect on 1 July 2000 includes a goods and services tax (GST) and the abolition of a number of Commonwealth, State and Territory taxes, including the wholesale sales tax. The individual income tax rates were reduced and, in the GST system, some goods (in particular food items) and services, including various health and community services, are GST-free. There were also increases to family assistance and compensation for social security recipients, including aged pensioners and people in receipt of rent assistance. Aspects of the changes to financial assistance are described in the relevant chapters of this report.

The impact of the new tax system on the living standards of individuals and households is complex. Based on various assumptions, research on the impact of the GST has identified types of households that would benefit or lose from the taxation changes (ACOSS 2000; Harding et al. 2000).

The impact of the new tax system on the delivery of community services is also complex. In addition to a variety of health and community services, the non-commercial activities of charitable institutions are GST-free. (This provision applies to all supplies, not only the categories of health and community services.) Non-commercial goods and services are those that are supplied or sold for nominal consideration, that is for less than 50% of their market value or for less than 75% of the consideration the charity provided for the good or service supplied (where it is a supply other than accommodation). From 1 July 2000, charities must be endorsed by the Australian Taxation Office if they wish to gain or maintain income tax exempt status.

Changes have also been made to the fringe benefits tax (FBT). Public benevolent institutions (PBI) were eligible to claim a total exemption from FBT before the introduction of the new tax system. From 1 April 2001, a limit of $30,000 per employee (grossed-up taxable value) has been placed on PBIs on the level of exemption from the FBT (www.ato.gov.au). Although a charitable organisation is not necessarily a PBI (Taxation Determination 93/11), many are and are therefore entitled to make use of the

FBT concession (ACOSS 1999; ATO 2000). Those charitable institutions without PBI status are entitled to claim a rebate on their FBT. This rebate has also been capped at a level of $30,000 grossed-up taxable value per employee from 1 April 2001.

The impact of GST on community services is made complicated because of the imprecise definition of charity and the complex relationship between charitable organisations and other related organisations. In September 2000, the Commonwealth commissioned an inquiry into the definitions of charitable and related organisations. The report in June 2001 proposed a definitional framework for altruistic community organisations that includes charities and within it benevolent charities (Treasury 2001).

The introduction of the new tax system will have a long-term influence on the financial relationship between the Commonwealth and the States and Territories and on the funding and delivery of community services. All revenue collected by the Commonwealth through the GST is passed onto the States and Territories, replacing the previous financial grants made by the Commonwealth to the States and the Territories.

State and Territory initiatives

In line with Commonwealth directions, early intervention, strengthening families, continuum of care, and integrated service have received further attention in State and Territory service programs. These emphases are set out in many of the strategic plans of State and Territory community services agencies (Queensland Department of Families, 2001a; South Australia DHS 1999; Victoria DHS 2000; Western Australia DFCS 2000).

In South Australia, the need to balance preventive types of services with intensive, targeted types of services was raised in a discussion paper on a social welfare services framework (South Australia DHS 2001).

In Queensland, a new Department of Families was formed in 2001 and a draft policy statement on the family places emphasis on the importance of early years and early intervention to a child s development (Queensland Department of Families 2001b). The Department of Health continues to manage the Positive Parenting Program, a multi-level and integrated model of prevention and treatment of behaviour problems in children.

In New South Wales, services to new areas have been added to the Family First Program. This whole-of-government program, supporting children aged under 8, is expected to be extended to cover the whole State by 2003—04 (AIHW 2001:36—7; New South Wales DOCS 2000). An important element of the program is that services are coordinated at the local level.

In Victoria, the Strengthening Families Program provides case management, in-home services and outreach support to divert families from the statutory child protection system. This program and other family support services, such as family counselling and the Positive Parenting Program, work together to provide a single service system for families (AIHW 2001).

The emphasis on prevention is clearly seen in the trends in child protection practices. In most jurisdictions, policies have been introduced in the past decade that allow for non-investigative responses to reports of concerns about children that are made to community services departments. This has led to a decrease in the number of child abuse investigations, but an increase in the provision of preventive support services.

Services to clients with complex and multiple needs are also an important area of focus. Approaches that integrate and coordinate across service sectors are being developed. For example, the Housing Ministers Advisory Council has initiated work that aims to achieve alignment of housing assistance programs with related ones in community services and health.

1.2 Developments in community services and housing information

There have been considerable activities in data development in the field of community services and housing since *Australia's Welfare 1999* was released.

The Commonwealth, State and Territory Governments jointly fund community services and housing assistance in Australia. These joint efforts are underpinned by Commonwealth—State agreements on funding and service provision. Four agreements (the Home and Community Care Agreement, the Commonwealth/State Disability Agreement, the Supported Accommodation and Assistance Program, and the Commonwealth—State Housing Agreement) have been renegotiated since 1998—99, with new agreements coming into operation in the last 2 years. All four require the collection of nationally consistent data to inform the operations of these programs. These agreements provide the framework that encourages quality data to be developed in these fields. Service providers collect the data as part of the reporting requirements in their contracts with government funders. Governments compile the data for policy and planning purposes. National data collation and publication are usually carried out by the Australian Institute of Health and Welfare (AIHW). Data development efforts in these four areas are described in the relevant chapters in this report.

The national information agreements

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

Under these agreements, information management groups, data committees and working groups are established to promote the development, collection and use of nationally consistent statistics.

The National Community Services Information Management Group

The National Community Services Information Management Group (NCSIMG) has established a Data Committee, sector-specific working groups and ad hoc project groups to assist in its work. Sector-specific work is reported in the various chapters in this report. The Data Committee and ad hoc project groups undertake NCSIMG projects that cut across community services sub-sectors. They are guided by the 1998 National Community Services Information Development Plan (SCCSISA 1999). Significant sector-wide projects in the last 2 years include the revision of the *National Community Services Data Dictionary,* improving the collection of Indigenous data, the development of protocols for the use of statistical linkage keys for community services data, and a review of the national classifications of community services.

The *National Community Services Data Dictionary*

The *National Community Services Data Dictionary* (*NCSDD*) is the authoritative repository for nationally endorsed definitions of data elements of relevance to community services (AIHW 2000). The data elements are intended to serve as the building blocks with which data items and systems can be constructed for specific services and purposes. Anyone who is compiling a data set particularly a National Minimum Data Set (MDS) is encouraged to use the data elements in the *NCSDD* to ensure that the resulting data are comparable with data from other community services collections.

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

The AIHW has recently been engaged in developing standard formats for performance indicator specification. For example, a template has been developed for specifying performance indicators for use in particular program areas and for identifying the individual data elements required to construct each indicator. The purpose of the template is to ensure that specifications are clear and concise and cover all information necessary for consistent implementation.

Version 2 of the *NCSDD* was published in 2000 and was a large expansion of version 1. It incorporated the results of consultations with a range of community services data development groups and with the ABS. Version 2 has also been made available in electronic form in the AIHW Internet-based Knowledgebase: Australia s Health and Community Services Data Registry (www.aihw.gov.au). NCSIMG members have committed their agencies to using the *NCSDD* definitions wherever possible, representing a significant step towards nationally consistent community services data in Australia.

Principles and standards for Indigenous client data

Data on the wellbeing of Indigenous people are available from the population censuses and household surveys conducted by the ABS. However, data from administrative sources on the use of housing and community services by Indigenous people are inadequate. In view of this, the NCSIMG has commissioned the ABS to develop a set of principles and standards for Indigenous identification in community services data. In developing these standards, the ABS has analysed the quality of Indigenous data in the Supported Accommodation Assistance Program collection, the child protection data collection and the national disability minimum data set collection. The NCSIMG has approved the proposed principles and standards and this will be published together with results of the data quality analysis. A plan for the implementation of these standards, including the preparation of training materials, is being developed.

Review of the National Classifications of Community Services

Version 2 of the National Classifications of Community Services will be published in 2002. It will update version 1 (AIHW 1997) which comprises three classifications: service activities, target groups, and service delivery settings. Version 2 will provide an authoritative basis for the consistent coding of relevant aspects of provision of community services.

Sector-specific data developments in community services

A number of important data development activities have been undertaken jointly by the AIHW, the Commonwealth and the States and Territories since the release of *Australia's Welfare 1999*, some of which are ongoing. These relate to the development or redevelopment of program-specific data sets and data dictionaries and are discussed in the relevant chapters. These include the Aged Care Assessment Program MDS, the Community Care Packages Data Dictionary, a review of the data items for the National Respite for Carers Program (all in Chapter 6), the Commonwealth/State Disability Agreement MDS (Chapter 7) and the children s services MDS (Chapter 5). The HACC Consumer Survey Instrument was also developed and endorsed by Home and Community Care Officials in this period.

In addition, the NCSIMG, working with the Australasian Juvenile Justice Administrators, has completed a project specifying data items to be collected in a juvenile justice national MDS. This data collection is being pilot tested in 2001—02 for possible implementation in the following year.

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

Established in 2000, the National Housing Data Agreement Management Group and the National Indigenous Housing Information Implementation Committee work closely with each other to develop performance indicators and associated data specifications for mainstream and Indigenous housing programs. Early priority has been given to Indigenous housing, the public rental housing programs and the community housing programs. Plans have been developed to extend this work to the Aboriginal Rental Housing Program, private rental assistance, and home purchase assistance. Indicators for crisis accommodation will need to be developed in conjunction with the administrators of the Supported Accommodation Assistance Program. While performance indicators for the various mainstream programs and Indigenous programs may vary, a single housing assistance data dictionary is being compiled to assist in the standardisation of definitions and classifications of data elements. Protocols for data collection, management, analysis and presentation are also being developed. Further details of housing data development initiatives are given in Chapter 3.

1.3 Performance indicators and data development

A significant factor that has assisted the development of quality data in community services is the emphasis now placed on performance measures for reporting purposes. Performance measures of service programs, in terms of effectiveness, efficiency, quality of service, equity of access, and so on, are now commonly required by funders to assess the performance of funded programs in meeting policy objectives. Specifying performance measures is an important first step, although not an exclusive factor, in defining data requirements. Specification requires the explicit enunciation of program objectives, and the translation of these objectives into a set of desired outcomes or targets against which performance can be measured. Program objectives and the related performance indicators may relate to the process, the outputs from the program and client outcomes.

The need for a framework to guide the development of performance measures is recognised by high-level ministerial advisory councils. An important outcome of the Strategic Plan for 2000—2002 of the Community Services Ministers Advisory Council is the enhanced use of quality information, research and knowledge systems for the improvement of services. The council has agreed to develop an agreed set of high-level outcome indicators for community services. Similarly, the Housing Ministers Advisory Council has also encouraged the development of performance indicators that explicitly align with the principles and objectives of the Commonwealth—State Housing Agreement.

High-level endorsements by all jurisdictions on the statements of objectives and the associated indicators are now normally required. The endorsement process ensures that the data are used for worthwhile purposes and fosters a sense of ownership of the data. Many data development exercises in community services and housing assistance have followed this path and are reported in this report.

Improved data in the past few years have assisted the annual Review of Commonwealth—State Service Provision. This review, established in 1993, has now reported for the sixth time (SCRCSSP 2001). In the 2001 report, as a consequence of national data development processes, improved data were reported for many welfare services, in particular housing assistance.

1.4 ABS activities

ABS household surveys on various social topics are important sources of information on social needs and use of services. The national Census of Population and Housing also provides critical small group/area data and base-line information on the demographic, social and housing status of the country. The last Census of Population and Housing was conducted in August 2001.

The ABS is undertaking research to measure Australia's progress and plans to release the first publication in 2002. The ABS gives regard to progress in three domains: economic, social and environmental. A set of indicators, reflecting key dimensions of concern across the domains, is being selected to measure progress.

The ABS household survey program

In 1999, after a review of its household surveys, the ABS finalised a survey program that includes the continuation of most of the current household surveys and the planning of new ones to meet the changing demands of users (ABS 2000). While there will be reductions in the frequency of some of the existing surveys, the overall ABS survey program will provide a range of statistics to monitor the social and economic wellbeing of Australians, and to support the development, implementation and evaluation of government policies and programs.

A number of new survey initiatives are planned by the ABS. A General Social Survey (GSS) will be conducted at regular intervals, starting in 2002. It will collect information on a range of topics, including demography, health (to include a supplementary Indigenous sample), housing, education and training, work, income and expenditure, leisure, communications, travel and transport, family and community participation, and crime. The data collected by the GSS are expected to inform issues relating to living standards and to provide some indicators related to 'social capital'. A new Indigenous Social Survey (ISS) is planned for 2002, and the sample will include households in remote areas.

The ABS has also planned a multi-topic survey that will be run in between GSS collections, using simple interview questions or established question modules. It is likely that housing topics will be included in the first multi-purpose household survey in 2003.

The ABS program does not include a specific housing survey, but housing data will be available from a range of other surveys, including the Survey of Income and Housing Costs.

The national community services industry survey

The ABS has conducted the second national community services survey in respect of the 1999—00 financial year (ABS 2001). It estimates the size and structure of the community services industry and includes the relative contributions of expenditure on community service activity by the government and private sectors. Labour force information is also collected in the survey. The results of the 1999—00 survey showed that the industry has grown since 1996 (by 15% in terms of the number of organisations, and 7% in terms of number of employees). Some of the results of this survey are included in Chapter 2.

1.5 Developments in longitudinal data and cross-sectoral analysis

The demand for longitudinal data comes from the need to understand the dynamics of change in addition to a cross-sectional description of the change over time. Users of services often use multiple services provided by a service provider, within a program of services and across programs. An understanding of the sequence of events helps to measure service usage and client outcomes within and across service programs. Longitudinal data allow a better analysis of the effectiveness of service provision by also identifying key points in people s lives at which service or interventions might be most effective.

Linking administrative by-product data is an effective and economical way to develop longitudinal data sets. Linkage keys for statistical purposes are collected and used within the Home and Community Care MDS, the Commonwealth/State Disability Agreement MDS and the Supported Accommodation Assistance Program data collection. These linkage keys are designed for policy analytical purposes and are not suitable, intended or available for client management purposes, for which unique identifiers are required. However, statistical linkage has not been undertaken across programs. Privacy issues as well as data access issues are central to any data linkage activity. The NCSIMG is investigating these issues in relation to the development of statistical keys to enable the linking of administrative data over time and across service programs. A project is being conducted to investigate the technical as well as privacy and access issues involved in the creation and use of such linkage keys.

The AIHW has initiated an experimental project to analyse the volume, path and characteristics of clients who move between hospitals and aged care homes through the use of statistical linkage keys.

The Commonwealth Department of Family and Community Services (FaCS) has initiated two longitudinal surveys and has a major project developing longitudinal data from FaCS administrative sources. The first survey is one linking labour market dynamics, income and family structures, as well as retirement. This survey (Household, Income and Labour Dynamics in Australia) is being conducted and is expected to generate the first set of data by 2002. The second longitudinal survey (Longitudinal Survey of Australian Children), funded as part of the Stronger Families and Stronger Communities Strategy, is at a development stage. The first wave of the survey is expected to be in the field by 2003 (see Chapter 5).

A third important activity in developing longitudinal data at FaCS is the extraction of client data from the social security system to form a FaCS Longitudinal Data Set. This data set allows the analysis of client pathways over time. It also gives information on clients circumstances and the amount and type of assistance they receive. By providing information on the impact of assistance on clients, the data set helps to inform policy review and program design.

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2 Welfare services resources

2.1 Introduction

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

- the number of persons employed in the community services industry;
- the number of paid and unpaid persons of the households sector who either work voluntarily for community service organisations or help others independently of organisations;
- the expenditure on the delivery of welfare services where payments were made (monetary expenditure); and
- the estimated cost of services provided by unpaid persons of the households sector (non-monetary expenditure).

The terms monetary expenditure and non-monetary expenditure are used in this chapter to distinguish between two broad types of activities involved in the provision of welfare services, in terms of their inclusion in estimates of gross domestic product (GDP).

The term monetary expenditure is used when payments are made and/or expenses are recorded as being incurred for the provision of welfare services. The related expenses incurred and/or payments made are included in the estimates of GDP.

The term non-monetary expenditure is used when no payments/expenses are recorded as being incurred for the provision of services. They are estimates of the costs that would have been incurred by governments and non-government community service organisations (NGCSOs) if they had employed workers to provide these services. It also includes revenue forgone by governments as a result of concessional taxation treatment for services provided by NGCSOs. These costs are not included in the estimates of GDP.

The four categories of welfare services are: family and child welfare services, welfare services for older people, welfare services for people with a disability, and other welfare services.

Expenditures not included in this chapter are:

- income support and long-term housing assistance; and
- high-level residential care (formerly called nursing homes) and domiciliary nursing care, which are predominantly health related.

Expenditure information on long-term housing assistance can be found in Chapter 3 and on high-level residential care and domiciliary nursing care in Chapter 6.

2.2 Total resources

The total value of resources devoted to welfare services in 1999—00 was estimated at $41.7 billion. Of this amount, 33% (valued at $13.7 billion and included in the national accounts) was for paid services, the source of funds for which is discussed in Section 2.5. The remaining $28.1 billion (not included in the national accounts because no money was exchanged) was for a combination of services provided by household members ($27.2 billion) and the NGCSO input tax exemption ($866 million) (Figure 2.1).

NGCSOs delivered $7.7 billion worth of welfare services in 1999—00, which represents 57% of the total monetary expenditure on welfare services. The funding sources for these services were governments (45%), clients fees, charges (32%) and the organisations own income from fund-raising, donations and other sources (23%) (see Table 2.16).

User charges account for a substantial proportion of the value of services provided by NGCSOs. Though much of the payment is from pensions (transfer payments from governments), households also pay from their income above pension limits where means tests apply. NGCSOs also receive input tax concessions, such as exemptions from fringe benefits tax and sales tax. The tax concession is a revenue forgone by governments, with the aim of easing the NGCSOs financial burden in providing welfare services to the community. The value of these concessions was estimated at $866 million in 1999—00. Moreover, substantial amounts of unpaid work are performed by volunteers working through community service organisations. The value of this work in 1999—00 was estimated at $1,269 million.

In total, the value (monetary and non-monetary) of production by NGCSOs was about $10 billion.[1]

In terms of workforce, full-time equivalent (FTE) a standardised measure used in converting number of persons in part-time employment to number of persons in full-time employment is used to compare the number of employed persons in the community services industry with the estimated number of unpaid household members providing care to others in the community. In estimating FTE for persons in the households sector caring for others, the average hours worked per week is applied to total hours spent by household members on providing such care. The averages were 38.4 hours per week for men and 38.2 hours per week for women working as Carers and aides in the community services industry (ABS 2001a). In 1999—00 there were 144,267 FTE employed persons working in the community services industry.[2] An estimated FTE of household members delivering welfare services at almost no charge was about 974,000, more than six times the number of paid workers. The unpaid household member therefore dominates as a provider of welfare services, either independently or by undertaking voluntary work through community service organisations.

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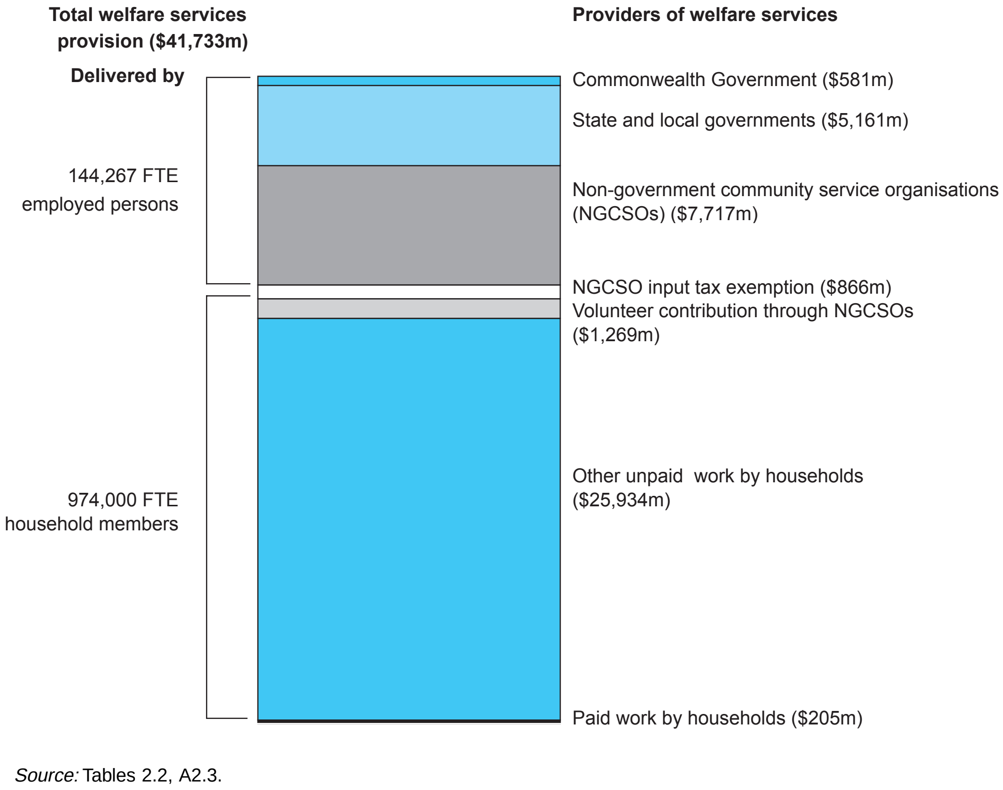
[1] That is, the sum of the estimated expenditure by NGCSOs in providing the services at $7,717m plus the estimated value of input tax exemption at $866 m plus the estimated value of volunteers' contribution at $1,269m.

[2] Estimated based on the ABS Labour Force Surveys 1999 and 2000 (unpublished data).



Source: Tables 2.2, A2.3.

Figure 2.1: Providers and value of welfare services, 1999–00

2.3 The contribution of the households sector

According to the System of National Accounts, the households sector is one of the five institutional sectors that make up the total economy producing goods and services to the community. The five sectors are: financial corporations, non-financial corporations, governments, households, and non-profit institutions serving households. Members of the households sector, although they are primarily classified as consumers, may be engaged in any kind of activity. They not only supply labour to the other sectors but may also provide either paid or unpaid labour independently of these other sectors (Inter-Secretariat Working Group 1993). The terms households sector and household members are used interchangeably in this chapter.

Some household members are in paid employment in the other sectors of the economy. Some provide unpaid voluntary work for other sectors, mainly governments and non-profit institutions serving households. Some provide either paid or unpaid labour independently of these other sectors. This section deals mainly with the latter two groups.

Table 2.1: Estimates of time spent providing welfare services, households sector, 1999–00

		Voluntary work and care			
		Child care–related	For adults independent of organisations	Through organisations	Total
		Million hours per year			
Aged 15–64 years	Males	128	438	8	574
	Females	332	563	43	937
	Persons	*459*	*1,001*	*51*	*1,511*
Aged 65+ years	Males	17	67	19	103
	Females	44	118	13	175
	Persons	*61*	*184*	*33*	*278*
All	Males	145	505	27	677
	Females	375	681	56	1,112
	Persons	**521**	**1,185**	**83**	**1,789**
		FTE			
All	Males	79,000	274,000	14,000	367,000
	Females	205,000	371,000	31,000	607,000
	Persons	**284,000**	**645,000**	**45,000**	**974,000**
		Percentage of hours per year			
Aged 15–64 years	Males	22	76	1	100
	Females	35	60	5	100
	Persons	*30*	*66*	*3*	*100*
Aged 65+ years	Males	17	65	19	100
	Females	25	67	8	100
	Persons	*22*	*66*	*12*	*100*
All	Males	21	75	4	100
	Females	34	61	5	100
	Persons	**29**	**66**	**5**	**100**

Note: Totals may not add due to rounding.

Source: Estimated by AIHW based on ABS Time Use Survey Unit Record File (ABS 1999c).

The households sector has a vital role in providing welfare services for family, friends and neighbours and for the wider community through community service organisations. This work reduces the demand for services provided by governments and NGCSOs. This sector therefore brings to the community large social contributions that are not included in the national accounts.

In 1999—00, it is estimated that households spent 1,789 million hours providing welfare services.[3] This constitutes about 974,000 FTE, 62% of whom were female and 38% male (Table 2.1). Of the total hours, 66% were spent on caring for relatives, friends and

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[3] The estimates for 1999–00 were based on the 1997 Time Use Survey, the results from which were scaled up by the growth rate of population in each age group between 1997 and 1999–00. (See AIHW 1999a:30 for further details of classifications and variables included in the analysis.)

neighbours (adults), 29% on child care—related activities for other people s children and for own sick child,[4] and 5% on voluntary work through community service organisations.

The majority of time spent was on services for adults: 75% by male carers and 61% by female carers. Child care—related activities constituted the second most time-consuming area of welfare assistance, with women spending proportionately more of their time (34%) than men (21%). For welfare services provided through community service organisations, women devoted 5% of their welfare services time to this activity, while men devoted 4%.

Men and women of working age (15 to 64 years) accounted for the bulk (84%) of the 1,789 million hours of welfare services provided by households in 1999—00. Household members aged 65 years and over provided the remaining 16%, or 278 million hours.

The imputed value of the time households spent in welfare services provision can be derived from the ABS time use survey data and data on the hourly wage rates of adult carers and aides. Such a valuation is based on the economic opportunity cost concept: household members could have used their time in the paid production of goods and services other than welfare services. This method of valuing the services is debatable. The alternative provider cost method was used here. It involved valuing services by unpaid persons according to the cost of employing paid workers within the community services sector. (See AIHW 1995:29 for more details about the valuation methods.)

The 1999—00 wage estimations were based on May 2000 ABS earnings data. The average weekly total earnings for adult male carers and aides (full-time non-managerial employees) was $633.80 per week. Based on an average of 38.4 hours per week, this implies an earning rate of $16.51 per hour. The average weekly total earnings for female carers and aides was $557.60 per week for a 38.2 hour week, or $14.60 per hour.

Using these earning rates, the value of welfare services provided by household members in 1999—00 was imputed at $27.4 billion (Table 2.2). This valuation uses the alternative provider cost method an estimate of the cost that would be incurred by governments and NGCSOs if they were to employ workers to provide these services instead of relying on the work supplied by households for almost no charge. It is, however, a conservative estimate, since the valuation includes neither overheads related to employing workers (superannuation, annual leave, sick leave) nor the cost of providing office and work space for employees.

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[4] Time spent caring for own children who are not sick is not welfare services. This was 4.3 times higher than time spent caring for others' children and own sick children.

Table 2.2: Estimates of the value of time devoted to welfare services by the households sector, by type of service, 1999–00 ($m)

Service type	Men	Women	Persons
Child care–related	2,397	5,479	7,876
Voluntary work and care			
Care for adults	8,330	9,933	18,263
Voluntary work through organisations	451	818	1,269
Total	**11,177**	**16,231**	**27,408**

Source: Time–As for Table 2.1; Average weekly total earnings–ABS 2001a.

Of the total imputed value of household welfare services of $27.4 billion, $205 million was payment made to informal carers for child care services.[5] This amount is included as monetary expenditure to be consistent with the national accounts, which imputes the value of paid work carried out in the informal sector. The balance of $27.2 billion related to unpaid services and was almost double the $13.7 billion total monetary expenditure on welfare services in 1999—00.

In terms of type of care, 67% ($18.3 billion) of the total imputed value of household welfare services was the estimated value of care provided to other adult family members, friends or neighbours. A further 29% ($7.9 billion) was the estimated value of households providing child care—related activities to others children and to their own sick children. The remaining $1.3 billion was the imputed value of voluntary welfare assistance provided through community service organisations.

Of the total imputed value of $27.4 billion, men accounted for $11.2 billion (41%) and women $16.2 billion (59%).

2.4 The community services workforce

The supply of and demand for community services are affected by a range of factors discussed in this and preceding editions of this report, and the community services workforce is a key factor in both supply and demand. For instance, the increasing number of women in the workforce has a dual effect on community services. The demand for services increases and the pool of unpaid labour providing services to children, disabled or older family members reduces (AIHW 1999a:58). On the other hand, the relatively large number of workers moving into retirement over the next few years may augment the number of volunteers providing such services.

The reporting of data in *Australia's Welfare* is in terms of services for groups such as older people, children, people with disabilities and homeless people. These data usually focus on the characteristics of the clients and the services they receive, rather than on the labour force.

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[5] Estimated based on data from ABS (2000a). See AIHW (1997b) for details of estimation method.

The community services workforce described in this chapter comprises those people (employees and volunteers) whose activities form the basis of social support provision for the community. The occupational groups and industries most closely identified with the community services workforce are those in which these activities represent the main focus.

Labour force data relating to community services

The main sources of labour force data for community services are the Australian Bureau of Statistics surveys of community services activity (described in Box 2.1), estimates from the monthly labour force surveys and the 5-yearly Census of Population and Housing. The surveys of community services activity provide detailed information about the activities of employees and volunteers. The Census is the only source that enables a detailed cross-classification of industry and occupation.

Box 2.1: Community services industries and activities classifications

The ABS survey of community services, conducted for 1995–96 and 1999–00, obtained data from employing businesses and private sector organisations involved in the provision of community services, including personal and social support, financial and material assistance, job placement and support for persons with disabilities, child care, accommodation for the aged, and other residential and non-residential care in both government and non-government sectors. Some of these services are provided directly—that is, to individuals or families on a face-to-face basis or on their behalf. Other services are provided indirectly.

The community services industries, as currently defined by the ABS, comprise three broad groups whose principal activities are reflected in the above description, viz., nursing homes, child care services and community care services (including accommodation for the aged, and residential and non-residential services). Although the term 'nursing homes' is no longer aligned with terminology used in the Aged Care Act 1997, *it is used in this chapter, as data shown were collected and previously published with that description.*

The scope of the survey comprised not only businesses and organisations in the community services industries, but also those in the industries of employment placement services, interest groups not elsewhere classified and government administration. Tables 2.3 and 2.4 relate to community services activities in all of the above industries, while Table 2.5 relates only to the community services industries.

Community services activities and industries

Information about community services activity was obtained from the ABS surveys, conducted for the reference periods 1995—96 and 1999—00 (ABS 1998a, 2001b). The survey showed that, in 1999—00, there were 341,447 employees engaged in community services activities in industries within the scope of the survey (see Box 2.1). This represented an increase of 7% since 1995—96, with those in the community services industry increasing by 9% and those in other industries remaining steady. These employees made up 5% of all employees in 1999—00 (ABS 2001c). In addition to these employees, there were 299,413 volunteers performing community services activities in these industries in 1999—00, 25% more than in 1995—96. The number of these volunteers in the community services industry increased by 31% over this period, while the number in other industries fell by 18% (Table 2.3).

Table 2.3: Employees and volunteers in community services activities,[(a)] 1995–96 and 1999–00

Employees and volunteers	**1995–96**	**1999–00**	**% change 1995–96 to 1999–00**
Employees performing community services activities at end of June			
In the community services industry	247,080	269,022	8.9
In other industries surveyed[(b)]	72,108	72,425	0.4
Total	**319,188**	**341,447**	**7.0**
All employees[(c)]	6,104,000	6,709,000	9.9
Volunteers performing community services activities during June			
In the community services industry	210,612	276,334	31.2
In other industries surveyed[(b)]	28,248	23,079	–18.3
Total	**238,860**	**299,413**	**25.4**

(a) Refers to employees and volunteers of businesses and organisations.

(b) Comprises industries included in the survey other than the community services industry (see Box 2.1).

(c) From ABS 2001c.

Source: ABS 1998a, 2001b.

Of the organisations surveyed, not-for-profit organisations had the most employees (217,838) and volunteers (278,347) in 1999—00, considerably more than the total government sector (59,246 and 17,954 respectively). Not-for-profit organisations experienced large percentage increases in employees and volunteers between 1995—96 and 1999—00 (21% and 31% respectively). The number of employees and volunteers in all other categories of organisation fell over the period, indicating a shift in the provision of community services to private sector not-for-profit organisations (Table 2.4).

Between 1995—96 and 1999—00, the 9% increase in the number of employees in community services industries (from 247,080 to 269,022) comprised a rise of 31% in those providing direct services, and a fall of 38% in other employees. Over this period, the 31% growth in the number of volunteers in community services industries (from 210,612 to 276,333) comprised an increase of 109% in those providing direct services, and a decrease of 19% in other volunteers (Table 2.5).

Of the three broad community services industries, nursing homes had the most employees (84,519) in 1999—00, slightly more than the number in non-residential care services (78,834). Non-residential care services had far more volunteers (211,741) than other community services industries. Between 1995—96 and 1999—00, residential care services had the strongest increases in employees (up by 48%) and volunteers (up by 99%). Employment in nursing homes fell from 98,896 to 84,519 (down by 15%), comprising an increase of 4% in those in direct service provision and a decrease of 65% in employees in other services. The number of volunteers in nursing homes hardly changed over the period (up 1%), with those providing direct services increasing by 60% and the number of other volunteers decreasing by 50% (Table 2.5).

Table 2.4: Employment and volunteers in community services activities, by type of service provision and organisation, 1995–96 and 1999–00

			Government			
Type of service provision	**For profit**	**Not for profit[(a)]**	**Common–wealth/ State**	**Local**	**Total**	**Total**
			1995–96			
Employment at end of June						
Direct community services provision[(b)]	56,445	114,661	35,844	16,214	52,058	223,164
Other	14,020	65,982	13,523	2,500	16,023	96,025
Total employees	**70,465**	**180,643**	**49,367**	**18,714**	**68,081**	**319,188**
Volunteers during June[(c)]	3,926	212,916	n.a.	22,018	22,018	238,860
			1999–00			
Employment at end of June						
Direct community services provision[(b)]	60,082	168,161	34,177	14,846	49,023	277,266
Other	4,281	49,677	7,695	2,528	10,223	64,181
Total employees	**64,363**	**217,838**	**41,872**	**17,374**	**59,246**	**341,447**
Volunteers during June[(c)]	3,111	278,347	n.a.	17,954	17,954	299,413
			Per cent change			
Employment at end of June						
Direct community services provision[(b)]	6.4	46.7	–4.7	–8.4	–5.8	24.2
Other	–69.5	–24.7	–43.1	1.1	–36.2	–33.2
Total employees	**–8.7**	**20.6**	**–15.2**	**–7.2**	**–13.0**	**7.0**
Volunteers during June[(c)]	–20.8	30.7	n.a.	–18.5	–18.5	25.4

(a) 'Not-for-profit' organisations are those whose status does not permit them to be a source of income, profit or other financial gain for the units that establish, control or finance them.

(b) Direct community services provision are those activities which are provided to individuals and families on an interactive or face-to-face basis or on their behalf.

(c) Data not collected for Commonwealth or State Governments.

Source: ABS 1998a, 2001b.

Table 2.5: Employment and volunteers in community services industries,[a] by type of service provision and community industry, 1995–96 and 1999–00

Type of service provision	Nursing homes	Child care services	Community care services: Accommodation for the aged	Community care services: Residential care services nec	Community care services: Non-residential care services	Total
			1995–96			
Employment at end of June						
Direct community services provision[b]	72,311	30,530	19,690	10,342	35,961	168,834
Other	26,585	5,604	13,730	4,633	27,693	78,245
Total employees	**98,896**	**36,134**	**33,420**	**14,976**	**63,654**	**247,080**
Volunteers during June						
Direct community services provision[b]	7,211	5,531	3,983	3,385	62,785	82,895
Other	8,367	14,006	14,701	6,984	83,660	127,718
Total volunteers	**15,578**	**19,537**	**18,684**	**10,369**	**146,444**	**210,612**
			1999–00			
Employment at end of June						
Direct community services provision[b]	75,298	38,346	35,569	19,022	52,446	220,681
Other	9,221	2,763	6,833	3,136	26,388	48,341
Total employees	**84,519**	**41,109**	**42,402**	**22,158**	**78,834**	**269,022**
Volunteers during June						
Direct community services provision[b]	11,523	3,987	11,406	14,363	131,685	172,964
Other	4,229	7,357	5,471	6,258	80,055	103,369
Total volunteers	**15,752**	**11,344**	**16,877**	**20,620**	**211,741**	**276,333**
			Per cent change			
Employment at end of June						
Direct community services provision[b]	4.1	25.6	80.6	83.9	45.8	30.7
Other	–65.3	–50.7	–50.2	–32.3	–4.7	–38.2
Total employees	**–14.5**	**13.8**	**26.9**	**48.0**	**23.8**	**8.9**
Volunteers during June						
Direct community services provision[b]	59.8	–27.9	186.4	324.3	109.7	108.7
Other	–49.5	–47.5	–62.8	–10.4	–4.3	–19.1
Total volunteers	**1.1**	**–41.9**	**–9.7**	**98.9**	**44.6**	**31.2**

(a) The industry data in this table relates to employees of businesses and organisations where community services activity is the main activity of the business and organisation. Therefore, this table excludes community services activity where it forms a minor part of the total activity of the business or organisation, such as a child care facility as part of a corporate business, or a nursing home as part of a hospital.

(b) Direct community services provision are those activities which are provided to individuals and families on an interactive or face-to-face basis or on their behalf.

Source: ABS 1998a, 2001b.

The community services workforce

In common with many occupations, but in contrast with those in the health industry, there is not a direct match between community services occupation and industry. People employed in community services occupations (such as pre-primary and special education, welfare, social and community workers; counsellors; welfare associate professionals; children s care workers and special care workers) work across a range of industries. Table 2.6 shows that counsellors, for example, work in a wide range of industries, some of which are community services industries, and some of which relate to health, education or correctional services. Special care workers may work in supported accommodation refuges or correctional, child protection, aged care or disability services.

Of the 69,137 employees in the occupation group of children s care workers, most (45,857) were in the child care services industry (AIHW 2001). Of the 41,703 special care workers, just over half (51%) worked in three industries: residential care services (other than accommodation for the aged) (7,295), non-residential care services (such as meals on wheels, welfare counselling) (7,105), or nursing homes (6,990). Of the 30,197 employees in the welfare, social and community workers occupation group, over half (57%) were employed in four industries: non-residential care services (8,331), government administration (3,586), community health centres (2,763) or hospitals (2,428) (Table 2.6).

Table 2.6: Employment in community services occupations, by industry and occupation, 1996

Industry	**Pre-primary & special education**	**Welfare, social & community workers**	**Coun-sellors**	**Welfare associate profess-ionals**	**Children's care workers**	**Special care workers**	**Total**
Community services							
Nursing homes	13	633	9	127	60	6,990	7,832
Child care services	3,544	708	19	180	45,857	1,778	52,086
Accommodation for the aged	3	384	3	34	20	3,483	3,927
Residential care services[(a)]	132	2,384	102	3,031	531	7,295	13,475
Non-residential care services	369	8,331	1,126	2,448	1,665	7,105	21,044
Community services (undefined)	26	1,381	34	349	165	1,174	3,129
Total community services	*4,087*	*13,821*	*1,293*	*6,169*	*48,298*	*27,825*	*101,493*
Other industries							
Government administration	514	3,586	297	906	1,923	2,777	10,003
Education	22,691	1,036	56	584	6,689	1,249	32,305
Hospitals	36	2,428	165	244	221	1,173	4,267
Community health centres	79	2,763	800	1,483	504	1,792	7,421
Other industries (incl. not stated)	2,213	6,563	747	3,788	11,502	6,887	31,700
Total	**29,620**	**30,197**	**3,358**	**13,174**	**69,137**	**41,703**	**187,189**

(a) Includes those other than accommodation for the aged.

Source: AIHW 2001.

Detailed community services occupations

The broad occupational groups described above and in Table 2.6 can be broken down into smaller occupational categories. Based on ABS Census data, Table A2.1 shows persons employed, and the number per 100,000 population, in the broad groups and the smaller categories within those groups, at August 1996.

Of the broad occupational groups, the largest was children s care workers, with 69,137 employees (390 per 100,000 population), followed by special care workers, with 41,703 employees (235 per 100,000). These two groups together accounted for well over half (59%) of all people employed in community services occupations.

Of the more detailed occupational categories, carers of aged or disabled persons (35,940 workers, or 203 per 100,000) and child care workers (31,201, or 176 per 100,000) were the largest. Together, workers in these two categories made up over a third (36%) of all those employed in community services occupations. Other categories with relatively large numbers of employed people were family day care workers (16,577, or 93 per 100,000), community workers (15,800 or 89 per 100,000) and pre-primary school teachers (12,584, or 71 per 100,000).

Nursing

The following information focuses on the nursing labour force, as it represents a major occupation providing community services.

Table 2.7: Nurses employed in selected areas of nursing, by type of nurse, 1993–97

Area of nursing/type of nurse	1993	1994	1995	1996	1997[(a)]	% change 1993–97
Geriatrics/gerontology						
Registered nurses	22,259	22,663	22,129	22,111	20,662	–7.2
Enrolled nurses	19,427	18,671	16,533	16,160	14,632	–24.7
Total	**41,685**	**41,334**	**38,662**	**38,271**	**35,294**	**–15.3**
Community/district/domiciliary nursing						
Registered nurses	8,447	8,956	8,108	7,995	7,408	–12.3
Enrolled nurses	685	728	698	773	887	29.5
Total	**9,132**	**9,684**	**8,806**	**8,768**	**8,295**	**–9.2**
Developmental disability nursing						
Registered nurses	2,163	2,183	2,398	2,266	1,838	–15.0
Enrolled nurses	918	942	556	738	697	–24.1
Total	**3,081**	**3,215**	**2,954**	**3,004**	**2,535**	**–17.7**
All nurses[(b)]						
Registered nurses	164,252	172,434	171,774	171,684	175,935	7.1
Enrolled nurses	52,444	52,676	48,892	46,488	46,274	–11.8
Total	**216,696**	**225,110**	**220,666**	**218,172**	**222,209**	**2.5**

(a) 1997 classification of clinical area is not strictly comparable with previous years.

(b) Includes all areas of nursing.

Source: AIHW 1997a, 1998a, 1999b, 2000.

Between 1993 and 1997, the number of nurses employed in the three main areas of nursing relating to community services geriatrics / gerontology, community / district / domiciliary nursing and developmental disability nursing fell by 15%, 9% and 18% respectively (AIHW 1997a, 1998a, 1999b, 2000). The percentage decreases for registered nurses (7%, 12% and 15% respectively) were less than those for enrolled nurses (25%, 29% and 24% respectively). These trends contrast with the changes in the numbers of all nurses over the period (up 3%), comprising an increase of 7% in registered nurses and a decrease of 12% in enrolled nurses (Table 2.7).

Between 1994 and 1997, decreases also occurred in the numbers of registered and enrolled nurses in all settings related to community care except community health centres, where there was an increase of 26% (Table 2.8). This pattern is consistent with the general shift in employment to private not-for-profit organisations noted earlier .

The decrease in the number of nurses employed in the geriatrics and gerontology area occurred during a period when the number of older people was increasing (see Chapter 6). The number of people residing in aged care homes increased from 122,480 in 1993 to 132,804 in 1997 (an 8.4% increase). However, the number of hospital bed-days used by older people fell slightly between 1993—94 and 1996—97, from 10,541,892 to 10,247,280 (a 2.8% decrease) (AIHW 1997c, 1998b).

Table 2.8: Nurses employed in selected work settings, by type of nurse, 1994–97

Work setting/type of nurse	1994	1995	1996	1997	% change 1994–97
Public nursing homes					
Registered nurses	9,813	8,008	8,344	9,648	–1.7
Enrolled nurses	10,514	7,750	7,529	7,997	–23.9
Total	**20,327**	**15,758**	**15,873**	**17,645**	**–13.2**
Private nursing homes					
Registered nurses	12,608	12,985	11,752	12,289	–2.5
Enrolled nurses	7,340	7,226	6,329	5,933	–19.2
Total	**19,948**	**20,211**	**18,081**	**18,222**	**–8.7**
Community health centres					
Registered nurses	8,760	9,325	9,557	11,051	26.2
Enrolled nurses	835	881	868	1,002	20.0
Total	**9,595**	**10,206**	**10,425**	**12,053**	**25.6**
Developmental disability service					
Registered nurses	2,454	2,526	2,325	2,268	–7.6
Enrolled nurses	962	825	741	814	–15.4
Total	**3,416**	**3,351**	**3,066**	**3,082**	**–9.8**
All nurses					
Registered nurses	172,434	171,774	171,684	175,935	2.0
Enrolled nurses	52,676	48,892	46,488	46,274	–12.2
Total	**225,110**	**220,666**	**218,172**	**222,209**	**–1.3**

Source: AIHW 1997a, 1998a, 1999b, 2000.

Reported nursing shortages

The Department of Employment, Workplace Relations and Small Business regularly collects data on skill shortages. The survey obtains data by telephone, primarily from employers who have recently advertised, and focuses on whether they have been able to find suitable applicants. Statistical trends, including the numbers commencing and completing training and the number of vacancies, are also considered.

Table 2.9 below shows that in February 2001 there was a widespread shortage of registered nurses in aged care across Australia, and considerable shortages in community nursing in most jurisdictions. In the context of expectations that aged people will represent higher percentages of the population in the medium and long terms, the downtrends in these areas of nursing are particularly critical.

Table 2.9: Shortages in nursing occupations, by State/Territory, February 2001

Area of nursing	NSW/ACT	Vic	Qld	WA	SA	Tas	NT	Australia
Aged care registered nurse	Y	Y	Y		Y	Y	Y	Y
Community nursing	Y	Y	Y	R			Y	Y

Note: Y indicates a shortage; R indicates shortage in some regional areas only.

Source: DEWRSB, unpublished data on national and State skills shortages.

The shortage of registered nurses in aged care reflects a more broadly based shortage of nurses in general, and one which has been observed at the international as well as the national level. The shortage has not gone unobserved by the aged care industry, nursing unions, or indeed by the government. Early in 2001, the Senate Community Affairs References Committee commenced an Inquiry into Nursing with two major areas of concern: the shortage of nurses in Australia and the impact that this is having on the delivery of health and aged care services; and the opportunities to improve current arrangements for the education and training of nurses, encompassing enrolled, registered and postgraduate nurses. In addition, a ministerially appointed expert panel has been set up to undertake a Review of Nurse Education. The review was agreed between Dr Wooldridge and Dr Kemp and will look at the effectiveness of the current arrangements for the education and training of nurses. In addition, the Australian Health Workforce Advisory Committee (set up in December 2000) has been requested by the Australian Health Ministers Advisory Council to consider the specialised nursing workforce as its first priority, and in particular the areas of critical care nursing, midwifery, mental health, aged care and emergency medicine.

More specifically, there have been some particular initiatives in the aged care field. The Aged Care Work Force Committee has been established within the Department of Health and Aged Care, as a subcommittee of the Aged Care Working Group. The committee has four objectives: to raise the profile of residential aged care work; to encourage the provision of appropriate education and continuing professional development for residential aged care workers and potential workers; to encourage the improvement of appropriate workforce employment practice and safety; and to maintain and analyse data on workforce issues in aged care. A number of specific projects have been undertaken. These include the Nurse Returners Project, being undertaken by La Trobe University into the key reasons for nursing attrition in the residential aged care sector and the factors which would encourage the return of nurses to this sector; and the Minister s Awards for Excellence in Residential Aged Care.

2.5 Monetary expenditure on welfare services

Total expenditure

Prior to 1998—99, government expenditure was consistently reported on a cash basis, where payments for welfare services provision are made in the financial year regardless of whether they are for services provided in the year. Since 1998—99, governments in most jurisdictions have reported on an accrual basis. Under this system, only the expenses which are related to the services provided in the year are reported. Estimates of items such as depreciation of capital used up in the process of production of goods and services in the financial year and unfunded superannuation are also included.

Table 2.10: Total welfare services expenditure and expenditure per person, (in current and constant 1998–99 prices)[(a)] and annual growth rate, 1990–91 to 1999–00

	Total expenditure ($m)		**Expenditure per person ($)**	
Year	**Current prices**	**Constant prices**	**Current prices**	**Constant prices**
		Amount		
1990–91	5,721	6,747	333	393
1991–92	6,298	7,061	362	406
1992–93	7,125	7,795	405	443
1993–94	7,726	8,398	435	473
1994–95	8,355	9,023	465	502
1995–96	9,069	9,586	498	527
1996–97	9,958	10,341	540	561
1997–98	10,874	11,130	583	597
Break in time series				
1998–99	12,818	12,818	680	680
1999–00	13,664	13,369	717	702
		Growth rate (per cent)		
1990–91 to 1991–92	10.1	4.6	8.7	3.3
1991–92 to 1992–93	13.1	10.4	11.9	9.2
1992–93 to 1993–94	8.4	7.7	7.4	6.7
1993–94 to 1994–95	8.1	7.4	7.0	6.3
1994–95 to 1995–96	8.5	6.2	7.1	4.9
1995–96 to 1996–97	9.8	7.9	8.4	6.5
1996–97 to 1997–98	9.2	7.6	8.0	6.4
Break in time series				
1997–98 to 1998–99	. .	. .	. .	. .
1998–99 to 1999–00	6.6	4.3	5.5	3.2
Average annual growth rate[(b)]				
1990–91 to 1997–98	9.6	7.4	8.3	6.2
1998–99 to 1999–00	6.6	4.3	5.5	3.2

(a) The GFCE implicit price deflator was applied to both government and non-government sector current price expenditure.

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

Source: Expenditure—AIHW database; Population—ABS 1996a, 1998b, 1998c, 1999a, 2001d.

Under this new reporting system, expenditure is expected to be higher than when it was compiled on the cash basis. It is not possible at this stage to evaluate the extent of the changes resulting from this change in the reporting system.

The term expenditure is used in this chapter regardless of whether the data on which the estimates of expenditure are made are reported on a cash or accrual basis or a mixture of both.

The provision and funding of monetary expenditure on welfare services is shared by both the government and non-government sectors. The government sector consists of the Commonwealth Government, the State and Territory Governments, and local governments. The non-government sector consists of the households sector and the NGCSOs, which operate either for profit or not for profit. The households sector is both a provider and a purchaser or funder of services. Households contribution as a funder of services is in the form of client fees for the services.

The switch from cash to accrual accounts reporting in the government sector results in a break in the expenditure series. The time series presented in this chapter are broken down into two periods: 1990—91 to 1997—98 when expenditure data were compiled on a cash basis, and 1998—99 and 1999—00 when they were compiled on an accrual basis.

In 1999—00, total monetary expenditure on welfare services was $13.7 billion and was 2.16% of GDP (Tables 2.10 and 2.11). Growth of total expenditure in real terms between 1990—91 and 1997—98 averaged 7.4% per year. Between 1998—99 and 1999—00 it was 4.3%.

Table 2.11: Welfare services expenditure and GDP (in current and constant 1998–99 prices), 1990–91 to 1999–00 ($m)

	Welfare services expenditure		**Gross domestic product[a]**		**Expenditure as % of GDP**
Year	**Current prices**	**Constant prices**	**Current prices**	**Constant prices**	**Current prices**
1990–91	5,721	6,747	396,684	440,389	1.44
1991–92	6,298	7,061	405,961	442,023	1.55
1992–93	7,125	7,795	426,746	457,985	1.67
1993–94	7,726	8,398	449,416	476,989	1.72
1994–95	8,355	9,023	473,381	498,550	1.77
1995–96	9,069	9,586	506,975	520,261	1.79
1996–97	9,958	10,341	532,170	539,088	1.87
1997–98	10,874	11,130	564,653	565,126	1.93
Break in time series					
1998–99	12,818	12,818	595,417	595,417	2.15
1999–00	13,664	13,369	632,416	621,186	2.16

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

Source: Welfare services expenditure—AIHW database; GDP—ABS 1999b, 1999d, 2001e.

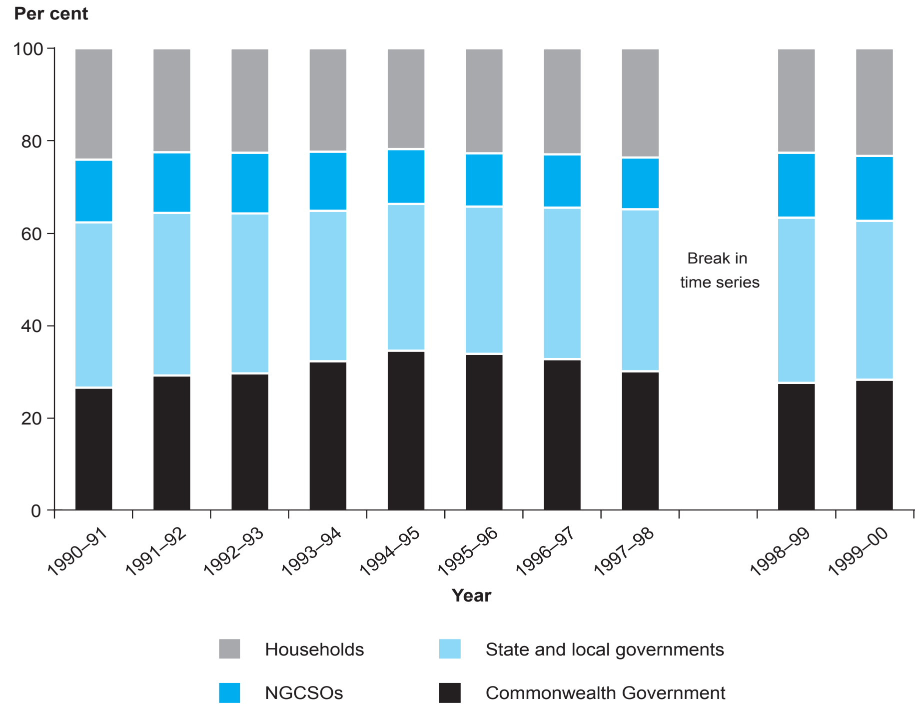
The Australian Bureau of Statistics has estimated that $12.6 billion was spent on community services in 1999—00 (ABS 2001b). The discrepancy between the AIHW and ABS estimates was due partly to estimation methods and partly to coverage of expenditure items. Items not included in the ABS estimate but included in the AIHW estimate are child care cash rebates, concessions on electricity, water, council rates to individuals, and services for refugees and Aboriginal and Torres Strait Islander people.

Per person expenditure on welfare services in 1999—00 was $717 in current prices, an increase in real terms over 1998—99 of 3.2%. Over the preceding period, 1990—91 to 1997—98, the average annual growth in per person expenditure in real terms was 6.2% (Table 2.10).

Total expenditure by source of funds

Between 1990—91 and 1997—98, governments financed an average of 65% of expenditure on welfare services (Table 2.12, Figure 2.2). The remaining 35% was funded by the household and NGCSO sectors. In the 1998—99 to 1999—00 period, the funding share of the government sector was 63% and the non-government sector 37%.

The Commonwealth Government's share of funding of total welfare services expenditure between 1990—91 and 1997—98 fluctuated between 27% (in 1990—91) and 35% (in 1994—95), averaging 31% over the entire period. State and Territory Governments' share of funding also fluctuated, averaging 33%. Local governments accounted for a small proportion of total welfare services expenditure, averaging 1% during the period. In the non-government sector, the share of funding by clients averaged 23% of total expenditure while NGCSOs accounted for 12%.



Source: Table 2.12.

Figure 2.2: Proportion of welfare services expenditure, by source of funds, 1990–91 to 1999–00

Table 2.12: Expenditure on welfare services (in current prices), by source of funds, 1990–91 to 1999–00

	Government sector				Non-government sector			
Year	Common-wealth[(a)]	State/ Territory[(b)]	Local[(c)]	Total[(d)]	NGCSOs[(e)]	House-holds[(f)]	Total	Total expenditure
				Amount ($m)				
1990–91	1,522	1,995	51	3,568	777	1,376	2,153	5,721
1991–92	1,839	2,199	19	4,056	825	1,417	2,242	6,298
1992–93	2,113	2,447	22	4,582	934	1,609	2,542	7,125
1993–94	2,494	2,469	46	5,008	990	1,728	2,718	7,726
1994–95	2,892	2,551	99	5,542	995	1,818	2,813	8,355
1995–96	3,074	2,737	157	5,968	1,039	2,062	3,100	9,069
1996–97	3,264	3,147	121	6,531	1,143	2,284	3,427	9,958
1997–98	3,273	3,593	219	7,084	1,229	2,561	3,790	10,874
Break in time series								
1998–99	3,538	4,249	345	8,132	1,796	2,891	4,687	12,818
1999–00	3,871	4,584	122	8,577	1,913	3,174	5,087	13,664
				Proportion (per cent)				
1990–91	27	35	1	62	14	24	38	100
1991–92	29	35	<1	64	13	23	36	100
1992–93	30	34	<1	64	13	23	36	100
1993–94	32	32	<1	65	13	22	35	100
1994–95	35	31	1	66	12	22	34	100
1995–96	34	30	2	66	12	23	34	100
1996–97	33	32	1	66	12	23	34	100
1997–98	30	33	2	65	11	24	35	100
Break in time series								
1998–99	28	33	3	63	14	23	37	100
1999–00	28	34	1	63	14	23	37	100
				Average proportion				
1990–91 to 1997–98	31	33	1	65	12	23	35	100
1998–99 to 1999–00	28	33	2	63	14	23	37	100

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

(b) Recurrent expenditure—CGC 2001, CGC unpublished data. Capital expenditure—ABS unpublished public finance data.

(c) Recurrent and capital expenditure—ABS unpublished public finance data. The GFS data are not reliable at the 4-digit level of GPCs. Hence, only total welfare services expenditure is broken down into recurrent and capital. There is also a data reliability problem, as shown by the fluctuation in expenditure on welfare services from year to year.

(d) Total government expenditure data compiled by the AIHW include subsidies and personal benefits such as child care rebates, which are not included in GFCE. The figures here are therefore different from those published in ABS 2000b.

(e) 1992–93 estimated by AIHW based on Industry Commission 1994; 1993–94 estimated based on Industry Commission 1995; 1994–95 AIHW estimates based on a sample of NGCSOs' financial reports; 1995–96 to 1999–00, estimated by same methods as used for 1994–95, with additional information from ABS 1998c taken into consideration.

(f) Household contribution in the form of client fees to NGCSOs is generally obtained in the process of estimating NGCSOs' contribution. Client fees for child care services are estimated based on ABS 1997, 2000a. Fee charges for services provided by government agencies are based on ABS unpublished public finance data.

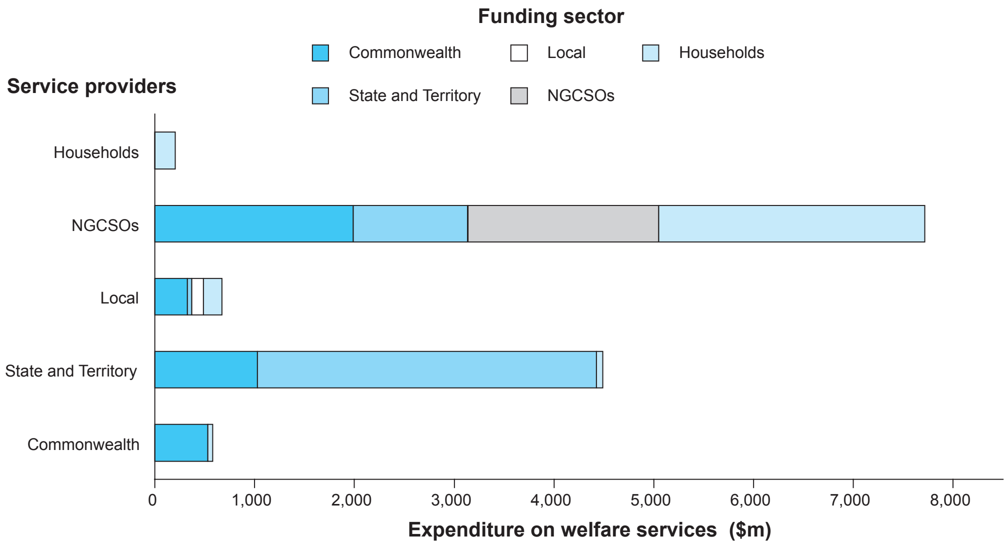
Note: Totals may not add due to rounding.

The State and Territory Governments share of funding in the 1998—99 to 1999—00 period was higher than that of the Commonwealth Government (33% and 28% respectively). The clients share, much of which came from pensions, was stable at 23% and the NGCSOs share was 14%.

Funding and provision of welfare services

In 1999—00, the government sector funded a total of $8.6 billion of welfare services expenditure. Of this amount, $5.4 billion (63%) was for services provided by the government sector itself; the remaining 37% was transferred to NGCSOs which then used these funds to provide services to the community (Table A2.2).

NGCSOs were predominantly providers of services (57%) but funded 14% worth of the total value of welfare services. Government agencies provided 42% worth: State and Territory government agencies delivered 33% and funded 34%; local government provided 5% and funded 1%; the Commonwealth Government provided 4% but funded 28% of the total value of welfare services. The remaining 2% ($205 million) was provided by the households sector (Table A2.2 and Figure 2.3).



Source: Table A2.2.

Figure 2.3: Funding and provision of welfare services by government and non-government sectors, total expenditure, 1999–00

This $205 million was the estimated cost of paid informal child care services. The estimated number of children using paid informal child care was 94,000 in 1999, representing only 11% of total children using informal child care (866,100). The remaining 89% were cared for by household members, to whom no payments were made. The majority of carers are grandparents (see Chapter 5).

Over time, NGCSOs were the major providers of welfare services, delivering an average of 58% of total welfare services expenditure between 1994—95 and 1999—00[6] (Table 2.13). Over this period, 39% of total welfare services expenditure was provided by government agencies and the remaining 2% was paid informal child care delivered by the households sector.

The Commonwealth Government and the State and Territory Governments were the major funders of welfare services, each funding on average just under one-third of total welfare services expenditure during the period 1994—95 to 1999—00.

Table 2.13: Funding and provision of welfare services, by sector, 1994–95 to 1999–00 (per cent)

	Government sector				Non-government sector		
	Common-wealth[(a)]	State/ Territory[(b)]	Local[(c)]	Total[(d)]	NGCSOs[(e)]	Households[(f)]	Total
Funding							
1994–95	35	30	1	66	12	22	34
1995–96	34	29	2	65	12	23	35
1996–97	33	31	1	65	12	23	35
1997–98	35	26	1	61	13	27	39
1998–99	28	33	3	63	14	23	37
1999–00	28	34	1	63	14	23	37
Provision							
1994–95	5	30	7	42	55	3	58
1995–96	4	28	8	39	58	3	61
1996–97	3	29	7	39	59	2	61
1997–98	4	21	6	32	66	2	68
1999–00	4	33	5	42	57	2	58

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

(b) Recurrent expenditure—CGC unpublished data. Capital expenditure—ABS unpublished public finance data.

(c) Recurrent and capital expenditure—ABS unpublished public finance data. The GFS data are not reliable at the 4-digit level of GPCs. Hence, only total welfare services expenditure is broken down into recurrent and capital. There is also a data reliability problem, as shown by the fluctuation in expenditure on welfare services from year to year.

(d) Total government expenditure data compiled by the AIHW include subsidies and personal benefits such as child care rebates, which are not included in GFCE. The figures here are therefore different from those published in ABS 2000b.

(e) 1992–93 estimated by AIHW based on Industry Commission 1994; 1993–94 estimated based on Industry Commission 1995; 1994–95 AIHW estimates based on a sample of NGCSOs' financial reports; 1995–96 to 1999–00, estimated by same methods as used for 1994–95, with additional information from ABS 1998c taken into consideration.

(f) Household contribution in the form of client fees to NGCSOs is generally obtained in the process of estimating NGCSOs' contribution. Client fees for child care services are estimated based on ABS 1997, 2000a. Fee charges for services provided by government agencies are based on ABS unpublished public finance data.

Note: Totals may not add due to rounding.

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6 Comparable data for estimates of household contributions go back to 1994–95 only.

Tax expenditure

Tax expenditures are tax concessions such as exemptions, deductions, rebates, reduced tax rates and deferral of tax liability. The tax deductibility of donations to NGCSOs is an example of a tax expenditure in the community services sector. Tax expenditures are measured in terms of the amount of tax revenue forgone by government as a result of concessional taxation treatment.

For NGCSOs, tax expenditures are an important and valuable form of assistance, accounting for about 7% of total expenditure.

Estimated total revenue forgone from tax expenditures in the community services sector increased from $443 million in 1993—94 to $989 million in 1999—00 (Table 2.14). It should be noted that these figures are likely to under-estimate the actual totals, as many tax expenditures in this area are not costed as a result of lack of data and conceptual difficulties associated with choosing a suitable tax benchmark (see AIHW 1999a:28—9 for more details). The average annual growth rate in real terms over the seven-year period was 12.4%. The fringe benefits tax exemption had the highest growth of all tax expenditures, with revenue forgone increasing by almost 36% on average between 1993—94 and 1999—00. This is a reflection of the growing reliance of the sector on fringe benefits as part of employee remuneration. The revenue forgone from government input tax exemptions made up the bulk of revenue forgone from all tax expenditures in the sector, averaging 86.4% of the total over the seven-year period.

Table 2.14: Estimates of tax expenditures(a) granted to NGCSOs (in current prices), 1993–94 to 1999–00(b) ($m)

	1993–94	**1994–95**	**1995–96**	**1996–97**	**1997–98**	**1998–99**	**1999–00**
Tax deductibility for donations	73	73	69	88	86	120	123
Commonwealth input tax exemptions							
Fringe benefits tax	30	70	75	150	180	190	210
Wholesale sales tax(c)	120	119	137	153	172	207	232
State/Territory input tax exemptions							
Payroll tax	80	79	91	102	115	138	154
Land tax	40	40	46	51	57	69	77
Stamp duty and bank taxes	100	99	114	127	144	172	193
Total government input tax exemptions	*370*	*408*	*463*	*583*	*668*	*775*	*866*
Total tax expenditure	**443**	**481**	**533**	**672**	**754**	**896**	**989**
Total welfare services expenditure	7,726	8,355	9,069	9,958	10,874	12,805	13,642
Tax expenditure as a proportion of total expenditure (%)	5.7	5.8	5.9	6.7	6.9	7.0	7.3

(a) Tax expenditures are recorded against the year in which the liability was incurred, not the year the expenditure is paid.

(b) 1994–95 to 1999–00 figures are AIHW estimates, except for the FBT exemption which was provided by Treasury.

(c) This tax was abolished 1 July 2000 following the introduction of 'The New Business Tax System' by the Commonwealth Government.

Note: Totals may not add due to rounding.

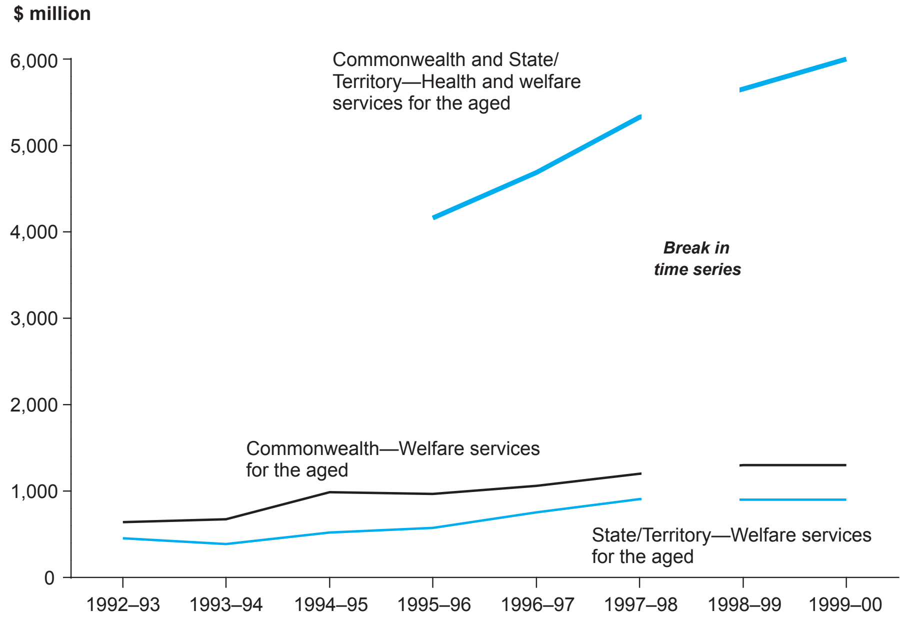
Source: Industry Commission 1995; Treasury 1997, 1999, 2001; AIHW welfare services expenditure database.

When revenue forgone by governments was added to total expenditure, welfare services expenditure as a proportion of GDP in 1999—00 rose from 2.16% to 2.31%. The share of funding by the Commonwealth Government rose from 28% to 30%, and by State and Territory Governments from 33% to 34%. NGCSOs share fell from 14% to 13% and households from 23% to 22%.

Recurrent government expenditure by area of expenditure

Data quality problems prevent further breakdown of State and Territory government capital expenditure and local government expenditure (both recurrent and capital) by area of expenditure. Analysis is possible only on recurrent expenditure by the Commonwealth Government and the State and Territory Governments. Furthermore, detailed information on concessions for pensioners, which enable the split of the aged and the disabled welfare services category into two categories aged care services and welfare services for people with a disability is not available for years earlier than 1992—93. The analysis of recurrent expenditure by the four welfare services categories therefore relates to the period 1992—93 to 1999—00 (Table 2.15).

Except for welfare services for the aged, expenditure by the State and Territory Governments was more than that by the Commonwealth Government in both the 1992—93 to 1997—98 and 1998—99 to 1999—00 periods.



Source: Table A2.3.

Figure 2.4: Funding of expenditure (in 1998–99 prices) on welfare services for the aged by the Commonwealth and State/Territory Governments, 1992–93 to 1999–00

Table 2.15: Commonwealth and State/Territory recurrent expenditure on welfare services (in current prices), 1992–93 to 1999–00

	Commonwealth[a]	State/Territory[b]	Total
		Amount ($m)	
Family and child welfare services			
1992–93	611.5	772.1	1,383.7
1993–94	758.9	814.4	1,573.2
1994–95	952.6	872.2	1,824.8
1995–96	1,088.4	985.6	2,074.0
1996–97	1,161.4	1,044.6	2,206.1
1997–98	1,089.2	1,129.3	2,218.5
1998–99 (accrual)	1,139.7	(c)1,343.5	2,483.1
1999–00 (accrual)	1,397.0	(c)1,449.6	2,848.6
Welfare services for the aged			
1992–93	586.6	414.0	1,000.6
1993–94	800.7	354.2	1,154.8
1994–95	911.3	482.2	1,393.5
1995–96	916.8	545.1	1,462.0
1996–97	1,023.7	725.4	1,749.1
1997–98	1,172.0	887.7	2,059.7
1998–99 (accrual)	1,301.5	902.4	2,203.9
1999–00 (accrual)	1,331.0	919.9	2,250.9
Welfare services for people with a disability			
1992–93	548.0	814.0	1,362.0
1993–94	596.3	919.4	1,515.7
1994–95	698.2	864.3	1,582.5
1995–96	729.1	887.3	1,616.4
1996–97	728.0	1,005.2	1,733.2
1997–98	744.2	1,166.8	1,911.0
1998–99 (accrual)	833.3	(c)1,522.5	2,355.8
1999–00 (accrual)	887.5	(c)1,650.1	2,537.6
Other welfare services			
1992–93	146.6	207.3	354.0
1993–94	155.5	211.3	366.8
1994–95	161.7	278.4	440.1
1995–96	202.4	272.9	475.3
1996–97	184.5	295.4	480.0
1997–98	182.0	347.1	529.1
1998–99 (accrual)	179.8	(c)405.8	585.7
1999–00 (accrual)	184.6	(c)463.0	647.7
Total welfare services			
1992–93	1,892.8	2,207.5	4,100.3
1993–94	2,311.3	2,299.3	4,610.6
1994–95	2,723.8	2,517.1	5,240.9
1995–96	2,936.8	2,691.0	5,627.7
1996–97	3,097.7	3,070.6	6,168.3
1997–98	3,187.4	3,531.0	6,718.3
1998–99 (accrual)	3,454.4	(c)4,174.2	7,628.5
1999–00 (accrual)	3,800.2	(c)4,482.6	8,282.8

(continued)

Table 2.15 (continued): Commonwealth and State/Territory recurrent expenditure on welfare services (in current prices), 1992–93 to 1999–00

	Commonwealth[a]	State/Territory[b]	Total
		Proportion (per cent)	
Average proportion by area of expenditure			
1992–93 to 1997–98			
Family and child welfare services	35	35	35
Welfare services for the aged	34	21	27
Welfare services for people with a disability	25	34	30
Other welfare services	6	11	9
Total	**100**	**100**	**100**
1998–99 to 1999–00			
Family and child welfare services	35	32	34
Welfare services for the aged	36	21	28
Welfare services for people with a disability	24	37	31
Other welfare services	5	10	8
Total	**100**	**100**	**100**
Average proportion by source of funding			
1992–93 to 1997–98			
Family and child welfare services	50	50	**100**
Welfare services for the aged	61	39	**100**
Welfare services for people with a disability	42	58	**100**
Other welfare services	37	63	**100**
1998–99 to 1999–00			
Family and child welfare services	48	52	**100**
Welfare services for the aged	59	41	**100**
Welfare services for people with a disability	35	65	**100**
Other welfare services	30	70	**100**

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

(b) Recurrent expenditure—CGC unpublished data. Capital expenditure—ABS unpublished public finance data.

(c) The figures are less reliable than previous years' data.

Note: Totals may not add due to rounding.

In the family and child welfare services area, the share of funding by the two levels of governments was roughly the same in both periods. In the aged care area, the Commonwealth Government's share was on average 61% in the period 1992—93 to 1997—98 and 59% in the period 1998—99 to 1999—00. However, the State and Territory Governments' share was higher than the Commonwealth Government's in the two other areas: welfare services for people with a disability area, 58% and 65% for the two periods respectively; and other welfare services area, 63% and 70% respectively.

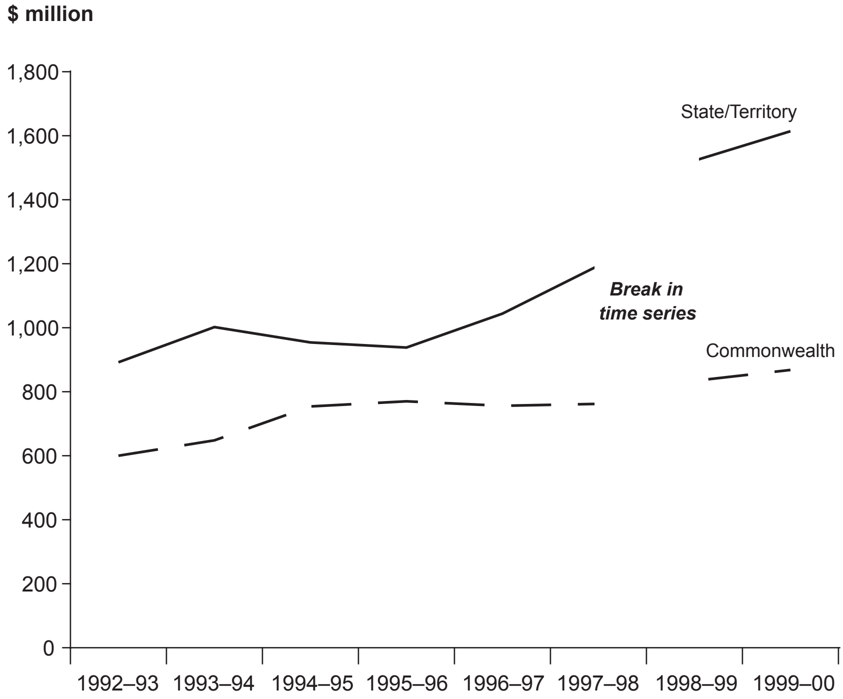
Of total recurrent expenditure by the Commonwealth Government, expenditure on family and child welfare services and welfare services for the aged each accounted for over one-third for both periods. Expenditure on welfare services for people with a disability accounted for about a quarter in both periods.

Of total recurrent expenditure between 1992—93 and 1997—98 by the State and Territory Governments, more than one-third was spent on family and child welfare services (35%) and welfare services for people with a disability (34%). Just under a quarter was spent on welfare services for the aged, and the remaining 11% on other welfare services.

In the 1998—99 to 1999—00 period, 37% of State and Territory government total recurrent expenditure went towards welfare services for people with a disability, followed by family and child welfare services (32%), welfare services for the aged (21%) and other welfare services (10%).

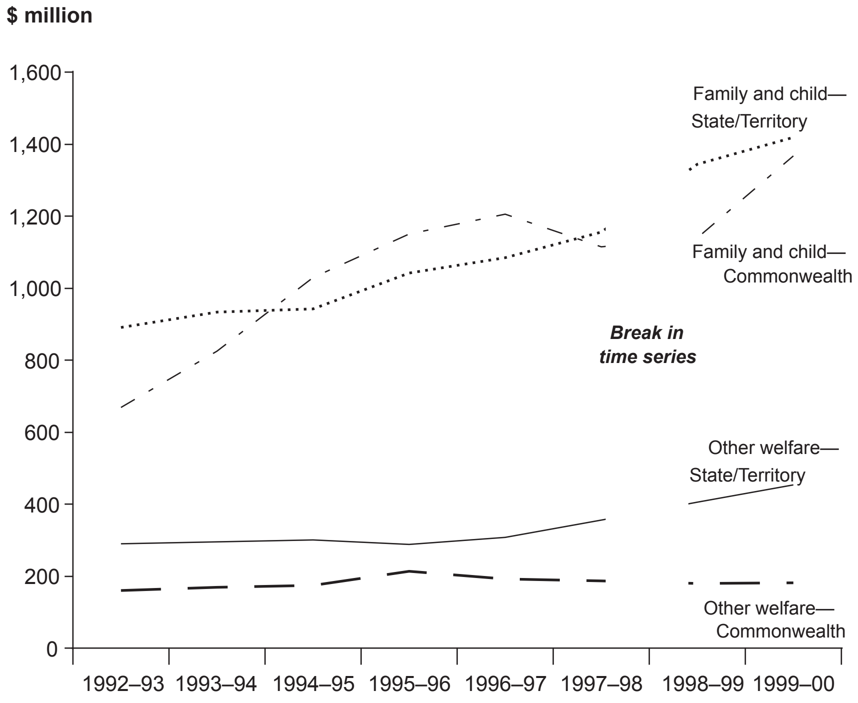
Expenditure by the two levels of government on the aged care in this chapter is related to the welfare services component only. If the health services component of residential care (high-level), domiciliary nursing care, and home and community care services were included, 1998—99 expenditure on aged care would be $5.7 billion (State and Territory high-level residential care data are available only up to 1998—99).

Comparative time-series data on recurrent expenditure by area of expenditure by the Commonwealth, State and Territory Governments in 1998—99 prices are in Table A2.3 and are displayed in Figures 2.4—2.6.



Source: Table A2.3.

Figure 2.5: Funding of expenditure (in 1998–99 prices) on welfare services for people with disabilities by the Commonwealth and State/Territory Governments, 1992–93 to 1999–00



Source: Table A2.3.

Figure 2.6: Funding of expenditure (in 1998–99 prices) on family and child welfare services and other welfare services by the Commonwealth and State/Territory Governments, 1992–93 to 1999–00

Non-government community service organisations

Non-government community service organisations operate on either a for-profit or not-for-profit basis.[7] Between 1992—93 and 1999—00, NGCSO recurrent expenditure was estimated to have increased from $3,933 million to $8,363 million (Table 2.16), at an average annual rate of 11.4% in current prices and 9.6% in constant prices.[8] The sources of funding of NGCSOs recurrent expenditure are government contributions, their own income sources, and client fees. In the eight-year period, 46% of their expenditure was funded by governments, 22% from their own income sources and 32% from client fees.

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[7] In 1995–96, 76.3% of NGCSOs were not-for-profit (ABS 1998a), and in 1999–00, 77.0% (ABS 2001b).

[8] Information on NGCSOs has been compiled on a consistent basis, so there is no break in the series.

The proportion of government funding of NGCSOs fluctuated, ranging between 44% and 48%. It was 47% in 1992—93 and 45% in 1999—00. The proportion of NGCSOs funding from their own income decreased fairly consistently, from 24% in 1992—93 to 20% in 1997—98, after which it increased to 24% in 1998—99. The increase was partly due to change in the distribution of these organisations total income as a result of the availability of more recent information from the Community Services Industry Survey (ABS 1998a), and of a larger sample of organisations being collected for the analysis.

Data prior to 1998—99 are estimated based on the report by the Industry Commission. For small and very small organisations providing welfare services for people with a disability, the distribution of sources of income was estimated from the survey by the Australian Council for the Rehabilitation of the Disabled (ACROD). The distribution was based on the 1992—93 financial year data which are out of date. The Industry Commission (1994:15—16) also was aware that the distribution may not be representative of all organisations.

Table 2.16: Sources of recurrent income,(a) all government-funded NGCSOs, 1992–93 to 1999–00

	Government funding(b)	NGCSO funding(c)	Client fees	Total
		Amount ($m)		
1992–93	1,846	934	1,153	3,933
1993–94	2,074	990	1,270	4,334
1994–95	1,973	995	1,338	4,306
1995–96	2,305	1,039	1,608	4,952
1996–97	2,552	1,143	1,831	5,526
1997–98	2,895	1,229	2,103	6,227
1998–99	3,260	1,796	2,404	7,460
1999–00	3,784	1,913	2,667	8,363
		Proportion (per cent)		
1992–93	47	24	29	100
1993–94	48	23	29	100
1994–95	46	23	31	100
1995–96	47	21	32	100
1996–97	46	21	33	100
1997–98	47	20	34	100
1998–99	44	24	32	100
1999–00	45	23	32	100

(a) The data above are income data. They are used to estimate NGCSO expenditure reported elsewhere in this report as the recurrent expenditure of these organisations is almost the same as their recurrent income (Industry Commission 1995: C16).

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

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

Source: Child care service clients' contribution—estimated by AIHW from ABS 1997, 2000a; Government funding—ABS unpublished data and DHFS, DHAC and DFACS unpublished data; NGCSO funding—estimated by AIHW.

The proportion of funding from client fees increased consistently between 1992—93 and 1997—98 from 29% in 1992—93 to 34% in 1997—98, after which it was stable, at around 32%. An average of 60% of client fees came from charges for child care services. About one-quarter was for aged care hostel services and the remainder comprised fees for other services. Residents of aged care hostels finance their fees from their own income, which consists mainly of age pensions and a lesser share from other sources.

The data in Table 2.16 do not provide a complete picture of the non-government sector s contribution to welfare services because detailed time-series data on the contribution of NGCSOs not funded by governments are not available. Furthermore, capital expenditure by NGCSOs receiving government funding (for example, NGCSO funding of expenditure on building new hostels) is not included. Therefore, the estimates of NGCSOs own income and client fees in Table 2.16 are conservative. Further information on NGCSOs is available in *Community Services, Australia* (ABS 1998a, 2001b).

2.6 International comparisons

This section compares the government welfare services expenditure of Australia with that of other members of the Organization for Economic Co-operation and Development (OECD) between 1985 and 1997 (see Box A2.1, for an explanation of the OECD financial year). Of the 30 countries that are presently members of the OECD, Hungary and the Slovak Republic are excluded from this comparison as there are currently no data reported for these countries.

The data presented here were obtained from the year 2000 version of the OECD s social expenditure database, which covers the period 1980 to 1997 (for a description of this database, see AIHW 1997d:44. Tables 2.17—2.18 relate only to government-funded expenditure on welfare services; expenditure funded by non-government organisations is not included.

The welfare services expenditures of different countries can be compared as a proportion of each country s GDP. This measure gives an indication of the proportion of a nation s productive effort that is spent on funding its welfare services. However, fluctuations in the welfare services-to-GDP ratio can be misleading when analysing changes in welfare services expenditure because the ratio may be as much an indication of movements in GDP as of changes in welfare services expenditure. Change in expenditure per person allows comparison between the welfare services expenditure of different countries without the distorting effect of GDP and the influence of population differences. However, this measure also has limitations as it does not allow for differences in demographic structure between countries. Welfare services expenditure per person is calculated allowing for the different purchasing power of each country s currency. In looking at both the expenditure-to-GDP ratio and per person expenditure, it is useful to consider the mean for each group in order to see where Australia fits vis-a-vis the average of the group .

The OECD has a set of standardised definitions for areas of social expenditure. Member countries are required to apply these definitions when providing data updates. Although this aims to ensure that the social expenditures of different countries are largely comparable, ultimately it is the member countries that interpret the OECD s requirements for each area of expenditure. As a result, caution is necessary when making comparisons, as there is likely to be some inconsistency, between countries and over time, in the allocation of expenditure to government welfare services.

The Nordic countries Denmark, Finland, Norway, Sweden and Iceland have consistently been the highest spenders on welfare services. This is partly because they classify as welfare services some activities that in most other countries would be coded as health. In particular, most aged care services are classified as welfare services in the Nordic countries.

Table 2.17: Government expenditure on welfare services as a proportion of GDP, OECD member countries, 1985–1997 (per cent)

	OECD financial year[(a)]				**Rank of countries**
Country	**1985**	**1990**	**1995**	**1997**	**in 1997**
Australia(b)	n.a.	0.90	1.18	1.25	11
Austria	0.83	0.85	1.08	1.27	10
Belgium	0.26	0.27	0.54	0.63	17
Canada	1.21	1.19	1.01	2.43	6
Czech Republic	n.a.	0.41	0.54	0.51	23
Denmark	4.56	5.12	5.56	5.53	2
Finland	2.32	2.80	3.28	3.26	4
France	1.01	1.14	1.28	1.99	7
Germany(c)	0.89	0.92	1.43	1.62	9
Greece	0.02	1.08	0.89	0.98	12
Iceland	n.a.	n.a.	3.14	3.24	5
Ireland	0.65	0.51	0.59	0.56	19
Italy	0.31	0.62	0.51	0.53	22
Japan	0.37	0.37	0.51	0.55	=20
Korea	n.a.	0.21	0.28	0.40	25
Luxembourg	0.48	0.75	0.89	0.88	14
Mexico	0.06	0.24	0.39	0.26	26
Netherlands	0.91	1.08	1.03	0.64	=15
New Zealand(d)	0.24	0.15	0.10	0.11	28
Norway	2.17	4.29	5.23	4.54	3
Poland	n.a.	0.25	0.40	0.45	24
Portugal	0.19	0.37	0.55	0.55	=20
Spain	0.16	0.36	0.40	0.60	18
Sweden	4.54	4.73	5.28	5.98	1
Switzerland	0.54	0.86	1.09	0.90	13
Turkey	0.07	0.06	0.09	0.16	27
United Kingdom	0.94	1.53	2.18	1.91	8
United States of America	0.66	0.60	0.72	0.64	=15
All countries' average(e)	**1.02**	**1.17**	**1.43**	**1.51**	

(a) See definition of 'OECD financial year' in Box A2.1.

(b) State/Territory government expenditure data available from 1987 only.

(c) Data for 1985 and 1990 relate to West Germany only; 1995 and 1997 data refer to the unified Germany.

(d) Data for 1985 are for the financial year commencing 1 April 1985, subsequent data refer to the financial year commencing 1 July in the year indicated.

(e) Unweighted mean. Excludes Australia, Czech Republic, Iceland, Korea and Poland in 1985. Excludes Iceland in 1990.

Note: The 'System of National Accounts 1968' (SNA68) definition of GDP is used here, which means that GDP is generally about 2–3% lower compared to GDP under SNA93, resulting in slightly higher welfare services expenditure-to-GDP ratios.

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

Sweden, which spent 5.98% of its GDP on welfare services in 1997, was the highest spender in that year (Table 2.17), followed by Denmark with 5.53% and Norway with 4.54%. Australia was ranked eleventh in the group of 28 OECD countries, with 1.25% of GDP devoted to welfare services, although below the group average of 1.51%. Although consistently below the group average, Australia moved closer to the average between

Table 2.18: Per person government expenditure on welfare services (in current prices), OECD member countries, 1985–1997 (A$)

	OECD financial year[(a)]				**Rank of countries in**
Country	**1985**	**1990**	**1995**	**1997**	**1997**
Australia[(b)]	n.a.	208	328	380	=11
Austria	121	200	294	380	=11
Belgium	37	63	149	191	15
Canada	209	308	297	768	6
Czech Republic	n.a.	61	85	86	23
Denmark	725	1,215	1,652	1,814	1
Finland	320	628	780	861	5
France	152	273	335	541	7
Germany[(c)]	140	236	386	473	9
Greece	1	138	145	174	18
Iceland	n.a.	n.a.	902	1,034	4
Ireland	57	80	138	155	19
Italy	42	140	133	146	20
Japan	54	93	151	178	17
Korea	n.a.	23	47	75	24
Luxembourg	84	246	373	392	10
Mexico	4	20	34	26	27
Netherlands	126	238	271	187	16
New Zealand[(d)]	32	28	24	28	26
Norway	351	1,040	1,572	1,585	3
Poland	n.a.	17	34	40	25
Portugal	14	50	96	105	22
Spain	14	59	74	123	21
Sweden	698	1,159	1,309	1,586	2
Switzerland	102	258	360	310	13
Turkey	3	4	7	14	28
United Kingdom	129	339	522	523	8
United States of America	126	176	241	239	14
All countries' average[(e)]	**154**	**270**	**384**	**443**	

(a) See definition of 'OECD financial year' in Box A2.1.

(b) State/Territory government expenditure data available from 1987 only.

(c) Data for 1985 and 1990 relate to West Germany only; 1995 and 1997 data refer to the unified Germany.

(d) Data for 1985 are for the financial year commencing 1 April 1985, subsequent data refer to the financial year commencing 1 July in the year indicated.

(e) Unweighted mean. Excludes Australia, Czech Republic, Iceland, Korea and Poland in 1985. Excludes Iceland in 1990.

Note: The 'System of National Accounts 1968' (SNA68) definition of GDP is used here, which means that GDP is generally about 2–3% lower compared to GDP under SNA93, resulting in slightly higher welfare services expenditure-to-GDP ratios.

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

1990 and 1997. Countries that were consistently low spenders were New Zealand, Turkey, Mexico and Korea. In 1997, New Zealand spent the smallest amount on welfare services (government expenditure only), devoting 0.11% of GDP to this area. The group average increased steadily during the period of the analysis, from 1.02% in 1985 to 1.51% in 1997.

In terms of expenditure per person, the trends are similar. Denmark spent most on welfare services throughout the period its per person government expenditure (in current prices) increased from A$725 in 1985 to A$1,814 in 1997 (Table 2.18). After Denmark came Sweden (A$1,586), Norway (A$1,585) and Iceland (A$1,034), all well above the OECD average of A$443. Australian government expenditure per person, was again towards the middle of the group, ranking eleventh equal in 1997 alongside Austria (A$380). Except for Greece in 1985, Turkey was the lowest spender on welfare services, its expenditure reaching A$14 in 1997. The average for the group increased nearly threefold over the 13-year period, from A$154 in 1985 to A$443 in 1997.

2.7 Summary

The total value of resources devoted to providing welfare services in 1999—00 was estimated at $41.7 billion, $13.7 billion of which were services provided where payments were made. The balance ($28.1 billion), which was slightly more than twice the value of the paid services, was composed of the imputed value of input tax exemption ($886 million) and unpaid services provided by the members of the households sector (valued at $27.2 billion). The estimated number of these unpaid household members was about 974,000 FTE which was more than six times larger than the size of the paid workforce in the community services industry, estimated at 144,267 FTE.

Community services workforce

Various demographic, social, economic and political factors affect the demand for, and supply of, community services namely, the propensity of couples to have fewer children, people working shorter or longer hours, living longer and some retiring earlier. Some factors, particularly the increasing number of women in the workforce, have a dual effect on community services the demand for services increases and the pool of unpaid labour providing services to children, disabled or older family members reduces. On the other hand, the relatively large number of workers moving into retirement over the next few years may augment the number of volunteers providing such services.

The reporting of data in *Australia's Welfare* is in terms of services for groups such as older people, children, people with disabilities and homeless people. These data usually focus on the characteristics of the clients and the services they receive, rather than on the labour force. The main source of labour force data for community services is the ABS the surveys of community services activity, the monthly labour force surveys, and the 5-yearly Census of Population and Housing.

Services are provided to the community by employees and volunteers, either as individuals or connected with a variety of businesses and charitable organisations, which operate across a wide range of industries. Community services include activities such as: personal and social support; child care; training and employment; financial and material assistance; residential care and accommodation support; statutory protection and placement; corrective services; other direct community service activities; and policy, community and service development and support. Some of these services are provided directly that is, to individuals or families on a face-to-face basis or on their behalf. Other services are provided indirectly.

Monetary expenditure on welfare services

Australian expenditure on welfare services as a proportion of GDP increased steadily from 1.4% in 1990—91 to 1.9% in 1997—98. After the change to accrual accounting, the welfare services expenditure-to-GDP ratio increased to 2.2% in 1998—99, remaining at that level in 1999—00. The ratio increased to 2.3% when tax expenditure was included.

Between 1990—91 and 1997—98, expenditure on welfare services in current prices almost doubled from $5.7 billion to $10.9 billion. This represents an average increase of 7.4% per year in real terms. From 1998—99 to 1999—00, total welfare services expenditure rose from $12.8 billion to $13.7 billion, or by 4.3% in real terms.

Per person expenditure on welfare services increased from $333 to $583 per head, in current prices between 1990—91 and 1997—98, corresponding to an average real growth of 6.2% per year. Expenditure per head was $680 in 1998—99, rising to $717 in1999—00 a 3.2% real increase.

In 1999—00, 63% ($8.6 billion) of total monetary welfare services expenditure was funded by the government sector, 14% ($1.9 billion) by non-government community service organisations and 23% ($3.2 billion) by households. Of the total government sector funding in 1999—00, 45% was provided by the Commonwealth, 54% by State and Territory Governments, and 1% by local governments.

Of the total Commonwealth government recurrent expenditure, family and child welfare services and welfare services for the aged each accounted for about one-third for both periods. Welfare services for people with a disability accounted for about one-quarter. The remaining 5—6% represented expenditure on other welfare services.

Of the total State and Territory government recurrent expenditure, family and child welfare services and welfare services for people with a disability each accounted for about one-third for both periods. Welfare services for the aged accounted for just over one-fifth. The remaining 10—11% represented expenditure on other welfare services.

The recurrent expenditure of NGCSOs increased from $3.9 billion in 1992—93 to $8.4 billion in 1999—00. Of the $8.4 billion, 23% came from their own funds, 32% from client fees and 45% from government grants.

In terms of international standing, Australia s public sector expenditure on welfare services in 1997 was around the average for the OECD.

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3 Assistance for housing

3.1 Introduction

This chapter examines current information on housing assistance: household types, characteristics of the recipients of housing assistance, the nature of assistance, and government expenditure. The aim of housing assistance is to overcome the problems that households face in obtaining or retaining suitable accommodation whether due to cost, availability or adequacy and to provide households with the flexibility to meet changing demand.

Housing assistance is an important element of Commonwealth, State and Territory Governments social policy and welfare frameworks. The Commonwealth and the States and Territories have developed and implemented strategies aimed at providing housing assistance to people on low incomes or with special needs, and at preventing and reducing homelessness. These include the Commonwealth—State Housing Agreement, the Stronger Families and Communities Strategy, the National Homelessness Strategy, and the Building a Better Future: Indigenous Housing to 2010 statement.

Governments provide a broad range of assistance across tenure types (see Table 3.1). All States and Territories provide assistance across all tenure types, although because of different social or economic needs, there is great variation between jurisdictions in the composition and range of assistance. Currently, the major forms of direct assistance are rent assistance in the private rental market, rent rebates in public housing and deposit assistance schemes for first home buyers. The major forms of indirect assistance are concessions to owner—occupiers. The non-taxation of capital gains on the family home is an example of a tax expenditure or tax concession. Changes to housing assistance in Australia in recent years have been characterised by growth in the extent of government assistance for households renting in the private market and reforms to public and community housing assistance.

Home ownership has been seen as an integral component of Australia s welfare system. Tax concessions to owner—occupiers have greatly contributed to home ownership rates at the later stages of the life-cycle, and hence to the affordability of housing for older people. As a result, considerable pressure has been taken off the age pension system and Commonwealth rent assistance payments.

The cost of housing is seen as an important issue in relation to poverty and social exclusion. In 1999, over 40% of Australians perceived poverty to be not having enough to buy basics like food, housing and clothing (Saunders 2001). Housing assistance can play an important role in addressing basic living costs by reducing the proportion of a household s budget that has to be spent on housing.

Table 3.1: Types of government housing assistance across tenure types

Tenure type	Government outlay (recurrent and capital)	Taxation	Government regulations and standards	Other
Home purchase/ ownership	First home owner grant Home purchase schemes	Non-taxation of imputed rent from owner occupation Rates and land tax concessions Capital gain and stamp duty exemptions	Financial regulations	Home purchase advisory and counselling services
Private rental	Assistance to pay rent Bond and relocation assistance	Negative gearing incentives for investors	Residential tenancy legislation Affordable housing planning regulations[(a)]	Automatic rent deductions for pension and benefits Advice services
Public rental	Rebate/subsidised rent Repairs, maintenance and upgrade Housing modification Construction and purchase		Appeals mechanisms Regulations aimed at ensuring only low-income households access low-income rental housing Allocations policy	Priority allocation and relocation Coordination of support services
Mainstream community housing	Rebate/subsidised rent Access to Commonwealth Rent Assistance Repairs, maintenance and upgrade Recurrent funding of organisations	Charitable tax status for organisations	Skills development Accreditation Regulations aimed at ensuring only low-income households access low-income rental housing Associations incorporation legislation	Sector coordination Partnerships and incentives Coordination of support services
Indigenous community housing	Capital funding for dwelling and infrastructure construction Access to Commonwealth Rent Assistance Recurrent funding of organisations	Charitable tax status for organisations	Skills development Accreditation Development of specific building guidelines Associations incorporation legislation	Sector coordination Provision of training in housing management Coordination of support services Community Development Employment Program
Crisis/transitional housing	Rebate/subsidised rent Access to Commonwealth Rent Assistance Repairs, maintenance and upgrade Construction and purchase	Charitable tax status for organisations	Accreditation	Sector coordination Transition paths to long-term accommodation Coordination of support services

(a) New South Wales has a planning mechanism that requires developers in some local government areas to include provision of some 'affordable housing' in new developments (NSWDUAP 2001).

Notes

1. Several other areas of government activity, such as building standards, zoning requirements and services by local governments, are often relevant across all tenure types.
2. All tenure types excluding home purchase are subject to State and Territory Residential Tenancies legislation.

Housing is also an important factor in general health and wellbeing. For example, the 1998 Tasmanian Healthy Communities Survey found a strong correlation between housing adequacy and subjective quality of life (TDHHS 1999). Table 3.2 presents the analysis from this survey, in which the results from a quality-of-life index are compared with the respondents assessed housing adequacy measured across 11 areas.[1] The survey found that subjective quality of life increases as the sense of housing adequacy increases, and declines as the sense of housing adequacy declines (TDHHS 1999:72).

Table 3.2: Population distribution of measures of quality of life and housing adequacy, persons 18 years and over, Tasmania, 1998

	Tasmanian Subjective Quality-of-Life Index rating				
Housing adequacy rating	**Top quartile**	**Second quartile**	**Third quartile**	**Bottom quartile**	**Total**
			Per cent		
Top quartile	47	26	18	10	100
Second quartile	25	31	25	18	100
Third quartile	15	25	30	30	100
Bottom quartile	11	18	27	44	100
			Number		
Total	**73,584**	**74,011**	**74,425**	**76,020**	**298,040**

Source: TDHHS 1999.

The impact of housing on the domains of people s lives, such as health, employment, education and community involvement, has been summarised in recent work for the Queensland Department of Housing. This work reflects the interest by governments in examining the whole of government costs of unmet housing need (Phibbs 2000:1—3).

In relation to welfare reform, addressing a person s housing needs is seen as an important part of supporting social and economic participation (Reference Group on Welfare Reform 2000:15). Currently with reforms to welfare and taxation systems, there is an increased interest in understanding the effects of specific forms of government-funded housing assistance. This includes understanding the range of potential modes of delivering assistance and the roles for different tenures in securing a range of housing outcomes.

National policy-driven housing research

To further progress research in these areas, Commonwealth, State and Territory Governments have commissioned the Australian Housing and Urban Research Institute (AHURI) to generate policy-relevant research in the related fields of housing and urban development.[2]

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1 The 11 housing measures covered adequacy in the areas of living space, privacy, number of bedrooms, health issues (such as dampness), distance from work and services and location.

2 AHURI is organised as an institute comprising a small management company, AHURI Ltd, in Melbourne, and eight participating research centres, throughout Australia. The role of AHURI Ltd is to lead the organisation, to manage and coordinate the research and dissemination process, and to stimulate policy debate. AHURI Ltd is governed by a board of directors and the research is undertaken by the research centres.

AHURI is a joint venture between governments and universities. Its aim is to provide policy-relevant research and enhance research capacity in housing and urban issues. Each year, research themes and key topics are reviewed by government, academic and university representatives. Up to $2.5 million per annum is available for research to be undertaken by the universities in the joint venture. The eight broad research themes are shown in Box 3.1.

Box 3.1: AHURI research program areas

Housing Assistance Programs—Examines how housing assistance programs for individuals and families (e.g. public housing) aim to meet people's need for shelter. It includes an assessment of the extent to which different forms of housing assistance and different types of housing tenure meet the needs of different socio-demographic groups, including older people and sole parents. This theme also seeks to understand how housing contributes to other outcomes, such as social and economic wellbeing. It covers the merits of building public housing versus the cash provision of rent assistance to tenants in the private rental market as well as the effectiveness of alternative forms of housing assistance, such as support for home ownership or community housing.

Housing Futures—Housing policy is continually confronted with changes in demographic, economic, social and institutional environments. This work will provide a view of the future environment, in the short, medium and long term, and is therefore essential for policy development. This is particularly the case with housing policy where housing has lifetime impacts—today's bricks and mortar decisions have a major impact on the scope and demands of the policy response in future years. It will also examine people's housing aspirations in terms of tenure, location, dwelling type and size, cost and privacy.

Program Integration and Housing Assistance—Recent trends in government policy and administration have resulted in housing assistance being viewed as a component of broader social policy outcomes, such as strengthening families and communities and increasing economic and social participation. It is therefore important to understand how housing assistance programs might more effectively link with other types of programs (for example, income support) to affect these higher order outcomes.

Innovation in the Provision of Housing—Internationally, the private sector is increasing its involvement in the provision of affordable housing for low-income groups. The new tax system and forthcoming renegotiation of the Commonwealth–State Housing Agreement provide two policy drivers for further research in this area. The key findings from this research will include how housing assistanmce can be more appropriately delivered, detailing the potential within the private sector for investment in low-income housing and understanding private sector investment requirements.

Urban Management and Infrastructure—The population pattern within metropolitan areas is continually shifting as households age and move, and new households form. The nature of these shifts is closely related to the provision of housing and housing assistance. The key findings from this research will include a profile of changes in labour markets within metropolitan areas and an assessment of the role of the housing system in these labour market developments.

(continued)

Box 3.1 (continued): AHURI research program areas

Transforming Communities—Different communities in Australia are affected by and respond to the forces of economic, cultural, political and demographic change in different ways. For example, some inner-suburban communities are being advantaged. Other communities, such as rural and remote communities and public housing estates, appear to be disadvantaged along multiple dimensions: high unemployment, outward population migration, an ageing of the resident population, high crime rates, high youth suicide rates, and so on. This research theme will investigate how to put in place programs that can handle complex dimensions of need.

Indigenous Housing—The level of disadvantage amongst Aboriginal and Torres Strait Islander people is generally higher than that of the Australian population at large. This applies particularly to their housing circumstances. Research on Indigenous housing issues will relate to each of the above themes as well as focus on specific Indigenous issues.

Homelessness and Marginal Housing—Homelessness has been a growing problem in Australia for many years, with demands on existing services increasing. While considerable research has been undertaken into the risk factors associated with homelessness and into enumerating the homeless, there remain significant knowledge gaps. Areas of interest are the identification of appropriate responses to homelessness that focus on its prevention, providing assistance to those in housing crisis and at immediate risk of homelessness, helping the homeless to secure more stable housing solutions, and, importantly, ensuring that interventions make a lasting difference.

Source: AHURI 2001.

The Australian Housing Policy Project

AHURI research is closely linked to policy and program issues. AHURI was asked by the Housing Ministers Advisory Committee to undertake the Australian Housing Policy Project, aimed at stimulating debate over the context and direction of housing policy in Australia. This will lead into the review of the current Commonwealth—State Housing Agreement (CSHA).

The project examines issues about the appropriate levels of government involvement for various forms of housing assistance at strategic and operational levels. The main issues covered include:

Drivers of change in the housing market and housing policy—including demographic and labour market changes, globalisation, taxation and welfare reform, other government policies and housing affordability issues.

Contemporary role of government in the housing market—objectives of government involvement (e.g. compensation for market failure, ensuring equitable access and broader objectives such as economic growth, retirement income policy, affordability, health and safety, community welfare, participation).

Possible changes in housing policy, with focus on housing assistance—what directions governments should take in terms of priorities and broad directions for change (e.g. affordability, integration, encouraging home ownership, industry policy, deregulation), the role of community housing, and stimulating private sector interest in affordable housing.

3.2 The economic and social background

This section presents current data around some of the policy issues raised in the previous section relating to the demographic profile, affordability, changes over time and availability of housing.

Australia by international standards is characterised by high levels of home ownership and a relatively small public and community housing sector (Table 3.3). The high levels of home ownership represent a pattern of household saving and private wealth accumulation. Generations of wage and salary earners have placed life savings into bricks and mortar in preference to other forms of investment (Badcock & Beer 2000:1).

Table 3.3: Housing tenure in selected OECD countries, mid-1990s (per cent)

Country	Owner-occupation	Private rental	Social/public rental[(a)]
Australia	70	24	6
Britain	68	11	21
Canada	63	30	7
Denmark	60	21	19
France	57	19	24
Germany	39	42	19
Netherlands	45	13	42
Sweden	41	21	38
United States	65	31	5

(a) Including local authority/council, state housing authority, housing authority, housing associations, housing co-operatives, publicly subsidised.

Source: Badcock & Beer 2000:Table 1.

Changes in demographics and the housing profile

Population growth and changes in household formation are important factors affecting the demand for housing and housing assistance. Between 1971 and 1996, the Australian population increased from 13.1 million people to 17.9 million, an annual growth rate of 1.3%. During this period, there was an annual household growth rate of 2.2%: from 3.7 million households in 1971 to 6.3 million in 1996 (AIHW 1999:131). The number of households is projected to increase to approximately 10.0 million in 2021, and household growth is also projected to be faster than population growth (24%) over this period (ABS 1999:1).

The number of one-person households increased from 14% of all households in 1971 to 23% in 1996 (AIHW 1999:132). One-person households are projected to show the greatest percentage increase of all household types between 1996 and 2021. This is related to the ageing of the population and the fact that older women, in particular, are more likely to live alone than others. The number of lone-person households is projected to increase by between 52% and 113%: from 1.6 million in 1996 to between 2.4 million and 3.4 million in 2021 (ABS 1999:1).

While the number of households has increased, household size has fallen slightly. From 1971 to 1996, the average number of people per household fell from 3.3 to 2.7 (AIHW 1999:131). The average household size in Australia is projected to decline to between

2.2 and 2.3 persons per household in 2021 (ABS 1999:1). The projected changes for household size and growth rates are consistent with those projected for Canada, New Zealand and the United States between 1996 and 2011 (Table 3.4).

While household size has fallen, the number of bedrooms per private dwelling has increased slightly. Three-bedroom dwellings consistently made up around half of all dwellings in 1971 and 1996. In the same period, however, the proportion of dwellings with two or fewer bedrooms fell from 36% to 28% and the proportion with four or more bedrooms rose from 13% to 22% (AIHW 1999:Table 5.3).

Table 3.4: Projected household growth between 1996 and 2011, selected countries (per cent)

Country	Projected average annual household growth rate	Average household size 1996	Average household size 2011
Australia	1.4	2.6	2.4
Canada	1.6	2.7	2.5
New Zealand	1.2	2.9	2.7
England	0.6	2.4	2.3
United States	1.1	(a)2.6	(b)2.5

(a) Average household size in 1995.

(b) Average household size in 2010.

Source: ABS 1999:6.

Table 3.5: All households, by composition and tenure, 1999

Household composition	Owners			Renters			Rent-free	Other tenure	Total
	Without a mortgage	With a mortgage	Total	Public housing	Private landlord	Total[a]			
				Per cent					
One family									
Couple only	34.1	19.3	27.5	10.1	17.4	16.5	19.0	16.1	24.2
Couple with dependent children only	13.7	43.3	26.9	9.8	19.3	17.9	23.2	21.8	24.3
Other couple	13.2	12.6	12.9	5.4	4.3	4.6	*5.5	*5.3	10.5
One parent with dependent children	2.2	4.6	3.3	23.6	10.3	12.3	*3.7	*5.1	5.8
Lone person	28.5	12.9	21.5	41.2	27.7	30.7	35.2	40.1	24.5
Group	1.0	1.9	1.4	*1.6	13.1	10.4	*4.3	**2.6	3.9
Other household	7.3	5.4	6.5	8.2	7.9	7.6	9.1	*9.0	6.8
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**
Per cent of all tenure types	38.8	31.3	70.1	5.1	20.3	27.2	1.7	1.0	100.0
				Number ('000)					
Estimated number of households	2,800.3	2,256.1	5,056.4	368.8	1,463.2	1,966.6	120.9	73.0	7,216.9

(a) Includes 'other renter'.

Source: ABS 2000a:Table 1.

Tenure types by household composition

In 1999, 70% of Australian households were home owners with or without a mortgage (Table 3.5). The most common tenure for couple-only households was home ownership without a mortgage, while for couples with dependent children it was ownership with a mortgage. Public housing (state housing authority) represents 5% of all households. Nearly one-quarter of public housing tenants are sole parents and 41% are lone persons.

Approximately 2.0 million households rent their dwelling; this accounts for 27% of all tenures. Private renters at 20% are the major renter group. Both public rental and private rental sectors contain a higher than average proportion of sole parents and single-person households.

Table 3.6 shows the distribution of housing across income groups. Whilst overall, home owners are distributed toward the higher income groups, owners without a mortgage are concentrated in the two lowest income groups and owners with a mortgage concentrated in the two highest income groups. This reflects the former group comprising aged persons in retirement and the latter comprising younger persons in employment. Variation is also present in the renter profile, with public renters being concentrated in the lowest income group and private renters in the second and third income groups.

Table 3.6: All households, by tenure and gross weekly income quintile, 1999

	Owners			**Renters**					
Gross weekly income quintile	**Without a mortgage**	**With a mortgage**	**Total**	**Public housing**	**Private landlord**	**Total**[(a)]	**Rent-free**	**Other tenure**	**Total**
				Per cent					
Lowest	27.6	5.1	17.6	55.3	17.0	24.3	26.7	38.9	19.8
Second	24.6	11.1	18.6	29.8	23.6	24.6	20.0	20.0	20.2
Third	16.7	21.7	18.9	11.8	25.5	22.5	25.2	18.4	20.0
Fourth	15.0	29.4	21.4	*2.6	19.5	16.5	20.1	*13.0	20.0
Highest	16.1	32.8	23.6	**0.5	14.4	12.0	*8.1	*9.6	20.0
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**
				Number ('000)					
Estimated number of households	2,800.3	2,256.1	5,056.4	368.8	1,463.2	1,966.6	120.9	73.0	7,216.9

(a) Includes 'other renter'.

Source: ABS 2000a:Table 1.

Relationship of household size to occupant use

Table 3.7 shows there are large differences in levels of housing utilisation across tenure types. Renters have the highest incidence of overcrowding, with 8% needing one or more bedrooms compared with 5% across all households.

Owners without a mortgage have the highest incidence of under-utilisation, with 85% having one or more bedrooms spare. Life-cycle factors may influence this result, especially the incidence of older persons living alone after dependent children have moved out of home.

Table 3.7: All households, by tenure and housing utilisation, 1999

Housing utilisation	Owners			Renters					
	Without a mortgage	With a mortgage	Total	Public housing	Private landlord	Total[(a)]	Rent-free	Other tenure	Total
				Per cent					
2 or more bedrooms needed	0.4	0.5	0.4	*0.9	1.0	0.9	*2.9	n.p.	0.6
1 more bedroom needed[(b)]	2.1	3.6	2.8	7.3	7.1	6.9	*2.8	**2.2	3.9
No extra bedrooms needed	12.6	23.2	17.3	45.6	35.5	37.1	22.9	25.1	22.9
1 bedroom spare	34.0	38.0	35.8	32.1	39.0	37.2	33.5	39.0	36.2
2 bedrooms spare	39.5	28.5	34.6	13.3	15.8	16.1	28.2	31.0	29.4
3 or more bedrooms spare	11.4	6.2	9.1	*0.8	1.7	1.6	9.8	**2.2	7.0
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**
				Number ('000)					
Estimated number of households	2,800.3	2,256.1	5,056.4	268.8	1,463.2	1,966.6	120.9	73.0	7,216.9

(a) Includes 'other renter'.

(b) Data for lone-person and couple-only households appear if their dwelling does not have any bedrooms (e.g. bedsits).

Source: ABS 2000a:Table 6.

Condition of housing stock

The 1999 ABS Australian Housing Survey (ABS 2000a) collected data on major structural problems and need for repairs, based on the perceptions of people living in their home. Table 3.8 shows that approximately one in five reported major structural problems (19%), 16% reported the need for interior repairs, and 17% for exterior repairs. Households in the rental sector reported above-average problems across these areas.

Table 3.8: All households, by tenure and physical condition of dwelling, 1999

Dwelling condition	Owners			Renters					
	Without a mortgage	With a mortgage	Total	Public housing	Private landlord	Total[(a)]	Rent-free	Other tenure	Total
				Per cent					
Major structural problems	13.2	14.1	13.6	34.5	31.9	32.1	26.9	21.3	19.0
Need for interior repairs[(b)]	10.8	14.1	12.3	30.1	24.9	25.6	20.0	16.6	16.1
Need for exterior repairs[(b)]	14.6	16.4	15.4	23.6	19.9	20.4	22.0	24.2	17.0
				Number ('000)					
Estimated number of households	2,800.3	2,256.1	5,056.4	368.8	1,463.2	1,966.6	120.9	73.0	7,216.9

(a) Includes 'other renter'.

(b) Excludes 'desirable but low need'.

Source: Table A3.1.

The more detailed data presented in Table A3.1 indicate that major cracks in the walls or floors are the most frequently reported major structural problems (7% of households). While 16% of households reported the need for interior repairs, only 1% considered the need essential and urgent. Similarly, essential and urgent exterior repairs were only reported by 1% of all households.

Changes in tenure

Analysis based on population census data for 1986 and 1996 shows that the number of households in Australia increased by 23% over this period. This was accompanied by changes in the tenure profile, with the rental sector growing at a faster rate than home ownership (33% and 19% respectively). Within the rental sector, growth had been greater in the private rental market (34%) than in the public sector (30%). During this period, growth in home ownership occurred among owners without a mortgage (34%), while the proportion of owners with a mortgage showed little change (1%). As the 19% increase in the total number of home owners from 1986 to 1996 was less than the overall growth in total housing, the underlying home ownership rate fell from 68% to 65% during this period (Yates & Wulff 2000:48).

More recent data have shown less change in tenure types over the five years between 1994 and 1999 (Table 3.9). In the rental sector, there has been a decline in public housing and an increase in private rental. In contrast to the population census analysis, owners have stayed relatively steady at around 70% of the population.[3] There has been a decline in owners without a mortgage, while the population with a mortgage has increased.

Table 3.9: All households: changes in household tenure between 1994 and 1999

	Owners			**Renters**			
Year	**Without a mortgage[(a)]**	**With a mortgage[(a)]**	**Total**	**Public housing**	**Private landlord**	**Total[(b)]**	**Total[(c)]**
1994							
Number ('000)	2,793.9	1,890.3	4,684.2	414.8	1,271.4	1,845.1	**6,677.9**
Per cent	41.8	28.3	70.1	6.2	19.0	27.6	**100.0**
1999							
Number ('000)	2,800.3	2,256.1	5,056.4	368.8	1,463.2	1,966.6	**7,216.9**
Per cent	38.8	31.3	70.1	5.1	20.3	27.3	**100.0**

(a) Care should be taken when comparing the data for owners with and without a mortgage from the 1994 and 1999 surveys as the methodology for collecting these data differed between the two surveys.

(b) Includes 'other renter'.

(c) Includes rent-free and other tenure.

Source: ABS 2000a:Table 3.

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3 Because of the lack of a standard way of measuring home ownership and differences in the way data are collected, estimates of home ownership vary between data sources. The census data should not be directly compared with data from housing surveys. For example, official estimates of home ownership in 1996 ranged from 68% to 71% (see Mudd et al. 1999).

Table 3.10 shows the different patterns of change in home ownership rates for specific life-cycle groups between 1994 and 1999. For young couple households without children, home ownership rates showed a significant decrease: from 60% to 52%. For one-parent families, there was an increase: from 31% to 40%. In older households, home ownership rates rose over the period. In couple-only households where the reference person was 65 years and over, the rates showed a slight increase, while for lone persons aged 65 and over, the rise was from 75% to 76%.

Table 3.10: All home owners: home ownership rates, by life-cycle group, 1994 and 1999

	1994		1999	
Life-cycle group	**’000**	**Per cent**	**’000**	**Per cent**
Lone person aged under 35 years	86.1	30.9	104.2	31.8
Couple only, reference person aged under 35 years	237.6	59.8	189.2	51.7
Couple, eldest child aged under 15 years	987.5	75.6	958.1	74.3
Couple, at least one dependent child aged 15 years and over	882.0	88.3	606.4	85.5
One-parent family, dependent children	94.9	31.0	165.3	39.8
Couple only, reference person aged 65 years and over	479.1	90.9	532.6	91.4
Lone person aged 65 years and over	441.7	74.8	519.1	76.1
Other groups	1,475.2	64.9	1,981.5	69.6
Total	**4,684.1**	**70.1**	**5,056.4**	**70.1**

Source: AIHW analysis of ABS 1994 and 1999 Australian Housing Surveys confidentialised unit record files.

Recent analysis of the trends in home ownership rates illustrated a range of factors affecting the level of ownership. Broader patterns in society, such as trends in family formation, increased levels of labour mobility and longer periods of education and training, may lower initial rates of home ownership in certain age groups but not necessarily flow on over the life-cycle (FaCS 1999c:1—3). However, continuing decline in home ownership rates, especially in younger ages, may have implications for housing affordability policies, especially in retirement.

Housing affordability

There is no official housing affordability measure applicable to all tenures, nor are there nationally agreed uniform occupancy standards. For example, the CSHA program measures of affordability are based on households, while the Department of Family and Community Services (FaCS) Commonwealth Rent Assistance measures are based on income units. Similarly, there is no official poverty line. There are neither nationally accepted estimates of poverty nor equivalence scales for adjusting income to account for the needs of households of different sizes and compositions. Australia currently lacks agreed methodologies and reliable data with which to assess the need for and effect of housing assistance (SCARC 1997). The lack of agreed measures leaves any examination of the need for and effect of housing assistance open to debate.

The ABS housing surveys provide the only detailed national data on the financial and non-financial housing status of all tenures. Table 3.11 shows affordability data from the 1999 survey (ABS 2000a). The survey measured the ongoing outlays incurred in housing, including mortgage or rental payments, water and general council rates, land tax and body corporate payments, and expenditure on repairs and maintenance. The data show that, in 1999, 87% of owners without a mortgage and 78% of public renters paid 25% or less of their income on housing costs. In contrast, 56% of private renters paid 25% or less. Just over 30% of private renters paid more than 30% of their income on housing costs and 11% paid more than 50%. These findings may be influenced by life-cycle choices, such as a young person spending a high proportion of their current income on housing, anticipating a substantial increase in income in the future. This table shows data for all renter households irrespective of income level and therefore differs from data, shown in later sections of this chapter, on low-income private renters and public renters receiving a rent subsidy. Furthermore, the definitions of income and housing costs used in the ABS survey may differ from those used in reporting on government housing assistance programs.

Table 3.11: All households, by tenure and housing costs as a proportion of income, 1999

	Owners			**Renters**					
Housing costs as a proportion of income	**Without a mortgage**	**With a mortgage**	**Total**	**Public housing**	**Private landlord**	**Total[(a)]**	**Rent-free**	**Other tenure**	**Total**
				Per cent					
25% or less[(b)]	86.8	64.3	76.8	77.8	56.3	61.6	91.8	70.3	72.8
More than 25%	5.7	25.6	14.6	17.4	39.2	33.7	n.p.	21.2	19.6
More than 30%	4.3	17.9	10.4	7.7	30.8	25.2	—	15.8	14.3
More than 40%	2.8	9.4	5.7	3.1	18.0	14.4	—	*7.7	8.0
More than 50%	1.8	5.3	3.4	*1.6	10.7	8.4	—	*4.3	4.7
Total[(c)]	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**
				Number ('000)					
Estimated number of households	2,800.3	2,256.1	5,056.4	368.8	1,463.2	1,966.6	120.9	73.0	7,216.9

(a) Includes 'other renter'.

(b) Includes nil and rounded to 0.

(c) Includes households with housing costs not known or with nil or negative income.

Source: ABS 2000a:Table 1.

The availability of affordable rental housing

Many households spend a high proportion of their income on housing and this is a particular feature of the private rental sector (see Table 3.11). This can create hardship for low-income households.

In many countries, the move away from supply-side measures based on the direct provision of public housing to demand-side assistance through rent assistance to social security recipients is based on the notion that:

- low income, rather than the unavailability of low-cost housing, is the prime contributor to problems of affordability in the rental sector; and
- increased income support provides low-income households with a greater range of choices in the private rental market than is available in public housing assistance.

This approach was presented in the National Housing Strategy (NHS 1991a:xi) in the Australian context and has since fuelled debate over the ability of the private rental market to meet the objective of providing secure, affordable and appropriate housing choices to those on low incomes.

Recent research points to evidence of a significant reduction in the proportion of lower priced rental housing since the mid-1980s. The possible loss of low-cost rental housing stock raises the question of the degree to which the private rental market can provide a range of housing options for low-income households (Yates & Wulff 2000).

Table 3.12: Changes in the distribution of private rental stock between 1986 and 1996

	Rent category ($ per week)[(a)]					
	Low ($1–99)	Low–moderate ($100–149)	Moderate–high ($150–199)	High ($200 and over)	Total stock	Mean rent
1986						
Number of stock ('000)	246.8	372.2	193.3	131.3	943.6	
Per cent	26.2	39.4	20.5	13.9	100.0	$139
1996						
Number of stock ('000)	177.4	479.7	379.1	231.6	1,267.9	
Per cent	14.0	37.8	29.9	18.3	100.0	$155
1986–96 % growth	–28.1	28.9	96.1	76.4	34.4	11.5

(a) Rental values for 1986 have been adjusted to 1996 values using 1996 prices.

Source: Yates & Wulff 2000:50.

Table 3.12 shows that, while there was a 34% increase in total private rental stock between 1986 and 1996, there was a significant decline in stock at the lower end of the rental market. The number of low rent stock fell from 246,800 to 177,400, a reduction of 28%, and the number of high rent stock rose from 131,300 to 231,600, an increase of 76%. The largest increase occurred in the moderate to high category, where there was a 96% rise in rental stock. The net reduction in the supply of low-cost rental housing has implications for housing policies, such as rent assistance programs, that utilise the private rental market to address housing affordability issues.

The decline in low-rent housing in the private rental market has led to increased interest by governments in examining strategies to ensure adequate provision of affordable rental housing through regulation and taxation mechanisms (Seelig 1999). Research into the factors related to investment and taxation benefits and risks suggests these may provide incentives for investors to finance high rather than low rental-value properties (Wood & Watson 1999). By examining the user cost per dollar of property value, it is possible to identify variation in costs across segments of the rental housing market.

Table 3.13 shows that, when graded by user cost from lowest to highest, it is the properties with a higher mean property value that are the most cost effective for an investor. For example, the lowest cost per dollar invested is for properties with a mean value of $167,500, while the most costly investment properties are on average the lowest value ones ($79,500). The implications are that properties with a low rental value are less financially attractive to investors and therefore less likely to be considered.

Table 3.13: Distribution of private rental investors, by user cost per dollar of property value, July 1993 ($'000)

Decile group based on user cost per dollar of property value										
Lowest	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**Highest**	**All**
167.5	142.8	145.0	129.5	141.7	120.1	116.0	119.6	93.3	79.5	125.5

Source: Wood & Watson 1999:79.

Box 3.2: Housing assistance—types and definitions

Private rental housing assistance

Assistance is available to people on low incomes who rent accommodation in the private market. Such assistance is provided in two quite different forms:

- *Commonwealth Rent Assistance is supplementary financial assistance that may be payable to recipients of social security, family tax benefit and Department of Veterans' Affairs payments who pay rents above specified threshold levels in the private rental market.*
- *Private Rental Assistance is a suite of housing assistance programs, provided by the States and Territories through the Commonwealth–State Housing Agreement (CSHA) and aimed at assisting low-income households experiencing difficulty in securing or maintaining private rental accommodation. Assistance is provided in the form of rental assistance (subsidies), bond assistance and other assistance (such as relocation expenses, utilities connection, and advice and information).*

Public and community rental housing assistance

Public housing is administered by the States and Territories, which provide publicly owned dwellings that are funded through the CSHA and used to provide appropriate, affordable and accessible shelter for low to moderate income earners who are unable to enter the private market. Eligibility for public housing is determined by multi-faceted criteria designed to identify those most in need.

Community housing is managed by non-profit community-based organisations such as local governments, churches and charity groups. It takes several forms: from emergency or crisis accommodation through medium-term or transitional accommodation to long-term housing. Community housing is available to people who are eligible for public housing and who may have special needs best catered for by a community-managed organisation.

Home purchase or home ownership assistance

Home purchase or home ownership assistance is provided for people who wish to buy their own house but need help with financing. Assistance can be in the form of deposit assistance, mortgage relief and access to surplus public housing stock.

The principal factor noted to explain the user cost differentials is the tax status of the investor owning the property. Investors with high marginal rates of tax obtain a greater tax benefit from the exemption of nominal capital gains, than investors with low marginal tax rates. The former therefore can supply rental housing services at a relatively lower user cost. Investors with high marginal tax rates thus tend to own properties with relatively high market values, leading to the pattern evident in Table 3.13 where the user cost of rental housing is higher at the cheaper end of the rental market than it is at the more expensive end (Wood & Watson 1999:84).

3.3 Housing services and assistance

Housing assistance is also important in contributing to whole-of-government outcomes of encouraging and supporting economically and socially stronger communities, families and individuals (FaCS 1999b:5). Social policy challenges, such as an increase in homelessness and people requiring personal support and care needs, have required the development of a whole-of-government approach that facilitates the linking of housing and support services.

This section presents data on a range of housing assistance, and examines CSHA-funded programs, including public housing, community housing, private rent assistance and crisis accommodation programs, and non-CSHA-funded programs, such as Commonwealth Rent Assistance and home purchase assistance (refer to Box 3.2). Because of housing s strong links with other areas of social policy, some funding for housing assistance comes from health and community services for long-term housing support programs for people with a disability or the frail aged. Additional information about short-term housing/accommodation support programs can be found in Chapter 8, and information on long-term housing/accommodation support programs can be found in Chapters 6 and 7.

Rental assistance

Figure 3.1 shows the distribution of recipients of rental assistance across the private, public and community rental sectors. The different data sources used, limit comparisons across sectors and highlight the need to improve data in the future (see Section 3.5).

