AUSTRALIA'S WELFARE 2005

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AUSTRALIA'S WELFARE 2005

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Australian Institute of Health and Welfare

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Australian Government
Australian Institute of Health and Welfare

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

Dear Minister

On behalf of the Board of the Australian Institute of Health and Welfare I am pleased to present to you *Australia's Welfare 2005,* as required under Subsection 31 (1A) of the *Australian Institute of Health and Welfare Act 1987*.

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

Yours sincerely

Hon. Peter Collins
Chairperson of the Board

14 November 2005

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Contents

Preface

As the Director of the AIHW, it gives me great pleasure to introduce the 2005 edition of Australia's Welfare. This is the seventh edition of this publication, and the last to be produced during my term as Director.

The publication has become increasingly comprehensive. It includes indicators of overall wellbeing and measures of resources (both human and financial) to provide a more general overview, and endeavours to describe the interactions between different welfare sectors. *Australia's Welfare 2005* provides the best available guide to how the Australian welfare system affects large groups of Australians.

Improving the understanding that Australians have about welfare services and housing assistance is an important focus for the Institute. Chapters in *Australia's Welfare 2005* provide a wealth of reference information and statistics on children, youth and families, older people, people with a disability, homelessness and housing.

Not all these services and assistance are provided through government agencies, non-government organisations or private providers. Family members and volunteers provide substantial support and assistance to other Australians. They form an intrinsic and invaluable part of the welfare 'sector'.

Australians are fortunate indeed to have the array of services available from so many committed, skilled people, both paid and unpaid. As well as their immediate value, these services allow many people to participate more fully in their families and the community and provide a strong measure of social cohesion for the community as a whole.

I am particularly pleased in the breadth of information available in this edition in the chapter on children, youth and families. Children and youth are the focus of several current inter-governmental undertakings and partnerships, and the chapter provides a valuable resource to those working in this critical area of social policy, whether as policy makers, policy analysts or service providers.

Many people have worked willingly and with considerable expertise to produce this edition. Their efforts have produced a reliable reference for all readers. My thanks go to them. I feel sure they would join me in wishing that *Australia's Welfare 2005* meets more than the Institute's legislative requirement. This seventh edition should make an important contribution to the current and ongoing debate about social policy in Australia.

Richard Madden
Director
Australian Institute of Health and Welfare

Symbols

N	number
m	million
b	billion
$	Australian dollars, unless another country is specified
%	per cent
nec	not elsewhere classified
'000	thousands
n.p.	when used in a table—not published by the data source
n.a.	when used in a table—not available
nfd	not further defined
. .	when used in a table—not applicable
—	when used in a table—nil or rounded to zero (including null cells)
*	when used in front of a numerical value in a table—estimate has a relative standard error of 25% to 50% and should be used with caution
**	when used in front of a numerical value in a table—estimate has a relative standard error greater than 50% and is considered too unreliable for general use

1 Introduction

Australia's Welfare 2005 is the Institute's seventh biennial report on Australia's welfare. It builds on and develops material presented in previous editions and, in keeping with the growing recognition of the importance of whole-of-government perspectives in presenting statistics and information, places continued emphasis on the interplay between formal services, informal assistance, public and community housing and cash benefits.

The last decade has seen substantial progress in the quality and quantity of research and statistics that provide a basis on which to monitor and develop Australia's welfare services and assistance. The material presented in this edition of *Australia's Welfare* is part of that developmental process, and the scope of material presented is broader than that available in previous years. Nonetheless, a number of challenges remain to be addressed. These include an understanding of the demographic changes that may occur in the future and their implications for community services and housing assistance; the continued emphasis on person-centred rather than program-centred statistical information; and finally the perennial demand for improved data on the outcomes of welfare services and assistance.

Impact of demographic trends on welfare services and assistance

Demographic change is a key driver of changes in the demand for welfare services and assistance. Some aspects of demographic change receive so much attention that they overshadow other equally important aspects of Australia's demographic profile. So for example, the rapid ageing of the population and the alarming decline in fertility are key popularly recognised demographic trends. As a consequence, there are widespread perceptions that the main welfare-related challenges facing Australian society are associated with an increasing demand for aged care services and income support. While services for older people are undoubtedly an important part of the welfare sector and will continue to be so in the future, the needs of other population groups will remain of substantial importance as well.

The popular perception of a falling fertility rate should be considered in the context of statistical evidence that shows that the total fertility rate has remained relatively constant at between 1.73 and 1.76 births per woman since 1998. Indeed, it has remained between 1.75 and 1.76 during that period with the single exception of 2001 when it was 1.73. The number of births has remained fairly steady at around 250,000 per year. Although the proportion of children in the population has declined in recent years the absolute number continues to increase. In 2004 there were about 4 million children aged under 15, comprising 20% of the total population. Thus welfare policies aimed at children, young people, families with dependent children and child-friendly communities remain an important focal point for the future.

Prior to 1998 fertility had been declining (see the discussion in *Australia's Welfare 1997*). The recognition that it has apparently stabilised is of relatively recent origin.

It is important to recognise that our current demographic projections are based on a continuing slow decline in fertility; many of the projected numbers may therefore underestimate the proportion of children in Australian society in the 2020s and beyond. The next few years should reveal whether or not this period of relative stability marks the end of this downward cycle in national fertility rates.

Person-centred rather than program-centred information

Recent years have seen continued emphasis on the need for a person-centred perspective across a wide range of policy areas. There has been a particular focus on providing integrated information concerning the needs and circumstances of young children, but there is also interest in the needs and circumstances of youth and families, older people and people with disabilities. Each of these population groups is of central relevance to the data assembled in this volume of *Australia's Welfare*.

While there is considerable agreement on the need for person-centred rather than program-centred information, the major national sources of statistical information on these groups of people continue to be administrative by-product data. By their nature, such data are program-specific. The difficulties in assembling person-oriented information are beginning to be addressed, but considerable work remains to be done before this goal is achieved. In several key community services databases, statistical data linkage is now routinely used to connect records relating to particular individuals within the program; this means that the data are organised around people rather than disparate episodes of service (for example, the SAAP, CSTDA and HACC databases). The device used is a statistical linkage key which does not identify individuals, meets national privacy requirements and has ethical approval.

This same statistical linkage strategy will be able to be extended across programs, to provide statistical information (not individual information) which relates to the person rather than the program. Some progress of this kind has been made in relation to older people (AIHW 2005a, 2005b) and in a number of studies undertaken in Western Australia (Brook et al. 2005). Further work will be an important step in providing the kind of statistical information necessary to inform whole-of-government and inter-jurisdictional agendas in welfare policy.

Improving data on outcomes

For at least 30 years policy analysts and social planners have been preoccupied with improving the measurement of outcomes across a range of social policy agendas. This is as much the case in community services and housing as it is in health and education. In 1995 the (then) Industry Commission instituted an annual cycle of performance monitoring for the welfare services sector; the demand for good outcome data has continued apace over the last decade. Program administrators are all too aware of the distinction between output and outcome measures, but true robust measures of outcome for disability services, aged care services, juvenile justice, child protection, homelessness services and other such programs continue to present difficulties at both the conceptual and measurement levels.

At the broadest level, outcomes for such programs could be understood to relate to the overall wellbeing of members of Australian society; these are the kinds of indicators that are set out in Chapter 2 and provide contextual information for those interested in

welfare services. Nonetheless, it is difficult to argue for clear causal links between specific programs and these broadly conceived social and economic indicators. Advocates of improved outcome data are generally interested in developing performance indicators where the link between program performance and changes in the performance indicator can be relatively clearly established.

The development of good performance indicators requires sustained collaboration between those with expertise in policy and those with expertise in statistical information. The task is characterised by measurement and conceptual difficulties; meanwhile the political implications of these data cannot be overlooked. While some progress has been made, the development of outcome measures and performance indicators remains an important area for future developmental activity.

Structure of the report

The next chapter of this report, 'Indicators of Australia's welfare', provides a context for the material on welfare services and assistance presented in subsequent chapters, and gives a broad indication of the welfare status of Australian society.

Subsequent chapters follow the long-established pattern for editions of *Australia's Welfare*, focusing in turn on children, youth and families (Chapter 3); ageing and aged care (Chapter 4); disability and disability services (Chapter 5); housing (Chapter 6); and homelessness (Chapter 7). In general, each chapter is structured to take account of recent policy developments, need for assistance, client profiles and patterns of service utilisation; as appropriate, material is also included on the role of informal care, expenditure and the outcomes of service provision.

In this edition, the traditional 'Children's and family services' chapter has been substantially expanded and developed into a special thematic chapter entitled 'Children, youth and families'. The increasing policy and public interest in the wellbeing of Australia's children was an important catalyst in the decision to produce this special chapter.

Chapter 8 'Welfare services resources' contains a wealth of material on community services labour force and expenditure. The chapter goes beyond the government sector to acknowledge and provide statistical information on the role played by the informal sector in caring for the wide variety of people who are in need of some form of assistance, whether by virtue of age, disability, health condition, family circumstances or socioeconomic context.

Finally Chapter 9 'Data environment' highlights changes and developments in national information on welfare services and assistance.

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Brook E, Rosman D, Holman C et al. 2005. Summary report: research outputs project, WA Data Linkage Unit (1995–2003). Perth: WA Department of Health.

2 Indicators of Australia's welfare

2.1 Introduction

This chapter provides broad summary indicators of the welfare of Australia's population as well as context for the following chapters that focus on specific aspects of welfare service provision. New information is presented, where available, against indicators developed and reported in previous editions of this report (AIHW 2001, 2003a).

The chapter introduces the conceptual framework underlying the indicators, then proceeds to describe each indicator, and to present, where possible, updated or trend data from authoritative sources.

Conceptual framework

A conceptual framework for welfare information is depicted in Figure 2.1. Welfare, placed at the top of the diagram, may be considered as a concept, goal or vision of individual and social wellbeing. In practice, welfare proves hard to define in specific and universally agreed terms. In certain contexts or policy areas, it may nevertheless be quite feasible to agree on definitions and operational goals. The three boxes—'Welfare components', 'Influential factors' and 'Interventions, services and assistance'—represent more tangible and measurable aspects of welfare and the 'welfare system' in human society (refer to AIHW 2001 for description of the development process).

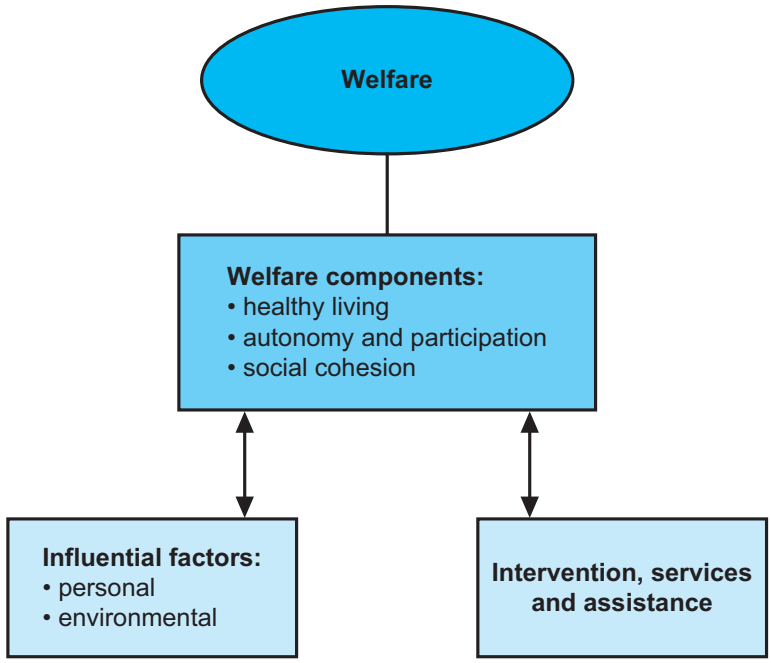


Figure 2.1: Conceptual framework for welfare information

The welfare of Australian people is reflected in the 'welfare components'—healthy living, autonomy and participation, and social cohesion—in particular the measurable aspects of welfare status. 'Influential factors' include the features of the physical and social environment in which a person lives, and the person's own characteristics, which work together to shape wellbeing. 'Interventions' encompass the system of formal services, financial assistance and unpaid assistance that contribute further to welfare. This chapter focuses on these welfare components and measures of their status, so as to provide contextual information for other chapters in this volume, which cover the welfare services and assistance available to Australians.

'Healthy living' embodies the prerequisites for human welfare—the basic needs of water, food and shelter, along with health and safety from harm. 'Autonomy and participation' reflects the value people place on freedom and their capability to act as autonomous beings, plus the opportunities to participate socially, economically and recreationally as they choose. Finally, 'social cohesion' represents the intricacy of relationships, interactions and social behaviours that form webs of cohesiveness between and within different members of society, and act to nurture individual and social wellbeing.

Figure 2.2 sets out 13 indicator topics that relate to these major components. These topics indicate the interconnected, valued components of human welfare and needs that can be measured statistically. The figure does not, however, assume a theoretical model of cause and effect, nor does it explicitly recognise the interconnection of many aspects of social advantage and disadvantage (for instance, education, income and health). This figure was constructed to illustrate the nature and scope of a field of measurement, rather than to explore or suggest directions of causality.

The indicator topics point to the broad subject areas on which the indicators in this chapter focus. On each of these topics, the three types of measures are:

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

Where possible, information for these measures is included.

Criteria used to select indicators of welfare are presented in Appendix Table A2.1; status of indicators presented in 2003 and 2005 is described in Appendix Table A2.2.

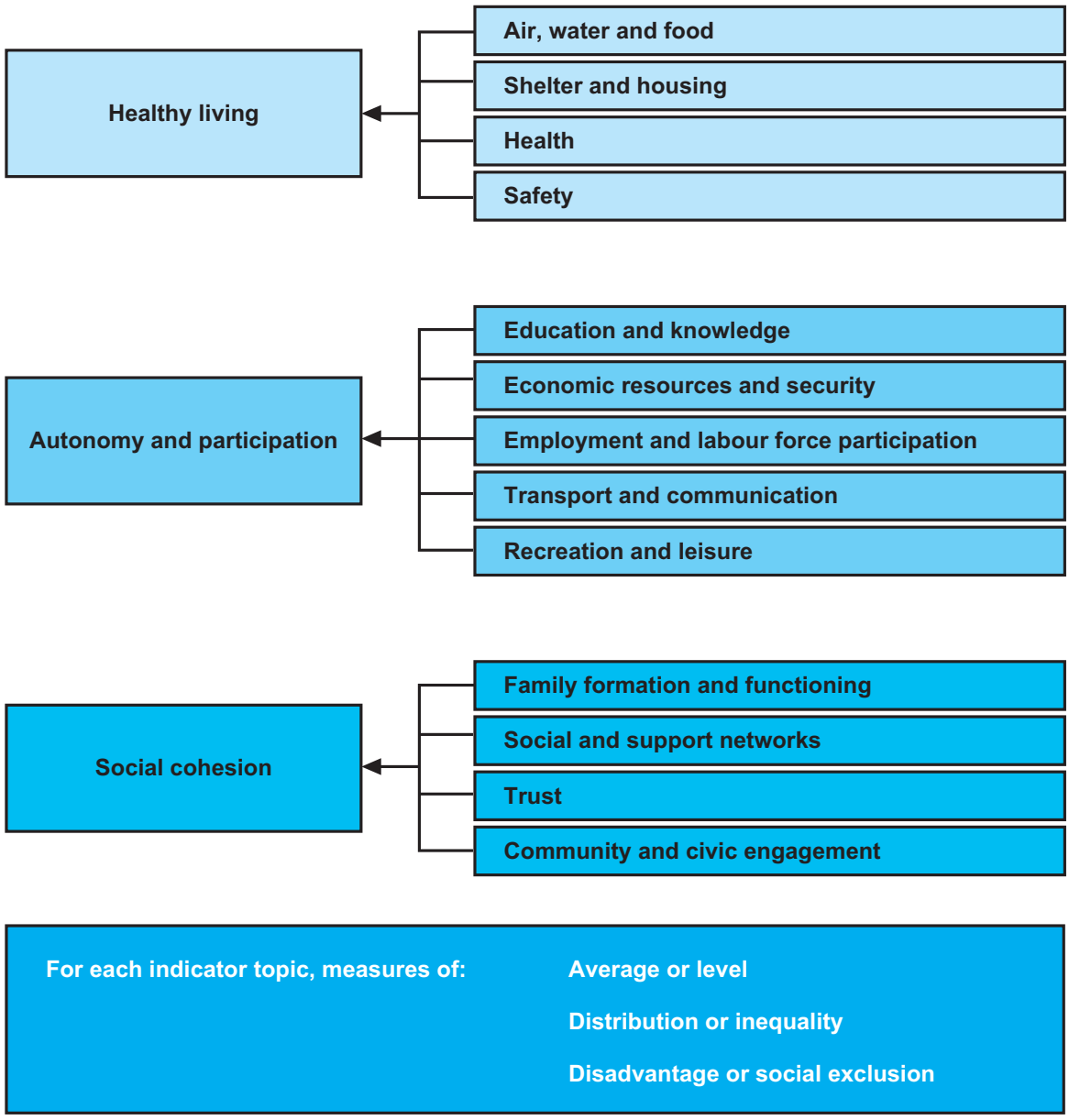


Figure 2.2: Welfare components and related indicator topics and measures

2.2 Healthy living

Healthy living encompasses the basic needs of life—a ready supply of clean water and nutritious food, access to shelter, a clean environment in which to live, and safety from harm—all fundamental to human health.

Air, water and food

Access to nutritious food and potable water are basic requirements of human life, and, together with air quality, greatly influence the current and future health and wellbeing of individuals and society at large. The indicators presented below—urban air quality,

access to potable water, reported usual daily intake of fruit and vegetables (an indicator of food and nutrient intake), and prevalence of obesity (as an indicator of nutritional status)—represent key issues in the monitoring of air and water quality, and nutrition, in Australia.

Urban air quality

Air quality in Australia is relatively good by international standards (Manins et al. 2001). In rural and regional Australia, levels of most pollutants are normally below actual or proposed national ambient air quality standards. However, some urban and industrial areas are susceptible to potentially dangerous levels of air pollutants, which can have serious impacts on people's health, the environment and economy, and subsequently on quality of life (EPAV 2000; Lewis et al. 1998; Morgan 2000; Simpson et al. 2000).

Particles with diameters 10 micrometres or less (known as PM10) and ozone are two air pollutants of concern in Australia (DEH 2004). Particles are emitted directly from motor vehicles, domestic wood fires, bushfires and industrial processes. Ozone is a secondary pollutant formed when oxides of nitrogen and volatile organic compounds react with sunlight in the atmosphere. Motor vehicle emissions and industrial activities are the main sources of these primary pollutants.

In 1998, Ambient Air Quality NEPM (National Environmental Protection Measure) standards were established with the goal of achieving air quality that protects human health and wellbeing (NEPC 1998). Particles (as PM10) and ozone are measured in terms of the number of days per year when the average concentration exceeds the Air NEPM. In 2003, standards for fine particles 2.5 micrometres or less in size (known as PM2.5) were included in the Air NEPM because of the adverse health effects of these finer particles which are known to penetrate deeper into the lung than larger size particles (EPHC 2004). Due to inconsistencies in the monitoring and reporting of past data, trend data for PM2.5 are not included in this section but may be available in the future.

The annual number of days in which the concentration of particles as PM10 exceeded the NEPM standard level of 50 µg/m3 generally fluctuated over the period 2000–03 (Table 2.1). The downward trend observed in most major capital cities over the period 1990–99 was not obvious across 2000–03.[1] Particle levels remained relatively high in Sydney and Melbourne; both cities exceeded the goal of 5 days per year in 2002 and 2003. Severe bushfires and dust storms may have been responsible for these peaks in Sydney in 2002, and Melbourne in 2003 (ABS 2005a). Perth was the only city which did not exceed the maximum allowable days of PM10 over the period.

Ozone concentrations exceeding 0.10 ppm per hour were much more frequent in Sydney during 2000–03 than in any of the other major capital cities. No obvious trend of increase or decrease in ozone pollution occurred for any of the capital cities during this period.

1. The 1990–99 data in *Australia's Welfare 2003* (AIHW 2003a) are not directly comparable with the 2000–03 data presented here and so have not been included as part of the trend information.

Table 2.1: Number of days per year when concentrations of PM10 and ozone exceeded the Air NEPM standard levels, in major capital cities, 2000–03

	2000	2001	2002	2003
Number of days when concentration of PM10 exceeded 50 g/m^3 (over 24 hours)[(a)]				
Sydney	2	5	17	10
Melbourne	0	2	6	13
Brisbane	0	1	7	2
Perth	0	1	2	1
Adelaide	n.a.	n.a.	1	6
Number of days when concentration of ozone exceeded 0.10 ppm (over 1 hour)[(b)]				
Sydney	4	9	2	4
Melbourne	1	0	0	2
Brisbane	0	0	2	0
Perth	0	0	0	0
Adelaide	n.a.	n.a.	0	0

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

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

Source: Data provided to AIHW by Department of Environment and Heritage (DEH).

Access to potable water

Water is a precious resource in a country as dry and climatically variable as Australia. Access to a reliable supply of clean safe water is a necessity for healthy living. The Australian Drinking Water Guidelines developed by the National Health and Medical Research Council, in collaboration with the Natural Resource Management Ministerial Council, provide the Australian community and the water supply industry with guidance on acceptable water quality in Australia (NHMRC & NRMMC 2003). The guidelines define good quality drinking water from the perspectives of both health and aesthetics (appearance, taste and odour); drinking water must be safe for human consumption (i.e. the levels of bacteria, chemicals and pesticides should not exceed levels stated in the guidelines), and should be aesthetically pleasing.

No national data are currently available on access to potable water. Regulation of drinking water is the responsibility of each state and territory; government bodies are responsible for establishing the level of impurities that is acceptable for a given water supply, and water authorities are required to regularly monitor the quality and safety of the water they distribute (NHMRC 2004).

Not all Australians have access to good quality drinking water. The 2001 Community Housing and Infrastructure Needs Survey found that 56 of the 169 Indigenous communities (about 17,000 people) that had been tested had drinking water supplies that failed testing at least once in the 12 months prior to the survey, a similar result to that obtained in 1999 (ABS 2002a:19).

Reported usual daily intake of fruit and vegetables

Regular consumption of fruit and vegetables plays an important role in ensuring a healthy diet which is fundamental to the maintenance of good health through all stages of life.

Fruit and vegetables provide significant protection against a number of major chronic diseases, including coronary heart disease, stroke, certain cancers, hypertension, and Type 2 diabetes (NHMRC 2003). Further, the consumption of fewer than 5 serves of fruit and vegetables per day was estimated to contribute to 3% of the total burden of disease and 11% of the total cancer burden in Australia in 1996 (AIHW: Mathers et al. 1999). Increasing the consumption of fruit and vegetables has been identified as a nutrition priority initiative to optimise health and reduce the burden of preventable diet-related death, illness and disability among Australians (SIGNAL 2001).

Dietary guidelines endorsed by the NHMRC recommend that women eat 4–7 serves of vegetables and legumes per day, and 2–3 serves of fruit; for men the recommendation is 5–8 serves of vegetables and legumes per day and 2–4 serves of fruit (NHMRC 2003). The 2001 National Health Survey provides the most recent national data on the food intake of Australian adults.

In 2001, just over half (53%) of the Australian population aged 12 years and over reported eating at least 2 serves of fruit a day (Table 2.2). Females, overall and for almost all age groups—with the exception of those aged 12–14 years—were more likely than males to do so. The proportion of people meeting the recommended daily fruit intake was generally higher at older ages.

Table 2.2: Self-reported usual daily intake of fruit and vegetables, by age, 2001 (per cent)[(a)]

	2 or more serves of fruit a day			4–5 or more serves of vegetables a day		
Age group	**Males**	**Females**	**Persons**	**Males**	**Females**	**Persons**
12–14	56.7	54.8	55.7	22.2	24.2	23.2
15–24	42.1	50.6	46.2	21.1	23.2	22.2
25–34	40.0	50.6	45.3	21.8	27.6	24.8
35–44	43.1	53.3	48.3	24.7	33.3	29.0
45–54	46.6	60.8	53.8	29.6	36.8	33.2
55–64	53.1	70.7	61.8	32.0	42.7	37.3
65–74	60.4	69.1	64.9	34.5	40.0	36.8
75+	61.9	68.4	65.7	36.1	38.6	37.6
Total	**47.1**	**58.1**	**52.7**	**26.4**	**32.8**	**29.7**

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

Source: ABS 2002b.

Only 30% of Australians aged 12 years and over reported consuming at least 4–5 serves of vegetables per day in 2001. Females, overall and for each age group, were more likely than males to meet this recommended daily intake of vegetables. The proportion of the population who reported their usual intake of vegetables as being 4 or more serves was higher in older age groups, especially from age 35+ years.

Prevalence of obesity

Body weight is an important indicator of past and current health status, as well as a predictor of future health and wellbeing. Obesity is related to a number of adverse health outcomes, including diabetes, heart and circulatory conditions, low participation in leisure-time physical activity, and poor self-reported health status (AIHW: O'Brien & Webbie 2004).

While many factors may influence an individual's body weight, a balanced diet and participation in regular physical activity are key elements in the prevention and management of obesity (NHMRC 1997). Obesity is, then, an indicator of 'disadvantage' when considering nutritional status.

In 2001, an estimated 2.4 million (16%) Australians aged 18 years and older were obese, and a further 4.9 million (34%) were overweight but not obese, based on self-reported height and weight data from the National Health Survey (AIHW: Dixon & Waters 2003; see Table 2.3 footnotes for definitions of 'overweight but not obese' and 'obese'). Men were more likely than women to be overweight but not obese—42% compared to 25%. However, women were just as likely as men to be obese—17% and 16% respectively. It is important to note that these results are based on self-reported height and weight estimates; thus the true prevalence of overweight and obesity is expected to be higher, as people tend to overestimate their height and underestimate their weight (ABS 1998a; AIHW: O'Brien & Webbie 2003). (See Chapter 4 for the prevalence of obesity among the population aged 65 years and older.)

Aboriginal and Torres Strait Islander people living in non-remote areas were almost twice as likely to be obese as other Australians living in similar locations in 2001—31% and 16% respectively. However, the prevalence of being overweight but not obese in 2001 was similar for Indigenous Australians and other Australians—32% and 34% respectively (AIHW: O'Brien & Webbie 2003).

The prevalence of obesity rose rapidly among both men (an 80% increase) and women (a 71% increase) between 1989–90 and 2001, a much greater increase than the prevalence of overweight but not obese (14% in both men and women) (Table 2.3). Among OECD countries, obesity levels in Australia now rank fourth behind the United States, Mexico and the United Kingdom (OECD 2004).

Table 2.3: Prevalence of overweight and obesity: Australian men and women aged 18 years and over, 1989–90, 1995 and 2001 (per cent)

	Overweight but not obese		Obese	
	Males	Females	Males	Females
1989–90	37.0	22.2	8.6	9.9
1995	40.3	24.3	11.6	12.2
2001	42.0	25.3	15.5	16.9

Notes

1. Data based on BMI (body mass index) derived from self-reported height and weight measurements. BMI is calculated as Weight (kg)/Height2(m). 'Overweight but not obese' is measured as BMI 25 and BMI <30. 'Obesity' is measured as BMI 30.
2. Age-standardised to the 2001 Australian population 18 years and older.

Source: AIHW: Dixon & Waters 2003:17.

Shelter and housing

A person's access to stable, adequate shelter is recognised as a basic human need. Housing provides shelter and a place where people are guaranteed security and privacy, and where they can form and maintain relationships with family and friends. Having a home also enables people to engage with the wider community—socially, recreationally and economically—and may influence both their physical and mental health.

Housing tenure, housing affordability, and homelessness are used here as indicators of the housing circumstances of Australians. However, housing adequacy, in terms of quality, condition and size of dwelling, and accessibility are also important indicators, and especially significant for some Indigenous communities and people living in remote areas (ABS 2004a; see also AIHW 2005a for other national indicators on Indigenous housing). Further information on assistance for housing can be found in Chapter 6, and services for persons experiencing homelessness in Chapter 7.

Housing tenure

Australians have traditionally aspired to home ownership and compared with other developed countries, Australia has one of the highest home ownership rates (ABS 2001a).

In 2002–03, 70% of Australian households owned their home (Table 2.4). Couple-only and lone-person households accounted for 37% and 28% of all households respectively that owned their home outright, while couples with dependent children made up 41% of all household owners with a mortgage. Public and private renters mostly lived in lone-person households (47% and 32% respectively).

Table 2.4: Tenure type and composition of households, 2002–03

	Owner without a mortgage	Owner with a mortgage	Public renter[a]	Private renter	Total[b]
Number ('000)	2,780.4	2,525.0	372.8	1,680.2	7,638.2
Per cent	36.4	33.1	4.9	22.0	100.0
	Household composition—per cent of each tenure type				
Couple-only households	37.2	21.1	7.7	18.1	25.4
Couple with dependent children only households	11.6	41.4	7.7	17.5	22.6
Other couple, one-family households	13.5	13.9	5.6	4.3	10.8
One-parent, one-family households with dependent children	2.7	4.9	24.4	12.6	6.9
Other family households	6.6	4.4	7.4	6.0	5.7
Lone person	27.6	12.5	46.6	31.9	25.2
Group households	0.8	1.9	0.6	9.5	3.2
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**

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

(b) Includes other renters and other tenure type.

Note: Totals may not add up due to rounding.

Source: ABS 2004b.

Between 1994 and 2003, the percentage of Australians who owned their homes stayed relatively even at around 70% (ABS 2005b:158). During this period, the proportion of households without a mortgage dropped from 42% in 1994 to 36% in 2003 and the proportion of households with a mortgage increased from 28% to 33%.

These differences partly reflect age effects—for instance, a large proportion of couple-only households are likely to be older couples, and home ownership rates increase with age

(AIHW 2003a:20). For example, in 2002–03, 80% of older person (i.e. 65 years and older) households lived in a dwelling they owned outright, compared with 25% of younger person households (ABS 2005b:168–9).

Indigenous households were less likely to own or be in the process of buying their homes. In 2002, 30% of Indigenous households were home owners or purchasers and 66% were renting (Table 2.5). Around 15% of Indigenous households were renting from Indigenous Community Housing Organisations and mainstream community housing organisations. Land tenure arrangements in remote and very remote areas often translate to community ownership of dwellings, rather than individual ownership, and may account in part for lower ownership among Indigenous Australians in these areas (ABS & AIHW 2003).

Table 2.5: Tenure type of Indigenous households, 2002

	Home owner/ purchaser	Private/other renter	Renter (state/territory housing)	Renter (Indigenous/ community housing)	Other	Total
Number ('000)	50.4	46.8	37.7	24.5	6.2	165.7
Per cent	30.4	28.2	22.8	14.8	3.7	100.0

Note: Totals may not add up due to rounding.

Source: ABS & AIHW 2005.

Housing affordability

Housing affordability indicates the capacity of households to meet housing costs while maintaining the ability to meet other living expenses. No single indicator of housing affordability has yet been recognised as an Australian standard, but most rely on cut-off points to identify 'low-income households', since such households should be considered at risk of having problems with affordability (AIHW: Karmel 1998).

A commonly used indicator of housing affordability is the proportion of low-income households that spend more than 30% of their income on housing costs. In Table 2.6, low-income households are defined as those with an equivalised disposable household income that is between the bottom 10% and bottom 40% of the distribution. Data are also presented on low-income households spending more than 50% of their income on housing costs, an indicator of more severe affordability problems. These households are described as those at potential risk of affordability problems.

In 2002–03, 20% of low-income Australian households spent more than 30% of their income on housing costs (i.e. major cash outlays such as mortgage repayments, property rates, or rent). Housing affordability problems were felt most by owners with a mortgage and by private renters—around 22% of all low-income household owners with a mortgage and 44% of private renters spent 30–50% of their income on housing costs, and 9% and 13% respectively spent more than 50%.

An alternative indicator, used to measure affordability stress among low-income Indigenous households, calculates the percentage of such households paying 25% or more of their income for rent. In 2002, 43% of low-income Indigenous households

(15,013 households in total) spent 25% or more of their income on rent (AIHW 2005a:35).[2]

Table 2.6: Households with equivalised disposable incomes in the bottom 10% and bottom 40%: households that spent between 30–50% and more than 50% of their gross income on housing costs,[(a)(b)] by tenure type, 2002–03 (per cent)[(c)]

	Proportion of gross income spent on housing costs	
Tenure type	**30–50%**	**More than 50%**
Owner without a mortgage	0.0	0.0
Owner with a mortgage	22.0	8.6
Renter—state/territory housing authority	5.0	0.0
Renter—private landlord	43.9	13.4
Total	**100.0**	**100.0**
All tenure types[(d)]	*14.9*	*4.7*

(a) Housing costs include major cash outlays on housing, that is, mortgage repayments and property rates for owners, and rent. Housing costs here do not include outlays such as repairs, maintenance and dwelling insurance.

(b) The use of gross weekly income in this method masks assistance on the income side, such as rent assistance. On the supply side, it illustrates that people renting public housing were less likely to have affordability problems.

(c) Per cent of all low-income households.

(d) Includes other renters.

Note: The percentages indicate the proportions of low-income households, as published in ABS (2005c). In *Australia's Welfare 2003* (AIHW 2003a), the percentages related to all households.

Source: ABS 2005c: Table 5.

Homelessness

Homelessness can be viewed as an indicator of housing deprivation and, more broadly, as evidence of social exclusion. Defining and counting homeless people remains a challenge and the various strategies and approaches used are discussed in Chapter 7. However, some of the approaches proposed to measure homelessness do not always 'fit' when estimating homelessness among particular groups in Australian society. An exploration of Indigenous Australians' interpretation of homelessness by Memmott et al. (2004) found quite different ideas about who may be considered homeless. They emphasised the importance of understanding cultural antecedents (e.g. culturally obliged transience) behind supposed episodes of homelessness, as opposed to the conventional and cultural expectations of the majority of other Australians that tend to focus on the lack of appropriate accommodation and security of tenure.

On Census night 2001, it was estimated that 99,900 people were homeless in Australia (Table 2.7). Forty-nine per cent of these people stayed with friends or relatives, and 23% lived in boarding houses. An estimated 105,300 people were homeless on Census night in 1996; however, changes to the definition of improvised dwellings between censuses make comparison between absolute numbers problematic. (See Chapter 7 for further data on homelessness.)

2. Low-income households were defined as those in the bottom 40% of all Australian gross household incomes spending more than 25% of their income on rent.

Table 2.7: The whereabouts of homeless people on Census night, 1996 and 2001

	1996		2001	
	Number	Per cent	Number	Per cent
SAAP accommodation[a]	12,926	12	14,251	14
Boarding house	23,299	22	22,877	23
Friends/relatives	48,500	46	48,614	49
No conventional accommodation[b]	20,579	20	14,158	14
Total homeless	**105,304**	**100**	**99,900**	**100**

(a) Provided under the Supported Accommodation Assistance Program.

(b) Includes improvised dwellings, tents and sleepers out. Counting rules in the 1996 Census included any dwelling which did not have a working bath/shower and toilet as an improvised dwelling. This methodological approach was not taken in 2001, to account for those Indigenous households who used bathroom and toilet facilities in properly constructed amenity blocks.

Sources: Chamberlain 1999; Chamberlain & McKenzie 2003.

Health

Health is broadly defined as 'a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity' (WHO 1946). This section takes a somewhat narrower view of health, as one subcomponent of welfare, recognising the important links between health and other aspects of welfare. Health can influence participation in many aspects of life, including education, work and recreation. Furthermore, a person's mental health can impact upon their social functioning and capacity to carry out everyday activities and responsibilities. Good health is therefore a major resource for personal, social and economic development as well as an important factor in quality of life (WHO 1986).

In this section we present indicators of health status. Some indicators of important determinants of health are presented in other sections of this chapter—notably dietary intake and obesity in 'Air, water and food' (see AIHW 2004a for an overview of determinants of health).

Life expectancy

Life expectancy refers to the average number of additional years a person of a given age and sex can expect to live if current age-specific mortality rates continue to apply throughout that person's lifetime. Life expectancy at birth provides an indication of the prevailing level of mortality in the population at a given point in time (ABS 1997a), while life expectancy at age 65 is a broad, mortality-based indicator of the health of older people (OECD 2001).

Life expectancies at birth in Australia are among the highest in the world and increased significantly over the twentieth century (AIHW 2004a; WHO 2005). In the period 1998–2000, life expectancy at birth was 76.6 years for males and 82.0 years for females (Table 2.8), a substantial increase from the beginning of the previous century when a male at birth was expected to live to 55.2 years and a female to 58.8 years (AIHW 2004a). There have also been substantial improvements in the life expectancy of the older population. In 1998–2000, males aged 65 years could expect to live to 81.9 years and females to 85.4 years—some 7 years more than people of the same age in the period 1901–10.

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

	Life expectancy at birth		Life expectancy at age 65	
	Males	Females	Males	Females
1996–2001				
Indigenous Australians[(a)]	59.4	64.8	10.7	12.0
1998–2000				
All Australians	76.6	82.0	16.9	20.4

(a) Data on life expectancy for Indigenous Australians are based on experimental life tables (see ABS 2004c).

Source: ABS & AIHW 2005.

The Indigenous Australian population has substantially lower life expectancy than the total Australian population—approximately 17 years less. This difference reflects much higher death rates in the Indigenous population, for both males and females, in every age group (ABS & AIHW 2005).

Life expectancy also varies with socioeconomic status—people in more disadvantaged groups tend to have shorter life expectancies. This pattern is illustrated by a comparison of life expectancies among regions categorised according to the Index of Relative Socioeconomic Disadvantage. In 2000–01, there was a 3.6 year gap in life expectancy at birth for males between the lowest and highest quintiles of socioeconomic disadvantage, and a 2.4 year gap for females (Table 2.9). The gap in life expectancy at 65 years was 1.6 years for males and 1.3 years for females.

Table 2.9: Life expectancy at birth and at age 65, by quintile of socioeconomic disadvantage[(a)], 2000–01 (years)

	Quintile of socioeconomic disadvantage				
	Lowest	Second	Third	Fourth	Highest
Life expectancy at birth					
Males	76.2	77.0	77.6	78.5	79.8
Females	82.1	82.8	83.0	83.5	84.5
Life expectancy at age 65					
Males	17.0	17.5	17.7	18.0	18.6
Females	20.8	21.2	21.2	21.4	22.1

(a) The measure of socioeconomic status used here (IRSD) categorises SLAs based on a range of attributes including levels of income, educational attainment, and unemployment. People are classified according to the average socioeconomic disadvantage of their area of residence at death.

Note: The quintiles of socioeconomic disadvantage are based on the 2001 Census and therefore cannot be compared with SEIFA data based on the 1996 Census such as the life expectancy by SEIFA presented in *Australia's Welfare 2003*.

Source: AIHW analysis of AIHW National Mortality Database.

Expected years of life lived with disability

Indicators of functioning and disability in the population are a key component of national health status measurement (NHPC 2004). Expected years of life lived with a disability is an estimate of the average number of years that a person, at birth, can expect to live with a disability. Just as life expectancy is a population average, so is this an indicator of population health rather than a prediction of any individual's experience.

According to 2003 data, men can expect, on average, to experience 19 years of life lived with a disability (5 of which are expected to be years of life lived with a severe or profound core activity limitation). Women can expect, on average, to experience 21 years of life lived with a disability (8 with a severe or profound core activity limitation) (Table 2.10; for definitions and further discussion of methodology, see AIHW: Wen (forthcoming)). The 1998 and 2003 estimates of years of life lived with a disability both equate to 24% of total life expectancy for men, and estimates of severe or profound core activity limitation to 7% of total life expectancy. For women, estimates of years of life lived with a disability equate to 25% of total life expectancy in 2003, up slightly from 24% in 1998, while years of life lived with a severe or profound core activity limitation equate to 10% of total life expectancy in 2003, up from 9% in 1998.

Table 2.10: Expected years of life lived with disability and with severe or profound core activity limitation, 1998 and 2003

	Males				Females			
	Number of years		% of total life expectancy		Number of years		% of total life expectancy	
	1998	2003	1998	2003	1998	2003	1998	2003
Expected years of life:								
Free of disability	58.0	59.1	76	76	62.1	62.2	76	75
With disability (all severity levels)[(a)]	17.9	18.6	24	24	19.4	20.7	24	25
With severe core activity limitation[(b)]	5.3	5.4	7	7	7.6	8.3	9	10
Total life expectancy at birth	**75.9**	**77.8**	**100**	**100**	**81.5**	**82.8**	**100**	**100**

(a) Disability is defined as the presence of one or more of 17 limitations, restrictions or impairments that lasted, or were likely to last, for at least 6 months, and which restricted everyday activities (see also Chapter 5).

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

Note: The 1998 data were calculated using 1998 Survey of Disability, Ageing and Carers CURF data and therefore are different to the 1998 data in Australia's Welfare 2003 which were extracted using definitions that were common to the previous surveys.

Sources: AIHW analysis of ABS 1998 and 2003 Survey of Disability, Ageing and Carers confidentialised unit record files; ABS unpublished abridged Australian life tables 1996–98, 2001–03.

Infant mortality

Infant mortality is defined as the number of deaths of children within their first year of life in a calendar year per 1,000 live births in the same calendar year.

Infant mortality in Australia has declined significantly since the beginning of the twentieth century, from 103 infant deaths per 1,000 live births in 1900 to 4.8 per 1,000 in 2003 (ABS 2004d). However, Australia's infant mortality rate is still relatively high compared with other industrialised countries, ranking equal eleventh (with Greece and the Netherlands) among 26 OECD countries in 2003—Iceland had the lowest rate with 2.4 deaths per 1,000 live births (OECD 2005a).

The Australian rate is relatively high partly because of the high death rates among Indigenous infants (NHPC 2004:32). Nonetheless, over the period 1991–2002, these rates in Western Australia, South Australia, and the Northern Territory all decreased significantly (Table 2.11).

Table 2.11: Indigenous infant mortality rates[(a)], WA, SA and NT, 1991–2002

	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002
Western Australia[(b)]	20.8	22.8	16.3	20.3	22.1	18.9	19.0	17.0	16.7	13.9	16.9	15.5
South Australia	16.9	25.0	13.5	7.5	16.2	14.4	8.5	4.5	6.3	11.1	8.2	11.8
Northern Territory	25.5	28.1	25.8	21.7	17.0	24.6	23.8	21.0	28.2	17.0	16.0	13.0

(a) Infant deaths per 1,000 live births.

(b) The average of births over 1993–95 in WA was used as the denominator for the estimates of the infant rates for 1991 and 1992. This is because implausibly small numbers of births were recorded for 1991 and 1992.

Note: Death data are based on year of death and state of usual residence. Birth data are based on year of registration.

Source: ABS & AIHW 2005.

Mental health

Mental ill-health is one of the leading causes of the non-fatal burden of disease and injury in Australia (AIHW 2004a). Mental health problems and disorders can affect people's ability to carry out their daily activities and responsibilities, and are associated with increased exposure to health risk factors, poorer physical health and higher rates of death from numerous causes including suicide. In 2001, an estimated 1,812,600 people, or 9.6% of the adult population, reported a long-term mental or behavioural problem (ABS 2004e).[3]

Psychological distress is a major risk factor for mental disorders. The 2001 National Health Survey included a set of 10 questions (the Kessler 10 scale) to measure psychological distress over the 4 weeks prior to the survey. The K10 scores were grouped into four categories: low (indicating little or no psychological distress), moderate, high, and very high (which may indicate a need for professional help).

In 2001, an estimated 508,700 people, or 3.6% of the adult population, were classified as having 'very high' levels of psychological distress (Table 2.12). Proportionally more women than men overall (4.4% and 2.7% respectively), and across almost all age groups, reported very high levels. The highest rates were recorded for persons aged 45–54 years (5.5% of women and 3.7% of men). Results from surveys conducted in 2003 in New South Wales and Victoria showed similar patterns but lower proportions (2.8% and 2.6%, respectively) (NSW Department of Health 2004; Victorian Department of Human Services 2004).

There are currently no national data concerning the incidence or prevalence of mental health disorders among Indigenous Australians. The 2004–05 National Aboriginal and Torres Strait Islander Health Survey included, for the first time, a module to assess various aspects of mental health and social and emotional wellbeing of Indigenous Australians. Results are expected to be available in 2006.

3. The 1998 Child and Adolescent Components of the National Survey of Mental Health and Wellbeing—the first and latest survey to investigate the mental health and wellbeing of young Australians at a national level—found that 14% of children and adolescents had mental health problems (Sawyer et al. 2000).

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

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

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

Note: Totals may not add up due to rounding.

Source: ABS 2002b.

Physical activity

The health benefits of regular physical activity are well established and include an overall reduced risk of premature mortality, as well as reduced risks of cardiovascular diseases, Type 2 diabetes, certain cancers, musculoskeletal disorders, injurious falls, obesity, and symptoms of mental ill-health (AIHW 2003b). Overall, physical inactivity ranks second only to tobacco, as the most important risk factor for preventable disease in Australia (Bauman et al. 2002).

Sufficient physical activity to achieve health benefits is interpreted as the accrual of at least 150 minutes of physical activity over at least five sessions per week (AIHW 2003c; DHAC 1999). Data from the 2000 National Physical Activity Survey identified that more than half (54%) of Australians aged 18–75 years did not undertake enough physical activity to obtain health benefits (AIHW 2004a). Rates were highest among 30–59 year olds and lowest among 18–29 year olds, for both males and females. More men (18%) than women (13%) reported 'no physical activity' during the week prior to the survey, with the proportion of people not doing any at all increasing with age—from 11% of men and 9% of women aged 18–29 years to 20% of men and 17% of women aged 45 years and over (see Chapter 4 for participation rates among the population aged 65 years and older).

Comparisons with the 1997 National Physical Activity Survey show that the proportion of Australians reporting insufficient physical activity increased from 49% in 1997 to 54% in 2000 (AIHW 2003c). It should be noted that non-leisure time physical activity such as work or domestic activity was not taken into account because of the difficulty in measuring this component.

There are currently no recent national data on the physical activity patterns of Australian children and adolescents; however, it has been found that many activities widely undertaken by young Australians involve very little physical activity. The 2003 Survey of Children's Participation in Cultural and Leisure Activities found that watching television and videos was the most popular leisure activity outside school hours—

undertaken by 98% of boys and girls aged 5–14 years for an average of 22 hours over a school fortnight (ABS 2004f).

Safety

Direct experiences or perceptions of safety can greatly impact upon a person's physical and mental health and wellbeing. Safety indicators are often expressed as negative indicators (or indicators of system breakdown), for instance experiences of crime and injury. The effects of these negative events are felt not only by the victims of crime or accidental injury, but also by their family and friends and members of the wider community, including those who are involved in rescuing and treating the victims and apprehending and sentencing the perpetrators of crime. Less directly, individuals and society at large experience these effects in terms of perceptions of danger or, more positively, feelings of safety and security.

Feelings of safety

In 2002, around 80% of people reported that they felt safe or very safe at home alone during the day, and 69% felt this way after dark (ABS 2003a). Females (61%) were less likely than males (78%) to report feeling safe particularly after dark. People in capital cities reported feeling less safe during the day (78%) and after dark (67%) than those in other areas (83% and 73%, respectively).

Data on perceptions of safety collected in the 2002 ABS General Social Survey showed similar patterns, but higher proportions (82%) of people reported feeling safe or very safe at home alone after dark (ABS 2003b). People living in rented accommodation or in low-income households and people not in the labour force were more likely to feel unsafe at home alone after dark.

Crime

Data on crime vary depending on the way information is collected. Household surveys provide a picture of crime as experienced by people and households and, for some crimes, present a more complete picture of crime victimisation than data on crimes reported to the police. Data from both household surveys and police records are used here.

An estimated 8.9% of households experienced at least one household crime in the 12 months prior to the 2002 National Crime and Safety Survey (ABS 2003a). This figure has remained much the same since 1998 (9.0%). Break-ins were the most commonly reported household crime in 2002, with 4.7% of households reporting at least one break-in to their home, garage or shed. Some 3.4% of households reported finding signs of at least one attempted break-in, and 1.8% reported at least one motor vehicle stolen from their household.

An estimated 5.3% of people aged 15 years and over were victims of at least one personal crime in the 12 months prior to the same survey (ABS 2003a). This figure increased slightly from 4.8% in 1998. Assault was the most commonly reported personal crime, with 4.7% of people reporting being victims of at least one assault in 2002. Some 0.6% of people reported being victims of at least one robbery, and 0.2% of people aged 18 years and over reported experiencing at least one sexual assault.

Data on crime victimisation collected in the 2002 ABS General Social Survey showed that 9.0% of people aged 18 years and over reported being victims of physical or threatened violence in the 12 months prior to the survey (ABS 2003b). Men were more likely (10.9%) than women (7.2%) to experience physical or threatened violence, with men aged 18–24 years the most likely (21.1%) to have been victims.

Almost one-quarter (24%) of Indigenous Australians aged 15 years and older in 2002 reported that they had been a victim of physical or threatened violence in the 12 months prior to the National Aboriginal and Torres Strait Islander Social Survey (ABS 2004g). This rate was nearly twice the rate reported in 1994 (13%). After adjusting for age differences between the Indigenous and non-Indigenous populations, Indigenous persons aged 18 years or over experienced more than double the victimisation rate of non-Indigenous persons (20% compared to 9%).

National data relating to victims of a selected range of crimes that were recorded by police in 2003 are presented in Table 2.13. It is important to keep in mind that not all crimes are reported to the police, nor are all incidents reported to police recorded as crimes and, to the extent that this is so, police data underestimate the complete picture of crime in Australia.

Table 2.13: Victims of crime,[(a)(b)] by sex, age, and offence category, 2003 (rate per 100,000 persons in age group)

	Murder		Driving causing death		Assault		Sexual assault		Robbery	
Age	**Males**	**Females**	**Males**	**Females**	**Males**	**Females**	**Males**	**Females**	**Males**	**Females**
0–9	0.7	1.0	n.p.	n.p.	162.0	104.7	89.9	195.8	4.5	1.7
10–14	n.p.	n.p.	n.p.	n.p.	760.1	510.7	87.9	474.7	114.1	18.3
15–19	2.4	n.p.	3.3	1.9	1,825.6	1,425.6	64.9	519.6	467.9	111.3
20–24	2.1	2.1	1.6	n.p.	1,852.8	1,415.5	24.7	213.6	310.9	117.0
25–34	3.6	1.2	1.6	0.8	1,594.5	1,159.4	18.6	122.7	144.7	71.9
35–44	2.8	1.1	1.2	n.p.	1,026.5	794.4	13.3	73.9	77.0	44.6
45–54	1.8	n.p.	1.0	n.p.	644.1	413.1	7.8	30.9	61.2	45.4
55–64	1.9	n.p.	n.p.	n.p.	357.9	183.8	2.2	10.8	38.4	35.5
65 and over	0.9	n.p.	n.p.	n.p.	126.2	60.4	n.p.	5.2	18.2	29.3
Total[(c)]	**2.0**	**0.9**	**1.1**	**0.6**	**918.8**	**663.9**	**33.0**	**148.8**	**115.8**	**49.8**
					Persons					
All ages[(c)]	1.5		1.2		798.0		91.7		84.2	
Total number[(c)]	302		245		158,629		18,237		16,736	

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

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

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

Source: ABS 2004h.

Based on police records, assault was the crime affecting most individuals in 2003—158,629 people, or a rate of 798 victims per 100,000 persons. This is a 2% decrease from

2002, and is the first decrease for this offence since 1995 (ABS 2004h). Persons aged between 15 and 34 years were most affected by assault. Overall, the male victim rate for assault (919 per 100,000) exceeded the female rate (664 per 100,000), and did so in every age group. Male rates also exceeded female rates for murder, driving causing death, and robbery. Females, however, experienced more sexual assault—149 per 100,000 were victims compared with 33 males per 100,000. As with crime generally, it was the younger age groups that were most affected by sexual assault, with the highest rate among males occurring in the 0–9 age group (90 per 100,000) and among females in the 15–19 age group (520 per 100,000).

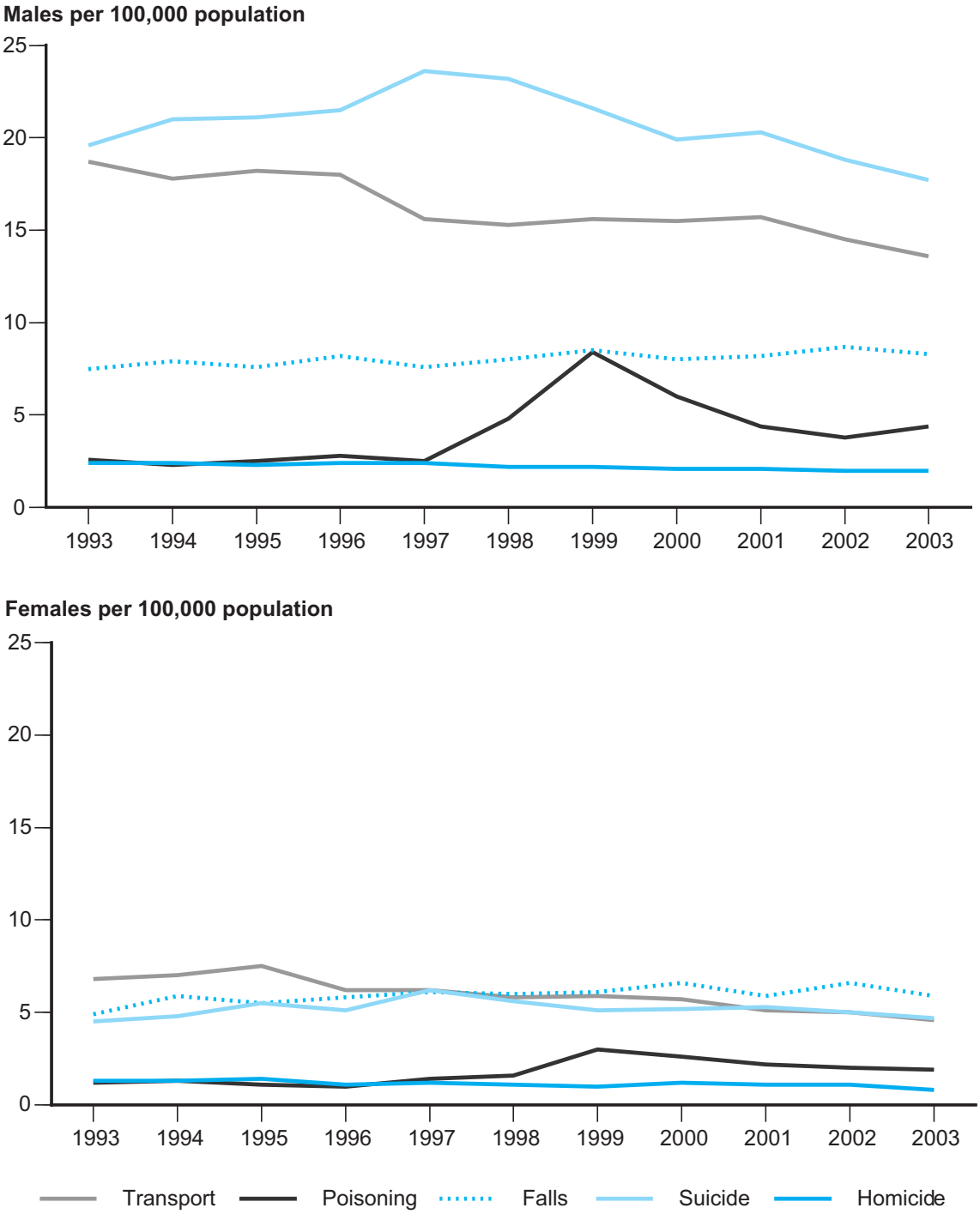
Injury

Injury (including poisoning) is the principal cause of death among people aged 1–44 years, and a leading cause of mortality, morbidity and permanent disability in Australia (AIHW 2004a). Injuries may cause a range of physical, cognitive and psychological disabilities that seriously affect the quality of life of injured people and their families. Furthermore, there are significant health costs attributable to injury—an estimated $4 billion in 2000–01, or 8% of total allocated health expenditure (AIHW 2005b).

In 2003, there were 7,749 deaths (5,273 males and 2,476 females) in Australia attributed to injuries and poisoning, a rate of 39.0 per 100,000 population (see Table A2.3). Suicide was the leading cause of injury death, accounting for 2,214 of all such deaths (11.1 per 100,000), followed by transport-related injuries (1,811 deaths, 9.1 per 100,000) and falls (1,447 deaths, 7.3 per 100,000). The male suicide rate was considerably higher than that for females from age 15+ years, and the overall male adjusted rate of 17.6 per 100,000 was approximately 3.7 times the female rate of 4.8 per 100,000. The main cause of death for which the number of females exceeded the number of males was falls (776 deaths or 7.8 per 100,000, compared with 671 deaths or 6.8 per 100,000); this reflects the predominance of women in the age group at most risk of this cause, that is, older women (AIHW: Pointer et al. 2003).

Rates of injury mortality are substantially higher among Indigenous Australians than non-Indigenous Australians (AIHW 2004a). Injury and poisoning accounted for 8.0% of all Indigenous deaths registered in South Australia, Western Australia, Queensland and the Northern Territory in 2002. Suicide was the leading cause of injury deaths (34%), followed by deaths related to transport accidents (27%).

Injury death rates have been subject to considerable change over recent years (Figure 2.3). The continual steady decline in transport-related deaths (from 12.6 deaths per 100,000 in 1993 to 9.1 per 100,000 in 2003) is perhaps the most noticeable feature of these trends. Suicide has continued to exceed transport-related deaths as the most common type of injury death among males since the early 1990s, although the rate has steadily declined since its peak in 1997 from 23.6 deaths per 100,000 to 17.7 per 100,000 in 2003. Female death rates for suicide and transport-related accidents converged in 1997 when suicide rates peaked, and both have steadily declined since. Falls have become the most common type of injury death for females since 1997, with no obvious declining trend. Death rates from poisoning appear to have risen in both males and females over the last decade, but the changes between 1998 and 1999 should be interpreted with caution due to changes in the coding systems (see footnotes to Table A2.4).



Source: Table A2.3

Figure 2.3: Injury and poisoning deaths, by sex and type of injury, 1993–2003

2.3 Autonomy and participation

Autonomy is a vital ingredient of welfare, and an objective for human development and social policy. Personal autonomy, or the 'opportunity to make and implement choices in life and to develop the capacities to do so' (AIHW 2003a:30), is promoted by and reflected in active participation in the economy and society, and the self-sufficiency to undertake activities of daily living (OECD 1999).

Employment, appropriate working conditions, a good education and a reliable income facilitate autonomy and an ability to participate more widely in society. Autonomy and participation also rely on having the means, either private or public, to move around the community and the ability to communicate within it, captured in the indicator topics of transport and communication. Finally, respite from the more structured demands of life, such as engaging in recreational activities and leisure, creates a more balanced lifestyle, and improves health and wellbeing.

Education and knowledge

Education and knowledge are important means by which individuals can enhance their autonomy. The acquisition of knowledge and skills attained through education allows people to realise their full potential and makes for a more competent and knowledgeable society. Education involves, and may also enhance, other participation in society, including employment, social and cultural life, and in civic and democratic engagements. While education tends to be particularly important during the earlier stages of life, it is increasingly recognised as a lifelong process.

This section focuses on indicators of education: levels of participation in education, educational attainment, and literacy among schoolchildren and adults.

Participation in education

Two commonly used indicators of educational participation are participation rates and apparent retention rates. School education in Australia is compulsory until 15 years of age (16 years in Tasmania and South Australia), thus participation rates in education are essentially 100% up until these ages.

Participation rates

Of the approximately 13.2 million Australians aged 15–64 years in May 2004, 18% were enrolled in a course of study (ABS 2004i).[4] Of these people, approximately 38% were attending a higher education institution, 29% were at school, 22% were at Technical and Further Education (TAFE) institutions, and 11% were at other educational institutions (for institution definitions, see ABS 2002c). People enrolled in a course of study were most likely to be aged 15–19 years (43%), due to completion of secondary schooling and strong retention to Year 12. (See Table 3.25 in Chapter 3 for participation rates for young people aged 15–19 years between 1994 and 2004.)

4. Rates presented here are for the total population from the annual Survey of Education and Work. There have been no new published data on these rates in population subgroups as presented in *Australia's Welfare 2003* (see Table A2.2).

In line with the emphasis on lifelong learning, the scope of the ABS Survey of Education and Work will increase from 15–64 years to 15–74 years from 2006. Data from the previous Census showed that some 8,400 persons aged 65 years and over (0.4% of this age group) attended TAFE, university or other tertiary institutions in 2001 (ABS 2003c).

Education is considered to be a key factor in improving the health and wellbeing of Indigenous Australians (ABS & AIHW 2005). In 2001, the Indigenous population was found to have lower participation rates in education than the total Australian population between the ages of 15 and 34 years—52% compared with 76% (ABS 2002c). However, the overall participation rate for Indigenous people aged 15–64 was similar to that of the population as a whole (21% and 20% respectively); this is related to the younger age profile of the Indigenous population compared with the population as a whole, and the higher participation rates in education among younger age groups in the total population (ABS 2002c).

Apparent retention rates at school

Completion of secondary school is important in equipping young people with knowledge and skills and providing increased opportunities to pursue further education or gain employment. The apparent retention rate provides an approximate measure of the proportion of students who remain at school until the final year of secondary education. Retention rates are termed 'apparent' because no adjustments are made for movements of students in and out of Australia, students repeating a year of education, or students moving between jurisdictions.

National retention rates increased rapidly during the 1980s, and more gradually from the mid-1990s (see Figure 3.10 in Chapter 3 for trends in retention rates). In 2004, 76% of Australians who had entered Year 7/8 stayed at school until Year 12 (Table 2.14). The retention rate for females (81%) was noticeably higher than the rate for males (70%). Some part of this difference is accounted for by higher male participation in post-school vocational education and training such as apprenticeships and traineeships (Ball & Lamb 2001). Retention rates for Aboriginal and Torres Strait Islander students (40%) were just over half that for all Australians in 2004 (ABS 2005d).

Table 2.14: Year 12 apparent retention rates, by sex and Indigenous status, 2004 (per cent)

	Males	Females	Indigenous	All Australians
Retention to Year 12 as % of cohort entering Year 7/8[(a)]	70.4	81.2	39.5	75.7

(a) The apparent retention rate to Year 12 is the percentage of students who remain in secondary education from the start of secondary schooling to Year 12. To calculate the apparent retention rate in Year 12 in 2004, the total number of full-time students enrolled in Year 12 in 2004 is divided by the number of full-time students who were in the base year—Year 7 in NSW, Vic, Tas and the ACT in 1999 and Year 8 in Qld, SA, WA and the NT in 2000.

Source: ABS 2005d.

Educational attainment

Levels of educational attainment in the population provide an indication of Australia's stock of knowledge and skills derived from formal education (ABS 2002c). The indicator used in this section focuses on the highest level of formal education completed by an individual (for information on how this measure is derived, see ABS 2004i:34–5).

In 2004, 22% of Australians aged 25–64 years reported their level of highest educational attainment as being a bachelor degree or above, 27% a certificate or diploma, 16% Year 12 and 28% Year 10 or below (Table 2.15). These percentages were seen to differ by age group—with each older age group, the proportion of people with Year 10 or below as their highest educational attainment increased, whereas a higher proportion of those aged 25–34 years held a bachelor's degree or higher compared with those aged 55–64 years (27% and 15% respectively). This indicates that levels of educational attainment in Australia have been increasing over time.

Table 2.15: Level of highest educational attainment, by age, 2004 (per cent)[(a)]

Age group	Bachelor degree or above[(b)]	Certificate or diploma[(c)]	Year 12	Year 11	Year 10 or below
25–34	27.0	27.7	22.6	6.5	15.5
35–44	22.0	28.0	15.0	8.0	25.8
45–54	22.6	27.8	13.4	6.0	30.3
55–64	15.2	25.7	9.6	4.5	43.3
Total	**21.9**	**27.4**	**15.5**	**6.4**	**27.6**

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

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

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

Source: ABS 2004i.

Literacy among schoolchildren

Reading, writing and numeracy are essential skills needed for functioning in everyday life, for further educational opportunities and for employment prospects. As part of monitoring national goals for schooling in Australia, performance against national benchmarks for reading, writing and numeracy are assessed for Year 3, 5 and 7 students (DEST 2002; MCEETYA 2002). These national benchmarks represent the minimum level of competence deemed necessary to allow meaningful participation in school learning.

Over the period 1999–2002, the majority of Year 3 and 5 students who participated in the testing achieved these benchmarks (Table 2.16). The results remained fairly stable over this 4-year period, with the only significant change being an increase in the proportion of Year 5 students meeting the reading benchmark (MCEETYA 2002). While it can be seen that the majority of Year 7 students also achieved the benchmark levels for the three subject areas in 2001 and 2002, the numeracy benchmark was not achieved by approximately one in six Year 7 students in the two reported years.

The proportion of female students in Years 3, 5 and 7 achieving the reading and writing benchmarks was higher than the proportion of male students for all reported years between 1999 and 2002; however, there was no apparent sex difference in the achievement of numeracy benchmarks (see Chapter 3 for further discussion).

Compared with Australian students as a whole, levels of achieving the reading, writing and numeracy benchmarks were slightly lower for students with language backgrounds other than English, and substantially lower for Aboriginal and Torres Strait Islander students.

Table 2.16: Year 3, 5 and 7 students achieving national educational benchmarks, by sex and Indigenous status, 1999–2002 (per cent)[a]

	National reading benchmark				National writing benchmark				National numeracy benchmark			
	1999	2000	2001	2002	1999	2000	2001	2002	1999	2000	2001	2002
Year 3												
Males	87.9	90.9	88.4	90.6	90.0	87.4	86.4	91.8	n.a.	92.7	93.7	92.5
Females	92.0	94.3	92.3	94.1	93.9	92.6	92.7	95.5	n.a.	92.8	94.3	93.1
All students	*89.7*	*92.5*	*90.3*	*92.3*	*91.9*	*90.0*	*89.5*	*93.6*	*n.a.*	*92.7*	*93.9*	*92.8*
Indigenous[b]	73.4	76.9	72.0	76.7	66.9	65.0	67.8	77.1	n.a.	73.7	80.2	77.6
LBOTE[b]	89.3	90.8	88.6	90.2	89.8	88.0	88.5	95.0	n.a.	90.3	92.5	91.3
Year 5												
Males	83.4	85.2	87.8	87.2	91.4	90.2	91.9	91.5	n.a.	89.4	89.5	89.9
Females	88.4	89.6	92.0	91.5	95.4	94.9	96.2	95.7	n.a.	89.8	89.8	90.2
All students	*85.6*	*87.4*	*89.8*	*89.3*	*93.0*	*92.5*	*94.0*	*93.6*	*n.a.*	*89.6*	*89.6*	*90.0*
Indigenous[b]	58.7	62.0	66.9	68.0	74.6	74.3	79.9	76.4	n.a.	62.8	63.2	65.6
LBOTE[b]	83.9	84.9	87.7	87.1	91.4	90.2	92.2	92.1	n.a.	87.1	87.9	87.9
Year 7												
Males	n.a.	n.a.	86.0	86.8	n.a.	n.a.	89.8	87.3	n.a.	n.a.	81.7	83.3
Females	n.a.	n.a.	91.0	91.6	n.a.	n.a.	95.6	94.1	n.a.	n.a.	81.9	83.8
All students	*n.a.*	*n.a.*	*88.4*	*89.1*	*n.a.*	*n.a.*	*92.6*	*90.7*	*n.a.*	*n.a.*	*82.0*	*83.5*
Indigenous[b]	n.a.	n.a.	60.1	65.3	n.a.	n.a.	74.3	71.6	n.a.	n.a.	48.6	51.9
LBOTE[b]	n.a.	n.a.	84.8	85.6	n.a.	n.a.	90.4	89.0	n.a.	n.a.	77.8	79.2

(a) The data represent students who have achieved the benchmark as a percentage of the students participating in the state and territory testing, including students who were formally exempted (these students are reported as below the benchmark). Students who were absent or withdrawn by parents/caregivers from the testing, and students attending a school not participating in the testing, are not included in the data.

(b) Methods used to identify Indigenous and students with a language background other than English (LBOTE) varied between jurisdictions. There is likely to be some overlap between these two groups.

Notes

1. Numeracy benchmark results were not reported in 1999.
2. Reading, writing and numeracy benchmark results for Year 7 students have only been published for 2001 and 2002.

Sources: MCEETYA 2001, 2002.

Population literacy

Prose literacy refers to the knowledge and skills needed to understand and use information from various texts, including newspapers, brochures and instruction manuals, in daily activities at home, at work and in the community (OECD 2000). The Survey of Aspects of Literacy conducted by the ABS in 1996 is the latest source of such information relating to Australian adults.[5] Prose literacy was measured using a five-point

5. The Australian Literacy and Lifeskills Survey will be conducted in 2006 and will update data from the 1996 Survey of Aspects of Literacy.

scale, in which Level 3 or above was deemed to be the level at which people could cope with many printed materials found in daily life (ABS 2002c).

In 1996, 53% of the population aged 15–74 years were at Level 3 or above for prose literacy. Younger people tended to have higher levels of literacy than older people. Rates were highest in the 20–24 year age group (64%) and lowest among people aged over 55 years (35% for those aged 55–64 and 24% for those aged 65–74). A greater proportion of females than males had prose literacy of Level 3 or above for most age groups. However, this situation was reversed for people aged over 55.

Greater proportions of Indigenous Australians had low literacy skills compared with the general population in 1996—41% at Level 1 compared with 20% (ABS 1997b). People for whom English was not their first language were also more likely to have lower prose literacy levels (48% at Level 1).

Economic resources and security

Income-based indicators are commonly used to measure and describe economic wellbeing. However, the income a household receives at any point in time may not give a full picture of economic wellbeing. For some households, income fluctuates markedly over time, so current income may not be a reliable indicator. Some households have greater financial commitments than others and need more income to achieve a given standard of material wellbeing, and some households have more assets than others, which may provide a buffer during periods of lower income. In this section, indicators of financial stress and household wealth are reported along with data on income distribution and income disadvantage, to give a more complete picture of economic wellbeing.

Income and income distribution

Equivalised disposable household income is used here as a basis for the indicators of income level, distribution, and disadvantage. Disposable income is gross income less direct tax and Medicare levy. This measure is adjusted for differences in household composition and size using an equivalence scale, to better reflect the level of economic wellbeing of each member of the household.[6]

In 2002–03, median equivalised weekly disposable household income was $448 per week (Table 2.17). Median income in the highest income quintile ($870) was nearly double this figure, and that of households in the lowest quintile ($218) was less than half the overall median. In real terms, median income increased by 14% between 1994–95 and 2002–03.

6. Equivalence scales are sets of ratios that show the relative income levels required for households of different size and composition to maintain a similar standard of living. Income data in this section have been standardised to the income requirements of a single person household, using the 'modified OECD' equivalence scale (see ABS 2004b: Appendix 3).

Mean equivalised weekly disposable income across all households ($510) was higher than median income, reflecting the effect on this measure of the very high incomes of a small proportion of households at the top of the income distribution.

Table 2.17: Weekly household equivalent disposable income, by quintile, 2002–03 (dollars)

	Weekly household equivalent disposable income quintile[a][b]					All households
	Lowest	Second	Third	Fourth	Highest	
Median income ($)	218	325	448	602	870	448
Mean income ($)	195	325	449	603	975	510

(a) The modified OECD equivalence scale has been used to facilitate comparisons of income levels across different household types. Data have been standardised to the income requirements of a single-person household.

(b) Quintiles have been calculated by ranking persons on the basis of weekly household equivalent disposable income and allocating an equal number of persons to each quintile.

Source: ABS 2004b.

Income is distributed asymmetrically in Australia, as in most countries, with a relatively small number of people in very high-income households and a large number of people in low-income households. The concept of income inequality is difficult to capture in a single indicator, as unequal distributions of income can occur in many different ways. However, looking at trends in a range of different measures, the ABS has concluded that income inequality appears to have risen over the period 1994–95 to 2002–03[7] (ABS 2004b). The share of total income received by people living in low-income households decreased, while the share received by people in high-income households increased (although only the former change is statistically significant at the 95% confidence level) (Table 2.18).

Table 2.18: Share of total income received by persons in low-income[a] and high-income[b] households, 1994–95 to 2002–03 (per cent)

	1994–95	1995–96	1996–97	1997–98	1999–2000	2000–01	2002–03
Low income[a]	10.8	11.0	11.0	10.8	10.5	10.5	10.6
High income[b]	37.8	37.3	37.1	37.9	38.4	38.5	38.3

(a) Persons in the second and third lowest income deciles.

(b) Persons in the highest income quintile.

Note: Data are not available for the years 1998–99 and 2001–02.

Source: ABS 2004b.

7. While most of the indicators considered by the ABS suggested growing inequality over the period, only two showed a trend that was statistically significant at the 95% confidence level.

Measures of disposable income do not take account of indirect taxes paid, government services received, or non-market activities (e.g. unpaid household work) that contribute to material living standards. The tax and transfer system in Australia redistributes income between households. Analysis focusing on the effects of major Australian Government direct and indirect taxes, cash transfers and non-cash benefits (e.g. government-provided health services) found that, in 2001–02, there was a net transfer from the most affluent 40% of Australians to the less affluent 60% (Harding et al. 2004). Aged and sole-parent households benefited most from this redistribution, while couples without children and single people on average paid more in taxes than they received in benefits. There was a general pattern of redistribution between households at different stages of the life-cycle, from younger households without children to older, retired households (Lloyd et al. 2005).

Using the Gini coefficient as a measure of the inequality of distribution of equivalised disposable household income,[8] Australia was close to the average for OECD countries around the year 2000 (Förster & d'Ercole 2005). Denmark had the least income inequality of all OECD countries, followed by Sweden and the Netherlands.

Income disadvantage

The indicator presented here focuses on households which have very low income relative to that of all households and which may, as a consequence, experience relatively low material living standards. A measure that has commonly been used in Australia and internationally is the proportion of households with equivalised disposable income below 50% of the median for all households (OECD 2005b). However, as 50% of median income is close to the value of some government benefits (e.g. the Age Pension), this measure may be sensitive to small changes in income support payments. Therefore, a suite of three measures is presented here—the proportion of households with income below 40%, 50% and 60% of median income—to give a more meaningful picture of income disadvantage.

In 2002–03, nearly 2.2 million Australians, including almost 501,600 children aged under 15, lived in households with an equivalised weekly disposable income below 50% of the median (Table 2.19).[9] Using this measure, 14% of households, 13% of children, and 11% of persons, were living in income disadvantage. Almost 4 million Australians (20%) lived in households with income that fell below the 60% median income threshold, and 989,000 (5%) lived in households with income below the 40% threshold.

8. The Gini coefficient is a single statistic that lies between 0 and 1 and summarises the degree of inequality, with values closer to 0 representing a lesser degree of inequality, and values closer to 1 representing greater inequality.
9. It should be noted that income data for households that report very low or negative current income may not accurately reflect the living standards of those households. Low or negative current income may be due to losses incurred in an unincorporated business or negative returns from investments. Many such households have higher expenditure levels than would be suggested by their low reported income, perhaps because they are able to draw on accumulated wealth or because their low income is temporary (ABS 2004b).

Table 2.19: Income disadvantage: households with weekly equivalised disposable income below 40%, 50% and 60% of the median for all households, and people and children living in those households, 2002–03

	Households	Children aged <15 living in low-income households	All persons living in low-income households
Below 40% median weekly equivalent disposable income			
Number ('000)	464.2	238.9	988.6
Per cent	6.1	6.1	5.1
Below 50% median weekly equivalent disposable income			
Number ('000)	1,101.5	501.6	2,178.5
Per cent	14.4	12.9	11.3
Below 60% median weekly equivalent disposable income			
Number ('000)	1,871.8	862.3	3,912.4
Per cent	24.5	22.1	20.3

Source: 2002–03 ABS Survey of Income and Housing Costs (unpublished data).

Trend data for the period 1995–96 to 2002–03 (Table 2.20) suggest that there were increases in the percentages of Australians living in households with incomes falling below each of these three thresholds between the first part of the period (1995–96 to 1997–98) and the second part (1999–2000 to 2002–03). Only the change in the below 50% indicator is significant at the 95% confidence level, although this could reflect small changes in welfare payments that are set at close to 50% of median household income.

Table 2.20: Trends in income disadvantage: Australians living in households with weekly equivalised disposable income below 40%, 50% and 60% of the median for all households, 1995–96 to 2002–03

	1995–96	1996–97	1997–98	1999–2000	2000–01	2002–03
Number of Australians ('000) living in households with equivalent weekly disposable income						
Below 40% of median	856.2	763.1	856.9	973.2	989.7	988.6
Below 50% of median	1,580.2	1,408.3	1,549.4	1,970.7	2,062.1	2,178.5
Below 60% of median	3,334.4	3,388.4	3,427.6	3,858.0	3,883.4	3,912.4
Percentage of Australians living in households with equivalent weekly disposable income						
Below 40% of median	4.8	4.2	4.7	5.2	5.2	5.1
Below 50% of median	8.8	7.8	8.5	10.6	10.9	11.3
Below 60% of median	18.7	18.7	18.8	20.7	20.6	20.3
Median income (in 2002–03 dollars)	388	402	409	429	438	448

Sources: ABS Surveys of Income and Housing Costs, 1995–96, 1996–97, 1997–98, 1999–2000, 2000–01, and 2002–03 (unpublished data).

As well as looking at the number of households that fall below a particular threshold, it is also important to know how far below that threshold they fall. This measure is sometimes referred to as the 'poverty gap'. A comparison of data for OECD countries showed that poverty gaps decreased in the second half of the 1990s in about half of the countries, including in Australia (Förster & d'Ercole 2005).

Financial stress and hardship

In the 2002 ABS General Social Survey, households were asked to report whether they had experienced certain 'cash flow problems' within the past 12 months. These included problems such as being unable to pay certain bills on time, having pawned or sold something because cash was needed, and going without meals.

While experiencing any one of these problems may not necessarily indicate financial stress, a combination of them is more likely to. Overall, 7% of households reported 3 or more cash flow problems in the last 12 months (Table 2.21). Using this indicator, one-parent households were the most likely to experience financial stress (23% did so).

Table 2.21: Proportion of households reporting 3 or more cash flow problems in last 12 months, and proportion of total population, 2002

Household type	3 or more cash flow problems	Proportion of total population
One-parent, one-family household with dependent children	22.9	8.5
Couple-only household (under 65)	3.3	12.8
Couple-only household (65 or over)	**0.1	6.0
Couple with dependent children	6.6	44.4
Lone person aged under 35	14.7	1.8
Lone person aged 35–64	7.9	4.1
Lone person aged 65 or over	*0.8	3.7
All households	**7.2**	**100.0**

Source: ABS 2004a.

Wealth and wealth distribution

Wealth is a source of economic security. Accumulated assets can buffer material living standards during periods of low income and can boost capacity to borrow money.

Analyses of the Household Income and Labour Dynamics in Australia (HILDA) survey showed that in 2002 the average household had a net worth (i.e. assets minus debts) of $404,300, while the median household had a net worth of $218,300 (Table 2.22). This large difference between mean and median household net worth reflects the asymmetry of wealth distribution. In 2002, the least wealthy 50% of households owned less than 10% of total household wealth, while the most wealthy 10% owned 45% of total household wealth (Headey et al. 2004).

Wealth varies with life-cycle stage. Median household net worth was $8,000 for households in which the reference person was aged 15–24 years, and $309,000 for households in which the reference person was aged 65–74 years (see Headey et al. 2004 for criteria used to identify a reference person for each household). The distribution of household income shows the opposite pattern—in 2002–03, mean equivalised disposable household income was highest for younger couples without children, and lowest for lone persons aged 65 and over (ABS 2004b:7).

Table 2.22: Assets, debts and net worth per household, 2002 ($'000)

	Mean	Median[(a)]
Total assets	472.8	270.5
Total debts	68.5	53.2
Net worth	404.3	218.3

(a) The reported medians are for the median household in the 50th and 51st percentiles of net worth, and not the median over the entire distribution.

Source: Headey et al. 2004: Table 3.

According to the HILDA data, housing and other property constituted 54% of household assets overall, and almost 75% of the assets of the median household. Superannuation was the second most significant asset category, accounting for 16% of household assets overall (Headey et al. 2004).

Employment and labour force participation

Income gained through employment provides the main financial means by which people obtain the goods and services they do not produce themselves. Paid work is therefore a major source of material wellbeing, the means by which people not only obtain the basic necessities to sustain life but also finance many social and recreational activities. Furthermore, satisfying and rewarding employment can contribute to personal development, a sense of identity and positive social interactions. The type and amount of work, as well as job security and working conditions, underpin the success of employment in providing these various sources of individual wellbeing.

Employment is also intricately linked to other aspects of a person's life that may affect wellbeing—notably housing, education and health. Furthermore, participation in employment is recognised as a key source of adult participation in society. Employment is, in these ways, an integral part of the 'autonomy and participation' component of welfare.

Trends in employment during the 1990s need to be interpreted in the context that this was a period of sustained economic growth in Australia.

Labour force participation and employment

In 2004, the labour force participation rate was 63.5% for the population aged 15 years or more—71.6% for men and 55.6% for women (Table 2.23). The overall participation rate was fairly steady over the decade, rising only slightly from 62.7% in 1994 (ABS 2005b:108). There was a slight fall in participation rates for men (from 73.6% in 1994 to 71.6% in 2004) and a slight rise for women (from 52.2% to 55.6%). This narrowed the gap between male and female participation rates from 21 percentage points in 1994 to 16 percentage points in 2004 (ABS 2005b). These differences between male and female participation rates should be kept in mind when considering differences in levels of employment and unemployment.

In 2004, an average of 5.8% of the labour force was unemployed—5.6% for males and 6.0% for females (Table 2.23). The overall unemployment rate fell over the decade, from 10.2% in 1994 (ABS 2005b:108). The long-term unemployment rate was 1.2% of the

labour force in 2004, a decrease from 3.5% in 1994. The extended labour force underutilisation rate is a broader measure, developed to take into account unemployment, underemployment and also some groups who are not in the labour force but would like to work (see footnote to Table 2.23). This rate was 12.2% in 2004.

Employment basis and conditions

In 2004, 28.4% of all people employed were part-time workers—14.7% of employed males and 45.6% of employed females (Table 2.23). These proportions have risen since 1994 for both males and females, when they were 10.5% and 42.2% respectively (ABS 2005b:108).

The proportion of workers without leave entitlements rose over the decade, from 23.7% in 1994 to 27.7% in 2004 (ABS 2005b). This change was due largely to the marked increase in the proportion of males without leave entitlements, as the proportion for females remained relatively stable. In 2004, 24.7% of males and 31.2% of females employed full-time had no leave entitlements; in 1994, these figures were 18.1% and 30.8% respectively.

Average weekly hours worked by full-time workers were 40.4 hours per week in 2004, with no noticeable trend since 1994 when the average was 40.7 hours (ABS 2005b). Of those persons employed full-time, 23.4% worked 50 or more hours per week in 2004. Again there was no obvious trend over the decade since 1994 when the figure was 23.7%.

Employment and labour force differentials

Employment and labour force participation vary considerably between age groups. The ages that might be termed 'middle working ages', from 25 to 54 years, share a similar labour force pattern characterised by high rates of participation (over 90% in 2004) and unemployment rates below the national average of 5.8 in 2004 (ABS 2004j). After the age of 55 years, labour force participation rates are found to decrease for each older age group (53.8% for people aged 60–64 years, and 10.9% for people aged 65 years and over, in October 2004), while unemployment rates remain relatively low.

The age group 15–19 years is characterised by relatively low labour force participation rates and relatively high unemployment rates—the unemployment rates for this age group include people attending school or a tertiary institution who are actively looking for work. (See Figure 3.19 in Chapter 3 for employment pattern trends for people aged 15–19 years.) The age group 20–24 years shares some similar characteristics, although its pattern is closer than the younger group's to the 'middle working age' pattern. The employment patterns of young people aged 15–24 years have changed in recent decades, with increases in educational participation and the growing tendency to combine part-time work with full-time study.

People with disabilities have a lower labour force participation rate than the general population (see Chapter 5 for further information). Their participation rate in 2003 was 53% compared with a rate of 81% for people without a disability. Participation rates for people with profound or severe core activity limitations were even lower—15.2% and 36.0% respectively (see Table 5.28, Chapter 5).

Table 2.23: Employment indicators, 2004

	Total ('000)	Total (%)	Males (%)	Females (%)
Employment and labour force participation				
Labour force (LF) size and participation rate	10,146	63.5	71.6	55.6
Employed (number and % of total population)	9,560	47.5	n.a.	n.a.
Unemployed (number and % of LF)	586	5.8	5.6	6.0
Long-term unemployed (% of LF)	n.a.	1.2	n.a.	n.a.
Extended labour force underutilisation rate	n.a.	12.2	n.a.	n.a.
Employment basis and conditions				
Part-time workers (% of total employed)	n.a.	28.4	14.7	45.6
Employees without leave entitlements (% of all employees)	n.a.	27.7	24.7	31.2
Average hours worked (full-time workers)	40.4[(a)]	. .	. .	. .
Full-time workers working 50+ hours per week (% of full-time employees)	n.a.	23.4	n.a.	n.a.

(a) Number is not presented in 1,000s.

Notes

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

Source: ABS 2005b.

Aboriginal and Torres Strait Islander people generally experience higher levels of unemployment and lower levels of labour force participation than non-Indigenous Australians. In 2002, 46.2% of Indigenous people aged 15 years and older were employed, up from 36.3% in 1994 (ABS 2004g). The Community Development Employment Projects (CDEP) scheme accounted for approximately one in four jobs held by Indigenous people in 2002.

After adjusting for the differing age structure of Indigenous and non-Indigenous population, 42.7% of Indigenous people aged 18 years and older were employed compared with 63.5% of other Australians in 2002 (Table 2.24). Indigenous people were also more than twice as likely to be unemployed as non-Indigenous people (9.4% compared with 3.7%), and were more likely to be not in the labour force (47.9% compared with 32.8%).

Table 2.24: Labour force status of persons aged 18 years and over, by Indigenous status, 2002[(a)]

	Indigenous	Other Australians
Labour force status:		
Employed: full-time	23.6	45.2
Employed: part-time	19.0	18.3
Total employed	42.7	63.5
Unemployed	9.4	3.7
Not in the labour force	47.9	32.8

(a) Results have been adjusted to account for differences in the age structure between Indigenous and other Australian populations, and to allow comparisons between the 2002 National Aboriginal and Torres Strait Islander Social Survey and the 2002 General Social Survey.

Source: ABS 2004g:30.

Transport and communication

Access to means of transport and communication is important in enabling people to participate fully in community life. With ongoing advances in technology, communication can act as a substitute for transport in some aspects of life, enabling people to participate in social and cultural activities, work and education, to access services, and to be informed about and have a voice in political issues.

While trends in some of the indicators presented here paint a picture of increasing access to means of transport and communication, inaccessibility remains an issue for certain groups, particularly people with disabilities and people living in regional and remote areas.

Transport

Nationally in 2002, 85% of people aged 18 and over had access to a motor vehicle to drive (Table 2.25). Access peaked among people aged 35–54 years (over 90% in this age group), and dropped to just 54% among those aged 75 and over. For all ages, higher proportions of males than females had access to motor vehicles to drive, but the difference was much more marked in older age groups.

Table 2.25: Access to motor vehicles to drive, 2002 (per cent)

	18–24	25–34	35–44	45–54	55–64	65–74	75+	All persons
Male	79.4	89.6	93.5	95.4	95.5	85.5	75.3	89.7
Female	75.3	88.2	90.9	87.5	81.8	65.5	38.3	80.4
Persons	**77.4**	**88.9**	**92.2**	**91.4**	**88.7**	**75.2**	**53.9**	**85.0**

Source: ABS 2003b.

These patterns of access to motor vehicles closely mirror data on whether people could easily get to the places they needed to go (Table 2.26)—overall, 84% of people said they could do so, while 4% could not, or often had difficulty. Of people aged 75 and over, 11% said they could not get, or often had difficulty getting, to where they needed to go.

Table 2.26: Ease of getting to places needed, 2002 (per cent)

	18–24	25–34	35–44	45–54	55–64	65–74	75+	All persons
Can easily get to the places needed	74.4	85.3	88.1	87.6	89.3	82.5	73.2	84.3
Cannot get, or often has difficulty getting, to the places needed	3.7	3.1	2.7	3.2	3.4	5.2	10.5	3.8

Note: Not all categories are shown for this data item.

Source: ABS 2003b.

Private motor vehicles are the most widely used mode of transport in Australia, even in cities. In Sydney, 70% of weekday trips in 2002 were made in a private vehicle, and only 14% of households did not have a car (down from 18% in 1991) (TPDC 2004). Car usage grew between 1991 and 2001—on average over that period the number of car trips made on a typical weekday increased by 1.8% annually and vehicle kilometres travelled increased by 2.3% annually. Annual population growth was only 1.3% over the same period (TPDC 2005).

Public transport is of particular importance in cities and for people who may not be able to afford or drive a car. National data on public transport use and accessibility are very limited. In Sydney in 2002, trains and buses together accounted for 11% of weekday trips. Of people who travelled to work by car, 36% gave the unavailability or inaccessibility of public transport as a reason why they used a car (TPDC 2004).

Accessible public transport can also be an important facilitator of participation in economic, social and cultural life for people with disabilities. In 2003, 39% of people aged 5 years and over with a disability used public transport (ABS 2004k). Nearly a third (30%) said that they had difficulty using public transport and, of these people, 44% reported difficulty with getting into or out of vehicles or carriages due to steps. These figures are similar to those from the 1998 disability survey, which could suggest that the accessibility of public transport for people with disabilities did not improve markedly between 1998 and 2003.

Communication

Communication involves both transmitting and receiving information. Indicators of people's ability to communicate may include measures of the accessibility of the technological means of communication (e.g. telephones, Internet, and communication aids such as tele-typewriter phones) as well as measures of the freedom and quality of the press, and individual freedom to communicate and express views. The indicators presented here focus on access to telephones and the Internet, as these are two key means of communication on which data are readily available.

Telephone access

The number of fixed phone lines and mobile phones increased markedly over the period from 1993 to 2002, from 52 to 118 per 100 Australians (International Telecommunications Union 2003, cited in ABS 2004a). This rise was largely driven by an increase in numbers of mobile phones—by 2002, 72% of households had a mobile phone (ABS 2003d). This apparent increase in access was accompanied by a fall in the price of telecommunications over the period 1994–95 to 2002–03 (ABS 2004l).

The code division multiple access (CDMA) terrestrial mobile phone network is the larger of the two networks that operate in Australia, the smaller being the global system for mobile communications (GSM). In 2003–04, the CDMA network covered around 20% of Australia's land area and over 98% of the population (ACA 2004). This is an increase from 13% of land area and 97% of the population in 2001–02 (ACA 2002). There is a government-funded satellite phone subsidy, to help improve phone access in areas not covered by the terrestrial mobile phone networks.

The use of payphones has been declining over recent years; the number of payphones Australia-wide dropped by 14% between 2000–01 and 2003–04 (ACA 2004). However, payphones remain an important means of communication, particularly for certain groups in the population, such as those who are financially disadvantaged, Indigenous communities and homeless people. In 2003–04 there were 3.2 payphones per 1,000 people in Australia, compared with 5.1 per 1,000 in the USA. The number of Telstra tele-typewriter-equipped payphones, which are used by people with speech or hearing impairments, increased from 88 in 1998–99 to 204 in 2004.

Internet access

The Internet is an increasingly important means of social and business communication, of accessing information and services, and of participating in the cultural, recreational and political aspects of society. The Internet is most commonly accessed through a computer. In 2002, 61% of households had a computer and 46% of households had Internet access (Table 2.27). By 2003, 66% of households had a computer and 53% had Internet access (ABS 2005b). Household Internet access has been increasing steeply, up from just 16% in 1998 (ABS 2004a).

Table 2.27: Households with computers and with Internet access, by income quintile and geographic location, 2002

	Households with computers (%)	Households with Internet access (%)	All households ('000)
Equivalised gross household income quintile[a]			
Lowest quintile	35.0	21.1	1,755
Second quintile	51.9	34.4	1,286
Third quintile	68.3	50.6	1,215
Fourth quintile	74.0	59.6	1,228
Highest quintile	80.5	69.2	1,462
Geographical area			
Major cities	64.0	49.9	5,048
Inner regional	57.9	41.0	1,515
Other areas[b]	48.3	32.6	933
All households	**60.8**	**46.0**	**7,495**

(a) Excludes households where household income was not known or was not adequately reported.

(b) Excludes sparsely settled areas.

Source: ABS 2003b.

Internet access varies with household income—in 2002 only 21% of households in the lowest income quintile had Internet access, compared with 69% of households in the highest quintile (Table 2.27). Access also varies with geographical area—50% of households in major cities had access, compared with 41% in inner regional areas and just 33% in other areas. Indigenous Australians, people with lower levels of educational qualifications and people who do not speak English very well or at all are other groups with much lower levels of Internet use than the general population (ABS: Lloyd & Bill 2004). Of the 4.1 million households without Internet access in 2002, 41% reported lack of interest in, or no use for the Internet as the main reason, while high costs was the main reason for 26% of households (ABS 2004a).

The proportion of people who had accessed the Internet at home in the past 12 months was highest in the 18–24 year age group, and declined steeply beyond age 44 (Table 2.28). In all age groups, a higher proportion of men than women had accessed the Internet from home. Of people aged 15 years and over with a disability in 2003, 61% reported that they had not used the Internet in the last 12 months (ABS 2004k).

Table 2.28: Proportion of people who accessed the Internet at home in last 12 months, 2002

	18–24	25–34	35–44	45–54	55–64	65–74	75+	Total
Males	60.2	54.8	57.2	47.9	35.9	18.9	7.5	46.5
Females	54.2	48.6	53.4	42.4	27.4	8.5	3.3	39.4
Persons	**57.3**	**51.7**	**55.3**	**45.1**	**31.7**	**13.5**	**5.1**	**42.9**

Source: ABS 2003b.

Recreation and leisure

Participation in recreational and leisure activities has important benefits for the physical and mental health and wellbeing of Australians. Recreation and leisure provide people with an opportunity to recover from work and the pressures of life, and offer important opportunities for personal development and physical activity, as well as social interaction and community engagement. So important is the human need for leisure, the United Nations Universal Declaration of Human Rights states that 'Everyone has the right to rest and leisure, including reasonable limitation of working hours and periodic holidays with pay' (UN 1948).

Participation is indicated by the time spent engaged in recreational and leisure activities. This approach enables the recognition of a balance in lifestyle, as time spent on recreation and leisure can be compared with time spent on other activities.

This section reports on how Australians spend their time, using data from the 1997 Time Use Survey (ABS 1998b). It is expected that this survey will be conducted again in 2006 (ABS 2001b). Time use is reported as an average across the whole population aged 15 years and over and across every day of the week. These estimated averages are based on household surveys and diary records kept by survey respondents (for further explanation on how this measure is derived, see ABS 1998b and AIHW: Bricknell et al. 2003). Because people can carry out more than one activity at a time, activities may be tabulated as 'main activities' (for which time used can be summed to a whole day) or else as 'all activities'.

Overall pattern of time use

In 1997, Australians spent almost half (46%) of their time on personal care activities, largely because of the inclusion of 'sleep' in this category, in which people spent an average of 36% of their time (ABS 1998b). Recreation and leisure was the next main activity (19% of people's time each day), followed by employment (14%) and domestic activities (10%).

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

Overall pattern of recreation and leisure activities

Almost half of a person's time spent on recreation and leisure activities involved audiovisual media (130 minutes per day of a total of 268 minutes on recreation and leisure), of which watching television and listening to the radio/CDs accounted for over 90% of this time. Talking was the second most common activity (35 minutes), followed by sports and outdoor activities (27 minutes), and reading (25 minutes) (Table 2.29). A number of differences were apparent between the sexes—females spent more time talking and males spent more time on sporting, outdoor, and audiovisual activities.

Recreation and employment

People who were employed full-time spent the least amount of time on recreation and leisure activities—an average of 30 minutes per day less than those who were employed part-time and 120 minutes less than those who were not employed (Table 2.30). Females spent less time on leisure and recreation than males, regardless of their employment status.

Table 2.29: Time spent on recreation and leisure as main activities, by sex, 1997

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

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

Source: ABS 1998b:18.

Table 2.30: Time spent on recreation and leisure as main activities, by employment status and sex, 1997

	Average daily time (minutes)		
Employment status	**Males**	**Females**	**Persons**
Employed full-time	225	198	217
Employed part-time	304	226	247
Not employed	392	303	337

Source: ABS 1998b:34.

2.4 Social cohesion

Social cohesion is defined here as 'the connections and relations between societal units such as individuals, groups (and) associations' (Berger-Schmitt 2000:2, following McCracken 1998); it is the 'glue' that holds communities together. Cohesiveness is created from connections based on a shared sense of belonging and attachment, similar values, trust and a sense of 'social solidarity'.

Implicit within social cohesion is the concept of social capital. Both conceptual areas have been an increasing focus of government policy and study, and academic research, primarily to gauge elements essential for building and sustaining community strength. This is considered of particular value for disadvantaged areas, where there is emerging evidence that community cohesiveness generates resilience and protects against further disadvantage (see, for example, Vinson 2004). Nonetheless, strong social capital on its own is not always a positive outcome, as it may result in the exclusion or discrimination of 'others'. For societies to be truly cohesive there must also be the purpose to reduce existing disparities and inequalities, and prevent the establishment of social exclusion (Berger-Schmitt 2000).

Family formation and functioning

The concepts of family and social capital are often interlinked in social theory and policy (e.g. Fukuyama 1999; Putnam 1995), with the prediction that factors shaping a cohesive society—trust, social support, and community and civic awareness—are often nurtured and developed within the family. With this comes the view that changes to the family are reflected in changes to the community, primarily that a high incidence of family breakdown produces less cohesive communities. Recent work by Hughes & Stone (2003) suggests some translation of family 'capital' to social 'capital'; however, the effect is on the whole relatively small.

Family formation

Families are 'embedded within society' and hence responsive to both social and economic changes (De Vaus 2004). In the last three decades, families have undergone considerable transformation, in both their composition—increases in de facto relationships, and couple-only and single-parent families—and their pattern of formation and dissolution, with decreases in registered marriage rates and fertility rates, and an increase followed by a decrease in divorce rates (AIHW 1997, 1999, 2001, 2003a;

De Vaus 2004; and see Chapter 3, Section 3.3, for further data on family formation and dissolution). Indicators of family formation described here include social marital status, family type and age-specific divorce rates.

Social marital status

Social marital status indicates persons in registered marriages and persons in de facto marriages, and includes both opposite-sex and same-sex couples among de facto marriages.

The percentage of persons aged 15 years and over in registered marriages declined from 56% in 1991 to 47% in 2001; the percentage of de facto marriages rose from 4% to 7% in the same period (Table 2.31). The proportion of people who were not married (i.e. never married, or separated, divorced or widowed) fell from 40% in 1991 to 37% in 2001. Because 9% of Australians were categorised within the 'not applicable' category in 1996 and 2001, these patterns in social marital status should be interpreted with caution.

De facto marriages were more common among younger couples, particularly those aged 25–34 years (ABS 2003e). Correspondingly, the greatest increase in de facto relationships between 1991 and 2001 occurred in this age group, from 8% to 14%.

Table 2.31: Social marital status of Australians aged 15 years and over, 1991, 1996 and 2001 (per cent)

	Registered marriage	De facto marriage[(a)]	Not married[(b)]	Not applicable[(c)]	Number ('000)
1991	56.2	4.2	39.6	n.a.	13,017.7
1996	49.4	5.5	36.5	8.6	13,914.9
2001	47.2	6.7	37.0	9.1	14,856.8

(a) In 1996 and 2001, de facto marriage includes same-sex couples.

(b) In 1991, not married includes 'Persons in non-classifiable households, 'Persons in non-private dwellings', 'Persons in migratory or off-shore CDs' and 'Visitors (from within Australia)'.

(c) In 1996 and 2001, not applicable includes 'Persons in non-classifiable households, 'Persons in non-private dwellings', 'Persons in migratory or off-shore CDs' and 'Visitors (from within Australia)'.

Source: ABS 2003e: Table T05.

Family type

Family structure is sensitive to social and economic trends. In Australia, for example, the decline in fertility means that more couples live together without children; relationship breakdown and remarriage are related to an increase in one-parent, step and blended families; and increased longevity means a greater number of persons living alone or in couple-only families (De Vaus 2004:7).

In 1976, the predominant family type in Australia was a couple with dependent children—48% of all family types (Table 2.32). By 2001, couples with dependent children had dropped to 39% of all family types, similar to couple families with no children (36%, a rise of 8 percentage points since 1976). The proportion of one-parent families with dependent children also rose, but not quite so markedly, from 7% to 11% respectively (see Table 3.4, Chapter 3, for additional data on family structure).

Table 2.32: Australian family types, 1976–2001 (per cent)

	1976	1981	1986	1991	1996	2001
Couple family with no children	28.0	28.7	30.3	31.4	34.1	35.7
Couple with dependent children	48.4	46.6	44.8	44.4	40.6	38.6
Couple family with non-dependent children	11.1	10.0	10.9	9.5	9.0	8.4
One-parent family with dependent children	6.5	8.6	7.8	8.8	9.9	10.7
Other families	5.9	6.0	6.2	5.9	6.4	6.5

Note: Other families include one-parent families with non-dependent children.

Source: De Vaus 2004 (based on ABS Census data).

Age-specific divorce rates

Between 1983 and 2003, the pattern in age-specific divorce rates for registered married couples varied depending on age group. Divorce rates declined among younger (under 35 years) Australians of both sexes, stayed much the same for 35–44 year olds, and rose slightly for those aged over 45 years (Table 2.33). In 1983, husbands aged 30–34 years and wives aged 25–29 years experienced the highest divorce rates (15.3 and 15.9 respectively). By 2003, the highest rates were experienced in older age groups—35–44 years for husbands (12.6) and 30–39 years for wives (13.1). This upward shift is probably related to later age of marriage and an increase in the duration of marriages before divorce (De Vaus 2004:214).

Table 2.33: Age-specific divorce rates,[(a)] 1983, 1993 and 2003

	<24	25–29	30–34	35–39	40–44	45–49	50–54	55+
Husbands								
1983	1.9	12.3	15.3	14.2	12.5	9.9	7.2	2.7
1993	1.0	8.5	13.1	13.1	12.8	10.8	8.4	2.7
2003	0.4	5.3	10.8	12.6	12.6	11.7	9.5	3.6
Wives								
1983	4.3	15.9	15.0	13.3	10.9	8.2	5.2	1.4
1993	2.3	12.5	13.9	13.2	11.5	9.4	5.9	1.3
2003	1.1	8.5	13.1	13.1	12.3	10.5	7.3	1.9

(a) Per 1,000 estimated resident males and females respectively, at 30 June for each year shown. In *Australia's Welfare 2003* the rates were per 1,000 married men and women.

Note: Overall divorce rates were not published in ABS (2005e).

Source: ABS 2005e.

Family functioning

How successfully a family 'functions' is influenced by the strength and quality of family relationships (i.e. cohesion) and the support family members offer one another (Amato 1998; Coleman 1988; Furstenburg & Hughes 1995). A well-functioning family could thus be envisaged as one which communicates well, maintains strong relations, and is resilient during episodes of stress.

Despite the importance attached to family functioning, particularly with relation to child wellbeing, there has been little progress in developing a single measure of family functioning. One potential measure described in *Australia's Welfare 2003* (AIHW 2003a)

collates responses to questions on the frequency of positive interactions between family members, such as conversation, attention and pursuit of common activities (Amato 1998; Berger-Schmitt 2000; Coleman 1988). Other potential indicators measure family discord and parental disciplinary style (Silburn et al. 1996) or the ability of family members to 'get on with one another' (see AIHW 2005c). These and other measures discussed in the literature, however, are liable to subjective interpretation, both on the part of the reporting family member and the collator of responses. More rigid definitions of functioning and its components are needed to develop a more appropriate indicator.

The antecedents or effects of family dysfunction are more quantifiable. Domestic violence and child abuse/neglect are commonly used indicators of serious family discord and breakdown.

Domestic violence

Domestic violence refers to all potential forms of family violence, including physical, sexual, verbal, psychological and emotional abuse (see a review of definitions in Laing & Bobic 2002), and can have serious consequences for the wellbeing of individuals and families, and the wider community. It is estimated that up to a quarter of young Australians aged 12–20 years have witnessed an incident of domestic violence against their mother or stepmother (NCP 2001), and a review of overseas and Australian literature describes an increased risk of child abuse within families suffering domestic violence (Laing 2000).

With the exception of the Supported Accommodation Assistance Program (SAAP) collection, data on domestic violence remain limited in Australia, and what are available tend to focus on violence inflicted on women by a male intimate partner. There are few or no data on men's experience of domestic violence, nor on the prevalence of violence between same sex partners. (Information on violence directed against men will be available in 2006 from data collected in the ABS Personal Safety Survey.) The data on women's experience of domestic violence are undermined by problems of under-reporting—at least two studies have shown that only a small proportion of women contact police or domestic violence crisis services while in abusive relationships (ABS 1996a; Keys Young 1998).

The 1996 Australian Women's Safety Survey found that 8% of women currently in a relationship had experienced domestic violence from their partner; around 3% had been victims of either physical or sexual violence in the 12 months preceding the interview (ABS 1996a). More recent data on domestic violence have been published by the Australian Institute of Criminology, drawn from the Australian component of the International Violence against Women Survey. In this survey, domestic violence, or intimate partner violence, was defined as 'actual or threatened physical, sexual, psychological or emotional violence involving current or former spouses (married and de facto partners) or current or former boyfriends' (Mouzos & Makkai 2004:42). Just under 5% of women interviewed reported experiencing intimate partner violence over 12 months prior to the December 2002—June 2003 survey; 34% had experienced at least one form of intimate partner violence over their lifetime. In the 2002 Crime and Safety Survey, 35% of women reported being assaulted by a family member, of whom 60% were a current or former partner (AIHW 2003a).

Domestic violence is a common reason for people, particularly women, to seek crisis accommodation and support. For each period starting 1996–97 through to 2003–04, domestic violence was the main reason clients sought assistance through SAAP for 20–24% of support periods (AIHW 2003a, 2004b, 2005d). In 2003–04, females seeking SAAP assistance because of domestic violence were accompanied by 31,800 children, who were provided with an estimated 32,700 support periods (AIHW 2005e).

Child abuse and neglect

Child abuse and neglect may result from family breakdown and domestic violence, lack of parenting skills, coping issues, and external factors such as social isolation. Estimates of prevalence are difficult to obtain and in Australia are inferred from reports provided by child protection agencies. One indicator of abuse and neglect is the rate of children who were the subject of a child protection substantiation. Notifications of child abuse to community services departments are substantiated if there is reasonable cause to believe that a child has been, was being or is likely to be abused, neglected or otherwise harmed. (See also the section on child protection in Chapter 3.)

The trend in rates of children in substantiations between 1998–99 and 2003–04 varied across jurisdictions and for most states and territories did not follow a particular pattern (Table 2.34). Only Queensland showed a steady change in rates, in this case an increase from 5.1 per 1,000 children in 1998–99 to 14.0 in 2003–04. Interpretation of these trends is complicated by changes to policies and procedures, in particular in New South Wales, Queensland, Tasmania and the Australian Capital Territory, where new Acts have been introduced in the last 5 years, combined with heightened public awareness and willingness to report child abuse and neglect (AIHW 2005f).

Table 2.34: Rates of children aged 0–16 per 1,000 who were the subject of a child protection substantiation, by state and territory, 1998–99 to 2003–04

Year	NSW	Vic	Qld	WA	SA	Tas	ACT	NT
1998–99	4.4	6.3	5.1	2.5	5.2	1.1	5.2	n.a.[(a)]
1999–00	3.9	6.3	5.6	2.3	5.0	0.7	2.6	6.2
2000–01	4.4	6.6	7.3	2.4	5.0	0.9	2.8	5.8
2001–02	4.8	6.6	8.3	2.4	5.3	1.4	2.7	5.8
2002–03	7.5[(b)]	6.3	10.1	1.9[(c)]	5.8	1.8	3.6	5.5
2003–04	n.a.[(d)]	6.4	14.0	2.0	5.9	3.0	6.7	8.7

(a) Data for 1998–99 were not available.

(b) Data for 2002–03 and previous years should not be compared. NSW implemented a modification to the data system to support
legislation and practice changes during 2002–03 which would make any comparison inaccurate.

(c) The decline in the number of notifications for 2002–03 is associated with organisational and practice charges.

(d) Data for 2003–04 were not available.

Source: AIHW 2005f.

Rates of substantiation in 2003–04 were again highest for children under 1 year and generally declined with age (Table 2.35). Indigenous children were also considerably more likely to be the subject of a substantiation. In Victoria, for example, the substantiation rate was almost 10 times as high for Indigenous children, and in South Australia and Western Australia, 8 times as high. The over-representation of Indigenous

children in child protection substantiations is a consequence of a complex web of factors, including the intergenerational effects of previous separations from family and culture, poverty and disadvantage, and substance abuse (HREOC 1997).

Table 2.35: Rates of children who were the subject of a child protection substantiation, by age, Indigenous status, and state and territory, 2003–04

Age (years)	NSW[(a)]	Vic	Qld	WA	SA	Tas	ACT	NT
<1	n.a	15.6	25.1	5.0	9.1	2.4	14.7	22.6
1–4	n.a	7.3	15.9	2.2	7.3	2.5	8.6	13.0
5–9	n.a	5.9	14.9	2.1	6.6	2.5	6.3	6.5
10–14	n.a	5.9	13.6	1.8	5.2	2.3	5.3	6.6
15–16	n.a	3.3	6.2	0.8	1.8	1.5	3.2	1.5
Indigenous	**n.a.**	**57.7**	**20.8**	**11.2**	**39.9**	**1.6**	**25.3**	**16.2**
Other Australian children	**n.a.**	**5.9**	**13.6**	**1.4**	**4.7**	**3.1**	**6.2**	**3.5**

(a) NSW unable to provide data due to ongoing implementation of data system.

Note: Data from Tas should be interpreted carefully due to low incidence of workers recording Indigenous status at time of substantiation.

Source: AIHW 2005f.

Social and support networks

Support networks can be extensive and embody connections from face-to-face contact with relatives and close friends, to local community groups and online, telephone and other communication with professionals. Support received from any of these sources may come in the form of information, practical help or emotional support. Social and support networks are defined here as those more informal networks between family members, friends and more immediate contacts such as neighbours and work colleagues.

The frequency of contact with family and friends, and particularly the quality of those interactions, build feelings of acceptance, social trust, and shared norms and identities between members of that network. Regular and harmonious contact with a support or social network can have a protective effect on a person's general health, morbidity and mental health (see, for example, Baum et al. 2000; Henderson 1991; Kendler et al. 2005; Seeman 1996) and can improve their ability to deal with stress (Cassel 1976; Monroe & Steiner 1986).

Data on the frequency of contact with families and friends, and sources of support in times of crisis, are collected in the ABS General Social Survey. However, no national data are collected on the quality of these contacts. Quality contact between people not only defines the existence of actual bonds between the persons involved in the relationship (Black & Hughes 2001) but also enables establishment of reciprocal bonds of support among different members of the network.

Contact with family and friends

In 2002, the great majority (over 90%) of Australians aged 18 years and over had contact with family or friends living outside the household (Table 2.36). There were no major differences between the sexes or age groups.

Table 2.36: Australians who were in contact in the last week with family and friends living outside the household, 2002 (per cent)

	Age group								Total
	18–24	25–34	35–44	45–54	55–64	65–74	75+	Total	('000)
Males	95.6	96.1	95.0	94.0	95.8	92.8	92.7	94.9	7,177.00
Females	94.7	97.1	95.4	95.8	96.8	96.2	95.4	96.0	7,237.00

Source: ABS 2003b.

Sources of support

Most Australians seek support from a family member when faced with a crisis (Table 2.37). Friends are another important source of support but much more so for younger age groups. For example, in 2002 Australians aged 18–24 years were equally likely to rely on a friend or a family member as a source of support (82% and 83% respectively). In contrast, only 40% of those aged 75 years or older felt they could seek support from a friend, compared with 82% who reported being able to rely on a family member.

Table 2.37: Sources of support in times of crisis, by age group, 2002 (per cent)

	Age group							
	18–24	25–34	35–44	45–54	55–64	65–74	75+	All persons
Family member	82.9	87.0	82.6	77.6	81.8	82.6	81.5	82.4
Friend	81.5	72.3	71.1	66.3	60.0	46.2	39.8	66.1
Neighbour	25.4	26.3	36.5	38.0	39.9	37.5	40.7	34.1
Work colleague	28.4	29.4	24.9	24.9	16.4	2.1	**0.2	21.5

Notes

1. Categories of sources of support are not mutually exclusive and do not include community, charity or religious organisation; local council or other government services; health, legal or financial profession; and other, as collected in the General Social Survey.
2. Types of crisis support include advice on what to do; emotional support; help when experiencing a serious injury or illness; help in maintaining family or work responsibilities; and provision of emergency money, accommodation and/or food.

Source: ABS 2003b.

Neighbours and work colleagues were less common but not unusual sources of support. Between 37% and 41% of Australians over the age of 35 years nominated a neighbour as a source of support, and persons aged over 75 years were equally likely to rely on a neighbour as they would a friend. (Neighbours are an important resource for older persons in the community (Schwirian & Schwirian 1993; Young et al. 2004).) Work colleagues were also reported by 25–28% aged 18–54 years as a reliable source of support.

Social detachment

For persons already experiencing some level of social exclusion, disengagement from their support network can impact even more harmfully on their ability to rejoin mainstream society. For example, Eyrich et al. (2003) found that periods of homelessness were significantly longer for people unable to count on their family and friends, and lower levels of social support are associated with, and may prompt, engagement in criminal behaviour (e.g. Colvin et al. 2002). Youth are also at a much increased risk of suicide if they have poor social supports (Esposito & Clum 2003).

Two indicators of social detachment are rates of suicide (see 'Safety') and rates of imprisonment. In the last 10 years, the imprisonment rate for all Australians rose from 126.9 per 100,000 in 1994 to 157.1 per 100,000 in 2004, with slight downturns in 2000 and 2002 (Table 2.38). Females made up less than 7% of the prison population in any one year—4.8% in 1995 to 6.9% in 2004 (ABS 2004m).

Table 2.38: Rates of imprisonment, all prisoners and Indigenous prisoners, 1994–2004

Year	All prisoners	Indigenous prisoners
1994	126.9	1,250.6
1995	128.7	1,307.3
1996	132.4	1,405.9
1997	137.3	1,507.7
1998	141.1	1,546.0
1999	150.7	1,737.5
2000	149.7	1,614.2
2001	152.5	1,711.9
2002	150.3	1,689.2
2003	154.9	1,766.5
2004	157.1	1,851.9

Notes

1. Data exclude persons held in juvenile institutions, psychiatric custody and policy custody. Data were collected on all persons held in Australian prisons on the night of 30 June of each reference year, based on administrative records held by corrective services in each Australian state and territory.
2. Rates are per 100,000 population in each age group and are age-standardised. They were derived using resident and estimated Indigenous populations for June of each reference year.

Source: ABS 2004m.

The Indigenous imprisonment rate also rose in this period from 1,251 per 100,000 to 1,852 per 100,000 (Table 2.38). Indigenous persons were imprisoned at a rate 10 to 12 times greater than the overall population between 1994 and 2004 and accounted for 17– 21% of all prisoners over the decade (ABS 2004m:Table 16).

Trust

Trust may be held in familiars (interpersonal trust), casual acquaintances and strangers (social trust), and in public or high-level institutions (civic trust). Social trust is perceived as a more sensitive measure of overall acceptance than interpersonal trust (Cox & Caldwell 2000). Less than half of Australians, however, are socially trusting—in 2003, 39% of Australians (41% of males and 37% of females) responding to the Australian Survey of Social Attitudes (AUSSA) agreed that most people can be trusted. A similar proportion of Australians in the 1990s reported trusting most people, down from 46% in the early 1980s (AIHW 2003a:53).

Civic trust reflects interactions between different strata in society, and potentially promotes better access to resources and socially useful links (Anheier & Kendall 2000; Black & Hughes 2001). Confidence in institutions is often used in Australian surveys as a proxy indicator of civic trust and is again used here for the same purpose.

Table 2.39: Levels of confidence in selected institutions,[a] 1983, 1995, 2001 and 2003

	Federal government	Legal system	Police[b]	Major Australian companies	Trade unions	Armed forces
1983[c]						
A great deal	8.6	11.6	27.4	15.6	4.3	22.2
Quite a lot	46.7	48.9	53.0	63.7	19.8	44.6
Not very much	37.4	34.9	17.3	19.2	55.7	28.5
None at all	7.3	4.6	2.2	1.6	20.2	4.6
1995[c]						
A great deal	2.2	4.9	18.5	5.7	2.9	14.7
Quite a lot	23.9	29.8	57.3	52.8	22.7	52.9
Not very much	53.3	53.2	20.2	36.7	51.9	28.0
None at all	20.5	12.1	4.0	4.7	22.4	4.5
2001[d]						
A great deal	6.2	4.9	13.2	2.9	2.3	26.2
Quite a lot	44.6	31.1	55.0	43.5	24.5	58.2
Not very much	37.8	51.3	27.2	44.3	56.6	14.2
None at all	11.3	12.7	4.6	9.4	16.8	1.4
2003[e]						
A great deal	4.5	4.4	12.6	1.7	3.3	24.3
Quite a lot	34.2	24.2	57.8	37.9	23.6	55.9
Not very much	43.5	46.0	22.7	43.6	45.3	15.6
None at all	14.2	23.5	5.3	10.5	22.6	1.7

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

(b) The 2003 data relate to police in their own state or territory.

(c) Data from Australian Values Survey and World Values Survey.

(d) Data from the 2001 Australian Election Study.

(e) Data from the 2003 Australian Survey of Social Attitudes.

Sources: Papadakis 1999 analysis of 1983 Australian Values Study and 1985 World Values Study; SSDA 2001; AUSSA 2003 unpublished data.

Among a small number of selected institutions, Australians, in 2003, had the highest level of confidence in the armed forces (80%), followed by the police force (70%) (Table 2.39). Confidence in other institutions was considerably lower, with less than 50% of the population holding a great deal or quite a lot of confidence in the federal government, major Australian companies, the legal system and trade unions.

Australians held similar levels of confidence in the police, armed forces and trade unions between 2001 and 2003. Confidence in the armed forces rose from 67% in 1995 to 80% in 2003, while remaining relatively even for trade unions at around 25%. The police force experienced a slight decline in public-held confidence since 1983. Confidence in the legal system, major Australian companies and the federal government fell considerably between 2001 and 2003. This decline in confidence in the former two institutions continued a downward trend observed since 1983. Confidence in the federal government followed a less clear pattern.

Community and civic engagement

Engagement with more formal social networks typifies community and civic participation, and allows individuals who may not normally associate with one another to do so. Some authors argue that interaction with people outside one's informal network builds understanding and acceptance of diversity (Hughes et al. 1999). The formation of 'bridges' between community members enhances social cohesion, by building the 'trust and capacity for collective action within the group' (Stolle & Rochon 1998:48).

Community engagement

Voluntary work is often considered a key indicator of social cohesion, since it demonstrates social trust and social investment. Volunteers tend to be more integrated within their community (Baum et al. 1999; Onyx & Leonard 2000) and so in communities where more people engage in voluntary work, social connectedness is considered more firmly established.

In 2002, 34% of the Australian population reported involvement in voluntary work in the previous 12 months (Table 2.40). A similar proportion (32%) engaged in voluntary work in 2000, up from 24% in 1995. Females were slightly more likely than males to volunteer.

Table 2.40: Participation in voluntary work in last 12 months, by age and sex, 1995, 2000 and 2002 (per cent)

	1995[a]	2000[a][b]	2002[c]
Age group			
18–24	16.6	26.8	28.1
25–34	20.4	27.5	28.8
35–44	31.7	40.1	42.0
45–54	27.7	35.4	39.2
55–64	23.8	32.5	38.0
65–74	23.0	30.3	32.0
75+	14.9	17.8	23.6
Sex			
Males	22.9	30.5	30.6
Females	24.4	33.0	35.1
All persons	**23.6**	**31.8**	**34.4**
Number ('000)	**3,189.4**	**4,395.6**	**4,931.0**

(a) Voluntary activity includes administration/clerical work/recruitment, befriending/supportive/counselling, coaching/judging/refereeing, fundraising/sales, management/committee work, performing/media production, personal care/assistance, preparing/serving food, repairing/maintenance/gardening, teaching/instruction/ providing information, and transporting people and goods (see source for definitions).

(b) Voluntary work for the Sydney 2000 Olympic and Paralympic Games is excluded from the data and thus does not account for the higher rate of volunteering in 2000.

(c) Voluntary work includes sport/recreation/hobby; welfare/community; health; emergency services; education/training/youth development; religious; environmental/animal welfare; business/professional/union; law/justice/political; arts/culture; foreign/international (excluding work done overseas).

Sources: ABS 1996b, 2001c, 2003b.

Rates of voluntary work varied across age groups but participation was most common among people aged 35–44 years. Participation in voluntary work increased for most age groups during this period, the biggest increase being for those aged 55–64 years—14 percentage points between 1995 and 2002. (Additional information on volunteering amongst persons aged 65 years and over is presented in Chapter 4.)

Just over a quarter (28%) of Indigenous Australians reported participation in voluntary work (ABS 2004g). There was little difference between the sexes and the age groups, although 35% of persons aged 35–44 years volunteered compared with around 25% for other age groups.

Philanthropy is an alternative indicator of community engagement by reflecting the desire to contribute financially to the betterment of other individuals, groups, the community or society in general. Monetary donations made to charitable and non-profit organisations, in which the donor does not receive any benefit from the donation, were made by three-quarters of Australians in 2000 (Table 2.41).

While more recent data are not available, the 'Giving Australia' project, which commenced in 2004, plans to examine in part current levels of, attitudes to and motivations for philanthropic giving by both individuals and businesses in Australia (see <http://www.partnerships.gov.au/philanthropy/philanthropy_research.html>). A report is planned for publication late in 2005 which will include data derived from individual giving and business community involvement surveys.

Table 2.41: People who made monetary donations to charities and non-profit organisations, by volunteer status, 2000

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

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

Source: ABS 2001c.

Civic engagement

Civic engagement is an extension of community engagement, delineating more 'active' participation in political and more civically oriented organisations or events. Such

active participation ranges from involvement in protest meetings and signing petitions to regular commitment to an organisation's activities and holding a decision-making role.

The 2003 Australian Survey of Social Attitudes asked respondents if they were a member, active member or office-holder in specific organisations. Active members were defined as those who were 'regularly involved in an organisation's activities', and office-holders as 'persons with a decision-making role in the group' as well as being regularly involved. These members are considered here as being 'actively engaged' in civic organisations.

In 2003, the percentage of respondents who were office-holders in specific organisations was very low—2% or less (Table 2.42). The proportion who were active members was not much higher, at 6% or less. Overall active membership (i.e. office-holders and active members) was largest for groups helping people with special needs and neighbourhood/community groups (both 7% of all respondents).

Table 2.42: Active membership in various civic organisations, 2003 (per cent)

	Level of membership				
	Office-holder[(a)]	Active member[(b)]	Member[(c)]	Does not belong	Total
Union	0.6	2.1	17.1	80.2	100.0
Political party	0.1	0.6	3.0	96.2	100.0
Lobby group	0.4	1.1	2.6	96.0	100.0
Group promoting human rights	0.5	1.5	3.6	94.3	100.0
Environmental group/aid organisation	0.3	1.5	8.8	89.3	100.0
Neighbourhood or community group	2.0	4.6	13.7	79.9	100.0
Group helping people with special needs	1.2	5.6	7.6	75.5	100.0
Self-help/consumer group	0.2	1.4	6.6	91.8	100.0

(a) Office-holders include persons who have a decision-making role in the group as well as participating in activities and paying membership fees etc.

(b) Active members include persons who are regularly involved in an organisation's activities as well as paying membership fees/subscriptions or making donations.

(c) Members include persons who pay membership fees/subscriptions or make donations, but do not get actively involved in the activities or running of the organisation.

Source: AUSSA 2003 unpublished data.

2.5 Conclusion

The 13 indicator topics presented in this chapter—under the welfare components of healthy living, autonomy and participation, and social cohesion—provide an updated picture of the welfare of the Australian population, and a context for the other chapters in this report.

This chapter represents the third stage in the development of indicators of Australia's welfare. The first stage, in 2001, described the development of the framework, and the second stage, in 2003, presented data against indicator topics. The third stage, reflected

here, further refined the indicators, added new data, and included trend analyses where possible. National data, particularly in the area of social cohesion, have been improved recently with collections such as the ABS General Social Survey and the National Aboriginal and Torres Strait Islander Social Survey.

The welfare of Australians

Healthy living

Overall, the health of the Australian population is good. There have been considerable improvements over the last century in life expectancy and infant mortality, although still not realised for Aboriginal and Torres Strait Islander peoples. Our health is supported by relatively low levels of air pollution in our capital cities, enjoyment of a nutritious diet, and regular engagement in physical activity. Most Australians are also adequately housed, with 70% either owning or buying their house, and many feel safe in their community.

Areas of concern, however, exist. Obesity rates have been rising in all age groups and an increase in sedentary behaviour, coupled with a sizeable proportion of Australians not consuming the recommended daily amounts of fresh fruit and vegetables, indicate risks to the population's health. Suicide continues to be the leading cause of injury among males, particularly younger males, where the suicide rate is higher than for transport-related injury deaths and 3.7 times higher than the suicide rate for females.

A proportion of Australians are also having difficulties accessing affordable and secure housing, with 20% of low-income households at risk of housing affordability problems, and around 100,000 Australians homeless.

Autonomy and participation

Educational and labour force participation continue to improve in Australia. Around three-quarters of secondary school students now stay to Year 12, and over 80% of Year 3, 5 and 7 students meet literacy and numeracy benchmarks. Labour force indicators suggest a similarly positive picture—unemployment rates have declined since 1993, and relatively high labour force participation rates (63.9%) have remained steady, with a small rise in female and Indigenous participation over the last 10 years. Counter to these favourable findings are indications of worsening working conditions, in particular an increase in the number of employees who do not have leave entitlements (around 28% in 2004), and a move towards longer working hours.

Australian households, on average, are enjoying rising levels of economic wellbeing in terms of their disposable income. As with health, results are mixed. While there is some evidence that the distribution of disposable income has become more unequal over the past decade or so, there is also evidence that the effect of government taxes and benefits tends to mitigate this inequality. Nonetheless, there is inequality in the distribution of economic resources in Australia, with the top income quintile receiving 38% of total household disposable income, and the top wealth quintile owning 63% of total household wealth. Measures of both income and wealth show strong life-cycle effects, with younger households tending to have higher income while older households have greater wealth. The measure of financial stress reported here indicates that one-parent households are more likely than other household types to struggle financially.

Social cohesion

The majority of Australians are confident they can rely on their support network in times of crisis, and they make contact with family and friends on a weekly basis. A third of Australians also spend their time engaging with the wider community, mostly as volunteers, and three-quarters donate money to charities and non-profit organisations. Only a small percentage, however, could be described as civically engaged, in terms of being regularly involved in the activities of a political, advocacy or community organisation. These patterns of communication and interaction within and between social groups suggest well developed cohesiveness among the Australian population, although less than half of Australians are socially trusting (i.e. of less well-known acquaintances and strangers).

The benefits of cohesiveness still elude some members of the Australian population, who for various reasons seem separated from support networks. Domestic violence and child abuse remain very real for some Australian women and children, and suicide rates, especially for young men, are still high, at over 25 deaths per 100,000 males aged 15–29 years in 2003. Rates of imprisonment have increased markedly, especially for Aboriginal and Torres Strait Islander people, who were 10 to 12 times more likely to be imprisoned than the overall Australian population between 1994 and 2004.

Overall welfare

Many, if not all, of the indicators presented in this chapter are influenced by one another, and act in concert to affect the welfare of the individual and of the population as a whole. These indicators suggest that the wellbeing of the Australian population is generally good, but that there are a number of areas for improvement. There are certain population groups, such as Aboriginal and Torres Strait Islander people, who experience disadvantage across multiple areas. Other groups, such as younger Australians, illustrate mixed patterns with many positive effects of life in Australia but some areas of considerable or emerging concern.

Future reports will include more trend analyses on the status of welfare among the Australian population and in the key factors affecting individual, community and national wellbeing.

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3 Children, youth and families

3.1 Introduction

Children and young people in Australia are growing up in an environment of rapid social and economic change. The impact this is having on their development, health and wellbeing has received growing attention over the last 5 years. Further, there is an extensive body of evidence that points to the long-term benefits that can be gained by investing in a child's early years. Childhood, particularly early childhood, has emerged as a key priority for governments and non-government organisations.

This chapter provides a contemporary profile of Australia's children, youth and families in a context of change. It captures the dynamic and diverse nature of childhood, adolescence and family life. Section 3.2 begins with a socio-demographic overview of children and youth from the 1980s, and presents population projections to 2026. Section 3.3 describes the characteristics of Australian families over the last decade. Section 3.4 presents information on trends in adoptions. Sections 3.5 and 3.6 examine the transitions in a young person's life: from early childhood to child care, preschool, school, higher education and finally to employment. Section 3.7 considers some of the risks associated with growing up and their outcomes—abuse, victimisation and homelessness. As child neglect is regarded as one of the strongest predictors of later youth offending, this section considers juvenile offending in a welfare context. The final section, 3.8, outlines some new national data collections that are being developed to provide a better basis for future policy and planning.

Broad policy framework for children and youth

In September 2001, the Australian Government established a Task Force on Child Development, Health and Wellbeing, to develop a whole-of-government approach to the early years of life. A major responsibility of the task force was to lead the development of a National Agenda for Early Childhood. The task force brings together policy makers across Australian Government departments to coordinate efforts to improve outcomes for children. In 2003, it published a consultation paper on the National Agenda (Commonwealth Task Force on Child Development 2003) which was used to create a draft policy framework. This focuses on four key action areas: healthy young families, early learning and care, supporting families and parenting, and creating child-friendly communities. The National Agenda is expected to be released by the end of 2005, after final consultations with state and territory governments.

Central to the National Agenda for Early Childhood is the capacity to be able to regularly monitor how Australia's children are faring, and how certain population groups, such as Indigenous children and children from rural and regional Australia, are faring by comparison (ACCAP 2004). Contributing to this process, several states and territories have commissioned reports monitoring the progress of children within their

jurisdiction (Centre for Epidemiology and Research 2002; NSW and Queensland Commissions for Children and Young People 2004; Tennant et al. 2003).

Most states and territories have also developed early childhood and parenting policies. In 2002, New South Wales introduced the Families First policy which is an early intervention and prevention strategy aimed at the parents of children aged 0–8 years. It has areas in common with the National Agenda as its focus is on children's health and wellbeing and community support for families, but it also includes the development of parenting skills (Families First 2003). Since 2002, Victoria has had a Children First policy, which focuses on developing services for children and families, such as children's centres, improved funding of preschools, helping children with special needs, protecting children from abuse, and improving neonatal and postnatal care and services (Bracks 2002). In 2004 the ACT launched its Children's Plan, which caters for children up to 12 years of age. The plan takes elements from all of the above-mentioned policies. For example, it looks at neonatal and postnatal services, access to education, protection of children, community services and participation of children in activities (ACT DHCS 2004). Western Australia has developed many policies in relation to children, but its most comprehensive policy is the Early Years Framework, which is centred around children aged 0–8 years and their families. This policy aims to create a cohesive approach to child and family services: community support for children and families, prevention and early intervention for children's health, and 'safety-net' type services (WA DCD 2004).

In addition to their policies focused on children, the Australian Government and all states and territories have created policies for youth. Nationally, the Australian Government has published *Living Choices*, a comprehensive guide to policies and programs related to the needs of young people (FaCS 2003). In terms of education and employment, the Ministerial Council on Education, Employment, Training and Youth Affairs has been instrumental in the advancement of youth issues. In 2002, representatives from the Australian Government and state and territory governments signed a declaration called Stepping Forward: Improving Pathways for All Young People that committed all jurisdictions to 'developing practical ways to increase the social, educational and employment outcomes of Australia's young people' (MCEETYA 2002a). This has established a common direction in developing transition opportunities for young people, particularly those most at risk.

At the state and territory level, New South Wales has created a youth policy independently of this declaration called Working Together—Working for Young People, which has very similar aims to the declaration (Office of Children and Young People 2002). The Northern Territory has a policy framework called Building a Better Future for Young Territorians, which is aimed at children and young people aged 12–25 years. It is similar to that proposed by New South Wales in that it focuses on providing opportunities for participation. However, it is also concerned with improving the health and wellbeing of youth (NT Office of Youth Affairs 2004). South Australia has recently released its policy framework, Youth Action Plan, which covers all of the above mentioned areas in its key goals (Office for Youth 2004). The Australian Capital Territory has produced the ACT Young People's Plan 2004–08, which emphasises participation and successful transitions (OCYFS 2004). In Victoria, the youth policy framework, Respect: The Government's Vision for Young People, aims to provide a common approach to future developments in youth policy and programs (DVC 2002).

Tasmania is has released a report called State of our Youth (Tasmanian Office of Youth Affairs 2002), which outlines Tasmania's programs and policies for young people and addresses a similar range of issues. Both South Australia and Queensland have an Office for Youth, and Western Australia, and Office for Children and Youth, which help to develop and coordinate policies, programs and services for young people.

3.2 Australia's children and youth

This section describes Australia's children and youth population, including its size and composition, regional distribution, and cultural diversity. It provides a context for exploring many issues influencing the wellbeing of children and youth. Understanding the size and composition of this population group contributes to good policy decisions about the services required by children and young people, including schools, child care and health and welfare services. In addition, parents' demographic and socioeconomic characteristics also have an impact on the health and wellbeing of children. The family context of Australia's children and young people is discussed in the next section.

Changing demographic profile

There are a number of ways to define children and youth, depending on either the particular data collections or legal requirements. Most commonly, children are persons aged 0–14 years and youth are those aged 15–24 years. While all children aged under 15 years are regarded as dependent on their parents for support, wellbeing and development, the ABS extends the definition of 'dependent children' to young people aged 15–24 years who are full-time students living at home with a parent in the household, and who do not have a partner or a child of their own. Non-dependent children include young people aged 15–24 years who live at home with their natural, step, adopted, foster or blended family and who are not in full-time education.

In most Australian jurisdictions only young people aged 15 years or over are permitted to work or leave school, although in some jurisdictions the legal minimum leaving age is higher than 15 years. Eighteen is the age at which young people legally attain adulthood and are allowed to vote. For many young people it also marks the end of formal schooling and the beginning of the transition to further studies, employment and independent living. Consequently many statistical collections use 18 years as a cut-off point between adolescence and adulthood. The data presented in this chapter use a variety of these definitions, depending on the subject matter under discussion and constraints imposed by the data source.

In June 2004, there were approximately 4 million children aged 0–14 years and 2.8 million young people aged 15–24 years living in Australia. This represented 20% and 14% of the total population respectively (ABS 2004a). When combined, the child and youth population aged 0–24 years account for 6.8 million people or one-third of the Australian population (Table 3.1).

Past and future trends

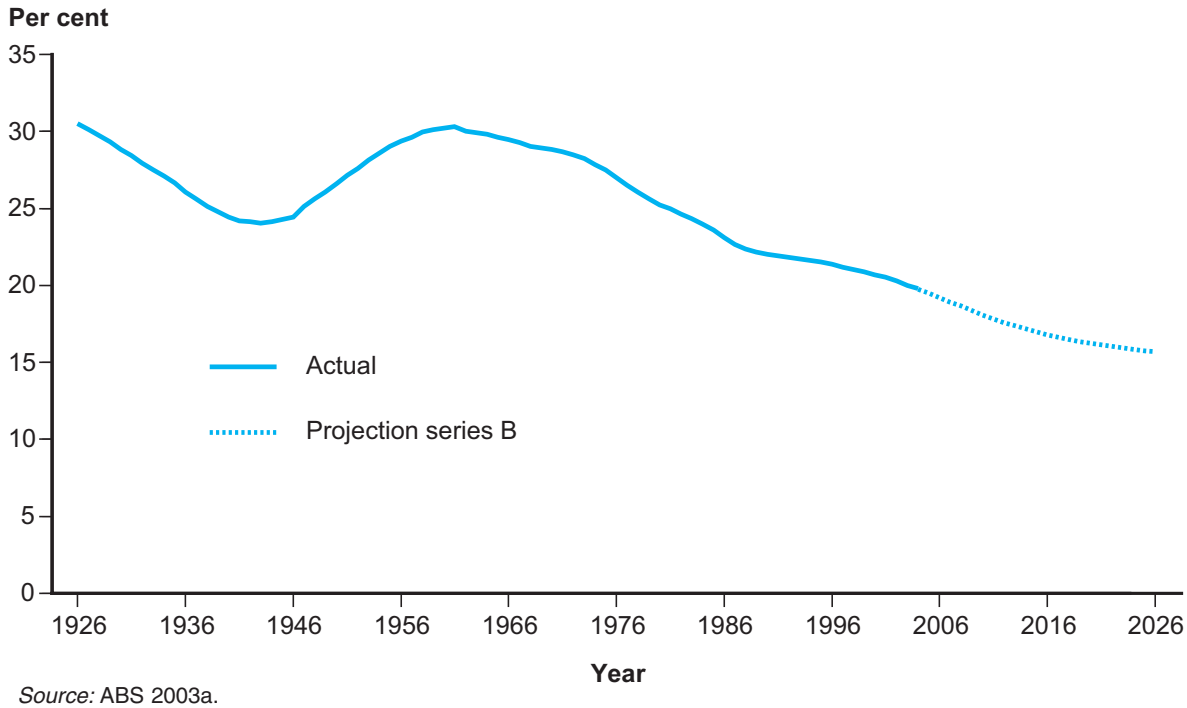
The proportion of children in the population has changed in response to changing fertility patterns. During the early 1920s in Australia, the total fertility rate (TFR) was 3.1 births per woman. The TFR fell to low levels during the Great Depression of the 1930s, reaching its lowest point of 2.1 births per woman in 1934. The TFR rose rapidly

following World War II, reaching a peak of 3.5 births per woman at the height of the baby boom in 1961. Since then, Australian fertility rates have declined for a variety of reasons, including the wider acceptance and use of oral contraceptives, delayed age of child-bearing and increasing proportion of women remaining childless (ABS 2004b). Over the last 6 years the TFR has stabilised and was 1.75 births per woman in 2003.

As a result of these trends in fertility, the proportion of children aged under 15 years in the population fell from the mid-1920s until World War II and rose during the baby-boom years. From a peak of 30% in 1961, the proportion fell to 20% in 2004, well below the previous low point of 24% in 1943 (Figure 3.1). The most recent ABS population projections indicate that if the TFR fell to 1.6 births per woman, the proportion of children in the total population would fall to 16% in 2026 (ABS 2003a). The decrease is mainly caused by the ageing of the population as large cohorts of baby boomers move into older age groups and survive longer than their forebears.

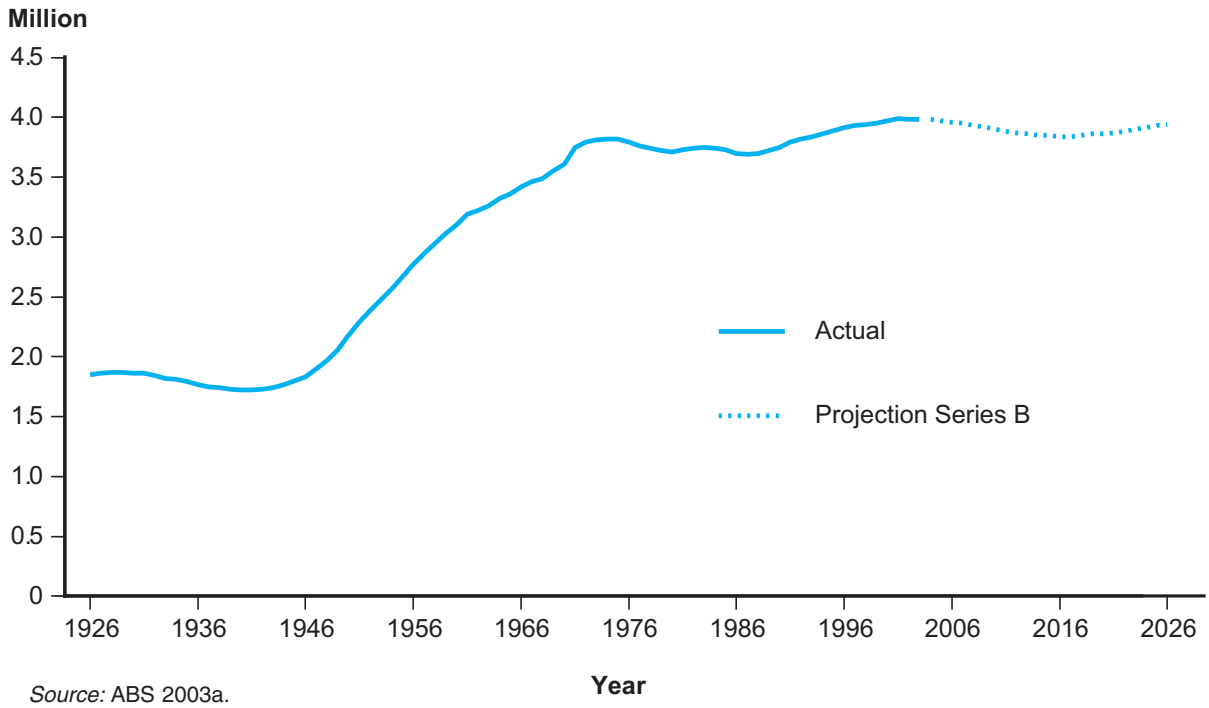
It is important to recognise that while their proportion has been declining since the early 1960s, the number of children increased rapidly until the mid-1970s, remained steady until the 1990s and then began to increase gradually once again (Figure 3.2). The number of children in 2026 is projected to be about 3.9 million, much the same as in 2004.

