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Health, Community Services, Housing

Steering Committee for the Review of Government Service Provision

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This report is in two volumes: Volume 1 contains Part A (Introduction), Part B (Early Childhood, Education and Training), Part C (Justice), Part D (Emergency Management) and the CD-ROM attachment; Volume 2 contains Part E (Health), Part F (Community Services), Part G (Housing) and Appendix A (the descriptive statistical appendix).

Volume 1

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PART B EARLY CHILDHOOD, EDUCATION AND TRAINING

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Volume 2

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Acronyms and abbreviations

AAT	Administrative Appeals Tribunal
ABS	Australian Bureau of Statistics
ABSCQ	Australian Bureau of Statistics Classification of Qualifications
ACAP	Aged Care Assessment Program
ACAT	Aged care assessment team
ACCMIS	Australian Community Care Management Information System
ACCRS	Aged Care Complaints Resolution Scheme
ACE	adult community education
ACER	Australian Council for Educational Research
ACHS	Australian Council on Healthcare Standards
ACOSS	Australian Council of Social Services
ACSAA	Aged Care Standards and Accreditation Agency
ACSQHC	Australian Commission for Safety and Quality in Health Care
ACT	Australian Capital Territory
ADR	Alternative Dispute Resolution
AEDI	Australian Early Development Index
AFAC	Australasian Fire Authorities Council
AFP	Australian Federal Police

AG	Activity Group
AGCCCS	Australian Government Census of Child Care Services
AGPAL	Australian General Practice Accreditation Limited
AGR	annual growth rate
AHCA	Australian Health Care Agreement
AHMAC	Australian Health Ministers’ Advisory Council
AIC	Australian Institute of Criminology
AIFS	Australian Institute of Family Studies
AIHW	Australian Institute of Health and Welfare
AJJA	Australasian Juvenile Justice Administrators
ANTA	Australian National Training Authority
ANZPAA	Australia and New Zealand Police Advisory Agency
AQF	Australian Qualifications Framework
AQTF	Australian Quality Training Framework
AR-DRG v 5.0	Australian refined diagnosis related group, version 5.0
ARHP	Aboriginal Rental Housing Program
ARIA	Accessibility and Remoteness Index for Australia
ARO	Authorised Review Officer
ASCED	Australian Standard Classification of Education
ASGC	Australian Standard Geographical Classification
ASOC	Australian Standard Offence Classification
ASSNP	measures need for assistance with core activities
ATSB	Australian Transport Safety Bureau
ATSIS	Aboriginal and Torres Strait Islander Services

Aust	Australia
AVETMISS	Australian Vocational Education and Training Management Information Statistical Standard
BBF	Building a Better Future
BEACH	Bettering the Evaluation and Care of Health
CAA	Council of Ambulance Authorities
CACP	Community Aged Care Package
CAD	Coordination and Development committee
CAP	Crisis Accommodation Program
CARDS	Court Assessment Referral Drug Scheme
CCB	Child Care Benefit
CCTR	child care tax rebate
CD	collection district
CD-ROM	Compact Disc Read Only Memory
CDSMAC	Community and Disability Services Ministers' Advisory Council
CFA	Country Fire Authority
CGC	Commonwealth Grants Commission
CHIP	Community Housing and Infrastructure Program
CHP	Community Housing Program
CI	confidence interval
CIS	Complaints Investigation Scheme
CISP	Courts Integrated Services Program
CJGs	Community Justice Groups
COAG	Council of Australian Governments

CRA	Commonwealth Rent Assistance
CRS	Commonwealth Rehabilitation Services
CSDWG	Children’s Services Data Working Group
CSHA	Commonwealth State Housing Agreement
CSMAC	Community Services Ministers’ Advisory Council
CSTDA	Commonwealth State/Territory Disability Agreement
CURF	confidentialised unit record file
DAC	delivery following primary caesarean
DATSIP	Department of Aboriginal and Torres Strait Islander Policy
DCIS	ductal carcinoma in situ
DEA	data envelopment analysis
DEST	Department of Education, Science and Training
DET	Department of Education (NSW)
DEWR	Department of Employment and Workplace Relations
DHS	Department of Human Services (Vic)
DoCS	Department of Community Services (NSW)
DoHA	Department of Health and Ageing
DVA	Department of Veterans’ Affairs
EACH	Extended Aged Care at Home
ECEC	early childhood education and care
EMA	Emergency Management Australia
ERP	estimated resident population
EWG	Evaluation Working Group

EYL	early years learning
FaCS	Department of Family and Community Services
FaCSIA	Department of Families, Community Services and Indigenous Affairs
FCA	Federal Court of Australia
FCoA	Family Court of Australia
FDCQA	Family Day Care Quality Assurance
FMC	Federal Magistrates Court of Australia
FTE	full time equivalent
FWE	full time workload equivalent
GDP	gross domestic product
GP	general practitioner
GPA Accreditation *plus*	General Practice Australia ACCREDITATION *plus*
GSP	gross state product
GSPMR	gestation standardised perinatal mortality rate
GSS	General Social Survey
GST	goods and services tax
HACC	Home and Community Care
HIP	Housing Implementation Project
HREOC	Human Rights and Equal Opportunity Commission
HRSCEET	House of Representatives Standing Committee on Employment, Education and Training
ICD-10-AM	Australian modification of the International Standard Classification of Diseases and Related Health Problems, version 10

ICH	Indigenous community housing
ICHO	Indigenous Community Housing Organisation
ICMS	Integrated Courts Management System
ICT	information and communication technology
IGA	Intergovernmental Agreement
IPD	Implicit Price Deflator
ISC	Industry Skills Council
ISO	International Organisation for Standardisation
ISS	Inclusion Support Subsidy
JET	Jobs, Education and Training
JJNMDS	Juvenile Justice National Minimum Data Set
K10	Kessler – 10 scale
K5	Kessler – 5 scale
LBOTE	Language background other than English
LGCSA	Local Government Community Services Association of Australia
LIPS	Litigants in Person Strategy
LSAC	Longitudinal Study of Australian Children
MBS	Medicare Benefits Schedule
MCEETYA	Ministerial Council on Education, Employment, Training and Youth Affairs
MCPEM-P	Ministerial Council for Police and Emergency Management
MCVTE	Ministerial Council on Vocational and Technical Education

MHENMDS	Mental Health Establishments National Minimum Data Set
MPS	multi-purpose services
na	not available
NATSIHS	National Aboriginal and Torres Strait Islander Health Survey
NATSISS	National Aboriginal and Torres Strait Islander Social Survey
NBCC	National Breast Cancer Centre
NCAC	National Childcare Accreditation Council
NCPASS	National Child Protection and Support Services data working group
NCRS	National Crime Recording Standard
NCSIMG	National Community Services Information Management Group
NCVER	National Centre for Vocational Education Research
NDC	National Data Collection
NDCA	National Data Collection Agency
NESB	non-English speaking background
NFD	not further defined
NHCDC	National Hospital Cost Data Collection
NHIMPC	National Health Information Management Principal Committee
NHMP	National Homicide Monitoring Program
NHMRC	National Health and Medical Research Council
NHPC	National Health Performance Committee

NHS	National Health Survey
NIDP	National Information Development Plan
NISC	National Industry Skills Committee
NMDS	national minimum data set
NMHS	National Mental Health Strategy
no.	number
np	not published
NQC	National Quality Council
NRCP	National Respite for Carers Program
NRF	National Reporting Framework
NSCSP	National Survey of Community Satisfaction with Policing
NSFATSIH	National Strategic Framework for Aboriginal and Torres Strait Islander Health
NSOC	National Senior Officials Committee
NSSC	National Schools Statistics Collection
NSW	New South Wales
NT	Northern Territory
NTSC	National Training Statistics Committee
OCYFS	Office for Children, Youth and Family Support (ACT)
OECD	Organisation for Economic Co-operation and Development
OSHCQA	Outside School Hours Care Quality Assurance
PBS	Pharmaceutical Benefits Scheme
PDF	Portable Document Format
PIP	Practice Incentives Program

PISA	Program for International Student Assessment
PMRT	Performance Measurement and Reporting Taskforce
PRHAP	Public Rental Housing Assistance Program
PRSS	Private Rental Support Scheme
PRTSS	Private Rental Tenancy Support Service
PWI	personal wellbeing index
QIAS	Quality Improvement and Accreditation System
Qld	Queensland
QPILCH	Queensland Public Interest Law Clearing House
QPRIME	Queensland Police Records and Information Management Exchange
RACGP	Royal Australian College of General Practitioners
RADL	remote access data laboratory
RCS	resident classification scale
ROSC	return of spontaneous circulation
RPBS	Repatriation Pharmaceutical Benefits Scheme
RPL	recognition of prior learning
RRMA	Rural, Remote and Metropolitan Areas
RSE	relative standard error
RTO	Registered Training Organisation
SA	South Australia
SAAP	Supported Accommodation Assistance Program
SAPOL	South Australia Police
SAR	service activity reporting

SCRCSSP	Steering Committee for the Review of Commonwealth/State Service Provision
SCRGSP	Steering Committee for the Review of Government Service Provision
SDA	service delivery area
SDAC	Survey of Disability, Ageing and Carers
SDR	service delivery review
SE	standard error
SEWB	Social and Emotional Wellbeing
SIQ	standard Indigenous question
SMART	SAAP Management and Reporting Tool
SOMIH	state owned and managed Indigenous housing
SPER	State Penalties Enforcement Registry
SPS	Suburban Policing Strategy
SSAT	Social Security Appeals Tribunal
SWPE	standardised whole patient equivalent
TAFE	technical and further education
TAHL	Tasmanian Affordable Housing Limited
Tas	Tasmania
TCP	Transition Care Program
TGR	total growth rate
TIMSS	Trends in International Mathematics and Science Study
TVET	technical and vocational education and training
UCC	user cost of capital
UEWI	unlawful entry with intent

VBAC	vaginal birth following primary caesarean
VCAT	Victorian Civil and Administrative Tribunal
VDHS	Victorian Department of Human Services
VET	vocational education and training
VHC	Veterans’ Home Care
Vic	Victoria
VOCAT	Victims of Crime Assistance Tribunal
VPSM	Victorian Patient Satisfaction Monitor
WA	Western Australia

Glossary

Definitions of indicators and other terms can also be found at the end of each chapter.

Access	Measures how easily the community can obtain a delivered service (output).
Appropriateness	Measures how well services meet client needs and also seeks to identify the extent of any underservicing or overservicing.
Constant prices	See ‘real dollars’.
Cost effectiveness	Measures how well inputs (such as employees, cars and computers) are converted into outcomes for individual clients or the community. Cost effectiveness is expressed as a ratio of inputs to outcomes. For example, cost per life year saved is a cost effectiveness indicator reflecting the ratio of expenditure on breast cancer detection and management services (including mammographic screening services, primary care, chemotherapy, surgery and other forms of care) to the number of women’s lives that are saved.
Current prices	See ‘nominal dollars’.
Descriptors	Descriptive statistics included in the Report that relate, for example, to the size of the service system, funding arrangements, client mix and the environment within which government services are delivered. These data are provided to highlight and make more transparent the differences among jurisdictions.
Effectiveness	Reflects how well the outputs of a service achieve the stated objectives of that service (also see program effectiveness).

Efficiency	Reflects how resources (inputs) are used to produce outputs and outcomes, expressed as a ratio of outputs to inputs (technical efficiency), or inputs to outcomes (cost effectiveness). (Also see ‘cost effectiveness’ and ‘technical efficiency’.)
Equity	Measures the gap between service delivery outputs or outcomes for special needs groups and the general population. Equity of access relates to all Australians having *adequate* access to services, where the term *adequate* may mean different rates of access for different groups in the community (see chapter 1 for more detail).
Inputs	The resources (including land, labour and capital) used by a service area in providing the service.
Nominal dollars	Refers to financial data expressed ‘in the price of the day’ and which are **not** adjusted to remove the effects of inflation. Nominal dollars do not allow for inter-year comparisons because reported changes may reflect changes to financial levels (prices and/or expenditure) and adjustments to maintain purchasing power due to inflation.
Output	The service delivered by a service area, for example, a completed episode of care is an output of a public hospital.
Outcome	The impact of the service on the status of individuals or a group, and the success of the service area in achieving its objectives. A service provider can influence an outcome but external factors can also apply. A desirable outcome for a school, for example, would be to add to the ability of the students to participate in, and interact with, society throughout their lives. Similarly, a desirable outcome for a hospital would be to improve the health status of an individual receiving a hospital service.
Process	Refers to the way in which a service is produced or delivered (that is, how inputs are transformed into outputs).
Program effectiveness	Reflects how well the outcomes of a service achieve the stated objectives of that service (also see effectiveness).

Quality	Reflects the extent to which a service is suited to its purpose and conforms to specifications.
Real dollars	Refers to financial data measured in prices from a constant base year to adjust for the effects of inflation. Real dollars allow the inter-year comparison of financial levels (prices and/or expenditure) by holding the purchasing power constant.
Technical efficiency	A measure of how well inputs (such as employees, cars and computers) are converted into service outputs (such as hospital separations, education classes or residential aged care places). Technical efficiency reflects the ratio of outputs to inputs. It is affected by the size of operations and by managerial practices. There is scope to improve technical efficiency if there is potential to increase the quantity of outputs produced from given quantities of inputs, or if there is potential to reduce the quantities of inputs used in producing a certain quantity of outputs.
Unit costs	Measures average cost, expressed as the level of inputs per unit of output. This is an indicator of efficiency.

PART E

HEALTH

E Health preface

Health services are concerned with promoting, restoring and maintaining a healthy society. They involve illness prevention, health promotion, the detection and treatment of illness and injury, and the rehabilitation and palliative care of individuals who experience illness and injury. Broadly defined, the health system also includes a range of activities that raise awareness of health issues, thereby reducing the risk and onset of illness and injury.

Health services in Australia are delivered by a variety of government and non-government providers in a range of service settings (box E.1). The Report primarily concentrates on the performance of public hospitals (chapter 10), primary and community health services (including general practice) (chapter 11) and the interactions among different service mechanisms for dealing with two health management issues: mental health and breast cancer (chapter 12). These services are selected for reporting as they:

- make an important contribution to the health of the community
- reflect government priorities, for example, they fall within the National Health Priority Areas
- represent significant components of government recurrent expenditure on health care
- have common objectives across jurisdictions.

The Australian, State, Territory and local governments spent $45.0 billion (expressed in 2004-05 dollars) on public hospitals, medical services (including payments to general practitioners [GPs] and other specialist practitioners), community and public health, medications and public dental services in 2005-06. These three areas of health care activity accounted for 85.0 per cent of government recurrent health expenditure in 2005-06 (table EA.4). There are no specific estimates of government expenditure on the management of breast cancer for 2005-06. Public health expenditure on breast cancer screening was $139 million in 2005-06 (table 12A.6). Government recurrent expenditure on specialist mental health services was estimated to be around $4.1 billion in 2005-06 (tables 12A.21 and 12A.22). Some of this expenditure was on psychiatric care provided by public (non-psychiatric) hospitals (chapters 10 and 12).

Estimates of government expenditure on health care provision exclude high level residential aged care services and patient transport services (ambulance services including pre-hospital care, treatment and transport services). These services are not covered in the health chapters in this Report, but are reported separately in chapter 9 ('Emergency management') and chapter 13 ('Aged care').

Box E.1 **Some common health terms**

Community health services: health services for individuals and groups delivered in a community setting, rather than via hospitals or private facilities.

General practitioners: medical practitioners who, for the purposes of Medicare, are vocationally registered under s. 3F of the *Health Insurance Act 1973* (Cwlth), hold fellowship of the Royal Australian College of General Practitioners or equivalent, or hold a recognised training placement.

Medicare: covers Australian Government funding of private medical and optometrical services (the Medicare Benefits Schedule [MBS]); selected medications (under the Pharmaceutical Benefits Scheme [PBS]); and public hospital funding (under the Australian Health Care Agreements [AHCAs]), aimed at providing public hospital services free of charge to public patients.

Primary health care: services that:

- provide the first point of contact with the health system
- have a particular focus on prevention of illness and/or early intervention
- are intended to maintain people's independence and maximise their quality of life through care and support at home or in local community settings.

Public health: an organised social response to protect and promote health, and to prevent illness, injury and disability. The starting point for identifying public health issues, problems and priorities, and for designing and implementing medical interventions, is the population (or subgroups). Public health is characterised by a focus on the health of the population (and particular at-risk groups) and complements clinical provision of health care services.

Public hospital: a hospital that provides free treatment and accommodation to eligible admitted people who elect to be treated as public patients. It also provides free services to eligible non-admitted patients and may provide (and charge for) treatment and accommodation services to private patients. Charges to non-admitted patients and admitted patients on discharge may be levied in accordance with the AHCAs (for example, charges for aids and appliances).

Other major areas of government involvement in health provision not covered in the health chapters, or elsewhere in the Report, include:

- public health programs, other than those for breast cancer and mental health
- funding for specialist medical practitioners.

Other government services — such as education, public housing, sanitation and water supply — also influence health outcomes. These are not formally part of Australia's health system and are not the subject of the health chapters. Education (chapters 4 and 5) and public housing (chapter 16) are included in other chapters of the Report.

Indigenous people and people in rural and remote areas often have different health care needs and may experience poorer health outcomes than those of the general community. It is a priority of the Review to improve reporting on the performance of government provided health care services for Indigenous people and for residents in regional Australia.

The remainder of this preface provides a summary of the nature of Australia's health care system, an overview of Indigenous health, and data on broad health outcomes. It also foreshadows future directions in reporting. A list of electronic attachment tables for this preface is provided at the end of the preface. Attachment tables are identified in references throughout the chapter by an 'A' suffix (for example, table EA.3 is table 3 in the electronic attachment tables). Attachment tables can be found on the Review web page (www.pc.gov.au/gsp).

Profile of health services

This section provides a brief overview of Australian health services as a whole. More detailed descriptions of public hospitals, primary and community health services, and mental health and breast cancer services are provided in chapters 10, 11 and 12 respectively.

Roles and responsibilities

The Australian Government's health services activities include:

- funding States and Territories through the Australian Health Care Agreements to deliver public hospital services
- providing rebates to patients for medical services provided by GPs and specialists and delivering public health programs
- funding the PBS
- funding high level residential aged care services
- funding private health insurance rebates
- funding Indigenous-specific primary health

- promulgating and coordinating health regulations
- undertaking health policy research and policy coordination across the Australian, State and Territory governments
- funding hospital services and the provision of other services through the Department of Veterans' Affairs
- funding the Medicare Safety Net.

State and Territory governments contribute funding for, and deliver, a range of health care services, such as:

- public hospital services
- public health programs (such as health promotion programs and disease prevention)
- community health services (including services specifically for Indigenous people)
- public dental services
- mental health programs
- patient transport
- the regulation, inspection, licensing and monitoring of premises, institutions and personnel
- health policy research and policy development
- specialist palliative care.

Local governments are generally involved in environmental control and a range of community-based and home care services, although the exact nature of their involvement varies across jurisdictions. The non-government sector plays a significant role in the health system, delivering general practice and specialist medical and surgical services, dental services, a range of other allied health services (such as optometry and physiotherapy), private hospitals and high level residential aged care services.

Funding

Funding the components of Australia's health care system is a complicated process. The Australian Government subsidises many of the services provided by the non-government sector (mostly through the MBS, the PBS, the private health insurance rebate and the Medicare Safety Net) and contributes funding to a number of nationally coordinated public health programs. It also provides funding under the AHCAs to the states and territories for public hospital services.

State and Territory governments, through income raised by taxes and from both general and specific purpose grants received from the Australian Government, contribute funds to public health, community health services and public hospitals (through casemix and other payments), which in turn fund specialists (through limited fee-for-service or sessional arrangements). Private individuals, health insurance funds and other non-government institutions also contribute funding to a range of health care providers, both government and non-government.

In 2005-06, the Australian, State, Territory and local governments spent $58.9 billion on health services ($56.7 billion expressed in 2004-05 dollars)[1] which represents 67.8 per cent of total health expenditure. The Australian Government accounted for the largest proportion of health care expenditure in Australia — $37.2 billion ($35.8 billion expressed in 2004-05 dollars) or 42.9 per cent of the total in 2005-06. State, Territory and local governments contributed $21.6 billion ($20.8 billion expressed in 2004-05 dollars) or 24.9 per cent of total health expenditure in that year (AIHW 2007a). These shares have remained relatively constant over the last five years. The remainder was paid by individuals, health insurance funds and workers compensation and compulsory motor vehicle third party insurance providers (figure E.1 and tables EA.1 and EA.7).

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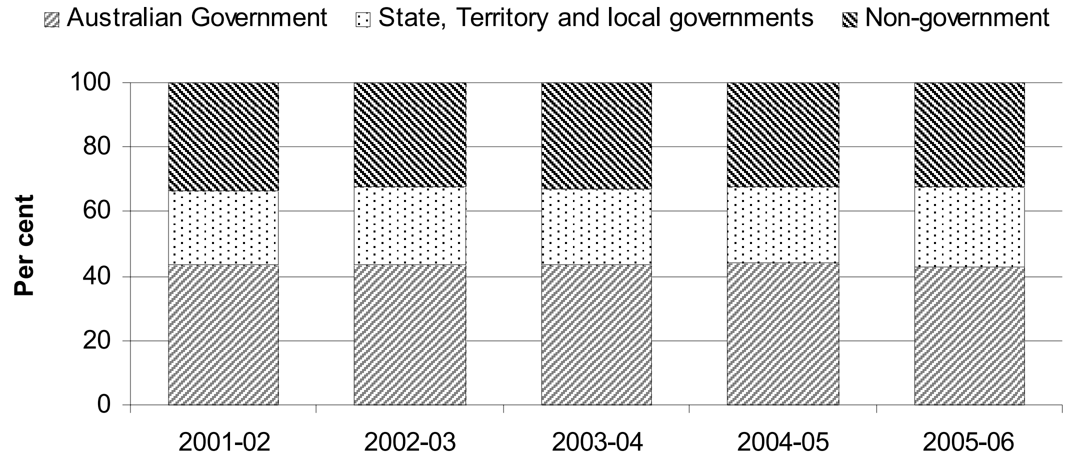
[1] The published source data from the AIHW use 2004-05 as the base year. The same base year is used here for consistency.

Figure E.1 **Total health expenditure, by source of funds (2004-05 dollars)**[a, b, c, d]



[a] Includes recurrent and capital expenditure. [b] Includes expenditure on high level residential aged care (reported in chapter 13) and ambulance services (reported in chapter 9). [c] Expenditure by Australian Government and non-government sources has been adjusted for tax expenditure in relation to private health incentives claimed through the taxation system. [d] 'Non-government' includes expenditure by individuals, health insurance funds, workers compensation and compulsory motor vehicle third party insurers.

Source: AIHW (2007a); table EA.1.

Size and scope of sector

Total expenditure (recurrent and capital) on health care services in Australia was estimated to be $83.6 billion in 2005-06 (in 2004-05 dollars) (table EA.1). This total was estimated to account for 9.0 per cent of gross domestic product in 2005-06, down slightly from 9.1 per cent in 2004-05 and up from 7.5 per cent in 1995-96 (AIHW 2007a). This indicates that health expenditure grew faster than the economy as a whole over the decade to 2005-06.

The growth of total health expenditure over the past decade was largely the result of an increase in expenditure by the Australian, State, Territory and local governments, which grew proportionally faster than expenditure by non-government sources. Between 1995-96 and 2005-06, the average annual rate of growth in real expenditure was 4.9 per cent for the Australian Government, 6.2 per cent for State, Territory and local governments, and 4.5 per cent for non-government sources (AIHW 2007a).[2]

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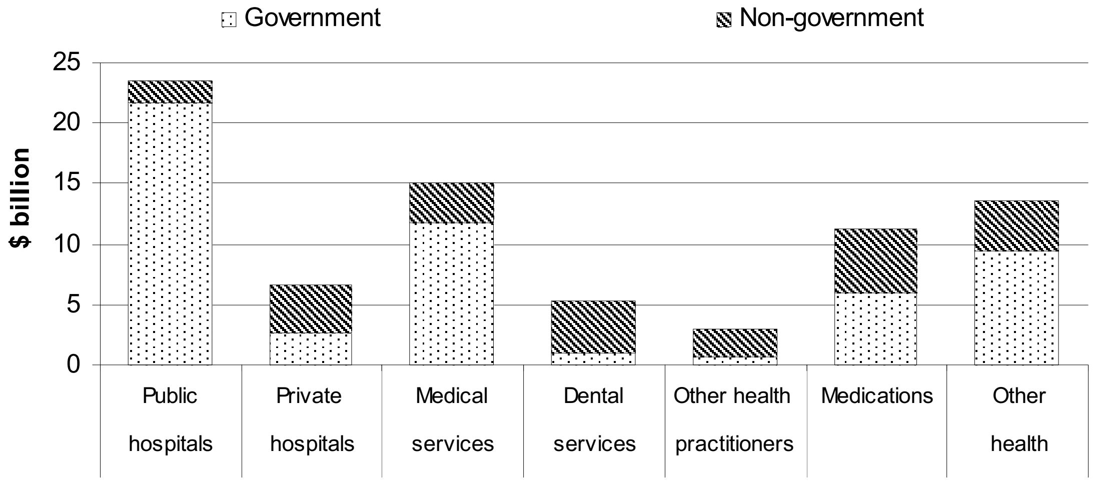
[2] There was a break in series due to differences in definitions of public hospital and public hospital services between 2002-03 and 2003-04.

The introduction of programs supporting private health insurance was a significant factor in the increase in expenditure by the Australian Government in the late 1990s. On 1 January 1999, the Australian Government replaced the Private Health Insurance Incentive Scheme with a 30 per cent rebate on private health insurance premiums. Australian Government expenditure on the rebate has increased each year from $2.1 billion in 2001-02 to $3.2 billion in 2005-06 in current prices (that is, not adjusted for inflation) (AIHW 2007a).

The Medicare Safety Net, introduced in March 2004, has also contributed to increased Australian Government expenditure. Under the Medicare Safety Net, patients are reimbursed for 80 per cent of their out-of-pocket costs for medical treatment received in a non-hospital setting, once a certain threshold is reached in a calendar year. Total Medicare Benefits Schedule Medicare Safety Net expenditure was $257.8 million in the year ending 31 December 2005 (DoHA 2006a).

Public hospitals were the single largest item of recurrent health care expenditure by government and non-government sources in 2005-06. Total real expenditure on public hospitals (which excludes expenditure on community and public health services, dental and ambulance services and health research undertaken by public hospitals) was $24.3 billion, of which governments paid $22.5 billion (in 2004-05 dollars) (figure E.2). Public hospitals accounted for 40.8 per cent of government recurrent expenditure on health care services in 2005-06. Medical services accounted for $12.2 billion of government expenditure (22.2 per cent of total health expenditure) and medications accounted for $6.1 billion (11.1 per cent) (table EA.2).

Figure E.2 Recurrent health expenditure, by area of expenditure, 2005-06 (2004-05 dollars)[a, b, c, d, e, f]



[a] Government funding of recurrent health expenditure is not adjusted for non-specific tax expenditures. [b] Almost all expenditure on medical services relates to services provided by practitioners on a fee-for-service basis, including those provided to private patients in hospitals. Excluded are the medical component of hospital care provided to public hospital inpatients and the outpatient medical services provided at public hospitals. [c] Medications include (but are not limited to) those provided under the PBS. [d] High level residential aged care services cover services to those residents requiring and receiving a level of care that falls within one of the four highest levels of care. These services are commonly classified as health services expenditure, but are discussed separately in this Report (chapter 13). [e] Government funding on other health practitioners includes DVA funding and DoHA hearing services (audiology component) which was previously included in 'other health'. [f] Other health expenditure includes ambulance, other institutional health nec., dental services, community health, aids and appliances, public health, other non-institutional health nec., administration and research.

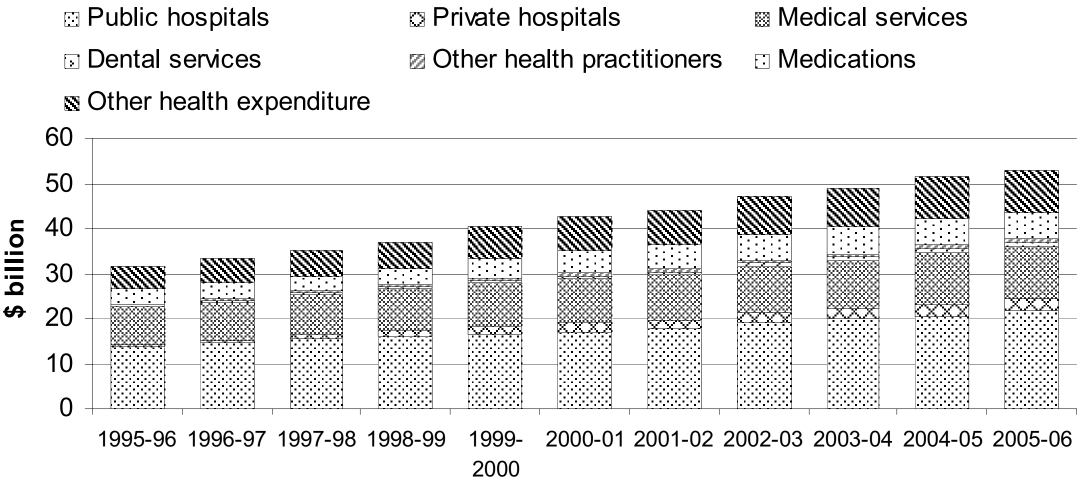
Source: AIHW (2007a); tables EA.2 and EA.3.

The relative share of government recurrent health expenditure allocated to public hospitals has fallen from 43.2 per cent in 1995-96 to 40.8 per cent in 2005-06. This decline reflects the more rapid growth over the decade of government expenditure on private hospitals and medications (figure E.3 and table EA.2). The average annual growth rate of government real recurrent expenditure on private hospitals was 25.0 per cent between 1995-96 and 2005-06 (albeit from a relatively low base), compared with 9.3 per cent for medications and 7.9 per cent for public hospitals (AIHW 2007a). Policy measures introduced over the decade that were aimed at restraining growth in government health expenditure included the restriction of Medicare provider numbers, initiatives to encourage the use of generic medication brands, and increases in co-payments for medications.

The high annual growth in expenditures on medications and private hospitals meant they also grew as a proportion of government health care expenditure over the period 1995-96 to 2005-06. Government expenditure on medications increased from 10.4 per cent of government health expenditure in 1995-96 to 11.1 per cent in

2005-06, and expenditure on private hospitals increased from 1.2 per cent to 5.0 per cent over the same period (table EA.2).

Figure E.3 **Government recurrent expenditure, by area of expenditure (2004-05 dollars)**[a, b, c, d, e]



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[a] Medications include (but are not limited to) those provided under the PBS. [b] Almost all expenditure on medical services relates to services provided by practitioners on a fee-for-service basis, including those provided to private patients in hospitals. Excluded are the medical component of hospital care provided to public hospital inpatients, and the outpatient medical services provided at public hospitals. [c] High level residential aged care is reported in chapter 13. [d] Other health expenditure includes community and public health services, funding for aids and appliances, administration, private hospitals, ambulance services (reported in chapter 9), research, dental services and public psychiatric hospitals. [e] Real (constant price) estimates have been calculated by applying the AIHW total health price index (table EA.7).

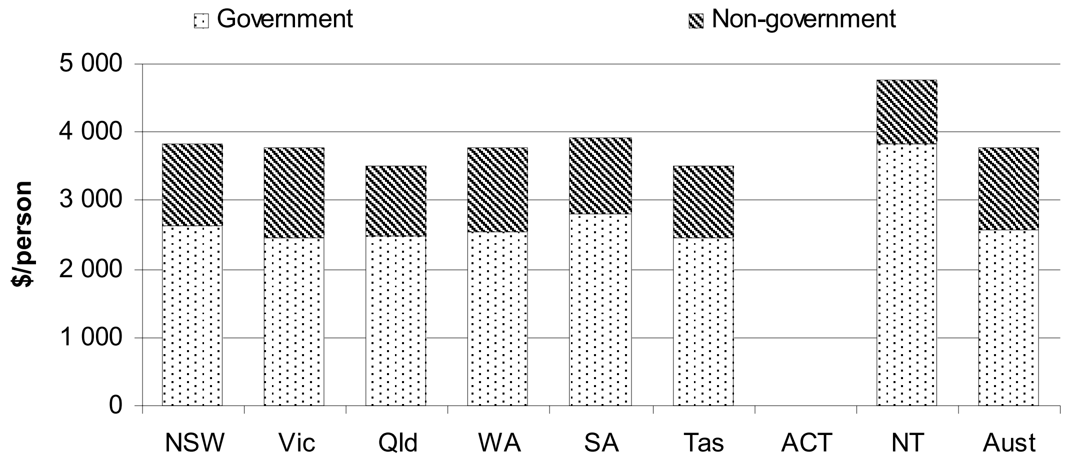
Source: AIHW (2007a); table EA.2.

Health expenditure per person

Health expenditure per person in each jurisdiction is affected by different policy initiatives and socioeconomic and demographic characteristics. Nationally, total health expenditure (recurrent and capital) per person in 2005-06 (expressed in 2004-05 dollars) was $3758 (table EA.5). Average health expenditure per person in Australia increased from $3378 in 2001-02 to $3758 in 2005-06 (expressed in 2004-05 dollars) (table EA.5). The average annual growth rate in average health expenditure per person (expressed in 2004-05 dollars) from 2001-02 to 2005-06 was 2.7 per cent (table EA.5).

Government real recurrent health expenditure per person in Australia increased from $2446 in 2001-02 to $2581 in 2005-06 (expressed in 2004-05 dollars). Non-government recurrent expenditure per person in Australia declined from $1191 in 2001-02 to $1182 in 2005-06 (expressed in 2004-05 dollars) (figure E.4 and table EA.6).

Figure E.4 **Recurrent health expenditure per person by source of funds, excluding high level residential aged care, 2005-06 (2004-05 dollars)**[a, b, c]



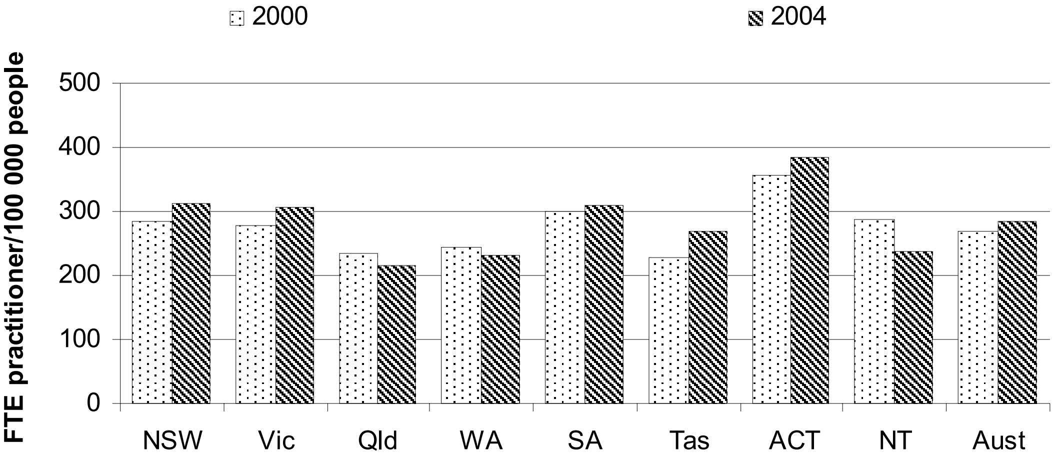
[a] Includes expenditure on high level residential aged care (reported in chapter 13) and ambulance services (reported in chapter 9). [b] Government expenditure includes expenditure by the Australian, State, Territory and local governments. [c] ACT per person figures are not calculated, as the expenditure numbers for the ACT include substantial expenditures for NSW residents, and the ACT population is not the appropriate denominator.

Source: AIHW (2007a); table EA.6.

Health workforce

In 2004, there were 58 211 registered medical practitioners in Australia working in medicine. A further 793 were in the medical labour force but on extended leave or looking for work. The majority of employed practitioners working in medicine were clinicians (92.7 per cent), of whom 40.8 per cent were primary care practitioners (mainly general practitioners), 35.3 per cent were specialists and 23.9 per cent were either specialists-in-training or hospital non-specialists (AIHW 2006a). The number of full time equivalent (FTE) practitioners per 100 000 people by jurisdiction is illustrated in figure E.5.

Figure E.5 **Employed medical practitioners**[a, b]

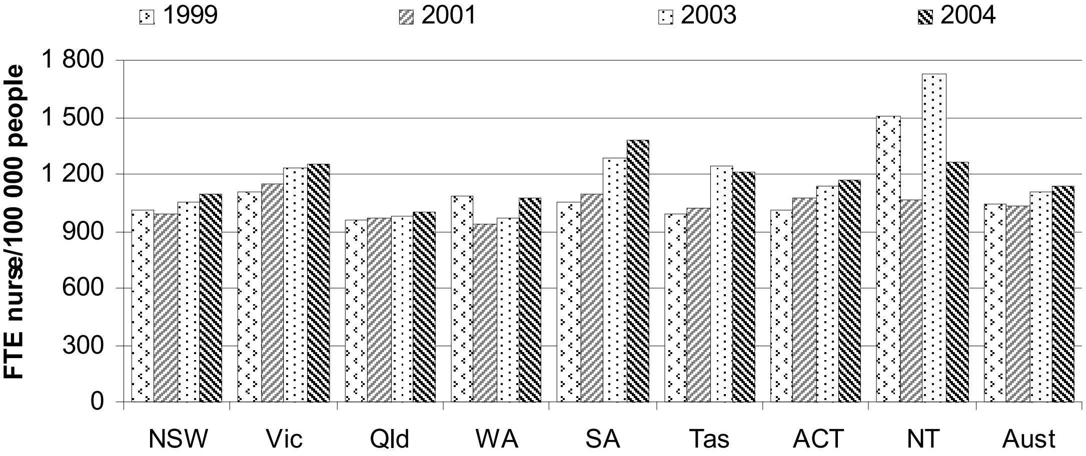


[a] FTE practitioner rate (per 100 000 people) based on a 45-hour week. [b] Number of 'employed medical practitioners' does not include medical practitioners on extended leave.

Source: AIHW (2006a); table EA.8.

The number of FTE nurses per 100 000 people by jurisdiction is illustrated in figure E.6. The national increase in FTE nurse rate in Australia arose from both an increase in the number of nurses employed and an increase in average hours worked (AIHW 2006b).

Figure E.6 **Employed nurses**[a, b]



[a] FTE nurse rate (per 100 000 people) based on a 45-hour week. [b] Number of 'employed nurses' does not include nurses on extended leave.

Source: AIHW (2006b); table EA.9.

Overview of Indigenous health

The Steering Committee has placed a high priority on reporting on government services to Indigenous people. Data on health outcomes and the provision of health services for Indigenous people are included where possible in this Report. This overview is designed to assist interpretation of these data and provide a broader understanding of Indigenous health issues.

Data are reported against several of these indicators for Indigenous Australians as well as for all Australians. The completeness of Indigenous identification in hospital admitted patient data varies across states and territories. The AIHW (2005b) report *Improving the Quality of Indigenous Identification in Hospital Separations Data* found that Indigenous patient data was of acceptable quality for analytical purposes only for Queensland, WA, SA, and public hospitals in the NT. Following new assessments of the quality of Indigenous identification in 2007, the National Health Information Management Principal Committee (NHIMPC) has recently approved NSW Indigenous patient data as acceptable in quality for analytical purposes, from the 2004-05 reference year. A proposal to accept Victorian data as acceptable was being considered by the NHIMPC in late 2007. Efforts to improve Indigenous identification across states and territories are ongoing.

The data are not necessarily representative of other jurisdictions. Indigenous patients are underidentified, to an extent that varies across jurisdictions. Because of improvements in data quality over time, caution also should be used in time series analysis of the data.

Australian Indigenous people are more likely to experience disability and significantly lower quality of life due to poorer health, and to have shorter life expectancies than the rest of the Australian population (SCRGSP 2007). These patterns are reflected in Australian data on: mortality, life expectancy and birthweights (later in this preface); hospital separation rates; hospitalisation rates for diabetes, assault and infectious pneumonia; fetal, neonatal and perinatal death rates (chapter 10); and suicide (chapter 12).

A number of recent publications include more comprehensive data on the health status of Indigenous people and Indigenous health-related factors. These include *Aboriginal and Torres Strait Islander Health Performance Framework 2006 Report: Detailed Analysis* (AIHW 2007b), *Overcoming Indigenous Disadvantage: Key Indicators 2007* (SCRGSP 2007), *Australia's Health* (AIHW 2006c), *Aboriginal and Torres Islander People with Coronary Health Disease* (AIHW 2006d) and *The Health and Welfare of Australia's Aboriginal and Torres Strait Islander Peoples* (ABS and AIHW 2005).

Contributing factors

The physical and social environments in which Indigenous people live affect their opportunities to live productive lives relatively free of serious illness. Many Indigenous people live today in conditions of clear social and economic disadvantage, which contributes to poor health in many groups of Indigenous people, along with other geographic, environmental and cultural factors.

There are relatively low education levels among Indigenous people. Nationally, Indigenous students were around half as likely to continue to year 12 as non-Indigenous students in 2006 (SCRGSP 2007).

Indigenous people have relatively low employment and income levels that may create financial barriers to accessing health services. In 2004-05 the full time employment rate for Indigenous people was much lower than that for non-Indigenous people for both males and females. Both household and individual incomes were lower on average for Indigenous people than for non-Indigenous people (SCRGSP 2007).

There are high imprisonment rates among Indigenous people. After adjusting for age differences, Indigenous people were 13 times more likely than other Australians to be imprisoned at 30 June 2006 (SCRGSP 2007).

Indigenous people have relatively high rates for health risk factors such as obesity, smoking, substance abuse and violence. In 2004-05, 50 per cent of Indigenous people aged 18 years and over were daily cigarette smokers.

In 2004-05, while Indigenous adults were twice as likely to have abstained from alcohol consumption in the last 12 months, as compared with the non-Indigenous population, over half of Indigenous adults (55 per cent) reported drinking alcohol at short term risky to high risk levels at least once in the last 12 months.[3] Around 16 per cent (similar to the proportion of non-Indigenous people) reported long term risky to high risk alcohol consumption in the week prior to interview (where long term risky to high risk alcohol consumption equates to average daily consumption of more than 50 millilitres per day for males and more than 25 millilitres per day for females for the previous seven days prior to interview). During 2004-05, Indigenous people were more than four times as likely to be in hospital for alcohol-related mental and behavioural disorders as other people (SCRGSP 2007).[4] The National

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[3] Short term risky to high risk alcohol consumption is mainly associated with 'binge' drinking.

[4] Short term risk is the risk of harm in short term associated with given levels of alcohol consumption on any one occasion. Long term risk is associated with regular daily patterns of

Health and Medical Research Council (NHMRC) Australian Alcohol Guidelines (2001) on which the definitions of risky and high risk drinking are based, are currently under revision.

Geographic distance to health services, particularly in remote and very remote areas contributes to health disadvantage of Indigenous people. In 2006, a total of 417 (35 per cent) discrete Indigenous communities[5] were located 100 kilometres or more from the nearest Aboriginal Primary Health Care Centre and of those, 92 (22 per cent) were larger communities. A total of 372 discrete Indigenous communities (31 per cent) were located 100 kilometres or more from the nearest community health centre and of these, 90 (24 per cent) were larger communities with a population of 50 or more people. A total of 755 (64 per cent) discrete Indigenous communities were located 100 kilometres or more from the nearest hospital. On a population basis, 25 per cent of Aboriginal and Torres Strait Islander people living in communities were 100 kilometres or more from the nearest hospital (ABS 2007c).

Indigenous people live in inadequate and overcrowded housing, particularly in remote and very remote areas. In 2004-05, 25 per cent of Indigenous people aged 15 years and over lived in overcrowded households (SCRGSP 2007).

Indigenous people have language barriers to accessing health and health-related services. In 2002 approximately 11 per cent of Indigenous people aged 18 years and over reported difficulties understanding or being understood by service providers. Indigenous people living in remote areas were more likely to report experiencing difficulties than those in non-remote areas (ABS and AIHW 2005).

These influences on the health status of Indigenous people vary across urban, rural and remote areas. Geographic and environmental health factors, for example, may be less relevant in urban areas (ABS and AIHW 2005). The extent to which jurisdictional differences in the reported health outcomes for Indigenous people can be attributed to the performance of government funded health services alone is limited. The limitation is due to the complexity of other influences on Indigenous health and ongoing data quality problems (discussed elsewhere in this preface).

A wide range of government provided or funded services (other than health services) seek to address the environmental, socioeconomic and other factors that

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alcohol consumption and defined by the average daily intake of alcohol over the seven days of the reference week.

[5] A geographic location, bounded by physical or cadastral (legal) boundaries, and inhabited or intended to be inhabited predominantly (i.e. greater than 50 per cent of usual residents) by Aboriginal or Torres Strait Islander peoples, with housing or infrastructure that is managed on a community basis.

affect Indigenous health. These services include government schools, housing, justice and correctional services, which are discussed elsewhere in this Report. The Steering Committee publication, *Overcoming Indigenous Disadvantage: Key Indicators 2007* (SCRGSP 2007), examines these and other multiple contributors (and their complex cross-links) to outcomes for Indigenous people.

Government policies and programs

The majority of government expenditure on Indigenous health is made through mainstream health programs (AIHW 2005a). In addition, the Australian, State and Territory governments fund Indigenous-specific health programs and undertake coordination and research activities. Most Australian Government expenditure on Indigenous-specific health programs is directed to Indigenous-specific primary health. State and Territory governments fund a range of community and public health programs that specifically target Indigenous people within their jurisdictions (see chapter 11).

At the national level, the National Aboriginal and Torres Strait Islander Health Council provides policy advice to the Australian Government Minister for Health and Ageing on Indigenous health issues. The Council has overseen the development of the National Strategic Framework for Aboriginal and Torres Strait Islander Health, which all health ministers endorsed at the July 2003 Australian Health Ministers Conference. This framework outlines agreed principles and the following nine key result areas for Indigenous-specific primary health:

- community controlled primary health care
- a health system delivery framework to improve the responsiveness of both mainstream and Indigenous-specific health services to Indigenous health needs
- a competent health workforce with appropriate skills and training in both mainstream and Indigenous-specific health services
- emotional and social wellbeing, focusing on mental health, suicide, family violence, substance misuse and male health
- environmental health, including safe housing, water, sewerage and waste disposal
- wider strategies that have an impact on health in portfolios outside the health sector, such as education, employment and transport
- data, research and evidence to improve information on health service effectiveness in meeting the needs of Indigenous Australians

- resources and finances commensurate with Indigenous health needs, the cost of delivering services and community capacity to deliver health outcomes
- accountability of health services to communities and governments.

The National Strategic Framework is complemented by a National Strategic Framework for Aboriginal and Torres Strait Islander Mental Health and Social and Emotional Wellbeing 2004–2009 (SEWB Framework), which was agreed by the Australian Health Ministers Advisory Council in March 2004. The SEWB Framework sits within the context of the National Strategic Framework for Aboriginal and Torres Strait Islander Health and the Third National Mental Health Plan. (For a discussion of the Third National Mental Health Plan see chapter 12).

Agreements on Aboriginal and Torres Strait Islander Health (framework agreements) have been established in each State and Territory between the Australian, State and Territory governments and the community sector. The agreements promote a partnership approach and commit signatories to work together to:

- increase the level of resources allocated to reflect the level of need
- plan jointly
- improve access to both mainstream and Indigenous-specific health and health related services
- improve Indigenous health data collection and evaluation.

Each State and Territory and the Australian Government is developing an implementation plan under the National Strategic Framework. Taking a whole of government approach, these plans detail information on existing and planned action by each government to improve health outcomes for Indigenous people. They outline programs and policy approaches which are the primary responsibility of each government both within the health department and in other portfolios. Each jurisdiction reports to health ministers on health portfolio progress under the plan every year and on the whole of government contribution every two years.

The Aboriginal and Torres Strait Islander Health Performance Framework has been developed under the auspices of the Australian Health Minister's Advisory Council to support the implementation of the National Strategic Framework for Aboriginal and Torres Strait Islander Health (NSFATSIH). The Health Performance Framework is designed to measure the impact of the NSFATSIH and inform policy analysis, planning and program implementation. The first Aboriginal and Torres Strait Islander Health Performance Framework Report was released in late 2006 and preparation for the 2008 Health Performance Framework Report is currently underway.

Expenditure

It is not always possible to make accurate estimates of health expenditure for Indigenous people and their corresponding service use. For example, Indigenous status is not always clearly stated or recorded. Data on Indigenous status are often unavailable for privately funded services (although they are available for many publicly funded health services). The scope and definition of health expenditures also have some limitations. Other (non-health) agency contributions to health expenditure, such as those incurred within education departments and prisons are not included. There may also be some inconsistencies across data providers resulting from limitations of financial reporting systems and different reporting mechanisms (AIHW 2005a).

The most recent estimates of health services expenditure for Aboriginal and Torres Strait Islander peoples are for 2001-02 (AIHW 2005a). Total recurrent government and non-government expenditure on health services for Indigenous people was estimated at $1788.6 million in 2001-02. This was equivalent to $3901 per Indigenous person compared with $3308 per non-Indigenous person. Because Indigenous people relied heavily on publicly funded health care providers, government expenditures were much higher for them than for other people — $3614 per person compared with $2225 (AIHW 2005a).

The higher levels of health expenditure on Indigenous people are a reflection of their average higher levels of morbidity and the much larger proportion who live in remote Australia where the cost of service provision is higher.

In 2001-02, governments are estimated to have provided 92.7 per cent of the funding for expenditure on health goods and services for Indigenous people. States and territories contributed 49.5 per cent and the Australian Government an estimated 43.1 per cent. Non-government sources such as injury compensation insurers, private health insurers and out-of-pocket payments supported the remaining funding by users of services (AIHW 2005a).

The majority of health expenditure on Indigenous people was allocated through mainstream health programs — admitted and non-admitted patient services, community health services, medical and medications health services, and public health services. A small proportion of health expenditure was allocated through programs directly targeting Indigenous people, the most significant being the Aboriginal and Torres Strait Islander Health Care Services (AIHW 2005a). More detailed Indigenous health expenditure data were reported in the 2002 Report (SCRGSP 2002). Information about expenditure on primary health care for Indigenous people was reported under the ‘access to primary health’ indicator in the *Overcoming Indigenous Disadvantage: Key Indicators 2007* report

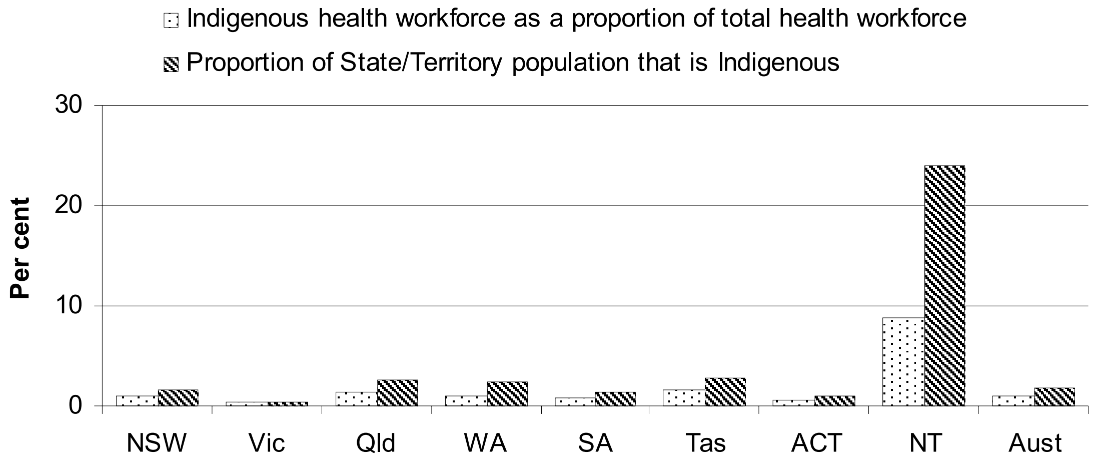
(SCRGSP 2007). In 2001-02, expenditure on primary health care (medical, community health and dental services) for Indigenous people was $1224 per person compared with $932 per non-Indigenous person.

Indigenous health workforce

Compared with non-Indigenous people, Indigenous people are significantly under-represented in the health workforce. This can potentially contribute to Indigenous peoples' reduced access to health services. One patient satisfaction survey found that the presence of an Indigenous doctor at a community health centre was a main reason for Indigenous people attending the clinic. In addition, the number of Indigenous patients attending the clinic increased markedly following the arrival of the Indigenous doctor and other changes in the service designed to make it more welcoming. Patients reported that an Indigenous doctor was 'more understanding of their needs' (DoHA 2006b).

In 2006, Indigenous people accounted for 1.0 per cent of the health workforce, but were 1.8 per cent of the total population. Indigenous health workers are still under-represented in each State and Territory (figure E.7).

Figure E.7 **Indigenous health workforce as a proportion of total health workforce, by jurisdiction, 2006[a, b, c]**



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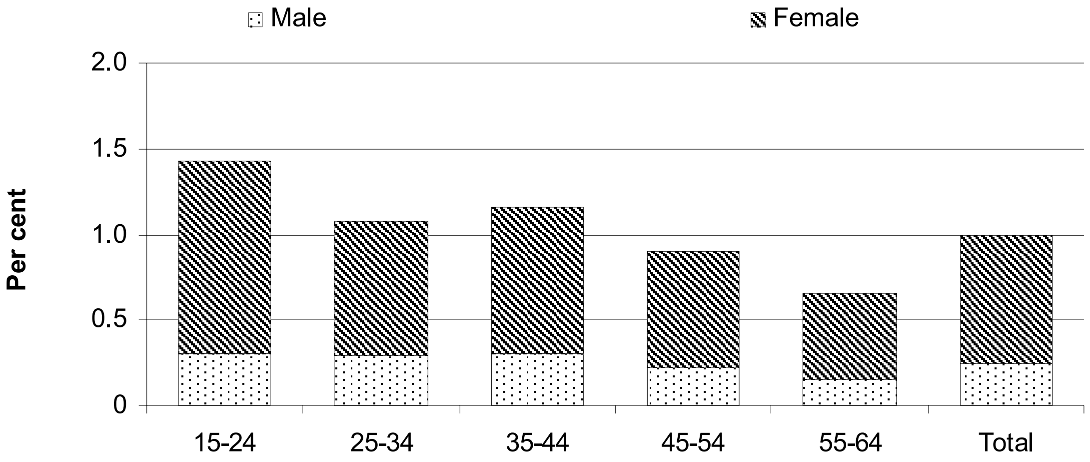
[a] Aged 15 years and over. [b] Cells in this table have been randomly adjusted to avoid the release of confidential data. [c] Australian total data includes other territories.

Source: ABS (unpublished), ABS (2007b); table EA.10.

For younger age-groups, Indigenous people make up a higher proportion of the health workforce — 1.4 per cent of the workforce aged 15–24 years and 1.1 per cent of the workforce aged 25–34 years. Indigenous females represented a higher proportion of the health workforce than Indigenous males across all age-groups (figure E.8).

Figure E.8 **Indigenous health workforce as a proportion of total health workforce, by age-group and sex, 2006**



Source: ABS (unpublished), *Census of Population and Housing*; table EA.11.

Indigenous health workforce by occupation

In 2006, there were 100 Indigenous people working as medical practitioners and 1223 Indigenous people working as midwifery and nursing professionals (table E.1).

After nursing, Indigenous people in the health workforce were most commonly employed as Aboriginal and Torres Strait Islander health workers (965 people). Aboriginal and Torres Islander health workers may be employed as specialists in areas such as alcohol, mental health, diabetes, eye and ear health, sexual health, or they may work as generalist members of primary care team, or as hospital liaison officers (table EA.12).

Table E.1 **Indigenous persons employed in selected health-related occupations, 2006[a, b]**

	Indigenous people	*All persons*	*Percent of Indigenous people in selected health-related occupations*
			Per cent
Health and Welfare Services Managers	141	10 807	1.3
Psychologists	39	13 437	0.3
Health diagnostic and promotion professionals	648	48 079	1.3
Health therapy professionals	321	64 597	0.5
Medical practitioners	100	55 075	0.2
Midwifery and nursing professionals	1 223	200 400	0.6
Health and welfare support workers	2 413	99 957	2.4
Total aged 15 years and over	**4 891**	**492 342**	**1.0**

[a] Aged 15 years and over. [b] Further information to the data included in this table and/or its interpretation is provided in table EA.12.

Source: ABS (unpublished), *Census of Population and Housing*; table EA.12.

Self-assessed health

The results from the 2006 General Social Survey indicate that the majority of Australians (84 per cent) aged 18 years or over reported their health as either, good, very good or excellent. The proportion of persons reporting fair or poor health generally increased with age, from 7 per cent of those aged 18 to 24 years to 39 per cent of those aged 75 years or over (ABS 2007d). Taking into account differences in age structure between the Indigenous and non-Indigenous populations, Indigenous people overall were almost twice as likely to report their health as fair or poor (29 per cent), than non-Indigenous Australians (15 per cent) in 2004-05 (ABS 2006d).

Data quality

Good quality data are needed to assess the effectiveness of programs and to evaluate policies designed to improve health services and outcomes for Indigenous people. Despite recent improvements, the quality of estimates of Indigenous health information is limited by problems with the underlying data and the calculation methodology. Some of the problems associated with Indigenous health data are outlined in (ABS 2006a), and (ABS and AIHW 2006) including:

- Indigenous people are not always accurately or consistently identified in administrative health data collections (such as hospital records and birth and death registrations), given variation in definitions, different data collection methods and inaccurate or incomplete recording of Indigenous status.
- The ABS has introduced a program of three yearly Indigenous household surveys with sample sizes designed to support the production of reliable State and Territory level data, so every three years, some health status and health risk factors are measured. Every six years, and in parallel with the National Health Survey, more detailed Indigenous health status information is collected, together with health service use, health actions, health related aspects of lifestyle and other health risks. This also enables Indigenous to non-Indigenous comparisons for relevant variables. Other health related surveys, which may include an Indigenous identifier, do not necessarily provide reliable data on Indigenous people, because of small sample size, limited geographic coverage or survey design.
- Inconsistent data definitions and differences in the accuracy of identifying Indigenous status have lead to problems making comparisons between jurisdictions, and comparisons over time.
- Experimental estimates of the Indigenous population are re-based by the ABS every five years following availability of new Census data. Once new Indigenous population estimates and projections have been produced by ABS, revisions may be required to various rates and rate ratios used in previous editions of the Report where those rates data are to be carried forward in new reports.

As part of the development of the Aboriginal and Torres Strait Islander Health Performance Framework, key priorities for data development will be identified to support an ongoing work program of data improvements.

Framework for measuring the performance of the health system

Government involvement in health services is predicated on the desire to improve the health of all Australians and to ensure equity of access (box E.2). Governments use a variety of services in different settings to fulfil these objectives.

Measuring the effectiveness, equity and efficiency of Australia’s health system is a complex task. It must account for the performance of a range of services (such as prevention and medical intervention) and of service providers (such as community health centres, GPs and public hospitals), and account for the overall outcomes generated by the health system. The appropriate mix of services — including the prevention of illness and injury, and medical treatment (prevention versus medical intervention) — and the appropriate mix of service delivery mechanisms (community-based versus hospital-based) play an important role in determining outcomes. Other relevant factors are external to the health system, such as the socioeconomic and demographic characteristics of the population, available infrastructure and the environment.

Box E.2 **Overall objectives of the health system**

Government involvement in the health system is aimed at efficiently and effectively protecting and restoring the health of the community by:

- preventing or detecting illness through the provision of services that can achieve improved health outcomes at relatively low cost
- caring for ill people through the use of appropriate health and medical intervention services
- providing appropriate health care services that recognise cultural differences among people
- providing equitable access to these services
- achieving equity in terms of health outcomes.

Primary prevention strategies are implemented before the diagnosis of an illness and generally aim to:

- reduce a person’s risk of getting a disease or illness by increasing protective factors
- delay the onset of illness.

Medical intervention strategies are implemented after a diagnosis.

The National Health Performance Committee has developed the National Health Performance Framework to guide the reporting and measurement of health service performance in Australia. A number of other groups involved in health performance indicator development have adopted this framework for use within specific project areas and in publications. These groups include the National Health Priority Performance Advisory Group, the former Australian Council for Safety and Quality in Health Care, the National Mental Health Working Group and the Australian Council on Healthcare Standards.

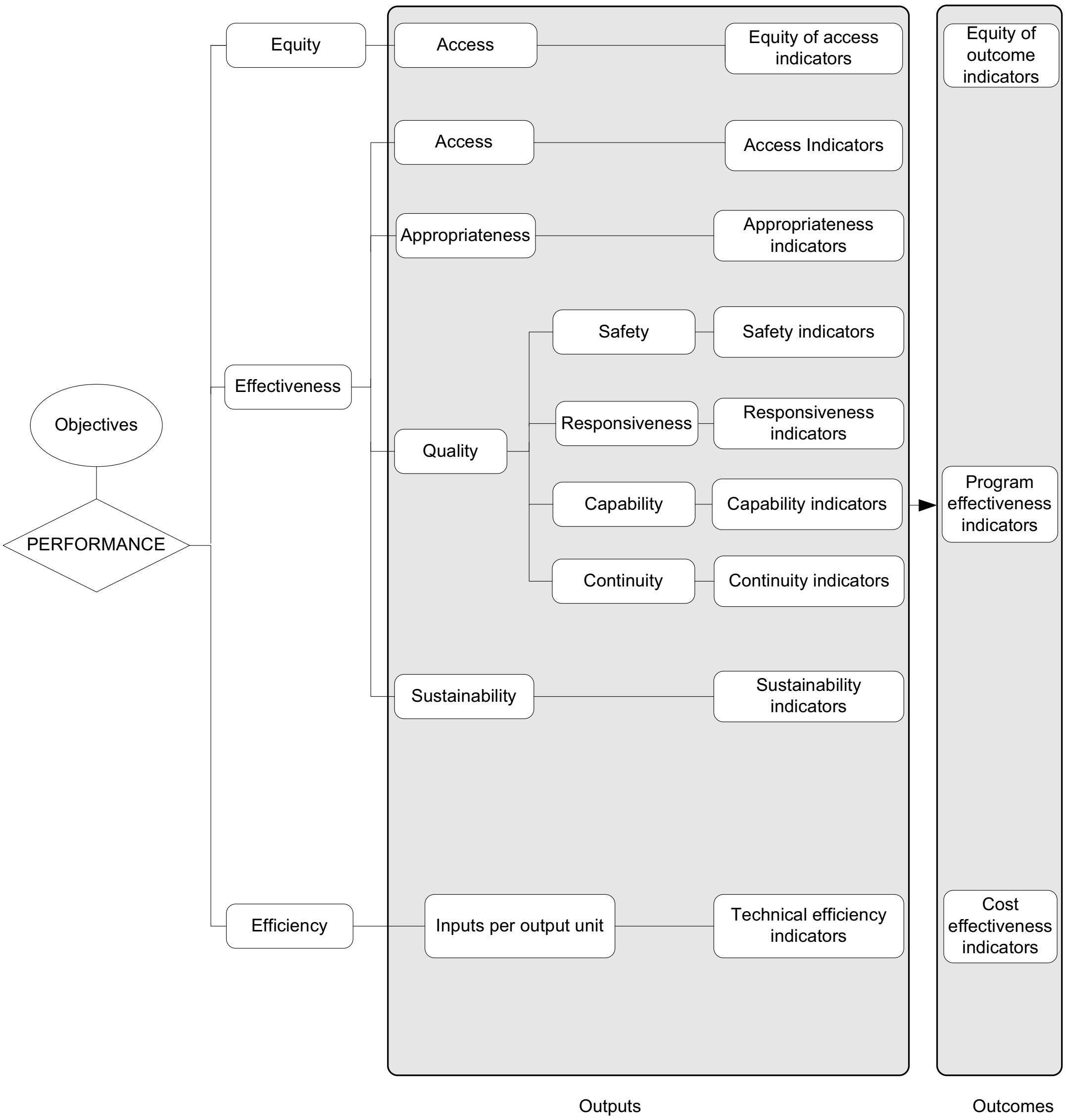
In the 2004 Report, the Steering Committee sought to align the general Review framework with the National Health Performance Framework as far as possible, for application to government health services. Complete alignment was not possible, given the different terms of reference of the two committees. The performance framework for health services in this Report thus reflects both the general Review framework and the National Health Performance Framework. It differs from the general Review framework (see chapter 1) in two respects. First, it includes four subdimensions of quality — safety, responsiveness, capability and continuity — and, second, it includes an extra dimension of effectiveness — sustainability (figure E.9). These additions are intended to address the following key performance dimensions of the health system in the National Health Performance Framework that were not explicitly covered in the general Review framework:

- *safety*: the avoidance, or reduction to acceptable levels, of actual or potential harm from health care services, management or environments, and the prevention or minimisation of adverse events associated with health care delivery
- *responsiveness*: the provision of services that are client oriented and respectful of clients' dignity, autonomy, confidentiality, amenity, choices, and social and cultural needs
- *capability*: the capacity of an organisation, program or individual to provide health care services based on appropriate skills and knowledge
- *continuity*: the provision of uninterrupted, timely, coordinated healthcare, interventions and actions across programs, practitioners and organisations
- *sustainability*: the capacity to provide infrastructure (such as workforce, facilities and equipment), be innovative and respond to emerging needs (NHPC 2001).

Other aspects of the Steering Committee's framework of performance indicators are defined in chapter 1. The Steering Committee has applied this performance framework to health services in two ways:

- It has developed detailed performance indicator frameworks for public hospitals (chapter 10) and primary and community health services (chapter 11).
- It has developed specific frameworks to examine the appropriate mix of services and service delivery mechanisms for two health management issues: breast cancer and mental health (chapter 12).

Figure E.9 **Performance indicator framework for health services**



Selected indicators of health outcomes

It is difficult to isolate the effect of health care services on the general health of the population. Socioeconomic factors (such as residential location, income levels and employment rates) and the provision of non-health care government services (such as clean water, sewerage, nutrition, education and public housing) each contribute to overall health outcomes. The outcomes and effectiveness of health services are also influenced by population factors external to governments' control, including geographic dispersion, age and ethnicity profiles, and socioeconomic status.

Appendix A summarises some of the demographic and socioeconomic factors that can influence health outcomes and government expenditure.

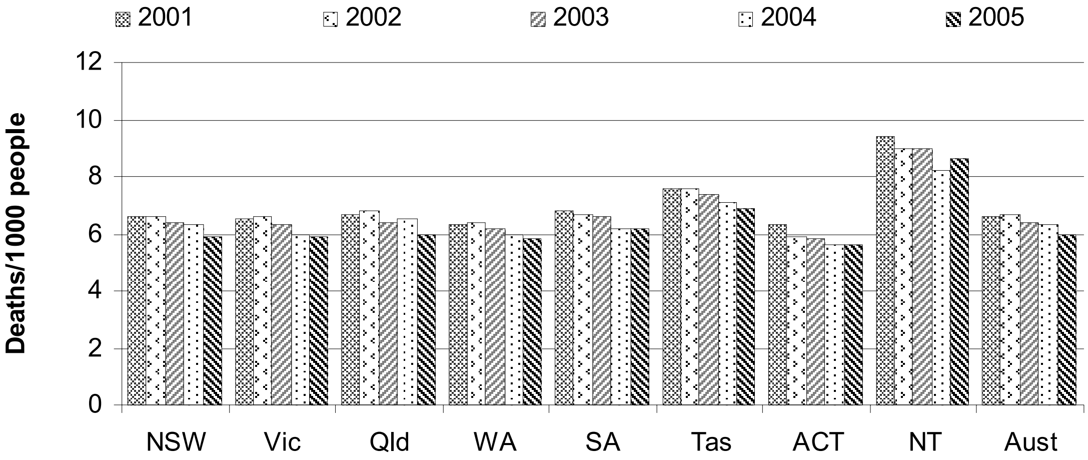
Data on health outcomes presented in this preface include self-assessed health status, mortality rates (for infants and all people), causes of death, life expectancy at birth, median age at death and birthweight. Where possible, data are presented for Indigenous people as well as the Australian population as a whole.

Mortality rates

Most components of the health system can influence mortality rates, although there may be a lag of decades between the action and the effect. A public health campaign to reduce smoking by young people, for example, may reduce premature deaths due to smoking-related conditions some years in the future. Factors external to the health system also have a strong influence on mortality rates.

There were 130 700 deaths in Australia in 2005 (ABS 2006a), which translated into an age standardised mortality rate of 6.0 per 1000 people (figure E.10). Death rates over the last 20 years have declined for all states and territories (ABS 2006a).

Figure E.10 **Mortality rates, age standardised**[a]



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[a] Deaths per 1000 population. Standardised death rates use total persons in the 2001 Australian population as the standard population. Rates are calculated using the direct method.

Source: ABS (2006a); table EA.13.

Indigenous mortality rates

Data on Indigenous mortality are collected through State and Territory death registrations. The completeness of the identification of Indigenous Australians in these collections varies significantly across states and territories. Because of this variation, care is required in making comparisons on the data.

Due to the relatively small number of Indigenous deaths and the consequent volatility in annual mortality rates, the data are presented for the five year period 2001–2005. To improve the comparability of age-related mortality rates, indirect age standardisation methods have been used for both the Indigenous and total population rates.

The NT, WA, SA and Queensland in that order are generally considered to have the best coverage of death registrations for Indigenous people.[6] For these four jurisdictions combined, the overall rates of mortality for Indigenous people were around twice as high as mortality rates for non-Indigenous people in 2001–2005 (figure E.11 and table EA.13). The exact magnitude of this difference cannot be established at this time due to variable identification of Indigenous Australians in death records. Reported mortality rates under-estimate the true mortality of Indigenous Australians (ABS and AIHW 2005).

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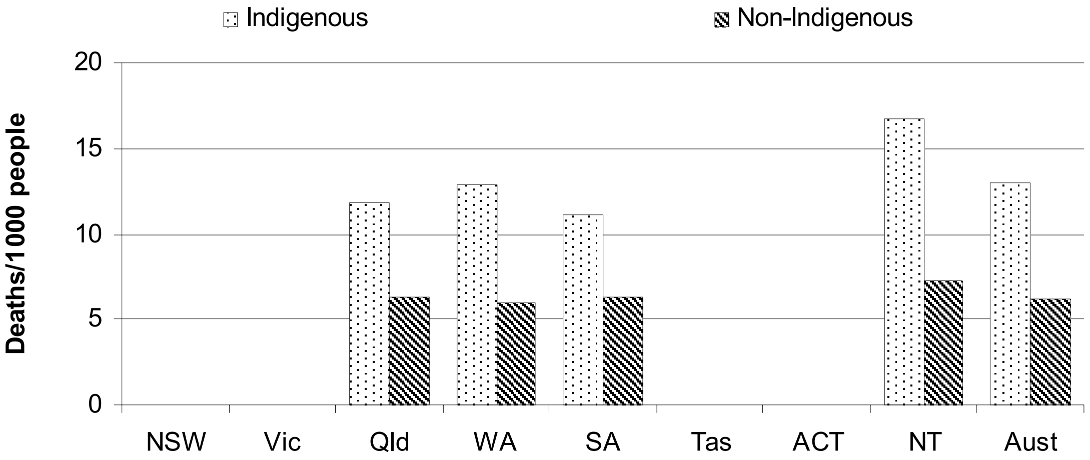
[6] The term 'coverage' refers to the number of Indigenous deaths registered as a percentage of the number of expected deaths based on the 2001 Census based experimental Indigenous population estimates and projections.

Figure E.11 **Mortality rates, age standardised, by Indigenous status, five year average, 2001–2005**[a, b]



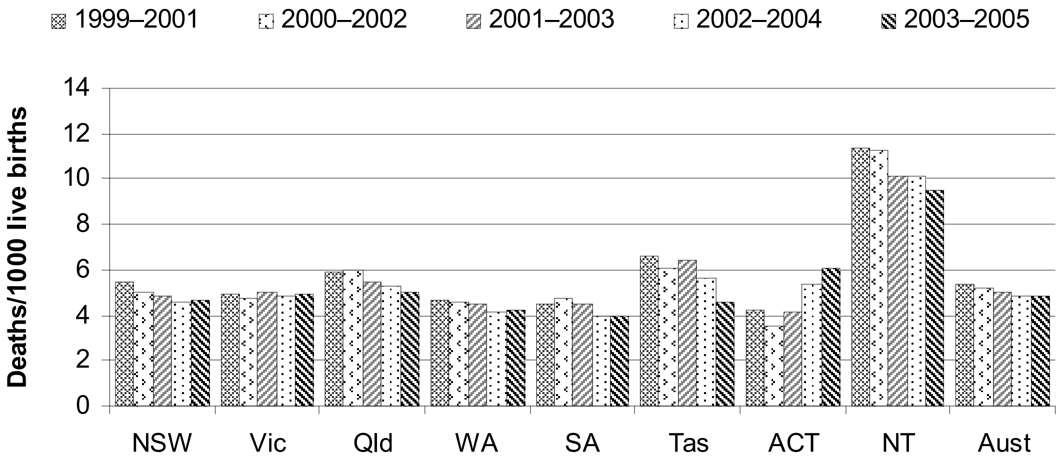
[a] Standardised death rates use the 2001 Australian population standard. [b] For Australia, Indigenous and non-Indigenous mortality rates are for Qld, WA, SA and NT combined.

Source: ABS Deaths Australia (unpublished); table EA.13.

Infant mortality rates

The infant mortality rate is defined as the number of deaths of children under 1 year of age in a calendar year per 1000 live births in the same year. Infant mortality rates are presented in this Report as an average over three years to reduce the volatility inherent in the annual rates due to small numbers and annual fluctuations. The infant mortality rate in Australia declined from 5.4 deaths per 1000 live births over the period 1999–2001 to an average of 4.8 deaths per 1000 live births over the period 2003–2005 (figure E.12).

Figure E.12 **Infant mortality rate, three year average**[a]



[a] Figures for Australia include ‘other territories’.

Source: ABS (2006a); table EA.14.

Indigenous infant mortality rates

For the period 2003–2005, the average infant mortality rate for Indigenous children is publishable for NSW, Queensland, WA, SA and the NT. Although the small numbers involved affect the ability to detect significant changes in Indigenous infant mortality, it is clear that Indigenous infant mortality rates are markedly higher than the average for all Australians (tables EA.14 and EA.15).

Principal causes of death

The most common causes of death among Australians in 2005 were: diseases of the circulatory system (including heart disease, heart attack and stroke), cancers, and diseases of the respiratory system (including influenza, pneumonia and chronic lower respiratory diseases) (tables E.2 and EA.16). Malignant neoplasms (cancers) were the main underlying cause of 29.4 per cent of all deaths in 2005 and ischaemic heart disease was the primary cause of a further 18.0 per cent (ABS 2007a).

Table E.2 **Cause of death, age standardised death rates, 2005**[a]

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*
Cancers[b]	177	177	177	174	176	205	161	208
Lung cancer[c]	34	33	36	37	34	44	23	50
Diabetes mellitus	12	19	16	18	16	29	18	30
Mental and behavioural disorders	15	15	12	15	19	17	16	37
Diseases of the nervous system	20	23	19	28	21	29	22	26
Diseases of the circulatory system	211	199	215	193	215	220	189	223
Heart disease[d]	105	102	115	102	112	115	80	106
Heart attack[e]	53	51	58	54	55	52	28	50
Stroke[f]	54	49	55	43	52	44	52	43
Diseases of arteries, arterioles and capillaries	11	10	11	10	10	12	14	10
Diseases of the respiratory system	50	46	50	43	56	47	37	88
Influenza and pneumonia	14	12	14	11	21	8	14	11
Chronic lower respiratory diseases	24	26	26	21	24	32	17	53
Diseases of the digestive system	20	21	20	19	22	22	25	39
Accidents	24	25	25	25	27	32	24	61
Transport accidents	6	8	8	9	11	11	9	25
Suicide[g]	8	10	12	10	15	16	11	23
All causes	**593**	**586**	**598**	**579**	**621**	**683**	**563**	**855**

[a] Standardised death rate per 100 000 of the mid-year 2002 population. Rounded to whole numbers. [b] Malignant neoplasms. [c] Cancer of the trachea, bronchus and lung. [d] Ischaemic heart disease and heart attacks. [e] Acute myocardial infarction. [f] Cerebrovascular diseases. [g] Intentional self-harm.

Source: ABS (2006b); table EA.16.

Causes of death for Indigenous people

In the jurisdictions for which age standardised death rates are available by Indigenous status (Queensland, WA, SA and the NT), death rates were far higher for Indigenous people than for non-Indigenous people during the period 2001–2005. In particular, Indigenous people died from diabetes at a rate that was up to 13.7 times that for non-Indigenous people; from kidney disease at a rate that was up to 6.7 times that for non-Indigenous people; and from digestive disease at a rate that was up to 6.4 times that for non-Indigenous people. The standardised death rate per 100 000 for all causes was over 3 times higher for Indigenous people than for non-Indigenous people (tables E.3 and EA.17).

Table E.3 **Cause of death by Indigenous status, Queensland, WA, SA and the NT, 2001–2005[a]**

	Indigenous age standardized rate per 100 000	*Non-Indigenous age standardized rate per 100 000*	*Ratio*
Underlying causes of death			
Circulatory disease	783.9	228.9	3.4
Accidents, poisonings and violence	123.5	39.3	3.1
Cancer	306.9	179.8	1.7
Lung cancer	79.3	34.9	2.3
Cervical cancer	5.8	1.1	5.3
Endocrine, metabolic and nutritional disorders	204.3	21.6	9.5
Diabetes	202.8	14.8	13.7
Respiratory diseases	243.2	54.1	4.5
Digestive diseases	131.0	20.6	6.4
Conditions originating in the perinatal period	7.9	2.9	2.7
Nervous system diseases	50.4	20.7	2.4
Infectious and parasitic diseases	39.1	7.3	5.4
Kidney disease	64.0	9.6	6.7
Other causes	143.7	37.1	3.9
All causes	**2043.7**	**621.7**	**3.3**

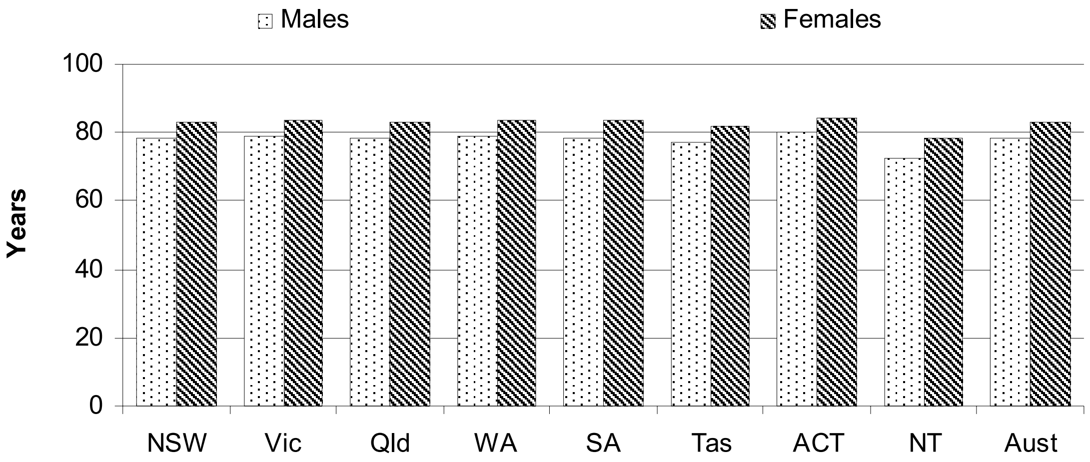
[a] Calculations of rates for the Indigenous population are based on ABS Experimental Projections, Aboriginal and Torres Strait Islander Australians (low series, 2001 base). There are not comparable population data for the non-Indigenous population. Calculations of rates for the non-Indigenous population are based on data derived by subtracting Indigenous population projections from total population estimates and should be used with care.

Source: ABS (2006b); table EA.17.

Life expectancy

The life expectancy of Australians improved dramatically during the twentieth century and so far during twenty first century. The average life expectancy at birth in the period 1901–1910 was 55.2 years for males and 58.8 years for females (ABS 2006c). It has risen steadily in each decade since, reaching 78.5 years for males and 83.3 years for females in 2003–2005 (figure E.13).

Figure E.13 **Average life expectancy at birth, by sex, three year average**[a]



[a] Figures for Australia include 'other territories'.

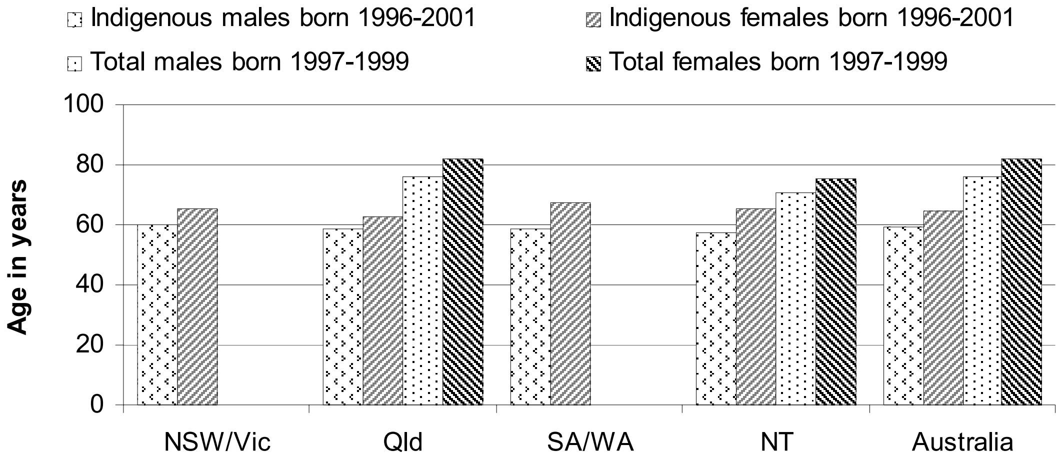
Source: ABS (2006a); table EA.18.

Indigenous life expectancy

The ABS advised that, due to incomplete identification of Indigenous deaths in the underlying source data, changes over time in mortality rates for Indigenous people cannot be determined. ABS Indigenous population estimates and projections assume, for each jurisdiction, constant age specific mortality rates across the period 1991–2009. These data are not comparable to — and replace — life expectancy estimates for Indigenous people previously published by the ABS. They should not be subjected to 'over-precise analysis … as measures of Indigenous health outcomes' (ABS 2004).

The life expectancies of Indigenous Australians are considerably lower than those of non-Indigenous Australians. ABS experimental population estimates indicate a life expectancy at birth of 59.4 years for Indigenous males and 64.8 years for Indigenous females born from 1996 to 2001 (figure E.14 and table EA.19). In a similar, but not directly comparable time period (1997–1999) the rates for all Australians were 76.2 years for all males and 81.8 years for females. Variations in life expectancy between Indigenous males and females and for Indigenous Australians in different states and territories should be interpreted with care as they are sensitive to the demographic assumptions and differences in data quality across jurisdictions.

Figure E.14 **Life expectancy at birth, Indigenous 1996–2001, total population 1997–1999**[a, b, c]



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[a] Indigenous data are for the Australian Aboriginal and Torres Strait Islander population, and include an adjustment for undercoverage of Indigenous deaths. [b] Indigenous life expectancy excludes Tasmania and the ACT. For Tasmania and the ACT, use data for Victoria and NSW, respectively. [c] Life expectancy data for Indigenous males and Indigenous females are for the period 1996–2001. Data for total males and females cover the period 1997–1999, the approximate mid-point of the Indigenous data.

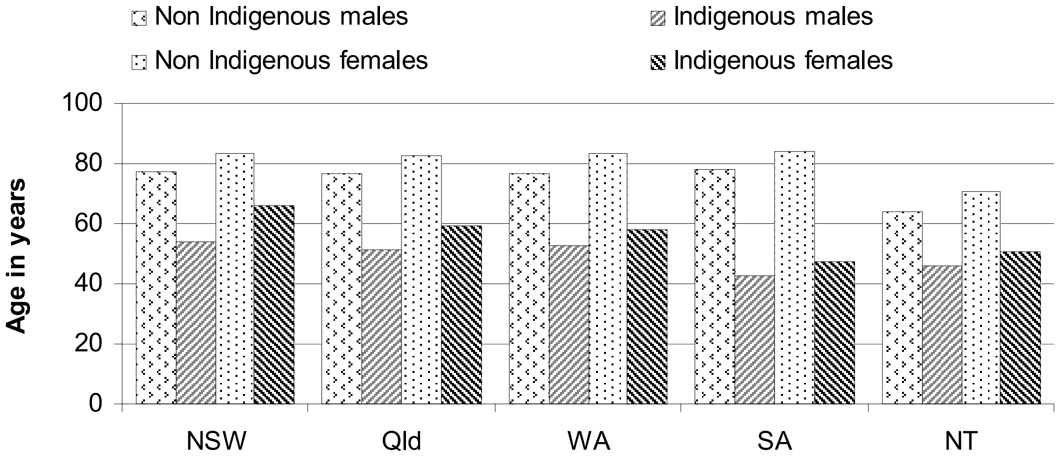
Source: ABS (2006a); table EA.19.

Median age at death

The median age at death represents the age at which exactly half the deaths registered (or occurring) in a given time period were deaths of people above that age and half were deaths below that age. Comparisons of the median age at death for Indigenous and non-Indigenous people are affected by different age structures in the populations and by differences in the extent of identification of Indigenous deaths across jurisdictions and across age groups. Identification of Indigenous status for infant deaths is high, but it falls significantly in older age groups. The median age of death for Indigenous people is therefore likely to be an underestimate.

For all Australian males and females in 2005, the median age at death was 76.8 years and 82.9 years respectively (figure E.15 and table EA.20). In the jurisdictions for which the data were available for Indigenous people in 2005 the median age at death for male Indigenous Australians varied between 42.4 and 54.3 years. The median age at death for female Indigenous Australians varied between 47.5 and 65.8 years (figure E.15 and table EA.20).

Figure E.15 **Median age at death, by sex and Indigenous status, 2005**[a]



[a] Median age at death by Indigenous status is available in NSW, Queensland, WA, SA and the NT only. The accuracy of Indigenous mortality data are variable as a result of varying rates of coverage across jurisdictions and age groups, and of changes in the estimated Indigenous population caused by changing rates of identification in the Census and births data.

Source: ABS (2006a); table EA.20.

Birthweight of babies

The birthweight of a baby is an important indicator of its health status and future wellbeing. In 2004, 91.7 per cent of liveborn babies in Australia weighed between 2500 and 4499 grams (Laws and Sullivan 2006). The average birthweight for all live births was 3374 grams. In 2004, the average birthweight of liveborn babies of Indigenous mothers was 3158 grams (tables EA.21 and EA.22). This was 224 grams lighter than the average of 3382 grams for liveborn babies of non-Indigenous mothers (Laws and Sullivan 2006).[7]

Babies are defined as low birthweight if they weigh less than 2500 grams, very low birthweight if they weigh less than 1500 grams and extremely low birthweight if they weigh less than 1000 grams (Laws and Sullivan 2006). In 2004, 6.4 per cent of all liveborn babies in Australia weighed less than 2500 grams (figure E.16). This included 1.1 per cent of babies who weighed less than 1500 grams (table EA.21).

Among live babies born to Indigenous mothers in 2004, the proportions with low and very low birthweights were around twice the proportions born to all Australian mothers, with 13.2 per cent weighing less than 2500 grams and 2.5 per cent weighing less than 1500 grams (figure E.16 and table EA.22).

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[7] Figures for births to Indigenous mothers exclude Tasmania.

Figure E.16 **Low birthweight babies (under 2500 grams), by Indigenous status, 2004**[a, b, c]

[a] Proportion of live births with birthweights under 2500 grams. [b] In the ACT, 16.3 per cent of women who gave birth were non-ACT residents. Care must be taken when interpreting percentages. For example, the proportion of liveborn low birthweight babies for ACT Aboriginal or Torres Strait Islander residents was 17.9 per cent in 2004. [c] Data for Indigenous mothers for Tasmania were not available because the 'Not stated' category for Indigenous status was not able to be distinguished from the 'Neither Aboriginal nor Torres Strait Islander origin' category.

Source: Laws and Sullivan (2006); tables EA.21 and EA.22.

Future directions

New features and developments in this Report are listed in chapter 2. Each of the health chapters has a section that covers the future directions for reporting.

Improving reporting on Indigenous health is a priority across all of the health chapters. Performance indicators for health services used by Indigenous Australians were first published in the 2000 Report. A strategy to improve reporting on Indigenous health was developed in 2003, and improvements have since been made where possible. This work is being informed by the new Aboriginal and Torres Strait Islander Health Performance Framework.

Attachment tables

Attachment tables are identified in references throughout this preface by an 'A' suffix (for example, table EA.3 is table 3 in the attachment). Attachment tables are provided on the CD-ROM enclosed with the Report and on the Review website (www.pc.gov.au/gsp). On the CD-ROM, the files containing the attachment tables are provided in Microsoft Excel format as \Publications\Reports\2008\AttachEA Hea_pref.xls and in Adobe PDF format as \Publications\Reports\2008\AttachEA Hea_pref.pdf. Users without access to the CD-ROM or the website can contact the Secretariat to obtain the attachment tables (see contact details on the inside front cover of the Report).

Table EA.1	Total health expenditure, by source of funds (2004-05 dollars)
Table EA.2	Government recurrent health expenditure, by area of expenditure (2004-05 dollars)
Table EA.3	Non-government recurrent health expenditure by area of expenditure (2004-05 dollars)
Table EA.4	Recurrent health expenditure, by source of funds and area of expenditure, 2005-06 (2004-05 dollars)
Table EA.5	Total health expenditure per person (2004-05 dollars)
Table EA.6	Recurrent health expenditure per person by source of funds, excluding high level residential aged care, 2005-06 (2004-05 dollars)
Table EA.7	Total health price index
Table EA.8	Employed medical practitioners
Table EA.9	Employed nurses
Table EA.10	Indigenous health workforce, by State/Territory, 2006
Table EA.11	Indigenous people in health workforce as a proportion of total health workforce, by age group and sex, 2006
Table EA.12	Indigenous persons employed in selected health-related occupations, 2006
Table EA.13	Mortality rates, age standardised for all causes (per 1000 people)
Table EA.14	Infant mortality rate, three year average (per 1000 live births)
Table EA.15	Indigenous Infant mortality rates, three year average
Table EA.16	All Australians causes of death, standardised death rates 2005
Table EA.17	Causes of death by Indigenous status, age standardised death rates, 2001–2005 (per 100 000 people)
Table EA.18	All Australians average life expectancy at birth (years)
Table EA.19	Indigenous life expectancy at birth (years)
Table EA.20	Median age at death (years)

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—— 2007d, *General Social Survey: Summary results, Australia*, Cat. no. 4159.0, ABS, Canberra.

—— and AIHW (Australian Institute of Health and Welfare) 2005, *The Health and Welfare of Australia's Aboriginal and Torres Strait Islander Peoples, 2005*, ABS Cat. no. 4704.0, ABS, Canberra.

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—— 2005b, *Improving the Quality of Indigenous Identification in Hospital Separations Data,* Cat. no. HSE 101, Health Services Series AIHW Canberra.

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10 Public Hospitals

Public hospitals are important providers of government funded health services in Australia. This chapter reports on the performance of State and Territory public hospitals, focusing on acute care services. It also reports separately on a significant component of the services provided by public hospitals — maternity services.

A profile of public hospitals is provided in section 10.1. A framework of performance indicators for public hospitals is outlined in section 10.2. Section 10.3 contains the key performance indicator results for public hospitals. A profile of maternity services provided by public hospitals is outlined in section 10.4. Section 10.5 presents the performance indicator framework for public hospital maternity services and section 10.6 reports the key performance indicator results for these services. Future directions in reporting are discussed in section 10.7. Terms and definitions are summarised in section 10.8. Section 10.9 lists the attachment tables for this chapter. Section 10.10 lists references used in this chapter.

Reporting on public hospitals has been improved this year with the introduction of hospital procedures measures, which provide data on the proportion of hospital separations for which procedures are reported by Indigenous status of the patient. These measures are included in section 10.1 'Profile of public hospitals' and include the following:

- separations with a procedure recorded by principal diagnosis
- separations with a procedure recorded by jurisdiction
- separations with a procedure recorded by remoteness.

The workforce sustainability indicators, which were new in the 2007 Report, have been expanded this year to provide more information about the age profile of the nursing and medical practitioner workforces. Data are reported for registered nurses and medical practitioners aged under 30; 30–39; 40–49; 50–59; and 60 or over both by jurisdiction and by region.

10.1 Profile of public hospitals

Definition

A key objective of government is to provide public hospital services to ensure the population has access to cost-effective health services, based on clinical need and within clinically appropriate times, regardless of geographic location. Public hospitals provide a range of services, including:

- acute care services to admitted patients
- sub-acute and non-acute services to admitted patients (for example, rehabilitation, palliative care, or long stay maintenance care)
- emergency, outpatient and other services to non-admitted patients
- mental health services, including services provided to admitted patients by designated psychiatric/psychogeriatric units
- public health services
- teaching and research activities.

This chapter focuses on services provided to admitted patients and emergency services provided to non-admitted patients in public hospitals. These services comprise the bulk of public hospital activity and, in the case of services to admitted patients, have the most reliable data available. Data in the chapter include sub-acute and non-acute care services.

In some instances, stand-alone psychiatric hospitals are included in this chapter, although their role is diminishing in accordance with the National Mental Health Strategy. Under the strategy, the provision of psychiatric treatment is shifting away from specialised psychiatric hospitals to mainstream public hospitals and the community sector. The performance of psychiatric hospitals and psychiatric units of public hospitals is examined more closely in ‘Health management issues’ (see chapter 12).

Some common health terms relating to hospitals are defined in box 10.1. Other terms and definitions are included in section 10.8.

Box 10.1 Some common terms relating to hospitals

Patients

admitted patient: a patient who has undergone a formal admission process in a public hospital to begin an episode of care. Admitted patients may receive acute, sub-acute or non-acute care services.

non-admitted patient: a patient who has not undergone a formal admission process, but who may receive care through an emergency department, outpatient or other non-admitted service.

Types of care

Classification of care depends on the principal clinical intent of the care received.

acute care: clinical services provided to admitted or non-admitted patients, including managing labour, curing illness or treating injury, performing surgery, relieving symptoms and/or reducing the severity of illness or injury, and performing diagnostic and therapeutic procedures. Most episodes involve a relatively short hospital stay.

sub-acute and non-acute care: clinical services provided to patients suffering from chronic illnesses or recovering from such illnesses. Services include rehabilitation, planned geriatric care, palliative care, geriatric care evaluation and management, and services for nursing home type patients. Clinical services delivered by designated psychogeriatric units, designated rehabilitation units and mothercraft services are considered non-acute.

Hospital outputs

separation: an episode of care for an admitted patient, which can be a total hospital stay (from admission to discharge, transfer or death), or a portion of a hospital stay beginning or ending in a change of type of care (for example, from acute to rehabilitation). Admitted patients who receive same day procedures (for example, renal dialysis) are included in separation statistics.

casemix-adjusted separations: the number of separations adjusted to account for differences across hospitals in the complexity of their episodes of care. Casemix adjustment is an important step to achieving comparable measures of efficiency across hospitals and jurisdictions.

non-admitted occasion of service: occasion of examination, consultation, treatment or other service provided to a non-admitted patient in a functional unit of a health service establishment. Services may include emergency department visits, outpatient services (such as pathology, radiology and imaging, and allied health services, including speech therapy and family planning) and other services to non-admitted patients. Hospital non-admitted occasions of service are not yet recorded consistently across states and territories, and relative differences in the complexity of services provided are not yet documented.

(Continued on next page)

Box 10.1 **(Continued)**

Other common health terms

AR-DRG (Australian refined diagnosis related group): a patient classification system that hospitals use to match their patient services (hospital procedures and diagnoses) with their resource needs. AR-DRG version 5.0 is based on the ICD-10-AM classification.