In March 2000 in the private rental market, 937,078 income units received Commonwealth Rent Assistance (SCRCSSP 2001:760).[4] Although it is not possible to readily identify how many households this represents, estimates based on 1994 ABS housing survey data indicate that in 1994, from a total of 970,000 income units, there were 626,000 households in receipt of Commonwealth Rent Assistance (AIHW: Karmel et al. 1998:191). Under the CSHA, private rental assistance was also provided to 202,429

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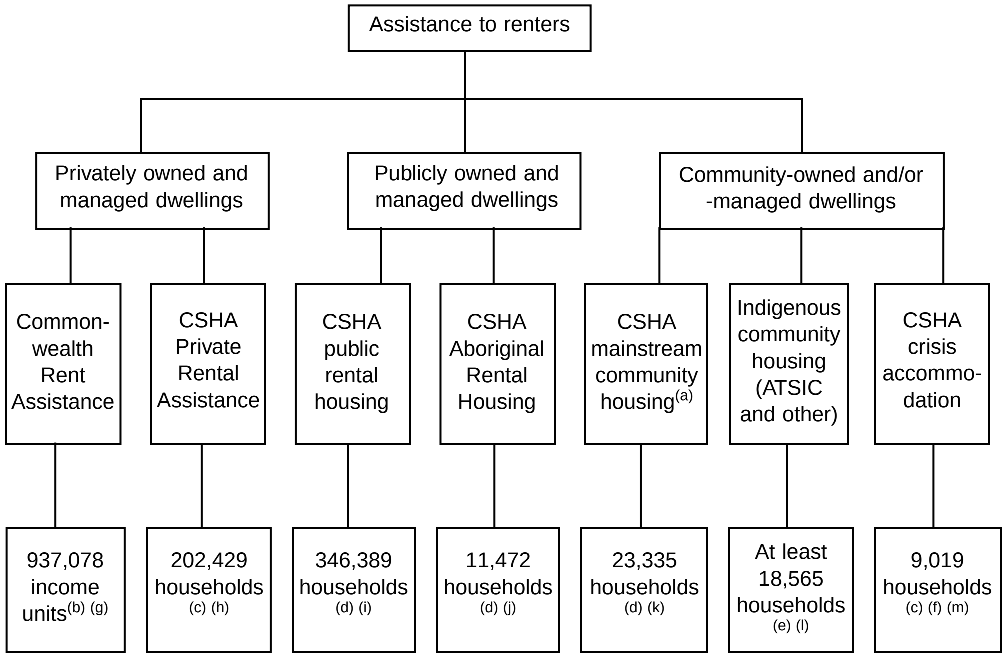
[4] An income unit is defined as either a single person or a couple with or without dependants receiving assistance (DSS 1998:186).

households in 1999—00 (Table 3.16). Because of the overlapping nature of these two types of assistance and because the data cannot be adjusted to avoid double-counting, the data cannot be added together to obtain a total number of households receiving some form of private rental assistance.



(a) Additional dwellings are funded under programs other than CSHA but data about these dwellings are not available.

(b) At 31 March 2000.

(c) For year ending 30 June 2000.

(d) At 30 June 2000.

(e) August to October 1999. The number of permanent and temporary occupied dwellings has been used as the proxy for the number of households. This figure may be an under-representation, as there may be more than one household per occupied dwelling.

(f) Estimated household data were provided by Victoria and Queensland only.

Source: (g) SCRCSSP 2001:Table 16.2; (h) See Table 3.16; (i) AIHW 2001e, unpublished; (j) AIHW 2001f, unpublished; (k) AIHW 2001a, unpublished; (l) ABS 2000c; (m) AIHW 2001b, unpublished.

Figure 3.1: Recipients of rental assistance across rental sectors, 2000

In June 2000, 346,389 households occupied mainstream public housing (AIHW 2001e, unpublished), paying either subsidised or full market rent.[5] A further 11,472 households were occupying public housing specifically for Indigenous Australians, provided through the CSHA Aboriginal Rental Housing Program (AIHW 2001f, unpublished).

At least 23,335 households in June 2000 lived in mainstream community housing provided through the CSHA and State and Territory community housing programs and other organisations not dependent on government funds (AIHW 2001a, unpublished).

In 1999, the ATSIC Community Housing and Infrastructure Needs Survey identified 18,565 permanent and temporary occupied dwellings that were managed by Indigenous community organisations (ABS 2000c:13).

In 1999—00, 9,019 households received crisis accommodation through the CSHA Crisis Accommodation Program in Queensland and Victoria (AIHW 2001b, unpublished).[6] Information about types of assistance provided to homeless persons through the Supported Accommodation Assistance Program is available in Chapter 8.

Commonwealth Rent Assistance

Assistance to private renters is mostly provided through Commonwealth Rent Assistance (CRA), paid by the Department of Family and Community Services (FaCS) and to a lesser extent the Department of Veterans Affairs (DVA) and the Department of Education, Training and Youth Affairs (DETYA). CRA is a non-taxable income supplement paid to individuals and families in recognition of the housing costs they incur in the private rental market. All pensioners, allowees (recipients of allowances such as Newstart Allowance), beneficiaries and people receiving more than the base rate of Family Tax Benefit Part A may be eligible for this assistance. It is paid at the rate of 75 cents per $1 of rent paid above the rent threshold, subject to maximum rates.

FaCS CRA expenditure increased by approximately 84% in real terms between 1990—91 and 1999—00, while annual expenditure on CSHA assistance has declined by almost 11% over the same period. FaCS CRA expenditure was $1,538 million in 1999—00 (Figure 3.2) and at March 2000 there were 937,078 income units in receipt of CRA. The average payment was $30.58 per week. The range between the highest and lowest average payments by location was relatively narrow, from $31.60 in Sydney to $29.00 in non-capital city Victoria. The range was wider by income unit: from $39.44 per week for couples with three or more children to $21.74 for single sharers aged less than 25 years (SCRCSSP 2001).

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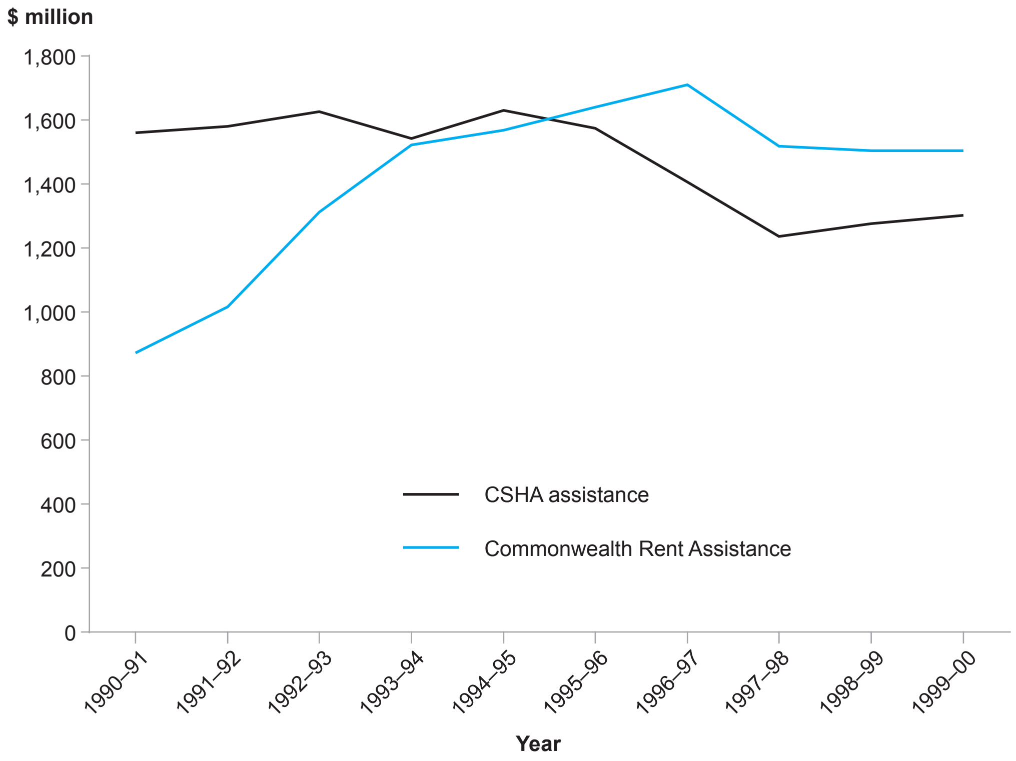
[5] Because of differences in the way administrative data and ABS survey data are collected, this figure does not match the 368,800 public renter households shown in Table 3.5.

[6] Crisis accommodation resident details were not available for other States and Territories.



Source: Table A3.2.

Figure 3.2: Real government expenditure on CSHA assistance and CRA, 1990–91 to 1999–00

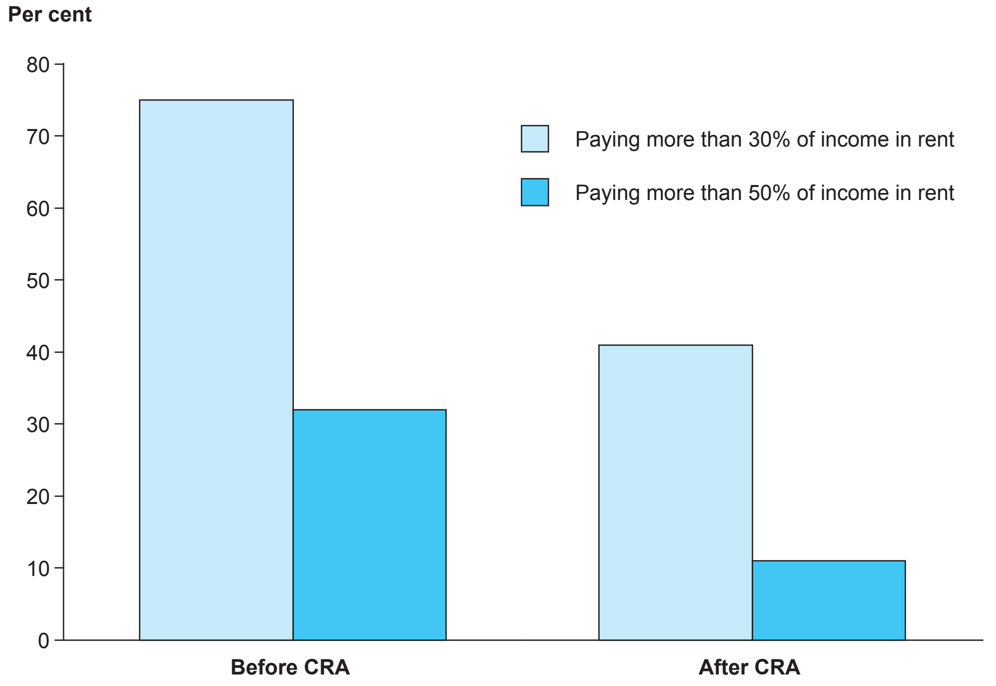
Table 3.14: Recipients of FaCS Commonwealth Rent Assistance, by other assistance received, 16 June 2000

	Income units		Gender of recipients (per cent)		
Other assistance	**Number**	**Per cent**	**Female only**	**Male only**	**Both members of a couple**
Newstart Allowance	235,093	25	42	54	4
Parenting Payment (Single)	181,205	19	93	7	0
Disability Support Pension	157,169	17	39	53	7
Age Pension	149,292	16	59	25	16
Family Allowance/Parenting Payment Partnered	95,702	10	93	7	0
Youth Allowance	90,458	10	58	41	1
Other payments	32,359	3	59	30	12
Total	**941,278**	**100**	**61**	**33**	**5**

Source: FaCS 2000:93.

Of those income units receiving FaCS CRA in 2000, 33% were age or disability support pensioners, 35% received allowances and 29% were recipients of family payments. Single-person income units were the majority of primary recipients (Table 3.14). Pensioners and allowees with dependent children receive CRA as part of their family payments and are therefore included in the family payments group.

Figure 3.3 illustrates that CRA improves housing affordability for those income units on low incomes. After receiving CRA, 41% of income units paid more than 30% of income on rent compared to 75% of income units before receiving it.

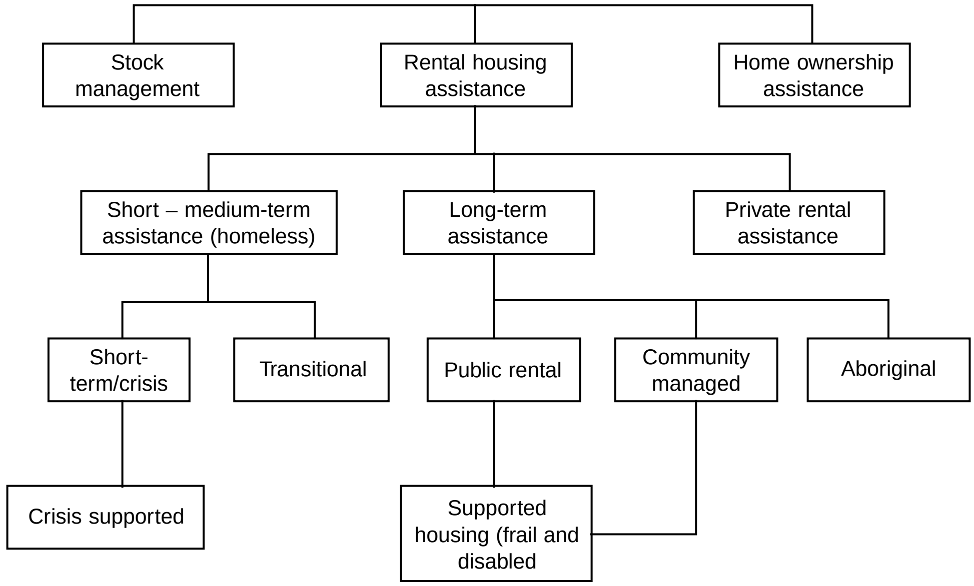


Source: Table A3.3.

Figure 3.3: Income units receiving Commonwealth Rent Assistance: ratio of housing costs to income before and after CRA receipt, March 2000

CSHA funding and administration

The Commonwealth—State Housing Agreement (CSHA) is the major national housing-specific government program. Its purpose is to provide appropriate, affordable and secure housing assistance for those who most need it, for the duration of their need (Commonwealth of Australia 1999c). The six major program areas of the CSHA are public housing, community housing, crisis accommodation, Aboriginal rental housing, private rental assistance, and home purchase assistance. The CSHA assists renters and some purchasers: cash benefits are provided to assist with rents and bonds for people renting privately and with mortgage repayments and deposits for people purchasing homes; in-kind assistance is provided in the form of subsidised public rental housing, community housing, Aboriginal rental housing and low-deposit loans for home purchase. The diversity of housing operations under the CSHA is illustrated by the range of services provided in Victoria to low-income households (Figure 3.4). Similar forms of assistance are provided in the other States and the Territories, but program boundaries and structures differ.



Source: VDHS 2001a:4.

Figure 3.4: Forms of CSHA housing assistance for low-income Victorians

The CSHA was established in 1945 and has undergone many changes. The current agreement covers the period 1 July 1999 to 30 June 2003. The focus of the CSHA has shifted from providing affordable accommodation to low-income households, to providing adequate, secure, appropriate and affordable housing for households in need. Under this CSHA, initiatives have been developed to improve housing outcomes for people whose housing needs cannot be appropriately or adequately met unassisted in the private rental market. This has resulted in a changing role for public and community housing, demonstrated by:

- housing agencies introducing segmented waiting lists in public housing programs in order to facilitate improved targeting of assistance to people with high needs. In Victoria, priority allocations comprised 44% of allocations in 1999—00 (VDHS 2001a:5);
- increasing numbers of people with multiple and complex support needs being housed in social housing programs. In Victoria, there was a 50% rise in priority approvals between 1999 and 2000. This increase comprised: an 87% increase in people classed as recurring homelessness (Public Housing Waiting List Segment 1); a 48%

increase in people requiring supported housing (Waiting List Segment 2); and a 43% increase in people with special housing needs (Waiting List Segment 3) (VDHS 2001b);

- increasing numbers of tenants with personal care and support needs, which has required an integration of service delivery systems at all levels. Formal links have been developed between housing providers and support services. For example, the Victorian Supported Housing Program allows tenants with aged care or mental health needs to receive support from other Department of Human Services program areas.

Over the current and previous CSHAs, there has been an increase in flexibility to allocate CSHA funds for recurrent and capital purposes (albeit within program boundaries). Programs such as the Crisis Accommodation Program (CAP), the Aboriginal Rental Housing Program (ARHP), and community and public housing have utilised this greater flexibility in a number of ways. For example, CSHA funds allocated to the CAP (previously used solely for the purchase, maintenance and upgrade of CAP dwellings) are being used to purchase emergency short-term hotel and caravan park accommodation for those in crisis. Also, public and community housing program funds are being used to head-lease dwellings from the private rental market as a response to specific housing needs and requirements that cannot be currently met using existing public and community (capital) stock.

In 1999—00, the Commonwealth, State and Territory Governments provided over $1,300 million for housing programs under the CSHA (Table 3.15). Public and community housing accounted for the majority of CSHA funding. The Commonwealth paid to the States and Territories $91.0 million for the ARHP, $39.7 million for the CAP, and $64.0 million for the Community Housing Program. Base funding is provided as general funding, to be used for any form of housing assistance.

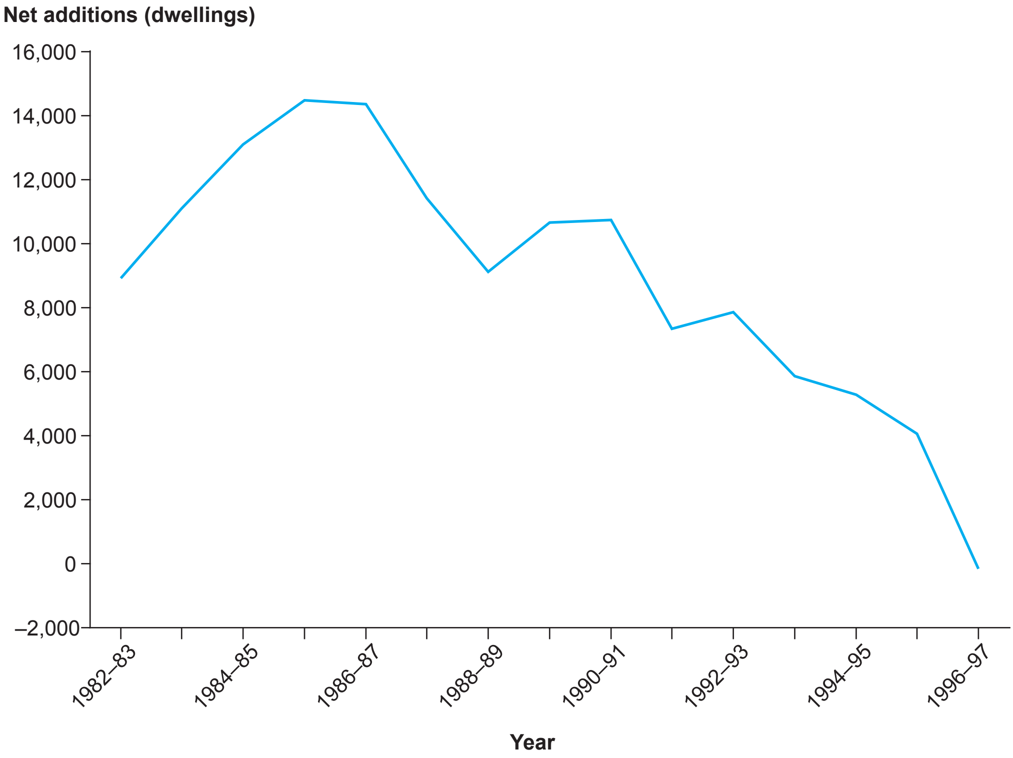
Table 3.15: CSHA funding, by funding arrangements, 1998–99 and 1999–00 ($m)

Funding arrangement	**1998–99**	**1999–00**
Base funding allocation	772.6	763.0
Less State fiscal contributions[(a)]	68.9	. .
Base funding grants[(b)]	703.8	763.0
Aboriginal Rental Housing Program	91.0	91.0
Crisis Accommodation Program	39.7	39.7
Community Housing Program	64.0	64.0
State matching grants	378.2	373.5
Total	**1,276.6**	**1,331.1**

(a) In 1998–99 some jurisdictions elected to use CSHA grants to offset their State fiscal contributions (SFCs) to the Commonwealth Government's 3-year deficit reduction program that was agreed at the 1996 Premiers' Conference. SFCs were deducted from the base funding allocations of the relevant States. 1998–99 was the last year that SFCs applied.

(b) Includes Public Housing, Home Purchase Assistance and Private Rental Assistance Programs.

Source: FaCS 2001, FaCS unpublished.



Source: Table A3.4.

Figure 3.5: Net additions to public housing stock (dwellings), 1982–83 to 1996–97

Figure 3.2 illustrates the reduction in CSHA expenditure and Figure 3.5 indicates that net additions to public housing stock have reduced since 1986. Between 1992 and 1996, the decline was sharp, and in 1996—97 there was a net reduction of 156 public housing dwellings. This does not accurately reflect the true picture of CSHA stock, as 3,755 dwellings were transferred from public housing to identified programs (mostly to community housing) in 1996 (FaCS 1999a). Other factors, such as ageing stock requiring maintenance and upgrades, and reconfiguration of stock to better meet client needs and sales, also contribute to the temporary reduction in public housing stock.

CSHA private rental market assistance

The Private Rental Assistance (PRA) Program is designed to enable people to access and maintain accommodation in the private rental market (AIHW 2000d, unpublished). The following are among the types of assistance provided:

- bond loans;
- assistance with rent payments, including advance rent payments and cash assistance additional to Commonwealth Rent Assistance; and

- relocation expenses, other one-off grants such as housing establishment grants, and advice and information.

In 1999—00, the States provided $66.8 million for private rental assistance (AIHW 2001d, unpublished). The diversity of types of assistance, the way in which assistance is targeted across States and Territories, and the lack of consistent national data, make it difficult to gain a national perspective. For example, a single episode of assistance may involve a one-off rent payment subsidy to prevent eviction and homelessness, or it may take the form of long-term assistance such as provision of a rental supplement over several months to resolve a housing affordability problem.

For the year ending 30 June 1999, over 200,000 Australian households received assistance under the PRA program. More than half of this assistance was provided in the form of bond loans (Table 3.16). Some States and Territories were unable to report on all types of assistance provided.

Table 3.16: CSHA Private Rental Assistance Program: number of households assisted, by type of assistance, 1999–00

Type of assistance	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust.
Bond loans	26,071	14,728	44,024	14,226	18,527	4,294	23	208	122,101
Rental grants/subsidies	14,428	12,642	712	. .	28,016	1,564	. .	10	57,372
Relocation expenses	2,812	1,686	. .	. .	. .	234	. .	. .	4,732
Other one-off grants	5,885	5,900	. .	. .	. .	6,439	. .	. .	18,224
Total households assisted	**49,196**	**34,956**	**44,736**	**14,226**	**46,543**	**12,531**	**23**	**218**	**202,429**

Notes

1. Households may be eligible for more than one type of assistance.
2. New South Wales figures represent the number of households that were approved for assistance in the 1999–00 financial year, not the actual number of households assisted.

Source: AIHW 2001d, unpublished

Public rental housing assistance

For Australia as a whole, about 6% of all households live in public housing tenures;[7] across the States and Territories, the proportion ranges from 4% in Victoria to 20% in the Northern Territory (Figure 3.6). In June 2000, 346,389 households occupied 348,584 public rental housing dwellings (AIHW 2001e, unpublished).[8] There were 362,967 public housing dwellings in total. Of the 14,383 vacant dwellings, 10,957 were untenantable.[9]

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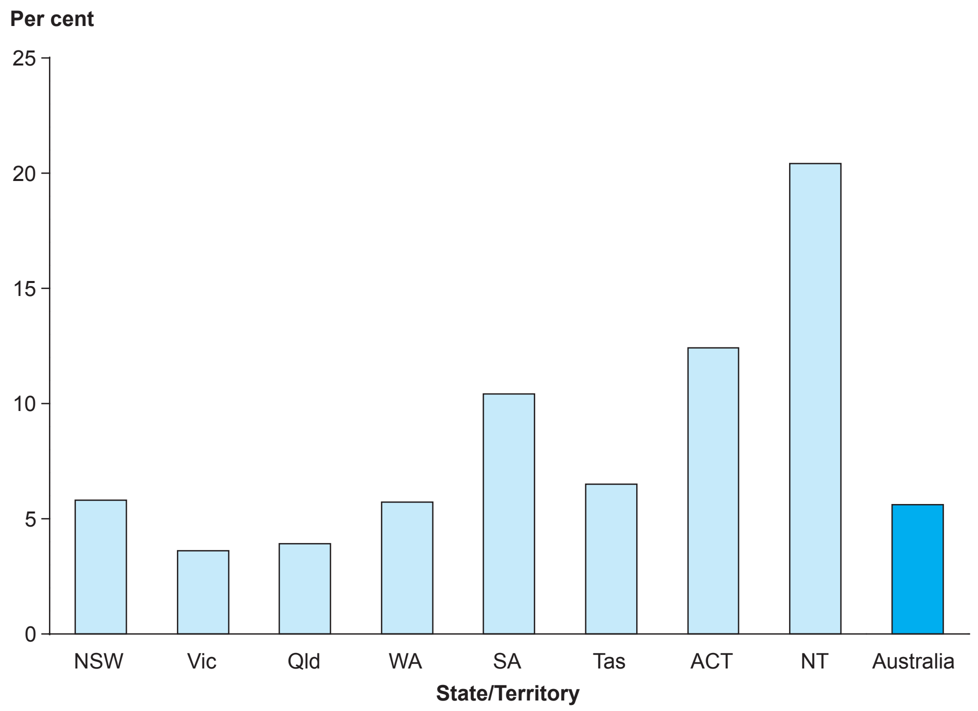
[7] Public rental dwellings include only public rental properties covered by the CSHA. Excluded are the CSHA Aboriginal Rental Housing Program (ARHP), Community Housing Program (CHP) and Crisis Accommodation Program (CAP) (AIHW 2000e, unpublished).

[8] The number of occupied dwellings reported is greater than the number of households as Western Australia excluded 907 households where data were unavailable, and the Northern Territory excluded police tenants in public housing from the count of households.

[9] ‘Untenantable’ refers to unoccupied dwellings where maintenance has been either deferred or not completed (AIHW 2000e, unpublished).



Source: Table A3.5.

Figure 3.6: Proportion of households residing in public housing, 1998

A new national performance indicator framework introduced under the 1999—03 CSHA reports about the efficiency and effectiveness of CSHA programs (Figure 3.7).

Households with special needs and priority housing needs

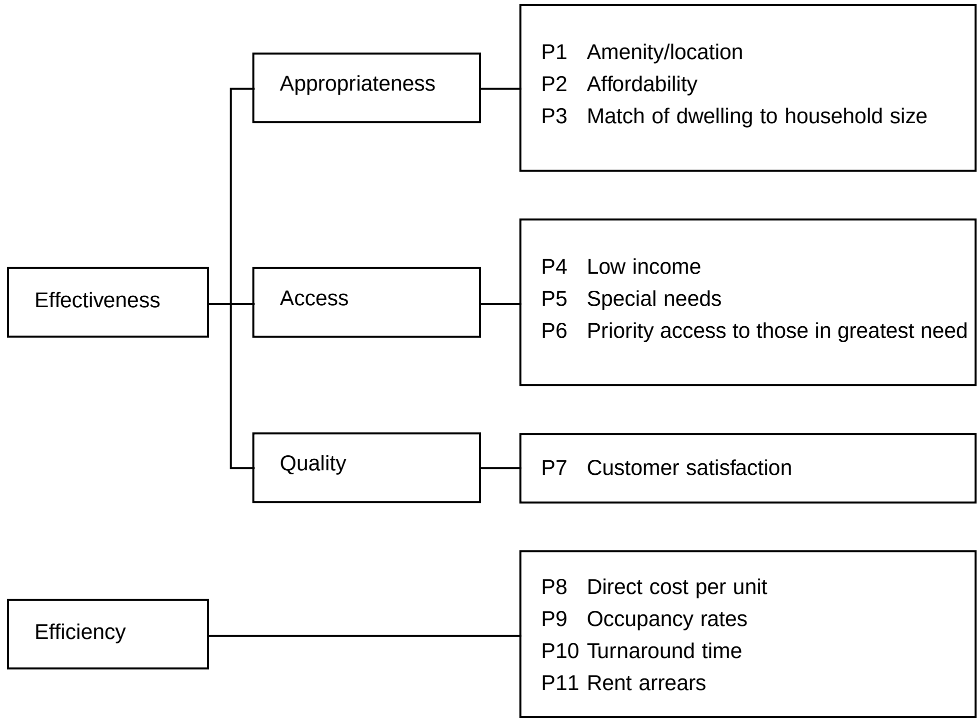
Two accessibility measures under the 1999—03 CSHA examine the proportion of new tenancies allocated to households with a household need status, covering those defined as households with special need and households with priority housing need . These are two distinct but interrelated concepts. The special need measure focuses on people who are unable to access appropriate accommodation in the private rental market because of discrimination or lack of appropriate housing stock (e.g. modified housing for people with a disability). Table 3.17 shows that 45% of housing allocations for 1999—00 were made to households in the special need category. New South Wales and South Australia had the highest proportion of households in the special need category that were allocated housing (55%) and the Australian Capital Territory had the lowest (12%).

Table 3.17: New households in CSHA Public Housing Program, by household need status and State/Territory, 1 July 1999 to 30 June 2000 (per cent)

Household need status	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust.
Special need	54.7	38.9	49.6	23.9	54.9	31.8	12.3	47.8	44.6
Priority housing need	39.1	38.9	3.7	16.8	44.9	22.8	26.2	10.1	27.0

Note: Jurisdictions defined 'special need' and 'priority housing need', using a range of factors that varied across jurisdictions. These factors included: Indigenous Australians, youth, aged, disabled, newly arrived Australians, people from culturally diverse backgrounds, at risk of domestic violence, homelessness, health condition, financial or social problems, adequacy of current accommodation and people in Supported Housing or Special Housing. Further information about the factors used to define these categories can be obtained from AIHW 2001e, unpublished.

Source: AIHW 2001e, unpublished.



Source: AIHW 2000e, unpublished.

Figure 3.7: 1999–03 CSHA National Performance Indicator Framework

The priority housing need measure focuses on people who require urgent access to housing due to their circumstances, such as homelessness, living in a life-threatening situation or inappropriate accommodation. Segmented waiting lists assist people with these high housing needs to be identified. Variation exists between jurisdictions in housing allocation policies (Box 3.3). For 1999—00, priority allocations comprised 27% of housing allocations. South Australia had the highest proportion of priority allocations (45%) and Queensland had the lowest (4%).

Box 3.3: Public housing waiting list priority category, by circumstance of housing need, 1999–00

Circumstance of housing need	**NSW**	**Vic**	**Qld**	**WA**	**SA**	**Tas**	**ACT**	**NT**
Homeless, pending homelessness (eviction) or exiting SAAP type accommodation	✓	✓	✓	✓	✓	✓	✓	✓
Appropriate & affordable accommodation not available in private sector	✓	✓	✓			✓		
Inadequate or unsuitable accommodation(a)	✓			✓	✓	✓	✓	✓
Life-threatening situation at home(b)		✓	✓	✓	✓	✓	✓	✓
Substance abuse		✓						
Natural disaster (flood, fire)			✓	✓	✓			
Severe financial difficulties							✓	✓
Victim of major crime			✓		✓			
Health or disability issues	✓		✓	✓	✓	✓	✓	✓
Persistent discrimination or harassment		✓	✓		✓			✓
Exiting institution care (include prison)		✓			✓			
Lack financial, cultural, social skills					✓			
Neighbourhood or tenancy disputes		✓	✓					
Witness protection			✓					
Family support								
Recent refugee or new to area		✓						
Child returned to care			✓					

(a) Includes severe medical condition or disability which is affected by current housing; present accommodation is dangerous, substandard or severely overcrowded; and insecurity of tenure.

(b) Includes domestic violence, sexual/emotional abuse, child abuse, at risk of violence.

✓ indicates that the circumstance of need enables listing on the waiting list priority category.

The lack of nationally uniform definitions of special need and priority housing need households influenced the variation in results between the States and Territories. The introduction of uniform definitions may overcome this problem.

Satisfaction with amenity/location of dwelling

The National Social Housing Survey, undertaken by State and Territory housing agencies, elicits responses from tenants chosen at random in relation to their satisfaction with their CSHA-funded dwelling in terms of the quality of services provided and the dwelling s amenity and location. The results of the survey are compiled and form part of the CSHA national performance indicator framework.

Table 3.18: Importance of and appropriateness of aspects of dwelling (national weighted average) for public housing tenants, 1999–00 (per cent)

	Dwelling aspect	
Importance rating	**Modifications for special needs**	**Ease of access and entry to dwelling**
Important and does not meet needs	9	8
Important and meets needs	25	62
Subtotal: rating aspect of dwelling as important	*34*	*70*
Not important	43	11
Not answered correctly	23	19
Total	**100**	**100**

Source: NFO Donovan Research 2000a:Figure 5.4.

In 1999—00, 29% of public housing tenants reported that they had a disability or health condition. Households with a person with a disability were just as likely to be satisfied or dissatisfied with public housing as the rest of the sample (NFO Donovan Research 2000a:24). Table 3.18 indicates that while only 34% of households rated dwelling modifications for special needs as important, 74% of these households had their needs met. Similarly, 89% of households that rated ease of access and entry to dwelling as important had their needs met.

Public housing rent rebates

Rents for public housing are generally charged as a proportion of the household s assessable income up to a ceiling equal to a market rent. Housing authorities have different definitions of assessable income , take different household members incomes into account, have different rates of payment according to different income thresholds, and value market rents differently. Often these varying arrangements are summarised broadly, so that it can be said that most households pay between 20% and 25% of their gross income in rent. In 1999—00, 96% of rebated public housing households paid 25% or less of their assessable income on rent (AIHW 2001e, unpublished). This contrasts with low-income households in the private rental market receiving Commonwealth Rent Assistance, where 59% of households pay up to 30% of their income on rent (refer to Figure 3.3).

The difference between the market rent and the rent charged is called the rent rebate . Table 3.19 indicates that public housing tenants would pay on average an additional 33% rental costs if they rented comparable accommodation in the private rental market. The difference between public housing and private rental costs is largest in New South Wales and smallest in Tasmania.

Table 3.19: Public rental households: rent charged as a proportion of market rent for each dwelling (adjusted for Commonwealth Rent Assistance), 1999–00 (per cent)

NSW	Vic	Qld	WA	SA	Tas[(a)]	ACT	NT	Aust.[(b)]
56.2	71.9	74.8	79.3	78.6	80.6	72.7	n.a.	67.1

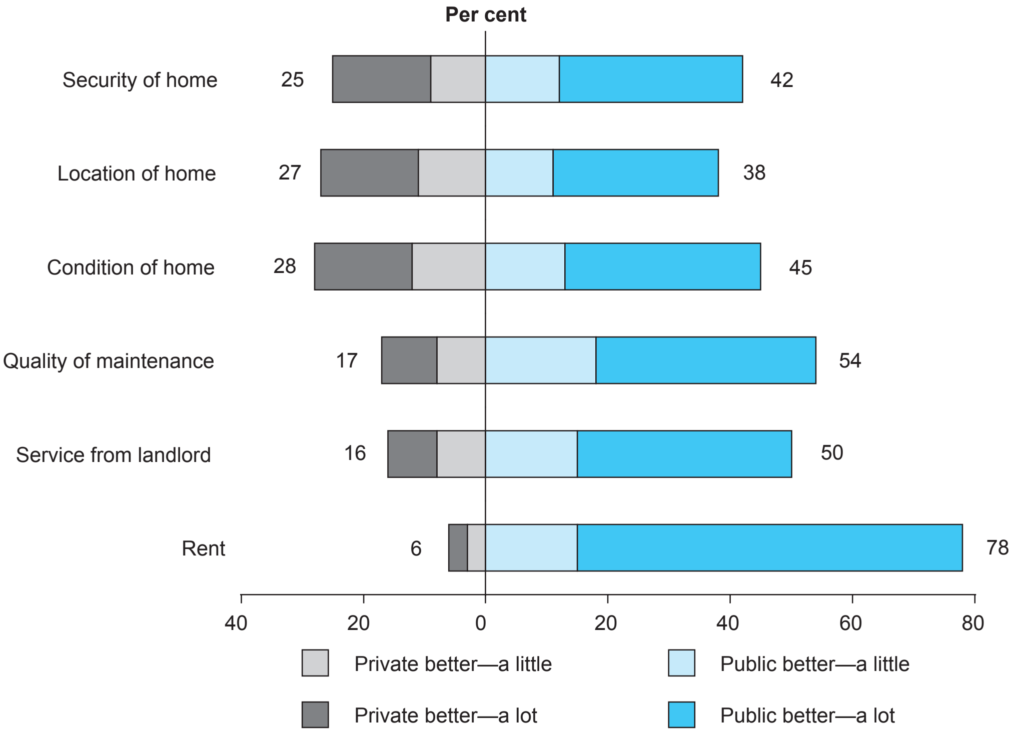
(a) Includes Aboriginal Rental Housing Program.

(b) Figure excludes Northern Territory figures as a full data set for this indicator was not provided.

Source: AIHW 2001e, unpublished:12.

Satisfaction with public housing

Figure 3.8 compares public housing tenants satisfaction with private and public housing. Public housing is rated more favourably than previous experience in private accommodation on all six attributes. Rent paid for the home is clearly the area of greatest satisfaction, with only 6% considering private accommodation better. In the National Social Housing Survey, public tenants reported low levels of satisfaction with non-emergency maintenance. However, 54% of tenants consider the quality of maintenance received in public housing to be better than their previous experience in private accommodation. The majority of public housing tenants (64%) expect to be renting their current accommodation in 5 years time and only 2% intend to be renting private accommodation (NFO Donovan Research 2000a:57,77).



Note: Totals do not sum to 100% because the scale points ‘neutral’ and ‘no response’ are not included in the graph.

Source: Table A3.6.

Figure 3.8: Public housing tenants’ satisfaction with public rental housing compared with private rental housing, 2000

Community housing

Community housing is delivered by non-profit community, church and local government providers and offers a range of housing choices that may not be available through the public or private housing markets. The number of community housing dwellings in Australia is small, compared to public housing, private rental and home ownership it represents less than half of 1% of all housing tenures. Its importance as a sector is the ability to provide flexible housing responses to people who may have special needs or require supported accommodation services with links to aged, disability and health services.

Difficulties are incurred in reporting about the community housing sector because of the diversity of programs, variation in funding sources, and provider capacity to supply reliable data. Table 3.20 illustrates problems with understanding the size of the sector. The National Community Housing Forum (NCHF) reported a total stock figure of 26,220 units, whereas the AIHW as part of the CSHA collection process counted a total of 24,316 dwellings. The difference between the figures may be partly explained by different counting rules, such as that applied to rooming house stock, where the NCHF counts bedrooms while the AIHW counts dwellings.

Table 3.20: Comparison of community housing stock data, 1999–00

	NSW	**Vic**	**Qld**	**WA**	**SA**	**Tas**	**ACT**	**NT**	**Total dwellings**
NCHF data	8,573	5,118	4,744	2,822	3,957	594	363	49	26,220
AIHW data	7,899	6,009	3,625	3,158	2,990	183	312	140	24,316

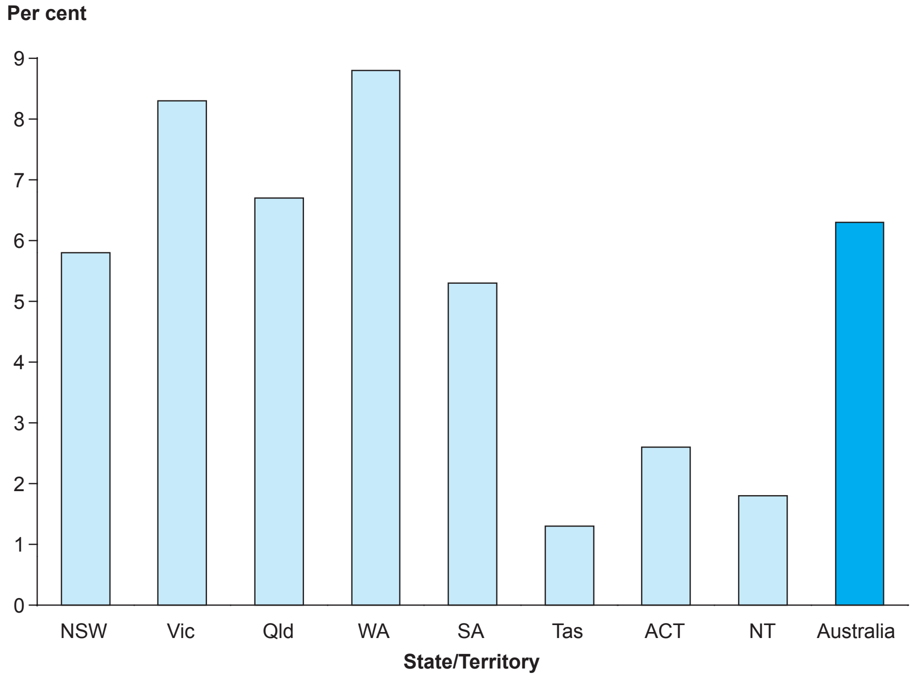
Notes

1. NCHF figures count bedrooms and include rooming houses, cooperatives, associations and all other management types.
2. NCHF figures for Tasmania and the Northern Territory are for 30 June 1999.
3. AIHW figures represent number of CSHA-funded dwellings.

Source: AIHW 2001a upublished:27; NCHF 2000.

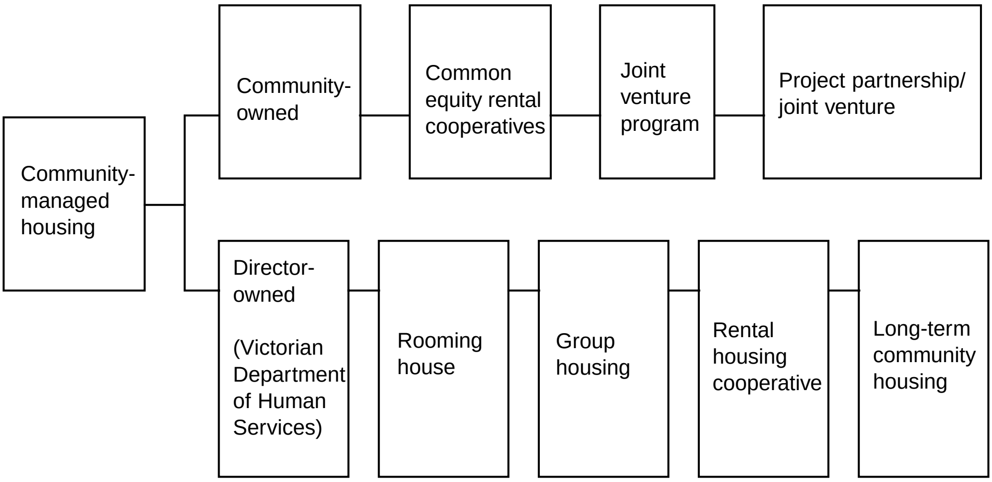
In Western Australia and Queensland, the majority of new households assisted with community housing in 1999—00 had a special need (97% and 93% respectively). In Tasmania, priority allocations comprised 35% of allocations in 1999—00 (AIHW 2001a, unpublished). In 1997—98, 4.5% of clients moved into community housing after leaving SAAP accommodation (AIHW: Wang & Wilson 2000:xx).

The size of the community housing sector varies between jurisdictions, reflecting not only the differing emphasis States and Territories place on community housing as an alternative to public housing but also on its role in deinstitutionalisation (NCHF 1998:3). Figure 3.9 shows that, as at 30 June 2000, Western Australia had the highest proportion of CSHA community housing (9%) and Tasmania had the lowest (1%).



Source: Table A3.7.

Figure 3.9: Community housing dwellings as a proportion of all public and community housing dwellings, 30 June 2000



Source: VDHS 2001a.

Figure 3.10: Victorian community housing assistance program types

The transfer of significant amounts of public housing stock to community housing management has been one of the national trends in community housing. Also worth noting is the significant percentage of community housing stock that is head-leased from the private rental market when compared to public housing. Over 5,000 of a total of 24,300 community housing dwellings are head-leased from the private rental sector (AIHW 2001a, unpublished). The 1999 public housing data repository was only able to identify 2,000 units of public housing stock that were head-leased from the private rental market.

The diversity in the types of community housing programs within a jurisdiction is illustrated in Figure 3.10. While similar diversity, in the forms of assistance provided, exists in the other States and the Territories, different program boundaries make construction of nationally consistent definitions of the types of assistance in this sector difficult.

Satisfaction with community housing

The first Community Housing National Social Housing Survey was administered in 2000 (NFO Donovan Research 2001). The majority of tenants (80%) indicated that they were satisfied with the overall service they received in community housing. Overall, three-quarters of tenants felt that living in community housing had improved their quality of life, with over half (52%) saying it had improved a lot. Table 3.21 highlights some of the benefits that tenants had derived from living in community housing, in comparison to previous experience in other tenures. The most widely cited and achieved benefits were feeling more settled, followed by managing money better (90% and 87% respectively). Two-thirds of tenants cited an improvement in health and 71% of tenants had achieved this benefit. Improving education and employment situation were each cited by over one-third of tenants, and in both instances approximately half of these respondents had achieved this benefit.

Table 3.21: Perceived benefits derived from community housing, 1999–00 (per cent)

	Applicable	Improved	Not improved yet	Not improved
Feel more settled	81	90	4	6
Manage money better	74	87	5	8
Enjoy better health	62	71	10	18
Better access to services	62	74	10	16
Start education or training	38	57	21	20
Better job situation	37	44	26	30

Source: NFO Donovan Research 2001.

Crisis community housing assistance

Government and churches and other welfare organisations use community housing organisations to provide a range of housing services to assist people who are in situations of actual or impending crisis or homeless. These programs have strong links to health and community services agencies that assist people in crisis. In the health area, housing agencies work closely with mental health and alcohol and drug abuse service providers; in the community services area, the major link is with supported accommodation and crisis services provided through the Supported Accommodation Assistance Program (SAAP).

The CSHA Crisis Accommodation Program (CAP) provides emergency accommodation, and funds are used for the purchase, lease and maintenance of dwellings that provide accommodation assistance to people who are homeless or in crisis. Table 3.22 shows that, at 30 June 2000, there were 2,857 CAP-funded dwellings in Australia (AIHW 2001b, unpublished).

Table 3.22: CSHA Crisis Accommodation Program: number of dwellings funded, by State/Territory, 30 June 2000

NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust.
1,014	178	910	333	187	150	45	40	2,857

Source: AIHW 2001b, unpublished:Table 14A.39.

The links between crisis housing assistance and other housing assistance were shown in an analysis of the housing needs of homeless persons using the 1997—98 SAAP national data (AIHW: Wang & Wilson 2000).

Housing outcomes for SAAP clients after receiving SAAP accommodation support are spread across tenure types. In 38% of completed support periods, clients moved into private rental accommodation, 20% into other SAAP accommodation and 11% into public housing accommodation.

Housing tenure before SAAP accommodation support was an important factor in both the type of housing/accommodation the client occupied following support and the reason for assistance being sought. There is a strong tendency for clients to return to their original accommodation arrangements where clients came from public, community or private rental housing, 60%, 68% and 59%, respectively, returned to the same housing tenure type. A significant proportion of clients (41%) previously living in SAAP accommodation returned to similar accommodation, and a significant proportion of clients previously in institutional settings returned to SAAP accommodation (15%) and in public housing and community housing (7%).

Domestic violence was, overall, the main reason for seeking assistance (23%), followed by family breakdown (17%). Persons previously living in public housing before seeking assistance were more likely to be seeking assistance for non-housing-related reasons. By far the main reason for seeking assistance was domestic violence (43%), followed by family breakdown (13%) and abuse (12%). Of the accommodation-related reasons usual accommodation becoming unavailable or eviction-related reasons (11%) and financial difficulties (6%) were the main reasons.

In contrast to public renters, persons renting privately before seeking support were more likely to cite accommodation-related matters as their main reason for seeking assistance. In particular, usual accommodation becoming unavailable or eviction-related reasons (19%) and financial difficulties (13%) were main contributors. However, domestic violence was still overall the main reason for seeking assistance (24%), while family breakdown accounted for 16% (AIHW: Wang & Wilson 2000:xvi—xviii). Further information about types of assistance provided to homeless persons through SAAP can be found in Chapter 8.

CSHA Home Purchase Assistance

Home Purchase Assistance (HPA) under the CSHA is designed to make home ownership (including shared home ownership) more accessible for people who are otherwise unable to obtain private sector finance for home ownership. A range of programs is available, which vary across the States and the Territories, including direct lending, shared home ownership, government guarantees, deposit assistance, interest rate assistance, home purchase advisory and counselling services, mortgage insurance protection and mortgage relief (AIHW 2000a, unpublished).

In 1999—00, the total value of HPA provided to households by the States and Territories through the CSHA and related programs was $2,098.8 million.[10] Table 3.23 shows the diversity in the way home purchase assistance is provided, and the different types and

Table 3.23: CSHA Home Purchase Assistance, by type of assistance to households and State/ Territory, 1999–00

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust.
Households receiving assistance (number)									
Direct lending	4,016	13,207	9,880	24,908	18,790	2,587	n.a.	3,492	76,880
Deposit assistance	. .	n.a.	245	290	363	195	n.a.	394	1,487
Interest rate assistance	. .	n.a.	. .	418	3,503	1,076	n.a.	340	5,337
Mortgage relief	1,495	201	843	n.a.	125	. .	n.a.	. .	2,664
Home purchase advisory and counselling services	13,663	0	. .	n.a.	n.a.	0	n.a.	. .	13,663
Other types of assistance	. .	12	0	n.a.	. .	0	n.a.	94	106
Total households receiving assistance	**19,174**	**13,420**	**10,968**	**25,616**	**22,781**	**3,858**	**n.a.**	**4,320**	**100,137**
Value of assistance ($m)									
Direct lending[(a)]	250.2	. .	326.5	459.8	812.2	7.8	n.a.	223	2,079.5
Deposit assistance	. .	n.a.	2.8	0.5	0.6	0.3	n.a.	0.6	4.7
Interest rate assistance	. .	n.a.	. .	n.a.	2.4	. .	n.a.	0.2	2.5
Mortgage relief	7.5	0.017	2.4	n.a.	0.2	. .	n.a.	. .	10.1
Home purchase advisory and counselling services	0	0	. .	n.a.	n.a.	0	n.a.	. .	0
Other types of assistance	. .	1.0	0	n.a.	n.a.	0	n.a.	0.9	1.8
Total value of assistance	**257.7**	**1.0**	**331.7**	**460.3**	**815.3**	**8.1**	**n.a.**	**224.7**	**2,098.8**

(a) New South Wales, Queensland, South Australia, the Australian Capital Territory and the Northern Territory calculated this item using the total value of loans outstanding. Victoria, Western Australia and Tasmania calculated this item using the value of new assistance.

Source: AIHW 2001c, unpublished.

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10 Because of the way in which home purchase funds are managed in some States and Territories, it is not possible to separately identify CSHA and other funding.

monetary values of the services provided indicate the difficulty in making comparisons between States and Territories. This is reflected in the fact that larger States, such as New South Wales and Victoria report lower numbers and values of assistance than do smaller States, such as Western Australia and South Australia. It is important to note that New South Wales, Queensland, South Australia, the Australian Capital Territory and the Northern Territory calculate the total value of direct lending using the total value of loans outstanding. Victoria, Western Australia and Tasmania calculate this item using the value of new assistance.

Active CSHA home purchase programs exist where market circumstances allow the purchase of dwellings by low-income people. Active schemes are available in some jurisdictions that allow public housing tenants and those eligible for public housing to purchase either in full or part public housing dwellings.

Other assistance to home owners and purchasers

In addition to the CSHA home purchase assistance, households owning or purchasing their home may also receive a range of other government assistance through government outlays and tax expenditures.

To offset the impact of the introduction of the goods and services tax, from 1 July 2000 the Commonwealth Government established the First Home Owner Grant. The grants are administered by States and Territories and provide Australian citizens who purchase a new or established dwelling with a one-off $7,000 payment. Assistance is not means-tested, but the applicant must not have previously owned a home and the property must be intended to be a principal place of residence (FHOG On-line 2001).

During March 2001, the Commonwealth Government introduced an Extra First Home Owner Grant for New Homes, providing an additional $7,000 grant, non-means-tested, for first home owner applicants constructing or purchasing a new dwelling. This additional grant is not available to applicants purchasing an established dwelling and the grant is available for a limited time only, from 9 March to 31 December 2001. The States and Territories also administer this grant (FHOG On-line 2001).

Data on other assistance to households owning or purchasing their home, particularly through the taxation system, are currently limited. However, its impact is considered significant (Bourassa et al. 1995; Pender 1994).

Tax expenditures are measured in terms of the amount of tax revenue forgone by government as a result of concessional taxation treatment. This is, however, probably an understatement of the actual amount, as many tax expenditures in this area are uncosted because of a lack of data and because of conceptual difficulties in choosing a suitable tax benchmark. In the housing sector, the Commonwealth exempts the principal residence and does not subject the imputed rental income arising from ownership to taxation. Most States and Territories also offer stamp duty exemptions for first home buyers and usually exempt the principal residence from land taxes.

The most recent analysis, based on data for 1984—85, concluded that the value of assistance was on average $1,890 per household per year for owners and $890 for purchasers; this compares with $2,890 for public renters and $970 for private renters

(AIHW 1997:Table 5.4; Flood 1993). For owners and purchasers, much of the assistance was in the form of tax expenditures,[11] such as exemptions for capital gains and imputed rent, rather than direct government subsidy.

The capital gains tax exemption for gains on the disposal of a taxpayer s main residence (Treasury 2001:27) is recognised as an important area of housing assistance.[12] The value of this exemption is not available from official sources and is not calculated in reporting tax expenditures. An indication of the size of this assistance was, however, provided in Flood s study of housing subsidies, which estimated, using 1984—85 data, that the non-taxation of capital gains for home owners represented a subsidy of $1.5 billion (AIHW 1999:153; Flood 1993:Appendix 3).

Owner-occupied housing is also treated differently from other assets because the service, or imputed rent, from the dwelling is not taxed.[13] Assets such as bank savings, shares and investment properties produce income that is taxed; owner-occupied housing provides an imputed income stream that is not. On the other hand, costs associated with producing the service are not tax exempt; for example, mortgage interest payments cannot be deducted from a person s taxable income. This presents a short-term disadvantage for purchasers, but the long-term advantage of a non-taxed imputed rent has been calculated to more than outweigh this at given rates of mortgage repayment (Bourassa et al. 1995).

State and Territory taxes also provide assistance to home owners, for example through transaction tax exemptions for first home buyers and land tax exemptions. Land tax exemption has been raised as a source of horizontal inequity between renters and owner-occupiers and as a disincentive to rental property investment (NHS 1991b:59; Yates 1994:22).

Assistance is also provided to pensioners, who receive subsidies for their local government rate payments. These subsidies are funded by State and Territory Governments, which reimburse local governments. The size and number of subsidies vary from State to State and no comparable information is available.

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[11] The Australian Taxation Office recognises the role taxation plays in providing benefits by way of government revenue forgone as a result of concessional tax treatment (Treasury 2001).

[12] Unlike other assets, owner-occupied housing is exempt from capital gains tax. This issue is sometimes interpreted to mean that owners can make untaxed gains by selling their homes in the market in which the value of their home has increased at rates greater than inflation (Pender 1997).

[13] Imputed rent from owner-occupied dwellings refers to the imputed value of the services, such as shelter, that ownership provides to households after the deduction of expenses and depreciation.

3.4 Housing assistance to Indigenous Australians

Housing assistance to Indigenous people is provided through a range of means, including targeted State/Territory-managed housing, and community-managed housing which supplements assistance available through mainstream housing programs.

The 1999 ABS Australian Housing Survey and the ATSIC Community Housing and Infrastructure Needs Survey identified considerable housing need amongst Indigenous people[14] (ABS 2000c, 2001). Indigenous Australians are more likely to live in subsidised housing, are much less likely to be owners or purchasers, and are more likely to live in overcrowded housing and housing in need of repairs (Tables 3.24; A3.8). Furthermore, the SAAP data for 1999—00 show that Indigenous Australians, who represent only 2% of the total Australian population, accounted for 14% of support periods (AIHW 2000f:14). These findings are seen as a function of a range of issues, including low income levels, high dependency ratios and discrimination in the (private) housing market (FOCUS Pty Ltd 1999:25).

Table 3.24: Housing tenure, by Indigenous status, 1999 (per cent)

Tenure	Indigenous households	Non-Indigenous households
Owner with and without mortgage	38.8	70.7
Private rental	27.3	20.1
Public rental housing	22.4	4.8
Other landlord	8.5	1.7
Total renters[(a)]	*58.2*	*26.7*

(a) Includes ‘other renter’.

Note: A family is defined as Indigenous if any adult or child in the family is identified as Indigenous. This differs from standard ABS practice of considering adult family members of married couple and sole-parent families only. In some areas of housing assistance, eligibility is based on the Indigenous status of all family members.

Source: ABS 2001.

In May 2001, housing ministers endorsed a 10-year statement on directions for Indigenous housing reform to provide better housing for Indigenous Australians (HMAC 2001). This statement addressed the 1997 ministers reform agenda that focused on:

- identifying and addressing outstanding need;
- improving the viability of Indigenous community housing organisations;

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[14] These two surveys are not directly comparable because the Australian Housing Survey collected information from persons in both urban and rural areas only. Persons living in sparsely settled or remote parts of Australia where there were fewer than 0.06 dwellings per square kilometre were excluded from the survey. The Community Housing and Infrastructure Needs Survey, however, was a complete enumeration of all Indigenous housing organisations and discrete Indigenous communities, including organisations and communities located in urban and sparsely settled areas.

- establishing safe, healthy and sustainable housing for Indigenous Australians, especially in rural and remote communities; and
- establishing a national framework for the development and delivery of improved housing outcomes for Indigenous Australians by State, Territory and community housing providers.

Indigenous housing need

Current data show high levels of Indigenous housing need in both urban and non-urban locations and provide a challenge for both mainstream housing assistance and that targeted to Indigenous households. To improve understanding of the various components of need, a new multi-measure approach to determining Indigenous housing need was developed in 1998 (Jones et al. 1998). This approach considers measures of housing need under four interrelated dimensions:

- adequacy (measures of homelessness, overcrowding, services and stock condition);
- affordability (measures of household income available for housing after other basic needs have been met and costs to public and community housing suppliers of charging tenants affordable levels of rent);
- appropriateness of housing; and
- security of tenure.

In addition, measures of future growth in demand for housing are required to take account of the needs of a rapidly growing Indigenous population (Jones et al. 1998:vi). The value of each of these measures depends on the availability and reliability of relevant data. At present, there are gaps in data for a number of the measures and no data for others.

Particularly in rural and remote areas, the condition of housing stock is a key factor in housing need. The 1999 Community Housing and Infrastructure Needs Survey gathered information about Indigenous housing organisations in 1,291 discrete Indigenous communities. The survey identified that 73% of these communities had a usual population of less than 50 and 12% had a usual population of 200. Table 3.25 reveals that 21% of dwellings surveyed were in need of major repair and 8% required replacement. Stock in discrete communities was more likely to be in need of major repairs or replacement (33%) than that in towns or other locations (18%) (ABS 2000c:1—3, 5).

These findings compare with the picture across all households, Indigenous and non-Indigenous, where 19% of dwellings occupied by Indigenous households are in high need of repairs. This compares with 7% for non-Indigenous households (Table A3.8).

The 1999 survey also demonstrated the strong links between housing assistance and community infrastructure in rural and remote areas. In discrete Indigenous communities, it reported that:

- about 1% of communities had no organised water supply and 34% of communities failed water testing at least once in the preceding year; 35% of communities with a population of 50 or more experienced water restrictions, and equipment breakdown was the main contributing factor to these restrictions;

- 10% of communities had no electricity supply (including generators); and
- 5% of communities had no sewerage system, and 59% of communities with a population of 50 or more experienced overflows or leakages of sewerage systems. Forty-one of these communities were found to have a method of grey-water disposal that was undesirable to Australian public health authorities (ABS 2000c:20).

Table 3.25: Condition of dwellings managed by Indigenous housing organisations, by location, 1999

	Discrete community		Town or other location		Total	
	Number	Per cent	Number	Per cent	Number	Per cent
Minor or no repair	9,696	65.6	4,568	80.9	14,264	69.8
Major repairs	3,468	23.5	783	13.9	4,251	20.8
Replacement	1,407	9.5	233	4.1	1,640	8.0
All dwellings[(a)]	**14,777**	**100.0**	**5,647**	**100.0**	**20,424**	**100.0**

(a) Includes ‘not stated’.

Source: ABS 2000c.

Addressing Indigenous housing need

The diversity of circumstances of Indigenous Australians has led to a range of policies and programs to address their housing need. At the Commonwealth level, in addition to the provision of Commonwealth Rent Assistance and Aboriginal Rental Housing Program funds administered by FaCS, the Aboriginal and Torres Strait Islander Commission (ATSIC) provides housing funds. ATSIC provided $116.5 million in 1999—00 in housing output disbursements (ATSIC 2000:96). The majority of this funding was spent through the National Aboriginal Health Strategy and Regional Council components of the Community Housing and Infrastructure Program (CHIP). From this funding, 403 houses were constructed or purchased and 1,036 houses were renovated or upgraded (ATSIC 2000:100). The ATSIC Community Development Employment Program has over 1,600 individuals employed or contracted in housing construction and/or maintenance.

Large environmental health projects are funded under the National Aboriginal Health Strategy. Between 1996 and 2000, approximately $260 million was provided for housing and environmental infrastructure, resulting in improved health conditions in Indigenous communities. The new triennium for the health strategy began in July 2000, with approximately $200 million allocated to assist approximately 95 communities (ATSIC 2000:106, 108).

The ATSIC—Army Community Assistance Program was initiated in late 1996 and targets communities with an urgent need for upgrading of both housing and infrastructure. In 1996—97, $11.6 million was allocated across six communities and this program was extended for 4 years from late 1998, with $40 million allocated from both the Commonwealth Department of Health and Aged Care and ATSIC (ATSIC 2000:109).

The Fixing Houses for Better Health Project was established in 1999 and involves assessment of the state of repair of houses and immediate provision of urgently required minor maintenance. In 1999—00, 1,000 houses in Indigenous communities across Australia were surveyed and repaired under this project (ATSIC 2000:99).

Programs to address Indigenous housing need are also funded at the State and Territory level. For example, the New South Wales Aboriginal Housing Office implemented a registration process for funded Indigenous Housing Organisations in 1998. This is aimed at improving the availability of data and better understanding the needs of the sector (NSWAHO 2001). In 1999, the Queensland Government commenced a Five-Year Capital Works Plan to construct 186 new houses and to upgrade 117 dwellings in Deed of Grant in Trust communities (QDOH 2000:42). The Community Housing Management Strategy is an integral part of the Works Plan, aimed at providing housing management support to community councils. The South Australian Government established the Aboriginal Home Ownership Program in 1999, and 50 tenants were offered the opportunity to purchase their current rental homes (SADHS 2000:29). A similar range of programs exists in other States and Territories.

Improving Indigenous housing

Basic environmental health infrastructure, including adequate sanitation, clean water and power supplies, and appropriate and fully functioning houses are essential if there is to be a significant and sustainable improvement in the health of Indigenous people. The National Framework for the Design, Construction and Maintenance of Indigenous Housing, endorsed by housing ministers, aims to achieve safe, healthy and sustainable housing for Indigenous people (Commonwealth of Australia 1999a, 1999b). The four principles of the National Framework are described in Box 3.4.

Building the Indigenous community housing sector

The Indigenous community housing sector has a critical role in delivering housing to Indigenous people. However, Indigenous community housing organisations face a number of problems that impact on their capacity to manage dwellings. Generally, they cannot generate sufficient income to cover the recurrent costs of housing relating to the operation, repair and maintenance of dwellings. A shortage of funds for maintenance means dwellings deteriorate rapidly and need to be replaced prematurely.

Low levels of rent, poor housing design and construction, limited administrative infrastructure, and poor asset and tenancy management skills are factors which may add to the financial and management burdens of Indigenous community housing organisations.

Commonwealth, State and Territory Governments are currently working with community organisations to improve the capacity of the Indigenous community housing sector to manage and maintain housing assets more efficiently. Initiatives in this area include:

- Aboriginal Rental Housing Program funds being directed towards housing management and maintenance functions, as well as being used for the construction and upgrade of houses;
- developing the National Skills Development Strategy for Indigenous Community Housing Management (FaCS 2000:84); and

Box 3.4: Principles of the National Framework for the Design, Construction and Maintenance of Indigenous Housing

Principle 1—*Houses for Aboriginal and Torres Strait Islander peoples will be designed, constructed and maintained for safety. Houses will:*

- *have properly installed electrical and gas connections and appliances;*
- *be connected to a potable (drinkable) water source;*
- *be built with approved, safe and non-toxic materials; and*
- *have properly designed and soundly constructed waste removal systems.*

Principle 2—*Houses will be designed, constructed and maintained to support healthy living practices. Houses must support nine healthy living practices (in order of priority):*

1. *washing people, particularly children under 5 years of age;*
2. *washing clothes and bedding;*
3. *removing waste safely from the living area;*
4. *improving nutrition—the ability to store, prepare and cook food;*
5. *reducing crowding and the potential for the spread of infectious disease;*
6. *reducing negative contact between people and animals, vermin or insects;*
7. *reducing the negative impact of dust;*
8. *controlling the temperature of the living environment;*
9. *reducing trauma (or minor injury) around the house and living environment.*

Principle 3—*Quality control measures will be adopted in the design and construction of houses.*

- *Houses should be designed and constructed, and construction supervised, to minimum standards as set by the State and local government regulations based on the Building Code of Australia and State and Territory remote area building standards.*
- *Housing should be constructed under a properly established quality control system that is subject to periodic monitoring and evaluation.*
- *Building inspections should be conducted at various stages of construction to ensure quality control. Payment to contractors can be linked to inspection points. The involvement of local government in building inspections should be encouraged.*

Principle 4—*Houses will be designed and constructed for long-term function and ease and economy of maintenance.*

- *Water, waste removal and electrical facilities and building fabric—'health hardware'—should be of a quality that meets the rigours of remote locations and provides good amenity.*
- *In order to sustain houses—to keep them functional and habitable—they should be maintained regularly. Establishing emergency and cyclical maintenance programs should be a priority.*

(continued)

Box 3.4 (continued): Principles of the National Framework for the Design, Construction and Maintenance of Indigenous Housing

- *Access to tradespeople for maintenance of health hardware should be taken into account at the design stage.*
- *Long-term maintenance requirements and costs should be included in initial housing design and life-cycle budgets.*
- *Health hardware should be selected on the basis of quality, effectiveness and efficiency in reducing running costs and keeping the safety and health benefits provided by houses affordable.*
- *Indigenous community housing organisations should have access to the appropriate equipment and training for routine maintenance of essential health and safety items.*

Source: Commonwealth of Australia 1999a, 1999b.

- improving rent collection for Indigenous community housing organisations through the introduction of Centrepay, a scheme that allows income support recipients to automatically direct a portion of their Centrelink payments to their housing organisation, for payment of rent and other essential services. In January 2000, 243 Indigenous Community Housing Organisations had joined Centrepay, and 4,318 Centrelink customers had deductions paid directly to these organisations (ATSIC 2000:95).

Improving coordination

In the past, Indigenous housing assistance has been planned in isolation from other forms of government assistance, often resulting in overlapping and confusing service delivery. Indigenous housing agreements provide a structure for the Commonwealth, ATSIC, the Torres Strait Regional Authority, and each State and Territory to work together to improve and simplify the planning, coordination and delivery of Indigenous housing programs. Agreements have been signed between the ATSIC chairperson, the Commonwealth housing minister, and housing ministers in the Northern Territory, Western Australia, New South Wales and South Australia. A Torres Strait housing and infrastructure bilateral agreement has also been signed. Finalisation of other agreements with Queensland and Victoria is subject to a decision on Commonwealth administrative arrangements, and negotiations are continuing with Tasmania and the Australian Capital Territory.

3.5 Data development

A variety of data development initiatives has been implemented to improve data availability and consistency. Two important developments are the National Housing Data Agreement (NHDA) and the Agreement on National Indigenous Housing Information (ANIHI) (Box 3.5). These agreements seek to improve data quality and the compatibility of information about housing assistance.

Box 3.5: National housing information agreements

The National Housing Data Agreement

The National Housing Data Agreement (NHDA) was signed in January 2000. It is a subsidiary agreement to the Commonwealth–State Housing Agreement, between Commonwealth, State and Territory Governments and key data agencies, to provide and fund national data development activities. The NHDA Management Group oversees the development, review and implementation of the agreement, makes recommendations to the Commonwealth, States and Territories through the Housing Ministers' Advisory Committee on information priorities, funding implications, and manages the work of the National Housing Data Development Committee. The NHDA aims:

- *to ensure that nationally relevant housing data collected throughout Australia are consistent and compatible between the different collections; and otherwise*
- *to improve the quality of and access to housing data at the national level and at the same time maintain and protect the confidentiality of the data for individuals and for signatories to the Agreement.*

The long-term goal of this Agreement is to have a workable means of obtaining nationally compatible housing data in a way that is compatible and consistent with other information initiatives in Australia, such as the National Community Services Information Agreement and the National Health Information Agreement.

Source: AIHW 2000c.

The Agreement on National Indigenous Housing Information

The Agreement on National Indigenous Housing Information (ANIHI) was signed in December 1999. It is an agreement between Commonwealth, State and Territory Indigenous housing administrators and key data agencies to provide and fund national data development activities. The agreement aims to improve Indigenous housing data collection activities in order to develop a greater understanding of the housing situation of Indigenous Australians and, in turn, improve housing outcomes.

The National Indigenous Housing Information Implementation Committee (NIHIIC) is the management committee established under the ANIHI and manages the work of the National Indigenous Housing Minimum Data Set Sub-committee. The Indigenous Housing Information Management Strategy aims to improve the quality of, and access to, Indigenous housing information at the national level and at the same time maintain and protect the confidentiality of the data for individuals and for the signatories to the agreement.

Source: AIHW 2000b.

The major components of the NHDA Management Group work program are based on four priority policy areas for national data: public rental housing, private rental market assistance, community housing, and Indigenous housing. Indigenous housing priorities are being progressed jointly with the National Indigenous Housing Information Implementation Committee (NIHIIC) which operates under the ANIHI.

The major areas of work under the NHDA are the development of national minimum data sets based on administrative data, the establishment of national data standards and national performance reporting.

Significant progress in the development of national housing data has been made with the establishment of the new performance reporting framework and data collection for public and community housing (see Figure 3.7). This framework was developed specifically for the 1999—03 Commonwealth—State Housing Agreement (CSHA) and avoids duplication of effort by being aligned with the framework used for the Review of Government Services reporting. This has been accompanied by a standardised national financial reporting framework for the CSHA and the development and conduct of two National Social Housing Survey collections covering public and community housing. In 2001, the NHDA Management Group endorsed the first National Housing Assistance Data Dictionary (AIHW 2001g).

The ANIHI will be progressed under the direction of the recently formed Indigenous Housing Standing Committee of the Housing Ministers Advisory Council to address national data requirements, particularly in the acknowledged priority areas of:

- Indigenous housing need;
- viability of Indigenous housing organisations;
- sustainable and healthy housing; and
- delivery of improved housing outcomes.

The compatibility of mainstream and Indigenous housing data with health and community services information are objectives of both the NHDA and the ANIHI. These agreements support relevant work across areas such as priority access to housing services and the links to community services programs such as the Supported Accommodation Assistance Program (SAAP).

3.6 Conclusion

Housing assistance aims to meet housing needs as well as contribute to broader outcomes, such as improved social and economic wellbeing for individuals, families and communities.

Population growth along with changes in household formation and changes in the housing markets have affected the demand for housing assistance. Recent economic and social changes have also contributed to changes in the demand and supply of housing. There is evidence of a change in home ownership patterns indicating that home ownership is occurring at a later stage in the family life-cycle. Also the private rental market has grown faster than other segments of housing but the supply of low-cost private rent has not shown a similar increase.

Housing accessibility and affordability are addressed through a range of government policies and programs. Assistance to private renters is the major form of government expenditure, followed by assistance to public and community housing tenants through the CSHA. Expenditure trends on private rent assistance through the CRA has shown an increase over the last ten years in real terms while expenditure on CSHA assistance has been declining. Assistance to first home owners has re-emerged as a major form of assistance to home purchasers.

In the private rental market approximately 940,000 income units receive regular rent assistance through the CRA, with additional assistance being provided under the CSHA. The CRA improves housing affordability after receiving CRA, 41% of income units paid more than 30% of income on rent compared to 75% of income units before receiving it.

Public housing provides assistance to at least 357,000 households through mainstream public rental housing and ARHP. CSHA community housing provides 23,000 households with mainstream housing and over 9,000 households with crisis accommodation. Community housing also provides assistance for a further 19,000 Indigenous households through Indigenous community housing programs operated by ATSIC and individual States and Territories.

Public and community housing is increasingly being targeted to those low-income households who have additional needs that cannot be met by the private rental market. As a result, links between housing providers and health and community support services have increased. Improving housing services for tenants who are homeless or have complex needs is a focus of the 1999—2003 CSHA.

Indigenous households are still over-represented in public and community housing and have below-average rates of home ownership. The quality of Indigenous housing impacts on health and wellbeing. Improving housing and related social outcomes for Indigenous households is a major concern of housing ministers.

Currently there is little consistent national data to contribute to the understanding of how housing and housing assistance improve people s lives. Current data developments are aimed at improving understanding of housing assistance itself and the role that housing plays in the lives of individuals, households and communities.

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4

Deinstitutionalisation: the move towards community-based care

4.1 Introduction

The term deinstitutionalisation has traditionally been most closely associated with mental health and intellectual disability. In this context, its original meaning lay in relation to the movement of actual individuals from an institutional setting to a community setting. But over time the term has attained a broader meaning in policy debates, being used in relation to the shift away from institutional services and towards care in the home and the community, regardless of the movement of particular individuals.

In this sense, deinstitutionalisation is a shift in the system of service delivery the process can be observed in a diverse array of service areas, including aged care, out-of-home care for children, services for people with disabilities, accommodation for the homeless, and acute hospital services. This latter category may be regarded as somewhat tangential to the topic of deinstitutionalisation. However, the expansion of day surgery and hospital in the home initiatives, taken together with home-based post-acute care services, has moved a set of services which were previously provided in an institutional setting out into the community. And aged care institutions, while not subject to the large-scale closures which characterised mental health and intellectual disability institutions during the 1970s and 1980s, have progressively come to cater to a smaller proportion of the older population as the growth in residential aged care beds has been kept to a slower pace than that of the growth in the aged population.

The process of deinstitutionalisation was undoubtedly one of the leading policy and structural transformations in health and community services over the second half of the twentieth century. But while we have documentation of the processes and outcomes of specific institutional closures (Molony & Taplin 1988, 1990; Parmenter et al. 1994; Young et al. 2001), and reports of reviews and inquiries advocating deinstitutionalisation (e.g. Burdekin 1993; Richmond 1983; Senate Select Committee on Private Hospitals and Nursing Homes 1985), there has been no national appraisal of the size and scope of deinstitutionalisation across the diverse array of fields in which the transformation has occurred. This absence is hardly surprising, as the data which are available to paint such a broad picture are in many ways inadequate to the task. There has been no central repository for such information.

These various services are not only funded and provided by a mixture of Commonwealth, State and Territory and local governments, and not-for-profit and for-profit providers, but they also operate within different frameworks and from different service and disciplinary philosophies, aiming to provide services and assistance to very different client groups. Considering the frequently conflicting priorities of different levels of government, the competing paradigms of various professional groups, and the ideological tensions manifested by proponents of the medical versus social models of service delivery, particularly when these are compounded by programmatic tensions, it is hardly surprising that a single coherent picture has failed to emerge.

This chapter attempts to develop a comprehensive picture of the nature and scope of the deinstitutionalisation process in Australia over recent decades. While the move from institutional to community-based care is widely recognised, and frequently cited, its dimensions and implications are less well understood. The chapter is concerned not only with the move away from institutions, but equally with the move towards community care and community living. It is concerned not only with what has gone, but also with what has appeared to replace it. The broad scope of the chapter includes health and welfare services, but not educational or corrective facilities. More detailed data and examples are drawn from the areas of aged care, disability services, mental health, acute hospitals, and out-of-home care for children.

The chapter begins by considering the concept of institution, taking into account both historical developments and programmatic differences (Section 4.2). There is no intention to develop one single concept of institution that is appropriate for all services at all points in time, but rather to identify some of the elements that have been centrally associated with the term institution. This discussion is undertaken partly for purposes of clarity and definition, but more importantly to contribute to an understanding of how and why deinstitutionalisation emerged as a policy direction with such a broadly based coalition of support in the 1970s and 1980s. Understanding why deinstitutionalisation was so strongly supported in the past provides a useful basis from which to explore the situation as it has developed today, not simply in numerical terms, but also in terms of policy developments. Is, for example, the ultimate goal of deinstitutionalisation the closure of all forms of institutional care in all service delivery fields? The maintenance of some bare minimum? Or the maintenance and reform of institutional care where it is necessary, supported by a plurality of alternative forms of community-based care and accommodation? Or simply a strategy to replace more costly forms of institutional provision with cheaper forms of community-based care?

The next section of the chapter (Section 4.3) uses national census data to explore the broad dimensions of the shift from institutional to community living. While there are limitations on the quality of data capture pertaining to the non-household sector, these are nonetheless the most comprehensive data available on the living arrangements of Australians, and the proportion who live in health and welfare institutions. The section provides an overview of the process of deinstitutionalisation in Australia between 1981 and 1996, and the population sub-groups most affected by the observed changes.

The final substantive section (Section 4.4) deals with key policy developments and the dimensions of change in each of five program areas: aged care, disability services, mental health, substitute care for children, and acute hospitals. At this more specific level, more detailed information is available on the alternative models of care developed in different fields to replace institutional modes of service delivery, with data on types of programs, the number of clients and changing patterns of expenditure.

4.2 From institution to community

The ‘traditional’ institution

What is an institution, and why did it come to be viewed as the wrong vehicle for the provision of health and community services? There are a range of factors which have been used implicitly or explicitly to define institutions, including size, separateness from the community, regimentation, external control, residents who lack identity, choice and autonomy, and a physically and emotionally barren environment. Institution is rarely taken to be a positive term. The classic and often quoted definition is that provided by Goffman in 1961:

> A basic social arrangement in modern society is that the individual tends to sleep, play and work in different places, with different co-participants, under different authorities, and without an overall rational plan. The central feature of total institutions can be described as a breakdown of the barriers ordinarily separating these three spheres of life. First, all aspects of life are conducted in the same place and under the same single authority. Second, each phase of the member’s daily activity is carried on in the immediate company of a large batch of others, all of whom are treated alike and required to do the same thing together. Third, all phases of the day’s activities are tightly scheduled, with one activity leading at a prearranged time into the next, the whole sequence of activities being imposed from above by a system of explicit formal rulings and a body of officials. Finally, the various enforced activities are brought together into a single rational plan purportedly designed to fulfill the official aims of the institution. (Goffman 1968 / 1961:17)

This description of an institution is specific to a particular place and time, yet these kinds of attributes have come to be synonymous with the term institution . Going back even further in history, to the nineteenth century, there was also a punitive aspect to some forms of institutional care. Workhouses, for example, did not just happen to be undesirable places to reside, they were actively intended to be so. A high level of regimentation served, first, to control and regulate these potentially disruptive members of society and, second, to make workhouses and almshouses unattractive options for those capable of working to support themselves (Fraser 1983:260). Third, there was an emphasis on the physical separation of these individuals from mainstream society, a belief that society was better off if protected from those who were physically or mentally ill, frail, old, or disabled. This perception of the advantages of providing institutionally based assistance to people who were sick, destitute or disabled was one of the key arguments employed against those who were proponents of outdoor relief (or providing assistance to those in need in their own homes) (Dear & Wolch 1987:35—7). In contemporary terms, outdoor relief can be translated to mean income support and home-based care.

An appreciation of the history of institutional care, and its emphasis on controlling and separating from mainstream community life those who were poor, disabled, ill or simply old, provides a useful context for understanding the strength of the attacks launched on institutional care in the 1960s by such influential critics as Goffman (1968 / 1961) and Townsend (1962), by advocates of human rights, and by the families and lobby groups engaged in assisting particular client groups.

If regimentation, isolation from the community, lack of independence, dignity and privacy, poor quality of care, and control by others were seen as the essence of an institution, then there is little wonder that social reformers and health and welfare advocates in the 1960s and 1970s argued for deinstitutionalisation. Yet while this period saw the deinstitutionalisation movement translated from philosophy into a tangible social program in the United States (Dear & Wolch 1987:3), the implementation of deinstitutionalisation came somewhat later to Australia for most service areas.

Forces for change

Apart from the criticisms that were aimed at traditional institutions by social researchers and social reformers, there were also important influences at work in the emergence of normalization theory and the application of human rights discourses to the fields of mental health, and intellectual and physical disability. The normalization principle emerged from Scandinavia in the 1960s (Bank-Mikkelsen 1969; Nirje 1964), and was popularised by Wolfensberger in the early 1970s (1972). While Wolfensberger s definition and philosophy developed over the next decade, he consistently emphasised the means of achieving the desired end, rather than simply the endpoint itself. In 1980 he defined normalization as The use of culturally valued means in order to live culturally valued lives , but suggested a change in terminology to social role valorization (Wolfensberger 1980, 1983). A key associated concept was that of the least restrictive alternative principle, which requires that the level of support provided should be at the minimum level to support the person with a disability. The intention of this principle is not to minimise assistance, but rather to minimise the creation of dependence (or indeed to avoid interference with the further development of an individual s independence). This concern with the possible creation of dependence has emerged not only with regard to areas such as intellectual and physical disability, but has also become evident among those working in the field of aged care (Baltes & Baltes 1990; Baltes & Silverberg 1994; Gibson 1985).

These trends were mirrored in such human rights developments as the United Nations Declaration on the Rights of Mentally Disabled Persons in 1971, and the United Nations Declaration on the Rights of Disabled Persons in 1975. These declarations emphasised the inherent right to human dignity , the need to become as self-reliant as possible and to hasten the process of their social integration and re-integration . Further attention was drawn to human rights issues among potentially vulnerable populations by the International Year of the Child in 1979, the International Year of Disabled Persons in 1981 and the United Nations Convention on the Rights of the Child 1989. The United Nations Resolution on the Protection of Rights of People with Mental Illness (UN 1991) also emphasised both the importance of human rights and the desirability of a more community-based pattern of service delivery.

As these trends among intellectuals and advocacy groups gained momentum, more attention began to be paid to the views of clients themselves. Developments in the USA in the 1950s and 1960s wrought change in that country, mirroring and influencing developments in other countries. The growing awareness of conditions in mental hospitals for people with intellectual and psychiatric disability was sharpened by the autobiographies and activism of former inmates. The search for and availability of treatment brought other options to the fore, as did the activism of parents of children with disabilities who sought improvements in institutions or support for care in the community (Braddock & Parish 2001). By the 1980s, it had become more common to read of the preferences of older people and those with disabilities to remain in their own homes. In the United Kingdom, the independent living movement gained rapid ground, particularly among people with physical disabilities (Morris 1993:17—21; Shearer 1982). In Australia, these ideas were emphasised with regard to older people in the aptly titled report of the House of Representatives Standing Committee on Expenditure *In a Home or at Home* (HRSCE 1982). This report emphasised the need to develop community-based services to allow people to remain at home in keeping with their own preferences.

Last, but certainly not least, there was the strong conviction among many policy makers, both politicians and public servants, that community-based care was a less costly alternative to institutional care (AIHW 1993:11). Where care is provided at home, there are often substantial cost savings associated with the availability of informal carers, and certainly home-based care does not (in the vast majority of cases) involve the provision of 24-hour care characteristic of most institutions. Moreover, there are also the substantial savings to be generated by the much more limited capital costs associated with the provision of home-based care services. In the field of aged care, for example, the issue of capital funding for aged care homes has proved to be a highly contentious policy issue as attempts to improve the quality of stock placed financial demands upon the aged care system (Gregory 1993, 1994). The closure of large-scale institutions in many cases also provided windfall gains for State and local governments through the sale of valuable real estate in prime positions. These capital savings are, of course, less relevant where large-scale institutions are replaced by group homes or small-scale community-based facilities which themselves require capital investment. The transitional costs of specific deinstitutionalisation initiatives can be considerable. The Richmond report in New South Wales considered a range of relevant transitional issues, including a chapter devoted to staffing and industrial issues staffing levels, entitlements, union demarcations, budgetary practices and other conflicting rigidities in the institutional system that had to be addressed in achieving a shift to community care (Richmond 1983, Part 1, ch. 8).

Implementation in Australia

While these ideas were gaining increasing currency, and there was growing activity among advocacy and special interest groups, there was little evidence of broad-scale implementation of deinstitutionalisation policies in Australian health and welfare services until the 1980s. But this decade, and the one that followed, saw the emergence of a range of important policy developments across all of the service areas discussed in this chapter. In the field of mental health and intellectual disability, the New South Wales based *Inquiry into Health Services for the Psychiatrically Ill and Developmentally Disabled* (Richmond 1983) and the federally based *National Inquiry into the Human Rights of People with Mental Illness* (Burdekin 1993) were key developments. In aged care, the so-called McLeay (HRSCE 1982) and Giles (Senate Select Committee on Private Hospitals and Nursing Homes 1985) reports were highly influential, supported by some of the work undertaken by advocacy groups, with such titles as *Prisoners of Neglect* (Social Welfare Action Group 1985), *If Only I'd Known* (ACC 1986) and *A Consumers' Eye*

View of Nursing Homes: Straight from the Heart (ADARDS 1987). In 1983, a major review of the Handicapped Persons Assistance Act and the associated programs and services for people with a disability was initiated by the Commonwealth Government. The recommendations of the review were published in a report entitled *New Directions* (DCS 1985), and implemented with the enactment of the *Disability Services Act 1986*.

Despite this upsurge of activity in the 1980s, one service area discussed in this chapter had begun its migration away from institutional care some decades earlier. Child protection services, having oscillated between home-based and institutional provision in the first part of the twentieth century, began to move steadily away from institution-based services in the late 1950s and 1960s. A highly influential piece of work by Bowlby (1951) on maternal deprivation linked emotional adjustment and mental health to maternal love and care in childhood, and other research in this period pointed in a similar direction. Government and non-government child welfare agencies reviewed their practices towards the institutionalisation of children in the light of this emerging research. The increasing emphasis was on care of children in the home, preferably their own home, but, if not, either in the care of family members or where necessary foster care. Western Australia and Queensland led the way, but a national trend was generally in place by the 1980s, with the closure of many large institutions (Senate Standing Committee on Social Welfare 1985:14).

In all of these reports and reviews, the principles of facilitating the move from segregated, institutionalised services to community-based services, and increasing the range of service options available, have been both central and explicit. The idea of improving the nature of institutional services themselves has received less consistent attention, although some (in particular the Richmond and Giles reports) have explicitly recognised the need for improved quality of services for those remaining in institutional care.

The nature of the shift varied partly with the field; in aged care services, for example, it was assumed that many older people could remain living in their own home, and assistance could be provided to them there through government services and the care of family members and friends. For a more dependent sub-set, it was assumed that the need for institutional care would continue, but that the conditions under which that care was provided could be improved.

In disability services, group homes emerged as a dominant service model in the deinstitutionalisation process in the 1980s, acting both as a destination for people moving out of institutions and an alternative for those who had previously lived elsewhere, and particularly with their families. In more recent years there has been an increasing awareness that a mix of services is preferred. There is recognition of the need to offer genuine choice, including not only group homes, home-based support services and individualised funding packages but also residual and redesigned facilities, such as cluster housing developments where that is the choice of the people and families involved (AIHW 1997a:47—8; Bracks 2001; Ryan 1997). The non-institutionalisation of people with disabilities was recognised as a significant trend, underpinned by the care and support of relatives with whom they live (see, for instance, AIHW: Wen and Madden 1998). The nature and quality of arrangements in the community remain important issues:

> We have recognised for some time that the greatest post deinstitutionalisation period challenge was to help people with intellectual disability become part of the community rather than being merely physically located in it. (Parmenter 2001:289)

In the mental health area, community-based care was intended to be substantially non-residential assistance, a shift facilitated by changing models of medical and pharmaceutical management of mental health problems. Here the movement towards deinstitutionalisation was undertaken in conjunction with an emphasis on the mainstreaming of mental health services. It was accepted that some institutional services would continue to be required, partly for the management of acute episodes, and for some on a continuing basis. A policy emphasis was placed on opening psychiatric wards within or in association with acute care hospitals, rather than the continuation of large-scale stand-alone psychiatric hospitals.

In the fields of aged care, disability services and mental health, the establishment of income support payments has been a significant underpinning to the shift towards community-based care. The emergence and growth of cash payments to sick people, older people and people with disabilities was, of course, the policy change that signalled the end of workhouses and almshouses at the turn of the century. While the term outdoor relief is now an historical oddity, it was the emergence of these cash payments (for example, the introduction by the Federal Government of the invalid and aged pensions in 1908) which signalled the first shift away from institutional provision for the old, the chronically ill, and the so-called blind, paralytic, lame, or idiotic (Dickey 1989). The contemporary array of income support payments includes the Age Pension, the Disability Support Pension, the Mobility Allowance, the Sickness Allowance, the Carer Allowance, and the Carer Pension (see Chapters 6 and 7).

For out-of-home care for children, the emphasis was initially on foster homes, and later on in-home placement with relatives and friends, and support of children within their own family home. In this area, too, the growing role of cash payments to support low-income families and sole parents which dates from the 1970s was an important component of the trend toward deinstitutionalisation, although generally not perceived in exactly those terms.

The term deinstitutionalisation has had little salience with regard to acute care hospitals, but here too the 1980s saw a trend towards limiting the use of institutional services. This shift came about partly through earlier release back to the community and partly through the dramatic expansion of day surgery, but both developments meant that more care was occurring in the home, and less in the institutional context. Thus, while the term deinstitutionalisation has not been applied in this sphere, it is certainly the case that there has been a shift of care, including post-acute care, from the hospital to the community setting.

In the area of housing, there is evidence of the demands that deinstitutionalisation is placing on services. The 1999—2003 Commonwealth—State Housing Agreement (CSHA) has an increased emphasis on social housing meeting the needs of low-income households whose needs cannot be met by the private rental market. Many of the households targeted in the new CSHA are not traditional low-income families but those that require some additional support for their housing needs to be met. This includes the need for modification to dwellings, access to specific health and community support services or for appropriate group housing. Criteria used in the wait list for public and community housing have been revised to include priority access to those groups who previously would have accessed institutionalised care. Housing agencies now, more than ever before, are providing the shelter component of assistance previously provided as part of the institutionalised setting.

Deinstitutionalisation, then, was about much more than the closure of large traditional types of institutions. It was about the need to provide a range of services which best suited the needs of the individuals requiring assistance. It involved the belief that many of those services would be better provided in the community, either in small community-based services or in the recipient s own home. It included an emphasis on cost containment. It was about a philosophy of care which emphasised better outcomes for individuals, and the maximisation of independence. It was about the need to develop community-based alternatives as much as the need to close large-scale institutions, and it was also about the need to reform institutional care itself.

In more recent times, deinstitutionalisation has emerged as a vehicle for promoting client choice and independence. However, there has been some recognition that deinstitutionalisation in itself is not a sufficient condition to ensure quality of care and quality of life. For some people institutional care will continue to be the best alternative; the challenge then becomes to develop a new generation of institutional care which maximises the advantages of such services for the individual resident, while minimising the disadvantages. Parmenter (1994), for example, has pointed to the prime importance of trying to determine the quality of life of people with a disability, wherever they live, and Young et al. (1998) have identified with some concern the relative lack of critical evaluation of deinstitutionalisation initiatives in Australia. Such reminders indicate a second sense in which governments and service providers can continue to pursue a policy of deinstitutionalisation by further reducing the institutional aspects for those who continue to require 24-hour care in a residential setting.

Institutions: context and history

These brief descriptions of deinstitutionalisation in different areas of service, when considered together with some of the historical material presented earlier, illustrate an important but often neglected aspect of our understanding of institutions that understanding is historically and contextually specific. The concept of institution evident in the quote presented early in this chapter does not represent a modern-day aged care home; the nature of what constitutes acceptable institutional care has undergone a substantial transformation over the course of the last 40 years, and indeed over the course of the last century.

But these historical changes are not limited to our understanding of the traditional institution. The shift towards group homes for people with intellectual disabilities, which was seen as the epitome of deinstitutionalisation in the 1970s and 1980s, is now being regarded by some in the disability services field as a staging post, a type of halfway house between institutional care and independent living. The perception of independent living for people with intellectual disabilities has itself undergone its own transformation, with changing expectations compared with those which predominated 20 years ago. The shifting nature of what constitutes an institution is a contemporary, as well as an historical, phenomenon.

These perceptions do not only change over time, they also differ from field to field. There is no evidence in the aged care field, for example, of a belief that institutional care as provided in a large-scale aged care home is an inappropriate form of care for frail or disabled older people, once a certain level of dependency is reached. Yet such statements are regularly made with regard to younger people with disabilities, and with regard to people with mental illnesses, and with regard to children. The idea of a group home has hardly emerged in the aged care services area, although it is commonplace in both disability services and substitute care for children.

These changing perceptions of institutions have interesting implications for policy makers and advocates, who may find that there are useful models or examples which can be borrowed from quite separate fields of community and health services. Changing perceptions also have implications for data development the statistician who attempts to document the process of moving from the institutional context to the community context has a difficult task, as the category of institution is itself changing. Just as census and survey definitions change over time, so too do people s perceptions of what falls into a specific category. It is impractical and indeed undesirable to halt such changes, but the consequence is that we must learn to live with some imperfections in our counting rules when we are describing a social phenomenon which is itself changing over time.

The role of informal care

Informal carers have traditionally provided the bulk of care and assistance to those who cannot fully care for themselves.[1] The shift from institutional care to community care has in many cases included the recognition that there is an increased reliance on informal carers. This has resulted in the development of programs specifically aimed at supporting carers, in particular respite provisions either at home, in a day centre or in a residential context, and the provision of income support through the Carer Payment, and further cash assistance via the Carer Allowance.

The question of cash payments for carers is an area of some policy debate. In Australia, informal carers are generally not paid from government funds for the care which they provide. Foster care programs, for example, reimburse carers of children in substitute care for expenses but provide no financial reimbursement for the work and care involved. Carers pensions are a form of income support for those unable to participate in the labour market as a result of their caring responsibilities; they are not intended as payment for services provided. Some overseas countries have, however, chosen to move partly in this direction. In Germany, under the current system of provision,

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[1] See Chapters 2, 6 and 7.

eligible recipients may opt for a discounted cash payment as an alternative to direct service provision. They may then use that money to pay family or friends to perform the caring role (OECD 1996:44).

The adequacy of community-based support is of direct relevance for such carers, and there are also questions to be considered as to what degree of assistance can be expected from informal carers, particularly where ongoing care is required. Is the right to participation in the paid workforce, for example, something that informal carers can legitimately claim? Current respite services are aimed at giving carers a break from their caring responsibilities, and not at providing them with regular assistance consistent with paid workforce participation. In a system which aims to accommodate increasingly disabled people in the community, the needs and rights of carers is an area which undoubtedly deserves further scrutiny.

4.3 Analysing the census data

Despite the differences evident among the program areas, there was a clear trend emerging by the 1980s towards policies which emphasised the deinstitutionalisation of health and welfare services. The impact of these policy trends is examined at the broadest possible level by exploring the patterns evident in the national census data for the period from 1981 to 1996.

Table 4.1: Living arrangement, by sex, 1981, 1986, 1991 and 1996

Living arrangement	Males	Females	Persons
1981			
Private dwellings	6,807,842	6,926,223	13,734,065
Health and welfare institutions	73,574	121,669	195,243
Other institutions	37,578	26,799	64,377
Non-institutional population	129,637	59,433	189,070
Other (including not stated)	218,445	175,130	393,575
1986			
Private dwellings	7,397,455	7,522,775	14,920,230
Health and welfare institutions	83,278	145,436	228,714
Other institutions	39,954	25,151	65,105
Non-institutional population	122,141	57,293	179,434
Other (including not stated)	126,399	85,579	211,978
1991			
Private dwellings	7,960,489	8,137,289	16,097,778
Health and welfare institutions	61,598	107,342	168,940
Other institutions	36,849	25,293	62,142
Non-institutional population	88,450	48,020	136,470
Other (including not stated)	215,429	169,781	385,210
1996			
Private dwellings	8,514,393	8,753,432	17,267,825
Health and welfare institutions	74,275	135,911	210,186
Other institutions	46,222	31,788	78,010
Non-institutional population	107,065	56,957	164,022
Other (including not stated)	107,272	65,115	172,387

Source: AIHW analysis of ABS census data.

The broad trends

In 1996, and indeed for the entire period under scrutiny in this chapter, the vast majority of people lived in private dwellings (96.5%). The focus of this chapter, however, is on that small minority of the population who did not live in private dwellings those 210,186 people who, at the time of the 1996 Census, were resident in a health or welfare institution. Health and welfare institutions as defined here are based on relevant census data categories and include residential services for children, corrective institutions for children, residential services for people with a disability, aged care residential services, psychiatric institutions, and hospitals.

The number of people living in health and welfare institutions increased by 8% between 1981 and 1996, but this overall trend conceals a shift in trends over the 15-year period. In broad terms, there was substantial growth between 1981 and 1986, followed by a reduction in the following decade. In 1981, there were 195,243 people living in health and welfare institutions, a figure which increased to 228,714 by 1986. By 1996, this figure had dropped to 210,186, an 8% decrease over the decade (Table 4.1).

These trends are consistent with the information reported in the next section, where the data are drawn from administrative by-product collections. They are clouded, however, by the other category in Table 4.1, which includes a proportion of not-stated responses. The quality of classification of non-private dwelling data for the Census has been the subject of criticism in the past, and considerable effort was made to improve this aspect of the data in the 1996 Census, with a pleasing consequent decrease in the other category.[2] In particular, it seems likely that the substantial increase in the number of other responses in 1991 (an 82% increase from 1986) is partly responsible for the decrease in the number of people recorded as accommodated in health and welfare institutions in that year (and indeed for the decrease in the other institutions and non-institutional population categories). For this reason, the 1986 to 1996 trend is taken to be a more robust indicator of the pattern of change over the period.

The pattern of growth in the institutional population followed by decline should be interpreted, of course, in the context of a substantial amount of growth in the population as a whole over the 15-year period (24%). Residency rates provide a useful measure of the pattern of institutionalisation, as they illustrate the rate of use independent of the effects of the growth of the population. Residency rates increased marginally from 13.1 per 1,000 people in 1981 to 14.3 per 1,000 in 1986, dropping to 11.5 per 1,000 by 1996.

Types of institutions

While considering the overall trends discussed in this section of the chapter, it is important to recognise that these six types of institutions (residential services for children, corrective institutions for children, residential services for people with a

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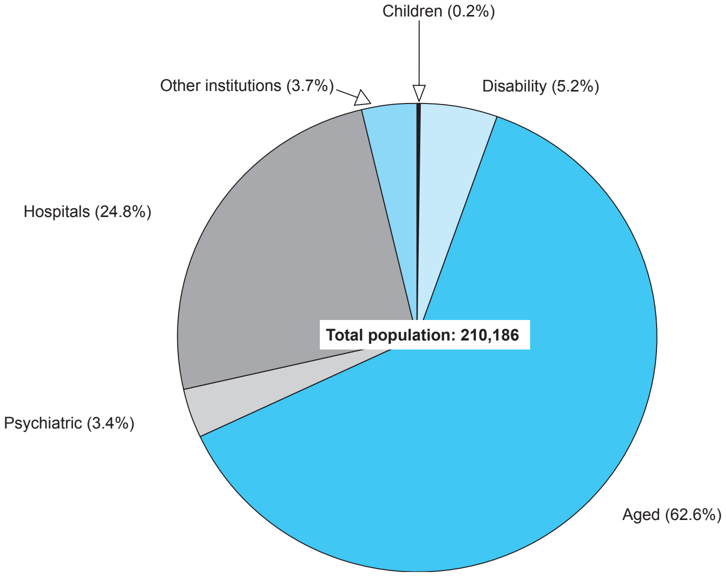
[2] See Fine et al. (1995) for a further account of the difficulties in analysing non-private dwelling census data. This report also provides a useful resource on institutional populations between 1976 and 1991.

disability, aged care residential services, psychiatric institutions, and acute care hospitals) do not account for equal proportions of the population resident in health and welfare institutions. Residential aged care services account for by far the largest proportion (62.6% or 131,598 people in 1996). A further 52,193 people were accommodated in hospitals at the time of the 1996 Census. Disability services institutions accounted for 10,919 persons and psychiatric institutions for 7,135 residents. Children in residential services or corrective institutions constituted only a small proportion of the health and welfare institutional population (Figure 4.1).



Source: Table A4.1.

Figure 4.1: Population in health and welfare institutions, 1996

Age and sex trends

In 1996, the majority of people in health and welfare institutions were women (64.7%). Women aged 80 or over made up 58.4% of women, and 37.8% of all people, in such institutions. While older age groups also predominate in the male population, the trend is much less marked, with only 32.3% of men in health and welfare institutions being aged 80 or more. Men aged 80 and over make up only 11.4% of the total population of health and welfare institutions, but, taken together with women aged 80 and over, this means that 49.2% of people in these institutions in 1996 were aged 80 and over. The higher proportion of women is a consequence of higher rates of use at older ages. Women on average have a higher life expectancy than men and therefore are more likely to be both alive and without the informal care of a spouse at extreme old age. At younger ages, the proportions of males and females in health and welfare institutions are similar (Table 4.2).

Table 4.2: Australians living in health and welfare institutions, by age and sex, 1981, 1986, 1991 and 1996

Age/sex	1981	1986	1991	1996
Males				
0–14	8,126	6,563	5,182	4,100
15–24	6,804	6,537	3,120	3,219
25–39	7,665	9,340	5,706	7,083
40–64	17,409	17,893	12,082	13,836
65–79	19,971	24,405	19,136	22,023
80+	13,819	18,540	16,372	24,014
Total males	*73,794*	*83,278*	*61,598*	*74,275*
Females				
0–14	6,256	5,182	4,955	3,337
15–24	9,195	8,292	3,763	3,512
25–39	11,372	12,370	7,591	8,361
40–64	15,405	15,691	10,135	11,606
65–79	30,580	39,335	27,432	29,668
80+	49,031	64,566	53,466	79,427
Total females	*121,839*	*145,436*	*107,342*	*135,911*
Persons				
0–14	14,382	11,745	10,137	7,437
15–24	15,999	14,829	6,883	6,731
25–39	19,037	21,710	13,297	15,444
40–64	32,814	33,584	22,218	25,442
65–79	50,551	63,740	46,567	51,691
80+	62,850	83,106	69,838	103,441
Total persons	**195,633**	**228,714**	**168,940**	**210,186**

Source: AIHW analysis of ABS census data.

Back in 1981, at the beginning of the period under scrutiny, women also predominated, although to a slightly lesser extent (62.3%). The 15 years have, however, seen a fairly dramatic change in the age structure of the group, with only 32.1% of those in health and welfare institutions being aged 80 or over in 1981 (Figure 4.2). This represents a substantial increase in the proportion at older ages, and a corresponding decrease in the proportions at younger ages.

The dimensions of this change in patterns of institutionalisation are evident (Table 4.3) when one examines the percentage change in the institutional population for different age groups over the period. There was a marked decline at younger ages, a more modest decline in the middle age groups, and an increase for those aged 80 and over.[3]

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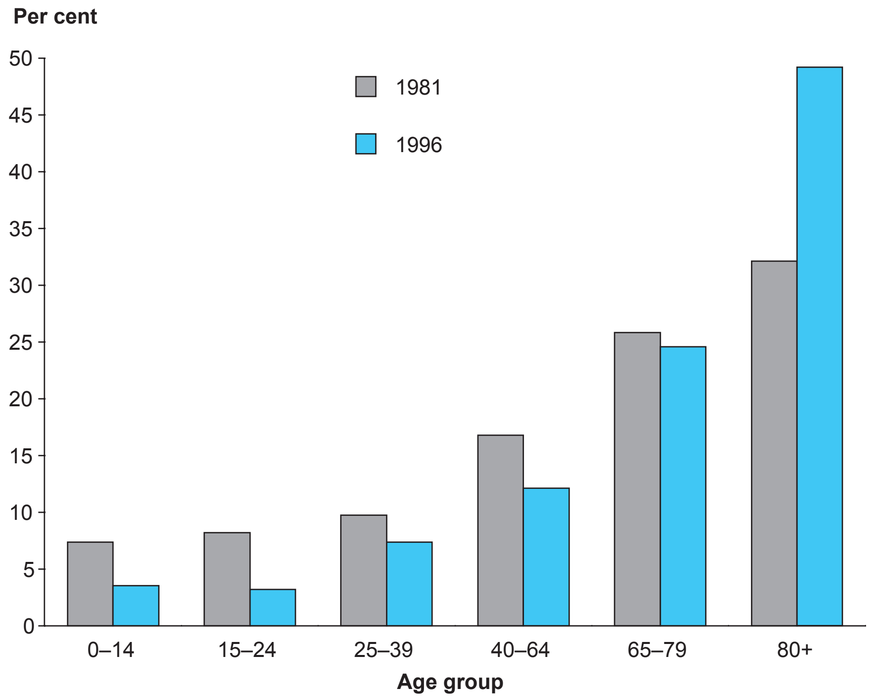
[3] As already noted, the 1991 data appear less reliable with regard to the numbers of people in health and welfare institutions given the large increase in the ‘other’ category in that year. Consequently this discussion emphasises the trends between 1981 and 1986 and between 1986 and 1996.



Source: Table 4.2.

Figure 4.2: Age structure of population in health and welfare institutions, 1981 and 1996

Between 1981 and 1996, there was a 48.3% decline in the number of people aged 0—14 accommodated in health and welfare institutions, and a 57.9% decline among those aged 15—24. These decreases were similar for both males and females, except in the 15—24 age group, where the number of females decreased faster than the number of males. This decrease occurred despite the fact that the total number of people in these age groups was growing as a result of population growth. The movement away from institutional care has thus, on the evidence of these data, been strongest among children and young adults.

For those in the next two age groups (25—39 and 40—64), there has been a more modest decline in the number accommodated in health and welfare institutions (18.9% and 22.5% respectively), with the change occurring in the period between 1986 and 1996. When the data are examined separately by sex, however, it is clear that this decline was much less evident among men aged 25—39 (a 7.6% reduction).

For the older age groups, there has been a very small increase in the numbers of people aged 65—79 living in institutions (2.3%). However, this 15-year trend is a combination of an increase between 1981 and 1986, and a decrease between 1986 and 1996. Again, the decrease in the decade to 1996 is much more marked in the female than the male population. In the 80 and over population, there has been a substantial growth in numbers between 1981 and 1996, a trend which is evident for both sexes. Overall, the size of the institutionalised population aged 80 and over grew by 64.6% during the 15-year period.

Table 4.3: Growth rates for persons in health and welfare institutions, by age and sex, 1981–1986, 1986–1996, and 1981–1996

Age/sex	1981–1986	1986–1996	1981–1996
Males			
0–14	–19.2	–37.5	–49.5
15–24	–3.9	–50.8	–52.7
25–39	21.9	–24.2	–7.6
40–64	2.8	–22.7	–20.5
65–79	22.2	–9.8	10.3
80+	34.2	29.5	73.8
Total males	*12.9*	*–10.8*	*0.7*
Females			
0–14	–17.2	–35.6	–46.7
15–24	–9.8	–57.6	–61.8
25–39	8.8	–32.4	–26.5
40–64	1.9	–26.0	–24.7
65–79	28.6	–24.6	–3.0
80+	31.7	23.0	62.0
Total females	*19.4*	*–6.5*	*11.5*
Persons			
0–14	–18.3	–36.7	–48.3
15–24	–7.3	–54.6	–57.9
25–39	14.0	–28.9	–18.9
40–64	2.3	–24.2	–22.5
65–79	26.1	–18.9	2.3
80+	32.2	24.5	64.6
Total persons	**16.9**	**–8.1**	**7.4**

Source: AIHW analysis of ABS census data.

This growth in the very old population living in health and welfare institutions reflects the rapid growth occurring in that age group over the period in question. Residency rates give an indication of the pattern of use distinct from changes driven by population size. They show the proportion of the population in that age and sex group who were living in institutions at different points in time, thus controlling for the effects of population growth in making a time-series comparison (Table 4.4).

The data on residency rates for the younger age groups confirm the strong trend towards reduced use of institutional accommodation, with the rate of use essentially halving. For those aged under 14, residency rates dropped from 3.9 per 1,000 to 1.9 per 1,000 between 1981 and 1996, with the corresponding figures for the 15—24 age group being 6.2 and 2.5. The patterns were consistent for both sexes.

There has also been a reduction in residency rates for those aged 25—39, although this trend is less pronounced than that for younger ages. The rate of use dropped from 5.5 per 1,000 in 1981 to 3.6 per 1,000 in 1996, with the reduction being more pronounced among women. There was a more substantial shift in the 40—64 age group, from 8.9 per 1,000 in 1981 to 4.9 per 1,000 in 1996.

Table 4.4: Residency rates of people living in health and welfare institutions, per 1,000 persons in the total population, by age and sex, 1981, 1986, 1991 and 1996

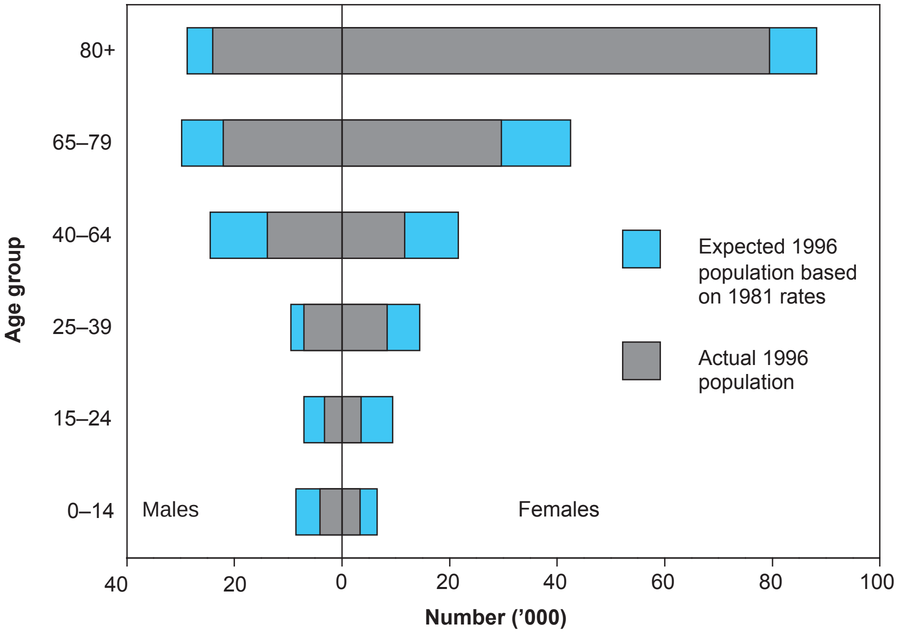
Age/sex	1981	1986	1991	1996
Males				
0–14	4.3	3.5	2.7	2.0
15–24	5.2	4.8	2.2	2.4
25–39	4.4	4.8	2.7	3.3
40–64	9.3	8.7	5.1	5.3
65–79	37.5	40.1	27.0	27.8
80+	173.1	183.5	127.3	144.5
Total males	*9.9*	*10.4*	*7.1*	*8.2*
Females				
0–14	3.4	2.9	2.7	1.8
15–24	7.2	6.3	2.8	2.7
25–39	6.7	6.4	3.7	3.9
40–64	8.4	7.8	4.4	4.5
65–79	45.9	51.8	31.9	32.1
80+	277.2	302.7	209.3	249.6
Total females	*16.3*	*18.1*	*12.4*	*14.8*
Persons				
0–14	3.9	3.2	2.7	1.9
15–24	6.2	5.5	2.5	2.5
25–39	5.5	5.6	3.2	3.6
40–64	8.9	8.3	4.8	4.9
65–79	42.2	46.6	29.7	30.1
80+	244.8	264.4	181.8	213.6
Total persons	**13.1**	**14.3**	**9.8**	**11.5**

Source: AIHW analysis of ABS census data.

While the actual numbers at older ages have increased over the period, the residency rates show a clear downward trend. There has been a marked reduction in the residency rates at ages 65—79, from 42.2 per 1,000 to 30.1 per 1,000. The reduction is slightly more evident among women, but residency rates for women remain somewhat higher than those for men in this age group (32.1 per 1,000 compared with 27.8 per 1,000). At ages 80 and over, the rates have also declined, from 244.8 per 1,000 to 213.6 per 1,000. The pattern was more pronounced for men. The residency rates for women remain significantly higher than those for men throughout the period. In 1996, they were 249.6 per 1,000 for women and 144.5 per 1,000 for men.

While residency rates at older ages declined between 1986 and 1996, there was an increase in the period between 1981 and 1986. This pattern of an increase followed by a decrease was consistent with the policy directions of the period, as in aged care the emphasis on expanded home-based care options, and control of the expansion of residential aged care beds, did not come into play until the mid-1980s. Between 1986 and 1996, residency rates declined from 46.6 to 30.1 among those aged 65—79 and from 264.4 to 213.6 among those aged 80 and over.

Figure 4.3 shows the number of people in each age group who would have been in health and welfare institutions in 1996 if the 1981 patterns of use had been maintained until that time. In other words, it shows the situation as it would have been if the rate of institutionalisation in 1981 had continued into the present and if other factors (e.g. technology, pharmaceuticals) had remained unchanged. The differences are significant: there would have been an extra 7,700 under 14; 9,700 aged 15—24; 8,500 aged 25—39; 20,700 aged 40—64; 20,600 aged 65—79; and 13,500 aged 80 and over. Taken together, this totals 80,700 people, or 38% more people than were actually present in health and welfare institutions in 1996.



Source: Table A4.2.

Figure 4.3: Population that would have been in health and welfare institutions in 1996 based on 1981 residency rates, compared with actual population in health and welfare institutions in 1996

4.4 Specific policy areas

Aged care

Policy context

By the early 1980s, there was a general recognition in the aged care field that Australia had an overly large and expensive long-term institutional-care sector, and a correspondingly under-developed home-based care sector. A series of government reports emphasised the need for this shift in emphasis towards community-based care (DCS 1986; HRSCE 1982; Senate Select Committee on Private Hospitals and Nursing Homes 1985). Since 1985, the whole system has experienced a lengthy period of substantial reform, aimed at improving the level of efficiency, equity of access, service quality and responsiveness.[4] These reforms (loosely referred to as the Aged Care Reform Strategy) were initiated under a rubric of social justice combined with fiscal restraint; in 1997, a further round of reforms (the *Aged Care Act 1997)* emphasised the need for cost containment and efficiency, in addition to improved service quality and responsiveness. New directions included the merging of the former nursing home and hostel sectors into a single system, and a greater focus on user charges aimed at improving the sustainability of the aged care system.[5]

A key component of these reforms has been the drive to reduce reliance on institutional care for older people, and to increase the range of services available in the community. In 1986, an official planning ratio of 100 places (40 nursing home places plus 60 hostel places) per 1,000 people aged 70 and over was established to guide the allocation of additional nursing home and hostel places in the institutional care sector. The aim was both to contain growth of the sector overall, and to shift the balance of supply away from the more intensive nursing home care and toward less intensive hostel care. In 1985, the Home and Community Care Program (HACC) was implemented by combining and expanding a number of existing community care services previously delivered under a range of disparate arrangements. Between 1992 and 1995, the official planning ratio for residential care was progressively revised down to 90 places per 1,000 persons aged 70 and over, with 10 equivalent places per 1,000 people aged 70 and over to be supplied through community aged care packages. The latter program had commenced in 1992 to further expand access to home-based care.

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[4] The Aged Care Reform Strategy emerged from a series of government reviews and inquiries during the 1970s and 1980s. These reviews and inquiries raised concerns as to the over-supply of institutional care, the quality of services provided, the efficiency and equity of the system, and the lack of flexibility and responsiveness to service users. See, for more detailed information, Gibson (1996), Gibson (1998) and DHHCS (1991).

[5] See AIHW (1997b:255–8) and AIHW (1999:176–7).

Community-based services

The HACC program provides a range of home-delivered and community-based services to older people and to younger people with disabilities. The target group for the program is described as people with moderate to severe disabilities living at home, and their carers. The program provides assistance in the form of home help, personal care, home nursing, delivered meals, centre-based meals, in-home respite, centre-based respite, home maintenance, transport and paramedical services. It is jointly funded by the Commonwealth, State and Territory Governments, and generally delivered by not-for-profit agencies, although local governments have traditionally played a significant role in Victoria. Some larger agencies (e.g. Home Care in New South Wales and Silver Chain in Western Australia) provide a range of services to clients, while others are service-specific. The HACC program also provides some brokerage services through community options or linkages projects, which coordinate services for clients with more complex care needs.

While the HACC program provides the bulk of community care services to older people, the community aged care package program has been growing rapidly since its inception in 1992, and particularly so in more recent years. From a base of 235 packages in 1992, it grew to 6,124 in 1997, and then quadrupled over the next four years to reach 24,430 packages in 2001. This Commonwealth-funded program provides a similar range of services to the HACC program (excluding home nursing), and is aimed at assisting people who would otherwise require low-level care (formerly hostel care) in an aged care home. The key difference between community aged care packages and HACC is that community aged care packages involve a central agency which organises all services required by the client, either through direct provision or purchase from other agencies.

The broad concept of aged care homes has remained largely unchanged through this period, without the shifts towards cluster housing or group housing which have emerged in mental health and disability services. An alternative style of accommodation for older people has emerged in the private sector with the creation of retirement villages, but these are not aimed at highly dependent older people. While there are no national data on retirement villages, they are recognised as an increasingly popular alternative for some older people.

Although aged care institutions may not have developed in the same way as those in the mental health and disability services fields, it would be wrong to suggest that institutional care for older persons has remained a static phenomenon. Reforms over the period have seen attention paid to de-institutionalising aspects of aged care homes, with an increasing emphasis on the desirability of one resident per room, and a rejection of the old ward style provision of residential services. Values such as privacy, dignity, choice, individuality and a home-like environment were emphasised by the quality control mechanisms put in place in the late 1980s, and there is considerable evidence of shifts in the style of care which is deemed to be acceptable in aged care homes (AIHW 1997b; Braithwaite et al. 1993). These values remain evident in the revised system of accreditation implemented under the *Aged Care Act 1997*.

Trends over time

Services

The national database on aged care homes (formerly nursing homes and hostels) provides the most reliable source of data on the use of institutional care by older people in Australia. Unlike census data or survey data, which can be affected by classification problems, these data provide an exhaustive accounting of those being cared for in aged care homes as they are based on financial information systems. While detailed data are really only available for the 1990s, there are some baseline data for earlier periods. In 1981, the level of residential provision was 111 places per 1,000 people aged 70 and over. This had fallen to 99 places per 1,000 people aged 70 and over by 1985, and to 94 places per 1,000 people aged 70 and over by 1991. In 1995, this fell further to 90 places per 1,000 people aged 70 and over, and then again to 82 places per 1,000 people aged 70 and over in 2001. This change is even more marked if one takes into account the ageing of the aged population which occurred during this period. The use of residential aged care services increases sharply at around age 80, and even more so at age 85. In 1981, 11% of the population aged 70 and over were aged 85 or over; by 2000 this proportion had increased to 15%.

Table 4.5: Aged care institutionalisation rates, age by sex, 30 June 1992 and 2000

	Females		Males		Persons	
Age	**1992**	**2000**	**1992**	**2000**	**1992**	**2000**
65–69	7.8	6.5	8.2	6.8	8.0	6.7
70–74	19.8	16.7	16.1	14.7	18.1	15.7
75–79	54.5	44.0	36.0	31.2	46.8	38.5
80–84	137.3	111.9	80.3	65.2	116.3	93.8
85+	362.3	315.3	202.9	174.7	316.0	271.8
Total 65+	**73.3**	**72.2**	**33.7**	**33.2**	**56.3**	**55.0**

Source: AIHW analysis of DHAC data.

More detailed data on residency rates in aged care institutions are presented in Table 4.5 for the period from 1992 to 2000. These data show a decline in residency rates for all age groups. The decline has been most marked in the 80—84 age group, dropping from 116 persons per 1,000 to 94 persons per 1,000 and in the 85 and over group, dropping from 316 persons per 1,000 to 272 persons per 1,000.

Table 4.6 provides data on the hours of HACC service provision in relation to the numbers of people aged 70 and over. For personal care, in-home respite care, and centre day care there has been a substantial increase in the hours of service delivered. Home maintenance services and paramedical services also increased. For home nursing and home help services, there has been a decrease in the number of hours provided per 1,000 persons aged 70 and over, and there has also been a decrease in the provision of home-delivered and centre-based meals per 1,000 persons aged 70 and over. Given the rapid growth of the population aged 70 and over during this period, these changes in HACC service delivery per 1,000 persons aged 70 and over are underpinned by a substantial absolute growth in the program over the period from 1985 onward, as is evident in the expenditure data (AIHW 1995; Chapter 6 of this volume). This growth was, however, more rapid in the early to mid-1990s, and has slowed in more recent years.

Table 4.6: HACC[(a)] service provision, in a sample month, by main service type, 1993–94 and 1999–00[(b)]

	Per 1,000 persons aged 70 and over	
Service type	**1993–94**	**1999–00**
Home help (hours)	428	378
Personal care (hours)	109	150
Home nursing (hours)[(c)]	206	129
Paramedical (hours)	20	24
Respite care (hours)	155	192
Centre day care (hours)	421	539
Home maintenance (hours)	42	48
Home meals (meals)	746	683
Centre meals (meals)	101	91

(a) Home and Community Care.

(b) Data on transport, other food services and other unspecified services are not included in this summary table. For more detailed information, see Table A6.2.

(c) Home nursing services are not provided by the Northern Territory.

Source: DHAC unpublished data; AIHW 1999:186.

At the same time, there has been an expansion of community aged care packages since their inception in 1992. The level of provision increased from 1 per 1,000 persons aged 70 and over in 1994 to 4 per 1,000 in 1997, and then more rapidly to 11 per 1,000 in 2001 (see Chapter 6: Table 6.12).

Expenditure

Table 4.7 documents expenditure on home-based and institutional care services in the aged care sector over the 14-year period from 1985—86 to 1999—00. Over this period, total recurrent expenditure on aged care services (including nursing homes and hostels, HACC (including Community Options) and the more recent community aged care packages and National Respite for Carers Program) has increased from $1,379.4 million to $4,612.6 million. This represents an increase of 111% in real terms since the mid-1980s and an increase of 49% since 1993—94.

With the inception of HACC in the mid-1980s, followed by community aged care packages and the National Respite for Carers Program in the early to mid-1990s, it is no surprise that the increase in community care funding has been more dramatic than the increase in residential care funding: 263% in real terms since 1985—86, compared with 93% for residential care. However, this difference is not as dramatic for recent years. Since 1993—94, the increases in recurrent expenditure for community and residential care have become more similar, at 57% and 47% respectively.

Table 4.7: Recurrent expenditure on aged care, by sector, 1985–86 to 1999–00 ($m)

Sector[(a)]	**1985–86**	**1987–88**	**1989–90**	**1991–92**	**1993–94**	**1995–96**	**1997–98**	**1999–00**
				Current prices				
Community care	151.8	234.1	322.2	413.2	498.5	587.1	714.3	871.3
Residential care	1,227.6	1,553.2	1,827.3	2,145.0	2,283.4	2,695.0	3,381.0	3,741.3
Total	*1,379.4*	*1,787.3*	*2,149.6*	*2,558.2*	*2,782.0*	*3,282.1*	*4,095.3*	*4,612.6*
				Constant prices[(b)]				
Community care	235.1	329.4	399.8	463.2	541.9	620.6	731.1	852.5
Residential care	1,900.8	2,185.4	2,267.2	2,404.7	2,482.0	2,848.8	3,460.6	3,660.8
Total	*2,136.0*	*2,514.8*	*2,667.0*	*2,867.9*	*3,023.9*	*3,469.5*	*4,191.7*	*4,513.3*
				Proportion (per cent)				
Community care	11.0	13.1	15.0	16.2	17.9	17.9	17.4	18.9
Residential care	89.0	86.9	85.0	83.8	82.1	82.1	82.6	81.1
Total	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*

(a) Community care includes Home and Community Care (HACC), Community Options (COPs), Community Aged Care Packages (CACP) and expenditure on the National Respite for Carers Program (NRCP).

(b) Deflated to constant prices using the 1998–99 GFCE deflator (ABS 2000).

Source: AIHW health expenditure database; DHAC 1998, 2000a, unpublished data; DHFS 1996.

The relative allocation of funds between community and residential care shows a rapid change in favour of community care between 1985—86, when 11% of expenditure was devoted to community care, and 1993—94 when this proportion reached 18%. In the period from 1993—94 to 1999—00, the proportion has remained relatively stable, at around 17—19%.

Disability services

Policy context

As discussed in Section 4.2, the late 1960s and early 1970s saw important changes in attitudes toward disability, driven by normalization theory and the growth of the human rights movement.[6] These changing attitudes were translated into changes in policies and services in the 1980s, with a greater emphasis on consumer involvement, integration, and an emphasis on moving away from institutional models towards community-based services. These directions were clearly evident in the *Disability Services Act 1986.*

In 1991, the first Commonwealth / State Disability Agreement (CSDA) was signed by the Commonwealth and State and Territory Governments. Under the first CSDA, the Commonwealth assumed responsibility for employment services and agreed to provide transition funding of $5 million in 1991—92, increasing to $53 million in 1995—96 to help with the process of transferring accommodation services from the Commonwealth to the States and Territories. Key initiatives implemented with these funds included the closure of institutional-style services, such as special purpose nursing homes and hostels, and the opening of community-based services, including group homes and

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6 See AIHW (1993, chs 1 and 6) for a further account of these developments.

community access/recreation services for clients living in the community. The second CSDA (1998) confirmed Commonwealth responsibility for the planning, policy setting and management of employment services, with the States and Territories having these responsibilities for all other specialist disability services (see Box 7.7 for definitions of service types). Advocacy, print disability and information services are considered shared responsibilities under this agreement.

In relation to accommodation services, the deinstitutionalisation of disability services has thus, during the 1990s, been largely a State and Territory government responsibility, with each jurisdiction introducing a range of reforms emphasising community-based care and in-home support. There were developments also in the field of employment support services. As part of the 1986 reforms at Commonwealth level, employment services were separated from other support services, reflecting the move away from whole-of-life service provision by one organisation. Open employment services are now a significant feature of CSDA service funding by the Commonwealth, accompanied by initiatives to move away from the sheltered employment model. Commonwealth income support payments such as the Disability Support Pension and the Carer Allowance provide financial support to people with disabilities and their families living in the community (see Box 7.5 and Tables 7.6—7.8). These payments are (respectively) descendants of the Invalid Pension, first introduced in 1910 as significant outdoor relief , and the Handicapped Child s Allowance introduced in 1974 (AIHW 1993:279).