The relative proportion of children in the population has important implications for planning and the distribution of resources. The resources allocated to children and families may account for a smaller proportion of government spending on services in the future. For example, as the proportion of young people in the population declines, education costs as a share of gross domestic product may fall. A range of social welfare payments including family assistance, parenting allowances and unemployment benefits will account for a smaller proportion of overall government expenditure (SCRCSSP 2005).



Source: ABS 2003a.

Figure 3.1: Children as a proportion of the total Australian population, 1926–2026



Source: ABS 2003a.

Figure 3.2: Children in the Australian population, 1926–2026

Geographical distribution of children and youth

In 2004, one-third of Australian children lived in New South Wales, almost a quarter in Victoria and almost one-fifth in Queensland (Table 3.1). While only 1% of children lived in the Northern Territory, they accounted for more than a quarter of the total population of the Northern Territory itself. This is partly explained by the younger age profile of Indigenous people, who make up a large proportion of the population of the Northern Territory.

Table 3.1: Distribution of children and young people across the states and territories, June 2004

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Australia[(a)]
					Number				
0–14 years	1,326,389	959,572	797,906	399,636	285,832	97,102	63,187	50,560	3,980,951
15–24 years	912,714	687,237	550,951	285,846	206,059	64,570	52,148	30,527	2,790,406
Total population	6,731,295	4,972,779	3,882,037	1,982,204	1,534,250	482,128	324,021	199,913	20,111,297
					Proportion of state or territory population (%)				
0–14 years	19.7	19.3	20.6	20.2	18.6	20.1	19.5	25.3	. .
15–24 years	13.6	13.8	14.2	14.4	13.4	13.4	16.1	15.3	. .
					Proportion of Australian population (%)				
0–14 years	33.3	24.1	20.0	10.0	7.2	2.4	1.6	1.3	100.0
15–24 years	32.7	24.6	19.7	10.2	7.4	2.3	1.9	1.1	100.0

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

Source: ABS 2004a.

In 2003, 64% of children lived in major cities, 22% in inner regional areas and 11% in outer regional areas (Table 3.2). Children living in remote or very remote areas accounted for approximately 3% of the child population. In comparison, a slightly higher proportion of young people aged 15–24 years lived in major cities (69%), and slightly lower in other areas. Compared to other jurisdictions, the Northern Territory had the highest proportion of children and young people living in very remote areas (30% for both cohorts). Of all children living in very remote areas, the vast majority lived in the Northern Territory (31%), Queensland (29%) and Western Australia (27%). The same was true of young people living in very remote areas—34% lived in the Northern Territory, 27% in Queensland and 26% in Western Australia.

Table 3.2: Distribution of children and young people across remoteness areas, June 2003 (per cent)

Remoteness category	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Australia
					Children aged 0–14 years				
Major cities	69.4	70.9	49.9	66.8	68.5	. .	99.8	. .	63.5
Inner regional	21.9	23.4	26.8	13.6	13.9	62.1	0.2	. .	22.2
Outer regional	7.8	5.6	18.7	10.8	12.9	35.6	. .	49.1	11.2
Remote	0.7	0.1	2.8	5.6	3.6	1.8	. .	21.2	1.9
Very remote	0.2	. .	1.8	3.2	1.1	0.5	. .	29.7	1.2
					Young people aged 15–24 years				
Major cities	74.1	76.1	56.1	74.4	75.4	. .	98.8	. .	69.1
Inner regional	19.4	19.7	23.6	11.1	11.2	68.1	0.2	. .	19.4
Outer regional	5.9	4.1	16.8	8.2	9.9	30.1	. .	51.5	9.1
Remote	0.5	0.1	2.1	3.8	2.6	1.3	. .	18.8	1.4
Very remote	0.1	. .	1.4	2.5	0.9	0.4	. .	29.6	1.0

Source: AIHW, derived from ABS Statistical Local Area population estimates.

Indigenous children and young people

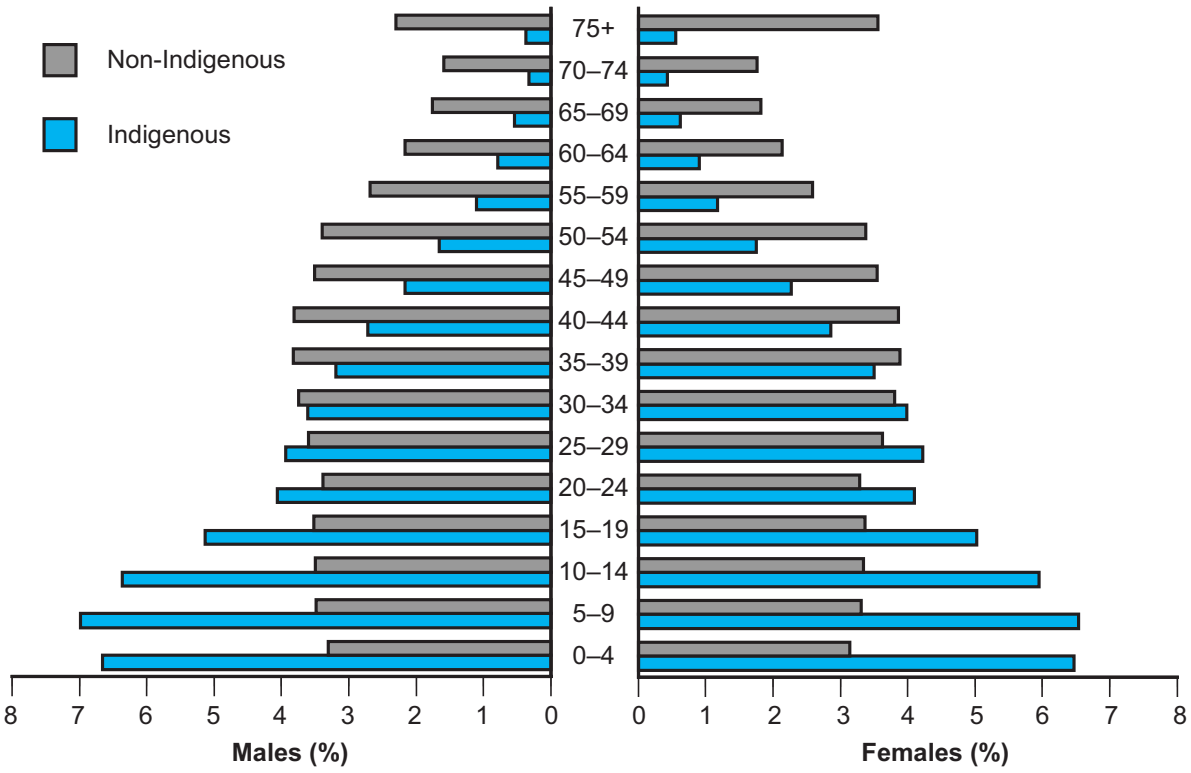
In 2001, Indigenous children made up 4.5% of all children while Indigenous young people made up 3.2% of all young people (ABS 2003b). The Indigenous population has a much younger age structure than other Australians (Figure 3.3). In June 2001 there were 179,000 Indigenous children aged 0–14 years, and 84,000 Indigenous young people aged 15–24 years. Children made up 39% of Indigenous Australians, compared with 20% of other Australians. Similarly, young people made up 18% of the Indigenous population and 14% of other Australians. This reflects both the higher birth rate among the Indigenous population, and higher levels of mortality at younger ages.

Cultural and linguistic diversity

With almost one-quarter of the population born overseas, Australia is one of the most culturally diverse countries in the world. The proportions of children and young people born overseas are somewhat lower than the total population, at 6% and 16% respectively in 2003 (ABS 2004c). However, children born in Australia to overseas-born parents are not included in these figures.

In 2003, of the 227,000 children born overseas, the largest groups were born in New Zealand (19%) and England (11%). Of those born in non-English-speaking countries, the largest groups were from the Philippines and India (4% each), China (3%), and South Korea, Indonesia, Iraq, Sri Lanka, Singapore, Malaysia and Vietnam (2% each).

In all, 430,000 young people were born overseas. Their birthplaces were somewhat more diverse, although New Zealand and England were again the most common countries of birth among this age group (13% and 8% respectively). The impact of overseas students living in Australia long-term can be seen in the other large groups, most of which are non-English-speaking: China and Vietnam (5% each), and the Philippines, Hong Kong (SAR of China), Malaysia, Indonesia and South Africa (all with 4%).



Source: ABS 2003b.

Figure 3.3: Age structure of Indigenous Australian and other Australian populations, 2001

3.3 Australian families

Family formation and dissolution

With changing social attitudes towards marriage and fertility choices, Australian families have changed markedly over the last 30 years (ABS 2003c). Children today grow up in a wider variety of family types. Fewer Australians are entering a registered marriage and those who do are marrying at an older age.

In 2003, the highest registered marriage rates were in the 25–29 year age group (Table 3.3). Between 1997 and 2003 there was a 28% decline in marriage rates for those aged 24 years

and under. Over the same period, there was an increase in marriage rates among older age groups, particularly in the 30–34 year age group (with an increase of almost 14%). Reflecting these trends, the median age at first marriage increased during this period, from 27.8 to 29.2 years for males and from 25.9 to 27.3 years for females. On average, males are about 2 years older than females when they first marry.

Divorce rates increased only marginally over the 1997–2003 period, from 12.5 to 13.1 per 1,000 married people (Table 3.3). In 1991 the rate was 11.6 per 1,000 married males and 11.5 per 1,000 married females (ABS 2004d). (See Table 2.33 for age-specific divorce rates for 1983 to 2003.)

Table 3.3: Indicators of family formation and dissolution, 1997 and 2003

	Males		Females	
	1997	2003	1997	2003
Age-specific first marriage rates[a]				
19 years and under[b]	1.0	0.8	5.0	3.8
20–24 years	26.7	19.2	44.7	34.0
25–29 years	48.9	46.4	47.7	49.2
30–34 years	29.5	33.5	23.1	28.0
35–39 years	15.7	17.5	11.5	13.5
40–44 years	9.4	10.3	7.3	7.9
45–49 years	7.3	7.4	5.8	5.9
50 years and over	3.4	3.5	1.9	2.0
Median age at first marriage	27.8	29.2	25.9	27.3
Divorce rate[c]	12.5	13.1	12.5	13.1

(a) Per 1,000 never married male or female population of the appropriate ages, at 30 June for each year shown.

(b) Per 1,000 never married male or female population aged 15–19 years, at 30 June for each year shown.

(c) Per 1,000 married males or females respectively, at 30 June for each year shown. Rates in 2003 are for 2001 data.

Sources: ABS 1998; ABS 2004e; ABS 2005a.

The proportion of marriages that are de facto has slowly increased and the 2001 Census showed that 12% of people living in couples were in a de facto relationship (including same-sex couples), up from 7% in 1991 (see Table 2.31). Similarly, more recent data from the ABS Family Characteristics Survey showed that 12% of all couples with children aged 0–17 years were in a de facto marriage in 2003 (ABS 2004f).

Family types

The ABS categorises Australian families into two broad groups: couple families, which include intact, step and blended families; and one-parent families. In 2003, couples in both step (56%) and blended families (39%) were more likely than those in intact families (8%) to be in a de facto marriage (ABS 2004f). Table 3.4 shows the distribution of these family types in Australia during 1992 and 2003.

Between 1992 and 2003 the number of families with children aged 0–17 years increased by 5.5%. Both the number and proportion of intact couple families declined over this period. Against this, the number of both step and blended couple families and one-parent families increased slightly. However, step and blended families made up about

the same proportion of all families over this period (6% in 1992 and 7% in 2003), while the proportion of one-parent families increased from 17% to 22%. Lone mother families were the most common type of one-parent families and consequently accounted for most of this increase.

Table 3.4: Types of families with children aged 0–17 years, 1992 and 2003

	1992				2003			
	Families		Children		Families		Children	
Family structure	Number ('000)	Per cent	Number ('000)	Per cent	Number ('000)	Per cent	Number ('000)	Per cent
Couple families								
Intact	1,815.2	76.3	3,529.3	77.9	1,775.5	70.7	3,333.8	71.8
Step	84.3	3.5	125.1	2.8	98.6	3.9	158.4	3.4
Blended	68.1	2.9	200.3	4.4	78.1	3.1	224.4	4.8
Total[(a)]	1,974.7	83.0	3,863.1	85.3	1,967.1	78.4	3,738.2	80.5
One-parent families								
Lone mother	349.6	14.7	582.0	12.9	466.4	18.6	786.4	16.9
Lone father	53.4	2.2	83.2	1.8	76.1	3.0	117.5	2.5
Total	403.0	16.9	665.2	14.7	542.6	21.6	903.9	19.5
Total families with children	**2,377.8**	**100.0**	**4,528.3**	**100.0**	**2,509.6**	**100.0**	**4,642.1**	**100.0**

(a) Includes 'other' couple families which are not classified as intact, step or blended, for example, grandparent couple families or families with only foster children.

Source: ABS 2004f.

Between 1992 and 2003 the number of children aged 0–17 years living in families increased by 2.5%. Paralleling the decline in the number of intact couple families, the number of children living in intact couple families fell by 6%. At the same time, the number of children living in all other family types increased, with the most notable increase being children in one-parent families (36%). As a result of these changes, the proportion of children living in intact couple families declined from 78% to 72%, while the proportion living in one-parent families increased from 15% to 20%. It is worth noting, however, that more than seven out of ten children lived in intact couple families in 2003.

The relationship between family type and a child's wellbeing is not a simple one. Many factors contribute to a child's experience, including the quality of the parent–child relationship, parenting style and monitoring, parental care and family discord (De Vaus & Gray 2003; Wise 2003). Studies suggest that children undergoing transitional change from one kind of family to another sometimes encounter difficulties adjusting to these changes (Sawyer et al. 2000; Silburn et al. 1996; Vimpani et al. 2002). Difficulties arise from children having to adjust to new parent–child relationships, parental stressors such as changed socioeconomic status, different parenting styles and discipline, disruption to family cohesion, sibling relationships and parental mental health issues (Deater-Deckard & Dunn 1999, cited in Wise 2003). Thus, while a child's welfare is not directly dependent on family type, certain factors which affect welfare are more likely to occur in particular family types.

Young people living at home

The ABS Family Characteristics Survey also sheds light on changing living arrangements for young people living at home (Table 3.5). The number of young people aged 15 years or over living in the family home has been growing, in some instances substantially. Between 1992 and 2003, the number of dependent students aged 15–24 years living at home increased by 46% to just over 1 million. The increase was greater among those living in couple families (51%) than those in one-parent families (30%). Similar trends can be seen among non-dependent young people, with increases of around 50% over the 10-year period.

Table 3.5: Living arrangements of children and young people, 1992 and 2003

	Children and young people in couple families			Children and young people in one-parent families			All children and young people in families		
(Age (years)	1992 ('000)	2003 ('000)	Change (%)	1992 ('000)	2003 ('000)	Change (%)	1992 ('000)	2003 ('000)	Change (%)
				Dependent					
0–14	3,806.2	3,137.8	–17.6	630.6	751.7	19.2	4,436.8	3,889.5	–12.3
15–24	563.9	848.8	50.5	144.7	188.3	30.1	708.6	1,037.1	46.4
				Non-dependent					
15–24	422.0	627.7	48.7	100.0	152.0	52.0	522.0	779.7	49.4
Total	4,961.6	4,963.3	0.0	1,002.4	1,281.4	27.8	5,964.1	6,244.7	4.7

Source: ABS 2004f:24.

Non-resident parents

One of the consequences of family breakdown, whether through a de facto partnership ending or through separation and divorce, is that the children involved no longer live with both their natural parents. In 2003, there were 493,200 non-resident parents of children aged 0–17 years (Table 3.6). Most non-resident parents were fathers (82%). Further, almost half of non-resident parents had formed new relationships, with 47% living in a couple family. However, non-resident parents were less likely to work full-time (64% compared with the national average of 72%), and more likely to be unemployed (8% compared with the national average of 6%) (ABS 2004f).

Grandparent families and kinship carers

Since 2000 both the community and the government have become more aware of the needs of grandparents who are raising their grandchildren. Grandparents take on the role of primary carers of their grandchildren when the parents are no longer able to fulfil their parental responsibilities. The reasons for this include parental substance abuse, the death of one or both parents, a parent's mental or physical illness, or the child's need for a more protective environment (COTA National Seniors Partnership 2003). Since grandparents are part of a larger group of kinship carers, the issues they face have close links with the development of kinship care policy. Kinship care is ongoing care provided by a relative, close family friend or member of the community, and is often seen as a preferred option to foster care since it can maintain stability in a child's life (see 'Care and protection orders and out-of-home care', later in this chapter).

National data about grandparent families are contained in the 2003 ABS Family Characteristics Survey. In 2003 there were more than 22,500 grandparent families caring for more than 31,100 children aged 17 years or under (Table 3.7). In most of these families the youngest child was aged between 5 and 11 years, and grandparents were often caring for more than one child. In two-thirds of grandparent families, neither grandparent was employed.

Table 3.6: Non-resident parents of children aged 0–17 years, 2003

	Number ('000)	Per cent
Family type of non-resident parent		
Couple family with children	156.2	31.7
Couple family without children	73.8	15.0
One-parent family	70.5	14.3
Other family[(a)]	9.6	1.9
Total family members[(b)]	*310.0*	*62.9*
Total non-family members	*183.2*	*37.1*
Age of non-resident parent		
15–24 years	21.0	4.3
25–44 years	337.8	68.5
45 years and over	134.3	27.2
Labour force status		
Employed—full-time	315.3	63.9
Employed—part-time	55.8	11.3
Unemployed	37.4	7.6
Not in the labour force	84.8	17.2
Total non-resident parents of children	**493.2**	**100.0**

(a) Refers to families where there are no partners or children (e.g. adult siblings living together without a parent).

(b) Non-family members include persons in lone person and group households, and unrelated individuals in family households.

Source: ABS 2004f.

Table 3.7: Grandparent families caring for children aged 0–17 years, 2003

	Grandparent families		Children in grandparent families	
	Number ('000)	%	Number ('000)	%
Age of youngest child (years)				
0–4	3.3	14.8	6.8	21.9
5–11	8.4	37.4	11.5	36.8
12–14	8.0	35.8	9.8	31.5
15–17	2.7	12.1	3.0	9.7
Total	*22.5*	*100.0*	*31.1*	*100.0*
Labour force status				
One or both grandparents employed	7.6	33.8	10.1	32.5
No grandparent employed	14.9	66.2	21.0	67.5

Source: ABS 2004f.

These statistics lend weight to the findings of the report into grandparents raising children, commissioned by the Australian Government through the Council on Ageing in each state and territory. The report studied the experiences of 499 grandparents raising 548 children. It found that grandparents caring for grandchildren face many hardships, including upheaval, and additional financial, legal and social costs, often with little extra support (COTA National Seniors Partnership 2003:6–7). Some become isolated, overwhelmed and at risk of 'granny burn-out'. Changes in policy have made various forms of family support, such as the Family Tax Benefit (see Box 3.1) and Child Care Support (see Box 3.5), accessible to grandparents raising their grandchildren. Many payments are not income- or assets-tested for eligible grandparent carers. However, as guardianship arrangements tend to be informal, grandparents may be left to bear the extra costs without the support that would typically be available to foster carers (COTA National Seniors Partnership 2003:8). Of particular concern is the unknown number of Indigenous kinship carers who are also in this situation. In June 2004 the Council of Australian Governments (COAG) asked the Community and Disability Services Ministers' Council to report on the nature and extent of the needs of grandparent carers and what measures could be taken to address them. A report, with recommendations, will be considered by the council for forwarding to COAG in 2005.

Families and employment patterns

One of the most significant changes to family life over the last four decades has been the increased participation of women in the labour force (Gilding 1997). The majority of Australians now view child-rearing and generating family income as joint responsibilities (Bittman & Pixley 1997). Increased participation rates in employment reflect not only an increasing reliance on dual incomes to sustain a desired lifestyle but also the value women place on having a career. Whatever the reasons for the change, one consequence has been a heightened demand for child care places (see Section 3.5).

Table 3.8 presents data on the employment status of parents in families where the youngest child was aged 0–14 years. Between 1993 and 2003, the proportion of couple families where both parents were employed increased from 51% to 59%, making this the most common arrangement for couple families. The traditional male bread-winner model was the next most common family type for couple families, making up 32% of couple families, although the proportion has fallen from 36% in 1993. Families who are potentially at most risk (i.e. those where neither parent is employed) made up a small and declining proportion of couple families (6% in 2003, down from 11% in 1993). However, approximately 200,000 children aged 0–14 years lived in these families in 2003 (ABS 2004f:26).

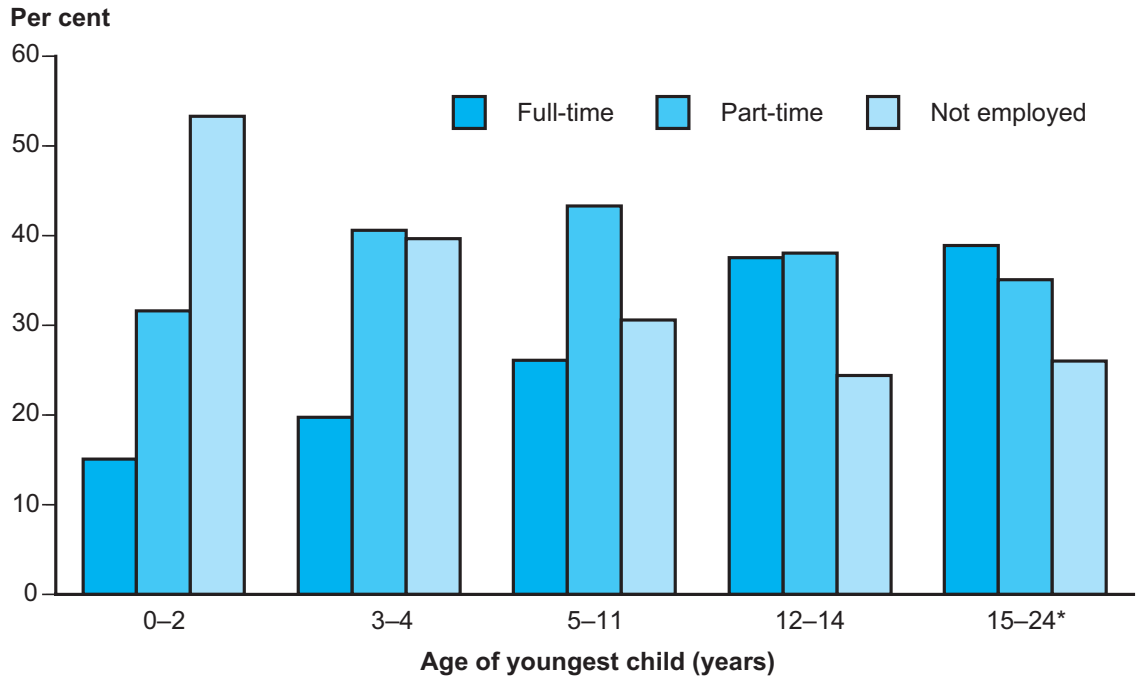
The picture is somewhat different for one-parent families with the youngest child aged under 15 years, 90% of whom were lone-mother families in 2003. Although the proportion of mothers who were employed increased from 39% to 46% between 1993 and 2003, the majority of lone mothers were not employed in either year (61% and 55% respectively were either unemployed or not in the labour force). Lone fathers were more likely to be employed than lone mothers, although the proportion declined between 1993 and 2003 from 61% to 57%. Over 400,000 children lived in one-parent families where the parent was not employed in 2003 (ABS 2004f:26).

Table 3.8: Employment status of parents with the youngest child aged 0–14 years, 1993 and 2003

	1993		2003	
	Number ('000)	Per cent	Number ('000)	Per cent
Couple families				
Both parents employed	856.2	50.6	1,017.8	58.6
Mother only employed	47.0	2.8	57.4	3.3
Father only employed	606.6	35.9	558.6	32.1
Neither parent employed	182.3	10.8	104.4	6.0
Total	**1,692**	**100.0**	**1,738.2**	**100.0**
One-parent families				
Lone-mother families	*311.2*	*90.1*	*408.7*	*87.6*
Mother employed	122.2	39.3	185.9	45.5
Mother not employed	189.0	60.7	222.8	54.5
Lone-father families	*34.3*	*9.9*	*57.9*	*12.4*
Father employed	20.9	60.9	33.1	57.2
Father not employed	13.4	39.1	24.8	42.8
Total	**345.5**	**100.0**	**466.6**	**100.0**

Sources: ABS 1993; ABS 2004f.

The age of the youngest child in a family affects the working patterns of parents, particularly mothers. The majority of women whose youngest child was aged 0–2 years were not employed in 2003 (53%), while only 15% worked full-time (Figure 3.4).



* Dependent students aged 15–24 years.

Source: Table A3.1

Figure 3.4: Employment status of mothers, by age of youngest child, June 2003

For women with the youngest child aged 3–4 years, 41% worked part-time, 40% were not employed, and 20% worked full-time. The proportion of women who worked full-time increased steadily as the age of the youngest child increased, but levelled out once high school age was reached. The opposite pattern was apparent for the proportion of women not employed. Even when the youngest child was of high school age or older, about a quarter of women were not employed. Part-time work stands out as the most common form of employment for most women up until the youngest child reached early high school age.

Family income

Children living in families without economic security are at a greater risk of poor outcomes in both the short and longer term. The immediate impact of economic hardship is evident. Living in a low-income family can affect a child's nutrition, access to medical care, the safety of their environment, the level of stress in the home, and the quality and stability of their care (Shore 1997). In addition, research confirms that for a number of health and social outcomes, including socio-emotional functioning, mental health, physical health, educational attainment and later employment prospects, children in the lowest income groups are at a higher risk of disadvantage than other children (for overview, see Bradbury 2003; Mayer 2002). Evidence of the association between low socioeconomic status (which encompasses education and occupation as well as low income) and less favourable outcomes for children is documented in *A Picture of Australia's Children* (AIHW 2005a).

Income distribution is generally analysed using equivalised income. This enables a meaningful comparison of the incomes of households adjusted for size and age composition (Table 3.9). In 2002–03, 22% of Australia's children aged 0–14 years (854,000) lived in households with incomes in the lowest quintile. The proportion of children in one-parent households with incomes in the lowest quintile was more than twice that of children in couple households (43% compared with 17%). Therefore, compared to children living in couple families, children living in one-parent families have fewer resources available to them. The financial resources available to a household can have a significant impact on levels of household financial stress and consequently the wellbeing and future prospects of the children who live within them (AIHW 2005a).

Families experiencing financial stress

One-parent families and jobless families are most at risk of experiencing financial stress because of their low incomes. However, financial stress is not limited to these family types. Some couple families with one or more employed adults also experience some degree of financial hardship.

The ABS 2002 General Social Survey collected information on a range of indicators of financial stress which adds a new dimension to understanding the economic wellbeing of families (Table 3.10). Almost two-thirds of those living in jobless one-parent households, one-third of employed one-parent households, and 12% of couple families with at least one adult employed reported that they could not raise $2,000 in a week. However, seeking financial help from friends or family was not uncommon, with 32% of jobless one-parent households, 22% of jobless couple households, and 23% of employed one-parent households reporting that they had sought such help in the last 12 months.

Table 3.9: Equivalised income quintiles for households with children aged 0–14 years, 2002–03 (per cent)

	Equivalised disposable income quintile (per cent distribution)						Total
	Lowest	Second	Third	Fourth	Highest	Total	('000)
Households							
Couple, one-family household	16.6	22.4	26.1	20.6	14.2	100.0	1,698,539
One-parent, one-family household	38.3	29.4	21.5	8.0	2.8*	100.0	434,600
Multiple family household	11.5**	33.0	21.0*	23.8	10.7*	100.0	63,035
Total households with dependants	*20.8*	*24.1*	*25.1*	*18.2*	*11.9*	*100.0*	*2,196,174*
Children							
Couple, one-family household	17.3	24.6	26.1	19.4	12.6	100.0	3,091,655
One-parent, one-family household	43.2	29.6	18.2	6.9	2.2*	100.0	702,937
Multiple family household	16.3**	33.9*	19.4*	22.3*	8.2*	100.0	99,213
Total children aged 0–14 years	*21.9*	*25.7*	*24.5*	*17.2*	*10.6*	*100.0*	*3,893,806*

Note: Multiple family households contain two or more families. The vast majority of children in Australia (97.5%) live in one-family households.

Source: ABS data available on request, 2002–03 Survey of Income and Housing Costs.

Table 3.10: Selected household financial stress indicators, 2002

	Jobless households with children under 15				Households with children under 15 and with one or more adults employed			
	One-parent family		Couple family		One-parent family		Couple family	
Financial stress indicators	No. ('000)	(%)	No. ('000)	(%)	No. ('000)	(%)	No. ('000)	(%)
Could not raise $2,000 within a week	121.8	64.3	51.8	52.2	70.9	33.0	194.0	12.1
Could not pay electricity, gas or telephone bill on time	96.6	51.0	38.3	38.6	67.3	31.1	236.5	14.8
Could not pay mortgage or rent on time	34.6	18.3	13.0	13.1	31.8	14.8	87.4	5.5
Could not pay for car registration or insurance on time	31.1	16.4	21.0	21.2	27.2	12.7	110.1	6.9
Could not make minimum payment on credit card	14.0	7.4	9.8	9.9	18.6	8.7	74.6	4.7
Pawned or sold something for quick cash	38.7	20.5	14.8	14.9	12.9	6.0	32.8	2.1
Went without meals	28.9	15.3	6.7	6.7	10.3	4.8	13.8	0.9
Was unable to heat home	11.9	6.3	2.7	2.8	5.2	2.4	7.9	0.5
Sought financial help from families/friends	60.2	31.8	21.3	21.5	50.0	23.3	139.2	8.7
Sought assistance from welfare organisation	43.6	23.0	12.6	15.7	11.3	5.3	24.6	1.5
Total households in group ('000)	**189.4**	**. .**	**99.3**	**. .**	**214.8**	**. .**	**1,598.6**	**. .**

Note: Categories are not mutually exclusive.

Source: ABS General Social Survey 2002 confidentialised unit record file.

Paying bills on time posed a difficulty for many families. For example, about half of jobless one-parent households and one-third of employed one-parent households had been unable to pay electricity, gas or telephone bills on time in the last 12 months. Further, 15% of couple families with at least one adult employed were also unable to pay these bills on time. The ability to make minimum credit card repayments and to heat the home were less common sources of stress, with less than 10% of all family types having difficulty meeting these, although again one-parent jobless families had the most difficulty (see Chapter 2, Economic resources and security, in Section 2.3 Autonomy and participation).

Assistance for families

The Australian Government provides support for families in the forms of family assistance payments and income support payments (Box 3.1). Family assistance is designed to help middle- and low-income families with the costs of raising children, including recognising the indirect costs of reduced workforce participation by some families with young children. Higher assistance is targeted to families with low incomes. Income support in the form of Parenting Payment is available for sole parents with no income or a low income and for parents whose partner has no income or is on a low income.

There have been recent changes in support for new mothers. The Maternity Payment has replaced the Maternity Allowance and the Baby Bonus. This payment recognises the legal relationship between a mother and her newborn baby, the role of the mother in the birth of the baby and the extra costs associated with birth or adoption. The Maternity Payment is made as a lump sum and is not income-tested. It is intended to benefit the primary carer, who is most commonly the natural mother but who could also be an adoptive parent or a long-term foster carer.

Family assistance is available through the Family Tax Benefit (FTB) Part A and Part B. FTB Part A helps families with the cost of raising dependent children while FTB Part B provides extra assistance to families with only one main income earner, including sole parents.

Other assistance is available for families in special circumstances: a multiple birth allowance if three or more children are born at the same time, available until the children turn 6 years old; the large family supplement for four or more children, receiving Family Tax Benefit Part A; and the double orphan pension.

Research has shown that between 1997 and 2004 the average income of low-income families (those with a disposable income in the lowest 20%) rose by 18% (or $87) in real terms (Macnamara et al. 2004). The rise was mainly attributable to increases in family payments in the 2000 tax package and 2004 federal budget. Without this assistance, the gap between low-income families and average families would have widened. The study revealed that benefits from the increase in family payments were not evenly distributed across different family types—low-income families with a child aged under 5 years, and large families, did better than those with dependent children aged over 16 years (who missed out on both the increases in family payments). As a result, many of the latter families suffered reduced living standards. For example, a low-income family with two older children received up to $73 less per week in income support than a similar family with two preschoolers, despite the fact that it is more costly to raise older children.

Box 3.1: Australian Government family payments and tax relief

Family Tax Benefit Part A *is paid to low- and middle- income families with dependent children under 21 years and/or dependent full-time students aged 21–24 years. It is paid for each dependent child in the family. The payment is subject to an assets test. The maximum rate is payable below a lower income threshold. For income above this threshold the payment rate reduces by 20 cents for every dollar until the base rate is reached. Payment continues at the base rate until the higher income threshold is reached. The payment rate is then reduced by 30 cents for every dollar until the rate is nil. Maximum rate of payment varies with the age of the child, with the payments increasing for teenagers aged 13–15 years.*

Family Tax Benefit Part B *provides additional assistance to single-income families, including single parents, with a child under 16 years or a child aged 16–18 years studying full-time. Higher rates are payable where families have a child under 5 years. The payment is not means-tested for single parents. For couple families, it is means-tested on the income of the partner with the lower income (secondary income).*

Parenting Payment *is an income support payment for low-income people with responsibility for caring for a child under 16 years of age. The two main streams are the Parenting Payment (single) paid to single parents with no income or a low income and the Parenting Payment (partnered) paid to the primary carer in a couple family where both parents have no income or a low income. The Parenting Payment is subject to income and assets tests.*

Maternity Payment *is a lump sum payment (currently $3,079) to the primary carer for each new baby, adopted child or child in long-term foster care in the family, born on or after 1 July 2004.*

Maternity Immunisation Allowance *is a payment for children aged 18–24 months who are fully immunised or have an approved exemption from immunisation. It is currently $213.60 per child.*

Double Orphan Pension *is paid 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.*

Sources: FaCS 2004a; FAO 2005.

Trends in family assistance

The vast majority of FTB recipients receive assistance through fortnightly payments from Centrelink: 2 million people (91% of recipients) in 2002–03. Around 82,000 received Centrelink lump sum payments and another 109,000 were paid lump sums through the tax system as a tax offset (FaCS 2004a).

At June 2004, just over 1.8 million families with 3.5 million children received the FTB Part A as a fortnightly payment, a slight increase from 2001 (Table 3.11). In all years from 2001 to 2004, more than half of these families were paid more than the base rate—57% in 2004.

Just over 1.2 million families with 2.3 million children received FTB Part B at June 2004. Almost half of those receiving the payment were sole parents—49% in 2004. The number of sole parents receiving the maximum payment increased by 6% across the period. Around 209,000 families received the Maternity Allowance and 204,000 the Maternity Immunisation Allowance in 2004, much the same numbers as in previous years.

Between 2001 and 2004, over 600,000 people each year received the Parenting Payment—626,000 in 2004. However, there were clear trends within the two groups receiving the payment. While the number of people receiving the Parenting Payment (partnered) declined by 14% over the 4-year period, the number receiving the Parenting Payment (single) increased by 8% (FaCS 2004a). This increase partly reflects growth in the number of single-parent families with children aged under 16 years in the general population.

Table 3.11: Recipients of family assistance, 30 June 2001 to 30 June 2004 ('000)

	Recipients				Children			
Type of payment[a]	**2001**	**2002**	**2003**	**2004**	**2001**	**2002**	**2003**	**2004**
Family Tax Benefit Part A								
Maximum rate (with income support payment)	509.8	485.9	475.8	473.4	962.2	914.8	894.7	886.7
Maximum rate (without income support payment)	127.2	134.4	139.4	142.4	243.8	253.7	258.7	258.9
Broken rate	406.1	431.6	427.5	423.5	874.7	927.7	919.7	912.8
Base rate	725.4	708.7	701.3	721.4	1,333.0	1,298.5	1,286.5	1,332.1
Below base rate	31.2	34.2	39.3	47.0	68.5	76.5	86.4	106.3
Total	*1,799.7*	*1,794.8*	*1,783.3*	*1,807.7*	*3,482.2*	*3,471.2*	*3,446.0*	*3,496.8*
Family Tax Benefit Part B								
Maximum rate (for sole parents)	559.4	570.7	583.5	595.0	951.2	965.2	986.4	1,004.7
Maximum rate (for couples)	290.0	300.4	322.4	298.8	622.7	638.8	685.7	637.1
Broken rate (for couples)	331.7	328.0	317.7	311.8	702.3	689.3	666.0	655.1
Total	*1,181.1*	*1,199.1*	*1,223.6*	*1,205.6*	*2,276.2*	*2,293.3*	*2,338.1*	*2,296.9*
Maternity Allowance[b]	210.1	212.2	207.0	209.2	214.4	216.1	210.5	211.6
Maternity Immunisation Allowance[b]	203.9	206.8	203.9	203.7	207.5	210.6	206.3	205.4
Double Orphan Pension	1.2	1.2	1.1	1.2	1.6	1.6	1.5	1.5
Parenting Payment (single)[c]	416.7	427.8	437.0	449.3	. .	. .	. .	. .
Parenting Payment (partnered)[c]	205.4	191.6	181.4	177.2	. .	. .	. .	. .

(a) The data on FTB recipients relate to those who claim fortnightly payments.

(b) The number assisted is the number who received a payment during the financial year.

(c) The number assisted is the number who received a payment in June (not at 30 June).

Sources: FaCS 2001; FaCS 2004a.

3.4 Adopted children

In Australia, each state and territory has responsibility for all aspects of adoption within its jurisdiction, including its own legislation, policies and practices in relation to adoption. The Institute is funded by the state and territory community services departments to collect and publish national data on adoptions. The data reported on

here were provided by the departments, in regard to adoptions that were finalised within their jurisdictions between 1999–2000 and 2003–04. The categories used to classify adoptions in the national collection are outlined in Box 3.2. For further information, see *Adoptions Australia* series (e.g. AIHW 2004a).

This section examines adoptions data from the last five years, while also making reference to important trends in the number of adoptions occurring in Australia over the last 30 years.

Box 3.2: 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.*

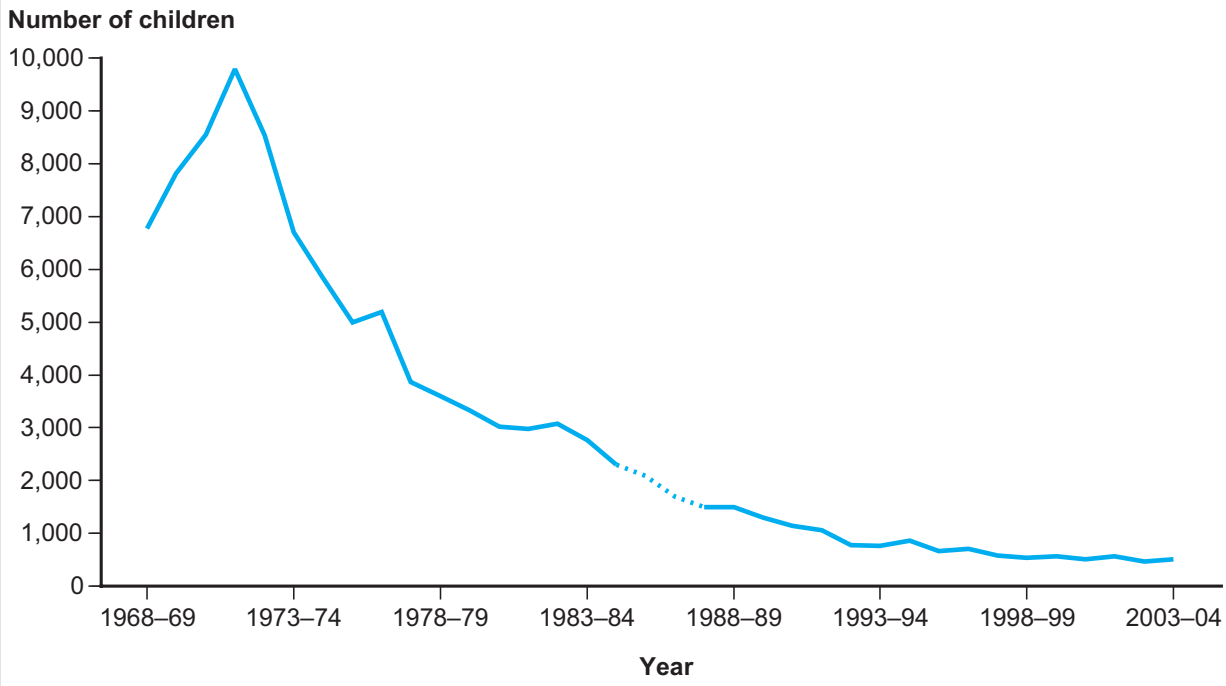
'Known' child adoptions: *adoptions of children who have a pre-existing relationship with the adoptive parent(s) and who are generally not available for adoption by anyone other than the adoptive parent(s). 'Known' child adoptions include adoptions by step-parents, other relatives and carers.*

Before 1998–99, adoptions were categorised as either relative or non-relative adoptions. The major difference between the categories used now and those used then is that adoptions by carers are now included with adoptions by step-parents and other relatives, rather than with adoptions by non-relatives.

Trends in adoption

Since the 1970s, the number of adoptions has declined along with declining fertility rates. Australia experienced a substantial fall in the number of adoptions between the early 1970s and the early 1990s, from almost 10,000 in 1971–72 to 764 in 1993–94 (Figure 3.5). After that, the number fluctuated and flattened out. The number of children adopted fell to a low of 472 in 2002–03, but increased slightly to 502 in 2003–04.

The long-term decrease is primarily due to the fall in the number of local adoptions and 'known' child adoptions and is reflective of the number of Australian-born children who are placed for, or require, an adoption. Factors that have contributed to this decrease since the 1970s include the availability of more effective birth control, and changed community attitudes that have coincided with increased levels of support available to single parents. Legislative changes introduced by state and territory departments over the last two decades have also facilitated a greater use of alternative legal orders, often replacing the need for adoption orders. These orders, such as permanent care orders in Victoria, transfer the guardianship and custody of a child to a person other than the parent—in most cases to relatives or carers that the child is currently living with.



Note: National data were not collected between 1985–86 and 1986–87.

Source: AIHW 2004a.

Figure 3.5: Adoptions in Australia, 1968–69 to 2003–04

As local adoptions continue to decrease, the proportion of intercountry adoptions has been increasing. In 1999–00, just over half (53%) of all children adopted were from countries other than Australia and by 2003–04 this figure had increased to 74% (Table 3.12).

Table 3.12: Adoptions in Australia, 1999–00 to 2003–04

	Local placement adoptions	'Known' child adoptions	Intercountry adoptions	Total
1999–00	106	159	301	566
2000–01	85	140	289	514
2001–02	107	160	294	561
2002–03	78	116	278	472
2003–04	73	59	370	502

Source: AIHW 2004a.

Local adoptions

Local adoptions continued the general trend of the last 30 years and declined in number by 31%, from 106 in 1999–00 to 73 in 2003–04 (Table 3.12). Although the number is decreasing, many characteristics of local adoptions have remained unchanged throughout the last few decades—the majority of local children placed for adoption are still born to unmarried mothers and the majority of children adopted continue to be under 1 year of age.

However, in other areas, such as the way in which local placement adoptions are conducted, significant changes have been made over the last two decades. For example, 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. Out of all of the agreements made at the time of an adoption in 2003–04, only 7% included a clause of 'no contact or information exchange'. The remaining 93% would be considered to be 'open' adoptions (AIHW 2004a).

Consequently, a large area of activity for community services departments is in assisting people who were party to an adoption prior to 'open' adoption practices, to gain information about their adoption. In all jurisdictions, people party to an adoption can apply for either identifying or non-identifying information regarding the adoption. This may lead to contact between the parties, for example between an adoptee and their birth mother. If a party to the adoption wishes to remain anonymous, some states and territories allow a veto to be lodged which makes it illegal for the other parties to either gain information and/or have contact. In 2003–04 there were 3,407 information applications lodged in Australia, compared with 63 contact and information vetoes (AIHW 2004a).

'Known' child adoptions

The number of 'known' child adoptions decreased significantly over the last 5 years, from 159 in 1990–00 to 59 in 2003–04 (Table 3.13). Most (66%) were by step-parents wishing to legally incorporate children into their new family. However, as the data show, this practice is becoming less common. Other types of 'known' child adoptions (those by other relatives or carers) are also significantly decreasing. In most states and territories, adoptions by carers and relatives other than step-parents are only allowed in exceptional circumstances, that is, when a guardianship or custody order would not adequately provide for the welfare of the child (AIHW 2004a).

Table 3.13: Relationship of adoptive parent(s) in 'known' child adoptions, 1999–00 to 2003–04

	Step-parent	Other relative	Carer	Unknown	Total
1999–00	114	2	43	—	159
2000–01	98	1	29	12	140
2001–02	103	5	52	—	160
2002–03	72	2	29	13	116
2003–04	31	3	25	—	59

Source: AIHW 2004a.

Adoptions by carers made up 28% of all 'known' child adoptions between 1999–00 and 2003–04. These adoptions would usually have been of children placed with their carers in long-term out-of-home care placements. For example, in Western Australia, new legislation introduced in 2003 specifies that adoptions by carers can occur only when the child has been in their full-time care for at least 3 years. These adoptions would also occur only where the parent has given their consent or the appropriate court dispenses with the parent's consent.

There were 13 adoptions of children by relatives other than step-parents between 1999–2000 and 2003–04, representing 2% of all 'known' adoptions over the period. This low number is reflective of community services departments' policies and practices that generally discourage adoption by relatives, because of the confusion and distortion that may occur to biological relationships. When children need to be placed in the care of relatives other than parents, most jurisdictions have policies that promote the use of guardianship or custody orders rather than adoption (Stonehouse 1992).

Intercountry adoptions

Over the last 5 years, intercountry adoptions rose by 23%, from 301 in 1999–00 to 370 in 2003–04 (Table 3.14). Two important developments in intercountry adoptions since the beginning of 1999 may have impacted on this overall increase.

Table 3.14: Intercountry adoptions, 1999–00 to 2003–04

Country of birth	1999–00	2000–01	2001–02	2002–03	2003–04	Total
China	1	15	39	46	112	213
Colombia	17	15	9	7	7	55
Ethiopia	46	37	36	39	45	203
Fiji	5	3	5	—	1	14
India	37	40	40	33	29	179
South Korea	77	75	93	101	98	444
Philippines	29	18	12	18	29	106
Romania	36	22	2	1	—	61
Sri Lanka	3	4	2	2	2	13
Thailand	33	35	28	17	39	152
Other[(a)]	17	25	28	14	8	92
Total	**301**	**289**	**294**	**278**	**370**	**1,532**

(a) Other includes: Burkina Faso, Bolivia, Chile, Croatia, England, Guatemala, Hong Kong, Italy, Lebanon, Malta, Poland, Taiwan, Tonga, Uganda and the United States of America.

Source: AIHW 2004a.

First, in December 1998, Australia ratified the Hague Convention on the Protection of Children and Cooperation in Respect of Intercountry Adoptions. The Hague Convention helps people who wish to adopt children from overseas by establishing uniform standards and procedures between countries (AIHW 2004a). More importantly, it also protects the rights of the children, by ensuring that their best interests are paramount in any intercountry adoption process. Since 1998, 38 additional countries have ratified or acceded to the Convention. In June 2005, a total of 66 countries were a party to the Convention (Hague Conference on Private International Law 2005).

Second, in December 1999, Australia entered into a bilateral agreement with China. This agreement has similar arrangements to the Hague Convention—in particular, it allows Australian residents to adopt children from China, with the adoption order being finalised there and automatically recognised in Australia (AIHW 2004a). Since the agreement was signed, the number of children adopted from China has increased

each year—culminating in 2003–04 with 112 children, more than from any other country (AIHW 2004a). A total of 213 children have been adopted from China since 1999 (Table 3.14).

Bilateral agreements which existed prior to the Hague Convention ratification remain in place, with the understanding that they will be reviewed on a regular basis to ensure that they comply with the principles of the Convention. The most recent review, in 2004, recommended that the bilateral agreements with China, Fiji, Hong Kong, South Korea and Taiwan continue. This was endorsed by the Community and Disability Services Ministers' Council in July 2005. A further review will take place in 2009.

Overall between 1999–00 and 2003–04, the majority of children adopted from countries other than Australia have come from South Korea (29%), followed by China (14%), Ethiopia (13%), India (12%) and Thailand (10%).

Adoptions of Aboriginal and Torres Strait Islander children

Adoptions of Aboriginal and Torres Strait Islander children are conducted in accordance with the Aboriginal Child Placement Principle, which outlines a preference for the placement of Indigenous children with Indigenous people when the children are placed outside their family (Lock 1997).

Between 1999–2000 and 2003–04, 15 Indigenous children were adopted in Australia. In 73% of these adoptions, the adoptive parents were Indigenous and/or relatives of the adopted child (AIHW 2004a).

3.5 Transitions from early childhood to school entry

Transition from home to care

In early childhood the first major transition for an increasing number of Australian children is their entry to child care. Child care can be either formal or informal, and can be provided in a family home, community or educational setting. Child care provides opportunities for development, education and socialisation, gives parents the opportunity to work, study and engage in other community activities, and provides additional support networks (CSMAC 2004). Formal child care services include long day care centres, family day care, occasional care, outside school hours care and vacation care. Many children also attend preschool, which provides additional education and developmental opportunities for those about to enter full-time schooling. Informal care is provided by grandparents and other relatives, babysitters and nannies. The definitions of the various types of formal child care services can be found in Box 3.3.

In 2002, almost half of Australia's 3.1 million children aged under 12 years used some form of child care. Two-thirds of the youngest children, aged less than 1 year, used no form of care. Of those who did use care, most used only informal care provided by grandparents (ABS 2003d). Use of child care increases with the age of the child and peaks among 4 year olds, 83% of whom were in formal care (including preschool) in 2002. This means that although the point of transition is different for each child, most children have experienced some type of formal care before beginning school.

Box 3.3: Child care and preschool services

Formal care *is regulated care generally away from the child's home. The main types of formal care are long day care, family day care, occasional care, preschool and outside school hours care.*

Informal care *is non-regulated care, arranged by a child's parent/guardian, either in the child's home or elsewhere. It comprises care by (step) brothers or sisters, by grandparents, by other relatives (including a parent living elsewhere) and by other (unrelated) people such as friends, neighbours, nannies or babysitters. It may be paid or unpaid.*

Centre-based long day care *comprises services aimed primarily at 0–5 year olds that are provided in a centre usually by a mix of qualified and other staff. Educational, care and recreational programs are provided based on the developmental needs, interests and experience of each child. In some jurisdictions, primary school children may also receive care before and after school, and during school vacations. Centres typically operate for at least 8 hours per day on normal working days, for a minimum of 48 weeks per year.*

Family day care *comprises services provided in the carer's home. The care is largely aimed at 0–5 year olds, but primary school children may also receive care before and after school, and during school vacations. Central coordination units in all states and territories organise and support a network of carers, often with the help of local governments.*

Occasional care *comprises services usually provided at a centre on an hourly or sessional basis for short periods or at irregular intervals for parents who need time to attend appointments, take care of personal matters, undertake casual and part-time employment, study or have temporary respite from full-time parenting. These services provide developmental activities for children and are aimed primarily at 0–5 year olds. Centres providing these services usually employ a mix of qualified and other staff.*

Preschool *comprises services usually provided by a qualified teacher on a sessional basis in dedicated preschools. Preschool programs or curricula may also be provided in long day care centres and other settings. These services are primarily aimed at children in the year before they commence full-time schooling (that is, when children are 4 years old in all jurisdictions except WA, where children are 5 years old), although younger children may also attend in some circumstances.*

Outside school hours care *comprises services provided for school-aged children (5–12 year olds) outside school hours during term and vacations. Care may be provided on student-free days and when school finishes early.*

Other services *comprise government-funded services to support children with additional needs or in particular situations (including children from an Indigenous or non-English-speaking background, children with a disability or of parents with a disability, and children living in regional and remote areas).*

Source: SCRCSSP 2005.

Data sources

The main sources of data for children's services are the ABS Child Care Survey, the FaCS Census of Child Care Services, Centrelink administrative data and data from the Report on Government Services (Box 3.4). Although there are many sources of data available, the comparability of data is limited as collections have different scopes and different definitions for variables. For example, the ABS Child Care Survey is a household survey on the use of child care services (including formal, informal and preschool) for children aged 0–11 years, while the FaCS Census collects information from Australian government-funded service providers on children aged 0–12 years. In addition, state and territory collections have different definitions of a preschool service, which limits the comparability of the data.

Box 3.4: Child care and preschool services data collections

*The **Australian Bureau of Statistics Child Care Survey** is conducted every 3 years and is a supplement to the ABS Labour Force Survey. The latest survey was conducted in 2005. This is an Australia-wide household sample survey on the use of and demand for child care and preschool services.*

*The **Australian Government Census of Child Care Services** is a census of Australian Government-supported child care service providers, conducted by the Department of Family and Community Services. The census collects information from Australian Government approved service providers on their staff, the children and parents using the service and various other aspects of service provision. The latest census of these services was carried out in March 2004.*

***State and territory government data collections** contain information about the child care and preschool services that these governments fund and/or license. There are, however, great variations in the nature and extent of these collections. The best source of these data is the Report on Government Services (SCRCSSP 2005), produced annually, and available online at <http://www.pc.gov.au/gsp/reports/rogs/2005/>.*

*The **Household, Income and Labour Dynamics in Australia (HILDA) Survey** is a longitudinal survey that began in 2001. It collects information about child care use that can be related to other aspects of the survey, including household structure, family background and formation, education, employment history, current employment, income, health and wellbeing and housing. The survey was initiated and funded by the Australian Government through the Department of Family and Community Services. For more information, see <http://www.melbourneinstitute.com/hilda/>.*

***Growing Up in Australia, the Longitudinal Study of Australia's Children**, explores family and social issues relevant to children's development, and addresses a range of research questions including non-parental child care and education. It will examine the impact of non-parental child care on a child's developmental outcomes over time, and the impact of various risk factors such as multiple care arrangements, type of care and age of entry into child care. The first report was released in May 2005. The study was initiated and funded by the Australian Government Department of Family and Community Services as part of its Stronger Families and Communities Strategy. For more information, see <http://www.aifs.gov.au/growingup/home.html>.*

Many of these issues will be addressed by the Children's Services National Minimum Data Set (CS NMDS), which is being developed by the AIHW, in consultation with the Children's Services Data Working Group of the NCSIMG. The CS NMDS is designed to collect data from all government-funded and/or licensed child care and preschool services. It will provide nationally comparable and consistent data on children who use child care and preschool services, the workers who provide care and the services themselves. Data items have been pilot tested in two stages, most recently during 2004 in every jurisdiction, and strategies for implementation are currently under discussion. The implementation of the CS NMDS will provide data which fill the existing knowledge gaps, as well as giving a consistent, national picture of children's services.

Need for child care and preschool services

With 3.5 million children aged 12 years and under in Australia, the potential demand for children's services is very large. However, the demand is influenced not only by the number and age of children in the population, but also on trends in social factors such as family structure, employment patterns and population mobility. For example, the growing number of one-parent families (discussed in more detail in Section 3.3) has increased the need for child care services. An analysis of HILDA data showed that lone-parent families are more likely to use formal care (NATSEM 2005). This may be due to a lack of informal care options (e.g. two sets of grandparents), or because lone parents lack a partner to share household responsibilities with, and thus need more hours of child care in order to complete tasks such as shopping, banking or attending appointments.

Current trends in the participation in the labour force of both couple and single parents suggest an expanding need for child care services, particularly as children get older (see Section 3.3). However, participation in employment is not by itself an accurate indicator of the level of need for child care services, because many parents use child care for study, personal reasons or for the benefit of the child (ABS 2003d).

Moving—especially interstate—can weaken support networks of family and friends. These are the people who provide most informal child care and, without them close at hand, the need for formal child care services may increase. Child care and preschool provide opportunities for establishing new support and social networks and so can contribute to the social wellbeing of families who use formal care when they move. Between 1996 and 2001, 42% of the population aged 5 years and over (more than 6 million people) changed address (ABS 2004c). Most people who moved were aged 20–34 years, and many of these had young children. Of those who moved, 20% were less than 15 years of age (Figure 3.6).

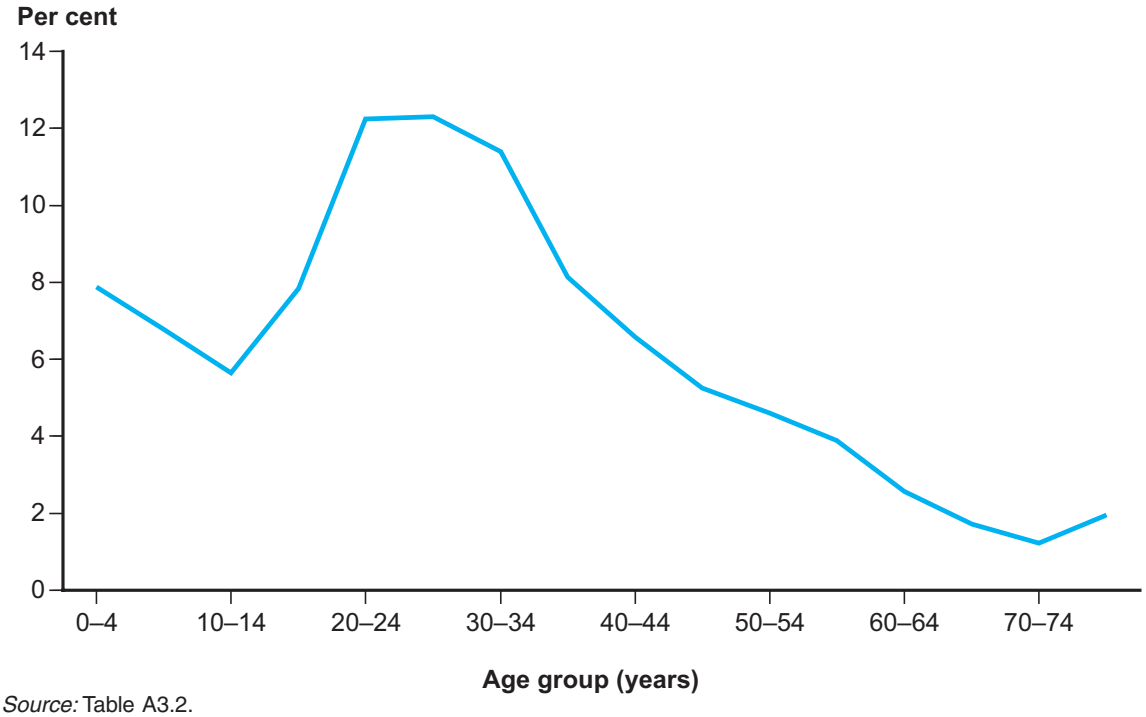
Policy context of child care and preschool service provision

Under the Stronger Families and Communities Strategy, the Australian Government Department of Family and Community Services (FaCS) supports the provision of formal child care services through the Child Care Support Program (CCSP) (Box 3.5). The CCSP incorporates a range of strategies to promote the supply, accessibility, flexibility, quality and affordability of child care services (FaCS 2004b).

The policies put forward in the CCSP have generated a number of other programs. The Australian Government funds two programs aimed at improving access to services for children with special needs (McIntosh & Phillips 2002). These are the Supplementary Services Program and the Special Needs Subsidy Scheme. The Supplementary Services Program funds the employment of trained people who educate child care workers in the appropriate care of special needs children. They also assist in creating programs for special needs children, serve as relief workers and provide information materials. The Special Needs Subsidy Scheme is similar to the Supplementary Services Program except that it is aimed at supporting individual high needs children, instead of improving the overall capacity of child care services to care for special needs children.

In addition to the funding that children's services can receive under the CCSP, the Australian Government provides a number of other payments. These can include establishment grants, set-up grants, equipment grants, and capital assistance (McIntosh & Phillips 2002). Some child care services receive a disadvantaged area subsidy which aims to improve access to work-related child care for those in rural and remote locations. Private providers are encouraged to support rural and remote communities by setting up new long day care centres which attract funding from the government for two years.

The Jobs, Education and Training Child Care program is primarily designed to help those receiving the Parenting Payment to enter or re-enter the workforce. It provides advice, training and employment opportunities, as well as arranging child care places (McIntosh & Phillips 2002). This program can also be utilised by those people on the work for the dole program.



Source: Table A3.2.

Figure 3.6: Age structure of interstate migrants, 2001

Box 3.5: Australian Government child care support

Prior to 2004, a Child Care Support Broadband (CCSB) was in place which was designed to provide funding to child care services. Funding for services covered areas such as training, operational subsidies, funding for children with special needs and set-up grants. In 2001, FaCS was asked to redevelop the CCSB in response to the Commonwealth Child Care Advisory Council's report (CCCAC 2002).

In June 2004, after extensive consultation, outcomes from the CCSB redevelopment were announced, and the new Child Care Support Program (CCSP) was officially launched.The CCSB was redeveloped so that funding arrangements could keep pace with current priorities identified in the child care sector. The priorities identified by the Australian Government at the commencement of the redevelopment were:

a need to better support those services that are marginal, in rural and regional areas or struggling to combine viability with flexible service delivery, to better support families and children with additional needs and also to focus on the need for a quality early learning and development experience for all children accessing formal child care services.

Consequently, funding under the new CCSP is targeted at supporting child care services, particularly in high-need rural, regional and Indigenous communities, and ensuring that children with additional needs can be provided with quality child care.

The Child Care Support Program has four strategic priorities:

1. ***Quality Support:** Programs that promote quality child care, including training and professional development and quality accreditation measures ($26m in funding for 2004–05).*
2. ***Inclusion Support:** Programs to support access to quality child care for families and children with additional needs ($60m in funding for 2004–05).*
3. ***Community Support:** Programs to support access to child care for children and families in areas or in circumstances where the market would otherwise fail to provide child care services ($138m in funding for 2004–05).*
4. ***Program Support:** Planning, monitoring, evaluation and communication measures to support the government's investment in child care ($2m in funding for 2004–05).*

The total funding for these priorities during 2004–05 is $226 million.

Source: AIHW 2003; FaCS 2004b; 2004c.

State and territory governments, as well as local governments, provide additional funding and support to child care services (McIntosh & Phillips 2002). State and territory governments are responsible for providing preschools and the licensing of services. They also provide information and support for providers and parents. Local governments contribute land and administrative support to community centres.

Preschool services are those that are primarily aimed at children in the year before they commence full-time schooling (SCRCSSP 2005:14.2–14.3). They provide children with educational and developmental opportunities and are usually staffed by a qualified teacher.

Preschool services are provided by state governments, private bodies and within long day care centres. The funding for these services varies across jurisdictions. Private preschools attract varying levels of subsidies, and preschools within child care centres are funded differently to stand-alone services and those attached to government schools (ACT Department of Treasury 2004:140). In New South Wales and Victoria, preschool is seen as part of the community services portfolio, rather than the educational system as in other jurisdictions. This means that preschools are not provided free of charge, with parents incurring a small fee (AEU 2001). Because the provision of preschool services to the community is so complex, it is difficult to collect consistent data on the numbers of places offered and who uses them. Preschool services are discussed below under 'Use of child care'.

Australian Government-supported child care services

During 2004, the Australian Government supported more than 10,100 agencies across Australia. Most of these services were owned and operated by either community organisations or private-for-profit organisations (Table 3.15). Of the long day care centres that received support, almost 70% were owned by private-for-profit organisations. In contrast, almost all family day care, outside school hours care and occasional care services were owned by community-based bodies.

Table 3.15: Australian Government-supported child care services, 2004 (per cent)

	Long day care centres	Family day care[a]	Outside school hours care[b]	Occasional /other care[c]
Private-for-profit	69.4	5.1	7.7	0.0
Community-based[d]	30.6	94.9	92.3	100.0
Total	**100.0**	**100.0**	**100.0**	**100.0**
Total number of agencies	**4,484**	**409**	**5,091**	**142**

(a) Family day care coordination units. Also includes family day care schemes offering in-home care, and stand-alone in-home care services.

(b) Includes before and after school care and vacation care.

(c) Includes occasional care centres and multifunctional Aboriginal children's services.

(d) Includes services operated by community groups, religious organisations, charities, local governments, and by or in state government premises.

Source: FaCS 2004 administrative data.

Between 1991 and 2004, the number of Australian Government-supported child care places increased markedly (Figure 3.7). The largest growth was in places for outside school hours care, which was four times higher than in 1991, with most of the increase since the late 1990s. The large increase between 1997 and 1998 was mainly due to the inclusion of some Australian Government-supported places not previously recorded in the database, and to changes in the counting methodology. The number of places in

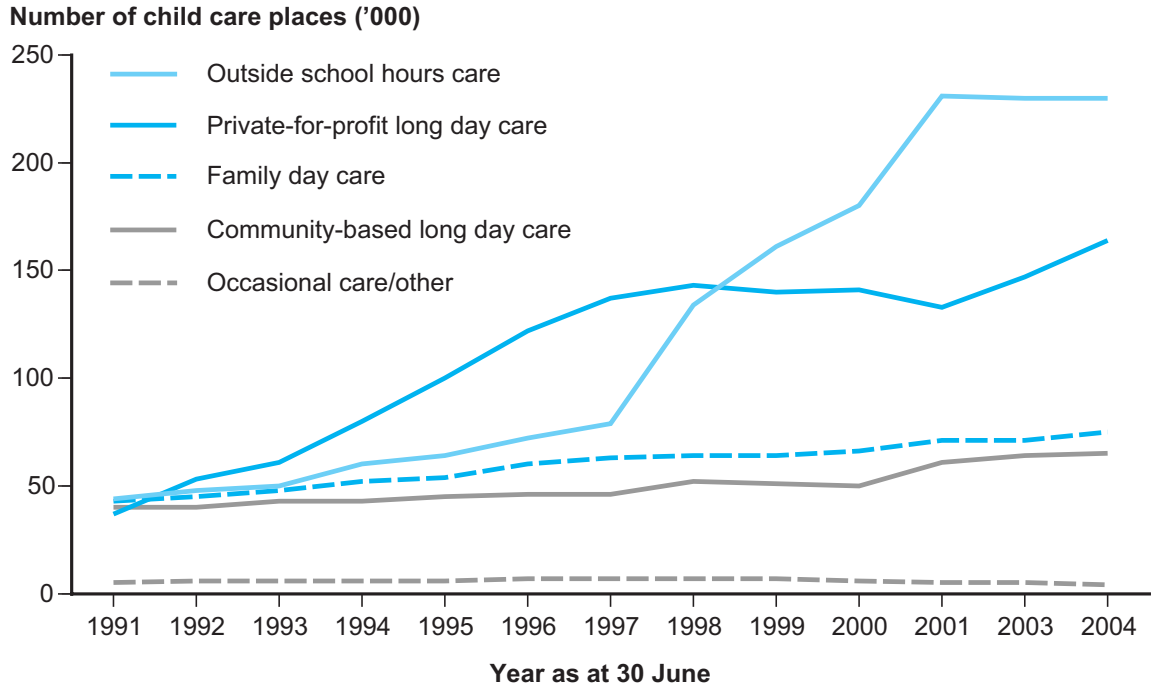
private-for-profit long day care centres increased three and a half times to 164,300 over the period. Places for other types of care grew more moderately, with occasional care the only type to register a small decline of 20%.

Use of child care and preschool

Formal and informal care

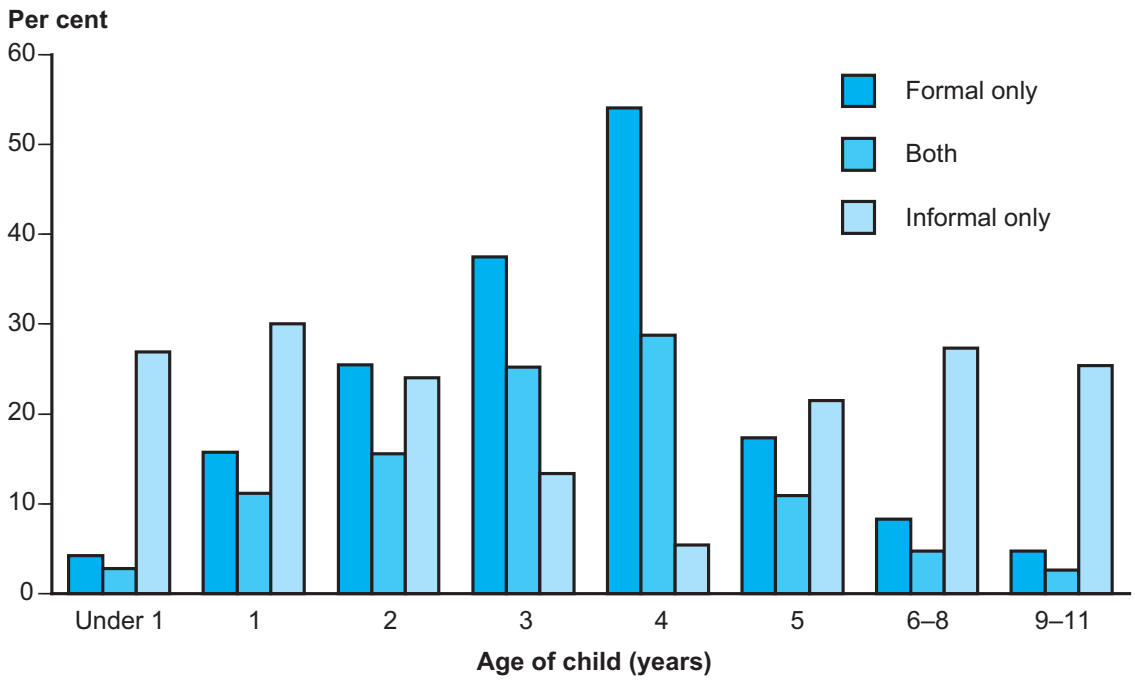
According to the latest ABS Child Care Survey, in 2002 about half the children aged under 12 years used some type of child care (ABS 2003d). Over the last decade this figure has not changed. However, the proportion of children using formal care—regulated care that takes place away from the child's home, including preschool—gradually increased, from 19% in 1993 to 25% in 2002. At the same time, the proportion using informal care decreased from 38% to 33%. Informal care is unregulated care provided by relatives, friends or nannies. Grandparents provided 58% of informal care to children aged under 12 years.

The use of formal and informal child care also varied across age groups (Figure 3.8). Children aged 3 and 4 years are more likely to use formal child care due to their attendance at preschool. In contrast, children aged 1 year or younger, or over 5 years, were more likely to use informal child care. About half the children aged under 12 years did not use any type of care—formal or informal, with the highest proportions among the youngest (66% of children less than a year old) and oldest (67% of 9–11 year olds).



Source: Table A3.3.

Figure 3.7: Australian Government-supported child care operational places, 1991–2004



Source: Table A3.4.

Figure 3.8: The use of formal and informal child care, 2002

Patterns of use for informal and formal care vary by household type and employment status of parents. Research based on the Household Income and Labour Dynamics of Australia (HILDA) survey has shown that one-parent families were more likely to use formal care, or a combination of formal and informal care, than other family types (NATSEM 2005). Another analysis of HILDA data showed that of families who worked either full or part-time, 15% did not use any formal child care (Mance 2005). Those families who were employed part-time used more informal care than those employed full-time, while those families who were employed full-time most often used a mixture of formal and informal care. Single working mothers used twice the amount of formal child care than the number of hours worked. For example, a single mother working approximately 16 hours per week used 31 hours of formal child care, compared to mothers in couple families, who worked 22 hours per week and used 28 hours of formal child care. This suggests that single mothers use formal care for non-work-related reasons such as study, shopping, appointments and personal time, whereas a couple can share the care of children in these circumstances.

Although most of this section focuses on formal child care services, the above discussion highlights the importance of informal child care in Australia. Many state, territory and Australian Government agencies are currently working on projects to improve the collection of data on the use of informal care to assess its contribution to the Australian community.

Australian Government-supported child care

The number of children using Australian Government-supported child care services more than doubled between 1991 and 2004, from 262,200 to 646,800 (Table 3.16).

Over this period, the number of children attending long day care centres almost tripled, to 383,000, while the number attending outside school hours care more than tripled to 160,800. Parallelling this trend, the use of vacation care services has also increased markedly.

Of the children who used formal child care during 2004, 59% attended long day care centres; 14% family day care. Children who attended outside school hours care (18%) are likely to overlap with those who attended vacation care (16%).

It is important to note that the data from the FaCS Census of Child Care Services may not be strictly comparable from year to year. For example, the large increase in outside school hours care places between 1997 and 1998 was mainly due to the inclusion of some Australian Government-supported places not previously recorded in the database, and to changes in the counting methodology.

As noted above, age is a key factor in the use of informal and formal care. It is equally important in the type of care that children use (Table 3.17). The most common type of Australian Government-supported child care used children under 4 years of age was long day care. However, only 8% of the 253,000 children aged under 1 year in 2004 used an Australian Government-supported formal care service, mainly long day care. Three year olds were the largest group using long day care, but these centres continued to care for many 4 year olds, as they provide preschool services within the centre. Once attending full-time school, children most commonly used outside school hours care and vacation care.

The Australian Government provides specific funding to assist parents and children with special needs to access services (see the section on policy context). The groups eligible for this support are 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 (FaCS 2004d) (Table 3.18). During 2004 children from one-parent families accounted for the majority of special needs children using Australian Government-supported child care services. The next largest group were children from culturally diverse backgrounds.

Some caution should be used in interpreting these data. For example, multifunctional children's services are mostly located in rural and remote areas where the population is too small to support specialised services (FaCS 2002). Recent data on disability in children indicate that there is a higher rate of disability in areas outside of capital cities (AIHW 2004b), which may partially account for the high rate of special needs children in this type of service.

Preschool services

At present the ABS Child Care Survey is the most reliable source of information about the use of preschool services across Australia. Its drawbacks are that it is only collected every 3 years, has a high relative standard error for the smaller states, cannot provide information about rural and remote areas, and does not identify preschool programs run within long day care centres.

Table 3.16: Number of children in Australian Government-supported child care services, 1991–2004

	Long day care	Family day care	Outside school hours care	Vacation care	Other formal care[a]	Total[b]
1991	135,400	61,000	46,800	. .	19,000	262,200
1992	158,400	66,100	50,700	. .	26,500	301,700
1993	190,600	78,800	53,500	. .	20,900	343,800
1994	227,300	88,700	63,900	n.a.	16,800	396,700
1995	251,000	85,600	n.a.	n.a.	n.a.	n.a.
1996	n.a.	n.a.	96,400	24,300	19,100	n.a.
1997	294,700	85,000	99,500	31,000	n.a.	n.a.
1999	301,500	83,100	107,400	69,300	16,100	508,200
2000	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
2001	n.a.	95,800	n.a.	n.a.	n.a.	n.a.
2002	367,100	97,100[c]	148,000	103,600	11,600	623,900
2003	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
2004	383,000	92,500	160,800	101,700	10,400	646,800

(a) Includes occasional care centres, multifunctional Aboriginal children's services (MACS) and other multifunctional services.

(b) Components may not add to totals due to rounding to the nearest 100. Vacation care places are not included in the total to reduce the amount of double-counting.

(c) Includes in-home care.

Notes

1. These data measure occurrences of care and include some double-counting where children attend more than one service. Totals for 1999 and 2002 exclude children in vacation care, since many of these children would also have been attending before/after school care.
2. Figures for 1991–94 are estimates based on previous years Census data. Figures for 1995–97 are from the CP Census conducted in August of each year and are weighted for non-response. However, not all service types were surveyed in each of these years. Figures for 1999 and 2002 are from the Census conducted in May in each of those years and are weighted for non-response.

Sources: AIHW 1999; FaCS unpublished data.

Table 3.17: Age distribution of children using Australian Government-supported child care services, 2004

	Age of children (years)							
Type of service	**<1**	**1**	**2**	**3**	**4**	**5**	**6+**	**Total**
Long day care centres	14,463	50,921	88,205	108,865	88,498	16,130	15,937	383,021
Family day care	4,664	14,664	18,445	16,891	12,505	4,942	17,187	89,300
Before/after school care	—	2	1	85	3,353	20,724	136,626	160,791
Vacation care	—	7	7	38	1,148	11,078	89,432	101,710
Occasional care/other[a]	772	2,253	3,363	3,440	2,012	493	1,311	13,642
Total	**19,899**	**67,847**	**110,021**	**129,319**	**107,515**	**53,367**	**260,495**	**748,464**

(a) Includes occasional care centres, multifunctional Aboriginal children's services, multifunctional children's services and in-home care services.

Source: FaCS 2005.

Table 3.18: Children with special needs as a proportion of all children using Australian Government-supported child care services, 2004 (per cent)

Type of special need	Long day care centres	Family day care	Occasional care	Multi-functionals, MACS, in-home care	Before/ after school care	Vacation care	All services[(a)]
Children from one-parent families	18	25	13	30	27	n.a.	21
Child with disability	1	3	2	10	2	4	2
Parent with disability	1	<1	1	3	<1	<1	<1
Child at risk of abuse/neglect	<1	1	1	3	<1	<1	<1
Aboriginal or Torres Strait Islander	2	1	2	24	1	1	2
Culturally diverse background	13	9	11	3	11	10	12
Total number of children in care	**383,021**	**89,300**	**7,586**	**6,056**	**160,791**	**101,710**	**646,754**

(a) Total excludes children in vacation care, since many of these children would also have been attending before/after school care.

Notes

1. Data on family type were not collected for vacation care services.
2. Some children may be included in more than one special needs category.
3. These data are weighted for agency non-response.

Source: FaCS 2005.

In June 2002, 239,100 children in Australia were attending preschool. Of these, 62% (148,000) were aged 4 years. Almost 20% of children attending preschool were aged 3 years, with another 18% aged 5 years. The median amount of time per week spent at preschool was 10 hours; 54% of those attending preschool spent between 10 and 19 hours per week there. Two-thirds of children attended 2 or 3 days per week; 18% went 1 day per week.

Outcomes

The aims and objectives of government support for child care 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 (see Box 3.7).

The discussion in this section, however, focuses on service rather than client outcomes, in terms of accessibility, affordability and quality.

Accessibility

The accessibility of child care services is a major concern for both parents and governments. Unmet demand is an important indicator of accessibility. One direct measure of unmet demand comes from the 2002 ABS Child Care Survey, which asked

parents whether they wanted to use either some formal child care or additional formal care, but did not do so (ABS 2003d:30). In these terms, about 6% of children aged under 12 years needed additional formal care, well below the level of 16% in 1993. Unmet demand decreased the most for preschool services (83%) and occasional care (80%) (Table 3.19).

Even so, this amounted to 174,500 children requiring additional formal care in 2002. Of this group, 27% required after school hours care, 27% required long day care and 22% occasional care. Unmet need was higher among children aged 0–4 years (9%) than those age 5–11 years (4%).

Table 3.19: Children under 12 years of age for whom parents required some or more formal care, 1993, 1999 and 2002 ('000)

Main type of (additional) formal care required	1993	1999	2002
Before/after school care	125.1	62.6	47.8
Long day care centres	63.8	45.4	46.3
Family day care	60.2	24.5	29.1
Occasional care	191.8	43.7	37.6
Preschool	30.0	11.2	*5.1
Other formal care	18.3	13.7	8.6
Total children who required (additional) formal care	**489.2**	**201.1**	**174.5**

Note: Although some changes were made to the survey between 1999 and 2002, they do not affect the questions on unmet need.

Source: ABS 2003d.

Table 3.20: Carers reporting difficulties in accessing child care during the last 12 months, 2001 (per cent)

Type of difficulty	Carers reporting no difficulties	Carers reporting difficulties
Finding care for a sick child	63.7	36.3
The cost of child care	73.6	26.4
Finding the right person to take care of child	76.5	23.5
Getting care for the hours needed	77.4	22.6
Finding good quality care	78.9	21.1
Finding a place at the child care centre of choice	77.0	23.0
Finding a child care centre in the right location	81.0	19.0
Juggling multiple child care arrangements	80.5	19.5
Finding care during the holidays	82.0	18.0
Finding care the child/ren are happy with	85.7	14.3
Finding care for a difficult or special needs child	88.8	11.2

Notes

1. Proportions exclude those who did not answer the question. The proportion of those who did not answer the question varies from item to item.
2. Items are considered a problem if the carer rated them 7 or above on a 10 point scale where 0 meant 'not a problem at all' and 10 meant 'very much a problem'.

Source: AIHW analysis of Wave 2 HILDA data.

Many of the reasons given for not using the required formal care related to access. Over 61,000 children could not access services because all the places at the service were booked; 30,000 children could not access services because of the expense of these services; and 22,000 children could not access child care services because there were no services available in the area (ABS 2003d).

A more specific barrier was finding care for a sick child (NATSEM 2005). Over one-third of carers reported that this was an issue for them in accessing child care, making this the most common difficulty reported. Supporting the findings of the ABS Child Care Survey, the second most common difficulty was the cost of child care, identified as an issue by 26% of carers. Although finding care for a difficult or special needs child was the least problematic of the 11 items, 11% of carers reported difficulties in this area.

Both surveys point to a number of areas where carers are encountering barriers to accessing child care and preschool services. Even though accessibility is increasing, there are still many obstacles to overcome before all carers can access services to their satisfaction. The Australian Government has gone some way towards addressing these needs by providing extra places in outside school hours care and family day care (FaCS 2004a).

Affordability

The cost of children's services is an issue that can affect access to and use of children's services. If the Child Care Benefit (Box 3.6) does not keep up with rising costs in child care, parents will be faced with an increasing cost burden. Recent wage rises awarded to some child care staff may result in higher child care costs if they are passed on to parents.

Trends in the affordability of selected child care services have been monitored since 1991, by calculating the cost of child care services as a proportion of the disposable income of five different family types (ABS 2002; AIHW 2001; AIHW analysis of 2002 data) (Table 3.21). Since 2000, the cost of child care as a proportion of disposable income has increased for all family types except couple families with high incomes. Although the cost decreased between 1998 and 2000, it has risen again in more recent years to a level similar to that of 1998 (Figure 3.9).

Over the last 15 years, policy changes have had a clear impact on trends in affordability of child care. Most recently, the Australian Government Child Care Benefit (CCB), introduced in 2000, resulted in greater affordability of child care services for many families. This is evidenced by the 'dip' in the trend graph for 2000. Other policies which have had an impact on affordability include the availability of the Child Care Cash Rebate (as it was known then) to high-income families after 1994, and the subsequent reduction of this rebate in 1997 (AIHW 2001).

Figure 3.9 shows the impact of these policy changes on affordability of child care for three family types using private long day care. Sole parents who were not working, but who were receiving the Parenting Payment, spent the highest proportion of their disposable income on child care of all the family types examined. In 2004, the cost of child care was 15.1% of disposable income for this group. Since 1991, the proportion of disposable income spent on child care by couple families with two incomes earning 1.75 the national average weekly earnings has been higher than that spent by working sole parents.

Box 3.6: Australian Government Child Care Benefit (CCB)

For children who are using approved care, the Australian Government funds the Child Care Benefit (CCB) which entitles the families of children to a reduced cost of care, dependent on income. For families with incomes of $31,755 or less, the maximum rate of CCB ($137 per week) is applied. This rate is for one child who is not at school, and who is in care for 50 hours per week. The rate under these conditions is equivalent to $2.74 per hour. If families earn more than $31,755, the CCB tapers down to a minimum rate of $23.00 per child for 50 hours of care per week – or $0.46 per hour. If a family has an income greater than $91,035, they are eligible for only the minimum rate. 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.

In addition to this, families can also claim the minimum rate of CCB if their child is attending registered care. Registered care may be provided by grandparents, relatives and friends as well as some private preschools, kindergartens, outside school hours care services and occasional care centres as long as they have been registered through the Family Assistance Office (FAO).

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 FAO at the end of the financial year. Families using registered care can claim CCB from the FAO during the year by submitting the child care receipts within 12 months of having the care provided.

The amount of CCB for the standard hourly rate for approved care rose by $0.30 between 2000–01 and 2003–04, while the amount for registered care rose by $0.05.

In January 2005, a Grandparent Child Care Benefit was introduced. Under this benefit, the normal work, training and study test is waived. This means that grandparents who are primary carers of their grandchildren can receive CCB for up to 50 hours a week, regardless of whether or not they are working or studying.

Sources: Centrelink 2001, 2004.

Policy changes have also affected child care affordability for other family types. Couple families with two incomes who earn 2.5 times the national average weekly earnings (i.e. high-income earners) were the only group to have experienced an increase in the affordability of child care over the 1991–2004 period (see Table 3.21 and AIHW 2001). The cost of child care was similar for working sole parents, couple families with one income and couple families with two incomes (1.75 AWE).

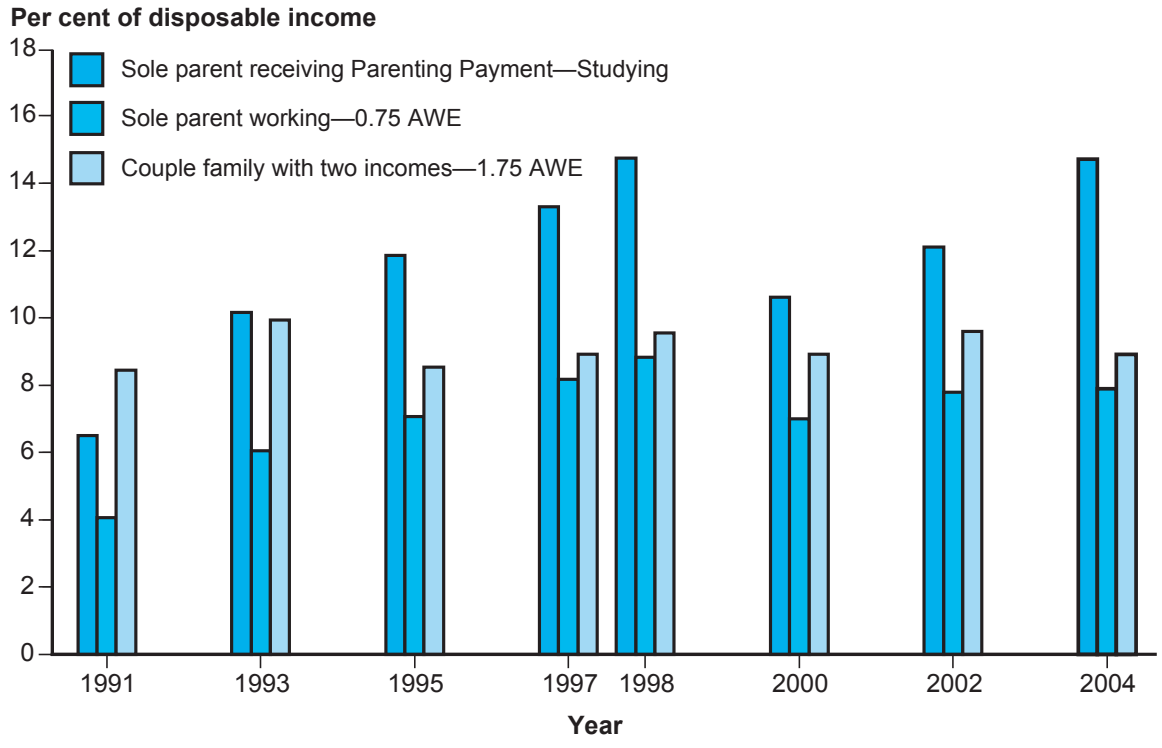
Data from more recent years show a steady decline in the affordability of child care services in four out of the five family types (Table 3.21). As noted earlier, 20 hours is the average number of hours per week that a child is in centre-based long day care or family day care services.

Between 2000 and 2004 the affordability of community-based and private long day care centres declined for all family types except couple families earning 2.5 times AWE.

Sole-parent families receiving the Parenting Payment pay a higher proportion of their disposable income on long day care services than other family types. Over the same period, the affordability of family day care services declined for all family types. These services were previously free for sole-parent families, but in 2004 were still more affordable than long day care for this group.

Although these data are helpful as an indicator of the affordability of child care services, they do not fully show the impact of the costs of child care on different families. In particular, sole-parent families on the Parenting Payment have very low disposable incomes. Once child care is paid for, less money is available for other necessities such as food, shelter and clothes than for families with higher disposable incomes. Note that the figures are based on the cost of child care for a single child. Many families have more than one child using child care services and each child may attend different types of service depending on their age and parental employment status (Bowes et al. 2003; Qu & Wise 2004). This would increase the cost of child care for a family.

A further limitation of these data is that they assume that families receive every possible government or tax benefit available to them. The systems for obtaining these benefits can be complex and confusing, so not all families may be accessing all the payments they are entitled to. Affordability in these cases may be even more of an obstacle to obtaining care.



Note: AWE is a measure of the national average weekly earnings of Australians. 1.75 AWE represents a couple family with one member working full-time and the other part-time.

Source: Table 3.21.

Figure 3.9: Cost of child care as a proportion of disposable income, for one child using private long day care for 40 hours per week, 1991–2004

Table 3.21: Cost of child care as a proportion of disposable income, July 2000 to May 2004 (per cent)

	20 hours			40 hours		
Type of service, family type and income level	**2000**	**2002**	**2004**	**2000**	**2002**	**2004**
Community-based long day care centres						
Sole parent receiving Parenting Payment—Studying	4.8	5.1	6.1	12.5	13.0	15.1
Sole parent working—0.75 AWE	3.2	3.3	3.3	8.3	8.4	8.1
Couple family with one income—AWE	3.6	3.8	4.0	8.6	9.0	9.1
Couple family with two incomes—1.75 AWE	4.5	4.7	4.4	9.6	10.0	9.0
Couple family with two incomes—2.5 AWE	4.9	5.0	4.1	9.9	10.2	8.3
Private long day care centres						
Sole parent receiving Parenting Payment—Studying	3.9	4.6	5.9	10.6	12.1	14.7
Sole parent working—0.75 AWE	2.6	3.0	3.2	7.0	7.8	7.9
Couple family with one income—AWE	3.0	3.5	3.9	7.5	8.5	9.0
Couple family with two incomes—1.75 AWE	4.2	4.6	4.3	8.9	9.6	8.9
Couple family with two incomes—2.5 AWE	4.6	4.9	4.0	9.4	9.9	8.2
Family day care services						
Sole parent receiving Parenting Payment—Studying	—	—	0.3	—	—	2.8
Sole parent working—0.75 AWE	—	—	0.1	—	—	1.5
Couple family with one income—AWE	0.8	0.9	1.6	1.7	2.1	4.0
Couple family with two incomes—1.75 AWE	3.0	3.3	3.3	6.0	6.6	6.8
Couple family with two incomes—2.5 AWE	3.9	4.1	3.6	7.4	8.4	7.2

Notes

1. Taxable income includes any earned income and Centrelink payments and allowances which are considered taxable (e.g. Parenting Payment). Gross income includes income, payments and allowances (including non-taxable items). Net income is gross income minus tax and Medicare levy, taking into account any tax offsets such as low-income earners rebate.
2. In couple families with one income, one parent is working, the other studying. In other couple families, both parents are working.
3. For couple families with two incomes, the taxable income split is assumed to be 1:0.75.
4. Average weekly earnings (AWE) at July 2000 were $646.90.
5. Average weekly earnings (AWE) at November 2002 were $688.40.
6. Average weekly earnings (AWE) at May 2004 were $952.50.

Sources: ABS 2002; AIHW 2001; AIHW analysis of 2004 data.

Quality

Legislative regulations and accreditation systems are the two mechanisms for ensuring quality in the child care sector. The regulations specify the minimum standards which must be met in order for the service to operate. Accreditation processes, on the other hand, focus on measuring the quality aspects of the services that are delivered (NCAC 2003).

All states and territories license and regulate centre-based long day care and occasional care services. Family day care schemes and/or providers are licensed and regulated in New South Wales, Queensland, Western Australia and the Australian Capital Territory, while outside school hours care services are licensed and regulated in Queensland, Western Australia and the Australian Capital Territory. Since child care licensing regulations vary across jurisdictions, in the early 1990s sets of national standards for long day care centres, family day care and outside school hours care services were developed by the Australian Government and state and territory governments and endorsed by the (then) Community Services Ministers Conference.

The Australian Government is responsible for accrediting all Australian Government-supported long day care centres, family day care schemes and outside school hours care services. It does this through the Quality Improvement and Accreditation System (QAIS) administered by the National Child Care Accreditation Council (NCAC) (Box 3.7). All of the above-mentioned services must participate in the QAIS in order to be approved for the Child Care Benefit funding through the CCSP as well as any other Australian Government funding (NCAC 2003).

The NCAC regularly publishes statistics on the accreditation status of long day care, family day care and outside school hours care services. Although the total number of accredited long day care services increased from 3,683 in June 2003 to 3,819 in June 2004, the proportion that were accredited declined slightly (Table 3.22). The proportion not accredited remained stable, while the proportion undergoing the process of accreditation increased slightly throughout the 2001 to 2004 period.

Box 3.7: Quality improvement systems

The Quality Improvement and Accreditation System (QAIS) began in 1994 as a way to provide accreditation to long day care centres that meet certain quality standards, and to indicate areas for potential improvement in these services. Since 1998, the QAIS has used 10 quality areas to form its underlying structure. Each quality area contains several principles. The quality areas and principles are intended both as a guide for long day care centres in improving their performance, and as a measurement tool for assessing centres for their accreditation status.

The 10 quality areas are: relationships with children; respect for children; partnerships with families; staff interactions; planning and evaluation; learning and development; protective care; health; safety; and managing to support quality. The principles within these areas cover such items as the equitable treatment of children, good teamwork of staff, the maintenance of records of children's learning and wellbeing, and the maintenance of appropriate health and safety standards. Contained within the areas and principles of the QAIS are the minimum standards required for state and territory government licensing of centres.

In order to gain accreditation through the QAIS, a centre must progress through five steps – registration, self-study, validation, moderation and accreditation. Accreditation currently lasts for two and a half years, at which time a service will be reassessed against the relevant criteria.

Source: NCAC 2003.

Workforce issues

The lack of qualified staff is part of a larger concern regarding the child care services workforce and quality of care issues. Many sources cite critical shortages and lack of retention of staff in the child care workforce as major problems facing the sector (CCCAC 2002; NSWCCYP 2002; SPRC 2004a). Child care workers are generally poorly paid and their jobs undervalued. The sector is characterised by limited career paths, poor working conditions and high workloads. As a result, many skilled workers move to other occupations (Tasman Economics 2001). Although it has been recognised that

higher pay would be beneficial, many services feel that they cannot offer increases as this would result in a similar increase in the cost of providing the service, which would then be passed on to parents (NSWCCYP 2002).

Associated with these workforce issues is the recognition that quality of child care service is strongly related to the training and experience of staff (Brennan 1998 cited in SPRC 2004b; Fleer 2002:39). In 2004, the proportion of staff with qualifications varied greatly depending on the type of service (FaCS 2005). During 2004, about 60% of the staff at long day care centres were appropriately qualified. This compared with 25% of family day care providers, 40% of outside school hours care and vacation care workers, and 47% of occasional care workers. In all service types, except family day care, less than 25% of staff had 3 or more years of experience in the child care sector (see Appendix Table A3.5).

In-service training is offered by many services as part of licensing requirements, with a high proportion of staff participating in such training during the 12 months prior to the census. The number of qualified workers in the child care sector may be bolstered due to legal requirements as to the ratio of qualified workers to children.

Many services rely on unpaid workers such as volunteers, work experience students, parents and trainees (Table 3.23). Although the proportion of unpaid workers in Australian Government-supported services is relatively small, this group plays an important role in the provision of services. However, little is known about unpaid workers, since most reports on the child care workforce have focused solely on its paid sector.

The information available on unpaid workers shows that they are present in all child care services types. The number of workers has fluctuated over time, ranging from 3,721 in 1997 (5% of the workforce) to 2,492 in 2004 (3%). Since 1999 the number of unpaid workers has declined. In 2004, unpaid workers were most highly represented in occasional care and other care services, with 7% of all staff being unpaid.

The second ABS survey of community services (ABS 2001) found that there were approximately 4,000 volunteers working in direct provision of child care services in 1999–2000. The number of volunteers has declined by 28% since 1995–96. This could be attributed to the increasing difficulty and expense of obtaining police checks and personal accident and/or public liability insurance for volunteers (Volunteering Queensland 2004), as well as the need to closely supervise volunteers.

Table 3.22: Accreditation status of Australian Government-supported long day care centres 1997–2004

	June 1997		July 1999		April 2001		June 2003		June 2004	
Accreditation status	**No.**	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**
Accredited	2,799	68	3,584	87	3,669	91	3,683	87	3,819	85
Plan of action—not accredited	283	7	269	6	205	5	270	6	216	5
Undergoing process[(a)]	1,052	25	289	7	149	4	300	7	430	10
Total	**4,134**	**100**	**4,142**	**100**	**4,023**	**100**	**4,253**	**100**	**4,465**	**100**

(a) Includes in self-study, in review and in moderation or awaiting council decision.

Source: NCAC various years.

Table 3.23: Estimated number of paid and unpaid child care workers, 1997–2004

	1997		1999		2002		2004	
Type of service	**Paid**	**Unpaid**	**Paid**	**Unpaid**	**Paid**	**Unpaid**	**Paid**	**Unpaid**
Long day care centres	36,779	2,675	35,722	3,113	40,787	2,549	46,471	1,622
Community-based	13,703	841	12,173	1,009	17,069	1,162	18,124	669
Private-for-profit	23,076	1,834	23,549	2,104	23,718	1,387	28,347	953
Family day care coordination unit staff	1,663	53	1,580	31	1,693	36	1,770	33
Family day care providers[(a)]	14,039	. .	12,691	. .	13,047	. .	12,018	. .
Before/after school care	7,633	452	7,746	323	10,457	411	11,531	291
Vacation care	3,514	320	6,732	499	9,950	445	10,998	459
Occasional /other care[(b)]	1,494	221	1,296	185	1,581	129	1,105	87
Total[(c)]	**65,122**	**3,721**	**65,767**	**4,151**	**77,515**	**3,570**	**83,893**	**2,492**

(a) Family day care providers are not categorised as paid/unpaid.

(b) Includes occasional care centres, multifunctional Aboriginal children's services, multifunctional children's services and also in-home care services in 2002.

(c) Totals do not include workers in vacation care, since many of these would have also been working in before/after school care services.

Note: Data are from the FaCS Census of Child Care Services and are adjusted for service provider non-response (weighted).

Source: FaCS Census of Child Care Services, various years.

3.6 Pathways from education to employment

The pathways that young people take from school to further education to employment, from family life to independent living and adulthood, have changed significantly since the 1980s, when less than half of school students went on to higher education. Typical pathways of those who were in Year 10 between 1986 and 1988, and who did not go on to higher education, were to take up full-time work immediately (20%), or after a brief interruption (24%), complete training such as an apprenticeship and then enter full-time work (13%), or undertake full-time study and then gain employment (12%). Almost one-third spent a considerable portion of their post-school years unemployed, working part-time or out of the labour force (ABS 2003c:96). Although many pathways were possible, they tended to be simple and linear in that people moved directly from education to work.

Since then the proportion of young people who complete Year 12 has more than doubled and the transition from education to employment is generally longer and may involve several steps. Of students who were in Year 9 in 1995, 79% completed Year 12. Almost half of these went on to higher education. For those who did not, the transition from school to full-time work took many forms, including intermittent casual or part-time employment, further study, periods of job searching and unemployment. Of those who did not complete Year 12, 11% were unemployed in 2000, while the most common experience was working full-time in 2000. For both those who completed Year 12 and those who did not, combining part-time study with full-time work was relatively common (22% and 28% respectively) (ABS 2003c:96). Australia's open education system means that young people have many options available to them in terms of combining work and study, and moving from work back to study. This section examines the trends in educational retention, participation and employment of young people.

Education

Education is important for the overall wellbeing of young people as well as the productive capacity of society. An educated workforce contributes to a prosperous society. Education and training increase young people's chances of making a successful transition into the workforce. More broadly, all educational institutions including schools, technical and further education colleges and universities provide opportunities for social interaction. Participating in education promotes feelings of connectedness to the school community and has flow-on effects to the academic side of schooling as well (Fullarton 2002). This section presents an overview of student achievement at different points in their education, retention rates and participation rates of children and young people in school and post-secondary settings.

Literacy and numeracy

Proficiency in literacy and numeracy is regarded as essential to being able to participate in the daily routines of life and successfully undertake further education, development or training. In Australia, the Ministerial Council on Education, Employment, Training and Youth Affairs (MCEETYA) has established national benchmarks for reading, writing and numeracy (Table 3.24), which represent minimum standards of performance below which students will have difficulty progressing satisfactorily at school.

One use of these benchmarks is to identify children who are at risk and target intervention strategies to improve their chances of educational success. The data show that most children in Australia are achieving the minimum standard. (See also Chapter 2, Section 2.3.)

Table 3.24: Students in Years 3 and 5 meeting national benchmarks, 1999–2002 (per cent)

	Reading				Writing				Numeracy			
	1999	2000	2001	2002	1999	2000	2001	2002	1999	2000	2001	2002
Year 3 students												
Males	87.9	90.9	88.4	90.6	90.0	87.4	86.4	91.8	n.a.	92.7	93.7	92.5
Females	92.0	94.3	92.3	94.1	93.9	92.6	92.7	95.5	n.a.	92.8	94.3	93.1
Year 5 students												
Males	83.4	85.2	87.8	87.2	91.4	90.2	91.9	91.5	n.a.	89.4	89.5	89.9
Females	88.4	89.6	92.0	91.5	95.4	94.9	96.2	95.7	n.a.	89.5	89.8	90.2

Source: MCEETYA 2002b.

In addition to national benchmarking, Australia participates in the OECD's Programme for International Student Assessment (PISA), which measures students' reading, mathematics and science literacy across OECD countries. It aims to assess the extent to which students, who are generally in their final year of compulsory schooling, have acquired some of the knowledge and skills that are essential for full participation in society, to reveal factors that influence the development of these skills at home and at school, and to examine what the implications are for policy development (DEST 2004).

Australian students did very well in both the 2000 and 2002 testing. In 2002, only Korea and Japan performed significantly better. Australian students did as well as or better than the OECD average on all but one of the items on the test. The very best of the

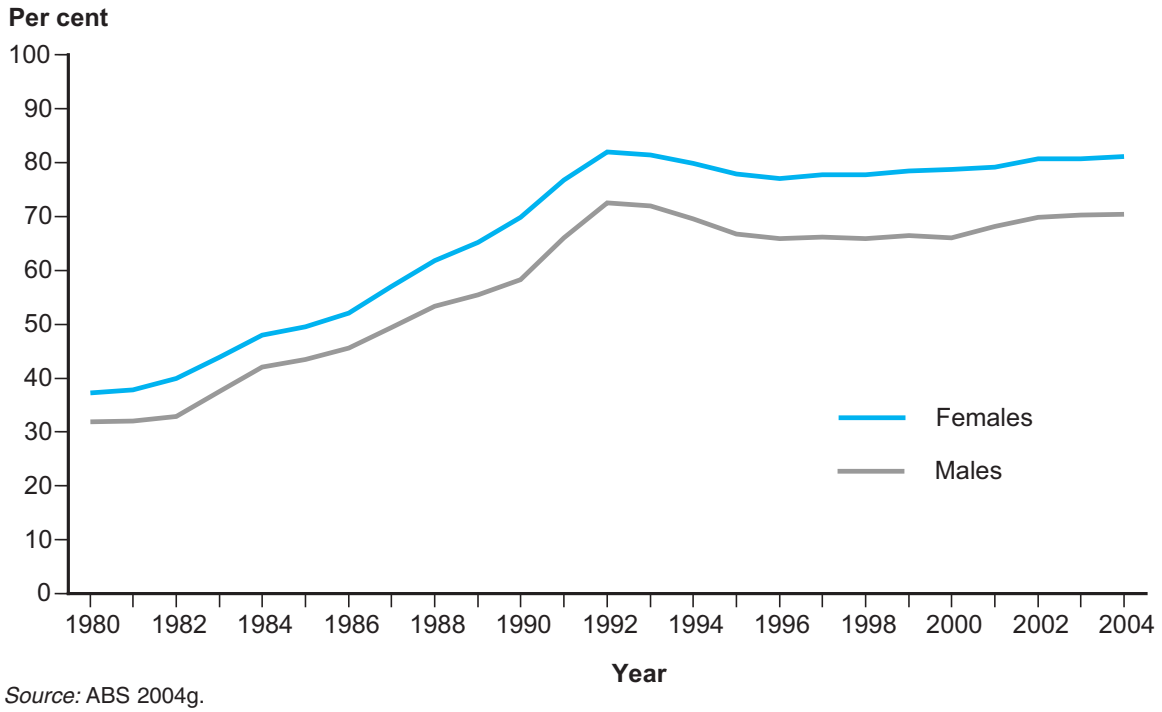
Australian students did as well as the very best from other countries and the spread of scores for the top 75% of Australian students was less than the OECD average. However, for the lowest achieving 25% of students the range of scores was similar to the range across the OECD for these lower achieving students.

The PISA results highlighted a number of areas of concern for Australia: Indigenous students performed poorly in all three areas of testing; boys did not perform as well as girls; and children from lower socioeconomic backgrounds did not perform as well as those from higher socioeconomic backgrounds. In contrast, countries such as Finland, Korea and Canada have both a high average performance and a narrow range of scores. Further, the correlation between student social background and student performance was much lower in Korea and Finland. Both these findings suggest that it is possible to achieve both quality and equity in educational outcomes (McGaw 2002).

Retention rates

It is becoming increasingly important for young people to complete Year 12. Those who leave school before completing Year 10 or Year 12 limit their chances of getting a job as employers increasingly require post-secondary qualifications (DSF 2002). Even so, other options exist for young people who do not complete Year 12, such as post-school training or apprenticeships.

The apparent retention rate measures the proportion of students who remain in secondary school from the start of Year 7 until the completion of Year 12 (see Section 2.3 in Chapter 2). Nationally, apparent retention rates increased rapidly during the 1980s, and more gradually from the mid-1990s (Figure 3.10). In 1980, 32% of males and 37% of females completed Year 12, compared to 70% of males and 81% of females in 2004.



Source: ABS 2004g.

Figure 3.10: Apparent retention rates to Year 12, 1980–2004

The trend was interrupted by a period of high unemployment and fewer job opportunities in the early 1990s which led to a peak in the proportion of young people remaining at school. Throughout the period retention rates remained higher for females than males. The difference between their rates was 5% in 1980. This gender gap has since widened to 11% in 2004.

Participation rates

The shift in Australia to a greater emphasis on lifelong learning means that it is useful to examine participation in education beyond compulsory schooling. Education participation rates of young people have been steadily increasing over the last decade (Table 3.25). These rates measure participation in school and post-secondary school studies for young people aged 15–24 years. They include full and part-time studies at school, TAFE, colleges and tertiary institutions.

The education participation rates of 15–19 year olds increased from 73.1% in 1994 to a peak of 77.3% in 2000. Since then they have fallen slightly to 75.2% in 2004. Over the same period, education participation rates for the 20–24 age group followed a similar trend, with a peak of 37.8% in 2002. Overall, participation was 10% higher in 2004 than in 1994.

Table 3.25: Education participation rates for young people, 1994–2004 (per cent)

Age	1994	1996	1998	2000	2001	2002	2003	2004
15–19 years	73.1	72.8	77.0	77.3	76.7	76.0	76.9	75.2
20–24 years	26.8	30.2	31.7	34.3	35.1	37.8	37.6	36.4

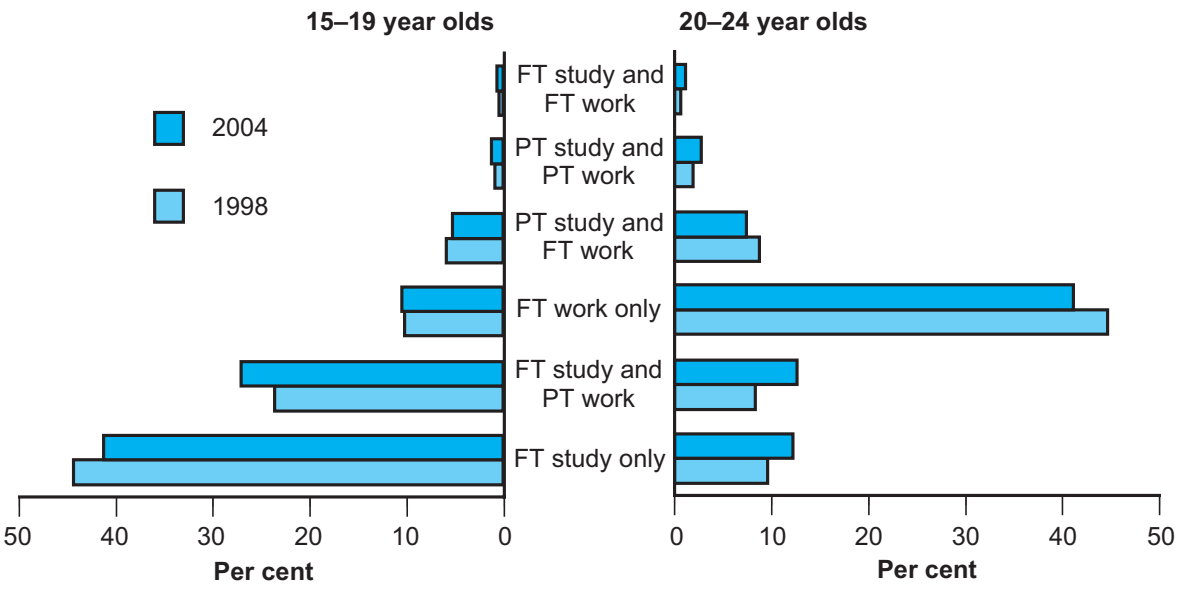
Source: ABS 2004h.

It is becoming increasingly common for young people to combine work and study, starting from their schooldays. Overall, 29% of young people aged 15–24 combined work and study in some way in 2004 (Figure 3.11). However, the combination of part-time work with part-time study was uncommon, suggesting that either work or study takes precedence. In 2004, one-third of 15–19 year olds combined work and study. Between 1998 and 2004 the proportion who were studying full-time and working part-time increased from 24% to 27%. Although the most common experience of this group was full-time study alone, the proportion choosing this option fell from 44% to 41%.

The patterns changed quite markedly as people left school and moved into their early twenties. One-quarter of people aged 20–24 years combined work and study in 2004, increasing from 20% in 1998. Those working full-time were still the largest group (45%) but the size of this group had declined. This suggests that many young people are extending the period spent in study of some kind, either full- or part-time, and delaying taking up full-time work.

Participation in employment

The patterns described above are consistent with longer term trends in the youth labour market. The most notable change has been an increase in participation in education and a consequent deferral of entry into the full-time, long-term labour market. Associated with this has been an increased participation in part-time work.



Source: Table A3.6.

Figure 3.11: Combinations of study and work, 1998 and 2004

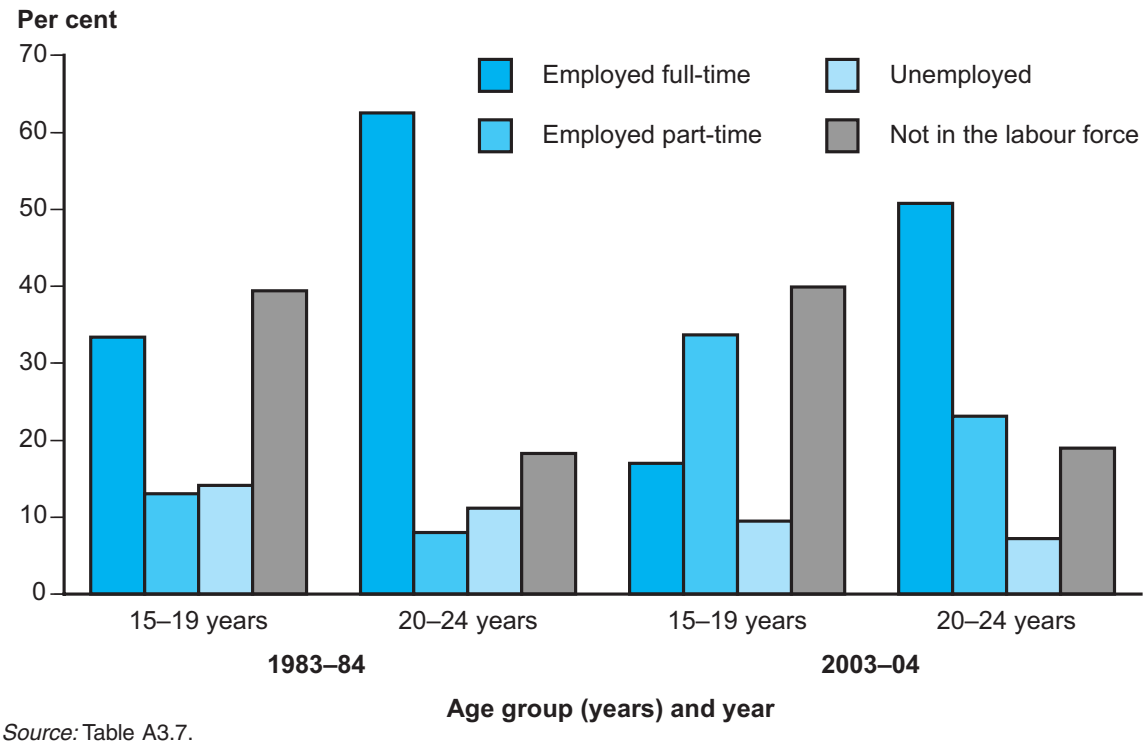
Young people are more likely to be employed than 20 years ago. Between 1983–84 and 2003–04, the proportion of young people aged 15–24 years who were employed increased from 59% to 62% (Figure 3.12). However, the most notable change was in the hours that young people worked. Between 1983–84 and 2003–04, the proportion of young people in full-time employment declined, halving for those aged 15–19 years, from 33% to 17%, and falling from 63% to 51% for young people aged 20–24 years. Over the same period, the proportion employed part-time increased from 13% to 34% for 15–19 year olds, and from 8% to 23% for 20–24 year olds. Over the 10 year period, the proportion of young people who were unemployed also fell slightly, from 14% to 9% for those aged 15–19 years, and from 11% to 7% for those aged 20–24 years.

In the face of these quite substantial changes, the proportion of young people not in the labour force has remained virtually the same—about 40% of 15–19 year olds and 19% of 20–24 year olds. Many of those not in the labour force were in full-time education or, for young women aged 20–24 years, looking after their own children.

3.7 Risks associated with childhood and youth

There is much evidence that the health and wellbeing of children can be dependent on the environment they grow up in. A child who is raised in a supportive, nurturing environment will more likely have better social, behavioural and health outcomes. The reverse is true as well (Tennant et al. 2003).

Child protection services in each jurisdiction provide assistance for some of the more vulnerable children in society. This may be due to child abuse or neglect, or the parent's inability to care for the child. The services range from advice to family support to out-of-home care.



Source: Table A3.7.

Figure 3.12: Trends in labour force participation of young people, 1983–84 and 2003–04

There are well-developed relationships between the welfare of a child and criminal offending later in life. In fact, neglect is considered to be one of the strongest predictors of later youth offending (Weatherburn & Lind 1997).

This section discusses children and young people in the child protection system and also young people in the juvenile justice system. Children and young people as victims of crime are also discussed.

Child protection and out-of-home care services

Child protection is the responsibility of the community services department in each state and territory. Children who come into contact with the department for protective reasons include those:

- who have been, or are being, abused or neglected or otherwise harmed; and
- whose parents cannot provide adequate care or protection.

The aim of child protection services is to protect children and young people who are at risk of harm within their families, or whose families do not have the capacity to protect them. The services include:

- receiving and responding to reports of concern about children and young people, including investigation and assessment where appropriate;
- providing support services (directly or through referral) where harm or a risk of significant harm is identified, to strengthen the capacity of families to care safely for their children;

- initiating intervention where necessary, including applying for a care and protection order through a court and, in some situations, placing children or 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 out-of-home/alternative care when it is determined that a child is unable to be returned to the care of his or her parents, and working with young people to identify alternative supported living arrangements where family reunification is not possible (SCRCSSP 2005:15.2–15.3).

This section examines trends in these services over the last 5 years. Some data on trends for Indigenous children are also provided.

Data sources

The Australian Institute of Health and Welfare has collected the national child protection data since the early 1990s. The data cover four main areas of child protection, namely:

- child protection notifications, investigations and substantiations (formerly referred to as child abuse and neglect);
- children on care and protection orders;
- children in out-of-home care; and
- Intensive Family Support Services.

The national child protection data were extracted from the administrative systems of the state and territory community services departments according to definitions and counting rules agreed to by the departments and the Institute. For more information about child protection processes, see *Child Protection Australia 2003–04* (AIHW 2005b).

Children who are in need of protection

The purpose of child protection services is to respond to reports of concerns about children and to identify those who are in need of protection from abuse, neglect or harm. Concerns about children can be brought to the attention of the community services departments by parents, other relatives, children themselves, by people outside the family or by professionals who have contact with children and families.

Many families involved with community services departments have complex needs and experience a range of problems. These may include financial difficulties, limited social support networks, domestic violence, emotional health problems, health issues and problems with unsafe, unsanitary or uninhabitable housing (Layton 2003).

For example, a 2002 Victorian study examined the characteristics of parents of children in substantiated cases of abuse or neglect. It found that 73% of these parents had at least one issue or problem in addition to the child protection concern. Of these, 52%

experienced domestic violence, 33% substance abuse, 31% alcohol abuse, 19% had a psychiatric disability, 4% a physical disability and 3% an intellectual disability. Two or more of these problems were experienced by 44% of the parents (VicDHS 2002).

The findings above are similar to those of an audit of 150 children under the guardianship of the Minister in the Australian Capital Territory. The audit found that 56% of parents used drugs and/or alcohol excessively; 49% had repeated incidences of domestic violence; 38% had a parent with diagnosed mental illness or personality disorder; and 15% of families had a parent with a criminal history or a parent currently in gaol (Murray 2004).

Socioeconomic status is another important factor related to child abuse and neglect. Available data indicate that children in the child protection system are most likely to be from families with low socioeconomic status. While data are not available on this at the national level, studies in a number of jurisdictions demonstrate the link between child protection and economic disadvantage.

For example, the Social Health Atlas of Young South Australians (Tennant et al. 2003) investigated the correlation of substantiated child protection cases with a number of social indicators. The study found a strong relationship between substantiations and children living in dwellings with no motor vehicles, dwellings rented from SA Housing Trust, low-income families and single-parent families.

The high rates of Indigenous children in the child protection system are consistent with these findings. The national child protection data show that Aboriginal and Torres Strait Islander children are nearly 10 times more likely than other Australian children to be the subject of a child protection substantiation, and are over six times more likely to be in out-of-home care (AIHW 2005b). The generally lower socioeconomic status of Aboriginal and Torres Strait Islander families is likely to be a key reason for this over-representation.

Family disruption appears to be another important factor 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 form a higher proportion of substantiated cases than the children in other family types (AIHW 2005b).

Use of child protection services

This section provides information on notifications, investigations and substantiations (Box 3.9).

Notifications, investigations and substantiations

Table 3.26 shows rates of notifications, investigations and substantiations by state and territory over the 5 years from 1999–00 to 2003–04. Trends in these rates are not simple to present or interpret. The data are a measure of the activity of the community services departments, so are influenced by legislation, policies, practices and data systems. The area is constantly evolving, so even comparing one year's data to the next within a jurisdiction can be very misleading.

Increases in notifications may be due to more children requiring a child protection response, for example, due to an increase in the incidence of child abuse and neglect or

inadequate parenting causing harm to a child. However, changes in the data from year to year are more likely to be a result of:

- increased reporting by professionals as a result of the mandatory reporting provisions in most jurisdictions;
- increased community awareness due to media and departmental campaigns about child abuse and neglect and the role of community service departments in this area; or
- changes to policies, practices and data reporting methods.

Box 3.9: Definitions for notifications, investigations and substantiations

Notification *– 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 *– 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.*

Not all notifications are investigated. Some do not warrant investigation. Some are dealt with by other means, such as family support or referral to another service, and some are unable to be investigated as the information is incomplete or the child is unable to be located.

Examination of national data indicates that the rate per 1,000 children who were the subject of a notification, investigation or substantiation has steadily increased over the past 5 years. National trends, however, mask the different trends that have occurred in each state and territory. Increases in numbers of children in the child protection system in one jurisdiction can cancel out decreases in another, so that what has occurred in each jurisdiction can vary significantly from the national patterns.

In particular, policy changes within jurisdictions can have a major impact on the number of children in the child protection system. For example, between 1999–00 and 2003–04 the rate per 1,000 children of child protection notifications in New South Wales increased considerably, from 16.4 to 46.7. However, this increase is not necessarily due to increases in the level of child abuse and neglect in New South Wales. In December 2000, the *Children and Young Persons (Care and Protection) Act 1998* was proclaimed. This

Act introduced a central intake system and also broadened mandatory reporting requirements in New South Wales. While the rate of notifications did increase during the period 2000 to 2002, the department's data system did not have the capacity to record the new policies and practices correctly. This changed in 2002–03, when the KiDS system was implemented. The new system recorded the activity of the department more accurately, making notifications appear to have doubled, when in fact this simply reflected more accurate reporting.

Over the same period, substantiations did not increase to the same extent as notifications, but this is mainly because a new category—carer/family concerns—was introduced for those years. About 5,000 cases were included in this category in both years. This category was removed in 2002–03, and those cases are again recorded as substantiations. This example illustrates how changes to the administrative recording systems impact on the quality and reliability of the time series, with New South Wales being an obvious case in point. These types of issues should be taken into consideration when interpreting trend data for each state. Such changes in recording practices and policies make comparison of data within states from year to year very difficult and comparison of differences among states almost impossible.

Another interesting example is in Tasmania. Prior to 2003–04, notifications were made to individual area offices and further examination was conducted before the call was recorded on the system as a notification. This changed in 2003–04 when a central intake system was introduced. Now all calls relevant to child protection concerns are recorded as a notification and as a result it falsely appears that notifications have increased 10-fold (from 4.8 to 47 per 1,000).

It is also not possible to compare across the states and territories, given the differences in policies and practices. The wide range in the rates per 1,000 of children in each category is more an indication of how each jurisdiction defines these practices, rather than a true variation in the levels of abuse and neglect in each jurisdiction. For more information on these differences, see Bromfield 2005.

Care and protection orders and out-of-home care

Children on care and protection orders

At any point in the child protection process (from notification, through investigation to substantiation), the community services department can apply to the relevant court to place the child on a care and protection order. Such action is usually taken only as a last resort in situations where the department believes that continued involvement with the child is warranted. This may occur in situations where supervision and counselling are resisted by the family, where other avenues for resolution of the situation have been exhausted, or where removal of a child into out- of-home care requires legal authorisation.

There was a 15% increase in the number of children on care and protection orders across Australia between 30 June 2000 and June 2003—from 19,262 to 22,130 (Figure 3.13). The number continued to rise between 2002–03 and 2003–04 in all of the states and territories that provided data (AIHW 2005b). Increases were particularly large in the Northern Territory, where the number increased by 26%, in the Australian Capital Territory (25%), and in Queensland (19%) (AIHW 2005b:33).

Table 3.26: Children aged 0–16 years who were the subject of a substantiation, investigation or notification, 1999–00 to 2003–04

Year	NSW[(a)]	Vic	Qld	WA	SA	Tas	ACT	NT	Total
Rate per 1,000 children who were the subject of a notification									
1999–00	16.4	24.9	16.9	5.2	28.5	2.1	13.0	20.3	17.9
2000–01	20.7	25.7	18.8	5.7	21.4	2.7	9.2	20.9	19.5
2001–02	25.3	25.9	21.9	5.9	23.3	4.0	9.2	23.5	21.9
2002–03	43.3	26.0	24.4	4.7	27.0	4.8	20.2	24.6	28.8
2003–04	46.7	25.6	27.5	4.9	29.9	47.0[(b)]	37.5	29.6	32.0
Rate per 1,000 children who were the subject of an investigation									
1999–00	8.0	10.2	9.3	4.7	11.4	1.9	10.4	10.0	8.6
2000–01	10.8	10.7	11.0	4.8	11.9	2.0	7.0	11.7	10.0
2001–02	13.3	10.4	12.3	4.8	12.7	3.3	6.2	13.4	11.1
2002–03	11.8	10.2	14.7	3.9	13.8	3.8	9.0	12.3	11.1
2003–04	n.a.	9.9	19.3	4.2	14.2	6.2	11.6	16.5	n.a.
Rate per 1,000 children who were the subject of a substantiation									
1999–00	3.9	6.3	5.6	2.3	5.1	0.7	2.6	6.2	4.7
2000–01	4.4	6.3	7.4	2.5	5.0	1.9	2.8	5.8	5.3
2001–02	4.8	6.5	8.3	2.4	5.3	1.4	2.7	5.8	5.6
2002–03	7.5	6.3	10.1	1.9	5.8	1.8	3.6	5.7	6.8
2003–04	n.a.	6.4	14.0	2.0	5.9	3.0	6.7	8.7	n.a.

(a) NSW was unable to provide data on investigations and substantiations for 2003–04 due to ongoing implementation of a new data system.

(b) Data for 2003–04 and previous years should not be compared because of a change in recording practices due to the centralisation of the intake service, known as the Child Protection Advice and Referral Service.

Sources: AIHW 2005b; AIHW unpublished data.

Children in out-of-home care

While children may be placed in out-of-home care as well as on a care and protection order, the two data collections are separate (see Box 3.10 for definitions). The trend in out-of-home care was of increasing numbers of children using the services. Between June 2000 and June 2004 the number of children in out-of-home care increased from 16,923 to 21,795, an increase of 29% (Table 3.27; Figure 3.13). The rate rose from 3.6 children per 1,000 in 2000 to 4.5 per 1,000 in 2004 (AIHW 2003). Growth in the use of out-of-home care occurred in all jurisdictions over the period (Table 3.27). There were particularly large increases in Queensland (68%), and New South Wales and the Northern Territory (30% and 47%, respectively).

There are several reasons for the rise in the number of children on care and protection orders and in out-of-home care from 2000 onwards. At the broad level, it indicates an increasing number of children in families who are considered unable to adequately care for them. This may be due to growing pressures on families through, for example, increases in joblessness, family disruption, substance abuse or family violence. It may also reflect changing community standards in relation to child safety. The increase corresponds to the growing number of child protection notifications that occurred in most jurisdictions during the same period.

Table 3.27: Number of children aged 0–17 years in out-of-home care, at 30 June 2000–04

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Australia
2000	7,041	3,867	2,634	1,326	1,131	548	200	176	16,923
2001	7,786	3,882	3,011	1,436	1,175	572	215	164	18,241
2002	8,084	3,918	3,257	1,494	1,196	544	224	163	18,880
2003	8,636	4,046	3,787	1,615	1,245	468	277	223	20,297
2004	9,145	4,309	4,413	1,681	1,204	487	298	258	21,795

Source: AIHW 2005b.

Box 3.10: Care and protection orders and out-of-home care

Care and protection orders *are legal or administrative orders or arrangements which give community services departments some responsibility for a child's welfare. The level of responsibility varies with the type of order or arrangement. These orders include guardianship and custody orders; supervision and other finalised orders; and interim and temporary orders.*

Out-of-home care *is defined as out-of-home overnight care for children and young people under 18 years of age where the state or territory makes a financial payment. It includes residential care, foster care and relative/kinship care. Children in out-of-home care can be placed in a variety of living arrangements or placement types. The following categories are used in the national data collection:*

Home-based care *– where placement is in the home of a carer who is reimbursed for expenses incurred in caring for the child. This category is further divided into:*

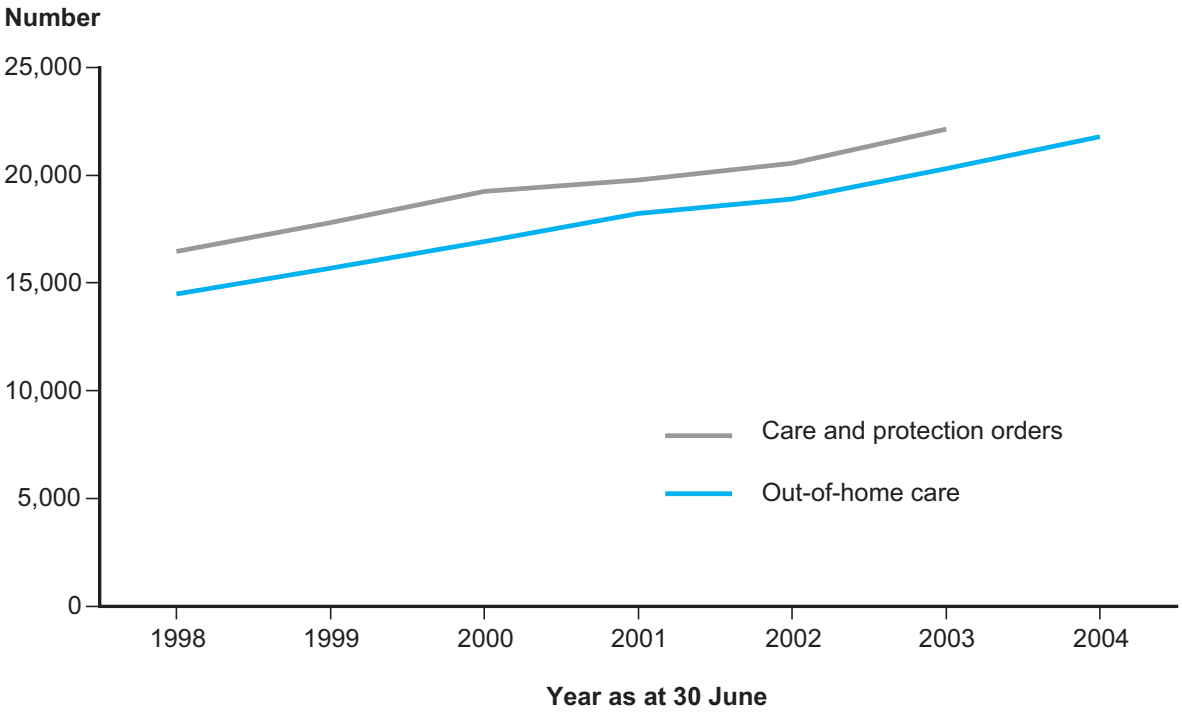
- *relative/kinship care – where the caregiver is a family member or a person with a pre-existing relationship to the child;*
- *foster care – where care is provided in the private home of a substitute family which receives a payment which is intended to cover the child's living expenses;*
- *other home-based care – care in private homes that does not fit into the above categories.*

Residential care *– where placement is in a residential building whose purpose is to provide placements for children and where there are paid staff.*

Family group homes *– these provide short-term care in departmentally-owned homes. These homes do not have salaried staff but are available rent free to approved carers, who receive board payments to reimburse them for the cost of looking after the children in their care.*

Independent living *– where young people are living independently, such as those in private boarding arrangements and lead-tenant households.*

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.



Source: Table 3.30.

Figure 3.13: Children on care and protection orders, 1998–2003 and children in out-of home care, 1998–2004

Types of out-of-home care

Between 2000 and 2004 a number of changes occurred in the proportion of children placed in different types of out-of-home care. The number of children in residential care decreased over the period, falling from 1,222 to 1,037 (this number includes children in family group homes) (Table 3.28). This decrease continues the longer term trend towards the deinstitutionalisation of children that began in the late 1960s (Johnstone 2001). Residential facilities nowadays are generally small, with less than 10 children living together. They can enable large sibling groups to be placed together and cater for children with complex needs. The children in residential care also tend to be older. This is a far cry from the institutions used in the past. A parliamentary inquiry was held during 2004 to examine the use of these institutions and the outcomes for people who accessed these services during the early part of the 20th century (Box 3.11 on page 115).

Over the same period, there was an increase in the number of children who were in home-based care arrangements. The proportion of children living in home-based care increased from 90% in 2000 to 94% in 2004 (Table 3.28). The trend towards more home-based care reflects policies of placing children, particularly young children, in a home-based rather than residential environment where possible.

In the last 5 years, the proportion of children in different types of home-based care has changed. Foster care is still the main type of out-of-home care, with the proportion of children placed in it relatively stable at just over 50%. The proportion of children living with relatives/kin on the other hand has increased—from 38% at 30 June 2001 to 40% at 30 June 2004.

Table 3.28: Children in out-of-home care, 30 June 2000–04

Type of care	2000	2001	2002	2003	2004
			Number		
Foster care	n.a.	9,429	9,668	10,348	11,589
Relative/kinship care	n.a.	6,940	7,439	8,069	8,618
Other home-based care	n.a.	192	164	217	268
Total home-based care[(a)]	*15,169*	*16,561*	*17,271*	*18,634*	*20,475*
Family group homes[(b)]	. .	. .	. .	. .	67
Residential care	1,222	1,177	1,057	1,063	970
Independent living[(b)]	208	203	221	210	221
Other[(c)]	324	300	331	390	62
Total	**16,923**	**18,241**	**18,880**	**20,297**	**21,795**
			Per cent		
Foster care	n.a.	52	51	51	53
Relative/kinship care	n.a.	38	39	40	40
Other home-based care	n.a.	1	1	1	1
Total home-based care	*90*	*91*	*91*	*92*	*94*
Family group homes[(b)]	. .	. .	. .	. .	—
Residential care	7	6	6	5	5
Independent living[(b)]	1	1	1	1	1.0
Other[(c)]	2	2	2	2	0.3
Total	**100**	**100**	**100**	**100**	**100**

(a) Data on type of home-based care could not be provided by all jurisdictions in 2000.

(b) Included with 'Residential care' prior to 2003–04.

(c) Includes unknown living arrangements.

Source: AIHW Child Protection Australia, various years.

National Plan for Foster Children, Young People and their Carers 2004–06

The National Plan for Foster Children, Young People and their Carers was developed for the Community and Disability Services Ministers' Conference (CDSMC) by the Australian and state and territory governments. This plan was developed in recognition of the importance of foster carers and the impact they have on the lives of children in the out-of-home care system. The plan centres on children in foster care and on improving their wellbeing and life chances (CDSMC 2003). There are four main areas of focus: training, research, uniform data collection, and support. National standards for foster care are being developed, and the intention is to incorporate these into the jurisdictions' own guidelines. Also, the AIHW has been invited by the states and territories to aid in the development of a data collection on foster carers and relative/kin care.

Trends for Aboriginal and Torres Strait Islander children

The over-representation of Aboriginal and Torres Strait Islander children in the child protection system is well documented. For example, in 2003–04 the rate of

substantiations in Indigenous families was 10 times higher than for other families in Victoria and around 8 times higher in Western Australia and South Australia (AIHW 2005b). This section includes trends of Indigenous children subject to child protection substantiations, on care and protection orders and in out-of-home care.

The quality of the data on Indigenous status is one of the major issues to be considered when analysing trends for Aboriginal and Torres Strait Islander children since data quality varies across jurisdictions and over time. Increases in the recorded number of Indigenous children in the child protection system over time may therefore be due to improvements in the quality of the data.

Substantiations

The available data indicate that the rate per 1,000 Indigenous children aged 0–16 years who were the subject of a substantiation increased in all jurisdictions except Western Australia between 1999–00 and 2003–04 (Table 3.29).

Care and protection orders and out-of-home care

The number of Aboriginal and Torres Strait Islander children on care and protection orders increased considerably between June 2000 and June 2003, from 3,861 to 4,803 (24%). The number of other children on care and protection orders rose by only 13% over the same period (Table 3.30).The number of Indigenous children in out-of-home care also increased, from 3,496 in 2000 to 5,059 in 2004 (a 45% rise). In comparison, the number of other children in out-of-home care increased by 25%.

Box 3.11: Forgotten Australians—a report on Australians who experienced institutional or out-of-home care as children

On 30 August 2004 the Senate Community Affairs Committee tabled the report, Forgotten Australians. *The report focused on children who were in institutional and out-of-home care, mainly from the 1920s, until deinstitutionalisation in the 1970s began to see large institutions replaced by smaller residential homes, foster care or other out-of-home care options. Upwards of, and possibly more than, 500,000 Australians experienced care in an orphanage, home or other form of out-of-home care during this period. The report included information on the role of governments and churches in placing children in care, the treatment of children in care and the long-term effects of experiences while in care. The issues of responsibility, acknowledgement and reparation were also canvassed, as were issues relating to the accessing of records and information, and the provision of wide-ranging services for care leavers, which are critical to ensuring that they and their families can improve their quality of life.*

A second report, Protecting Vulnerable Children: A National Challenge, *was tabled on 17 March 2005. This report focused on contemporary foster case issues, children in care with disabilities and the contemporary government and legal framework in which child welfare and protection issues operate.*

The processes for preparing a response to the recommendations in both reports are currently underway.

The Aboriginal Child Placement Principle

The Aboriginal Child Placement Principle outlines preferences for the placement of Aboriginal and Torres Strait Islander children when they are placed outside their immediate family (Lock 1997:50):

- with the child's extended family;
- within the child's Indigenous community; then
- with other Indigenous people.

All jurisdictions have adopted the Aboriginal Child Placement Principle either in legislation or policy. The impact of the Principle is reflected in the relatively high proportions of Indigenous children who were placed either with Indigenous caregivers or with relatives in many jurisdictions (Figure 3.14).

At 30 June 2004, the proportion of Indigenous children who were placed in accordance with the Principle ranged from 81% in Western Australia to 40% in Tasmania. The relatively low proportion of children who were placed with an Indigenous carer or relative/kin in Tasmania and the Australian Capital Territory is probably related to the small size of the Indigenous population as well as issues related to the identification of Indigenous status in that state (AIHW 2003).

Table 3.29: Aboriginal and Torres Strait Islander children aged 0–16 years who were the subject of a substantiation, 1999–00 to 2003–04 (per 1,000 children)

Year	NSW	Vic	Qld	WA	SA	Tas[a]	ACT[a]	NT
1999–00	13.2	48.5	9.3	11.9	31.6	0.5	3.7	7.7
2000–01	14.9	50.9	12.4	12.6	29.4	0.3	12.1	6.8
2001–02	15.4	48.4	14.3	13.6	31.8	0.3	6.6	9.7
2002–03	31.9[b]	55.3	15.6	9.6[c]	32.0	2.5	19.4	8.6
2003–04	n.a.[d]	57.7	20.8	11.2	39.9	1.6	25.3	16.2

(a) Rates from Tas and ACT should be interpreted with care due to small numbers. Any fluctuation in numbers of children has a large impact on rates.

(b) The data for 2002–03 and previous years should not be compared. NSW implemented a modification to the data system to support legislation and practice changes during 2002–03 which would make any comparison inaccurate.

(c) The decline in number of substantiations is due to decreased number of notifications.

(d) NSW were unable to provide data due to ongoing implementation of the data system.

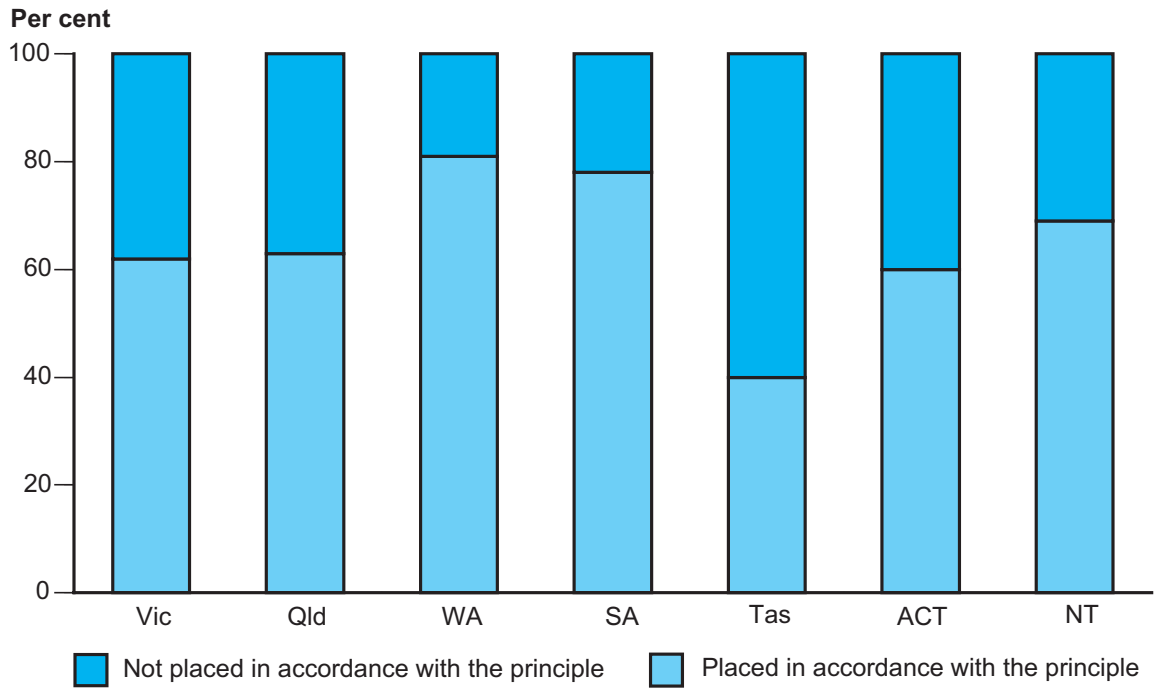
Source: AIHW 2005b.