ICD-10-AM (the Australian modification of the International Standard Classification of Diseases and Related Health Problems): the current classification of diagnoses and procedures, replacing the earlier ICD-9-CM.

Source: AIHW (2006a); NCCH (1998); NHDC (2001, 2003).

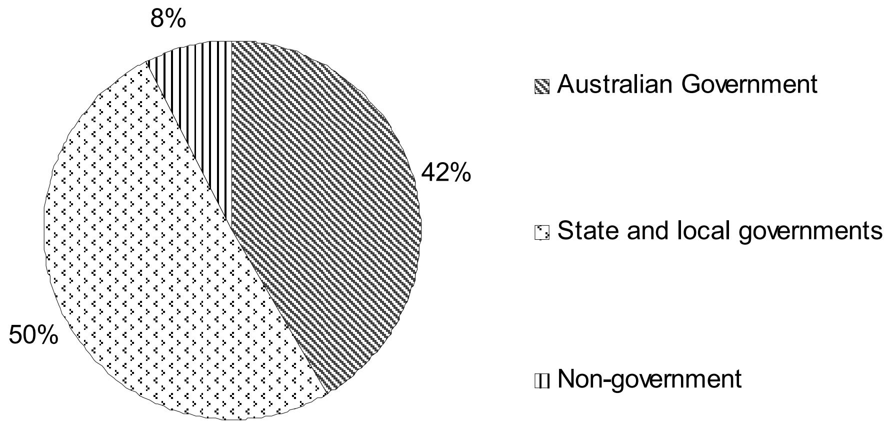
Funding

Total recurrent expenditure on public hospitals (excluding depreciation) was $24 billion in 2005-06 (table 10A.1). In real terms, expenditure increased by 5.6 per cent between 2004-05 and 2005-06 (AIHW 2007a).

The majority of total public hospital recurrent expenditure is spent on admitted patients. Non-admitted patients account for a much smaller share. For selected public hospitals, in 2005-06, the proportion of total public hospital recurrent expenditure that related to the care of admitted patients (based on the admitted patient cost proportion) ranged from 69.0 per cent to 77.0 per cent across jurisdictions (AIHW 2007a).

Funding for public hospitals comes from a number of sources. The Australian, State and Territory governments, health insurance funds, individuals, and workers compensation and compulsory motor vehicle third party insurance contribute to expenditure on public hospitals. Governments contributed about 92.4 per cent of funding for public hospitals in 2005-06 (figure 10.1). Public hospitals accounted for 40.8 per cent of government recurrent expenditure on health services in 2005-06 (AIHW 2007b).

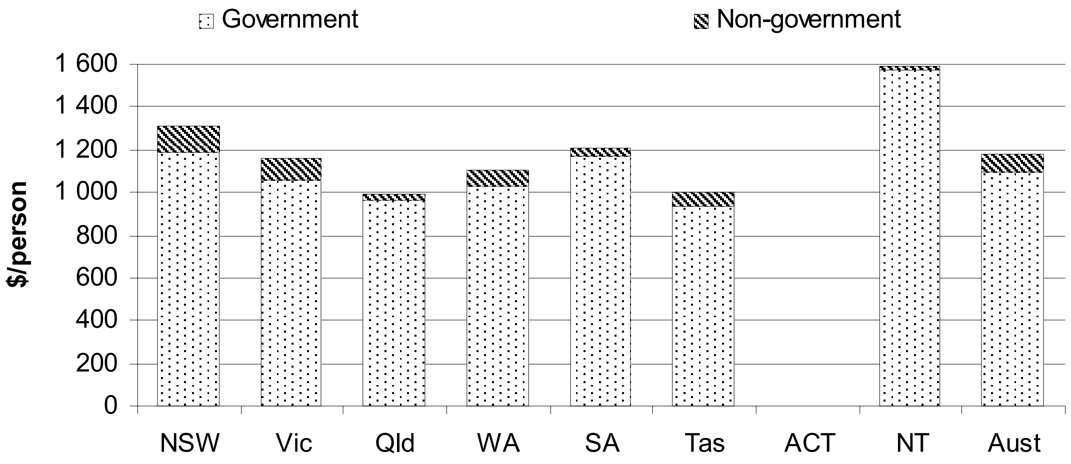
Figure 10.1 **Recurrent expenditure, public hospitals, by source of funds, 2005-06**



Source: AIHW (2007b).

In 2005-06, public hospitals received $1.8 billion from non-government sources — an amount that accounted for 7.6 per cent of all recurrent expenditure (AIHW 2007b). Non-government expenditure in each jurisdiction comprised revenue from health insurance funds, individuals and workers' compensation and compulsory third-party motor vehicle insurers as well as other sources. The proportion of hospital revenue per person funded from non-government sources varied across jurisdictions in 2005-06 (figure 10.2).

Figure 10.2 **Source of public hospital recurrent expenditure, 2005-06[a, b, c, d]**



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[a] Government expenditure excludes depreciation. Non-government expenditure on depreciation is included in recurrent expenditure. [b] Non-government expenditure includes expenditure by health insurance funds, individuals, workers' compensation, compulsory third-party motor vehicle insurers and other sources. [c] WA figures do not include recurrent expenditure associated with public patients at Joondalup and Peel Health Campuses. [d] ACT per person figures are not calculated, as the expenditure numbers for the ACT include substantial expenditures for NSW residents. Thus the ACT population is not the appropriate denominator.

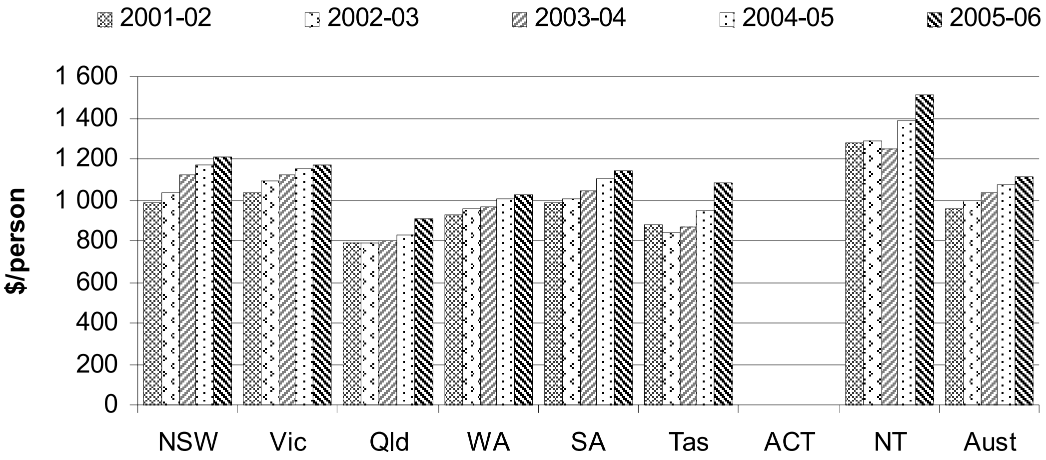
Source: AIHW (2007b); ABS (unpublished) *Australian Demographic Statistics*; table 10A.2.

Expenditure data in figures 10.1 and 10.2 are from *Health Expenditure Australia 2005-06* (AIHW 2007b) and are not directly comparable with other expenditure data used in this chapter, which are drawn from *Australian Hospital Statistics 2005-06* (AIHW 2007a). The data in Health Expenditure Australia have a broader scope than the data in Australian Hospital Statistics and include some additional expenditures (such as those relating to blood transfusion services) (Australian Institute of Health and Welfare (AIHW) unpublished).

In 2005-06, government real recurrent expenditure on public hospitals (in 2004-05 dollars) was $1117 per person for Australia, up from $956 in 2001-02 (figure 10.3). It is difficult to make comparisons between jurisdictions based on these recurrent expenditure data due to differences in the coverage of the data. Some of the differences are:

- the inclusion by some jurisdictions of expenditure on community health services as well as public hospital services
- the exclusion by some jurisdictions of expenditure on privately owned or privately operated hospitals that have been contracted to provide public hospital services.

Figure 10.3 **Real recurrent expenditure per person, public hospitals (including psychiatric) (2004-05 dollars)**[a, b, c, d, e, f, g, h]



[a] Expenditure data exclude depreciation and interest payments. [b] Recurrent expenditure on purchase of public hospital services at the State, or area health service level, from privately owned and/or operated hospitals is excluded. [c] Expenditure data are deflated using the hospital/nursing home care price index from AIHW (2007b). [d] NSW expenditure against primary and community care programs is included from 2001-02. From 2003-04, hospital expenditure recorded against special purposes and trust funds is excluded. [e] Queensland pathology services were purchased from a statewide pathology service rather than being provided by hospital employees. [f] WA recurrent expenditure per person increases to $1094 in 2005-06 if the expenditure on public patients at Joondalup and Peel Health Campuses is included. [g] For 2001-02, data for two small Tasmanian hospitals are not included and data for one small hospital are incomplete. For 2002-03, data for one small hospital are not included and data for five other small hospitals are incomplete. For 2003-04, data for five small hospitals are not included. For 2004-05 and 2005-06, data for one hospital are not included. [h] ACT per person figures are not calculated, as the expenditure numbers for the ACT include substantial expenditures for NSW residents. Thus the ACT population is not the appropriate denominator.

Source: AIHW (2003, 2004, 2005a, 2006a, 2006b, 2007a, 2007b); ABS (unpublished) *Australian Demographic Statistics*; table 10A.3.

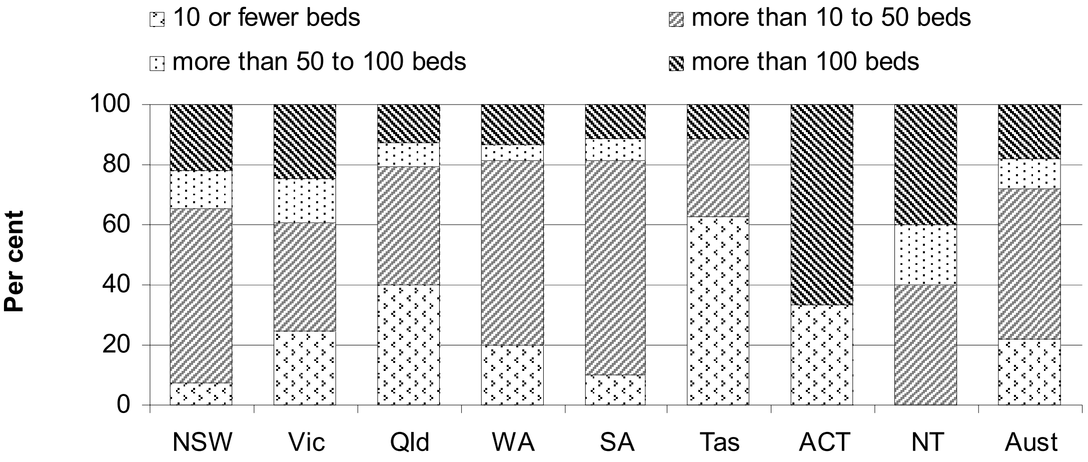
Size and scope of sector

There are several ways to measure the size and scope of Australia’s public hospital sector. This chapter reports on: the number and size of hospitals; the number and location of public hospital beds; the number and types of public hospital separations; the proportion of separations by age group; the number of separations and incidence of treatment by procedure by Indigenous status of the patient; the number of hospital staff; and the types of public hospital activity.

Hospitals

In 2005-06, Australia had 755 public hospitals (including 19 psychiatric hospitals) (AIHW 2007a). Although 71.9 per cent of hospitals had 50 or fewer beds, these smaller hospitals represented only 18.6 per cent of total available beds (figure 10.4 and table 10A.4).

Figure 10.4 **Public hospitals, by size, 2005-06**[a, b, c, d, e]



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[a] The number of hospitals reported can be affected by administrative and/or reporting arrangements and is not necessarily a measure of the number of hospital buildings or campuses. [b] Size is based on the average number of available beds. [c] The comparability of bed numbers can be affected by the casemix of hospitals including the extent to which hospitals provide same day admitted services and other specialised services. [d] The count of hospitals in Victoria is a count of the campuses that report data separately to the National Hospital Morbidity Database. [e] WA proportion of hospitals with 100+ available beds would increase if the public bed components at Joondalup and Peel Health Campuses were included.

Source: AIHW (2007a); table 10A.4.

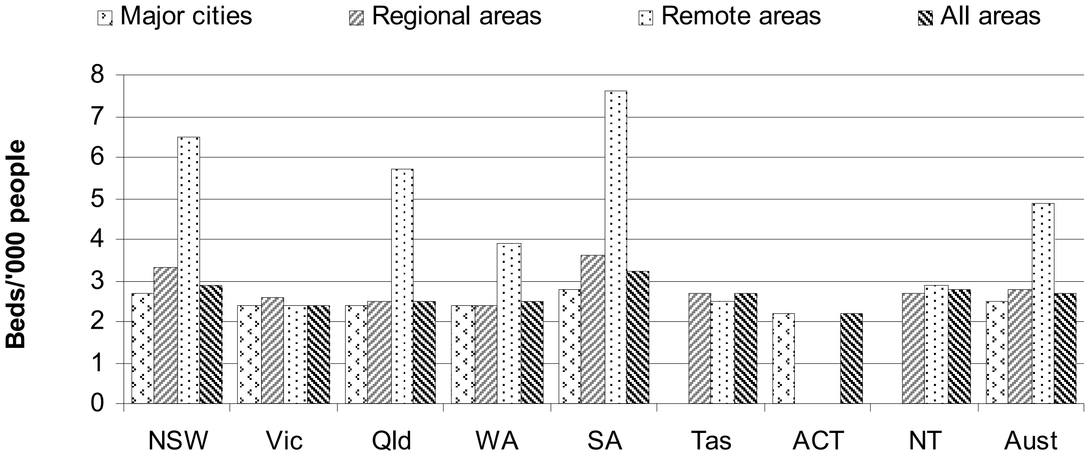
Beds

There were 54 601 available beds in public hospitals in 2005-06 (table 10A.4). The concept of an available bed (the definition of which is under review) is becoming less important in the overall context of hospital activity, particularly in light of increasing same day hospitalisations and the provision of hospital-in-the-home care (AIHW 2007a).

The comparability of bed numbers can be affected by the casemix of hospitals, including the extent to which hospitals provide same day admitted services and other specialised services. There are also differences in how available beds are counted, both across jurisdictions and over time.

Nationally, more beds were available per 1000 people in remote areas (figure 10.5). The patterns of bed availability may reflect a number of factors including patterns of availability of other health care services, patterns of disease and injury and the relatively poor health of Indigenous people, who have higher population concentrations in remote areas (AIHW 2006a). These data also need to be viewed in the context of the age and sex structure (see appendix A) and the morbidity and mortality (see 'Health preface') of the population in each State and Territory.

Figure 10.5 **Available beds, public hospitals, by location, 2005-06**[a, b, c, d, e]



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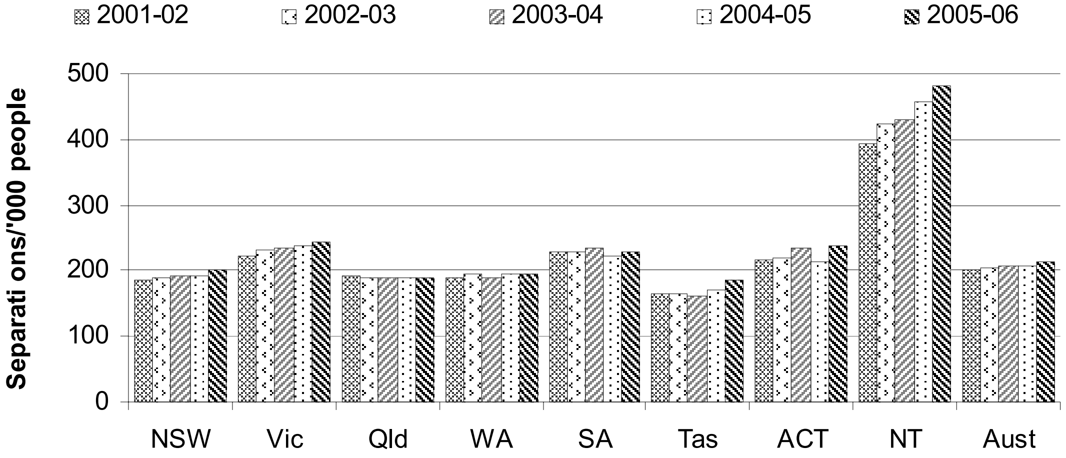
[a] An 'available bed' is one that is immediately available to be used by an admitted patient. A bed is immediately available for use if it is located in a suitable place for care, with nursing and auxiliary staff available within a reasonable period. Both occupied and unoccupied beds are included. Surgical tables, recovery trolleys, delivery beds, cots for normal neonates, emergency stretchers/beds not normally authorised or funded, and beds designated for same day non-admitted patient care are excluded. Beds in wards that were closed for any reason (except weekend closures for beds/wards staffed and available on weekends only) are also excluded (NHDC 2003). [b] Analysis by remoteness area is of less relevance to geographically smaller jurisdictions and those jurisdictions with small populations residing in remote areas (such as Victoria) (AIHW 2007a). [c] WA total increases from 2.5 to 2.7 if the beds available for public patients at Joondalup and Peel Health Campuses are included. [d] Tasmania and the NT do not have major cities and the ACT does not have remote areas. [e] There were no available beds in regional areas in the ACT.

Source: AIHW (2007a); table 10A.5.

Total separation rates

There were approximately 4.5 million separations from public (non-psychiatric) hospitals in 2005-06 (table 10A.6). Nationally, this translates into 212.8 separations per 1000 people (figure 10.6).

Figure 10.6 **Separation rates in public (non-psychiatric) hospitals**[a, b, c]



[a] Excludes separations for which the care type was reported as 'newborn with no qualified days' and records for hospital boarders and posthumous organ procurement. [b] Rates are directly age standardised to the Australian population at 30 June 2001. [c] WA 2005-06 separation rates per 1,000 people increase from 195.7 to approximately 220 if the public patient separations at Joondalup and Peel Health Campuses are included.

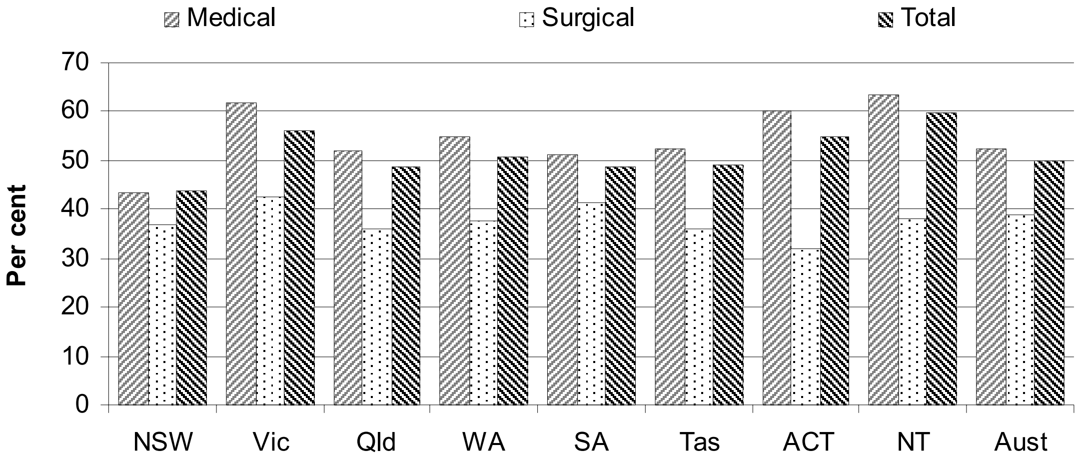
Source: AIHW (2002, 2003, 2004, 2005a, 2006a, 2007a); table 10A.7.

Same day separations in public (non-psychiatric) hospitals increased by 5.6 per cent between 2004-05 and 2005-06, although same day separations as a proportion of total separations remained relatively constant over this period. Overnight separations in public (non-psychiatric) hospitals increased by 3.4 per cent between 2004-05 and 2005-06 (table 10A.7).

Differences across jurisdictions in separation rates reflect variations in the health profiles of the people living in each State and Territory, the decisions made by medical staff about the type of care required and people's access to services other than public hospitals (for example, primary care and private hospitals).

Variations in admission rates can reflect different practices in classifying patients as either admitted same day patients or outpatients. The extent of differences in classification practices can be inferred from the variation in the proportion of same day separations across jurisdictions for certain conditions or treatments. This is particularly true of medical separations. Significant variation across jurisdictions in the proportion of same day medical separations was evident in 2005-06 (figure 10.7). Lower jurisdictional variation is likely in admission practices for surgical procedures, as reflected by the lower variability in the proportion of same day surgical separations.

Figure 10.7 **Proportion of medical, surgical and total separations that were same day, public (non-psychiatric) hospitals, 2005-06**[a]



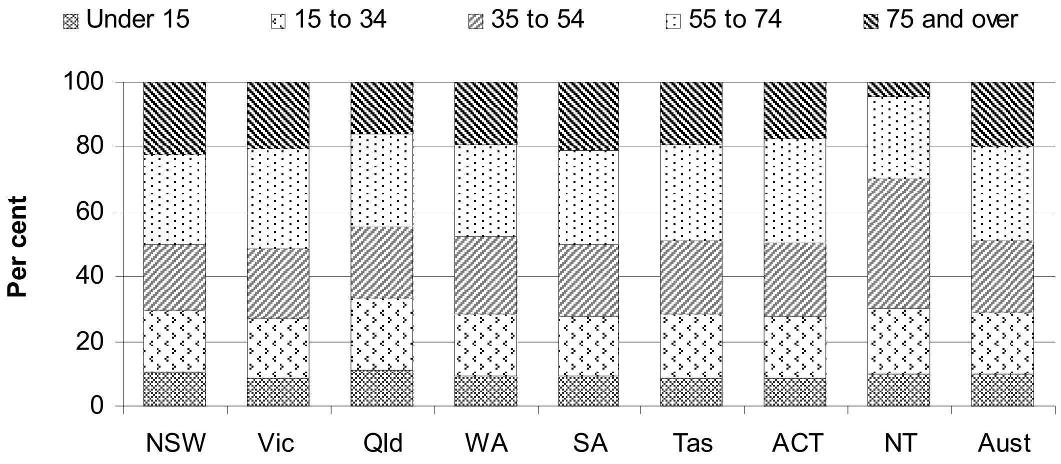
[a] 'Total' includes medical, surgical, chemotherapy, radiotherapy and 'other' separations based on AR-DRG version 5.0 categories.

Source: AIHW (unpublished); table 10A.8.

Separations by age group

Persons aged 55 years and over accounted for almost half of the separations in public hospitals (48.7 per cent) in 2005-06, even though they accounted for only 23.9 per cent of the estimated resident population at 30 June 2005 (figure 10.8 and AIHW 2007a). The proportion of hospital separations for this and other age groups varies across states and territories (figure 10.8). This variation largely reflects differences in the age profiles of jurisdictions (see table AA.1).

Figure 10.8 **Separations by age group, public hospitals, 2005-06**[a]



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[a] Excludes separations for which the care type was reported as 'newborn with no qualified days' and records for hospital boarders and posthumous organ procurement.

Source: AIHW (2007a); table 10A.9.

Separation rates for Indigenous patients

The completeness of Indigenous identification in hospital admitted patient data varies across states and territories. The AIHW (2005b) report *Improving the Quality of Indigenous Identification in Hospital Separations Data* found that Indigenous patient data was of acceptable quality for analytical purposes only for Queensland, WA, SA, and public hospitals in the NT. Following new assessments of the quality of Indigenous identification in 2007, the National Health Information Management Principal Committee (NHIMPC) recently approved NSW Indigenous patient data as acceptable in quality for analytical purposes, from the 2004-05 reference year. A proposal to approve Victorian data was being considered by the NHIMPC in late 2007. Efforts to improve Indigenous identification across states and territories are ongoing.

The available data are not necessarily representative of other jurisdictions. Indigenous patients are underidentified, to an extent that varies across jurisdictions. Because of improvements in data quality over time, caution also should be used in time series analysis of the data.

In 2005-06, separations for Indigenous people accounted for around 4.6 per cent of total separations and 7.2 per cent of separations in public hospitals in NSW, Queensland, WA, SA and the NT (table 10.1), but the Indigenous population made up only around 2.7 per cent of the population in these jurisdictions (table AA.4). Most separations involving Indigenous patients (93.6 per cent) in these jurisdictions occurred in public hospitals. The low proportion of private hospital separations for Indigenous people may be due partly to a lower proportion of Indigenous patients being correctly identified in private hospitals in addition to their lower use of private hospitals.

Table 10.1 **Separations, by Indigenous status of patient and hospital sector, 2005-06**[a, b]

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*	*Total*[c]
Public hospital separations ('000)										
Indigenous	47.3	np	58.4	40.5	15.8	np	np	55.6	np	217.6
Non-Indigenous	1 354.5	np	677.7	354.5	351.5	np	np	27.8	np	2 766.0
Not reported	18.7	np	14.2	–	10.4	np	np	–	np	43.2
Total	1 420.5	np	750.3	395.0	377.7	np	np	83.4	np	3 026.8
Private hospital separations ('000)										
Indigenous	1.0	np	4.0	9.4	0.5	np	np	np	np	14.9
Non-Indigenous	756.3	np	638.5	310.0	216.8	np	np	np	np	1 921.6
Not reported	8.6	np	69.1	–	2.8	np	np	np	np	80.5
Total	765.9	np	711.5	319.4	220.2	np	np	np	np	2 017.0
Indigenous separations as proportion of total separations (%)										
Public hospitals	3.3	np	7.8	10.3	4.2	np	np	66.6	np	7.2
Private hospitals	0.1	np	0.6	2.9	0.2	np	np	np	np	0.7
All hospitals	2.2	np	4.3	7.0	2.7	np	np	np	np	4.6
Separations in public hospitals as a proportion of separations in all hospitals (%)										
Indigenous	98.0	np	93.6	81.2	96.7	np	np	np	np	93.6
Non-Indigenous	64.2	np	51.5	53.3	61.8	np	np	np	np	59.0

[a] Excludes separations for which the care type was reported as 'newborn with no qualified days' and records for hospital boarders and posthumous organ procurement. [b] Identification of Indigenous patients is not considered complete and completeness varies across jurisdictions. The AIHW advised that only data for NSW, Queensland, WA, SA and the NT are considered to be acceptable for the purpose of analysis. Nevertheless, data for these jurisdictions should be interpreted with caution as there are jurisdictional differences in data quality. In addition, these jurisdictions are not necessarily representative of the excluded jurisdictions. [c] The total rates include data only for NSW, Queensland, WA, SA, and the NT. – Nil or rounded to zero. **np** Not published.

Source: AIHW (2007a); table 10A.10.

In 2005-06, on an age standardised basis, 792.1 public hospitals separations (including same day separations) for Indigenous patients were reported per 1000 Indigenous people in NSW, Queensland, WA, SA and the NT (table 10.2). This rate was markedly higher than the corresponding rate for these jurisdictions' combined total population of 205.7 per 1000 (table 10.2). Incomplete identification of Indigenous people limits the validity of comparisons over time, as well as across jurisdictions.

Table 10.2 Estimates of public hospital separations per 1000 people, by Indigenous status of patient[a, b]

	NSW[c]	*Vic*	*Qld*[c]	*WA*[c]	*SA*[c]	*Tas*	*ACT*	*NT*[c]	*Aust*	*Total*[d]
2001-02										
Indigenous	np	np	676.5	752.7	743.6	np	np	1129.6	np	np
Total population	np	np	192.5	190.7	229.7	np	np	394.3	np	np
2002-03										
Indigenous	np	np	685.2	809.4	788.1	np	np	1223.3	np	np
Total population	np	np	189.4	195.4	231.0	np	np	422.5	np	np
2003-04										
Indigenous	np	np	710.9	789.3	853.9	np	np	1286.2	np	np
Total population	np	np	189.3	191.0	235.9	np	np	428.9	np	np
2004-05										
Indigenous	np	np	733.6	821.5	822.2	np	np	1441.0	np	907.0
Total population	np	np	188.1	195.2	225.3	np	np	456.2	np	205.2
2005-06										
Indigenous	495.6	np	745.4	845.2	875.0	np	np	1548.0	np	792.1
Total population	204.7	np	188.5	198.8	229.7	np	np	491.4	np	205.7

[a] The rates are directly age standardised to the Australian population at 30 June 2001. [b] Identification of Indigenous patients is not considered complete and completeness varies across jurisdictions and time. [c] The AIHW advised that only data for NSW, Queensland, WA, SA and the NT are of acceptable quality in 2005-06. Nevertheless, data for these jurisdictions should be interpreted with caution as there are jurisdictional differences in data quality and changes in hospitalisation rates for Indigenous people over time that may include a component due to improved identification. In addition, these jurisdictions are not necessarily representative of the excluded jurisdictions. [d] Total rates include data for Queensland, WA, SA, and the NT for all years, and for 2005-06 incorporate NSW. Total rates before 2005-06 are not comparable with the 2005-06 total. **np** Not published.

Source: AIHW (unpublished); table 10A.11.

Separations with a procedure recorded for Indigenous patients

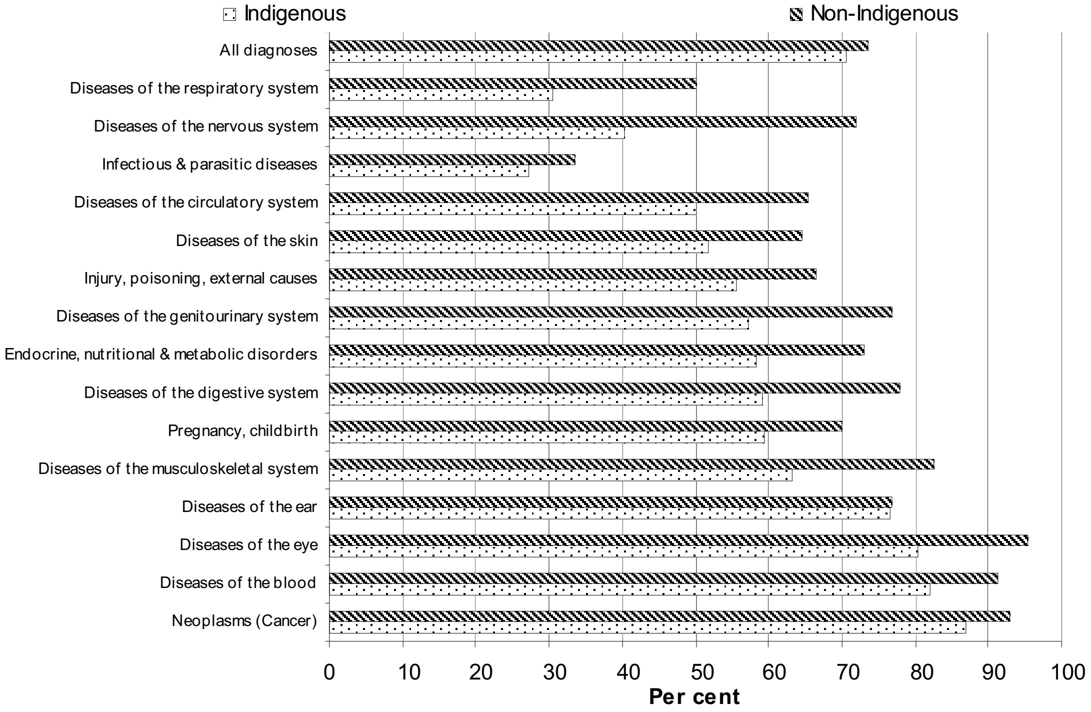
While Indigenous Australians are more likely to be hospitalised than non-Indigenous Australians, they are less likely to be treated by medical or surgical procedure while in hospital. The underlying reasons for this are not well understood and are likely to reflect a range of factors, including, for example, clinical judgements about the appropriateness of treatment by procedure, patient preferences and concerns, and distance from appropriate facilities (AHMAC 2006). Other factors are also likely to affect the data, including those relating to variations in casemix, comorbidities and stage at presentation.

Data for NSW, Queensland, WA, SA and NT public hospitals for separations with a procedure recorded by principal diagnosis are presented in figure 10.9. Separations with a procedure recorded both by jurisdiction and by remoteness are presented in figures 10.10 and 10.11, and include data for all patients treated in public hospitals and public patients treated in private hospitals. Private hospital data are not published for the NT, but the extent to which public patients are treated in private hospitals in that jurisdiction is limited.

In the period July 2004–June 2006, excluding care involving dialysis, consistently lower proportions of separations with a procedure were recorded for Indigenous patients compared with non-Indigenous patients in almost all categories of principal diagnosis (figure 10.9). The differences can be observed across all jurisdictions for which data are available (figure 10.10). While remoteness is associated with progressively reduced rates of separation with a procedure recorded for all patients, differences were more pronounced for Indigenous patients (figure 10.11).

Care involving dialysis accounts for the greatest number of separations, with end-stage renal disease requiring frequent dialysis treatments, often several times per week. The alternative to dialysis is a kidney transplant. Indigenous people have very high levels of end-stage renal disease as a consequence of high rates of diabetes, hypertension and related illnesses. In addition, few Indigenous people receive kidney transplants (AHMAC 2006). Without the exclusion of dialysis the result would overestimate the numbers of Indigenous people being treated by procedure for other conditions.

Figure 10.9 **Separations with a procedure recorded by principal diagnosis, public hospitals, by Indigenous status of patient, July 2004–June 2006**[a]



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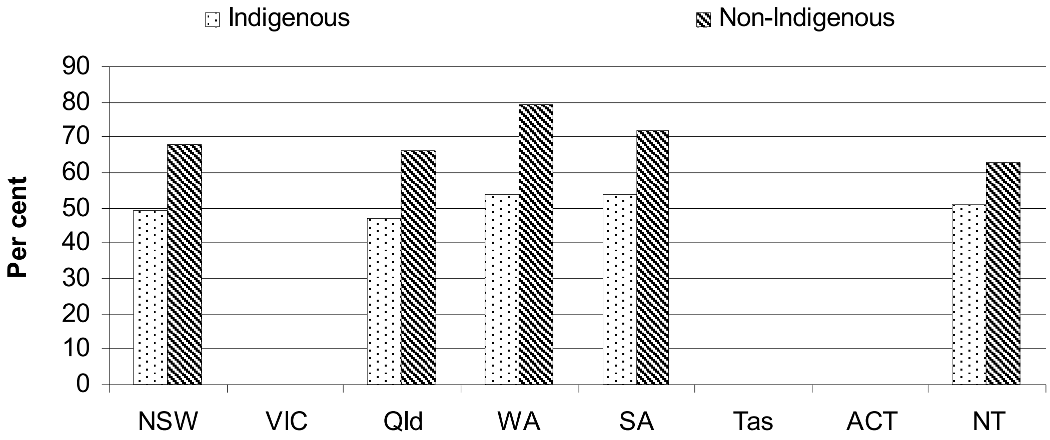
[a] Includes patients treated in public hospitals in NSW, Queensland, WA, SA and NT.

Source: AIHW (unpublished), table 10A.12.

Figure 10.10 Separations with a procedure recorded, by Indigenous status of patient, July 2004–June 2006[a, b]



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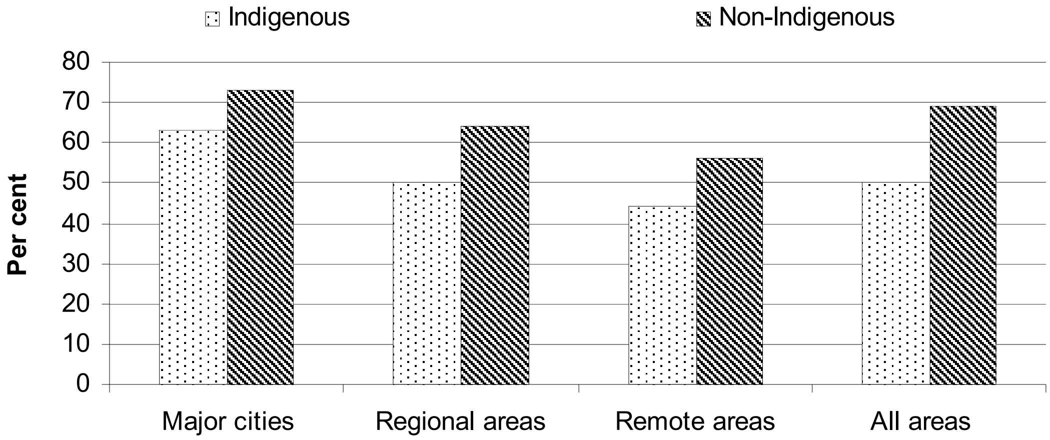
[a] Includes all patients treated in public hospitals and public patients treated in private hospitals. Excludes private hospital data for NT due to the poor quality of Indigenous data. [b] The AIHW advised that only data for NSW, Queensland, WA, SA and the NT are considered to be acceptable for the purpose of analysis. Nevertheless, data for these jurisdictions should be interpreted with caution as there are jurisdictional differences in data quality. In addition, these jurisdictions are not necessarily representative of the excluded jurisdictions.

Source: AIHW (unpublished), table 10A.13.

Figure 10.11 Separations with a procedure recorded, by Indigenous status of patient and remoteness, July 2004–June 2006[a]



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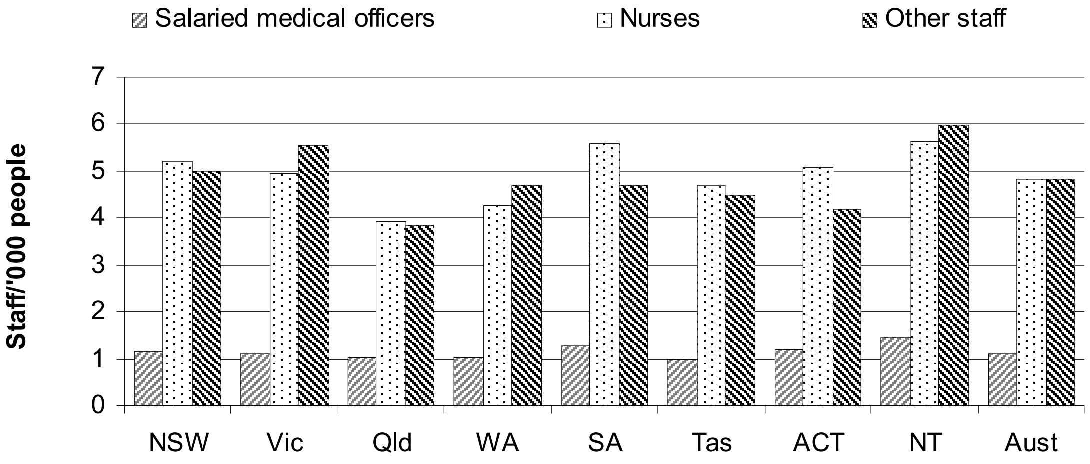
[a] Includes all patients treated in public hospitals and public patients treated in private hospitals in NSW, Queensland, WA, SA and NT. Excludes private hospital data for NT due to the poor quality of Indigenous data.

Source: AIHW (unpublished), table 10A.14.

Staff

In 2005-06, nurses comprised the single largest group of full time equivalent (FTE) staff employed in public hospitals (4.8 per 1000 people in Australia) (figure 10.12). Comparing data on FTE staff across jurisdictions needs to be undertaken with care because these data are affected by differences across jurisdictions in the recording and classifying of staff. The outsourcing of services with a large labour related component (for example, food services and domestic services) can have a large impact on hospital staffing figures. Differences in outsourcing may explain some of the differences in FTE staff in some staffing categories and across jurisdictions (AIHW 2007a).

Figure 10.12 **Average FTE staff per 1000 people, public hospitals, 2005-06**[a, b, c, d, e, f, g]



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[a] 'Other staff' include diagnostic and allied health professionals, other personal care staff, administrative and clerical staff, and domestic and other staff. [b] Where average FTE staff numbers were not available, staff numbers at 30 June 2006 were used. Staff contracted to provide products (rather than labour) are not included. [c] Staff per 1000 people are calculated from ABS population data at 31 December 2005 (table AA.2). [d] For Victoria, FTEs may be slightly understated. [e] Queensland pathology services staff employed by the State pathology service are not included. [f] WA figures do not include FTEs working with public patients at Joondalup and Peel Health Campuses. [g] Data for two small Tasmanian hospitals are not included.

Source: AIHW (2007a); ABS (unpublished) *Australian Demographic Statistics*; tables 10A.15 and AA.2.

Activity — admitted patient care

There were around 4.6 million acute, sub-acute and non-acute separations in public hospitals in 2005-06. Of these, acute separations accounted for 96.1 per cent, newborns with some qualified days accounted for 1.0 per cent, and rehabilitation care accounted for 1.5 per cent (table 10A.16). Palliative care, non-acute care and other care made up the residual. Public psychiatric hospitals accounted for around

0.3 per cent of total separations in public hospitals in 2005-06. Of the total number of separations in public (non-psychiatric) hospitals, 49.7 per cent were for same day patients (table 10A.6).

Table 10.3 shows the 10 AR-DRGs with the highest number of overnight acute separations in public hospitals for 2005-06. These 10 AR-DRGs accounted for 17.3 per cent of all overnight acute separations.

Table 10.3 Ten AR-DRGs (version 5.0) with the most overnight acute separations, public hospitals, 2005-06[a, b]

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Separations for AR-DRGs as a proportion of all overnight acute separations (%)									
Vaginal Delivery W/O Cat/Severe CC	4.4	4.8	4.6	4.3	3.2	4.2	5.0	3.6	4.4
Chest Pain	2.3	1.8	2.5	1.6	2.4	1.5	1.4	2.1	2.1
Oesophagitis, Gastroent & Misc Digestive Systm Disorders Age>9 W/O Cat/Severe CC	2.0	1.7	1.8	1.8	2.0	1.6	1.3	1.0	1.8
Caesarean Delivery W/O Cat/Severe CC	1.7	1.8	2.0	1.7	1.4	1.8	1.9	1.6	1.8
Antenatal and other Obstetric Admission	1.6	1.4	1.8	1.9	1.4	1.8	1.4	2.6	1.6
Cellulitis (Age >59 W/O Cat/Severe CC) or Age <60	1.3	1.3	1.7	1.7	1.2	1.0	1.4	5.2	1.5
Vaginal Delivery Single Uncomplicated W/O Other Condition	1.2	0.6	1.9	1.0	0.8	1.1	1.4	1.3	1.1
Respiratory Infections/Inflammations W/O CC	1.1	0.9	1.0	1.1	0.9	1.1	1.1	1.9	1.0
Abdominal Pain or Mesenteric Adenitis W/O CC	1.1	1.0	1.0	1.0	1.0	0.8	0.8	0.7	1.0
Bronchitis and Asthma Age <50 W/O CC	1.1	0.9	0.8	1.1	1.4	0.9	0.7	0.7	1.0
Ten AR-DRGs with the most overnight acute separations (%)	**17.7**	**16.1**	**19.1**	**17.0**	**15.7**	**15.8**	**16.2**	**20.7**	**17.3**
Total overnight acute separations ('000)	**766**	**528**	**367**	**185**	**187**	**46**	**30**	**33**	**2143**

cat = catastrophic. cc = complications and comorbidities. sev = severe. w/o = without. w = with. [a] Includes separations for which the care type was reported as 'acute' or 'newborn with qualified days', or was not reported. [b] Excludes same day separations and separations where patients stayed over 366 days.

Source: AIHW (unpublished); table 10A.17.

Table 10.4 lists the 10 AR-DRGs that accounted for the most patient days (18.0 per cent of all patient days recorded) in 2005-06. Schizophrenic disorders associated with mental health legal status accounted for the largest number of patient days, followed by vaginal delivery without complicating diagnosis.

Table 10.4 **Ten AR-DRGs (version 5.0) with the most patient days, public hospitals, 2005-06**[a, b]

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Patient days for AR-DRGs as a proportion of patient days (%)									
Schizophrenia Disorders W Mental Health Legal Status	3.0	3.6	4.9	4.4	3.6	2.1	2.4	1.0	3.5
Vaginal Delivery W/O Cat/Sev CC	2.4	2.6	2.4	2.6	1.8	2.1	2.5	2.1	2.4
Tracheostomy or Ventilation >95 hours	2.4	2.4	2.5	2.4	2.4	2.4	2.8	2.2	2.4
Major Affective Disorders Age <70 W/O Cat/Sev CC	2.0	1.8	2.0	2.6	2.6	1.9	2.8	1.3	2.1
Schizophrenia Disorders W/O Mental Health Legal Status	1.8	1.4	1.0	1.8	1.5	3.3	1.1	1.8	1.6
Chronic Obstructive Airways Disease W Cat/Sev CC	1.5	1.4	1.4	1.1	1.7	1.6	0.9	1.5	1.4
Caesarean Delivery W/O Cat/Sev CC	1.4	1.5	1.5	1.5	1.2	1.3	1.4	1.5	1.4
Cellulitis (Age >59 W/O Cat/Sev CC) or Age <60	1.0	1.3	1.3	1.2	1.0	0.8	1.1	3.5	1.2
Respiratory Infections/Inflammations W Cat CC	1.1	1.3	0.8	0.9	1.1	0.9	1.0	1.0	1.1
Respiratory Infections/Inflammations W Sev or Moderate CC	1.1	1.0	0.9	1.0	0.9	1.1	1.0	2.4	1.0
Ten AR-DRGs with the most patient days (%)	**17.6**	**18.1**	**18.6**	**19.5**	**17.8**	**17.4**	**17.0**	**18.3**	**18.0**
Total patient days ('000)	**4 304**	**2 762**	**1 860**	**974**	**1 052**	**288**	**169**	**184**	**11 593**

cat = catastrophic. cc = complications and comorbidities. sev = severe. w/o = without. w = with. [a] Includes separations for which the care type was reported as 'acute' or 'newborn with qualified days', or was not reported. [b] Excludes same day separations and separations where patients stayed over 366 days.

Source: AIHW (unpublished); table 10A.18.

Activity — non-admitted patient services

There is no agreed classification system for services to non-admitted patients, so activity is difficult to measure and cannot be compared across jurisdictions. As well as differences in the way data are collected, differing admission practices lead to variation in the services reported across jurisdictions. In addition, states and territories may differ in the extent to which these types of service are provided in non-hospital settings (such as community health centres) (AIHW 2006a). Services to non-admitted patients are measured in terms of occasions of service. Differences in the complexity of the occasion of service are not taken into account — for example, a simple urine glucose test is treated equally with a complete biochemical analysis of all body fluids (AIHW 2001a).

A total of 44.7 million individual occasions of service were provided to non-admitted patients in public hospitals in 2005-06 (table 10.5). In addition, public hospitals also delivered 384 934 group sessions during this time (a group session is defined as a service provided to two or more patients, excluding services provided to two or more family members) (table 10A.19). In public hospitals in 2005-06, accident and emergency services comprised 14.1 per cent of all occasions of service to non-admitted patients. 'Other medical, surgical and obstetric services' (22.5 per cent), 'pathology services' (15.3 per cent) and 'pharmacy' (10.4 per cent) were the most common types of non-admitted patient care (table 10.5).

Table 10.5 **Ten most common types of individual non-admitted patient care, public hospitals, 2005-06[a]**

	NSW	*Vic*	*Qld*	*WA*[b]	*SA*	*Tas*	*ACT*	*NT*[c]	*Aust*
Occasions of service for the most common types of non-admitted patient care as a proportion of all occasions of service for non-admitted patients (%)									
Accident and emergency	10.6	19.8	14.2	14.4	22.4	14.5	19.9	29.1	14.1
Outpatient services									
Other medical/surgical/ obstetric	20.9	21.5	23.7	14.1	40.6	34.1	44.6	27.0	22.5
Allied health	4.1	14.9	5.6	20.7	10.2	9.7	8.2	2.7	8.2
Pathology	12.3	9.9	31.3	10.7	..	22.2	7.2	19.7	15.3
Radiology and organ imaging	3.8	8.1	8.8	9.0	11.2	9.0	13.6	14.2	6.7
Pharmacy[d]	16.8	6.0	5.9	4.4	–	8.0	0.2	7.2	10.4
Mental health	4.1	9.9	1.1	0.9	1.2	..	0.6	–	3.8
Dental	3.0	2.5	3.6	0.3	0.5	0.1	–	–	2.5
Other non-admitted services									
Community health	8.6	4.1	1.7	17.4	0.6	..	1.6	–	6.6
District nursing[e]	7.3	2.7	0.9	4.1	0.9	–	–	–	4.3
Ten most common types of non-admitted patient care (%)	**91.6**	**99.6**	**96.9**	**96.0**	**87.7**	**97.6**	**96.0**	**100.0**	**94.4**
Total occasions of service for non-admitted patients ('000)	**20 077**	**7 102**	**9 154**	**4 364**	**2 213**	**927**	**501**	**411**	**44 749**

[a] Individual non-admitted patient care services. Excludes group sessions. Reporting arrangements vary significantly across jurisdictions. [b] The WA total occasions of service figure for individuals increases to 4 480 679 if the public patient activity at Joondalup and Peel Health Campuses is included. [c] Radiology figures for the NT are underestimated and pathology figures relate to only three of the five hospitals. [d] Justice Health (formerly known as Corrections Health) in NSW reported a large number of occasions of service that may not be typical of pharmacy. [e] Justice Health (formerly known as Corrections Health) in NSW reported a large number of occasions of service that may not be typical of district nursing. .. Not applicable. – Nil or rounded to zero.

Source: AIHW (2007a); table 10A.19.

10.2 Framework of performance indicators for public hospitals

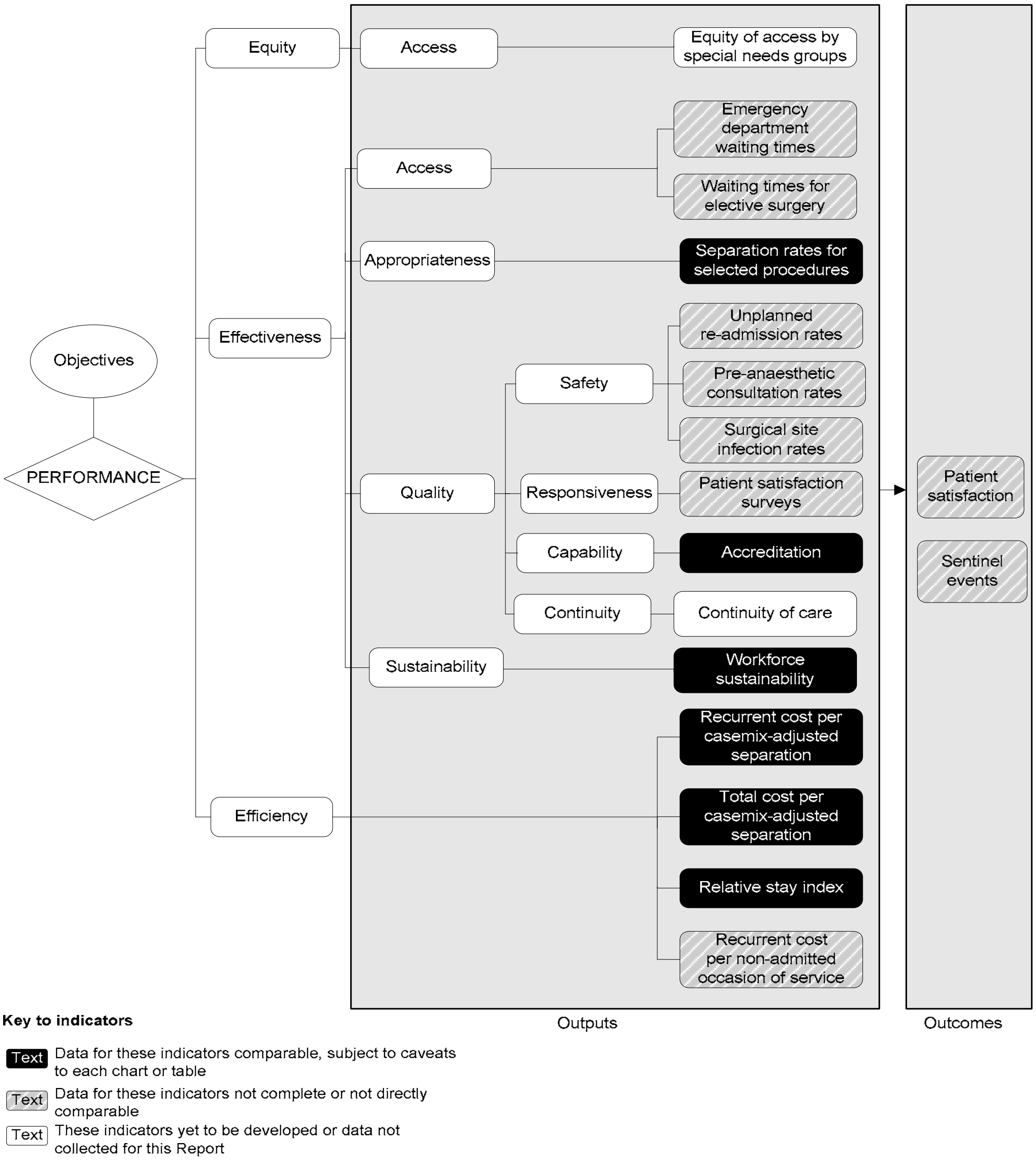
The performance indicator framework is based on the shared government objectives for public hospitals (box 10.2). The performance indicator framework shows which data are comparable in the 2008 Report (figure 10.13). For data that are not considered directly comparable, the text includes relevant caveats and supporting commentary. Chapter 1 discusses data comparability from a Report-wide perspective. The ‘Health preface’ explains the performance indicator framework for health services as a whole, including the subdimensions of quality and sustainability that have been added to the standard Review framework for health services.

Box 10.2 **Objectives for public hospitals**

The common government objectives for public hospitals are to provide cost-effective acute and specialist services that are:

- safe and of high quality
- responsive to individual needs
- accessible
- equitably and efficiently delivered.

Figure 10.13 **Performance indicators for public hospitals**



10.3 Key performance indicator results for public hospitals

Different delivery contexts, locations and types of client may affect the equity, effectiveness and efficiency of health services. Appendix A of the Report contains statistical profiles on each State and Territory, which may assist in interpreting the performance indicators presented in this chapter.

As discussed in section 10.1, public hospitals provide a range of services to admitted patients, including some non-acute services such as rehabilitation and palliative care. The extent to which these non-acute treatments can be identified and excluded from some data differs across jurisdictions. Similarly, psychiatric treatments are provided in public (non-psychiatric) hospitals at different rates across jurisdictions.

Outputs

Outputs are the actual services delivered (while outcomes are the impact of these services on the status of an individual or group) (see chapter 1, section 1.5).

Equity — access

Equity indicators measure how well a service is meeting the needs of certain groups in society (see chapter 1). Public hospitals have a significant influence on the equity of the overall healthcare system. While access to public hospital services is important to the community in general, it is particularly so for people of low socioeconomic status (and others) who may have difficulty in accessing alternative services, such as those provided by private hospitals.

Equity of access by special needs groups

The Steering Committee has identified 'equity of access by special needs groups' as an indicator of equity of access to public hospitals. This indicator is for development in future reports (box 10.3).

Box 10.3 **Equity of access by special needs groups**

'Equity of access by special needs groups' is an indicator of governments' objective to provide accessible services. Specifically, the Review seeks to report on the performance of agencies providing services for three identified special needs groups: Indigenous people; people living in communities outside the capital cities (that is, people living in other metropolitan areas, or rural and remote communities); and people from a non-English speaking background. This indicator has been identified for development and reporting in future.

Effectiveness — access

Emergency department waiting times

'Emergency department waiting times' is an indicator of effectiveness of access to public hospitals (box 10.4).

Box 10.4 **Emergency department waiting times**

'Emergency department waiting times' is an indicator of governments' objective to provide accessible services. It measures the proportion of patients seen within the benchmarks set according to the urgency of treatment required.

The nationally agreed method of calculation for waiting times is to subtract the time at which the patient presents at the emergency department (that is, the time at which the patient is clerically registered or triaged[a], whichever occurs earlier) from the time of commencement of service by a treating medical officer or nurse. Patients who do not wait for care after being triaged or clerically registered are excluded from the data.

The benchmarks set according to triage category, are as follows:

- triage category 1: need for resuscitation — patients seen immediately
- triage category 2: emergency — patients seen within 10 minutes
- triage category 3: urgent — patients seen within 30 minutes
- triage category 4: semi-urgent — patients seen within 60 minutes
- triage category 5: non-urgent — patients seen within 120 minutes (NHDC 2003).

It is desirable that a high proportion of patients are seen within the benchmarks set for each triage category. Non-urgent patients who wait longer are likely to suffer discomfort and inconvenience, and more urgent patients may experience poor health outcomes as a result of extended waits.

[a] The triage category indicates the urgency of the patient's need for medical and nursing care.

The comparability of emergency department waiting times data across jurisdictions may be influenced by differences in data coverage (table 10.6) and clinical practices — in particular, the allocation of cases to urgency categories. The proportion of patients in each triage category who were subsequently admitted may indicate the comparability of triage categorisations across jurisdictions and thus the comparability of the waiting times data (table 10A.20).

Nationally, in 2005-06, 99 per cent of patients were seen within the triage category 1 timeframe and 77 per cent of patients were seen within the triage category 2 timeframe. For all triage categories, 69 per cent of patients were seen within triage category timeframes (table 10.6).

Table 10.6 Emergency department patients seen within triage category timeframes, public hospitals, 2005-06 (per cent)

Triage category	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
1 — Resuscitation[a]	100	100	100	98	99	95	100	100	99
2 — Emergency	81	83	66	77	69	68	71	59	77
3 — Urgent	61	79	55	69	56	57	44	59	64
4 — Semi-urgent	66	71	58	67	62	59	47	53	65
5 — Non-urgent	87	89	86	90	85	89	84	87	87
Total	**69**	**77**	**60**	**71**	**62**	**62**	**52**	**60**	**69**
Data coverage[b]	81	89	65	68	68	86	100	100	78

[a] Resuscitation patients whose waiting time for treatment was less than or equal to two minutes are considered to have been seen on time. [b] Data coverage is estimated as the number of occasions of service with waiting times data divided by the number of emergency department occasions of service. This may underestimate coverage because some occasions of service are for other than emergency presentations, for which waiting times data are applicable. For some jurisdictions, the number of emergency department occasions of service reported to the Non-admitted Patient Emergency Department Care Database exceeded the number of accident and emergency occasions of service reported to the National Public Hospital Establishments Database. For these jurisdictions the coverage has been estimated as 100 per cent.

Source: AIHW (2007a); table 10A.20.

Waiting times for elective surgery

‘Waiting times for elective surgery’ is an indicator of effectiveness of access to public hospitals (box 10.5).

Box 10.5 **Waiting times for elective surgery**

‘Waiting times for elective surgery’ is an indicator of governments’ objective to provide accessible services. Two measures are reported:

- ‘overall elective surgery waiting times’
- ‘elective surgery waiting times by clinical urgency category’.

‘Overall elective surgery waiting times’ are calculated by comparing the date on which patients are added to a waiting list with the date on which they are admitted. Days on which the patient was not ready for care are excluded. ‘Overall waiting times’ are presented as the number of days within which 50 per cent of patients are admitted and the number of days within which 90 per cent of patients are admitted. The proportion of patients who waited more than one year is also shown.

Fewer days waited at the 50th and 90th percentile and a smaller proportion of people waiting more than 365 days are desirable.

(Continued next page)

Box 10.5 **(Continued)**

‘Elective surgery waiting times by clinical urgency category’ reports the proportion of patients who were admitted from waiting lists after an extended wait.

The three generally accepted urgency categories for elective surgery are:

- category 1 — admission is desirable within 30 days
- category 2 — admission is desirable within 90 days
- category 3 — admission at some time in the future is acceptable.

There is no specified or agreed desirable wait for category 3 patients, but the term ‘extended wait’ is used for patients waiting longer than 12 months for elective surgery, as well as for category 1 and 2 patients waiting more than the agreed desirable waiting times of 30 days and 90 days respectively.

A smaller proportion of patients who have experienced extended waits at admission is desirable. However, variation in the way patients are classified to urgency categories should be taken into account. Rather than comparing jurisdictions, the results for individual jurisdictions should be viewed in the context of the proportions of patients assigned to each of the three urgency categories (table 10.8).

Not all elective surgery is covered by these measures. The measures do not cover all the in-scope procedures (87 per cent in 2005-06) (table 10.7), and the in-scope procedures are defined as excluding a range of procedures that may be regarded as surgery, such as elective procedures involving the insertion of a stent.

Patients on waiting lists who were not subsequently admitted to hospital are excluded from both measures (box 10.5). Patients may be removed from waiting lists because they are admitted as emergency patients for the relevant procedure, no longer need the surgery, die, are treated at another location, decline to have the surgery, or cannot be contacted by the hospital (AIHW 2007a). In 2005-06, 15.3 per cent of patients were removed from waiting lists for reasons other than elective admission (AIHW 2007a).

The two measures are affected by variations across jurisdictions in the method used to calculate waiting times for patients who transferred from a waiting list managed by one hospital to a waiting list managed by a different hospital. For patients who were transferred from a waiting list managed by one hospital to that managed by another, the time waited on the first list is included in the waiting time reported for some but not all states and territories (AIHW 2007a). NSW, Victoria, Queensland, WA and the ACT reported the total time waited on all waiting lists. This approach may have the effect of increasing the apparent waiting times for admissions in these jurisdictions compared with other jurisdictions. Queensland and SA have indicated that patients rarely switch between waiting lists managed by different hospitals in their jurisdictions (AIHW 2007a).

Nationally, in 2005-06, 90 per cent of patients were admitted within 237 days and 50 per cent were admitted within 32 days (table 10.7). The proportion of patients who waited more than a year was 4.6 per cent. Nationally, waiting times at the 50th percentile increased by five days between 2001-02 and 2005-06. In 2001-02, 27 days were waited at the 50th percentile and this increased to 32 days by 2005-06. However, there were different trends in different jurisdictions and for different sized hospitals over that period (figure 10.14 and table 10A.21).

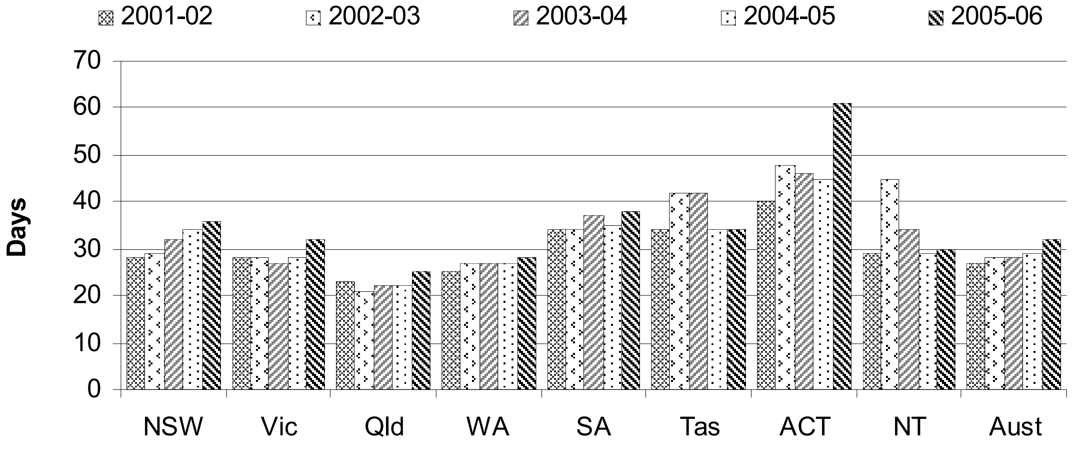
Table 10.7 **Elective surgery waiting times, public hospitals, 2005-06**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Number of days waited at:										
50th percentile	no.	36	32	25	28	38	34	61	30	32
90th percentile	no.	291	224	127	205	212	332	372	313	237
Proportion who waited more than 365 days	%	5.4	4.5	2.1	4.3	4.2	8.7	10.3	7.7	4.6
Estimated coverage of elective surgery separations[a]	%	100	79	96	76	63	100	100	100	87

[a] The number of separations with urgency of admission reported as 'elective' and a surgical procedure for public hospitals reporting to the National Elective Surgery Waiting Times Data Collection as a proportion of the number of separations with urgency of admission of 'elective' and a surgical procedure for all public hospitals.

Source: AIHW (2007a); table 10A.21.

Figure 10.14 **Days waited for elective surgery by the 50th percentile, public hospitals**



Source: AIHW (2003, 2004, 2005a, 2006a, 2007a); table 10A.21.

‘Elective surgery waiting times by urgency category’ data not only provide an indication of the extent to which patients are seen within a clinically desirable time, but also draw attention to the variation in the way in which patients are classified across jurisdictions. Jurisdictional differences in the classification of patients by urgency category in 2005-06 are shown in table 10.8. The states and territories with lower proportions of patients in category 1 also had relatively smaller proportions of patients in this category who were ‘not seen on time’. Victoria and the ACT, for example, had the lowest proportions of patients in category 1 and also had the lowest proportions of patients in category 1 who had extended waits (tables 10.8, 10A.26 and 10A.35).

The system of urgency categorisation for elective surgery in public hospitals is important to ensure that priority is given to patients according to their needs. While elective surgery waiting times by urgency category are not comparable across jurisdictions, this measure has the advantage over other measures in that it provides an indication of the extent to which patients are seen within a clinically desirable time period according to the urgency category to which they have been assigned.

Table 10.8 **Classification of elective surgery patients, by clinical urgency category, 2005-06 (per cent)**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*
Patients on waiting lists								
Category 1	6.8	2.4	8.0	5.9	8.4	8.0	2.4	9.7
Category 2	32.4	44.0	36.7	35.0	22.8	47.0	47.5	37.2
Category 3	60.8	53.6	55.3	59.1	68.9	45.0	50.0	53.1
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Patients admitted from waiting lists								
Category 1	41.5	22.4	36.2	35.3	34.6	45.0	29.9	48.9
Category 2	30.6	46.9	44.8	26.7	27.4	34.0	46.1	33.0
Category 3	28.0	30.7	19.0	38.0	37.9	21.0	24.0	18.1
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

Source: State and Territory governments (unpublished).

Reporting of ‘elective surgery waiting times by clinical urgency category’ includes the proportions of patients with extended waits at admission across jurisdictions. The proportions of patients on waiting lists who had already had an extended wait at the date of the census are reported in tables 10A.24, 10A.25, 10A.28, 10A.30, 10A.32, 10A.34, 10A.35 and 10A.37. Census data do not represent the completed waiting time of patients (unlike patients with extended waits at admission).

Of patients admitted from waiting lists in NSW in 2005-06, the percentage of patients classified to each category and the percentage with an extended wait were:

- 41.5 per cent were classified to category 1, of whom 22.8 per cent had an extended wait
- 30.6 per cent were classified to category 2, of whom 29.5 per cent had an extended wait
- 28.0 per cent were classified to category 3, of whom 15.8 per cent had an extended wait.

Overall in NSW, 22.9 per cent of all patients experienced extended waits (table 10A.24).

Of patients admitted from waiting lists in Victoria in 2005-06, the percentage of patients classified to each category and the percentage with an extended wait were:

- 22.4 per cent were classified to category 1, of whom zero per cent had an extended wait
- 46.9 per cent were classified to category 2, of whom 27.7 per cent had an extended wait
- 30.7 per cent were classified to category 3, of whom 10.3 per cent had an extended wait.

Overall in Victoria, 16.2 per cent of all patients experienced extended waits (table 10A.26).

Of patients admitted from waiting lists in Queensland in 2005-06, the percentage of patients classified to each category and the percentage with an extended wait were:

- 36.2 per cent were classified to category 1, of whom 14.3 per cent had an extended wait
- 44.8 per cent were classified to category 2, of whom 15.6 per cent had an extended wait
- 19.0 per cent were classified to category 3, of whom 10.2 per cent had an extended wait.

Overall in Queensland, 14.1 per cent of all patients experienced extended waits (table 10A.28).

Of patients admitted from waiting lists in WA in 2005-06, the percentage of patients classified to each category and the percentage with an extended wait were:

- 35.3 per cent were classified to category 1, of whom 18.9 per cent had an extended wait

- 26.7 per cent were classified to category 2, of whom 32.1 per cent had an extended wait
- 38.0 per cent were classified to category 3, of whom 8.3 per cent had an extended wait.

Overall in WA, 18.4 per cent of all patients experienced extended waits (table 10A.30).

Of patients admitted from waiting lists in SA in 2005-06, the percentage of patients classified to each category and the percentage with an extended wait were:

- 34.6 per cent were classified to category 1, of whom 22.4 per cent had an extended wait
- 27.4 per cent were classified to category 2, of whom 22.9 per cent had an extended wait
- 37.9 per cent were classified to category 3, of whom 10.5 per cent had an extended wait.

Overall in SA, 18.0 per cent of all patients experienced extended waits (table 10A.32).

Of patients admitted from waiting lists in Tasmania in 2005-06, the percentage of patients classified to each category and the percentage with an extended wait were:

- 45.0 per cent were classified to category 1, of whom 28.0 per cent had an extended wait
- 34.0 per cent were classified to category 2, of whom 43.0 per cent had an extended wait
- 24.0 per cent were classified to category 3, of whom 23.0 per cent had an extended wait.

Overall in Tasmania, 32.0 per cent of all patients experienced extended waits (table 10A.34).

Of patients admitted from waiting lists in the ACT in 2005-06, the percentage of patients classified to each category and the percentage with an extended wait were:

- 29.9 per cent were classified to category 1, of whom 3.7 per cent had an extended wait
- 46.1 per cent were classified to category 2, of whom 48.3 per cent had an extended wait

- 21.0 per cent were classified to category 3, of whom 27.0 per cent had an extended wait.

Overall in the ACT, 29.9 per cent of all patients experienced extended waits (table 10A.35).

Of patients admitted from waiting lists in NT in 2005-06, the percentage of patients classified to each category and the percentage with an extended wait were:

- 48.9 per cent were classified to category 1, of whom 16.7 per cent had an extended wait
- 33.0 per cent were classified to category 2, of whom 31.0 per cent had an extended wait
- 18.1 per cent were classified to category 3, of whom 22.7 per cent had an extended wait.

Overall in the NT, 22.5 per cent of all patients experienced extended waits (table 10A.37).

Attachment 10A includes data on ‘elective surgery waiting times’ by hospital peer group, specialty of surgeon and indicator procedure (tables 10A.21, 10A.22 and 10A.23). All jurisdictions (except Tasmania) also provided data on urgency category waiting times by clinical specialty for 2005-06 (tables 10A.25, 10A.27, 10A.29, 10A.31, 10A.33, 10A.36 and 10A.38).

Effectiveness — appropriateness

Separation rates for selected procedures

‘Separation rates for selected procedures’ is an indicator of the appropriateness of public hospital services (box 10.6).

Box 10.6 **Separation rates for selected procedures**

The purpose of this indicator is to help determine whether 'hospital separation rates for selected procedures' are appropriate. The procedures are selected for their frequency, for being elective and discretionary, and because alternative treatments are sometimes available.

'Separation rates for selected procedures' is defined as separations per 1000 people for certain procedures, and for caesarean section separations per 100 in-hospital births.

Higher/lower rates are not necessarily associated with inappropriate care. However, large jurisdictional variations in rates for particular procedures, may require investigation to determine whether service levels are appropriate.

Care needs to be taken when interpreting the differences in the separation rates of the selected procedures. Variations in rates may be attributable to variations in the prevalence of the conditions being treated, or to differences in clinical practice across states and territories. Higher rates may be acceptable for certain conditions and not for others. Higher rates of angioplasties and lens insertions, for example, may represent appropriate levels of care, whereas higher rates of hysterectomies or tonsillectomies may represent an over-reliance on procedures. No clear inference can be drawn from higher rates of arthroscopies or endoscopies. Some of the selected procedures, such as angioplasty and coronary artery bypass graft, are alternative treatment options for people diagnosed with similar conditions.

The 'separation rates for selected procedures' reported here include all hospitals and reflect the activities of both public and private health systems. The most common procedures of those reported in 2005-06 were lens insertions, caesarean sections and cholecystectomies (table 10.9). For all procedures, separation rates varied across jurisdictions. Statistically significant and material differences in the separation rates for these procedures may highlight variations in treatment methods across jurisdictions. Table 10A.39 presents standardised separation rate ratios — comparing the separation rate in each jurisdiction with the national rate — along with confidence intervals for each ratio.

Table 10.9 Separations for selected procedures or diagnoses per 1000 people, all hospitals, by patient's usual residence, 2005-06[a, b, c]

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Total*[d]
Procedure/diagnosis									
Appendectomy	np	np	np	np	np	np	np	np	np
Coronary artery bypass	0.7	0.7	0.8	0.4	0.6	0.6	0.5	0.9	0.7
Coronary angioplasty	1.7	1.7	1.3	1.6	1.5	1.5	1.8	1.2	1.6
Caesarean section:									
separation rate	4.0	4.0	4.6	4.7	4.2	4.2	3.7	4.7	4.2
separations per 100 in-hospital births[e]	28.8	30.4	32.4	34.0	32.8	28.0	28.5	30.9	30.7
Cholecystectomy	2.2	2.3	2.3	2.1	2.3	2.2	2.0	1.7	2.2
Diagnostic gastrointestinal endoscopy	np	np	np	np	np	np	np	np	np
Hip replacement	1.3	1.4	1.1	1.5	1.4	1.7	1.5	0.8	1.3
Revision of hip replacement	0.2	0.2	0.1	0.2	0.1	0.2	0.2	0.1	0.2
Hysterectomy[f]	1.3	1.2	1.4	1.5	1.6	1.6	1.4	1.3	1.3
Lens insertion	8.3	7.5	9.2	8.1	7.0	6.1	6.4	7.0	8.1
Tonsillectomy	1.8	1.8	1.8	1.8	2.4	1.1	1.4	1.0	1.8
Myringotomy	1.2	1.7	1.4	1.9	2.9	1.2	1.3	0.7	1.6
Knee replacement	1.7	1.3	1.4	1.5	1.5	1.5	1.9	0.9	1.5
Prostatectomy	1.3	1.5	1.1	1.2	1.3	1.4	1.2	1.2	1.3
Arthroscopic procedures	np	np	np	np	np	np	np	np	np

[a] Excludes separations for which the care type was reported as 'newborn with no qualified days' and records for hospital boarders and posthumous organ procurement. Excludes multiple procedures/diagnoses for the same separation within the same group. [b] The procedures and diagnoses are defined using ICD-10-AM codes. [c] Rates per 1000 people were directly age standardised to the Australian population at 30 June 2001. [d] Includes other territories. Excludes non-residents and unknown state or territory of residence. [e] Caesarean sections divided by separations for which in-hospital birth was reported. This is an approximate measure of the proportion of all births that are by caesarean section because births out of hospital are not included. [f] Includes hysterectomies for females aged 15–69 years only. Rate is determined using total population for state or territory. **np** Not published.

Source: AIHW (2007a); table 10A.39.

Effectiveness — quality

There is no single definition of quality in healthcare, but the Australian Commission on Safety and Quality in Healthcare (ACSQHC) has defined quality as 'the extent to which the properties of a service or product produces a desired outcome' (Runciman 2006). No single indicator can measure quality across all providers. An alternative strategy is to identify and report on aspects of quality of care. The aspects of quality recognised in the performance indicator framework are safety, responsiveness, capability and continuity. Data are reported against all of these aspects except continuity.

There has been considerable debate and research to develop suitable indicators of the quality of healthcare both in Australia and overseas. This chapter reports data for clinical indicators of safety (‘unplanned re-admission rates’, ‘pre-anaesthetic consultation rates’ and ‘surgical site infection rates’), patient satisfaction and the accreditation of public hospital beds.

All Australian health ministers agreed to the establishment of the Australian Council for Safety and Quality in Health Care in January 2000, with a view to taking a systematic approach to assessing and improving the quality of healthcare. The Australian Council for Safety and Quality in Health Care was replaced in January 2006 by the ACSQHC. A key objective of the ACSQHC is to achieve safe, effective and responsive care for consumers. The ACSQHC will continue to maintain the Council’s focus on improving the safety of hospitals and will also seek to improve the quality of primary health care and the private health sector.

Various states and territories publicly report performance indicators for public hospital quality. Some have adopted the same indicators as reported in this chapter. In NSW, for example, reporting of Australian Council on Health Care Standards (ACHS) ‘surgical site infection rates’ is mandatory for public hospitals. Both the WA and Tasmanian health department annual reports include information on ‘unplanned re-admission rates’. All Victorian hospitals are required to publish annual quality care reports that include safety and quality indicators for infection control, medication errors, falls monitoring and prevention, and pressure wound monitoring and prevention. Queensland Health releases an annual public hospitals performance report which shows a wide range of hospital performance information including clinical performance, efficiency and patient satisfaction. There are currently 31 clinical indicators that monitor clinical performance in Queensland Health hospitals spanning Medical, Surgical and Obstetrics and Gynaecology.

Safety

Improving patient safety is an important issue for all hospitals. Studies on medical errors have indicated that adverse healthcare related events occur in public hospitals in Australia and internationally, and that their incidence is potentially high (for example, Wilson et al. 1995; Thomas et al. 2000; Runciman and Moller 2001, Runciman et al. 2000 and Davis et al. 2001). These adverse events can result in serious consequences for individual patients, and the associated costs can be considerable (Kohn et al. 1999).

Data for the ‘safety’ indicators come from the ACHS Comparative Report Service (Clinical Indicators). The ACHS data are collected for internal clinical review by individual hospitals. They are predominantly used to demonstrate the potential for improvement across Australian hospitals, if all hospitals could achieve the same outcomes as the hospitals that achieve the best outcomes for patients. When interpreting results of these indicators, emphasis needs to be given to the potential for improvement. Statewide conclusions cannot be drawn because participation by public hospitals in the Comparative Report Service (Clinical Indicators) is generally voluntary, so the data are not necessarily drawn from representative samples of hospitals (box 10.7).

Box 10.7 **Reporting of ACHS clinical indicators**

The data for the clinical indicators of 'unplanned re-admissions to hospital', 'pre-anaesthetic consultation rates' and 'surgical site infection rates' come from the ACHS. The ACHS's method for reporting clinical indicators is explained in Determining the Potential to Improve Quality of Care (ACHS 2007). The ACHS reports the average (that is, mean) rate of occurrence of an event and the performance of hospitals at the 20th and 80th centiles. Where a lower rate implies better quality, national performance at the 20th centile represents the rate at, or below which, the best performing 20 per cent of ACHS reporting hospitals performed. Where a higher rate implies better quality, national performance at the 80th centile represents the rate at, or above which, the best performing 20 per cent of ACHS reporting hospitals performed. This method is designed to allow hospitals to determine whether their performance is above or below average, and what scope exists for improvement.

Particular attention is paid to systematic variation between hospitals and between different categories of hospital (including different jurisdictions), and to individual hospitals that vary significantly from the average for all hospitals (that is, outliers).

The ACHS calculates the average occurrence of an event for all hospitals and uses the shrinkage estimation method to estimate shrunken rates for individual hospitals. From these shrunken rates, the performance of hospitals at the 20th and 80th centiles is calculated. The potential gains from shifting 'mean' hospitals to the 20th/80th centile are obtained by calculating the change in the occurrence of the event measured if the mean were equal to performance at the 20th/80th centile.

Shrunken rates are used rather than actual rates because actual rates of zero per cent and 100 per cent may be obtained for individual hospitals based on random variation where there are low denominators. Shrinkage estimators adjust each hospital's observed rate using the hospital's numerator and denominator, together with the mean and standard deviations of other hospitals to obtain corrected rates. The smaller the denominator for an individual hospital, the larger is the shift to the overall mean.

Using the shrunken rates, mean rates are calculated for individual categories of hospital (including jurisdictions) to determine stratum rates. If the stratum explains more than 10 per cent of the variation in rates, this is reported as a possible explanatory variable. The potential gains of each category shifting performance to the stratum with the lowest mean are also calculated.

(Continued on next page)

Box 10.7 **(Continued)**

Finally, using the shrunken rates for individual hospitals, the observed occurrence of the event measured is compared to the expected occurrence of the event to measure difference from the mean. To avoid responding to random variation, three standard deviations are plotted, and values outside the three standard deviations are assumed to be systematically different from the average rate. The potential gains from shifting the performance of these outliers to the performance of mean hospitals are calculated (outlier gains).

Source: ACHS (unpublished, 2003).

Safety — unplanned re-admission rates

'Unplanned re-admission rates' is an indicator of hospital safety (box 10.8). These estimates should be viewed in the context of the statistical (standard) errors. High standard errors signal that data are potentially unreliable. The statistical terms used to describe this indicator are explained in box 10.9.

Box 10.8 **Unplanned re-admission rates**

'Unplanned re-admission rates' show the rate at which patients unexpectedly return to hospital within 28 days for further treatment of the same condition or a condition related to the initial admission. The aim of this indicator is to measure unintentional additional hospital care. Patients might be re-admitted unexpectedly if the initial care or treatment was ineffective or unsatisfactory, if post discharge planning was inadequate, or for other reasons outside the control of the hospital, for example poor post-discharge care.

The 'unplanned re-admission rate' is the total number of unplanned and unexpected re-admissions within 28 days of separation as a percentage of the total number of separations (excluding patient deaths). High rates for this indicator suggest the quality of care provided by hospitals, or post-discharge care or planning, should be examined because there may be scope for improvement.

There are some difficulties in identifying re-admissions that were unplanned. A re-admission is considered unplanned if there is no documentation to verify that the re-admission was planned and/or if the re-admission occurred through the accident and emergency department of a hospital.

This indicator identifies only those patients re-admitted to the same hospital, so there is some under-reporting (for example, where patients go to another hospital). Unplanned re-admission rates are not adjusted for casemix or patient risk factors, which may vary across hospitals and across jurisdictions.

Box 10.9 Definition of terms for ACHS clinical indicators

centile: any of the 99 numbered points that divide an ordered set of scores into 100 parts, each of which contains one 100th of the total. Where a lower rate implies better quality, national performance at the 20th centile represents the rate at, or below which, the best performing 20 per cent of ACHS reporting hospitals performed. Where a higher rate implies better quality, national performance at the 80th centile represents the rate at, or above which, the best performing 20 per cent of ACHS reporting hospitals performed.

centile gains: the potential gains from shifting mean (average) hospitals to the performance at the 20th/80th centile (depending on whether a high or low rate is desirable), is obtained by calculating the change in the occurrence of an event if the mean were equal to performance at the 20th/80th centile.

denominator: the term of a fraction or equation showing the number of parts into which the numerator is being divided (usually written below the line). For the unplanned re-admissions indicator, for example, the denominator is the total number of admissions in the participating hospital.

mean: the sum of a set of numbers divided by the amount of numbers in the set, often referred to as an average.

numerator: the term of a fraction or equation showing how many parts of the fraction are taken (usually written above the line). For the unplanned re-admissions indicator, the numerator is the total number of unplanned re-admissions in the participating hospital; for the infections indicators, the numerator is the number of infections for the selected procedure in the participating hospital.

outlier gains: the potential gains from moving the performance of outlier hospitals to the performance of mean (average) hospitals, obtained by calculating the change in the occurrence of an event if the outlier performance were equal to performance at the mean.

rate: the sum of the numerators divided by the sum of the denominators, which is also the weighted mean of the individual rates of the ACHS reporting hospitals. This mean may not be the same as the unweighted mean of the rates, especially if a few ACHS reporting hospitals with large denominators have different rates (extremely high or low) from the other ACHS reporting hospitals.

stratum gains: the potential gains from a particular category of hospitals moving to the performance of the stratum with the lowest mean.

stratum rate: mean rates for a particular jurisdiction.

Source: ACHS (2001).

Nationally, among all public hospitals participating in the ACHS Comparative Report Service in 2006, the mean rate of ‘unplanned re-admissions’ was 2.8 per 100 admissions (table 10.10). The ACHS estimated that if the performance of all ACHS reporting public hospitals in Australia matched national performance at the 20th centile, there would be 1.6 per cent (or 18 136) fewer re-admissions to these public hospitals (ACHS unpublished). National performance at the 20th centile shows the rate at, or below which, the best performing 20 per cent of ACHS reporting hospitals performed.

These national results are based on approximately one quarter of total public hospital separations. The number of ACHS reporting hospital separations used to derive this indicator was 1.1 million in 2006 (ACHS unpublished), whereas the total number of separations in 2005-06 was around 4.5 million (AIHW 2007a). For jurisdictions with more than five hospitals reporting ‘unplanned readmissions’ to the ACHS Comparative Report Service, the mean rates of unplanned re-admissions in 2006 are shown in table 10.10. The coverage of the ACHS data may differ across these states. Data for Tasmania, the ACT and the NT are not reported separately because fewer than five hospitals reported ‘unplanned re-admissions’ in each of those jurisdictions.

Table 10.10 Unplanned re-admissions, ACHS reporting public hospitals, 2006[a]

	Unit	*Results*
National rate	%	2.8
National performance at 80th centile (rate)	(%)	5.1
National performance at 20th centile (rate)	(%)	1.2
NSW		
Numerator (re-admissions)	no.	13 410
Denominator (separations)	no.	395 782
Rate	%	3.4
Standard error (±)		0.3
ACHS reporting hospitals	no.	58
Victoria		
Numerator (re-admissions)	no.	5 857
Denominator (separations)	no.	233 809
Rate	%	2.5
Standard error (±)		0.3
ACHS reporting hospitals	no.	30
Queensland		
Numerator (re-admissions)	no.	7 373
Denominator (separations)	no.	224 206
Rate	%	3.3
Standard error (±)		0.3
ACHS reporting hospitals	no.	14
WA		
Numerator (re-admissions)	no.	1 295
Denominator (separations)	no.	86 270
Rate	%	1.5
Standard error (±)		0.5
ACHS reporting hospitals	no.	23
SA		
Numerator (re-admissions)	no.	2 641
Denominator (separations)	no.	58 097
Rate	%	4.5
Standard error (±)		0.7
ACHS reporting hospitals	no.	9

[a] The ACHS data are not designed to measure the performance of states and territories, but are for internal clinical review by individual hospitals. In addition, health organisations contribute data voluntarily to the ACHS, so the samples are not necessarily representative of all hospitals in each jurisdiction. As a result, statewide comparisons and conclusions regarding the performance of individual states cannot be drawn.

Source: ACHS (unpublished); tables 10A.40; 10A.41, 10A.42; 10A.43 and 10A.44.

Safety — pre-anaesthetic consultation rates

‘Pre-anaesthetic consultation rates’ is an indicator of hospital safety (box 10.10). Due to a redevelopment of the ACHS’s anaesthetic indicators between their 2004 and 2005 data collections, there was a reduction in the number of hospitals providing data for this indicator for this and last year’s Reports. Pre-anaesthetic consultation rate estimates should be viewed in the context of the statistical (standard) errors. High standard errors signal that data are potentially unreliable. The statistical terms used to describe this indicator are explained in box 10.9.

Box 10.10 **Pre-anaesthetic consultation rates**

‘Pre-anaesthetic consultation rates’ is an indicator of safety because consultation by an anaesthetist is essential for the medical assessment of a patient before anaesthesia for surgery (or another procedure), to ensure that the patient is in an optimal state for anaesthesia and surgery.

The ‘pre-anaesthetic consultation rate’ is the number of procedures where there is documented evidence that the patient has seen an anaesthetist before entering the operating theatre suite, anaesthetic room, or procedure room as a percentage of the total number of procedures with an anaesthetist in attendance. Low rates for this indicator suggest the quality of pre-anaesthetic care provided by hospitals should be examined because there may be scope for improvement.

This indicator identifies only pre-anaesthetic consultations for which there is documented evidence, so there may be some under-reporting due to some consultations not being documented. In addition, the data include some pre-anaesthetic consultations not conducted by the attending anaesthetist but by one of the medical members of the same anaesthetic department or group. Consultations by the attending anaesthetist are preferable.

Source: ACHS (2004).

Nationally, among all public hospitals participating in the ACHS Comparative Report Service in 2006, the mean rate of ‘pre-anaesthetic consultations’ was 94.7 per 100 procedures (table 10.11). The ACHS estimated that if the performance of all ACHS reporting public hospitals in Australia matched national performance at the 80th centile, there would be 5.3 per cent (or 1006) more pre-anaesthetic consultations in these public hospitals (ACHS unpublished). National performance at the 80th centile shows the rate at, or above which, the best performing 20 per cent of ACHS reporting hospitals performed.

These national results are based on approximately 1.4 per cent of total public acute hospital anaesthetic procedures. The number of ACHS reporting hospital procedures used to derive this indicator was 18 912 in 2006 (ACHS unpublished).

The estimated total number of anaesthetic procedures in 2005-06 was 1.3 million (AIHW unpublished).

NSW was the only jurisdiction with five or more hospitals reporting 'pre-anaesthetic consultations' to the ACHS Comparative Report Service in 2006 (table 10.11). Data for 2006 for other jurisdictions are not reported separately because fewer than five hospitals reported 'pre-anaesthetic consultations' in each of those jurisdictions. Data for previous years are reported for Victoria and SA in tables 10A.46 and 10A.48 respectively.

Table 10.11 **Pre-anaesthetic consultation rates, ACHS reporting public hospitals, 2006[a]**

	Unit	*Results*
National rate	%	94.7
National performance at 80th centile (rate)	(%)	100.0
National performance at 20th centile (rate)	(%)	91.6
New South Wales		
Numerator (pre anaesthetic consultations)	no.	6 400
Denominator (procedures)	no.	6 428
Rate	%	99.6
Standard error (±)		1.0
ACHS reporting hospitals	no.	6.0

[a] The ACHS data are not designed to measure the performance of states and territories, but are for internal clinical review by individual hospitals. In addition, health organisations contribute data voluntarily to the ACHS, so the samples are not necessarily representative of all hospitals in each jurisdiction. As a result, statewide comparisons and conclusions regarding the performance of individual states cannot be drawn.

Source: ACHS (unpublished); table 10A.45.

Safety — surgical site infection rates

'Surgical site infection rates' are reported for four frequently performed procedures — hip prosthesis, knee prosthesis, lower segment caesarean section and abdominal hysterectomy (box 10.11). These estimates should be viewed in the context of the statistical (standard) errors. High standard errors signal that the data may be potentially unreliable. The statistical terms used to describe this indicator are explained in box 10.9.

Box 10.11 **Surgical site infection rates**

‘Surgical site infection rates’ is an indicator of safety because surgical site infections can result in serious consequences for individual patients, place a significant burden on the health system and are influenced by the safety of hospital practices and procedures.

This indicator is calculated as the average (that is, mean) rate of post-operative in-hospital occurrence of surgical site infection rates for selected surgical procedures (see section 10.8 for definitions). Rates are reported for hip and knee prosthesis, lower segment caesarean section and abdominal hysterectomy. Low ‘surgical site infection rates’ are consistent with the quality standards required in the public hospital sector.

Reporting by procedure reduces the potential for casemix to influence the rates of infection, but some cases are more susceptible to infection than others. Reporting is also affected by the time period during which infections are recorded — for example, some surgical infections do not present until after discharge from hospital. Surgical infection rates are not reported for each procedure where fewer than five hospitals are included in the data.

Nationally, among all public hospitals participating in the ACHS Comparative Report Service in 2006, the mean ‘surgical site infection rate’ for hip prosthesis surgery was 1.4 per 100 separations. The ACHS estimated that if the performance of all ACHS reporting public hospitals in Australia matched national performance at the 20th centile, there would be 0.29 per cent (or 22) fewer infections after hip prosthesis surgery in these public hospitals (ACHS unpublished). National performance at the 20th centile shows the rate at, or below which, the best performing 20 per cent of ACHS reporting hospitals performed.

The mean ‘surgical site infection rate’ following knee prosthesis surgery was 0.9 per 100 separations. The ACHS estimated that if the performance of all ACHS reporting public hospitals in Australia matched national performance at the 20th centile, there would be 0.3 per cent (or 23) fewer infections following knee prosthesis surgery in these public hospitals (ACHS unpublished).

The mean ‘surgical site infection rate’ following lower segment caesarean section surgery was 1.1 per 100 separations. The ACHS estimated that if the performance of all ACHS reporting public hospitals in Australia matched national performance at the 20th centile, there would be 0.89 per cent (or 220) fewer infections following lower segment caesarean section surgery in these public hospitals (ACHS unpublished).

The mean ‘surgical site infection rate’ following abdominal hysterectomy surgery was 1.5 per 100 separations. The ACHS estimated that if the performance of all

Australian public hospitals matched national performance at the 20th centile, there would be 0.46 per cent (or 8) fewer infections following abdominal hysterectomy surgery (ACHS unpublished).

These national results are based on approximately 55.0 per cent of hip prosthesis, 68.9 per cent of knee prosthesis, 49.2 per cent of lower segment caesarean section and 21.4 per cent of abdominal hysterectomy surgical procedures. The number of ACHS reporting hospital surgical procedures in 2006 used to derive this indicator was 7415 for hip prosthesis, 7631 for knee prosthesis, 24 701 for lower segment caesarean section and 1736 for abdominal hysterectomy. The total number of these surgical procedures in 2005-06 was 13 477 for hip prosthesis (AIHW 2007a), 11 080 for knee prosthesis, 50 243 for lower segment caesarean section and 8117 for abdominal hysterectomy surgical procedures (AIHW unpublished).

For jurisdictions with more than five hospitals reporting ‘surgical site infections’ to the ACHS Comparative Report Service, the mean rates in 2006 are shown in table 10.12. The coverage of the ACHS data may differ across these states. ‘Surgical site infection rates’ for Tasmania, the ACT and the NT are not reported separately because fewer than five hospitals participated in the ACHS Comparative Report Service.

Table 10.12 Surgical site infections, ACHS reporting public hospitals, by selected procedure, 2006[a, b]

	Unit	*Hip prosthesis*	*Knee prosthesis*	*Lower segment caesarean section*	*Abdominal hysterectomy*
National rate	%	1.4	0.9	1.1	1.5
National performance at 80th centile (rate)	(%)	1.7	1.3	1.8	2.0
National performance at 20th centile (rate)	(%)	1.1	0.6	0.2	1.0
NSW					
Numerator (infections)	no.	11	16	26	np
Denominator (procedures)	no.	1 749	2 396	5 767	np
Infection rate	%	0.6	0.7	0.5	np
Standard error (±)		0.1	0.1	0.3	np
ACHS reporting hospitals	no.	13	12	13	np
Victoria					
Numerator (infections)	no.	27	17	np	np
Denominator (procedures)	no.	1 348	964	np	np
Infection rate	%	2.0	1.8	np	np
Standard error (±)		0.1	0.1	np	np
ACHS reporting hospitals	no.	6	6	np	np
Queensland					
Numerator (infections)	no.	15	6	73	10
Denominator (procedures)	no.	1 516	1 662	8 668	1 006
Infection rate	%	1.0	0.4	0.8	1.0
Standard error (±)		0.1	0.1	0.2	0.2
ACHS reporting hospitals	no.	8	9	10	7
WA					
Numerator (infections)	no.	21	14	18	np
Denominator (procedures)	no.	1 308	1 325	2 400	np
Infection rate	%	1.6	1.1	0.8	np
Standard error (±)		0.1	0.1	0.4	np
ACHS reporting hospitals	no.	7	7	8	np

(Continued on next page)

Table 10.12 **(Continued)**

	Unit	*Hip prosthesis*	*Knee prosthesis*	*Lower segment caesarean section*	*Abdominal hysterectomy*
SA					
Numerator (infections)	no.	16	6	58	np
Denominator (procedures)	no.	632	704	4 454	np
Infection rate	%	2.5	0.9	1.3	np
Standard error (±)		0.1	0.2	0.3	np
ACHS reporting hospitals	no.	5	5	6	np

[a] The ACHS data are not designed to measure the performance of states and territories, but are for internal clinical review by individual hospitals. In addition, health organisations contribute data voluntarily to the ACHS, so the samples are not necessarily representative of all hospitals in each jurisdiction. As a result, statewide comparisons and conclusions regarding the performance of individual states cannot be drawn. [b] Since 2003, the ACHS surgical site infection indicators have been collected in pairs, one for each of superficial and deep/organ space surgical site infections. An indirectly standardised rate was derived for each pair. The rate for each combined pair was estimated as the sum of the two rates (deep and superficial). The final rate for each State was calculated as the sum of observed infections divided by the sum of expected infections, multiplied by the rate for the combined pair. **np** Not published.