The shift towards community-based care is continuing in jurisdictions across Australia. Different terms are used to describe the process, and there are some differences in policy approaches. In New South Wales, for example, devolution describes a staged approach aimed at moving all people currently in institutions into community-based accommodation over the next 10 years. In Victoria, the redevelopment of institutions is in process through a combination of closure, infrastructure improvement and the development of new cluster housing. A number of alternative systems of assistance have been put in place in all States and Territories to support community-based living for people with disabilities. A particular landmark in 2000 was the closure of Australia s oldest institution for the care of people with an intellectual disability the Willow Court Centre in Tasmania. The centre closed its doors after 173 years; since 1987, almost 300 residents had been progressively relocated to community-based services (Jackson 2000).

Community-based services

In-home support services and individual support packages

These services provide support and assistance to people with disabilities living independently in the community, most often with the assistance of family and friends. Services provided under the CSDA include attendant care, in-home living support, recreation and holiday programs, social and community support and respite services. During the 1990s, State and Territory Governments committed growth funds to an expansion of services, such as post-school options, service brokerage and early intervention, to help prevent or delay the need for out-of-home accommodation. Services provided under the HACC program are also an important source of assistance to people with disabilities, and to informal carers.

Another recent development is the growth in individual funding packages, which allocate funding to the individual consumer, with the aim of providing a flexible mix of services to meet the individual s needs. There is considerable variation from jurisdiction to jurisdiction in the way in which these packages operate, with some providing funds to the individual directly and some via a brokerage agency, with varying degrees of input from the client in deciding what services are purchased.

Group homes

Group homes provide combined accommodation and support services to people living in the community. Usually no more than six people live in a house, and a single organisation controls the house and provides support services. Group homes appear to remain the dominant accommodation model for people with intellectual disability moving out of institutional settings (Bostock et al. 2001), and are generally accepted as an important community-based accommodation option. However, questions have been raised about the degree of autonomy and choice experienced by the residents of some group homes (AIHW: Maples & Madden 1996; Parmenter et al. 1994), and more individualised in-home support options are also being emphasised. Increasingly, the group home is being seen as a half-way house , in both the physical and policy senses, in the evolving deinstitutionalisation process.

Centre-based care

Despite the general trend to community-based care, there is a recognition that some form of centre-based care is needed as an option within the disability services system (Young et al. 2001). Here, too, however, there are moves away from traditional large-scale institutions, with cluster housing as in the case of Kew Residential Services emerging as a viable alternative (Bracks 2001). Cluster housing models have been implemented or flagged for development in several jurisdictions, including Queensland, Victoria and New South Wales. The redevelopment of existing institutional sites to reduce the scale of facilities is also occurring (Bostock et al. 2001:36; Emmerson et al. 2000).

Trends over time

The main source of data for looking at trends over time in the accommodation of people with disabilities is the Survey of Disability, Ageing and Carers conducted by the Australian Bureau of Statistics in 1981, 1988, 1993 and 1998. Despite some changes in methodology between the surveys, comparisons are possible for the 17-year period from 1981 to 1998. As is evident from Table 4.8, the proportion of people with a severe or profound core activity restriction living in cared accommodation has decreased substantially over this period. Persons with a severe or profound core activity restriction are those who always or sometimes require personal assistance or supervision with activities of daily living (self-care, mobility and verbal communication).

For those aged 5—64 with a severe or profound core activity restriction, the percentage living in cared accommodation fell from 10% in 1981 to 3% in 1998. The reduction is very pronounced in the 15—29 age group, moving from 19% in 1981 to 3% in 1998. The proportion of such persons aged 5—14 living in cared accommodation has all but disappeared, at 0.4% in 1998. Much of this change occurred during the 1980s for the younger age groups, but at middle to older ages the changes were more concentrated in the 1990s.

Table 4.8: People aged 5–64 with a severe or profound core activity restriction, by accommodation type and age, 1981–1998

Year	5–14	15–29	30–44	45–64	5–64
Living in cared accommodation					
1981	3,525	7,340	4,920	11,253	27,038
1988	997	6,866	5,533	10,815	24,211
1993	1,130	3,091	6,165	8,756	19,142
1998	471	2,541	5,608	10,803	19,423
Per cent					
1981	8.5	18.9	8.4	8.5	10.0
1988	1.8	13.1	7.0	7.8	7.4
1993	1.6	4.5	6.3	5.6	4.9
1998	0.4	2.8	3.8	3.5	2.9
Living in households					
1981	38,023	31,470	53,420	121,236	244,149
1988	54,286	45,492	74,063	128,652	302,493
1993	69,581	64,846	92,360	146,528	373,315
1998	117,758	88,519	143,898	294,522	644,697
Per cent					
1981	91.5	81.1	91.6	91.5	90.0
1988	98.2	86.9	93.0	92.2	92.6
1993	98.4	95.5	93.7	94.4	95.1
1998	99.6	97.2	96.2	96.5	97.1

Source: AIHW analysis of the ABS Survey of Disability, Ageing and Carers; ABS population data.

Another source of data is the annual CSDA minimum data set collection, which provides information about the disability support services provided or funded under the CSDA. The collection is an annual census of services provided on a single snapshot day . For accommodation services, the number of consumers on the snapshot day provides a good indication of the number of clients who receive services (it provides a less good indication for services which are accessed with low frequency, such as in-home respite care).[7] Table 4.9 presents data on the period between 1996 and 2000.

Over the 5-year period, the proportion of services received from institutions and large residentials has decreased steadily from 32% in 1996 to 24% in 2000. Likewise, there has been a trend of decline for hostels: from 5.7% to 3.6%. While there has not been a clear trend of increase or decrease for group homes, they accounted for 43.5% of all

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7 These data are counts of the number of times people received services on the snapshot day, rather than counts of individual consumers. A person may have received services from more than one provider on the snapshot day and would therefore be counted more than once. It is necessary to use counts of services received to look at trends over time, because the statistical record linkage key, which allows estimation of the number of individual consumers, was not available before 1999. This is not considered to be a significant issue with regard to accommodation, however, as clients are unlikely to be using more than one accommodation service at a single point in time. It is of more relevance for other service types covered by the collection (see Chapter 7).

accommodation support services received in 2000, which was higher than in the four previous years. Outreach, in-home and drop-in support services have increased steadily between 1996 and 2000, from 14.6% to 20.4% of all accommodation support services received. These are community-based services, such as in-home living support, that are supplied independently of the person s accommodation.

Table 4.9: CSDA-funded accommodation support services received on a snapshot day, 1996–2000 (per cent)

Service type	**1996**	**1997**	**1998**	**1999**	**2000**
Institutions/large residentials	32.1	29.6	26.4	25.8	24.3
Hostels	5.7	6.0	5.6	4.5	3.6
Group homes	39.4	42.3	40.1	41.1	43.5
Attendant care	3.5	2.9	4.8	6.2	5.1
Outreach/other 'in-home'/drop-in support	14.6	16.5	16.5	19.8	20.4
Alternative family placement	0.5	0.3	1.3	0.6	0.5
Accommodation support: other/not stated	4.3	2.3	5.3	2.2	2.5
Total number of accommodation support services received	*19,093*	*20,149*	*21,124*	*21,453*	*21,870*
Accommodation support services as a percentage of all services received	*27.9*	*31.3*	*30.5*	*28.9*	*29.2*

Source: AIHW analysis of CSDA minimum data set collection, 1996–2000.

Some younger people with disabilities have also traditionally been accommodated in residential aged care homes. These numbers have increased slightly over the 1990s, from 5,890 in 1993 to 6,151 in 2000 (see Table 7.17). The reasons for this rise can only be speculative. The residential aged care collection has no information about the types of disabilities of residents, nor indeed about the appropriateness of these placements.

A national research project investigating the placement of younger people in nursing homes collected data from 811 nursing homes across the country (NSW Department of Community Services 1995). There were 1,515 current or very recent younger nursing home residents aged under 60 years participating in the study, equivalent to approximately 4% of the total nursing home population. People were spread across all age groups, with 51 (3% of the sample) aged under 25 years; however, 832 (over 50%) were aged 50 years and over. The majority of younger nursing home residents had an acquired brain injury as their primary disability type. It appeared that the relative support needs of those remaining in nursing home care do not appear significantly greater than those former younger nursing home residents who have been relocated to other residential options (page 24).

Mental health services

Policy context

Historically, Australians have relied on stand-alone psychiatric hospitals as the focal point for the provision of specialised mental health care. The advent of effective anti-psychotic medication, changes in clinical practice and the emergence of the human rights movement provided the impetus for major structural reform of mental health care. Reforms undertaken have encompassed both a shift in the treatment and accommodation of people with a mental health disorder from institutional to community-based settings and the integration of specialised mental health care into mainstream health services.

Deinstitutionalisation of services for people with mental health disorders became an international issue in the 1960s, with the development of humanitarian and medical arguments against institutional health care. In Australia, there was growing pressure for the reform of mental health services, evidenced by the formation of the Australian National Association for Mental Health in 1968 (Dax 1992), and the emergence of consumer-based associations such as the Schizophrenia Association in the 1970s. These shifts began to take more tangible policy forms in Australian mental health service delivery systems in the 1980s.

In 1983, the Richmond Inquiry documented the conditions of institutional care and limited community services available for people with a mental health disorder in New South Wales. The inquiry recommended a process of deinstitutionalisation, with the development of community-based care and rehabilitation services as high-order priorities. Later, the Human Rights Commissioner undertook a National Inquiry into the Human Rights of People with Mental Illness (Burdekin 1993) which continued the themes of the Richmond report at the national level, and drew attention to the need for expansion of community-based mental health services.

In recent years, the policy framework for enhancing mental health care nationwide has been the National Mental Health Strategy (NMHS). The strategy was endorsed by Australian health ministers in 1992 and commenced in 1993. The strategy included the *Mental Health Statement of Rights and Responsibilities*, the *National Mental Health Policy*, and the *National Mental Health Plan* (AHMC 1991, 1992a, 1992b). Medicare agreements were drawn up detailing the transfer of federal funding to support the reform process.

The *Mental Health Statement of Rights and Responsibilities* (AHMC 1991) outlined the directional changes to be undertaken across the mental health care sector. The statement promoted equity, access, social justice and a compassionate society, with mental health as its primary goal, and aimed to promote consistency with the United Nations Resolution for the Protection of the Rights of the Mentally Ill. The *National Mental Health Policy* (AHMC 1992a) codified the acceptance of community-based mental health treatment in Australia and acknowledged the impact of the transition on both community services and specialist carers. The objectives of the policy included improving and expanding access to care, support for non-government organisations, establishment of service standards and practices, research and service delivery monitoring. Reiterating the need for reform of the mental health services, the policy defined mainstreaming and identified community-based care as a basic human right.

The Mental Health Strategy identified nationally agreed priorities and outlined agreed approaches to reform in five-year National Mental Health Plans for 1993—1998 and 1998—2003. The first plan strengthened the reforms in the provision of mental health services of the past two decades, leading to substantial change in the way people with a mental health disorder are treated. The service reform objectives included reducing or closing existing psychiatric hospitals and providing sufficient acute hospital, accommodation and community-based services. The first plan also aimed to integrate the management and delivery of psychiatric services within general health care services and to establish effective links between mental health, general health and non-health services.

The second and current phase of the strategy (1998—2003) has focused on improving quality of care, increasing consumer participation and developing models of best practice. Throughout the strategy there has been a strong focus on promotion, prevention and early intervention and a recognition that the care of people with a mental health disorder in the community was not the sole responsibility of the mental health sector, with accommodation and social support services critical for community-based care (AHMC 1992b, 1993; AHM 1998).

Service types

In the Australian health care system, mental health care is provided by both hospital-based and community-based services. Mental health care for admitted patients is provided by stand-alone public psychiatric hospitals and specialised psychiatric units and wards in public acute care hospitals. Patients of public psychiatric hospitals tend to remain in hospital for longer than those in public acute care hospital psychiatric units. Private psychiatric hospitals and private hospitals with psychiatric units also provide a substantial amount of admitted patient mental health care, which tends to be of shorter duration (AIHW 2001b).

Public hospitals increasingly provide mental health care for non-admitted patients through psychiatric outpatient services and community outreach programs. The involvement of private hospitals in non-admitted patient mental health care is limited, reflecting the way in which health insurance funds pay benefits for mental health care.

In the past two decades, there has been substantial development in public community mental health services. Community-based mental health care services provide a range of residential and non-residential services. Residential mental health care services include those which are staffed 24 hours a day and those with less frequent staff support. Special psychiatric units for the elderly are often included in this category of care, including psychogeriatric units, also referred to as units for the confused and disturbed elderly (CADE units) in New South Wales. Non-government organisations also play a role in the delivery of community-based mental health care, including the provision of psychiatric disability support services.

The available data indicate that, in comparison to community-based services, hospital-based services tend to have better-developed systems for capturing and reporting service activity data. Significant systems development has been undertaken by community-based services nationally to rectify this imbalance.

Care in acute care hospitals

Deinstitutionalisation has been primarily concerned with moving service delivery away from institutions and towards community-based services, such as community support services, home services, rehabilitation programs, training programs and residential care services. Within mental health care, shifting psychiatric care from stand-alone psychiatric hospitals to specialised units in acute care hospitals has been seen as an important contemporary trend, which has run in parallel with deinstitutionalisation in

Table 4.10: Establishments providing mental health services and available beds, 1989–90 to 1999–00

Institution type	1989–90	1991–92	1992–93	1993–94	1994–95	1995–96	1996–97	1997–98	1998–99	1999–00
Institutions										
Units in public acute hospitals[(a)]	n.a.	n.a.	n.a.	94	105	108	129	104	115	112
Public psychiatric hospitals[(b)]	59	45	36	37	35	34	32	24	21	22
Residential care[(c)]	n.a.	n.a.	n.a.	40	48	56	65	n.a.	32	n.a.
Available beds[(d)]										
Public acute hospitals[(a)]	n.a.	n.a.	2,189	2,258	2,406	2,551	2,645	2,876	n.a.	n.a.
Public psychiatric hospitals[(b)]	8,513	7,266	5,802	5,348	4,673	4,000	3,723	3,112	2,943	2,759
Residential care[(c)]	n.a.	n.a.	824	792	975	1,157	1,313	1,363	1,301	n.a.

(a) These data come from two separate sources: National Survey of Mental Health Services data for 1993–94 to 1996–97 (1997–98 for available beds) and National Public Hospital Establishments Database data for 1997–98 to 1999–00. Psychiatric unit data from acute care hospitals not available prior to 1992–93.

(b) These data come from three separate sources: Hospital Utilisation and Costs Study data for 1989–90 and 1990–91; National Survey of Mental Health Services data from 1992–93 to 1996–97 and National Public Hospital Establishments Database data for 1997–98 to 1999–00.

(c) These data come from three separate sources: National Survey of Mental Health Services data from 1992–93 to 1997–98 and National Community Mental Health Establishments Database data for 1998–99. Residential services unit record data not available prior to 1993–94.

(d) Average available beds where possible, otherwise available beds at 30 June.

Source: AIHW National Public Hospital Establishments Database; AIHW/DHAC National Survey of Mental Health Services; AIHW National Community Mental Health Establishments Database.

recent years. Although this shift is more accurately seen as desegregation or mainstreaming than deinstitutionalisation, it is viewed by many in the mental health care field as a significant component of deinstitutionalisation, which has allowed for the downsizing or closure of stand-alone psychiatric hospitals.

In this context, the term mainstreaming refers to a reduction in the amount of care that is delivered in settings isolated from mainstream services or from the general community. The intention is to allow people with severe mental disorders to receive treatment when required in the specialised psychiatric units of acute care hospitals rather than spending extended periods in stand-alone psychiatric hospitals.

Trends over time

The National Survey of Mental Health Services (NSMHS) is the main source of historical data on mental health services (DHAC 2000b). The survey is an annual collection of establishment-level data from publicly funded hospital and community mental health care services. The NSMHS has been used for annual performance monitoring for the Mental Health Strategy since 1993. Some earlier data on psychiatric hospitals is available through the Hospital Utilisation and Costs Study data.

The development of mainstream health care data collections, such as the National Public Hospital Establishments Database and the National Hospital Morbidity Database (NHMD), has progressively replaced data from the NSMHS, the future of which is currently under review. In recent years, activity data from NHMD have provided detailed information on hospital separations from specialised psychiatric care, including the number of days spent in specialised psychiatric care. In 1998—99, separations with specialised psychiatric care accounted for 2.9% of total hospital separations (168,579 separations) and involved 2,174,551 days in specialised psychiatric care (AIHW 2001b). In years to come, these data will enable accurate tracking of service provision trends in hospital-based mental health services.

There was a substantial reduction in the number of public psychiatric hospitals between 1989—90 and 1992—93, from 59 to 36 facilities, reducing to 22 establishments in 1999—00. The number of available beds in these institutions has declined from 8,513 in 1989—90 to 2,759 in 1999—00, while those in specialised psychiatric units in public acute hospitals have increased from 2,189 in 1992—93 to 2,876 in 1997—98 (Table 4.10).

There has been a corresponding increase in the number of beds provided in community-based residential care services with 24-hour staffing, from 824 beds in 1992—93 to 1,301 beds in 1998—99. These community-based residential care services represent a growing segment of the overall service delivery in specialised mental health services. They provided 9% of the available beds in 1992—93 in all admitted or residential care settings (that is, psychiatric and acute hospitals, and community-based residential units with 24-hour staffing); the proportion increased to 19% in 1997—98. Data are not yet available to adequately describe the volume of care in non-residential community settings (e.g. outpatient clinics, day programs in community mental health services), either in terms of patient numbers or occasions of service, nor are there reliable data to monitor changes over time.

Census data also provide an indication of the number of persons accommodated in mental institutions. These data show a distinct decrease in the number of patients over the period, from 21,248 residents in 1981 to 7,135 in 1996.

Monitoring shifts in expenditure

Total expenditure on public mental health service delivery[8] (not including expenditure for central health authority or regional administration, nor other items such as teaching, research or health promotion activities) increased from $1,082 million in 1992—93 to $1,433 million in 1997—98 (Table 4.11), representing an increase in expenditure of 34% (or 19% in real terms) over the 6-year period (DHAC 2000b).

As a proportion of total expenditure on public mental health services, expenditure for psychiatric hospitals decreased from 48% in 1992—93 to 28% in 1997—98. In the same period, expenditure for designated psychiatric units in acute hospitals increased from 21% to 24%, as did expenditure in the community residential care sector (24-hour staffed only) (from 4% to 6%) and on ambulatory patient services (from 22% to 33%). Ambulatory patient services include same-day services for admitted patients, outpatient services for non-admitted patients and community-based non-residential care services.

Table 4.11: Recurrent expenditure in specialised public mental health services, 1992–93 to 1997–98 ($'000)

Year	Stand alone public psychiatric hospitals	Co-located services, acute hospitals	Residential services	Ambulatory services	NGOs[(a)]	Indirect expenditure	Total expenditure
1992–93	515,599.0	229,958.8	46,425.7	242,659.7	20,931.6	26,855.2	1,082,429.9
1993–94	492,265.1	226,392.8	41,658.1	273,598.9	24,518.2	27,904.5	1,086,337.5
1994–95	480,129.8	243,333.3	52,373.2	317,849.4	30,546.9	32,317.3	1,156,549.8
1995–96	421,636.3	281,464.7	71,530.8	389,969.4	38,383.0	35,654.0	1,238,638.2
1996–97	416,028.8	303,341.2	84,036.3	441,293.3	54,530.0	47,535.2	1,346,764.8
1997–98	395,310.4	345,972.1	84,948.9	476,793.6	68,217.8	61,331.7	1,432,574.5

(a) Non-government organisations.

Notes

1. Recurrent expenditure includes all services managed by State and Territory agencies, from all funding sources. Agreed indirect costs have been distributed across service settings.
2. Depreciation excluded for all years.
3. For all years, NSW and SA expenditure includes expenditure on psychiatric service delivery in repatriation hospitals transferred from the Commonwealth on 1 July 1994.

Source: DHAC 2000b.

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[8] Public mental health services exclude private psychiatric hospitals and private psychiatric services.

Substitute care for children

Policy context

In the area of substitute care for children,[9] the move away from institutional care began somewhat earlier than it did for other fields of care described in this chapter. Developments in psychology from the early 1950s drew attention to the adverse effects of institutional care on child development (Bowlby 1951). While patterns varied across jurisdictions, the late 1950s and early 1960s saw the beginning of a trend away from large-scale institutional care in most States and Territories.

Apart from these changing ideologies of care, there were also concerns about the quality of care provided in institutions and growing financial considerations. Many institutions were under-funded, with low staff numbers and children themselves required to undertake many of the domestic functions (Commission of Inquiry into Abuse of Children in Queensland Institutions 1999:99). As moves were made to improve the conditions in these institutions, the costs associated with providing institutional care increased (Markiewicz 1996:35). By the mid-1970s, the cost of institutional care had increased considerably, providing an economic incentive for governments to develop alternative forms of care for children. It has been estimated, for example, that in 1974—75 the weekly cost of care per child in Victoria was $100 in children s homes, $75 in family group homes and $15 in foster care (Boss cited in Mellor 1990:14).

Another important element in the area of assistance for families with children was the substantial expansion of cash assistance provided to low-income families by the Commonwealth Government over the last quarter of a century. The introduction of the Supporting Mothers Benefit in 1973 (renamed in 1977 the Supporting Parent s Benefit) extended government assistance to unmarried mothers, deserted de facto wives and other separated wives not previously eligible for a government pension. During the 1980s and 1990s, there was a significant expansion in government assistance to all low-income families with children, beginning with the implementation of the Family Income Supplement in 1983. The result has been a reduction in the number of children living in poverty between 1982 and 1997—98, despite increases in the number of low-income families over the period (Harding & Szukalska 2000:26). These government benefits have made it much less likely that parents will relinquish the care of their children to the state for financial reasons.

Today, intervention by the statutory welfare services is most likely to be due to allegations of child abuse and neglect or harm to a child, rather than solely because of family poverty as in earlier years. The research indicates, however, that the majority of

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[9] Substitute care refers to care provided to children and young people whose parents are unwilling, unable or otherwise deemed unsuitable to care for them. There are four main types of substitute care: adoption, residential care (including institutional care where care is provided in large establishments), foster care, and relative/kinship care. For further details, see Chapter 5.

children in the child protection system are from families with low socio-economic status (AIHW 1999:282; Hood 1998:29).

During the 1990s, child protection responses have become less punitive and interventionist, and more focused on collaboration and providing assistance to families to prevent children being removed from home. Where it is necessary to remove a child, placement in the wider family and community is preferred. Foster care and placements with relatives or kin account for the large majority of placements in out-of-home care.[10] Residential care is now, almost entirely, cottage-sized family-type care, rather than institutional care.

State and Territory governments continue to fund a diverse range of services that provide support to families. Child protection services are increasingly being complemented by these family support services which build on strengths which exist in families rather than focusing on dysfunctional aspects of family life. There is also a focus in many jurisdictions on preventative services and early intervention (AIHW 2001a). The Commonwealth Government also funds a range of initiatives aimed at strengthening family relationships (see Chapter 5).

Trends over time

National data on children in substitute care are fairly patchy, with annual data on children in out-of-home care available only from 1996 onwards. There are, however, data available from various other sources that provide a broad indication of the trends in the number of children and young people in substitute care.

Between 1972 and 1993, the estimated number of children in substitute care fell by 68%, from 39,600 to 12,800 (Figure 4.4). From 1993 onwards, however, the number of these children increased, rising by 34% to reach 17,200 in 2000.

There were also major changes in the types of care in which children were placed over the last 40 years. In the 1960s and 1970s, adoption was a significant form of substitute care for babies, but this is not the case today. The number of children in residential care, including institutional care, also fell from the 1960s onwards. This trend can be illustrated using data on children on guardianship orders (who constitute the majority of children in out-of-home care) that were collected for various years from 1980 onwards. Between 1980 and 2000, the proportion of children on guardianship orders who were living in residential care fell from 29% to 8% (Table 4.12).

In relation to institutional care, between 1968 and 1982, the average number of children in institutions decreased from 57 to 17 (Senate Standing Committee on Social Welfare 1985:44). Today there are very few larger institutions left and most residential care for children is provided in family group homes or in smaller residential establishments. The decline in the institution as a form of residential care is evident in the trends in Victoria between 1970 and 1990, when the number of children in institutional care fell by 90%, from 2,487 to 258 (Markiewicz 1996).

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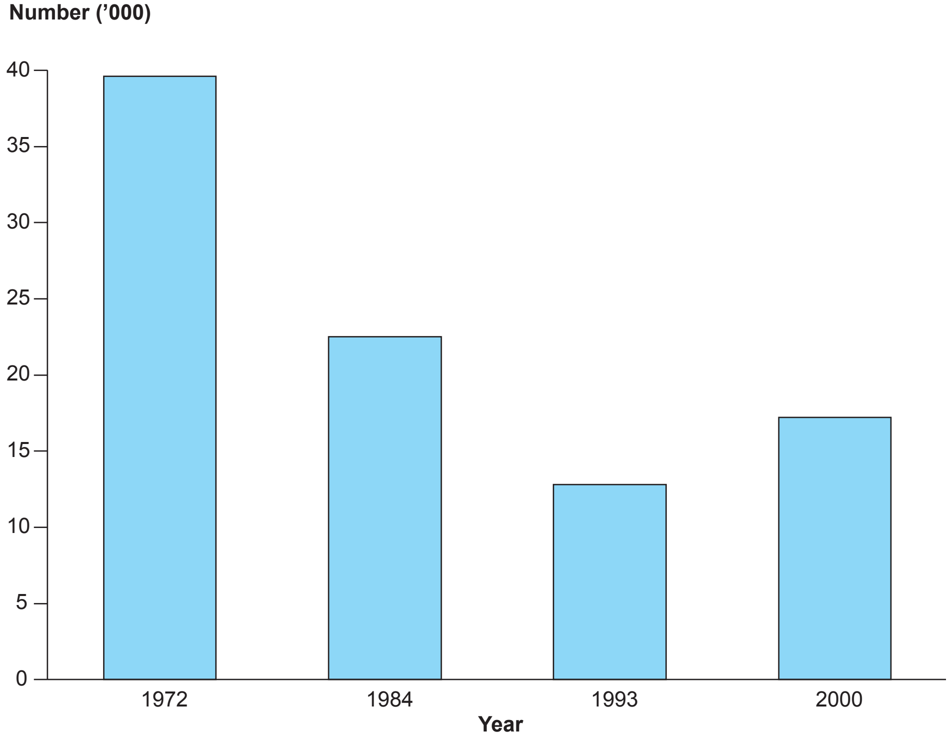
[10] Out-of-home care refers to that sub-set of substitute care that is reimbursed. For further details, see Chapter 5.



Source: Table A4.3.

Figure 4.4: Estimated number of children in substitute care, various years, 1972–2000

Table 4.12: Children on guardianship orders, by living arrangements, selected years from 30 June 1980 to 30 June 2000[(a)]

Type of living arrangement	1980	1982	1991	1993	1995	1997	2000 [(b)]
				Number			
Residential care	5,218	4,548	1,657	1,260	1,144	1,296	1,106
Foster care	5,936	5,346	4,273	4,596	5,088	5,520	6,097
Living with parents/other relatives	4,407	4,361	1,778	1,319	1,024	3,048	6,118
Other[(c)]	2,148	1,313	606	640	744	900	1,375
Total	**17,709**	**15,568**	**8,314**	**7,815**	**8,000**	**10,764**	**14,696**
				Per cent			
Residential care	29	29	20	16	14	12	8
Foster care	34	34	51	59	64	51	41
Living with parents/other relatives	25	28	21	17	13	28	42
Other[(c)]	12	8	7	8	9	8	9
Total	**100**	**100**	**100**	**100**	**100**	**100**	**100**

(a) Table excludes South Australia.

(b) In 2000, the guardianship orders category was expanded to include administrative arrangements that had the effect of transferring custody or guardianship.

(c) Includes children living independently, other adult placement and unknown.

Source: AIHW: Johnstone 2001.

Between 1980 and 1995, there were increases in the proportion of children on guardianship orders in foster care: from 34% to 64%; followed by decreases between 1995 and 2000, with the proportion falling to 41% (Table 4.12). These later decreases coincided with the emergence of a growing proportion of children on guardianship orders living with parents or other relatives in the late 1990s. These relatives or kin may or may not be reimbursed by the state, but the trend is evidence of the increasing value placed on maintaining children within their own family environment. While this trend is not part of deinstitutionalisation per se, it is consistent with the increased emphasis in the shift towards community care on maintaining individuals in their home environment to the maximum extent possible. Recent data from the Institute indicate that, between 1997 and 2000, there was an increasing proportion of children on guardianship orders living both with relatives/kin who were not reimbursed (from 12% to 22%), and with relatives/kin who were reimbursed (from 7% to 12%) (AIHW: Johnstone 2001).

The shifting trends in substitute care are nowhere more evident than in the history of the removal of Aboriginal and Torres Strait Islander children from their families by state welfare authorities. There were large numbers of Indigenous children in institutional care in the 1960s, while in the 1970s and 1980s increasing numbers were placed with non-Indigenous foster families (HREOC 1997:34). Current policies seek to place Indigenous children with their extended families or with other Indigenous caregivers.

Hospitals

Policy context

Hospitals are the key institutions of the health sector, hence their inclusion in this discussion of deinstitutionalisation in a report which is predominantly concerned with welfare services may seem unusual. However, the focus of this chapter is on the move from institutional to community-based care, and this is a trend which has spanned both the health and community services sectors. While deinstitutionalisation as a term is not usually applied to the hospital sector, there is no doubt that this area of service delivery has been subject to the same trend towards community-based care:

> …the nature of acute health care services is changing. Patients are increasingly being cared for in the community with support from a hospital, and quite sophisticated surgical procedures can now be done without an overnight stay. (Duckett 2000:107)

Government policy has encouraged the reduction of bed provision ratios, with an emphasis on reduced length of stay and expanded day hospital procedures. These trends are driven partly by pressures for increasing productivity, but also by changing patterns of medical practice and improved medical technology. Procedures such as endoscopy and renal dialysis, for example, now almost always involve day-only admissions (AIHW 1996:153; Duckett 2000:110—14). Private free-standing day hospital facilities have expanded substantially, from 39 facilities in 1989—90 to 207 in 1999—00. The recent introduction of hospital in the home care in both public and private sectors may well extend this broad trend even further in the future.[11] Developments in pharmaceutical treatment and changes in related service areas (such as mental health services, palliative care and residential aged care) have also contributed to shifts in the nature of hospital services.

Data trends

Since 1986, there has been a substantial decline in the hospital bed provision ratio in the public sector, with the private bed provision ratio being relatively stable. In 1985—86, there were 4.1 public and 1.3 private acute hospital beds per 1,000 population, dropping to 3.3 and 1.2 respectively by 1991—92, and then to 2.6 and 1.2 in 1999—00 (Table 4.13). In numerical terms, public hospital beds have fallen from 64,692 in 1985—86, to 57,053 in 1991—92, to 50,172 in 1999—00. Private hospital beds fell from 21,101 in 1985—86 to 20,745 in 1991—92, then increased to 23,665 in 1999—00. The overall ratio of hospital bed provision has thus fallen by 15.5% between 1991—92 and 1999—00, while the absolute number of beds has fallen by 5.1% in this period.

Table 4.13: Available beds, by hospital type, 1991–92 to 1999–00

Hospital type	1991–92	1992–93	1993–94	1994–95	1995–96	1996–97	1997–98	1998–99	1999–00
Available beds									
Public acute	57,053	54,116	56,140	54,211	54,709	53,411	52,597	51,310	50,172
Private	20,745	20,860	21,241	22,370	22,757	22,966	23,091	23,746	23,665
Available beds per 1,000 population									
Public acute	3.3	3.1	3.2	3.0	3.0	2.9	2.8	2.7	2.6
Private	1.2	1.2	1.2	1.2	1.3	1.2	1.2	1.3	1.2

Source: AIHW National Public Hospital Establishments Database; unpublished data from the ABS Private Health Establishments Collection.

Despite this decline in bed provision ratios, there has been an increase in separations per capita over the period (Table 4.14). In 1991—92, there were 236.8 separations per 1,000 population, rising to 297.9 separations per 1,000 population in 1999—00. This apparent contradiction between reduced bed provision ratios and increased rates of use is mainly a consequence of the increased use of day surgery; there has been little by way of reduction in length of stay for non-same-day admissions. In 1991—92, 30.6% of separations were same-day separations; by 1999—00, this had reached 49.2%. Length of stay in 1985—86 was 6.9 days for public hospitals and 5.5 days for private hospitals; by 1999—00, it was 3.9 days and 3.1 days respectively (Table 4.15). Patient days per 1,000 people dropped overall; this was a result of the drop in the public sector.

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[11] Hospital in the home care is defined as the provision of care to hospital-admitted patients in their place of residence, as a substitute for hospital accommodation.

Table 4.14: Separations from public acute and private hospitals, 1991–92 to 1999–00

Separation type	1991–92	1992–93	1993–94	1994–95	1995–96	1996–97	1997–98	1998–99	1999–00
Separations per 1,000 population[(a)]									
Public acute	167.7	176.9	186.0	192.0	193.2	193.1	197.0	198.7	196.5
Private	69.1	70.5	74.7	82.2	85.1	89.2	93.2	95.5	101.4
Same-day separations as per cent of total									
Public acute	29.3	n.a.	34.2	37.7	39.8	42.0	43.3	44.7	45.8
Private	33.9	n.a.	43.3	46.1	48.9	51.0	53.1	54.8	56.2
Patient days per 1,000 population[(a)]									
Public acute	868.2	912.5	895.6	826.7	827.1	789.4	774.1	751.3	740.2
Private	276.6	282.0	291.0	293.2	311.6	302.0	303.8	299.4	307.7

(a) Crude rate for years 1991–92 to 1994–95; age standard rate for years 1995–96 to 1999–00.

Source: AIHW National Hospital Morbidity Database.

Table 4.15: Average length of stay in public and private hospitals, 1991–92 to 1999–00

Hospital type	1991–92	1992–93	1993–94	1994–95	1995–96	1996–97	1997–98	1998–99	1999–00
Average length of stay (days)									
Public acute	5.1	n.a.	4.8	4.6	4.4	4.2	4.0	3.9	3.9
Private	4.0	4.0	3.9	3.7	3.7	3.5	3.3	3.2	3.1
Average length of stay excluding same-day separations (days)									
Public acute	6.9	n.a.	6.8	6.7	6.6	6.5	6.4	6.3	6.4
Private	5.5	n.a.	6.1	6.0	6.4	6.0	6.0	5.9	5.9

Source: AIHW National Hospital Morbidity Database.

Deinstitutionalisation, imprisonment and mental health

Prisons are not within the scope of this chapter, yet there is a widespread belief that one consequence of deinstitutionalisation has been an increase in rates of imprisonment among those with intellectual or psychiatric disability. Unfortunately, national data on this issue are not available. A recent AIHW report has emphasised the need for such data, describing information on the health status of prisoners as sporadic, inconsistent and incomplete (AIHW: Grau 2001:1). The report documents the need and likely future direction for the development of an information system on prisoner health. The New South Wales Law Reform Commission (1996), in a report on people with an intellectual disability and the criminal justice system, also drew attention to the inadequacy of information on this topic. Some indicative data addressing this issue are presented below.

In New South Wales, it is estimated that 12—13% of inmates have an intellectual disability, compared with 2—3% of the general population. Research undertaken for the New South Wales Law Reform Commission (1996, ch. 2) suggests that more than one-third of persons appearing before New South Wales local courts have an intellectual disability. The Law Reform Commission suggests that deinstitutionalisation is a likely factor in the increasing contact between people with an intellectual disability and the judicial system.

Similar concerns have been raised with regard to people with a psychiatric disability, although the evidence is scanty. In 1995, the New South Wales Mental Health Review Tribunal reported that an increasing number of prisoners are being transferred from prisons to hospitals because of chronic mental illness which is often believed to have existed prior to, and at the time of, their defence (Hayes et al. 1995 cited in Freeman 1998:7). According to the annual report of the New South Wales Corrections Health Service (1999:42), a significant proportion of inmates have mental health problems: More than 50% of male inmates and 30% of female inmates warrant referral to a mental health professional for major depression, 18% of males and 30% of females for schizophrenia and 11% and 20% of males and females respectively for bipolar illness .

4.5 Conclusion

Although the data are somewhat variable in quality and coverage, the material drawn together in this chapter serves to illustrate that deinstitutionalisation is indeed occurring, and it is occurring across a number of service fields. These trends are most evident in the latter part of the 1980s and the first half of the 1990s, although in some fields they have continued unabated. While the census data have some limitations with regard to the accuracy and consistency of the classification of health and welfare institutions, there is broad evidence of a reduction in residency rates over the 15-year period surveyed. If the use patterns which were in place in 1981 had been continued in 1996 (i.e. in the absence of deinstitutionalisation policies), there would have been an additional 80,700 people in health and welfare institutions at the time of the 1996 Census. This means that, in 1996, the actual population in health and welfare institutions was three-quarters that which it would have been in the absence of such changes in policy and practice.

The data in this chapter provide some detailed information on the process of deinstitutionalisation in different fields. In some areas, this has involved the actual movement of people from institutional facilities out into the community; in all areas, the process also involved reducing the numbers of people who actually entered institutional care. In the fields of aged care, disability services, mental health and out-of-home care services for children, there is evidence of a concomitant growth in home-based and community services, but the question as to whether that expansion has provided an adequate substitute for institutional care across all sectors remains to be addressed.

Studies of deinstitutionalisation have been limited in their scope. They tend to focus on a particular geographic area, a particular jurisdiction, or even a particular institution, and they almost always focus on one particular service area. One of the important points to emerge from this chapter is that services and individuals who are providing care in the community context may be providing assistance to people from a variety of service areas. Their clients may include people who would previously have been cared for in a psychiatric institution, an institution for people with intellectual disabilities, an institution for those with physical disabilities, or an aged care home, or those who are moving out of acute care hospitals more quickly than they would previously have done. Some programs, such as hospital in the home, are set up to deal with a very specific client group. Other programs, such as HACC, provide assistance to a much more broadly based clientele; HACC does not, as is sometimes assumed, simply draw its clientele from a population which would formerly have been cared for in aged care homes.

The question of the adequacy of current levels of community-based provision is constantly on the agenda of policy makers, service providers, clients and informal carers, and will undoubtedly continue to be so. There is very little by way of national information on this topic, and the political, practical and methodological difficulties inherent in the task make it an area which is probably destined to remain poorly documented at the national level for some time to come.[12] The current chapter does not bear directly on the question of adequacy, but it does serve as a reminder of the importance of the question. Home-based assistance is not the only alternative to residential care imprisonment, neglect, abuse and homelessness also remain possibilities.

Of course, many of those who may need or desire assistance from community-based services would never have entered an institution these are the majority of people with a disability, a mental health problem or frail older people who have always been and continue to be cared for at home by family members and friends. This group of people also draws on and has need of community-based services. Thus, planning for the development of community-based services must take into account not only those who would previously have been cared for in an institution, but also those who always have been and continue to be cared for in the community.

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[12] See AIHW (1997a) for one exception to this statement: an investigation of the adequacy of service provision in the disability services field at the national level.

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5 Children’s and family services

5.1 Introduction

Children’s and family services include a wide range of services provided by governments or with government funding. They include child care and preschool services, parent education and advice, family support and early intervention services, and child protection and out-of-home care services. Services for families and children can be provided or funded by all three tiers of government.

Income support for children and families is the sole responsibility of the Commonwealth Government. The Commonwealth has also provided funding for child care and family support services since the 1970s. A recent Commonwealth initiative is the Stronger Families and Communities strategy, introduced in 2000, which provides funds for a range of initiatives aimed at strengthening family relationships and community networks. These include early intervention programs to improve parenting and family relationships, and funding for community development activities. The strategy is also funding a longitudinal survey of Australian children that will address a major gap in knowledge and information about early childhood experiences and their impact on education, health, employment, crime and social problems.

State and Territory Governments are responsible for child protection and out-of-home care services. In addition, they are increasingly providing support to families through a broader range of services. All jurisdictions now provide some funds for child care, preschools and family support services. There has also been an increasing focus on early intervention services, which are seen to be effective in reducing the need for more intrusive child protection interventions at later stages.

Many State and Territory Governments have introduced cross-departmental strategies, such as Families First in New South Wales and Strengthening Families in Victoria. These strategies attempt to assist families in a more holistic way, by facilitating coordinated service delivery and providing seamless access to different types of children’s and family services.

This chapter includes those family and children’s services for which national data are available: child care and preschool services, child protection and out-of-home care services, and adoptions. A focus of the chapter is on the trends in children’s and family services from 1990 onwards. It is not possible, however, to provide a national picture on the full range of these services. In particular, it is very difficult to compile national data on many of the services provided by State and Territory Governments, as the type and nature of such services vary across jurisdictions.

The chapter begins with some background information on the social and economic changes to families that have occurred over the last decade. Section 5.3 provides data on trends in Commonwealth family payments, as well as on Commonwealth expenditure on family payments and tax expenditures. Section 5.4 examines the use of formal and informal child care and preschool services, the provision of and trends in formal child care services, and the outcomes of these services. Sections 5.5 on child protection and out-of-home care services, and 5.6 on adoptions, present information on the trends in these areas between 1990 and 2000. Section 5.7 discusses national data developments in children s and family services, including in the area of family support services.

5.2 Families and children in Australia

There have been major social and economic changes in Australia in the last 30 years that have led to significant alterations in family structures. Some of the more important of these include:

- declining fertility rates and an increasing preference for smaller families;
- increasing numbers of de facto relationships;
- increasing divorce rates;
- increasing numbers of one-parent families;
- increasing labour force participation rates of women of child-bearing age; and
- increasing joblessness in families (Gregory 1999; McDonald 2000).

Many of these changes began in the late 1960s, with the pace of change increasing during the 1970s and 1980s and slowing somewhat during the 1990s. This section focuses on social and economic changes in families over the last decade, as well as on the current state of families in Australia. The changes in family structures and patterns have implications for the types of services needed to support families and provide a useful context in which the data on trends in children s and family services can be interpreted.[1]

Family formation and dissolution

Patterns of family formation continued to change during the 1990s. In particular, there were decreases in marriage and fertility rates, further delays in family formation, and increases in the proportion of children born outside marriage.

The age-specific marriage rate for men decreased from 43.5 per 1,000 to 34.8 per 1,000 and for women from 41.6 per 1,000 to 32.8 per 1,000. The fertility rate also decreased falling from 1.9 births per 1,000 women to 1.75 births. The median age of both men and women at first marriage increased by around 2 years during the decade, and the median age of mothers at birth increased by 1.4 years (Table 5.1).

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[1] For more detail about socio-demographic change and families, refer to AIHW (1997).

The proportion of children born outside marriage increased from 22% of births in 1990 to 29% in 1999. Children born outside marriage include those born in de facto relationships, as well as those born to single mothers. While there was an increase in the proportion of children born outside marriage, there was also an increase in the proportion of births where paternity was acknowledged: from 95% in 1990 to nearly 98% in 1999.

Table 5.1: Indicators of family formation and dissolution, 1990 and 1999

	1990	**1999**
Marriages		
Age-specific marriage rate (per 1,000 men/women)(a)	43.5/41.6	34.8/32.8
Median age at first marriage (men/women)(a)	28.1/25.8	30.1/27.9
Births		
Median age of mother at birth(b)	28.3	29.7
Total fertility rate (no. of children per woman)(b)	1.90	1.75
Per cent of children born outside marriage(b)	22.2	29.2
Per cent of births where paternity acknowledged(b)	95.0	97.6
Divorces		
Age-specific divorce rate (per 1,000 men/women)(a)	10.9/10.9	12.7/12.7
Rate of children under 18 involved in divorce (per 1,000 children)(a)	9.8	11.3

(a) ABS 1991a, 2000a, 2001a.

(b) ABS 1991b, 2000b.

Family dissolution was also more prevalent, with divorce rates continuing on an upward trend. The age-specific divorce rates for both men and women increased from 10.9 per 1,000 in 1990 to 12.7 per 1,000 in 1999. There was also an increase over the decade in the number of children affected by divorce: from 9.8 per 1,000 children aged 0—17 years in 1990 to 11.3 per 1,000 in 1999.

These changes in family formation and dissolution are reflected in the changes in the characteristics of families with dependent children.

Characteristics of families

One of the most significant changes in families in the 1990s was the large increase in the number of one-parent families. The estimated number of one-parent families with children aged 0—14 years increased by 54% over the decade to reach 453,600 in 2000 (Table 5.3). The number of couple families with dependent children aged 0—14 grew only marginally over the same period. Broad data for 30 June 2000 show that there were 2,171,300 families with children aged 0—14 years, with 79% of these being couple families and 21% one-parent families (Figure 5.1).

Couple families

In 1997 there were 1,905,300 couple families with children aged 0—17 years (ABS 1998).[2]

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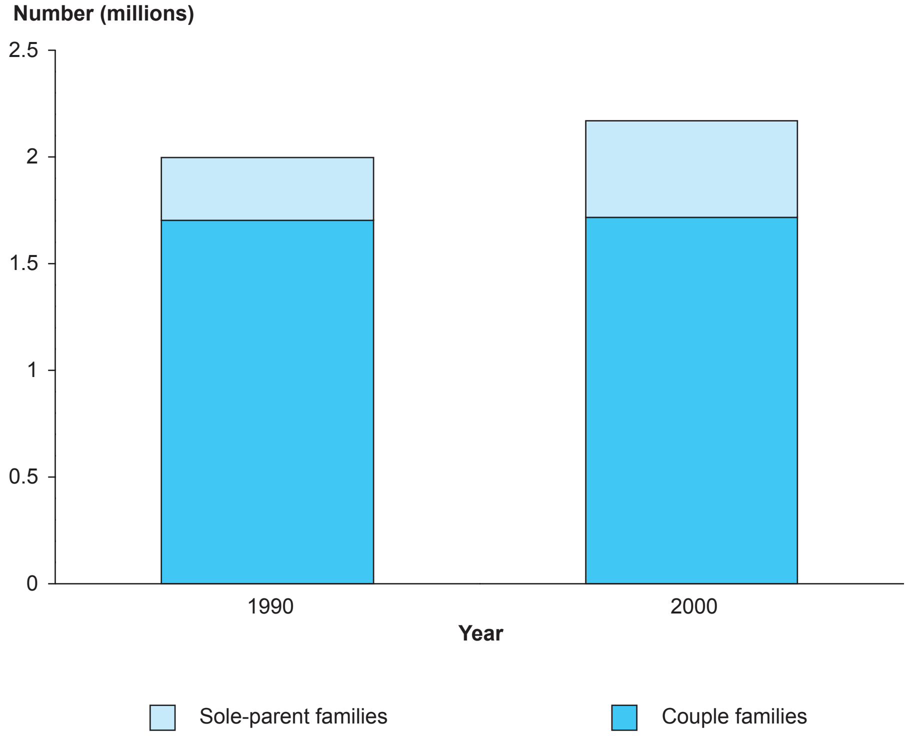
[2] Detailed data on families with children aged 0–17 years are not available after 1997.

Couple families had an average of 2.0 children. In 91% of couple families with dependent children the parents were married, while in 9% they were living in a de facto relationship.

Just under 9% of couple families with children aged 0—17 were step or blended families with 363,800 children in this age group living in them.



Source: Table 5.3.

Figure 5.1: Families with children aged 0–14 years, by family type, 1990 and 2000

One-parent families

In 1997 there were 502,900 one-parent families with children aged 0—17 years. The majority of sole parents (84%) were female. On average, sole parents had fewer children than couples, with an average of 1.7 children aged 0—17. Most sole parents with dependent children had previously been married (63% separated or divorced, 7% widowed) and 30% had never married (ABS 1998).

Children

The number of children in Australia aged 0—17 years increased by 164,100 (4%) between June 1990 and 2000 (Table 5.2). The number of children aged over 4 years rose in all age ranges over this period, while the number aged 0—4 began to decline in the mid-1990s. This decrease reflects declining fertility rates.

While the number of children aged 0—17 increased over the decade, they represent a falling proportion of the total population. At 30 June 1990 this group constituted 27% of the population, compared with 25% at 30 June 2000 (Table 5.2). The distribution of the child population by age, however, varies somewhat across States and Territories, ranging from 24% in South Australia and Victoria to 31% in the Northern Territory (Table A5.1).

Table 5.2: Estimated number of children aged 0–17 years and as proportion of total population, by age group, selected years from 30 June 1990 to 30 June 2000

Age (years)	1990	1992	1994	1996	1998	2000
			Number ('000)			
0–4	1,258.2	1,284.7	1,298.0	1,297.0	1,283.6	1,263.1
5–12	1,996.7	2,034.9	2,057.1	2,090.4	2,110.0	2,129.5
13–17	1,308.3	1,266.2	1,257.7	1,289.4	1,322.7	1,334.7
Total children 0–17	*4,563.2*	*4,585.8*	*4,612.8*	*4,676.8*	*4,716.3*	*4,727.3*
Total population	**17,065.1**	**17,494.7**	**17,854.7**	**18,310.7**	**18,751.0**	**19,157.0**
			Proportion of total population			
0–4	7	7	7	7	7	7
5–12	12	12	12	11	11	11
13–17	8	7	7	7	7	7
Total children 0–17	*27*	*26*	*26*	*26*	*25*	*25*

Source: ABS 2001.

Families and employment

The 1990s was a period of relatively strong economic growth, with the number of employed people increasing from a low of 7.6 million in 1993 to over 9 million at June 2000 (ABS 2000c). There was a corresponding fall in the unemployment rate: from 11% in August 1992 to 7% in June 2000.

The labour force participation rates of women of child-bearing age continued to rise in the decade up to June 2000, though the increase was not as great as in previous decades. The rates for women aged 25—34 years, for example, increased from 66% in August 1990 to 70% in August 2000 (ABS 1990a, 2000d).

The growth in employment between 1990 and 2000 also benefited families with dependent children. The number of couple families with dependent children aged 0—14 years and both partners employed increased by 44,600, and the number of employed sole parents with children aged 0—14 by 84,100 (Table 5.3).

While the number of families with all parents in employment grew over the decade, there was also an increase in the number of families with no parent employed, particularly among one-parent families. The number of these families increased by 74,300 between 1990 and 2000. In addition there was a rise of 21,300 in the number of couple families in which neither partner was employed.

Table 5.3: Employment patterns of families with dependent children,[a] by family type, 1990 and 2000

Employment patterns and family type	1990 Number ('000)	1990 Per cent	2000 Number ('000)	2000 Per cent
Couple families				
Both partners employed	932.0	54.7	976.6	56.3
One partner only employed				
Husband employed	633.5	37.2	573.9	33.4
Wife employed	30.0	1.8	47.1	2.7
Neither partner employed	107.8	6.3	129.1	7.5
Total	**1,703.3**	**100.0**	**1,717.7**	**100.0**
One-parent families				
Parent employed	130.3	44.1	214.4	47.3
Parent not employed	164.9	55.8	239.2	52.7
Total	**295.2**	**100.0**	**453.6**	**100.0**

(a) Includes children aged 0–14 years.

Source: ABS 1990b, 2000e.

In 2000, 56% of couples with children aged 0—14 years had both partners in employment, while 8% had neither partner in employment. In one-parent families with dependent children aged 0—14, 47% had a parent who was employed.

Aboriginal and Torres Strait Islander families

The profile of Aboriginal and Torres Strait Islander families differs from that of other Australian families in a number of ways. Indigenous families are more likely to be one-parent families and to have on average a larger number of children and larger households (Daly & Smith 1996). Indigenous parents also tend to be younger and to have lower levels of education than other Australian parents. Indigenous families are much more likely to be economically disadvantaged, with lower employment rates of parents and much lower median incomes.

5.3 Assistance for families

Up to July 2000, the Commonwealth Government provided a range of assistance for families in the form of income support payments, family assistance payments and tax expenditures. Family assistance payments and tax transfers for families were designed to assist with the costs of raising children, including recognising the indirect costs of reduced workforce participation by some families with young children. Higher assistance was targeted to families with low incomes. Income support in the form of Parenting Payment was also available for sole parents with no income or a low income and parents whose partner had no income or was on a low income (FaCS 2000a). These payments and tax transfers are described in more detail in Box 5.1.

The tax reform package that took effect from 1 July 2000 provided for a fundamental restructure of family assistance. The stated aims of these reforms were to:

¥ simplify payment structures;

¥ improve work incentives;

Box 5.1: Commonwealth family payments and tax expenditures

Applicable prior to 1 July 2000

Family Allowance—paid to low- and middle-income families with dependent children, subject to an income and assets test. The rate paid was dependent on family size. Extra assistance in the form of Guardian Allowance was available for sole parents. Minimum Family Allowance was paid to families with incomes below a means-tested threshold, while a lower income threshold was used to identify families eligible for the More than Minimum Family Allowance.

Family Tax Initiative—included the Family Tax Payment which provided additional assistance to families with low to middle incomes. Part A was available for each dependent child, while Part B was paid to single income families with children aged under 5 years. The Family Tax Assistance was the equivalent type of assistance accessed through the tax system.

Parenting Payment—income support payments for one parent with responsibility for caring for a child under 16 years of age. The two main streams were Parenting Payment (single) paid to sole parents with no income or low income and Parenting Payment (partnered) for the primary carer in a couple family. For couple families Parenting Payment was broken down into Basic Parenting Payment which was non-taxable and income-tested on the income of the parent receiving the payment and Additional Parenting Payment which was taxable and income-tested on family income.

Dependent Spouse Rebate (with children) and Sole Parent Rebate—provided tax relief in the form of rebates for sole parents and tax-payers with a dependent spouse and children.

From 1 July 2000

All these forms of assistance (excluding Additional Parenting Payment) were combined to form the Family Tax Benefit.

Family Tax Benefit Part A replaced the following payments to provide assistance with the general costs of children—Minimum Family Allowance, More than Minimum Family Allowance, Family Tax Payment Part A and Family Tax Assistance Part A.

Family Tax Benefit Part B replaced the following assistance formerly provided to single income families, including sole parents—Basic Parenting Payment, Guardian Allowance, Family Tax Payment Part B, Family Tax Assistance Part B, Dependent Spouse Rebate (with children) and Sole Parent Rebate.

Other forms of assistance for families that are still available include:

- Parenting Payment (couple) and Parenting Payment (single);
- Maternity Allowance—an income-tested lump sum payment for each newborn or adopted child in the family;
- Maternity Immunisation Allowance—payable at age 18 months for fully immunised children (appropriate for the age); and
- Double Orphan Pension—for children whose parents are both dead, or one parent is dead and the other cannot care for the child, and for refugee children under certain circumstances.

Source: ATO 2000; FaCS 2000a.

- provide a choice of delivery through the transfer payments or the tax systems; and
- support the choices families make in balancing their work and parenting responsibilities.

The new Family Tax Benefit, Parts A and B, combined ten forms of assistance that were previously available in the tax and transfer systems. The forms of assistance now paid as the Family Tax Benefit are outlined in Box 5.1. The reforms also included the introduction of the Family Assistance Office to administer the new system of family assistance. These offices are located in all existing Centrelink, Australian Taxation Offices and Medicare offices (ATO 1999).

There were also changes to the assistance provided for child care, with the Child Care Benefit replacing Childcare Assistance and the Childcare Rebate (see Box 5.6).

Trends in family assistance

The number of families in receipt of Family Allowance decreased by 8% between 1990 and 2000, from 1.89 million to 1.74 million. There was a similar fall in the number of children for whom the allowance was paid, from 3.67 million in 1990 to 3.41 million in 2000, a decrease of 7% (Table 5.4).

The number of families in receipt of More than Minimum Family Allowance (MMFA) increased significantly over the decade, rising from 564,000 in 1990 to 926,300 in 1999 and then falling to 911,300 in 2000. Since the MMFA was targeted to low-income families, the data indicate that there was a large increase in the number of families with incomes below the income test threshold.

Over the same period, there was a decrease in the number of families in receipt of Minimum Family Allowance: from 1,326,900 to 832,300. The fall in the number of middle-income families eligible for this payment is likely to be related to the rise in the number of low-income families as well as to an increase in the number of families with incomes above the income test cut-out.

The introduction of the Family Tax Payment in 1997 provided additional assistance to a significant number of families with children. There were 867,000 families in receipt of Family Tax Payment Parts A and B in June 2000 (Table 5.4). The number receiving Family Tax Payment Part A declined from 512,700 in 1997 to 454,700 in 1999, but then increased to 510,200 in 2000. There was a similar trend for Part B, with the numbers declining from 393,000 in 1997 to 342,600 in 1999 and then increasing to 356,500 in 2000.

In relation to income support payments for families, the number of sole parents receiving Parenting Payment (single) increased by nearly 60% during the 1990s to reach 397,300 in 2000. This is in line with the rise in the number of sole parents over the decade (as outlined earlier). It should be noted that many sole parents receive a partial rate of Parenting Payment because they also have earned income.

The number of recipients of Parenting Payment (partnered) decreased by around 17,000 between 1996 and 2000, probably related to falls in the number of unemployment payment recipients in the last few years of the 1990s.

Table 5.4: Number of recipients of family assistance and income support payments for families, selected years from June 1990 to June 2000 ('000)

Type of payment	1990	1992	1994	1996	1997	1998	1999	2000
Family assistance payments								
Number of recipients								
Family Allowance[(a)]								
More than Minimum	564.0	772.7	841.9	883.9	918.5	909.2	926.3	911.3
Minimum	1,326.9	1,156.8	986.0	928.5	893.2	866.4	846.9	832.3
Family Tax Payment								
Part A	. .	. .	. .	. .	512.7	479.3	454.7	510.2
Part B	. .	. .	. .	. .	393.0	364.2	342.6	356.5
Number of children								
Family Allowance[(a)]								
More than Minimum	1,142.6	1,495.5	1,683.1	1,759.1	1,821.2	1,799.4	1,770.6	1,791.3
Minimum	2,529.9	2,224.6	1,855.9	1,738.3	1,669.9	1,619.4	1,670.6	1,614.7
Family Tax Payment								
Part A	. .	. .	. .	. .	976.6	919.9	868.1	951.2
Part B	. .	. .	. .	. .	852.1	797.3	751.7	773.1
Income support payments								
Number of recipients								
Parenting Payment (single)	248.9	287.2	313.4	342.3	358.9	372.3	384.8	397.3
Parenting Payment (partnered)[(b)]	. .	. .	. .	237.3	239.3	236.5	227.7	220.3

(a) Over the decade there were some changes in the income test thresholds for Family Allowance which may have impacted on the numbers eligible for More than Minimum and Minimum rates.

(b) Refers to parents receiving Additional Rate.

Source: FaCS 2001.

Increases in levels of assistance

The amount of Commonwealth assistance provided to families with children, particularly to low-income families, increased over the 1990s. This was due to the introduction of the Family Tax Initiative in 1997 for low- and middle-income families, but also to increases in the rates of other payments for families. For a sole parent with one child under 5 in receipt of Parenting Payment, for example, rates of assistance rose by 13% in real terms between 1991 and 2000. For unemployed couples with one child under 5, real rates of assistance rose by 6% over the same period (FaCS 2000a).

Increases in the assistance the Commonwealth provides to families with dependent children have been an important factor in reducing rates of child poverty (Harding & Szukalska 2000). Higher levels of assistance have benefited unemployed couples, sole parents and low-income working families.

Commonwealth expenditure on assistance for families

Commonwealth outlays on the main types of family payments and tax expenditures for families in the 1999—00 period are shown in Table 5.5. Family Allowance and Parenting Payment were the two largest expenditure items, accounting for some 90% of assistance for families. The total cost to the government on the main types of assistance for families (excluding the Dependent Spouse Rebate with Children) was $13.7 billion.

Table 5.5: Commonwealth expenditure on the main types of assistance for families, 1999–00

Type of expenditure	**($m)**
Family assistance and income support payments	**Outlays**
Family Allowance	6,564.8
Family Tax Payment	537.2
Maternity Allowance	211.6
Parenting Payment	5,764.0
Tax expenditure	**Revenue forgone**
Family Tax Assistance	390
Sole Parent Rebate	260

Note: Data were not available for the Dependent Spouse Rebate with Children.

Source: FaCS 2000a, 2001; Treasury 2001.

5.4 Child care and preschool services

Formal child care services provide care and developmental activities for children usually between the ages of 0 and 12 years. Informal child care is provided by relatives and friends and other individuals such as paid babysitters and nannies. Child care enables parents to participate in employment, education and training, community activities, and personal activities such as attending medical appointments or going shopping it may also be used for family support. Preschool services offer educational and developmental programs for children in the year or two before full-time school (see Box 5.2). Child care and preschool services are important in satisfying children s needs for companionship, play opportunities and social, physical, emotional and intellectual development.

The section that follows discusses data sources, the need for child care and preschools, the use of formal and informal child care and the provision and delivery of formal child care services, including government expenditure. The section concludes by examining service outcomes in terms of accessibility (including affordability) and quality.

Data sources

There are a number of different data collections relating to child care and preschool services (see Box 5.3). The information used in this chapter, however, is mainly drawn from the ABS Child Care Survey and the Commonwealth Child Care Census and Child Care System. While the ABS survey and the Commonwealth census are used to present a picture of the overall patterns of use, the data are not directly comparable. The survey collects information from parents on the use of child care by children aged 0—11 years, with child care including all formal child care services and preschools, as well as informal care. The census collects information from Commonwealth-supported child care service providers, with children using these services generally being 0—12 years (AIHW 2000b).

Data on child care and preschool services funded solely by States and Territories are not used in this chapter. It is difficult to combine data from the different jurisdictions to present a national picture of child care services, because of factors such as differences in the scope and coverage of the collections and in the classifications and definitions used. A major limitation of the data on child care and preschool services is that data on the

Box 5.2: Formal child care services—funding/licensing types and definitions

Long day care centres *are facilities (purpose-built or modified to provide child care) in which staff provide care and developmental activities primarily for children under school age. These centres are generally open for at least 8 hours per day, 5 days per week, 48 weeks of the year.*

Preschools and kindergartens *offer educational and developmental programs for children in the year or two before they begin full-time school. Dedicated preschools offer sessional programs during school terms only. Sessional programs generally involve a distinct group of children meeting for around two to four sessions per week, each session lasting half the normal school day or the full school day. A long day care centre may also provide a preschool program run by a qualified early childhood teacher.*

Family day care schemes *comprise networks of individuals who provide care and developmental activities in their own homes for children 0–12 years. Family day care providers are recruited and supported by a central coordination unit, which administers the scheme.*

Outside school hours care services *offer care and developmental activities for primary school-aged children out of school hours. The main types of services provided are before school care, after school care, vacation care and care on ‘pupil-free’ days.*

Occasional care services *generally provide care and developmental activities for children under school age for short periods of time, to assist parents who need care for reasons such as attending adult education classes, medical appointments, going shopping, or simply for respite.*

Other formal services *include multifunctional services, multifunctional Aboriginal children’s services (MACS) and mobiles. Multifunctional services are located in rural areas and provide a number of different child care services for children 0–12 years from the one building. MACS are culturally specific services for Aboriginal and Torres Strait Islander children. Mobiles provide services such as preschool services, playgroups, older children’s activities, toy and book library services, and parental support and advice for families living in rural and remote areas.*

Source: AIHW 2000b.

provision of care continues to be collected by the type of funded and/or licensed service (Box 5.2). This no longer captures the complexity of contemporary child care services, however, nor the reality of service delivery (AIHW 2001a). In the past decade, services have changed considerably, both in the way they are provided and the way they are used by parents and children. Service providers have moved into a more flexible type of service provision in order to meet parents’ and children’s needs and market demands. A service provider funded and licensed as a long day care centre, for example, will provide long day care but may also provide a preschool program, occasional care, and after school care for primary school children. A new method of data collection, reflecting the current state of the sector, has been proposed for the National Children’s Services Minimum Data Set, now under development. This is discussed in more detail in Section 5.7.

Box 5.3: Child care and preschool services data collections

The Australian Bureau of Statistics (ABS) Child Care Survey is conducted every 3 years and is a supplement to the ABS Labour Force Survey. The latest survey was conducted in 1999. This is an Australia-wide sample survey on the use of and demand for child care and preschool services.

The Commonwealth Child Care Census (CCC) is a census of Commonwealth-supported child care service providers, conducted by the Department of Family and Community Services (FaCS). In most years between 1988 and 1999, the census collected information from Commonwealth Child Care Support service providers on their staff, the children and parents using the service and various other aspects of service provision. The latest complete census of all Commonwealth-supported services was carried out in 1999. A census of family day care, multifunctional, MACS and mobile services was conducted in May 2001.

The Child Care System (CCS) was an administrative database that was managed by FaCS and which contained information about Commonwealth-supported child care service providers. This system ceased operation at the end of 2000.

Centrelink has two data systems operating for Child Care Benefit payments (see section on Provision below). One system contains details about families and children eligible for CCB; the other (COS—Child Care Operator System) contains a limited amount of information about child care service providers.

State and Territory government data collections contain information about the child care and preschool services that these governments fund and/or license (see Provision section). There are, however, great variations in the nature and extent of these collections.

The need for child care and preschool services

All parents of children 12 years of age and younger could potentially need someone other than themselves to care for their children. In 2000 there were nearly 3.4 million children aged 12 years and under in Australia, representing the upper limit of the potential population in need of child care (see Table 5.2). Of these children, approximately 260,000 were 4 years of age and represent the potential population needing preschool services (ABS 2001).[3]

One of the main reasons that parents need child care is to participate in the workforce. Data on parents participation in the labour force, that is, in paid employment or looking for work, can therefore be used to estimate the potential number of families who need child care for employment-related reasons.

In 2000 there were 839,500 couple families and 162,800 one-parent families in Australia with at least one child under 5 years of age. In nearly half of the couple families both

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[3] The age at which children are eligible to attend preschool services, however, varies somewhat between jurisdictions (Press & Hayes 2000:64).

parents were in the labour force and almost 40% of the sole parents were in the labour force (Table 5.6). Where the youngest child in the family was aged 5—9 years, both parents in 69% of couple families were in the labour force, as were 61% of sole parents. Labour force participation for mothers increased steadily according to the age of the youngest child: 32% in 1996 where the youngest child was aged less than 1 year, compared with 66% where the youngest child was aged 6 (AIHW 1999a:97).

Table 5.6: Families with both parents (or a sole parent) in the labour force, by age of youngest child, June 2000 ('000)

Age of youngest child (years)	Both parents (or a sole parent) in labour force	Per cent of total families	Total families
Couple families with youngest child aged:			
0–4	415.1	49.4	839.5
5–9	335.4	69.2	484.4
10–14	289.0	73.4	393.7
One-parent families with youngest child aged:			
0–4	63.0	38.7	162.8
5–9	93.9	60.9	154.1
10–14	92.7	67.8	136.8

Note: The labour force includes people who are employed and people who are not employed but are actively looking for work.

Source: ABS 2000d.

It is important to note that the potential need for child care is not the same as the expressed need for child care. Potential need is a broader concept and can include those who have not yet expressed a need for child care, but who may do so in the near future and/or start to use child care. Not all parents in the workforce will express a need for child care. For instance, in couple families where parents are in paid employment, one parent may work at home, or they may work different hours because they prefer to look after their children themselves.

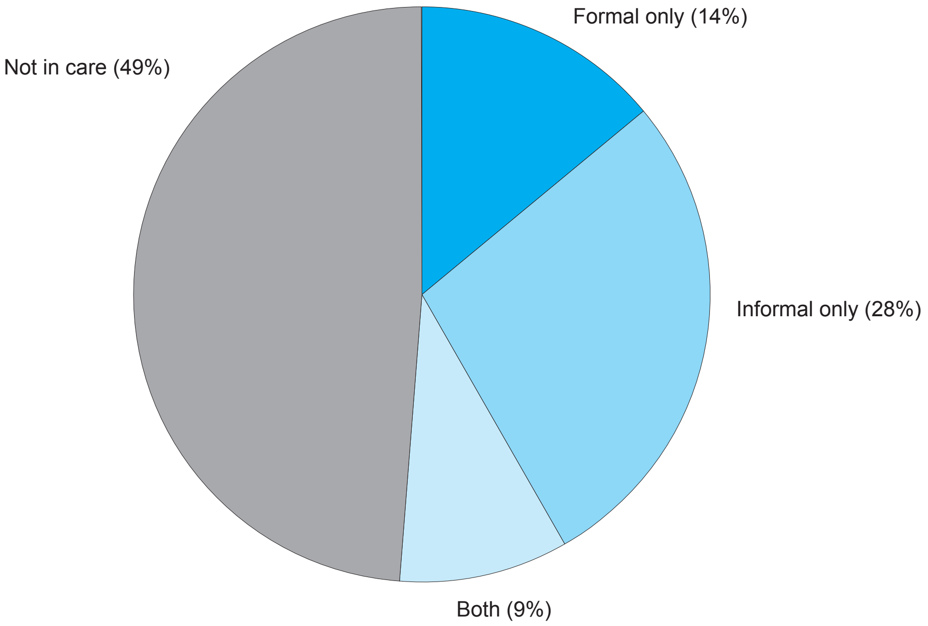
The need for child care may increase following the new Welfare Reform initiatives which are aimed at increasing participation in employment, education and training by parents dependent on government income support. These initiatives include an expanded range of training, employment and support services for these parents, including improved child care fee assistance and an additional number of before and after school child care places. Parents in receipt of Parenting Payment whose youngest child is at least 6 years of age will be required to attend an annual interview at Centrelink, while those whose youngest child is between 13 and 15 years will be subject to an activity test (Commonwealth of Australia 2001).

While parents participation in employment, education and training creates much of the need for child care in Australia, there are other reasons. Parents may need child care for personal reasons, because they think it is beneficial for the child, or as a form of family support. There is also evidence that child care and preschool services can be particularly beneficial for children from low-income families (Centre for Community Child Health 2000). The provision of these services has been highlighted as a cost-effective early intervention strategy for such children.

The use of child care

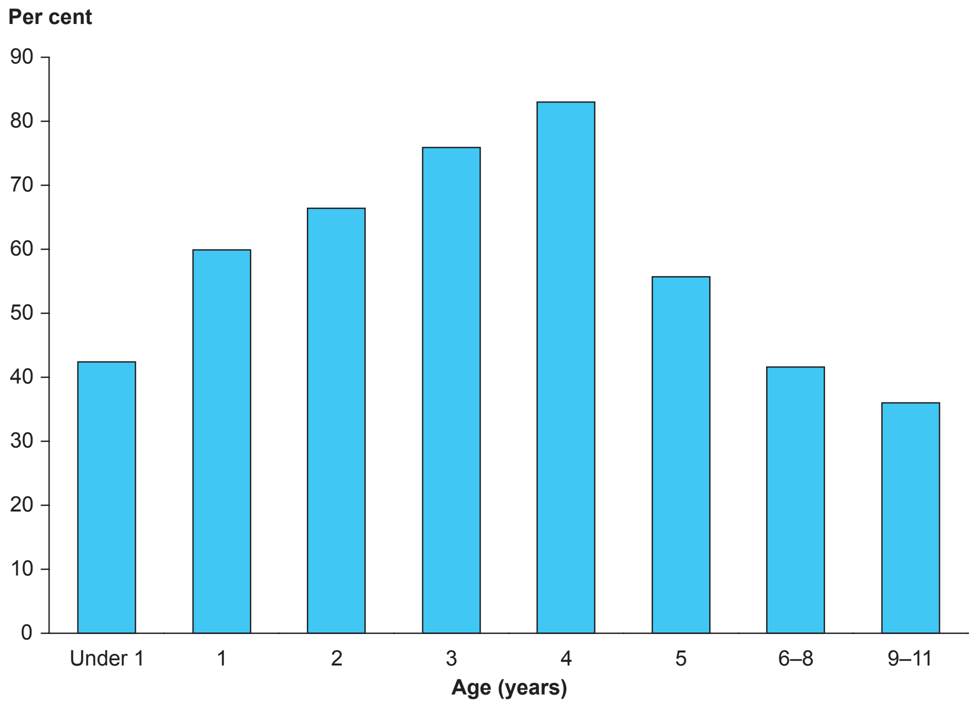
The ABS estimated that, in 1999, just over half (51%) of the 3.12 million children aged 0—11 years in Australia were in child care in the survey week, with 14% using only formal care, 28% only informal care and 9% both formal and informal care (Figure 5.2). The ABS definition of in care includes children using formal child care and preschool services as well as those being cared for in informal arrangements by family members (other than parents) friends, neighbours and paid babysitters for 1 hour or more in the week prior to the survey (ABS 1999a:3).

The proportion of all children using care varied with the age of the child, being higher for each year of age up to age 4. In 1999, 42% of children aged less than 1 year were in care, compared with 83% aged 4 years (Figure 5.3). The proportion of children using care was significantly lower at age 5 (56%) and lower again at ages 9—11 years (36%) (ABS 2000f). Most children aged 5 and older are at school and thus less likely to need care.



Source: Table A5.2.

Figure 5.2: Children aged 0–11 years in child care, 1999



Source: Table A5.2.

Figure 5.3: The proportion of children aged 0–11 years in child care, 1999

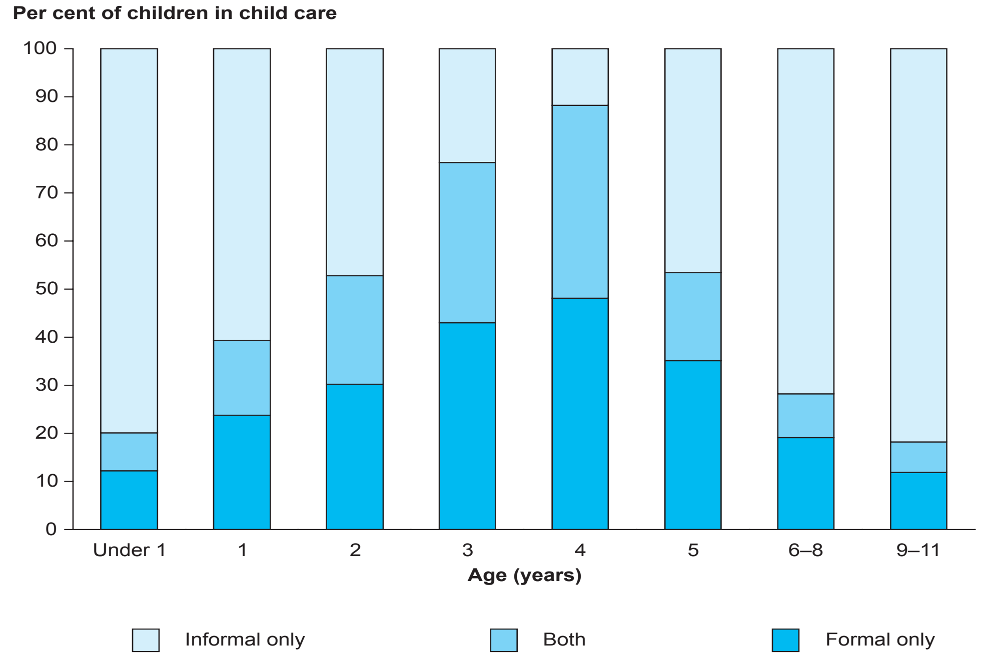
Use of formal and informal child care

The types of child care used also varied with the age of the child. Informal care was the most common both for very young children and for children aged 6 years and over. In 1999, the proportion of children in child care who were using only informal care was 80% for those aged under 1 year, 12% for those aged 4 and 82% for those aged 9—11 (Figure 5.4).

The use of formal care varied correspondingly, being higher for each year of age up to age 4. For children aged under 1 year using care, 12% were in formal care only and 8% were using both formal and informal care, while for children aged 4 the corresponding percentages were 48% and 40%. The high proportion of children using formal care at age 4 reflects the fact that almost half (49%) were attending preschool services. The proportion of children aged 5 years in child care who used formal care was significantly lower, with 35% using only formal care and 18% using both formal and informal care. For children aged 9—11 using care, 12% were using only formal care and 6% both formal and informal care.

Types of formal and informal care

The types of formal and informal care used by children in 1999 are shown in Table 5.7. It should be noted that where a child was in more than one type of care during the survey period, they were counted for each type.



Source: Table A5.2.

Figure 5.4: The types of care used by children aged 0–11 years, 1999

Among children aged 0—4 years in care, the most common type was care by a grandparent (45%) and the next most common was in a long day care centre (27%), followed by preschool (22%). For children aged 5—11, care by a grandparent was also the most common type (38%). Care by an unrelated person was the next most common type (25%), followed by before and after school care (20%).

While grandparents were the most common carers for children in both age groups, children cared for by grandparents and other informal carers were more likely to be in care for shorter periods of time than children in formal care. The relationship between hours of care and the use of formal and informal care is discussed in the following section.

Table 5.7: Children aged under 12 years in child care, by type of care and by age group, 1999

	0–4 year olds		5–11 year olds	
Type of care	**Number ('000)**	**% of total in care**	**Number ('000)**	**% of total in care**
Formal care				
Before and after school care	*1.6	*<1	152.5	20
Long day care centre	225.9	27	16.1	2
Family day care	72.1	9	15.0	2
Occasional care	41.5	5	*1.4	*<1
Preschool	186.0	22	45.7	6
Other formal care	24.2	3	5.2	1
Total children who used formal care(a)	*509.6*	*61*	*223.6*	*29*
Informal care				
Grandparent	376.6	45	286.1	38
Brother/sister	12.3	1	61.9	8
Other relative	94.8	11	127.4	17
Other person	104.7	13	189.3	25
Total children who used informal care(b)	*549.0*	*66*	*613.2*	*80*
Total children in care(c)	**837.5**	**100**	**761.8**	**100**

(a) Components do not add to total as children could use more than one type of formal care.

(b) Components do not add to total as children could use more than one type of informal care.

(c) Components do not add to total as children could use both formal and informal care.

* Estimate has a relative standard error of between 25% and 50% and should be used with caution.

Source: ABS 2000f:11.

Hours in care

Overall, the majority of children (85%) in child care were there for less than 30 hours per week (Table A5.3). Only 7% were using care for 45 hours or more per week.

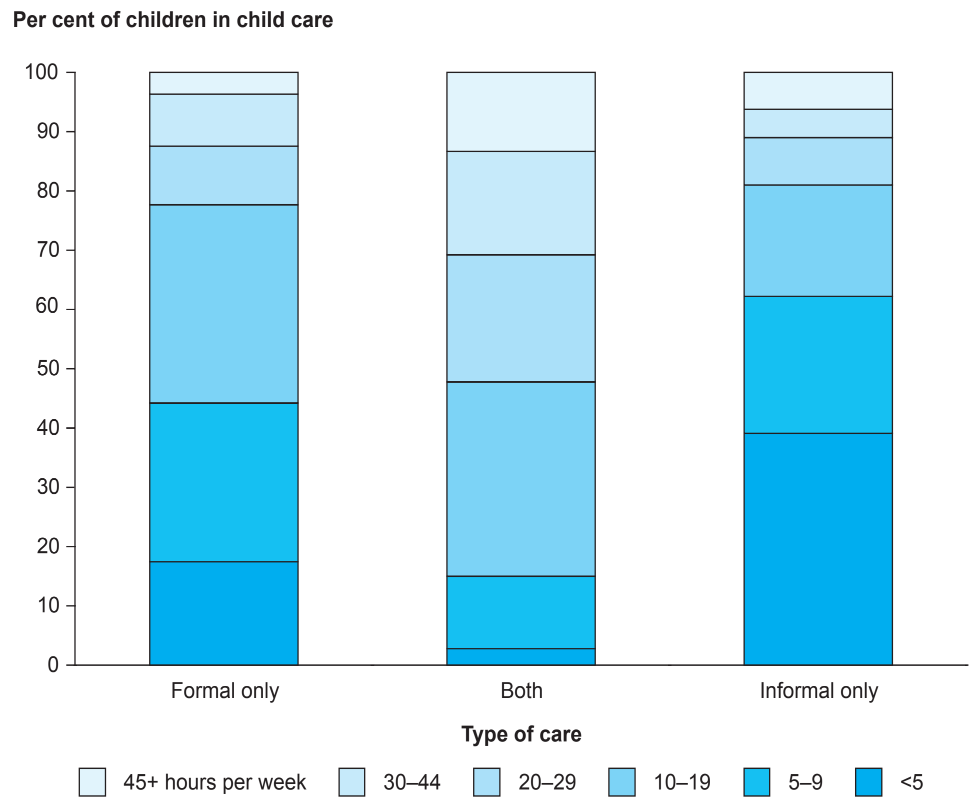
Children using informal care only were much more likely to be in care for fewer hours than those using formal care only or those using both formal and informal care (Figure 5.5). For example, 39% of children using only informal care were in care for less than 5 hours per week, compared with 17% using only formal care and 3% using both.

Children who used both types of care were most likely to be in care for longer periods: 30% for 30 hours or more per week, compared with 11% using only informal care and 13% only formal care.

Reasons for using child care

The main reason parents gave for using child care differed by the type of care and the age of the child (Table 5.8). For children aged 0—4 years the most common reason for using formal care was that it was considered beneficial for the child (44%), closely followed by work reasons (37%), while informal care was mostly used for personal reasons (49%).

For around half or more of children aged 5—11 in care, parents reported that the main reason was work-related (67% of children in formal care and 49% in informal care). Parents were more likely to report that they mainly used *formal* care because it was



Source: Table A5.3.

Figure 5.5: The amount of time spent in care by children aged 0–11 years, 1999

beneficial for the child rather than for personal reasons, while they were more likely to report that they used *informal* care for personal reasons rather than because it was beneficial for the child. For 18% of children aged 5—11 in formal care and 4% in informal care, the main reason given was that it was beneficial for the child. Personal reasons were the main reason care was used for 36% of children in informal care and 7% in formal care.

It is important to note that the ABS survey does not provide information on what types of services parents use to care for their children while they are working. Parents may use a child care or preschool service for their child while they are at work, but may not say that the main reason (or one of the reasons) for using this service is work-related. Thus in 1999, for example, both parents (or the sole parent) of 44% of children attending preschools were employed. However, parents of only 14% of children in preschools said that the main reason they were using this service was work-related, while parents of 20% of children gave work-related as one of the reasons for using the service (ABS 1999a:33, 17).

Table 5.8: Children aged 0–11 years in child care, by main reason parents gave for using care, by type of care and age group, 1999

	Formal care		Informal care	
Main reason	**Number ('000)**	**Per cent**	**Number ('000)**	**Per cent**
0–4 year olds				
Work-related	189.0	37	218.9	40
Personal	69.7	14	268.7	49
Beneficial for the child	222.5	44	18.6	3
Other	28.4	6	42.7	8
Total	**509.6**	**100**	**549.0**	**100**
5–11 year olds				
Work-related	149.9	67	303.2	49
Personal	16.3	7	222.6	36
Beneficial for the child	40.6	18	22.2	4
Other	16.7	7	65.2	11
Total	**223.5**	**100**	**613.2**	**100**

Note: 'Work-related' includes working, looking for work and studying/training for work. 'Personal' includes non-work-related study or training, shopping, social or sporting activities, giving parents a break, doctor's visits and voluntary/community activities. 'Beneficial for the child' includes 'good for the child' and to 'prepare child for school'.

Source: ABS 2000f:17–18.

Trends in the use of child care

During the 1990s there was an increase in the number of children 0—11 years using child care. Between June 1993 and June 1999 the number of children aged 0—4 in care rose by 7% from 780,900 to 837,500, while the number aged 5—11 rose by 5% from 724,000 to 761,800 (Table 5.9). The increase in the 0—4 age group in care occurred during a period when the total number of children in this age group declined (Table 5.2).

This trend in the use of care was due to a rise in the numbers of children in both age groups using formal care between 1993 and 1999. Those aged 0—4 years using only formal care increased by 17%, from 245,900 to 288,500, while those using both formal and informal care increased by 14%, from 193,300 to 221,100 (Table 5.9). Over the same period, the number of children aged 5—11 using only formal care rose by 60%, from 92,800 to 148,600, and those using both formal and informal care rose by 17%, from 64,200 to 74,900 (ABS 2000f).

Table 5.9: Children aged 0–11 years in child care, by age group and type of care, June 1993 and June 1999 ('000)

Type of care	June 1993	June 1999
0–4 years		
Formal only	245.9	288.5
Both	193.3	221.1
Informal only	341.7	327.9
Total	**780.9**	**837.5**
5–11 years		
Formal only	92.8	148.6
Both	64.2	74.9
Informal only	567.0	538.2
Total	**724.0**	**761.8**

Source: ABS 2000f:11.

In contrast, the number of children using only informal care decreased between 1993 and 1999 for both age groups: 4% for those aged 0—4 years and 5% for those aged 5—11.

The provision of formal child care services

The Commonwealth Department of Family and Community Services (FaCS) supports the provision of formal child care services through Commonwealth Child Care Support (Box 5.4). The Commonwealth has a range of strategies under this program that promote the supply, affordability and quality of child care services in order to support parents to participate in the workforce and the community (FaCS 1999a:182).

Box 5.4: Commonwealth Child Care Support

The key objective of Commonwealth Child Care Support (CCCS) is to assist families with dependent children to participate in the workforce and the general community by supporting the provision of affordable quality child care. The major funding mechanisms include:

Child Care Benefit—which assists families with their child care costs (see Affordability, page 170).

- *Since July 2000, most long day care centres, all family day care schemes, most outside school hours care services, some occasional care services, and some multifunctional services are approved to offer the Child Care Benefit (CCB) to eligible children using their services. These services offer the maximum rate of CCB (depending on family income) for up to 50 hours of work-related care and for up to 20 hours of non-work-related care a week. Service providers are required to participate in the Commonwealth's quality assurance processes (where this applies). Services previously approved for the former Childcare Assistance payment are approved for the CCB.*
- *Service providers not approved for the CCB (such as State/Territory-only funded occasional care and preschool services) and individuals providing informal care can register for the CCB. Parents using registered services can claim the minimum CCB if they use care for work-related reasons. Service providers previously registered for the former Childcare Rebate are registered for the CCB.*

Operational and capital funding—all family day care schemes, some occasional care centres, some multifunctional services, all Multifunctional Aboriginal children's services (MACS) and some mobiles receive operational funding on an ongoing basis. Some long day care centres and outside school hours care services in rural, remote and urban fringe areas receive the Disadvantaged Areas Subsidy (DAS). Family day care schemes and outside school hours care services may also receive capital funding in the form of loans, grants and upgrades.

Additional support for children with special needs—all types of service providers can receive funding to assist them to integrate children with additional needs, such as children with a disability, into their services.

Source: AIHW 1999a:99; FaCS website 2001 www.facs.gov.au.

Box 5.5: Commonwealth child care initiatives, 1999–2001

In December 1999, the then Minister for Family and Community Services, the Hon. Jocelyn Newman, announced the funding of two Family Crisis Child Care Pilot Projects. These pilot projects were aimed at assisting families in severe crisis, such as families where parents have an alcohol or drug addiction. Additional pilots were announced in 2000 and 2001, including the Caravan Parks Family Crisis Pilot in January 2001.

In the 2000–01 Federal Budget, a number of child care initiatives were announced as part of the Stronger Families and Communities Strategy and have now been introduced.

- *From January 2001, under the In Home Care Initiative, families who do not have access to standard child care services or whose child care needs cannot be met by existing services are eligible to have child care provided in their own home. This includes families living in rural areas, parents who work shift hours or non-standard hours of work and parents with a sick child or a child with a disability.*
- *From January 2001, operators of long day care centres (community-based and private) and other private-for-profit bodies are eligible for Commonwealth funding to provide family day care and outside school hours care in areas of need as identified by the National Planning System.*
- *From 1 July 2001, the Commonwealth provides incentives to encourage private operators to establish child care centres in rural areas where there is unmet demand for child care for children under school age and no existing child care centre.*

Source: FaCS 2000c; Newman 2000, 2001.

New priority of access guidelines are now in operation for parents wanting to access Commonwealth-supported child care services (FaCS 2000b:5). These guidelines give first priority to a child at risk of serious abuse or neglect, followed by a child of a single parent who satisfies, or of parents who both satisfy, the work/training/study test. Within each of these categories, children in Aboriginal or Torres Strait Islander families; children in families which include a person with a disability; children in families on low incomes; children in families with a culturally diverse background; children in socially isolated families; children of single parents are to be given priority.

The Commonwealth has introduced a number of initiatives in relation to child care in the last few years. The most important of these was the introduction of the Child Care Benefit (CCB) in July 2000. The CCB, which assists families with their child care costs, replaced Childcare Assistance and the Childcare Rebate (see Affordability section, page 170, for more detail). With the introduction of the CCB, there was a shift in focus from funding service providers to funding parents to use approved services. Various other Commonwealth child care initiatives have been introduced in the past 2 years, including the In Home Care Initiative, where families with particular needs are supported to have child care provided in their own homes (Box 5.5).

All State and Territory Governments fund dedicated preschool services for children in the year or two before they begin school full-time (Press & Hayes 2000). They also provide some funding for child care services mainly occasional care services, vacation care services and, in some jurisdictions, long day care centres (AIHW 1999a:100—6). These governments are also responsible for licensing/regulating child care services within their jurisdiction. The Commonwealth and some State and Territory Governments have accreditation processes in place for some of their funded services.

As noted previously, nationally comprehensive and comparable data on State and Territory funded preschool and child care services are not available, although illustrative data are published in the *Report on Government Services* (SCRCSSP 2001:641—69). For instance, the report shows that in 2000 there were around 61,500 children in Victoria, 18,000 in South Australia and 6,4000 in Tasmania attending preschool services in the year before full-time school.

Because of the lack of national data, the following sections will focus solely on formal child care services supported by the Commonwealth, using data from the Commonwealth child care data collections (see Box 5.3).

Sponsorship of service providers

Although the Commonwealth has a major role in supporting the provision of child care services, it does not directly provide such services. Prior to 1 July 2001, with the exception of centre-based long day care services, generally only non-profit bodies were eligible for Commonwealth support to provide child care services. This situation has now changed, however, with private-for-profit bodies now eligible for Commonwealth support to provide family day care and outside school hours care services in specified geographic areas (see Box 5.5).

In June 2000, the type of sponsorship of Commonwealth-supported child care services varied according to the type of service provided.[4] For example, outside school hours care (75%) and occasional care services (62%) were predominantly sponsored by non-profit organisations (Table 5.10). Local government (41%) and non-profit organisations (39%) were the main sponsors of family day care services. In contrast, the majority of long day care centres (67%) were privately owned. State and Territory Governments were responsible for sponsoring only a small minority of Commonwealth-supported child care services, ranging from 1% of long day care centres to 11% of occasional care services. As noted, the Commonwealth Government did not sponsor any child care services.

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[4] A sponsor is the entity (person, organisation or enterprise) that is legally responsible for the provision of the services. For licensed services, the sponsor is the licensee. For funded services, the sponsor is the entity that signs the funding agreement and is accountable for the funds.

Table 5.10: Commonwealth-supported child care service providers, by type of sponsorship and service, 30 June 2000 (per cent)

Type of sponsorship	Long day care centres	Family day care[(a)]	Outside school hours care[(b)]	Occasional/ other care[(c)]
Local government	9	41	16	11
Non-profit	20	39	75	62
Religious/charitable	4	16	6	15
Privately owned	67	—	—	1
State/Territory Government	1	3	3	11
Total	**100**	**100**	**100**	**100**
Total number of agencies	**4,012**	**372**	**4,706**	**655**

(a) Family day care coordination units.

(b) For these services, the ‘sponsor’ is counted for each service type rather than each service provider. Note that one service provider may provide more than one service type (before school care, after school care, vacation care).

(c) Includes occasional care centres and neighbourhood model services, MACS and other multifunctional services.

Source: FaCS unpublished data.

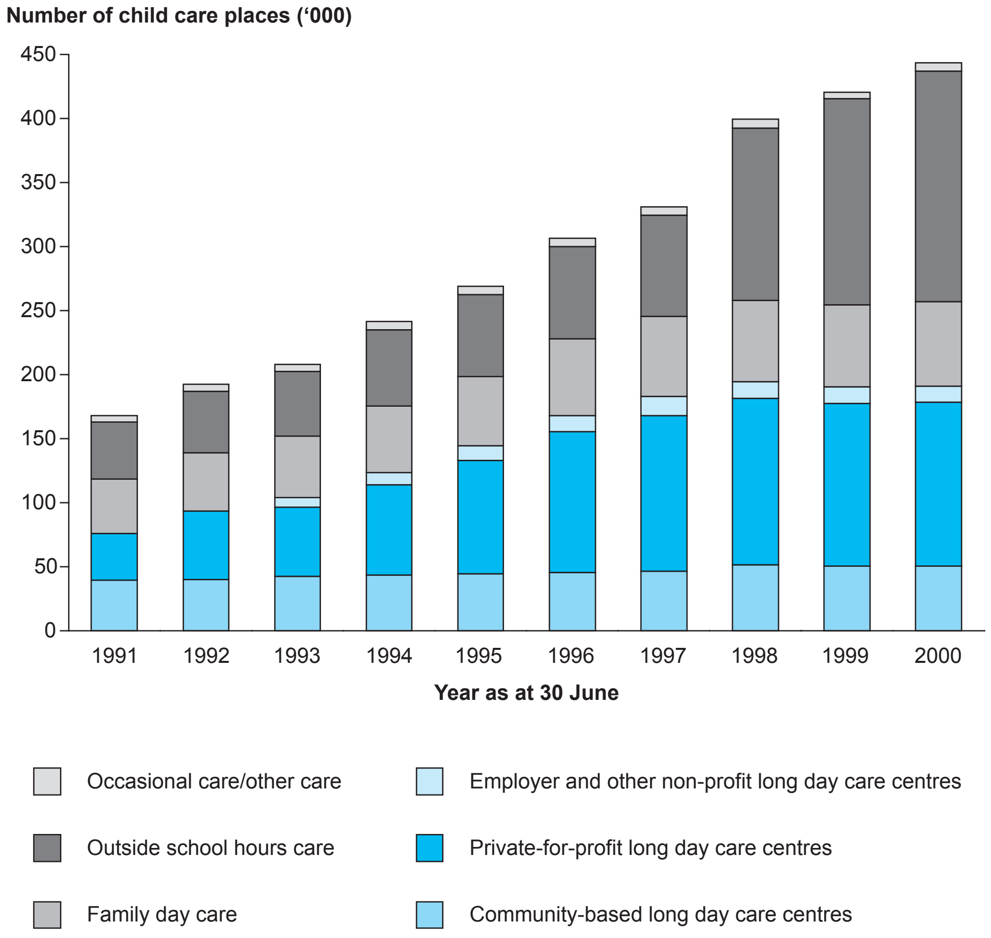
Trends in Commonwealth-supported child care

Number of service providers and child care places

Between 1991 and 2000, the total number of service providers supported by the Commonwealth increased by 145% (from 3,972 to 9,745) (Table A5.4), while the total number of Commonwealth-supported child care places increased by 164% (from 168,276 to 443,444) (Table A5.5). For each service provider, the total number of child care places is equivalent to the total number of children who can use the service at any one time during the hours that the service operates. The number of children using child care services is higher than the number of places, since most children are not in care full-time (Powlay 2000).

Although there was a significant increase in Commonwealth-supported services and places over the period, the increase was not evenly distributed across all service types (Figure 5.6).

The number of long day care centres places grew at a very fast rate between June 1991 and June 1996, reflecting the enormous unrestricted growth in the private-for-profit sector over that period. Prior to 1998, private-for-profit long day care centres (unlike community-based centres) were not subject to strict planning requirements in the form of the Commonwealth s needs-based planning process (AIHW 1997:105). Between June 1996 and June 1998, the rate of growth of this sector was much slower, with the number of funded places increasing by 18% compared with a 55% increase in the preceding 2 years. The number of places in private-for-profit centres increased by only 7% from June 1997 to June 1998, probably reflecting the implementation of the National Planning System in April 1998 (which covered all types of long day care centres) (AIHW 1997:104). Between June 1998 and June 2000 the number of places in private-for-profit centres fell slightly by 1%.



Source: Table A5.5.

Figure 5.6: Commonwealth-supported child care operational places, 1991–2000

The number of places in community-based centres rose between 1991 and 1998 from 39,567 to 51,710 (31%), but then fell slightly (by 3%) over the next 2 years. The number of places in employer and other non-profit centres also increased up to 1997, but then fell over the next 3 years. The fall in the total number of places in long day care centres from 1998 probably reflects problems with the viability of services because of falling utilisation rates over the period (see section on Met demand).

Places in family day care services grew steadily over the decade, from 42,501 in 1991 to 66,294 in 2000, an increase of 56%. In recent years, the Commonwealth has focused on increasing the supply of family day care places, partly because it is considered to be a more flexible form of care and to meet the needs of parents who do not work standard hours (AIHW 1995:134). Family day care fees are also cheaper than those for centre-based care, making family day care more affordable for families (AIHW 2001b).

The number of places in outside school hours care services recorded in the CCS database increased from 44,449 in 1991 to 179,743 in 2000. It is important to note, however, that the large increase between 1997 and 1998 (from 78,970 to 134,354) was mainly due to the inclusion of some Commonwealth-funded places not previously recorded in the database (following changed funding arrangements) and to changes in counting methodology (AIHW 1999a:102).

Number of children

The total number of children using Commonwealth-supported services almost doubled between 1991 and 1999: from 262,200 to 508,200 (Table 5.11). Between 1991 and 1995, the number of children using long day care centres increased at around the same rate as the number of places (85% compared with 89%). From 1995 to 1999, however, the number of children using services increased by 20% while the number of places grew by 32%, reflecting declining utilisation rates over the period (see section on Met demand).

In 1999, more than half (59%) of the children in Commonwealth-supported child care were using long day care centres and 21% were in before and after school care.

Characteristics of children in Commonwealth-supported child care

The majority of children using Commonwealth-supported services were in families with both parents (or a sole parent) in the labour force or studying/training for work. The proportion of children in this category in 1999 ranged from 89% of children using private-for-profit centres to 99% in before/after school care services (FaCS 2000b:8). This reflects the previous priority of access guidelines (AIHW 1995:137).

Table 5.11: Number of children in Commonwealth-supported child care, by type of service, 1991–99

Type of service	1991	1992	1993	1994	1995	1996	1997	1999
Long day care centres	135,400	158,400	190,600	227,300	251,000	n.a.	294,700	301,500
Family day care	61,000	66,100	78,800	88,700	85,600	n.a.	85,000	83,100
Before and after school care	46,800	50,700	53,500	63,900	n.a.	96,400	99,500	107,400
Vacation care	. .	. .	. .	n.a.	n.a.	24,300	31,000	69,300
Other formal care	19,000	26,500	20,900	16,800	n.a.	19,100	n.a.	16,100
Total children	**262,200**	**301,700**	**343,800**	**396,700**	**n.a.**	**n.a.**	**n.a.**	**508,200**

Notes

1. ‘Other formal care’ includes occasional care centres, MACS and other multifunctional services.
2. These data measure occurrences of care and include some double-counting where children attend more than one service. Total for 1999 excludes children in vacation care, since many of these children would also have been attending before/after school care.
3. Figures for 1991–94 are estimates based on previous years Census data. Figures for 1995–97 are from the CP Census conducted in August of each year and are weighted for non-response. However, not all service types were surveyed in each of these years.
4. Components may not add to totals due to rounding.

Source: AIHW 1999a; FaCS 2000b.

Age of children

The age distribution of children attending the different types of services varied, reflecting the different aims of these services. Long day care services, for instance, are targeted to children below school age. In 1999, the majority of children in long day care centres and family day care services were aged 0—4 years, while almost all the children in outside school hours care services were 5 years and older (Table A5.6). There was, however, a strong indication of a more flexible type of service provision, with 29% of the children in family day care and 13% in private-for-profit long day care centres being 5 years and older and thus using these services for school-aged care.

Private-for-profit centres tended to have a lower proportion of very young children than other types of long day care centres. For example, 34% of children using private-for-profit services were 2 years and younger, compared with 45% in community-based centres.

Table 5.12: Children with special needs as a proportion of all children using Commonwealth-supported child care, by special need and type of service, 1999 (per cent)

Type of special need	Long day care centres	Family day care	Occasional/ other care [(a)]	Before/after school care	Vacation care	All services [(b)]
Children from one-parent families	19.3	26.6	17.9	25.4	n.a.	21.9
Child with disability	1.8	3.5	2.4	2.0	3.2	2.1
Parent with disability	0.9	0.3	0.7	0.3	0.3	0.6
Child at risk of abuse/neglect	0.4	0.5	1.2	0.1	0.4	0.4
Aboriginal or Torres Strait Islander	1.4	1.0	12.3	0.9	1.2	1.5
Culturally diverse background	12.6	7.5	7.2	10.5	7.9	11.1
Total number of children in care	**270,235**	**81,418**	**10,979**	**99,902**	**57,521**	**462,534**

(a) Includes occasional care centres, multifunctional services and MACS.

(b) Total excludes children in vacation care, since many of these children would also have been attending before/after school care.

Notes

1. Some children may be included in more than one special needs category.
2. These data are unweighted and therefore are not adjusted for agency non-response.

Source: AIHW analysis of FaCS 1999b.

Children with special needs

The Commonwealth provides specific funding to assist parents and children with special needs to access services (AIHW 1999a:99). Parents and children with special needs include children from one-parent families, children and/or parents with a disability, children of Aboriginal or Torres Strait Islander descent, children from culturally diverse backgrounds, and children at risk of abuse or neglect.

In 1999, children from one-parent families constituted the largest group of children with special needs using Commonwealth-supported child care services (22%), followed by children from a culturally diverse background (11%) (Table 5.12). The proportion of children from other groups with special needs using child care was 2% or less. The use of services by children with special needs varied by service type. The relatively high proportion of children in occasional care/other services who were Aboriginal and

Torres Strait Islander is because this category includes multifunctional Aboriginal children s services (MACS) which are specifically provided to meet the cultural needs of these children.

The proportion of children in Commonwealth-supported child care (22%) who were from one-parent families was higher than the proportion in the population. In 1997, 16% of Australian children aged 0—4 and 19% aged 5—11 were from one-parent families (ABS 1999a). It is hardly surprising that one-parent families are more likely to use child care services than other families, given that they are likely to have a greater need for child care because there is no co-resident parent available to provide care.

In contrast, the proportion of children in child care who had a disability and the proportion who were Aboriginal or Torres Strait Islander was lower than the proportion of these groups of children in the population.[5] Of children in Commonwealth-supported child care services in 1999, 2.1% had a disability, while 4% of children in Australia aged 0—4 years and 9% aged 5—14 had a disability (ABS 1999b:14). Similarly, only 1.5% of children in these child care services were of Aboriginal and Torres Strait Islander descent, whereas Indigenous children were estimated to constitute 4% of the Australian population aged 0—12 years in 2000 (AIHW 1999a). One of the main reasons why Aboriginal and Torres Strait Islander families are less likely to use formal child care than other families is that many of them prefer to use informal care provided by family and friends (ABS 1995).

No population data are available to classify Australian children according to the definition of culturally diverse background used in the Commonwealth Child Care Census. There are also no population data on parents with a disability or children at risk of abuse or neglect.

Government expenditure on child care

Between 1991—92 and 1996—97, Commonwealth expenditure on child care services more than doubled in real terms (constant prices), increasing from $503 million to $1,134 million (Table 5.13). This was mainly due to the growth in expenditure on Childcare Assistance fee subsidies, reflecting the increase in the number of private-for-profit long day care centres over the period. From 1996—97 to 1998—99, however, total Commonwealth expenditure on child care services fell by 4% (in constant prices), falling by 7% between 1996—97 and 1997—98 and then increasing again by 4% from 1997—98 to 1998—99. Between 1996—97 and 1998—99, expenditure on Childcare Assistance and the Childcare Rebate fell by 8% in real terms, while expenditure on service provision (including JET assistance) fell by 13%. The fall in expenditure on fee subsidies probably reflects the drop in utilisation rates of long day care centres over the period.

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[5] In making these comparisons, however, it is important to note that the definitions of ‘disability’ and ‘Aboriginal and Torres Strait Islander’ used in the ABS population surveys are not identical to those used in the Commonwealth Child Care Census, and the methods used in collecting these data are different.

Between 1991—92 and 1998—99, there was a shift from expenditure on service provision to expenditure on measures that reduce the costs of child care for parents. Over the period, the proportion of Commonwealth expenditure on Other services for families with children (which included capital loans, capital grants and upgrades, and operational subsidies) fell from 32% of total expenditure to 17%, while the proportion of expenditure on fee subsidies increased from 64% to 73%.

From 1999—00, child care expenditure is reported on an accrual basis, rather than on a cash basis. Child care expenditure in 1999—00 was $1,278 million in current prices.

Table 5.13: Commonwealth expenditure on child care services by type of expenditure, 1991–92 to 1999–00 ($m in current and constant prices)

	Childcare Assistance[a]	**Childcare Rebate**	**Other services[a][b]**	**JET[c]**	**Departmental running costs**	**Total (current prices)**	**Total constant (1998–99 prices)**	**Deflator**
1991–92	289	. .	145	. .	14	449	503	89.2
1992–93	384	. .	154	. .	16	555	607	91.4
1993–94	497	. .	170	. .	23	691	751	92.0
1994–95	592	87	181	. .	34	894	965	92.6
1995–96	657	121	191	10	36	1,014	1,072	94.6
1996–97	711	127	206	7	41	1,092	1,134	96.3
1997–98	640	123	218	5	40	1,026	1,050	97.7
1998–99	677	121	182	10	102	1,091	1,091	100.0
Break in series								
1999–00	749	164	195	11	158	1,278	1,250	102.2

(a) Including Special Purpose Payments.

(b) Other services for families with children. Includes: Operational subsidy and capital funding.

(c) Jobs, Education and Training Program (JET). Child care for eligible parents undergoing training (AIHW 1999a:99).

Note: In 1999–00, expenditure is reported on an accrual basis. Prior to 1999–00, it is reported on a cash basis.

Source: ABS 2000g; FaCS unpublished data.

Outcomes

The aims and objectives of government support for child care services are to provide services that are accessible, affordable and of high quality, and that allow parents to participate in the labour force and undertake other activities. As a condition of government funding and regulation, these services must promote and enhance children s emotional, intellectual, social and physical development.

The long-term effects of child care on children continue to be the subject of considerable research and debate. One of the main aims of the FaCS longitudinal study of Australian children, for instance, is to assess the impact of non-parental care on children s development and wellbeing.

The discussion in this section, however, focuses on service outcomes rather than client outcomes. Service outcomes are discussed in terms of accessibility including affordability and quality.

Accessibility

Unmet demand for formal child care services

One direct measure of unmet demand comes from the ABS Child Care Survey, which asks parents whether they wanted to use either some formal child care or additional formal care, but did not do so (ABS 2000f:26). In 1999, the survey found that the proportion of children for whom parents said that they wanted to use formal care but did not do so was 6% (or 201,100 children). The main reasons for parents not using the formal care they wanted were that the care available was too expensive (33% of children), there were no places available (14%), and no care existed in the local area or parents had no knowledge of its existence (12%) (ABS 2000f:32).

The survey also found another 6% of children (193,600) whose parents said that they did not want to use any formal care (or any additional care) because of problems with the accessibility of services. The main reasons were that the care available was too expensive (82%), care was not available when required (10%) and transport or distance was a problem (8%) (ABS 2000f:32).

The level of unmet demand relates to the population of children for whom parents had problems in accessing formal care, rather than only to those who reported that they needed formal care but could not obtain it. Thus, in 1999, the level of unmet demand for formal care would be for 397,400 children. This compares with a total of 733,200 children using formal care at this time.

Commonwealth estimates of met demand

FaCS uses labour force survey data and other information to estimate the extent to which its funded services have met the demand for work-related child care. Met demand is expressed as the ratio of the number of places provided to the estimated number of places required.

The department s National Supply Demand Model estimates the number of places required for children needing work-related care. In making these estimates, the model takes into account factors such as the number of children with both parents (or a sole parent) working, looking for work, studying or training; parents full-time and part-time labour force participation. It also takes into account parents preferences for formal/informal care; and parents preferences for different service types (DHFS 1998:144). The model, however, does not take into account the effect of cost (or affordability) on parents demand for child care.

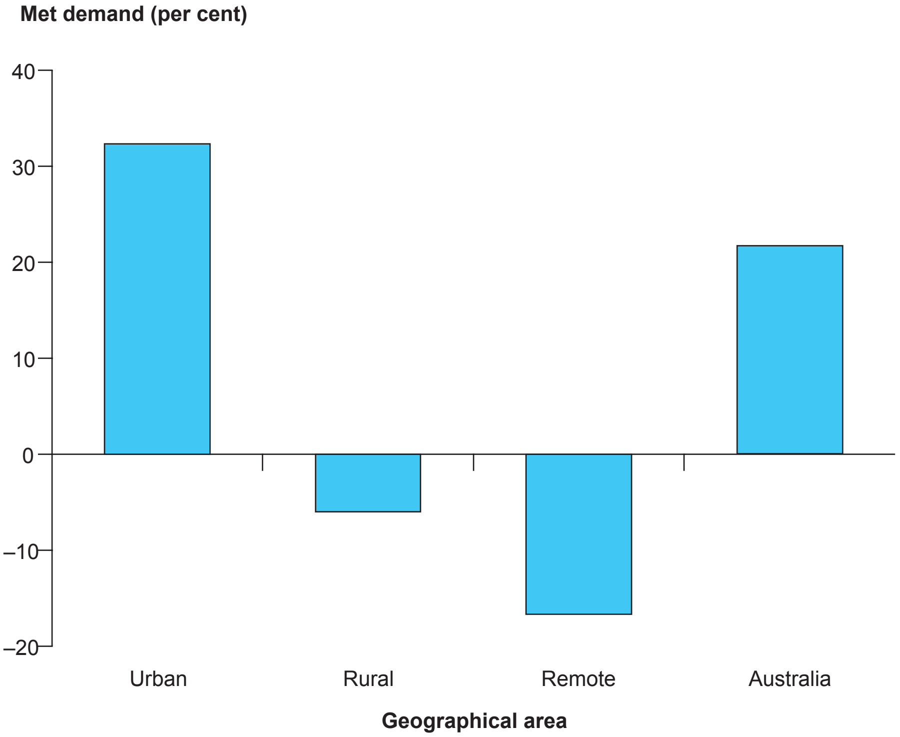
The FaCS estimates of met demand and the ABS Child Care Survey estimates of unmet demand use very different methodologies and have a different scope. The FaCS model examines the extent to which Commonwealth-supported child care services meet the demand for work-related care, while the ABS survey asks parents to report their unmet demand for all child care and preschool services for work-related care and non-work-related care. However, even when these differences are taken into account, the FaCS estimates are inconsistent with the ABS estimates.

In June 2000, FaCS estimated that, Australia-wide, there was an oversupply of places of 22% for children under school age needing work-related care (Figure 5.7). The estimated level of oversupply varied considerably, however, by geographic area.

Oversupply was estimated to be greatest in urban areas (32%), while there was an under-supply in rural areas (6%) and remote areas (16%).

In relation to outside school hours care services, at the national level there was an estimated oversupply of before/after school care places and an under-supply of vacation care places. At June 2000, FaCS estimated that, Australia-wide, the level of met demand for before/after school care was 110% and for all outside school hours care places (including vacation care), 84% (FaCS 2000a:197). Wide variations in met demand by geographic area were also noted.

FaCS (2000b:12-13) has pointed to the declining utilisation rates of long day care centres and before/after school services as a further indication of an oversupply of places. Between 1997 and 1999, average utilisation rates in long day care centres measured by total child hours paid for as a percentage of total capacity fell from around 80% to 71%, continuing the fall from a 90% utilisation rate in 1995. Similarly, average utilisation rates for before/after school care measured by total days attended as a percentage of total days available fell from 76% to 68% between 1997 and 1999.



Source: Table A5.7.

Figure 5.7: Estimated met demand for child care places, 2000

Box 5.6: Commonwealth Child Care Benefit (CCB)

From July 2001, where children use approved *services, families with incomes of $29,857 or less receive the maximum rate of CCB of $129 per week for 50 hours of care for one child not at school—or $2.58 per hour of care used. Above this income level, the CCB tapers down to a minimum rate of $21.70 per child for 50 hours of care per week—or $0.434 per hour of care used. Families with one child in care are eligible for the minimum rate of CCB when family income is $85,653 or more. The rate of CCB for children at school is 85% of that payable for children not at school. Families with more than one child in care are paid a loaded (additional) rate of CCB, as are families with children using long day care centres and family day care services for part-time care.*

Families with children in work-related care using registered *services (e.g. State/Territory-only funded child care or preschool services, or informal care) can claim the minimum rate of CCB.*

Families using approved *care can choose to have their CCB paid to the child care services (i.e. directly reduce the fees that they pay) or can receive it in the form of a lump sum from the Family Assistance Office (FAO) at the end of the financial year. Families using* registered *care can claim the CCB from the FAO during the year.*

As the ABS Child Care Survey found, however, affordability of care has an impact on parents demand for care. It is thus likely that the falling utilisation rates in long day care centres between 1995 and 1999 can partly be attributed to the decline in the affordability of care over the period. More recently, utilisation rates in long day care centres increased from 74% in April 2000 to 87% in October 2000 (Datacol 2001). This increase followed the introduction of the CCB, which improved the affordability of care.

Affordability

As noted earlier, the Commonwealth Government provides fee subsidies to make child care more affordable for families. The Child Care Benefit (CCB) was introduced in July 2000, as part of a new tax system to improve the affordability of care (Box 5.6). The payment is not only higher in dollar terms than the fee subsidies that it replaced (Childcare Assistance and the Childcare Rebate), but is simpler to calculate and administer (AIHW 1999a:116—18). The payment is indexed annually.

In the 2000 December quarter, 444,400 families had claimed the CCB as a fee reduction, around 39% receiving the maximum rate and around 26% the minimum rate. At this time, there were another 26,500 families using approved services who were eligible to claim the CCB as a lump sum at the end of the 2000—01 financial year (FaCS unpublished).

Despite assistance having been increased, most families receiving the maximum CCB still pay some of the costs of child care, since fees are generally higher than the maximum amount of assistance available. The amount that families pay for child care depends on the fees charged, family income, the number of children in care and the hours of care that they use.

At June 2000, average full-time weekly fees for community-based long day care centres were $175, and for private centres (private-for-profit and employer-sponsored) $167 a week (FaCS unpublished). Fees for 50 hours a week of family day care were $139 at May 1999 (FaCS 2000b:77). This compares with the maximum CCB of $122 for 50 hours of care a week at 1 July 2000. A family with one child in care full-time at a private centre, for example, and receiving the maximum CCB would thus have had child care costs of $45 per week in mid-2000. In 1999, however, most children in long day care services were not using full-time care only 14% of children in long day care centres (community-based and private) and 3% in family day care were using 50 hours of paid care per week (Powlay 2000). Thus, when examining the affordability of child care, it is more appropriate to look at costs for part-time care.

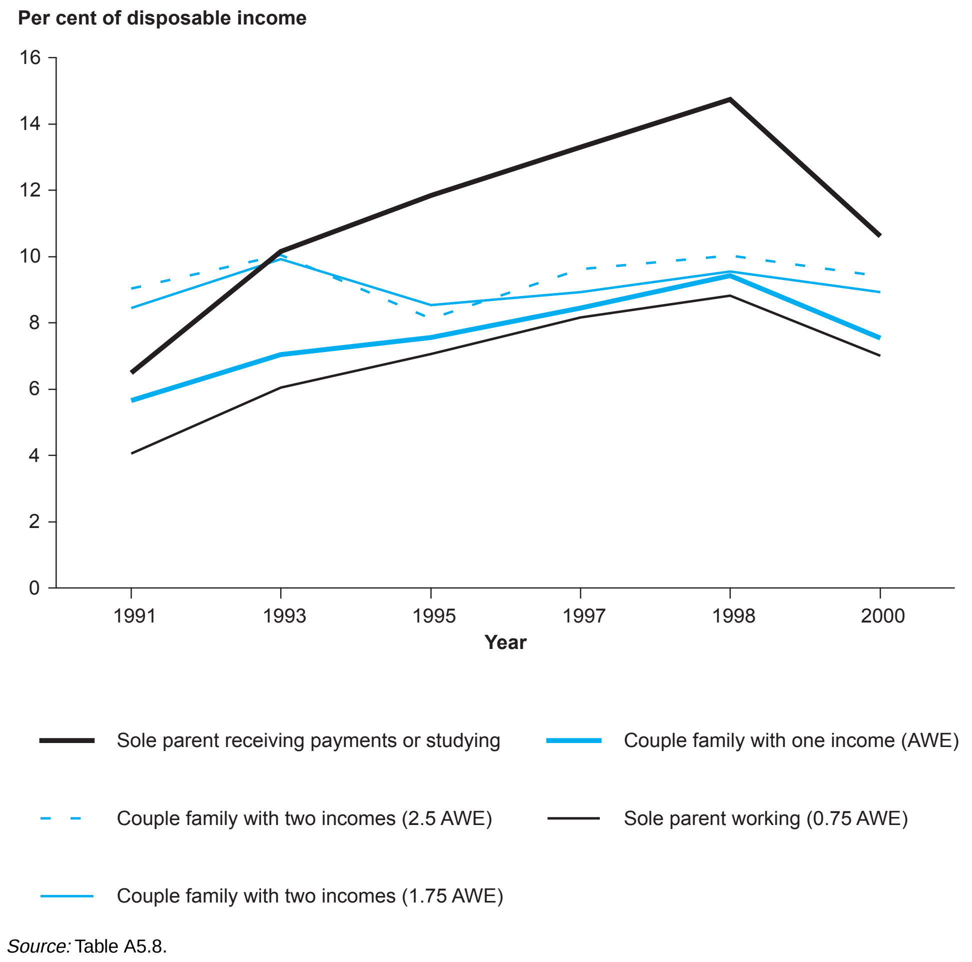
Changes over time

The AIHW (2001b) has examined changes over time in the affordability of long day care services. This analysis examines affordability for five different hypothetical families with one child using 20 hours of paid care a week and with one child using 40 hours of paid care a week. Child care costs (fees charged, less government assistance) as a percentage of disposable income were taken as the indicator of child care affordability. Data for families with one child using 40 hours of care in a private long day care centre are presented here for illustrative purposes (Figure 5.8).

Over the period 1991—98, child care became less affordable for all the family types using long day care centres. Child care costs as a proportion of disposable income increased for all family types, particularly for the low-income families. For example, for a couple on average weekly earnings (AWE) using a private long day care centre for 40 hours a week, child care costs relative to disposable income increased from 5.7% to 9.4%. In contrast, the affordability of family day care services fell slightly for the lower income families but improved slightly for the two highest income families over the same period (AIHW 2001b). Among families using family day care for 40 hours a week, for example, child care costs as a proportion of income increased from 5.3% to 6.2% for sole parents on Parenting Payment and fell from 9% to 8% for couple families on 2.5 AWE.

Child care costs as a proportion of disposable income fell for all family types using all types of long day care services in July 2000 following the introduction of the CCB. Between 1998 and 2000, child care costs relative to disposable income for families using private long day care centres for 40 hours a week fell from 14.7% to 10.6% for a sole parent on Parenting Payment and from 9.4% to 7.5% for a couple on AWE. Affordability improved markedly for families with low and middle incomes who were using family day care services (AIHW 2001b). In 2000, sole parents on Parenting Payment and sole parents on 0.75 AWE were paying nothing for 20 or 40 hours of family day care, while couples on AWE were paying 0.8% of their disposable income for 20 hours of care and 1.7% for 40 hours of care.

These data, however, overstate the improvements in the affordability of care at this time (except where costs fell to zero). One of the reasons for child care costs falling relative to disposable income is that disposable incomes increased to compensate families for the effects of the goods and services tax (GST). Because purchasing power reduced with the



Source: Table A5.8.

Figure 5.8: Trends in affordability of child care, for one child using private long day care for 40 hours per week, 1991–2000

introduction of the GST, the increases in disposable income (and thus in child care affordability) are generally not as great as they appear. Affordability might not have improved at all, however, if the new tax system had applied the GST to child care fees.

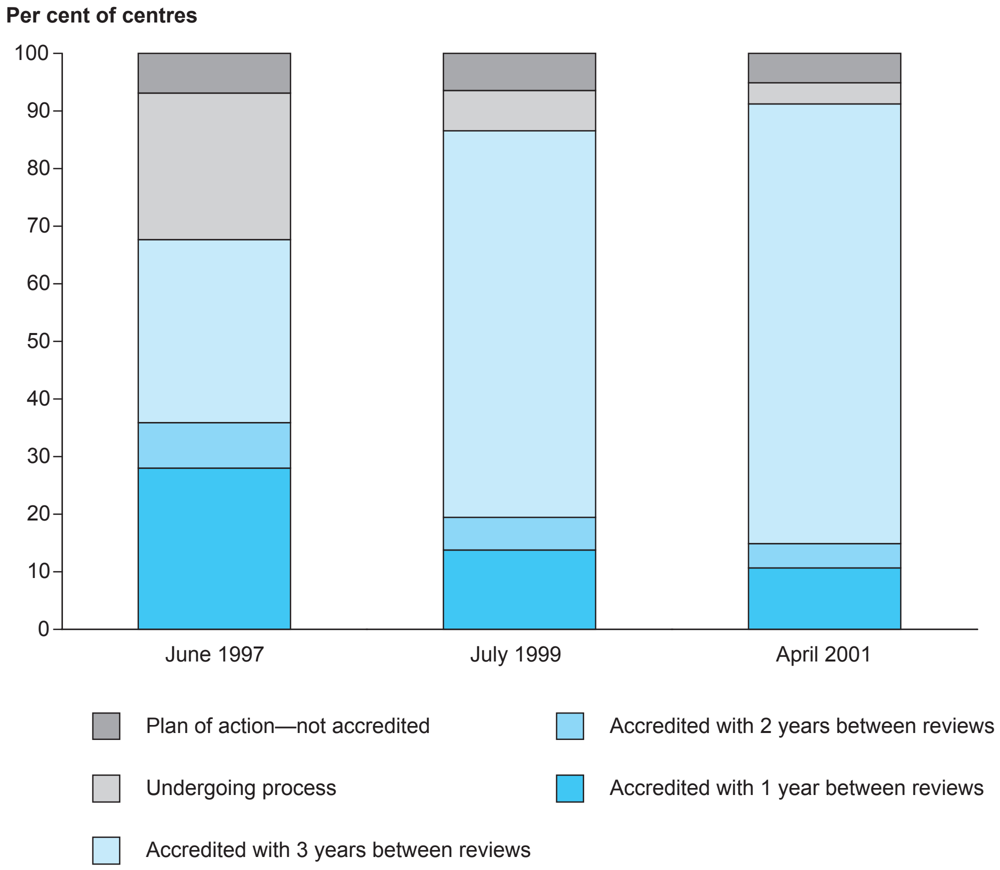
Quality

Legislative regulations (or funding guidelines) and accreditation (or quality assurance) systems are the two mechanisms for assuring quality in the child care sector. The regulations specify the minimum standards which must be met (or quantifiable inputs) in order for the service to operate. These standards relate to the physical environment, health and safety, staff—child ratios, staff qualifications and program activities. Licensing provisions exist for many, but not all, types of child care services.

Accreditation processes (or quality assurance systems), on the other hand, focus on measuring the quality of aspects of the services that are delivered, for instance staff responsiveness to children in their care (AIHW 1997:127).

Accreditation

The Commonwealth Government is responsible for accrediting all long day care centres approved for the CCB through its Quality Improvement and Accreditation System (QIAS), which is administered by the National Childcare Accreditation Council. The current accreditation system has been reviewed and revised, but the revised QIAS will not be implemented until 2002 (NCAC 2001). From 1 July 2001, family day care schemes are required to participate in a quality assurance scheme that was developed in consultation with the family day care sector. A quality assurance system is also being developed for outside school hours care services in consultation with that sector, with implementation planned for 2002—03.



Source: Table A5.9.

Figure 5.9: Accreditation status of Commonwealth-supported long day care centres, June 1997, July 1999 and April 2001

At April 2001, almost all long day care centres approved for the CCB were accredited, around three-quarters of them for the maximum period (3 years). Between June 1997 and April 2001, the proportion of all long day care centres that were accredited increased from 68% to 91%, with the proportion accredited for 3 years increasing from 32% to 76%. The number of long day care centres undergoing the process of accreditation decreased from 25% in 1997 to 4% in 2001. At April 2001, only 5% of all long day care centres were not accredited and were working through a plan of action approved by the National Childcare Accreditation Council to bring them up to standard (Figure 5.9).

Staff qualifications

The quality of care has been shown to be strongly related to whether or not staff working in those services have had appropriate training in the child care area (Ochiltree 1994). State and Territory child care licensing regulations all contain specifications of recognised qualifications for various staffing positions.

Information on relevant qualifications held by child care workers was collected in the Commonwealth Child Care Census for every service type. While relevant qualifications vary slightly by service type, they generally include qualifications in early childhood and primary teaching, child care, nursing and other relevant areas such as social work and business management. In 1999 just over half of workers in long day care centres, one-fifth of family day care providers, and around 40% of workers in other services had at least one relevant qualification (Table A5.10). The proportion of workers with no relevant qualification but currently studying for one ranged from 6% in family day care to 20% in vacation care. The proportion of workers who had no relevant qualifications and were not studying for any, but who had worked in the child care sector for more than 3 years, was highest for family day care providers (44%) and lowest for workers in private-for-profit long day care centres (14%).

Information on in-service training undertaken by staff was also available from the Child Care Census. In 1999 more than half of workers in all types of child care services had undertaken in-service training in the previous 12 months (Table A5.10). Family day care workers were the most likely to have done so (88% of coordination unit staff and 77% of care providers), followed by staff in private-for-profit long day care centres (70%).

5.5 Child protection and out-of-home care services

Child protection is the responsibility of the community services department in each State and Territory. Children who come into contact with the department for protective reasons include those:

- who have been or are being abused or neglected or otherwise harmed; and/or
- whose parents cannot provide adequate care or protection.

The aim of child protection services is to protect children and young people who are at risk of harm within their families, or whose families do not have the capacity to protect them. The services include:

- receiving and responding to reports of concern about children and young people, including investigation and assessment where appropriate;
- providing support services to strengthen the capacity of families to care safely for their children;
- initiating intervention, including applying for a care and protection order through a court if necessary and placing children and young people in out-of-home care to secure their safety;
- ensuring the ongoing safety of children and young people by working with families to resolve protective concerns;
- working with families to reunite children (who were removed for safety reasons) with their parents as soon as possible; and
- securing permanent alternative care when children are unable to live with their parents (SCRCSSP 2001:686).

This section examines trends over the last decade in the number of child protection notifications, investigations and substantiations, children on care and protection orders, and children in out-of-home care. Some data on trends for Indigenous children are also provided.

Data sources

The AIHW has been responsible for collecting the national child protection data since the early 1990s. The data cover three main areas of child protection:

- child protection notifications, investigations and substantiations (formerly referred to as child abuse and neglect);
- children on care and protection orders; and
- children in out-of-home care.

In addition, some preliminary national data on family preservation services were collected for the first time in 1999—00. These are specialist services that seek to prevent the separation of children from their families, or to reunify families where separation has already occurred. Only three jurisdictions, however, could provide data on the characteristics of clients receiving these services so the data on these services are not included in this chapter. There are no other national data on family support services or on the other work undertaken by child protection workers to keep children safe.

The national child protection data were extracted from the administrative systems of the State and Territory community services departments according to definitions and counting rules agreed to by the departments and the AIHW. For more information about child protection processes, refer to AIHW (2001c).

Children who are in need of protection

Concerns about children and young people who may be in need of child protection services can be brought to the attention of the community services departments by parents, other relatives or children themselves, by people outside the family or by professionals who have contact with children and families.