Table 3.30: Children on care and protection orders and children in out-of-home care, June 2000 to June 2004

	Children on care and protection orders			Children in out-of-home care		
	Indigenous	Other children	Total	Indigenous	Other children	Total
2000	3,861	15,401	19,262	3,496	13,427	16,923
2001	4,146	15,637	19,783	4,037	14,168	18,205
2002	4,264	16,293	20,557	4,199	14,681	18,880
2003	4,803	17,327	22,130	4,750	15,547	20,297
2004	n.a.[a]	n.a.[a]	n.a.[a]	5,059	16,736	21,795

(a) National totals could not be calculated because data were not available from NSW in 2003–04 due to ongoing implementation of the data system.

Source: AIHW 2005b.



Source: Table A3.8.

Figure 3.14: Aboriginal and Torres Strait Islander children in out-of-home care by whether placed in accordance with the Aboriginal Child Placement Principle, at 30 June 2004

Data developments

There are significant gaps in the current national data on child protection. Apart from the intensive family support services data, there are no other data at the national level on the support services used by children in need of protection and their families. Work is currently being undertaken by National Child Protection and Support Services (NCPASS) to broaden the scope of the national data collection and to improve comparability. A new national framework has been developed to count responses to calls received by community services departments in relation to the safety and wellbeing of children, including responses that occur outside the formal child protection system. Data elements such as the provision of advice and information, and assessment of needs, as well as general and intensive family support services, are incorporated into the new framework. National reporting will be aligned to this framework over the next few years.

Juvenile justice

The responsibility for juvenile justice in Australia rests within the community services sector, rather than the correctional sector. There are well-established connections between the welfare of young people and their involvement in juvenile offending. Several welfare issues are consistently related to youth offending, including:

- poor parental supervision of the child, parental rejection of the child, child's rejection of the parent, low parent–child involvement, harsh and authoritarian discipline, parental conflict (Farrington 1995; Loeber & Stouthamer-Loeber 1986);

- physical abuse and neglect (Stewart et al. 2002; Weatherburn & Lind 1997);
- high levels of socioeconomic disadvantage (Lynch et al. 2003); and
- substantiated child protection notifications (Lynch et al. 2003).

Neglect is considered to be one of the strongest predictors of later youth offending (Weatherburn & Lind 1997). Factors leading to child neglect include economic hardship, housing inadequacy, poor social support networks, poor family functioning, and parental and child characteristics (Salmelainen 1996).

A survey of young people in detention in New South Wales found that they experienced a range of health problems, including alcohol consumption in the hazardous/harmful range, injecting drug use, intellectual disability, symptoms of psychiatric disorders, symptoms of personality disorders, psychosocial problems, suicide and self-harm. These factors combine with low levels of accessing health care outside the juvenile justice system (Allerton & Champion 2003).

The juvenile justice system seeks to reduce youth offending. A major part of this process is to address the risk factors associated with offending. Many of these risk factors are welfare related, and as such, the juvenile justice system becomes an important vehicle for the provision of welfare services to young offenders.

During childhood, some young people will have an encounter with the criminal justice system. Most episodes of juvenile offending behaviour are relatively minor and transient in nature, confined to one-off events (Carcach & Leverett 1999). A very small proportion of children have more serious interaction with the juvenile justice system leading to outcomes such as community service orders or sentences involving detention in custody. It is these children who are most vulnerable to continued and more serious offending later in life (Makkai & Payne 2003).

How the juvenile justice system operates

The juvenile justice system is responsible for dealing with young people who have committed or allegedly committed an offence while considered to be a 'juvenile'. Juvenile justice is a state and territory responsibility and each has its own legislation that dictates the policies and practices of juvenile justice within its jurisdiction. While this varies in detail, the intent of the legislation is very similar across Australia. For example, key principles of juvenile justice in all jurisdictions include: diversion of young people from court where appropriate; incarceration as a last resort; victim's rights; the acceptance of responsibility by the offender for his or her behaviour; and community safety.

One of the ways in which the legislation varies across states and territories is in the definition of a 'juvenile'. In Queensland, juvenile justice legislation applies to those people aged 10–16 years at the time of offence. However, in most other jurisdictions those who were aged 10–17 years are included as juveniles. Victoria's legislation was previously similar to Queensland's, but from July 2005, it applies to juveniles aged 10–17 years. Victoria also has a sentencing option for adult courts which allows 17–20 year olds to be sentenced to detention in juvenile justice facilities where appropriate.

The juvenile justice system in each state and territory comprises several organisations, each having a different primary role and responsibility in dealing with young offenders:

- the police, who are usually the young person's first point of contact with the justice system;
- the courts (usually a special children's or youth court), where matters regarding the charges against the young person are heard. The courts are largely responsible for decisions regarding bail (and remand) and sentencing options if the young person admits guilt or is found guilty by the court; and
- the juvenile justice departments, which are responsible for the supervision of juveniles on a range of community-based orders and supervised bail. They are also responsible for the administration of juvenile detention centres.

Police

Police may administer cautions and warnings to juveniles, which may be either formally recorded or informal. Cautions are used in all jurisdictions in Australia, and may have voluntary or mandatory conditions attached, such as attendance at a program or community service. Currently there are no national data available on the use of, or outcomes associated with, police cautions. In some jurisdictions, the police may use conferencing to divert juveniles from proceeding to court.

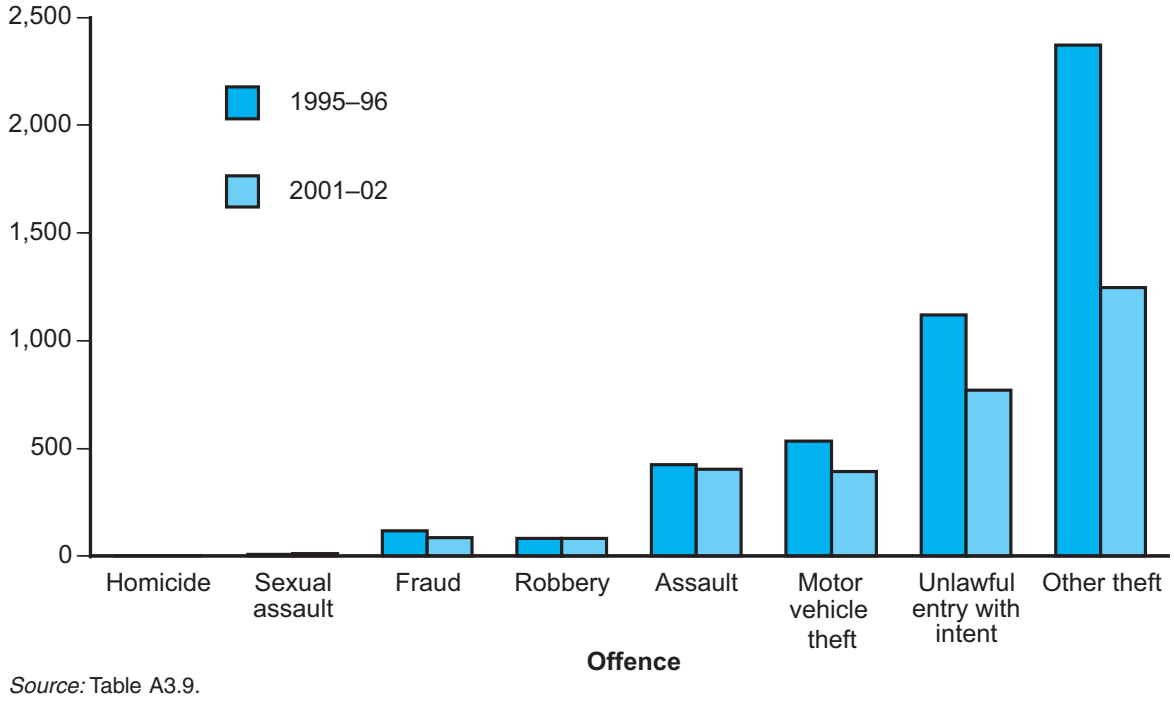
In 2001–02, juveniles accounted for one-fifth of the total offender population as measured by police apprehensions in Victoria, South Australia and Queensland (AIC 2003). Offending rates for juveniles are almost twice as high as those for adults. The disparity has lessened in recent years, with a trend to declining rates for juveniles. Between 1995–96 and 2001–02, the rate of juvenile police apprehensions declined from 4,664 to 3,003 per 100,000 juveniles. During this period, the rate of adult apprehensions declined slightly.

Juvenile offenders are most commonly apprehended for property-related offences such as theft. Following the trend of declining rates of juvenile apprehension by police, the rates of property-related offences (motor vehicle theft, unlawful entry with intent, other theft) by juveniles decreased between 1995–96 and 2001–02 (Figure 3.15). The most substantial decline was in the rate of other theft, which fell by 47% over this period (AIC 2003).

Diversions

In recent years, several jurisdictions have reported high levels of young people on remand (being held in custodial facilities prior to sentencing), with many of them afterwards receiving non-custodial sentences (Polk et al. 2003). In response to this, programs have been established which seek to provide alternatives to remand. These have included bail programs with intensive supervision, and hostels for those with accommodation difficulties.

A range of other diversionary programs exist throughout the juvenile justice system, which include both voluntary and involuntary participation, and programs focusing on rural areas and Indigenous young people. These programs target family relationships, employment and skills, arts and drug rehabilitation.



Source: Table A3.9.

Figure 3.15: Juvenile offenders, 1995–96 and 2001–02

Conferencing

All Australian jurisdictions now include conferencing in their juvenile justice systems. Conferencing may occur at various stages of the criminal justice system, and be the responsibility of police, courts or the juvenile justice department. The restorative justice principles on which many conferencing models are based focus on a group of people coming together to discuss an offence and its impact, and to agree on sanctions or reparations. The attendees are the young offender (who must have admitted the offence) and their supporters (often including parents or guardians), the victim/s and their supporters, a police officer, and the conference convenor. Conferencing is designed to be less stigmatising and adversarial than the court system and to provide better opportunities for both the offender and the victim to discuss the offence and its impacts.

The increasing popularity of conferencing and restorative justice practices has been accompanied by outcome research in a number of Australian jurisdictions. These studies have focused on results from the point of view of both the offender and the victim, with mixed results. Studies on re-offending and re-conviction rates for conferenced offenders versus those going on to court have ranged from moderate reductions following conferences (Luke & Lind 2002), to no difference. Victims have been found to have high levels of satisfaction with the conferencing process (Polk et al. 2003).

Formal sanctions

The vast majority of young offenders who are not diverted from the formal juvenile justice system are supervised within the community rather than in detention centres (Figure 3.16). At 30 June 2004, between 83% and 95% of juvenile justice clients were in the community.

As these data are collected at a point in time, care should be taken in interpreting them, particularly for jurisdictions with smaller populations where a small change to the number of young people in detention can make a significant difference to the proportion of the population. Additionally, it is important to note that the proportion of juvenile justice clients who are 18 years and over varies between jurisdictions, and that the data presented in the following figures do not include these clients.

The number of young people being held in detention throughout Australia has decreased over the last 22 years (AIC 2004). Since 1981, the Australian Institute of Criminology has collected data on young people in detention on the last day of each quarter. Between June 1981 and June 1989, the number of young people in detention declined by 44%, from 1,352 to 759. Since then the number has fluctuated while showing a general decline, with a low of 545 on 30 June 2002. There were 640 young people in detention in Australia on 30 June 2003.

As with the adult criminal justice system, Indigenous persons are over-represented in the juvenile justice system. Over the last 10 years, the rate per 100,000 of juveniles being detained has fallen for Indigenous persons by 22% and for other Australian persons by 34%. However, the level of over-representation of Indigenous persons has not improved (Figure 3.17). During the last 10 years, Indigenous young people have remained approximately 15–20 times more likely than other Australian young people to be in juvenile detention (AIC 2003).

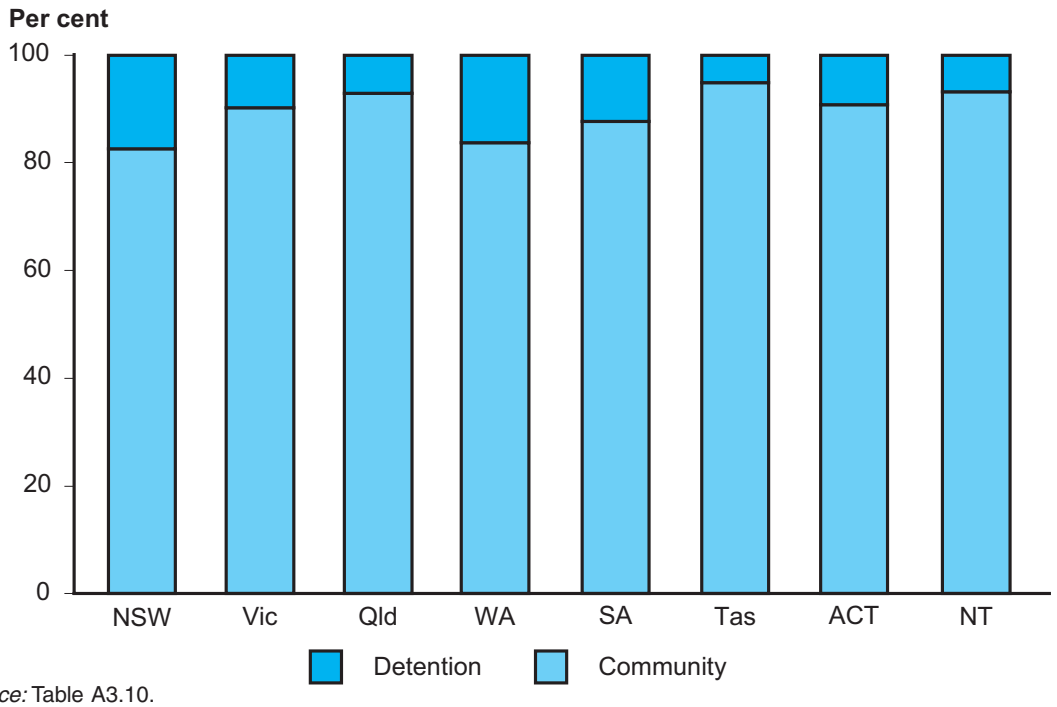
Data developments

In 2000 the AIHW began development of a Juvenile Justice National Minimum Data Set (JJ NMDS) on behalf of the NCSIMG and the Australasian Juvenile Justice Administrators (AJJA). Each state and territory department responsible for the management of juvenile justice in their jurisdiction contributed to the development, along with the Australian Bureau of Statistics, the Australian Institute of Criminology and the Queensland Criminal Justice Commission (now the Crime and Misconduct Commission).

Comprehensive field and pilot testing concluded in 2003. With the agreement of the AJJA, the JJ NMDS has been implemented as an ongoing data collection, with the AIHW as the data custodian. The NMDS provides a unique source of information on the flow of young offenders through juvenile justice supervision over time, and from one form of 'intervention' to another, including both community- and custody-based supervision. The foundation of this is the concept of the 'juvenile justice episode'. Each client can have multiple episodes in any one supervision period. The first report of the JJ NMDS, with data from 2000–01 to 2003–04, is due for publication in early 2006.

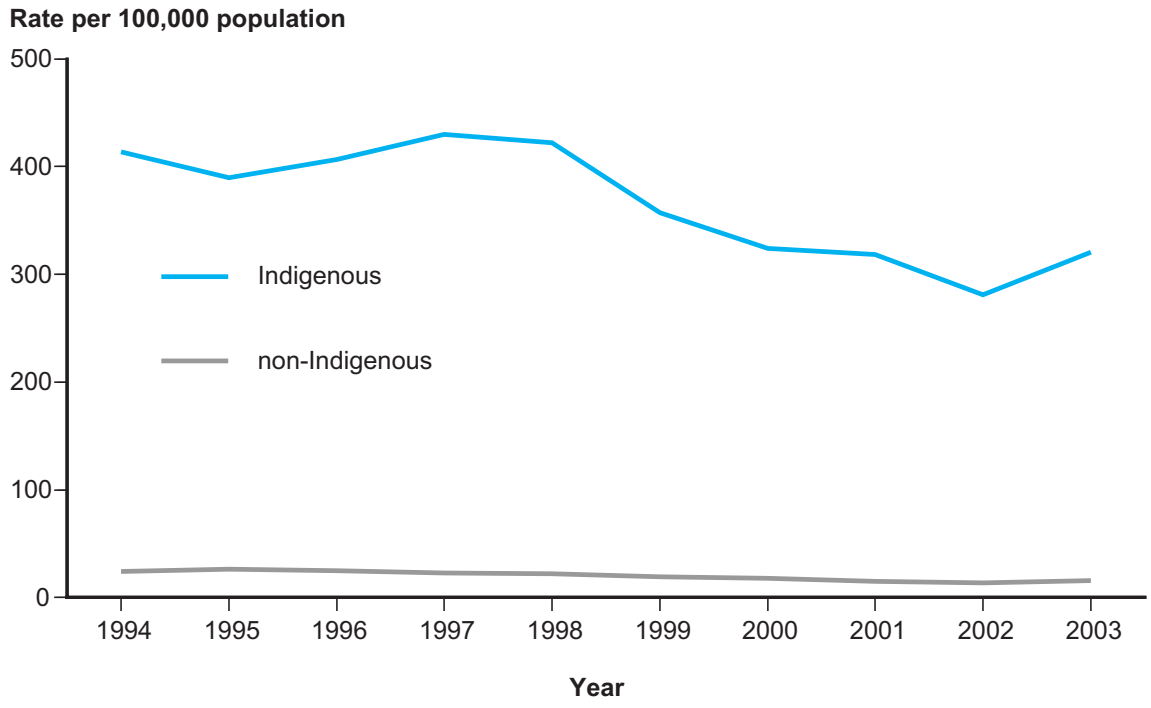
Children and young people as victims

Victims of violence are often reluctant to report crimes to the police and therefore the actual level of crime experienced by children is likely to be underestimated. The reasons victims have given for not reporting crimes include their belief that the police cannot do anything, or that the violence they have experienced is too trivial to be reported (Carcach 1997; Williams & Bryant 2000). Children and young people, in particular, may feel intimidated and reluctant to report personal crimes if the perpetrator is known to them or is in a position of power (perhaps because the perpetrator is older or is an authority figure).



Source: Table A3.10.

Figure 3.16: Juvenile justice clients aged 10–17 years, supervised in the community and in detention centres, at 30 June 2004



Note: Rate (based on ABS high series Indigenous population estimates) as at 30 June each year. Rates exclude Tasmanian figures between 30 Sept 1996 and 31 Dec 2002 as data are unavailable.

Source: Table A3.11.

Figure 3.17: Rates of Indigenous and other Australians aged 10–17 years in juvenile detention, 1994–2003

While crime victim surveys are used to measure the extent of unreported or hidden victimisation, no Australian surveys currently include children aged under 15 years in their sample (ABS 2004i). The two main sources of information about criminal victimisation of children are administrative data sets: recorded crime statistics and substantiations of child abuse. Since 1993, the ABS has published an annual report of recorded crime statistics collected by the police in each state and territory, according to standard offence classifications. These data are used below to present a picture of child and youth victimisation.

Children and young people are more vulnerable than adults to being victims of crimes of violence, although there are notable differences between males and females (Table 3.31). Young people are more likely than adults to be victims of sexual assault and kidnapping/abduction, with females at a higher risk than males.

Table 3.31: Victims of violent crime, 2003

Age group (years)	Murder	Attempted murder	Driving causing death	Assault	Sexual assault	Kidnapping /abduction	Robbery	Blackmail /extortion
				Number				
Males								
0–9	10	11	2	2,161	1,200	50	60	4
10–14	2	3	2	5,369	621	47	806	1
15–19	17	15	23	12,848	457	40	3,293	31
20–24	15	42	1	12,976	173	40	2,177	21
All males (0–75+)	*201*	*235*	*111*	*90,688*	*3,255*	*260*	*11,429*	*229*
Females								
0–9	13	13	3	1,326	2,480	79	22	1
10–14	4	2	1	3,431	3,189	78	123	—
15–19	6	9	13	9,592	3,496	111	749	11
20–24	14	12	6	9,574	1,445	58	791	15
All females (0–75+)	*94*	*114*	*59*	*66,445*	*14,892*	*447*	*4,988*	*103*
				Rate per 100,000 persons				
Males								
0–9	0.7	0.8	—	162	89.9	3.7	4.5	—
10–14	—	—	—	760.1	87.9	6.7	114.1	—
15–19	2.4	2.1	3.3	1,825.6	64.9	5.7	467.9	4.4
20–24	2.1	6.0	1.6	1,852.8	24.7	5.7	310.9	3.0
All males (0–75+)	*2*	*2.4*	*1.1*	*918.8*	*33*	*2.6*	*115.8*	*2.3*
Females								
0–9	1.0	1.0	—	104.7	195.8	6.2	1.7	—
10–14	—	—	—	510.7	474.7	11.6	18.3	—
15–19	—	—	1.9	1,425.6	519.6	16.5	111.3	1.6
20–24	2.1	1.8	n.p.	1,415.5	213.6	8.6	117	2.2
All females (0–75+)	*0.9*	*1.1*	*0.6*	*663.9*	*148.8*	*4.5*	*49.8*	*1.0*

Source: ABS 2004j.

Assault is the most commonly reported crime for both men and women. The 15–19 year age range begins a time of increased vulnerability to assault, with males at higher risk than females (Figure 3.18). The likelihood of being assaulted is highest for those aged 15–24 years, but the risk period continues until 44 years of age. Overall, just over 70% of assaults occur during the 15–44 year age range for both males and females (ABS 2004j).

Reported sexual assault is much less common than assault. However, in 2003, eight out of ten victims were girls and women and seven out of ten victims were young—aged under 25 years (Figure 3.19). Children aged 10–14 years and young people aged 15–19 years were three times more likely to be a victim of sexual assault than the rest of the population (ABS 2004j:5).

Outcomes of victimisation

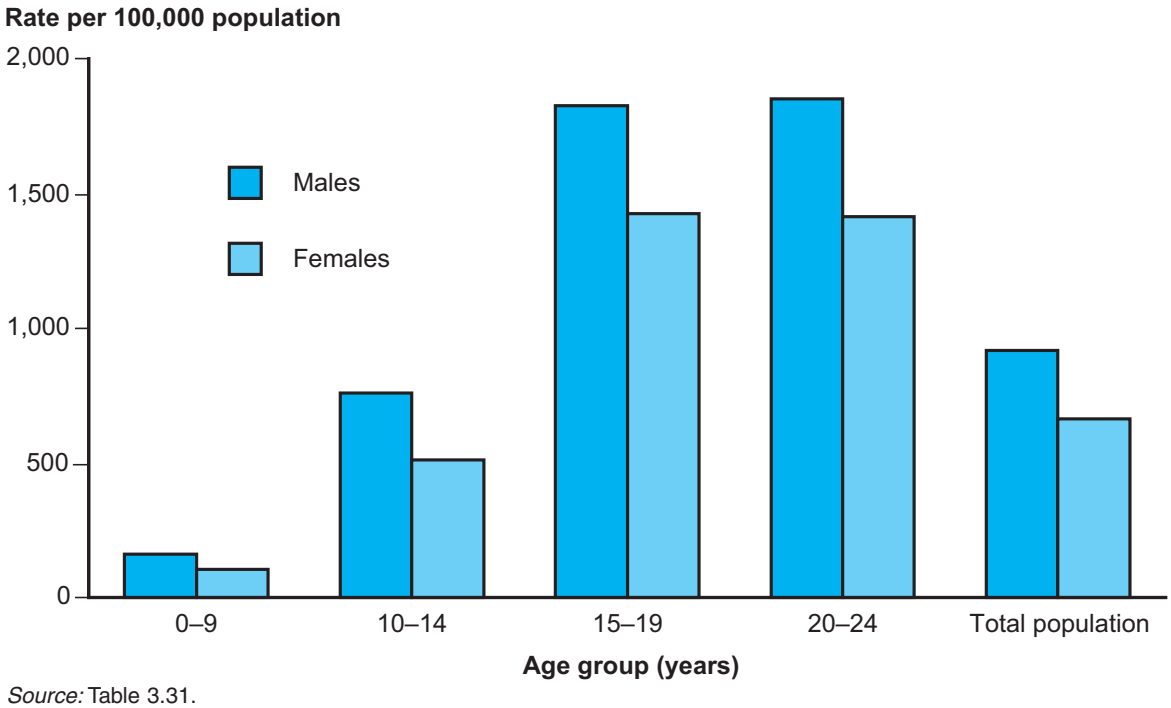
Victims of assault and sexual assault not only experience harm in the short term, but are at risk of further harm or harming others later in life. A key concern is that children who are victimised are at a greater risk of later victimising others (Lauritsen et al. 1991; Weatherburn & Lind 1997). Other research suggests that victimisation can lead to diminished educational attainment and wide-ranging effects on socioeconomic attainment in early adulthood (Macmillan & Hagan 2004). Adverse outcomes for young victims of violent crime can range from injuries to suicidal ideation and behaviour (Simon et al. 2002), and depression (Arboleda-Florez & Wade 2001). A large body of international research suggests that physical and sexual abuse have multi-faceted short- and long-term negative effects on childhood development (Paolucci et al. 2001). The overlap between victim and offender populations, and instances of intergenerational family violence, are cited as evidence of the cycle of violence, and of the need to break that cycle through the prevention of child abuse (Regoeczi 2000:494).

Children in homeless families

Children may experience adverse educational, social and health consequences as a result of being homeless. Homeless children spend less time in school have lower immunisation rates, and experience psychological problems such as depression and low self-esteem (Efron et al. 1996; Molner et al. 1990). Parents in homeless families are also likely to be suffering from depression or stress, which may mean they are unable to give their children adequate attention or affection. A high proportion of homeless children may also have witnessed or experienced domestic violence and are at a greater risk of becoming a victim of crime or involved in criminal activities themselves (AIHW 2004c; NCP 1999). Indeed, domestic violence was the most common reason (two-thirds of all support periods) for client groups with children seeking assistance from SAAP services (AIHW 2004c).

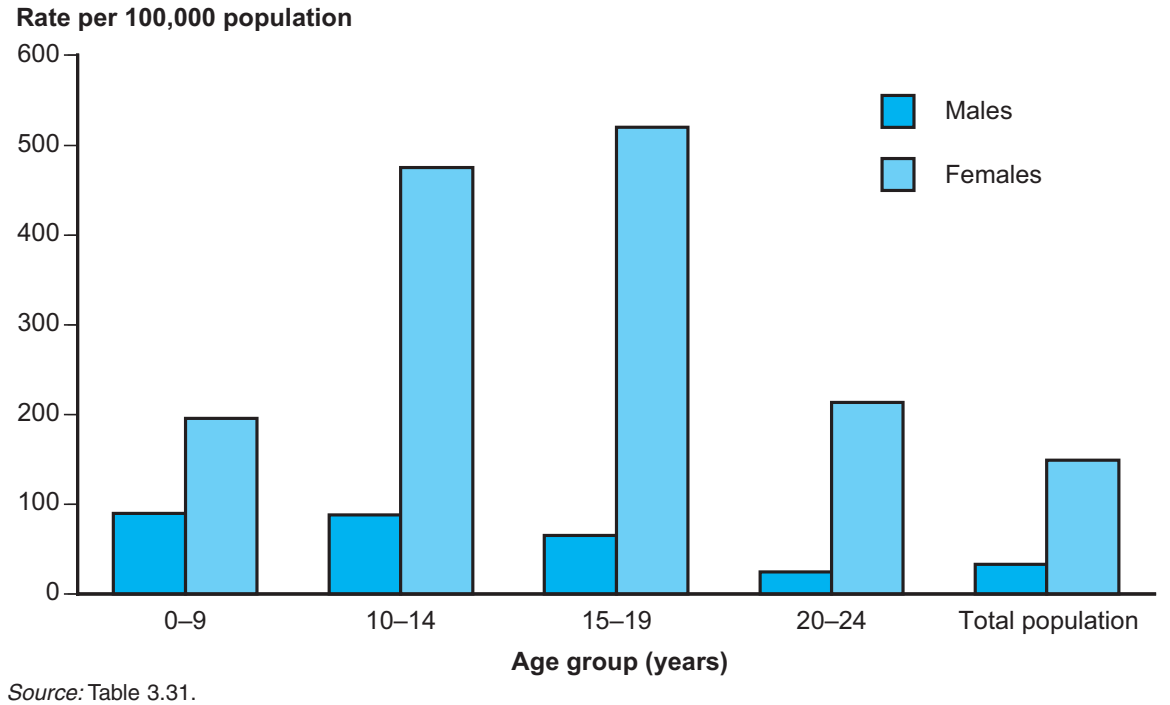
A high rate of family homelessness has meant a significant proportion of Australia's homeless population are now children. In 2003–04, 52,500 children aged 0–17 years accompanied a parent or guardian who sought assistance through the Supported Accommodation Assistance Program (SAAP). This equates to a rate of nearly 11 children per 1,000 in the general population (Table 3.32). Of these children, 45% were aged under 5 years, a rate of 18.6 per 1,000. In comparison, the rate for 10–14 year olds was 5.9 per 1,000. Clients with children made up 27% of SAAP support periods in 2003–04 (AIHW 2005c).

The majority (81%) of these clients were single women with children, 13% were couples with children and 6% were single men with children.



Source: Table 3.31.

Figure 3.18: Assault rates, 2003



Source: Table 3.31.

Figure 3.19: Sexual assault rates, 2003

Table 3.32: SAAP accompanying children, 2003–04

Age group	Number	Rate per 1,000 children
0–4 years	23,500	18.6
5–9 years	22,600	10.4
10–14 years	4,800	5.9
15–17 years	1,700	3.1
Total	**52,500**	**10.6**

Notes

1. Number excluded due to errors and omissions (weighted): 226.
2. The numbers do not add to the total due to rounding.
3. Table excludes high-volume records because not all items were included on the high-volume form.
4. 'Per 1,000 population' shows how many children out of every 1,000 in the general population aged 17 years and under accompany SAAP clients. The rate is estimated by comparing the number of SAAP clients with the estimated resident population in the designated age group as at 30 June 2003 (final estimates).
5. Figures have been weighted to adjust for agency non-participation and client non-consent.

Source: AIHW 2004c.

Measuring homelessness

Obtaining an accurate count of homeless people is difficult for practical reasons. People often move in and out of homelessness and may never be counted. One method of estimation is to count the number of people seeking assistance from a SAAP agency. As SAAP services are provided not only to clients but also to the children who accompany them, these data are valuable in attempting to measure childhood homelessness (Table 3.32). However, a major limitation in using SAAP data as a measure of homelessness is that they do not include homeless people who do not seek SAAP assistance or those who are turned away from SAAP. For example, in 2003–04 the chance of a child receiving accommodation requested was just over one in three, or 37% (AIHW 2004d).

In an attempt to better count homeless people, changes were made to the ABS Australian Census of Population and Housing, making it possible to count homeless people staying temporarily with others and those in improvised dwellings or sleeping on the street. In a recent analysis of 2001 Census data combined with SAAP data, it was estimated that on census night 9% of homeless households were families, and homeless families made up one-quarter of the homeless population. There were 9,941 homeless children under 12 years, making up 10% of the homeless population and 0.3% of the Australian population under 12 years of age (ABS 2003e). See Chapter 7 for more information on homelessness.

3.8 Conclusion

Families continue to be the cornerstone of Australian society. They provide the environment in which children learn and develop and young people are supported as they move into adulthood. All the indications are that families are continuing to do well in fulfilling these responsibilities. Across early childhood, school, later education and employment most children and young people are making successful transitions. However, families are inevitably affected by the many changes occurring within Australian society.

In June 2004 there were about 4 million children aged 0–14 years and 2.8 million young people aged 15–24 years. Although the proportion of children in the population has been gradually declining as the population ages, the number of children has been increasing slowly over the last decade. Trends in family formation and dissolution mean that children today are growing up in a wider variety of family types than 30 years ago. Even so, seven out of ten children still live in intact families with their natural parents. About two out of ten children live in a lone-parent family and the rest in step or blended families. The number of dependent and independent young people living in the family home has grown substantially, although the increase has been greater in couple families.

The role that grandparents play in caring for grandchildren is of growing importance. Many grandparents provide informal care for young grandchildren whose parents are working. There are also a small number of grandparent families raising grandchildren whose parents are unable to care for them.

Changes in patterns of participation in employment continue to affect families. Over the last decade the number of couple families where both parents were employed has increased while the traditional male wage-earner family type has declined. The picture is somewhat different for lone-parent families with over half of mothers in lone-parent families, and 43% of fathers, not employed.

The majority of families in the community undoubtedly continue to function well in the face of these macro-level changes in family structures and employment patterns. However, these changes do have implications for the wellbeing of some families and children. In 2002–03, 854,000 children lived in households with incomes in the lowest quintile, placing them in a position of risk in terms of both current wellbeing and future successful outcomes. The Australian Government provides support for families, as family assistance payments and income support payments, mainly aimed at middle and lower income families.

There has been a gradual shift from informal to formal child care over the last 10 years and about half of children aged under 12 years currently use some form of formal care, including preschool. The biggest increases in formal care have been in long day care and outside school hours care, as the Australian Government has increased the number of places available. The affordability of child care services remains an issue, particularly for sole parents who are not working. Overall, the cost of child care as a proportion of disposable income has increased for almost all family types since 2000, in spite of the initial improvement when the Child Care Benefit was introduced.

Across the years of compulsory schooling there is strong evidence that the majority of children and young people fare well both in the national and international arenas. About eight out of ten young people complete Year 12 and half of these go on to higher education. However, the pathways that young people take in the transition from education to work are more varied and complex than in the past and often extend over longer periods. It is increasingly common to combine work and study through this period. Associated with this trend is the growing number of young people who work part-time.

While most young Australians are doing well, a small group are in greater need of help and support. Difficulties that arise are often associated with circumstances such as poverty, unemployment, discrimination, a shortage of adequate and affordable housing in the community, and personal problems such as domestic violence, drug and alcohol abuse, and relationship and family breakdown. Child protection services provide assistance for the more vulnerable children—those who are abused or neglected, or whose parents are unable to care for them. In the past 5 years, there have been inquiries into the child protection departments in a number of jurisdictions which have initiated improvements in service delivery. This is a dynamic area where the constant changes in policies and procedures make it difficult to interpret long-term trends in the data. However, it is clear that the number of children in the child protection system is increasing.

During childhood and adolescence, some young people have an encounter with the criminal justice system. For most, this is usually for relatively minor and transient offences, confined to one-off events, but a very small proportion of young people have repeated or more serious offending which results in supervision by a juvenile justice department such as community service orders or detention in custody. Although juvenile offending rates are almost twice as high as for adults, they have declined over recent years and offending often decreases or ceases entirely after early adulthood. Of serious concern is the continuing over-representation of Indigenous people in the juvenile justice system.

Homelessness can affect educational, social and health outcomes of children and young people. In 2002–03, 52,000 children under 16 years of age accompanied a parent or guardian in seeking support from the Supported Accommodation Assistance Program (SAAP). Forty-six percent of these children were under 5 years of age.

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4 Ageing and aged care

4.1 Introduction

Interest in the ageing of Australia's population has been growing steadily since the early 1990s when *Australia's Ageing Population – Policy Options* (Bureau of Immigration Research: Young 1990) was released. Government attention to the implications of population ageing was sharpened with the release of the first *Intergenerational Report* (Costello 2002). A succession of government inquiries and reports on the topic has followed, with the most recent being *Economic Implications of an Ageing Australia* (Productivity Commission 2005), a report prepared at the request of the Australian Treasurer on behalf of the Council of Australian Governments.

A key concern of these reports is that population ageing will lead to high levels of public expenditure on services for older people which will be borne by a relatively shrinking labour force. The concern is heightened because Australia experienced a lengthy postwar baby boom which resulted in a large cohort of people who, over the next couple of decades, will retire and contribute to a rapid increase in the number of older people eligible for government income support and other services.

The Productivity Commission's 2005 report had a particular focus on the implications for productivity, labour force and fiscal outcomes across the three tiers of government. The report argued for coordinated reforms in key human services areas such as health and aged care in response to growing demands placed on these sectors. It also argued that increasing labour force participation and productivity growth could partly offset the impacts of ageing. The importance of labour force participation in addressing some of the issues raised by population ageing underpins some recent policy initiatives by the Australian Government.

The broad policy framework of reports such as the *Intergenerational Report* stimulated renewed interest in improving the efficiency and effectiveness of aged care policy and program delivery, leading to a number of strategic reviews in the area. Reports from two major policy reviews were published in 2004: *Review of Pricing Arrangements in Residential Aged Care* (Hogan 2004), and *A New Strategy for Community Care – The Way Forward* (DoHA 2004c). In the following year the *National Aged Care Workforce Strategy* was released (Aged Care Workforce Committee 2005; see Section 4.3 for more detail). In broad terms, these reviews have focused on ways to meet the demand for aged care services in coordinated and cost-effective ways while ensuring that the services are directed to those most in need.

The other major prong of the policy response to population ageing involves initiatives to minimise demand for health and aged care services through the promotion of improved health among older people. This policy response is supported by a growing research effort. In December 2002, the Prime Minister announced the government's National Research Priorities, including as a priority goal *Ageing well, ageing productively* under the national priority of *Promoting and maintaining good health* (DEST 2002).

As part of this, Australia's peak research bodies, the National Health and Medical Research Council and the Australian Research Council, funded the Ageing Well Research Network in 2004 for 5 years (ARC/NHMRC Research Network in Ageing Well 2005; NHMRC 2004), and in June 2005, called for expressions of interest in the Ageing Well, Ageing Productively Research Program (up to $10 million is available over 5 years).

Improving the process of translating research evidence into policy and practice is one of the priorities of the Building Ageing Research Capacity project. Funded through the Office for an Ageing Australia and implemented jointly with the AIHW, this project aims to facilitate collaboration and coordination between Australian researchers and policy makers on ageing issues. Its activities have included developing a framework for an Australian ageing research agenda and implementing an interactive web-based directory of ageing-related research projects, courses of study and research grants (<www.aro.gov.au>).

Chapter outline

This chapter discusses the characteristics of Australia's older population and the care and services that they receive. The chapter has a primary focus on those aged 65 years and over, the age from which people can access the Age Pension. Other age groups are also sometimes relevant in discussions about ageing. For example, workers aged 45 and over—mature age workers—are the focus of research and policy designed to retain older workers in the labour force. Where relevant and useful, the chapter also includes data on age groups younger than 65.

Section 4.2 provides an overview of demographic changes resulting in population ageing. A focus on the problems caused by population ageing can result in a failure to appreciate that the majority of older Australians enjoy good health and lead active lives, making valuable contributions to the welfare of their communities. This section also reports on the health and disability levels of older Australians and on their contributions as volunteers and carers of people with disabilities.

There is also a risk that the debate about population ageing can encourage a view that all older people have the same needs for health and aged care. It is not possible here to examine the full diversity of the ageing experience. The chapter does, however, disaggregate data by age group wherever possible, revealing large differences between the 'younger' old and the very old in their health and disability status (Section 4.2) and use of aged care services (Sections 4.4 and 4.5).

Older people are eligible for, and make use of, a range of benefits and services that are available to the general population, such as housing (see Chapter 6), hospital care, medical care and pharmaceuticals (see AIHW 2004a). However, certain types of income support and care services are either targeted to, or primarily used by, older people. Section 4.3 provides an overview of the support and services available to older people. It should be noted that the population aged 65 years and over is not used by government as a planning or funding tool for the majority of the programs discussed, and that younger people can and do access these services. The use of services by younger disabled people is examined in Chapter 5.

Sections 4.4 to 4.7 present data on national aged care services and assistance, the clients of these services and the expenditure involved by both government and service users. Section 4.8 discusses outcomes for older people in relation to aged care services, and a brief summary follows in Section 4.9. Regionally-limited services (state, territory or local government) are not included in the chapter. Information on aged care services within states and territories can be found in the annual *Report on Government Services* (SCRCSSP 2005).

Presenting the picture

The analysis presented in this chapter draws on a number of data sources to present a picture of older people's welfare. New data sources used in this edition include the ABS Survey of Disability, Ageing and Carers conducted in 2003, and data from the Aged Care Assessment Program MDS version 2.0. Extensive use is made of data collections that are now well-established, notably on the residential aged care program and the Home and Community Care MDS version 1.0 which provides a comprehensive account of HACC clients and service use.

Reflecting the policy development activity in aged care, a number of recent national data development activities have occurred that will allow improved analysis of the aged care sector in the future (Box 4.1).

4.2 Ageing in Australia

As discussed in the last edition of *Australia's Welfare* (AIHW 2003a:279–82), the Australian population is ageing numerically in that the number of older people is increasing, and structurally in that the proportion of people who are aged at least 65 years is rising.

Population structure and change

On 30 June 2004, people aged 65 years and over represented 13% of Australia's total population, or 2.6 million people (ABS 2004b; Table 4.1). Fifty-three per cent were aged 65–74 years, 36% were aged 75–84, and a significant minority—over 298,000 people—were aged 85 and over (11%). Fifty-five per cent of older people (65+) were women. As age increases, this predominance becomes progressively more evident and by age 85 and over, there were more than twice as many women as men. In absolute numbers, in June 2004 there were 274,000 more women than men aged 65 and over in Australia.

In the 20 years to 2024, the number of people aged 65 and over is expected to increase by 92%, from 2.6 million to almost 5.0 million, and comprise 20% of the population by that time. This compares with a rise of 66% (or an increase of 1 million people) in the 20 years from 1984 when older people accounted for 10% of the population (ABS 2004b). The number of people aged 85 and over, among whom we find those most likely to be in need of services and assistance, is projected to expand more rapidly than other age groups: from 298,300 in 2004 to 725,300 in 2024, an increase of 143%. In addition, as a proportion of the total population, the number of people aged 85 and over is projected to rise from 1.5% in 2004 to 2.9% in 2024.

Box 4.1: Data development in aged care services

*The **ACAP Minimum Data Set version 2.0** was implemented progressively from 1 April 2003. By 30 June 2004 this version of the MDS was in use in all areas of Australia except Queensland and some parts of New South Wales.*

*An evaluation of the Home and Community Care Minimum Data Set version 1.0 (HACC MDS version 1.0) was concluded in 2003 (Alt Beatty Consulting & Australian Institute for Primary Care 2003). The HACC Data Reform Working Group examined a range of possible amendments based on the evaluation results. Its recommendations have been accepted by HACC Officials and are reflected in the **HACC MDS version 2.0** to be implemented from 1 January 2006. In version 2.0, information about the care recipient and their carer is recorded on the same client record. New data elements include those specifically related to the care recipient's need for assistance or dependency status, dates of entry into and exit from HACC service episodes and a range of carer characteristics. A new HACC MDS User Guide incorporating the HACC Data Dictionary and Guidelines to the HACC MDS is being developed.*

***HACC service standards:** Part of the HACC evaluation process included reporting on 'options for the future direction of managing compliance to the HACC Standards' (Australian Healthcare Associates 2005:6). Key recommendations included ensuring that in the future the process is nationally consistent, shifting the focus from compliance to quality improvement, and revising the National Service Standards Instrument to make it easier to use. There was general support, both from service providers and government, for a service standards appraisal program using an improved NSSI (Australian Healthcare Associates 2005:8–14, 46).*

*The **National Respite for Carers Program Minimum Data Set** has been developed. Analysis and assessment of initial data is currently being undertaken.*

*In 2003 and 2004, the need for a **national minimum data set for community-based palliative care** was examined (AIHW 2004e), and the resulting recommendations led to the decision to develop a national Data Set Specification. Final specifications are expected to be endorsed in 2006. At this stage, there is no commitment to implement a national data collection based on these specifications. Over the same period, performance indicators for palliative care were developed, with four indicators being endorsed by the Palliative Care Intergovernmental Forum. A trial national collection of data from regions and agencies to support the calculation of these four performance indicators was held in the second half of 2005.*

People born overseas

Past migration patterns have a significant impact on the mix of backgrounds found among the older population. On 30 June 2003, of people aged 65 and over, 518,100 (20% of older Australians) were originally from mainly non-English-speaking countries, 336,700 (13%) were from the main English-speaking countries and 1,691,600 (66%) were born in Australia (ABS 2005c).

Table 4.1: Persons aged 65 years and over, 30 June 2004[(a)] and 30 June 2024[(b)]

Age	Males	Females	Persons	Males	Females	Persons
2004		**Number**			**Per cent of people 65+**	
65–69	367,800	377,400	745,200	31.6	26.2	28.6
70–74	300,200	325,900	626,100	25.8	22.6	24.0
75–79	247,100	301,800	548,800	21.2	21.0	21.1
80–84	155,500	230,900	386,400	13.3	16.0	14.8
85+	94,800	203,500	298,300	8.1	14.1	11.5
Total	**1,165,500**	**1,439,400**	**2,604,900**	**100.0**	**100.0**	**100.0**
				Per cent of population aged 65+		
Total population	**9,994,500**	**10,116,800**	**20,111,300**	**11.7**	**14.2**	**13.0**
2024				**Per cent of people 65+**		
65–69	678,300	711,900	1,390,200	29.0	26.8	27.8
70–74	587,000	631,600	1,218,600	25.1	23.7	24.4
75–79	482,700	529,200	1,012,000	20.7	19.9	20.3
80–84	299,700	350,800	650,500	12.8	13.2	13.0
85+	289,500	435,800	725,300	12.4	16.4	14.5
Total	**2,337,300**	**2,659,300**	**4,996,600**	**100.0**	**100.0**	**100.0**
				Per cent of population aged 65+		
Total population	**12,257,500**	**12,413,300**	**24,670,800**	**19.1**	**21.4**	**20.3**

(a) Estimated resident population.

(b) Projected.

Note: Components may not add to total due to rounding.

Sources: ABS 2003b: series 8, 2004b.

A higher proportion of overseas-born Australians in 2003 were aged 65 or over compared with the rest of the population: 19% from mainly non-English-speaking countries and 18% from the main English-speaking countries compared with 11% of the Australian-born population. Much of this difference results from the under-representation of children among migrants: for people aged 45 and over, around 50% were aged 65 and over in all three birthplace groups. The age profile of older people from the non-English-speaking countries was younger than that of people from the main English-speaking countries and those born in Australia: only 7% of older people born in non-English-speaking countries were aged 85 or over, compared with 11% from the main English-speaking countries and 12% of those born in Australia (ABS 2005c).

As well as having a different age structure, Australians born overseas have a different mix of the sexes. In 2003, a relatively high proportion of older people born overseas were males: 49% from non-English-speaking countries and 47% born in English-speaking countries, compared with 43% of those born in Australian. This pattern was particularly noticeable for the 65–74 age group, among whom men outnumbered women among overseas-born people but not among those born in Australia. The ratio of women to men increased with age in both the overseas-born and Australian-born older populations (ABS 2005c).

The older population (65+) born in non-English-speaking countries is projected to increase more quickly and age more rapidly than the older Australian-born population (AIHW: Gibson et al. 2001). This more rapid ageing reflects both the waves of postwar immigration and the concentrated age profile of migrants, with large numbers of those from non-English-speaking countries now moving into the older age groups. In the 15 years between 1996 and 2011, the older population born in non-English-speaking countries is projected to increase by approximately 66%, compared with an increase of 23% among the older Australian-born population. In particular, the proportion of older people who are aged 80 or over is projected to grow faster among those born in non-English-speaking countries than among people born in Australia. Consequently, the proportion of people aged 80 and over who are from non-English-speaking countries is projected to increase from 13% to 22% (AIHW: Rowland & Karmel 2004). These changes will not be uniform across all countries of birth, with some communities expanding rapidly and others contracting, depending on the timing and strength of migration waves. The ageing of the older population born in non-English-speaking countries will impact considerably on service provision, both because people from different backgrounds prefer different types of services (see Section 4.6) and because people tend to revert to their mother tongue in their later years.

Aboriginal and Torres Strait Islander people

Indigenous Australians have a shorter life expectancy than other Australians. For the period 1996–2001, life expectancy at birth was 59.4 years for Indigenous men and 64.8 years for Indigenous women. In contrast, life expectancy at birth for all Australians was about 17 years longer (76.6 years for men and 82 years for women for the period 1998–2000) (ABS & AIHW 2005; also see Table 2.8 in Chapter 2).

Because of their different life expectancies, the age distributions of Indigenous and non-Indigenous Australians are quite different (see Figure 3.2). People aged 65 years and over were a relatively small proportion of all Indigenous Australians in 2004, accounting for just 2.8% of the population, compared with 13% for all Australians (ABS 2004b, 2004c). Aboriginal and Torres Strait Islander people aged 50 and over (51,700 people) accounted for 11% of Australia's total Indigenous population; among all Australians this age group made up 30% of the population.

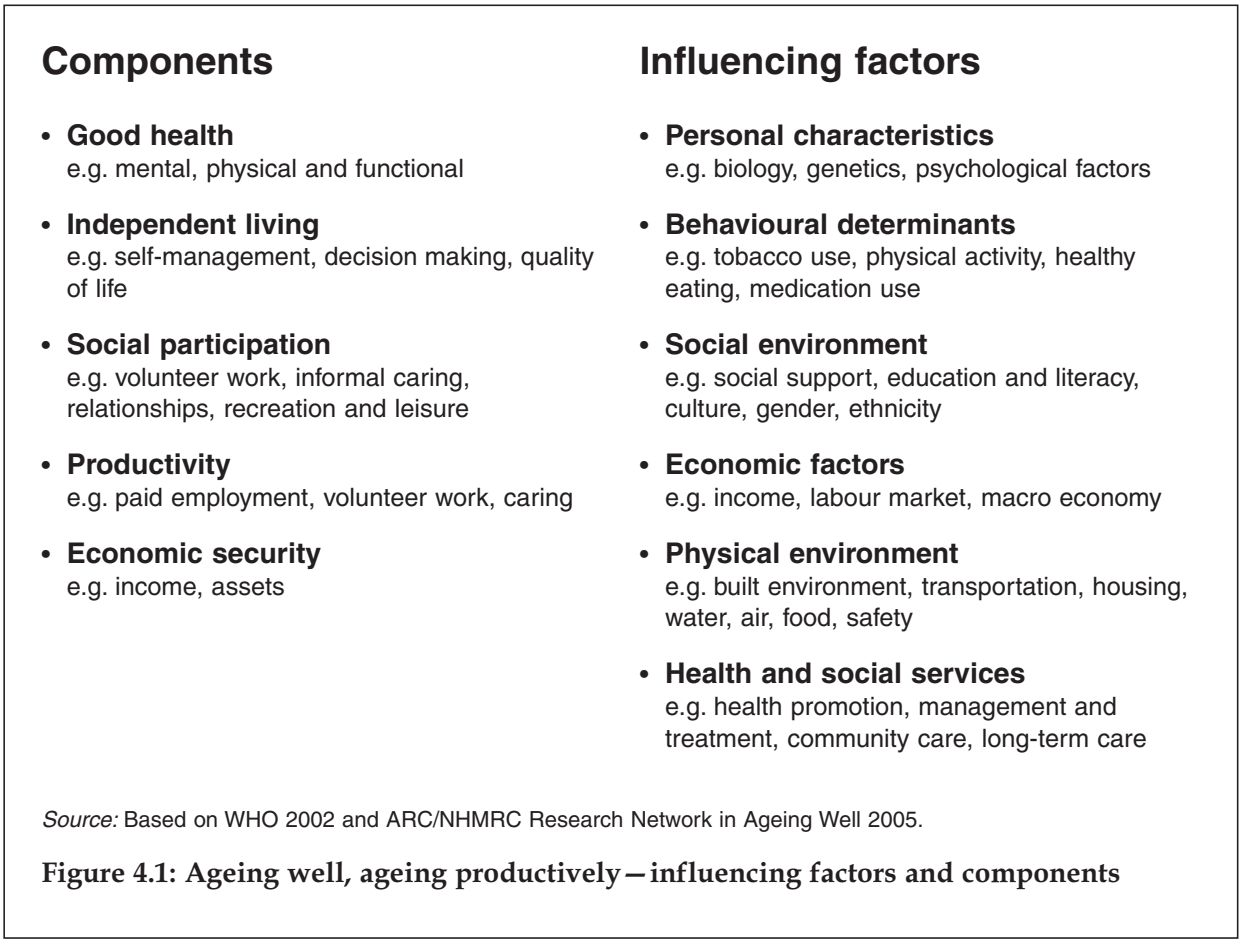
Of Indigenous Australians aged 50 and over, 74% were aged 50–64 years, 18% were aged 65–74 years, and 8% were aged 75 and over; 53% were women. The predominance of women becomes more evident as age increases, reaching a ratio of approximately three women for every two men in the oldest age group (75+). In absolute numbers, in June 2004 there were 3,000 more Indigenous women than Indigenous men aged 50 and over in Australia (ABS 2004c).

Like the total Australian population, the structure of the Aboriginal and Torres Strait Islander population is ageing but at a much slower pace than that of the general population. On 30 June 1996, 10% of the Indigenous population were aged 50 or over. By 2009, this group is expected to have increased to 12% (ABS 2004c).

Ageing well, ageing productively

The aim of the priority goal *Ageing well, ageing productively* research initiative is to reduce the risk of disease and disability, to maintain mental and physical function, and

to encourage active engagement with families, local communities and the broader society as people age. The ability of individuals and populations to age well and age productively is influenced by many factors. Figure 4.1 is a simple representation of some of the components of ageing well and productively, and the broad factors that influence them, together with some brief examples.



Source: Based on WHO 2002 and ARC/NHMRC Research Network in Ageing Well 2005.

Figure 4.1: Ageing well, ageing productively—influencing factors and components

Maintaining and improving good physical and mental health and functioning are central to notions of 'ageing well'. These are necessary conditions for older people to continue living independently in the community with relatively low demands on formal care and health systems. They also enhance the capacity of older people to remain productive as they age by being actively involved in their community, for example, through voluntary work, the provision of care to others or through paid employment activities.

A number of factors clearly influence older people's ability to maintain good health and to participate in their community. These include sufficient income, adequate and safe housing, and a physical environment which facilitates independence and mobility (see Chapter 2 for a discussion of these). Older people's own behaviour in respect of health risks and their individual social and genetic characteristics are also important influences on their health status. It is worth noting that these factors are not only pertinent to the ageing process, but also contribute to a person's experience of health and socioeconomic

participation throughout their lives. The impact of these factors through an individual's younger life may continue to affect their experience of ageing.

Ageing well

Health

Falling death rates in each of the age groups 65–74, 75–84, and 85 years and over are strong evidence that the health of older Australians has been improving. Much of the reduction has been due to large falls in death rates for cardiovascular diseases, attributed mainly to improvements in health behaviours and medical care. Death rates have also declined for cancer, with marked falls among smoking-related causes in men. This falling mortality has contributed to increasing life expectancy for older Australians. At age 65, men can expect to live for a further 17 years and women for 20 years. In addition, Australians experience about 90% of their life span in good health, without illness or disability. Australian males can expect to live for about 71 years without reduced functioning and Australian females about 74 years (AIHW 2004a).

Many older people have a positive view of their health even though older age is generally associated with increasing levels of disability and illness. Self-assessed health status is used as an indicator of general health and wellbeing, and has been found to be a strong indicator of future mortality (Idler & Benjamini 1997). By far the majority of older Australians consider themselves to be in good, very good or excellent health, although the proportion of older men and women reporting fair or poor health increases with age (Table 4.2). This pattern is similar to that observed in 1995 and 2001 (ABS 2002).

Table 4.2: Self-assessed health status of older Australians, 2002

Self-assessed health status[(a)]	Males			Females		
	55–64	65–74	75+	55–64	65–74	75+
Excellent/ very good	44.2	36.2	29.0	48.7	32.8	28.2
Good	30.3	31.3	34.7	27.9	33.3	32.3
Fair/ poor	25.5	32.5	36.3	23.5	33.9	39.5
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**

(a) The person's general assessment of their own health against a five point scale from excellent through to poor.

Note: Components may not add to total due to rounding.

Source: ABS 2003a.

Healthy behaviour

Healthy behaviour is an important determinant of health and is usually measured by behavioural risk factors that put an individual at increased risk of experiencing disease. Some risk factors have an accumulative effect over the life course and risk factor behaviour in middle age can lead to poorer health in later life. There is, however, potential for health gain at all stages of life through appropriate management of these risk behaviours in addition to early prevention. The prevalence of major preventable risk behaviours that can lead to ill-health in older Australians is shown in Table 4.3.

Table 4.3: Prevalence of risk behaviours among older Australians, 2001 (per cent within age group)

	Males			Females		
Risk behaviour	**55–64**	**65–74**	**75+**	**55–64**	**65–74**	**75+**
Smoking[a]	21.7	12.4	7.4	15.8	9.4	4.8
Obesity[b]	17.8	14.6	8.9	21.8	20.1	10.5
Physical inactivity[c]	34.9	30.9	44.0	31.2	38.8	55.9
Poor diet						
Low fruit consumption[d]	46.9	39.6	38.1	29.4	30.8	31.7
Low vegetable consumption[e]	68.0	66.5	63.9	57.3	60.0	61.3
Usually add salt to food[f]	38.6	40.5	39.8	23.9	22.1	27.5
Risky alcohol consumption[g]	15.1	9.1	4.6	8.5	7.0	4.7

(a) Current regular (daily) smoker or current smoker not regular.

(b) A body mass index of 30 kg/m2 or more.

(c) Sedentary (exercise score less than 100, including no exercise) during previous 2 weeks. The exercise score was based on frequency, intensity and duration of exercise (for recreation, sport or fitness).

(d) Usual daily intake of 1 serve or less. Dietary guidelines recommend at least 2 serves of fruit per day (NHMRC 2003).

(e) Usual daily intake of 3 serves or less. Dietary guidelines recommend at least 5 serves of vegetables per day (NHMRC 2003).

(f) Dietary guidelines recommend choosing foods low in salt and using salt sparingly (NHMRC 2003).

(g) Based on the NHMRC risk levels for harm in the long term (NHMRC 2001).

Note: Estimates are based on self-reported data. Individuals may be engaged in more than one type of behaviour.

Source: ABS 2002.

Smoking levels have declined generally in Australia, but particularly among older Australians (ABS 2002). The lower rates among older Australians are likely to reflect a greater prevalence of smoking cessation in older age groups and greater mortality among smokers than non-smokers (AIHW 2004a). Smoking rates remain higher among older men than older women. Smoking is a major risk factor for coronary heart disease, stroke, peripheral vascular disease, cancer, chronic obstructive pulmonary diseases and a variety of other diseases and conditions. There is evidence that smoking cessation can have a substantial effect on subsequent mortality (Anthonisen et al. 2005).

Obesity rates in Australia have increased substantially over recent years, including for older Australians. Based on self-reported data, which are likely to underestimate the true prevalence, by 2001 obesity rates had reached 15% for men and 20% for women, aged 65–74. The likely health consequences for older Australians of increased body fatness are premature death from life-threatening diseases and debilitating conditions that impair quality of life (WHO 2000). This has implications for health care costs, for carers and their wellbeing, and for aged care services (AIHW: Bennett et al. 2004).

There has been little change in exercise levels among older Australians (AIHW 2004a). Physical inactivity is relatively more common in older age groups, perhaps reflecting reduced functioning and increased rates of disability in older age. Physical activity at all ages can help reduce the likelihood of obesity, and delay functional decline and the onset of chronic disease. It can also reduce the severity of disability associated with chronic diseases, improve mental health, promote social contacts, prolong independent living and reduce the risk of falls (Bauman & Smith 2000; WHO 2002).

Despite general concerns about the contribution of over-eating to the rising prevalence of obesity, many older Australians are not consuming adequate amounts of fruit and vegetables. Older men are more likely than older women to report low fruit intake and, to a lesser degree, low vegetable intake. For men, both low fruit intake and low vegetable intake are less common in older age groups. This is not the case for women. The prevalence of older Australians who reported that they usually add salt to food varied little by age but was higher among men than women.

The prevalence of alcohol consumption at levels that pose a risk to health in the longer term is lower in older age groups and less than 5% in Australians aged 75 years or older. Alcohol in sufficient levels over time increases the risk of developing some cancers, cirrhosis of the liver, alcohol dependence, cognitive problems, dementia, and sexual difficulties in men. Although there is evidence that low levels of alcohol may protect against heart disease and some types of stroke, heavy drinking has no additional benefits for heart disease and increases the risk of stroke. Although older people tend to drink less than people do in their younger or middle years, it remains an important part of social life that often expands in retirement. However, as people age their tolerance for alcohol tends to decrease; they are more likely to take medication, which may interact with alcohol; falls become a greater risk which is further increased with intoxication; and driving ability, which may be influenced by the effects of ageing, can be further impaired (NHMRC 2001).

Ageing and disability

Key factors affecting the ability of many people to take part in the daily activities of life—from workforce participation to independent living—include illness or injury and the related level of disability which arises. While many older Australians are free from a disability for which they require assistance, a proportion have more intensive care and assistance needs.

In 2003, the ABS conducted the fifth Survey of Disability, Ageing and Carers. This survey provides, among other things, information on the prevalence of disability in the Australian population, people's need for assistance, and the assistance they received (for more details about the survey, see Chapter 5 and Technical Appendix of this publication; ABS 2004a). The survey covered people in both private and non-private dwellings, including those in cared-accommodation establishments but excluding those in gaols and correctional institutions. Data from this survey were released in 2004, and are used in the following discussion.

In 2003, over half of all people aged 65 years and over (56% or 1.4 million) had at least one form of disability (see Tables 5.1; A5.2). While almost all older people with a disabling condition also reported a limitation or restriction in at least one of 10 specific and non-specific types of activities (see Table A5.2), having a disability does not necessarily imply a need for assistance. For example, while a person may have reduced mobility they may not require assistance undertaking the activities of daily living. Core activity limitation—which relates to difficulty or need for assistance with self-care, mobility or communication—provides a more useful indicator of the level of difficulty experienced or help needed in performing activities basic to living. Core activity limitations, as recorded in the 2003 survey, range from profound or severe, where assistance is always or sometimes needed, to moderate or mild, where assistance is not

required but difficulty in performing core activities may be experienced or aids and equipment may be used. The group of older people most likely to be in need of assistance from aged care programs providing relatively high levels of care are those with a profound or severe limitation. Therefore, the following discussion focuses on this group.

In 2003, almost one-quarter (23%) of older people (560,900) reported a profound or severe core activity limitation (Table 5.1). The rates of such limitation were quite low until age 75, remaining under 15%. The rates then rose markedly with age, increasing from 20% among people aged 75–79 to 58% among the very old (85+) (see Figure 5.3). Overall, a higher percentage of women (27%) than men (17%) had a profound or severe core activity limitation, and this was true for all age groups over 65.

Aids and equipments used by people with a disability to assist them with tasks can influence the level of impairment, limitation or restriction experienced. In addition, the use of equipment has been suggested as being more efficacious in the management of disability than personal assistance (see AIHW: Bricknell 2003: ch. 3 for literature review). In 2003, 923,400 people aged 65 or over with a disability reported using one or more aids. Overall, these people used over 2.4 million aids—an average of 2.6 aids per individual. This compares with an average number of between 1.4 and 1.7 aids used by people with a disability in younger age groups (see Table 5.9). The length of time that a person lives with a disability also affects their overall quality of life; age at onset of disability is discussed in Chapter 5.

Respondents to the 2003 Survey of Disability, Ageing and Carers provided detailed information on their health conditions, allowing the relationship between health conditions and level of disability to be examined. It should be noted that the survey relied on self-reporting by people or their carers to identify their health conditions. Self-identification of conditions in the absence of clinical assessment can result in mis-reporting, particularly in mild or moderate cases. Thus the estimated association between a condition and the experience of profound or severe core activity limitation may be biased for some conditions.

Overall, 87% of people aged 65 and over reported a long-term health condition, with many reporting more than one. The five most commonly reported conditions were hypertension (37%), arthritis and related disorders (36%), hearing disorders (29%), heart diseases (18%) and back problems (16%) (AIHW analysis of ABS 2003 SDAC data). Other health conditions affecting more than 10% of the older population were diabetes, high cholesterol and stroke.

Some conditions are more likely than others to be associated with profound or severe core activity limitation. Ninety-eight per cent of people reported with dementia and Alzheimer's disease had this level of limitation. Severe or profound disability was also high among people with paralysis (89% of older sufferers), problems with speech (87%), Parkinson's disease (79%), and schizophrenia (76%) (see Table A5.7).

The combination of the prevalence of a health condition and the extent of disability among those with the condition determines the overall burden of a disease on the population. Consequently, the prevalence of a certain condition among people with a profound or severe core activity limitation can be used to look broadly at the burden

that the particular disease places on the community. Twenty-three per cent of the older population had a profound or severe limitation. Among this older population, arthritis was the most commonly occurring health condition, affecting 50% of these people. Hearing disorders (43%), hypertension (38%), heart diseases (30%) and stroke (23%) were also commonly reported conditions among older people with a profound or severe disability. For all of these conditions, fewer than 50% of older sufferers had profound or severe core activity limitation, but the high prevalence of the condition in the older population generally—ranging from 10% of the older population having suffered from stroke to 37% with hypertension—leads to considerable burden on the community.

In contrast, although dementia and Alzheimer's disease together were reported by only 4% of the older population, 17% of older people with a profound or severe core activity limitation had this condition. Similarly 3% of older people reported speech problems, and 12% of older people with a profound or severe limitation had such problems. Detailed work on the burden of disease, which takes into account which condition is the main cause of disability, is currently being carried out by the AIHW and will be released within the next 12 months.

Ageing productively

Older people are actively involved in Australian society in a number of ways, making important contributions to the family, community and economy. Since the late 1990s there have been a number of policy initiatives aimed at giving people greater choices in their working lives before final retirement from the paid workforce. Some of these encourage older people to remain in the workforce while others remove the retiree/worker dichotomy, thereby taking away the necessity to choose between being either in or out of the workforce. Early initiatives aimed at supporting older people who would like to remain in the workforce at least part-time were the Pension Bonus Scheme (introduced on 1 July 1998) and the Senior Australians' Tax Offset (from July 2001) (see Box 4.4).

Since 2004, there have been several further changes that support older people in the workforce. In particular, the *Age Discrimination Act 2004* prohibits discrimination on the basis of age in key areas of public life, including employment. Other policy initiatives have included:

- The mature age worker tax offset (from 1 July 2004), which rewards workers aged 55 years or more who stay in the workforce by providing a tax offset of up to $500 a year, with the final value of the offset depending on the person's net income from working.
- The transition to retirement policy (from 1 July 2005) which gives older employees greater flexibility in arranging their working lives before final retirement by allowing people who have reached their preservation age to access their superannuation through a non-commutable income stream while continuing in the workforce. Previously, people had to retire completely from the workforce to access their superannuation benefits.
- Changes to job search requirements for job seekers aged over 50 years and the introduction of a new employment service, Employment Preparation, for mature age job seekers on income support (announced in the 2005 Budget).

In May 2005, 42% of people aged 60–64 and 7% of those aged 65 and over were in the workforce (ABS 2005b: table 1.2). The corresponding figures for December 2002 were 38% and 6% (AIHW 2003a:286).

Two other areas where older people make valuable contributions are through organised volunteer work and the provision of care to family and friends.

Older people as volunteers

Many Australians, including older people, provide support to the wider community by voluntary work through organisations. In the 2002 General Social Survey, voluntary work was defined as the provision of unpaid help—in the form of time, service or skills—through an organisation or group in the last 12 months. Around 32% of people aged 65–74 years and 24% of people aged 75 and over undertook voluntary work in 2002 (Table 4.4). This represents 634,000 people aged 65 and over.

These rates of volunteering are higher than equivalent estimates from the 2000 Survey of Voluntary Work: 30% for people aged 65–74 and 18% for those 75 years and over. Although the gap between the two surveys was less than 2 years, the General Social Survey results suggest a growing trend in volunteering that has been noticeable in older Australians since the mid-1990s; for example, from 24% in 1995 to 33% in 2000 for people aged 55–64 years (ABS 2001). Similarly, rates increased from 23% to 30% for people aged 65–74.

Table 4.4: Volunteering among older Australians, 2002

	Age group			Age group		
	55–64	65–74	75+	55–64	65–74	75+
	Number ('000)			Per cent within age group		
Males	347.2	175.0	100.0	36.5	28.3	24.6
Females	368.7	235.2	123.7	39.5	35.5	22.3
Total	**715.9**	**410.2**	**223.7**	**38.0**	**32.0**	**23.6**
Main types of voluntary work						
Sport/recreation/hobby	188.4	85.9	37.9	10.0	6.7	4.0
Welfare/community	310.9	232.0	117.6	16.5	18.1	12.4
Health	54.6	51.3	27.5	2.9	4.0	2.9
Education/training/youth development	75.4	25.6	22.8	4.0	2.0	2.4
Religious	201.6	128.2	81.5	10.7	10.0	8.6

Note: Estimates are based on self-reported data. Individuals may be engaged in more than one type of voluntary work.
Source: ABS 2003a.

The rates of volunteering differed little between men and women overall. On the other hand, they varied with age, with higher rates during middle age and lower rates among the older age groups. However, the median number of hours of voluntary work was highest in the 65–74 age group (2.5 hours per week in 2000) (ABS 2001).

Older Australians were most likely to volunteer to assist welfare and community organisations, and religious organisations. While volunteering to assist sport-, recreation- or hobby-related organisations also featured among people aged 65 years and over, rates were not as high as among younger Australians.

Older people as carers

Many older people provide care for family and friends who need assistance in their daily lives. They supply a substantial amount of informal care for children, and in almost 23,000 families, children are being raised by grandparents (see Chapter 3). In addition, older people play an active role in the community as carers of their ageing spouse. A number continue to provide care for adult children with disabilities, a role that a lot of them have been undertaking for many years.

In 2003, nearly 454,000 people aged 65 years and over provided assistance to people with a disability (ABS 2004a: table 27). Around one-quarter of these care providers (113,200) were a primary carer, that is, they provided the most assistance—in terms of help or supervision—to the care recipient. Overall, people aged 65 and over accounted for 24% of primary carers of people with a disability (Table 4.5).

Nearly one-fifth (17%) of older carers were aged at least 80. As with all primary carers in 2003, older carers were predominantly women. However, this preponderance was greater in the younger than older age groups: in 2003, 63% of primary carers aged 65–74 were female compared with just (50%) of carers aged 80 and over.

Table 4.5: Older primary carers (aged 65+), 2003

Age	Males	Females	Persons
		Number ('000)	
65–69	11.3	22.7	33.9
70–74	11.6	16.0	27.6
75–79	15.5	17.3	32.8
80–84	*8.1	*8.3	16.4
85+	**1.3	**1.2	*2.5
Total 65+	**47.7**	**65.4**	**113.2**
All primary carers	**135.4**	**337.1**	**472.5**
		Per cent	
65–69	23.6	34.6	30.0
70–74	24.3	24.4	24.4
75–79	32.5	26.4	28.9
80–84	*16.9	*12.7	14.5
85+	**2.7	**1.9	*2.2
Total 65+	**100.0**	**100.0**	**100.0**
		Carer rate within age–sex population (%)	
65–69	3.3	6.4	4.8
70–74	3.9	4.9	4.4
75–79	6.7	5.9	6.2
80–84	*5.5	*3.8	4.5
85+	**1.4	**0.6	*0.9
Total 65+	**4.3**	**4.7**	**4.5**

Notes

1. Table excludes people living in remote and sparsely settled parts of Australia.
2. Components may not add to total due to rounding.

Source: AIHW analysis of ABS 2003 Survey of Disability, Ageing and Carers confidentialised unit record file.

Overall, 4.5% of those aged 65 years and over were primary carers and this proportion increased with age, reaching a peak in the 75–79 age group among whom 6% were primary carers. By age 85 years few people were the primary carers of others (under 1%). Estimates suggest that while women aged 65–74 had higher carer rates than men of a similar age, the reverse was true for people aged 75 and over.

Primary carers aged 65 and over mainly care for their partner, and this is particularly true for men: in 2003, 92% of male carers compared with 76% of female carers (ABS 2004a: table 30). As a consequence, older carers generally lived with the care recipient. However, while 99% of older people caring for their partner lived in the same household as their partner, among those caring for another relative or friend around 40% were not co-resident with the care recipient. Around 9,000 older people were primary carers for people who were neither their partner, child nor parent.

4.3 Support and care for older people

In Australian society, support and care for older people are provided by the government in two ways: through income assistance to ensure financial security, and through the provision of services to people needing care and to those caring for their family and friends.l

Policy and program development

The last 2 years have been a period of considerable activity in relation to aged care policy (Box 4.2). The Review of Pricing Arrangements in Residential Aged Care examined current and alternative funding arrangements and long-term financing options for residential aged care (Hogan 2004). It made 20 recommendations to improve arrangements in the short to medium term, covering planning, place allocations, aged care assessment, funding supplements, workforce development and expansion, industry accountability and consumer financial contributions. The review also proposed six longer-term options for government consideration. A consultation process to progress this phase will commence in 2005–06 (DoHA 2005b).

The Australian Government's response to the review's recommendations has largely been put into effect through budget measures announced in 2004 and 2005 (Bishop 2004). The aged care provision ratio will increase from 100 to 108 operational places for every 1,000 persons aged 70 years and over, and the weighting for community care places within that ratio will double to 20 places (Community Aged Care Packages and Extended Aged Care at Home places combined). The allocation of places will be announced 3 years in advance with the intention that this will improve the ability of providers to plan for expansion.

In the 2004 Budget, the government announced that in 2006 the number of classification categories for basic subsidy funding in residential aged care would be reduced from eight to three and two supplements would be introduced covering dementia and nursing/palliative care to better target existing funding towards residents with high care needs. The new Aged Care Funding Instrument will replace the current Resident Classification Scale (RCS) and will focus on assessing resident care needs rather than care provided.

Box 4.2: Policy developments in aged care, 2003 to 2005

*On 5 April 2004, Professor Warren Hogan presented his **Final Report of the Review of Pricing Arrangements in Residential Aged Care** to the government, making 20 recommendations with respect to planning, assessment and funding systems, workforce training and user contribution arrangements (Hogan 2004).*

*The **2004 Budget** paper Investing in Aged Care: More Places, Better Care (Bishop 2004) outlined a range of initiatives in response to the review's recommendations, including:*

- *increased provision of places and funding supplements for special need care recipients such as those with dementia;*
- *from 1 July 2004, a new Medicare rebate was introduced for GPs to provide assessments for aged care residents. From the same date, the requirement to reassess residents moving between low and high care in the same facility was removed;*
- *a new taskforce to oversee delivery of budget initiatives designed to further protect residents' bonds (announced on 13 August 2004);*
- *improved training for the aged care workforce, including through the allocation of increased nursing places at universities; and*
- *a new program, the **Transition Care Program**, to provide support to older people immediately following a hospital stay, to allow them and their families time to assess their options for future care. The program will have up to 2,000 places to become operational over 3 years.*

*In 2004, the government released **A New Strategy for Community Care—The Way Forward** (DoHA 2004c). This strategy arose from the review of community care programs and is intended to ensure programs operate in a more consistent and coordinated way.*

*The 2005 Budget announced the creation of 2,000 new **dementia-specific Extended Aged Care at Home** places over the next 4 years. In addition, dementia was declared a National Health Priority in recognition of its impact among older people, and the growing number of people that will be affected as the population ages.*

From 1 July 2005, lump sum accommodation bonds paid by residents in aged care facilities are not included when applying the social security and Veterans' Affairs assets test. Also, an aged care resident who pays an accommodation bond wholly or partly by periodic payments can rent out their former home without the value of the home or the rental income affecting their rate of pension (DoHA 2005d).

*The **National Aged Care Workforce Strategy** was released in March 2005. It identifies the workforce profile of the residential aged care sector and its likely needs until 2010 (Aged Care Workforce Committee 2005).*

*A national trial of the new **Aged Care Funding Instrument** was conducted in all states and territories between May and October 2005 to test its usability by aged care providers and external assessors, including staff from Aged Care Assessment Teams in some states and territories (see DoHA 2005e).*

Community care programs are based on the premise that most people value being able to live in their own home, and the recognition that some older people and people with a disability may find this difficult without assistance. The growing complexity and diversity of the community care environment prompted the Community Care Review, begun in March 2003. The outcome of this review is outlined in *A New Strategy for Community Care – The Way Forward* (DoHA 2004c), which broadly describes the action that the Australian Government will take, in conjunction with state and territory governments, service providers and consumer representatives from the 2004–05 financial year. The aim is to improve coordination of community care through: addressing gaps and overlaps in service delivery; making services easier to access; enhancing service management; and streamlining Australian Government programs.

The Australian, state and territory governments met in 2004 to discuss the broad principles of the Community Care Review and, specifically, how they might apply to a new Home and Community Care Agreement. The most important issues were the development of consistent assessment processes and uniform reporting requirements across all similar programs, including standard approaches to financial reporting, quantity reporting (through a minimum data set) and quality reporting. The first 3-year reporting cycle for a combined quality reporting process for the Community Aged Care Packages and Extended Aged Care at Home programs and the National Respite for Carers Program began on 1 July 2005.

Improvement in the provision of care at the interface between aged care and other kinds of care, such as hospital care, is encouraged via funding of pilot services or projects through the Aged Care Innovative Pool (DoHA 2005f:16). This Pool allows the Australian Government, in partnership with other stakeholders, to allocate aged care places to services that will: provide aged care services in new ways; provide aged care services to client groups for whom current services are limited or to newly-emerging client groups; and provide aged care via new models of partnership and collaboration. Pilots that include services that are the responsibility of state or territory governments are jointly funded with those governments. At 30 June 2004, Innovative Pool projects had a total of 1,352 places available across five types of projects: Innovative Care Rehabilitation Services pilots (383 places); Intermittent Care Service pilots (396 places); Disability pilots (231 places); Dementia pilots (234 places); and High Needs pilots (107 places).

The interface between aged care and the acute/subacute care system has been recognised for some time as an important site for appropriate responses to older people's needs for rehabilitation, recovery and care needs assessment. Transition care is a new model of care located at this interface. Transition care is designed to provide care recipients who have completed their hospital episode with low-intensity therapy services and support to stabilise their care needs, optimise their independence and confidence, and give them time to decide on a suitable long-term care option. A new program based on these principles is currently being developed. The Transition Care Program will provide care in either a residential or community setting and will build upon the experiences of earlier initiatives under the Aged Care Innovative Pool, namely the Innovative Care Rehabilitation Service pilots and Intermittent Care Service pilots. The program will have up to 2,000 places for older people who are recovering after a stay in hospital under a cost-shared model with state and territory governments.

The 2004 and 2005 federal budgets also contained a number of measures designed to provide support for carers (Box 4.3).

Box 4.3: Policy initiatives affecting carers

In 2003, the Australian Government commissioned a study by the COTA National Seniors Partnership to examine the financial, legal and social issues facing grandparents who are raising grandchildren (COTA National Seniors 2003).

From 1 November 2004, grandparents with primary care of their grandchildren may be eligible to access Child Care Benefit for up to 50 hours per week through a waiver of the work, training and study test. Grandparent carers who also receive an income support payment may be eligible for the Grandparent Child Care Benefit which covers the full cost of approved child care (Centrelink 2004a).

In June 2004 Carer Payment recipients were given a one-off payment of $1,000, and Carer Allowance recipients were given a one-off payment of $600 as part of the 2004 budget process (Treasury 2004:1). Similar one-off payments were included in the 2005 Budget.

From 1 September 2004, eligibility for the Carer Allowance was extended to carers who do not live with the people for whom they provide substantial levels of personal care in a home on a daily basis (at least 20 hours per week).

From 1 April 2005, the number of hours a week that a carer can work, train or study without losing eligibility for Carer Payment was increased from 20 to 25.

In the 2004 Budget, older carers were specifically targeted with the provision of up to 4 weeks a year respite for parents over 70 years of age who are caring for a son or daughter with a disability, and parents aged between 65 and 69 years who need to be hospitalised will be entitled to up to 2 weeks respite a year (to be cost-shared with state and territory governments) (Treasury 2004).

Income support

Australians today are living longer, and so spending longer in retirement, than those in preceding generations. Income security during these years is important if older people are to be able to participate in society as much as they can.

Pensions

Currently, the majority of older people are on publicly-funded income support (Box 4.4). The Age Pension and payments from the Department of Veterans' Affairs (DVA) are the two main sources of income support for older people. At the end of 2004, nearly 1,888,000 people were receiving either a full or part Age Pension and 363,700 were receiving DVA payments (Table 4.6). As a result, 80% of people aged 65 and over—and 63% of Australians aged 60 and over—received either the Age Pension (full and part pensions) or a DVA payment. The proportion of people receiving payments from either of these sources increased with age, ranging from 70% for 65–69 year olds to 88% of people aged 80–84. For both pension types, nearly 60% of pensioners were women.

Older people may also be eligible for the Senior Australians' Tax Offset. Had this offset not existed, it is estimated that the Australian Taxation Office would have collected an additional $1,630 million in tax in the 2003–04 financial year (Treasury 2005:54). For 2002–03, the latest year for which figures are available, the ATO recorded that 599,201 people who lodged tax returns received the tax offset (ATO 2005b:19).

The Pension Bonus Scheme provides an incentive for older Australians to defer claiming income support—that is, the Age Pension—and instead remain in the workforce. In June 2004, among those over Age Pension age who were working, 32% received some Age Pension while they worked and another 17% were registered in the Pension Bonus Scheme. As at 30 June 2004, 67,975 people were registered in the scheme, and during 2003–04 a total of $88 million was paid in bonuses to 7,416 people—an average of $11,868 per recipient (Centrelink unpublished data).

Table 4.6: Age and DVA pension recipients, December 2004/ January 2005

	Age group							
	[a]60–64	65–69	70–74	75–79	80–84	85–89	90+	Total
				Per cent of Age pensioners[b]				
Males	—	12.6	12.1	9.5	3.8	1.7	0.9	40.7
Females	6.7	14.6	13.0	10.3	7.3	4.5	2.9	59.3
Persons	**6.7**	**27.3**	**25.1**	**19.8**	**11.1**	**6.2**	**3.8**	**100.0**
Persons (number)	*126,289*	*515,176*	*474,472*	*374,648*	*209,453*	*117,008*	*70,940*	*1,887,986*
Per cent of age group population[c]	*13.7*	*68.0*	*75.9*	*68.2*	*53.2*	*61.1*	. .	*[d]66.9*
				Per cent of DVA pensioners[b]				
Males	2.6	2.1	2.2	7.3	18.6	7.1	1.6	41.4
Females	2.3	3.0	6.4	17.1	19.1	7.8	2.7	58.6
Persons	**5.0**	**5.1**	**8.6**	**24.4**	**37.8**	**14.9**	**4.3**	**100.0**
Persons (number)	*18,006*	*18,541*	*31,414*	*88,618*	*137,297*	*54,258*	*15,518*	*363,652*
Per cent of age group population[c]	*1.9*	*2.4*	*5.0*	*16.1*	*34.9*	*22.7*	. .	*[d]13.1*
Total as % of age group population[c]	**15.6**	**70.4**	**80.9**	**84.3**	**88.1**	**83.8**	. .	**[d]80.0**

(a) Eligibility for Age Pension in December 2004 was 62.5 years for women and 65 years for men.

(b) Age Pensions administered by DVA are included in the 'DVA pensioner' figures. Some of these pensioners were also in receipt of DVA payments. After allowing for people who received payments from more than one source, these added 2,676 to the DVA pensioner numbers (aged 60+).

(c) Age and DVA pension recipients aged 85–89 and 90+ have been combined to enable the percentage of age group to be calculated.

(d) As per cent of people aged 65+.

Notes

1. 37 DVA cases with unknown age have been excluded.
2. Table includes full and part pensioners.
3. DVA pensioners include any person in receipt of a Service Pension, Disability Pension, War Widow Pension or Orphan Pension.
4. Age pensioners as at December 2004; DVA pensioners as at 7 January 2005; population as at 31 December 2004 (preliminary estimates).
5. Components may not add to total due to rounding.

Sources: ABS 2005a; Centrelink unpublished data; DVA unpublished data.

Box 4.4: Income support

Age Pension: *The Age Pension is assets- and income- tested, and in December 2004 was available to men aged 65 years and over and women aged 62.5 years and over. The qualification age for women, which was 60 years until 1 July 1995, has been gradually increasing and will be raised to age 65 by 2014. The maximum single base rate of pension is set to at least 25% of male total average weekly earnings. Each member of a couple receives approximately 83% of the single rate of pension. The maximum single rate is adjusted every 6 months in line with the consumer price index. At the end of 2004, a single person on the maximum rate Age Pension received $235.35 per week, and a couple $393 per week. Age pensioners may also be entitled to a range of additional payments and benefits, depending on their circumstances, including the Pharmaceutical Allowance, Rent Assistance, Telephone Allowance, Remote Area Allowance, Utilities Allowance and a Pension Concession Card entitling the holder to reduced cost medicines as well as a range of state and local government concessions (Centrelink 2004d; private correspondence with FaCS).*

DVA pension and benefits: *The Service Pension is paid to veterans, eligible partners, widows and widowers. It is similar to the Age Pension, being paid at the same rate and subject to income and assets tests. In general, it is available 5 years earlier than the Age Pension; however, it may be granted at an earlier age to partners and in cases of invalidity. There are also forms of compensation available from DVA which are neither taxable nor subject to means testing. These include the war widow(er)'s pension, disability compensation, and ancillary benefits. Depending on their age, family circumstances and income and assets, people on the war widow(er)'s pension may also be eligible for the income support supplement (ISS). Allowances payable in association with the Service Pension and ISS include a pharmaceutical allowance, rent assistance, telephone allowance, annual utilities allowance and remote area allowance (DVA 2005).*

Senior Australians' Tax Offset: *Regardless of the source of their income, older Australians of Age Pension age are entitled to the income-tested Senior Australians' Tax Offset. The effect of the offset is to increase the non-taxable income threshold so that individuals who earn below $20,500 per year and couples who earn a combined amount of less than $33,612 per year do not pay income tax. As income rises, the amount of the tax offset is reduced by 12.5 cents per dollar earned above the tax-free income levels. In addition, people eligible for the tax offset pay no Medicare levy if their income is below $20,500 (ATO 2005a).*

Pension Bonus Scheme: *The Pension Bonus Scheme was introduced on 1 July 1998 to provide an incentive for older Australians to defer claiming the Age Pension and instead remain in the workforce. The scheme is voluntary and provides a tax-free lump sum to eligible scheme members who defer taking the Age Pension and continue to work at least 960 hours each year for a minimum of 1 year. Bonuses can be accrued for up to a maximum of 5 years, and cannot be accrued after age 75. The scheme pays a once-only, tax-free lump sum to registered members when they finally claim and receive the Age Pension. The amount of pension bonus is based on a multiple of the registrant's annual rate of Age Pension payable when the pension is granted. At the end of 2004, the maximum bonus payable to a person on the Age Pension varied between $1,150 and $28,760 for a single person and from $961 to $24,012 each for a person with a partner, depending on the number of bonus years the person had accrued. For those entitled to a part-pension, the bonus is reduced proportionately (Centrelink 2004c).*

Income support for older carers

In addition to general income support, depending on their circumstances, older people who are carers may be able to access two government payments: the Carer Payment and the Carer Allowance. People receiving these payments may be caring for more than one person (see Tables A4.1, A4.2).

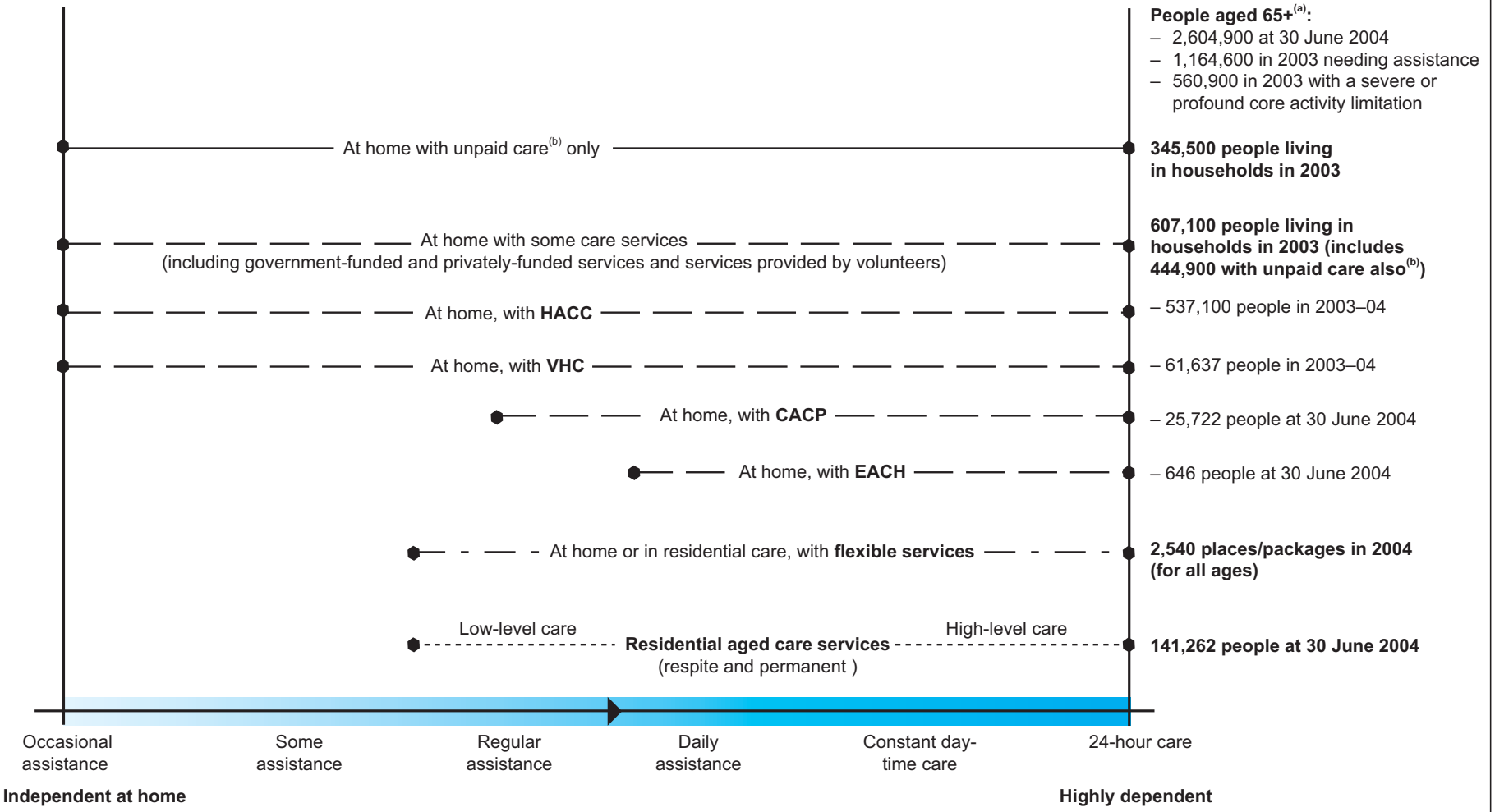
The Carer Payment is an income support benefit payable to people who, because of their caring responsibilities, are unable to support themselves (see Box 5.7). It is set at the same rate as the Age Pension and is subject to the same income and assets tests. Because it is for people forgoing paid work due to caring responsibilities, relatively few older people receive it. At the end of 2004, a total of 91,024 people were receiving the Carer Payment (see Table A4.1). People aged 65 and over accounted for just over 3% (2,863) of all recipients. A large majority (85%) of these older recipients were aged 65–74, and just over one-half were female.

The Carer Allowance is payable to carers who provide full-time daily care at home to people who need substantial amounts of care because of a disability or a severe medical condition or because they are frail older people (see Box 5.7). The allowance can be paid to carers whether or not they are in receipt of a government pension or benefit and is not income- or assets-tested. Since 1 April 2005, some non-co-resident carers have also been eligible for this allowance (see Box 4.3). It is adjusted on 1 January each year, and in 2005 was set at $92.40 per fortnight (Centrelink 2004b). In December 2004, 324,030 people were receiving the Carer Allowance (see Table A4.1). The majority (56%, or 66,610) of recipients looking after people aged 65 and over were themselves aged at least 65, while just 6% (12,696) of recipients caring for younger people were aged 65 and over. Older allowance recipients were more likely to be men than younger recipients: 40% compared with 18%for recipients aged under 65.

Care for older people

While many older people manage on their own at home, or with help from relatives and friends, others rely on a range of care services or a combination of services and informal help (Figure 4.2). In some cases, without these services people would not be able to remain living in the community, but would need to move into residential care.

There is evidence that in recent years there has been a shift in the mix of formal and informal care services that people access. In 1998 nearly 347,000 people aged 65 and over were living at home using only informal care services (that is, unpaid care), and 507,000 were living at home accessing formal care services. Seventy-two per cent of this second group were also assisted by unpaid carers (AIHW 2003a:294). By 2003, despite population growth, there had been virtually no change in the number of older people at home with only unpaid care (345,500), while the number using formal care services had increased by 20% to 607,100. Again, nearly three-quarters of those with formal care also had unpaid carers (73%). Over the same period, the number of people aged 65 and over grew by 10% while the number of older people with a severe or profound limitation grew by 17% (see Table 5.1; ABS 1999) These figures suggest that the use of formal care services increased in line with the number of people with a severe or profound core activity limitation. At the same time, relatively fewer people were remaining at home with only unpaid care.



(a) Due to data availability, numbers refer to different time periods.

(b) Excluding payments from government pensions and benefits.

Note: Figure includes selected government-funded programs only. Some services can be used concurrently. Hospital services are not included.

Sources: Tables 4.1, 4.7, 4.19, A5.1; AIHW analysis of ABS SDAC data; AIHW analysis of DoHA ACCMIS database.

Figure 4.2: Range of care arrangements for older people[a]

There are three main national programs which provide care to people living in their own homes: Home and Community Care, Community Aged Care Packages, and Veterans' Home Care and associated programs such as DVA nursing. A fourth program—the Extended Aged Care at Home Program—is still quite new and therefore provides services to a relatively small number of people. In addition, there are a number of smaller programs which also support people and their carers, including the National Respite for Carers Program. When people can no longer remain at home, either in the short term due to a temporary change in care needs, or for the longer term, they may access residential aged care services. States and territories may also provide a range of services independently of the Australian Government.

Care needs

A person's care needs and their personal resources (both social and economic) influence whether and how they access care. The assistance needed varies from person to person depending on the type and severity of the disability being experienced. In 2003, 47% of people aged 65 years or over (1,164,600 persons) reported needing assistance with at least one personal activity (for example, self-care or health care) or other daily activities (for example, paperwork, housework or meal preparation). People often required assistance in more than one area—on average, with three to four activities (Table 4.7).

Table 4.7: Need for assistance, 2003

	65–69	70–74	75–79	80–84	85–89	90+	Total	No. ('000)
Personal activities[a]				**Per cent within age group**				
Self-care	6.1	8.4	12.2	21.2	34.7	58.0	14.3	356.2
Mobility	7.2	11.6	17.8	31.1	46.6	69.4	19.3	482.9
Communication	1.7	2.2	3.4	8.7	17.1	34.2	5.6	139.9
Cognition or emotion	5.1	5.9	9.2	17.0	29.5	46.4	11.3	282.0
Health care	10.0	18.3	24.5	40.3	53.7	72.5	25.2	629.8
Total for personal activities[b]	*15.9*	*23.2*	*29.9*	*46.9*	*60.0*	*79.9*	*30.9*	*772.5*
Other activities								
Paperwork	3.7	5.4	10.8	19.1	34.9	49.3	11.9	298.5
Transport	8.6	15.8	22.6	33.4	43.3	36.7	20.7	516.5
Housework	9.7	15.1	20.5	30.0	34.6	29.8	18.9	473.2
Property maintenance	16.2	23.8	31.6	37.2	39.5	35.3	26.9	672.3
Meal preparation	2.2	4.2	7.8	10.6	18.2	15.5	6.8	170.3
Total for any activity[b]	**26.7**	**38.2**	**49.6**	**65.5**	**79.2**	**94.8**	**46.6**	**1,164.6**
Assistance not needed	**73.3**	**61.8**	**50.4**	**34.5**	**20.8**	***5.2**	**53.4**	**1,334.2**
Number ('000)	**701.6**	**622.0**	**525.2**	**366.3**	**191.5**	**92.1**	**. .**	**2,498.7**

(a) These activities were only asked of persons with a disability.

(b) Total may be less than the sum of the components as persons may need assistance with more than one activity.

Note: Table includes people living in both private and non-private dwellings.

Source: Derived from ABS 2004a: Table 21.

Overall, 31% of all older Australians needed assistance with personal activities. Health care was the most common area of personal need for all age groups, with 25% needing help in this area; this was followed by need for assistance with mobility (19%), self-care

(14%), and cognition or emotion (11%). At 6%, assistance with communication was required the least. Twenty-seven per cent of older Australians needed help with property maintenance, with other common areas of need including transport (21%) and housework (19%).

The proportion of older people needing assistance with at least one activity increased with age, rising from 27% among those aged 65–69 to 95% among those aged 90 or over. This pattern held generally for all activities examined, although a drop in need for assistance was observed among the very old for all the non-personal activities looked at, except paperwork.

Sources of care

The group of older people who could be considered as most in need of assistance are those with a profound or severe core activity limitation in the areas of self-care, mobility or communication. Informal care networks of family, friends and neighbours provided much of the help received by this group of older people living in the community in 2003 (Table 4.8). Over one-third relied solely on social networks, and 62% on a combination of both formal and informal care providers. Only 3% received only formal care assistance.

Table 4.8: Source of assistance received by people aged 65 years and older with profound or severe limitations living in households, 2003

	Source					
Assistance needed	**None**	**Informal only**	**Formal only**	**Informal and formal**	**Total needing assistance**	
Core activity		**Per cent**				**No. ('000)**
Self-care	9.6	64.3	9.8	16.2	100.0	207.9
Mobility	7.7	67.8	5.7	18.8	100.0	339.8
Communication	**2.5	91.5	**1.6	**4.4	100.0	35.7
Total core activity[(a)]	*7.4*	*65.2*	*6.7*	*20.7*	*100.0*	*400.5*
Other activity (in addition to core activity)						
Cognition or emotion	*4.1	73.2	*3.0	19.7	100.0	107.2
Health care	4.7	36.9	33.6	24.8	100.0	286.3
Housework	*2.7	53.7	19.4	24.1	100.0	281.9
Property maintenance	3.5	59.1	19.5	17.8	100.0	291.5
Paperwork	*3.2	90.8	*2.5	*3.5	100.0	129.5
Meal preparation	*2.8	74.4	10.9	11.9	100.0	146.9
Transport	5.5	79.3	4.6	10.6	100.0	298.3
Total with core activity limitation and limitation in another activity[(b)]	*1.2*	*33.2*	*5.0*	*60.5*	*100.0*	*383.7*
Total with core activity limitation and perhaps limitation in another activity	**1.3	**33.7**	**3.2**	**61.8**	**100.0**	**400.5**

(a) Includes people who need help sometimes or always with at least one core activity. As people may have different sources of care for different activities, these percentages are not simply the average of the percentages for the individual activities.

(b) Includes people who need help with one or more non-core activities and who sometimes or always need help with at least one core activity. As people may have different sources of care for different activities, the percentages are not simply the average of the percentages for the individual activities.

Note: Components may not add to total due to rounding.

Source: AIHW analysis of ABS 2003 Survey of Disability, Ageing and Carers confidentialised unit record file.

Assistance with communication (92%) and paperwork (91%) were most often provided through social networks alone, along with transport (79%) and meal preparation (74%). Such informal assistance was least likely to be the source of help with health care (37%), which was more likely than other types of assistance to be obtained only through formal providers (34%) (including government organisations, private agencies funded through government programs and privately purchased services). For most activities, 10–25% of those needing and receiving assistance were getting help from both formal and informal sources.

Unmet need for care

Unmet need occurs when a person receives insufficient or no assistance with activities when help is required. Figures on receipt of assistance show that relatively large numbers of older people with a profound or severe core activity limitation living in households reported receiving no assistance. Overall, 7% of such people reported receiving no assistance with these core activities. Between 3% and 6% of those needing assistance with another activity as well as a core activity had no assistance with that other activity. Within particular care needs, 10% of those needing assistance with self-care received no help; other needs which had relatively high levels of unmet need were mobility (8%) and transport (5.5%) (Table 4.8).

These figures do not tell the full story as having a source of assistance does not imply that a person's needs are fully met: a person's need for assistance in one or more areas may still only be partially met. Also, people with care needs do not all have a severe or profound core activity limitation. Looking at the broader population, among all people aged 60 years or over who were living in households in 2003 and who needed some assistance, either with core activities or other activities, 64.5% (788,100 out of 1,221,500 people) had all their needs fully met and 29.7% (363,400) had their needs partly met; 5.7% (70,000) reported that none of their needs were met, even partially. The areas with the highest proportions of older people reporting that their need for assistance was completely unmet were transport (11%) and self care (10%) (ABS 2004a: Table 22).

The above figures give an indication of the level of unmet need in 2003. If the provision of help by either informal or formal care providers changes relative to the number of people requiring assistance, then the level of unmet need will also change. Analysis of the likely availability of primary carers over the next few years indicates that, on the basis of demographic changes alone, the ratio of primary carers to persons with a severe or profound core activity limitation is expected to fall— by an estimated 7% between 1998 and 2013 (AIHW 2004b:xiv, 41–3). This is despite a projected 27% increase in the absolute number of primary carers (AIHW 2003a:108). A general decline in propensity to become a carer, due to other social or economic factors, will aggravate this situation. For highly dependent people, reduced assistance from family and friends (especially co-resident carers) will place increased demands on formal care services to provide assistance that enables the person to remain in their own home. For people with relatively few care needs, lower availability of informal care may result in their accessing formal care services earlier than is currently the case.

Accessing aged care services

While access to most community care services can be gained directly through providers, there are two key programs which provide information on available services and which assist people in accessing residential and community care: the Commonwealth Carelink Centres and the Aged Care Assessment Program.

Commonwealth Carelink Centres

To help people find appropriate services, in 2001 the Australian Government set up a network of Commonwealth Carelink Centres. These centres provide a single point of contact for obtaining comprehensive information on community aged care, residential care, and disability and other support services available in any region within Australia. The centres are operated by a wide range of organisations, including not-for-profit and for-profit non-government organisations, and government agencies, with a total of 65 shopfronts and over 90 access points such as free phones in rural and remote localities (Centrelink 2005). During 2004–05, the centres had 235,000 contacts, including phone calls, visits, emails and facsimiles, up from almost 200,000 the year before (DoHA unpublished data; SCRCSSP 2005: table 12A.59).

Aged Care Assessment Program

The Aged Care Assessment Program (ACAP) funds Aged Care Assessment Teams (ACATs) across Australia. These teams play a crucial role in the aged care system as they determine eligibility for Community Aged Care Packages, Extended Aged Care at Home places, and residential aged care. They also function as a source of advice and referral concerning Home and Community Care services but do not determine eligibility for these services.

Implementation of the revised ACAP minimum data set (MDS v2.0), begun in April 2003, has improved the information available on assessments undertaken, on the people seeking assessment and the resulting ACAT recommendations. While recommendations are valid for up to 12 months, people may have multiple assessments in a year if their situation changes; data from the last assessment in the financial year were used in the following analysis. Data on assessments undertaken in Queensland and some parts of New South Wales (for about one-third of clients) were not available in the MDS v2.0 format, and are therefore not included in the analysis.[1]

In 2003–04, 158,988 people had 176,955 assessments completed by an ACAT, an average of 1.1 per client over the year. Close to 95% of clients were aged 65 and over (see Table 4.19). The proportion of the population having an assessment during the year increased substantially with age, from 14 per 1,000 people aged 65–74 up to 220 per 1,000 aged 85 and over (see Table 4.22). When compared with the number of people with a severe or profound core activity limitation, for every 1,000 people aged 65 and over with such a limitation 261 had an assessment some time during the year (Table A4.5).

1. Data for this analysis were provided by the Lincoln Centre for Ageing and Community Care Research (Lincoln Centre).

Up until 30 June 2004, all aged care residents needed an assessment in order to change from low care to high care (or vice versa). Consequently, at the time of assessment, although nearly three-quarters of ACAP clients aged 65 and over were living in a private residence, 13% were in institutional settings, predominantly residential aged care (Table 4.9). Of those still living in the community, 37% were already receiving services through Home and Community Care (HACC) and 10% through Community Aged Care Packages (CACPs) (Table 4.10). Smaller numbers were getting help through Veterans' Home Care, Extended Aged Care at Home (EACH) places and other programs. Thirty-five per cent of those assessed while still living at home were not receiving any assistance through government programs at the time of their assessment.

Table 4.9: ACAP clients: accommodation at assessment and as recommended, [(a)] 2003–04 (per cent)

	Usual accommodation at assessment			Recommended long-term care setting at assessment		
	<65	65+	Total	<65	65+	Total
Community setting						
Private residence	76.1	74.0	74.1	51.5	43.3	43.7
Independent living within a retirement village	1.1	6.9	6.6	1.1	2.9	2.8
Supported community accommodation	5.5	1.6	1.8	5.3	0.9	1.1
Other	9.4	4.3	4.6	2.8	0.8	0.9
Total	*92.1*	*86.8*	*87.0*	*60.8*	*47.9*	*48.5*
Institutional setting						
Residential aged care service—low-level care	4.4	11.5	11.2	13.9	22.1	21.7
Residential aged care service—high-level care	1.5	1.1	1.1	24.0	29.5	29.2
Hospital	0.8	0.3	0.3	0.4	0.4	0.4
Other institutional care	1.2	0.3	0.4	0.9	0.1	0.1
Total	*7.8*	*13.2*	*13.0*	*39.2*	*52.1*	*51.5*
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**
Total (number)	**5,117**	**97,257**	**102,374**	**5,264**	**99,750**	**105,014**

(a) Qld and some parts of NSW have not yet adopted the MDS v2 format for reporting data on usual accommodation setting; 51,974 clients assessed in these regions are therefore not included in this table.

Notes

1. Table excludes cases with missing, unknown or inadequately described information on accommodation setting: 4,592 cases at assessment (including all assessments in the ACT), and 1,952 recommendations; 48 cases with missing age are also excluded.
2. Components may not add to total due to rounding.

Source: Lincoln Centre and AIHW analysis of ACAP MDS v2.

Permanent residential aged care was recommended for over half of older ACAP clients (52%), mostly for high care (Table 4.9). Among those with recommendations to stay living in the community, HACC services were recommended for 40% and a CACP or EACH place was recommended for 40% (Table 4.10). No continuing program support was recommended for a relatively small number of people (15%).

Table 4.10: ACAP clients: community program support at assessment and as recommended,[(a)] 2003–04 (per cent)

	Program support at time of assessment received by clients living in the community			Program support recommended at assessment for clients with a recommendation to live in the community		
	<65	65+	Total	<65	65+	Total
CACP	6.0	9.8	9.6	26.3	36.9	36.3
EACH	0.7	0.4	0.4	2.8	1.9	2.0
HACC	33.8	36.5	36.4	37.5	39.6	39.5
Veterans' Home Care	0.4	6.5	6.2	0.5	7.5	7.0
Day Therapy Centre	2.3	2.4	2.3	4.1	4.7	4.6
National Respite for Carers Program	5.7	4.3	4.4	16.5	17.0	17.0
Other	13.0	6.2	6.6	13.2	7.7	8.0
None	39.3	35.1	35.3	21.7	15.1	15.5
Total (number)	**4,552**	**82,209**	**86,761**	**3,040**	**45,716**	**48,756**

(a) Qld and some parts of NSW have not yet adopted the MDS v2 format for reporting data on program support; 51,974 clients assessed in these regions are therefore not included in this table.

Notes

1. 'At time of assessment' figures exclude clients living permanently in residential aged care, hospitals or other institutional settings. 'Recommended at assessment' figures exclude clients recommended to living permanently in residential aged care or other institutional settings.
2. Table excludes cases with missing, unknown or inadequately described information on program support: 2,325 cases at assessment, and 2,187 recommendations.
3. As clients can receive assistance from/be recommended for more than one program, percentages do not sum to 100.

Source: Lincoln Centre and AIHW analysis of ACAP MDS v2.

Among older people living at home at the time of assessment, over two-thirds were receiving help in the areas of domestic assistance, meals and transport, with around half receiving assistance with health-care tasks, home maintenance and self-care; only 8% were not already getting some kind of assistance (Table 4.11). For many activities, the assistance was provided most commonly by unpaid carers. The exceptions to this were self-care, health-care tasks and domestic assistance: for these three activities the majority of assistance was provided either by paid helpers or through a combination of paid and unpaid carers.

For the clients with an ACAT recommendation to live in the community, domestic assistance was the most commonly recommended formal assistance (recommended for 68% of older clients). Recommendations for between 35% and 45% of clients were also made for formal assistance with meals, transport, social activities, health-care tasks and self-care. Around 11% received no recommendation for formal assistance with particular tasks. At 5%, communication was the activity least likely to get a recommendation for formal assistance, followed by movement activities (8%).

In addition to continuing program support, ACATs may recommend respite care. Among people assessed in 2003–04, a large majority of those living in the community at the time of assessment had not used respite care in the previous 12 months (82% of older clients).

In contrast, respite care was recommended for 69% of clients aged 65 and over with a recommendation to live in the community (Lincoln Centre unpublished data). Most of the respite recommendations involved residential respite care, with non-residential respite care alone being recommended for a small number of clients (2%); both residential and non-residential respite care were recommended for 12%.

Table 4.11: Older ACAP clients (65+): assistance with activities,[(a)(b)] 2003–04 (per cent)

	Source of assistance for clients living in the community						Formal assistance recommended for clients with a recommendation to live in the community
Assistance	Formal	Informal	Both	Not stated	Total	All	
Self-care	39.6	42.2	13.1	5.0	100.0	46.4	36.2
Movement activities	20.5	62.1	11.3	6.1	100.0	17.6	7.6
Moving around places at or away from home	13.0	70.9	11.1	5.0	100.0	38.2	20.5
Communication	10.9	73.4	10.9	4.8	100.0	12.5	4.6
Health-care tasks	35.1	48.5	12.0	4.4	100.0	55.4	38.5
Transport	13.1	69.3	13.5	4.1	100.0	70.3	44.4
Activities involved in social and community participation	16.9	64.9	13.8	4.4	100.0	55.1	42.4
Domestic assistance	40.0	41.7	13.9	4.4	100.0	82.6	68.5
Meals	29.1	57.8	8.9	4.3	100.0	71.1	44.7
Home maintenance	23.5	64.9	7.3	4.3	100.0	53.7	33.3
Other	37.6	48.8	3.5	10.1	100.0	4.0	7.5
None	. .	. .	. .	. .	. .	7.5	11.1
Total (number)	**. .**	**. .**	**. .**	**. .**	**. .**	**77,875**	**44,260**

(a) Qld and some parts of NSW have not yet adopted the MDS v2 format for reporting data on assistance; 51,974 clients assessed in these regions are therefore not included in this table.

(b) Formal assistance involves payment for services; informal assistance is unpaid.

Notes

1. 'Source of assistance for clients living in the community' figures exclude clients living permanently in residential aged care, hospitals or other institutional settings. 'Clients with a recommendation to live in the community' figures exclude clients recommended to living permanently in residential aged care or other institutional settings.
2. Table excludes cases with missing or inadequately described data on assistance: 5,955 cases at assessment and 2,122 recommendations, as recorded on MDS v2.
3. Components may not add to total due to rounding.

Source: Lincoln Centre and AIHW analysis of ACAP MDS v2.

4.4 Use of community care

In general, aged care programs are targeted at frail or disabled older people with care needs related to activities of daily living (personal care, mobility and communication), and their carers. The following discussion examines the use of services from the main community care programs by all people aged 65 years and over. It also examines the services provided relative to the number of people defined in the 2003 ABS Survey of

Disability, Ageing and Carers as having a severe or profound core activity restriction—the categories of people identified by the survey as sometimes or always needing assistance with core activities of daily living (see Technical Appendix).

Home and Community Care

The bulk of home- and community-based services for older people are provided under the auspices of the HACC program. While it is important to recognise that the HACC target population is people of all ages requiring assistance due to disability and/or frailty (and their carers), older people account for the great majority of clients. During the 12 months between 1 July 2003 and 30 June 2004, at least 707,000 clients received services through HACC (see Table 4.19). Of these, just over three-quarters (76%, or 537,100) were aged 65 years or more. Information on services provided to people aged under 65 with a disability are discussed in Chapter 5.

The aim of the program is to enhance the independence of people and avoid premature or inappropriate admission to long-term residential care. The program is jointly funded by the Australian (60%) and state and territory governments (40%); clients can be asked to contribute to the cost of services provided.

An ACAT assessment is not a prerequisite to accessing the program. However, many clients assessed by ACATs are recommended for HACC services, which include home nursing services, delivered meals, home help and home maintenance services, transport and shopping assistance, allied health services, home- and centre-based respite care, and advice and assistance of various kinds. HACC also provides brokered or coordinated care for some clients, through community options or linkages projects.

The HACC program commenced in 1985, and since then both the quantity and variety of service types have increased substantially, as has government expenditure (see Table 4.24 and AIHW 2001:243). As at 30 June 2003, there were around 3,100 service providers across the country who were part of this program, and throughout 2003–04 approximately 3,500 organisations provided HACC-funded services (DoHA 2004b:4, 13). In the following discussion, data from the HACC minimum data set quarterly collections—begun in January 2001—are used to describe the services provided. Not all agencies participate in the collection, and, as for 2002–03, it is estimated that 83% of funded service providers submitted data for 2003–04. Using these data, the demographic profile of service users, and the services they received, are examined.

Patterns of service use (HACC)

During 2003–04, among every 1,000 people aged 65 years and over in the population at least 210 used HACC services (see Table A4.5). In general, people are increasingly more likely to access these services as they get older, with at least 100 per 1,000 people aged 65–74 doing so in 2003–04, compared with at least 480 per 1,000 aged 85 and over (see Table 4.22). For every 1,000 people aged 65 and over with a severe or profound core activity limitation there were at least 930 who used HACC services at some time during the year.[2]

In 2003–04, assessment and associated services were the service types reported for the largest number of older HACC clients (44%) (Table 4.12). Other services commonly reported were assistance with domestic chores (31% of older clients), and meals, nursing and transport services (all around 20%). Centre-based day care and personal

care were used by around 10% of older HACC clients, while respite care was reported for 1%. Based on reported service use, during 2003–04 older HACC clients used an average of 2.1 of the service groups listed in the table.

Table 4.12: Services received by Home and Community Care clients, 2003–04

	<65	65–74	75–84	85+	Total 65+
	Per cent of clients within age group				
Assessment, case management and case planning/review[(a)]	40.1	42.2	43.9	45.0	43.6
Domestic assistance	19.8	26.9	31.5	33.6	30.7
Meals (at home and/or at a centre)[(a)]	11.1	15.9	22.7	28.4	22.4
Nursing (home and/or centre-based)[(a)]	24.6	20.5	19.7	23.8	20.9
Transport services	13.3	15.7	17.7	16.5	17.0
Allied health (at home and/or at a centre)[(a)]	14.0	19.0	15.3	14.4	16.0
Home maintenance	8.5	15.3	16.1	13.6	15.1
Counselling and/or social support[(a)]	18.9	14.4	14.4	15.5	14.8
Centre-based day care	11.5	10.7	10.6	11.2	10.8
Personal care	7.1	6.5	8.1	12.7	8.8
Goods and equipment[(a)]	4.4	5.3	5.2	5.5	5.3
Home modification	2.1	3.5	3.5	3.3	3.4
Respite care[(b)]	6.5	1.6	0.8	0.5	1.0
Other food services	0.5	0.3	0.4	0.5	0.4
Linen services	0.3	0.2	0.2	0.2	0.2
Average number of services per client	**1.8**	**2.0**	**2.1**	**2.2**	**2.1**
Total clients (number)	**170,100**	**139,200**	**257,600**	**140,300**	**537,100**

(a) Service type includes more than one service category.

(b) For respite care, the carer is considered the HACC client. Anecdotal evidence indicates that the provision of respite care may be under-reported.

Notes

1. Age is as at 30 June 2004. Age was missing (date of birth reported as 1 January 1900 or 1901 (see AIHW: Karmel 2005)) or greater than 110 for 3,243 clients. These clients are assumed to be aged 65 and over, and have been pro-rated accordingly.
2. Not all HACC agencies submitted data to the HACC MDS. For 2003–04, the proportion of HACC-funded agencies that submitted HACC MDS data differed across jurisdictions, and ranged from 77% to 99%. Actual client numbers will therefore be higher than those reported here. Because of this incomplete coverage, and because of cases with missing age, numbers have been rounded to the nearest 100.

Source: AIHW analysis of the HACC MDS.

Overall, the average number of services used by clients increased with age, from 1.8 services for clients aged under 65 to 2.2 for those aged 85 and over. However, use did not increase with age for all service types. While older clients were more likely than younger clients to receive services involving assessment and associated services, domestic assistance, nursing, transport and personal care, for most other services there

2. Note that this is a ratio of clients to potential users and not a usage rate, as disability status is not available in the HACC MDS and not all HACC clients will necessarily have a profound or severe core activity restriction as defined by the ABS.

was no strong relationship between age and service provision. In contrast, use of respite services declined with age, from almost 7% of clients aged under 65 to 1.6% of those aged 65–74 and 0.5% of clients aged 85 and over.

Table 4.13: Volume of services received by Home and Community Care clients, 2003–04

		65–74	75–84	85+	Total 65+	Total 65+	<65
Time-based services		**Column per cent**				**Volume ('000)**	**Per cent**
Centre-based day care	Care hours	40.4	42.1	40.3	41.1	8,161.7	32.2
Domestic assistance	Care hours	24.4	26.6	25.4	25.7	5,096.6	16.7
Personal care	Care hours	10.2	9.4	13.7	10.8	2,144.3	18.1
Nursing (home and/or centre-based)	Care hours	8.5	8.6	9.8	8.9	1,769.1	6.5
Assessment, case management and/or case planning/review	Care hours	5.6	5.6	5.5	5.5	1,102.0	5.4
Home maintenance	Care hours	3.2	3.2	2.4	3.0	593.6	2.0
Allied health (at home and/or at a centre)	Care hours	2.5	1.9	1.5	2.0	387.9	2.4
Respite care	Care hours	3.8	1.5	0.6	1.9	370.5	14.4
Counselling and/or social support	Care hours	1.2	0.8	0.6	0.8	168.5	1.8
Other food services	Care hours	0.3	0.3	0.4	0.3	65.5	0.5
Total	**Care hours**	**100.0**	**100.0**	**100.0**	**100.0**	**. .**	**100.0**
Total volume (row % and '000)	**Care hours**	**24.4**	**46.4**	**29.2**	**100.0**	**19,859.5**	**8,521.9**
Unit-based services			**Row per cent**			**Volume ('000)**	
Meals (at home and/or at a centre)	Number	14.9	47.1	38.0	100.0	10,297.1	1,410.2
Linen services	Deliveries	26.1	43.1	30.8	100.0	18.0	9.9
Transport	One-way trips	22.1	49.5	28.4	100.0	3,196.4	932.5
Goods and equipment	Number	39.0	46.8	14.3	100.0	16.6	5.2
Home modification	$	30.6	45.7	23.8	100.0	4,643.6	2,574.2

Notes

1. Age is as at 30 June 2004. Age was missing or greater than 110 for 3,243 clients. These clients are assumed to be aged 65 and over, and are included in the Total 65+.
2. Not all HACC agencies submitted data to the HACC MDS. For 2003–04, the proportion of HACC-funded agencies that submitted HACC MDS data differed across jurisdictions, and ranged from 77% to 99%. Actual volume will therefore be greater than reported here.
3. Components may not add to total due to rounding.

Source: AIHW analysis of the HACC MDS.

HACC provided 19.9 million hours of service to older clients during 2003–04 (Table 4.13). Because some services by their very nature take longer to deliver than others, higher use of one service than another by clients does not necessarily translate into greater numbers of service hours. For example, while only 11% of older HACC clients used centre-based day care, the time involved in providing a single instance of this service meant that it accounted for the greatest number of hours of service: 8.2 million hours, or 41% of hours of timed services. The next most time-consuming service was domestic assistance which used 26% of total hours of service, with personal care and

nursing accounting for around 10% of service hours each. The distribution of volume of service provision was very similar among the three older age groups examined, with a slightly higher percentage of hours of service to very old clients (aged 85+) being used for personal care and fewer being expended on respite care compared with younger clients. The distribution of service hours was quite different for clients aged under 65.

In addition to hour-based services, over the year older HACC clients received between them a total of 10.3 million meals, and went on 3.2 million one-way trips. In addition, just over $4.6 million was used to fund home modifications. Formal linen services were rarely provided to HACC clients, with only 0.2% of older HACC clients (920 people) using this service. Consequently, in 2003–04 only 18,000 deliveries were made by HACC providers.

Veterans' Home Care and in-home respite for veterans

Begun in January 2001, Veterans' Home Care (VHC) is similar in purpose and content to the HACC program, and is designed to help veterans, war widows and widowers with low-level care needs to enjoy a healthier lifestyle and remain living in their own homes longer. The program has a preventive focus and, through the early intervention of home support services, aims to reduce the use of formal medical services and delay entry to residential aged care services. While available generally to eligible veterans and war widow(er)s, the program targets those aged 70 years and over.

Provision of services is based on assessed need. Assessments are undertaken by designated regional assessment agencies, which also arrange for the services to be provided. Services include domestic assistance, personal care and safety-related home and garden maintenance (the latter limited to 15 hours in a financial year). Although funded separately, respite care is also arranged through Veterans' Home Care, up to a limit of 28 days (196 hours) of in-home or residential respite, or a combination of both, in any one financial year (7 hours in-home respite is deemed equivalent to 1 day in residential respite care). Except for respite care, clients are required to make a co-payment for VHC services.

Veterans and war widow(er)s continue to be eligible to be assessed for the full range of services provided under HACC through arrangements with state and territory governments. Veterans and war widow(er)s currently receiving HACC services are able to transfer to Veterans' Home Care. However, clients can access different services from both programs at the same time.

Patterns of service use (VHC)

During 2003–04, just over 62,700 people received services through Veterans' Home Care. Of these, just over 61,600 (98%) were aged 65 years and over. Domestic assistance (90% of clients) and safety-related maintenance (18%) were the services received by the most clients some time during the year (Table 4.14). Similar proportions of clients in the three age groups examined used domestic assistance. However, older clients were more likely than younger clients to receive in-home respite care and personal care, while the reverse was true for home and garden maintenance.

Table 4.14: Services received by Veterans' Home Care clients, 2003–04

	65–74	75–84	85+	Total 65+	
Clients	**Per cent within client age group**				**[a]Number**
Domestic assistance	91.0	89.3	91.7	90.1	55,506
Home and garden maintenance	26.5	19.0	13.7	18.0	11,119
Respite care (excluding residential respite)	7.8	12.0	17.4	13.2	8,144
Personal care	2.3	3.3	6.2	4.0	2,492
Total (number)	**3,663**	**41,266**	**16,708**	**. .**	**61,639**
Volume of assistance		**Per cent**			**Total ('000 hours)**
Domestic assistance	79.7	73.9	65.6	71.7	1,698.1
Home and garden maintenance	3.7	2.4	1.4	2.1	50.2
Respite care (excluding residential respite)	14.8	21.1	28.8	23.1	548.0
Personal care	1.8	2.6	4.2	3.1	72.7
Total (all types)	**100.0**	**100.0**	**100.0**	**100.0**	**2,369.1**
Total volume ('000s)	**113.1**	**1,538.2**	**717.8**	**2,369.1**	**. .**

(a) Total number of recipients will be less than the sum for all service types, as one recipient may receive more than one service type during the financial year. Table totals include services provided to two people of unknown age.

Note: Components may not add to total due to rounding.

Source: DVA unpublished data (DVA database as at 15 April 2005).

During 2003–04, nearly 2.4 million hours of assistance were provided to people aged 65 and over through Veterans' Home Care—around 12% of the volume of hours provided through the HACC program. Reflecting the time-consuming nature of respite care, this type of assistance accounted for 23% of the total hours of assistance although it was used by only 13% of clients. Conversely, although 18% of clients received home and garden maintenance, this type of help accounted for only 2% of all hours of assistance. Over two-thirds of hours of assistance related to domestic assistance. The proportion of hours of service expended on respite care and personal care increased with age, while younger clients used more hours for domestic assistance and maintenance than their older counterparts.

Community Aged Care Packages

Community Aged Care Packages (CACPs) provide support services for older people with complex needs living at home who would otherwise be eligible for admission to 'low-level' residential care. They provide a range of home-based services, excluding home nursing assistance (which may, however, be provided through HACC), with care being coordinated by the package provider. To receive a package, an ACAT approval specifically for a CACP is required. On 30 June 2004 there were 27,657 people in receipt of a Community Aged Care Package; 25,722 of these recipients were aged 65 and over (see Table 4.19). These figures do not include supplementary clients or recipients of flexible care and Multi-purpose Service packages.[3]

Unlike the HACC program which is jointly funded by the Australian and state and territory governments, the CACP program is solely Commonwealth funded. On 1 July 2004, the daily subsidy paid by the Australian Government for a Community Aged Care

Package was $32.04, which is in the middle of the subsidy range for low-level residential aged care (DoHA 2004d). Clients may be asked to contribute towards the cost of their care (see Section 4.7). Begun in 1992, the program has expanded rapidly, and reached 29,048 operational packages as at 30 June 2004 (including flexible care and Multi-purpose Service packages, discussed separately later).

Patterns of service use (CACP)

On 30 June 2004, nearly 10 out of every 1,000 people aged 65 years and over were receiving a Community Aged Care Package (not including supplementary clients or recipients of flexible care and Multi-purpose Service packages). This equates to 44 CACP recipients for every 1,000 people aged 65 and over with a severe or profound core activity limitation (see Table A4.5). As with HACC services, use of a package increased with age, from 3 per 1,000 people aged 65–74 to 33 per 1,000 people aged 85 and over (see Table 4.22).

At the time of the 2002 CACP census, more than half of older CACP recipients had a carer, with the percentage increasing with age (from 50% among recipients aged 65–69 to 60% among those aged 90 and over). However, carers were more likely to be co-resident for younger than older package recipients: for recipients aged 60–64, 73% of people with a carer lived with their carer compared with 40% for those aged 90 and over (AIHW 2004c:44–5).

A range of services can be included in a Community Aged Care Package, including domestic assistance, personal care, social support, rehabilitation, respite care, meals and food preparation, home maintenance, transport and linen services. In 2002, data on the type and quantity of services people received were collected for the first time, via the CACP census (AIHW 2004c). The collection reported information on services provided to package recipients within the census week. Since not all services used by a CACP recipient are provided each week, the census underestimates the total number of services provided to an individual as part of the package. Four service types were received by more than half the package recipients aged 65 and over during the census week: domestic assistance (received by 83% of recipients aged 65 or more), case management and care coordination (73%), social support (60%) and personal care (54%) (Table 4.15). Transport services (36% of older clients), meal preparation and other food services (29%), and delivered meals (21%) were also commonly received.

The percentage of clients receiving the service increased with age for personal care, domestic assistance, social support, and other food services. For delivered meals there was no clear relationship between service provision and client age. For all other service types the proportion of clients in a particular age group receiving the service decreased with age.

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3. Package recipients are permitted to take leave from their packaged care for a number of reasons (e.g. for a holiday, residential respite care, or a stay in hospital). In these situations, the subsidy paid for these packages may be used to fund care for other recipients who are eligible for placement in a package. These recipients are called 'supplementary care recipients'.

Older CACP clients receiving assistance during the census received an average of 3.8 service types each. The amount of assistance provided varied by type (Table 4.16). Although provided to only 4% of clients, respite care involved the most time per client, entailing at least 2½ hours per week for half of the older people using this service. Other services commonly involving more than 1 hour of help per week were domestic assistance (median of 2 hours), meal preparation and other food services (1¼ hours), personal care (2 hours) and social support (1¾ hours).

Table 4.15: Services received by CACP recipients, census week 2002

	<65	65–74	75–84	85+	Total 65+
	Per cent of clients within age group				
Domestic assistance	74.8	81.3	83.2	83.9	83.1
Case management/care coordination	73.4	72.5	73.1	73.0	73.0
Social support[(a)]	53.0	57.1	60.7	60.7	60.1
Personal care	42.2	48.4	52.0	59.2	54.2
Transport trips	38.8	38.3	36.7	32.9	35.5
Other food services	21.6	24.7	27.8	33.2	29.4
Delivered meals	21.3	17.9	20.1	23.4	21.0
Home maintenance	19.9	17.2	15.6	14.9	15.6
Respite care	6.4	6.3	4.3	3.5	4.3
Rehabilitation	3.8	3.0	2.4	1.7	2.2
Linen deliveries	1.7	1.2	0.8	0.9	0.9
No service recorded in census week	2.8	3.3	2.6	2.6	2.7
Total clients (number)	**1,743**	**3,896**	**10,494**	**9,117**	**23,507**
Average number of services for people receiving any services	**3.6**	**3.7**	**3.8**	**3.9**	**3.8**

(a) Includes services to assist people with their personal affairs, such as letter writing, managing paperwork and making telephone-based contacts; shopping, bill paying and banking (when the person is accompanied by the care worker); keeping the person company; and, accompanying the person to social activities. Also includes attending centre-based day care where attendance at the centre is paid for by the CACP provider, or the care recipient is accompanied by a CACP care worker.

Notes

1. Age is as at end of the census period.
2. Table excludes 189 cases with missing age.
3. Not all CACP service outlets submitted data; an estimated that 94% of CACP service outlets responded to the census.
4. Table includes clients of Multi-purpose and flexible service places or packages.

Source: AIHW analysis of 2002 CACP census.

Overall, the median number of hours of assistance given to people aged 65 years and over receiving timed assistance during the census week was 5½. While there were some differences between the age groups in the amount of assistance being provided, there was not a strong relationship between age and amount. Because of the large number of people receiving domestic assistance, overall this service accounted for the greatest number of hours of services (32%) provided under Community Aged Care Packages during the census week. Personal care and social support each accounted for just over one-fifth of all hours of service provided.

Table 4.16: Volume of services received by CACP recipients, census week 2002 (median)

	<65	65–74	75–84	85+	Total 65+	Total volume 65+	
Time-based services			**Median volume**				**Unit**
Personal care	2	2	2	2	2	29,592	hours
Domestic assistance	2	2	2	2	2	43,833	hours
Social support[(a)]	2	2	1¾	1½	1¾	30,250	hours
Other food services	1¼	1	1¼	1¼	1¼	11,592	hours
Respite care	3	2¾	2½	2½	2½	3,322	hours
Rehabilitation	1¼	1	1	1	1	685	hours
Home maintenance	1	1	1	¾	1	3,725	hours
Case management/care co-ordination	1	¾	¾	½	¾	16,107	hours
All hour-based services	**5¼**	**5¼**	**5½**	**5½**	**5½**	**139,105**	**hours**
Unit-based services							
Delivered meals	5	5	5	5	5	29,834	meals
Linen deliveries	2	1	1	1	1	380	deliveries
Transport trips	2	2	2	2	2	24,094	one-way trips
Total volume			**Total volume**				
All hour-based services	10,654	23,030	61,111	54,965	139,105	. .	hours
Total volume–delivered meals	2,393	4,198	12,567	13,069	29,834	. .	meals
Total volume–linen deliveries	81	70	134	176	380	. .	deliveries
Total volume–transport trips	2,424	4,588	11,145	8,361	24,094	. .	one-way trips

(a) Includes services to assist people with their personal affairs, such as letter writing, managing paperwork and making telephone-based contacts; shopping, bill paying and banking (when the person is accompanied by the care worker); keeping the person company; and, accompanying the person to social activities. Also includes attending centre-based day care where attendance at the centre is paid for by the CACP provider, or the care recipient is accompanied by a CACP care worker.

Notes

1. Age is as at end of the census period.
2. Table excludes 189 cases with missing age.
3. Median hours for a service are based on people receiving some of the service. Amounts of service were reported to the nearest 15 minutes.
4. Not all CACP service outlets submitted data; an estimated that 94% of CACP service outlets responded to the census.
5. Table includes clients of Multi-purpose and flexible service places or packages.
6. Components may not add to total due to rounding.

Source: AIHW analysis of 2002 CACP census.

For the 21% of clients receiving delivered meals, at least half received 5 meals a week. The median number of one-way trips provided to CACP recipients was 2 per week, and the small number of people using formal linen services in general received 1 delivery a week.

In 2003–04, there were nearly 12,800 separations from packages by people aged 65 and over (see Table A4.4). Of these, nearly half of the recipients had been receiving the package for more than 1 year, with one-fifth having been in receipt of one for between 2 and 4 years. The most common reasons for the cessation of a package were clients moving into residential aged care, or death: in 2003–04, nearly half (48%) of all separations—including those for younger people—were to residential aged care, while 19% were the result of the death of the care recipient (AIHW 2005a:48). In addition, 8% of separations related to a recipient leaving one care package to take up another.

Extended Aged Care at Home

The Extended Aged Care at Home (EACH) program aims to deliver care at home that is equivalent to high-level residential care. Begun as a pilot in 2000 with 300 clients in 10 areas, EACH was established in 2002 by the Australian Government as an ongoing program. As with CACPs, access to a place is through assessment and approval by an ACAT. The daily subsidy for a place is aligned with that for the second highest care-need category in high-level residential aged care, with supplements for use of oxygen and enteral feeding. On 1 July 2004, the daily subsidy was set at $107.10 ($109.25 in Victoria), with care service supplements of up to $23.24 (DoHA 2004d). As with the other community care programs, clients may be asked to contribute to the cost of their care (see Section 4.7).

As at 30 June 2004, there were 858 EACH operational places (see Table 4.25). Because of small delays in converting operational places into occupied places, at that time there were 707 people living at home with the support of EACH, including 646 aged 65 and over. Illustrating the rapid growth of the program, by the end of June 2005 the number of operational places had grown to 1,672 and the number of recipients had reached 1,125 (DoHA unpublished). It is planned that by 2006 there will be over 3,224 places available (DoHA 2004c:14).

Many of the services available to EACH recipients are similar to those provided to CACP recipients. In addition, nursing and allied health care services can be provided as part of an EACH place. Information on the characteristics of recipients, and the services they received, was collected for the pilot project in the 2002 EACH one-week census (AIHW 2004d:28). At that time, nearly 90% of EACH clients received personal care and 65% were provided with domestic assistance. In addition, nursing was provided to 54% of recipients, and social support to 47%. At 13% and 9% of recipients, allied health services and home maintenance, respectively, were the services least likely to be provided. Three-quarters of EACH recipients had a co-resident carer and a further 15% had a non-resident carer (AIHW 2004d:22). While administrative by-product data on people accessing EACH places are available on an ongoing basis, data on services provided to recipients have not been collected since EACH was established as an ongoing program.

Respite care and National Respite for Carers Program

With the trend towards increasing home-based care and reduced rates of residential care, respite care has emerged as an important area of service provision. This has been evident in a number of government policy initiatives, in particular in the development of the National Respite for Carers Program.

Respite care may be provided in the home, at a centre during the day, or in a residential service. In 2003–04, 11% (57,800) of older HACC clients used centre-based day care and 1% (5,200) used in-home respite care services (see Table 4.12).[4] In

4. In the case of respite care, the carer is considered the HACC client. Anecdotal evidence suggests that the provision of respite care may be under-reported.

addition, 13% (8,100) of Veterans' Home Care clients aged 65 years and over received in-home or emergency respite care during 2003–04 (see Table 4.14). Among older CACP recipients, 4%(about 1,000 people) accessed respite assistance during the 2002 census week (see Table 4.15).

In addition to the above respite services, nearly half of all admissions into residential aged care are for respite care. Among the 95,322 admissions for older people into residential care in 2003–04, nearly 44,100 were for respite care—an increase of 8% since 2001–02 (AIHW 2003a:466, 2005b:52, 54). In addition, while the average length of stay in respite care fell slightly between 2001–02 and 2003–04 (from 3.2 to 3.1 weeks for respite care residents of all ages), the increase in respite admissions resulted in the total number of respite bed-days rising by over 4%, from 960,300 occupied place-days to over 1 million (1,002,200) (AIHW 2003b:24, 2005b:15).

Respite services can also be accessed through the National Respite for Carers Program, which provides information and support for carers as well as respite care. The program funds respite services, Commonwealth Carer Respite Centres (which provide information on respite services and arrange respite), Commonwealth Carer Resource Centres (which provide carers with information about their caring role and the services available to them), and the National Carer Counselling Program. An ACAT assessment is not required for people accessing respite through the National Respite for Carers Program; there are, however, assessment procedures within the program with the focus being on primary carers and the relative need of clients. An ACAT assessment is necessary for people wanting respite care in aged care facilities.

In 2003–04, the program funded the eight state- and territory-based and one national Commonwealth Carer Resource Centres, over 90 regional Commonwealth Carer Respite Centres and outlets, and more than 430 community-based respite service providers. During 2003–04, the Respite Centres assisted an estimated 47,800 carers providing 110,100 occasions of service, and the Resource Centres helped 42,600 carers. In addition, an estimated 2,000 carers received counselling under the National Carer Counselling Program delivered through Commonwealth Carer Resource Centres (DoHA 2004a: carer support, 2005c:139).

Other programs

In addition to the main national services, there are many smaller programs—at Australian, state/territory and local government levels—targeting older people. Given the importance of dementia in an ageing population (as reflected in its becoming a National Health Priority—see Box 4.2), a number of national programs focus on people with dementia and their carers, including the National Dementia Helpline (through Alzheimer's Australia), the Early Stage Dementia Support Program and Psychogeriatric Care Units. Other programs include the Day Therapy Centre Program, which provides therapy services to people to maintain or recover a level of independence, the Continence Aids Assistance Scheme, and the Assistance with Care and Housing for the Aged program which assists frail low-income older people who are renting, are in insecure or inappropriate housing, or are homeless, to remain in the community by accessing suitable housing linked to community care.

4.5 Use of residential care

Residential aged care services provide accommodation and support for older people who can no longer live at home. Two levels of care are available: low-level care (Resident Classification Scale (RCS) categories 5 to 8, see later), and high-level care (RCS categories 1 to 4). Short-term respite care services are also available. All residential care services are required to meet a number of national standards (see Section 4.8). To enter residential care, people must have an assessment and approval for such care by an ACAT. In addition, up to 30 June 2004 an ACAT approval was also required for people moving between low and high permanent residential aged care. However, from 1 July 2004, this requirement was lifted if the person remained within the same facility.

Residential aged care is mainly funded by the Australian Government, via daily subsidies. In addition, all residents pay fees, including an income-tested component, and government subsidies for individual permanent residents are reduced in line with the income-tested fees paid by residents (see Section 4.7). The daily subsidy paid by the government varies with the type of care provided and the situation of the residential aged care service, including the number of concessional residents it has and the viability of the facility (due, for example, to operating in a remote area). Subsidies increase with the care-needs category of the resident, with permanent residents in the lowest care-needs category (RCS8) attracting no daily subsidy. Excluding all supplements, for 2004–05 basic subsidies for permanent residents in other RCS groups ranged from $25.27 per day for RCS7 up to $118.12 for RCS1 (Table 4.17). The basic subsidy for respite residents has two levels, and during 2004–05 these were $32.92 for low-care residents and $92.27 for high-care residents.

Table 4.17: Australian Government residential care basic daily subsidy rates, 2004–05

	High care				Low care			
Care type	**RCS1**	**RCS2**	**RCS3**	**RCS4**	**RCS5**	**RCS6**	**RCS7**	**RCS8**
Permanent	$118.12	$107.10	$92.27	$65.22	$39.73	$32.92	$25.27	$0.00
Respite	$92.27				$32.92			

Notes

1. Amounts do not include any supplements that may be applicable. Supplements depend on the type of care provided and the situation of the residential aged care service.
2. Rates vary marginally across states and territories.

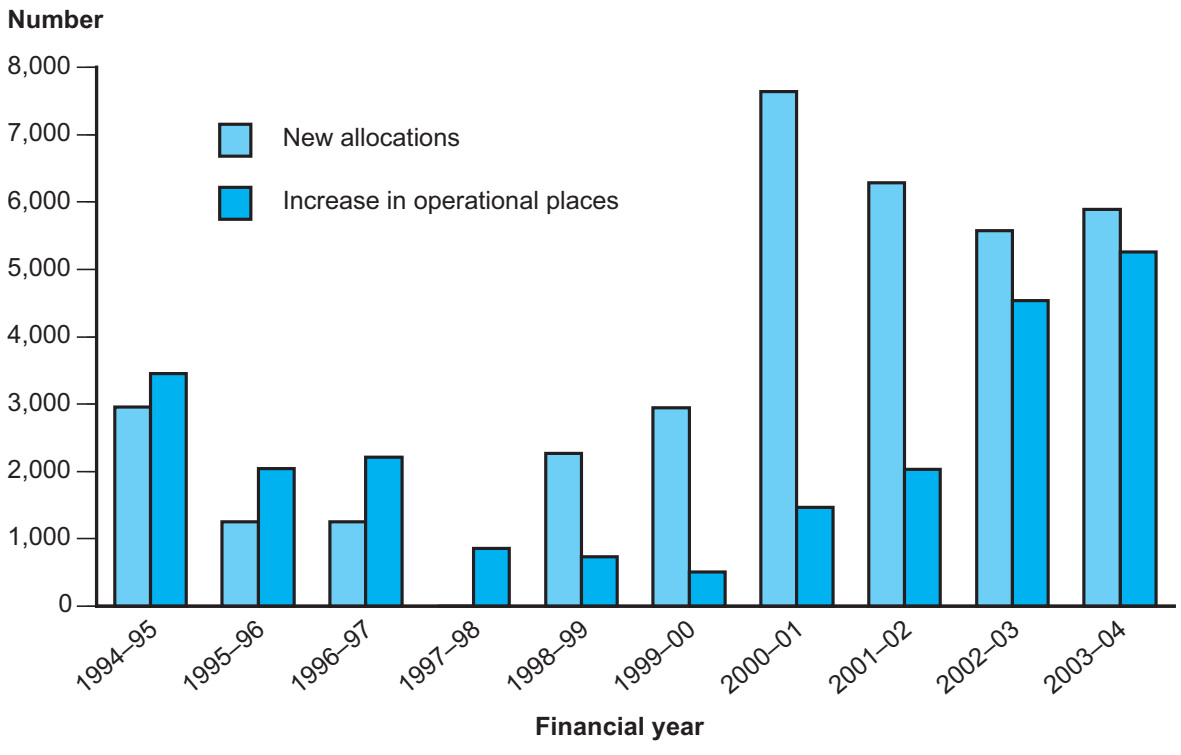
Source: DoHA 2004d.