Source: ACHS (unpublished); tables 10A.49, 10A.50, 10A.51, 10A.52, 10A.53.

Responsiveness — patient satisfaction surveys

The use of ‘patient satisfaction surveys’ is an indicator of responsiveness in public hospitals (box 10.12). Prior to the 2006 Report, this indicator provided information on whether, and when, jurisdictions have conducted patient satisfaction surveys in recent years. This section now reports how jurisdictions use patient satisfaction surveys to improve the quality of public hospital services.

Box 10.12 **Patient satisfaction surveys**

‘Patient satisfaction surveys’ is an indicator that provides a proxy measure of governments’ objective to deliver services that are high quality and responsive to individual patient needs. Surveys can be useful for obtaining information on patient views of both clinical and non-clinical hospital care (such as whether patients feel they were treated with respect and provided with appropriate information regarding their treatment). If public hospitals respond to patient views and modify services, service quality can be improved to better meet patients’ needs.

This indicator provides information on how jurisdictions used patient satisfaction surveys to improve public hospital quality in recent years. The more public hospitals use patient satisfaction surveys the greater the potential for increasing the quality of public hospital services to better meet patients’ needs.

This is the third edition of this Report to present information on how patient satisfaction surveys are used to improve the quality of public hospital services. Some jurisdictions have provided general information. Over time this information will be refined to identify more specific examples of how public hospital quality has improved. Jurisdictions provided the following information in relation to their most recent survey (results from the NSW and the NT surveys conducted in 2004 and 2004-05 respectively were included in the 2006 Report).

- In Victoria, the survey provides government and hospital management with important information as to where quality improvement activities should be directed (table 10A.74).
- In Queensland, a series of recommendations generated from the survey were being considered by the Minister for Health (table 10A.75).
- In WA, each participating hospital receives detailed information from the survey, which is used to inform service improvement. Some examples of how hospitals have used the survey results to improve public hospital quality include: the development of bedside patient information packages; improved discharge coordination procedures; improved call bell systems and lighting; information noticeboards; and improved pre-admission services (table 10A.76).
- In SA, the survey results inform the public hospital system of the key areas of care and service that are important to maternity patients, as well as the areas of care and service that require improvement from the patient’s perspective (table 10A.77).
- In Tasmania, the survey results are used to identify areas requiring review or modification. It is intended that focus surveys will direct strategies to remediate problems (table 10A.78).
- In the ACT, information from Survey 1 was discussed at various Quality and Safety committees. Elements of the results have been taken up in safety programs – for example, medication received in a timely manner has been incorporated into the medication safety program and discharge issues are being addressed in various aspects of the discharge process. Additionally, the advising of patients’ rights and responsibilities and the way to make a complaint are ongoing. In Survey 2, opportunities for improvement were prioritised and action plans formed. Areas that were identified as needing improvement in a previous survey had higher levels of satisfaction in this survey (table 10A.79).

Capability — hospital accreditation

‘Hospital accreditation’ is an indicator of capability in public hospitals (box 10.13). Data for this indicator are shown in figure 10.15.

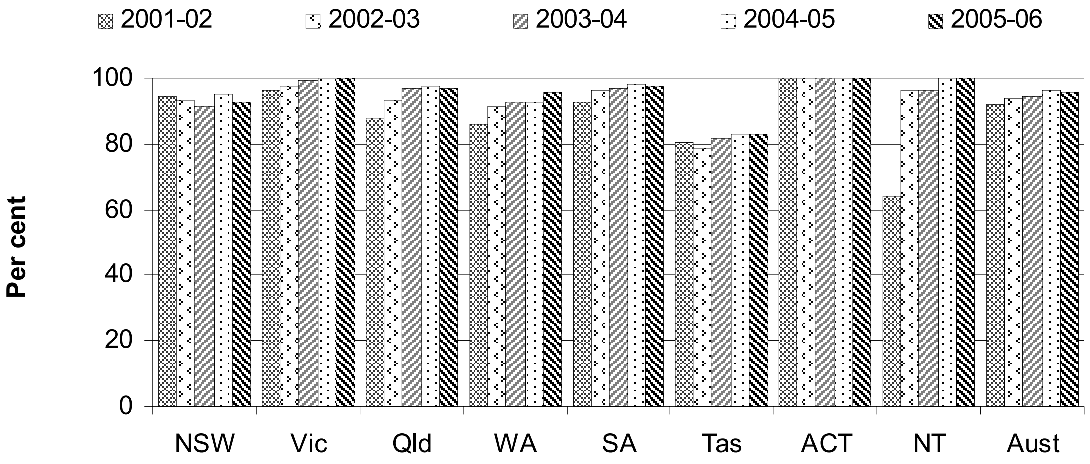
Box 10.13 **Accreditation**

'Accreditation' signifies professional and national recognition awarded to hospitals and other healthcare facilities that meet defined industry standards. Accreditation of healthcare facilities has contributed significantly to quality practices and system wide awareness of quality issues, although accreditation processes could be improved (ACSQHC 2002). Public hospitals may seek accreditation through the ACHS Evaluation and Quality Improvement Program, Business Excellence Australia (previously known as the Australian Quality Council), the Quality Improvement Council, and through certification as compliant with the International Organization for Standardization's (ISO) 9000 quality family or other equivalent programs. Jurisdictions apply specific criteria to determine which accreditation programs are suitable. Quality programs require hospitals to demonstrate continual adherence to quality improvement standards to gain and retain accreditation.

'Accreditation' is reported as the ratio of accredited beds to all beds in public hospitals, because the number of beds indicates the level of hospital capacity or activity.

It is not possible to draw conclusions about the quality of care in those hospitals that do not have 'accreditation'. Public hospital accreditation is voluntary in all jurisdictions except Victoria, where it is now mandatory for all public hospitals (excluding those that provide only dental or mothercraft services). The costs of preparing a hospital for accreditation are significant, so a low level of accreditation may reflect cost constraints rather than poor quality. Also, the cost of accreditation may not rise proportionally with hospital size. This would be consistent with larger hospitals being more active in seeking accreditation (because it is relatively less costly for them).

Figure 10.15 **Proportion of accredited beds, public hospitals**[a, b]



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[a] Where average available beds for the year were not available, bed numbers at 30 June were used.
[b] Includes psychiatric hospitals.

Source: AIHW (2007a and various issues); table 10A.54.

Continuity — continuity of care

The Steering Committee has identified 'continuity of care' as an indicator of the continuity aspect of public hospital quality. This indicator is for development in future reports (box 10.14).

Box 10.14 **Continuity of care**

The Steering Committee has agreed to develop an indicator of the continuity of care — that is, the provision of uninterrupted, timely, coordinated healthcare, interventions and actions across programs, practitioners and organisations.

Effectiveness — sustainability

Workforce sustainability

'Workforce sustainability' is an indicator of public hospital sustainability (box 10.15).

Box 10.15 **Workforce sustainability**

The 'workforce sustainability' indicator helps determine whether sustainability problems might arise in the delivery of current/future public hospitals services. Labour is the most significant and costly resource used in providing public hospital services (figure 10.22). Nurses and medical practitioners are the most significant groups of skilled professionals employed in public hospitals (figure 10.12). The sustainability of the 'public hospital' workforce is affected by a number of factors, in particular, whether the number of new entrants are sufficient to maintain the existing workforce, and the proportion of the workforce who are close to retirement.

Age profiles for nurse and medical practitioner workforces show the proportions of registered nurses and medical practitioners in ten year age brackets. The data are presented both by jurisdiction and by region.

The smaller the proportion of the workforce who are new entrants and/or the larger the proportion of the workforce who are close to retirement, the more likely sustainability problems are to arise in the coming decade as the older age group starts to retire.

(Continued on next page)

Box 10.15 **(Continued)**

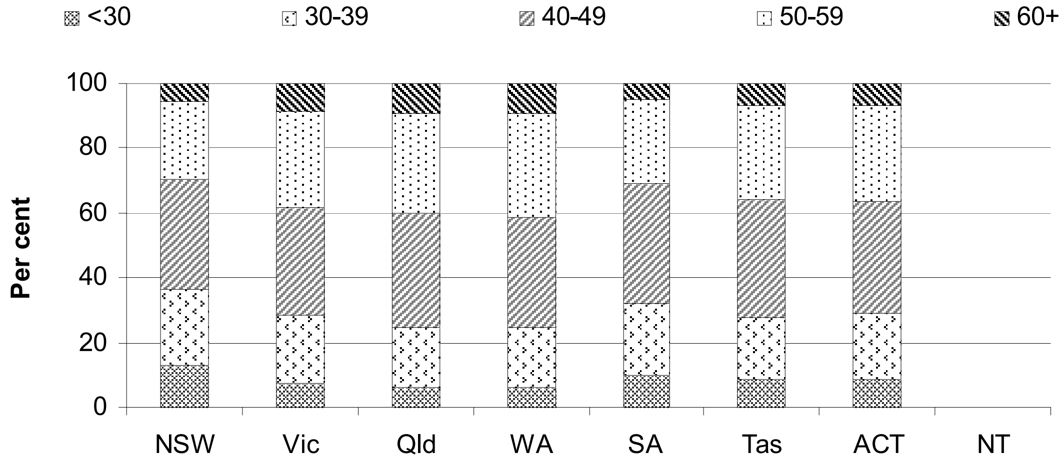
All registered nurses and medical practitioners are included in these measures as crude indicators of the potential respective workforces for public hospitals.

These measures are not a substitute for a full workforce analysis that allows for migration, trends in full-time work and expected demand increases. They can, however, indicate that further attention should be given to workforce sustainability for public hospitals.

Source: National Health Performance Committee (2004).

The age profile of the nursing workforce (which includes midwives) for each jurisdiction, except the NT, is shown in figure 10.16. Nursing workforce data by region are shown in figure 10.17.

Figure 10.16 **Nursing workforce, by age group, 2005**[a, b]



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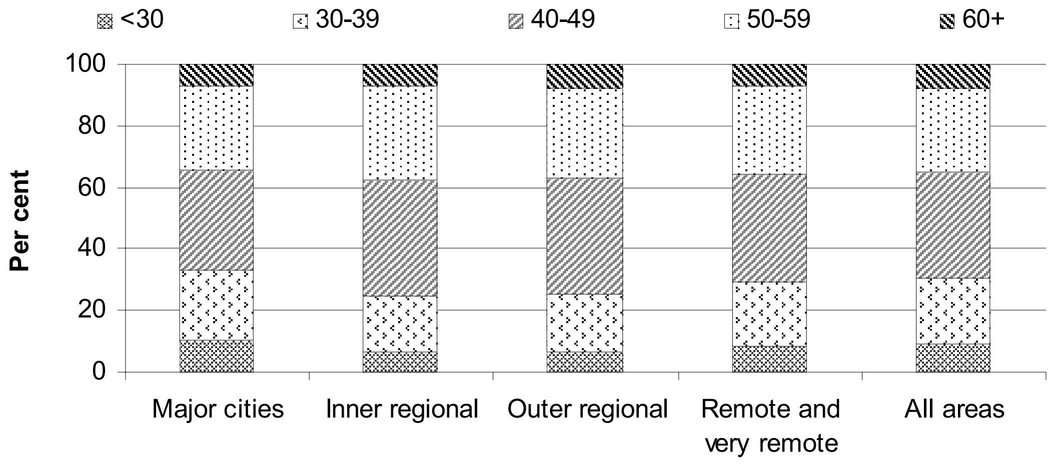
[a] Includes registered and enrolled nurses (including midwives) who are employed in nursing, on extended leave and looking for work in nursing. [b] Estimates for the NT are not separately published due to the very low response rate (13.7 per cent) in that jurisdiction to the AIHW Nursing and Midwifery Labour Force Survey.

Source: AIHW (unpublished) *Nursing and Midwifery Labour Force Survey*; table 10A.56.

Figure 10.17 **Nursing workforce, by age group and region, 2005**[a]



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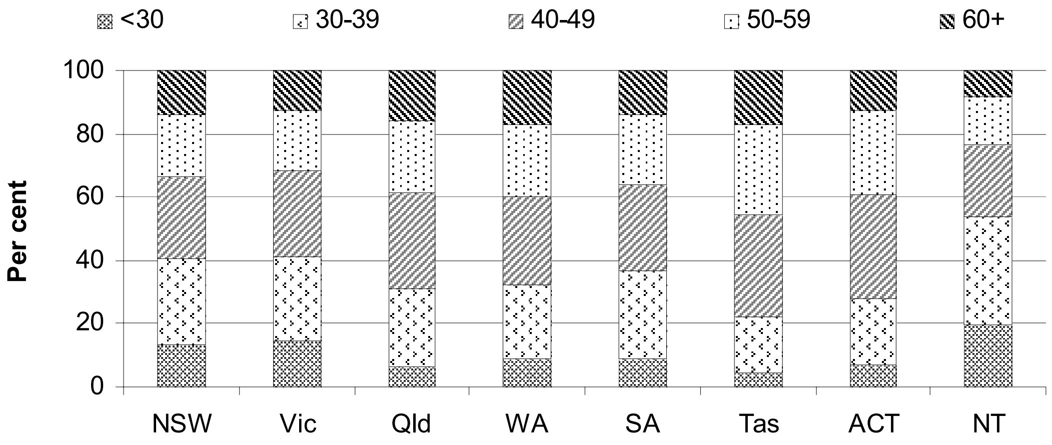
[a] Includes registered and enrolled nurses (including midwives) who are employed in nursing, on extended leave and looking for work in nursing.

Source: AIHW (unpublished) *Nursing and Midwifery Labour Force Survey*; table 10A.55.

The age profile of the medical practitioner workforce for each jurisdiction is shown in figure 10.18. Medical practitioner workforce data by region are shown in figure 10.19.

Figure 10.18 **Medical practitioner workforce, by age group, 2005**[a, b]



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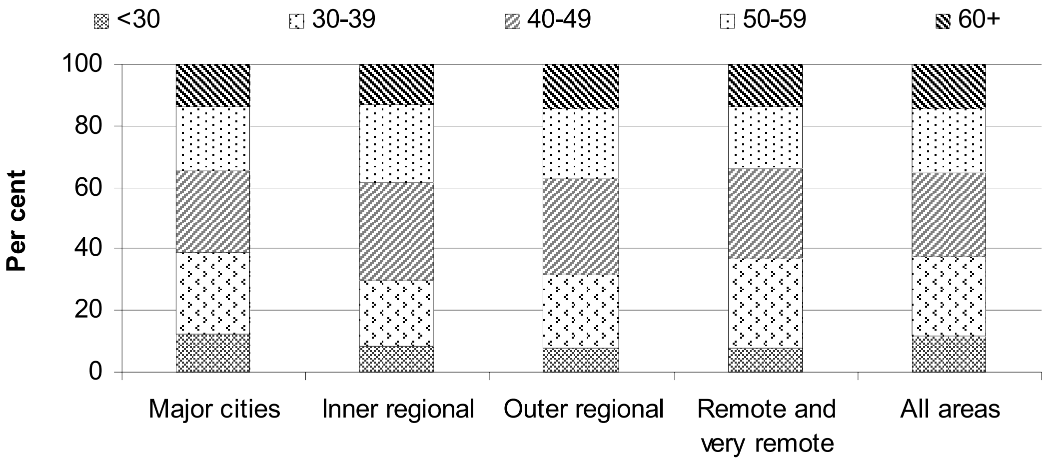
[a] Includes employed medical practitioners, registered medical practitioners on extended leave and registered medical practitioners looking for work in medicine. [b] Estimates for the NT should be treated with caution due to the low response rate (31.8 per cent) in that jurisdiction to the AIHW Medical Labour Force Survey.

Source: AIHW (unpublished) *Medical Labour Force Survey*; table 10A.58.

Figure 10.19 **Medical practitioner workforce, by age group and region, 2005**[a]



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[a] Includes employed medical practitioners, registered medical practitioners on extended leave and registered medical practitioners looking for work in medicine.

Source: AIHW (unpublished) *Medical Labour Force Survey*; table 10A.57.

Efficiency

Two approaches to measuring the efficiency of public hospital services are used in this Report: the 'cost per casemix-adjusted unit of output' (the unit cost) and the 'casemix-adjusted relative length of stay index'. The latter is used because costs are correlated with the length of stay at aggregate levels of reporting.

The Steering Committee's approach is to report the full costs of a service where they are available. Where the full costs of a service cannot be accurately measured, the Steering Committee seeks to report estimated costs that are comparable. Where differences in comparability remain, the differences are documented. The Steering Committee has identified financial reporting issues that have affected the accuracy and comparability of unit costs for acute care services. These include the treatment of payroll tax, superannuation, depreciation and the user cost of capital associated with buildings and equipment. A number of issues remain to further improve the quality of these estimates.

Costs associated with non-current physical assets (such as depreciation and the user cost of capital) are potentially important components of the total costs of many services delivered by government agencies. Differences in the techniques for measuring non-current physical assets (such as valuation methods) may reduce the comparability of cost estimates across jurisdictions. In response to concerns regarding data comparability, the Steering Committee initiated a study, reported in

Asset Measurement in the Costing of Government Services (SCRCSSP 2001). The study examined the extent to which differences in asset measurement techniques applied by participating agencies may affect the comparability of reported unit costs.

The results reported in the study for public hospitals indicate that different methods of asset measurement could lead to quite large variations in reported capital costs. However, considered in the context of total unit costs, the differences created by these asset measurement effects were relatively small, because capital costs represent a small proportion of total cost (although the differences may affect cost rankings across jurisdictions). A key message from the study was that the adoption of nationally uniform accounting standards across all service areas would be a desirable outcome. The results are discussed in more detail in chapter 2.

Care needs to be taken, therefore, in comparing the available indicators of efficiency across jurisdictions. Differences in counting rules, the treatment of various expenditure items (for example, superannuation) and the allocation of overhead costs have the potential to affect such comparisons. In addition, differences in the use of salary packaging may allow hospitals to lower their wage bills (and thus State or Territory government expenditure) while maintaining the after-tax income of their staff. No data were available for reporting on the effect of salary packaging and any variation in its use across jurisdictions.

Differences in the scope of services being delivered by public hospitals may also reduce the comparability of efficiency measures. Some jurisdictions admit patients who may be treated as non-admitted patients in other jurisdictions (AIHW 2000).

Recurrent cost per casemix-adjusted separation

‘Recurrent cost per casemix-adjusted separation’ is an indicator of the efficiency of public hospitals (box 10.16). ‘Recurrent cost per casemix-adjusted separation’ data are presented in figure 10.20.

Box 10.16 **Recurrent cost per casemix-adjusted separation**

‘Recurrent cost per casemix-adjusted separation’ is an indicator of governments’ objective to deliver services in a cost effective manner. It measures the average cost of providing care for an admitted patient (overnight stay or same day) adjusted with AR-DRG cost weights for the relative complexity of the patient’s clinical condition and of the hospital services provided (AIHW 2000).

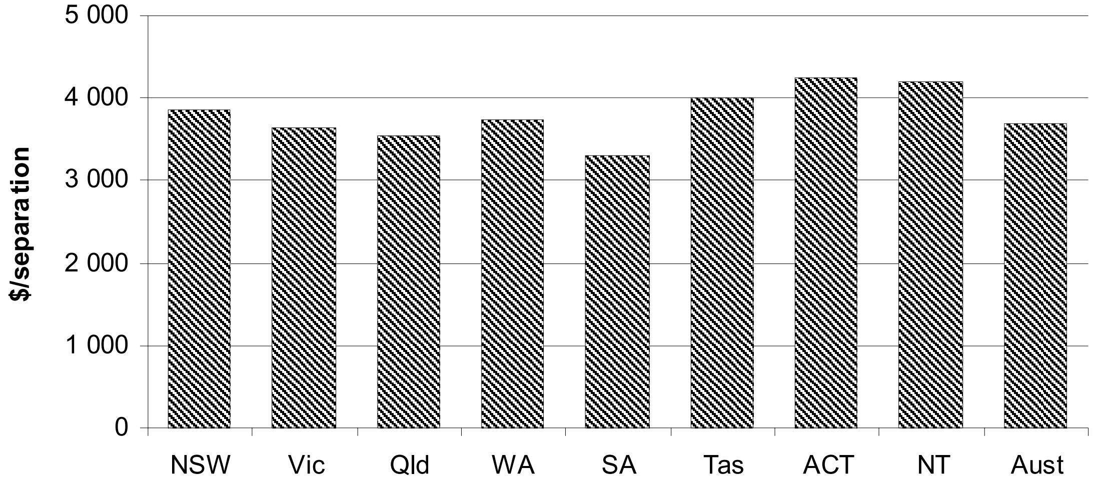
This measure includes overnight stays, same day separations, private patient separations in public hospitals and private patient recurrent costs. It excludes non-acute hospitals, mothercraft hospitals, multipurpose hospitals, multipurpose services, hospices, rehabilitation hospitals, psychiatric hospitals and hospitals in the ‘unpeered and other’ peer groups. The data exclude expenditure on non-admitted patient care, the user cost of capital and depreciation, and research costs.

All admitted patient separations and their costs are included, and most separations are for acute care. Cost weights are not available for admitted patients who received non-acute care (around 4.0 per cent of total admitted patient episodes in 2005-06), so the same cost weights for acute care are applied to non-acute separations. The admitted patient cost proportion is an estimate only.

Some jurisdictions have developed experimental cost estimates for non-psychiatric acute patients which are also reported here. Separations for non-acute patients and psychiatric acute care patients are excluded from these estimates because AR-DRG cost weights are a poor predictor of these separations.

Lower ‘recurrent cost per casemix-adjusted separation’ may reflect more efficient service delivery in public hospitals. However, this indicator needs to be viewed in the context of the set of performance indicators as a whole, as cost is not necessarily related to quality and efficiency.

Figure 10.20 **Recurrent cost per casemix-adjusted separation, 2005-06[a, b, c, d, e, f, g]**

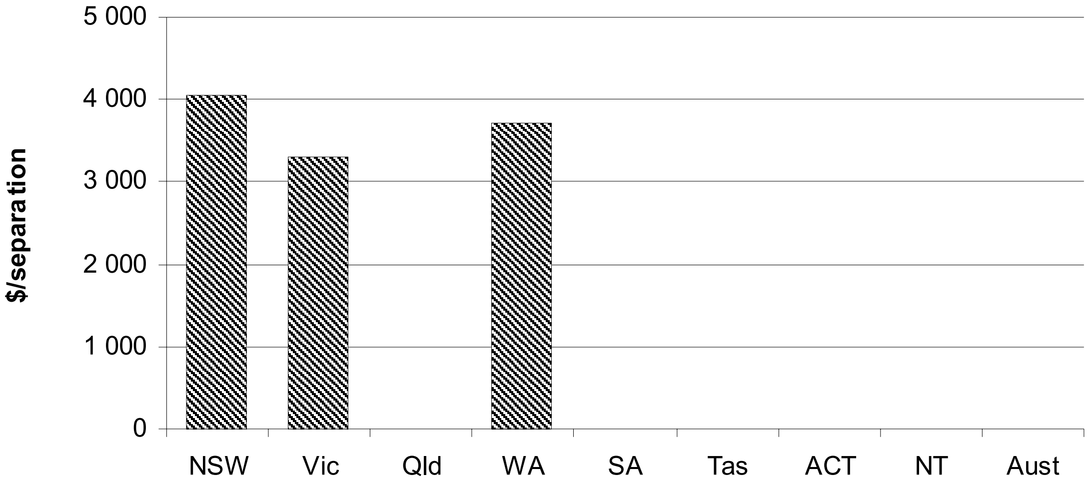


[a] Excludes depreciation and the user cost of capital, spending on non-admitted patient care and research costs. [b] Casemix-adjusted separations are the product of total separations and average cost weight. Average cost weights are from the National Hospital Morbidity Database, based on acute and unspecified separations and newborn episodes of care with qualified days, using the 2004-05 AR-DRG v 5.0 cost weights (DoHA 2006). [c] Excludes separations for which the care type was reported as 'newborn with no qualified days', and records for hospital boarders and posthumous organ procurement. [d] Psychiatric hospitals, drug and alcohol services, mothercraft hospitals, unpeered and other hospitals, hospices, rehabilitation facilities, small non-acute hospitals and multi-purpose services are excluded from these data. The data are based on hospital establishments for which expenditure data were provided, including networks of hospitals in some jurisdictions. Some small hospitals with incomplete expenditure data were not included. [e] Of the selected hospitals, three small hospitals had their admitted patient cost proportion estimated by the Health and Allied Services Advisory Council ratio. Admitted patient cost proportion was previously called the inpatient fraction. [f] Hospital recurrent expenditures on Indigenous and non-Indigenous people may differ (AIHW 2001b). These differences may influence jurisdictional variation in unit costs. [g] NT data need to be interpreted in conjunction with the cost disabilities associated with hospital service delivery in the NT.

Source: AIHW (2007a); table 10A.59.

Experimental estimates of 'recurrent cost per casemix-adjusted separation' for acute non-psychiatric patients are reported for NSW, Victoria and WA (figure 10.21). (These estimates relate to a subset of the selected public hospitals reported in figure 10.20 and are not available for other jurisdictions.) The experimental estimates aim to overcome the need to apply cost weights for acute care to non-acute care separations (box 10.16). The effect of restricting the analysis to acute non-psychiatric admitted patients was to increase the estimated recurrent cost per casemix-adjusted separation for the subset of hospitals by 3.4 per cent for NSW, and to decrease this cost by 9.7 per cent for Victoria and 1.0 per cent for WA (AIHW 2007a).

Figure 10.21 **Recurrent cost per acute non-psychiatric casemix-adjusted separation, subset of hospitals, 2005-06**[a, b, c, d, e, f]



[a] Excludes psychiatric hospitals, sub-acute, non-acute and unpeered hospitals. This subset excludes hospitals where the inpatient fraction was equal to the acute inpatient fraction and more than 1000 non-acute patient days were recorded. Also excludes hospitals where the apparent cost of non-acute patients exceeded $1000 per day and more than $1 million of apparent expenditure on non-acute patients days was reported. [b] Separations are those where the care type is acute, newborn with qualified days, or not reported. Psychiatric separations are those with psychiatric care days. [c] Average cost weight from the National Hospital Morbidity Database, based on acute, newborn with at least one qualified day, or not reported, using the 2004-05 AR-DRG version 5.0 cost weights (DoHA 2006). [d] Cost estimates include adjustment for private patient medical costs: $199 for NSW, $90 for Victoria and $100 for WA. [e] These estimates are not available for Queensland, SA, Tasmania, the ACT or the NT. [f] Data are from table A1.12 of AIHW (2007a).

Source: AIHW (2007a); table 10A.59.

'Recurrent cost per casemix-adjusted separation' is affected by differences in the mix of admitted patient services produced by hospitals in each jurisdiction. Hospitals have been categorised by 'peer groups' to enable those with similar activities to be compared. The public hospital peer groups include 'Principal referral and Specialist women's and children's hospitals', 'Large hospitals', 'Medium hospitals' and 'Small acute hospitals'.

The dominant peer classification is the 'Principal referral and Specialist women's and children's' category. The 77 hospitals representing this group had an average of 40 878 separations each at a cost of $3726 (table 10A.60 and table 10.13). The data for each of the hospital peer groups are presented in table 10.13. Detailed data for all peer groups are presented in table 10A.60.

Table 10.13 **Recurrent cost per casemix-adjusted separation, by hospital peer group, 2005-06 ($ million)**[a, b, c]

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Hospital peer group									
Principal referral and Specialist women's and children's	3 919	3 619	3 665	3 634	3 346	3 951	np	4 102	3 726
Large	3 710	3 702	3 024	3 706	3 420	..	np	..	3 608
Medium	3 637	3 626	2 929	4 047	3 024	..	..	..	3 524
Small acute	3 882	4 566	2 755	4 271	3 047	5 914	..	4 810	3 790
All hospitals[d]	**3 852**	**3 646**	**3 537**	**3 733**	**3 299**	**3 994**	**4 250**	**4 187**	**3 698**

[a] Data exclude depreciation and the user cost of capital, spending on non-admitted patient care and research costs. [b] The data are based on hospital establishments for which expenditure data were provided, including networks of hospitals in some jurisdictions. Some small hospitals with incomplete expenditure data were not included. [c] Separations for which the care type was reported as newborn with no qualified days, and records for hospital boarders and posthumous organ procurement have been excluded. [d] Includes all hospitals in this cost per casemix-adjusted analysis. .. Not applicable. **np** Not published

Source: AIHW (2007a); table 10A.60.

Total cost per casemix-adjusted separation

'Total cost per casemix-adjusted separation' is an indicator of the efficiency of public hospitals (box 10.17). Total cost includes both the recurrent costs (as discussed above) and the capital costs associated with hospitals services. Results for this indicator in 2005-06 are reported in figure 10.20. Labour costs accounted for the majority of costs per casemix-adjusted separation in all jurisdictions.

Box 10.17 **Total cost per casemix-adjusted separation**

'Total cost per casemix-adjusted separation' is an indicator of governments' objective to deliver services in a cost effective manner. This indicator is defined as the recurrent cost per casemix-adjusted separation plus the capital costs per casemix-adjusted separation. Recurrent costs include labour and material costs, and capital costs include depreciation and the user cost of capital for buildings and equipment. The indicator is included because it allows the full cost of hospital services to be considered in a single measure. The hospitals included in this measure are the same as for recurrent cost per casemix-adjusted separation (box 10.16).

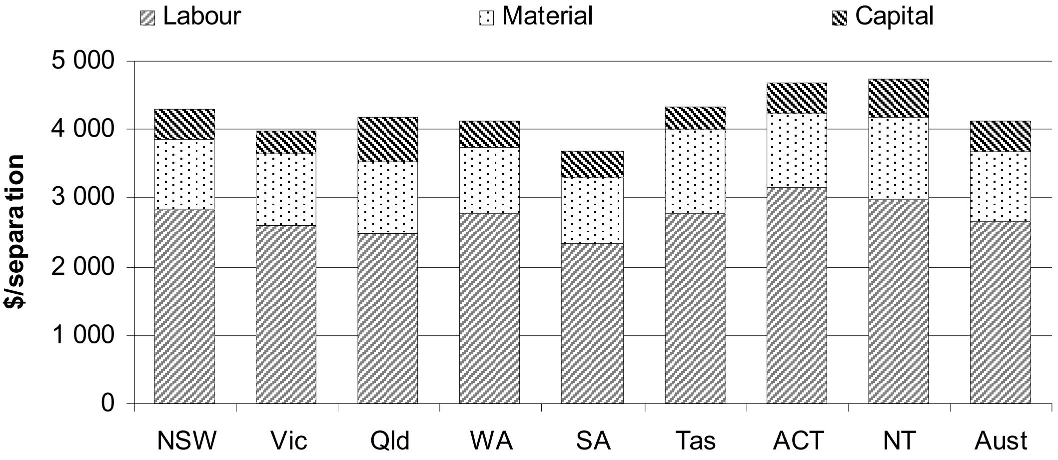
(Continued on next page)

Box 10.17 **(Continued)**

Depreciation is defined as the cost of consuming an asset's services. It is measured by the reduction in value of an asset over the financial year. The user cost of capital is the opportunity cost of the capital invested in an asset, and is equivalent to the return foregone from not using the funds to deliver other government services or to retire debt. Interest payments represent a user cost of capital, so are deducted from capital costs in all jurisdictions to avoid double counting.

A lower 'total cost per casemix-adjusted separation' may reflect more efficient service delivery in public hospitals. However, this indicator needs to be viewed in the context of the set of performance indicators as a whole, as cost is not necessarily related to quality and efficiency.

Figure 10.22 **Total cost per casemix-adjusted separation, public hospitals, 2005-06**[a, b, c]



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[a] 'Labour' includes medical and non-medical labour costs. 'Material' includes other non-labour recurrent costs, such as repairs and maintenance (table 10A.59). [b] 'Capital cost' includes depreciation and the user cost of capital for buildings and equipment that is associated with the delivery of admitted patient services in the public hospitals as described in the data for recurrent cost per casemix-adjusted separation. 'Capital cost' excludes the user cost of capital associated with land (reported in table 10A.61). [c] Variation across jurisdictions in the collection of capital related data suggests the data are only indicative. The capital cost per casemix-adjusted separation is equal to the capital cost adjusted by the inpatient fraction, divided by the number of casemix-adjusted separations.

Source: AIHW (2007a); State and Territory governments (unpublished); tables 10A.59 and 10A.61.

Relative stay index

The 'relative stay index' is an indicator of the efficiency of public hospitals (box 10.18). Data for this indicator are reported in figure 10.23. The 'relative stay index' is reported by patient election status and by medical, surgical and other AR-DRGs in tables 10A.62 and 10A.63 respectively.

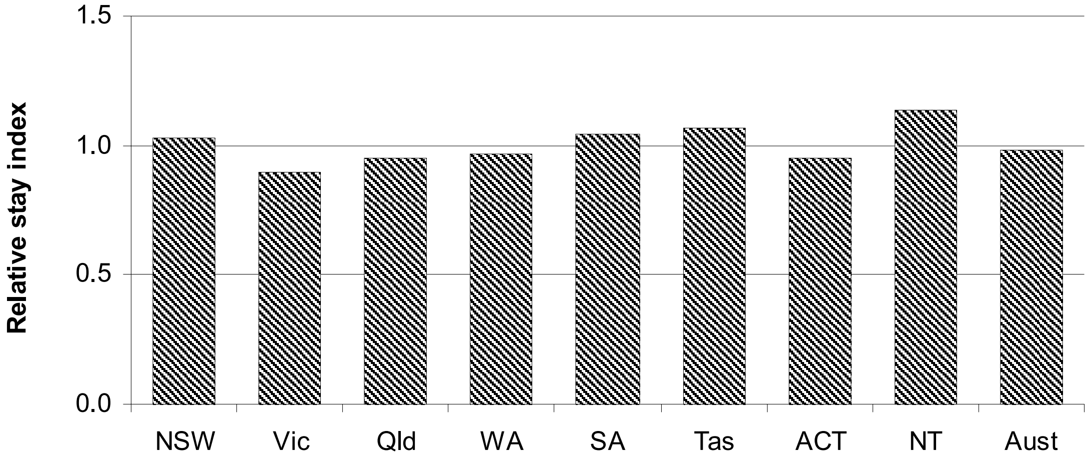
Box 10.18 **Relative stay index**

'Relative stay index' is an indicator of governments' objective to deliver services efficiently. The 'relative stay index' is defined as the actual number of acute care patient days divided by the expected number of acute care patient days adjusted for casemix. Casemix adjustment allows comparisons to take account of variation in types of service provided but not other influences on length of stay, such as the Indigenous status of the patient. Acute care separations only are included. Section 10.8 contains a more detailed definition outlining exclusions from the analysis.

The 'relative stay index' for Australia for all hospitals (public and private) is one. A 'relative stay index' greater than one indicates that average length of patient stay is higher than expected given the jurisdiction's casemix distribution. A 'relative stay index' of less than one indicates that the number of bed days used was less than expected. A low 'relative stay index' is desirable if it is not associated with poorer health outcomes or significant extra costs outside the hospital systems (for example, in-home care).

States and territories vary in their thresholds for classifying patients as either same day admitted patients or outpatients. These variations affect the 'relative stay index'.

Figure 10.23 **Relative stay index, public hospitals, 2005-06**[a, b]



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[a] Includes separations for which the care type was reported as 'acute' or 'newborn with qualified days', or was not reported. [b] The relative stay index is based on all hospitals and is estimated using the indirect standardisation method and AR-DRG version 5.0. The indirectly standardised relative stay index is not strictly comparable between jurisdictions but is a comparison of the jurisdiction with the national average based on the casemix of the jurisdiction.

Source: AIHW (2007a); table 10A.62.

Recurrent cost per non-admitted occasion of service

'Recurrent cost per non-admitted occasion of service' is an indicator of the efficiency of public hospitals (box 10.19).

Box 10.19 **Recurrent cost per non-admitted occasion of service**

'Recurrent cost per non-admitted occasion of service' is an indicator of governments' objective to deliver services in a cost effective manner. Non-admitted occasions of service (including emergency department presentations and outpatient services) account for a significant proportion of hospital expenditure.

The recurrent cost per non-admitted occasion of service is the proportion of recurrent expenditure allocated to patients who were not admitted, divided by the total number of non-admitted patient occasions of service in public hospitals. Occasions of service include examinations, consultations, treatments or other services provided to patients in each functional unit of a hospital.

Lower recurrent cost per non-admitted occasion of service may reflect more efficient service delivery in public hospitals. However, this indicator needs to be viewed in the context of the set of performance indicators as a whole, as cost is not necessarily related to quality and efficiency. This indicator does not adjust for the complexity of service — for example, a simple urine glucose test is treated equally with a complete biochemical analysis of all body fluids (AIHW 2000).

These data are not comparable across jurisdictions. Reporting categories vary across jurisdictions, and further inconsistencies arise as a result of differences in outsourcing practices. In some cases, for example, outsourced occasions of service may be included in expenditure on non-admitted services, but not in the count of occasions of service. Jurisdictions able to supply 2005-06 data for this indicator reported the following results for non-admitted patient services:

- In NSW, the emergency department cost per occasion of service was $191 for 2.0 million occasions, the outpatient cost per occasion of service was $85 for 14.0 million occasions and the overall cost per occasion of service (emergency plus outpatient plus other) was $96 for 19.3 million occasions (table 10A.64).
- In WA, the emergency department cost per occasion of service was $369 for 629 590 occasions, the outpatient cost per occasion of service was $135 for 3.4 million occasions and the overall cost per occasion of service (emergency plus outpatient plus other) was $130 for 5.0 million occasions (table 10A.66).
- In SA, the emergency department cost per occasion of service was $263 for 491 571 occasions, the outpatient cost per occasion of service was $199 for 1.4 million occasions and the overall cost per occasion of service (emergency plus outpatient) was $216 for 1.9 million occasions (table 10A.67).

- In Tasmania, the emergency department cost per occasion of service was $249 for 126 607 occasions and the outpatient cost per occasion of service was $107 for 418 289 occasions. An overall cost per occasion of service was not available (table 10A.68).
- In the ACT, the emergency department cost per occasion of service was $479 for 99 624 occasions, the outpatient cost per occasion of service was $92 for 584 633 occasions and the overall cost per occasion of service (emergency plus outpatient) was $149 for 684 257 occasions (table 10A.69).

Victoria collects data on the basis of cost per non-admitted patient encounter. An encounter includes the clinic visit and all ancillary services provided within a 30 day period either side of the clinic visit. Based on cost data from 14 hospitals, the average cost per encounter was $146 for 1.2 million encounters in 2005-06 (table 10A.65).

Given the lack of a nationally consistent non-admitted patient classification system, this Report includes national data from the Australian Government Department of Health and Ageing's National Hospital Cost Data Collection (NHCDC). The NHCDC collects data across a sample of hospitals that is expanding over time. The sample for each jurisdiction is not necessarily representative because hospitals contribute data on a voluntary basis. The NHCDC data are affected by differences in costing and admission practices across jurisdictions and hospitals. Therefore, an estimation process has been carried out to create representative national activity figures from the sample data. In addition, the purpose of the NHCDC is to calculate between-DRG cost weights, not to compare the efficiency of hospitals.

Outpatient data were contributed by 170 public hospitals for all types of public hospital outpatient clinics (tier 0). These data suggest that 'cost per non-admitted clinic occasions of service' for the public hospitals sector in 2005-06 was $169 for 12.6 million occasions (table 10A.70). 'Cost per non-admitted clinic occasions of service' data are also shown for seven categories of outpatient clinics (tier 1) (table 10.14). These tier 1 outpatient clinics data were provided by 170 public hospitals. Emergency department data, provided by 166 public hospitals, show the 'cost per occasion of service for emergency departments' by triage class (table 10.15).

Table 10.14 Non-admitted clinic occasions of service for tier 1 clinics, sample results, public sector, 2005-06[a, b, c]

	Occasions of service	*Average cost*
	no.	$/occasion of service
Allied health and/or clinical nurse specialist	846 918	91
Dental	15 574	210
Medical	941 983	272
Obstetrics and gynaecology	421 869	148
Paediatric	125 766	195
Psychiatric	82 520	114
Surgical	628 293	164
Total	**3 062 923**	**175**

[a] Includes depreciation costs. [b] Based on 170 public sector hospitals. [c] Excludes Victorian outpatient data.

Source: DoHA, *NHCDC, Round 10* (2007); table 10A.72.

Table 10.15 Emergency department average cost per occasion of service, public hospitals, by triage class, 2005-06 (dollars)[a, b, c, d, e]

Triage category	*Population estimated — average cost per occasion of service*[f]	*Actual — average cost per occasion of service*
Admitted triage 1	993	1 042
Admitted triage 2	579	603
Admitted triage 3	507	534
Admitted triage 4	441	465
Admitted triage 5	290	341
Non-admitted triage 1	527	556
Non-admitted triage 2	398	409
Non-admitted triage 3	349	361
Non-admitted triage 4	258	269
Non-admitted triage 5	169	187
Did not wait[g]	81	88
Total	**325**	**347**

[a] Not all hospitals that submit data to the NHCDC submit emergency department data. The emergency department national database contains only acute hospitals with emergency department cost and activity. [b] Based on data from 166 public sector hospitals. [c] Victorian emergency department data are not included. [d] Costing and admission practices vary across jurisdictions and hospitals. [e] Depreciation costs are included. [f] Estimated population costs are obtained by weighting the sample results according to the known characteristics of the population. [g] 'Did not wait' means those presentations to an emergency department who were triaged but did not wait until the completion of their treatment, at which time they would have been either admitted to hospital or discharged home.

Source: DoHA, *NHCDC, Round 10* (2007); table 10A.71.

Outcomes

Outcomes are the impact of services on the status of an individual or group (while outputs are the actual services delivered) (see chapter 1, section 1.5).

Patient satisfaction

'Patient satisfaction' is an indicator of public hospital quality (box 10.20). In 2005, the Steering Committee engaged Health Policy Analysis Pty Ltd to undertake a study reviewing patient satisfaction and responsiveness surveys conducted in relation to public hospital services in Australia. The study identified and examined current patient satisfaction surveys conducted by State and Territory governments that are relevant to measuring 'public hospital quality'. A major objective of the study was to identify points of commonality and difference between patient satisfaction surveys and their potential for concordance and/or for forming the basis of a minimum national data set on public hospital 'patient satisfaction' or 'patient experience'.

The study found that, although there is some potential for harmonising approaches (as most surveys assess similar aspects of patient experience and satisfaction), different survey methodologies posed significant impediments to achieving comparable information. It suggested that a starting point for harmonising approaches would be to identify an aspiring body and create a forum through which jurisdictions can exchange ideas and develop joint approaches (Pearse 2005). A copy of this study can be found on the Review web page (www.pc.gov.au/gsp).

Box 10.20 **Patient satisfaction**

'Patient satisfaction' provides a proxy measure of governments' objective to deliver services that are high quality and responsive to individual patient needs. Patient satisfaction surveys are different from other sources of hospital quality data, because they provide information on hospital quality from the patient's perspective.

Overall patient satisfaction ratings taken from each jurisdiction's patient surveys are reported. Results are expressed in percentage terms or as scale scores. A higher proportion of patients who were satisfied (or a higher score) is desirable because it suggests the hospital care received was of high quality and better met the expectations and needs of patients.

Given that 'patient satisfaction surveys' differ in content, timing and scope across jurisdictions, it is not possible to compare these results nationally. This indicator will be further developed over time as data become more comparable.

Jurisdictions reported the following results from patient satisfaction surveys:

- The Victorian Patient Satisfaction Monitor (VPSM) was conducted between March 2006 and February 2007 using a mailout questionnaire to adult acute and sub-acute patients of Victorian public hospitals. During this period, 15 806 patients answered the questionnaire, which represented a response rate of 39.0 per cent. The statewide Overall Care Index was 78.1, which translates into 'very good' under the VPSM rating system (table 10A.74).
- In Queensland, computer assisted telephone interviews were conducted with admitted mothers who had given birth in Queensland public hospitals and were discharged between June 2006 and September 2006. The sample size was 4767 with a response rate of 82.0 per cent. More than 80.0 per cent of respondents described the care they and their babies received after the birth as good or very good (table 10A.75).
- In WA, a computer assisted telephone interview survey was conducted between February 2007 and June 2007. The sample size was 8605, with an 85.5 per cent response rate. Four patient groups were reported on. The patient-rated overall indicator of satisfaction scores for each of the patient groups were as follows: child admitted, 86.5; adult admitted, 84.8; child outpatient, 79.8; and adult outpatient, 77.7. These scores are weighted by the importance of each issue as ranked by the patient and scored from 0 to 100, where 100 is the highest possible overall satisfaction score, taking into account all of the satisfaction domains measured (table 10A.76).
- In SA, a computer assisted telephone interview survey was conducted between December 2006 and January 2007 with 848 female patients aged 16 or over who had at least one live birth. This represented a response rate of 90.1 per cent. The overall satisfaction score was 86.1 (scored from 0 to 100, being least to most satisfied). The scores achieved for the seven individual areas of care ranged from 80.9 to 92.1 (table 10A.77).
- In Tasmania, up to 96 patients per ward requiring an overnight stay and 496 emergency department patients were surveyed by mailout questionnaire between June 2007 and September 2007. The survey results were not available at the time of printing (table 10A.78).
- In the ACT, two hospital-specific surveys were conducted. Between February 2007 and May 2007, Survey 1, a mailout survey, was conducted with three groups: emergency department patients; day surgery patients; and public acute inpatients. Between September 2006 and February 2007, Survey 2, a questionnaire survey, was conducted with admitted patients. For Survey 1: emergency department patients' overall satisfaction rating was 76.4 points (sample size was 135, with a response rate of 27.2 per cent); day surgery

patients' overall satisfaction rating was 87.8 points (sample size was 204, with a response rate of 57.9 per cent); and inpatients' overall satisfaction rating was 81.6 points (sample size was 160, with a response rate of 41.7 per cent). For Survey 2, results indicated that 94.0 per cent of patients were fairly or very satisfied with all aspects of their hospital stay. Survey 2 was conducted with 444 admitted patients and had a response rate of 39.0 per cent (table 10A.79).

Sentinel events

'Sentinel events' is an indicator of public hospital quality and safety (box 10.21). Data for 2005-06 are available for all jurisdictions except the NT, where numbers were suppressed for confidentiality reasons (table 10.16). For the ACT a total only is included.

Sentinel event programs have been implemented by all State and Territory governments. The purpose of these programs is to facilitate a safe environment for patients by reducing the frequency of these events (DHS 2004). The programs are not punitive, and are designed to facilitate self reporting of errors so that the underlying causes of the events can be examined, and action taken to reduce the risk of these events re-occurring.

In 2007 the AIHW, in conjunction with the ACSQHC, published a report that included national sentinel event data for 2004-05 (AIHW and ACSQHC 2007). The report notes that nationally consistent sentinel event definitions have not been agreed and as a result the data are not considered comparable across jurisdictions.

Box 10.21 **Sentinel events**

'Sentinel events' is an indicator of governments' objective to deliver public hospital services that are safe and of high quality. A sentinel event is an adverse event that occurs because of hospital system and process deficiencies and which results in the death of, or serious harm to, a patient. Sentinel events occur relatively infrequently and are independent of a patient's condition (DHS 2004). Sentinel events have the potential to seriously undermine public confidence in the healthcare system.

Australian health ministers have agreed on a national core set of sentinel events for which all public hospitals are required to provide data. The eight nationally agreed core sentinel events are:

1. Procedures involving the wrong patient or body part.
2. Suicide of an admitted patient.

(Continued on next page)

Box 10.21 **(Continued)**

3. Retained instruments or other material after surgery requiring re-operation or further surgical procedure.
4. Intravascular gas embolism resulting in death or neurological damage.
5. Haemolytic blood transfusion reaction resulting from ABO (blood group) incompatibility.
6. Medication error leading to the death of a patient reasonably believed to be due to incorrect administration of drugs.
7. Maternal death or serious morbidity associated with labour or delivery.
8. Infant discharged to the wrong family.

The indicator is defined as the number of reported sentinel events. A high number of sentinel events may indicate hospital system and process deficiencies that compromise the quality and safety of public hospitals.

Over time an increase in the number of sentinel events reported might reflect improvements in incident reporting mechanisms at a health service level and organisational cultural change, rather than an increase in the frequency of such events. However, trends need to be monitored to establish whether this is the underlying reason (DHS 2004).

Source: DHS (2004); NSW Department of Health (2005a).

Table 10.16 **Nationally agreed core sentinel events, 2005-06 (number)**[a]

Sentinel event	*NSW*	*Vic*	*Qld*	*WA*[b]	*SA*	*Tas*	*ACT*	*NT*	*Aust*	*Total*[c]
1. Procedures involving the wrong patient or body part	18	25	6	5	11	–	np	na	np	65
2. Suicide of an admitted patient	6	7	4	5	3	–	np	na	np	25
3. Retained instruments or other material after surgery requiring re-operation or further surgical procedure	11	6	6	1	1	–	np	na	np	25
4. Intravascular gas embolism resulting in death or neurological damage	–	–	–	–	1	–	np	na	np	1
5. Haemolytic blood transfusion reaction resulting from ABO incompatibility	–	–	1	–	–	–	np	na	np	1
6. Medication error leading to the death of a patient reasonably believed to be due to incorrect administration of drugs	–	2	1	1	1	–	np	na	np	5
7. Maternal death or serious morbidity associated with labour or delivery	3	2	1	1	3	–	np	na	np	10
8. Infant discharged to the wrong family	–	–	–	–	–	–	np	na	np	–
Total	**38**	**42**	**19**	**13**	**20**	**–**	**7**	**na**	**np**	**139**

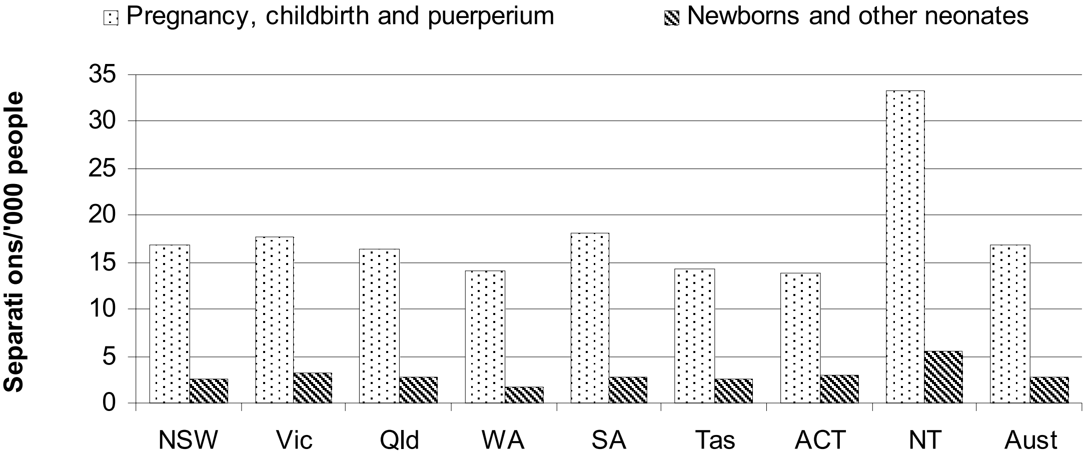
[a] Sentinel event definitions can vary across jurisdictions. [b] Includes public and private hospitals. [c] Totals relate to those jurisdictions for which data are published. **na** Not available. – Nil or rounded to zero. **np** Not published.

Source: State and Territory governments (unpublished); table 10A.81.

10.4 Profile of maternity services

Maternity services (defined as AR-DRGs relating to pregnancy, childbirth and the puerperium, and newborns and other neonates) accounted for 9.3 per cent of total acute separations in public hospitals (table 10A.83) and around 10.9 per cent of the total cost of all acute separations in public hospitals in 2005-06 (table 10A.82). Figure 10.24 shows the rate of acute separations per 1000 people for maternity services across jurisdictions in 2005-06.

Figure 10.24 **Separation rates for maternity services, public hospitals, 2005-06**[a, b]



[a] The puerperium refers to the period of confinement immediately after labour (around six weeks). [b] Newborns and other neonates include babies aged less than 28 days or babies aged less than one year with admission weight of less than 2500 grams.

Source: AIHW (2007a); tables AA.2 and 10A.83.

In Australian public hospitals in 2005-06, vaginal deliveries without complicating diagnosis accounted for a substantial proportion of the separations for pregnancy, childbirth and the puerperium (27.8 per cent) (tables 10A.83 and 10A.84). In the context of all AR-DRGs in public hospitals, vaginal deliveries without complicating diagnosis comprised the largest number of overnight acute separations (4.4 per cent of all separations) (table 10.3) and the second highest cost ($377.1 million) (table 10A.84).

The complexity of cases across jurisdictions for maternity services is partly related to the mother’s age at the time of giving birth. The mean age of mothers giving birth varied across jurisdictions in 2004, 2005 and 2006 (table 10.17).

Table 10.17 **Mean age of mothers at time of giving birth, public hospitals**

	NSW	*Vic*	*Qld*[a]	*WA*	*SA*[b]	*Tas*	*ACT*[c]	*NT*
2004								
First birth	27.7	28.1	25.3	25.9	26.8	25.2	27.6	23.9
Second birth	29.9	30.3	27.9	28.4	29.2	27.5	30.4	26.3
Third birth	31.3	31.8	29.6	29.7	30.8	28.8	31.2	27.7
All births	29.5	29.9	27.7	28.0	28.8	27.8	29.5	26.4
2005								
First birth	27.8	27.7	25.5	25.9	26.6	25.1	27.6	24.2
Second birth	29.9	29.9	28.0	28.6	29.4	27.3	29.7	26.3
Third birth	31.4	31.4	29.5	29.9	31.1	29.4	31.0	28.0
All births	29.6	29.5	27.8	28.1	28.9	27.2	29.3	26.5
2006								
First birth	27.1	27.7	25.5	26.0	26.8	na	27.7	23.8
Second birth	30.4	29.9	28.1	28.5	29.4	na	30.0	26.3
Third birth	31.6	31.5	29.6	29.8	31.0	na	31.4	28.2
All births	29.3	29.5	27.9	28.1	29.0	na	29.6	26.5

[a] 2006 data exclude mothers whose age was 'not stated'. [b] Age is based on exact age (years) to 4 decimal places. [c] ACT 2006 data are preliminary. Care must be taken when interpreting percentages as these data include both ACT and non-ACT residents where the birth occurred in the ACT. In 2006, 16.2 per cent of women who gave birth in the ACT were not residents. **na** Not available.

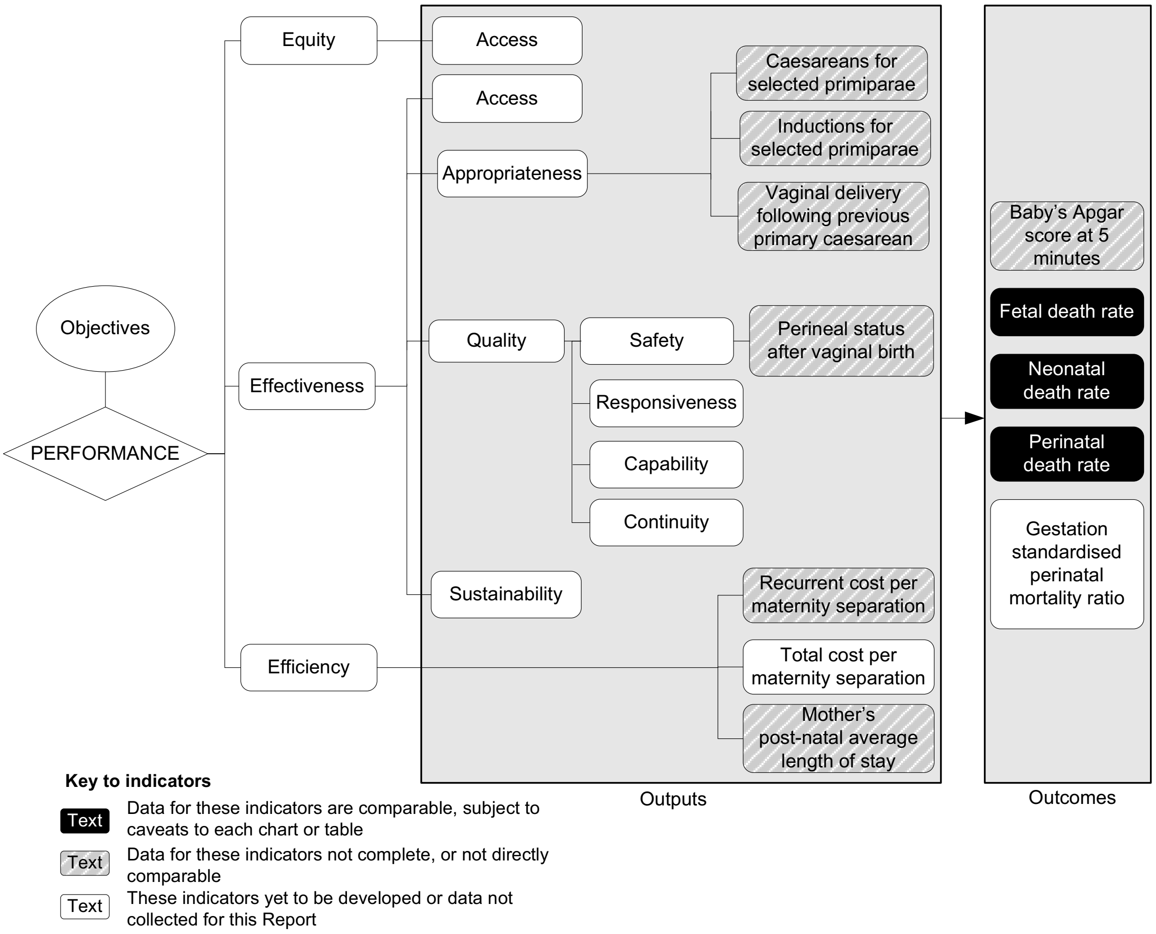
Source: State and Territory governments (unpublished).

10.5 Framework of performance indicators for maternity services

The performance framework for maternity services is outlined in figure 10.25, and has the same objectives as those for public hospitals in general. The framework is under development by the Steering Committee and, as with all the performance indicator frameworks, will be subject to regular review. The performance indicator framework shows which data are comparable in the 2008 Report. For data that are not considered directly comparable, the text includes relevant caveats and supporting commentary. Chapter 1 discusses data comparability from a Report-wide perspective (see section 1.6). The 'Health preface' explains the performance indicator framework for health services as a whole, including the subdimensions for quality and sustainability that have been added to the standard Review framework for health services.

This year the 'Gestation standardised perinatal mortality ratio' (GSPMR) has replaced the 'Rate of survival to 28 days of very low birthweight babies', but no data were available for this Report. This measure of perinatal mortality is risk-adjusted to enable hospitals with higher proportions of low gestation infants (and therefore a higher likelihood of perinatal mortality) to be validly compared with hospitals with a different casemix (DHS 2007).

Figure 10.25 **Performance indicators for maternity services**



10.6 Key performance indicator results for maternity services

Outputs

Outputs are the actual services delivered (while outcomes are the impact of these services on the status of an individual or group) (see chapter 1, section 1.5).

Equity — access

The Steering Committee has identified equity of access as an area for development in future reports. Equity of access indicators will measure access to maternity services by special needs groups such as Indigenous people or people in rural and remote areas.

Effectiveness — access

The Steering Committee has identified the effectiveness of access to maternity services as an area for development in future reports. Effectiveness of access indicators will measure access to appropriate services for the population as a whole, particularly in terms of affordability and/or timeliness.

Effectiveness — appropriateness

Caesareans and inductions for selected primiparae

'Caesareans for selected primiparae' and 'Inductions for selected primiparae' are indicators of the appropriateness of maternity services in public hospitals (box 10.22).

Box 10.22 **Caesareans and inductions for selected primiparae**

Labour inductions and birth by caesarean section are interventions that are appropriate in some circumstances, depending on the health and wellbeing of mothers and babies.

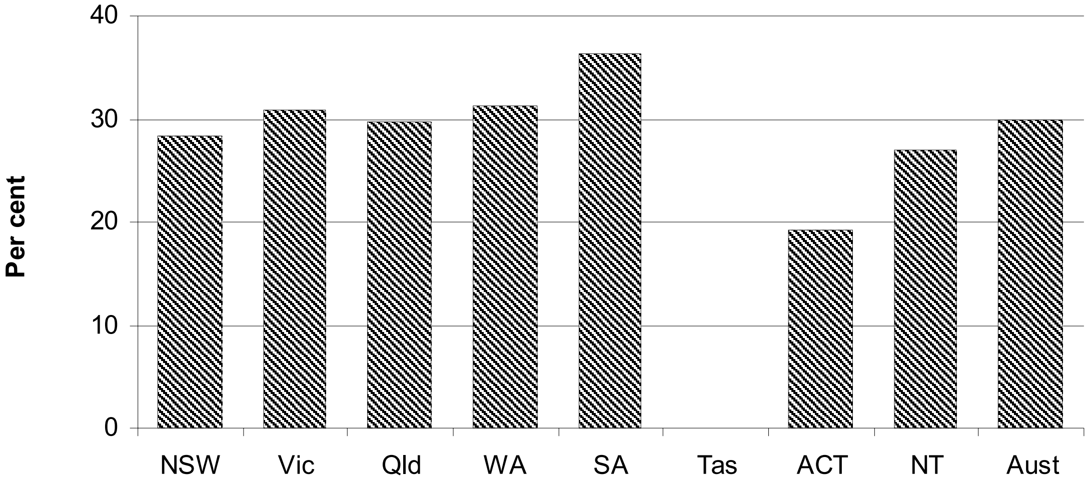
Caesareans and inductions for selected primiparae are reported for women aged between 25 and 29 years who have had no previous deliveries, with a vertex presentation (that is, the crown of the baby's head is at the lower segment of the mother's uterus) and a gestation length of 37 to 41 weeks. This group is considered to be low risk parturients [a], so caesarean or induction rates should be low in their population.

These indicators are defined as the number of inductions or caesareans for the selected primiparae divided respectively by the number of the selected primiparae who give birth. High intervention rates may indicate a need for investigation.

[a] Parturient means 'about to give birth'. Primiparae refers to pregnant women who have had no previous pregnancy resulting in a live birth or stillbirth (Laws and Sullivan 2004).

Induction rates for selected primiparae in public hospitals are reported in figure 10.26. Induction rates for private hospitals are shown in table 10A.85 for comparison. They are higher than the rate for public hospitals in all jurisdictions for which data are available. Data for all jurisdictions for earlier years are included in tables 10A.86–93.

Figure 10.26 **Inductions for selected primiparae, public hospitals, 2006**[a, b, c]

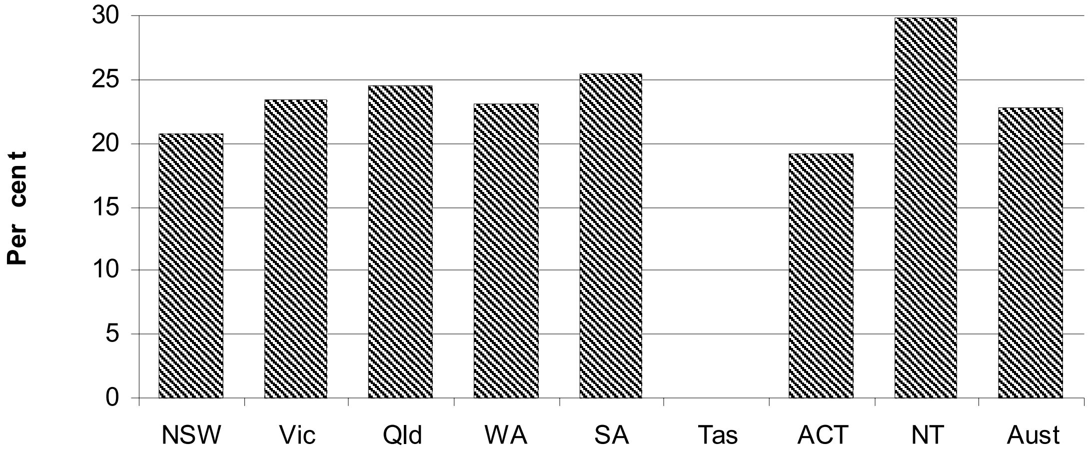


[a] Data for Tasmania are not available. [b] ACT data are preliminary. Care must be taken when interpreting percentages as these data include both ACT and non-ACT residents where the birth occurred in the ACT. In 2006, 16.2 per cent of women who gave birth in the ACT were not residents. [c] Rate for Australia includes only jurisdictions for which data are available.

Source: State and Territory governments (unpublished); table 10A.85.

Caesarean rates for selected primiparae in public hospitals are reported in figure 10.27. Caesarean rates for private hospitals are shown in table 10A.85 for comparison. They are higher than the rate for public hospitals in all jurisdictions for which data are available. Data for all jurisdictions for earlier years are included in tables 10A.86–93.

Figure 10.27 **Caesareans for selected primiparae, public hospitals, 2006**[a, b, c]



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[a] Data for Tasmania are not available. [b] ACT data are preliminary. Care must be taken when interpreting percentages as these data include both ACT and non-ACT residents where the birth occurred in the ACT. In 2006, 16.2 per cent of women who gave birth in the ACT were not residents. [c] Rate for Australia includes only jurisdictions for which data are available.

Source: State and Territory governments (unpublished); table 10A.85.

Vaginal birth following previous primary caesarean

'Vaginal birth following previous primary caesarean' is an indicator of the appropriateness of maternity services in public hospitals (box 10.23).

Box 10.23 **Vaginal birth following previous primary caesarean**

Birth by caesarean section is appropriate in some circumstances related to the health and wellbeing of mothers and babies. It may also be undertaken inappropriately, resulting in overmedicalisation of labour, poorer health outcomes and/or unnecessary costs.

The rate of 'vaginal delivery following previous primary caesarean section' is defined as the number of women delivering vaginally following a previous primary (first) caesarean section, as a proportion of the total number of women delivering who have had a previous primary caesarean section and no intervening pregnancies of longer than 20 weeks gestation (ACHS 2002).

Interpretation of this indicator is ambiguous. There is ongoing debate about the relative risk to both mother and baby of a repeat caesarean section compared with a vaginal birth following a previous primary caesarean. Low rates of vaginal birth following a previous primary caesarean may warrant investigation, or on the other hand, they may indicate appropriate clinical caution. When interpreting this indicator, emphasis needs to be given to the potential for improvement.

Data for ‘vaginal birth following a previous primary caesarean’ are sourced from the ACHS Comparative Report Service (Clinical Indicators) and collected for internal clinical review by individual hospitals. The ACHS data are predominantly used to demonstrate the potential for improvement across Australian hospitals if all hospitals could achieve the same outcomes as those of hospitals with the best outcomes for patients. Statewide conclusions cannot be drawn from the data because healthcare organisations contribute to the ACHS on a voluntary basis, so the data are not necessarily drawn from representative samples (box 10.7). Estimated rates should be viewed in the context of the statistical (standard) errors. High standard errors signal that data are potentially unreliable. The statistical terms used to describe this indicator are explained in box 10.9.

The mean rates of ‘vaginal birth following a primary caesarean’ in 2006 are shown in table 10.18 for jurisdictions with more than five hospitals reporting to the ACHS Comparative Report Service. The coverage of the ACHS data may differ across these states. Data for Tasmania, the ACT and the NT are not reported separately because fewer than five hospitals reported ‘vaginal birth following a primary caesarean’ in each of those jurisdictions.

Nationally, among all public hospitals participating in the ACHS Comparative Report Service in 2006, the mean rate of ‘vaginal birth following a previous primary caesarean’ was 16.6 per 100 deliveries (table 10.18). Given the uncertainty regarding whether high/low rates of vaginal birth following a previous primary caesarean are desirable, this Report does not include potential centile gains for this indicator.

Table 10.18 **Vaginal births following previous primary caesarean, public hospitals, 2006**[a, b]

	Unit	*Results*
National rate	(%)	16.6
National performance at 80th centile (rate)	(%)	19.9
National performance at 20th centile (rate)	(%)	12.4
NSW		
Numerator (no. of VBACs)	no.	542
Denominator (no. of DACs)	no.	3 387
Rate	%	16.0
Standard error (±)		0.7
ACHS reporting hospitals	no.	36
Victoria		
Numerator (no. of VBACs)	no.	389
Denominator (no. of DACs)	no.	2 413
Rate	%	16.1
Standard error (±)		0.8
ACHS reporting hospitals	no.	23
Queensland		
Numerator (no. of VBACs)	no.	230
Denominator (no. of DACs)	no.	1 383
Rate	%	16.6
Standard error (±)		1.0
ACHS reporting hospitals	no.	10
WA		
Numerator (no. of VBACs)	no.	209
Denominator (no. of DACs)	no.	1 176
Rate	%	17.8
Standard error (±)		1.1
ACHS reporting hospitals	no.	11
SA		
Numerator (no. of VBACs)	no.	239
Denominator (no. of DACs)	no.	1 308
Rate	%	18.3
Standard error (±)		1.1
ACHS reporting hospitals	no.	12

VBAC = vaginal birth following primary caesarean. DAC = delivery following primary caesarean. [a] Defined as the number of patients delivering vaginally following a previous primary caesarean section divided by the total number of patients delivering who had a previous primary caesarean section and no intervening pregnancies of longer than 20 weeks gestation. [b] The ACHS data are not designed to measure the performance of states and territories, but are for internal clinical review by individual hospitals. In addition, health organisations contribute data voluntarily to the ACHS, so the samples are not necessarily representative of all hospitals in each jurisdiction. As a result, statewide comparisons and conclusions regarding the performance of individual states cannot be drawn.

Source: ACHS (unpublished); tables 10A.94, 10A.95, 10A.96, 10A.97 and 10A.98.

Effectiveness — quality

The Steering Committee has identified four subdimensions of quality for health services: safety; responsiveness; capability; and continuity. For maternity services in this Report, data are reported against the subdimension of safety only. Other subdimensions of quality have been identified by the Steering Committee for future development.

Safety — perineal status after vaginal birth

'Perineal status after vaginal birth' is an indicator of the safety of maternity services (box 10.24).

Box 10.24 **Perineal status after vaginal birth**

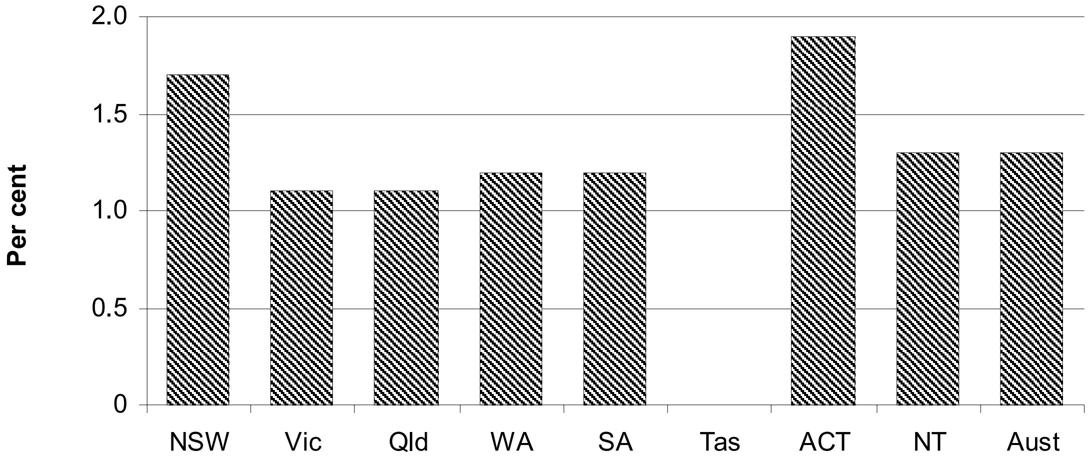
'Perineal status after vaginal birth' is an indicator of governments' objective to provide safe and high quality services. Perineal lacerations caused by childbirth are painful, take time to heal and may result in ongoing discomfort and debilitating conditions such as faecal incontinence. Maternity services staff aim to minimise lacerations, particularly more severe lacerations (third and fourth degree), through labour management practices.

'Perineal status after vaginal birth' is the state of the perineum following a vaginal birth (NHDC 2003). A third or fourth degree laceration is a perineal laceration or rupture (or tear following episiotomy) extending to, or beyond, the anal sphincter (see section 10.8 for definitions) (NCCH 1998).

Severe lacerations (third and fourth degree laceration) of the perineum are not avoidable in all cases and so safe labour management is associated with a low (rather than zero) proportion of third or fourth degree lacerations.

The proportion of mothers with third or fourth degree lacerations to their perineum following vaginal births is shown in figure 10.28. More information on 'perineal status after vaginal birth' (including the proportion of mothers with intact perineum following vaginal births) is contained in attachment table 10A.99.

Figure 10.28 **Perineal status — mothers with third or fourth degree lacerations after vaginal births, 2004**[a, b, c, d]



[a] For multiple births, the perineal status after birth of the first child was used. [b] Data for Tasmania are not available in a form that are comparable with other jurisdictions. [c] Data include all women who gave birth vaginally, including births in public hospitals, private hospitals and outside of hospital, such as homebirths. [d] ACT data are preliminary. Care must be taken when interpreting percentages as these data include both ACT and non-ACT residents where the birth occurred in the ACT. In 2006, 16.2 per cent of women who gave birth in the ACT were not residents.

Source: Laws, Grayson and Sullivan (2006); table 10A.99.

Responsiveness

The Steering Committee has identified the responsiveness of maternity services as an area for development in future reports. While there is currently no indicator for the responsiveness of maternity services, the patient satisfaction surveys reported earlier in this chapter generally cover maternity patients.

Capability

The Steering Committee has identified the capability of maternity services as an area for development in future reports.

Continuity

The Steering Committee has identified the continuity of care provided by maternity services as an area for development in future reports.

Effectiveness — sustainability

The Steering Committee has identified the sustainability of maternity services as an area for development in future reports.

Efficiency

Recurrent cost per maternity separation

'Recurrent cost per maternity separation' is an indicator of the efficiency of maternity services in public hospitals (box 10.25).

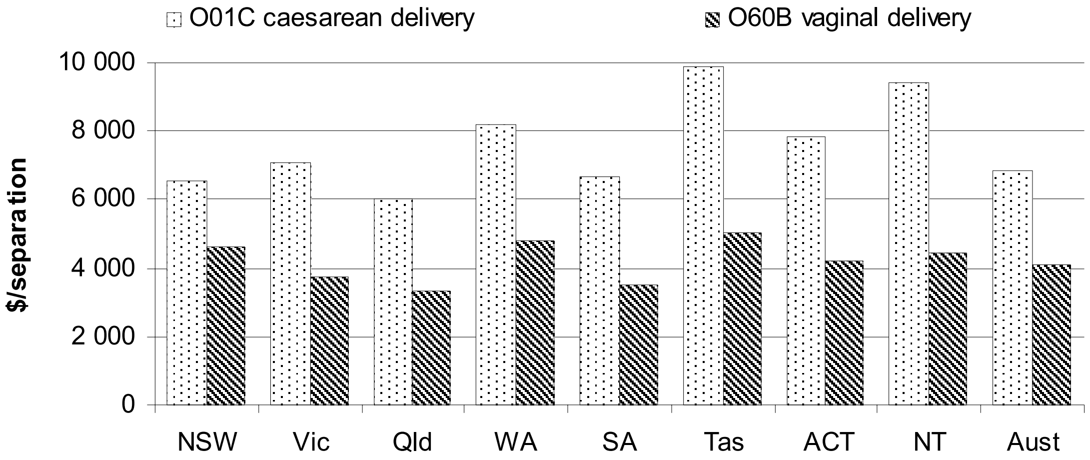
Box 10.25 **Recurrent cost per maternity separation**

'Recurrent cost per maternity separation' is an indicator of governments' objective to deliver cost effective services. It is presented for the two AR-DRGs (version 5.0) that account for the largest number of maternity patient days: caesarean delivery without catastrophic or severe complications and comorbidities; and vaginal delivery without catastrophic or severe complications and comorbidities.

Lower 'recurrent costs per maternity separation' may reflect higher efficiency in providing maternity services to admitted patients. However, this is only likely to be the case where the low cost maternity services are provided at equal or superior effectiveness.

Data are reported for the two most common maternity AR-DRGs: caesarean delivery without catastrophic or severe complications and comorbidities; and vaginal delivery without catastrophic or severe complications and comorbidities (figure 10.29). Data for a number of other maternity related AR-DRGs are shown in table 10A.100. Data are sourced from the NHCDC. The NHCDC is a voluntary annual collection, the purpose of which is to calculate between-DRG cost weights. The samples are not necessarily representative of the set of hospitals in each jurisdiction. An estimation process has been carried out to create representative national activity figures from the sample data.

Figure 10.29 **Estimated average cost per separation for selected maternity related AR-DRGs, public hospitals, 2005-06**[a, b]



[a] Includes AR-DRG O01C caesarean delivery without catastrophic or severe complications and comorbidities and AR-DRG O60B vaginal delivery without catastrophic or severe complications and comorbidities. [b] Average cost is affected by a number of factors including admission practices, sample size, remoteness and the types of hospital contributing to the collection. Direct comparisons between jurisdictions are difficult because there are differences in hospital costing systems.

Source: DoHA, *NHCDC, Round 10* (2007); table 10A.100.

Total cost per maternity separation

The Steering Committee has identified the 'total cost per maternity separation' (recurrent cost plus capital cost) as an indicator of the efficiency of public hospital maternity services, but no data are available for this Report (box 10.26).

Box 10.26 **Total cost per maternity separation**

The Steering Committee has agreed to develop an indicator of the 'total cost per maternity separation' as a measure of the efficiency of public hospital maternity services. A method for calculating the capital cost component of the 'total cost per maternity separation' indicator has not yet been determined, so no data can be reported.

Mothers average length of stay

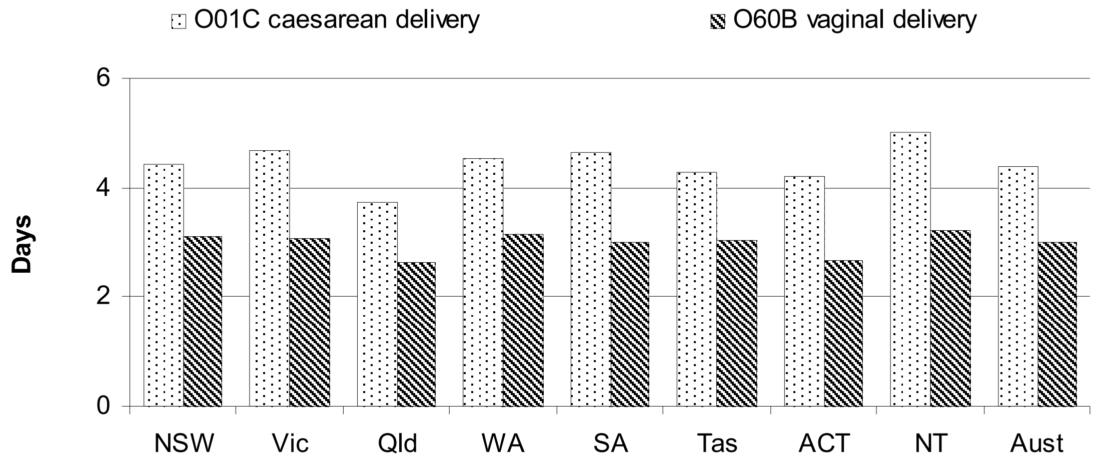
'Mothers average length of stay in hospital' is an indicator of the efficiency of maternity services in public hospitals (box 10.27). Data are reported for the two most common maternity AR-DRGs: caesarean delivery without catastrophic or severe complications and comorbidities; and vaginal delivery without catastrophic or severe complications and comorbidities (figure 10.30).

Box 10.27 **Mothers average length of stay**

'Mothers average length of stay' is an indicator of governments' objective to deliver services efficiently. Mother's average length of stay is defined as the total number of patient days for the selected maternity AR-DRG (version 5.0), divided by the number of separations for that AR-DRG.

Shorter stays for mothers reduce hospital costs but whether they represent genuine efficiency improvements depends on a number of factors. Shorter stays may, for example, have an adverse effect on the health of some mothers and result in additional costs for in-home care. The indicator is not adjusted for multiple births born vaginally and without complications but requiring a longer stay to manage breastfeeding.

Figure 10.30 **Average length of stay for selected maternity-related AR-DRGs, public hospitals, 2005-06**[a]



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[a] Includes AR-DRG O01C caesarean delivery without catastrophic or severe complications and comorbidities and AR-DRG O60B vaginal delivery without catastrophic or severe complications and comorbidities.

Source: DoHA, *NHCDC, Round 10* (2007); table 10A.100.

Outcomes

Outcomes are the impact of services on the status of an individual or group (while outputs are the actual services delivered) (see chapter 1, section 1.5).

Apgar score

'Apgar score of babies at five minutes after birth' is an indicator of the outcomes of maternity services (box 10.28). 'Low' Apgar scores for babies by birthweight category are contained in table 10.19. The range of Apgar scores for 2002 to 2006 are reported in table 10A.101.

Box 10.28 **Apgar score at five minutes**

'Apgar score at five minutes' is an indicator of governments' objective to deliver maternity services that are safe and of high quality. The Apgar score is a numerical score that indicates a baby's condition shortly after birth. Apgar scores are based on an assessment of the baby's heart rate, breathing, colour, muscle tone and reflex irritability. Between 0 and 2 points are given for each of these five characteristics and the total score is between 0 and 10. The Apgar score is routinely assessed at one and five minutes after birth, and subsequently at five minute intervals if it is still low at five minutes (Day et al. 1999). The future health of babies with lower Apgar scores is often poorer than those with higher scores.

Low Apgar scores (defined as less than 4) are strongly associated with babies' birthweights being low. The management of labour in hospitals does not usually affect birthweights, but can affect the prevalence of low Apgar scores for babies with similar birthweights. Within birthweight categories therefore, Apgar scores may indicate relative performance.

This indicator is defined as the number of live births with an Apgar score of 3 or less, at five minutes post-delivery, as a proportion of the total number of live births by specified birthweight categories.

Factors other than hospital maternity services can influence Apgar scores within birthweight categories — for example antenatal care, multiple births and socioeconomic factors.

Table 10.19 Live births with an Apgar score of 3 or lower, five minutes post-delivery, public hospitals, 2006

Birthweight (grams)	*Unit*	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*[a]	*NT*
Less than 1500	no.	1 014	455	579	252	196	na	64	52
Low Apgar	%	14.3	15.0	16.4	8.0	6.6	..	17.2	17.3
1500-1999	no.	1 012	641	579	265	193	na	64	56
Low Apgar	%	1.3	1.3	1.0	0.4	–	..	–	5.4
2000-2499	no.	2 872	2 042	1 659	715	616	na	163	187
Low Apgar	%	0.5	0.5	0.4	0.7	0.5	..	1.2	–
2500 and over	no.	64 305	44 192	35 766	15 631	12 538	na	2 962	2 637
Low Apgar	%	0.2	0.1	0.1	0.1	0.1	..	0.2	0.2

[a] ACT data are preliminary. Care must be taken when interpreting percentages as these data include both ACT and non-ACT residents where the birth occurred in the ACT. In 2006, 16.2 per cent of women who gave birth in the ACT were not residents. **na** Not available. .. Not applicable. – Nil or rounded to zero.

Source: State and Territory governments (unpublished); table 10A.101.

Fetal death rate

The 'fetal death rate' is an indicator of the outcomes of maternity services (box 10.29).

Box 10.29 **Fetal death rate**

Fetal death (stillbirth) is the birth of a child who did not at any time after delivery breathe or show any other evidence of life, such as a heartbeat. Fetal deaths by definition include only infants weighing at least 400 grams or of a gestational age of at least 20 weeks.

'Fetal death rate' is reported as an indicator because maternity services for admitted patients have some potential to reduce the likelihood of fetal deaths. However, this potential is limited and other factors (such as the health of mothers and the progress of pregnancy before hospital admission) are also important.

The 'fetal death rate' is calculated as the number of fetal deaths divided by the total number of births (live births and fetal deaths combined), by state or territory of usual residence of the mother. The rate of fetal deaths is expressed per 1000 total births. This indicator is also reported by the Indigenous status of the mother.

(Continued on next page)

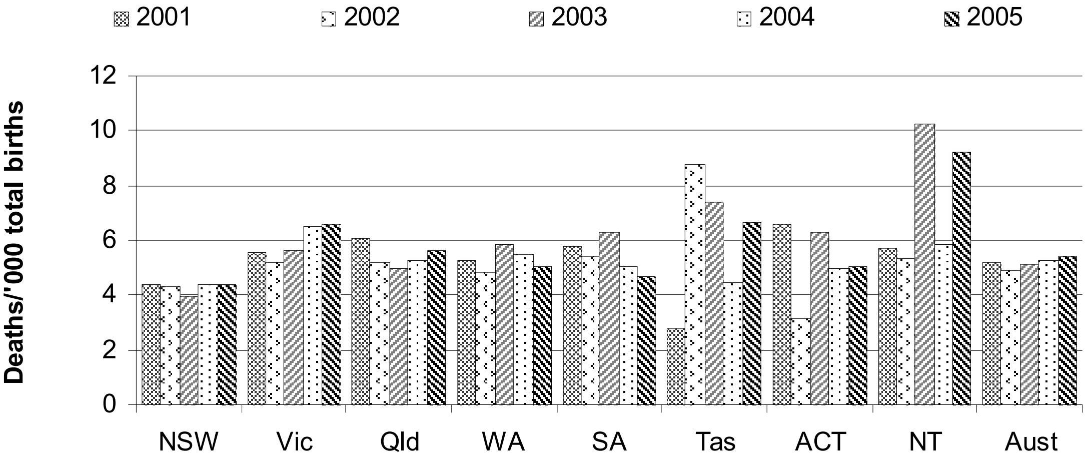
Box 10.29 **(Continued)**

Low fetal death rates may indicate high quality maternity services. In jurisdictions where the number of fetal deaths is low, small annual fluctuations in the number affect the annual rate of fetal deaths.

Differences in the 'fetal death rate' between jurisdictions are likely to be due to factors outside the control of maternity services for admitted patients. To the extent that the health system influences fetal death rates, the health services that may have an influence include outpatient services, general practice services and maternity services.

Fetal death rates are reported in figure 10.31. Nationally, fetal death rates remained stable over the period 2001–2005 although there was variation over this period in some jurisdictions (these annual fluctuations are generally a result of the low incidence of fetal deaths and small populations). National time series for fetal death rates for the period 1993 to 2005 are included in table 10A.104. Fetal deaths rates by the Indigenous status of the mother are shown in figure 10.34.

Figure 10.31 **Fetal death rate**[a, b]



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[a] Statistics relate to the number of deaths registered — not those that occurred — in the years shown. The ABS estimates that about 5–6 per cent of deaths occurring in one year are not registered until the following year or later. These data may differ, therefore, from other published sources (such as AIHW or State and Territory government publications). [b] Annual rates fluctuate (in particular, for smaller jurisdictions) as a result of a low incidence of fetal deaths and small populations.

Source: ABS (unpublished*) Causes of Death*, Cat. no. 3303.0; table 10A.102.

Neonatal death rate

The 'neonatal death rate' is an indicator of the outcomes of maternity services (box 10.30).

Box 10.30 **Neonatal death rate**

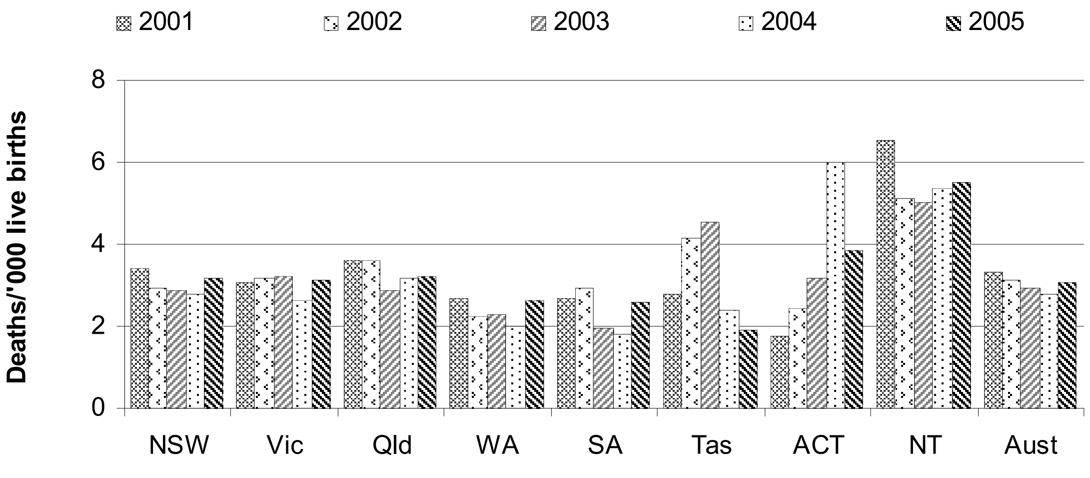
Neonatal death is the death of a live born infant within 28 days of birth (see section 10.8 for a definition of a live birth). As for fetal deaths, a range of factors contribute to neonatal deaths. However, the influence of maternity services for admitted patients is greater for neonatal deaths than for fetal deaths, through the management of labour and the care of sick and premature babies.

The 'neonatal death rate' is calculated as the number of neonatal deaths divided by the number of live births registered. The rate of neonatal deaths is expressed per 1000 live births, by state or territory of usual residence of the mother. This indicator is also reported by the Indigenous status of the mother.

Low 'neonatal death rates' may indicate high quality maternity services. The rate tends to be higher among premature babies, so a lower neonatal death rate may also indicate a lower percentage of pre-term births.

Neonatal death rates are reported in figure 10.32. Nationally, neonatal death rates generally declined over the period 2001–2004 with a small increase in 2005, although there was variation over this period in some jurisdictions (these annual fluctuations are generally a result of the low incidence of neonatal deaths and small populations). National time series for neonatal death rates for the period 1993 to 2005 are included in table 10A.104. Neonatal death rates by the Indigenous status of the mother are shown in figure 10.34.

Figure 10.32 **Neonatal death rate**[a, b]



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[a] Statistics relate to the number of deaths registered — not those that occurred — in the years shown. The ABS estimates that about 5–6 per cent of deaths occurring in one year are not registered until the following year or later. These data may differ, therefore, from other published sources (such as AIHW or State and Territory government publications). [b] Annual rates fluctuate (in particular, for smaller jurisdictions) as a result of a low incidence of neonatal deaths and small populations.

Source: ABS (unpublished) *Causes of Death*, Cat. no. 3303.0; table 10A.103.

Perinatal death rate

The 'perinatal death rate' is an indicator of the outcomes of maternity services (box 10.31). Perinatal death rates are shown in figure 10.33. Perinatal death rates by the Indigenous status of the mother are shown in figure 10.34. National time series for perinatal death rates for the period 1993 to 2005 are included in table 10A.104.

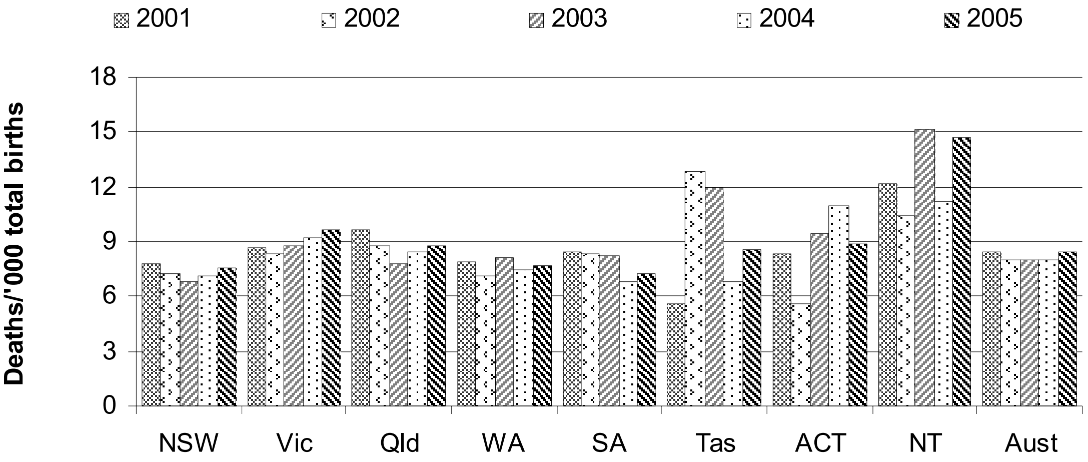
Box 10.31 **Perinatal death rate**

A perinatal death is a fetal or neonatal death (boxes 10.29 and 10.30).

The 'perinatal death rate' is calculated as the number of perinatal deaths divided by the total number of births (live births registered and fetal deaths combined) in each jurisdiction. It is expressed per 1000 total births. This indicator is also reported by the Indigenous status of the mother.

The caveats that apply to fetal and neonatal death rates also apply to perinatal death rates.

Figure 10.33 **Perinatal death rate**[a, b]



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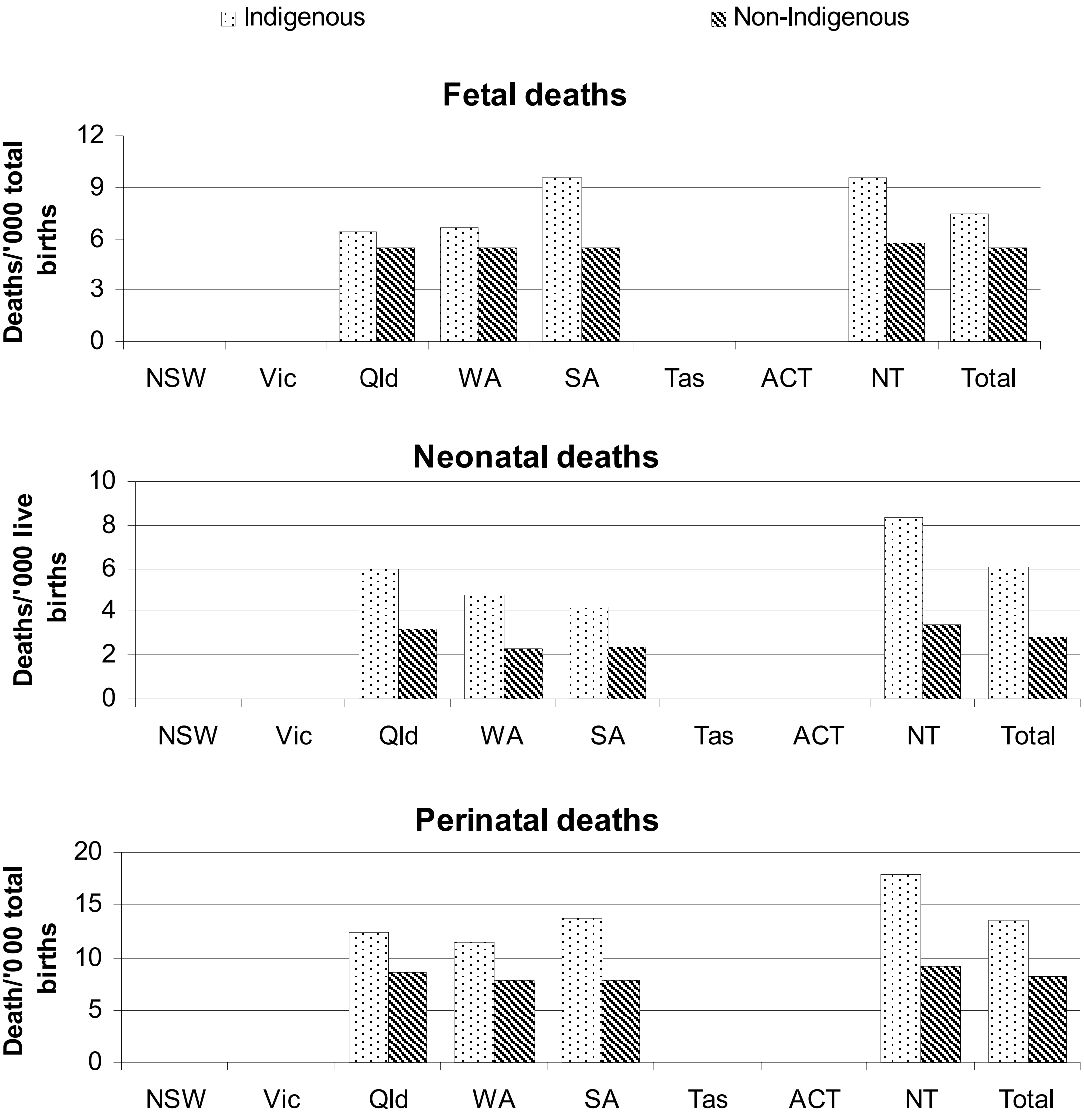
[a] Statistics relate to the number of deaths registered — not those that occurred — in the years shown. The ABS estimates that about 5–6 per cent of deaths occurring in one year are not registered until the following year or later. These data may differ, therefore, from other published sources (such as AIHW or State and Territory government publications). [b] Annual rates fluctuate (in particular, for smaller jurisdictions) as a result of a low incidence of perinatal deaths.