Box 5.7: Child protection in the 1990s

Child protection policies have continued to evolve during the 1990s. During this period increasing numbers of children were reported to State and Territory child protection authorities for child protection reasons. This put the child protection system under increasing pressure as more resources were required to deal with larger numbers of children coming into the system.

During the 1990s it was also recognised that a forensic style investigation was generally not the most appropriate way of dealing with many of the families who were reported to child protection authorities. A large number of the reports that come to community services departments are about situations in which parents are under stress and not coping with their parental responsibilities. Across Australia, the responses of child protection authorities to reports of concerns about children or harm to a child have become less punitive and less interventionist, and more focused on collaboration and helping parents.

Most jurisdictions have introduced options for differential responses, that is ways of responding to the less serious reports about children. These differential responses do not involve a formal investigation and generally involve the provision of some kind of advice or family support service. More resources have been directed to family support services although there are no data at the national level on the number of families or children in receipt of such services (see Data Developments section, page 192).

At the same time many jurisdictions have changed the focus of their child protection systems away from the actions of the parents and guardians to the outcomes for the child. The focus has therefore moved from the identification and investigation of narrowly defined incidents referred to as child abuse and neglect, towards the identification and investigation of actual harm or risk of harm to the child, and to meeting the child's protective needs.

Other significant changes include the introduction of structured risk assessment tools (for example in South Australia) to help workers identify children in high-risk circumstances, to determine what services are necessary for the child and the family, and to document the basis for decisions and provide some consistency of response.

The importance of early intervention and prevention has also been recognised and more resources have been allocated to this area. Early support for families is now seen to be effective in preventing or reducing the level of more intrusive interventions at later stages.

Source: AIHW 2001c; Cashmore 2001; Johnstone 2000.

There are, however, a number of factors associated with involvement in child protection services. Socioeconomic status is one important factor, with the available data indicating that it is children from families with low socioeconomic status who are most likely to be in the child protection system. Data on the socioeconomic status of families in the child protection system are not available at the national level, but studies in a number of different jurisdictions have demonstrated the link between child protection and low socioeconomic status.

A 1995 Victorian study, for example, found that families who were investigated by the child protection services were more likely to be on a pension or benefit than those in the wider community (58% compared to 26%) and were more likely to be in rental housing (60% compared to 23%) (Prent & Lewis 1996). A South Australian study (Hood 1998), examining referrals from the child protection services to the Women s and Children s Hospital, found that 82% of the children referred lived in areas in the two lowest socioeconomic clusters. A New South Wales study (Weatherburn & Lind 1997) also found that reports (or notifications) of child abuse and neglect to the Department of Community Services were correlated with poverty and unemployment.

Weatherburn and Lind (1997) argue that both economic stress and social disadvantage can disrupt the parenting process in ways that lead to child abuse or neglect. Their study found a correlation between the level of social and economic stress in an area and the rates of notifications of child abuse and neglect. They noted, however, that the effects of social and economic stress can be exacerbated or ameliorated by a range of other factors.

The relatively high rates of Indigenous children in the child protection system are consistent with these findings. The national data show that the rates of Aboriginal and Torres Strait Islander children in substantiations are six times higher than the rates of other Australian children, while the rates of Indigenous children in out-of-home care are nine times higher than those of other children (AIHW 2001c). The lower socioeconomic status of Aboriginal and Torres Strait Islander families is likely to be an important factor in this over-representation.

Family disruption appears to be another important factor that is associated with involvement in the child protection system. The national child protection data show that children from one-parent families and from step or blended families are over-represented in child protection substantiations (AIHW 2001c). This over-representation is likely to be related to the additional stresses that sole parents face. For example, they are more likely to have low incomes and be financially stressed, and to have less support in their immediate family.

Other factors that have been associated with involvement in the child protection system include residential instability, crowded dwellings, domestic violence, alcohol and substance abuse, and psychiatric disability (Prent & Lewis 1996; Weatherburn & Lind 1997).

Trends in the use of child protection services

The AIHW has national data on the number of child protection investigations and substantiations for the years from 1990—91 to 1999—00, and on the number of notifications for the years from 1995—96 to 1999—00. The definitions of these terms are provided in Box 5.8.

Before examining national trends it is important to note that each jurisdiction has its own legislation, policies and practices in relation to child protection. The related data reflect some important variations in what jurisdictions do and in how they count child protection matters. These differences are apparent in the variation in the rates of children aged 0—16 years in child protection notifications, investigations and substantiations. In relation to substantiations, for example, rates ranged from 6.3 per 1,000 children in Victoria to 0.7 per 1,000 in Tasmania. For more information about the differences between jurisdictions, see AIHW (1999b).

Box 5.8: Definitions for notification, investigation and substantiation

Notification—is a contact made to the authorised department by persons or other bodies making allegations of child abuse and neglect, child maltreatment or harm to a child. The data on child protection notifications, investigations and substantiations in the national data collection relate to those notifications received by community services departments between 1 July and 30 June of the relevant financial year.

Investigation—is the process whereby the community services department obtains more detailed information about a child who is the subject of a notification and makes an assessment of the degree of harm or risk of harm for the child. After an investigation is completed, a notification will either be 'substantiated' or 'not substantiated'.

Substantiation—a notification will be substantiated where it is concluded after investigation that the child has been, is being or is likely to be abused or neglected or otherwise harmed.

It should be noted that children can be the subject of more than one notification, investigation and substantiation in any year.

Notifications, investigations and substantiations

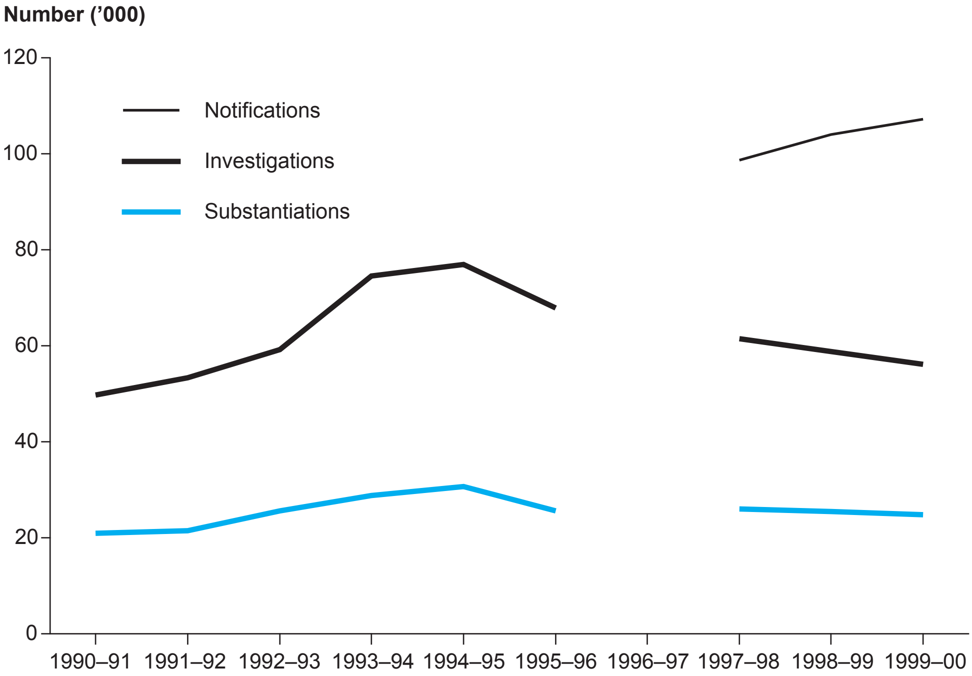
The national trend in notifications is one of increasing numbers between 1995—96 and 1999—00 (Figure 5.10). Across Australia, the number of notifications increased by 17% over this 4-year period to reach 107,134 in 1999—00. While there are no earlier national data on notifications, it is likely that the number of notifications increased significantly in the first half of the 1990s as there were large increases in the number of investigations.

Possible reasons for the increase in the number of notifications include:

- increased reporting by professionals as a result of the mandatory reporting provisions in most jurisdictions;
- increased awareness in the community about child abuse and neglect and the role of community services departments in this area; and
- increases in the number of children who require a child protection response, for example, because of an increase in the incidence of child abuse and neglect or inadequate parenting causing harm to a child.

Between 1990—91 and 1994—95, the number of investigations across Australia increased by 55% to reach 76,954. The number then fell each year to 56,083 in 1999—00. The trend in substantiations during the 1990s was similar, that is one of increasing numbers up to

1994—95, followed by a period of decreasing numbers. Substantiations rose by 47% from 20,868 in 1990—91 to 30,615 in 1994—95, and then fell by 19% to 24,732 in 1999—00 (Table A5.11).



Note: National data not available for 1996–97.

Source: Table A5.11.

Figure 5.10: Notifications, investigations and substantiations in Australia, 1990–91 to 1999–00

National trends, however, mask the different trends that have occurred in each State and Territory over the last decade. Increases in numbers of children in the child protection system in one jurisdiction can cancel out decreases that occur in another, so that what has occurred in each jurisdiction can vary significantly from the national trends.

In particular, policy changes within jurisdictions can have a major impact on the numbers of children in the child protection system. The decrease in the number of investigations and substantiations from the mid-1990s, for example, was primarily due to changes in child protection policy in a number of jurisdictions. These changes allowed for a significant proportion of reports of concerns about children to be dealt with in ways other than through a formal investigation. These policies were introduced at different times in these States, but in each case led to substantial decreases in the number of investigations and substantiations.

In jurisdictions where these types of policies were not introduced, such as Victoria and Queensland, the number of investigations and substantiations did not significantly decrease, and in some cases continued to increase over the 1990s.

Trends in Queensland and Western Australia

The data for Queensland and Western Australia illustrate the different trends and show the impact of policy changes on the number of child protection notifications, investigations and substantiations.

The broad trend in Queensland was one of increasing numbers of children in the child protection system. Notifications increased by 24% between 1995—96 and 1999—00. Investigations decreased for a period in the early 1990s and then increased up to 1997—98. The number of investigations fell by 25% between 1990—91 and 1992—93, then increased by 79% to reach 15,245 in 1997—98, remaining relatively stable since then (Figure 5.11). The number of substantiations followed a similar trend to the number of investigations, with the overall trend one of increasing numbers.

The decrease in the number of investigations and substantiations in the early 1990s followed the introduction of a new framework for managing child protection matters in 1992. The three tenets of this framework were: a three-level response to reports of harm to ensure the level of intervention does not exceed that which is necessary to protect the child; ongoing assessment of the child s protective needs; and participation by families in decision-making processes (Elliott & Sultmann 1998).

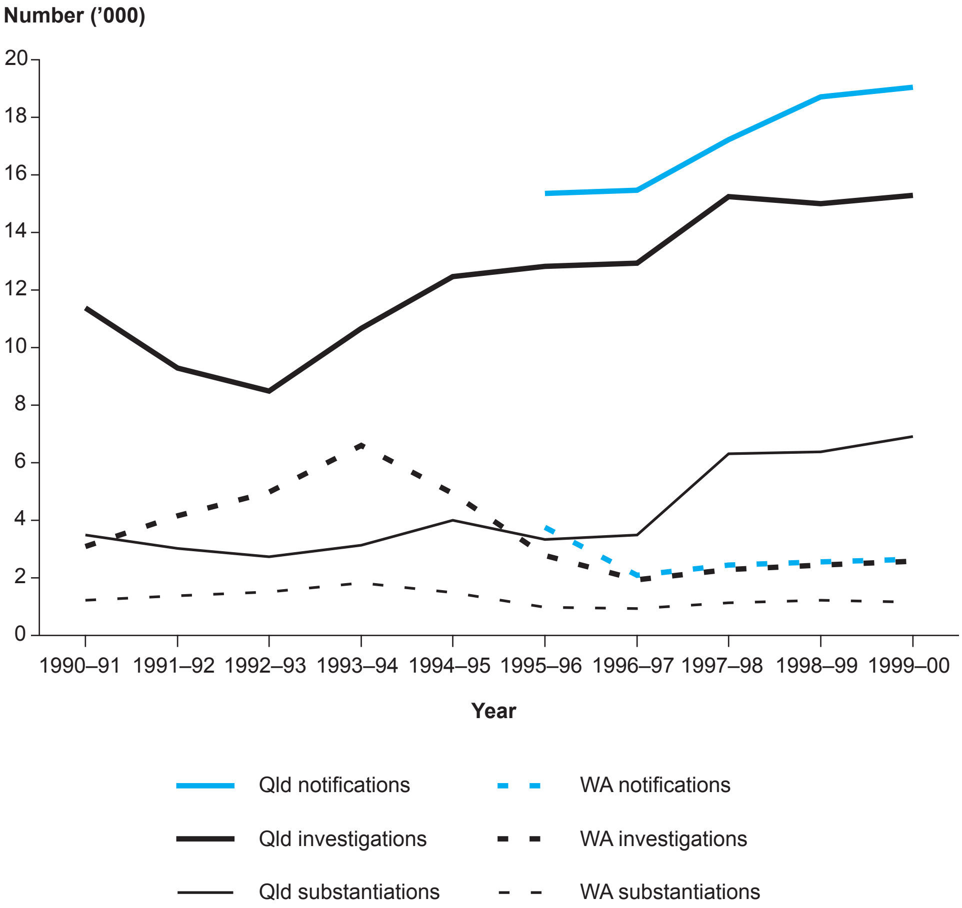
The trends in Western Australia were very different from those in Queensland and reflect the major new policy directions taken in the mid-1990s. Under New Directions , which was piloted in 1994 and phased in during 1995 and 1996, reports of concerns about children and their families were distinguished from concerns about maltreatment of children, and where there was no indication of maltreatment, they were dealt with separately and not classified as a notification. A new definition of maltreatment that focused on harm to a child rather than an action was also introduced.

After the piloting and phased introduction of New Directions , there was a substantial decrease in the number of notifications, investigations and substantiations (Figure 5.11). The number of investigations, for example, decreased by over 71% between 1993—94 and 1996—97.

The very different trends in child protection services in these two jurisdictions illustrate the impact that policy changes can have on the number of children in the child protection system. Major changes in policies can have fairly dramatic effects on numbers, and can make it very difficult to determine underlying trends in the incidence of child abuse and neglect or children who are in need of protection.

Care and protection orders and out-of-home care

The trends in the numbers of children on care and protection orders and the number in out-of-home care may be better indicators of such trends (see Box 5.9 for definitions). This is because these areas have not been subject to such major changes in policies, and because they generally involve children for whom there are more serious concerns about their safety and wellbeing.



Note: Data on notifications were not collected prior to 1995–96.

Source: Table A5.12.

Figure 5.11: Notifications, investigations and substantiations in Queensland and Western Australia, 1990–91 to 1999–00

Children on care and protection orders

At any point in the child protection process, the community services department can apply to the relevant court to place the child on a care and protection order. Such action is usually only taken as a last resort in situations where the department believes that continued involvement with the family is required to ensure the protection of a child. This may occur in situations where supervision and counselling are resisted by the family, where other avenues for resolution of the situation have been exhausted, or where removal of a child into out-of-home care requires legal authorisation.

Box 5.9: Definitions of care and protection orders and out-of-home care

Care and protection orders *are legal or administrative orders or arrangements which give community services departments some level of responsibility for a child's welfare. The level of responsibility varies with the type of order or arrangement. These orders include guardianship and custody orders; supervision and other finalised orders; and interim and temporary orders.*

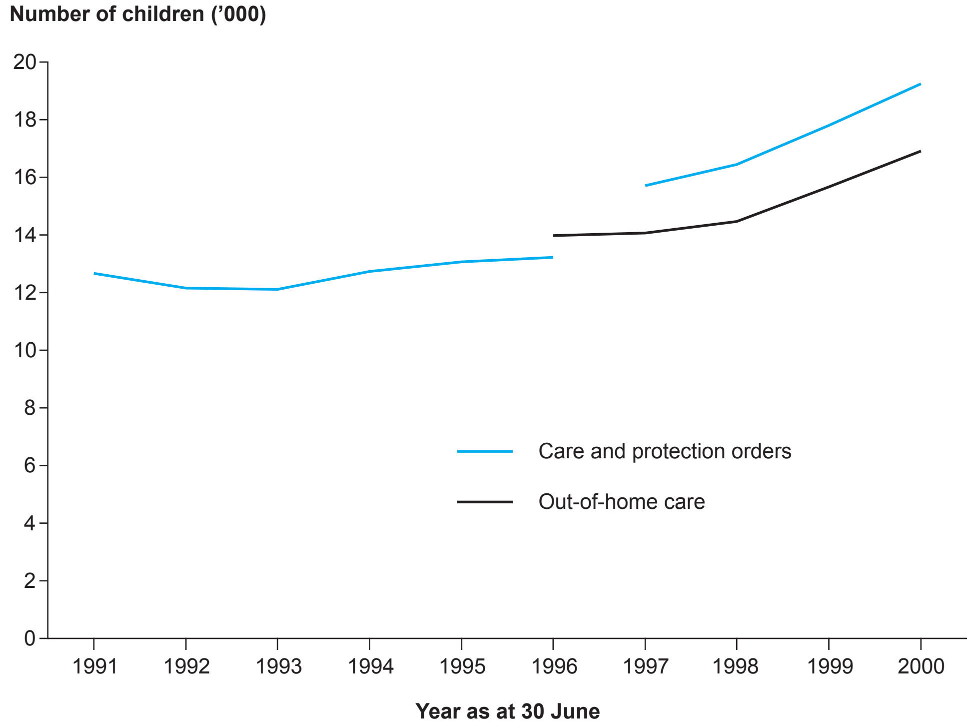
Out-of-home care *is defined as out-of-home overnight care for children and young people under 18 years of age where the State or Territory makes a financial payment. It includes residential care, foster care and relative/kinship care. Children in out-of-home care can be placed in a variety of living arrangements or placement types. The following categories are used in the national data collection:*

- Home-based care*—where placement is in the home of a carer who is reimbursed for expenses incurred in caring for the child. This category of placement 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 an approved carer who receives a payment which 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.*
- Facility-based care*—where placement is in a residential building whose purpose is to provide placements for children and where there are paid staff. This category includes facilities where there are rostered staff, where there is a live-in carer (including family group homes), where staff are off-site (for example, a lead tenant or supported residence arrangement), as well as other facility-based arrangements.*
- Independent living*—where children are living independently, such as those in private boarding arrangements.*

In the national data, the number of children on orders and the number of children in out-of-home care are counted at 30 June of the relevant year and are therefore a prevalence measure.

There was a large increase in the number of children on care and protection orders across Australia between 30 June 1991 and 30 June 2000 (Figure 5.12). The data from 1991 to 1996 include children on guardianship and non-guardianship orders. The number of children on these orders increased by 4%, from 12,680 in 1991 to 13,241 in 1996.

The scope of the data collection was broadened in 1997 to include a wider range of care and protection orders and administrative arrangements that were issued for protective reasons. The number of children on care and protection orders continued to increase



Note: Gap in graph indicates a change in the definitions used for care and protection orders.

Source: Table A5.13; Table 5.14.

Figure 5.12: Children on care and protection orders, 30 June 1991 to 30 June 2000, and children in out-of-home care, 30 June 1996 to 30 June 2000

from 1997, rising 23% from 15,718 in 1997 to 19,262 in 2000. There was a corresponding increase in the rates of children on orders: from 3.3 to 4.1 per 1,000 children over the same period (AIHW 1998, 2001c).

The number of children on orders rose in all jurisdictions except Tasmania and the Australian Capital Territory between 1997 and 2000. Increases were particularly large in the Northern Territory, where the number doubled, in Western Australia where it increased by 40% and in New South Wales where it rose by 32%.

Children in out-of-home care

While children may be placed in out-of-home care as well as on a care and protection order, the two data collections are separate and children are counted separately in each collection (see Box 5.9 for definitions). The trend in out-of-home care has been one of increasing numbers of children using these services. Between June 1996 (when national data were first collected) and June 2000, the number of children in out-of-home care in Australia rose from 13,979 to 16,923, an increase of 21% (Table 5.14, Figure 5.12). The rate of children in out-of-home care also increased over this period, from 3.0 children per 1,000 in 1996—97 to 3.8 per 1,000 in 1999—00 (AIHW 1998, 2001c).

Table 5.14: Number of children aged 0–17 in out-of-home care, by State/Territory, 30 June 1996 – 30 June 2000

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Australia
1996	5,437	3,385	2,110	1,206	1,064	508	181	88	13,979
1997	5,486	3,393	2,211	1,050	1,193	461	173	111	14,078
1998	5,603	3,615	2,346	1,093	1,055	442	179	137	14,470
1999	6,359	3,581	2,613	1,192	1,045	533	174	177	15,674
2000	7,041	3,867	2,634	1,326	1,131	548	200	176	16,923

Source: AIHW 2001c.

The number of children in out-of home care increased in all jurisdictions between 1996 and 2000, particularly in New South Wales (by 30%) and in the Northern Territory (by 50%) (Table 5.14).

There is likely to be a range of complex reasons for the increases in the number of children on care and protection orders and in out-of-home care from 1996 onwards. At the broad level the increase indicates that there are growing numbers of children whose families are considered unable to adequately care for them. This may be due to broader economic changes placing greater pressures on families, higher levels of family disruption or the increased prevalence of other problems such as substance abuse. The increase is consistent with the rising number of child protection notifications that occurred in most jurisdictions during the 1990s. Increases may also be related to greater use of short-term care orders for children, and improvements in recording practices.

Types of out-of-home care

There was some change in the types of out-of-home care in which children were placed between 1996 and 2000. The number of children in facility-based care fell significantly over this period, from 1,818 at 30 June 1996 to 1,222 at 30 June 2000 (Table 5.15). This decrease continues the longer term trend towards the deinstitutionalisation of children that began in the late 1960s (see Chapter 4).

Over the same period, there was a 25% increase in the number of children who were in home-based care arrangements: from 12,156 in 1996 to 15,169 in 2000. Not all jurisdictions, however, were able to provide data on the type of home-based care in which children were living over this 5-year period, and national data are available only for 1998 and 1999. Between June 1998 and June 1999 the number of children in foster care grew slightly, from 8,089 to 8,212, while the number of children in relative/kinship care increased by 18%, from 4,446 to 5,254.

Data from three jurisdictions, New South Wales, Victoria and Western Australia, are provided for 30 June 1996 to 30 June 2000 to give some indication of trends in the different types of home-based care over that period (Table A5.14). In New South Wales the number of children in foster care decreased by 6%, from 2,661 to 2,510, and those in relative/kinship care increased by 78%, from 2,143 to 3,812. At 30 June 2000 relative/kinship care represented 54% of all placements in out-of-home care in New South Wales.

Table 5.15: Children in out-of-home care, by type of care, 30 June 1996 – 30 June 2000

Type of care[(a)]	**1996**	**1997**	**1998**	**1999**	**2000**
			Number		
Foster care	n.a.	n.a.	8,089	8,212	n.a.
Relative/kinship care	n.a.	n.a.	4,446	5,254	n.a.
Other home-based care	n.a.	n.a.	126	183	n.a.
Total home-based care	*12,156*	*12,553*	*12,661*	*13,649*	*15,169*
Facility-based care	1,818	1,509	1,415	1,314	1,222
Independent living[(b)]	n.a.	n.a.	183	218	208
Other[(c)]	5	16	211	316	324
Total	**13,979**	**14,078**	**14,470**	**15,497**[(d)]	**16,923**
			Per cent		
Foster care	n.a.	n.a.	55.9	53.0	n.a.
Relative/kinship care	n.a.	n.a.	30.7	33.9	n.a.
Other home-based care	n.a.	n.a.	0.1	1.2	n.a.
Total home-based care	*87*	*89*	*88*	*88*	*90*
Facility-based care	13	11	10	9	7
Independent living[(b)]	n.a.	n.a.	1	1	1
Other[(c)]	—	—	2	2	2
Total	**100**	**100**	**100**	**100**	**100**

(a) Data on type of home-based care could not be provided by all jurisdictions in 1996, 1997 and 2000.

(b) These data were not collected prior to 1998.

(c) This includes unknown living arrangements.

(d) Data exclude 177 children from the Northern Territory because data on type of care could not be provided.

Source: AIHW 1997, 1998, 1999a, 2000a, 2001c.

In Victoria and Western Australia, there were increases in the number of children in both foster care and relative/kinship care over the same period. In Victoria, the number in foster care rose by 21%, from 1,849 to 2,237, while those in relative/kinship care rose by 51%, from 638 to 962. In Western Australia the rate of increase was not as great: foster care numbers increased by 18%, from 651 to 769, and relative/kinship care numbers by 10%, from 309 to 341.

Trends for Aboriginal and Torres Strait Islander children

The over-representation of Aboriginal and Torres Strait Islander children in the child protection system has been well documented. For example, in 1999—00 their rates in substantiations were four times higher than those for other children in New South Wales and seven times higher in Western Australia (AIHW 2001c).

This section includes trends data on Aboriginal and Torres Strait Islander children in child protection substantiations, on care and protection orders and in out-of-home care. These data are not as comprehensive as the data for all children since not all jurisdictions could provide data on Indigenous status for each year.

The quality of the data on Indigenous status is one of the major issues to be considered when analysing trends for Aboriginal and Torres Strait Islander children. The data vary across jurisdictions and over time. Increases in the recorded numbers of Aboriginal and Torres Strait Islander children in the child protection system over time may therefore be due to improvements in the quality of the data. For example, in New South Wales during 1998—99, the system for recording Indigenous status was improved. While there was a large increase in the number of Aboriginal and Torres Strait Islander children in substantiations, on care and protection orders and in out-of-home care in this year, it is not clear how much of this increase can be attributed to improved reporting methods.

In 2000 the National Community Services Information Management Group (NCSIMG) commissioned the ABS to develop a set of principles and standards to govern the collection and use of Indigenous client data in community services, including child protection. These standards and principles have been approved by the NCSIMG and a plan for their implementation is currently being developed.

Substantiations

The available data indicate that the greatest number of substantiations involving Aboriginal and Torres Strait Islander children occurred in 1997—98. The number peaked at different times, however, in different jurisdictions. For example, in New South Wales, it peaked in 1994—95, while in South Australia the number continued to increase throughout the 1990s (Table 5.16). These trends are influenced by changes in the number of Aboriginal and Torres Strait Islander children in need of protection as well as changes in child protection policies and, as noted above, in the methods used to identify and record Indigenous status.

Table 5.16: Number of child protection substantiations involving Indigenous children, by State/Territory, 1993–94 to 1999–00

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total
1993–94	1,216	301	n.a.	414	198	9	33	n.a.	n.a.
1994–95	1,405	239	660	342	225	14	23	194	3,102
1995–96	1,060	269	539	208	203	12	41	117	2,449
1996–97	n.a.	365	565	217	239	16	23	128	n.a.
1997–98	749	514	1,085	302	330	3	44	178	3,205
1998–99	1,026 (a)	n.a.	856	327	337	8	25	n.a.	n.a.
1999–00	763	570	504	332	338	4	6	172	2,689

(a) From 1998–99 the system for recording Indigenous status in New South Wales was improved, resulting in an increase in the number of clients who were identified as Indigenous.

Source: AIHW 1997, 1998, 1999a, 2000a, 2001c.

Care and protection orders and out-of-home care

The number of Aboriginal and Torres Strait Islander children on care and protection orders at 30 June increased considerably from 1995 onwards (Table 5.17). Much of this increase occurred after the scope of the data collection was broadened in 1997. Between June 1997 and June 2000 the reported number of Aboriginal and Torres Strait Islander children on care and protection orders rose by 52%, from 2,548 to 3,861. In comparison, the number of other children on care and protection orders grew by only 17% over the same period.

Table 5.17: Number of children on care and protection orders at 30 June 1995 – 30 June 2000 and number in out-of-home care at 30 June 1996 – 30 June 2000, by Indigenous status

	Children on care and protection orders		Children in out-of-home care	
	Indigenous	**Other children**	**Indigenous**	**Other children**
1995	2,048	11,020	n.a.	n.a.
1996	1,951	11,290	2,711	11,268
1997[(a)]	2,548	13,170	2,785	11,293
1998	2,868	13,581	2,634	11,836
1999[(b)]	n.a.	n.a.	n.a.	n.a.
2000	3,861	15,401	3,496	13,427

(a) The scope of the data collection on children on care and protection orders was changed in 1997, so the data collected from 1997 onwards are not comparable with those collected in prior years.

(b) The system used to record the Indigenous status of children in New South Wales was changed in 1998–99 resulting in a large increase in the number of Aboriginal and Torres Strait Islander children in the child protection system. Victoria could not provide data on Aboriginal and Torres Strait Islander children in 1999.

Source: AIHW 1997, 1998, 1999a, 2000a, 2001c.

The trend in the numbers of Aboriginal and Torres Strait Islander children in out-of-home care was also one of increase: from 2,711 in 1996 when data were first collected to 3,496 in 2000. Between 30 June 1996 and 30 June 2000 the number of Indigenous children in out-of-home care rose by 29%, while the number of other children rose by 19%. The data indicate that the numbers of Aboriginal and Torres Strait Islander children on orders and in out-of-home care have increased at a higher rate than those of other children, though some of this increase may be due to improvements in the quality of the Indigenous data.

5.6 Adoptions

The community services departments in each State and Territory are also responsible for all adoptions in Australia. These include both local and intercountry adoptions. Each State and Territory has its own legislation, policies and practices in relation to adoption.

When an adoption order is granted, the legal relationship between the child and the biological parents is severed. The legal rights of the adopted child are as if he or she had been born to the adoptive parents, and the legal rights that exist from birth with regard to the birth parents (inheritance and name, for instance) are removed. A new birth certificate is issued to the child bearing the name(s) of his or her adoptive parent(s) as the legal parent(s), and the new name of the child, where a change has occurred (AIHW 2001d).

This section examines the trends in adoptions in the 1990s and some of the reasons for these trends. Data are also provided on the adoptions of Aboriginal and Torres Strait Islander children.

Box 5.10: Categories of adoption used in the national data collection

Placement adoptions—adoptions of children who are legally available and placed for adoption but who have had no previous contact or relationship with the adoptive parents. Placement adoptions are broken down into the following two categories:

- *local placement adoptions—adoptions of children who were born in Australia or who were permanent residents of Australia before the adoption; and*
- *intercountry placement adoptions—adoptions of children from countries other than Australia.*

'Known' child adoptions—adoptions of children who have a pre-existing relationship with the adoptive parent(s) and who are generally not available for adoption by anyone other than the adoptive parent(s). 'Known' child adoptions include adoptions by step-parents, other relatives and carers.

Before 1998–99, adoptions were categorised as either relative or non-relative adoptions. The difference between the old and the new categories is that adoptions by carers are now included with adoptions by step-parents and other relatives, whereas prior to 1998–98 they were included with adoptions by non-relatives.

Data sources

As with child protection, the national data on adoptions come from the administrative systems of each State and Territory community services department. The categories used to classify adoptions in the national data collection are outlined in Box 5.10. For more information about the data and definitions, refer to the *Adoptions Australia* series (for example, AIHW 2001d).

Table 5.18: Number of adoptions in Australia, by type of adoption, 1990–91 to 1999–00

	Adoptions of Australian children by non-relatives	Adoptions of Australian children by relatives	Intercountry adoptions	Total
1990–91	472	277	393	1,142
1991–92	418	295	338	1,052
1992–93	306	250	227	783
1993–94	314	228	222	764
1994–95	311	320	224	855
1995–96	217	177	274	668
1996–97	263	177	269	709
1997–98	178	154	245	577
	Local placement adoptions	**'Known' child adoptions**		
1998–99	127	172	244	543
1999–00	106	159	301	566

Note: From 1998–99 the categories for adoptions were changed. Carers who had a previous relationship to the child were included with adoptions by step-parents and other relatives in the category ' "known" child adoptions'. Prior to 1998–99 adoptions by carers were included in the category 'adoptions by non-relatives' (see Box 5.10).

Source: AIHW 2001d.

Trends in adoption

The overall trend in adoptions in Australia over the last decade is one of decreasing numbers (Table 5.18). There was a large decrease in the first half of the 1990s when the number fell from 1,142 in 1990—91 to 764 in 1993—94. The number of adoptions then fluctuated over the next few years before decreasing to 577 in 1997—98. The number remained fairly stable after this and in 1999—00 there were 566 adoptions. This trend during the 1990s follows a strong downward trend that began in the early 1970s when there were nearly 10,000 adoptions in Australia (AIHW 2001d).

Local placement adoptions

The decrease in adoptions during the 1990s was primarily due to a fall in the number of Australian-born children being adopted by non-relatives (now referred to as local placement adoptions). This fall is attributable to the decrease in the number of Australian-born babies who are available for adoption, because of more effective fertility control and changed community attitudes to single parents.

The way that local placement adoptions are conducted has undergone major changes in the past decade. To a varying degree in different jurisdictions, adoption has changed from a guarded practice, where files were sealed and parties to the adoption had no contact with each other, to an open practice where each party to the adoption can have some say in what happens to the child. Of those local adoptions in 1999—00 where the type of agreement was known, 92% had some type of information exchange or contact between the parties to the adoption, with only 8% of relinquishing parents requesting no contact (Table 5.19). (These data were not collected prior to 1998—99.)

Table 5.19: Local placement adoptions, by type of agreement between parties to the adoption,(a) 1999–00

Type of agreement	Number	Per cent
Contact and information exchange	46	74
Contact only	—	—
Information exchange only	11	18
No contact(b)	5	8
Total(b)	**62**	**100**

(a) This table excludes 24 adoptions in Queensland where there are no provisions for information exchange or contact agreements at the time of the adoption and 20 adoptions for which information on type of agreement was unknown.

(b) This includes one dispensation by the Family Court.

Source: AIHW 2001d.

In addition, a large area of activity for community services departments in relation to adoption is in assisting people who were party to an adoption prior to open adoption practices to gain information about their adoption. In all jurisdictions, people who were party to an adoption can apply for identifying or non-identifying information regarding the adoption. This may lead to contact between the parties, for example between an adoptee and their birth mother. If a party to the adoption wishes to remain anonymous and/or not to be contacted, a veto may be lodged which makes it illegal for the other parties to either gain information and/or to have contact. Such vetos are not available in Victoria. In 1999—00 there were 5,008 information applications lodged in Australia, compared with 114 contact vetos and 32 information vetoes (AIHW 2001d).

‘Known’ child adoptions

The number of Australian-born children adopted by relatives (now included in known child adoptions) decreased by 44% between 1990—91 and 1997—98. The number of known child adoptions continued to decrease up to 1999—00 (Table 5.18). Most known child adoptions (72%) in 1999—00 were adoptions by step-parents who wished to legally incorporate the child into the new family, but this practice has become less common over the last decade. There were 253 children adopted by step-parents in 1990—91, compared with 114 in 1999—00 (AIHW 1993, 2001d).

Adoptions by relatives, other than step-parents, are generally discouraged because of the confusion and distortion that may occur to biological relationships. There were only two adoptions by relatives other than step-parents in 1999—00 (AIHW 2001d). When children need to be placed in the care of relatives other than parents, most jurisdictions have policies that promote the use of guardianship or custody orders rather than adoption.

Intercountry adoptions

The number of intercountry adoptions declined in the first half of the 1990s, but increased by one-third between 1993—94 and 1999—00 (Table 5.18). The increase is likely to be related to the continuing decreases in the number of local children available for adoption as well as the greater availability of overseas-born children for adoption, partly as a result of the opening of adoption to Australian families in some countries.

An important development in relation to intercountry adoptions was the ratification of the Hague Convention on the Protection of Children and Cooperation in Respect of Intercountry Adoptions by Australia in December 1998. The convention streamlines the processes required for intercountry adoptions and establishes uniform procedures to be followed by the countries who are parties to the convention (see AIHW 2001d). At June 2001, 31 countries had ratified and 15 countries had signed but not yet ratified the convention. The number of countries ratifying the convention is likely to increase over the next few years.

In December 1999 Australia and China signed a bilateral agreement that allows Australian residents to adopt children from China. The first adoptions of Chinese children under this agreement will be reported in the 2000—01 adoptions data.

Since 1990—91, the majority of children in intercountry adoptions have come from South Korea (32%), followed by India (11%) and Thailand (9%) (Table 5.20).

Table 5.20: Intercountry adoptions by country of origin, 1990–91 to 1999–00

Country of origin	Number	Per cent	Country of origin	Number	Per cent
South Korea	888	32	Guatemala	45	2
India	303	11	Mauritius	31	1
Thailand	252	9	Bolivia	27	1
Philippines	202	7	Other Americas	22	1
Sri Lanka	190	7	Other Europe	21	1
Colombia	189	7	Poland	19	1
Ethiopia	142	5	Other Asia	15	1
Fiji	97	4	Cambodia	13	—
Romania	66	2	Other Africa	6	—
Chile	53	2	Oceania	5	—
Taiwan	51	2	Middle East	4	—
Hong Kong	50	2			
Brazil	46	2	Total	2,737	100

Notes

1. Other Europe includes: Albania, England, Germany, Greece, Macedonia, Malta, Portugal, Serbia, Turkey and Yugoslavia.
2. Other Americas includes: Argentina, Canada, Costa Rica, Haiti, Honduras, Peru, United States and Uruguay.
3. Other Asia includes: Bangladesh, China, Japan, Malaysia, Nepal, Pakistan and Vietnam.
4. Other Africa includes: Ghana, Mauritius, Morocco, South Africa and Zimbabwe.
5. Oceania includes: Papua New Guinea, Nauru, New Zealand, Samoa and Vanuatu.
6. Middle East includes: Lebanon and Syria.

Source: Unpublished AIHW data.

Adoptions of Aboriginal and Torres Strait Islander children

Since 1991—92 when data on adoptions of Indigenous children were first collected, there have been 63 Aboriginal and Torres Strait Islander children adopted in Australia. The number of such adoptions of decreased sharply after 1994—95 (Table 5.21). The relatively low number of adoptions of Indigenous children reflects cultural differences in relation to adoption. If an Aboriginal or Torres Strait Islander child cannot be cared for by his/her parents, the role of caregiver is traditionally assumed by an appropriate member of the extended family, without a formal adoption (Boss 1992).

The Aboriginal Child Placement Principle, which outlines a preference for the placement of Indigenous children with other Indigenous people when they are placed outside their family, applies to adoption as well as to out-of-home care (Lock 1997). In more than half of these adoptions between 1991—92 and 1999—00, the adoptive parents were also Indigenous.

Table 5.21: Number of Indigenous adoptions, by relationship to and Indigenous status of adoptive parents, 1991–92 to 1999–00

	Indigenous adoptive parent			Non-Indigenous adoptive parent			
	Relative	**Non-relative**	**Total**	**Relative**	**Non-relative**	**Total**	**Total**
1991–92	2	3	5	–-	3	3	8
1992–93	—	5	5	—	2	2	7
1993–94	1	6	7	—	6	6	13
1994–95	–-	7	7	—	5	5	12
1995–96	—	2	2	—	5	5	7
1996–97	2	1	3	—	4	4	7
1997–98	—	3	3	—	1	1	4
1998–99	—	—	—	—	3	3	3
1999–00	1	1	2	—	—	—	2
Total	**6**	**28**	**34**	**—**	**29**	**29**	**63**

Source: AIHW 2001d.

5.7 Data developments

Over the last few years, there have been a number of important developments at the national level in the data on children’s and family services.

Child care and preschool services

At the end of 1999, the National Children’s Services Data Working Group of the NCSIMG agreed on a set of data items to be included in the first and second stages of a National Minimum Data Set (NMDS) for child care and preschool services. In the first half of 2000, the AIHW developed a draft data manual for the first stage of the NMDS. A data collection form based on the draft data manual was field tested in the second half of the year. The field test was undertaken in New South Wales, Queensland, Tasmania and the Australian Capital Territory and involved 17 child care and preschool service providers. The field test, in particular, highlighted the complexity of service provision and the lack of consistency between the types of services that providers were licensed and/or funded to provide and those that they actually offered in response to parents’ and children’s needs (AIHW 2001a).

Following the field test, the Data Working Group agreed that the data collection would be structured around the services actually offered to children, rather than the type of funded and/or licensed service. It was also agreed that, where possible, information would be collected on individual children and their families and on individual workers rather than aggregated by service provider. The draft data manual was extensively revised to reflect these and other recommendations arising from the field testing. The Data Working Group is currently finalising the first stage of the NMDS for child care and preschool services.

Child protection

In 2000 the National Child Protection and Support Services data working group (NCPASS) reviewed the national framework for collecting and reporting data on child protection and child concern reports. The aim of this review was to establish the feasibility of updating the national reporting framework to:

- more accurately reflect the current responses of States and Territories to child protection and child concern reports;
- present a more comprehensive data set; and
- increase the consistency and comparability of the reported data.

After consultations with States and Territories a proposed new framework for national reporting on child protection and child concern matters was developed. The proposed framework reflects the significant shift in child protection policy and practice that locates child protection as part of a broader framework of services for the safety and wellbeing of children. It focuses reporting on:

- the range of reports received in relation to the safety and wellbeing of children;
- the range of responses to such reports; and
- the outcomes of direct departmental contact with children and/or families.

While reflecting new concepts that underpin changes in policy and practice by most States and Territories in recent years, for most jurisdictions the framework will not require a significant shift in what is being reported nationally. The feasibility of the new framework is currently being assessed by States and Territories and by NCPASS. The outcomes of the review of the national framework will then be reported to the NCSIMG.

Family support services

In 2000 a scoping study of family support services was commissioned by the NCSIMG. The aim of the study was to assess the scope of family support services funded by State, Territory and Commonwealth community services departments, and to provide an overview of the current data collection efforts in relation to these services.

An agreed definition of family support services was developed for the purposes of the study: ‘Services that seek to benefit families by improving their capacity to care for children and/or strengthening family relationships’.

The report from the scoping study *Family Support Services in Australia 2000* (AIHW 2001e) describes the programs that each jurisdiction funds or delivers in the area of family support services, and provides a broad description of the data collection systems in place or planned. The major categories of family support services identified were:

- information and referral;
- education/skill development;

- counselling, mediation or therapy;
- residential and in-home support; and
- advocacy.

The report noted that data collections relating to family support services were in place, at least in part, in New South Wales, Victoria, South Australia, Western Australia, the Northern Territory and the Commonwealth. Plans existed to commence collections in other jurisdictions, and to extend or review existing collections in most States, Territories and the Commonwealth. Data systems varied from detailed unit record collections about activities, to 6-monthly aggregates of information on key outputs and performance measures.

This scoping study is one step in an ongoing process to provide meaningful, useful and beneficial information about an important area of community services.

5.8 Conclusion

Over the last decade there have been ongoing changes in family structures and patterns that have implications for children s and family services. There were increases in both the number of one-parent families and the number of families with no parent in employment. The number of sole parents on income support increased by nearly 60% between 1990 and 2000, and there was also a significant increase in the number of low-income families in receipt of More than Minimum Family Allowance. Over the same period there were real increases in the level of Commonwealth income support provided to families with dependent children.

In the area of child care, the number of Commonwealth-supported service providers and child care places increased considerably over the decade. A large component of this increase was due to the growth in the number of places in Commonwealth-supported private-for-profit long day care centres up to 1998. In the first half of the decade, the number of children using long day care centres increased at around the same rate as the number of places. However, from 1995 to 1999 the number of places increased at a greater rate than the number of children using services, reflecting declining utilisation rates over the period.

During the 1990s there was a shift from Commonwealth expenditure on child care service provision (operational subsidies and capital funding) to expenditure on measures that reduce the costs of child care for parents (fee subsidies). Expenditure grew rapidly up to 1996—97, but then fell slightly in real terms to 1999—00 mainly because of the fall in expenditure on operational subsides and fee subsidies probably reflecting falling utilisation rates.

The introduction of the Child Care Benefit in July 2000 (at the beginning of the 2000—01 financial year) improved the affordability of child care and the utilisation of services improved, at least in the short term. It will be interesting to examine trends in service use and expenditure over the longer term, when data become available.

The use of State and Territory child protection and out-of-home care services also increased in the 10 years up to 2000. During the last 5 years there were rises in the number of child protection notifications, as well as large increases in the number of children on care and protection orders and in out-of-home care. These indicate that there are growing numbers of children whose families are considered to be unable to provide adequate care or protection for them.

Aboriginal and Torres Strait Islander children continue to be over-represented in child protection and out-of-home care services. Over the last 5 years the number of them on care and protection orders and in out-of-home care increased at a greater rate than the number of other Australian children in these services. Some of this increase was due to improvements in the identification of Indigenous status.

The number of adoptions in Australia continued to fall between 1990—91 and 1999—00, mainly due to decreases in local adoptions. Intercountry adoptions declined during the first few years of the 1990s, but increased by more than one-third between 1993—94 and 1999—00. A large area of activity for State and Territory community services departments is in assisting people who were party to an adoption in earlier years to obtain more information about their adoption.

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6 Aged care

6.1 Introduction

The goal of the Australian aged care service delivery system is the provision of a cohesive framework of high quality and cost-effective care services for frail older people and their carers (DHFS 1996:117). Accordingly, this chapter focuses on three sets of information that are essential to the task of reviewing progress towards the achievement of that goal:

- the need for services and assistance (Section 6.2);
- the amount and type of services and assistance being provided and the characteristics of the clients to whom they are being provided (Section 6.3); and
- the outcomes of those services and assistance (Section 6.4).

The range of services and assistance available to older people in Australia is extensive and by no means all such provisions are included in this chapter. For example, programs concerned with healthy ageing, hospital care, medical care, pharmaceuticals and housing are not included. Moreover, although it is common to view aged care only in terms of programs aimed specifically at older people, it must be remembered that older people are also eligible for, and make use of, various benefits and services that are available to the general population.

This chapter focuses on the services and assistance designed to provide care for frail and disabled older people and on the services and assistance available to those who care for them. This includes services and assistance provided in both domiciliary and residential care settings, and the assessment programs and regulatory practices associated with those services. These services are funded and/or provided by Commonwealth, State and Territory, and local governments, the not-for-profit sector and the private for-profit sector. In addition, extensive informal assistance is provided by family and friends who care for older people in both residential and domiciliary settings.

6.2 The need for care

Age, sex and dependency

Traditionally, chronological age is the most commonly used predictor of the need for assistance among older people. The proportion of people aged 65 and over has, for example, always been a key component of the labour force dependency ratio, one of the calculations commonly undertaken by economists to test the economic viability of different societies at different times.[1] In analysing income security, the proportion of the

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[1] The traditional dependency ratio is the proportion of the population aged 0–14 and 65 and over in relation to that proportion aged 15–64 years.

population aged 65 and over is a useful indicator of likely need for assistance. For analysts whose primary concern is aged care services, however, the population aged 75 and over, and indeed aged 85 and over, is a better guide, as rates of use of aged care services, particularly residential aged care, rise steeply at more advanced ages. The usefulness of age-based data is further increased if the data are classified by sex: women are not only more likely than males to survive to more advanced ages, they are also more likely to be poor, have a disability and be living in residential care (Gibson 1998:chs 4, 7).

As at 30 June 2000, the Australian Bureau of Statistics (ABS) estimated that there were 2.4 million people aged 65 years and over in Australia; this represents 12.3% of the total population. Of people aged 65 and over, 55% were aged 65—74 years, 34% were aged 75—84, and 11% were aged 85 and over. Thus, while over half of all older people are aged between 65 and 74, there is a significant minority (over a quarter of a million people) who are aged 85 and over. Fifty-six per cent of older people (65+) are women; this predominance becomes progressively more evident in the older age categories. In the 65—74 age group, the proportions of men and women are almost equal; by age 85 and over, however, there are over twice as many women as men. In absolute numbers, there are 283,300 more women than men aged 65 and over in Australia (Table 6.1). The numerical predominance of women is declining slowly as the life expectancy of older males increases relative to that of older females. In 1994, the sex ratio was 0.76, but by 2000 it was 0.79.

Table 6.1: Persons aged 65 years and over, by sex and age group, 30 June 2000

	65–74 years		75–84 years		85 years and over		Total aged population	
Sex	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**
Males	624,000	26.4	336,100	14.2	78,400	3.3	1,038,500	44.0
Females	675,300	28.6	472,600	20.0	173,800	7.4	1,321,800	56.0
Persons	**1,299,300**	**55.0**	**808,700**	**34.3**	**252,200**	**10.7**	**2,360,200**	**100.0**

Source: ABS 2000a.

While age and sex combine to provide a useful indicator of the level of need for aged care services, direct measures of dependency are also useful. The surveys of disability, ageing and carers conducted by the ABS provide direct information about dependency levels in the older population, as reported by older people themselves. The most recent data are drawn from the 1998 Disability, Ageing and Carers Survey, the fourth since 1981.

The severe or profound core activity restriction categories are the most appropriate measures of need for assistance in relation to aged care services, since they describe people who are unable to perform a core activity or who always need assistance in doing so (profound core activity restriction), and people who sometimes need assistance (severe core activity restriction). Core activities are self-care (bathing, showering, dressing, eating, using the toilet and managing incontinence), mobility (moving around at home and away from home, getting into or out of a bed or chair, and using public transport) and communication (understanding and being understood by others, including strangers, family and friends).

Among older people, the rates of severe or profound core activity restriction are quite low until age 75. For those aged 65—69 years, for example, in 1998 only 8% of men and 9% of women were so affected. The rates rise quite markedly with age, however, so that, by ages 75—79, 19% of men and 25% of women reported such a restriction, while at ages 80—84 the rates had risen to 24% and 36% respectively. By age 85 and over, more than half the population reported a severe or profound core activity restriction. At these advanced ages, the degree of difference between the sexes lessens somewhat, although the rates reported by women (69%) are still substantially higher than those reported by men (56%) (AIHW 1999a:169).

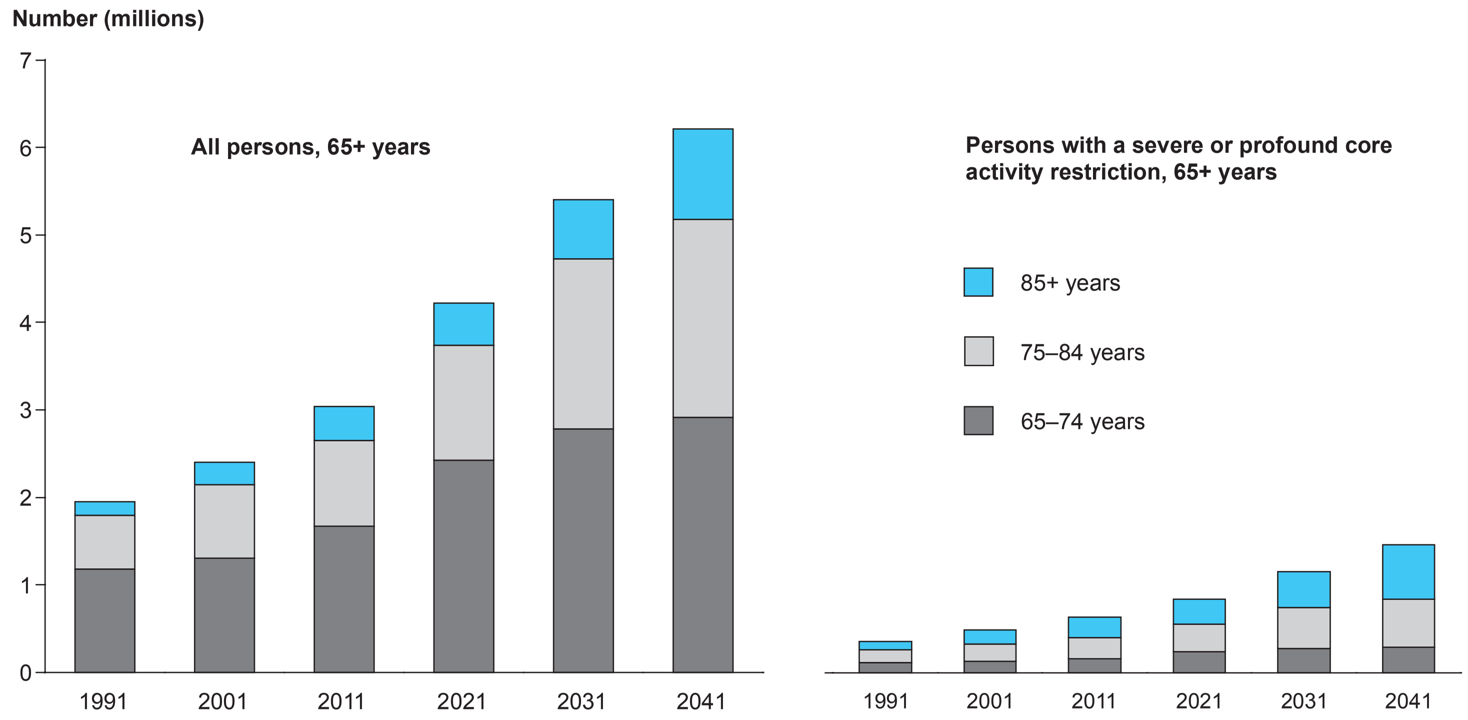
While rates of severe or profound restriction increase at older ages, the majority of people with such restrictions continue to live in the community, rather than in an institutional setting. Among people with a severe or profound restriction, 84% of 65—79 year olds and 55% of those aged 80 and over lived in the community, with the remainder living in some form of institutional care (AIHW 1999a:171).

The future

In 1991, the Australian population aged 65 and over numbered 2.0 million (11% of the total population), in 2001 it was 2.4 million (12%), and the ABS estimates that it will reach 3.0 million by 2011 (14%). Within the older population, the number of people aged 85 and over is projected to expand rapidly over this period: from 154,000 in 1991 to 260,000 in 2001, and to 389,000 in 2011 (Figure 6.1 and Table A6.1). Between 1991 and 2001, the population aged 85 and over grew by 69%, compared to 10% for the population aged 65—74. Between 2001 and 2011, the comparable figures are projected to be 49% and 28%. From 2011 to 2021, however, this pattern reverses, as the baby-boom generation begins to enter old age. Over this decade, the 85 and over population is projected to increase by only 23%, and the 65—75 year old population by 46%.

While these increases are large, it is important to recognise that the numbers of older people who are likely to require a substantial amount of assistance (i.e. those with a severe or profound core activity restriction in ABS terms) are considerably more modest. Using standard age- and sex-specific activity restriction rates derived from the 1998 ABS survey, among the 2.0 million people aged 65 and over living in Australia in 1991, there would have been around 385,000 older Australians with a severe or profound core activity restriction (some 20% of the older population). By 2001, this figure would be 526,000 (22% of the older population) and by 2011, 682,000 (22% of the older population). As is evident from Figure 6.1, the number of people aged 65 and over who are likely to be in need of some assistance (i.e. those with a severe or profound core activity restriction) is of a substantially lesser magnitude than the entire population aged 65 and over.

Another noteworthy feature in Figure 6.1 is the projected increase in the proportion of older people with a severe or profound core activity restriction who are aged 85 and over. In 1991 this proportion was 26%. In 2001 it was 32%. In 2011 it is projected to be 37%.



Source: Table A6.1.

Figure 6.1: Estimated and projected populations for all persons and persons with a profound or severe restriction, by age, 1991 to 2041

Calculations such as these are based on a constant age- and sex-specific activity restriction rate and allow the changing structure of the aged population together with increases in absolute numbers to determine changing patterns over time.[2] This is a straightforward and easily grasped basis from which to examine past trends and explore future projections. However, such a strategy assumes a constant rate of disability in the older population, an assumption which has been the subject of considerable debate in the international and national literature in recent years.

The background to the debate was an apparent trend towards increasing disability associated with population ageing, reported largely by researchers in the United States in the early 1980s, and based on data from the 1970s (Colvez & Blanchet 1981; Verbrugge 1984; Verbrugge et al. 1989). More recently, however, some international commentators have argued that there is evidence emerging of a decline in disability rates at older ages (Cambois et al. 1999; Waidmann & Liu 2000; Waidmann & Manton 1998). Findings did vary, however, according to country. No evidence of a decline in disability rates was reported for Australia, the United Kingdom and the Netherlands. Mixed findings (i.e. declines in some age or sex categories but not others) were reported for Canada and Sweden. Declines in disability were reported for the United States, Germany, France and Japan, among others.

Researchers from the United States have been the most vigorous exponents of the decline in disability hypothesis (Crimmins et al. 1997; Manton et al. 1993, 1997; Waidmann & Liu 2000). The reported decline, however, is concentrated in lower levels of disability, with no evidence of a decline among those with more severe personal care type disability (Schoeni et al. 2001).

The categorisation of Australia as showing no evidence of a decline in these reports may have been somewhat misleading, as available evidence to date has suggested at least the possibility of an increase in disability rates. The ABS has recently released a paper which undertakes a detailed exploration of the observed increase in the proportion of the Australian population with a severe restriction, and with a disability, over the period from 1988 to 1998 (ABS: Davis et al. 2001). Much of this observed increase occurred among younger population age groups, and some of the observed effect can be explained by changes in the population structure (particularly population ageing).[3]

Table 6.2 presents disability and severe restriction rates for older people, derived from the 1988, 1993 and 1998 surveys but standardised for age structure and adjusted (as far as is possible) for variations in the survey methodology. Of particular interest here is the observed increase with regard to severe restriction.[4] The increase is evident for men

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[2] Calculations are undertaken using the rates of severe or profound core activity restriction for each 5-year age group for males and females, based on the 1998 ABS Survey of Disability, Ageing and Carers.

[3] See Section 7.2 for a discussion of these trends in relation to younger people with a disability.

[4] The severe restriction activity combines the severe and profound restriction (or severe and profound handicap in earlier surveys) categories. A number of adjustments are made to maximise comparability among the three surveys.

aged 75—79, and 85 and over. For the 65 and over population as a whole, once the data has been age standardised, the proportion with a severe restriction varies only marginally: from 18.4% in 1988, to 17.5% in 1993, to 19.6% in 1998. The question of interest for policy purposes is whether the increases which are observed represent a real increase in severe restriction, or whether they are a result of changes in the methodology. While the data presented in Table 6.2 have been adjusted where possible to standardise across the surveys, some methodological differences remain (see ABS: Davis et al. 2001 for a discussion of these differences). Of interest in the older population is the inclusion of more specific questions about stroke and dementia, which appear to have led to improved capture related to these diseases. Increasing numbers of very old people in the oldest age group may have contributed to an actual increase in prevalence in this group, and it is also thought that there may have been an actual increase of prevalence among men aged 75—79. The authors estimate that about half the reported increase is due to changes in prevalence in these two groups, and about half to changes in survey design (ABS: Davis et al. 2001:38).

The Australian evidence, then, suggests a relatively stable picture of severe restriction rates in the older population, with some possibility that increases may have occurred among males aged 75—79, and those aged 85 and over. Internationally, the evidence is somewhat mixed; the topic continues to be an area of active debate.

Table 6.2: Persons aged 65 and over with a severe restriction or disability, 1988, 1993 and 1998 (per cent)

	Males			**Females**			**Persons**		
	1988	**1993**	**1998**	**1988**	**1993**	**1998**	**1988**	**1993**	**1998**
Severe restriction									
65–69	7.5	5.9	7.2	7.9	7.7	8.2	7.7	6.8	7.7
70–74	10.2	8.5	9.8	12.3	13.7	12.7	11.3	11.3	11.4
75–79	10.8	11.7	17.8	20.5	18.2	22.6	16.4	15.4	20.5
80–84	25.7	22.8	22.3	31.9	33.9	34.3	29.5	29.7	29.8
85+	38.6	48.1	53.0	69.6	58.1	67.6	60.1	55.1	63.1
Total 65+	*13.1*	*12.6*	*14.9*	*22.6*	*21.3*	*23.3*	*18.4*	*17.5*	*19.6*
Disability									
65–69	47.3	44.0	45.4	35.9	35.2	35.9	41.3	39.5	40.5
70–74	50.8	58.3	55.2	45.9	48.6	45.1	48.1	53.1	49.8
75–79	53.0	59.6	65.1	54.1	53.7	55.9	53.6	56.2	59.8
80–84	67.8	73.2	66.9	66.9	61.5	67.2	67.2	65.9	67.0
85+	76.3	81.0	86.4	85.4	79.5	82.5	82.9	80.0	83.7
Total 65+	*53.7*	*57.0*	*57.3*	*52.7*	*51.6*	*52.5*	*53.1*	*54.0*	*54.6*

Note: Only criteria common to the three ABS disability surveys have been used to derive the data for comparative purposes. Age standardised to the 1998 benchmark population for the Survey of Disability, Ageing and Carers.

Source: ABS: Davis et al. 2001.

Dementia

One of the particular concerns associated with the ageing of the aged population is the increase in the number and proportion of the older population with dementia, and the associated need for both home-based and residential care. In 1998, Henderson and Jorm produced estimates of the number of dementia cases in Australia, based on an earlier meta-analysis of prevalence rates undertaken by Jorm et al. (1987).[5] On the basis of those prevalence rates, it is possible to estimate the number of people with dementia in Australia. The prevalence rates ranged from 1.4% at ages 65—69, to 5.6% at ages 75—79, and to 23.6% for those aged 85 and over. In 2000, there were an estimated 146,800 persons aged 65 and over with dementia, a number which is projected to increase to 191,100 in 2010 and to 242,600 in 2020.

Dementia among residents of aged care homes

Although there is no measure of dementia per se in the national residential aged care database, there are indicators of behaviours which are associated with a diagnosis of dementia. Those indicators are constituent elements of the Resident Classification Scale. In 2000, 33% of residents had extensive difficulty with understanding and undertaking living activities. This question alludes to remembering, planning and performing general living tasks. Other behaviours in which residents were rated as requiring extensive monitoring included being verbally disruptive or noisy (25%), problem wandering or intrusive behaviour (17%), and physically aggressive behaviour (12%).

The need for informal care

While government-funded aged care services are an important source of assistance to frail and disabled older people, it has been widely recognised that informal carers, predominantly family members, provide a large proportion of needed assistance.

According to the 1998 ABS Survey of Disability, Ageing and Carers, there were 125,300 primary carers providing help to persons aged 65 and over (Table 6.3). Two-thirds were women (67%), and the majority of carers of older people were themselves over 65 (58%). Older women were almost equally likely to be receiving care from older males (42%) or from women aged 25—64 (41%). This pattern differed by age. Women aged 65—74 were most likely to be cared for by an older male (58%), while women aged 75 and older were most likely to be cared for by a female carer aged 25—64 (51%), although older male carers also remained important in this age group (35%). Older men were most likely to be receiving help from older women (71%), followed by women aged 25—64 (22%). This pattern was consistent for both groups of older men, although the predominance of older female carers was more marked among men aged 75 and over (81%) than among men aged 65—74 (59%). This somewhat larger proportion of younger (aged 25—64) female carers for males aged 65—74 is presumably due to the tendency of males to marry younger women, with the 25—64 age category including spouse carers as well as daughters (and daughters in law) for males aged 65—74 (most same-age carers are spouses or partners) (see AIHW 1999a:174—5).

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[5] These prevalence rates were very similar to those derived from a meta-analysis undertaken by Hofman et al. in 1991, and higher than those derived by Ritchie et al. in 1992 (Henderson & Jorm 1998).

Table 6.3: Primary carer of persons aged 65 years or over, by age and sex of the carer and care recipient, 1998

	Male carer		Female carer		All carers	
	25–64	65+	25–64	65+	25–64	65+
			Number			
Female care recipient						
65–74	*3,700	11,800	*3,800	**800	*7,600	12,600
75+	*4,600	17,400	25,100	**2,500	29,700	19,900
Total females	**8,300*	*29,200*	*28,900*	**3,300*	*37,200*	*32,500*
Male care recipient						
65–74	**1,200	**0	8,900	14,700	10,100	14,700
75+	*2,600	**0	*3,300	24,900	*5,900	24,900
Total males	**3,800*	***0*	*12,200*	*39,600*	*16,000*	*39,600*
Total	**12,200**	**29,200**	**41,100**	**42,900**	**53,200**	**72,100**
			Per cent			
Female care recipient						
65–74	*18.5	58.4	*18.9	**4.2	*37.4	62.6
75+	*9.3	35.1	50.6	**5.0	59.9	40.1
Total females	**11.9*	*41.9*	*41.4*	**4.8*	*53.4*	*46.6*
Male care recipient						
65–74	**4.9	**0.0	36.0	59.1	40.9	59.1
75+	*8.4	**0.0	*10.7	80.9	*19.1	80.9
Total males	**6.9*	***0.0*	*22.0*	*71.2*	*28.8*	*71.2*
Total	**9.7**	**23.3**	**32.8**	**34.2**	**42.5**	**57.5**

Note: Estimates marked ** are subject to sampling variability too high for most practical purposes. Estimates marked * have an associated relative sampling error of between 25% and 50%. These estimates should be interpreted accordingly.

Source: AIHW analysis of the ABS Disability, Ageing and Carers Survey, 1998.

Table 6.4: Persons aged 65 and over receiving assistance, by source of assistance, 1993 and 1998 (per cent)

	1993				1998			
Source of assistance	**Formal care**	**Informal care**	**Both**	**All receiving assistance (N)**	**Formal care**	**Informal care**	**Both**	**All receiving assistance (N)**
Self-care	23	89	12	119,900	25	90	15	141,100
Mobility	7	95	2	190,400	20	95	15	258,600
Communication	0	100	0	22,000	0	100	0	25,200
Housework	37	72	9	349,200	46	73	19	386,700
Health care	65	46	11	275,700	67	49	16	354,100
Meal preparation	14	91	5	92,700	28	83	11	139,200

Note: Some of those surveyed reported that they did not receive assistance from formal or informal sources but did receive assistance from another source. These are included in the totals but individual values are not shown separately as they all have a relative standard error of more than 50%.

Source: AIHW analysis of the ABS Disability, Ageing and Carers Surveys, 1993 and 1998.

Table 6.4 shows how the pattern of assistance received by persons with a severe or profound core activity restriction has changed between the 1993 and 1998 ABS surveys. The proportion of older people receiving assistance from informal sources has remained relatively constant, with the possible exception of a modest decline in the proportion of people receiving assistance with meals: from 88% to 83%. The data suggest, however, that the proportion of people receiving assistance from formal sources (i.e. government-funded programs or privately purchased services) has generally increased. This trend was most pronounced for mobility (from 7% to 20%), housework (from 32% to 46%) and meal preparation (from 15% to 28%). This trend is in keeping with contemporary trends towards maintaining older people in the community, and reducing the reliance of the aged care system on residential services.

6.3 Service provision

This section summarises recent policy developments, and presents data on patterns of income support and service use by older people. First, recent policy events are discussed, and a summary of key changes since 1999 presented. Second, some basic data are presented on pensions, superannuation and retirement income in old age. This is followed by a discussion of recent trends in assessment, home-based care, residential care, respite care, client profiles and aged care expenditure.

While a number of policy developments have occurred in the last 5 years, the restructuring of the residential aged care system in 1997 remains the most significant policy change in the recent history of aged care services in Australia. With the introduction of the *Aged Care Act 1997*, the two-tier system of residential care was replaced by a single system, and the contributions required of residents significantly expanded. The two-tier arrangement (nursing homes and hostels) had been in place since the implementation of personal care subsidies in aged person's homes almost 30 years earlier. The other dominant policy trend of recent years is a continuation of, rather than a departure from, developments in earlier years. The move towards an increased emphasis on community care and a decreased emphasis on residential provision has been evident in government policy since the implementation of the HACC (Home and Community Care) Program in 1985. This shift was further demonstrated by the expansion of HACC in subsequent years, the development of respite care services, and the introduction and rapid growth of community aged care packages in the 1990s.

In the context of these major policy trends, there have also been more specific developments since the publication of *Australia's Welfare 1999* (AIHW 1999a). Box 6.1 summarises recent key policy initiatives and events in aged care. Most notably, in 2001 the Department of Veterans' Affairs commenced delivery of its Home Care Program, Commonwealth Carelink Centres began operations, the report of the two year review of aged care reforms was released (see Box 6.2), and the Aged Care Standards and Accreditation Agency completed an accreditation cycle for all aged care homes in Australia. This latter policy development is taken up in more detail in Section 6.4.

Veterans' Home Care extends the range of services available to veterans and war widows/widowers through the Department of Veterans' Affairs. Formerly, eligible members of the veteran community could receive community nursing, in-home and residential respite care, allied health services, home modifications, and transport for health care. Veterans' Home Care adds to this list domestic assistance, personal care, garden and home maintenance, care coordination, delivered meals, and additional respite care. These services were previously available to veterans and war widows/widowers through HACC, financed by payments from the Department of Veterans' Affairs to the Department of Health and Aged Care (DHAC). The development of Veterans' Home Care reverses an earlier policy shift in 1987 when the Department of Veterans' Affairs transferred its Veterans' Home Help Program to HACC.

Box 6.1: Policy changes and events in aged care, 1999 to 2001

1999

The International Year of Older Persons was celebrated.

From July, the Domiciliary Nursing Care Benefit was merged with the Child Disability Allowance to become the Carer Allowance.

A background paper, discussion papers on Healthy Ageing and Independence and Self Provision, and an issues paper on Employment for Mature Age Workers were released by the Minister for Aged Care as part of the developmental process for the National Strategy for an Ageing Australia (Bishop 1999a, 1999b, 1999c, 199d).

The Aged Care Standards and Accreditation Agency, which came into being in 1998, began active accreditation work in September, following a delayed passage of the enabling Principles.

2000

A pilot test of the new HACC National Minimum Data Set (NMDS) was successfully completed, and the first national collection scheduled for implementation from January 2001.

Discussion papers on World Class Care and Attitude, Lifestyle and Community Support were released by the Minister for Aged Care as part of the developmental process for the National Strategy for an Ageing Australia (Bishop 2000a, 2000b).

The Residential Aged Care Funding Equalisation and Assistance Package was introduced to accelerate the transition to standard rates of Commonwealth subsidy across all States and Territories.

Income testing arrangements for clients of residential aged care services were simplified by moving from a daily to a quarterly assessment of fees.

An evaluation was undertaken of the Extended Aged Care at Home (EACH) Packages pilot program which provides services at home to people eligible for high-level care in an aged care home.

2001

Veterans' Home Care, a Department of Veterans' Affairs program to provide home-based care services to veterans, commenced in January.

Commonwealth Carelink Centres, announced in the 1999–00 Budget, became operational. The 54 centres across Australia provide a single contact point for information about community care services in the local area.

The Aged Care Standards and Accreditation Agency completed an accreditation process for all aged care homes by 1 January.

The report of the Two Year Review of Aged Care Reforms, commissioned by the Commonwealth Government in 1998, was released. The review was chaired by Professor Len Gray and its purpose was to evaluate the impact of the reforms (see Box 6.2).

(continued)

Box 6.1 (continued): Policy changes and events in aged care, 1999 to 2001

The new HACC NMDS *collection was implemented, with the first quarter of national data being successfully collated and analysed.*

The National Continence Management Strategy *was implemented.*

There was an expansion of resources for culturally appropriate care*, including both 'ethnic clusters' and ethno-specific homes.*

Box 6.2: Report of the Two Year Review of Aged Care Reforms

In May 2001 the report on the impact of the 1997 aged care reforms on residential aged care was released. The task set for the review was to assess and report on the extent to which the Aged Care Act 1997 *was achieving its objectives. The ambit of the review included accessibility, affordability, quality, efficiency, industry viability, State and Territory programs, choice, appropriateness, and other considerations including dementia. Professor Len Gray, the chair of the review, noted in the report that there remained some significant ongoing challenges for the industry with regard to 'the scale of building and restructuring required to meet the new standards and the future needs of the industry', 'the availability of staff and staff costs' and 'continuing improvement in quality of care' (2001:xxx). Nevertheless, he put forward the following overall conclusion:*

> *It is my conclusion, on completion of the Review, that the reforms have delivered substantial improvements to the aged care system. The fine-tuning undertaken to smooth the implementation of the reforms and address unanticipated anomalies has been largely successful. (Gray 2001:xxxi)*

The review makes seven recommendations concerning the need: for a review of indicators of supply and demand for residential and community care; for a critical analysis of current measures of need for care, type of care and care delivery; to consider the availability of appropriate acute, sub-acute and non-acute care options across a range of service delivery settings; to undertake a detailed analysis of respite services; to investigate the needs of and provision for people with dementia; to improve the availability of information available to intending residents and to simplify admissions procedures; to ask the Aged Care Standards and Accreditation Agency to review consistency issues between assessments and to continue to take particular care with regard to medication and nursing issues in homes with a small proportion of high care residents; to consider the introduction of objective measures of continuous improvement; and to further consider the processes and outcomes of accreditation with a view to future developments now that the first round of assessments is complete (Gray 2001:xxxi–xxxii).

Carelink Centres are an initiative of the Commonwealth Government, announced in the 1999—00 Budget, to provide a nation-wide network of information centres to facilitate access to a range of community services. The centres are intended to link health professionals, general practitioners, other service providers, carers and individuals in need of assistance with the agencies providing care and support in the region.

Information available through Commonwealth Carelink Centres include the types of services available and how to contact them, service availability, waiting list information, eligibility criteria and the costs associated with receiving the service.

Income support

Australia has 1,762,511 people receiving the Age Pension and a further 413,428 people aged 60 and over receiving pensions from the Department of Veterans Affairs (DVA). The Age Pension is income and assets tested, as is the Income Support Pension paid by DVA. Compensation pensions[6] are neither taxable nor subject to means testing. In March 2001 the single rate for the DVA Income Support and Age pensions was $402.00 per fortnight, while the couple rate was $335.50 each per fortnight.

Table 6.5: Age and DVA pension recipients, by age and sex, 31 December 2000 (per cent)

Pension/sex	60–64	65–69	70–74	75–79	80–84	85–89	90+	Total
Age pensioners								
Males	0.0	13.1	12.8	6.1	3.3	2.0	0.8	38.1
Females	9.8	14.3	12.8	9.9	7.4	5.1	2.6	61.9
Persons	9.8	27.4	25.6	16.0	10.7	7.1	3.4	100.0
Total (N)	**173,252**	**482,058**	**451,436**	**281,978**	**188,622**	**125,630**	**59,535**	**1,762,511**
DVA pensioners								
Males	1.5	1.8	4.1	20.7	12.2	3.6	0.7	44.6
Females	2.1	4.3	13.3	19.5	10.7	4.1	1.4	55.4
Persons	3.6	6.1	17.4	40.2	22.9	7.7	2.1	100.0
Total (N)	**15,060**	**25,079**	**72,018**	**166,300**	**94,547**	**31,739**	**8,686**	**413,428**

Note: Eligibility for Age Pension is 61.5 years for women and 65 years for men.

Source: Unpublished data, Centrelink; DVA Ad Hoc Information System.

Women made up 62% of age pensioners and 55% of DVA pensioners (that is, those aged 60 and over). While over a third of age pensioners were aged between 60 and 69, a substantial minority (10.5%) were aged 85 and over. There were 59,535 age pensioners in Australia aged 90 and over. DVA pensioners were heavily concentrated in the 75—84 age groups: only 10% were aged between 60 and 69; 63% were aged between 75 and 84; 10% were aged 85 and over (Table 6.5). As at 31 December 2000, 84% of Australians over the age of 65 were receiving at least a partial Age or DVA pension (86% of women and 82% of men). The proportion receiving at least a part pension increased from 79% among those aged 65—74 to 89% among those aged 75 and over.

According to the 1997 ABS Survey of Retirement and Retirement Intentions, 71% of retired people aged 65 and over were dependent on a pension or benefit (predominantly the Age Pension) as their main source of income. Superannuation either a superannuation pension or a pension or annuity bought with superannuation lump-sum or rollover money was the main source of income for only 10% of this age

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[6] Includes Disability Pension, War or Defence Widow's/Widower's Pension, and Orphan's Pension.

group. This pattern is likely to change in the future because the introduction of superannuation provisions into award entitlements in 1986 and the superannuation guarantee in 1992 has substantially increased superannuation coverage in all age groups. Growth in superannuation coverage was very rapid during the 1990s for older age groups (AIHW 1999a; OSW 1999). In the late 1990s, coverage of those in the workforce has grown slightly for both men and women, reaching around 87—88% by 2000. Rates of coverage are lower in the 60 and over age group than in the 55—59 age group, an effect which is likely to be partly a cohort effect, and partly to do with more part-time work (and hence lower superannuation coverage) in the 60 and over population (see Table 6.6). While superannuation coverage of the working population is now high at all ages and for both men and women, it must be remembered that increased coverage will take some time to translate into substantial retirement benefits, since entitlements are determined by the length of time during which superannuation has been accrued. Assuming a 40-year working life, the first cohort to be completely covered over their working life by the superannuation guarantee will not retire until 2032.

The Carer Payment (previously known as the Carer Pension) is an income-support benefit payable to people who, because of their caring responsibilities, are unable to engage in a substantial level of paid work. It is income and assets tested. In 2001, there were 23,268 people caring for a person aged 65 and over who were receiving the Carer Payment. The majority (68%) of these recipients were women. A large proportion of persons receiving the Carer Payment (and caring for a person aged 65 and over) were aged 45—64 (65% of men and 72% of women) (Table 6.7).

Table 6.6: Persons in workforce aged 55 and over, superannuation coverage by age and sex, 1997–00 (per cent)

Sex/age	1997	1998	1999	2000
Male				
55–59	91.9	90.8	92.6	91.4
60+	77.6	82.7	82.7	79.9
Total 55+	*86.3*	*87.6*	*88.6*	*87.0*
All in workforce, aged 55+ (N)	**339,700**	**366,500**	**376,100**	**422,800**
Female				
55–59	89.4	90.8	91.1	92.6
60+	76.0	78.1	77.8	80.1
Total 55+	*85.0*	*86.6*	*87.0*	*88.4*
All in workforce, aged 55+ (N)	**181,400**	**211,600**	**206,600**	**263,400**
Persons				
55–59	91.0	90.8	92.0	91.9
60+	77.1	81.2	81.3	80.0
Total 55+	*85.8*	*87.3*	*88.0*	*87.5*
All in workforce, aged 55+ (N)	**521,100**	**578,100**	**582,600**	**686,200**

Source: ABS survey of employee earnings, benefits and trade union membership, 1997–2000, unpublished data.

Table 6.7: Persons receiving Carer Payment, by age and sex of carer and care recipient, 30 March 2001 (row per cent)

	Male carer						Female carer						
Sex/age	0–24	25–44	45–64	65–79	80+	Total males	0–24	25–44	45–64	65–79	80+	Total females	Total carers (N)
Female care recipient													
65–69	0.6	18.3	27.7	5.4	0.0	52.0	1.8	33.9	11.5	0.4	0.3	48.0	1,568
70–79	0.7	13.2	20.3	1.5	0.3	35.9	2.0	23.1	38.7	0.3	0.0	64.1	5,577
80–89	0.4	3.9	24.1	0.9	0.2	29.5	0.9	7.3	60.9	1.3	0.1	70.5	7,352
90+	0.5	1.7	20.8	3.4	0.0	26.4	0.6	4.2	60.1	8.5	0.2	73.6	1,771
Total (%)	*0.5*	*8.2*	*22.8*	*1.8*	*0.2*	*33.5*	*1.3*	*14.9*	*48.4*	*1.6*	*0.1*	*66.5*	*16,268*
Total (N)	**87**	**1,340**	**3,706**	**293**	**31**	**5,457**	**217**	**2,432**	**7,881**	**266**	**15**	**10,811**	**16,268**
Male care recipient													
65–69	1.4	11.4	4.4	0.4	0.0	17.6	1.5	14.6	63.1	3.1	0.0	82.4	1,400
70–79	1.0	17.2	12.9	0.6	0.0	31.7	1.7	22.9	38.2	5.3	0.1	68.3	2,491
80–89	0.6	8.4	25.2	0.2	0.0	34.3	0.7	10.9	51.4	2.2	0.5	65.7	2,452
90+	0.9	4.6	26.3	1.2	0.0	33.0	0.6	5.8	55.6	4.6	0.5	67.0	657
Total (%)	*0.9*	*11.8*	*16.8*	*0.5*	*0.0*	*29.9*	*1.2*	*15.5*	*49.4*	*3.7*	*0.3*	*70.1*	*7,000*
Total (N)	**64**	**825**	**1,174**	**33**	**0**	**2,096**	**84**	**1,082**	**3,461**	**258**	**19**	**4,904**	**7,000**

Source: Centrelink, unpublished data.

Table 6.8: Persons receiving Carer Allowance, by age and sex of carer and care recipient, 30 March 2001 (row per cent)

	Male carer						Female carer						
Sex/age	0–24	25–44	45–64	65–79	80+	Total males	0–24	25–44	45–64	65–79	80+	Total females	Total carers (N)
Female care recipient													
65–69	0.2	5.8	12.4	61.0	1.1	80.6	0.7	12.5	4.7	1.1	0.4	19.4	4,262
70–79	0.2	5.0	8.8	42.9	10.3	67.3	0.6	11.8	18.9	1.2	0.2	32.7	13,698
80–89	0.2	1.9	14.4	8.7	17.9	43.1	0.4	5.0	46.8	4.1	0.6	56.9	13,725
90+	0.1	0.6	10.6	7.8	3.9	23.0	0.2	2.2	45.7	27.6	1.3	77.0	4,119
Total (%)	*0.2*	*3.4*	*11.6*	*27.9*	*11.4*	*54.5*	*0.5*	*8.2*	*31.0*	*5.3*	*0.5*	*45.5*	*35,804*
Total (N)	**72**	**1,224**	**4,152**	**9,985**	**4,076**	**19,509**	**187**	**2,933**	**11,095**	**1,906**	**174**	**16,295**	**35,804**
Male care recipient													
65–69	0.3	2.6	1.0	0.4	0.0	4.4	0.4	4.3	55.6	34.8	0.5	95.6	5,171
70–79	0.1	2.4	1.9	0.3	0.1	4.8	0.3	4.0	18.3	69.9	2.7	95.2	15,554
80–89	0.1	1.7	5.7	0.4	0.1	7.9	0.1	3.1	16.8	46.6	25.4	92.1	10,547
90+	0.1	1.7	9.8	2.6	0.1	14.3	0.1	2.3	32.4	21.9	29.0	85.7	1,607
Total (%)	*0.1*	*2.2*	*3.4*	*0.5*	*0.1*	*6.2*	*0.2*	*3.7*	*24.4*	*54.5*	*11.0*	*93.8*	*32,879*
Total (N)	**45**	**716**	**1,108**	**156**	**21**	**2,046**	**74**	**1,203**	**8,021**	**17,931**	**3,604**	**30,833**	**32,879**

Source: Centrelink, unpublished data.

The Carer Allowance (see Box 6.1) is paid to people caring for someone who requires a lot of additional care because of a disability or severe medical condition, in their own home.[7]

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[7] Medical eligibility for Carer Allowance (Adult) where the person being cared for is at least 16 years old is measured by the Adult Disability Assessment Tool (ADAT). This tool measures the functional ability of the person receiving care.

As at July 2001, the payment rate for the Carer Allowance was $82.00 per fortnight. It is not means tested, nor is it treated as income for social security or taxation purposes. In March 2001, there were 68,683 people caring for a person aged 65 and over who were receiving the Carer Allowance, a substantial increase on the 32,700 people receiving the Domiciliary Nursing Care Benefit in relation to the care of a person aged 65 or over in 1999. Just over two-thirds (69%) of these recipients of the Carer Allowance were women. Carer Allowance recipients caring for older women were most likely to be men aged 65 and over (39%) or women aged 45—64 (31%). Recipients caring for older men were most likely to be women aged 65 and over (66%) or women aged 45—64 (24%) (Table 6.8).

Assessment

Aged care assessment teams play a crucial role in the Australian aged care system. They determine eligibility for community aged care packages and for admission to residential aged care. They also function as a source of advice and referral concerning HACC services but do not determine eligibility for these services. The desirability and practicality of establishing a national assessment strategy for HACC services has been a subject of ongoing policy discussions in recent years, including a government-sponsored consultancy on the topic (LGC 1998).

In the 15 years since their inception, aged care assessment teams have become an established part of the aged care system. In the process of determining eligibility, the teams generate data on the clients they assess: their age and sex, their dependency levels, and their assessed level of need for services. While these data provide some information about the flow of clients into the aged care system, the current 22-item national minimum data set has some limitations (particularly in relation to the measurement of dependency and the availability of informal care). The development of a revised national minimum data set for the Aged Care Assessment Program is all but complete, and a review of the data collection environment required to support the new national minimum data set has been undertaken. A firm date for implementation has yet to be identified, but it will not occur prior to the 2002—03 financial year (see Box 6.3 for further details).

Between January and June 2000, aged care assessment teams carried out 85,444 assessments of persons aged 65 and over (Table 6.9).[8] This was 11,000 more assessments (an increase of 15%) than were carried out during the same period in 1997 (74,463 assessments). The percentage increase was markedly higher in the oldest age group (24% among those aged 85 and over) than in the younger age groups (2% for those aged 65—74, and 13% for those aged 75—84). This increase in the number of assessments being undertaken by aged care assessment teams is consistent with the trend in earlier years; between 1994 and 1997, there was a 14% increase in assessments.

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[8] It should be noted that while the data are reported here as national data, there are some interstate differences in the data collections; in particular, there have been historical differences in what is and is not defined as an ‘assessment’ in different jurisdictions. This was discussed in more detail in *Australia’s Welfare 1995* (AIHW 1995:183–5).

Box 6.3: Data development in aged care

In 1999, the AIHW began work on the Community Care Data Development Project under a Memorandum of Understanding with the Commonwealth Department of Health and Aged Care (DHAC). The project aims to improve the quality, relevance, consistency and comparability of national data on community care service provision. Ensuring consistency with national data standards (especially the National Community Services Data Dictionary) is a key focus of this project.

Aged Care Assessment Program

A major component of the project has been the development of Version 2.0 of the Aged Care Assessment Program Minimum Data Set (ACAP MDS V2.0). There have been many changes in the aged and community care sector since the introduction of the ACAP MDS V1.0 in 1994. The 127 aged care assessment teams across Australia play a pivotal role in this sector, applying a range of clinical and professional expertise to the comprehensive assessment of frail older persons and making recommendations on their future care needs. The Commonwealth and State/Territory Officials responsible for the program (ACAP Officials) wanted to ensure that the information reported in the MDS was relevant to the current and future needs of the program for policy development, planning and performance measurement. Version 2.0 of the MDS was endorsed by ACAP Officials in May 2001, with implementation to occur no sooner than 1 July 2002.

Major features of Version 2.0 of the ACAP MDS are the inclusion of information about informal carers, and more detailed information about the health condition of people assessed and their need for assistance in various areas of activity (e.g. self-care, mobility, communication, domestic assistance, transport). A set of national program-level performance indicators was also developed in conjunction with the development of Version 2.0. These indicators were also endorsed by ACAP Officials in May 2001 and will be reviewed 18 months after implementation of Version 2.0. The main product of this project is the ACAP Data Dictionary Version 1.0, containing definitions of all MDS Version 2.0 data elements and the national performance indicators.

Community aged care packages

Another major component of the Community Care Data Development Project has been the development of data definitions for the Community Aged Care Package (CACP) Program. This program has grown significantly in recent years and is designed to provide an individually tailored package of home and community-based care and assistance for people who would otherwise be eligible for low-level care in an aged care home. The Commonwealth Department of Health and Aged Care wanted to improve the amount, quality and relevance of information available about people receiving a community aged care package and the nature of the assistance they receive under it. As with the ACAP MDS V2.0 project, a set of national program-level performance indicators has been developed in conjunction with the development of data definitions. The main product of this project is the CACP Data Dictionary Version 1.0, containing definitions of data elements and the national program performance indicators. The Institute's work on CACP data development is scheduled for completion late in 2001.

(continued)

Box 6.3 (continued): Data development in aged care

Comparison of data collections

A report identifying any gaps or inconsistencies across data collections for the HACC, ACAP, CACP and the National Respite for Carers programs is another key product of the Community Care Data Development Project. This report uses the National Community Services Information Model as a framework. Each data element is assessed for consistency with national standards, and for internal consistency across these four programs.

During 2001–02, the AIHW's work on the Community Care Data Development Project will focus on developing minimum data sets for the Day Therapy Centre Program and the Continence Aids Assistance Scheme.

The rate of assessment (that is, the proportion of the age group assessed) has also increased slightly over the period: from 3.1% in 1994, to 3.3% in 1997, and to 3.6% in 2000. The rate was highest in the 85 and over age group (12.5%, compared with 4.8% of those aged 75—84 and 1.1% of those aged 65—74). These figures suggest quite a significant amount of contact between aged care assessment teams and those at more advanced ages, with around one in 8 of all people aged 85 and over being seen by a team in the given 6-month period. For the two younger age groups, the rate remained stable over the period, with a slight increase (from 11.3% in 1994 to 12.5% in 2000) for the 85 and over age group. Rates of assessment continue to be marginally higher among women than men in all age groups.

The proportion of people assessed who were deemed to require low and high residential care has changed little in recent years, remaining at around 22—23% over the period from 1994 to 2000 for high care places (formerly nursing homes) and at 21% over the same period for low-level places (formerly hostels). The proportion who received a recommendation for community aged care packages (or community options services) increased substantially, however, from 2% in 1994 to 10% in 2000. This latter result reflects the large increase in the number of community aged care packages available during the period. The vast majority of remaining clients had a recommended long-term living arrangement in the community, some with additional support from HACC services. For a small minority of clients, long-term arrangements were not specified or were classified as other .

Table 6.9: ACAT[(a)] assessment rates and recommendations, by age and sex, January–June 1994, 1997 and 2000 (per cent)

	1994				1997				2000			
Sex/recommendations	**65–74**	**75–84**	**85+**	**Total**	**65–74**	**75–84**	**85+**	**Total**	**65–74**	**75–84**	**85+**	**Total**
Males												
Residential care:												
High care/Nursing home	20	24	29	24	20	23	28	24	21	23	28	24
Low care/Hostel	14	18	21	18	15	18	21	18	15	17	20	18
CACPs/COPs	2	2	2	2	4	4	5	4	9	9	11	10
Total assessments	**5,992**	**10,851**	**6,073**	**22,916**	**6,604**	**12,430**	**7,352**	**26,386**	**6,471**	**14,076**	**9,193**	**29,740**
All males	596,251	261,821	53,281	911,353	617,619	298,356	63,988	979,963	623,952	336,140	78,391	1,038,483
Per cent assessed	*1.0*	*4.1*	*11.4*	*2.5*	*1.1*	*4.2*	*11.5*	*2.7*	*1.0*	*4.2*	*11.7*	*2.9*
Females												
Residential care:												
High care/Nursing home	16	19	28	22	16	18	27	21	16	21	28	23
Low care/Hostel	16	23	25	23	16	23	25	23	16	22	25	22
CACPs/COPs	2	2	2	2	5	5	4	5	12	11	10	11
Total assessments	**7,950**	**20,088**	**15,162**	**43,200**	**7,785**	**22,173**	**18,021**	**47,979**	**8,148**	**24,958**	**22,311**	**55,417**
All females	671,773	394,968	127,506	1,194,247	680,038	434,694	149,112	1,263,844	675,349	472,565	173,837	1,321,751
Per cent assessed	*1.2*	*5.1*	*11.9*	*3.6*	*1.1*	*5.1*	*12.1*	*3.8*	*1.2*	*5.3*	*12.8*	*4.2*
Persons												
Residential care:												
High care/Nursing home	17	21	29	23	18	20	27	22	18	21	28	23
Low care/Hostel	15	21	25	21	15	21	24	21	15	20	24	21
CACPs/COPs	2	2	2	2	5	5	5	5	10	10	10	10
Total assessments	**13,957**	**30,969**	**20,492**	**65,418**	**14,405**	**34,629**	**25,429**	**74,463**	**14,663**	**39,166**	**31,615**	**85,444**
All persons	1,268,024	656,789	180,787	2,105,600	1,297,657	733,050	213,100	2,243,807	1,299,301	808,705	252,228	2,360,234
Per cent assessed	*1.1*	*4.7*	*11.3*	*3.1*	*1.1*	*4.7*	*11.9*	*3.3*	*1.1*	*4.8*	*12.5*	*3.6*

(a) Aged Care Assessment Team.

Notes

1. Total numbers of assessments reported for 1994 are higher than reported in *Australia's Welfare 1999*, as a result of revised figures supplied by ACAP Evaluation Units. In addition to the recommendations listed above, ACATs may also recommend a continuation of living in the community either alone or with a spouse, with others such as relatives, or in a boarding house.
2. The table shows the proportion of ACAT clients who are recommended for residential care or coordinated community care (CACPs or COPs). The remaining clients generally receive a recommendation to continue living in the community, some with the assistance of HACC-funded services.

Source: ACAP Evaluation Units; ABS 2000a.

Table 6.10: ACAT[(a)] clients, by dependency, 1994–95 to 1999–00 (per cent)

Dependency	**1994–95**	**1995–96**	**1996–97**	**1997–98**	**1998–99**	**1999–00**
Mobility						
Walks independently	65.7	65.8	65.6	61.5	64.4	63.9
Does not walk independently	34.3	34.2	34.4	38.5	35.6	36.1
Number	*127,419*	*158,011*	*160,501*	*160,897*	*173,011*	*179,341*
Continence						
Fully continent	65.1	65.5	64.8	61.5	61.5	61.4
Not fully continent	34.9	34.5	35.2	38.5	38.5	38.6
Number	*124,293*	*154,337*	*157,228*	*160,897*	*170,148*	*176,276*
Orientation						
Aware, time & place	66.0	66.2	65.5	68.9	65.7	67.1
Not aware	34.0	33.8	34.5	31.1	34.3	32.9
Number	*125,621*	*154,731*	*158,467*	*160,043*	*169,075*	*174,740*
Total number	**132,957**	**164,862**	**166,410**	**171,660**	**178,915**	**183,572**

(a) Aged Care Assessment Team.

Source: AIHW 1999a; LGC 2000; ACAP Evaluation Units, 1999–00 unpublished data.

The Aged Care Assessment Program national minimum data set contains three items on client dependency: mobility, continence and orientation. For the period from 1994—95 to 1999—00, there was no clear change in the dependency profile of aged care assessment team clients as measured by these three items, although there was a modest decrease in the proportion who were fully continent (Table 6.10).[9]

Home and Community Care Program

The Home and Community Care (HACC) Program is jointly funded by the Commonwealth and State and Territory Governments. The bulk of home- and community-based services for older people are provided under the auspices of this program. It is important to recognise, however, that the target population is people of all ages with a moderate or severe level of disability (and their carers). The program includes home nursing services, delivered meals, home help and home maintenance services, transport and shopping assistance, paramedical services, home- and centre-based respite care, and advice and assistance of various kinds. HACC also provides brokered or coordinated care for some clients, through community options or linkages projects. (Community aged care packages, an alternative source of coordinated home-based care, are discussed later in this section.) While the implementation of the new HACC minimum data set will provide a rich basis for analysis of the HACC program, those data will not be available for analysis until late 2001. The discussion here is therefore somewhat limited, owing to the hiatus between the ending of the old HACC data collections and the as-yet unavailability of the new collection.

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[9] The inconsistency in the 1997–98 patterns for the mobility and orientation items may be related to the re-assessment of (former) hostel residents which occurred as a result of the restructuring of residential aged care services into one single system in late 1997.

Table 6.11: HACC[(a)] service provision, in a sample month, by main service type, 1993–94, 1996 and 1999–00[(b)]

Main service types	1993–94	1996	1999–00
		Total hours	
Home help (hours)	596,874	644,537	634,887
Personal care (hours)	152,462	188,810	251,759
Home nursing (hours)[(c)]	287,838	258,110	215,968
Paramedical (hours)	27,421	34,694	40,617
Home respite care (hours)	216,111	229,589	322,744
Centre day care (hours)	586,604	679,012	905,155
Home maintenance/modification (hours)	58,603	64,245	80,005
Home meals (meals)	1,040,599	1,120,744	1,147,807
Centre meals (meals)	141,117	172,112	152,292
Total hours[(d)]	**1,339,309**	**1,419,985**	**1,545,979**
		Per 1,000 persons aged 70 and over	
Home help (hours)	428	429	378
Personal care (hours)	109	126	150
Home nursing (hours)[(c)]	206	172	129
Paramedical (hours)	20	23	24
Home respite care (hours)	155	153	192
Centre day care (hours)	421	452	539
Home maintenance/modification (hours)	42	43	48
Home meals (meals)	746	746	683
Centre meals (meals)	101	115	91
Total hours[(d)]	**960**	**946**	**920**
		Per 1,000 persons aged 65 and over with a severe or profound restriction	
Home help (hours)	1,423	1,648	1,244
Personal care (hours)	364	483	493
Home nursing (hours)[(c)]	686	660	423
Paramedical (hours)	65	89	80
Home respite care (hours)	515	587	632
Centre day care (hours)	1,399	1,736	1,773
Home maintenance/modification (hours)	140	164	157
Home meals (meals)	2,481	2,866	2,249
Centre meals (meals)	337	440	298
Total hours[(d)]	**3,193**	**3,631**	**3,029**

(a) Home and Community Care.

(b) Data on transport, other food services and other unspecified services are not included in this summary table. For more detailed information, see Table A6.2.

(c) Home nursing services are not provided by the Northern Territory.

(d) Excludes centre day care, home and centre meals, transport, other food services and other unspecified services.

Source: ABS 2000a; AIHW analysis of the ABS Disability, Ageing and Carers Survey 1998; AIHW 1997a,1999a; DHAC unpublished data.

Table 6.11 provides data on the total hours of services provided under the program, and the hours in relation to the number of people aged 70 and over and the number of people aged 65 and over with a severe or profound restriction.[10] In 1999—00, HACC delivered a total of 1,545,979 hours of service in the main program service areas.[11] The supply of services increased throughout the period: by 60% between 1993—94 and 1996, and by 8.9% between 1996 and 1999—00.

The remainder of the table explores the provision of HACC services in relation to the size of the potential client group in the aged population, allowing changes in the level of provision to be examined in the context of the increasing size of the aged population between 1993—94 and 1999—00. Neither of the two measures employed captures the entire potential client population, however, as HACC provides services to people with disabilities regardless of their age. It is estimated that 25% of HACC services are delivered to clients aged under 65; a clearer indication of these service patterns will be possible when data from the new HACC MDS are available for analysis.

The target group for the HACC program specifies people of all ages with a moderate or severe disability, and their carers. In a number of contexts, this has been defined as equivalent to those people who fall into the ABS category (Survey of Disability, Ageing and Carers) of having a moderate, severe or profound core activity restriction. In analyses undertaken by the AIHW, the moderate core activity restriction category is not included, as it refers by definition to people who do not require assistance with activities of daily living. In this and other AIHW publications, the HACC target population is therefore operationalised as equivalent to those people with a severe or profound core activity restriction in the terms employed by the ABS survey.

In 1999—00, HACC agencies provided 1,244 hours of home help (per month) per 1,000 people aged 65 and over with a severe or profound restriction. They also provided (again per month) 1,773 hours of centre-based respite care and 2,249 home-delivered meals per 1,000 people aged 65 and over with such restriction. The levels of provision were lower in the more intensive service types: for home-based respite care, 632 hours; for personal care, 493 hours; and for home nursing, 423 hours.

Five categories of HACC service showed a substantial increase in relation to the population aged 65 and over with a severe or profound restriction since 1993—94: personal care (a 35% increase), paramedical services (23%), respite care services (23%), centre day care (27%) and home maintenance (12%). There was a substantial reduction in home nursing (a 38% decrease), home help (13%), home-delivered meals (9%) and centre-based meals (12%). Much of this decrease has occurred in the period between 1996 and 2000, with service types such as home help, and home-delivered and centre-based meals, increasing between 1993—94 and 1996, and then decreasing thereafter. The pattern of expansion of HACC services in relation to the size of the aged population, which characterised the mid-1990s, appears to have slowed, or in the case of some service types reversed, in recent years. During this later period, however, the expansion of community aged care packages has been pronounced (see Table 6.12).

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[10] The base population data used for these and other service use calculations are included in Table P.4.

[11] See Table A6.2 for more detailed data on all service types by State and Territory.

There are quite interesting State and Territory variations in these patterns of service delivery (see Table A6.2). The Northern Territory has a much higher level of provision for all HACC services in relation to both the number of people aged 70 and over and the number of people aged 65 and over with a severe or profound restriction. For example, for home help services, 6,863 hours were delivered per 1,000 people aged 65 and over with a severe or profound restriction, compared to the national average of 1,244 hours. This pattern is to be expected, given the high proportion of Indigenous Australians in the Northern Territory, their higher levels of morbidity and lower life expectancy, and their consequent need for both home-based and residential aged care services at (on average) younger ages than non-Indigenous Australians.

There are considerable variations among the other States and the Australian Capital Territory, and there is no clear evidence that these different patterns are converging over time. For home help in 1999—00, Victoria, Western Australia and Tasmania were relatively high providers, at 1,472, 1,567 and 1,713 hours respectively per 1,000 people aged 65 and over with a severe or profound restriction. The corresponding figure for South Australia was 925. For personal care services, New South Wales, Western Australia and the Australian Capital Territory were relatively high providers (respectively, 631, 584 and 659 hours), while Queensland was a relatively low provider (230 hours). For home-based respite care, the Australian Capital Territory and South Australia were comparatively high providers (respectively, 1,954 and 814 hours), while Victoria and Tasmania provided relatively low levels of this type of service (respectively, 403 and 564 hours).

It may be that these variations are partly artificial, deriving from State and Territory differences in how forms of care are defined for example, whether assistance is defined as personal care rather than home help, or as home nursing rather than respite care. Another possible contributing factor is that these differences represent a trade-off among service types. These explanations do not, however, fully account for the observed differences. If the hours of assistance provided in home help, home nursing, personal care, paramedical services, home-based respite care, home maintenance and other services are added together, there remains a clear difference in the level of supply across the States and Territories. The Northern Territory undoubtedly has the highest level of service provision (but note the earlier caveat about its population profile), at 13,487 hours per 1,000 persons aged 65 and over with a severe or profound restriction, even though hours of home nursing are not included as it is not a HACC-funded service in the Northern Territory. Next is the Australian Capital Territory (with 5,556 hours of service), followed by South Australia (3,933), Tasmania (3,793), Victoria (3,590), Western Australia (3,560), Queensland (3,128) and New South Wales (2,953).

The HACC program has undergone a substantial amount of review and development work in recent years. Developments include the implementation of both the HACC National Service Standards Instrument (from 1 July 1999) and the HACC NMDS (from 1 July 2000). Both the instrument and the data set were developed by the Institute (AIHW: Ryan et al. 1999; AIHW: Jenkins et al. 1998). A consumer appraisal instrument for use in the Service Standards review process was developed by the AIHW at the request of HACC Officials and accepted for implementation by HACC Officials (see Box 6.4). While no national data are yet available from the HACC National Service Standards Instrument, preliminary data have been received for the first quarter of the NMDS (January to March 2001). Other important issues in the HACC program revolve around consideration of the findings of the report *Targeting in the Home and Community Care Program* (NARI & BECC 1998), the consultancy undertaken on standardised dependency items for use in the program, and of the role to be played by comprehensive assessment in community care.

Box 6.4: The HACC Service Standards Consumer Appraisal Data Development Project (1998–99)

Client appraisal of agency performance is an important component of the assessment of quality of service in HACC agencies. At the request of the HACC Officials Standards Working Group, the AIHW has developed a consumer survey instrument for use in the assessment of agencies against the HACC National Service Standards.

The four principal objectives of the HACC Service Standards Consumer Appraisal Data Development Project were:

- *to refine the survey tool;*
- *to test the usefulness of survey methods in providing information about the quality of the service provided by an agency;*
- *to test the capacity of this tool to stand alone as an accurate indicator of agency service quality, as described by the HACC National Service Standards, and to analyse the extent to which consumer appraisals provide a useful means of validating and informing HACC agency appraisals; and*
- *to examine the viability of survey methods according to such criteria as cost, timeliness, practicality, acceptability to clients, and usefulness to service providers.*

The first stage of the project involved a review of the current literature on consumer involvement in the appraisal of a range of health and welfare services. This review aimed to examine the best methods for obtaining consumer feedback from users of community services generally, but particularly from consumers representative of the HACC target group: frail or disabled older people, younger people with disabilities, and carers. It also examined the special problems in obtaining feedback from people from diverse cultural backgrounds and from Indigenous Australians. The literature review is available as a working paper (AIHW: Cooper & Jenkins 1998).

The second stage of the project involved an extensive field trial, with data collected from over 2,000 HACC clients from a sample of 41 participating HACC agencies, in addition to interviews and questionnaires completed by agency staff and HACC agency assessors. As a result of the fieldwork, a refined tool was developed which is expected to yield valid and reliable measures of client appraisals of HACC services, based on the HACC National Service Standards, for incorporation into the assessment process (see AIHW: Jenkins 2000 and AIHW: Jenkins & Gibson 2000 for further details).

Residential aged care and community aged care packages

As at 30 June 2001, there were 2,973 occupied aged care homes in Australia providing a total of 142,444 places. In addition, 24,430 community aged care packages were provided. Community aged care packages are designed to provide care services to those living at home who would otherwise be eligible for low-level residential care. This section presents data on operational aged care places and packages. Allocated places and packages are not included here, but are discussed in a later section.

Because aged care places and community aged care packages (CACPs) are intrinsically linked, they are usually combined to present an indication of the provision of aged care against the planning ratio. The planning ratio target is 100 places and packages per 1,000 persons aged 70 years and over. The provision ratio declined in the late 1980s and early 1990s but stabilised in the mid-1990s at around 93 places and packages per 1,000 persons aged 70 years and over (AIHW 1995:381—2; AIHW 1997a:384—5). Recently the ratio has begun to rise, reaching 96.5 in 2001. Table 6.12 shows the number and ratio of operational aged care places and community aged care packages in Australia from 1996 to 2001.

Supply

Community aged care packages, first implemented in 1992, provide support services for people living at home who would otherwise be eligible for admission to what was previously Personal Care level in a hostel (approximately equivalent to RCS levels 5 to 7 in the present system). They provide a range of home-based services, excluding home nursing assistance, with care being coordinated by the care package provider. Unlike the HACC program which is jointly funded by Commonwealth and State and Territory Governments, the community aged care packages program is Commonwealth funded. From a small beginning of some 470 community aged care packages in 1992, the program had grown to reach 18,149 care packages by 2000, and 24,430 by 2001 (provisional data).[12] The bulk of this growth occurred in the past 4 years, with the number virtually quadrupling: from 6,124 packages in 1997 to 24,422 in 2001. This growth rate is higher than that of the population aged 70 and over, with the consequence that care packages are providing care to an increasing proportion of older people in need of formal assistance. In 1997 there were 3.9 packages per 1,000 people aged 70 and over (or 13.1 packages per 1,000 people aged 65 and over with a severe or profound core activity restriction); by 2001, this figure had increased to 14.1 packages per 1,000 people aged 70 and over (provisional data) (or 46.4 packages per 1,000 people aged 65 and over with a severe or profound core activity restriction) (Table 6.12). Patterns for State and Territory provision are presented in Table A6.3.

While community age care package provision has expanded rapidly, the growth in residential aged care places has been slower. Residential aged care places have increased over the past 4 years: from 136,851 operational places in 1996, to 139,917 in 1998, and to 142,310 in 2001 (provisional).[13] The ratio of places to people in need of assistance has declined over the period. In terms of the Commonwealth government

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[12] These numbers refer to operational packages.

[13] The data in this sub-section on supply refer to operational places.

provision ratio, there has been a shift from 90.6 places per 1,000 people aged 70 and over in 1996, to 87.4 places in 1998, and to 82.4 places in 2001. In terms of the more closely targeted measure also presented in Table 6.12, this represents a decline from 300.7 places per 1,000 people aged 65 and over with a severe or profound core activity restriction in 1996, to 270.5 places per 1,000 people aged 65 and over with a severe or profound core activity restriction in 2001.

Table 6.12: Operational aged care places and packages, 30 June 1996 to 30 June 2000

			Ratio of places/ packages per 1,000 persons	
Year	**Aged care type**	**No. of places/packages**	**Aged 70+**	**Aged 65+ with a severe or profound restriction**
1996	Community aged care packages	4,431	2.9	9.7
	Hostels	62,471	41.4	137.2
	Nursing homes	74,380	49.2	163.4
	Residential aged care[(a)]	136,851	90.6	300.7
	Total	**141,282**	**93.5**	**310.4**
1997	Community aged care packages	6,124	3.9	13.1
	Hostels	64,825	41.7	138.2
	Nursing homes	74,233	47.7	158.2
	Residential aged care[(a)]	139,058	89.4	296.4
	Total	**145,182**	**93.3**	**309.5**
1998	Community aged care packages	10,046	6.3	20.7
	Residential aged care	139,917	87.4	288.8
	Total	**149,963**	**93.7**	**309.5**
1999	Community aged care packages	13,753	8.4	27.7
	Residential aged care	140,651	85.6	283.3
	Total	**154,404**	**94.1**	**311.1**
2000	Community aged care packages	18,149	10.8	35.4
	Residential aged care	141,162	83.8	275.5
	Total	**159,311**	**94.5**	**311.0**
2001	Community aged care packages[(b)]	24,430	14.1	46.4
	Residential aged care[(b)]	142,310	82.4	270.5
	Total[(b)]	**166,740**	**96.5**	**316.9**

(a) Residential aged care combines nursing homes and hostels; from 1 October 1997 nursing homes and hostels were combined into one residential care system.

(b) Rates are calculated using population projections for 30 June 2001, 2001 data supplied by DHAC are provisional figures.

Source: ABS 2000a; AIHW 1999a:192; AIHW 2000a, 2000b, 2001a, 2001b; AIHW analysis of ABS Survey of Disability, Ageing and Carers, 1998; DHAC, unpublished data.

The availability of residential places has thus declined in recent years, to be below the official planning ratio for residential care of 90 places per 1,000 people aged 70 and over, set in the mid-1980s. Since 1985, the provision ratio for high care places (formerly nursing home beds) has moved from 67 places per 1,000 people aged 70 and over to 44 places in 2000, while that for low-level places (formerly hostel places) has moved from 32 places per 1,000 people aged 70 and over to 40 places (SCRCSSP 2001). The target planning ratio has been set for some years at 40 high care places and 50 low care places per 1,000 people aged 70 and over.

The national residential provision ratio of 83.8 places per 1,000 people aged 70 and over in 2000 conceals some noticeable differences in supply at the State and Territory level, with Victoria well below the national average at 79.7 places. New South Wales, Western Australia, South Australia, Tasmania and the Australian Capital Territory all lie quite close to the national average, while Queensland and the Northern Territory are higher at 88.3 and 89.2 respectively. The Northern Territory level of provision must be understood in the context of the comparatively high proportion of Indigenous Australians in the Northern Territory, the poorer health status of these people, their shorter life expectancy, and their use of aged care services at younger ages.

New allocations

The development of new community aged care packages and residential aged care places can only occur where packages and places have been formally allocated to a provider as part of an Approvals Round. Prior to the Approvals Round process, the Commonwealth Government determines the number of places and packages to be offered and their general geographic distribution. Each Approvals Round takes place over a period of several months. The minister makes an initial announcement of the numbers of places and packages to be made available at the beginning of the Approvals Round, submissions for those places and packages are then received and reviewed, and an announcement of the final number of allocated places and packages is made at the conclusion of the Approvals Round.[14] Figure 6.2 shows data on new allocations for community aged care packages and residential aged care places over the period from 1987 to 2001.

The number of new allocations for care packages rose steadily from their inception in 1993, reaching 6,532 in the 2000 Approvals Round (announced in January 2001). The number of packages (2,029) released as part of the 2001 Approvals Round is lower than in recent years.

The number of new allocations for residential care places was between three and four thousand in the late 1980s, rising to over 8,000 in 1991 (with two approvals rounds in that year). From 1992, the number of residential places allocated in the approvals rounds began to fall, with 1,253 places allocated in 1995, and none in 1996. By 1998, the

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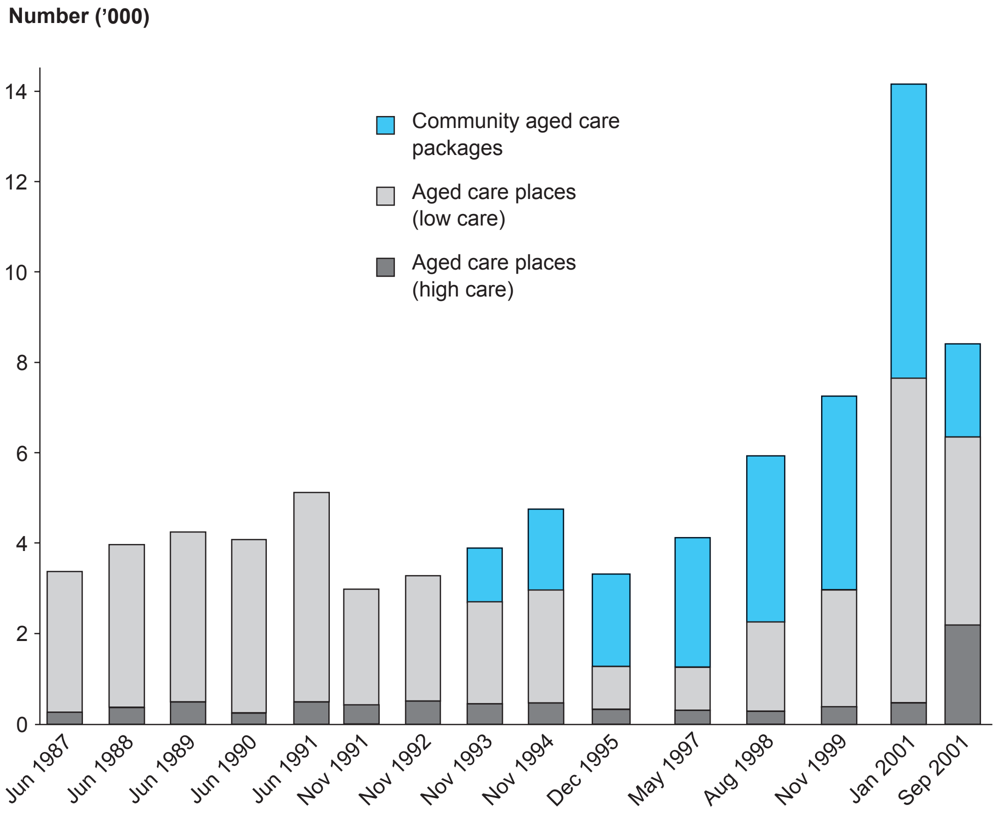
[14] Allocated places and packages refer to the end point of the approvals process, when places and packages have been allocated to a specific provider who undertakes to begin supply of that service within the subsequent 2 years. The time period between allocation and the service becoming available to clients varies. On the one hand, the majority of care packages become available for use reasonably quickly, but on the other, where residential aged care places require capital works, the period to commencement of service is substantially longer. In recent years, a modest number of places have been made available outside the Approvals Round process for allocation to flexible care, emergency care and multi-purpose services.

number of new places allocated had begun to rise again, and this trend has accelerated in the last 2 years. There were 7,642 residential places allocated to providers in the 2000 Approvals Round, and a further 6,362 were made available to providers in the 2001 Approvals Round.[15]



Source: Table A6.4.

Figure 6.2: Number of new allocations of residential care places and community aged care packages, Aged Care Approvals Rounds, June 1987 to September 2001

Multi-purpose services and flexible services provided under the Aboriginal and Torres Strait Islander Aged Care Strategy

In addition to the services already described, the Commonwealth Government provides aged care services through multi-purpose services in rural and remote communities, and through flexible services under the Aboriginal and Torres Strait Islander Aged Care

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15 A further 975 residential places are available in 2001, outside the Approvals Round, for flexible care, emergency care and multi-purpose services.

Strategy. Multi-purpose services were trialed in 1990 and expanded in 1994. In 2000, there were 44 multi-purpose services providing 905 residential places and 68 packages. Flexible services provided under the Aged Care Strategy for Indigenous Australians began operating in 1996, with a total of 27 places and packages, expanding to 246 places and packages by 1997. In 2000, there were 21 flexible services providing 275 places and 92 packages.[16]

Respite care

With the increasing trend towards home-based care and away from residential service provision, respite care has emerged as an important area of service provision. This has been evident in a number of government policy initiatives, with the announcement of the national Respite for Carers Program in the 1996—97 Budget, and respite care being a key component of the Staying at Home measures announced in the 1998—99 Budget. The data presented in Table 6.11 demonstrate that there was substantial growth in the provision of in-home respite care under the HACC program in relation to the population aged 65 and over with a profound or severe restriction (23% since 1993—94). Indeed, in-home respite and centre-based day care are the only areas of HACC where growth in program hours has outpaced growth in that population aged 65 and over with a profound or severe restriction in recent years. Respite care is also provided under the community aged care packages program, although no data are available as to the actual services received by care package recipients. The ratio of care package provision has also increased dramatically from its beginnings in 1993, and continued to expand rapidly in recent years (Table 6.12).

Residential respite care is also recognised as an important component of the carer support system, whether for emergency care, to provide a break while carers attend to other affairs or take a holiday, or for instances where carers themselves encounter health, personal or family problems. The number of days of residential respite supplied has steadily increased over the last decade, as has the proportion of residential care days used for respite care. Total respite days increased from 337,020 in the year ending 1991 to 978,408 in the year ending 30 June 2000; this is an average annual percentage increase of 12.8%. The increase was most pronounced during the period from 1991 to 1996 (19% per annum), weakening to an average of 5.0% per annum between 1996 and 2000. Between 1999 and 2000, the number of residential respite bed-days provided fell marginally (the only time this decade): from 980,545 to 978,408 (0.2% decrease in total days). This fall was more pronounced in Victoria (a 5.6% decrease) and in the Australian Capital Territory (8.9%), with more stable patterns in South Australia and Tasmania, and increases in New South Wales, the Northern Territory, Western Australia and Queensland. As a percentage of total bed-days, respite care increased from 0.8% in 1991 to 1.7% in 1996, and then to 2.0% in 1999, remaining at that figure in 2000 (Table A6.5).

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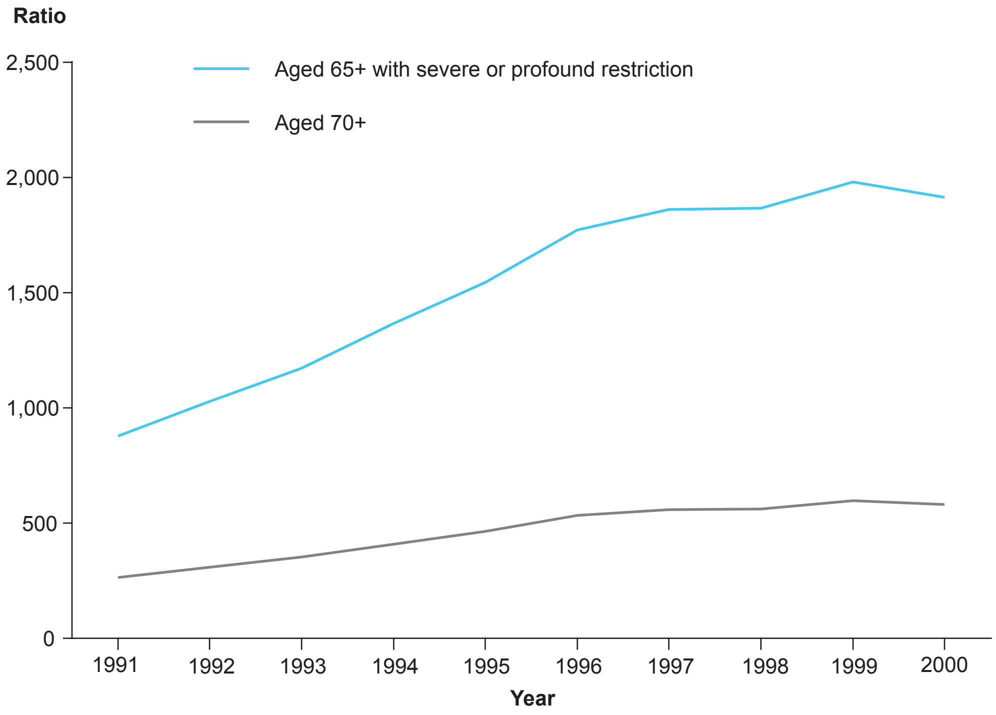
[16] More detailed information on these programs is provided in AIHW: Gibson et al. (2000).

The policy target for residential respite is generally regarded as the equivalent of 2 places per 1,000 persons aged 70 and over. Converting place days to places at the rate of 365 days per annum gives a figure of 0.72 places per 1,000 people aged 70 and over in 1991, rising to 1.64 places in 1999, then falling to 1.59 places in 2000.

These data on available respite can also be considered in relation to the population aged 70 and over and the population aged 65 and over with a severe or profound restriction. In 1990—91, 877 days of residential respite were provided per 1,000 people aged 65 and over with a severe or profound restriction. By 1998—99, this figure had more than doubled: to 1,979 days per 1,000 people aged 65 and over with a severe or profound restriction. The ratio of residential respite provision dropped slightly in 1999—00: to 1,913 days of residential respite per 1,000 people aged 65 and over with a severe or profound restriction.



Source: Table A6.6.

Figure 6.3: Occupied residential aged care respite days per 1,000 persons in population, 30 June 1991 to 30 June 2000

Patterns of use in residential care

Data on the number of residential care places and the ratios of provision are static measures of the availability of residential care. The way these services are used that is, the movement of people through the residential care system is also important. Time-series data on admissions, separations, turnover, occupancy rates and length of stay have usually been included in this section. The merging of hostels and nursing homes into one system of care (and the consequent creation of a single residential care database) has, however, rendered certain of these measures largely non-comparable before and after the reforms. Movements from low care to high care were formerly recorded as a separation and admission as a resident moved from hostel to nursing home. Under the new system, low and high care will frequently be provided in the one aged care home, and thus a separation and admission is no longer recorded. Similarly, under the old system, length of stay in a hostel followed by length of stay in a nursing home were two separate measures; now they are often one continuous measure. Thus, the number of admissions and separations is lower in the new single system than the total for the dual system, and the length of stay is longer for those moving between low and high care. In this volume of *Australia's Welfare*, therefore, data are reported on these measures since the restructuring of the system in October 1997. Reliable data are not available for the period July to December 1997, so half-yearly data only are reported for that financial year.

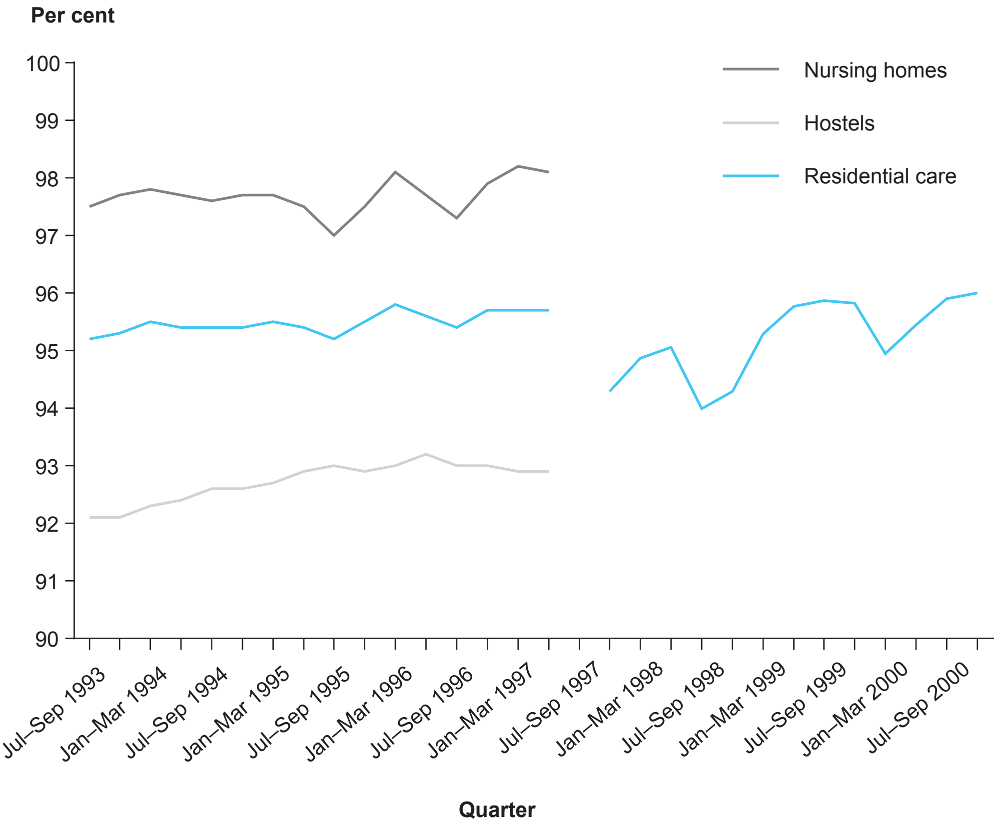
In 1999—00, 45,476 people were admitted to aged care homes for permanent care, compared to 45,258 in 1998—99. For respite care, the figures were 42,531 in 1999—00, and 40,806 in 1998—99. Thus, almost half the admissions were for respite care, although in terms of bed-days respite residents occupy only 2%. Turnover for permanent residents did not change between 1998—99 and 1999—00, remaining constant at 0.32 permanent admissions per bed (Table 6.13).

Table 6.13: Residential aged care admissions, by care type, January–June 1998, 1998–99 and 1999–00

Care type	**Jan–Jun 1998**	**1998–99**	**1999–00**
Permanent	21,165	45,258	45,476
Respite	18,487	40,806	42,531
Total	**39,652**	**86,064**	**88,007**

Source: AIHW 1999b, 2000b, 2001b.

Figure 6.4 presents quarterly data on occupancy rates for nursing homes, hostels and the two systems combined for the period from July 1993 to December 2000. The combined system occupancy rate has been stable over the period, mostly ranging between 95% and 96%. Occupancy rates appear to drop slightly at the time of the reforms (1997), but there was a discontinuity in the data series at this time (owing to a change in the method of calculation) which makes the apparent shift unreliable. Since late 1997, occupancy has been trending up slightly: from 94.3% in the fourth quarter of 1997, to 96% in the fourth quarter of 2000.



Source: Table A6.7.

Figure 6.4: Occupancy rates for residential care, by quarter, July 1993 to December 2000

Table 6.14 presents data on length of stay for permanent residents of aged care homes as at 30 June 1998, 1999 and 2000. The data refer to people who were residents of an aged care home at that point in time. There is no strong trend evident in these data, although there is some evidence of a modest increase in the proportion of residents in the longer stay categories. Thus, at 30 June 1998, 38% of residents had stayed 3 years or more, while by 2000 the comparable figure was 42%. This change may well be associated with the impact of the ageing in place policy, implemented as part of the 1997 reforms, which allowed formerly low care residents who are reclassified to the higher care category to remain in the same aged care home (with service provider agreement).

Table 6.14: Current permanent residents, length of stay to date, 30 June 1998 to 30 June 2000 (per cent)

Length of stay	1998	1999	2000
<4 weeks	2.4	3.0	2.5
4–<13 weeks	4.6	5.8	4.8
13–<26 weeks	6.4	7.8	6.1
26–<52 weeks	13.4	13.8	11.9
1–<2 years	21.0	20.5	18.2
2–<3 years	14.7	14.6	14.5
3–<5 years	17.4	17.7	20.1
5 years or more	20.2	16.8	21.9
Total (%)	*100*	*100*	*100*
Total (N)	**131,170**	**132,420**	**133,387**

Note: Residential aged care combines nursing homes and hostels; from 1 October 1997 nursing homes and hostels were combined into one residential care system.

Source: AIHW 1999b:47, 2000b:47, 2001b:46.