Growth in provision of residential care

Between 30 June 1998 and 30 June 2002, the number of operational residential aged care places grew by an average of 1% a year (including flexible and Multi-purpose Service places) (AIHW 2003a:307). However, after 2002 the growth rate increased, with the number of operational places rising by 3.4% and then 3.6% in the 2 years from June 2002 (see Table 4.25). At 30 June 2004, there were 2,961 residential aged care services in Australia providing 156,580 operational places. By 30 June 2005, there were 161,165 operational places (DoHA provisional estimate).

Given the time lags between residential places being approved and allocated and then becoming operational, consideration of operational places alone does not give the complete picture of aged care provision. The development of residential aged care places (and similarly new CACPs and EACH places) can only occur when they have been formally allocated to a provider by the Australian Government, usually through an Approvals Round.

While the majority of CACPs and EACH places become available for use reasonably quickly, residential aged care places may take longer to come on line, especially where capital works are involved. The time lag between allocation of residential places and their becoming operational is apparent in Figure 4.3 which shows that, while allocations began to increase from 1998–99, the number of new operational places in a year did not start to increase until 2 years later. As can be seen, between 1998–99 and 2001–02 there were substantially more approvals than new places coming on line. However, the number of new operational places in 2002–03 was over 4,500—more than double the number for 2001–02—and in both 2002–03 and 2003–04 the increase in new places was higher than it had been at any time in the preceding decade. In addition, a further 8,860 places were approved for allocation in the 2004 Aged Care Approvals Round (DoHA 2005a). Since the majority of allocated places do generally become operational, and because 30,600 new places have been allocated since 1997–98 and only 15,400 have as yet become newly operational, such growth is likely to continue over the next few years.



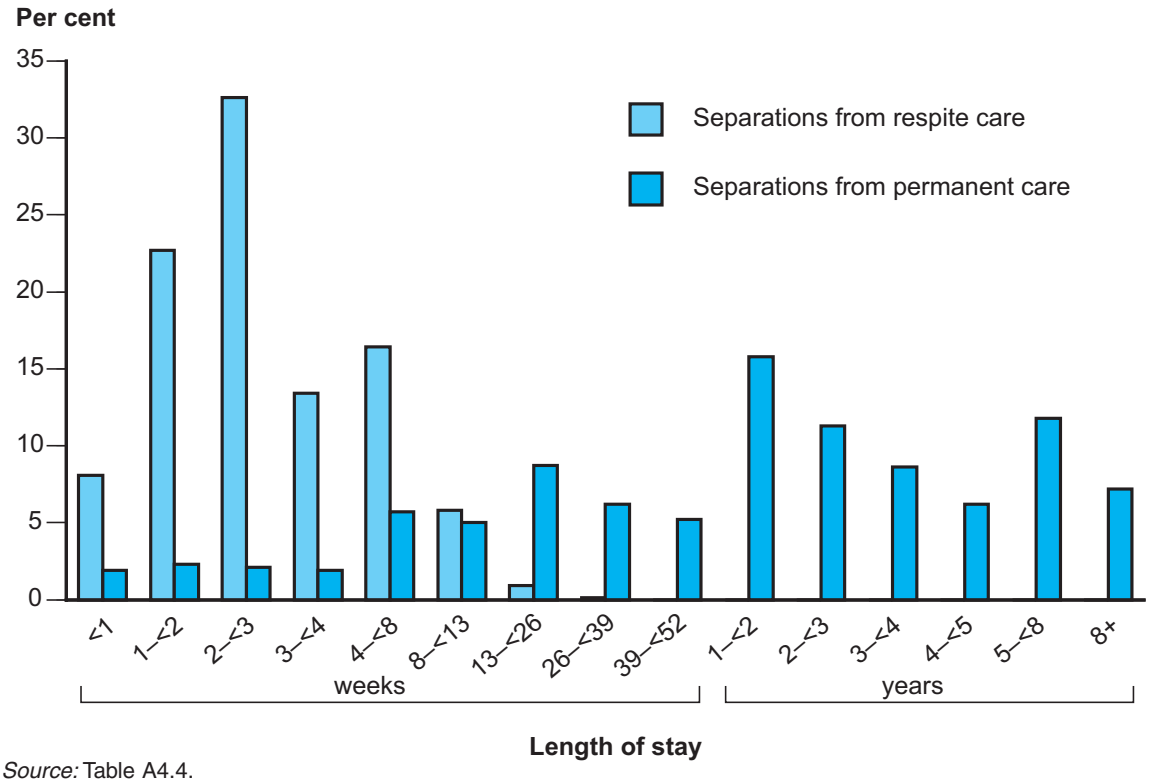
Source: Table A4.3.

Figure 4.3: New residential aged care allocations and operational places, 1994–95 to 2003–04

Mix of respite and permanent care

People may use residential care either as their permanent place of residence, or for the short-term accommodation and care associated with respite care. Residential respite care is important both for people who need a higher level of care just for the short term and as a component of the carer support system, whether for emergency care or to provide a 'break' while carers attend to other affairs or take a holiday. On 30 June 2004, respite residents made up just under 2% (2,508) of the 141,262 aged care service residents aged 65 years and over (AIHW 2005b:35–7). However, because it provides short-term care, respite accounted for over half (54%) of the 95,332 admissions for older people during 2003–04. Just over 60% of respite care episodes lasted 3 weeks or less compared with a similar proportion of permanent care episodes lasting at least 9 months (Figure 4.4).

As the name 'respite' suggests, most of the people who are admitted for respite care return to the community: 69% in 2003–04 (AIHW 2005b:27–8). In only 1% of episodes the person died while in residential respite care, with the remainder either going to another residential aged care service or to hospital (13% and 5%, respectively). The story for permanent residents is quite different, with 84% of separations resulting from the death of the resident, and just 4% involving a return to the community. The remainder of people who left a permanent residential aged care service were fairly evenly split between going to hospital and moving to another aged care service (following 6% and 5% of separations, respectively).



Source: Table A4.4.

Figure 4.4: Length of stay of older clients (65+) who left residential aged care during 2003–04

Patterns of service use

Currently, residential aged care is the second most commonly used aged care program after HACC. While there has been some fluctuation, there has been little change in the use of residential aged care since 2000: on 30 June 2004, 53 out of every 1,000 people aged 65 years and over (or 5%) were permanent aged care residents, compared with 54 per 1,000 in 2000. Just 1 additional person per 1,000 was in residential respite care on 30 June 2004 (see Table A4.5; AIHW 2001:247, 2005b:37). Use of residential care increases substantially with age, from 10 permanent residents per 1,000 people aged 65–74 to 249 per 1,000 people aged 85 and over (see Table 4.22). Comparing use with the number of people with a disability, on 30 June 2004 for every 1,000 people aged 65 and over with a severe or profound core activity limitation, there were 237 people in permanent residential aged care and 4 people in residential respite care.

Overall, during the 12 months to 30 June 2004, there were 17 respite admissions into residential services per 1,000 people aged 65 and over (see Table A4.5). As with permanent residential care, residential respite care is accessed more by older than younger people: there were 4 respite admissions over the year per 1,000 people aged 65–74, 21 per 1,000 aged 75–84 and 64 per 1,000 aged 85 and over (see Table 4.22).

Use of permanent residential care by younger people

While the vast majority of permanent residents of residential aged care services are aged at least 65 (96% in 2004; see Table 4.19), age per se is not a criterion for admission and younger people also use these services. On 30 June 2004, there were around 6,200 people aged under 65 living permanently in residential aged care, and of these the great majority were aged 50–64 with one-sixth (almost 1,000) aged under 50 (Table 4.18). In comparison, nearly 33,200 people used CSTDA-funded accommodation support in 2003–04, comprising 5,300 people using institutional accommodation, 11,300 using group homes and 17,300 using other types of accommodation support (see Table 5.13).

Table 4.18: Younger permanent residents of residential aged care, 30 June 2004

	High care					Low care					
Age	**RCS1**	**RCS2**	**RCS3**	**RCS4**	***RCS1–4***	**RCS5**	**RCS6**	**RCS7**	**RCS8**	***RCS5–8***	**Total**
					Number						
Under 50	381	280	130	26	*817*	58	59	48	5	*170*	987
50–64	1,396	1,274	739	251	*3,660*	592	488	444	28	*1,552*	5,212
65+	29,692	33,680	19,973	6,577	*89,922*	16,630	14,653	15,450	1,052	*47,785*	137,707
Total	**31,469**	**35,234**	**20,842**	**6,854**	***94,399***	**17,280**	**15,200**	**15,942**	**1,085**	***49,507***	**143,906**
					Per cent						
Under 50	38.6	28.4	13.2	2.6	*82.8*	5.9	6.0	4.9	0.5	*17.2*	100.0
50–64	26.8	24.4	14.2	4.8	*70.2*	11.4	9.4	8.5	0.5	*29.8*	100.0
65+	21.6	24.5	14.5	4.8	*65.3*	12.1	10.6	11.2	0.8	*34.7*	100.0
Total	**21.9**	**24.5**	**14.5**	**4.8**	***65.6***	**12.0**	**10.6**	**11.1**	**0.8**	***34.4***	**100.0**

Notes

1. Table excludes 1,088 residents whose dependency was not reported.
2. Components may not add to total due to rounding.

Source: AIHW 2005b: table 4.27.

While permanent residents aged 50–64 have a dependency profile which is similar to that of older residents, younger residents have greater levels of dependency. Men were more common among younger than older clients: 53% of clients aged under 50 compared with 28% of those aged 65 and over (AIHW 2005b:66).

Flexible aged care services

The Australian Government also provides flexible aged care services through Multi-purpose Services in rural and remote communities, and through services under the National Aboriginal and Torres Strait Islander Aged Care Strategy. Multi-purpose Services were trialled in 1990 and expanded in 1994. As at June 2004, there were 95 of these services providing 1,757 residential care places and 204 Community Aged Care Packages. Flexible services provided under the strategy began operating in 1996. In June 2004, there were 29 operational flexible services providing 336 residential care places and 243 packages (AIHW 2005a:4).

Data on clients of these flexible aged care services are not currently included on the national database (ACCMIS) for residential aged care and Community Aged Care Packages. Consequently, there is no information available on the precise number and characteristics of people using these services.

Support services for residential care

A number of programs support residential care providers and their clients, such as: the Community Visitors Scheme,a national program that provides companionship to socially isolated people living in Australian Government-funded aged care facilities; resident advocacy services, including the Complaints Resolution Scheme which seeks to resolve complaints about the health, safety and/or welfare of people receiving aged care; and aged care workforce support which includes funding to train staff, for example, to ensure they are able to meet the diverse cultural needs of older Australians as overseas-born people make up an increasing proportion of people using residential aged care (Bishop 2005; DoHA 2004a).

4.6 Client profiles

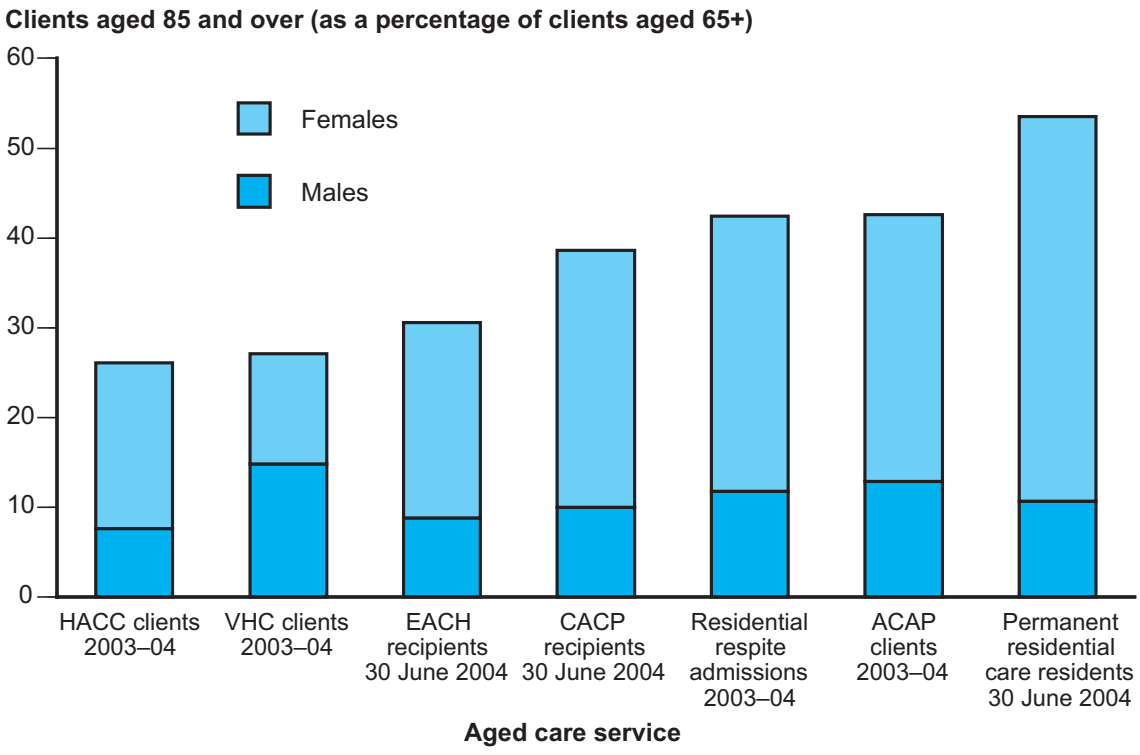
The programs included in this section are the Aged Care Assessment Program, Home and Community Care, Veterans' Home Care, Community Aged Care Packages, Extended Aged Care at Home and residential aged care. For most programs, care (or assessment) is long-term, and so the characteristics of individuals using a service are of interest. However, respite care is generally for short periods and a client may have multiple care episodes in a year. In this case, client profiles across all respite admissions in a year are examined. Data limitations have meant that some client characteristics for particular programs could not be assessed.

Age and sex

In all the aged care services examined, except Veterans' Home Care, the clients were predominantly women (Table 4.19). In 2004, 49% of VHC clients were women; for other

services, the proportion ranged from 62% of EACH recipients to 73% of permanent aged care residents. Reflecting their greater longevity, the predominance of women in aged care services generally increases with age (again, with the exception of VHC). This effect is particularly noticeable in permanent residential aged care: in June 2004 in the 65–74 year age group, there were similar numbers of male and female residents, while among residents aged 90 and over there were nearly five times as many women as men.

A greater proportion of people in residential aged care than in community care is very old (aged 85+) (Figure 4.5). On 30 June 2004, over half (54%) of older permanent residents were aged 85 and over, and, during 2003–04, 42% of respite admissions were for very old people. Of the community care programs examined, Community Aged Care Packages had the oldest age profile, with two-fifths of older recipients being aged 85 and over. HACC and VHC had the youngest age profiles, and around one-quarter of their older clients were aged 85 and over. Although Extended Aged Care at Home places provide a higher level of care than Community Aged Care Packages, EACH recipients had an age profile between those of HACC and CACP clients, with 31% of older recipients being aged 85 and older. People being assessed for aged care services—that is, ACAP clients—had a slightly older profile than CACP clients (43% aged 85+).



Source: Table 4.19.

Figure 4.5: Use of aged care services by clients aged 85 and over, 2003–04

Table 4.19: Use of selected aged care services, 2004 (per cent)

Sex/age	VHC 2003–04	HACC 2003–04	ACAP 2003–04	CACP 30 June 2004	EACH 30 June 2004	Permanent residential care 30 June 2004	Residential respite 2003–04
Males	**Clients**	**Clients**	**Clients**	**Recipients**	**Recipients**	**Residents**	**Admissions**
65–69	0.5	3.6	2.1	2.4	4.3	1.6	2.4
70–74	1.1	5.6	3.8	3.2	7.1	2.8	4.3
75–79	9.9	7.8	7.0	5.4	9.8	4.9	7.9
80–84	24.8	7.9	9.6	6.8	8.2	6.7	10.0
85–89	11.9	5.0	7.9	6.0	5.6	6.0	7.6
90+	2.9	2.6	5.0	4.0	3.3	4.8	4.2
Total males	*51.1*	*32.5*	*35.4*	*27.8*	*38.2*	*26.7*	*36.4*
Females							
65–69	0.8	6.5	2.3	3.6	5.6	1.6	2.1
70–74	3.6	10.2	4.9	7.2	8.2	3.4	4.2
75–79	13.7	15.0	10.4	13.1	13.6	8.4	10.1
80–84	18.6	17.3	17.4	19.6	12.5	17.0	16.6
85–89	9.4	11.8	16.9	17.3	12.5	20.5	17.9
90+	2.9	6.7	12.8	11.3	9.3	22.2	12.6
Total females	*48.9*	*67.5*	*64.6*	*72.2*	*61.8*	*73.3*	*63.6*
Persons							
65–69	1.3	10.1	4.3	6.0	9.9	3.2	4.5
70–74	4.7	15.8	8.7	10.4	15.3	6.3	8.5
75–79	23.6	22.8	17.3	18.5	23.4	13.3	18.0
80–84	43.3	25.2	27.0	26.4	20.7	23.7	26.7
85–89	21.3	16.8	24.8	23.3	18.1	26.5	25.5
90+	5.8	9.3	17.8	15.3	12.5	27.0	16.9
Total persons	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**
Total persons 65+ (number)	**61,637**	**537,100**	**150,672**	**25,722**	**646**	**138,754**	**44,068**
Clients aged <65 (number)	**1,082**	**170,100**	**8,172**	**1,935**	**61**	**6,240**	**2,564**
Clients aged <65 (% clients all ages)	**1.7**	**24.0**	**5.1**	**7.0**	**8.6**	**4.3**	**5.5**

Notes

1. For point in time estimates, age is as at the point in time. For ACAP clients age is as at the time of the last assessment in the financial year. For residential respite, age is as at the end of the respite period. For HACC and VHC clients, age is as at 30 June 2004.
2. Residential respite care annual figures exclude transfers between service providers for care of the same type (that is, respite care).
3. For ACAP, 144 clients with missing age and/or sex have been excluded; for VHC, 2 cases with both sex and age missing have been excluded from the table. There were no cases with missing age and/or sex for CACP, EACH or residential aged care.
4. In the HACC MDS, age was unknown (date of birth reported as 1 January 1900 or 1901 (see AIHW: Karmel 2005), or age greater than 110) for 3,243 clients. These clients are assumed to be aged 65 and over, and have been pro-rated accordingly. Sex was missing for 1,224 and 3,386 records for people aged under 65 and aged 65 and over, respectively; 342 records had both missing age and sex. Percentages are based on cases with known sex after pro-rating for unknown age.
5. Not all HACC agencies submitted data to the HACC MDS. For 2003–04, the proportion of HACC-funded agencies that submitted HACC MDS data differed across jurisdictions, and ranged from 77% to 99%. Actual client numbers will therefore be higher than those reported here. Because of this incomplete coverage, and because of cases with missing age and sex, numbers have been rounded to the nearest 100.
6. Table does not include clients of Multi-purpose and flexible service places or packages.
7. Components may not add to total due to rounding.

Sources: AIHW analysis of DoHA ACCMIS database (as at November 2004), AIHW analysis of HACC MDS; DVA unpublished data (DVA database as at 15 April 2005); Lincoln Centre analysis of ACAP MDS v1 and v2.

Dependency

No dependency information is available from the administrative by-product data collected regularly for CACP recipients. Using data from the 2002 CACP 1-week census, at that time around two-thirds of older CACP recipients had care needs related to self-care and mobility (64% and 70%, respectively) (Table 4.20). Only 15% of recipients needed assistance or support with communication. Overall, 85% of CACP clients had care needs with one or more of self-care, mobility and communication. The proportion of clients with dependency needs in self-care increased with age, while dependency rates in communication decreased with age.

Recent years have seen a continuing rise in the profile of care needs of permanent aged care residents (AIHW 1999:205; Table 4.21). This trend has been in evidence at least since the early 1990s (DHAC: Gray 2001:44–6), and reflects both the increased availability of community care and greater targeting of residential aged care to people with high-level needs. In June 1999, 60% of older residents had high-care needs; by June 2004, this had risen to 65%. In addition, the greatest increase in the eight categories was in the highest care group (RCS1): from 12% of older permanent residents in 1999 to 22% in 2002. A shift towards higher care needs was also seen among low-care residents: in 1999, one-fifth (21%) were in the lowest two care groups (RSC7 and RCS8), compared with 12% in 2004.

As is to be expected given the CACP target group—that is, those requiring care equivalent to low-level residential care—the care needs of people in permanent residential care with respect to core activities are considerably more than those of CACP recipients. In June 2004, 98% of older permanent residents had needs in at least one of eating, bathing, dressing, toileting and managing incontinence (i.e. with self-care), and 97% required some assistance with communication (i.e. with understanding others or being understood) (Table 4.20). A large majority also had problems related to mobility (85%).[5] Furthermore, nearly all had care needs related to their behaviour (96%) or other needs such as particular medical or social needs (99.9%). From this it can be seen that an overwhelming majority of aged care residents have multiple care requirements. Of the dependency items examined, only the prevalence of mobility problems appeared to increase with the age of residents: 81% of residents aged 65–74 had mobility-related care needs compared with 86% of those aged 85 and over.

Service use by people born overseas

People born overseas are an increasing proportion of the older population (see Section 4.2). The use of particular aged care services varies across birthplace groups. Programs providing community care have relatively more clients born in non-English-speaking countries compared with residential care services, and community care services providing packages of care (CACP and EACH) have even higher use by this group compared with the services provided through the HACC program. In 2004, between 18% and 25% of older community care recipients were born in non-English-speaking

5. In the CACP census, the measure of mobility needs included moving or manipulating objects, an aspect not included in the residential aged care measure.

countries, compared with around 13% of people in residential aged care and 20% of all people aged 65 and over (see Table A4.5; Section 4.2). A relatively low proportion of older people getting ACAT assessments (14%) were born in non-English-speaking countries.

Table 4.20: Type of dependency (per cent within each age group)

Dependency item	65–74	75–84	85+	Total	Number
Permanent residential aged care (30 June 2004)					
Self-care[a]	98.1	98.0	98.1	98.0	135,007
Mobility[b]	81.3	83.7	86.0	84.7	116,671
Communication[c]	96.8	96.7	97.6	97.2	133,813
Total with at least one of the above	*99.4*	*99.4*	*99.6*	*99.5*	*137,034*
Behaviour[d]	97.4	96.3	95.4	96.0	131,935
Other[e]	99.9	99.9	99.9	99.9	131,041
Total with at least one of all of the above	*99.9*	*100.0*	*100.0*	*100.0*	*137,113*
Total	**9.5**	**37.0**	**53.5**	**100.0**	**. .**
Total (number)	**13,062**	**50,970**	**73,675**	**137,707**	**137,707**
Community Aged Care Packages (2002)					
Self-care[f]	61.0	62.0	68.4	64.3	14,884
Mobility[g]	68.7	68.9	70.6	69.5	16,087
Communication[h]	16.8	15.0	13.7	14.8	3,423
Total with at least one of the above	*82.7*	*83.9*	*87.2*	*85.0*	*19,659*
Total with none of the above	*17.3*	*16.1*	*12.8*	*15.0*	*3,479*
Total	**16.5**	**44.7**	**38.8**	**100.0**	**. .**
Total (number)	**3,820**	**10,332**	**8,986**	**23,138**	**23,138**

(a) Includes at least some assistance or support required in any of the following areas: meals and drinks, personal hygiene, toileting, bladder management and bowel management (RCS questions 3 to 7).

(b) Includes at least some assistance or support required in the area of walking and transfers (RCS question 2).

(c) Includes at least some assistance or support required in any of the following areas: communicating with staff, relatives, friends and others, and in understanding and undertaking living activities (RCS questions 1 and 8).

(d) Includes at least some assistance or support required in any of the following areas: problem wandering or intrusive behaviour, verbally disruptive or noisy, physically aggressive, emotional dependence, danger to self and others, and other behaviour (RCS questions 9 to 14).

(e) Includes at least some assistance or support required in any of the following areas: social and human care needs (either for the care recipients or for family and friends), medication, technical and complex nursing procedures, therapy and 'other' services (RCS questions 15 to 20).

(f) Recipient sometimes or always needs assistance/supervision with: eating; showering/bathing; dressing; toileting; or managing incontinence.

(g) Recipient sometimes or always needs assistance/supervision with: maintaining or changing body position; carrying, moving or manipulating objects related to the tasks of daily living; getting in or out of bed or chair; or walking and related activities.

(h) Recipient sometimes or always needs assistance/supervision with: understanding others or making oneself understood by others.

Notes

1. Table does not include clients of Multi-purpose and flexible service places or packages.
2. RCS assessments were unavailable for 1,047 permanent residents aged 65 and over in 2004; table also excludes 588 cases with missing age and/or dependency information in the 2002 CACP census.

Sources: AIHW analysis of DoHA ACCMIS database as at November 2004, AIHW analysis of 2002 CACP census.

Table 4.21: Level of dependency of permanent aged care residents aged 65 and over, at 30 June 1999,[(a)] 2000, 2002 and 2004

	High care					Low care					
	RCS1	RCS2	RCS3	RCS4	RCS1–4	RCS5	RCS6	RCS7	RCS8	RCS5–8	Total
						Number					
1999	15,005	31,925	22,170	5,644	*74,744*	10,762	12,650	21,882	3,869	*49,163*	**123,907**
2000	17,618	32,205	20,818	5,820	*76,461*	11,071	12,933	21,153	2,978	*48,135*	**124,596**
2002	24,010	32,455	19,016	5,964	*81,445*	13,643	14,057	17,989	1,781	*47,470*	**128,915**
2004	29,692	33,680	19,973	6,577	*89,922*	16,630	14,653	15,450	1,052	*47,785*	**137,707**
						Per cent					
1999	12.1	25.8	17.9	4.6	*60.3*	8.7	10.2	17.7	3.1	*39.7*	**100.0**
2000	14.1	25.8	16.7	4.7	*61.4*	8.9	10.4	17.0	2.4	*38.6*	**100.0**
2002	18.6	25.2	14.8	4.6	*63.2*	10.6	10.9	14.0	1.4	*36.8*	**100.0**
2004	21.6	24.5	14.5	4.8	*65.3*	12.1	10.6	11.2	0.8	*34.7*	**100.0**

(a) Reliable data for 30 June 1998 are not available.

Notes

1. Assessments were unavailable for 2,722 residents in 1999, 2,821 residents in 2000, 1,591 residents in 2002, and 1,047 residents in 2004.
2. Table does not include clients of Multi-purpose and flexible services.
3. Components may not add to total due to rounding.

Source: AIHW analysis of DoHA ACCMIS database as at November 2004.

In the general community, the age and sex profiles of different population groups vary (see Section 4.2). Some of these differences are apparent in the observed usage patterns of the groups. For example, for all programs examined, the median age of older clients born in non-English-speaking countries was lower than that for those born elsewhere, and the ratio of female to male clients was lower among clients born overseas than among those born in Australia.

The pattern of increased use with age was evident for both Australian-born and overseas-born people for all services (Table 4.22). However, people born in Australia had higher usage rates than others in all age groups for all services except Community Aged Care Packages. For CACPs, people born in non-English-speaking countries had the highest usage rates among those aged at least 75.

Service use by Aboriginal and Torres Strait Islander people

As a result of their poorer health status, Aboriginal and Torres Strait Islander people tend to need and use aged care services at a relatively young age. Consequently, the examination here of their use of these services includes people aged 50 and over.

Like other groups in the population, Indigenous Australians access some services in preference to others. A relatively high percentage of CACP recipients are Indigenous: 4%as at 30 June 2004 compared with less than 1% of aged care residents (0.6% of permanent residents and 1% of respite admissions) and 0.9% of all people aged 50 and over (see Table A4.6; ABS 2004b, 2004c). In comparison, it is estimated that Aboriginal and Torres Strait Islander people made up around 2% of HACC and EACH clients aged 50 and over.

The differences in the age profiles of Indigenous and other Australians are reflected in the client profiles of these two groups for all aged care services. For all services examined, Aboriginal and Torres Strait Islander clients had a younger median age than other clients: between 9 and 13 years less in 2004. However, although the sex ratio among older Indigenous and other Australians is very similar (on 30 June 2004, 47% and 48% of people aged 50 and over were male for the two groups, respectively), Indigenous clients of services have a lower female to male ratio than other clients.

Among people aged 50–74 years, Indigenous Australians had much higher usage rates than other people for all services examined. For example, Indigenous Australians aged 65–74 used HACC services at a rate of 393 per 1,000, compared with 99 per 1,000 for all other Australians and 73 per 1,000 for people born in the main English-speaking countries (Tables 4.22, 4.23). In the oldest age group for which population data were available for Indigenous Australians (75+), data given in Table 4.23 suggest that while they use community care and respite services at higher rates than other people, both groups use permanent residential aged care at the same rate. However, the comparison between usage rates is affected significantly by the different age structures of the two populations, that is, by the relatively low percentage of Indigenous Australians aged 75 and over.

Table 4.22: Usage rates and country of birth of clients of selected aged care services, 2004

Age	HACC 2003–04	ACAP 2003–04	CACP 30 June 2004	Permanent residential care 30 June 2004	Residential respite 2003–04
	Clients	Clients	Recipients	Residents	Admissions
Australian-born			Number per 1,000		
65–74	111.1	16.2	3.4	11.0	4.8
75–84	290.8	78.5	11.6	57.8	22.4
85+	506.3	234.1	32.7	257.8	65.8
Overseas-born: main English-speaking countries					
65–74	72.8	10.1	2.0	7.1	3.7
75–84	233.1	57.0	11.0	50.3	21.8
85+	396.3	187.5	31.3	253.8	69.1
Overseas-born: non-English-speaking countries					
65–74	94.6	12.0	3.0	7.0	2.9
75–84	275.0	63.1	16.2	47.6	17.5
85+	426.4	176.9	38.3	195.1	49.7
All					
65–74	102.2	14.4	3.1	9.6	4.2
75–84	280.2	72.8	12.4	54.9	21.4
85+	481.1	220.3	33.3	248.8	64.0

Note: See notes to Table A4.5 concerning derivation of statistics and caveats, including allowing for missing values.

Sources: ABS 2005c; AIHW analysis of DoHA ACCMIS database (as at 30 November 2004), AIHW analysis of HACC MDS; Lincoln Centre and AIHW analysis of ACAP MDS v1 and v2.

Table 4.23: Usage rates and Indigenous status of clients of selected aged care services, 2004

Age	HACC 2003–04	CACP 30 June 2004	Permanent residential care 30 June 2004	Residential respite 2003–04
	Clients	Recipients	Residents	Admissions
Indigenous Australians		Number per 1,000		
50–64	132.7	9.5	5.1	2.9
65–74	393.5	41.9	23.6	14.8
75+	772.6	71.1	100.4	53.6
Non-Indigenous Australians				
50–64	23.7	0.4	1.5	0.6
65–74	99.5	2.8	9.5	4.1
75+	321.1	17.2	101.8	31.0
All Australians				
50–64	24.9	0.5	1.5	0.6
65–74	101.5	3.1	9.6	4.2
75+	322.5	17.4	101.8	31.1

Note: See also notes to Table A4.6 concerning derivation of statistics and caveats, including allowing for missing values.

Sources: AIHW analysis of DoHA ACCMIS database; ABS 2004b, 2004c.

4.7 Expenditure

Overall, because it has primary responsibility for funding residential aged care, the largest source of funds for the aged care system is the Australian Government. It also provides funding for a number of other programs, including Community Aged Care Packages, Extended Aged Care at Home, Multi-purpose and flexible services, Aged Care Assessment Teams, and the Home and Community Care and Veterans' Home Care programs. The HACC program is cost-shared with state and territory governments, which also provide some funding for other areas of aged care, including residential aged care and assessment services. Governments are not, however, the only source of funding in the aged care system. Users of programs meet part of the costs, and non-government community services organisations contribute funds to some services (see Chapter 8). In addition, volunteers contribute to the sector.

Government expenditure on aged care

Aged care expenditure is spread across both health and welfare services. When classifying expenditure to either health or welfare, expenditure on residents in high-level care in residential aged care services is generally included in health while expenditure on low-level residential care and community-based programs is allocated to welfare. In the following discussion, expenditure on both levels of residential care is included, along with that for a range of community care programs, to give an overall picture of expenditure on aged care. For this reason, the figures presented here differ from those in Chapter 8 for expenditure on older people. In addition, due to data

availability, expenditure by local government and non-government organisations has not been included. Government concessions (such as concessional land and water rates) and welfare-related social expenditures (for example, the Age Pension) that can be accessed by older people are discussed in Chapter 8.

Total Australian, state and territory recurrent government expenditure on aged care services increased from $5,339.7 million in 2000–01 to $7,321.7 million in 2003–04 (see Table A4.7). As has been historically the case, in 2003–04 the largest area of expenditure was in residential aged care ($5,356.5 million), representing 73% of expenditure, compared with 75% in 2000–01 (Table 4.24).[6] The overwhelming majority of these funds—over 99%—was spent on residential care subsidies. Expenditure on older people in the Home and Community Care Program was the second largest area of expenditure. Overall, around $1.2 billion in capital and recurrent funds were provided for the HACC program in 2003–04; of this, an estimated $917.1 million was used to deliver services to people aged 65 and over. Consequently, in 2003–04 HACC accounted for just under 13% of recurrent expenditure on aged care, slightly down from the 13–14% observed for the 3 previous years. Community care places and packages are the other main area of expenditure, and in 2003–04 EACH places and CACP packages together accounted for 4.4% of government expenditure on aged care services ($15.5 and $307.9 million, respectively). At $326.9 million, expenditure on the Carer Allowance, where the care recipient was aged 65 and over, accounted for 4.5% of expenditure. This was up slightly on previous years due to the one-off payment of $600 made to allowance recipients in June 2004. Other programs which accounted for more than 1% of expenditure in 2003–04 were the National Respite for Carers program ($101.5 million, or 1.4%), and Veterans' Home Care including in-home respite ($91.1 million, or 1.2%).

Comparisons of program expenditure as expressed in constant prices show whether there has been growth in real terms; that is, in terms of what the programs would have cost had the same prices operated in each of the years being compared. As such, changes in constant prices reflect changes in the actual quantity of goods and services used to produce welfare services (that is, real growth) rather than simply showing the amount of dollars used each year. For example, given a fixed amount of money, the 60% increase that occurred in average weekly earnings of carers and aides between 2002 and 2004 would have resulted in a substantial reduction in the capacity to produce welfare services, simply because each dollar could purchase fewer resources (see Table 8.24 and AIHW 2003a:145). The constant price estimates remove the effect of such distortions due to inflation and show whether more or fewer physical resources were being used.

In real terms, total government expenditure on aged care services increased by 23% over the years examined, from $5,747.8 million in 2000–01 to $7,067.3 million in 2003–04 (expressed in 2002–03 prices, Table 4.24). Overall expenditure on largest program, residential aged care, rose 20% in the same period. This growth was driven by both the increasing provision of residential aged care and the rising care needs of residents

6. Figures do not include some state and territory expenditure, see note (a) to Appendix Table 4.24.

(see Sections 4.6, 4.8). Between 2000–01 and 2003–04 the number of high-care bed-days occupied by permanent residents increased by nearly 12%, while the number of low-care days declined by 0.5% (AIHW analysis of ACCMIS database). In addition, more of those receiving high care were in the top care-need category (RCS1) which attracts the highest subsidies: among residents aged 65 and over, between June 2002 and June 2004 there was a 24% increase in the number of people in RCS1 but only a 7% increase in the number of permanent residents overall (see Table 4.21). The effect that these two trends have on expenditure on subsidies is clear when noting that on 1 July 2004 the RCS1 basic subsidy was 10% higher than that for RCS2 and 38% higher than that for RCS3 (DoHA 2004d).

Table 4.24: Recurrent government expenditure on aged care services, 2000–01 to 2003–04[(a)] ($m)

Program[(b)]	2000–01	2001–02	2002–03	2003–04	2003–04
	Constant 2002–03 prices				Current prices
Residential aged care–subsidies	4,291.7	4,375.7	4,506.7	5,150.6	5,336.0
Residential aged care–resident and provider support	9.3	9.9	15.5	19.7	20.4
Community Aged Care Packages	209.5	255.0	287.9	297.2	307.9
Home and Community Care	780.5	814.0	853.0	885.2	917.1
Veterans' Home Care and DVA in-home respite	25.1	64.1	93.5	87.9	91.1
Extended Aged Care at Home	9.1	9.3	10.5	14.9	15.5
Day Therapy Centres	30.7	30.3	31.0	30.5	31.6
Multi-purpose and flexible services	36.6	41.7	51.4	58.6	60.7
National Respite for Carers	73.9	70.9	94.0	98.0	101.5
Carer Allowance	193.3	197.2	228.0	315.5	326.9
Assessment	42.2	42.4	42.9	46.7	48.4
Commonwealth Carelink Centres	13.0	11.9	12.1	13.4	13.9
Accreditation	11.2	13.0	11.9	6.3	6.5
Flexible care pilot projects	. .	. .	4.6	16.9	17.6
Other	21.8	30.5	27.7	25.7	26.6
Total	**5,747.8**	**5,965.9**	**6,270.6**	**7,067.3**	**7,321.7**
Amount per person aged 65 and over with a profound or severe core activity limitation (dollars)	**10,682**	**10,763**	**11,008**	**12,057**	**12,491**
GFCE deflator	92.9	96.6	100	103.6	. .

(a) Expenditure excludes departmental program administration and running costs. Only state and territory funding for high-level residential aged care subsidies and HACC have been included. Comparisons with ABS welfare expenditure estimates on older people (see AIHW 2003c:5, 9; excludes expenditure on high-level residential care) indicate that including other state/territory expenditure would have resulted in an increase in the estimate of expenditure for 2000–01 of about 7%.

(b) To improve coverage, the programs included here have changed slightly from those in the corresponding table in the previous edition of this publication (AIHW 2003a: table 7.13). Consequently, the numbers in the two publications are not strictly comparable.

Notes

1. See notes to Appendix Table A4.7 for information on expenditure derivation and comparability with previous editions. Constant dollar values were calculated using the GFCE deflator, referenced to 2002–03.
2. Components may not add to total due to rounding.

Sources: Tables A4.7, A4.8.

Expenditure in real terms on HACC services (provided to people aged 65+) increased by 13%. VHC and HACC provide similar services, and if the expenditures on these programs are amalgamated, the combined rise for these home-based services was 21%.

The emphasis on developing community support programs is demonstrated in expenditure on the CACP and the National Respite for Carers programs, which rose by 42% and 33%, respectively, over the 3 years. Expenditure on Carer Allowance also increased—by 63%. In contrast, expenditure on the accreditation of residential aged care providers dropped by 44%, reflecting the cyclic nature of residential aged care facility accreditation, with the second round of accreditation being completed mid 2003–04.

While the above analysis shows that expenditure on aged care services has been increasing in real terms, it does not indicate whether expenditure has been keeping pace with the growing need for services caused by the ageing of the population. As stated earlier, the segment of the older population most likely to be in need of assistance from aged care programs in general is people aged 65 and over with a severe or profound core activity limitation. Over the 3 years since 2000–01, estimates indicate that the number of such people grew by 9%, compared with a 23% growth in real expenditure (AIHW estimates). Consequently, real (constant price) program expenditure has been more than keeping pace with the increasing number of people in this group (see Table A4.8). In 2000–01, total aged care expenditure in real terms broadly equated to $10,682 for every person aged 65 and over with a profound or severe limitation (in 2002–03 prices). By 2003–04, this figure is estimated to have risen by 13% to $12,057. More than half of this growth occurred in the last year (10% between 2002–03 and 2003–04).

Per person growth was not consistent either over time or across programs. Relative to the number of people aged 65 and over with a profound or severe core activity limitation, expenditure on residential aged care subsidies rose by 10% to $8,787 (in 2002–03 prices) between 2000–01 and 2003–04, with nearly all of this growth occurring in the last year. Relative expenditure on the Carer Allowance rose by around 50%; again most of this growth happened in the last year and was partly due to the one-off lump sum paid to allowance recipients in June 2004. On the other hand, while CACP expenditure grew by 30% over the period to $507 for every person aged 65 years and over with a profound or severe limitation, nearly all of this growth occurred before 2003–04. Taken together, the HACC and VHC programs increased by 11% over the 3 years, and reached $1,660 per person by 2003–04. However, the two programs had quite different growth patterns.

User contributions to cost of aged care

Users of many aged care services pay a contribution towards the provision of the service. However, in both residential and community care, government-set limits are placed on fees chargeable by providers.

Clients of the HACC program may be asked to pay a service fee in accordance with the relevant state or territory government's fees policy (which are based on the draft HACC Fees Policy (DoHA 2002:28–33)). The amount charged varies across service types and between states and territories. However, if such a contribution causes financial difficulty for the user, the provider is obliged to reduce or waive charges. Veterans' Home Care clients are required to make a co-payment for all services except respite care. As at July 2005, contributions for VHC services were $5 per hour of assistance, with the contribution for personal care capped at $10 a week.

CACP and EACH recipients may also be required to make a contribution. Full pensioners can be asked to pay up to 17.5% of their pension (excluding the GST supplement), and at 30 June 2004 this equated to $5.67 per day, or 18% and 5% of the basic daily CACP and EACH subsidies, respectively. Those on higher incomes can be asked to pay more, up to a maximum of 50% of their income above the pension. As for HACC services, people cannot be denied services they need based on an inability to pay fees. Data are not generally collected on user payments for community care; however, estimates for the above three programs were derived for the Review of Pricing Arrangements in Residential Aged Care. For 2002–03, user payments by HACC clients were estimated at $43 million, and CACP and EACH recipients contributed an estimated $50 million towards service provision (Hogan 2004:108).

Care fees payable by people in residential aged care depend on both the person's resident status and pensioner status. For all respite residents and pensioner permanent residents (both full and part-pensioner), the maximum standard daily care fee is set at 85% of the Age Pension ($27.54 at 1 January 2005). Non-pensioner permanent residents can be charged a higher standard daily fee—up to $34.76 as at 1 January 2005 (DoHA 2005g). In addition to these maximum basic daily care fees, part-pensioner and non-pensioner permanent residents who are on higher incomes may pay income-tested fees (reviewed quarterly). Such fees are capped at 25 cents for every additional dollar of income over the relevant pension income test free area, and cannot exceed three times the daily standard pensioner rate or the cost of care, whichever is the lower (DoHA 2001: section 7.3.4.1). In 2002–03, the basic daily care fees yielded $1,274.8 million in basic user charges, and income-tested fees amounted to an additional $92.9 million (AIHW and DoHA analysis of ACCMIS database). Basic daily care fees raised $1,411.8 million in 2003–04, while the income-tested contributions provided $119.2 million. These fees were in addition to the $5,336.0 million spent in 2003–04 on residential aged care subsidies by the Australian, state and territory governments (Table 4.24), and, similar to previous years, accounted for just over one-fifth of the $6,867 million spent in total on care in residential aged services.

In addition to the basic and income-tested care fees, people entering permanent residential aged care may contract, on entry, to make accommodation payments to contribute to the cost of their accommodation. These payments are assets-tested, and can only be charged to people who have assets exceeding a prescribed minimum level and who entered into an accommodation payment agreement on entry into their current permanent care. Payments may be either in the form of an accommodation bond or accommodation charge. An accommodation bond is an amount payable by people who enter residential care at low-level care, and by those who receive care on an extra service basis (with either high- or low-level care needs). Residents can choose to pay an accommodation bond as a lump sum, as a regular periodic payment, or a combination of both. The service provider can retain part of the accommodation bond, with the balance of the bond being refunded to the resident (or their estate) on departure. An accommodation charge is an additional daily amount which is payable by people who enter permanent residential care at a high level of care; it is payable for up to 5 years.

The amount of the accommodation bond or charge is agreed by the resident and the aged care provider, and may vary widely between residents, both within a residential

aged care service and between services. The Australian Government does not dictate the amount of bonds for residents at different assets levels, but provides a number of legislative protections, including the requirement that residents be left with a minimum level of assets after payment of the accommodation bond; as at 1 July 2004 this minimum was set at $29,000, indexed to $29,500 on 20 September 2004 and $30,000 on 20 March 2005. Other than meeting the minimum assets requirement, there is no upper limit for an accommodation bond. Unlike accommodation bonds, maximum daily accommodation charges are set by the Australian Government, with annual indexation. However, the daily rate for existing residents does not change when these indexations occur. For 2004–05, the maximum daily accommodation charge for new residents was $16.25 (DoHA 2001: ch. 8, 2005g). In addition, residents may choose to pay for additional services not funded through care fees.

4.8 Outcomes

As with other welfare services, the measurement of outcomes for aged care services is an important tool for examining the delivery and quality of the services provided. However, outcome measurement lends itself more readily to the acute care context, where desired outcomes can be more clearly specified, than to aged care services. In care contexts where successful management may be followed by death or deterioration in health status, determining and then measuring desired outcomes is problematic. However, it is still possible to report on measures relevant to program achievements. This section presents data on the accessibility and quality of aged care services.

Accessibility

Accessibility is examined below by considering the provision of residential and community care places and packages, and their use over time. It is currently not possible to provide similar analysis of the HACC program—the other key aged care program—as the provision of HACC services is not bundled into countable packages, and much of the large increase in client numbers seen in the recent HACC MDS collections is more likely the result of increasing participation in the collection than the result of large increases in client numbers.

Supply of residential aged care places and community packages

One of the tools used to plan the provision of residential aged care places and community care places and packages is the planning ratio; this ratio is based on achieving a desired number of places and packages for the number of people likely to need these services. Residential aged care places, Extended Aged Care at Home places and Community Aged Care Packages are intrinsically linked because CACPs aim to provide care equivalent to low care in residential aged care, and EACH places are intended to provide care equivalent to high care in residential aged care. All three are included in the planning ratio, and so are combined to present a comparison of the provision of aged care services against the planning ratio. At the same time, an individual's circumstances may affect whether or not the person can take up a CACP or EACH place, so there is not a strict substitution effect.

As part of the Australian Government's response to the 2004 Review of Pricing Arrangements in Residential Aged Care (Australian Government 2004; Hogan 2004), the planning ratio will be increased from the long-standing 100 operational places and packages per 1,000 persons aged 70 years and over (including places in flexible care) to 108 over 4 years from July 2004. The new provision ratio will be divided into 88 residential aged care places and 20 community care places and packages per 1,000 people aged 70 and over; 55 of the residential places are assigned to high-level care.

In 1999, the total provision of places and packages stood at 94.0 per 1000 people aged 70 and over (AIHW 2003a:321). However, as a result of continued growth in the CACP program and large increases in aged care places since 2001–02, this ratio had reached 100.3 places and packages by 30 June 2004 (Table 4.25). An additional 7,252 places and packages became operational during 2004–05 (DoHA provisional estimate).

While the overall ratio has been increasing since 1996, the provision of residential aged care places declined steadily during the 1990s relative to the number of people aged 70 and over (AIHW 1999:192, 2003a:321). However, this trend has been reversed, with the provision ratio for residential aged care places increasing since 2002. On 30 June 2004, the ratio stood at 84.2 per 1,000 people aged 70 and over, up from its low of 81.7 places in June 2002.

Since the program's inception, CACP provision has grown from year to year relative to the older (70+) population, although in recent years this growth has been slowing. By June 2004 there were 15.6 Community Aged Care Packages per 1,000 people aged 70 and over, up from 14.0 in 2001, and 10.8 in 2000 (AIHW 2003a:321). In addition to these places, the nascent EACH program provided 0.5 community care places per 1,000 in June 2004.

In terms of the more closely targeted supply measure of places and/or packages per 1,000 people aged 65 and over with a severe or profound core activity limitation, between 2001 and 2004 provision changed from 45.8 to 51.0 community care places and packages, and from 267.6 to 267.1 residential aged care places. Consequently, on this measure over the 4 years the number of places and packages per 1,000 people aged 65 and over with a severe or profound limitation rose from 313.4 to 318.2. This equates to an increase of 1.5%, compared with an increase of 7% in places per 1,000 people aged 70 and over. The difference in growth for these two measures is a consequence of the ageing of the population: because disability rates increase with age, as greater proportions reach very old age so too are larger proportions of the older population affected by severe or profound core activity limitations.

Use of residential aged care places and community packages

The use of places and packages by older people reflects the growth patterns in their provision discussed above. Between 2001 and 2004, the rates of use of packages grew for both men and women in all age groups (Table 4.26): by between 14% (among men aged 85 and older) and 33% (among women aged 65–74). On the other hand, within age and sex groups, the use of residential aged care places remained stable or decreased slightly over the period. Taken together, the use of residential aged care places and community care packages rose for women in all age groups, and for men aged 75–84; for men in the other age groups, small declines in use were observed.

Table 4.25: Operational residential aged care places and community care places and packages, 30 June 2001 to 30 June 2005

		Number of places/ packages	Places/packages per 1,000 persons	
			Aged 70+	Aged 65+ with a severe or profound core activity limitation
2001	Community Aged Care Packages	24,629	14.0	45.8
	Residential aged care places	144,013	82.2	267.6
	Total	**168,642**	**96.2**	**313.4**
2002	Community Aged Care Packages	26,425	14.8	47.7
	Extended Aged Care at Home places[(a)]	290	0.2	0.5
	Residential aged care places	146,268	81.7	263.9
	Total	**172,983**	**96.6**	**312.1**
2003	Community Aged Care Packages	27,881	15.3	48.9
	Extended Aged Care at Home places	255	0.1	0.4
	Residential aged care places	151,181	82.8	265.4
	Total	**179,317**	**98.3**	**314.8**
2004	Community Aged Care Packages	29,063	15.6	49.6
	Extended Aged Care at Home places[(a)]	858	0.5	1.5
	Residential aged care places	156,580	84.2	267.1
	Total	**186,501**	**100.3**	**318.2**
2005[(b)]	Community Aged Care Packages	30,916	n.a.	n.a.
	Extended Aged Care at Home places	1,672	n.a.	n.a.
	Residential aged care places	161,165	n.a.	n.a.
	Total	**193,753**	**n.a.**	**n.a.**

(a) In June 2002, EACH places were still formally provided under pilot projects.

(b) 2005 data supplied by DoHA are provisional figures. Places/packages per 1,000 people can be derived once ABS population estimates for June 2005 become available.

Notes

1. Table includes places and packages provided by Multi-purpose Services and flexible funding under the Aboriginal and Torres Strait Islander Aged Care Strategy.
2. Resident population estimates used to derive provision rates are from those released by the ABS in December 2004.
3. Population estimates by disability status are obtained using age/sex disability rates from the ABS 1998 Survey of Disability, Ageing and Carers in conjunction with the estimated resident population. The estimates assume constant disability rates over time within age/sex groups.

Sources: ABS 2004b; AIHW 2005b:3; AIHW analysis of DoHA ACCMIS database (as at 30 November 2004), AIHW analysis of ABS 2003 Survey of Disability, Ageing and Carers; DoHA unpublished data.

While the use of residential care within all age and sex groups examined dropped over the 3-year period, the overall usage rate among people aged 65 and over increased. This apparently contradictory result arises directly from the ageing of the population: although use within groups dropped, the ageing of the population meant that a greater proportion of people fell into the older age groups, which had higher use of residential care than younger groups, so that the overall effect was a rise in the usage rate among

those aged 65 and over. The effect is also seen in the usage rates for places and packages combined: the growth in use among those aged 65 and over is greater than would be expected on simple inspection of the changes in the rates within age groups. This phenomenon illustrates the importance of looking more deeply into use patterns when the structure of a population is changing, as a simple total population usage rate may not provide a true indication of whether provision of services is keeping pace with population growth and change.

The high occupancy rate seen recently in residential care services—averaging around 96% since 2000—indicates continuing high demand for residential places (AIHW 2005b:17, and earlier editions). While the overall provision of aged care places and packages has been keeping pace with the growth in the population aged 70 and over, the ageing of the older population, combined with the greater use of services at older ages, is likely to place increasing pressure on the accessibility of aged care. The announced changes in the planning ratio and rising new annual allocations are both aimed at addressing this issue. Whether these measures will be effective is yet to be seen. However, to obtain a broader picture of the accessibility of aged care, and to examine how general access is changing as the population ages, time-series data on age-specific usage rates of HACC services and unmet demand for all programs would be required. Such data are not currently available.

Table 4.26: Usage rates of residential and community care, 30 June 2001 to 2004 (per 1,000 population)

	Males				Females				Persons			
	65–74	75–84	85+	*65+*	65–74	75–84	85+	*65+*	65–74	75–84	85+	*65+*
CACP and EACH												
2001	1.8	6.7	24.5	*5.1*	3.1	12.8	29.8	*10.2*	2.5	10.3	28.1	*8.0*
2004	2.3	8.1	27.8	*6.4*	4.1	16.1	36.8	*13.2*	3.2	12.7	33.9	*10.1*
3-year growth (%)	**27.9**	**19.9**	**13.5**	***23.5***	**32.7**	**26.1**	**23.8**	***29.0***	**30.8**	**23.5**	**20.7**	***27.0***
Residential aged care												
2001	10.1	41.0	166.1	*32.1*	11.0	68.0	299.0	*70.6*	10.6	56.7	257.9	*53.6*
2004	9.5	41.0	160.1	*32.6*	10.1	67.6	295.6	*71.7*	9.8	56.1	252.5	*54.2*
3-year growth (%)	**–5.9**	**–0.1**	**–3.6**	***1.4***	**–8.1**	**–0.6**	**–1.1**	***1.7***	**–7.1**	**–1.0**	**–2.1**	***1.2***
Total												
2001	11.8	47.7	190.6	*37.3*	14.1	80.8	328.7	*80.8*	13.0	67.0	286.0	*61.6*
2004	11.7	49.0	187.9	*38.9*	14.2	83.7	332.4	*84.9*	13.0	68.8	286.5	*64.4*
3-year growth (%)	**–0.8**	**2.7**	**–1.4**	***4.5***	**0.8**	**3.6**	**1.1**	***5.1***	**0.1**	**2.7**	**0.1**	***4.5***

Notes

1. Until June 2002, EACH places were provided under pilot projects. EACH recipients recorded on ACCMIS as at 30 November 2004 were: 51 in 2001, 82 in 2002, 138 in 2003 and 707 in 2004.
2. Residential care includes permanent and respite residents.
3. Table does not include clients of Multi-purpose and flexible service places or packages.
4. Resident population estimates used to derived usage rates are from those released by the ABS in December 2004.
5. Components may not add to total due to rounding.

Sources: ABS 2004b; AIHW analysis of DoHA ACCMIS database as at November 2004.

Standards and quality of care

Previously data on national standards and quality of care have only been available for residential aged care services. However, the completion in June 2004 of a 3-year appraisal program for HACC agencies means that data on quality of care are now also available for the HACC program.

The HACC National Service Standards were introduced by the Australian Government in 1991 'as part of a commitment to providing high quality services to consumers of community care' (Australian Healthcare Associates 2005:15). The HACC National Service Standards Instrument and Guidelines were developed in 1998 to provide a nationally consistent and reliable means of measuring and monitoring agency compliance with the standards (Box 4.5).

Box 4.5: HACC National Service Standards Instrument (NSSI)

The NSSI addresses the seven objectives of the HACC National Service Standards:

1. *Access to services*
2. *Information and consultation*
3. *Efficient and effective management*
4. *Coordinated, planned and reliable service delivery*
5. *Privacy, confidentiality and access to personal information*
6. *Complaints and disputes*
7. *Advocacy.*

The NSSI comprises 25 performance questions and the Consumer Survey Instrument, and is designed to identify whether agencies are meeting the standards. (HACC Officials 1998; DoHA 2000; see AIHW 1999 and AIHW 2001 for discussion of instrument development).

Between 2000–01 and 2003–04, HACC-funded agencies underwent their first external appraisal using the HACC National Service Standards Instrument (NSSI). In the absence of detailed implementation guidelines, each state and territory adopted individual approaches when assessing agencies against the NSSI. As a consequence, the results for each state and territory from the first 3-year assessment cycle are not directly comparable. During the evaluation cycle, 2,709 out of 3,335 HACC agencies were assessed using the HACC NSSI; of these, 46% had an overall rating of 'High', 29% rated 'Good', 18% rated 'Basic' and 7% rated 'Poor'. The level of compliance varied across the states and territories, both in terms of their overall rating and within the seven service standard objectives for individual jurisdictions (Australian Healthcare Associates 2005:22–3).

Unlike HACC, national data on standards and quality of care for residential aged care have been available for a number of years. Two processes are in place to ensure quality of residential aged care: certification and accreditation (Box 4.6).

Box 4.6: Residential aged care service certification and accreditation processes

Certification

Certification is managed by the Department of Health and Ageing. New services, and extensions and modifications to existing services, are assessed for certification either prior to occupancy or once residents have moved in. To achieve certification a service is assessed in an on-site building inspection. The building assessments focus on seven areas, with the following weightings: fire safety (25%); hazards (12%); privacy (26%); access, mobility and occupational health and safety (13%); heating and cooling (6%); lighting and ventilation (6%); and security (12%) (DoHA 2001: ch. 13). Residential aged care services are required to achieve a safety score of at least 19 out of 25, and an overall score of 60 out of 100. If the service is new, compliance with the 1999 privacy and space standards is also assessed; these include a mandatory maximum average of 1.5 residents per room, with no room accommodating more than two people.

Accreditation

Service accreditation is undertaken by the Aged Care Standards and Accreditation Agency Ltd. Accreditation is based on assessment against the residential aged care Accreditation Standards. These standards include 44 expected outcomes relating to four matters: management systems, staffing and organisational development; health and personal care; residents' lifestyle; and physical environment and safe systems (for details, see AIHW 2001:442–3).

The agency makes accreditation decisions based on audits by registered aged care quality assessors, other site visits, and other relevant information. It is currently funded for an average of 1.25 visits per residential aged care facility per year, with most services getting one visit per year and a few getting multiple visits, depending on the risk profile (ACS&AA 2004b:2).

Generally, residential aged care services that satisfy all of the Accreditation Standards receive 3 years accreditation. Services accredited for periods of less than 3 years may have areas of current non-compliance or a recent history of non-compliance, and the agency may refuse to accredit a service altogether. Before new residential aged care services can claim residential care subsidies they must be accredited. Such commencing services can only receive 12 months accreditation (ACS&AA 2003:24–5, 2005). The agency regularly reviews all residential aged care services through planned accreditation rounds.

Certification aims to ensure the physical quality of the residential aged care service. A service must be certified for it to be able to charge accommodation payments or to receive concessional resident supplements. While there is no mandatory review mechanism for certification, the certification status of an established residential aged care service can be re-assessed at any time. Many of the issues that could lead to a review of certification are covered in the accreditation process, and consequently the need for review of a service's certification may be indicated by poor performance in one or more of the areas (including the physical environment) examined in the accreditation process.

Because services are certified when they are new, or when building modifications are made, data on the certification status relate to the date of its certification, and so, as these dates differ for each service, it is not possible to provide data on the physical quality of all services at any one time.

While certification ensures the quality of the building when a residential aged care service is established, regular accreditation ensures the ongoing quality of care for aged care residents. Established in 1997, the Aged Care Standards and Accreditation Agency Ltd manages the accreditation process and promotes high-quality care. Residential aged care services must be accredited in order to receive residential care subsidies from the Department of Health and Ageing (ACS&AA 2004a:16).

During 2003–04 the agency completed its second round of accreditation, round one having been completed at the end of 2000. It conducted 879 accreditation site visits, 86 review audits and 553 spot checks. In addition, its assessors carried out 2,815 on-site support contacts (ACS&AA 2004a:22). The previous year 1,965 site audits, 68 review audits, 242 spot checks and 1,310 on-site support contacts were conducted (ACS&AA 2003:15). The difference in activity mix between the 2 years resulted from the cyclic nature of accreditation.

In the 2 years up to 30 June 2004, two services were refused accreditation (Table 4.27), and as at 30 June 2004, 91% of the 2,898 accredited residential aged care services (not including 51 commencing facilities) had been given 3 years accreditation. In addition, 'of those that did have some non-compliance, about half were non-compliant in only one expected outcome' (ACS&AA 2004a:4). Excluding the 51 commencing services, 91% of accredited services were accredited for at least 3 years, and 6% were accredited for between 2 and 3 years. Just 1% were accredited for 1 year or less. Similar results were observed for the previous year, although a higher proportion of services had 3 years accreditation (96%).

4.9 Summary

Policy developments

The last 2 years have witnessed a continuing strong interest in population ageing and its implications for the social and economic future of Australia. Reflecting this, there has been a considerable amount of activity in respect of aged care policy. The Review of Pricing Arrangements in Residential Aged Care was completed, and the 2004 and 2005 federal budgets included a number of initiatives which responded to its recommendations. These include increasing the provision ratio for aged care places, introducing funding supplements for residents with complex care needs and declaring dementia a National Health Priority. The Community Care Review resulted in the 2004 release of *A New Strategy for Community Care – The Way Forward* which establishes a framework to progress work on improving accessibility to and coordination of community care programs.

The establishment of the Ageing Well Research Network and the funding available through the Ageing Well, Ageing Productively Research Program confirm the importance of building ageing research capacity and provide new opportunities to strengthen the evidence base for future policy.

Table 4.27: Accreditation status of residential aged care services as at 30 June 2003 and 2004

Length of accreditation	2003	2004
Existing residential aged care services		
<1 year	—	0.1
1 year	0.5	0.9
>1 and <2 years	0.2	1.2
2 years	2.1	3.7
>2 and <3 years	1.7	2.7
3 years	95.5	91.1
4 years[(a)]	—	0.2
Total	*100.0*	*100.0*
Total number	*2,887*	*2,898*
Commencing residential aged care services		
1 year[(b)]	57	51
Total accredited residential aged care services	**2,944**	**2,949**
Accreditations undertaken in the year		
Accreditation granted	1,655	294
Accreditation refused	2	—
Total	**1,657**	**294**

(a) Prior to July 2005, a service could be awarded 4 years accreditation after showing consistent and exceptional performance against the Accreditation Standards. From 1 July 2005, the maximum period of accreditation was limited to 3 years, with higher ratings being replaced with Better Practice in Aged Care awards.

(b) Legally, commencing services can be accredited for 1 year only.

Note: Components may not add to total due to rounding.

Sources: ACS&AA 2003:24–5, 2004a:16–17.

Ageing in Australia

In the 20 years from 2004, the number of people aged 65 years and over is expected to increase by 92% to reach almost 5 million by 2024. The number of very old people (85+) is expected to grow even faster and is projected to reach 725,300 in 2024; by then this group of people will make up nearly 15% of the population aged 65 and over, up from 12% in 2004.

Like the total Australian population, the Aboriginal and Torres Strait Islander population is ageing both numerically and structurally, albeit at a much slower pace. The older population (65+) born in non-English-speaking countries is projected to increase more quickly and age more rapidly than the older Australian-born population.

Ageing of the population is one of the most important issues facing Australia over the coming decades, with significant implications for the health sector, the economy, and the social and physical environments. A range of strategies and policies have been and are being developed to address these issues, and there is increasing emphasis on facilitating healthy and productive ageing.

Older Australians are experiencing falling death rates and greater life expectancy, most of which is lived without reduced functioning, and most rate their health as good or better. While many older people live with some disability, the rates of profound or severe limitation are quite low until age 75 (under 15% in 2003). Only around 5% of people aged over 65 live permanently in residential aged care.

Older people contribute to society in a variety of ways, including through volunteer work and caring. In 2002, 634,000 people aged 65 and over (28%) undertook volunteer work through an organisation or group. Many older people also provide care for family and friends. In 2003, nearly 454,000 people aged 65 and over provided assistance to people with a disability—113,200 as the primary carer of the care recipient (equating to 4.5% of older people).

Aged care services

Increasing emphasis on community care and decreasing emphasis on residential care has continued. For all aged care services, the proportion of people using a service increases with age.

The bulk of home- and community-based services for older people is provided under the auspices of the Home and Community Care program. In 2003–04, at least 537,100 people aged 65 and over received HACC services—or 210 people per 1,000. In the same year, Veterans' Home Care assisted 61,600 older people, and as at 30 June 2004, 25,700 people aged 65 and over were on a Community Aged Care Package.

Respite services continue to play an important role in supporting home-based care. In 2003–04, 57,800 older HACC clients used centre-based respite care and 5,200 used in-home respite. In addition, 8,100 VHC clients aged 65 and over received in-home or emergency respite. Furthermore, 46% (or 44,100) of admissions into residential aged care for older people during 2003–04 were for respite care.

Residential aged care is the second most commonly used aged care service after HACC. At 30 June 2004, 141,300 people aged 65 and over were in residential aged care, either permanently or for respite care, so that out of every 1,000 people aged 65 and over, 53 were in permanent residential aged care, with just 1 additional person being in residential respite care. The profile of care needs of permanent residents has continued to shift towards higher care, and 65% of older permanent residents had high care needs, with nearly all having multiple care needs. There were 161,165 operational residential aged care places, including flexible and Multi-purpose Service places, by 30 June 2005.

Aboriginal and Torres Strait Islander peoples have a shorter life expectancy than other Australians, and use aged care services at a younger age: among people aged 50–74 years, Indigenous people had much higher usage rates than other people for all services examined.

Programs providing community care have relatively more clients born in non-English-speaking countries compared with residential care services. However, people born in Australia had higher usage rates than others in all age groups for all services except Community Aged Care Packages.

The provision of residential aged care places and community places and packages would appear to be keeping pace with growth in the population aged 65 and over with a severe or profound limitation. However, growth in the population of very old people aged 85 and above would appear to be driving increased demand for care and a rise in the overall usage rate for the population aged 65 and over.

Expenditure

Total government expenditure on aged care services was $7,321.7 million in 2003–04, an increase of 23% in real terms since 2000–01. Overall, the increase in expenditure on aged care services kept pace with the growth in the number of older people likely to need some assistance.

Users of aged care services also contribute to the cost of their care. In 2003–04, residents of residential aged care services contributed just over $1,500 million in basic and income-tested fees. Clients of community care programs also make contributions, and for 2002–03 it is estimated that HACC clients contributed $43 million and CACP and EACH recipients together paid $50 million towards the cost of their care.

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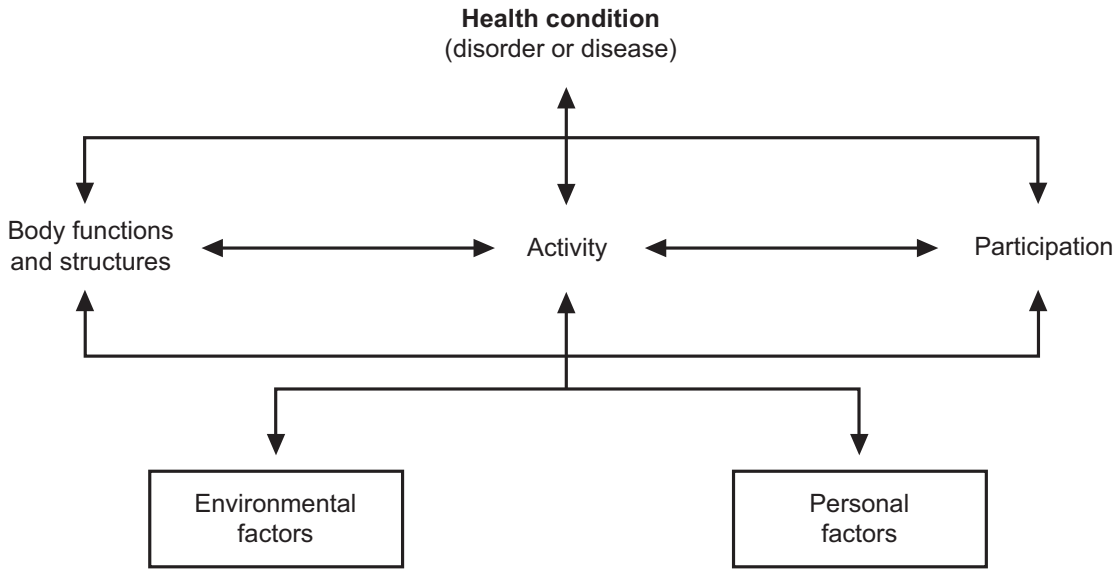
5 Disability and disability services

5.1 Introduction

Disability affects many people, directly or indirectly. It may be a life-altering event or experience, it may have large or small effects on people's daily lives. Increasingly, disability is recognised as something that affects most people in the population, to varying degrees and at different life stages. It can be measured along a continuum and estimates vary with the particular definition used.

In 2003 there were 3.9 million people (20% of the population) in Australia whose lives were affected by an impairment, activity limitation or participation restriction in the environment in which they lived; 2.6 million were aged under 65 years. This chapter provides a profile of these people, the services they may use, and the outcomes for them. The focus here is chiefly on people aged less than 65 years; Chapter 4, on ageing and aged care, focuses on older Australians.

The experience of disability is crucially influenced by environmental factors. The International Classification of Functioning, Disability and Health (ICF) recognises that the components of functioning and disability—body functions and structures, activities and participation—reflect an interaction between health conditions and the person's environment (Figure 5.1; WHO 2001). This important conceptual framework underpins much Australian data.



Source: WHO 2001:18.

Figure 5.1: Interactions between components of the ICF

Section 5.2 outlines recent developments in the disability field, including data developments. Section 5.3 gives an overview of disability in the Australian population, including a brief discussion of disability and ageing, childhood disability, and disability among Aboriginal and Torres Strait Islander peoples. Data on services and assistance are presented in Section 5.4. Section 5.5 outlines participation outcomes for people with disabilities. Section 5.6 summarises and concludes the chapter.

5.2 Recent developments

The lives of people with a disability are affected by many social trends and policies. This section provides a brief picture of recent developments affecting people with a disability and the disability services field.

Human rights and ethics

Many policies in the disability field in Australia are grounded in a human rights philosophy, reflecting the basic principle that people with disabilities should have the same opportunities to participate in society as do others (see, for example, AIHW 1993:266–79; UN 1994). Australia is now participating in the work of a United Nations committee developing proposals for a Convention on the rights of people with disabilities; drafting covers a wide range of rights and freedoms relevant to all areas of life and all age groups. The Human Rights and Equal Opportunity Commission (HREOC) has conducted relevant seminars and consultations in Sydney and Canberra (HREOC 2005a).

The Biwako Millennium Framework for Action was adopted by the UN Economic and Social Commission for Asia and the Pacific in 2002, setting out a 'framework for action towards an inclusive, barrier-free and rights-based society for persons with disabilities' (UNESCAP 2002). The framework proposes action in a number of target areas, including early intervention, training and employment, access to built environments and to information, poverty alleviation, self-help organisations, families and women. The Department of Family and Community Services and the AIHW both participated in a regional forum on employment, in April 2004, contributing (respectively) on Australian government policies and initiatives, and on data developments focusing on rights and participation. The relevance of the ICF for data development was recognised, with its focus on participation and the key role of environment in the creation and experience of disability. The ICF 'has been accepted as one of the United Nations social classifications and is referred to in and incorporates the Standard Rules on the Equalization of Opportunities for Persons with Disabilities' (WHO 2001:5).

In May 2005 the World Health Assembly passed a resolution on 'Disability, including prevention, management and rehabilitation' (WHA 2005). This resolution recognised the important contribution of people with disabilities, the need for prevention, health, rehabilitation and support services, and the need to provide equipment and recognise environmental (including cultural) barriers. Member states were urged to act on these matters, and to gather 'more reliable data'; the ICF was specifically recognised in the resolution.

Disability Discrimination Act

The *Disability Discrimination Act (DDA) 1992* is one of the major national expressions of the human rights approach to disability, making discrimination on the grounds of disability unlawful, and providing a framework and process for the setting of disability standards (Box 5.1).

Box 5.1: Recent progress in implementing the *Disability Discrimination Act 1992*

Disability Standards for Access to Premises

A draft standard was released for public comment and consultation on 9 January 2004. A large number of submissions (almost 300) were received relating to the draft standards. Work on finalising these standards is continuing during 2005.

Disability Standards for Education

Education standards were tabled in Parliament on 17 March 2005 and came into effect on 18 August 2005. These Standards clarify the obligations of education and training providers in relation to students with disabilities, including providing guidance as to how these obligations can be met.

Insurance and superannuation

Revised guidelines are designed to assist providers of insurance and superannuation in complying with the DDA.

Mental health consultations

A report on the experiences of mental health consumers in each state and territory is due for release in late 2005. This report is being produced by the Mental Health Council of Australia and the Brain and Mind Research Institute, with guidance from HREOC.

Voluntary banking standards

HREOC has recently reviewed voluntary banking standards (released in April 2002) for electronic banking services such as ATMs, Internet banking and EFTPOS. Preliminary results showed some progress towards achievement of accessibility to these products for people with disabilities, but a lack of awareness of the availability of these products.

Sources: DEST 2005a; HREOC 2005b; Ruddock 2005.

A review of the Act was conducted by the Productivity Commission in 2004 (Box 5.2). In response to the review, the government accepted '26 of those recommendations either in full, in part or in principle' (Attorney-General's Department 2005). Recommendations not accepted include those relating to insurance, wages and immigration.

Whole-of-government policies

Whole-of-government approaches to disability have been recognised as essential for some years. The Commonwealth Disability Strategy, in existence for more than a decade, provides a whole-of-government strategy aimed at 'enabling full participation of people with disabilities' (FaCS 2005a). In 1997 a whole-of-government Disability Policy Framework was developed in New South Wales to promote a holistic approach

to service delivery, addressing the diverse needs of people with a disability (NSW Government 1997). The framework was initially based on a categorisation of needs and services, developed by the Institute for its study of unmet demand for disability support services (AIHW 1997). This study reflected the 'whole person' approach which is at the heart of whole-of-government approaches to human need. The ICF (then in draft) provided an essential framework for understanding the needs of people with disabilities across the spectrum of activities, participation and the life-cycle.

Box 5.2: Main findings of the review of the *Disability Discrimination Act 1992*

Overall, the DDA has been reasonably effective in reducing discrimination. But its report card is mixed and there is some way to go before its objectives are achieved.

- *Access to public transport and education has improved more than employment opportunities. (Finding 5.1 states that 'disability discrimination in employment remains a significant issue' and Finding 5.7 that the 'Commonwealth Disability Strategy … has been ineffective in improving employment opportunities for people with disabilities in the Australian Public Service'.)*
- *People with physical disabilities have been helped more than those with mental illness or intellectual disabilities – but other factors might be relevant.*
- *People with disabilities in regional areas, from non-English-speaking backgrounds and Indigenous Australians still face particular disadvantages – but race discrimination, language, socioeconomic background and remoteness also play a part.*
- *The nature of the challenge facing the DDA will change as the focus shifts from removing physical barriers to addressing attitudinal barriers.*

The DDA meets the Competition Principles Agreement legislation review requirements.

- *Many benefits are intangible but widespread.*
- *Costs of compliance are likely to be quite small for many organisations.*
- *In-built safeguards help ensure a net benefit to the Australian community.*
- *Its impact on competition appears to have been limited.*
- *No satisfactory alternatives for achieving its objectives exist.*

Care needs to be taken in the way the DDA is implemented through disability standards if it is to continue to produce net benefits. While the DDA should be amended to allow standards to be developed for all areas of the Act, they should not be able to alter the fundamental scope of the Act.

The unjustifiable hardship defence should be strengthened and extended to all areas of the Act. It should also apply to all standards.

An explicit duty to make 'reasonable adjustments' should be included in the DDA.

- *It should cover all areas of the Act.*
- *It should exclude adjustments that would cause unjustifiable hardship.*
- *Its costs should be shared between affected organisations and government.*

Source: Productivity Commission 2004a.

Across Australia, disability services are delivered under the Commonwealth State/Territory Disability Agreement (CSTDA 2003). The 2002–07 Agreement has five key policy priorities which reflect this understanding, placing specialist disability services within the broad field of human services for all people:

- to strengthen access to generic services by people with disabilities;
- to strengthen across-government linkages;
- to strengthen individuals, families and carers;
- to improve long-term strategies to respond to, and manage demand for, specialist disability services; and
- to improve accountability, performance reporting and quality.

The Australian Government is now placing considerable emphasis on the need to develop and implement whole-of-government approaches: 'Most of the pressing problems of public policy do not respect organisational boundaries. Nor do most citizens' (Shergold 2004).

Income support and economic participation

Reducing welfare dependence and increasing workforce participation was flagged as a priority of the Australian Government after its re-election in October 2004 (Howard 2004). Two of the complementary goals of welfare reform were to encourage workforce participation for people with disabilities, and to limit the growth in the number of people receiving the Disability Support Pension (DSP). For several years, change has been flagged and discussed in a series of reports (outlined in AIHW 2001:270–1, 2003a:333–6). The underlying philosophy is one of mutual obligation of government and citizens, and there has been consultation and debate over these years to attempt to balance and implement these obligations appropriately (see, for instance, Disability and Participation Alliance 2005). Employment retention, not just obtaining a job, is seen as an essential component of reform, especially by disability advocates (Diamond 2005).

It was announced in May 2005 Budget statements that, from 1 July 2006, people with disabilities who are new claimants of income support and are able to work between 15 and 29 hours per week within a 2-year period at award wages in the open labour market would receive an enhanced Newstart Allowance or Youth Allowance (rather than DSP) and be subject to part-time mutual obligation requirements. These people would be eligible for the Pensioner Concession Card, Pharmaceutical Allowance and Telephone Allowance (Dutton 2005). The planned changes to DSP were accompanied by extra employment services designed to promote workforce participation: disability open employment services, the Job Network, vocational rehabilitation and the Personal Support Program. These initiatives are being introduced at a time of population ageing and projected slowing in labour force growth (Andrews 2005). Efforts are being made by government to encourage employers to expand work opportunities for people with disabilities.

In its 2005 Budget submission, ACROD advocated the need for related initiatives, including removing the ceiling on employment assistance places in specialist disability services, increasing vocational training participation rates among people with

disabilities, and for Australian governments themselves to improve their record of employing people with disabilities (ACROD 2005). Australia's relatively poor performance in employing people with 'mental health disorders' has been pointed to by the Mental Health Council of Australia which has stated its intention to be 'a very active player' in the promised consultation process (MHCA 2005).

A national inquiry on employment and disability is due to report in November 2005 (HREOC 2005c). In launching its inquiry, HREOC pointed to the lower participation rates of people with disability, their higher unemployment rates, and lower earnings (see also Section 5.5).

Advocacy and advice

A range of advocacy and advisory bodies provide advice to Australian governments as well as information to policy makers and the public more generally.

Nationally-focused non-government organisations include:

- National Advisory Council on Disability and Carer Issues, which will meet for the first time in late 2005. This new body will provide the government with advice on issues affecting people with disability, carers and the caring process (FaCS 2005b). It replaces two former advisory groups, the National Disability Advisory Council and National Family Carers Voice.
- Australian Federation of Disability Organisations, which was established in November 2004. Its mission is 'to champion the rights of people with disability in Australia, and help them participate fully in Australian life' (AFDO 2005).
- ACROD, which describes itself as the national industry association for disability services, with a network of state, territory and national offices. Its areas of interest are indicated in its recent budget submission, covering topics such as: open and supported employment services and policies for government funding, regulation and support thereof; the need for benchmarks for the provision of disability services; the need for a 'properly resourced national equipment strategy'; and strategies to address disability and ageing (ACROD 2005).
- Association of Competitive Employment (ACE), which is the national peak body for open employment services for people with disabilities.

There are state counterparts of many of these organisations, as well as specific groups representing, for instance, people with particular disabilities or health conditions.

National developments in disability support services

The 2002–07 CSTDA and the previous two agreements provide the national framework for the funding and provision of disability support services. The Australian Government is responsible for the planning, policy setting and management of employment services under this agreement, while the states and territories are responsible for all other disability support services. Advocacy, information and print disability services are considered shared responsibilities under the Agreement. The five key policy priorities under the CSTDA are listed previously in this chapter.

The third CSTDA introduced a schedule that specifies the annual production of performance indicators as part of the accountability measures for all governments, indicators relating to service access and expenditure. These were produced for the first time in 2002–03 and published in the National Disability Administrators' (NDA) first CSTDA Public Report (NDA 2004; see also AIHW 2004c). The second CSTDA Public Report, using 2003–04 data, was released in 2005 (NDA 2005).

The agreements commit the parties to work together to address key issues for people with a disability, including:

- flexibility between service provision by different levels of government;
- the situation of young people living in Australian Government-funded residential aged care facilities; and
- issues facing people with a disability who are ageing (FaCS 2005c).

The situation of younger people in residential aged care facilities was also given attention by a Senate Committee. Such accommodation was found 'unacceptable in most instances' and it was recommended that individual situations be assessed and alternative accommodation be provided (Senate Community Affairs Committee 2005).

The current CSTDA is a two-tiered arrangement of multilateral and bilateral agreements. The 2004–05 federal budget included a bilateral funding offer to all states and territories for additional respite for older carers. Under these bilateral agreements, carers aged 70 years or above who are caring for their son or daughter with a disability would be eligible for up to 4 weeks of respite per year, and carers aged between 65 and 69 years who need to spend time in hospital would be eligible for up to 2 weeks respite per year (FaCS 2004a).

Current state and territory government policy directions for disability support services vary somewhat between jurisdictions (NDA 2004; SCRCSSP 2005). Common areas of focus include:

- family-oriented approach to services—focusing on supporting young people with disabilities and their carers;
- supporting people with disabilities so that they can live in the community;
- provision of flexible services aimed at serving the needs of individuals (sometimes based on individualised funding packages), and the desire to move people out of inappropriate services (e.g. young people in aged care homes); and
- a review of disability legislation being undertaken in a number of states and territories.

In late 2004, responsibility for administration of open employment services operating under the CSTDA moved from the Department of Family and Community Services (FaCS) to the Department of Employment and Workplace Relations (DEWR). As a result, DEWR proposed that, from July 2005:

- open employment services will operate as a specialist network of services (separate from the mainstream Job Network);

- case-based funding will be fully implemented in these services—that is, higher levels of funding will be available for services taking on clients with the highest support needs; and
- Job Network member agencies will be able to register job seekers who receive the DSP (DEWR 2005a).

Consultations on the proposed operation of open employment services under DEWR were held in early 2005. DEWR reported strong support for the case-based funding model. Open employment services are still in a 'transition' period (DEWR 2005b).

The Australian Government's National Respite for Carers Program has resource centres in each capital city which are designed to act as a single point of contact for carers to obtain information and access to relevant services (see also Chapter 4). This program provides respite for carers of young people with a disability, when their needs are not being met by existing state/territory programs.

Disability data developments and challenges

Disability data continue to improve. The National Aboriginal and Torres Strait Islander Social Survey 2002 has now provided information on Indigenous disability. The first full year of data from the redeveloped CSTDA NMDS collection provides a new benchmark collection on disability services for future reference. These enhanced sources, as well as new data from the 2003 Survey of Disability, Ageing and Carers, are reflected in this chapter.

Further developments are in train:

- A disability question in the Australian Census has been developed for 2006. This decision follows some years of representation by the disability sector and the AIHW, and of options testing by the ABS. The collection of basic disability information in the Census will enable small area data to be improved, for service planning purposes, information on subpopulations to be compiled, and disability information to be related to the rich array of other social data from the Census.
- The AIHW (as the Australian Collaborating Centre for the WHO Family of International Classifications) is continuing to work on the implementation of the ICF. A data capture tool has been developed to assist users to apply the classification—the Functioning and Related Health Outcomes Module (AIHW 2005a). The module reflects national data standards that already incorporate the ICF (AIHW 2005b). This tool is intended to support whole-of-government consistency in the identification and measurement of functioning and disability.
- There is considerable interest and activity in implementing the ICF in internationally comparable disability surveys. Both the AIHW and the ABS have been involved in the UN's Washington Group, as well as in UNESCAP work in 2004 on disability statistics in the Asia Pacific region.
- An Australian Forum on improving disability data and the use of the ICF, is planned for February 2006, with an Australian ICF User Guide (version 2) to be produced later in that year, both reflecting the vigorous interest in Australia in the use of the classification. The AIHW is promoting the use of the ICF in a wide range of fields, to improve the quality, relevance and consistency of disability information (see also Chapter 1).

- There is increasing adoption of national data standards, based on the ICF, in administrative data collections. The national disability services collection has for several years used the Activities and Participation dimension in a key data item on support needs. For the new national minimum data set for children's services, a relevant data item for disability has been developed which relates to national standards, thus enabling data comparisons with the relevant population survey.

All these developments will provide improved infrastructure for 'disability identification' in generic services, enabling access to and outcomes from these services to be monitored. Some of these initiatives are challenging, particularly when they involve bringing a newer and more holistic conceptualisation of disability into the sphere of health surveys and information systems (Madden et al. 2005), and into the plethora of assessment scales now used in human services fields in Australia. This very variability, however, makes greater consistency (or at least 'inter-operability') all the more an important goal.

The long-term vision is that, with more consistent approaches to disability data across the spectrum of human services, the resulting 'joined up' data will support whole-of-government approaches to the provision of services relevant to people with a disability.

5.3 Disability in the Australian population

This section presents an overview of disability in Australia, drawing on two new sources of population data. The 2003 Survey of Disability, Ageing and Carers is used to profile the population, by updating major analyses carried out since the last survey in 1998. The National Aboriginal and Torres Strait Islander Social Survey provides a first useful picture of disability among Indigenous Australians.

In 2003 there were an estimated 3,946,400 people with a disability—about 20% of the Australian population (Table 5.1).[1] Of these, 2,556,000 people were aged under 65 years, representing 14.8% of the population in that age range. 'Disability', as defined by the survey, is a mix of 17 impairments, activity limitations and participation restrictions identified in the survey screening questions (see Technical Appendix). These estimates cover a broad spectrum of disabilities, in terms of both the nature and extent of the effects on the person.

The extent to which these disabilities affect everyday life is indicated by the presence of a 'profound or severe core activity limitation'. In 2003, 6.3% of the population (1,238,600 people) experienced such limitations, meaning that they always or sometimes needed assistance with activities of self-care, mobility and communication.

1. The estimates of disability are based on the confidentialised unit record file (CURF) of the ABS 2003 Survey of Disability, Ageing and Carers. To protect confidentiality, some children's records and any households that were identifiable have been dropped from the CURF. Therefore, the estimates based on the CURF do not exactly match those of ABS published reports. CURF estimates are used throughout the chapter for internal consistency.

This total comprised 677,700 people aged under 65 (3.9% of the population aged under 65) and 560,900 aged 65 and over (22.5% of those 65 and over). Of children aged 0–14 years, 4.3% had profound or severe core activity limitations, compared to 2.2% of people aged 15–24 years; otherwise, the higher the age group, the greater the likelihood of such limitations. Disability and ageing will be discussed in more detail later in this section.

Table 5.1: All persons by disability status and severity of core activity limitation, 2003

	Core activity limitation				
Age group	Profound	Severe	Total profound or severe	Total with disability	Total population
			Number ('000)		
0–14	78.0	87.3	165.3	317.9	3,850.6
15–24	24.0	36.9	61.0	249.3	2,786.4
25–34	20.6	46.8	67.5	314.3	2,948.9
35–44	23.7	73.6	97.3	418.5	2,951.8
45–64	86.2	200.5	286.7	1,256.0	4,684.7
65+	359.6	201.3	560.9	1,390.4	2,496.8
Total	**592.2**	**646.4**	**1,238.6**	**3,946.4**	**19,719.3**
Total <65	***232.6***	***445.1***	***677.7***	***2,556.0***	***17,222.5***
			Per cent[(a)]		
0–14	2.0	2.3	4.3	8.3	. .
15–24	0.9	1.3	2.2	8.9	. .
25–34	0.7	1.6	2.3	10.7	. .
35–44	0.8	2.5	3.3	14.2	. .
45–64	1.8	4.3	6.1	26.8	. .
65+	14.4	8.1	22.5	55.7	. .
Total	**3.0**	**3.3**	**6.3**	**20.0**	**. .**
Total <65	***1.4***	***2.6***	***3.9***	***14.8***	***. .***

(a) Per cent of the Australian population of that age.

Note: See Technical Appendix for definitions of terms used to categorise 'disability status' in the survey.

Sources: Tables A5.1, A5.2; AIHW analysis of ABS 2003 Survey of Disability, Ageing and Carers confidentialised unit record file.

The nature of the disabilities experienced is sometimes described by terms such as 'intellectual' or 'physical' disability, and the AIHW has developed a series of estimates of these groups (see Box 5.3 for terms; and AIHW 2003b for methods and previous estimates). Prevalence estimates vary with the scope and level of disabilities under consideration. Four sets of estimates are accordingly provided, to support different applications and to illustrate the variation arising from the different bases of estimation (Table 5.2). The estimates based on 'main disabling condition' are used when people with multiple conditions are to be counted only once, but not when a full picture of all disabilities—personally or within the population—is needed (see Technical Appendix).

Box 5.3: Disability groups

Intellectual/learning disability *is associated with impairment of intellectual functions, with limitations in a range of daily activities and with restriction in participation in various life areas. Support may be needed throughout life, the level of support tending to be consistent over a period of time but may change in association with changes in life circumstances.*

Psychiatric disability *is associated with clinically recognisable symptoms and behaviour patterns frequently associated with distress that may impair personal functioning in normal social activity. Impairments of global or specific mental functions may be experienced, with associated activity limitations and participation restrictions in various areas. Support needed may vary in range, and may be required with intermittent intensity during the course of the condition. Changes in level of support tend to be related to changes in the extent of impairment, or in the environment. Psychiatric disability may be associated with schizophrenia, affective disorders, anxiety disorders, addictive behaviours, personality disorders, stress, psychosis, depression and adjustment disorders.*

Sensory/speech disability *is associated with impairment of the eye, ear and related structures and of speech, structures and functions. The extent of impairment and activity limitation may remain consistent for long periods. Activity limitations may occur in various areas, for instance communication and mobility. A specific range of environmental factors will affect the level of disability experienced by people in this grouping. Once in place, the level of support tends to be relatively consistent.*

Physical/diverse disability *is associated with the presence of an impairment, which may have diverse effects within and among individuals, including effects on physical activities such as mobility. The range and extent of activity limitation and participation restriction will vary with the extent of impairment as well as with environmental factors. Environmental adjustments and support needs are related to areas of activity limitation and participation restriction, and may be required for long periods. Levels of support may vary with both life changes and extent of impairment. Included in this broad category is the subcategory* ***Acquired brain injury*** *which is used to describe multiple disabilities arising from damage to the brain acquired after birth. It can occur as a result of accidents, stroke, brain tumours, infection, poisoning, lack of oxygen, degenerative neurological disease, etc. Effects include deterioration in cognitive, physical, emotional or independent functioning.*

Sources: AIHW 2005b; NCSDC 2004.

Physical/diverse disabilities were the most prevalent, whichever of the four estimates is considered (Table 5.2). Based on consideration of all reported conditions, 2,043,400 people aged under 65 years reported one or more physical/diverse disabilities (12% of the population of that age). Of these, 1,995,300 also reported one or more activity limitations or participation restrictions (12% of the under 65 population) and, using the narrowest scope, 512,600 (3.0%) had a profound or severe core activity limitation.

One or more sensory/speech disabilities were reported by an estimated 728,300 people aged under 65 years in 2003 (or 4.2% of this age group), based on consideration of all reported conditions. Of these, 713,200 people (4.1%) also reported one or more activity limitations or participation restrictions, and 254,700 (1.5%) had a profound or severe activity limitation.

Table 5.2: Estimates of main disability groups in Australia, 2003

	Aged under 65		Aged 65+		All ages	
	Number ('000)	% of people aged <65	Number ('000)	% of people aged 65+	Number ('000)	% of total population
All disabling conditions						
Intellectual	436.2	2.5	152.5	6.1	588.7	3.0
Psychiatric	722.1	4.2	295.8	11.8	1,017.9	5.2
Sensory/speech	728.3	4.2	768.0	30.8	1,496.3	7.6
Acquired brain injury[(a)]	317.4	1.8	120.9	4.8	438.3	2.2
Physical/diverse	2,043.4	11.9	1,307.2	52.4	3,350.6	17.0
All disabling conditions and activity limitations and participation restrictions						
Intellectual	432.0	2.5	152.5	6.1	584.5	3.0
Psychiatric	720.0	4.2	295.8	11.8	1,015.8	5.2
Sensory/speech	713.2	4.1	768.0	30.8	1,481.2	7.5
Acquired brain injury[(a)]	311.8	1.8	120.9	4.8	432.7	2.2
Physical/diverse	1,995.3	11.6	1,307.2	52.4	3,302.6	16.7
All disabling conditions and profound or severe core activity limitations						
Intellectual	215.1	1.2	135.9	5.4	351.0	1.8
Psychiatric	277.7	1.6	215.1	8.6	492.8	2.5
Sensory/speech	254.7	1.5	325.1	13.0	579.8	2.9
Acquired brain injury[(a)]	99.9	0.6	57.5	2.3	157.5	0.8
Physical/diverse	512.6	3.0	538.5	21.6	1,051.1	5.3
Main disabling condition						
Intellectual	162.7	0.9	*3.0	*0.1	165.7	0.8
Psychiatric	326.0	1.9	106.2	4.3	432.2	2.2
Sensory/speech	247.1	1.4	165.2	6.6	412.3	2.1
Acquired brain injury[(a)]	27.3	0.2	**1.4	**0.1	28.7	0.1
Physical/diverse	1,792.8	10.4	1,114.6	44.6	2,907.4	14.7
Total with a disability	**2,556.0**	**14.8**	**1,390.4**	**55.7**	**3,946.4**	**20.0**
Total population	**17,222.5**	**. .**	**2,496.8**	**. .**	**19,719.3**	**. .**

(a) Acquired brain injury is included in 'physical/diverse' when only four main disability groups are being considered (see Box 5.3).

Notes

1. Estimates marked with * have an associated relative standard error (RSE) of between 25% and 50% and should be interpreted accordingly.
2. Estimates marked with ** have an associated relative standard error (RSE) of greater than 50% and should be interpreted accordingly.

Source: AIHW analysis of ABS 2003 Survey of Disability, Ageing and Carers confidentialised unit record file.

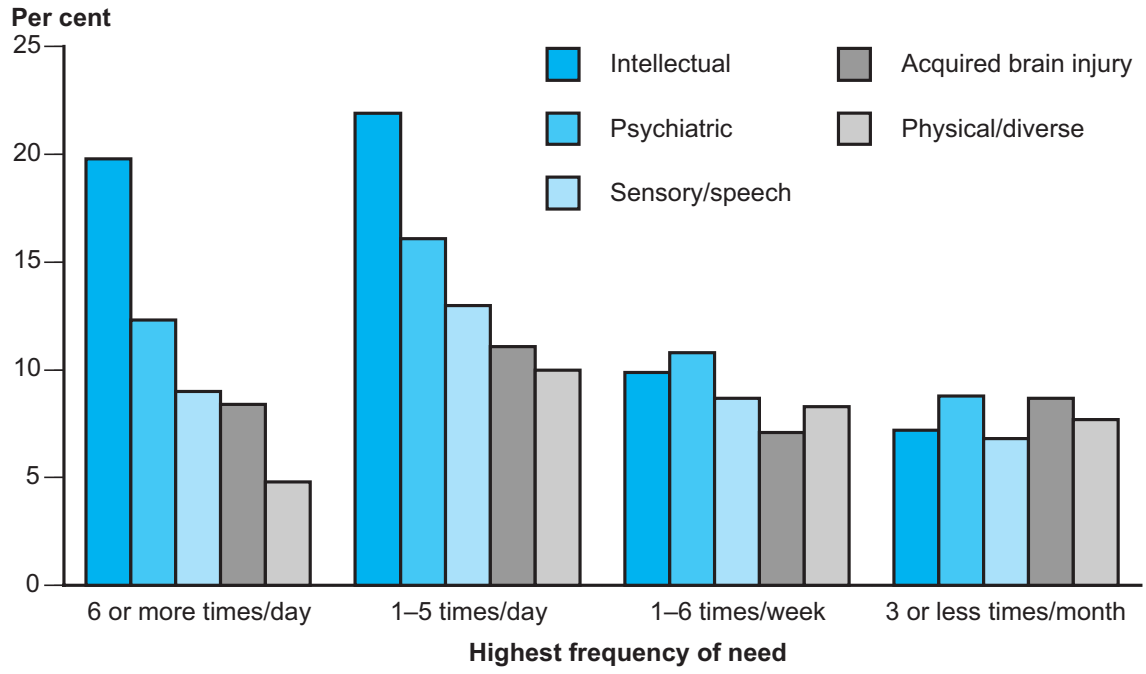
Similarly, focusing on 'all disabling conditions' estimates (Table 5.2):

- psychiatric disability was reported for an estimated 722,100 people aged under 65 (4.2% of the age group), of whom 720,000 (4.2%) had activity limitations or participation restrictions, and 277,700 (1.6%) had a profound or severe activity limitation;

- intellectual disability was reported by 436,200 people aged under 65 (2.5% of the age group), of whom 432,000 (2.5%) had activity limitations or participation restrictions, and 215,100 (1.2%) had a profound or severe activity limitation; and
- acquired brain injury was reported by 317,400 people aged under 65 (1.8% of the age group), of whom 311,800 (1.8%) had activity limitations or participation restrictions, and 99,900 (0.6%) had a profound or severe activity limitation associated with acquired brain injury.

Focusing only on the 'main disabling condition' of each person, 15% of the total population reported physical/diverse as the disability most affecting their daily life, as did 10% of people aged under 65. Among those aged under 65, 1.4% had a sensory/speech main disability, 1.9% psychiatric, 0.9% intellectual disability and 0.2% acquired brain injury.

There is some relationship between the nature of disability, as indicated by these disability groupings, and the extent of disability, as indicated by the frequency of need for assistance with the core activities (Figure 5.2). People with intellectual disability were the most likely to report needing assistance 6 or more times per day (20%), followed by people with psychiatric disability (12%). People reporting physical disabilities were the least likely to report needing such frequent assistance (4.8%). Similar differences among the disability groups held for people needing assistance 1–5 times per day. The differences became less marked when the highest frequency of assistance was less than daily.



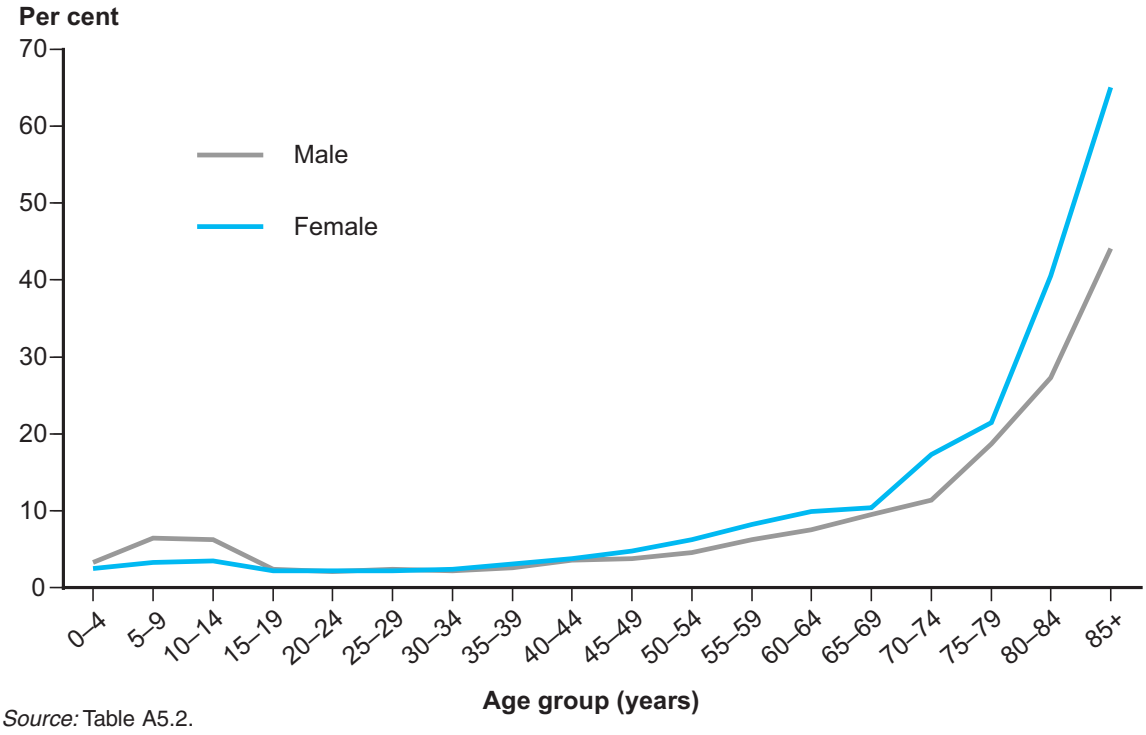
Source: Table A5.3.

Figure 5.2: Highest frequency of need for assistance with core activities, as a proportion of people with a specific disability, 2003

People with physical/diverse disabilities were the most likely to report needing no help at all (see Table A5.3) and those with intellectual disabilities the least likely. It was people aged 65+ with intellectual or psychiatric disabilities who were the most likely of all to need assistance 6+ times per day.

Disability and ageing

The relationship between disability and age is not necessarily straightforward, even though at first glance it may seem so because of the general tendency for the likelihood of disability to increase with age (Figure 5.3). Here attention is focused on the age- and sex-specific rates of profound or severe core activity limitations. The graph reflects what happens to people during the life-cycle, their changing environments and the accumulation of risks they encounter.



Source: Table A5.2.

Figure 5.3: Age- and sex-specific rates of people with a profound or severe core activity limitation, 2003

The peak in early childhood and school years may reflect the environment of family, early intervention services and school, which may combine to identify a greater proportion of disabilities than at later ages. This pattern has been present in previous years, and these and other factors are discussed later in this section (under 'Children with a disability'; see also AIHW 2004a). The prevalence rate was lower among adolescents than children, and remained at a rate just under 2.5% among people in their 20s and early 30s.

From age 35, disability prevalence rates increased with age, as new risk factors for disability impacted on the population. For young adults, injury is a relatively high risk (see Chapter 2). Young adult males, in particular, may experience injuries such as spinal

cord and brain injuries that can lead to lifelong disability (AIHW NISU: Cripps 2004; AIHW NISU: O'Connor 2002). Working ages may see work-related injuries occur; these middle years are also the years of onset of musculoskeletal and other conditions such as arthritis and heart diseases associated with physical disabilities, as well as hearing and psychiatric disabilities (AIHW 2003b, 2004b). In the older age groups, more illnesses affecting human functioning become prevalent, including cardiovascular diseases, cancers and dementia, and the rates of vision, hearing and movement-related disabilities are higher. (Sex differences at older ages are discussed in Chapter 4, and in childhood under 'Children with a disability' in this chapter.)

The patterns of age at onset of disability are illustrated in Table 5.3. Among people of all ages reporting intellectual disabilities, 94% reported an age at onset of 14 years or younger. Psychiatric disabilities and acquired brain injury were most likely to have started at ages 15–44 years (50% and 56% respectively). The onset of physical disabilities was more evenly spread across the life-cycle; while most likely to start in the age range 15–44 years (39% did so), this was the most likely of the disability groups to have an age of onset 65 years or above. Each of the groupings is quite broad and there is variation within them. For instance, speech disabilities have a likely earlier age of onset than vision disabilities—in 1998, about 87% of people with speech as a main disabling condition first experienced the condition at age 0–4 years, compared with 15% for those with vision disorders (AIHW 2003b:71). (See Box 5.4 on the need for caution when interpreting age-at-onset data.)

Table 5.3: People of all ages with a disability living in households: age at onset of main disabling condition by disability groups (based on main disabling condition), 2003

	Age at onset of main condition					
	0–14	15–44	45–64	65+	Not known	Total
			Number ('000)			
Intellectual	152.1	*5.1	**0.2	**0.9	*3.7	162.0
Psychiatric	107.4	183.4	50.0	16.8	6.6	364.0
Sensory/speech	137.7	108.1	86.5	64.1	8.7	405.0
Acquired brain injury[(a)]	*9.0	15.3	*2.9	—	—	27.2
Physical/diverse	385.2	1,103.2	844.7	448.6	28.6	2810.3
Total	**791.3**	**1.415.1**	**984.3**	**530.4**	**47.5**	**3,768.5**
			Per cent			
Intellectual	93.9	*3.1	**0.1	**0.5	*2.3	100.0
Psychiatric	29.5	50.4	13.7	4.6	1.8	100.0
Sensory/speech	34.0	26.7	21.3	15.8	2.1	100.0
Acquired brain injury[(a)]	*33.1	56.3	10.5	—	—	100.0
Physical/diverse	13.7	39.3	30.1	16.0	1.0	100.0
Total	**21.0**	**37.5**	**26.1**	**14.1**	**1.3**	**100.0**

(a) Acquired brain injury is included in 'physical/diverse' when only four main disability groups are being considered (see Box 5.3).

Notes

1. Estimates marked with * have an associated relative standard error (RSE) of between 25% and 50% and should be interpreted accordingly.
2. Estimates marked with ** have an associated relative standard error (RSE) of greater than 50% and should be interpreted accordingly.

Source: AIHW analysis of ABS 2003 Survey of Disability, Ageing and Carers confidentialised unit record file.

While it is well known that the overall population is ageing, there is also evidence that people with early-onset disabilities are living longer than previously (AIHW 2000a; see Chapter 4 for discussion of ageing more generally). A Western Australian study (Leonard et al. 2004:25), based on linked data sets for that state, found that:

> Average life expectancy for affected persons has greatly increased over the past 50 years, such that a person with moderate intellectual disability is expected to live to at least 67 years of age, and people with mild intellectual disability should, on average, live to 74 years of age ... For people with Down syndrome … average survival is now 59 years.

Box 5.4: Interpreting data on age at onset

Survey information about 'age when accident happened/onset of main disabling condition' is used as a proxy measure to indicate 'age of onset of disability,' and this information was not collected among people living in cared accommodation. Therefore some data limitations need to be considered. For instance, the exclusion of people in cared accommodation affects comparisons among condition groups, possibly associated with underestimates of some disabilities in the older age groups. The analysis in Table 5.3 relates to 'main' conditions only. (This information was collected for main disabling condition only.) A person with an early-onset condition who has learned to cope with that condition might find a recently acquired condition more disabling and report this as the main condition.

Comparisons of ages of onset among people of different current ages are not attempted, as the survey data are cross-sectional – essentially a snapshot at a point in time. This means that for each age group, there is a limited range of possible ages of onset – for instance, a person aged under 45 cannot have a disability reported to have begun at age 50.

The reported patterns of onset partly reflect current age structures of the population. The high proportion of people reporting onset before age 65 relates to the high proportion of people with a disability who were aged under 65 in 2003 (65% – Table 5.1 – 2,556,000 of 3,946,400).

The relationship between disability and ageing thus has several facets. The picture for people aged 45–64 years with a disability is of particular interest. These are people who are approaching the years when they may need aged care, or to make a transition from disability services to aged care services. The great majority of these people had a physical disability in 2003 (82%, based on the main condition reported) and, for most, this had commenced in adult years (only 7.4% had an age of onset under 15 years; see Table A5.4). In contrast, the relatively small proportion of people in the 45–64 years age group reporting a main condition associated with intellectual disability (0.5%) were very likely (78%) to report the age of onset as being 14 years or under.

People in older age groups needed more frequent assistance than younger people, and with more core activities. People aged 65+ years, with a disability, were much more likely to report needing assistance 6+ times per day than younger people, and this held across all disability groups (see Table A5.3). Most notably, 48% of people aged 65+ with intellectual disability reported needing assistance 6+ times per day, compared to 10% of

those aged under 65. Of those with psychiatric disability, 29% reported needing assistance 6+ times per day, compared to 5% of those aged under 65. There was no indication that people aged 45–64 years had more frequent needs for assistance than those aged under 45 years and, in fact, there were higher proportions needing no help with any core activities.

Among people with profound or severe core activity limitations, almost 40% of those aged 65+ years needed assistance with two or three of the core activities, compared to 38% of those aged 0–44 years and 35% of those aged 45–64 years (Table 5.4). Older people also had higher numbers of health conditions associated with disability (see Figure 5.5).

Table 5.4: People with a profound or severe core activity limitation living in households: number of activities with which assistance needed, by age, 2003

	0–44 years		45–64 years		Total <65 years		65+ years	
	Number ('000)	Per cent	Number ('000)	Per cent	Number ('000)	Per cent	Number ('000)	Per cent
At least one of ten daily activities[(a)]	376.2	97.8	273.4	98.8	649.5	98.2	405.1	99.6
One core activity	223.2	58.0	174.9	63.2	398.0	60.2	238.4	58.6
Two core activities	94.8	24.6	91.1	32.9	185.9	28.1	141.3	34.7
Three core activities	51.7	13.4	*5.9	*2.1	57.6	8.7	20.8	5.1
Total with two or three core activities	146.5	38.1	97.0	35.0	243.5	36.8	162.1	39.8
Total profound or severe	**384.7**		**276.7**		**661.4**		**406.9**	

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

Note: Estimates marked with * have an associated relative standard error (RSE) of between 25% and 50% and should be interpreted accordingly.

Source: AIHW analysis of ABS 2003 Survey of Disability, Ageing and Carers confidentialised unit record file.

Disability trends 1981–2003

As the population grows and ages and as life expectancy increases, there will be more people in Australia at older ages and more people with disabilities, but there is no evidence that the age-standardised rates of severe disability are rising (ABS 2004a; AIHW 2000a, 2003a). The evidence from the five population disability surveys since 1981 is that:

- the reported age-standardised rates of 'severe disability' in Australia were fairly stable between 1981 and 1993;
- there was an increase in rates from 1993 to 1998, mainly attributed, after considerable analysis, to changes in the survey methodology, questions and administration, and population ageing;
- the 2003 survey maintained the 1998 survey questions and methods, and the results confirmed the previous, stable rates of 'severe disability'. The age-standardised rates for profound or severe core activity limitations were 6.4% in 1998 and 6.3% in 2003; and
- overall, then, it has been concluded that there was no change in rates for profound or severe core activity limitations between 1981 and 2003. The rise in reported rates in 1998 is attributable to survey methodology changes rather than population changes.

Even though underlying age-specific prevalence rates appear relatively stable, population growth and population ageing are associated with an increase in the number of people with a disability. Between 1998 and 2003, the number of people with a profound or severe core activity limitation increased by 9.6%, from 1,135,900 to 1,244,500 (ABS 1999, 2004a). With population ageing, the increase in the number of older people (aged 65 and over) with a disability could be associated with an increase in the overall number of people with multiple health conditions and people needing more frequent assistance with daily activities (because of the association of these with age—see Tables A5.3, A5.6; AIHW 2004b).

Children with a disability

There are distinctive patterns of disability in childhood years which deserve special attention. The AIHW compiled a report on the topic in 2004 (AIHW 2004a). Some key findings from this report are updated here.

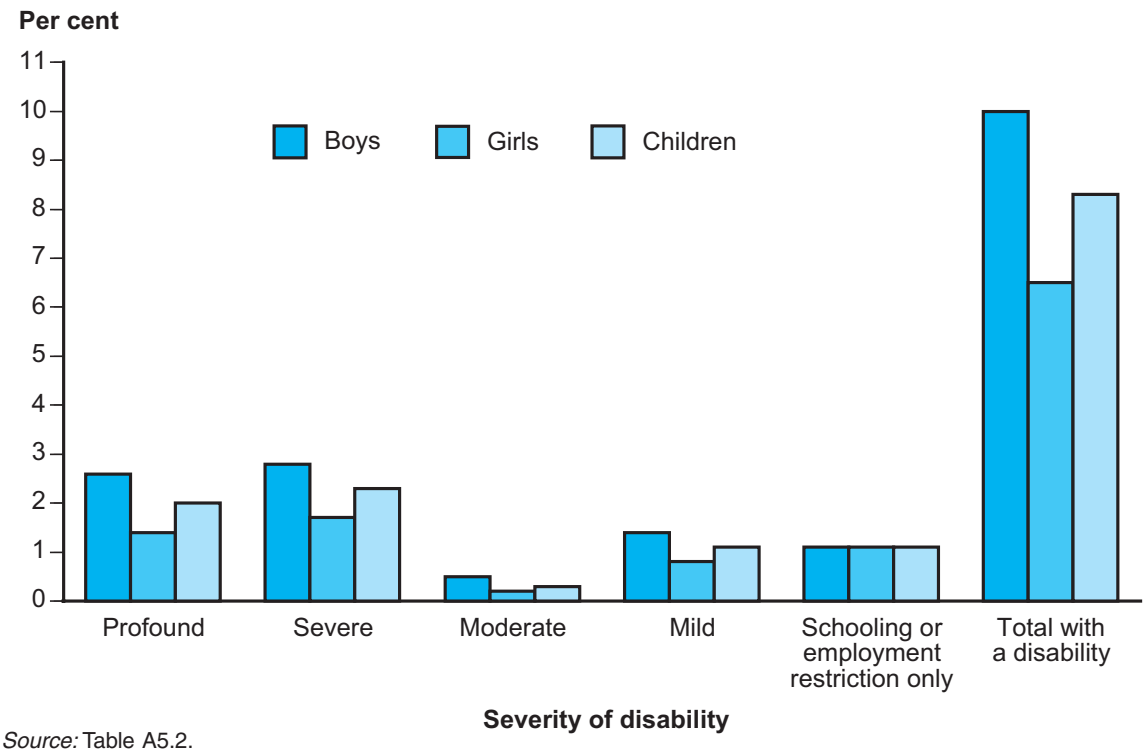
In 2003, children aged under 15 years had higher rates of profound or severe core activity limitation (4.3%) than people in the next age group (2.2% of 15–24 year olds; see Table 5.1). Congenital conditions, present since birth, do not simply disappear when people reach 19 years of age, and the downturn observed in Figure 5.3 could be related to a number of factors. These could include: successful interventions in childhood that have increased the level of functioning; the person moving to more inclusive or accepting environments than school; or a reduction in the person's own propensity to report difficulties with daily activities (in comparison, say, with parents' responses on the child's behalf in previous years).

It is possible that the environment of family, early intervention services and school may combine in the early years to identify a greater proportion of disabilities than at later ages. It may also be that 'communication' as a core activity has a particular influence on profound or severe core activity limitation rates in childhood—in 1998, children with disabilities were far more likely to report profound or severe core activity limitations involving communication than did other people with disabilities (AIHW 2004a:17–18).

Another possible factor in this pattern, but one on which the evidence is not clear, is that prevalence rates of related conditions may have risen in recent years. For instance, Attention Deficit Hyperactivity Disorder (ADHD) and autism are conditions where numbers are reportedly rising; some researchers attribute this mainly to changing diagnostic methods and increased awareness of the conditions (AIHW 2004a:37–40).

In 2003, 10% of boys, and 6.5% of girls aged under 15 years had a disability (Figure 5.4; Tables A5.2, A5.5). There were age and sex differences in both prevalence rates and severity:

- Higher disability rates for boys also held across all age groups—for instance, of boys aged 5–9 years, 12% reported disability and 2.9% reported 'profound' core activity limitations; the figures for girls aged 5–9 years were 6.4% and 1.5% respectively.
- Boys were more likely than girls to report disability in all 'severity' categories; 2.6% of boys and 1.4% of girls reported 'profound' disability. While the rates for boys were higher in most age and severity groups, the pattern was not universal.
- The higher rates for boys held, in a fairly consistent pattern, across all disability groups.



Source: Table A5.2.

Figure 5.4: Children aged under 15 years with a disability, disability status by sex, 2003

Disability among Aboriginal and Torres Strait Islander peoples

Data on disability among Aboriginal and Torres Strait Islander people have been inadequate, but national statistics have recently been significantly improved. The National Aboriginal and Torres Strait Islander Social Survey (ABS 2004b) has overcome a number of the challenges previously identified for this field, although the question of Indigenous conceptualisation of disability still remains for discussion (e.g. AIHW 1999:224).

In 2002, 102,900 (37%) of Aboriginal or Torres Strait Islander people aged 15 years and over had a disability or a long-term health condition (Table 5.5). Of these, 21,800 (or 8% of the population aged 15 years and over) had a profound or severe core activity limitation, meaning that they always or sometimes needed assistance with activities of everyday living (self-care, mobility and communication). These estimates are not strictly comparable with those for the general population presented previously in this section (e.g. Table 5.1). There were fewer survey screening questions in remote areas, probably leading to under-enumeration of physical and psychiatric disabilities in these areas and in the overall estimates (which use common criteria for both remote and non-remote areas) (ABS & AIHW 2005).

The disability status of Indigenous people can be compared to that of non-Indigenous people in the General Social Survey, using broader criteria, for non-remote areas (ABS & AIHW 2005). The Indigenous to non-Indigenous age-standardised rate ratio for people aged 18 years and over with a profound or severe core activity limitation is calculated to be 2.1 (2.5 for males, 1.8 for females).

This means that, if the Indigenous and non-Indigenous populations had the same age structure as the total Australian population, the number of Indigenous people in non-remote areas with profound or severe core activity limitation would be 2.1 times the corresponding number of non-Indigenous people. If the broader criteria used in non-remote areas had been used in remote areas, it is likely that the prevalence estimates for remote areas would be higher, as would the rate ratios. In general terms, then, it can be said that Aboriginal and Torres Strait Islander people have severe disability rates at least 2.1 times those of other Australians.

Table 5.5: Aboriginal and Torres Strait Islander people aged 15 or over by disability status, Australia, 2002

	Profound/severe core activity limitation		Disability/ limitation (nfd)		Total with disability or long-term health condition		Has no disability or long-term health condition		Total	
Age group	No. ('000)	Per cent	No. ('000)	Per cent	No. ('000)	Per cent	No. ('000)	Per cent	No. ('000)	Per cent
Males										
15–24	*1.6	4.0	7.2	17.6	8.9	21.6	32.3	78.4	41.2	100.0
25–34	2.3	6.9	7.7	22.9	10.0	29.8	23.5	70.2	33.4	100.0
35–44	1.4	5.2	8.8	32.2	10.2	37.4	17.1	62.6	27.4	100.0
45–54	1.9	10.4	8.0	43.5	9.9	53.9	8.5	46.1	18.5	100.0
55–64	1.1	12.0	5.2	59.1	6.3	71.1	2.6	28.9	8.9	100.0
65+	1.7	28.7	2.8	48.0	4.5	76.7	1.4	23.3	5.9	100.0
Total	*10.0*	*7.4*	*39.8*	*29.5*	*49.8*	*36.9*	*85.4*	*63.1*	*135.2*	*100.0*
Females										
15–24	*1.5	3.6	8.4	20.3	9.9	23.9	31.6	76.1	41.5	100.0
25–34	1.9	5.0	8.7	23.2	10.6	28.2	27.0	71.8	37.7	100.0
35–44	2.7	8.9	9.1	29.9	11.8	38.9	18.6	61.1	30.4	100.0
45–54	2.8	14.1	6.3	31.5	9.1	45.6	10.8	54.4	19.9	100.0
55–64	1.3	12.7	5.5	52.6	6.8	65.3	3.6	34.7	10.4	100.0
65+	1.6	22.3	3.3	46.6	4.8	68.8	2.2	31.2	7.0	100.0
Total	*11.8*	*8.0*	*41.3*	*28.1*	*53.1*	*36.1*	*93.9*	*63.9*	*147.0*	*100.0*
Persons										
15–24	3.1	3.8	15.7	19.0	18.8	22.7	63.9	77.3	82.7	100.0
25–34	4.2	5.9	16.4	23.1	20.6	29.0	50.5	71.0	71.1	100.0
35–44	4.1	7.2	17.9	31.0	22.0	38.2	35.7	61.8	57.8	100.0
45–54	4.7	12.3	14.3	37.3	19.0	49.6	19.4	50.4	38.4	100.0
55–64	2.4	12.4	10.7	55.6	13.1	68.0	6.2	32.0	19.3	100.0
65+	3.2	25.2	6.1	47.2	9.3	72.4	3.6	27.6	12.9	100.0
Total	**21.8**	**7.7**	**81.1**	**28.7**	**102.9**	**36.5**	**179.3**	**63.5**	**282.2**	**100.0**

Notes

1. 'Total with disability or long term health condition' is the sum of persons with 'profound/severe core activity limitation' and persons with 'disability/limitation nfd'.
2. Common criteria were used to identify persons with a disability in both non-remote and remote areas. This means that people with a psychological disability cannot be explicitly identified and some people with physical disability will not be included.
3. Estimates marked with * have an associated relative standard error (RSE) of between 25% and 50% and should be interpreted accordingly.

Source: ABS & AIHW 2005.

Among Aboriginal and Torres Strait Islander people aged 18–64 years, those with a disability or long-term health condition had completed fewer years of school on average than other people. In non-remote areas, 52% of Indigenous people with a disability or long-term health condition had completed only Year 9 or below, compared with 28% of people without a disability or long-term health condition. In remote areas, the corresponding proportions were 64% and 43% (Table 5.6). Indigenous people in remote areas with a profound or severe core activity limitation were the least likely to have progressed beyond Year 9, with 71% educated to this level or below. People with no disability were about twice as likely as others to have completed Year 12, in both remote and non-remote areas.

Table 5.6: Aboriginal and Torres Strait Islander people aged 18–64 years or over by highest year of school completed by remoteness and disability status (per cent), 2002

	Non-remote area				Remote area			
Highest year of school completed	Profound or severe core activity limitation	Total with a disability or long-term health condition	No disability or long-term health condition	Total	Profound or severe core activity limitation	Total with a disability or long-term health condition	No disability or long-term health condition	Total
Completed Year 12	*12.1	11.8	25.6	20.3	*6.2	8.3	17.0	13.7
Completed Year 10 or 11	33.4	36.0	46.9	42.8	*23.3	28.2	39.7	35.3
Completed Year 9 or below[(a)]	54.5	52.2	27.5	37.0	70.5	63.5	43.3	50.9
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**
Total (number)[(b)]	**14,000**	**69,300**	**111,600**	**180,900**	**6,700**	**26,100**	**42,900**	**69,100**

(a) Includes persons who never attended school.

(b) Excludes persons who were still at school.

Notes

1. Common criteria were used to identify persons with a disability in both non-remote and remote areas. This means that people with a psychological disability cannot be explicitly identified and some people with physical disability will not be included.
2. Estimates marked with * have an associated relative standard error (RSE) of between 25% and 50% and should be interpreted accordingly.

Source: ABS & AIHW 2005.

Aboriginal and Torres Strait Islander people with a disability or long-term health condition were much less likely to be employed, especially full-time, and less likely to be in the labour force than those without a disability or long-term health condition (Table 5.7). This was true for both men and women. People with a profound or severe core activity limitation were the least likely to be employed, with only 30% of men and 23% of women being employed either full-time or part-time, compared with 70% of men and 49% of women with no disability or long-term health condition. Most people with a profound or severe core activity limitation were not in the labour force (56% of men and 72% of women).

Employment is not the only area of further disadvantage experienced by Aboriginal and Torres Strait Islander people with disabilities. In 2002, they also experienced lower income levels and were more likely to have been removed from their natural families (ABS & AIHW 2005). The reasons for these multiple disadvantages may be related to age and geography, as well as to other complex social factors. Nevertheless, it is clear that Aboriginal and Torres Strait Islander people with disabilities were more likely to be

experiencing a range of other social disadvantages than other Indigenous people, themselves generally disadvantaged when compared with other Australians.

Social participation is a notable exception to this pattern. Some 61% of Aboriginal and Torres Strait Islander people aged 15 years and over in non-remote areas, and 87% in remote areas, had attended a cultural event in the 12 months before the survey; 90% had been involved in social activities in the previous 3 months (ABS & AIHW 2005). People with varying levels of disability were equally involved in these activities.

Table 5.7: Indigenous persons aged 18–64 years, labour force status by disability status and sex, 2002 (per cent)

	Males				Females			
	Profound or severe core activity limitation	Disability or long-term health condition	No disability or long-term health condition	Total	Profound or severe core activity limitation	Disability or long-term health condition	No disability or long-term health condition	Total
Employed full-time	*10.8	25.0	45.9	38.2	*4.2	12.6	21.9	18.5
Employed part-time	*19.0	19.3	23.8	22.2	18.2	18.8	27.5	24.4
Total employed	*29.8*	*44.4*	*69.8*	*60.5*	*22.5*	*31.5*	*49.4*	*43.0*
Total unemployed	*14.3	15.5	16.3	16.0	*5.5	10.2	10.4	10.3
Not in the labour force	56.0	40.1	13.9	23.5	72.0	58.3	40.2	46.7
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**
Total (number)	**7,700**	**41,600**	**71,700**	**113,400**	**9,800**	**44,900**	**80,300**	**125,200**

Notes

1. Common criteria were used to identify persons with a disability in both non-remote and remote areas. This means that people with a psychological disability cannot be explicitly identified and some people with physical disability will not be included.
2. Estimates marked with * have an associated relative standard error (RSE) of between 25% and 50% and should be interpreted accordingly.

Source: ABS & AIHW 2005.

Disability, related health conditions and other factors

Disability and its components (i.e. impairments, activity limitations and participation restrictions) are related to health conditions, environmental factors and personal factors (see Figure 5.1).

The presence of multiple health conditions tends to be associated with more 'severe' disability (Figure 5.5; Table A5.6). In 2003, the average number of conditions for people in the general population was 0.9, for people with a disability 3.1, and for people with a profound core activity limitation 4.1. Older age groups (65+ years) had higher average numbers of health conditions, across all categories of disability status.

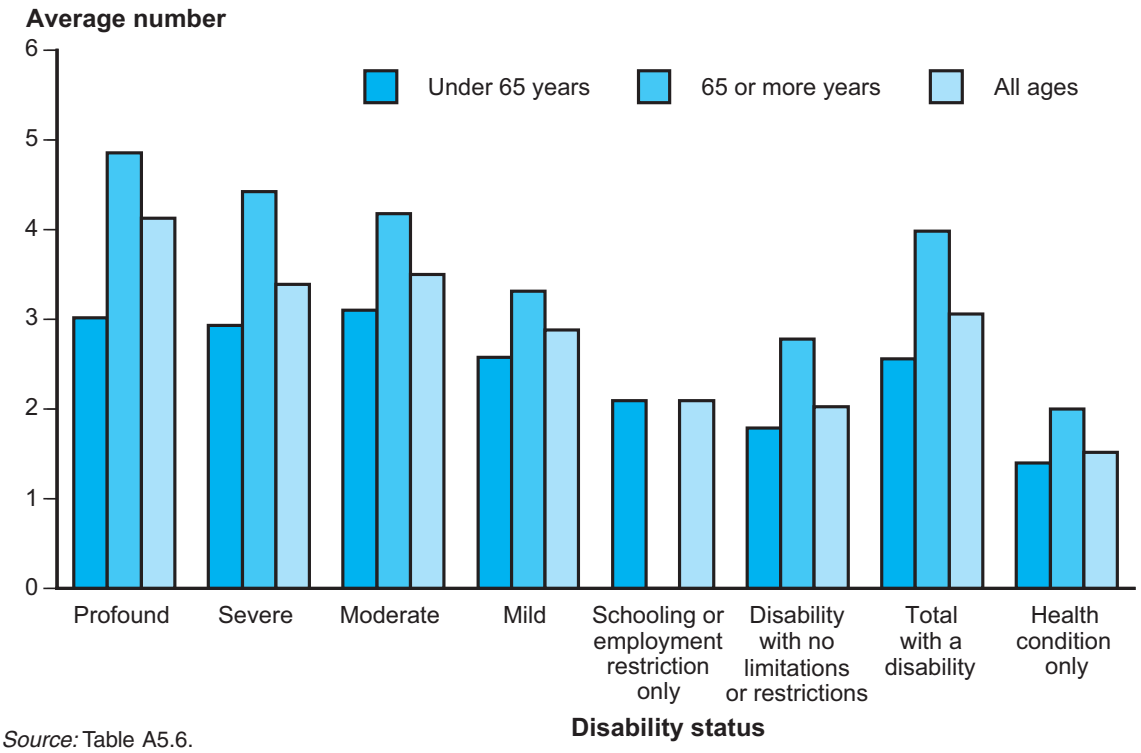
The relationship between health conditions and disability can be looked at in a number of ways. One way is by examining health conditions most likely to be associated with profound or severe core activity limitation. The 15 health conditions (of those recorded in the disability survey) most likely to be associated with profound or severe core activity limitations are shown in Figure 5.6. Of people aged under 65 with autism in

2003, 82% reported such limitations in 2003, as did 79% of those with paralysis, 67% of those with speech-related conditions and 64% of those with cerebral palsy (Figure 5.6). Dementia (98%) led the list of top five conditions for people aged 65 years and over with a profound or severe core activity limitation, followed by 89% of those with paralysis, 87% of those with speech-related conditions, 79% with Parkinson's disease and 76% with schizophrenia. Most of these conditions are highly related to age.

Another way of looking at the relationship between disability and health conditions is to ask the question: when looking at profound or severe core activity limitation in the population, which are the most common associated diseases or conditions? Here, a different picture emerges, related to the prevalence of the health conditions themselves.

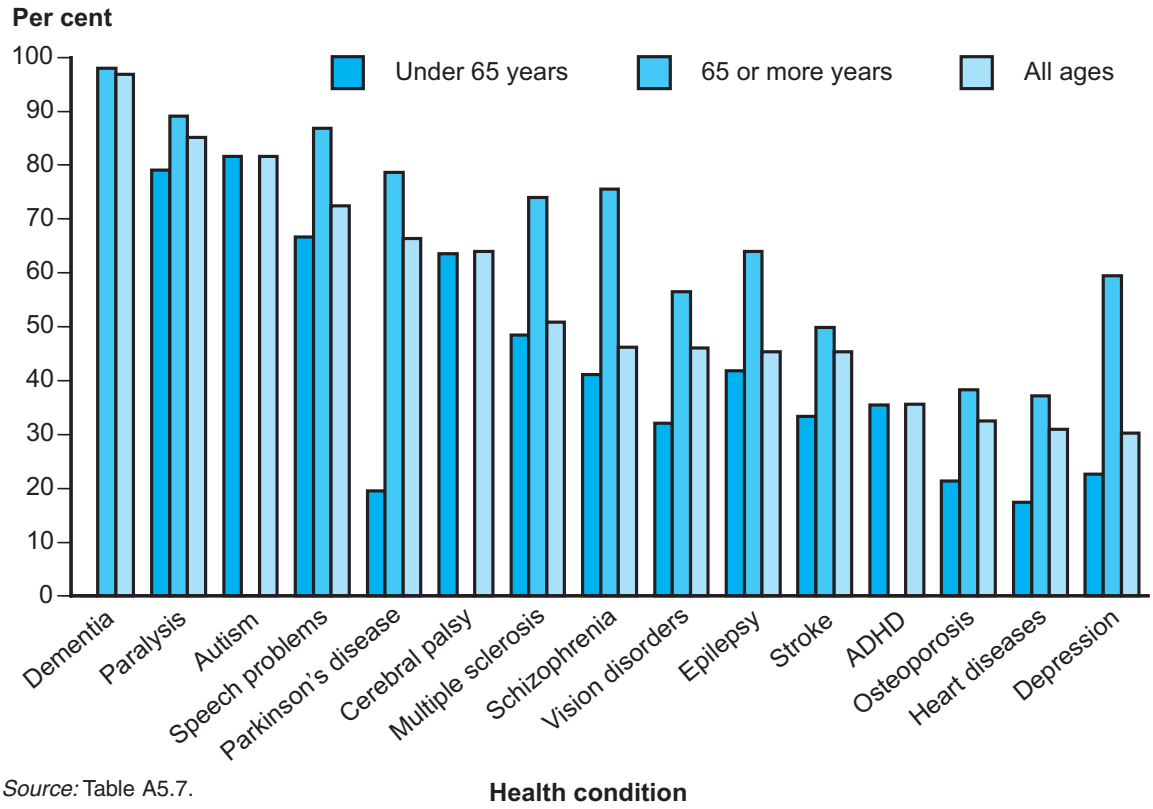
The leading conditions associated with profound or severe core activity limitations among people aged under 65 in 2003 were back problems and arthritis—1.2% of people of this age reported back problems and a profound or severe core activity limitation, and 0.9% reported arthritis and a profound or severe core activity limitation (Figure 5.7; Table A5.8). For the population of all ages, arthritis, hearing, and back problems led the list. Conditions such as ADHD, autism and dementia, while highly likely to be related to profound or severe core activity limitations, were less common as they were generally less prevalent (Figure 5.7; Table A5.8, and AIHW 2004b).

It is not suggested that these conditions and diseases explain or 'account for' most disability in the population. The ICF model does not suggest direct causal relationships, but rather acknowledges that a health condition is one of several important factors in the creation of disability (see Figure 5.1).



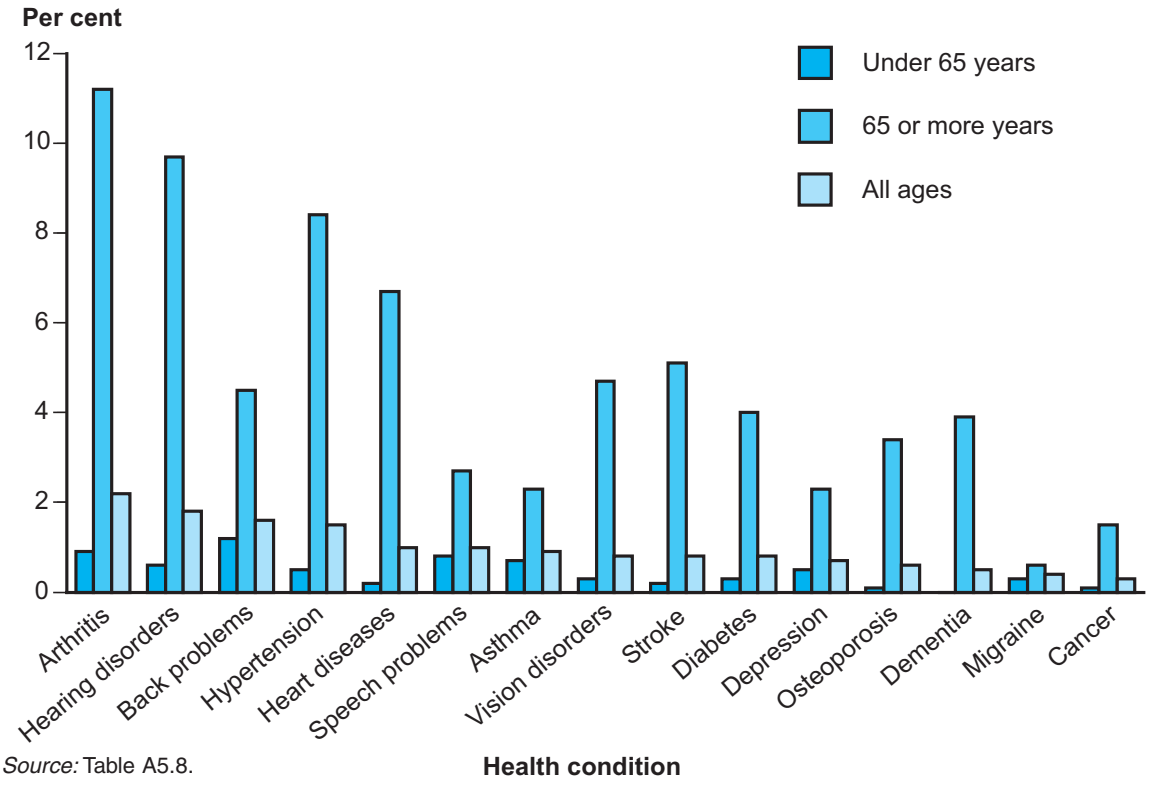
Source: Table A5.6.

Figure 5.5: Average number of health conditions in the population, by disability status and age group, 2003



Source: Table A5.7.

Figure 5.6: Proportion of profound or severe core activity limitation among people with a specific health condition (based on all conditions), by age, 2003



Source: Table A5.8.

Figure 5.7: People with a profound or severe core activity limitation: prevalence rate of health conditions (based on all conditions), by age, 2003

Further analyses have been conducted to examine the relationships between disability, environmental and personal factors as well as health conditions, and how these relationships vary with different measures of 'severity' of disability. Findings from these analyses are summarised in Box 5.5.

Box 5.5: Disability, health conditions and other factors, 1998—multivariate analyses

Multivariate analyses – conducted to investigate the interrelationships between disability, health conditions, and environmental and personal factors – did not reveal key, simple indicators of disability severity from among all the factors it was possible to consider. Rather, they confirmed the complexity of relationships between disability severity, health conditions, and personal and environmental factors.

Personal factors (demographic characteristics, such as age and sex, and socioeconomic factors such as education and employment) and environmental factors (such as informal care and use of equipment) were found to be strongly related to severity of disability. The further variability in these relationships, according to specific health conditions, suggests that health conditions also play a complex and varying role in the creation of disability, although these effects are not simple to predict. The fact that a number of health conditions are very age-related (e.g. dementia and autism) further complicates the relationships. Overall, it appears likely that there are three-way interactions between the severity of disability, the environmental factors that may affect it, and the underlying long-term conditions associated with the disability.

The main results were reasonably similar for the severity measures examined: regularity of need for assistance with core activities (sometimes, always, never); frequency of need for assistance (daily, 3 times a day, etc.); and hours of informal care. This may not be surprising given the probable relationship between these measures.

The number of long-term conditions a person had was highly correlated with the severity of disability, however measured. This means that co-morbidity is very important in examining the relationships between particular conditions and the severity of disability.

The multivariate analyses also found that use of equipment, as one of the 12 personal and environmental factors under consideration, was associated with profound or severe core activity limitation.

Source: AIHW 2004b.

Environmental factors: equipment

Equipment is a key aspect of people's environment, and one which can significantly facilitate functioning. In 2003 a total of 1,886,200 people (48% of people with a disability) used equipment (Table 5.9).

For people aged under 65 years with a disability, the most commonly used equipment was 'medical aids' (used by 611,000 people or 24% of people with disability in this age group) and mobile or cordless phones (222,800 or 8.7%) (Table 5.8). Equipment of all kinds was likely to be used by people with profound activity limitations, especially equipment associated with the core activities—self-care, mobility and communication.

Medical aids were used by 29% of people with a profound core activity limitation; aids for showering/bathing were used by 19%; aids for toileting 12% and incontinence 11%; wheelchairs—manual by 9% and electric by 3%; and mobile or cordless phones by 16%.

Table 5.8: Aids and equipment used by people aged under 65 years with a disability, by type of aid/equipment and disability status, 2003

	Core activity restriction									
	Profound		Severe		Moderate		Mild		Total with disability	
	No. ('000)	Per cent	No. ('000)	Per cent	No. ('000)	Per cent	No. ('000)	Per cent	No. ('000)	Per cent
Aid/equipment used										
Eating aids	11.4	4.9	*5.6	*1.3	**0.2	**0.0	**1.3	**0.2	18.5	0.7
Showering/bathing aids	43.7	18.8	37.3	8.4	15.2	3.5	*3.7	*0.6	100.0	3.9
Toilet aids	27.3	11.7	12.0	2.7	7.9	1.8	**0.7	**0.1	47.8	1.9
Incontinence aids	24.7	10.6	*6.0	*1.4	6.2	1.4	*2.4	*0.4	39.3	1.5
Dressing aids	17.0	7.3	17.9	4.0	4.3	1.0	—	—	39.2	1.5
Electric wheelchair/ scooter	*6.9	*3.0	*3.3	*0.7	—	—	**0.3	**0.1	10.5	0.4
Manual wheelchair	20.4	8.8	*3.3	*0.7	—	—	—	—	23.7	0.9
Cane	*5.5	*2.4	*7.6	*1.7	*4.0	*0.9	—	—	17.2	0.7
Crutches/walking stick	20.3	8.7	33.7	7.6	12.3	2.8	*7.0	*1.1	73.2	2.9
Walking frame	12.3	5.3	*4.6	*1.0	**1.9	**0.4	—	—	18.8	0.7
Seating/bedding aids	18.3	7.9	21.2	4.8	*6.7	*1.5	**1.4	**0.2	47.6	1.9
Other mobility aids	10.1	4.3	*5.6	*1.3	**0.8	**0.2	*3.6	*0.6	20.1	0.8
Reading/writing aids	13.3	5.7	11.3	2.5	*2.8	*0.6	*8.5	*1.4	35.9	1.4
Speech aids	*5.3	*2.3	*2.5	*0.6	**0.4	**0.1	—	—	*8.2	*0.3
Mobile/cordless phone	37.9	16.3	95.9	21.5	45.4	10.4	29.9	4.8	222.8	8.7
Fax machine	**1.4	**0.6	*9.3	*2.1	*4.0	*0.9	**2.1	**0.3	19.6	0.8
Meal preparation aids	*8.3	*3.6	15.9	3.6	*4.9	*1.1	**0.4	**0.1	32.2	1.3
Medical aids	68.2	29.3	153.9	34.6	142.2	32.6	126.1	20.1	611.0	23.9
Total	**232.6**	**. .**	**445.1**	**. .**	**436.5**	**. .**	**626.7**	**. .**	**2,556.0**	**. .**

Notes

1. Aids or equipment used are those needed because of disabling conditions.
2. Reading/writing and speech aids include both low and high technology aids.
3. 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 only are not presented but included in total with disability.
4. Estimates marked with * have an associated relative standard error (RSE) of between 25% and 50% and should be interpreted accordingly.
5. Estimates marked with ** have an associated relative standard error (RSE) of greater than 50% and should be interpreted accordingly.

Source: AIHW analysis of ABS 2003 Survey of Disability, Ageing and Carers.