Source: ABS (unpublished) *Causes of Death*, Cat. no. 3303.0; table 10A.105.

Fetal, neonatal and perinatal deaths for Indigenous people

Fetal, neonatal and perinatal deaths data by the Indigenous status of the mother are available for Queensland, WA, SA and the NT only. Data are for the period 2001–2005 combined. Data for other jurisdictions are not included due to small numbers or poor coverage rates (ABS 2004). In those jurisdictions for which data are available, the fetal, neonatal and perinatal death rates for Indigenous people are higher than those for non-Indigenous people (figure 10.34).

Figure 10.34 **Fetal, neonatal and perinatal deaths, by Indigenous status of mother, 2001–2005**[a]



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[a] The total relates to those jurisdictions for which data are published. Data are not available for other jurisdictions.

Source: ABS (unpublished) *Causes of Death*, Cat. no. 3303.0; table 10A.106.

Gestation standardised perinatal mortality ratio

The Steering Committee has identified GSPMR an indicator of the outcomes of maternity services (box 10.32). No data for this indicator are currently available.

Box 10.32 **Gestation standardised perinatal mortality ratio**

This measure of perinatal mortality (box 10.31) is standardised according to gestational age. It excludes infants less than 20 weeks gestation or where gestation is unknown, weighing less than 400 grams, terminations of pregnancy and deaths due to congenital malformations (DHS 2007). This indicator has been identified for development and reporting in the future. Data were not available for the 2008 Report.

10.7 Future directions in performance reporting

Priorities for future reporting on public hospitals and maternity services include the following:

- Improving the comprehensiveness of reporting by filling in gaps in the performance indicator frameworks. Important gaps in reporting for public hospitals include indicators of equity of access to services for special needs groups (particularly Indigenous people), and indicators of continuity of care. Gaps in the maternity services framework include equity of access, effectiveness of access, three aspects of quality — responsiveness, capability and continuity — and the effectiveness subdimension of sustainability.
- Improving currently reported indicators for public hospitals and maternity services where data are not complete or not directly comparable. There is scope to improve reporting of the quality and access dimensions of the public hospitals framework, and the output indicators for maternity services.

The Steering Committee is seeking to improve the reporting of elective surgery waiting times by urgency category in order to achieve greater comparability across jurisdictions in assessing the extent to which patients are seen within a clinically desirable period.

The Steering Committee is seeking to improve the reporting of hospital accreditation in order to provide more meaningful comparative information about the capability of public hospitals across jurisdictions. The ACSQHC is currently undertaking a review of safety and quality accreditation standards in Australia with a view to recommending an alternative model for accreditation including a national set of health standards by which health services would be assessed. The outcomes of the review may inform options for future reporting in this area.

10.8 Definitions of key terms and indicators

Accreditation	Professional recognition awarded to hospitals and other healthcare facilities that meet defined industry standards. Public hospitals may seek accreditation through the ACHS Evaluation and Quality Improvement Program, the Australian Quality Council (now known as Business Excellence Australia), the Quality Improvement Council, the International Organisation for Standardization 9000 Quality Management System or other equivalent programs.
Acute care	Clinical services provided to admitted or non-admitted patients, including managing labour, curing illness or treating injury, performing surgery, relieving symptoms and/or reducing the severity of illness or injury, and performing diagnostic and therapeutic procedures. Most episodes involve a relatively short hospital stay.
Admitted patient	A patient who has undergone a formal admission process in a public hospital to begin an episode of care. Admitted patients may receive acute, sub-acute or non-acute care services.
Admitted patient cost proportion	The ratio of admitted patient costs to total hospital costs, also known as the inpatient fraction.
Allied health (non-admitted)	Occasions of service to non-admitted patients at units/clinics providing treatment/counselling to patients. These include units providing physiotherapy, speech therapy, family planning, dietary advice, optometry and occupational therapy.
Apgar score	Numerical score used to evaluate a baby’s condition after birth. The definition of the reported indicator is the number of babies born with an Apgar score of 3 or lower at 5 minutes post delivery, as a proportion of the total number of babies born. Excludes fetal deaths in utero before commencement of labour.
AR-DRG	Australian Refined Diagnosis Related Group - a patient classification system that hospitals use to match their patient services (hospital procedures and diagnoses) with their resource needs. AR-DRG version 5.0 is based on the ICD-10-AM classification.
Average length of stay	The mean length of stay for all patient episodes, calculated by dividing total occupied bed days by total episodes of care.
Caesarean section	Operative birth through an abdominal incision.
Casemix adjusted	Adjustment of data on cases treated to account for the number and type of cases. Cases are sorted by AR-DRG into categories of patients with similar clinical conditions and requiring similar hospital services. Casemix adjustment is an important step to achieving comparable measures of efficiency across hospitals and jurisdictions.
Casemix adjusted separations	The number of separations adjusted to account for differences across hospitals in the complexity of episodes of care.
Catastrophic	An acute or prolonged illness usually considered to be life threatening or with the threat of serious residual disability. Treatment may be radical and is frequently costly.
Community health services	Health services for individuals and groups delivered in a community setting, rather than via hospitals or private facilities.
Cost of capital	The return foregone on the next best investment, estimated at a rate of 8 per cent of the depreciated replacement value of buildings,

	equipment and land. Also called the ‘opportunity cost’ of capital.
Cost per casemix adjusted separation	Recurrent expenditure multiplied by the inpatient fraction and divided by the total number of casemix-adjusted separations plus estimated private patient medical costs.
Cost per non-admitted occasion of service	Recurrent expenditure divided by the inpatient fraction and divided by the total number of non-admitted occasions of service.
Elective surgery waiting times	The time elapsed for a patient on the elective surgery waiting list, from the date on which he or she was added to the waiting list for a procedure to admission or a designated census date.
Emergency department waiting times to service delivery	The time elapsed for each patient from presentation to the emergency department (that is, the time at which the patient is clerically registered or triaged, whichever occurs earlier) to the commencement of service by a treating medical officer or nurse.
Emergency department waiting times to admission	The time elapsed for each patient from presentation to the emergency department to admission to hospital.
Episiotomy	An obstetrics procedure. A surgical incision into the perineum and vagina to prevent traumatic tearing during delivery.
Fetal death	Delivery of a child who did not at any time after delivery breathe or show any other evidence of life, such as a heartbeat. Excludes infants that weigh less than 400 grams or that are of a gestational age of less than 20 weeks.
Fetal death rate	The number of fetal deaths divided by the total number of births (that is, by live births registered and fetal deaths combined).
General practice	The organisational structure with one or more GPs and other staff such as practice nurses. A general practice provides and supervises healthcare for a ‘population' of patients and may include services for specific populations, such as women’s health or Indigenous health.
ICD-10-AM	The Australian modification of the International Standard Classification of Diseases and Related Health Problems. This is the current classification of diagnoses and procedures in Australia.
Inpatient fraction	The ratio of admitted patient costs to total hospital costs, also known as the admitted patient cost proportion.
Labour cost per casemix-adjusted separation	Salary and wages plus visiting medical officer payments, multiplied by the inpatient fraction, divided by the number of casemix-adjusted separations.
Length of stay	The period from admission to separation less any days spent away from the hospital (leave days).
Live birth	Birth of a child who, after delivery, breathes or shows any other evidence of life, such as a heartbeat. Includes all registered live births regardless of birthweight.
Medicare	Australian Government funding of private medical and optometrical services (under the Medicare Benefits Schedule). Sometimes defined to include other forms of Australian Government funding such as subsidisation of selected pharmaceuticals (under the Pharmaceutical Benefits Scheme) and public hospital funding (under the Australian Health Care Agreements), which provides public hospital services free of charge to public patients.

Mortality rate	The number of deaths per 100 000 people.
Neonatal death	Death of a live born infant within 28 days of birth. Defined in Australia as the death of an infant that weighs at least 400 grams or that is of a gestational age of at least 20 weeks.
Neonatal death rate	Neonatal deaths divided by the number of live births registered.
Nursing workforce	Registered and enrolled nurses who are employed in nursing, on extended leave or looking for work in nursing.
Medical practitioner workforce	Registered medical practitioners who are employed as medical practitioners, on extended leave or looking for work as a medical practitioner.
Non-acute episode of care	Clinical services provided to admitted and non-admitted patients, including planned geriatric respite, palliative care, geriatric evaluation and management and services for nursing home type patients. Clinical services delivery by designated psychiatric or psychogeriatric units, designated rehabilitation units and mothercraft services are also considered non-acute.
Non-admitted occasions of service	Occasion of examination, consultation, treatment or other service provided to a non-admitted patient in a functional unit of a health service establishment. Services may include emergency department visits, outpatient services (such as pathology, radiology and imaging, and allied health services, including speech therapy and family planning) and other services to non-admitted patients. Hospital non-admitted occasions of service are not yet recorded consistently across states and territories, and relative differences in the complexity of services provided are not yet documented.
Non-admitted patient	A patient who has not undergone a formal admission process, but who may receive care through an emergency department, outpatient or other non-admitted service.
Perinatal death	Fetal death or neonatal death of an infant that weighs at least 400 grams or that is of a gestational age of at least 20 weeks.
Perinatal death rate	Perinatal deaths divided by the total number of births (that is, live births registered and fetal deaths combined).
Perineal laceration (third or fourth degree)	A ‘third degree’ laceration or rupture during birth (or a tear following episiotomy) involves the anal sphincter, rectovaginal septum and sphincter NOS. A ‘fourth degree’ laceration, rupture or tear also involves the anal mucosa and rectal mucosa (NCCH 1998).
Perineal status	The state of the perineum following a birth.
Pre-anaesthetic consultation rate	The number of procedures where there is documented evidence that the patient has seen an anaesthetist before entering the operating theatre suite, anaesthetic room, or procedure room as a percentage of the total number of procedures with an anaesthetist in attendance (ACHS 2004).
Primary care	Essential healthcare based on practical, scientifically sound and socially acceptable methods made universally accessible to individuals and families in the community.
Primipara	Pregnant woman who has had no previous pregnancy resulting in a live birth or a still birth.
Public hospital	A hospital that provides free treatment and accommodation to eligible admitted persons who elect to be treated as public patients.

	It also provides free services to eligible non-admitted patients and may provide (and charge for) treatment and accommodation services to private patients. Charges to non-admitted patients and admitted patients on discharge may be levied in accordance with the Australian Health Care Agreements (for example, aids and appliances).
Puerperium	The period or state of confinement after labour.
Real expenditure	Actual expenditure adjusted for changes in prices.
Relative stay index	The actual number of patient days for acute care separations in selected AR–DRGs divided by the expected number of patient days adjusted for casemix. Includes acute care separations only. Excludes: patients who died or were transferred within 2 days of admission, or separations with length of stay greater than 120 days, AR-DRGs which are for ‘rehabilitation’, AR-DRGs which are predominantly same day (such as R63Z chemotherapy and L61Z admit for renal dialysis), AR DRGs which have a length of stay component in the definition, and error AR-DRGs.
Same day patients	A patient whose admission date is the same as the separation date.
Sentinel events	Adverse events that cause serious harm to patients and that have the potential to undermine public confidence in the healthcare system.
Separation	A total hospital stay (from admission to discharge, transfer or death) or a portion of a hospital stay beginning or ending in a change in the type of care for an admitted patient (for example, from acute to rehabilitation). Includes admitted patients who receive same day procedures (for example, renal dialysis).
Separation rate	Hospital separations per 1000 people or 100 000 people.
Selected primiparae	Primiparae with no previous deliveries, aged 25–29 years, singleton, vertex presentation and gestation of 37–41 weeks (inclusive).
Sub-acute and non-acute care	Clinical services provided to patients suffering from chronic illnesses or recovering from such illnesses. Services include rehabilitation, planned geriatric care, palliative care, geriatric care evaluation and management, and services for nursing home type patients. Clinical services delivered by designated psychogeriatric units, designated rehabilitation units and mothercraft services are considered non-acute.
Surgical site infection rate for selected surgical procedures	The number of surgical site infections for a selected procedure (hip and knee prosthesis, lower segment caesarean section or abdominal hysterectomy) performed during the surveillance period divided by the total number of the selected procedures performed during the surveillance period. Since 2003, the ACHS surgical site infection indicators have been collected in pairs, one for each of superficial and deep/organ space surgical site infections. An indirectly standardized rate was derived for each pair. The rate for each combined pair was estimated as the sum of the two rates (deep and superficial). The indirectly standardized rate for each State was calculated as: State rate = (sum of observed infections in State/sum of expected

	infections for State)*rate for indicator pair Where Rate of indicator pair = rate of superficial infection + rate of deep/organ infection.
Triage category	The urgency of the patient’s need for medical and nursing care: category 1 — resuscitation (immediate within seconds) category 2 — emergency (within 10 minutes) category 3 — urgent (within 30 minutes) category 4 — semi-urgent (within 60 minutes) category 5 — non-urgent (within 120 minutes).
Unplanned hospital re-admission	An unexpected hospital admission for treatment of: the same condition for which the patient was previously hospitalised; a condition related to one for which the patient was previously hospitalised; or a complication of the condition for which the patient was previously hospitalised.
Unplanned hospital re-admission rate	The number of unplanned re-admissions to the same hospital within 28 days of separation, during the time period under study, divided by the total number of separations (excluding deaths) for the same time period, including day stay patients.
Urgency category for elective surgery	Category 1 patients — admission is desirable within 30 days for a condition that has the potential to deteriorate quickly to the point that it may become an emergency. Category 2 patients — admission is desirable within 90 days for a condition that is causing some pain, dysfunction or disability, but that is not likely to deteriorate quickly or become an emergency. Category 3 patients — admission at some time in the future is acceptable for a condition causing minimal or no pain, dysfunction or disability, that is unlikely to deteriorate quickly and that does not have the potential to become an emergency.

10.9 Attachment tables

Attachment tables are identified in references throughout this appendix by an ‘A’ suffix (for example, table 10A.3 is table 3 in the attachment). Attachment tables are provided on the CD-ROM enclosed with the Report and on the Review website (www.pc.gov.au/gsp). On the CD-ROM, the files containing the attachment tables are provided in Microsoft Excel format as \Publications\Reports\2008\Attach10A.xls and in Adobe PDF format as \Publications\Reports\2008\Attach10A.pdf. Users without access to the CD-ROM or the website can contact the Secretariat to obtain the attachment tables (see contact details on the inside front cover of the Report).

Table 10A.1	Recurrent expenditure, public hospitals (including psychiatric hospitals), current prices, ($ million)
Table 10A.2	Recurrent expenditure, public hospitals, by source of funding, 2005-06
Table 10A.3	Recurrent expenditure per person, public hospitals (including psychiatric) (2004-05 dollars)
Table 10A.4	Public hospitals (including psychiatric hospitals) by hospital size, 2005-06
Table 10A.5	Available beds per 1000 people, by region, public hospitals (including psychiatric) (number)
Table 10A.6	Summary of separations, public hospitals 2005-06
Table 10A.7	Separations, public (non-psychiatric) hospitals
Table 10A.8	Separations, public (non-psychiatric) hospitals, 2005-06
Table 10A.9	Separations in public hospitals, by age group, 2005-06
Table 10A.10	Separations by hospital sector and by Indigenous status of patient, 2005-06
Table 10A.11	Indicative estimates of separations per 1000 people, by Indigenous status of patient (number)
Table 10A.12	Separations with a procedure recorded, selected principal diagnosis, public hospitals, by Indigenous status of patient, July 2004 – June 2006 (per cent)
Table 10A.13	Separations with a procedure recorded, by Indigenous status of patient, July 2004 – June 2006 (per cent)
Table 10A.14	Separations with a procedure recorded, by Indigenous status of patient and remoteness, July 2004 – June 2006 (per cent)
Table 10A.15	Average full time equivalent (FTE) staff per 1000 persons, public hospitals (including psychiatric hospitals)
Table 10A.16	Separations, by type of episode of care, public hospitals (including psychiatric), 2005-06
Table 10A.17	Australian refined diagnosis related groups (AR-DRGs) version 5.0 with the highest number of overnight acute separations, public hospitals, 2005-06
Table 10A.18	Top 10 AR-DRGs (version 5.0) with the most patient days, excluding same day separations, public hospitals, 2005-06

10.10 References

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11 Primary and community health

This chapter covers general practice, primary healthcare services for Indigenous people, drug and alcohol treatment, public dental services, maternal and child health, the Pharmaceutical Benefits Scheme (PBS) and a range of other community health services. The scope of this chapter does not extend to:

- Home and Community Care program services (see chapter 13, 'Aged care')
- public hospital emergency departments and outpatient services (see chapter 10, 'Public hospitals')
- community mental health services (see chapter 12, 'Health management issues').

The primary and community health sector is the part of the healthcare system most frequently used by Australians. It is important in providing preventative care, diagnosis and treatment of illness, and referral to other healthcare services.

Descriptive information about primary and community health services is contained in section 11.1. A framework of performance indicators is presented in section 11.2, and key performance indicator results are discussed in section 11.3. Future directions for reporting are covered in section 11.4, and relevant terms are defined in section 11.5. Section 11.6 lists the attachment tables for this chapter. Attachment tables are identified in references throughout the chapter by an 'A' suffix (for example, table 11A.3 is table 3 in the attachment). Attachment tables are available on the CD-ROM enclosed with the Report or from the Review website: www.pc.gov.au/gsp. Section 11.7 lists references used in this chapter.

The following improvements have been made in the reporting of primary and community health in this Report:

- data are reported for a new indicator of equity of access, 'early detection and early treatment for Indigenous people'
- data for both Australian general practice accrediting bodies are reported against the indicator 'general practices with accreditation' (data have previously been available for only one accrediting body).

11.1 Profile of primary and community health

Definitions, roles and responsibilities

General practitioners (GPs) are a significant part of the medical practitioner workforce. The medical practitioner workforce comprises doctors trained in a specialty (including general practice) and other medical practitioners (OMPs). The Royal Australian College of General Practitioners (RACGP) defines a GP as 'a medical practitioner who provides primary comprehensive and continuing care to patients and their families within the community' (Britt *et al.* 2008). Most of the data in this chapter include two types of medical practitioner who provide GP services:

- vocationally recognised general practitioners (GPs) — medical practitioners who are vocationally recognised under s.3F of the *Health Insurance Act 1973* (Cwlth), hold Fellowship of the RACGP or equivalent (Fellowship of the RACGP has been required since 1996, to achieve vocational recognition) or hold a recognised training placement
- other medical practitioners (OMP) — medical practitioners who are not vocationally recognised GPs.

While the majority of GPs provide services as part of a general practice, some GPs are employed by hospitals or other organisations in full time or part time capacities. General practice is the business structure within which one or more GPs and other staff, such as practice nurses, provide and supervise healthcare for patients presenting to the practice. General practices are predominantly privately owned, by either the GPs or corporate entities. In Australia, general practices are an important source of primary healthcare. The services they provide include: diagnosing and treating illness (both chronic and acute); providing preventative care through to palliative care; referring patients to consultants, allied health professionals, community health services and hospitals; and acting as gatekeepers for other healthcare services (DHFS 1996). Definitions for common health terms are provided in section 11.5.

A patient's ability to access GP services can influence demand for other health services, for example, a lack of GP services in a particular area can be related to high use of emergency departments. Not having a regular GP, or dissatisfaction with the usual sources of primary health care, may also lead to increased use of emergency departments (Van Konkelenberg, Esterman, Van Konkelenberg 2003). In some of these cases, the use of an emergency department may not be appropriate for the patient's condition, which could be better treated by a GP or some other form of primary care. Inappropriate attendance at an emergency department has been found to be related to the patient's proximity to, or convenience of, the emergency department. It is also related to the patient's trust and regard for the emergency department staff (Van Konkelenberg, Esterman, Van Konkelenberg 2003).

The Australian Government provides the majority of general practice income through Medicare fee-for-service and other payments, with the remainder coming from insurance schemes, patient contributions, and State and Territory government programs. Through its funding role, the Australian Government seeks to influence the supply, regional distribution and quality of general practice services. State and Territory governments are responsible for registering and licensing GPs in their jurisdiction. Some provide additional incentives for GPs to locate in rural and remote areas.

The Australian Government also subsidises the cost of many prescription medicines through the PBS. The PBS aims to provide all Australians affordable, reliable and timely access to prescription medicines. Around 80 per cent of prescriptions dispensed in Australia are subsidised under the PBS (DoHA 2007a). Users make a co-payment, with the Australian Government paying the remaining cost for drugs eligible for subsidy. For concession card holders the co-payment is currently $4.90. For other people (general consumers), the co-payment is currently $30.70. These amounts are normally adjusted in line with inflation on 1 January each year. Both concession card holders and general consumers are subject to a safety net threshold. Once spending within a calendar year has reached the relevant threshold, PBS medicines will generally be cheaper or free for the rest of the calendar year for these people. The 2007 safety net threshold is $1059.00 for general patients and $274.40 for people holding a concession card (DoHA 2007b).

The Repatriation Pharmaceutical Benefits Scheme (RPBS) provides subsidised pharmaceuticals to war veterans and war widows. Unlike the PBS, which is a universal scheme, the RPBS provides access to additional pharmaceutical items and dressings for entitled veterans and war widows. The RPBS is administered by the Department of Veterans' Affairs (DVA). The drugs eligible for subsidy under the RPBS differ from those eligible under the PBS, and drugs eligible for subsidy under the RPBS may not be eligible under the PBS.

Community health services usually consist of multidisciplinary teams of salaried health professionals who aim to protect and promote the health of particular communities (Quality Improvement Council 1998). They are either provided directly by governments (including local governments) or funded by government and managed by a local health service or community organisation. State and Territory governments are responsible for most community health services. There is no national strategy for community health, and there is considerable variation in the services provided across jurisdictions. The Australian Government's main role in the community health services covered in this chapter is in health services for Indigenous people.

The Australian Government also supports patients with chronic conditions and complex care needs through access to certain allied health services under Medicare. From 1 July 2005, eligible patients were able to receive a Medicare rebate for up to five allied health and three dental services per twelve month period, on referral from a GP. The dental services component was considerably expanded in November 2007.

The Australian Government and the states and territories play different roles in supporting dental services in Australia's mixed system of public and private dental health care. The Australian Government supports the provision of dental services primarily through the 30 per cent private health insurance rebate. The Australian Government also provides Medicare funding for dental services for patients with chronic conditions and complex care needs, and for a limited range of medical services of an oral surgical nature. In addition, the Australian Government provides funding for the dental care of war veterans and full-time and part-time members of the Australian Defence Force. It also has a role in the provision of dental services through Community Controlled Aboriginal Medical Services. The states and territories have the main responsibility for the delivery of the major public dental health care programs, primarily directed at children and disadvantaged adults. Each jurisdiction determines its own eligibility requirements for accessing public dental services, usually requiring a person to hold a concession card issued by Centrelink.

Funding

General practice

Almost all of the services provided by private GPs are at least partly funded by the Australian Government through Medicare and the DVA. This is illustrated by data from the annual Bettering the Evaluation and Care of Health (BEACH) survey of general practice activity in Australia. The BEACH survey found that 94.4 per cent of all encounters with GPs in 2006-07 were for services at least partly funded by Medicare or the DVA (table 11.1). The Australian Government also provides payments to GPs through the Practice Incentives Program (PIP) and the General Practice Immunisation Incentives Scheme (GPII) (DHAC 2000). These payments are included in the data for Australian Government expenditure presented in figure 11.24. The Australian Government also invests in general practice through the Divisions of General Practice Program.

The Australian Government spent approximately $5.1 billion, or $247 per person, on general practice in 2006-07, including through Medicare, non-Medicare funding, expenditure by the DVA and other funding programs (figure 11.24). This does not give a complete picture of government expenditure on primary health because it does not include expenditure on Indigenous primary health care services, other community health services, and services delivered through hospital accident and emergency departments. These types of primary healthcare are more prevalent in rural and remote areas. Accordingly, expenditure on primary health is understated, particularly in jurisdictions with larger proportions of Indigenous people and people living in rural and remote areas. The Health preface includes expenditure data for Indigenous primary and community health services for 2001-02.

Table 11.1 **GP encounters, by source of funding, 2006-07**[a, b, c]

	Number[d]	*Per cent of all encounters*[e]	*95% LCL*	*95% UCL*
GPs participating in the BEACH survey	930	..	..	..
Total encounters for which BEACH data were recorded	91 805	..	..	..
Encounters with missing data	7 167	..	..	..
Direct encounters	83 106	98.2	97.9	98.4
No charge	430	0.5	0.4	0.6
Medicare paid[f]	79 193	94.4	94.9	99.1
Workers compensation	1 925	2.3	2.1	2.5
Other paid (hospital, State, etc.)	876	1.0	0.8	1.3
Indirect encounters[g]	1 531	1.8	1.6	2.1

LCL = lower confidence limit. UCL = upper confidence limit. [a] April 2006 to March 2007. [b] An 'encounter' is any professional interchange between a patient and a GP (Britt *et al*. 2008). [c] Data from the BEACH survey may not be directly comparable with the other data on medical practitioners that are reported in this chapter. [d] Number of encounters after post-stratification weighting for GP activity and GP age and sex. [e] Missing data removed. [f] Includes Australian Government payments made through the DVA. [g] Indirect encounters are those at which the patient is not seen by the GP but that generate a prescription, a referral, a certificate or another service. .. Not applicable.

Source: Britt *et al.* (2008); table 11A.1.

State and Territory governments provide funding for general practice through a number of programs. Generally, this funding is provided indirectly through support services for GPs (such as assistance with housing and relocation, education programs, and employment assistance for spouses and family members of doctors in rural areas), or education and support services for public health issues such as diabetes management, smoking cessation, sexual health, and mental health and counselling. Non-government sources — insurance schemes (such as private health insurance, workers compensation and third party insurance) and private individuals — also provide payments to GPs.

Pharmaceutical Benefits Scheme and Repatriation Pharmaceutical Benefits Scheme

Expenditure on the PBS and RPBS was around $5.9 billion, or $284 per person, in 2006-07. Expenditure on the PBS was around $5.5 billion in 2006-07, 80.4 per cent of which was expenditure on concessional patients (table 11.2). Data on government expenditure on pharmaceuticals is also presented in the 'Health preface.'

Table 11.2 **PBS and RPBS expenditure, 2006-07 ($ million)**[a]

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
PBS general[b]	359.0	259.9	206.1	107.8	81.2	21.9	22.4	6.1	1 064.4
PBS concessional[c]	1 529.6	1 105.3	832.3	367.9	382.9	124.6	45.4	13.4	4 401.4
PBS doctor's bag	3.9	2.6	2.3	0.7	0.8	0.2	0.1	–	10.7
PBS total	1 892.4	1 367.8	1 040.7	476.4	464.9	146.7	68.0	19.5	5 476.5
RPBS total[d]	154.4	96.5	99.2	34.4	34.3	13.2	6.4	0.8	439.3
Total	**2 046.8**	**1 464.3**	**1 139.9**	**510.7**	**499.3**	**160.0**	**74.4**	**20.3**	**5 915.7**
$ per capita	298.6	283.5	275.9	245.4	316.8	325.3	221.1	95.7	283.7

[a] State and Territory level data are only available on a cash basis for general, concessional and doctor's bag categories. These figures are not directly comparable to those published in the DoHA annual report which are prepared on an accrual accounting basis and also include other categories administered under special arrangements (such as dispensing conducted under S100 of the *National Health Act 1953* [Cwlth]). [b] Includes PBS general ordinary and safety net. [c] Includes concessional ordinary and concessional free safety net. [d] Includes RPBS ordinary and RPBS safety net. – Nil or rounded to zero.

Source: DoHA (unpublished).

Community health services

Expenditure data that precisely match the community health services covered in this chapter are not available. The Australian Institute of Health and Welfare (AIHW) publishes expenditure data on community and public health, and dental services. However, the former category includes public health activities that are not covered in this chapter, such as food safety regulation and media campaigns to promote health awareness. The dental services category includes private dental services (funded by insurance premium rebates and non-government expenditure) that are also not reported in this chapter. In 2005-06, government expenditure on community and public health was around $5.0 billion, with State, Territory and local government providing 75.7 per cent and the Australian Government providing 24.3 per cent of this expenditure (table 11.3). Australian Government direct outlay expenditure on dental services was $96 million in 2005-06, and State, Territory and local government expenditure was $515 million (table 11.3). In some states and territories, additional expenditure is incurred through schemes that fund the provision by private practitioners of public dental health services for eligible people.

Table 11.3 Estimated funding on community and public health, and dental services, 2005-06 ($ million)

	Australian Government						
	Direct outlays	*Premium rebates*[a]	*Total*	*State and local govt*	*Total govt*	*Non-govt*	*Total*
Community and public health[b]	1 217	–	1 217	3 799	5 016	360	5 376
Dental services[c]	96	384	480	515	995	4 342	5 337

[a] Government expenditure on premium rebates relates to private health and dental services that are not within the scope of this chapter. [b] Includes some expenditure that was previously classified as 'other non-institutional (not elsewhere classified)', as well as expenditure on community and public health services. [c] Australian Government direct outlays on dental services are for services provided to veterans through DVA. – Nil or rounded to zero.

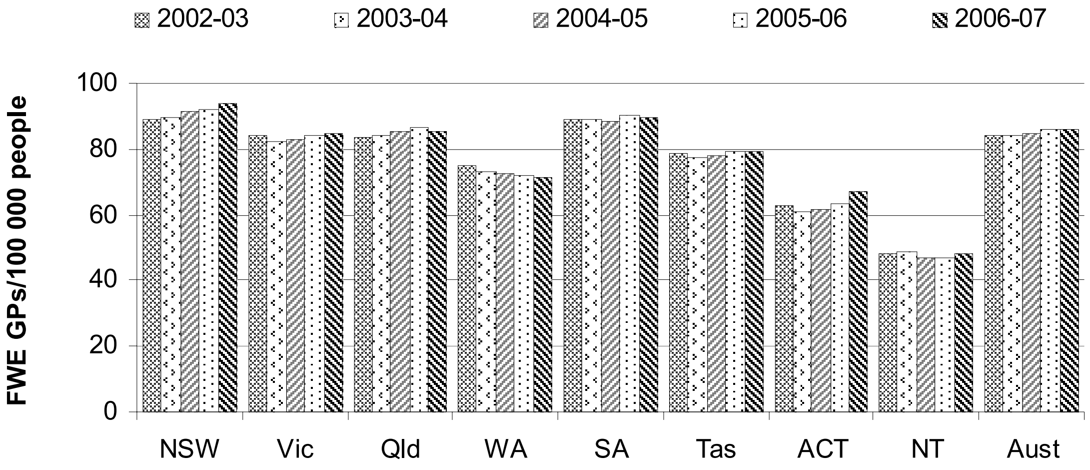
Source: AIHW (2007c).

Size and scope

General practice

There were 25 564 vocationally recognised GPs and OMPs billing Medicare in Australia in 2006-07. On a full time workload equivalent (FWE) basis, there were 18 091 vocationally recognised GPs and OMPs (see section 11.5 for a definition of FWE). This was equal to 86.1 FWE recognised GPs and OMPs per 100 000 people (table 11A.3). These data exclude services provided by GPs working with the Royal Flying Doctor Service and GPs working in Indigenous-specific primary health care services and public hospitals. In addition, the data are based on Medicare claims, which for some GPs (particularly in rural areas) pay for only part of their workload. Compared with metropolitan GPs, those in rural or remote areas spend more of their time working in local hospitals, for which they are not paid through Medicare. The numbers of FWE vocationally recognised GPs and OMPs per 100 000 people across jurisdictions are shown in figure 11.1.

Figure 11.1 **Availability of GPs (full time workload equivalent)**[a]



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[a] Data include vocationally recognised GPs and OMPs who are allocated to a jurisdiction based on the postcode of their major practice.

Source: DoHA (unpublished); table 11A.3.

Pharmaceutical Benefits Scheme and Repatriation Pharmaceutical Benefits Scheme

There were around 183 million services provided under the PBS and RPBS in 2006-07, amounting to 8.8 scripts per person. There were around 169 million services provided under the PBS in 2006-07, of which 85.2 per cent were concessional (table 11.4).

Table 11.4 **PBS and RPBS services, 2006-07 (million services)**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
PBS general[a]	8.3	6.1	4.8	2.5	1.8	0.5	0.5	0.1	24.6
PBS concessional[b]	49.6	36.4	27.2	12.1	12.3	4.2	1.4	0.4	143.6
PBS doctor's bag	0.1	0.1	0.1	–	–	–	–	–	0.4
PBS total	58.1	42.6	32.0	14.6	14.1	4.7	1.9	0.6	168.5
RPBS total[c]	5.2	3.3	3.3	1.2	1.1	0.5	0.2	–	14.8
Total	**63.2**	**45.9**	**35.3**	**15.7**	**15.3**	**5.2**	**2.1**	**0.6**	**183.4**
Services per capita	9.2	8.9	8.5	7.6	9.7	10.6	6.2	2.8	8.8

[a] Includes PBS general ordinary and safety net. [b] Includes concessional ordinary and concessional free safety net. [c] Includes RPBS ordinary and RPBS safety net. – Nil or rounded to zero.

Source: DoHA (unpublished).

Community health services

The range of community health services available varies considerably across jurisdictions. Tables 11A.47–11A.55 provide information on community health programs in each jurisdiction. The more significant of these programs are described below. Other community health programs provided by some jurisdictions include:

- women's health services that provide services and health promotion programs for women across a range of health related areas
- men's health programs, including mainly promotional and educational programs
- allied health services
- community rehabilitation programs.

Community health programs that address mental health, home and community care, and aged care assessments are reported in chapters 12 (Health management) and 13 (Aged care).

Maternal and child health

All jurisdictions provide maternal and child health services through their community health programs. These services include: parenting support programs (including antenatal and postnatal programs); early childhood nursing programs; disease prevention programs (including childhood immunisations); and early intervention and treatment programs related to child development and health. Some jurisdictions also provide specialist programs through child health services, including hearing screening programs, and mothers and babies residential programs. Performance indicators for maternity services in public hospitals are reported in chapter 10 (Public hospitals).

Public dental services

All jurisdictions provide some form of public dental service for primary school children. Some jurisdictions also provide dental services to secondary school students. In WA, SA, Tasmania, and the NT, for example, general dental care (including preventative care) is provided for school children up to 18 years of age (tables 11A.51 [WA], 11A.52 [SA], 11A.53 [Tasmania] and 11A.55 [NT]).

States and territories also provide some general dental services and a limited range of specialist dental services to disadvantaged adults (holders of concession cards issued by Centrelink). In some jurisdictions, specialist dental services are provided mainly by qualified dental specialists; in others, they are provided in dental teaching hospitals as part of training programs for dental specialists (National Advisory Committee on Oral Health 2004). A number of jurisdictions indicated to the Review that they provided public dental services in 2006-07 targeted at disadvantaged people (tables 11A.47–11A.55).

Alcohol and other drug treatment

Alcohol and other drug treatment activities range from a brief intervention to long term residential treatment. Types of treatment include detoxification, pharmacological treatment (also known as substitution or maintenance treatment), counselling and rehabilitation. The data included here have been sourced from a report on the Alcohol and Other Drug Treatment Services National Minimum Data Set (AIHW 2007a). Treatment activities excluded from that report include opioid pharmacotherapy treatment where no other treatment is provided, the majority of services for Indigenous people that are funded by the Australian Government, treatment services within the correctional system, and treatment units associated with acute care and psychiatric hospitals.

A total of 664 alcohol and other drug treatment services contributed 2005-06 data for the National Minimum Data Set. Of these, 285 (42.9 per cent) identified as government providers and 379 (57.1 per cent) identified as non-government providers (table 11A.8). All of the non-government providers received some government funding for 2005-06. There were 151 362 reported closed treatment episodes in 2005-06 (see section 11.5 for a definition of closed treatment episode). Clients seeking treatment for their own substance use, of whom 67.2 per cent were male, accounted for 144 963 closed treatment episodes (AIHW 2007a).

Alcohol was the most commonly reported principal drug of concern in closed treatment episodes for clients seeking treatment for their own substance abuse (38.7 per cent). Cannabis was the next most common drug of concern (24.6 per cent), followed by heroin (13.6 per cent) and amphetamines (11.0 per cent) (AIHW 2007a). Further information on alcohol and other drug treatment services funded by governments is included in tables 11A.47–11A.55.

Indigenous community healthcare services

Indigenous Australians use a range of primary health care services, including private general practitioners and Aboriginal and Torres Strait Islander Community Controlled Primary Health Care Services. There are Aboriginal and Torres Strait Islander Community Controlled Primary Health Care Services in all jurisdictions. These services are planned and governed by local Indigenous communities and aim to deliver holistic and culturally appropriate health and health-related services.

Funding is provided by Australian, State and Territory governments. In addition to these healthcare services, health programs for Indigenous Australians are funded by a number of jurisdictions. In 2006-07 these programs included services such as health information, promotion, education and counselling; alcohol, tobacco and other drug services; sexual health services; allied health services; disease/illness prevention; and improvements to nutrition standards (tables 11A.47–11A.55).

Information on Aboriginal and Torres Strait Islander primary healthcare services that receive funding from the Australian Government is collected through service activity reporting (SAR) questionnaires. Many of these services receive additional funding from State and Territory governments and other sources. The SAR data reported here represent the health-related activities, episodes and workforce funded from all sources.

For 2005-06, SAR data are reported for 150 Indigenous primary healthcare services (table 11A.4). Of these services, 55 (36.7 per cent) were located in remote or very remote areas (table 11A.5). They provided a wide range of primary healthcare services, including the diagnosis and treatment of illness and disease, the management of chronic illness, immunisations and transportation to medical appointments (table 11A.6). An episode of healthcare is defined in the SAR data collection as contact between an individual client and staff of a service to provide healthcare. Nearly 1.7 million episodes of healthcare were provided by participating services in 2005-06 (table 11.5). Of these, around 560 000 (33.3 per cent) were in remote or very remote areas (table 11A.5). The services included in the SAR data collection employed 1920 full time equivalent health staff (as at 30 June 2006). Of these, 1158 were Indigenous (60.3 per cent). The proportions of doctors and nurses employed by surveyed services who were Indigenous were relatively low (4.5 per cent and 13.8 per cent respectively), although for doctors this was considerably higher than for the previous year (0.9 per cent). Caution should be exercised in interpreting this rise, as the number of Indigenous doctors was low in both years (SCRGSP 2007b; table 11A.7).

Table 11.5 **Estimated episodes of healthcare for Indigenous people by services for which SAR data are reported ('000)[a]**

	NSW and ACT[b]	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*NT*	*Aust*
2001-02	357	136	214	313	144	18	233	1 416
2002-03	423	130	234	337	140	20	216	1 499
2003-04	430	169	267	302	142	22	280	1 612
2004-05	415	151	254	274	145	23	323	1 585
2005-06[c]	507	177	240	282	103	29	347	1 685

[a] An episode of healthcare involves contact between an individual client and service staff to provide healthcare. Group work is not included. Transport is included only if it involves provision of healthcare/ information by staff. Outreach provision, for example episodes at outstation visits, park clinics and satellite clinics, is included. Episodes of health care delivered over the phone are included. [b] Data for NSW and the ACT have been combined for confidentiality purposes. [c] 2005-06 data are preliminary results.

Source: DoHA (unpublished).

11.2 Framework of performance indicators

The performance indicator framework is based on the shared government objectives for primary and community health (box 11.1). The framework provides information on equity, effectiveness and efficiency, and distinguishes outputs from outcomes. This approach is consistent with the general performance indicator framework for this Review that has been agreed by the Steering Committee (see chapter 1). The framework will evolve as better indicators are developed and as the focus and objectives for primary and community health change. In particular, the Steering Committee plans to develop and report against more indicators relating to community health services.

Box 11.1 **Objectives for primary and community health**

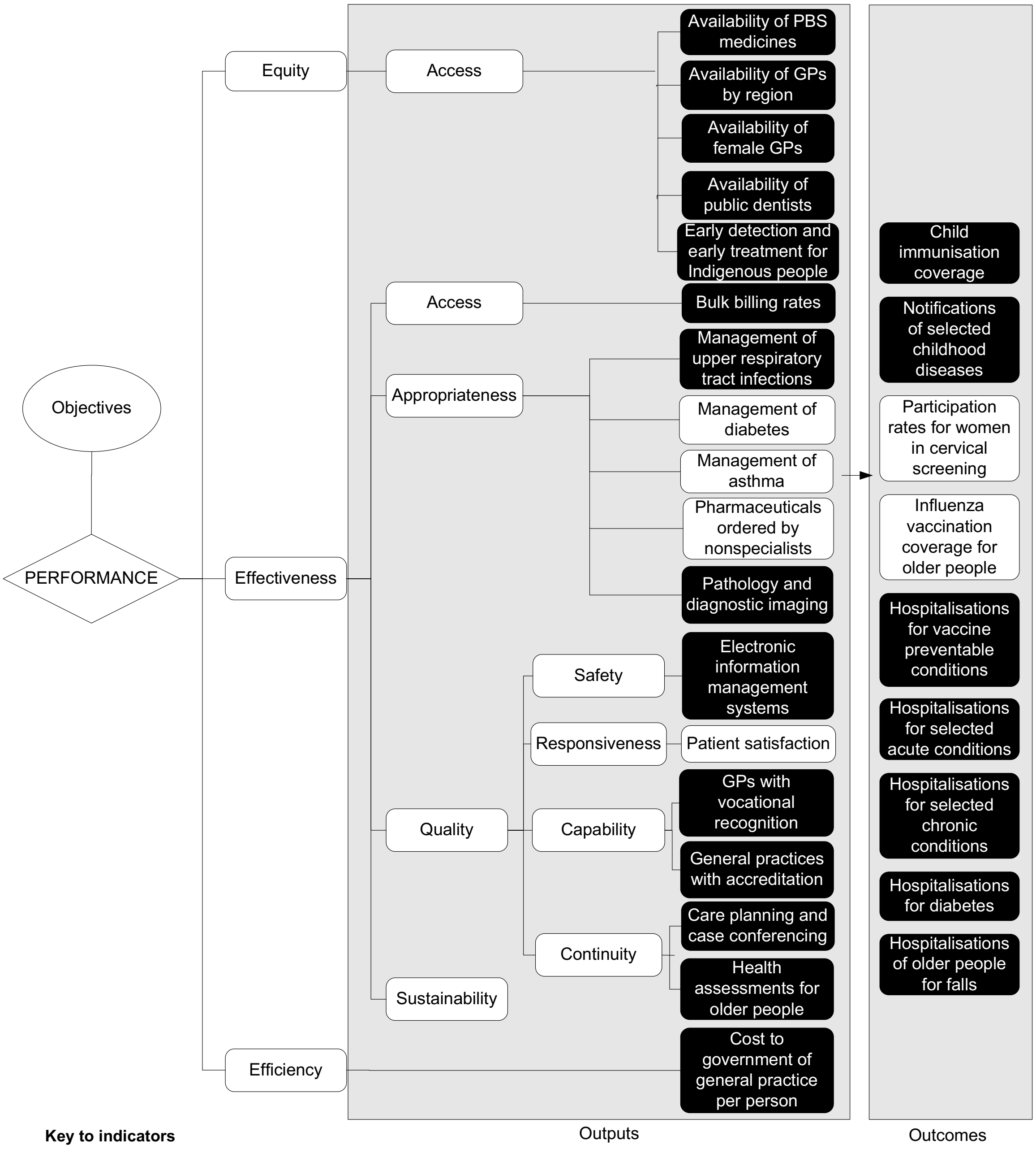
Primary and community health services aim to promote the health of Australians by:

- acting as the first point of entry to the healthcare system
- providing healthcare that promotes changes in lifestyle behaviour and prevents possible illness
- coordinating and integrating healthcare services on behalf of clients
- providing continuity of care

in an equitable and efficient manner based on the best available evidence of the effectiveness of healthcare interventions.

The performance indicator framework shows which data are comparable in the 2008 Report (figure 11.2). For data that are not considered directly comparable, the text includes relevant caveats and supporting commentary. Chapter 1 discusses data comparability from a Report-wide perspective (see section 1.6). The ‘Health preface’ explains the performance indicator framework for health services as a whole, including the subdimensions for quality and sustainability that have been added to the standard Review framework for health services.

Figure 11.2 **Performance indicators for primary and community health**



Key to indicators

Text	Data for these indicators comparable, subject to caveats to each chart or table
Text	Data for these indicators not complete or not directly comparable
Text	These indicators yet to be developed or data not collected for this Report

11.3 Key performance indicator results

Different delivery contexts, locations and types of client may affect the equity, effectiveness and efficiency of health services. Appendix A contains detailed statistics and short profiles on each State and Territory, which may assist in interpreting the performance indicators presented in this chapter.

Outputs

Outputs are the actual services delivered (while outcomes are the impact of these services on the status of an individual or group) (see chapter 1, section 1.5).

Equity

For the purposes of this Report, equity is defined in terms of adequate access to government services for all Australians. Many people experience difficulties in accessing services due to factors such as gender, age, limited English language proficiency, disability, ethnicity or geography (see chapter 1). Such barriers contribute to the generally poor health status of Indigenous people relative to other Australians (see the ‘Health Preface’ and SCRGSP 2007a). Ensuring adequate access to government services for all Australians requires that barriers experienced by particular groups be addressed.

Access

Five indicators of equity of access to primary and community health services are reported this year: ‘availability of PBS medicines’ (box 11.2); ‘availability of FWE GPs by region’ (box 11.3); ‘availability of female GPs’ (box 11.4), ‘availability of public dentists’ (box 11.5) and ‘early detection and early treatment for Indigenous people’ (box 11.6).

Availability of PBS medicines

Box 11.2 **Availability of PBS medicines**

Medicines are important in treating illness and can also be important in preventing illness from occurring. The availability of medicines is therefore a significant determinant of people's health and medicines should be available to those who require them regardless of where they live.

Three measures are presented for this indicator:

- People per pharmacy by region
- PBS expenditure per person by region
- The proportion of PBS prescriptions filled at a concessional rate.

A decrease in people per pharmacy indicates improved availability of PBS medicines. An increase in PBS expenditure per person indicates improved availability of PBS medicines. An increase in the proportion of PBS prescriptions filled at a concessional rate indicates an improved access to PBS prescriptions. It is also important that there are not large discrepancies in these measures by region.

This indicator does not provide information on whether the services are appropriate for the needs of the people receiving them.

The distribution of pharmacies underlies access to the PBS. Across Australia, the number of people per pharmacy in 2006-07 was 4051 in urban areas and 3933 in rural areas. In most states and territories, the number of people per pharmacy was similar or lower in rural areas compared with urban areas (figure 11.3).

In addition to pharmacies, 83 medical practitioners and 198 hospitals — 67 private and 131 public[1] — were approved to supply PBS medicines to the community in 2006-07. There were 83 medical practitioners and 68 hospitals (10 private) located in rural areas (table 11A.10). These additional services may help to improve access to PBS medicines in some locations.

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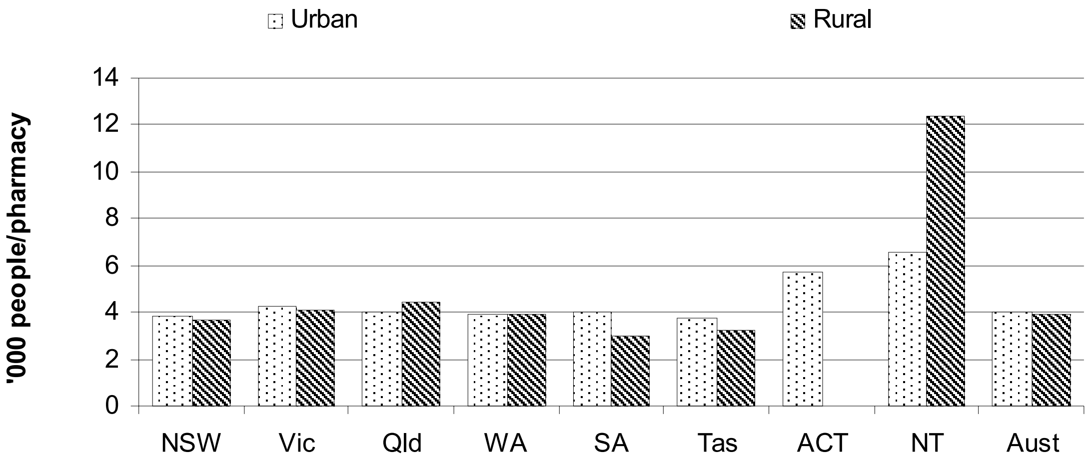
[1] PBS approved private hospitals supply medicines to outpatients, while public hospitals provide medicines only to patients on discharge.

Figure 11.3 **People per pharmacy, 2006-07**[a]



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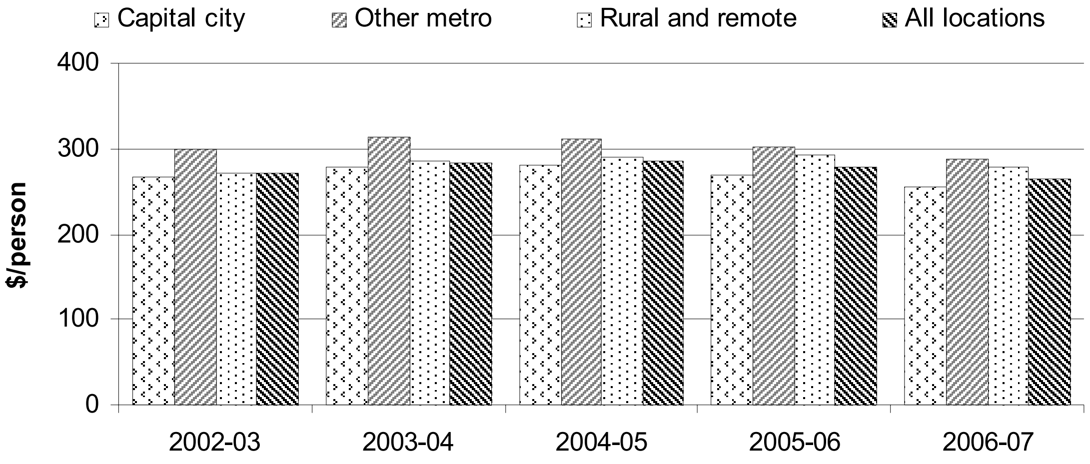
[a] Geolocation based on the Pharmacy Access/Remoteness Index of Australia (PhARIA). Urban = PHARIA 1. Rural = PHARIA 2–6. The ACT has no rural statistical areas.

Source: DoHA (unpublished); table 11A.10.

For Australia as a whole, PBS expenditure per person increased each year from 2002-03 to 2004-05 and has since decreased each year to 2006-07 (figure 11.4). PBS expenditure per person has been lowest in capital cities and highest in other metro areas for the period 2002-03 to 2006-07 (in 2006-07 dollars).

Figure 11.4 **PBS expenditure per person (2006-07 dollars)**[a]



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[a] Locality level data are only available on a cash basis for general and concessional categories. These figures are not directly comparable to those published in DoHA's annual report which are prepared on an accrual accounting basis and include other categories administered under special arrangements (such as medications dispensed under S100 of the *National Health Act 1953* [Cwlth]).

Source: DoHA (unpublished); table 11A.11.

The proportion of PBS prescriptions filled at a concessional rate is reported by State and Territory (although this is not available by regional location) in table 11A.9. Australia-wide, 85.2 per cent of prescriptions subsidised under the PBS were concessional in 2006-07.

Availability of GPs by region

Box 11.3 **Availability of GPs by region**

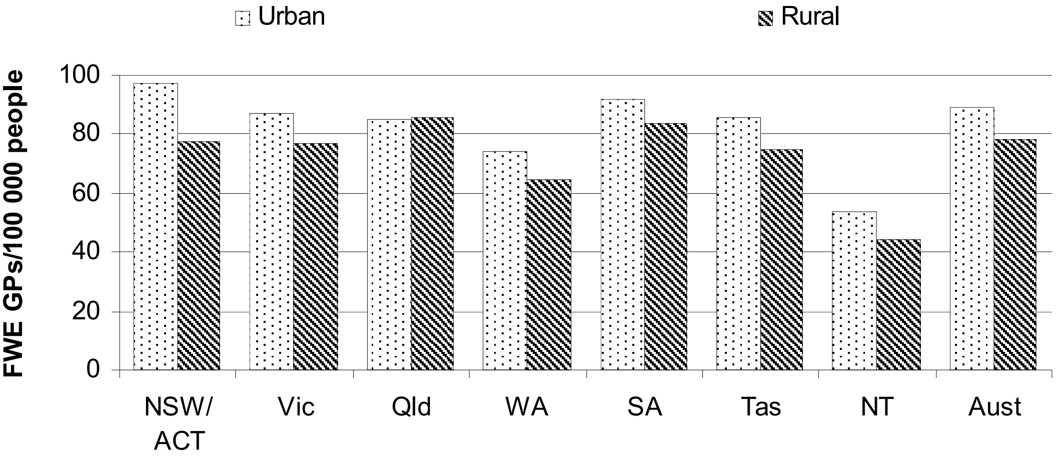
The availability (or supply) of GPs by region affects people's access to general practice services, particularly in rural and remote areas. Low availability can result in increased travel distance to a practice, increased waiting times to see a GP, and difficulty in booking long consultations. Low availability may also reduce bulk billing rates because there is less competition for patients. Australian, State and Territory governments seek to influence the availability of GPs by providing incentives for the recruitment and retention of GPs in rural and remote areas.

The indicator is defined as the number of FWE GPs per 100 000 people by region.

An increase in the availability of GPs indicates improved access to GP services. However, this indicator does not provide information on whether people are accessing GP services or whether the services are appropriate for the needs of the people receiving them.

In terms of FWE GPs per 100 000 people, in all states and territories except Queensland there were more GPs available in urban than in rural areas in 2006-07 (figure 11.5). The bulk billed proportion of non-referred attendances was generally lower in rural and remote centres, except other remote areas, than in capital cities or other metropolitan centres (table 11A.20).

Figure 11.5 **Availability of GPs (full time workload equivalent), 2006-07**[a, b, c]



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[a] Urban areas consist of capital city and other metro areas. Rural areas consist of large rural centres, small rural centres, other rural areas, remote centres, other remote areas and other areas. [b] FWE GP numbers include vocationally recognised GPs and OMPs, who are allocated to a jurisdiction based on the postcode of their major practice. [c] Data for NSW and the ACT have been combined for confidentiality reasons.

Source: DoHA (unpublished); table 11A.12.

Availability of female GPs

Box 11.4 **Availability of female GPs**

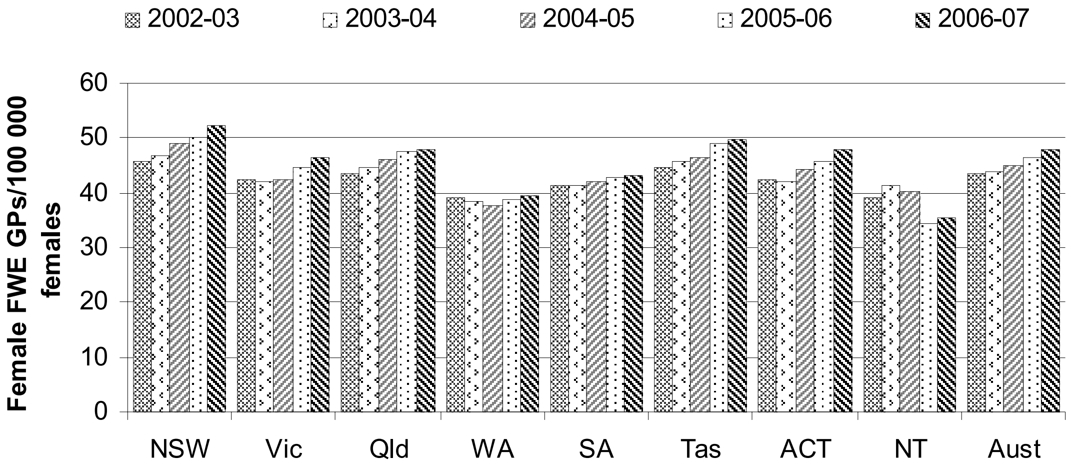
This indicator measures equity of access, recognising that some female patients prefer to discuss health matters with, and to receive primary healthcare from, a female GP.

The indicator is defined as the number of female FWE GPs per 100 000 females.

A higher rate means it is more likely that female patients who prefer to visit female GPs will have their preference met. However, this indicator does not provide information on whether women are accessing female GPs or whether the services are appropriate for the needs of the people receiving them.

In 2006-07, 38.0 per cent of Australia's GPs were female. This represented 27.9 per cent of FWE GPs (tables 11A.3 and 11A.13). In 2006-07, there were 47.8 female FWE GPs per 100 000 females in Australia (figure 11.6).

Figure 11.6 **Availability of female GPs (full time workload equivalent)**[a]



[a] Data relate to vocationally recognised GPs and OMPs.

Source: DoHA (unpublished); table 11A.13.

Availability of public dentists

Box 11.5 **Availability of public dentists**

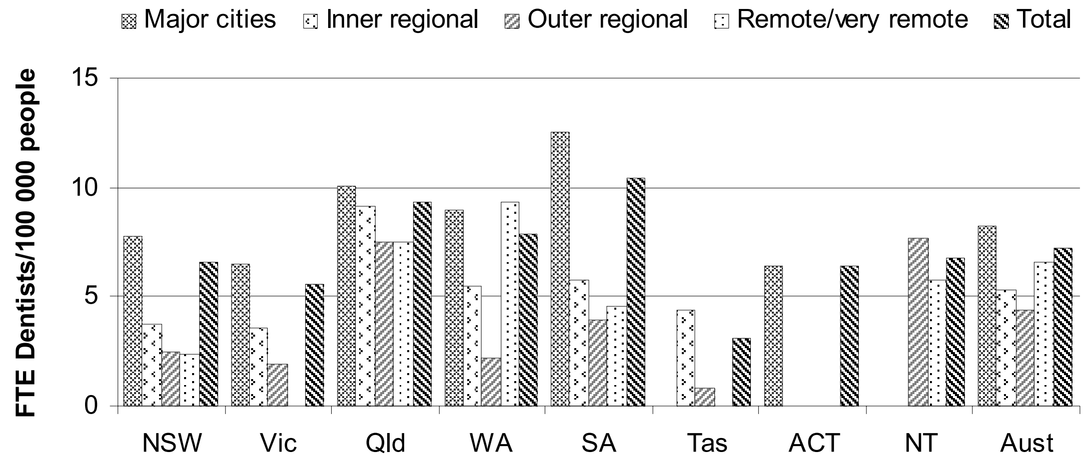
The availability (or supply) of public dentists by region affects people's access to public dental services, particularly in rural and remote areas. Low availability can result in increased travel distance to a dentist and increased waiting times to see a dentist.

The indicator is defined as the number of full time eqivalent (FTE) public dentists per 100 000 people by region.

An increase in the availability of public dentists indicates improved access to dental services. However, this indicator does not provide information on whether people are accessing the service or whether the services are appropriate for the needs of the people receiving them.

In 2005 there were more FTE public dentists per 100 000 people in major cities than in regional or remote areas for all states and territories (figure 11.7; table 11A.14).

Figure 11.7 **Availability of public dentists, 2005**[a, b, c]



[a] FTE based on 40-hour week. [b] There were no public dentists in remote and very remote areas in Victoria or Tasmania. There were no public dentists in inner regional areas in the ACT. [c] Tasmania had no major cities. The ACT had no outer regional, or remote and very remote, areas. The NT had no major cities or inner regional areas.

Source: AIHW (unpublished); table 11A.14.

Early detection and early treatment for Indigenous people

Box 11.6 **Early detection and early treatment for Indigenous people**

The high prevalence of preventable and/or treatable health conditions in the Indigenous population is strongly associated with relatively poor health outcomes for Indigenous people (AIHW 2007d; SCRGSP 2007a). Early detection and early treatment refers to the identification of individuals who are at high risk for, or in the early stages of, such conditions. Early detection and early treatment services provide opportunities for timely prevention and intervention measures to improve and maintain health. Such services have the potential to improve access to appropriate healthcare for Indigenous people.

Voluntary health assessments and checks are Medicare Benefit Schedule (MBS) items that allow GPs to undertake comprehensive examinations of patient health, including physical, psychological and social functioning. They are available for older Australians as well as for Indigenous people of all ages, as the prevalence of preventable and/or treatable conditions is high in both population groups. The availability and uptake of early detection and early treatment services is understood to be a significant determinant of people’s health.

(Continued on next page)

Box 11.6 **(Continued)**

Four measures are presented for this indicator:

- Older people who received a voluntary health assessment by Indigenous status
- Older Indigenous people who received a voluntary health assessment, time series
- Indigenous people who received a voluntary health assessment or check by age group
- Aboriginal and Torres Strait Islander primary healthcare services that provided early detection services.

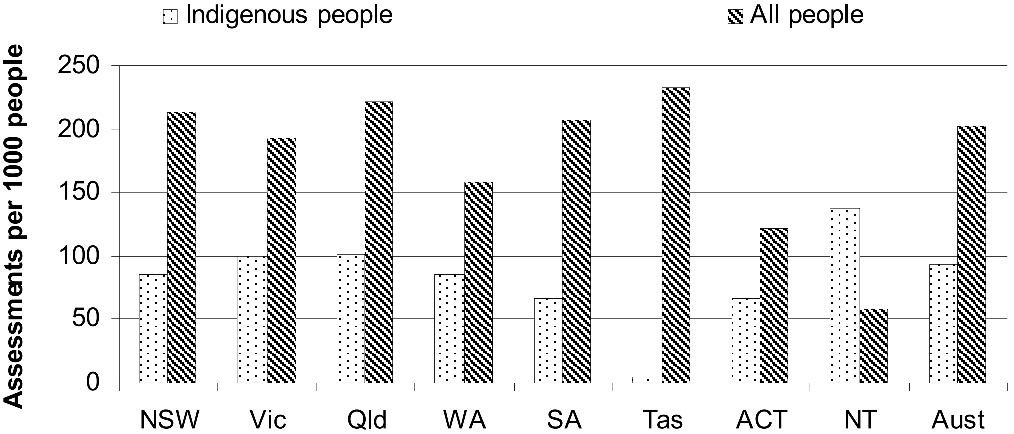
A reduction in the gap between the proportion of all older people and older Indigenous people that received a health assessment indicates improved access to early detection and early treatment services for Indigenous people. An increase in the proportion of Indigenous people that received a health assessment or check indicates improved access to these services. An increase in the proportion of Aboriginal and Torres Strait Islander primary healthcare services providing early detection activities indicates improved access to these services for Indigenous Australians.

This indicator provides no information about early detection and early treatment services that are not provided under Medicare. Such services are provided by salaried GPs in community health settings, hospitals and Indigenous-specific primary health care services, particularly in rural and remote areas. Accordingly, this indicator understates the proportion of people who received early detection and early treatment services.

For this indicator, older people are defined as non-Indigenous people aged 75 years or over and Indigenous people aged 55 years or over, excluding hospital inpatients and people living in aged care facilities. The larger age range for Indigenous people recognises that they typically face increased health risks at younger ages than most other groups in the population. It also broadly reflects the difference in average life expectancy between the Indigenous and non-Indigenous populations (see the 'Health preface').

Figure 11.8 shows that in 2006-07 the proportion of Indigenous older people who received an annual health assessment was considerably lower than the proportion of all older people who received an annual health assessment. This suggests that access to early detection and early treatment services for older Indigenous people is inequitable.

Figure 11.8 **Older people who received an annual health assessment by Indigenous status, 2006-07**[a, b]



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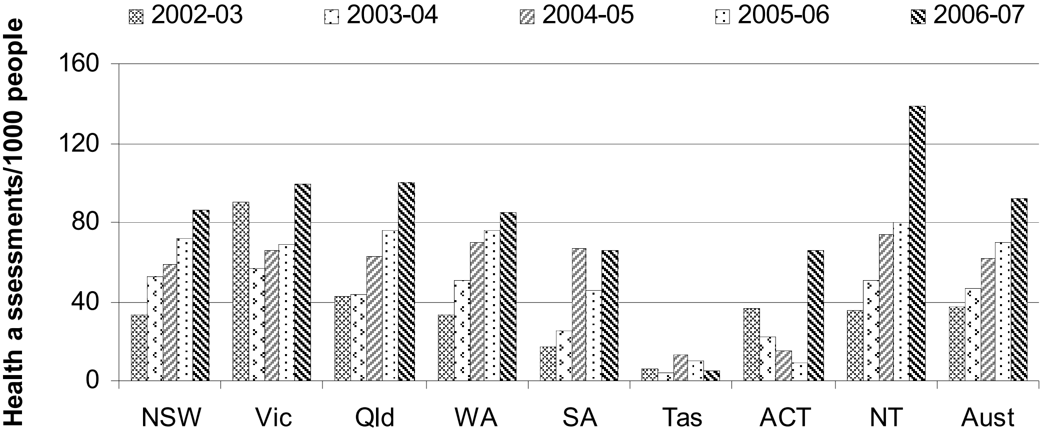
[a] Older people are defined as Indigenous people aged 55 years and over and non-Indigenous people aged 75 years and over. [b] Indigenous status is determined by self-identification. Indigenous people aged 75 years or over may have received a health assessment under the 'all older people' MBS items. This is considered unlikely to affect the overall proportions significantly, due to the relatively low average life expectancy of Indigenous people.

Source: Medicare Australia (unpublished); ABS (2004, 2006a, 2006b) 3238.0; 3101.0; 3222.0; table 11A.16.

Figure 11.9 shows that the proportion of older Indigenous people who received an annual health assessment steadily increased between 2002-03 and 2006-07 in most jurisdictions. This indicates that access to early detection and early treatment services has improved for this population in most jurisdictions.

Figure 11.9 **Older Indigenous people who received an annual health assessment**[a]



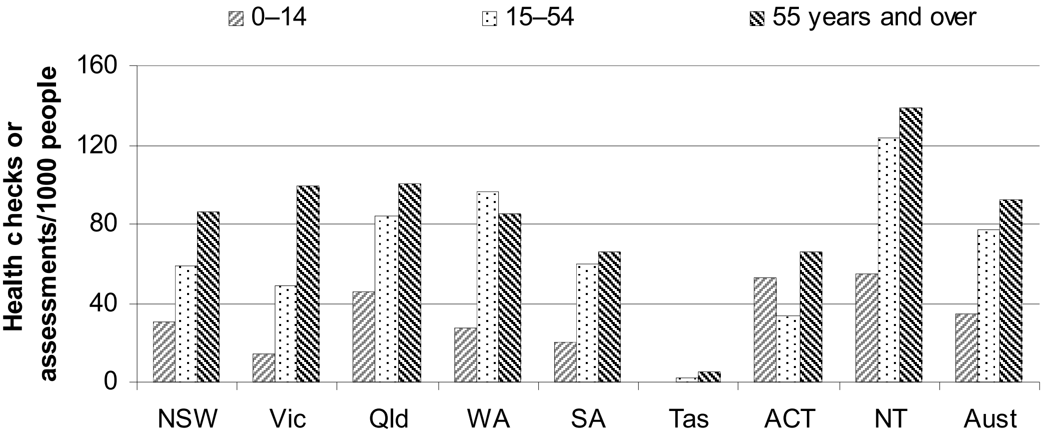
[a] Indigenous status is determined by self-identification. Indigenous people aged 75 years or over may have received a health assessment under the 'all older people' MBS items. This is considered unlikely to significantly affect the overall proportions due to the relatively low average life expectancy of Indigenous people.

Source: Medicare Australia (unpublished); ABS Cat. No. 3238.0; table 11A.17.

Health check MBS items were introduced for Indigenous people aged 15–54 years in May 2004, and Indigenous children aged 0–14 years in May 2006. Health checks are available annually for children aged 0–14 years, and biennially for 15–54 year-olds.

Figure 11.10 shows that the proportion of the eligible Indigenous population that received a health assessment or check was highest for older people and lowest for children aged 0–14 years in most jurisdictions. This may in part reflect differences in how long the items have been available, as factors such as awareness and additional administrative requirements affect the uptake of new MBS items (AIHW 2007d).

Figure 11.10 Indigenous people who received a health check or assessment by age[a, b]



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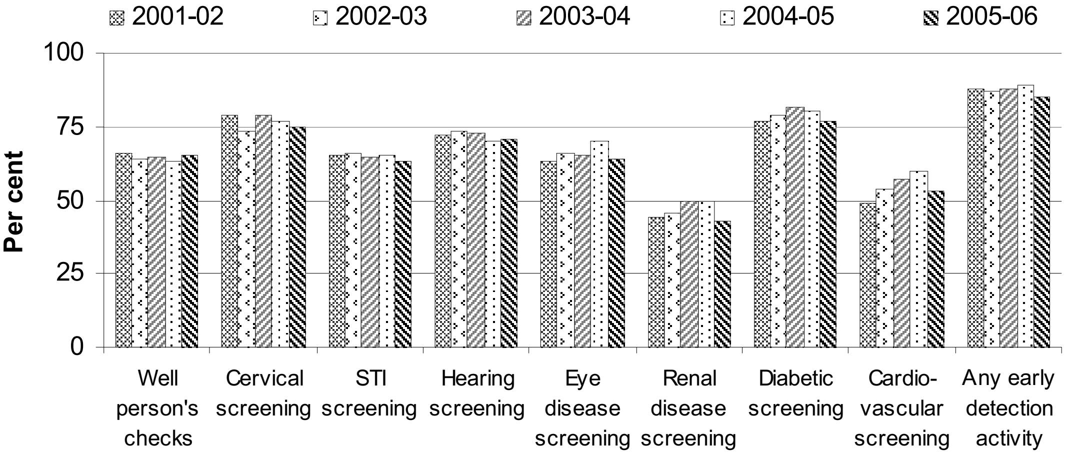
[a] Indigenous status is determined by self-identification. Indigenous people aged 75 years and over may have received a health assessment under the ‘all older people’ MBS items. This is considered unlikely to significantly affect the overall proportions due to the relatively low average life expectancy of Indigenous people. [b] Health checks for 0–14 year olds, and health assessments for those aged 55 years and over, are available annually. Data for these age groups are for the period 1 July 2006 to 30 June 2007. Health checks for 15–54 year olds are available biennially, and these data are for the period 1 July 2005 to 30 June 2007.

Source: Medicare Australia (unpublished); ABS Cat. No. 3238.0; table 11A.18.

Figure 11.11 shows the proportion of Indigenous primary healthcare services for which SAR data are reported that provided various early detection services over the five year period to 2005-06.

Figure 11.11 Indigenous primary healthcare services for which SAR data are reported that provided early detection services



Source: DoHA (unpublished); table 11A.19.

Effectiveness

Access

‘Bulk billing rates’ (box 11.7) is currently the only indicator reported against effectiveness and access.

Bulk billing rates

Box 11.7 **Bulk billing rates**

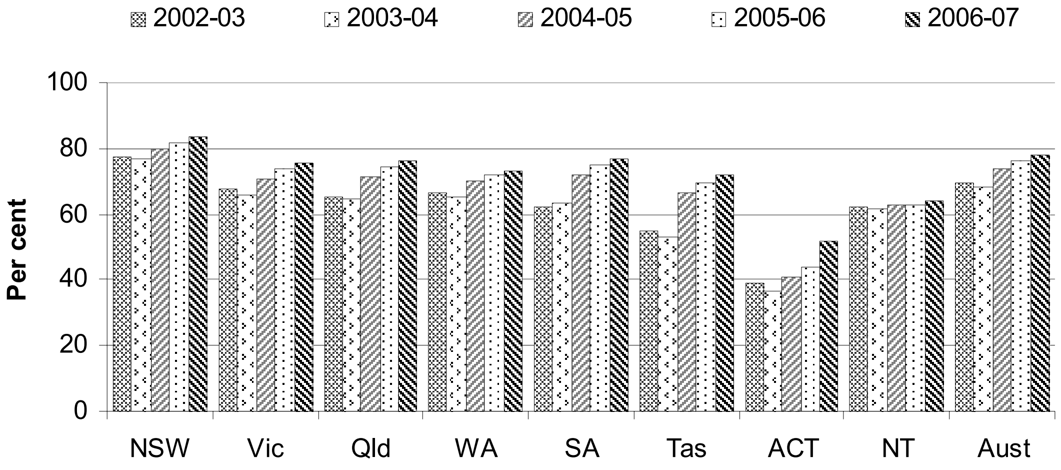
Patient visits to GPs are classed as non-referred attendances under Medicare. Patients are either bulk billed or required to pay part of the cost of the non-referred attendance. Where a patient is bulk billed, the GP bills Medicare Australia directly and since 1 January 2005 receives 100 per cent of the Schedule fee (the patient's rebate) as full payment for the service. The 100 per cent Medicare rebate applies to most services provided by a GP. The patient makes no out-of-pocket contribution. The bulk billed proportion of non-referred attendances indicates the affordability of GP services.

The indicator is defined as the number of non-referred attendances that were bulk billed as a proportion of all non-referred attendances.

A higher proportion of bulk billed attendances indicates greater affordability of GP services. However, this indicator does not provide information on whether the services are appropriate for the needs of the people receiving them.

Australia-wide, the bulk billed proportion of non-referred attendances, including those by practice nurses, was 78.0 per cent in 2006-07. This proportion varied across jurisdictions (figure 11.12). The bulk billed proportion of non-referred attendances was higher in capital cities than in rural areas and remote centres, and similar to that in other remote areas (table 11A.20).

Figure 11.12 **Non-referred attendances that were bulk billed**[a]



[a] Includes attendances by practice nurses since 2003-04.

Source: DoHA (unpublished); table 11A.21.

Appropriateness

Two indicators of the appropriateness of GP services are reported: the ‘management of upper respiratory tract infections’ (box 11.8) and ‘pathology tests and diagnostic imaging ordered by non-specialists’ (box 11.12). ‘Management of diabetes’ (box 11.9) has been reported in previous Reports, but data were not available for this indicator for the 2008 Report. The Steering Committee has also identified ‘management of asthma’ (box 11.10) and ‘pharmaceuticals ordered by non-specialists’ (box 11.11) as indicators of the appropriateness of GP services. However, data for these indicators were not available for the 2008 Report.

Management of upper respiratory tract infections

Box 11.8 **Management of upper respiratory tract infections**

Upper respiratory tract infections without complications are most often caused by viruses. Antibiotics have no efficacy in the treatment of viral infections but are nevertheless frequently prescribed for viral infections. Unnecessarily high rates of antibiotic prescription for upper respiratory tract infections have the potential to increase pharmaceutical costs and to increase antibiotic resistance in the community.

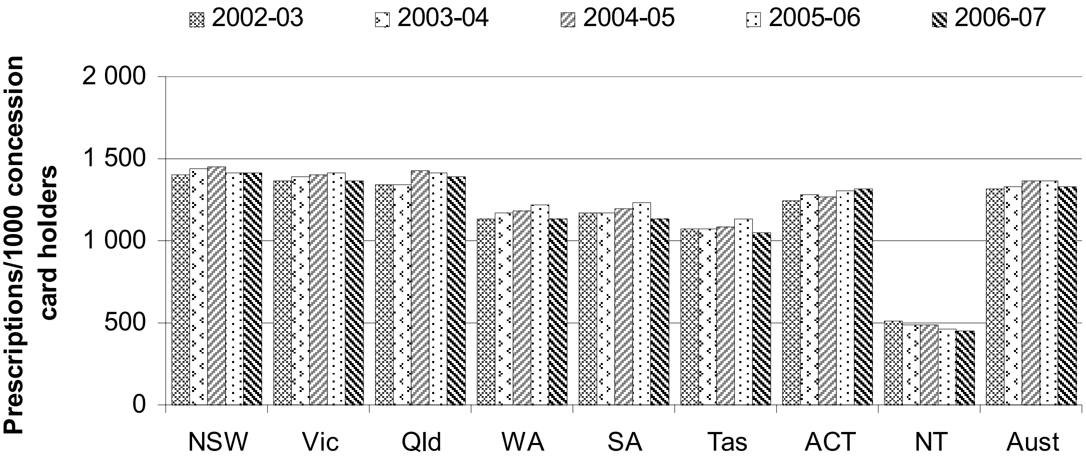
Ideally, this indicator would be based on the total population, but data restrictions mean it is based only on PBS concession card holders. The indicator is defined as the number of prescriptions for those oral antibiotics most commonly prescribed to treat upper respiratory tract infection that are provided to PBS concession card holders per 1000 PBS concession card holders.

A reduction in the prescription rate may indicate that GPs are offering more appropriate treatment for viral infections.

Due to the effects of population ageing, the complexity of pharmaceutical needs of concession card holders may increase. In addition, the selected oral antibiotics may be prescribed for illnesses other than upper respiratory tract infections. The trend in the prescription of oral antibiotics should nevertheless be downwards if GPs more closely follow guidelines for the treatment of upper respiratory tract infections.

Australia-wide, the prescription rate for the oral antibiotics most commonly used to treat upper respiratory tract infection in 2006-07 was 1324.5 per 1000 PBS concession card holders. Prescription rates for these antibiotics fluctuated around the same level in most states and territories between 2002-03 and 2006-07 (figure 11.13).

Figure 11.13 **Rate of prescription of the oral antibiotics used most commonly to treat upper respiratory tract infections**



Source: DoHA (unpublished); table 11A.22.

Management of diabetes

Data have previously been reported against the indicator ‘management of diabetes’. These data were sourced from a project conducted between 2000 and 2002 and can be found in the 2007 Report (SCRGSP 2007b). Current data were not available for this indicator for the 2008 Report (box 11.9).

Box 11.9 **Management of diabetes**

‘Management of diabetes’ has been identified as an indicator of appropriateness. Data were not available for this indicator for the 2008 Report.

Management of asthma

The Steering Committee has identified ‘management of asthma’ as an indicator of the appropriateness of GP services (box 11.10). Data for this indicator were not available for the 2008 Report.

Box 11.10 **Management of asthma**

‘Management of asthma’ has been identified as an indicator of appropriateness, but a specific measure has not yet been developed.

Pharmaceuticals ordered by non-specialists

The Steering Committee has identified ‘pharmaceuticals ordered by non-specialists’ as an indicator of the appropriateness of GP services (box 11.11). Data for this indicator were not available for the 2008 Report.

Box 11.11 **Pharmaceuticals ordered by non-specialists**

‘Pharmaceuticals ordered by non-specialists’ has been identified as an indicator of appropriateness, but no data are currently available.

Pathology tests and diagnostic imaging ordered by non-specialists

Box 11.12 **Pathology tests ordered and diagnostic imaging referrals by non-specialists (vocationally recognised GPs and OMPs)**

The number of pathology tests ordered and diagnostic imaging referrals by vocationally recognised GPs and OMPs that are rebated through Medicare, per person, is used as a proxy for this indicator of the appropriateness of diagnostic and monitoring patterns of GPs.

Four measures are reported:

- pathology tests ordered by vocationally recognised GPs and OMPs, that are rebated through Medicare, per person
- diagnostic imaging referrals by vocationally recognised GPs and OMPs, that are rebated through Medicare, per person
- Medicare benefits paid per person for pathology tests
- Medicare benefits paid per person for diagnostic imaging.

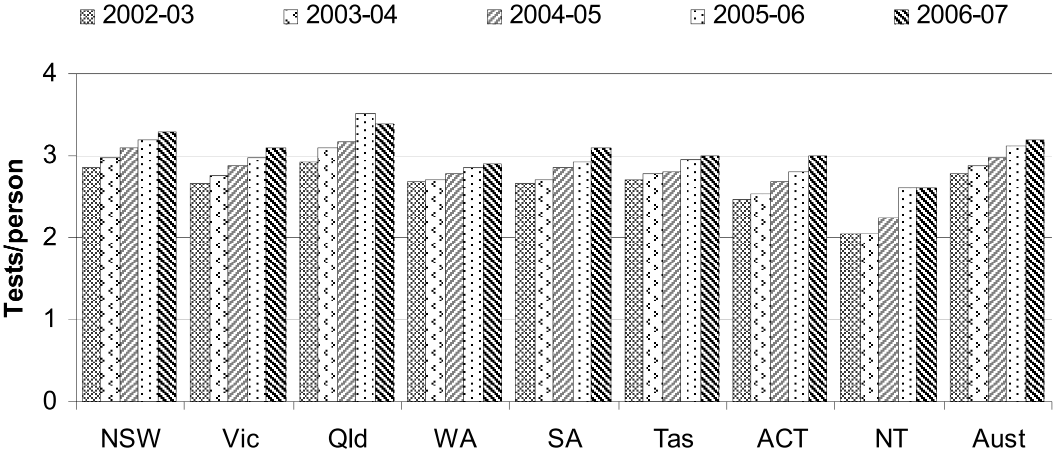
Differences across jurisdictions and over time may reflect variation in the appropriateness of utilisation of these services for diagnosis and treatment decisions. While high levels may indicate GPs’ over-reliance on these diagnostic tools, low levels may indicate underuse. Reporting these data contributes to the discussion of such issues.

Pathology tests and diagnostic imaging are important tools used by GPs in the diagnosis of many diseases, and in monitoring response to treatment. Their underuse may contribute to the misdiagnosis of disease, and to relatively poor treatment decisions. Excessive use may reflect overreliance of GPs on tools to support the diagnostic process. While what constitutes appropriate levels of use cannot be determined, reporting of the differences across jurisdictions and over time contributes to the discussion of these issues.

Information on the total number of pathology tests ordered and diagnostic imaging referrals by GPs is not available from Medicare. Information is available only for those that were rebated through Medicare. The number of pathology tests ordered may be higher than the number rebated through Medicare (where multiple tests are ordered, rebates are provided only for the three most expensive tests). Radiologists may identify a need for more or different imaging procedures than patients are referred for. The difference between the number of pathology tests ordered and the number for which rebates are claimed is not available from Medicare. Nor is the difference between the imaging procedures that are ordered by GPs and those for which rebates are claimed. Thus, the information that is available from Medicare is used as a proxy in reporting against this indicator.

Nationally, the number of pathology tests ordered and rebated through Medicare per person increased from 2.8 in 2002-03 to 3.2 in 2006-07 (figure 11.14).

Figure 11.14 **Pathology tests ordered by GPs and rebated through Medicare**[a]



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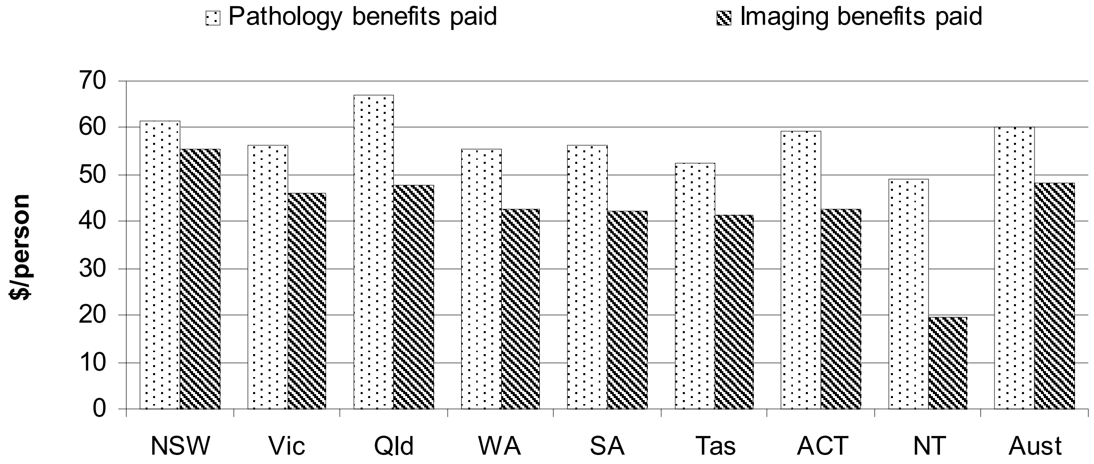
[a] Data include tests ordered by vocationally recognised GPs and OMPs and rebated through Medicare. Data include tests ordered at the request of a patient (patient episode initiated items).

Source: DoHA (unpublished); table 11A.23.

Australian Government expenditure (under Medicare) on pathology tests amounted to $1.3 billion in 2006-07, equal to $60 per person. Nationally, Medicare benefits worth $1.0 billion were paid for diagnostic imaging in 2006-07, equal to $48 per person (figure 11.15).

Figure 11.15 **Benefits paid for pathology tests and diagnostic imaging, 2006-07**[a]

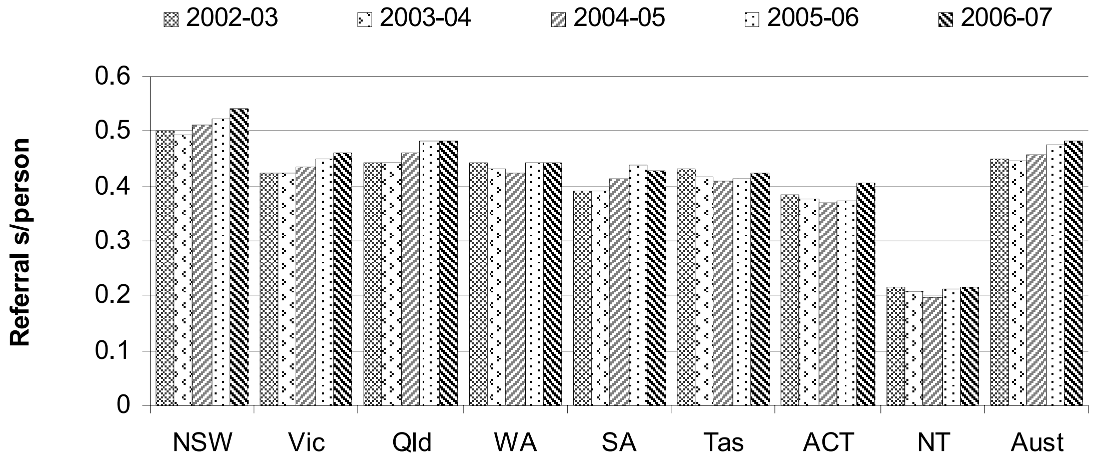


[a] Includes benefits paid through Medicare (including DVA data) for pathology tests ordered, and diagnostic imaging referred, by vocationally recognised GPs and OMPs.

Source: DoHA (unpublished); tables 11A.23 and 11A.24.

Nationally, there has been a gradual upward trend in the number of diagnostic imaging referrals per person between 2003-04 and 2006-07 (figure 11.16).

Figure 11.16 **Diagnostic imaging referrals from GPs**[a]



[a] Data relate to vocationally recognised GPs and OMPs.

Source: DoHA (unpublished); table 11A.24.

Quality — safety

General practices with electronic information management systems

The Practice Incentives Program (PIP) provides payments to general practices based on patients' ongoing healthcare needs (rather than on service volumes), promoting activities such as: use of electronic information management systems; after-hours care; teaching medical students; employment of practice nurses; and improved chronic disease management.

The PIP Information Management, Information Technology initiative provides two incentives to encourage the computerisation of practices (box 11.13). The first requires that practices maintain electronic patient records, including clinical data on allergies/sensitivities for the majority of active patients, and implement appropriate information security measures. The second requires that practices, in addition, use electronic patient records to record and store clinical information on the majority of active patients, including current and past major diagnoses and current medications. These replaced previous incentives for electronic prescribing and transmission of clinical data in November 2006. Computerisation of general practices may improve the safety (in terms of quality and effectiveness) of GP services (box 11.13).

Box 11.13 **General practices with electronic clinical information management systems**

The proportion of general practices with electronic information management systems is an indicator of safety, because such systems may reduce prescribing and dispensing errors. Reductions in these types of errors reduce the likelihood of harm to patients from adverse drug reactions. Electronic information management systems may also improve other aspects of quality by providing access to timely clinical data and improving the maintenance of patient health records. Use of such technology can, for example, facilitate best practice chronic disease management and preventive health activities such as screening (DHAC 2000).

Two measures are presented for this indicator:

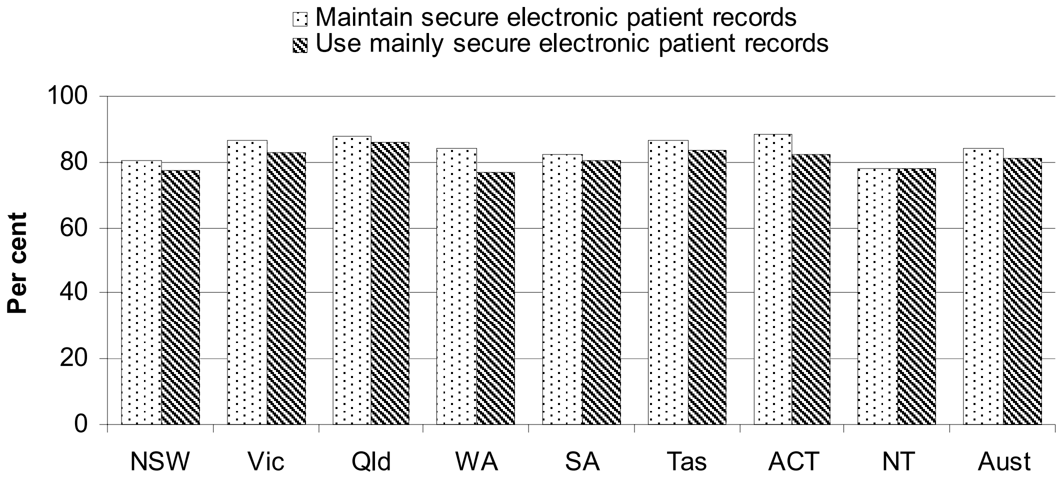
- the proportion of PIP practices that maintain secure electronic patient records
- the proportion of PIP practices that manage patient records predominantly using secure electronic management systems.

An increase in these proportions may indicate an improvement in the level of safety in patient management by general practices.

The PIP does not include all practices in Australia. PIP practices covered around 81 per cent of Australian patients (measured as standardised whole patient equivalents) in May 2007 (DoHA unpublished; table 11A.25).

Australia-wide, 84.0 per cent of PIP practices maintained secure electronic patient records in May 2007. Patient records were managed predominantly using secure electronic management systems in 80.9 per cent of PIP practices (figure 11.17). In previous Reports, time series data have been reported for PIP practices using computers for clinical purposes by area. As data for previous and current incentives are not comparable, only 2007 data are reported here. Time series data for the previous incentives are reported in tables 11A.25 and 11A.26.

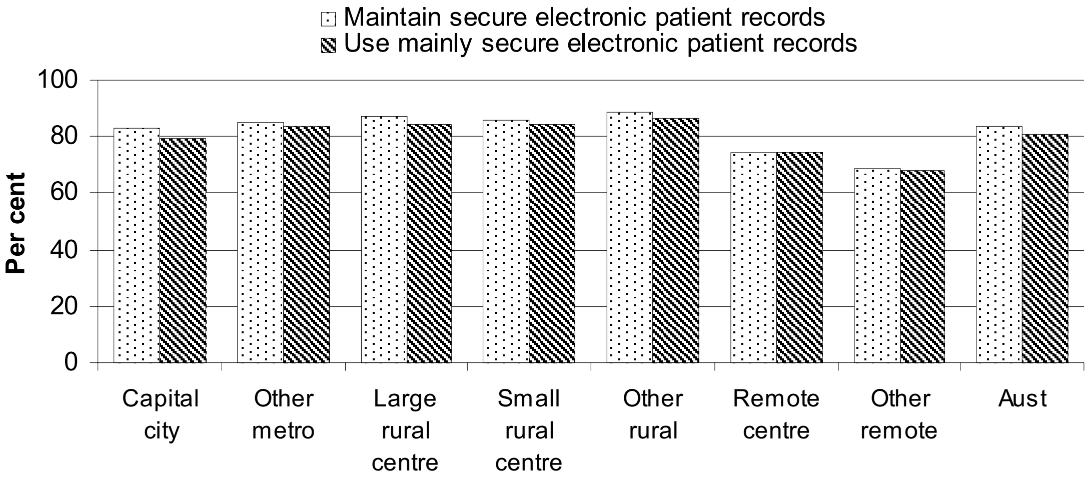
Figure 11.17 **PIP practices using computers for clinical purposes, May 2007**



Source: DoHA (unpublished); table 11A.25.

In May 2007, PIP practices in rural areas were more likely than PIP practices in metropolitan areas or remote areas to maintain computerised patient records (figure 11.18). Remote practices in the NT have difficulty meeting the accreditation requirements to qualify for the PIP, which affects the coverage of these data.

Figure 11.18 **PIP practices using computers for clinical purposes by area, May 2007[a]**



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[a] Capital city = State and Territory capital city statistical divisions; other metropolitan centre = one or more SLAs that have an urban centre with a population of 100 000 or more; large rural centre = SLAs where most of the population resides in urban centres with a population of 25 000 or more; small rural centre = SLAs in rural zones containing urban centres with populations between 10 000 and 24 999; other rural area = all remaining SLAs in the rural zone; remote centre = SLAs in the remote zone containing populations of 5000 or more; other remote area = all remaining SLAs in the remote zone. SLA = statistical local area. *Source*: DoHA (unpublished); table 11A.26.

Quality — responsiveness

Patient satisfaction

The Steering Committee has identified ‘patient satisfaction’ as an indicator of the quality of the responsiveness of GP services to patients (box 11.14). Data for this indicator were not available for the 2008 Report.

Box 11.14 **Patient satisfaction**

‘Patient satisfaction’ has been identified as an indicator of responsiveness, but no data are currently available.

Quality — capability

Two indicators of the quality of GP services, relating to GPs’ capability to provide services, are reported here: the proportion of GPs with vocational registration (box 11.15); and the proportion of general practices with accreditation (box 11.16).

GPs with vocational registration

Box 11.15 **GPs with vocational registration**

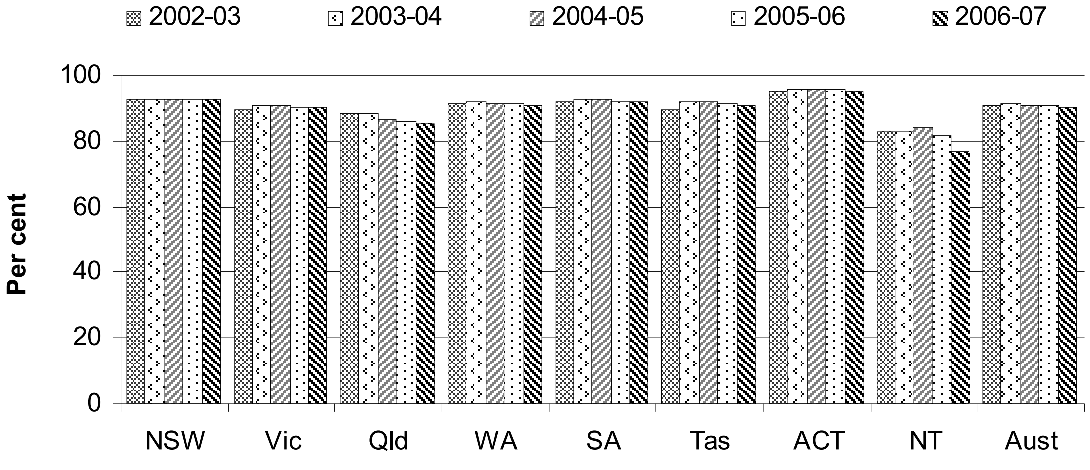
Since 1996, a GP can only achieve vocational registration by attaining Fellowship of the Royal Australian College of General Practitioners (RACGP) or equivalent. GPs can attain Fellowship through the successful completion of a formal general practice training program or through the ‘practice eligible’ route. Once vocational registration is achieved, GPs must demonstrate ongoing involvement in continuing professional development activities in order to maintain their Fellowship status (DoHA unpublished).