Ageing in place

One of the more significant ramifications of the merging of the two systems of residential care, and the creation of the single eight-category Resident Classification Scale, was that residents of what were formerly hostels acquired the capacity, subject to the agreement of the service management, to age in place . Ageing in place is one of the specified objectives of the *Aged Care Act 1997*, and simply means that low care residents who become more dependent and require additional care can move to a high care classification within the same aged care home, without physically moving from a low care to a high care home. This has the advantage for residents that they (or their relatives) do not have to negotiate a move to a new service, and there is no need to adjust to new surroundings, new staff and new co-residents. This section explores the extent to which this policy has been taken up by residents and low care service providers by focusing analytic attention on those aged care homes which were historically hostels prior to the reforms, and hence exclusively low care providers.[17]

A number of effects can be expected as a result of the implementation of this policy. The most direct effect would be an increase in the level of dependency amongst residents of former hostels. Another expected effect would be a change in patterns of separation.

Between 30 June 1998 and 30 June 2000, the proportion of high care residents in former hostels increased from 11% to 19% (Table 6.15). The 11% represents the proportion of clients who were reclassified within the 9 months following the implementation of the ageing-in-place policy, and the shift from 11% to 19% the continuing impact of the

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17 Increases in dependency can result from either the ‘ageing in place’ of existing residents or the admission of an increased proportion of high-dependency residents. By focusing on former hostels, which generally continue to be providers of low care services, this analysis essentially excludes increases in dependency associated with the admission of a greater proportion of high care residents, and focuses on those residents living in services which admit low care residents.

policy over the next 2-year period. By 30 June 2000, almost one in five residents living in what were hostels under the old system were receiving a high care level of subsidy. Most of these residents were at RCS levels 3 and 4, with less than 1% at RCS level 1 and only 3% at RCS level 2.[18] Another trend evident in Table 6.15 is that, even among low care residents in former hostels, dependency as indicated by RCS category increased, with the proportion of RCS level 8 residents falling from 10% to 5%, and the proportion of RCS level 7 residents falling from 45% to 37%. By contrast, the proportion in RCS level 6 remained relatively steady, while that in RCS level 5 (the highest level of dependency in the low care category) increased.

While Table 6.15 shows that a change in RCS levels did occur among residents of former hostels, it does not indicate to what extent this shift was concentrated among particular establishments or occurred more generally across a large proportion of services. To establish how widespread the policy shift has been in this sense, service-level data are required (Table 6.16). Less than a year after the implementation of the reforms, at 30 June 1998, only 28% of former hostels had no high care residents. By 30 June 2000, this proportion had dropped even further, to 14%. These data suggest a very broadly based uptake of the ageing-in-place policy across former hostel establishments. Although the policy is widespread, for most of these establishments only a minority of clients fall into the high care category. At 30 June 2000, 41% of former hostels had no more than 10% of high care clients, 21% had between 11% and 20%, and 17% had between 21% and 30%. The time series presented in the table does suggest, however, that the proportion of former hostels with a larger percentage of high care residents is increasing over time.

Table 6.15: Permanent residents in former hostels, by dependency level, 30 June 1998 to 30 June 2000

	High care					**Low care**					
Year	**RCS 1**	**RCS 2**	**RCS 3**	**RCS 4**	***RCS 1–4***	**RCS 5**	**RCS 6**	**RCS 7**	**RCS 8**	***RCS 5–8***	**Total**
						Number					
1998	50	618	2,750	2,536	*5,926*	7,686	11,539	24,651	5,362	*49,145*	**55,071**
1999	268	1,332	4,707	2,983	*9,239*	9,465	12,040	21,296	3,772	*46,441*	**55,680**
2000	406	1,728	5,189	3,427	*10,750*	9,655	12,209	20,441	2,856	*45,161*	**55,911**
						Per cent (row)					
1998	0.1	1.1	5.0	4.6	*10.8*	13.9	20.9	44.7	9.7	*89.2*	**100**
1999	0.5	2.4	8.4	5.3	*16.6*	16.9	21.6	38.1	6.8	*83.4*	**100**
2000	0.7	3.1	9.3	6.1	*19.2*	17.3	21.8	36.6	5.1	*80.8*	**100**

Note: RCS is the Resident Classification Scale.

Source: AIHW analysis of DHAC ACCMIS database.

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[18] The Resident Classification Scale (RCS) is an eight-point scale used to classify residents in aged care homes. High care (formerly nursing home) residents have an RCS rating of 1 to 4, while low care (formerly hostel) residents have a rating of 5 to 8. The RCS level determines the level of payment which the home receives for each resident. In July 2001, the full Commonwealth daily subsidy for an RCS 5 resident was $36.63 and for an RCS 1 resident it was $109.97 (New South Wales data are used here; there are some interstate variations in subsidy levels for high care places).

Table 6.16: Former hostels, by per cent of high care residents, 1998, 1999 and 2000

	Per cent of high care residents (RCS 1–4)									
Year	**0–10**	**11–20**	**21–30**	**31–40**	**41–50**	**51–60**	**61–70**	**71–80**	**81–90**	**91–100**
					Number					
1998	971	273	131	56	29	16	13	6	4	2
1999	684	357	189	129	56	26	20	9	4	6
2000	597	314	242	150	72	40	20	12	10	7
					Per cent (row)					
1998	64.7	18.2	8.7	3.7	1.9	1.1	0.9	0.4	0.3	0.1
1999	46.2	24.1	12.8	8.7	3.8	1.8	1.4	0.6	0.3	0.4
2000	40.8	21.4	16.5	10.2	4.9	2.7	1.4	0.8	0.7	0.5

Notes

1. RCS is the Resident Classification Scale.
2. There were 419,249 and 210 services in 1998, 1999 and 2000 respectively with no high care residents.

Source: AIHW analysis of DHAC ACCMIS database.

Table 6.17: Discharges from former hostels for permanent residents, by separation mode, 1994–95 to 1999–00 (per cent)

Separation mode	**1994–95**	**1995–96**	**1996–97**	**1997–98**	**1998–99**	**1999–00**
Death	30.1	29.4	32.3	43.4	53.0	53.5
Return to community	9.0	8.6	7.8	8.5	7.4	6.5
To hospital	17.6	17.8	16.9	16.1	17.6	18.3
To other residential care	42.2	42.8	40.8	27.6	17.3	17.0
Unknown	1.2	1.4	2.1	4.4	4.7	4.6
Total separations (N)	**16,306**	**17,117**	**17,895**	**14,208**	**12,276**	**12,496**

Source: AIHW analysis of DHAC ACCSIS and ACCMIS databases.

Table 6.17 demonstrates the changing patterns of separation for residents of former hostels as a result of the implementation of the ageing-in-place policy. Between 1994—95 and 1999—00, the proportion of residents who left the (former) hostel in order to move to another residential care service decreased from 42% to 17%. (It is reasonable to assume that the majority of these moves would have been to a nursing home for higher level care.) Over the same period, the proportion of residents who remained in the home until their death increased from 30% to 54%, consistent with a strong trend towards ageing-in-place for these residents.

A cohort perspective

Apart from the conventional measures of the flow of residents through the residential aged care system, the movement of residents within the system is also of interest. This aspect of understanding the way in which residential aged care services are used by clients has received little attention to date, but has become more important under the present one-tier system of residential care. Figure 6.5 presents the results of an analysis which explores the extent of client movement within the residential care system. It focuses on the cohort of residents who entered aged care homes for permanent care between 1 January and 30 June 1998, and records the various transitions which occurred in the course of their stay.

In total, 17,978 people were admitted to aged care homes for permanent care over the first 6 months of 1998 (transfers are not included). This is the study population for the present discussion. By 30 June 1998 (i.e. the end of the 6-month entry period), 3,232 people (18%) had already been discharged. The majority of these had died (2,587), but 393 had returned to live in the community and 150 had been discharged to an acute care hospital. In the second 6-month period, from 30 June to 31 December, a further 3,193 people (18%) left aged care homes. Again, the vast majority of these had died (2,542), but a certain number returned to live in the community (285) and others separated to hospital (247). By the end of the period, 30 June 2000, 10,175 of the original cohort (57%) had left the system. While most had died (45% of the original admissions), a small proportion (5%) had returned to live in the community and another 4% had been discharged and admitted to an acute care hospital.

Over the period of study, there were 1,162 transitions from low to high care (as determined by the RCS category of residents), based on care status of the residents at the end of each 6-month period. There were also 265 transitions from high to low care. Looking at each 6-month period in turn, this shows a modest but significant proportion of care transitions. Of the 11,553 people still resident at 31 December 1998, 2% had moved from low to high care since admission, and 0.1% from high to low care. Between 31 December 1998 and 30 June 1999, 4% of those remaining at the end of the period had moved from low to high care, and 2% from high to low. In the next 6-month period to 31 December 1999, 2% had moved from low to high care and 0.2% from high to low. And in the final 6-month period, 5% of remaining residents were reclassified from low to high care, and 1% from high to low. Only 54% of those who were classified as low care residents at 30 June 1998 remained in the system classified as low care residents at the end of the period. The corresponding figure for high care residents was 42%.

Of those cohort members who left the system during the period under study, a number were re-admitted at a later stage.[19] Of the original cohort members, 19% were subsequently discharged and re-admitted once, 3% twice, and 0.6% three or more times.

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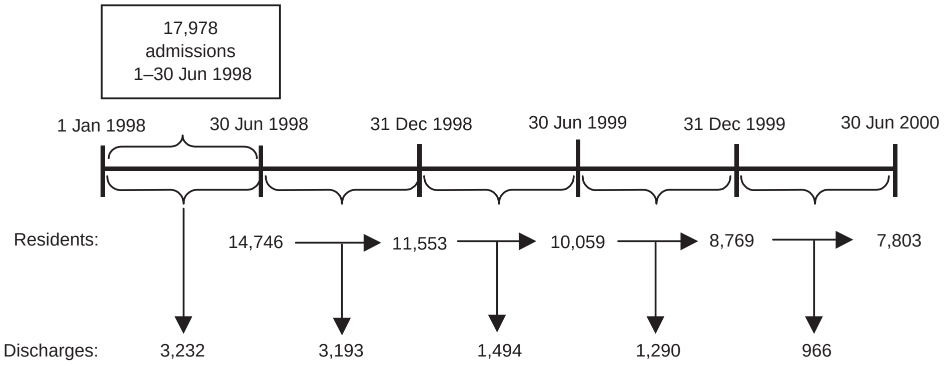
[19] The analysis presented here focuses on the cohort admitted from 1 January to 30 June 1998. Those who were discharged and re-admitted at a later date remain outside the scope of the analysis.



Remaining residents

	30 Jun 1998	31 Dec 1998	30 Jun 1999	31 Dec 1999	30 Jun 2000
High	8,448	6,334	5,597	4,818	4,445
Low	5,984	5,012	4,342	3,872	3,306
No RCS category[(a)]	314	207	120	79	52
Total number	**14,746**	**11,553**	**10,059**	**8,769**	**7,803**

Movements

	1 Jan 1998 to 30 Jun 1998	1 Jul 1998 to 31 Dec 1998	1 Jan 1999 to 30 Jun 1999	1 Jul 1999 to 31 Dec 1999	1 Jan 2000 to 30 Jun 2000	Cumulative total
Category changes						
Low to high	n.a.	185	452	142	383	1,162
High to low	n.a.	12	167	17	69	265
Insufficient information	n.a.	207	204	109	85	605
No change during 6-month period						
High	n.a.	6,149	5,131	4,673	4,059	—
Low	n.a.	5,000	4,105	3,828	3,217	—
Total	*n.a.*	*11,149*	*9,236*	*8,501*	*7,276*	—
No change since 30 Jun 1998						
High	—	6,149	4,987	4,147	3,546	—
Low	—	5,000	4,096	3,625	3,045	—
Total	—	*11,149*	*9,083*	*7,799*	*6,591*	—
Discharges						
To the community	393	285	82	48	27	835
To hospital	150	247	165	119	100	781
Died	2,587	2,542	1,193	1,065	798	8,185
Other	102	119	54	58	41	374
Total discharges	*3,232*	*3,193*	*1,494*	*1,290*	*966*	*10,175*

Note: Does not allow for readmissions and the initial cohort excludes residents without a residential classification.

(a) RCS = Residential Classification Scale.

Source: AIHW analysis of Department of Health and Aged Care ACCMIS database.

Figure 6.5: The movement of the cohort of aged care home clients, by high (RCS 1–4) or low (RCS 5–8) dependency,[(a)] who were admitted between 1 January and 30 June 1998

Probability of using an aged care home

Cross-sectional data indicate only the proportion using an aged care home at a particular point in time, and hence tend to give the impression that aged care homes are relevant only to a small proportion of older people. Table 6.18 presents data on the probability of entering an aged care home during the remaining lifetime, given that they have never entered an aged care home before, at various ages for both men and women. These data are important because they give an indication of the likelihood that any individual in the community will come to use an aged care home before they die. At any point in time, only 5.5% of people over the age of 65 are living in an aged care home. However, at age 65, the likelihood that a man in the community will enter an aged care home for permanent care before he dies is 0.28, or in other words 28% of men aged 65 living in the community could expect to enter an aged care home before they die. The corresponding figure for women is much higher, at 46%. These probabilities increase with age, meaning that those who survive to more advanced old age have a higher chance of entering an aged care home prior to death. At age 80, the probabilities are 0.36 for men and 0.52 for women, while at age 90 they increase again: to 0.42 for men and 0.54 for women.

The probabilities are higher again if respite care is included as well as permanent care. If the probabilities were calculated for all men and women at a given age, the probability of use before death is higher. These issues have been discussed in more detail, and alternative probabilities calculated, in a recent publication of the Institute (AIHW: Mason et al. 2001).

Table 6.18: Probability of someone in the community entering an aged care home, by care type and sex, 1999–00

	Age (years)							
Care type/sex	**0**	**65**	**70**	**75**	**80**	**85**	**90**	**95**
Permanent care								
Males	0.24	0.28	0.30	0.33	0.36	0.40	0.42	0.33
Females	0.42	0.46	0.47	0.50	0.52	0.54	0.54	0.48
Permanent and respite care combined								
Males	0.33	0.39	0.41	0.45	0.49	0.55	0.61	0.50
Females	0.59	0.64	0.67	0.70	0.74	0.79	0.87	1.00

Notes

1. The databases used in this analysis were the DHAC SPARC system 2000; ABS 1999:93–4; ABS 2000b:16–33.
2. The data in this table are estimated using life table models based on 1999–00 use patterns in aged care homes. These life tables are not included in this report.
3. The term ‘someone in the community’ is used to refer to a person who is not in an aged care home and has not used one before.

Source: AIHW: Mason et al. 2001.

Client profiles

Age and sex

Table 6.19 presents the most recent available data on the age and sex profiles of clients of community aged care packages and residential services. In contemporary Australia, aged care homes generally cater to a very old clientele. In 2000, almost one-quarter were aged over 90, fully half the residents were aged 85 or older, and almost three-quarters were aged 80 and over. Women predominate, making up 72% of the total resident population. Two in every five residents were women aged 85 or older. Community aged care package clients are somewhat younger, although the majority (59%) are still aged 80 or older. As was the case for residential aged care, women make up the majority of package clients (71%). Data on the clientele of HACC services are not yet available from the new HACC MDS, while data from the most recently completed HACC client survey (1998) were reported in *Australia's Welfare 1999* (AIHW 1999a:197).

Table 6.19: Aged care clients, by age, sex and dependency, 30 June 2000 (per cent)

		Residential aged care clients		
Sex/age	**Community aged care package clients**	**High (1–4)**	**Low (5–8)**	**Total**
Females				
Under 65	3.9	2.5	1.6	2.1
65–69	3.6	1.8	1.4	1.7
70–74	7.2	4.2	3.7	4.0
75–79	12.8	9.4	9.0	9.2
80–84	17.9	14.6	16.4	15.3
85–89	16.4	19.8	22.8	20.9
90+	8.9	19.6	18.6	19.2
Total females	*70.6*	*71.8*	*73.4*	*72.4*
Males				
Under 65	3.1	2.6	2.1	2.4
65–69	2.1	1.7	1.5	1.6
70–74	3.5	3.3	2.9	3.2
75–79	5.2	5.4	4.3	4.9
80–84	6.3	5.8	5.3	5.6
85–89	5.9	5.7	6.2	5.9
90+	3.3	3.7	4.4	4.0
Total males	*29.4*	*28.2*	*26.6*	*27.6*
Persons				
Under 65	7.0	5.1	3.7	4.5
65–69	5.7	3.5	3.0	3.3
70–74	10.7	7.6	6.6	7.2
75–79	18.0	14.8	13.3	14.2
80–84	24.2	20.4	21.7	20.9
85–89	22.3	25.4	28.9	26.8
90+	12.2	23.3	51.9	23.1
Total persons	*100.0*	*100.0*	*100.0*	*100.0*
Total (N)	**16,617**	**80,483**	**49,833**	**130,316**

Note: This table excludes 3,071 residents whose dependency levels were not reported.

Source: AIHW 2001a, 2001b.

Use by Aboriginal and Torres Strait Islander people

Table 6.20 shows the rates of use for Indigenous and non-Indigenous Australians using residential aged care services and community aged care packages.[20] The age categories employed are somewhat different to those used in the remainder of the chapter, owing to the relatively small size and the younger age structure of the Indigenous resident population. Usage rates for community aged care packages were markedly higher for Indigenous Australians than for non-Indigenous Australians. Among people aged 50—74, the rate of use was 8 per 1,000 for Indigenous Australians and 1 per 1,000 for non-Indigenous Australians. For those aged 75 and over, the rates were 39 per 1,000 and 12 per 1,000 respectively.

Rates of residential care use were also higher for Indigenous Australians than for non-Indigenous Australians. For those aged 50—74, the rate of use was 10 per 1,000 persons for Indigenous Australians, and 4 per 1,000 for non-Indigenous Australians. At ages 75 and over, the numbers were 133 per 1,000 and 106 per 1,000 respectively. This finding of higher use rates within these age categories is striking, given that the average age of Indigenous people in each age category is lower than the average age of non-Indigenous people in the comparable category.

Table 6.20: Age- and sex-specific usage rates for aged care services, by Indigenous status, 30 June 2000

	Community aged care packages per 1,000 population		**Permanent residential aged care places per 1,000 population**	
Indigenous status/sex	**50–74**	**75+**	**50–74**	**75+**
Indigenous				
Female	10	42	8	151
Male	6	34	11	105
Total Indigenous	*8*	*39*	*10*	*133*
Not Indigenous				
Female	1	14	4	133
Male	1	8	4	65
Total not Indigenous	*1*	*12*	*4*	*106*

Notes

1. Residents with unknown status have been pro rated.
2. This table does not include places and packages provided by multi-purpose services operating in regional and remote areas of Australia or places and packages funded under the Aboriginal and Torres Strait Islander Flexible Care Program for which no age data are available.

Source: ABS 1998, 2000a; AIHW analysis of DHAC ACCMIS database.

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[20] Data on the use of HACC services by Aboriginal and Torres Strait Islander people are not yet available from the new HACC MDS, and data from the most recently completed HACC client survey were reported in *Australia's Welfare 1999*. Rates of use are calculated as the number of clients in each age and sex group per 1,000 people in that age and sex group.

Use by people from culturally and linguistically diverse backgrounds

Table 6.21 shows rates of use of community aged care packages and residential care services by overseas-born people from culturally and linguistically diverse backgrounds, overseas-born people from English-speaking backgrounds, and the Australian born.[21] The table shows the different rates of use according to English Proficiency (EP) Group. The EP Group classification was developed by the Bureau of Immigration, Multicultural and Population Research in 1999 (DIMA 1999), and divides the overseas-born population into four groups based on the English proficiency levels of recently arrived migrants according to country of birth. EP Group 1 comprises people born in English-speaking countries; EP Group 2 comprises those countries from which at least 80% of recent immigrants speak only English or another language and good English (e.g. Malta, Austria and Germany); EP Group 3 comprises those countries from which at least 50% but less than 80% of recent immigrants speak only English or another language and good English (e.g. Greece, Italy and Poland); and EP Group 4 comprises those countries from which less than 50% of recent immigrants speak only English or another language and good English (e.g. Turkey, Viet Nam and China).[22] The classification was developed to counter the tendency to use concepts such as Non-English-Speaking Background (NESB) which fail to recognise the diversity evident within that category. The EP Group classification has been shown to be a useful tool in exploring the social and economic circumstances of older people from a culturally and linguistically diverse background, and their use of government benefits and services (AIHW: Benham & Gibson 2000).

As is evident from the table, the rates of use for community aged care packages were largely comparable across all groups, ranging from 5 to 7 packages per 1,000 people aged 65 and over. When age-specific categories are examined, however, some differences do emerge. For the older age categories, and especially among people aged 85 and over, EP Groups 2, 3 and 4 have higher rates of use of community aged care packages than either EP Group 1 (those from English-speaking countries) or the Australian born. These differences are concealed in the general 65 and over usage rate because older overseas-born people from a culturally and linguistically diverse background tend to have a younger population profile than either EP Group 1 or the Australian born. As the population profiles of EP Groups 2, 3 and 4 are expected to age more rapidly over the next decade than the Australian born, these data suggest a likely increasing demand for community aged care packages among older overseas-born people from a culturally and linguistically diverse background.

For residential aged care, the usage rates for persons 65 and over show a marked difference among the five groups. Rates are highest among the Australian born, at 60 people per 1,000 persons aged 65 and over, with a somewhat lower rate of use by those in EP Group 1 (49 people per 1,000). Rates for EP Groups 2, 3 and 4 are substantially

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[21] Data on the use of HACC services by overseas-born people from culturally and linguistically diverse backgrounds are not yet available from the new HACC MDS, and data from the most recently completed HACC client survey were reported in AIHW (1999a).

[22] For more details of the classification, see AIHW: Benham & Gibson (2000).

lower, at 38 per 1,000, 27 per 1,000 and 20 per 1,000 respectively. Older Australian-born people are thus three times more likely to use aged care homes than members of EP Group 4, and twice as likely as members of EP Group 3. When the age structure of the population is taken into account by examining age-specific usage rates, the differences do become somewhat less pronounced, but they remain substantial. Among those aged 85 and over, for example, there were 279 Australian-born people in aged care homes for every 1,000 in the population. The comparable numbers are 235 for EP Group 1, 224 for EP Group 2, 153 for EP Group 3 and only 106 for EP Group 4.

Table 6.21: Age- and sex-specific usage rates for aged care services, by English Proficiency Group, 30 June 2000

	CACP[(a)] recipients per 1,000 population				Residential aged care clients per 1,000 population			
Sex/EP Group	**65–74**	**75–84**	**85+**	**65+**	**65–74**	**75–84**	**85+**	**65+**
Females								
EP1	2	8	20	7	8	56	276	67
EP2	3	13	28	9	9	63	263	50
EP3	3	11	21	7	7	45	185	35
EP4	2	11	18	7	6	35	129	28
Australian born	2	9	20	7	12	74	319	77
Total females	*2*	*9*	*21*	*7*	*11*	*68*	*299*	*69*
Males								
EP1	1	4	14	3	7	32	151	28
EP2	2	6	22	4	8	40	147	25
EP3	1	5	15	3	6	28	108	19
EP4	1	6	17	4	4	20	62	12
Australian born	1	5	16	4	12	46	180	36
Total males	*1*	*5*	*16*	*4*	*10*	*41*	*164*	*32*
Persons								
EP1	1	6	18	5	7	46	235	49
EP2	2	10	26	7	9	53	224	38
EP3	2	8	18	5	6	37	153	27
EP4	2	9	18	5	5	29	106	20
Australian born	2	7	19	6	12	63	279	60
Total persons	**2**	**7**	**19**	**6**	**10**	**57**	**257**	**53**

(a) Community Aged Care Packages.

Notes

1. There were 3,205 residential aged care residents and 2,380 CACP recipients for whom country of birth data were missing.
2. The English Proficiency Groups classification was developed by the Bureau of Immigration, Multicultural and Population Research. This classification uses the English proficiency levels of recently arrived migrants in order to divide the overseas-born population into four groups. Overseas-born people are assigned to a group according to their country of birth.

Source: ABS 2000a; AIHW 2001a, 2001b.

Dependency levels

Data on dependency are collected for residents of aged care homes, but no recent data are available on the dependency levels of community aged care package clients, and dependency data are not collected in the HACC program.[23] This means that the only service-based dependency data are those describing the residential aged care program.

Recent years have seen considerable conjecture and debate about the rising dependency levels of residents in aged care homes. There was some evidence of rising dependency within the former two-level residential care system. Previous data published by the AIHW have shown that dependency levels were increasing in both nursing homes and hostels (AIHW 1997b, 1998a, 1998b, 1998c, 1999b). In addition, the relative increase in the number of hostel places has meant that, with time, an increasing proportion of the residential care population was accommodated in hostels rather than in nursing homes (AIHW 1999a:204—5). Under the current single-tier system, the proportion of residents at higher dependency levels has also been increasing. In 1998, 57.8% of residents were classified as RCS 1 to 4, and by 2000 it was 61.8%. At the other end of the spectrum, the percentage of residents classified as RCS 8 has declined from 4.5% in 1998 to 2.3% in 2000 (Table 6.22). The change in systems has made comparison over time difficult, as the various dependency classifications in use prior to and after the reforms are not strictly comparable.

Table 6.22: Permanent residents, by level of dependency at 30 June 1998, 1999 and 2000

Year	RCS 1	RCS 2	RCS 3	RCS 4	RCS 5	RCS 6	RCS 7	RCS 8	Total
					Number				
1998	8,868	32,279	26,250	7,398	9,910	12,576	26,287	5,835	129,403
1999	15,971	33,279	22,995	5,875	11,072	13,036	22,383	3,944	128,555
2000	18,786	33,835	21,781	6,081	11,538	13,399	21,869	3,027	130,316
					Per cent (row)				
1998	6.9	24.9	20.3	5.7	7.7	9.7	20.3	4.5	100.0
1999	12.4	25.9	17.9	4.6	8.6	10.1	17.4	3.1	100.0
2000	14.4	26.0	16.7	4.7	8.9	10.3	16.8	2.3	100.0

Notes

1. RCS is the Resident Classification Scale.
2. In 1998, 1999 and 2000, there were 1,767, 3,865 and 3,071 residents respectively whose dependency levels were not recorded in the databases at the time.

Source: AIHW 1999b, 2000b 2001b.

There are, however, some personal care items which were in use in the previous hostel and nursing home classifications, and are also in use in the present residential classification scale. Data on these items are presented in Table 6.23 for 1994, 1997 and 2000. These data show a substantial increase in the proportion of residents requiring at

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[23] A consultancy on possible dependency measures for inclusion in the HACC MDS has recently been completed. Such measures, if agreed, will not be scheduled for inclusion in the HACC MDS prior to July 2003.

least some assistance with toileting, eating and drinking, washing and dressing, continence, and the management of verbally disruptive behaviour or physical aggression. The greater part of this increase appears to have occurred in the period from 1997 to 2000. By 2000, 93% of residents required at least some assistance with washing and dressing, 81% with continence, 76% with eating and drinking, 68% with toileting, and 55% with regard to verbally disruptive or physically aggressive behaviour. Some caution must be exercised in interpreting these data, however, as although the data items are consistent across the time series, the items form part of the RCI and PCAI scales for 1994 and 1997, and the RCS in 2000.[24]

Table 6.23: Dependency of permanent residents of aged care homes, by selected RCS(a) items, 30 June 1994, 1997 and 2000

	Per cent requiring at least some assistance		
Assessment items	**1994**	**1997**	**2000**
Toileting	59	60	68
Eating and drinking	60	64	76
Washing and dressing	81	83	93
Continence	55	58	81
Verbal disruption/physical aggression	28	30	55

(a) RCS is the Resident Classification Scale.

Source: AIHW analysis of DHAC ACCMIS database.

As was demonstrated earlier in this chapter, some 20% of former hostel places are now occupied by high care residents. While some component of this change involves the simple reclassification of people who were previously inappropriately classified as low care residents, the dependency items reported here suggest that there may well have been a real shift in the dependency levels of the client population. This pattern, while in some ways quite dramatic, is broadly consistent with government policy, which aims to provide assistance to a greater proportion of frail and disabled older people at home, rather than in residential care, via services provided through community aged care packages and the HACC program. Residential aged care is thus being concentrated on a progressively more dependent component of the aged population.

Pension status

Table 6.24 shows the pension status of aged care home residents admitted during the period 1993—94 to 1999—00. The most obvious trend is the reduction in the proportion of missing data. Taking this into account, it appears that the pension status profile of persons entering aged care homes remained largely unchanged over the period. For those residents admitted during 1999—00, 87% received either a full or part pension, 10% no pension, and data were not available for the remaining 3%. Data presented in

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24 The Resident Classification Instrument (RCI) and Personal Care Assessment Instrument (PCAI) were the scales on which Commonwealth subsidy levels were based in nursing homes and hostels respectively, prior to the implementation of the 1997 aged care reforms.

Table 6.24: Admissions to residential aged care, by sex and pension status, 1993–94 to 1999–00 (per cent)

Sex/pension status	1993–94	1994–95	1995–96	1996–97	1998[(a)]	1998–99	1999–00
Males							
Receives pension	79	80	85	87	84	85	86
Does not receive pension	4	3	4	4	8	10	10
Missing data[(b)]	17	17	12	10	8	6	4
Total males (N)	*17,118*	*18,191*	*17,447*	*17,562*	*13,190*	*16,016*	*15,482*
Females							
Receives pension	80	82	86	87	80	87	87
Does not receive pension	3	2	3	3	8	9	10
Missing data[(b)]	16	16	11	10	11	3	3
Total females (N)	*31,950*	*33,755*	*33,645*	*33,632*	*7,748*	*28,164*	*28,935*
Persons							
Receives pension	80	81	85	87	83	86	87
Does not receive pension	4	3	3	3	8	9	10
Missing data[(b)]	17	16	11	10	9	4	3
Total persons (N)	**49,068**	**51,946**	**51,092**	**51,194**	**20,938**	**44,180**	**44,417**

(a) Six-month period (January to June 1998) only.

(b) Missing data are unknown plus not reported.

Source: AIHW 1999a, 2001b.

the *Two Year Review of Aged Care Reforms* report indicate that, of those admitted during 1999—00, just under three-quarters of those receiving a pension were receiving a full pension (Gray 2001:64).

Expenditure

Government expenditure on aged care services

Table 6.25 presents data on aged care recurrent expenditure in both current and constant (1998—99) prices for the years from 1995—96 to 1999—00. Total expenditure on aged care homes, HACC, assessment, community aged care packages, multi-purpose services, Carer Allowance and the Accreditation program increased from $3,379.8 million in 1995—96 to $4,839.9 million in 1999—00 (current prices). This represents an increase of 43% in real terms over the past 4 years. The proportions allocated to each area have remained relatively stable, although there has been an increase in the proportion allocated to community aged care packages (from 1% to 3%, or in actual dollar terms from $33.1 million to $148.9 million). Aged care homes were the largest area of expenditure, dropping slightly from 80% in 1995—96 to 77% in 1999—00. HACC remained relatively constant, moving from 16% in 1995—96 to 15% in 1999—00.

Table 6.25: Recurrent aged care expenditure in current and constant (1998–99) dollars, by program, 1995–96 to 1999–00

Program	1995–96	1996–97	1997–98	1998–99	1999–00
			Current prices ($m)		
Aged care homes	2,695.0	2,997.0	3,381.0	3,584.0	3,741.3
Home and community care[(a)]	554.0	615.6	630.2	673.4	722.4
Assessment	38.2	38.4	39.8	38.6	40.1
Community aged care packages	33.1	51.6	84.1	121.8	148.9
Multi-purpose flexible services	12.8	17.7	25.3	29.4	38.7
DNCB[(b)]/Carer Allowance[(c)]	46.7	51.9	52.9	71.6	140.8
Accreditation	—	—	5.1	5.9	7.8
Total	**3,379.8**	**3,772.2**	**4,218.3**	**4,524.7**	**4,839.9**
			Constant prices ($m)		
Aged care homes	2,848.8	3,112.1	3,460.6	3,584.0	3,660.7
Home and community care[(a)]	585.7	639.3	645.0	673.4	706.8
Assessment	40.4	39.9	40.7	38.6	39.2
Community aged care packages	35.0	53.6	86.1	121.8	145.7
Multi-purpose flexible services	13.5	18.4	25.8	29.4	37.9
DNCB[(b)]/Carer Allowance[(c)]	49.4	53.9	54.1	71.6	137.8
Accreditation	—	—	5.2	5.9	7.6
Total	**3,572.8**	**3,917.2**	**4,317.6**	**4,524.7**	**4,735.7**

(a) Includes expenditure on the National Respite for Carers Program.

(b) Domiciliary Nursing Care Benefit.

(c) Carer Allowance estimated according to the proportion of recipients aged 65 or more years.

Source: AIHW health expenditure database; DHAC 1998, 1999, 2000; DHAC, unpublished data; DHFS 1996, 1997; FaCS 2000.

Table 6.26 presents data on aged care recurrent expenditure, in both current and constant (1998—99) prices for the years from 1995—96 to 1999—00, in relation to the number of people aged 65 and over with a severe or profound restriction. The increase in expenditure on aged care services overall has kept pace with the growth in the number of older people needing some assistance; indeed, the amount of expenditure per person aged 65 and over with a severe or profound restriction increased during the last 4 years in real terms. In 1995—96, total aged care expenditure (in constant 1998—99 prices) was $7,857.7 per person aged 65 and over with a severe or profound restriction. In 1999—00, the figure had increased to $9,243.5. Annual growth was around 6 to 7% per person per annum for the first part of the period, falling to 1.8% in the period between 1997—98 and 1998—99 and then to 1.4% in the period from 1998—99 to 1999—00. The largest areas of growth in terms of expenditure per person aged 65 years and over with a severe or profound restriction were community aged care packages, multi-purpose and flexible type services and the Carer Allowance. For assessment, expenditure per person aged 65 years and over with a severe or profound restriction declined over the period.

Table 6.26: Recurrent aged care expenditure per person with a profound or severe core activity restriction, in constant (1998–99) dollars, 1995–96 to 1999–00

Program	1995–96	1996–97	1997–98	1998–99	1999–00
			Constant prices ($m)		
Aged care homes	6,265.5	6,639.3	7,178.6	7,220.0	7,145.2
Home and community care[(a)]	1,288.1	1,363.8	1,338.0	1,356.6	1,379.6
Assessment	88.8	85.1	84.5	77.8	76.6
Community aged care packages	77.0	114.3	178.6	245.4	284.4
Multi-purpose flexible services	29.8	39.3	53.6	59.2	73.9
DNCB[(b)]/Carer Allowance[(c)]	108.6	115.0	112.3	144.2	268.9
Accreditation	—	—	10.7	11.9	14.8
Total	**7,857.7**	**8,356.7**	**8,956.3**	**9,115.1**	**9,243.5**
			Annual growth rates (per cent)		
Aged care homes	—	6.0	7.5	0.6	–1.0
Home and community care[(a)]	—	5.9	–1.9	1.4	1.7
Assessment	—	–4.2	–0.7	–8.0	–1.5
Community aged care packages	—	48.5	36.0	37.4	15.9
Multi-purpose flexible services	—	31.9	26.8	10.5	24.9
DNCB[(b)]/Carer Allowance[(c)]	—	5.9	–2.4	28.4	86.4
Accreditation	—	—	—	10.9	24.7
Total	**—**	**6.4**	**6.7**	**1.8**	**1.4**

(a) Includes expenditure on the National Respite for Carers Program.

(b) Domiciliary Nursing Care Benefit.

(c) Carer Allowance estimated according to the proportion of recipients aged 65 or more years.

Source: AIHW health expenditure database; DHAC 1998, 1999, 2000; DHAC, unpublished data; DHFS 1996, 1997; DHAC FaCS 2000.

User charges

Although no national data are available on user charges for community care services, there are some data for residential care. For residents who meet the income and assets test, the maximum daily care fee is set at 85% of the Age Pension. For residents on higher incomes, income-tested fees are charged, at the rate of 25 cents for every additional dollar of income, up to a maximum level of three times the pensioner rate or the cost of care, whichever is the lower.

In 1997—98, the basic daily care fee yielded $1,067.5 million in user charges, and the income-tested component an additional $1.7 million. By 1999—00, the comparable figures were $1,138.0 million and $37.5 million. Focusing on payments for care services (i.e. excluding accommodation payments and Commonwealth capital subsidies), user charges accounted for 26.1% of the $4,098 million available to aged care homes in 1997—98, and 24.8% of the $4,740 million available in 1999—00. Taking all payments by the Commonwealth Government and residents into account, residents contributed 27.6% in 1997—98, and 29.0% in 1999—00.

Expenditure on older Australians

Table 6.27 provides a broader view of expenditure on older Australians, taking into account expenditure on income support (including both Department of Veterans Affairs and Age pensions), residential care, home-based care, and medical, hospital and pharmaceutical services. Total expenditure on people aged 65 and over in 1998—99 was

$29,000 million. The largest area of expenditure was income support ($16,611 million), followed at some distance by hospital expenditure ($5,228 million) and residential care ($3,423 million). Over the period from 1989—90 to 1998—99, the fastest growing areas of expenditure were pharmaceutical services and home-based care (both 8.6% per annum), followed by medical services. The slowest growth was in the area of income security (2.7% per annum).

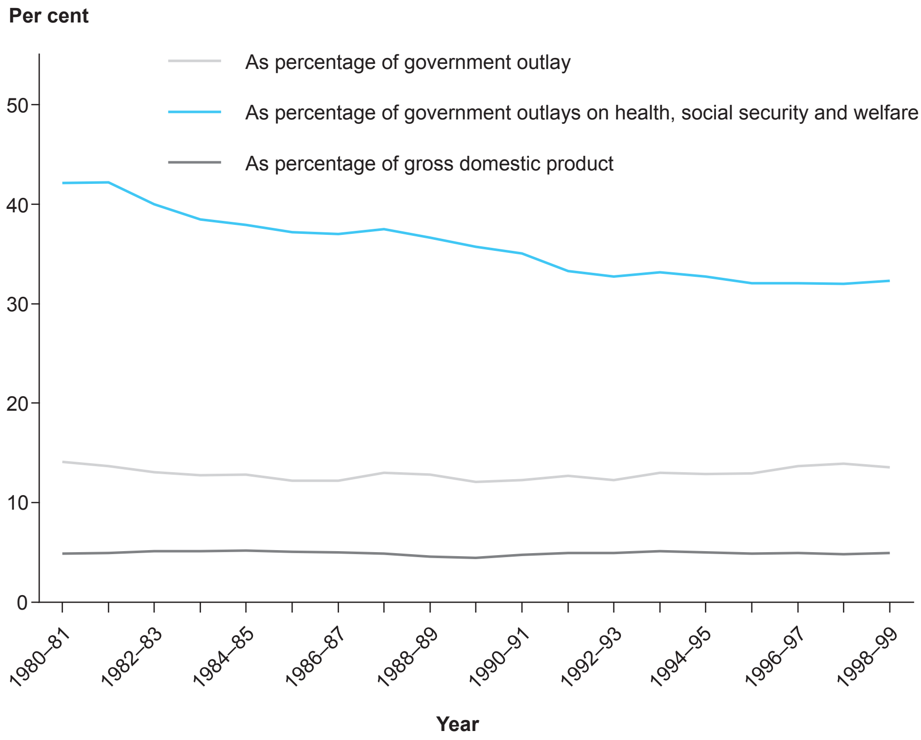
Table 6.27: Expenditure on people aged 65 and over, by service type, 1998–99

Service type	$million	Average annual growth 1989–90 to 1998–99
Age Pension[(a)]	16,611	2.7
Public hospitals	5,228	4.9
Medical services	1,874	7.5
Pharmaceutical services	959	8.6
Residential aged care	3,423	5.6
Home-based care[(b)]	905	8.6

(a) Includes Age Pension, Veteran's Pension, Widow's Pension and Wife's Pension.

(b) Includes community aged care packages, Commonwealth-funded respite services, the Aged Care Assessment Program, HACC and Cover Allowance.

Source: Updated from AIHW: Choi 1998.



Source: Table A6.8.

Figure 6.6: Aged care expenditure, 1980–81 to 1998–99

As a proportion of GDP, government expenditure on older Australians remained relatively unchanged over the 18 years from 1980—81 to 1998—99 (at around 4.9%). As a proportion of total government outlays, expenditure has remained relatively stable, moving from 14.1% in 1980—81 to 13.5% in 1998—99. As a proportion of government outlays on health, welfare and social security, expenditure on older Australians declined from 42.2% in 1980—81 to 32.1% in 1995—96, and since then has largely stabilised (see Figure 6.6).

6.4 Outcomes

Deriving outcome measures for aged care services and indeed for all chronic care services remains a problematic task. Outcome measurement lends itself more readily to the acute care context, where desired outcomes can be more clearly specified and appropriate measures agreed, and to areas such as education, where there can be a reasonable level of agreement on literacy and numeracy standards and the levels to be achieved at various points in the education system. Aged care with its varied client mix, combining a range of chronic and acute conditions, receiving varied services from the formal sector and supported by a myriad of informal sector activities does not readily lend itself to clearly specified outcome measures (Gibson 1998:ch. 8). In a care context where successful management may still result in death or a deterioration in health status, such measures are problematic. These caveats aside, it is still possible to report on measures relevant to program achievements. This section presents data on the appropriateness, accessibility and quality of aged care services.

Accessibility

The measure of accessibility used in this chapter has previously related admissions to the population with a severe or profound core activity restriction (AIHW 1999a). Given that this would allow only a 2-year time series, however, in this edition the number of residents at a point in time has been substituted as a numerator, thus allowing a longer time series to be presented. This measure should be a reasonable indicator of accessibility, given that there is no evidence of a significant change in turnover.

Section 6.3 presents data on changes in the number of permanent and respite admissions to aged care homes in the last 2 years and on changes in turnover. The restructuring of residential care into a single residential care system in late 1997 precludes comparison with data prior to 1998—99, as admissions and separations prior to that point included movements between hostels and nursing homes, movements which are not recorded. There was a very small trend towards reduced turnover for permanent care prior to the structural reforms (AIHW 1999a), while in the 2 years of data since the reforms turnover has been stable.

In 1994, there were 56 people aged 65 and over living in aged care homes for every 1,000 people aged 65 and over in Australia (Table 6.28). In 1997, that figure was still 56, but by 2000 it had dropped to 54. The change was most evident in the 85 and over age group, dropping from 307 persons per 1,000 people aged 85 and over in 1994 to 256 in 2000. There was virtually no change in the usage rate for those aged 65—74, with a shift from 12 per 1,000 to 11 per 1,000. The change in rate of use was also somewhat more pronounced among women than men. These figures inevitably show that access to aged care homes in Australia has reduced in this period. However, it is important to recognise that this shift is consistent with government policy, which has for a number of years focused on expanding the range of community-based services, and increasing the proportion of frail and disabled older people who are able to remain in their own homes. In this context, declining accessibility to aged care homes is not necessarily negative, if it indicates an expression of the preference among older people to remain in the community with appropriate levels of assistance. Such data are best interpreted in conjunction with survey information on unmet demand for residential care, or data on waiting times for those people actively seeking admission to an aged care home.[25] Unfortunately, such data are not available.

Table 6.28: Age- and sex-specific usage rates for residents of aged care homes, 30 June 1994, 1997 and 2000

	Per 1,000 persons											
	Female				Male				Persons			
	65–74	**75–84**	**85+**	**65+**	**65–74**	**75–84**	**85+**	**65+**	**65–74**	**75–84**	**85+**	**65+**
1994	12.5	85.1	351.1	72.7	11.0	50.0	200.9	33.3	11.8	71.1	306.9	55.6
1997	12.2	80.1	331.1	73.2	10.8	46.3	183.9	32.9	11.5	66.4	286.9	55.6
2000	11.6	70.8	299.0	70.5	10.6	41.6	161.6	32.0	11.1	58.7	256.3	53.6

Source: ABS 2000a; AIHW 2001b; DHSH 1995.

Geographic distribution of services

Figure 6.7 provides a summary illustration of the supply of HACC services, community aged care packages and residential aged care per 1,000 people aged 70 and over by geographic region. The vertical axis represents the supply of residential places plus care packages, while the horizontal axis represents HACC service hours per month. The dotted lines indicate the national average for both service types.

If residential aged care places are considered separately (Table A6.10), it is clear that some regions have a level of supply well below the national average (84.5). The remote regions of New South Wales, and the rural regions of Western Australia and of South Australia, were all more than 10 places per 1,000 people aged 70 and over below the national average. The other metropolitan and the rural regions of New South Wales, Melbourne, remote Victoria and remote Tasmania were all five or more places below the national average. However, most of these regions have supplies of home-based care services (through the Community Aged Care Packages and HACC programs) which are above the national average. Overall, a recent AIHW analysis of this issue concluded that there was a reasonable level of equity in the overall supply of aged care services across States and Territories and regions (AIHW: Gibson et al. 2000).

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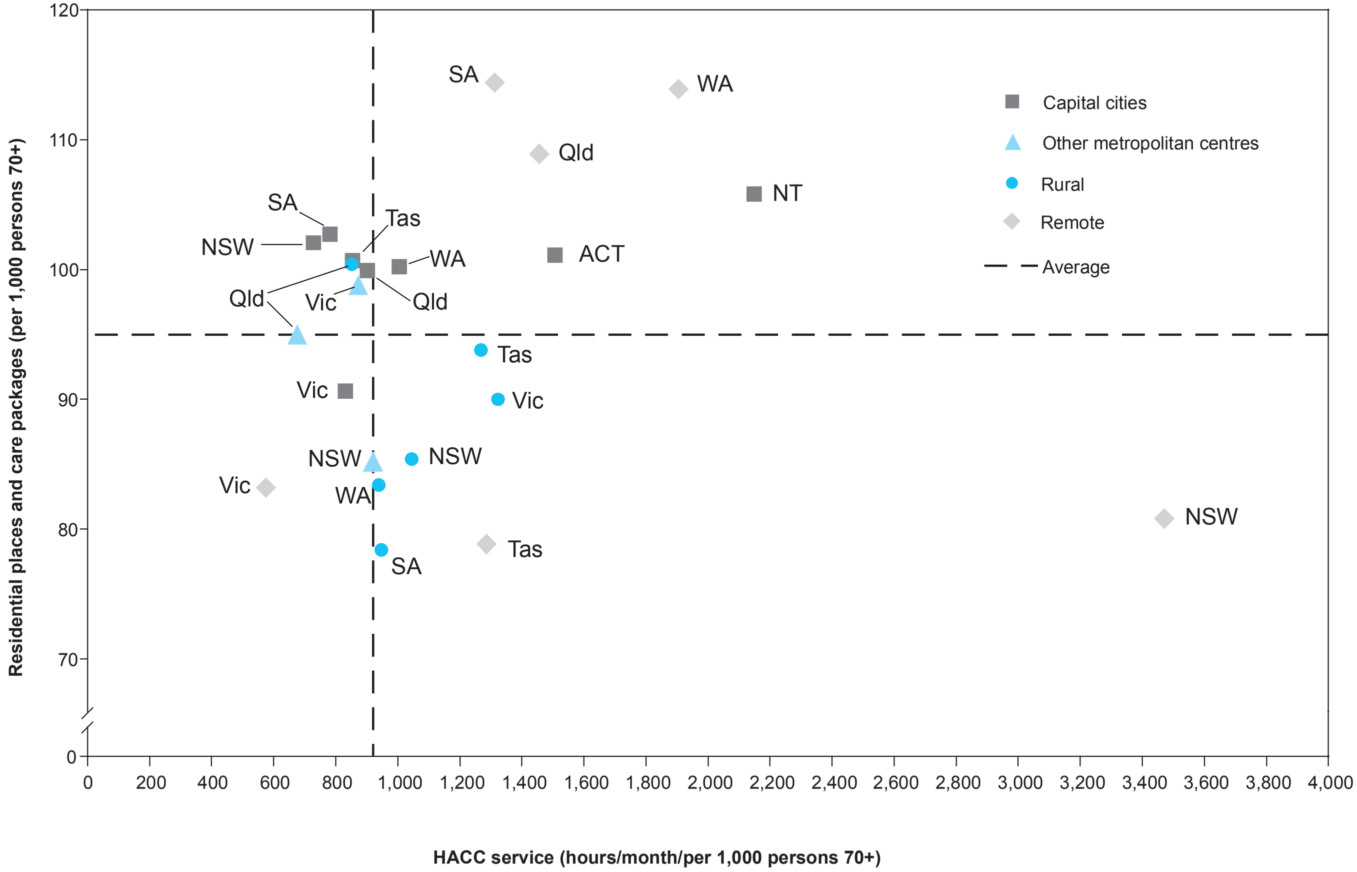
[25] There are presently no data available on length of time from the date of decision to enter an aged care home to date of admission. DHAC and the Productivity Commission publish data on elapsed time between an aged care assessment team recommendation for admission to an aged care home, and actual admission to a home. However, such data include people who elect not to enter the home at that time, or who delay entry for personal reasons unrelated to the availability of care. This substantially reduces the usefulness of such a measure as an indication of the unmet demand for residential care.



Note: The remote regions of the Northern Territory are not shown on the graph.

Source: Tables A6.9, A6.12.

Figure 6.7: Locality of service provision (combined places and packages), 2000

Figure 6.7 shows that this continues to be the case, with most regions in most States and Territories clustered around the national average. Those regions which were somewhat more widely dispersed were either high on both dimensions (i.e. in the right upper quadrant), as was the case with remote Queensland, or below average on one dimension with a compensating higher supply on the other, such as Sydney or remote Tasmania. The lower left quadrant represents those regions which have a lower than average supply on both dimensions. Only remote Victoria and Melbourne fell into this quadrant, with Melbourne being relatively close to the national average on both dimensions.

Some areas fell below the average level of supply on one dimension, without a compensating above-average level of supply on the other dimension. The other metropolitan areas of New South Wales, and the rural areas of South Australia and Western Australia, had a below-average supply of places and packages, with a roughly average level of HACC services. Rural Queensland had a lower than average supply of HACC services, combined with an average supply of places and packages. More detailed tables on levels of services available in each region of each State and Territory are included in the Appendix (Tables A6.9, A6.10, A6.11).

Standards and quality of care

Recent years have seen significant developments with regard to quality appraisal in both residential care and HACC services. The accreditation process for residential aged care homes is now well established, and national data are now available. For the HACC program, although implementation is well under way in most States and Territories, no national data are available. The data presented in this section thus focus on residential care.

The *Aged Care Act 1997* sets out a process of accreditation which residential aged care homes must undergo successfully in order to continue to receive Commonwealth government funding as approved providers of residential aged care services. The Aged Care Standards and Accreditation Agency (the Agency) is the body authorised to conduct accreditation against the Accreditation Standards (the four standards are discussed below, and the 44 associated outcomes are included in Table A6.13).

The Agency has four legislated roles: to manage the residential aged care accreditation process; to promote high-quality care and assist the industry to improve service quality by identifying best practice and providing information, education and training; to assess and strategically manage services working towards accreditation; and to liaise with the Commonwealth regarding services not meeting the relevant standards.

The Agency was established as an independent, but wholly owned, Commonwealth entity. The Board of the Agency first met in November 1997. The Accreditation Grant Principles were gazetted in September 1999 and the Agency commenced accreditation audits shortly after. By 1 January 2001, all residential aged care homes in Australia had received an accreditation decision from the Agency (the results are presented in Table 6.29).

Table 6.29: Performance against aged care accreditation standards to 31 December 2000

	Assessor ratings								
	Commendable		Satisfactory		Unacceptable		Critical		Total
Standard	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**
1 Management systems, staffing and organisational development	277	9.4	2,576	87.7	54	1.8	29	1.0	2,936
2 Health and personal care	274	9.3	2,519	85.8	124	4.2	19	0.6	2,936
3 Residents' lifestyle	293	10.0	2,593	88.3	41	1.4	9	0.3	2,936
4 Physical environment and safe systems	240	8.2	2,568	87.5	78	2.7	50	1.7	2,936

Note: These data do not include commencing services. A site audit is not undertaken for commencing services. Table A6.13 lists the expected outcomes for each standard.

Source: Aged Care Standards and Accreditation Agency.

The accreditation process involves the following steps:

- Self-assessment against 44 outcomes of the Accreditation Standards
- Application for accreditation
- Desk audit by a team of registered Quality Assessors
- Site visit by the team of registered Quality Assessors
- A site audit report to the Agency by the team of registered Quality Assessors
- An accreditation decision by the Agency
- Publication of the site audit report

In its report to the Agency, the team of Quality Assessors appraises each of the 44 outcomes against one of four ratings. These are commendable, satisfactory, unacceptable and critical. A rating is also given to each of the four standards. The residential aged care service has an opportunity to rectify deficiencies before an accreditation decision is made.

The Agency is required under the Accreditation Grant Principles to make its accreditation decision based on the following information: the desk audit report, the site audit report, information (if any) received from the Secretary about matters that must be considered under Division 38 of the *Aged Care Act 1997*, for the certification of the service, other information (if any) received from the Secretary, information (if any) received from the applicant in response to the report of the site audit, and whether it is satisfied that the residential care service will undertake continuous improvement, measured against the Accreditation Standards. On the basis of this information, the Agency awards a period of accreditation or can make a decision not to accredit.

The results of the accreditation process are reported in Table 6.29. Around one in 10 aged care homes received a rating of commendable on each of the four aged care standards. A rating of commendable means that the service has demonstrated a high level of achievement, innovation and creativity in its quality system, that its policies and procedures are well documented and regularly reviewed, that it achieves consistent results, and that there is evidence of continuous improvement. The vast majority of homes (86—88%) received a rating of satisfactory on each of the four standards. A satisfactory rating indicates that the service generally achieves the requirements of the standards but with some minor discrepancies which can be rectified within an agreed time.

A minority of homes were rated either unacceptable or critical against the standards. An unacceptable rating means that major deficiencies have been identified which will require considerable time to remedy. A critical rating means that a major health or safety risk or major concern about residents wellbeing has been identified and immediate corrective action is required.

Standard 1 is entitled Management Systems, Staffing and Organisational Development. The principle associated with this standard is: Within the philosophy and level of care offered in the residential care service, management systems are responsive to the needs of residents, their representatives, staff and stakeholders, and the changing environment in which the service operates. Two per cent of homes were rated unacceptable against this standard, and 1% critical.

Standard 2, Health and Personal Care, asserts that Residents physical and mental health will be promoted and achieved at the optimum level in partnership between each resident (or his or her representative) and the health care team. This was the standard with the highest proportion of unacceptable ratings, at 4%, with a further 1% rated as critical.

The principle associated with Standard 3, Resident Lifestyle, is Residents retain their personal, civic, legal, and consumer rights, and are assisted to achieve active control of their own lives within the residential care service and in the community. Only 1% of homes were rated as unacceptable against this standard, and well under 1% as critical.

Standard 4 is entitled Physical Environment and Safe Systems. Its principle is Residents live in a safe and comfortable environment that ensures the quality of life and welfare of residents, staff and visitors. Three per cent of homes were rated unacceptable against this standard, and 2% as critical.

Of the 2,936 aged care homes which had undergone a full assessment process as at 1 January 2001, only one had its approval as an aged care provider withdrawn. Twenty homes were allowed to continue to operate under an exceptional circumstances determination, which means that the home was given a further 6 months to meet its accreditation requirement, while continuing to receive a government subsidy. As at 3 May 2001, 11 homes had sanctions in place. The most commonly imposed sanction was the requirement that an advisor or administrator be appointed to the home, followed by a loss of Commonwealth government funding for new residents for a certain period. Another sanction imposed was that no further allocation of places was to be allowed for a period of either 6 or 12 months. Only one aged care home had places revoked.

6.5 Summary

Increases in demand

In June 2000, there were 2.4 million people aged 65 and over in Australia, representing some 12.3% of the total population. The figure was 2 million in 1991, and it is projected to reach 3 million by the year 2011 and 5.4 million by 2031. Quite a small proportion of these people, however, are in need of or will be in need of aged care services. Of people aged 65 and over in 2000, for example, 55% were aged 65—74 and only 9.4% in this age group required assistance with basic activities of daily living (self-care, mobility and communication).

The number of people aged 65 and over who require at least some assistance with the basic activities of daily living is increasing, however, from just over a third of a million in 1991 to a projected half a million by 2001, and just over two-thirds of a million by 2011. The proportion of this group who are aged 85 and over is also increasing: from 26% in 1991 to 32% in 2001, and a projected 37% in 2011.

Trends such as these raise the question as to whether the increasing longevity which has characterised the last quarter century has brought with it an increased level of disability. Are older people living longer, but in a condition of greater disability? Or is disability among the older population falling due to improved medical and technological interventions, and improved lifestyle choices concerning health-related behaviour? The evidence on this question remains mixed, with some international commentators arguing strongly that disability is falling at older ages, and others reporting some evidence of increases within particular age and sex groups. A recent ABS analysis suggests that there may have been a modest increase in severe disability levels among men aged 75—79 and 85 and older, although the methodological issues are far from straightforward.

The continuing role of informal care

With the continued emphasis on maintaining older people at home, the important role played by informal carers seems set to continue into the future. In 1998, there were 125,345 primary carers providing help to persons aged 65 and over. Two-thirds were women, and the most carers of older people were themselves over 65.

The changing system of residential care

The new system of residential care introduced in 1997 is now well established. The bringing together of nursing homes and hostels into a single residential aged care system, the introduction of a new single instrument for the classification of residents according to their care needs, the extended use of accommodation bonds and charges, and the introduction of means-tested fees all combine to produce a system that is very different from that which operated prior to 1997. The new quality appraisal system for the accreditation of residential aged care facilities has now completed a full annual cycle of aged care home inspections, with only one home having its approval as a provider withdrawn, and another 20 operating under an exceptional circumstances determination , which means that the homes were given a further 6 months to meet accreditation requirements, while continuing to receive a government subsidy.

The number of residential care places continues to increase: up from 137,653 in 1996 to 139,917 in 1998, and to 141,162 in 2000. The ratio of residential care places to people aged 70 and over has decreased: from 91 places per 1,000 people aged 70 and over in 1996 to 82 places in 2001. This trend has been counterbalanced by the increasing availability of community aged care packages the combined residential care and care package ratio has been relatively stable for much of the period, at 93—94 places and packages per 1,000 people aged 70 and over, rising most recently to 96.5 places in 2001.

Increasing dependency levels in residential care

Available data support the view that dependency levels in aged care homes increased during the 1990s. Prior to the amalgamation of the residential aged care system in 1997, dependency levels had been increasing in both nursing homes and hostels. Between 1998 and 2000, the proportion of residents classified as high care (RCS 1 to 4) increased. Individual data items drawn from the dependency classification scales in use over the past 7 years show a substantial increase in frailty levels; in 2000, 93% of residents required at least some assistance with washing and dressing, 76% with eating and drinking, and 55% with regard to verbally disruptive or physically aggressive behaviour.

Home-based care

Home-based care services continue to expand, although the expansion of services provided under the HACC program evident in the mid-1990s has slowed in more recent years. Community aged care packages, a coordinated and intensive form of home-based care, have expanded quite dramatically in the last 3 years, virtually tripling from 6,124 places in 1997 to 18,149 places in 2000. In relation to the size of the aged population, this represents a large increase in supply: from 4 places per 1,000 people aged 70 and over in 1997 to 11 places in 2000. Despite this expansion, HACC remains by far the major supplier of home-based care services for older Australians.

Trends in expenditure on older Australians

Total expenditure on aged care homes, HACC, assessment, community aged care packages, multi-purpose services, Carer Allowance, and accreditation was $4,839.9 million in 1999—00, an increase of 43% in real terms over the past 4 years. The proportions allocated to each area of expenditure (i.e. assessment, community care, residential care) remained relatively stable. The increase in expenditure on aged care services overall has kept pace with the growth in the number of older people needing some assistance; indeed, expenditure per person aged 65 and over with a severe or profound restriction increased during the last 4 years in real terms.

A more broadly based picture of expenditure on older Australians taking into account income support, residential care, home-based care, and medical, hospital and pharmaceutical services shows a total outlay on people aged 65 and over in 1998—99 of $29,203 million. In the two decades since 1980—81, total government expenditure on older people has remained stable as a percentage of GDP, declined marginally as a percentage of total government outlays, and declined more markedly as a percentage of government outlays on health, welfare and social security.

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7 Disability services

7.1 Introduction

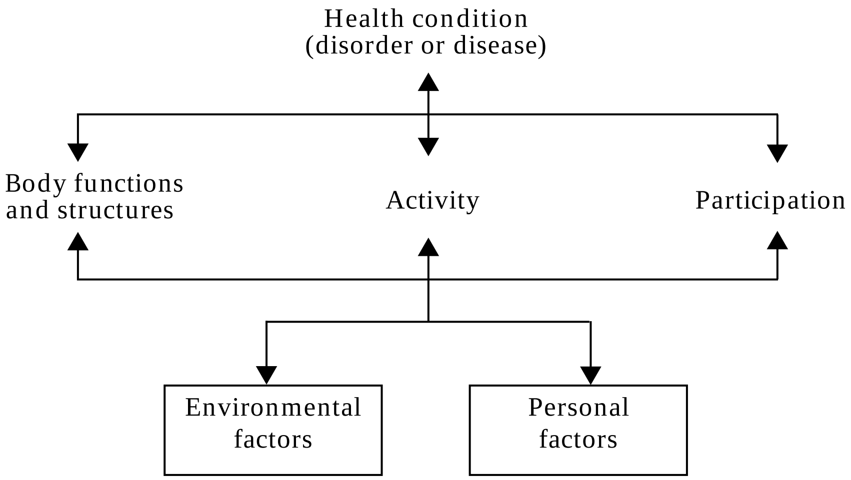
This chapter presents a national picture of disability services in Australia.

Disability is conceptualised as multidimensional, relating to the body functions and structures of people, the activities they do, the life areas in which they participate, and factors in their environment which affect these experiences (see Figure 7.1, Box 7.1).

Services of relevance to people with a disability may seek to ameliorate disadvantage associated with any of these components of disability, including the environmental factors. This chapter focuses chiefly on people aged under 65 years, and on services and assistance directed primarily towards their activities and participation in various areas of life:

- formal services and assistance, such as income support, specialist disability services, and relevant generic services;
- equipment or environmental modifications;
- informal support from family and friends.

In this fifth biennial report it is possible to examine trends over recent years, and this is done in each of the three following sections on population data, service data and outcome data. Section 7.2 provides data on the Australian population with a disability and describes their needs for services and assistance. Section 7.3 provides data on services and assistance and outlines recent developments in the field, including data



Source: WHO 2001.

Figure 7.1: Interactions between components of the ICF

developments. Section 7.4 discusses outcomes for people with a disability and presents some data on participation, and Section 7.5 concludes the chapter.

Box 7.1: The new ICF—a conceptual framework for functioning and disability

In May 2001 the new International Classification of Functioning, Disability and Health (ICF) was endorsed by the World Health Assembly (WHO 2001). This marked the finalisation of a revision of the ICIDH (WHO 1980), a process involving several years of redevelopment and testing by WHO and its Collaborating Centres including the AIHW. The ICF is a core member of the WHO family of health-related classifications, complementary to the other core member, the ICD, which focuses on diseases and health conditions.

The ICF is organised in two parts. The first part recognises two main components of functioning and disability:

- *a body component comprising classifications of Body Function and Body Structure; and*
- *an Activities and Participation component providing a complete set of domains for aspects of functioning from both an individual and a societal perspective.*

A person's functioning and disability is conceived as a dynamic interaction between health conditions and environmental and personal factors (WHO 2001:6). Environmental factors are presented in the second part of the classification and represent an important new component. The interactions between the components of functioning, disability and health can be represented visually (Figure 7.1).

Disability is the umbrella term for any or all of: an impairment of body structure or function, a limitation in activities, or a restriction in participation. The key components of disability are defined as follows:

- ***Body functions** are the physiological functions of body systems (including psychological functions).*
- ***Body structures** are anatomical parts of the body such as organs, limbs and their components.*
- ***Impairments** are problems in body function and structure, such as significant deviation or loss.*
- ***Activity** is the execution of a task or action by an individual.*
- ***Participation** is involvement in a life situation.*
- ***Activity limitations** are difficulties an individual may have in executing activities.*
- ***Participation restrictions** are problems an individual may experience in involvement in life situations.*
- ***Environmental factors** make up the physical, social and attitudinal environment in which people live and conduct their lives. These are recorded as either facilitators or barriers (both on a 5-point scale) to indicate the effect they have on the person's functioning.*

7.2 Prevalence of disability and need for assistance

This section presents an overview of the patterns of prevalence of disability and need for assistance in the Australian population. The impact of population ageing on disability prevalence is analysed, and other factors affecting recent changes in prevalence are reviewed.

Disability in the Australian population

The most recent national population survey of disability is the Australian Bureau of Statistics (ABS) 1998 Survey of Disability, Ageing and Carers. Previous surveys were conducted in 1981, 1988 and 1993. The 1998 survey reported a great increase in the proportion of people with a disability between 1993 and 1998, largely due to changes in survey design and methods (see pages 267—269).

Table 7.1: People with a disability, by disability status and severity of core activity restriction, as a proportion of the State/Territory or Australian population of that age, 1998 (per cent)

	Severity of core activity restriction				Schooling or employment restriction only	Total with specific restrictions	Total with specific restrictions adjusted	Total with a disability	Total with a disability adjusted	Population ('000)
	Profound	Severe	Moderate	Mild						
0–64 years										
NSW	1.3	2.5	2.5	4.1	1.8	12.2	12.2	14.3	14.2	5,520.7
Vic	1.2	2.4	2.3	3.8	1.8	11.4	11.4	13.2	13.1	4,058.7
Qld	1.6	3.1	2.8	3.3	2.3	13.1	13.3	15.3	15.5	3,061.7
WA	1.2	2.6	3.2	3.9	2.0	12.8	13.0	15.3	15.5	1,629.7
SA	1.6	2.7	3.3	4.7	2.9	15.1	14.8	17.2	16.8	1,273.5
Tas	*1.3	4.1	2.9	3.9	2.2	14.3	14.1	17.0	16.8	409.4
ACT	*1.0	*2.7	*2.3	*3.0	*2.0	10.9	11.4	13.7	14.2	285.6
NT	**1.0	*2.4	*2.4	*2.8	**1.2	9.8	9.0	11.8	10.9	150.1
Australia	1.3	2.7	2.6	3.9	2.0	12.5	. .	14.6	. .	**16,389.4**
Australia ('000)	**218.1**	**436.6**	**433.8**	**632.2**	**327.9**	**2,048.7**	**. .**	**2,385.1**	**. .**	**. .**
All ages										
NSW	2.9	3.1	3.5	5.8	1.6	16.9	16.7	19.3	19.1	6,325.8
Vic	2.8	3.0	3.2	5.3	1.5	15.9	15.7	18.0	17.8	4,644.9
Qld	2.9	3.7	3.7	4.9	2.1	17.3	17.8	19.9	20.5	3,449.2
WA	2.6	3.0	4.0	5.4	1.8	16.8	17.6	19.5	20.4	1,820.4
SA	3.3	3.0	4.2	6.9	2.5	19.9	18.8	22.4	21.2	1,484.7
Tas	3.1	4.5	3.8	5.9	1.9	19.2	18.7	22.3	21.7	471.3
ACT	*2.3	3.1	*2.7	4.2	*1.9	14.2	16.3	17.2	19.5	309.1
NT	**1.2	*2.9	*2.3	*3.6	**1.1	11.2	12.7	13.3	14.8	155.0
Australia	2.9	3.2	3.5	5.5	1.8	16.9	. .	19.3	. .	**18,660.6**
Australia ('000)	**537.7**	**598.2**	**660.3**	**1,031.8**	**327.9**	**3,155.9**	**. .**	**3,610.3**	**. .**	**. .**

Notes

1. Estimates marked ** are subject to sampling variability too high for most practical purposes. Estimates marked * have an associated relative sampling error of between 25% and 50%. These estimates should be interpreted accordingly.
2. Core activities comprise communication, mobility and self-care.
3. Adjusted percentages were calculated using the age- and sex-specific rates for the Australian estimated resident population for March 1998.

Source: ABS 1998 Survey of Disability, Ageing and Carers, unpublished data tables.

In the 1998 survey, 3,610,300 people reported one or more of 17 limitations, restrictions or impairments (Box A7.1) which had lasted, or were likely to last, for at least 6 months and which restricted everyday activities.[1] Of these, 2,385,100 were aged under 65, of whom 1,283,600 (53.8%) were male and 1,101,500 (46.2%) were female (Tables 7.1, A7.1).

The survey also collected information about specific activity restrictions, of which there are five categories: restrictions in the three core activities of daily living (self-care, mobility and communication), and restrictions in schooling and employment (Box 7.2).

Box 7.2: ABS 1998 Survey of Disability, Ageing and Carers: restrictions and their severity

Specific restrictions are

- *core activity restrictions; and/or*
- *schooling or employment restrictions.*

Core activities are

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

A core activity restriction may be

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

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

Source: ABS 1999.

In 1998, of those with a disability, 2,048,700 people aged under 65 had at least one specific activity restriction: 12.5% of the population in that age group. Of these people, 655,000 or 4.0% of the population aged under 65, reported a severe or profound restriction, which means that they sometimes or always needed personal assistance or supervision with the activities of daily living.

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[1] The 1998 ABS disability survey equates this to 'disability' (ABS 1999).

States with higher proportions of older people, such as South Australia and Tasmania (ABS 1998a), tended to have higher rates of disability and specific restrictions than the national average. The Australian Capital Territory and the Northern Territory have a younger population age structure and correspondingly relatively low disability prevalence rates. When age-adjusted rates are compared, rates in the Australian Capital Territory are close to the national average, although the Northern Territory rates are still lower than the national average (Tables 7.1, A7.2).

Table 7.2: People with a severe or profound core activity restriction living in households, by activity type in which assistance needed and age group, 1998

	Age group (years)							
	0–14	**15–19**	**20–29**	**30–44**	**45–64**	**Total<65**	**65+**	**All ages**
				Number ('000)				
Self-care	85.2	9.7	22.6	82.5	161.2	361.2	155.2	516.4
Mobility	72.9	22.7	39.7	105.3	210.3	451.0	273.6	724.6
Communication	90.9	12.7	10.3	15.4	*9.0	138.3	28.6	166.9
Health care	72.7	14.0	20.6	68.8	145.8	321.9	216.4	538.3
Housework	. .	11.4	19.8	76.6	144.8	252.6	226.2	478.8
Property maintenance	. .	11.2	19.6	87.4	192.3	310.6	250.2	560.7
Paperwork	. .	17.7	19.4	40.6	52.3	129.9	110.3	240.3
Meal preparation	. .	*8.0	14.4	38.9	60.2	121.6	120.2	241.8
Transport	32.4	16.1	22.9	80.9	141.3	293.6	232.2	525.8
Guidance	102.8	21.8	28.8	59.6	87.7	300.7	69.6	370.4
Total needing assistance	*142.4*	*30.7*	*48.8*	*135.5*	*276.0*	*633.4*	*324.6*	*958.0*
Total severe or profound	**143.6**	**30.7**	**49.4**	**136.2**	**276.0**	**636.0**	**325.6**	**961.6**
				Per cent				
Self-care	2.2	0.7	0.8	1.9	4.0	2.2	6.8	2.8
Mobility	1.9	1.7	1.4	2.5	5.2	2.8	12.1	3.9
Communication	2.3	1.0	0.4	0.4	*0.2	0.8	1.3	0.9
Health care	1.9	1.1	0.7	1.6	3.6	2.0	9.5	2.9
Housework	. .	0.9	0.7	1.8	3.6	1.5	10.0	2.6
Property maintenance	. .	0.9	0.7	2.0	4.8	1.9	11.0	3.0
Paperwork	. .	1.3	0.7	0.9	1.3	0.8	4.9	1.3
Meal preparation	. .	*0.6	0.5	0.9	1.5	0.7	5.3	1.3
Transport	0.8	1.2	0.8	1.9	3.5	1.8	10.2	2.8
Guidance	2.6	1.7	1.0	1.4	2.2	1.8	3.1	2.0
Total needing assistance	*3.6*	*2.3*	*1.7*	*3.2*	*6.8*	*3.9*	*14.3*	*5.1*
Total population ('000)	**3,905.6**	**1,316.1**	**2,827.9**	**4,292.8**	**4,048.7**	**16,391.1**	**2,268.6**	**18,659.7**

Notes

1. Estimates marked * have an associated relative standard error of between 25% and 50% and should be interpreted accordingly.
2. The total number of people needing assistance is less than the sum of activity types since people may need help with more than one activity.
3. Percentages are based on the Australian population for each age group.

Source: AIHW 2000b; AIHW analysis of ABS 1998 Survey of Disability, Ageing and Carers confidentialised unit record file.

Activities with which assistance is needed

In 1998, 958,000 people (5.1% of Australians) with a severe or profound restriction living in households reported need for assistance with at least one of 10 activities (Table 7.2). This figure included 633,400 people aged under 65 (3.9% of the population of that age) and 324,600 people aged 65 or more (14.3%). Overall, need for assistance was most commonly reported with mobility (3.9% of the total population), property maintenance (3.0%), health care (2.9%), self-care (2.8%) and transport (2.8%). The need for assistance with all activities generally increased with age after age 30.

Of all people with a severe or profound restriction living in households, 386,700 (40.2%) reported need for assistance with more than one core activity. Of these, 73,000 (7.6%) needed help with all three core activities (self-care, mobility and communication). For people aged under 65, about 264,300 (41.6%) needed assistance with more than one core activity, including 56,000 (8.8%) who needed help with all three (Table A7.3).

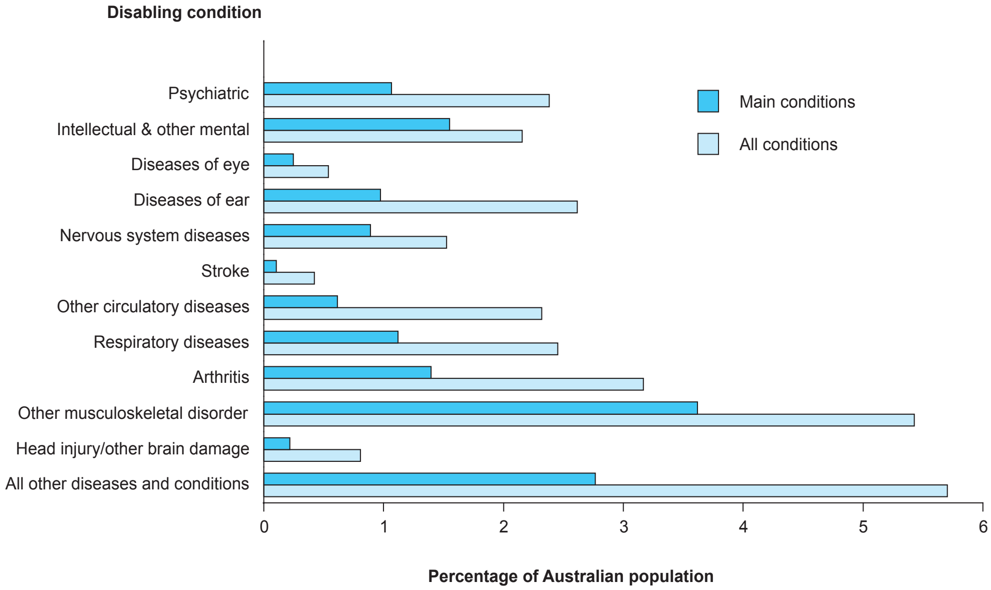
A person s main condition was defined in the 1998 disability survey as a long-term condition identified by a person as the one causing the most problems (ABS 1999:69). For people aged under 65 years in 1998 most disabilities were associated with physical main conditions: 10.7% of the population in this age group reported such main conditions. The most common were arthritis (1.4%) and other musculoskeletal disorders (3.6%). The next most frequent group was disabling conditions affecting intellectual abilities (1.6%), followed by sensory (1.2%) and psychiatric (1.1%) conditions (Table A7.4).

The prevalence of a particular condition will be underestimated if main conditions only are considered, since people with multiple conditions are counted only once, according to the main condition. Figure 7.2 compares the prevalence of various conditions, according to whether they were reported as the main condition or among a number of disabling conditions. Reported prevalence is higher when all conditions are considered, suggesting the common occurrence of multiple conditions in the population with a disability. In particular, head injury and brain damage, stroke and other circulatory diseases were frequently reported in combination with another condition.

Disability groups

Estimates of the prevalence of main disabling conditions can be obtained directly from the ABS disability surveys; however, a more widely used concept is that of disability groups. Disability groupings, such as intellectual disability and physical disability , are a broad categorisation of disabilities based not only on underlying health conditions, but also on impairment, activity limitations, participation restrictions and related environmental factors They are generally recognised in the disability field and in legislative and administrative contexts in Australia (AIHW 2000a).

The prevalence of disability groups can be estimated from the ABS disability surveys using a multidimensional approach that combines information from a number of questions, and this has been done for some significant disability groups using the 1993 survey (AIHW: Fortune & Wen 1999; AIHW: Wen 1997; AIHW: Wen & Fortune 1999). The extended range of questions in the 1998 survey provides new opportunities for refining the prevalence estimates. The AIHW plans to update and extend these estimates using the 1998 survey.



Source: Table A7.4.

Figure 7.2: Prevalence of main and all conditions in people aged under 65 with a disability, 1998

Disability, population ageing, and growth in severe restriction

Population ageing is indicated by an increase in the proportion of older people in the population. The Australian population will continue to age as the result of declining mortality rates and low levels of fertility over a long period. Population projections indicate a clear long-term trend of decline in growth rate: from 1.2% in 1996—97 to between zero and 0.3% by 2051. The median age of the Australian population is projected to increase from 34.3 years in 1997 to between 43.7 and 46.2 years in 2051. The proportion of people aged 65 years and over is projected to increase rapidly: from 12% (2.2 million) in 1997 to 26% (6.3 million) in 2051 (ABS 1998a).

The bulge of the post—World War II baby-boom generation is currently affecting the population age profile, in particular the structure of the under-65 population. From now to 2006, the 50—64 age group is projected to increase at a markedly higher rate (16.4%) than the 65-plus age group (9.5%). Between 2006 and 2011, the 60—64 age group is expected to increase at a higher rate (26.9%) than any other age group (Table 7.3). Between 1997 and 2051, the greatest growth is occurring in the 45—64 age group from 4 million to over 6 million (AIHW 2000b).

Table 7.3: Estimated and projected percentage changes in selected age groups, 1981–2051

Age (years)	1981–86	1986–91	1991–96	1996–2001	2001–06	2006–11	2011–21(c)	2021–31(c)	2031–41(c)	2041–51(c)
45–49	14.5	22.2	(a)25.7	5.1	8.4	0.9	1.3	1.7	2.7	–2.5
50–54	(b)–4.9	14.9	19.8	(a)26.9	5.1	8.5	1.5	–2.1	6.7	–0.7
55–59	2.0	(b)–3.9	14.0	21.1	(a)26.9	5.3	9.7	1.6	2.0	3.0
60–64	17.3	2.4	(b)–3.6	13.5	21.3	(a)26.9	14.6	2.0	–1.7	7.0
65–69	6.3	17.8	3.1	(b)–2.8	14.1	21.6	34.2	10.3	2.2	2.5
70–74	17.9	7.9	18.1	3.9	(b)–1.8	14.7	(a)55.2	15.8	3.0	–0.9
75–79	24.5	18.5	10.1	20.7	5.1	(b)–1.0	41.4	36.2	11.8	3.6
80–84	20.1	24.2	22.9	12.9	22.2	6.2	16.4	(a)59.1	19.1	5.6
85+	26.0	19.3	30.9	26.7	18.0	22.0	19.7	39.0	50.3	23.3
Total 45–64	6.6	9.3	15.2	15.9	14.0	9.0	6.4	0.8	2.4	1.6
Total 50–64	3.9	4.4	10.5	21.3	16.4	12.4	8.3	0.5	2.3	3.0
Total 65+	15.6	16.0	12.9	8.3	9.5	13.1	36.2	25.6	12.8	5.8
Total 70+	21.0	15.1	18.1	13.3	7.7	9.5	37.1	32.6	16.7	6.9
Total 75+	23.5	20.3	18.1	19.6	13.2	6.9	27.4	43.5	24.0	10.3

(a) This shift mainly reflects the passage of the large cohort of the post–World War II baby-boom generation.

(b) This shift mainly reflects the passage of the people born in the low-fertility years of the 1930s.

(c) 10-year period has been applied.

Source: ABS 1998a; AIHW 2000b:8.

As a result of general population ageing, the population with a disability is also ageing. Among people aged under 65 with a severe or profound restriction, the proportion aged 45—54 increased from 17.5% in 1988 to 22.3% in 1998, reflecting the fact that the baby-boom generation is now entering age groups associated with high risk of disability (Table 7.4). During the coming decade (2001—11), the progressive upward movement of this generation in the population age pyramid is likely to continue to increase the number of people with a severe or profound restriction in the 55—64 year age group.

Table 7.4: People aged under 65 years with a severe or profound core activity restriction, by age group, 1981, 1988, 1993 and 1998 (per cent)

Age (years)	1981	1988	1993	1998
5–14	16.9	18.1	17.8	19.0
15–24	9.8	9.2	10.9	8.7
25–34	11.9	13.2	14.0	11.3
35–44	14.3	18.6	18.0	15.7
45–54	19.4	17.5	18.8	22.3
55–59	14.0	10.6	11.1	12.4
60–64	13.7	12.9	9.4	10.6
Total under 65	**100.0**	**100.0**	**100.0**	**100.0**
Total 45–64	*47.2*	*40.9*	*39.3*	*45.3*
Total under 65 ('000)	239.7	297.2	329.4	510.1

Notes

1. Disability data were re-derived using criteria common to the four surveys.
2. In the 1981, 1988 and 1993 disability surveys, severity of core activity restriction was not determined for children aged 0–4 years.

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

Ageing of people with an early onset disability

In 1998, of people with a severe or profound restriction living in households, 11.0% (30,200) of those aged 45—64 and 4.1% (13,000) of those aged 65 or over had acquired a disability before age 18 (AIHW 2000b).

Empirical evidence indicates that people with an intellectual disability resulting from certain conditions age earlier. Signs of premature ageing have consistently been reported in people with Down syndrome and intellectual disability resulting from other chromosomal causes (e.g. Janicki et al. 1985; Suttie 1995). Dementia occurs at higher rates among adults and older people with intellectual disability (not related to Down syndrome) than among the general population. Some people with an intellectual disability may acquire dementia relatively early in life, at around age 50 (Cooper 1997).

Some studies show that people with severe physical disabilities such as spinal cord injury and brain injury also show signs of ageing earlier than the general population, and that a range of health conditions worsen with increased duration of disability (Crewe 1990; Fethney 1998; Gething & Fethney 1998; Menter et al. 1993).

Growth estimates of severe or profound restriction

The projected demographic changes, in particular population ageing, indicate a significant future growth in the number of people with a severe or profound restriction (AIHW 2000b). Based on the age- and sex-specific prevalence rates of the 1998 ABS disability survey, growth estimates suggest that between 2000 and 2006 (Tables 7.5, A7.5):

- the total number of people of all ages with a severe or profound restriction will increase by 12%, from 1,189,500 to 1,327,100;
- the number of people aged 0—64 with a severe or profound restriction will increase by 9%, from 681,600 to 742,900; and
- the greatest increases will be in the age groups 45—64 (19%, or 59,500 people) and 65 and over (15%, or 76,300 people).

Table 7.5: Percentage change in the estimated number of people with a severe or profound core activity restriction, by age group, 2000–06(a)(b)

Age (years)	2000–01	2001–02	2002–03	2003–04	2004–05	2005–06	2000–06
0–14	–0.1	–0.1	–0.2	–0.4	–0.6	–0.7	–2.0
15–19	0.8	0.3	0.1	0.3	0.8	0.8	3.0
20–29	–0.9	–0.6	0.0	0.3	0.4	0.8	–0.1
30–44	1.1	0.9	0.5	0.3	0.0	–0.2	2.7
45–64	3.1	3.2	3.1	2.9	2.9	2.8	19.3
65+	2.6	2.3	2.2	2.0	2.4	2.7	15.0
Total 0–64	1.6	1.6	1.5	1.4	1.3	1.3	9.0
Total 15–64	2.0	2.0	1.9	1.9	1.8	1.8	12.0
Total	**2.0**	**1.9**	**1.8**	**1.7**	**1.8**	**1.9**	**11.6**

(a) ABS 1998 population projections (Series K) as at 30 June.

(b) Estimated numbers were calculated using age- and sex-specific prevalence rates derived from the ABS 1998 Survey of Disability, Ageing and Carers.

Source: ABS 1998a; AIHW 2000b; AIHW analysis of ABS 1998 Survey of Disability, Ageing and Carers data.

It should be noted that the growth estimates rely on two underlying assumptions: the age- and sex-specific prevalence rates of severe or profound restriction in 1998 remain constant over the projection period; and other factors affecting the prevalence of severe or profound restrictions remain unchanged in the future. Therefore, the estimates should be interpreted in the context of these assumptions.

Changes in the prevalence of disability

Impact of population changes on prevalence, 1981–98

The number of people with a severe or profound restriction in 1998 was more than twice that in 1981 (Table A7.6). Population change contributed about 45% of this increase. The remaining changes may be attributed to a combined effect of various factors, such as changes in survey design and interview methods, and in community perceptions and awareness of disability (Table A7.7; AIHW 2000b). The overall effects of population change have two major components: change in total population size, and differential growth among age groups, resulting in population ageing. Over the entire 17 years, the contributions of population ageing and increase in population size appeared to be similar (20.5% versus 24.4%). However, during the most recent 10 years (1988—98), the effect of population ageing has contributed much more than growth in population size to this increase (31.0% versus 11.7%).

Reported changes in prevalence, 1993–98

The age-standardised prevalence rates of severe or profound restriction were relatively stable during the 1980s and early 1990s, remaining at around 4% of the Australian population (AIHW 1997a; AIHW: Wen et al. 1995). However, between 1993 and 1998 the estimated rate of severe or profound restriction, as reported by the ABS, increased from 4.1% (721,000 people) to 6.1% (1,135,900 people), an increase of 2 percentage points or 414,800 people (ABS 1993, 1999). Based on the information and analyses to date, the increase does not reflect a substantial increase in the underlying prevalence of disability. Rather, it is largely due to the changes in design and methods of the 1998 survey which captured a larger number of people with a severe or profound restriction than the 1993 survey (AIHW 1999a, 2000b; ABS: Davis et al. 2001).

It has been suggested that between 1993 and 1998 over half (1.2 percentage points) of the increase in the rate was attributable to improvements in survey method. About 0.3 percentage points resulted from changes in population age structure, and the remaining 0.5 percentage points might be explained by increased awareness of a disability, increased willingness to report a disability, and/or actual increased severe or profound restrictions (ABS: Davis et al. 2001). Box 7.3 details the changes in ABS survey design and implementation methodology.

Three population groups accounted for about 80% of the reported increase in severe or profound restrictions. People aged 45—64, mostly with musculoskeletal conditions other than arthritis, accounted for almost half of the increase. Children, mostly boys, aged 5—14 with intellectual and behavioural disorders, and older people, especially men, aged 75—79 and 85+, made up a third of the increase together (ABS: Davis et al. 2001).

Box 7.3: Changes in disability survey design and implementation method

Two aspects of changes in survey method appear to have impacted significantly on the reported rates of prevalence.

First, modifications in the 1998 ABS survey screening questions (in effect, the criteria for defining disability) have resulted in an increase in the base disability population who were then asked questions to determine the severity of core activity restrictions. For instance, a new screening question about chronic pain was introduced and changes were made to the wording of other screening questions. People who had been identified by another person as having a long-term health condition but no disability (based on screening questions) were for the first time given an opportunity to answer for themselves whether they were restricted by their condition.

Second, some other developments have resulted in increased capture of severe or profound restrictions:

- *The SF-12 assessment instrument of health status was introduced and placed after the survey screening questions but before questions on core activity restriction.*(a) *Although it could not have affected the size of the disability population, it could have prompted respondents to focus on the day-to-day effect of their condition and thus answer more fully in the subsequent questions on core activity restrictions and need for assistance.*
- *The use of Computer Assisted Interviewing (CAI) allowed a smoother flow of the interview and may have encouraged more positive responses to questions about core activity restriction.*
- *The introduction of severity assessment of activity restrictions for children under age 5 has identified 28,100 children aged 0–4 with a severe or profound restriction.*
- *Additional information was collected to distinguish severe from moderate restriction in cared accommodation,*(b) *resulting in an increase in the number of people with a severe restriction in cared accommodation.*

(a) The SF-12 is a commonly used international instrument consisting of 12 questions that provide a generic measure of health status (Ware et al. 1996).

(b) The cared accommodation component of the survey includes hospitals, aged care homes and cared components of retirement villages, and other ‘homes’, such as children’s homes. Smaller disability group homes (with fewer than six people) were not included in the cared accommodation component (ABS 1999).

Source: AIHW 1999a; ABS: Davis et al. 2001.

The factors affecting the reported increase vary for each of the population groups. Increased capture had the greatest impact on the 45—64 age group, resulting in up to 75% of the increase in this group. The new screening question about chronic pain contributed substantially to the increase in reported musculoskeletal disorders other than arthritis (mainly back pain), which was accompanied by an increase in the number of people reporting need for assistance.

For children aged 0—14, especially boys, the change of wording from slow at learning or understanding to difficulty learning or understanding has encouraged more reporting of intellectual, developmental and behavioural disorders. Increase in diagnosis and public awareness of these conditions, in particular Attention Deficit Hyperactivity Disorder (ADHD), may also have contributed to the increase. The number of people with ADHD in 1998 (10,700) was greater than the total number of people reporting mental disorder in 1993.[2]

Among the population aged 65 or more, changes in survey methods mostly affected the 75—79 age group. Most of the increase in this group was made up of people with circulatory conditions. The modification of the screening question on learning and understanding appears to have improved the capture of people with dementia. The specific question about stroke may also have led to increased reporting of these conditions.

The next ABS Survey of Disability, Ageing and Carers (2003) will focus on maintaining comparability of survey methods and data over time, allowing actual changes in prevalence of disability and severe or profound restriction to be more easily measured.

Trends in mortality and morbidity

Changes in mortality and morbidity can influence the prevalence of disability. In Australia, mortality due to a number of significant external causes, such as transport and road injuries, has decreased in recent years (AIHW: Bordeaux & Harrison 1996; AIHW: Bordeaux 1999; AIHW: Delooper & Bhatia 2001). The age-standardised death rate due to all causes of injury fell from 48.9 deaths per 100,000 population in 1989 to 42.7 in 1999. The death rate for road vehicle accidents over the same period has fallen from 17.0 deaths per 100,000 population in 1989 to 9.7 in 1999. The Australian Spinal Cord Injury Register data show that the age-adjusted incidence rate of spinal cord injury was 1.45 per 100,000 in 1998—99, a small decrease from 1.52 per 100,000 in 1997—98 (AIHW: O Connor 2000).

The incidence and prevalence of congenital malformations may also indicate the possibility of early onset of disability. The reported overall incidence of congenital malformations was higher in the late 1980s and the 1990s than in the early 1980s, though the trend varied for different malformations (AIHW: Hurst et al. 1999; AIHW: Lancaster & Pedisich 1995; AIHW: Lancaster et al. 1997).

Perinatal deaths due to congenital malformations declined from 35.9 per 10,000 births in 1973 to 15.6 in 1996. Infant deaths due to congenital malformations also declined from 28.8 per 10,000 live births in 1980 to 14.8 in 1996.

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[2] It is not possible to identify those with ADHD in the 1993 disability survey as it was not separately classified (ABS: Davis et al. 2001). For further discussion of ADHD, see also Section 7.3 (new developments) concerning the new ICF and the role of environmental factors in disability creation.

The incidence rate for Down syndrome in births was 12.4 per 10,000 births during the period 1981 to 1997. Incidence of spina bifida in Australia declined gradually from 7.1 per 10,000 births in 1987 to 3.4 in 1997 (AIHW: Hurst et al. 1999; Hurst et al. 2001).

7.3 Services and assistance

This section provides data on services and assistance to people with a disability. Formal services include:

- income support, particularly disability-specific income support;
- specialist disability support services; and
- relevant generic services, particularly those that target people with a disability specifically.

Data about informal care and assistance are also presented. First, recent developments in disability services are briefly outlined.

Recent developments

The disability field remains one of active debate and policy development. Nationally, expenditure on services continues to grow (see Figure 2.5) in response to population growth and ageing as well as recognition of unmet need in the population.

Commonwealth developments in income support

Developments in the disability services arena are taking place at the time of a wider debate about the purpose and role of welfare services and assistance in Australia.

The Commonwealth Government is playing a leading role in the discussion of income support and its relationship to the idea of mutual obligation : the obligation of individual people, including people with disability, to seek to participate in and contribute to society, and the obligation of government and the wider community to assist them to do so (Reference Group on Welfare Reform 2000 the McClure report; Newman 2000b; see also Chapter 1). This discussion encompasses the role of government, the role of the non-government sector (both not-for-profit and for-profit), the role of families and individuals, and the social structures in which rights and obligations are negotiated. The McClure report recommends a central gateway and assessment approach , designed to enable people to find their way to the right type and level of assistance to meet their needs, for instance financial support with or without general labour market support or specialist disability support services.

Some critics fear that these developments are driven by a desire to control rising public expenditure on income support, and that they reflect diminished social acceptance of the moral duty to protect the vulnerable (Goodin 2000). Accordingly, it will be important to ensure that mutual obligation in operation is capability building rather than merely controlling or even disabling (Yeatman 2000). Non-government service providers, like service recipients, may have little bargaining power in negotiations with government; trust and flexibility can make these partnerships work more effectively (Lyons 2000).

The Commonwealth Government announced a range of initiatives in May 2001 to support the reforms and to promote the goals of: stronger families, stronger communities, and economic and social participation (Commonwealth of Australia 2000; FaCS 2001a). In particular, $177 million over 4 years was announced to provide people with disabilities with early intervention and more thorough assessment of their work capacity, and to increase their opportunities for employment, education and training. Improved employment assistance will include 7,000 new disability employment assistance places, greater quality assurance of disability employment services, and another 500 places in the FaCS Assessment and Contestability Trial. A further 16,300 employment assistance and rehabilitation places were also announced to assist parents and mature-aged workers with disabilities.

Assessment for the Disability Support Pension will still involve medical assessment by the treating practitioner, but assessment of ability to work will be carried out using a range of external expertise such as psychologists or occupational therapists as well as Centrelink expert staff. Improved financial incentives to take up part-time and casual work are to be supported by the establishment of a Working Credit .

Decisions about assessment and referral to services for people with disabilities are to be informed by the Assessment and Contestability Trial, which is investigating whether a more detailed assessment of an individual s needs and abilities, including capacity to work, leads to better targeting of interventions and better outcomes for the individual.

National developments in disability services

The contractual emphasis of mutual obligation has a counterpart in structures delivering services where, in recent years, purchaser/provider contracts have reflected agreed outputs or outcomes, and service agreements between service providers and recipients often specify amounts or types of service and agreed desired goals. There are pressures to increase competitiveness and efficiency, to ensure the quality of service delivered to vulnerable groups, and a need for services to diversify their incomes to ensure their financial viability (see, for example, ACROD 2001). Adjustments have been made in the FBT area with the introduction of the new tax system in mid-2000. The resulting complexity of the roles and the relationship to government of non-government service providers is reflected in the establishment of an independent inquiry into the definitions of charitable, religious and community service not-for-profit organisations . The aim is to enhance the clarity and consistency of the existing definitions in Commonwealth law and administrative practice , leading to legislative and administrative frameworks that are appropriate for, and adapted to, the social and economic environment of Australia (Commonwealth of Australia 2001; see also Chapter 1).

Nationwide, the focus is on individualised, flexible and local services, accompanied by assessment, targeting and emphasis on performance measurement (see Section 7.4 and Chapter 9). For instance, a FaCS Case Based Funding Trial is examining a range of issues arising from the 1996—97 Budget decision to move from block grant funding to case-based payments for specialist disability employment services, with funding based on job seeker need . The trial aims to test the impact of a new funding method on employment outcomes, the suitability of the classification process, the appropriateness of funding levels, the impact on service viability and responsiveness, as well as identifying financial incentives and disincentives for service providers (see, for example, FaCS 2000a).

Changes in the way services are funded and delivered to clients (people with disabilities and their families) are wide ranging. Common themes about service flexibility include tailoring services to meet individual needs and encouraging client involvement in service planning and assessment. Efforts to promote linkage and transition are proposed to overcome possible problems with service stovepipes and blockages in programs, such as respite and post-school options (that is, lack of movement through what are designed to be temporary or transitional support arrangements). New accommodation service models of respite care and of shared care (involving a mix of formal and informal care) are also being developed.

Deinstitutionalisation is an ongoing drive in all jurisdictions. Evidence of the overall trend to community care is presented in Section 7.4, and in Chapter 4 where there is a broader discussion across a number of fields. These trends are the result not only of providing community-based alternatives for younger people (non-institutionalisation) but also of efforts to redevelop existing congregate care. In Victoria, for example, Kew Residential Services, now a segregated institution for 460 people with an intellectual disability, is to be redeveloped. Some 50—100 residents are choosing to remain on the site in new homes, but the remainder will relocate to new supported homes in the community, closer to family and friends (Bracks 2001).

Under the Commonwealth/State Disability Agreement (CSDA), all Australian governments Commonwealth, State and Territory cooperate to fund and provide disability support services to people with a disability who need ongoing support (see data later in this section). The second CSDA saw recognition of unmet need for these services and a subsequent total additional commitment, from all jurisdictions, of $510 million over 2 years (Newman 2000a). A third CSDA is to be negotiated, providing a national framework to underpin future funding and administrative arrangements for disability services from 2001 (Disability Ministers 2000).

Population ageing remains a significant factor affecting the planning of disability services. A study of disability and ageing commissioned by National Disability Administrators (AIHW 2000b) found five main implications for services:

- Demography population growth, ageing and the baby boom is a significant factor for service planning.

- The ageing of the CSDA client population itself appears to be a feature of CSDA service trends.

- The emphasis of governments on individual needs and flexible services is a useful approach. Despite some patterns of difference between older and younger people with disability, it is impossible to generalise on the basis of the statistics.

- Disability service and aged care links are needed, as well as perhaps greater clarity concerning their respective responsibilities for people now ageing with a disability.

- Informal carers are the main providers of support for people with disabilities, and remain the linchpin of the whole system . It is not possible to predict whether current patterns of informal care will continue unchanged. The challenge for the formal service system is to support this role in the hope that it will continue to be a strong feature of the disability and aged care fields.

This last issue the relationship between formal and informal care is being actively canvassed by some carer organisations. The rights of family carers to an annual holiday, to paid work and to retirement from the caring role have been enunciated by at least one carers group (Gippsland Carers Association 2001). There is growing policy recognition of the importance of respite care in sustaining families involved in such informal care.

These interface issues between the disability and aged care systems, between formal and informal care, between the disability and mental health systems, and between specialist and generic services are very much on the policy agenda for disability administrators around Australia.

Indigenous disability

A new Indigenous disability network has been proposed, to promote better understanding of disability among Aboriginal and Torres Strait Islander peoples, consultation among those responsible for service design and delivery, and cross-border coordination in some areas of Australia. It is proposed that the new network provide advice to the AIHW and the ABS on Indigenous disability data collection (ATSIC and NDAC Joint Working Party 2000). The limits of national understanding of disability among Aboriginal and Torres Strait Islander people have been discussed in previous editions of *Australia's Welfare* (AIHW 1997a, 1999a) and no better population statistics are yet available.

National organisations

The social and physical environment shapes the experience of people with disabilities. Organisations such as the National Disability Advisory Council and the Human Rights and Equal Opportunity Commission (HREOC) continue to work on issues associated with this environment. The current Advisory Council is working in five priority areas: monitoring welfare reform; identifying issues for the CSDA renegotiation; contributing to standards under the Disability Discrimination Act; raising awareness about difficulties encountered by people with disabilities in the health care system; and raising awareness about issues for Indigenous people with a disability.

The HREOC commissioned a report on the sterilisation of young women and girls with a disability following debate about varying estimates of the practice (Brady et al. 2001). The report recognised efforts by the Commonwealth Government to make medical practitioners fully aware that such procedures are unlawful except in the course of treatment for disease (e.g. cancer) or where authorisation is given by the Family Court or a tribunal with jurisdiction. The authors advocated that decisions be made in a non-adversarial atmosphere and pointed to the need for education and support services for these young women and their families.

Disability Discrimination Act

Progress has been made on developing, consulting on and agreeing standards under the Disability Discrimination Act (DDA), as summarised in Box 7.4.

Box 7.4: Implementing the Disability Discrimination Act

Disability Standards for Accessible Public Transport: The Government announced in late 2000 that it would implement Disability Standards for Accessible Public Transport. The Government agreed that the draft standards be amended to exclude dedicated school bus services, small aircraft and airports that do not accept scheduled regular public transport services, limousine, hire cars and charter boats and unresolved technical issues, to vary the requirements in relation to boarding devices and electronic notices and extend the implementation timetable for buses, trains and trams. It also agreed to amend the Disability Discrimination Act 1992 (DDA) *so that HREOC may grant exemptions from the Standards in appropriate circumstances.*

Disability Standards for Access to Premises used by the Public: An amendment to the DDA to add the power to formulate a standard in relation to access to public premises came into effect on 13 April 2000. In April 2001 the Commonwealth formally tasked the Australian Building Codes Board with developing proposals for revisions to be made to the Building Code of Australia to allow it to form the basis of a national disability standard on access to premises, to ensure that buildings do not provide unnecessary and inaccessible barriers to people with disabilities.

Disability Standards for Education: A Taskforce on Disability Standards in Education, established by the Ministerial Council on Education, Employment, Training and Youth Affairs, released draft standards for consultations across Australia and sought submissions on them in 2000. The taskforce revised the draft standards in the light of the consultations and submissions and referred them to the Ministerial Council for consideration in July 2001. The Ministerial Council directed the Australian Education Systems Officials Committee (AESOC) 'to consider the Standards, agree on amendments and clarifications and develop a Regulatory Impact Statement to facilitate implementation, and to report back to Ministers by the end of 2001'.

Access to Commonwealth Information: The Government OnLine Strategy specifies some new standards for use by agencies in electronic publishing, aimed at extending and standardising the publication of information on the Internet. Commonwealth departments and agencies are already obliged by the DDA to ensure that online information and services are accessible by people with disabilities, and under the strategy they are required to observe the World Wide Web Consortium's (W3C) Web Content Accessibility Guidelines to a sufficient extent that their web sites pass recognised tests of accessibility. The guidelines are widely recognised internationally and have the support of HREOC and disability groups. The Online Council has agreed to the adoption of the W3C Guidelines as the common best-practice standard for all Australian government web sites.

Source: Information provided by Civil Justice Division, Attorney-General's Department 2001.

Ethics and genetics

The disability field has developed and attempts to base itself on a system of ethics and philosophy relating to human rights (see, for example, UN 1994; AIHW 1993 for history). New developments such as gene technology and the human genome project create the need to refine or defend this philosophy. The promises and threats of the human genome project were discussed by speakers and participants at a workshop convened by the Centre for Developmental Disabilities in May 2000 (CDDS 2000). The challenges of blending and reconciling the various sectors of interest scientific, economic and legal, personal, policy, social and ethical were discussed. While a number of the benefits of genetic testing were recognised, fears were also expressed that a new era of eugenics was dawning, where disability is considered undesirable and preventable, leading to intolerance of those who slip through the scientific detection and intervention net or who are the result of personal and family choice.

Conceptual and data development

The new International Classification of Functioning, Disability and Health has resulted from some seven years of international collaboration and development involving a range of countries, including Australia (see Box 7.1). Its implementation in Australia should, ideally, introduce a coherent conceptualisation of disability into a wider range of relevant fields than at present, including health and rehabilitation, aged care and other community services, as well as generic services such as education and employment. One mechanism for achieving this will be the inclusion of revised and new items in the two national data dictionaries (AIHW 2000a, 2001a). There are many challenges and opportunities in implementing a multidimensional classification such as the new ICF, perhaps in particular in defining disability in relation to the environment. The rising reported prevalence of ADHD illustrates this point (see Section 7.2). Can we adequately report on such changes without also being able to quantify changes in school organisation, in community tolerance of certain behaviours, in medical and pharmaceutical resources and in the rates of prescribing of related drugs?

Income support

Commonwealth programs

The Commonwealth Government is the main source of income support services to people with a disability and their carers in Australia (Box 7.5).

Disability Support Pension (DSP), Disability Pension (DP) and Carer Payment (CP) are the main income support payments assisting people with a disability who are under 65 years and their carers. Several other allowances are available to assist with the extra costs associated with having a disability or caring for someone with a disability.

In June 2000, 602,280 people received DSP and expenditure on DSP payments through 1999—00 was $5.2 billion (Table 7.6). Expenditure has increased from $4.6 billion in 1997—98 (AIHW 1999a:Table 7.6).

Box 7.5: Commonwealth disability-related payments and allowances

Disability Support Pension *(DSP) is an income support payment available to people with a disability who are unable to work full-time in open employment at full award wages, or to be retrained for work, within 2 years. They must have impairment assessed as above a specific level and be at least 16 years old and less than Age Pension age at the time of claiming.*

Disability Pension *(DP) is a compensation payment to veterans for injuries or disease caused or aggravated by war service or certain defence service on behalf of Australia. Non-veterans may also receive DP if they are dependants of deceased or incapacitated veterans.*

Mobility Allowance *is a payment to people with disabilities who are in paid employment, voluntary work, doing vocational training, or are in receipt of Newstart Allowance, Austudy, Youth Allowance, and who cannot use public transport without substantial help.*

Sickness Allowance *is paid to people who are employed or, in some cases, studying full-time and who must temporarily stop working in their job or studying due to an illness, injury or disability.*

Carer Allowance *(CA) is paid to people who are caring at home for a child or an adult with a severe disability or chronic medical condition or who are frail aged. The person being cared for must require a lot more daily care and attention than a person of the same age who does not have a disability. The Child Disability Assessment Tool and Adult Disability Assessment Tool are used to assess eligibility for CA for children and adults respectively.*

Carer Payment *(CP) is an income support payment to those who provide constant care for six months or more to a person aged 16 years or more with a severe physical, intellectual or psychiatric disability. CP may also be available to carers of children under 16 with a profound disability or two or more children with a disability who together need the level of care required by a child with a profound disability. The carer must be a recipient of Commonwealth income support (including DSP, Age Pension, Service Pension) or meet an income and assets test. Care is provided in the person's home or while they are temporarily in respite care or in hospital. The Adult Disability Assessment Tool is the basis for assessment of eligibility of carers of adults for CP. CP recipients may also be eligible for CA.*

Wife Pension *is paid to the wife of a recipient of DSP, Age Pension or other payment who is not receiving a pension in her own right. Since 1 July 1995 Wife Pension has been closed to new applicants (except people transferring from another payment).*

Newstart Allowance (incapacitated) *and* **Youth Allowance (incapacitated)** *are provided to people—21 years or more or under 21 years respectively—who, due to illness or injury, are temporarily (up to two years) unable to work for more than 8 hours a week or, in the case of Youth Allowance, to study. Full-time students aged 21–24 may also be eligible for Youth Allowance (incapacitated). Newstart Allowance itself is an income support payment and involves complying with a Preparing for Work Agreement, encompassing possible medical treatment and rehabilitation, and satisfying 'Mutual Obligations'. The*

(continued)

Box 7.5 (continued): Commonwealth disability-related payments and allowances

Activity Test usually applied to unemployed people is waived for those with an illness or injury. 'Mutual Obligations' also does not apply when the person is ill for an extended period or receiving Intensive Assistance, that is one-to-one help for job seekers, including those likely to experience difficulty in getting a job.

The Continence Aids Assistance Scheme*, which commenced in January 1993, enables people who are employed, doing job training or looking for work to be supplied with continence aids (up to a predetermined credit limit) to defray the costs of their disability.*

Table 7.6: Commonwealth disability-related payments and allowances, recipients and expenditure, 1999–00

	Recipients as at June 2000	**Administered expenses 1999–00 ($m)**	**Department**
Disability Support Pension	602,280	5,238.4	FaCS
Mobility Allowance	35,154	53.4	FaCS
Sickness Allowance	10,733	90.6	FaCS
Carer Allowance (Child)(a)	n.a.	n.a.	FaCS
Carer Allowance (Adult)(a)	194,887	417.5	FaCS
Carer Payment (DSP)	24,500	(b)368.0	FaCS
Carer Payment (AP)	15,346	(b)n.a.	FaCS
Carer Payment (other)	7,704	(b)n.a.	FaCS
Wife Pension (DSP)	59,934	486.7	FaCS
Wife Pension (AP)	31,362	241.5	FaCS
Newstart Allowance (incapacitated)	68,016	(c)n.a.	FaCS
Youth Allowance (incapacitated)(d)	5,883	(c)n.a.	FaCS
Continence Aids Assistance Scheme	15,525	7.6	DHAC
Disability Pension	162,730	1,007.8	DVA

(a) Recipients and administered expenses for Carer Allowance (Child) and Carer Allowance (Adult) are combined.

(b) Administered expenses for Carer Payment (DSP), Carer Payment (AP) and Carer Payment (other) are combined.

(c) Administrative expenses for Newstart Allowance (incapacitated) and Youth Allowance (incapacitated) are not available as they are included in the larger funding budget for these two programs.

(d) Data are for March 2001.

Notes

1. Payments with bracketed qualifiers, for example Carer Payment (DSP), indicate that the recipient's payment depends on a characteristic of another person. In this example, the person being cared for is receiving Disability Support Pension.
2. Expenditure does not include running costs and corporate overheads. It includes any additional allowances such as rent assistance paid to recipients.
3. Carer Allowance (Child) and Carer Allowance (Adult) are income supplements (replacing Domiciliary Nursing Care Benefit and Child Disability Allowance from 1 July 1999) available to people who provide daily care and attention to a person who has a disability or severe medical condition. See also Box 7.5.
4. Disability Pension expenditure is for veterans and their dependants.
5. Disability Pension recipients may also receive Service Pension associated with service in the armed forces. There were 88,502 DP veterans also receiving SP (in March 2000).

Source: Centrelink 2001; DHAC 2000; DVA 2000, 2001; FaCS 2000b, 2001c; FaCS 2001 unpublished data.

Expenditure on DP payments totalled $1.0 billion in 1999—00 and in June 2000 DP was being paid to 162,730 veterans (Table 7.6). Of veterans receiving DP, 50,360 were under age 65 in March 2001 (Table 7.7). There were 14,998 veterans under age 65 years receiving Service Pension, many of whom were also receiving DP.

Table 7.7: Recipients of disability-related Commonwealth payments and allowances, by sex and age group, June 2000 (FaCS payment) or March 2001 (DVA payment)

	Age (years)								
	<16	**16–19**	**20–29**	**30–39**	**40–49**	**50–59**	**60–64**	**65+**	**Total**
Males									
Disability Support Pension	n.a.	8,896	30,157	50,948	74,649	120,293	95,403	2,005	382,351
Mobility Allowance	0	1,462	4,618	5,117	4,342	2,770	715	649	19,673
Sickness Allowance	0	0	1,955	2,087	1,673	1,376	350	2	7,443
Carer All. (Child)(a)	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
Carer Allowance (Adult)(a)	13	169	782	3,199	4,496	5,151	2,811	12,866	29,487
Carer Payment (DSP)	1	130	545	1,385	2,426	4,041	1,939	99	10,566
Carer Payment (AP)	0	28	206	737	1,294	1,782	1,310	217	5,574
Carer Payment (other)	1	54	223	646	849	746	187	58	2,764
Newstart All. (incapac.)	1	1	9,235	11,986	11,096	9,190	1,845	9	43,363
Youth All. (incapacitated)(b)	11	1,659	814	0	1	0	0	0	2,484
Disability Pension (DVA)(b)	0	0	601	6,241	10,211	26,342	5,002	106,937	155,363
Females									
Disability Support Pension	0	6,016	21,252	31,152	51,766	92,575	16,941	227	219,929
Mobility Allowance	0	1,125	3,782	3,920	3,512	2,236	485	421	15,481
Sickness Allowance	0	0	915	694	889	754	38	0	3,290
Carer All. (Child)(a)	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
Carer Allowance (Adult)(a)	20	357	14,408	59,990	43,954	18,202	6,903	21,566	165,400
Carer Payment (DSP)	6	239	896	1,738	4,211	5,867	839	138	13,934
Carer Payment (AP)	0	83	350	1,086	2,671	4,300	983	299	9,772
Carer Payment (other)	1	65	428	1,021	1,495	1,621	193	116	4,940
Wife Pension (DSP)	0	0	534	5,016	15,576	33,062	5,558	98	59,934
Wife Pension (AP)	0	0	28	358	2,184	17,432	10,506	854	31,362
Newstart All. (incapac.)	0	0	6,363	4,816	7,986	5,184	304	0	24,653
Youth All. (incapacitated)(b)	18	2,538	843	0	0	0	0	0	3,399
Disability Pension (DVA)(b)	1	0	128	1,049	623	136	26	4,869	6,837

(a) Recipients and administered expenses for Carer Allowance (Child) and Carer Allowance (Adult) are combined.

(b) Data are for March 2001.

Notes

1. Data for all FaCS payments are as at June 2000 except Youth Allowance (incapacitated), and for DVA payments are as at March 2001.
2. Disability Pension recipient data include 29 male and 5 female veterans of unknown age in the 'all ages' totals.
3. Youth Allowance is paid to job seekers up to and including the age of 20 and students up to and including the age of 24. Students who turn 25 remain on Youth Allowance until completion of their current course.

Source: Centrelink 2001; DVA unpublished data from the Ad hoc Information System; FaCS unpublished data.

Expenditure on CP in 1999—00 was $368 million and increased from $259 million in 1997—98 (AIHW 1999a:Table 7.6). About 47,550 people received CP in June 2000, of whom around 24,500 were caring for a person receiving DSP and 15,346 were caring for an age pensioner.

In July 1998, people providing constant care and attention to children aged less than 16 years with profound disabilities became eligible to receive CP. On 1 July 1999, eligibility for CP was extended to carers of an adult with a disability and that adult s dependent child who also needs care or to have their care supervised. Reflecting these changes, between June 1998 and June 2000 recipients of CP (other) increased from 3,683 to 7,704 (FaCS 1999:Table 10).

Trends in disability-related payment recipients

The number of recipients of most payments increased over the last decade, though the magnitude of the increase has varied with the type of payment (Table 7.8; AIHW 1999a:Table 7.8).

Table 7.8: Recipients of disability-related income support payments, June 1993 – June 2000

	1993	1994	1995	1996	1997	1998	1999	2000
Disability Support Pension	406,572	436,234	464,430	499,235	527,514	553,336	577,682	602,280
Mobility Allowance	16,160	20,795	22,851	24,985	26,595	28,975	31,001	35,154
Sickness Allowance	46,579	47,132	47,311	33,215	15,759	16,285	11,181	10,733
Carer Allowance (Child)(a)	61,174	69,693	78,898	90,644	95,520	90,830	100,452	n.a.
Carer Allowance (Adult)(a)	35,025	37,169	38,408	42,047	44,103	45,675	51,857	194,887
Carer Payment (DSP)	8,056	9,450	10,633	13,483	15,735	18,556	21,392	24,500
Carer Payment (AP)	6,507	7,441	8,324	9,500	10,954	11,740	13,407	15,346
Carer Payment (other)	482	808	1,141	2,054	2,869	3,683	5,271	7,704
Wife Pension (DSP)	108,327	116,036	121,839	107,803	91,307	79,892	68,523	59,934
Wife Pension (AP)	33,520	36,539	39,611	41,125	36,577	36,233	32,196	31,362
Newstart All. (incapac.)(b)	n.a.	n.a.	n.a.	n.a.	n.a.	48,792	59,670	68,016
Youth All. (incapacitated)(c)	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	3,929	5,883
Disability Pension (DVA)(c)	156,923	156,286	157,298	159,079	160,145	161,829	162,810	162,730

(a) Recipients for Carer Allowance (Child) and Carer Allowance (Adult) are combined.

(b) Data for Newstart Allowance before 1999 may not be comparable with previous years due to a major redevelopment of the Newstart System in May 1998. Youth Allowance was introduced on 1 July 1998 and replaced Newstart Allowance for 16–20 year olds.

(c) Data are for March 2001.

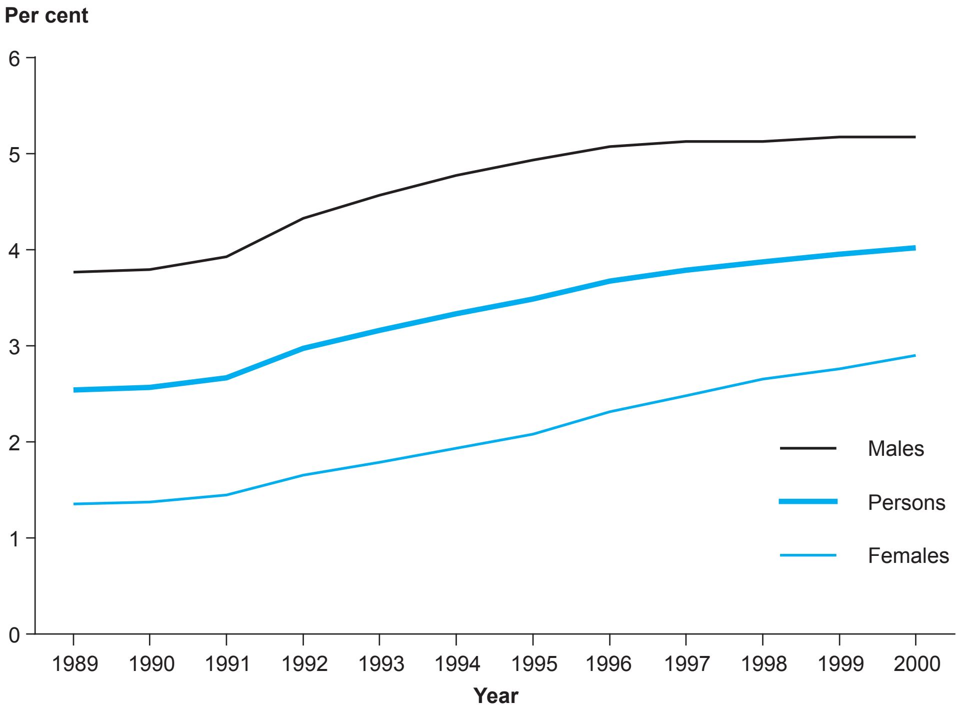
Notes

1. Payments with bracketed qualifiers, for example Carer Allowance (Child), indicate that the recipient's payment depends on characteristics of another person. In this example, the person being cared for is the recipient's child with a disability and is aged less then 25 years.
2. Carer Allowance (Adult) was introduced in July 1999 following transfer of 51,857 recipients from the former Domiciliary Nursing Care Benefit. CA (Adult) recipient data for 1993 are estimated using the numbers of people being cared for from 1993, and the average ratio of recipients to people being cared for from 1994 to 1998.
3. CA (Child) was also introduced in July 1999 following transfer of 100,666 recipients from the former Child Disability Allowance.
4. From 1 July 1998, Carer Payment (CP) recipients can include carers of a child with a profound disability. In June 1999, there were 762 people receiving CP on this basis. On 1 July 1999, eligibility for CP was extended to carers of an adult and that adult's dependent child who also needs care or to have their care supervised. CP recipients may also be eligible for CA.

Source: Centrelink 2001; DVA 2000, 2001; FaCS 1999, 2000b, 2001b; FaCS 2001 unpublished data.

Between June 1989 and June 2000, DSP recipient numbers nearly doubled (Table A7.8; FaCS 2001b:Table 2.4.1). The increase in DSP numbers between June 1991 and June 1992 was particularly high (13.3%). Rates of growth have generally declined each year since then, with the exception of 1995—96, to 4.3% for 1999—00. After adjusting annual DSP recipient growth rates for growth of the Australian population and for changes in age and sex distribution of the population, the annual growth rate for 1999—00 was 1.8%.

DSP recipient numbers have grown as a proportion of the Australian population (Figure 7.3). In June 2000, 4.0% of Australians were receiving DSP compared with 2.4% 10 years earlier (or 2.6% after adjustment for population changes (Table A7.8)). For men, after June 1996, the proportion slowed its growth and was 5.2% in June 2000. Male DSP recipients aged 50—64 years the age group with by far the highest proportion of the population receiving DSP accounted for this slowing of growth after June 1996; rates dropped a little for men 50—64 years. For women, the proportion continued increasing and was 2.9% in June 2000. Like men under 50 years, the proportion of women under 50 years receiving DSP has gradually increased over the last decade. However, female DSP recipients aged 50 and over have shown more substantial increases, particularly for women 60—64 years after June 1995. This may reflect recent adjustments to the eligibility ages for Age Pension and the closure of Wife Pension to new recipients. It is also contributing to declines in the percentage of DSP recipients who are male. In June 1989, 74% of DSP recipients were men (FaCS 2001b:Table 2.4.1), while 63% were men in June 2000 (see Table 7.7).



Source: Table A7.8.

Figure 7.3: Disability Support Pension recipients in the Australian population, 1989–2000

Concession cards

Some concessions are available to people with a disability if they are eligible for certain identification cards (Box 7.6). The cards entitle the holder to concessions for specific Commonwealth, State / Territory and local government services and some private sector concessions. Possession of a Commonwealth-issued concession card is also often used as the eligibility criterion for concessions available from other jurisdictions. The concession areas covered are at the discretion of each jurisdiction and may include ambulance services, travel for isolated patients, glasses, dental care, taxi subsidies, and so on. The core areas agreed by State and Territory Governments are energy consumption, water and sewerage, municipal rates and transport (including public transport, motor vehicle registration and licence fees). The value of concessions in each area varies and data are not available on the total.

Box 7.6: Commonwealth concession cards

*A **Pensioner Concession Card** is automatically available to DSP, CP and Wife Pension recipients, as well as Age Pensioners. It entitles them to Pharmaceutical Benefits Scheme prescription medicines at a small cost per prescription, free hearing assessments and aids, some public transport concessions, and so on. In May 2001, 3.0 million people were covered by a Pensioner Concession Card.*

*The **Gold Repatriation Health Card** entitles some veterans, including disabled veterans and their dependants, to free treatment for all health conditions. There were 287,476 Gold Card holders as at 30 June 2000.*

*A **Health Care Card** may be available to Sickness, Newstart, Youth and Mobility Allowance recipients, and Carer Allowance (Child) recipients for the child's use. It entitles them to Pharmaceutical Benefits Scheme prescription medicines at a small cost per prescription. In May 2001, 1.7 million people were covered by a Health Care Card.*

Source: FaCS unpublished data; DVA 2000: Table 74.

Personal injury compensation schemes

Other significant sources of income support for people with a disability are the personal injury compensation schemes, mainly for work- and transport-related injuries. These schemes operate under specific legislation in each State and Territory and require contributions from employers and road users respectively. They generally aim to replace lost income and to cover medical expenses incurred.

During 1998—99, 29,637 claims were made for worker s compensation involving events with non-fatal outcomes in the most serious category recorded, that is resulting in 60 days or more absence from work (Table 7.9). Of these, most involved injury / poisoning (24,711 or 83% in fact, only 42 cases of poisoning were recorded). Next most prominent were claims involving people with mental disorders (1,971 or 7%), followed by diseases of the musculoskeletal system and connective tissues (1,725 or 6%). The large injury category comprises mainly sprains and strains of joints and muscles (16,477 or 67% of the injuries), and fractures (3,499 or 14%). There were 171 fractures of the vertebral column. Men made up 65% of the claimants for these events.

Table 7.9: Worker's compensation claims with non-fatal outcomes resulting in work absences of 60 days or more, by nature of injury or disease and age group, 1998–99

	Age (years)						
	<20	**20–29**	**30–39**	**40–49**	**50–54**	**55+**	**Total**
Injury/poisoning							
Fractures	168	779	849	858	385	460	3,499
Fracture of vertebral column	8	41	43	40	17	22	171
Sprains/strains of joints and adjacent muscles	345	3,068	4,573	4,844	1,946	1,696	16,477
Open wounds	107	377	357	273	95	97	1,306
Contusions with intact skin surface & crush injuries	51	299	400	385	174	168	1,477
Other injury/poisoning	95	467	601	423	168	173	1,927
Total injury/poisoning	*774*	*5,031*	*6,680*	*6,823*	*2,785*	*2,616*	*24,711*
Nervous system/sense organ diseases	8	62	108	137	61	50	426
Musculoskeletal system and connective tissue diseases	29	269	492	550	209	176	1,725
Mental disorders	21	307	551	673	276	143	1,971
Other diseases/not stated/not available	26	135	180	205	123	135	804
Total	**858**	**5,804**	**8,011**	**8,388**	**3,454**	**3,120**	**29,637**

Notes

1. Claims made in the Australian Capital Territory are excluded.
2. Some figures include minor random adjustments in order to account for small cell values, for confidentiality reasons.
3. Of the 24,711 claims in the injury/poisoning category, 24,669 involved injury and 42 involved poisoning.

Source: National Occupational Health and Safety Commission 2000.

The area of medical indemnity is becoming of greater interest and significance. Although medical defence organisations collect information to support the processing of medical negligence claims, there is at present no system in Australia for collating and analysing these data.

Disability support services

CSDA-funded disability support services

Services provided under the Commonwealth/State Disability Agreement (CSDA) are designed for people who need ongoing support with everyday life activities. While, in practice, services are generally directed to people aged under 65 years, the CSDA places no age-based restrictions on access to them. Under the second CSDA (1998), it is agreed that the Commonwealth has responsibility for the planning, policy setting and management of employment services, while the States and Territories have these responsibilities for all other specialist disability services (see Box 7.7 for definitions of service types). Advocacy, print disability and information services are considered shared responsibilities under this agreement.

Information on disability support services provided or funded under the CSDA is collected in the framework of the CSDA Minimum Data Set (MDS), jointly developed and maintained by the AIHW and the Commonwealth, States and Territories, under the auspices of the National Disability Administrators (comprising the heads of government disability services throughout Australia). Consumers and service providers supply data on a snapshot day to funding departments in each jurisdiction, and the

Box 7.7: Definitions of service types covered by the CSDA

Accommodation support	*Services that provide accommodation to people with a disability and services that provide the support needed to enable a person with a disability to remain in their existing accommodation.*
Community support	*Services that provide the support needed for a person with a disability to live in a non-institutional setting (not including support with the basic needs of living such as meal preparation and dressing included under accommodation support).*
Community access	*Services designed to provide opportunities for people with a disability to gain and use their abilities to enjoy their full potential for social independence. People who do not attend school or who are not employed full-time mainly use these services.*
Respite	*Respite services provide a short-term and time-limited break for families and other voluntary caregivers of people with a disabilities, to assist in supporting and maintaining the primary care-giving relationship, while providing a positive experience for the person with a disability.*
Employment	*Services that either provide employment assistance to people with a disability in obtaining and/or retaining paid employment in another organisation (open employment), and/or that support or employ people with a disability within the same organisation (supported employment).*
Other	*Other services include service evaluation and training, research and development, and services provided by peak bodies.*

Source: AIHW 2001b.

Institute collates these data nationally. In 1999 and 2000 for the first time, a statistical linkage key was collected, which enables the number of consumers to be estimated from data on services received without any consumer being personally identified (see Box 7.8). As part of the current redevelopment of the MDS, it is planned to extend the collection to cover consumers for the full financial year (see Box 7.9).

CSDA service types, funding and service numbers

The total expenditure on disability support services by Australian governments under the CSDA in 1999—00 was $2,246 million, an increase of 8.8% in real terms from the level in 1998—99 (Table 7.10; SCRCSSP 2000). Accommodation support services accounted for over half of this expenditure ($1,157 million or 52%), with about one-tenth of funding each for community support ($250 million), community access ($221 million) and employment support ($221 million) services. The remaining expenditure was for administration ($204 million), respite services ($119 million) and other support services ($74 million).