Table 5.9: Aids and equipment used, by type of aid/equipment and age group (people with a disability), 2003

	0–14 years		15–29 years		30–44 years		45–64 years		65+ years		All ages	
	No. ('000)	Per cent	No ('000)	Per cent	No ('000)	Per cent	No. ('000)	Per cent	No. ('000)	Per cent	No. ('000)	Per cent
Self-care	24.8	16.8	19.7	11.5	45.4	14.1	154.8	17.8	785.2	32.7	1,030.0	26.3
Mobility	11.6	7.8	12.9	7.5	43.8	13.7	145.9	16.8	699.5	29.1	913.7	23.4
Communication	39.2	26.6	41.6	24.3	67.6	21.0	148.8	17.1	175.9	7.3	473.2	12.1
Hearing	10.2	6.9	11.7	6.8	14.6	4.5	72.7	8.4	344.3	14.3	453.4	11.6
Meal preparation	*2.5	*1.7	*4.2	*2.4	*8.2	*2.6	17.3	2.0	28.0	1.2	60.2	1.5
Medical	59.4	40.2	81.3	47.4	141.5	44.1	328.9	37.9	371.3	15.4	982.3	25.1
Total aids used	**147.6**	**100.0**	**171.4**	**100.0**	**321.2**	**100.0**	**868.3**	**100.0**	**2,404.1**	**100.0**	**3,912.7**	**100.0**
Number of users	104.8	71.0	125.5	73.2	207.1	64.5	525.5	60.5	923.4	38.4	1,886.2	48.2
Average number of aids	1.4		1.4		1.6		1.7		2.6		2.1	

Notes

1. Estimates marked with * have an associated relative standard error (RSE) of between 25% and 50% and should be interpreted accordingly.
2. Estimates marked with ** have an associated relative standard error (RSE) of greater than 50% and should be interpreted accordingly.

Source: AIHW analysis of ABS 2003 Survey of Disability, Ageing and Carers confidentialised unit record file.

The patterns of use of equipment varied somewhat with age (Table 5.8), as might be expected, given the age variations in disability groups and frequency of need for assistance (see also Tables 5.2, A5.3; AIHW 2004b). Medical aids were commonly used in all age groups and:

- Children made frequent use of communication aids (27% of all aids used by children aged under 15 with a disability) and self-care aids (17%).
- People aged 15–29 years (and 30–44 years) with a disability also made frequent use of these aids—24% (and 21%) were communication aids and 12% (and 14%) were self-care aids.
- The pattern changed for people aged 45–64 years, with self-care aids (18%), mobility aids (17%) and communication aids (17%) being the most commonly used apart from medical aids.
- People aged 65 years and over most commonly used self-care aids (33%) and mobility aids (29%).
- People aged 45 years and over reported the highest average number of types of aids used (1.7 for those aged 45–64 years and 2.6 for those aged 65+).

5.4 Services and assistance

This section provides information on the assistance available to people with a disability. Formal services and assistance include:

- income support, particularly disability-specific income support;
- specialist disability support services; and
- relevant generic services, particularly those that specifically target people with a disability.

Most assistance received by people aged under 65 with a disability is provided by family and friends, and these carers are briefly profiled in this section.

Income support

Australian Government payments and allowances

The Australian Government is the main source of income support for people with a disability and for their carers (Box 5.6).

In 2004, the Disability Support Pension (DSP) was the most common payment for people with a disability, with close to 697,000 recipients and accounting for almost $7.5 billion expenditure in 2003–04 (Tables 5.10, 5.11). The Australian Government Department of Veterans' Affairs Disability Pension was received by over 154,000 veterans at a cost of $1.3 billion. Payments to carers accounted for nearly $1.9 billion. Carer Allowance (Child and Adult) payments were received by close to 300,000 recipients in June 2004 (96,153 Carer Allowance Child and 201,454 Carer Allowance Adult) and accounted for $965 million expenditure. Carer Payment was received by over 84,000 recipients at a cost of $921 million.

Box 5.6: Australian Government disability-related payments and allowances

Disability Support Pension *(DSP) is a means-tested income support payment for people aged at least 16 years but under Age Pension (AP) age (at date of claim lodgement), who have a physical, intellectual or psychiatric impairment and an overall impairment rating of at least 20 points on the impairment tables. Eligibility criteria until 30 June 2006 are that, as a result of the impairment, recipients must have an inability to work 30 hours per week at full award wages in open employment, and be unable to undertake educational or vocational training which would equip them for work, within the next 2 years of their life. People of the same age who are permanently blind are also eligible for DSP. Except for permanently blind people, payments are income- and assets-tested, combined tests being applied for people with a spouse/partner. Changes to apply from 1 July 2006 were described earlier in this chapter.*

Mobility Allowance *is a non-means-tested income supplement, paid to people aged 16 years or over with a disability to help with transport costs to employment, vocational training, voluntary work or any combination of these activities, or job search, who are unable to use public transport without substantial assistance. It is also payable to recipients of Newstart Allowance and Youth Allowance.*

Sickness Allowance *is paid to people over 21 years of age but under Age Pension age who are temporarily incapacitated for work or full-time study because of disability, illness or injury and who have a job or full-time study to return to. It is not payable to Youth Allowance recipients who become incapacitated for study.*

Carer Allowance *(Child/Adult) is an income supplement payment available to people who provide daily care and attention in a private home to a person who has a disability or severe medical condition or who is frail aged. The Child Disability Assessment Tool and the Adult Disability Assessment Tool are used to assess eligibility. Up until September 2004 an eligibility requirement was that the care recipient and carer must live together in the same private residence (for Carer Allowance Child) or care must be provided in the home of the carer or care recipient (Carer Allowance Adult). Carer Allowance is free of income and assets tests and may be paid in addition to Carer Payment or other payments.*

Carer Payment *(DSP/AP/other) is an income support payment for people whose caring responsibilities prevent them from substantial workforce participation. The recipient must be providing constant care, permanently or for an extended period of time, to: a person (aged 16 or over) who has a severe physical, intellectual or psychiatric disability that qualifies the carer under the Adult Disability Assessment Tool; or to a child (aged under 16 years) with a profound disability; or to two or more children with disabilities. Carer Payment cannot be received as well as another income support payment, and the person being cared for must be receiving a social security pension or payment (e.g. DSP, AP) or satisfy specific income and assets tests. The recipient is not required to live with or adjacent to the person being cared for, but must be providing constant care in a private home.*

Wife Pension *(DSP/AP) is paid to female partners of DSP or Age Pension recipients who were on these payments as at 30 June 1995. Since 1 July 1995, this payment has been closed to new applicants.*

Newstart Allowance (incapacitated) *and* ***Youth Allowance (incapacitated)*** *provide an exemption from 'activity test requirements' available to people – 21 years or more or under 21 years, respectively – who, due to a medical condition, illness or injury, are temporarily unable to work or, in the case of Youth Allowance, to study.*

Disability Pension *is a compensation payment to veterans for injuries or diseases caused or aggravated by war service or certain defence service on behalf of Australia. Non-veterans may also receive it if they are dependants of deceased or incapacitated veterans.*

Continence Aids Assistance Scheme provides *assistance to people who have permanent and ongoing incontinence as a result of a neurological condition or severe impairment who are aged 16–64 years, or 65+ years and working in paid employment at least 8 hours per week. The aim of the program is to help eligible clients to meet the costs of continence aids.*

Table 5.10: Australian Government disability-related payments and allowances, recipients and expenditure (all ages), 2003–04

	Recipients as at June 2004	Administered expenses 2003–04 ($m)
Disability Support Pension	696,742	7,492.5
Mobility Allowance	47,402	82.2
Sickness Allowance[(a)]	8,478	85.4
Carer Allowance (Child/Adult)[(b)]	297,607	965.4[(c)]
Carer Payment (DSP/AP/other)	84,082	921.0
Wife Pension (DSP)	33,183	326.1
Newstart Allowance (incap.)	51,171	n.a. [(d)]
Youth Allowance (incap.)	3,861	n.a. [(d)]
Continence Aids Assistance Scheme	18,173	10.15
Disability Pension (DVA)	154,602	1,289

(a) From July 2002 FaCS introduced a revised method of counting Sickness Allowance, Newstart Allowance, Mature Age Allowance, Partner Allowance, Widow Allowance, Special Benefit, Youth Allowance and Austudy Payment clients, based on eligibility and entitlement.

(b) Excluded from this count: 17,464 received Carer Allowance (Child) Health Care Card only.

(c) Administered expenses and recipients for Carer Allowance (Child) and Carer Allowance (Adult) are combined.

(d) Administrative expenses for Newstart Allowance (incapacitated) and Youth Allowance (incapacitated) are not available as they are included in the larger funding budget for these two programs.

Sources: DVA 2004; FaCS unpublished data.

For the last decade, there has been an upward trend in the numbers of DSP recipients (Table 5.11; AIHW 2003a:351–2). Several factors have been suggested for these increases—labour market conditions for older workers, changes to eligibility criteria and benefit levels, as well as growth in and ageing of the population. There has also been a steady rise in the numbers of people receiving a reduced rate of DSP, reflecting other sources of income, including employment-derived; however, fewer than 10% of DSP recipients in 2002 and 2003 had earnings from paid employment (FaCS 2002b, 2003). The increase in these numbers is generally commensurate with growth in DSP numbers overall.

Table 5.11: All recipients of disability-related payments and allowances, June 1995 – June 2004

	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
Disability Support Pension (all)	464,430	499,235	527,514	553,336	577,682	602,280	623,926	658,915	673,334	696,742
DSP (maximum rate)	398,964	421,301	449,934	463,577	484,662	501,304	515,839	552,583	563,023	n.a.
DSP (reduced rate)	65,466	77,934	77,580	89,759	93,020	100,976	108,087	106,332	110,311	n.a.
Mobility Allowance	22,851	24,985	26,595	28,975	31,001	35,154	37,574	41,997	44,562	47,402
Sickness Allowance[a]	47,311	33,215	15,759	16,285	11,181	10,733	10,942	9,522	8,755	8,478
Carer Allowance (Child)[b]	78,898	90,644	95,520	90,830	100,452	116,955	111,691	115,404	119,003	96,153
Carer Allowance (Adult)[c]	38,408	42,047	44,103	45,675	51,857	84,104	123,350	153,863	180,606	201,454
Carer Payment (DSP)[d]	10,633	13,483	15,735	18,556	21,392	24,500	28,171	34,963	75,937	84,082
Carer Payment (AP)	8,324	9,500	10,954	11,740	13,407	15,346	18,097	20,227	n.a.[d]	n.a.[d]
Carer Payment (other)	1,141	2,054	2,869	3,683	5,271	7,704	10,922	12,070	n.a.[d]	n.a.[d]
Wife Pension (DSP)	121,839	107,803	91,307	79,892	68,523	59,934	51,225	44,238	37,880	33,183
Wife Pension (AP)	39,611	41,125	36,577	36,233	32,196	31,362	26,476	23,730	20,230	19,646
Newstart Allowance (incapacitated)	n.a.	n.a.	n.a.	48,792	59,670	68,016	76,850	76,882	54,243	51,171
Youth Allowance (incapacitated)	n.a.	n.a.	n.a.	n.a.	3,929	5,883	5,959	5,792	3,941	3,861
Disability Pension (DVA)	157,298	159,079	160,145	161,829	162,810	162,730	162,505	159,425	157,865	154,602

(a) From July 2002 FaCS introduced a revised method of counting Sickness Allowance, Newstart Allowance, Mature Age Allowance, Partner Allowance, Widow Allowance, Special Benefit, Youth Allowance and Austudy Payment clients, based on eligibility and entitlement.

(b) Excluded from these counts are those who receive Carer Allowance (Child) Health Care Card only (only applies to data from 1999 on).

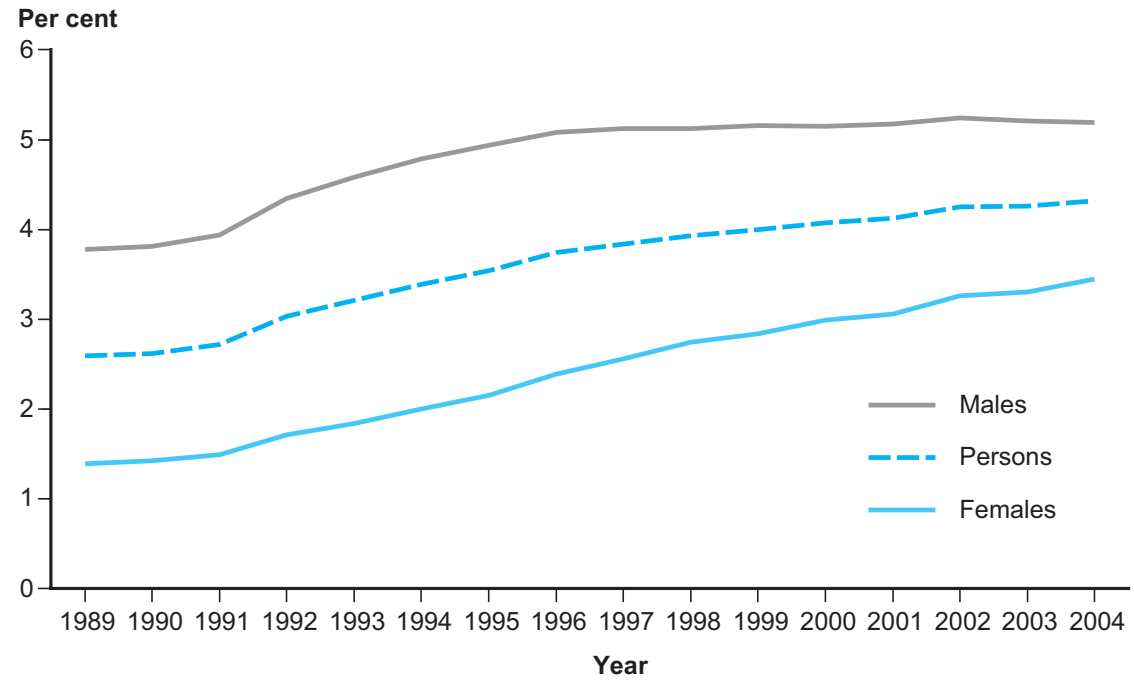
(c) From 2001 includes those who receive both Carer Allowance (Adult) and Carer Allowance (Child) and those not coded by type of payment.

(d) Carer Payment figures split by DSP, AP and other are unavailable for 2003 and 2004; hence totals for Carer Payment (DSP) in 2003 and 2004 are the sum of these components.

Sources: AIHW 2003a; DVA 2003, 2004; FaCS 2001 and FaCS unpublished data.

Several other payments and allowances experienced upward trends in recipient numbers between 1995 and 2004 (Table 5.11). The number of people receiving the Carer Allowance (Adult) continued its steep rise since 2000 (from 84,104 in 2000 to 201,454 in 2004). Similarly, there was a noticeable increase in the number of people receiving Carer Payment, almost twofold over the same period. Several reasons have been suggested for these trends, including demographic changes (e.g. the ageing of the population and associated rise in the number of people with a disability); greater awareness of these payments; reduction in access to other forms of income support (e.g. wife and widow pensions); and the increase in the number of people with disabilities and medical conditions being cared for at home (FaCS 2002b, 2003, 2004c). The Wife Pension (DSP/AP) continued its downward trend since the payment was closed to new applicants in 1995. (See Chapter 4 for further discussion of recent Carer Payment and Carer Allowance data.)

Not all the rise in DSP recipient numbers can be attributed to population growth and ageing, since age-adjusted rates rose over the period 1989–2004 (Figure 5.8; Table A5.9). Male rates have levelled off in recent years (to about 5.2% of the male population aged 16+ years). Male recipients aged 50–64 years—the age group with the highest proportion of the population receiving DSP—accounted for this slowing of growth from 1996; rates for younger age groups have continued a gradual upward trend.



Source: Table A5.9.

Figure 5.8: Disability Support Pension recipients: age-standardised rates by sex, 1989–2004

Female rates have continued to rise, although more slowly and, in 2004, about 3.5% of the female population aged 16+ years received the DSP. As with men aged under 50 years, the proportion of women under 60 years receiving DSP gradually increased over the period, approximately doubling in all age groups since 1990. The age group 60–64 years was where the large changes occurred: the rate grew from 0.2% in 1995 to 8.4% in 2004. The increases in female rates overall could be related to a number of factors, including the closure in 1995 of the Wife Pension to new recipients. The increase in the age group 60–64 years may reflect adjustments to the eligibility ages for Age Pension (60 years to 1995, 62 years in 2002 and due to be 65 years, as for men, by 2014). Trends in female rates could also be affected by changes in the sex relativities of labour force participation and earnings, and how these might affect the partners' combined assets test and, in turn, DSP receipt.

In June 1989, 26% of DSP recipients (80,510 of 307,795) were women compared to 40% in June 2004 (277,913 of 696,742).

Concessions

The Australian Government provides a range of concession cards to eligible people with a disability and their carers. These cards entitle the holder to various concessions on specific national, state and territory, and local government services, as well as some private sector concessions. 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). Other concession areas vary across the country, for instance ambulance travel for isolated patients, glasses, dental care, taxi subsidies, and so on.

A Companion Card scheme currently operates in Victoria and will be introduced in Western Australia during 2005 (Disability Services Commission 2005; Victorian Government 2005). This enables an eligible person with a disability to attend particular events and venues with their carer for the price of a single ticket. The card is for people with a significant permanent disability, who always need a companion to provide attendant care type support (see Chapter 8 for more information on concessions and their costs).

Personal injury compensation schemes

Personal injury compensation schemes are significant sources of income and ongoing support for people with a disability. Schemes, mainly for work- and transport-related injury, operate under specific legislation in each state and territory. National data are few.

The Productivity Commission, in its 2004 review of workers compensation and occupational heath and safety, pointed to 'a total economic cost in excess of $31 billion annually [due to] work-related fatalities, injuries and illnesses' (Productivity Commission 2004b:XXII). The review called for greater national consistency in approaches to workers compensation. It also pointed to the counter-productive aspects of fault-based systems, where compensation is related to the ability to establish fault rather than need.

Disability support services

CSTDA-funded disability support services and expenditure

Services provided under the Commonwealth State/Territory Disability Agreement (CSTDA) are targeted at people with a need for ongoing support in everyday activities, and aim to 'maximise the opportunity for people with disabilities to participate socially and economically in the community' (CSTDA 2003:12) The 2002–07 Agreement specifies that a disability experienced by a CSTDA service user should be manifest before the age of 65 years; however, services generally do not place upper age restrictions on their clients (see Section 5.2 for more details on this Agreement).

The main CSTDA service groups are:

- accommodation support services—providing accommodation, or support to enable a person with a disability to remain in existing accommodation or move to more appropriate accommodation;
- community support services—providing the support needed for a person with a disability to live in a non-institutional setting;
- community access services—providing opportunities for people with a disability to gain social independence;
- respite services—providing a short-term and time-limited break for families and other voluntary caregivers of people with a disability; and
- employment services—providing employment assistance to people with a disability in obtaining and/or retaining paid employment through open employment or supported employment services. Note that people with disabilities also have access to generic employment services (see below).

National data on services provided under the CSTDA are collected through the CSTDA National Minimum Data Set (NMDS), which includes information relating to CSTDA-funded services and the people who use these services throughout a financial year. Data are collected by each state and territory and the Australian Government, and forwarded to the AIHW for national collation and analysis on an annual basis. The NMDS underwent a major redevelopment process during 1999–2002, to better capture the full extent of service usage throughout a year and to include some new items. Before the redeveloped collection was implemented in October 2002, data were collected on a 'snapshot' day—that is, a single day of the year. Data presented here are from the 2003–04 data collection, which is the first full year of data from the redeveloped collection, and represents a new benchmark for future analysis.

Expenditure (by all governments) on disability support services during 2003–04 totalled $3.28 billion (Table 5.12). Over half this expenditure was used to fund accommodation support services ($1,638 million). A further $390 million was spent on community access services, $352 million on community support, and $301 million on employment services. Respite services received $185 million in funding, while $282 million went towards administration costs. (See also Table 8.11 for funding sources for disability services.)

Table 5.12: Expenditure on disability support services by Australian, state and territory governments, by service group and administration expenditure, 2003–04 ($ million)

Service group	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	AustGovt	Aust.
Accommodation support	602.75	481.46	200.02	148.69	119.13	50.34	25.05	11.02	—	1,638.46
Community support	82.67	125.59	46.13	47.11	25.55	7.92	8.11	8.81	—	351.89
Community access	116.71	157.07	58.09	20.75	14.02	12.16	3.10	2.20	5.58[(a)]	389.68
Respite	65.51	41.24	34.02	19.00	10.81	5.16	4.02	1.28	4.43[(a)]	185.47
Employment	—	—	—	—	—	—	—	—	301.28	301.28
Advocacy, information and print disability	7.52	6.39	5.21	1.89	2.18	1.76	0.73	0.12	13.22	39.02
Other support	5.57	33.69	7.83	8.17	10.73	1.01	1.97	0.07	26.07	95.11
Subtotal	*880.73*	*845.44*	*351.30*	*245.61*	*182.42*	*78.35*	*42.98*	*23.50*	*350.58*	*3,000.91*
Administration	111.61	75.37	30.55	14.13	12.85	4.31	4.52	0.99	27.95	282.28
Total	**992.33**	**920.81**	**381.85**	**259.74**	**195.26**	**82.66**	**47.50**	**24.49**	**378.54**	**3,283.18**

(a) Australian Government-funded community access and respite services are not funded under the CSTDA. They are funded under the Disability Services Act Discretionary Fund.

Notes

1. Data presented in this table are from *Report on Government Services 2005* (SCRSSP 2005), for all jurisdictions except Queensland. Queensland data are inclusive of CSTDA-funded specialist psychiatric disability services which are excluded from SCRCSSP reporting.
2. Total expenditure on services quoted from SCRCSSP 2005 includes actual payroll tax for NSW, Victoria (in part), Tasmania and the NT.

CSTDA service users

A total of 187,806 service users accessed CSTDA-funded services during 2003–04 (Table 5.13; AIHW 2005c). The most widely accessed service group was community support (used by 42% of service users), followed by employment (34%) and community access (25%). Employment services were used by 64,281 service users, including 43,042 using open employment, 18,637 supported employment, and 4,100 dual open and supported employment services. Accommodation support services were accessed by 33,175 service users (18%), with 5,303 of these people using institutional accommodation. The proportion of recipients of accommodation support services using 'community-based' services (that is, accommodation other than institutions and hostels) rose from 60% on the 1995 snapshot day to 73% in 2001 and 2002 (AIHW 2001; SCRCSSP 2002, 2003). These trends are not comparable with 2003–04 data because full financial year data are now collected.

Table 5.13: Users of CSTDA-funded services, service group by state and territory, 2003–04

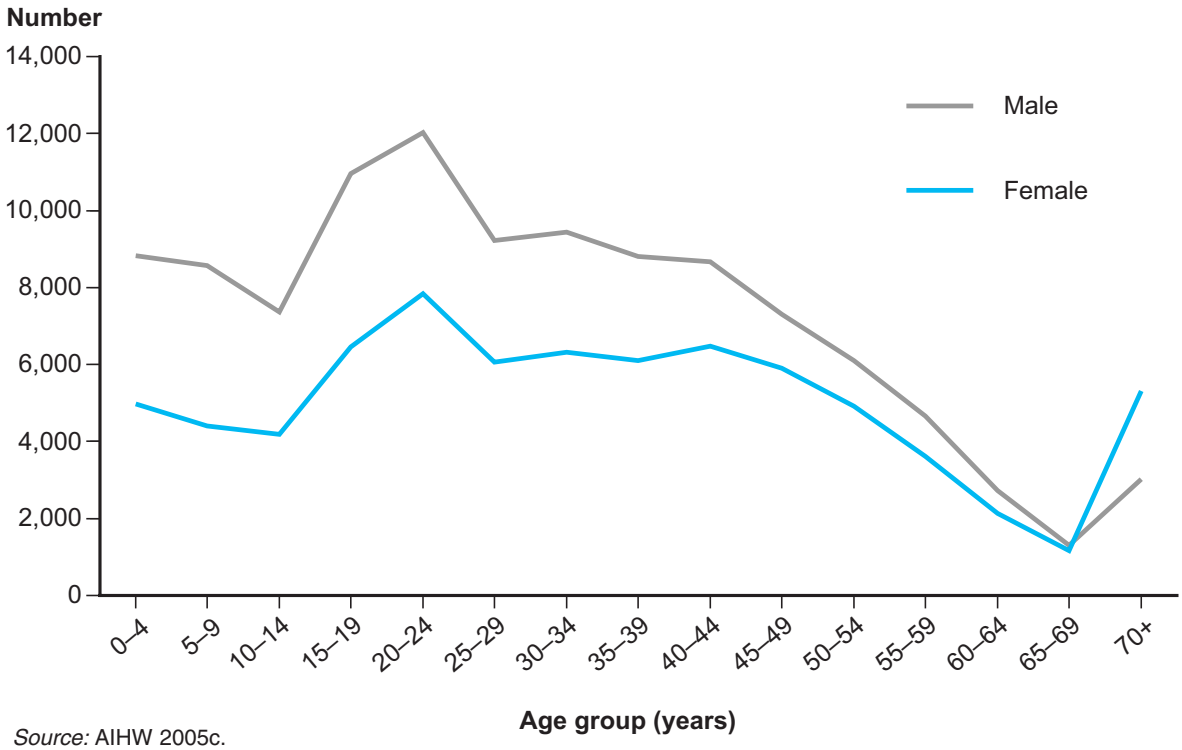
Service group	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total	%
Accommodation support	6,440	12,989	4,933	3,136	4,069	1,069	334	212	33,175	17.7
Institutions/residentials/hostels	1,824	942	935	518	866	218	0	0	5,303	. .
Group homes	3,345	4,490	903	1,092	674	460	200	146	11,308	. .
Other accommodation types	1,440	7,768	3,228	1,576	2,635	420	136	71	17,271	. .
Community support	18,013	28,485	8,564	11,138	9,916	2,173	188	509	78,847	42.0
Community access	6,483	18,441	5,354	10,354	4,827	1,493	419	286	47,636	25.4
Respite	4,153	8,607	3,306	2,464	1,390	238	255	155	20,547	10.9
Employment	19,003	18,283	12,036	6,217	5,911	1,667	898	410	64,281	34.2
Open employment	11,915	12,480	9,831	3,939	3,098	861	704	304	43,042	. .
Supported employment	6,695	4,454	2,058	1,946	2,780	532	82	117	18,637	. .
Open and supported employment	854	1,786	319	491	211	302	122	15	4,100	. .
Total service users	**43,619**	**68,238**	**26,352**	**22,896**	**19,099**	**5,197**	**1,638**	**1,258**	**187,806**	**. .**
Total per cent	**23.2**	**36.3**	**14.0**	**12.2**	**10.2**	**2.8**	**0.9**	**0.7**	**. .**	**. .**

Notes

1. Service user data are estimates after use of a statistical linkage key to account for individuals who received services from more than one service type outlet during the twelve month period from 1 July 2003 to 30 June 2004. Service type totals may not be the sum of components since individuals may have accessed more than one service type during the 12-month period. Totals for Australia may not be the sum of the components since individuals may have accessed services in more than one state or territory during the twelve month period.
2. Victorian data are reported to be significantly understated; errors in the 'date of last service received' as well as a lower than expected response rates have led to under-counting of service users in the current year.

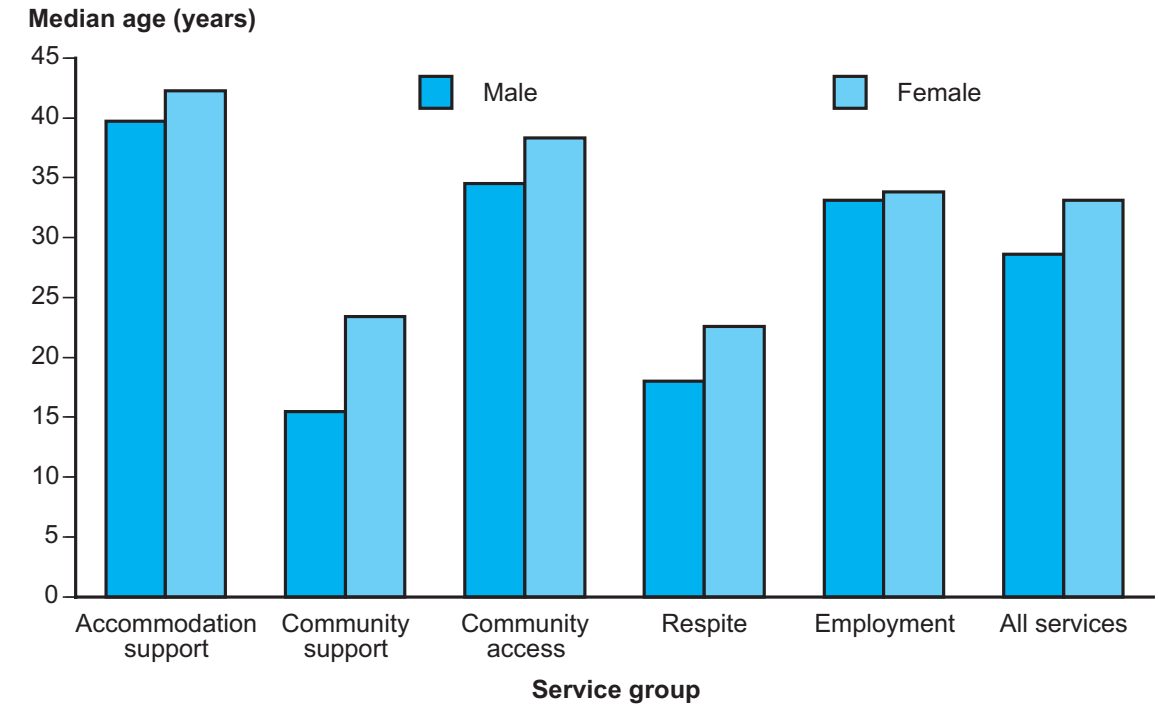
Source: AIHW 2005c.

Around three-fifths of service users in 2003–04 were male (110,177 or 59%) (AIHW 2005c). There was a higher number of males in all 5-year age groups except for those aged 70 years or more (Figure 5.9). The number of service users was highest for the 20–24 age group, for both sexes. Female service users had a higher median age than males, across all service groups (Figure 5.10). The difference in median age was greatest for users of community support services (23.4 years for females, 15.5 years for males), and smallest for employment services (33.8 years for females, 33.1 years for males).



Source: AIHW 2005c.

Figure 5.9: Users of CSTDA-funded services, age by sex, 2003–04



Source: AIHW 2005c.

Figure 5.10: Users of CSTDA-funded services, median age by service group and sex, 2003–04

A total of 6,524 service users (3.5%) were identified as being of Aboriginal or Torres Strait Islander origin (Table 5.14)—this represents a higher proportion than in the overall population (2.4%; ABS 2004c). Indigenous service users were present in larger proportions for respite (5.2%), community support (4.6%) and accommodation support (3.8%) services, but in smaller proportions for employment (2.6%) and community access (2.8%) services (AIHW 2005c).

Indigenous service users were more likely to report intellectual (43%) or physical (18%) disability as their primary disability type than non-Indigenous service users (40% and 13% respectively) (Table 5.14). On the other hand, non-Indigenous service users were more likely to report neurological (6%) or psychiatric (9%) disability than Indigenous service users (4% and 6% respectively).

Table 5.14: Users of CSTDA-funded services, primary disability group by Indigenous status, 2003–04

	Indigenous		Non-Indigenous		Not stated/ not collected		Total	
Primary disability group	**No.**	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**
Intellectual	2,785	42.7	65,225	39.9	3,691	20.6	71,701	38.2
Specific learning/ADD	213	3.3	5,160	3.2	326	1.8	5,699	3.0
Autism	237	3.6	7,747	4.7	265	1.5	8,249	4.4
Physical	1,146	17.6	21,902	13.4	1,737	9.7	24,785	13.2
Acquired brain injury	438	6.7	7,182	4.4	297	1.7	7,917	4.2
Neurological	259	4.0	9,396	5.8	426	2.4	10,081	5.4
Deafblind	33	0.5	465	0.3	14	0.1	512	0.3
Vision	136	2.1	5,794	3.5	3,315	18.5	9,245	4.9
Hearing	176	2.7	4,863	3.0	401	2.2	5,440	2.9
Speech	63	1.0	1,173	0.7	67	0.4	1,303	0.7
Psychiatric	406	6.2	14,225	8.7	928	5.2	15,559	8.3
Developmental delay	261	4.0	8,884	5.4	583	3.3	9,728	5.2
Not stated/not collected	371	5.7	11,384	7.0	5,832	32.6	17,587	9.4
Total	**6,524**	**100.0**	**163,400**	**100.0**	**17,882**	**100.0**	**187,806**	**100.0**

Notes

1. Service user data are estimates after use of a statistical linkage key to account for individuals who received services from more than one service type outlet during the 12-month period.
2. In tables the term 'Indigenous' refers to service users who identified as Aboriginal and/or Torres Strait Islander people. 'Non-Indigenous' refers to service users who reported not being Aboriginal or Torres Strait Islander people.
3. 'Not stated/not collected' includes both service users accessing only 3.02 services for whom Indigenous and primary disability data were not collected and other service users with no response.

Source: AIHW 2005c.

Individualised funding involves the application of funding to a particular service outlet/s which the service user (or their carer/advocate) has chosen as relevant to his or her needs. Such funding is allocated to individual service users on the basis of a needs assessment, funding application, or similar process (AIHW 2004d). In 2003–04, around 17% of service users reported that they received individualised funding (Table 5.15). Those in respite (24%) and employment (22%) services were most likely to report receiving such funding.

Table 5.15: Users of CSTDA-funded services, individual funding status by service group, 2003–04

	Has individualised funding		Does not have individualised funding		Not known		Not stated/ not collected		Total	
Service group	**No.**	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**
Accommodation support	6,992	21.1	22,621	68.2	1,824	5.5	1,738	5.2	33,175	100.0
Community support	12,988	16.5	53,041	67.3	5,834	7.4	6,984	8.9	78,847	100.0
Community access	10,040	21.1	31,228	65.6	2,574	5.4	3,794	8.0	47,636	100.0
Respite	4,893	23.8	13,592	66.2	1,256	6.1	806	3.9	20,547	100.0
Employment	13,812	21.5	50,469	78.5	0	—	0	—	64,281	100.0
Total	**31,193**	**16.6**	**135,496**	**72.1**	**9,190**	**4.9**	**11,927**	**6.4**	**187,806**	**100.0**

Notes

1. Service user data are estimates after use of a statistical linkage key to account for individuals who received services from more than one service type outlet during the 12-month period. Total for all service groups may not be the sum of components since individuals may have accessed services from more than one service group over the twelve month period Service user data were not collected for all CSTDA service types.
2. Case Based Funding is currently being implemented within employment services. Once fully implemented, 100% of employment service users will be funded under this mechanism.
3. 'Not stated/not collected' includes both service users accessing only 3.02 services for whom individualised funding data were not collected and other service users with no response.

Source: AIHW 2005c.

The availability of full year data makes analysis of multiple service usage more meaningful than with previous snapshot day collections. It is now possible to examine the full range of CSTDA-funded services accessed over an entire year. During 2003–04, a total of 42,326 service users (23%) accessed services from two or more CSTDA-funded service groups (Table 5.16). The most common combination of service groups was accommodation support and community access, followed by community support and community access.

In 2003–04, a total of 78,360 service users (42%) indicated that they had an informal carer—defined as 'a person such as a family member, who provides care and assistance on a regular and sustained basis' (Table 5.17; AIHW 2005c). A further 38% indicated that they did not have such a carer, while this information was not reported for around 20% of service users—2003–04 was the first time this data item was collected over a full year; therefore this missing rate is expected to improve in future collections.

Service users aged under 15 years were most likely to report having a carer (79%), followed by those aged 15–24 years (48%). One–fifth (20%) of service users aged 65 years or more reported that they had a carer. Of the 78,360 service users with a carer, 53,012 (68%) indicated that the carer was a 'primary' carer—defined as someone who assists with activities of daily living, including self-care, mobility and communication (AIHW 2005c). When considering these findings, it should be recognised that the roles of parent and carer are often difficult to distinguish, particularly in the case of children—many parents consider themselves also carers if they are providing more care than would be typical of the care provided to a child of the same age without a disability.

Table 5.16: Users of CSTDA-funded services, service group combinations most commonly received, 2003–04

Service groups used	Number	Per cent of service users using two or more services	Per cent of all service users
Five most common combinations			
Accommodation and community access	14,013	33.1	7.5
Community support and community access	13,484	31.9	7.2
Accommodation and community support	10,710	25.3	5.7
Community support and respite	8,993	21.2	4.8
Accommodation and employment	5,640	13.3	3.0
Other combinations			
Three or more services involving above combinations	11,994	28.3	6.4
All other combinations	7,198	17.0	3.8
Total	**42,326**	**100.0**	**22.5**

Notes

1. Service user numbers reflect use of any of five service groups: accommodation support, community support, community access, respite and employment.
2. Service users with three, four or five service groups are included under all relevant combinations. Thus, numbers in a column may not add up to the total.
3. 'All other combinations' includes three two-way combinations for service users of respite services other than with accommodation, the combination of community support and employment, and other three-, four- and five-way combinations of service groups.

Source: AIHW 2005c.

Table 5.17: Users of CSTDA-funded services, existence of an informal carer by service user age group, 2003–04

	Has an informal carer		Does not have an informal carer		Not stated/ not collected		Total	
Age group of service user (years)	**No.**	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**
0–14	26,117	79.4	1,550	4.7	5,217	15.9	32,884	100.0
15–24	17,950	48.1	13,491	36.2	5,868	15.7	37,309	100.0
25–44	21,771	35.6	30,981	50.7	8,356	13.7	61,108	100.0
45–64	10,343	27.7	21,221	56.8	5,815	15.6	37,379	100.0
65+	2,131	19.8	4,873	45.3	3,762	34.9	10,766	100.0
Not stated	48	0.6	22	0.3	8,290	99.2	8,360	100.0
Total	**78,360**	**41.7**	**72,138**	**38.4**	**37,308**	**19.9**	**187,806**	**100.0**

Notes

1. Service user data are estimates after use of a statistical linkage key to account for individuals who received services from more than one service type outlet during the twelve month period.
2. 'Not stated/not collected' includes both service users accessing only 3.02 services for whom informal carer data were not collected and other service users with no response.

Source: AIHW 2005c.

Most service users with a carer reported that the carer was their mother (69%) (Table 5.18). This was by far the most common relationship reported—fathers were the next most common (6%), followed by wife/female partner, husband/male partner and other female relative (all around 5%). Carers in the age group 25–44 were more likely than

other age groups to be the mother of a service user (83%). Of those carers aged under 15 years, 64% reported they were the daughter (33%) or son (31%) of the service user. Of the 6,472 carers aged 65 years and over, 3,959 were mothers (61%), 749 fathers (12%), 543 a husband/male partner (8%) and 446 a wife/female partner (7%).

Table 5.18: CSTDA-funded service users with an informal carer, relationship of carer to service user by age group of carer, 2003–04

Relationship of carer to service user	Age group of carer (years)						
	0–14	15–24	25–44	45–64	65+	Not stated/ not collected	Total
				Number			
Wife/female partner	0	36	830	1,312	446	1,065	3,689
Husband/male partner	0	31	850	1,474	543	635	3,533
Mother	0	709	24,156	13,685	3,959	11,241	53,750
Father	0	10	1,048	1,582	749	1,511	4,900
Daughter	33	118	238	234	17	100	740
Son	31	87	122	103	8	77	428
Daughter-in-law	0	1	8	16	1	7	33
Son-in-law	0	0	1	3	0	1	5
Other female relative	7	67	652	1,431	461	1,011	3,629
Other male relative	1	21	248	381	81	360	1,092
Friend/neighbour—female	0	17	248	426	81	566	1,338
Friend/neighbour—male	0	8	119	124	47	341	639
Not stated/not collected	27	29	491	328	79	3,630	4,584
Total	**99**	**1,134**	**29,011**	**21,099**	**6,472**	**20,545**	**78,360**
				Per cent			
Wife/female partner	—	3.2	2.9	6.2	6.9	5.2	4.7
Husband/male partner	—	2.7	2.9	7.0	8.4	3.1	4.5
Mother	—	62.5	83.3	64.9	61.2	54.7	68.6
Father	—	0.9	3.6	7.5	11.6	7.4	6.3
Daughter	33.3	10.4	0.8	1.1	0.3	0.5	0.9
Son	31.3	7.7	0.4	0.5	0.1	0.4	0.5
Daughter-in-law	—	0.1	0.0	0.1	0.0	0.0	0.0
Son-in-law	—	—	0.0	0.0	—	0.0	0.0
Other female relative	7.1	5.9	2.2	6.8	7.1	4.9	4.6
Other male relative	1.0	1.9	0.9	1.8	1.3	1.8	1.4
Friend/neighbour—female	—	1.5	0.9	2.0	1.3	2.8	1.7
Friend/neighbour—male	—	0.7	0.4	0.6	0.7	1.7	0.8
Not stated/not collected	27.3	2.6	1.7	1.6	1.2	17.7	5.8
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**

Notes

1. Service user data are estimates after use of a statistical linkage key to account for individuals who received services from more than one service type outlet during the twelve month period.
2. 'Not stated/not collected' includes both service users accessing only 3.02 services for whom informal carer data were not collected and other service users with no response.

Source: AIHW 2005c.

Other disability-specific services

Home and Community Care

The Home and Community Care (HACC) program provides a range of community care services, targeting frail and older people with disabilities, as well as younger people with disabilities and their carers. During 2003–04, there were 170,100 HACC clients under the age of 65 years (24% of the total 707,200). The most commonly used services by these clients were assessment, case management and case planning/ review (40%); nursing (25%); and domestic assistance (20%). These younger clients used 1.8 services over the year, on average, compared with 2.1 for those 65 years and over (see Table 4.12). See Chapter 4 for detailed discussion of the HACC program.

Aged care

There were 6,240 clients aged under 65 years in permanent residential aged care as at 30 June 2004, representing 4.3% of all residents. Of these clients, 987 (16%) were aged under 50 years. There were also 1,935 people under the age of 65 years who accessed Community Aged Care Packages (7% of all CACP recipients) (see Tables 4.18, 4.19).

Rehabilitation, hearing services and equipment

CRS Australia provides vocational rehabilitation services to people with a disability, injury or health condition to gain or maintain employment. It also offers independent living and counselling services. All CRS services are free to people receiving income support payments from Centrelink (CRS Australia 2005).

During 2003–04, CRS assisted a total of 41,354 customers (16,819 existing and 24,535 new customers). Of the new customers supported, the most commonly reported primary disability type was physical (58%), followed by psychiatric disability (28%). Of the 23,587 customers who exited a CRS rehabilitation program during 2003–04, 8,874 (38%) achieved a 'durable' employment outcome—that is, they were employed for 13 weeks or more (FaCS 2004b).

Australian Hearing is the sole government-funded provider of hearing services to eligible recipients—primarily people under the age of 21 years, age pensioners, sickness allowance recipients and some veterans. During 2003–04, it provided 335,638 services, including 280,065 to pensioners and veterans, and 45,993 people under the age of 21. Around half of Australian Hearing clients were aged 80 years and over, while over a third were less than 10 years old (Australian Hearing 2004). 'Eligible recipients' aged 21 years or more can access free assessment, rehabilitation and aid fitting services by applying for a voucher. During 2003–04, the Office of Hearing Services issued 178,413 vouchers (DoHA 2005).

Equipment services in Australia are somewhat fragmented, being provided by a mosaic of services, generally through the health or veterans systems or the non-government sector (see e.g. AIHW: Bricknell 2003) No national data on these various programs are compiled. Some indication of the importance of equipment is provided by the population data in Tables 5.8 and 5.9.

Relevant generic services

Health

There is growing interest in the question of access to health services by people with disabilities, and how adequate and effective this access is. Various authors have raised a range of concerns about the health outcomes of people with disabilities; their access to services; the quality of services received, including problems in communication between health professionals and people with disabilities; health professionals' inadequate knowledge of health conditions of people with disabilities, including patterns of dual diagnoses such as mental health and intellectual disability; the adequacy of medical records; and the appropriateness of services provided (see AIHW 2003a:368–9; Leonard et al 2004).

Similar issues were raised in a health forum in 2004 (HREOC 2004):

- the problem of 'diagnostic overshadowing' when 'a person's symptoms or condition is wrongly attributed to their disability rather than a separate medical condition';
- the need for improved education and training of health professionals and related non-medical staff;
- the need for medical professions to ensure sexually active people with disabilities are respected and given the 'appropriate information and support to protect themselves';
- the need for Medicare schedules to recognise that some people with disabilities require longer consultations to ensure the required communication takes place;
- the need for Auslan services;
- affordability of equipment;
- medication labelling and instructions—various formats are needed; and
- the need for trials of new drugs to include a wider range of people, including people with disabilities.

Improved screening methods of people with intellectual disabilities are being trialled in Queensland (University of Queensland 2005). Results so far indicate that previously missed health problems included hearing and sight, that immunisations needed updating, and weight problems needed attention.

Education and training

Students with a disability may attend either 'special' schools or mainstream schools, sometimes with special educational assistance. Enrolment in special education services, in both special and mainstream schools, is dependent on satisfying specified criteria stipulated by the government of the state or territory in which a student is enrolled. There is significant variation across jurisdictions in the criteria used to identify a student with a disability. For example, criteria relating to social or emotional impairment exist in some jurisdictions, such as New South Wales, but not in others, such as the Australian Capital Territory (SCRCSSP 2005). A Senate Committee inquiry into the education of students with disabilities highlighted the need for nationally agreed definitions of disabilities, as well as recommending further inquiry into the transition of such students from school to further study, employment and lifelong learning (Commonwealth of Australia 2002).

Table 5.19: Students with disabilities attending government and non-government schools, 2004 (FTE)[a]

	NSW[b]	Vic	Qld	WA[c]	SA	Tas	ACT	NT	Total
Government schools[d]									
Mainstream	29,066	13,964	12,120	9,495	11,536	2,769	1,316	4,210	84,476
Special	3,981	7,180	2,612	735	996	184	287	195	16,170
Total	*33,047*	*21,144*	*14,732*	*10,230*	*12,532*	*2,953*	*1,603*	*4,405*	*100,646*
Percentage attending mainstream schools	88.0	66.0	82.3	92.8	92.1	93.8	82.1	95.6	83.9
Percentage of all government school students	4.4	3.9	3.3	4.1	7.4	4.7	4.5	12.0	4.4
Non-government schools[e]									
Mainstream	8,986	5,727	2,700	1,546	2,391	304	300	181	22,135
Special	1,245	506	143	34	137	16	0	0	2,081
Total	*10,231*	*6,233*	*2,843*	*1,580*	*2,528*	*320*	*300*	*181*	*24,216*
Percentage attending mainstream schools	87.8	91.9	95.0	97.8	94.6	95.0	100.0	100.0	91.4
Percentage of all non-government school students	2.8	2.2	1.4	1.5	3.0	1.5	1.2	2.1	2.2
Total students with disabilities	**43,278**	**27,377**	**17,575**	**11,810**	**15,060**	**3,273**	**1,903**	**4,586**	**124,862**
Total all students ('000)	1,108.6	826.4	648.0	358.6	252.0	83.8	59.9	45.4	3,382.7
Percentage of all school students	3.9	3.3	2.7	3.3	6.0	3.9	3.2	10.1	3.7

(a) FTE students are not the actual number attending. For example, a student attending for half the normal school hours will be half an FTE student. The number of enrolled students will normally be greater than the number of FTE.

(b) Data for government mainstream schools in NSW include students with disabilities in regular classes (16,600 students) and special classes (12,466). Only students with disabilities in regular classes were reported in 2002.

(c) Data for government special schools in WA include education support schools and education support centres.

(d) Data for government schools in NSW include students at kindergarten level; in Vic, exclude kindergarten level and early special education facilities; in Qld, exclude kindergarten level and may include early special education facilities depending on where they are based; in WA, include kindergarten or pre-primary level; in SA, exclude preschools; in Tas, include kindergarten level but exclude early special education facilities; in NT, include preschools; and in the ACT include kindergarten or pre-primary level.

(e) Data for non-government schools include students at kindergarten level.

Sources: DEST 2004 Non-government Schools Census, unpublished data; and data provided to AIHW by state and territory education authorities.

In 2004, there were 124,862 school students with disabilities—100,646 attending government schools, of whom 84% were in mainstream schools, and 24,216 attending non-government schools, of whom 91% were in mainstream schools (Table 5.19). Variation between jurisdictions in the proportion of students attending mainstream schools in the government sector was marked—from 66% in Victoria to 96% in the Northern Territory. In the non-government sector, the proportion of students attending mainstream schools varied from 88% in New South Wales to 100% in the Australian Capital Territory and the Northern Territory. This variation may reflect differences between jurisdictions in terms of enrolment integration policies as well as the availability of special schools.

Students with disabilities as a proportion of all students attending government and non-government schools ranged from 3% in Queensland to 10% in the Northern Territory. In all jurisdictions, the proportion of students with disabilities was greater in government schools than in non-government schools; nationally, the proportion of students with disabilities was twice as high in government schools (4%) as in non-government schools (2%).

National statistics on students with disabilities attending higher education have been collected since 1996. Since that time, the number has increased from 11,656 (1.9% of all students) to 24,593 (3.7%) in 2004 (DEST 2005b). It is important to note that these students identified through self-report.

The number of students in Vocational Education and Training (VET) reporting a disability has steadily increased, from 53,475 in 1998 (3.5% of all students) to 91,439 in 2003 (5.3%) (NCVER 2005). A number of factors have contributed to the apparent growth in participation levels, including the addition of new disability groups to the original definition, improved methods of identifying people with a disability, and greater and more coordinated efforts to improve access and participation for these people. Physical disabilities were the most common form of disability reported in 2003 (20%), followed by medical (17%), visual (15%), learning (14%) and hearing-related disabilities (12%). The majority (86%) of students with a reported disability had a single disability. Over the period 2001–04 the proportion of VET graduates with a disability who were employed after training increased from 45% to 51%, while the proportion who were unemployed after training declined from 21% to 16% (NCVER 2005). Despite these improvements, the proportion of graduates with a disability employed after training remained lower than graduates without a disability in 2004 (51% compared with 77%) and the proportion unemployed was higher than for those without a disability (16% compared with 11%).

Employment assistance

Centrelink provides an assessment and referral service for job seekers with a disability. Job seekers are assessed to determine the level of assistance required by an individual seeking employment. Disability Employment Indicators may also be used for further assessment if a person indicates that they have a disability that may affect their ability to work; this instrument is used to gauge the type and level of support a person will require in their employment. Depending on the level of support these measures indicate a person will need, Centrelink refers them to the Job Network, or a specialist disability employment service (see CSTDA service user information above), or a vocational rehabilitation program delivered by CRS Australia.

People with disabilities thus have access to mainstream employment services through DEWR's Job Network. DEWR has several processes in place to assist people with

disabilities seeking mainstream employment. The Active Participation Model, introduced in July 2003, was designed to improve access to job seekers with a disability through individualised support. Included in this assistance is access to a Job Seeker Account, which allows individuals to receive additional assistance to meet their specific needs, such as training and equipment. There is also a range of specialist Job Network providers who address the needs of specific disability groups, such as people with hearing or vision impairments or mental health issues. The Employer Incentive Strategy is designed to encourage employers to provide opportunities for people with disabilities; during 2003–04 this incentive assisted 6,280 people through the supported wage system (3,425), wage subsidies (2,580) and workplace modifications (275) (DEWR 2004a).

During 2003–04, 27,160 people with disabilities commenced the Job Placements program (5.2% of the total 518,008 people in this program), and a further 46,728 people with disabilities commenced Intensive Support (7.6% of the total) (DEWR 2004a).

A person is said to have achieved a 'positive outcome' in a Job Network program if they are employed, in training, or in education 3 months after completion of the program. Of the 4,452 job seekers with a disability who exited the Job Placements program between 1 July 2003 and 30 June 2004, 59% achieved a positive outcome, compared with 74% of all job seekers (Table 5.20). Of the 18,984 job seekers with a disability exiting customised Intensive Support, 46% achieved a positive outcome, compared with 53% of all job seekers exiting this type of support. There were a further 2,907 job seekers with a disability who exited intensive job search training support—53% of these achieved a positive outcome, compared with 63% of all job seekers who exited this type of support.

Table 5.20: Job seekers exiting Job Network programs and proportion achieving positive outcomes, 2003–04

	Job seekers with a disability		All job seekers	
	Number of exits	Positive outcomes	Number of exits	Positive outcomes
Job Placements	4,452	59.2%	121,815	74.4%
Intensive Support: customised assistance	18,984	45.8%	185,126	53.0%
Intensive Support: job search training	2,907	52.9%	133,136	63.1%

Note: numbers include those people who exited Job Network services between 1 July 2003 and 30 June 2004, and outcomes achieved 3 months after their exit date (up to 30 September 2004).

Source: DEWR 2004b.

Housing and accommodation assistance

At 30 June 2004, there were 99 community housing organisations funded under the Commonwealth State Housing Agreement (CSHA) with specifically targeted assistance to people with a disability. Just over 5,000 households living in CSHA community housing contained a person with a disability, representing 21% of all households assisted (AIHW 2005d).

Forty-two percent of public housing tenants aged 15–64 years reported a disability in 2003, compared with 17% of people in all housing tenure types. At 30 June 2004, 27% of public housing tenants and 17% of SOMIH tenants reported that their main source of household income was DSP (see Tables 6.6, 6.15 and 6.16).

People accessing services from the Supported Accommodation Assistance Program (SAAP) were considered part of the 'disability' client group if they received DSP or DVA disability pension; were referred from or to a psychiatric unit; or requested or received disability-specific services (AIHW: Murdoch 2005). During 2002–03, of the total 97,600 SAAP clients, 24,900 (26%) were in the SAAP 'disability' client group[2]. These 'disability' clients had an average of 1.80 support periods, compared with 1.67 for all other clients. People in this client group were more likely than other SAAP clients to be male (58% compared with 38%), and were on average 7 years older (mean age of 36.8 years compared with 29.8 years for other SAAP clients). See Chapter 7 for more discussion of the SAAP program.

Unpaid care

The provision of unpaid care is not only a vital part of Australian family life, but a critically important complement to formal services. Trends in deinstitutionalisation and non-institutionalisation mean that greater numbers and proportions of people with severe disabilities now live in the community, frequently with families (AIHW 2001; AIHW: Madden et al. 1999; AIHW: Wen & Madden 1998). Outcomes for people with disabilities and the wellbeing of Australian families are thus strongly affected by the adequacy and quality of in-home support.

In 2003, Australians aged less than 65 years who needed help with self-care, mobility or communication received most of the assistance they needed from family and friends—65% received informal assistance only, 26% received both formal and informal assistance, 3% received formal assistance only and 6% had no provider of assistance (Table 5.21). People needing assistance with communication were likely (63%) to be receiving a mix of formal and informal assistance. The picture was slightly different for the 'non-core activities' listed—43% of people received informal assistance only with these activities, 51% both informal and formal assistance, 4% formal service only, and 2% had no assistance.

'Primary carers' are those who provide the most ongoing assistance with core activities (self-care, mobility, communication). In 2003, primary carers (ABS 2004a):

- were mainly female (71%);
- cited a range of reasons for their caring role, the most common being 'family responsibility' (58% of primary carers), the belief that they could provide better care (39%), and 'emotional obligation' (35%);
- had a lower labour force participation rate (39%) than people who were not carers (68%); and
- spent long hours caring—37% of primary carers spent on average 40 hours or more per week providing care; 18% spent 20–39 hours per week.

Previous analyses of Australian survey data have pointed more generally to the reasons for and effects of caring (AIHW 2000a, 2002). 'For some, the primary caring role imposes considerable burden, but it is a role that people take on out of a sense of responsibility and the desire to provide the best possible care' (AIHW 2003a:114). A review of literature

2. This number may be an underestimate because some data items used to estimate the SAAP 'disability' group were not collected by all SAAP agencies (see AIHW: Murdoch 2005 for details).

dealing with carers' quality of life, while recording some positive findings, such as better relationships and understanding, concluded that 'caregivers of people with severe disability are at extreme risk of being highly stressed, clinically depressed, and with subjective quality of life that is way below normal' (Cummins 2001:97).

In 2003 there were 202,000 primary carers of people aged under 65, living with the main recipient of their care (Table 5.22). They were most likely to be a parent caring for a son or daughter (89,400 or 44%) or someone caring for a spouse or partner (88,600 also 44%).

Table 5.21: People aged under 65 years with a profound or severe core activity limitation living in households: type of assistance received, activity in which help is needed, 2003

	Type of provider				
Activity with which help needed	**No provider**	**Informal only**	**Formal only**	**Informal and formal**	**Total**
			Number ('000)		
Self-care	30.5	253.9	*9.0	25.2	318.6
Mobility	22.6	339.9	11.3	92.9	466.6
Communication	*4.0	48.5	*6.4	98.4	157.3
Total core activity[a]	**40.9**	**415.9**	**18.1**	**166.6**	**641.5**
Cognition or emotion	10.8	133.8	19.1	153.0	316.8
Health care	14.7	160.7	37.5	92.5	305.4
Housework	*9.1	211.6	14.6	24.3	259.6
Property maintenance	*8.6	197.2	22.9	49.9	278.5
Paperwork	*5.8	103.4	*7.7	*9.6	126.6
Meal preparation	*2.4	103.8	*4.8	*5.2	116.2
Transport	*9.4	225.1	13.3	20.6	268.3
Total non-core activity[b]	***9.1**	**237.6**	**24.6**	**282.9**	**554.2**
			Per cent		
Self-care	9.6	79.7	*2.8	7.9	100.0
Mobility	4.8	72.8	2.4	19.9	100.0
Communication	*2.6	30.8	*4.1	62.5	100.0
Total core activity[a]	**6.4**	**64.8**	**2.8**	**26.0**	**100.0**
Cognition or emotion	3.4	42.3	6.0	48.3	100.0
Health care	4.8	52.6	12.3	30.3	100.0
Housework	*3.5	81.5	5.6	9.4	100.0
Property maintenance	*3.1	70.8	8.2	17.9	100.0
Paperwork	*4.6	81.7	*6.1	*7.6	100.0
Meal preparation	*2.1	89.3	*4.1	*4.4	100.0
Transport	*3.5	83.9	5.0	7.7	100.0
Total non-core activity[b]	***1.6**	**42.9**	**4.4**	**51.0**	**100.0**

(a) Includes people who need help with at least one core activity.

(b) Includes people who need help with at least one core activity and one or more non-core activities.

Note: Estimates marked with * have an associated relative standard error (RSE) of between 25% and 50% and should be interpreted accordingly.

Source: AIHW analysis of ABS 2003 Survey of Disability, Ageing and Carers confidentialised unit record file.

Table 5.22: Primary carers of people aged under 65 years: years in caring role and age group, by relationship to main recipient of care, 2003

	Partner		Parent		Son or daughter		Other		Total	
	No. ('000)	Per cent	No. ('000)	Per cent	No. ('000)	Per cent	No. ('000)	Per cent	No. ('000)	Per cent
Years in caring role										
Does not know	*3.1	*3.5	**0.7	**0.7	**0.5	**4.1	—	—	*4.2	*2.1
Less than 1 year	*4.5	*5.1	*2.9	*3.3	**0.4	**3.3	**0.5	**3.8	*8.3	*4.1
1–4 years	29.2	33.0	19.3	21.5	*6.0	*50.4	*5.7	*47.6	60.2	29.8
5–9 years	23.5	26.5	22.7	25.4	*2.7	*22.6	*2.6	*21.6	51.5	25.5
10–14 years	14.2	16.0	20.3	22.7	**0.7	**5.5	**0.2	**2.1	35.4	17.5
15–19 years	*6.4	*7.2	*8.6	*9.7	—	—	**1.5	**12.2	16.5	8.2
20 or more years	*7.7	*8.7	14.9	16.7	**1.7	**14.1	**1.6	**12.9	25.9	12.8
Total	**88.6**	**100.0**	**89.4**	**100.0**	**11.9**	**100.0**	**12.1**	**100.0**	**202.0**	**100.0**
Age group of carer										
15–24	*3.4	*3.8	*3.0	*3.4	*8.2	*68.6	—	—	14.6	7.2
25–44	22.6	25.5	51.6	57.7	*2.9	*24.2	*3.9	*32.5	81.0	40.1
45–64	54.5	61.5	30.7	34.3	—	—	*6.0	*49.9	91.1	45.1
65+	*8.2	*9.2	*4.1	*4.6	**0.9	**7.2	**2.1	**17.6	15.3	7.6
Total	**88.6**	**100.0**	**89.4**	**100.0**	**11.9**	**100.0**	**12.1**	**100.0**	**202.0**	**100.0**

Notes

1. Table includes primary carers aged 15 years or more living in households with the main recipient of care.
2. The estimates of disability are based on the confidentialised unit record file (CURF) of the ABS 2003 Survey of Disability, Ageing and Carers (SDAC). To protect the confidentiality of survey respondents, some children's records have been dropped and any households that were identifiable have been dropped from the CURF. Therefore, the estimates based on the CURF do not exactly match those of ABS published reports. The estimates from the CURF are used throughout the chapter for internal consistency.
3. Estimates marked with * have an associated relative standard error (RSE) of between 25% and 50% and should be interpreted accordingly.
4. Estimates marked with ** have an associated relative standard error (RSE) of greater than 50% and should be interpreted accordingly

Source: AIHW analysis of ABS 2003 Survey of Disability, Ageing and Carers confidentialised unit record file.

The majority of parent carers were in the 25–44 age range (58%); and 34% were aged 45–64 years. An estimated 4,100 were aged 65 years and over; a total of 6,400 primary parent carers were aged 65+ (ABS 2004a:52). Care had been provided by parents over a much longer time span than by others—23% had cared for their son or daughter for 10–14 years (compared to 16% for spouse carers), 10% for 15–19 years (compared to 7%) and 17% for 20 or more years (compared to 9% for spouse carers).

People with profound or severe core activity limitations aged under 65 years were, then, located in an environment of assistance provided chiefly by family and friends, with a further ingredient of formal assistance to them and their carers. How well did this mix work for the carers?

- Some 20% of carers living with a person aged under 65 reported the need for further assistance—12% received some assistance but needed more, while 8% needed assistance and received none; 35% received assistance and needed no more while 45% did not need assistance (Table 5.23).
- Most carers (63%) reported that there was another person providing regular assistance with caring tasks, but 29% said there was not.
- Respite services played a limited role in their lives. The majority of primary carers (76%) said that they had never received respite and did not want it. However, 8% of primary carers had never received respite and needed it. For those who had used respite, there was incomplete reach of the service—3% of primary carers had received a formal respite service in the previous 3 months and did not need further assistance; 5% had received such respite but needed more; 4% did not receive such respite but needed it. Overall, then, some 18% of primary carers of people with severe/profound core activity limitations needed more respite provided by formal services.

More information on the care of older Australians is provided in Chapter 4. The total imputed value of unpaid care is discussed and estimated in Chapter 8.

5.5 Outcomes

Participation is a widely recognised goal of people with disabilities, an explicit goal of disability programs, and hence a key criterion for judging outcomes for people with disabilities within Australian society (see Sections 5.2 and 5.4). A discussion of participation by people with disabilities in Australian society is the primary focus of this section, following a brief overview of some service-related outcomes.

Service-related outcomes

Accessibility

Access to services is an important indicator of service or program outcomes. Access to generic services such as health, education and employment is indicated in Section 5.4, although there is room for data improvement.

Access to disability support services provided under the CSTDA is indicated in Table 5.24. CSTDA services are targeted at people needing ongoing assistance with self-care, mobility and communication. The 'potential population' for these services is

calculated from population disability survey estimates of these numbers, further applying an Indigenous factor to allow for higher rates of disability in that group and a labour force factor for employment services. Respite potential population figures allow for family arrangements (AIHW 2005c). It is not suggested that every person needing ongoing assistance needs a formal service. The 'potential population' estimates were constructed for comparative purposes, to provide indications of relative need, for interstate comparisons and trend analyses.

Table 5.23: Primary carers of people aged under 65 years, by carers age group and assistance needed, 2003

	15–64 years		65+ years		Total 15+ years	
	No. ('000)	Per cent	No. ('000)	Per cent	No. ('000)	Per cent
Need for and receipt of assistance						
Receives assistance and:						
does not need further assistance	64.1	34.3	6.0	39.0	70.0	34.7
needs further assistance	22.6	12.1	2.1	13.7	24.7	12.2
Does not receive assistance and:						
needs assistance	15.3	8.2	1.0	6.9	16.4	8.1
does not need assistance	84.7	45.4	6.2	40.5	90.9	45.0
Total	186.7	100.0	15.3	100.0	202.0	100.0
Availability of fall-back carer						
Available	120.5	64.5	6.8	44.5	127.3	63.0
Not available	50.5	27.1	7.1	46.2	57.6	28.5
Don't know if available	15.7	8.4	1.4	9.3	17.1	8.5
Total	186.7	100.0	15.3	100.0	202.0	100.0
Need for and receipt of respite care						
Received in the last 3 months and:						
does not need further care	*6.2	*3.3	**0.2	**1.5	*6.5	*3.2
needs further care	10.4	5.6	**0.5	**3.5	10.9	5.4
None received in the last 3 months and:						
does not need care	*6.7	*3.6	**0.7	**4.7	*7.4	*3.7
needs care	*7.0	*3.8	**0.9	**5.6	*7.9	*3.9
Never received respite care and:						
does not need or want care	139.7	74.8	12.9	84.6	152.6	75.5
needs care	16.7	8.9	—	—	16.7	8.3
Total	**186.7**	**100.0**	**15.3**	**100.0**	**202.0**	**100.0**

Notes

1. Includes primary carers aged 15 years or more living in households with the main recipient of care.
2. Estimates marked with * have an associated relative standard error (RSE) of between 25% and 50% and should be Interpreted accordingly.
3. Estimates marked with ** have an associated relative standard error (RSE) of greater than 50% and should be interpreted accordingly.

Source: AIHW analysis of ABS 2003 Survey of Disability, Ageing and Carers confidentialised unit record file.

Employment services reach relatively more of their potential target group (196 service users per 1,000 potential population), and accommodation support services the fewest of the major service categories (48 service users per 1,000 potential population—Table 5.24).

This basic indicator takes no account of the different levels of service provided—for instance accommodation support services, in some cases, provide a high level of support over many hours —nor the presence of complementary informal care, possibly more likely for people needing accommodation support than employment support.

CSTDA services are not entitlement services nor do they, as do some aged care services, have a planning ratio (see Chapter 4 and AIHW 2002:214–16). Unmet need in 2001 for specialist disability services was reported by the AIHW as: 12,500 people needing accommodation and respite services, 8,200 places for community access services, and 5,400 people needing employment support (AIHW 2002). These estimates have not been updated. This report and others have pointed to the unmet need for relevant equipment and the fragmentation of national supply mechanisms (AIHW: Bricknell 2003). 'Managing demand' remains one of the five key policy priorities under the CSTDA, advocacy groups continue to point to ongoing unmet need for disability support services, and the figures in Table 5.23 suggest that informal carers need further assistance from formal services.

Table 5.24: CSTDA-funded service users and 'potential populations' for selected service groups, 2003–04

Service group	Service users, 2003–04	Potential population (June 2003)	Service users per 1,000 potential population
Accommodation support	33,175	687,710	48.2
Community support	78,847	687,710	114.7
Community access	47,636	687,710	69.3
Respite	20,547	213,298	96.3
Employment	64,281	328,677	195.6

Notes

1. The potential population for accommodation support and community access is the number of people aged under 65 years, with profound or severe core activity limitation, multiplied by an Indigenous factor.
2. The potential population for respite is the number of people aged under 65 years, with profound or severe core activity limitation and a primary carer, multiplied by an Indigenous factor.
3. The potential population for employment services is the number of people aged 15–64 years with profound or severe core activity limitation, multiplied by both an Indigenous factor and the labour force participation rate.
4. Numbers of people with profound or severe core activity limitation are AIHW estimates derived using the ABS 2003 Survey of Disability, Ageing and Carers data.
5. The Indigenous factor was calculated using weighted population data for all people and multiplying the data for Indigenous Australians by two and adding the data for non-Indigenous Australians. Hence Indigenous Australians are weighted at two and non-Indigenous Australians at one.

Source: AIHW 2005c.

CSTDA quality and outcome indicators

It is possible to monitor the achievement of explicit program goals believed to relate to service quality and outcomes for people. Deinstitutionalisation, for instance, has been a goal in the disability services field for some years, and the proportion of people receiving 'community-based' accommodation support services (receiving support while in accommodation other than institutions and hostels) has risen since 1995 (Section 5.4). Disability services under the CSTDA are required to meet nationally agreed standards (DHSH 1993; FaCS 2005d).

There was considerable discussion of the need to have better outcome and quality indicators during the CSTDA NMDS redevelopment process (AIHW 2003c). While service quality has been promoted by the creation of service standards and the establishment of monitoring processes, no feasible way of collecting meaningful national data reflecting 'quality' was identified or agreed. An outcome framework suitable for the CSTDA is described in the redevelopment report; it was anticipated that the framework could be used to plan for and to record client outcomes. Nevertheless it was recognised that the recording of client outcomes by service providers, for accountability purposes, in a field such as the disability field, is of questionable validity. 'Client satisfaction' and similar concepts can, in theory, provide information about service quality and client outcomes. In practice, consumer satisfaction surveys have achieved poor response rates and yielded limited new meaningful information (E-QUAL and Donovan Research 2000). Thus a feasible way of improving indicators of service quality and client outcomes in the CSTDA NMDS collection has yet to be developed.

Participation as a whole-of-government outcome

In previous editions of *Australia's Welfare*, outcomes for people with a disability have been described using the framework of the International Classification of Functioning, Disability and Health (ICF); this is the approach used here. Participation, according to the ICF, is recorded in nine broad life areas in which all people, irrespective of disability, can expect to participate. In reflecting a 'whole person' and whole-of-life approach to participation, the ICF underpins a whole-of-government perspective for reviewing outcomes for people with disabilities.

The section provides a summary picture of participation in Australian society by people with disabilities. Population survey data are applied to the international standard framework of the ICF.

The outcome measures presented here are population measures. That is, they indicate a 'status' measure, but the cause cannot be attributed to any specific services or other factors. Further, they do not include outcomes for all people affected by disability, for instance the carer outcomes illustrated in Section 5.4. Nevertheless the data in this section are relevant outcome indicators for whole-of-government approaches to service provision to people with a disability.

Overview of participation

Measures now in national data standards are used here (where relevant data are available) to indicate outcomes in each of the nine ICF life areas or domains in which all people expect to participate—the difficulty experienced, assistance needed, the extent of participation, and satisfaction with participation. The analyses also illustrate gaps and further areas for improvement in this important ABS survey.

Extent of participation

The extent to which people with disabilities participate in the various life domains of the ICF is best indicated by comparison of their participation with that of the general population; this is in line with the underlying rights philosophy (see Section 5.2).

Such comparisons were included in *Australia's Welfare 1999* and *2001*. Overall, it was found in these analyses that people with disabilities were participating in many areas of Australian life, although often not to the same extent as the overall population. They were more likely to be living in the community than in previous years, but they tended to report lower levels of health, and they tended to have lower incomes than the general population, although the receipt of government pensions and allowances helped mitigate these income differentials. These comparative analyses will be updated in the future.

Difficulty and assistance with activities, and satisfaction with participation

An overview of eight of the nine ICF life areas (domains) is presented in Table 5.25, indicating difficulty and assistance with activities, and satisfaction with participation, for people with disabilities. This is not a complete picture, as explained in Box 5.7, where possible improvements to source data are identified, and future updates of previous analyses foreshadowed.

Of the 2,556,000 people with disabilities aged under 65 years in Australia in 2003, difficulty was most often reported in the survey areas of:

- employment—1,536,700 people;
- interpersonal interactions and relationships—1,068,000 people;
- property maintenance—852,600 people;
- transport (public and private)—823,900 people;
- mobility (including public transport)—821,700 people; and
- health care—772,600 people.

In terms of the broad ICF domains, mobility and 'major life areas' were the two where there were large numbers of people with disabilities experiencing difficulties.

When the focus is on people who need assistance, the most frequent areas reported in the survey were:

- employment—726,000 people;
- transport (public and private) —667,100 people;
- property maintenance—658,600 people; and
- interpersonal interactions and relationships—635,800 people.

The broad life areas (ICF domains) in which the need for assistance was most often reported were therefore mobility, domestic life, interpersonal interactions and relationships and 'major life areas'.

Satisfaction with participation, as indicated by the likelihood of receiving the assistance needed, was lowest in the life areas of interpersonal interactions and relationships (38% not receiving the help needed—either 'none at all' or 'not enough'); communication (33%); and domestic life (with around 26% of people not receiving the help needed in housework and domestic relationships).

Box 5.7: Areas for improving and updating information on participation by people with disabilities

Table 5.25 extracts as much relevant information as possible from the ABS 2003 SDAC survey on the 9 participation domains of the ICF. Data on 8 of the 9 participation domains are presented; later tables provide some information on the 9th domain – community, social and civic life – as well as more detail on the 'major life areas' of employment and education.

Two areas of improvement in the disability survey are desirable: more complete coverage of the 9 ICF domains for activities and participation; and more information 'measuring' activities and participation in these 9 areas. Of the 9 life areas, several, such as self-care, mobility and communication, are covered well and others, such as learning and applying knowledge, are scarcely touched on. Others are mixed with and cannot be disentangled from unrelated ideas; for instance, the 'cognition and emotion' area of the survey includes relationships, feelings and decision making – mixing details from 'interpersonal interactions and relationships' and 'general tasks and demands' in the ICF.

Ideally, to be able to report fully in terms of Australian data standards, it would be possible to report on each of these ICF life areas according to the national data standards (see AIHW 2005b; NCSDC 2004) – that is, for each area, to have data on difficulty and assistance with activities, on the extent of participation in comparison with the rest of the Australian population, and on people's satisfaction with participation.

Table 5.25 focuses on difficulty and the need for assistance. 'Extent' of participation has been reported on in previous editions of Australia's Welfare, where relevant population data enable comparisons of the experience of people with disability and the rest of the population (e.g. in relation to housing and time use); these comparisons will be updated in future editions as new population data become available. 'Satisfaction' is defined in the national data standards in terms of the duration, frequency, manner and outcome of the participation, with the issue of 'choice' also recognised. Data are not available nationally. The closest we can come to 'satisfaction' with current survey data is 'reported unmet need for assistance' in each life area.

Finally, there is the considerable challenge of measuring the effect of environmental factors on outcomes.

The ABS is committed to using international standards and will be reviewing the content of the survey in the lead-up to the next disability survey in 2009.

In the areas of employment and education, the provision of assistance is indicated differently from other areas of the survey. A schooling or employment restriction may indicate one of a range of difficulties or needs for assistance: these include being unable to work or attend school; being restricted in the type of work or hours that can be worked; needing special arrangements at work; attending a special class at school; and experiencing difficulty with schooling or employment. Of people with schooling restrictions, some 69% received some kind of support or special arrangement (such as a signing interpreter, disability support person, special equipment, special access or transport arrangements). Only 18% of those with employment restrictions received similar support or special arrangements.

Table 5.25: People aged under 65 with a disability living in households: activities by whether has difficulty, assistance needed, assistance received, and extent to which need for assistance met, 2003

ICF Activities and participation domains[a]	ABS 2003 disability survey activity and participation areas	Total with difficulty or needing help[b]	Need help[c]	Extent to which need for assistance met (% of total needing help)			Support and arrange-ments received
		No. ('000)	No. ('000)	Fully	Partly	Not at all	
Learning and applying knowledge	Learning and understanding	413.1	n.a.	n.a.	n.a.	n.a.	(d)
General tasks and demands	Paperwork	280.6	223.1	78.9	14.7	6.3	. .
	Decision making or thinking through problems[e]	(e)	333.3	(e)	(e)	(e)	. .
Communication	Communication	198.2	157.3	67.2	30.2	2.6	. .
	Speech	181.8	n.a.	n.a.	n.a.	n.a.	. .
Mobility	Mobility (including public transport)	821.7	466.6	82.3	12.8	4.8	. .
	Public and private transport	823.9	667.1	n.a.	n.a.	n.a.	. .
	Private transport[f]	502.6	426.9	82.3	9.9	7.7	. .
Self-care	Self-care	613.6	318.6	86.3	4.1	9.6	. .
	Health care	772.6	496.6	80.3	13.1	6.6	. .
Domestic life	Housework	693.1	477.5	74.0	19.4	6.6	. .
	Property maintenance	852.6	658.6	73.6	20.3	6.1	. .
	Meal preparation	179.4	143.6	86.7	10.8	2.5	. .
Interpersonal interactions and relationships	Cognition and emotion[e]	1,068.0	635.8	61.8	33.0	5.2	. .
	Making or maintaining relationships[e]	(e)	313.6	(e)	(e)	(e)	. .
	Coping with feelings or emotions[e]	(e)	473.1	(e)	(e)	(e)	. .
				% of total with a restriction			
Major life areas	Schooling	256.9	132.2	(d)	(d)	(d)	68.7
	Employment	1,536.7	726.0	(g)	(g)	(g)	18.1

(a) The ICF domains also include community, social and civic life (See Table 5.26).

(b) For schooling and employment, this category refers to total with a schooling restriction or an employment restriction.

(c) For schooling and employment, this category refers to total with a profound or severe schooling restriction or employment restriction.

(d) See support and special arrangements for people with a schooling restriction. These include special equipment (including computer), special tuition, special assessment procedure, a counsellor or disability support person, special access or transport arrangements and other support.

(e) The 'Cognition and emotion' area of the survey includes making or maintaining relationships, coping with feelings or emotions and decision making or thinking through problems. In ICF terms, this grouping mixes 3 chapters across 2 dimensions (body function and activities).

(f) Private transport refers to going to places away from the usual place of residence. Need for help or difficulty are defined for this activity as the need to be driven and difficulty going to places without help or supervision.

(g) See support and special arrangements for people with an employment restriction. These include special leave arrangements, a special support person to assist/train on the job, help from someone at work, special equipment, modifying buildings/fittings, special/free transport or parking, training/retraining, allocating different duties and other support.

Source: AIHW analysis of ABS 2003 Survey of Disability, Ageing and Carers confidentialised unit record file.

There are no data in the disability survey on the area of 'economic life' (e.g. economic self-sufficiency, engaging in transactions). Analyses of more economically focused surveys may yield more useful information. As might be expected from their experience in the labour market, households whose members include people with disabilities have been found to be more likely to have low incomes and to experience financial hardship than others. Saunders (2005) found that 9.4% of households with at least one adult with a disability, and 12.3% of households with no adults but at least one child with a disability, had incomes below the 50% median income benchmark (see Chapter 2 for data on this benchmark). These figures compared to 7.4% of other households. There were even greater differentials on five indicators of hardship: financial hardship, restricted participation, severe financial stress, expressed need and lack of support.

Community, social and civic life

'Community, social and civic life' is the 9th ICF domain for activities and participation. The available survey data relevant to this domain are structured differently from the data in Table 5.25, and are summarised in Table 5.26.

Table 5.26: People aged 5–64 years with a disability living in households: community participation, by disability status and age, 2003 (per cent)

	Profound core activity limitation		Severe core activity limitation		Total with disability	
Community participation	**5–44 years**	**45–64 years**	**5–44 years**	**45–64 years**	**5–44 years**	**45–64 years**
At home in the last 3 months						
Visits from family/friends	84.7	86.3	92.9	88.7	90.7	89.2
Telephone calls with family/friends	68.3	87.6	86.1	90.4	88.8	92.3
Craftwork for/with other people	15.0	15.8	19.3	12.5	19.2	14.1
Church/special community activities	*6.9	*5.3	9.8	6.2	7.1	7.3
Voluntary work (including advocacy)	*2.2	*3.5	8.1	9.0	6.3	9.3
None of the above	9.6	*4.4	*2.9	*4.1	2.6	3.2
Total population ('000)	**118.8**	**77.6**	**230.2**	**199.1**	**1,239.2**	**1,244.9**
Away from home in the last three months						
Visited family/friends	79.4	70.8	91.4	84.9	89.6	87.0
Went to a restaurant or club	44.1	33.5	57.4	55.1	63.0	62.0
Attended church activities	18.0	14.4	20.0	20.3	18.9	20.3
Voluntary work (including advocacy)	9.1	*8.5	14.8	15.9	16.8	18.9
Organised performing arts activities	*8.2	**2.5	9.1	*3.9	7.6	4.6
Organised art/craft group activities	*6.1	*4.2	8.7	6.9	8.2	7.6
Other special interest group activities	18.1	*7.5	16.3	14.8	17.1	14.8
None of the above	8.7	15.4	*4.1	10.3	4.2	6.5
Does not leave home	*4.0	*3.5	—	*0.3	*0.5	*0.4
Total population ('000)	**118.8**	**77.6**	**230.2**	**199.1**	**1,239.2**	**1,244.9**

Notes

1. Estimates marked with * have an associated relative standard error (RSE) of between 25% and 50% and should be interpreted accordingly.
2. Estimates marked with ** have an associated relative standard error (RSE) of greater than 50% and should be interpreted accordingly.

Source: AIHW analysis of ABS 2003 Survey of Disability, Ageing and Carers confidentialised unit record file.

Many people with a disability, including those with a profound or severe core activity limitation, had participated in social events and community activities in the 3 months preceding the 2003 Survey of Disability Ageing and Carers (Table 5.26). The predominant activities for all disability groups and all age groups were visits from and to family and friends, telephone calls with family and friends, and visits to restaurants and clubs. Thus, in 2003, not only did family and friends provide most of the assistance needed by people with disabilities, they were also the main focus of these people's social lives.

People with profound core activity limitations were less likely than other people with disabilities to have participated in these social activities. For instance, 79% of those aged 5–44 and 71% of those aged 45–64 had visited family and friends away from home in the previous 3 months, compared to 90% (and 87%) of people with disability in the same age groups. They were also the age groups most likely to respond that they had not participated in any of the listed social activities at home (9.6% and 4.4% respectively for the two age groups) or away from home (8.7% and 15.4%). Of people with a profound core activity limitation, 4.0% of people aged 5–44, and 3.5% of those aged 45–64, reported that they 'do not leave home'.

Major life areas: a focus on employment and education

Participation in education

People aged 15–64 years with a disability, in particular with a profound or severe limitation, had participated less in the education system than had people with no disability. In 2003, 69% (and 58%) of people with profound (or severe) core activity limitation had 'no non-school qualification', compared with 48% of people with no disability (ABS 2004a:22). Only 21% (and 26%) of people with a profound (or severe) limitation had completed Year 12, in contrast to 49% of people with no disability.

The inclusion of students with a disability in mainstream education is a generally accepted policy in Australian school systems. Previous analysis illustrated the effectiveness of these policies:[3] rising percentages of people aged 5–20 years in school and reporting a disability between 1981 and 1998; and rising percentages of people with disabilities (including severe disabilities) in the school population, in mainstream schools in special classes and in mainstream schools in ordinary classes (AIHW 2001:313). 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 2003, attendance rates for people aged 5–20 years with profound (91%) or severe (85%) limitations were higher than for people with a disability overall (79%) (Table 5.27). This is possibly because, of people who were not attending school, those with 'moderate' core activity limitation were more likely to have finished school (89%), compared to those with profound limitations, who were likely to be prevented by their

3. The disability survey data on education among people with a disability are not directly comparable to the collections of education departments (see Table 5.19). Some students reported in the survey as having a disability were not recognised by the education departments.

Table 5.27: Percentage of school-aged people (aged 5–20 years) with a disability living in households, by school attendance and type of school and class, by disability status, 2003 (per cent)

	Core activity limitation				Schooling restriction only	Total with specific restrictions	Disability without restriction	Total with a disability
	Profound	Severe	Moderate	Mild				
Attending school								
Ordinary school class	38.5	59.9	76.9	67.8				
Ordinary school (special class)	23.3	30.9	23.1	28.2	33.7	28.8	—	25.1
Special school	38.3	*9.2	—	*4.1	—	12.4	—	10.8
Total	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*
Total ('000)	**65.0**	**82.4**	**15.6**	**58.0**	**60.6**	**281.6**	**40.9**	**322.5**
Not attending school								
Reason for not attending:								
Condition prevents attendance	*41.0	*18.3	—	**10.7	18.4	16.1	—	12.1
Too young	—	*17.2	**11.4	**7.9	—	*7.7	**2.2	*6.3
Finished school	*59.0	*64.5	*88.6	81.3	81.6	76.2	97.8	81.6
Total	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*
Total ('000)	***6.5**	**14.4**	***8.1**	**18.6**	**15.4**	**63.0**	**20.9**	**83.9**
Total all school-aged people ('000)	**71.6**	**96.8**	**23.6**	**76.6**	**76.0**	**344.6**	**61.8**	**406.4**
Per cent attending school	**90.8**	**85.1**	**66.1**	**75.7**	**79.7**	**81.7**	**66.2**	**79.4**

Notes

1. Estimates marked with * have an associated relative standard error (RSE) of between 25% and 50% and should be interpreted accordingly.
2. Estimates marked with ** have an associated relative standard error (RSE) of greater than 50% and should be interpreted accordingly.

Source: AIHW analysis of ABS 2003 Survey of Disability, Ageing and Carers confidentialised unit record file.

Table 5.28: People aged 15–64 years living in households, by labour force status and by disability status, 2003

	Core activity limitation				Schooling or employment restriction only	Total with specific restrictions	Total with a disability	Total without a disability	Total
	Profound	Severe	Moderate	Mild					
Unemployment rate						Per cent			
Males	**8.5	*10.1	*7.2	9.0	14.3	10.3	8.7	4.8	5.3
Females	**24.6	*9.0	*8.1	*6.3	14.3	9.3	8.2	5.2	5.6
Persons	*13.9	9.5	7.6	7.7	14.3	9.8	8.5	5.0	5.4
Participation rate									
Males	22.1	38.5	56.3	53.1	73.1	53.4	59.3	89.0	84.0
Females	*9.4	33.9	40.3	48.1	61.8	42.1	47.0	72.3	68.1
Persons	15.2	36.0	48.0	50.6	68.4	47.8	53.3	80.6	76.1
Total in labour force						Number ('000)			
Males	14.3	62.6	114.2	156.6	146.1	493.9	671.8	4,968.8	5,640.7
Females	7.1	65.4	89.0	138.8	87.3	387.7	511.1	4,009.5	4,520.5
Persons	21.4	128.0	203.3	295.4	233.4	881.6	1,182.9	8,978.3	10,161.2
Total									
Males	64.6	162.6	202.8	295.2	199.9	925.0	1,133.1	5,584.1	6,717.2
Females	76.3	193.0	220.7	288.7	141.3	920.0	1,086.9	5,549.1	6,636.0
Persons	140.9	355.6	423.5	583.9	341.2	1,845.0	2,220.0	11,133.2	13,353.2

Notes

1. Estimates marked with * have an associated relative standard error (RSE) of between 25% and 50% and should be interpreted accordingly.
2. Estimates marked with ** have an associated relative standard error (RSE) of greater than 50% and should be interpreted accordingly.

Source: AIHW analysis of ABS 2003 Survey of Disability, Ageing and Carers confidentialised unit record file.

condition from attending (41%). Of the 79% of people with disabilities aged 5–20 years who were attending school in 2003, 64% were in ordinary classes, 25% were in special classes in ordinary schools, and 11% were in special schools. People with profound core activity limitations were the most likely to be in special schools in 2003 (38%).

Employment and labour force participation

In 2003, people aged 15–64 years with a disability had a lower level of involvement in the paid workforce than the rest of the population: a participation rate of 53%, compared with 81% for people without disability (Table 5.28). Participation rates for people with profound and severe core activity limitations were even lower—15% and 36% respectively. Women's rates were lower than men's across all disability levels.

Unemployment rates must be interpreted in the context of these lower participation rates, for both men and women. The unemployment rate for males participating in the labour force and having a disability was 8.7%—higher than that for men with no disability (4.8%) or for men generally (5.3% as measured in this survey[4]). The unemployment rate for women with a disability was 8.2%, higher than that for women generally (5.6%). Women with profound core activity limitations had very high unemployment rates—25%.

People with disabilities who were employed worked in a quite similar array of industries and occupations as other employed people. They were as likely to be 'managers and administrators' or professionals (8.4% and 18.4%) as others (8.1% and 19.2%) but slightly more likely to be 'intermediate production and transport workers' or labourers (10.6% and 10.9%) than others (7.7% and 7.9%) (ABS 2004a:27). They were more likely to be employed in government (including administration and defence), education, and health and community services (a total of 25.2%) than others (21.8%).

5.6 Summary and conclusion

Disability services are being delivered in a context of ongoing change. Population changes are significant: the Australian population overall is growing and ageing, and so is the population of people with disabilities. Differences between 'older Australians' and 'ageing people with disabilities' are not always clear-cut, and there is an acknowledged need to blend aged care and disability services more seamlessly and to improve intergovernmental linkages. Unpaid carers remain the main providers of assistance to people with disabilities and they and the service system together face these population pressures. Transitions to 'retirement' are seen to be needed, for both people with disabilities and for family carers, in addition to earlier life transitions, notably from school to work. Specialist disability services are looking to a flexible, individually focused model of service provision—and this, in turn, brings the challenge of accurate assessment of needs related to individualised, portable funding. Planning and funding for specialist service programs take place in a wider context of generic services of importance to people

4. The 2003 disability survey used a less rigorous definition of unemployment than the standard: thus, while the figures quoted here enable comparisons, they do not match exactly the ABS labour force data of the time.

with disabilities. Demand management is on the agenda of both government and non-government funders and providers. Other programs and funding policies—such as those provided by insurance systems, where assistance is provided on the basis of fault as well as need—add to the mix. Beyond the service context are changes in the fields of science, technology and genetics which pose ethical dilemmas as well as the possibility of providing enabling equipment that could expand people's opportunities. The consensual foundation of the field overall is that of human rights, and the need to create enabling environments so that people with disabilities can participate in every area of society.

This chapter, and the AIHW's work in this field, attempt to provide statistics which inform people interested in disability, and those attempting to meet the challenges of this changing context. Ongoing improvements to national data, outlined in Section 5.2, are essential infrastructure for the overall system. Not least of these is the implementation of the ICF into more of the relevant data collections, to provide more consistent and 'joined up' data, so as to support 'whole person', whole-of-government policies.

Population

In 2003 there were 3.9 million people with a disability in Australia—20% of the population. The majority, 2.6 million, were aged under 65 years and, of these, 677,700 people (3.9% of people aged under 65) had a profound or severe core activity limitation, meaning that they needed assistance with self-care, mobility or communication. The age-standardised rates of these more severe disabilities have not changed significantly in over 20 years. Nevertheless, because of population growth and ageing, the actual number of people with these disabilities is rising.

Equipment of all kinds was likely to be used by people with profound activity limitations, especially equipment associated with the core activities—self-care, mobility and communication.

For the first time it has been possible to include national data on disability among Aboriginal and Torres Strait Islander people, who had severe disability rates more than double those of other Australians in 2002.

Services and assistance

The largest income support programs in 2003–04 were:

- Disability Support Pension, with almost 697,000 recipients in June 2004 and expenses of close to $7.5 billion in 2003–04;
- Carer Allowance (Child/Adult), with 297,600 recipients and $965 million expenses, and Carer Payment (DSP/AP/other) with 84,100 recipients and $921 million expenses; and
- Disability Pension (DVA), with almost 155,000 recipients in June 2004 and $1,289 million expenses.

Some but not all of the growth in DSP recipient numbers over recent years can be attributed to population growth and ageing. While male age-adjusted rates of DSP receipt have levelled off in recent years, female rates have not.

Disability support services under the CSTDA were provided to 187,806 service users during 2003–04. The most widely accessed service group was community support (used by 42% of service users), followed by employment (34%) and community access (25%). Accommodation support services were accessed by 33,175 service users (18%), with 5,303 of these people using institutional accommodation. Government expenditure on disability support services during 2003–04 totalled $3.28 billion. Over half this expenditure was used to fund accommodation support services ($1,638 million).

Employment services reached relatively more of their potential target group (196 service users per 1,000 'potential population'), and accommodation support services the fewest of the major service categories presented (48 per 1,000). Unmet need for disability support services remains on the agenda of advocacy groups, as does managing demand for disability administrators.

A total of 6,524 CSTDA service users (3.5%) were identified as being of Aboriginal or Torres Strait Islander origin, or both. While this represents a higher proportion than in the overall population (2.4%), it is less than might be expected given their rates of disability, now estimated to be more than double those of other Australians.

Many CSTDA service users rely on informal carers (although the data on carers are still improving in coverage). Of these, 6,472 carers were aged 65 years and over: 3,959 were mothers of the service user (61%), 749 fathers (12%), 543 a husband/male partner (8%) and 446 a wife/female partner (7%).

During 2003–04, there were 170,100 HACC clients under the age of 65 years (24% of the total 707,200). There were also 6,240 clients aged under 65 years in permanent residential aged care facilities as at 30 June 2004—representing 4.3% of all residents in receipt of these services.

The available data on rehabilitation and hearing services, and on generic services such as education, employment and housing, are reported here, but there are none on the increasingly important area of equipment services. The health of people with disabilities, and the adequacy of health services for them, remain areas of concern.

Unpaid care remains the mainstay of the support system for people with disabilities. In 2003 there were 202,000 primary carers of people aged under 65, living with the main recipient of care (primary carers are the main providers of assistance with self-care, mobility and/or communication). They were most likely to be caring for a son or daughter (44%), or spouse or partner (44%). Some 20% of carers reported the need for further assistance themselves, and 18% needed more respite provided by formal services.

Outcomes—and data enhancements needed

A summary picture of participation in Australian society by people with disabilities is provided, with reference to the nine ICF 'activities and participation' life areas in which all people, irrespective of disability, expect to participate. Indicators are sought to 'measure' activity and participation in these life areas, reflecting national data standards.

Previous analyses have shown that people with disabilities are participating actively in all areas of Australian life, although not always to the same extent as other Australians. This new analysis confirms these findings and sheds light on some of the reasons why

this may be so. Very large numbers of people experienced difficulties in key areas such as mobility, interpersonal relationships and the 'major life areas' such as employment. The areas in which the need for assistance was most often reported were mobility, domestic life, interpersonal interactions and relationships, and employment.

These analyses, and the data gaps found in doing them, illustrate the benefits of using the ICF framework. It enables us to draw on various useful sources of data to compile a coherent summary picture. It also shows clearly the distance we still have to go before national data will really support a whole-of-government evaluation of the status of people with disabilities in Australian society. (Some specific directions for data are outlined in Sections 5.2 and 5.5.)

While Australia is relatively rich in information on people with disability and the specialist services they use, data on environmental factors (including equipment) and generic services (including health) are inadequate. Future enhancement may be needed to the national disability survey, to include more complete information on participation and environmental factors, using the ICF framework. The identification of people with disabilities in generic service collections, and greater consistency across disability and aged care services data, would promote understanding of person-centred outcomes and whole-of-government policy monitoring.

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6 Assistance for housing

6.1 Overview

A person's access to stable, adequate shelter is recognised as a basic human need. As noted in Chapter 2 healthy living encompasses the basic needs of life—a ready supply of clean water and nutritious food, access to shelter, a clean environment in which to live, and safety from harm. Housing is an important component of healthy living and also contributes to the other aspects of welfare status raised in this report covering autonomy and participation, and social cohesion. The following two chapters examine in more detail housing circumstances of Australians in terms of tenure, affordability and homelessness.

Homes more than provide shelter; they are also the major store of household wealth and the major source of household debt. Moreover, the delivery of housing services is an important part of the Australian economy: Australia has roughly 8 million dwellings, valued at over $2,200 billion (including the land). Dwellings account for almost two-thirds of private sector wealth—well above the levels in countries such as the United States and the United Kingdom (Productivity Commission 2004).

Since *Australia's Welfare 2003* there has been an increased focus by governments and the community on the level of and trends in housing affordability. In particular, the impact of housing affordability on housing outcomes has been examined for:

- low-income renter households in housing stress due to their inability to afford rental accommodation; and
- those households wishing to purchase a home that may be prevented by the high cost of doing so.

The higher priority given to these issues is set against a trend, commencing in the 1970s, to diversify housing assistance through various programs and policies aimed at spreading the assistance safety net wider. The key assistance areas are: Commonwealth Rent Assistance (CRA), an income support payment for private renters linked to the eligible household's private rental costs; public rental housing; community housing managed by not-for-profit organisations; and various types of home ownership assistance targeted at lower income households, including the First Home Owners Grant, low start loans, capital indexed loans and shared equity schemes.

In the past few years various changes have impacted on the effectiveness of current approaches to housing assistance:

- demographic change, including the ageing of the population, with a rise in the number and proportion of smaller households with smaller incomes and increased numbers of persons with a disability living in the community;
- housing preferences changing away from home ownership towards renting, placing more demand pressure on the private rental market;
- a reduced supply of low-rent dwellings in the private and social housing sectors;

- escalating house prices associated with low interest rates, assistance to home buyers and speculative behaviour by investors;
- concerns around the lack of acceptance of low-cost housing in the community and related innovation in the building industry; and
- labour market change and the related uneven changes in real incomes between income groups and across geographic regions of Australia.

These issues have been the subject of housing-related research undertaken by the Australian Housing and Urban Research Institute (AHURI), funded by Commonwealth, state and territory governments[1], and are discussed later in this chapter.

The rest of this chapter examines in more detail the need for housing assistance reflected in housing affordability for low-income households as well as other demographic and social characteristics of the population. Assistance provided to households is examined in terms of government programs aimed at households that are renting covering private, public and community housing. The issue of homelessness is raised in this context but is discussed in more detail in Chapter 7. Assistance to home owners who are buying or have purchased their home is then examined. This level of reporting on housing programs raises a number of data development and measurement issues and the final section discusses these.

6.2 Housing affordability

Recent research by AHURI has identified that finding affordable, secure and appropriate housing is a major problem for lower income Australian households. This problem has been increasing in size and depth and is now affecting moderate as well as low-income households (Milligan et al. 2005). The major concerns are:

- Limits to the ability of public and community housing stock to increase at a time of static or declining funding commitments under the Commonwealth–State Housing Agreement (CSHA). The need to target available vacancies to those most in need has diminished income from rent for state housing authorities. In many states and territories public housing stocks are aged. This has led to many public housing authorities having to dedicate CSHA capital funds to stock renewal, often at the expense of increasing the stock numbers of units in their portfolios (Hall & Berry 2004).
- CRA payments, while providing an important income supplement for eligible low-income households, often are not able to fully alleviate housing stress after the payment is taken into account. Australia-wide, one-third of CRA recipients pay more than 30% of their income in rent. This ratio also varies geographically with variation in rental markets (i.e. the proportion of households still in housing stress is larger in certain metropolitan areas) (AIHW 2004d).

1. AHURI is a joint venture between governments and universities. Each year, research themes and key topics are reviewed and research areas identified. Up to $2.6 million per annum is available for research to be undertaken by AHURI research centres, which are located in all states and territories.

- There is an overall shortage in the supply of private low-cost housing suitable for low-income households, with growth in the supply of private rental dwellings focused toward the high-rent end of the market (Yates, Wulff & Reynolds 2004).
- In the GST environment, uncertainty surrounds the respective ongoing roles of the Commonwealth and the states and territories in the provision of housing assistance.

Housing affordability is related to more than just the cost of housing. The following section examines the context in which housing affordability issues are occurring in terms of household income and debt.

Household income

Table 6.1 shows household income distribution by tenure type based on equivalised gross household income. In the lower income quintiles, public housing renters and owners without a mortgage are over-represented, while in the higher income groups owners with a mortgage are more common. Private renters are fairly evenly distributed across all income groups, accounting for between 16.9% and 22.0% in all quintiles.

Compared to all other tenure types, households renting from a state or territory housing authority are more likely to have a gross household income in the lowest quintile (66.2% of all public renters). In addition, only 14.2% of households renting from a state or territory housing authority have a gross income above the second quintile.

Table 6.1: Income quintiles of households, 2002 (per cent)

Equivalised gross household income quintiles[a]	Owner without mortgage	Owner with mortgage	Renter with state or territory housing authority	Renter with private landlord	All other tenure types	All persons
Lowest	25.6	8.2	66.2	16.9	26.0	19.6
Second	20.6	14.2	19.6	22.0	23.2	18.7
Third	17.6	20.6	9.2	21.4	14.4	18.9
Fourth	16.7	26.3	4.0	18.3	18.3	19.9
Highest	19.5	30.7	1.0[b]	21.4	18.0	22.9
Total	**100**	**100**	**100**	**100**	**100**	**100**

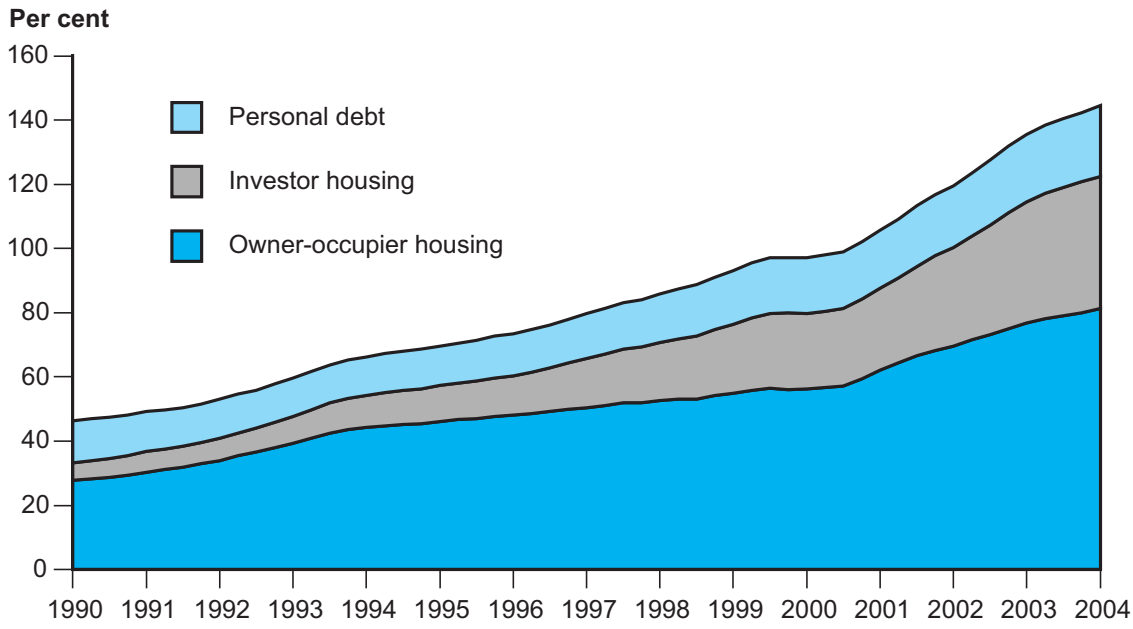
(a) Excludes persons where household income was not known or was not adequately reported.

(b) Estimate has a relative standard error of between 25% and 50% and should be used with caution.

Source: ABS 2004d.

Housing debt and borrowing for housing

Since the beginning of the 1990s, household debt (comprising debt from owner-occupied housing, investor housing and personal debt) has increased more than three and a half times in real terms. Over the same period, real household disposable income has risen by around 30%. Consequently, household debt as a proportion of household disposable income has increased from 49% in 1990–91 to 143% in 2004 (Figure 6.1). The Reserve Bank of Australia (Productivity Commission 2003b: 14) notes this growth in household debt has been very rapid by international standards, with the result that Australia has moved from the lower end of the debt-to-income spectrum to close to the top.



Note: The separation of housing debt is based on bank lending data.

Source: Productivity Commission 2004: fig. 3.3 (using Reserve Bank of Australia Statistical Reports).

Figure 6.1: Trends in household debt as a proportion of annual household disposable income, 1990–2003

The major component of this rise in household debt has been the even greater increase in borrowing for housing. Such borrowing has grown more than fourfold in real terms since 1990, with housing-related debt accounting for 84% of total household debt in 2004, up from 69% in 1990. Not all of this debt is actually spent on housing services as an increasing number of households have been using borrowed funds secured against property for other purposes.

While in dollar terms most of the increase in borrowing since 1990 has been for owner-occupied dwellings, the rate of growth in loans for investment properties has been much higher. This has resulted in the share of investment loans in total housing-related debt held by the banks rising from 14% in 1990 to 33% in 2003 (Productivity Commission 2003b).

Recent focus on affordability

The 2003 CSHA (Box 6.1) contains a broader focus on affordable housing than previous agreements. The last of its 11 principles seeks to 'promote a national, strategic, integrated and long term vision for affordable housing in Australia through a comprehensive approach by all levels of government'. The 2003 CSHA also specifically calls for the development of new programs that will involve the private sector in the financing and management of affordable housing delivery (Commonwealth of Australia 2003).

Box 6.1: The 2003 Commonwealth-State Housing Agreement (CSHA)

The 2003 CSHA will provide an estimated $4.75 billion, primarily for public, community, Indigenous and crisis housing.

The 2003 CSHA consists of a multilateral agreement accompanied by bilateral agreements between the Commonwealth and each state and territory. The CSHA specifies the guiding principles, funding arrangements and operating procedures. It also specifies an outcomes measurement framework based on bilateral information and a core set of nationally consistent indicators and data for benchmarking purposes. This includes the National Housing Data Agreement (NHDA) as a subsidiary agreement to the CSHA. The Commonwealth and the states and territories will provide such data as are required under the Data Agreement, according to specified standards, and will provide specific funding for data management and other purposes. The bilateral housing agreements allow for flexibility in the delivery of housing assistance according to each jurisdiction's needs and priorities.

The major guiding principles underlying the CSHA include:

- *to maintain a core Social Housing sector to assist people unable to access alternative suitable housing options;*
- *to develop and deliver affordable, appropriate, flexible and diverse housing assistance responses that provide people with choice and are tailored to their needs, local conditions and opportunities;*
- *to provide assistance in a manner that is non-discriminatory and has regard to consumer rights and responsibilities, including consumer participation;*
- *to commit to improving housing outcomes for Indigenous people in urban, rural and remote areas, through specific initiatives that strengthen the Indigenous housing sector and the responsiveness and appropriateness of the full range of mainstream housing options;*
- *to promote innovative approaches to leverage additional resources into Social Housing, through community, private sector and other partnerships; and*
- *to ensure that housing assistance supports access to employment and promotes social and economic participation.*

The Commonwealth and the states and territories agree that the bilateral agreements will be the main instruments for approving housing assistance outcomes and objectives.

Source: Commonwealth of Australia 2003.

Also, the Report of the Inquiry into First Home Ownership commissioned by the Commonwealth Government was released in 2004. The Treasurer had asked the Productivity Commission to undertake a public inquiry to evaluate the affordability and availability of housing for first home buyers, recognising that 'the ability to achieve home ownership continues to be of vital importance in maintaining family and social stability' (Treasury 2003). The Inquiry found that 'housing markets are large, diverse and

interactive' and that there 'is no "quick fix" to address affordability concerns'; however, 'there is scope for governments to increase the efficiency of housing markets and thereby to improve price and affordability outcomes over time'. The report identifies several areas where action could be taken (Productivity Commission 2004).

In the wider community these and many other issues concerning affordability were examined at the National Summit on Housing Affordability, conducted in June 2004 and hosted by the Housing Industry Association, Australian Council of Social Service, Australian Council of Trade Unions, Australian Local Government Association, and the National Housing Alliance. This forum identified several aspects of affordable housing in Australia requiring attention (Powall & Withers 2004: 31-38):

- increasing the supply of affordable housing;
- increasing access to housing that is affordable;
- enhancing delivery arrangements for social and affordable housing; and
- consideration of market efficiency and effectiveness.

Affordability for low-income households

The issue of housing affordability for people on low incomes is usually measured in terms of housing stress. This measure uses a household or income unit's[2] housing cost as a proportion of their income and is restricted to those in the bottom 40% of the income distribution[3].

Recent analysis undertaken by the National Centre for Social and Economic Modelling (NATSEM) estimated that in 2004 there were 883,000 families and singles in housing stress[4]. This represents 8.8% of all income units or 1.7 million people (Harding et al. 2004). Table 6.2 shows that two-thirds of all families and singles in housing stress are private renters, followed by owners with a mortgage (one-quarter). The risk of being in housing stress, expressed as the proportion in the tenure type in stress, also focuses on private renters, with 20.8% or around one in five families and singles privately renting being in housing stress. This proportion is much lower for all other tenures, with owners with a mortgage the next highest group at 9.4%.

2. An income unit is the basic unit used to determine eligibility for social security payments. Income units are analogous to family units with the distinction that non-dependent children and other adults living in the same household are treated as separate income units. Children receiving an income support payment, for example Youth Allowance, are also treated as a separate income unit even though they may not be regarded as independent (AIHW2004d).
3. There is no official housing affordability measure applicable to all tenures. For example, the CSHA program measures are based on households while the CRA measures are based on income units. For more information, see AIHW (2001).
4. The definition of housing stress used by NATSEM was 'families and singles were in housing stress if their estimated housing costs exceeded 30 per cent of their disposable income and they were in the bottom 40 per cent of the equivalent income distribution using an OECD equivalence scale' (Harding et al. 2004: 5).

NATSEM also examined the income unit type of those families and singles in housing stress. It was estimated that 55% of them were single person income units, 18% couples with children, 14% couples with no children and 13% sole parents. However, the estimated risk of being in housing stress for each of these family types was 10% for singles, 5% for couples with no children, 14% for couples with no children and highest for sole parents at 17% (Harding et al. 2004: fig 5 and 6). Related data for households are shown in Chapter 2 (Table 2.6), indicating that 13.4% of private renters and 8.6% of owners with a mortgage who are in the two lowest gross weekly income quintiles spend more than 50% of their gross income on housing costs.

Table 6.2: Income units in housing stress, June 2004

	Owners		Renters			
	Without mortgage	With mortgage	Public	Private	Other tenure	Total
			Number of income units			
In housing stress	38,000	231,000	23,000	590,000	0	883,000
Not in housing stress	3,114,000	2,233,000	433,000	2,249,000	1,143,00	9,173,000
Total	**3,152,000**	**2,464,000**	**456,000**	**2,839,000**	**1,143,000**	**10,056,000**
			Per cent of tenure			
In housing stress	1.2	9.4	5.1	20.8	0.0	8.8
Not in housing stress	98.8	90.6	94.9	79.2	100.0	91.2
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**
Total in housing stress (%)	**4.3**	**26.2**	**2.6**	**66.8**	**0.0**	**100.0**

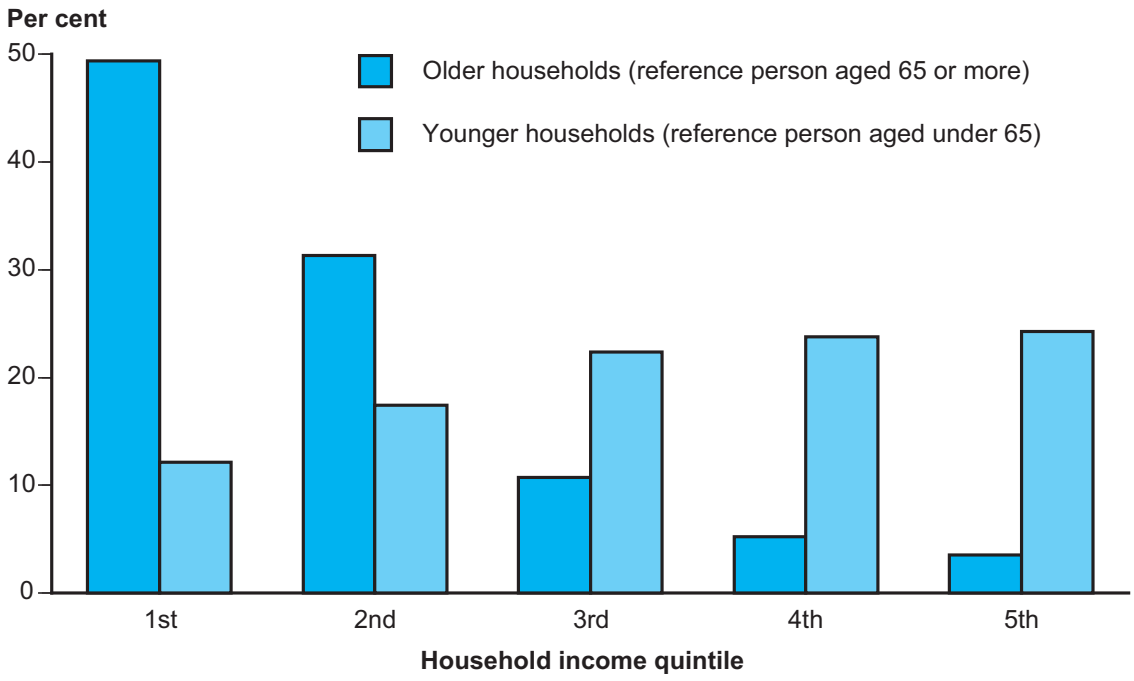
Note: Cell numbers may not add to total due to rounding.

Source: Harding et al. 2004: table 3.

Affordability for older Australians

Figure 6.2 presents household income distribution by age group of the household reference person, as reported in the 1999 Australian Housing Survey. Households with an older reference person (65+) are generally on lower incomes (i.e. the first and second quintiles) than younger households (under 65). About 30% of these younger households have income within the bottom 40% of income distribution. On the other hand, this proportion is 81% for older households. For older public housing tenants, 95% are in the two low-income quintiles; for older private renters the comparable figure is 88% (Table A.6.1).

The overall home ownership rate among older Australians living in private dwellings increased from 71.4% in 1991 to 73.0% in 2001. (Data presented in this section are based on the age of the households' reference person). This was made up of an increase in owners without a mortgage, from 64.7% to 68.5%, and a decrease in owners with a mortgage, from 6.7% to 4.5%. Also over this decade covering the last three Census years (1991, 1996 and 2001), there was a change in the rental housing profile of older Australians. The proportion renting private dwellings rose from 6.2% to 7.1%, while the proportion in public housing fell from 5.3% to 4.4% (see Table A6.2).



Source: Table A6.1.

Figure 6.2: Household income distribution by age of reference person, 1999

The proportion of older Australians living in non-private dwellings (residential institutions) decreased from 9.9% in 1991 to 9% in 1996 and 8.1% in 2001. This trend reflects the deinstitutionalisation process and the policy implementation of 'ageing in place' in Australia over the last decade. The trend was stronger for older age groups. For people within the 75–79 age group, 9.6% were in non-private dwellings in 1991, dropping gradually to 7.4% in 1996 and 6.1% in 2001. For people aged 80 years and over, nearly 27% were in non-private dwellings in 1991; however, in 2001 this proportion dropped to 21%. Further details on ageing and aged care can be found in Chapter 4.

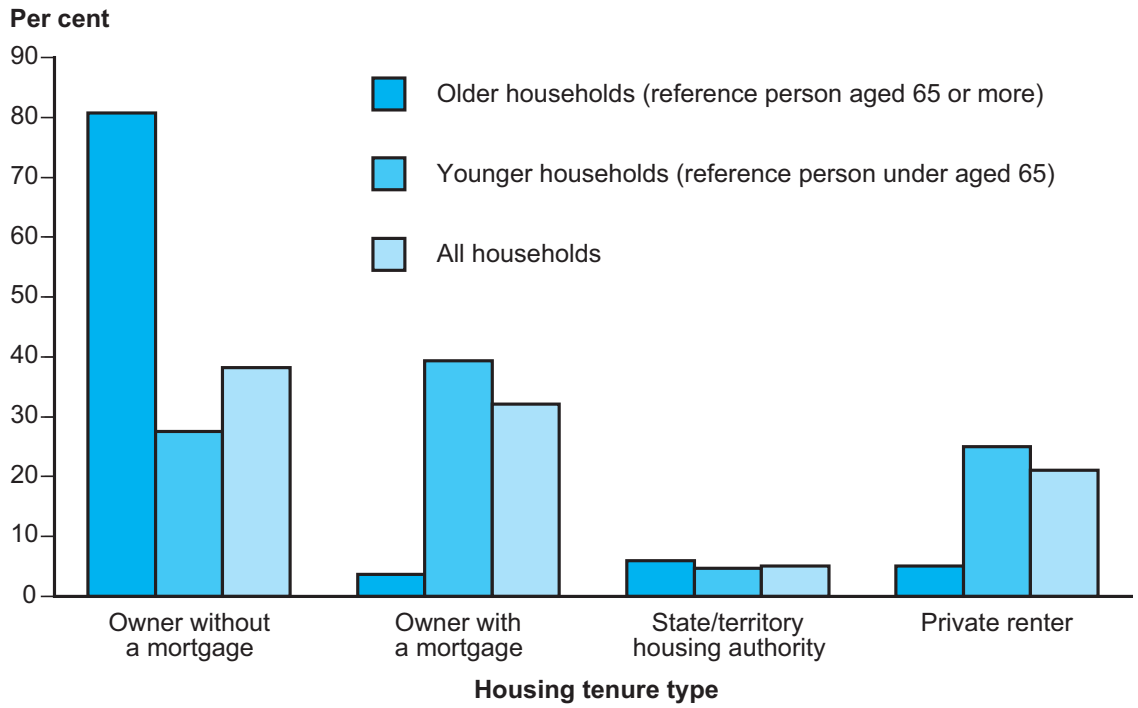
Figure 6.3 shows the different housing tenure profile of those aged 65 years and over and those aged under 65 years in 2001. Overall 70% of households were home owners. Older Australians are characterised by very high rates of home ownership: 81% of older households were home owners without a mortgage compared with only 21% of younger households. Overall, 84% of older households were home owners in 2001.

While the majority of older households own their home, 6% of older households were renting in public housing and 5% in the private rental market. For households with a younger reference person, nearly 20% were private renters, while only 3.6% were in public housing.

An area requiring closer examination is the nearly 30% of older CRA recipients who spend 30% or more of their income on rent after CRA payments. In particular, 6.5% (more than one in 20) of older CRA recipients spend over half their total income on rent.

For people in extreme housing stress (paying half or more of their income on rent), those paying 'private rent' and 'maintenance and other fees' are over-represented. Those who spend less than half but over 30% of their income on rent are mainly paying 'private rent' or for 'board and lodgings' (see Table A6.4).

The low-income older renters are found to have a limited capacity to meet increasing costs in the private rental market. Also some older people, particularly those on a low income with specific housing needs, are unable to find appropriate housing. Government housing assistance is seen as critical for helping these high-needs older people to overcome housing stress. Section 6.3 further discusses the housing needs of older Australians.



Source: Table A6.3.

Figure 6.3: Housing tenure, by age of reference person, 2001

Ways to improve housing affordability

In seeking to address affordability, governments and housing researchers are currently examining a range of policies and programs to identify which are the most appropriate (Berry & Hall 2001; Milligan et al. 2004). The areas being examined fall into six categories:

1. *Housing market efficiency*—to improve the operation of the housing market generally so that it produces and allocates dwellings at lowest cost and prices.
2. *Affordable housing market efficiency*—to improve efficiency in the management / delivery of affordable or subsidised housing.
3. *Supply-side subsidies*—to expand the stock of affordable housing.
4. *Demand-side subsidies*—to provide explicit or implicit income assistance for lower income renters and buyers.

5. *Fund-raising regulatory or taxation measure*—to raise cash or in-kind resources to fund the subsidies in categories 3 and 4 above.

6. *Ethical investment and charities*—as a means of funding affordable housing subsidies.

A number of affordable housing initiatives have been developed in recent years by state housing authorities, state land commissions, state planning and development agencies, local authorities, and the not-for-profit sector. Many are demonstration or pilot projects and some schemes operate under the broad framework of the CSHA while others are non-CSHA initiatives. They have in common a broad goal to make more affordable housing for lower income Australians (Milligan et al. 2005).

The distribution of government assistance

The distribution of government housing assistance has been illustrated in recent research (Yates 2003; see also AIHW 2004e). The most obvious is that provided through capital and recurrent funding through the CSHA and CRA to public and private renters. The effect of this form of assistance is immediate and fairly easily measured. Indirect assistance comes through the taxation and regulatory mechanisms of government. These provide benefits to households over a lifetime and may not be immediately obvious. In particular, the relatively high level of home ownership in Australia and the investment by Australians in their own home or as small property investors are facilitated by the assistance provided through tax and regulatory markets (see Section 6.5).

On a household basis, the value of assistance relating to capital gains and imputed rent in 1999 was on average $4,400 per household per year for owners and $900 for purchasers. This compares with $3,698 for public renters and $1,655 for private renters (Table 6.3). While the value of indirect assistance is greater than direct assistance by a factor of five, its different nature and the basis used to measure these benefits make such direct comparison unreliable (AIHW 2004e).[5]

The distribution of this group of benefits varies across households by income group, household type and location, with benefits to renters being targeted to low-income households while benefits to home owners are not (see Table A6.5). For example:

- More than 77% of the total CRA benefit was received by households with incomes in the lowest two income quintiles; 90% of the total public housing rental subsidy was received by households in public housing with incomes in the lowest two income quintiles.
- Assistance to home owners, on the other hand, primarily benefits higher income households. Nearly 70% of tax benefits to home purchasers went to households with incomes in the top two income quintiles. The tax benefit to home owners without mortgages shows that a significantly higher proportion of this benefit (93%) was received by households with incomes in the top two income quintiles.

5. While the value of imputed rent can be calculated, its use in a housing policy context is subject to debate (Productivity Commission 2004: 83-84).

Further information on the types of government housing assistance is provided in Sections 6.4 and 6.5.

Table 6.3: Value of direct and indirect assistance to households(a), 1999 ($)

	Household quintile (by weekly income from all sources)					
	1st quintile	2nd quintile	3rd quintile	4th quintile	5th quintile	All
Recurrent expenditure						
Private renter—CRA amount	1,645	1,694	1,709	1,342	979	1,655
FHOG 'one-off' amount[(b)]	7,000	7,000	7,000	7,000	7,000	7,000
Capital expenditure						
Public renters subsidy	3,550	3,990	3,710	3,325	. .	3,698
Tax expenditure						
Outright owners	0	2,100	2,500	4,600	8,800	4,400
Home purchasers	0	400	100	500	2,100	900

(a) Annual average amount.

(b) First Home Owners Grant (FHOG): Represents the lump sum one-off payment of $7,000 and is not an annual recurring benefit. Estimate of FHOG value for 1999 based on value at time of introduction on 1 July 2000.

Source: AIHW 2004e.

6.3 Demographic and social background

This section examines some of the factors that currently shape the demand for housing assistance in Australia. As noted previously, along with the rising demand for affordable housing there has been a drop in the level of public housing stock, decreasing nationally from around 372,100 dwellings in 1995–96 to 345,300 dwellings in 2003–04 (see Table A6.6). Also, as already mentioned, the availability of low-rent housing in the private rental market has not kept pace with the increased demand by low-income households (Yates & Wulff 2000).

Current analysis indicates that several of the links between housing consumption and life-cycle stages of individuals and families have been changing and will continue to change (Baxter & McDonald 2004; Bradbury & Chalmers 2003; Howe 2003; McDonald 2003b; Taylor et al. 2004). This research indicates:

- regional differences in housing opportunities along with a mismatch between housing location and labour markets;
- falling home purchase rates among 25–34 year olds;
- people remaining longer in the private rental market;
- delays in leaving the parental home and delays in household formation;
- fewer households with children and more children being raised in single parent households;
- persons living longer, with a rise in the number of 'old old' persons, which has implications for the provision of housing for this group; and
- people not achieving or unable to sustain home ownership.

The change is also an outcome of the varying rates of growth in Australia's population across age groups. In the past decade or so, growth has been highest among those older than 44 years, who as a group are more likely to be trading up to more expensive houses than entering the home purchase market for the first time (see Table A6.7). This is offset by the observation that, since 1996, there has been virtually no population growth in the 25–34 age group, which is usually the group most likely to include the majority of first home buyers.

In the long term these changes, particularly around structural ageing of the population along with reduced ability to achieve home ownership, may result in:

- persons who have spent all or most of their adult lives in private rental housing having higher lifetime housing costs, with subsequent implications for their ability to achieve financial independence in retirement;
- a reduced ability to keep older Australians in their own homes because it is rented rather than owned;
- growing long-term demand for private rental assistance; and
- the need for new types of housing assistance within the social housing sector.

Structural ageing and housing assistance

In the past three decades, the proportion of the older population in Australia (those aged 65 years and over) has risen by over 60%, from 8% in 1971 to 13% in 2001. The continuation of this trend, combined with apparent reductions in home ownership over the life-cycle, is expected to increase both the number and proportion of older people who rent, resulting in a higher demand for rental housing assistance by lower income older renters in years to come. Changes in levels of affordability, if sustained over the long term, may also have a fundamental impact. Similarly, changes in household structure over the last two decades or so—the increase in single person households through divorce or separation—have significant implications for the housing needs of older Australians.

Housing can have an influence on quality of life and overall wellbeing, particularly for the older population. The ability to remain in the community with assistance has been shown to be important to people's capacity to maintain health and wellbeing (Waters 2001).

Home ownership constitutes a significant financial resource for many older people, as well as a personal and social resource, providing a sense of security and continuity. This can reduce other stresses and delay entry into residential aged care, particularly where appropriate home-based services are available. As noted previously, it is generally recognised that home ownership has maintained the living standards of many older Australians and falling home ownership rates may, in the longer term, generate greater demands for income support.

It is argued that appropriate and affordable rental housing assistance to older people with few assets can, like home ownership, provide a stable basis of support. To date, social housing has provided such support and it is this solid public housing commitment that has been seen as the most important means of preventing poverty and hardship among older Australians who are economically disadvantaged and who do not live in their own home (COTA 1997).

In addition to affordability, security of tenure and rent regulation are also major issues for older private tenants. In some states, with the loss of low-cost rental accommodation, caravan parks or marinas may become a de facto low cost housing option. AHURI research suggests that such cheaper accommodation is often inappropriate to the needs of older persons not only in terms of access to facilities (supermarkets, transport, health services) and infrastructure (adequate lighting, safety features, flat well-maintained paths), but also because tenants may have limited legal rights (Jones et al. 2003).

Household formation

Based on current estimates the number of dwellings required nationally will grow more rapidly than the aggregate population if the average number of people per household continues to fall. During the 1990s and into the 2000s, the number of households has increased by 1.8% per year, while the population has grown by 1.2%, meaning that average household size has declined from 2.8 to 2.6 persons (AIHW 2003j). The shift to smaller households accounted for approximately 40 per cent of the growth in the number of households in the first half of the 1990s and 30% in the second half (BIS Shrapnel 2004).

Table 6.4 shows the projected growth of households, families and population between 2001 and 2026. The number of households is expected to grow by 41.7%, and the number of families by 31.4% compared with population growth of 24.7%. Single person households are projected to show the greatest increase (74.5%) and couples with children the least (4.7%).

The link between population growth and household formation is influenced by a large number of social and demographic factors. The current major influences include population ageing, the growing incidence of family breakdown, the declining birth rate, more people remaining single, and young adults staying at home for longer. Some of these factors encourage household formation and some work against it. Overall, these trends are increasing the underlying demand for housing.

Table 6.4: Projected growth of households, families and population, 2001–26 ('000)

	2001	2026	Change %
Households			
Family	5,269	6,920	31.3
Group	293	371	26.6
Lone person	1,805	3,149	74.5
Total	**7,368**	**10,441**	**41.7**
Families			
Couple families with children	2,492	2,610	4.7
Couple families without children	1,918	3,108	62.0
Lone parent	838	1,192	42.2
Other families	99	111	12.1
Total	**5,346**	**7,022**	**31.4**
Population	19, 413.2	24,201.8	24.7

Note: Projections based on Series II assumptions.

Source: ABS 2004c tables 6.4 to 6.6.

Health and disability

On a self-assessed basis, state or territory housing authority tenants consider themselves to have poorer health than those in other tenure types. Only 34.7% of such tenants consider themselves to have excellent health, compared to the national average of 59.2%. In addition, the percentage who rated their health as fair or poor was 37.2%, more than twice the national average (15.9%) (Table 6.5).

Table 6.5: Self-assessed health status of households, 2002 (per cent)

	Owner without a mortgage	Owner with a mortgage	Renter with state or territory housing authority	Renter with private landlord	All other tenure types[(a)]	All persons
Excellent/very good	51.3	68.2	34.7	63.2	63.5	59.2
Good	28.1	22.3	28.1	23.4	20.5	24.9
Fair/poor	20.6	9.5	37.2	13.4	16.0	15.9
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**

(a) Includes 'other renter' and 'other tenure types'.

Source: ABS 2003b.

While public housing tenants are more likely to assess their own health as poor, it appears that the provision of public housing itself brings improvements over their previous housing situations. Recent research found that health improvements for new public housing tenants included reduced stress, more money to buy better food, reduced dust and hazards in the home, and improved self-esteem. The study also found a slight decline in the costs and use of health services and that greater security led to people feeling safer (Phibbs & Young 2005).

For people with a disability, housing needs range from affordability to specific modifications and support services. People with a disability often cannot access secure, affordable, appropriate housing in the private market. Housing choice is limited by factors such as the additional costs of living associated with disability, the need for extra support services and dwelling modifications, and discrimination (AIHW 2003j).

In 2003 19.0% of Australians (3,958,300 people) had a reported disability (see Chapter 5). Approximately 3.8 million people with a disability were living as part of households in private dwellings (rather than in a residential setting) and of these, 61% needed assistance to manage their health condition and/or tasks of daily living (ABS 2004a).

The tenure group with the highest proportion of persons with a disability was public housing. Approximately 41% of public housing tenants reported a disability and this trend persisted across age groups (see Table A6.8). The tenures with lower proportions of people with a disability across age groups were owners with a mortgage, boarders and those living rent-free. In 2003 nearly one-third (32.8%) of state or territory housing

authority tenants[6] said they had a core activity limitation (Table 6.6). The number of people with a disability in public housing is increasing. In the 1998 ABS Disability, Ageing and Carers Survey, 38.7% of persons aged 15–64 years in public housing reported a disability (170,700 persons out of 441,000)(AIHW 1999: table 5.5). In the 2003 survey, this figure had increased to 41.6%.

The deinstitutionalisation of disability services has resulted in a greater need for community–based accommodation and support for people with disabilities (Bostock et al. 2001). Public and community housing are now, more than ever before, providing assistance to people who require additional support to sustain their housing (AIHW 2003j). For example, the deinstitutionalisation of those with intellectual disabilities continues to shape demands upon housing assistance. Research has found that, while there remain a significant number of people who could be deinstitutionalised, the rate of deinstitutionalisation is slowing across most jurisdictions in Australia, with the exception of New South Wales and Victoria. In New South Wales, almost 2,500 people will move into community-based housing over the next 10 years. Another 900, according to reports from other states, will make this move by 2011. As people with disabilities often cannot find appropriate housing in the private market, the main

Table 6.6 Disability status of people aged 15–64 living in households, 2003

	Core activity limitation[a]					
	Profound/ severe	Moderate	Mild	All with disability[b]	No disability	Total with/ without disability
	Distribution of disability status within each tenure type (%)					
Owner without mortgage	4.6	5.3	6.8	21.9	78.1	100.0
Owner with mortgage	2.7	2.4	3.1	13.4	86.6	100.0
Public housing renter	14.2	8.4	10.2	41.6	58.4	100.0
Private renter	3.4	2.8	4.0	15.7	84.3	100.0
Boarder	3.8	1.3	3.9	15.6	84.4	100.0
Living rent-free	3.7	1.6	3.2	12.9	87.1	100.0
Other[c]	4.5	1.8	3.5	13.7	86.3	100.0
Total	**3.7**	**3.2**	**4.4**	**16.6**	**83.4**	**100.0**

(a) Core activities comprise communication, mobility and self-care (see Chapter 5).

(b) Includes those with employment or schooling restrictions or people without restrictions but still screened as disabled.

(c) Includes life tenure schemes and rent/buy or shared equity schemes.

Source: AIHW analysis of ABS 2003 Survey of Disability, Ageing and Carers confidentialised unit record file.

6. The ABS classification of tenure types used in this survey includes the following rental categories:
   - State or territory housing authority.
   - Private landlord—a real estate agent, parent or other relative not in the same household, or another person not in the same household.
   - Other renter—a parent or other relative in the same household, the owner/manager of a caravan park, an employer (including a government authority), a housing cooperative, community or church group, or any other landlord not included elsewhere.

impact on housing demand as a result of deinstitutionalisation is likely to fall greatest upon the social housing sector (Bostock et al. 2001).

The impact of unmet housing need

The costs of unmet housing need are numerous and diverse and are often referred to as social costs. The most obvious and extreme form of such need is homelessness, although it is widely acknowledged that housing which is not affordable or adequate can also generate significant social and economic costs (Box 6.2).

Box 6.2: The costs of unmet housing need

Individual costs

- *homelessness*
- *family breakdowns*
- *physical and mental health problems (including drug and alcohol abuse and the inability to meet nutritional needs)*
- *problems of continuing formal education for both individuals and their children*
- *problems of obtaining or retaining employment or social security benefits*
- *social isolation and loneliness*
- *increased cost of travel due to location*
- *frustration and a sense of powerlessness*
- *discrimination*
- *loss of identity*
- *violence, anti-social behaviour and criminalisation*
- *health problems that can stem from the lack of follow-up treatment that is likely to occur if a person is constantly on the move*
- *poor nutrition resulting from limited or non-existent cooking facilities*
- *dwellings that are too small can exert pressure on a variety of households by: curtailing recreational or educational pursuits; increasing levels of conflict or stress; inhibiting visits from friends and relatives thereby increasing social isolation*
- *domestic violence can also become a problem within marginally housed families.*

Social costs

- *the lost opportunity cost of public, private and non-profit expenditure on homeless shelters and associated support services*
- *the opportunity costs of lost productivity due to illness and increased levels of morbidity*
- *environmental and maintenance costs of poor quality or poorly planned housing*
- *possible increased levels of crime*
- *costs of vacancies and eviction proceedings for private landlords.*

Source: Phibbs et al. 1999.

Factors contributing to unmet housing need include:

- mismatches between housing supply and demand of housing;
- poor location of housing (with respect to employment, transport and services);
- poor quality or poorly designed housing;
- poor physical and/or social planning (e.g. Radburn-style[7] developments; or concentrations of socioeconomically disadvantaged groups leading to a reduction in community diversity and 'ghettoisation');
- poorly maintained housing;
- the rigidity of specific housing assistance measures.

Many of these factors relate to non-housing outcomes and there is interest in how housing conditions impact on social and economic inequalities in Australia. In relation to low-income renters, recent AHURI research found that housing in itself is not the root cause of disadvantage and that the housing assistance received was not able to overcome the relative disadvantage experienced by the recipients (Mullins & Western 2001).

6.4 Housing assistance to low-income renters

In 2003–04, the value of assistance provided to private renters was over $2.0 billion. This comprised nearly $2.0 billion from the CRA program, and $78.4 million through CSHA private rent assistance (Tables A6.9, and 6.13). Also in 2003–04, the Commonwealth, state and territory governments provided nearly $1.3 billion for housing programs under the CSHA (Table 6.7), with public and community housing accounting for the majority of this funding. The Commonwealth paid to the states and territories $100 million for the Aboriginal Rental Housing Program, $64 million for community housing and nearly $40 million for crisis accommodation.

Table 6.7: CSHA funding, 2002–03 and 2003–04 ($m)

Funding arrangement	2002–03	2003–04
Base funding grants[(a)]	824.2	725.2
Aboriginal Rental Housing Program	100.0	[(b)] 100.7
Crisis Accommodation Program	39.7	39.7
Community Housing Program	64.0	64.0
State matching grants	359.5	355.0
Total	**1,387.4**	**1,284.5**

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

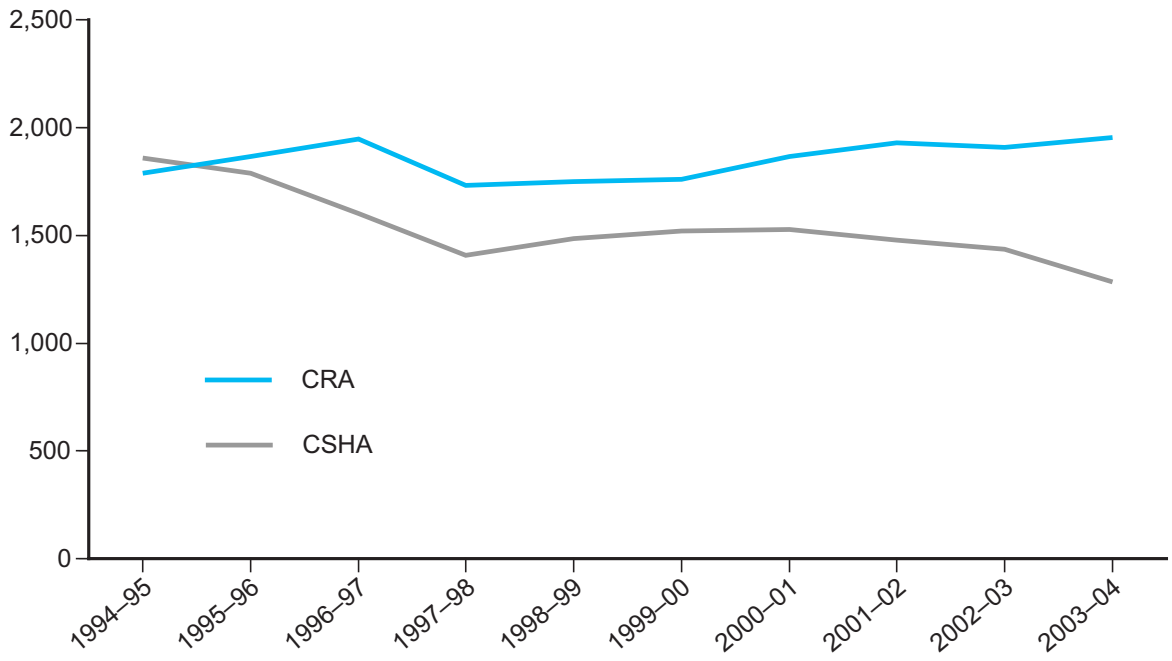
(b) Tas received $351,000 of their ARHP allocation of $696,000 as allowed in the CSHA. The remainder was not paid as there was no agreed Indigenous Housing Plan for ARHP for Tas for 2003–04.

Sources: FaCS 2003, 2005.

7. Features of Radburn public housing estates are: separation of motor vehicles and pedestrian access, large areas of internal open space connected by walkways, houses facing open space with back doors facing the street, housing constructed on superlots (not separate title) which makes subdivision and individual sale difficult.

Over the period 1994–95 to 2003–04, there were significant shifts in government expenditure for the CSHA and CRA (Figure 6.4). In 1994–95, government expenditure for the CSHA was 4% higher than for CRA. However, an increase of 9% for CRA expenditure and an 31% decrease for CSHA expenditure in constant price terms resulted in CRA expenditure surpassing that for the CSHA.

The figure should be interpreted with caution because of the differing nature of the programs. CRA is a recurrent expenditure program that is driven by demand (SCRCSSP 2002). Increases in CRA expenditure over the period are due to the extended coverage of the program and also to increases in the maximum rates of CRA during the early 1990s (FaCS 2001a, 2001b). CSHA expenditure includes recurrent and capital components. The capital component has provided funding for public housing stock totalling over $30 billion that is continually used for housing assistance (FaCS 2001a). A decline in CSHA expenditure may not necessarily result in a decrease in available CSHA stock; however, recent trends have shown a decline in public housing stock (see Table A6.6).



Source: Table A6.9.

Figure 6.4: Government expenditure on CSHA funding and CRA, 1994–95 to 2003–04

Benefits of housing assistance

The benefits of housing assistance to individuals, families and communities vary across the different assistance types. For example, CRA can provide long-term assistance for Centrelink clients, while CSHA private rent assistance is of a more 'one-off' nature intended to assist either transitions into private rent (bond loans, movement fees) or to address specific episodes of financial stress ('top-up' CRA to improve affordability and prevent eviction) (see also Burke 2002).

The advantages of public rental housing identified by recent research (Burke et al. 2002) include: regulation by the government, therefore reduced likelihood of discrimination; affordable rent, as no tenant pays more than 25% of income on rent; and public housing generally meets the requirement of people with special needs, such as disabled tenants needing modifications to their dwellings. In addition to these advantages, there are other aspects of public housing that tenants also identify as benefits. In the 2003 National Social Housing Survey (NSHS), tenants noted that public housing helps them 'feel more settled in general' and they are able to 'manage rent/money better' (Table 6.8). Other aspects perceived to have improved tenants' quality of life and psychological wellbeing included being able to continue living in the same area, having better access to services, being 'more able to cope', feeling part of the local community and enjoying better health (CBSR 2003). Many of these aspects relate to the security of tenure afforded by public housing.

Data for community housing were also collected in the 2002 NSHS (see Section 6.4). Unfortunately, similar data on low-income private renters and home owners are not available so it is not possible to explore these issues for these tenure types.

Table 6.8: Ways in which public rental housing helped tenants, April–May 2003 (per cent)[(a)]

	Yes it has helped	It hasn't helped yet but may in the future	No it hasn't helped	Per cent
Feel more settled in general	91	3	6	100
Manage rent/money better	91	3	6	100
Been able to stay living in this area	88	3	9	100
More able to cope	87	3	10	100
Better access to services	80	5	15	100
Feel part of local community	74	6	20	100
Enjoy better health	66	8	26	100
Start or continue education/training	50	18	34	100
See an improvement in job situation	40	19	42	100

(a) The base for percentages is all respondents with an opinion and who say this statement applies to them (base size varies by statement).

Source: CBSR 2003.

Who benefits from housing assistance?