The measure reported is the proportion of FWE GPs with vocational registration.

An increase in the proportion of GPs with vocational registration may indicate an improvement in the capability of the GP workforce to deliver high quality services. However, GPs without vocational registration may deliver services of equally high quality.

The proportion of GPs with vocational registration remained relatively constant over the five years to 2006-07 (figure 11.19). The proportions of GPs with vocational registration were highest in capital cities, other metro centres and large rural centres, and lowest in other remote areas, in 2006-07 (table 11A.27).

Figure 11.19 **GPs (full time workload equivalent) with vocational registration**



Source: DoHA (unpublished); table 11A.28.

General practices with accreditation

Box 11.16 **General practices with accreditation**

Accreditation of general practice is a voluntary process of peer review that involves the assessment of general practices against a set of standards developed by the RACGP. Accredited practices, therefore, have been assessed as complying with a set of national standards.

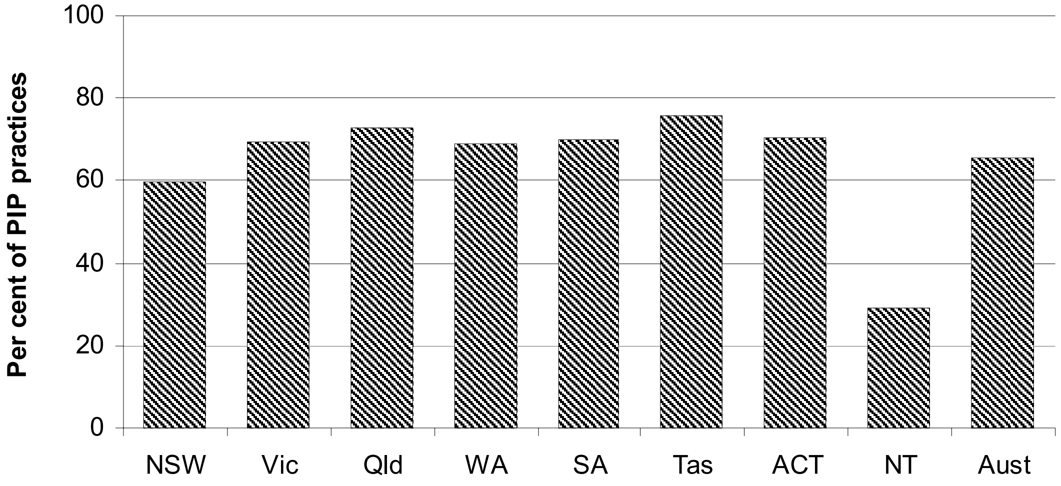
The two providers of general practice accreditation services are Australian General Practice Accreditation Limited (AGPAL) and General Practice Australia ACCREDITATION *plus* (GPA Accreditation *plus*). This indicator is defined as the number of general practices that are accredited by these organisations as a proportion of all general practices in Australia.

An increase in the proportion of practices with accreditation may indicate an improvement in the capacity of general practices to deliver high quality services. However, general practices without accreditation may deliver services of equally high quality. For a particular general practice, the decision to seek accreditation might be influenced by perceived costs and benefits unrelated to its quality standards. Accreditation affects eligibility for some government programs (such as PIP), so there are financial incentives for gaining accreditation.

Reporting against this indicator has improved for the 2008 Report, with the inclusion of data from both accrediting bodies for the first time (data were previously available only from AGPAL). In addition, data for the number of general practices in Australia were for the first time sourced from the Annual Survey of Divisions of General Practice (PHC RIS, DoHA unpublished). Completion of this survey by Divisions is required under contractual agreements with DoHA.

In June 2007, 4835 general practices — representing 65.7 per cent of general practices — were accredited Australia-wide (figure 11.20).

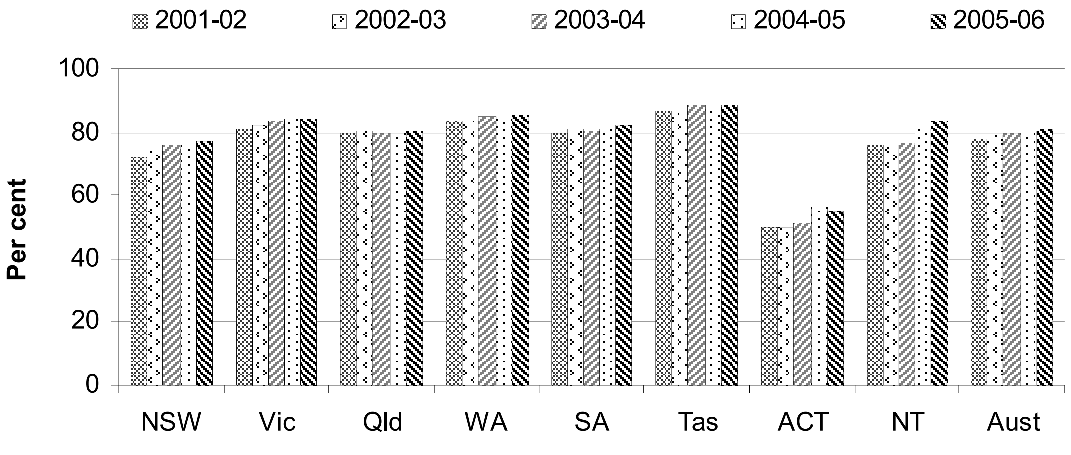
Figure 11.20 **General practices with accreditation, June 2007**



Source: AGPAL (unpublished); GPA Accreditation *plus* (unpublished); Primary Health Care Research and Information Service (PHC RIS), DoHA (unpublished); table 11A.29.

The proportion of patients attending accredited practices provides useful additional information relating to accreditation. For this measure, PIP practices provide a proxy for accredited practices, as accreditation is a requirement for PIP registration. Australia-wide, there appears to have been a slight increase in the proportion of patients, measured as standardised whole patient equivalents (SWPEs), seen in PIP practices over the period 2001-02 to 2005-06 (figure 11.21).

Figure 11.21 **Proportion of patients in PIP practices**[a]



[a] Patients are measured as SWPEs. A SWPE is an indicator of practice workload based on the number of patients seen. The SWPE value for a jurisdiction is the sum of the fractions of care provided by doctors in that jurisdiction to their patients, weighted for the age and sex of each patient in accordance with national ratios.

Source: DoHA (unpublished); table 11A.30.

Quality — continuity

The continuity aspect of the quality of primary healthcare services relates to the timely, coordinated provision of services that address the needs of individual patients. For example, chronic disease imposes a significant burden on the health and wellbeing of Australians. Patients may need a range of services from within and outside the health sector. Continuity of care can help prevent or delay the progression of many circulatory, respiratory, endocrine, nutritional and metabolic diseases (NHPAC 2006). Two indicators of this aspect of quality are reported here: the use of care planning and case conferencing (box 11.17); and the use of health assessments for older people (box 11.18).

Care planning and case conferencing

Box 11.17 **Care planning and case conferencing**

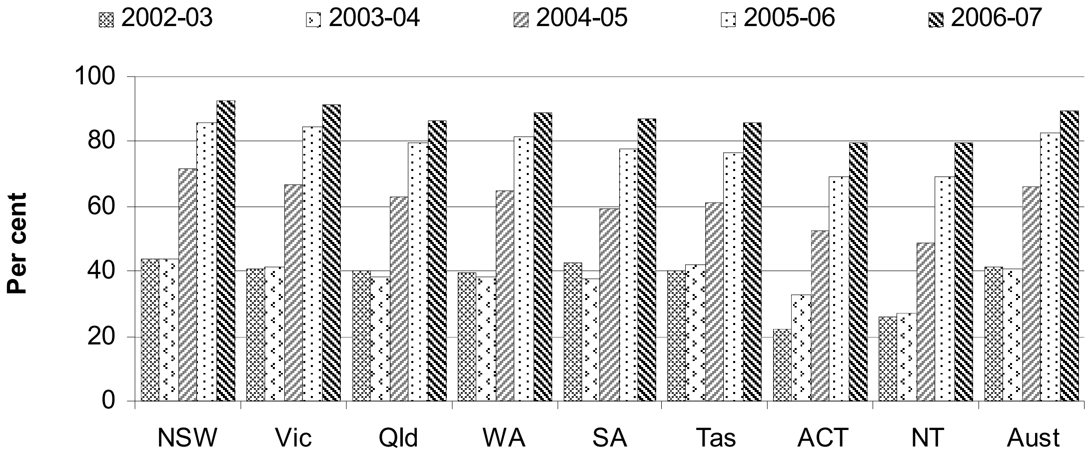
Care planning and case conferencing refer to chronic disease management items in the Medicare Benefits Schedule (MBS). These items allow for the preparation and regular review of care plans for individuals with chronic or terminal medical conditions, through GP managed or multidisciplinary team-based care. The rationale for the indicator is that GPs with some experience using care planning and case conferencing are more likely to continue to use those options when they have the potential to improve patient care.

This indicator is defined as the proportion of GPs who used the chronic disease management items for care planning or case conferencing at least once during a 12 month period.

An increase in the proportion of GPs who use these chronic disease management items may indicate an improvement in the continuity of care provided to people with chronic or terminal medical conditions, including people with complex, multidisciplinary care needs.

Nationally, 89.8 per cent of GPs used the chronic disease management items for care planning or case conferencing in 2006-07 (figure 11.22).

Figure 11.22 **GP use of chronic disease management Medicare items for care planning and case conferencing**[a]



[a] The increase in the number of GPs using chronic disease management MBS items for care planning or case conferencing in 2004-05 may be due to the introduction of the Strengthening Medicare initiative on 1 July 2004. This initiative provided access to a range of allied health and dental care treatments for patients with chronic conditions and complex needs, on referral from a GP. The continued increase in subsequent years may be linked to the introduction of additional chronic disease management MBS items on a number of occasions.

Source: DoHA (unpublished); table 11A.31.

Health assessments for older people

Box 11.18 **Health assessments for older people**

An annual voluntary assessment for older people is an MBS item that allows a GP to undertake an in-depth assessment of a patient’s health. Health assessments cover the patient’s health and physical, psychological and social functioning, and aim to facilitate more timely preventive actions or treatments to enhance the health of the patient (see also box 11.6).

This indicator is defined as the proportion of older people who received a voluntary health assessment. Older people are defined as non-Indigenous people aged 75 years or over and Indigenous people aged 55 years or over, excluding hospital inpatients and people living in aged care facilities. The larger age range for Indigenous people recognises that they typically face increased health risks at younger ages than most other groups in the population. It also broadly reflects the difference in average life expectancy between the Indigenous and non-Indigenous populations (see the ‘Health preface’). Results for Indigenous people are reported under equity indicators (see box 11.6).

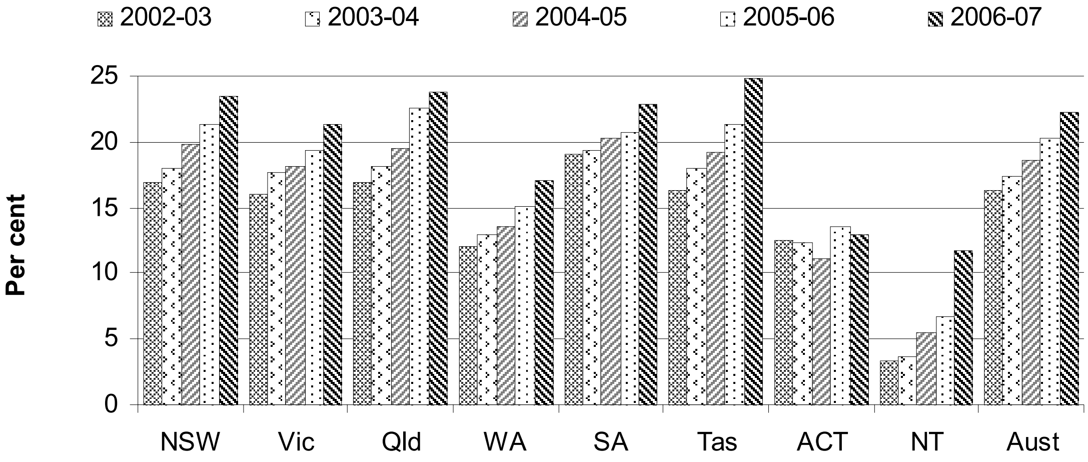
(Continued on next page)

Box 11.18 **(Continued)**

An increase in the proportion of eligible older people who received a voluntary health assessment may indicate a reduction in health risks for older people, through early and timely prevention and intervention measures to improve and maintain health.

Nationally, the proportion of older people who received a voluntary health assessment increased from 18.7 per cent in 2004-05 to 22.2 per cent in 2006-07 (figure 11.23).

Figure 11.23 **Older people who received a voluntary health assessment**[a]



[a] Older people are defined as non-Indigenous people aged 75 years or over and Indigenous people aged 55 years or over, excluding hospital inpatients and people living in aged care facilities.

Source: DoHA (unpublished); table 11A.32.

Sustainability

The Steering Committee has identified the sustainability of primary and community health as a key area for development in future reports.

Efficiency

Cost to government of general practice per person

The 'cost to government of general practice per person' is one indicator of the efficiency of general practice (box 11.19). Nationally, the recurrent cost to the

Australian Government of general practice was $247 per person in 2006-07 (figure 11.24).

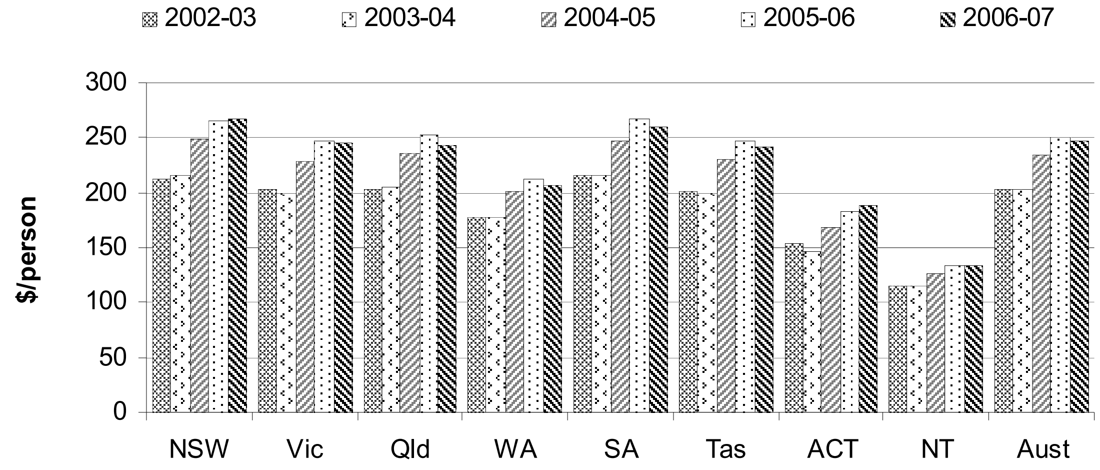
Box 11.19 Cost to government of general practice per person

'Cost to government of general practice per person' is an indicator of efficiency. It is defined as the cost to government of general practice (including the cost of Medicare, non-Medicare funding such as for the PIP, and expenditure by the DVA) per person in the population.

A lower cost per person may indicate higher efficiency. However, this is likely to be the case only where the lower cost is associated with services of equal or superior effectiveness.

This indicator needs to be interpreted with care because a lower cost per person may reflect service substitution between primary healthcare and hospital services or specialist services (the latter two both being potentially higher cost than primary care). Further, the indicator does not include costs for all primary healthcare services. Some primary healthcare services are provided by salaried GPs in community health settings, particularly in rural and remote areas, through accident and emergency departments, and Indigenous-specific primary health care services. Consequently, this indicator will understate costs for primary care in jurisdictions with larger proportions of rural and remote populations, where a salaried GP services delivery model is used.

Figure 11.24 **Australian Government real expenditure per person on GPs (2006-07 dollars)**[a, b]



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[a] The data include Medicare, PIP, DVA, Divisions of General Practice and General Practice Immunisation Incentives Scheme payments. DVA data cover consultations by local medical officers (LMOs), whether vocationally recognised GPs or not. From available files, it is not possible to extract the amounts paid to LMOs (as opposed to specialists) for procedural items. It is expected, however, that the amounts for these services are small compared with payments for consultations. The Australian Government invests in general practice through the Divisions of General Practice Program.

Source: DoHA (unpublished); table 11A.2.

Outcomes

Outcomes are the impact of services on the status of an individual or group (while outputs are the actual services delivered) (see chapter 1, section 1.5).

Indicators of both *intermediate* and *final* primary and community health outcomes are reported here. 'Child immunisation coverage' indicates the *intermediate* outcome of immunisation against disease (box 11.20). 'Notifications of selected childhood diseases' indicates the *final* outcome — the incidence of diseases — that child immunisation can prevent (box 11.21). The final outcome indicator 'potentially preventable hospitalisations' is also reported (box 11.24). Current data were not available this year for two outcome indicators previously reported — cervical screening (box 11.22) and influenza vaccinations for older people (box 11.23).

Child immunisation coverage

Box 11.20 **Child immunisation coverage**

'Child immunisation coverage' is an indicator of outcomes for primary and community health services, because one of the objectives of GPs and community health services is the achievement of high immunisation coverage levels for children. Many providers deliver child immunisation services (table 11.6). GPs are encouraged to achieve high immunisation coverage levels under the General Practice Immunisation Incentives Scheme, which provides incentives for the immunisation of children under seven years of age.

Two measures are reported for this indicator:

- the proportion of children aged 12 months to less than 15 months who are fully immunised. Children assessed as fully immunised at 12 months are immunised against diphtheria, tetanus, whooping cough, polio, *Haemophilus influenzae* type b and hepatitis B
- the proportion of children aged 24 months to less than 27 months who are fully immunised. Children assessed as fully immunised at 24 months are immunised against diphtheria, tetanus, whooping cough, polio, *Haemophilus influenzae* type b, hepatitis B, and measles, mumps and rubella.

An increase in the proportion of children who are fully immunised indicates a reduction in the risk of children contracting a range of diseases, including measles, whooping cough and *Haemophilus influenzae* type b.

Data on valid vaccinations supplied to children under 7 years of age from the Australian Childhood Immunisation Register (ACIR) are shown in table 11.6. Around 91.2 per cent of Australian children aged 12 months to less than 15 months at 30 June 2007 were assessed as fully immunised (figure 11.25).

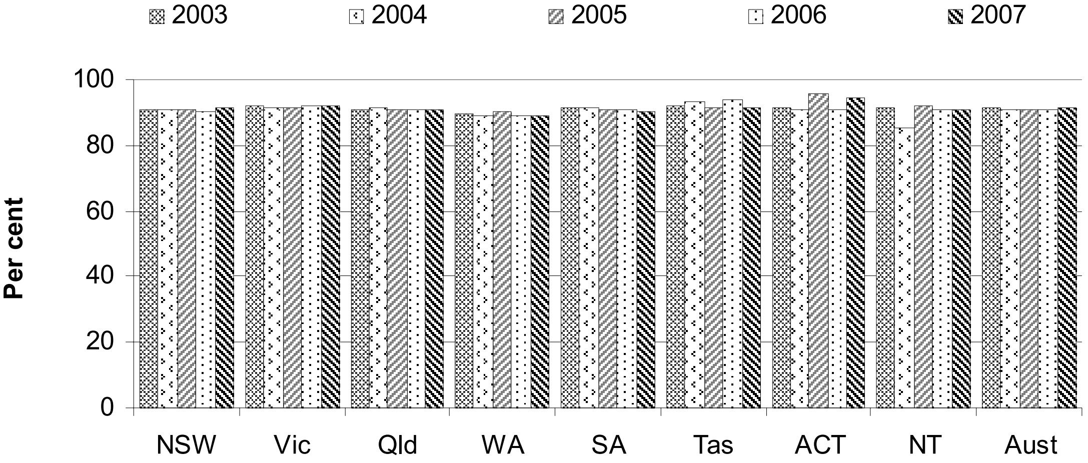
Table 11.6 **Valid vaccinations supplied to children under 7 years of age, by provider type, 1996–2007 (per cent)[a, b]**

Provider	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*[c]	*NT*	*Aust*
GP	83.8	52.6	82.5	63.5	68.6	86.2	39.5	3.1	70.7
Council	6.0	46.0	7.3	6.9	18.1	12.9	–	–	17.3
State or Territory health department	–	–	–	5.9	0.1	0.1	22.6	0.3	1.0
Flying doctor service	–	–	0.3	–	0.1	–	–	–	0.1
Public hospital	2.2	0.4	3.1	5.4	3.0	0.2	0.8	7.6	2.3
Private hospital	0.1	–	–	–	–	–	–	0.9	0.1
Indigenous health service	0.5	0.1	0.7	0.6	0.5	–	0.2	9.1	0.6
Indigenous health worker	–	–	0.5	–	0.1	–	–	0.2	0.1
Community health centre	7.4	0.8	5.6	17.7	9.6	0.6	36.8	78.8	8.0
Community nurse	–	–	–	–	–	–	–	–	–
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**

[a] 1 January 1996 to 30 June 2007. Data relate to the State or Territory in which the immunisation provider was located. [b] A valid vaccination is a National Health and Medical Research Council's Australian Standard Vaccination Schedule vaccination administered to a child under the age of 7 years. [c] Due to changes in provider classification in the ACT between 1996 to 2007, some vaccinations undertaken by ACT Health's Maternal and Child Health nurses are reported under 'State or Territory health departments' and some are reported under 'Community health centre'. The total proportion of vaccinations provided by ACT Health during this period was 59.4 per cent. – Nil or rounded to zero.

Source: DoHA (unpublished); table 11A.33.

Figure 11.25 **Children aged 12 months to less than 15 months who were fully immunised**[a, b, c]

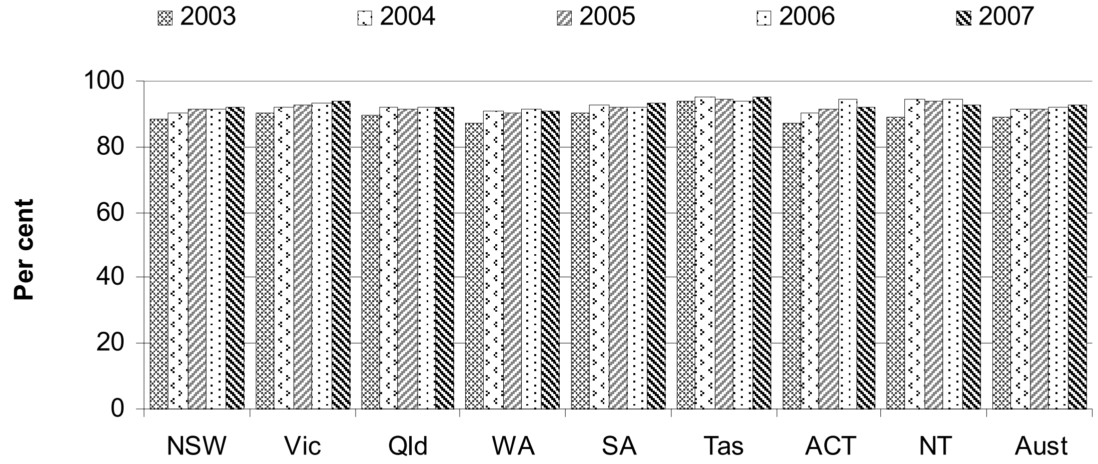


[a] Coverage measured at 30 June for children turning 12 months of age by 31 March, by State or Territory in which the child was located. [b] The ACIR includes all children under 7 years of age who are registered with Medicare. By the age of 12 months, over 98 per cent of Australian children have been registered with Medicare (NCIRS 2000). [c] There may be some under-reporting by providers, so vaccination coverage estimates calculated using ACIR data are considered minimum estimates (NCIRS 2000).

Source: DoHA (unpublished); table 11A.34.

Nationally, 92.5 per cent of children aged 24 months to less than 27 months at 30 June 2007 were assessed as being fully immunised (figure 11.26).

Figure 11.26 **Children aged 24 months to less than 27 months who were fully immunised**[a, b, c]



[a] Coverage measured at 30 June for children turning 24 months of age by 31 March, by State or Territory in which the child was located. [b] The ACIR includes all children under 7 years of age who are registered with Medicare. By the age of 12 months, over 98 per cent of Australian children have been registered with Medicare (NCIRS 2000). [c] There may be some under-reporting by providers, so vaccination coverage estimates calculated using ACIR data are considered minimum estimates (NCIRS 2000).

Source: DoHA (unpublished); table 11A.35.

Notifications of selected childhood diseases

Box 11.21 **Notifications of selected childhood diseases**

Notification rates for selected childhood vaccine preventable diseases (measles, pertussis [whooping cough] and *Haemophilus influenzae* type b) are an outcome indicator of primary and community health, because the activities of GPs and community health services can influence the prevalence of these diseases through immunisation (and consequently the notification rates). These childhood diseases are nationally notifiable diseases — that is, if they are diagnosed, there is a requirement to notify the relevant State or Territory authority. The debilitating effects of these diseases can be long term or even life threatening. The complications from measles, for example, can include pneumonia, which occurs for one in 25 cases.

For each disease, the rate of notifications is defined as the number of notifications for children aged 0–14 years per 100 000 children in that age group.

A reduction in the notification rate for the selected diseases indicates the effectiveness of the immunisation program.

In 2007, there were 5 notifications of measles across Australia to 31 August. There were fewer than 15 notifications per year for the period 2002–2005, preceding a high of 68 notifications in 2006. The national notification rate in 2007 was 0.2 per 100 000 children aged 0–14 years (figure 11.27).

Figure 11.27 **Notifications of measles per 100 000 children aged 0–14 years**[a, b]

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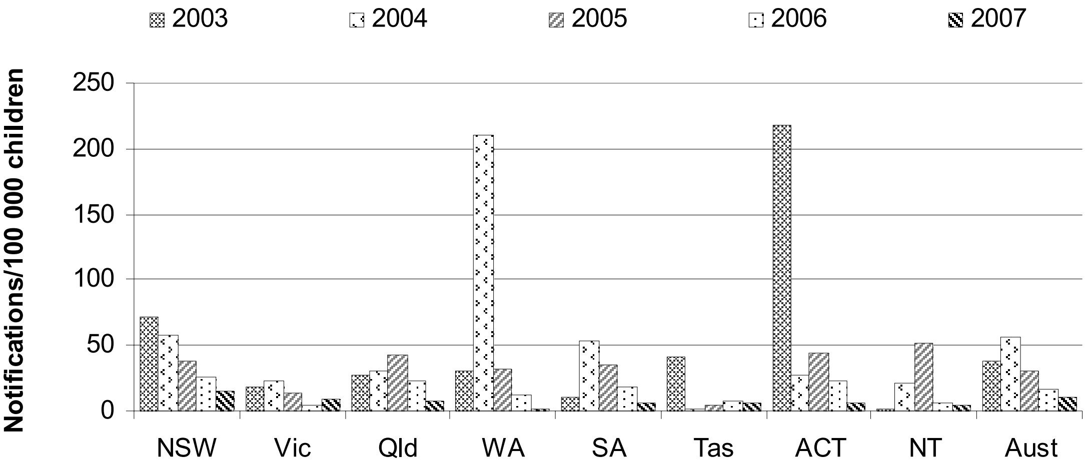
[a] Notifications for 2007 are to 31 August. [b] Where a notification rate for a particular year is zero, no notifications were made in that jurisdiction.

Source: DoHA (unpublished); table 11A.36.

In 2007 the downward trend in notifications of pertussis (whooping cough) across Australia continued, with 318 notifications to 31 August. This represented a national notification rate of 10.0 per 100 000 children aged 0–14 years (figure 11.28).

Figure 11.28 **Notifications of pertussis (whooping cough) per 100 000 children aged 0–14 years**[a]

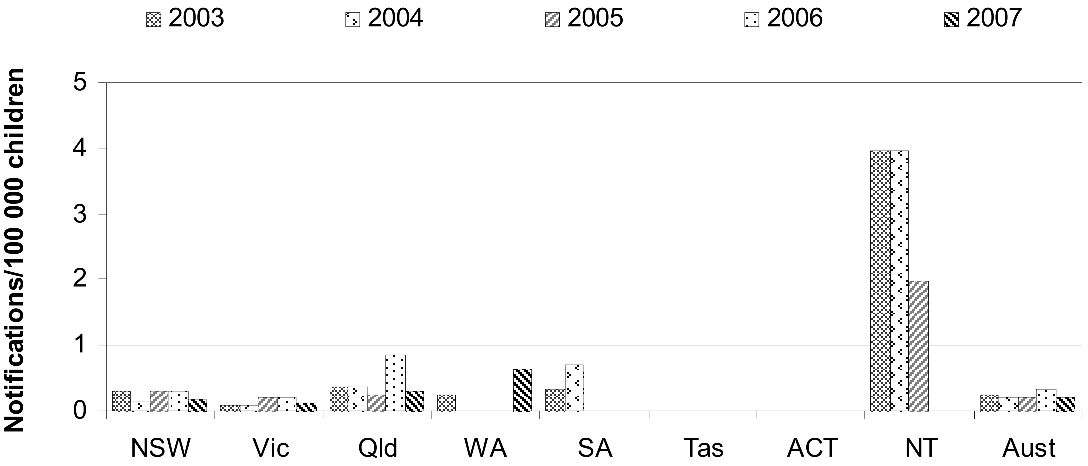


[a] Notifications for 2007 are to 31 August.

Source: DoHA (unpublished); table 11A.37.

In recent years, notification rates for *Haemophilus influenzae* type b have remained low. In 2007, the notification rate Australia-wide to 31 August was 0.2 per 100 000 children aged 0–14 years (figure 11.29).

Figure 11.29 **Notifications of *Haemophilus influenzae* type b among children aged 0–14 years**[a, b]



[a] Notifications for 2007 are to 31 August. [b] Where a notification rate for a particular year is zero, no notifications were made in that jurisdiction.

Source: DoHA (unpublished); table 11A.38.

Participation rates for women in cervical screening

‘Participation rates for women in cervical screening’ is an indicator of primary and community healthcare outcomes (box 11.22). Data for the 24 month period 2005–2006 were not available for the 2008 Report. Data for previous years are reported in table 11A.39.

Box 11.22 **Participation rates for women aged 20–69 years in cervical screening**

‘Cervical screening rate for target population’ (women aged 20–69 years) is an indicator of a primary and community healthcare outcome. It is estimated that up to 90 per cent of the most common type of cervical cancer (squamous cervical cancer) may be prevented if cell changes are detected and treated early (Mitchell, Hocking, Saville 2003). A range of healthcare providers offer cervical screening tests (Pap smears). The National Cervical Screening Program involves GPs, gynaecologists, family planning clinics and hospital outpatient clinics.

This indicator is defined as the number of women aged 20–69 years who are screened over a two year period, as a proportion of all women aged 20–69 years. Adjustments are made to account for differences in the female age distribution across states and territories, and to remove from the population of women 20–69 years old (the rate denominator) those who have had a hysterectomy.

An increase in the proportion of women aged 20–69 years who have been screened would be expected to result in a reduction in the number of women dying from this disease. Current data were not available for the 2008 Report.

Influenza vaccination coverage for older people

‘Influenza vaccination coverage for older people’ is an indicator of primary and community healthcare outcomes (box 11.23). The Adult Vaccination Survey was not conducted in 2005, and therefore updated data were not available for the 2008 Report. Data for previous years are reported in table 11A.40. The hospitalisation rate of people for influenza and pneumonia is included as a separate indicator (box 11.25).

Box 11.23 **Influenza vaccination coverage for older people**

Each year, influenza and its consequences result in many older people being hospitalised, as well as a considerable number of deaths. Influenza vaccinations for older people have been demonstrated to reduce hospitalisations and deaths (National Health Performance Committee unpublished). GPs provide the majority of influenza vaccinations for older people.

The indicator is defined as the proportion of people aged 65 years or over who have been vaccinated against influenza.

An increase in the proportion of older people vaccinated against influenza reduces the risk of older people contracting influenza and suffering consequent complications. Current data were not available for the 2008 Report.

Potentially preventable hospitalisations

The following five outcome indicators relate to potentially preventable hospitalisations for a range of conditions. The first three indicators — hospitalisations for vaccine preventable conditions (box 11.25), selected acute conditions (box 11.26) and selected chronic conditions (box 11.27) — were developed by the National Health Performance Committee, based on empirical research (box 11.24). The other two outcome indicators in this category relate to hospitalisations for diabetes (box 11.28) and the hospitalisation of older people for falls (box 11.29).

Box 11.24 **Potentially preventable hospitalisation indicators**

Potentially preventable hospitalisations refer to hospital admissions that may be avoided by appropriate management in the primary healthcare sector and/or the broader community. They include vaccine preventable, acute and chronic conditions, defined according to the *Victorian Ambulatory Care Sensitive Conditions Study* (DHS 2002). This study built on research into ambulatory care sensitive conditions (for example, Billings, Anderson and Newman 1996; Bindman *et al.* 1995; Weissman, Gatsonis and Epstein 1992) that had recently been the subject of systematic review and empirical analysis.

(Continued on next page)

Box 11.24 **(Continued)**

These studies show that the availability of non-hospital care explains a significant proportion of the variation between geographic areas in hospitalisation rates for the specified conditions. Other explanations for this variation include variation in the underlying prevalence of the conditions, clinical coding standards and the likelihood that a patient will be treated as an outpatient rather than an admitted patient. Potentially preventable hospitalisations will never be entirely eliminated, but the variation across geographic areas demonstrates considerable potential for strengthening the effectiveness of non-hospital care.

Source: NHPC (2004).

Data are reported against these indicators for Indigenous Australians as well as for all Australians. The completeness of Indigenous identification in hospital admitted patient data varies across states and territories. The AIHW (2005) report *Improving the Quality of Indigenous Identification in Hospital Separations Data* found that Indigenous patient data were of acceptable quality for analytical purposes only for Queensland, WA, SA, and public hospitals in the NT. Following new assessments of the quality of Indigenous identification in 2007, the National Health Information Management Principal Committee (NHIMPC) has recently approved NSW Indigenous patient data as acceptable in quality, for analytical purposes, from the 2004-05 reference year. A proposal to accept Victorian data as acceptable was being considered by the NHIMPC in late 2007. Efforts to improve Indigenous identification across states and territories are ongoing.

Reported data are not necessarily representative of other jurisdictions. Indigenous patients are underidentified, to an extent that varies across jurisdictions. Because of improvements in data quality over time, caution also should be used in time series analysis.

Vaccine preventable hospitalisations

‘Vaccine preventable hospitalisations’ is an indicator of primary and community healthcare outcomes (box 11.25).

Box 11.25 **Vaccine preventable hospitalisations**

The effectiveness of primary and community healthcare has a significant influence on the rates of hospitalisation for vaccine preventable conditions. This influence occurs mainly through the provision of vaccinations and the encouragement of high rates of vaccination coverage for target populations.

This indicator is defined as the number of hospital separations for influenza and pneumonia, and other vaccine preventable conditions, per 1000 people. This indicator is reported for Indigenous people as well as for all people. Adjustments are made to account for differences in the age structures of these populations across states and territories.

A reduction in hospitalisation rates may indicate improvements in the effectiveness of the vaccination program. Effective treatment by primary health providers may also reduce hospitalisations.

Factors outside the control of the primary healthcare sector also influence the rates of hospitalisation for vaccine preventable conditions; for example, the number and virulence of influenza strains from year to year.

Australia-wide, the age standardised hospital separation rate for all vaccine preventable conditions was 0.7 per 1000 people in 2005-06. Nationally, influenza and pneumonia accounted for 78.0 per cent of hospital separations for vaccine preventable conditions in 2005-06 (table 11.7).

Table 11.7 **Separations for vaccine preventable conditions, by state and territory of usual residence, per 1000 people, 2005-06[a]**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Influenza and pneumonia	0.5	0.4	0.6	0.7	0.6	0.4	0.4	1.4	0.5
Other conditions	0.1	0.2	0.1	0.1	0.1	0.1	0.1	0.6	0.6
Total[b]	**0.7**	**0.6**	**0.7**	**0.8**	**0.7**	**0.5**	**0.4**	**2.0**	**0.7**

[a] Separation rates are directly age standardised to the Australian population at 30 June 2001. [b] Totals may not equal the sum of individual conditions due to rounding.

Source: AIHW (2007b).

The age standardised hospital separation rate of Indigenous people for all vaccine preventable conditions was 3.1 per 1000 Indigenous people in 2005-06 for NSW, Queensland, WA, SA and the NT combined. The quality of Indigenous identification is considered acceptable for the purposes of analysis for these jurisdictions. Over 80 per cent of vaccine preventable separations for Indigenous people were accounted for by influenza and pneumonia in 2005-06 (table 11.8).

Table 11.8 **Separations of Indigenous people for vaccine preventable conditions, per 1000 Indigenous people, 2005-06**[a, b]

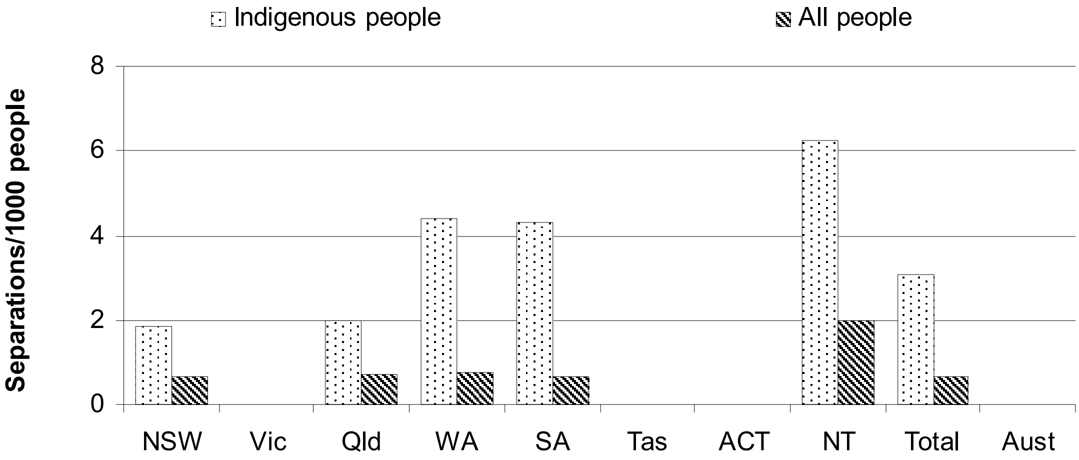
	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Total*[c]	*Aust*
Influenza and pneumonia	1.7	np	1.5	3.9	3.8	np	np	4.6	2.5	np
Other conditions	0.2	np	0.5	0.5	0.5	np	np	1.6	0.5	np
Total	**1.8**	**np**	**2.0**	**4.4**	**4.3**	**np**	**np**	**6.3**	**3.1**	**np**

[a] Separation rates are directly age standardised to the Australian population at 30 June 2001. [b] Includes data only for NSW, Queensland, WA, SA, and the NT (NT data are for public hospitals only), for which the quality of Indigenous identification is considered acceptable for purposes of analysis. Caution should be used in the interpretation of these data because of jurisdictional differences in data quality. Data for the five states and territory are not necessarily representative of other jurisdictions. [c] Total comprises NSW, Queensland, WA, SA and the NT only. **np** not published.

Source: AIHW (unpublished).

The age standardised hospital separation rate of Indigenous people for vaccine preventable conditions was higher than that for all people in 2005-06 in all jurisdictions for which data were published (figure 11.30).

Figure 11.30 **Separations for vaccine preventable conditions, 2005-06**[a, b, c, d]



[a] Separation rates are directly age standardised to the Australian population at 30 June 2001. [b] Includes data only for NSW, Queensland, WA, SA, and the NT (NT data are for public hospitals only), for which the quality of Indigenous identification is considered acceptable for purposes of analysis. Caution should be used in the interpretation of these data because of jurisdictional differences in data quality. Data for the five states and territory are not necessarily representative of other jurisdictions. [c] Total comprises NSW, Queensland, WA, SA and the NT only. [d] Indigenous separation rates are based on state of hospitalisation while all person rates are based on state of usual residence. Care should be taken when comparing the two.

Source: AIHW (unpublished).

Age standardised hospital separation rate ratios for infectious pneumonia illustrate differences between the rates of hospital admissions for Indigenous people and those for all Australians, taking into account differences in the age structures of the populations. Rate ratios close to one indicate that Indigenous people have similar separation rates to all people, while higher rate ratios indicate relative disadvantage. For both males and females there was a marked difference in 2005-06 between the separation rates for Indigenous people and those for the total population for infectious pneumonia diagnoses. For NSW, Queensland, WA, SA and the NT combined, the separation rate for Indigenous males was higher than that for all Australian males, and the separation rate for Indigenous females was higher than the rate for all females (tables 11A.41 and 11A.42).

Hospitalisations for selected acute conditions

Box 11.26 **Hospitalisations for selected acute conditions**

The effectiveness of primary and community healthcare services has a significant influence on the rates of hospitalisation for the following selected acute conditions: dehydration and gastroenteritis; pyelonephritis (kidney inflammation caused by bacterial infection); perforated/bleeding ulcer; cellulitis; pelvic inflammatory disease; ear, nose and throat infections; dental conditions; appendicitis; convulsions and epilepsy; and gangrene.

This indicator is defined as the number of hospital separations for the selected acute conditions per 1000 people. The indicator is reported for Indigenous people as well as for all people. Adjustments are made to account for differences in the age structures of these populations across states and territories.

A reduction in hospitalisation rates may indicate improvements in the effectiveness of primary and community healthcare providers' treatment of these conditions.

Factors outside the control of the primary healthcare sector also influence the rates of hospitalisation, for example, the underlying prevalence of the conditions. Public health measures not covered in this chapter may also influence hospitalisation rates.

Of the selected acute conditions, dental conditions and dehydration and gastroenteritis had the highest rates of hospitalisation nationally in 2005-06 (table 11.9).

Table 11.9 Separations for potentially preventable acute conditions, by state and territory of usual residence, per 1000 people, 2005-06[a]

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Dehydration and gastroenteritis	2.1	2.7	2.4	2.0	2.7	2.0	1.5	1.9	2.3
Pyelonephritis[b]	2.1	2.3	2.2	2.0	1.9	1.6	2.1	3.0	2.1
Perforated/bleeding ulcer	0.2	0.3	0.2	0.3	0.3	0.2	0.3	0.3	0.2
Cellulitis	1.6	1.6	1.6	1.5	1.4	1.2	1.4	4.7	1.6
Pelvic inflammatory disease	0.2	0.3	0.3	0.3	0.3	0.3	0.3	0.6	0.3
Ear, nose and throat infections	1.7	1.4	1.8	1.6	2.5	1.2	1.1	2.2	1.7
Dental conditions	2.2	3.0	2.7	3.5	3.1	1.8	1.7	1.8	2.7
Appendicitis	0.2	0.2	0.1	0.2	0.2	0.1	0.2	0.3	0.2
Convulsions and epilepsy	1.7	1.5	1.5	1.5	1.7	1.6	1.6	3.2	1.6
Gangrene	0.1	0.2	0.2	0.3	0.2	0.1	0.1	0.6	0.2
Total[c]	**12.1**	**13.4**	**13.0**	**13.0**	**14.3**	**10.0**	**10.2**	**18.6**	**12.9**

[a] Separation rates are directly age standardised to the Australian population at 30 June 2001. [b] Kidney inflammation caused by bacterial infection. [c] Totals may not equal the sum of individual components as more than one acute condition may be reported for a separation.

Source: AIHW (2007b).

The age standardised hospital separation rate of Indigenous people for all potentially preventable acute conditions was 32.1 per 1000 Indigenous people in 2005-06 for NSW, Queensland, WA, SA and the NT combined. Over half of potentially preventable acute separations for Indigenous people were accounted for by convulsions and epilepsy, pyelonephritis, and cellulitis in 2005-06 (table 11.10).

Table 11.10 **Separations of Indigenous people for potentially preventable acute conditions, per 1000 Indigenous people, 2005-06**[a, b]

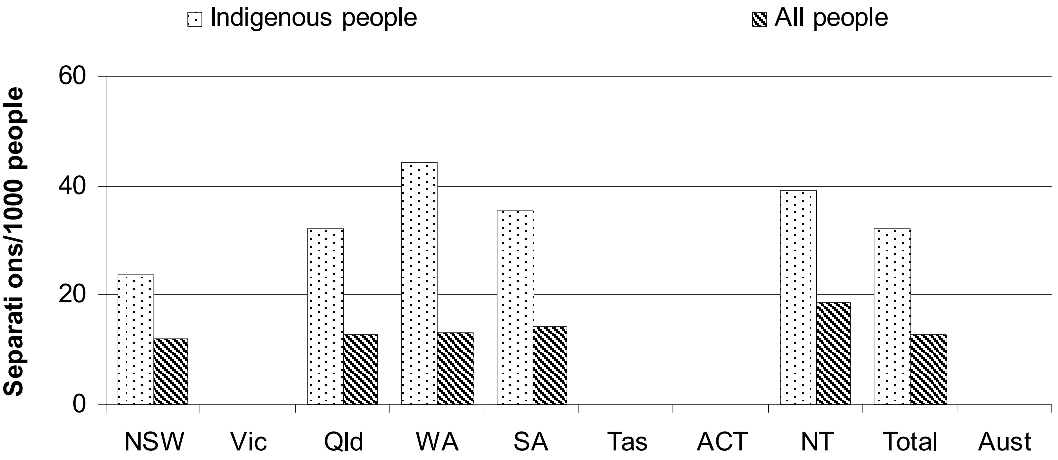
	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Total*[c]	*Aust*
Dehydration and gastroenteritis	2.7	np	4.2	5.1	5.8	np	np	3.9	3.9	np
Pyelonephritis[d]	4.8	np	7.1	7.8	5.2	np	np	7.5	6.4	np
Perforated/bleeding ulcer	0.4	np	0.4	0.2	0.2	np	np	0.2	0.3	np
Cellulitis	2.9	np	5.8	7.1	3.9	np	np	7.5	4.8	np
Pelvic inflammatory disease	0.4	np	0.6	1.0	1.1	np	np	1.6	40.7	np
Ear, nose and throat infections	3.0	np	3.7	4.3	4.7	np	np	3.4	3.6	np
Dental conditions	2.9	np	2.9	3.7	3.1	np	np	2.9	3.0	np
Appendicitis	0.2	np	0.2	0.2	0.2	np	np	0.4	0.2	np
Convulsions and epilepsy	6.1	np	6.4	12.3	10.8	np	np	10.0	8.0	np
Gangrene	0.4	np	0.9	2.5	0.5	np	np	1.8	1.1	np
Total	**23.8**	**np**	**32.2**	**44.3**	**35.4**	**np**	**np**	**39.2**	**32.1**	**np**

[a] Separation rates are directly age standardised to the Australian population at 30 June 2001. [b] Includes data only for NSW, Queensland, WA, SA, and the NT (NT data are for public hospitals only), for which the quality of Indigenous identification is considered acceptable for purposes of analysis. Caution should be used in the interpretation of these data because of jurisdictional differences in data quality. Data for the five states and territory are not necessarily representative of other jurisdictions. [c] Total comprises NSW, Queensland, WA, SA and the NT only. [d] Kidney inflammation caused by bacterial infection. **np** Not published.

Source: AIHW (unpublished).

The age standardised hospital separation rate of Indigenous people for all potentially preventable acute conditions was higher than that for all people in 2005-06 in all jurisdictions for which data were published (figure 11.31).

Figure 11.31 **Separations for potentially preventable acute conditions, 2005-06**[a, b, c, d]



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[a] Separation rates are directly age standardised to the Australian population at 30 June 2001. [b] Includes data only for NSW, Queensland, WA, SA, and the NT (NT data are for public hospitals only), for which the quality of Indigenous identification is considered acceptable for purposes of analysis. Caution should be used in the interpretation of these data because of jurisdictional differences in data quality. Data for the five states and territory are not necessarily representative of other jurisdictions. [c] Total comprises NSW, Queensland, WA, SA and the NT only. [d] Indigenous separation rates are based on state of hospitalisation while all person rates are based on state of usual residence. Care should be taken when comparing the two.

Source: AIHW (unpublished).

Hospitalisations for selected chronic conditions

Box 11.27 **Hospitalisations for selected chronic conditions**

The effectiveness of primary and community healthcare has a significant influence on the rates of hospitalisation for the following selected chronic conditions: asthma; congestive cardiac failure; diabetes complications; chronic obstructive pulmonary disease; angina; iron deficiency anaemia; hypertension; nutritional deficiencies; and rheumatic heart disease. Diabetes is considered in detail in a separate indicator.

This indicator is defined as the number of hospital separations for the selected chronic conditions per 1000 people. This indicator is reported for Indigenous people as well as for all people. Adjustments are made to account for differences in the age structures of these populations across states and territories.

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Box 11.27 **(Continued)**

A reduction in hospitalisation rates may indicate improvements in the effectiveness of primary and community healthcare providers' treatment of these conditions.

Factors outside the control of the primary healthcare sector also influence the rates of hospitalisation, for example, the underlying prevalence of the conditions. Public health measures that are not reported in this chapter may also influence the hospitalisation rates.

Of the selected chronic conditions (excluding diabetes, which is discussed below) chronic obstructive pulmonary disease, congestive cardiac failure, asthma and angina had the highest rates of hospitalisation nationally in 2005-06. The hospitalisation rate for diabetes complications was more than three times higher than the rate for any of these conditions (table 11.11).

Table 11.11 **Separations for potentially preventable chronic conditions, by state and territory of usual residence, per 1000 people, 2005-06**[a, b, c]

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Asthma	2.0	1.9	1.7	1.8	2.8	1.4	1.2	1.7	1.9
Congestive cardiac failure	1.8	2.1	1.9	1.9	1.9	1.7	1.7	2.7	1.9
Diabetes complications	7.0	8.8	9.4	24.7	8.1	12.8	5.1	14.3	9.9
Chronic obstructive pulmonary disease	2.5	2.5	2.8	2.5	3.1	2.6	1.9	5.5	2.6
Angina	1.6	1.9	2.5	1.6	1.7	1.8	1.3	3.1	1.9
Iron deficiency anaemia	0.9	1.5	0.9	1.3	1.0	1.1	0.8	1.2	1.1
Hypertension	0.3	1.2	1.4	0.2	0.3	0.3	0.2	0.3	0.3
Nutritional deficiencies	–	–	–	–	–	–	–	–	–
Rheumatic heart disease[b]	0.1	0.1	0.2	0.1	0.1	0.1	–	–	0.1
Total[c]	**15.2**	**17.8**	**18.6**	**33.2**	**17.9**	**20.8**	**11.3**	**27.3**	**18.6**

[a] Separation rates are directly age standardised to the Australian population at 30 June 2001. [b] Rheumatic heart disease includes acute rheumatic fever as well as the chronic disease. [c] Totals may not equal the sum of individual components as more than one chronic condition may be reported for a separation. – Nil or rounded to zero.

Source: AIHW (2007b).

The age standardised hospital separation rate of Indigenous people for all potentially preventable chronic conditions was 60.7 per 1000 Indigenous people in 2005-06 for NSW, Queensland, WA, SA and the NT combined. The quality of Indigenous identification is considered acceptable for the purpose of analysis only for these jurisdictions. Excluding diabetes (discussed below), chronic obstructive pulmonary disease, congestive cardiac failure and angina had the highest potentially preventable chronic hospitalisation rates for Indigenous people in 2005-06 (table 11.12).

Table 11.12 **Separations of Indigenous people for potentially preventable chronic conditions, per 1000 Indigenous people, 2005-06**[a, b]

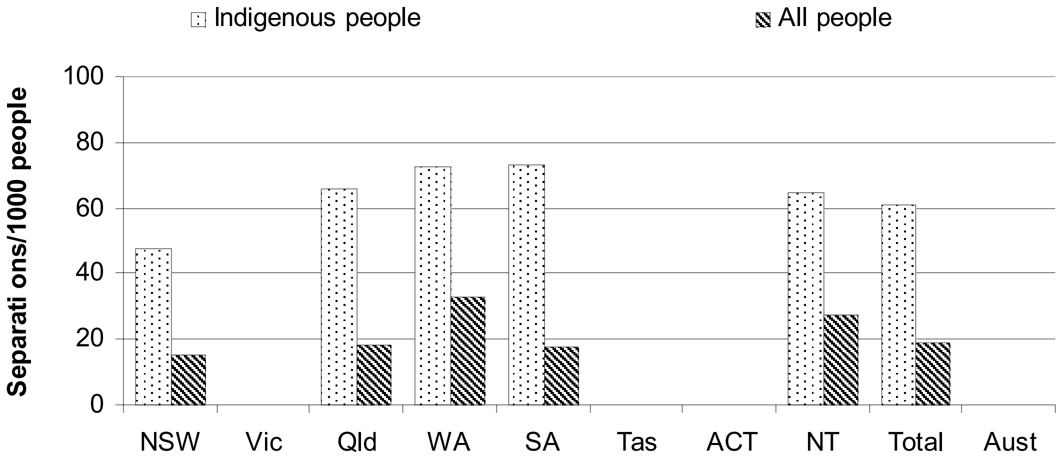
	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Total*[c]	*Aust*
Asthma	4.1	np	4.7	6.6	6.9	np	np	2.8	4.7	np
Congestive cardiac failure	4.9	np	9.4	9.4	7.5	np	np	6.7	7.3	np
Diabetes complications[d]	21.4	np	34.1	42.7	42.2	np	np	34.2	31.6	np
Chronic obstructive pulmonary disease	13.8	np	14.7	12.2	15.9	np	np	16.5	14.2	np
Angina	4.8	np	6.7	5.4	6.4	np	np	5.1	5.6	np
Iron deficiency anaemia	1.4	np	1.2	2.8	1.4	np	np	2.4	1.7	np
Hypertension	1.1	np	1.6	1.0	0.9	np	np	0.8	1.2	np
Nutritional deficiencies	0.0	np	0.0	0.0	0.0	np	np	0.1	0.0	np
Rheumatic heart disease[e]	0.1	np	1.0	0.8	0.4	np	np	2.2	0.8	np
Total	**47.3**	**np**	**65.9**	**72.3**	**73.2**	**np**	**np**	**64.7**	**60.7**	**np**

[a] Separation rates are directly age standardised to the Australian population at 30 June 2001. [b] Includes data only for NSW, Queensland, WA, SA, and the NT (public hospitals only), for which the quality of Indigenous identification is considered acceptable for purposes of analysis. Caution should be used in the interpretation of these data because of jurisdictional differences in data quality. Data for the five states and territory are not necessarily representative of other jurisdictions. [c] Total comprises NSW, Queensland, WA, SA and the NT only. [d] Excludes separations with a principal diagnosis of renal dialysis and an additional diagnosis of diabetes. [e] Rheumatic heart disease includes acute rheumatic fever as well as the chronic disease. **np** Not published.

Source: AIHW (unpublished).

The age standardised hospital separation rate of Indigenous people for all potentially preventable chronic conditions was higher than that for all people in 2005-06 in all jurisdictions for which data were published (figure 11.32).

Figure 11.32 Separations for potentially preventable chronic conditions, 2005-06[a, b, c]



[a] Separation rates are directly age standardised to the Australian population at 30 June 2001. [b] Includes data only for NSW, Queensland, WA, SA, and the NT (NT data are for public hospitals only), for which the quality of Indigenous identification is considered acceptable for purposes of analysis. Caution should be used in the interpretation of these data because of jurisdictional differences in data quality. Data for the five states and territory are not necessarily representative of other jurisdictions. [c] Indigenous separation rates are based on state of hospitalisation while all person rates are based on state of usual residence. Care should be taken when comparing the two.

Source: AIHW (unpublished).

Hospitalisations for diabetes

Box 11.28 Hospitalisations for diabetes

The effectiveness of primary and community healthcare has a significant influence on the rates of hospitalisation for diabetes.

Hospital separation rates are reported for patients with diabetes mellitus as the principal diagnosis, and for patients with a lower limb amputation as well as a principal or additional diagnosis of diabetes. These rates are calculated per 100 000 people and adjusted to account for differences in the age structures of State and Territory populations.

A reduction in these rates may indicate an improvement in GPs' and community health providers' management of patients' diabetes.

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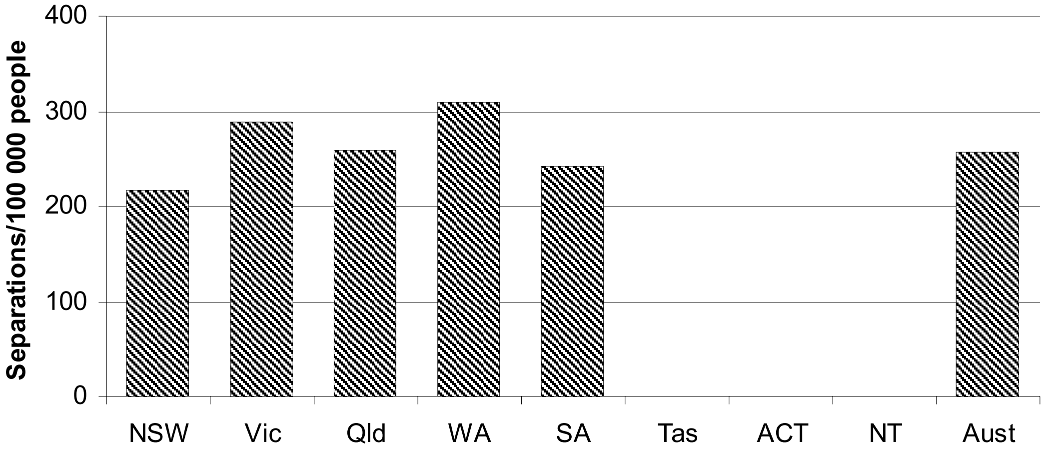
Box 11.28 **(Continued)**

A comparison of Indigenous and all other people is also made by presenting the ratio of age standardised hospital separation rates of Indigenous people to all people. Rate ratios close to one indicate that Indigenous people have similar separation rates to all people, while higher rate ratios indicate relative disadvantage.

Factors outside the control of the primary healthcare sector also influence the rates of hospitalisation, for example, the underlying prevalence of the conditions. Public health measures that are not reported in this chapter may also influence the hospitalisation rates.

Australia-wide, the age standardised hospital separation rate in 2005-06 where the principal diagnosis was Type 2 diabetes mellitus was 257.7 separations per 100 000 people (figure 11.33).

Figure 11.33 **Separations for Type 2 diabetes mellitus as principal diagnosis, all hospitals, 2005-06**[a, b, c, d]



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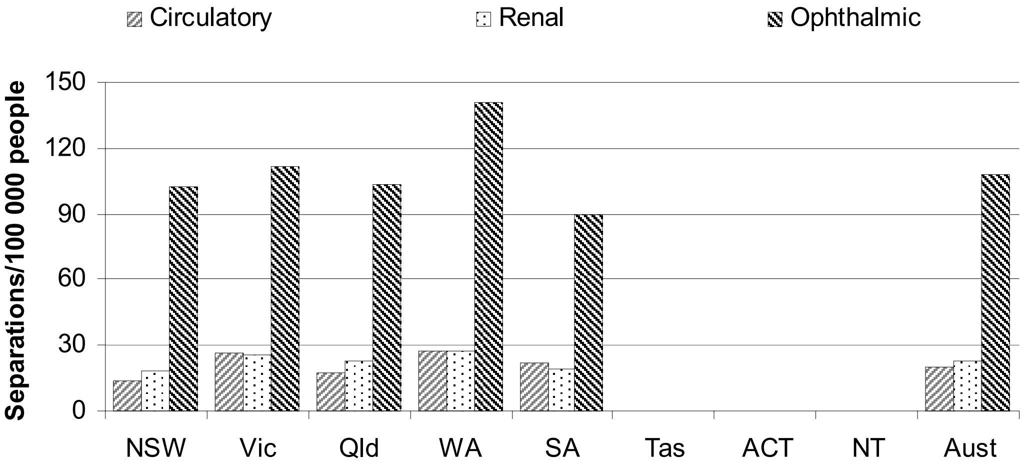
[a] Results for individual complications may be affected by small numbers, and need to be interpreted with care. [b] Differences across jurisdictions in policy and practice relating to the admission of patients, the availability of outpatient services and the incentives to admit patients rather than treat them as outpatients will affect estimates of hospital separations. [c] Morbidity data are coded under coding standards that may differ over time and across jurisdictions. [d] Data for Tasmania, the ACT and the NT are not published separately (due to hospital confidentiality arrangements) but are included in the total for Australia.

Source: AIHW (unpublished); table 11A.43.

The three most common complications from Type 2 diabetes that led to hospitalisation in 2005-06 were ophthalmic, renal and circulatory complications. Across all jurisdictions for which data were published, the highest hospital separation rates were for ophthalmic complications (figure 11.34). Each patient may have one or more complication (circulatory, renal and ophthalmic) for each diabetes hospital separation.

Figure 11.34 **Proportion of separations for principal diagnosis of Type 2 diabetes mellitus by selected complications, all hospitals, 2005-06**[a, b, c, d]



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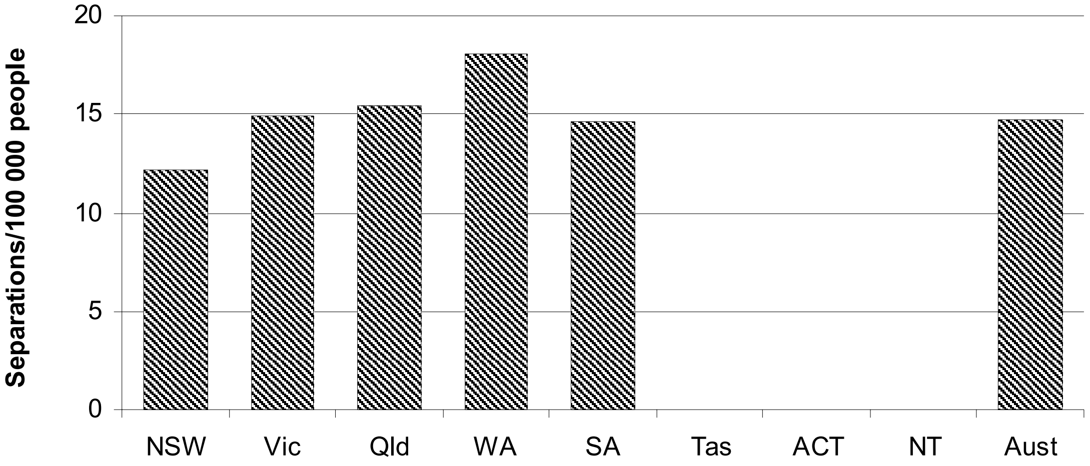
[a] Results for individual complications may be affected by small numbers, and need to be interpreted with care. [b] Differences across jurisdictions in policy and practice relating to the admission of patients, the availability of outpatient services and the incentives to admit patients rather than treat them as outpatients will affect estimates of hospital separations. [c] Morbidity data are coded under coding standards that may differ over time and across jurisdictions. [d] Data for Tasmania, the ACT and the NT are not published separately (due to private hospital confidentiality arrangements) but are included in the total for Australia.

Source: AIHW (unpublished); table 11A.43.

Treatment for Type 2 diabetes and related conditions is also provided in ambulatory care settings but the number of people accessing ambulatory services is not included in the hospital separations data. Differences across jurisdictions in policy and practice relating to the admission of patients, the availability of outpatient services and the incentives to admit patients rather than treat them as outpatients affect hospital separation rates. This effect is partly reflected in the substantial variation in the proportion of separations that are ‘same day’ across jurisdictions. Nationally, 48.0 per cent of separations for Type 2 diabetes were same day in 2005-06 (table 11A.44).

Amputation of a lower limb can be an outcome of serious diabetes-related complications. In 2005-06, there were 14.7 hospital separations per 100 000 people (age standardised) for lower limb amputations where Type 2 diabetes mellitus was a principal or additional diagnosis (figure 11.35).

Figure 11.35 **Separations for lower limb amputation with principal or additional diagnosis of Type 2 diabetes, all hospitals, 2005-06**[a, b, c]



[a] Separation rates are directly age standardised to the Australian population at 30 June 2001. [b] Includes unspecified diabetes. The figures are based on the ICD-10-AM classification. The codes used are ICD-10-AM diagnosis codes E11.x for diabetes, and ICD-10-AM procedure block 1533 and procedure codes 44370-00, 44373-00, 44367-00, 44367-01 and 44367-02 for lower limb amputation. [c] Data for Tasmania, the ACT and the NT are not published separately (due to private hospital confidentiality arrangements) but are included in the total for Australia.

Source: AIHW (unpublished); table 11A.45.

Age standardised hospital separation ratios for all diabetes diagnoses[2] illustrate differences between the rate of hospital admissions for Indigenous people and that for all Australians, taking into account differences in the age structures of the two populations. For both males and females there was a marked difference in 2005-06 between the separation rates for Indigenous people and those for the total population for all diabetes diagnoses. The quality of Indigenous identification is considered acceptable for the purpose of analysis only for NSW, Queensland, WA, SA and the NT. For these jurisdictions combined, the separation rate for Indigenous males was 7.3 times higher than those for all Australian males. The separation rate for Indigenous females was 12.2 times the rate for all females (figure 11.36).

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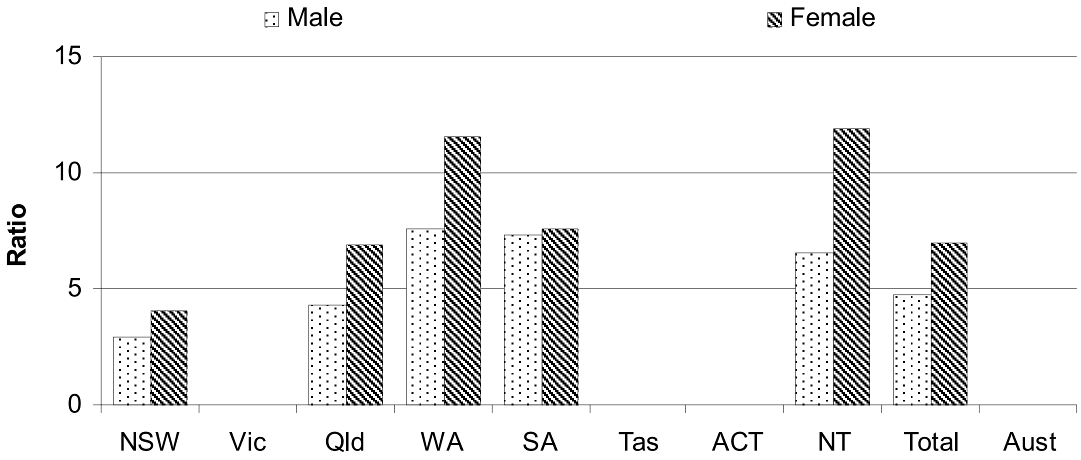
[2] 'All diabetes' refers to separations with either a principal or additional diagnosis of diabetes, except where dialysis is the principal diagnosis.

Figure 11.36 **Ratio of separation rates of Indigenous people to all people for all diabetes diagnoses, 2005-06**[a, b, c, d, e]



[a] The ratios are directly age-standardised to the estimated resident population at 30 June 2001. [b] The Total includes data only for NSW, Queensland, WA, SA and the NT (NT data for public hospitals only), for which the quality of Indigenous identification is considered acceptable for purposes of analysis. Data for the five states and territory are not necessarily representative of the other jurisdictions. [c] 'All diabetes' refers to separations with a principal and/or additional diagnosis of diabetes, except where dialysis is the principal diagnosis. [d] Patients aged 75 years and over are excluded. [e] Indigenous separation rates are based on state of hospitalisation while all person rates are based on state of usual residence. Caution should be used in the interpretation of these data because of jurisdictional differences in data quality.

Source: AIHW (unpublished); tables 11A.41and 11A.42.

Hospitalisations of older people for falls

Box 11.29 **Hospitalisation of older people for falls**

The effectiveness of primary and community healthcare has an influence on the rates of hospitalisation of older people for falls. Primary and community healthcare can help to prevent falls occurring or may assist in reducing the severity of injury from a fall and also the chance of hospitalisation.

The indicator is defined as the number of hospital separations for older people with a reported external cause of falls per 1000 older people, adjusted to take account of differences in State and Territory age distributions. Older people are defined as aged 65 years or over for this indicator.

(Continued on next page)

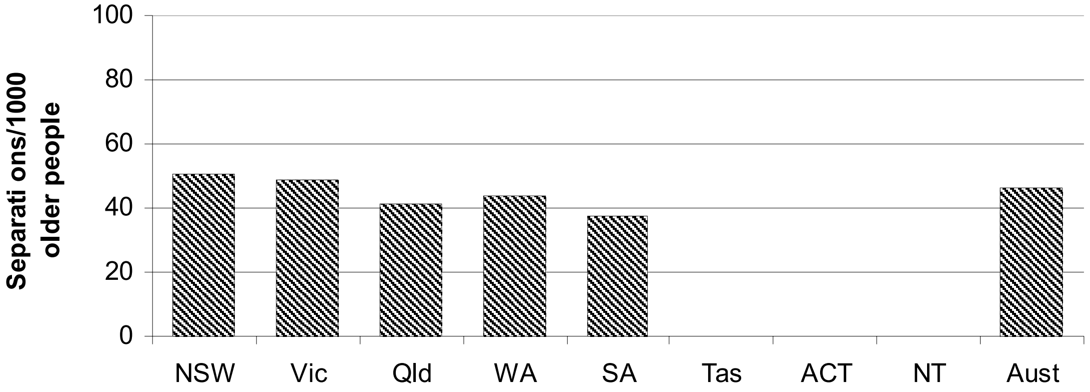
Box 11.29 **(Continued)**

A reduction in the rate of hospitalisation due to falls may indicate improvements in the effectiveness of primary healthcare services provided to older people who are at risk of falls.

Factors outside the control of the primary healthcare system also influence the rates of hospitalisation. These include the support available to older people from family and friends, and the provision of aged care services such as Home and Community Care program services and residential care.

Nationally, the hospital separation rate in 2005-06 for older people with injuries due to falls was 46.2 per 1000 older people (figure 11.37).

Figure 11.37 **Separations for older people with a reported external cause of falls, 2005-06**[a, b, c]



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[a] Older people are defined as people aged 65 years or over. In previous reporting against this indicator, older people were defined as people aged 75 years and over and Indigenous people aged 55 years and over. [b] Data for Tasmania, the ACT and the NT are not published separately (due to private hospital confidentiality arrangements) but are included in the total for Australia. [c] Separation rates are crude rates using the 2005 population aged 65 years and over as denominator.

Source: AIHW (unpublished); table 11A.46.

11.4 Future directions in performance reporting

While the topic of this chapter is all primary and community health services, the indicators remain heavily focused on general practice services. This partly reflects the lack of data available on a nationally consistent basis to support reporting against indicators for other primary and community health services. The Steering Committee has identified possible areas for which indicators may be available for inclusion in the 2009 Report or future reports. These include:

- dental health services
- community-based drug and alcohol treatment services
- additional indicators relating to the use of the MBS chronic disease management items
- management of asthma
- management of diabetes.

In addition, the currently reported indicator ‘management of upper respiratory tract infection’ has been identified for reporting improvements.

The scope of this chapter may also be further refined to ensure the most appropriate reporting of primary health services against the Review’s terms of reference and reporting framework (see chapter 1).

Indigenous health

Barriers to accessing primary health services contribute to the poorer health status of Indigenous people compared to other Australians (see the ‘Health preface’). In recognition of this issue, the Steering Committee has identified primary and community health services for Indigenous people as a priority area for future reporting. The ‘early detection and early treatment’ indicator of accessibility of primary and community health services to Indigenous people has been included in the 2008 Report. The Steering Committee will continue to examine options for the inclusion of further such indicators. The Aboriginal and Torres Strait Islander Health Performance Framework developed under the auspices of the Australian Health Ministers’ Advisory Council will inform the selection of future indicators of primary and community health services to Indigenous people.

The completeness of Indigenous identification in hospital admitted patient statistics remains variable across states and territories. There has been some improvement, for example, NSW data are now considered to be of acceptable quality, whereas on previous assessment this was not the case. Victorian data are being considered for publication. The quality of data for Tasmania and the ACT is considered to be too poor for publication. Continued efforts to improve Indigenous identification are necessary in order to better measure the performance of primary and community health services in relation to the health of Indigenous Australians. The AIHW is currently undertaking a project to develop best practice guidelines for identification.

11.5 Definitions of key terms and indicators

Age standardised	Removing the effect of different age distributions (across jurisdictions or over time) when making comparisons, by weighting the age-specific rates for each jurisdiction by the national age distribution.
Cervical screening rates for target population	Proportion of women aged 20–69 years who are screened for cervical cancer over a two year period.
Closed treatment episode	A closed treatment episode is a period of contact between a client and an alcohol and other drug treatment agency. It has defined dates of commencement and cessation, during which the principal drug of concern, treatment delivery setting and main treatment type did not change. Reasons for cessation of a treatment episode include treatment completion, and client non-participation in treatment for three months or more. Clients may be involved in more than one closed treatment episode in the data collection period.
Community health services	Health services for individuals and groups delivered in a community setting, rather than via hospitals or private facilities.
Consultations	The different types of services provided by GPs.
Cost to government of general practice per person	Cost to the Australian Government of total non-referred attendances by non-specialist medical practitioners per person.
Divisions of General Practice	Geographically-based networks of GPs. There are 119 Divisions of General Practice, 8 State Based Organisations and a peak national body, the Australian General Practice Network (AGPN). The Divisions of General Practice Program evolved from the former Divisions and Projects Grants Program established in 1992. The Divisions of General Practice Program aims to contribute to improved health outcomes for communities by working with GPs and other health services providers to improve the quality and accessibility of health care at the local level.
Full time workload equivalents (FWE)	A measure of medical practitioner supply based on claims processed by Medicare in a given period, calculated by dividing the practitioner's Medicare billing by the mean billing of full time practitioners for that period. Full time equivalents are calculated in the same way as FWE except that full time equivalents are capped at 1 for each practitioner.
Fully immunised at 12 months	A child who has completed three doses of diphtheria, tetanus, pertussis vaccine, three doses of oral polio vaccine and three doses of HbOC (HibTITER) (or two doses of PRP-OMP [PedvaxHIB]).
Fully immunised at 24 months	A child who has received four doses of diphtheria, tetanus, pertussis vaccine, three doses of oral polio vaccine, four doses of HbOC (HibTITER) (or three doses of PRP-OMP [PedvaxHIB]) and one dose of measles, mumps and rubella vaccine.
General practice	The organisational structure with one or more GPs and other staff such as practice nurses. A general practice provides and supervises healthcare for a 'population' of patients and may include services for specific populations, such as women's health or Indigenous health.

General practitioner (GP)	Vocationally recognised GPs — medical practitioners who are vocationally recognised under s.3F of the *Health Insurance Act 1973* (Cwlth), hold Fellowship of the RACGP, ACRRM, or equivalent (From 1996, vocational registration was available only to GPs who attained Fellowship of the RACGP; since April 2007, it has also been available to Fellows of the ACRRM), or hold a recognised training placement. Other medical practitioners — medical practitioners who are not vocationally recognised GPs.
Health management	An ongoing process beginning with initial client contact and including all actions relating to a client. Includes: assessment/evaluation; education of the person, family or carer(s); diagnosis and treatment; management of problems associated with adherence to treatment; and liaison with, or referral to, other agencies.
Immunisation coverage	A generic term indicating the proportion of a target population that is fully immunised with a particular vaccine or the specified vaccines from the National Immunisation Program for that age group.
Management of upper respiratory tract infections	Number of prescriptions ordered by GPs for the oral antibiotics most commonly used in the treatment of upper respiratory tract infections per 1000 people with PBS concession cards.
Non-referred attendances	GP services, emergency attendances after hours, other prolonged attendances, group therapy and acupuncture. All attendances for specialist services are excluded because these must be 'referred' to receive Medicare reimbursement.
Non-referred attendances that are bulk billed	Number of non-referred attendances that are bulk billed and provided by medical practitioners, divided by the total number of non-referred non-specialist attendances.
Nationally notifiable disease	A communicable disease that is on the Communicable Diseases Network Australia's endorsed list of diseases to be notified nationally (DoHA 2004). On diagnosis of these diseases, there is a requirement to notify the relevant State or Territory health authority.
Notifications of selected childhood diseases	Number of cases of measles, pertussis and *Haemophilus influenzae* type b notified to State and Territory health authorities.
Other medical practitioner (OMP)	A medical practitioner other than a vocationally recognised GP who has at least half of the schedule fee value of his/her Medicare billing from non-referred attendances. These practitioners are able to access only the lower A2 Medicare rebate for general practice services they provide, unless the services are provided through certain Departmental incentive programs.
Pap smear	A procedure for the detection of cancer and pre-cancerous conditions of the female cervix.
Per person benefits paid for GP ordered pathology	Total benefits paid for pathology tests ordered by GPs, divided by the population.
Per person benefits paid for GP referred diagnostic imaging	Total benefits paid for diagnostic imaging tests referred by GPs, divided by the population.

Primary healthcare	The primary and community healthcare sector includes services that: • provide the first point of contact with the health system • have a particular focus on illness prevention or early intervention • are intended to maintain people's independence and maximise their quality of life through care and support at home or in local community settings.
Prevalence	The proportion of the population suffering from a disorder at a given point in time (point prevalence) or during a given period (period prevalence).
Proportion of GPs who are female	Number of all FWE GPs who are female, divided by the total number of FWE GPs.
Proportion of GPs with vocational recognition	Number of FWE GPs who are vocationally recognised, divided by the total number of FWE GPs.
Proportion of general practices registered for accreditation	Number of practices that have registered for accreditation through either of the two accreditation bodies, AGPAL and GPA ACCREDITATION *plus*, divided by the total number of practices in the Divisions of General Practice.
Proportion of general practices with electronic information management systems	Number of practices that maintain and/or use predominantly secure electronic patient records, that are registered under the PIP, divided by the total number of practices registered.
Public health	The organised, social response to protect and promote health and to prevent illness, injury and disability. The starting point for identifying public health issues, problems and priorities, and for designing and implementing interventions, is the population as a whole or population subgroups. Public health is characterised by a focus on the health of the population (and particular at-risk groups) and complements clinical provision of healthcare services.
Reasons for encounter	The expressed demand of the patient for care, as perceived and recorded by the GP.
Recognised immunisation provider	A provider recognised by Medicare Australia as a provider of immunisation to children.
Recognised specialist	A medical practitioner classified as a specialist on the Medicare database earning at least half of his or her income from relevant specialist items in the schedule, having regard to the practitioner's field of specialist recognition.
Screening	The performance of tests on apparently well people to detect a medical condition at an earlier stage than would otherwise be possible without the test.
Vocationally recognised general practitioner	A medical practitioner who is vocationally recognised under s.3F of the *Health Insurance Act 1973* (Cwlth), holds Fellowship of the RACGP, ACRRM, or equivalent, or holds a recognised training placement, and who has at least half of the schedule fee value of his/her Medicare billing from non-referred attendances.

11.6 Attachment tables

Attachment tables are identified in references throughout this chapter by a ‘11A’ suffix (for example, table 11A.3 is table 3 in the attachment). Attachment tables are provided on the CD-ROM enclosed with the Report and on the Review website (www.pc.gov.au/gsp). On the CD-ROM, the files containing the attachment tables are in Microsoft Excel format as \Publications\Reports\2008\Attach_11A.xls and in Adobe PDF format as \Publications\Reports\2008\Attach_11A.pdf. Users without access to the CD-ROM or the website can contact the Secretariat to obtain the attachment tables (see contact details on the inside front cover of the Report).

Table 11A.47	Australian Government, community health services programs
Table 11A.48	New South Wales, community health services programs
Table 11A.49	Victoria, community health services programs
Table 11A.50	Queensland, community health services programs
Table 11A.51	Western Australia, community health services programs
Table 11A.52	South Australia, community health services programs
Table 11A.53	Tasmania, community health services programs
Table 11A.54	Australian Capital Territory, community health services programs
Table 11A.55	Northern Territory, community health services programs

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12 Health management issues

Health management is concerned with the management of diseases, illnesses and injuries using a range of services (promotion, prevention/early detection and intervention) in a variety of settings (for example, public hospitals, community health centres and general practice). This chapter reports on the management of breast cancer and mental health, which represent some activities of the Australian, State and Territory governments in health management.

Overviews of health management and the health management performance measurement framework are provided in sections 12.1 and 12.2 respectively. Sections 12.3 and 12.4 report on the performance of breast cancer and mental health management respectively. Section 12.5 outlines the future directions for the chapter, while jurisdictions' comments relating to all the health chapters appear in section 12.6. Definitions are listed in section 12.7. Attachment tables are identified in references throughout this chapter by an 'A' suffix (for example, table 12A.3 is table 3 in the attachment). Attachment tables are available on the CD-ROM enclosed with the Report and from the Review website www.pc.gov.au/gsp. Section 12.8 lists the attachment tables for this chapter and section 12.9 lists references used in the chapter.

12.1 Overview of health management

Health management is the ongoing process beginning with initial client contact and including all actions relating to the client: assessment/evaluation; education of the person, family or carer(s); diagnosis; and treatment. Problems associated with adherence to treatment and liaison with, or referral to, other agencies are also included.

This chapter examines the performance of a number of services in influencing outcomes for women with breast cancer and for people with a mental illness. Breast cancer and mental illness are significant causes of morbidity and mortality in Australia. Cancer control and mental health are identified by governments as national health priority areas (as are asthma, cardiovascular health, diabetes mellitus, injury prevention and control, arthritis and musculoskeletal conditions). The national health priority areas represent almost 80 per cent of the total burden of disease and injury in Australia, and their management offers considerable scope for reducing this burden (AIHW 2003b).

Breast cancer detection and management services comprise a number of major components: primary care and community-based services, including general practitioner (GP) services and community-based women's health services; screening services; acute services based in hospitals, including both inpatient and outpatient services; private consultations for a range of disciplines; and post-acute services, including home-based and palliative care (DHS 1999). Relevant clinical disciplines include surgery, plastic and reconstructive surgery, pathology, radiation and medical oncology, nursing, diagnostic radiology, radiography, physiotherapy, allied health, and psychological and psychiatric services. Post-acute services include a range of further treatments, such as radiotherapy and chemotherapy (most of which take place on a same day or outpatient basis) and a range of follow-up and palliative care services (DHS 1999).

Specialist mental health management services include a range of government and non-government service providers offering promotion, prevention, treatment and management, and rehabilitation services. Community mental health facilities, psychiatrists, clinical psychologists, psychotherapists, mental health clinicians in private practice, counsellors, Aboriginal health workers, Aboriginal mental health workers, public hospitals with specialist psychiatric units and stand-alone psychiatric hospitals all provide specialist mental health care. In addition, a number of health services provide care to mental health patients in a non-specialist health setting — for example, GPs, Aboriginal community controlled health services, public hospital emergency departments and outpatient departments, and public hospital general wards (as opposed to specialist psychiatric wards). Some people with a mental disorder are cared for in residential aged care services.

Both breast cancer and mental health are subjects of programs designed to improve public health. Public health programs require the participation of public hospitals, primary and community health services, and other services. The performance of public hospitals is discussed in chapter 10 and the performance of primary and community health services generally is discussed in chapter 11.

Several improvements have been made to the chapter this year:

- Time series data on five year relative breast cancer survival rates are reported.
- BreastScreen Australia geographic location participation rates have changed from reporting on two categories ('metropolitan or capital city' and 'rural and remote or rest of State') to reporting on five Australian Standard Geographical Classification categories: major cities, inner regional, outer regional, remote and very remote.

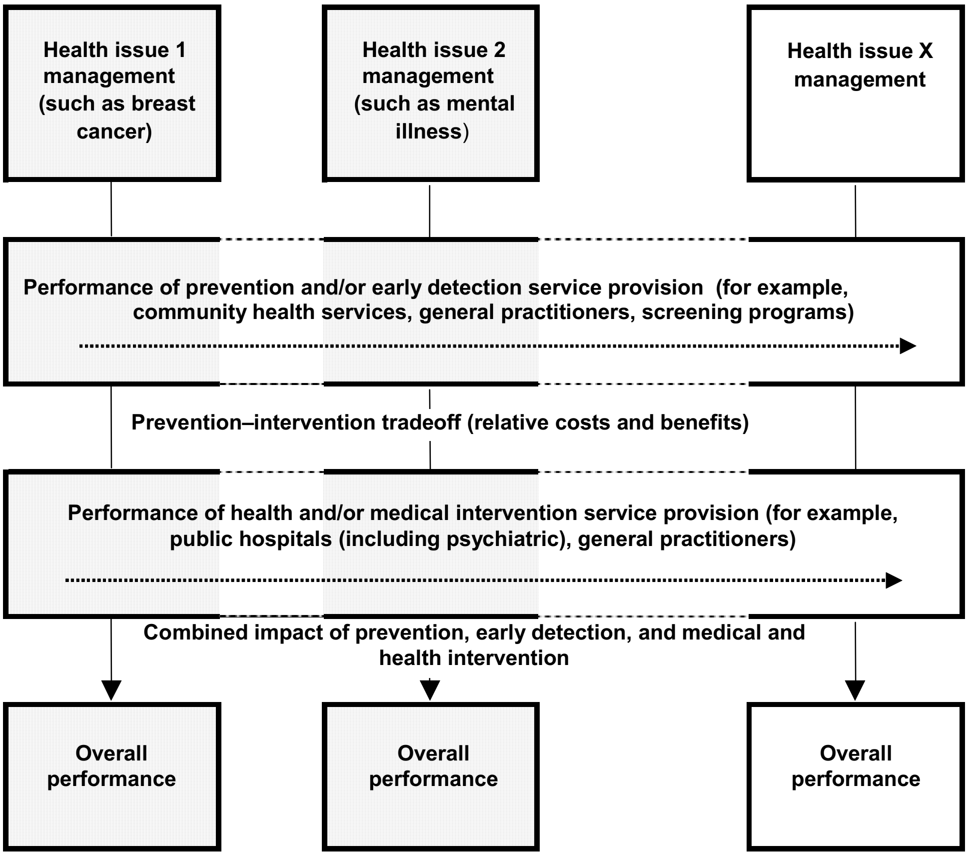
- Public health expenditure on breast cancer screening has been refined to present expenditure on a per female aged 40 years and over basis, rather than a per person basis.
- Data for Indigenous people on levels of psychological distress (K5) have been included.
- The following 'yet to be developed' indicators for mental health are included (it is expected that data for these indicators will be reported in the 2009 Report):
  - 'rates of community follow up for people within the first seven days of discharge from hospital'
  - 'readmissions to hospital within 28 days of discharge'.

12.2 Framework for measuring the performance of health management

Policy makers are seeking alternative service delivery settings and a more coordinated approach to managing health problems. Measuring performance in the management of a health problem involves measuring the performance of both service providers, and the overall management of a spectrum of services, including prevention, early detection and treatment programs.

The 'Health preface' of this Report outlines the complexities of reporting on the performance of the overall health system in meeting its objectives. Frameworks for public hospitals and primary and community health services report the performance of particular service delivery mechanisms. The appropriateness of the mix of services (prevention versus intervention) and the appropriateness of the mix of delivery mechanisms (hospital-based versus community-based) are the focus of reporting in this chapter. The measurement approach is represented diagrammatically in figure 12.1.

Figure 12.1 **The Australian health system — measurement approach**



The appropriate mix of services — including the prevention of illness and injury, medical treatment and the appropriate mix of service delivery mechanisms — is measured by focusing on a specific health management issue (represented by the vertical arrows). As in previous years, the chapter covers breast cancer detection and management, and specialised mental health services. The breast cancer management framework integrates early detection and medical intervention strategies, which should inform the decisions in the allocation of resources between these two strategies. The mental health framework provides information on the interaction and integration arrangements between community-based and hospital-based providers in meeting the needs of Australians with a mental illness.

12.3 Breast cancer

Profile

Breast cancer is a disease whereby uncontrolled or malignant cell division leads to the formation of a tumour or tumours in a woman's breast (box 12.1).[1] Tumours may expand locally by invading surrounding tissue, or they may spread via the lymphatic or vascular systems to the rest of the body. If left untreated, most malignant tumours result in the death of the affected person (AIHW 2003a). The focus of this Report is on invasive cancers, although some data are reported on ductal carcinoma in situ (DCIS — noninvasive tumours residing in the ducts of the breast).

Box 12.1 **Some common health terms used in breast cancer detection and management**

breast conserving surgery: an operation to remove the breast cancer but not the breast itself. Types of breast conserving surgery include lumpectomy (removal of the lump), quadrantectomy (removal of one quarter of the breast) and segmental mastectomy (removal of the cancer as well as some of the breast tissue around the tumour and the lining over the chest muscles below the tumour).

BreastScreen Australia: BreastScreen Australia is the national mammographic population screening program. It is aimed at well women, without symptoms or family history. It provides free screening mammograms at two-yearly intervals for women aged 50–69 with the aim of reducing deaths from breast cancer in this target group through early detection of the disease. Women aged 40–49 years and 70 years and over are eligible to attend but are not actively targeted. Services provided by BreastScreen Australia include all screening and assessment services to the point of diagnosis. The program includes health promotion activities, information provision, counselling and data collection across the screening and assessment pathways. BreastScreen Australia is jointly funded by the Australian, State and Territory governments.

ductal carcinoma in situ (DCIS): abnormal cells that involve only the lining of a duct. The cells have not spread outside the duct to other tissues in the breast. DCIS is also known as intraductal carcinoma.

(Continued on next page)

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[1] Breast cancer in males is rare. It is not examined in this Report.

Box 12.1 **(Continued)**

incidence rate: the proportion of the population newly diagnosed with a particular disorder or illness during a given period (often expressed per 100 000 people).

invasive cancer: a tumour whose cells invade healthy or normal tissue.

prevalence: the number of cases of a disease present in a population at a given time (point prevalence) or during a given period (period prevalence).

screening: the performance of tests on apparently well people to detect disease at an earlier stage than would otherwise be the case.

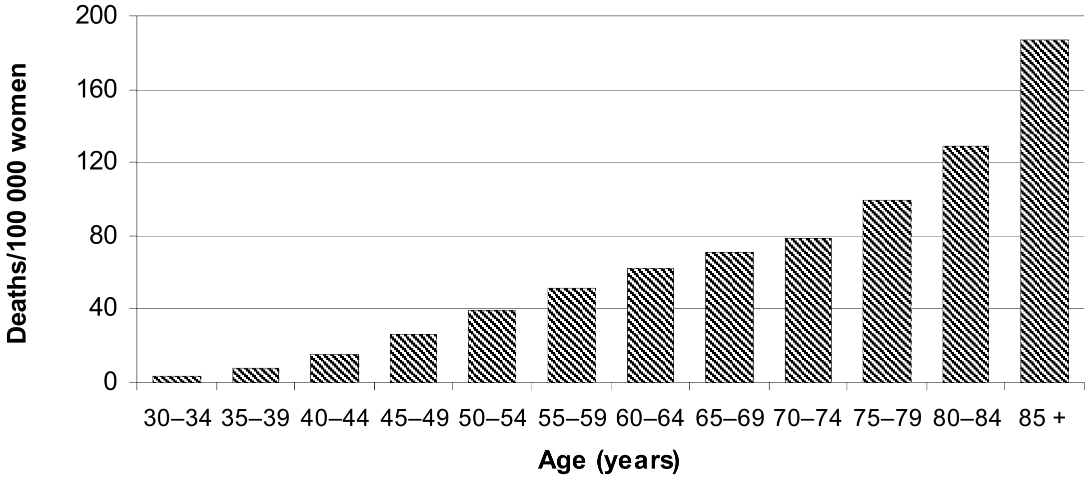
screening round (first): a woman's first visit to a BreastScreen Australia service.

screening round (subsequent): a woman's second or subsequent visit to a BreastScreen Australia service.

total mastectomy: removal of the breast (also known as a simple mastectomy).

Breast cancer was responsible for 2719 female deaths in 2005, making it one of the most frequent causes of death from cancer for females (ABS 2007). The strong relationship between age and the mortality rate from breast cancer is shown for the period 2001–2005 in figure 12.2. Women aged 40–44 years had an annual average mortality rate over this period of 15.6 per 100 000, whereas women aged 75–79 years had an annual average mortality rate of 99.3 per 100 000.

Figure 12.2 **Annual average mortality rates from breast cancer, by age group, 2001–2005**

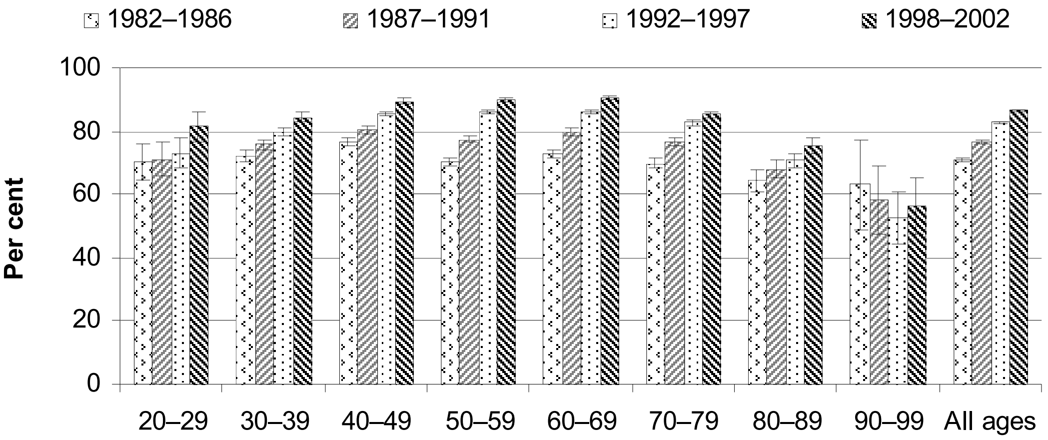


Source: Australian Institute of Health and Welfare (unpublished); table 12A.1.

Relative survival after diagnosis of breast cancer in females is good compared with other cancers. The relative survival rate 10 years after diagnosis was 73.6 per cent for women diagnosed in 1992–1997 (AIHW and NBBC 2006). For women diagnosed during the period 1998–2002, the relative survival rate was 96.7 per cent one year after diagnosis, and 86.6 per cent five years after diagnosis.

There was a significant increase in the five year relative survival rate after diagnosis of breast cancer in females between 1982–1986 and 1998–2002 (figure 12.3). Five year relative survival for breast cancer in Australia at diagnosis over the period 1998–2002 increased with age from the age group 20–29 years (81.5 per cent) to a peak for the age groups 40–49 years (89.5 per cent), 50–59 years (90.0 per cent) and 60–69 years (90.4 per cent). The five year relative survival rate declined with age for women over 70 years (figure 12.3).

Figure 12.3 **Breast cancer five year relative survival at diagnosis, by age group[a]**



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[a] Five year relative survival results for the 0–19 age group are not presented because interpretation is made difficult by statistical instability.

Source: AIHW and NBBC (2006); table 12A.2.

Incidence and prevalence

Breast cancer is the most prevalent type of cancer affecting Australian women. In 2001, the estimated risk of a woman in Australia developing breast cancer before the age of 75 years was one in eleven (AIHW and AACR 2004). The number of new cases of breast cancer diagnosed in Australian women increased from an annual average of 10 526 over the period 1996–2000 to an annual average of 11 823 over the period 2000–2004 (table 12.1). The increase in the number of cases detected reflected both an increase in the underlying rate of breast cancer, as well as the early detection of cancers that previously would not have been discovered for some years, primarily through the activity of BreastScreen Australia (AIHW 2003a).