Box 7.8: Definitions and major counts of the CSDA MDS collection

Services received

A service is a support activity delivered to a consumer, in accord with the CSDA. Services within the scope of the collection are those for which funding has been provided by a government organisation operating under the CSDA. The number of services received are not counts of individual consumers, since a person may have received more than one service on the snapshot day and hence may be counted more than once.

Consumers

A consumer is a person who receives a CSDA service.

In 1999 and 2000 a statistical linkage key was collected as part of the CSDA MDS. This statistical linkage key enables the number of consumers to be estimated from the data on services received without any consumer being personally identifiable. In both 1999 and 2000 the number of services received was about 20% greater than the estimated number of consumers.

Service outlets and types

A service outlet is a service provider funded to provide a particular CSDA service type at a discrete location. The CSDA MDS is progressing towards an outlet-based collection but this has not been completely achieved in all jurisdictions, because of some of the complexities of funding processes. Service type is the support activity which the service outlet has been funded to provide under the CSDA (see Box 7.7 for definitions of the main service types).

Snapshot day

The use of a snapshot day permits the number of consumers to be estimated at a point in time and can also be regarded as a sample of the people who use CSDA-funded services. The number of consumers in this snapshot sample, as a proportion of consumers over the year, will differ by service type. In particular, it will be greater for accommodation and community access services, which in general are used on a more frequent and regular basis than employment, recreation and respite services.

The statistical linkage key makes it possible to analyse the use of multiple services by consumers on the snapshot day. This will not give the full picture of multiple service use, because the snapshot day provides only a sample of service usage. However, it provides an indication of some common combinations of services used and the groups of consumers who are likely to use them.

Source: AIHW 2000c, 2000d, 2001b.

The Commonwealth Government s direct funding ($276 million) to disability support services under the CSDA was mostly for employment services. The Commonwealth also provided some of the funds expended by State and Territory Governments ($356 million). Its overall contribution to total CSDA funding was 29%.

Box 7.9: Redevelopment of the CSDA Minimum Data Set

The AIHW and the National Disability Administrators are working together to redevelop the CSDA MDS collection. The AIHW is managing the redevelopment project, working closely with a Facilitation and Implementation Group that includes coordinators from each State and Territory and the Commonwealth, as well as two representatives for non-government organisations and one consumer representative.

The CSDA MDS collection is being redeveloped in order to align it more closely with changing service delivery and funding models, and to enable it to meet a wider range of information needs, including gaining insights into the duration and intensity of service provision. The multi-faceted project plan includes a number of rounds of field testing with administrations, service providers and consumers; development of data principles to govern the collection, transmission and collation of data; development and testing of data transmission methods; and ensuring improved data outputs from the collection. The most significant change to the collection is that, for most service types, a profile of all consumers during the year will be available, rather than information only about consumers who access services on a selected snapshot day.

The redevelopment project is planned to proceed over 2 years, with implementation of a redeveloped collection from July 2002.

Further information is available at
www.aihw.gov.au/disability/csda_public/index.html.

Table 7.10: CSDA funding of services by Australian governments, by service type (with administration expenditure), 1999–00 ($m)

Service type	**NSW**	**Vic**	**Qld**	**WA**	**SA**	**Tas**	**ACT**	**NT**	**C'wealth**	**Australia**
					Amount					
Accommodation support	417.80	334.84	133.49	117.78	89.72	40.13	16.28	7.03	—	1,157.07
Community support	75.70	62.67	31.47	7.86	46.75	4.71	4.68	3.81	12.57	250.21
Community access	60.35	106.31	24.34	14.42	5.40	8.01	1.73	1.07	0.07	221.70
Respite	33.82	28.56	20.81	19.53	5.15	3.96	2.16	0.73	4.05	118.75
Employment	—	—	—	—	—	—	—	—	220.99	220.99
Other support	5.58	22.91	4.21	20.47	6.64	0.29	0.07	0.08	13.74	73.98
Subtotal	*593.24*	*555.28*	*214.32*	*180.06*	*153.66*	*57.09*	*24.92*	*12.71*	*251.41*	*2,042.70*
Administration	67.51	58.01	32.30	7.20	5.79	2.86	4.02	1.32	24.70	203.71
Total	**660.75**	**613.29**	**246.62**	**187.25**	**159.46**	**59.95**	**28.94**	**14.03**	**276.11**	**2,246.41**

Notes

1. Figures for community access services in Victoria do not include funds previously directed to independent living training services.
2. Data provided by the Commonwealth are preliminary and cover 99% of Commonwealth-funded services.

Source: SCRCSSP 2001:Table 13A.8.

The CSDA MDS collection reported on 7,378 service outlets in 2000 (Table A7.9). The majority (75%) were provided by the non-government sector for all service types. Accommodation support services had the most outlets (3,143 or 43%).

The average number of full-time equivalent (FTE) staff for all service outlets for the week leading up to the snapshot day was 6.7 (Table 7.11). Community support services reported the lowest average staff hours per week (142) and accommodation support services, the highest (322). This is at least partly because most accommodation services operate 7 days a week (AIHW 1999b:Table A3.29). Non-government-auspiced services reported higher mean staff hours for all service types except community support and accommodation support. The large difference between the government and non-government sectors for the latter service type results mainly from higher average staff hours worked in government institutions and outreach services (AIHW 2001b).

Table 7.11: Mean hours worked by all staff and volunteers for CSDA-funded service outlets, by service type and auspicing organisation, 2000

	Government		**Non-government**		**All services**		
Service type	**No. of service outlets**	**Mean hours per week per service**	**No. of service outlets**	**Mean hours per week per service**	**No. of service outlets**	**Mean hours per week per service**	**Mean no. of FTE staff per week**
Accommodation support	911	502	1,580	218	2,491	322	8.5
Community support	306	195	997	126	1,303	142	3.7
Community access	79	209	762	226	841	224	5.9
Respite	117	222	277	252	394	243	6.4
Employment support	14	193	830	258	844	257	6.8
Other/not stated	11	236	29	171	40	189	5.0
Total with known staff hours	1,438	393	4,475	208	5,913	253	6.7
Staff hours not known	409	. .	1,056	. .	1,465	. .	. .
Total	**1,847**	**. .**	**5,531**	**. .**	**7,378**	**. .**	**. .**

Notes

1. A service outlet may be a single outlet, or an aggregation of two or more outlets of the same service type, for a service provider.
2. Data for hours worked are the mean number of hours worked over one 7-day week in May. They are used here as a guide and should not be considered a typical week in 2000 for all service types.
3. Government-auspiced employment services are not directly provided by the Commonwealth but by organisations classified as Commonwealth-related (such as universities).
4. Full-time equivalent (FTE) staff numbers are based on a 38-hour working week.
5. Data provided by the Commonwealth are preliminary and cover 99% of Commonwealth-funded services.

Source: AIHW 2001a:Table 5.4.

Consumers of CSDA services

In 2000, 62,341 consumers received 74,929 CSDA-funded services on the snapshot day (see Box 7.8 for explanation of terms). Over one-third of consumers (34%) received an accommodation support service, and group homes were the most commonly used accommodation support service type (45% of accommodation consumers). A total of 17,373 consumers (28%) received an employment support service on the snapshot day, with about two-thirds of these (66%) using supported employment (Table 7.12; AIHW 2001b:Table 3.22).

Over a quarter of consumers (27%) used community support services and almost another quarter (24% or 14,658) used a community access service, with 56% of these using post-school options, social community support or access services. Respite services were used by only 4% of consumers on the snapshot day, with 44% of these being a centre-based respite service.

Table 7.12: Consumers of CSDA-funded services on a snapshot day, by service type and State/Territory, 2000

Service type	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total	%
Accommodation support	6,027	6,700	3,273	2,156	2,009	789	292	112	21,356	34.3
Community support	3,415	5,902	1,430	3,919	1,855	182	251	63	17,011	27.3
Community access	3,089	7,575	2,192	666	434	544	113	47	14,658	23.5
Respite	567	929	460	333	169	54	51	35	2,598	4.2
Employment	5,847	3,783	2,663	2,247	1,871	549	294	119	17,373	27.9
Total consumers	**16,441**	**21,104**	**8,324**	**8,004**	**5,566**	**1,719**	**864**	**354**	**62,341**	**100.0**

Notes

1. Consumer data are estimates after use of a statistical linkage key to account for individuals who have received more than one service on the snapshot day. Totals may not be the sum of the components since individuals may access more than one service type on the snapshot day. There were 35 consumers who accessed services in more than one State or Territory, mainly in 'border' towns.

2. Data for consumers of CSDA-funded services with the following service types were not collected: advocacy; information/referral; combined advocacy/information; print disability/alternate formats of communication; service evaluation/training; peak bodies; research/development; and other services.

3. Data provided by the Commonwealth are preliminary and cover 99% of Commonwealth-funded services.

Source: AIHW 2001a:Table 1.1.

Nearly three-fifths of consumers (36,353 or 58%) were male, which was similar to previous years. There was considerable variation between the sexes in service use patterns. In particular, males used employment services comparatively more frequently (64%) and community support services comparatively less frequently (54%; AIHW 2001b). Overall, the age distribution was similar for the two sexes, although females were slightly older on average, with a median age of 34 years compared to 32 years for males (Table A7.10).

The age pattern of consumers varied with service type: consumers of community support and respite services were generally much younger than those of accommodation, community access and employment (AIHW 2001b). From 1996 to 2000, there has been a consistent increase in the average age of recipients of accommodation services.[3] The median age increased from 36 to 39 and the peak age group shifted from 30—34 to 35—39 (Figure 7.4). There was a smaller increase in age for employment, community access and some respite services (AIHW 2001b).

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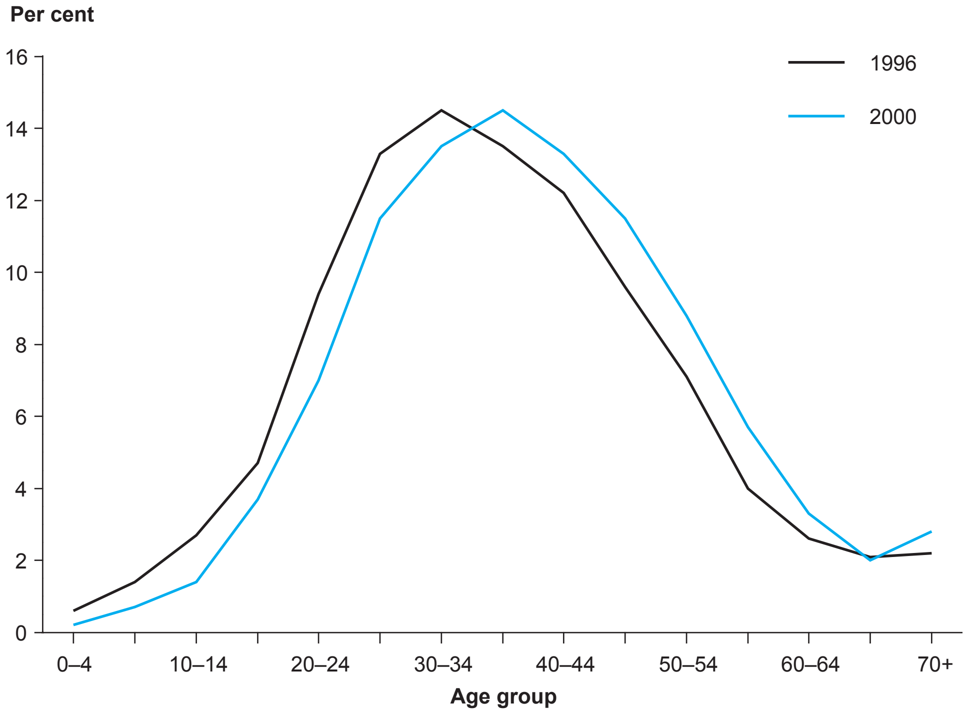
[3] For the first four CSDA MDS collections (1995–98), there was no way to determine consumer counts from the data on services received. Hence, trends in consumer characteristics in the 1996–00 period have to be examined at the level of services received or 'recipients'.



Note: Data for 1996 were weighted based on equivalent 1997 data to adjust for full-year data supplied by Western Australia in that year.

Source: AIHW 2001b.

Figure 7.4: Age trends for recipients of CSDA-funded accommodation support services on a snapshot day (proportion of all accommodation support recipients), 1996 and 2000

Three-fifths (60%) of people receiving CSDA services in 2000 had an intellectual disability as their primary disability (Table 7.13). The next most frequently reported were physical disability (12%) and psychiatric disability (9%). Since 1996 the proportion of CSDA recipients with a psychiatric disability or autism as their primary disability has increased (AIHW 2001b).

Overall, 1,629 or 2.6% of CSDA consumers (or 2.8%, excluding the 8% of consumers for whom Indigenous status was not known) were identified as being of Aboriginal or Torres Strait Islander origin or both (AIHW 2001b:Table 3.10). This figure is similar to their estimated representation in the population, which in 2000 was 2.4% of Australians aged less than 65 years (ABS 1998a). However, the proportion of Aboriginal or Torres Strait Islander consumers on the snapshot day varied from 1.7% for employment services to 5.7% for respite services (excluding consumers for whom Indigenous status was not known, and all Queensland consumers of whom 29% were of unknown Indigenous status; AIHW 2001b:Table 3.12).

Table 7.13: Consumers of CSDA-funded services on a snapshot day, by primary disability group and all significant disability groups, 2000

	Primary disability group reported for each consumer		All significant disability groups reported by consumers, including primary	
Disability group	**Number**	**% of all consumers**	**Number**	**% of all consumers**
Developmental delay	1,576	2.5	2,200	3.5
Intellectual	37,484	60.1	42,446	68.1
Specific learning/ADD	923	1.5	2,062	3.3
Autism	2,133	3.4	4,064	6.5
Physical	7,673	12.3	17,826	28.6
Acquired brain injury	2,285	3.7	3,122	5.0
Deafblind	168	0.3	518	0.8
Vision	1,359	2.2	5,930	9.5
Hearing	847	1.4	3,736	6.0
Speech	335	0.5	12,450	20.0
Psychiatric	5,381	8.6	9,323	15.0
Neurological	1,738	2.8	9,002	14.4
Not stated	439	0.7	439	0.7
Total	**62,341**	**100.0**	**112,679**	**. .**

Notes

1. Consumer data are estimates after use of a statistical linkage key to account for individuals who have received more than one service on the snapshot day.
2. Data for consumers of CSDA-funded services with the following service types were not collected: advocacy; information/referral; combined advocacy/information; print disability/alternate formats of communication; service evaluation/training; peak bodies; research/development; and other services.
3. The data for all significant disability groups reported adds to more than the total number of consumers since consumers may be counted in more than one disability group.
4. Data provided by the Commonwealth are preliminary and cover 99% of Commonwealth-funded services.

Source: AIHW 2001a:Table 3.5.

Compared to other consumers, those of Aboriginal and Torres Strait Islander origin reported a need for more frequent support in activities of daily living, that is in the areas of self-care, mobility and/or communication (Table 7.14). About two-thirds (887 of 1,360, or 65%, excluding Queensland consumers) of Indigenous consumers needed frequent or continual support with these activities, compared to 56% of non-Indigenous consumers (28,060 of 50,217).

Thus, it appears that Aboriginal and Torres Strait Islander consumers have higher support needs than other consumers of CSDA services. Therefore the provision of some disability support services to Indigenous people at higher rates per capita than for the non-Indigenous population could be considered well-targeted. These higher support needs may also indicate higher levels of unmet need in the Indigenous community than in the rest of the population, but it is not possible to draw this conclusion without better data on the distribution of disability in the Indigenous population.

Table 7.14: Consumers of CSDA-funded services on a snapshot day, by frequency of support needed in activities of daily living and by Indigenous status, 2000

	Indigenous		Non-Indigenous		Total	
Frequency of support needed	**Number**	**%**	**Number**	**%**	**Number**	**%**
None	133	9.8	7,226	14.4	7,676	14.2
Occasional	296	21.8	13,246	26.4	14,117	26.1
Frequent	364	26.8	11,368	22.6	12,197	22.6
Continual	523	38.5	16,692	33.2	17,837	33.0
Not stated	44	3.2	1,685	3.4	2,194	4.1
Total	**1,360**	**100.0**	**50,217**	**100.0**	**54,021**	**100.0**

Notes

1. Consumer data are estimates after use of a statistical linkage key to account for individuals who have received more than one service on the snapshot day.
2. Data for consumers of CSDA-funded services with the following service types were not collected: advocacy; information/referral; combined advocacy/information; print disability/alt; formats of communication; service evaluation/training; peak bodies; research/development; and other.
3. Totals include 2,444 consumers whose Indigenous status was not known or not stated.
4. Data for consumers in Queensland have not been included due to a high 'not known' rate of Indigenous status (29%).
5. Data provided by the Commonwealth are preliminary and cover 99% of Commonwealth-funded services.

Source: AIHW 2001a:Table 3.15.

Use of CSDA services

Most consumers (84%) received a service in only one of the five service type categories of accommodation, community support, community access, respite and employment, on the snapshot day. The other 16% received between two and four services in the different categories (AIHW 2001b). Table 7.15 shows the different combinations of service types. The shaded figures in the central diagonal show those consumers who used only one service type on the snapshot day in 2000. For example, 13,406 consumers used an accommodation service only and they were 63% of all consumers who used an accommodation service.

Consumers of community access and accommodation were the most likely to have used another service type (38% of consumers using community access services and 37% of those using accommodation services on the snapshot day used another service type). These two service types formed the most common combinations of multiple service usage.

The level and pattern of multiple service usage varied among consumers depending upon such characteristics as primary disability group, number of disabilities, method of communication, frequency of support needed for activities of daily living and main source of income. In particular, people with an intellectual primary disability were the most likely to have used more than one service type, and multiple service use tended to increase with the number of disability groups and the frequency of support needed (AIHW 2001b).

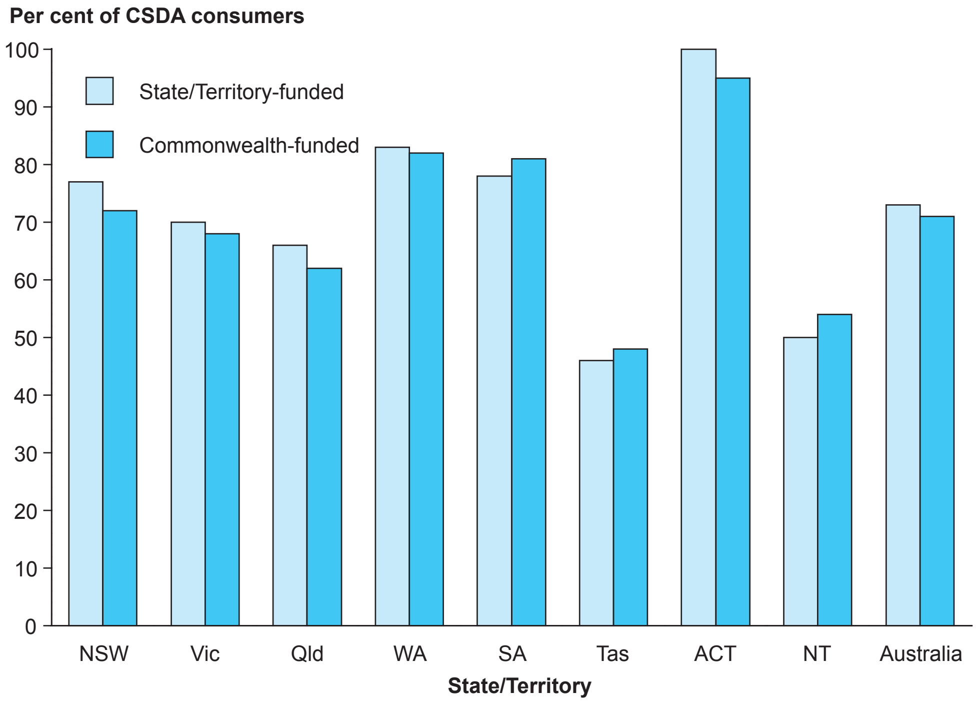
Table 7.15: Consumers of CSDA-funded services on a snapshot day, by service type combinations received, 2000

	Service type 1									
	Accommodation		**Community support**		**Community access**		**Respite**		**Employment**	
Service type 2	**No.**	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**
Accommodation	13,406	62.8	1,468	8.6	4,542	31.0	87	3.3	2,594	14.9
Community support	1,468	6.9	14,243	83.7	930	6.3	379	14.6	649	3.7
Community access	4,542	21.3	930	5.5	9,074	61.9	317	12.2	421	2.4
Respite	87	0.4	379	2.2	317	2.2	1,814	69.8	100	0.6
Employment	2,594	12.1	649	3.8	421	2.9	100	3.8	13,968	80.4
Total consumers	**21,356**	**100.0**	**17,011**	**100.0**	**14,658**	**100.0**	**2,598**	**100.0**	**17,373**	**100.0**

Notes

1. Consumers with service types 1 and 2 the same (shaded) are those consumers who used only one service type, for example, 13,406 consumers used an accommodation service only and they were 62.8% of all consumers who used an accommodation service.
2. Consumers with three or four service types are included under all relevant combinations. Thus numbers in a column do not necessarily add up to the total number of consumers.
3. Data provided by the Commonwealth are preliminary and cover 99% of Commonwealth-funded services.

Source: AIHW 2001a:Table 4.2.



Source: Table A7.11.

Figure 7.5: Consumers of CSDA-funded services on a snapshot day using only an urban service outlet, for State/Territory-funded and Commonwealth-funded services, 2000

The geographic distribution of outlets among urban, rural and remote areas is similar for State and Territory-funded services, and Commonwealth-funded services within each State and Territory (Figure 7.5). Apart from the Australian Capital Territory, which is almost all urban, Western Australia and South Australia had the highest proportion of consumers using urban-located service outlets (83% and 78% respectively for State-funded services, and 82% and 81% for Commonwealth-funded services), followed by New South Wales, Victoria and Queensland. Tasmania has by far the highest rural proportion (54% for State-funded, 52% for Commonwealth-funded), and the Northern Territory has the highest proportion of remote service outlets (50% and 46% respectively). These data will become more informative with the redeveloped CSDA MDS collection, with improved data on the location of all service users in the year, enabling a meaningful comparison with relevant population data.

CSDA accommodation support services: trends in use

The proportion of recipients receiving accommodation support services as group homes or in-home support (rather than in institutions and hostels) increased from 60% in 1995 to 71% in 2000 (Table 7.16). This proportion increased in the six States over the period, although in 2000 it varied from 52% for South Australia to 86% for Queensland. It has remained at 100% in the Australian Capital Territory since 1997 and in the Northern Territory since 1995.

The collection of the statistical linkage key in 1999 and 2000 makes it possible to match the services used by consumers on the snapshot day in both years (see Box 7.8). Such analysis suggests that there was little movement of consumers among the three major

Table 7.16: Consumers of CSDA-funded community-based accommodation support services on a snapshot day, by State/Territory, 1995–00

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Australia
				Percentage of all consumers of accommodation support					
1995	51.30	64.17	79.72	59.84	42.65	54.35	92.03	100.00	60.37
1996	53.96	66.40	77.08	65.95	46.51	54.35	n.a.	100.00	61.88
1997	53.94	70.27	79.55	58.19	46.60	56.07	100.00	100.00	62.93
1998	53.78	75.70	83.81	66.90	45.08	66.28	100.00	100.00	65.90
1999	57.21	75.73	84.95	73.43	45.63	68.94	100.00	100.00	68.84
2000	61.76	79.25	85.60	75.15	51.62	61.34	100.00	100.00	71.39

Notes

1. Community-based or 'in-home' accommodation support services are group homes, attendant care, outreach/other 'in-home'/drop-in support, alternative family placement, and other accommodation.
2. Data for consumers or recipients of CSDA-funded accommodation support services exclude services identified by jurisdictions as being psychiatric services.
3. Data for 1995–98 are numbers of services received by consumer. An individual may be counted more than once if they used more than one accommodation support service type on the snapshot day.
4. Data for 1999–00 are estimates of consumers after use of a statistical linkage key to account for individuals who have received more than one service on the snapshot day. Where the accommodation support service type was inconsistently recorded for the same consumer, the consumer was counted as not receiving a community-based service.
5. Data provided by the Commonwealth are preliminary and cover 99% of Commonwealth-funded services.

Source: AIHW 1997b: 21, 1999b:Table 5.11, 2000c:Table A5.12, 2000d:Table A.14; AIHW: Black & Maples 1998:Table 5.11; AIHW: Black et al. 1998:Table 5.11.

accommodation service groupings institutions and hostels, group homes and other forms of accommodation services (AIHW 2001b:Table 4.8) over 1999 to 2000. Instead, the growth in the number of consumers in group homes appears to have been mainly due to an influx of people who had not been using an accommodation service previously, or possibly may have been using an intermittent service not picked up on the snapshot day. Conversely, most of the decline in the numbers using institutions and hostels appears to be due to people previously using these services no longer using a CSDA accommodation service at all.

These service trends are consistent with trends in the living arrangements of CSDA service consumers from 1997 to 2000. Over this period, the proportion of consumers living with family members gradually increased, while the proportion of those living in institutional accommodation decreased (AIHW 2001b:Table 3.20).

The improved ability to monitor service trends is a vital policy tool in a climate where there is active debate about the value and appropriateness of varying service models (see also Chapter 4).

Other disability support services

Residential aged care and HACC

People who have a disability and are aged less than 65 years may have their accommodation and other support needs met through services within the aged care sector. Nationally, there were 6,151 such people in aged care homes in June 2000 (Table 7.17).[4] Of these 6,151 people, 4,976 were aged 50—64 years, of whom 161 were Aboriginal and Torres Strait Islander people.

Table 7.17: People aged less than 65 years living in aged care homes, by State/Territory of the home, 30 June 1997 – 30 June 2000

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Australia
					Number				
1997	2,136	1,374	1,111	534	318	157	60	78	5,768
1998	2,231	1,435	1,162	488	318	156	64	70	5,924
1999	2,302	1,482	1,202	525	313	151	54	65	6,094
2000	2,367	1,454	1,232	505	332	150	40	71	6,151
					Number per 100,000 population				
1997	39.0	34.1	36.8	33.2	25.0	38.1	20.9	43.1	35.4
1998	40.3	35.2	37.9	29.8	24.9	38.1	22.5	38.1	36.0
1999	41.2	36.0	38.6	31.5	24.5	37.1	18.9	34.9	36.6
2000	42.0	35.0	39.0	30.0	25.9	36.9	14.0	37.6	36.6

Note: Data for 1997 combine nursing homes and hostels. These categories of residential care were restructured from 1 October 1997 into a single program of residential aged care.

Source: AIHW 1998a:Tables 1.1 and 2.1, 1998b:Table 2.1, 1999c, 2000e, 2001b.

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[4] This compares with 5,702 people of all ages living, on snapshot day in 2000, in institutions and hostels funded under the CSDA (AIHW 2001b).

Overall, there were 37 residents aged under 65 years per 100,000 Australians of that age, varying from 14 in the Australian Capital Territory to 42 in New South Wales. There has been an increase in the proportion of the population under 65 years using aged care homes, from 35 in June 1997 to 37 in June 2000.

Of the 6,151 people aged under 65 in residential aged care, 6,004 were living permanently in aged care homes, accounting for 4.5% of permanent residents of all ages. Over 80% (4,855) were aged 50—64. However, there were 87 permanent residents aged 10—29. Permanent residents aged under 65 as a percentage of all permanent residents varied considerably among States and Territories, ranging from 2.5% in South Australia to 20.1% in the Northern Territory (Table 7.18).

Table 7.18: People aged under 65 years living in aged care homes, by age group and State/ Territory, 30 June 2000

Age (years)	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Australia
10–29	37	17	22	2	4	2	0	3	87
30–49	416	228	230	95	50	27	5	11	1,062
50–64	1,846	1,184	952	398	271	119	32	53	4,855
Total 10–64	**2,299**	**1,429**	**1,204**	**495**	**325**	**148**	**37**	**67**	**6,004**
Total 10–64 (% of all residents)	4.9	4.4	5.0	4.5	2.5	4.1	2.7	20.1	4.5

Note: 147 residents aged 10–64 years receiving respite care are excluded.

Source: AIHW analysis of data supplied by the Department of Health and Aged Care from the ACCMIS Warehouse.

The Home and Community Care (HACC) program also provides services for younger people with a disability and their carers. The services include home help and home maintenance, home nursing and personal care, delivered meals, transport and shopping assistance, paramedical services, home- and centre-based respite care, and advice and assistance of various kinds (see Chapter 6). While a new HACC Minimum Data Set is being implemented, the data will not be available for analysis until late 2001.

Rehabilitation and hearing services

CRS Australia (formerly known as the Commonwealth Rehabilitation Service) provides rehabilitation assistance to people aged 15—65 with disabilities. The aim is to maintain people with a disability in their current employment or return them to suitable employment. CRS Australia deals with people from a diverse set of disability groups. Over half of their clients have a physical disability and 25% have a psychiatric disability. Around 7% have an acquired brain injury (ABI), 5% an intellectual disability and 5% a sensory disability. CRS Australia provided programs to 17,759 new clients in the financial year 1999—00. Of the 8,560 clients who completed a rehabilitation program, a total of 6,108 (71%) achieved a durable employment outcome of 13 weeks or more (FaCS 2000b).

Australian Hearing is the sole government-funded provider of hearing services. In 1999—2000, Australian Hearing provided services to 108,447 pensioners and veterans, 43,321 children (aged under 21 years), and 7,219 COMCARE and CRS clients and Defence personnel. These figures included 12,046 adult clients (8% of all clients) who were identified as having severe/profound hearing loss and/or severe communication problems. The total 159,987 clients represented a 4% decrease from 1997—98 (Australian Hearing Services 2000).

The voucher system has operated since late 1997. This allows eligible clients (including Pensioner Concession Card holders, people on Sickness Allowance and those holding a Health Care Card) to obtain vouchers to receive services from any hearing service provider whether it be public or private. In 1999—00, almost 121,000 eligible adult clients received a Hearing Services Voucher (Australian Hearing Services 2000).

Table 7.19: People aged 5–64 years with a disability, by use of aid/equipment and by disability status, 1998

	Core activity restriction								**Total with disability**	
	Profound		**Severe**		**Moderate**		**Mild**			
	’000	**%**	**’000**	**%**	**’000**	**%**	**’000**	**%**	**’000**	**%**
Aid/equipment used										
Eating aids	14.2	7.0	*3.0	0.7	**0.5	0.1	**1.7	0.3	19.4	0.8
Showering aids	41.6	20.4	30.5	7.2	12.2	2.9	*4.3	0.7	88.6	3.8
Toilet aids	26.9	13.2	15.4	3.6	*5.0	1.2	**0.6	0.1	48.0	2.1
Incontinence aids	16.6	8.1	*6.6	1.6	*6.6	1.5	—	—	29.8	1.3
Dressing aids	14.6	7.1	10.0	2.4	**2.1	0.5	—	—	26.7	1.1
Electric wheelchair/scooter	13.9	6.8	*2.9	0.7	**0.1	0.0	**1.2	0.2	17.9	0.8
Manual wheelchair	26.7	13.1	*7.9	1.9	**0.9	0.2	**1.8	0.3	37.2	1.6
Cane	*6.3	3.1	*4.1	1.0	**1.8	0.4	**1.1	0.2	13.4	0.6
Crutches/walking stick	13.9	6.8	37.5	8.8	14.4	3.3	*5.7	0.9	71.4	3.1
Walking frame	12.1	5.9	*3.1	0.7	**0.9	0.2	**0.9	0.1	17.0	0.7
Seating/bedding aids	14.4	7.1	19.0	4.5	*5.3	1.2	—	—	38.7	1.7
Car aids	*7.3	3.6	*3.2	0.7	**0.7	0.2	**0.2	0.0	11.3	0.5
Other mobility aids	13.5	6.6	17.7	4.2	*7.0	1.6	*3.7	0.6	41.9	1.8
Reading/writing aids	16.6	8.1	13.9	3.3	**2.0	0.5	*8.7	1.4	41.2	1.8
Speech aids	*7.5	3.7	**0.9	0.2	**0.3	0.1	**0.7	0.1	9.4	0.4
Mobile/cordless phone (communication)	26.2	12.8	57.7	13.6	32.5	7.6	26.0	4.1	142.4	6.1
Fax machine (communication)	*3.7	1.8	11.5	2.7	*4.5	1.1	*5.7	0.9	25.4	1.1
Meal preparation aids	13.3	6.5	15.7	3.7	*4.5	1.1	*4.2	0.7	37.7	1.6
Medical aids	67.9	33.2	161.7	38.1	151.7	35.3	150.1	23.7	531.3	22.7
Total	**204.3**		**424.2**		**430.1**		**631.9**		**2,340.0**	

Notes

1. Estimates marked ** are subject to sampling variability too high for most practical purposes. Estimates marked * have an associated relative sampling error of between 25% and 50%. These estimates should be interpreted accordingly.
2. Aids or equipment used are those needed because of disabling conditions.
3. Reading/writing and speech aids include both low and high technology aids.
4. Totals are not the sum of the components because more than one aid or piece of equipment may be used by each person, or because people with schooling or employment restriction are included.

Source: AIHW analysis of ABS 1998 Survey of Disability, Ageing and Carers.

Equipment services

The use of aids and equipment can substantially improve function and reduce or resolve difficulties in task performance (Verbrugge et al. 1997; Verbrugge and Sevak, in prep.). Compared to personal assistance, equipment use may be associated with feelings of autonomy and self-sufficiency, may be adapted to specific functional problems, and may be more readily to hand when needed.

A total of 936,600 people with a disability and aged 5—64 years used aids and equipment in 1998 (AIHW 1999a). Medical aids were the most common form of aid or equipment, used by 22.7% of people with a disability (Table 7.19). Communication aids mobile or cordless phones (6.1%) and fax machines (1.1%) required due to condition were the second most used form, followed by crutches/walking sticks (3.1%) and showering aids (3.8%).

People with profound restrictions were more likely to be using aids and equipment than were other disability groups. Use of aids for showering (20.4%), the toilet (13.2%), eating (7%) and other self-care requirements was higher, as was the use of mobility aids such as manual wheelchairs (13.1%).

Relevant generic services

People with a disability use the same services that all members of the community require and use. It is only possible here to report on some generic services that are perhaps of special relevance. Some other chapters report on access to services by people with a disability. Chapters 3 and 8 on housing and homelessness do so (see some highlights following) and Chapter 5 on child care, where it is noted that the proportion of children with a disability in child care was lower than their proportion in the general population (Table 5.12 and related discussion).

Health services

While people with a disability have frequently wished to distance themselves from a medical model of disability, it is nevertheless recognised that, when they are sick, they need access to appropriate health services (see, for example, Parmenter 2000). This need occurs whether people are in residential care or in the community.

A recent review of the 211 deaths of people with disabilities who died in care in New South Wales between 1991 and 1998 pointed to a range of improvements needed to avoid premature death: the need for health screening and reviews by health professionals, for better training of other staff and for adequate monitoring systems, for instance in the handling of epilepsy (NSW Community Services Commission 2001).

As systems promote deinstitutionalisation, it becomes crucial to ensure that the health needs of vulnerable people in the community can be ascertained and met. The health status of people with intellectual disability in a Sydney area has been suggested to be considerably worse than the rest of the population in Australia (Beange et al. 1995) and there have been more recent, similar findings in the United States of America (Horwitz et al. 2000).

People with mental illness often have associated disabilities. Almost one in five adult Australians were found to have had a mental disorder at some time during the 12 months prior to an ABS survey in 1997 (ABS 1998b). Of these, 44% had mild, moderate or severe disability , as measured by the Brief Disability Questionnaire. Only a small proportion of people with mental disorders now spend extended periods in psychiatric hospitals or residential facilities; most are cared for in the community. There were 1,301 available beds in public community residential mental health care services that were staffed for 24 hours a day (AIHW 2001c).

There is generally no systematic information on the experience of people with disability in the health service system.

Education and training

Students with disabilities may attend special schools or mainstream schools, either in regular classes or in special or support units or classes. Enrolment in special education settings, both in mainstream and special schools, requires formal assessment of the student in terms of severity of disability and need for support. Students with a range of profound, severe or multiple disabilities can enrol in special schools, although in South Australia only students with intellectual disabilities can be enrolled. Jurisdictional variation occurs in services provided and the definitions of disability used to regulate eligibility for education support funding. In some jurisdictions, such as Tasmania, full education support funding is only available to students with severe disabilities, excluding students with lower support needs from the data. In New South Wales, specialised support may be provided in any of the settings by itinerant teachers; this applied to 780 students with vision impairment and 1,089 students with hearing impairments not included in Table 7.20.

There were 97,546 students recorded with disabilities in 2000: 77,977 in government schools, of whom 81% attended mainstream schools, and 19,569 attending non-government schools, of whom 91% attended mainstream schools (Table 7.20). Variation between jurisdictions in the proportion of students attending mainstream schools in the government sector was marked: from 65.3% in Victoria to 97.2% in the Northern Territory. This may reflect the variation in the availability of special schools and the different integration policies in place.

Students with a disability as a proportion of all students attending government and non-government schools ranged from 0.9% in Tasmania to 10.6% in the Northern Territory. In all jurisdictions, attendance was greater in government schools than in non-government schools, with the exception of Tasmania.

Post-school education data are available for apprentices and trainees. In 1999, a total of 63,200 apprentices and trainees enrolled in a course or completing a qualification were reported as having a disability (Australian National Training Authority 2000). The national percentage of trainees and apprentices with a reported disability was 3.8%, with State and Territory percentages ranging from 2.5% in Western Australia to 4.8% in New South Wales and the Australian Capital Territory. Physical disabilities were the most common form of disability reported (22%), followed by visual (18.2%), intellectual (14.1%) and hearing disabilities (11.7%). Chronic illnesses were also classified as a disability type.

Section 7.4 provides information on trends in education participation among people aged 5—20 years with a disability.

Table 7.20: Students with disabilities attending government and non-government schools, by State/Territory, 2000 (full-time-equivalents)

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total
Government schools									
Mainstream	24,748	10,142	8,213	3,746	10,009	382	1,153	4,894	63,287
Special	3,620	5,396	2,304	1,938	855	152	284	141	14,690
Total	*28,368*	*15,538*	*10,517*	*5,684*	*10,864*	*534*	*1,437*	*5,035*	*77,977*
Percentage attending mainstream schools	87.2	65.3	78.1	65.9	92.1	71.5	80.2	97.2	81.2
Percentage of all government school students	3.8	2.9	2.4	2.1	6.1	0.8	3.8	12.5	3.4
Non-government schools									
Mainstream	7,559	3,903	2,292	1,270	2,032	249	271	212	17,788
Special	1,039	470	100	19	139	13	1	0	1,781
Total	*8,598*	*4,373*	*2,392*	*1,289*	*2,171*	*262*	*272*	*212*	*19,569*
Percentage attending mainstream schools	87.9	89.3	95.8	98.5	93.6	95.0	99.6	100.0	90.9
Percentage of all non-government school students	2.6	1.6	1.3	1.3	2.9	1.3	1.2	2.5	1.9
Total students with disabilities	**36,966**	**19,911**	**12,909**	**6,973**	**13,035**	**796**	**1,709**	**5,247**	**97,546**
Total all students ('000)	1,082.7	805.3	610.7	364.3	253.0	90.0	60.3	48.7	3,315.0
Percentage of all school students	3.4	2.5	2.1	1.9	5.2	0.9	2.8	10.6	2.9

Notes

1. Full-time equivalent (FTE) students are not the actual number attending. For example, a student attending for half the normal school hours will be half a FTE student. The number of enrolled students will normally be greater than the number of FTE.

2. Data for non-government schools include students at kindergarten level. Data for government schools in New South Wales include students at kindergarten level; in Victoria, exclude students at kindergarten level and in early special education facilities; in Queensland, exclude students at kindergarten level and may include students at early special education facilities depending on where they are based; in Western Australia, include students at kindergarten or pre-primary level; in South Australia, exclude students at preschools; in Tasmania, include students at kindergarten level but exclude students in early special education facilities; in the Northern Territory, include students at preschools; and in the Australian Capital Territory, include students at kindergarten or pre-primary level.

3. Data for government special schools in Western Australia include education support schools and education support centres.

Source: DETYA 1998 Non-government Schools Census, unpublished data; and data provided by State education authorities (NSW Department of Education and Training, Education Victoria Office of Schools, Education Queensland, Department of Education Training and Employment (South Australia), Education Department of WA, Department of Education, Tasmania, ACT Department of Education and Community Services, NT Department of Education).

Employment assistance

From 1 May 1998, Centrelink became responsible for assessing and referring all eligible job seekers to appropriate employment assistance services. Centrelink staff use the Job Seeker Classification Instrument (JSCI) to identify the relative difficulty that job seekers have in gaining employment and to classify the level of assistance they should receive (DEWRSB 1998:2). Job seekers identified by certain trigger questions in the JSCI process are referred to a Centrelink Disability Officer for a secondary classification process, generally undertaken using the Work Ability Tables, or WATs. These tables determine the impact of a job seeker s disability on their capacity to work. Job seekers with severe to moderate disability impacts are streamed to CSDA-funded specialist disability employment services (see Tables 7.10—7.15). Those with milder disabilities are considered for access to the Job Network, funded by the Department of Employment, Workplace Relations and Small Business.

During the period 1 October 1999 to 30 September 2000, 77% (52,972) of job seekers who were classified using the JSCI and the WATs, were referred to CSDA-funded specialist disability employment services. The remaining 23% (15,692) of job seekers were assessed as having a disability of a low to moderate impact on their ability to work and were referred to Job Network (DEWRSB unpublished information).

The vast majority of job seekers with a disability do not undergo the WATs and are streamed directly to Job Network, where in 1999 they comprised approximately 15.5% of the total Job Network register (DEWRSB 2000a). The Job Network provides three major types of employment service: Intensive Assistance, Job Search Training and Job Matching (DEWRSB 2000a). Intensive Assistance generally provides up to 12 months of personalised assistance to a disadvantaged job seeker (DEWRSB 2001). Post-assistance outcomes for people with disabilities accessing these Job Network services appear to be poorer than for the Job Network population as a whole: nearly one-third (33.1%) of people with disabilities receiving Intensive Assistance achieved positive outcomes (employment or education/training), compared with 42.5% of all Intensive Assistance participants; 44% of those receiving Job Search Training, compared with 51% overall; and 54.9% of those receiving Job Matching assistance, compared with 70.6% of overall (DEWRSB 2000b).

Housing and homelessness

Some data on housing services and assistance for people with a disability are provided in Chapter 3 (see Tables 3.13, 3.16, 3.17). In June 2000, 17% (157,169) of the total number of income units receiving FaCS Commonwealth Rent Assistance were recipients of Disability Support Pension. During 1999—00, 44.6% of housing allocations were made to households with special needs, including people with a disability. Of households that rated dwelling modifications for special needs as important, 74% had their needs met, and of households that rated ease of access and entry to dwelling as important, 89% had their needs met.

The Housing Ministers Advisory Committee (2000) has established a working group to address issues associated with the accommodation and support requirements of people with complex needs. People with a disability are included in the target client group with complex needs.

Homelessness among people receiving disability pensions is discussed as a feature of Chapter 8 of this report. People receiving disability pensions accounted for 17% of people using supported accommodation services under the Supported Accommodation Assistance Program. They reported financial difficulty (48%) more often than any other reasons for seeking assistance, and were more likely than other groups to report psychiatric illness, and drug and alcohol abuse, as reasons for seeking assistance (see Table 8.10).

Informal assistance

In 1998, 450,900 people, or 2.4% of the total population, were primary carers. A primary carer is defined as the person who provides the most informal assistance to a person with one or more disabilities (ABS 1999). Of primary carers, 78.6% were aged under 65 years and 70.4% were females (AIHW 2000b). Some 247,000 primary carers were caring for a main recipient aged less than 65 years (AIHW 1999a:Table A7.6).

Informal carers were the main source of assistance with self-care, mobility and communication for more than 80% of people with a severe or profound restriction and living in households. In 1998, 9,700 parent primary carers were aged 65 years or over. Most ageing parent carers (8,800) were mothers living with a son or daughter. Many carers had been in their caring role for a long time: 40% (178,300) for at least 10 years and 13% (59,600) for at least 25 years. Thirty-six per cent of primary carers (161,300) spent, on average, 40 hours or more per week providing care (AIHW 2000b:Tables 16.2, 16.4).

There are many positive aspects of caring. Regarding their relationship with their main care recipient, 32.7% of primary carers said that they had been brought closer together and 39.7% said that their relationship remained unaffected. More than half (55.3%) reported that their caring role had not affected their friendships with others (AIHW 2000b:Table 16.8).

However, many primary carers reported that the caring role impacted on their financial situation, their relationships with others, and their health and wellbeing. Nearly a quarter said that they had lost or were losing touch with existing friends, and 22% said that their relationship with the main care recipient had become strained as a result of the caring role. Nearly 30% of primary carers reported difficulty in meeting living costs. About 34% said they frequently felt weary or lacked energy, and 17% said that they felt angry or resentful, due to their caring role. Over 10% reported a stress-related illness. Nearly half of primary carers relied on a government pension or allowance as their principal source of income, compared with 20% of those who were not in a caring role (AIHW 2000b:Tables 16.5, 16.8, 16.9, 16.10).

In 1998, 24,100 (9.7%) primary carers of recipients aged under 65 reported that they needed assistance but did not receive any, and 39,200 (15.8%) needed more assistance than they currently received (Table 7.21). Over 150,000 (60.8%) reported that a fall-back carer was available, but 77,900 (31.5%) did not have a fall-back carer.

Most primary carers (86.9% or 215,000 people) had never received respite care services, and the majority of them (191,400) stated that they did not need or want such services. However, 23,600 said that they needed respite services but had never received them. Some 22,600 (9.1%) had used respite care services and, of them, 13,900 (5.6%) needed more assistance.

Table 7.21: Primary carers aged over 14 years of people aged under 65 years, by age group of carer and whether assistance is needed and received, 1998

	15–64 years		65+ years		Total 15+ years	
	No.	**%**	**No.**	**%**	**No.**	**%**
Need for and receipt of assistance						
Receives assistance and:						
- does not need further assistance	70,100	30.4	*4,900	29.3	75,000	30.3
- needs further assistance	35,500	15.4	*3,700	22.1	39,200	15.8
Does not receive assistance and:						
- does not need assistance	102,500	44.4	*6,700	40.1	109,200	44.1
- needs assistance	22,700	9.8	**1,400	8.5	24,100	9.7
Total	**230,700**	**100.0**	**16,800**	**100.0**	**247,500**	**100.0**
Availability of a fall-back carer						
Available	142,400	61.7	*8,000	47.7	150,400	60.8
Not available	70,300	30.5	*7,600	45.4	77,900	31.5
Don’t know if available	18,000	7.8	**1,200	6.9	19,200	7.8
Total	**230,700**	**100.0**	**16,800**	**100.0**	**247,500**	**100.0**
Need for and receipt of respite care						
Received in the last three months and:						
does not need further care	*8,700	3.8	—	—	*8,700	3.5
needs further care	12,600	5.5	**1,300	7.6	13,900	5.6
None received in the last three months and:						
- does not need care	*4,600	2.0	**2,100	12.6	*6,700	2.7
- needs care	*3,200	1.4	—	—	*3,200	1.3
Total received in the last three months	*21,300*	*9.2*	***1,300*	*7.6*	*22,600*	*9.1*
Never received respite care and:						
- does not need or want care	179,700	77.9	11,700	70.0	191,400	77.3
- needs care	21,900	9.5	**1,700	9.9	23,600	9.5
Total never received respite care	*201,600*	*87.4*	*13,400*	*79.8*	*215,000*	*86.9*
Total	**230,700**	**100.0**	**16,800**	**100.0**	**247,500**	**100.0**

Notes

1. People being cared for are main care recipients aged under 65 years with a severe or profound disability.
2. Numbers are estimates rounded to the nearest thousand carers. Estimates marked with ** have an associated relative standard error (RSE) of 50% or more. Estimates marked with * have an associated RSE of between 25% and 50%. These estimates should be interpreted accordingly.

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

7.4 Outcomes

Outcomes for people may be measured as broad status indicators relating, in the disability services field, to a person’s quality of life and participation in various life domains. They may also be measured in a service-specific context, to relate to service goals and to gauge service effectiveness. The latter outcome indicators are less well defined nationally in the disability services field, but significant progress has been made over the last two years. This section outlines this progress, in particular the agreement on an enhanced framework for indicators. Data for some service-related outcomes are presented, followed by some data on trends in participation outcomes for people with a disability.

An indicator framework

An indicator framework for the disability services field has now been developed by the AIHW in partnership with disability administrators, and accepted as the basis for further work in the CSDA MDS redevelopment (AIHW 2000f). The framework is depicted in two main diagrams (Figures 7.6, 7.7).

A broad contextual framework

First, a broad indicator framework reflects the person in society, those components of their wellbeing that are relevant to the disability services field, and the personal and environmental factors that also affect them (Figure 7.6). This framework reflects and synthesises high-level themes and goals in the disability field nationally and internationally:

- High-level goals are well articulated in the disability services field in Australia, most particularly in the main goal statement of the 1998 CSDA (Clause 4(1)):

  > The Commonwealth and the States strive to enhance the quality of life experienced by people with a disability through assisting them to live as valued and participating members of the community.

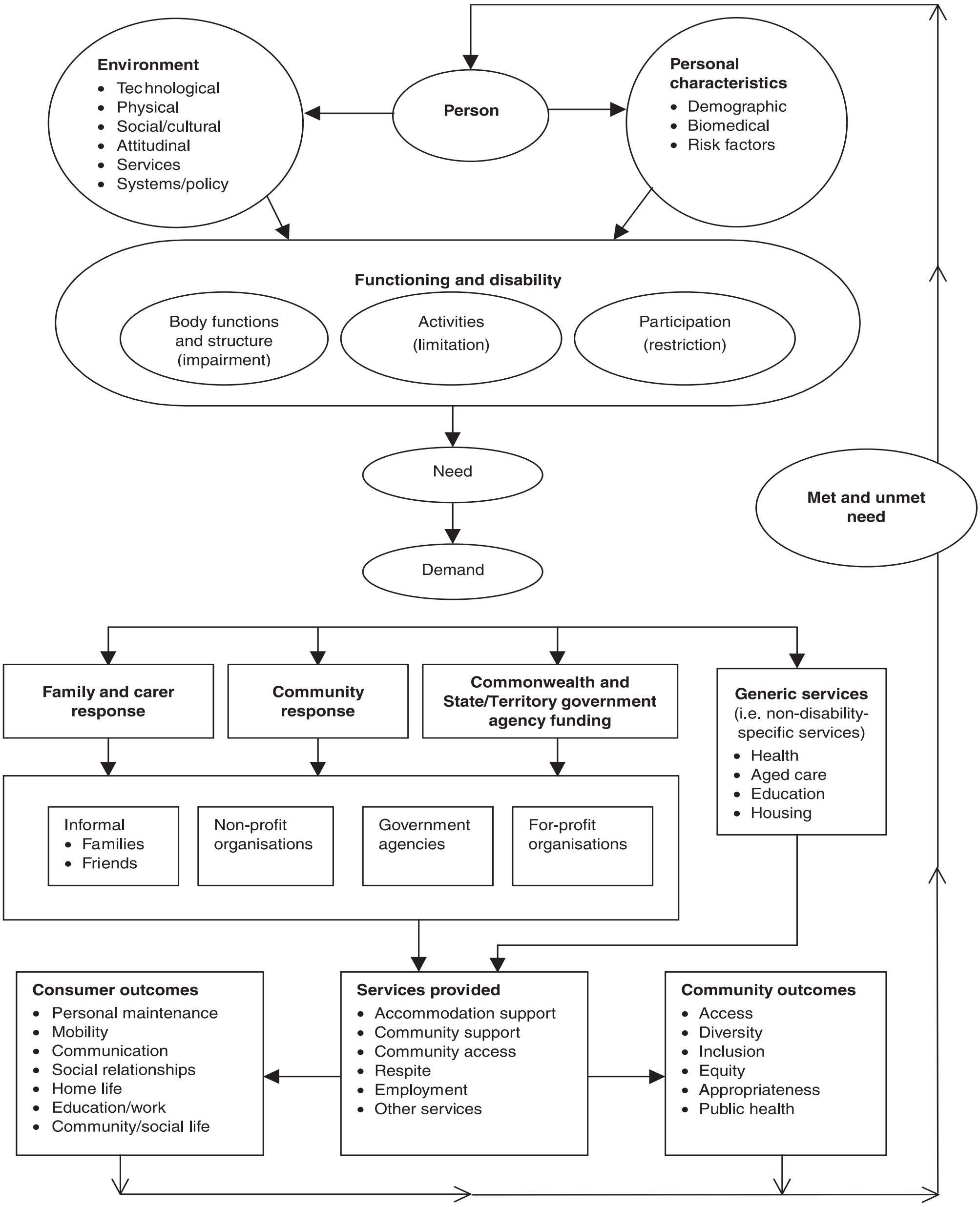
- The themes of participation and quality of life are reflected strongly in many jurisdictional policy statements and in the National Disability Standards.
- The United Nations Standard Rules on the Equalization of Opportunities for Persons with Disabilities (UN 1994:8—9) also highlight participation as a key goal:

  > In all societies of the world there are still obstacles preventing persons with disabilities from exercising their rights and freedoms and making it difficult for them to participate fully in the activities of their societies. It is the responsibility of States to take appropriate action to remove such obstacles.

- The conceptual framework of the new ICF (see Box 7.1) which is recognised as relating to the UN Standard Rules (1994).

Participation and quality of life should clearly, then, be the themes of indicators of outcomes for people with disabilities. The framework offered by the ICF classification can be used for monitoring broad participation outcomes in the population and for the construction of performance indicators for disability services; this framework is represented in the Figure 7.6 under Functioning and disability .

The social system of services and assistance formal and informal, government and non-government is depicted in the lower half of the diagram. Three categories of outcomes are represented: consumer outcomes, community outcomes and service-related outcomes. These three categories should be related.



Source: AIHW 2000f.

Figure 7.6: Major players and structures in the disability services field

Individual (consumer) outcomes

Individual outcomes in the disability services field should be defined in terms of broad participation in the community. In a specific service setting, service goals that relate to the specific enhancements of participation and quality of life shape the specific form of the indicators.

Many jurisdictions are moving on defining consumer outcomes, in areas where they consider that services may affect these outcomes. Victoria has tested a question on consumer participation in various life domains in the course of the redevelopment of the CSDA MDS collection, the question being based on trial items in the National Community Services Data Dictionary (DHS Victoria 2000; AIHW 2000a). There are well-recognised difficulties in attributing outcomes to service interventions, and complexities in measuring outcomes with a broad focus and subjective components, such as quality of life and participation (AIHW 2000f). The alternative is to maintain a narrower, service-oriented focus. Under the Commonwealth's proposed case-based funding trial, payments to service providers are based on the achievement of employment outcomes for individuals. Employment outcome is defined as work of at least 8 hours per week and at a wage which is either award-based or part of a legal industrial agreement, or self-employment. Payments are linked to the amount of time an individual has been in employment. Thus, client outcomes are defined specifically to relate to one area of participation (i.e. paid work). Taking this approach, achievement of outcomes can be assessed, and more probably attributed to the service intervention. Concerns have nevertheless been expressed about the performance indicators used, the possible incentives to move high support needs clients out of employment services and into activity services, and the quality of the employment outcomes achieved (see, for instance, Knowles 2001; DICE 2001).

With the rise of consumer-based funding models, there is a trend towards individuals being involved in specifying their own outcome goals, against which service outputs are purchased (for instance, the Adult Lifestyle Support program in Queensland, Individual Service Plans in the Australian Capital Territory, and the Post School Options program in Tasmania AIHW 2000f).

Community-level outcomes

Community-level outcomes should reflect an aggregation of individual consumer outcomes, plus factors that can only be measured at the community level, such as community attitudes to disability and equity of access to services. They commonly incorporate notions of participation, rights and inclusion. Such outcomes, articulated by governments, are often about providing access to appropriate services that will help improve the quality of life of people with disabilities.

Service-related outcomes

Service funding and administration have undergone considerable change over the last 10—15 years; in particular, models of commercial or market practice have been integrated into the funding relationships and processes. Service providers funded by government are often required to report on achievement of outcomes, to demonstrate accountability. Information on outcome achievement may also be used for internal service management purposes. A distinction can be made between service provider outcomes and service-level outcomes (AIHW 2000f). Service-level outcomes are based on aggregations of individual outcomes, and thus reflect how well a service is achieving outcomes for its clients. Service provider outcomes, in contrast, relate to how a service is conducting its business. A service provider outcome may be improved efficiency, or compliance with quality standards. There should be a relationship between these two, because a service agency that is conducting its business well might be expected to be better at delivering outcomes to its clients.

Increasingly, service agreements between funding bodies and service delivery agencies specify outcome of the purchased activity. These outcomes frequently focus on outcomes for clients, such as health, safety, rights and opportunities, friendships, employment, flexibility and appropriateness of the service for the client, and client satisfaction with the service. The push for systems that have a focus on client satisfaction is geared to achieving positive outcomes for clients in a more contestable and accountable service market .

Service-related outcomes may be aggregated to program-level outcomes as well as to community outcomes (see also Chapter 9).

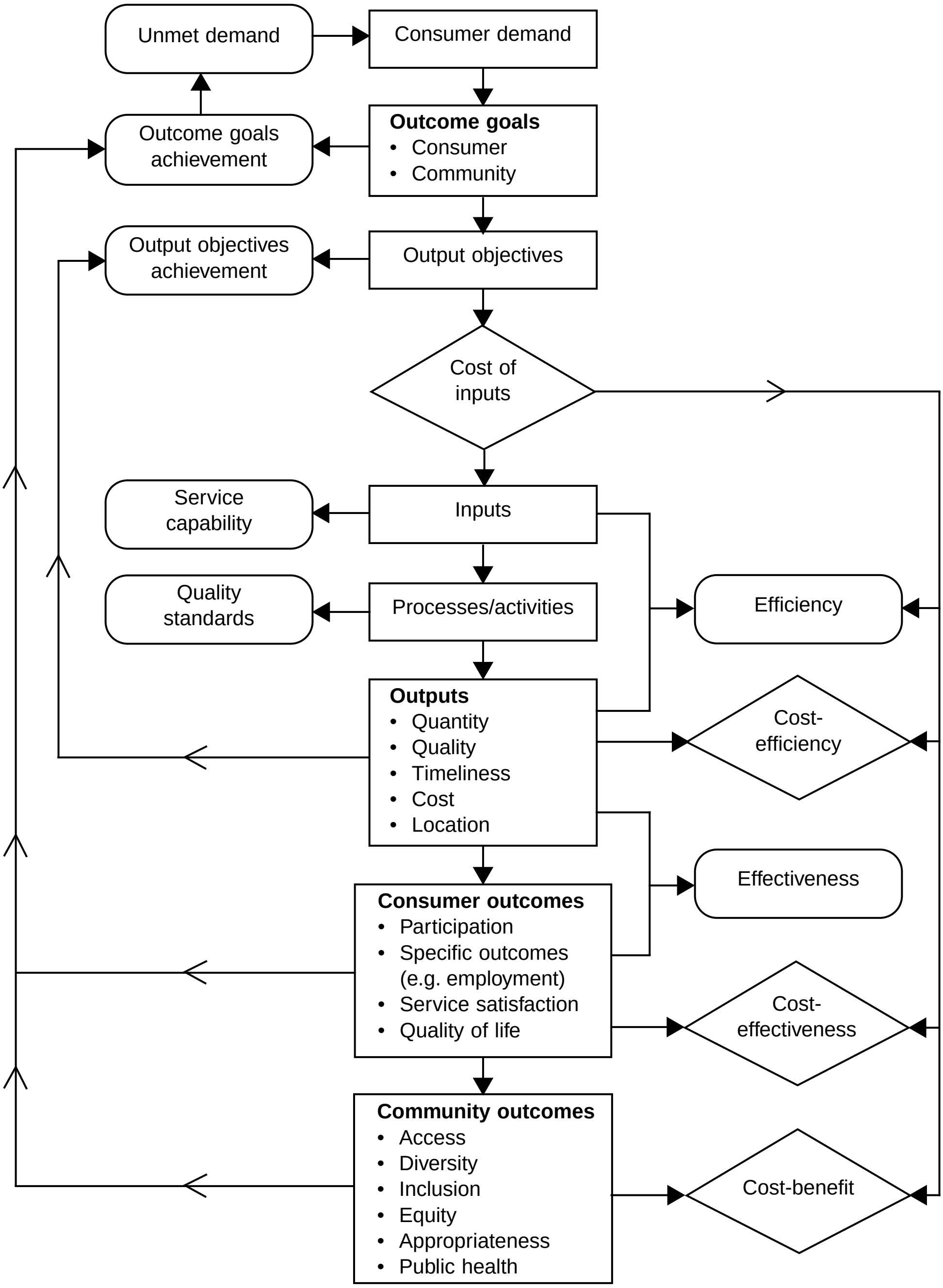
A performance indicator framework

The second part of the new indicators framework for the disability services field is the performance indicator framework (Figure 2.3 in AIHW 2000f), which expands on the lower half of Figure 7.6 and illustrates the relationships between performance-related concepts and measures.

The central column of Figure 7.7 shows flowing from consumer demand outcome goals (often specified at whole-of-government level) and output objectives (specified at program level or in service funding contracts), which determine the service outputs purchased. Service or program funding is used to purchase inputs (resources) which, through service processes or activities, are used to produce outputs (goods or services). From a performance perspective, there may be interest in measuring or assessing the quantity, quality, timeliness and cost of outputs produced, and perhaps also where the outputs were provided (i.e. location). The quality of service processes (as distinct from outputs) may also be assessed, perhaps against specific quality standards.

Service outputs contribute to outcomes for consumers, which may be defined narrowly (e.g. finding a job) or more broadly (e.g. quality of life). Community outcomes reflect an aggregation of individual consumer outcomes, plus factors that can only be measured at the community level, such as community attitudes to disability. These other factors may potentially be influenced by disability services.

The boxes in the right-hand column represent performance indicators of efficiency (the rate of translation of inputs into outputs), effectiveness (the rate of translation of outputs into outcomes), and various related measures that involve an element of cost (represented by diamond-shaped boxes).



Source: AIHW 2000f.

Figure 7.7: Performance indicator framework

On the left side of the figure, performance indicators related to the achievement of output objectives and outcome goals are represented. Output objectives may be specified not only in terms of the quantity of outputs produced, but also in terms of the quality, timeliness and, in some cases, where the outputs are delivered (i.e. location). The extent of achievement of outcome goals is expected to impact on the level of unmet demand in the community or the target population.

Some service-related outcomes

National Disability Administrators, during the redevelopment of the CSDA MDS, are working with the AIHW to improve performance indicators for disability services in Australia. It is anticipated that these efforts, together with ongoing work in the context of the Report on Government Services, will continue to improve the quality of reporting on services and outcomes in the future.

Some highlights of current service-related outcome indicators information include:

- greater use of community-based or in-home accommodation support services, rather than institutional: the proportion of recipients receiving community-based or in-home support increased from 60% in 1995 to 71% in 2000 (Table 7.16); and
- a national client satisfaction survey sponsored by disability administrators: despite the acknowledged difficulties of such a methodology, there were some interesting results, including an overall satisfaction level of 75—85% among CSDA clients and 65—76% among their families (E-Qual and Donovan Research 2000).

Access to services

Access to services is an important indicator of service or program outcome.

National studies, based on 1993 data, were commissioned to examine the level of unmet demand for disability support services funded or provided under the CSDA (e.g. AIHW 1997c). Additional funds of $510 million have since been allocated to CSDA services by Australian governments (Newman 2000a; Section 7.3).

In 1998, 958,000 people with a severe or profound restriction living in households reported the need for assistance with at least one of the 10 activities listed in Table 7.2. A substantial number of people with a severe or profound restriction in 1998 reported no main provider of assistance with activities of mobility (46,700), self-care (40,700), property maintenance (31,000), health care (28,400) and transport (22,200) (AIHW 2000b). Health care, property maintenance and housework were the activities with which people were most likely to rely on formal services as their main source of assistance.

Government organisations played a greater role than non-government organisations as the main formal service providers for core activities, in particular mobility and communication. Private organisations, in particular private for profit organisations, were more likely to be the main providers of formal services with health care and property maintenance (AIHW 2000b:Table 15.7).

Support services and other resources play an important role in reducing the stress of carers, particularly among ageing carers. However, in 1998, 24,100 primary carers of main recipients aged under 65 reported that they needed assistance but did not receive any, and 39,200 needed more assistance than they currently received. Some 23,600 primary carers needed respite services but had never received them (Section 7.3).

Outcomes for people with a disability

The previous edition of this biennial report presented information on participation outcomes for people with a disability in various life domains: living arrangements, housing, self-care, self-perceived health, mobility and transport, communication, social relationship and community life, time use and leisure, education, employment and economic life (AIHW 1999a:255—63).

This section uses available time-series data from the four ABS disability surveys to examine some trends in community living, employment status and school attendance among people with a disability for almost two decades.[5]

Trends towards community living

Living in community settings is a common goal of people with a disability and increasingly an explicit goal of service programs. There is a continuing shift from residential care to community care in the fields of aged care, disability services and mental health, although there are some variations between the fields in terms of how this shift is occurring (Chapter 4; AIHW: Madden et al. 1999). The sense of inclusion in the community, as well as residence there, is more difficult to measure.

Marked increases in the number and proportion of people with a severe or profound restriction living in households have been reported previously, based on comparative analyses of data from the ABS 1981, 1988 and 1993 disability surveys (AIHW 1997a, 1997c; AIHW: Wen & Madden 1998). The most recent survey (1998) showed that the trend towards community living has continued (AIHW 1999a).

For almost two decades (1981—98), there has been a consistent increase in the rates of people living in households and a decline in the rates of living in institutional-style cared accommodation[6] among people aged under 65 with a severe or profound restriction (Figure 7.8). The largest increase in community living was in the rate and number of people with a severe or profound restriction living with their families (Table A7.12; AIHW: Wen & Madden 1998). The increase in the number of people living in the community was markedly greater than the decrease in the number of those living

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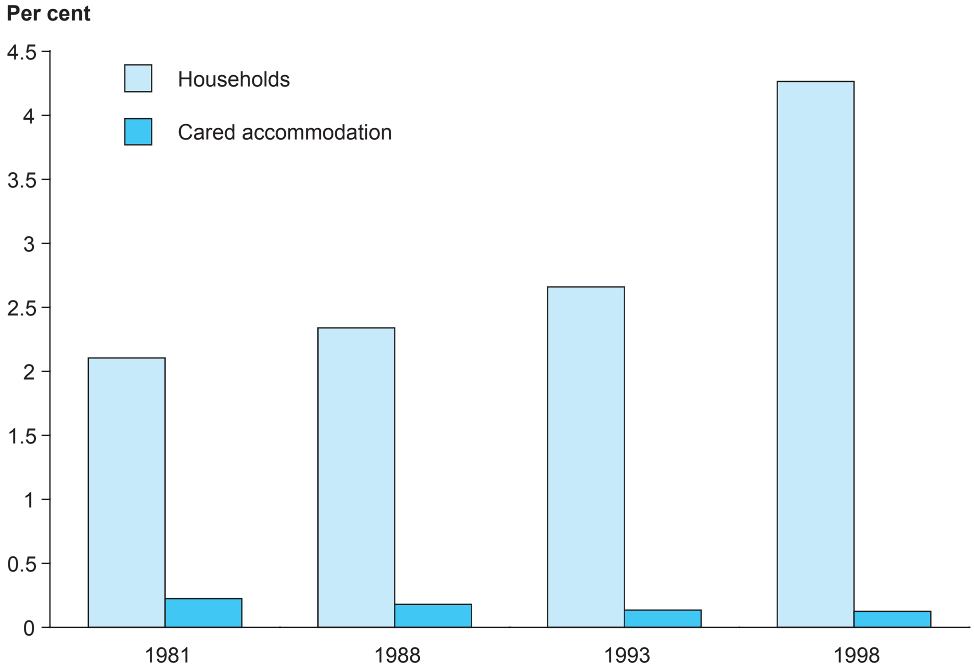
[5] The 1993 and 1998 disability survey data were re-derived using definitions as close as possible to the definitions of the 1981 and 1988 disability surveys. However, some of the changes between surveys are difficult to be controlled for (see Section 7.2).

[6] 'Cared accommodation' in the survey includes hospitals, aged care homes and cared components of retirement villages, and other 'homes', such as children's homes. Smaller disability group homes (with fewer than six people) were not included in the cared accommodation component (ABS 1999).

in cared accommodation (AIHW 1999a:Table 7.19). The large difference suggests that these reflect non-institutionalisation, that is, people staying in the community throughout their life rather than ever living in an institution.

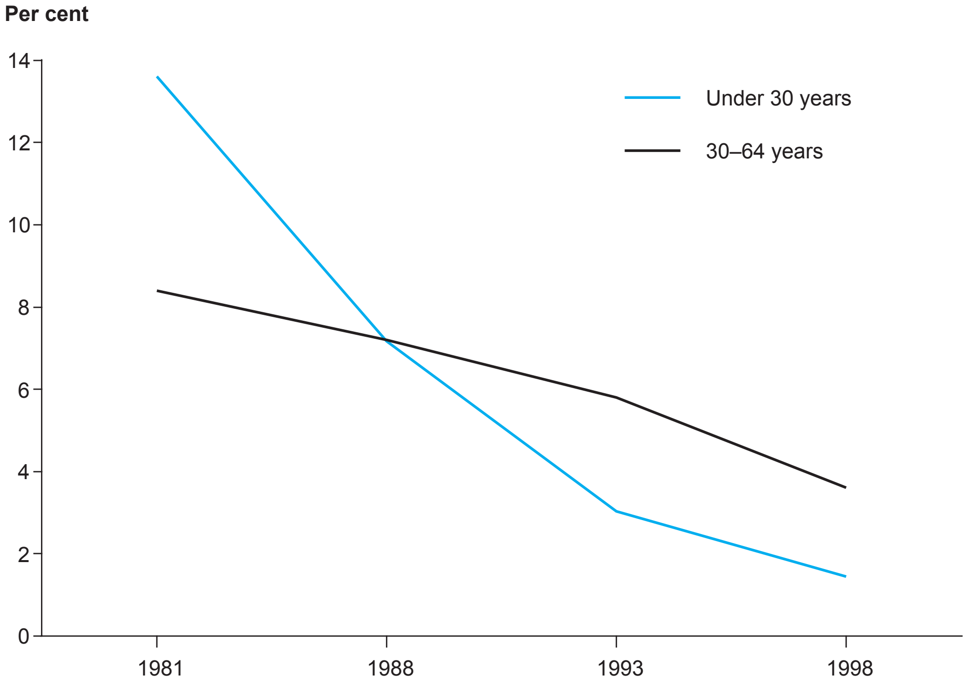


Source: Table A7.12.

Figure 7.8: People aged under 65 with a severe restriction, by place of residence, as a percentage of the Australian population of that age, 1981–98

The deinstitutionalisation trend is particularly evident among younger people with a severe or profound restriction. In 1981, of people with a severe or profound restriction, the proportion aged under 30 living in cared accommodation was substantially higher than that for people aged 30—64. In 1988, the proportions for the two age groups were the same, reflecting a great decline in the under-30 age group during 1981—88. By 1998, the proportion for people aged under 30 was 60% lower than the proportion for those aged 30—64 (Figure 7.9; Table 7.22). This comparison suggests that the individual de-institutionalisation and non-institutionalisation efforts have been focused on younger people. For example, in New South Wales, priority has been placed on minimising the institutionalisation of children (AIHW 2000b:Section 5.3).

Findings from analysis of data on CSDA-funded services are consistent with trends reflected in population data. Between 1995 and 2000, the proportion of recipients receiving accommodation support services as community-based or in-home support increased from 60% to 71%. During 1997—2000, the proportion of consumers of CSDA-funded services living with family members gradually increased, while the proportion of those living in institutions declined (Section 7.3). (See also Chapter 4 for further discussion.)



Source: Table 7.22.

Figure 7.9: People aged under 65 with a severe restriction, proportion living in cared accommodation, 1981–98

Table 7.22: People aged under 65 with a disability living in cared accommodation, by age and disability status,(a) 1981, 1988, 1993, 1998 (per cent)

Age (years)	1981	1988	1993	1998
Severe restrictions				
Under 30	13.6	7.2	3.0	1.4
30–64	8.4	7.2	5.8	3.6
Total <65	9.7	7.2	4.9	2.9
Total with specific restrictions				
Under 30	4.8	2.1	1.2	0.7
30–64	3.1	2.0	1.8	1.4
Total <65	3.5	2.0	1.6	1.2
Total with a disability				
Under 30	2.8	1.7	1.2	0.6
30–64	2.0	1.8	1.5	1.1
Total <65	2.2	1.8	1.4	1.0

(a) The proportions have been age standardised using the age and sex distributions of the Australian estimated resident population for March 1998 for comparative purposes. The estimates for the 1993 and 1998 disability survey data were made using definitions as close as possible to the definitions of the 1981 and 1988 disability surveys.

Source: Unpublished data tables from the ABS 1981 and 1988 disability surveys; AIHW analysis of ABS 1993 and 1998 Survey of Disability, Ageing and Carers confidentialised unit record file.

Employment

In 1998, the level of labour force participation was significantly lower for people with a disability (53.2%) than for people with no disability (80.1%). The participation rate for people with a severe or profound restriction was even lower, 40.2% and 18.9% respectively. Participation rates for females were lower than those for males across different severities of disability (ABS 1999:Table 20).

Over the past 17 years (1981—98), although overall participation rates for people with a disability varied slightly between 51.8% and 53.9%, participation rates for people with a schooling or employment restriction only increased markedly: from 40.0% to 61.7% (Table 7.23). Overall participation rates for people with specific restrictions rose from 39.9% to 47.4% between 1981 and 1993, while the rates dropped slightly between 1993 and 1998. These changes may partially reflect an increasing effort by people with a disability to join the labour force, or an increased number of people in the labour force who were experiencing, or willing to report, restrictions (AIHW 1997a), or an increase in the proportion of people reporting a disability generally.

In 1998, the unemployment rate among people with a disability (11.2%) was well above that for people with no reported disability (7.9%). There was a sharp increase in the unemployment rate for people with specific restrictions between 1988 and 1993. The rate has fallen since 1993, reflecting an improvement in the labour market since then and possibly also reflecting improved capture in the 1998 survey (AIHW 1999a: Chapter 3; Section 7.2).

Education

People of working age (aged 15—64) with a disability, in particular with a severe or profound restriction, had participated less in the education system than had people with no disability. According to the 1998 disability survey, 38.8% of people with a severe or profound restriction had post-school qualifications, compared with 46.8% of people with no disability. Only about one in five people with a severe or profound restriction completed Year 12, in contrast to 43.9% of people with no disability (AIHW 1999a:Table 7.23).

Comparative analysis of data from the four ABS disability surveys provides some insights on trends in education participation among people aged 5—20 with a disability.[7] Based on self-reported school attendance data from the surveys, overall, there was a higher percentage of people aged 5—20 years in school and reporting a disability in 1998 than in 1981. This trend occurs irrespective of disability status. In 1981, 5.7% of people aged 5—20 were in school and reporting a disability. This figure had risen to 9.2% in 1998. For people with a severe restriction in this age group, the rise was 1.2% to 3.7%, and it occurred across all school types, including, notably, the rise from 0.5% to 1.8% in ordinary school classes (Table 7.24).

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[7] The disability survey data on education among people with a disability are not directly comparable to the collections of education departments (see Table 7.20). Some students reported in the survey as having a disability were not recognised by the education departments.

Table 7.23: People aged 15–64 years in households: unemployment and labour force participation rates,[a] by disability status, 1981–98[b]

	Year	Core activity restriction			Schooling or employment restriction only	Total with specific restrictions	Without specific restrictions	Total with a disability	No disability	Total with & without a disability
		Severe	Moderate	Mild						
Unemployment rate										
Males	1981	6.6	7.6	8.7	19.9	10.1	4.7	6.9	n.a.	n.a.
	1988	7.9	10.5	8.0	17.2	11.1	6.7	9.9	6.5	6.9
	1993	17.8	14.3	22.2	20.5	19.5	14.6	17.7	11.5	12.2
	1998	12.9	20.2	11.8	18.6	15.0	9.7	12.9	7.8	8.4
Females	1981	13.1	12.4	16.3	21.2	15.4	12.0	13.6	n.a.	n.a.
	1988	13.9	9.3	12.1	16.7	12.8	14.4	13.1	9.5	9.8
	1993	18.4	18.2	18.5	15.5	17.5	17.1	17.4	12.1	12.5
	1998	7.6	9.7	5.3	11.6	8.0	9.1	8.4	8.1	8.1
Persons	1981	9.3	9.0	11.1	20.4	11.9	6.8	9.0	n.a.	n.a.
	1988	10.9	10.1	9.5	17.0	11.7	9.1	11.0	7.7	8.0
	1993	18.1	15.8	20.7	18.7	18.7	15.4	17.6	11.8	12.3
	1998	10.6	16.1	9.3	16.3	12.3	9.5	11.2	7.9	8.3
Participation rate										
Males	1981	37.2	55.3	57.1	51.2	49.8	90.2	67.5	n.a.	n.a.
	1988	37.3	49.4	62.0	68.3	55.0	88.7	61.6	90.0	86.0
	1993	34.2	47.5	54.8	70.7	53.0	84.9	61.4	88.3	84.2
	1998	38.5	40.0	57.8	67.8	50.4	85.5	59.8	89.1	84.1
Females	1981	23.9	32.1	33.3	28.1	28.7	50.2	37.2	n.a.	n.a.
	1988	31.2	33.4	41.1	45.3	37.1	56.4	40.2	62.4	59.7
	1993	25.5	38.8	44.7	56.5	40.7	56.8	44.4	65.3	62.8
	1998	31.5	33.4	42.2	52.2	38.2	62.4	44.4	70.7	67.0
Persons	1981	30.4	45.6	46.6	40.0	39.9	73.2	53.9	n.a.	n.a.
	1988	34.0	42.2	52.3	58.9	46.6	75.5	51.8	76.1	73.0
	1993	29.7	43.7	50.1	65.0	47.4	73.1	53.8	76.7	73.6
	1998	35.1	37.1	50.7	61.7	44.9	75.4	52.9	79.8	75.6

(a) Data in this table may differ from those reported in the ABS Labour Force Survey due to differences in survey sample size, the scope rules applied and the complexity of questions asked to determine labour force status.

(b) The rates have been age standardised using the age and sex distributions of the Australian estimated resident population for March 1998 for comparative purposes. The estimates for the 1993 and 1998 disability survey data were made using definitions as close as possible to the definitions of the 1981 and 1988 disability surveys.

Source: Unpublished data tables from the ABS 1981 and 1988 disability surveys; AIHW analysis of ABS 1993 and 1998 Survey of Disability, Ageing and Carers confidentialised unit record file.

The increase in the percentage of people aged 5—20 attending school (and those not attending) among people with a disability was partly associated with the increase in reported disability prevalence among the population of that age.

In previous editions of this biennial report, as in this one, the focus has been on broad outcomes for people in the community, outcomes not necessarily attributable to any particular cause or service that is, on status measures. Now that the indicator framework described in this chapter has been agreed, it should be possible, in future editions, to enhance the service-related outcome data and better relate them to population data.

Table 7.24: People aged 5–20 years with a disability: school attendance by type of school and class, by disability status, as a percentage of the Australian population of that age, 1981–98[(a)]

	Core activity restriction					
Type of school/class	**Severe**	**Moderate**	**Mild**	**Schooling or employment restriction only**	**Total with specific restrictions**	**Total with a disability**
Ordinary school class						
1981	0.5	0.2	0.2	0.6	1.5	3.1
1988	0.8	0.5	0.9	0.9	3.0	4.0
1993	0.8	0.2	0.5	0.8	2.3	3.6
1998	1.8	0.4	0.6	0.8	3.5	n.a.
Ordinary school (special class)						
1981	0.2	0.1	0.0	0.3	0.6	0.6
1988	0.3	0.1	0.1	0.3	0.8	0.8
1993	0.6	0.1	0.1	0.5	1.4	1.4
1998	0.8	0.1	0.1	0.6	1.6	n.a.
Special school						
1981	0.3	0.0	0.0	0.1	0.4	0.4
1988	0.4	0.0	0.0	0.1	0.5	0.5
1993	0.3	0.0	0.0	0.0	0.3	0.3
1998	0.5	0.0	0.0	0.0	0.6	n.a.
Total attending school						
1981	1.0	0.3	0.3	0.9	2.5	4.2
1988	1.5	0.6	1.0	1.2	4.3	5.2
1993	1.8	0.4	0.6	1.3	4.0	5.3
1998	3.1	0.5	0.7	1.3	5.7	7.1
Not attending school						
1981	0.2	0.1	0.1	0.1	0.6	1.5
1988	0.3	0.2	0.3	0.3	1.1	1.4
1993	0.5	0.1	0.3	0.3	1.2	1.6
1998	0.6	0.1	0.4	0.3	1.5	2.1
Total						
1981	1.2	0.4	0.4	1.1	3.1	5.7
1988	1.7	0.8	1.3	1.6	5.3	6.7
1993	2.2	0.5	0.9	1.6	5.2	7.0
1998	3.7	0.6	1.1	1.6	7.1	9.2

(a) The percentages have been age standardised using the age and sex distributions of the Australian estimated resident population for March 1998 for comparative purposes. The estimates for the 1993 and 1998 disability survey data were made using definitions as close as possible to the definitions of the 1981 and 1988 disability surveys

Source: Unpublished data tables from the ABS 1981 and 1988 disability surveys; AIHW analysis of ABS 1993 and 1998 Survey of Disability, Ageing and Carers confidentialised unit record file.

7.5 Conclusion

Disability is a multidimensional experience described in terms of the person's body, their activity limitations and participation restrictions, and the environmental factors affecting them. Statistically, disability can be measured along a continuum, and estimates of disability vary with the particular definition. Thus, the ABS estimates that some 14.6% (2,385,100 people) of the population aged under 65 had a disability, which means that they reported at least one of a list of activity limitations, health conditions or impairments. This compares with an estimate of 4.0% (655,000 people) who had a severe or profound restriction, which means that they reported needing assistance with one or more of the core activities of self-care, mobility and communication.

Whatever definition is used, the impact of population ageing is reflected in the numbers of people reporting disability and in the population projections. The number of people aged 0—64 years with severe or profound restrictions is projected to increase by 9% between 2000 and 2006, with the number aged 45—64 years increasing by 19% over the same period.

These trends appear to be reflected in the ageing of people with a disability receiving accommodation support services under the CSDA. The policy trends towards flexible, individualised disability support services hold out hope for providing suitable services for people ageing with a disability, but there is evidence of the need also for policy and administrative links between aged care, health and disability services.

Funding for disability support services provided under the CSDA totalled $2.246 billion nationally in 1999—00, an increase in real terms of 8.8% over the previous year. On a snapshot day in 1999—00, an estimated 62,341 people accessed 74,929 services.

Growth in expenditure and recipient numbers has also been a characteristic of income support programs. There were over 600,000 recipients of the Disability Support Pension in June 2000, and the administered expenses of the program were $5.2 billion in 1999—00. The number of recipients almost doubled between June 1989 and June 2000, although rates of growth are much lower when the growth and ageing of the general population are allowed for (for instance, the annual growth rate for 1999—00 becomes 1.8% rather than 4.3%).

Informal carers remain the main providers of support for people with disabilities and are the mainstay of deinstitutionalisation trends. The challenge for the formal service system is to support this role in the hope it will continue. Some carer groups are beginning to outline the support they need, for instance by enunciating their rights to holidays, access to paid work and retirement from the caring role.

Outcomes for people with a disability are mixed. Service-specific outcomes range from the positive for instance, evidence of a consistent trend towards the provision of more community-based accommodation services, relative to institutional services to the negative, with deaths in institutions resulting in calls for significantly improved health care in these institutions and in the community generally.

Trends in educational participation suggest that there are increasing rates of school attendance by people with disabilities, especially in ordinary school classes, and that this trend holds irrespective of disability status, including for people with severe restrictions. Employment trends confirm previous findings that people with a disability have poorer labour market outcomes (participation and employment) than do others, but that improvements in the general labour market do flow through to people with disabilities.

The emergence of a new Indigenous disability network holds out the promise of a clearer understanding of the needs of Indigenous people, as well as a new source of advice to organisations such as the AIHW with the responsibility of improving data in this area. The particular needs of Aboriginal and Torres Strait Islander people for disability services are indicated by their high reported support needs, even allowing for their over-representation (in population terms) in some CSDA service types.

There are significant ongoing efforts to improve disability data in Australia, and significant challenges to be met.

National Disability Administrators, in partnership with the AIHW, are working to improve national data on CSDA disability support services and associated performance indicators. Mainstream services are variable in their ability to report on people with a disability. Education departments nationally are able to report on access to specialist programs and mainstream schools by children with disability. Given the range of changes occurring in the Commonwealth sphere, in income support and employment assistance, it will be vital to maintain effort on data quality to ensure that outcomes for people can be monitored over time.

The Institute plans to place particular emphasis, in the immediate future, on publishing advice on the use of the new International Classification of Functioning, Disability and Health, with the aim of improving the availability, quality and consistency of disability data in Australia, not only for specialist services but also for mainstream services.

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8

Services for homeless people

8.1 Introduction

Homelessness is a complex issue, resulting from a variety of personal and societal factors. Structural factors such as poverty, unemployment and an inadequate supply of affordable housing are major contributors to homelessness in Australia (CACH 2001:8). Personal circumstances such as discrimination, poor physical or mental health, intellectual disability, drug and alcohol abuse, gambling, family and relationship breakdown, domestic violence, and physical and sexual abuse may increase a person's risk of becoming or remaining homeless (Ecumenical Housing & Thomson Goodall 1999:40—1).

People experiencing homelessness may access a wide range of government services provided for the broader community. These include general health services, particularly drug rehabilitation programs, general community services and housing assistance. There are also programs specifically for people experiencing, or at risk of, homelessness. Examples of these are the Supported Accommodation Assistance Program (SAAP), Crisis Accommodation Program (CAP) and Reconnect.

Since *Australia's Welfare 1999*, an important national response to homelessness has been the development of the National Homelessness Strategy (FaCS 2000a:1). The strategy acknowledges that greater cross-program relationships, between SAAP (the major targeted program) and services such as mental health services, drug and alcohol programs and crisis services, are required to assist homeless people. Furthermore, in recent years there has been added emphasis on early intervention. Many measures under the new strategy aim to provide early intervention responses that target people at imminent risk of homelessness and those who have just become homeless.

Section 8.2 discusses the continuing work on estimating the homeless population, including the development of an accepted definition of homelessness. Section 8.3 discusses a number of specific Commonwealth and State intervention initiatives for homeless people and those at risk of homelessness. Section 8.4 provides data on the level of demand for services by homeless people. An analysis of support available and outcomes achieved is of particular interest. Due to the very limited data available on many programs, the analysis of service usage is generally restricted to SAAP. The use of SAAP services by different population groups is discussed in Section 8.5 with a focus on four groups, three of which are the primary subjects of other chapters: young people; people escaping domestic violence; people on disability pensions; and older people.

8.2 Concepts of homelessness

Homelessness is a complex phenomenon and encompasses more than the absence of adequate shelter. A key issue for estimating its extent lies in defining it (DRAC 2000:1, 35).

This is difficult because of the range of circumstances: from no shelter at all, to having shelter that places its occupants at risk of homelessness. Furthermore, there is a temporal dimension to homelessness, with experiences ranging from brief, one-off episodes to long-term transience.

The concept of homelessness has changed during the past 30 years. In the 1970s it was perceived as the lack of a house or other type of shelter. More recently, perceptions have incorporated notions of people at risk of homelessness because they live in unsatisfactory or inappropriate accommodation. Definitions and resulting methodologies have become more complex as this shift in perception has continued. One example is the classification of people living in boarding houses or caravans. Some residents of these dwellings, as well as researchers estimating homelessness, consider them to be a home. Others consider them a temporary, unsatisfactory solution to a lack of appropriate housing (FaCS 2001).

Concepts of homelessness and inadequate housing are culturally bound:

> …in order to define homelessness, it is necessary to identify the shared community standards about the minimum housing that people have the right to expect in order to live according to the conventions and expectations of a particular culture. (Chamberlain 1999:8)

There is a widespread view in Australia that the most desirable housing option is home ownership, while the minimum community standard is a small rented flat with a bedroom, living room, kitchen and bathroom and a degree of security of tenure (Chamberlain 1999:11). This is the minimum accommodation that is available to most people renting in the private market. There is also a group of marginally housed that includes people in housing situations slightly below the minimum standard but who could still be considered to have adequate shelter.

Although the minimum community standard is a useful tool for assessing homelessness and inadequate housing in contemporary Australian society (Chamberlain 1999:9), there is a degree of subjectivity prescribed by cultural norms in trying to draw the boundaries of the homeless population. Different groups, such as Aboriginal and Torres Strait Islander people, may have different needs and preferences, and the weight given to aspects of adequate housing, for example security of tenure, may differ from group to group. Such issues are not easily resolved and an all-encompassing definition of homelessness is very difficult to achieve.

Estimating the number of homeless people

Estimates of the size of the homeless population and its different sub-populations are important for the development of effective policies and programs to assist homeless people (FaCS 2001). There are numerous difficulties in collecting quality data: the diverse circumstances of homeless people; locating and counting itinerant populations, who often wish to remain undetected and anonymous (resulting in under-counting or double-counting); lack of an agreed methodology for data collection; and inconsistent definitions of homelessness (DRAC 2000:31).

Australia's Welfare 1999 contained a more detailed discussion of the difficulties in enumerating homeless populations. Since then, the results of two projects aimed at producing accurate estimates have been released. The Australian Bureau of Statistics (ABS) applied Chamberlain and MacKenzie s (1992) definition of homelessness in the 1996 Census of Population and Housing homeless enumeration strategy. Table 8.1 shows this definition as well as a definition applied to a project completed by the Consilium Group that attempted to develop a model to estimate the number of homeless people in Australia.

The final results of the Chamberlain—ABS project showed that there were 105,000 homeless people on census night 1996 (Chamberlain 1999:7), whereas the Consilium project estimated a figure of 53,000 on 30 June 1997 (Consilium Group 1998:83). As the definitions used by both were very similar (see Table 8.1), the differences in the estimates have four possible explanations.

First, different methodologies were used. Chamberlain—ABS counted the number of homeless people, while Consilium used a model-based approach. The Census used a household-based collection methodology, which would under-count highly mobile people with no permanent residence. It is recognised, however, that the ABS attempted to enumerate these populations by adopting special collection procedures. The amount of under-count at the 1996 Census was estimated to be 1.6% (ABS 2001). The homeless population is most likely to have been under-counted by more than this amount. On the other hand, the Consilium method relied on the accuracy of the dependent and predictive variables as well as the adequacy of the model itself.

Second, the two projects nominated different reference points, almost a year apart, to enumerate the homeless. This would account for some fluctuation in the data. Third, there were differences in how the components of the definition were operationalised. The projects used different methods to estimate homeless children and the sleeping rough population (those living on the streets, in squats, and so on). Furthermore, people staying temporarily with friends and relatives without their own usual address were counted as homeless in the Census, whereas the Consilium project did not specifically enumerate this group.

Finally, the Consilium model projected a national figure using data collected in New South Wales and Victoria, whereas the ABS counted the homeless in every region of Australia. The Consilium model did not, therefore, account for regional differences between Queensland, the Northern Territory and Western Australia, and Victoria and New South Wales. The ABS found that the greater number of homeless per 10,000 of the population were located in the northern Australian States (77.3, 71.5 and 523.1 per 10,000 in Queensland, Western Australia and the Northern Territory respectively, compared to 49.4 and 41.0 in New South Wales and Victoria) (Chamberlain 1999:43—6). This reason could account for a large proportion of the differences between the two projects.

Table 8.1: Recent estimates of the number of homeless people, Australia

	Enumeration method	Model method
Project name	*Counting the Homeless: Implications for Policy Development* (Chamberlain 1999).	*Estimating the Number of Homeless People in Australia* (Consilium Group 1998).
Definition	The 1996 Census used the cultural definition of homelessness proposed by Chamberlain and MacKenzie (1992). It identifies three segments in the homeless population:	Consilium used a definition of homelessness similar to that of the Census. In this definition, the homeless are people who are:
	Primary homelessness—people without conventional accommodation, such as those living on the streets, sleeping in parks, squatting in derelict buildings, or using cars or railway carriages for temporary shelter.	Living on the streets, in squats, in railway carriages, and so on, or
	Secondary homelessness—people who move frequently from one form of temporary shelter to another. It covers: people using emergency accommodation (such as hostels for the homeless or night shelters); teenagers staying in youth refuges; women and children escaping domestic violence (staying in women's refuges); people residing temporarily with other families (because they have no accommodation of their own); and those using boarding houses on an occasional or intermittent basis.	Moving around various forms of temporary shelter, including with friends and acquaintances and in refuges, or
	Tertiary homelessness—people who live in boarding houses on a medium to long-term basis. Residents of private boarding houses do not have a separate bedroom and living room; they do not have kitchen and bathroom facilities of their own; their accommodation is not self-contained; and they do not have security of tenure provided by a lease.	Living in single rooms in private boarding houses and private hotels and who do not have other housing options.
Sources of data	• 1996 Census • 1994 data on homeless students • 1996–97 SAAP data	• 1996 Census • 1998 field data • 1996–97 SAAP data
Methodology	Homeless people in the following categories were counted: • Number of people in private boarding houses. • Number of people in SAAP services (census figure was corrected with 1996 SAAP data). • Number staying with friends and relatives temporarily, with 'no usual address'. 1994 National Census of Homeless Students data were used to correct numbers for teenagers staying with the families of friends. • Number of people sleeping out (small correction for under-estimation).	Estimate constructed from: • 68 regions of New South Wales and Victoria. • Homelessness in local areas estimated by key informants from welfare agencies using local knowledge. • 90 census and other variables were correlated with estimated local area homelessness figures. • A selected set of highly correlated variables was analysed to obtain the regression equation and rate of homelessness.
Point-in-time estimate	105,304 individuals (73,000 households) [August 1996]	53,000 individuals (46,000 adults and 7,000 children) [30 June 1997]
Annual estimate	Not estimated	283,000 (255,000 adults and 28,000 children) [1996–97]

Source: Chamberlain 1999; Consilium Group 1998; FaCS 2001.

Homelessness defined

A forum in October 2000, sponsored by the SAAP National Coordination and Development Committee (CAD), aimed to resolve definitional and measurement issues and to consider future social policy development implications for homelessness. The CAD recently agreed on a definition of homelessness and has been promoting its use among researchers and the wider community services and housing sectors. This definition was considered the most useful for future research and is based on that provided by Chamberlain and MacKenzie (1992) (see Table 8.1), with new descriptions that better reflect the different levels of homelessness (FaCS 2001).

The three levels of homelessness are:

- sleeping rough , for those people without shelter (primary homelessness);
- stop gap accommodation , for those in crisis but temporarily sheltered (secondary homelessness); and
- marginal accommodation , for those in insecure accommodation (tertiary homelessness).

The definition is preceded by a preamble to provide a context to and a description of the circumstances of homeless people (FaCS 2001). The preamble was based on that used in the *Supported Accommodation Assistance Act 1994*, the legislation governing services to homeless people and those at risk:

> Homelessness is one extreme of a spectrum of disadvantage in terms of access to safe, affordable and secure housing. Homelessness has an implication of lack of options or choice. A person is homeless if he or she has inadequate access to safe and secure housing. Inadequate housing:
>
> - damages, or is likely to damage, the person s health; or
> - threatens the person s safety; or
> - fails to provide access to:
>   - — adequate personal amenities;
>   - — the economic and social support that a home normally affords.

The use of such a preamble effectively combines Chamberlain and MacKenzie s cultural definition , which has provided a basis for estimating homelessness in Australia, with a service delivery definition (Chamberlain 1999:2). Service delivery definitions such as that currently governing the SAAP data collections recognise that people at risk of homelessness should be included in the definition. In addition, the delivery of programs providing services to improve social wellbeing often encompass preventative and early intervention strategies and establish eligibility criteria for assistance. As such, persons enumerated using a service delivery definition may not be enumerated in a cultural definition. It should therefore be noted that the service delivery definition may result in counts of people in the homeless population that are different from those obtained using a cultural definition.

8.3 Services available

Governments provide funds for a number of programs and services that can be accessed by people in crisis, including homeless people or those at risk. This assistance includes emergency accommodation and material aid such as food vouchers, cash and clothing. Information, advocacy and referrals are also commonly provided forms of assistance (AIHW 1999:301). With the exception of SAAP, CAP and Reconnect, there are very few programs directed specifically at homeless people. However, there are many which address some of the circumstances of people at risk of, or experiencing, homelessness.

National Homelessness Strategy

Although there were many examples of service partnerships working to prevent or resolve homelessness, a lack of coordination was hindering the achievement of a holistic approach to service delivery. To address this, the Commonwealth Government launched a National Homelessness Strategy in May 2000 (FaCS 2000a:1, 6).

The strategy provides a strategic framework for policies to prevent, reduce and respond to homelessness in Australia. In October 2000, the Commonwealth Advisory Committee on Homelessness (CACH) was appointed to provide advice on the development of the strategy. Its resulting paper (CACH 2001) provides a comprehensive analysis of homelessness and develops a range of recommendations for government. The CACH will undertake community consultation on the paper and provide a final report to government by the end of 2001.

Partnerships Against Domestic Violence Program

The Partnerships Against Domestic Violence Program targets one of the major factors contributing to homelessness. The Partnerships program aims to examine ways to prevent and respond to domestic violence. As a result, a number of projects have been implemented, such as programs for perpetrators of domestic violence, providing relationship support to men, community education campaigns, and prevention and early intervention programs to improve the wellbeing of children affected by domestic violence (FaCS 2000a:1, 12).

Housing assistance programs

Many housing assistance programs (see Chapter 3) have a role both in assisting homeless people and in preventing homelessness by helping those at risk. The Commonwealth—State Housing Agreement (CSHA) signed in early 1999 includes homeless people as a priority group for assistance (FaCS 2000a:13). The agreement encourages a diverse housing sector with links to other programs to assist those at risk of homelessness who may also have high support needs. The CSHA is the instrument through which public housing and community housing are funded and provided. Among other forms of housing assistance that may be accessed by those who are homeless or at risk of homelessness are rent, bond and relocation assistance provided under the Private Rental Program, and mortgage relief provided through the Home Purchase Assistance Program (SCRCSSP 2001:755—6).

Commonwealth income support

There are no Commonwealth government income support payments specifically for people experiencing homelessness. However, these people may receive income support via a number of government benefits, among them Newstart Allowance, Parenting Payment (for sole and partnered parents) and Disability Support Pension. Depending on individual circumstances, some people may also receive other allowances, such as Rent Assistance. For details of Commonwealth income support payments and eligibility criteria, see *A Guide to Commonwealth Government Payments* (Centrelink 2001).

Centrelink employs community officers to provide services to homeless people who otherwise have difficulty accessing Centrelink. Contact points are provided in SAAP services and other locations to ensure this access. An estimated 52,000 homeless people contact these community service officers across Australia annually (FaCS 2000a:19).

Until July 1998 the main form of assistance for young people in housing crisis was the Independent Homeless Rate, paid on a number of benefits and allowances (AIHW 1999:306). However, in July 1998 several payments associated with the Independent Homeless Rate (including Youth Training Allowance, Newstart and AUSTUDY) were integrated into a single program Youth Allowance. A special homeless rate was not retained. Youth Allowance is generally paid to full-time students aged 16—24, to unemployed people under 21 years of age looking for work, and to those studying part time in conjunction with an approved activity (Centrelink 2001). Different rates are paid according to the young person s circumstance, the highest being the away-from-home and independent rates. The eligibility criteria for these rates usually apply to young homeless people. Fifteen year olds may be approved for an away-from-home rate if they are in full-time study or undertaking a combination of approved activities.

The Commonwealth provides additional financial support through the Emergency Relief Program administered by the Department of Family and Community Services. Through this program, financial or other assistance is provided for one-off episodes or continuing problems. A diverse range of church, welfare and community organisations distributes emergency relief. Agencies may receive funds from both the SAAP and the Emergency Relief Program (AIHW 1999:308). In 2000—01, $26.6 million was allocated by the Commonwealth to agencies that distribute emergency relief through almost 1,400 outlets. Other funds for this program were provided by donations and fund-raising by charitable organisations and from State, Territory and local governments (FaCS 2000b).

State and Territory programs

State and Territory departments (particularly those related to health, community services, education and justice) offer a wide range of services aimed at assisting people at risk of, or experiencing, homelessness with various facets of their lives (AIHW 1999:308). The following are indicative of the services provided.

- Some health care services to homeless people on the streets and in accommodation centres are provided by NSW Health, the City of Sydney and community agencies. Other health services for homeless people are provided by the South East and Central Sydney Area Health services (NSW DOCS 2001:ii).

- The Victorian Department of Human Services funds the Royal District Nursing Service to Homeless Persons Program, which offers a primary health care outreach service to homeless people in inner Melbourne (AIHW 1999:308). The department is also conducting a 3-year Homeless and Drug Dependency Trial. This project is aimed at implementing and evaluating a strategy to enhance management of the needs of people dependent on drugs by the State s three main Crisis Supported Accommodation Services *(*Victorian Department of Human Services, pers. comm., 3 July 2001*)*.
- The Queensland Department of Families funds the Youth Support Coordinator Program, an early intervention initiative aimed at reducing the incidence of youth homelessness and early school-leaving. The program funds 13 youth worker positions around the State, using schools as a key site for the identification of, and intervention with, young people at risk (Queensland Department of Families, pers. comm., 24 August 2001).
- The Western Australian Department for Housing and Works in conjunction with SAAP funds a Youth Housing Program to provide accommodation and support to prevent young people from becoming homeless and to assist them into mainstream housing. The department also has a program that targets evicted or homeless Aboriginal and Torres Strait Islander families with children to help them to return to public housing (Western Australian Department of Family and Children s Services, pers. comm., 27 June 2001).

Reconnect

Some researchers emphasise the value of early intervention in reducing the various stages of chronic homelessness (for example, Chamberlain and MacKenzie 1998:70). Service providers have also advocated early intervention, seeing it as a cost-effective response that acts to block pathways into homelessness. In 1996, the Prime Ministerial Youth Homeless Taskforce was established in recognition of the increase in problems facing young people at risk of homelessness and their families. The taskforce established the Youth Homelessness Pilot Programme to examine ways of improving support for young people and their families, based on early intervention and prevention strategies using family relations approaches (AIHW 1999:305). On the basis of the resulting recommendations made by the taskforce, the Commonwealth launched Reconnect in December 1999.

Reconnect is a community-based early intervention program for young people who are homeless, or at risk of homelessness, and their families. The objective is to improve the level of engagement of these young people with family, work, education, training and the community. The Reconnect program is especially designed to break the cycle of homelessness, which can begin at an early age. It provides early intervention support through counselling, adolescent mediation, and practical help to the family. In the period from December 1999 to June 2001, 5,656 young people commenced support with Reconnect.

The program includes all sections of the community. In particular, the participation of Aboriginal and Torres Strait Islander communities is ensured through the selection process for the program. As at June 2001, 89 Reconnect services were operating in high-need communities across Australia. A further 11 communities are undertaking community development processes and Reconnect services are expected to be announced progressively in these areas over the next year (FaCS, pers. comm., 16 August 2001).

In the 1999—2000 Budget, the Commonwealth allocated $60 million over 1999—2003 for Reconnect, with ongoing funding of $20 million a year.

Supported Accommodation Assistance Program

The principal measures for helping homeless people and those at risk of becoming homeless are provided under two Commonwealth—State initiatives: the Crisis Accommodation Program (CAP) and the Supported Accommodation Assistance Program (SAAP). CAP provides capital funding for dwellings to be used to accommodate people who are homeless or in crisis, details of which are discussed in Chapter 3 on housing assistance. The remainder of this chapter is devoted to SAAP.

SAAP is a support program assisting people who are homeless or at risk of homelessness through a range of support and supported accommodation services. It is an important part of Australia s overall response to homelessness and represents a broader social safety net designed to assist those in crisis in the community.

SAAP provides recurrent funding for the operational costs associated with supplying housing and support to people who are experiencing, or who are at risk of, homelessness. The program helps people to move as quickly as possible to independent living, where appropriate, or to alternatives such as long-term supported housing (AIHW 1999:302).

The program is cost shared and jointly managed at a national level by the Commonwealth and the States and Territories. Delivery of services is carried out primarily by non-government agencies, with some local government participation. In 1999—00, SAAP funded 1,207 non-government and community organisations (AIHW 2000b:3).[1]

The agencies that provide services through SAAP are diverse, and they may receive funds through other government programs, as well as from non-government sources. The experience and infrastructure of such agencies place them in a good position to help homeless people and those at risk of homelessness. For example, an agency may provide a number of emergency services, such as crisis accommodation, referrals for transitional housing, domestic violence support and assistance with health problems (AIHW 1999:302).

SAAP employs a client-centred case management approach, which gives it greater capacity to provide early intervention services through assessment and referrals to other services (Thomson Goodall 1999a:v).

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1 This figure represents agencies funded for all or some part of the financial year.

The increased emphasis on case management during the third SAAP Agreement has resulted in a steady increase in the number of support periods in which support plans have been used (AIHW 2000b:48).[2] Support plans were used in 46% of support periods that finished in 1996—97; in 1999—00 they had been used in 61% of completed support periods. Over the same period, the proportion of support periods in which support plans were not thought to be appropriate dropped from 31% to 25%. By 1999—00 support plans were being used in 81% of support periods for which they were thought to be appropriate, compared to 67% in 1996—97.

As the use of support plans has increased, so too has the duration of support (AIHW 2000b:48). Whether this is cause and effect is not known; however, there has been a steady shift from short to longer support periods: in 1996—97, 60% of support periods that finished in that year lasted 1 week or less; by 1999—00 the proportion had fallen to 54%. In 1996—97 almost 50% of support periods lasted 3 days or less and the median length was 4 days. By 1999—00 only 44% were less than 4 days long and the median length was 6 days.

The fourth SAAP Agreement includes a revised policy and program framework informed by data from the SAAP National Data Collection and the National Evaluation of SAAP III (FaCS 2001) (see AIHW 1999:302 for an overview of the evaluation, and Boxes 8.1 and 8.2 for a brief description of the collection and the definitions used). The agreement features directions for further development, including increased accountability for outcomes, and a commitment to consultation with key community partners at major stages in SAAP IV development and implementation. Aboriginal and Torres Strait Islander homelessness, and homeless people with complex needs, have been identified in the Memorandum of Understanding signed by the Commonwealth and State and Territory community services ministers as priorities during SAAP IV.

SAAP funding

The total recurrent funding for SAAP in 1999—00 was $245.5 million (Table 8.2). Around 94% of this, or $231.7 million, went to the 1,207 SAAP agencies operating across Australia. The remaining 6% was allocated for purposes such as administration, training, data, research and evaluation.

Between 1996—97 and 1999—00, total recurrent funding rose from $219.8 million to $245.5 million. This represented a 5% real increase (in 1998—99 dollars). Most of this increase was due to a 4% rise, in real terms, in funding between 1998—99 and 1999—00: $229.9 million to $240.2 million. Over the preceding 3 years, SAAP recurrent funding increased by $1.7 million in real terms.

Recurrent funding to SAAP agencies had a somewhat different pattern: an increase of 16% between 1996—97 and 1999—00 (from $200.5 million to $231.7 million), a real increase of 9%. The growth in funding between 1997—98 and 1998—99 was less than in

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[2] A support or case management plan contains a statement of the client's problem or need, case goals, and strategies to achieve goals. A support plan is developed and agreed jointly by the agency and the client.

Box 8.1: The SAAP National Data Collection: an overview

Information on SAAP operations is obtained through the SAAP National Data Collection. The National Data Collection Agency (NDCA), within the Australian Institute of Health and Welfare, collects the data. The National Data Collection consists of five separate collections: the Client Collection; the Administrative Data Collection; the Unmet Demand Collection; the Casual Client Collection; and the Special Issue Collections.

The Client Collection *is the main component, consisting of information about all 'clients' receiving support under SAAP. (See Box 8.2 for key definitions.) Conducted continuously since 1 July 1996, it contains a wide range of data on client characteristics and service provision. A client 'linkage key' (derived from a client's 'alpha code') is used to enumerate repeat use of SAAP services by clients.*

From 1 July 1999 to 30 June 2000, there were 1,207 SAAP agencies funded for part or all of the financial year. Some agencies provide one-off assistance only so do not participate in the Client Collection. Of the 1,159 SAAP agencies that should have responded to the Client Collection in 1999–00, 93% participated in the data collection. Participating agencies reported on 146,793 occasions of support. For 21% of these 'support periods' consent was not obtained and client information, including the alpha code, was not collected. As a result, less information is available for these support periods. In addition, errors or omissions meant that linkage keys were not available for another 2% of support periods, so that the overall effective consent rate was 77% (AIHW 2000b:57). This compares with a participation rate of 95% and a consent rate of 72% in 1998–99. In 1996–97, the first year of the collection, participation and consent rates were 95% and 64% respectively (AIHW 2000a:9).

The Institute has developed a scheme that adjusts for incomplete coverage in the Client Collection. It adjusts estimates to allow for agency non-participation, for clients who do not consent to provide complete information for support periods, for clients who give valid consent for some support periods but not for others, and for clients who do not give consent in any of their periods of support (see AIHW: Karmel 1999).

In this report all estimates obtained using data from the Client Collection have been adjusted for agency non-participation and, where applicable, client non-consent using the scheme just outlined. No other adjustments have been made for errors or omissions or for data not obtained as a result of question exclusions on the high-volume form.

Agencies that have a high client throughput—catering for a large number of clients in a short period—are not required to record the same level of client detail as other agencies. They fill in the shorter high-volume form for clients rather than the general form.

The Administrative Data Collection *consists of general information about agencies funded to provide accommodation and support services. This information is provided to the NDCA by State and Territory funding departments.*

The Unmet Demand Collection *operated over a 2-week period in 1999–00. It measured the level of unmet demand for SAAP services by collecting information about the number of people who requested support or accommodation from SAAP agencies but who, for whatever reason, did not receive it. The most recent collection for which data are available*

(continued)

Box 8.1 (continued): The SAAP National Data Collection: an overview

covers the period 11–24 November 1999. In 1999–00, the participation rate for the Unmet Demand Collection was 71% of relevant agencies (AIHW 2001); in 1998–99, it was 79% (AIHW 2000a:6).

The two-week Casual Client Collection *is conducted annually in May–June to elicit information about short-term or one-off assistance provided to homeless people. The most recent collection for which data are available covers the period 18–31 May 2000. In 1999–00, the participation rate for the Casual Client Collection was 83% of relevant agencies (AIHW 2001); in 1998–99, it was 75% (AIHW 2000a:6).*

The Special Issue Collections *are conducted to obtain information on a special topic for a limited period; they are an adjunct to the Client Collection. The initial Casual Client Collection was the first such survey. The second, the Accompanying Children in SAAP Collection, was conducted in 1998. The third, the Income Issues Collection, was conducted in 2000, with the report due to be published in late 2001.*

Source: AIHW 1999, 2000a, 2000b.

the other years. Allowing for inflation, in 1998—99 dollars between 1996—97 and 1997—98 there was a $9.5 million rise in funds; the following year saw an increase of $2.6 million, while between 1998—99 and 1999—00 funding rose by $6.4 million.

The Commonwealth has allocated some $830 million over the 5 years commencing in 2000—01 under the new SAAP IV Agreement. This includes $115 million additional funds for growth, parity and indexation.

Figure 8.1 shows the allocation of all recurrent SAAP funds by State and Territory and compares it with the distribution of the Australian population (aged 10 and over) and the support periods provided by agencies. In 1999—00, the four smallest jurisdictions received relatively more funding than the larger ones. In particular, Tasmania, the Australian Capital Territory and the Northern Territory received 10% of the funds but had only 5% of the population. On the other hand, Victoria was allocated 21% of SAAP funding and had 25% of the population.

Levels of funding are reflected to a large extent in the amount of support provided, as measured by the number of support periods. There was, however, some divergence. In particular, while Victoria received 21% of the funding allocation, its agencies supplied 27% of support periods. Conversely, agencies in the four smallest States and Territories provided 16% of support periods but were allocated 19% of the funds. However, these differences may reflect varying approaches to service provision, rather than differences in the relative provision of support. For example, in some States, SAAP manages transitional housing for clients moving out of crisis accommodation to medium-term housing, whereas in Victoria a separate program exists for those in transitional housing, with SAAP agencies providing support to some tenants in transitional housing.

Box 8.2: Principal definitions used in the SAAP National Data Collection

A **client** *is a person aged 18 years or more, or a person of any age not accompanied by a parent or guardian, who:*

- *receives from a SAAP agency support or assistance 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; or*
- *is accommodated by a SAAP agency; or*
- *enters into an ongoing support relationship with a SAAP agency.*

An **accompanying child** *is a person aged under 18 years who receives support and/or supported accommodation from a SAAP agency and whose parent or guardian is a client of the same agency at the time.*

A **potential client** *is a person who wishes to become a SAAP client but is not accepted, or the person does not accept the agency's offer of support or supported accommodation (see 'Unmet demand').*

A **support period** *is an occasion of support provided to a SAAP client. A support period begins when a client begins to receive support from a SAAP agency. It is considered completed when the client ends the relationship with the agency or the agency ends the relationship with the client. If it is not clear whether the agency or the client has ended the relationship, the support period is assumed to have ended if no assistance has been provided to the client for 1 month. In such a case, the date the support period ended is 1 month after the last contact with the client.*

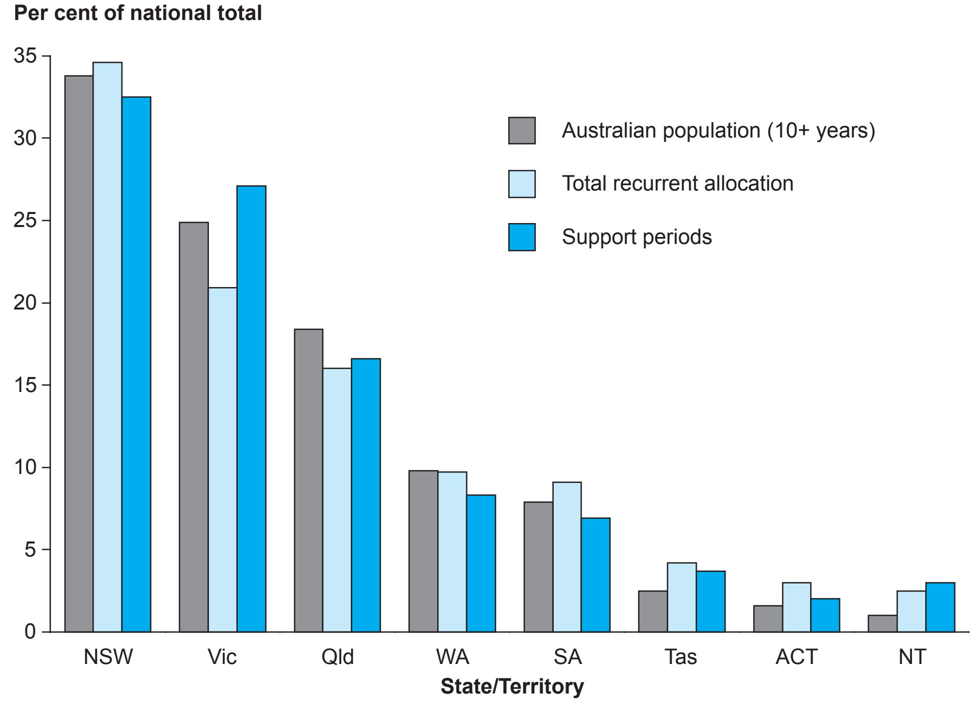
A **casual client** *is a person who receives assistance from a SAAP agency for less than 1 hour on a given day and does not establish an ongoing support relationship with the agency. A casual client may receive one-off assistance from an agency on more than one occasion.*

One-off assistance *is assistance provided to a person who is not a client. It might include the provision of a meal, a shower, transport, money, clothing, telephone advice, information or a referral.*

The **alpha code** *is a predetermined combination of letters from a person's name, together with a letter designating the person's gender, that is joined to the person's year of birth and encrypted to create a linkage key. The* **linkage key** *is used to combine data from more than one support period for a client without requiring the actual name of the person to be recorded and can therefore be used to identify repeat use of SAAP services.*

Unmet demand *occurs when a person requests—but does not receive—support or supported accommodation. That is, the person wishes to become a client of a SAAP agency but is not accepted, or the person does not accept the agency's offer of support or supported accommodation. Reasons for not meeting such requests for assistance may include insufficient accommodation at the agency; the person not being within the agency's target group; the agency not having appropriate facilities to cater for special needs; and the agency being unable to offer the specific services requested by the person.*

Source: AIHW 2000b:xiii–xv.



Source: AIHW 2000b:5.

Figure 8.1: Comparison between SAAP funding allocations, Australian population and support periods, 1999–00

SAAP agencies and target populations

In 1999—00, over half (56%) of all SAAP agencies were located in capital cities, 7% in other metropolitan centres and 6% in remote areas (Table 8.3). Nine per cent were in large rural centres and 22% in other rural areas. In capital city areas, agencies were allocated, on average, $213,700. Those in large rural centres and in other metropolitan centres received, on average, $179,800 and $172,300 respectively. Allocation of funds to agencies in other rural and remote areas was lower per agency, being $132,400 and $158,700 respectively.

SAAP agencies have six primary target populations (see Table 8.3). In 1999—00, agencies directing their services at young people were provided with 34% of total agency funds, followed by agencies targeting women escaping domestic violence (28%). Cross-target agencies received 14% and those targeting single men and families, 11% and 7% respectively. Single women s agencies recorded 3% of total recurrent funding. In terms of funding per agency, however, those targeting women escaping domestic violence had the highest average allocation ($243,600). Funds going to agencies for single men averaged $240,100, while family agencies and those with cross-target, multiple target and general target groups received the lowest average amounts ($151,100 and $144,400 respectively). Agencies for single women and young people were allocated an average of $175,400 and $170,600 respectively.

Table 8.2: Supported Accommodation Assistance Program: funding, by State/Territory, 1996–97 to 1999–00 ($'000)

	1996–97	1997–98	1998–99	1999–00
		Current dollars		
NSW	72,679	78,829	78,320	80,398
Vic	44,466	46,237	46,991	46,730
Qld	28,027	29,468	31,049	38,167
WA	17,043	17,633	21,395	23,414
SA	18,066	19,905	21,530	20,865
Tas	8,990	9,156	9,382	9,518
ACT	6,517	6,705	6,705	6,948
NT	4,751	4,834	4,955	5,677
All agencies	*200,539*	*212,768*	*220,328*	*231,717*
Other funds	*19,232*	*10,893*	*9,561*	*13,794*
Total funding	**219,771**	**223,661**	**229,889**	**245,511**
		Constant 1998–99 dollars		
NSW	75,471	80,685	78,320	78,667
Vic	46,174	47,325	46,991	45,724
Qld	29,104	30,162	31,049	37,345
WA	17,698	18,048	21,395	22,910
SA	18,760	20,374	21,530	20,416
Tas	9,335	9,372	9,382	9,313
ACT	6,767	6,863	6,705	6,798
NT	4,934	4,948	4,955	5,555
All agencies	*208,244*	*217,777*	*220,328*	*226,729*
Other funds	*19,971*	*11,149*	*9,561*	*13,497*
Total funding	**228,215**	**228,926**	**229,889**	**240,226**
Number of agencies	**1,183**	**1,190**	**1,191**	**1,207**

Notes

1. Additional funds may have been allocated on a non-recurrent basis.
2. Deflated using GFCE price deflator.
3. Components may not add to totals due to rounding.
4. Total recurrent funds for 1999–2000 include $1,532,000 provided through the Partnerships Against Domestic Violence Program. Of this, $834,000 was allocated to agencies.
5. 'Other funds' are funds not made to agencies; for example, funds allocated for administration, training, research and evaluation.

Source: ABS 2000a; AIHW 2000b.

Table 8.3: SAAP agencies: recurrent allocations and mean funding per agency, by State/Territory, region and primary target group, 1999–00

	Agencies (N)	Recurrent allocation (%)	Mean funding per agency ($)
State/Territory			
NSW	391	34.7	205,600
Vic	327	20.2	142,900
Qld	188	16.5	203,000
WA	118	10.1	198,400
SA	80	9.0	260,800
Tas	41	4.1	232,200
ACT	32	3.0	217,100
NT	30	2.4	189,200
Total	**1,207**	**100.0**	**192,000**
Region			
Capital city	674	62.2	213,700
Other metropolitan centre	88	6.5	172,300
Large rural centre	110	8.5	179,800
Other rural area	263	15.0	132,400
Remote area	72	4.9	158,700
Total	**1,207**	**100.0**	**192,000**
Primary target group			
Young people	466	34.3	170,600
Single men only	103	10.7	240,100
Single women only	45	3.4	175,400
Families	102	6.6	151,100
Women escaping domestic violence	270	28.4	243,600
Cross-target/multiple/general	221	13.8	144,400
Total	**1,207**	**100.0**	**192,000**

Notes

1. Recurrent allocation excludes funds not allocated to agencies; for example, funds allocated for administration, training, research and evaluation.
2. Recurrent allocations to agencies for 1999–00 include $834,000 provided through the Partnerships Against Domestic Violence Program.
3. The number of agencies is the total of all agencies funded for all or some part of the financial year.

Source: AIHW 2000b.

8.4 Demand for services

A national survey conducted by the Australian Council of Social Service (ACOSS) in 2000 showed that many community welfare agencies were unable to meet the demand for their services or had been forced to reduce the help they provide to those in need. For example, 67% of the 974 welfare agencies responding to the survey indicated that they had experienced an increase in the number of people assisted. The most common reasons cited were an increase in referrals by other agencies and the greater complexity of client needs. Agencies also reported that changes in government policies, such as those to Centrelink administration and benefit entitlement rules, had increased the demand for services (ACOSS 2000:4).

Not all of the agencies surveyed provide assistance to homeless people. However, the findings of the ACOSS study are supported by a survey of six major service outlets of crisis accommodation in inner urban Melbourne (Thomson Goodall Associates 1999b). The survey was undertaken in 1999 over a 4-week period and it showed that the six providers had a high level of unmet demand. Those seeking crisis accommodation included people from outer Melbourne suburbs, country Victoria and interstate.

The overall provision of SAAP services in 1999—00 can be gauged by combining data from the main collections in the National Data Collection.[3] On an average day, SAAP agencies were involved in providing 16,750 periods of support, with 6,350 of these involving accommodation (AIHW 2001). The agencies also provided one-off assistance to an average of 2,290 casual contacts each day (see Box 8.2 for explanations of these terms). The number of people receiving this assistance is not known, as people can get one-off assistance more than once in a day and may access both one-off assistance and ongoing support. However, the figures indicate that between 16,750 and 19,040 people are supported by SAAP on a daily basis.[4]

While SAAP agencies assist many people on a daily basis, it is not always possible to assist all those requesting help. Unmet demand data are collected in the Unmet Demand Collection on those seeking ongoing support or accommodation but who do not receive this support. Given the importance of accommodation for homeless people, the data concentrate on unmet demand for accommodation. Unfortunately, no information is collected on those who fail to get one-off assistance (see Box 8.1).

Table 8.4 compares the number of clients accommodated by SAAP agencies with the number of requests for immediate accommodation that were not met, and the number of referrals for accommodation provided in response to those requests.

Among the 820 agencies participating in both the Client Collection and the Unmet Demand Collection, on an average day in the collection period 200 people started SAAP accommodation, 208 left and 5,538 remained in accommodation. This represents a 4% turnover rate. Furthermore, the data show that SAAP services appear to be operating to capacity in terms of accommodation vacancies, with the number of valid unmet requests for immediate accommodation averaging 219 a day over the 2-week period. An average of 127 of these unmet requests a day could not be referred to other agencies as the average number of referrals for the 2-week period was 92.[5] The 200 newly accommodated clients may include these referrals. The data show that demand for SAAP accommodation across the country is greater than the capacity of SAAP services to provide it.

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[3] Services and assistance provided to clients and casual clients approximates met demand. Unmet requests by potential clients are derived from the Unmet Demand Collection.

[4] These figures are conservative—for example, see notes to Table 8.3.

[5] For collection purposes, a referral occurs when a SAAP agency contacts another agency and that agency accepts the person concerned for an appointment or interview. A referral for accommodation does not always result in a person receiving the accommodation they require.

Table 8.4: Supported Accommodation Assistance Program: average daily number of support periods with accommodation and unmet requests for immediate accommodation, by type of demand, 11–24 November 1999

Agencies participating	Clients newly accommodated on that day	Clients with continuing accommodation	Clients with accommodation ending on that day	Estimated valid requests for immediate accommodation: Unmet requests	Estimated valid requests for immediate accommodation: Referrals
In both the Client Collection and the Unmet Demand Collection					
Daily average	200	5,538	208	219	92
In the Client Collection					
Daily average	233	6,615	240	n.a.	n.a.

Notes

1. Client Collection and Unmet Demand Collection cases excluded from table due to missing data: 592.
2. The accommodation status of a client on a particular day is based on the reported periods of accommodation within a support period.
3. Referrals for accommodation may not be for immediate accommodation.
4. Clients are deemed to be supported on all days in a support period, including on both the start and end dates.
5. Valid unmet requests exclude those made at an agency of an inappropriate target group, or if requested service (for example, accommodation) is not provided by the agency, or if proffered assistance is refused. An adjustment for missing information on validity of request has been made.
6. 'Immediate accommodation' is that which is required within 24 hours. An adjustment for missing information on when accommodation was needed has been made.
7. To facilitate comparisons, only agencies which participated in both the Client Collection and the Unmet Demand Collection contribute to the individual daily figures in this table. Consequently the figures will understate the level of activity in SAAP agencies. The number of agencies participating in both collections is 820. The number participating in the Client Collection is 1,080.

Source: AIHW 2001.

8.5 Assistance to SAAP clients

Support to clients may include the provision of supported accommodation and/or a range of support services, generally on an ongoing basis. Such support may be provided in the context of an agreed support plan. It may be intensive and short-lived for clients in extreme crisis. Conversely, services such as the provision of a meal are instances of one-off assistance and not part of an ongoing support period (AIHW 2000a:55). An individual client can receive support or supported accommodation on more than one occasion, so the number of support periods exceeds the number of clients. Individual clients include children under 18 years of age presenting without a parent or guardian. Children presenting at a SAAP agency with a parent or guardian are not included in analyses based on clients.

Overall, 157,600 occasions of support were provided to 90,000 clients in 1999—00 (Table 8.5). It is estimated that there were 156,500 support periods in 1996—97, increasing to 164,300 in 1997—98 and decreasing slightly to 163,200 in 1998—99 (AIHW 2000b:46). The number of clients provided with SAAP services showed a similar pattern over the 4 years, although the number in 1999—00 was only slightly fewer than in 1998—99. In 1996—97, an estimated 83,200 clients received support; the figure rose to 94,100 in 1997—98 and then fell to 90,700 for 1998—99.