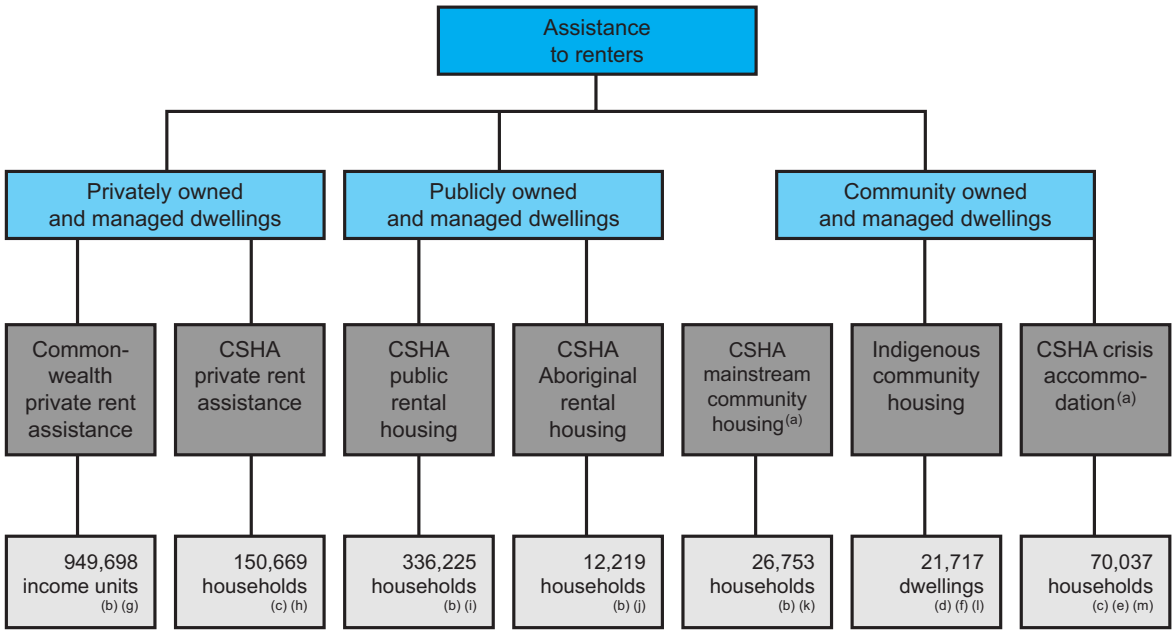
Figure 6.5 shows the distribution of recipients of rental assistance across the private, public and community rental sectors. The different data sources limit comparisons across sectors and highlight the need to improve data in the future (see Section 6.6).

In June 2004 in the private rental market, 949,698 income units received CRA (AIHW 2003a). Although it is not possible to readily identify how many households this represents, estimates based on 1999 ABS housing survey data indicate that in 1999 the 594,600 income units identified as receiving CRA were living in 426,200 households. This represents a ratio of 1.4 income units per household (AIHW 2003i; see also AIHW: Karmel et al. 1998:191). Under the CSHA, private rental assistance was also provided to

150,669 households in 2003–04 (see Table 6.13). Because of the overlapping nature of these two types of assistance and because the data cannot be adjusted to avoid double-counting, the data cannot be added together to obtain a total number of households receiving some form of private rental assistance.

In June 2004, 336,255 households occupied mainstream public housing, paying either rebated or non-rebated rent. A further 12,219 households were occupying public housing specifically for Indigenous Australians, provided through the CSHA Aboriginal Rental Housing Program (AIHW 2005a).

At least 26,753 households in June 2004 lived in mainstream community housing provided through the CSHA and state and territory community housing programs (AIHW 2005b). A 2001 ATSIC survey identified 18,842 permanent and temporary occupied dwellings that were managed by Indigenous community organisations (ABS 2002:15).



(a) Additional dwellings are funded under programs other than CSHA; but data about these dwellings are not available. CSHA crisis accommodation 2003–04 data for NSW and Vic have significantly increased since Australia's Welfare 2003 due to changes in coverage.

(b) At 30 June 2004. Figures are not consistent with those reported in the 2003 Report on Government Service Provision as they are from a different data set.

(c) For year ending 30 June 2004.

(d) March to June 2001. The number of community owned or managed dwellings has been used as the proxy in this figure. The figure may be an over-representation as dwellings may be uninhabitable (i.e. CHINS reported that 11% of community owned or managed Indigenous dwellings needed replacement and 21% needed major repair). However, the figure may be an under-representation as there may be more than one household per dwelling.

(e) Household data were provided by Vic, Qld and WA only.

(f) Of these 18,735 were state administered and 2,982 were administered by the Commonwealth through FaCS.

Sources: (g) see Table A6.10; (h) see Table 6.13; (i) AIHW 2005f; (j) AIHW 2005g; (k) AIHW 2005b; (l) ABS 2002; (m) AIHW 2005c.

Figure 6.5: Recipients of rental assistance across rental sectors, 2004

In addition to CSHA-funded and Indigenous targeted housing, other organisations provide community housing. For example, several community housing organisations provide housing to aged persons using stock outside the CSHA that was established through subsidies provided by the Commonwealth Government under the Aged Persons' Homes Act. It should also be noted that some affordable housing initiatives funded under the CSHA may provide housing through not-for-profit housing organisations but are not represented in CSHA community housing data as they are not funded through this program.

In 2003–04, 70,037 households received crisis accommodation through the CSHA Crisis Accommodation Program in Victoria, Queensland and Western Australia (AIHW 2005c). Information about additional types of assistance provided to homeless persons through the Supported Accommodation Assistance Program can be found in Chapter 7.

Assistance across rental sectors

With the recent concerns around declining home ownership rates, particularly for younger households, the demand for rental accommodation has been strong. In addition to causing increased housing stress for many low-income households for whom home ownership is always likely to be beyond reach, the growing shortage of rental housing that is affordable for low-income households may also make it more difficult for some households to save a housing deposit. This concern was noted in the Productivity Commission's report on First Home Ownership and reflected in the recommendation that a national public inquiry should be established to examine the housing needs of low-income households across Australia, including in Indigenous communities, and the nature and extent of assistance to help meet those needs (Productivity Commission 2004).

Assistance to renters across private, not-for-profit and public rental housing is undertaken in an environment where:

- private renters may have difficulty finding low-rent housing and as a result face high rental costs; and
- demand for social housing from public and community housing is high, reflected in significant wait lists in a situation of stagnant or declining public housing stock and slow growth in the community housing stock.

How governments are able to allocate scarce funds to achieve efficient and effective outcomes now includes a greater focus on tailoring housing assistance to meet particular needs for defined periods.

The role of social housing

Under the 1999 and 2003 CSHA there has been greater recognition that assistance should be to those in greatest need and be restricted to the duration of that need. Housing assistance to renters has a greater focus on the differing duration of need. Programs and policies are now more tightly focused on providing assistance to address a short-term, one-off or unexpected need for assistance, transitional assistance or ongoing assistance.

This focus on those in greatest need is changing the profile of recipients of assistance. Table 6.9 illustrates this by examining the types of needs tenants had when they entered public housing. The data show that far more newer tenants (those in public housing for less than a year) give, as a reason for moving into public housing, 'homeless/in a refuge/ living with friends' or 'in a violent/dangerous situation' than longer term tenants.

Table 6.9: Reasons for moving into public housing, April–May 2003 (per cent)

	Total time as public tenant						
	6 months or less	Over 6 months to 1 year	Over 1 to 2 years	Over 2 to 5 years	Over 5 to 10 years	Over 10 years	Total[(a)]
Couldn't afford private rental	37	49	48	48	53	43	47
It offered low or lower rent	40	45	48	45	48	39	44
Security of tenure/not having to move	33	31	36	36	37	30	34
Was homeless/in a refuge/ living with friends	39	31	27	20	18	12	20
Wanted to live in this area/ meant I could afford to live in this area	18	20	18	17	19	15	18
Previous housing was poor quality/this is a better house	18	10	13	16	14	16	14
Couldn't get private rental	14	14	10	8	7	9	9
Was in a violent/dangerous situation	9	9	9	9	6	4	7

(a) Total does not add to 100% as more than one answer was allowed.

Source: CBSR 2003.

Across states and territories both public and community housing organisations work with community services agencies to provide accommodation to homeless persons. The SAAP program is the major program operating across all jurisdictions (see Chapter 7). Quite often national-level data do not reflect the diversity that operate in each jurisdiction. Different programs and allocation policies in public and community housing as well as the links to support services have built differences in the way homeless persons enter social housing. Nationally 17% of all new allocations to public housing in 2002–03 were to people who were homeless (Table 6.10). The Australian Capital Territory had the highest proportion of homeless allocations (78.2%), followed by Tasmania (59.8%). Queensland had the lowest proportion (2.8%).

Table 6.10: CSHA public rental housing homeless allocations, 2002–03

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total
Number of homeless allocations	727	2,170	145	152	724	810	740	n.a.	5,468
Percentage of allocations	7.2	32.5	2.8	3.5	19.2	59.8	78.2	n.a.	16.8
Total of all new allocations	10,129	6,670	5,251	4,411	3,776	1,355	946	827	33,365

Note: see Table 6.11.

Source: AIHW analysis of NHDA NMDS state and territory data files.

Of all new housing allocations to state owned and managed Indigenous housing (SOMIH) in 2002–03, 7% were to people who were homeless (Table 6.11). South Australia had the highest rate, at over 15%, while Queensland had the lowest at 1.3%.

Table 6.11: New SOMIH placements for Indigenous homeless, 2002–03

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total
Number of homeless allocations	30	20	4	19	34	0	. .	. .	107
Percentage of allocations	6.8	11.8	1.3	4.4	15.1	0.0	. .	. .	6.5
Total of all new allocations	440	169	312	428	225	83	. .	. .	1657

Notes

1. NSW, Vic, Qld and WA provide only one priority reason. However, some new allocations may have more than one priority reason, so homelessness may be undercounted.
2. SA has a single priority code that covers two categories, that is, HA = homelessness/at risk and access barriers. Households have been split equally between the two categories.

Source: AIHW analysis of NHDA NMDS state and territory data files.

For mainstream community housing at 30 June 2003 there were 41 CSHA community housing providers who primarily assisted the homeless, which represents 3% of all CSHA community housing providers in Australia (Table 6.12). At 30 June 2004 there were 7,129 dwellings funded through the CSHA Crisis Accommodation Program (CAP).

Table 6.12: Community housing providers at 30 June 2003(a), and dwellings funded through the CSHA Crisis Accommodation Program, 30 June 2004

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total
Total number of community housing providers with a primary target group of homeless people	12	19[(b)]	5	2	1[(b)]	1	1	0[(b)]	41
Proportion of community housing providers targeting homeless people (%)	6.3	8.1	1.5	0.8	0.8	2.1	11.1	0.0	3.3
Total number of community housing providers	190	234	345	255	126	48	9	22	1,229
Number of crisis accommodation dwellings	1,355	3,779	1,015	447	243	118	56	116	7,129

(a) Data are provided by survey except where noted and may be affected by low response rates.

(b) Results pertain to administrative data—all other data for community housing are based on jurisdiction surveys.

Source: AIHW 2003a, 2005c.

In recent years there has been a shift to more community housing providers taking on the role of assisting homeless persons that was previously provided through CAP and SAAP. This shift in response has come about for a number of reasons related to homelessness no longer being restricted to specific situations or people, due to such things as rising unemployment and a decrease in the availability of low-cost housing, with all kinds of people being affected. The deinstitutionalisation of people with mental illness has been a further contributing factor (NCHF 2003).

Also the increase in people requiring crisis-related accommodation and the decrease in affordable housing have led to the need for greater length of time in crisis accommodation, leading in turn to a growth in the supply of medium-term or transitional housing and long-term options. Providers have taken on a broader role and operate to provide a wider range of housing and support services (NCHF 2003). An example of this is shown in Box 6.3.

Box 6.3: One organisation's approach—Multi Agency Community Housing Association (MACHA)

MACHA is a community housing provider targeting low-income and homeless adults in the inner city of Adelaide. Established in 1991 it currently manages approximately 120 properties, and is gradually expanding due to unmet need.

MACHA was established through the cooperation of a group of welfare organisations and undertakes the function of a landlord, pursuing housing development opportunities, while member agencies provide support services to tenants. All tenant referrals are taken from member agencies. If applicants are then approved they are put on a waiting list and placed in housing as it becomes available. After applicants have been housed, MACHA works closely with member agencies in the ongoing management of tenancies.

Many of the support services provided to MACHA tenants are funded through SAAP, but also draw on funding through other Commonwealth, state and local governments, churches and other charitable organisations.

MACHA has an annual turnover of approximately 16% and an average length of stay of almost 2 years. This organisation has been able to develop a growing level of stability for its tenants and has been successful in its attempts to provide for this special needs group.

Sources: Farrar et al. 2003; Woodward 1999.

Assistance to private renters

Private rental accommodation has unique attributes that make it a desirable form of assistance for some renters. Private renters have greater choice regarding the size, location and quality of their dwelling. Such choice may involve a trade-off between these factors and price, but it allows private renters to have direct control over their standard of housing.

In Australia, the current forms of housing assistance for the private rental market cover a range of policies and programs. The major types of assistance are: government budget outlays, including financial assistance to households to pay rent, bond and relocation costs; taxation expenditure, providing incentives for investors and landlords through negative gearing; government regulations and standards for tenants and landlords, including residential tenancy legislation and 'affordable housing' planning regulations; and other services, such as tenant advice services and automatic rent deductions for income support recipients.

Commonwealth Rent Assistance

Commonwealth Rent Assistance (CRA) is a non-taxable income supplement paid through Centrelink to individuals and families who rent in the private rental market. It aims to address basic living costs by reducing the proportion of an income unit's budget that has to be spent on housing. As noted previously, in 2003–04 the CRA program provided nearly $2.0 billion of assistance to private renters (see Table A6.9).

Recipients of a Centrelink pension or allowance, or an amount of Family Tax Benefit over the base rate of Family Tax Benefit Part A (FTB A), who are also paying private rent above minimum thresholds, may be eligible for CRA (FaCS 2002). It is generally not paid to home owners/purchasers, people living in public housing, or people living in residential aged care services with government-funded beds.

CRA is paid at a rate of 75 cents for every dollar paid by the income unit above the thresholds until a maximum rate is reached. The maximum rates and thresholds vary according to a client's family situation, the number of dependent children they have and amount of rent paid. For single people without children, the rent threshold and maximum rate also vary according to whether or not accommodation is shared with others. Rent thresholds and maximum rates are indexed twice each year (March and September) to reflect changes in the consumer price index. More information on CRA eligibility rules including minimum rent amounts and maximum amounts of CRA payable for various income unit types can be obtained from Centrelink's website at <www.centrelink.gov.au>.

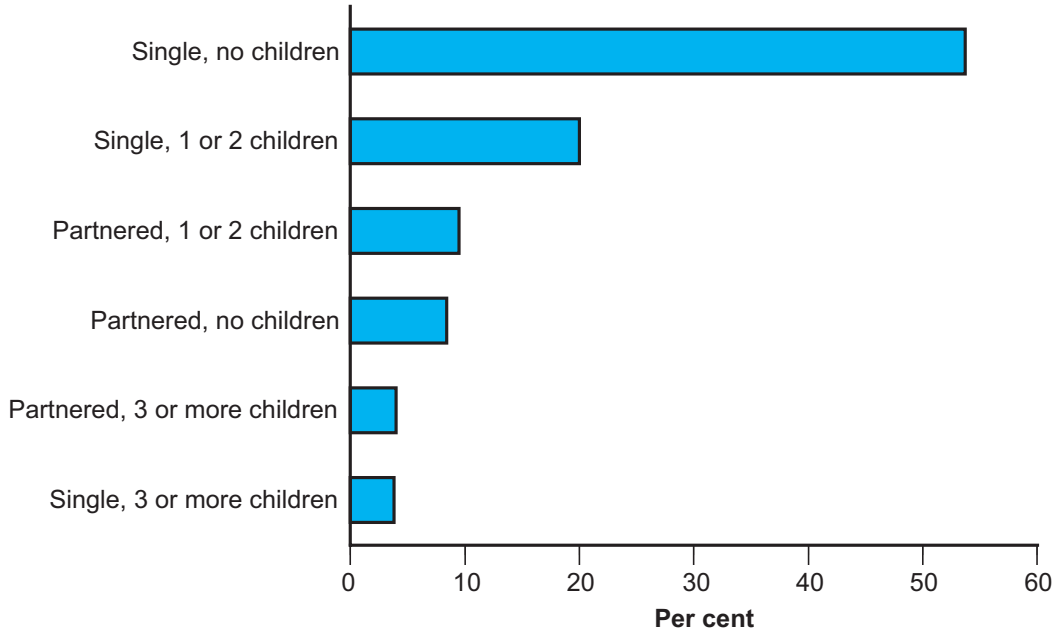
The results presented in this section are derived using data on income units who were in receipt of a Centrelink pension or allowance, or an amount of Family Tax Benefit over the base rate of FTB A, for the fortnight ending 14 June 2004. The source for all data presented here is the Department of Family and Community Services (FaCS) housing data set.

Profile of CRA recipients

In June 2004, of the 3,975,800 Centrelink clients, 949,700 (about 24%) had an ongoing entitlement to and were receiving CRA. (This subgroup of income units is hereafter referred to as 'CRA recipients'). Figure 6.6 shows the significant differences in CRA recipient rates between income unit types, ranging from 53.7% for single people without children to 3.8% for single parents with three or more children. The proportion of people in different groups (e.g. age, income unit type, Indigenous status, etc.) who are eligible for CRA depends on a number of factors, including the level of home ownership, the availability of public housing, the proportion of young people living with parents, and rental obligations. Separate analysis of the CRA entitlement rate based on these variables is difficult to undertake as the rental circumstances of income units not entitled to CRA may not be verified or updated.

Impact on housing affordability

The aim of CRA is to assist low-income families and single persons with meeting their private housing rental costs. It is not intended to meet a specific benchmark for housing affordability but rather to improve affordability. This section examines the impact CRA has on housing affordability by comparing the proportion of income that recipients would spend on rent both before and after CRA is received. CRA has been treated as a housing subsidy, and deducted from rent, to calculate affordability after CRA is received.[8]



Notes

1. CRA recipients are income units in receipt of a Centrelink payment and received CRA during the fortnight ending 11 June 2004 and have an ongoing entitlement to CRA at the end of this period.
2. The category 'Single, no children' includes single people in shared accommodation.
3. The category 'Partnered, no children' includes Partnered, no children, temporarily separated or separated due to illness.

Source: Table A6.10.

Figure 6.6: Distribution of CRA recipients, by income unit type, June 2004

Figure 6.7 shows the proportion of income units receiving CRA in June 2004 that paid more than 30% of their income on rent, with and without CRA. Before CRA payments, 65% of income units did so; after CRA payments, the proportion fell to 31%. There was a similar pattern for income units that spent more than 50% of income on rent: before CRA, 28% of income units; after CRA, 9% (see Table A6.11). The Australian Capital Territory, New South Wales and the Northern Territory contained the largest proportions of CRA recipients spending 30% or more of their income on rent before CRA was received (73%, 72%, and 70% respectively). This reflects the high market rents in these jurisdictions. After receipt of CRA, affordability improved substantially, with the proportions decreasing significantly (33.5%, 43.6% and 47% respectively).

8. Affordability without CRA is the ratio of rent to total income (excluding CRA), and expressed as a proportion. It is calculated by 'Affordability without CRA' = rent/total income * 100. Affordability with CRA is calculated by subtracting CRA from the actual rent paid, then dividing this by total income (excluding CRA), and expressed as a proportion. That is, 'Affordability with CRA' = (rent less CRA)/(total income excluding CRA) * 100. Other approaches to calculating affordability can be used (National Shelter & Australian Council of Social Service 2003). The approach used here follows the convention used in national reporting by FaCS and the Productivity Commission (SCRCSSP 2003).

Source: Table A6.11.

Figure 6.7: Income units receiving CRA paying more than 30 per cent of income on rent, with and without CRA, 2004

The Australian Capital Territory and New South Wales also had the largest proportions of CRA recipients paying more than 50% of their income on rent before CRA was received (39% and 32% respectively). After receiving CRA, however, the Australian Capital Territory remained the jurisdiction with the highest proportion of such recipients (over 16%), followed closely by New South Wales (12%) (see Table A6.11).

CSHA private rent assistance

Funding is also provided under the CSHA to enable people to access and maintain accommodation in the private rental market. The types of assistance include bond loans; assistance with rent payments, including advance rent payments and cash assistance additional to CRA; and relocation expenses, other one-off grants such as housing establishment grants, and advice and information. In 2003–04, states and territories provided almost $73 million of CSHA-funded private rent assistance to over 150,000 Australian households. More than half of this assistance was in the form of bond loans (Table 6.13). The diversity of types of assistance, the varying ways 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 a rental supplement over several months to resolve a housing affordability problem.

Table 6.13: Assistance provided under CSHA private rent assistance, 2003–04

	NSW[a]	Vic	Qld[b]	WA	SA	Tas	ACT	NT	Aust.
					Total households assisted (number)[c]				
Bond loans	15,606	14,432	17,378	14,128	13,057	3,497	67	766	78,931
Rental grants/subsidies	8,775	35,423	950	. .	12,368	956	. .	. .	58,472
Relocation expenses	. .	2728	. .	. .	. .	121	. .	. .	2,849
Other one-off grants	3,774	1,569	. .	. .	. .	5,074	. .	. .	10,417
Total households assisted	**28,155**	**54,152**	**18,328**	**14,128**	**25,425**	**9,648**	**67**	**766**	**150,669**
					Total value of assistance ($'000)				
Bond loans	14,758	8,746	12,081	5,800	7,066	1,236	47	499	50,233
Rental grants/subsidies	14,146	5,648	911	. .	3,511	165	. .	. .	24,381
Relocation expenses	14	354	. .	. .	. .	32	. .	. .	400
Other one-off grants	3,081	280	. .	. .	. .	. .	. .	. .	3,361
Total value of assistance	**31,999**	**15,028**	**12,992**	**5,800**	**10,577**	**1,433**	**47**	**499**	**78,375**

(a) Figures represent the number of households that were approved for assistance in the 2003–04 financial year, not the actual number of households assisted.

(b) The proxy for number of households assisted is the number of bond loans paid to the Rental Tenancies Authority and the number of rental grants paid to the agent/lessor.

(c) Households may be eligible for more than one type of assistance.

Source: AIHW 2005e.

Public housing and state owned and managed Indigenous housing

Since 1945, Commonwealth and state governments have provided long-term housing assistance to Australian families and individuals under the CSHA. The 2003 CSHA aims to provide affordable and appropriate housing assistance for those who most need it, for the duration of their need. In 2003-04, governments provided $1.28 billion of housing assistance under the CSHA, with public housing accounting for the majority of CSHA funding.

There are two government housing programs that operate under the CSHA: public housing, and state owned and managed Indigenous housing (SOMIH). At 30 June 2004, these programs accommodated 348,469 households consisting of 724,483 people. The public housing program determines the eligibility of tenants by multi-faceted criteria designed to identify those most in need and is open to all households. The SOMIH program, however, provides housing assistance specifically for Indigenous households.

Under the public housing and SOMIH program, tenants usually pay reduced rents to state and territory housing authorities. The level of rent paid is based largely on household income. Although rent rebate schemes are not uniform across state and territory housing authorities, most of the states and territories share a consensus that tenants eligible for a rebate will not pay more than 25% of their assessable household income on rent.

Following the introduction of the 1999 CSHA, the national level of public housing stock decreased from 362,967 dwellings in 1999–00 to 345,335 dwellings in 2003–04 (see Table A6.6). This reduction was a result of several factors, including: the transfer of public

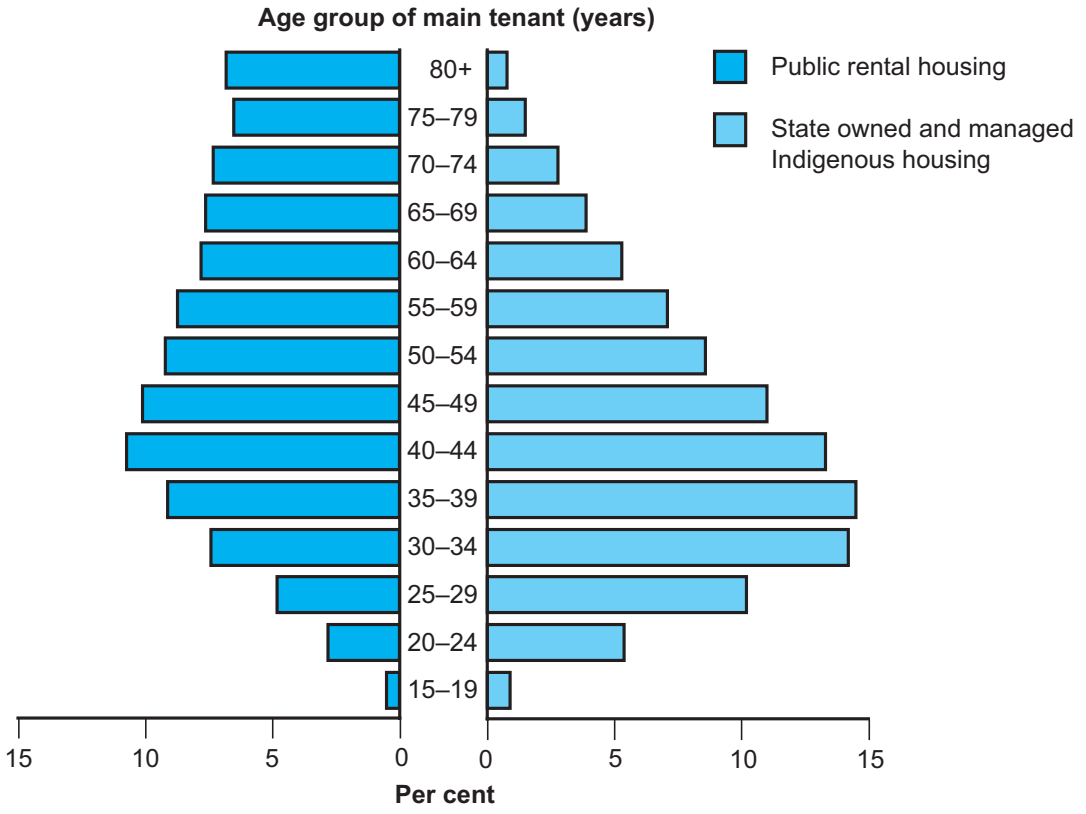
housing dwellings to other social housing stock; ageing stock requiring maintenance and upgrades; and the reconfiguration of stock to better meet client needs (AIHW 2001).

Rebated households at 30 June 2004

The large majority of public rental housing tenants (88%) and SOMIH tenants (83%) receive a rental rebate (see Tables A6.13, A6.14). This represents a total of 304,598 public rental and SOMIH households. The rent paid by rebated households is lower than the actual market rent of the occupied dwelling. The rebate amount is generally the difference between the market rent and the rent paid by the tenant.

This section focuses on the characteristics of only those tenants receiving rental rebates, because in most jurisdictions the administrative data for rebated tenants is more accurate than for non-rebated tenants.

There is a marked difference between the ages of public housing tenants and SOMIH tenants (Figure 6.8). On average, public housing tenants are older than SOMIH tenants (53 and 43 years respectively). Three per cent of public housing tenants are aged under 25 years, compared to 6% of SOMIH tenants. Less than one-third (32%) of public housing tenants are aged 25-44 years; over half (52%) of SOMIH tenants are in this age group. Nearly 30% of public housing tenants are 65 years and over, compared to only 9% of SOMIH tenants. The differences in age distribution can be largely accounted for by higher levels of fertility and lower life expectancy in the Indigenous population (ABS 2003a).



Source: Table A6.12.

Figure 6.8: Public rental housing and SOMIH tenants, by age group, at 30 June 2004

Household composition and size

More than half (52%) of public housing households and 21% of SOMIH households consist of a single adult (Table 6.14). A key difference is the proportion of each household group who are single adults aged 65 or more (22% in public housing but only 4% in SOMIH). Couples without dependent children account for 9% of public housing households and 5% of SOMIH households.

Sole parents with dependent children are almost twice as prevalent in the SOMIH program (47%) as in public housing (24%). Similarly, couples with dependent children are nearly twice as common in SOMIH (11%) as in public housing (6%). A large majority of sole parents (89%) are female in both public housing and SOMIH. Sole female parents have, on average, more children aged under 16 years than sole male parents (1.7 and 1.3 children respectively). Sole parents in SOMIH have, on average, more children aged under 16 than sole parents in public housing (2.0 and 1.5 respectively). Sole parents have fewer children aged under 16 years than couples with children (average 1.5 and 1.9 respectively).

Table 6.14: Rebated public rental and SOMIH households, at 30 June 2004

	Public rental housing		SOMIH	
Household composition	**Number**	**Per cent**	**Number**	**Per cent**
Single, aged <25	3,722	1.3	93	0.9
Single, aged 25–64	82,701	28.1	1,603	15.8
Single, aged 65+	65,525	22.3	434	4.3
Single adult total	*151,948*	*51.6*	*2,130*	*21.0*
Couple only, <65	11,627	3.9	367	3.6
Couple only, 65+	14,968	5.1	133	1.3
Couple only total	*26,595*	*9.0*	*500*	*4.9*
Sole parent with dependent children	70,911	24.1	4,759	46.9
Couple with dependent children	17,813	6.0	1,138	11.2
Group household	13,052	4.4	500	4.9
Multiple household	13,832	4.7	1,124	11.1
Total[(a)]	**294,441**	**100.0**	**10,157**	**100.0**

(a) Includes unknown composition.

Source: AIHW 2005h (forthcoming): table 3.

The average size of SOMIH households is 3.0 people, while the average size of public housing households is 1.9 people. Nearly 18% of SOMIH households consist of five or more people, compared with fewer than 5% of public housing households (see Tables A6.13, A6.14).

Source of income: public housing tenants

Table 6.15 shows the main source of income of public housing tenants by household composition. More than 93% of all public housing households rely on a government pension or benefit as their main source of income. More than one-quarter (27%) receive a Disability Support Pension, and 26% an Age Pension. Nearly one-third (32%) obtain their main income from some other government pension or benefit, for example, Youth Allowance or Service Pensions.

Table 6.15: Main source of income of rebated public rental housing tenants, at 30 June 2004 (per cent)

Household composition	Wages/ salary	Disability Support Pension	Age Pension	Unemploy-ment benefit	Other govern-ment pension/ benefit	Other (super-annuation/ compensation)	Nil income	All	Number of households
Single, aged <25	8.9	27.7	0.7	23.4	36.3	0.7	2.2	100.0	3,390
Single, aged 25–64	7.6	60.0	4.4	17.6	9.3	0.9	0.1	100.0	82,669
Single, aged 65+	0.2	2.4	82.2	0.1	12.9	1.9	0.4	100.0	65,513
Single adult total	*4.4*	*34.4*	*37.9*	*10.2*	*11.5*	*1.3*	*0.3*	*100.0*	*151,572*
Couple only, <65	6.3	58.0	3.7	11.5	18.7	0.9	0.9	100.0	11,512
Couple only, 65+	0.4	3.9	76.4	0.3	17.1	1.8	0.2	100.0	14,945
Couple only total	*3.0*	*27.4*	*44.8*	*5.2*	*17.8*	*1.4*	*0.5*	*100.0*	*26,457*
Sole parent with dependent children	6.6	10.1	3.2	4.8	74.7	0.5	0.1	100.0	70,829
Couple with dependent children	10.1	23.6	3.8	15.9	45.1	0.8	0.7	100.0	17,683
Group household	7.3	31.9	26.2	14.0	19.2	1.1	0.4	100.0	12,931
Multiple household	6.3	20.8	10.3	8.7	52.6	0.7	0.5	100.0	13,672
Total	**5.4**	**26.5**	**26.3**	**8.9**	**31.6**	**1.1**	**0.3**	**100.0**	**292,932**

Note: 2,509 rebated households with unknown income source or household composition are excluded from this table.

Source: AIHW 2005h (forthcoming): table 4.

Wages and salaries are the main sources of income for a very small proportion of public housing tenants (just over 5%). A further 9% receive an unemployment benefit. Hence, 14% of public housing tenants are in the workforce or seeking work. Of single adults aged less than 25 years old, 9% receive wages and 23% unemployment benefits. A relatively high percentage of young single adults (28%) receive a Disability Support Pension. Of single adults aged 25–64 years, nearly 8% receive wages as their main source of income, 18% unemployment benefits and a large percentage (60%) a Disability Support Pension.

Source of income: SOMIH tenants

Table 6.16 shows the main source of income across the different household compositions for SOMIH tenants. The pattern is different from the one for the public housing tenants, but is similar in the overall proportion of tenants receiving a government pension or benefit.

Over 91% of all SOMIH tenants rely on a government pension or benefit as their main source of income. About 17% receive a Disability Support Pension, and 10% an Age Pension. The main source of income for more than 50% of tenants is some other government payment, for example, Youth Allowance or Service Pensions.

The proportion of SOMIH tenants on wages and salaries is higher than for public housing tenants (8% versus 5%), but the level of unemployment benefit recipients is similar (10% compared with 9% for public housing tenants). Of single adults less than 25 years old, 22% receive wages, a significantly higher proportion than in public housing. A further 22% receive unemployment benefits and 17% a Disability Support Pension.

Of single adults aged 25–64 years, 11% receive wages and salaries as their main source of income, 27% unemployment benefits, and 47% a Disability Support Pension.

Table 6.16: Main source of income of rebated SOMIH tenants, at 30 June 2004 (per cent)

Household composition	Wages/ salary	Disability Support Pension	Age Pension	Unemploy-ment benefit	Other govern-ment pension/ benefit	Other (super-annuation/ compen-sation)	Nil income	All	Number of households
Single, aged <25	22.2	16.7	. .	22.2	32.2	1.1	5.6	100.0	90
Single, aged 25–64	10.8	46.7	3.6	27.0	10.5	1.1	0.2	100.0	1,602
Single, aged 65+	1.2	2.8	92.9	0.5	2.3	0.5	.	100.0	434
Single adult total	*9.3*	*36.5*	*21.7*	*21.4*	*9.8*	*0.9*	*0.4*	*100.0*	*2,126*
Couple only, <65	9.8	46.9	2.8	20.7	17.9	0.3	1.7	100.0	358
Couple only, 65+	3.0	3.0	89.5	.	3.0	1.5	.	100.0	133
Couple only total	*7.9*	*35.0*	*26.3*	*15.1*	*13.8*	*0.6*	*1.2*	*100.0*	*491*
Sole parent with dependent children	5.7	5.7	3.1	3.6	81.2	0.4	0.1	100.0	4,751
Couple with dependent children	14.2	13.2	4.4	16.5	50.7	0.3	0.7	100.0	1,130
Group household	11.0	31.3	20.4	18.6	17.4	1.0	0.2	100.0	499
Multiple household	5.7	14.6	10.4	6.5	61.7	0.7	0.4	100.0	1,114
Total	**7.8**	**16.7**	**10.0**	**10.4**	**54.2**	**0.6**	**0.3**	**100.0**	**10,111**

Note: 51 rebated households with unknown income source or household composition are excluded from this table.

Source: AIHW 2005h (forthcoming): table 5.

Comparing CRA recipients to Centrelink clients in public housing

At June 2002, approximately 331,800 income units receiving Centrelink payments were living in public housing (see Table A6.15). The Age Pension and Disability Support Pension were the most common primary Centrelink payments received (29% and 28% respectively), followed by Parenting Payment Single (22%). For CRA recipients (see Table A6.16), the most common payment types were Newstart Allowance (22%), Parenting Payment Single (20%) and Disability Support Pension (17%), followed by the Age Pension (16%). Taken together, clients receiving the Age Pension or Disability Support Pension accounted for 56% of public housing tenants receiving a Centrelink payment, but only 33% of CRA recipients.

Labour force participation

The greater majority of public housing tenants (76%) in 2003 were neither employed nor looking for work. The next biggest group comprised those who were employed full or part-time (17%) (Table 6.17). Of these 8% of tenants who were unemployed and looking for work, when asked why they were not employed, almost half (44%) said they needed more education and training, and 42% said there were no jobs in the types of work they wanted. In addition, 20% were concerned about a rent increase and 15% that they might have to leave their current housing (see Table A6.17). The 2003 NSHS also found that as the length of time spent in public housing increases, the proportion of respondents who are employed also increases and the proportion who are unemployed decreases (CBSR 2003).

Table 6.17: Employment status of public housing tenants, April–May 2003 (per cent)

Household type	Employed	Unemployed, actively looking for work	Not available for or looking for work	Total	Total number
Single alone	11	6	83	100	4,035
Single with children	22	10	68	100	2,106
Couple only	12	3	84	100	1,079
Couple with children	35	14	51	100	1,020
Group	18	17	65	100	81
Other	13	7	80	100	160
Total	**17**	**8**	**76**	**100**	**8,480**

Note: 523 cases are excluded from the table due to either missing household type values or no-response to employment status.
Source: CBSR 2003.

Community housing

Characteristics of community housing

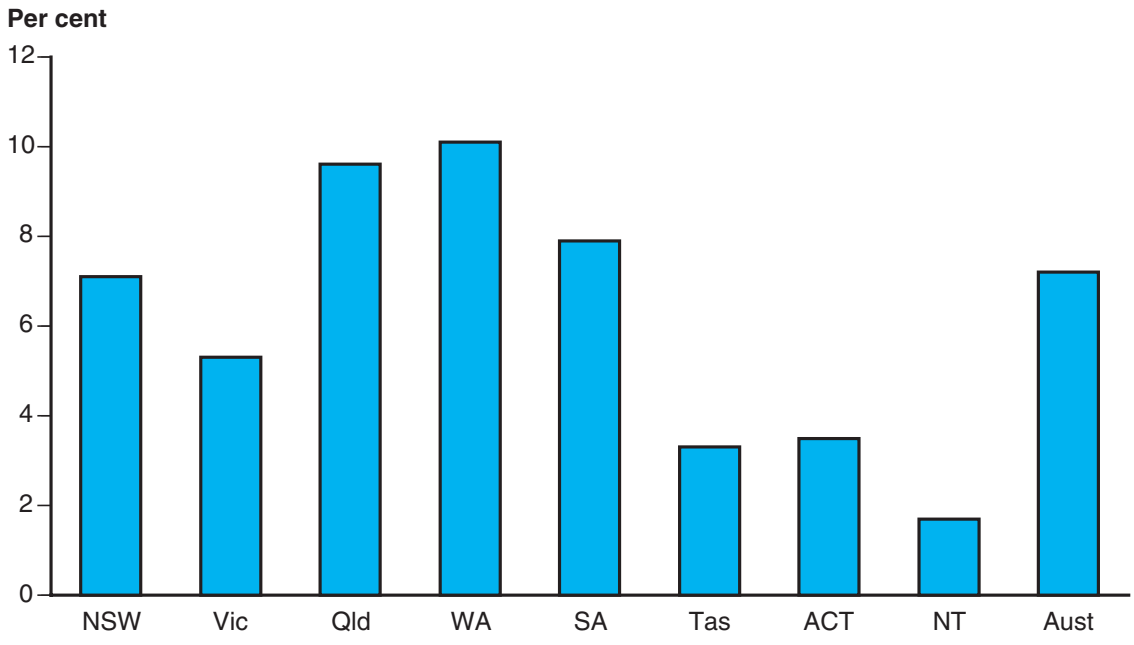
In Australia, community housing has traditionally seen housing organisations established as either housing cooperatives or housing associations. Housing cooperatives are self-managed organisations, while housing associations are managed on behalf of tenants by a committee.

Approximately one in every 200 households in Australia lives in community housing. While a relatively small component of housing, it has the ability to provide the most flexible and diverse types of housing assistance to ensure families and single persons have adequate housing. Community housing organisations are not-for-profit community groups that manage all tenancy matters such as tenant selection, rent collection and property maintenance. State and territory governments provide a regulatory framework for the community housing sector and facilitate its continued operation and growth.

The size of the 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 its role in deinstitutionalisation (NCHF 1998:3). At 30 June 2004, Western Australia had the highest proportion of CSHA community housing (10%) and Northern Territory had the lowest (2%) (Figure 6.9).

Community housing has been growing gradually and in June 2004 under the CSHA more than 1,100 organisations were managing 26,753 dwellings. This constitutes around 7% of all CSHA-funded housing. In addition to this CSHA mainstream community housing sector there is also a significant crisis and transitional housing sector (around 7,000 CSHA Crisis Accommodation Program dwellings); an Indigenous community housing sector (approximately 21,000 dwellings managed by 616 organisations); and specialised providers operating in the aged and disability sectors[9].

In 1998 it was estimated that approximately 15,000 dwellings across Australia were providing mainstream community housing outside of the CSHA and mostly by different providers to those operating in the CSHA sector.



Source: Table A6.18.

Figure 6.9: Community housing dwellings as a proportion of all public and community housing dwellings, 2004

Increased concern about providing adequate and affordable housing for Australians has brought a greater acceptance that community housing has a growing role in meeting this demand. Community housing organisations generally cater for low-income people and families. Increasingly, moderate income households are also provided for, as many in this group experience housing stress from living in unaffordable housing. The major source of income for most households is Centrelink payments, such as disability and age pensions and unemployment and training-based benefits (NCHF 2003:73).

The transfer of substantial amounts of public housing stock to community housing management has been a national trend in social housing. Also worth noting is the significant percentage of community housing stock that is head-leased from the private rental sector. At 30 June 2004, of the 26,750 CSHA community housing dwellings 7,600 had been head-leased (AIHW 2005b).

Generating diversity of housing options

Community housing provides an expanded range of choice for social housing tenants and is an alternative to public rental housing. Through the provision of safe, secure,

9. Several community housing organisations provide housing using stock outside the CSHA that was established through subsidies provided by the Commonwealth Government under the Aged Persons' Homes Act. This housing is commonly referred to as Independent Living Units and approximately 33,000 dwellings were constructed between 1954 and 1996 (McNeils & Herbert 2003:viii).

appropriate and affordable housing by way of community-based initiatives, it has the ability to integrate a range of community services to meet tenant needs.

Community housing can provide specialised housing services to meet particular areas of need within the community—women escaping domestic violence, mental health, aged, disability, youth, families, homeless and students. It is also able to create close collaborative links between housing providers and support services for tenants with particular needs. For example, the 2002 NSHS found that prior to moving into community housing, 43% of tenants surveyed had been unable to afford private rental housing, 20% had been homeless and 9% had been living in a violent or dangerous situation (NFO Donovan Research 2002).

In 2003–04, 65% of new households assisted with community housing had a special need[10] (AIHW 2005b). The Australian Capital Territory and Victoria had the highest proportion of special needs allocations (89% and 87% respectively), while Tasmania had the lowest (13%). Priority allocations to households in greatest need comprised 70% of community housing provision. The Australian Capital Territory had the highest proportion of priority allocations (99%) and Tasmania had the lowest (18%).

Providing a supported environment

Community housing, like public housing, is able to contribute to broader social issues such as strengthening communities and building community capacity, 'to counteract the growing patterns of social exclusion in Australia today and to support greater social and economic participation' (Farrar et al. 2003:5).

Recent research has found a general lack of understanding in Australia of the contribution of effective housing provision to sustaining communities. The exception is the case estate renewal and Indigenous community renewal (Farrar et al. 2003). The research identified a range of community-building activities undertaken by community housing providers including: improving housing access; brokering more effective access to community services; and supporting tenants in economic and social participation. The value of volunteer work undertaken by community housing to provide a range of housing and support services to tenants has never been fully measured. However, as with other welfare areas such as health and community services, the value to the community of this effort is likely to be significant.

Providing opportunities for individuals

The ability of tenants to be involved in decision making and management is an aspect that differentiates many community housing models from other forms of social housing.

10. 'Special need' is defined as low-income households that: satisfy the Indigenous household definition; or have a member with a disability; or where the principal tenant is aged 24 years or under, or 75 years or more. The 'Priority access to those in greatest need' national standard includes low-income households that at the time of allocation were subject to one or more of the following circumstances: they were homeless; their life or safety was at risk in their accommodation; their health condition was aggravated by their housing; their housing was inappropriate to their needs; or they had very high rental housing costs.

Community housing helps individuals to achieve social integration and avoid stigmatisation. The opportunities for social inclusion through self-help and personal development are often cited as major benefits of community housing for individuals and communities.

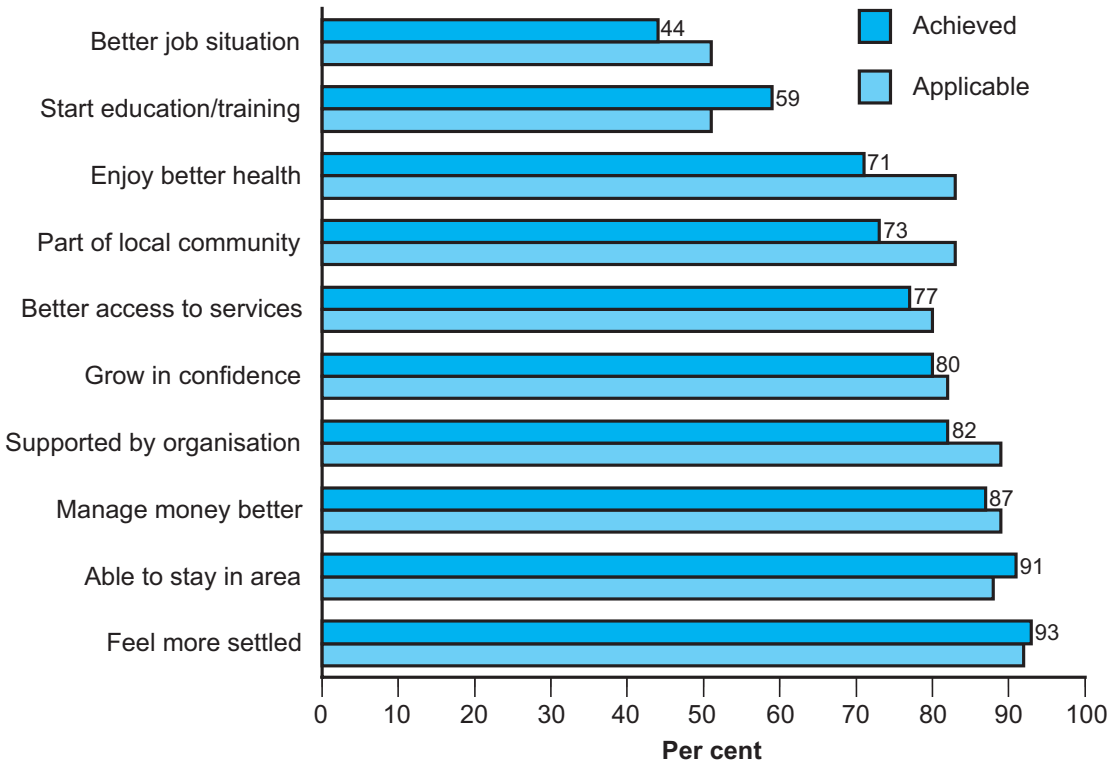
Participation in the operation of the organisation helps tenants to build social and work-related skills. This can provide access to work experience, training or education and improved employment prospects. In the 2002 NSHS of community housing tenants, the following aspects of participation were identified:

- Eighty-five per cent of tenants in cooperatives said they were involved, compared to 35% of tenants in other types of organisations.
- The most common forms of involvement were providing help (33%) and attending meetings/member (34%).
- Involvement was lowest among younger tenants, with 66% of 15–24 year olds saying they had little or no involvement.
- Involvement tended to increase with length of tenancy—27% of tenants of less than 1 year duration compared to 53% with over 5 years duration.

The 2002 NSHS asked tenants whether they felt community housing had helped them in a various ways (Figure 6.10). For each benefit, they were asked to report on whether it was something they had wanted to achieve or to have. If it was, they were then asked whether they thought living in community housing had helped, hadn't helped, or hadn't helped yet but might in the future. The following findings emerged:

- The benefit which applied to the most people (92%) was that of feeling more settled. This was also one of the most widely achieved aspects (93%).
- Eighty-nine per cent said that they wanted to manage money better and 87% had found living in community housing to help in this way. A similar proportion said feeling supported by the organisation was a benefit they sought; 82% said community housing had helped.
- A benefit which was widely required but against which community housing had been less effective was enjoying better health (83% saying it was relevant; of those, 71% thought community housing had helped).
- An improvement in job situation or starting/continuing education were benefits that were relevant to about one-half of tenants. In both instances the extent to which living in community housing had helped was lower than in the other areas; 44% of those for whom this was relevant said their job situation had been helped and 59% their education/training prospects.

Over half of all tenants (54%) felt living in community housing had improved their quality of life a lot and a further 24% said it had improved it a little; hence in total three-quarters had seen an improvement. Only 2% said their quality of life had worsened (NFO Donovan Research 2002).



Source: Table A6.19.

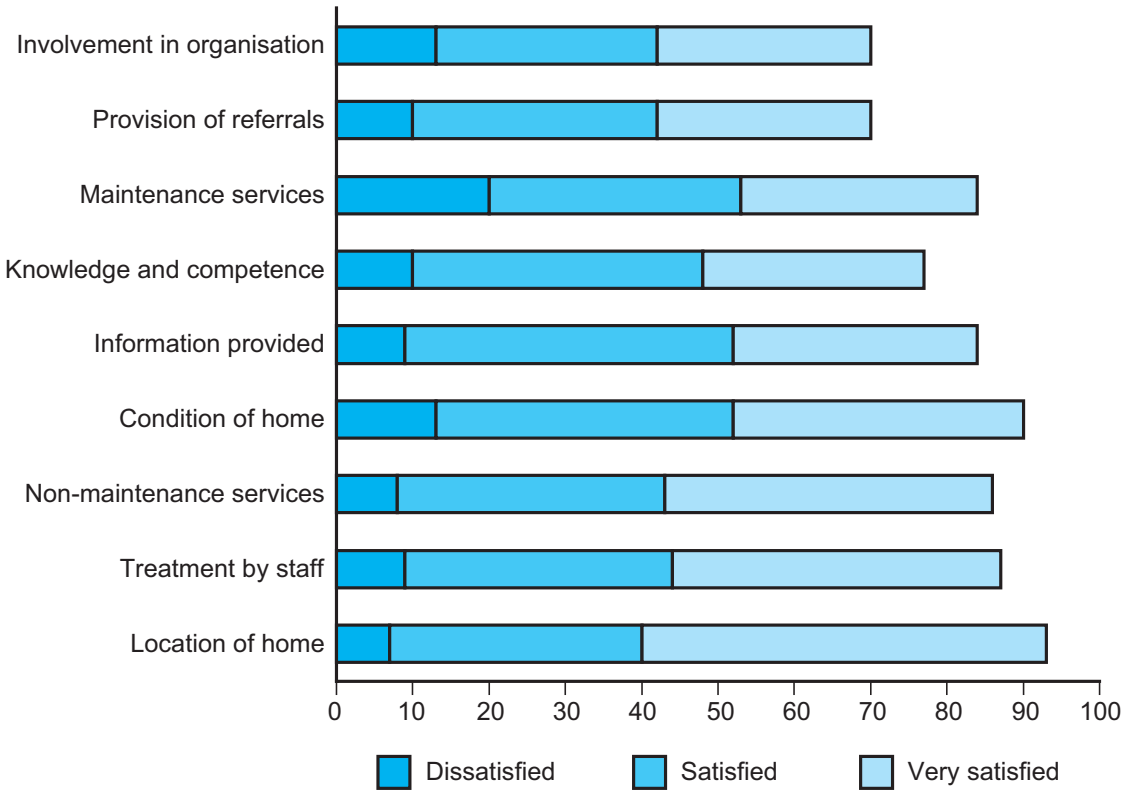
Figure 6.10: Benefits of living in community housing, 2002

Tenant satisfaction

The 2002 NSHS of community housing tenants examined tenant satisfaction with the service being provided by housing cooperatives and housing associations (Figure 6.11). The survey reported high levels of satisfaction for 'treatment by staff' and 'non-maintenance related service' with 43% of tenants very satisfied and less than 10% dissatisfied with each aspect. The highest level of dissatisfaction was associated with maintenance services (20%); however, 64% of tenants were still satisfied or very satisfied. More detailed analysis of the survey identified that tenants' overall satisfaction is influenced most by the manner and helpfulness of the staff more than the quality of their home. Involvement in the organisation and provision of support/referrals have slightly less influence on overall satisfaction than the condition of the home (NFO Donovan Research 2002:9).

The results from the 2002 NSHS indicate that 77% of community housing tenants were satisfied or very satisfied with the service provided by their community housing organisation. As with most customer satisfaction surveys, including the public housing NSHS, the level of satisfaction with community housing increases with age (NFO Donovan Research 2002:5). Tenants aged 65 years or over were more likely than tenants aged 15–34 years to be very satisfied (47% and 32% respectively) and were less likely to be dissatisfied (6% and 15% respectively) (see Table A6.21).

Tenants living in shared accommodation (i.e. a room in a shared house or living in a larger rooming house) were more likely to be dissatisfied (16%) than those living in a separate house, attached house or self-contained unit (11%, 7% and 10% respectively). Although overall levels of satisfaction were similar for Indigenous and non-Indigenous tenants, Indigenous tenants were less likely to be very satisfied (23% and 40% respectively) (see Table A6.21).



Source: Table A6.20.

Figure 6.11: Satisfaction with home and specific aspects of housing organisation services, 2002

Generating diversity of management and financing

Recently the community housing sector has become more involved with government policies and programs that have been established with the specific purpose of delivering affordable housing. Under the 2003 CSHA this entails the development of approaches that endeavour to attract a greater level of involvement from the private sector to partly finance affordable housing. Many of these approaches will need to utilise the capacity of community housing providers to attract financial benefits through their ability to utilise CRA, and GST exemptions, and their status as income tax exempt charities and public benevolent institutions. Community housing is also seen as the sector that already has a range of housing assistance products along with the expertise to offer choice and be cost effective. The continuation of the current policy direction may see more rapid growth as community housing takes on a changing role to become a high-volume supplier of affordable rental housing in Australia (Milligan et al. 2004).

6.5 Assistance to home owners and purchasers

The Productivity Commission (2004) report on first home ownership identified a range of social benefits of home ownership, noting that access to affordable and quality housing is central to community wellbeing. Apart from meeting the basic need for shelter, it provides a foundation for family and social stability, and contributes to improved health and educational outcomes and a productive workforce. This enhances both economic performance and 'social capital'. Home ownership can also reduce the extent of welfare dependency later in life. In effect home ownership is a form of 'forced' saving which, like superannuation, can subsequently be drawn on as an alternative to welfare payments (Productivity Commission 2003b: box 1.1).

In Australia, assistance for home owners or purchasers includes government outlays, such as for the First Home Owner Grant; taxation expenditures, rates and land tax concessions, and capital gain and stamp duty exemptions; government regulations and standards in housing and financial markets; and other assistance, such as directly subsidising purchases by some home buyers and offering home purchase advisory and counselling services. This support is in addition to the exclusion of the family home from the income support assets test by Centrelink.

First Home Owner Grant (FHOG)

Direct assistance to first home buyers is provided through the FHOG which was introduced in July 2000 as an offset to the GST. The basic grant of $7,000 is funded by the Australian Government and administered by state and territory governments. Over the period from March 2001 to June 2002, the basic grant was supplemented by top-up grants funded by the Australian Government. The rationale for these was to provide additional support to the building construction industry. By January 2004, the scheme had provided around $4.3 billion in assistance, including the top-up grants, to over half a million first home buyers (FHOG 2005).

The Productivity Commission report noted that the FHOG is not targeted to low-income households and that grant levels will need to be substantially increased if the grant is to make a significant difference to home ownership levels among lower income households. It recommended that, if the FHOG continues, assistance should be targeted to the housing needs of these households (Productivity Commission 2004: rec. 10.2).

State and territory assistance

Every state and territory provides stamp duty concessions for first home buyers, though in the Australian Capital Territory they are available to all home buyers, subject to an income test. Concessions generally take the form of reduced amounts of duty while in Tasmania first home buyers are allowed to stagger stamp duty payments over a 2 year period. These concessions are generally restricted to homes below specified threshold values.

In addition, state and territory governments also assist home ownership through a range of other support for housing purchases under the CSHA. Eligibility is often linked to income and other household characteristics and may require that applicants do not already own, or part-own, a home or land.

Home purchase assistance under the CSHA is designed to make home ownership (including shared home ownership) more accessible for people who are otherwise unable to obtain private sector finance for home ownership. Active CSHA home purchase programs exist where market circumstances allow the purchase of dwellings by low-income people. The range of support available, which varies across the states and the territories, includes direct lending, deposit assistance, interest rate assistance, home purchase advisory and counselling services, and mortgage relief (AIHW 2005d). Examples of some of the programs are provided in Box 6.4.

Box 6.4: Examples of home purchase assistance programs

- *The Keystart Home Loan scheme in Western Australia offers low-deposit loans to low-income earners who do not own or part-own a home or land. Fee assistance of up to $2,000 can be capitalised into the loan, which does not require mortgage insurance.*
- *HomeStart Finance in South Australia offers an 'Advantage Loan' of up to $165,000 to eligible home buyers.*
- *The Victorian Government provides mortgage interest relief of up to $15,000 over a maximum of 2 years for people who have experienced an unavoidable change in circumstances for which adequate preparations could not be made, and where mortgage repayments exceed 27 per cent of income.*
- *The Streets Ahead program in Tasmania offers a range of incentives to low to moderate income home buyers. Assistance may be provided in one or more forms, including deposit assistance, payment of transactions costs (such as stamp duty and mortgage insurance), prepayment of rates for the first year, contributions towards home improvements, and provision of advice on home finances or property condition. Also, Housing Tasmania's Sales Program gives precedence to public housing tenants and others on low incomes when public housing properties are put up for sale.*

Source: Productivity Commission 2004.

In 2003–04, the total value of home purchase assistance to households by the states and territories through the CSHA was more than $830 million (Table 6.18). The different types and monetary values of the services provided indicate the difficulty in making comparisons across jurisdictions.

The emphasis of the 2003 CSHA on housing affordability has seen increased activity around the development of affordability objectives by the government-owned land development agencies. New regulations and programs encourage private developers to supply affordable housing in their residential developments. For example, VicUrban is required to contribute to improvements in housing affordability in Victoria while undertaking its functions in a commercial manner; and in the future the ACT Government's Land Development Agency will make a proportion of its serviced land affordable to specific sectors of the market, such as first home buyers (Productivity Commission 2004:205).

Table 6.18: CSHA home purchase assistance, 2003–04

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust.
				Total households receiving assistance (number)					
Direct lending	. .	99[a]	41	4,346	13,465	121	. .	194	18,266
Deposit assistance	. .	. .	18	. .	. .	244	. .	281	543
Interest rate assistance	. .	. .	160	23	3,070	. .	. .	505	3,758
Mortgage relief	172	6	4	. .	. .	. .	61[b]	. .	243
Home purchase advisory and counselling services	12,329[c]	. .	. .	4,346	. .	. .	. .	. .	16,675
Other types of assistance	. .	61[d]	5	742	. .	. .	. .	. .	808
Total households receiving assistance	**12,501**	**166**	**228**	**9,457**	**16,535**	**365**	**61**	**980**	**40,293**
				Value of assistance ($m)					
Direct lending	. .	6.0	3.2	530.3	247.2	6.0	. .	20.4	813.1
Deposit assistance	. .	. .	0.07	. .	. .	1.0	. .	0.4	1.4
Interest rate assistance	. .		n.a.[e]	0.1	12.4	. .	. .	0.5	13.0
Mortgage relief	0.7	0.03	0.02	. .	. .	. .	0.1	. .	0.9
Home purchase advisory and counselling services	. .	. .	. .	0.1	. .	. .	. .	. .	0.1
Other types of assistance	. .	0.3	0.05	1.5	. .		. .	. .	1.9
Total value of assistance	**0.7**	**6.3**	**3.4**	**532.1**	**259.6**	**6.9**	**0.1**	**21.3**	**830.4**

Note: Cell numbers may not add to total due to rounding

(a) Includes 48 households that sought refinancing through the private sector during the year.

(b) All ACT Government home buyer lending for public housing tenants ceased in 1996. New households assisted during the year refers to those households who had taken out a mortgage on their government home prior to that date in 1996 and who became eligible for deferred assistance in the 2003-04 financial year because their standard monthly loan instalment became greater than 27% of their household income.

(c) Total number of calls to the Home Purchase Advisory Service during 2003-04. Excludes calls from clients seeking general information about other forms of assistance provided by the Department of Housing.

(d) Excludes 4 loans approved in June 2004 but advanced in July 2004.

(e) Interest rates assistance is linked to direct lending as part of the product package. Therefore a specific value on the assistance provided is not available.

Source: AIHW 2005d.

Taxation expenditures

Currently, there are no official estimates on the assistance provided through the taxation system to households owning or purchasing their home. However, recent research has shown that its impact is significant (Bourassa et al. 1995; Pender 1994; Yates 2002).

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

(Bourassa et al. 1995; Yates 2002). The capital gains tax exemption for gains on the disposal of a taxpayer's main residence (Treasury 2001) is also recognised as an important area of housing assistance.

The value of indirect assistance provided to owner-occupied housing through taxation expenditures in 2001 was estimated to be $21 billion (Yates 2002). This consisted of:

- $13 billion arising from the non-taxation of capital gains under the post-1999 approach to taxing capital gains; and
- $8 billion arising from the non-taxation of imputed rent, consisting of a $13 billion benefit from the non-taxation of net imputed rent and a $5 billion cost from the non-deductibility of mortgage interest costs.

The most recent analysis of how these benefits were distributed across the population showed that in 1999 the estimated distribution of the annual value of capital gains was $1,200 per household that fully owned or were purchasing their dwelling, ranging from zero in the lowest income quintile to $2,300 per household in the top income quintile (AIHW 2004e: table A3.2). The average annual value of non-taxation of the imputed rent was $1,600 across all income groups. This ranged from zero for home owners in the lowest income quintile to $2,400 per year per household in the top quintile. For owners without a mortgage (outright owners) the average value was $3,200, while for owners with a mortgage (purchasers) the value was negative $300 per year per household (Yates 2003).

6.6 Data development

Under the NHDA (AIHW 2000a) and the Agreement on National Indigenous Housing Information (ANIHI) (AIHW 2000b), a variety of data development initiatives have been implemented to improve housing assistance data availability, quality and consistency. The major components of the NHDA Management Group work program are based on four priority policy areas for national data: public rental housing, private rental market assistance, community housing, and Indigenous housing. Indigenous housing priorities are being progressed jointly with the National Indigenous Housing Information Implementation Committee which operates under the ANIHI.

These groups are working to improve the policy relevance and quality of data to build on the development and standards work undertaken for the 1999 CSHA. That work included the development of national performance indicator frameworks and the establishment of standards to measure housing assistance across the range of performance areas, including the identification of Indigenous access to mainstream assistance and measuring priority access to those in greatest need (AIHW 2003i, 2004f,).

Under the 2003 CSHA several areas are given more prominence, such as measuring affordability, improving data on Indigenous access to mainstream assistance and improved reporting of financial data. Also, data gaps in areas such as community housing, public housing non-rebated tenants and measuring the impact of assistance on workforce participation will be examined. The emergence of longer term research ventures by AHURI in several of these areas requires a close relationship between researchers and statisticians.

The compatibility of mainstream and Indigenous housing data with the health and community services information is an objective of both the NHDA and the ANIHI. These agreements support relevant work across areas such as priority access to housing services and the links to community services programs such as the Supported Accommodation Assistance Program. Also, understanding the relationship of housing assistance and homelessness assistance for health target groups, such as persons with a mental illness, requires joint work with health data development.

As noted in the previous issue of *Australia's Welfare*, work is ongoing in improving the measures of households in different tenure types. In particular, work is continuing to better understand the different measures of affordability (Gabrielle et al. 2005; Karmel 1998) and variation in the way different tenures are identified in Census, survey and administrative data, including:

- Home ownership rates at the national level may vary by several percentage points in the same time period (AIHW 2001:56).
- Public rental housing numbers vary due to identification and definition differences, particularly in the treatment of public rental dwellings that are specifically targeted to Indigenous households (AIHW 2003j: table 5.39).
- Difficulties in measuring the size of the community housing sector arise due to the diversity of programs, variation in funding sources, and provider capacity to supply reliable data (AIHW 2001:75).

Through the NHDA and the ANIHI, state and territory housing authorities and FaCS work with the ABS and the AIHW to improve the understanding of data differences and their impact on policy and program reporting, and analysis will continue.

6.7 Conclusion

Housing provides shelter and a place where people are guaranteed security and privacy, and where they can form and maintain relationships with family and friends. Having a home also enables people to engage with the wider community—socially, recreationally and economically—and may influence both their physical and mental health.

Housing assistance aims to meet housing needs as well as contribute to broader outcomes, such as the improved social and economic wellbeing of individuals, families and communities. Under the 2003 CSHA, research and data development are being undertaken to better understand the most appropriate ways of delivering assistance to those in need.

Population growth along with changes in household formation and in housing markets has affected the demand for housing assistance and this will continue as Australia's population ages. Also recent economic and social changes have contributed to changes in the demand for and supply of housing, particularly for low-income households. 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. The effect of tax expenditures in providing short- and long-term benefits to home owners and in influencing the type of housing stock produced is increasingly being recognised as an important area of housing assistance.

The private rental sector has grown faster than other segments of the housing market but the supply of low-cost private rental properties has not shown a similar increase. Social housing is increasingly being targeted to those in greatest need. Increasing pressure on housing assistance to meet the diverse needs of homeless and other marginalised persons, at a time when public housing stock is diminishing, has emphasised the importance of the community housing sector to meet needs that cannot be met through the private rental market.

With concerns around housing affordability for low- and middle-income households, governments are looking to identify and develop new approaches to the provision of housing assistance. As the population ages, maintaining current levels of home ownership is important as, on current evidence, the capacity for private and social rental housing to meet the growing needs of low-income households is limited. Improvements to the supply of low-rent housing to meet housing needs will remain a major challenge to governments.

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7 Services for people experiencing homelessness

7.1 Introduction

Australia is one of only a handful of countries in the world who can claim to rigorously estimate their homeless population, an enterprise that has proven beneficial for both policy development and advocacy purposes. This count is largely derived from two sources of information—the ABS Census of Population and Housing, and statistics collected from homeless refuges funded under the Supported Accommodation Assistance Program (SAAP), the major government response to homelessness.

An estimated 99,900 people were reported as experiencing homelessness on the night of the last Census in 2001 (Chamberlain & MacKenzie 2003), although in this chapter an argument is presented for reporting a higher figure of around 122,770 homeless people on that night.

The chapter begins by introducing the cultural definition of homelessness which underlies the Census, the operationalisation of this definition and the resulting numbers, contrasting these with the previous Census. Some implications of this approach for policy development and advocacy purposes are considered, followed by a discussion on its limitations.

Iterative homelessness, a complementary approach for characterising homelessness, is then introduced with a discussion of its implications for policy development and advocacy. This approach, as developed by Robinson (2003), focuses on the ongoing movement of people through different forms of tenuous or marginal housing and seeks to answer the question of which factors contribute to their repeated uprootings and failures to establish a home.

SAAP data are introduced to test the usefulness and limitations of this approach drawing on particular sectors of the SAAP client population, namely, older men, women escaping domestic violence, and younger men and women. The chapter concludes with presentations of new initiatives that address homelessness, both within SAAP and in other responses of the Australian and state and territory governments.

7.2 Who counts as homeless?

The ABS Census is a point-in-time count of Australia's population, held every 5 years. For the past two Censuses, Census data have been used to estimate the number of people who were homeless on that particular night. SAAP data and, to a lesser extent, a national census of homeless school students are also used to further refine the estimate (Chamberlain & MacKenzie 2003). This statistical estimation is based on the widely

used definition of cultural homelessness, first developed by Chamberlain and MacKenzie in 1992 (Chamberlain & MacKenzie 1992).

This cultural definition was reviewed along with other definitions of homelessness in the last edition of *Australia's Welfare* (AIHW 2003a) and defines homelessness by reference to the degree to which people's housing met with conventional expectations of, or the minimum culturally acceptable concept of, a dwelling. Such culturally acceptable minimum community standards of housing, it was argued, encompass having one room to sleep in, one to live in, and your own kitchen and bathroom, along with some security of tenure. The homeless, those without such accommodation, were then categorised into three tiers—primary, secondary and tertiary homelessness. This cultural definition underpinned the 1996 Census (AIHW 2003a), and was again employed during the 2001 Census (Chamberlain & MacKenzie 2003).

The ABS identified people as belonging in one of these homelessness tiers through a series of questions, or counting rules (Chamberlain & MacKenzie 2003). These counting rules identified three operational categories of people which, because of collection restraints, differed slightly from the underlying cultural definition's classification (Box 7.1).

Box 7.1: ABS operational categories of homelessness

Primary

People without conventional accommodation, such as people living on the streets, in parks, squatting in derelict buildings or using cars or railway carriages and makeshift dwellings.

Secondary

People who were staying with friends or relatives and who had no other usual address, as well as people in SAAP services. This category excluded short-term residents of boarding houses.

Tertiary

People living in boarding houses, both short and long term.

On this basis, 99,900 people were estimated to have been homeless on Census night 2001, less than the estimated 105,304 people on Census night 1996 (Table 7.1). The largest difference evident between the two Censuses is the drop in the number of primary homeless from 20,579 to 14,158, a result of procedural changes between the two Censuses.

This decrease was caused by a change in the counting rules concerning improvised dwellings in remote Indigenous communities. In 2001, the ABS modified its instructions such that, if such residences were permanent structures built for the purpose of housing people, they were *no longer to be counted as improvised dwellings*. If this change had not been made, the number of homeless counted by the two Censuses is likely to have stayed much the same (Chamberlain & MacKenzie 2003).

Table 7.1: Homeless people, by whereabouts, Census night 1996 and 2001

	1996		2001	
	Number	Per cent	Number	Per cent
Tertiary—boarding house	23,299	22	22,877	23
Secondary—SAAP	12,926	12	14,251	14
Secondary—friends/relatives	48,500	46	48,614	49
Primary—sleeping rough/improvised	20,579	20	14,158	14
Total homeless	**105,304**	**100**	**99,900**	**100**

Source: Chamberlain & MacKenzie 2003.

The change to the counting rule for remote Indigenous dwellings had a differential effect on the number of homeless in the states and territories (Table 7.2). For the Northern Territory, particularly, there was a large drop in the rate of homelessness over the 5 years between Censuses, from 523 per 10,000 to 288. This can be directly attributed to the changed counting rules for remote Indigenous communities. Queensland, Western Australia, New South Wales and the Australian Capital Territory also showed decreases in their rates of homelessness. Conversely, in the most southern of the states (Tasmania, Victoria and South Australia), the rates rose.

Table 7.2: Homelessness rates, by state/territory, Census night 1996 and 2001

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT
				Rate per 10,000 population				
1996	49.4	41.0	77.3	71.5	48.1	43.9	40.3	523.1
2001	42.2	43.6	69.8	64.0	51.6	52.4	39.6	288.3

Source: Chamberlain & MacKenzie 2003.

Generally speaking, in all of the southern states and territories the rate was consistently between 40 and 50 homeless people per 10,000 people in the population, with Western Australia and Queensland having a higher rate between 64 and 70. The Northern Territory, however, experienced a far higher rate, regardless of the large decrease between 1996 and 2001.

Using these estimations, Chamberlain and MacKenzie draw certain conclusions about policy development for programs directed at assisting the homeless, especially SAAP. Historically, monies from SAAP had more or less been distributed to states and territories on the basis of their populations (see AIHW 2003a), on the assumption that the homeless population was distributed in proportion to the general population. According to Chamberlain and MacKenzie, however, their work shows that the geographical distribution of the homeless population across states and territories is very uneven, and they argue that this should inform how SAAP resources are distributed (Chamberlain & MacKenzie 2003:57).

Chamberlain and MacKenzie's interpretation of the Census data provides a strong argument for the redeployment of SAAP funds to those states and territories with the higher rates of homelessness, although they acknowledge that there are other factors

needing consideration, such as the proficiency of local service providers, the special needs of minority groups and the expressed needs of different groups of homeless people such as women and children escaping domestic violence or homeless teenagers. Given the high profile of the Census and the work of Chamberlain and MacKenzie and its ensuing policy implications, careful assessment must be made of the internal consistency and value for policy development of this approach. The following begins this assessment by discussing difficulties in the application of the Census definition and approach to particular sections of the population.

The categorisation of Indigenous homelessness

In the 1996 Census, interviewers in remote Indigenous communities were instructed that, for a residence to be counted as a dwelling, it needed to have both a working shower or bath and a toilet. If not, the dwelling was classified as an improvised house. In 2001, the ABS modified these instructions such that, if such residences were permanent structures built for the purpose of housing people, they were *no longer to be counted as improvised dwellings*. As a consequence, the number of Indigenous people counted as living in improvised dwellings in remote communities dropped from 9,750 in 1996 to 2,680 in 2001 (Chamberlain & MacKenzie 2003:56).

The inherent methodological difficulties in enumerating homelessness are illustrated by the differences between the Census count and the count of improvised dwellings in the Community Housing and Infrastructure Needs Survey (CHINS) (ABS 2002a). The CHINS estimated that there was more than double the number of people living in improvised dwellings than estimated in the Census. This discrepancy is attributable to different field procedures that resulted in differences in applying the definition of improvised dwellings. This in turn influenced the count of people without conventional accommodation.

In the 2001 Census, primary homelessness (i.e. people without conventional accommodation) varied as a percentage of total homelessness in each jurisdiction. from a low of 6% in the Australian Capital Territory to 40% of all the homeless counted in the Northern Territory (Table 7.3). The next highest proportions were in Western Australia (19%) and Queensland (16%). The high percentages in these three states could be related to the size of their remote Indigenous populations. In the 1996 Census, almost all improvised Indigenous dwellings were located in remote areas (ATSIC 2002, cited in AIHW 2003a). This is likely to have been the case for 2001 as well.

Table 7.3: Homeless people, by whereabouts and state/territory, Census night 2001 (per cent)

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust
Tertiary—boarding house	29	26	22	15	19	11	5	17	23
Secondary—SAAP	15	25	9	8	15	13	24	4	14
Secondary—friends/relatives	45	40	53	58	54	66	65	39	49
Primary—sleeping rough/improvised	11	9	16	19	12	10	6	40	14
Total homeless	*100*	*100*	*100*	*100*	*100*	*100*	*100*	*100*	*100*
Total homeless (number)	**26,676**	**20,305**	**24,569**	**11,697**	**7,586**	**2,415**	**1,229**	**5,423**	**99,900**

Source: Chamberlain & MacKenzie 2003.

Those Indigenous Australians living in improvised dwellings had a significant impact on the number of Indigenous Australians counted as homeless. Of the 6,862 Indigenous people identified as homeless, around 2,676 had no conventional accommodation, including people who were living on the streets, in parks, squats or improvised dwellings. These homeless Indigenous Australians comprised just under 19% of the 14,158 Australians identified as having no conventional accommodation on Census night 2001 (Table 7.4). If the CHINS had been used as the basis of the estimates, the number of Indigenous homeless would have increased by about 43% from about 6,900 to about 9,800 (ABS 2002a; Chamberlain & MacKenzie 2003).

Table 7.4: Homeless people, by whereabouts and Indigenous status, Census night 2001 (per cent)

	Tertiary—boarding house	Secondary—SAAP	Secondary—friends/relatives[(a)]	Primary—sleeping rough/improvised	Australia
Indigenous	7.1	11.0	3.4	18.9	8.5
Non-Indigenous	92.9	89.0	96.6	81.1	91.5
Total homeless	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*
Total homeless (no.)	**22,877**	**14,251**	**29,439**	**14,158**	**[(a)] 80,725**

(a) These numbers include a correction for undercounting 19,175 young people in the friends/relative category. The total reflects this change (from 99,9000; see Table 7.3).

Source: Chamberlain & MacKenzie 2003.

In changing the counting rules for remote Indigenous communities for the 2001 Census, the ABS noted that, in such communities, bathroom and toilet facilities are often provided in communal amenities blocks used by multiple households and proposed that this 'accorded with the wishes of the local community', although no supporting evidence was offered (Chamberlain & MacKenzie 2003:56). In their discussion of these changes, Chamberlain & Mackenzie (2003:22) suggest that this ABS decision could be argued to be culturally appropriate, while acknowledging that the point could generate some debate.

The possibility of multiple culturally appropriate understandings of homelessness provokes a discussion of a single standard approach. The beauty of the Census is that it provides a single, rigorous point-in-time national count of the homeless that is useful for broad policy development and advocacy. The latest changes in counting rules for remote Indigenous housing, however, highlight the difficulties in this 'one size fits all' approach to defining homelessness when a finer analysis is needed. As the way in which Indigenous homelessness is defined or categorised influences how policy responses are framed, the Census data need to be carefully examined so that the implications for the way in which homelessness is defined can be understood and appreciated.

In this context, the Census has been criticised as marginalising or misrepresenting Indigenous homelessness. Memmott, for example, has claimed that the Census was designed to collect non-Indigenous categories of information that either may make little sense within Indigenous contexts, or which may be interpreted differently in cross-cultural situations (Box 7.2).

Box 7.2: ABS and Indigenous definitions

Usual place of residence

While the ABS methodology assumes households occupy one place of residence, there is strong evidence in remote Aboriginal communities of linked or clustered households that are characterised by an extended family group dispersed across a number of places of residence. As Aboriginal people in remote Australia may consider themselves to reside in an area or within a number of localities, the concept of 'usual place of residence' that underlies the ABS data is problematic.

Family

The ABS definition of family is based on the standard definition of a mainstream nuclear family whereas many Aboriginal people think of family in broader terms. As well as members of the immediate 'nuclear family', this can include blood relationships and classificatory relationships.

Source: Memmott et al. 2004a:4–5.

The ABS concept of 'usual place of residence' is used in the Census to identify the secondary homeless—people who have no other usual address and have been staying temporarily with friends or relatives. As indicated in Box 7.2, however, Indigenous people could interpret questions based on 'usual place of residence' and 'family' within a very different cultural framework. When, for example, Indigenous people leave where they are living to escape domestic violence or other family problems and move in with members of their extended family, this could still be considered their usual address, of which there would be a number.

In fact, the Census identified only 1,000 Indigenous Australians in the secondary homelessness category, the smallest number of Indigenous Australians in any of the four categories (3.4% of the 29,439 in Table 7.4). In contrast, for non-Indigenous Australians, this was the largest category of people identified as homeless. Under the framework provided by the Census, these figures represent an undercounting of the secondary homeless population in those cases where Indigenous Australians are not reporting they are living somewhere other than their usual place of residence, according to the standard ABS definition of these terms.

On closer examination of what it means to be Indigenous and homeless, however, these figures could be viewed as an example of the cultural misrepresentation of Indigenous homelessness, whose lived experience of homelessness may be influenced by such culturally specific factors as a broad understanding of family, distributed places of residence, and cultural mobility requirements and other cultural obligations. It may be that the services required by Indigenous people identified as homeless by the Census are something other than housing or accommodation (Memmott et al. 2004b), and policy responses certainly need to be informed by a wider understanding of Indigenous homelessness than that provided by the Census alone.

An attempt at objectivity would seem vital to an enterprise such as the Census, and the universal application of a single cultural definition of homelessness provides such

objectivity. But the difficulties apparent in applying such a definition to those Indigenous Australians living in remote communities illustrate the inherent constraints imposed by any single approach to homelessness, and the importance of exploring different definitions for different policy contexts.

Counting the 'marginally housed' as homeless

Reservations have been expressed about the inclusion of the 'tertiary' homeless in the Census count, those people identified as living in boarding houses. While some may accept that people staying temporarily with friends or relatives can be considered as homeless, others have criticised the inclusion of boarding house residents when counting the homeless (Chamberlain & MacKenzie 2003:13, 52). Of all three categories, boarding house residents are closer to the accepted norm of culturally defined housing standards and are perceived as having more variable housing conditions.

The history of boarding houses dates back to the 1800s, when boarding houses were established in central locations in the large cities to provide accommodation for many younger men, as well as for couples, single women, and families. At that time, boarding houses were seen as fashionable and reputable accommodation. They were usually run by women and provided safe and respectable shelter, meals, laundry and other housekeeping services. In some areas, they were also established at seaside and other locations to accommodate holiday makers (Greenhalgh et al. 2004).

The decline in the reputation of boarding houses has been linked to the changing fortunes of the inner cities. This decline was also influenced by both the 1970s government policy of deinstitutionalisation and the ongoing gentrification of the inner city which started in the 1980s. Changing profiles of ownership, an increasing number of residents with high and complex needs, and changes to the viability of the boarding house industry were also factors.

The residents of boarding houses are considered homeless because their accommodation is below the minimum community standard. Boarding houses, as opposed to hotels and motels, are seen to provide cheap accommodation for people living in single rooms with only basic amenities and insecure tenure. Of the 99,900 people the 2001 Census identified as homeless, 22,877 (23%) were residents of boarding houses (see Table 7.1). The majority were male (72%) and 74% were either unemployed or outside the labour force (Chamberlain & MacKenzie 2003:38, 51).

There were large differences in the proportion of tertiary homeless identified in each jurisdiction, ranging from 5% of the homeless in the Australian Capital Territory to just under 30% in New South Wales and Victoria (see Table 7.3). These figures are influenced by the concentration of such establishments in cities such as Sydney and Melbourne; 67% of boarding houses are located in capital cities. In regional centres, country towns and remote locations, in contrast, they were relatively absent. In such locations, as Chamberlain and MacKenzie (2003:50) note, caravan parks can be said to have taken over the role of boarding houses in providing cheap accommodation to marginalised populations.

The use of caravan parks as long-term or permanent housing is relatively recent, only legally available in all jurisdictions since 1993. Before this, parks were developed as

holiday destinations and used for short-term accommodation. The number of people living in caravan parks long-term increased by 6,263 between the 1996 and 2001 Censuses, with a total of 61,463 people identified as permanent residents in 2001. The elderly were over-represented, with 23% of permanent residents aged over 65 years, and another 19% aged between 55 and 64 years. The tenure of permanent residents can include owning or purchasing a van while renting a site or renting both. Most caravan parks have a mixture of both types of tenure, with the availability of permanent arrangements depending on various factors such as local and state licensing and planning controls (Wensing et al. 2003).

The populations in caravan parks are very diverse, with the 2001 Census identifying four different populations, leaving aside visitors from overseas. As well as holiday makers—those having a usual address elsewhere in Australia—there were another two groups who were viewed as having made a 'deliberate if constrained lifestyle choice' to live in a park. These were people either owning or purchasing their caravan, and people renting a caravan, at least one of whom had a full-time job. The fourth group were renting a caravan, had no other usual address, and no-one living in the van had full-time employment.

Table 7.5: Homeless people including those in caravan parks, by state/territory, Census night 2001

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust
Marginal residents of caravan parks	6,881	3,407	7,989	2,503	932	271	110	775	22,868
ABS identified homeless	26,676	20,305	24,569	11,697	7,586	2,415	1,229	5,423	99,900
Total homeless	**33,557**	**23,712**	**32,558**	**14,200**	**8,518**	**2,686**	**1,339**	**6,198**	**122,768**

Source: Chamberlain & MacKenzie 2003.

There were 22,868 people identified in this group, classified as marginal residents of caravan parks (Table 7.5), and 78% of these marginal residents were housed in caravan parks outside of capital cities, in contrast to the clustering of marginal residents of boarding houses in major cities. Many of the remainder were in caravan parks in the industrial areas or outer suburbs of major cities. On socioeconomic measures these marginal residents faired as poorly as boarding house residents, and far more poorly than the secondary homeless staying temporarily with friends and family (Chamberlain & MacKenzie 2003:51–2).

Despite acknowledging that the marginally housed in caravan parks are at least as badly off as the tertiary homeless in boarding houses, and worse off than the secondary homeless, Chamberlain and MacKenzie decided not to include them when counting the homeless, saying that 'the cultural definition stands'. It is clear, however, that such marginal residents of caravan parks do not meet the stated culturally acceptable minimum community standards of housing, namely, having one room to sleep in and one to live in, your own kitchen and bathroom, and some security of tenure. If the definition of homelessness underpinning the Census is expanded to include those who are marginally housed in caravan parks, then the number of people identified as experiencing homelessness by the Census in 2001 increases from 99,900 to 122,770.

7.3 Another approach to defining the homeless

Census figures have been used to argue that the geographical distribution of the homeless population across states and territories is uneven, providing a basis for policy considerations concerning the redeployment of SAAP funds. However, the Census approach does contain inherent limitations. These are illustrated by the difficulties it faces in incorporating Indigenous Australians living in remote areas and the marginal residents of caravan parks, which, in turn, require consideration when these counts are considered as the basis for policy review and development.

Furthermore, the three-tiered definition underlying the Census, and the naming of these tiers as primary, secondary and tertiary, carries implications of degrees of disadvantage for people experiencing homelessness. The use of the word 'primary' calls to mind such notions as main, foremost, most important, essential, core, basic and fundamental. The implication is that this type of homelessness—living on the streets, in cars, squats and in improvised dwellings—brings with it the greatest degree of disadvantage, and that secondary and tertiary homelessness imply lesser levels of disadvantage.

The combination of a Census count of the homeless—taking a snapshot of society on 1 day every 5 years—with a hierarchical definition that emphasises structure rather than process, suggests that homeless people are easily slotted into one or another of these increasingly disadvantaged homelessness categories. Policy development can then be predicated on the numbers of people experiencing homelessness in each category, with service provision targeted accordingly, perhaps at those seen as more needy—the secondary homeless rather than tertiary homeless, for example. The question is whether other approaches are available that could complement policy development.

Although Chamberlain and MacKenzie's definition carries an element of temporal dynamics in its characterisation of the secondary homeless and they turn to the notion of process when discussing marginal residents of caravan parks, it is a downward one-way progression through the categories, an assumed linear process leading to a gradual loss of options until only one is left—'the end of the track'. A complementary approach that pays more attention to the temporal dynamics of homelessness arises from recent work on the homelessness experiences of people with a mental illness. In this, Robinson (2003) borrows the term 'iterative homelessness' to describe the repeated moves of people through different types of marginal or tenuous housing (Box 7.3).

Box 7.3: Iterative homelessness

'It is a term used to refer to the repeated and ongoing loss of, or movement through, accommodation in both the short and long term contexts of homelessness. Iterative homelessness is used . . . to highlight the fact that most homeless people do not sleep rough on the street, though they may do so at times. Many remain tenuously housed at continuous risk of street-homelessness in their cycle through many different forms of tenuous and unacceptable forms of accommodation such as hostels, licensed and unlicensed boarding houses, caravan parks, staying with friends, etc' (Robinson 2003).

With a focus on the lived experience of ongoing homelessness, this approach seeks to describe the sense of movement and repetition and to answer the question of why people continue to experience homelessness, and which factors contribute to their repeated uprootings and failures to establish a home, both physically and emotionally. The key indicator of homelessness, in this approach, is the movement through different forms of tenuous or marginal accommodation.

Chamberlain and MacKenzie developed a definition of homelessness that outlined the varying degrees of disadvantage, and the ensuing policy implications, for people experiencing homelessness. If the notion of iterative homelessness is utilised, it is no longer such an easy task to pinpoint those people who are experiencing the greatest disadvantage. Furthermore, the continued vulnerability that is experienced by those cycling through tenuous housing, moving from boarding house to friends, to hostels, time on the streets or SAAP accommodation, may not even be visible when viewed through the lens of the Census.

Robinson's development of the notion of iterative homelessness is largely based on her work with people experiencing mental health problems. She uses 'accommodation biographies', longer-term life histories and housing trajectories, to map the constant movement and continued vulnerability that is hidden in changing forms of accommodation. This work is at a relatively early stage of research, and it has not been established how widespread iterative homelessness is or how useful it will be in a broader context. It has, however, already been applied and found useful in the context of Indigenous women's homelessness (Cooper & Morris 2003), while Wensing et al.(2003:49), when investigating young people in caravan parks, reported that 'the typical pathways recounted involve regular movements between friends, hostels, sleeping rough and living in caravans', indicating that it is also useful in this context.

Conjointly with proposing her iterative homelessness definition, Robinson has also suggested that the key need, at least for homeless people with mental health problems, is the need for the healing of cumulative or 'lifestyle' trauma. She uses the notion of a healing framework, introduced by Coleman in a discussion of Indigenous women's homelessness (cited in Robinson 2003:33), which views homelessness as symptomatic of deeper issues and sees that housing is just one aspect of the process of iterative homelessness. Effective responses need to be pitched with the aim of *healing* the individual by equipping them to better cope with accumulated trauma as well as by working towards practical improvements in their immediate situation.

Robinson (2003:42) suggests that such effective responses would include points of stability, such as those that can be provided by SAAP accommodation services, drop-in centres, key workers or support groups and, most likely, by the coincidence of all of these and more. Such points of stability provide care within a framework aimed at developing relationships with clients, addressing their core traumatic experiences and helping them to develop positive and appropriate coping mechanisms. The key point is the capacity of such services to build relationships with their clients. In the context of people suffering mental health disorders, Robinson (2003) claims that housing and mental health management will continue to break down as long as service provision is 'outcome' structured, to be answered by accommodation alone, and that existing

policies and practices may actually squander the opportunities that could be offered by agencies at points of intervention and care.

The understanding of the lived experience of homelessness is not well developed. Robinson's work clearly illustrates how important temporal dimensions of homelessness can easily be overlooked in favour of the more static, easy to measure, dimensions. Homelessness data, of course, are notoriously difficult to collect. However, existing SAAP data can help shed some light on the lived experience of homelessness and the usefulness, or otherwise, of the notion of iterative homelessness.

The definition of homelessness which underpins the SAAP National Data Collection recognises that people experiencing or at risk of homelessness should be eligible for a range of support services besides accommodation that may help them to work through the underlying issues that prevent them from moving into or maintaining sustainable housing (Box 7.4). Furthermore, the SAAP definition acknowledges that a person may be living in their own home, one that meets culturally acceptable standards, but may be considered homeless or at imminent risk of homelessness due to violence in that home. This is particularly pertinent to women and children living with domestic violence who would not have been counted as homeless by the Census.

The next section first introduces the coverage and diversity of SAAP services, illustrating how SAAP provides different service responses to various client groups with different needs. The effect of this diversity on the numbers of people seeking accommodation is canvassed, with figures presented on the number of people seeking accommodation who are unable to find a bed in a SAAP service. Four different client groups are then profiled, comprising about half of the total SAAP population, to investigate what the data can tell us about their lived experiences of homelessness and to test the usefulness or otherwise of the notion of iterative homelessness.

Box 7.4: Homelessness and SAAP: a service delivery definition

The SAAP Act (1994) defines a person as homeless if, and only if, he or she has inadequate access to safe and secure housing. This includes housing situations that may damage health; threaten safety; marginalise a person from both personal amenities and the economic and social support a home normally offers; where the affordability, safety, security or adequacy of housing is threatened; or where there is no security of tenure. A person is also considered to be homeless under the Act if living in SAAP or other emergency accommodation.

The Act also stipulates that 'people who are homeless' include: people who are in crisis and at imminent risk of becoming homeless and people who are experiencing domestic violence and are at imminent risk of becoming homeless.

7.4 Homelessness within SAAP

During 2003–04, 1,300 SAAP agencies were funded. There were 1,291 agencies still operating at the end of the year, and 66 of these agencies (around 5%) did not

participate in the Client Collection. It is estimated that 1 in 130 Australians received SAAP support at some time during the year, with the 1,225 participating agencies supporting 100,200 clients and 52,700 accompanying children. It should be noted that, within the program, only adults and children who do not accompany a parent/guardian are considered as clients in their own right, and the information collected on accompanying children is quite limited (AIHW 2005).

Clients in SAAP during 2003–04 were provided with 187,200 support periods, which is the discrete period of time during which a client receives support from an agency. The greater number of support periods than clients indicates that some clients access SAAP services more than once during the year. The 52,700 accompanying children were provided with 73,200 support periods.

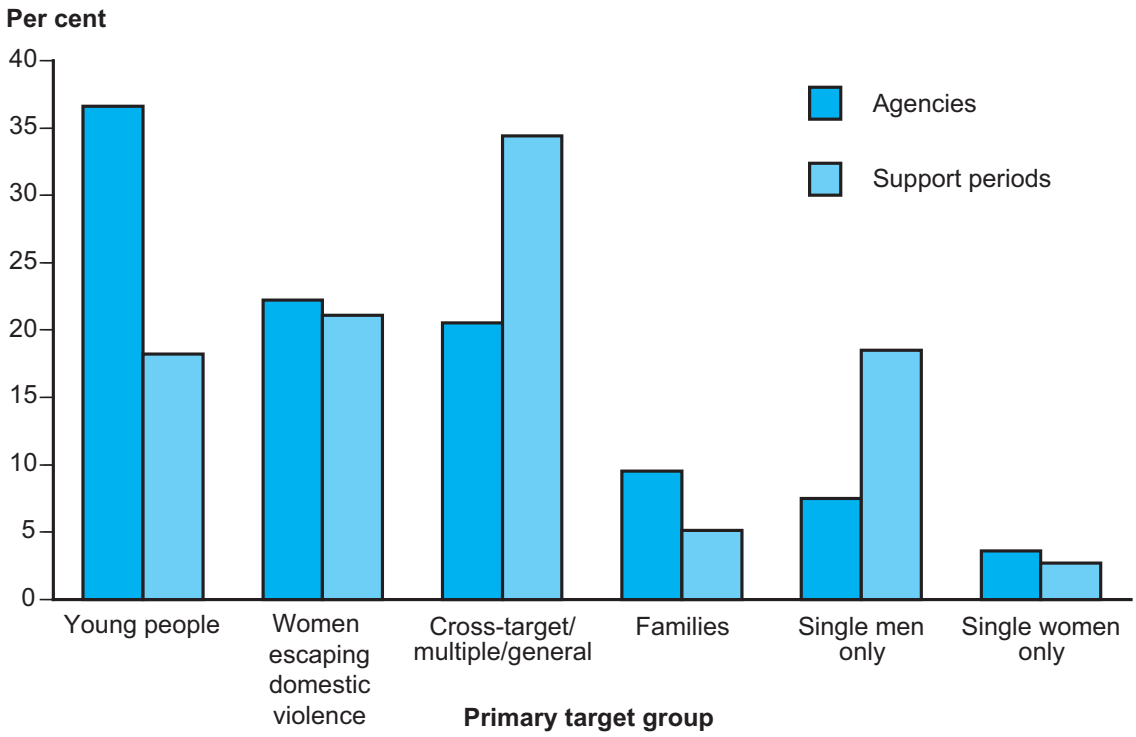
These SAAP clients and accompanying children have enormously diverse characteristics and circumstances, and many SAAP agencies target quite specific client groups, such as single men, single women, women and children escaping domestic violence, young people within particular age ranges, and families. These different SAAP sectors often have quite different histories, with the roots of single men's agencies, for example, stretching back to the early 1900s, while agencies for women escaping domestic violence were initially engendered by the feminist movement in the 1970s.

The largest sector in SAAP, totalling 37% of agencies, comprises agencies targeting young people in nominated age categories, with the next largest group of agencies catering for women and children escaping domestic violence (23%), followed by cross-target or general agencies (19%) (Figure 7.1). Different jurisdictions, however, depart from this national pattern, with the majority of services in both the Northern Territory and Western Australia targeting women escaping domestic violence (AIHW 2003a).

Because of their different histories and the varied needs of their client groups, SAAP sectors also have quite distinct operational procedures. Agencies targeting young people, for example, are often quite small and may have legal requirements to provide intensive 24-hour care to a relatively small number of clients, while those targeting single men often operate with a very high client turnover and less client contact. As a consequence, the proportion of support periods provided, as well as the type, number and length of support, can vary significantly between the sectors.

Consequentially, while agencies targeting young people make up 37% of all SAAP agencies, they provided only 19% of the 187,200 SAAP support periods in 2003–04. In contrast, single men's agencies accounted for 8% of SAAP agencies, but 19% of the support periods. General agencies provided 34% of all support periods, and domestic violence agencies 21% (Figure 7.1).

The length of support generally provided to clients, and the availability of SAAP services that cater to particular client groups, determine to a large extent the number of people that are supported by SAAP, and what the characteristics and circumstances of the overall SAAP population will be. These are also some of the factors that constrain the number of people able to access SAAP services when in need of accommodation—not all people who seek accommodation at SAAP agencies are successful.



Source: Table A7.1

Figure 7.1: SAAP agencies and support periods provided, by primary target group, 2003–04

The National Data Collection Agency attempts to measure both met and unmet requests for accommodation, as well as the capacity at which SAAP services are operating, through the Demand for Accommodation Collection, which runs for 2 separate weeks during the year. Because of seasonal factors, and because people can have several unmet requests in a year, extrapolating from these data to annual figures is not possible. Furthermore, from the perspective of planning for service delivery, annual data do not inform planners of the extent to which additional funds are required to cater for excess demand each night.

This collection indicated that, on an average day in 2003–04, of the 399 people requesting immediate accommodation, 213 (53%) were unable to be accommodated by the end of the day, mainly because there was insufficient accommodation at the SAAP agency where the request was made. The turn-away rate for accompanying children was even higher. Of the 195 children who required accommodation with their parent/guardian on an average day during the 2003–04 collection, 125 were not accommodated (a turn-away rate of 64%). This suggests that SAAP is more able to provide accommodation for individual(s) who present without children, with these people having the lowest national daily turn-away rate (AIHW 2005).

The 213 potential clients who were turned away represent just 3% of the total number of clients that SAAP was accommodating on that average day, which seems to suggest that a 3% increase in bed capacity could satisfy reported unmet demand for accommodation.

However, this assumes both that all those who needed SAAP accommodation were approaching SAAP agencies and that demand was consistent across target groups and geographical locations. There is sufficient evidence to suggest that neither of these is the case. Furthermore, of the large number of homeless people counted by the Census, only 14% were accommodated in SAAP, suggesting a significant level of hidden need—although exactly what services are needed by this homeless population is unknown.

The SAAP program, then, has distinct and diverse sectors that cater to different groups of homeless people. The next section begins by establishing the differences in the SAAP interventions between four of these client populations, who are largely but not solely drawn from three distinct SAAP sectors: single men's agencies, agencies targeting women escaping domestic violence, and youth agencies.

Differences between SAAP clients

The four client groups encompass single older men aged 45 and over, comprising 8% of SAAP clients, women escaping domestic violence aged 20 years and over, comprising 26%, and young men and women aged 15–19 years, comprising 7% and 10%, respectively (Table 7.6). The client population of women escaping domestic violence was drawn from female clients aged 20 years and over who requested assistance from SAAP due to domestic violence, or who needed, were provided with, or were referred on for counselling and support. As all groups are scoped to be mutually exclusive, young women aged between 15 and 19 who are escaping domestic violence—less than 10% of all women escaping domestic violence—will be excluded from the women escaping domestic violence client group.

Table 7.6: SAAP clients and length of support and accommodation periods provided, by client group, 2003–04

	Male clients 15–19	Female clients 15–19	Women escaping DV 20+	Single men 45+	Other	Total
Clients	6,600	10,500	26,000	7,800	54,400	100,200
Mean length of closed support periods (days)	57	68	56	25	38	44
Median length of closed support periods (days)	15	17	9	1	3	4
Mean length of accommodation periods (days)	41	50	39	29	35	37
Median length of accommodation periods (days)	11	10	6	4	6	6

Notes

1. Number excluded due to errors and omissions for length of support (weighted): 100 closed support periods.
2. Number excluded due to errors and omissions for length of accommodation (weighted): 7,200 closed support periods.
3. Number of clients within a Subpopulation relate to clients who ever presented with the criteria used to form the group. Since a client may have presented with varying characteristics and consent, Subpopulation figures do not sum to the national figure.
4. Figures have been weighted to adjust for incomplete coverage.

Source: SAAP Client Collection.

The cultural and linguistic profiles of these four client groups are quite diverse (Table 7.7). Indigenous Australians are over-represented in SAAP—although only 2% of the Australian population identify as Indigenous, over 16% of all SAAP clients were Indigenous.

This over-representation is most exaggerated for women escaping domestic violence (DV), with over 21% of these clients identifying as Indigenous. These figures are influenced by the composition of SAAP agencies. At the national level, services for women escaping domestic violence comprise the second largest SAAP sector (see Figure 7.1), but in the Northern Territory and Western Australia, both jurisdictions with large Indigenous populations, this sector forms the largest proportion of SAAP services (AIHW 2003a).

The overrepresentation of Indigenous Australians influences the relative proportions of other cultural and linguistic groups in SAAP. People born overseas in the English proficiency group 1 comprised 4% of the total SAAP population, compared to 10% of the Australian-born population. (Group 1 countries are Canada, Ireland, New Zealand, South Africa, the UK and the USA.) This group was well represented among older single men, with 9% from this background. People born in countries grouped as English proficiency groups 2–4 (predominantly non-English-speaking countries) comprised 16% of women escaping domestic violence and 12% of single older men but only 10% of the overall SAAP population compared to 16% of the overall population.

Table 7.7: SAAP clients, by cultural and linguistic diversity and client group, 2003–04 (per cent)

	Male clients 15–19	Female clients 15–19	Women escaping DV 20+	Single men 45+	Other	Total	Australian population aged 10 and over	
							Per cent	Number
Indigenous Australians	13.0	19.1	21.1	8.0	16.4	16.5	2.0	345,000
Australian-born non-Indigenous people	79.2	74.7	58.3	71.5	70.7	68.9	71.8	12,220,500
People born overseas, English profic. group 1	2.7	1.9	4.5	8.5	4.2	4.3	10.2	1,730,700
People born overseas, English profic. groups 2–4	5.2	4.3	16.1	11.9	8.7	10.4	16.0	2,727,500
Total	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*. .*
Total (number)	**6,300**	**10,100**	**25,200**	**7,600**	**52,100**	**96,500**	**. .**	**17,023,700**

Notes

1. Number excluded due to errors and omissions at national level for cultural and linguistic diversity (weighted): 3,700 clients.
2. Number of clients within a subpopulation relates to clients who ever presented with the criteria used to form the group. Since a client may have presented with varying characteristics and consent, subpopulation figures do not sum to the national figure.
3. 'Australian population 10+' refers to the estimated resident population aged 10 years and over at 30 June 2002. The figures for Indigenous Australians are from experimental estimates based on the 2001 Census produced by the ABS. The number of 'Australian-born non-Indigenous people' is derived from the Australian-born population minus the number of Indigenous Australians.
4. Figures have been weighted to adjust for incomplete coverage.

Sources: SAAP Client Collection; ABS 2004b, 2004c.

As SAAP clients, these groups are provided with a variety of services during their support periods, which may or may not include accommodation. A support period is the discrete period of time during which a client receives support from an agency, with a closed support period being one which finished before the end of the reporting year. An accommodation period is the time during which a client had a bed at an agency, which will always be as part of their support period. During a support period with accommodation, clients will also receive other services such as meals, counselling or health and medical services.

Young female clients, on average were both supported and accommodated for longer periods than the other client groups, at 68 days and 50 days, respectively (Table 7.6). The average length of support and accommodation for young men was shorter, at 57 and 41 days, respectively. The clients with the shortest average length of support and accommodation were the older men (25 and 29 days, respectively). The median length of support for this group was just a single day, indicating that many are using SAAP just for an overnight stay. Note that in this table the mean and median length of accommodation excludes accommodation that starts and ends the same day.

The male client groups, both the single older men and the young males, were more likely to be accommodated by SAAP services (in 65% and 62% of support periods, respectively) than young female clients or women escaping domestic violence (51% each) (Table 7.8). Single older men were also the most likely to receive drug and alcohol services, in 31% of support periods. Young men were the next most likely to receive these services, in 10% of support periods. However, single older men were less likely than any other group to receive other broad types of services such as general support/advocacy (in 70% of support periods), counselling (in 34%), or financial or employment assistance (in 26%).

The types of services that women escaping domestic violence were most likely to receive were general support/advocacy and counselling (both in 82% of support periods), followed by basic support (56%). All four client groups accessed health and medical services fairly equally (10% to 13%).

Table 7.8: Support periods provided to SAAP clients, by type of service and client group 2003–04 (per cent)

Broad type of service	Male clients 15–19	Female clients 15–19	Women escaping DV 20+	Single men 45+	Other	Total
SAAP accommodation	61.5	51.1	51.2	65.4	47.3	51.5
Assistance to obtain/maintain non-SAAP/CAP accommodation/housing	37.2	39.7	31.7	17.8	27.2	28.9
Financial/employment	39.3	39.5	40.6	26.2	32.9	34.9
Counselling	46.8	58.9	81.6	33.6	38.7	47.9
General support/advocacy	77.7	77.5	82.2	69.8	68.9	72.5
Health/medical services	9.9	12.7	13.0	12.9	9.1	10.6
Drug/alcohol support or intervention	10.2	5.8	4.6	31.1	12.5	12.3
Other specialist services	8.0	14.2	21.1	5.0	8.7	11.0
Basic support	66.5	56.4	56.0	73.3	56.3	58.9
No services provided directly	2.5	2.2	0.9	1.7	3.1	2.5
Total (number)	**11,100**	**17,000**	**38,400**	**17,900**	**107,300**	**180,400**

Notes

1. Number excluded due to errors and omissions (weighted): 7,000 (including cases with no information on service requirements or provision).
2. Clients were able to receive multiple services, so percentages do not total 100.
3. Figures have been weighted to adjust for incomplete coverage.

Source: SAAP Client Collection.

These profiles indicate that the four client groups presented have different experiences with their SAAP interventions. The lengths of support and accommodation differ markedly between the groups, the use of particular sectors of SAAP by Indigenous Australians varies, and the types of support received are different. The next section introduces SAAP data which can give insight into some of the temporal dimensions of the homelessness being experienced by these four client groups. The data are used to develop two indicators of iterative homelessness in order to examine the groups for indications of ongoing tenuous housing cycles, before turning to investigate the nature of homelessness within each group in turn.

7.5 Iterative homelessness in the client groups

Iterative homelessness refers to the repeated and ongoing movement through tenuous and marginal types of accommodation. One indicator of this movement that can be derived from the SAAP data is the incidence of being marginally housed prior to SAAP: This can be indicated by clients sleeping rough or in improvised dwellings, by being in SAAP, a rooming house, hostel, hotel or caravan, being in an institution, or by living rent-free in a house or flat prior to their SAAP intervention. It could be argued that not all these options necessarily indicate tenuous housing and without knowledge of the previous housing trajectory of clients this can never be clear—the data cannot tell us for how long, if at all, clients have been moving between different forms of housing. In all these types of accommodation, however, security of tenure is lacking, creating circumstances where housing is more tenuous.

Of all four client groups, young men and single older men experienced the most marginal housing conditions prior to SAAP support. Young men were previously marginally housed in 74% of their support periods (Table 7.9) and single older men in 71%. Younger women were previously marginally housed in 63% of their support periods while women escaping domestic violence were housed marginally in only 31% of support periods. Note that this indicator, consisting as it does of previous housing that had no tenure, cannot capture the incidence of emotionally tenuous housing conditions which women coming from situations of domestic violence have lived through.

For both young men and young women, the most common form of prior housing was living rent-free in a house of flat (in 28% and 32% of support periods, respectively), for single older men it was sleeping rough outside or in improvised dwellings (23%) and for women escaping domestic violence, private rental was the most common form of housing prior to SAAP (25%).

For both young men and single older men, the second most common form of prior housing was another SAAP service. Young male clients were previously housed in emergency accommodation in 26% of their support periods, and single older men in 21%. The second most common form of prior housing for young women was boarding in a private house (in 19% of support periods) and for women escaping domestic violence it was public or community housing (in 22%).

Table 7.9: Closed support periods provided to SAAP clients, by type of accommodation immediately before support and client group, 2003–04 (per cent)

Type of accommodation	Male clients 15–19	Female clients 15–19	Women escaping DV 20+	Single men 45+	Other	Total	
						Per cent	Number
Marginal housing							
Living in a car/tent/park/street/squat	8.3	4.0	2.4	23.4	15.3	11.9	18,200
SAAP or other emergency housing	25.7	19.4	15.1	21.4	15.8	17.1	26,100
Rooming house/hostel/hotel/caravan	5.5	4.9	4.1	17.1	12.2	9.9	15,100
Institutional	6.6	2.9	1.4	5.3	5.3	4.3	6,600
Living rent-free in house/flat	27.6	32.0	7.5	3.4	9.9	11.8	18,000
Subtotal	*73.7*	*63.2*	*30.5*	*70.6*	*58.5*	*55.0*	*84,000*
Non-marginal housing							
Boarding in a private home	15.9	18.7	9.9	4.0	10.3	10.7	16,300
Public or community housing	2.9	5.9	21.6	14.3	12.3	13.3	20,400
Private rental	5.1	9.4	24.7	7.8	14.3	14.8	22,600
Own home	0.6	0.7	11.6	1.3	1.4	3.4	5,200
Subtotal	*24.5*	*34.7*	*67.8*	*27.4*	*38.3*	*42.2*	*64,500*
Other	1.8	2.1	1.6	2.1	3.3	2.6	4,000
Total	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*
Total (number)	**9,200**	**13,900**	**32,100**	**15,500**	**81,900**	**. .**	**152,600**

Notes

1. Number excluded due to errors and omissions (weighted): 16,600 (clients).
2. Figures have been weighted to adjust for incomplete coverage.

Source: SAAP Client Collection.

Another source of insight into the temporal dimensions of homelessness of SAAP clients is the number of times a client returns to SAAP services in any one year. The time during which a client is given support by an agency is called a support period, and this finishes when the relationship between the client and an agency ends. Later, however, clients may return again to either the same agency or another one for another support period. This repeat use rate is measured by the number of support periods the client has in the year.

Clients with high repeat rates are sometimes described as 'churning' through the system, with the implication that they go in and out of the revolving SAAP door without any noticeable change in their circumstances. It is just as possible, however, to interpret high repeat rates as a positive experience for clients. Using the paradigm supplied by the notion of iterative homelessness, SAAP services can be viewed as providing points of stability for clients where, over time, they may establish trust and rapport with workers and begin to work through the underlying issues that prevent them moving into sustainable housing options.

The same groups who experienced the most marginal housing tenure prior to their SAAP interventions also had the highest repeat rates of SAAP usage. In the 2003–04 year, 5.2% of the older single men and 3.5% of younger men had 6 or more support periods (Table 7.10), in line with their relatively high rates of being previously

accommodated in a SAAP service (Table 7.9). In contrast, 91% of women escaping domestic violence had only 1 or 2 support periods last financial year. For young women the corresponding figure is 87%, while 86% of young men and 84% of older single men had just the 1 or 2 support periods.

Table 7.10: SAAP clients, by number of support periods provided per client and client group, 2003–04 (per cent)

Number of support periods per client	Male clients 15–19	Female clients 15–19	Women escaping DV 20+	Single men 45+	Other	Total
1	71.9	72.6	78.0	68.6	73.2	71.6
2	14.2	14.8	13.0	15.0	13.9	14.4
3	5.9	6.1	4.7	6.3	5.2	5.9
4	2.6	2.7	2.1	3.3	2.5	2.8
5	1.9	1.4	1.0	1.7	1.6	1.7
6 or more	3.5	2.3	1.3	5.2	3.7	3.6
Total	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*
Mean number of support periods per client	**1.77**	**1.69**	**1.50**	**2.33**	**1.85**	**1.87**
Total (number of clients)	**6,600**	**10,500**	**26,000**	**7,800**	**54,400**	**100,200**

Notes

1. Number of clients within a subpopulation relate to clients who ever presented with the criteria used to form the group. Since a client may have presented with varying characteristics and consent, subpopulation figures do not sum to the national figure.
2. Figures have been weighted to adjust for incomplete coverage.

Source: SAAP Client Collection.

These two measures of iterative homelessness, then, have been useful in showing up the differences between the temporal dimensions of homelessness as experienced by the four client groups. In particular, they have highlighted the likelihood of previous marginal housing conditions and of ongoing cycles of SAAP interventions being experienced by young men and older single men. Each of these client groups will now be investigated in more detail.

Single older men

Single older men are very often clients at men's shelters, that is, SAAP agencies with very high client turnover. Historically, these agencies have collected a limited amount of information about their clients and, for this reason, detailed information about this client group, including presenting reasons and changes in situations before and after support, are not complete. This will change as at July 2005, and complete information will be available after the 2005–06 Demand for Accommodation Collection.

Homeless men often have physical disabilities and health problems more often seem in people 10 or 20 years older than themselves, and many 'view their lives as over' (FaCS 2003a). For such reasons, conventional chronological classification of the elderly as 65 years or over is not applied to homeless men, who are often classed as elderly at 50 years of age. Premature ageing is even more pronounced for Indigenous men who, with life expectancies of around 17 years less than non-Indigenous men, are often classed as elderly when aged 45 and over. This is the age at which we will begin this

analysis of older men. These older men are more likely to access SAAP services than women of the same age; 21% of male SAAP clients over the age 45 in 2003–04 and only 13% of female clients (AIHW 2005).

Reflecting the high level of disabilities in this client group, the main source of income for these clients in 2004–04 was the Disability Support Pension, in 61% of support periods, compared with 17% for the remaining SAAP clients (see Table A7.2). This was true for all ages below those eligible for the Age Pension. The Age Pension was the main source in 70% of support periods for the 65–74 year olds, and, interestingly, in only 57% of support periods for those aged 75 and over. However, this older age group also received other types of pensions in a further 12% of their support periods.

The best indicator currently available as to why this client group is accessing SAAP is provided by looking at the types of services they receive, as the three services most often provided to single older men were SAAP accommodation (in 65% of support periods), laundry or shower facilities (61%) and meals (60%) (Table A7.3). Single older men were far more likely than other SAAP clients to have their belongings looked after (in 40% of support periods compared to 19%). They were also far more likely to need drug or alcohol support or intervention (31% compared with 10%), indicating that underlying many of the physical disabilities and health problems experienced by this client group are significantly high levels of drug and/or alcohol abuse and/or mental health issues.

The small group of men using SAAP who are aged 75 years or older have a very different pattern of service provision. For this group, the services most often provided were advice and information and SAAP accommodation, both in just 45% of support periods, and laundry and shower facilities, in 40%. Compared to the younger age groups of men, they received less emotional support (in 26% of support periods), were provided with less retrieval, storage or removal of belongings (26%) and had fewer meals provided (36%). They also received less drug and alcohol support (in 17% of support periods), which may be influenced by earlier mortality rates for chronic abusers. On the other hand, they were provided with more financial assistance (in 25% of support periods).

There is evidence that some men in this client group have difficulties in even accessing SAAP services. In 2003–04, a review of the exclusion policy and procedures of SAAP agencies undertaken by the Community Services Commission in New South Wales showed how eligibility policies prevent potential clients from gaining access. It also highlighted how exclusion can operate through practices such as early exiting, banning, blacklisting, eviction, time-out and background checks (NSW Ombudsman 2004). In this review, single men's agencies, far more than any other type of agency, indicated that not wanting to abide by rules was a sufficient reason to deny access to clients. Further, more than any other sector, previous experience with the person was a more likely factor in denying them access. The most common characteristic of people turned away from single men's agencies was that of having a drug and alcohol problem—there were an estimated 130 men turned away for this reason in the 6 months prior to the survey (AIHW 2003a:427), again highlighting the underlying issues of many of these clients.

This tallies with a survey carried out in 2002 in Sydney which identified upwards of 100 people barred from one or all SAAP services for periods ranging from a few days to life (Robinson 2002, cited in Hurni 2004). In a similar vein, a Queensland survey in 2001 found that the behaviours for which clients were most frequently excluded, in order of response rate, were violence (past or present), intoxication or substance abuse (past or present) and perception of mental illness (Jeanneret 2004).

This client group has been characterized as largely the chronic, repeat, incipient, prolonged, or long-term homeless, or as having adopted homelessness as a way of life (Hurni 2004). This ongoing homelessness is captured by the group's repeat use of SAAP services (Table 7.11), which reports the average number of support periods clients have in any one year. In 2003–04, single older men had an average of 2.3 support periods compared to a 1.8 average for the rest of the SAAP population. However, as this client group ages, they tended to have less support periods in the year, with 67% of the men aged 45–54 having only one support period, compared to 80% of those aged 75 and over. Five per cent of the 45–54 year olds, and 6% of the next age group, had 6 or more support periods in the year, dropping to 2% of those aged 75 and over.

Table 7.11: Single male SAAP clients aged 45 and over, by number of support periods provided per client and age group, 2003–04 (per cent)

Number of support periods per client	Single men aged 45 and over						Other SAAP clients	
					Total			
	45–54	55–64	65–74	75+	%	Number	%	Number
1	67.4	68.5	70.4	80.1	68.6	5,400	72.0	66,800
2	14.9	15.5	14.6	13.2	15.0	1,200	14.3	13,300
3	7.0	5.4	6.0	3.6	6.3	500	5.8	5,300
4	3.6	3.2	2.6	0.6	3.3	300	2.8	2,600
5	1.8	1.6	1.7	0.3	1.7	100	1.6	1,500
6+	5.2	5.8	4.7	2.1	5.2	400	3.5	3,200
Total	100.0	100.0	100.0	100.0	100.0	. .	100.0	. .
Mean number of support periods per client	2.35	2.31	2.54	1.68	. .	2.33	. .	1.82
Total (number)	**4,700**	**2,000**	**700**	**400**	**. .**	**7,800**	**. .**	**92,700**

Notes

1. Number of clients within a subpopulation relate to clients who ever presented with the criteria used to form the group. Since a client may have presented with varying characteristics and consent, subpopulation and other SAAP figures do not sum to the national figure.
2. Figures have been weighted to adjust for incomplete coverage.

Source: SAAP Client Collection.

We reported previously (see Table 7.9) that single older men, together with young men in the 15–19 age group, were experiencing the most vulnerable housing conditions before their SAAP support periods. These clients were previously marginally housed in 71% of support periods, compared to 53% of support periods for the remaining SAAP clients (Table 7.12). Different age groups of single older men, however, showed a lot of variation in the incidence of previous marginal housing. The highest incidence was in the 45–54 age group, who were previously marginally housed in 72% of support periods.

In the 55–64 age group, the incidence dropped to 68%, largely due to a decrease in the incidence of clients sleeping rough before their SAAP intervention (from 25% of support periods for the 45–54 year olds to 20% for the next age group).

The proportion of these clients living in rooming houses, hostels and caravan parks decreased with increasing ages, from a high of 18% of support periods in the 55–64 age group, to 15% in the oldest age group. In contrast, the percentage of support periods in which this client group was previously living in a SAAP or other emergency accommodation was greatest for the oldest age group (a quarter of all support periods). The percentage of support periods in which these clients were previously living in an institution was also greatest for those aged 75 and over, increasing from 5% of support periods for the other age groups to 7% of support periods. Although these figures cannot illuminate how often these clients are moving between different types of tenuous housing, they do highlight the difficulties they face in maintaining sustainable housing options.

Table 7.12: Closed SAAP support periods provided to single men aged 45 or over, by type of accommodation immediately before support and age group, 2003–04 (per cent)

	Single men aged 45 and over					Other SAAP
Type of accommodation	**45–54**	**55–64**	**65–74**	**75+**	**Total**	**clients**
Marginal housing						
Living in a car/tent/park/street/squat	25.4	19.7	23.1	14.1	23.4	10.7
SAAP or other emergency housing	20.9	22.1	20.5	25.4	21.4	16.6
Rooming house/hostel/hotel/caravan	17.0	17.8	16.3	14.6	17.1	9.1
Institutional	5.4	4.9	4.8	6.8	5.3	4.2
Living rent-free in house/flat	3.6	3.5	2.1	3.3	3.4	12.8
Subtotal	*72.3*	*68.0*	*66.8*	*64.2*	*70.6*	*53.4*
Non-marginal housing						
Boarding in a private home	4.3	3.9	3.0	2.5	4.0	11.4
Public or community housing	12.4	16.0	19.9	19.6	14.3	13.2
Private rental	7.7	7.9	7.1	10.2	7.8	15.6
Own home	1.1	1.8	1.3	0.9	1.3	3.7
Subtotal	25.5	29.6	31.3	33.2	27.4	43.9
Other	2.1	2.3	1.9	2.6	2.1	2.7
Total	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*
Total (number)	**9,400**	**4,100**	**1,500**	**500**	**15,500**	**137,100**

Notes

1. Number excluded due to errors and omissions (weighted): 16,600.
2. Valid data for 'Other SAAP' include records with errors and omissions in age.
3. Figures have been weighted to adjust for incomplete coverage.

Source: SAAP Client Collection.

As well as accessing SAAP services more often than other clients, this client group also had generally shorter interventions, with an average length of support of 25 days, compared with the 46 days for the rest of the SAAP population (Table 7.13). Their median length of support was just 1 day, compared with 5 for other SAAP clients,

suggesting that in a majority of support periods they are using the SAAP services as day drop-in centres. Unlike the average length of support, which does not vary between the ages, the average length of accommodation steadily rises with age from 27 days in the 45–54 age group to 40 days in the 75 and over age group. The median length, at 4 days, is not very different from that of other SAAP clients.

Combined with information on the relatively shorter lengths of support and accommodation for these clients (see Table 7.6), it seems that single older men tend to have a unique pattern of SAAP usage, with shorter and more frequent support periods. In Robinson's parlance, this could be interpreted as offering points of stability in these men's lives, thereby providing opportunities for developing trust so that deeper issues, such as those underlying their substance abuse, which are reflected in their service provision and preventing their sustainable and ongoing housing, could be addressed.

Table 7.13: Closed SAAP support periods provided to single men aged 45 and over, by length of support and accommodation periods and age group, 2003–04

	Single men 45 aged 45 and over					Other SAAP clients
	45–54	55–64	65–74	75+	Total	
Mean length of support (days)	25	27	26	27	25	46
Median length of support (days)	1	1	1	—	1	5
Mean length of accommodation (days)	27	32	33	40	29	38
Median length of accommodation (days)	4	3	3	6	4	7

Notes

1. Number excluded due to errors and omissions for length of support (weighted): 100.
2. Number excluded due to errors and omissions for length of accommodation (weighted): 7,200.
3. Figures have been weighted to adjust for incomplete coverage.

Source: SAAP Client Collection.

Women escaping domestic violence

It has been argued strongly that many of the current definitions of homelessness have a gendered terrain: 'homelessness, particularly single homelessness, is seen as a male problem, the image of the male tramp on the park bench, the zipless torn trousers, the laceless shoes, is a dominant one. Women's homelessness takes different forms and finds different "solutions"' (Watson 1988, cited in Beer et al. 2003:15). In the previous section the SAAP data revealed more about this traditional subject of the homelessness debate, and how men's experiences of homelessness and SAAP changed as they aged. In this section we see what the data can tell us about women escaping domestic violence, both Indigenous and non-Indigenous, and their children.

As has been said, homelessness is most often identified with men found sleeping rough, a point of view supported by the Census, where over 60% of the 'primary' homeless were men (Chamberlain & Mackenzie 2003:4). The many women and children living with domestic violence in their own homes are not classed as homeless by the Census, and this and other forms of homelessness experienced by women is often unseen and as a result undercounted, with the consequence that women's needs are marginalised. This notion of hidden homelessness is congruent with the types of tenuous housing trajectories described by Robinson, with the cycles of marginal housing described by her

often being invisible under such homelessness measurements as that supplied by the Census. If a woman and her family, for example, have been sharing accommodation with another family for longer than 3 months, she is not counted as homeless in the Census.

If this is true for non-Indigenous women, then it is probably even more relevant for Indigenous women. As discussed earlier, for example, some Census concepts may be less appropriate in an Indigenous context, raising the potential for the marginalisation and cultural misrepresentation of Indigenous homelessness. Indeed, the lived homelessness experiences of homeless Indigenous women, together with their views on home and community, are only just starting to be given a voice (e.g. Cooper & Morris 2003). The SAAP data may shed more light on such experiences, for both Indigenous and non-Indigenous women.

In the SAAP population, women consistently outnumber men. In 2003–04, 58% of clients were women, 42% men (AIHW 2005), with Indigenous women considerably over-represented, comprising over 21% of all women escaping domestic violence (see Table 7.7). Such figures are influenced by the proportion of SAAP services that target women or, more specifically, women escaping domestic violence. This sector is the second largest nationally (see Figure 7.1).

The proportion of women who attended SAAP agencies in 2003–04 accompanied by children was very similar both for Indigenous and non-Indigenous women: about 60% of support periods in both cases (see Table A7.4). In around one-half of their support periods, both Indigenous and non-Indigenous women escaping domestic violence cited physical and emotional abuse as an additional reason for seeking assistance and both also commonly cited relationship and family breakdown (in 30% and 37% of support periods, respectively), indicating the high levels of violence and emotional uprooting faced by this large proportion of SAAP clients.

There were differences between these Indigenous and non-Indigenous clients. Indigenous women more often reported seeking assistance for having time out from family and other situations (in 25% of support periods compared to 13% for non-Indigenous women) and were also more likely to cite problems with drug, alcohol or substance abuse as a reason for seeking assistance (in 15% and 8% of support periods, respectively), although it is unclear whether this refers to their own substance abuse or that of members of their family.

In this context, the importance of home and family in an Indigenous context can be clearly seen in the data on living situations before and after accessing SAAP services (see Table A7.5). Indigenous women were living with parents or relatives before accessing SAAP in 24% of support periods and in 30% afterwards, compared with just 10% of support periods, both before and after SAAP for non-Indigenous women. Both Indigenous and non-Indigenous women were more likely to be living alone with their children after leaving SAAP. The percentage of Indigenous women living alone rose from 16% of support periods to 30%, while for non-Indigenous women the increase was from 23% to 43%.

There were large differences in the length of support and of accommodation, depending both on the Indigenous status of the women and whether they were accompanied by children. Non-Indigenous women were supported for longer (a median of 15 days) and

had longer accommodation periods (13 days) than did Indigenous women, whose median length of both support and accommodation was 3 days (Table 7.14). The average length of accommodation for non-Indigenous women with children was 59 days, compared to 22 days for Indigenous women with children. Stays without children were generally much shorter, on average 40 days for non-Indigenous women and just 9 days for Indigenous women.

Table 7.14: Closed SAAP support periods provided to women aged 20 and over escaping domestic violence, by length of support and accommodation, whether accompanied by a child and Indigenous status, 2003–04

	Indigenous			Non-Indigenous		
	With accom-panying child(ren)	Without accom-panying child(ren)	Total	With accom-panying child(ren)	Without accom-panying child(ren)	Total
Mean length of support (days)	35	21	29	74	51	65
Median length of support (days)	4	2	3	21	9	15
Mean length of accommodation (days)	22	9	17	59	40	52
Median length of accommodation (days)	3	2	3	15	9	13

Notes

1. Number excluded due to errors and omissions for length of support and Indigenous status (weighted): 800.
2. Number excluded due to errors and omissions for length of accommodation and Indigenous status (weighted): 900.
3. Figures have been weighted to adjust for incomplete coverage.

Source: SAAP Client Collection.

The SAAP services received by women escaping domestic violence also varied considerably depending on Indigenous status (see Table A7.6). For Indigenous women, the three broad types of services most likely to be received were basic support (in 77% of support periods), SAAP accommodation (in 76%) and counselling (in 71%). For non-Indigenous women, it was general support and advocacy (in 86% of support periods), counselling (in 85%) and basic support (in 50%). Non-Indigenous women accessed accommodation in just 44% of support periods overall, indicating that Indigenous women were far more likely to use SAAP services for accommodation. For Indigenous and non-Indigenous women alike, accessing SAAP agencies without accompanying children generally meant receiving fewer types of services.

The data so far for women escaping domestic violence indicate that the SAAP experiences are quite different, depending on clients' Indigenous status. Indigenous women are likely to have much shorter lengths of support and accommodation, most commonly just 3 days for either, and are more likely to be accommodated during their SAAP interventions. SAAP data also provide insight into the importance of Indigenous ties to community, with Indigenous women far more likely to be staying with family, including relatives, either before or after their SAAP support, and also more likely to use SAAP services for time out from family.

Women escaping domestic violence had the lowest incidence of previous marginal housing of all four client groups in 2003–04 (in 31% of support periods, see Table 7.9). Indigenous women were marginally housed prior to 34% of their support periods while non-Indigenous women were marginally housed prior to 30% (Table 7.15). Both showed

a similar increase in the incidence of marginal housing after receiving SAAP support, rising to 36% of support periods for Indigenous women and 32% for non-Indigenous women.

Table 7.15: Closed SAAP support periods provided to women aged 20 and over escaping domestic violence, by type of accommodation immediately before and after support and Indigenous status, 2003–04 (per cent)

	Indigenous		Non-Indigenous	
Type of accommodation	**Before support**	**After support**	**Before support**	**After support**
Marginal housing				
Living in a car/tent/park/street/squat	3.9	2.0	2.0	0.8
SAAP or other emergency housing	15.9	18.8	15.0	20.9
Rooming house/hostel/hotel/caravan	3.1	3.4	4.5	3.6
Institutional	1.7	2.2	1.3	1.4
Living rent-free in house/flat	9.1	9.5	7.2	5.6
Subtotal	*33.7*	*35.9*	*30.0*	*32.3*
Non-marginal housing				
Boarding in a private home	11.0	10.7	9.5	9.5
Public or community housing	43.7	42.9	14.6	18.3
Private rental	9.6	8.6	29.8	27.4
Own home	1.0	0.8	15.2	11.4
Subtotal	*65.3*	*63.0*	*69.1*	*66.6*
Other	1.0	1.1	0.9	1.1
Total	*100.0*	*100.0*	*100.0*	*100.0*
Total (number)	**7,600**	**6,000**	**22,500**	**19,200**

Notes

1. Number excluded due to errors and omissions before support (weighted): 3,600.
2. Number excluded due to errors and omissions after support (weighted): 8,600.
3. Table excludes high-volume records because not all items were collected on the high-volume form.
4. Figures have been weighted to adjust for incomplete coverage.

Source: SAAP Client Collection.

However, as already said, this indicator cannot capture the incidence of emotionally tenuous housing and emotional uprootings which women in domestic violence live with. This is better indicated by the prevalence of domestic violence and concurrent high levels of physical and emotional abuse in this client group. In fact, the grouping of housing into marginal and non-marginal hides very significant differences in the types of non-marginal housing experienced by Indigenous and non-Indigenous women.

While public and community housing was the most common type of accommodation for Indigenous women (in 44% of support periods before SAAP and 43% after), private rental was the most usual for non-Indigenous women (30% before and 27% after). Non-Indigenous women were living in their own home in 15% of support periods before accessing SAAP, dropping down to 11% afterwards, while private ownership was virtually unknown among the Indigenous women using SAAP (in 1% or less of support periods) (Table 7.15).

In summary, then, it has proved more difficult to pull out information from the SAAP data indicating whether or not iterative homelessness is a useful concept for these clients. Further confounding this issue are the mobility patterns of many Indigenous women, deriving from factors such as kinship obligations (Memmott et al. 2004a:14–15), indicating that cross-cultural indicators of iterative homelessness will need further thought. What these SAAP data have shown, however, is that the SAAP experiences of women escaping domestic violence are quite distinct for Indigenous and non-Indigenous, and should be analysed separately.

Young people aged 15–19 years

This section provides an overview of young females and males who have accessed SAAP services as clients in their own right, that is, when not accompanying a parent or guardian. Young people in SAAP are of particular interest, in part because it is thought that 'those who experience marginalisation and homelessness during young adulthood have a greatly diminished chance of finding a stable and productive role in the community in the longer term' (CACH 2001:57).

The young people examined here are primarily those between the ages of 15 and 19 years, although some information on clients under the age of 15 will also be presented. Nationally, the largest proportion of SAAP agencies target people under 25 years of age (see Figure 7.1), so it is not surprising that clients in the 15–19 age group comprised 17% of all SAAP clients in 2003–04 (AIHW 2005:84).

In the 2003–04 year there were 1,700 young people aged 15 years who used SAAP services (see Table A7.7). This number swelled to 4,200 for 17 year olds, and then slowly decreased to 3,600 young people aged 19 years. For each of these age groups there were more young women, with 61% of clients aged 19 and under being female. The least disparity between the sexes was for those clients aged 15 years and under. For young men this group comprised 4% of all clients, or 11% of all young men using SAAP, indicating that although boys access SAAP less than girls, they tend to utilise these services at an earlier age. Furthermore, as shown earlier, young men were more likely to be marginally housed prior to their SAAP intervention (in 74% of their support periods, compared to 63% for young women). High repeat rates of interventions were also more likely for young men, with 4% having 6 or more support periods, and only 2% of younger women (see Tables 7.9 and 7.10).

Taken together, these data support Wensing's observation (2003) about young people, and especially young men, having housing trajectories which typically involved regular movements between friends, hostels, sleeping rough and living in caravans. The SAAP data presented here indicates that young men are moving into these cycles of tenuous housing at an earlier age than young women.

Supporting this assertion are the differences between the sexes in the broad types of services received from SAAP (see Table A7.8). Young men were consistently more likely than young women to be accommodated as part of their SAAP intervention (in 61% versus 50% of support periods, overall). The pattern of SAAP accommodation differed between the sexes too, with a peak of accommodation being received by males, in 66% of support periods, at 16 years old. For young women, accommodation peaked at 57% of support periods for 15 year olds.

The sexes also differed in the services received for substance abuse issues, with young men consistently receiving more support or intervention (in 10% of support periods for young men, 6% for young women). For young men, this type of intervention peaked with the 18 year olds (12% of support periods). Young men were also more likely than young women to be provided with basic support services, including meals, showers and laundry (66%). Young women received such services in 61% of support periods (see Table A7.8).

Overall, the two types of services most likely to be received by both young men and young women were general support/advocacy (in 77% of support periods for both sexes) and basic support (in 66% and 61%, respectively). SAAP accommodation was the next most likely type of service to be received by young men (in 61% of support periods), while counselling was the next most likely for young women (in 57%). An interesting trend, and one that is contrary to the policy implications of the iterative homelessness approach, is that as the clients got older there was a decrease in the likelihood of receiving counselling. Both young men and young women were most likely to receive counselling when under 15 years of age, in 64% of support periods for young men and 71% for young women. At 19 years of age, young men were receiving counselling in just 41% of support periods and young women in 58%.

Some of the results of SAAP interventions for young people are outlined in Table 7.16, which compares their housing prior to and post their SAAP support. This indicates that, for both sexes, there was a decrease in the incidence of marginal housing after SAAP intervention: for young men from 73% of support periods to 64%, and for young women from 62% to 52%.

Most of this decrease is attributable to a drop in the incidence of living rent-free, often called 'couch surfing', from 28% to 23% of support periods before and after support for young men, and from 29% to 21% before and after support for young women. There was also a drop for both sexes in the incidence of sleeping rough, from 8% to 3% of support periods for young men, and from 4% to 2% for young women. At the same time, there was a rise in the incidence of young men and women achieving housing with more secure tenure, with increases in the likelihood that they would be living in either public or community housing or renting privately after SAAP support.

Over the last few years there has been an increasing emphasis on the role of case-management in SAAP as the preferred 'early intervention' strategy. Such strategies are generally deemed to be especially appropriate in those services that target young people as it is often assumed that, as these clients are in the 'early' stages of homelessness, the issues they face are more tractable and so more amenable to SAAP interventions.

Given this emphasis, it is interesting to examine the effects that being case-managed had on young men and young women. Table 7.17 examines where young men and women were living after their SAAP intervention, as in the previous table, but presented according to whether or not a support plan was agreed to by the young clients—a support plan being one of the major tools of case-management, whereby the client and the agency set out the agreed goals of the young person and the steps that need to be taken to meet those goals. Case-management, of course, may not always be an option for a SAAP service as when, for example, the SAAP client has a truncated support period, or does not agree to participate in the case-management process.

Furthermore, although a support plan may be developed by an agency working with a client, this does not guarantee that any of the agreed goals will be met.

From the previous table we found that SAAP intervention was followed by a fall in the number of young people living in marginal housing, and that a large proportion of that decrease was attributable to a drop in the incidence of living somewhere rent-free. The following table shows that this decrease, for both sexes, was influenced by whether a support plan was in place. For young men, though, this difference was quite small, from 28% of support periods prior to SAAP to 22% after SAAP when a support plan was in place and to 24% where a plan was not in place. For young women, the existence of a case plan had a larger effect, from 29% of support periods prior to SAAP to 19% after SAAP with a support plan, but 25% without a support plan (Table 7.17).

Note that this measure is very rough as it does not take into account how well, if at all, such plans were implemented. However, the smaller effect for young men is consistent with previous data showing that these clients are more likely to have been in tenuous housing at a younger age and to have more substance abuse issues. Under the approach outlined by Robinson, case-management would still be considered a useful tool for SAAP agencies, but one that would be developed over time as trust grew between the agency and the client, and a tool that set goals to deal with the issues underlying clients' inability to sustain tenable housing, rather than a tool dealing with the clients presenting issues.

Table 7.16: Closed SAAP support periods for young people aged 15–19, by type of accommodation immediately before and after support and gender, 2003–04 (per cent)

	Males		Females	
Type of accommodation	**Before support**	**After support**	**Before support**	**After support**
Marginal housing				
Living in a car/tent/park/street/squat	8.2	3.3	4.2	2.0
SAAP or other emergency housing	24.8	25.1	20.2	21.3
Rooming house/hostel/hotel/caravan	5.5	6.8	5.1	4.7
Institutional	6.4	5.4	3.1	2.8
Living rent-free in house/flat	28.3	22.9	29.2	21.1
Subtotal	*73.2*	*63.5*	*61.8*	*51.9*
Non-marginal housing				
Boarding in a private home	16.5	17.2	20.1	18.8
Public or community housing	2.7	5.3	6.1	10.6
Private rental	5.2	10.9	9.2	15.4
Own home	0.6	0.5	0.7	0.7
Subtotal	*25.0*	*33.9*	*36.1*	*45.5*
Other	1.8	2.6	2.1	2.8
Total	*100.0*	*100.0*	*100.0*	*100.0*
Total (number)	**8,800**	**6,700**	**12,700**	**10,300**

Notes

1. Number excluded due to errors and omissions before support (weighted): 1,900.
2. Number excluded due to errors and omissions after support (weighted): 6,400.
3. Table excludes high-volume records because not all items were collected on the high-volume form.
4. Figures have been weighted to adjust for incomplete coverage.

Source: SAAP Client Collection.

Table 7.17: Closed SAAP support periods provided to young people aged 15–19, by type of accommodation immediately after support, existence of support plan and gender, 2003–04 (per cent)

	Males			Females		
Type of accommodation	Support plan in place	No support plan or not applicable	Total	Support plan in place	No support plan or not applicable	Total
Marginal housing						
Living in a car/tent/park/street/squat	2.0	5.6	3.2	1.4	3.2	2.0
SAAP or other emergency housing	24.8	25.3	25.0	21.4	20.4	21.1
Rooming house/hostel/hotel/caravan	5.9	9.0	6.9	4.2	6.0	4.8
Institutional	5.3	5.6	5.4	2.5	3.0	2.7
Living rent-free in house/flat	22.0	24.0	22.7	19.3	24.5	21.0
Subtotal	*60.0*	*69.5*	*63.2*	*48.8*	*57.1*	*51.6*
Non-marginal housing						
Boarding in a private home	18.7	14.5	17.3	20.0	16.3	18.8
Public or community housing	6.1	3.5	5.3	11.5	8.5	10.5
Private rental	12.1	8.9	11.0	16.8	12.9	15.5
Own home	0.3	0.8	0.5	0.6	1.0	0.7
Subtotal	37.2	27.7	34.1	48.9	38.7	45.5
Other	2.7	2.7	2.7	2.2	4.1	2.8
Total	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*
Total	**67.1**	**32.9**	**100.0**	**67.9**	**32.1**	**100.0**
Total (number)	**4,200**	**2,100**	**6,300**	**6,700**	**3,100**	**9,800**

Notes

1. Number excluded due to errors or omissions (weighted): 7,300.
2. Table excludes high-volume records because not all items were collected on the high-volume form.
3. Figures have been weighted to adjust for incomplete coverage.

Source: SAAP Client Collection.

7.6 SAAP data from 1996–97 to 2003–04

This section begins by presenting time series data from the SAAP program, including funding levels, the number of clients and support periods, and the average number of support periods per client. This is followed by a discussion of some new developments in the SAAP National Data Collection.

Recurrent funding for SAAP has risen by 46% over the 8 years of the collection, from $219.8 million in 1996–97 to $321.4 million in 2003–04 (Table 7.18). When adjusted for inflation, in real terms funding increased by 19%. Funding levels in real terms remained similar between 1996–97 and 1999–2000, except for a 5% increase in 1998–99. Funding increased by 8% in real terms in 2000–01, 3% in 2001–02 and 4% in 2002–03, before falling by 2% in 2003–04.

Recurrent funding to SAAP agencies followed a slightly different pattern. From 1996–97 to 2003–04 actual recurrent funding to agencies increased by 54%, from $200.5 million in 1996–97 to $308.7 million in 2003–04. In real terms, this represented an increase of 26% over the 8 years, with relatively large annual increases in 1998–99 (6%), 2000–01 (8%)

and 2002–03 (6%). However, funding to agencies in real terms decreased by almost 2% in 2003–04. Interestingly, the number of agencies 'in scope' to participate in the Client Collection increased from 1,202 in 2002–03 to 1,225 in 2003–04 (AIHW 2005: table 9.9). However, 8 new agencies were funded late in the financial year and did not report any client data.