Table 12.1 **Annual average new cases of breast cancer diagnosed (number)**[a]

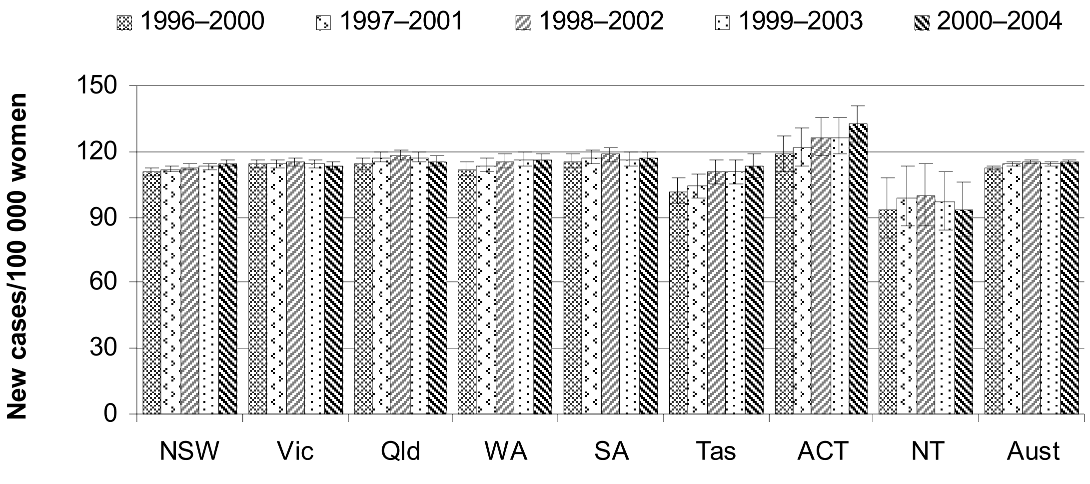
	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
1996–2000	3 573	2 726	1 887	953	930	249	159	50	10 526
1997–2001	3 698	2 792	2 000	999	962	261	169	54	10 936
1998–2002	3 813	2 864	2 078	1 045	991	282	182	55	11 310
1999–2003	3 895	2 892	2 132	1 087	989	287	187	59	11 529
2000–2004	4 023	2 940	2 177	1 112	1 010	300	200	60	11 823

[a] A new case is defined as a person who has a cancer diagnosed for the first time. One person may have more than one cancer, so may be counted twice in incidence statistics if it is decided that the two cancers are not of the same origin.

Source: AIHW (unpublished); table 12A.3.

Annual average age standardised incidence rates of breast cancer are presented in figure 12.4. Breast cancer incidence data are averaged over five year periods to smooth volatility in year-on-year movements, particularly for smaller jurisdictions that tend to have fewer cases and relatively large variations in rates from year to year. The Australian incidence rate increased from an annual average of 112.4 per 100 000 women for the period 1996–2000 to an annual average of 114.9 for the period 2000–2004.

Figure 12.4 **Annual average age standardised incidence rates of breast cancer for women of all ages**[a, b]

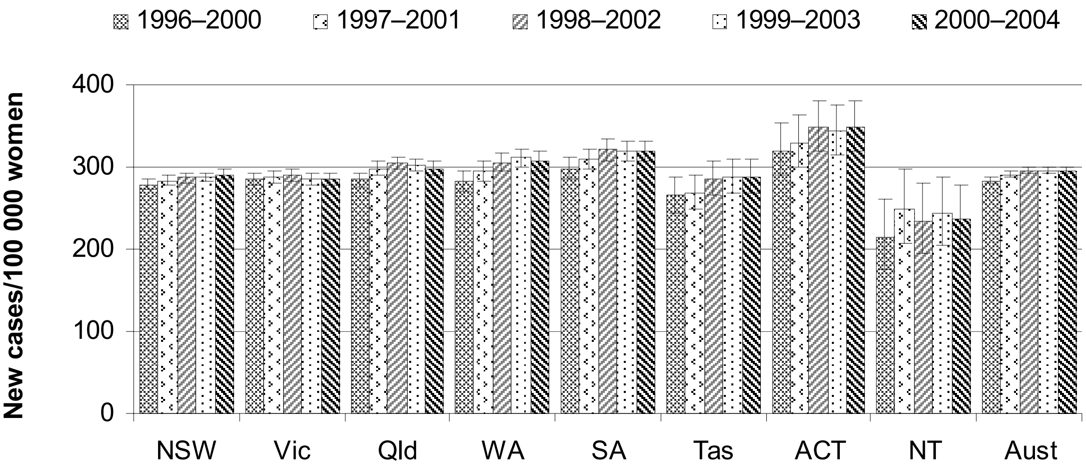


[a] Incidence refers to the number of new cases of breast cancer per 100 000 women. [b] Rates are age standardised to the Australian 2001 population standard.

Source: AIHW (unpublished); table 12A.4.

Annual average age standardised incidence rates of breast cancer for women aged 50–69 years are shown in figure 12.5.

Figure 12.5 **Annual average age standardised incidence rates of breast cancer for women aged 50–69 years[a, b]**



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[a] Incidence refers to the number of new cases of breast cancer per 100 000 women. [b] Rates are age standardised to the Australian 2001 population standard.

Source: AIHW (unpublished); table 12A.4.

Size and scope of breast cancer detection and management services

A fundamental component of breast cancer control is the use of screening mammography to enable early detection of breast cancer. There is evidence that population-based screening of women aged 50–69 years can reduce deaths from breast cancer. According to the National Breast Cancer Centre, women whose cancer is diagnosed before it has spread outside the breast have a 90 per cent chance of surviving five years. The five year survival rate drops to 20 per cent if the cancer spreads to other parts of the body before diagnosis (NBCC 2003). It is generally accepted that cancers detected early may be treated more conservatively and that these women have a higher likelihood of survival.

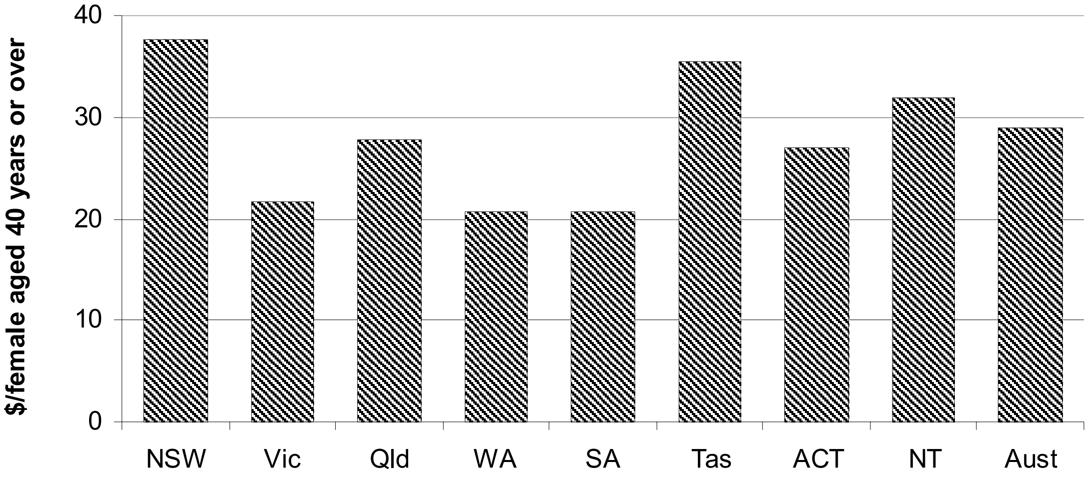
BreastScreen Australia, jointly funded by the Australian, State and Territory governments, undertakes nationwide breast cancer screening. It targets women aged 50–69 years for screening once every two years. The program aims to have 70 per cent or more of women aged 50–69 years participating in screening over a 24 month period. All recruitment activities undertaken by BreastScreen Australia specifically target women in this age group, although women aged 40–49 years and those over 70 years may also use the service.

Services provided by BreastScreen Australia in each State and Territory include all screening and assessment services to the point of diagnosis. The program includes health promotion activities, information provision, counselling and data collection across the screening and assessment pathways. Each jurisdiction manages a central BreastScreen registry to ensure women with a screen detected abnormality receive follow-up treatment and to enable women to be invited for re-screening at the appropriate interval. Data collected from the registries allow for quality assurance, monitoring and evaluation of the program. All jurisdictions perform fine needle aspiration biopsy and core biopsies as part of their assessment services, but Queensland, SA, Tasmania and the NT do not include open biopsies in the funded program (table 12A.5).

Information on BreastScreen Australia program performance is published by the Australian Institute of Health and Welfare (AIHW) in the BreastScreen Australia monitoring reports, the most recent of which was published in 2007 (AIHW 2007b).

Governments spent around $139 million on breast cancer screening in 2005-06 (table 12A.6). Estimates of government expenditure on breast cancer screening per woman aged 40 years or over are presented by jurisdiction in figure 12.6. These estimates include Australian, State and Territory government expenditure. Differences across jurisdictions partly reflect variation in the proportion of women in the target age group for breast cancer screening, data deficiencies and collection methods, as well as the nature of the services and their relative efficiency. Some differences may also be due to the geography of a State or Territory, and to the proportion of the target population living in rural and remote areas. The data therefore need to be interpreted with care.

Figure 12.6 **Public health expenditure on breast cancer screening, 2005-06[a, b, c, d, e, f, g]**



[a] In every jurisdiction, BreastScreen Australia is a joint initiative funded by both the State or Territory government and the Australian Government under the Public Health Outcome Funding Agreements. [b] The data need to be interpreted with care because of data deficiencies, differences across jurisdictions relating to the use of cash accounting and accrual methods, the treatment of corporate and central office costs, differences in methods used to collect expenditure figures, and differences in the interpretation of public health expenditure definitions. [c] The Australian total includes Australian Government direct project expenditure, database or registry and other program support, population health non-grant program costs and running costs. [d] Medicare funding for radiographic breast examinations is excluded because it is not public health expenditure. [e] Victorian data include depreciation. [f] Data for the ACT include expenditure on BreastScreen ACT and the Cancer Registry. [g] Data for the NT for direct expenditure include public health information systems, disease surveillance and epidemiological analysis, public health communication and advocacy, public health policy, program and legislation development, and public health workforce development.

Source: AIHW (unpublished); ABS, Estimated Residential Population Cat. no. 3101.0 (unpublished); tables AA.1 and 12A.6.

The number of women aged 40 years or over screened by BreastScreen Australia indicates the size of the BreastScreen Australia program. Over 857 000 women in this age group were screened in 2006, compared with 835 000 in 2002 (table 12.2).

Table 12.2 **Number of women aged 40 years or over screened by BreastScreen Australia[a]**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
2002	294 027	187 714	177 281	69 697	68 571	22 204	11 793	4 167	835 454
2003	289 913	188 782	180 396	76 059	69 182	22 424	10 651	4 547	841 954
2004	270 598	198 743	191 084	78 773	69 882	23 107	9 995	4 045	846 227
2005	235 812	197 627	199 981	81 351	70 909	25 440	11 901	4 481	827 502
2006	257 211	202 462	200 992	88 667	67 476	24 963	11 446	4 136	857 353

[a] First and subsequent screening rounds, for women aged 40 years or over.

Source: State and Territory governments (unpublished); table 12A.7.

Breast cancer is diagnosed outside the BreastScreen program when women elect to screen privately or when they have symptoms which make it inappropriate for the diagnosis to be made through screening. For these women, GPs are critical as the initial point of referral to specialists for diagnosis and treatment services.

Inpatient separations in public hospitals for selected breast-cancer related Australian refined diagnosis related groups (AR-DRGs)[2] in 2005-06 are presented in table 12.3. Most of the data relating to breast cancer detection and management in this Report are provided by BreastScreen Australia. At present, data for breast cancer services other than screening are limited.

Table 12.3 **Separations for selected AR-DRGs related to breast cancer, public hospitals, 2005-06 (per 10 000 people)[a, b]**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Breast cancer related conditions									
Major procedures for malignant breast conditions	3.0	3.3	2.6	2.7	3.1	3.1	2.8	1.2	3.0
Minor procedures for malignant breast conditions	1.1	1.2	1.4	1.1	1.0	1.3	1.0	0.5	1.2
Skin, subcutaneous tissue and breast plastic operating room procedures	2.8	3.1	3.5	2.9	5.7	3.1	1.8	2.0	3.2
Other skin, subcutaneous tissue and breast procedures	12.5	24.2	19.6	18.1	21.2	22.2	8.9	12.6	18.2
Malignant breast disorders (Age >69 W CC) or W (Cat or Sev CC)	0.6	0.6	0.4	0.3	0.8	1.5	0.4	0.3	0.6
Malignant breast disorders (Age>69 W/O CC) or W/O (Cat or Sev CC)	0.3	0.9	0.3	1.5	0.4	0.5	0.2	np	0.6
All conditions[c]	2 029.5	2 451.4	1 808.5	1 894.9	2 378.8	1 894.6	2 133.9	4 034.0	2 121.8

W=with. W/O=without. CC=complications and co-morbidities. Cat or Sev=catastrophic or severe. **a** Care needs to be taken when comparing jurisdictions because admission practices vary. **b** AR-DRG version 5.0. **c** The total includes separations for which the care type was reported as acute, or newborn with qualified patient days, or was not reported. Crude rate based on the Australian population as at 31 December 2005. **np** Not published.

Source: AIHW (2007a); table 12A.8.

Framework of performance indicators

The indicators developed to report on the performance of breast cancer detection and management are based on the shared government objectives for managing the

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[2] AR-DRGs are a patient classification system that hospitals use to match their patient services (hospital procedures and diagnoses) with their resource needs. AR-DRG version 5.0 is based on the ICD-10-AM classification (see chapter 10 for more detail).

disease (box 12.2). The ‘Health preface’ explains the performance indicator framework for health services as a whole, including the health services subdimensions for quality and sustainability that have been added to the standard Review framework. The framework for breast cancer detection and management focuses on achieving a balance between early detection and treatment. It has a tripartite structure — that is, performance indicators presented relate to early detection, intervention and overall performance. Breast cancer prevention is excluded from the framework in the absence of definitive primary preventative measures, although there are known associated risk factors. There are ongoing trials examining possible preventative interventions for the small proportion of the population at high risk of breast cancer due to the presence of BRCA1 or BRCA2 genetic variations.

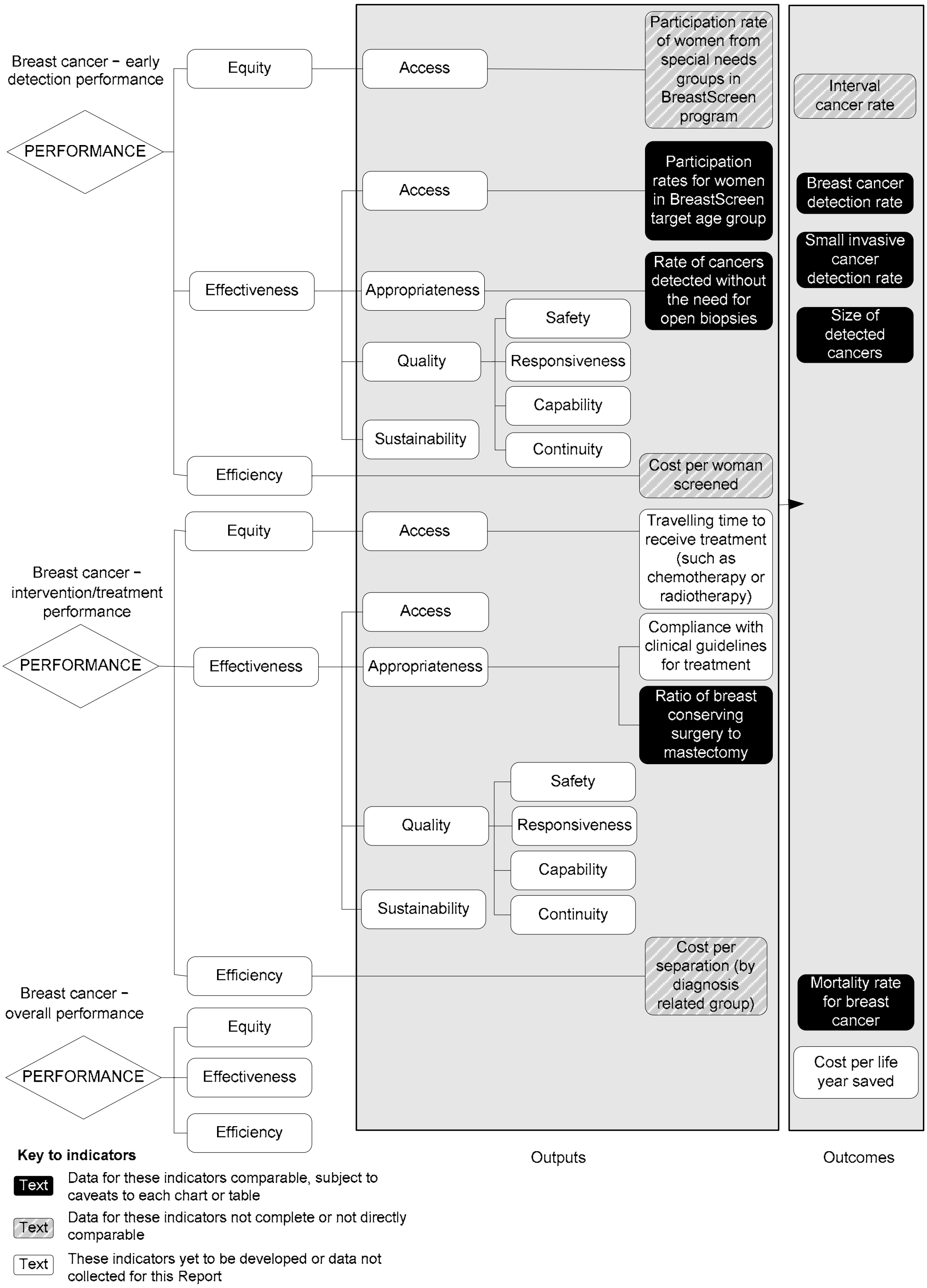
The performance indicator framework shows which data are comparable in the 2008 Report (figure 12.7). For data that are not considered directly comparable, the text includes relevant caveats and supporting commentary. Chapter 1 discusses data comparability from a Report-wide perspective (see section 1.6).

No changes have been made to the breast cancer detection and management framework for the 2008 Report.

Box 12.2 **Objectives for breast cancer detection and management**

The objectives for breast cancer detection and management are to reduce morbidity and mortality attributable to breast cancer, and to improve the quality and duration of life of women with breast cancer in a manner that is equitable and efficient.

Figure 12.7 **Performance indicators for breast cancer detection and management**



Key performance indicator results

Given the significant amounts of available data relating to breast cancer screening, screening is the focus of reporting. Data relating to the management and treatment of breast cancer are less readily available, and it is a Steering Committee priority to extend reporting in this area in the future.

Ongoing monitoring of the BreastScreen Australia program involves reporting program performance against specific indicators such as participation, detection of small invasive cancers, sensitivity, detection rate for ductal cancinoma in situ, recall to assessment and rescreening rates. Data are collected at the jurisdictional level and provide an overview of the performance of the Program.

In addition, each of the BreastScreen Australia services is assessed against 173 National Accreditation Standards as part of their accreditation process. These Standards include a number of indicators that collectively assess the safety of the services provided by individual BreastScreen Australia services.

Outputs

Outputs are the actual services delivered (while outcomes are the impact of these services on the status of an individual or group) (see chapter 1, section 1.5).

Early detection — participation rate of women from selected community groups in BreastScreen programs

The ‘participation rate of women from selected community groups in BreastScreen programs’ is an indicator of equity of access (box 12.3). This year, for the first time participation rates by geographic area are reported using the five Australian Standard Geographical Classification categories: major cities, inner regional, outer regional, remote and very remote (table 12.4). In previous reports, data were reported using two geographic categories (‘metropolitan or capital city’ and ‘rural and remote or rest of State’). Data are reported according to the classification for previous years in table 12A.10.

Box 12.3 Participation rate of women from selected community groups in BreastScreen programs

The ‘participation rate of women from selected community groups’ — that is, Indigenous women, women from non-English speaking backgrounds (NESB) and women living in outer regional, remote and very remote areas — in breast cancer screening is an indicator of equity of access. Women from these groups may experience particular language, cultural and geographic barriers to accessing breast cancer screening. This indicator measures the performance of the BreastScreen program in overcoming these barriers. This reflects the importance of screening to the early detection of breast cancers. Early detection is associated with better outcomes for women with breast cancer, in terms of morbidity and mortality.

The participation rate measures the proportion of the eligible population in the community group attending the screening program within a 24 month period. Participation rates for community groups that are at, or close to, those for the total population indicate success in overcoming group-specific barriers to access.

In 2005-06, the national age standardised participation rate for Indigenous women aged 50–69 (38 per cent) was below the total participation rate in that age group (56.7 per cent), although this may be influenced by problems with Indigenous identification (table 12A.10). For the same 24 month period and age group, the national participation rate for NESB women (49.6 per cent) was also lower than that of the national total female population (table 12.4). Care needs to be taken when comparing data across jurisdictions, given differences in the collection of data by Indigenous, NESB, and rural and remote status.

Table 12.4 Age standardised participation rates of women aged 50–69 years from selected communities in BreastScreen Australia programs, 2005 and 2006 (24 month period) (per cent)[a, b]

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Indigenous[c]	38.6	35.9	49.9	30.4	31.3	33.0	50.4	24.5	38.0
NESB[d]	51.4	37.6	67.0	65.0	58.3	36.2	52.3	38.6	49.6
Major cities and inner regional[e]	53.1	56.9	58.3	58.4	58.5	48.7	60.3	na	na
Outer regional, remote and very remote[e]	78.2	53.6	59.9	56.3	67.3	70.1	..	na	na
All women aged 50–69 years	55.5	56.8	58.0	57.4	59.0	57.1	58.4	40.8	56.7

[a] First and subsequent rounds. [b] Rates are standardised to the 2001 Australian population standard. [c] Those women who self-identify as being of Aboriginal or Torres Strait Islander descent. [d] Non-English speaking background (NESB) is defined as speaking a language other than English at home. [e] Remoteness categories are based on Census Collection Districts (CDs) and defined using the Australian Standard Geographical Classification categories. The Australian Standard Geographical Classification is a measure of the remoteness of a location from the services provided by large towns or cities. **na** Not available. **..** Not applicable.

Source: State and Territory governments (unpublished); tables 12A.9 and 12A.10.

Early detection — participation rate of women in the BreastScreen target age group

The 'participation rate of women in the BreastScreen target age group' is an indicator of how effective the program is at reaching its target population (box 12.4).

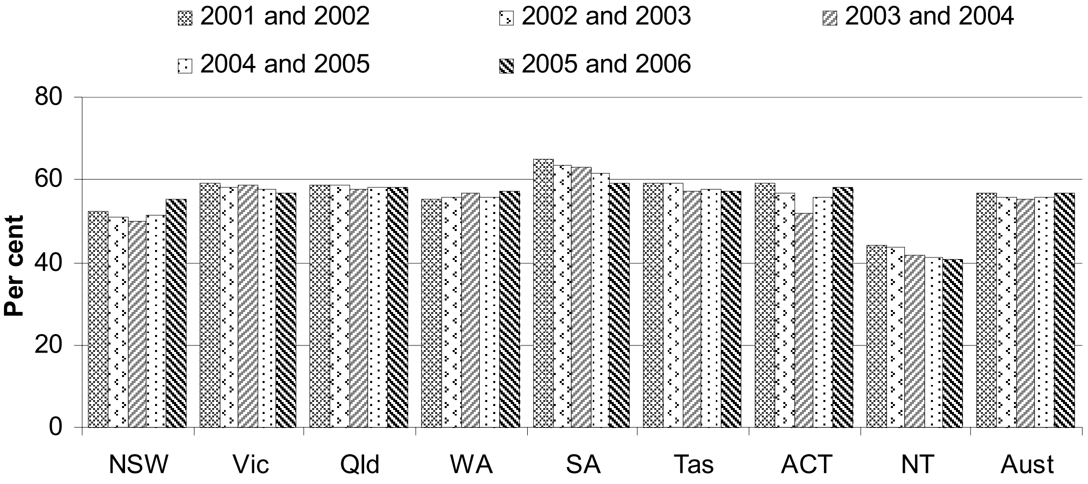
Box 12.4 **Participation rate of women in the BreastScreen target age group**

The 'participation rate of women in the BreastScreen target age group' of 50–69 years is an indicator of how effective the program is at reaching its target population. It reflects the importance of screening to the early detection of breast cancers. Early detection is associated with better outcomes for women with breast cancer, in terms of morbidity and mortality.

The participation rate measures the proportion of the eligible population attending the screening program within a 24 month period. Higher screening participation rates are more desirable. The aim under the National Accreditation Standards (2004) is that at least 70 per cent of women aged 50–69 years participate in screening over a 24 month period. Recruitment activities undertaken by BreastScreen specifically target women in this age group although access to the program is also provided for women aged 40–49 years and 70 years or over (BreastScreen Australia 2004).

The national participation rate of women aged 50–69 years in BreastScreen Australia screening programs was 56.7 per cent in the 24 month period 2005 and 2006. At a national level, the participation rate has been relatively steady since 2001-2002, well below the 70 per cent aim under the National Accreditation Standards (figure 12.8).

Figure 12.8 **Age standardised participation rates of women aged 50–69 years in BreastScreen Australia screening programs (24 month period)**[a, b]



[a] The participation rate is the number of women resident in the jurisdiction who were screened during the reference period, divided by the number of women resident in the jurisdiction, using the ABS estimated resident population. This value represents the estimated population at the midpoint of the reference period. It is an average of the two estimated resident populations for the two calendar years (by adding both years and dividing by two). [b] Rates are standardised to the 2001 Australian population standard.

Source: State and Territory governments (unpublished); table 12A.9.

Early detection — rate of cancers detected without the need for open biopsies

The 'rate of cancers detected without the need for open biopsies' is an indicator of the effectiveness of early detection (box 12.5).

Box 12.5 **Rate of cancers detected without the need for open biopsies**

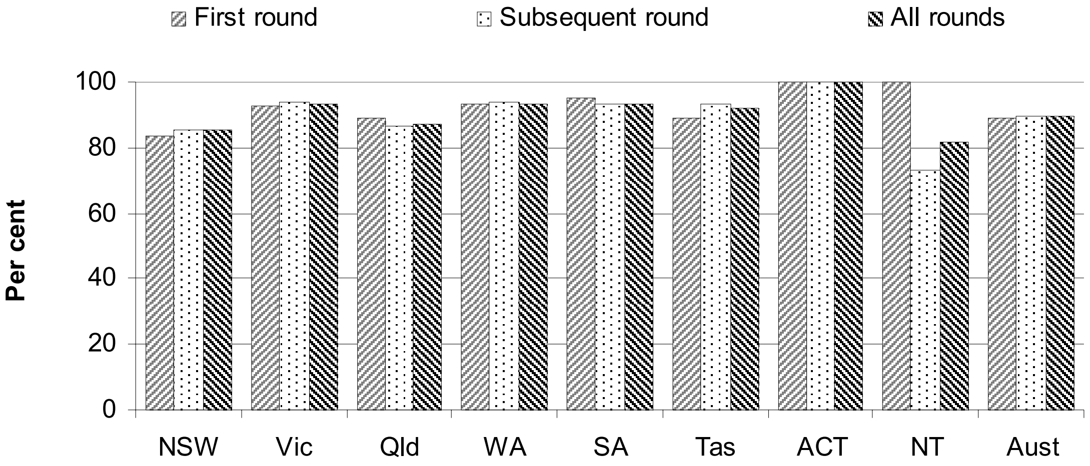
The ‘rate of cancers detected without the need for open biopsies’ is an indicator of the effectiveness of BreastScreen Australia in diagnosing breast cancer without the need for invasive procedures.

This indicator is defined as the number of diagnoses made without a diagnostic open biopsy, as a proportion of all breast cancers detected (invasive and DCIS). High rates of cancers detected without the need for open biopsies indicates effectiveness in detecting malignancies while minimising the need for invasive procedures.[3]

The BreastScreen Australia National Accreditation Standards (2004) state that 75 per cent or more of invasive cancers or DCIS should be diagnosed without the need for a diagnostic open biopsy (BreastScreen Australia 2004).

In 2006, for women attending their first screening round, the rate of cancers detected without the need for open biopsies was 89.1 per cent Australia wide. For women attending a subsequent round the rate was 89.5 per cent Australia wide, well above the National Accreditation Standard of 75 per cent (figure 12.9).

Figure 12.9 **Rate of cancers detected without the need for open biopsies, all women, 2006**



Source: State and Territory governments (unpublished); table 12A.11.

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[3] A breast biopsy is a procedure for obtaining a breast tissue specimen for microscopic examination to establish a diagnosis.

Early detection — cost per woman screened

The ‘cost per woman screened’ is an indicator of the efficiency of early detection performance (box 12.6).

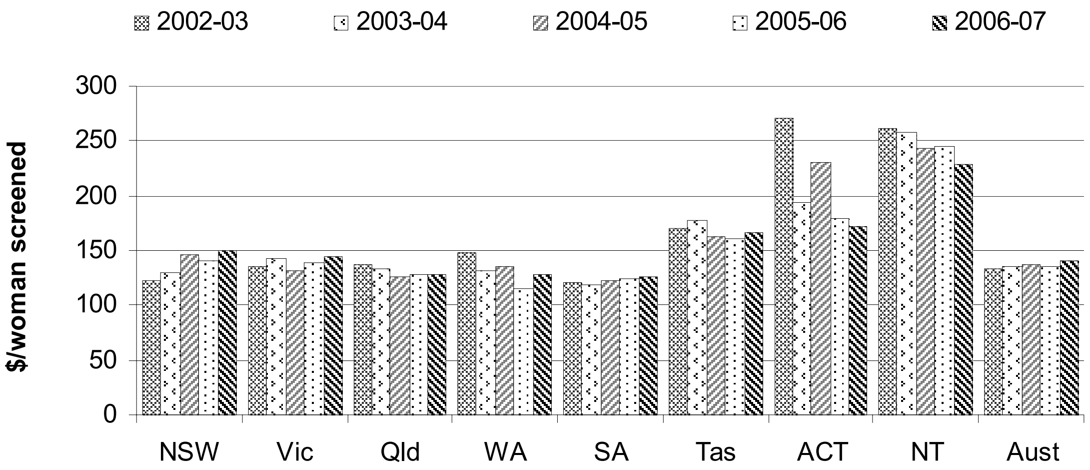
Box 12.6 **Cost per woman screened**

The ‘cost per woman screened’ is an indicator of the efficiency of the breast cancer screening program. An objective of breast cancer detection and management is that services are provided in an efficient manner.

‘Cost per woman screened’ measures the total cost of providing services (including screening, assessment and program management), divided by the number of women screened. A low ‘cost per woman screened’ can indicate efficiency, but caution must be used when interpreting indicators in this way because the cost does not provide any information on the quality of service provided.

Care needs to be taken when making comparisons across jurisdictions. There are potential differences in the items included in the measures of cost (particularly in the treatment of depreciation and capital asset charges, and the inclusion of subsidies). There may also be differences across jurisdictions in the scope of activities being costed. The Review is working to identify these differences across jurisdictions to improve data comparability in future (table 12A.13). Preliminary estimates of costs in each jurisdiction are presented in figure 12.10. The average cost per woman screened in Australia in 2006-07 was around $141.

Figure 12.10 **Real cost per woman screened, BreastScreen Australia services (2006-07 dollars)**[a, b, c]



[a] Constant price expenditure (in 2006-07 dollars) using the Gross Domestic Product price deflator (table AA.26). [b] Data for NSW do not include subsidies. [c] Data for Queensland include depreciation and user cost of capital for 2002-03.

Source: State and Territory governments (unpublished); tables AA.26 and 12A.12.

Intervention/treatment — travelling time to receive treatment

The Steering Committee has identified a woman's 'travelling time to receive treatment' as an indicator of the equity of intervention and treatment performance (box 12.7). Data on this indicator were not available for the 2008 Report.

Box 12.7 **Travelling time to receive treatment**

The Steering Committee has identified the 'travelling time to receive treatment' indicator for development and reporting in future. This indicator relates to access to breast cancer intervention and treatment services such as chemotherapy or radiotherapy. A shorter 'travelling time to receive treatment' suggests that intervention and treatment services are accessible in terms of distance travelled. A shorter travelling time also implies that services are well located in terms of the population served.

Intervention/treatment — compliance with clinical guidelines for treatment

The Steering Committee has identified 'compliance with clinical guidelines for treatment' as an indicator of the effectiveness and appropriateness of intervention and treatment performance (box 12.8). Data for this indicator were not available for the 2008 Report.

Box 12.8 **Compliance with clinical guidelines for treatment**

The Steering Committee has identified the ‘compliance with clinical guidelines for treatment’ indicator for development and reporting in future. This indicator relates to the appropriateness of breast cancer intervention and treatment. Compliance with clinical guidelines and treatment suggests breast cancer intervention and treatment are appropriate.

Intervention/treatment — ratio of conserving surgery to mastectomy

The ratio of ‘conserving surgery to mastectomy’ is an indicator of the appropriateness of intervention and treatment performance (box 12.9).

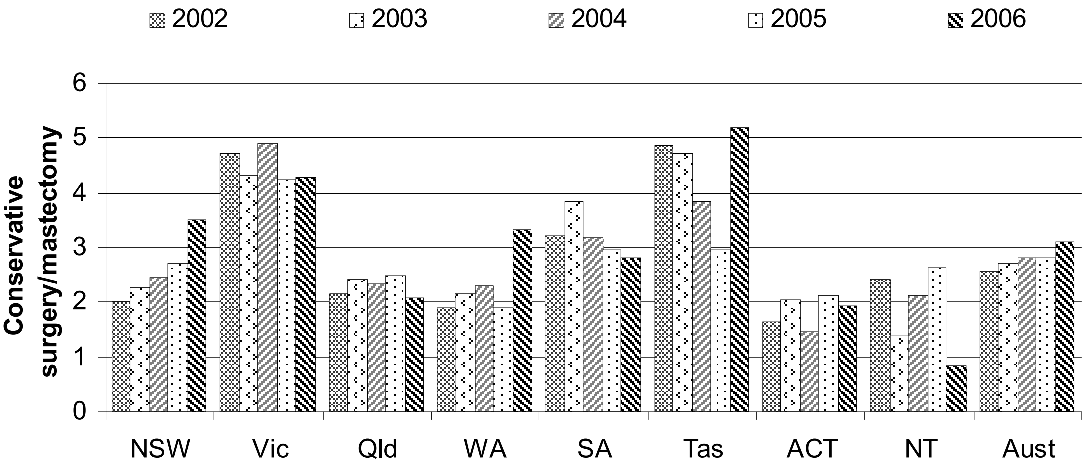
Box 12.9 **Ratio of conserving surgery to mastectomy**

The ratio of ‘conserving surgery to mastectomy’ is an indicator of the appropriateness of breast cancer intervention and treatment that aims to reduce morbidity and mortality. It can also reflect the early detection of breast cancer, because breast conserving surgery is more likely to be possible when cancers are detected at an early stage.

The ratio is defined as the number of cases for which breast conserving surgery or no surgery was performed, divided by the number of cases requiring mastectomy. Breast conserving surgery removes the breast cancer but not the whole breast. In terms of intervention and treatment, the ratio should reflect the appropriate mix of treatment. In terms of early detection of breast cancer, a high ratio is desirable. Other factors — such as the surgeon’s judgment as to the best treatment for the patient — can also affect the type of surgery undertaken.

Data for this indicator are derived from BreastScreen Australia and represent only a portion of the total possible treatment information available. BreastScreen Australia aims to diagnose small cancers that can be treated more effectively and with reduced morbidity for women, so these data are not necessarily a good indication of general clinical practice relating to breast cancer. In 2006, the ratio of conserving surgery to mastectomy averaged 3.1:1 nationally, but varied across jurisdictions (figure 12.11).

Figure 12.11 **Ratio of conserving surgery to mastectomy**[a, b]



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[a] Applies for women of all ages. [b] The numbers used to measure this indicator were small, resulting in large variations from year to year. It is advisable to view this indicator over time rather than from one year to the next.

Source: State and Territory governments (unpublished); table 12A.14.

Intervention/treatment — cost per separation by diagnosis related group

The 'cost per separation by diagnosis related group' is an indicator of the efficiency of intervention and treatment performance (box 12.10).

Box 12.10 **Cost per separation by diagnosis related group**

'Cost per separation by diagnosis related group' is a proxy indicator of efficiency. An objective of breast cancer detection and management is to provide services in an efficient manner.

This indicator is defined as the cost of care per separation in public hospitals for selected breast cancer related conditions. A low cost per separation can indicate efficiency, but caution must be used when interpreting the indicator in this way, because the cost per separation does not provide any information on the quality of service provided. In addition, not all intervention strategies are reported.

Data for this indicator are sourced from the National Hospital Cost Data Collection (NHCDC) and are based on the AR-DRG classification version 5.0. The NHCDC is an annual collection of hospital cost and activity data covering the financial year before the collection period. Participation in the NHCDC is voluntary, so the samples are not necessarily representative of all hospitals in each jurisdiction (although coverage is improving over time). An estimation process has been carried out to create representative national activity figures from the sample data. In addition, the purpose of the NHCDC is to calculate DRG cost weights, not to compare the efficiency of hospitals (DoHA 2007).

Table 12.5 summarises costs per separation for selected breast cancer AR-DRGs. The average cost of major procedures for malignant breast conditions across Australia was $6056 per separation in 2005-06; minor procedures for malignant breast conditions cost $3213 per separation on average. Table 12A.15 summarises the average length of stay (in public hospitals) associated with each AR-DRG.

Table 12.5 **Average cost per separation, public hospitals by selected breast cancer AR-DRGs, 2005-06 (dollars)[a, b, c]**

AR-DRG	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Major procedures for malignant breast conditions									
	5 700	6 692	5 942	6 079	5 221	6 109	7 974	8 984	6 056
Minor procedures for malignant breast conditions									
	3 235	2 917	3 374	3 172	3 554	3 099	3 889	2 450	3 213
Malignant breast disorders (Age >69 W CC) or W (Cat or Sev CC)									
	5 176	4 179	4 985	4 974	5 985	6 212	3 492	9 991	5 015
Malignant breast disorders (Age>69 W/O CC) or W/O (Cat or Sev CC)									
	1 915	1 884	3 023	606	1 818	1 352	np	np	1 682

W=with. W/O=without. CC=complications and co-morbidities. Cat or Sev=catastrophic or severe. [a] Estimated population costs are obtained by weighting the sample results according to the known characteristics of the population. [b] Average cost is affected by a number of factors, including admission practices, sample size, remoteness and the types of hospital contributing to the collection. Direct comparison across jurisdictions is difficult because there are differences in hospital costing systems. [c] In accordance with NHCDC methodology, depreciation and some capital costs are included in these figures, except for Victoria, which does not include depreciation. **np** Not published due to low volume and privacy concerns.

Source: DoHA 2007; table 12A.15.

Outcomes

Outcomes are the impact of services on the status of an individual or group (while outputs are the actual services delivered) (see chapter 1, section 1.5).

Early detection — interval cancer rate

The ‘interval cancer rate’ is an outcome indicator of the effectiveness of early detection (box 12.11).

Box 12.11 **Interval cancer rate**

An interval cancer is an invasive breast cancer diagnosed in the interval between a negative screening result and the next scheduled screening examination. The purpose of the 'interval cancer rate' indicator is to help determine how effective the BreastScreen Australia program is in detecting breast cancer at an early stage. Measuring the interval cancer rate helps to obtain an early measure of the likely impact of the screening program on mortality.

The 'interval cancer rate' is defined as the number of interval cancers per 10 000 women at risk of interval or screen-detected breast cancer. Those at risk are women aged 50–69 years who attend for screening less than 12 months following a negative screening episode. A low interval cancer rate is desirable because it suggests the breast screening process is effective in detecting breast cancer.

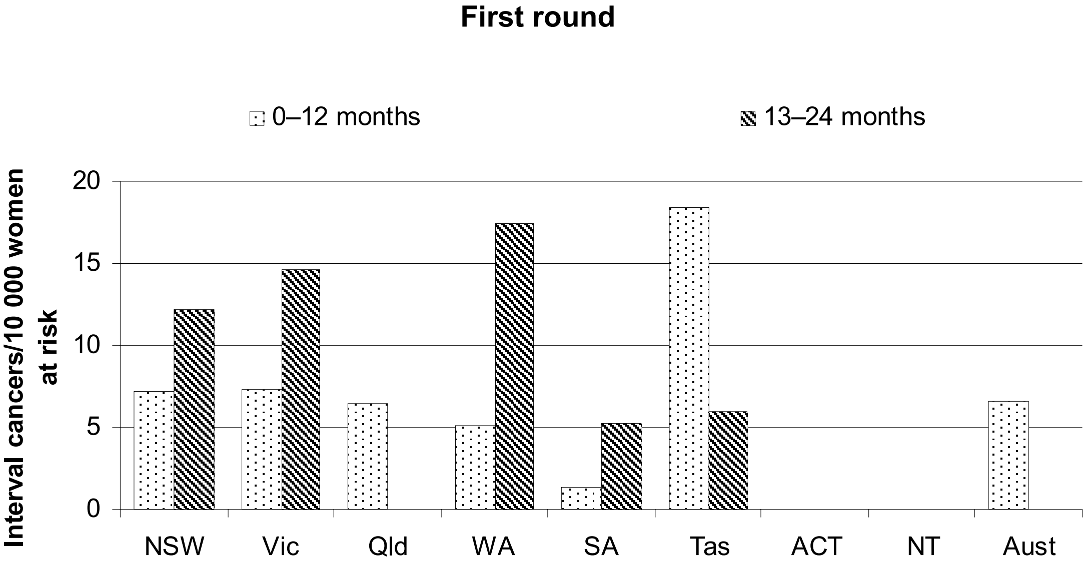
This rate should be interpreted in conjunction with the breast cancer detection indicators.

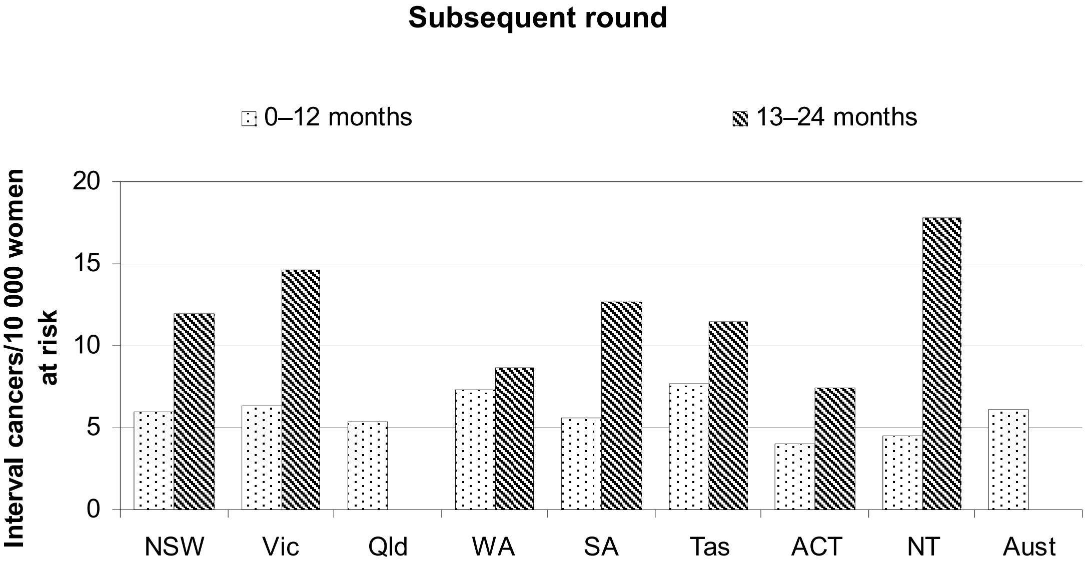
There is a time lag in obtaining data for this indicator, because the detection period falls between the last screening visit in the reference screening year and the next scheduled screening appointment. Following that period, a further time lag is required for the reporting of those cancers to the cancer registry, before a process of data matching can occur between each jurisdiction's screening program and its cancer registry. As a result, the most recent data available for this Report are for women screened during 2003. Stratification is by first and subsequent screening rounds to allow for expected variation in interval cancer rates between rounds.

Figure 12.12 presents the age standardised interval cancer rate by screening round for women aged 50–69 years. Differences in the rates across jurisdictions may be caused by differences in the policies of the BreastScreen services in each jurisdiction. Some jurisdictions (such as SA and some services in NSW) do not further investigate an abnormality of the breast if the mammogram appears normal, even when a symptom is reported. These women are advised to visit their GP for a referral to a diagnostic service. This could have the effect of increasing the jurisdiction's interval cancer rate and reducing their cancer detection rate if an invasive breast cancer is subsequently diagnosed outside the breast cancer screening program. Comparisons across jurisdictions therefore need to be made with care.

In 2003, for all women aged 50–69 years in the first round of screening, the interval cancer rate 0–12 months following screening was 6.6 per 10 000 women at risk. In subsequent rounds this decreased to 6.0 per 10 000 women at risk. Interval cancer rates 13–24 months following screening are also shown in figure 12.12.

Figure 12.12 **Age standardised interval cancer rate, women aged 50–69 years, 2003**[a, b, c, d]





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[a] Rates are expressed as the number of interval cancers per 10 000 women at risk. [b] The numbers used to measure this indicator were small, resulting in large variations from year to year. It is advisable to view this indicator over time rather than from one year to the next. [c] Data for Queensland for 13–24 months for the first and subsequent screening rounds were not available. [d] Data for the ACT and the NT were zero in the first round for 0–12 and 13–24 months.

Source: State and Territory governments (unpublished); table 12A.16.

Early detection — breast cancer detection rate

The ‘breast cancer detection rate’ is an outcome indicator of early detection (box 12.12).

Box 12.12 **Breast cancer detection rate**

The ‘breast cancer detection rate’ is an indicator of the effectiveness of screening services in identifying breast cancers at an early stage. Early detection of cancers while they are still small and localised to the breast is associated with better outcomes for women with breast cancer, in terms of morbidity and mortality.

The ‘detection rate’ is the number of detected cancers per 10 000 women screened. Although a high incidence of breast cancer is not desirable, a high rate of detecting these cancers is desirable.

The following relevant BreastScreen Australia National Accreditation Standards for detection rates are based on the expected Australian rates (BreastScreen Australia 2004):

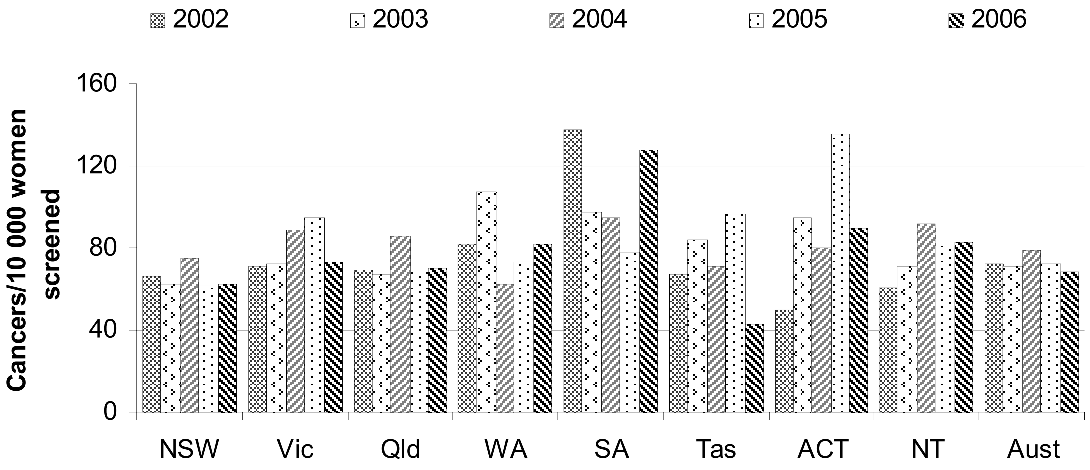
- Greater than or equal to 50 per 10 000 women aged 50–69 years who attend for their first screen are diagnosed with invasive breast cancer.
- Greater than or equal to 35 per 10 000 women aged 50–69 years who attend for their second or subsequent screen are diagnosed with invasive breast cancer.
- Greater than or equal to 12 per 10 000 women aged 50–69 years who attend for their first screen are diagnosed with DCIS.
- Greater than or equal to seven per 10 000 women aged 50–69 years who attend for their second or subsequent screen are diagnosed with DCIS.

It is important to consider together all of the following rates: the invasive cancer detection rate, the small invasive cancer detection rate, the DCIS detection rate and the interval cancer rate.

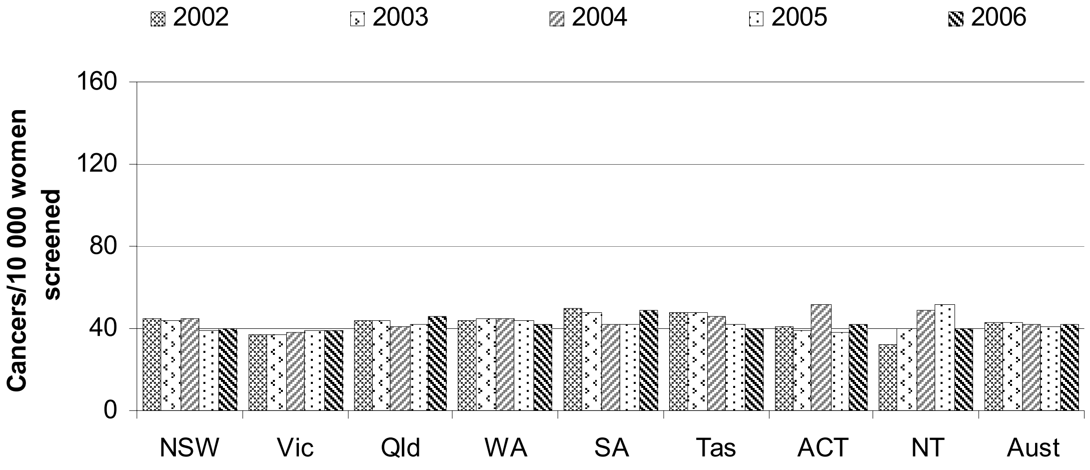
Figure 12.13 reports the age standardised number of invasive cancers detected per 10 000 women screened aged 50–69 years, by screening round. Nationally, in 2006 for the first screen, the age standardised invasive breast cancer detection rate for women aged 50–69 years was 68.4 per 10 000 attending their first screen. This was above the Breastscreen Australia National Accreditation Standard of greater than or equal to 50 per 10 000 women aged 50–69 years who attend for their first screen being diagnosed with invasive breast cancer. Nationally, for the second or subsequent screen, the age standardised invasive breast cancer detection rate for women aged 50–69 years was 41.9 per 10 000 attending their second or subsequent screen. This was above the National Accreditation Standard of greater than or equal to 35 per 10 000 women aged 50–69 years who attend for their second or subsequent screen being diagnosed with invasive breast cancer. DCIS detected per 10 000 women screened is reported in table 12A.17. (Relevant definitions can be found in box 12.1 and section 12.7.)

Figure 12.13 **Age standardised breast cancer detection rate for women aged 50–69 years, invasive cancers**[a]

First round



Subsequent round



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[a] Rates are per 10 000 women screened, and age standardised to the Australian population of women attending a BreastScreen service in 1998.

Source: State and Territory governments (unpublished); table 12A.17.

Early detection — small invasive cancer detection rate

The ‘small invasive cancer detection rate’ is an outcome indicator of early detection performance (box 12.13).

Box 12.13 **Small invasive cancer detection rate**

The ‘small (less than 15 millimetres in diameter) invasive cancer detection rate’ is an indicator of the early detection of breast cancers. Early detection of cancers while they are still small and localised to the breast is associated with better outcomes for women with breast cancer, in terms of morbidity and mortality.

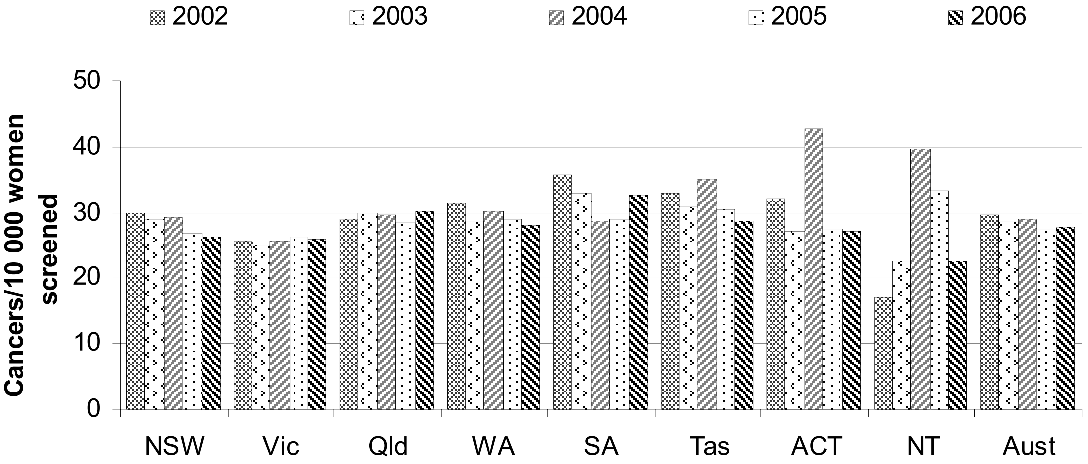
The ‘small invasive cancer detection rate’ is defined as the number of invasive cancers detected with a diameter of 15 millimetres or less, per 10 000 women screened. It is desirable that a high proportion of cancers detected are small cancers: detection of small cancers is generally associated with increased survival rates and reduced morbidity and mortality, leading to some cost savings to the health care system and women (AIHW, BreastScreen Australia and the NCSP 1998).

The BreastScreen Australia National Accreditation Standards (2004) specify that 25 or more women per 10 000 women aged 50–69 years who attend screening are expected to be diagnosed with a small (15 millimetres or less) invasive breast cancer (BreastScreen Australia 2004).

It is important to consider together all of the following rates: the invasive cancer detection rate, the small invasive cancer detection rate, the DCIS detection rate and the interval cancer rate.

Age standardised rates for small invasive cancer detection for women aged 50–69 years screened by BreastScreen Australia in 2006 are reported in figure 12.14. This shows that the rate for Australia was 27.7 cancers per 10 000 women screened in 2006, close to the Breastscreen Australia accreditation standard of 25 or more women per 10 000 women aged 50–69 years who attend screening to be diagnosed with a small invasive breast cancer.

Figure 12.14 **Age standardised small diameter cancer detection rate for women aged 50–69 years, all rounds of screening[a, b]**



[a] Small diameter cancers are defined as invasive cancers up to and including 15 millimetre diameter. Prior to the 2003 Report, small diameter cancers were defined as 10 millimetre in diameter or less, so data are not comparable to data published before the 2003 Report. [b] Rates are per 10 000 women screened, and age standardised to the Australian population of women attending a BreastScreen service in 1998.

Source: State and Territory governments (unpublished); table 12A.18.

Early detection — size of detected cancers

The ‘size of detected cancers’ is an outcome indicator of the success of early detection (box 12.14).

Box 12.14 **Size of detected cancers**

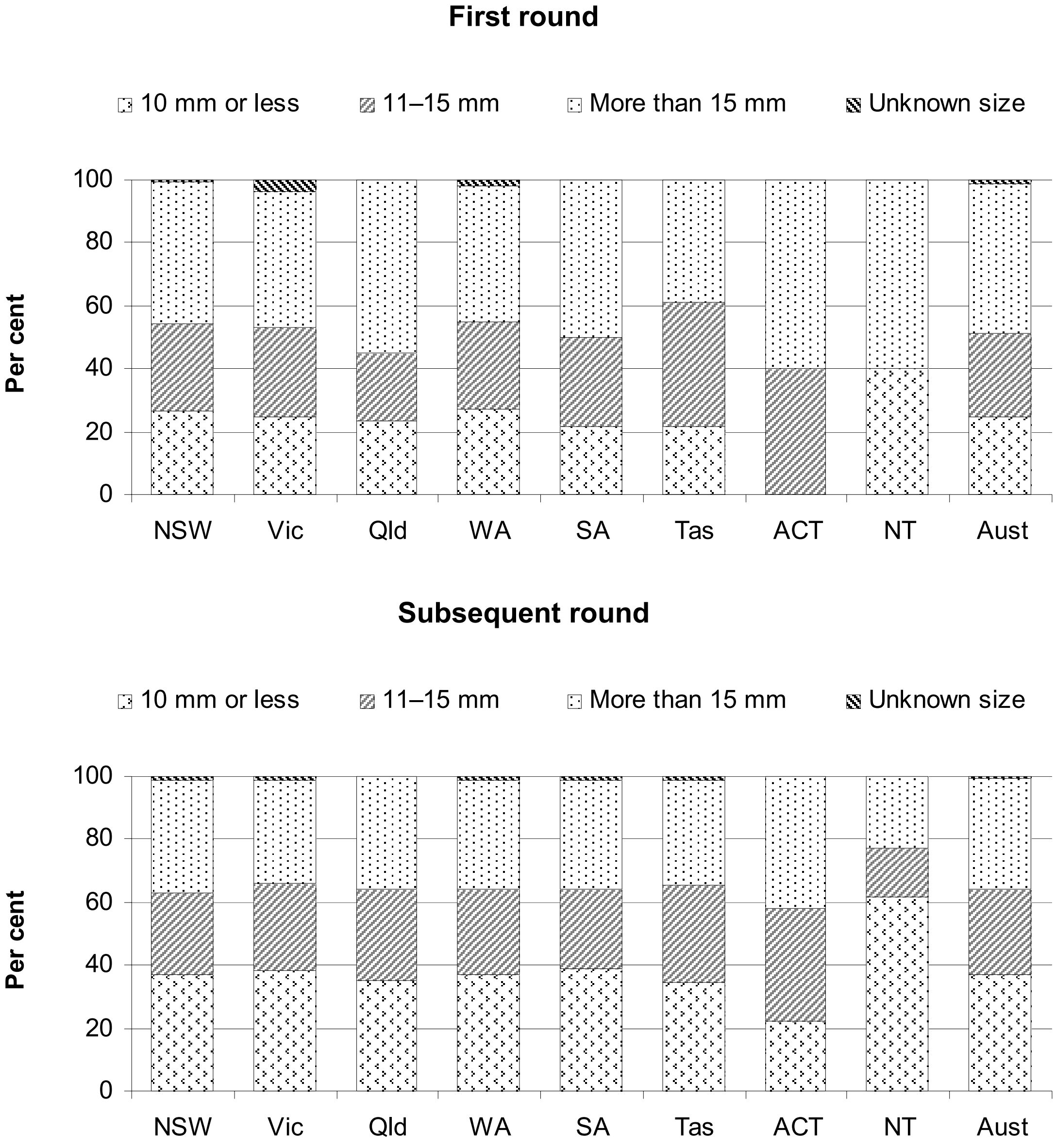
The ‘size of detected cancers’ is an indicator of the early detection of breast cancers. Detection of small cancers (those with a diameter of 15 millimetres or less) is generally associated with increased survival rates and reduced morbidity and mortality, leading to some cost savings to the health care system and women (AIHW, BreastScreen Australia and the NCSP 1998).

This indicator measures detected invasive cancers by size of cancer, as a proportion of total detected invasive cancers for women aged over 40 years. High detection of small cancers relative to large cancers is desirable because it is likely to result in reduced morbidity and mortality.

Data are reported by round because larger cancers are expected to be found in the first round of screening. In subsequent rounds, cancers should be smaller if the program is achieving its objective (that is, early detection of small cancers through regular two yearly screening).

Figure 12.15 presents the proportion of cancers by size by screening round for 2006. The data are from BreastScreen Australia and cover only its clients.

Figure 12.15 **Detected invasive cancers, women aged over 40 years, by screening round and size of cancer 2006**[a, b]



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[a] Non-breast malignancies were not counted. [b] For small jurisdictions, fluctuations due to small numbers can make comparisons unreliable.

Source: State and Territory governments (unpublished); table 12A.19.

Overall performance — mortality rate for breast cancer

The ‘mortality rate for breast cancer’ is an outcome indicator of overall system performance (box 12.15).

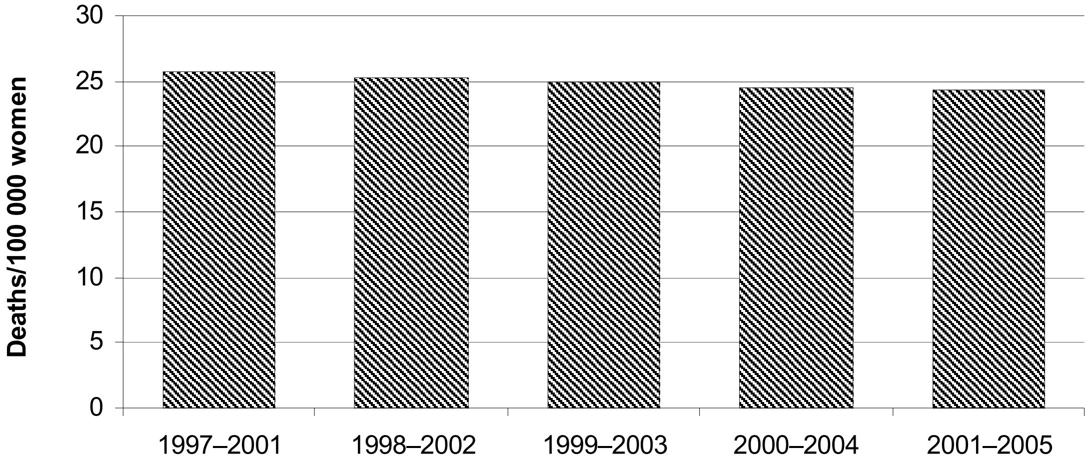
Box 12.15 **Mortality rate for breast cancer**

The ‘mortality rate for breast cancer’ is an outcome indicator of the effectiveness of both early detection and treatment services for breast cancer. It expresses mortality from breast cancer per 100 000 women as a five year rolling average.

Breast cancer mortality data are averaged over five year periods to smooth volatility in year-on-year movements, particularly for smaller jurisdictions that tend to have fewer cases and relatively large variation in rates from year to year. Caution should still be used when comparing results for smaller jurisdictions (table 12A.1).

Age standardised mortality rates are the most appropriate measure for examining changes in mortality rates. The average annual age standardised mortality rate for breast cancer declined from 25.8 per 100 000 women over the period 1997–2001 to an average of 24.4 per 100 000 women over the period 2001–2005 (figure 12.16).

Figure 12.16 **Annual average age standardised mortality rate from breast cancer, all ages**[a]

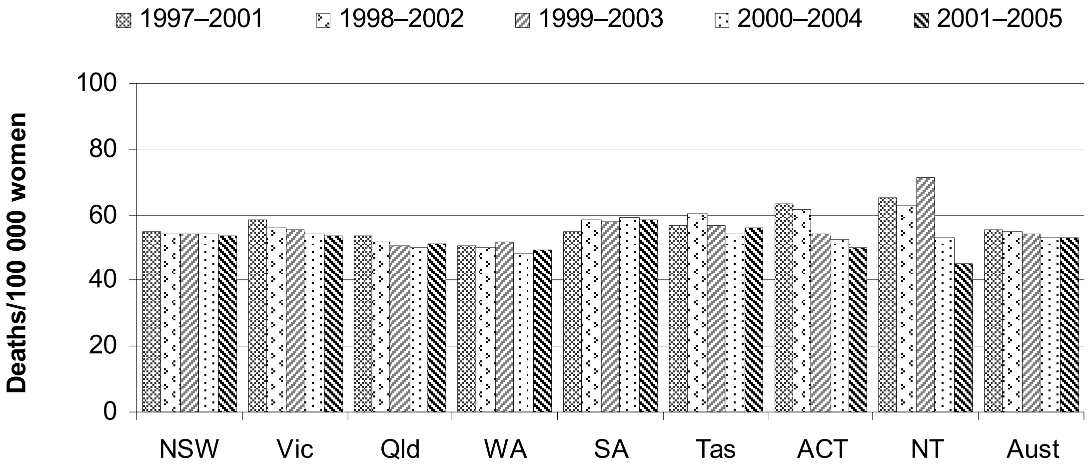


[a] Age standardised to the Australian population at 30 June 2001.

Source: AIHW (unpublished); table 12A.1.

The annual average age standardised mortality rate from breast cancer for women aged 50–69 years also declined, from 55.3 per 100 000 women over the period 1997–2001 to 53.1 per 100 000 women over the period 2001–2005 (figure 12.17).

Figure 12.17 **Annual average age standardised mortality rate from breast cancer, women aged 50–69 years**[a]



[a] Age standardised to the Australian population at 30 June 2001.

Source: AIHW (unpublished); table 12A.1.

Overall performance — cost per life year saved

The Steering Committee has identified ‘cost per life year saved’ as an outcome indicator of the efficiency of overall performance (box 12.16). Data for this indicator were not available for the 2008 Report.

Box 12.16 **Cost per life year saved**

The Steering Committee has identified the ‘cost per life year saved’ as an indicator for development and reporting in future. The indicator is a measure of the efficiency of breast cancer detection and management services.

12.4 Mental health

Profile

Mental health relates to an individual's ability to negotiate the daily challenges and social interactions of life without experiencing undue emotional or behavioural incapacity (DHAC and AIHW 1999). There is a wide range of mental disorders that can affect an individual's functioning and quality of life. Each of these disorders is unique in terms of its incidence across the lifespan, causal factors and treatments.

This section covers specialist mental health care services that treat mostly low prevalence but severe mental disorders. Other health services are also important for people with a mental disorder. Other health and related service providers include GPs and alcohol and drug treatment services (chapter 11), public hospitals (chapter 10), and aged care services (chapter 13). This Report does not include specific performance information on these services treatment of people with a mental illness. Some common terms used in mental health management are outlined in box 12.17.

Mental health patients often have complex needs that may affect other services they receive, such as those covered in chapter 4 ('School education'), chapter 8 ('Corrective services'), chapter 9 ('Emergency management') and chapter 14 ('Services for people with a disability').

Box 12.17 **Some common terms relating to mental health**

acute services: mental health services that primarily provide specialist psychiatric care for people with acute episodes of mental disorder. These episodes are characterised by recent onset of severe clinical symptoms of mental disorder, that have potential for prolonged dysfunction or risk to self and/or others. The key characteristic of acute services is that treatment effort is focused on the short term. Acute services may focus on assisting people who have had no prior contact or previous psychiatric history, or individuals with a continuing mental disorder for whom there has been an acute exacerbation of symptoms.

ambulatory care services: mental health services dedicated to the assessment, treatment, rehabilitation and/or care of non-admitted inpatients, including but not confined to crisis assessment and treatment services, mobile assessment and treatment services, outpatient clinic services (whether provided from a hospital or community mental health centre), child and adolescent outpatient treatment teams, social and living skills programs (including day programs, day hospitals and living skills centres), and psychogeriatric assessment teams and day programs.

(Continued on next page)

Box 12.17 **(Continued)**

community residential services: staffed residential units established in community settings that provide specialised treatment, rehabilitation and/or care for people affected by a mental disorder. To be defined as community-based residences, the services must provide residential care, be located in a community setting external to the campus of a general hospital or psychiatric institution, employ onsite staff for at least some part of the day, and be government funded.

early intervention: actions that are appropriate for and specifically target people displaying the early signs and symptoms of a mental health problem or mental disorder and people developing or experiencing a first episode of mental disorder.

inpatient services: mental health services that provide admitted patient care. These are stand-alone psychiatric hospitals or specialist psychiatric units located within general (non-psychiatric) hospitals.

mental disorder: a diagnosable illness that significantly interferes with an individual’s cognitive, emotional and/or social abilities. For the purposes of this chapter, it includes mental illness and psychiatric disability.

mental health: the capacity of individuals within groups and the environment to interact with one another in ways that promote subjective wellbeing, the optimal development and use of mental abilities (cognitive, affective and relational) and the achievement of individual and collective goals consistent with justice.

mental health problem: diminished cognitive, emotional and/or social abilities, but not to the extent that the criteria for a mental disorder are met.

mental health promotion: any action taken to maximise mental health and wellbeing among populations and individuals. It is aimed at changing environments (social, physical, economic, educational, cultural) and enhancing the ‘coping’ capacity of communities, families and individuals by giving power, knowledge, skills and the necessary resources.

mental illness prevention: interventions that occur before the initial onset of a disorder to prevent its development. The goal of prevention interventions is to reduce the incidence and prevalence of mental health problems and disorders.

(Continued on next page)

Box 12.17 **(Continued)**

non-acute services: rehabilitation services that have a primary focus on intervention to reduce functional impairments that limit the independence of patients. Rehabilitation services focus on disability and the promotion of personal recovery. They are also characterised by an expectation of substantial improvement over the short to medium term. Patients treated by rehabilitation services usually have a relatively stable pattern of clinical symptoms. Non-acute services also consist of extended care services that provide care over an indefinite period for patients who have a stable but severe level of functional impairment and inability to function independently without extensive care and support. Patients of extended care services usually show a relatively stable pattern of clinical symptoms, which may include high levels of severe unremitting symptoms of mental illness. Treatment effort focuses on preventing deterioration and reducing impairment. Improvement is expected only over a long period.

non-government organisations: private not-for-profit community managed organisations that receive State and Territory government funding specifically to provide community support services for people affected by a mental disorder. Programs provided by non-government organisations may include supported accommodation services (including community-based crisis and respite beds), vocational rehabilitation programs, advocacy programs (including system advocacy), consumer self-help services, and support services for families and primary carers.

outpatient services (community-based): services primarily provided to non-admitted patients on an appointment basis and delivered from health centres located in community settings physically separated within hospital sites. Services provided may also include outreach or domiciliary care as an adjunct to services provided from the centre base.

outpatient services (hospital-based): services primarily provided to non-admitted patients on an appointment basis and delivered from clinics located within hospitals. Services provided may also include outreach or domiciliary care as an adjunct to services provided from the clinic base.

prevalence: the number of cases of a disease present in a population at a given time (point prevalence) or during a given period (period prevalence).

specialised care service: services whose primary function is to provide treatment, rehabilitation or community support targeted to people affected by a mental disorder. This criterion is applicable regardless of the source of funds. Such activities are delivered from a service or facility that is readily identifiable as both specialised and serving a mental health function.

Source: AIHW (2006); DoHA (2005).

Prevalence

As part of the National Health Survey (NHS) in 2004-05, the ABS surveyed adults on the level of psychological distress that they had experienced in the four weeks before the survey. This survey used the Kessler 10 (K10) scale, which consists of 10 questions about non-specific psychological distress and seeks to measure the level of current anxiety and depressive symptoms that a person might have experienced in the four weeks before the interview (ABS 2006c).[4] The 2004-05 data showed that, nationally, 61.8 per cent of those aged 18–64 years had experienced a low level of distress, 24.7 per cent had experienced moderate distress and 13.4 per cent had experienced a high or very high level of distress. Generally, people aged 65 years or over were less likely to experience moderate and high to very high levels of distress, compared with the younger age group (table 12.6). Overall, in percentage terms, more females than males had experienced moderate and high to very high levels of distress (table 12A.20).

The 2004-05 National Aboriginal and Torres Strait Islander Health Survey (NATSIHS) included for the first time selected questions from the Kessler Psychological Distress Scale–10 (K10). The K10 was reduced to five questions (K5) to provide an appropriate short set of questions to identify psychological distress (ABS 2006b). The wording of two of the K10 questions was modified slightly for the NATSIHS K5 version. Nevertheless, these modifications are unlikely to significantly affect the comparability of Indigenous and non-Indigenous (K5) data on levels of psychological distress.

In 2004-05, after adjusting for age differences between the Indigenous and non-Indigenous populations, 26.6 per cent of Indigenous people had experienced a high to very high level of psychological distress compared with 13.1 per cent of non-Indigenous people (figure 12.18).

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[4] Respondents were asked whether in the previous four weeks they had felt: tired for no good reason; nervous; so nervous nothing could calm them down; hopeless; restless or fidgety; so restless they could not sit still; depressed; everything was an effort; so sad that they could not be cheered up; and worthless. For each question, there is a five level response scale based on the amount of time that the respondent reported experiencing the particular problem. Generally, each item was scored from one for 'none of the time', to five for 'all of the time'. Scores of the 10 questions were then summed, yielding a minimum possible score of 10 and a maximum possible score of 50. Low scores indicated low levels of psychological distress and high scores indicated high levels of psychological distress (ABS 2006c).

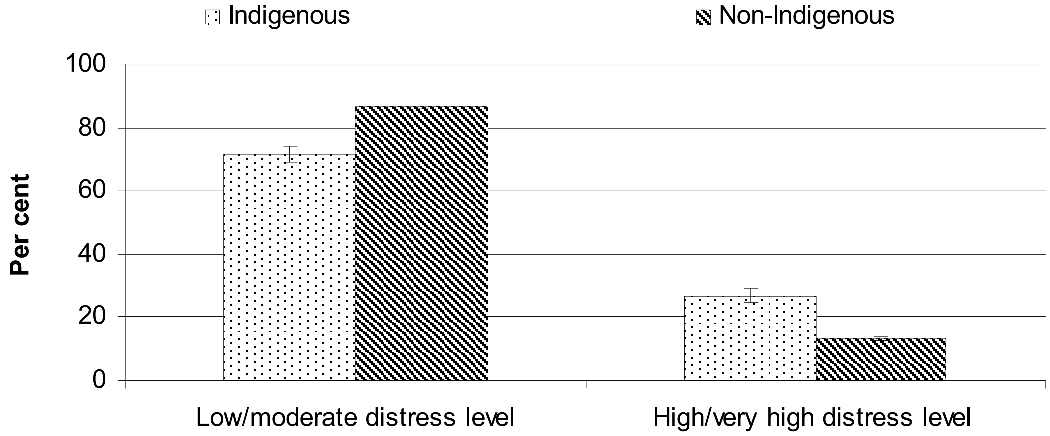
Table 12.6 K10 level of psychological distress, 2004–05 (per cent of population)[a, b]

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*[c]	*Aust*
18–64 years									
Low	62.3	59.9	61.3	65.7	61.6	66.3	60.6	na	61.8
Moderate	25.0	26.0	24.3	21.7	25.3	20.4	27.0	na	24.7
High and very high	12.7	13.8	14.4	12.6	13.0	13.2	12.4	na	13.4
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**na**	**100.0**
65 years or over									
Low	67.9	68.4	63.8	77.8	72.5	71.1	63.0	na	68.6
Moderate	20.0	21.6	21.9	15.0	18.9	18.9	27.3	na	20.2
High and very high[d]	12.1	9.5	14.1	7.2	8.6	10.0	9.7	na	11.0
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**na**	**100.0**
Total adults									
Low	63.2	61.3	61.6	67.5	63.6	67.2	60.9	na	62.9
Moderate	24.1	25.3	23.9	20.7	24.1	20.1	27.0	na	24.0
High and very high	12.6	13.1	14.3	11.8	12.2	12.6	12.1	na	13.0
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**na**	**100.0**

[a] Psychological distress as measured by the K10 scale. [b] Numbers may not add up to 100 due to rounding. [c] Separate estimates for the NT are not available for this survey, but the NT contributed to national estimates. [d] The Queensland and Tasmanian estimates have relative standard errors of 25–50 per cent and need to be interpreted with caution. **na** Not available.

Source: ABS (2006c); table 12A.20.

Figure 12.18 K5 level of psychological distress, people aged 18 years and over, age standardised, 2004-05[a, b, c]

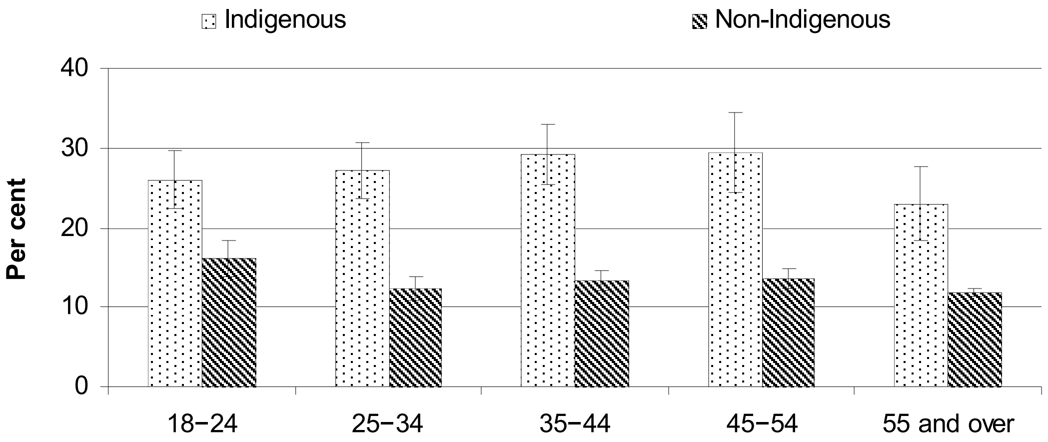


[a] Error bars represent 95 per cent confidence intervals around each estimate. [b] Low/moderate distress level represents a K5 score of 5–11 (maximum score is 25). [c] High/very high distress level represents a K5 score of 12–25 (maximum score is 25).

Source: ABS 2004-05 NATSIHS (unpublished); ABS 2004-05 NHS (unpublished); SCRGSP (2007).

In all age groups, Indigenous people were more likely to have experienced high to very high levels of psychological distress than non-Indigenous people in 2004-05 (figure 12.19).

Figure 12.19 **High to very high level of psychological distress, by age, Australia, 2004-05[a, b]**



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[a] Error bars represent 95 per cent confidence intervals around each estimate. [b] High/very high distress level represents a K5 score of 12–25 (maximum score is 25).

Source: ABS 2004-05 NATSIHS (unpublished); ABS 2004-05 NHS (unpublished); SCRGSP (2007).

In the 2003 ABS Survey of Disability, Ageing and Carers (ABS 2004), 16.1 per cent of all people with a disability (636 900 out of 3.96 million people) and 3.2 per cent of the total population, reported a mental or behavioural disorder as the main health condition causing their disability. Among people who had a disability that caused a profound or severe core activity limitation (around 1.2 million people or 31.4 per cent of all people with a disability), 23.4 per cent reported a mental or behavioural disorder as their main health condition (ABS 2004).

Roles and responsibilities

State and Territory governments are the primary sources of funding and service delivery for specialist public mental health services. The Australian Government provides funding to states and territories via the Australian Health Care Agreements and to private psychiatrists and GPs through the Medicare Benefits Schedule. On 1 November 2006, new Medicare items for GPs, psychiatrists and allied mental health professionals (clinical psychologists, psychologists, social workers and occupational therapists) were introduced for people with assessed mental disorder. The Australian Government also provides funding to individuals through the

Pharmaceutical Benefits Scheme, Medicare Safety Net and the Department of Veteran's Affairs (DVA).

The Australian, State and Territory governments also fund other services that people with mental disorders can access, such as emergency relief, employment, accommodation, income support, rehabilitation, residential aged care and other services for older people and people with a disability (see chapters 13 and 14 respectively).

Funding

Real government recurrent expenditure of around $4.1 billion was allocated to mental health services in 2005-06 (tables 12A.21 and 12A.22).[5] State and Territory governments made the largest contribution ($2.7 billion, or 64.4 per cent), although this included some Australian Government funds under the Australian Health Care Agreements (table 12A.22). The Australian Government spent $1.5 billion (this does not include $8.6 million spent on the National Suicide Prevention Strategy). Real Australian Government expenditure per person rose from $69 in 2001-02 to $71 in 2005-06. National average State and Territory expenditure per head in 2005-06 was $129, up from $107 in 2001-02 (figure 12.20).

Data in this Report relating to publicly funded mental health services come from State and Territory governments. Data up until 2004-05 were collected under the National Survey of Mental Health Services. From 2005-06, these data are being collected under the Mental Health Establishments National Minimum Data Set (MHE NMDS). Data for 2005-06 are preliminary and should be interpreted with care. Final validation is ongoing prior to publication in future National Mental Health reports.

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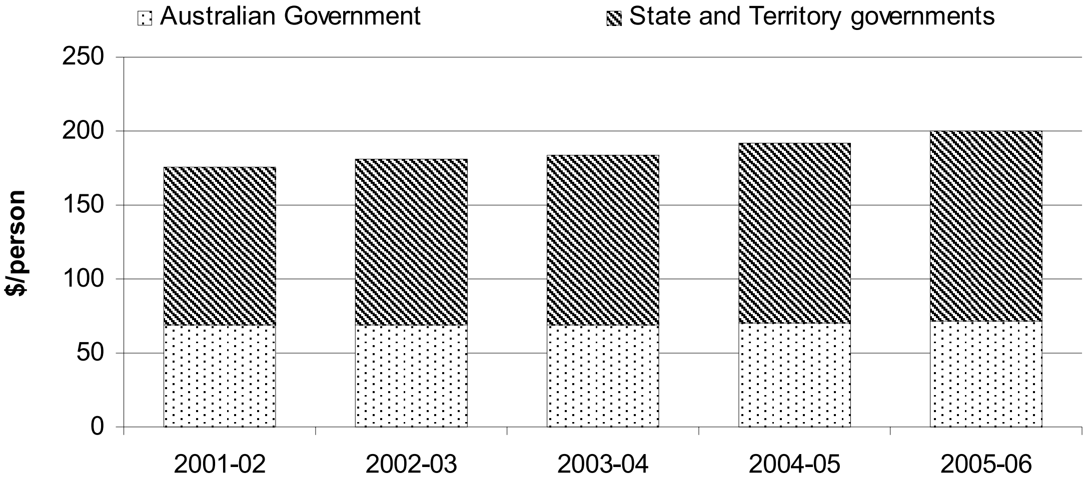
[5] These data include revenue from other sources (including patient fees and reimbursement by third party compensation insurers) and 'other Australian Government funds'.

Figure 12.20 **Real government recurrent expenditure on mental health services per person (2005-06 dollars)**[a, b, c]



[a] Data for 2005-06 are preliminary; final validation is ongoing. [b] Constant price expenditure for all years (2005-06 dollars), using the implicit price deflator for non-farm gross domestic product (table 12A.55) for Australian Government expenditure, and the State and Territory implicit price deflators for general government final consumption expenditure on hospital clinical services for State and Territory expenditure (table 12A.54). [c] Australian Government expenditure does not include expenditure on the National Suicide Prevention Strategy. In 2005-06, this expenditure was $8.6 million.

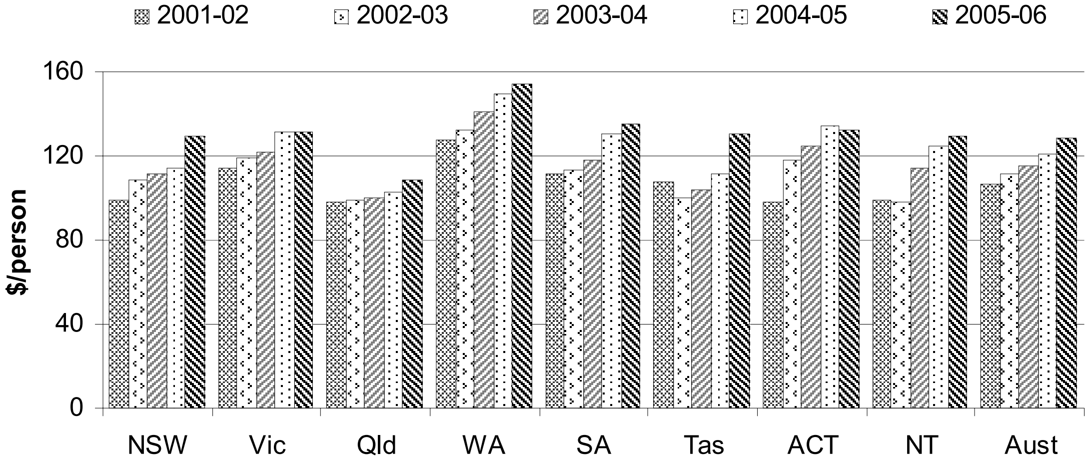
Source: Department of Health and Ageing (DoHA) (unpublished); State and Territory governments (unpublished); tables 12A.22 and 12A.23.

The largest component of Australian Government expenditure on mental health services in 2005-06 was expenditure under the Pharmaceutical Benefits Schedule for psychiatric medication ($638 million). Expenditure on psychiatric medication increased by an annual average rate of 2.4 per cent between 2001-02 and 2005-06 and rose slightly from 43.2 per cent of Australian Government expenditure on mental health services in 2001-02 to 43.5 per cent in 2005-06. The annual rate of growth of expenditure on psychiatric medication has declined over the reporting period (from 6.1 per cent from 2001-02 to 2002-03 to -2.9 per cent from 2004-05 to 2005-06) (table 12A.21). The reduced rate of growth in expenditure on psychiatric medication is due to a number of frequently prescribed medications coming off patent, which allowed lower cost generic medicines to be used.

In 2005-06, the next largest component of Australian Government expenditure for mental health services was GPs (15.9 per cent), followed by Medicare Benefits Schedule payments for consultant psychiatrists (15.1 per cent). The residual was provided by the National Mental Health Strategy (NMHS) (9.6 per cent), DVA (8.6 per cent), private hospital insurance premium rebates (4.4 per cent), and research and other time limited program and project support (3.0 per cent) (table 12A.21).

Real expenditure per person at State and Territory discretion has increased over time (figure 12.21). Data in figure 12.21 for State and Territory government expenditure include Australian Government funds provided as part of base grants under the Australian Health Care Agreements, but exclude special purpose grants provided for mental health reform and also funding provided to states and territories by the DVA. The data are therefore referred to as expenditure ‘at State and Territory discretion’. The data in figure 12.21 exclude depreciation. Estimates of depreciation are presented in table 12A.25. State and Territory government expenditure estimates excluding revenue from other sources and other Australian Government funds are presented in table 12A.24. The revenue categories are subject to minimal validation and may be inconsistently treated across jurisdictions. In addition, it is not possible to extract revenue from other sources and other Australian Government funds uniformly across time.

Figure 12.21 **Real recurrent expenditure at the discretion of State and Territory governments, per person (2005-06 dollars)**[a, b, c, d, e]

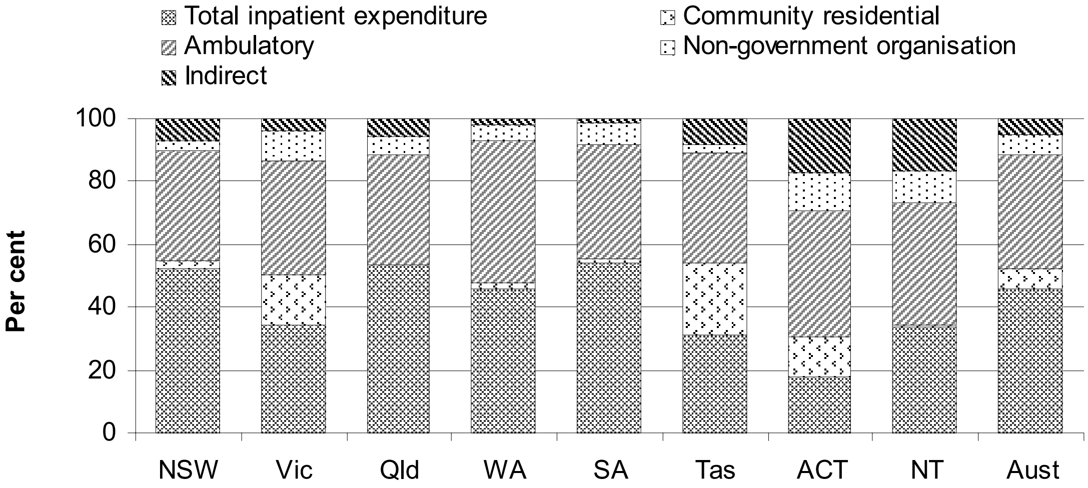


[a] Data for 2005-06 are preliminary; final validation is ongoing. [b] Constant price expenditure (2005-06 dollars), using State and Territory implicit price deflators for general government final consumption on hospital clinical services (table 12A.54). [c] Estimates of State and Territory government spending include revenue from other sources (including patient fees and reimbursement by third party compensation insurers) and ‘other Australian Government funds’, but exclude Australian Government funding provided under the NMHS and through the DVA. [d] Depreciation is excluded for all years. Depreciation estimates are reported in table 12A.25. [e] SA total recurrent expenditure data used to derive these results for 2003-04 and 2004-05 have been revised.

Source: State and Territory governments (unpublished); DoHA (unpublished); table 12A.22.

Figure 12.22 shows how expenditure at the discretion of State and Territory governments was distributed across the range of mental health services in 2005-06. It does not show the distribution of the Australian Government expenditure discussed under figure 12.20.

Figure 12.22 State and Territory recurrent expenditure, by service category, 2005-06[a, b, c, d, e, f]



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[a] Data for 2005-06 are preliminary; final validation is ongoing. [b] Includes all State and Territory expenditure on mental health services regardless of source of funds. [c] Depreciation is excluded. Depreciation estimates are reported in table 12A.25. [d] A community residential mental health service is a specialised mental health service that: employs mental health-trained staff on-site; provides rehabilitation, treatment or extended care to residents that is in a domestic-like environment and that is intended to be on an overnight basis; and encourages the resident to take responsibility for their daily living activities. These services include those that employ mental health trained staff on-site 24 hours per day and other services with less intensive staffing. However, all these services employ on-site mental health trained staff for some part of each day. [e] The differential reporting of clinical service providers and non-government organisations artificially segregates the mental health data. Given that the role of non-government organisations varies across jurisdictions, the level of non-government organisation resourcing does not accurately reflect the level of community support services available. [f] Queensland does not fund community residential services, but it funds a number of extended treatment services (both campus and non-campus-based), which provide longer term inpatient treatment and rehabilitation services with full clinical staffing for 24 hours a day, seven days a week.

Source: State and Territory governments (unpublished); table 12A.26.

Size and scope of sector

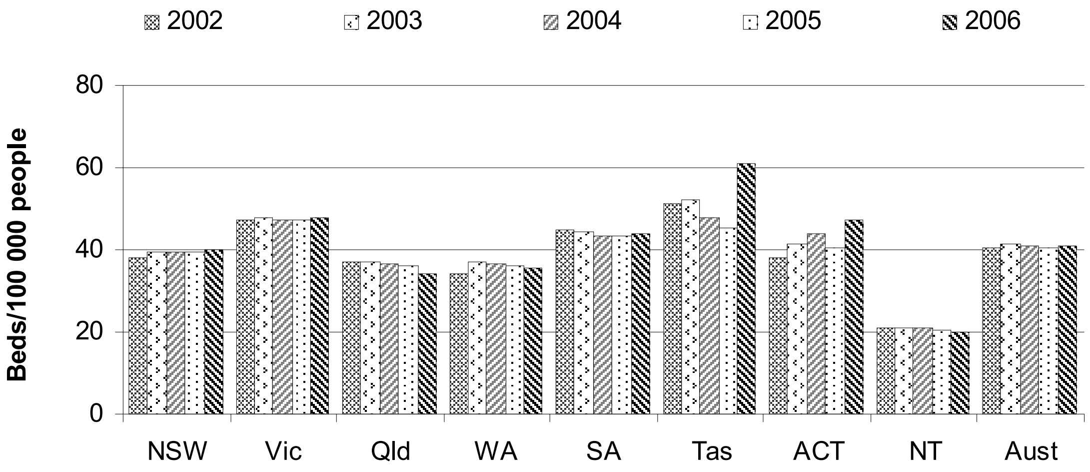
Mental health beds

Beds are counted as those immediately available for use by admitted patients if required. They are available for use immediately — or within a reasonable period of time — if located in a suitable place for care with nursing or other auxiliary staff available.

Available beds were counted differently across jurisdictions in 2005-06. Some jurisdictions counted available beds as the average of monthly available bed numbers. Other jurisdictions counted available beds as at 30 June. For previous years, all jurisdictions counted beds at 30 June. In addition, for 2005-06 some jurisdictions counted available beds as excluding beds in wards which were closed for any reason (except weekend closures for beds/wards staffed and available on weekdays only). Other jurisdictions included beds in wards that were temporarily closed for reasons such as renovation or strike, but that would normally have been open. For previous years, all jurisdictions included wards that were temporarily closed for reasons such as renovation or strike, but that would normally be open.

Figure 12.23 presents the number of beds per 100 000 people for public hospitals and community residential facilities combined.

Figure 12.23 **Mental health beds in public hospitals and publicly funded community residential units, 30 June**[a, b, c, d, e]



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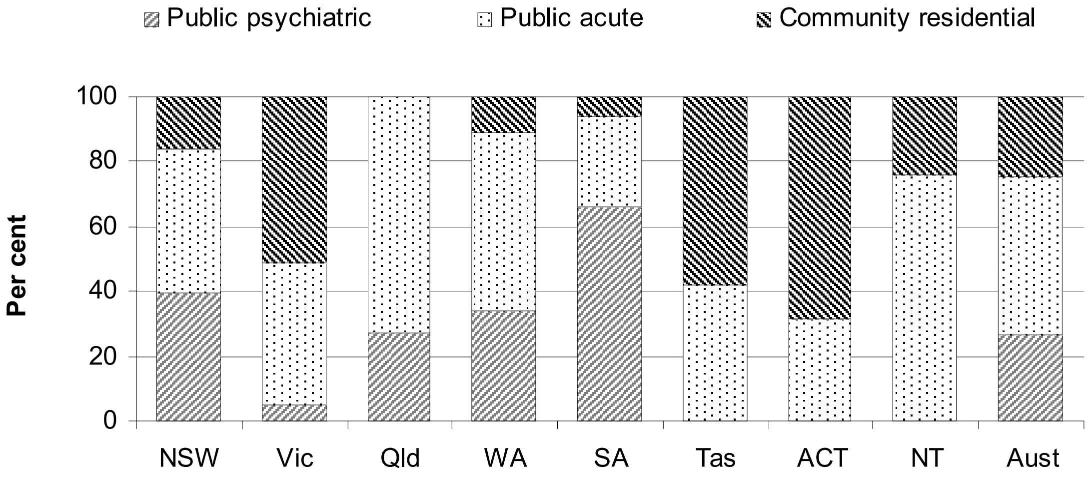
[a] Data for 2006 are preliminary; final validation is ongoing. [b] Includes beds in public hospitals and publicly funded community residential units. [c] The reduction in the number of beds in Queensland is a result of a temporary closure of some acute beds in one hospital and the permanent closure of some transitional extended treatment beds. [d] Bed numbers in WA for 2006 include emergency department observation beds in one hospital. [e] In Tasmania, for 2006, non-government organisations' residential beds funded by government are included for the first time in the publicly funded community residential facilities category. This has led to a significant change in the bed numbers between 2005 and 2006.

Source: State and Territory governments (unpublished); table 12A.27.

Figure 12.24 presents the number of beds by service category for 2006. These data show the differences in service mix across states and territories. Queensland funds a number of extended treatment services (both campus- and non-campus-based) that provide longer term inpatient treatment and rehabilitation services with full clinical staffing for 24 hours a day, seven days a week. Queensland does not report these beds as community residential beds.

Figure 12.24 **Beds, by service category, 30 June 2006**[a, b, c]



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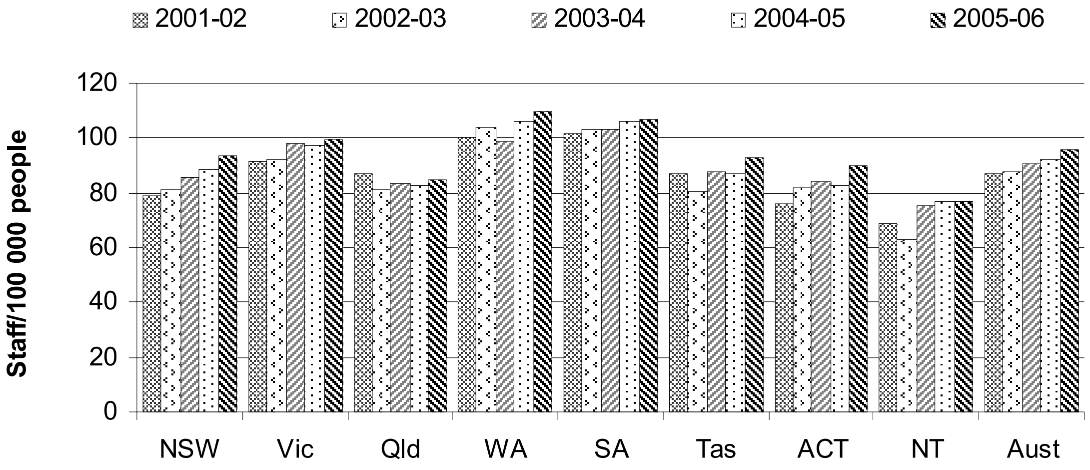
[a] Data for 2006 are preliminary; final validation is ongoing. [b] Queensland does not fund community residential services, but it funds a number of campus-based and non-campus-based extended treatment services. These services are reported either as beds in public acute hospitals or beds in public psychiatric hospitals. [c] Tasmania, the ACT and the NT do not have public psychiatric beds.