Table 8.5: Supported Accommodation Assistance Program: number of clients and support periods per client, by State/Territory, 1996–97 to 1999–00

	1996–97	1997–98	1998–99	1999–00	
		Clients			**Clients per 10,000 population**
NSW	25,400	27,700	25,900	24,400	44
Vic	22,900	27,000	28,000	27,400	67
Qld	13,900	15,500	14,400	15,000	49
WA	7,400	7,800	7,500	8,100	49
SA	6,400	7,900	6,800	7,000	56
Tas	3,000	3,600	3,300	3,300	86
ACT	1,900	1,900	1,800	1,900	65
NT	2,300	2,800	3,000	2,800	156
Australia	**83,200**	**94,100**	**90,700**	**90,000**	**55**
		Support periods per client			**Total support periods**
NSW	2.43	2.02	2.02	1.93	51,200
Vic	1.50	1.54	1.64	1.63	42,700
Qld	1.70	1.62	1.63	1.68	26,100
WA	1.62	1.61	1.64	1.61	13,100
SA	1.75	1.64	1.70	1.63	10,900
Tas	1.66	1.57	1.67	1.70	5,800
ACT	1.70	1.68	1.70	1.80	3,200
NT	1.95	1.75	1.93	1.70	4,700
Australia	**1.87**	**1.72**	**1.76**	**1.73**	**157,600**
Total support periods	**156,500**	**164,300**	**163,200**	**157,600**	**. .**
Mean number of support periods on 15th day of the month	**13,700**	**15,600**	**16,600**	**18,100**	**. .**

Notes

1. The totals of this table do not necessarily match the totals of other tables in this chapter because of questionnaire errors or omissions.
2. ‘Per 10,000 population’ shows how many people out of every 10,000 in the general population (aged 10 and over) became clients of SAAP in 1999–00. The rate is estimated by comparing the number of SAAP clients aged 10 and over to the estimated resident population aged 10 and over as at 30 June 1999. Age-standardised estimates have been derived to allow for different age distributions in the various jurisdictions. The Australian estimated resident population as at 30 June 1999 has been used as the reference population.

Source: AIHW analysis of SAAP Administrative Data and Client Collections; ABS 2000b.

Nationally, there was no obvious trend in the average number of support periods clients received. In 1999—00, the average number per client was 1.73. The highest level of repeat use of SAAP services was recorded in 1996—97, when clients averaged 1.87 support periods each. New South Wales had the highest repeat use in all years.[6] The

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[6] In 1997–98, new reporting procedures were introduced which reduced the number of support periods recorded for people frequently being placed with SAAP agencies by police. This change affected only New South Wales.

most constant level of repeat use over the 4 years was in Western Australia, ranging between 1.61 and 1.64 support periods per client.

The mean number of support periods on the 15th day of each month has grown steadily (13,700 in 1996—97 to 18,100 in 1999—00). This reflects the fact that, generally, support periods have become longer (see Section 8.3). It also appears to indicate that, commensurate with greater funding, the amount of daily support available has increased.

Overall, 55 people out of every 10,000 in the population aged 10 years and over were SAAP clients in 1999—00. The use of SAAP services varied across jurisdictions, ranging from 44 per 10,000 people in New South Wales to 156 in the Northern Territory.

The pattern of service provision varied across regions (Table 8.6). Agencies in capital cities (63%) provided more support periods than those in rural centres (25%), other metropolitan centres (7%) and remote areas (5%). Proportionally within jurisdictions, apart from the Australian Capital Territory (all of which is classified as a capital city), Adelaide had the highest proportion (77%) of SAAP support periods of any capital city, while Darwin had the lowest (37%). Sixty-three per cent of support periods in the Northern Territory occurred in remote areas, compared with Western Australia (19%) which had the second highest provision of services in remote areas. Support periods were provided more often in rural areas in Tasmania (52%), and in other metropolitan centres in Queensland (18%), than in any other State or Territory.

Table 8.6: Supported Accommodation Assistance Program: support periods, by State/Territory and region, 1999–00 (per cent)

	Capital city	Other metropolitan centre	Rural area	Remote area	Australia	Number
NSW	63.0	9.0	24.6	3.4	100.0	51,200
Vic	72.4	2.8	24.5	0.3	100.0	42,600
Qld	43.4	18.0	35.1	3.5	100.0	26,100
WA	66.2	0.0	15.2	18.6	100.0	13,000
SA	77.4	0.0	21.9	0.7	100.0	10,900
Tas	47.8	0.0	52.2	0.0	100.0	5,800
ACT	100.0	0.0	0.0	0.0	100.0	3,200
NT	37.1	0.0	0.0	62.9	100.0	4,700
Australia	**63.0**	**6.7**	**25.1**	**5.2**	**100.0**	**. .**
Australia (N)	**99,200**	**10,500**	**39,600**	**8,200**	**. .**	**157,400**

Note: The totals of this table do not necessarily match the totals of other tables in this chapter because of questionnaire errors or omissions.

Source: AIHW analysis of SAAP Administrative Data and Client Collections.

Use of SAAP by different groups

The overall aim of SAAP is to help homeless people to attain the maximum possible degree of self-reliance and independence. However, the achievement of such goals does not depend on the intervention of SAAP agencies alone. A complex interplay of policies, programs and other factors relating to income security, housing and community services, as well as an individual's personal circumstances, will influence outcomes for clients.

SAAP agencies provide a range of services, reflecting the diverse nature of the needs of homeless people and those at imminent risk. The four groups that are the focus of analysis in this section are young people, people escaping domestic violence, people on disability pensions and older people (Box 8.3). It should be noted that these groups are not mutually exclusive.

Box 8.3: Identifying population groups in SAAP

Young people: *those aged between 10 and 24 years.*

People escaping domestic violence: *those indicating that domestic violence is a reason for seeking assistance and/or those receiving support from agencies that target women escaping domestic violence. Information on homeless people is collected through the completion of a general client form or a high-volume client form (Box 8.1). As reasons for seeking assistance do not appear on the high-volume form, the number of clients and number of support periods may be an under-estimate of the total number of people escaping domestic violence who accessed SAAP services.*

People on disability pensions: *those indicating that they receive a disability pension, from either Centrelink or the Department of Veterans' Affairs (DVA), before or after support. Those that should be on the age pension are excluded; for 1999–00, they include women born in or before 1939 and men born in or before 1935. Also, people have to be aged 16 or over to receive the disability pension. Therefore, if a client indicated that they were under 16 and receiving a disability pension, they were excluded from this analysis.*

Older people: *those aged 55 years and over.*

Table 8.7: Supported Accommodation Assistance Program: clients, by age and population group, 1999–00 (per cent)

Age (years)	**Young people**	**People escaping domestic violence**	**People on disability pensions**	**Older people**	**All SAAP clients**
Under 15	5.0	1.2	—	—	1.9
15–17	28.7	4.9	1.1	—	10.7
18–19	23.3	4.9	2.6	—	8.7
20–24	42.9	15.2	8.1	—	16.1
25–44	—	61.8	55.3	—	49.0
45–59	—	10.0	30.1	43.5	10.8
60+	—	2.0	2.9	56.5	2.7
Total	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*
Total	**37.4**	**32.3**	**16.6**	**4.9**	**. .**
Total (N)	**33,500**	**29,000**	**14,900**	**4,300**	**89,600**

Notes

1. The totals of this table do not necessarily match the totals of other tables in this chapter because of questionnaire errors or omissions.
2. Clients may be in none or more than one population group; therefore, the sum of the groups does not equal the total for all SAAP clients.

Source: AIHW analysis of SAAP Client Collection.

Individual characteristics

In 1999—00, young people who accessed SAAP services without a parent or guardian made up 37% of the client population, compared with 5% of older clients aged 55 years and over (Table 8.7). Thirty-two per cent of clients were escaping domestic violence and 17% reported receiving a disability pension.

Forty-three per cent of young clients were aged between 20 and 24, with 29% aged 15—17, 23% aged 18—19 and 5% aged under 15 years. The majority of people escaping domestic violence (62%) and people on disability pensions (55%) were aged between 25 and 44.

Overall, more females (55%) than males (45%) were SAAP clients in 1999—00 (Table 8.8). In particular, those escaping domestic violence were predominantly female (95%). However, males on disability pensions (68%) and older males (64%) made up a larger proportion of these population groups than females. The gender difference is less among young people (58% female, 43% male) than it is in the other groups.

Table 8.8: Supported Accommodation Assistance Program: clients, by gender and population group, 1999–00

	Young people						
Gender	**Under 18**	**18 to 24**	**Total**	**People escaping domestic violence[(a)]**	**People on disability pensions[(b)]**	**Older people**	**All SAAP clients**
				Per cent			
Male	42.3	42.7	42.5	5.1	68.0	63.5	45.0
Female	57.7	57.3	57.5	94.9	32.0	36.5	55.0
Total	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*
Total	**12.6**	**24.7**	**37.2**	**32.4**	**16.6**	**4.8**	**. .**
Total (N)	**11,200**	**22,000**	**33,300**	**28,900**	**14,800**	**4,300**	**89,400**
				Clients per 10,000 population[(c)]			
Male	44	98	69	2	n.a.	15	50
Female	63	137	98	46	n.a.	7	60
Total	**53**	**117**	**83**	**24**	**n.a.**	**11**	**55**

(a) The reference population to calculate the 'per 10,000 population' for people escaping domestic violence is the estimated resident population aged 15–59 as at 30 June 1999. This age range is the same as SAAP clients presenting with domestic violence as a reason for seeking assistance or were clients of agencies targeting domestic violence.

(b) The use of a comparative measure of SAAP clients and 'per 10,000 population' for people receiving a disability pension (from DVA or Centrelink) is problematic; therefore, no data are available.

(c) 'Per 10,000 population' shows how many people out of every 10,000 in the general population become SAAP clients. The rate is estimated by comparing the number of SAAP clients aged 10 and over to the estimated resident population aged 10 and over as at 30 June 1999. The Australian estimated resident population as at 30 June 1999 has been used as the reference population.

Notes

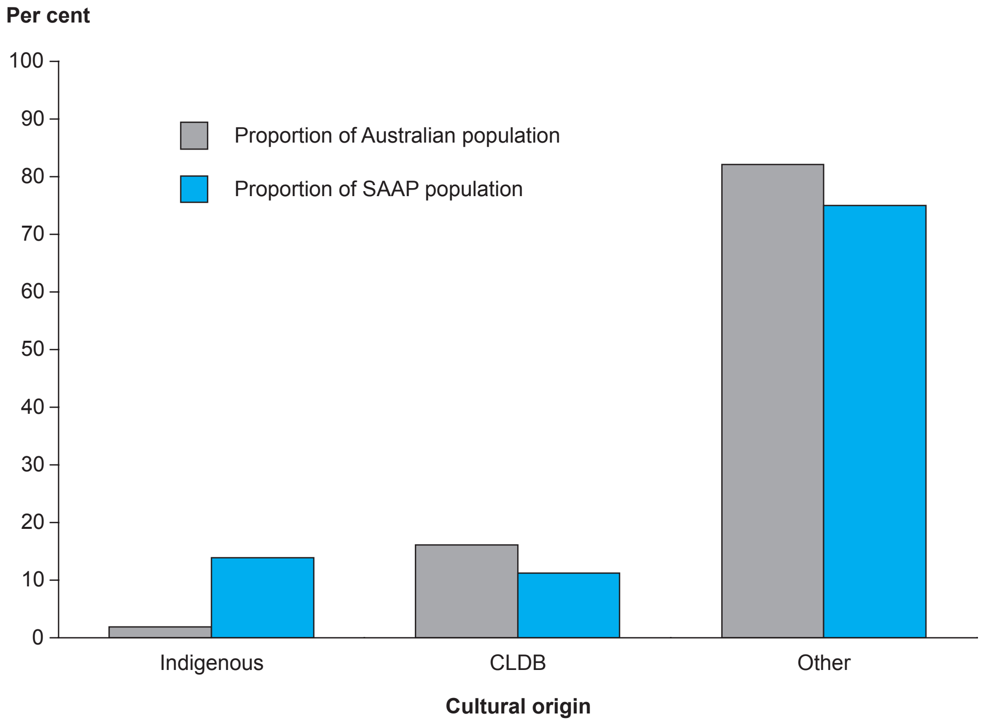
1. The totals of this table do not necessarily match the totals of other tables in this chapter because of questionnaire errors or omissions. The number of records excluded due to errors is 11. The number excluded due to omissions is 649.
2. Clients may be in none or more than one population group; therefore, the sum of the groups does not equal the total for all SAAP clients.

Source: AIHW analysis of SAAP Client Collection; ABS 2000b.

The age and sex distribution of clients reflects, to a certain extent, the distribution in the general population. For instance, more males than females were on disability support pensions as at June 1999 (FaCS 1999); therefore, it is not unreasonable to expect that a greater proportion of SAAP clients on disability pensions were males. Examining the number of clients per 10,000 population (aged 10 and over) indicates the relative use of SAAP by the various groups. Table 8.8 shows that 55 of every 10,000 people accessed services in 1999—00. Usage was higher for females (60 per 10,000) than for males (50 per 10,000). People aged 18—24 had relatively high levels of SAAP usage, at 137 for females and 98 for males. Relatively few older people access SAAP: 11 for every 10,000 people. Also, 46 per 10,000 women used a SAAP service at some time during the year because of domestic violence, whereas the corresponding number for males was 2.

Aboriginal and Torres Strait Islander clients

Aboriginal and Torres Strait Islander communities were over-represented (14%) in the SAAP population in 1999—00, compared with the overall Australian population aged 10 and over (2%) (AIHW 2000b:14) (Figure 8.2).



Note: CLDB = culturally and linguistically diverse background.
Source: Table 8.9.

Figure 8.2: Cultural origin of SAAP clients, 1999–00

The highest proportion of Aboriginal and Torres Strait Islander clients in any of the four population groups of interest were those escaping domestic violence (21%), compared with young people (13%), people on disability pensions (10%) and older people (7%) (Table 8.9). Furthermore, 468 Aboriginal and/or Torres Strait Islander women aged 15—59 escaping domestic violence accessed SAAP services for every 10,000 in the population.

Table 8.9: Supported Accommodation Assistance Program: clients, by cultural origin and population group, 1999–00

Cultural origin	**Young people**			**People escaping domestic violence**	**Women escaping domestic violence**[a]	**People on disability pensions**[b]	**Older people**	**All SAAP clients**	**Aust. population (aged 10+)**
	Under 18	**18 to 24**	**Total**						
					Per cent				
Indigenous Australian	12.5	13.1	12.9	20.7	21.1	10.1	7.3	13.8	1.8
Culturally & linguistically diverse background	4.3	8.4	7.0	16.8	17.3	8.2	21.5	11.2	16.1
Other	83.1	78.4	80.0	62.5	61.6	81.7	71.2	75.0	82.1
Total	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*
Total	**12.6**	**24.7**	**37.4**	**32.4**	**30.5**	**16.6**	**4.8**	**. .**	**100.0**
Total (N)	**11,000**	**21,500**	**32,500**	**28,200**	**26,600**	**14,500**	**4,200**	**87,000**	**16,332,700**
					Clients per 10,000 population[c]				
Indigenous Australian	181	543	328	—	468	n.a.	120	403	—
Culturally & linguistically diverse background	33	72	58	—	47	n.a.	11	37	—
Other	48	107	75	—	34	n.a.	9	49	—
Total	**52**	**114**	**81**	**—**	**45**	**n.a.**	**11**	**53**	**—**

(a) The reference population to calculate the ‘per 10,000 population’ for people escaping domestic violence is the estimated resident population aged 15–59 as at 30 June 1999. This age range is the same as SAAP clients presenting with domestic violence as a reason for seeking assistance or were clients of agencies targeting domestic violence.

(b) The use of a comparative measure of SAAP clients and ‘per 10,000 population’ for people receiving a disability pension (from DVA or Centrelink) is problematic; therefore, no data are available.

(c) ‘Per 10,000 population’ shows how many people out of every 10,000 in the general population become SAAP clients. The rate is estimated by comparing the number of SAAP clients aged 10 and over to the estimated resident population aged 10 and over as at 30 June 1999. The Australian estimated resident population as at 30 June 1999 has been used as the reference population.

Notes

1. The totals of this table do not necessarily match the totals of other tables in this chapter because of questionnaire errors or omissions. The number of records excluded due to omissions is 2,985.
2. Culturally and linguistically diverse background is based on country of birth. For the purposes of this report, people born in a country where English is not the main language spoken have such a background. ‘Other’ refers to people born in countries where English is the main language (i.e. Australia, Canada, the Republic of Ireland, New Zealand, South Africa, the United Kingdom, and the United States).
3. Clients may be in none or more than one population group; therefore, the sum of the groups does not equal the total for all SAAP clients.

Source: AIHW analysis of SAAP Client Collection; ABS 1998, 2000b.

Clients from culturally and linguistically diverse backgrounds

Individuals from a range of culturally and linguistically diverse backgrounds access SAAP services.[7] People born in non-English-speaking countries (11%) were under-represented among SAAP clients in 1999—00, compared with 16% of all Australians aged 10 or more (Table 8.9). Older people from these backgrounds accounted for 22% of all older people in SAAP, the highest proportion of any targeted population group. People from culturally and linguistically diverse backgrounds accounted for 17% of women escaping domestic violence, 8% of people on disability pensions and 7% of young clients. Relatively high SAAP usage rates among those born in a country in which English is not the main language spoken were recorded for young people aged 18—24 (72 for every 10,000).

Presenting client groups

The majority of SAAP support periods in 1999—00 were provided for male and female clients presenting alone (72%) (Table 8.10). The percentages varied, however, across the client groups: 94% for older people, 92% for those receiving a disability pension, 79% for young people, and 42% for those escaping domestic violence.

Males presented alone more often than females for all client groups except the people escaping domestic violence group. Seventy-two per cent, 69% and 42% of support periods were respectively provided for males presenting alone on disability pensions, older people and young people. The vast majority of support periods for males on disability pensions presenting alone were for those aged 25 years and over (66%). Among women escaping domestic violence, those presenting alone constituted 39% of periods of support. It is also worth noting that females under 18 years of age (50%) presented alone more often than males (43%).

Support to people escaping domestic violence was most often given to females with children (55%). A significant proportion of support periods for young people also went to women (particularly those aged 18—24) with children. Support was provided less often to females on disability pensions (4%), females under 18 years (3%) and older females (2%) who presented alone with children. Males presented alone with children in only 1% of support periods. For couples presenting with or without children, most support periods were provided to young people aged between 18 and 24 (7%), compared with young people under 18 years (3%), older people (3%) and people on disability pensions (3%).

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[7] People from culturally and linguistically diverse backgrounds are defined for the purpose of this report as those born in countries where English is not the main language spoken. The term ‘culturally and linguistically diverse backgrounds’ (CLDB) was developed as a response to the limitations of the non-English-speaking background (NESB) term because there are many migrants who may speak English well yet have cultural backgrounds which are very different from those of Anglo-Celtic Australians (AIHW: Gibson et al. 2001:1).

Table 8.10: Supported Accommodation Assistance Program: support periods, by client group and population group, 1999–00 (per cent)

	Young people						
Client group	**Under 18**	**18 to 24**	**Total**	**People escaping domestic violence**	**People on disability pensions**	**Older people**	**All SAAP clients**
Male alone, under 25	42.8	41.3	41.8	2.2	5.9	—	15.3
Male alone, 25+	—	—	—	1.3	65.6	68.9	30.8
Female alone, under 25	49.9	30.1	36.7	11.2	3.3	—	13.5
Female alone, 25+	—	—	—	27.7	17.1	24.6	12.4
Couple, no children	1.9	4.1	3.4	0.8	2.0	2.1	2.6
Couple with child(ren)	0.7	3.3	2.4	0.9	1.3	0.8	3.2
Male with child(ren)	0.1	0.4	0.3	0.3	0.4	0.3	0.8
Female with child(ren)	2.7	19.3	13.7	54.7	3.8	2.3	20.6
Other	1.8	1.5	1.6	0.9	0.6	0.9	0.9
Total	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*
Total	**12.3**	**24.4**	**36.6**	**27.8**	**18.2**	**5.1**	**. .**
Total (N)	**18,800**	**37,400**	**56,200**	**42,600**	**28,000**	**7,800**	**153,500**

Notes

1. The totals of this table do not necessarily match the totals of other tables in this chapter because of questionnaire errors or omissions. The number of records excluded due to omissions is 4,053.
2. Clients may be in none or more than one population group; therefore, the sum of the groups does not equal the total for all SAAP clients.

Source: AIHW analysis of SAAP Client Collection.

Reasons for seeking assistance

Overall, the reasons given most often for seeking assistance were financial difficulty (39%), relationship or family breakdown (37%), domestic violence (29%) and physical or emotional abuse (26%) (Table 8.11). Fifty-five per cent of young people aged under 18 years and 47% of people escaping domestic violence sought assistance because of relationship or family breakdown. Not surprisingly, people escaping domestic violence most often reported domestic violence (83%) and physical or emotional abuse (58%) as reasons for seeking assistance. People on disability pensions, people aged 18—24 years and older people most often gave financial difficulty as a reason (47%, 43% and 42% respectively). Compared with other groups, people on disability pensions most often reported drug and alcohol abuse (23%) and psychiatric illness (19%) as reasons for seeking assistance (national average 16% and 5% respectively).

Table 8.11: Supported Accommodation Assistance Program: support periods, by population group and reasons for seeking assistance, 1999–00 (per cent)

Reason	Young people: Under 18	Young people: 18 to 24	Young people: Total	People escaping domestic violence	People on disability pensions	Older people	All SAAP clients
Usual accommodation unavailable	27.8	25.6	26.4	14.8	21.8	20.0	22.1
Time out from family/ other situation	33.5	20.6	25.2	20.6	15.6	12.4	19.1
Relationship/family breakdown	55.1	39.5	45.0	47.4	23.5	21.5	37.1
Interpersonal conflicts	35.2	26.0	29.3	31.0	18.8	15.3	24.3
Physical/emotional abuse	19.6	21.3	20.7	58.0	15.6	18.2	25.5
Domestic violence	12.0	22.3	18.6	82.6	15.8	21.1	28.9
Sexual abuse	4.6	4.3	4.4	8.2	3.7	2.0	4.2
Financial difficulty	23.9	42.5	35.9	25.8	46.7	41.6	39.2
Eviction/previous accommodation ended	26.0	25.4	25.6	10.1	17.2	13.3	19.8
Drug/alcohol/substance abuse	10.3	16.2	14.1	10.2	23.1	13.8	15.8
Emergency accommodation ended	5.8	4.7	5.1	2.9	4.0	2.9	4.0
Recently left institution	2.4	3.2	2.9	1.0	5.6	3.4	3.3
Psychiatric illness	1.8	4.3	3.4	3.2	18.8	6.8	5.1
Recent arrival to area with no means of support	7.3	12.3	10.5	7.4	18.4	17.8	12.7
Itinerant	10.0	12.7	11.7	5.4	15.8	12.4	10.6
Other	10.4	10.6	10.5	5.4	9.9	11.8	9.8
Total (N)	**17,200**	**31,100**	**48,300**	**41,500**	**16,900**	**4,600**	**118,600**

Notes

1. The totals of this table do not necessarily match the totals of other tables in this chapter because of questionnaire errors or omissions. The number of records excluded due to omissions is 5,518.
2. Excludes high-volume records because not all items were included on high-volume form.
3. Clients may be in none or more than one population group; therefore, the sum of the groups does not equal the total for all SAAP clients.

Source: AIHW analysis of SAAP Client Collection.

Services requested and support provided

In over two-thirds of closed support periods,[8] clients requested supported accommodation (68%) and over one-third requested other accommodation services (36%) (Table 8.12). Most support periods also involved requests for general support and advocacy services (74%), other support such as meals, or shower and laundry facilities (71%), and counselling (44%). People escaping domestic violence made relatively more requests for general support and advocacy (77%), counselling (72%), and specialist

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[8] A closed support period is one that finished before the end of the reporting period: 30 June 2000.

services (39%). Young people tended to make more requests for employment and training assistance (11%) than any other group. People on disability pensions and older people requested SAAP or CAP accommodation (76% and 73% respectively) and other support services (82% and 77% respectively) rather more often, but generally had relatively fewer requests for other types of services.

Table 8.12: Supported Accommodation Assistance Program: closed support periods, by type of service requested and population group, 1999–00 (per cent)

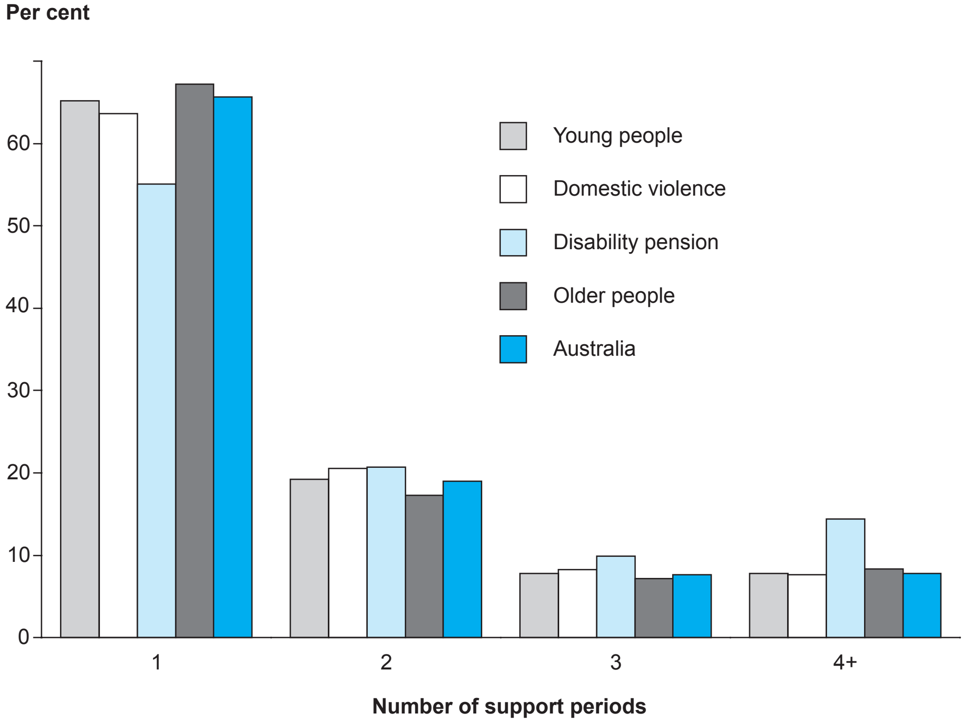
	Young people			People escaping domestic violence	People on disability pensions	Older people	All SAAP clients	Number
Broad service type	**Under 18**	**18 to 24**	**Total**					
SAAP/CAP accommodation	66.6	63.9	64.8	68.5	75.6	73.1	68.4	95,800
Other accommodation services	37.0	43.9	41.6	38.6	28.8	24.2	35.8	50,100
Financial services/ assistance	37.9	42.1	40.7	42.2	36.0	30.1	39.5	55,400
Employment/training assistance	14.1	9.6	11.1	4.3	2.4	1.2	6.0	8,400
Counselling	49.7	44.2	46.0	71.7	32.5	31.1	44.0	61,700
General support/ advocacy	73.3	74.3	74.0	77.4	73.5	69.7	73.5	103,100
Specialist services	28.1	31.6	30.4	39.0	36.1	29.5	32.0	44,900
Other support	68.5	66.4	67.1	69.0	82.0	77.1	71.3	100,000
Total support periods (N)	**16,500**	**33,700**	**50,200**	**39,500**	**26,500**	**7,100**	**—**	**140,200**

Notes

1. The totals of this table do not necessarily match the totals of other tables in this chapter because of questionnaire errors or omissions.
2. Clients are able to receive multiple services so percentages do not total 100.
3. Clients may be in none or more than one population group; therefore, the sum of the groups does not equal the total for all SAAP clients.

Source: AIHW analysis of SAAP Client Collection.

Length of support and the number of services required varied according to the population group (Figure 8.3). People on disability pensions (76%) and older people (73%) reported needing SAAP or CAP accommodation more often than people escaping domestic violence (68%) and young people under 18 years (67%). However, people under the age of 18 tended to have relatively long periods of support (50% for more than 13 days), while people on disability pensions and older people had relatively short support periods, with 50% lasting 4 days or less. Ninety per cent of accommodation periods lasted 92 days or less for young people, 21 days above the figure for all clients (71 days).



Source: Table 8.13.

Figure 8.3: Overview of support provided to SAAP clients, 1999–00

On average, people escaping domestic violence requested and received more services in a support period (requested 7.2 and received 6.0) than did young people (6.3 and 5.3), people on disability pensions (5.9 and 5.2) and older people (5.4 and 4.8) (Table 8.13). People on disability pensions had the highest level of repeat use (14% with 4 or more support periods) of SAAP services in 1999—00, compared with other population groups (national figure of 8% with 4 or more support periods).

In addition, children accompanied clients to a SAAP agency in 31,600 support periods (Table 8.14). If these children aged under 18 were to be considered clients in their own right, this would equate to 67,100 support periods. There was little variation in the average number of children across client groups. On average, couples with children presented with more children (2.3) than did female clients presenting with children (2.1). The average across all client groups was 2.1 children. Eighty-eight per cent of accompanying child visits occurred where females with children presented at a SAAP agency.[9] This is proportional to the number of support periods in which female clients

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[9] The number of accompanying child visits is calculated by adding each valid response in the accompanying children age groups for each support period.

presented with children (88%), and significantly greater than the number of support periods for couples with children (9%) or males with children (3%). Child care or kindergarten / school liaison assistance was provided to females with children in almost a quarter of all support periods (22%). The figure was substantially lower for males (10%) and couples (9%) with accompanying children.

Table 8.13: Supported Accommodation Assistance Program: overview of support, by population group, 1999–00

	Young people			People escaping domestic violence	People on disability pensions	Older people	All SAAP clients
	Under 18	18 to 24	Total				
Closed support periods							
Length of support period—median (days)	13	6	8	7	4	4	6
Length of support period—90th percentile (days)	135	135	135	115	78	104	107
Proportion needing SAAP/CAP accommodation (%)	67.0	64.0	65.0	68.0	76.0	73.0	68.0
Proportion accommodated (%)	64.0	59.0	61.0	64.0	73.0	70.0	65.0
Length of accommodation—median (days)	8	7	7	7	5	4	6
Length of accommodation—90th percentile (days)	84	98	92	67	50	70	71
Mean number of services requested per support period	6.7	6.1	6.3	7.2	5.9	5.4	6.1
Mean number of services requested and provided per support period	5.7	5.1	5.3	6.0	5.2	4.8	5.2
Proportion of requested services that were provided (%)	84.9	83.8	84.1	84.1	87.9	89.5	85.7
Clients							
Age—median (years)	16	21	19	31	39	61	29
Age—90th percentile (years)	17	24	23	46	54	73	48
Support periods per client—mean	1.7	1.7	1.7	1.6	2.0	1.8	1.7
Proportion of clients with only 1 support period (%)	64.0	65.8	65.2	63.6	55.1	67.2	65.6
Proportion of clients with 4 or more support periods (%)	8.2	7.5	7.8	7.6	14.4	8.3	7.8

Notes

1. The totals of this table do not necessarily match the totals of other tables in this chapter because of questionnaire errors or omissions. The number of records excluded due to omissions is 244.
2. Accommodation statistics are for support periods with accommodation.
3. Clients may be in none or more than one population group; therefore, the sum of the groups does not equal the total for all SAAP clients.

Source: AIHW analysis of SAAP Client Collection.

Table 8.14: Supported Accommodation Assistance Program: closed support periods with accompanying children, by services provided to children and client group, 1999–00 (per cent)

Support services provided to accompanying children	Couple with child(ren)	Male with child(ren)	Female with child(ren)	Other with child(ren)	Total	Number
Counselling	6.5	10.4	20.3	18.1	18.9	6,000
Child care, kindergarten/ school liaison	8.8	9.5	22.3	26.5	20.8	6,600
Access arrangements	0.8	2.1	2.2	5.0	2.1	700
Other	14.0	15.8	22.5	25.6	21.6	6,800
Summary totals						
Total support periods (%)	8.3	2.9	88.4	0.4	100.0	. .
Total support periods (number)	2,600	900	28,000	100	. .	31,600
Total accompanying child visits (%)	9.2	2.6	87.9	0.3	100.0	. .
Total accompanying child visits (number)	6,200	1,700	59,000	200	. .	67,100
Mean number of accompanying children per support period with accompanying children	2.3	1.8	2.1	1.7	. .	2.1

Notes

1. The totals of this table do not necessarily match the totals of other tables in this chapter because of questionnaire errors or omissions. The number of records excluded due to omissions is 1,234.
2. Figures in this table (excluding those on total accompanying child visits) exclude high-volume records because not all items were included on the high-volume form.
3. ‘Accompanying child visits’ include support periods at high-volume agencies. These accounted for only a very small proportion of such visits.
4. Accompanying children were able to receive multiple services, so percentages do not total 100.
5. An accompanying child may be counted in more than one support period, so the total number does not equal the actual number of accompanying children assisted.
6. Although each member of a couple has an individual support period, in this table a couple presenting with children contributes only one support period. The table is therefore not directly comparable with other tables showing the number of support periods by client group.
7. Clients may be in none or more than one population group; therefore, the sum of the groups does not equal the total for Australia.

Source: AIHW analysis of SAAP Client Collection.

The 1999—00 SAAP data collection identified 31 distinct types of support services.[10] Of the 852,900 requests for services throughout the year, 11% were for SAAP or CAP accommodation (Table 8.15a). The service most often requested was for other support

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[10] It also allows agencies to record other types of support not listed on the data collection form. This report presents support service data in eight groupings: SAAP/CAP accommodation; other accommodation services; financial services/assistance; employment/training assistance; counselling; general support/advocacy; specialist services; and other support.

(30%).[11] General support or advocacy (24%) was the second most requested service, more than twice as often as any other service. Counselling was also requested in a substantial number of cases (11% of requests), indicating that people required a great deal of emotional support in crisis situations. The least requested service was for employment or training assistance (1% of requests).

Requests for services may be provided directly by the SAAP agency, referred on, or neither provided nor referred. Services required by clients were provided in 86% (731,600) of requests (Table 8.15b). Across all clients, the requested support services most often provided were 'other' services (95%), general support or advocacy (93%), SAAP or CAP accommodation (91%) and counselling (84%). Specialist services[12] (60%) and employment or training assistance (49%) were the requested services least likely to be provided directly by a SAAP agency.

Overall, more requested services were provided directly to older people than any other group. These included general support and advocacy (95%), counselling (90%), financial assistance (84%), other accommodation services (68%) and specialist services (63%). People on disability pensions requested and were provided with 'other' support (96%) more often than other groups, and SAAP or CAP accommodation was requested and provided most often to people on disability pensions and older people (94% each). Employment and training assistance was requested and provided most often to young people aged under 18 (54%) and least often to people escaping domestic violence (45%). Counselling (78%) and financial assistance (74%) were requested services that were provided least often to young people under 18 years.

Alternatively, if a requested service cannot be provided directly, it may be met through referral. Agencies were able to refer 6% (54,200) of requested services from clients to other appropriate services. Twenty-seven per cent of requests for employment or training assistance and 22% for specialist services were referred on.

Compared with other population groups, people escaping domestic violence were more often referred into employment and training assistance (30%), SAAP or CAP accommodation (9%) and general support and advocacy services (4%). Requests for specialist services (25%) and counselling (8%) were referred on mostly for young people. Requests for financial assistance by people on disability pensions (9%) and older people (9%) were referred on less often than for other groups.

Overall, 8% (67,100) of requests for services by clients were neither provided nor referred to another agency. Most commonly, these requests were for employment and training assistance (24% of unmet services), accommodation services other than SAAP or CAP (22%) and specialist services (18%).

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[11] 'Other' support includes meals, laundry or shower facilities, recreation, transport, brokerage services, and other.

[12] Specialist services include psychological services, psychiatric services, pregnancy support, family planning support, drug or alcohol support or rehabilitation, physical disability services, intellectual disability services, culturally appropriate support, interpreter services, and health or medical services.

Table 8.15a: Supported Accommodation Assistance Program: closed support periods, by services requested and population group, 1999–00

	Young people			**People escaping domestic violence**	**People on disability pensions**	**Older people**	**All SAAP clients**
Broad service type	**Under 18**	**18 to 24**	**Total**				
				Services requested (%)			
SAAP/CAP accommodation	10.0	10.4	10.3	9.5	12.8	13.7	11.2
Other accommodation services	6.7	8.8	8.1	6.6	5.9	5.4	7.2
Financial services/ assistance	7.8	9.2	8.7	8.0	7.4	6.7	8.4
Employment/training assistance	2.1	1.6	1.8	0.6	0.4	0.2	1.0
Counselling	11.4	11.0	11.1	18.3	7.6	8.1	11.3
General support/advocacy	25.1	24.4	24.6	23.2	21.9	22.3	23.5
Specialist services	6.1	7.7	7.2	8.4	9.3	8.0	7.7
Other support	30.8	26.9	28.2	25.3	34.7	35.7	29.7
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**
				Services requested (N)			
SAAP/CAP accommodation	11,000	21,500	32,500	27,000	20,100	5,200	95,800
Other accommodation services	7,300	18,200	25,500	18,700	9,200	2,000	61,500
Financial services/ assistance	8,600	18,900	27,500	22,700	11,500	2,500	71,900
Employment/training assistance	2,300	3,200	5,600	1,700	600	100	8,400
Counselling	12,600	22,600	35,200	52,000	11,900	3,100	96,000
General support/advocacy	27,700	50,300	78,000	65,900	34,300	8,400	200,600
Specialist services	6,800	15,900	22,700	23,900	14,500	3,000	65,500
Other support	34,000	55,400	89,400	71,700	54,200	13,500	253,200
Total	**110,400**	**206,100**	**316,500**	**283,700**	**156,200**	**37,900**	**852,900**
% of services requested	**12.9**	**24.2**	**37.1**	**33.3**	**18.3**	**4.4**	**—**

Notes

1. The totals of this table do not necessarily match the totals of other tables in this chapter because of questionnaire errors or omissions.
2. Clients may be in none or more than one population group; therefore, the sum of the groups does not equal the total for all SAAP clients.

Source: AIHW analysis of SAAP Client Collection.

For people on disability pensions, the requested services that were most frequently not able to be provided or referred, in comparison with the other population groups, were employment and training assistance (29%) and specialist services (22%). Both young people and people escaping domestic violence requested financial assistance which could not be provided or referred in 12% of cases, relatively more often than other groups. Young people aged 18—24 had the highest level of requested SAAP or CAP accommodation which was unable to be provided or referred (5%).

Table 8.15b: Supported Accommodation Assistance Program: closed support periods, by provision of services requested and population group, 1999–00 (per cent)

	Young people							
Broad service type	**Under 18**	**18 to 24**	**Total**	**People escaping domestic violence**	**People on disability pensions**	**Older people**	**All SAAP clients**	**Number**
Requested service provided								
SAAP/CAP accommodation	89.6	87.9	88.5	87.8	93.9	93.6	90.8	87,000
Other accommodation services	63.0	62.4	62.6	65.6	64.2	68.1	63.7	39,200
Financial services/ assistance	74.1	75.2	74.9	75.5	82.1	83.8	77.3	55,600
Employment/training assistance	54.1	49.5	51.4	45.0	46.0	51.0	48.5	4,100
Counselling	77.9	82.5	80.8	84.2	85.4	89.6	84.0	80,700
General support/advocacy	93.1	93.0	93.0	90.8	94.2	95.1	93.1	186,700
Specialist services	56.9	56.8	56.8	59.3	57.0	62.6	59.5	39,000
Other support	94.2	94.0	94.1	93.0	96.2	95.3	94.5	239,300
Subtotal (N)	*93,600*	*172,600*	*266,300*	*238,400*	*137,300*	*34,000*	—	*731,600*
Requested service referred on only								
SAAP/CAP accommodation	6.0	7.0	6.7	8.9	2.2	2.7	5.0	4,800
Other accommodation services	15.7	16.4	16.2	14.1	13.2	13.7	14.6	9,000
Financial services/ assistance	13.5	13.4	13.4	12.9	9.0	9.0	12.5	9,000
Employment/training assistance	26.4	27.1	26.8	29.7	25.0	22.4	27.3	2,300
Counselling	9.1	7.0	7.7	7.1	4.9	3.8	6.8	6,500
General support/advocacy	1.4	2.2	2.0	3.7	1.6	1.9	2.3	4,600
Specialist services	25.2	25.3	25.2	24.3	21.3	18.1	22.1	14,500
Other support	1.4	1.8	1.6	2.0	1.0	0.9	1.4	3,400
Subtotal (N)	*7,300*	*15,600*	*22,900*	*21,900*	*7,600*	*1,600*	—	*54,200*
Requested service neither provided nor referred on								
SAAP/CAP accommodation	4.3	5.0	4.8	3.4	3.9	3.6	4.1	4,000
Other accommodation services	21.3	21.2	21.2	20.3	22.6	18.2	21.7	13,300
Financial services/ assistance	12.4	11.4	11.7	11.5	8.9	7.2	10.2	7,300
Employment/training assistance	19.5	23.5	21.8	25.3	29.0	26.6	24.2	2,000
Counselling	13.0	10.6	11.4	8.7	9.7	6.5	9.2	8,800
General support/advocacy	5.5	4.8	5.0	5.5	4.2	3.0	4.6	9,200
Specialist services	18.0	17.9	17.9	16.3	21.8	19.3	18.3	12,000
Other support	4.5	4.2	4.3	5.0	2.8	3.8	4.1	10,400
Subtotal (N)	*9,465*	*17,847*	*27,313*	*23,403*	*11,341*	*2,308*	—	*67,100*
Total services requested (N)	**110,400**	**206,100**	**316,500**	**283,700**	**156,200**	**37,900**	**. .**	**852,900**

Notes

1. The totals of this table do not necessarily match the totals of other tables in this chapter because of questionnaire errors or omissions.
2. For a particular service type within a population group: %provided + %referred + %neither provided nor referred = 100.
3. Clients may be in none or more than one population group; therefore, the sum of the groups does not equal the total for all SAAP clients.

Source: AIHW analysis of SAAP Client Collection.

Outcomes for clients

The circumstances of clients before and after occasions of support were collected in the SAAP National Data Collection for income source, accommodation type and legal processes. The data provide useful indicators of short-term outcomes for SAAP clients. The response rate, however, for data items relating to client circumstances after support is relatively low. Thus, the data in this section have limitations and should be interpreted with caution when attempting to assess SAAP’s success, or otherwise, on the basis of client circumstances before and after support.

Table 8.16: Supported Accommodation Assistance Program: closed support periods, by population group and income source before and after support, 1999–00 (per cent)

	Young people							
Income source	**Under 18**	**18 to 24**	**Total**	**People escaping domestic violence**	**People on disability pensions**	**Older people**	**All SAAP clients**	**Number**
Before support								
No income	38.2	5.6	17.1	7.2	0.4	3.5	9.5	9,400
No income, registered/awaiting benefit	3.0	1.5	2.1	1.0	0.2	0.8	1.4	1,400
Government pension/benefit	53.2	87.1	75.2	79.3	99.1	88.9	81.2	79,900
Wages/salary/ own business	4.4	4.2	4.3	7.3	0.2	3.6	5.2	5,100
Other	1.1	1.6	1.4	5.2	0.2	3.2	2.7	2,600
Total	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	. .
Total (N)	**13,900**	**25,600**	**39,600**	**35,000**	**15,300**	**3,600**	**—**	**98,400**
After support								
No income	30.5	3.2	13.1	5.0	0.2	2.2	6.9	5,887
No income, registered/awaiting benefit	2.7	1.0	1.6	0.9	0.0	0.5	1.1	951
Government pension/benefit	60.5	88.6	78.4	84.7	99.2	91.8	84.1	72,044
Wages/salary/ own business	4.9	5.8	5.4	6.4	0.5	3.2	6.0	5,169
Other	1.3	1.4	1.3	2.9	0.1	2.4	1.9	1,639
Total	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	. .
Total (N)	**12,400**	**22,000**	**34,400**	**31,500**	**13,600**	**3,200**	**—**	**85,700**

Notes

1. The totals of this table do not necessarily match the totals of other tables in this chapter because of questionnaire errors or omissions. The number excluded due to errors is 1,349 before support and 747 after support. The number excluded due to omissions is 8,790 before support and 21,218 after support.
2. Excludes high-volume records because not all items were included on high-volume form.
3. Clients may be in none or more than one population group; therefore, the sum of the groups does not equal the total for all SAAP clients.

Source: SAAP Client Collection.

Income

Before receiving support, SAAP clients were recipients of a government pension or benefit in 81% of closed support periods (Table 8.16). In a further 10% of support periods, clients were reported as having no source of income and 5% were in receipt of wages, salary or income from their own business. In another 3% of support periods, clients were reported as having other sources of income, and 1% had no income but were awaiting a pension or benefit.[13]

These proportions had changed slightly by the time support had ended. Afterwards, the proportion of support periods in which clients were on a government pension or benefit had increased to 84%, while the proportion in which clients had no income and were not awaiting a pension or benefit had dropped to 7%.

Some 38% of clients aged under 18 years had no income and were not awaiting a pension or benefit before support and 53% were in receipt of a government pension or benefit. The proportion of support periods in which these clients had no income had dropped to 31% after support. Those accessing a government pension or benefit had increased to 61% upon completion of support.

There were smaller changes in income status in the other groups of interest. The greatest change was in the proportion of support periods for people escaping domestic violence in which clients were on a government payment in 79% of support periods before support and 85% after support. Before support, 4% of older people had no income and 89% received a government pension. After support, the proportion of support periods in which older people had no income dropped to 2% and increased for those in receipt of a government payment to 92%. Income status for people on disability pensions remained relatively unchanged.

Accommodation

The extent to which clients returned to the same accommodation type varied across population groups (Table 8.17). The most common forms of client accommodation immediately before support were private rental (in 18% of support periods) and SAAP or other emergency housing (18%), followed by living rent-free in a house or flat (14%), and boarding in a private home (14%). Ten per cent of clients were accommodated in public or community housing and 9% were living in a car, tent, park, street or squat prior to support.

After support, there were several noticeable differences in the use of types of accommodation. Overall, the proportion of clients accommodated in public or community housing increased to 16%, and decreased to 3% for clients living in a car, tent, park, street or squat. More specifically, the use of private rental accommodation by young people increased from 13% of support periods before support to 18% after

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[13] 'Other' income sources include workcover / compensation, maintenance / child support, spouse / partner's income and any response given as other.

Table 8.17: Supported Accommodation Assistance Program: closed support periods, by population group and type of accommodation before and after support, 1999–00 (per cent)

	Young people							
Accommodation	**Under 18**	**18 to 24**	**Total**	**People escaping domestic violence**	**People on disability pensions**	**Older people**	**All SAAP clients**	**Number**
Before support								
SAAP or other emergency housing	25.3	17.5	20.3	16.1	18.6	16.7	17.7	16,900
Living rent free in house/flat	36.4	15.6	23.0	9.7	7.3	6.9	13.8	13,200
Private rental	5.8	16.9	13.0	25.1	15.2	16.7	18.3	17,600
Public or community housing	2.7	8.6	6.5	18.3	9.8	10.6	10.1	9,700
Rooming house/ hostel/hotel	2.8	6.6	5.3	4.5	11.7	12.7	7.2	6,900
Boarding in a private home	15.4	19.3	17.9	10.2	10.9	7.3	13.6	13,000
Own home	0.8	0.8	0.8	10.1	2.5	13.0	4.5	4,300
Living in a car/tent/ park/street/squat	5.3	8.9	7.6	3.1	14.7	9.3	8.7	8,300
Institutional	3.6	4.1	4.0	1.7	8.2	5.6	4.6	1,400
Other	1.9	1.5	1.6	1.3	1.3	1.2	1.5	4,400
Total	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	. .
Total (N)	**13,800**	**25,100**	**38,900**	**33,700**	**14,300**	**3,500**	**—**	**95,800**
After support								
SAAP or other emergency housing	23.1	19.0	20.5	22.7	19.0	17.4	19.1	13,300
Living rent free in house/flat	32.4	11.2	19.0	8.5	5.3	4.9	11.1	7,800
Private rental	11.4	22.1	18.1	22.1	17.2	18.5	21.4	14,900
Public or community housing	4.0	14.0	10.3	20.7	17.2	18.4	15.5	10,800
Rooming house/ hostel/hotel	3.9	6.9	5.8	4.3	13.0	11.7	7.5	5,200
Boarding in a private home	16.4	16.5	16.4	10.2	9.2	6.4	11.9	8,300
Own home	1.0	0.6	0.8	7.0	2.0	11.8	3.7	2,500
Living in a car/tent/ park/street/squat	1.7	2.6	2.3	0.7	5.8	2.9	2.9	2,000
Institutional	3.2	4.5	4.0	2.0	8.7	6.2	4.6	1,700
Other	3.0	2.5	2.7	1.9	2.6	1.6	2.4	3,200
Total	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	. .
Total (N)	**10,300**	**17,600**	**27,900**	**28,000**	**9,700**	**2,700**	**—**	**69,800**

Notes

1. The totals of this table do not necessarily match the totals of other tables in this chapter because of questionnaire errors or omissions. The number excluded due to errors is 912 before support and 180 after support. The number excluded due to omissions is 13,867 before support and 37,714 after support (includes responses of no information).
2. Excludes high-volume records because not all items were included on high-volume form.
3. Support period figures have been weighted to adjust for agency non-participation and client non-consent.
4. Clients may be in none or more than one population group; therefore, the sum of the groups does not equal the total for all SAAP clients.

Source: AIHW analysis of SAAP Client Collection.

support. People escaping domestic violence were living in SAAP or other emergency housing in 16% and their own home in 10% of support periods prior to assistance, compared with 23% and 7% respectively after support.

Public or community housing use rose from 10% of support periods before support to 17% after for people on disability pensions, who also reported living in a car, tent, park, street or squat (15%) prior to support, more often than any other group. After support, their proportion dropped to 6%. The proportion of older people who were in public or community housing increased from 11% before support to 18% after support.

Legal processes

Legal status before and after support changed marginally for young people (Table 8.18). Overall, 70% were not involved in any legal process before support, compared to 69% after support. Intervention, protection or restraining orders increased from 4% before support to 5% after support.

There were, however, more noticeable changes for people escaping domestic violence. For example, 65% were not involved in any legal processes before support, compared to 56% after support. The existence of an intervention, protection or restraining order increased from 17% before support to 21% after support. Involvement in other legal processes also increased: from 15% to 20%.

Table 8.18: Supported Accommodation Assistance Program: closed support periods, by population group and legal processes before and after support, 1999–00 (per cent)

	Young people			People escaping
Legal processes	**Under 18**	**18 to 24**	**Total**	**domestic violence**
Before support				
None	67.5	72.0	70.3	64.8
Protection or guardianship order[(a)]	7.4	1.8	3.8	3.1
Intervention/protection or restraining order[(b)]	2.1	5.6	4.3	16.8
Other	23.0	20.7	21.6	15.3
Total (N)	**13,000**	**22,500**	**35,500**	**33,600**
After support				
None	66.4	70.0	68.6	55.6
Protection or guardianship order[(a)]	7.3	1.8	3.9	3.5
Intervention/protection or restraining order[(b)]	2.2	6.7	4.9	20.9
Other	24.1	21.5	22.5	20.0
Total (N)	**11,000**	**17,600**	**28,600**	**29,100**

(a) Including wardship or equivalent.

(b) As a result of violence perpetrated against the client.

Notes

1. The totals of this table do not necessarily match the totals of other tables in this chapter because of questionnaire errors or omissions. The number excluded due to omissions is 23,267 before support and 39,852 after support (includes responses of no information).
2. Excludes high-volume records because not all items were included on high-volume form.
3. Clients were able to be involved in multiple legal services, so percentages do not total 100.

Source: AIHW analysis of SAAP Client Collection.

Summary of population groups

Young people

Overall, the proportion of females among young people receiving SAAP services is larger than that of males. The majority of support periods provided to young people aged under 18 were to females presenting alone (50%). Among those aged between 18 and 24, males presenting alone represented 41%. Young people tended to have longer periods of support than other groups. In particular, more than 50% of clients under 18 years had a median support period of 13 days or more compared with the national figure of 6 days (Tables 8.8, 8.10, 8.13).

Generally, young people more often reported relationship or family breakdown and financial difficulty as reasons for seeking assistance. Overall, they most often requested general support and advocacy (74%), other support (67%) and SAAP or CAP accommodation (65%). More specifically, the differences in requests between young people under 18 years and those aged 18—24 were more obvious. Those under 18 requested other support (69%), counselling (50%) and employment and training assistance (14%) more often than those aged 18—24 (66%, 44%, and 10% respectively). Conversely, young people aged 18—24 requested other accommodation services (44%), financial services (42%) and specialist services (32%) more often than those under 18 (37%, 38% and 28% respectively) (Tables 8.11, 8.12).

Compared with other groups, outcomes in relation to income status for young people under 18 years showed the most noticeable change. There was a decrease in the proportion of support periods in which they had no income after support and an increase in receipt of a government payment. Young people showed the greatest increase in private rental accommodation use after support, compared with other groups: from 13% before support to 18% after (Tables 8.16, 8.17).

People escaping domestic violence

The greatest proportion of people escaping domestic violence was aged between 25 and 44 years. This population group was predominantly female (95%) and most often presented alone with children (55%). Women of Aboriginal and Torres Strait Islander background (21%) were over-represented among people escaping domestic violence (average 14% for all SAAP clients) (Tables 8.7—8.10).

People escaping domestic violence most often gave domestic violence (83%), physical and emotional abuse (58%) and relationship or family breakdown (47%) as the reasons for seeking assistance. These clients requested general support and advocacy (77%), counselling (72%), financial counselling (42%) and specialist services (39%) more often than other groups (national average 74%, 44%, 40% and 32% respectively). They also often requested other support (69%) and SAAP or CAP accommodation (69%) (Tables 8.11, 8.12).

On average, people escaping domestic violence requested the highest number of services within a support period (7.2) and had the greatest number of services requested and provided per support period (6.0) (national average number of 6.1 and 5.2) (Table 8.13).

The greatest increase before and after support for clients accommodated in SAAP or other emergency housing occurred for people escaping domestic violence (from 16% to 23%). This compares, nationally, with 18% before support to 19% after support. The proportion of support periods in which people escaping domestic violence were in receipt of a government payment increased after support (79% before and 85% after). After receiving assistance, intervention, protection or restraining orders had increased for people escaping domestic violence, as did their involvement in other legal processes (Tables 8.16—8.18).

People on disability pensions

Overall, people on disability pensions accounted for 17% of SAAP clients. This group had by far the highest repeat use of SAAP services but had relatively shorter periods of support, the median length of stay being 4 days compared with the national average of 6 days. There was a larger proportion of males (66%) than females (32%) among people on disability pensions. In particular, 72% of males presented alone, compared with females (20%) (Tables 8.7, 8.8, 8.10, 8.13).

People on disability pensions gave financial difficulty (47%) more often than any other reason for seeking assistance, and they requested other support (82%) and SAAP or CAP accommodation (76%) more often than other groups. Financial support was requested in only 36% of support periods, compared with the national figure of 40%. People on disability pensions reported psychiatric illness and drug and alcohol abuse as reasons for seeking assistance much more often than other groups. They requested specialist services in 36% of support periods and counselling in 33% of support periods the national average for these services was 32% and 44% respectively (Tables 8.11, 8.12).

People on disability pensions reported the biggest change of all client groups for living in a car, tent, park, street or squat from before to after support. However, they still remained in this living situation after support twice as often as other groups (6% compared with the national figure of 3%). Public or community housing use increased more than other forms of accommodation for people on disability pensions (from 10% to 17%). Income status for this population group, however, remained relatively unchanged. The most notable difference was that in less than 1% of support periods clients received an income from wages, salary or their own business before support and 1% after support, compared with the national figure of 5% and 6% respectively (Tables 8.16, 8.17).

Older people

Fewer females (37%) aged 55 years and over than males (64%) accessed SAAP services. Older people were provided with the shortest periods of accommodation, compared with the other population groups, the median length of stay being 4 days. Relatively short periods of support were also provided for older clients, the same as for people on disability pensions (4 days). On average, older clients requested the least number of services in a support period (5.4) of any population group (national average 6.0), but proportionally had the greatest number of requests met (90%) (Tables 8.8, 8.13).

Older people gave financial difficulty (42%) more often than any other reason for seeking assistance, but requested financial support less than any other group (in 30% of support periods, compared with the national average of 40%). Furthermore, this population group requested other support (77%), SAAP or CAP accommodation (73%) and general support and advocacy (70%) more often than other services (Tables 8.11, 8.12).

The proportion of support periods in which older people had no source of income dropped slightly after support (4% to 2%) and increased for those on a government pension (89% to 92%). Public or community housing use by older people increased from 11% before support to 18% after (Tables 8.16, 8.17).

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9

Needs, interventions, outcomes: measurement frameworks

9.1 Introduction

Welfare services and assistance are provided within the environment created by social and economic conditions and the range of other services that may affect the welfare of the population. The interrelationships between social conditions, welfare services and assistance, and the outcomes of these interventions are illustrated in Figure 9.1, from the Institute s first biennial report (AIHW 1993). Each of the preceding chapters of this current report is based on the form of this diagram and recognises the broad context in which services are delivered and in which needs for services are measured; the chapters include relevant population data and information on trends in policy and the provision of services and assistance. Nevertheless, each chapter focuses on a particular service area, population group or aspect of service provision. The goal of this chapter is to reflect more broadly on the welfare system as a whole and on the environment in which these services are provided.

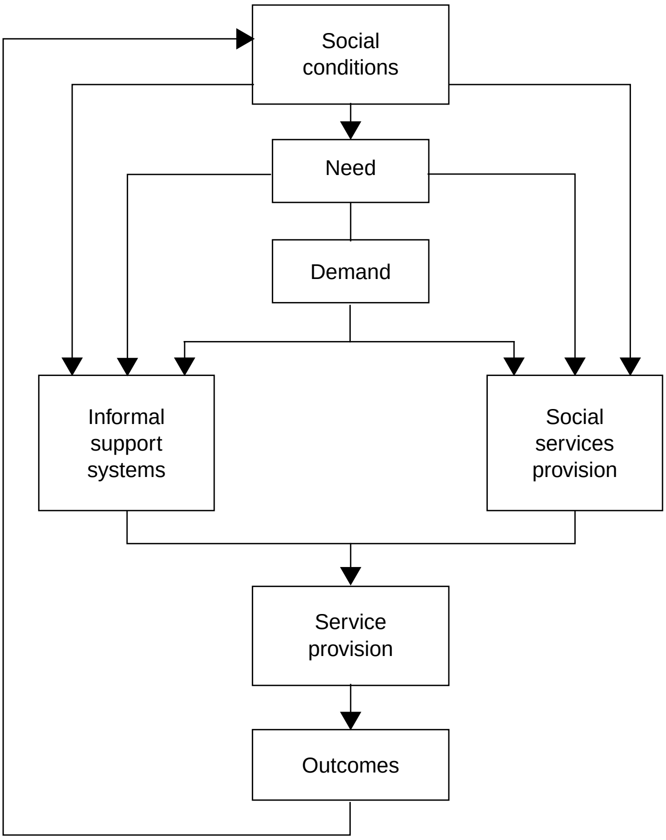
The need to reflect this wider perspective was recognised some time ago by senior welfare administrators. A national plan for community services information, endorsed by the chief executives of relevant government departments, recognised the need for national data in a framework comprising: population wellbeing, service provision and utilisation, and client and carer outcomes (SCCSISA 1999). This chapter moves into this more general framework. One of the purposes is to work towards providing a broader scope of information in future biennial reports, to enhance their usefulness as a public and parliamentary information resource.

Against this background, this introductory section first outlines some major frameworks, both national and international, that support the complex task of identifying and measuring components of welfare and aspects of the welfare system.

Then, in Section 9.2, a simplified version of Figure 9.1 is presented as a framework for discussion in the chapter and for data presentation in the future. There is a brief discussion of each of the main areas of this framework: welfare and its components; interventions, services and assistance; and other factors that affect welfare. Section 9.3 proposes more detailed topics for welfare measurement in Australia, some illustrative indicators and some sources of meaningful data. Section 9.4 concludes with suggested directions for further development and data to be presented in future biennial reports.

Major existing frameworks and indicator sets

There is currently renewed international interest in social indicators, and the literature on indicator development and related frameworks in the health and welfare fields, already considerable, continues to grow.[1] While there is an extensive literature on human wellbeing and its measurement, this chapter does not attempt to review it. Rather, the focus here is on key national and international frameworks that are derived from and consistent with this literature and that are relevant to national statistical presentation.



Source: AIHW 1993.

Figure 9.1: A framework for welfare services and assistance statistics

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1 Recent reviews of some aspects of the literature can be found in Zapf (2000), Berman and Phillips (2000) and Hagerty et al. (2001).

OECD social indicators

In its development of a structured grouping of social indicators, the OECD, in a decision supported by the Australian Government as an OECD member, has adapted the Pressure-State-Response (PSR) framework originally derived for environmental performance assessment (OECD 1993). The PSR framework has three primary components: pressures, state and response. The conceptual thinking behind the framework is that pressures are exerted on the state, which elicits (societal) responses that change the state and thereby feed back to lessen pressures. The three components are largely, but not solely, linked by a linear relationship, with a feedback loop from response back to pressure.

The OECD social indicators framework replaces the customary PSR components with social context, social status and societal actions (OECD 1999). The component social status is used to measure social situations as influenced by policy action and is hence a measure of policy effectiveness and resultant social outcomes. Social context gives contextual background and explanation to social status and is used to measure social conditions. The third component, societal actions, reveals what society is doing in relation to social status and focuses on policy actions.

Four primary objectives of social policy were identified for the selection and classification of indicators: promotion of autonomy,[2] equity, healthy living and social cohesion. Indicators within each objective are further classified as relating to one of the three components. The OECD exercise is specifically located in the context of public policy designed to ameliorate the social situation. Despite the use of neutral terms in its title (social indicators), one of its key stated objectives is the indication of wellbeing.

Indicators of autonomy measure active participation in the economy and society and include employment and unemployment rates, labour force participation, educational participation and literacy attainment. Equity is defined in terms of equity of outcome and can be measured in terms of indicators such as income distribution, minimum wages and social expenditure. Healthy living uses indicators of life expectancy and infant mortality, health care spending, and availability of personnel and equipment. The final objective of social cohesion is yet to be defined but indicators have been selected. Most of these identify pathologies considered to undo social cohesion, such as crime and suicide rates and work stoppages, but also include indicators measuring group membership and election participation rates. A new social indicators publication *Society at a Glance: OECD Social Indicators* is scheduled for publication in late 2001.

European Union system of social indicators

A recent proposal for a system of social indicators for the European Union was based on an extensive review of social reporting activities and conceptual frameworks, as well as an analysis of various European treaty documents. Three main categories of social goals were identified from the treaty documents: economic and social progress, improvement of quality of life; strengthening economic and social cohesion; and

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[2] The OECD in its more recent work (e.g. Pearson et al. 2000) refers to 'self sufficiency' rather than autonomy.

sustainable development. The authors then proceed to integrate both perspectives the scientific and political perspective into a common conceptual framework (Berger-Schmitt & Noll 2000:37).

The resulting social indicator framework is based on the concepts of quality of life, social cohesion and sustainability. Each concept is related to goals that aim to: improve objective living conditions, enhance subjective wellbeing, reduce disparities and inequalities, strengthen social capital, and preserve and enhance human and natural capital. The goals are considered relevant to 14 life areas: population; households and families; housing; transport; leisure, media and culture; social and political participation and integration; education and vocational training; labour market and working conditions; income, standard of living and consumption patterns; health; environment; social security; public safety and crime; and total life situation. Groups of indicators are still being developed to measure attainment of the goals in these life areas but are already substantial in number and diversity.

UNDP Human Development Index

The Human Development Index or HDI uses the concepts of capabilities and the enhancement of choice as goals of development and hence wellbeing (UNDP 1990). The index itself is an aggregate measure of four indicators reflecting three life components crucial to individuals and their capability: longevity, knowledge and standard of living.[3] In Australia, Castles (2000) and others have expressed reservations about the use of a single index and related statistical issues. Conceptually, however, the HDI s value lies in generating cross-country comparison and, through assessment of each component, examining the inequalities or disparities existing between different demographic groups.

Various UN initiatives and summits have generated indicator sets across the social spectrum. To date, there is no common framework, although the UN Statistical Commission has initiated some work on rationalisation.

Australian frameworks and indicator sets

AIHW welfare and health information frameworks

A framework for welfare services and assistance was developed in 1993 and has since provided a common structure for many of the chapters of each edition of *Australia's Welfare* (in terms of needs, services and outcomes). The framework illustrates the relationship between social conditions and the social service and support systems, and acknowledges the concepts of need and demand engendered by social conditions, and from which the type and level of service provision are generated (Figure 9.1). Outcomes were also incorporated into the framework as being a direct result of services received and their effects on social conditions are illustrated through a feedback relationship.

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[3] The HDI is a composite indicator rather than a framework, although it relies on strong intellectual underpinning from the work of Sen (UNDP 1999).

The framework has since been used as a template for an illustration of the major players and structures in the disability services field, as part of a study designed to integrate theory and practice in indicator development in this field (AIHW 2000a). The evolution and application of the welfare services framework illustrate how a general and relatively simple structure can be modified and built on to produce a more detailed framework relevant to a specific field.

Major health frameworks in use in Australia are more immediately related to the OECD PSR conceptualisation. In the AIHW biennial health report, health and wellbeing are visualised as a state affected both by determinants of health (environmental and individual) and by health service interventions of various kinds (AIHW 2000b). A framework to measure health performance in Australia has recently been developed, based on both the AIHW health framework and a Canadian Health Indicators framework (AIHW 2001a; Canadian Institute for Health Information 1999, 2000). This framework is a three-tiered system of components, the three tiers being Health Outcomes, Determinants of Health and Health System Performance. Work is now progressing to enhance information infrastructure by reviewing and harmonising the National Health Information Model, and health performance indicator frameworks of national significance.

Information models and data dictionaries

Increasingly important in data development, in Australia and elsewhere, is the systematic specification of information models and data definitions. Such work is reflected in Australian data dictionaries in the health, housing and community services fields and provides the technical infrastructure for national efforts to improve the quality and consistency of national health and welfare information, particularly service-related data (see also Chapter 1). These models and dictionaries are the means by which the scope of data collections and the data definitions themselves are refined and standards set. The high-level information models and system-wide data dictionaries provide the structure and menu for service-specific (business) information models and data sets, and related performance indicator frameworks and sets (see, for example, AIHW 2000c, 2001b).

Box 9.1: Terminology for the chapter

Frameworks

A framework depicts the structure of a field, showing how related parts fit and unite within a defined border. Frameworks are useful in broad, complex fields such as health and welfare statistics because of the need for structure and perspective in organising data and setting priorities among many possible data development, collection and preservation options. In such fields, frameworks should relate to underlying explanatory models, where these exist, as well as to administrative and policy structures.

Concepts

A concept is a 'thought, idea or notion … a theoretical construct' (Macquarie University 1988). In this chapter it is, further, a high-level 'idea' on which information is sought. The UN Statistics Division defines concepts as 'abstract summaries, general notions, knowledge etc of a whole set of behaviours, attitudes or characteristics which are seen to have something in common' (UNSD 2001).

(continued)

Box 9.1 (continued): Terminology for the chapter

Components

The term 'component' is used here to mean not only a constituent part (its usual dictionary meaning) but also to represent a step along the way to giving a concrete form to the concept of welfare. That is, in specifying the constituent parts of concepts such as welfare, we are also, in this chapter, taking the extra step of specifying observable phenomena to which measurements can be attached. In some frameworks, components of health and welfare may reflect thoughtful social theory; in some, they reflect statements of specific social policy goals. In others, the specification of 'components' may simply be a useful intermediate step, providing headings that help specify, organise and focus otherwise diffuse lists of indicators.

Indicators

'Indicators' are particular data items or amalgams of data items that relate to key concepts or components within frameworks. The term 'indicator' may suggest a theoretical relationship (possibly causal) or an element of doubt about the direct connection between the data collected and the concept on which information is sought. Indicators may be developed to 'indicate' components whose measurement is difficult, or to summarise complex material (see AIHW 2000a). In a framework encompassing services, indicators are characteristically policy relevant and relate to key policy goals.

'Summary measure' or 'summary indicator' is a term often used for indicators that are composites of other indicators; in the heath field, for instance, 'summary health measures' often refer to the combination of indicators of mortality, morbidity and disability into a single 'health status' measure for a population.

Statistics and data items

Statistics, as a discipline, 'deals with the data obtained by counting or measuring the properties of populations'. A 'statistic … is the name given to an estimate of an unknown measure of a population' (Kendall & Stuart 1958:1,2). Statistics are, thus, counts or estimates of any data item, concept or indicator we wish to measure; statistics embrace quantifiable or statistical indicators. Statistical estimation is characterised by uncertainty, and the need to estimate the degree of 'confidence' to be placed in specific estimates. This uncertainty arises both from the underlying assumptions that are made about the patterns of variation within the population and from the uncertainty or confidence in the available measurement methods. Statistical indicators are the main focus of this chapter, although not all indicators are necessarily in the form of statistics.

Data items in national collections are defined in relation to the concepts, indicators and statistics of importance in the field captured within the framework and agreed to be of national importance.

Terminology in use: an example

To illustrate the use of this terminology: a significant component of wellbeing *in society may be enunciated to be 'social and economic participation'.* Indicators *of such participation could include a range of* statistics *relating to employment, voluntary work, and family caring responsibilities.* Data items *in national collections can be defined to produce the necessary statistics.*

A framework for community services information

Senior administrators of community services in Australia, in conjunction with the AIHW, published an information development plan for improving data across the field (SCCSISA 1999). The plan identified four key foci for data required: population wellbeing, service provision, service utilisation, and client/carer outcomes. While the plan focused on priorities for action by administrators, in terms of sector-specific collections and national data infrastructure, it also emphasised the importance of data on population wellbeing to monitor population needs and outcomes.

ABS work on social indicators and social trends

From 1976, the Australian Bureau of Statistics (ABS) produced a series of five publications on social indicators , the last of which was its guide to Australian social statistics, which traced the history of the social indicators movement and outlined the system of social statistics available at the time (ABS 1992). The organisational frameworks seen in these publications are largely based on the original conception of areas of concern developed by the OECD in the 1970s and have since been more fully developed, as described in *Measuring Wellbeing: Frameworks for Australian Social Statistics* (ABS 2001a). The *Australian Social Trends* series, published annually since 1994, contains a rich array of data drawn from ABS collections and other official sources, describing social conditions in Australia and how they are changing over time (see ABS 2001b and earlier editions). The publication is also organised into chapters relating to areas of concern (namely, population, family, health, education and training, work, income and expenditure, and housing, and some editions have also included chapters relating to crime and justice and to recreation and leisure). Each chapter comprises analysis and data on key topics in the subject area and also presents summary data over the last decade for each State and Territory (ABS 2001b).

The ABS is now also working on a publication, *Measuring Australia's Progress*, which aims to present a set of headline indicators (about 15) that will help to describe whether or not progress in key areas of concern is being realised. The publication, due for release in 2002, will comprise indicators referring to economic, social and environmental conditions in Australia. The desirability of broadening national measures beyond economic ones such as GDP has been discussed for decades by a range of authorities in the field (see, for instance, the recent collection of papers in Eckersley 1998).

Welfare and wellbeing

There is some interchangeability of the concepts of wellbeing and welfare and this is acknowledged and maintained in this chapter. Both words can indicate a very broad scope. The field of welfare economics, for instance, potentially embraces any aspect of wellbeing (e.g. Sen 1982), as does the idea of progress in the ABS work described above. Generally, however, this chapter will use the term welfare to signify a relatively narrower scope, related to the welfare system .

Terminology

Some terminology used in the chapter is explained in Box 9.1.

9.2 Frameworks for measuring welfare and service performance

This section outlines a framework for the measurement of welfare and related service performance, drawing on the frameworks outlined in the introduction to the chapter. This framework will shape the presentation of further material in the chapter, in particular clarifying the process for suggesting indicator topics in Section 9.3.

The suggested organising framework for the chapter (Figure 9.2):

- is based on previous AIHW frameworks and also benefits from recent OECD, European and other Australian work; and
- is designed to give structure to indicators that are relevant to welfare and service performance.

Welfare is placed at the top of the diagram and may be considered as a goal, as a vision or, in the terminology of the chapter, as a concept, which may be hard to define in general and universally agreed terms. Nevertheless, the term welfare reflects highly valued human ideals and for which, in certain contexts, it may be quite feasible to agree definitions and operational goals. The definition of health endorsed by the World Health Organization is an example of a broad conceptual statement of values: a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity (WHO, quoted in AIHW 2000b:2). Many applications proceed to locate themselves in specific, limited territory within this broad field, while retaining the ethos of the statement. Similarly, various approaches to defining welfare have been outlined in the Institute s previous biennial reports on welfare (AIHW 1993, 1997), which then reported on the specific examples of welfare services listed in the AIHW legislation. Figure 9.2 recognises both these qualities of the term welfare on the one hand, the value but elusiveness of the concept; on the other, the importance of being prepared to translate it into concrete terms in specific contexts.

Figure 9.2 is, like a number of the frameworks described in Section 9.1, derived from a pressure-state-response framework, where the influential factors replace the pressure , the welfare components are the state and the interventions are the response . It can also be regarded as a simplified version of Figure 9.1, where the social conditions are similar to the factors (the pressure), the outcomes and needs are encapsulated as the welfare components (the state) and the formal and informal systems are the interventions or response .

Each of the three boxes in Figure 9.2 components, interventions and factors is now discussed in turn. In particular, the expansion of welfare components (in Figure 9.3) leads on to providing a framework for welfare indicators, to be discussed in Section 9.3.

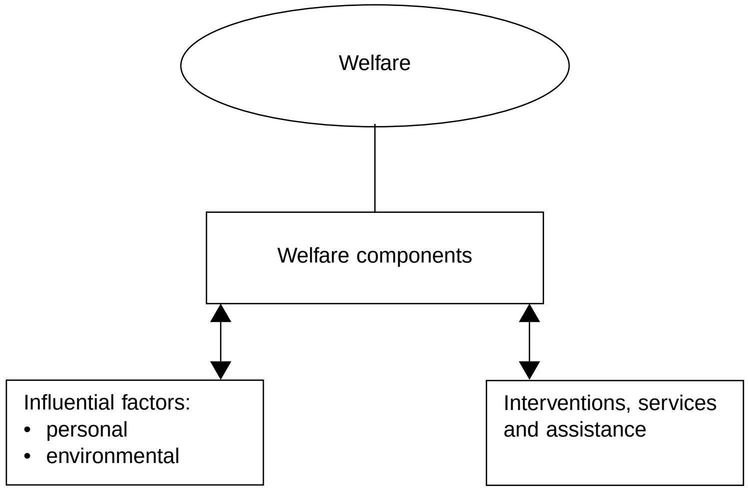

Figure 9.2: Conceptual framework for welfare information

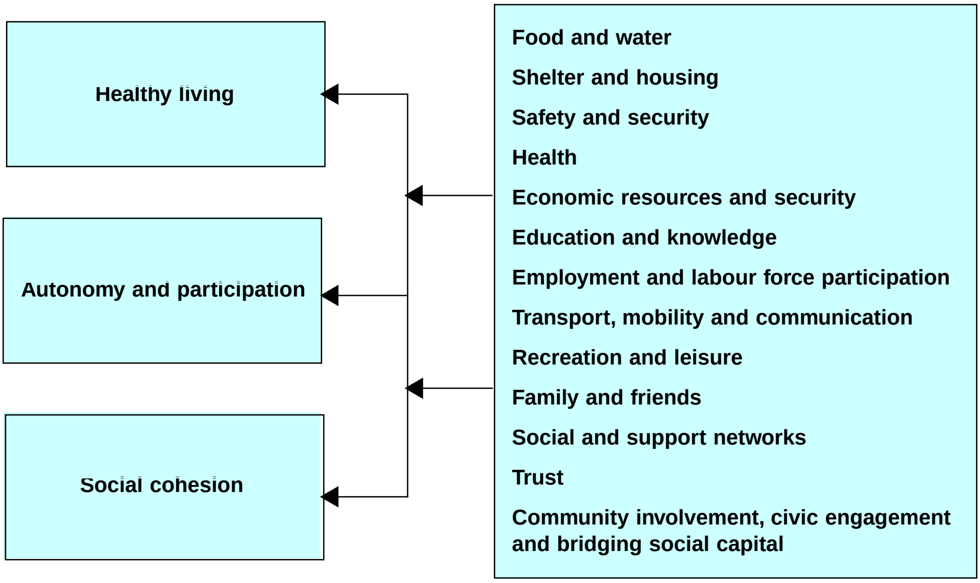

Figure 9.3: Components and related sub-components of welfare

Welfare components

The welfare components represented in Figure 9.2 are the embodiments of the welfare concept and reflect what is considered purposeful and possible to attempt to measure (see also Box 9.1). Welfare components are specified on the basis that they are generally accepted to be crucial to human welfare and also hold out the prospect of being the subject of feasible data definition and collection. Indicators of welfare can be constructed in relation to these components and may be used for the purposes of codifying or measuring welfare status, the need for services or assistance and/or outcomes from interventions. For instance, the need for assistance with self-care is sometimes used as a status measure (for instance, of the severity of disability), sometimes as an indicator of need for assistance or formal services, and sometimes as an outcome measure (for instance, when need diminishes with the provision of suitable equipment).

Figure 9.3 suggests three broad components of welfare: healthy living, autonomy and participation, and social cohesion. These components (and the related sub-components listed beside them) draw on and are broadly consistent with four major sources:

- The four OECD component headings are autonomy, equity, healthy living and social cohesion. Social cohesion is considered a valuable part of the OECD framework, particularly in light of current national social policies (on building stronger families and communities). Equity can be included via measures of the *distribution* of the status measures (see Section 9.3).
- Literature on human needs and the essentials for human wellbeing has also informed Figure 9.3. A recent framework relevant to current health and welfare policy thinking in Australia is that of Doyal and Gough (1991). Health and autonomy are argued to be the key prerequisites to participation, the highest level human goal. This framework thus links the OECD ideas to current policy goals in Australia (in particular, social and economic participation). The sub-components in Figure 9.3 include Doyal and Gough s intermediate needs which, they argue, are universal (i.e. of cross-cultural importance). These sub-components in turn draw on much preceding literature on human needs. For instance, Maslow (1943, 1968) suggested a hierarchy of needs, from basic physiological needs though to the highest (self-actualisation). Allardt (e.g. 1975) classified basic needs into three categories: having (needs related to material resources); loving (needs related to love, companionship and solidarity); and being (needs denoting self-actualisation and the obverse of alienation). The related components, used in Scandinavian surveys, have been also used as a checklist for Figure 9.3. Allardt firmly relates the notion of welfare to the notion of needs and distinguishes it from happiness and the subjective components of quality of life .
- The framework of the new WHO Classification of Functioning, Disability and Health (ICF) has a well-developed conceptualisation of human functioning, including a list of life domains for the description of human activities and participation: learning and applying knowledge; general tasks and demands; communication; mobility; self-care; domestic life; interpersonal interactions and relationships; major life areas (e.g. education, work and employment, and economic life); and community, social and civic life (WHO 2001; see also Box 7.1). This framework is useful in specifying the

sub-components of participation on the right of Figure 9.3 and the environmental factors.

- The framework suggested for use in Europe (Berger-Schmitt & Noll 2000; see also Section 9.1) has also been drawn on, as a check for completeness of the sub-components and, later, measurement methods. It is valuable for this purpose because of its review of relevant literature, particularly in the area of social cohesion.

In one sense, the component headings in Figure 9.3 are of secondary importance, as it is the sub-components (on the right in the diagram) that will shape indicator construction. Many of the sources mentioned in this chapter start from different standpoints and develop different component headings, but finish with a very similar set of sub-components to those listed in Figure 9.3.[4] The specification of components is sometimes based on some form of social theory, on widely held social values, or on the particular purpose of the framework. While it is possible to attempt to relate specific components to specific sub-components, this generally proves to be a distraction in a broad conceptualisation such as this one. The components can be regarded as an explanatory prism, through which the diffused beams of high-level concepts are focused onto the page to become a set of measurable indicators. The overall purpose in defining such components is to structure and contextualise otherwise long lists of indicators. The resulting lists often bear a strong resemblance to each other, despite apparent differences in the intervening prism. The value of the prism (the welfare components) often lies in the provision of organisation and structure, rather than in providing or justifying any particular explanatory social theory. The purpose of the prism is, suitably, transparency of purpose, context and values.

The framework in Figure 9.3 is a diagram of the interconnected, valued components of human welfare and needs that are to be measured descriptively. The framework does not rest on theoretical models of cause and effect, as will be further illustrated in the following discussion of social cohesion. The components are not theoretical outcomes of all other processes in Figure 9.2 and do not reflect a large causal hypothesis of social or welfare system functioning. Rather, they are part of the landscape recognised as relevant to human wellbeing and the measurement of needs. While particular studies may seek to explore statistical relations among various elements (and name some as cause and some as effect), Figure 9.3 is simply illustrating the nature and scope of a field of measurement.

Social cohesion

Healthy living and participation are relatively familiar concepts, with fairly well-developed descriptions of individual welfare (AIHW 2000b; WHO 2001).

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[4] This is true of other relevant sources, for example, Salvaris et al. (2000) in their work on developing social ‘benchmarks and indicators’ for Victoria. These authors also advocate the involvement of the community in establishing such benchmarks.

However, the third component in Figure 9.3 social cohesion is currently the subject of discussion and conceptual development both nationally and internationally. For instance, a new detailed proposal for indicators for social inclusion in the European Union is now being finalised for publication in December 2001 — January 2002 (Atkinson et al. forthcoming).

Some brief discussion here may provide useful background to the selection of the sub-components in Figure 9.3 and (subsequently) the suggestion of indicators in Table 9.1. A thoughtful review of approaches to the concept of social cohesion identified two main themes or societal goal dimensions (Berger-Schmitt 2000:4):

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

Both dimensions are important. Strong social capital on its own may result in the exclusion of or discrimination against people not belonging to a particular community or group. Narayan (1999) accordingly distinguishes bonding social capital (within a group) and bridging social capital (strong cross-cutting ties among groups), both of which are important. Such elements of social cohesion are clearly crucial in a multicultural society such as Australia. Moreover, says Narayan, it is bridging social capital that enables social and economic mobility and prevents the entrenchment of privilege. Social cohesion, then, is a critical element in social stability and economic welfare over any extended period (Narayan 1999:1).

The two dimensions suggested have measurement implications, with both social capital and social exclusion being potentially measured across a broad range of life domains (Berger-Schmitt & Noll 2000). In this chapter, measurement is discussed in Section 9.3, where social exclusion is indeed measured across all domains (down the fourth column of Table 9.1), but the positive aspects of social capital are included as topics, separately, in rows of Table 9.1. Topics such as social and support networks, family and friends, trust, community involvement and civic engagement, volunteering and philanthropy reflect the common ideas in the social capital literature (for instance, Putnam 2000).

While some Australian literature has begun to make suggestions about measurable concepts for social capital (e.g. Cox 1998), and the development of the ABS General Social Survey (ABS 2001c) should provide relevant data, much remains to be done to develop national indicators. The Australian Institute of Family Studies is undertaking a major research project on Families, social capital and citizenship (e.g. Stone 2001; Stone & Hughes 2000). Winter (2000:29) proposes a working definition of social capital as: social relations of mutual benefit characterised by norms of trust and reciprocity .

Different notions regarding what constitutes a source, and what an outcome, of social cohesion can compound issues of definition and measurement. Trust, for instance, is seen by some as a constituent of shared values and norms constituting social cohesion (OECD 2001), while for others it is simply an outcome of these values and norms (Woolcock 2001). The separation of cause and effect is, however, primarily an issue when explanation is being sought and a causal model being tested. For instance, Zubrick et al. (2000) regard family functioning (an element of social cohesion) as an indicator of, and on a causal pathway to, child health and welfare. Such authors are setting out to test the relationships between elements defined as outcomes and elements defined as potential causes, and are searching for explanatory factors. This is useful in a particular context; but the context will then shape the form of the hypothesis, which will in turn dictate what is put on which side of the cause and effect diagram. In other models, the same variables can be examined from other perspectives and causes and effects sometimes inverted. For example; family cohesion can be considered an indicator of child health, as described above, but childhood disability is also recognised as a source of family stress.

Figure 9.3 recognises social cohesion as a good in its own right, valued in national and state goal statements about stronger communities and families. It is therefore given status as a desired outcome (welfare component) rather than being relegated to being a factor in, or cause of, other desirable outcomes.

Interventions, services and assistance—and performance indicators

The second main box in Figure 9.2 relates to the whole system of formal services, financial assistance and informal (unpaid) assistance that contributes to human welfare. There is increasing interest across governments in measuring the performance of health and welfare service programs, against goals set by governments. Other chapters in this biennial report describe many of these systems and reflect the broad array of information available about welfare-related systems in Australia. Services and assistance could include, for instance, early intervention in childhood disability, rental assistance to people with low incomes, or informal assistance to an older person in their own home.

While performance indicators generally concentrate on this area of Figure 9.2, they relate to the other two boxes, as follows. Interventions are designed with the purpose of affecting wellbeing that is, indicators of needs and outcomes should relate to the welfare components. The existence of major service programs represents a formal social recognition of the importance of particular welfare components, confirming but not defining the significance of these components. Indeed, the measurement of these broader welfare components can be used to identify gaps in welfare services provision. Equally, interventions are usually designed with an awareness of factors , or to influence factors (for instance, public health campaigns to reduce risk factors such as smoking).

The trend towards performance measurement

The trend towards performance measurement for community services can be understood in the context of changes in the way governments approach the administration and management of service programs. Over the past two decades, factors such as population growth, advances in knowledge and technology, and changing expectations concerning appropriate service levels have placed pressure on governments to find more effective and efficient ways to provide services. In response, governments have adopted a range of management practices, including the use of strategic plans that identify goals and objectives, the outsourcing of non-core functions, increased focus on client needs, and greater accountability for outcomes (AIHW 2000a:10).

In Australia, as in other countries, the introduction of competition and the creation of quasi-markets in the delivery of community services have been seen as a way of increasing efficiency and improving consumer choice (Hoyes et al. 1992). Output- and outcome-based funding is being introduced in many Australian jurisdictions, often within formal frameworks laid down by treasuries and coordinating departments. Under output-based funding, government funding of service provider agencies is linked, at least in part, to the number of units of service output purchased. Under outcome-based funding, funding is provided on the basis of outcomes achieved (AIHW 2000a). Under these funding models, agencies compete for funding on the basis of cost-efficiency and cost-effectiveness of their service provision.

What are performance indicators?

Performance has been defined as how well a service meets its objectives, recognising the influence of external factors (SCRCSSP 2001:2).

In that the ultimate goal of community services is to improve levels of wellbeing, a coherent relationship needs to exist between service performance indicators and indicators of wellbeing. Therefore, an indicator of wellbeing may also be an appropriate indicator of service performance. Service performance indicators may be developed for use at different levels of the service system, as follows.

Service system level

International organisations such as the OECD and WHO play a role in monitoring and comparing the performance of the health service systems of nations. The OECD has developed a set of social indicators, which is envisaged as a valuable tool to assist in any comparison of the results of social programmes across countries (OECD 1999:2). (See also Section 9.2.)

Service program level

In most Australian jurisdictions, governments require regular reporting of performance indicators at service program level. For example, in Victoria, performance measures and costs for each human services output group are published in the annual budget papers (Victorian Department of Treasury and Finance 2000). Nationally, performance indicators of efficiency and effectiveness are reported annually in the *Report on Government Services* for a range of human service areas covering education and training, health, justice, emergency services, community services and housing (SCRCSSP 2001). These are high-level indicators, developed to broadly reflect the performance of service programs at jurisdiction level and to allow comparison among all Australian jurisdictions.

Service provider level

Agencies that receive government funding to provide services are often required to report regularly to funding departments against performance indicators, which are specified in funding contracts. Indicators at the service provider level are often different in nature from those at service program level, in that they tend to be more detailed and may be a mix of quantitative and qualitative indicators. Indicators at the service provider level may feed up into program level indicators.

Purposes of performance indicators

Three reasons put forward for measuring performance are: to improve accountability; to encourage ongoing performance improvements; and to encourage efficient service provision. Comparative performance reporting can also enable jurisdictions to learn from the experience of other jurisdictions, particularly in terms of new policy approaches (SCRCSSP 2001:7—9).

Performance indicators can be used by government funding departments to assist in making decisions about the allocation of resources between service types (e.g. where one type is more effective in achieving desired outcomes) or between providers (e.g. where one operates more efficiently than another does).

The New South Wales Council of Social Service (1990) identified a number of purposes for which non-profit organisations could use performance indicators. These included: evaluating performance; gaining feedback from consumers; reassessing investment policies; demonstrating value for money for funds provided; improving policies, programs and procedures; assisting in budget preparation and justification; and motivating employees.

A range of potential problems with the development and use of performance indicators has been identified in the literature (AIHW 2000a):

- Choice of indicators may be overly influenced by what data are readily available, or what is easily measured, rather than by the information that is needed (Mussared 1999).
- Measurement of selected aspects of program performance may divert attention from important but unmeasured activities; in the context of human services this can mean that managers may focus on short-term, quantifiable results and ignore longer-term, qualitative outcomes.
- Creaming describes the practice of service providers giving preference to clients who are likely to achieve better outcomes and/or consume fewer resources, thus maximising the quantity of service outputs produced for a given cost. Misuse or misinterpretation of performance information may impact negatively on service provider organisations, who may become less willing to provide performance information, thus potentially leading to lower data quality.

Also, in developing performance indicators, it is important to be aware that much of the theory comes from the private, for-profit sector. Principles underlying their use are not necessarily directly transferable to the public sector (La Trobe University & Flinders University 1999).

Key performance concepts

Box 9.2 presents definitions of key performance-related terms. However, the usage and understanding of performance-related terminology vary. Differences in the use of terms and concepts can reflect the level at which frameworks and indicators are intended to operate high-level frameworks tend to be built around high-level concepts that can be difficult to operationalise, while lower-level frameworks are often built around more concrete and measurable entities.

Box 9.2: Definitions used in the *Report on Government Services*

Effectiveness	*A reflection of how well the outputs of a service achieve the stated objectives of that service.*
Efficiency	*A reflection of how well organisations use their resources to produce services. Unit cost is an indicator of efficiency used throughout the Report.*
Inputs	*The resources (including land, labour and capital) used by a service area in providing the service.*
Process	*The way in which a service is produced or delivered.*
Output	*The service provided by a service area—for example, a treated case is an output of a public acute care hospital.*
Outcome	*The impact of the service on the status of individuals or a group. A service provider can influence an outcome but external factors can also apply.*

Source: SCRCSSP 2001:xv.

Objectives might be broad program objectives or more specific objectives for a service type or individual provider. High-level objectives often relate to outcomes, but lower-level output objectives are also often articulated (e.g. the number of service outputs expected to be delivered). Resources include both financial and non-financial resources (often called inputs) that, through service processes, are used to produce outputs (goods or services).

Service outputs contribute to outcomes, although, in assessing the achievement of outcomes, it is widely acknowledged that it is often difficult to isolate the impact of a service from the impact of other factors. Outcomes can be defined and measured at consumer and/or community level. Key performance concepts are efficiency (rate of translation of resources into outputs) and effectiveness (rate of translation of outputs into outcomes). While the term efficiency strictly means the translation of inputs (non-financial resources) into outputs, it is often used more loosely to mean cost per output (cost-efficiency).

Quality is also an important performance concept. Measures of service quality generally relate either to the quality of service outputs or to the quality of service processes. Information on quality is particularly important when there is a strong focus on increasing efficiency, as efficiency gains may be made by compromising service quality (SCRCSSP 2001).

Performance indicator activities in the welfare services field in Australia

Report on Government Services

The Review of Commonwealth/State Service Provision was established by heads of government in 1993 to develop objective and consistent data on the performance of services that are central to the wellbeing of Australians. Government agencies and statistical bodies such as the AIHW and the ABS have worked together to develop performance indicators for a range of national programs and to assemble relevant data. These performance data are published annually in the *Report on Government Services* (SCRCSSP 2001).

A general performance indicator framework is used throughout the report (SCRCSSP 2001:10). The framework identifies effectiveness and efficiency as the two dimensions of performance against which indicators are presented. Effectiveness indicators cover outcomes, access and equity, appropriateness and quality. Some service areas use different or additional components of effectiveness (e.g. affordability, targeting). Efficiency is indicated by the level of government inputs per unit of output, reflecting the report s focus on achieving better value for the broader community from the use of government resources. However, the point is made that such an indicator should not be interpreted as reflecting a service s full cost to society.

Comparability is one of the main guiding principles of the review. Reporting comparable data across jurisdictions has a higher priority than using a better indicator that does not allow comparison (SRCSSP 2001:18).

Program-specific developments

In many community service areas in Australia, performance indicators are currently in use or under development. Often the development of indicators is supported by extensive conceptual developmental work, with the identification of explicit links between performance indicators and program goals, and with statements of desired outcomes for each indicator. Some examples are outlined in Box 9.3.

Performance indicator development has been an added stimulus to the implementation and development of nationally consistent data. Work on common data definitions and classifications, and national data dictionaries for the community services, housing and health sectors, as well as sub-sectors such as disability, public housing and child protection has been sharpened in focus because of this relationship.

Performance indicators are being vigorously developed in a number of fields in Australia. This chapter does not attempt to further synthesise this work. More detail and some available data are presented in SCRCSSP (2001) and in Chapters 3, 5, 6, 7 and 8 of this report.

Box 9.3: Examples of program-specific developments in performance indicators

Housing assistance

The 1999–2003 Commonwealth–State Housing Agreement (CSHA) is a multilateral agreement between the Commonwealth, States and Territories, and is accompanied by bilateral agreements between the Commonwealth and each State and Territory. The stated aim of the CSHA is 'to provide access to appropriate, affordable and secure housing assistance for those who most need it, for the duration of their need'.

Under the 1999–2003 CSHA, a new national performance indicator framework has been developed. The framework has attempted to overcome a number of problems that had been identified with the 1996 CSHA public rental housing indicators, including a lack of clear links between performance indicators and strategic objectives. The new framework is adapted for use with the Report on Government Services *framework for housing services.*

Seven effectiveness and four efficiency indicators are specified. Effectiveness indicators are divided into three groups: appropriateness, access and quality. Appropriateness is measured using indicators of affordability, satisfaction with amenity/location of dwelling and match of dwelling to household size. The three indicators representing access are intended to measure targeting to people on very low incomes, targeting to people with special needs, and allocation processes that ensure priority access for those in greatest need. Quality is indicated by customer satisfaction measures. Currently there is no benchmarking against these indicators, although this is planned for the future.

Disability services

The 1998 Commonwealth/State Disability Agreement (CSDA) states that 'the Commonwealth and the States strive to enhance the quality of life experienced by people with a disability through assisting them to live as valued and participating members of the community'. The CSDA also emphasises that parties have continuing responsibilities for 'transparency and accountability to Parliaments, funders and citizens concerning the equitable, efficient and effective provision of specialist disability services'. It states that governments with responsibilities for administering services will 'report against agreed nationally consistent performance indicators of efficiency and effectiveness'.

In 1999 the AIHW undertook a project for the National Disability Administrators aimed at identifying opportunities for integrating practical and theoretical practices to performance indicators, to contribute to improved data collection and service planning, delivery, funding, monitoring and management in the disability services field. In the course of the project, three frameworks were developed and used to identify three priority areas for indicator development: outcomes, outputs and cost. These areas were identified as priorities because they were policy relevant, administratively meaningful and feasible, currently information-poor and in need of improvement on a national basis. This work has now fed into a major project to redevelop the Commonwealth/State Disability Agreement Minimum Data Set (CSDA MDS)—Australia's national disability services data collection. (See also Chapter 7, in particular Figures 7.6 and 7.7.)

(continued)

Box 9.3 (continued): Examples of program-specific developments in performance indicators

Child protection services

Child protection services are provided to protect children and young people who are at risk of harm within their families, or whose families do not have the capacity to protect them. The only child protection performance indicators currently reported at the national level are those published in the Report on Government Services *(SCRCSSP 2001). Further work on these performance indicators is progressing currently and national guidelines for interpretation of the indicators are being developed.*

Two outcome indicators and one targeting indicator are reported. An example is the outcome indicator 'substantiation rate after decision not to substantiate', where 'substantiation' is the term used when there is reasonable cause to believe that a child has been, is being or is likely to be abused or neglected or otherwise harmed (AIHW 2001c). This indicator measures the proportion of children who were the subject of an investigation which did not lead to a substantiation, but who were subsequently the subject of a substantiation within three and/or twelve months. Nationally comparable data are not currently available for all three indicators, but data are comparable within each jurisdiction over time.

Aged care services

During 1999–2000, the AIHW undertook a project for the Aged Care Assessment Program (ACAP) officials to identify information needed to support performance measurement. The overall objective of ACAP is to 'comprehensively assess the needs of frail older people and facilitate access to available care services appropriate to their care needs'.

During the project, nine lower-level objectives for the program were identified and used as a basis for developing performance indicators. These objectives were arranged into four broad 'outcome' groupings: equity, effectiveness, quality and efficiency. For some of the nine objectives, several high-level national performance indicators were developed for reporting on ACAP as a whole. For each indicator, the desired outcome is stated (e.g. 'maintain or increase % "at risk" clients recommended a Community Aged Care Package'). However, it is recognised that the achievement of desired outcomes might depend on factors outside the control of assessment teams.

Influential factors

Figure 9.2 recognises the existence of important factors that may influence welfare and the welfare system . These factors will be discussed only briefly in this chapter.

Influential factors encapsulate features of the physical and social environment, or characteristics of individual people, that are considered to have important and potentially explanatory relationships to both the other boxes. The factors box recognises that there are important factors that are generally considered to be separate from, but which affect, the welfare components and / or the welfare system . Personal factors may include age and sex, or genetic factors; environmental factors may include air, water and the quality of the built environment, as well as components reflecting the national or local economy or aspects of the social or legal systems. These factors are often included in measurement frameworks when they are considered critical to welfare and health (where they are often referred to as determinants or even causes), or when their influence and explanatory power is such that they indicate useful social policies (e.g. the reduction of smoking in promoting health). In some cases, this explanatory power is such that these factors virtually become health and welfare indicators in their own right; in general, however, it appears more useful to preserve the distinction.

It is not suggested that the dividing line between factors and the other two boxes is immutable, for all purposes. First, the relationship between welfare components and factors depends on the focus of interest in any analysis. Once a focus is chosen (or variable of analysis, in the case of multivariate analysis), then other related variables are candidates for causes or factors generally (or covariates, in the case of multivariate analysis). Second, the dividing line between interventions and factors depends on the scope of services under scrutiny in any analysis. As the scope of the service box broadens, the more services shift out of the factors box. For instance, the education system is listed above as a factor or perhaps a welfare-related service; it is not a welfare service , even though knowledge and education are taken as indicators of human welfare in Figure 9.3.

One of the potential frameworks to help specify such influential factors systematically is the new International Classification of Functioning, Disability and Health (the ICF WHO 2001). This classification recognises the importance of what it calls contextual factors , comprising both personal and environmental factors. Personal factors include demographic characteristics such as age, sex, and country of birth, and also more behavioural qualities such as lifestyle , habits, coping styles, and past and current experience. Environmental factors in the ICF comprise:

- products and technology (ranging over food and drugs, products for use in daily living, education, communication, mobility, recreation, as well as products for design, building and construction);
- natural environment and human-made changes to the environment (including physical geography, population factors including population density, flora and fauna, climate, light, sound and air quality);
- support and relationships (family, friends and acquaintances, paid care providers, and so on);
- attitudes (individual and societal); and
- services, systems and policies (ranging over architecture, open-space planning, housing, communication, transport, law, economics, social security, health, education, labour and employment, politics).

These influential factors reflect the cultural and political climate in which policies are derived, for instance the social philosophy of the community that decides to take a particular stance on unemployment, youth suicide or homelessness. In turn, the interventions feed back into the environment, thereby reshaping it. For instance, public education campaigns may lower community tolerance for drink driving, and building regulations may affect the accessibility of the human-made environment.

9.3 Developing indicators of welfare

This section illustrates the ideas of the preceding section in operation, in shaping working tables of welfare indicator topics and indicators. The previous section proposed a broad framework for welfare information (Figure 9.2) and discussed its three main areas: components of welfare, factors influencing welfare, and the system of interventions (services and financial and other assistance) designed to promote human welfare or wellbeing. Components of welfare were presented in Figure 9.3, to define the subject areas on which the indicators of welfare could focus: healthy living, autonomy and participation, and social cohesion.

This section first discusses measurement, suggesting that indicators of welfare should include three broad types of measures:

- measures of average or level;
- measures of distribution or inequality; and
- measures of deprivation, disadvantage or social exclusion.

Combining these measurement proposals with the components of Figure 9.3 synthesises the key ideas from the national and international literature, to propose the content and the form of welfare indicators.[5] This section takes these ideas and illustrates what a working table of Australian indicators of welfare might look like (Table 9.1).

Constructing measures of the welfare components

The components of Figure 9.3 provide the basis for detailed indicator topics, by defining the broad *subject areas* on which the indicators will focus. Indicator topics are suggested under each sub-component, based on a brief review of the field, outlined in the following text. In general, indicator topics have been framed in a positive way to clarify their relationship to the idea of welfare. While welfare indicators may be negatively constructed (e.g. crime), they are, where possible, constructed within a broader, positive, welfare-related concept .

It is essential also to consider the *form* the indicators might take, as well as some issues relating to measurement.

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[5] As previously stated, indicators for 'factors' and 'interventions' (e.g. service performance) are not included in this chapter, although their importance is recognised in Figure 9.3 and they are discussed in Section 9.2.

Inequality and social cohesion: measures of distribution

As with most statistical measures, not only is the *level* or average of interest but also the spread, or distribution, of the entities being estimated for instance, the distribution across:

- the population; for instance, if *income* is included as a measure of welfare, we may wish to calculate measures of spread across population deciles or population groups, or more complex indicators of inequality such as Gini coefficients;
- other components of welfare; for instance, the distribution of income across different education groups or the distribution of health across income groups;
- the personal factors in the framework; for instance, the distribution of life expectancy between males and females, or between Indigenous and non-Indigenous Australians, or the distribution of employment rates across different age groups;
- the environmental factors in the framework; for instance, the distribution of employment across geographic regions.[6]

Thus, four possible types of inequality may be of interest for any component or sub-component of welfare. This type of analysis may be driven by an interest in equity as a social goal (as in the OECD framework described previously),[7] or by a more general search for explanation (for instance, in investigating the relationship between education and subsequent socioeconomic status). A connection between income inequality and average life expectancy of the population has been found, and between the scale of health inequalities and the scale of income differences (Wilkinson 1996:108). This illustrates the importance of being able to disaggregate data into groups of interest (see Box 9.4) and of being able to monitor trends in various components of welfare, simultaneously, over similar time periods.

An interest in the distribution of welfare components across various community groups is also relevant to the view of social cohesion that suggests that *social capital* can be measured across a range of life domains (see discussion of social cohesion in Section 9.2). This view suggests that one indication of *bridging social capital* is the degree to which, for instance, participation in employment is spread across various community groups, for example people of differing cultural backgrounds. Table 9.1 is not rigid in its approach to defining the groups of interest, between which bridging is being indicated, but allows some flexibility of analysis according to which groups are considered of most concern for which welfare components. Thus, the middle column in Table 9.1 provides an indication of social capital in various domains, as well as the unequal spread of valued welfare outcomes.

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[6] A recent Australian study focused entirely on the geographic distribution of indicators relating to housing, labour force and income, to support regional needs analysis (Bray 2001).

[7] For those who start with an overriding interest in equality, the question is ‘equality of what’ (Sen 1992:1). The approach here reflects that of Berger-Schmitt & Noll (2000) and effectively states that the uneven distribution of any component of welfare may be of interest.

Deprivation and social exclusion

As well as the average level and distribution of welfare components, there is often an interest in finding out more about groups at the extremes of the distribution, in particular those most disadvantaged. The UN Development Programme takes this approach and recommends the examination of average measures, measures of distribution and measures of deprivation (UNDP 2000:108). For instance, in examining the sub-component economic resources in Figure 9.3, we could be interested in average household incomes, in the distribution of these incomes (perhaps via a comparison of average income in different income deciles), and also in estimating the numbers of households of a particular composition living below a defined income (a poverty line). Sen (1981:157) makes the point thus: the problem of poverty assessment is quite distinct from the issue of assessment of inequality and requires paying particular attention to the category of the poor .

A related conceptualisation is that of social exclusion , reflecting the absence or impairment of social cohesion. Social exclusion has been described as an impact on individuals caused by failure in the way in which institutions regulate and thereby constrain access to goods, services, activities and resources which are generally associated with citizenship rights (Berger-Schmitt 2000:5). The literature on social exclusion has, in turn, evolved from a recognition of the multidimensional nature of poverty and disadvantage.

Table 9.1 reflects these ideas, in the fourth column. Some suggestions are made to illustrate the ideas, but the column is neither complete nor definitive.

Measurement and purpose

Measurement, like indicator construction, varies with purpose and context. Whole volumes have been written on statistical measurement. While no overview can be sensibly attempted, several points are worth making in the present context.

Checklists of the desirable qualities of indicators, and caveats on their use, are common adjuncts to sets of statistical indicators. Box 9.4 presents a useful example. Validity, relevance and fitness for use are critical. Indicators must provide information relevant to the key concept or key policy question being asked.

A further consideration, not mentioned in Box 9.4, is the feasibility and cost of data collection. As with all data collections, the costs of compiling indicators must be justifiable in terms of the benefits to be gained. Related to this criterion is the desirability of identifying a parsimonious set of indicators which maximises the amount, quality and relevance of information, without relying on an overwhelming number of indicators. This criterion can lead back to consideration of summary measures, which should ideally be located at the apex of a hierarchy of related measures and data, forming a coherent and integrated statistical framework (Wolfson 1998). Data lower in the hierarchy should be capable of being analysed so as to explain shifts and trends in the higher-level indicators, and the whole structure should link back to factors amenable to policy .

Box 9.4: 'Handle with care'—UNDP advice on the use of statistical indicators

Statistics come with strings attached. They provide great power for clarity, but also for distortion. When based on careful research and method, indicators help establish strong evidence, open dialogue and increase accountability. But they need to be:

Policy relevant	*Giving messages on issues that can be influenced, directly or indirectly, by policy action.*
Reliable	*Enabling different people to use them and get consistent results.*
Valid	*Based on identifiable criteria that measure what they are intended to measure.*
Consistently measurable over time	*Necessary if the indicator is to show whether progress is being made and targets are being achieved.*
Possible to disaggregate	*For focusing on social groups, minorities and individuals.*
Designed to separate the monitor and the monitored where possible	*Minimising the conflicts of interest that arise when an actor monitors its own performance.*

Getting the facts straight is serious when rights are at risk. The powerful impact of statistics creates four caveats in their use:

Overuse	*Statistics alone cannot capture the full picture of rights and should not be the only focus of assessment. All statistical analysis needs to be embedded in an interpretation on broader political, social and contextual analysis.*
Underuse	*Data are rarely voluntarily collected on issues that are incriminating, embarrassing or simply ignored… Even when data are collected, they may not be made public for many years – and then there may be political pressure on the media not to publicise the findings.*
Misuse	*Data collection is often biased towards institutions and formalised reporting, towards events that occur, not events prevented or suppressed. But lack of data does not always mean fewer occurrences. Structural repression is invisible when fear prevents people from protesting, registering complaints or speaking out.*
Political abuse	*Indicators can be manipulated for political purposes to discredit certain countries or actors. And using them as criteria for trade or aid relationships would create new incentives to manipulate reporting.*

Source: UNDP 2000, Box 5.1.

Criteria for the selection of performance indicators for the health system in Australia (AIHW 2001a) state that they should:

- be worth measuring;
- be measurable for diverse populations;
- be understood by people who need to act;
- galvanise action;
- be relevant to policy and practice;
- reflect the results of actions if measured over time;
- be feasible to collect and report; and
- comply with national processes for data definitions.

Indicators may be reported in absolute terms, measured against defined standards. The approach proposed for this chapter (above, and in Table 9.1), implicitly lends itself to a more relative approach with the statistics compared against each other, over time or among different population groups.

An indicator may be based on a variety of measurement methods: self-reported conditions gathered in social surveys, professional assessments using a variety of methods, and a wide range of means of recording information in administrative systems. Understanding the method of measurement and collection is usually crucial to accurate interpretation of the resulting statistics.

Indicators may be simple or composite. Simple or disaggregated indicators relate to one sub-component of Figure 9.3 and are generally based on one method of collection. Composite (or summary) indicators attempt to capture higher-level concepts in a single figure, often by weighting and combining several indicators (Doyal & Gough 1991:166—7). The dangers of composite indicators include the inadvisability of trading off one basic need against another and possible challenges to the validity of the weights used. Composite indicators such as quality of life are often informed by measures from different perspectives (by combining so-called objective and subjective data) and bring in yet another contentious measurement issue, namely the perspective of the measurer. Travers and Richardson (1993:49) identify three contentious points in the construction of composite indices: the selection of which factors to take into account; how to aggregate these; and the assumed relation between the *level* of each factor and the contribution made by an *increment* in it. This chapter tends to focus on disaggregated indicators, although the distinction between these and composite indicators is not always sharp.

While the basic individual needs for physical health and autonomy are universal, many goods and services required to satisfy those needs are culturally variable (Doyal & Gough 1991:155). The choice of a small number of indicators from a wide range of possibilities may be influenced by local practice, local values and policies, and by the availability or otherwise of relevant data.

A working table for the development of welfare indicators

Indicator tables can now be shaped, using these ideas about measurement combined with the components of welfare suggested in Figure 9.3. The rows of Table 9.1 are defined by the sub-components of Figure 9.3 (and are further split into more precise topic areas). The columns are defined by the ideas about measurement: average level, distribution and deprivation. The final column indicates possible relevant data sources, thereby also highlighting areas where the necessary data may not be available.

Table 9.1 was assembled after the following process:

- Major international indicator sets (chiefly those relating to literature outlined in the chapter, with an emphasis in the search on indicators of state) were reviewed and indicators, or indicator topics, mapped into the table. This part of the process was designed not only to take advantage of the international work but also to promote international comparability.
- Major Australian reports relating to the areas of the sub-components were sought, particularly where goal statements were made or indicators sets developed.
- Some explanatory literature has been referred to, to help define and refine suitable indicators relating to key ideas in the fields of the components and sub-components.
- Statistical syntheses (in particular, the ABS *Australian Social Trends* series and the AIHW biennial health and welfare reports) were searched, to fill what appeared to be gaps in the international sets and, particularly, to balance an apparent tendency for the international indicators to be focused on negative aspects of the state of wellbeing.
- Relevant Australian data sources were then identified for the suggested indicators. Major national data sets, including ABS social data collections, were reviewed and included in the table under the relevant component and measure. Emphasis has been placed on sources that would provide national time-series data. This process was designed to promote national comparability, quality and availability (including availability over time). The process has identified not only significant data sources that could be used to shed light on the components and sub-components suggested, but also possible data gaps.
- The criteria for inclusion (Box 9.4 and surrounding text) were adhered to as far as possible.

Table 9.1 as a working table

The indicator topics in Table 9.1 are *not* a final recommended set. They illustrate how the content and form suggested in this chapter *might* translate to specific indicators. In some areas, there is considerable emerging literature that will influence ongoing development (for instance, on topics relating to social cohesion and social capital). Indicator definition and development can also be expected to be the subject of debate. Indeed, many indicators can be considered ambiguous or open to different interpretations; to some extent this is inevitable and reflects the need to understand the context of data collection. This is perhaps particularly true of data produced as an administrative by-product; numbers of crimes reported to the police, for instance, are related to the numbers of police, community propensity to report crimes to the police, as well as the underlying crime rates and a range of other factors.

Most areas of the table are evolving and under development, reflecting the high level of interest in the field and the dedication of resources to work in the area by governments and academic institutions. Some of this work is briefly referred to in the following discussion of the indicator topics, and it is recognised that most areas of the table need also to evolve in line with this work.

Table 9.1 is thus a working table . It is based on the framework of Figure 9.3 and on the measurement proposals outlined earlier in this section. As with other recent frameworks (described in Section 9.1), the purpose is to shape and scope the field. The working table thus illustrates areas for ongoing and evolving work to select, define and measure the most appropriate indicators and topic areas for monitoring trends over time.

The sub-component areas of Table 9.1

Each heading in the first column of Table 9.1 corresponds to a sub-component in Figure 9.3. This sub-section provides a brief justification of the related indicator topics suggested in the second column of the table.

Food and water

The importance of basic nutrition is recognised in Australia with work in the public health sphere on an agenda for action in public health nutrition (SIGNAL 2000a). An integral part of this work is the recognition of the need to develop a better system for monitoring the food and nutrition situation: Data collections are not adequate to meet the needs of the Strategy and are not linked or always compatible (SIGNAL 2000a:81). The indicator topics suggested in Table 9.1 broadly reflect the thinking in this strategy and in other documents such as the National Aboriginal and Torres Strait Islander Nutrition Strategy and Action Plan, 2000—2010 (SIGNAL 2000b) and previous related research (AIHW: Coles-Rutishauser & Lester 1995).

The topics for which indicators are suggested in Table 9.1 focus on areas of recognised importance, including the food supply (its adequacy, safety and accessibility to all sectors of the population), food intake (e.g. actual food intake and its nutritional value may be broadly indicated by expenditure on food groups) as well as the nutritional status of the population. These indicators will be refined in the light of developments in this important area of public health. This is an area where there is a need for disaggregated data; Sen (1981) notes that aggregate food availability does not reveal what significant sub-groups actually receive and that there are many factors at work, not all of which are related to food production processes.[8]

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[8] Sen (1981:162) attributes famines to ‘failures of entitlement’ and views them as ‘economic disasters not just as food crises’.

Access to potable and palatable water is listed as one of the Nutrition Goals and Targets devised by the National Health and Medical Research Council, public health nutritionists and the food industry (AIHW: Lester 1994). Information on access to potable water is not currently available. This may be because in the densely populated areas of Australia accessibility has, to date, been assumed. In rural and remote areas, accessibility has been and remains an important public health issue.

Shelter and housing

Housing is widely recognised as a fundamental human need and a key component of quality of life. The availability of housing is a key element in the avoidance of poverty and disadvantage (see Chapter 3). Australian governments have identified three key areas for monitoring: affordability, appropriateness (for instance, the need for maintenance and the degree of overcrowding) and accessibility. These areas are reflected in the table.

On any population census night, not all of the Australian population will be located in housing . Trends in institutional living and their relationship to social policy in other areas of the biennial report are discussed in Chapter 4. The fact that people may be homeless or housed in institutions is, accordingly, reflected in Table 9.1.

Safety and security

The experience and feeling of physical and personal safety is generally indicated by a range of data on accidents and injury, crimes of various kinds and environmental risks. These largely negative indicators (or indicators of system failure) are included in Table 9.1 in the level or average column, although ideally more positive or neutral indicators would also be available.

Ideally, also, there would be national data on all significant accidents and injuries, whatever the cause. The most significant data sources are by-products of systems for compensating work and transport injuries. Statistics on causes of death and hospital in-patients give useful information in other areas.

It is generally considered that the best indicators of crimes actually occurring are those reported in victimisation surveys, as not all crimes are reported to the police and reporting rates may be influenced by a range of social and administrative factors. Nevertheless, police data are accepted as indicative of major crimes, especially murder and manslaughter, and provide the major and more regular time series.

Environmental safety is represented by the key area of air quality, where the four pollutants chosen have been selected by national authorities for monitoring on a routine basis.

Health

Health is a prerequisite to participation and many other aspects of human wellbeing. A very wide range of indicators of the health status of Australians is included in the Institute s biennial health reports; a selection of key indicators is included here. Life expectancy at birth, infant mortality rates and causes of death are accepted as key indicators in international and national comparative analyses (AIHW 2000b, 2001a; WHO 2000). Indicators of disability are also a key component of national health status measures, but internationally comparable or even nationally stable data are still under development (see Chapters 6 and 7 for discussion of trends, the complexities of measurement and the relative stability in Australia of rates of severe core activity restriction). Some health sources use composite indicators to combine mortality and morbidity data, but separate information on disability in its own right is considered more useful for this table, and more in line with this chapter s concentration on disaggregated rather than composite indicators (see foregoing discussion on measurement).

Economic resources and security

Economic resources and security are recognised as important, and the area has generated a great deal of literature, but there is not national agreement on measurement. The definition and measurement of income vary with the components included, for instance cash income, benefits in cash or kind, the imputed value of housing and unpaid time of household members (Travers & Richardson 1993). The effects on income inequality of the income-tax and cash-transfer systems can be significant (e.g. ABS 2001d; Harding 1998). The notion of final or social income takes account of services as well as cash income and benefits (see also discussion of the social wage and the impact of health, education and social security policies in AIHW 1993:9). Household income is best understood in relation to household composition, and income-based measures are generally adjusted for family size and composition using equivalence scales. Income inequality is of interest in its own right, not only as an indicator of equity in an important and basic area but also because of its relationship to other measures of wellbeing, for instance life expectancy and heath inequality (see Wilkinson 1996). There are indications of growing income inequality in Australia since the late 1980s, driven by a decline in the income share of the bottom 10% of Australians and an increase in the income share of the top 10% (Harding & Greenwell 2001).

Measures of deprivation reflect all the same complexities of measurement, as well as different emphases on relative or absolute concepts of poverty and living standards (see, for instance, Brownlee 1990). Sen (1981:37) points to the limitations of various single measures of poverty (based on headcounts or average income gap of those below a poverty line) the assessment of overall poverty has to take note of a variety of considerations capturing different features of absolute and relative deprivation . Fincher and Saunders (2001:6) discuss the complexity of understanding poverty, inequality and disadvantage and the full range of components and processes involved, although they also urge researchers not to allow the complexities disguise the overall themes their work reveals .

Ever since the Henderson poverty line was established and related numbers of people and families in poverty were estimated in the 1970s (Henderson et al. 1970; Commission of Inquiry into Poverty 1975), there has been debate about the definition of poverty in Australia and appropriate estimation methods. The ABS in 1998 published estimates derived from a line set at 50% of median equivalised income (MEI) for all income units, adjusted by OECD equivalence scales (ABS 1998).

Education and knowledge

Knowledge and education are vital inputs to and indicators of individual autonomy and collective capability (OECD 1999; UNDP 1990). Nationally, the relationship between early school leaving and reduced employment prospects is recognised (MCEETYA 1999). Ongoing education is valued in a time of structural change in the workplace and rapid technological development. Participation and attainment in various forms and levels of education is therefore often used as an indication of education outcomes and knowledge (e.g. OECD 1999).

In Australia, concern about possibly declining literacy and numeracy levels, and their relation to early school leaving and low employment prospects, has led to the implementation of the National Literacy and Numeracy Plan. The plan includes development of national benchmarks in literacy and numeracy for selected age groups Years 3, 5 and 7 and national reporting on achievement in numeracy, reading, writing and spelling. The aim is to monitor specific knowledge acquisition, not just participation in educational programs. Each jurisdiction retains its own literacy and numeracy monitoring programs, which are assessed against national benchmarks and reported annually. The 1999 Year 3 reading results have already been published and Years 3 and 5 literacy achievement results for 2000 are to be available in 2001.

Employment and labour force participation

Nationally accepted indicators in this area have been published over a period of years by the ABS in its regular series of labour force surveys. Key indicators relate to participation in the labour force and to employment and unemployment rates. The ABS also publishes useful associated data, for instance on underemployment (i.e. people who, while employed, would prefer to work longer hours or make more use of their training and skills). Information on job vacancies allows the problem of unemployment to be placed in perspective, by comparing the numbers of people looking for work with the numbers of jobs available.

Transport, mobility and communication

The ability to move around the community is considered an important aspect of human functioning (e.g. WHO 2001). Transport and communications technology are vital in facilitating community participation, particularly for people whose mobility is otherwise at risk (e.g. those with disabilities; see also Chapter 7). Two broad indicators of mobility are access to private motor vehicles and access to public transport (such as trains, buses and aeroplanes). Telecommunication (via telephone and Internet) is also a facilitator of communication and social capital in a geographically large country like Australia.

Recreation and leisure

Recreation and leisure activities can be major contributors to physical and mental health, as well as offering important opportunities for social interaction and participation. This contribution is recognised by the inclusion of these topics in many indicator sets. Suggested indicator areas relate to time use, vacations and household expenditure.

Family and friends

The importance of family is well accepted in Australia. Strengthening families is an explicit policy goal of the national government, and State and Territory Governments also provide a range of services towards this end (see, for example, Chapters 1 and 5; AIHW 2001d). However, the concept of family is fluid, and its definition complex and evolving in the context of current social trends (AIHW 1997:55—94; MacDonald 1998). Data on family formation and dissolution, as well as basic descriptions of living arrangements, can provide a historical picture of family definition and characteristics in Australia.

In the context of measuring social cohesion in the family realm, family functioning is considered of key relevance. Silburn et al. (1996:37) defined family functioning as achieving some degree of acceptance of each individual, reaching consensus on decisions, communicating feelings and solving day to day problems. Zubrick et al. (2000:xi) suggest five key resource domains for social and family functioning: income, time, human capital, psychological capital, and social capital.[9]

Social and support networks

The ability to find or provide assistance during times of need is often used to measure the strength of social supports and networks (e.g. Baum et al. 2000; Hofferth 1995 cited in Stone 2001). One concept, employed by Hofferth, is that of stocks and investments in time and money and how readily these are available in emergencies, for example the lending of money to a friend or relative in need. This concept also introduces the notion of reciprocity, another core element of social cohesion.

The planned General Social Survey (ABS 2001c) has a range of proposed data items related to social capital, including connections with family and friends, availability of support in time of crisis, voluntary work, level of trust, fear of crime. The content of the survey appears to emphasise what survey respondents *receive* from family, friends and social contacts rather than what they *offer in reciprocation*. The giving side is confined to voluntary work and involvement in group and community activities.

The absence of social attachments and support is an indication of social isolation, extreme indicators of which could include suicide, illicit drug use and imprisonment.

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[9] Elements of these resource domains, in particular those relating to time, and psychological and human capital, are recognised in the range of indicators selected for ‘family functioning’. Other elements, such as income, are included elsewhere. Time use is relevant to other areas of the table and appears in more than one place, while social capital is interpreted in this chapter as a broader notion that includes family functioning as well as other components (see previous discussion).

Trust

Trust is seen as one of the key ingredients of social capital (Cox & Caldwell 2000; OECD 2001). Trust is the expectation that arises within a community of regular, honest and cooperative behaviour, based on commonly shared norms, on the part of other members of the community (Fukuyama 1995).

Trust is often discussed in conjunction with social networks and, in particular, participation in voluntary and other community-based activities. Three levels of trust are generally defined: trust of familiars (particularised, interpersonal), trust of strangers (generalised, social) and trust in institutions (civic trust). Cox and Caldwell (2000) believe that social trust may be a more important value than interpersonal trust when assessing social capital, since trust of the familiar may be based on distrust of the other. A general trust of strangers indicates an accumulation of bridging social capital. The suggested indicator topic in Table 9.1 Acceptance of diversity is an important variant on this theme in a multicultural society such as Australia.

Community involvement

The most commonly used indicator of community involvement is participation in community groups or projects (e.g. Baum et al. 1998; Onyx & Bullen 2000; Stolle & Rochon 1998). Onyx & Bullen (2000) regard such participation as one of the four contexts in which networks occur.[10]

Participation is thought to create or enhance social cohesion through the formation of trust between members and through the generation of mutually beneficial cooperative behaviour. Stolle and Rochon (1998:48) define this as private civicness, where membership builds trust and capacity for collective action within the group. Private civicness in turn can lead to public civicness in which the trust developed through group membership is extended outside the group. The groups suggested for indicators of community involvement in Table 9.1 are those of importance or popularity in Australia (caring for children outside the household, sporting associations) and those regularly mentioned in international literature and indicator sets (political and professional organisations).

Community level indicators are not suggested in the table, but are under development. For instance, the collective measures of community strength being developed by FaCS include many of the ideas in the literature on social cohesion, and also include indicators only measurable at community level, such as communities developing their own solutions and resolving conflict (Black & Hughes 2001).

Volunteering and philanthropy

According to Putnam (1993), social capital originates in membership of voluntary organisations and in dense networks of such organisations in any community. These are settings where people learn to trust, reciprocate and act in concert. Criticisms have been

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[10] The other contexts include neighbourhood connections, family and friend connections, and work connections.

levelled at participation in voluntary organisations as an indicator of social capital, largely because it is considered too indirect. Specifically: its use assumes that trust and reciprocity flow from such participation (Harriss & de Renzio 1997; Putzel 1997); it becomes an end in itself rather than a means to an end (Newton 1997); there may be no correlation between membership of voluntary organisations and other indicators of social capital such as trust (Knack & Keefer 1997).

This is an area likely to develop significantly with the work being carried out by the ABS and the Centre for Australian Community Organisations and Management (CACOM 2001) on the Australian Non-Profit Data Project, an important potential source of data for social cohesion indicators. General themes employed by previous studies on social cohesion community involvement, social and support networks, volunteering, and trust are repeated in these projects.

Further issues

Units of enumeration—and overall population data

In its present form, Table 9.1 is not specific as to the unit of focus or enumeration. Data could relate to individuals, families or households, events or communities. At times this may be inferred from the description of the indicator. Further development of the table and its purposes would result in more specificity, or the acceptance of ongoing variability according to purpose.

Population

Information describing the overall Australian population its age and sex profile, its growth and other trends, its fertility and migration patterns are considered indicative of the overall health and wellbeing of the nation (Berger-Schmitt & Noll 2000). Such data are not easily reflected in the current framework, except as factors (Figure 9.2), since the components of welfare (Figure 9.3) can all be interpreted at the individual level, as well as at aggregate levels.

Further development within the framework

Table 9.1 is essentially an illustration of what a set of welfare indicators might look like for Australia, designed to be in general conformity with international developments, and in a format lending itself to measurement with Australian data. The contents of the table require further development. Like other recent national and international frameworks, it suggests a structure in which work can proceed, and a set of indicator topics to be developed and refined over time. The discussion in this chapter has suggested such a structure and has illustrated how some first steps could be taken.

9.4 Future directions

The Institute s biennial welfare reports to the minister and the Australian Parliament are mandated to provide statistics and related information concerning the provision of welfare services to the Australian people and an outline of the development of welfare-related information and statistics (AIHW Act, Clause 31). This chapter was prepared with the purpose of enhancing the perspective of these biennial reports by placing welfare service provision in the broader context of the welfare of the population the context in which the welfare system operates and which it may seek to ameliorate. The chapter begins the process of focusing available statistical information more sharply on components of welfare that are considered nationally and internationally to be important, and to suggest suitable forms of measurement.

The frameworks proposed in Figures 9.2 (the broad framework), Figure 9.3 (the component list) and Table 9.1 (the indicator topics) give shape to these suggestions. They are built on the foundations laid by previous AIHW biennial reports in both the welfare and health areas, as well as on relevant international frameworks, important national data sources and a range of related literature. Work is actively progressing in all three areas of the main framework welfare components, interventions and factors. Discussion in Section 9.3 illustrates that, within most areas of the working table for indicator development (Table 9.1), there is room for discussion, refinement and further statistical development. The Institute proposes to continue working with other experts in the field on these developments, so as to be able to publish relevant data in the next and subsequent biennial reports.