Table 7.18: SAAP funding to agencies and mean funding per support period and client, 1996–97 to 2003–04

	Total recurrent funding	Funding to agencies	Funding per support period	Funding per client
		Current $		
1996–97	219,771,000	200,539,000	1,280	2,410
1997–98	223,661,000	212,768,000	1,300	2,260
1998–99	229,889,000	220,328,000	1,350	2,430
1999–00	245,511,000	231,717,000	1,470	2,570
2000–01	268,537,000	251,367,000	1,470	2,700
2001–02	285,039,000	268,960,000	1,520	2,810
2002–03	310,359,000	296,635,000	1,680	3,040
2003–04	321,413,000	308,749,000	1,650	3,080
		Constant 2003–04 $		
1996–97	269,276,000	245,712,000	1,570	2,950
1997–98	267,946,000	254,895,000	1,550	2,710
1998–99	281,672,000	269,958,000	1,650	2,980
1999–00	282,194,000	266,339,000	1,690	2,960
2000–01	306,047,000	286,478,000	1,680	3,080
2001–02	314,536,000	296,793,000	1,680	3,100
2002–03	328,346,000	313,827,000	1,780	3,220
2003–04	321,413,000	308,749,000	1,650	3,080

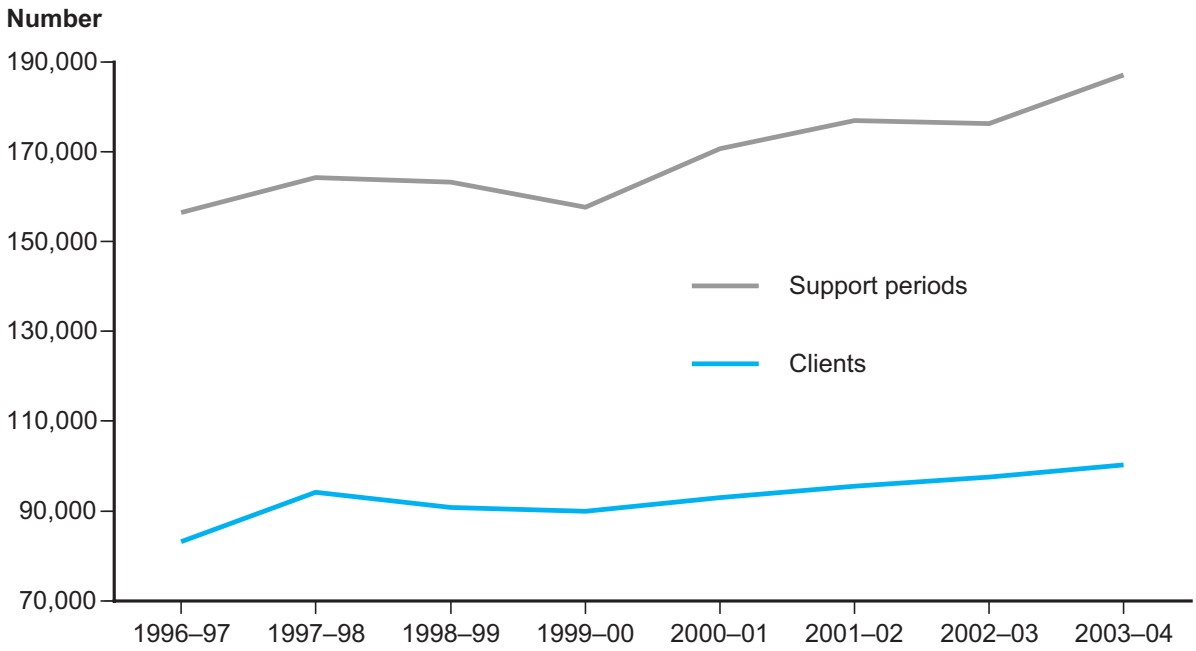
Notes

1. Funding per support period and funding per client are based on recurrent allocations to agencies.
2. 'Total recurrent funding' for 1999–00, 2000–01 and 2001–02 includes relatively small amounts provided through the Partnerships Against Domestic Violence Program.
3. 'Recurrent allocation' includes state-only recurrent allocations provided by Vic, Qld, WA and the ACT which are in addition to the SAAP agreement between each of those jurisdictions and the Australian Government.
4. Support period and client figures have been weighted to adjust for incomplete coverage.

Source: AIHW 2005.

There were 156,500 support periods in 1996–97, increasing to 164,300 in 1997–98 but dropping back over the next 2 years, returning almost to 1996–97 levels in 1999–00 (Figure 7.2). In 2000–01 there was a sharp rise to 170,700 support periods, mainly caused by the introduction of a new large agency, with another increase in 2001–02 to 177,000. Changes in reporting practices of the new agency caused a decrease in the number of support periods reported in 2002–03 to 176,300. In 2003–04, however, there was a sharp increase to 187,200 support periods, due to the reinvolvement of another large agency. These variations highlight the possible effects on the data collection of inconsistencies in the application of the definition of support period by large agencies.

It is planned that the introduction of the Core Data Set, reported on in the next section, with its refined definitions, supported by training opportunities, will minimise these inconsistencies.



Source: Table A7.9.

Figure 7.2: SAAP support periods and clients, 1996–97 to 2003–04

Trends in the number of clients provided with SAAP services showed a pattern similar to that for support periods over the 8 years, although the changes were less pronounced in the last 5 years (Figure 7.2). In 1996–97 an estimated 83,200 clients were provided with support; the figure rose to 94,100 in 1997–98 and then fell to 90,000 in 1999–00. In 2000–01 the number of clients increased again to 93,000 and has continued to increase each year since then. The highest number of clients of any of the 8 years was recorded in 2003–04, with 100,200 clients provided with SAAP services.

Nationally since 1997–98, the rate of SAAP use was highest in 2003–04, when 58 people out of every 10,000 aged 10 years and over became SAAP clients (Table 7.19). The lowest rate was in 1999–00, when 55 people per 10,000 aged 10 years and over used SAAP services at some time during the year. Nationally, the number of support periods that clients received in a reporting period has remained relatively stable over time, ranging between 1.8 and 1.9 support periods per client across the years (Table 7.20). In 2003–04 the number of support periods per client was relatively high, at 1.9.

Table 7.19: SAAP client rates, by state/territory, 1997–98 to 2003–04

	1997–98	1998–99	1999–00	2000–01	2001–02	2003–03	2003–04
	Clients per 10,000 population aged 10 and over (age-standardised)						
NSW	54	50	47	46	47	44	43
Vic	71	73	70	68	69	71	81
Qld	56	51	52	58	58	58	54
WA	52	49	52	59	53	54	49
SA	70	60	61	61	70	74	75
Tas	97	90	90	91	97	110	116
ACT	79	72	74	72	63	58	54
NT	180	183	170	167	169	166	172
Australia	**59**	**56**	**55**	**56**	**56**	**57**	**58**

Notes

1. Since a client may have support periods in more than one state or territory, national numbers of clients per 10,000 population are not the simple mean of the state and territory figures.
2. 'Clients per 10,000 population aged 10+' shows how many people out of every 10,000 aged 10 years and over in the general population became clients of SAAP. The rate is estimated by comparing the number of SAAP clients aged 10 years and over with the estimated resident population aged 10 years and over at 30 June just before the reporting period. Age-standardised estimates have been derived to allow for different age distributions in the various jurisdictions. The Australian estimated resident population at 30 June 2003 (final estimates) has been used as the reference population.
3. Figures have been weighted to adjust for incomplete coverage.

Sources: SAAP Client Collection; ABS 2004a.

Table 7.20: Mean SAAP support periods per client, by state/territory, 1998–99 to 2003–04

	1998–99	1999–00	2000–01	2001–02	2002–03	2003–04
NSW	2.02	1.98	1.90	1.81	1.88	1.94
Vic	1.53	1.50	1.54	1.54	1.60	1.92
Qld	1.68	1.63	2.15	2.25	1.96	1.58
WA	1.57	1.54	1.57	1.63	1.61	1.63
SA	1.46	1.42	1.44	1.63	1.50	1.52
Tas	1.60	1.64	1.44	1.57	1.55	1.46
ACT	1.51	1.43	1.38	1.37	1.41	1.81
NT	1.72	1.54	1.69	1.56	1.44	1.50
Australia	**1.80**	**1.75**	**1.83**	**1.85**	**1.81**	**1.87**

Notes

1. Since a client may have support periods in more than one state or territory, national numbers of support periods per client are not the simple mean of the state and territory figures.
2. The method used to calculate the support periods per client was adjusted in 2002–03 and has been applied to all data on support periods per client presented in this table.
3. Figures have been weighted to adjust for incomplete coverage.

Source: SAAP Client Collection.

Future directions

Since SAAP was established in 1985 it has been through periodic reviews and four extensive national evaluations. During the previous 5-year agreement, SAAP IV, a review identified a need to improve the timeliness, relevance and accessibility of program information, while streamlining data collection processes and maximising cost

effectiveness. This resulted in the development of the Information Management Plan. The SAAP IV Agreement finished in September 2005 after a 3-month extension to finalise negotiations for SAAP V.

Following on from SAAP IV, the SAAP Core Data Set was developed and introduced in July 2005. It reduces the original SAAP Client Collection, which had not been substantially changed since its introduction in July 1996. One of the most far-reaching changes in its implications is the introduction of a Statistical Linkage Key which will enable cross-program data analysis of clients using SAAP and other community services and health services. This will enable better analyses of the pathways that people who are experiencing homelessness, take into and out of SAAP, and their interaction with other services. Protocols governing the potential use of this linkage key are being developed.

All States and Territories signed the SAAP V Multilateral Agreement with the Australian Government by the end of September 2005.

Under the SAAP V Agreement, the Australian Government will contribute approximately $932 million and the State and Territory governments approximately $878 million over the 5 years of the agreement (i.e. until 30 September 2010). Change in funding arrangements between state/territory and the Australian Governments will see a transition over the life of SAAP V to a minimum 50% funding from the states and territories.

The SAAP V Agreement will include an Innovation and Investment Fund totalling almost $120 million. The fund is directed at improving the outcomes for SAAP clients by achieving more targeted, effective and efficient service models. It aims to address the 3 strategic priority areas for SAAP V, namely to:

- increase involvement in early intervention and prevention strategies;
- provide better assistance to people who have a number of support needs; and
- provide ongoing assistance to ensure stability for clients post crisis.

This fund will be resourced through the combination of Australian Government, State and Territory cash contributions and some approved state-only funded SAAP services that meet the strategic priorities for SAAP V.

7.7 Australian Government initiatives

There are many Australian Government initiatives that have been implemented to assist the homeless and those at risk of becoming homeless. These include the National Homelessness Strategy, Housing Assistance programs, the Stronger Families and Communities Strategy and programs that target specific groups, such as youth and migrants. All of these programs have evolved in tandem to increase understanding of the complexities of the many issues faced by the homeless. These programs also aim to build and maintain strategic ways of preventing and dealing with homelessness across circumstantial diversity. The Australian Government has provided funding for the continuation of existing programs, as well as the research and development of new initiatives to assist the homeless (See for example, FaCS 2005a, Howard 2004, and Patterson 2004a).

National Homelessness Strategy (NHS)

The NHS brings together targeted homelessness programs, such as the Supported Accommodation Assistance Program (SAAP), Reconnect and JPET and other non-targeted programs, which address issues of particular significance to homeless people.

Specific initiatives funded under the NHS include:

- Complex Demonstration Projects to develop innovative ways to prevent and respond to homelessness;
- The Commonwealth Advisory Committee on Homelessness (CACH), an advisory body to the Commonwealth Minister for Family and Community Services on issues relating to homelessness; and
- Dissemination of the extensive NHS knowledge base to raise awareness of homelessness issues and best practice around Australia.

Information derived from the demonstration projects and other research and evaluation will be used to develop programs and policies to address the complex needs of the homeless and those at risk of homelessness.

Household Organisational Management Expenses (HOME) Advice Program

The HOME Advice Program is an early intervention program for families at risk of becoming homeless. Community agencies are funded to help families stabilise their housing and financial circumstances, and assist them with access to community services, labour market programs and employment. These agencies work closely with Centrelink social workers to ensure seamless service delivery for families. The HOME Advice Program extends the Family Homelessness Prevention Pilots (FHPPs), an initiative of the 2001–02 Budget, for a further 4 years, with the eight existing FHPP services continuing to be funded and is expected to help around 400 families per year.

Stronger Families and Communities Strategy (SFCS)

As of April 2004, the government announced the continuation of the program for a further 4 years. The focus on early childhood outcomes has intensified since the original SFCS was launched. Consultations during 2003 on the National Agenda for Early Childhood confirmed the need for action to improve outcomes for children. These results are reflected in the new SFCS, which now has more emphasis on community-based early intervention, using and recognising existing community resources and networks, and providing ways of sharing new, best-practice approaches. The new SFCS has four components:

- *Communities for Children*—will target around 35 disadvantaged communities, providing local early childhood initiatives;
- *Early Childhood—Invest to Grow* will expand proven early childhood intervention programs and resources;
- *Local Answers*—will provide communities with the opportunity and capacity to develop their own solutions to local problems; and
- *Choice and Flexibility in Child Care*—will continue to provide parents with flexible and innovative child care solutions (FaCS 2004a).

Box 7.4: NHS Demonstration Projects completed in 2004–05

Development of Training Materials for Use in Rural and Remote Regions: *This project is run by the Australian Federation of Homelessness Organisations (AFHO) and aims to provide training on recognising and dealing with homelessness to agencies, hospitals, health centres and schools. The AFHO will develop materials to support this training, which will be delivered by experts from the homelessness sector in rural and remote regions around Australia. There will be a strong Indigenous component in this project.*

A New Approach to Assisting Young Homeless Job Seekers (Vic): *This project aims to provide integrated support services to homeless job seekers in relation to housing, health and personal development, with employment being the key goal. The project has been implemented by a consortium of community agencies, including Hanover Welfare Services, Melbourne City Mission, Brotherhood of St Laurence and Loddon Mallee Housing Services.*

Traditional Living Transitional Lifestyle Project (SA): *This project aims to help traditional living Aboriginal families in moving to urban centres by providing early intervention and prevention services to help these families to support their tenancies, so that they do not become homeless.*

Family & Community Network Initiative (Mission Australia): *Clients from Campbell House crisis accommodation facility for single men experience complex issues such as mental illness, substance abuse, gambling, family breakdown and poverty. This project will fund the development and implementation of a new service delivery model for these clients aimed at providing early intervention and extensive case-management. The project will also investigate and implement strategies to provide the most appropriate services to Indigenous men.*

Homeless Persons' Legal Service: *This project will be run through a partnership between private legal firms and community agencies and aims to identify the legal issues faced by homeless people and recommend how these can be resolved.*

Best-practice Report on Sentencing Alternatives for Homeless People (Qld): *This project will examine the ways in which jurisdictions around Australia respond to the 'offending' behaviour of homeless people, in order to identify best-practice strategies to deal with infringements of summary offences law.*

Uniting Families Project: This project is run by Uniting Care Harrison Community Services and aims to reduce youth homelessness by stabilising young people within their families. Families will be offered mediation in their own homes, parenting courses and family therapy.

Family Makeover Project (NSW): This project is run by Wesley Mission and will work with families at risk of homelessness and will assist them to develop independent living skills. Specialist teams will provide medical and psychiatric, counselling and family support services.

Youth homelessness

There are several Australian Government initiatives that specifically target homeless young people and those at risk of homelessness. These include: Towards Independent Living Allowance, Innovative Health Services for Homeless Youth, the Reconnect Program and the Job Placement Employment and Training Program. These multifaceted programs aim to prevent youth homelessness and help young people start on pathways back to their families, their communities, education and employment.

Reconnect

There are currently 98 Reconnect services across Australia that work towards improving the level of engagement of young people with family, work, education, training and the community. Following positive outcomes highlighted in a recent program evaluation, funding for Reconnect has been extended for a further 4 years (FaCS 2004b).

Job Placement and Employment Training (JPET)

As of 1 February 2005, the JPET program has been extended for a further 4 years. There are currently 135 agencies around Australia that will continue to operate and it is expected that 10 new 'multifunctional' services will be established to provide both Reconnect and JPET services. These new services will be located in areas where there are high levels of settlement by young, newly arrived migrants. The continuation of the Reconnect and JPET programs is expected to provide assistance to over 1,000 newly arrived young migrants each year.

This new focus on providing assistance to young migrants is a result of the findings of the Review of Settlement Services for Migrants and Humanitarian Entrants. The review found that people who have recently arrived in Australia are having difficulty accessing mainstream government services and recommended that early intervention strategies at a whole-of-government level recognise and support schoolchildren and young people at risk of not making successful transitions due to their pre-migration experiences, low English language proficiency and recent arrival in Australia (FaCS 2005b).

7.8 State and territory government initiatives

New South Wales

The New South Wales 'Partnership Against Homelessness' strategy aims to: help homeless people access services; coordinate support services; improve access by homeless people to temporary or crisis accommodation; and facilitate the move to long-term accommodation. As part of its commitment to these aims, the partnership has introduced a number of new initiatives, including:

- The Inner City Homelessness Action Plan—an integrated set of strategies involving state, local and non-government agencies working together to address homelessness. Achievements under the Plan in 2004 include two Support and Outreach Services for rough sleepers; two pilot projects to assist older people and people with disabilities who are living in insecure housing or squalor; and 30 additional leases for homeless

clients under the My Place initiative, which provides leased accommodation and is managed by the Office for Community Housing.

- The After Hours Temporary Accommodation Line—this service is available on weekday evenings and weekends across New South Wales and provides temporary accommodation in low-cost motels, caravan parks and similar accommodation for people who are in housing crisis or are homeless.
- The Signpost—a homelessness assessment and referral pilot service managed by Mission Australia that aims to improve integrated service provision for homeless people in the Hunter region. The Signpost has recently been evaluated and the Partnership is reviewing the evaluation report in order to develop and improve this service (NSW DoH 2004).

Victoria

Funding of about $107 million was provided by the Victorian Government for homelessness assistance in 2004, $8.8 million dollars of which was allocated to the Youth Housing Action Plan, a part of the Victorian Homelessness Strategy, in the 2003–2004 budget (AFHO 2004).

A series of pilot projects were funded for a 2-year period, until June 2005, as a direct outcome of the *VHS Action Plan and Strategic Framework – Directions for Change*, to test new approaches to assisting people who are homeless and particularly at severe risk of homelessness. The intention is to inform any future investment, but also to emphasise the need for improved connectedness between services and integration, better understanding of clients' needs and achieving long-term outcomes for users of the Homelessness Service System.

The pilot projects were as follows:

- Supporting at Risk Tenancies in Public Housing;
- Assisting Older People in Tenuous Private Rental;
- Preventing People with a Mental Illness Being Discharged into Homelessness;
- Indigenous Tenants at Risk of Eviction; and
- Housing Options for Women Experiencing Family Violence (FaCS 2003b; Newman 2003).

Queensland

In addition to funding directed through core homelessness responses, the Queensland Government will direct an additional $235.52 million over the next 4 years to enhance existing and implement innovative responses to homelessness. The aim of these new initiatives is to create an integrated service system accessible by homeless people and, over time, to reduce the number of people without shelter. The $235.52 million will:

- provide more accommodation and support;
- connect people with services;
- respond to public space issues, including substance misuse;

- provide more support and services, including mental health services, to address the health needs of homeless people;
- provide more support and services to address the needs of homeless people in the legal system; and
- help residential services, including boarding houses, to stay open.

Funds for the new initiatives will be directed through seven Queensland Government agencies: Department of Communities, Department of Housing, Department of Aboriginal and Torres Strait Islander Policy, Queensland Health, Department of Justice and Attorney-General, Department of Tourism, Fair Trading and Wine Industry Development through the Office of Fair Trading, and the Queensland Police Service.

Western Australia

By the end of 2005, an evaluation of the impact and outcomes of the State Homelessness Strategy (implemented in 2002) will be undertaken. The Department of Housing and Works commenced the construction of 53 durable housing dwellings for Indigenous people during 2004. There are plans to construct a further 224 dwellings during 2005, with the majority being located in remote communities.

During 2004, the In House Practical Support Program operated from five locations, providing support and skills development to Indigenous families in conventional housing. Negotiations are continuing for the program to service Indigenous families during 2005 that are located in Newman, Halls Creek, Bidyadanga and Warburton. A pilot project was funded in 2003–04 at the Koolbardi Aboriginal Corporation in Queens Park. The project is currently being reviewed which will include a report on outcomes (WA DHW 2004).

South Australia

The South Australian Government established an Action Plan focusing on homelessness which has been funded through to 2008 (AFHO 2004). The Action Plan included recommendations and actions to be taken across government to:

- address the structural factors that lead to homelessness;
- prevent homelessness among people who are perceptibly at risk;
- minimise the length of time people spend in homelessness;
- integrate and coordinate responses; and
- prioritise the needs of Indigenous people who are homeless or at risk of homelessness (SA Social Inclusion Unit 2003).

Funding of $23 million over the 5 years was allocated to a series of project initiatives to support implementation of the plan. These initiatives tackle homelessness on a range of fronts, from supporting people who are at risk of social and private housing tenancies, through to preventing people being discharged from hospital to homelessness (Rann 2005). Linked to the action plan is the State Housing Plan which identifies strategies to increase affordable and high-need housing.

Tasmania

In September 2003 Tasmania launched the Enhanced Assessment Training Course for staff working in SAAP-funded agencies. This course, delivered in seven modules, incorporates the requirements of the SAAP IV strategic framework and nationally accredited units in case-management and assessment of clients' needs linked with the new Community Services Training Package. The course is being delivered by TAFE Tasmania and most SAAP services are participating (Tasmania Department of Health and Human Services, pers. comm.).

In December 2003, the Affordable Housing Strategy was launched. It aims to ensure that there is safe, adequate housing for Tasmanians receiving low incomes, including those with special needs. The first stage of the program has been funded for $45 million for 2004–08 (AFHO 2004).

Australian Capital Territory

In April 2004, the ACT Government published *Breaking the Cycle – the ACT Homelessness Strategy* which addresses homelessness through a range of practical strategies to effectively support people at risk of homelessness. The strategy also provides the means for people who are homeless to access appropriate supports to decrease the impact and occurrence of homelessness.

Four key themes and objectives establish the framework for the strategy:

- integrated and effective service responses;
- client focus and client outcomes;
- access to appropriate housing and housing assistance; and
- supporting and driving innovation and excellence (AFHO 2004).

Northern Territory

The Home Territory 2010 Strategy will provide coordination and direction for a whole-of-government and community-based response to homelessness. A taskforce comprising key stakeholders from across Government and the community has been established to develop a homelessness framework. Community consultations and collaboration will be facilitated through the taskforce and a report is expected to reach Government in early 2006 (NT Department of Community Development, Sport & Cultural Affairs 2004a).

The Community Harmony Strategy has two over-arching objectives:

- A significant reduction in the incidence of anti-social behaviour by 'itinerants' in urban areas;
- The delivery of infrastructure, intervention programs and health services responding to identified needs of 'itinerants'.

The strategy's rationale is to provide opportunities and pathways for 'itinerants' to move away from destructive lifestyles towards either a return to home community or living a more productive lifestyle in permanent and appropriate accommodation in town (NT Department of Community Development, Sport & Cultural Affairs 2004b).

7.9 Summary

This chapter has brought together two complementary approaches to homelessness, distinguished by their differing emphasis on the temporal dynamics of homelessness, and has contrasted their ensuing policy implications. The Census count of homelessness, and its underlying hierarchical cultural definition, was introduced first. Some of the difficulties of defining and counting people experiencing homelessness under this approach, including counting Indigenous residents of improvised dwellings, were covered. It also suggested that if the cultural definition was uniformly applied across all population groups, long term residents of caravan parks should also be included in the count of people experiencing homelessness. This would raise the count of homeless people on Census night to at least 122,770.

Under this approach, the three tiers of homelessness carry the implication of degrees of disadvantage, with those people experiencing secondary and tertiary homelessness experiencing decreasing levels of disadvantage relative to the primary homeless. Ensuing policy development can then be predicated on the numbers of people experiencing homelessness in each category, with service provision targeted accordingly.

A complementary approach to understanding homelessness—iterative homelessness—was introduced next. This approach arises from recent work on the homelessness experiences of people with a mental illness. Rather than emphasising the housing circumstances of people at some point in time, it pays attention to the repeated moves of people through different types of marginal or tenuous housing. The approach makes the claim that, for interventions to be successful, they need to address the underlying trauma that prevents clients from maintaining ongoing sustainable housing, and the notion of a healing framework was introduced.

Research into iterative homelessness is at a relatively early stage, so SAAP data was used to test the usefulness of this approach in a wider context. Four different client groups were discussed, younger men and younger women, older single men, and women escaping domestic violence. Some indicators of iterative homelessness derived from SAAP data, capturing previous marginal housing and ongoing SAAP usage, were applied to these groups.

The SAAP data examined suggested differences between the housing trajectories of the four client groups, and the notion of iterative homelessness was found particularly useful for the single older men who use SAAP services. It was noted that, for this client group, the policy implications of defining the role of SAAP services as points of stability—that allowed trust to develop so that healing work could proceed—are very different from the policy implications of the view that repeated movements of clients through SAAP is simply "churning".

The notion of iterative homelessness, however, were not found as useful for women escaping domestic violence, whose previous tenuous housing may have involved emotional uprootings rather than physical ones. The Indigenous and non-Indigenous women in this group were found to have distinctly different experiences in SAAP, which could be influenced by the strong family and community ties of Indigenous women which were indicated by the data. Younger men and women, although

generally accessing the same SAAP sector, nevertheless were found to have quite distinct homelessness experiences. Young men had many characteristics in common with the single older men, and the indicators of iterative homelessness were also useful for this group.

In general, the SAAP data vividly demonstrated the different experiences of various client groups experiencing homelessness in SAAP, but it also highlighted the difficulties in capturing the course of this homelessness. The final section of the chapter presented time series data from the SAAP program, along with information on the directions in which SAAP is now heading. Finally, some other government programs were reported, both federal and state and territory initiatives, targeted at working with the homeless in Australia.

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8 Welfare services resources

8.1 Introduction

This chapter presents information on the resources devoted to welfare services in Australia. Broadly, these resources can be depicted in two ways:

- by describing the sector's financial resources, that is, the funds that are made available for expenditure on services or for other forms of assistance (such as cash benefits, benefits-in-kind or concessions); and
- by describing the sector's physical resources, that is, its human resources (the people who provide or support community services), its capital resources (equipment, buildings, land and other assets), the materials and energy consumed during service provision, and so on.

As to the financial depiction of resources for welfare services, the statistics describe, on the one hand, those who provide the funding and the amounts of money they provide for various services and other assistance and, on the other hand, those who incur the expenditures and the amounts of money they spend on various services and other assistance.

The financial statistics presented in this chapter cover three kinds of activity or assistance:

- welfare services, such as the provision of a child care service
- concessions, such as concessional fares on public transport for age pensioners
- cash benefits and benefits-in-kind, such as disability support pensions.

Data on the financial value of **services** and other support are readily available when a financial transaction is involved, say, when a wage or salary is paid to an employee who provides a child care service or when a cash benefit is paid to an age pensioner.

But many welfare services provided in Australia do not involve direct financial transactions. These include care provided by families or neighbours to older people, people with disabilities or families with children. They also include the work that volunteers do to support organisations that provide welfare services. To present as comprehensive a picture as possible of the total value of welfare services that are provided to Australians, it is informative to include an equivalent dollar value for these unpaid welfare services. In the absence of direct financial measurement, it is necessary to invoke assumptions to impute a value to services produced by the unpaid workforce; the assumptions and data sources that underlie the estimates have been detailed in previous editions of *Australia's Welfare*.

Concessions are of two kinds: concessions to households or individuals (through lower fares, fees and other charges); and concessions to non-government providers of

community services (also called 'tax expenditures'). In the main, the data presented in this chapter cover concessions to households and individuals; estimates are not yet available for a major class of concessions to service providers, namely Goods and Services Tax (GST) concessions.

Data on **cash benefits and benefits-in-kind** are included in *Australia's Welfare* for the first time. These data, which provide a broader view than is provided by expenditures on welfare services alone, have been compiled in accordance with the international standard, the OECD's Social Expenditure (SOCX) framework.

As to the physical depiction of resources for community services in Australia, the available statistics refer, in the main, only to human resources. The statistics presented in this chapter cover three groups of people:

- people who are in paid employment within community services industries, such as employees in the child care services industry. These comprise people who provide direct care (those in community services occupations) and people who provide support (those in other occupations);
- people who are in paid employment in community services occupations within other industries, such as child and youth services workers employed in the education industry; and
- people who provide or support the provision of community services on an unpaid basis, either through community services organisations or as informal carers of family members, neighbours and friends.

To present as comprehensive a picture as possible of human resources in the sector, it is necessary to describe all three groups.

8.2 Total resources for welfare services

The total value of welfare services provided during 2002–03 was estimated at $49.5 billion. Of this, 34.6% ($17.1 billion) related to services for which expenditure was incurred (Figure 8.1).

Of the remaining $32.4 billion, some $30.9 billion was 'imputed' as the value of services where no payments or expenses were actually incurred. The rest ($1.4 billion) was payments to carers by the Australian Government through the social security system.

Of the $17.1 billion in expenditure, $16.9 billion was incurred by governments and non-government community services organisations (NGCSOs). The remaining $208 million was fees paid by households for informal child care services provided by other members of the household sector.

The $30.9 billion of expenses not actually incurred comprised $735 million of revenue forgone by governments as a result of concessional tax treatment for NGCSOs, and the household sector's contribution estimated at $30.2 billion. Of the latter, $1.5 billion was in the form of voluntary work through organisations, but most ($28.8 billion) was the imputed value of informal care in the household sector. This included neighbours providing care to others, informal child care arrangements, and informal care of older

people and people with disabilities. However, Australian Government payments to informal carers through the social security system in the form of Carer Allowance or Carer Payments (see Box 5.7) which, in 2002–03, totalled $1.4 billion (FaCS 2003:181) have been separately identified as contributing to the funding of such informal care. This represented 4.4% of the total imputed value of informal care.

The paid workforce involved in providing welfare services and/or providing administrative and managerial support to services in 2002–03 was estimated at around 268,000 full-time equivalent (FTE) workers. The unpaid workforce was estimated to be more than three times the paid workforce (in terms of FTEs).

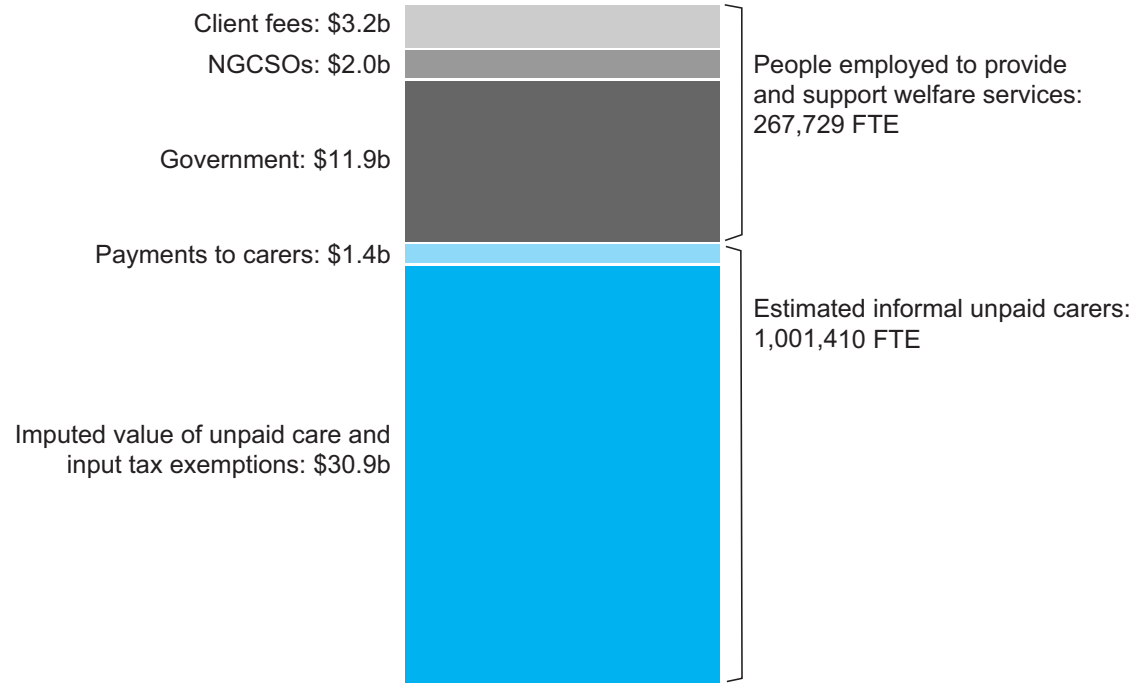


Figure 8.1: Total resources on welfare services provision, 2002–03

8.3 Expenditure on welfare services

Australia spent an estimated $17.1 billion on welfare services in 2002–03 (Table 8.1: Welfare services expenditure, current and constant[(a)] prices, share of gross domestic product (GDP) and annual growth, 1992–93 to 2002–03). This represented 2.3% of gross domestic product in that year.

In real terms, expenditure on welfare services grew at an average rate of 5.7% per year between 1998–99 and 2002–03. Estimated real growth in the latest year, 2002–03, was higher, at 8.2%, than it had been in any of the preceding three years. As a share of GDP, estimated expenditure on welfare services increased from 2.1% in each of the years 1998–99 to 2001–02 to 2.3% in 2002–03.

Table 8.1: Welfare services expenditure, current and constant[(a)] prices, share of gross domestic product (GDP) and annual growth, 1992–93 to 2002–03

	Current prices		Constant prices[(a)]	
Year	Expenditure ($m)	Share of GDP (%)	Expenditure ($m)	Growth (%)
1992–93	7,124.9	1.7	8,812.3	. .
1993–94	7,726.4	1.7	9,620.4	9.2
1994–95	8,355.3	1.8	10,291.6	7.0
1995–96	9,068.6	1.8	11,044.6	7.3
1996–97	9,958.0	1.9	11,719.0	6.1
1997–98	10,874.2	1.9	12,520.3	6.8
Break in time series				
1998–99	12,087.4	2.1	13,694.1	. .
1999–00	13,096.7	2.1	14,658.1	7.0
2000–01	14,026.4	2.1	15,086.2	2.8
2001–02	15,288.6	2.1	15,827.1	4.9
2002–03	17,130.5	2.3	17,130.5	8.2
Average annual growth rate				
1992–93 to 1997–98	—	—	—	7.3
1998–99 to 2002–03	—	—	—	5.7

(a) Constant price estimates are expressed in terms of 2002–03 prices.

Source: AIHW 2005.

Box 8.1: Break in expenditure time series

Most governments in Australia moved from cash to accrual accounting from the beginning of 1998–99. This, combined with some substantial changes in data sources after 1997–98, has resulted in a break in the time series data after 1997–98. The earlier figures are presented to provide context, but the analysis in this chapter concentrates on the later period.

Most expenditure on welfare is for recurrent purposes. It goes to pay the wages and salaries and the many other operating expenses incurred by individuals, governments and non-government organisations in providing or arranging the provision of the services concerned. In 2002–03 estimated recurrent expenditure on welfare services was $16,906.0 million (Table 8.2). A further $224.5 million was for capital purposes.

Three broad sectors incurring expenditure are governments, NGCSOs and households. The proportion of expenditure incurred by NGCSOs has been higher than for the other two sectors, and rose from 49.6% in 1998–99 to 52.6% in 2002–03 (Table 8.3). Sources of funding for NGCSO expenditure are governments, clients and own source (Table 8.15). The role of NGCSOs is predominantly as providers of services rather than as funders.

Table 8.2: Welfare services expenditure, by type of expenditure, current prices, 1992–93 to 2002–03 ($m)

Year	Recurrent expenditure	Capital expenditure[(a)]	Total
1992–93	6,648.0	476.9	7,124.9
1993–94	7,347.0	379.4	7,726.4
1994–95	8,112.3	243.0	8,355.3
1995–96	8,851.4	217.3	9,068.6
1996–97	9,671.7	286.3	9,958.0
1997–98	10,679.5	194.7	10,874.2
Break in time series			
1998–99	11,859.8	227.6	12,087.4
1999–00	12,887.3	209.4	13,096.7
2000–01	13,754.3	271.0	14,025.4
2001–02	15,099.6	189.0	15,288.6
2002–03	16,906.0	224.5	17,130.5

(a) Only includes expenditure on capital that was funded by governments.

Source: AIHW 2005.

The average rate of expenditure on welfare services per Australian resident in 2002–03 was $867—up from $782 in 2001–02 (Table 8.4). Per person expenditure grew, in real terms, by 7.0% in 2002–03; real growth averaged 4.5% per year between 1998–99 and 2002–03.

8.4 Funding for welfare services

Funding for welfare services comes largely from governments, particularly the Australian Government and state and territory governments. Local governments also provide funding for some welfare services. In addition, welfare services clients are charged fees for some services, and NGCSOs are sometimes called upon to use their own resources to support some of the welfare services that they provide.

Over two-thirds (69.5% or $11.9 billion) of all the funding for welfare services in 2002–03 was provided by governments (Table 8.5). The states and territories contributed $6.0 billion (35.3%) and the Australian Government $5.4 billion (31.6%). The remainder of government funding for welfare services was contributed by local governments ($456 million).

Households, through the payment of fees for particular welfare services, contributed $3.2 billion in funding during 2002–03, with NGCSOs providing a further $2.0 billion from their own resources.

The relative shares changed little between 1998–99 and 2002–03. The Australian Government contribution in 1998–99 ($3.8 billion) represented 31.2% of total funding; the state and territory governments' contribution of $4.4 billion was 36.0%; and the non-government sector's contribution of $3.7 billion was 30.5%. Thus, the rates of growth for the different funding sources were quite similar between 1998–99 and 2002–03.

Government funding and non-government funding both grew at an average rate of 5.7% per year.

Table 8.3: Welfare services expenditure, by sector incurring expenditure, current prices, 1998–99 to 2002–03 ($m)

	Sector incurring expenditure			
Year	Governments[a]	NGCSOs	Households[b]	All sectors
1998–99	5,890.9	5,989.8	206.7	12,087.4
1999–00	6,319.0	6,582.5	195.2	13,096.7
2000–01	6,580.6	7,260.5	184.3	14,025.4
2001–02	7,145.6	7,969.0	174.0	15,288.6
2002–03	7,925.7	9,010.8	194.0	17,130.5

(a) Includes Australian Government, state and territory governments and local governments; expenditure has been derived by subtraction.

(b) Includes only estimated client fees paid by households for informal child care services.

Source: Australian Government –- compiled from DHAC 1999, 2000, DoHA 2001, 2002, 2003; FaCS 1999, 2000, 2001, 2002, 2003; DIMIA unpublished data; Department of Veterans' Affairs unpublished data; State/territory government — Recurrent expenditure — PC 2004; ABS unpublished public finance data; Capital expenditure — ABS unpublished public finance data; Local government –- ABS unpublished public finance data; NGCSOs — AIHW estimates based on a sample of NGCSOs' financial reports; Household sector –- Child care service clients' contribution –- estimated by AIHW from ABS 1997, 2000, 2003.

Table 8.4: Average welfare services expenditure, per person, current and constant[a] prices and annual real growth, 1992–93 to 2002–03

	Expenditure per person ($)		
Year	Current prices	Constant prices[a]	Annual real growth (%)
1992–93	405	501	. .
1993–94	435	542	8.1
1994–95	465	573	5.8
1995–96	498	607	5.9
1996–97	540	636	4.8
1997–98	584	673	5.7
Break in time series			
1998–99	642	728	. .
1999–00	688	770	5.8
2000–01	727	782	1.6
2001–02	782	810	3.5
2002–03	867	867	7.0
Average annual growth rate			
1992–93 to 1997–98	—	—	6.1
1998–99 to 2002–03	—	—	4.5

(a) Constant price estimates are expressed in terms of 2002–03 prices.

Source: AIHW 2005.

Table 8.5: Funding for welfare services(a), by source, current prices, 1992–93 to 2002–03 ($m)

	Government funding sources				Non-government funding sources			
Year	Australian Government	State and territory	Local	Total	NGCSOs	Households	Total	Total funding
1992–93	2,113.4	2,446.5	22.5	4,582.4	934.0	1,609.0	2,543.0	7,125.4
1993–94	2,493.9	2,468.5	45.9	5,008.4	990.0	1,728.0	2,718.0	7,726.4
1994–95	2,891.5	2,551.5	99.3	5,542.3	995.0	1,818.0	2,813.0	8,355.3
1995–96	3,074.5	2,736.9	157.0	5,968.4	1,039.0	2,062.0	3,101.0	9,069.4
1996–97	3,263.5	3,146.9	121.0	6,531.4	1,143.0	2,284.0	3,427.0	9,958.4
1997–98	3,272.6	3,592.5	218.9	7,084.0	1,229.0	2,561.0	3,790.0	10,874.0
Break in time series								
1998–99	3,771.3	4,361.9	270.1	8,403.3	1,368.3	2,315.8	3,684.1	12,087.4
1999–00	4,010.7	4,694.1	288.8	8,993.6	1,550.4	2,552.7	4,103.2	13,096.7
2000–01	4,328.8	5,041.9	274.0	9,644.6	1,620.4	2,760.3	4,380.7	14,025.4
2001–02	4,945.3	5,489.7	252.7	10,687.7	1,741.4	2,859.6	4,601.0	15,288.6
2002–03	5,405.8	6,038.6	456.4	11,900.9	2,019.2	3,210.5	5,229.6	17,130.5

(a) Does not include funding of expenditure on high-level residential aged care and state government nursing homes, both of which are regarded as health expenditures (estimated at $4,934 million in 2002–03).

Source: AIHW 2005.

Government funding

Total government funding for welfare services in 2002–03 was estimated at $11.9 billion (Table 8.6). Of this, $11.7 billion (98.1%) was for recurrent purposes and the remainder for capital purposes. The recurrent share of total government funding fluctuated from year to year, but has generally shown an upward trend from 97.3% in 1998–99.

Table 8.6: Total government funding for welfare services, by type of expenditure, current prices, 1992–93 to 2002–03 ($m)

Year	Recurrent expenditure	Capital expenditure	Total
1992–93	4,105.5	476.9	4,582.4
1993–94	4,628.9	379.4	5,008.4
1994–95	5,299.3	243.0	5,542.3
1995–96	5,751.1	217.3	5,968.4
1996–97	6,245.1	286.3	6,531.4
1997–98	6,889.3	194.7	7,084.0
Break in time series			
1998–99	8,175.8	227.6	8,403.3
1999–00	8,784.2	209.4	8,993.6
2000–01	9,374.7	271.0	9,645.7
2001–02	10,498.7	189.0	10,687.7
2002–03	11,676.4	224.5	11,900.9

Source: AIHW 2005.

Recurrent funding by governments

A little over half (50.8%) of estimated recurrent funding by governments for welfare services in 2002–03 came from state and territory governments' own funding (derived from Table 8.7). This share fell from 52.1% in 1998–99; the Australian Government's share rose over the period from 44.9% to 45.6%; the local government share rose from 3.0% to 3.5%.

Table 8.7: Recurrent government funding for welfare services, by level of government, current prices, 1992–93 to 2002–03 ($m)

Year	Australian Government	State and territory government	Local government	Total government
1992–93	1,892.8	2,207.5	5.2	4,105.5
1993–94	2,311.3	2,299.3	18.3	4,628.9
1994–95	2,723.8	2,517.1	58.4	5,299.3
1995–96	2,936.8	2,691.0	123.3	5,751.1
1996–97	3,097.7	3,070.6	76.8	6,245.1
1997–98	3,187.4	3,531.0	170.9	6,889.3
Break in time series				
1998–99	3,671.8	4,262.3	241.7	8,175.8
1999–00	3,956.6	4,577.3	250.3	8,784.2
2000–01	4,253.1	4,868.2	252.3	9,373.7
2001–02	4,877.9	5,383.6	237.2	10,498.7
2002–03	5,329.3	5,934.1	413.0	11,676.4

Source: AIHW 2005.

Only funding by the Australian Government and the state and territory governments is included in the remainder of this discussion of government funding of welfare services. Data are not available to allow the decomposition of funding by local government.

When allocating funding by governments to the different categories of welfare services (that is, services for families and children, for older people, and for people with disabilities), there were some kinds of funding that could not be easily identified as having flowed to particular categories. These included funding for services for unaccompanied women in crisis, as well as funding to support a broad range of services for Indigenous Australians or other disadvantaged groups within the Australian community. The estimates of funding that flowed to such welfare services fluctuated considerably from year to year. Sometimes, this was due to specific initiatives in the areas concerned and at other times it was because of better identification of where the funding was being directed in a particular year. Consequently, the estimates for 'Other recipients of welfare services (nec)' is regarded as the residual after the identified welfare services funding estimates have been deducted from the estimates of total funding for welfare services. In 2002–03, estimated government funding for these types of services was $1.8 billion, or 15.8% of total funding by governments for welfare services.

Government funding for welfare services grew, in real terms, at an average rate of 5.7% per year between 1998–99 and 2002–03. By far the most rapid growth was in welfare services for families and children, which averaged 10.0% per year over the period (Table 8.8).

Table 8.8: Recurrent funding of welfare services by the Australian, state and territory governments, by major area of expenditure, constant prices[a], and annual real growth 1992–93 to 2002–03

	Families and children		Older people[b] [c]		People with disabilities		Other recipients of welfare services		Total welfare services	
Year	Amount ($m)	Growth (%)	Amount ($m)	Growth (%)	Amount ($m)	Growth (%)	Amount ($m)	Growth (%)	Amount ($m)	Growth (%)
1992–93	1,729.5	n.a.	1,250.8	n.a.	1,702.5	n.a.	442.4	n.a.	5,125.1	n.a.
1993–94	1,954.4	13.0	1,434.7	14.7	1,882.9	10.6	455.7	3.0	5,727.6	11.8
1994–95	2,252.8	15.3	1,720.4	19.9	1,929.0	2.5	543.3	19.2	6,445.6	12.5
1995–96	2,513.9	11.6	1,772.0	3.0	1,959.3	1.6	576.1	6.0	6,821.3	5.8
1996–97	2,620.0	4.2	2,077.3	17.2	2,058.4	5.1	570.0	–1.1	7,325.7	7.4
1997–98	2,594.7	–1.0	2,409.0	16.0	2,235.1	8.6	618.8	8.6	7,857.7	7.3
Break in time series										
1998–99	2,431.9	n.a.	2,141.3	n.a.	2,702.3	n.a.	1,758.4	n.a.	9,027.5	n.a.
1999–00	2,779.8	14.3	2,285.2	6.7	2,836.6	5.0	1,677.7	–4.6	9,578.0	6.1
2000–01	2,737.7	–1.5	2,398.4	5.0	2,946.1	3.9	1,745.4	4.1	9,827.6	2.6
2001–02	3,305.8	20.8	2,436.3	1.2	3,151.4	7.1	1,742.8	–0.1	10,629.0	8.2
2002–03	3,565.7	7.9	2,637.6	8.7	3,271.7	3.7	1,788.5	2.6	11,263.5	6.0
Average annual growth										
1992–93 to 1997–98	—	8.5	—	14.0	—	5.6	—	6.9	—	8.9
1998–99 to 2002–03	—	10.0	—	5.4	—	4.9	—	0.5	—	5.7

(a) In constant prices (estimates expressed in terms of 2002–03 prices).

(b) Does not include Australian Government funding, through the residential aged care subsidies, for high-level care, which is regarded as expenditure on health services (estimated at $3,643 million in 2002–03).

(c) Does not include nursing home funding by state and territory governments, which is regarded as expenditure on health services (estimated at $452 million in 2002–03).

Source: AIHW 2005.

A little over half (52.8%) of the recurrent funding for welfare services for families and children during 2002–03 came from the Australian Government (Table 8.9). It provided $1.9 billion in funding these services, compared with $1.7 billion by the states and territories. The relative shares changed little between 1998–99 and 2002–03, with the Australian Government share having fallen by 0.5 percentage points, from 53.3% to 52.8%. There was a corresponding increase in the share met by state and territory governments.

The Australian Government was the largest source of government funding for welfare services for older people. In 2002–03 it provided more than two-thirds (68.7%) of all such funding (Table 8.10). Further analysis of the services for older people can be found in Chapter 4. The following paragraphs concentrate on expenditure on the welfare services component.

Most of the funding for welfare services for people with disabilities was provided by state and territory governments. In 2002–03, they provided an estimated $2.1 billion out of total government funding of $3.3 billion (Table 8.11). This represented almost two-thirds (63.7%) of the combined funding by the Australian and the state and territory governments on services for people with disabilities.

Table 8.9: Recurrent funding of welfare services by government for families and children, current prices, 1992–93 to 2002–03

	Australian Government		State and territory government		Total government	
Year	Amount ($m)	Share (%)	Amount ($m)	Share (%)	Amount ($m)	Share (%)
1992–93	611.5	44.2	772.1	55.8	1,383.6	100.0
1993–94	758.9	48.2	814.4	51.8	1,573.3	100.0
1994–95	952.6	52.2	872.2	47.8	1,824.8	100.0
1995–96	1,088.4	52.5	985.6	47.5	2,074.0	100.0
1996–97	1,161.4	52.6	1,044.6	47.4	2,206.0	100.0
1997–98	1,089.2	49.1	1,129.3	50.9	2,218.5	100.0
Break in time series						
1998–99	1,139.7	53.3	997.4	46.7	2,137.1	100.0
1999–00	1,397.8	56.4	1,078.9	43.6	2,476.7	100.0
2000–01	1,360.4	53.5	1,181.0	46.5	2,541.5	100.0
2001–02	1,685.3	52.8	1,507.2	47.2	3,192.5	100.0
2002–03	1,881.9	52.8	1,683.7	47.2	3,565.7	100.0

Source: AIHW 2005.

Table 8.10: Recurrent funding[(a)] for welfare services by government for older people, current prices, 1992–93 to 2002–03

	Australian Government[(b)]		State and territory government[(c)]		Total government	
Year	Amount ($m)	Share (%)	Amount ($m)	Share (%)	Amount ($m)	Share (%)
1992–93	586.6	58.6	414.0	41.4	1,000.6	100.0
1993–94	800.7	69.3	354.2	30.7	1,154.9	100.0
1994–95	911.3	65.4	482.2	34.6	1,393.5	100.0
1995–96	916.8	62.7	545.1	37.3	1,461.9	100.0
1996–97	1,023.7	58.5	725.4	41.5	1,749.1	100.0
1997–98	1,172.0	56.9	887.7	43.1	2,059.7	100.0
Break in time series						
1998–99	1,324.1	70.5	555.4	29.5	1,879.4	100.0
1999–00	1,356.3	66.7	676.4	33.3	2,032.8	100.0
2000–01	1,539.4	69.1	688.2	30.9	2,227.6	100.0
2001–02	1,628.6	69.5	714.4	30.5	2,342.9	100.0
2002–03	1,810.9	68.7	826.7	31.3	2,637.6	100.0

(a) Includes only funding by the Australian Government and by state and territory governments.

(b) Does not include Australian Government funding, through the residential aged care subsidies, for high-level care, which is regarded as expenditure on health services (estimated at $3,643 million in 2002–03).

(c) Does not include state and territory governments' funding for government nursing homes, which is regarded as expenditure on health services (estimated at $452 million in 2002–03).

Source: AIHW 2005.

Other welfare services (not elsewhere classified) comprise services to recipients not classified to the first three target groups. These include services for Aboriginal and Torres Strait Islander people; services for women who have been subject to domestic violence; prisoners' aid; care of refugees; pre-marital education, information and advice; homeless persons' assistance; and crime victim support, referral and crisis support services.

In 2002–03, recurrent government expenditure on these welfare services was $1.8 billion. State and territory governments accounted for 75% of this amount.

Table 8.11: Recurrent funding[(a)] of welfare services by government for people with disabilities, current prices, 1992–93 to 2002–03

	Australian Government		State and territory government		Total government	
Year	Amount ($m)	Share (%)	Amount ($m)	Share (%)	Amount ($m)	Share (%)
1992–93	548.0	40.2	814.0	59.8	1,362.0	100.0
1993–94	596.3	39.3	919.4	60.7	1,515.7	100.0
1994–95	698.2	44.7	864.3	55.3	1,562.5	100.0
1995–96	729.1	45.1	887.3	54.9	1,616.4	100.0
1996–97	728.0	42.0	1,005.2	58.0	1,733.2	100.0
1997–98	744.2	38.9	1,166.8	61.1	1,911.0	100.0
Break in time series						
1998–99	867.0	36.6	1,503.2	63.4	2,370.2	100.0
1999–00	886.7	35.1	1,641.2	64.9	2,527.9	100.0
2000–01	985.2	36.0	1,748.8	64.0	2,734.0	100.0
2001–02	1,121.2	36.8	1,923.0	63.2	3,044.3	100.0
2002–03	1,188.5	36.3	2,083.2	63.7	3,271.7	100.0

(a) Includes only funding by the Australian Government and by state and territory governments.

Sources: Australian Government –- compiled from DHAC 1999, 2000, DoHA 2001, 2002, 2003; FaCS 1999, 2000, 2001, 2002, 2003; DIMIA unpublished data; Department of Veterans' Affairs unpublished data. State and territory government — Recurrent expenditure compiled from PC 2004; ABS unpublished public finance data.

Australian Government recurrent funding

Services to families and children and to older people accounted for the largest shares of Australian Government funding for welfare services in 2002–03: 35.3% and 34.0% of the total, respectively. The composition of services receiving Australian Government funding changed somewhat between 1998–99 and 2002–03. At the beginning of that period, estimated funding of services for older people represented 36.1% of its welfare services funding, while funding for families and children was lower, at 31.0%.

State and territory government recurrent funding

Services for people with disabilities and for families and children received substantial shares of state and territory government funding. Services for people with disabilities attracted more than one-third (35.1%) of such funding in 2002–03; this share has been fairly stable since 1998–99. The next largest share (28.4%) went to fund services for families and children; this share has risen noticeably since 1998–99.

The shares of state and territory funding that supported services for people with disabilities changed little between 1998–99 and 2002–03, generally remaining around

35–36% of the total. Funding for services for families and children increased as a share of the total, from 23.4% in 1998–99 to 28.4% in 2002–03. This was counterbalanced by a decrease in the estimated share attributed to 'unidentified welfare services' (down from 28.3% to 22.6%).

Capital funding by governments

Government funding for capital expenditure may take the form of direct outlays—usually by state and territory or local governments—or it may involve grants and subsidies to support private sector investment in welfare services infrastructure.

Total welfare-related capital expenditure in 2002–03 was estimated at $224.5 million (Table 8.12). Almost half of that—$104.5 million or 46.5%—came from state and territory governments, and the remainder chiefly from the Australian Government.

Capital expenditure is, by nature, quite 'lumpy' -- that is, the relative shares of capital funding fluctuate from one year to the next. For example, in 1998–99 the amounts of funding by the Australian Government and the state and territory governments were almost equal, at $99.5 million and $99.6 million, respectively. In the next year, estimated funding by state and territory governments ($116.8 million) was more than double that provided by the Australian Government ($54.2 million).

Table 8.12: Government funding for welfare-related capital expenditure, current prices, 1992–93 to 2002–03 ($m)

	Australian Government	State and territory government	Total	Local government	Total
1992–93	220.6	239.0	459.6	17.3	476.9
1993–94	182.6	169.2	351.8	27.6	379.4
1994–95	167.7	34.4	202.1	40.9	243.0
1995–96	137.7	45.9	183.6	33.7	217.3
1996–97	165.8	76.3	242.1	44.2	286.3
1997–98	85.2	61.5	146.7	48.0	194.7
Break in time series					
1998–99	99.5	99.6	199.1	28.5	227.6
1999–00	54.2	116.8	171.0	38.4	209.4
2000–01	75.7	173.7	249.4	21.6	271.0
2001–02	67.5	106.1	173.6	15.5	189.0
2002–03	76.5	104.5	181.0	43.4	224.5

Source: AIHW 2005.

Indirect government funding

Two forms of indirect funding of welfare services are examined here. They are tax expenditures, most of which flow to people involved in the provision or funding of welfare services; and concessions to or for people within social groups in need of special assistance.

Tax expenditures include concessions such as exemptions, deductions, rebates, reduced rates and deferral of tax liability.

Some tax expenditures go (in the form of tax deductions) to individual taxpayers who make donations or gifts to organisations that provide services or who directly provide care to dependants assessed as being in need of assistance. Tax expenditures flowing to such individuals in 2002–03 were estimated at $680 million (Table 8.13: Tax expenditures by governments for welfare services, current prices, 1995–96 to 2002–03 ($m)13).

A second form of tax expenditure relates to special treatments afforded to service providers in respect of some inputs to the services they provide. The major such tax expenditures in 2002–03 were exemption from the Australian Government's fringe benefits tax for benevolent organisations ($165 million); and exemptions from a number of state and territory government taxes, including payroll tax ($207 million), land tax ($104 million) and stamp duty and bank taxes ($259 million). In all, estimated tax expenditures related to inputs totalled $735 million in 2002–03.

Table 8.13: Tax expenditures by governments for welfare services, current prices, 1995–96 to 2002–03 ($m)

Tax expenditure type	1995–96	1996–97	1997–98	1998–99	1999–00	2000–01	2001–02	2002–03
Donations to benevolent institutions	160	169	184	230	250	300	310	340
Tax offset for housekeeper who cares for a prescribed dependant	579	400	400	420	430	360	340	340
Australian Government tax exemptions on inputs								
Fringe benefits tax	75	150	180	60	210	230	230	165
Wholesale sales tax	137	153	172	207	227	—	—	—
State and territory government tax exemptions on inputs								
Payroll tax	91	102	115	138	151	167	183	207
Land tax	46	51	57	69	76	83	92	104
Stamp duty, etc.	114	127	144	172	189	209	229	259
Total input tax exemptions	463	583	668	645	853	689	734	735
Total tax expenditures	1,226	1,179	1,278	1,295	1,533	1,349	1,384	1,415
Total welfare services expenditure	9,069	9,958	10,874	12,087	13,096	14,026	15,289	17,130
Tax expenditure proportion of total welfare spending (%)	13.5	11.8	11.8	10.7	11.7	9.6	9.1	8.3

Source: AIHW 2005.

The proportion of welfare services expenditure that is funded through identified tax expenditures fell from 13.5% in 1995–96 to 8.3% in 2002–03. This was influenced, to a large extent, by the removal of one major input tax expenditure—exemption from wholesale sales tax—following the reform of the tax system by the Australian Government in 2000. But, even if the new wholesale sales tax arrangement is backcast, tax expenditures as a proportion of total welfare services expenditure fell from 12.0% in 1995–96 to 8.3% in 2002–03.

Concessions that are allowed by government service providers are treated as indirect government expenditures, and some of these are classified as indirect expenditures on welfare services. Estimates of such welfare-related concessions are included in the

expenditure accounts as 'core' concessions; they include concessions on electricity, public transport, water and sewerage and on local government rates. In 2002–03, indirect expenditure by governments through core concessions was estimated at $1,146.5 million (Table 8.14). Some other government concessions are available to individuals (such as schoolchildren) who are outside the accepted welfare services target group categories; they are not included in the figures presented here.

In earlier years, eligibility for many state and territory government concessions was restricted to people identified by governments as requiring such assistance (usually limited to full-rate social security pensioners and beneficiaries and eligible veterans). Since 1997–98, however, the Australian Government has entered into agreements with the states and territories to extend eligibility for concessions to a much broader range of social security recipients.

Table 8.14: Core government concessions for welfare services target populations, current prices, 1998–99 to 2001–02 ($m)

	Core concession type				
Year	Electricity	Public transport	Water and sewerage	Council rates	Total concessions
Estimated total expenditure on concessions					
1998–99	178.5	412.4	160.0	220.6	971.5
1999–00	212.6	402.6	161.9	226.3	1,003.5
2000–01	228.6	420.8	178.9	221.0	1,049.3
2001–02	263.0	429.4	188.9	248.1	1,129.4
2002–03	258.7	439.2	190.8	257.9	1,146.5
Funded by Australian Government through extension of fringe benefits funding to states and territories					
1998–99	27.9	64.4	25.0	34.5	151.8
1999–00	32.9	62.3	25.1	35.0	155.3
2000–01	35.8	66.0	28.0	34.6	164.5
2001–02	39.8	65.0	28.6	37.5	170.9
2002–03	40.2	68.3	29.7	40.1	178.3
Funded by states and territories from own sources					
1998–99	150.6	347.9	135.0	186.2	819.7
1999–00	179.7	340.3	136.9	191.3	848.2
2000–01	192.8	354.8	150.8	186.3	884.8
2001–02	223.3	364.4	160.4	210.6	958.6
2002–03	218.4	370.9	161.1	217.8	968.2

Source: AIHW 2005.

Non-government sector funding

There are two major non-government sources of funding for welfare services:

- funding provided by NGCSOs from their own sources—in 2002–03, NGCSOs provided $2,019.2 million from their own sources (Table 8.15); and
- fees charged to the clients of services—in 2002–03, client fees provided $3,210.5 million (Table 8.16).

Table 8.15: Recurrent funding of NGCSOs' welfare services expenditure, amount and share, by source of funds, current prices, 1992–93 to 2002–03

	Funding source						Total expenditure by NGCSOs	
	Governments		NGCSOs		Client fees			
Year	Amount ($m)	Share (%)	Amount ($m)	Share (%)	Amount ($m)	Share (%)	Amount ($m)	Share (%)
1992–93	1,846.0	46.9	934.0	23.7	1,153.0	29.3	3,933.0	100.0
1993–94	2,074.0	47.9	990.0	22.8	1,270.0	29.3	4,334.0	100.0
1994–95	1,973.0	45.8	995.0	23.1	1,338.0	31.1	4,306.0	100.0
1995–96	2,305.0	46.5	1,039.0	21.0	1,608.0	32.5	4,952.0	100.0
1996–97	2,552.0	46.2	1,143.0	20.7	1,831.0	33.1	5,526.0	100.0
1997–98	2,895.0	46.5	1,229.0	19.7	2,103.0	33.8	6,227.0	100.0
Break in time series								
1998–99	2,805.4	46.8	1,368.3	22.8	1,816.2	30.3	5,989.8	100.0
1999–00	2,951.5	44.8	1,550.4	23.6	2,080.6	31.6	6,582.5	100.0
2000–01	3,383.5	46.6	1,620.4	22.3	2,256.6	31.1	7,260.5	100.0
2001–02	3,887.1	48.8	1,741.4	21.9	2,340.6	29.4	7,969.0	100.0
2002–03	4,319.8	47.9	2,019.2	22.4	2,671.9	29.7	9,010.8	100.0

Source: AIHW 2005.

Table 8.16: Funding of welfare services, through fees paid by clients, amount and share, by provider sector, current prices, 1998–99 to 2002–03

	Provider sector							
	Governments		NGCSOs		Households as providers of informal childcare		Total client fee funding	
Year	Amount ($m)	Share (%)	Amount ($m)	Share (%)	Amount ($m)	Share (%)	Amount ($m)	Share (%)
1998–99	292.9	12.6	1,816.2	78.4	206.7	8.9	2,315.8	100.0
1999–00	276.9	10.8	2,080.6	81.5	195.2	7.6	2,552.7	100.0
2000–01	319.4	11.6	2,256.6	81.8	184.3	6.7	2,760.3	100.0
2001–02	345.0	12.1	2,340.6	81.9	174.0	6.1	2,859.6	100.0
2002–03	344.6	10.7	2,671.9	83.2	194.0	6.0	3,210.5	100.0

Source: AIHW 2005.

Most client fee funding in 2002–03 was directed to services provided by NGCSOs. These were for privately provided services such as private childcare services and care facilities for older people. Client fee funding of services provided by NGCSOs in 2002–03 was estimated at $2,671.9 million, or 83.2% of total estimated client fee funding for welfare services.

In the case of client fee funding of services provided by households, the only estimates that are available relate to childcare services. It is estimated that $194.0 million was provided by clients to support childcare services provided by households in 2002–03; this represented 6.0% of all identified client fee funding.

It is possible that some of the informal care provided by households to older people and people with disabilities may also have attracted funding from this source, but information that would support estimation of the expenditure and funding for such informal services is not available.

8.5 Welfare-related social expenditure

This section looks at Australia's spending on welfare services in the context of its overall social expenditure. This provides a broader picture than can service expenditures alone of the levels of support provided to people in need of assistance. Examining overall social expenditure helps to abstract from some of the fluctuations that can occur when funding for services is replaced by cash benefits to individuals and families (to provide them with greater capacity to purchase services, for example).

For the purposes of this analysis, the scope of social expenditures has been confined to those directed at groups in society that would access the types of services usually covered in analyses of expenditures on welfare services. The international social expenditure (SOCX) classifications that have been developed by the OECD provide the broad framework for this analysis. For the analysis below, the SOCX classifications have been limited to welfare-related categories by excluding some classes of expenditure (Table 8.17).

Table 8.17: SOCX categories and their treatment in respect of welfare-related social expenditure

SOCX category no.	SOCX category title	Treatment
1	Old age	Included
2	Survivors[(a)]	Included
3	Incapacity-related benefits	Included
4	Health	Excluded
5	Family	Included
6	Active labour market programs	Excluded
7	Unemployment	Excluded
8	Housing	Excluded[(b)]
9	Other social policy areas	Excluded[(c)]

(a) 'Survivors' refers to widowed spouses and orphans.

(b) All expenditures on housing classified by OECD into category 9 are excluded except those expenditures that come within the scope of the ABS government purpose classification (GPC) 262 'welfare services'. For Australia the included housing expenditures have been included in category 9.

(c) Includes social expenditures classified by ABS to GPC 2619 'Social security (nec)' and those housing expenditures that come within the scope of the GPC 262 class.

Estimated welfare-related social expenditure in Australia during 2002–03 was $69.1 billion (Table 8.18). Just over three-quarters (75.2% or $52.0 billion) of this was in the form of cash benefits and the rest was benefits-in-kind.

Most expenditure on cash benefits in 2002–03 was directed to older people ($22.0 billion) and families ($18.7 billion).

The expenditure on benefits-in-kind here relates to expenditure on welfare services. Overall, they accounted for around one-quarter (24.8%) of estimated welfare-related

social expenditures in 2002–03. Benefits-in-kind accounted for 26.2% of welfare-related social expenditures for people with disabilities, and this changed only marginally over the period since 1998–99, when it was estimated at 25.8%. In the case of older people, benefits-in-kind played a somewhat lesser role than for people with disabilities. In 2002–03, estimated benefits-in-kind comprised 10.7% of the welfare-related social expenditures for older people. The corresponding proportion for families was 16.0%.

Table 8.18: Social expenditure, current prices, 1998–99 to 2002–03 ($m)

SOCX category	1998–99	1999–00	2000–01	2001–02	2002–03
1. Old age					
Cash benefits[(a)]	16,424.4	16,826.6	22,369.8	20,916.6	22,044.2
Benefits-in-kind	1,879.4	2,032.8	2,227.6	2,342.9	2,637.6
Total	*18,303.8*	*18,859.3*	*24,597.4*	*23,259.6*	*24,681.8*
2. Survivors					
Cash benefits[(b)]	1,402.7	1,425.9	1,608.3	1,751.8	1,840.9
3. Incapacity-related benefits					
Cash benefits	6,801.6	7,135.4	8,039.7	8,704.1	9,209.1
Benefits-in-kind	2,370.2	2,527.9	2,734.0	3,044.3	3,271.7
Total	*9,171.9*	*9,663.3*	*10,773.7*	*11,748.4*	*12,480.7*
5. Family					
Cash benefits	12,040.1	13,938.7	17,285.8	18,606.7	18,703.4
Benefits-in-kind	2,137.1	2,476.7	2,541.5	3,192.5	3,565.7
Total	*14,177.2*	*16,415.4*	*19,827.3*	*21,799.1*	*22,269.1*
9. Other social policy areas					
Cash benefits	204.1	120.1	139.9	149.5	156.7
Benefits-in-kind	5,700.7	6,059.5	6,523.3	6,708.9	7,655.5
Total	*5,904.8*	*6,179.6*	*6,663.2*	*6,858.5*	*7,812.2*
Total					
Cash benefits	36,873.0	39,446.7	49,443.5	50,128.6	51,954.2
Benefits-in-kind	12,087.4	13,096.7	14,026.4	15,288.6	17,130.5
Total	**48,960.4**	**52,543.4**	**63,469.9**	**65,417.3**	**69,084.7**

(a) Not including mandatory employer superannuation contribution of $22,899 million, $25,955 million, $27,416 million, $28,574 million, and $34,676 million in 1998–99, 1999–00, 2000–01, 2001–02, and 2002–03 respectively.

(b) Benefits in-kind for survivors should include welfare services provided to widows. But in the Australian data, these are classified to the SOCX category 'Other social policy'. Category 9 also includes all recurrent funding for welfare services by local governments, plus government capital expenditure, and expenditure by NGCSOs and households.

Sources: Benefits-in-kind: AIHW; Cash benefits: FaCS 1999, 2000, 2001, 2002, 2003.

International comparisons of social expenditures have been drawn from the SOCX database. The latest year for which comprehensive estimates are available is 2001. In that year, all OECD members, except Turkey, reported social expenditures (Table 8.19).

Overall, Australia's social expenditure as a proportion of GDP was estimated at 13.7% in 2001 if superannuation payments are included in social expenditures and 9.2% if they are excluded. The former is about the middle of the range of expenditures and above the weighted mean for all OECD countries (11.6%).

Table 8.19: Social expenditure[a] by SOCX category, OECD countries, current prices, 2001 ($m)

	SOCX category						
Country[b]	**Old age**	**Survivors**	**Incapacity-related**	**Family**	**Other**	**Total[c]**	**Total as % of GDP**
Austria	32,648	8,137	10,380	8,902	1,477	61,544	20.2
Switzerland	33,644	4,445	12,246	3,738	1,801	55,874	19.6
Sweden	29,468	1,978	18,429	9,328	1,997	61,200	19.1
Germany	326,631	12,116	101,134	55,663	14,566	510,109	18.2
Greece	31,590	2,145	4,461	4,552	1,535	44,284	17.8
France	230,104	32,465	46,456	60,735	8,531	378,291	17.5
Poland	45,599	11,362	29,685	5,077	1,212	92,934	17.4
Belgium	32,273	9,861	12,130	8,602	1,533	64,399	17.3
Denmark	17,384	23	8,630	7,933	2,199	36,169	17.3
Norway	14,946	658	13,615	7,076	1,378	37,674	17.1
Italy	221,989	51,057	41,624	19,301	702	334,674	17.0
Finland	14,669	1,781	7,074	5,510	958	29,992	16.4
Luxembourg	2,175	174	1,038	1,000	63	4,451	15.3
United Kingdom	182,830	12,530	54,512	47,455	3,996	301,324	14.2
Hungary	14,182	514	4,783	4,442	334	24,256	13.7
Portugal	19,446	3,650	7,208	2,847	649	33,801	13.7
Australia[d]	55,826	1,752	11,748	21,799	6,858	97,984	13.7
Australia[e]	23,260	1,752	11,748	21,799	6,858	65,417	9.2
Netherlands	39,156	4,176	29,611	6,993	3,847	83,784	13.6
Iceland	606	63	468	284	48	1,469	13.3
Czech Republic	13,607	1,870	6,108	3,243	1,255	26,084	12.8
Slovak Republic	5,662	139	1,947	1,249	980	9,977	12.2
Spain	95,390	6,565	27,198	5,770	1,721	136,643	11.9
Japan	354,488	54,606	29,886	27,039	7,306	473,324	10.5
New Zealand	5,272	121	3,130	2,417	100	11,039	9.9
Canada	59,270	5,360	10,142	10,888	29,955	115,616	9.4
Mexico	90,184	2,026	1,826	3,530	2,527	100,092	8.3
United States	702,677	111,813	180,995	51,000	63,515	1,110,000	8.3
Ireland	4,095	1,225	2,166	2,507	730	10,724	7.0
Korea	12,273	2,049	6,076	1,599	4,750	26,748	2.7
OECD total[b]	2,655,518	344,662	684,708	390,481	166,525	4,241,895	11.6

(a) Includes public and mandatory private social expenditures.

(b) Excludes Turkey.

(c) Excludes health, active labour market programs, unemployment and housing.

(d) Including superannuation payments.

(e) Excluding superannuation payments.

Note: Expenditures converted to Australian dollar values using GDP purchasing power parities.

Source: OECD SOCX database 2004.

8.6 Human resources in community services

Human resources in community services comprise:

- people in paid employment in community services occupations that provide and support community services; and
- volunteers who contribute their time to community services organisations.

In addition to services provided by organisations, the equivalents of many welfare services (for instance emergency relief, or non-parental care for children or care for people who are ageing or have disabilities) are provided informally by networks of family members, friends and neighbours. While these networks are not part of the formal welfare system, consideration of human resources in community services is incomplete without discussion of carers, as they have shaped and continue to complement the more formal services.

There is a complex interplay within and between these groups (Figure 8.2). Consider, for example, the effects of an ageing population: on the one hand, the number of people exiting the paid workforce is likely to increase in years to come; and, on the other hand, the number of older people requiring assistance will increase. Together, these influences change the demand for new entrants into the aged care workforce.

Potential entrants into the paid community services workforce may come from the education system, migrants or the pool of former workers re-entering the paid workforce. Of those exiting the paid workforce, some may continue to contribute in the form of voluntary work with community services organisations, or may provide informal care to family members. The supply of labour for community services is affected by changes in the hours worked as well as by the number of workers.

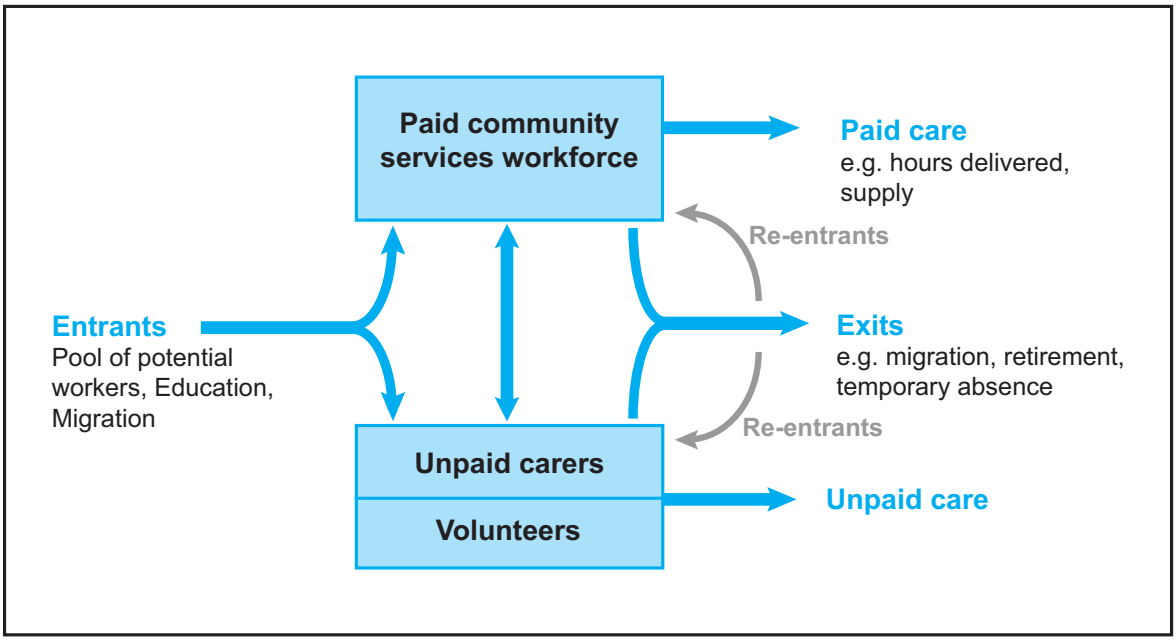


Figure 8.2: Human resources in the community services supply 'pipeline'

This section reports the current status of the paid workforce using the most recent information from various sources, including reported shortages and entrants into the paid workforce. This is followed by a description of the unpaid workforce.

Paid workforce

Community services industries and occupations

The community services industry, as defined by the Australian and New Zealand Standard Industry Classification, includes units that are mainly engaged in providing either child care or community care services (comprising accommodation for the aged, residential and non-residential services, and other community and community care services undefined). Community services industry workers are composed of two groups:

- those employed in community services occupations, based on the Australian Standard Classification of Occupations, who provide services directly to clients (such as counsellors and aged care workers); and
- those who are employed in the community services industry to provide support and infrastructure (such as administrative staff and computer technicians).

Typically, workers in community services occupations who provide services directly to clients are employed in the community services industry; but a larger number of workers in such occupations are employed across a range of other industries, particularly the health, education and government administration and defence industries (see shaded box in Figure 8.3).

	Community services industries	Other industries	Total
Community services occupations	159,678 persons employed in community services occupations in community services industries, e.g. children's care workers in the child care services industry	174,672 persons emplyed in community services occupations in other industries, e.g. counsellors in the education industry	334,350 (267,729 FTE)
Other occupations	83,647 persons employed in other occupations in community services industries, e.g. managers, accountants, auditors, tradespersons and computing professionals who support community services industries		
Total	243,235 (202,906 FTE)		

Source: ABS 2005b.

Figure 8.3: Relationship of community services occupations to community services and other industries, 2004

In 2004, workers in community services industries who were employed in community services occupations (i.e. providing direct care) comprised approximately two-thirds of the industry. The remaining one-third worked in other occupations providing managerial and infrastructure support for the delivery of care. Figure 8.3 illustrates how community service occupations and industries relate to one another.

According to the ABS Labour Force Survey, in 2004 there were approximately 243,000 people employed in community services industries in Australia, representing 2.5% of all employed persons across all industries. The number of persons employed in community services industries increased by 22.6%, between 1999 and 2004. This compares with a 10.5% increase across all industries. Within community services industries, the number employed in childcare services increased by 42.0% and in community care services increased by 10.2% (Table A8.1).

In 2004, employees in community services were predominantly female (81.0%) and nearly half worked part-time (45.8%). Other industries with a broadly similar profile include health services (77.3% female, 41.6% part time) and education (67.7% female, 34.5% part time; Table A8.1).

Box 8.2: The use of different data sources

Because the Labour Force Survey is a sample survey, it has limited capacity for providing more detailed breakdown of community services occupations by industry. So the 2001 Census of Population and Housing data have been used to describe the distribution of community services occupations across industries. Census data also allow analyses of specific occupations; however, to align with the categories used in the Labour Force Survey, broader occupational categories from the Census have been used in this report. Consequently, some figures in this publication differ from those previously published (e.g. AIHW & ABS 2003) because of the inclusion of some specific occupational categories.

Data from the 2001 Census show that approximately 44.8% of people working in community services occupations were employed in community services industries. Within these industries, children's care workers was the largest occupational group (39.6%), followed by special care workers (27.5%), welfare and community workers (10.0%) and welfare associate professionals (8.9%). Across other industries, education was the second largest employer, employing a third (33.0%) of all community services occupations, followed by health (8.5%; Table 8.20).

The ABS Labour Force Survey estimated that between 1999 and 2004 there was a 23.4% increase in the number of persons employed in community services occupations, compared with an increase of 10.5% across all occupations. In 2004 the majority of workers were female (86.6%) and just over half (51.6%) worked part-time. This compares with 44.6% female and 28.4% part-time for all occupations. Children's care workers were predominantly female (96.0%) and were generally younger than other community service occupations, with three-quarters (75.3%) aged under 45 years compared with 59.0% of all community services workers; and just over half (51.2%) worked part-time. Overall, pre-primary school teachers were predominantly female (98.1%). Aboriginal

and Torres Strait Islander health workers were predominantly male (57.7%). Counsellors tended to be older (56.7% aged over 45) and tended to work full-time (35.6% part-time; Table A8.2).

Table 8.20: Persons employed in community services occupations, by industry, 2001

	Community services industries			Other industries				
Occupation	Child care services	Community care services	Total community services[a]	Health services	Gov. admin. and defence	Education	Other industries	Total all industries
Child care coordinator	4,353	92	4,471	46	104	1,578	179	6,400
Pre-primary school teacher	1,406	16	1,440	24	126	12,445	80	14,151
Special education teacher[b]	24	241	286	82	215	10,955	137	11,701
Social welfare professional nfd	14	318	367	200	162	86	108	930
Social worker	119	2,679	3,195	3,052	1,588	202	438	8,542
Welfare and community worker	893	9,208	11,678	3,552	4,869	1,081	2,407	23,730
Counsellor[c]	18	3,611	3,838	2,009	792	3,176	924	10,804
Welfare associate professional[d]	199	9,391	10,379	913	2,309	742	2,023	16,528
Indigenous health worker	3	61	84	551	151	7	30	841
Carer or aide nfd	115	1,963	2,241	1,088	337	158	527	4,700
Education aide[e]	261	162	466	73	1,529	42,650	625	45,558
Children's care worker[f]	44,933	1,072	46,274	575	785	11,587	6,468	67,299
Special care worker[g]	361	30,556	32,148	10,062	2,287	1,383	2,895	49,831
Total	**52,699**	**59,370**	**116,867**	**22,227**	**15,254**	**86,050**	**16,841**	**261,015**

(a) Includes community services industries, undefined.

(b) Includes special needs teacher, teacher of the hearing impaired, teacher of the sight impaired, and special education teachers nec.

(c) Includes rehabilitation counsellor, drug and alcohol counsellor, family counsellor, careers counsellor, student counselor, and counsellors nec.

(d) Includes parole or probation officer, youth worker, residential care officer, disabilities services officer, and family support worker.

(e) Includes preschool aide, integration aide, teacher's aide, and Indigenous education worker.

(f) Includes child care worker, family day care worker, and nanny.

(g) Includes hostel parent, child or youth residential care assistant, refuge worker, aged or disabled person carer, and therapy aide.

Note: Totals will differ from those published in previous reports because of the use of broader occupational categories.

Source: AIHW & ABS 2003.

While there was an increase in the number of workers in community services occupations, changes in the proportion working part-time need to be taken into account when ascertaining whether there was any change in the supply of community services between 1999 and 2004. Also, changes in the size of the population may affect the level of supply. To account for these factors, the full-time equivalent (FTE) number of workers per 100,000 population is used as a measure of supply. In 2004, there were approximately

1,362 FTE workers per 100,000 population, up from 1,156 in 1999, a 17.8% increase in the rate of supply. In comparison, the total supply of labour in the Australian workforce increased from 46,949 FTE per 100,000 population in 1999 to 48,722 in 2004, a 3.8% increase in supply (Table A8.2).

Average weekly earnings

Employed community services workers are relatively low-paid. The biennial ABS Survey of Employee Earnings and Hours provides weekly earnings for various categories of employees by occupation and industry.

According to the 2004 survey, the average total weekly earnings of full-time non-managerial employees working in each of the community services occupations was lower than that for all occupations ($916 per week). Social workers and counsellors were paid the highest average total weekly earnings ($909.89 and $905.95, respectively). Aboriginal and Torres Strait Islander health workers and children's care workers were the lowest paid ($547.76 and $570.09, respectively; Table 8.21).

Table 8.21: Average weekly earnings and hours paid for full-time non-managerial adults, selected community services occupations, 2004

Occupation[a]	Average weekly earnings[b]	Average hours paid for[c]
Social worker	$909.89	37.5
Welfare and community worker	$877.54	37.1
Counsellor	$905.95	37.2
Social welfare professional	$885.27	37.4
Pre-primary school teacher	$846.87	37.4
Special education teacher	$824.51	37.3
Welfare associate professional	$842.13	38.3
Aboriginal and Torres Strait Islander health worker	$547.76	36.6
Education aide	$679.21	36.5
Children's care worker	$570.09	38.2
Special care worker	$692.42	38.1
Carer and aide	$650.29	37.8
Total all occupations	**$915.66**	**39.5**

(a) Excludes child care coordinator.

(b) Average total earnings for full-time non-managerial adults. Includes ordinary time and overtime earnings.

(c) Average total hours paid for. Includes ordinary time and overtime hours.

Source: ABS 2005a.

Earnings of workers in these community services occupations also varied depending on the industry in which they worked. In 2004, the average total weekly earnings of full-time non-managerial employees working in community services occupations and whose jobs were in the health and community services industry ($725.20) were lower than that for all industries ($757 per week). Within the health and community services industry, workers in these occupations within the health sector earned more per week, on average ($760), than their colleagues within the community services sector ($701.90 per week; Table 8.22).

Table 8.22: Average weekly earnings and hours paid for full-time non-managerial adults employed in selected community services occupations, selected industries, 2004

Industry	Average weekly earnings[(a)]	Average hours paid for[(b)]
Health and community services	*725.20*	*38.2*
Health services	760.00	37.9
Community services	701.90	38.4
Education	752.50	36.9
Government and administration	903.60	37.2
Other industries	784.30	37.2
Total all industries	**757.00**	**37.7**

(a) Average total earnings for full-time non-managerial adults. Includes ordinary time and overtime earnings.

(b) Average total hours paid for. Includes ordinary time and overtime hours.

Source: ABS 2005a.

Workforce shortages

Information on workforce shortages in various community services occupations was obtained from the Department of Employment and Workplace Relations (DEWR), which monitors occupational labour markets in Australia and assesses whether skill shortages exist. This is done through consultation with employers, industry, employer and employee organisations, and education and training providers. DEWR does not quantify the skill shortage of the occupations that it identifies are in shortage.

In addition to the general shortages shown in Table 8.23, DEWR reported that shortages of child care coordinators in New South Wales were mainly for degree-qualified coordinators in long day care centres, while in Victoria, shortages were for all qualified child care coordinators. In Western Australia, shortages were greatest in some regional and outer metropolitan areas.

Table 8.23: Shortages in community services occupations, states and territories, March 2004

Client group/occupation	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Australia
Child care coordinator	M, R-D	S	S	R	D	S	*	D	N
Child care worker	M, R-D	S	S	S	S	S	*	D	N
Social workers	R	R-D	*	*	*	R	*	R-D	*
Aged care registered nurse	S	S	S	S	S	S	*	S	N
Community nursing	S		S	S	S	S	*	S	N
Enrolled nurses	S	S	S	S	S	S	S	S	N

Note: N = national shortage, S = state-wide shortage, D = recruitment difficulties, M = shortage in metropolitan areas, R-D = recruitment difficulties in regional areas, R = shortage in regional areas, * = no shortage assessed.

Source: DEWR national and state skills shortage lists.

For child care workers, shortages were particularly evident in long day care centres in New South Wales, while in Victoria shortages were again for all qualified child care workers. Shortages of registered community nurses and aged care nurses in Tasmania were particularly apparent for positions outside Hobart. Finally, recruitment difficulties for social workers in Victoria were restricted to some regional areas and specialist areas such as aged care and trauma counselling.

Box 8.3: National skills shortages

DEWR defines skills shortages as follows:

'Skills shortages exist when employers are unable to fill, or have considerable difficulty in filling vacancies for an occupation, or specialised skill needs within that occupation, at current levels of remuneration and conditions of employment, and reasonably accessible location. Shortages are typically for specialised and experienced workers, and can coexist with relatively high unemployment overall or in the occupation. An occupation may be assessed in shortage even though not all specialisations may be in shortage. Occupations may be in shortage in particular geographical areas and not in others.' <http://www.workplace.gov.au/Workplace>.

The skills shortages list may not be complete in that occupations/skills where the number employed is very small may not be identified in the consultations with industry bodies and other stakeholders. In addition, occupations that require only a very limited period of training and/or experience to acquire (e.g. disability carers) are not included in the list.

Occupational categories are reported using the Australian Standard Classification of Occupations. Therefore, only occupations that are related to community services, defined previously, have been included in this report. The categories of aged care and community nurses have also been included in this section because they are generally employed in community services industries. While a large proportion of enrolled nurses work in aged care and mental health facilities, a detailed breakdown of the different subspecialties is not available.

National shortages were reported for child care workers and coordinators, and for aged care and community nurses. The next section provides more detailed information about these two groups of workers.

Child care workers

This section focuses on child care workers who work predominantly in direct contact with children. More detailed information on child care and child care services is available in Chapter 3.

Information on child care workers is available from the Census of Child Care Services conducted by the Department of Family and Community Services. This census collects information about service operation and characteristics of children, parents and staff, from child care services that receive Australian Government funding. According to the 2004 census there were 67,658 people employed and 2,371 unpaid workers in positions where the majority of their work was spent in direct contact with children (Table 8.24). Another 12,864 were engaged as caregivers in family day care and in-home care services. Staff involved in direct contact with children worked across a range of services, including private long day care services (41.4%), vacation care services (17.5%), community-based day care (16.5%), and outside school hours care services (16.5%). Community-based and private day care centres had the highest proportion of full-time workers (45.1% and 43.2%, respectively), while the majority of those employed in vacation care and outside school hours services were paid on a casual basis (80.1% and 70.4%, respectively).

Of caregivers engaged in family day care, two-thirds (66.7%) worked full-time (on average 46.4 hours per week) compared with one-third (33.8%) of caregivers in in-home schemes (on average 27.5 hours in the reference week).

Table 8.24: Direct contact staff and caregivers working in child care services[(a)]: hours worked and employment status, 2004

	Paid staff				Unpaid staff	
	Working full-time (%)	Working casual (%)	Average hours worked	Total paid staff	Average hours worked	Total unpaid staff
Direct contact staff						
Private centres	43.2	26.7	29.9	28,038	14.3	881
Community-based centres	45.1	27.5	28.0	11,135	12.4	445
Outside school hours care services	4.8	70.4	12.3	11,156	7.9	266
Vacation care services	6.2	80.1	23.3	11,840	20.0	488
Other services	31.8	34.3	25.3	1,222	10.7	102
Total	**30.9**	**43.5**	**25.3**	**67,658**	**14.3**	**2,371**
Caregivers						
Family day care schemes	66.7	—	46.4	12,018	. .	. .
In-home care schemes	33.8	3.8	27.5	846	. .	. .
Total	**64.5**	**0.3**	**45.7**	**12,864**	**. .**	**. .**

(a) Excludes administrative and coordination staff.

Source: FACS, 2004 Census of child care services, unpublished.

Aged care, disability and community nursing workers

The nursing labour force represents a major component of community services occupations. The main areas of nursing required in community service provision are those related to ageing and disability nursing.

Between 1999 and 2003 there was a slight increase (3.6%) in the total number of employed clinical nurses. Against this, there was a 12.0% decrease in the number of clinical nurses working in aged care, a 24.4% increase in community/domiciliary care and minimal change in developmental disability/rehabilitation. Although aged care nurse numbers decreased, those working increased their hours, on average, by 2.6 hours per week. The net effect of this increase was a decrease in supply, from 27,626 FTE to 26,578 FTE nurses. In contrast, there were increases in community/domiciliary and developmental disability/rehabilitation nursing, from 7,863 to 9,881 FTE and from 6,549 to 6,784 FTE, respectively (Table 8.25).

The use of FTE nurse numbers masks the effects of changes in the population. For example, while the FTE nurse numbers in aged care increased between 2001 and 2003, changes in the size of the population resulted in a stable level of supply at 134 FTE nurses per 100,000 population in those two years. Between 1999 and 2003, the supply of nursing increased from 42 to 50 FTE nurses per 100,000 population for community/ domiciliary nursing and remained relatively stable for disability/ rehabilitation, where it decreased from 35 to 34 FTE per 100,000 population.

Table 8.25: Clinical nurses[a] employed in selected areas of nursing: type of nurse, 1999 to 2003

Clinical area	1999	2001	2003	Change 1997–2003 (%)
Aged care nursing				
Number of clinical nurses	34,781	32,212	30,600	–12.0
Average hours	27.8	28.2	30.4	. .
FTE nurses[b]	27,626	25,954	26,578	. .
Community/district/domiciliary nursing				
Number of clinical nurses	9,235	8,895	11,490	24.4
Average hours	29.8	29.6	30.1	. .
FTE nurses[b]	7,863	7,522	9,881	. .
Developmental disability / rehabilitation nursing				
Number of clinical nurses	7,163	7,383	7,261	1.4
Average hours	32.0	32.0	32.7	. .
FTE nurses[b]	6,549	6,751	6,784	. .
All employed clinical nurses				
Number of clinical nurses	200,219	201,754	207,451	3.6
Average hours	30.2	30.3	31.9	. .
FTE nurses[b]	172,760	174,661	189,077	. .
Total population	18,925,855	19,413,240	19,872,646	5.0

(a) Comprises nurse clinicians and clinical nurse managers only. Includes both registered and enrolled nurses.

(b) Full-time equivalent based on a standard 35-hour week.

Source: AIHW, Nursing labour force survey 1999 to 2003.

Potential entrants into the paid workforce: Students

There are three main sources of additional workers to maintain and/or increase the paid workforce. These are: re-entry into the paid workforce from extended leave or retirement; migration of skilled labour from other countries; and the education system, more specifically, vocational or higher educational institutions. The main source is the education system. Some information on higher education course completions is available from the Department of Education, Science and Training (DEST). Because of changes in the classification of courses, however, comparisons over time cannot be made prior to 2001.

Between 2001 and 2003 the number of students completing courses related to community services occupations increased from 4,915 to 5,529, a 12.5% increase. Of those students, approximately three-quarters (74.7%) completed undergraduate degrees. Early childhood teacher education had the highest proportion of undergraduate completions (92.5%) while counselling was predominantly a postgraduate degree (21.1%). As with the employed labour force, students in community services occupations were predominantly female, ranging from 71.6% in human welfare studies and services nec to 97.8% in early childhood teacher education (Table 8.26).

Table 8.26: Australian citizens/permanent residents completing selected community services-related higher education courses, sex and course level, 2001 and 2003

	2001			2003		
Field of education	Number	% female	% under-graduate	Number	% female	% under-graduate
Teacher ed.: Early childhood	1,615	97.9	90.6	1,986	97.8	92.5
Teacher ed.: Special education	503	90.5	29.4	607	86.8	38.4
Human welfare studies and services	481	80.9	67.8	437	87.0	78.3
Social work	1,330	86.7	89.9	1,363	86.0	87.7
Children's services	25	96.0	96.0	21	90.5	85.7
Care for the aged	45	93.3	33.3	51	90.2	47.1
Care for the disabled	73	87.7	91.8	97	88.7	89.7
Counselling	482	75.5	20.3	629	79.3	21.1
Welfare studies	231	83.5	85.7	153	84.3	82.4
Human welfare studies and services, nec	45	68.9	35.6	102	71.6	49.0
Total	**4,915**	**88.8**	**74.0**	**5,529**	**89.4**	**74.7**

Note: Time series is limited because of changes in the field of education classifications used by DEST.

Source: AIHW analyses of DEST data.

In addition to higher education courses, students may enter community services occupations by completing vocational education courses. Identification of the type of course is more difficult with such courses due to their nature. For example, some courses may consist of a single module whereas others contain a number of modules. Consequently, reliable data on completions is available only at the broad course level.

In 2003 the National Centre for Vocational Education Research (NCVER) reported that 1,663 students completed courses in teacher education, of whom 79.4% were female. In comparison, 23,562 students completed courses in human welfare studies and services, of whom 88.3% were female (Table 8.27).

Table 8.27: Vocational course completions for selected community services-related courses by sex, 2002 and 2003

	2002		2003	
	Number	% female	Number	% female
Teacher education	1,483	64.2	1,663	79.4
Human welfare studies and services	22,146	88.9	23,562	88.3

Source: NCVER unpublished data.

Unpaid workforce

Volunteers

According to the 2002 General Social Survey conducted by the ABS, approximately one-third (34.4%) of all persons aged 18 years and over had volunteered some of their time, skills or services to various types of organisations or groups within the 12 months prior to the survey. The rate of volunteering differed across age groups, ranging from 42.0%

of those in the 35–44 age group to 23.6% of those aged 75 years and over. Nearly a third of all volunteers assisted welfare and community services organisations, accounting for 11.2% of all persons aged 18 years and over. The rate of voluntary work ranged from 6.9% in the 25–34 age group to 18.1% in the 65–74 age group (Table 8.28).

Table 8.28: Persons aged 18 years and over participating in volunteer work by age group, 2002

	Age group (years)							
	18–24	25–34	35–44	45–54	55–64	65–74	75+	All persons
Volunteered in welfare/community (%)	7.9	6.9	10.0	12.1	16.5	18.1	12.4	11.2
All persons volunteering (%)	28.1	28.8	42.0	39.2	38.0	32.0	23.6	34.4
Total persons aged 18 or more ('000)	1,905	2,907	2,933	2,645	1,884	1,282	948	14,503

Source: ABS 2003b.

Carers

Complementary to the formal provision of services is the informal network of family members, friends and neighbours caring for older people or people with a disability.

The ABS Survey of Disability, Ageing and Carers provides some information on carers of people with a disability or the aged. The ABS defines a carer as:

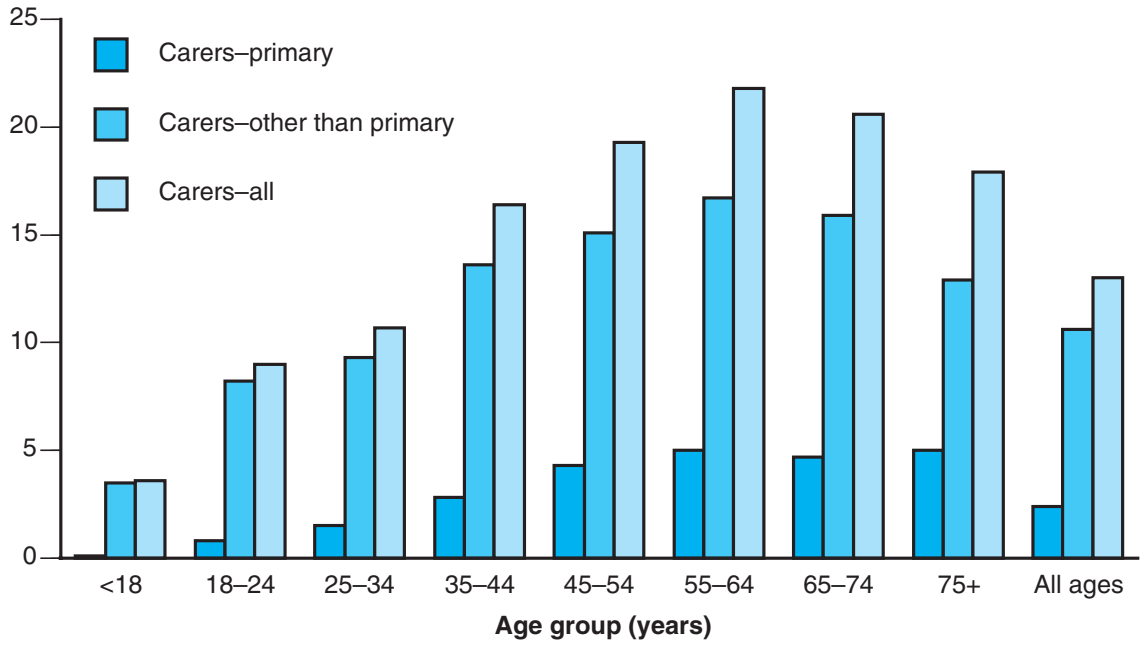
> A person of any age who provides any informal assistance, in terms of help or supervision, to persons with disabilities or long-term conditions, or older persons . . . This assistance has to be ongoing, or likely to be ongoing, for at least six months. (ABS 2003:71)

In 2003, the survey revealed that there were approximately 2.6 million people who were carers, representing approximately 13.0% of people living in households. Just under half (45.9%) of all carers were male. The proportion of people who were carers ranged from 3.6% in the under-18 age group to 21.8% in the 55–64 age group (Figure 8.4; ABS 2004).

Carers aged 75 years and over were more likely to be primary carers, consistent with the likelihood that the more able-bodied partners of retired couples tend to care for partners with a disability.

Primary carers represented 18.6% of all carers and were predominantly female (71.3%). Just under half (45.4%) were in the 45–64 age group and almost a quarter (23.9%) were aged 65 years and over (ABS 2004). Over a third (40.5%) of primary carers in 2003 spent up to 20 hours per week in the caring role, of whom 42.0% cared for persons who lived in other households. Of those who spent 40 hours or more in the caring role, the majority (70.2%) cared for persons with profound or severe core activity limitations living in the same household (Table 8.29).

The main implication for the 39.7% of primary carers spending 40 or more hours per week in the caring role is their limited opportunity for employment. In 2003 over a third (39.0%) of primary carers aged between 15 and 64 years were in the labour force (of whom only 45.7% worked full-time), compared with 69.3% for the total labour force. Consistent with this, over half (55.3%) of all primary carers relied on a government pension or allowance as the primary source of income, compared with around a quarter (26.2%) for the population aged 15 years and over (Table 8.30).



Source: ABS 2004.

Figure 8.4: Age-specific rates of carers, by type and age of carer, 2003

Table 8.29: Time spent by primary carers aged 15 years and over in their caring role, by selected characteristics of the main care recipient, 2003

Characteristic of main recipient of care	Average current weekly hours spent in caring role: Less than 20 hours	20–39 hours	40 hours or more	Not stated	Total
			Proportion (%)		
Main recipient of care lives in the same household as the primary carer and is:					
Aged less than 15 years	5.8	16.6	19.9	*19.5	14.0
Aged 15 and over, with a profound or severe core activity limitation and can cope on his/her own for:					
a few days	22.2	16.9	*5.0	*17.7	14.5
up to one day	8.5	16.4	12.0	*11.0	11.5
a few hours or less	10.8	26.6	53.1	*27.2	30.6
Subtotal	*41.7*	*59.8*	*70.2*	*55.9*	*56.6*
Aged 15 years with characteristics other than above	10.5	*7.1	*4.3	*11.7	7.7
Main recipient of care lives in a different household to the primary carer	42.0	16.5	*5.6	*12.9	21.8
All primary carers aged 15 years and over	100.0	100.0	100.0	100.0	100.0
			Number ('000)		
All primary carers aged 15 years and over	178.3	87.3	175.0	34.2	474.6

Source: ABS 2004.

Table 8.30: Carers aged 15 years and over living in households, type of carer by labour force status and income, 2003

	Primary carer	Not a primary carer	Total carers	Not a carer	Total
Labour force status					
Employed full-time (%)	45.7	64.2	61.7	70.5	69.3
Total employed ('000)	179.5	1,118.9	1,298.4	8,543.9	9,842.2
Participation rate[(a)] (%)	39.0	60.2	56.1	67.9	66.1
Income					
Principal source Government pension or allowance (%)	55.3	35.0	39.0	23.9	26.2
Total ('000)	**474.6**	**1,980.8**	**2,455.4**	**13,272.8**	**15,728.2**

(a) In the ABS Survey of Disability, Ageing and Carers, participation rate is defined as the number of persons in the labour force expressed as a proportion of the population aged between 15 and 64.

Source: ABS 2004.

Box 8.4: Data development relating to the community services workforce

*The five-yearly ABS **Census of Population and Housing** and monthly **Labour Force Survey** are the only data sources that provide information on the full range of community services occupations and industries. The ABS **Community Services Survey** provides information on businesses or organisations in the sector, including finances, characteristics of employment and volunteers. While these sources are invaluable, they all have limitations. The Census, which is the primary source of data for this sector and the best source for geographical coverage, is not designed to keep up with short-term changes, and the information provided is not detailed. The Labour Force Survey is a sample survey, and cross-tabulations for this diverse sector are subject to sampling error. The Community Services Survey is conducted irregularly, and is restricted to those workers employed in the Community services industries.*

*In addition, the ABS **Survey of Employee Earnings and Hours** is a useful source of information on pay and hours worked for all employees, by industry.*

To supplement these sources, a number of other collections have been developed, or are under development, to provide more detailed information on particular groups of community services workers.

*In 2002, the AIHW conducted the first pilot test of the **Children's Services National Minimum Data Set**, which covers services defined as child care and preschools receiving government funding. A second pilot test, which included 50 children's services agencies, was conducted in 2004. The development stages for this collection concluded in mid-2005. It is expected that this will become a yearly collection providing data on the characteristics of the agencies, the children in their care and their employees.*

*The Australian Government Department of Family and Community Services has conducted the **Census of Child Care Services** every two years since 1986. It provides staff-related demographic and work characteristics. The most recent census in 2002 covered ten service types funded through Australian Government Child Care Support.*

*The CSMAC **Structural Issues in the Workforce Sub-Committee** undertook a preliminary workforce data collection for the community services (government) workforce in 2004. This included the workforce sub-sectors of child protection, juvenile justice, disability, child care and general community services and was focused on service delivery employees. The data were sourced via an administrative by-product collection from the state and territory human resource systems, and provided information on selected characteristics of employees and their employment circumstances. The Community and Disability Services Ministers' Council has approved funding for 2005–06 for a project to profile the community services workforce, including government and non-government sectors.*

*The **Commonwealth–State/Territory Disability Agreement (CSTDA) National Minimum Data Set collection**, for which the AIHW is the custodian, was implemented in 2002. This is an annual service-based administrative collection that includes data items on hours worked by paid and unpaid staff in agencies receiving government funding under the CSTDA and providing services for disabled people.*

*The Department of Health and Ageing conducted the **National Aged Care Workforce Census and Survey** in 2003, which supplied information on the workforce in residential aged care facilities and information about the facilities.*

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9 Data environment

Community services and housing assistance information relates to a broad array of services, provided to a widely ranging group of clients and delivered by a complex system of government and non-government organisations. As a consequence, the development of high-quality data which is consistently defined and collected across both programs and jurisdictions is a challenging and multi-faceted task.

Community services are provided to individuals and families of widely differing ages and in widely differing social and economic circumstances. They protect and support vulnerable individuals and families at key stages of their lives. Community services also contribute to the development of community infrastructure and networks that in turn promote the social, emotional, physical, psychological and economic well-being of individuals and families.

This chapter describes the national infrastructure supporting the development of nationally consistent community services and housing assistance data and highlights recent changes and developments in national information on welfare services and assistance.

9.1 The national information infrastructure

Information agreements provide the structure and processes needed to support the national statistical effort in both welfare and health statistical work. These agreements are signed by the relevant government departments in all jurisdictions, the Australian Bureau of Statistics (ABS) and the AIHW. Three such agreements are currently in operation in the welfare sector:

- the National Community Services Information Agreement (NCSIA; AIHW 2005a), renewed for a further 5 years in 2004;
- the National Housing Data Agreement (NHDA; AIHW 2000a), renewed for a further 5 years in 2003; and
- the Agreement on National Indigenous Housing Information (ANIHI; AIHW 2000b), renewed in 2003.

A similar agreement in the health sector was renewed in 2004 (AIHW 2005b).

Under each of these agreements, information management groups, data committees and working groups are established to promote the development, collection and use of nationally consistent statistics. In addition, within program areas, groups of administrators support the development of nationally consistent data collections across jurisdictional boundaries. Such groups include the National Disability Administrators, Home and Community Care Officials, the Supported Accommodation Assistance Program Coordination and Development Committee and the Australasian Juvenile Justice Administrators. Under the new NCSIA—negotiated in 2004—each of these groups

has become a signatory to a Schedule to the Agreement as indication of their commitment both to the principles of the NCSIA and to participating in achieving its objectives.

The goal pursued within the context of these national arrangements (for more quality and consistency in national statistics) is supported by a national metadata infrastructure for the development, processing, management and dissemination of data standards. This infrastructure has been developed and maintained by the AIHW since 1997. It has comprised the National Data Dictionaries and the Knowledgebase which has now been redeveloped and is replaced by *METeOR*, the Institute's new metadata online registry which is available at <www.meteor.gov.au>.

METeOR was launched in mid-2005 as Australia's repository for national data standards for the health, community services and housing assistance sectors. It will facilitate the work of the national community services and housing information management committees in promoting greater consistency and comparability across community services and housing assistance data. It also fulfills the same role for health data and contributes to greater consistency of data across the health, housing and community services sectors. Activities to date have involved the re-engineering of existing national standards from the original metadata registry (the Knowledgebase) into a format consistent with recent international standards for metadata registries.

National community services information management

The development and management of the NCSIA and related structures and processes is the responsibility of the National Community Services Information Management Group (NCSIMG) which is a subcommittee of the Community Services Ministers' Advisory Council. Membership of the Management Group comprises representatives of signatories to the NCSIA and the groups of administrators who signed Schedules to the Agreement. The Advisory Council appoints one of its members as Chair of NCSIMG.

NCSIMG has established the National Community Services Data Committee (NCSDC), sector-specific working groups and ad hoc project groups to assist in its work. The NCSDC and ad hoc project groups undertake NCSIMG projects that cut across community services sub-sectors. The NCSDC also has oversight of the National Community Services Data Dictionary.

The NCSIMG and its working groups are responsible for an extensive work program of data development across the community services sector. The NCSDC Communication Strategy, which aims to promote the benefits of nationally consistent data standards within the sector, was endorsed. Specific plans have been developed in consultation with several jurisdictions and non-government organisations to implement the strategy. NCSIMG, principally through the activities of the Data Committee, has also been actively involved in the development of *METeOR*.

Since 1999, national community service information development has been guided by the priorities set down in the National Community Services Information Development Plan (AIHW 1999). This first Plan was developed by NCSIMG and approved by CSMAC. The program of work priorities identified in the initial plan has been completed. During 2005 the NCSIMG developed a draft National Community Services Information Strategic Plan to guide its work program over the next 5 years.

The draft plan was the subject of extensive consultation with both government and non-government sectors. The final version is scheduled for release in December 2005 (AIHW forthcoming). The strategic plan outlines key priorities under the following three domains:

- maintaining and strengthening national data standards infrastructure to support information activities across the community services sector;
- improving the scope and quality of sector-specific data and information for reporting and monitoring within program areas; and
- developing cross-sectoral data that crosses program boundaries, and recognises the growing need for person-centred rather than program-centred information.

National housing information management

The 2003 Commonwealth-State Housing Agreement (CSHA) continued the arrangement established in 1999 to include a subsidiary NHDA. The agreement is managed by the National Housing Data Agreement Management Group which includes representatives of all jurisdictions, the AIHW and the ABS. The 2003 CSHA also strengthened existing arrangements to resource national data development work in Indigenous housing assistance, continuing the ANIHI. The ANIHI is managed by the National Indigenous Housing Information Implementation Committee. This approach provides a commitment to the development and provision of nationally consistent data and continues, for the duration of the current CSHA, the partnership between the Housing Ministers' Advisory Council and the AIHW to resource national data development work.

As part of the agreements around the 2003 CSHA, a joint review was undertaken of both the NHDA and the ANIHI. The extensive review process reported back to the Advisory Council in August 2004; the recommendation was that both agreements be retained for the duration of the 2003 CSHA. Some modifications were, however, introduced.

Whereas formerly the National Housing Data Development Committee was a subcommittee of the Management Group, from August 2004 the committee was tasked with supporting the work of both the Management Group and Implementation Committee. This joint approach ensures shared expertise across the full range of data development and reporting. The development of common approaches across the CSHA and related programs to defining and measuring need, alignment of national reporting requirements and the use of common standards should be further supported under this arrangement. This new working relationship also recognises that housing assistance to Indigenous Australians is a key component of the 2003 CSHA.

Also as a result of the review, the Management Group now reports to the Advisory Council through the Advisory Council's Policy and Research Working Group, whereas under the 1999 CSHA it had reported directly to the Advisory Council. This change brings a greater interaction between the data and the policy and research agendas of housing ministers. The Implementation Committee reports to the Advisory Council through the Standing Committee on Indigenous Housing.

The NHDA identifies three major work areas comprising development of national minimum data sets, national performance indicators and national data definitions and standards. The work program also meets the national CSHA performance reporting requirements for the Council of Australian Governments' Review of Government Services. The work program for Indigenous housing data development work supports the Standing Committee's national reporting framework. The major component of the work program for Indigenous housing data development is improving the data for the National Reporting Framework for Indigenous Housing. The framework is a set of 37 performance indicators used to monitor changes in housing conditions for Indigenous Australians. The focus of data development work will be on improving the quality of data reported for the Indigenous community housing sector and on developing new measures of dwelling condition.

National Indigenous information development

Improving the quality and quantity of information available on Aboriginal and Torres Strait Islander people within community services and housing assistance data collections continues to be an area where national statistical agencies, particularly the ABS and the Institute, take an active role across all their collections. Efforts to improve Indigenous statistics in the community services and housing areas are driven by the information governance bodies and articulated through the national information plans and agreements described above.

A number of national statistical surveys and reports describing the information available on Indigenous Australians in the community services and housing assistance areas are conducted or produced regularly. Most recently these include: the National Aboriginal and Torres Strait Islander Social Survey (ABS 2004); the biennial report *The Health and Welfare of Australia's Aboriginal and Torres Strait Islander peoples* (ABS & AIHW 2005); the reports on *Overcoming Indigenous disadvantage: key indicators 2005* (SCRGSP 2005), *Indigenous housing indicators 2003–04* (AIHW 2005c) and *State Owned and Managed Indigenous Housing for 2003–04* (AIHW 2005d).

In addition, an assessment of the quality of Indigenous identification in a number of national community services data collections—covering disability services, child protection, aged care and homelessness collections—has been undertaken (AIHW 2004a). The results will assist in furthering the quality of Indigenous identification for those specific national collections.

In the area of juvenile justice, where a new NMDS has been implemented, the ABS standard question on Indigenous status is one of the items collected. The recently agreed Children's Services National Minimum Data Set also includes data items on the Indigenous status of both children and workers which matches the standard question recommended by the ABS.

In mainstream housing data collections, a number of jurisdictions have introduced processes to improve the quality of their Indigenous identification and the number of new households in public housing with 'unknown' Indigenous status is much lower than for all households.

National data dictionaries

National Community Services Data Dictionary

The National Community Services Data Dictionary is the reference on agreed data definitions and information standards of relevance to the community services sector. In essence, the aim is to provide a 'common language' for the various agencies and governments involved in community services.

Version 3 of the dictionary (NCSDC 2004) contains the first set of data definitions common to both this dictionary and the National Health Data Dictionary (AIHW 2004b). It also includes refinement of existing items, in particular for consistency with the International Classification of Functioning, Disability and Health (WHO 2001) and to take account of a review by the ABS on conformity with ABS standards used for population and household surveys. Subsequent versions of the dictionary will be produced electronically using *METeOR*.

Further work will continue to align data definitions between the community services, health and housing sectors where possible and desirable, and to improve access to national data standards for use in national data collections and national minimum data sets.

The dictionary is an initiative under the NCSIA, and all signatories to the agreement have agreed to use the dictionary as the authoritative source of information about endorsed metadata for use in data collections in the community services field. The data standards outlined in the dictionary are compiled by the NCSDC under the auspices of the NCSIMG.

National Housing Assistance Data Dictionary

The National Housing Assistance Data Dictionary is part of the national data infrastructure for housing assistance information development. It provides the basis for consistent national data and is designed to make data collection activities more efficient by providing standards for core data items, and more effective by ensuring that information to be collected is appropriate for its purpose. The dictionary is also designed to be compatible with national data dictionaries in other relevant sectors.

Version 3 of the dictionary (AIHW forthcoming) is scheduled for release in late 2005. It will incorporate new data items related to Indigenous housing and community housing and the specification of performance indicators under the 2003 CSHA National Performance Indicator Framework. In addition, it will contain updated data standards and data items from the previous two versions, which includes the alignment of a number of data definitions with the health and community services sectors.

The dictionary is compiled under the direction of the National Housing Data Development Committee, operating under the auspices of both the Management Group and Implementation Committee. The dictionary forms the basis for six national collections relating to the CSHA, and is used to guide other related collections and initiatives such as the National Social Housing Surveys conducted at the direction of the National Housing Advisory Council and managed by the AIHW.

9.2 Sector-specific and cross-cutting data development activities

Child, youth and family services

Since 2003, significant data development work has been undertaken in the area of child, youth and family services, contributing substantially to national welfare information infrastructure. These activities relate to child protection, children's services and juvenile justice.

The AIHW, working in conjunction with the National Child Protection and Support Services subcommittee of NCSIMG has developed and agreed a draft national minimum data set for the National Child Protection Data Collection. This developmental work shifts the collection to a unit record base, and will be pilot tested early in 2006. The subsequent collection, scheduled for implementation from 1 July 2006, will provide a much richer data source with substantially improved analytic potential, enabling improved national reporting on what is happening to children in the child protection system.

The development phase (including extensive consultations and pilot testing) of the Children's Services National Minimum Data Set (CS NMDS) for child care and preschool services is now complete (AIHW 2004c). This project was undertaken by the AIHW at the request of NCSIMG, under the direction of the Children's Services Data Working Group (a subcommittee of NCSIMG). Full pilot testing of all data items was completed in September 2004, and the final report on the development of the CS NMDS and the data dictionary are scheduled for release in late 2005. NCSIMG has approved the CS NMDS and commenced discussions about implementation processes and associated funding requirements.

At the request of the Australasian Juvenile Justice Administrators, the AIHW has developed, tested and implemented a Juvenile Justice National Minimum Data Set. This work was undertaken under the auspices of these administrators, and with advice and direction from the Juvenile Justice Data Working Group (a subcommittee of the Administrators). The Juvenile Justice NMDS was developed in accordance with the principles set down under the NCSIA, and reviewed and approved by the NCSDC and the NCSIMG (AIHW 2004d). The new collection was successfully implemented by jurisdictions in 2004-05, and a national database established at the AIHW covering 4 years of data, from 2000–01 to 2003–04. The first report is scheduled for release in late 2005 (AIHW forthcoming). This database provides, for the first time, statistical information on all young people under juvenile justice supervision, including not only those on detention but also those under community-based supervision.

Services for people experiencing homelessness

The Supported Accommodation and Assistance Program (SAAP) national data collection was redeveloped, along with the appropriate software updates, and the new 'core data set' implemented on time from 1 July 2005.

Major changes to the data collection that provides an evidence base for SAAP, the major program that supports homeless people, were introduced from 1 July 2005. A review of

the SAAP national data collection (Gleeson & Wilkins 2000) produced a SAAP Information Management Plan (Gleeson et al 2000) which recommended a paradigm shift from data collection to management of information for SAAP service providers. A key characteristic of the plan was to develop a 'core data set' for SAAP.

After extensive consultation with all data collection stakeholders and pilot testing of paper and electronic data collection instruments, a new pared down data set was signed off by the SAAP Coordination and Development Committee. It constitutes a net reduction of six questions (from 29 to 23 items). The questions align more closely with standard data elements collected in other community services data collections and, significantly, the SAAP statistical linkage key will be changed to agree with the linkage key used in other community services data collections such as those relating to HACC and the Commonwealth/State/Territory Disability Agreement. The latter change will provide the potential, once acceptable linkage protocols are developed, to analyse use by homeless clients of other community services over time.

Disability and disability services

A disability question for the 2006 Census has been developed by the ABS in consultation with relevant organisations including the AIHW. The collection of basic disability data in the Census will improve data pertaining to relatively small geographic areas, and will support service planning. Disability in relatively small population subgroups will be more accurately described. Information on the experience of people with disability in key areas such as housing and employment will be more comparable with that of the overall population.

With the aim of improving the quality and consistency of national disability data, the AIHW (as the Australian Collaborating Centre for the WHO Family of International Classifications) is continuing to work on the implementation of the International Classification of Functioning, Disability and Health. National metadata standards are included in *METeOR*. A related data capture tool to assist users to apply the classification has been developed—a Functioning and Related Health Outcomes Module—that:

- can be used to describe health status, outcomes of health interventions, and the need for assistance in areas of human functioning; and
- enable the efficient and effective storage and transmission of data on human functioning in a wide range of human service systems.

The National Minimum Data Set for services funded and provided under the Commonwealth State/Territory Disability Agreement, redeveloped by National Disability Administrators in collaboration with the AIHW, produced the first full year of data for 2003–04. Data from the collection, including new information on informal carers, are included in this report.

Ageing and aged care

Several information-related developments have occurred in the ageing and aged care sector. The inclusion of the disability question in the Census (described above) will be a substantial contribution to the quality of information on disability among older people in Australia, particularly as it pertains to geographical areas.

The Community Care Review (DoHA 2004) highlighted the need for increased comparability and consistency across community care data collections maintained by the Australian Government Department of Health and Ageing. This department is considering ways in which this agenda might be taken forward. As a preliminary step, it has asked the AIHW to undertake a review of its community care data collections, with a focus on areas of consistency and inconsistency in existing collections. This work is scheduled for completion in 2006.

Meanwhile, redevelopment of the HACC NMDS has been undertaken under the auspices of the HACC Data Reform Working Group, which consists of the Australian Government, states and territories, service providers and the AIHW. Version 2 has been finalised, and implementation is scheduled from January 2006. One of the key developments has been the inclusion of measures of dependency for the first time, based on the HACC Screening Tool. Version 1 of the HACC NMDS will continue to be supported for a further period as a transitional arrangement.

Finally, in response to the Review of Pricing Arrangements in Residential Aged Care (Hogan 2004), the Australian Government Department of Health and Ageing has commissioned the development of a new instrument—the Aged Care Funding Instrument—that will serve as a replacement for the Resident Classification Scale. The new instrument is intended to simplify reporting and funding arrangements, and is currently in a testing phase.

Housing assistance

Since 2003, the implementation of the new CSHA has identified areas requiring significant data development work. Unlike previous agreements, the CSHA introduced in July 2003 has an emphasis on Indigenous housing assistance, including access to mainstream housing and affordable housing provision through private and social ventures including community housing.

The specific inclusion of Indigenous housing in general terms rather than just specific to the CSHA Aboriginal Rental Housing Program has led to more cross-cutting data development work. This has led to major data development work on Indigenous housing assistance and mainstream housing assistance requiring housing assistance data to be supplemented with data from community services areas such as Centrelink income support and SAAP homeless data. Significant data development work is being undertaken to: align measures of mainstream and Indigenous housing assistance need; align national mainstream and Indigenous housing assistance reporting; and build mainstream and Indigenous community housing data capabilities.

Improving national data on community housing assistance for both Indigenous and mainstream areas is recognised as a major challenge. To address these data issues, a strategy for improving the quality and coverage of community housing data for the 2003 CSHA was developed and endorsed by the National Housing Data Agreement Management Group in 2004. The guiding principles for this data development work cover:

- recognition of the fundamental differences between the public and community housing sectors;
- engaging the sector;

- consultation with stakeholders;
- ensuring data are appropriate to the purpose;
- minimising collection burden;
- use of data standards; and
- alignment of data development work with other housing, health and community services areas to ensure comparability and reduce duplication.

Related to this has been the development and conduct in 2005 of three National Social Housing Surveys covering public rental housing, mainstream community housing, and state owned and managed Indigenous housing.

Data linkage

In 2004–05 the AIHW established a new unit responsible for driving the integration and linkage of data in the community services sector. The unit was created to facilitate the developed of person-centred rather than program-centred data, in order to support whole-of-government approaches to policy in the community services arena. Linked data sets have long been recognised as essential to understanding the interrelationships between services and client pathways (NCSIMG 2004).

With this new unit, the AIHW has expedited the linkage work already emerging in the ageing and aged care area, and allowed the development of technical and methodological skills relating to data linkage in community services and related areas. An important output from this work is a recommended linkage protocol which ensures—when linking aged care data sets—consistency in linkage procedures over time and across data sets while protecting the privacy of individuals. The work has also generated an aged care data set that made possible the examination of the extent and nature of movements between services, allowing an analytic focus on the flow of clients through the aged care sector rather than simply measures relating to a specific program at a point in time.

Data linkage in community services has progressed in the last couple of years via the use of statistical linkage keys. Different data collections retained different statistical linkage keys, but in the last year or so there has been a shift to promoting the use of a common linkage key (that is, the HACC-type statistical linkage key) across a number of community services data collections, including HACC, disability services, SAAP, child protection and juvenile justice data collections. SAAP has recently piloted and implemented use of the HACC-type statistical linkage key. The adoption of a common statistical linkage key, including clearance by appropriate ethics bodies, would increase the ease of linking community services data sets. In addition to cross-program data linking currently being undertaken in the area of aged care (for example, HACC, Community Aged Care Packages and Residential Aged Care services data linkage; Residential Aged Care services and hospital admissions data linkage), some new possibilities are already being identified; for example, linking child protection data with SAAP data to analyse the extent to which children in out-of-home or institutional care move on to be supported by the SAAP program.

9.3 Conclusion

Throughout Australia there is currently substantial data development activity being undertaken in the community services and housing assistance sectors. This represents a considerable investment of time and resources by governments and the many agencies involved. The complexity of the welfare sector is reflected in the range of committees and working groups which have some influence on the development of community services and housing assistance information.

There are potential benefits, including cost savings, to all agencies, providers and clients from an approach that minimises duplication in data development, collection and reporting activities. A major objective of the NCSIA, NHDA and ANIHI is the development of nationally consistent data. There have been significant achievements towards that end in recent times.

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Appendix tables

Chapter 2 Indicators of Australia's welfare

Table A2.1: Criteria for indicators of welfare

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

Table A2.2: Status of indicators, 2003 and 2005

	2003		2005		Changes between 2003 and 2005
Indicator	**Table heading**	**Data year(s)**	**Table heading**	**Data year(s)**	
Urban air quality	Number of days per year when concentrations of PM10 and ozone exceeded the Air NEPM standard level in selected cities (Table 2.2)	1990–99	Number of days per year when concentrations of PM10 and ozone exceeded the Air NEPM standard level, in major capital cities (Table 2.1)	2000–03	Updated trend data
Access to potable water	—	No national data	—	No national data	None
Reported usual daily intake of fruit and vegetables	Reported usual daily intake of fruit and vegetables, by age (Table 2.3)	2001	Self-reported usual daily intake of fruit and vegetables, by age (Table 2.2)	2001	No updated data
Prevalence of obesity	Rates of obesity in Australian adults, by sex and age (Table 2.4)	2001	Prevalence of overweight and obesity: Australian men and women aged 18 years and over (Table 2.3)	1989–90, 1995 and 2001	Trend data
Housing tenure	Tenure type and composition of households (Table 2.5)	2000–01	Tenure type and composition of households (Table 2.4)	2002–03	Updated data
	Tenure type of Indigenous households (no table)	2001	Tenure type of Indigenous households (Table 2.5)	2002	Updated data
Housing affordability	Households in the two lowest gross weekly income quintiles: households that spent more than 30% and more than 50% of their gross income on housing costs, by tenure type (Table 2.6)	1999	Households with equivalised disposable incomes in the bottom 40%: households that spent between 30–50% and more than 50% of their gross income on housing costs, by tenure type (Table 2.6)	2002–03	Updated data based on equivalised disposable income; different definition of housing costs applied.
Homelessness	The whereabouts of homeless people on Census night (Table 2.7)	1996	The whereabouts of homeless people on Census night (Table 2.7)	1996 and 2001	Added 2001 data
Life expectancy	Life expectancy, by Indigenous status (Table 2.8)	1999–2001	Life expectancy, by Indigenous status (Table 2.8)	1996–2001 Indigenous Australians 1998–2000 All Australians	Updated data

(continued)

Table A2.2 (continued): Status of indicators, 2003 and 2005

	2003		2005		Changes between 2003 and 2005
Indicator	**Table heading**	**Data year(s)**	**Table heading**	**Data year(s)**	
Life expectancy *(continued)*	Life expectancy at birth, by quintile of socioeconomic disadvantage (Table 2.9)	1995–97	Life expectancy at birth and at age 65, by quintile of socioeconomic disadvantage (Table 2.9)	2000–01	Updated data
Expected years of life with disability	Expected years of life with disability and with severe core activity limitation (Table 2.11)	1998	Expected years of life with disability and with severe or profound core activity limitation (Table 2.10)	1998 and 2003	Updated data
Infant mortality	Average infant mortality, by Indigenous status (Table 2.10)	1999–2001	Indigenous Infant mortality rates, WA, SA and NT (Table 2.11)	1991–2002	Updated trend data; inclusion of only Indigenous rates for WA, SA and NT
Mental health	Number and proportion of the adult population reporting very high levels of psychological distress, by age and sex (Table 2.12)	2001	Number and proportion of the adult population reporting very high levels of psychological distress, by age and sex (Table 2.12)	2001	No updated data
Physical activity	Proportion of persons aged 18 years and over whose physical activity levels were considered sedentary (no table)	1997–2000	Proportion of persons aged 18 years and over whose physical activity levels were considered sedentary (no table)	1997–2000	No updated data; inclusion of children's sedentary activity
Feelings of safety	Proportion of persons who felt safe or very safe at home alone during the day, and after dark (no table)	2002	Proportion of persons who felt safe or very safe at home alone during the day, and after dark (no table)	2002	No updated data
Victims of crime	Victims of crime, by sex, age and offence category (rate per 100,000 persons) (Table 2.13)	2002	Victims of crime, by sex, age and offence category (rate per 100,000 persons in age group) (Table 2.13)	2003	Updated data
Injury	Injury and poisoning deaths, by sex and type of injury (Figure 2.3)	1990–2000	Injury and poisoning deaths, by sex and type of injury (Figure 2.3)	1993–2003	Updated trend data
Participation in education	Proportion of the population aged 15–64 participating in education (full-time or part-time), population subgroups, by age (Table 2.14)	2001	Proportion of Australians aged 15–64 participating in education, by type of educational institution (no table)	2004	Participation broken down by educational institution due to absence of new, published data on population subgroups

	2003		2005		Changes between 2003 and 2005
Indicator	**Table heading**	**Data year(s)**	**Table heading**	**Data year(s)**	
Participation in education *(continued)*	Year 12 apparent retention rates, by sex and Indigenous status (Table 2.15)	2002	Year 12 apparent retention rates, by sex and Indigenous status (Table 2.14)	2004	Updated data
Educational attainment	Level of highest educational attainment, by age (Table 2.16)	2002	Level of highest educational attainment, by age (Table 2.15)	2004	Updated data
Literacy among schoolchildren	Year 3 and Year 5 students achieving national educational benchmarks, by sex and Indigenous status (Table 2.17)	2000	Year 3, 5 and 7 students achieving national educational benchmarks, by sex and Indigenous status (Table 2.16)	1999–2002	Updated trend data; inclusion of national writing and Year 7 benchmarks
Population literacy	Proportion of adults aged 15–74 years with prose and document literacy (no table)	1996	Proportion of adults aged 15–74 years with prose and document literacy (no table)	1996	No updated data
Income and income distribution	Households, equivalent weekly disposable income, by quintile ($) (Table 2.18)	2000–01	Weekly household equivalent disposable income, by quintile ($) (Table 2.17)	2002–03	Median, not mean, discussed in text
			Share of total income received by persons in low-income and high-income households (Table 2.18)	1994–95 to 2002–03	New indicator
Income disadvantage	Income disadvantage: households with equivalent weekly disposable income below 40%, 50% and 60% of the median for all households, and people and children living in those households (Table 2.19)	2000–01	Income disadvantage: households with weekly equivalised disposable income below 40%, 50% and 60% of the median for all households, and people and children living in those households (Table 2.19)	2002–03	Updated data
			Trends in income disadvantage: Australians living in households with weekly equivalised disposable income below 40%, 50% and 60% of the median for all households (Table 2.20)	1995–96 to 2002–03	Trend data
Financial stress and hardship	Households: level of financial stress, by selected life-cycle groups (Table 2.20)	1998–99	Proportion of households reporting 3 or more cash flow problems in last 12 months, and proportion of total population (Table 2.21)	2002	New presentation of indicator

(continued)

Table A2.2 (continued): Status of indicators, 2003 and 2005

	2003		2005		Changes between 2003 and 2005
Indicator	**Table heading**	**Data year(s)**	**Table heading**	**Data year(s)**	
Wealth and wealth distribution	Median household net worth, by household type (Table 2.21)	2000	Assets, debts and net worth per household ($000) (Table 2.22)	2002	New presentation of indicator
Labour force participation	Employment indicators (Table 2.22)	2002	Employment indicators (Table 2.23)	2004	Updated data
Employment basis and conditions	Proportion of part-time workers, by sex (in Table 2.22) Proportion of full-time workers without leave entitlements, by sex (in Table 2.22) Average weekly hours worked, by sex (in Table 2.22)	2002	Proportion of part-time workers, by sex (in Table 2.23) Proportion of full-time workers without leave entitlements, by sex (in Table 2.23) Average weekly hours worked, by sex (in Table 2.23)	2004	Updated data
Employment and labour force differentials	Indigenous labour force status of persons aged 15 years and over (Table 2.23)	2001	Labour force status of persons aged 18 years and over, by Indigenous status (Table 2.24)	2002	Updated data: population excludes 15–17 year olds
Transport	Car use and access (no table)	2001	Access to motor vehicles to drive (Table 2.25)	2002	New indicator
			Ease of getting to places needed (Table 2.26)	2002	New indicator
	Access to public transport (general population) (no table) Access to public transport (people with a disability) (no table)	2000–01 1998	Access to public transport (general population) (no table) Access to public transport (people with a disability) (no table)	2002 (general public) 2003 (people with a disability)	Updated data; general public transport for Sydney residents only
Telephone access	Number of fixed phone lines (no table)	1996 and 2000	Number of fixed phone lines and mobile phones (no table)	1993–2002	New presentation of indicator
Internet access	Household Internet access (no table)		Households with computers and with Internet access, by income quintile and geographic location (Table 2.27)	2002	New indicator
		1990–99	Proportion of people who accessed the Internet at home in last 12 months (Table 2.28)	2002 (in table) 2003 (in text)	Updated data

	2003		2005		Changes between 2003 and 2005
Indicator	**Table heading**	**Data year(s)**	**Table heading**	**Data year(s)**	
Overall pattern of time use	Overall pattern of time use: main activity (no table)	1997	Overall pattern of time use: main activity (no table)	1997	No updated data
Overall pattern of recreation and leisure activities	Average daily time spent on recreation and leisure as main activities, by sex (Table 2.24)	1997	Time spent on recreation and leisure as main activities, by sex (Table 2.29)	1997	No updated data
	Average daily time spent on recreation and leisure, by age and sex (Table 2.25)	1997	—	—	Indicator removed
Recreation and employment	Average daily time spent on recreation and leisure as main activities, by employment status and sex (Table 2.26)	1997	Time spent on recreation and leisure as main activities, by employment status and sex (Table 2.30)	1997	No updated data
Family formation	Social marital status, by sex and age (Table 2.27)	2001	Social marital status of Australians aged 15 years and over (Table 2.31)	1991, 1996 and 2001	Trend data; not broken down by age or sex
	Australian family types (Figure 2.4)	2001	Australian family types (Table 2.32)	1976–2001	Trend data
	Age-specific divorce rates (Table 2.28)	1991 and 2001	Age-specific divorce rates (Table 2.33)	1983, 1993 and 2003	Trend data; divorce rates calculated per resident males and females
Family functioning	No indicator developed		No indicator developed		
Domestic violence	Domestic violence: Australians who were assaulted by a partner, ex-partner or other family member (Table 2.29)	2002	Proportion of women who had been a victim of male intimate partner violence in last 12 months and in lifetime (no table)	2003	Updated data
			Proportion of clients stating domestic violence as the main reason seeking SAAP assistance (no table)	1996–1997 to 2003–04	Trend data
Child abuse and neglect			Rates of children aged 0–16 per 1,000 who were the subject of a child protection substantiation, by state and territory (Table 2.34)	1998–99 to 2003–04	Trend data

(continued)

Table A2.2 (continued): Status of indicators, 2003 and 2005

	2003		2005		Changes between 2003 and 2005
Indicator	**Table heading**	**Data year(s)**	**Table heading**	**Data year(s)**	
Child abuse and neglect *(continued)*	Rates of children who were the subject of a child protection substantiation, by age, Indigenous status, and state and territory (Table 2.30)	2001–02	Rates of children who were the subject of a child protection substantiation, by age, Indigenous status, and state and territory (Table 2.35)	2003–04	Updated data
Social and support networks	Frequency of contact with family and friends	No national data	Australians who were in contact in the last week with family and friends living outside the household (Table 2.36)	2002	New indicator
	Access to social support in times of crisis	No national data	Sources of support in times of crisis, by age group (Table 2.37)	2002	New indicator
Social detachment	Rates of imprisonment, by age, sex and Indigenous status (Table 2.31)	2002 (30 June)	Rates of imprisonment, all prisoners and Indigenous prisoners (Table 2.38)	1994–2004 (30 June)	Trend data, not broken down by age or sex
Trust	Per cent of Australian population who felt they could trust most people (no table)	1995–96	Per cent of Australian population who felt they could trust most people (no table)	2003	Updated data
	Level of confidence in selected institutions (Table 2.32)	1983, 1995 and 2001	Levels of confidence in selected institutions (Table 2.39)	1983, 1995, 2001 and 2003	Trend data; added additional year of data
Community engagement	Participation in voluntary work: time spent, by age and sex (Table 2.33)	1995 and 2000	Participation in voluntary work in last 12 months, by age and sex (Table 2.40)	1995, 2000 and 2002	Trend data; added additional year of data; presented as per cent involved in voluntary work only
	People who made monetary donations to charities and non-profit organisations, by volunteer status (Table 2.34)	2000	People who made monetary donations to charities and non-profit organisations, by volunteer status (Table 2.41)	2000	No updated data
Civic engagement	No indicator developed	No national data	Active membership in various civic organisations (Table 2.42)	2003	New indicator

Table A2.3: Injury deaths, by age, sex, and type of injury, 2003 (number and rate per 100,000 population)

	Transport		Poisoning		Falls		Suicide		Homicide		All injuries/ poisoning	
Sex/ age	**No.**	**/100,000**	**No.**	**/100,000**	**No.**	**/100,000**	**No.**	**/100,000**	**No.**	**/100,000**	**No.**	**/100,000**
Males												
0–4	26	4.0	1	0.2	0	0.0	0	0.0	8	1.2	73	11.3
5–14	42	3.0	0	0.0	1	0.1	6	0.4	3	0.2	70	5.0
15–19	171	24.3	11	1.6	14	2.0	89	12.6	12	1.7	333	47.3
20–29	311	22.5	112	8.1	25	1.8	342	24.7	54	3.9	945	68.3
30–44	342	15.3	204	9.1	39	1.7	609	27.2	73	3.3	1,444	64.5
45–64	276	11.6	84	3.5	75	3.2	453	19.1	37	1.6	1,122	47.3
65+	168	14.8	22	1.9	516	45.5	237	20.9	10	0.9	1,282	113.0
Total males	*1,336*	*13.5*	*434*	*4.4*	*671*	*6.8*	*1,737*	*17.6*	*198*	*2.0*	*5,273*	*53.4*
Females												
0–4	20	3.2	2	0.3	2	0.3	0	0.0	11	1.8	78	12.7
5–14	30	2.3	0	0.0	1	0.1	7	0.5	5	0.4	55	4.2
15–19	53	7.9	9	1.3	3	0.4	24	3.6	5	0.7	105	15.6
20–29	74	5.5	31	2.3	2	0.1	66	4.9	20	1.5	220	16.2
30–44	86	3.8	68	3.0	10	0.4	172	7.6	20	0.9	401	17.7
45–64	92	3.9	50	2.1	24	1.0	152	6.4	10	0.4	390	16.5
65+	120	8.5	35	2.5	734	52.0	56	4.0	11	0.8	1,227	86.9
Total females	*475*	*4.7*	*195*	*1.9*	*776*	*7.8*	*477*	*4.8*	*82*	*0.8*	*2,476*	*24.7*
Persons												
0–4	46	3.6	3	0.2	2	0.2	0	0.0	19	1.5	151	11.9
5–14	72	2.7	0	0.0	2	0.1	13	0.5	8	0.3	125	4.6
15–19	224	16.3	20	1.5	17	1.2	113	8.2	17	1.2	438	31.8
20–29	385	14.1	143	5.2	27	1.0	408	14.9	74	2.7	1,165	42.5
30–44	428	9.5	272	6.0	49	1.1	781	17.3	93	2.1	1,845	40.9
45–64	368	7.8	134	2.8	99	2.1	605	12.8	47	1.0	1,512	31.9
65+	288	11.3	57	2.2	1,250	49.1	293	11.5	21	0.8	2,509	98.6
Total	**1,811**	**9.1**	**629**	**3.2**	**1,447**	**7.3**	**2,214**	**11.1**	**280**	**1.4**	**7,749**	**39.0**

Note: The 5 topics reported here do not include all injury deaths. Some categories of injury death, such as burns, fire and scalds, are not listed separately here but are included within the injuries/poisoning total.

Source: AIHW National Injury Surveillance Unit processed, checked and combined the relevant data years to facilitate analysis.

Table A2.4: Injury deaths per 100,000 population,(a) by sex and type of injury, 1993–2003

	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003
Males											
Transport	18.7	17.8	18.2	18.0	15.6	15.3	15.6	15.5	15.7	14.5	13.6
Poisoning	2.6	2.3	2.5	2.8	2.5	4.8	8.4	6.0	4.4	3.8	4.4
Falls	7.5	7.9	7.6	8.2	7.6	8.0	8.5	8.0	8.2	8.7	8.3
Suicide	19.6	21.0	21.1	21.5	23.6	23.2	21.6	19.9	20.3	18.8	17.7
Homicide	2.4	2.4	2.3	2.4	2.4	2.2	2.2	2.1	2.1	2.0	2.0
Total males	*61.0*	*61.0*	*60.6*	*62.9*	*61.8*	*63.3*	*65.5*	*61.0*	*59.2*	*56.6*	*55.6*
Females											
Transport	6.8	7.0	7.5	6.2	6.2	5.8	5.9	5.7	5.1	5.0	4.6
Poisoning	1.2	1.3	1.1	1.0	1.4	1.6	3.0	2.6	2.2	2.0	1.9
Falls	4.9	5.9	5.5	5.8	6.1	6.0	6.1	6.6	5.9	6.6	5.9
Suicide	4.5	4.8	5.5	5.1	6.2	5.6	5.1	5.2	5.3	5.0	4.7
Homicide	1.3	1.3	1.4	1.1	1.2	1.1	1.0	1.2	1.1	1.1	0.8
Total females	*22.0*	*23.2*	*24.4*	*22.4*	*24.2*	*23.6*	*24.7*	*24.9*	*22.8*	*23.3*	*22.2*
Persons											
Transport	12.6	12.3	12.7	12.0	10.8	10.5	10.6	10.5	10.3	9.7	9.1
Poisoning	1.9	1.8	1.8	1.9	1.9	3.2	5.7	4.3	3.3	2.9	3.2
Falls	6.0	6.8	6.4	6.9	6.8	6.9	7.1	7.3	6.9	7.5	6.9
Suicide	11.9	12.8	13.1	13.1	14.7	14.3	13.2	12.3	12.7	11.8	11.1
Homicide	1.8	1.9	1.9	1.8	1.8	1.7	1.6	1.7	1.6	1.5	1.4
All injuries/poisoning	**40.9**	**41.6**	**42.0**	**42.1**	**42.5**	**43.0**	**44.5**	**42.5**	**40.5**	**39.5**	**38.4**

(a) Age-standardised rates per 100,000 population.