Source: State and Territory governments (unpublished); table 12A.27.

Staff

Figure 12.25 reports full time equivalent (FTE) health professional direct care staff per 100 000 people. It includes only staff within the health professional categories of ‘medical’, ‘nursing’ and ‘allied health’. ‘Medical’ staff consist of consultant psychiatrists, psychiatry registrars, and other medical officers who are neither registered as psychiatrists within the State or Territory, nor are formal trainees of the Royal Australian and New Zealand College of Psychiatrists’ Postgraduate Training Program. ‘Nursing’ staff consist of registered and non-registered nurses. ‘Allied health’ staff consist of occupational therapists, social workers, psychologists and other allied health staff. ‘Other personal care’ direct care staff are excluded. ‘Other personal care’ staff include attendants, assistants, home companions, family aides, ward helpers, orderlies, ward assistants and nursing assistants who are engaged primarily in the provision of personal care to patients or residents and who are not formally qualified or are still training in nursing or allied health professions. Definitions for staffing categories are provided in more detail in section 12.7.

Figure 12.25 **FTE health professional direct care staff per 100 000 people**[a, b, c]



[a] Data for 2005-06 are preliminary; final validation is ongoing. [b] Includes health professional occupational categories only. [c] The apparent drop in the FTE staff rate for Queensland since 2001-02, is due in part to the completion of the downsizing and redevelopment of two of the psychiatric hospital campuses which resulted in substantial staff movements and some short term reduction in staffing. The decrease in the rate of FTE per 100 000 also reflects Queensland's high population growth rate.

Source: State and Territory governments (unpublished); table 12A.28.

Nursing staff comprise the largest FTE component of health care professionals employed in mental health services. Across Australia in 2005-06, 62.0 nurses per 100 000 people were working in specialised mental health services, compared with 22.8 allied health care staff and 10.8 medical staff (table 12A.28). FTE direct care staff employed in specialised mental health services, by service setting, are reported in table 12A.29.

Services provided

Estimating activity across the specialised mental health services sector is problematic. Data for patient days are provided in figure 12.26 by acute, non-acute and 24 hour staffed community residential care (as defined in box 12.17).[6] Hospital inpatient days and community residential patient days are included in figure 12.26, but other types of community services are not covered. Collection of data outlining community mental health care patient contacts commenced in July 2000 as part of the national minimum data set, but there are continuing difficulties with data quality. As noted earlier, Queensland does not fund community residential services,

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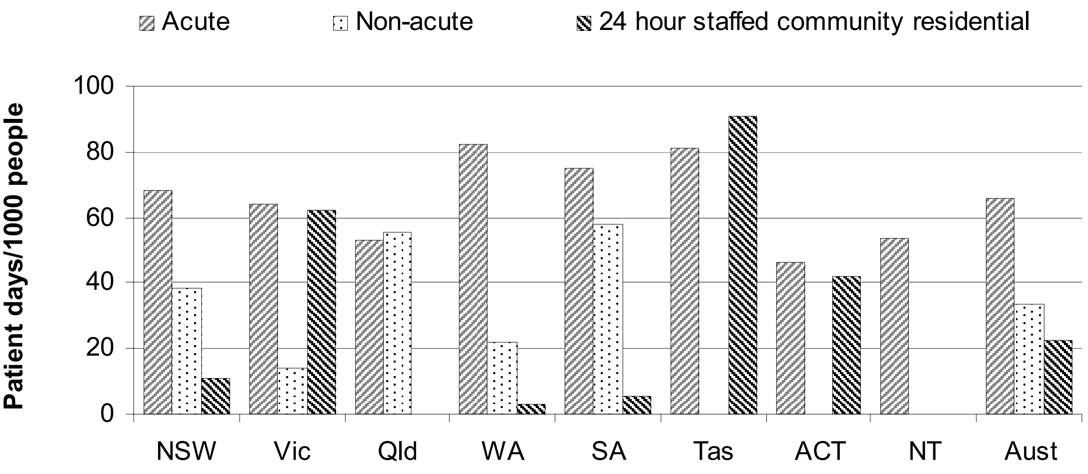
[6] Patient days are all days or part days for which the patient was in care during the relevant period, regardless of the original date of admission.

but a number of campus based and non-campus-based extended treatment services. Patient days in these services are included as non-acute.

Figure 12.26 **Mental health patient days, 2005-06[a, b, c, d]**



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[a] Data for 2005-06 are preliminary; final validation is ongoing. [b] Queensland does not fund community residential services, but it funds a number of campus based and non-campus-based extended treatment services. Data from these services are included as non-acute. [c] Tasmania, the ACT and the NT did not provide mental health care in non-acute units. [d] The NT did not provide mental health care in 24 hour staffed community residential facilities.

Source: State and Territory governments (unpublished); table 12A.30.

In 2004-05, there were 76 172 separations with specialised psychiatric care in public acute hospitals and 12 887 specialised psychiatric care separations in public psychiatric hospitals (table 12A.31). Schizophrenia accounted for a large proportion of separations with specialised psychiatric care in public hospitals (22.9 per cent in public acute hospitals and 25.1 per cent in public psychiatric hospitals) (table 12A.31).

Unlike the general acute hospital sector, mental health has few procedural same day admissions. Electroconvulsive therapy treatment of people living in the community represented 6–10 per cent of all same day separations. Work for the Mental Health Classification and Service Costs Project suggested that the majority of same day hospitalisations are better described as ambulatory care and involve consumer attendance at a variety of day and group-based programs that otherwise could be provided in community settings (Buckingham *et al.* 1998). In 2004-05, there were 10 510 ambulatory equivalent same day separations with specialised psychiatric care in public acute hospitals and 1775 in public psychiatric hospitals (AIHW 2007c).

Services by general practitioners

Limited data are available on GP care of mental health patients. The following data are collected from a sample of 1000 GPs as part of the BEACH (Bettering the Evaluation and Care of Health) survey. In 2006-07, 11.0 of every 100 encounters with a GP involved mental health problems. The most frequently reported mental health related problem managed in GP encounters was depression (3.7 per 100 GP encounters). Anxiety (1.7 per 100 GP encounters) and sleep disturbance (1.6 per 100 GP encounters) were the next most common psychological problems managed. In 2006-07, depression was the seventh most frequently managed problem by a GP (Britt *et al*. 2008).[7]

Indigenous patients

Limited data are available on specialised psychiatric care of Indigenous patients in hospital. Comparisons are difficult because data on Indigenous status are incomplete and Indigenous people and other Australians may differ in their use of hospital services relative to other health services. The data reflect a range of factors, such as: the spectrum of public, primary care and post-hospital care available; Indigenous people's access to these as well as hospital services; social and physical infrastructure services for Indigenous people; and differences in the complexity, incidence and prevalence of disorders. For the jurisdictions for which data are available, the total average length of stay for Indigenous people was shorter than for non-Indigenous people (table 12.7).

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[7] A GP often managed more than one problem at a single encounter. Problems managed reflect the GP's understanding of the health problem presented by the patient.

Table 12.7 **Specialised psychiatric care, by Indigenous status, 2004-05[a, b]**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Total*[c]
Indigenous										
Separations	no.	np	np	1 181	610	332	np	np	494	2 617
Separation rate	per '000 people	np	np	9.9	9.1	13.0	np	np	7.7	9.5
Patient days	no.	np	np	30 381	11 153	5 795	np	np	4 037	51 366
Psychiatric care days	no.	np	np	30 228	11 091	5 795	np	np	3 999	51 113
Average length of stay[d]	no.	np	np	27.4	18.3	17.8	np	np	9.2	20.7
Non-Indigenous										
Separations	no.	np	np	26 141	11 121	9 848	np	np	680	47 790
Separation rate	per '000 people	np	np	7.0	5.8	6.5	np	np	4.7	6.5
Patient days	no.	np	np	537 377	215 611	199 829	np	np	7 065	959 882
Psychiatric care days	no.	np	np	533 950	213 241	199 829	np	np	7 038	954 058
Average length of stay[d]	no	np	np	23.9	20.4	23.0	np	np	10.9	22.6

[a] The completeness of data on Indigenous status varies, so these data need to be used with care. [b] Specialised psychiatric care refers to separations in which at least one day of specialised psychiatric care was received. [c] Data are for Queensland, WA, SA and the NT only. [d] Includes data for overnight separations only. **np** Not published.

Source: AIHW (2007c); table 12A.32.

Framework of performance indicators

Preventing the onset of mental illness is challenging, primarily because individual disorders have many origins. Most efforts have been directed at treating mental illness when it occurs, determining the most appropriate setting for providing treatment and emphasising early intervention.

The framework of performance indicators for mental health services builds on government objectives for mental health service delivery (box 12.18) as encompassed in the NMHS and the Council of Australian Governments (COAG) National Action Plan on Mental Health. The framework reports on the equity, effectiveness and efficiency of specialised mental health services. It covers a number of service delivery types (institutional and community-based services) and indicators of systemwide performance. Improving the framework is a priority of the Steering Committee.

Box 12.18 **Objectives for mental health services**

Key objectives include to:

- improve the effectiveness and quality of service delivery and outcomes
- promote, where appropriate, community awareness of mental health problems
- prevent, where possible, the development of mental health problems and mental disorders
- undertake, where appropriate, early intervention of mental health problems and mental disorders
- reduce, where possible, the impact of mental disorders on individuals, families and the community
- assure the rights of persons with mental disorders
- encourage partnerships among service providers and between service providers and the community
- provide services in an equitable (including improved access to mental health services, particularly in Indigenous and rural communities) and efficient manner.

Governments also aim to improve mental health and facilitate recovery from illness through more stable accommodation and support and meaningful participation in recreational, social, employment and other activities in the community.

The Australian, State and Territory governments endorsed the NMHS in 1992. The Strategy consists of the National Mental Health Policy and the National Mental Health Plan.

- The National Mental Health Policy describes the broad aims and objectives of the Strategy. The Policy has 38 objectives, including those that relate to the shift from institutional to community-based services, and the delivery of services in mainstream settings (AIHW 2007c).
- The National Mental Health Plan describes the approach to implementing the aims and objectives of the Policy. A Third Plan (2003–2008) was endorsed by all Australian Health Ministers in July 2003. This plan consolidates reforms begun under the first two plans (AIHW 2007c).

The National Strategic Framework for Aboriginal and Torres Strait Islander People's Mental Health and Social and Emotional Well Being 2004–2009 (the Social and Emotional Well Being Framework) was endorsed by the Australian Health Ministers' Advisory Council in December 2004. It aims to provide a framework for action by all governments and communities to improve the social and emotional wellbeing and mental health needs of Indigenous Australians over the next five years.

In 2006, COAG agreed to the National Action Plan on Mental Health 2006–2011 (COAG 2006). This plan involves a joint package of measures and new investments by all governments aimed at promoting better mental health and providing additional support to people with mental illness, their families and their carers. The Action Plan is directed at achieving four outcomes:

- reducing the prevalence and severity of mental illness in Australia
- reducing the prevalence of risk factors that contribute to the onset of mental illness and prevent longer term recovery
- increasing the proportion of people with an emerging or established mental illness who are able to access the right health care and other relevant community services at the right time, with a particular focus on early intervention
- increasing the ability of people with a mental illness to participate in the community, employment, education and training, including through an increase in access to stable accommodation.

A series of measures have been identified to monitor progress against these outcomes. Australian Health Ministers agreed to report annually to COAG on implementation of the Plan, and on progress against the agreed outcomes. Governments also agreed to an independent evaluation and review of the Plan after five years (COAG 2006).

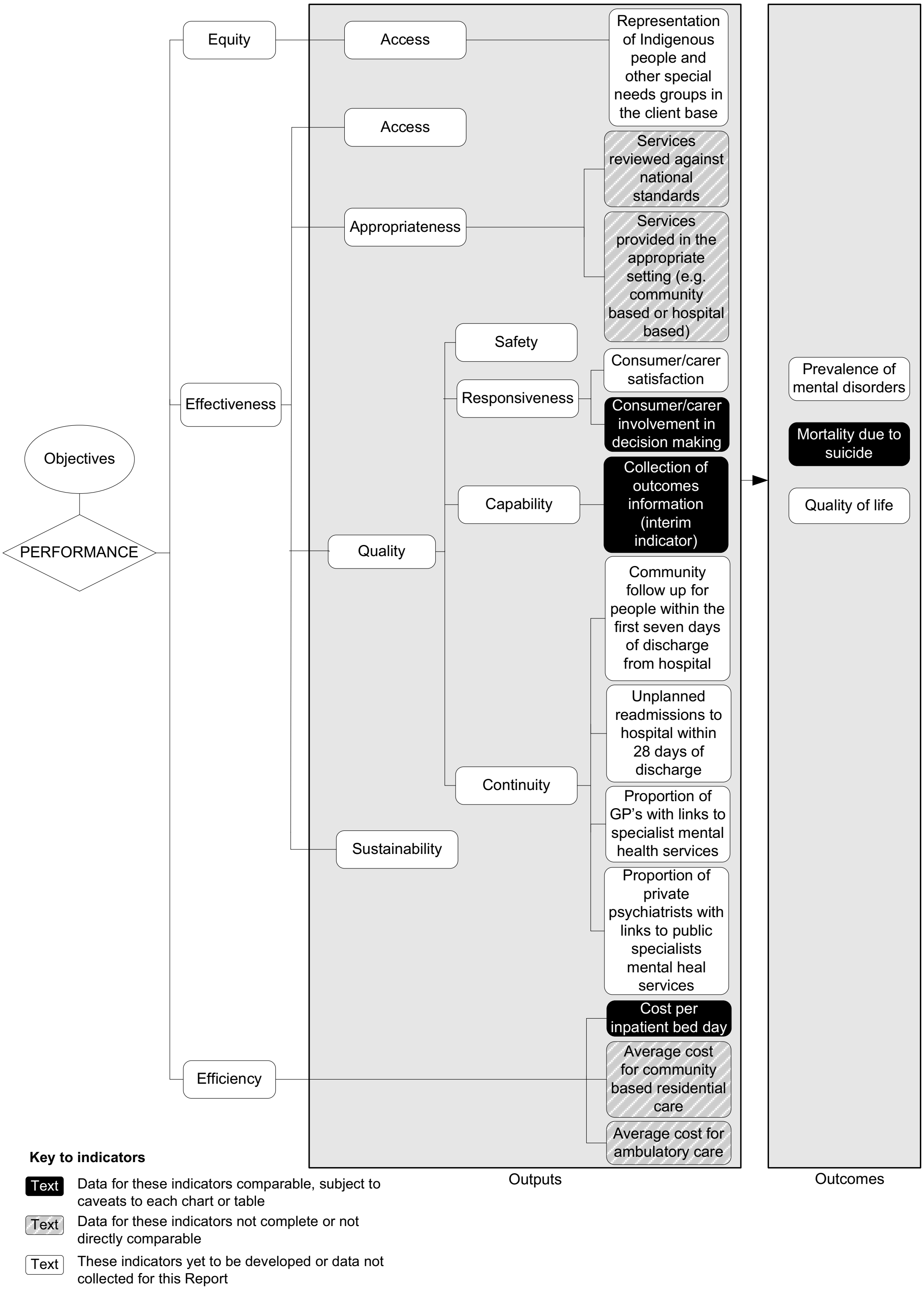
The performance indicator framework shows which data are comparable in the 2008 Report (figure 12.27). For data that are not considered directly comparable, the text includes relevant caveats and supporting commentary. Chapter 1 discusses data comparability from a Report-wide perspective (see section 1.6). The 'Health preface' explains the performance indicator framework for health services as a whole, including the sub-dimensions for quality and sustainability that have been added to the standard Review framework for health services.

Some changes have been made to the mental health framework for the 2008 Report. The following 'yet to be developed' indicators have been included:

- 'community follow-up for people within seven days of discharge from hospital'
- 'unplanned readmissions to hospital within 28 days of discharge'.

These new indicators are agreed national key performance indicators and are progress measures under the COAG National Action Plan on Mental Health. National reporting against the indicators is yet to be published. Data for these indicators should be available for inclusion in the 2009 Report.

Figure 12.27 **Performance indicators for mental health management**



Key performance indicator results

Outputs

Outputs are the actual services delivered (while outcomes are the impact of these services on the status of an individual or group) (see chapter 1, section 1.5).

Equity — representation of Indigenous people and others in the client base

The Steering Committee has identified the 'representation of Indigenous people and other special needs groups in the client base' as a key area for development in future reports (box 12.19).

Box 12.19 **Representation of Indigenous people and other special needs groups in the client base**

The 'representation of Indigenous people and other special needs groups in the client base' is an indicator of governments' aim to provide mental health services in an equitable manner, including access to services by special needs groups such as Indigenous people.

Access

The Steering Committee has identified access as an area for reporting, but no indicators have yet been developed.

Appropriateness — services reviewed against the national standards

'Services reviewed against the national standards for Mental Health Services and assessed as meeting all or most standards' is an indicator of the appropriateness of mental health services (box 12.20).

Box 12.20 **Services reviewed against the national standard**

‘Services reviewed against the national standards for Mental Health Services and assessed as meeting all or most standards’ is a process indicator of appropriateness, reflecting progress being made in meeting the national standards for mental health care. Data are reported separately for the proportion of services assessed at level 1 and at level 2, where level 1 and level 2 are defined as:

- Services assessed at level 1. The number of specialised public mental health services that have been reviewed against the National Standards for Mental Health Services by an external accreditation agency and assessed as meeting all Standards.
- Services assessed at level 2. The number of specialised public mental health services that have been reviewed against the National Standards for Mental Health Services by an external accreditation agency and assessed as meeting some but not all Standards.

The national standards are outlined in box 12.21. The National Standards are currently undergoing a comprehensive review. The second phase of the review commenced in March 2007 and is scheduled to conclude in January 2008. The third and final phase of the review will commence in January 2008 and conclude in May 2008. The final phase will refine the Standards and the implementation process including assessment tools. During this phase, the monitoring and reporting processes will also be developed.

External accreditation agencies, such as the Australian Council on Healthcare Standards, undertake accreditation of a parent health organisation (for example, a hospital) that may cover a number of specialist services, including mental health services. Accreditation of a parent organisation does not currently require a mental health service to be separately assessed against the national standards; rather, assessment against the national standards must be specifically requested and involves a separate review process.

Box 12.21 **The National Standards for Mental Health Services**

The National Standards for Mental Health Services were developed under the First National Mental Health Plan for use in assessing service quality and as a guide for continuous quality improvement in all Australian mental health services. They comprise 11 major criteria:

1. rights
2. safety
3. consumer and carer participation
4. promoting community acceptance
5. privacy and confidentiality
6. prevention and mental health promotion
7. cultural awareness
8. integration
9. service development
10. documentation
11. delivery of care.

Source: DoHA (2002).

Table 12.8 shows the percentage of specialised public mental health services that have completed an external review process against the National Standards for Mental Health Services and have been assessed as meeting ‘all standards’ (level 1) or of meeting ‘some but not all standards’ (level 2).

Table 12.8 **Specialised public mental health services reviewed against the National Standards for Mental Health Services, 30 June (per cent)**

	NSW	*Vic*	*Qld*	*WA*[a]	*SA*	*Tas*	*ACT*	*NT*	*Aust*[b]
2002									
Level 1	na	na	85.6	na	na	na	81.3	–	67.9
Level 2	na	na	na	na	na	na	..	–	–
2003									
Level 1	na	na	31.1	na	11.7	na	81.3	–	22.8
Level 2	na	na	62.2	na	14.6	na	..	–	32.7
2004									
Level 1	na	100.0	84.2	na	49.5	na	81.3	50.0	67.3
Level 2	na	–	9.2	na	5.6	na	..	–	5.2
2005									
Level 1	73.4	100.0	80.0	64.5	72.7	46.9	87.5	50.0	74.8
Level 2	0.6	–	7.5	12.9	2.7	–	..	50.0	2.2
2006									
Level 1	78.0	100.0	77.0	54.8	62.9	36.4	100.0	50.0	75.4
Level 2	0.9	–	2.5	6.5	3.4	15.2	–	50.0	2.2

[a] WA has a number of services currently involved in re-accreditation as well as internal review against the National Standards that are not included in the table. [b] The Australian totals only apply to jurisdictions for which data are available. **na** Not available. .. Not applicable – Nil or rounded to zero.

Source: State and Territory governments (unpublished); table 12A.33.

Appropriateness — services provided in the appropriate setting

'Services provided in the appropriate setting' is an indicator of the extent to which mental health services are provided in an appropriate setting, that is in local and community settings (box 12.22).

Box 12.22 **Services provided in the appropriate setting**

‘Services provided in the appropriate setting’ is an indicator of the development of local comprehensive mental health service systems advocated by the NMHS. Mental health services must be capable of responding to the individual needs of people with mental disorders and of providing continuity of care, so consumers can move between services as their needs change. The strategy advocates:

- a reduced reliance on stand-alone psychiatric hospitals
- the expanded delivery of community-based care integrated with inpatient care
- mental health services being mainstreamed with other components of health care.

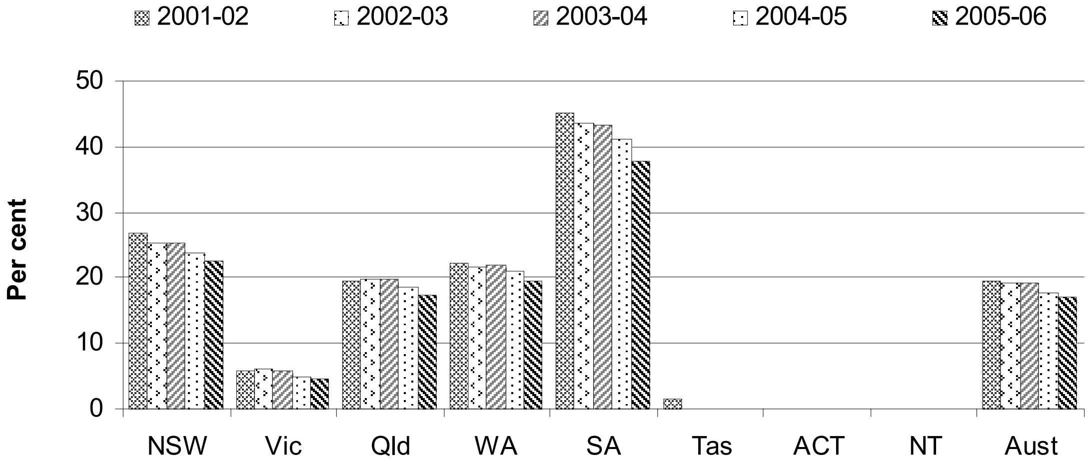
More appropriate treatment options can be provided by encouraging the treatment of patients in community settings and public (non-psychiatric) hospitals rather than in stand-alone psychiatric hospitals.

Two measures of ‘services provided in the appropriate setting’ are reported.

- Recurrent expenditure on stand-alone psychiatric hospitals as a proportion of total spending on mental health services. A low proportion for this indicator is desirable, reflecting a low reliance on stand-alone psychiatric hospitals.
- Acute patient days in public acute hospitals as a proportion of the total acute inpatient bed days in public acute and psychiatric hospitals. A high proportion for this indicator is desirable, reflecting greater mainstreaming of mental health services.

Figure 12.28 shows recurrent expenditure on stand-alone psychiatric hospitals as a proportion of total expenditure on mental health services.

Figure 12.28 **Recurrent expenditure on stand-alone psychiatric hospitals as a proportion of total expenditure on mental health services**[a, b, c]



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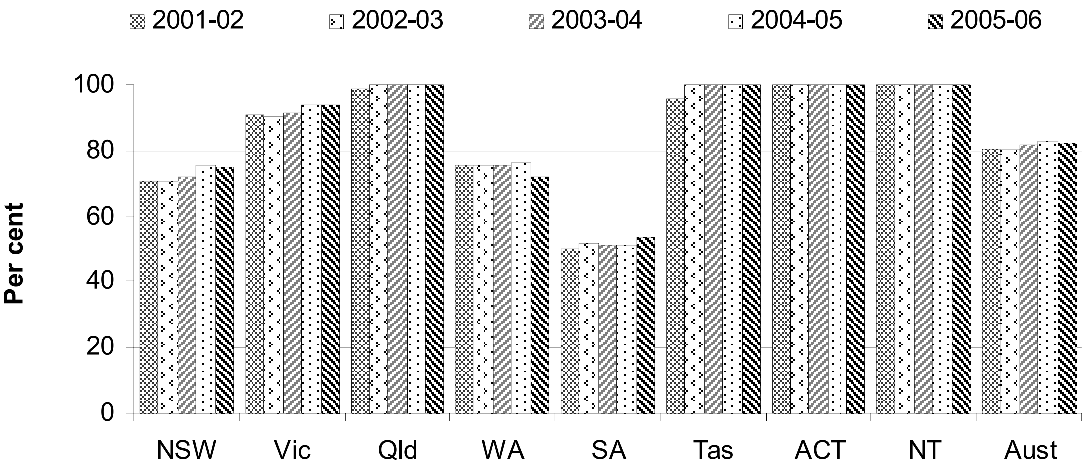
[a] Data for 2005-06 are preliminary; final validation is ongoing. [b] SA total recurrent expenditure data for 2003-04 and 2004-05 that were used to derive these results have been revised. [c] The ACT and the NT do not have public psychiatric hospitals. Tasmania has not had public psychiatric hospitals since 2001-02.

Source: State and Territory governments (unpublished); table 12A.34.

Figure 12.29 shows acute patient days in public acute hospitals as a proportion of the total acute inpatient bed days in public acute and psychiatric hospitals. Nationally, the proportion of acute patient days in public acute hospitals as a proportion of total acute inpatient bed days in public acute and psychiatric hospitals has increased slightly over the period from 2001-02 to 2005-06.

Figure 12.29 **Acute patient days in public acute hospitals as a proportion of total acute inpatient bed days in public acute and psychiatric hospitals**[a]



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[a] Data for 2005-06 are preliminary; final validation is ongoing.

Source: State and Territory governments (unpublished); table 12A.34.

Quality — consumer and carer satisfaction

The Steering Committee has identified ‘consumer and carer satisfaction’ as an area for development in future reports (box 12.23).

Box 12.23 **Consumer and carer satisfaction**

‘Consumer and carer satisfaction’ is an indicator of satisfaction with both clinician’s responses and with services provided in all areas of mental health. Both are important aspects of the NMHS.

Quality — consumer and carer involvement in decision making

‘Consumer and carer involvement in decision making’ is an effectiveness indicator of mental health management (box 12.24).

Box 12.24 **Consumer and carer involvement in decision making**

‘Consumer and carer involvement in decision making’ is an important aspect of the NMHS. It is an indicator of consumers’ and carers’ involvement at the service delivery level, where they have the opportunity to influence the services they receive. This indicator has the following two measures:

- ‘Organisations with consumer participation in decision making’
- ‘Paid consumer and carer consultants per 10 000 clinicians’.

‘Organisations with consumer participation in decision making’ relates to the arrangements that allow consumers to contribute to local service planning and delivery in specialised mental health services. Arrangements are grouped into four categories:

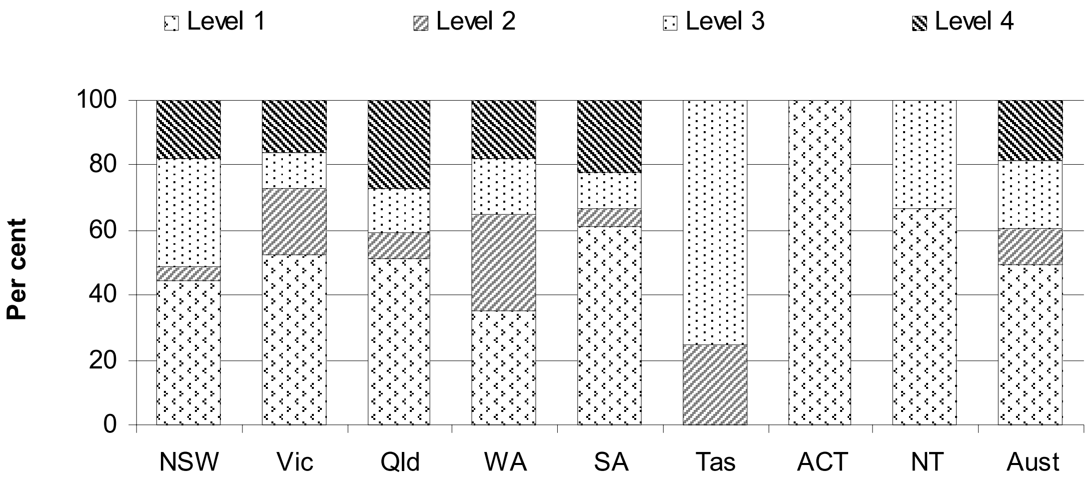
- level 1 — organisation has a formal position for mental health consumers on the management committee or a specific mental health consumer advisory group exists to advise on all aspects of service delivery
- level 2 — organisation has a specific mental health consumer advisory group to advise on some but not all aspects of service delivery
- level 3 — organisation includes mental health consumers on a broadly based advisory committee
- level 4 — organisation has minimal/no arrangements for mental health consumer participation in planning and evaluation of services.

An organisation can be classified at only one level. A high proportion of organisations with level 1 arrangements is desirable, while a high proportion of organisations with level 4 arrangements is undesirable.

‘Paid consumer and carer consultants per 10 000 clinicians’ reports the number of paid consumer consultants per 10 000 clinical staff and the number of paid carer consultants per 10 000 clinical staff. Higher numbers of such staff imply a greater chance that paid consumers and carers can be involved in decision making.

Figure 12.30 illustrates the degree of consumer participation in decision making. As notes to figure 12.30 indicate, current categories do not match all jurisdictions arrangements for consumer participation in decision making. Work to improve reporting in this area is needed.

Figure 12.30 **Organisations with consumer participation in decision making, 2005-06**[a, b, c, d]



[a] Data for 2005-06 are preliminary; final validation is ongoing. Non-government organisations are included only where they provide staffed residential services. [b] NSW advised that the government has no authority to require consumer participation in services delivered through the primary care program. [c] WA advised that these data do not accurately represent consumer and carer participation strategies used in WA. High priority is given to the involvement of consumers and carers at a state, regional and health service level in developing a responsive mental health service. Several key consumer and carer advisory groups are supported and provided with financial assistance and, collectively, these groups provide advice and representation on consumer and carer issues. [d] An expanded range of indicators of consumer and carer participation for 2002-03 are reported in the *National Mental Health Report 2005*.

Source: State and Territory governments (unpublished); table 12A.35.

Table 12.9 illustrates the number of paid FTE consumer and carer consultants per 10 000 FTE clinicians.

Table 12.9 **Paid FTE consumer and carer consultants per 10 000 FTE clinical staff**[a]

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Paid consumer consultants per 10 000 clinicians									
2002-03	na	na	19.5	na	12.7	na	na	–	na
2003-04	25.9	na	21.6	na	16.6	na	na	–	na
2004-05	26.7	na	24.4	na	23.8	na	na	–	na
2005-06	40.2	38.7	29.1	2.2	16.7	–	41.1	–	30.3
Paid carer consultants per 10 000 clinicians									
2002-03	na	na	3.2	na	–	na	na	–	na
2003-04	na	na	3.1	na	–	na	na	–	na
2004-05	3.3	na	3.1	na	–	na	na	–	na
2005-06	4.1	23.1	2.9	–	–	–	–	–	0.8

[a] Data for 2005-06 are preliminary; final validation is ongoing. **na** Not available. – Nil or rounded to zero.

Source: State and Territory governments (unpublished); table 12A.35.

Quality — collection of outcomes information (interim indicator)

The 'collection of outcomes information' is an interim effectiveness indicator of mental health management (box 12.25).

Box 12.25 **Collection of outcomes information (interim indicator)**

The 'collection of outcomes information' is an interim indicator until information on client outcomes is available. Establishing a system for the routine monitoring of consumer outcomes was introduced as part of the National Mental Health Plan 2003–2008. Jurisdictions are introducing a collection that will enable reporting in future.

States and territories have taken the following approach to introducing consumer outcomes measurement as part of day-to-day service delivery:

- measures to include ratings by clinicians and self-ratings by consumers
- all clinical staff to have undergone training in collection
- processes established to ensure uniformity in collection
- funding for information systems to store, analyse and report on the data
- a national approach to data analysis, reporting and benchmarking (DoHA 2002).

This indicator is the proportion of specialised mental health services that have introduced routine collection of consumer outcomes information. A high proportion is desirable for this indicator.

The percentages of specialised mental health services that have introduced routine consumer outcomes measurement are shown in table 12.10.

Table 12.10 **Specialised mental health services that introduced the routine collection of consumer outcomes measurement (per cent)[a]**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
June 2002	55.8	11.3	–	–	–	17.6	–	–	33.2
June 2003	77.3	72.6	47.1	7.4	–	94.4	100.0	100.0	63.3
June 2004	100.0	98.1	100.0	71.0	49.5	94.4	100.0	100.0	82.9
June 2005	100.0	98.2	100.0	100.0	78.1	96.9	100.0	100.0	93.2
June 2006	100.0	96.9	100.0	100.0	77.6	97.0	100.0	100.0	93.0

[a] Data are based on reports from jurisdictions. Jurisdictions report at varying levels, reflecting differences in service structure — for example, data may be reported at area health service level or at hospital level, with each level containing a number of specialist mental health services. Data are thus aggregated. – Nil or rounded to zero.

Source: State and Territory governments; table 12A.36.

Quality — community follow up for people within the first seven days of discharge from hospital

The Steering Committee has identified ‘community follow up for people within the first seven days of discharge from hospital’ as an indicator of the effectiveness of mental health management (box 12.26). This indicator is a progress measure under the COAG National Action Plan. Data for this indicator should be available for the 2009 Report.

Box 12.26 **Community follow up for people within the first seven days of discharge from hospital**

‘Rates of community follow up for people within the first seven days of discharge from hospital’ is an indicator of the objective of mental health service delivery to provide continuity of care. A responsive community support system for people who have experienced an acute psychiatric episode requiring hospitalisation is essential to maintain clinical and functional stability and to minimise the need for readmission to hospital.

Quality — unplanned readmissions to hospital within 28 days of discharge

The Steering Committee has identified ‘readmissions to hospital within 28 days of discharge’ as an indicator of the effectiveness of mental health management (box 12.27). This indicator is a progress measure under the COAG National Action Plan. Data for this indicator should be available for the 2009 Report.

Box 12.27 **Readmissions to hospital within 28 days of discharge**

‘Readmissions to hospital within 28 days of discharge’ is an indicator of the objective of mental health service delivery to provide continuity of care. While inpatient services aim to provide treatment that enables individuals to return to the community as soon as possible, unplanned admissions following a recent discharge may indicate that inpatient treatment was either incomplete or ineffective, or that follow-up care was inadequate to maintain the person out of hospital. Therefore, readmission rates can identify deficiencies in the functioning of the overall care system.

Quality — proportion of GPs with links to specialist mental health services

The Steering Committee has identified the ‘proportion of GPs with links to specialist mental health services’ as an indicator of the effectiveness of mental health management (box 12.28). Data for this indicator were not available for the 2008 Report.

Box 12.28 **Proportion of GPs with links to specialist mental health services**

The 'proportion of GPs with links to specialist mental health services' is an indicator of the objective of mental health service delivery to provide continuity of care. GPs can be an important first point of contact for those with a mental illness.

Quality — proportion of private psychiatrists with links to public specialist mental health services

The Steering Committee has identified the 'proportion of private psychiatrists with links to public specialist mental health services' as an indicator of the effectiveness of mental health management (box 12.29). Data for this indicator were not available for the 2008 Report.

Box 12.29 **Proportion of private psychiatrists with links to public specialist mental health services**

The 'proportion of private psychiatrists with links to public specialist mental health services' is an indicator of the objective of mental health service delivery to provide continuity of care.

Sustainability

The Steering Committee has identified sustainability as an area for reporting but no indicators have yet been identified.

Efficiency

Data for 2005-06 are preliminary and will be further validated as part of the production of a future National Mental Health Report. They therefore need to be interpreted with caution.

Efficiency — cost per inpatient bed day

'Cost per inpatient bed day' is an efficiency indicator of mental health management (box 12.30).

Box 12.30 **Cost per inpatient bed day**

The 'cost per inpatient bed day' is a proxy indicator of the efficiency of mental health service delivery. An aim of mental health service delivery is to provide services in an efficient manner.

This indicator is defined as the cost of providing inpatient services per inpatient bed day. A low cost per inpatient bed day can indicate efficiency, although caution must be used because the cost per inpatient bed day does not provide any information on the quality of service provided.

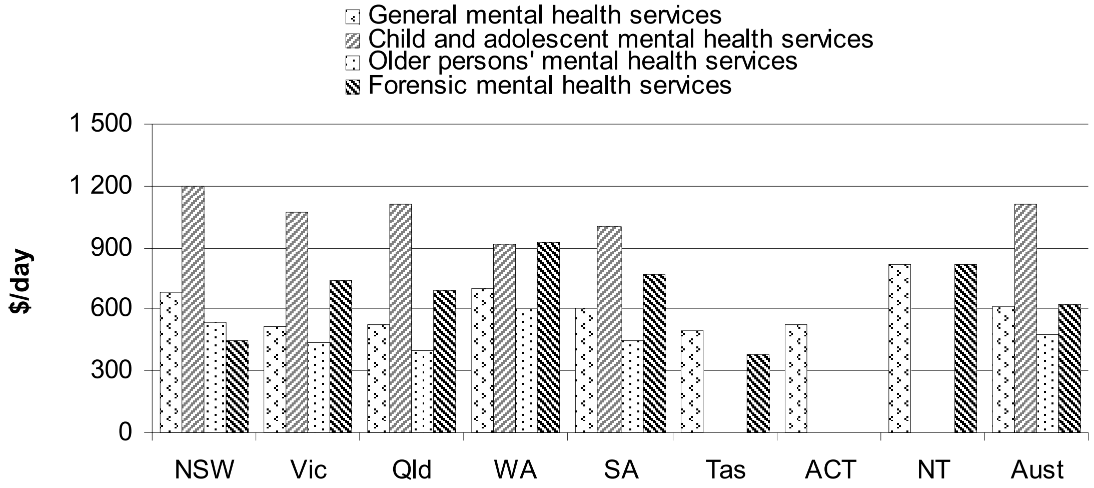
Reported real inpatient costs per day are disaggregated by inpatient program type (general mental health services, child and adolescent mental health services, older persons' mental health services and forensic mental health services) and hospital type (psychiatric hospitals (acute units), psychiatric hospitals (non-acute units) and general hospitals). Disaggregating these data improves comparability across jurisdictions.

This indicator is affected by factors such as differences in the client mix and average length of stay. The client mix in inpatient settings may differ — for example, some jurisdictions treat a higher proportion of less complex patients in inpatient settings rather than in the community. Longer lengths of stay may also be associated with lower average inpatient day costs because the costs of admission, discharge and more intensive treatment early in a stay are spread over more days of care.

The most suitable indicator for mental health services would be to adjust the number of separations by the type and complexity of cases, to develop a cost per casemix adjusted separation similar to that presented for public hospitals (chapter 10), but casemix data for specialised mental health services are not available.

Inpatient costs per day are presented in figures 12.31 (by inpatient program type) and 12.32 (by hospital type). Changes over time partly reflect institutional change in accordance with the NMHS (for example, a shift to the delivery of services in mainstream settings).

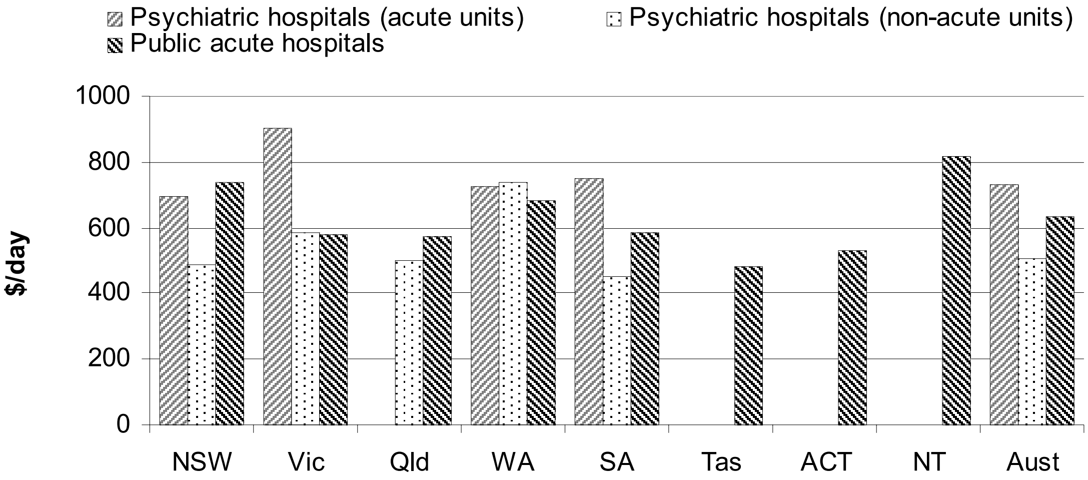
Figure 12.31 **Average recurrent cost per inpatient bed day, public hospitals, by inpatient program type, 2005-06**[a, b, c, d, e, f]



[a] Data for 2005-06 are preliminary; final validation is ongoing. [b] Depreciation is excluded. [c] Costs are not adjusted for differences in the complexity of cases across jurisdictions and may reflect differences in the rate of institutional change (that is, the mainstreaming of mental health services). [d] Queensland advised that it provides older persons' mental health services using different service models, including campus-based and non-campus based options. All service types are reported as older persons' mental health services, which may have the effect of lowering the average patient day costs compared with the costs of jurisdictions that report older persons' care units separately. [e] Tasmania and the NT do not provide, or cannot separately identify, child and adolescent mental health services or older persons' mental health services. [f] The ACT does not have separate forensic, child and adolescent and older persons' mental health inpatient services.

Source: State and Territory governments (unpublished); table 12A.37.

Figure 12.32 **Average recurrent cost per inpatient bed day, public hospitals, by hospital type, 2005-06**[a, b, c, d, e, f]



[a] Data for 2005-06 are preliminary; final validation is ongoing. [b] Depreciation is excluded. [c] Costs are not adjusted for differences in the complexity of cases across jurisdictions and may reflect differences in the rate of institutional change (that is, the mainstreaming of mental health services). [d] Mainstreaming has occurred at different rates in different jurisdictions. Victoria advised that the data for psychiatric hospitals comprise mainly forensic services, because nearly all general psychiatric treatment occurs in mainstreamed units in general acute hospitals. This means the client profile and service costs are very different from those of a jurisdiction in which general psychiatric treatment still occurs mostly in psychiatric hospitals. [e] Queensland data for general hospitals include costs associated with two extended treatment units that report through general acute hospitals. Queensland does not provide acute services in psychiatric hospitals. [f] Tasmania, the ACT and the NT do not have psychiatric hospitals.

Source: State and Territory governments (unpublished); table 12A.38.

Efficiency — average cost for community-based residential care

The ‘average cost for community-based residential care’ is an efficiency indicator of mental health management (box 12.31).

The average recurrent cost to government per patient day for community residential services is presented in table 12.11. For general adult units in 2005-06, the average cost to government per patient day for 24 hour staffed community residential services was an estimated $341 nationally. For non-24 hour staffed community residential units, the average cost to government per patient day was $123 nationally.

Box 12.31 **Average cost for community-based residential care title**

The 'average cost for community-based residential care' is an indicator of the efficiency of mental health service delivery. An aim of mental health service delivery is to provide services in an efficient manner.

This indicator is defined as the cost of providing community-based residential care per patient day. A low average cost can indicate efficiency, although caution must be used because the average cost does not provide any information on the quality of service provided.

These data are likely to be affected by institutional changes occurring as a result of the NMHS (for example, a shift to the delivery of services in mainstream settings). In addition, differences across jurisdictions in the types of patient admitted to community residential care affect average costs in these facilities. Average recurrent costs to government per patient day for these services are reported for both the care of adults and the care of older people. The distinction is made to reflect the differing unit costs of treating the two groups.

For jurisdictions that had community-based older persons' care units in 2005-06, the average recurrent cost to government per patient day for 24 hour staffed community residential services was $272 nationally (table 12.11).

Table 12.11 **Average recurrent cost to government per patient day for community residential services, 2005-06[a, b, c]**

	NSW	*Vic*	*Qld*[d]	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
General adult units									
24 hour staffed units	255	381	..	396	215	310	375	..	341
Non-24 hour staffed units	81	165	..	129	251	..	58	105	123
Older persons' care units									
24 hour staffed units	274	270	..	..	..	354	61	..	272
Non-24 hour staffed units	105	..	..	..	..	..	..	..	105

[a] Data for 2005-06 are preliminary; final validation is ongoing. [b] Depreciation is excluded. [c] Costs are not adjusted for differences in the complexity of cases across jurisdictions and may reflect differences in the rate of institutional change (that is, the mainstreaming of mental health services). [d] Queensland does not fund community residential services, although it funds a number of campus-based and non-campus-based extended treatment services. .. Not applicable.

Source: State and Territory governments (unpublished); table 12A.39.

Efficiency — average cost for ambulatory care

The ‘average cost for ambulatory care’ is an efficiency indicator of mental health management (box 12.32).

Box 12.32 **Average cost for ambulatory care**

The ‘average cost for ambulatory care’ is an indicator of the efficiency of mental health service delivery. An objective of mental health service delivery is to provide services in an efficient manner.

This indicator is defined as the cost of providing ambulatory care per treated patient in the community. A low average cost can indicate efficiency, although caution must be used because the average cost does not provide any information on the quality of service provided.

The provision of ambulatory treatment, rehabilitation and support to non-inpatients, and post-acute care are important components of service provision, and the Steering Committee has identified continued improvement in reporting in these areas as a priority.

Unit costs (dollars per treated patient in the community) for 2005-06 are reported below for all states and territories. However, these data are unreliable and comparisons across jurisdictions are not possible for several reasons. First, information about service costs across jurisdictions is incomplete or inconsistent (for example, depreciation is not measured consistently across states and territories). Second, the absence of unique patient identifiers in many jurisdictions means clients who use mental health services other than their usual service may be counted twice. This double counting may artificially reduce average costs in some states or territories. Victoria, WA and the NT have statewide systems of unique identifiers, so the potential for overcounting of patients in these jurisdictions is relatively low compared with that in other jurisdictions. Third, differences across jurisdictions in the complexity of cases treated, the service options available for treatment and the admission practices adopted reduce the comparability of data across states and territories.

- NSW reported ambulatory care unit costs of $1154 per treated patient in the community in 2005-06, with 7.7 per cent of services (accounting for 3.0 per cent of expenditure) not reporting (table 12A.40).
- Victoria reported ambulatory care unit costs of $3172, with 18.0 per cent of services (accounting for 2.5 per cent of expenditure) not reporting (table 12A.41).

- Queensland reported ambulatory care unit costs of $1755, with all services reporting (table 12A.42).
- WA reported ambulatory care unit costs of $3151, with all services reporting (table 12A.43).
- SA reported ambulatory care unit costs of $1641, with 5.4 per cent of services (accounting for 4.5 per cent of expenditure) not reporting (table 12A.44).
- Tasmania reported ambulatory care unit costs of $2328 with 4.3 per cent of services (accounting for 3.0 per cent of expenditure) not reporting (table 12A.45).
- The ACT reported ambulatory care unit costs of $1978, with 16.7 per cent of services (accounting for 0.9 per cent of expenditure) not reporting (table 12A.46).
- The NT reported ambulatory care unit costs of $1607, with all services reporting (table 12A.47).
- Across Australia, average ambulatory care unit costs per treated patient in the community were $1781, with 8.8 per cent of services (accounting for 2.0 per cent of expenditure) not reporting (table 12A.48).

Outcomes

Outcomes are the impact of services on the status of an individual or group (while outputs are the actual services delivered) (see chapter 1, section 1.5).

Prevalence of mental disorders

The Steering Committee has identified the ‘prevalence of mental disorders’ as an indicator for development in future reports (box 12.33).

Box 12.33 **Prevalence of mental disorders**

The ‘prevalence of mental disorders’ is an outcome indicator of the objective of mental health service delivery to prevent and reduce mental health problems where possible.

There are no nationally comparable data on the prevalence of mental disorders treated by specialised mental health services. Data on levels of psychological distress (K10) are included in section 12.4. While there is an association between high levels of physiological distress and mental disorders (Andrews and Slade 2001), these data are not included under this indicator as they may not provide a sufficiently robust measure.

Mortality due to suicide

‘Mortality due to suicide’ is an outcome indicator of mental health management (box 12.34).

Box 12.34 **Mortality due to suicide**

Mortality due to suicide’ is a mental health management indicator because evidence indicates that people with a mental disorder are at a higher risk of suicide than are the general population. (They are also at a higher risk of death from other causes, such as cardiovascular disease.)

This indicator is reported as the suicide rate per 100 000 people for all people, people aged 15–24 years, people living in capital cities, people living in other urban areas, people living in rural areas and Indigenous people. While the performance of mental health services is important in reducing suicide, other government services also play a significant role. Public mental health programs are primarily concerned with providing treatment and support services for individual clients affected by serious mental illness, some of whom have either attempted, or indicated the intention, to commit suicide. Suicide prevention targeted at the wider population is also addressed through the initiatives of other government departments, non-government organisations and other special interest groups. Any impact on suicide rates, therefore, will be a result of a coordinated response across a range of collaborating agencies, including police, education, housing, justice and community services agencies.

In addition, many factors outside the control of mental health services may influence a person’s decision to commit suicide. These include environmental, sociocultural and economic risk factors — for example, adverse childhood experiences (such as sexual abuse) can increase the risk of suicide, particularly in adolescents and young adults. Alcohol and other drugs are also often associated with an increased risk of suicidal behaviour. Other factors that can influence suicide rates include economic growth rates, which affect unemployment rates and social disadvantage. Often, a combination of these factors can increase the risk of suicidal behaviour.

A number of factors impact on the quality of suicide data.

- Coroners may take different approaches to the determination of intent. Determination of intent of a death relates to whether the death results from intentional self harm, accident, homicide or undetermined intent.
  - In general, coroners may be reluctant to determine suicidal intent (particularly in children and young people). In some cases, no statement of intent will be made by a coroner.
  - For deaths where it is difficult to determine suicidal intent (for example, single vehicle accidents or drownings), the burden of proof needed for the

coroner to establish that the death was suicide may make a finding of suicide less likely (ABS 2007b).

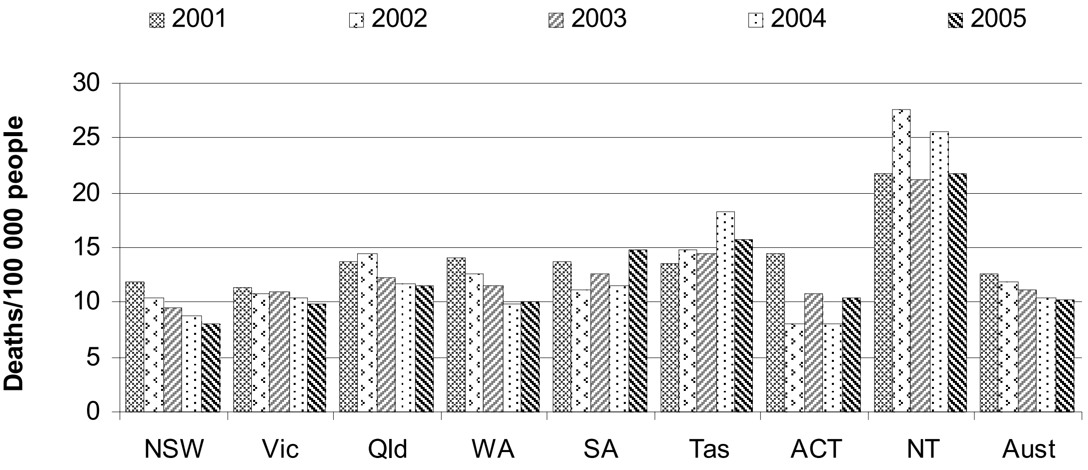
- Incomplete information is available on the National Coronial Information System when the ABS compiles the *Causes of Deaths* data (ABS 2007b).
  - Not all coronial cases are finalised (that is, closed) when *Causes of Deaths* data are compiled. In order to classify a death as suicide (intentional self-harm) specific documentation from a medical or legal authority need to be available regarding the self-inflicted nature and suicidal intent of the incident. If this is not available, then the death must be classified as accidental. The case generally needs to be closed to code a suicide as such, unless there is conclusive information in the police report or the autopsy report to show that the death was intentional (ABS 2007b). Any reported decline in the number of deaths due to suicide, therefore, may reflect an increase in open coroners' cases when the statistics were finalised.

In 2005, 2101 deaths by suicide were recorded in Australia (table 12A.49) — equivalent to 10.3 deaths per 100 000 people (figure 12.33). The national rate fell each year from 1997 to 2000, followed by a slight increase in 2001 and has continued to fall each year to 2005 (table 12A.50). The rate for males (16.4 per 100 000 males) was almost four times that for females (4.3 per 100 000 females) in 2005 — a ratio that was relatively constant over the 10 years to 2005 (figure 12.34).

In 2005, suicide was the second leading cause of death (after transport accidents) for people aged 15–24 years, accounting for 22.2 per cent of deaths in this age group. Suicide was the leading cause of death for 25–34 year olds in 2005, with 22.0 per cent of deaths in this age group resulting from suicide (ABS 2007a). Table 12A.51 shows suicide death rates per 100 000 people aged 15–24 years old for all states and territories.

Nationally the suicide rate in 2005 was higher in rural areas. There were 9.5 suicides per 100 000 people in capital cities and 11.2 suicides per 100 000 people in other urban areas, compared with 12.5 suicides per 100 000 people in rural areas in Australia in 2005 (figure 12.35).

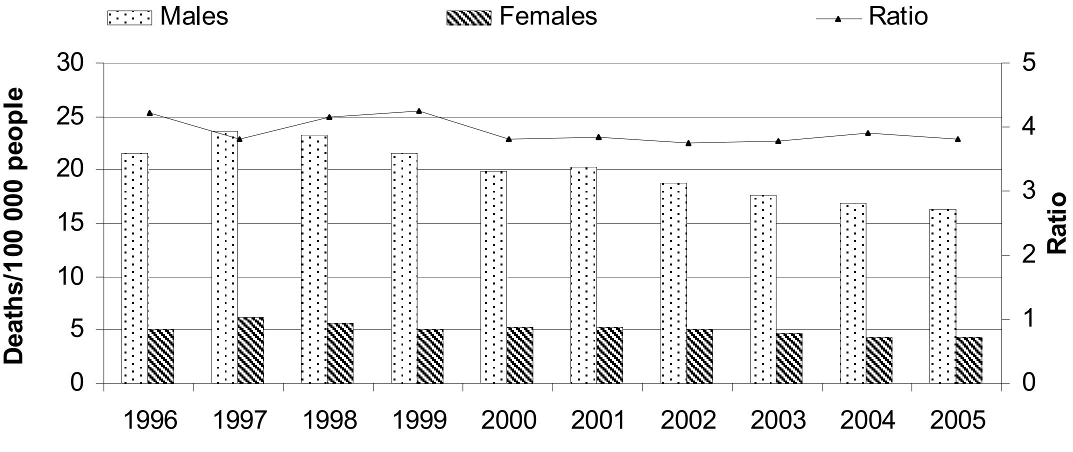
Figure 12.33 **Suicide rates**[a, b, c]



[a] By year of registration of death. Year-to-year variation can be influenced by coronial workloads. [b] The death rate is age standardised to the mid-year 2001 population. [c] Low populations can result in small variations in the number of suicides appearing as large changes in rates.

Source: ABS (unpublished) *Causes of Deaths, Australia*; table 12A.50.

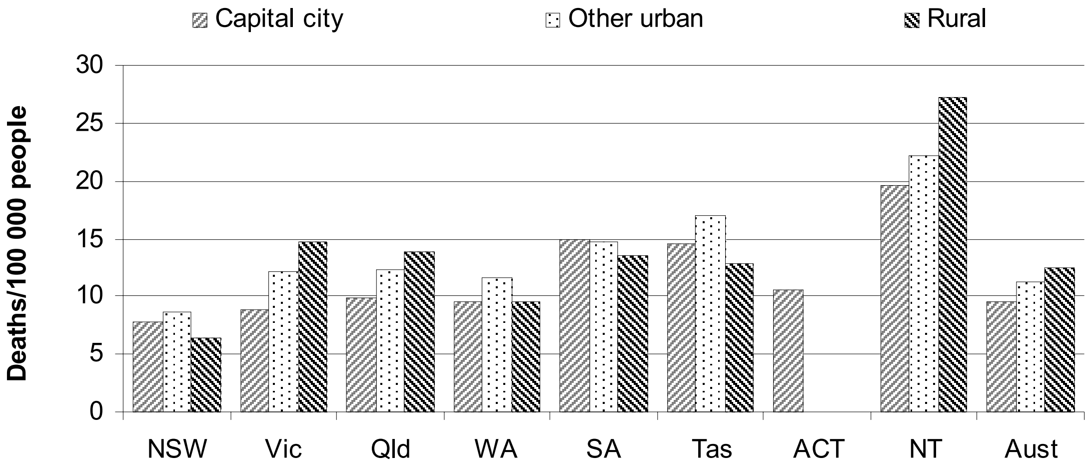
Figure 12.34 **Suicide rates, by gender**[a, b]



[a] By year of registration of death. Year-to-year variation can be influenced by coronial workloads. [b] The death rate is age standardised to the mid-year 2001 population.

Source: ABS (2007c); table 12A.49.

Figure 12.35 **Suicide rates, by area, 2005**[a, b, c, d]



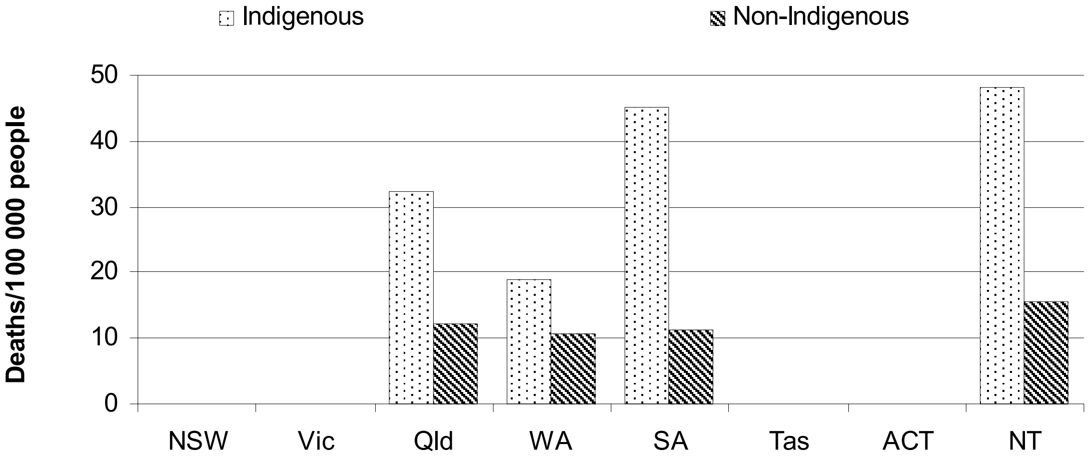
[a] 'Other urban' comprises centres with more than 20 000 people. 'Rural' comprises all areas except capital cities and other urban. [b] Death rate is age standardised to the mid-year 2001 population. [c] By year of registration of death. Year-to-year variation can be influenced by coronial workloads. [d] The ACT does not have any 'other urban' or 'rural' areas.

Source: ABS (unpublished) *Causes of Deaths, Australia*; table 12A.52.

The Indigenous suicide rate is presented for the period 2001–2005 for four jurisdictions: Queensland, WA, SA and the NT (figure 12.36). After adjusting for age differences between populations, the suicide rates for Indigenous people for the period 2001–2005 in the jurisdictions for which data are presented are considerably higher than the corresponding rates for non-Indigenous people.

Care needs to be taken when interpreting these data because data for Indigenous people are incomplete and data for some jurisdictions are not published. In addition, Indigenous people are not always accurately identified in administrative collections (such as hospital records, and birth and death registrations) due to definition variations, different data collection methods and failure to record Indigenous status. The rate calculations have not been adjusted for differences in the completeness of identification of Indigenous deaths across jurisdictions. The 'Health preface' discusses the quality of Indigenous mortality and other data.

Figure 12.36 **Suicide rates, by Indigenous status, 2001–2005**[a]



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[a] Indigenous population figures are based on ABS Experimental Projections, Aboriginal and Torres Strait Islander Australians (low series, 2001 base). There are no comparable population data for the non-Indigenous population. The non-Indigenous population figures are based on data derived by subtracting Indigenous population projections from total population estimates and should be used with care. Rates are calculated on an age standardised basis.

Source: ABS (unpublished) *Causes of Deaths, Australia*; table 12A.53.

Quality of life

The Steering Committee has identified ‘quality of life’ as an indicator for development in future reports, but no indicators have yet been developed (box 12.35).

Box 12.35 **Quality of life**

‘Quality of life’ is an outcome indicator of the objective of mental health service delivery to prevent and reduce mental health problems so as to improve the quality of life for people with a mental illness.

12.5 Future directions in performance reporting

Breast cancer

Key challenges for improving reporting of breast cancer include:

- expanding reporting on intervention and treatment and overall performance

- further developing indicators of outcomes
- improving the measurement and comparability of existing indicators.

Existing performance data for breast cancer management place more emphasis on the performance of State and Territory BreastScreen Australia programs than on the treatment and ongoing management of breast cancer. This emphasis is largely due to the relative availability of breast cancer screening data across jurisdictions. The Steering Committee aims to expand reporting to incorporate treatment and clinical outcomes data.

The BreastScreen Australia program is being reviewed over July 2006 to June 2008. The evaluation will examine the benefits of the program and the risks associated with mammographic screening at two-yearly intervals for various age groups including the impact of assessment and investigation of women without a subsequent breast cancer diagnosis. The evaluation will address the appropriateness and adequacy of the reporting arrangements and key performance indicators for the Program. The Steering Committee will draw upon this evaluation when determining an appropriate indicator of early detection safety.

Mental health

Key challenges for improving the reporting of mental health management are similar to those of previous years:

- improving the reporting of effectiveness and efficiency indicators for Indigenous, rural/remote and other special needs groups
- revising the performance indicator framework to account for the Third National Mental Health Plan and the COAG National Action Plan on Mental Health, to ensure reporting remains consistent with government policy objectives for mental health
- improving the reporting of effectiveness/efficiency indicators for community-based mental health care.

A set of key performance indicators for use in Australia’s public sector mental health services has been developed, based on the National Health Performance Framework and linked to the strategic directions of the National Mental Health Plan 2003–2008. Some of these indicators are included as progress measures for reporting on the COAG National Action Plan on Mental Health. The Steering Committee will investigate including some or all of these indicators in future reports. Further work is required to develop indicators and data collections in the areas of safety and responsiveness of services. This will then provide data covering all the domains of the National Health Performance Framework. Further information can be found in National Mental Health Working Group Information Strategy Committee Performance Indicator Drafting Group (2005).

12.6 Jurisdictions’ comments

This section provides comments from each jurisdiction on the services covered in this section of the Report. Appendix A contains data that may assist in interpreting the performance indicators presented in this chapter. These data cover a range of demographic and geographic characteristics, including age profile, geographic distribution of the population, income levels, education levels, tenure of dwellings and cultural heritage (such as Indigenous and ethnic status).

Australian Government comments

“ The Australian Government will contribute $103.4 million over four years to the Council of Australian Governments (COAG) $200 million cost-shared initiative to address the growth in type 2 diabetes.

The Commonwealth will also fund the introduction of a new Medicare item for General Practitioners to undertake a diabetes risk review for people in the 40–49 year age group and funding to subsidise access to lifestyle modification programs for those at high risk of type 2 diabetes.

The Commonwealth is also contributing a total of $250 million over four years, (2006–2010) to the $500 million COAG Australian Better Health Initiative (ABHI), which aims to start to refocus the health system to promote good health and reduce the burden of chronic disease.

The Australian Government supports the inclusion of new measures of ‘hospitalisations with a procedure recorded’ by Indigenous status. These measures first published in the Aboriginal and Torres Strait Islander Health Performance Framework 2006 report, will inform policy analysis, planning and program development.

The Australian Government supports enhancement of performance indicators for workforce sustainability by inclusion of additional information about the age profile of the nursing and medical practitioner workforce.

Through the 2003–08 Australian Health Care Agreements the Australian Government will maintain its commitment to the public hospital system. Assistance will be provided to the States and Territories of up to $42 billion over five years, an increase of $10 billion over the previous Agreements. This includes funding for Mental Health, Palliative Care and the Pathways Home program.

The Australian Government is committed to achieving sustainable gains in the health of Aboriginal and Torres Strait Islander Australians. In 2007-08 the Australian Government allocated more than $560 million for health programs specific to Aboriginal and Torres Strait Islander people, including new Indigenous-specific Medicare items, hearing services, aged care, population health and prevention programs. This includes funding to expand access to primary health care for Aboriginal and Torres Strait Islander people in regional and remote areas; to improve child and maternal health outcomes through home visits to children and families by health professionals; and to improve the quality of Indigenous health services through accreditation and additional support.

In addition, the Australian Government has also committed $83 million in 2007-08 to health initiatives under the Northern Territory Emergency Response. This funding will provide additional medical services such as health checks and follow up treatment for Indigenous children under the age of 16, as well as increased drug and alcohol services to remote Northern Territory Indigenous communities. ”

New South Wales Government comments

“ New South Wales continues to support the development and implementation of performance indicators for health. These provide a framework for understanding the delivery of services and monitoring and comparing performance.

The 2005-06 reporting period was a year in which the NSW health system continued its major undertaking to change the way health care is provided in NSW. Like other international systems, the NSW health system faces many pressures that impact on the capacity to deliver quality health services. These include:

- increasing demand for health services
- population changes, particularly the ageing of the population
- clinical workforce shortages
- changes in the nature of illness
- introduction of new technologies
- increasing expectations of patients and providers.

Throughout 2005-06, NSW developed and implemented a range of new strategies to cope with demand more effectively. These strategies included additional funding for increased bed capacity, and a range of community-based health services to enable people to receive health care closer to home.

These have been complemented by a number of clinical redesign strategies to enhance the patient journey and improve performance to meet increasing demand, including:

- patient flow units
- clinical services re-design
- better ways of managing emergency patient demand and admission
- predictable surgery plans.

NSW has adopted a performance framework to support the implementation of these strategies and monitor progress to achieving targets. ”

Victorian Government comments

One of the goals guiding Victoria's future is to strengthen its performance in the provision of high quality, accessible health services. Progress measures that are monitored over time include improvements in the health of Victorians, and waiting times for emergency, elective and dental services.

To that end Victoria supports the ongoing development and monitoring of performance indicators in the Report on Government Services.

A constant challenge is managing the continuing and cumulative pressures that result in an increased demand for services. This increasing demand stems from many factors including a growing population, its relative ageing, and the increasing variety of treatment modalities made possible by new technology. Strategies to manage demand for tertiary services include the Hospital Admission Risk — Chronic Disease Management Program, hospital located GP services and the Multiple and Complex needs initiative. Victoria also aims to deliver more appropriate care and support in the community.

This is done through programs such as Hospital In the Home, Primary Care Partnerships and integrated ambulatory care.

The creation of a new ministerial portfolio for Mental Health and Drugs has reinforced the Government's commitment to mental health reform. Directions for service reform include improved coordination between mental health and drug and alcohol services, and better connection between the component parts of the extended mental health system to enable consumers to access the right services for their specific needs. A cultural diversity strategy was released in 2006 that sets policies and directions to strengthen the responsiveness of mental health services to culturally and linguistically diverse communities.

Victoria's vision for a high performing health service system is to reorient service delivery around strong community-based health and wellbeing support services. These services will be underpinned by the self-management of health and wellbeing needs, while ensuring that tertiary services are high quality, are accessible in a timely way, and are linked with community based services at the critical stages of entry to or exit from tertiary level care. Increasingly, the focus is turning to tackling cancer and the rising prevalence of chronic diseases such as diabetes.

Queensland Government comments

Queensland Health delivers a comprehensive health service to Queensland's population of over 4 million people, including health promotion, disease prevention, acute hospital and non-admitted patient services, rehabilitation, mental health services, community-based care and aged care.

The Queensland Government is continuing to implement health system reforms through a five-year plan launched in October 2005, Action Plan: Building a better health service for Queensland. The release of the Action Plan, coupled with the biggest funding injection in Queensland's history, started the reform and renewal of the public health system. The Government has built on this commitment, providing an extra $2 billion in funding to take the 2007-08 budget to $7.15 billion. Significant progress has already been made in implementing the Action Plan. For example, the targets for recruitment of clinical staff by the end of December 2006 have been exceeded:

- 548 doctors were appointed, 248 more than the target
- 2109 nurses were appointed 1609 more than the target
- 786 professional and allied health workers were appointed, 386 more than the target.

Another significant reform is the establishment of the Health Quality and Complaints Commission, a $7.7 million independent body to monitor the standards in health services and investigate complaints.

To further improve health services for all Queenslanders, the Queensland Statewide Health Services Plan 2007–2012 was released in March 2007. The Health Services Plan builds on those reforms implemented by the Action Plan by providing medium to longer term strategies to improve health services in Queensland.

A key focus of the reforms will be to improve linkages between the public sector, private sector, non-government organisations, other key agencies and departments and the broader community. The Plan details some of the unique challenges Queensland faces in delivering health care, including the ageing and diversity of the population, the increasing population, the uneven distribution of people throughout the State and the changing patterns of health needs.

To meet these challenges, the Health Services Plan focuses on two key reform areas: improving access to safe and sustainable health services, and better meeting people's needs across the health continuum. Within these areas, the Plan contains a range of reforms, including establishing links between services to create safe and sustainable service networks, improving the safety of health services, promoting good health and health lifestyle choices, preventing illness, and providing high quality, timely health services.

The Health Services Plan will, over the next five years, provide a new way forward for service planning and delivery of health services in order to better meet the ever-changing needs of people using the health system.

Western Australian Government comments

> The broad health reform program in WA continues and the commitment to ensure that high-quality, safe and accessible health care is available to all Western Australians remains firm. Significant progress was made in all the priority areas.
>
> Healthy Workforce — Attracting and retaining sufficient workforce numbers to meet the needs of our current and future public health services is critical. Strategies implemented include the work life balance and family friendly policies, increased undergraduate and clinical training places and job redesign with 40 nurses now registered as Nurse Practitioners in WA.
>
> Healthy Hospitals — Care closer to home and improved access to care is being realised with a range of initiatives and improvement programs. Two surgi-centres were established to increase the flow of high volume surgical cases and the Ambulatory Surgery Initiative was expanded to improve waiting times for elective surgery. Construction of the new Rockingham Kwinana District Hospital started and the new Geraldton Regional Resource Centre opened.
>
> Healthy Partnerships — Strong relationships continue to be cultivated and formalised in the delivery of innovative, cost-effective and high-quality health care services. Close work with a number of non-government agencies, consumers, private providers, health professionals and other government agencies continued. Performance agreements that clarify the performance of the health system and its progress in reform were established.
>
> Healthy Communities — Health promotion, illness prevention, early detection of disease and access to affordable community-based healthcare services are vital to the delivery of a sustainable health service. A number of strategies have been implemented to serve that end, including the Australian Better Health Initiative (ABHI), Indigenous Healthy Lifestyle Program, obesity prevention and health promotion programs, drug and alcohol campaigns and the Patient First initiative.
>
> Healthy Resources — Strategies to ensure best value for the health care dollar are structured into the reform program with good outcomes achieved through streamlining and consolidating corporate services and governance structures, revised procurement strategies and system wide planning for infrastructure development and investment in medical, information and communication technology.
>
> Healthy Leadership — Increasing leadership capacity and effectiveness continued with progress in identifying, nurturing and promoting strong leadership at all levels within health care services through a structured leadership development program. Progress was made in understanding, valuing and enhancing diverse leadership styles that help staff to perform more effectively for the benefit of the WA community.

South Australian Government comments

The South Australian Government released its Health Care Plan in June 2007, announcing a major step toward providing this State with one of the most integrated health systems in Australia. The Plan outlines the most significant single investment in health care in South Australia's history. The Government will build the 800-bed Marjorie Jackson-Nelson Hospital, a state-of-the-art facility in Adelaide's city centre that will become Australia's most advanced hospital. The 10-year plan also proposes new investment in other major hospitals, promotes healthy lifestyles and illness prevention through new GP Plus Health Care Centres, and aims to make South Australia the best place for health professionals to work.

SA's Health Care Plan will reform our health system so that it meets the health challenges of an ageing population, the increasing incidence of chronic diseases, international health workforce shortages and ageing infrastructure. These changes will ensure South Australians have access to the best available health care in hospitals, health care centres and through GP and other health professionals.

SA's Health Care Plan will mean:

- better coordinated hospital services
- a responsive health workforce for the future
- GP Plus Health Care Centres, with more primary health care services
- more elective surgery
- less pressure on emergency departments
- improved management of chronic diseases.

South Australia's mental health system is currently undergoing major reform to modernise and improve mental health services across the State. Since February 2007, the State Government has committed $107.9 million toward reforming South Australia's mental health system. This reform includes the development of key mental health facilities and co-location of drug and alcohol services, and additional developments providing community, aesthetic and environmental benefits. The specialist health services will include a new hospital and supported accommodation units for people recovering from mental illness as well as a mental health intermediate care facility, which is a new model of care for people who are becoming unwell or are leaving hospital but still need extra support.

Major health governance and legislative reforms are underway in South Australia. To support the Health Care Plan, the Health Care Bill 2007 has been introduced into Parliament to update and improve existing governance structures, and facilitate the move toward an integrated health system. Draft legislation has been developed to replace the existing Mental Health Act 1993. The Mental Health Bill 2007 reflects national and international best practice in the treatment, support and protection of persons with mental illness.

Tasmanian Government comments

The Department will continue to progress structural reform and culture change to develop a sustainable people-oriented health and human services system which delivers quality services as well as supporting individuals and communities to be active participants in their own health and wellbeing. A reform agenda is being implemented through Tasmania's Health Plan. Similar reforms are being progressed in mental health services, alcohol and drug services, disability services and housing services.

Tasmania's Health Plan is an integrated strategy incorporating both acute health services (the Clinical Services Plan) and primary health services (the Primary Health Services Plan). The key focus and objective of Tasmania's Health Plan is sustainability. This includes ensuring health services are safe, effective and accessible and make the best use of available resources.

Tasmania's Health Plan includes a greater focus on primary health, increasing health promotion and better management of chronic illnesses. It establishes a new tiered service structure for both primary and acute health, with a change of role for some facilities including reconfiguring under-used district hospital services.

A new Service Capability Framework will determine the future roles of the major hospitals in providing local, regional and statewide services based on sound sustainability and safety principles. Clinical Networks are being established to formalise clinical governance arrangements across all health services.

A new Royal Hobart Hospital is to be constructed in Hobart and this is a major long term project to meet the future needs of Tasmanians. A major redevelopment of the Department of Emergency Medicine at the Launceston General Hospital will commence during 2008. Other initiatives include additional nurse educators, implementing a universal newborn hearing screening program and establishing a state-wide refugee health service.

Mental Health Services will continue the implementation of strategies outlined in the Mental Health Services Strategic Plan 2006–2011, including the implementation of a Clinical Group Program and assertive case management as part of the model of care, a review of the *Mental Health Act 1996*, the introduction of the Consumer and Carer participation framework and the implementation of core and statutory training for staff.

Oral Health Services will continue the implementation of the Better Dental Care Package including the establishment of an education and service centre in Hobart; the development of a teaching curriculum; and the establishment of a new model of service delivery for clients to be treated at dental surgeries in the major hospitals.

In relation to breast cancer screening, the ageing population and workforce shortages continue to place pressure on Tasmania's ability to meet targets for participation rates in the target age group. Despite this BreastScreen Tasmania has achieved increased attendance numbers for each biennial screening cohort.

Australian Capital Territory Government comments

“ The ACT Government provides health services to local residents through two major hospitals: The Canberra Hospital and Calvary Public Hospital (via a contractual agreement with the Little Company of Mary Health Care ACT). These public hospitals provide the full range of acute care, including inpatient, outpatient and emergency department services. Both hospitals are teaching hospitals in cooperation with the Australian National University’s Medical School. The Canberra Hospital is the major trauma referral hospital for the ACT and surrounding region of NSW.

ACT Health works closely with other ACT Government agencies such as the Department of Disability, Housing and Community Services, Office of Children, Youth and Family Support and emergency service providers, and has partnerships in place with non-government organisations, aged care organisations, the private sector and NSW Health. The cross-border agreement with the latter agency is of particular significance due to the ACT’s role as a service hub for the entire region.

NSW residents account for around one quarter of ACT public hospital inpatient episodes. In 2005-06, only around 5 per cent of ACT residents were treated in other jurisdictions’ public hospitals, with many of these being referrals for specialised or complicated treatments. These include severe burns and organ transplantations, which require a higher volume of throughput than the current ACT demand to be clinically viable.

The ACT’s data needs to be viewed in the context of the Territory’s relatively small population size (estimated at 339 865 residents as of 30 June 2007), which can make indicators for selected services and target groups subject to large variations over time. Smaller jurisdictions such as the ACT are also more likely to be disadvantaged when it comes to economies of scale.

While the ACT supports the reporting of data across jurisdictions as a means of evaluating the performance of its own health system against other States and Territories and over time, readers need to be aware that the much of the data in the Report is not strictly comparable across jurisdictions. For example, direct comparisons of costs are not advisable, because States and Territories may use different accounting methods for costing their health services. ”

Northern Territory Government comments

The Department of Health and Community Services is the major provider and funding source for hospital and community services as well as for a substantial portion of primary care in the Territory. Service integration is integral to providing coordinated care between public hospitals, a network of 106 government/non government community health centres and 132 GP practices. The NT population is 208 500 a third of whom are Indigenous persons.

There are five public hospitals located in each of the major population centres of Darwin, Nhulunbuy, Katherine, Tennant Creek and Alice Springs and inpatient mental health services in Darwin and Alice Springs. Public hospitals provide 626 inpatient beds and work closely with the one private hospital in the NT to meet demand for hospital beds. Hospitals form a network between the smaller hospitals and the larger Royal Darwin and Alice Springs Hospitals to ensure the full range of medical services are available to people living in remoter areas. Each hospital is able to retain their local identity but able to share resources within the network. Movement of people to access medical care is supported by specialist health access programs for travel to hospital, between hospitals and interstate when required.

Closing the Gap of Indigenous Disadvantage: A Generational Plan of Action is the NT Government's plan of action to overcome Indigenous disadvantage. A key action to close the gap is training and employment of Indigenous health workers.

Prevention of illness and early intervention underpin community health services to reduce preventable diseases. These services include: programs for nutrition, physical activity, preventable chronic disease, women's health, hearing, children/youth, home birth, breast screening, injury prevention, immunisation and community mental health.

The NT is faced with increasing demand on health services, a significant gap in life expectancy between Indigenous people and other Territorians and health systems requiring ongoing reforms to manage finite resources. Strategies that have emerged to meet these challenges include the Rapid Admission and Planning Unit at Royal Darwin Hospital to remove bottlenecks to hospital admissions, the Chronic Disease Strategy, the Mental Health Action Plan and the use of electronic health records. Work force issues related to recruitment and retention due to chronic shortages of health workers is a major ongoing challenge.

Legislative reform can support better provision of health services. In 2005 government enacted the Volatile Substance Abuse Prevention Act providing police and other authorised persons the power to seize inhalants and to take people into protective custody in response to a serious health issue in the NT. The Act has been supported by measures for prevention and treatment of volatile substance abuse.

12.7 Definitions of key terms and indicators

AR-DRG v5.0 (Australian refined diagnosis related group, version 5.0)	A patient classification system that hospitals use to match their patient services (hospital procedures and diagnoses) with their resource needs. AR-DRG v5.0 is based on the ICD-10-AM classification.
Casemix adjustment	Adjustment of data on cases treated to account for the number and type of cases. Cases are sorted into diagnosis related groups (AR-DRGs) that represent a class of patients with similar clinical conditions requiring similar hospital services.
General practice	The organisational structure in which one or more GPs provide and supervise health care for a 'population' of patients. This definition includes medical practitioners who work solely with one specific population, such as women's health or Indigenous health.
Health management	The ongoing process beginning with initial client contact and including all actions relating to the client. Includes assessment/evaluation, education of the person, family or carer(s), and diagnosis and treatment. Involves problems with adherence to treatment and liaison with, or referral to, other agencies.
Incidence rate	Proportion of the population experiencing a disorder or illness for the first time during a given period (often expressed per 100 000 people).
Separation	An episode of care for an admitted patient, which can be a total hospital stay, or a portion of a hospital stay beginning or ending in a change of type of care (for example, from acute to rehabilitation). Separation also means the process by which an admitted patient completes an episode of care.

Breast cancer

Breast conserving surgery	An operation to remove the breast cancer but not the breast. Types of breast conserving surgery include lumpectomy (removal of the lump), quadrantectomy (removal of one quarter of the breast) and segmental mastectomy (removal of the cancer as well as some of the breast tissue around the tumour and the lining over the chest muscles below the tumour).
Cost per woman screened	The total cost of the provision of breast screening services, divided by the number of women screened. The total cost includes the cost of providing the BreastScreen Australia program in each jurisdiction, in addition to the cost of providing the program to women.
Detection rate for small cancers	The rate of small (less than or equal to 15 millimetres) invasive breast cancers detected per 10 000 women screened.
Ductal carcinoma in situ	Abnormal cells that involve only the lining of a duct. The cells have not spread outside the duct to other tissues in the breast. Also known as intraductal carcinoma.
Invasive cancer	A tumour whose cells invade healthy or normal tissue.
Modified radical mastectomy	Surgery for breast cancer in which the breast, some of the lymph nodes under the arm, the lining over the chest muscles, and sometimes part of the chest wall muscles are removed.
Mortality rate from breast cancer	The age-specific and age standardised mortality rates of women who die as a result of breast cancer, expressed per 100 000 women in the population.
Participation	The number of women resident in the catchment area screened,

	divided by the number of women resident in the catchment area, expressed as a percentage. If a woman is screened more than once during the reference period, then only the first screen is counted. Catchment area is a geographic region based on service size in relation to the population, accessibility and the location of other services. It is uniquely defined for each service based on postcode or statistical local area.
Radiation therapy	The use of high energy radiation from X-rays, gamma rays, neutrons, and other sources to kill cancer cells and shrink tumours. Radiation may come from a machine outside the body (external beam radiation therapy) or from materials called radioisotopes. Radioisotopes produce radiation and can be placed in or near the tumour or in the area near cancer cells. This type of radiation treatment is called internal radiation therapy, implant radiation, interstitial radiation or brachytherapy. Systemic radiation therapy uses a radioactive substance (such as a radiolabeled monoclonal antibody) that circulates throughout the body.
Screening	The performance of tests on apparently well people to detect a medical condition at an earlier stage than otherwise would be the case.
Screening round (first)	A woman's first visit to a BreastScreen Australia mammography screening service.
Screening round (subsequent)	A woman's visit to a BreastScreen Australia mammography screening service when she has previously attended such a service.
Size of detected cancers	Invasive cancers detected, classified according to tumour size.
Total mastectomy	Removal of the breast — also known as simple mastectomy.

Mental health

Acute services	Services that primarily provide specialist psychiatric care for people with acute episodes of mental disorder. These episodes are characterised by recent onset of severe clinical symptoms of mental disorder that have potential for prolonged dysfunction or risk to self and/or others. The key characteristic of acute services is that the treatment effort focuses on symptom reduction with a reasonable expectation of substantial improvement. In general, acute psychiatric services provide relatively short term treatment. Acute services may: • focus on assisting people who have had no prior contact or previous psychiatric history, or individuals with a continuing psychiatric disorder for whom there has been an acute exacerbation of symptoms • target the general population or be specialist in nature, targeting specific clinical populations. The latter group include psychogeriatric, child and adolescent, and forensic mental health services.
Affective disorders	A mood disturbance, including mania, hypomania, bipolar affective disorder, depression and dysthymia.
Ambulatory care services	Mental health services dedicated to the assessment, treatment, rehabilitation or care of non-admitted inpatients, including but not confined to crisis assessment and treatment services, mobile assessment and treatment services, outpatient clinic services (whether provided from a hospital or community mental health centre), child and adolescent outpatient treatment teams, social and living skills programs (including day programs, day hospitals and living skills centres), and psychogeriatric assessment teams and day programs.

Anxiety disorders	Feelings of tension, distress or nervousness. Includes agoraphobia, social phobia, panic disorder, generalised anxiety disorder, obsessive–compulsive disorder and post-traumatic stress disorder.
Available beds	The number of immediately available beds for use by admitted patients if required. Beds are immediately available for use if located in a suitable place of care with nursing or other auxiliary staff available within a reasonable period. In many cases, available beds will be less than the number of approved beds, with the former controlled by utilisation factors and resourcing levels, while the latter refers to the maximum capacity allowed for the hospital, given sufficient resources and community demand.
Child and adolescent mental health services	Services principally targeted at children and young people up to the age of 18 years. Classification of services in this category requires recognition by the regional or central funding authority of the special focus of the inpatient service on children or adolescents. These services may include a forensic component.
Co-located services	Psychiatric inpatient services established physically and organisationally as part of a general hospital.
Community-based residential services	Staffed residential units established in community settings that provide specialised treatment, rehabilitation or care for people affected by a mental disorder or psychiatric disability. To be defined as community-based residences, the services must: provide residential care to people with mental disorders or psychiatric disability; be located in a community setting external to the campus of a general hospital or psychiatric institution; employ onsite staff for at least some part of the day; and be government funded.
Co-morbidity	The simultaneous occurrence of two or more disorders such as depressive disorder with anxiety disorder, or depressive disorder with anorexia.
Consumer involvement in decision making	Consumer participation arrangements in public sector mental health service organisations according to the scoring hierarchy (levels 1–4) developed for monitoring State and Territory performance under Medicare Agreements Schedule F1 indicators.
Cost per inpatient bed day	The average patient day cost according to the inpatient type.
Depression	A state of gloom, despondency or sadness lasting at least two weeks. The person usually suffers from low mood, loss of interest and enjoyment, and reduced energy. Sleep, appetite and concentration may be affected.
Forensic mental health services	Services principally providing assessment, treatment and care of mentally disordered individuals whose behaviour has led them to commit criminal offences or makes it likely that they will offend in the future if not adequately treated and contained. This includes prison-based services, but excludes services that are primarily for children and adolescents and for older people even where they include a forensic component.
General mental health services	Services that principally target the general adult population (18–65 years old) but that may provide services to children, adolescents or older people. Includes, therefore, those services that cannot be described as specialist child and adolescent, older persons' or forensic services. General mental health services include hospital units whose principal function is to provide some form of specialised service to the general adult population (for example, inpatient psychotherapy) or to focus on

	specific clinical disorders within the adult population (for example, post-natal depression, anxiety disorders).
Mental disorder	A diagnosable illness that significantly interferes with an individual's cognitive, emotional and/or social abilities.
Mental health	The capacity of individuals within groups and the environment to interact with one another in ways that promote subjective wellbeing, the optimal development and use of mental abilities (cognitive, affective and relational) and the achievement of individual and collective goals consistent with justice.
Mental health problems	Diminished cognitive, emotional or social abilities, but not to the extent of meeting the criteria for a mental disorder.
Mental health promotion	Actions taken to maximise mental health and wellbeing among populations and individuals. It is aimed at changing environments (social, physical, economic, educational, cultural) and enhancing the 'coping' capacity of communities, families and individuals by giving power, knowledge, skills and necessary resources.
Mental illness prevention	Interventions that occur before the initial onset of a disorder to prevent its development. The goal of prevention interventions is to reduce the incidence and prevalence of mental health problems and mental disorders.
Mortality rate from suicide	The percentage of the population who die as a result of suicide.
Non-acute services	Non-acute services are defined in two categories: • Rehabilitation services that have a primary focus on intervention to reduce functional impairments that limit the independence of patients. Rehabilitation services are focused on disability and the promotion of personal recovery. They are characterised by an expectation of substantial improvement over the short to mid term. Patients treated by rehabilitation services usually have a relatively stable pattern of clinical symptoms. • Extended care services that primarily provide care over an indefinite period for patients who have a stable but severe level of functional impairment and an inability to function independently, thus requiring extensive care and support. Patients of extended care services present a stable pattern of clinical symptoms, which may include high levels of severe unremitting symptoms of mental disorder. Treatment is focused on preventing deterioration and reducing impairment; improvement is expected to occur slowly.
Non-government organisations	Private not-for-profit community managed organisations that receive State and Territory government funding specifically for the purpose of providing community support services for people affected by a mental illness or psychiatric disability. Programs provided by the non-government organisation sector may include supported accommodation services (including community-based crisis and respite beds), vocational rehabilitation programs, advocacy programs (including system advocacy), consumer self-help services, and support services for families and primary carers.
Older persons' mental health services	Services principally targeting people in the age group 65 years or over. Classification of services in this category requires recognition by the regional or central funding authority of the special focus of the inpatient service on aged persons. These services may include a forensic component. Excludes general mental health services that may treat older people as part of a more general service.
Outpatient services — community-based	Services primarily provided to non-admitted patients on an appointment basis and delivered from health centres located in

	community settings, physically separated within hospital sites. They may include outreach or domiciliary care as an adjunct to services provided from the centre base.
Outpatient services — hospital-based	Services primarily provided to non-admitted patients on an appointment basis and delivered from clinics located within hospitals. They may include outreach or domiciliary care as an adjunct to services provided from the clinic base.
Patient days (occupied bed days)	All days or part days for which patient was in hospital during the reporting year (1 July to 30 June), regardless of the original date of admission or discharge. Key definitional rules include the following: • For a patient admitted and discharged on different days, only the day of admission is counted as a patient day. • Admission and discharge on the same day are equal to one patient day. • Leave days are not included when they involve an overnight absence. • A patient day is recorded on the day of return from leave.
Percentage of facilities accredited	The percentage of facilities providing mental health services that are accredited according to the National Standards for Mental Health Services.
Prevalence	The number of cases of a disease present in a population at a given time (point prevalence) or during a given period (period prevalence).
Preventive interventions	Programs designed to decrease the incidence, prevalence and negative outcomes of disorders.
Psychiatrist	A medical practitioner with specialist training in psychiatry.
Public health	The organised, social response to protect and promote health, and to prevent illness, injury and disability. The starting point for identifying public health issues, problems and priorities, and for designing and implementing interventions, is the population as a whole or population subgroups. Public health is characterised by a focus on the health of the population (and particular at-risk groups) and complements clinical provision of health care services.
Public (non-psychiatric) hospital	A hospital that provides at least minimum medical, surgical or obstetric services for inpatient treatment and/or care, and around-the-clock, comprehensive, qualified nursing services, as well as other necessary professional services.
Schizophrenia	A combination of signs and symptoms that may include delusions, hallucinations, disorganised speech or behaviour, a flattening in emotions, and restrictions in thought, speech and goal directed behaviour.
Specialised mental health inpatient services	Services provided to admitted patients in stand-alone psychiatric hospitals or specialist psychiatric units located within general hospitals.
Specialised mental health services	Services whose primary function is specifically to provide treatment, rehabilitation or community support targeted towards people affected by a mental disorder or psychiatric disability. Further, such activities are delivered from a service or facility that is readily identifiable as both specialised and serving a mental health function. This criterion applies regardless of the source of funds.

Specialised residential services

Services provided in the community that are staffed by mental health professionals on a 24 hour basis.

Staffing categories (mental health)

Medical officers: all medical officers employed or engaged by the organisation on a full time or part time basis. Includes visiting medical officers who are engaged on an hourly, sessional or fee-for-service basis.

Psychiatrists and consultant psychiatrists: medical officers who are registered to practice psychiatry under the relevant state or territory medical registration board; or who are fellows of the Royal Australian and New Zealand College of Psychiatrists or registered with Health Insurance Commission as a specialist in Psychiatry.

Psychiatry registrars and trainees: medical officers who are formal trainees within the Royal Australian and New Zealand College of Psychiatrists' Postgraduate Training Program.

Other medical officers: medical officers employed or engaged by the organisation who are not registered as psychiatrists within the State or Territory, or as formal trainees within the Royal Australian and New Zealand College of Psychiatrists' Postgraduate Training Program.

Nursing staff: all categories of registered nurses and enrolled nurses, employed or engaged by the organisation.

Registered nurses: people with at least a three year training certificate or tertiary qualification who are certified as being a registered nurse with the State or Territory registration board. This is a comprehensive category and includes general and specialist categories of registered nurses.

Enrolled nurses: Refers to persons who are second level nurses who are enrolled in all states except Victoria where they are registered by the state registration board to practise in this capacity. Includes general enrolled nurse and specialist enrolled nurse (e.g. mothercraft nurses in some states).

Diagnostic and health professionals: qualified staff (other than qualified medical or nursing staff) who are engaged in duties of a diagnostic, professional or technical nature. This category covers all allied health professionals, such as social workers, psychologists, occupational therapists, physiotherapists, and other diagnostic and health professionals.

Social workers: people who have completed a course of recognised training and are eligible for membership of the Australian Association of Social Workers.

Psychologists: people who are registered as psychologists with the relevant State or Territory registration board.

Occupational therapists: people who have completed a course of recognised training and who are eligible for membership of the Australian Association of Occupational Therapists.

Other personal care staff: attendants, assistants, home companions, family aides, ward helpers, warders, orderlies, ward assistants and nursing assistants who are engaged primarily in the provision of personal care to patients or residents, and who are not formally qualified or who are undergoing training in nursing or allied health professions.

Administrative and clerical staff: staff engaged in administrative and clerical duties. Excludes medical, nursing, diagnostic and health professional and domestic staff wholly or partly involved in administrative and clerical duties, who should be counted under their appropriate occupational categories. Civil engineers and computing

	staff are included in this category. *Domestic and other staff:* staff involved in the provision of food and cleaning services including domestic staff primarily engaged in administrative duties such as food services manager. Dieticians are excluded.
Stand-alone psychiatric hospitals	Health establishments that are primarily devoted to the treatment and care of inpatients with psychiatric, mental or behavioural disorders, and that are situated at physically separate locations from a general hospital. Stand-alone hospitals may or may not be managed by the mainstream health system. Psychiatric hospitals situated at physically separate locations from a general hospital are included within the ‘stand-alone’ category regardless of whether they are under the management control of a general hospital. A health establishment that operates in a separate building but is located on, or immediately adjoining, the acute care hospital campus may also be a stand-alone hospitals if the following criteria are **not** met: • a single organisational or management structure covers the acute care hospital and the psychiatric hospital • a single employer covers the staff of the acute care hospital and the psychiatric hospital • the location of the acute care hospital and psychiatric hospital can be regarded as part of a single overall hospital campus • the patients of the psychiatric hospital are regarded as patients of the single integrated health service.
Substance use disorders	Disorders in which drugs or alcohol are used to such an extent that behaviour becomes maladaptive, social and occupational functioning is impaired, and control or abstinence becomes impossible. Reliance on the drug may be psychological (as in substance misuse) or physiological (as in substance dependence).

12.8 Attachment tables

Attachment tables are identified in references throughout this chapter by an 'A' suffix (for example, table 12A.3 is table 3 in the attachment). Attachment tables are provided on the CD-ROM enclosed with the Report and on the Review website (www.pc.gov.au/gsp). On the CD-ROM, the files containing the attachment tables are provided in Microsoft Excel format as \Publications\Reports\2008\Attach12A.xls and in Adobe PDF format as \Publications\Reports\2008\Attach12A.pdf. Users without access to the CD ROM or the website can contact the Secretariat to obtain the attachment tables (see contact details on the inside front cover of the Report).

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Table 12A.54	Deflators used to calculate real state and territory mental health expenditure
Table 12A.55	Deflator used to calculate real Australian Government mental health expenditure
Table 12A.56	Estimated resident populations used in mental health per head calculations

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PART F

COMMUNITY SERVICES

F Community services preface

Families are the principal providers of care for children, older people and people with a disability (ABS 2001). Community services aim to:

- help families to undertake these roles
- fulfil these roles when families are not in a position to provide care
- provide interventions where individual needs are not able to be met by the community without special intervention.