Future editions will then be able to present data that reflect the social conditions in which the Australian welfare system operates. As these data are built up, trends may emerge, and the interconnections between the various welfare components become more apparent. The chapter should then assist the reader of these biennial reports to assess the efficacy of welfare services in meeting the welfare needs of Australians, and the outcomes associated with the provision of services and assistance.

Table 9.1: A working table for the development of welfare indicators

Welfare sub-component	**Indicator topics on which to *measure average or level***	**Population subgroups among whom to *measure distribution***	**Approach to measuring *deprivation, disadvantage or exclusion***	**Source data or references(a)**
Food and water	Food supply: • adequacy • safety • accessibility/ security	Age Income group Family type Indigenous status	Lack of access, e.g. people seeking assistance with meals or other emergency assistance data	The Total Diet Survey[1] Apparent Consumption of Foodstuffs[2] SAAP National Data[3]
	Food and nutrient intake	Age Sex Income group Family type Indigenous status		National Nutrition Survey[4,5] Household Expenditure Survey[6,7] Apparent Consumption of Foodstuffs (ABS)[2]
	Nutrition and health status	Age Sex Income group Family type Indigenous status	Underweight Overweight Obesity	National Health Survey[8]
	Access to potable and palatable water	Income group Family type Indigenous status Geographic area		ATSIC Community Housing and Infrastructure Needs Survey[9]
Shelter and housing	Housing affordability	Income group Family type Indigenous status Geographic area Tenure	'Very high' % of income spent on housing (in lowest income quintiles)	Australian Housing Survey[10] AIHW Commonwealth–State Housing Agreement Data[11] FaCS CRA data[12]
	Condition of housing stock (appropriateness)	Income group Family type Indigenous status Geographic area Tenure Country of birth	example: % living above specified ratio of persons per room See, e.g., Canadian Occupancy Standard	Australian Housing Survey[10] ATSIC Community Housing and Infrastructure Needs Survey[9]

(continued)

Table 9.1 (continued): A working table for the development of welfare indicators

Welfare sub-component	**Indicator topics on which to *measure average or level***	**Population subgroups among whom to *measure distribution***	**Approach to measuring *deprivation, disadvantage or exclusion***	**Source data or references[(a)]**
Shelter and housing *continued*	Accessibility: % in tenure types	Income group Family type Indigenous status Geographic area Country of birth	Homelessness Access to crisis accommodation: turnaway and unmet demand/ need Access to housing assistance	Australian Housing Survey[10] SAAP National Data[3] AIHW Commonwealth–State Housing Agreement Data[11]
	Institutional living	Age Sex Indigenous status Disability Income group		See Chapter 4 for data sources
Safety and security	Feelings of safety	Age Sex Income group Family type Indigenous status Geographic area		
	Work injuries and deaths (rates)	Age Sex Occupation Industry		National Worker's Compensation Statistics Database[13] Work Related Injuries, Australia[14]
	Traffic injuries and deaths (rates)	Age Sex		Australian Transport Safety Bureau[15]
	Other injuries and deaths (rates)	Age Sex		
	Selected serious crime rates (as reported in victim surveys): • selected assaults • driving offences causing death • other selected crimes	Age Sex Income group Indigenous status Geographic area		International Crime Victim Survey[16] Crime and Safety Survey[17]

(continued)

Table 9.1 (continued): A working table for the development of welfare indicators

Welfare sub-component	**Indicator topics on which to *measure average or level***	**Population subgroups among whom to *measure distribution***	**Approach to measuring *deprivation, disadvantage or exclusion***	**Source data or references[(a)]**
Safety and security *continued*	Selected serious crime rates (as reported to police): • murder • driving offences causing death • selected assaults • other selected crimes	Age Sex Income group Indigenous status Geographic area		Recorded Crime, Australia[18]
	Level of pollutants above specified levels: • carbon monoxide • ozone • lead • particles as PM10	Geographic area		State Environment Protection Authorities[19–24]
Health	Life expectancy	Age Sex Income group Indigenous status Geographic area		Deaths, Australia[25]
	Years of life lived with severe activity limitation	Age Sex Income group Indigenous status Geographic area		Survey of Disability, Ageing and Carers[26]
	Causes of death	Age Sex Income group Indigenous status Geographic area	Key conditions, e.g.: • lung cancer • breast cancer	Causes of Death, Australia[27]
	Infant mortality	Age Sex Income group Indigenous status Geographic area		Deaths, Australia[25] AIHW National Mortality Database[28]

(continued)

Table 9.1 (continued): A working table for the development of welfare indicators

Welfare sub-component	Indicator topics on which to *measure average or level*	Population subgroups among whom to *measure distribution*	Approach to measuring *deprivation, disadvantage or exclusion*	Source data or references[(a)]
Economic resources and security	Earnings/income level: • main source	Age Sex Family type Indigenous status Geographic area Education group Employment group Occupation and industry Comparison of deciles (e.g. income and expenditure groups)	People below 'poverty line' levels Time spent with low income	Survey of Employee Earnings and Hours[29] Survey of Income and Housing Costs[30] Poverty Lines, Australia[31] Household, Income and Labour Dynamics Survey–FaCS[(a)]
	Household disposable income	Household income unit Household expenditure groups (e.g. deciles)	Households (rates) below: • 50% of MEI (Median Equivalised Income)	Survey of Income and Housing Costs[(a)] Household Expenditure Survey[32] Poverty Lines, Australia[31]
	Financial stress, hardship	Age Sex Family type Indigenous status		General Social Survey[33] Household Expenditure Survey[(a)]
	Accumulated savings, assets, liabilities, retirement income	Age Sex Family type Education group Employment group		General Social Survey[33] Survey of Retirement and Retirement Intentions[34,35] Household Expenditure Survey[(a)]
	People primarily dependent on government income support: • Age Pension • Unemployment (Newstart) benefits • Disability Support Pension	Age Sex Family type Indigenous status Country of birth		Centrelink data[(a)] Survey of Income and Housing Costs[(a)]

(continued)

Table 9.1 (continued): A working table for the development of welfare indicators

Welfare sub-component	**Indicator topics on which to *measure average or level***	**Population subgroups among whom to *measure distribution***	**Approach to measuring *deprivation, disadvantage or exclusion***	**Source data or references[(a)]**
Education and knowledge	Participation in primary, secondary, post-school and adult education: • retention to Year 12	Age Sex Income group Family type Indigenous status Geographic area Country of birth		Schools, Australia[36] Education and Training Experience[37] Labour Force Status and Other Characteristics of Migrants[38] Education and Training in Australia[39] Transition from Education to Work[40]
	Educational attainment: • literacy and numeracy • highest qualification	Age Sex Income group Family type Indigenous status Geographic area Country of birth Disability		National Report on Schooling in Australia[41] ABS Census of Population and Housing[42] Transition from Education to Work[40]
Employment and labour force participation	Participation in the labour force: • occupation type • hours worked • employment basis and conditions	Age Sex Income group Family type Indigenous status Geographic area Education group Disability		Labour Force Survey[43] Survey of Disabilities, Ageing and Carers[26] Survey of Employment Arrangements and Superannuation[29,35]
	Employment, unemployment and underemployment	Age Sex Income group Family type Indigenous status Geographic area Education group Disability	Long-term unemployment Households with no employed person	Labour Force Survey[43]

(continued)

Table 9.1 (continued): A working table for the development of welfare indicators

Welfare sub-component	**Indicator topics on which to *measure average or level***	**Population subgroups among whom to *measure distribution***	**Approach to measuring *deprivation, disadvantage or exclusion***	**Source data or references[(a)]**
Employment and labour force participation *continued*	Employment vacancies			Job Vacancies[44]
	Shift to retirement	Age Sex Income group Family type Employment group		Survey of Retirement and Retirement Intentions[34]
Transport, mobility and communication	Car ownership	Age Sex Income group Family type Indigenous status Geographic area		Household Expenditure Survey[7] Time Use Survey(a) Survey of Motor Vehicle Use[45]
	Access to and use of transport	Age Sex Income group Family type Indigenous status Geographic area Disability		Environmental Issues[46] General Social Survey[33]
	Time and distance to: • work • services			Time Use Survey(a)
	Communication (e.g. access to telephone, Internet)			
Recreation and leisure	Amount and nature of leisure time	Age Sex Income group Family type Indigenous status Disability		Time Use Survey[47] Involvement in Sport[48]

(continued)

Table 9.1 (continued): A working table for the development of welfare indicators

Welfare sub-component	**Indicator topics on which to *measure average or level***	**Population subgroups among whom to *measure distribution***	**Approach to measuring *deprivation, disadvantage or exclusion***	**Source data or references(a)**
Recreation and leisure *continued*	Recreation and vacations: • household expenditure and time • vacation trips	Age Sex Income group Family type Indigenous status Disability		Time Use Survey[47] Household Expenditure Survey[7] Travel by Australians[49]
Family and friends	Family formation: • marriage • fertility • living arrangements	Family structure and characteristics of members	Family dissolution, e.g. divorce	Family Characteristics Survey[50] Census of Population and Housing[42] Marriages and Divorces[51] Births, Australia[52] Labour Force Status and Other Characteristics of Families[53]
	Family functioning Quality of relations between family members, e.g. trust • time use including 'unpaid work' • family participation in the wider community, e.g. employment • resilience and adaptability	Family structure and characteristics of members?	Domestic violence Child protection (abuse and neglect) Children in out-of-home care Children living in a family where no parent works	SAAP National Data[3] Longitudinal Survey of Australia's Children—FaCS(a) Crime and Safety Survey[17] Family Characteristics Survey[50] Survey of Disability, Ageing and Carers[26] Household, Income and Labour Dynamics Survey—FaCS(a) Time Use Survey[47] Labour Force Status and Other Characteristics of Families[53] Labour Force, Australia[43] Reconnect data—FaCS(a)

(continued)

Table 9.1 (continued): A working table for the development of welfare indicators

Welfare sub-component	**Indicator topics on which to *measure average or level***	**Population subgroups among whom to *measure distribution***	**Approach to measuring *deprivation, disadvantage or exclusion***	**Source data or references**[(a)]
Family and friends *continued*	Involvement as carer			Survey of Disability, Ageing and Carers[26]
	Availability and quality of friendship relations			Mental Health Survey[54]
Social and support networks	Access to help/ support/information when needed (involving time and/or money)	Age Sex Family type Disability Country of birth		General Social Survey[33] Disability, Ageing and Carers Survey[26] Mental Health Survey[54]
	Provision of help/ support/information when needed (involving time and/or money)	Age Sex Family type Disability Country of birth		Time Use Survey
	Contact with family and friends outside the home	Age Sex Family type Disability Country of birth		General Social Survey[33] Time Use Survey[47]
	Social attachment	Age Sex Income group Family type Indigenous status Country of birth	Suicide Drug use Prisoners and deaths in custody (rates)	Causes of Death, Australia[27] Statistics on Drug Use in Australia[55] Prisoners in Australia[56] Australian Deaths in Custody[57,58]
Trust	Trust in institutions: • government • political system • trade unions • legal system • police	Age Sex Income group Family type Indigenous status		World Values Survey[59]
	Trust in community/ people generally/ strangers Acceptance of diversity	Age Income group Family type Indigenous status Country of birth		

(continued)

Table 9.1 (continued): A working table for the development of welfare indicators

Welfare sub-component	**Indicator topics on which to *measure average or level***	**Population subgroups among whom to *measure distribution***	**Approach to measuring *deprivation, disadvantage or exclusion***	**Source data or references(a)**
Community involvement, civic engagement, bridging social capital	Participation in community/sporting groups and projects (Types of communities may be geographically defined, COB, Indigenous etc.)	Age Sex Income group Family type Disability Country of birth		Time Use Survey[47] General Social Survey[33] Involvement in Sport[48]
	Participation in: • political organisations (parties and unions) • professional organisations	Age Sex Income group Education group		
	Support for children outside household	Sex Income group Family type		General Social Survey[33]
Volunteering and philanthropy	Participation in volunteering	Age Sex Income group		Voluntary Work Survey[60] Time Use Survey[47] ANDP Data[61]
	% of income given to charities	Age Sex Income group		ANDP Data[61] Voluntary Work Survey[60]

(a) Sources listed contain relevant data. In some cases, especially those referring to this footnote, the source may not contain or publish all data required for the suggested indicators (e.g. distributional indicators).The numbered reference list following this table identifies the references and data sources separately.

Data sources list

References in Table 9.1 to surveys are generally to related publications. In some cases, however, relevant data are unpublished.

1. ANZFA (Australian & New Zealand Food Authority) 2001. 19th Australian total diet survey. Canberra: ANZFA.
2. ABS (Australian Bureau of Statistics) 2000a. Apparent consumption of foodstuffs, Australia. Cat. no. 4306.0. Canberra: ABS.
3. AIHW (Australian Institute of Health and Welfare) 2000a. SAAP national data collection annual report 1999—2000 Australia. Cat. no. HOU 50. Canberra: AIHW (SAAP NDCA report. Series 5).

4. ABS (Australian Bureau of Statistics) 1998a. National nutrition survey: nutrient intakes and physical measurements, Australia. Cat. no. 4805.0. Canberra: ABS.

5. ABS (Australian Bureau of Statistics) 1999a. National nutrition survey: foods eaten, Australia. Cat. no. 4804.0. Canberra: ABS.

6. ABS (Australian Bureau of Statistics) 2000b. Household expenditure survey, Australia: summary of results. Cat. no. 6530.0. Canberra: ABS.

7. ABS (Australian Bureau of Statistics) 2000c. Household expenditure survey, Australia: detailed expenditure items. Cat. no. 6535.0. Canberra: ABS.

8. ABS (Australian Bureau of Statistics) 1997a. National health survey, summary of results. Cat. no. 4364.0. Canberra: ABS.

9. ABS (Australian Bureau of Statistics) 2000d. Housing and infrastructure in Aboriginal and Torres Strait Islander communities 1999. Cat. no. 4710.0. Canberra: ABS.

10. ABS (Australian Bureau of Statistics) 2000e. Australian housing survey housing characteristics, costs and conditions. Cat. no. 4182.0. Canberra: ABS.

11. AIHW (Australian Institute of Health and Welfare) 2001. Australia s welfare 2001: services and assistance. Canberra: AIHW.

12. FaCS (Department of Family and Community Services) 1999. Commonwealth Rent Assistance recipient information, September 1998. Unpublished data.

13. National Occupation Health & Safety Commission 2001. National workers compensation statistics database [cited May 2001]. Available on Internet: nohsc.info.au.com/

14. ABS (Australian Bureau of Statistics) 2001a. Work related injuries, Australia. Cat. no. 6324.0. Canberra: ABS.

15. Australian Transport Safety Bureau 2001. Road fatalities Australia [cited July 2001]. Available on Internet: www.atsb.gov.au/road/stats/current.cfmhttp

16. International Crime Victim Survey 2001. Tables with key statistics [cited July 2001]. Available on Internet: www.rulj287.leidenuniv.nl/group/jfcr/www/icvs

17. ABS (Australian Bureau of Statistics) 1999b. Crime and safety, Australia. Cat. no. 4509.0. Canberra: ABS.

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Appendix tables

Chapter 2 Welfare services resources

OECD financial year

For the majority of countries, the year of reporting in the OECD social expenditure database is the calendar year. Australia, Canada, Japan, New Zealand, the United Kingdom and the United States are the exceptions to this rule. Box A2.1 shows the concept of year for member countries, using the 1997 OECD year as an example.

Box A2.1: OECD member countries: periods relating to OECD year 1997

Country	*Financial year*	*Country*	*Financial year*
Australia	*1 Jul 1997 to 30 Jun 1998*	*Korea*	*1 Jan 1997 to 31 Dec 1997*
Austria	*1 Jan 1997 to 31 Dec 1997*	*Luxembourg*	*1 Jan 1997 to 31 Dec 1997*
Belgium	*1 Jan 1997 to 31 Dec 1997*	*Mexico*	*1 Jan 1997 to 31 Dec 1997*
Canada	*1 Apr 1997 to 31 Mar 1998*	*Netherlands*	*1 Jan 1997 to 31 Dec 1997*
Czech Rep.	*1 Jan 1997 to 31 Dec 1997*	*New Zealand*	*1 Jul 1997 to 30 Jun 1998*
Denmark	*1 Jan 1997 to 31 Dec 1997*	*Norway*	*1 Jan 1997 to 31 Dec 1997*
Finland	*1 Jan 1997 to 31 Dec 1997*	*Poland*	*1 Jan 1997 to 31 Dec 1997*
France	*1 Jan 1997 to 31 Dec 1997*	*Portugal*	*1 Jan 1997 to 31 Dec 1997*
Germany	*1 Jan 1997 to 31 Dec 1997*	*Spain*	*1 Jan 1997 to 31 Dec 1997*
Greece	*1 Jan 1997 to 31 Dec 1997*	*Sweden*	*1 Jan 1997 to 31 Dec 1997*
Iceland	*1 Jan 1997 to 31 Dec 1997*	*Switzerland*	*1 Jan 1997 to 31 Dec 1997*
Ireland	*1 Jan 1997 to 31 Dec 1997*	*Turkey*	*1 Jan 1997 to 31 Dec 1997*
Italy	*1 Jan 1997 to 31 Dec 1997*	*UK*	*1 Apr 1997 to 31 Mar 1998*
Japan	*1 Apr 1997 to 31 Mar 1998*	*USA*	*1 Oct 1996 to 30 Sep 1997*

Table A2.1: Persons employed in community services occupations, 1996

Occupation	**Number**	**Per cent**	**Number per 100,000 population**
Pre-primary and special education			
Pre-primary school teacher	12,584	6.7	70.9
Special needs teacher	8,826	4.7	49.7
Teacher of the hearing impaired	608	0.3	3.4
Teacher of the sight impaired	251	0.1	1.4
Special education teacher nec	1,398	0.7	7.9
Preschool aide	3,075	1.6	17.3
Integration aide	2,878	1.5	16.2
Total	*29,620*	*15.8*	*166.9*
Welfare, social and community workers			
Welfare centre manager	984	0.5	5.5
Social worker	7,193	3.8	40.5
Welfare worker	6,220	3.3	35.0
Community worker	15,800	8.4	89.0
Total	*30,197*	*16.1*	*170.1*
Counsellors			
Rehabilitation counsellor	1,207	0.6	6.8
Drug and alcohol counsellor	752	0.4	4.2
Family counsellor	1,399	0.7	7.9
Total	*3,358*	*1.8*	*18.9*
Welfare associate professionals			
Parole or probation officer	828	0.4	4.7
Youth worker	5,391	2.9	30.4
Residential care officer	1,024	0.5	5.8
Disabilities services officer	4,930	2.6	27.8
Family support worker	1,001	0.5	5.6
Total	*13,174*	*7.0*	*74.2*
Children’s care workers			
Child care coordinator	7,135	3.8	40.2
Child care worker	31,201	16.7	175.8
Family day care worker	16,577	8.9	93.4
Nanny	6,574	3.5	37.0
Children’s care worker nfd	7,650	4.1	43.1
Total	*69,137*	*36.9*	*389.5*
Special care workers			
Hostel parent	1,627	0.9	9.2
Child/youth resident care assistant	3,592	1.9	20.2
Refuge worker	482	0.3	2.7
Aged or disabled person carer	35,940	19.2	202.5
Special care worker nfd	62	0.0	0.3
Total	*41,703*	*22.3*	*234.9*
Total	**187,189**	**100.0**	**1,054.6**

Source: AIHW 2001.

Table A2.2: Funding and provision of welfare services, 1999–00 ($m)

Provider of services	Source of funds: Commonwealth	State/Territory	Local	Total governments	NGCSOs(a)	Households	Total	Proportion of services provision (%)
Commonwealth	525	—	—	525	—	51	576	4
State /Territory	1,027	3,364	—	4,391	—	68	4,459	33
Local	324	45	133	502	—	183	685	5
Total governments	*1,876*	*3,409*	*133*	*5,418*	—	*302*	*5,720*	*42*
NGCSOs	1,990	1,144	3	3,138	1,913(b)	2,667	7,717	57
Households	—	—	—		—	205	205	2
Total	3,866	4,553	136	**8,555**	1,913	3,174	13,642	100
Proportion of funding (%)	*28*	*33*	*1*		*14*	*23*	*100*	

(a) Profit from sale of assets is included but not the value of the assets sold.

(b) Capital expenditure is not included for NGCSO-sourced funds.

Note: Totals may not add due to rounding.

Source: See Notes (a)–(e) in Table 2.12.

Table A2.3: Commonwealth and State/Territory recurrent expenditure on welfare services (in 1998–99 prices), 1992–93 to 1999–00 ($m)

	Commonwealth(a)	State/Territory(b)	Total
Family and child welfare services			
1992–93	669.1	890.2	1,559.3
1993–94	824.9	933.1	1,757.9
1994–95	1,028.7	941.9	1,970.6
1995–96	1,150.6	1,041.8	2,192.4
1996–97	1,206.1	1,084.8	2,290.8
1997–98	1,114.8	1,155.9	2,270.7
1998–99 (accrual)	1,139.7	(c)1,343.5	2,463.1
1999–00 (accrual)	1,365.9	(c)1,418.4	2,785.3
Average annual growth rate			
1992–93 to 1997–98	10.7%	5.4%	7.8%
1998–99 to 1999–00	19.9%	5.6%	12.2%
Welfare services for the aged			
1992–93	641.8	451.5	1,093.3
1993–94	870.3	386.3	1,256.6
1994–95	984.2	520.7	1,504.9
1995–96	969.2	576.2	1,545.4
1996–97	1,063.1	753.3	1,816.4
1997–98	1,199.6	908.6	2,108.2
1998–99 (accrual)	1,301.5	(c)902.4	2,203.9
1999–00 (accrual)	1,302.3	(c)900.1	2,202.4
Average annual growth rate			
1992–93 to 1997–98	13.3%	15.0%	14.0%
1998–99 to 1999–00	—%	–0.1%	—%

(continued)

Table A2.3 (continued): Commonwealth and State/Territory recurrent expenditure on welfare services (in 1998–99 prices), 1992–93 to 1999–00 ($m)

	Commonwealth[a]	State/Territory[b]	Total
Welfare services for people with a disability			
1992–93	599.5	892.1	1,491.6
1993–94	648.1	1,002.4	1,650.5
1994–95	754.0	955.0	1,708.9
1995–96	770.7	938.0	1,708.7
1996–97	756.0	1,043.8	1,800.0
1997–98	761.7	1,194.2	1,955.9
1998–99 (accrual)	833.3	(c)1,522.5	2,355.8
1999–00 (accrual)	868.4	(c)1,614.6	2,483.0
Average annual growth rate			
1992–93 to 1997–98	4.9%	6.0%	5.6%
1998–99 to 1999–00	4.2%	6.0%	5.4%
Other welfare services			
1992–93	160.4	290.6	451.1
1993–94	169.0	295.7	464.7
1994–95	174.6	300.7	475.3
1995–96	214.0	288.5	502.5
1996–97	191.6	306.7	498.3
1997–98	186.3	355.3	541.6
1998–99 (accrual)	179.8	405.8	585.7
1999–00 (accrual)	180.7	453.1	633.7
Average annual growth rate			
1992–93 to 1997–98	3.0%	4.1%	3.7%
1998–99 to 1999–00	0.5%	11.6%	8.2%
Total welfare services			
1992–93	2,070.9	2,524.5	4,595.3
1993–94	2,512.2	2,617.5	5,130.0
1994–95	2,941.5	2,718.2	5,660.0
1995–96	3,104.4	2,644.6	5,949.0
1996–97	3,216.8	3,188.5	6,405.3
1997–98	3,262.4	3,614.0	6,876.4
1998–99 (accrual)	3,454.4	(c)4,174.2	7,628.5
1999–00 (accrual)	3,718.4	(c)4,386.1	8,104.5
Average annual growth rate			
1992–93 to 1997–98	9.5%	7.4%	8.4%
1998–99 to 1999–00	7.6%	5.1%	6.2%

(a) Compiled from DHHCS 1991, 1992; DHHLGCS 1993; DHSH 1995a, 1995b; DHFS 1996, 1997, 1998; DHAC 1999, 2000; DHRD 1994, 1995; FACS 1999, 2000; Department of Immigration and Ethnic Affairs unpublished data; Department of Veterans' Affairs unpublished data.

(b) Recurrent expenditure—CGC unpublished data. Capital expenditure—ABS unpublished public finance data.

(c) The figures are less reliable than previous years' data.

Note: Totals may not add due to rounding.

Chapter 3 Assistance for housing

Table A3.1: All households, by tenure and physical condition of dwelling, 1999

	Owners			Renters					
	Without a mortgage	With a mortgage	Total	Public housing	Private landlord	Total[a]	Rent-free	Other tenure	Total
Major structural problems				**Per cent**					
Rising damp	2.6	3.0	2.8	9.3	8.3	8.2	4.6	3.2	4.3
Major cracks in walls/floors	4.1	3.8	4.0	14.1	12.6	12.7	12.5	8.5	6.6
Sinking/moving foundations	3.9	3.3	3.6	7.3	7.1	7.2	6.3	6.2	4.7
Sagging floors	1.8	2.3	2.0	6.0	6.3	6.1	9.8	3.8	3.3
Walls/windows out of plumb	2.1	2.6	2.3	9.7	8.3	8.5	7.9	6.0	4.1
Wood rot/termite damage	2.1	2.5	2.3	4.8	5.3	5.2	4.0	4.7	3.1
Major electrical problems	0.5	0.6	0.5	2.5	4.0	3.6	4.6	1.9	1.4
Major plumbing problems	1.4	2.1	1.7	5.7	8.6	7.9	3.3	4.8	3.5
Major roof defect	1.4	1.8	1.6	4.2	4.8	4.8	4.4	2.9	2.5
Other problems	1.0	1.0	1.0	4.9	3.1	3.4	1.2	1.5	1.7
Not known	1.2	0.7	1.0	1.9	2.6	2.5	1.3	1.1	1.4
No major structural problems	85.6	85.2	85.4	63.6	65.5	65.4	71.8	77.6	79.6
Need for interior repairs									
Essential and urgent need	0.5	0.7	0.6	4.2	2.8	3.1	1.7	2.9	1.3
Essential need	1.8	2.1	1.9	10.5	6.2	6.9	5.0	1.4	3.3
Moderate need	8.5	11.4	9.8	15.5	15.9	15.6	13.4	12.4	11.4
Desirable but low need	23.1	31.0	26.6	23.5	31.2	29.4	30.0	25.8	27.4
No need	66.1	54.9	61.1	46.4	43.9	45.0	50.0	57.6	56.5
Need for exterior repairs									
Essential and urgent need	0.7	0.7	0.7	2.7	2.0	2.2	3.0	1.2	1.1
Essential need	2.8	3.1	2.9	6.9	4.4	4.9	6.0	2.3	3.5
Moderate need	11.0	12.7	11.8	14.0	13.6	13.4	13.1	20.7	12.3
Desirable but low need	25.8	31.2	28.2	19.8	27.4	25.9	31.6	25.0	27.6
No need	59.6	52.4	56.4	56.6	52.7	53.7	46.4	50.8	55.4
				Number ('000)					
Estimated number of households	2,800.3	2,256.1	5,056.4	368.8	1,463.2	1,966.6	120.9	73.0	7,216.9

(a) Includes 'other renter'.

Note: Summing the per cent of structural problems for each tenure type may yield more than 100% due to some households having more than one category of structural problem.

Source: AIHW analysis of ABS 1999 Australian Housing Survey confidentialised unit record file.

Table A3.2: Real government expenditure on CSHA assistance and CRA, 1990–91 to 1999–00 ($m in current and constant prices)

	CSHA assistance		CRA		
	Current prices	Constant prices 1998–99	Current prices	Constant prices 1998–99	Deflator
1990–91	1,322.9	1,560.0	740.0	872.6	84.8
1991–92	1,409.0	1,579.6	907.0	1,016.8	89.2
1992–93	1,485.4	1,625.2	1,199.0	1,311.8	91.4
1993–94	1,419.6	1,543.0	1,401.0	1,522.8	92.0
1994–95	1,509.6	1,630.2	1,453.0	1,569.1	92.6
1995–96	1,489.8	1,574.8	1,552.0	1,640.6	94.6
1996–97	1,353.4	1,405.4	1,647.0	1,710.3	96.3
1997–98	1,207.4	1,235.8	1,484.0	1,518.9	97.7
1998–99	1,276.6	1,276.6	1,505.0	1,505.0	100.0
1999–00	1,331.0	1,302.3	1,538.0	1,504.9	102.2

Notes

1. Constant dollar values were calculated using the 1998–99 GFCE deflator. This differs from the Domestic Final Demand index that was used to derive constant CSHA assistance in Table A5.4 of *Australia's Welfare 1999*.
2. Care should be taken in interpreting data as CRA is a demand-driven recurrent expenditure program, whereas CSHA expenditure includes a component for capital investment that has resulted in approximately $30 billion of public housing assets that are continually used for housing assistance.
3. Data include all CSHA expenditure.

Source: ABS 2000d; ABS unpublished; SCRCSSP 2001:Figure 16.1.

Table A3.3: Income units receiving CRA: ratio of housing costs to income before and after receipt, June 1997 to March 2000 (per cent)

	Paying more than 30% of income in rent		Paying more than 50% of income in rent	
	Before CRA	After CRA	Before CRA	After CRA
June 1997	77	39	35	8
June 1998	74	38	30	9
June 1999	76	42	33	12
March 2000	75	41	32	11

Source: FaCS 2000:93.

Table A3.4: Net additions to public housing stock (dwellings), 1982–83 to 1996–97

Year	Net change
1982–83	8,916
1983–84	11,100
1984–85	13,089
1985–86	14,479
1986–87	14,365
1987–88	11,421
1988–89	9,110
1989–90	10,660
1990–91	10,739
1991–92	7,329
1992–93	7,867
1993–94	5,851
1994–95	5,274
1995–96	4,054
1996–97	–156

Source: DHHLGCS 1993; DHRD 1994, 1995; DSS 1996, 1997; FaCS 1999a; Foard et al. 1994.

Table A3.5: Type of housing tenure, by State/Territory, 1998 (per cent)

Tenure type	NSW	Vic	Qld	WA	SA	Tas	ACT	NT[(a)]	Aust.
Owner without a mortgage	41.1	41.4	36.9	37.3	37.8	42.4	29.0	15.0	39.4
Owner with a mortgage	26.7	33.7	30.3	33.5	31.3	30.7	33.9	27.7	30.4
Public housing renter	5.8	3.6	3.9	5.7	10.4	6.5	12.4	20.4	5.6
Private landlord renter	21.7	18.2	24.5	19.6	15.7	16.4	20.8	22.7	20.5

(a) Estimates for the Northern Territory relate to mainly urban areas only.

Note: Components for each State/Territory do not total 100% because other renters (paying rent to the manager of a caravan park, an employer, a housing cooperative, or a church or community group), as well as other types of tenure (rent-free and others), are not included.

Source: ABS 2000b:167.

Table A3.6: Public housing tenants' satisfaction with public and private rental housing: weighted national data (per cent)

Comparative rating	**Rent paid for home**	**Overall service received from landlord**	**Quality of maintenance services**	**Overall condition of home**	**Location of home**	**Security of home**
Private better—a lot	3	8	9	16	16	16
Private better—a little	3	8	8	12	11	9
Private better—total	*6*	*16*	*17*	*28*	*27*	*25*
Public better—a lot	63	35	36	32	27	30
Public better—a little	15	15	18	13	11	12
Public better—total	*78*	*50*	*54*	*45*	*38*	*42*
Public and private about the same	15	31	26	26	32	31
No response	2	3	2	1	3	2
Total	**101**	**100**	**99**	**100**	**100**	**100**

Note: Some totals do not add up to 100% due to rounding.

Source: NFO Donovan Research 2000b:Table 109.

Table A3.7: Number of CSHA public and community housing dwellings, by State/Territory, 30 June 2000

	NSW	**Vic**	**Qld**	**WA**	**SA**	**Tas**	**ACT**	**NT**	**Aust.**
Number of community housing dwellings	7,899	6,009	3,625	3,158	2,990	183	312	140	24,316
Number of public housing dwellings	127,513	65,996	50,662	32,697	53,485	13,405	11,758	7,451	362,967
Total number of dwellings	**135,412**	**72,005**	**54,287**	**35,855**	**56,475**	**13,588**	**12,070**	**7,591**	**387,283**

Source: AIHW 2001a unpublished, 2001e unpublished.

Table A3.8: Selected characteristics of all households, by Indigenous status, 1999

Selected characteristics	Indigenous households	Non-Indigenous households
	Per cent	
Tenure		
Owner with or without mortgage	38.9	70.6
Private rental	27.3	20.1
Public rental housing	22.4	4.8
Other landlord	8.5	1.7
Total renters(a)	*58.2*	*26.7*
Gross household weekly income		
Less than $343	19.7	23.1
$343–$524	20.2	12.6
$525–$854	20.1	18.3
$855–$1,297	19.7	20.1
$1,298 or more	20.3	25.9
Housing costs as a proportion of income		
15% or less(b)	40.5	53.6
16%–25%	30.7	20.6
26%–30%	7.3	3.9
More than 30%	15.5	14.3
Housing utilisation		
1 or more extra bedrooms needed	12.7	4.4
No extra bedrooms needed	33.6	22.7
1 bedroom spare	33.8	36.2
2 or more bedrooms spare	19.9	36.7
Need for repairs to dwelling(c)		
No need	33.7	43.5
Low need	28.2	32.6
Medium need	19.0	16.7
High need	19.1	7.2
	Number ('000)	
Total households(d)	145.5	7,057.0

(a) Includes 'other renter'.

(b) Includes nil or rounded to zero.

(c) Categorised according to combination of need for interior and exterior repairs.

(d) Includes rent-free and other tenure; and includes households with housing costs not known or with nil or negative income.

Source: ABS 2001a.

Chapter 4 Deinstitutionalisation: the move towards community-based care

Table A4.1: People living in health and welfare institutions, by sex and type of institution, 1996

Institution type	Females	Males	Total
Children	171	319	490
Disability	4,885	6,034	10,919
Aged	95,348	36,250	131,598
Psychiatric	3,135	4,000	7,135
Hospitals	29,788	22,405	52,193
Other institutions	2,583	5,268	7,851

Source: AIHW analysis of ABS census data.

Table A4.2: Population in health and welfare institutions, expected and actual, 1996

Age/sex	Expected 1996 based on 1981 rates	Actual 1996
Males		
0–14	8,555	4,100
15–24	7,029	3,219
25–39	9,458	7,083
40–64	24,510	13,836
65–79	29,754	22,023
80+	28,759	24,014
Total males	*108,064*	*74,275*
Females		
0–14	6,549	3,337
15–24	9,436	3,512
25–39	14,478	8,361
40–64	21,652	11,606
65–79	42,503	29,668
80+	88,209	79,427
Total females	*182,827*	*135,911*
Persons		
0–14	15,104	7,437
15–24	16,464	6,731
25–39	23,936	15,444
40–64	46,163	25,442
65–79	72,256	51,691
80+	116,968	103,441
Total persons	**290,891**	**210,186**

Source: AIHW analysis of ABS census data.

Table A4.3: Estimated number of children in substitute care, various years, 1972–2000

1972	1984	1993	2000
39,600	22,500	12,800	17,200

Source: AIHW: Johnstone 2001.

Chapter 5 Children's and family services

Table A5.1: Estimated number of children aged 0–17 years, by age group and State/Territory, 30 June 2000 ('000)

Age (years)	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust.
0–4	431.2	302.7	240.9	126.6	92.5	30.6	20.8	17.6	1,263.1
5–12	710.8	517.4	410.7	215.7	158.5	54.2	34.6	27.2	2,129.5
13–17	440.6	320.4	259.8	138.8	102.2	35.2	22.5	15.0	1,334.7
Total 0–17	*1,582.6*	*1,140.5*	*911.3*	*481.1*	*353.2*	*120*	*77.8*	*59.7*	*4,727.4*
Total population	**6,463.5**	**4,765.9**	**3,566.4**	**1,883.9**	**1,497.6**	**470.4**	**310.8**	**195.5**	**19,157.0**
Children aged 0–17 as a percentage of total population	25	24	26	26	24	26	25	31	25

Source: ABS 2001b.

Table A5.2: The use of formal and informal care, by type of care and age of child, 1999

	Age (years)								
Type of care	**Under 1**	**1**	**2**	**3**	**4**	**5**	**6–8**	**9–11**	**Total**
					Number ('000)				
Formal only	13.0	35.4	51.3	83.9	104.8	51.5	63.3	33.8	437.0
Both	8.5	23.1	37.3	64.9	87.4	26.9	30.2	17.9	296.2
Informal only	85.3	90.4	80.3	46.2	25.7	68.2	237.4	232.6	866.1
Total children in care	*106.8*	*148.9*	*168.9*	*195.0*	*217.9*	*146.6*	*330.9*	*284.3*	*1,599.3*
Not in care	145.0	99.5	86.0	61.8	44.5	116.4	465.3	505.3	1,523.7
Total children	**251.8**	**248.4**	**254.9**	**256.8**	**262.4**	**263.0**	**796.2**	**789.6**	**3,122.9**
					Percentage of children in care				
Formal only	12	24	30	43	48	35	19	12	27
Both	8	16	22	33	40	18	9	6	19
Informal only	80	61	48	24	12	47	72	82	54
Total children in care	*100*	*100*	*100*	*100*	*100*	*100*	*100*	*100*	*100*
					Percentage of all children				
Formal only	5	14	20	33	40	20	8	4	14
Both	3	9	15	25	33	10	4	2	9
Informal only	34	36	31	18	10	26	30	30	28
In care	*42*	*60*	*66*	*76*	*83*	*56*	*42*	*36*	*51*
Not in care	58	40	34	24	17	44	58	64	49
Total children	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**

Source: ABS 2000f:12.

Table A5.3: Children aged 0–11 years in child care, by type of care and hours per week in care, 1999

	Hours per week						
Type of care	**Less than 5**	**5–9**	**10–19**	**20–29**	**30–44**	**45+**	**Total**
				Number			
Formal only	76.1	117.3	146	43.3	38.5	15.8	437.2
Both	8.3	35.9	97.2	63.5	51.7	39.6	296.0
Informal only	338.3	200.4	162.9	69.4	41.4	53.7	866.1
Total in care	**422.7**	**353.6**	**406.1**	**176.2**	**131.6**	**109.1**	**1,599.3**
				Per cent			
Formal only	17	27	33	10	9	4	100
Both	3	12	33	21	17	13	100
Informal only	39	23	19	8	5	6	100
Total in care	**26**	**22**	**25**	**11**	**8**	**7**	**100**

Source: ABS 2000f:15.

Table A5.4: Number of Commonwealth-supported child care providers, by type of service, 30 June 1991 – 30 June 2000

Type of service	**1991**	**1992**	**1993**	**1994**	**1995**	**1996**	**1997**	**1998**	**1999**	**2000**
Long day care centres										
Community-based	984	990	1,048	1,061	1,094	1,112	1,122	1,118	1,089	1,093
Private-for-profit	1,030	1,295	1,369	1,705	2,058	2,456	2,658	2,757	2,639	2,646
Employer and other non-profit centres	(a)	(a)	193	249	274	292	306	295	285	273
Total long day care centres	*2,014*	*2,285*	*2,610*	*3,015*	*3,426*	*3,860*	*4,086*	*4,170*	*4,013*	*4,012*
Family day care coordination units	327	342	354	363	370	366	381	360	331	372
Outside school hours care(b)	1,304	1,414	1,528	2,494	2,617	3,055	3,544	3,958	4,496	4,706
Occasional care/other(c)	327	497	537	619	653	651	655	648	677	655
Total	**3,972**	**4,538**	**5,029**	**6,491**	**7,066**	**7,932**	**8,666**	**9,136**	**9,517**	**9,745**

(a) 'Employer and other non-profit centres' are included in 'Private-for-profit long day care centres' in 1991 and 1992.

(b) From 1993 includes vacation care services funded under Year-Round Care.

(c) Includes occasional care centres, neighbourhood model services, MACS, and multifunctional services.

Source: FaCS unpublished data.

Table A5.5: Number of Commonwealth-supported child care places, by type of service, 30 June 1991 – 30 June 2000

Type of service	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000
Long day care centres										
Community-based[a]	39,567	40,262	42,777	43,399	44,566	45,601	46,294	51,710	50,589	50,368
Private-for-profit	36,700	53,210	53,920	70,587	88,614	109,691	121,559	129,671	127,128	128,415
Employer and other non-profit centres	[b]	[b]	7,455	9,787	11,295	12,771	15,012	13,173	12,609	12,132
Total long day care centres	*76,267*	*93,472*	*104,152*	*123,733*	*144,475*	*168,063*	*182,865*	*194,554*	*190,326*	*190,915*
Family day care	42,501	45,454	47,855	51,651	54,041	60,091	62,714	63,725	64,037	66,294
Outside school hours care[c]	44,449	48,222	50,340	59,840	64,046	71,846	78,970	134,354	160,955	179,743
Occasional care/ other[d]	5,059	5,634	5,626	6,228	6,365	6,575	6,564	6,711	6,722	6,492
Total	**168,276**	**192,782**	**207,973**	**241,492**	**268,927**	**306,575**	**331,113**	**399,355**	**422,040**	**443,444**

(a) Between June 1996 and June 1998, around 5,600 places in community-managed centres that were formerly categorised as ‘employer-sponsored and other non-profit’ places were transferred to the ‘community-based’ category.

(b) ‘Employer and other non-profit centres’ are included in ‘Private-for-profit long day care centres’ in 1991 and 1992.

(c) The large increase in outside school hours care places between June 1997 and June 1998 is due to the inclusion for the first time of vacation care places previously funded under block grant arrangements and to the change to a consistent counting methodology.

(d) Includes occasional care centres, neighbourhood model services, MACS and multifunctional services.

Source: FaCS unpublished data.

Table A5.6: Children in Commonwealth-supported child care, by age of child and type of service, 1999 (per cent)

	Age of child (years)					Total children	
Type of service	Under 1	1–2	3–4	5	6+	%	No.
Long day care centres							
Community-based	4	41	51	3	1	100	76,450
Private-for-profit	3	31	54	6	7	100	175,599
Employer and other non-profit	5	38	51	3	2	100	18,186
Family day care	5	34	31	7	22	100	81,418
Before/after school care	. .	. .	1	12	86	100	99,902
Vacation care	. .	. .	1	11	88	100	57,521
Occasional care/other care[a]	5	44	46	2	2	100	10,979

(a) Includes occasional care centres, MACS and other multifunctional services.

Notes

1. Double-counting may occur for children in before/after school care and vacation care services.
2. These data are unweighted and therefore are not adjusted for agency non-response.

Source: AIHW analysis of FaCS 1999b.

Table A5.7: Estimated level of met demand for work-related child care, by geographical area, June 2000 (per cent)

Geographical area	Met demand
Urban	132.3
Rural	94.0
Remote	83.7
Australia	121.7

Source: FaCS 2000a:197–8.

Table A5.8: Child care costs as a proportion of disposable income,[(a)] by family type and income level, selected years (per cent)

Family type and income level	1991	1993	1995	1997	1998	2000
Sole parent receiving payments/studying	6.5	10.2	11.9	13.3	14.7	10.6
Sole parent working—0.75 AWE	4.1	6.1	7.1	8.2	8.8	7.0
Couple family with one income—AWE	5.7	7.0	7.6	8.4	9.4	7.5
Couple family with two incomes—1.75 AWE	8.4	9.9	8.5	8.9	9.6	8.9
Couple family with two incomes—2.5 AWE	9.0	10.0	8.1	9.6	10.0	9.4

(a) Based on one child using centre-based private long day care for 40 hours per week.

Note: AWE = average weekly earnings.

Source: AIHW 2001b.

Table A5.9: Accreditation status of Commonwealth-supported long day care centres, June 1997, July 1999, April 2001

	June 1997		July 1999		April 2001	
Accreditation status	**Number**	**%**	**Number**	**%**	**Number**	**%**
Accredited with 1 year between reviews	1,158	28	572	14	427	11
Accredited with 2 years between reviews	327	8	235	6	170	4
Accredited with 3 years between reviews	1,314	32	2,777	67	3,072	76
Total accredited	*2,799*	*68*	*3584*	*87*	*3,669*	*91*
Undergoing process[(a)]	1,052	25	289	7	149	4
Plan of action—not accredited	283	7	269	6	205	5
Total	**4,134**	**100**	**4,142**	**100**	**4,023**	**100**

(a) ‘Undergoing process’ includes centres: in self-study, in review, and in moderation or awaiting council decision.

Source: National Child Care Accreditation Council unpublished data.

Table A5.10: Qualifications and training of child care workers employed in Commonwealth-supported services, by type of service, 1999 (per cent)

	Qualification status[(a)]					In-service training[(b)]		
Type of service	**Qualified**	**Studying**	**Experienced (3 years)**	**None of these**	**Total**	**Yes**	**No**	**Total workers(N)**
Long day care centres								
Community-based	54	11	21	14	100	67	33	13,182
Private-for-profit	53	16	14	17	100	70	30	22,314
Employer and non-profit	57	12	17	14	100	69	31	3,339
Family day care								
Coordination unit staff	70	5	18	7	100	88	12	1,611
Family day care providers	21	6	44	28	100	77	23	12,437
Before/after school care	39	17	20	24	100	55	45	8,069
Vacation care	40	20	16	24	100	n.a.	n.a.	7,231
Occasional care/other[(c)]	44	12	19	26	100	58	42	1,481

(a) 'Qualified' workers have relevant qualifications. Workers who are 'studying' do not have relevant qualifications but are studying for relevant qualifications. Workers who are 'experienced (3 years)' have 3 or more years experience in the child care industry.

Each worker has been counted once. However, a 'qualified' worker may also be studying for a qualification and/or have 3 or more years experience. Similarly, a worker with no qualification who is studying for a qualification may also have 3 or more years experience.

(b) In-service training indicates whether the workers have or have not undertaken in-service training in the last 12 months.

(c) Includes occasional care centres, MACS and other multifunctional services.

Notes

1. Double-counting may occur for workers in before/after school care and vacation care services.
2. Each worker has been counted once for qualification status and once for in-service training.
3. These data are unweighted and therefore are not adjusted for agency non-response.

Source: AIHW analysis of FaCS 1999b.

Child protection

Table A5.11: Number of child protection notifications, investigations and substantiations, 1990–91 to 1999–00

	1990–90	**1991–92**	**1992–93**	**1993–94**	**1994–95**	**1995–96**	**1996–97 [(a)]**	**1997–98**	**1998–99 [(b)]**	**1999–00**
Notifications	n.a.	n.a.	n.a.	n.a.	n.a.	91,734	n.a.	98,568	103,980	107,134
Investigations	49,721	53,296	59,122	74,436	76,954	67,816	n.a.	61,452	58,717	56,083
Substantiations	20,868	21,371	25,630	28,711	30,615	25,558	n.a.	26,025	25,447	24,732

(a) A national total for the year 1996–97 could not be calculated as no data were available for New South Wales for this period.

(b) An estimate using 6 months of data for the Northern Territory was used to form the national total for the year 1998–99.

Note: Data on the number of notifications were not collected prior to 1995–96.

Source: AIHW 2001c.

Table A5.12: Number of child protection notifications, investigations and substantiations, Queensland and Western Australia, 1990–91 to 1999–00

	1990–91	1991–92	1992–93	1993–94	1994–95	1995–96	1996–97	1997–98	1998–99	1999–00
					Queensland					
Notifications	n.a.	n.a.	n.a.	n.a.	n.a.	15,362	15,478	17,233	18,721	19,057
Investigations	11,390	9,296	8,496	10,672	12,476	12,816	12,926	15,245	15,010	15,298
Substantiations	3,500	3,027	2,743	3,127	4,000	3,332	3,487	6,323	6,373	6,919
					Western Australia					
Notifications	n.a.	n.a.	n.a.	n.a.	n.a.	3,748	2,099	2,447	2,568	2,645
Investigations	3,084	4,160	4,979	6,609	4,936	2,780	1,933	2,285	2,450	2,577
Substantiations	1,223	1,380	1,519	1,830	1,484	982	945	1,135	1,215	1,169

Note: Data on the number of notifications were not collected prior to 1995–96.

Source: AIHW 2001c.

Table A5.13: Number of children aged 0–17 years on care and protection orders, by State/Territory, 30 June 1991 – 30 June 2000

At 30 June	NSW[(a)]	Vic	Qld	WA	SA	Tas	ACT	NT	Australia
1991	3,101	3,810	3,027	706	1,275	598	67	96	12,680
1992	3,134	3,099	2,916	629	1,332	821	131	97	12,159
1993	3,410	2,941	2,951	623	1,265	713	138	91	12,132
1994	3,904	3,133	2,903	661	1,283	630	112	124	12,750
1995	4,331	3,105	2,931	708	1,185	456	215	137	13,068
1996	4,669	3,180	2,859	781	981	424	247	100	13,241
1997[(b)]	5,764	3,865	3,249	785	1,172	508	264	111	15,718
1998	5,987	4,215	3,433	799	1,102	520	255	138	16,449
1999	6,948	4,358	3,609	1,019	1,024	440	236	177	17,811
2000	7,661	4,752	3,612	1,105	1,210	470	232	220	19,262

(a) New South Wales data from 1998 onwards do not include children on supervisory orders.

(b) The scope of the data collection changed in 1997, so data collected from 1997 onwards should not be compared with data from previous years.

Source: AIHW 2001c.

Table A5.14: Children in out-of-home care by type of care, New South Wales, Victoria and Western Australia, 30 June 1996 – 30 June 2000

Type of care	1996	1997	1998	1999	2000
New South Wales					
			Number		
Residential care	475	311	351	342	306
Foster care	2,661	2,583	2,395	2,338	2,510
Living with relatives/kin	2,143	2,375	2,507	3,253	3,812
Other[(a)]	158	217	350	426	413
Total	**5,437**	**5,486**	**5,603**	**6,359**	**7,041**
			Per cent		
Residential care	9	6	6	5	4
Foster care	49	47	42	37	36
Living with relatives/kin	39	43	45	51	54
Other[(a)]	3	4	6	7	6
Total	**100**	**100**	**100**	**100**	**100**
Victoria					
			Number		
Residential care	794	689	619	568	521
Foster care	1,849	1,893	1,988	2,048	2,237
Living with relatives/kin	638	737	888	817	962
Other[(a)]	104	74	120	148	146
Total	**3,385**	**3,393**	**3,615**	**3,581**	**3,867**
			Per cent		
Residential care	24	20	17	16	14
Foster care	55	56	55	57	58
Living with relatives/kin	19	22	25	23	25
Other[(a)]	3	2	3	4	4
Total	**100**	**100**	**100**	**100**	**100**
Western Australia					
			Number		
Residential care	209	177	158	164	175
Foster care	651	649	689	709	769
Living with relatives/kin	309	216	226	277	341
Other[(a)]	37	8	20	42	41
Total	**1,206**	**1,050**	**1,093**	**1,192**	**1,326**
			Per cent		
Residential care	17	17	15	14	13
Foster care	54	62	63	60	58
Living with relatives/kin	26	21	21	23	26
Other[(a)]	3	1	2	4	3
Total	**100**	**100**	**100**	**100**	**100**

(a) 'Other' includes other family care, independent living and unknown living arrangements.

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

Source: AIHW Child Protection Database.

Chapter 6 Aged care

Table A6.1: Estimated and projected populations, by age and disability status, 1991 to 2041

Age	1991	2001	2011	2021	2031	2041
Persons with profound or severe restriction						
65–74 years	126,400	142,300	177,300	262,600	302,900	317,300
75–84 years	158,100	214,800	253,600	333,100	499,400	583,400
85+ years	100,600	169,100	251,200	307,100	431,900	659,500
Total 65+	*385,200*	*526,200*	*682,000*	*902,800*	*1,234,200*	*1,560,200*
All persons						
65–74 years	1,182,100	1,305,300	1,667,200	2,427,700	2,783,100	2,916,300
75–84 years	614,300	837,500	979,600	1,314,100	1,945,400	2,262,500
85+ years	154,200	260,300	389,200	478,600	676,600	1,034,400
Total 65+	**1,950,700**	**2,403,100**	**3,036,000**	**4,220,400**	**5,405,100**	**6,213,200**

Note: Estimated by applying the age/sex-specific disability rates from the 1998 ABS Disability, Ageing and Carers Survey to ABS population data.

Source: ABS 2000a, 2000c; AIHW analysis of ABS Survey of Disability, Ageing and Carers 1998.

Table A6.2: Home and Community Care services in a sample month, by service type and State/Territory, 1999–00

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Australia
Service type	May'00	May'00	Nov'99	May'00	May'00	May'00	Nov'99	May'00	
Total service provision									
Home help (hours)	186,160	195,525	102,547	67,579	44,591	23,851	6,315	8,319	634,887
Personal care (hours)	113,391	57,659	19,828	25,211	22,571	7,630	3,386	2,083	251,759
Home nursing (hours)	57,123	80,176	39,077	14,523	12,246	7,790	5,033	. .	215,968
Paramedical (hours)	7,178	14,705	7,510	4,446	5,661	626	300	191	40,617
Home respite care (hours)	129,238	53,573	53,907	26,287	39,256	7,855	10,044	2,584	322,744
Centre day care (hours)	206,175	257,866	230,426	121,661	58,575	20,671	3,503	6,278	905,155
Home meals (meals)	335,946	306,460	216,737	103,232	129,070	30,538	9,334	16,490	1,147,807
Centre meals (meals)	44,255	26,720	39,810	16,602	15,978	3,801	496	4,630	152,292
Other food (hours)	7,678	. .	1,689	1,160	1,753	. .	294	445	13,019
Home maintenance/ modification (hours)	18,066	18,489	25,405	7,450	6,816	2,168	1,114	497	80,005
Transport (clients)	38,238	. .	23,628	5,387	14,945	4,310	1,026	1,466	89,000
Other services (hours)	12,054	56,908	19,357	6,909	56,787	2,901	2,078	2,230	159,224
Total hours[(a)]	*530,888*	*477,035*	*269,320*	*153,565*	*189,681*	*52,820*	*28,564*	*16,349*	*1,718,222*

(continued)

Table A6.2 (continued): Home and Community Care services in a sample month, by service type and State/Territory, 1999–00

Service type	NSW May'00	Vic May'00	Qld Nov'99	WA May'00	SA May'00	Tas May'00	ACT Nov'99	NT May'00	Australia
Average hours per month per 1,000 persons aged 70 and over									
Home help (hours)	314	449	360	481	281	523	364	2,050	378
Personal care (hours)	191	132	70	179	142	167	195	513	150
Home nursing (hours)	96	184	137	103	77	171	290	. .	129
Paramedical (hours)	12	34	26	32	36	14	17	47	24
Home respite care (hours)	218	123	189	187	248	172	579	637	192
Centre day care (hours)	347	592	809	866	370	454	202	1,547	539
Home meals (meals)	566	704	760	735	815	670	538	4,063	683
Centre meals (meals)	75	61	140	118	101	83	29	1,141	91
Other food (hours)	13	. .	6	8	11	. .	17	110	8
Home maintenance/ modification (hours)	30	42	89	53	43	48	64	122	48
Transport (clients)	64	. .	83	38	94	95	59	361	53
Other services (hours)	20	131	68	49	358	64	120	549	95
Total hours[(a)]	*894*	*1,096*	*945*	*1,093*	*1,197*	*1,159*	*1,646*	*4,028*	*1,023*
Average hours per month per 1,000 persons aged 65 and over with a profound or severe restriction									
Home help (hours)	1,036	1,472	1,191	1,567	925	1,713	1,228	6,863	1,244
Personal care (hours)	631	434	230	584	468	548	659	1,718	493
Home nursing (hours)	318	603	454	337	254	559	979	. .	423
Paramedical (hours)	40	111	87	103	117	45	58	158	80
Home respite care (hours)	719	403	626	609	814	564	1,954	2,132	632
Centre day care (hours)	1,147	1,941	2,676	2,820	1,215	1,484	681	5,179	1,773
Home meals (meals)	1,869	2,306	2,517	2,393	2,676	2,193	1,816	13,603	2,249
Centre meals (meals)	246	201	462	385	331	273	96	3,820	298
Other food (hours)	43	. .	20	27	36	. .	57	367	26
Home maintenance/ modification (hours)	100	139	295	173	141	156	217	410	157
Transport (clients)	213	. .	274	125	310	309	200	1,209	174
Other services (hours)	67	428	225	160	1,177	208	404	1,840	312
Total hours[(a)]	*2,953*	*3,590*	*3,128*	*3,560*	*3,933*	*3,793*	*5,556*	*13,487*	*3,367*

(a) Excludes centre day care, delivered and centre meals, and transport services.

Note: Home nursing is not HACC-funded in the Northern Territory; other food services are not provided by Tasmania and Victoria; and Victoria does not provide transport services.

Source: ABS 2000a; ABS Survey of Disability, Ageing and Carers, unpublished data; DHAC, unpublished data.

Table A6.3: Community aged care packages and residential aged care places, by State/Territory, 30 June 1996 – 30 June 2001

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Australia
Operational CACPs									
1996	1,517	1,104	731	383	468	160	47	21	4,431
1997	2,199	1,369	1,027	538	634	228	84	45	6,124
1998	3,538	2,314	1,728	822	989	378	168	109	10,046
1999	4,685	3,323	2,440	1,161	1,258	450	266	170	13,753
2000	6,294	4,514	3,147	1,524	1,609	566	308	187	18,149
2001	8,583	5,971	4,118	2,219	2,238	661	336	304	24,430
Residential aged care places									
1996	49,291	32,883	24,721	11,342	13,377	3,613	1,276	349	136,851
1997	49,230	34,119	25,062	11,745	13,424	3,766	1,348	364	139,058
1998	49,682	34,458	25,000	11,812	13,455	3,732	1,416	362	139,917
1999	49,761	34,510	25,349	11,839	13,608	3,796	1,426	362	140,651
2000	49,824	34,688	25,604	11,893	13,512	3,795	1,484	362	141,162
2001	50,142	35,106	25,805	12,080	13,483	3,828	1,480	386	142,310
Operational CACPs per 1,000 people aged 70 and over									
1996	2.8	2.8	2.9	3.1	3.3	3.8	3.2	6.3	2.9
1997	4.0	3.4	3.9	4.2	4.3	5.3	5.4	12.8	3.9
1998	6.2	5.6	6.3	6.2	6.5	8.7	10.3	29.5	6.3
1999	8.1	7.8	8.7	8.5	8.1	10.1	15.6	43.9	8.4
2000	10.6	10.4	10.9	10.8	10.2	12.4	17.4	46.1	10.8
2001(a)	14.1	13.3	13.9	15.3	13.8	14.3	18.4	74.5	14.1
Residential aged care places per 1,000 people aged 70 and over									
1996	91.8	84.1	96.9	91.5	92.9	86.4	86.2	104.9	90.6
1997	89.2	84.9	95.0	91.6	90.8	88.4	87.1	103.4	89.4
1998	87.6	83.4	91.7	89.3	88.5	85.5	86.9	98.0	87.4
1999	85.8	81.5	90.2	86.9	87.8	85.2	83.6	93.4	85.7
2000	83.9	79.7	88.3	84.7	85.3	83.3	83.7	89.2	83.8
2001(a)	82.3	78.4	87.2	83.4	83.4	82.9	81.0	94.6	82.4
Operational CACPs per 1,000 people aged 65 and over with a severe or profound handicap									
1996	9.4	9.3	9.6	10.1	10.8	12.8	10.9	20.7	9.7
1997	13.3	11.2	13.0	13.7	14.3	17.8	18.6	42.2	13.1
1998	20.7	18.4	21.0	20.3	21.5	28.6	35.0	98.8	20.7
1999	26.8	25.8	28.8	27.8	26.9	33.3	53.0	146.8	27.7
2000	35.0	34.0	35.8	35.3	33.4	40.6	58.2	154.3	35.4
2001(a)	46.4	43.7	45.8	50.0	45.3	46.8	61.1	252.8	46.4
Residential aged care places per 1,000 people aged 65 and over with a severe or profound handicap									
1996	306.6	277.2	324.1	298.7	309.5	288.9	296.3	344.8	301.0
1997	296.7	279.8	316.6	299.1	301.8	293.2	297.7	341.7	296.4
1998	290.5	274.2	304.4	291.3	292.9	282.3	294.8	328.3	288.8
1999	284.7	268.0	299.5	284.0	290.4	281.2	284.2	312.5	283.3
2000	277.2	261.1	291.3	275.7	280.2	272.5	280.6	298.6	275.5
2001(a)	271.1	256.9	286.9	272.1	272.9	270.7	269.2	321.0	270.5

(a) Rates are calculated using population projections for 30 June 2001.

Source: ABS 2000a; AIHW 1999a:192, 2000a, 2000b, 2001a, 2001b; AIHW analysis of ABS Survey of Disability, Ageing and Carers 1998.

Table A6.4: Number of new allocations of residential care places and community aged care packages, Aged Care Allocations Rounds, June 1987 – September 2001

	Residential aged care places			Community aged care packages	Total places and packages
	High care places	Low care places	Total places		
Jun 1987	276	3,082	3,358	—	3,358
Jun 1988	396	3,552	3,948	—	3,948
Jun 1989	486	3,767	4,253	—	4,253
Jun 1990	236	3,862	4,098	—	4,098
Jun 1991	492	4,621	5,113	—	5,113
Nov 1991	421	2,531	2,952	—	2,952
Nov 1992	521	2,756	3,277	—	3,277
Nov 1993	484	2,201	2,685	1,184	3,869
Nov 1994	472	2,483	2,955	1,815	4,770
Dec 1995	324	929	1,253	2,055	3,308
May 1997	310	948	1,258	2,825	4,083
Aug 1998	285	1,971	2,256	3,657	5,913
Nov 1999	395	2,551	2,946	4,275	7,221
Jan 2001	478	7,164	7,642	6,532	14,174
Sep 2001	2,164	4,198	6,362	2,029	8,391

Note: This table presents a time series on places allocated as part of the Aged Care Allocations Rounds. A small proportion of places were reserved for allocation outside of the Aged Care Allocations Round in January 2001. For September 2001, the table provides data on proposed allocations (announced on 3 April 2001). An additional 1,150 places announced in April 2001 will be allocated outside of the Aged Care Allocations Round and are not included in this table. The breakdown of places for these is: 315 high care places, 310 low care places, 175 community aged care packages and 350 flexible care places.

Source: AIHW 2001a:15, 2001b:1; Bishop 2001a, 2001b; DHAC, unpublished data.

Table A6.5: Occupied respite bed-days in residential aged care, by State/Territory, 1990–91 to 1999–00

	1990–91	1991–92	1992–93	1993–94	1994–95	1995–96	1996–97	1997–98	1998–99	1999–00
						Number				
NSW	116,665	144,334	173,374	203,840	235,401	282,737	323,360	338,196	379,560	383,340
Vic	68,195	81,085	91,756	133,110	164,018	192,230	209,057	202,160	203,711	192,249
Qld	64,664	77,121	88,328	99,036	118,603	131,324	141,221	148,128	166,719	169,419
WA	26,500	27,890	33,860	35,660	40,526	69,046	70,216	75,722	85,318	89,950
SA	43,077	56,528	70,565	79,018	85,563	88,154	83,181	86,658	96,956	96,028
Tas	13,588	16,488	18,251	21,065	21,831	25,712	26,250	26,890	28,685	28,302
ACT	3,279	4,043	4,809	5,981	7,319	10,245	11,496	14,192	13,717	12,489
NT	1,052	1,154	1,533	2,711	3,840	4,522	5,342	5,762	5,879	6,631
Australia	**337,020**	**408,643**	**482,476**	**580,421**	**677,101**	**803,970**	**870,123**	**897,708**	**980,545**	**978,408**
						Per cent of total bed-days				
NSW	0.8	0.9	1.1	1.2	1.4	1.6	1.8	2.0	2.2	2.2
Vic	0.7	0.8	0.9	1.3	1.5	1.7	1.8	1.7	1.7	1.6
Qld	0.9	1.0	1.1	1.2	1.4	1.4	1.5	1.7	1.9	1.9
WA	0.7	0.8	0.9	0.9	1.0	1.8	1.8	1.9	2.1	2.2
SA	1.0	1.3	1.6	1.8	1.9	1.9	1.8	1.8	2.0	2.0
Tas	1.3	1.5	1.5	1.7	1.8	2.0	2.0	2.0	2.1	2.1
ACT	1.0	1.1	1.3	1.5	1.9	2.3	2.5	2.9	2.8	2.5
NT	1.1	1.1	1.5	2.6	3.5	3.9	4.4	4.6	4.7	5.3
Australia	**0.8**	**1.0**	**1.1**	**1.3**	**1.5**	**1.7**	**1.8**	**1.9**	**2.0**	**2.0**

Source: AIHW analysis of DHAC ACCSIS and ACCMIS databases derived from residential aged care payment systems.

Table A6.6: Occupied residential aged care respite days per 1,000 persons in population, 30 June 1991 – 30 June 2000

	Per 1,000 people aged 70 and over	Per 1,000 people aged 65 and over with a severe or profound restriction
1991	263.4	877.0
1992	308.2	1,027.2
1993	351.9	1,172.6
1994	409.1	1,366.9
1995	463.1	1,544.2
1996	532.1	1,771.8
1997	559.4	1,860.1
1998	561.5	1,866.0
1999	597.3	1,979.2
2000	580.6	1,913.4

Source: AIHW analysis of DHAC ACCSIS and ACCMIS databases derived from residential aged care payment systems.

Table A6.7: Occupancy rates[(a)] for residential aged care, by type of care and quarter, July 1993 to December 2000

	1993		1994				1995			
	3	4	1	2	3	4	1	2	3	4
Nursing homes	97.5	97.7	97.8	97.7	97.6	97.7	97.7	97.5	97.0	97.5
Hostels	92.1	92.1	92.3	92.4	92.6	92.6	92.7	92.9	93.0	92.9
Residential care	*95.2*	*95.3*	*95.5*	*95.4*	*95.4*	*95.4*	*95.5*	*95.4*	*95.2*	*95.5*

	1996				1997				1998	
	1	2	3	4	1	2	3	4	1	2
Nursing homes	98.1	97.7	97.3	97.9	98.2	98.1	. .	. .	. .	. .
Hostels	93.0	93.2	93.0	93.0	92.9	92.9	. .	. .	. .	. .
Residential care[(b)]	*95.8*	*95.6*	*95.4*	*95.7*	*95.7*	*95.7*	*n.a.*	*94.3*	*94.9*	*95.1*

	1998		1999				2000			
	3	4	1	2	3	4	1	2	3	4
Residential care	94.0	94.3	95.3	95.8	95.9	95.8	95.0	95.5	95.9	96.0

(a) Calculation of occupancy rate:

To June 1997 occupancy rate = (occupied place days in the period/ (((beds at the beginning of period + beds at the end of period)/2)*number of days in the period))*100.

From September 1997 occupancy rates are calculated from places/day and residents/day, averaged over the period. Data are unavailable for the July–September 1997 quarter.

(b) From 1 October 1997 nursing homes and hostels were merged into one residential care system.

Source: June 1993 – June 1997: AIHW 1999a. July 1997 – December 2000: DHAC, unpublished data.

Table A6.8: Aged care expenditure, 1980–81 to 1998–99

	1980–81	1981–82	1982–83	1983–84	1984–85	1985–86	1986–87
As a per cent of:							
Government outlays on health, social security and welfare	42.2	42.2	40.0	38.5	37.9	37.2	37.0
Total government outlays	14.1	13.7	13.0	12.7	12.8	12.2	12.2
GDP	4.9	4.9	5.1	5.1	5.2	5.0	5.0

	1987–88	1988–89	1989–90	1990–91	1991–92	1992–93	1993–94
As a per cent of:							
Government outlays on health, social security and welfare	37.5	36.6	35.7	35.1	33.3	32.7	33.2
Total government outlays	13.0	12.8	12.1	12.2	12.7	12.3	13.0
GDP	4.9	4.5	4.5	4.8	4.9	4.9	5.1

	1994–95	1995–96	1996–97	1997–98	1998–99
As a per cent of:					
Government outlays on health, social security and welfare	32.8	32.1	32.0	32.0	32.1
Total government outlays	12.9	12.9	13.7	13.9	13.5
GDP	5.0	4.9	4.9	4.8	4.9

Source: ABS Year Book, various years; AIHW, unpublished data; AIHW: Choi 1998.

Table A6.9: Combined places and community aged care packages,(a) by geographic region(b) and State/Territory, 30 June 2000

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Australia
				Places and packages per 1,000 people aged 70 and over					
Capital	102.1	90.6	99.9	100.2	102.7	100.7	101.1	105.8	98.3
Other metropolitan	85.2	98.8	95.0	—	—	—	—	—	89.7
Rural	85.4	90.0	100.4	83.4	78.4	93.8	—	—	89.6
Remote	80.8	83.2	108.9	113.9	114.4	78.9	—	236.1	112.2
Total	**95.0**	**90.7**	**99.7**	**97.6**	**96.8**	**96.6**	**101.0**	**152.3**	**95.3**

(a) Includes places and packages provided under the Aboriginal and Torres Strait Islander Flexible Care Program and from operating multi-purpose services.

(b) Regions as defined in DPIE & DHSH 1994.

Source: AIHW analysis of DHAC ACCMIS database; AIHW population database, based on SLA resident population estimates compiled by ABS.

Table A6.10: Places in residential aged care,(a) by geographic region(b) and State/Territory, 30 June 2000

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Australia
				Places per 1,000 people aged 70 and over					
Capital	90.5	79.5	91.5	90.1	92.3	88.2	83.7	85.1	87.4
Other metropolitan	75.2	83.4	81.6	—	—	—	—	—	78.1
Rural	76.3	82.0	89.1	72.3	68.8	80.6	—	—	79.9
Remote	71.2	76.0	81.4	85.6	94.4	78.9	—	146.4	85.3
Total	**84.3**	**80.3**	**88.8**	**86.4**	**86.5**	**83.8**	**83.7**	**104.7**	**84.5**

(a) Includes places provided under the Aboriginal and Torres Strait Islander Flexible Care Program and from operating multi-purpose services.

(b) Regions as defined in DPIE & DHSH 1994.

Source: AIHW analysis of DHAC ACCMIS database; AIHW population database, based on SLA resident population estimates compiled by ABS.

Table A6.11: Community aged care packages,(a) by geographic region,(b) 30 June 2000

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Australia
				Packages per 1,000 people aged 70 and over					
Capital	11.6	11.0	8.4	10.1	10.4	12.5	17.4	20.7	10.9
Other metropolitan	10.0	15.4	13.4	—	—	—	—	—	11.6
Rural	9.1	8.0	11.2	11.0	9.6	13.2	—	—	9.7
Remote	9.6	7.2	27.5	28.3	20.0	0.0	—	89.7	26.9
Total	**10.7**	**10.4**	**10.9**	**11.2**	**10.3**	**12.8**	**17.4**	**47.5**	**10.9**

(a) Includes packages provided under the Aboriginal and Torres Strait Islander Flexible Care Program and from operating multi-purpose services.

(b) Regions as defined in DPIE & DHSH 1994.

Source: AIHW analysis of DHAC ACCMIS database; AIHW population database, based on SLA resident population estimates compiled by ABS.

Table A6.12: Home and Community Care services received in a sample month,(a) by geographic region,(b) 1999–00

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Australia
				Hours per 1,000 people aged 70 and over					
Capital	729	831	902	1,005	781	855	1,507	2,148	833
Other metropolitan	920	873	676	—	—	—	—	—	841
Rural	1,045	1,323	852	939	947	1,268	—	—	1,069
Remote	3,471	575	1,456	1,905	1,313	1,286	—	5,475	2,091
All regions	**861**	**965**	**870**	**1,036**	**828**	**1,095**	**1,506**	**3,369**	**920**

(a) Data are for May 2000, except for Australian Capital Territory and Queensland data which are for November 1999. Excludes home meals, centre meals and transport services.

(b) Regions as defined in DPIE & DHSH 1994.

Source: DHAC, unpublished data; AIHW population database, based on SLA resident population estimates compiled by ABS.

Table A6.13: Accreditation standards for residential aged care homes, 1997

Item	Matter indicator	Expected outcome
1. Management systems, staffing and organisational development		
1.1	Continuous improvement	The organisation actively pursues continuous improvement
1.2	Regulatory compliance	The organisation's management has systems in place to identify and ensure compliance with all relevant legislation, regulatory requirements, professional standards and guidelines
1.3	Education and staff development	Management and staff have appropriate knowledge and skills to perform their roles effectively
1.4	Comments and complaints	Each resident (or his or her representative) and other interested parties have access to internal and external complaints mechanisms
1.5	Planning and leadership	The organisation has documented the residential care service's vision, values, philosophy, objectives and commitment to quality throughout the service
1.6	Human resource management	There are appropriately skilled and qualified staff sufficient to ensure that services are delivered in accordance with these standards and the residential care service's philosophy and objectives
1.7	Inventory and equipment	Stocks of appropriate goods and equipment for quality service delivery are available
1.8	Information systems	Effective management systems are in place
1.9	External services	All externally sourced services are provided in a way that meets the residential care service's needs and service quality goals
2. Health and personal care		
2.1	Continuous improvement	The organisation actively pursues continuous improvement
2.2	Regulatory compliance	The organisation's management has systems in place to identify and ensure compliance with all relevant legislation, regulatory requirements, professional standards, and guidelines, about health and personal care
2.3	Education and staff development	Management and staff have appropriate knowledge and skills to perform their roles effectively
2.4	Clinical care	Residents receive appropriate clinical care
2.5	Specialised nursing care needs	Residents' specialised nursing care needs are identified and met by appropriately qualified nursing staff
2.6	Other health and related services	Residents are referred to appropriate health specialists in accordance with the residents' needs and preferences
2.7	Medication management	Residents' medication is managed safely and correctly
2.8	Pain management	All residents are as free as possible from pain
2.9	Palliative care	The comfort and dignity of terminally ill residents is maintained
2.10	Nutrition and hydration	Residents receive adequate nourishment and hydration
2.11	Skin care	Residents' skin integrity is consistent with their general health
2.12	Continence management	Residents' continence is managed effectively
2.13	Behavioural management	The needs of residents with challenging behaviours are managed effectively
2.14	Mobility, dexterity and rehabilitation	Optimum levels of mobility and dexterity are achieved for all residents
2.15	Oral and dental care	Residents' oral and dental health is maintained
2.16	Sensory loss	Residents' sensory losses are identified and effectively managed
2.17	Sleep	Residents are able to achieve natural sleep patterns

(continued)

Table A6.13 (continued): Accreditation standards, 1997

Item	Matter indicator	Expected outcome
3. Residents' lifestyle		
3.1	Continuous improvement	The organisation actively pursues continuous improvement
3.2	Regulatory compliance	The organisation's management has systems in place to identify and ensure compliance with all relevant legislation, regulatory requirements, professional standards, and guidelines, about resident lifestyle
3.3	Education and staff development	Management and staff have appropriate knowledge and skills to perform their roles effectively
3.4	Emotional support	Each resident receives support in adjusting to life in the new environment and on an ongoing basis
3.5	Independence	Residents are assisted to achieve maximum independence, maintain friendships and participate in the life of the community within and outside the residential care service
3.6	Privacy and dignity	Each resident's right to privacy, dignity and confidentiality is recognised and respected
3.7	Leisure interests and activities	Residents are encouraged and supported to participate in a wide range of interests and activities of interest to them
3.8	Cultural and spiritual life	Individual interests, customs, beliefs and cultural and ethnic backgrounds are valued and fostered
3.9	Choice and decision-making	Each resident (or his or her representative) participates in decisions about the services the resident receives, and is enabled to exercise choice and control over his or her lifestyle while not infringing on the rights of other people
3.10	Resident security of tenure and responsibilities	Residents have secure tenure within the residential care service, and understand their rights and responsibilities
4. Physical environment and safe systems		
4.1	Continuous improvement	The organisation actively pursues continuous improvement
4.2	Regulatory compliance	The organisation's management has systems in place to identify and ensure compliance with all relevant legislation, regulatory requirements, professional standards, and guidelines, about physical environment and safe systems
4.3	Education and staff development	Management and staff have appropriate knowledge and skills to perform their roles effectively
4.4	Living environment	Management of the residential care service is actively working to provide a safe and comfortable environment consistent with residents' care needs
4.5	Occupational health and safety	Management is actively working to provide a safe working environment that meets regulatory requirements
4.6	Fire, security and other emergencies	Management and staff are actively working to provide an environment and safe systems of work that minimise fire, security and emergency risks
4.7	Infection control	An effective infection control program
4.8	Catering, cleaning and laundry services	Hospitality services are provided in a way that enhances residents' quality of life and the staff's working environment

Source: Australia 1997.

Chapter 7 Disability services

Box A7.1: Areas of limitation, restriction or impairment identified by the ABS

Affirmative responses to any of the following categories, where the limitation, restriction or impairment has lasted or was likely to last for 6 months or more, 'screen' the person into the ABS survey:

- *loss of sight, not corrected by glasses or contact lenses;*
- *loss of hearing, with difficulty communicating or use of aids;*
- *loss of speech;*
- *chronic or recurring pain that restricts everyday activities;*
- *shortness of breath or breathing difficulties that restrict everyday activities;*
- *blackouts, fits, or loss of consciousness;*
- *difficulty learning or understanding;*
- *incomplete use of arms or fingers;*
- *difficulty gripping or holding things;*
- *incomplete use of feet or legs;*
- *a nervous or emotional condition that restricts everyday activities;*
- *restriction in physical activities or physical work;*
- *disfigurement or deformity;*
- *head injury, stroke or any other brain damage with long-term effects that restrict everyday activities;*
- *needing help or supervision because of a mental illness or condition;*
- *treatment or medication for any other long-term condition or ailment and still restricted;*
- *any other long-term condition that restricts everyday activities.*

This list thus creates the implicit definition of disability for the ABS 1998 Survey of Disability, Ageing and Carers (ABS 1999).

Table A7.1: People aged 0–64 years with a disability, by disability status, severity of core activity restriction and sex, 1998

	Core activity restriction				Schooling or employment restriction only	Total with specific restrictions	Without specific restrictions	Total with a disability
	Profound	**Severe**	**Moderate**	**Mild**				
					Number ('000)			
Males	119.0	224.2	227.4	340.7	188.3	1,099.6	184.0	1,283.6
Females	99.2	212.5	206.3	291.6	139.5	949.0	152.5	1,101.5
Persons(a)	**218.2**	**436.8**	**433.7**	**632.3**	**327.6**	**2,048.6**	**336.5**	**2,385.1**
					Per cent(b)			
Males	1.4	2.7	2.7	4.1	2.3	13.3	2.2	15.5
Females	1.2	2.6	2.5	3.6	1.7	11.7	1.9	13.6
Persons	**1.3**	**2.7**	**2.6**	**3.9**	**2.0**	**12.5**	**2.1**	**14.6**

(a) Figures may not add precisely to totals due to rounding.

(b) Percentage of the Australian population of that sex and age group.

Source: ABS 1999:14; AIHW 1999.

Table A7.2: People with a disability, by disability status and severity of core activity restriction, 1998 ('000)

	Severity of core activity restriction				Schooling or employment restriction only	Total with specific restrictions	Total with disability	Total population
	Profound	**Severe**	**Moderate**	**Mild**				
0–64 years								
NSW	72.0	137.9	140.5	226.9	99.0	676.3	786.9	5,520.7
Vic	48.2	98.7	92.1	153.0	71.7	463.7	534.7	4,058.7
Qld	49.3	94.0	86.0	101.1	71.6	401.9	469.6	3,061.7
WA	19.2	43.2	51.8	62.9	32.3	209.4	249.0	1,629.7
SA	19.9	34.8	41.7	59.8	36.8	192.9	218.5	1,273.5
Tas	*5.2	16.7	11.8	15.9	9.2	58.7	69.6	409.4
ACT	*2.8	*7.7	*6.4	*8.5	*5.7	31.2	39.0	285.6
NT	**1.5	*3.6	*3.6	*4.2	**1.8	14.7	17.7	150.1
Australia	**218.1**	**436.6**	**433.8**	**632.2**	**327.9**	**2,048.7**	**2,385.1**	**16,389.4**
All ages								
NSW	186.1	199.0	218.6	366.1	99.0	1,068.8	1,221.3	6,325.8
Vic	131.6	137.8	147.8	248.0	71.7	736.9	834.7	4,644.9
Qld	100.2	127.8	127.5	170.5	71.6	597.5	686.7	3,449.2
WA	47.5	53.8	73.4	98.1	32.3	305.2	355.5	1,820.4
SA	48.9	44.6	62.9	102.5	36.8	295.7	333.3	1,484.7
Tas	14.4	21.2	17.9	27.9	9.2	90.6	105.1	471.3
ACT	*7.0	9.6	*8.4	13.1	*5.7	43.9	53.1	309.1
NT	**1.8	*4.5	*3.6	*5.6	**1.8	17.3	20.6	155.0
Australia	**537.7**	**598.2**	**660.3**	**1,031.8**	**327.9**	**3,155.9**	**3,610.3**	**18,660.6**

Notes

1. Estimates marked ** are subject to sampling variability too high for most practical purposes. Estimates marked * have an associated relative sampling error of between 25% and 50%. These estimates should be interpreted accordingly.

2. Core activities comprise communication, mobility and self-care.

Source: ABS 1998 Survey of Disability, Ageing and Carers, unpublished data tables; ABS 1999.

Table A7.3: People with a severe or profound core activity restriction living in households, by core activities in which assistance is needed and by age group, 1998

	Under 65 years		65+ years		All ages	
	Number	**%**	**Number**	**%**	**Number**	**%**
Self-care only	111,800	17.6	39,500	12.1	151,300	15.7
Mobility only	204,300	32.1	152,700	46.9	357,000	37.1
Communication only	49,900	7.8	*3,200	*1.0	53,100	5.5
Self-care and mobility only	175,800	27.6	97,100	29.8	272,900	28.4
Self-care and communication only	17,600	2.8	**1,500	**0.5	19,200	2.0
Mobility and communication only	14,900	2.3	6,800	2.1	21,700	2.3
All three core activities	56,000	8.8	17,000	5.2	73,000	7.6
Total with two or three core activities	*264,300*	*41.6*	*122,400*	*37.6*	*386,700*	*40.2*
Total severe or profound	**636,000**	. .	**325,600**	. .	**961,600**	. .

Notes

1. Estimates marked ** have an associated relative standard error (RSE) of 50% or more. Estimates marked * have an associated RSE of between 25% and 50%. These estimates should be interpreted accordingly.
2. Numbers are rounded to the nearest 1,000. Percentages are based on the number of people with a severe or profound core activity restriction of that age group.

Source: AIHW 2000b; AIHW analysis of ABS 1998 Survey of Disability, Ageing and Carers confidentialised unit record file.

Table A7.4: People aged under 65 years with a disability, by condition type and main and all disabling conditions, as a percentage of the Australian population under 65 years, 1998

	Main disabling condition		All disabling conditions	
Condition type	**Number ('000)**	**%**	**Number ('000)**	**%**
Psychiatric[a]	**174.7**	**1.1**	390.4	2.4
Intellectual and other mental[b]	**254.1**	**1.6**	353.5	2.2
Sensory	**200.7**	**1.2**	. .	. .
Diseases of eye	40.8	0.2	88.1	0.5
Diseases of ear	159.9	1.0	428.5	2.6
Physical	**1,757.8**	**10.7**	. .	. .
Nervous system diseases	145.9	0.9	250.3	1.5
Stroke	17.0	0.1	69.2	0.4
Other circulatory diseases	100.8	0.6	380.4	2.3
Respiratory diseases	183.4	1.1	402.3	2.5
Arthritis	228.6	1.4	519.4	3.2
Other musculoskeletal disorder	593.0	3.6	889.3	5.4
Head injury/any other brain damage	35.7	0.2	132.3	0.8
All other diseases and conditions[c]	453.5	2.8	934.4	5.7
Total population aged under 65	**16,391.1**	**100.0**	. .	. .

(a) Includes the groups entitled 'Psychoses/mood affective disorders' and 'Neurotic/stress-related/somatoform disorders' in ABS publications. This definition has changed since the 1993 survey (see AIHW 1997a).

(b) Includes the groups entitled 'Intellectual and developmental disorders' and 'Other mental and behavioural disorders'. This definition has changed since the 1993 survey and now includes Down syndrome (see AIHW 1997a).

(c) Includes other physical diseases and conditions such as spina bifida, neoplasms and diseases of urinary system, genital organs and breast.

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

Table A7.5: Estimated number of people with a severe or profound core activity restriction, by age and sex, 2000–31[(a)(b)] ('000)

Age/sex	2000	2001	2002	2003	2004	2005	2006	2011	2021	2031
Males										
0–14	98.2	98.1	98.0	97.9	97.5	96.9	96.2	92.8	91.2	92.9
15–19	17.9	18.1	18.1	18.1	18.2	18.3	18.5	18.8	17.4	17.4
20–29	26.0	25.8	25.7	25.8	25.9	26.0	26.2	27.2	27.6	25.9
30–44	66.4	67.2	67.9	68.3	68.5	68.5	68.2	68.5	71.0	73.4
45–64	147.3	151.8	156.7	161.6	166.2	170.8	175.4	192.6	208.6	214.8
65+	172.1	177.0	181.8	186.3	190.8	196.3	202.5	233.9	315.6	424.6
Total 0–64	355.7	361.0	366.5	371.6	376.2	380.5	384.5	399.9	415.8	424.4
Total 15–64	257.6	262.9	268.4	273.7	278.7	283.6	288.3	307.2	324.6	331.5
Total	*527.8*	*538.0*	*548.2*	*557.9*	*567.0*	*576.8*	*587.1*	*633.8*	*731.4*	*849.0*
Females										
0–14	47.2	47.1	47.1	47.0	46.8	46.5	46.1	44.4	43.6	44.5
15–19	13.9	14.0	14.0	14.0	14.1	14.2	14.3	14.5	13.4	13.4
20–29	25.5	25.2	25.0	24.9	25.0	25.1	25.3	26.3	26.6	25.0
30–44	78.1	78.9	79.5	79.8	80.1	80.1	80.1	80.3	81.8	84.6
45–64	161.2	166.1	171.3	176.4	181.7	187.1	192.5	214.0	233.2	238.0
65+	335.8	343.9	351.2	358.3	364.7	372.7	381.7	425.3	540.8	729.3
Total 0–64	325.8	331.3	336.9	342.3	347.6	353.0	358.3	379.6	398.7	405.5
Total 15–64	278.7	284.2	289.8	295.3	300.8	306.5	312.2	335.1	355.1	361.0
Total	*661.7*	*675.3*	*688.1*	*700.5*	*712.3*	*725.7*	*740.1*	*804.8*	*939.5*	*1,134.8*
Persons										
0–14	145.3	145.2	145.1	144.8	144.3	143.4	142.4	137.2	134.8	137.4
15–19	31.8	32.0	32.1	32.1	32.2	32.5	32.7	33.3	30.8	30.7
20–29	51.5	51.1	50.7	50.7	50.9	51.1	51.5	53.5	54.2	50.9
30–44	144.5	146.0	147.3	148.1	148.6	148.7	148.3	148.9	152.8	158.0
45–64	308.4	318.0	328.0	338.0	347.8	357.8	368.0	406.6	441.8	452.8
65+	507.9	520.9	533.0	544.6	555.5	569.0	584.3	659.2	856.4	1,153.9
Total 0–64	681.6	692.3	703.3	713.8	723.8	733.5	742.9	779.5	814.5	829.9
Total 15–64	536.2	547.1	558.2	569.0	579.5	590.1	600.5	642.3	679.7	692.5
Total	**1,189.5**	**1,213.2**	**1,236.3**	**1,258.4**	**1,279.4**	**1,302.5**	**1,327.1**	**1,438.7**	**1,670.9**	**1,983.8**

(a) ABS 1998 population projections (Series K) as at 30 June.

(b) Estimated numbers were calculated using age- and sex-specific prevalence rates derived from the ABS 1998 Survey of Disability, Ageing and Carers.

Source: ABS 1998a; AIHW 2000b; AIHW analysis of ABS 1998 Survey of Disability, Ageing and Carers data.

Table A7.6: Changes in disability prevalence, by age and disability status, 1981–98[(a)]

Year	Age (years)	Severe or profound core activity restriction[(b)]	Specific restrictions[(b)]	Total with disability
Reported number ('000)				
1981	Under 65	239.7	855.0	1,348.1
	65+	213.2	449.3	594.1
	Total	*452.9*	*1,304.3*	*1,942.2*
1988	Under 65	297.2	1,300.6	1,622.7
	65+	303.3	782.5	920.4
	Total	*600.5*	*2,083.1*	*2,543.1*
1993	Under 65	329.4	1,364.6	1,839.6
	65+	337.6	893.1	1,081.0
	Total	*667.1*	*2,257.7*	*2,920.5*
1998	Under 65	510.1	1,761.9	2,263.5
	65+	444.8	1,034.5	1,240.2
	Total	*954.9*	*2,796.4*	*3,503.7*
Increases in reported number ('000)				
1981–88	Under 65	57.5	445.6	274.6
	65+	90.1	333.3	326.3
	Total	*147.6*	*778.8*	*600.9*
1988–93	Under 65	32.2	64.0	216.9
	65+	34.3	110.6	160.6
	Total	*66.6*	*174.6*	*377.5*
1993–98	Under 65	108.7	379.3	423.9
	65+	107.2	141.4	159.2
	Total	*287.9*	*538.7*	*583.2*
1981–93	Under 65	89.8	509.6	491.4
	65+	124.4	443.9	486.9
	Total	*214.2*	*953.4*	*978.3*
1988–98	Under 65	212.9	461.3	640.8
	65+	141.5	252.0	319.8
	Total	*354.5*	*713.3*	*960.6*
1981–98	Under 65	270.4	906.9	915.4
	65+	231.6	585.2	646.1
	Total	*502.0*	*1,492.1*	*1,561.5*

(a) Disability data were re-derived using criteria common to the four surveys.

(b) Only people aged 5 years and over are included.

Source: AIHW 2000b:219; AIHW analysis of the ABS 1998 Survey of Disability, Ageing and Carers unpublished data tables.

Table A7.7: Effects of population growth on disability prevalence, 1981–98[(a)]

Period	Age (years)	Severe or profound core activity restriction	Specific restrictions	Total with disability
% changes due to overall population growth				
1993–98	Under 65	14.1	28.5	34.1
	65+	47.8	85.0	87.1
	Total	*26.6*	*43.3*	*48.6*
1988–98	Under 65	22.7	46.7	40.6
	65+	72.5	95.9	86.7
	Total	*42.6*	*64.1*	*56.0*
1981–98	Under 65	26.1	28.9	44.0
	65+	66.7	51.0	58.8
	Total	*44.8*	*37.6*	*50.1*
Decomposition of population effects—% changes due to:				
1988–98	*Differential growth between age groups*			
	Under 65	1.9	8.1	5.8
	65+	74.7	94.3	84.1
	Total	*31.0*	*38.6*	*31.9*
	Growth in population size alone			
	Under 65	20.8	38.6	34.8
	65+	–2.2	1.6	2.6
	Total	*11.7*	*25.5*	*24.1*
1981–98	*Differential growth between age groups*			
	Under 65	2.2	3.5	4.4
	65+	41.8	30.3	34.0
	Total	*20.5*	*14.0*	*16.6*
	Growth in population size alone			
	Under 65	23.9	25.4	39.6
	65+	24.9	20.7	24.8
	Total	*24.4*	*23.6*	*33.5*

(a) This table summarises the results of demographic decomposition. Detailed illustrations of the method and calculation can be found in AIHW 2000b.

Source: Table A7.6; AIHW 2000b; AIHW analysis of the ABS 1998 Survey of Disability, Ageing and Carers unpublished data tables.

Table A7.8: Disability Support Pension recipients, age-specific rates and growth rates, June 1989 – June 2000

	Age (years)											
	16–19	20–29	30–39	40–49	50–59	60–64	65+	All ages 16+	Adjusted all ages 16+	Recipients (number)	Growth rate	Adjusted growth rate
Males												
1989	0.7	1.1	1.7	3.3	9.6	19.6	0.5	3.6	3.8	227,285	3.7	n.a.
1990	0.7	1.1	1.7	3.2	9.4	20.5	0.5	3.6	3.8	233,251	2.6	0.7
1991	0.8	1.2	1.8	3.3	9.5	21.5	0.5	3.7	3.9	244,699	4.9	3.5
1992	1.2	1.3	2.2	3.8	10.2	22.9	0.5	4.1	4.3	273,697	11.9	10.3
1993	1.2	1.4	2.4	4.0	10.7	24.2	0.5	4.3	4.6	291,471	6.5	5.4
1994	1.0	1.7	2.6	4.2	11.1	25.2	0.4	4.6	4.8	309,123	6.1	4.6
1995	1.1	1.7	2.8	4.4	11.4	25.3	0.4	4.7	4.9	324,672	5.0	3.3
1996	1.2	1.8	3.0	4.7	11.6	25.2	0.4	4.9	5.1	340,256	4.8	2.9
1997	1.4	1.9	3.2	4.9	11.5	25.1	0.2	5.0	5.1	352,607	3.6	1.0
1998	1.4	2.0	3.3	5.0	11.2	24.7	0.3	5.0	5.1	361,539	2.5	0.0
1999	1.5	2.0	3.4	5.2	11.0	24.6	0.2	5.1	5.2	373,340	3.3	0.9
2000	1.6	2.1	3.5	5.4	10.7	24.3	0.2	5.2	5.2	382,351	2.4	0.0
Females												
1989	0.6	0.8	1.1	2.0	3.9	0.2	0.0	1.2	1.4	80,510	3.6	n.a.
1990	0.6	0.8	1.1	2.1	4.0	0.2	0.0	1.3	1.4	83,462	3.7	1.7
1991	0.6	0.8	1.1	2.2	4.3	0.2	0.0	1.3	1.4	89,535	7.3	5.4
1992	0.9	0.9	1.3	2.5	4.8	0.2	0.0	1.5	1.7	104,861	17.1	14.4
1993	1.0	1.0	1.4	2.6	5.4	0.2	0.0	1.7	1.8	115,101	9.8	8.0
1994	0.8	1.1	1.5	2.8	5.9	0.2	0.0	1.8	1.9	127,111	10.4	8.2
1995	0.9	1.2	1.6	2.9	6.5	0.2	0.0	2.0	2.1	139,758	9.9	7.5
1996	0.9	1.3	1.8	3.1	7.2	1.0	0.0	2.2	2.3	158,979	13.8	11.2
1997	1.0	1.4	1.9	3.3	7.9	1.0	0.0	2.4	2.5	174,907	10.0	7.2
1998	1.1	1.4	2.0	3.4	8.1	2.7	0.0	2.6	2.7	191,797	9.7	7.0
1999	1.1	1.5	2.1	3.6	8.4	3.0	0.0	2.7	2.8	204,342	6.5	4.1
2000	1.1	1.5	2.1	3.7	8.5	4.4	0.0	2.9	2.9	219,929	7.6	5.2

	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000
Persons												
All ages 16+	2.4	2.4	2.5	2.8	3.0	3.2	3.3	3.5	3.7	3.8	3.9	4.0
Adjusted all ages 16+	2.5	2.6	2.7	3.0	3.2	3.3	3.5	3.7	3.8	3.9	4.0	4.0
Growth rate	3.7	2.9	5.5	13.3	7.4	7.3	6.5	7.5	5.7	4.9	4.4	4.3
Adjusted growth rate	n.a.	1.0	4.0	11.4	6.2	5.6	4.6	5.4	3.0	2.3	2.0	1.8

Notes

1. Data for DSP recipients of particular age groups are the number of recipients of each age and sex group expressed as a percentage of the Australian population of that age group and sex for each year.
2. Data for growth of DSP recipients are the change in numbers from June of the previous year to June of the specified year expressed as a percentage of the numbers as at June the previous year.
3. Adjusted data are age- and sex-standardised, based on the Australian estimated resident population as at June 2000.

Source: FaCS 2001b:Table 2.4.1; ABS Australian Demographic Statistics Cat. No. 3101.0.

Table A7.9: CSDA-funded service outlets, by service type and auspicing organisation, Commonwealth, States and Territories, 2000

	Government				Non-government			
Service type	**C'wlth**	**State/ Territory**	**Local**	**Sub-total**	**Charit./ religious**	**Other**	**Sub-total**	**Total**
Accommodation support	0	1,080	30	1,110	848	1,185	2,033	3,143
Community support	1	426	41	468	803	487	1,290	1,756
Community access	0	61	25	86	488	439	927	1,013
Respite	0	129	15	144	197	204	401	545
Employment support	5	6	3	14	821	9	830	844
Service type other/not stated	0	24	1	25	9	41	50	77
Total	**6**	**1,726**	**115**	**1,847**	**3,166**	**2,365**	**5,531**	**7,378**

Notes

1. A service outlet may, in some cases, represent two or more locations that provide the same service type.
2. Commonwealth-auspiced employment services are not directly provided services, but funded organisations such as universities classified as 'Commonwealth Related'.
3. 'Service type other/not stated' includes evaluation/training, peak bodies and research and development.
4. Data provided by the Commonwealth are preliminary and cover 99% of Commonwealth-funded services.

Source: AIHW 2001a:Table 5.1.

Table A7.10: Consumers of CSDA-funded services on a snapshot day, by age group and sex, 2000

	Males		Females		Not stated		Total	
Age (years)	**No.**	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**
0–4	1,850	5.1	1,025	4.0	4	4.5	2,879	4.6
5–9	1,870	5.1	1,026	4.0	8	9.0	2,904	4.7
10–14	1,625	4.5	933	3.6	4	4.5	2,562	4.1
15–19	2,846	7.8	1,737	6.7	4	4.5	4,587	7.4
20–24	3,769	10.4	2,666	10.3	3	3.4	6,438	10.3
25–29	3,939	10.8	2,756	10.6	5	5.6	6,700	10.7
30–34	4,158	11.4	2,798	10.8	2	2.2	6,958	11.2
35–39	4,021	11.1	2,798	10.8	6	6.7	6,825	10.9
40–44	3,421	9.4	2,700	10.4	6	6.7	6,127	9.8
45–49	2,875	7.9	2,144	8.3	—	0.0	5,019	8.1
50–54	2,124	5.8	1,623	6.3	—	0.0	3,747	6.0
55–59	1,330	3.7	1,041	4.0	2	2.2	2,373	3.8
60–64	751	2.1	570	2.2	1	1.1	1,322	2.1
65–69	403	1.1	354	1.4	—	0.0	757	1.2
70 or over	615	1.7	923	3.6	4	4.5	1,542	2.5
Not stated	756	2.1	805	3.1	40	44.9	1,601	2.6
Total	**36,353**	**100.0**	**25,899**	**100.0**	**89**	**100.0**	**62,341**	**100.0**

Notes

1. Consumer data are estimates after use of a statistical linkage key to account for individuals who have received more than one service on the snapshot day.
2. Data for consumers of CSDA-funded services with the following service types were not collected: advocacy; information/referral; combined advocacy/information; print disability/alt. formats of communication; service evaluation/training; peak bodies; research/development; and other services.
3. Data provided by the Commonwealth are preliminary and cover 99% of Commonwealth-funded services.

Source: AIHW 2001a:Table A2.2.

Table A7.11: Consumers of CSDA-funded services on a snapshot day, by location of service outlets attended and by State/Territory and Commonwealth funding source, 2000

Location of service	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Australia
				State/Territory services					
Urban	8,920	12,533	4,123	5,264	3,208	578	638	124	35,382
Rural	2,644	5,344	1,957	901	469	670	—	—	11,971
Urban and rural	23	33	34	27	10	—	—	—	129
Remote	17	5	106	179	2	—	—	123	432
Urban and remote	—	3	2	6	—	—	—	1	12
Rural and remote	1	1	—	2	—	—	—	—	4
Not stated	—	—	—	—	449	—	—	—	443
Total	**11,605**	**17,919**	**6,222**	**6,379**	**4,138**	**1,248**	**638**	**248**	**48,373**
				Commonwealth services					
Urban	4,198	2,562	1,657	1,850	1,513	261	280	64	12,385
Rural	1,636	1,219	928	318	352	287	14	—	4,754
Urban and rural	—	2	1	—	1	1	—	—	5
Remote	13	—	77	79	5	—	—	55	229
Total	**5,847**	**3,783**	**2,663**	**2,247**	**1,871**	**549**	**294**	**119**	**17,373**

Notes

1. Consumer data are estimates after use of a statistical linkage key to account for individuals who have received more than one service on the snapshot day. Totals for Australia may not be the sum of the components since individuals may have accessed services in more than one State or Territory on the snapshot day. Location was classified as ‘unknown’ only if the location of all service outlets attended by the consumer were not known. There were 35 consumers who accessed services in more than one State or Territory.
2. Data for consumers of CSDA-funded services with the following service types were not collected: advocacy; information/referral; combined advocacy/information; print disability/alt. formats of communication; service evaluation/training; peak bodies; research/development; and other services.
3. Data provided by the Commonwealth are preliminary and cover 99% of Commonwealth-funded services.

Source: AIHW 2001a:Table 3.21.

Table A7.12: People aged under 65 years, living arrangements by disability status, as a percentage of the Australian population of that age, 1981–98[(a)] (per cent)

Living arrangements	Severe	Total with specific restrictions	Total with a disability	Total without a disability	Total with & without a disability
Households					
Lives alone					
1981	0.1	0.6	1.0	n.a.	n.a.
1988	0.1	0.9	1.1	3.3	4.4
1993	0.2	1.2	1.5	3.8	5.3
1998	0.4	1.4	1.9	4.0	6.0
Lives with relatives					
1981	1.9	5.4	9.0	n.a.	n.a.
1988	2.1	7.9	9.6	80.1	89.7
1993	2.3	7.5	9.9	79.5	89.4
1998	3.7	8.4	11.1	77.8	88.9
Lives with non-relatives					
1981	0.0	0.2	0.4	n.a.	n.a.
1988	0.1	0.5	0.6	5.1	5.7
1993	0.1	0.4	0.5	4.4	4.9
1998	0.1	0.4	0.6	4.4	5.0
Total households					
1981	2.1	6.2	10.4	n.a.	n.a.
1988	2.3	9.3	11.3	88.5	(b)99.8
1993	2.7	9.1	12.0	87.7	(b)99.6
1998	4.3	10.3	13.7	86.2	(b)99.9
Cared accommodation					
1981	0.2	0.2	0.2	n.a.	n.a.
1988	0.2	0.2	0.2	0.0	0.2
1993	0.1	0.1	0.2	0.0	0.2
1998	0.1	0.1	0.1	0.0	0.1

(a) The percentages have been age standardised using the age and sex distributions of the Australian estimated resident population for March 1998 for comparative purposes. The estimates for the 1993 and 1998 disability survey data were made using definitions as close as possible to the definitions of the 1981 and 1988 disability surveys.

(b) Excluded boarding school pupils.

Source: Unpublished data tables from the ABS 1981 and 1988 disability surveys; AIHW analysis of ABS 1993 and 1998 Survey of Disability, Ageing and Carers confidentialised unit record file.

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
ACCSIS	Aged and Community Care Strategic Information System
ACOSS	Australian Council of Social Service
ACROD	National industry association for disability services
ADD	Attention Deficit Disorder
ADHD	Attention Deficit Hyperactivity Disorder
AGPS	Australian Government Publishing Service
AHS	Australian Housing Survey
AHURI	Australian Housing and Urban Research Institute
AIC	Australian Institute of Criminology
AIFS	Australian Institute of Family Studies
AIHW	Australian Institute of Health and Welfare
ANIHI	Agreement on National Indigenous Housing Information
ANZSIC	Australian and New Zealand Standard Industrial Classification
ARHP	Aboriginal Rental Housing Program
ATO	Australian Taxation Office
ATSIC	Aboriginal and Torres Strait Islander Commission
ATY	Accredited Training for Youth
AWE	Average Weekly Earnings
CA	Carer Allowance
CACH	Commonwealth Advisory Committe on Homelessness
CACP	Community Aged Care Packages
CAP	Crisis Accommodation Program
CCB	Child Care Benefit

CDA	Child Disability Allowance
CDDS	Centre for Developmental Disabilities
CGC	Commonwealth Grants Commission
CHP	Community Housing Program
COAG	Council of Australian Governments
COP	Community Options Projects
CP	Carer Payment
CPI	Consumer Price Index
CRA	Commonwealth Rent Assistance
CRS	Commonwealth Rehabilitation Service
CSDA	Commonwealth / State Disability Agreement
CSHA	Commonwealth—State Housing Agreement
CSMAC	Community Services Ministerial Advisory Council
DAS	Disadvantaged Areas Subsidy
DCS	Department of Community Services
DDA	Disability Discrimination Act 1992 (Commonwealth)
DEETYA	former Department of Employment, Education, Training and Youth Affairs (Commonwealth)
DETYA	Department of Education, Training and Youth Affairs (Commonwealth)
DEWRSB	Department of Employment, Workplace Relations and Small Business (Commonwealth)
DFYCC	Department of Families, Youth and Community Care (Queensland)
DHAC	Department of Health and Aged Care
DHFS	former Department of Health and Family Services (Commonwealth)
DHS	Department of Human Services (Victoria)
DHSH	Department of Human Services and Health
DIMA	Department of Immigration and Multicultural Affairs
DIST	Department of Industry, Science and Technology
DPIE	Department of Primary Industry and Energy
DSP	Disability Support Pension
DSS	former Department of Social Security (Commonwealth)
DVA	Department of Veterans Affairs (Commonwealth)
FaCS	Department of Family and Community Services (Commonwealth)
FAMQIS	Family Quality Strategy and Information System

FAO	Family Assistance Office
FBT	Fringe Benefits Tax
GDP	Gross Domestic Product
GFCE	Government Final Consumption Expenditure
GPP	General Purpose Payment
GST	Goods and Services Tax
HACC	Home and Community Care
HMAC	Housing Ministers Advisory Council
HPA	Home Purchase Assistance
HREOC	Human Rights and Equal Opportunity Commission
HRSCE	House of Representatives Standing Committee on Expenditure
HRSCFCA	House of Representatives Standing Committee on Family and Community Affairs
ICD	International Classification of Diseases
ICF	International Classification of Functioning and Disability
IHR	Independent Homeless Rate
IPD	Implicit Price Deflator
JSA	Job Search Allowance
LEAP	Landcare and Environment Action Programme
MACS	Multifunctional Aboriginal children’s services
MDS	Minimum Data Set
NCAC	National Childcare Accreditation Council
NCHF	National Community Housing Forum
NCSDD	National Community Services Data Dictionary (AIHW)
NCSIMG	National Community Services Information Management Group
NDA	National Disability Administrators
NDC	National Data Collection (for SAAP)
NDCA	National Data Collection Agency (for SAAP)
NEIS	New Enterprise Initiative Scheme
NET	National Evaluation Team (for SAAP III)
NGCSO	Non-government community service organisation
NGOs	Non-government organisation
NHDA	National Housing Data Agreement

NHS	National Housing Strategy
NIHIIC	National Indigenous Housing Information Implementation Committee
NMHP	National Mental Health Plan
NMHS	National Mental Health Strategy
NOOSR	National Office of Overseas Skills Recognition
NRCP	National Respite for Carers Program
NWO	New Work Opportunities
OECD	Organization for Economic Co-operation and Development
OLMA	Office of Labour Market Adjustment
PCAI	Personal Care Assessment Instrument
PPS	Post Placement Support
PRA	Private Rent Assistance
QIAS	Quality Improvement and Accreditation System
RCI	Resident Classification Instrument
RCS	Resident Classification Scale
RSE	Relative Standard Error
SAAP	Supported Accommodation Assistance Program
SAP	Special Assistance Programme
SCARC	Senate Community Affairs References Committee
SCCSISA	Standing Committee of Community Services and Income Security Administrators (predecessor to CSMAC)
SCRCSSP	Steering Committee for the Review of Commonwealth / State Service Provision
SDAC	Survey of Disability, Ageing and Carers Survey (of ABS)
SLA	Statistical Local Area
SPP	Specific Purpose Payment
TAFE	Technical and Further Education
TAP	Training for Aboriginals and Torres Strait Islanders Programme
TFR	Total fertility rate
TUS	Time Use Survey
WHO	World Health Organization
YA	Youth Allowance
YCIAP	Youth Careers Information and Advisory Programme
YHA	Young Homeless Allowance

YSU	Youth Service Units
YTA	Youth Training Allowance

Australian jurisdictions

ACT	Australian Capital Territory
Aust.	Australia
NSW	New South Wales
NT	Northern Territory
Qld	Queensland
SA	South Australia
Tas	Tasmania
Vic	Victoria
WA	Western Australia

Glossary

accreditation (aged care): A process through which residential aged care homes must go in order to be recognised as approved providers under the *Aged Care Act 1997*.

admission day: The first day of a person's stay in nursing home or hostel. Where the time between leaving one nursing home (or hostel) and entering another is less than two days, the date of the initial admission is defined as the admission day. Permanent and respite admissions are treated separately.

age-specific rate: A rate for a specific age group. The numerator and denominator relate to the same age group.

age-standardised rate: Weighted average of age-specific rates according to a standard distribution of age to eliminate the effect of different age distributions and thus facilitate valid comparison of groups with differing age compositions.

ambulatory care: Care provided to hospital patients who are not admitted to the hospital, such as patients of emergency departments and outpatient clinics. The term is also used to refer to care provided to patients of community-based (non-hospital) health care services.

apparent retention rate: The ratio of the number of students in a given year to the number originally entering secondary school.

capital expenditure: Expenditure in a period on the acquisition or enhancement of an asset. This includes new and second-hand fixed assets (e.g. building, information technology), increase in stocks, lands and intangible assets (e.g. patents and copyrights), capital transfer payments, and net advances which are acquisitions of financial assets (e.g. shares and equities).

community residential services: 24-hour staffed residential units established in community settings that provide specialised treatment, rehabilitation or care for people affected by a mental illness or psychiatric disability.

constant price expenditure: Expenditure which adjusts for the effects of inflation. This adjustment for inflation allows comparison across different years of the quantity of goods and services that are produced by the expenditure.

deinstitutionalisation: A term referring to a shift in service delivery away from institutional care, towards care in the home and community.

estimated resident population: Australia's population statistics are compiled by the ABS according to the place of usual residence of the population. Usual residence is defined as the place where a person has lived or intends to live for a period of 6 months or more.

full-time equivalent (FTE): A standardised measure used in converting number of persons in part-time employment to number of persons in full-time employment.

Indigenous: A person who identifies himself or herself as being of Aboriginal and/or Torres Strait Islander origin and is accepted as such by the community in which he or she lives.

International Classification of Diseases (ICD): The World Health Organization s internationally accepted classification of death and disease. The tenth revision (ICD-10) is currently in use.

International Classification of Functioning, Disability and Health (ICF): The World Health Organization s internationally accepted classification of functioning, disability and health. The new classification was endorsed by WHO in May 2001.

labour force: The labour force includes people who are employed and people who are unemployed (not employed and actively looking for work).

length of stay (hospital or aged care home): The time between the date of admission and the date a person has been discharged from a hospital or aged care home. For a current resident, it is the time between the date of admission and a specified date. A same-day patient is allocated a length of stay of 1 day.

non-government community service organisations (NGCSOs): Organisations, operated on either a for-profit or not-for-profit basis, privately managed to provide community services for family with children, youth, adults, older people, people with disabilities, and people from different ethnic backgrounds.

non-government organisations (NGOs): Private not-for-profit community managed organisations that receive State and Territory government funding specifically for the purpose of providing community support services for people affected by a mental illness or psychiatric disability.

Organization for Economic Co-operation and Development (OECD): An organisation of 24 developed countries, including Australia.

patient days: The number of full or partial days of stay for patients who were admitted for an episode of care and who underwent separation during the reporting period. A patient who is admitted and separated on the same day is allocated 1 patient day.

permanent admission: Admission to a nursing home or hostel for long-term care purposes.

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

principal carer: Defined by the ABS as a person aged 15 years or more providing the most informal care for the activities of self-care, mobility or verbal communication for a person with a profound or severe handicap.

private hospital: A privately owned and operated institution, catering for patients who are treated by a doctor of their own choice. Patients are charged fees for accommodation and other services provided by the hospital and relevant medical and paramedical practitioners. Includes private freestanding day hospital facilities.

public hospital: A hospital controlled by a State or Territory health authority. In Australia public hospitals offer free diagnostic services, treatment, care and accommodation to all who need it.

recurrent expenditure: Expenditure on goods and services which does not result in the creation of fixed assets or in the acquisition of land, buildings, intangible assets or second-hand plant and equipment. This consists mainly of expenditure on wages, salaries and supplements, purchases of goods and services, and recurrent transfer payments (e.g. age pensions).

respite admission (aged care): Admission to a residential aged care home, designed to provide the carer with a short-term break from his or her caring role.

separation: The formal process by which a hospital records the completion of treatment and/or care for an admitted patient.

stand-alone psychiatric hospital: Establishments devoted primarily to the treatment and care of inpatients with psychiatric disorders.

total fertility rate (TFR): Indicates the average number of babies that would be born over a lifetime to a hypothetical group of women if they were to experience the age-specific birth rates applying in a given year.

transfer payments: Payments made by governments either to other levels of government or to non-government organisations for the purpose of financing the current operation of the recipients (recurrent transfer payments), or of meeting part of the cost of capital expenditure of the recipient (capital transfer payments).

Population tables

Table P1: Indigenous Australians (estimated resident populations), by age group, sex, and State/Territory, 30 June 2000

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	(a)Australia
Indigenous males									
Less than 1	1,751	344	1,708	812	322	233	52	728	5,951
1–4	6,762	1,395	6,632	3,201	1,218	893	214	2,930	23,249
5–9	8,089	1,621	7,978	3,977	1,594	1,044	189	3,673	28,177
10–14	7,437	1,390	7,128	3,880	1,530	1,063	194	3,317	25,944
15–19	6,609	1,244	6,232	3,198	1,261	971	210	2,933	22,675
20–24	4,969	1,024	5,093	2,693	957	715	169	2,701	18,335
25–29	4,693	1,055	4,775	2,575	985	556	190	2,697	17,537
30–34	3,879	925	4,121	2,246	840	514	121	2,330	14,985
35–39	3,560	803	3,481	1,983	740	533	115	1,700	12,920
40–44	2,956	655	2,923	1,609	632	460	123	1,429	10,795
45–49	2,479	502	2,186	1,156	485	398	45	1,043	8,300
50–54	1,911	398	1,652	891	337	311	44	770	6,323
55–59	1,324	276	1,069	589	270	172	12	567	4,282
60–64	925	177	734	404	175	110	6	429	2,964
65–69	618	112	586	291	97	88	7	233	2,034
70–74	343	89	297	190	71	35	5	175	1,205
75+	308	86	362	206	77	35	1	182	1,257
All males	*58,613*	*12,096*	*56,957*	*29,901*	*11,591*	*8,131*	*1,697*	*27,837*	*206,933*

(continued)

Table P1 (continued): Indigenous Australians (estimated resident populations), by age group, sex, and State/Territory, 30 June 2000

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	(a)Australia
Indigenous females									
Less than 1	1,666	324	1,627	769	311	222	47	688	5,655
1–4	6,526	1,307	6,419	2,998	1,242	863	174	2,688	22,219
5–9	7,957	1,543	7,807	3,710	1,559	979	215	3,286	27,068
10–14	7,091	1,377	6,933	3,941	1,401	946	197	3,015	24,908
15–19	6,139	1,158	6,022	3,176	1,342	966	193	2,882	21,886
20–24	4,890	962	5,094	2,628	1,047	798	170	2,710	18,305
25–29	5,080	986	5,145	2,631	1,109	670	182	2,613	18,425
30–34	4,554	1,004	4,615	2,510	1,035	570	158	2,289	16,743
35–39	4,129	916	3,913	2,145	884	560	156	1,815	14,522
40–44	3,400	745	3,121	1,788	640	524	117	1,546	11,891
45–49	2,691	515	2,621	1,296	497	377	81	1,178	9,260
50–54	2,022	381	1,842	938	391	275	40	972	6,869
55–59	1,438	255	1,232	618	263	154	25	602	4,592
60–64	986	193	914	458	198	133	7	543	3,432
65–69	724	165	671	379	138	73	7	347	2,506
70–74	467	122	449	259	102	55	7	229	1,692
75+	522	146	537	296	107	77	7	240	1,935
All females	*60,282*	*12,099*	*58,962*	*30,540*	*12,266*	*8,242*	*1,783*	*27,643*	*211,908*
All Indigenous persons	**118,895**	**24,195**	**115,919**	**60,441**	**23,857**	**16,373**	**3,480**	**55,480**	**418,841**

(a) Australia totals include Federally Administered Territories.

Source: ABS Experimental Projections of the Aboriginal and Torres Strait Islander Population, June 1996 – June 2006. ABS Catalogue No. 3231.0.

Table P2: Australians (estimated resident populations), by age group, sex, and State/Territory, 30 June 2000

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	(a)Australia
Males									
0–4	220,936	156,027	123,262	65,193	47,298	15,706	10,522	9,062	648,118
5–9	228,301	166,259	132,138	68,381	50,505	17,314	11,014	9,071	683,142
10–14	225,495	163,942	131,001	71,015	51,545	17,599	11,068	8,196	680,034
15–19	227,993	166,534	134,865	71,026	52,158	17,583	12,749	7,637	690,697
20–24	227,690	176,790	129,519	72,181	50,649	15,056	14,322	8,958	695,242
25–29	249,134	187,923	137,885	75,269	53,582	14,892	13,063	10,454	742,348
30–34	238,186	180,907	129,860	71,256	53,507	15,142	11,828	9,524	710,358
35–39	254,311	184,884	137,060	75,272	57,030	17,371	12,037	9,016	747,138
40–44	243,461	177,393	133,408	73,698	56,182	17,706	11,643	7,964	721,592
45–49	224,517	163,166	126,040	68,838	52,729	16,683	11,409	7,030	670,566
50–54	211,944	153,237	119,686	63,198	50,261	15,760	11,089	6,157	631,471
55–59	165,310	118,919	92,659	46,943	38,928	12,490	7,375	4,227	486,910
60–64	134,635	97,629	72,632	36,755	31,930	10,307	5,253	2,523	391,716
65–69	114,722	84,084	58,770	29,752	28,174	8,956	4,058	1,490	330,029
70–74	102,718	75,182	51,628	25,369	26,931	7,910	3,126	1,052	293,923
75–79	77,115	55,605	38,252	18,237	20,514	5,750	2,366	530	218,376
80–84	41,630	29,650	21,153	9,512	11,156	3,230	1,178	249	117,764
85+	26,487	20,753	13,926	6,741	7,516	2,074	682	208	78,391
All males	*3,214,585*	*2,358,884*	*1,783,744*	*948,636*	*740,595*	*231,529*	*154,782*	*103,348*	*9,537,815*
Females									
0–4	210,256	146,704	117,643	61,396	45,204	14,938	10,263	8,512	615,018
5–9	216,797	157,688	125,518	64,600	48,158	16,422	10,518	8,383	648,248
10–14	214,926	156,604	123,872	67,246	48,754	16,801	10,682	7,633	646,703
15–19	216,926	160,266	127,713	67,398	49,937	17,107	11,513	7,064	658,054
20–24	219,675	169,084	125,252	68,456	47,967	14,481	13,098	7,799	665,870
25–29	249,536	185,659	136,601	71,540	51,285	15,618	13,083	9,311	732,731
30–34	238,375	183,803	130,471	69,704	52,484	16,051	12,192	8,883	712,112
35–39	251,920	186,868	139,899	74,309	57,402	18,063	12,420	8,106	749,160
40–44	242,167	179,784	134,061	72,815	57,104	18,109	12,411	7,074	723,665
45–49	223,329	167,095	124,620	67,889	53,879	16,921	12,054	6,171	672,070
50–54	204,497	153,231	114,893	59,101	50,427	15,570	10,849	4,964	613,596
55–59	160,372	117,426	88,149	43,881	38,990	12,242	7,324	3,121	471,555
60–64	133,959	99,229	69,251	35,669	33,027	10,496	5,184	1,848	388,689
65–69	120,444	89,378	59,690	30,600	30,082	9,421	4,079	1,226	344,928
70–74	116,888	85,998	56,170	27,727	30,309	8,775	3,680	861	330,421
75–79	101,835	74,713	48,188	22,957	27,390	7,834	3,219	529	286,669
80–84	66,365	47,669	31,679	14,969	17,713	5,247	1,915	336	185,896
85+	60,603	45,773	28,943	14,967	16,927	4,751	1,573	294	173,837
All females	*3,248,870*	*2,406,972*	*1,782,613*	*935,224*	*757,039*	*238,847*	*156,057*	*92,115*	*9,619,222*
All persons	**6,463,455**	**4,765,856**	**3,566,357**	**1,883,860**	**1,497,634**	**470,376**	**310,839**	**195,463**	**19,157,037**

(a) Australia totals include Federally Administered Territories.

Source: ABS Australian Demographic Statistics Catalogue No. 3101.0.

Table P3: Projected Australian population, by sex and age group, 2001–2051 ('000)

	2001	2021	2051	Ratio of 2021 to 2001	Ratio of 2051 to 2021
Females					
0–4	609.9	589.1	575.5	96.6	97.69
5–9	647.6	598.4	589.9	92.4	98.57
10–14	653.2	612.2	607.9	93.7	99.30
15–19	661.7	651.5	643.4	98.5	98.76
20–24	672.6	709.3	707.9	105.5	99.80
25–29	725.0	753.0	728.9	103.9	96.80
30–34	736.7	762.8	737.9	103.5	96.74
35–39	744.1	767.6	744.1	103.2	96.95
40–44	741.8	757.3	753.2	102.1	99.45
45–49	684.4	789.6	776.0	115.4	98.28
50–54	638.9	776.0	791.9	121.5	102.04
55–59	493.9	759.6	809.6	153.8	106.59
60–64	401.5	735.9	792.2	183.3	107.65
65–69	344.6	657.3	765.6	190.7	116.48
70–74	332.3	585.9	719.0	176.3	122.71
75–79	290.6	418.7	691.3	144.1	165.09
80–84	196.1	287.0	587.0	146.4	204.52
85+	179.4	300.8	761.4	167.7	253.11
Total females	**9,754.1**	**1,1512.1**	**12,782.7**	**2,298.4**	**2,160.54**
Males					
0–4	643.4	621.7	607.5	96.6	97.71
5–9	682.9	631.9	623.2	92.5	98.61
10–14	686.4	646.5	642.4	94.2	99.37
15–19	694.0	686.4	677.8	98.9	98.75
20–24	700.8	739.1	735.8	105.5	99.56
25–29	737.7	773.5	747.5	104.9	96.64
30–34	733.9	774.9	751.8	105.6	97.02
35–39	740.5	778.2	759.2	105.1	97.56
40–44	738.0	767.9	768.2	104.1	100.04
45–49	681.6	792.0	790.1	116.2	99.76
50–54	652.5	766.7	805.1	117.5	105.01
55–59	509.4	747.0	819.8	146.7	109.75
60–64	406.2	717.9	793.2	176.8	110.48
65–69	330.6	630.4	754.9	190.7	119.75
70–74	297.8	554.1	691.3	186.1	124.77
75–79	224.3	377.0	631.3	168.1	167.47
80–84	126.5	231.4	494.2	182.9	213.57
85+	80.9	177.8	532.4	219.7	299.41
Total males	**9,667.2**	**11,414.3**	**12,625.8**	**2,411.9**	**2,235.25**

Source: ABS Population Projections: 1999–2101 Catalogue No. 3222.0 (Series Q projections).

Table P.4: Base population data used in aged care service utilisation calculations in Chapter 6, 1996 to 2001

Status	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Australia
Persons aged 65 and over with a profound or severe restriction									
1996									
Males	53,345	39,252	26,557	12,955	14,293	4,190	1,446	425	152,468
Females	107,433	79,354	49,718	25,011	28,933	8,314	2,859	587	302,216
Persons	160,778	118,606	76,275	37,967	43,226	12,504	4,305	1,012	454,684
1997									
Males	55,218	40,446	27,567	13,418	14,716	4,290	1,514	444	157,616
Females	110,521	81,391	51,508	25,811	29,721	8,541	3,009	621	311,129
Persons	165,739	121,837	79,075	39,229	44,437	12,831	4,522	1,064	468,745
1998									
Males	56,907	41,780	28,646	13,832	15,180	4,391	1,611	465	162,818
Females	113,193	83,334	53,245	26,519	30,444	8,736	3,139	635	319,253
Persons	170,100	125,114	81,891	40,351	45,625	13,127	4,749	1,101	482,071
1999									
Males	58,673	43,224	29,633	14,333	15,636	4,528	1,705	492	168,231
Females	116,098	85,531	55,002	27,358	31,217	8,974	3,312	666	328,165
Persons	174,771	128,756	84,635	41,691	46,853	13,501	5,017	1,158	496,396
2000									
Males	60,617	44,787	30,860	14,856	16,178	4,668	1,802	518	174,293
Females	119,146	88,082	57,033	28,280	32,051	9,259	3,488	694	338,041
Persons	179,763	132,869	87,893	43,136	48,228	13,926	5,289	1,212	512,334
2001									
Males	62,563	46,070	31,726	15,356	16,592	4,741	1,894	506	179,457
Females	122,391	90,560	58,211	29,033	32,818	9,398	3,604	697	346,724
Persons	184,954	136,630	89,937	44,389	49,410	14,139	5,498	1,203	526,181
Persons aged 70 and over									
1996									
Male	219,448	158,914	108,261	51,750	58,707	17,128	6,038	1,589	621,854
Female	317,281	232,280	146,759	72,268	85,224	24,693	8,761	1,736	889,017
Persons	536,729	391,194	255,020	124,018	143,931	41,821	14,799	3,325	1,510,871
1997									
Male	226,891	164,082	112,405	53,823	60,663	17,537	6,324	1,690	643,434
Female	325,117	237,883	151,358	74,434	87,238	25,087	9,160	1,830	912,122
Persons	552,008	401,965	263,763	128,257	147,901	42,624	15,484	3,520	1,555,556
1998									
Male	233,986	169,662	116,570	55,702	62,527	17,967	6,689	1,797	664,920
Female	332,267	243,110	156,036	76,465	88,971	25,547	9,542	1,884	933,838
Persons	566,253	412,772	272,606	132,167	151,498	43,514	16,231	3,681	1,598,758
1999									
Male	241,135	175,254	120,661	57,744	64,264	18,452	7,050	1,928	686,507
Female	339,061	248,360	160,431	78,493	90,653	26,079	10,000	1,948	955,044
Persons	580,196	423,614	281,092	136,237	154,917	44,531	17,050	3,876	1,641,551

(continued)

Table P.4 (continued): Base population data used in aged care service utilisation calculations in Chapter 6, 1996 to 2001

Status	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Australia
				Persons aged 70 and over					
2000									
Males	247,950	181,190	124,959	59,859	66,117	18,964	7,352	2,039	708,454
Females	345,691	254,153	164,980	80,620	92,339	26,607	10,387	2,020	976,823
Persons	593,641	435,343	289,939	140,479	158,456	45,571	17,739	4,059	1,685,277
2001									
Male	255,681	186,960	128,075	62,101	67,662	19,280	7,684	2,036	729,508
Female	353,489	260,571	168,000	82,689	94,053	26,906	10,594	2,044	998,375
Persons	609,170	447,531	296,075	144,790	161,715	46,186	18,278	4,080	1,727,883

Note: Population data for 1996–1999 are final estimates; population data for 2000 are preliminary estimates; population data for 2001 are ABS Series Q population projections

Source: ABS 2000a, 2000c; AIHW analysis of ABS Disability and Carers Survey, 1998.

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