Notes

1. Changes observed between 1998 and 1999 are likely to be due, at least in part, to the transition from ICD-9 to ICD-10. Apparent changes in rates during the transition period should be interpreted with special caution, particularly with respect to poisoning, falls and homicide categories.

   Transport: (ICD-9 E800–E848) (ICD-10 V01 to V99)

   Poisoning: (ICD-9 E850–E858, E860–E869) (ICD-10 X40–X49)

   Suicide: (ICD-9 E950–E959) (ICD-10 X60–X84)

   Falls: (ICD-9 E880–E888) (ICD-10 W00–W19; ICD-10 revised for comparability with ICD-9 E880–E888 W00–W19; or X59 and any Multiple Cause code S02, S12, S32, S42, S52, S62, S72, S82, S92, T02, or T14.2)

   Homicide: (ICD-9 E960–E978, E990–E999) (ICD-10 X85 to Y09)

2. The 5 topics reported here do not include all injury deaths. Some categories of injury death, such as burns, fire and scalds, are not listed separately here but are included within the injuries/poisoning total.

Source: AIHW National Injury Surveillance Unit processed, checked and combined the relevant data years to facilitate analysis.

Chapter 3 Children, youth and families

Table A3.1: Employment status of mothers, June 2003 (per cent)

	Age of youngest child (years)				
Hours worked	**0–2**	**3–4**	**5–11**	**12–14**	**15–24***
Full-time	15.1	19.8	26.1	37.6	38.9
Part-time	31.6	40.6	43.3	38.0	35.1
Not employed	53.3	39.7	30.6	24.4	26.0
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**

* Dependent students aged 15–24 years.

Source: ABS 2004f.

Table A3.2: Age structure of interstate migrants, 2001

Age group (years)	Per cent
0–4	7.9
5–9	6.8
10–14	5.6
15–19	7.8
20–24	12.2
25–29	12.3
30–34	11.4
35–39	8.1
40–44	6.6
45–49	5.2
50–54	4.6
55–59	3.9
60–64	2.6
65–69	1.7
70–74	1.2
75+	2.0

Source: ABS 2004c.

Table A3.3: Australian Government-supported child care operational places, 1991–2004

	Long day care centres				
	Community-based[a]	Private-for-profit[b]	Family day care[c]	Outside school hours care[d]	Occasional care/ other[e]
1991	39,567	36,700	42,501	44,449	5,059
1992	40,262	53,210	45,454	48,222	5,634
1993	42,777	61,375	47,855	50,340	5,626
1994	43,399	80,374	51,651	59,840	6,228
1995	44,566	99,909	54,041	64,046	6,365
1996	45,601	122,462	60,091	71,846	6,575
1997	46,294	136,571	62,714	78,970	6,564
1998	51,710	142,844	63,725	134,354	6,722
1999	50,589	139,737	64,037	160,955	6,754
2000	50,368	140,547	66,294	179,743	6,492
2001	61,248	132,561	70,840	230,511	4,867
2002	n.a.	n.a.	n.a.	n.a.	n.a.
2003	64,255	147,390	71,123	229,934	4,952
2004	65,260	164,343	74,508	229,603	4,045

(a) From 2001 includes those operated by community groups, religious organisations, charities, local governments, and by or in state government premises.

(b) Employer and other non-profit centres are included until 2000. In 2001, with the introduction of the Child Care Operator System, data from employer and other non-profit centres were recorded according to ownership status to either community or private.

(c) Also includes family day care schemes offering in-home care, and stand-alone in-home services; 2003 includes planned and pooled places as at 5 September 2003.

(d) The large increase 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 a change to a consistent counting methodology. Includes before and after school care and vacation care; 2003 includes planned and pooled places as at 5 September 2003.

(e) From 1992 to 1997 includes occasional care centres, neighbourhood model services, multifunctional Aboriginal children's services, and multifunctional services. After 1997 excludes neighbourhood model services. For 2004, components of multifunctional children's services are included in the relevant service type categories.

Source: Centrelink administrative data.

Table A3.4: The use of formal and informal child care, 2002 (per cent)

	Age of child (years)								
Type of care	**Under 1**	**1**	**2**	**3**	**4**	**5**	**6–8**	**9–11**	**Total**
Formal and/or informal									
Formal only	4.2	15.7	25.5	37.5	54.1	17.3	8.3	4.7	15.8
Both	2.8	11.2	15.6	25.2	28.8	10.9	4.7	2.6	9.6
Informal only	26.9	30.0	24.0	13.4	5.4	21.5	27.3	25.4	23.3
Total in care	*33.9*	*57.0*	*65.1*	*76.1*	*88.4*	*49.7*	*40.4*	*32.6*	*48.7*
No care used	66.1	43.0	34.9	23.9	11.6	50.3	59.6	67.4	51.3
All children	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
All children ('000)	**242.2**	**247.4**	**249.3**	**252.3**	**250.9**	**257.6**	**793.4**	**806.8**	**3,100.0**

Source: ABS 2003d.

Table A3.5: Qualifications and training of workers in Australia Government-supported child care services, 2004 (per cent)

	Level of qualifications					In-service training in last 12 months		
Type of service	Has qualifi-cations	Studying for qualifi-cations	3+ years' experience	None of these	Total	Training under-taken	No training	Total
Long day care centres	60	16	12	13	100	76	24	100
Community-based	60	11	16	13	100	75	25	100
Private-for-profit	60	18	10	12	100	76	24	100
Family day care coordination unit staff	73	5	14	7	100	87	13	100
Family day care providers	25	6	39	30	100	84	16	100
Before/after school care	40	25	13	22	100	66	34	100
Vacation care	41	25	12	22	100	n.a.	n.a.	n.a.
Occasional care/other[(a)]	47	11	14	28	100	68	32	100

(a) Includes occasional care centres, multifunctional Aboriginal children's services, multifunctional children's services and in-home care services.

Notes

1. Double-counting may occur for workers in before/after school care and vacation care services.
2. Each worker has been counted once for level of qualifications and once for in service training. However, a qualified worker may also be studying for a qualification and/or have 3 or more years experience.
3. These data are weighted (adjusted for agency non-response).
4. Workers include paid and unpaid workers.
5. Vacation care does not report on in-service training undertaken by staff.
6. Some rows may add to less than or greater than 100 due to rounding.

Source: FaCS 2005.

Table A3.6: Combinations of study and work, 1998 and 2004

	15–19 year olds				20–24 year olds			
	1998	2004	1998	2004	1998	2004	1998	2004
Work/study combinations	Number ('000)		Per cent		Number ('000)		Per cent	
Full-time study and full-time work	5.7	8.6	0.4	0.6	8.1	15.6	0.6	1.1
Full-time study and part-time work	305.0	370.6	23.5	27.0	111.8	174.9	8.3	12.6
Part-time study and full-time work	75.2	71.5	5.8	5.2	117.2	103.3	8.7	7.4
Part-time study and part-time work	10.9	16.6	0.8	1.2	25.8	37.3	1.9	2.7
Full-time study only[(a)]	574.0	565.4	44.3	41.2	128.3	169.5	9.6	12.2
Full-time work only	131.6	142.9	10.1	10.4	599.5	570.1	44.6	41.1
Population in age group ('000)	1,296.8	1,373.1	. .	. .	1,343.0	1,387.8	. .	. .

(a) Employment status of unemployed or not in the labour force.

Source: ABS 2004h.

Table A3.7: Trends in labour force participation of young people, 1983–84 and 2003–04 (per cent)

	15–19 year olds		20–24 year olds	
Employment status	**1983–84**	**2003–04**	**1983–84**	**2003–04**
Employed full-time	33.36	16.98	62.53	50.77
Employed part-time	13.04	33.72	7.97	23.13
Unemployed	14.10	9.45	11.19	7.21
Not in the labour force	39.46	39.88	18.27	18.93
Population ('000)	1,278.7	1,383.3	1,328.1	1,393.3

Source: ABS 2005b.

Table A3.8: Aboriginal and Torres Strait Islander children in out-of-home care by whether placed in accordance with the Aboriginal Child Placement Principle, at 30 June 2004

Relationship	**NSW[(a)]**	**Vic**	**Qld**	**WA**	**SA**	**TAS**	**ACT**	**NT**
				Number				
Indigenous relative/kin	n.a.	98	326	282	37	3	26	67
Other Indigenous caregiver	n.a.	117	236	127	131	3	5	53
Other non-Indigenous relative/kin	n.a.	81	42	33	15	13	3	n.a.[(b)]
Indigenous residential care	n.a.	12	3	28	—	—	1	—
Total in accordance with the Principle	*n.a.*	*308*	*607*	*470*	*183*	*19*	*35*	*120*
Other non-Indigenous caregiver	n.a.	155	351	77	51	28	18	55
Non-Indigenous residential care	n.a.	36	—	33	2	—	5	—
Total not placed in accordance with the Principle	*n.a.*	*191*	*351*	*110*	*53*	*28*	*23*	*55*
Total	n.a.	499	958	580	236	47	58	175
				Per cent				
Indigenous relative/kin	n.a.	20	34	49	16	6	45	38
Other Indigenous caregiver	n.a.	23	25	22	56	6	9	30
Other non-Indigenous relative/kin	n.a.	16	4	6	6	28	5	n.a.[(b)]
Indigenous residential care	n.a.	2	—	5	—	—	2	—
Total in accordance with the Principle	*n.a.*	*62*	*63*	*81*	*78*	*40*	*60*	*69*
Other non-Indigenous caregiver	n.a.	31	37	13	22	60	31	31
Non-Indigenous residential care	n.a.	7	—	6	1	—	9	—
Total not placed in accordance with the Principle	*n.a.*	*38*	*37*	*19*	*22*	*60*	*40*	*31*
Total	n.a.	100	100	100	100	100	100	100

(a) NSW was unable to provide data due to the ongoing implementation of the data system.

(b) The relationship of the caregiver to children placed with other caregivers was not available and these children were places in the 'other Indigenous caregiver' category.

Source: AIHW 2005b.

Table A3.9: Juvenile offenders, 1995–96 and 2001–02 (rate per 100,000 persons)

Offence type	1995–96	2001–02
Homicide	2.5	2.3
Assault	424.4	404.3
Sexual assault	10.1	13.4
Robbery	83.1	82.1
Motor vehicle theft	533.3	394.6
Unlawful entry with intent	1,120.1	771.5
Other theft	2,371.9	1,246.6
Fraud	119.0	87.8

Source: AIC 2003: figure 49.

Table A3.10: Juvenile justice clients aged 10–17 years, supervised in the community and in detention centres, at 30 June 2004[a, b, c]

	NSW	Vic[(d)]	Qld[(e)]	WA[(f)]	SA	Tas	ACT	NT
				Number				
Community	209	65	94	118	63	28	17	10
Detention	991	597	1232	607	449	514	167	135
				Per cent				
Community	82.6	90.2	92.9	83.7	87.7	94.8	90.8	93.1
Detention	17.4	9.8	7.1	16.3	12.3	5.2	9.2	6.9

(a) Only those young people who are under the supervision or case management of juvenile justice departments on a pre or post sentence legal arrangement or order are included (e.g. young people on supervised bail, remand, a community services order, parole and in detention).

(b) The table does not include juvenile justice clients over 17 years of age at 30 June 2004.

(c) Clients may be on multiple orders at any one time. The distribution is therefore not based on order type but where the client was located at 30 June 2004.

(d) Children's court legislation in Vic applies to persons aged 10–16 years. However, Vic has a dual track system for persons aged 17–20 years at the time of sentencing in the adult court system. Such persons may be sentenced to the juvenile justice system but there is no provision for detaining persons aged 17 years and over who are only on remand. Vic detention count excludes clients on imprisonment and adult correction orders. Clients in detention do not include those custodial clients that have escaped; however, these clients are included in calculating 100% of Vic clientele.

(e) Legislation applies to those young people who were aged 10–16 years at the time of the offence. The data do, however, include those 17 year olds who were still on supervision in the juvenile justice system at 30 June 2004.

(f) Exclude persons subject to Juvenile Justice Team Referrals.

Source: SCRCSSP 2005.

Table A3.11: Indigenous and other Australians aged 10–17 years in juvenile detention (rate per 100,000 relevant population as at 30 June), 1994 -2003

	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003
Indigenous	413.9	389.7	406.4	429.9	422.5	357.5	323.9	318.1	281.4	320.9
Other Australian	24.3	26.5	24.8	22.9	22.0	19.0	17.8	15.1	13.5	16.1

Source: AIC 2004: tables 5b, 5d.

Chapter 4 Ageing and aged care

Table A4.1: Carers receiving Carer Payment and Carer Allowance, 4th quarter 2004 (number)

	Carer Payment			Carer Allowance		
Carer age	**Males**	**Females**	**Persons**	**Males**	**Females**	**Persons**
Carer looking after person(s) aged under 65						
<25	n.a.	n.a.	n.a.	1,254	3,743	4,997
25–44	n.a.	n.a.	n.a.	10,824	94,413	105,237
45–64	n.a.	n.a.	n.a.	20,396	63,606	84,002
65–74	n.a.	n.a.	n.a.	4,986	5,050	10,036
75+	n.a.	n.a.	n.a.	665	1,995	2,660
Total	**n.a.**	**n.a.**	**n.a.**	**38,125**	**168,807**	**206,932**
Carer looking after person(s) aged 65+						
<25	n.a.	n.a.	n.a.	263	390	653
25–44	n.a.	n.a.	n.a.	3,299	6,182	9,481
45–64	n.a.	n.a.	n.a.	9,180	32,305	41,485
65–74	n.a.	n.a.	n.a.	10,574	23,110	33,684
75+	n.a.	n.a.	n.a.	15,375	17,551	32,926
Total	**n.a.**	**n.a.**	**n.a.**	**38,691**	**79,538**	**118,229**
All carers						
<25	1,318	2,061	3,379	1,518	4,123	5,641
25–44	8,947	15,693	24,640	14,118	100,573	114,691
45–64	20,197	39,945	60,142	29,452	95,235	124,687
65–74	1,091	1,337	2,428	15,501	27,993	43,494
75+	169	266	435	16,024	19,493	35,517
Total	**31,722**	**59,302**	**91,024**	**76,613**	**247,417**	**324,030**

Notes

1. Recipients may look after more than one person; consequently, the sum of individual constituents may not equal the total. People may receive both the Allowance and Payment.
2. Carer Allowance figures do not include those carers of a child with a disability who are ineligible for the Allowance but entitled to a Health Care Card due to the care needs of the child.

Source: Centrelink unpublished data: Carer Payment data as at 10 December 2004, Carer Allowance data as at 7 January 2005.

Table A4.2: Care recipients of carers receiving Carer Allowance, 4th quarter 2004 (number)[(a)]

Age of care recipient	Males	Females	Persons
0–14	74,308	35,011	109,319
15–24	16,303	9,589	25,892
25–44	14,733	12,323	27,056
45–64	37,884	25,436	63,320
65–74	22,744	18,526	41,270
75+	36,717	42,706	79,423
Total	**202,689**	**143,591**	**346,280**

(a) Equivalent information is not available for care recipients of carers receiving the Carer Payment.

Note: Carer Allowance figures do not include those children with a disability who are cared for by a carer who is ineligible for the Allowance but entitled to a Health Care Card due to the care needs of the child.

Source: Centrelink unpublished data, as at 7 January 2005.

Table A4.3: New residential aged care allocations and operational places, 1994–95 to 2003–04

Financial year	New allocations	Increase in operational places
1994–95	2,955	3,459
1995–96	1,253	2,041
1996–97	1,258	2,207
1997–98	—	859
1998–99	2,266	734
1999–00	2,946	511
2000–01	7,642	1,465
2001–02	6,286	2,032
2002–03	5,579	4,537
2003–04	5,889	5,255

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

Source: AIHW 2005b; AIHW analysis of DoHA ACCMIS database as at November 2004.

Table A4.4: Length of stay in a CACP or residential aged care by people aged 65 and over, separations during 2003–04 (per cent)

	CACP	Respite care	Permanent care
<1 week	0.4	8.1	1.9
1–<2 weeks	1.0	22.7	2.3
2–<3 weeks	1.1	32.6	2.1
3–<4 weeks	1.3	13.4	1.9
4–<8 weeks	5.6	16.4	5.7
8–<13 weeks	7.0	5.8	5.0
13–<26 weeks	13.8	0.9	8.7
26–<39 weeks	10.5	0.1	6.2
39–<52 weeks	8.4	—	5.2
1–<2 years	23.3	—	15.8
2–<3 years	13.7	—	11.3
3–<4 years	6.7	—	8.6
4–<5 years	3.1	—	6.2
5–<8 years	3.8	—	11.8
8+ years	0.4	—	7.2
Total	**100.0**	**100.0**	**100.0**
Total (separations)	**12,782**	**43,993**	**47,421**

Notes

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

Source: AIHW analysis of DoHA ACCMIS database as at November 2004.

Table A4.5: Key statistics of clients (aged 65+) of selected aged care services, by country of birth, 2004

	HACC 2003–04	ACAP 2003–04	CACP 30 June 2004	EACH 30 June 2004	Permanent residential care 30 June 2004	Residential respite 2003–04
Use (%)	**Clients**	**Clients**	**Recipients**	**Recipients**	**Residents**	**Admissions**
Australian-born	72.0	75.1	67.9	63.6	74.2	73.1
Overseas-born: main English-speaking countries	10.5	10.5	11.4	11.0	12.5	13.5
Overseas-born: non-English-speaking countries	17.5	14.4	20.7	25.4	13.3	13.4
Total	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*
Total (number)	*537,100*	*150,800*	*25,722*	*646*	*138,754*	*44,068*
Median age 65+ (years)						
Australian-born	80.5	83.6	83.3	80.6	85.9	83.8
Overseas-born: main English-speaking countries	80.9	83.8	83.9	80.7	86.5	84.0
Overseas-born: non-English-speaking countries	78.7	81.5	81.4	79.6	83.7	82.0
All	*80.3*	*83.3*	*83.0*	*80.3*	*85.7*	*83.6*
Ratio of female to male clients						
Australian-born	2.2	1.9	2.7	1.8	2.9	1.8
Overseas-born: main English-speaking countries	1.8	1.7	2.3	1.2	2.7	1.7
Overseas-born: non-English-speaking countries	1.8	1.6	2.4	1.4	2.1	1.5
All	*2.1*	*1.8*	*2.6*	*1.6*	*2.7*	*1.7*
Usage rate (per 1,000 people aged 65+)	**208.8**	**58.6**	**9.9**	**0.2**	**53.3**	**17.1**
Ratio of clients to people 65+ with severe or profound disability (per 1,000 people)	**931.0**	**261.4**	**43.9**	**1.1**	**236.7**	**76.4**

Notes

1. 'Australian-born' includes those born in Australian external territories. The main English-speaking country category for those born overseas comprises people born in New Zealand, Ireland, United Kingdom, United States of America, Canada or South Africa. The non-English-speaking country category for those born overseas comprises people born in other countries.
2. Resident population estimates used to derived usage rates are from those released by the ABS in December 2004. Usage rates over the year are derived using December 2003 population estimates; usage rates as at 30 June 2004 are derived using June 2004 population estimates.
3. Population estimates by disability status are obtained using age/sex disability rates from the ABS 2003 Survey of Disability, Ageing and Carers in conjunction with the estimated resident population for December 2003 and June 2004.
4. Not all HACC agencies submitted data to the HACC MDS. For 2003–04, the proportion of HACC-funded agencies that submitted HACC MDS data differed across jurisdictions, and ranged from 77% to 99%. Actual client numbers will therefore be higher than those reported here.
5. Residential care annual figures exclude transfers between service providers for care of the same type (that is, respite care).
6. All cases with missing data are included in the table, using pro-rating. Missing rates (age, sex and/or country of birth) were as follows. ACAP: 4.3%; HACC: 7.3%; CACP (country of birth only): 6.1%; RACS respite (country of birth only): 0.1%; RACS permanent (country of birth only): 0.8%. For HACC, clients with unknown age (date of birth reported as 1 January 1900 or 1901 (see AIHW: Karmel 2005), or age greater than 110) are assumed to be aged 65 and over.
7. Table does not include clients of Multi-purpose and flexible service places or packages.

Sources: ABS 2004b; AIHW analysis of DoHA ACCMIS database (as at 30 November 2004), AIHW analysis of HACC MDS; Lincoln Centre and AIHW analysis of ACAP MDS v1 and v2.

Table A4.6: Key statistics of clients (aged 50+) of selected aged care services, by Indigenous status, 2004

	HACC 2003–04	CACP 30 June 2004	EACH 30 June 2004	Permanent residential care 30 June 2004	Residential respite 2003–04
Use (%)	Clients	Recipients	Recipients	Residents	Admissions
Indigenous Australians	1.9	3.8	2.1	0.6	1.0
Non-Indigenous Australians	98.1	96.2	97.9	99.4	99.0
Total	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*
Total (number)	*622,300*	*27,416*	*701*	*143,999*	*46,139*
Median age 50+ (years)					
Indigenous Australians	67.4	69.4	(a)	74.8	74.0
Non-Indigenous Australians	78.8	82.7	(a)	85.4	83.3
All Australians	*78.6*	*82.4*	*79.4*	*85.3*	*83.2*
Ratio of female to male clients					
Indigenous Australians	1.8	1.9	(a)	1.3	1.5
Non-Indigenous Australians	2.0	2.5	(a)	2.6	1.7
All Australians	*2.0*	*2.5*	*1.6*	*2.6*	*1.7*
Usage rate (per 1,000 people aged 50+)	**104.5**	**4.5**	**0.1**	**23.9**	**7.7**

(a) Only 15 EACH recipients were identified as Indigenous. Therefore, median age and the female to male ratio data have not been presented.

Notes

1. Resident population estimates used to derived usage rates are from those released by the ABS in December 2004. Usage rates over the year are derived using December 2003 population estimates; usage rates as at 30 June 2004 are derived using June 2004 population estimates.
2. Not all HACC agencies submitted data to the HACC MDS. For 2003–04, the proportion of HACC-funded agencies that submitted HACC MDS data differed across jurisdictions, and ranged from 77% to 99%. Actual client numbers will therefore be higher than those reported here.
3. For a couple of states and territories, in some age groups the numbers of HACC clients identified as Aboriginal and Torres Strait Islanders were close to or greater than the ABS estimates of the corresponding Indigenous population. This suggests that Indigenous status was not well-recorded in the HACC MDS in some states/territories.
4. Figures for CACP recipients and residential care exclude clients of Multi-purpose and flexible services. Residential care annual figures exclude transfers between service providers for care of the same type (that is, respite care).
5. All cases with missing data are included in the table, using pro-rating. Missing rates (age, sex and/or Indigenous status) were as follows. HACC: 10.9%; CACP (Indigenous status only): 1.3%; EACH (Indigenous status only): 4.3%; RACS respite (Indigenous status only): 3.6%; RACS permanent (Indigenous status only): 7.5%. For HACC, Indigenous clients with unknown age (date of birth reported as 1 January 1900 or 1901 (see AIHW: Karmel 2005), or age greater than 110) are assumed to be aged 50 and over; Non-Indigenous clients with unknown age are assumed to be aged 65 and over.
6. Table does not include clients of Multi-purpose and flexible service places or packages.

Sources: ABS 2004b; AIHW analysis of DoHA ACCMIS database as at November 2004, AIHW analysis of HACC MDS.

Table A4.7: Recurrent government expenditure on aged care services, 2000–01 to 2003–04[a] ($m current prices)

Program[b]	2000–01	2001–02	2002–03	2003–04
Residential aged care–subsidies[c]	3,987.0	4,226.9	4,506.7	5,336.0
Residential aged care–resident and provider support[d]	8.7	9.5	15.5	20.4
Community Aged Care Packages	194.6	246.3	287.9	307.9
Home and Community Care[e]	725.1	786.4	853.0	917.1
Veterans' Home Care and in-home respite[f]	23.3	61.9	93.5	91.1
Extended Aged Care at Home	8.4	8.9	10.5	15.5
Day Therapy Centres	28.5	29.3	31.0	31.6
Multi-purpose and flexible services[g]	34.0	40.3	51.4	60.7
National Respite for Carers[h]	68.6	68.5	94.0	101.5
Carer Allowance[i]	179.6	190.5	228.0	326.9
Assessment[j]	39.2	41.0	42.9	48.4
Commonwealth Carelink Centres	12.1	11.5	12.1	13.9
Accreditation	10.4	12.5	11.9	6.5
Flexible care pilot projects	. .	. .	4.6	17.6
Other[k]	20.3	29.4	27.7	26.6
Total	**5,339.7**	**5,763.1**	**6,270.6**	**7,321.7**

(a) Expenditure excludes departmental program administration and running costs. Only state and territory funding for high-level residential aged care subsidies and HACC have been included. Comparisons with ABS welfare expenditure estimates on older people indicate that including other state/territory expenditure would have resulted in an increase in the estimate of expenditure for 2000–01 of about 7% (see AIHW 2003c:5, 9; excludes expenditure on high-level residential care).

(b) To improve coverage, the programs included here have changed slightly from those in the corresponding table in the previous edition of this publication (AIHW 2003a: table 7.13). Consequently, the numbers in the two publications are not strictly comparable. See below for information on expenditure derivation and comparability with previous editions.

(c) Includes DoHA, DVA and state and territory funding. Subsidies are primarily the responsibility of the Australian Government, and the state/territory contribution (high care only included) was between $207 million and $253 million for the 4 years in the table. The state and territory funding for 2003–04 has been estimated based on DoHA administrative data and AIHW calculations.

(d) Includes Australian Government expenditure only. Main expenditures were on: Aged Care Workforce Support (new in 2002–03), the Community Visitors Scheme, the Complaints Resolution Scheme, Culturally and Linguistically Diverse Background grants, and several user rights programs. This expenditure was not included in the previous edition.

(e) Includes Australian and state and territory government funding for the aged (estimated using the percentage of clients aged 65+), and funding for HACC planning and development ($0.4m in 2003–04). Expenditure for 2001–02 has been revised slightly since Australia's Welfare 2003.

(f) Includes funding for all ages (in-home respite was not included in the previous edition).

(g) Includes funding provided for Multi-purpose Services, the National Aboriginal and Torres Strait Islander Aged Care Strategy and for rural/remote multi-purpose centres. Funding for Aged Care Program Support has been moved from this category (where it was included in the 2003 edition of this publication) to 'other' expenditure. In addition, expenditure figures on rural/remote multi-purpose centres for 2000–01 and 2001–02 have been significantly revised since the 2003 edition.

(h) Includes funding for the Carers Information and Support Program ($1.8m in 2003–04).

(i) Carer Allowance expenditure on older people is based on the proportion of care recipients aged 65 and over among those cared for by people receiving the allowance.

(j) Includes funding for the Aged Care Assessment Program and for Targeted Dementia Assessment.

(k) 'Other' comprises Aged Care Program Support, Assistance with Care and Housing for the Aged, Dementia Education and Support program, Safe at Home, the Continence Management program (including the Continence Aids Assistance Scheme), and Psychogeriatric Care Units. This last program was included under 'Assessment' in previous editions, but has been moved for this edition as its focus has shifted from assessment to support services.

Note: Components may not add to total due to rounding.

Sources: AIHW 2003a: table 7.13, AIHW health expenditure database; DoHA unpublished data; DVA unpublished data; FaCS 2003:181, 2004:199.

Table A4.8: Recurrent government expenditure on aged care services,[(a)] expressed as dollars per person aged 65 and over with a profound or severe core activity limitation, 2000–01 to 2003–04

Program[(b)]	2000–01	2001–02	2002–03	2003–04	3-year growth
	Constant 2002–03 prices (dollars)				Per cent
Residential aged care–subsidies	7,976	7,894	7,912	8,787	10.2
Residential aged care–resident and provider support	17	18	27	34	94.3
Community Aged Care Packages	389	460	505	507	30.2
Home and Community Care	1,451	1,469	1,498	1,510	4.1
Veterans' Home Care and in-home respite	47	116	164	150	221.9
Extended Aged Care at Home	17	17	18	25	51.0
Day Therapy Centres	57	55	54	52	-8.8
Multi-purpose and flexible services	68	75	90	100	47.0
National Respite for Carers	137	128	165	167	21.8
Carer Allowance	359	356	400	538	49.8
Assessment	78	77	75	80	1.7
Commonwealth Carelink Centres	24	22	21	23	-5.4
Accreditation	21	23	21	11	-48.4
Flexible care pilot projects	. .	. .	8	29	. .
Other	41	55	49	44	8.1
Total	**10,682**	**10,763**	**11,008**	**12,057**	**12.9**
Estimated population aged 65 and over with a profound or severe core activity limitation ('000)	**538.1**	**554.3**	**569.6**	**586.2**	**. .**

(a) Expenditure excludes departmental program administration and running costs. Only state and territory funding for high-level residential aged care subsidies and HACC have been included. Comparisons with ABS welfare expenditure estimates on older people indicate that including other state/territory expenditure would have resulted in an increase in the estimate of expenditure for 2000–01 of about 7% (see AIHW 2003c:5, 9; excludes expenditure on high-level residential care).

(b) To improve coverage, the programs included here have changed slightly from those in the corresponding table in the previous edition of this publication (AIHW 2003a: table 7.13). Consequently, the numbers in the two publications are not strictly comparable.

Notes

1. See notes to Table A4.7 for information on expenditure derivation and comparability with previous editions. Constant dollar values were calculated using the GFCE deflator, referenced to 2002–03 (see Table 4.24).
2. Per person expenditure rates are based on population estimates for the end of the financial year. Population estimates by disability status are obtained using age/sex disability rates from the ABS 2003 Survey of Disability, Ageing and Carers in conjunction with the estimated resident population. The estimates assume constant disability rates over time within age/sex groups.
3. Components may not add to total due to rounding.

Sources: Table A4.7; ABS 2004b; AIHW analysis of ABS 2003 Survey of Disability, Ageing and Carers.

Table A5.1: All persons: disability status, by sex and age, 2003 ('000)

	Core activity limitation				Schooling or employment restriction only	Without specific limitations or restrictions	All with reported disability	Long-term health condition	No long-term health condition	Total population
	Profound	Severe	Moderate	Mild						
Males										
0–4	14.5	*6.3	**0.4	—	—	*8.5	29.7	40.8	553.2	623.7
5–9	19.2	24.1	*3.9	11.4	*8.3	11.5	78.2	76.0	515.0	669.2
10–14	17.8	24.8	*4.8	15.9	13.9	11.4	88.6	91.0	497.4	676.9
15–24	13.4	17.8	*7.3	28.3	31.2	29.4	127.4	196.4	1,094.0	1,417.8
25–34	11.2	23.0	19.0	34.0	43.0	42.9	173.0	263.6	1,044.8	1,481.4
35–44	15.4	30.7	35.3	41.9	43.1	47.0	213.4	299.9	960.3	1,473.5
45–54	15.3	40.5	60.1	82.2	45.9	45.4	289.4	351.5	705.5	1,346.3
55–64	16.8	52.1	81.1	109.3	36.8	44.2	340.4	328.5	339.9	1,008.8
65–69	11.9	20.9	29.0	53.6	—	31.8	147.2	122.8	76.7	346.7
70–74	15.0	18.6	33.2	56.7	—	21.7	145.2	110.6	38.4	294.3
75–79	29.4	14.1	22.7	60.5	—	12.9	139.6	60.1	32.7	232.5
80–84	24.4	15.8	23.6	35.8	—	*7.7	107.4	31.1	*8.9	147.3
85+	30.4	*9.2	8.7	21.1	—	**1.6	71.1	12.2	*6.6	89.9
Total	*234.8*	*297.8*	*329.1*	*550.7*	*222.1*	*316.1*	*1,950.6*	*1,984.5*	*5,873.3*	*9,808.4*
Females										
0–4	*7.7	*7.3	**1.0	**0.6	—	*7.2	23.8	32.7	542.4	598.8
5–9	*9.5	11.1	**1.3	*7.1	*3.9	*7.1	40.1	61.6	528.3	630.0
10–14	*9.2	13.8	**1.5	*7.1	16.9	*8.9	57.5	69.9	524.7	652.1
15–24	10.7	19.1	13.4	24.6	21.1	33.0	121.9	198.0	1,048.7	1,368.5
25–34	*9.4	23.9	10.9	30.1	32.9	34.1	141.3	307.3	1,018.9	1,467.5
35–44	*8.3	42.8	35.0	50.2	34.1	34.7	205.1	333.5	939.7	1,478.3
45–54	23.9	50.1	73.4	78.7	29.4	33.9	289.4	367.7	686.3	1,343.4
55–64	30.2	57.8	88.0	105.3	23.8	31.7	336.8	347.5	301.8	986.2
65–69	18.9	17.8	34.3	41.7	—	24.3	137.0	144.4	73.1	354.5
70–74	25.3	31.4	41.9	47.1	—	17.1	162.8	120.7	43.5	327.0

	Core activity limitation				Schooling or employment restriction only	Without specific limitations or restrictions	All with reported disability	Long-term health condition	No long term health condition	Total population
	Profound	Severe	Moderate	Mild						
Females (continued)										
75–79	39.6	23.3	33.5	58.1	—	13.0	167.6	89.7	34.7	292.0
80–84	60.4	28.3	20.2	36.1	—	*5.1	150.1	59.6	*9.2	218.9
85+	104.2	21.8	15.2	19.5	—	**1.6	162.4	23.2	*8.2	193.8
Total	*357.4*	*348.6*	*369.6*	*506.4*	*162.1*	*251.7*	*1,995.8*	*2,155.8*	*5,759.3*	9,910.9
Persons										
0–4	22.3	13.6	**1.3	**0.6	—	15.7	53.5	73.4	1,095.6	1,222.5
5–9	28.7	35.1	*5.2	18.5	12.1	18.6	118.2	137.6	1,043.3	1,299.2
10–14	27.0	38.6	*6.3	23.1	30.8	20.3	146.1	160.8	1,022.1	1,329.0
15–24	24.0	36.9	20.7	52.9	52.3	62.5	249.3	394.4	2,142.7	2,786.4
25–34	20.6	46.8	30.0	64.0	75.9	77.0	314.3	571.0	2,063.6	2,948.9
35–44	23.7	73.6	70.3	92.1	77.1	81.7	418.5	633.4	1,899.9	2,951.8
45–54	39.1	90.6	133.5	160.9	75.4	79.3	578.8	719.2	1,391.7	2,689.7
55–64	47.1	109.9	169.1	214.6	60.6	76.0	677.2	676.0	641.7	1,995.0
65–69	30.9	38.7	63.3	95.3	—	56.1	284.2	267.2	149.8	701.2
70–74	40.3	50.0	75.1	103.9	—	38.7	308.1	231.3	81.9	621.3
75–79	69.0	37.5	56.2	118.6	—	25.9	307.2	149.8	67.4	524.5
80–84	84.8	44.1	43.8	71.9	—	12.8	257.5	90.7	18.1	366.3
85+	134.6	31.0	23.8	40.7	—	*3.2	233.4	35.4	14.8	283.6
Total	**592.2**	**646.4**	**698.7**	**1,057.1**	**384.1**	**567.8**	**3,946.4**	**4,140.2**	**11,632.6**	**19,719.3**

Notes

1. Estimates marked with * have an associated relative standard error (RSE) of between 25% and 50% and should be interpreted accordingly.
2. Estimates marked with ** have an associated relative standard error (RSE) of greater than 50% and should be interpreted accordingly.

Source: AIHW analysis of ABS 2003 Survey of Disability, Ageing and Carers confidentialised unit record file.

Table A5.2: All persons: disability status, by sex and age, 2003 (per cent)

	Core activity limitation				Schooling or employment restriction only	Without specific limitations or restrictions	All with reported disability	Long-term health condition	No long-term health condition
	Profound	Severe	Moderate	Mild					
Males									
0–4	2.3	*1.0	**0.1	—	—	*1.4	4.8	6.5	88.7
5–9	2.9	3.6	*0.6	1.7	*1.2	1.7	11.7	11.4	77.0
10–14	2.6	3.7	*0.7	2.4	2.1	1.7	13.1	13.4	73.5
15–24	0.9	1.3	*0.5	2.0	2.2	2.1	9.0	13.9	77.2
25–34	0.8	1.5	1.3	2.3	2.9	2.9	11.7	17.8	70.5
35–44	1.0	2.1	2.4	2.8	2.9	3.2	14.5	20.4	65.2
45–54	1.1	3.0	4.5	6.1	3.4	3.4	21.5	26.1	52.4
55–64	1.7	5.2	8.0	10.8	3.6	4.4	33.7	32.6	33.7
65–69	3.4	6.0	8.4	15.5	—	9.2	42.5	35.4	22.1
70–74	5.1	6.3	11.3	19.3	—	7.4	49.3	37.6	13.1
75–79	12.6	6.1	9.8	26.0	—	5.5	60.1	25.8	14.1
80–84	16.6	10.7	16.0	24.3	—	*5.3	72.9	21.1	*6.0
85+	33.9	*10.2	*9.6	23.5	—	**1.8	79.1	13.6	*7.4
Total	*2.4*	*3.0*	*3.4*	*5.6*	*2.3*	*3.2*	*19.9*	*20.2*	*59.9*
Females									
0–4	*1.3	*1.2	**0.2	**0.1	—	*1.2	4.0	5.5	90.6
5–9	*1.5	1.8	**0.2	*1.1	*0.6	*1.1	6.4	9.8	83.9
10–14	*1.4	2.1	**0.2	*1.1	2.6	*1.4	8.8	10.7	80.5
15–24	0.8	1.4	1.0	1.8	1.5	2.4	8.9	14.5	76.6
25–34	*0.6	1.6	0.7	2.1	2.2	2.3	9.6	20.9	69.4
35–44	*0.6	2.9	2.4	3.4	2.3	2.3	13.9	22.6	63.6
45–54	1.8	3.7	5.5	5.9	2.2	2.5	21.5	27.4	51.1
55–64	3.1	5.9	8.9	10.7	2.4	3.2	34.2	35.2	30.6
65–69	5.3	5.0	9.7	11.8	—	6.8	38.6	40.7	20.6
70–74	7.7	9.6	12.8	14.4	—	5.2	49.8	36.9	13.3
75–79	13.6	8.0	11.5	19.9	—	4.5	57.4	30.7	11.9
80–84	27.6	12.9	9.2	16.5	—	*2.3	68.6	27.2	*4.2
85+	53.8	11.3	7.8	10.1	—	**0.8	83.8	12.0	*4.2
Total	*3.6*	*3.5*	*3.7*	*5.1*	*1.6*	*2.5*	*20.1*	*21.8*	*58.1*

	Core activity limitation				Schooling or employment restriction only	Without specific limitations or restrictions	All with reported disability	Long-term health condition	No long term health condition
	Profound	Severe	Moderate	Mild					
Persons									
0–4	1.8	1.1	**0.1	—	—	1.3	4.4	6.0	89.6
5–9	2.2	2.7	*0.4	1.4	0.9	1.4	9.1	10.6	80.3
10–14	2.0	2.9	*0.5	1.7	2.3	1.5	11.0	12.1	76.9
15–24	0.9	1.3	0.7	1.9	1.9	2.2	8.9	14.2	76.9
25–34	0.7	1.6	1.0	2.2	2.6	2.6	10.7	19.4	70.0
35–44	0.8	2.5	2.4	3.1	2.6	2.8	14.2	21.5	64.4
45–54	1.5	3.4	5.0	6.0	2.8	2.9	21.5	26.7	51.7
55–64	2.4	5.5	8.5	10.8	3.0	3.8	33.9	33.9	32.2
65–69	4.4	5.5	9.0	13.6	—	8.0	40.5	38.1	21.4
70–74	6.5	8.0	12.1	16.7	—	6.2	49.6	37.2	13.2
75–79	13.1	7.1	10.7	22.6	—	4.9	58.6	28.6	12.9
80–84	23.2	12.0	12.0	19.6	—	3.5	70.3	24.8	4.9
85+	47.5	10.9	8.4	14.3	—	*1.1	82.3	12.5	5.2
Total	**3.0**	**3.3**	**3.5**	**5.4**	**1.9**	**2.9**	**20.0**	**21.0**	**59.0**

Notes

1. Estimates marked with * have an associated relative standard error (RSE) of between 25% and 50% and should be interpreted accordingly.
2. Estimates marked with ** have an associated relative standard error (RSE) of greater than 50% and should be interpreted accordingly.

Source: AIHW analysis of ABS 2003 Survey of Disability, Ageing and Carers confidentialised unit record file.

Table A5.3: People with a disability: the highest frequency of need for assistance with core activities, as a proportion of people of a specific disability group based on all conditions by age, 2003 (per cent)

	6+/day	3–5/day	1–2/day	1–6/week	1–3/month	<1/month	Not known (cared accommodation)	No need for help	Total	Total number ('000)
Aged 0–44										
Intellectual	10.7	6.6	14.5	10.9	3.3	3.9	—	50.0	100.0	351.8
Psychiatric	7.2	4.8	9.5	9.6	4.5	4.8	**0.1	59.5	100.0	395.2
Sensory/speech	10.2	7.0	9.6	9.3	3.2	5.0	—	55.6	100.0	345.3
Acquired brain injury[(a)]	7.1	*4.4	*5.1	6.4	*4.4	*5.8	—	66.7	100.0	171.4
Physical/diverse	3.3	2.6	5.4	6.5	3.6	5.1	—	73.5	100.0	900.1
Aged 45–64										
Intellectual	*7.2	*4.9	*7.8	*10.8	*4.4	*7.2	**0.1	57.4	100.0	84.4
Psychiatric	*2.9	4.3	6.5	10.8	3.9	6.6	**0.1	64.9	100.0	326.9
Sensory/speech	*1.9	*2.4	4.7	7.1	3.1	4.0	—	76.5	100.0	382.9
Acquired brain injury[(a)]	*2.5	*3.9	*5.6	7.8	*4.1	*4.2	**0.1	71.8	100.0	146.0
Physical/diverse	1.2	2.3	4.0	7.5	3.2	5.0	—	76.7	100.0	1,143.3
Total under 65										
Intellectual	10.0	6.3	13.2	10.9	3.5	4.6	**0.1	51.5	100.0	436.2
Psychiatric	5.3	4.6	8.1	10.2	4.2	5.6	**0.1	61.9	100.0	722.1
Sensory/speech	5.8	4.6	7.1	8.2	3.2	4.5	—	66.6	100.0	728.3
Acquired brain injury[(a)]	5.0	4.2	5.3	7.1	4.3	5.0	—	69.1	100.0	317.4
Physical/diverse	2.1	2.4	4.7	7.1	3.4	5.1	—	75.3	100.0	2,043.4

	6+/day	3–5/day	1–2/day	1–6/week	1–3/month	<1/month	Not known (cared accommodation)	No need for help	Total	Total number ('000)
Aged 65+										
Intellectual	47.8	17.7	11.3	7.0	*2.7	*2.0	**0.6	10.9	100.0	152.5
Psychiatric	29.3	12.7	11.7	12.3	3.5	*2.5	*0.8	27.3	100.0	295.8
Sensory/speech	12.0	6.3	8.1	9.3	3.1	2.8	*0.5	58.0	100.0	768.0
Acquired brain injury[(a)]	17.2	*7.0	8.5	*7.1	*2.3	*4.8	**0.4	52.7	100.0	120.9
Physical/diverse	9.1	6.2	8.4	10.3	3.7	2.9	*0.4	59.1	100.0	1,307.2
All ages										
Intellectual	19.8	9.3	12.7	9.9	3.3	3.9	**0.2	41.0	100.0	588.7
Psychiatric	12.3	6.9	9.1	10.8	4.0	4.7	*0.3	51.9	100.0	1,017.9
Sensory/speech	9.0	5.4	7.6	8.7	3.1	3.6	*0.2	62.2	100.0	1,496.3
Acquired brain injury[(a)]	8.4	5.0	6.2	7.1	3.8	5.0	**0.1	64.5	100.0	438.3
Physical/diverse	4.8	3.9	6.1	8.3	3.5	4.2	*0.2	68.9	100.0	3,350.6

(a) Acquired brain injury is included in 'physical/diverse' when only four main disability groups are being considered (see Box 5.3).

Notes

1. Estimates marked with * have an associated relative standard error (RSE) of between 25% and 50% and should be interpreted accordingly.
2. Estimates marked with ** have an associated relative standard error (RSE) of greater than 50% and should be interpreted accordingly.

Source: AIHW analysis of ABS 2003 Survey of Disability, Ageing and Carers confidentialised unit record file.

Table A5.4: People aged 45 to 64 with a disability living in households: age at onset of main disabling condition, by disability group (based on main disabling condition), 2003

	Age at onset of main condition				
	0–14	15–44	45–64	Not known	Total
			Number ('000)		
Intellectual	*5.0	**1.4	—	—	*6.4
Psychiatric	*7.3	64.4	38.0	1.2	110.9
Sensory/speech	22.4	45.5	33.0	3.9	104.7
Acquired brain injury[(a)]	**0.3	*2.8	**2.1	—	*5.2
Physical/diverse	57.0	472.9	483.2	4.5	1,017.7
Total	**92.0**	**587.1**	**556.2**	**9.6**	**1,244.9**
			Per cent (sum horizontally)		
Intellectual	*77.7	**22.3	—	—	100.0
Psychiatric	*6.6	58.0	34.3	1.1	100.0
Sensory/speech	21.4	43.4	31.5	3.7	100.0
Acquired brain injury[(a)]	**6.3	*54.4	**39.3	—	100.0
Physical/diverse	5.6	46.5	47.5	0.4	100.0
Total	**7.4**	**47.2**	**44.7**	**0.8**	**100.0**
			Per cent (sum vertically)		
Intellectual	*5.4	**0.2	—	—	*0.5
Psychiatric	*8.0	11.0	6.8	12.6	8.9
Sensory/speech	24.3	7.7	5.9	40.2	8.4
Acquired brain injury[(a)]	**0.4	*0.5	**0.4	—	*0.4
Physical/diverse	62.0	80.6	86.9	47.2	81.7
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**

(a) Acquired brain injury is included in 'physical/diverse' when only four main disability groups are being considered (see Box 5.3).

Notes

1. Estimates marked with * have an associated relative standard error (RSE) of between 25% and 50% and should be interpreted accordingly.
2. Estimates marked with ** have an associated relative standard error (RSE) of greater than 50% and should be interpreted accordingly.

Source: AIHW analysis of ABS 2003 Survey of Disability, Ageing and Carers confidentialised unit record file.

Table A5.5: Children aged under 15 with a disability: disability group by level of core activity limitation and sex, as a percentage of the Australian population of that sex and age, 2003

	Boys		Girls		Children	
	Number ('000)	Per cent	Number ('000)	Per cent	Number ('000)	Per cent
All disabling conditions						
Intellectual	108.0	5.5	58.7	3.1	166.7	4.3
Psychiatric	53.8	2.7	27.1	1.4	81.0	2.1
Sensory/speech	83.7	4.3	45.9	2.4	129.7	3.4
Acquired brain injury[(a)]	18.3	0.9	*4.5	*0.2	22.8	0.6
Physical/diverse	91.5	4.6	62.6	3.3	154.1	4.0
All disabling conditions and severe or profound core activity limitations						
Intellectual	67.1	3.4	33.8	1.8	100.8	2.6
Psychiatric	36.9	1.9	16.6	0.9	53.4	1.4
Sensory/speech	57.6	2.9	32.7	1.7	90.3	2.3
Acquired brain injury[(a)]	*9.9	*0.5	*3.1	*0.2	12.9	0.3
Physical/diverse	49.0	2.5	27.8	1.5	76.8	2.0
Main disabling condition						
Intellectual	61.5	3.1	23.5	1.2	85.0	2.2
Psychiatric	28.5	1.4	18.9	1.0	47.5	1.2
Sensory/speech	36.4	1.8	23.8	1.3	60.2	1.6
Acquired brain injury[(a)]	*2.7	*0.1	**0.3	—	*3.0	*0.1
Physical/diverse	67.4	3.4	54.8	2.9	122.2	3.2
Main disabling condition and severe or profound core activity limitations						
Intellectual	36.5	1.9	13.7	0.7	50.2	1.3
Psychiatric	14.4	0.7	8.4	0.4	22.8	0.6
Sensory/speech	22.6	1.1	15.2	0.8	37.8	1.0
Acquired brain injury[(a)]	**0.5	—	—	—	**0.5	—
Physical/diverse	32.5	1.7	21.5	1.1	54.0	1.4
Total with a disability	**196.5**	**10.0**	**121.4**	**6.5**	**317.9**	**8.3**
Total children under 15	**1,969.8**		**1,880.8**		**3,850.7**	

(a) Acquired brain injury is included in 'physical/diverse' when only four main disability groups are being considered (see Box 5.3).

Notes

1. Estimates marked with * have an associated relative standard error (RSE) of between 25% and 50% and should be interpreted accordingly.
2. Estimates marked with ** have an associated relative standard error (RSE) of greater than 50% and should be interpreted accordingly.

Source: AIHW analysis of ABS 2003 Survey of Disability, Ageing and Carers confidentialised unit record file.

Table A5.6: Average number of health conditions in the population, by disability status and age group, 2003

Disability status	Males	Females	0–64 years	65+ years	Total
Profound	3.79	4.36	3.02	4.85	4.13
Severe	3.22	3.54	2.93	4.42	3.39
Moderate	3.49	3.51	3.10	4.18	3.50
Mild	2.91	2.84	2.58	3.31	2.88
Schooling or employment restriction only	2.13	2.02	2.09	. .	2.09
Disability no limitations or restrictions	2.06	1.98	1.79	2.78	2.03
Health condition only[(a)]	1.47	1.56	1.40	2.00	1.52
Total with a disability	2.94	3.19	2.56	3.98	3.06
Total with a condition[(b)]	2.20	2.34	1.90	3.27	2.27
Total population	**0.88**	**0.98**	**0.65**	**2.84**	**0.93**

(a) Includes people with a health condition but no disability.

(b) Includes people with or without a disability.

Source: AIHW analysis of ABS 2003 Survey of Disability, Ageing and Carers confidentialised unit record file.

Table A5.7: Proportion of profound or severe core activity limitations among people with a specific condition (based on all conditions), by age, 2003 (per cent)

Health condition	Aged under 65	Health condition	Aged 65+	Health condition	All ages
Autism	81.6	Autism	**100	Dementia	96.9
Paralysis	*79.1	ADHD	**100	Paralysis	*85.1
Speech problems	66.7	Dementia	98.0	Autism	81.6
Cerebral palsy	63.5	Paralysis	*89.1	Speech problems	72.5
Dementia	**55.1	Speech problems	86.9	Parkinson's disease	66.4
Multiple sclerosis	*48.4	Cerebral palsy	**84.9	Cerebral palsy	64.0
Epilepsy	41.8	Parkinson's disease	78.6	Multiple sclerosis	*50.8
Schizophrenia	41.1	Schizophrenia	*75.5	Schizophrenia	46.2
ADHD	35.5	Multiple sclerosis	**74.0	Vision disorders (total)	46.0
Stroke	33.4	Epilepsy	64.0	Epilepsy	45.4
Vision disorders (total)	32.1	Depression	59.5	Stroke	45.4
Depression	22.6	Vision disorders (total)	56.5	Glaucoma	39.7
Osteoporosis	21.3	Stroke	49.9	ADHD	35.6
Parkinson's disease	**19.5	Glaucoma	48.3	Osteoporosis	32.5
Cancer	17.9	Osteoporosis	38.3	Heart diseases	31.0
Heart diseases	17.4	Cancer	37.9	Depression	30.3
Hearing disorders (total)	16.1	Heart diseases	37.2	Cancer	28.1
Arthritis	16.1	Migraine	33.6	Hearing disorders (total)	25.0
Back problems	15.3	Hearing disorders (total)	33.1	Arthritis	23.6
Diabetes	14.5	Diabetes	33.0	Diabetes	23.4
Migraine	10.8	Asthma	32.1	Back problems	18.1
Hearing (noise-induced)	10.7	Arthritis	31.4	Hypertension	16.6
Hypertension	10.4	Back problems	27.4	Hearing (noise-induced)	15.7
Asthma	8.9	Hypertension	22.7	Migraine	12.8
Glaucoma	**2.8	Hearing (noise-induced)	21.5	Asthma	11.7

Notes

1. Estimates marked with * have an associated relative standard error (RSE) of between 25% and 50% and should be interpreted accordingly.
2. Estimates marked with ** have an associated relative standard error (RSE) of greater than 50% and should be interpreted accordingly.

Source: AIHW analysis of ABS 2003 Survey of Disability, Ageing and Carers confidentialised unit record file.

Table A5.8: People with a severe profound core activity limitation: prevalence of health conditions, by age, 2003

	Aged under 65 years			Aged 65+			All ages	
Health condition	**Number ('000)**	**Prevalence rate[(a)] (%)**	**Health condition**	**Number ('000)**	**Prevalence rate[(a)] (%)**	**Health condition**	**Number ('000)**	**Prevalence rate[(a)] (%)**
Back problems	207.4	1.2	Arthritis	280.5	11.2	Arthritis	429.1	2.2
Arthritis	148.6	0.9	Hearing disorders (total)	242.6	9.7	Hearing disorders (total)	349.5	1.8
Speech problems	129.3	0.8	Hypertension	210.3	8.4	Back problems	319.4	1.6
Asthma	115.2	0.7	Heart diseases	167.0	6.7	Hypertension	304.9	1.5
Hearing disorders (total)	106.8	0.6	Stroke	126.2	5.1	Heart diseases	203.0	1.0
Hypertension	94.7	0.5	Vision disorders (total)	116.2	4.7	Speech problems	197.0	1.0
Depression	83.8	0.5	Back problems	112.0	4.5	Asthma	171.9	0.9
Migraine	53.4	0.3	Diabetes	100.3	4.0	Vision disorders (total)	166.3	0.8
Vision disorders (total)	50.0	0.3	Dementia	97.3	3.9	Stroke	157.5	0.8
Diabetes	48.1	0.3	Osteoporosis	85.1	3.4	Diabetes	148.4	0.8
Heart diseases	36.1	0.2	Speech problems	67.8	2.7	Depression	142.1	0.7
Epilepsy	33.5	0.2	Depression	58.4	2.3	Osteoporosis	109.7	0.6
ADHD	33.4	0.2	Asthma	56.7	2.3	Dementia	98.8	0.5
Stroke	31.3	0.2	Hearing (noise-induced)	48.3	1.9	Hearing (noise-induced)	76.4	0.4
Hearing (noise-induced)	28.1	0.2	Cancer	37.6	1.5	Migraine	69.4	0.4
Autism	24.7	0.1	Glaucoma	26.9	1.1	Cancer	54.8	0.3
Osteoporosis	24.7	0.1	Parkinson's disease	20.8	0.8	Epilepsy	43.6	0.2
Schizophrenia	18.4	0.1	Migraine	16.0	0.6	ADHD	33.5	0.2
Cancert	17.2	0.1	Epilepsy	*10.2	*0.4	Glaucoma	27.2	0.1
Cerebral palsy	10.4	0.1	Paralysis	*6.2	*0.2	Autism	24.8	0.1
Multiple sclerosis	*6.0	*0.0	Schizophrenia	*5.9	*0.2	Schizophrenia	24.3	0.1
Paralysis	*3.8	*0.0	Multiple sclerosis	**0.9	—	Parkinson's disease	22.2	0.1
Dementia	**1.4	—	Cerebral palsy	**0.3	—	Cerebral palsy	10.7	0.1
Parkinson's disease	**1.3	—	ADHD	—	—	Paralysis	*10.0	*0.1
Glaucoma	**0.4	—	Autism	—	—	Multiple sclerosis	*6.9	—
Total population	**17,222.5**	**. .**		**2,496.8**	**. .**		**19,719.3**	**. .**

(a) Percentage of the Australian population of that age.

Notes

1. Estimates marked with * have an associated relative standard error (RSE) of between 25% and 50% and should be interpreted accordingly.
2. Estimates marked with ** have an associated relative standard error (RSE) of greater than 50% and should be interpreted accordingly.

Source: AIHW analysis of ABS 2003 Survey of Disability, Ageing and Carers confidentialised unit record.

Table A5.9: Disability Support Pension recipients, age- and sex-specific rates and growth rates, 1989–2004

	Age- and sex-specific rates											
	16–19	20–29	30–39	40–49	50–59	60–64	65+	Total aged 16+	Adjusted aged 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	. .	. .
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	10.1
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	4.5
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	25.0	0.2	5.0	5.1	352,607	3.6	0.8
1998	1.5	2.0	3.3	5.0	11.1	24.5	0.3	5.1	5.1	361,539	2.5	0.0
1999	1.6	2.1	3.4	5.2	11.0	24.2	0.2	5.2	5.2	373,340	3.3	0.7
2000	1.6	2.2	3.5	5.4	10.7	23.8	0.2	5.2	5.2	382,351	2.4	–0.1
2001	1.7	2.3	3.6	5.5	10.5	23.4	0.3	5.3	5.2	392,354	2.6	0.3
2002	1.7	2.4	3.7	5.7	10.5	23.1	0.3	5.4	5.2	406,893	3.7	1.4
2003	1.7	2.4	3.7	5.7	10.4	22.3	0.4	5.4	5.2	412,777	1.4	–0.6
2004	1.8	2.5	3.7	5.8	10.2	21.5	0.5	5.4	5.2	418,829	1.5	–0.4
Females												
1989	0.6	0.8	1.1	2.0	3.9	0.2	0.0	1.2	1.4	80,510	. .	. .
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	1.5	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	2.0	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	7.6
1996	0.9	1.3	1.8	3.1	7.2	1.0	0.0	2.2	2.4	158,979	13.8	11.3
1997	1.0	1.4	1.9	3.3	7.9	1.0	0.0	2.4	2.6	174,907	10.0	7.1
1998	1.1	1.4	2.0	3.4	8.1	2.7	0.0	2.6	2.7	191,797	9.7	6.9
1999	1.1	1.5	2.0	3.6	8.3	2.9	0.0	2.7	2.8	204,342	6.5	3.9

(continued)

Table A5.9 (continued): Disability Support Pension recipients, age-and sex-specific rates and growth rates, 1989–2004

	Age- and sex-specific rates											
	16–19	20–29	30–39	40–49	50–59	60–64	65+	Total aged 16+	Adjusted aged 16+	Recipients (number)	Growth rate	Adjusted growth rate
Females (continued)												
2000	1.2	1.6	2.1	3.7	8.4	4.3	0.0	2.9	3.0	219,929	7.6	5.0
2001	1.2	1.6	2.2	3.8	8.5	4.5	0.0	3.0	3.1	231,572	5.3	2.6
2002	1.2	1.7	2.3	4.0	8.8	6.1	0.0	3.2	3.3	252,022	8.8	6.5
2003	1.2	1.7	2.3	4.1	8.8	6.5	0.0	3.3	3.3	260,557	3.4	1.2
2004	1.2	1.8	2.4	4.2	8.8	8.4	0.0	3.5	3.5	277,913	6.7	4.6
Persons												
1989	0.7	0.9	1.4	2.7	6.8	9.8	0.2	2.4	2.6	307,795	. .	. .
1990	0.7	0.9	1.4	2.7	6.8	10.3	0.2	2.4	2.6	316,713	2.9	1.0
1991	0.7	1.0	1.5	2.8	7.0	10.8	0.3	2.5	2.7	334,234	5.5	4.0
1992	1.1	1.1	1.8	3.1	7.6	11.5	0.2	2.8	3.0	378,558	13.3	11.3
1993	1.1	1.2	1.9	3.3	8.1	12.2	0.2	3.0	3.2	406,572	7.4	6.2
1994	0.9	1.4	2.1	3.5	8.5	12.6	0.2	3.2	3.4	436,234	7.3	5.6
1995	1.0	1.5	2.2	3.7	9.0	12.7	0.2	3.3	3.5	464,430	6.5	4.5
1996	1.1	1.6	2.4	3.9	9.5	13.0	0.2	3.5	3.7	499,235	7.5	5.4
1997	1.2	1.6	2.5	4.1	9.7	13.0	0.1	3.7	3.8	527,514	5.7	2.9
1998	1.3	1.7	2.6	4.2	9.6	13.6	0.1	3.8	3.9	553,336	4.9	2.3
1999	1.4	1.8	2.7	4.4	9.6	13.6	0.1	3.9	4.0	577,682	4.4	1.8
2000	1.4	1.9	2.8	4.5	9.6	14.1	0.1	4.0	4.1	602,280	4.3	1.7
2001	1.4	2.0	2.9	4.7	9.5	14.0	0.1	4.1	4.1	623,926	3.6	1.1
2002	1.5	2.0	3.0	4.9	9.7	14.7	0.1	4.3	4.3	658,915	5.6	3.3
2003	1.4	2.1	3.0	4.9	9.6	14.5	0.2	4.3	4.3	673,334	2.2	0.1
2004	1.5	2.1	3.1	5.0	9.5	15.0	0.2	4.4	4.3	696,742	3.5	1.5

Notes

1. Number of recipients of each age and sex group is 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 previous year to June of specified year expressed as a percentage of the numbers as at June the previous year.
3. Adjusted data are age-standardised, based on the Australian estimated resident population as at June 2001.

Sources: ABS 2004d; FaCS 2001: table 2.4.1.

Chapter 6 Assistance for housing

Table A6.1: Households, by tenure group across income quintiles, 1999

Tenure	Income quintile 1st	2nd	3rd	4th	5th	All households ('000)
Reference person over 65						
Without mortgage owners	45.5	33.0	11.6	6.2	3.7	1,184.1
With mortgage owners	45.3	31.3	11.8	5.8	5.8	57.0
All owners	*45.5*	*32.9*	*11.6*	*6.2*	*3.8*	*1,241.1*
Rebated public renters	78.0	20.0	2.1	—	—	73.0
Non-rebated public renters	69.1	18.4	9.9	1.2	1.4	29.1
All public renters	*75.4*	*19.5*	*4.3*	*0.3*	*0.4*	*102.1*
Private renters with CRA	68.8	31.2	—	—	—	39.6
Private renters without CRA	48.3	28.2	16.3	—	7.2	38.9
All private renters	*58.7*	*29.7*	*8.0*	—	*3.6*	*78.5*
All[(a)]	**49.4**	**31.3**	**10.7**	**5.2**	**3.5**	**1,483.2**
Reference person under 65						
Without mortgage owners	14.5	18.4	20.5	21.3	25.3	1,616.2
With mortgage owners	4.1	10.5	21.9	30.0	33.5	2,199.1
All owners	*8.5*	*13.9*	*21.3*	*26.3*	*30.0*	*3,815.3*
Rebated public renters	53.1	34.6	11.2	1.1	—	202.3
Non-rebated public renters	30.5	31.1	25.6	10.7	2.1	64.4
All public renters	*47.6*	*33.7*	*14.7*	*3.5*	*0.5*	*266.7*
Private renters with CRA	30.9	42.5	20.2	5.4	1.1	359.5
Private renters without CRA	8.9	16.5	28.7	26.0	19.9	1,025.2
All private renters	*14.6*	*23.2*	*26.5*	*20.6*	*15.0*	*1,384.7*
All[(a)]	**12.1**	**17.4**	**22.4**	**23.8**	**24.3**	**5,733.7**

(a) Includes 'Other tenure' category.

Source: ABS Australian Housing Survey, 1999, confidentialised unit record files.

Table A6.2: Housing profiles of older Australians, 1991, 1996 and 2001 (per cent)

		Age group (years)				
	Year	65–69	70–74	75–79	80+	Total 65+
				Private dwellings		
Owners						
Owner	1991	69.2	67.4	65.1	52.7	64.7
	1996	73.2	71.1	67.3	54.1	67.3
	2001	73.0	73.2	70.4	56.8	68.5
Purchaser	1991	8.9	7.3	5.3	3.5	6.7
	1996	5.8	5.9	4.8	3.0	5.0
	2001	5.7	4.4	4.2	3.3	4.5
Renters						
Public tenant	1991	5.3	5.7	5.7	4.4	5.3
	1996	4.8	5.0	5.0	3.9	4.7
	2001	4.5	4.7	4.5	3.8	4.4
Private tenant	1991	6.3	6.5	6.5	5.4	6.2
	1996	7.3	6.6	6.7	5.8	6.7
	2001	8.0	7.2	6.7	6.1	7.1
Other tenures						
	1991	6.5	7.5	7.9	7.1	7.1
	1996	5.6	6.9	8.8	9.4	7.4
	2001	6.1	6.8	8.1	9.3	7.5
				Non-private dwellings		
All non-private dwellings	1991	3.7	5.5	9.6	26.9	9.9
	1996	3.3	4.6	7.4	23.7	9.0
	2001	2.7	3.7	6.1	20.7	8.1

Source: Howe A 2003: Table 1.

Table A6.3: Housing tenure profile of household, by age of reference person, 2000–01 (per cent)

Housing tenure type	Older households (65+)	Younger households (under 65)	All households
Owner without a mortgage	80.7	27.5	38.2
Owner with a mortgage	3.6	39.4	32.1
State/territory housing authority	6.0	4.7	5.0
Private renter	5.1	25.0	21.0
Other landlord	1.4	1.4	1.4
Total renters	12.5	31.1	27.4
Other tenure type	3.3	2.0	2.3
Total	**100.0**	**100.0**	**100.0**
Total number of households ('000)	**1,480.2**	**5,834.7**	**7,314.9**

Source: ABS 2004d.

Table A6.4: CRA recipients aged 65 or more, affordability by rent type, June 2002

	Less than 25%	25% and more to less than 30%	30% and more to less than 50%	50% and more	Total
			Before CRA payment		
Private	12.9	10.6	49.7	26.8	100.0
Board and lodging	14.0	8.5	39.1	38.4	100.0
Lodging only	15.1	14.3	57.4	13.1	100.0
Site and mooring fees	40.6	16.8	41.0	1.6	100.0
Maintenance and other fees	56.2	12.8	15.1	15.9	100.0
Total	19.9	11.4	44.7	24.0	100.0
			After CRA payment		
Private	50.1	15.5	27.0	7.4	100.0
Board and lodging	45.5	13.8	35.7	5.0	100.0
Lodging only	62.6	14.9	18.9	3.7	100.0
Site and mooring fees	93.4	4.3	2.0	0.2	100.0
Maintenance and other fees	80.6	2.5	5.1	11.8	100.0
Total	57.4	12.9	23.2	6.5	100.0

Source: 2002 FaCS Housing Data Set.

Table A6.5: Distribution of government assistance, 1999

Income quintile	CRA benefits for private renters	Public rental rebate	FHOG for first home buyers	Tax benefits for purchasers	Tax benefits for outright home owners
1st	34.5	57.3	6.4	0.0	0.0
2nd	42.6	33.1	12.2	16.9	4.9
3rd	18.2	8.8	31.9	13.8	2.4
4th	4.0	0.8	31.1	22.5	16.3
5th	0.6	0.0	18.4	46.8	76.4
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**

Notes

1. Since the FHOG was only introduced in 2000, the figures shown here are the estimate of what would have been the distribution of this benefit had the scheme been in place in 1999.
2. Income quintiles are derived from Australia-wide population.

Source: ABS Australian Housing Survey, 1999.

Table A6.6: Total number of public housing dwellings at 30 June, 1995–96 to 2003–04

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust.
Data reported prior to 1999 CSHA and NHDA									
1995–96	135,744	62,224	47,618	33,132	58,236	14,813	12,171	8,196	372,134
1996–97	133,714	62,014	49,306	32,839	56,695	14,913	11,945	7,914	369,340
1997–98	124,516	63,860	49,753	33,335	55,319	14,775	12,209	8,023	361,790
1998–99	125,083	67,423	50,273	32,926	54,041	13,590	11,791	7,320	362,447
Data reported under the 1999 CSHA and NHDA									
1999–00	127,513	65,996	50,662	32,697	53,485	13,405	11,758	7,451	362,967
2000–01	128,215	65,310	50,666	32,645	51,760	13,178	11,510	6,038	359,322
2001–02	127,754	64,656	50,157	32,551	49,134	12,656	11,154	6,062	354,124
2002–03	125,216	64,849	49,579	31,720	47,772	12,004	11,043	5,829	348,012
2003–04	124,735	64,855	49,144	31,470	46,695	11,695	11,679	5,618	345,335

Note: Excludes the Aboriginal Rental Housing Program (state/territory owned and managed Indigenous housing).
Sources: AIHW 2003b, 2003j: Table A5.9, AIHW 2005f.

Table A6.7: Annual percentage rates of population growth, by age group

	Age group (years)			
Period	**25–34**	**35–44**	**45–54**	**55 and over**
1991 to 1996	0.3	1.4	4.2	1.8
1996 to 2003	0.1	0.9	2.3	2.9

Source: ABS 2004b.

Table A6.8: All persons, by disability status, age and tenure type, 2003 (per cent)

	Core activity limitation[a]					Total persons	
Tenure type	Profound/ severe	Moderate	Mild	All with disability[b]	No disability	Per cent	('000)
Under 15 years	**Distribution of disability status within each tenure type**						
Owner without a mortgage	2.9	0.2	1.6	7.5	92.5	100.0	493.9
Owner with mortgage	3.3	0.2	0.8	6.7	93.3	100.0	2,240.7
Public housing renter	14.3	1.2	2.5	22.8	77.2	100.0	165.4
Private renter	6.2	0.5	1.1	10.1	89.9	100.0	821.5
Boarder	0.0	0.0	1.8	5.2	94.8	100.0	40.1
Living rent-free	2.1	0.8	1.2	9.0	91.0	100.0	75.5
Other	0.0	0.0	8.1	8.1	91.9	100.0	7.4
Total	*4.3*	*0.3*	*1.1*	*8.2*	*91.8*	*100.0*	*3,844.4*
15–64							
Owner without a mortgage	4.6	5.3	6.8	21.9	78.1	100.0	2,909.4
Owner with mortgage	2.7	2.4	3.1	13.4	86.6	100.0	5,509.5
Public housing renter	14.2	8.4	10.2	41.6	58.4	100.0	347.4
Private renter	3.4	2.8	4.0	15.7	84.3	100.0	2,762.5
Boarder	3.8	1.3	3.9	15.6	84.4	100.0	687.3
Living rent-free	3.7	1.6	3.2	12.9	87.1	100.0	1,006.4
Other	4.5	1.8	3.5	13.7	86.3	100.0	33.7
Total	*3.7*	*3.2*	*4.4*	*16.6*	*83.4*	*100.0*	*13,256.2*
65 and over							
Owner without a mortgage	15.3	9.8	18.8	50.0	50.0	100.0	1,587.1
Owner with mortgage	12.4	13.0	15.0	45.9	54.1	100.0	213.7
Public housing renter	18.9	15.7	19.0	62.1	37.9	100.0	119.9
Private renter	21.7	17.2	20.8	64.0	36.0	100.0	153.8
Boarder	48.5	6.9	7.6	65.7	34.3	100.0	22.5
Living rent-free	40.0	5.2	11.9	58.7	41.3	100.0	97.3
Other	22.3	17.9	17.5	64.4	35.6	100.0	24.6
Total	*17.2*	*10.8*	*18.2*	*51.9*	*48.1*	*100.0*	*2,219.0*
All ages							
Owner without a mortgage	7.8	6.2	10.1	29.4	70.6	100.0	4,990.4
Owner with mortgage	3.1	2.1	2.8	12.4	87.6	100.0	7,963.9
Public housing renter	15.1	7.9	9.9	40.6	59.4	100.0	632.7
Private renter	4.8	2.9	4.0	16.5	83.5	100.0	3,737.7
Boarder	5.0	1.4	3.9	16.6	83.4	100.0	750.0
Living rent-free	6.6	1.8	3.8	16.4	83.6	100.0	1,179.1
Other	10.7	7.6	9.2	32.0	68.0	100.0	65.7
Total	**5.4**	**3.5**	**5.3**	**19.0**	**81.0**	**100.0**	**19,319.6**

(a) Core activities comprise communication, mobility and self-care (see Chapter 5).

(b) Includes those with employment or schooling restrictions or people without restrictions but still screened as disabled.

Source: AIHW analysis of ABS 2003 Survey of Disability, Ageing and Carers confidentialised unit record file.

Table A6.9: Government expenditure on CSHA assistance and CRA, 1994–95 to 2003–04 ($m)

	CSHA assistance		CRA	
	Current prices	Constant prices 2003–04	Current prices	Constant prices 2003–04
1994–95	1,509.6	1,857.7	1,453.0	1,788.0
1995–96	1,489.8	1,790.2	1,552.0	1,864.9
1996–97	1,353.4	1,600.2	1,647.0	1,947.4
1997–98	1,207.4	1,408.3	1,484.0	1,730.9
1998–99	1,276.6	1,485.2	1,505.0	1,751.0
1999–2000	1,331.0	1,522.4	1,538.0	1,759.2
2000–01	1,406.5	1,528.4	1,717.0	1,865.9
2001–02	1,392.3	1,479.2	1,815.0	1,928.3
2002–03	1,387.4	1,434.5	1,847.7	1,910.5
2003–04	1,284.5	1,284.5	1,953.0	1,953.0

Notes

1. Care needs to be taken in interpreting data because CRA is a demand-driven recurrent expenditure program, whereas CSHA expenditure includes a component for capital investment that has resulted in around $52 billion of public housing assets that are continually used for housing assistance.
2. CSHA data for 1994–95 to 1995–96 have been adjusted to enable comparability (see source document for further explanation). Commonwealth CSHA expenditure differed from Commonwealth budgetary allocations for the three years from 1996–97 to 1998–99 as some states and territories chose CSHA funds as the source to offset their state fiscal contributions to the Commonwealth's debt reduction program, which was agreed at the 1996 Premiers' Conference.
3. CSHA expenditure in 2000–01 and 2001–02 contained $89.7 million of GST compensation paid to state and territory governments.

Sources: FaCS, Commonwealth State Housing Agreement, Canberra; DFaCS annual reports (various years); Housing Assistance Act 1996 annual reports (various years); ABS National Accounts: National Income Expenditure and Product, cat. no. 5206.0, Canberra.

Table A6.10: CRA by income unit, 2004 (per cent)

Type of income unit	Income units (no.)	Proportion of recipients (%)	Indigenous income units (no.)	Proportion of Indigenous recipients (%)
Single, no dependent children	369,998	39.0	8,024	31.9
Single, no children, sharer	139,796	14.7	2,636	10.5
Single, 1 or 2 dependent children	189,543	20.0	6,890	27.4
Single, 3 or more dependent children	35,709	3.8	2,176	8.6
Partnered, no dependent children	79,333	8.4	1,155	4.6
Partnered, 1 or 2 dependent children	90,531	9.5	2,475	9.8
Partnered, 3 or more dependent children	38,201	4.0	1,570	6.2
Partnered, illness or temporary separation, no dependent children	2,465	0.2	62	0.2
Unknown income unit	4,122	0.4	203	0.8
Total	**949,698**	**100.0**	**25,191**	**100.0**

Notes

1. At 11 June 2004.
2. Data are for CRA recipients who were clients of DFaCS only. Data exclude those paid Rent Assistance by, or on behalf of DVA or DEST.
3. Income units are analogous to family units except that nondependent children and other adults are treated as separate income units.
4. A child is regarded as dependent on an adult only if the adult receives Family Tax Benefit for the care of the child.
5. The maximum rate of assistance is lower for some single persons without dependent children who share accommodation.

Source: FaCS (unpublished).

Table A6.11: Proportion of income spent on rent with and without CRA, income units receiving CRA, 2004 (per cent)

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust.
More than 30 per cent of income spent on rent									
Major Cities									
With CRA	46.8	38.8	38.9	31.1	32.1	. .	48.5	. .	40.3
Without CRA	66.9	62.4	75.9	72.8	71.4	67.6	65.4	. .	73.0
Inner Regional Australia									
With CRA	31.5	25.4	30.0	22.6	23.3	25.8	. .	. .	28.7
Without CRA	66.9	62.4	65.4	60.1	57.4	65.4	. .	. .	64.8
Outer Regional Australia									
With CRA	21.7	22.2	26.4	20.8	17.4	16.1	. .	39.1	23.6
Without CRA	58.9	59.9	62.9	56.9	53.5	53.8	. .	71.9	60.3
Remote Australia									
With CRA	20.3	20.7	19.1	24.5	23.4	14.3	. .	31.8	22.6
Without CRA	55.4	55.6	56.8	58.2	55.6	52.3	. .	65.5	57.6
Very remote Australia									
With CRA	18.1	. .	19.6	24.0	27.7	8.0	. .	24.0	21.8
Without CRA	51.0	. .	50.7	58.7	54.1	34.0	. .	56.2	53.5
Migratory areas									
With CRA	—	—	—	—	—	—	. .	—	—
Without CRA	—	—	—	—	—	—	. .	—	—
Total									
With CRA	**40.7**	**35.0**	**34.0**	**28.9**	**29.5**	**22.7**	**48.5**	**37.1**	**35.5**
Without CRA	**72.1**	**69.9**	**68.0**	**65.4**	**63.1**	**61.7**	**73.0**	**70.0**	**69.1**
More than 50 per cent of income spent on rent									
Major cities									
With CRA	14.8	10.7	9.7	6.5	6.5	. .	16.2	. .	11.2
Without CRA	36.2	30.8	29.7	25.2	25.7	. .	38.6	. .	31.5
Inner regional Australia									
With CRA	6.4	5.1	6.0	3.7	3.7	4.8	. .	. .	5.7
Without CRA	24.8	20.8	22.9	18.7	18.8	21.7	. .	. .	22.7
Outer regional Australia									
With CRA	3.8	4.6	5.3	4.0	3.2	2.1	. .	8.7	4.5
Without CRA	18.5	19.6	21.9	17.7	15.9	14.9	. .	29.6	20.0
Remote Australia									
With CRA	4.3	5.9	3.5	5.6	4.9	1.7	. .	7.5	4.8
Without CRA	17.4	17.8	16.6	20.2	19.7	13.2	. .	24.8	18.9
Very remote Australia									
With CRA	4.1	. .	5.1	6.2	10.1	4.0	. .	5.6	5.9
Without CRA	15.6	. .	16.5	17.7	23.6	8.0	. .	19.3	17.7
More than 50 per cent of income spent on rent									
Total									
With CRA	**11.7**	**9.2**	**7.8**	**5.9**	**5.9**	**3.9**	**16.2**	**8.3**	**9.1**
Without CRA	**31.8**	**28.1**	**26.2**	**23.5**	**23.8**	**19.5**	**38.6**	**28.2**	**28.0**

Notes

1. As at 6 March 2004.
2. Location is derived from postcodes using the ARIA classification.

Source: FaCS (unpublished).

Table A6.12: Public rental housing tenants and SOMIH tenants, at 30 June 2004

	Public rental housing		SOMIH	
Age of main tenant	**Number**	**Per cent**	**Number**	**Per cent**
15–19	1,833	0.5	106	0.9
20–24	9,537	2.8	665	5.4
25–29	16,135	4.8	1,248	10.2
30–34	24,898	7.4	1,731	14.2
35–39	30,626	9.1	1,771	14.5
40–44	35,937	10.7	1,626	13.3
45–49	33,895	10.1	1,345	11.0
50–54	30,878	9.2	1,051	8.6
55–59	29,249	8.7	862	7.1
60–64	26,165	7.8	652	5.3
65–69	25,643	7.6	476	3.9
70–74	24,430	7.3	338	2.8
75–79	21,823	6.5	183	1.5
80+	23,019	6.8	92	0.8
Total	**336,250**	**100.0**	**12,219**	**100.0**

Source: AIHW 2005h.

Table A6.13: Summary characteristics of public housing tenants, at 30 June 2004 (per cent)

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust.
Household composition									
Single adult	49.2	51.5	48.6	53.4	61.7	57.2	48.4	39.1	51.6
Couple only	10.1	7.1	7.3	9.5	11.1	7.8	8.1	8.0	9.0
Sole parent with dependent	23.4	20.1	32.5	25.5	19.6	27.8	26.1	30.1	24.1
Couple with dependent	6.4	4.0	8.3	7.2	4.5	4.3	5.6	10.8	6.0
Group household	5.1	8.4	1.5	3.0	1.6	1.0	5.3	2.6	4.4
Multiple household	5.7	8.4	1.7	1.4	1.4	1.8	5.1	9.5	4.6
Total	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*
Size of household									
One	49.2	51.5	48.6	53.4	61.7	57.2	48.6	39.1	51.6
Two	25.7	23.5	23.5	23.7	23.5	22.3	24.3	23.0	24.3
Three	12.1	12.6	14.3	11.0	8.1	12.1	14.2	17.3	12.1
Four	6.8	6.9	7.8	6.4	3.9	5.6	7.6	10.8	6.6
Five	3.5	3.3	3.5	3.1	1.8	1.9	3.2	5.1	3.2
Six	1.5	1.3	1.4	1.4	0.6	0.7	1.3	3.0	1.3
Seven and more	1.0	0.9	0.9	1.1	0.4	0.2	0.8	1.7	0.9
Total	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*
ASGC									
Major city	80.5	71.7	61.7	70.4	77.3	..	99.6	..	71.4
Inner regional	15.3	22.7	19.4	9.6	6.9	72.8	0.4	..	16.9
Outer regional	3.8	5.5	16.6	9.5	13.9	26.3	..	70.7	9.5
Remote	0.3	0.0	1.7	7.2	1.8	0.6	..	25.4	1.7
Very remote	0.1	..	0.5	3.3	0.2	0.3	..	3.9	0.5
Total	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*
Sex of main tenants[(a)]									
Females	61.5	66.2	64.1	63.0	59.2	64.3	62.3	59.5	63.2
Males	38.5	33.8	35.9	37.0	40.8	35.7	37.8	40.5	36.8
Total	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*
Average age of main tenants (years)									
Females	47	51	50	52	49	49	49	46	49
Males	51	55	54	57	50	52	51	55	53
Total	*54*	*53*	*52*	*53*	*54*	*50*	*49*	*49*	*53*
Disability status									
With disability	14.7	11.5	36.4	11.2	20.4	35.4	0.9	24.9	18.1
Without disability	21.7	83.7	63.6	..	79.6	30.6	47.5	..	45.8
Unknown	63.6	4.8	..	88.8	..	34.0	51.6	75.1	36.1
Total	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust.
Rebate status									
Rebated households	90.0	87.6	84.0	90.0	84.4	82.9	85.0	90.0	87.6
Non-rebated households	10.0	12.4	16.0	10.0	15.6	17.1	15.0	10.0	12.4
Total	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*
Average household size	2.0	2.0	2.0	1.9	1.6	1.8	2.0	2.4	1.9
Length of tenancy									
6 months or less	5.9	6.4	7.0	9.1	5.8	7.2	5.7	9.9	6.5
Over 6 months to 1 year	5.9	6.4	5.9	7.5	5.7	6.4	5.4	8.2	6.1
Over 1 year to 2 years	9.7	11.3	10.5	13.1	9.7	11.0	8.5	12.7	10.5
Over 2 years to 5 years	22.7	24.2	27.9	25.3	19.8	25.8	23.9	25.3	23.8
Over 5 years to 10 years	23.6	25.3	27.2	23.5	23.8	24.1	26.5	19.6	24.5
Over 10 years to 20 years	22.8	20.9	16.7	17.8	35.2	18.8	21.0	20.1	22.5
More than 20 years	9.5	5.6	4.8	3.7	0.1	6.6	9.1	4.2	6.1
Total	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*
Number of new allocations	**9,943**	**5,939**	**4,590**	**4,103**	**3,634**	**1,170**	**790**	**793**	**30,962**
Total number of households	**123,105**	**62,647**	**48,490**	**30,012**	**44,529**	**11,375**	**10,823**	**5,269**	**336,250**

(a) Percentages were calculated using records where sex was known.

Source: AIHW 2005h.

Table A6.14: Summary characteristic of SOMIH tenants, at 30 June 2004 (per cent)

	NSW	Vic	Qld	WA	SA	Tas	Aust.
Household composition							
Single adult	16.9	22.1	18.9	19.2	32.9	33.6	21.0
Couple only	4.3	3.4	8.4	4.1	3.0	8.8	4.9
Sole parent with dependent children	51.0	43.8	42.8	49.6	41.4	45.2	46.9
Couple with dependent children	7.7	5.8	17.1	18.1	6.9	6.7	11.2
Group household	5.2	8.9	3.9	4.3	4.4	1.1	4.9
Multiple household	14.7	15.7	8.7	4.6	11.4	4.6	11.0
Total	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*
Size of household							
One	16.9	22.1	18.9	19.2	32.9	33.6	21.0
Two	28.5	25.3	25.3	21.4	24.0	31.1	25.6
Three	22.9	23.1	18.4	19.0	19.5	19.4	20.7
Four	16.2	15.0	15.1	16.8	10.6	10.2	15.0
Five	8.8	8.8	10.8	11.1	7.2	3.2	9.2
Six	3.7	3.5	5.5	7.0	3.1	1.8	4.5
Seven and more	2.8	2.3	6.0	5.5	2.7	0.7	3.8
Total	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*
ASGC							
Major city	41.2	37.8	13.2	29.4	61.6	..	34.3
Inner regional	31.9	37.1	14.4	7.9	8.1	82.7	22.2
Outer regional	19.8	24.7	46.0	22.0	17.2	17.3	26.1
Remote	5.4	0.4	10.3	20.5	6.1	0.0	8.6
Very remote	1.6	..	16.2	20.2	7.1	..	8.8
Total	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*
Sex of main tenants[(a)]							
Females	79.5	76.9	66.5	75.3	69.3	73.1	73.2
Males	20.5	23.1	33.6	24.7	30.7	26.9	26.8
Total	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*
Average age of main tenants (years)							
Females	37	40	46	41	41	40	41
Males	42	43	49	49	43	42	46
Total	*42*	*41*	*47*	*43*	*44*	*40*	*43*
Disability status							
With Disability	7.7	3.4	20.3	5.8	11.7	22.7	10.7
Without Disability	36.6	89.9	79.7	..	88.3	58.8	53.0
Unknown	55.7	6.7	..	94.2	..	18.5	36.3
Total	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*

	NSW	Vic	Qld	WA	SA	Tas	Aust.
Rebate status							
Rebated households	86.4	88.8	73.8	87.9	80.0	84.5	83.1
Non-rebated households	13.6	11.2	26.3	12.1	20.0	15.5	16.9
Total	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*
Average household size	3.0	2.8	3.2	3.3	2.6	2.3	3.0
Length of tenancy							
6 months or less	7.5	11.9	7.5	11.9	9.8	10.2	9.1
Over 6 months to 1 year	8.5	8.6	8.9	9.7	9.8	14.6	9.2
Over 1 year to 2 years	12.5	16.2	13.2	15.0	13.7	18.2	13.8
Over 2 years to 5 years	25.5	32.4	30.5	25.7	25.0	31.6	27.4
Over 5 years to 10 years	21.7	19.4	22.8	19.2	23.5	17.0	21.4
Over 10 years to 20 years	18.3	9.8	11.4	15.3	18.2	6.9	15.0
More than 20 years	6.1	1.6	5.6	3.4	..	1.5	4.1
Total	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*
Number of new allocations	460	160	299	409	277	62	1,667
Total number of households	4,007	1,219	2,720	2,187	1,751	335	12,219

(a) Percentages were calculated using records where sex was known.

Note: The ACT does not receive any funds specifically for Indigenous housing; Indigenous Australians are housed as part of the public housing program. No data available for the NT, as all Indigenous-specific housing programs are community managed and administered. The funding for the Indigenous housing program is pooled within the Indigenous Housing Authority of the NT (IHANT); therefore the NT is not able to differentiate funding among various funding sources.

Source: AIHW 2005h.

Table A6.15: Centrelink clients in public rental housing, June 2002 (per cent)

Primary Centrelink payment	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust.
Age Pension	29.8	28.4	24.8	29.9	33.2	21.9	24.3	19.8	28.6
Carer Payment	2.2	1.9	2.0	1.6	1.6	2.0	1.1	1.0	1.9
Disability Pension	29.1	26.6	26.8	25.1	30.6	29.9	23.5	20.9	27.8
Family Tax Benefit	2.9	2.7	5.0	3.5	2.7	2.6	6.2	7.4	3.4
Newstart Allowance	10.9	11.1	10.5	12.2	11.6	15.1	12.4	17.5	11.4
Parenting Payment Partnered[(a)]	1.2	1.3	1.7	1.7	0.9	1.2	1.8	2.2	1.3
Parenting Payment Single	20.6	23.8	25.4	22.0	15.6	22.1	24.5	27.6	21.6
Widow Allowance	1.3	1.4	1.6	1.5	1.1	1.0	1.1	0.7	1.3
Youth Allowance[(b)]	0.6	0.9	0.5	0.8	1.0	2.7	2.5	1.5	0.8
Other payments	1.5	1.9	1.7	1.6	1.7	1.5	2.6	1.3	1.7
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**
Total clients (no.)	**120,163**	**60,917**	**47,778**	**31,786**	**43,381**	**12,434**	**9,282**	**6,099**	**331,840**

(a) Includes Parenting Allowance Low Income Earner.

(b) Recipients may be undercounted because those living with parents are not necessarily recorded as being in public housing.

Note: Total excludes 281 income units that were resident overseas.

Source: AIHW 2004d.

Table A6.16: CRA recipients, by primary Centrelink payment type, June 2002 (per cent)

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust.
Age Pension	16.7	17.2	15.6	16.0	17.2	14.3	10.2	8.1	16.3
Carer Payment	1.1	1.1	1.1	0.7	0.8	1.1	0.5	0.6	1.0
Disability Support Pension	17.0	17.5	16.8	15.6	18.0	17.9	12.6	16.6	17.0
Family Tax Benefit	9.9	8.1	9.9	7.3	7.2	6.0	13.1	12.5	9.0
Newstart Allowance	20.9	22.0	21.4	24.1	21.8	22.0	19.0	29.5	21.7
Parenting Payment Partnered[(a)]	2.9	2.3	2.8	2.4	2.2	2.2	2.2	1.8	2.6
Parenting Payment Single	19.6	17.8	20.4	21.1	21.0	20.0	14.8	18.8	19.6
Widow Allowance	1.2	1.2	1.2	1.0	1.0	0.8	0.5	0.6	1.1
Youth Allowance[(b)]	8.3	10.7	9.5	10.2	9.2	14.3	25.3	10.4	9.6
Other payments	2.4	2.1	1.5	1.6	1.6	1.2	1.7	1.1	1.9
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**
Total CRA recipients (no.)	**305,804**	**194,521**	**227,852**	**83,635**	**62,164**	**21,897**	**7,631**	**5,558**	**909,062**

(a) Includes Parenting Allowance Low Income Earner.

(b) Recipients may be undercounted because those living with parents are not necessarily recorded as being in public housing.

Note: CRA recipients are income units in receipt of a Centrelink payment and received CRA during the fortnight ending 14 June 2002 and had an ongoing entitlement to CRA at the end of this period.

Source: AIHW 2004d.

Table A6.17: Unemployed public housing tenants: reasons for non-participation in the labour force, April–May 2003 (per cent)

Reason	Important (quite or very)	Neither	Unimportant	Don't know/Not applicable	Not answered
Unable to work (e.g. too young, old, ill or disabled)	22	8	18	42	11
Need more training/education	44	13	17	17	9
Want/need to stay home to take care of own children	24	5	13	46	12
Do not have enough work experience	38	13	18	22	9
No one wants to employ me	31	12	15	29	13
Not able to work the number of hours I want/need	27	13	20	27	12
My welfare payments/pension might be reduced	17	15	30	24	13
There are no jobs in the type of work I am looking for	42	13	16	18	10
There are no jobs where I live	34	12	17	26	11
If I work, my rent might go up	20	16	30	21	13
The pay I would get is too low	21	15	26	24	13
Transport to work is too expensive/unavailable	25	12	21	30	12
If I work, I might need to leave my current housing	15	13	28	32	12
Child care is too expensive/unavailable	12	5	12	59	13
I am studying	11	9	19	49	13
I want/need to stay home to take care of others besides my children	4	6	17	60	13
I do not speak English well enough	6	3	23	57	11
I am pregnant/on maternity leave	3	3	11	69	14

Note: Due to the relatively high non-response rate for this question, some caution should be used in interpreting these results.

Source: CBSR 2003.

Table A6.18: Number of CSHA dwellings, by program type, 30 June 2004

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust.
Public housing dwellings	124,735	64,855	49,144	31,470	46,695	11,679	11,139	5,618	345,335
Community housing dwellings	9,469	3,652	5,193	3,519	4,012	402	409	97	26,753
State owned and managed Indigenous housing	4,088	1,260	2,811	2,325	1,900	341	. .	. .	12,725
Crisis Accommodation Program	1,355	3,779	1,015	447	243	118	56	116	7,129
Total dwellings	**139,647**	**73,546**	**58,163**	**37,761**	**52,850**	**12,540**	**11,604**	**5,831**	**391,942**

Sources: AIHW 2003b, 2003c, 2005f, 2003g.

Table A6.19: Housing outcomes for community housing tenants, 2002 (per cent)

	Feel more settled	Manage money better	Supported by organisation	Able to stay in area	Part of local community	Enjoy better health	Grow in confidence	Better access to services	Start education/ training	Better job situation
Applicable	92	89	89	88	83	83	82	80	51	51
Achieved[(a)]	93	87	82	91	73	71	80	77	59	44

(a) The percentage achieved is of those who said it was applicable.

Source: NFO Donovan Research 2002.

Table A6.20: Satisfaction with home and specific aspects of service, 2002 (per cent)

	Very Satisfied	Satisfied	Dissatisfied
Provision of referrals	28	32	10
Location of home	53	33	7
Non-maintenance services	43	35	8
Maintenance services	31	33	20
Information provided	32	43	9
Involvement in organisation	28	29	13
Condition of home	38	39	13
Knowledge & competence	29	38	10
Treatment by staff	43	35	9

Source: NFO Donovan Research 2002.

Table A6.21: Satisfaction with community housing, 2002 (per cent)

	Very satisfied	Satisfied	Dissatisfied
Age			
15–34	32	41	15
35–44	41	36	12
45–64	41	41	8
65+	47	34	6
Dwelling type			
Separate	39	40	11
Attached	45	34	7
Unit	40	37	10
Shared/rooming	34	35	16
Indigenous status			
Indigenous	23	61	8
Non-Indigenous	40	38	10

Source: NFO Donovan Research 2002.

Table A6.22: Personal and housing household debt, March 1990–June 2005 quarter

	Personal debt			Housing debt			
	Credit cards	Other personal	Total personal	Owner-occupier	Investor	Total housing	Total household
	Per cent of household disposable income (debt year before interest payments deducted)						
March 1990	1.7	12.1	13.8	28.1	4.7	32.8	46.6
June 1990	1.8	12.1	13.9	28.1	4.9	33.0	46.8
September 1990	1.7	11.7	13.4	27.8	5.3	33.0	46.4
December 1990	1.7	11.4	13.1	27.8	5.5	33.3	46.4
March 1991	1.7	11.2	12.9	28.2	5.8	33.9	46.9
June 1991	1.7	11.1	12.8	28.7	6.0	34.7	47.5
September 1991	1.7	10.9	12.6	29.4	6.1	35.5	48.1
December 1991	1.7	10.7	12.4	30.4	6.4	36.8	49.2
March 1992	1.7	10.5	12.2	31.1	6.5	37.6	49.9
June 1992	1.7	10.3	12.0	31.8	6.7	38.5	50.5
September 1992	1.7	10.3	12.0	33.0	6.6	39.5	51.5
December 1992	1.8	10.2	12.0	34.0	7.0	41.0	53.1
March 1993	1.8	10.2	12.0	35.5	7.1	42.6	54.6
June 1993	1.8	10.0	11.8	36.6	7.4	44.1	55.9
September 1993	1.8	10.0	11.9	38.0	7.9	45.9	57.8
December 1993	1.9	10.0	11.9	39.3	8.4	47.7	59.6
March 1994	1.9	10.0	11.9	40.9	8.8	49.7	61.6
June 1994	1.9	10.0	11.9	42.6	9.3	51.8	63.8
September 1994	2.0	9.9	11.9	43.6	9.8	53.3	65.2
December 1994	2.0	10.0	12.0	44.2	10.1	54.3	66.3
March 1995	2.0	10.1	12.1	44.8	10.4	55.2	67.3
June 1995	2.0	10.2	12.3	45.2	10.5	55.7	68.0
September 1995	2.1	10.3	12.4	45.4	10.8	56.1	68.5
December 1995	2.2	10.3	12.4	46.1	11.2	57.3	69.7
March 1996	2.2	10.3	12.5	46.7	11.4	58.2	70.7
June 1996	2.3	10.5	12.8	47.1	11.6	58.8	71.6
September 1996	2.3	10.8	13.1	47.7	11.9	59.7	72.7
December 1996	2.3	10.8	13.1	48.1	12.3	60.5	73.6
March 1997	2.4	10.8	13.2	48.5	13.0	61.5	74.8
June 1997	2.5	10.9	13.3	49.2	13.7	62.9	76.2
September 1997	2.5	11.0	13.5	49.9	14.5	64.3	77.9
December 1997	2.6	11.3	14.0	50.4	15.3	65.7	79.6
March 1998	2.7	11.6	14.3	51.0	16.1	67.0	81.4
June 1998	2.8	11.6	14.5	51.9	16.8	68.6	83.1
September 1998	3.0	11.8	14.8	51.9	17.4	69.3	84.1
December 1998	3.0	12.1	15.2	52.6	18.1	70.7	85.9

(continued)

Table A6.22: Personal and housing household debt, March 1990–June 2005 quarter *(continued)*

	Personal debt			Housing debt			
	Credit cards	Other personal	Total personal	Owner-occupier	Investor	Total housing	Total household
	Per cent of household disposable income (debt year before interest payments deducted)						
March 1999	3.2	12.5	15.7	53.0	18.8	71.7	87.4
June 1999	3.2	12.7	15.9	53.2	19.6	72.8	88.7
September 1999	3.4	12.9	16.4	54.2	20.5	74.7	91.1
December 1999	3.5	13.1	16.7	55.0	21.4	76.4	93.0
March 2000	3.7	13.3	17.0	55.9	22.6	78.5	95.5
June 2001	3.8	13.5	17.4	56.4	23.4	79.9	97.2
September 2001	3.8	13.4	17.2	56.1	23.8	80.0	97.2
December 2001	4.0	13.5	17.4	56.2	23.5	79.8	97.2
March 2001	4.1	13.5	17.5	56.7	23.8	80.5	98.0
June 2001	4.1	13.4	17.5	57.2	24.2	81.4	98.9
September 2001	4.2	13.6	17.8	59.4	24.9	84.4	102.1
December 2001	4.3	13.7	18.0	62.1	25.5	87.6	105.6
March 2002	4.4	13.9	18.2	64.3	26.6	90.9	109.2
June 2002	4.5	14.3	18.8	66.6	27.9	94.5	113.3
September 2002	4.6	14.4	19.0	68.3	29.4	97.7	116.8
December 2002	4.6	14.4	19.1	69.7	30.7	100.3	119.4
March 2003	4.7	14.8	19.5	71.7	32.3	104.0	123.5
June 2003	4.7	15.4	20.1	73.3	34.1	107.4	127.6
September 2003	4.8	15.8	20.6	75.1	36.1	111.2	131.8
December 2003	4.9	16.0	20.9	76.8	37.8	114.6	135.6
March 2004	5.0	16.2	21.2	78.1	39.2	117.3	138.5
June 2004	5.0	16.3	21.3	79.0	40.1	119.2	140.5
September 2004	5.1	16.5	21.5	80.0	40.8	120.8	142.3
December 2004	5.1	16.9	22.1	81.4	41.1	122.5	144.6

Note: The separation of housing debt is based on bank lending data.

Source: Reserve Bank of Australia.

Chapter 7 Services for people experiencing homelessness

Table A7.1: SAAP agencies and support periods provided to clients, by primary target group, 2003–04

	Agencies		Support periods	
Primary target group	**Number**	**Per cent**	**Number**	**Per cent**
Young people	454	37.1	34,500	18.5
Women escaping domestic violence	283	23.1	39,400	21.1
Cross-target/multiple/general	229	18.7	64,200	34.4
Families	117	9.8	9,500	5.1
Single men only	95	7.8	34,500	18.5
Single women only	47	3.8	5,100	2.7
Total	**1,225**	**100.0**	**187,200**	**100.0**

Source: AIHW 2005: table A1.1; SAAP Client Collection.

Table A7.2: Closed SAAP support periods provided to single men aged 45 and over, by main source of income immediately before support and age group, 2003–04 (per cent)

	Single men aged 45 and over					Other SAAP
Main source of income	**45–54**	**55–64**	**65–74**	**75+**	**Total**	**clients**
No income	2.5	1.6	0.6	1.8	2.1	7.8
No income, awaiting pension/benefit	0.6	0.4	0.1	0.5	0.5	1.0
Age Pension	0.2	4.6	70.3	57.0	10.2	1.2
Disability Support Pension	65.0	71.4	22.2	9.5	60.6	16.7
DVA Disability Pension	1.2	4.3	2.3	5.2	2.2	0.6
Newstart Allowance	23.8	12.9	1.8	9.4	18.2	24.5
Other government pension/benefit	3.1	2.9	2.1	11.9	3.2	38.8
Other income	3.6	2.0	0.5	4.8	2.9	6.4
Total	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*
Total (number)	**9,400**	**4,100**	**1,600**	**500**	**15,500**	**136,800**

Notes

1. Number excluded due to errors and omissions (weighted): 16,900.
2. Valid data for 'Other SAAP' includes records with errors and omissions in age.
3. Figures have been weighted to adjust for incomplete coverage.

Source: SAAP Client Collection.

Table A7.3: SAAP support periods provided to single men aged 45 and over, by type of service and age group, 2003–04 (per cent)

	Single men aged 45 and over					Other SAAP
Type of service	**45–54**	**55–64**	**65–74**	**75+**	**Total**	**clients**
Housing/accommodation	72.8	73.1	73.9	50.7	72.2	63.5
SAAP/CAP accommodation	65.9	65.8	68.4	44.8	65.4	50.0
Assistance to obtain/maintain short-term accommodation	11.9	10.2	8.1	6.6	10.9	15.8
Assistance to obtain/maintain independent housing	10.2	9.8	9.2	9.5	10.0	19.9
Financial/employment	26.8	26.3	22.1	27.7	26.2	35.8
Assistance to obtain/maintain government payment	4.3	3.7	3.1	2.9	4.0	9.2
Employment/training assistance	1.6	0.6	0.1	0.2	1.2	3.9
Financial assistance/material aid	22.9	22.7	19.7	25.2	22.6	29.2
Financial counselling	4.2	4.1	2.1	2.1	3.9	6.9
Counselling	35.2	31.5	31.8	27.0	33.6	49.4
Incest/sexual assault	0.3	0.2	0.1	—	0.2	2.1
Domestic violence	0.5	0.5	0.2	0.6	0.5	15.7
Family/relationship	3.0	2.4	1.9	1.5	2.7	12.9
Emotional/other	34.4	30.8	31.3	25.9	32.8	44.4
Assistance with problem gambling	0.5	0.8	0.8	0.2	0.6	0.4
General support/advocacy	70.4	68.8	71.9	60.7	69.8	72.8
Living skills/personal development	7.0	6.2	5.5	3.7	6.6	14.0
Assistance with legal issues/court support	2.2	1.3	1.2	2.1	1.8	10.1
Advice/information	48.7	45.7	47.8	45.2	47.7	60.4
Retrieval/storage/removal of belongings	41.0	39.4	43.8	25.8	40.3	18.5
Advocacy/liaison on behalf of client	17.3	16.6	16.1	17.5	17.0	33.6
Brokerage services	2.5	2.1	1.6	2.2	2.3	5.6
Specialist services	40.8	41.2	46.2	29.7	41.0	25.2
Psychological services	0.9	0.5	0.7	0.6	0.8	1.2
Psychiatric services	2.1	1.5	0.5	0.4	1.7	1.5
Pregnancy support	—	—	—	—	—	1.5
Family planning support	—	—	—	—	—	0.9
Drug/alcohol support or intervention	31.0	31.4	34.4	19.9	31.1	10.2
Physical disability services	0.3	0.4	0.5	0.3	0.3	0.2
Intellectual disability services	0.1	0.4	—	—	0.2	0.3
Culturally appropriate support	2.4	1.9	2.6	1.9	2.3	7.0
Interpreter services	0.3	0.1	0.5	—	0.3	1.1
Assistance with immigration issues	0.1	0.2	0.1	0.3	0.2	0.7
Health/medical services	12.9	12.7	14.2	11.2	12.9	10.4
Basic support	74.3	73.6	74.1	51.0	73.3	57.4
Meals	61.6	58.3	60.6	39.4	59.9	40.1
Laundry/shower facilities	61.3	60.9	63.8	40.4	60.7	37.4
Recreation	22.6	20.0	18.9	15.0	21.3	21.4
Transport	11.0	11.8	11.7	13.4	11.3	26.6
Other	9.0	9.0	6.4	7.3	8.7	13.3
No services provided directly	1.6	1.5	1.6	6.3	1.7	2.6
Total (number)	**10,800**	**4,700**	**1,700**	**600**	**17,900**	**163,700**

Notes

1. Number excluded due to errors and omissions (weighted): 6,800 (cases with no information on service requirements or provision).
2. Clients were able to receive multiple services, so percentages do not total 100.
3. Figures have been weighted to adjust for incomplete coverage.

Source: SAAP Client Collection.

TableA7.4: SAAP support periods provided to women aged 20 and over escaping domestic violence, by reason for seeking assistance, whether accompanied by children and Indigenous status, 2003–04 (per cent)

	Indigenous			Non-Indigenous		
Reason for seeking assistance	**With accompanying children**	**Without accompanying children**	**Total**	**With accompanying children**	**Without accompanying children**	**Total**
Usual accommodation unavailable	14.2	15.4	14.7	12.5	12.1	12.3
Time out from family/other situation	25.7	24.4	25.2	13.3	13.0	13.2
Relationship/family breakdown	30.6	28.5	29.8	39.4	34.5	37.4
Interpersonal conflict	17.0	17.0	17.0	22.5	21.1	22.0
Physical/emotional abuse	50.0	49.0	49.6	53.0	50.5	52.0
Domestic violence	93.6	91.8	92.9	93.3	92.1	92.8
Sexual abuse	3.5	3.8	3.6	6.4	8.3	7.1
Financial difficulty	13.3	10.2	12.1	22.6	19.3	21.3
Gambling	0.6	0.9	0.7	0.8	1.0	0.8
Eviction/previous accommodation ended	5.7	3.6	4.9	9.3	7.8	8.7
Drug/alcohol/substance abuse	15.5	13.9	14.8	6.9	9.2	7.8
Emergency accommodation ended	1.7	1.1	1.4	2.4	2.6	2.5
Recently left institution	0.3	0.7	0.4	0.4	1.3	0.7
Psychiatric illness	0.8	2.2	1.4	2.1	4.4	3.0
Recent arrival to area with no means of support	5.9	4.3	5.3	4.9	5.0	4.9
Itinerant	2.8	2.2	2.6	1.9	2.7	2.2
Other	4.3	5.5	4.8	8.0	6.6	7.4
Total	**60.4**	**39.6**	**100.0**	**59.8**	**40.2**	**100.0**
Total (number)	**5,200**	**3,400**	**8,600**	**16,800**	**11,300**	**28,000**

Notes

1. Number excluded due to errors or omissions (weighted): 2,500.
2. Table excludes high-volume records because not all items were collected on the high-volume form.
3. Clients were able to indicate multiple reasons, so column percentages do not total 100.
4. Figures have been weighted to adjust for incomplete coverage.

Source: SAAP Client Collection.

Table A7.5: Closed SAAP support periods provided to women aged 20 and over escaping domestic violence, living situation immediately before and after support by Indigenous status, 2003–04 (per cent)

	Indigenous		Non-Indigenous	
Living situation	**Before support**	**After support**	**Before support**	**After support**
With parent(s)/relatives	24.4	29.8	9.9	9.6
With spouse/partner with children	30.3	16.5	31.2	11.7
With spouse/partner without children	18.8	8.8	16.9	6.0
Alone with children	16.1	29.6	22.8	42.6
Alone without children	4.3	7.3	8.0	14.5
With friends/other unrelated persons	5.6	6.9	10.0	13.3
Other	0.6	1.2	1.1	2.3
Total	*100.0*	*100.0*	*100.0*	*100.0*
Total (number)	**7,800**	**6,100**	**22,800**	**19,500**

Notes

1. Number excluded due to errors and omissions before support (weighted): 3,200.
2. Number excluded due to errors and omissions after support (weighted): 8,200.
3. Table excludes high-volume records because not all items were collected on the high-volume form.
4. Figures have been weighted to adjust for incomplete coverage.

Source: SAAP Client Collection.

Table A7.6: SAAP support periods provided to women aged 20 and over escaping domestic violence, by type of service, whether accompanied by a child) and Indigenous status, 2003–04 (per cent)

	Indigenous			Non-Indigenous		
Broad type of service	**With accompanying child(ren)**	**Without accompanying child(ren)**	**Total**	**With accompanying child(ren)**	**Without accompanying child(ren)**	**Total**
SAAP/CAP accommodation	77.3	74.8	76.3	46.2	40.0	43.7
Assistance to obtain/maintain non-SAAP/CAP accommodation/housing	29.6	19.9	25.8	37.3	27.9	33.6
Financial/employment	44.2	35.4	40.7	44.4	35.4	40.8
Counselling	74.1	66.9	71.3	86.6	81.6	84.6
General support/advocacy	69.8	66.5	68.5	87.5	84.5	86.3
Health/medical services	16.1	17.4	16.7	11.9	12.1	12.0
Drug/alcohol support or intervention	4.1	4.2	4.2	4.0	5.9	4.8
Other specialist services	37.0	30.5	34.4	17.4	17.1	17.3
Basic support	77.4	76.8	77.2	50.7	48.9	50.0
No services provided directly	0.7	0.3	0.6	1.1	0.8	1.0
Total (number)	**5,300**	**3,400**	**8,700**	**17,300**	**11,600**	**28,900**

Notes

1. Number excluded due to errors and omissions (weighted): 1,500 (including cases with no information on service requirements or provision).
2. Clients were able to receive multiple services, so percentages do not total 100.
3. Figures have been weighted to adjust for incomplete coverage.

Source: SAAP Client Collection.

Table A7.7: Young SAAP clients aged to 19 years, by age and gender, 2003–04 (per cent)

	Proportion of gender group		Proportion of young clients			
Age	**Males**	**Females**	**Males**	**Females**	**Total**	**Total (number)**
Under 15 years	10.6	9.8	4.1	6.0	10.1	1,900
15 years	9.1	9.3	3.5	5.7	9.2	1,700
16 years	16.4	18.1	6.3	11.1	17.5	3,300
17 years	22.5	22.5	8.7	13.8	22.5	4,200
18 years	22.3	21.0	8.6	12.8	21.5	4,000
19 years	19.0	19.4	7.4	11.9	19.3	3,600
Total	*100.0*	*100.0*	*38.7*	*61.3*	*100.0*	*. .*
Total (number)	**7,300**	**11,600**	**7,300**	**11,600**	**. .**	**18,800**
Mean age (years)	**16.8**	**16.8**	**. .**	**. .**	**. .**	**16.8**
Median age (years)	**17**	**17**	**. .**	**. .**	**. .**	**17**

Note: Figures have been weighted to adjust for incomplete coverage.

Source: SAAP Client Collection.

Table A7.8: SAAP support periods provided to clients aged to 19 years, by type of service, age and gender, 2003–04 (per cent)

Broad type of service provided	Clients aged to 19 years							Other SAAP clients
	Under 15	15	16	17	18	19	Total	
				Males				
SAAP accommodation	53.5	64.7	65.8	65.4	59.1	54.4	60.8	58.7
Assistance to obtain/ maintain non-SAAP/CAP accommodation/housing	15.4	24.8	32.0	36.4	41.7	42.7	35.3	23.9
Financial/employment	13.4	29.3	37.9	39.3	42.1	41.5	37.0	30.1
Counselling	64.4	55.2	51.0	46.1	46.1	40.9	48.3	33.7
General support/advocacy	67.2	75.1	78.4	78.7	78.1	76.5	76.8	69.9
Health/medical services	6.2	9.8	9.9	10.0	9.8	9.8	9.5	11.2
Drug/alcohol support or intervention	4.0	8.2	9.4	9.8	11.5	10.7	9.6	21.7
Other specialist services	14.8	9.5	7.8	7.9	7.4	8.3	8.6	6.0
Basic support	65.2	70.6	68.6	68.3	66.1	61.2	66.4	67.6
No services provided directly	3.2	3.5	2.4	2.3	2.6	2.3	2.6	2.5
Total (number)	**1,100**	**1,000**	**2,100**	**2,900**	**2,800**	**2,300**	**12,100**	**74,800**
				Females				
SAAP accommodation	41.9	57.2	53.2	53.7	48.3	46.3	50.3	43.3
Assistance to obtain/ maintain non-SAAP/CAP accommodation/housing	13.0	25.7	34.9	40.1	45.8	43.3	37.4	30.4
Financial/employment	17.1	31.3	37.5	39.7	43.1	40.9	37.6	37.9
Counselling	70.7	66.1	60.7	57.5	57.0	57.5	56.9	59.5
General support/advocacy	71.6	72.6	79.1	78.7	77.2	76.7	77.0	73.6
Health/medical services	9.2	13.0	12.4	11.9	13.5	12.9	12.4	9.8
Drug/alcohol support or intervention	2.9	4.7	5.7	6.5	5.9	5.4	5.6	5.0
Other specialist services	12.2	11.2	11.4	13.6	15.4	17.1	14.0	15.4
Basic support	71.6	67.2	60.8	60.9	57.9	54.5	60.5	50.1
No services provided directly	3.2	2.3	1.9	2.3	2.6	2.1	2.3	2.4
Total (number)	**1,600**	**1,600**	**3,400**	**4,300**	**4,000**	**3,700**	**18,700**	**80,400**

Notes

1. Number excluded due to errors and omissions (weighted): 6,000 (including cases with no information on service requirements or provision).
2. Clients were able to receive multiple services, so percentages do not total 100.
3. Figures have been weighted to adjust for incomplete coverage.

Source: SAAP Client Collection.

Table A7.9: SAAP clients and support periods provided to clients, 1996–97 to 2003–04

	Clients	Support periods
1996–97	83,200	156,500
1997–98	94,100	164,300
1998–99	90,700	163,200
1999–00	90,000	157,600
2000–01	93,000	170,700
2001–02	95,600	177,000
2002–03	97,600	176,300
2003–04	100,200	187,200

Source: AIHW 2005: table 9.2.

Chapter 8 Welfare services resources

Table A8.1: Employed persons by industry, 1999 and 2004

Industry	1999 Number ('000)	1999 Proportion part-time (%)	1999 Proportion female (%)	2004 Number ('000)	2004 Proportion part-time (%)	2004 Proportion female (%)	Growth in number 1999–2004 (%)
Total community services	*198.5*	*45.0*	*79.3*	*243.3*	*45.8*	*81.0*	*22.6*
Child care services	57.8	39.0	94.4	82.1	46.2	96.3	42.0
Community care services	140.6	47.5	73.0	155.0	45.5	73.4	10.2
Community services nfd	—	—	—	6.2	45.6	67.7	—
Health services	618.6	39.2	76.9	733.5	41.6	77.3	18.6
Health and community services nfd	—	—	—	4.5	41.9	88.3	—
Total health and community services	*817.0*	*40.6*	*77.5*	*981.3*	*42.7*	*78.2*	*20.1*
Other industries							
Government administration and Defence	351.5	13.8	45.9	448.9	17.6	49.8	27.7
Education	614.1	32.5	67.1	692.6	34.5	67.7	12.8
Other industries (incl. not stated)	6,937.6	24.7	37.4	7,513.5	26.7	37.8	8.3
Total all industries	**8,720.2**	**26.3**	**43.6**	**9,636.3**	**28.4**	**44.6**	**10.5**

Note: Annual figures are the average of the four quarters.

Source: ABS 2005b.

Table A8.2: Persons in community services occupations, selected characteristics 1999 and 2004

Occupation	1999 Number ('000)	1999 Proportion part-time (%)	1999 Proportion aged 45+ (%)	1999 Proportion female (%)	1999 FTE per 100,000 population[a]	2004 Number ('000)	2004 Proportion part-time (%)	2004 Proportion aged 45+ (%)	2004 Proportion female (%)	2004 FTE per 100,000 population[a]
Child care coordinator	5.6	26.3	33.9	71.4	32.8	8.2	32.8	31.3	85.6	39.8
Pre-primary school teacher	13.4	35.9	30.1	98.3	66.2	14.7	48.7	37.0	98.1	61.4
Special education teacher	10.4	30.6	51.9	79.0	51.3	13.9	32.7	53.1	84.7	68.6
Social worker	11.3	24.2	42.1	78.9	56.7	11.5	30.2	42.9	76.4	53.9
Welfare and community worker	22.5	33.6	41.8	78.6	112.7	29.3	31.8	50.8	81.6	135.7
Counsellor	14.5	40.8	45.7	75.1	67.3	17.3	35.6	56.7	74.7	77.1
Social welfare professional nfd	—	. .	. .	. .	. .	**0.2	—	53.2	100.0	0.9
Welfare associate professional	14.5	25.7	33.5	61.0	77.3	21.4	32.6	33.3	66.3	93.2
Indigenous health worker	**1.7	31.9	18.4	52.2	8.7	**0.7	42.3	36.6	42.3	2.9
Education aide	42.4	78.1	39.6	95.2	151.4	51.7	76.0	42.8	92.4	175.4
Children's care worker	71.6	49.8	22.4	98.1	300.5	86.7	51.2	24.7	96.0	348.5
Special care worker	63.2	66.2	42.9	88.2	231.4	77.5	60.6	51.7	82.7	299.2
Carer or aide nfd	—	. .	. .	. .	. .	**1.6	75.0	69.8	85.9	4.9
Total community services	**270.9**	**51.8**	**35.8**	**88.2**	**1,156.2**	**334.4**	**51.6**	**41.0**	**86.6**	**1,361.6**
Total all occupations	**8,720.2**	**26.3**	**31.9**	**43.6**	**46,949.4**	**9,636.3**	**28.4**	**35.3**	**44.6**	**48,721.5**

(a) Full-time equivalent based on a standard 35-hour week.

Note: Annual figures are the average of the four quarters.

Source: ABS 2005b.

Technical appendix on the ABS 2003 Survey of Disability, Ageing and Carers

A.1 The survey

The 2003 Survey of Disability, Ageing and Carers (ABS 2004) was conducted throughout Australia during the period June to November 2003. The aims of the survey were to:

- measure the prevalence of disability in Australia;
- measure the need for support of older people and those with a disability;
- provide a demographic and socioeconomic profile of people with disabilities, older people and carers compared with the general population; and
- estimate the number of and provide information about people who provide care to older people and people with disabilities.

Information was collected from the three target populations:

- people with a disability;
- older people (i.e. those aged 60 years and over); and
- people who care for persons with a disability and older people.

The survey covered people in both urban and rural areas in all states and territories, except for those living in remote and sparsely settled parts of Australia. It included people in both private and non-private dwellings, including those in cared accommodation establishments but excluding those in gaols and correctional institutions

Collection methods

Different data collection methods were used for the household component and the cared-accommodation component of this survey.

Data for the household component were collected by trained interviewers, who conducted computer-assisted personal interviews. Where possible, a personal interview was conducted with people identified in any of the three target populations. Proxy interviews were conducted for children aged less than 15 years, for those aged 15–17 years whose parents did not permit them to be personally interviewed, and for those with a disability that prevented them from having a personal interview.

Cared accommodation includes hospitals, homes for the aged such as nursing homes and aged care hostels, cared components of retirement villages, and other 'homes' such as children's homes. The cared-accommodation component was enumerated in two stages using a mail-based methodology directed to administrators of selected establishments who then selected survey participants using instructions provided by the ABS. A separate questionnaire was completed for each selected occupant meeting the coverage requirements.

The key measures used in the survey are described below.

A.2 Disability

For ABS survey purposes, a person has a disability if he/she has at least one of the following 17 limitations, restrictions or impairments, which has lasted, or is likely to last, for at least 6 months and restricts everyday activities (ABS 2004:72–3):

- loss of sight, not corrected by glasses or contact lenses;
- loss of hearing, with difficulty communicating or use of aids;
- speech difficulties (including speech loss);
- chronic or recurring pain or discomfort 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 in doing 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;
- receiving treatment or medication for any other long-term condition or ailment and still restricted in everyday activities; and
- any other long-term condition that restricts everyday activities.

The survey definition of disability aims to capture a broad range of people who have one or more impairments or limitations, or who have one or more health conditions which restrict everyday life. Thus, the 17 items were used as criteria to create the base 'disability' population which is the starting point for prevalence estimates.

Activity limitations and their severity

A 'specific limitation or restriction' is defined in the 2003 survey as a limitation in core activities (self-care, mobility and communication) or a restriction in schooling or employment. People who were identified as having a disability (using the above 17 criteria) and all people aged 60 years or over, were asked about their difficulty and need for assistance with various daily activities: self-care, mobility, communication, health care, housework, property maintenance, paperwork, meal preparation, transport, and cognition or emotion. Cognition or emotion refers to interacting, making or maintaining relationships, coping with feelings or emotions, making decisions or thinking through problems.

In the survey four levels of core activity limitation were determined, based on whether a person needs personal assistance with, has difficulty with, or uses aids or equipment for any of the core activities. A person's overall level of core activity limitation is determined by the highest level of limitation the person experienced in any of the core activity areas. The four levels of core activity limitation are:

- profound—unable to perform a core activity or always needing assistance;
- severe—sometimes needs assistance to perform a core activity, or has difficulty understanding or being understood by family or friends, or can communicate more easily using sign language or other non-spoken forms of communication;
- moderate—does not need assistance, but has difficulty performing a core activity; and
- mild—has no difficulty performing a core activity but uses aids or equipment because of disability; or cannot perform the activities of easily walking 200 metres, walking up and down stairs without a handrail, easily bending to pick up an object from the floor, and using public transport; or can use public transport but needs help or supervision; or needs no help or supervision but has difficulty using public transport.

Core activities comprise the following tasks contributing to the definition of profound or severe core activity limitation:

- self-care—bathing or showering, dressing, eating, using the toilet, and bladder or bowel control;
- mobility —getting into or out of a bed or chair, moving around at home and going to or getting around a place away from home; and
- communication—understanding and being understood by others: strangers, family and friends.

Four sets of prevalence estimates of disability groups

In Australia, the five disability groups 'intellectual/learning disability'; 'psychiatric disability'; 'sensory/speech disability'; 'physical/diverse disability'; and 'acquired brain injury' provide a broad categorisation of disabilities based not only on underlying health conditions and impairments but also on activity limitations, participation restrictions and related environmental factors. These groups are generally recognised in the disability field and in legislative and administrative contexts in Australia (NCSDC 2004).

Four main approaches have been used to obtain estimates of disability (see Table 5.2). These provide a spectrum of estimates that may suit different purposes. All the estimates start with the base 'disability population', that is those defined by the survey as having a disability.

Estimates based on '**main disabling condition**' relate to the condition that was identified by the survey respondents as causing the most problems, compared with any other conditions he or she may also have had. Using this method, the estimates of different disability groups are exhaustive and mutually exclusive. The numbers in each group total the number of people with a disability, as defined by the 2003 survey. People may, however, experience more than one disabling condition. The prevalence of a particular disability group will be underestimated if only main disabling conditions are considered. This approach to estimation is used when the focus is on people and each person is to be counted only once.

The remaining three sets of estimates are based on **all disabling conditions** and are in diminishing size, corresponding to an increasingly restrictive scope, according to severity, need for assistance or activity limitation:

- all disabling conditions
- all disabling conditions, plus activity limitations and participation restrictions
- all disabling conditions, plus severe or profound core activity limitations.

These estimates provide a better indication of the prevalence of particular disabilities. (See AIHW 2003:343 for more details.)

A.3 Long-term health condition

In the survey, a long-term health condition is defined as a disease or disorder which has lasted or is likely to last for at least 6 months; or a disease, disorder or event (e.g. stroke, poisoning, accident, etc.) which results in an impairment or restriction which has lasted or is likely to last for at least 6 months (ABS 2004:76). In other words, people may have a long-term health condition, but not a disability, if the health condition does not result in an impairment or restriction which has lasted or is likely to last for at least 6 months. Long-term health conditions have been coded to a classification based on the World Health Organization's International Classification of Diseases and Related Health Problems (WHO 1992).

References

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AIHW (Australian Institute of Health and Welfare) 2003. Australia's welfare 2003. Canberra: AIHW.

NCSDC (National Community Services Data Committee) 2004. National community services data dictionary. Version 3. Canberra: AIHW.

WHO (World Health Organization) 1992. International classification of diseases and related health problems. 10th revision. Geneva: WHO.

Abbreviations

ABS	Australian Bureau of Statistics
ACA	Australian Communications Authority
ACAP	Aged Care Assessment Program
ACAT	Aged Care Assessment Team
ACCAP	Australian Council for Children and Parenting
ACCMIS	Aged and Community Care Management Information System
ACE	Association for Competitive Employment
ACROD	National industry association for disability services
ADHD	Attention Deficit Hyperactivity Disorder
AEU	Australian Education Union
AFDO	Australian Federation of Disability Organisations
AFHO	Australian Federation of Homelessness Organisations
AGPS	Australian Government Publishing Service
AHURI	Australian Housing and Urban Research Institute
AIC	Australian Institute of Criminology
AIHW	Australian Institute of Health and Welfare
ANIHI	Agreement on National Indigenous Housing Information
ANZSIC	Australian and New Zealand Standard Industrial Classification
AP	Aged Pension
ARC	Australian Research Council
ASCO	Australian Standard Classification of Occupations
AUSSA	Australian Survey of Social Attitudes
ATM	Automatic Teller Machine
ATO	Australian Taxation Office
ATSIC	Aboriginal and Torres Strait Islander Commission
Aus Gov	Australian Government
BMI	Body mass index
CACH	Commonwealth Advisory Committee on Homelessness
CACP	Community Aged Care Packages
CAP	Crisis Accommodation Program
CBSR	Colmar Brunton Social Research
CCCAC	Commonwealth Child Care Advisory Council
CD	Collection district
CDSMC	Community and Disability Services Ministers' Conference
COAG	Council of Australian Governments
COTA	Council on the Ageing
CPI	Consumer Price Index
CRA	Commonwealth Rent Assistance
CRS	Commonwealth Rehabilitation Service
CSHA	Commonwealth–State Housing Agreement
CSMAC	Community Services Ministers' Advisory Council
CSTDA	Commonwealth/State/Territory Disability Agreement
CURF	Confidentialised unit record file (ABS)

DDA	Disability Discrimination Act 1992 (Commonwealth of Australia)
DEH	Australian Government Department of Environment and Heritage
DEST	Australian Government Department of Education, Science and Training
DEWR	Australian Government Department of Employment and Workplace Relations
DHAC	(former) Commonwealth Department of Health and Aged Care
DHS	Victorian Department of Human Services
DHSH	(former) Commonwealth Department of Human Services and Health
DHW	Western Australian Department of Housing and Works
DIMIA	Australian Government Department of Immigration and Multicultural and Indigenous Affairs
DoH	New South Wales Department of Housing
DoHA	Australian Government Department of Health and Ageing
DSP	Disability Support Pension
DTC	Day Therapy Centre
DV	Domestic violence
DVA	Australian Government Department of Veterans' Affairs
EACH	Extended Aged Care at Home
EFTPOS	Electronic funds transfer at point of sale
FaCS	Australian Government Department of Family and Community Services
FBT	Fringe benefits tax
FHOG	First Home Owner Grant
FTB	Family tax benefit (payable as Parts A and B)
FTE	Full-time equivalent
GDP	Gross domestic product
GFCE	Government Final Consumption Expenditure
GST	Goods and services tax
HILDA	Household, Income and Labour Dynamics in Australia Survey
HACC	Home and Community Care
HMAC	Housing Ministers Advisory Council
HREOC	Human Rights and Equal Opportunity Commission
ICF	International Classification of Functioning, Disability and Health
IRSD	Index of Relative Socioeconomic Disadvantage
LBOTE	Language background other than English
Lincoln Center	Lincoln Centre for Ageing and Community Care Research
MACHA	Multi Agency Community Housing Association
MCEETYA	Ministerial Council on Education and Employment, Training and Youth Affairs
MDS	Minimum data set
MHCA	Mental Health Council of Australia
NATSEM	National Centre for Social and Economic Modelling
NCHF	National Community Housing Forum
NCSDD	National Community Services Data Committee
NCSDD	National Community Services Data Dictionary

NCSIA	National Community Services Information Agreement
NCSIMG	National Community Services Information Management Group
NCVER	National Centre for Vocational Education Research
NDA	National Disability Administrators
NEPM	National Environment Protection Measure
NGCSO	Non-government community service organisation
NHDA	National Housing Data Agreement
NHMRC	National Health and Medical Research Council
NISU	National Injury Surveillance Unit (of the AIHW)
NHPC	National Health Performance Committee
NMDS	National minimum data set
NRCP	National Respite for Carers Program
NSSI	National Service Standards Instrument (HACC)
NSHS	National Social Housing Survey
OECD	Organisation for Economic Co-operation and Development
RSE	Relative standard error
SAAP	Supported Accommodation Assistance Program
SCRCSSP	Steering Committee for the Review of Commonwealth/State Service Provision
SDAC	(ABS) Survey of Disability, Ageing and Carers
SEIFA	Socioeconomic indexes for area
SLA	Statistical local area
SOCX	(OECD's) Social expenditure framework
SOMIH	State owned and managed Indigenous housing
SPP	Specific purpose payment
TAFE	Technical and further education
TPDC	Transport and Population Data Centre
UN	United Nations
UN	United Nations Economic and Social Commission for Asia and the Pacific
VET	Vocational education and training
VHC	Veterans' Home Care
WHA	World Health Assembly
WHO	World Health Organization

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.

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.

Auslan The sign language used among signing deaf people in Australia in their everyday communication with each other. A visual/gestural language with no written form and its own distinct grammatical structure.

capital expenditure Expenditure 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).

constant price expenditure Expenditure which has been adjusted for the effects of inflation. This adjustment for inflation allows comparison across different years of the quantity of goods and services on which the expenditure has been incurred.

core activity Defined by the ABS as self-care, mobility and communication. See Technical appendix for more information on these and related terms.

deinstitutionalisation A term referring to a shift in service delivery away from institutional care, towards care in the home and community.

disability An umbrella term for any or all of: an impairment of body structure or function, a limitation in activities, or a restriction in participation. Disability is a multidimensional concept, and is conceived as an interaction between health conditions and the environment.

disabling condition See Technical appendix.

disposable income Gross income less direct tax and Medicare levy.

employed person A person aged 15 years or more who, during the reference week of the labour force survey, worked for one hour or more for pay, profit or commission.

estimated resident population Australia's population statistics are compiled by the ABS according to the place of usual residence of the population. Usual residence is defined as the place where a person has lived or intends to live for a period of 6 months or more.

full-time equivalent (FTE) A standardised measure used in converting number of persons in part-time employment to number of persons in full-time employment.

full-time/part-time employed Full-time employed are those who work 35 or more hours per week; part-time employed are those who work less than 35 hours per week (see also employed person).

Indigenous A person who identifies himself or herself as being of Aboriginal and/or Torres Strait Islander origin and is accepted as such by the community in which he or she lives. (The 'Commonwealth Definition' given in High Court Judgment 1983).

International Classification of Diseases (ICD) The World Health Organization's internationally accepted classification of death and disease. The tenth revision (ICD-10) is currently in use.

International Classification of Functioning, Disability and Health (ICF) The World Health Organization's internationally accepted classification of functioning, disability and health. The classification was endorsed by WHO in May 2001.

labour force Includes people who are employed and people who are unemployed (not employed and actively looking for work).

length of stay (hospital or residential aged care) The time between the date of admission and the date a person is discharged from a hospital or residential aged care. For a current resident, it is the time between the date of admission and a specified date. A same-day hospital patient is allocated a length of stay of 1 day.

long-term health condition See Technical appendix.

mean A measure of the centre of a distribution. It is calculated by dividing the sum of the values by the number of values.

median A measure of the centre of a distribution. It is the middle value in a ranked set of values.

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) In Australia, non-profit institutions financed by the three levels of government and by households, corporations and other non-government organisations. They produce, for the large part, non-market goods and services for the benefit of individuals, households or groups of households.

Organisation for Economic Co-operation and Development (OECD) An organisation of 24 developed countries, including Australia.

patient days The number of full or partial days of stay for patients who were admitted for an episode of care and who underwent separation during the reporting

period. A patient who is admitted and separated on the same day is allocated 1 patient day.

permanent admission (aged care) Admission to residential aged care for long-term care purposes.

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

private hospital A privately owned and operated institution, catering for patients who are treated by a doctor of their own choice. Patients are charged fees for accommodation and other services provided by the hospital and relevant medical and paramedical practitioners. Includes private freestanding day hospital facilities.

projection Is not a forecast but simply illustrates changes that would occur if the stated assumptions were to apply over the period in question.

public hospital A hospital controlled by a state or territory health authority. In Australia public hospitals offer free diagnostic services, treatment, care and accommodation to all who need it.

recurrent expenditure Expenditure on goods and services which does not result in the creation of fixed assets or in the acquisition of land, intangible assets or second-hand plant and equipment. Recurrent expenditure consists mainly of expenditure on wages, salaries and supplements, purchases of goods and services, and recurrent transfer payments (e.g. age pensions).

respite admission (aged care) Admission to residential aged care for short-term, alternative care purposes.

separation The formal process by which a hospital records the completion of treatment and/or care for an admitted patient.

stand-alone psychiatric hospital Establishments devoted primarily to the treatment and care of inpatients with psychiatric disorders.

total fertility rate (TFR) Indicates the average number of babies that would be born over a lifetime to a hypothetical group of women if they were to experience the age-specific birth rates applying in a given year.

transfer payments Payments made by governments either to other levels of government or to non-government organisations for the purpose of financing the current operation of the recipients (recurrent transfer payments), or of meeting part of the cost of capital expenditure of the recipient (capital transfer payments).

unemployed person Person aged 15 years or more who was not employed during the reference week but who had actively looked for work and was currently available for work (see also employed person).

Population tables

Table P1: Indigenous Australians (experimental estimated resident populations), by sex, age and state/territory, 30 June 2001

Age group (years)	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Australia
Indigenous males									
Less than 1	1,877	326	1,727	858	301	237	43	779	6,151
1–4	7,448	1,450	6,893	3,500	1,289	889	201	2,720	24,400
5–9	9,624	1,940	9,090	4,511	1,735	1,183	292	3,683	32,065
10–14	8,704	1,702	7,923	4,349	1,577	1,269	203	3,417	29,152
15–19	6,899	1,429	6,272	3,355	1,354	982	210	3,007	23,526
20–24	5,250	1,115	4,943	2,667	1,031	658	170	2,758	18,600
25–29	4,963	1,117	4,819	2,711	1,035	563	186	2,669	18,069
30–34	4,642	1,038	4,433	2,483	969	551	166	2,274	16,566
35–39	4,271	856	3,905	2,174	852	520	133	1,895	14,612
40–44	3,787	767	3,296	1,759	715	506	132	1,500	12,471
45–49	3,031	630	2,545	1,432	557	437	100	1,194	9,933
50–54	2,333	529	2,044	1,031	420	325	54	872	7,611
55–59	1,714	316	1,229	688	291	223	32	593	5,089
60–64	1,223	216	869	488	183	154	18	463	3,623
65–69	820	147	673	342	122	109	12	262	2,489
70–74	428	90	402	229	91	55	1	177	1,473
75 or more	418	131	463	304	82	57	10	229	1,696
Total males	*67,432*	*13,799*	*61,526*	*32,881*	*12,604*	*8,718*	*1,963*	*28,492*	*227,526*
Indigenous females									
Less than 1	1,314	277	1,187	630	284	192	43	563	4,501
1–4	7,553	1,540	7,282	3,527	1,341	876	222	2,807	25,152
5–9	9,026	1,830	8,547	4,194	1,677	1,116	248	3,314	29,967
10–14	8,155	1,698	7,504	3,992	1,549	1,090	238	3,066	27,304
15–19	6,616	1,372	6,268	3,287	1,317	1,016	202	2,966	23,053
20–24	4,942	1,111	5,429	2,752	1,020	702	178	2,664	18,809
25–29	5,374	1,148	5,581	2,736	1,072	608	171	2,644	19,349
30–34	5,165	1,112	5,158	2,686	1,017	630	179	2,342	18,296
35–39	4,703	944	4,430	2,307	904	594	137	2,039	16,065
40–44	3,929	793	3,485	1,821	775	572	126	1,605	13,114
45–49	3,096	637	2,819	1,524	579	401	88	1,276	10,425
50–54	2,472	516	2,167	1,128	445	290	42	954	8,018
55–59	1,651	340	1,477	743	291	176	36	644	5,363
60–64	1,233	245	1,129	587	255	163	18	550	4,185
65–69	901	170	733	426	156	88	6	377	2,859
70–74	615	129	514	288	121	72	5	236	1,981
75 or more	711	185	674	422	137	80	7	336	2,553
Total females	*67,456*	*14,047*	*64,384*	*33,050*	*12,940*	*8,666*	*1,946*	*28,383*	*230,994*
Total Indigenous persons	**134,888**	**27,846**	**125,910**	**65,931**	**25,544**	**17,384**	**3,909**	**56,875**	**458,520**

Note: Data are final estimates. The data for 'Australia' include 'Federally Administered Territories'.

Source: ABS, Experimental Estimates and Projections, Indigenous Australians, cat. no. 3101.0.

Table P2: Australians (estimated resident populations), by sex, age and state/territory, 30 June 2004

Age group (years)	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Australia
Males									
Less than 1	44,438	31,839	25,111	12,838	8,892	3,003	2,123	1,899	130,160
1–4	174,720	124,579	103,301	50,862	36,474	12,591	8,123	7,139	517,895
5–9	226,431	164,517	137,293	68,610	49,206	16,583	10,694	8,649	682,106
10–14	235,661	170,638	143,845	72,361	51,728	17,728	11,280	8,458	711,825
15–19	232,188	170,511	140,153	74,093	53,191	17,523	12,097	7,673	707,528
20–24	234,633	178,675	141,792	72,358	52,873	15,582	14,586	8,621	719,208
25–29	230,151	171,737	130,459	67,579	48,460	13,220	12,840	8,652	683,157
30–34	255,226	189,195	144,677	74,505	53,589	15,043	12,742	9,301	754,384
35–39	241,135	182,799	137,424	73,115	54,261	15,597	11,881	8,737	725,037
40–44	258,356	187,251	146,423	77,625	58,622	18,058	12,072	8,650	767,179
45–49	236,760	174,081	136,049	72,711	55,160	17,727	11,342	7,134	711,073
50–54	217,792	158,392	127,159	67,280	51,725	16,693	10,974	6,752	656,895
55–59	201,565	145,369	120,074	60,332	48,263	15,486	9,702	5,246	606,115
60–64	153,533	110,507	90,054	44,008	36,189	12,305	6,302	3,559	456,517
65–69	125,608	90,604	70,237	34,739	30,007	9,965	4,583	2,050	367,833
70–74	104,107	75,863	55,080	27,023	25,478	8,013	3,421	1,208	300,211
75–79	86,460	62,785	43,910	21,265	22,543	6,487	2,797	813	247,065
80–84	54,730	39,575	27,623	13,148	14,341	3,943	1,783	371	155,521
85 or more	33,122	24,230	17,158	8,000	8,771	2,371	911	261	94,832
Total males	*3,346,616*	*2,453,147*	*1,937,822*	*992,452*	*759,773*	*237,918*	*160,253*	*105,173*	*9,994,541*
Females									
Less than 1	41,911	30,369	23,839	12,335	8,551	2,802	2,081	1,793	123,690
1–4	164,875	119,514	97,908	48,754	34,876	11,791	7,911	6,777	492,536
5–9	215,385	155,497	130,317	64,964	46,948	15,894	10,279	7,991	647,391
10–14	222,968	162,619	136,292	68,912	49,157	16,710	10,696	7,854	675,348
15–19	221,368	164,436	133,512	70,573	50,356	16,768	11,752	6,979	675,855
20–24	224,525	173,615	135,494	68,822	49,639	14,697	13,713	7,254	687,815
25–29	228,110	170,685	129,362	65,634	45,543	13,394	12,583	8,104	673,487
30–34	258,207	195,658	146,757	73,335	52,520	16,167	12,921	9,089	764,747
35–39	242,062	187,678	141,277	73,293	53,715	16,585	12,194	7,933	734,843
40–44	256,825	191,005	149,941	77,574	58,782	18,837	12,756	7,552	773,382
45–49	238,463	177,627	138,032	73,430	56,040	17,958	12,305	6,689	720,661
50–54	218,199	163,421	127,747	66,815	53,180	16,958	11,636	5,788	663,826
55–59	197,548	146,460	116,170	57,130	49,095	15,574	9,807	4,178	596,014
60–64	150,936	110,540	86,350	42,299	36,448	12,068	6,399	2,657	447,738
65–69	129,692	95,681	68,773	35,033	31,785	10,058	4,837	1,533	377,414
70–74	113,879	83,912	57,205	29,082	28,399	8,634	3,777	1,010	325,913
75–79	106,355	78,366	51,691	25,354	28,054	7,788	3,441	717	301,772
80–84	81,407	60,010	39,201	19,206	21,830	6,141	2,580	476	230,853
85 or more	71,964	52,539	34,347	17,207	19,559	5,386	2,100	366	203,471
Total females	*3,384,679*	*2,519,632*	*1,944,215*	*989,752*	*774,477*	*244,210*	*163,768*	*94,740*	*10,116,756*
Total persons	**6,731,295**	**4,972,779**	**3,882,037**	**1,982,204**	**1,534,250**	**482,128**	**324,021**	**199,913**	**20,111,297**

Note: Data are preliminary estimates. The data for 'Australia' include 'Federally Administered Territories'.

Source: ABS. Australian Demographic Statistics, cat. no. 3101.0.

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