Community services provide support to sustain and nurture the functioning of individuals, families and groups, to maximise their potential for development and to enhance community wellbeing (LGCSA 2002). Although community services are generally targeted to the individual, they may be delivered in larger settings. Services are typically provided by government and the not-for-profit sector, but the for-profit sector also has an important role (for example, as owners of aged care facilities). Community services also contribute to the development of community infrastructure to service needs (AIHW 2005).

What are community services?

Although there is a broad understanding of the nature of community services, the sector is complex, and consistent aggregate reporting of the sector across a range of measures is not possible at this time.

Definitions of the sector vary in their scope and can change over time. Community service activities typically include those activities ‘which assist or support members of the community in personal functioning as individuals or as members of the wider community’ (AIHW 1997, p. 3). They may include financial assistance and relief to people in crisis, and housing assistance of a short term or transitional nature (such as the Supported Accommodation and Assistance Program (SAAP)), but they exclude acute health care services, long term housing assistance and income support (such as social security pensions and allowances). Some of these interventions are included elsewhere in this Report; for example, Public hospitals (chapter 10), Health management issues (chapter 12) and Housing, including Commonwealth Rent Assistance (chapter 16).

In previous Reports, the children's services and juvenile justice data were included in the community services section and preface respectively. From this Report on, the Children's services chapter has been moved to the renamed 'Early childhood, education and training' section (box F.1), and the juvenile justice data have been moved from the Community services preface to the Protection and support services chapter (chapter 15).

Box F.1 **Changes to the scope of Community services in the Report on Government Services**

From the 2008 Report onwards, the Community services section of the Report will include chapters regarding Aged care services (chapter 13), Services for people with a disability (chapter 14) and Protection and support services, including child protection, juvenile justice and supported accommodation and assistance (chapter 15). The Children's services chapter has been moved to section B 'Early childhood, education and training' (previously 'Education') in recognition of the important link between children's services and educational outcomes. Where possible, children's services material previously in the community services preface has been moved to the Early childhood, education and training preface. However, due to the aggregated nature of much of the statistical material used, some 'community services' data will continue to reflect some elements of childcare and preschool services.

The definition of community service activities in this preface is based on the *National Classification of Community Services* developed by the Australian Institute of Health and Welfare (AIHW 2003) (box F.2). The scope of the preface is therefore somewhat broader than the three service specific chapters in this section of the Report (Aged care services, Services for people with a disability, and Protection and support services).

Box F.2 **Community service activities**

Personal and social support — activities that provide support for personal or social functioning in daily life. Such activities promote the development of personal skills for successful functioning as individuals, family members and members of the wider community. Personal and social support activities include the provision of information, advice and referral, personal advocacy, counselling, domestic assistance, provision of services that enable people to remain in their homes, disability services and other personal assistance services. The purpose of such support may be to enable individuals to live and function in their own homes or normal places of residence.

Support for children, families and carers — activities that seek to protect children from abuse and neglect or harm, through statutory intervention and support for families, are also included.

Training, vocational rehabilitation and employment — activities that assist people who are disadvantaged in the labour market by providing training, job search skills, help in finding work, placement and support in open employment or, where appropriate, supported employment.

Financial and material assistance — activities that enhance personal functioning and facilitate access to community services, through the provision of emergency or immediate financial assistance and material goods.

Residential care and supported accommodation — activities provided in special purpose residential facilities, including accommodation in conjunction with other types of support, such as assistance with necessary day-to-day living tasks and intensive forms of care such as nursing care.

Corrective services [in relation to young people and people with intellectual and psychiatric disabilities on court orders] — activities that involve correctional and rehabilitative supervision and the protection of public safety, through corrective arrangements and advice to courts and releasing authorities.[a]

Service and community development and support — activities that provide support aimed at articulating and promoting improved social policies; promoting greater public awareness of social issues; developing and supporting community-based activities, special interest and cultural groups; and developing and facilitating the delivery of quality community services. Activities include the development of public policy submissions, social planning and social action, the provision of expert advice, coordination, training, staff and volunteer development, and management support to service providers.

[a] This preface uses the term ‘juvenile justice’ to refer to detention and community-based supervision services for young people who have committed or allegedly committed an offence while considered by law to be a juvenile.

Source: AIHW (2003); States and territories (unpublished).

Other definitions of community services have broader scope. The National Community Services Information Agreement, managed by the National Community Services Information Management Group (NCSIMG), includes income support and concessions in its definition (NCSIMG 2007). Other definitions include additional activities such as advocacy, public transport, community safety and emotional support.

Profile of community services

This section examines the size and scope of the community services sector and the role of government in providing community services.

Roles and responsibilities

The Australian and State and Territory governments have a major role in the provision of community services. This role is based on a mandate to ensure basic rights and an acceptable standard of living, and a requirement to protect and support the vulnerable in society. Local governments are also important funders and providers of community services (AIHW 2005). However, community services funded solely by local government are outside the scope of this Report.

Government involvement in community services includes:

- providing services to clients directly
- funding non-government community service providers (which then provide community services to clients)
- regulating government and non-government providers
- undertaking policy development and administration.

The provision of community services is complex and the roles of the various tiers of government vary from program to program. Some services are funded solely by the Australian Government, some funded solely by State and Territory governments and some are funded jointly by the Australian and State and Territory governments.

Statutory child protection and placement, and juvenile justice services are primarily provided directly by government, while residential care, accommodation support and other community services activities are primarily provided by non-government organisations. Disability services funded by government are partially delivered by government. Most of the recurrent funding for aged care services is provided by the Australian Government, whereas in the fields of juvenile justice, child protection and disability services, State and Territory governments contribute most of the recurrent funding.

Increasingly, governments at all levels are entering partnerships with non-government organisations. Responsibilities under these partnerships vary considerably depending on the service, and mirror the complexity of the provision of services.

Effective regulation of non-government providers (through licensing, accreditation and quality assurance) enables services to be provided in response to need within an appropriate framework of agreed standards. Examples include the accreditation of residential aged care services, and Australian Government quality standards for Home and Community Care (HACC).

Policy development, resource allocation, performance assessment and service provision are key roles of government in the community services context. Requirements for effective service provision in the sector include understanding and responding to changing community expectations and the needs of individuals, meeting complex needs through the development of innovative solutions and case management, and the provision of capacity to meet future demand. Increasingly, governments are working with non-government providers of services to develop and plan services. This includes provision of funding to peak bodies, who are able to contribute to government policy and service delivery (FaCSIA 2007).

Expenditure

Community services expenditure

Estimates of community services expenditure are influenced by the scope of the services to be included. The following broad estimates of community services expenditure provide context for material included in the relevant chapters of this Report.

The most recent data on the range of community services expenditures are identified in the AIHW publication *Welfare expenditure Australia 2005-06* (AIHW 2007a). It includes expenditure incurred by governments, non-government organisations and individual households in providing services to assist members of the community with special needs (limited to families and children, older people, people with disabilities and other disadvantaged groups).

Welfare expenditure Australia 2005-06 identifies expenditure on welfare services in 2005-06 of $28.9 billion ($1404 per person), which represented 3.0 per cent of

Gross Domestic Product (GDP) in that year. This expenditure excludes welfare payments. In 1998-99, this expenditure represented 2.9 per cent of GDP. Over this period, the average annual growth in expenditure on these services was similar to the average annual growth of GDP (AIHW 2007a).

Government was the source of 70.8 per cent of all funding of welfare services in 2005-06 identified by *Welfare expenditure Australia 2005-06*, with the non-government sector providing the remaining 29.2 per cent of funding. Of this 29.2 per cent, households contributed 20.3 per cent and non-government community service organisations contributed the remaining 9.0 per cent (AIHW 2007a).

The most recent Australian Bureau of Statistics (ABS) Survey of Community Services (ABS 2001) identified government and non-government expenditure for the sector in 1999-2000. The scope of this survey included:

- nursing homes
- child care services
- accommodation for the aged
- residential care services not elsewhere classified
- non-residential care services not elsewhere classified
- employment placement services (only organisations supporting persons with disabilities)
- interest groups not elsewhere classified (only organisations involved in community service advocacy services)
- government administration (only government organisations responsible for funding community services or being directly involved in the provision of community services).

Some categories of government expenditure included in this Report were regarded as out-of-scope for the ABS survey. These included expenditure of $307 million on the Residential Care Subsidy, which was paid to non-community services organisations such as hospitals and allied health organisations, Commonwealth/State Disability Agreement funding of $180 million paid to organisations providing community nursing services, $176 million in Child Care Assistance paid to educational organisations such as primary and secondary schools and corporations providing child care in-house, and HACC Program funding of $148 million, also paid to organisations providing community nursing services (ABS 2001).

In total, ABS identified $12.6 billion spent on community services and related activities during 1999-2000 ($11.5 billion excluding child care services). This expenditure included $10.7 billion of direct community service expenditure ($9.6 billion excluding child care services). Including direct and indirect expenditure, $2.1 billion was expended by ‘for-profit’ organisations, $7.1 billion by ‘not-for-profit’ organisations and $3.4 billion by government organisations. Direct expenditure only, excluding child care services, was $1.5 billion by ‘for-profit’ organisations, $5.6 billion by ‘not-for-profit’ organisations and $2.5 billion by government organisations (ABS 2001). The next ABS survey of community services is planned for 2008.

Alternative sources of information on community services expenditure, including national accounts data, will be explored in future Reports.

Community services expenditure for services included in this Report

The following more detailed community services expenditure relates only to the activities reported in the community services chapters of this Report. The major programs reported on include:

- aged care services — aged care assessment, residential care and community care programs and HACC
- services for people with a disability — services under the third Commonwealth State/Territory Disability Agreement
- protection and support services — child protection and out-of-home care services, intensive family support services and the SAAP program.

Total government recurrent expenditure on community services covered by this Report was estimated to be $14.9 billion in 2006-07 (table F.1). This was equivalent to 1.4 per cent of GDP in that year, and 7.8 per cent of total government outlays (table F.1 and ABS 2007a).

Table F.1 **Government recurrent expenditure on community services (2006-07 dollars)**[a, b, c]

	Unit	*Aged care services*	*Services for people with a disability*	*Protection and support services*	***Total***
2002-03	$m	7 004.9	3 512.7	1 493.1	**12 010.7**
2003-04	$m	7 282.6	3 729.6	1 628.2	**12 640.4**
2004-05	$m	7 616.4	3 959.6	1 814.3	**13 390.3**
2005-06	$m	7 869.9	4 074.2	1 923.7	**13 867.7**
2006-07	$m	8 411.3	4 346.3	2 162.7	**14 920.4**
Increase 2002-03 to 2006-07	%	20.1	23.7	44.8	**24.2**

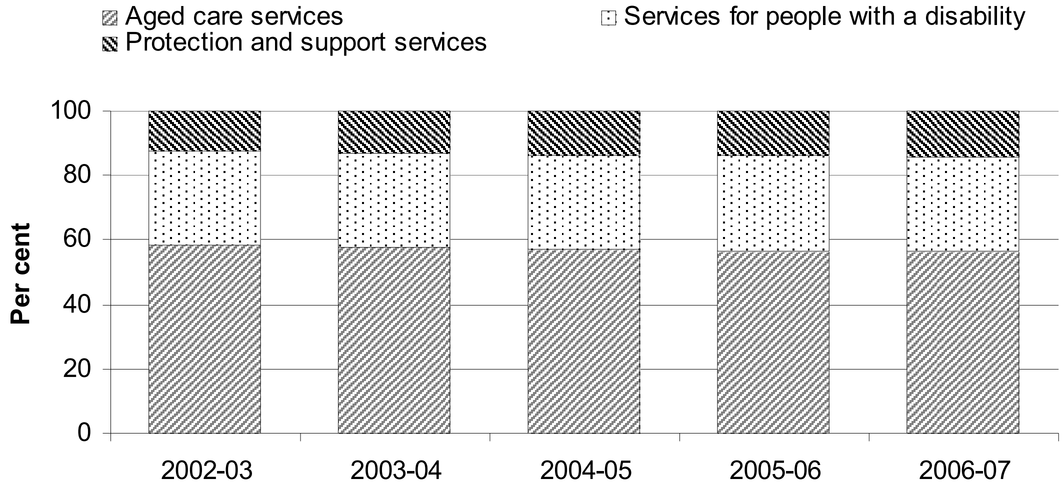
[a] Data for 2002-03 to 2005-06 have been adjusted to 2006-07 dollars using the gross domestic product (GDP) price deflator in table AA.26 of Appendix A. [b] Data for aged care services published in the 2007 Report and earlier reports differ due to revised data and additional expenditure items collected for 2006-07 in the 2008 Report. [c] Totals may not add as a result of rounding.

Source: Australian, State and Territory governments (unpublished); tables 13A.44-48, 13A.68-69, 14A.5, 15A.1 and 15A.177.

Between 2002-03 and 2006-07, real government recurrent expenditure on community services increased by $2.9 billion, or 24.2 per cent. The largest proportional increase in real expenditure was on protection and support services, which increased by 44.8 per cent between 2002-03 and 2006-07. The largest actual increase for a particular service between 2002-03 and 2006-07 was $1.4 billion for aged care services (table F.1).

In 2006-07, 56.4 per cent of government recurrent expenditure on community services related to aged care services, 29.1 per cent related to services for people with a disability, and 14.5 per cent related to protection and support services. These proportions have been fairly consistent from 2002-03 to 2006-07 (figure F.1).

Figure F.1 **Government recurrent expenditure on community services, 2006-07 (per cent)**[a]



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[a] Data for aged care published in the 2007 Report and earlier reports differ due to revised data and additional expenditure items collected for 2006-07 in the 2008 Report.

Source: Australian, State and Territory governments (unpublished); tables 13A.44-48, 13A.68-69, 14A.5, 15A.1 and 15A.177.

Figure F.2 identifies expenditure on community services included in the Report by jurisdiction for 2006-07. It includes direct expenditure by states and territories and Australian Government expenditure available for reporting at a state and territory level only (table F.2 and figure F.2).

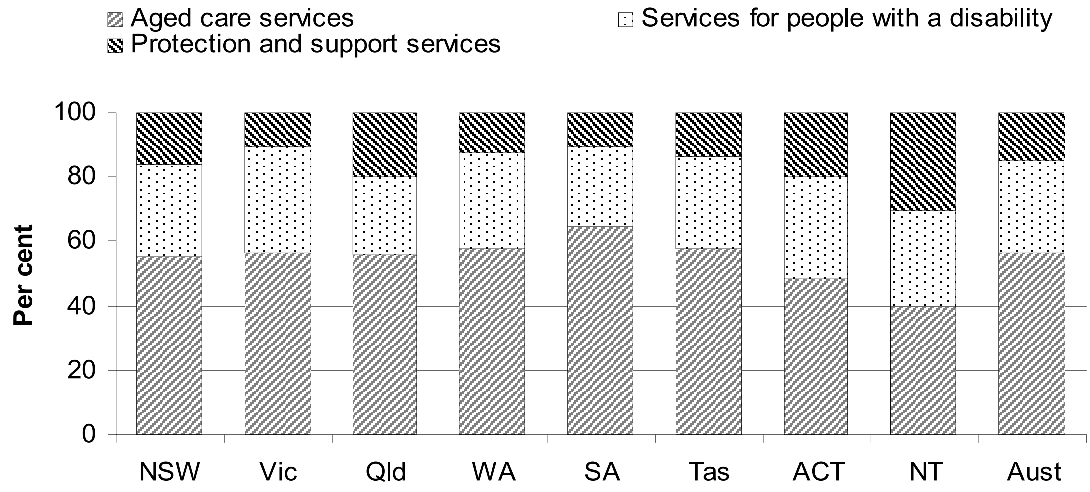
Table F.2 Government recurrent expenditure on community services, 2006-07[a, b]

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Total*
Recurrent expenditure on community services										
Aged care services	$m	2 774.9	2 111.7	1 531.1	729.3	827.1	243.0	102.1	48.4	8 380.7
Services for people with a disability	$m	1 425.8	1 234.2	669.1	377.4	311.3	121.8	66.6	35.6	4 241.9
Protection and support services	$m	792.0	403.1	538.2	155.8	137.0	56.9	42.7	37.1	2 162.7
Total	**$m**	**4 992.7**	**3 749.0**	**2 738.4**	**1 262.5**	**1 275.4**	**421.7**	**211.4**	**121.1**	**14 785.3**
Proportion of recurrent expenditure by service										
Aged care services	%	55.6	56.3	55.9	57.8	64.8	57.6	48.3	40.0	56.7
Services for people with a disability	%	28.6	32.9	24.4	29.9	24.4	28.9	31.5	29.4	28.7
Protection and support services	%	15.9	10.8	19.7	12.3	10.7	13.5	20.2	30.6	14.6
Total	**%**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**
Recurrent expenditure on community services per person in the population[c]										
Expenditure per person	$	728.3	725.8	662.7	606.7	809.4	857.6	628.2	569.8	709.1

[a] For aged care services and services for people with a disability, Australian Government expenditure available for reporting at a state and territory level is included in the analysis for the relevant jurisdiction. Australian Government expenditure not allocated to a state or territory is not included ($30.6 million in aged care services and $104.4 million in disability services). [b] Collection and reporting methods may vary across jurisdictions and services in this analysis. Therefore these data should be interpreted with care. [c] Population at 31 December 2006.

Source: Australian, State and Territory governments (unpublished); tables 13A.44-48, 13A.68-69, 14A.5, 15A.1 and 15A.177; table AA.2

Figure F.2 Government recurrent expenditure on community services, 2006-07 (per cent)[a, b]

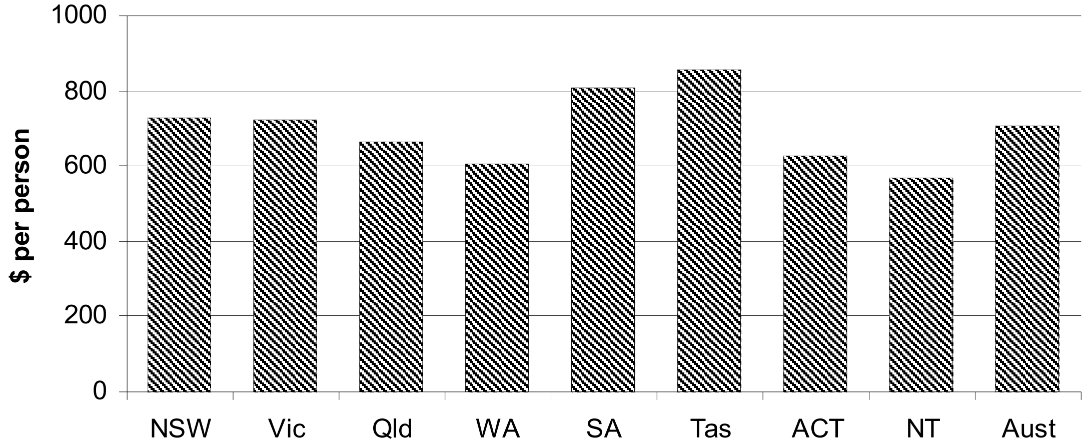


[a] For aged care services and services for people with a disability, Australian Government expenditure available for reporting at a state and territory level is included in the analysis for the relevant jurisdiction. Australian Government expenditure not allocated to a state or territory is not included ($30.6 million in aged care services and $104.4 million in disability services). [b] Collection and reporting methods may vary across jurisdictions and services in this analysis. Therefore these data should be interpreted with care.

Source: Australian, State and Territory governments (unpublished); table F.2.

In 2006-07, community services government recurrent expenditure was $709 per person nationally. This expenditure (which only includes direct expenditure by State and Territory governments and Australian Government expenditure available for reporting at the state and territory level) varied across jurisdictions (table F.2 and figure F.3).

Figure F.3 **Government recurrent expenditure on community services, per person in the population, 2006-07[a, b, c]**



[a] For aged care services and services for people with a disability, Australian Government expenditure available for reporting at a state and territory level is included in the analysis for the relevant jurisdiction. Australian Government expenditure not allocated to a state or territory is not included ($30.6 million in aged care services and $104.4 million in disability services). [b] Collection and reporting methods may vary across jurisdictions and services in this analysis. Therefore these data should be interpreted with care. [c] Population at 31 December 2006.

Source: Australian, State and Territory governments (unpublished); table F.2.

Size and scope

Current data on size and scope of the community services sector are limited. The ABS Survey of Community Services collected data on the number of organisations that provide community services. Almost 9300 organisations were providing community services (covering the not-for-profit, government and for-profit sectors) as at 30 June 2000. Of these, 30 per cent were for-profit organisations, 63 per cent were not-for-profit organisations and 6 per cent were government organisations. If non-government sector child care services are excluded, 14 per cent were for-profit organisations, 76 per cent were not-for-profit organisations and 10 per cent were government organisations (ABS 2001). From 1995-96 to 1999-2000, the number of for-profit and not-for-profit organisations across the sector increased by 32 per cent and 10 per cent respectively.

Workforce Information

The AIHW has noted difficulties identifying the true dimensions of the community services workforce. These difficulties include identifying the community services sector and sub-sectors in data sets (the varying measurements in this preface reflect these difficulties), data gaps relating to sub-sectors of community services and the lack of regular and consistent data (AIHW 2006a).

Available information suggests increasing levels of employment within the community services sector over the past decade.

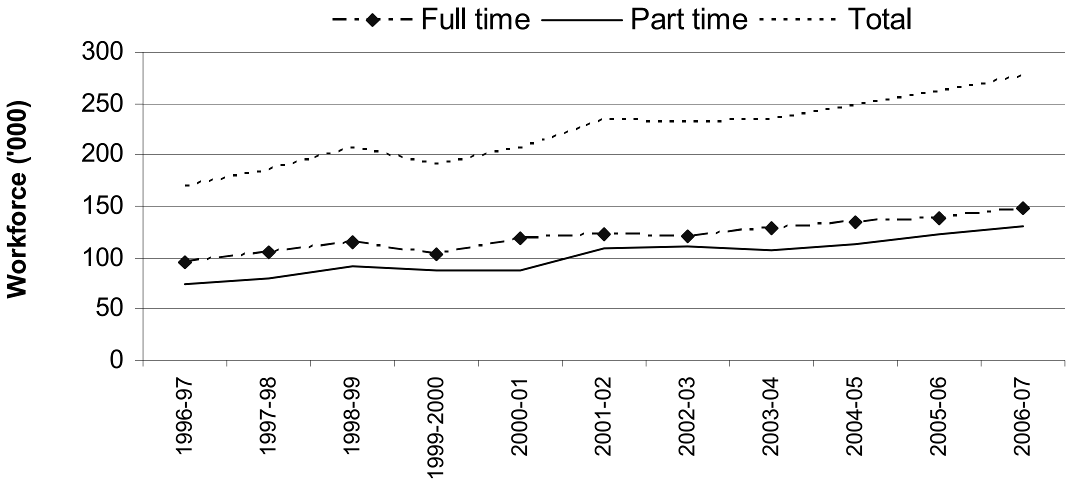
The ABS Survey of Community Services provides a detailed description of the workforce. In 1999-2000, not-for-profit, government and for-profit organisations employed a total of 341 400 people. Of these, 59 246 were employed by government organisations, and 277 300 people were employed in direct service provision. If childcare services are excluded from this analysis, 300 300 people were employed, including 238 900 in direct service provision. A further 299 400 volunteers (288 000 excluding child care services) assisted in community service activities (ABS 2001).

Subsequent developments in the community services workforce may be observed through ABS labour force survey data in *Labour Force, Australia, Detailed, Quarterly, August 2007* (ABS 2007b). These data provide a quarterly estimate of the full and part time workforce for the community services sector, within the broader industry classification 'Health and Community services'. This enables an ongoing measure of community services employment, although the 'Community services' classification is restricted to the following sub-categories of the Australian and New Zealand Standard Industrial Classification:

- nursing homes
- child care services
- accommodation for the aged
- residential care services not elsewhere classified
- non-residential care services not elsewhere classified.

Quarterly data have been averaged to provide an annual measure, which identifies that, from 1996-97 to 2006-07, the community services workforce has grown from 168 900 people (56.7 per cent full time and 43.3 per cent part time) to 276 900 people (53.1 per cent full time and 46.9 per cent part time). This represents an average annual increase in employment in the community services sector of 5.1 per cent (figure F.4) (ABS 2007b).

Figure F.4 **Full time, part time and total employment in community services, 1996-97 to 2006-07**



Source: ABS 2007(b).

Caution should be exercised in using these data to estimate the community services workforce. The numbers employed in a particular industry do not necessarily reflect the numbers of people in particular occupations. Employment in occupations typically associated with community services industries also occurs in other industries, for example in education and health services. The AIHW has reported that in 2006, over 188 000 workers were employed in community services occupations in other industries (AIHW 2007b).

The Australian Community Sector Survey 2007, published by the Australian Council of Social Services (ACOSS), estimates a 3.0 per cent increase in the community services workforce from 2004-05 to 2005-06. The same survey reports that demand for a broad range of community services (measured by the number of people assisted by agencies) increased by 4.0 per cent from 2004-05 to 2005-06 (ACOSS 2007).

Volunteers

Although this Report focuses on government provision of services, it is important to recognise that volunteering provides an important contribution to the community services sector, not generally identified in workforce data. ABS data show that in 2006, 16.3 per cent of all voluntary involvement was expended in the ‘community/welfare’ sector (which includes community services), and that 90.4 per cent of this volunteer work occurred in the not-for-profit sector. The highest proportion of volunteers in this sector were aged 65 years and over. Just over 7 per cent of all persons in the community aged 18 years and over volunteered in this sector (ABS 2007c).

The Department of Families, Community Services and Indigenous Affairs (FaCSIA) estimates that the total imputed dollar value of the time donated to welfare service by volunteers in 2001-02 ($27.4 billion), was almost double the total cash amount spent by all governments and non-government sources ($13.7 billion) in Australia. Informal help to family, friends and neighbours generates over two-thirds of the imputed value of the services (FaCSIA 2006a). The ABS 2003 Survey of Disability, Ageing and Carers (ABS 2004a) reveals that the number of people with a reported disability or with a profound or severe core activity limitation receiving assistance from informal providers (predominantly families), is significantly greater than the number of people receiving formal services (from government or non-government providers).

Community services developments

The continued growth of the community services sector is, in part, a response to changes occurring more broadly in society. Although these developments are not necessarily readily quantified, the following discussion summarises some of the movements observed in recent years.

The community services sector is influenced by changing demographic structures. For example, increases in the number and proportion of older people in the population may have an impact on the demand for aged care and disability services and the ability of the community to respond to these demands. Disability prevalence increases with age. In 2003, of the population aged 0–34 years, 9.2 per cent had a disability, whereas 21.9 per cent of the population aged 35–64 years had a disability. Of the population aged 65 years or over in 2003, 55.7 per cent had a disability (AIHW 2006b).

The Australian Government’s second *Intergenerational Report* (2007a) provides an indication of the extent to which such demographic changes may influence the sector in the future, and the impact of these changes on revenue and expenditure (box F.3).

Box F.3 **Future demographics and the Intergenerational Report 2007**

The projections in the Intergenerational Report 2007 show that over the next forty years:

- the Australian population will continue to increase in size but with a higher proportion of older people. The proportion of those over 65 is predicted to nearly double to 25 per cent of the population
- economic growth per person will slow as the proportion of the population of traditional working age falls
- substantial fiscal pressures will emerge due to projected increases in government spending, particularly in the areas of health, age pensions and aged care.

The report identifies productivity, population and participation as contributors to real GDP, which in turn, is a key factor in the ability of the economy to sustain service provision, including provision of community services.

Source: Australian Government 2007(a).

In addition to an ageing population, some commentators consider that rapidly changing economic and social environments over recent years have adversely affected family and community strength and the capacity to deal with issues. Some analysis has referred to a '…perceived decline in social cohesion which has placed stress on family and social functioning' (Zubrick et al. 2000, quoted in Davies and Taylor (2005)). These economic and social changes can partly be attributed to:

- labour market changes, associated with growth in technology and service industries
- population movements, associated with most Australians living in or moving to urban settings
- changing family structures, characterised by increased family breakdown and less reliance on the extended family
- decreasing engagement in community life (Davies and Taylor 2005).

These developments may provide some background to the increasing demand for a range of community services, although the explanations for changes in demand for any given service or an individual's demand of that service are likely to be complex.

The development of social capital (box F.4) as a result of the activities of community services and individuals is increasingly recognised as contributing to the wellbeing of society. Although social capital is multifaceted and difficult to measure, the ABS has identified some broad indicators of social capital, which include social participation, community support, economic participation and reciprocity (ABS 2006).

Box F.4 Community services and developing social capital

Social capital relates to the resources available within communities in networks of mutual support, reciprocity and trust. It is a contributor to community strength. The OECD defines social capital as 'networks, together with shared norms, values and understandings which facilitate cooperation within or among groups' and this is becoming a generally accepted definition.

Creation of social capital can generate benefits in a number ways:

- by reducing the costs of conducting day-to-day affairs and of doing business
- by facilitating the spread of knowledge and innovation
- by promoting cooperative and/or socially-minded behaviour in situations where narrow self-interest alone does not generate good outcomes for society
- through individual benefits — people with good access to social capital tend to be more 'hired, housed, healthy and happy' than those without
- through associated social spill-overs, such as lower health and welfare expenditures, and higher tax receipts.

Social capital may affect a range of areas of community and individual well being. Development of social capital may reduce the demand on community services — for example, increased social capital may result from employment or from increased contact with family and friends, which in turn may reduce the reliance on community services. Conversely, provision of well designed accessible community services may develop social capital within society.

Source: ABS 2004b; Productivity Commission 2003.

The Human Rights and Equal Opportunity Commission's 2007 report *It's About Time: Women, men, work and family Final Paper 2007* (HREOC 2007) identifies a range of possible solutions to the pressures faced by individuals managing the balance between work and family life. Many of these pressures relate to providing support in areas where community service interventions often occur, including support for people with a disability and older people. The report notes:

> Demographic changes such as low birth rates mean that in future many more people will not have family members living with them as they age. Providing support and care for people outside of one's home is likely to become a larger part of what we consider to be family and carer responsibilities. This also raises the need to consider care as a community responsibility, rather than simply that of individual households. This is particularly important for elder care, as many frail older people are choosing — and are increasingly encouraged – to remain in their own homes as they age. (HREOC 2007)

Cross-cutting community services issues

Community services pathways

Although this Report discusses three areas of community services in separate chapters, it is recognised that there are many linkages between different community services. Governments are increasingly emphasising the need for integrated, client-centred community services.

Many community services are linked by the provision of these services to individuals at different stages of life. Although some community services only apply to people in specific age groups (for example, child protection services or aged care services), other services are not as strictly age-specific (for example, disability services and SAAP). Some individuals may receive multiple services — for example, a child who is in receipt of juvenile justice services together with homelessness or child protection and disability services. Disability services may continue throughout an individual's lifetime and overlap with provision of aged care services.

The sequence of interventions or services may be referred to as 'pathways' of community service provision. However, there is limited information on the patterns of access by individuals to the range of community services, either concurrently or in succession over a lifetime. A greater understanding of the links between the use of various community services, the nature of these links, and whether interventions in one area of service provision result in reduced need for other services, will enhance the effectiveness and efficiency of the sector overall.

Examples of relevant research include:

- a cohort study carried out in Queensland, which found a correlation between contact with child protection services and the juvenile justice system. Of the 24 255 children born in 1983 or 1984 who had a contact with one or more of child protection services, police cautioning or children's courts, 6.2 per cent had both a child protection services contact and a children's court appearance. These 1500 children represented 28.7 per cent of those with a children's court appearance and 15.7 per cent of those with a child protection history (Stewart, Dennison and Hurren, 2005)
- a Community and Disability Services Ministers Advisory Council (CDSMAC) funded project to enable data linkage at a client level for individuals in receipt of services in the areas of child protection, juvenile justice and SAAP. The proposed data linkage may identify the extent and patterns of sequential take up of these services and may also help identify the characteristics of young people

who move between the three sectors. Analysis of these outcomes over time may provide information on the effectiveness of programs and identify possible future program developments

- a FaCSIA longitudinal study of Indigenous children (*Footprints In Time*) into the links between early childhood experiences and later life outcomes for Aboriginal and Torres Strait Islander children, covering areas such as culture, education, health, family and community (FaCSIA 2006b).

There are also links between community services and other government services. Access to effective community services may influence outcomes for clients of education, health, housing and justice sector services. In turn, access to these other service areas may affect outcomes for clients of community services.

The community services and health sectors are closely related and their effective interaction assists the provision of services in both sectors. The disability sector is also strongly linked to health services by the needs of clients, as people with a disability tend to have a larger number of health conditions than the general population (AIHW 2006b). The very young and very old in society are relatively large users of health services. Other links, such as the incidence of medical staff as a source of child protection notifications, also reinforce the importance of the relationship between community services and health.

HACC across the community services sector

Within the Report, HACC services are included in the Aged care services chapter, but the scope of the program is wider than just aged care. The National Program Guidelines for the HACC Program note that the Program provides funding for services which support people who are frail aged people and younger people with disability and their carers, who live at home and whose capacity for independent living is at risk or who are at risk of premature or inappropriate admission to long term residential care (Australian Government 2007b).

Provision of HACC services is primarily to aged people, but younger people including people with a disability, and their carers are also important recipients of HACC assistance.

In 2005-06, 24.3 per cent of HACC clients were aged under 65 years (up from 23.2 per cent in 2002-03). Analysis of data from the HACC program in 2005-06 indicates that clients aged under 65 years were significantly over-represented in particular assistance types, including care counselling support (33.3 per cent), carer counselling support (34.0 per cent), nursing care (centre) (38.3 per cent), and respite care (60.8 per cent) (DoHA 2003, 2007).

In 2005-06, 9.2 per cent of HACC clients nationally were in receipt of a Disability Support Pension. This proportion had decreased from 12.0 per cent in 2002-03. In 2005-06, 45.5 per cent of HACC clients classified as care recipients reported that they were also receiving assistance from a relative or friend-carer (DoHA 2003, 2007).

Community services, participation and productivity

Participation and productivity have been noted earlier in the preface as important contributors to economic growth (box F.3).

The Council of Australian Governments (COAG) agreed on a third wave of national reform in 2006 (COAG 2006). The key focus of the human capital stream of this Agenda is on the workforce. Increasing participation (through increased entry and re-entry into the workforce) and productivity (through better skills) will contribute to economic development over the next 40 years and may address some other issues raised in the Intergenerational Report (box F.3). Increasing participation and productivity may also have an impact on the demand for community services interventions over the longer term.

Some indicative outcomes have been agreed in relation to human capital reforms, and where available, these will be included in the various chapters of the Report. Those outcomes which may have specific relevance to the scope of the community services sector in the Report are listed in box F.5.

Box F.5 **National Reform Agenda — human capital reforms**

The following working age incentive outcomes have been established which may impact on the community services sector:

- improve overall workforce participation, with a particular focus on the target groups of income support recipients, the mature aged and women, in a manner consistent with the long term interests of the individual and the economy, giving due regard to productivity
- increased provision of flexible working arrangements within the workforce, in a manner consistent with the long term interests of the individual and the economy.

Indicative progress measures related to the above outcomes are:

- the participation rate, employment to population rate, and total hours worked, with a particular focus on the target groups
- the proportion of people, including from within the target groups, reporting barriers to participation and employment that reflects the individual's capacity, and the level of skills and experience achieved
- the proportion of employees having access to flexible working arrangements
- employer attitudes and practices regarding employing staff, in particular from within the target groups.

Source: COAG (2006).

Future directions in performance reporting

This preface has been significantly rewritten for the 2008 Report. The Steering Committee intends to continue expansion of the reporting in this preface on the characteristics of the community service sector. In particular, developments which span the various community services, such as measures of social capital, will be considered. Ongoing investigation of cross-cutting issues may allow improved reporting of community services as a whole.

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13 Aged care services

The aged care system comprises all services specifically designed to meet the care and support needs of frail older Australians. This chapter focuses on government funded residential and community care for older people and services designed for the carers of older people. Some government expenditure on aged care is not reported, but continual improvements are being made to the coverage and quality of the data. The services covered include:

- residential services, which provide high care, low care and residential respite care (box 13.1)
- community care services, which include Home and Community Care (HACC) program services, Community Aged Care Packages (CACPs), the Extended Aged Care at Home (EACH) program, the EACH Dementia program, the Transition Care Program (TCP)[1] and Veterans' Home Care (VHC) [2]
- respite services, which include HACC respite and centre-based day care and the National Respite for Carers Program (NRCP)
- assessment services, which are largely provided by the Aged Care Assessment Program (ACAP).

A profile of aged care services appears in section 13.1. A framework of performance indicators is outlined in section 13.2 and key performance results are discussed in section 13.3. Future directions in performance reporting are discussed in section 13.4. Jurisdictions' comments are reported in section 13.5. Section 13.6 contains definitions for key terms and indicators. Section 13.7 lists the attachment tables for this chapter. Attachment tables are identified in references throughout this chapter by an 'A' suffix (for example, table 13A.3 is table 3 in the attachment). Attachment tables are provided on the CD-ROM enclosed with the Report or from the Review website: http://www.pc.gov.au/gsp/home. Section 13.8 lists references used in this chapter.

Additions and improvements made to the chapter this year include:

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[1] Some aspects of the TCP are related to residential care services.

[2] Unless otherwise stated, HACC expenditure excludes the Department of Veterans' Affairs expenditure on VHC.

- reporting for the first time age specific approval rates for aged care services
- restructure of the 'funding' section, including provision of a summary table
- inclusion of two additional categories of experimental expenditure data, for state and territory capital expenditure on residential aged care and additional state and territory expenditure on HACC services
- inclusion for the first time of expenditure data in relation to Multi-Purpose Services (MPS), TCP and Indigenous specific services
- improved presentation of the indicator 'use by different groups'
- reporting for the first time the indicator 'long term aged care in public hospitals'
- revision and improvement of the indicator 'waiting times for residential care'.

Older Australians also use other government services covered in this Report, including disability services (chapter 14), specialised mental health services (chapter 12), housing assistance (chapter 16) and services across the full spectrum of the health system (preface E and chapters 10–12). There are also interactions between these services that are likely to affect performance results in this Report — for example, the number of operational residential aged care places may affect demand for public hospital beds, and changes in service delivery in the public hospital sector may affect demand for residential and community aged care.

Box 13.1 **Interpreting residential aged care data**

This chapter describes the characteristics and performance of residential aged care in terms of residential services, residents (clients), places and locality.

- *Residential services data*. This chapter groups residential services for reporting purposes based on the eight level Resident Classification Scale (RCS) profile of residential services' clients.
  - Aged care homes with 80 per cent or more residents classified as RCS 1–4 are described as high care services.
  - Aged care homes with 80 per cent or more residents classified as RCS 5–8 are described as low care services.
  - A service that is neither high care nor low care as defined above is called a mixed service.

  These categories have been used for descriptive purposes and do not have any legal foundation under the *Aged Care Act 1997 (Cwlth)*. Similarly, the choice of 80 per cent as a cut-off is arbitrary but considered appropriate for descriptive purposes.
- *Residents data*. This chapter classifies clients as high care or low care based on their RCS assessment. High care residents have been assessed as RCS levels 1–4, and low care residents have been assessed as RCS levels 5–8.

(Continued on next page)

Box 13.1 **(Continued)**

- *Places data*. Part 2.2 of the Aged Care Act details the processes for planning and allocating subsidised services to meet residential aged care needs and community care needs. Planning is based on a national formula for people aged 70 years or over for high and low care. High care places are planned to meet the needs of residents with care needs equivalent to RCS levels 1–4. Low care places are planned to meet the needs of residents with care needs equivalent to RCS levels 5-8.

Although a needs match is expected when residents enter vacant places (that is, vacant low care places should usually be filled by low care residents), this can change over time with ‘ageing in place’, which allows a low care resident who becomes high care to remain within the same service until he or she is discharged.

- *Locality data.* Geographic data are based on the Australian Bureau of Statistics (ABS) Australian Standard Geographic Classification of Remoteness Areas (ABS 2003). Data are classified according to an index of remoteness that rates each ABS Census district based on the number and size of towns, and the distance to major towns and urban centres.

13.1 Profile of aged care services

Service overview

Services for older people are provided on the basis of the frailty or functional disability of the recipients rather than specific age criteria. Nevertheless, in the absence of more specific information, this Report uses people aged 70 years or over as a proxy for the likelihood of a person in the general population requiring these services. Certain groups (notably Indigenous people) may require various services at a younger age. For Indigenous people, those aged 50 years or over are used as a proxy for the likelihood of requiring aged care services. The Australian Government also uses these age proxies for planning the allocation of residential care, CACPs EACH and EACH Dementia packages.

Government funded aged care services covered in this chapter relate to the three levels of government (Australian, State and Territory, and some local) involved in service funding and delivery. The formal, publicly funded services covered represent only a small proportion of total assistance provided to frail older people. Extended family and partners are the largest source of emotional, practical and financial support for older people: more than 90 per cent of older people living in the community in 2003 who required help with self-care, mobility or communications received assistance from the informal care network of family, friends and neighbours (ABS 2004a). Many people receive assistance from both formal aged care services and informal sources. Older people also purchase support services in the private market, and these services are not covered in this chapter.

Roles and responsibilities

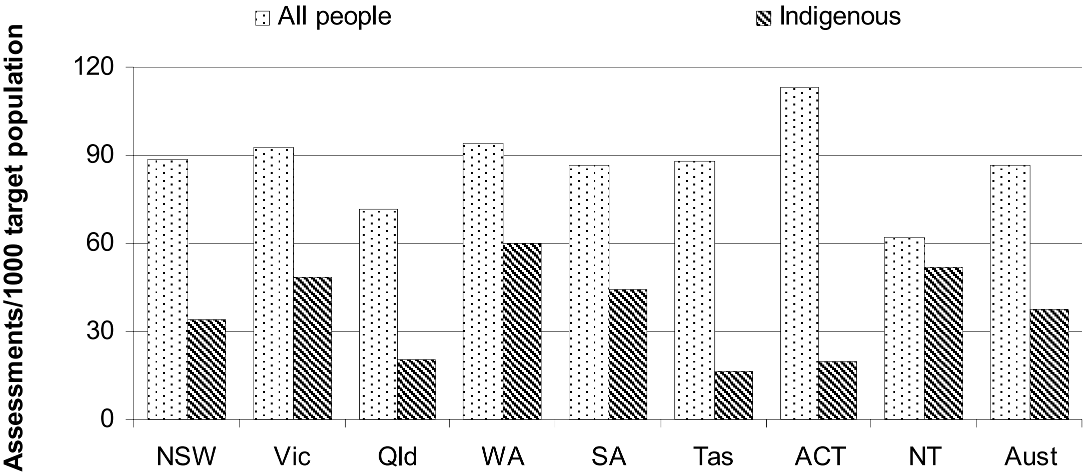
Assessment services

The Australian Government established the ACAP in 1984, based on the assessment processes used by State and Territory health services to determine (1) eligibility for admission into residential care and (2) the level of care required (and thus the subsidy paid to such services). The core objective of the ACAP is to assess the needs of frail older people and recommend appropriate services. Assessment and recommendation by Aged Care Assessment Teams (ACATs) are mandatory for admission to residential care or receipt of a CACP, EACH package, EACH Dementia package or TCP. People may also be referred by ACATs to other services, such as those funded by the HACC program. An ACAT referral is not mandatory for receipt of other services, such as HACC and VHC services.

State and Territory governments are responsible for the day-to-day operation and administration of the ACAP, and for provision of the necessary accommodation and support services. The scope and practice of the teams differ across and within jurisdictions, partly reflecting the service setting and location (for example, whether the team is attached to a residential service, a hospital, or a community service). This has an effect on program outputs.

The number of assessments per 1000 target population varied across jurisdictions in 2005-06. The national rate was 86.8 assessments per 1000 people aged 70 years or over and Indigenous people aged 50 years or over and 37.2 per 1000 Indigenous people aged 50 years or over (figure 13.1).

Figure 13.1 **Aged Care Assessment Team assessment rates, 2005-06**[a, b, c, d, e]



[a] Includes ACAT assessments for all services. [b] 'All people' includes all assessments of people aged 70 years or over and Indigenous people aged 50 years or over per 1000 people aged 70 years or over and Indigenous people aged 50 years or over. [c] 'Indigenous' includes all assessments of Indigenous people aged 50 years or over per 1000 Indigenous people aged 50 years or over. [d] The number of Indigenous assessments is based on self-identification of Indigenous status. [e] See table 13A.39 for further explanation of these data.

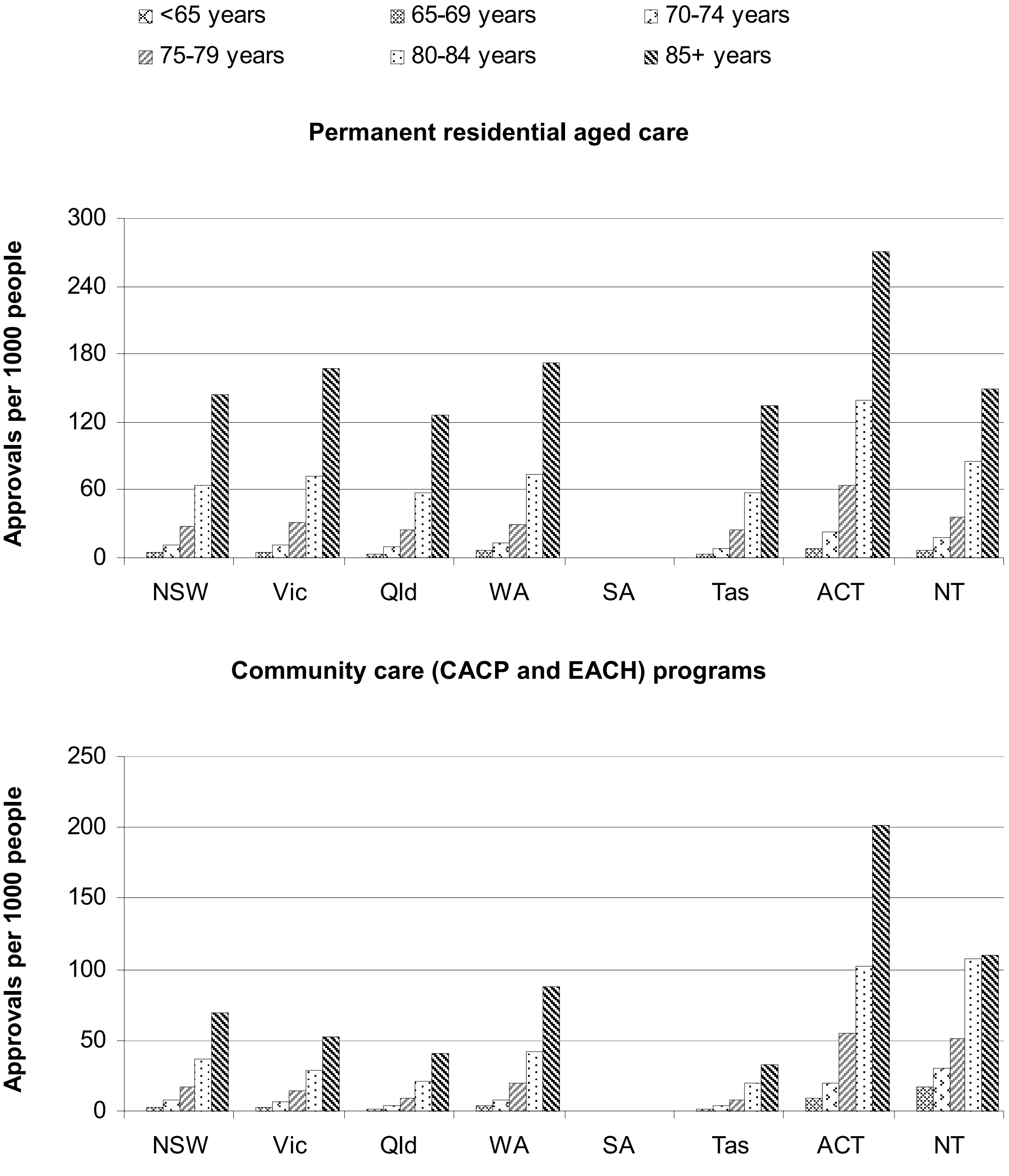
Source: Aged Care Assessment Program National Data Repository (unpublished); table 13A.39.

ACAT assessments which result in approvals of eligibility for various types of care can be shown by age-specific rates, for a series of age groups in the population. Data are provided for residential care and for community care (CACP, EACH and EACH Dementia).

These data reflect the numbers of approvals, which are a subset of assessments, as some assessments will not result in a recommendation or an approval for a particular level of care. The numbers of places accepted cannot be identified from these data (see boxes 13.9, 13.10 and 13.11 in relation to waiting time for residential and community care). As practices may vary across jurisdictions, data should be interpreted with care.

The approval rates for both residential and community care services vary across jurisdictions and increase with age (figure 13.2).

Figure 13.2 Age-specific approval rates, per 1000 persons in the population, 2005-06[a, b, c, d]



[a] Data for SA are not available. [b] Population numbers and the proportions of the population for older age groups in ACT and NT are smaller than other jurisdictions, and may show variation between years, so results should be interpreted with caution. [c] The age category population data for this table are derived from ABS estimated resident population figures as at 30 June 2006, which are preliminary and rebased on the 2006 Census of Population and Housing. [d] EACH packages include EACH Dementia packages.

Source: Aged Care Assessment Program National Data Repository (unpublished); table 13A.40; table AA.1.

The Council of Australian Governments (COAG) has agreed to improve aged care assessment services as part of its national health agenda (box 13.2).

Box 13.2 Improved performance and streamlining of assessment processes

In February 2006, COAG agreed to establish an initiative to simplify access to care services for the elderly, people with a disability and people leaving hospital.

The initiative consists of two components:

- more timely and consistent assessments for frail older people by ACATs
- simplified entry and assessment processes for the HACC Program.

The ACAT component provides for a range of activities to improve the timeliness, quality and consistency of ACAT recommendations, for implementation to improve the administration and performance of the ACAP. Initiatives already implemented include: a national ACAT Review, development of a National Training Strategy and a report on the variability of ACAT recommendations. In addition, states and territories are progressing a range of improvements to processes.

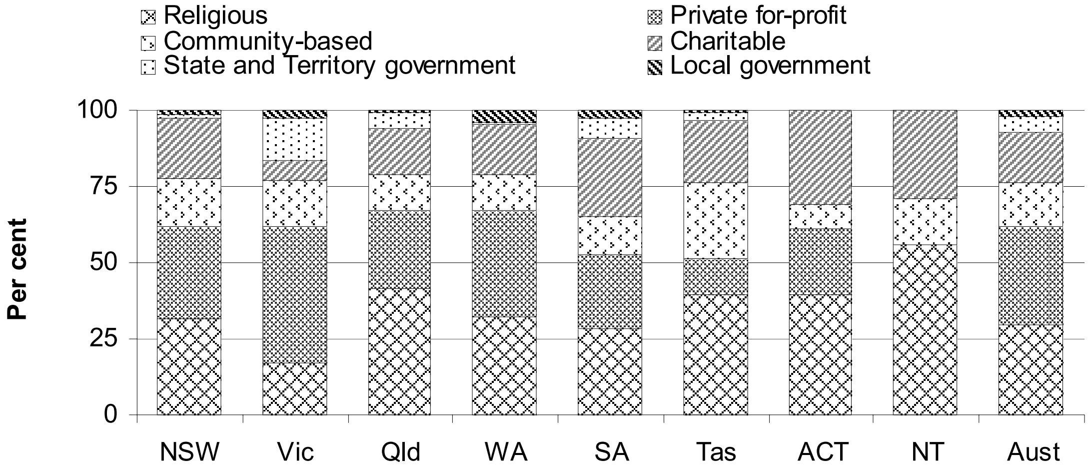
The HACC component has been progressed in 2006-07 to enable: increased national consistency in determining eligibility and assessment of client and carer; and simplified access points for clients and improved referral pathways. These are complex initiatives which affect other sectors such as primary care, residential aged care and disability services.

Source: DoHA (unpublished).

Residential care services

Religious and private for-profit organisations were the main providers of residential care at June 2007, accounting for 29.5 per cent and 32.5 per cent respectively of all Australian Government subsidised residential aged care places. Community-based organisations and not-for-profit charitable organisations accounted for a further 14.5 per cent and 16.0 per cent respectively. State, Territory and local governments provided the remaining 7.5 per cent (figure 13.3).

Figure 13.3 Ownership of operational mainstream residential places, June 2007[a, b]



[a] 'Community-based' residential services provide a service for an identifiable community based on locality or ethnicity, not for financial gain. [b] 'Charitable' residential services provide a service for the general community or an appreciable section of the public, not for financial gain.

Source: Department of Health and Ageing (DoHA) (unpublished); table 13A.4.

The Australian Government is responsible for most of the regulation of Australian Government subsidised residential aged care services, including accreditation of the service and certification of the standard of the facilities. State, Territory and local governments may also have a regulatory role in areas such as determining staffing and industrial awards, and monitoring compliance with building and fire safety regulations (box 13.3).

Box 13.3 **Examples of regulatory arrangements for residential services**

The Australian Government controls the number of subsidised places. In May 2004, following a recommendation of the Review of Pricing Arrangements in Residential Aged Care, the Australian Government adopted a new ratio of 108 places for each 1000 people in the population aged 70 years or over. Of the 108 places, 88 are residential care places (40 high care and 48 low care) and 20 are community care places (CACP and EACH packages).

Under the arrangements:

- Services are expected to meet regional targets for places for concessional residents. These targets range from 16 per cent to 40 per cent of places, and are intended to ensure residents who cannot afford to pay an accommodation bond or charge have equal access to care. (The criteria for being deemed a concessional resident are based on home ownership and occupancy, receipt of income support and the level of assets held at entry.)
- Extra service places (where residents pay for a higher standard of accommodation, food and services) are restricted.
- To receive an Australian Government subsidy, an operator of an aged care service must be approved under the Aged Care Act as a provider of aged care.
- Principles (regulations) created under the Aged Care Act establish the obligations of approved providers relating to quality of care and accommodation.

Various Australian, State and Territory laws govern regulatory arrangements for residential care. State and Territory legislation may prescribe matters such as staffing, the dispensing of medication and/or certain medical procedures, occupational health and safety, workers compensation requirements, building standards, and fire prevention and firefighting measures. Staff wages and conditions are generally set by jurisdiction-based awards. Local government bylaws may also apply (for example, waste disposal rules).

In February 2007, the Australian Government announced a further increase in the provision ratio from 108 to 113 operational places per 1000 people aged 70 years or over, to be achieved by June 2011. The proportion of places offered has been adjusted from 20 to 25 places for community care, with 4 of these places for every 1000 people aged 70 years or over to be for high level care. In residential care, the provision ratio for high level care was increased from 40 to 44 places, while the ratio for low level residential care was adjusted from 48 to 44 places for every 1000 people aged 70 years or over.

Source: DoHA (unpublished).

Community care services

The main community care programs reported in this chapter — the HACC, CACP and VHC programs — fund services that aim to provide practical assistance to enable frail older people (HACC and CACP), people with a disability (HACC) and veterans (VHC) to continue living in or return to the community. These services also provide assistance to carers. They are usually provided by State, Territory and local government organisations, charitable bodies, community organisations and commercial providers.

Flexibly funded services

Flexible care addresses the needs of care recipients in ways other than that provided through mainstream residential and community care. Flexible care provided under the Aged Care Act includes EACH packages, EACH dementia packages, Innovative Care Places, MPS and the TCP. In addition, flexible models of care are provided under the National Aboriginal and Torres Strait Islander Aged Care Strategy.

- The EACH program provides high level aged care to people in their own homes, complementing CACPs, which provide low level care. There were 3302 operational EACH places at 30 June 2007. EACH Dementia provides high level care in the home to people with complex care needs associated with dementia, as an alternative to high level residential care. There were 1267 operational EACH Dementia places at 30 June 2007 (table 13A.36).
- The Aged Care Innovative Pool is designed to test new approaches to providing aged care, either with time limited or ongoing flexible care allocations for innovative aged care services. It supports the development and testing of flexible models of service delivery in areas where mainstream aged care services may not appropriately meet the needs of a location or target group. For example, the TCP is built on the lessons learned from two pilot programs developed through the Innovative Pool which addressed the interface between aged care and hospital care — the Innovative Care Rehabilitation Services and the Intermittent Care Services (DoHA unpublished).
- The MPS program supports the integration and provision of health and aged care services for small rural and remote communities. At 30 June 2007, there were 101 operational services with a total of 2492 operational flexible aged care places. Some of the MPS serve more than one location (DoHA unpublished).

Transition care services

The TCP provides goal-oriented, time-limited and therapy-focused care to help eligible older people complete their recovery after a hospital stay. The TCP is intended to:

- enable a significant proportion of care recipients to return home, rather than enter residential care

- optimise the functional capacity of those older people who are discharged from transition care to residential care
- reduce inappropriate extended lengths of hospital stay for older people.

The TCP is jointly funded by the Australian Government and all states and territories. Its operation is overseen by the all-jurisdictional Transition Care Working Group chaired by the Australian Government.

Transition care can be provided in either a home-like residential setting or in the community, and targets older people who would otherwise be eligible for residential care. A person may only enter the TCP directly upon discharge from hospital. The average duration of care is 7 weeks, with a maximum duration of 12 weeks that may in some circumstances be extended by a further 6 weeks.

Across jurisdictions, the TCP operates with some differences, including differences in service systems, local operating procedures and implementation timetables, which are reflected in national data collections. An evaluation examining the impact of the TCP on consumers and the health and aged care systems is due to report in 2008.

At 30 June 2007, the Australian Government had allocated 2000 places to transition care, of which 1594 were operational, amongst 62 services across all jurisdictions. The average length of stay in 2006-07 was 48 days nationally (table 13A.69).

As part of the national health agenda, COAG have agreed to commence the Long stay older patient initiative (box 13.4).

Box 13.4 **Long stay older patient initiative**

From July 2006, a new four-year program commenced to assist older public patients who no longer require acute care or rehabilitation and are in hospital waiting for residential aged care by:

- providing more appropriate care for long-stay older patients in public hospitals, particularly in rural areas
- improving the capacity of rural hospitals to provide more age friendly services, including through making capital improvements such as establishing new multi-purpose services
- reducing avoidable or premature admission of older people to hospitals
- assisting older public patients requiring long-term care to take up appropriate care options.

Source: COAG (2006).

Indigenous-specific services

Aboriginal and Torres Strait Islander people access mainstream services under the Aged Care Act, including those managed by Aboriginal and Torres Strait Islander organisations, and services funded outside the Act, including those funded under the National Aboriginal and Torres Strait Islander Flexible Aged Care Program. Some services managed by non-Indigenous approved providers also have a significant number of Aboriginal and Torres Strait Islander clients.

All aged care services that are funded under the Act are required to provide culturally appropriate care. Whether they are located in a community or residential setting, services may be subject to specific conditions of allocation in relation to the proportion of care to be provided to particular groups of people, including Aboriginal and Torres Strait Islander people.

At 30 June 2007, there were 617 flexible places for Indigenous clients (outside the Aged Care Act) under the National Aboriginal and Torres Strait Islander Flexible Aged Care Program. This flexible care helps to ensure that Aboriginal and Torres Strait Islander people can access culturally appropriate care services as close as possible to their communities, mainly in rural and remote locations. As part of the 1994 National Strategy, services were established to provide aged care using a flexible model. Communities are encouraged to participate in every aspect of service provision, from the very early planning stages right through to the operation of the services. These services are now funded under the National Aboriginal and Torres Strait Islander Flexible Aged Care Program.

In the 2006-07 Federal Budget, an additional 150 places were allocated for the National Aboriginal and Torres Strait Islander Flexible Aged Care Program. The additional places will bring the total number of places under this program to 750 (DoHA unpublished).

Funding

Expenditure on aged care services covered by this Report was $8.4 billion in 2006-07 (table 13.1). Table 13.1 does not include the state and territory experimental estimates and capital expenditure reported at tables 13.3 and 13.4.

Table 13.1 **Expenditure on aged care services, 2006-07**[a, b]

Expenditure category	*$ million*
Assessment services	61.5
Residential care services	5 803.5
Community care services	2 546.3
Total	**8 411.3**

[a] Residential care services include DoHA, Department of Veterans Affairs (DVA) (including payroll tax supplement) and State and Territory expenditure. [b] Community care services include VHC, HACC and TCP (State and Territory expenditure), and other DoHA expenditure.

Source: tables 13A.44–48, 13A.68-69.

Assessment services

The Australian Government provided grants to State and Territory governments to operate 115 ACATs in 2005-06 (table 13A.56). There were 114 ACATs at 30 June 2007. In 2006-07, the Australian Government provided funding of $61.5 million nationally for aged care assessment (table 13A.48). Australian Government ACAT expenditure per person aged 70 years or over plus per Indigenous persons aged 50-69 years was $30.3 nationally during 2006-07 (table 13A.49). Some states and territories also contribute funding for ACATs, but this expenditure is not included in the Report.

Residential care services

The Australian Government provides most of the recurrent funding for residential aged care services. State and Territory governments also provide some funding for public sector beds. Residents provide most of the remaining service revenue, with some income derived from charitable sources and donations.

Australian Government expenditure

Australian Government expenditure on residential aged care was $5.7 billion in 2006-07, comprising DoHA expenditure of $4.8 billion (table 13A.44) and Department of Veterans' Affairs (DVA) expenditure of $870.4 million (table 13A.46). Combined DoHA and DVA expenditure per person aged 70 years or over (plus per Indigenous persons aged 50–69 years) was $2788 nationally during 2006-07 (table 13A.51).

Australian Government RCS subsidy

The Australian Government annual RCS subsidy for each occupied place varies according to clients' levels of dependency. The rates for each RCS level are at table 13A.5. At June 2007, the average annual RCS subsidy per residential place was $31 481 nationally (table 13.2). Variations across jurisdictions in average annual subsidies reflect differences in the dependency of residents. High care subsidy rates (RCS levels 1-4) and low care subsidy rates (RCS levels 5–8) are now uniform across all states and territories under the Australian Government's Funding Equalisation and Assistance Package. This is the first year that uniform national rates have been included.

Table 13.2 **Average annual Australian Government RCS subsidy per occupied place, and the dependency levels of high care and low care residents, June 2007**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Average annual Australian Government RCS subsidy per residential place[a, b]										
All RCS levels	$	31 772	31 123	30 703	30 733	33 255	32 064	31 928	31 546	31 481
Proportion of high care residents										
RCS 1	%	24.3	27.5	17.7	24.4	28.4	20.8	31.7	21.7	24.3
RCS 2	%	26.3	20.8	26.2	21.3	24.9	26.6	17.8	27.9	24.2
RCS 3	%	14.9	13.6	19.3	15.0	16.9	20.0	14.6	19.3	15.7
RCS 4	%	5.5	5.7	6.6	6.7	5.7	6.8	6.3	2.7	5.9
Proportion of low care residents										
RCS 5	%	11.2	14.5	11.4	14.9	10.8	10.4	13.0	7.0	12.3
RCS 6	%	9.1	10.1	9.3	10.4	7.7	7.9	9.7	8.3	9.3
RCS 7	%	8.2	7.6	8.9	7.2	5.4	7.4	6.7	10.2	7.8
RCS 8	%	0.5	0.2	0.6	0.2	0.2	0.1	0.1	2.9	0.4

[a] Includes only subsidies based on the RCS. Average Australian Government payments, including subsidies and supplements, were a total of $45 200 per high care resident (RCS 1–4), $16 200 per low care resident (RCS 5–8) and $36 000 for all permanent residents. [b] Differences in average annual subsidies reflect differences in the dependency of residents.

Source: DoHA (unpublished); table 13A.5.

State and Territory government expenditure

State and Territory government expenditure have been collected for three categories of residential care expenditure (adjusted subsidy reduction supplement, enterprise bargaining agreement supplement, and rural small nursing home supplement). Reported expenditure in these three categories was $148.1 million in 2006-07 (table 13A.68).

Capital expenditure

Although capital expenditure is not regarded as part of the total recurrent expenditure, it is presented here to illustrate this aspect of expenditure on aged care services. The Australian Government funds an ongoing program of targeted capital assistance to residential aged care services (table 13.3). In addition, experimental estimates of capital expenditure on residential services have been collected for some states and territories, for 2006-07. This category of expenditure is defined in section 13.6, but the data definition may require further development. Caution should be used in making comparisons across jurisdictions (table 13.3).

Table 13.3 **Selected capital expenditure 2006-07**[a]

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Total*
Australian Government targeted capital assistance to residential aged care services[b]									
$ million	17.2	4.0	7.2	6.7	3.2	6.9	–	1.8	47.0
Experimental estimates of State and Territory government capital expenditure on residential aged care[c]									
$ million	20.0	88.7	20.7	14.6	na	6.9	..	na	150.9

[a] These items of expenditure are not recurrent in nature and therefore not included in table 13.1. [b] Expenditure to assist aged care residential services that, as a result of their rural or remote location or because the homes target financially disadvantaged people, are unable to meet the cost of necessary capital works from the income they receive through resident accommodation payments (accommodation bonds and accommodation charges) and the capital component of Australian Government recurrent funding included in table 13.1. [c] Includes expenditure on building and other capital items, specifically for the provision of Australian Government funded residential aged care. **na** Not available. .. Not applicable – Nil or rounded to zero.

Source: DoHA (unpublished); State and Territory governments (unpublished).

Community care services

Following is a summary of expenditure on community care programs. More detailed data may be found in the attachment tables noted. Data on Australian Government expenditure per head of the target population by jurisdiction are contained in table 13A.49. Recipients of community care services may also contribute towards the cost of their care.

Expenditure on HACC, CACP, NRCP and DVA programs

Total government expenditure on HACC was $1.5 billion in 2006-07, consisting of $928.4 million from the Australian Government and $595.7 million from the State and Territory governments. The Australian Government contributed 60.9 per cent, while State and Territory governments funded the remainder (table 13A.45).

Experimental estimates of expenditure on HACC services (in addition to the State and Territory matching amounts expended under the HACC agreement and already reported) have been collected for some states and territories for 2006-07. This category of expenditure is defined in section 13.6. The data definition may require further development. Caution should be used in making comparisons across jurisdictions (table 13.4).

Table 13.4 **Experimental estimates of additional State and Territory government expenditure on HACC services 2006-07**[a]

	NSW[b]	*Vic*	*Qld*	*WA*	*SA*[c]	*Tas*	*ACT*	*NT*	*Total*
$ million	4.1	55.7	na	na	44.6	11.5	na	2.9	118.8

[a] Additional to state matching amount already reported but not including local Government. [b] NSW expenditure includes allocations to service providers to meet cost of award wage increases. [c] SA expenditure includes allocations to the Royal District Nursing Service to provide community nursing services, and to Domiciliary Care SA and Country Health Units for a range of HACC type services. **na** Not available.

Source: State and Territory governments (unpublished).

The Australian Government funds the CACP program, spending $404.9 million on the program in 2006-07 (table 13A.48). CACPs are also part funded by client contributions.

The NRCP provides community respite services and is funded by the Australian Government. Expenditure on this program was $166.9 million in 2006-07 (table 13.5). The NRCP assisted 129 803 people in 2006-07 (table 13A.36). A breakdown of Australian Government expenditure on the NRCP by State and Territory is provided in table 13.5.

Table 13.5 **Australian Government expenditures, National Respite for Carers Program, by state and territory, 2006-07 ($million)**[a, b]

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*National*	*Total*
Commonwealth Carer Respite Centres	14.8	11.5	9.8	4.6	4.6	2.1	0.9	2.9	–	51.2
Respite services	33.3	25.6	19.1	9.9	10.0	2.9	2.6	1.7	–	105.1
National projects[c]	–	–	–	–	–	–	–	–	10.6	10.6
Total	48.1	37.1	28.9	14.5	14.6	5.0	3.5	4.6	10.6	166.9

[a] Commonwealth Carer Respite Centres coordinate respite services, help carers access them, and arrange individual respite when needed. [b] Respite services reports funding for services directly providing respite care. [c] National project is for Carers Australia. – Nil or rounded to zero.

Source: DoHA (unpublished); table 13A.48.

The DVA also provided $94.9 million for the VHC program during 2006-07 (table 13A.47).

Flexibly funded services

The Australian Government funds the EACH and EACH Dementia programs, spending $103.9 million and $25.1 million respectively on these programs in 2006-07 (table 13A.48). EACH and EACH Dementia packages are also part funded by client contributions.

The Australian, State and Territory governments fund the TCP. In 2006-07 the Australian Government and the State and Territory governments spent $32.9 million and $35.1 million respectively (table 13A.69). The Australian Government also funds the MPS program and Indigenous specific services. In 2006-07, $69.2 million and $17.2 million were spent on each of these programs (table 13A.48).

Other community care services

Australian Government expenditure data by jurisdiction on a range of other community care programs targeting older people are contained in table 13A.48. These include Community Care Grants, Assistance with Care and Housing for the Aged, Day Therapy Centres, Continence Aids Assistance Scheme, Carers Information and Support, Commonwealth Carelink Centres and the National Continence Management Strategy. Australian Government expenditure on these programs was $70.6 million in 2006-07 (table 13A.48).

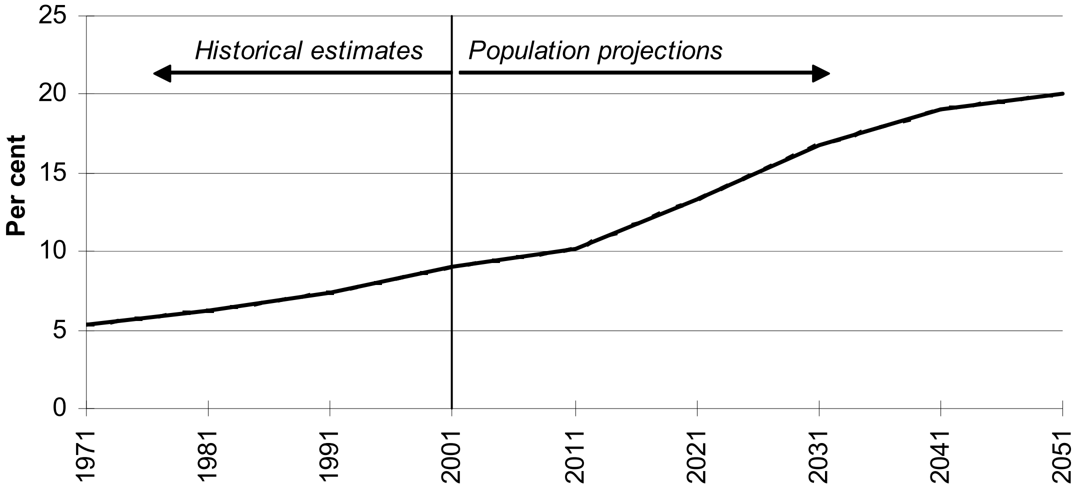
Size and scope of sector

Size and growth of the older population

The Australian population is ageing, as indicated by an increase in the proportion of people aged 70 years or over in the total population. This trend is expected to continue, and the proportion of older people is expected to increase dramatically in the 21st century (figure 13.4). The proportion of older people is 9.3 per cent nationally but varies across jurisdictions (figure 13.5). A breakdown by locality is provided in attachment table 13A.3. Higher life expectancy for females resulted in all jurisdictions (except the NT) having a higher proportion of older females than older males.

Demographic profiles affect the demand for aged care services because females use aged care services (particularly residential services) more than males. Females are more likely to use residential services partly because they tend to live longer (that is, there are more women than men in the older population) and they are less likely to have a partner to provide care.

Figure 13.4 Persons aged 70 years or over as a proportion of the total population[a]



[a] Historical estimates and population projections are based on the ABS 2001 Census of Population and Housing that is held at five year intervals. Population projections are derived from the 'B' series projections.

Source: ABS (2006a) *Australian Historical Population Statistics, 2006*, Cat. No. 3105.0.65.001; ABS (2006b) *Population Projections Australia 2004–2101* Cat. no. 3222.0.

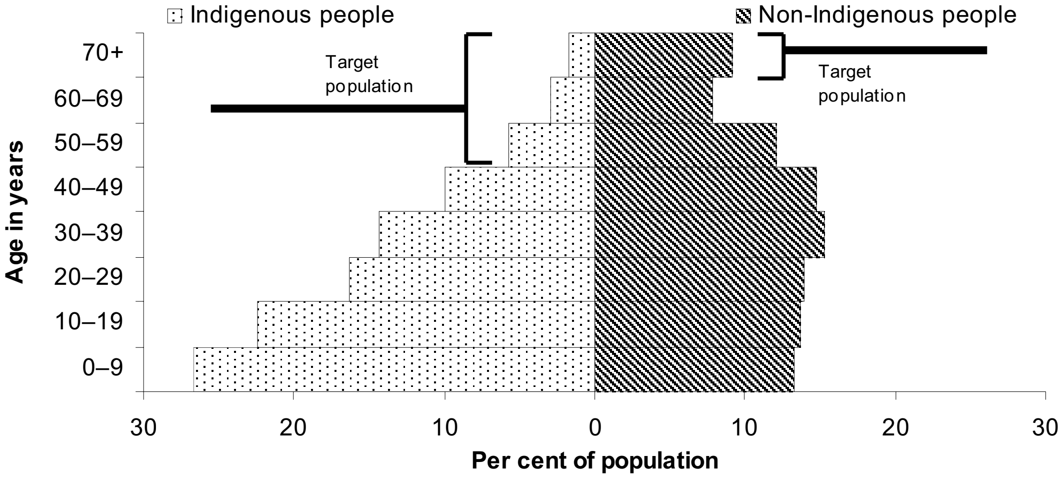
Figure 13.5 Estimated proportion of population aged 70 years or over, by gender, June 2007

Source: Population projections prepared by the ABS in 2007, using preliminary rebased estimated resident populations based on the 2006 Census according to assumptions agreed to by the Treasury and Department of Health and Ageing (unpublished); table 13A.1.

Characteristics of older Indigenous people

The ABS (based on assumptions provided by DoHA) estimates that about 55 600 Indigenous people were aged 50 years or over in Australia at 30 June 2007 (table 13A.2). Although the Indigenous population is also ageing, there are marked differences in the age profile of Indigenous Australians compared with non-Indigenous Australians (figure 13.6). Estimates for both males and females show life expectancy at birth in the Indigenous population is around 17 years less than in the total Australian population (ABS 2004b). These figures indicate that Indigenous people are likely to need aged care services earlier in life, compared with the general population.

Figure 13.6 **Age profile and target population differences between Indigenous and other Australians, June 2001**



Source: ABS (2004b).

Residential care services

The size and location of residential services — which may influence the costs of service delivery — vary across jurisdictions. Nationally, there were 167 070 mainstream operational places in residential care services (72 647 in predominantly high care services, 14 420 in predominantly low care services and 80 003 in services with a mix of high care and low care residents) at June 2007 (tables 13A.6–9). These figures exclude flexible care places in a residential setting.

As the trend towards 'ageing in place' (box 13.5) increases, there has been a steady increase in the number of services categorised as providing a mix of high care and low care places. In June 2003, 36.5 per cent of all places were located in services offering both high care and low care places. This proportion decreased to 33.4 per cent of places in June 2004, but increased to 47.9 per cent in June 2007 (table 13A.10).

Box 13.5 **Ageing in place in residential care**

In its Objects, the *Aged Care Act 1997* (Cwlth) aims to:

> *... encourage diverse, flexible and responsive aged care services that:*
>
> *(i) are appropriate to meet the needs of the recipients of those services and the carers of those recipients; and*
>
> *(ii) facilitate the independence of, and choice available to, those recipients and carers.*

Further, the Aged Care Act explicitly aims to encourage and facilitate 'ageing in place'. The Act does not define 'ageing in place', but one useful definition is 'the provision of a responsive and flexible care service in line with the person's changing needs in a familiar environment'. In effect, 'ageing in place' refers to a resident remaining in the same residential aged care service as his or her care needs increase from low level to high level. This is changing the profile of people in services.

The Aged Care Act does not establish any 'program' or require any residential aged care service to offer ageing in place. Rather, it creates the opportunity for providers to choose to provide the full continuum of care, by removing the legislative and administrative barriers that prevented this outcome in the past.

The concept of 'ageing in place' is linked to the outcomes of increasing choice and flexibility in residential aged care service provision. These are difficult outcomes to measure. Data on 'ageing in place' is reported for the indicator 'intensity of care'.

Source: DoHA (unpublished).

The client profile of services that had predominantly low care residents in 2000 has changed over time, with low care residents staying in their current service as their dependency levels rise, and with aged care services expanding and diversifying. Low care services are generally smaller (as measured by number of places) than high care services. At June 2007, 66.6 per cent of low care services had 60 or fewer places (table 13A.8), compared with 43.6 per cent of high care services (table 13A.7).

The combined number of operational high care and low care residential places per 1000 people aged 70 years or over at June 2007 was 85.5 (41.6 high care and 44.0 low care) on a national basis (table 13.6). Nationally, the proportion of low care places relative to high care places rose between 2003 and 2007 (table 13A.11).

Table 13.6 **Operational high care and low care residential places, 30 June 2007**[a, b, c]

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Number of places per 1000 people aged 70 years or over										
High care places	no.	43.9	39.7	39.4	38.0	46.0	44.5	29.0	60.0	41.6
Low care places	no.	40.5	46.5	45.8	45.1	46.3	41.3	42.0	44.0	44.0
Total places	**no.**	84.5	86.2	85.2	83.1	92.3	85.7	71.0	104.0	85.5
Proportion of places										
High care places	%	52.0	46.1	46.2	45.7	49.8	51.9	40.8	57.7	48.6
Low care places	%	48.0	53.9	53.8	54.3	50.2	48.1	59.2	42.3	51.4

[a] Excludes places that have been ‘approved’ but are not yet operational. Includes multi-purpose and flexible services attributed as high care and low care places. [b] For this Report, Australian Government planning targets are based on providing 88 residential places per 1000 people aged 70 years or over. In recognition of poorer health among Indigenous communities, planning in some cases also takes account of the Indigenous population aged 50–69 years. This means that the provision ratio based on the population aged 70 years or over will appear high in areas with a high Indigenous population (such as the NT). [c] See table 13A.11 for further information regarding the calculation of provision ratios, which vary from corresponding data published in the DoHA Annual Report 2006-07.

Source: DoHA (unpublished); table 13A.11.

Age specific usage rates for these services, by jurisdiction and remoteness, at 30 June 2007 are included at tables 13A.59 and 13A.61, and 13A.62 and 13A.64 respectively. Indigenous usage by remoteness category is identified at table 13A.65.

Community care services

Services provided under the HACC program include domestic assistance and home maintenance, personal care, food services, respite care, transport, allied health care and community nursing (box 13.6).

Box 13.6 **HACC Services**

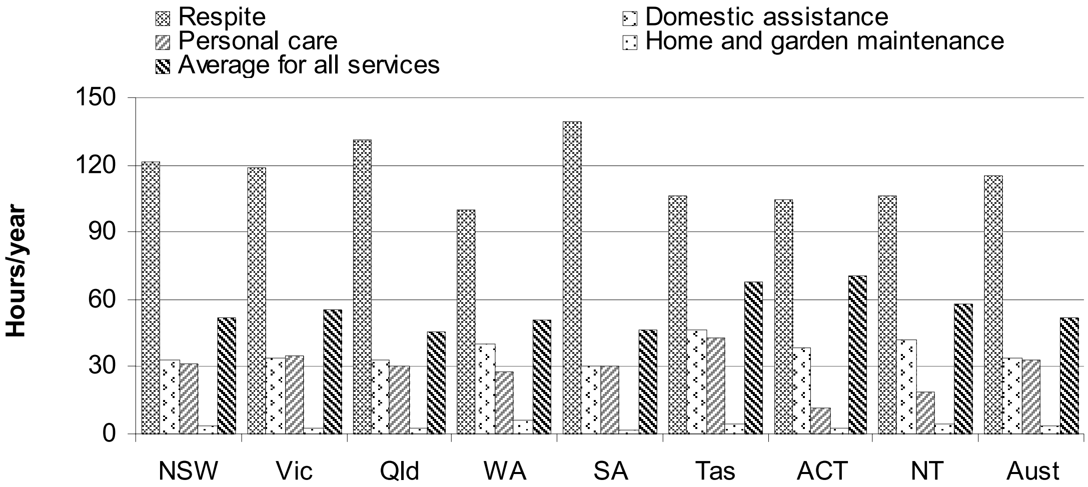
HACC services are basic maintenance and support services, including allied health care, assessment, case management and planning, centre-based day care, counselling, support, information and advocacy, domestic assistance, home maintenance, nursing, personal and respite care, social support, meals, home modification, linen service, goods and equipment, and transport.

Not all HACC services are directed towards the ageing population described in this chapter. The target population is defined as people living in the community who are at risk, without these services, of premature or inappropriate long term residential care. The target population comprises both frail aged people and younger people with a disability, and their carers.

Over 68 per cent of the program's recipients are aged 70 years or over, but the program is also an important source of community care for younger people with a disability and their carers, with nearly 12 per cent of recipients under 50 years (table 13A.34). (Chapter 14 covers services for people with a disability, which manifests before the age of 65 years, that are provided under the Commonwealth State/Territory Disability Agreement.)

The services of the VHC program target veterans and war widows/widowers with low care needs. There were 80 058 people approved for VHC services in 2006-07 (table 13A.47). The program offers veterans and war widows/widowers who hold a Gold or White Repatriation Health Card home support services, including domestic assistance, personal care, home and garden maintenance, and respite care. Other services, such as community transport, social support and delivered meals, are also available under the DVA's arrangements with State and Territory governments. Eligibility for VHC services is not automatic, but based on assessed need. The average number of hours approved per year for veterans who were eligible to receive home care services was 51.9 nationally in 2006-07 (figure 13.7).

Figure 13.7 **Average number of hours approved for Veterans' Home Care, 2006-07**



Source: DVA (unpublished); table 13A.47.

Provision of CACPs is an alternative home-based service for older people assessed by ACATs as eligible for care equivalent to low level residential care (RCS levels 5–8). A CACP typically provides 5 to 6 hours of direct assistance per week. The EACH program is similar to the CACP program but targets people who would be eligible for high level residential aged care. An EACH package typically provides 15 to 20 hours of direct assistance each week. The main distinctions between the HACC, CACP and EACH programs are summarised in table 13.7.

Table 13.7 Distinctions between the HACC, CACP and EACH programs

	HACC	*CACPs*	*EACH*
Range of services[a]	Wider range of services available	Narrower range of services available	Narrower range of services available
Relationship to residential care	Aims to prevent premature or inappropriate admission	Substitutes for a low care residential place	Substitutes for a high care residential place
Eligibility	ACAT assessment not mandatory	ACAT assessment mandatory	ACAT assessment mandatory
Funding	Cost shared by the Australian, State and Territory governments and client contributions	Funded by the Australian Government and client contributions	Funded by the Australian Government and client contributions
Target client groups[b]	Available to people with profound, severe and moderate disability and their carers. Not age specific.	Targets older people with care needs similar to low level residential care	Targets older people with care needs similar to high level residential care
Size of program	$1.5 billion funding in 2006-07 At least 800 505 clients in 2006-07[c]	$404.9 million funding in 2006-07 37 747 operational places at 30 June 2007[d]	For EACH and EACH Dementia: $129.0 million funding in 2006-07 4569 operational places at 30 June 2007.

[a] HACC services such as community nursing, which are not available under CACPs, can be supplied to someone receiving a CACP. [b] Most HACC recipients at the lower end of the scale would not be assessed as eligible for residential care — for example, an individual may receive only an hour of home care per fortnight. At the higher end, some people have levels of need that would exceed the level available under CACPs and EACH. [c] Based on 83 per cent of HACC funded agencies that submitted Minimum Data Set data for 2006-07. Consequently, the total number of clients will be higher than those reported here. [d] Excludes flexible care delivered in a community setting.

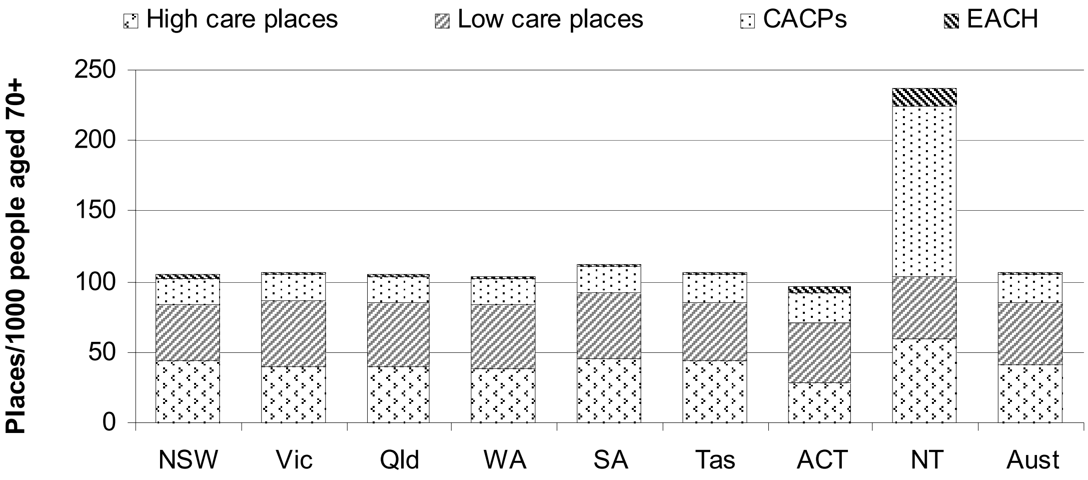
Source: DoHA (unpublished); tables 13A.33, 13A.36, 13A.45, 13A.48.

Changing government policies over the past decade — shifting the balance of care away from the more intensive types of residential care towards home-based care — have meant that the HACC, VHC, CACP and EACH programs have become increasingly important components of the aged care system. During 2006-07, the HACC program delivered approximately 18 599 hours per 1000 people aged 70 years or over plus Indigenous people aged 50–69 years (table 13A.21). The total number of CACPs per 1000 people aged 70 years or over plus Indigenous people aged 50–69 years increased between June 2003 and June 2007, from 15.2 to 18.6 (table 13A.12).

Combined residential and community care services rates

The combined number of high care residential places, low care residential places, CACPs and EACH packages, at 30 June 2007, was 106.3 per 1000 people aged 70 years or older (figure 13.8). EACH Dementia and Transition Care places add an additional 0.6 and 0.8 packages respectively per 1000 people aged 70 years or older. The Australian Government's targets for the provision of residential and community care places were outlined previously (box 13.3).

Figure 13.8 **Operational residential places, CACPs and EACH packages, 30 June 2007**[a, b, c, d, e, f]



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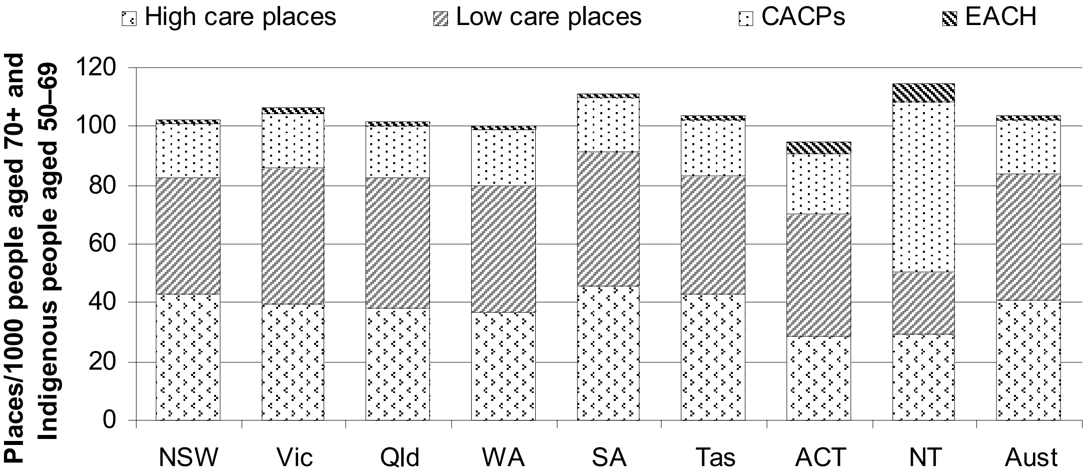
[a] Excludes places that have been approved but are not yet operational. [b] 'Ageing in place' may result in some low care places being filled by high care residents. [c] For this Report, Australian Government planning targets are based on providing 108 places per 1000 people aged 70 years or over. However, in recognition of poorer health among Indigenous communities, planning in some cases also takes account of the Indigenous population aged 50–69 years. This means that the provision ratio based on the population aged 70 years or over will appear high in areas with a high Indigenous population (such as the NT). [d] CACPs and EACH packages are not residential services but are included in the Australian Government planning targets (see boxes 13.1 and 13.3 for an interpretation of residential care data and Australian Government planning targets). [e] EACH Dementia places and TCP are not shown (table 13A.11). [f] See table 13A.11 for further information regarding the calculation of provision ratios, which vary from corresponding data published in the DoHA Annual Report 2006-07.

Source: DoHA (unpublished); table 13A.11.

The number of operational places can also be shown using the target population that incorporates Indigenous people aged 50–69 years (figure 13.9). Use of this 'adjusted' target population has a noticeable effect on the NT, which has a large proportion of Indigenous people.

Age-specific usage rates for these services, by jurisdiction and remoteness and for Indigenous usage, at 30 June 2007 are reported in tables 13A.59 to 13A.65.

Figure 13.9 Operational residential places, CACPs and EACH packages adjusted for Indigenous people age 50–69, 30 June 2007[a, b, c, d, e]



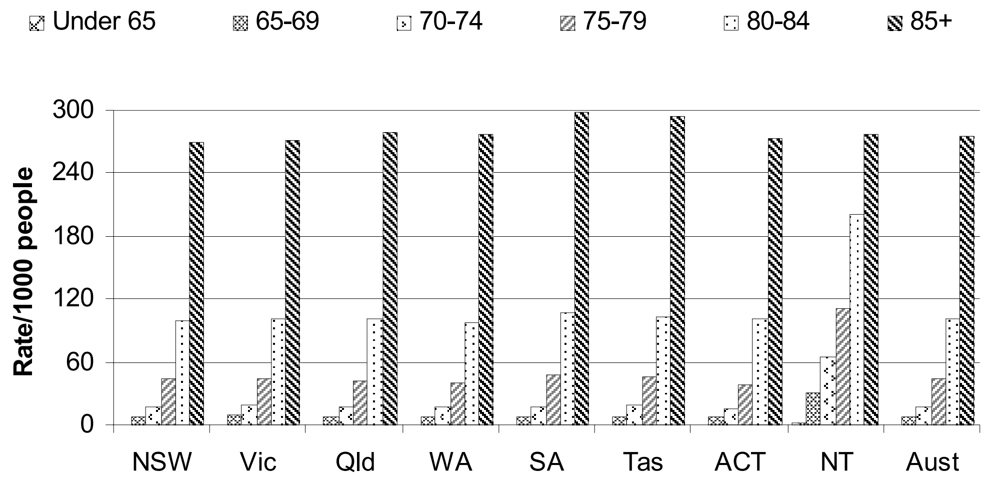
[a] Places do not include those that have been approved but are not yet operational. [b] 'Ageing in place' may result in some low care places being filled by high care residents. [c] CACPs and EACH packages are not residential services but are included in the Australian Government planning targets (boxes 13.1 and 13.3 contain an interpretation of residential care data and Australian Government planning targets). [d] CACPs provide a more flexible model of care more suitable to remote Indigenous communities, so areas with a high Indigenous population (such as the NT) may have a higher proportion of CACPs. [e] EACH Dementia places and TCP places are not shown (table 13A.12).

Source: DoHA (unpublished); table 13A.12.

Presentation of age-specific usage rates raises particular data issues. In particular, if the numbers of people within a particular range for a given service are small, this may lead to apparently large fluctuations in growth rates. This can be seen from some of the usage rates identified for the EACH program, which, whilst growing rapidly, are doing so from a relatively small base.

Age-specific rates in this Report are for 2006-07. The national age specific usage rates per 1000 persons for high and low residential care, CACP and EACH in combination at 30 June 2007 is 0.5 for people under 65 rising to 275.6 for people over 85. These rates vary across jurisdictions (figure 13.10).

Figure 13.10 **Permanent aged care residents, CACP and EACH recipients at 30 June 2007: age specific usage rates per 1000 persons**[a, b, c, d]



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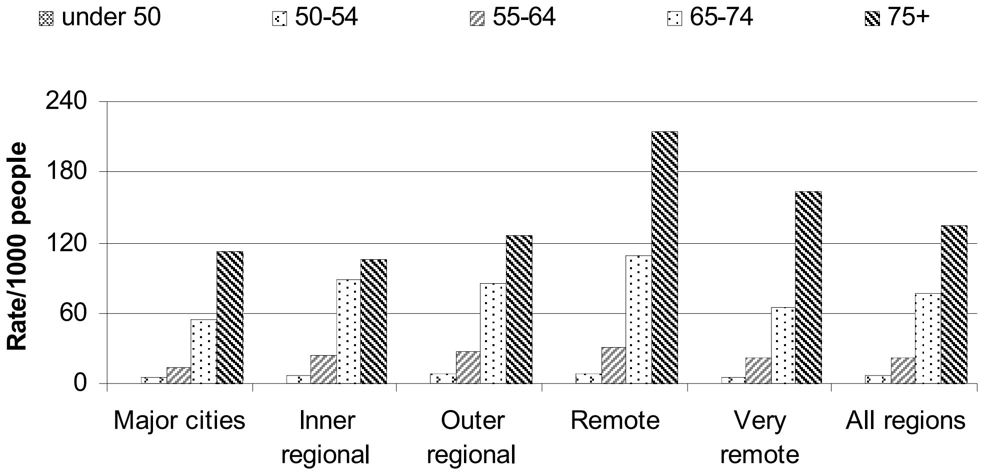
[a] Population projections by SLA for 2002-2022 based on 2001 census prepared by ABS according to assumptions agreed to by the Department of Health and Ageing. [b] Residents without a recorded RCS were omitted. [c] These figures exclude places funded by Multi-purpose services and those provided by flexible funding under the Aboriginal and Torres Strait Islander Aged Care Strategy. [d] EACH packages include EACH Dementia packages.

Source: DoHA (unpublished); table 13A.61.

The national age specific usage rates per 1000 Indigenous persons for high and low residential care, CACP and EACH in combination at 30 June 2007 is 0.3 for people under 50 rising to 133.7 for people over 75. The data show that Indigenous people tend to access these services at a younger age than the population as a whole. These rates vary by remoteness category (figure 13.11).

Figure 13.11 **Indigenous permanent residents classified as high or low care and Indigenous CACP, and EACH at 30 June 2007: age specific usage rates per 1000 persons by remoteness**[a, b, c, d, e]



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[a] Geographical data are based on the ABS Australian Standard Geographic Classification of Remoteness Areas 2001. Data are classified according to an index of remoteness which rates each ABS Census District based on the number and size of towns, the distance to major towns and urban centres. [b] Indigenous population estimates are based on ratios from ABS Census 2001 data applied to population projections by SLA 2002-2022. This is a different measure from those used for these age specific usage data in previous Reports. [c] Residents without a recorded RCS were omitted. [d] These figures exclude places and packages funded by Multi-purpose services and those provided by flexible funding under the Aboriginal and Torres Strait Islander Aged Care Strategy. [e] EACH packages include EACH Dementia packages.

Source: DoHA (unpublished); table 13A.65.

13.2 Framework of performance indicators

The framework of performance indicators aims to provide information on equity, efficiency and effectiveness, and to distinguish the outputs and outcomes of government aged care services. This approach is consistent with the general performance indicator framework and service process diagram outlined in chapter 1 (see figures 1.2 and 1.3) that have been agreed by the Steering Committee. The performance indicators relate to government objectives in the aged care sector (box 13.7). At this stage, no outcome indicators are reported for aged care services.

Box 13.7 **Objectives for aged care services**

The aged care system aims to promote the wellbeing and independence of frail older people and their carers through the funding and delivery of care services that are:

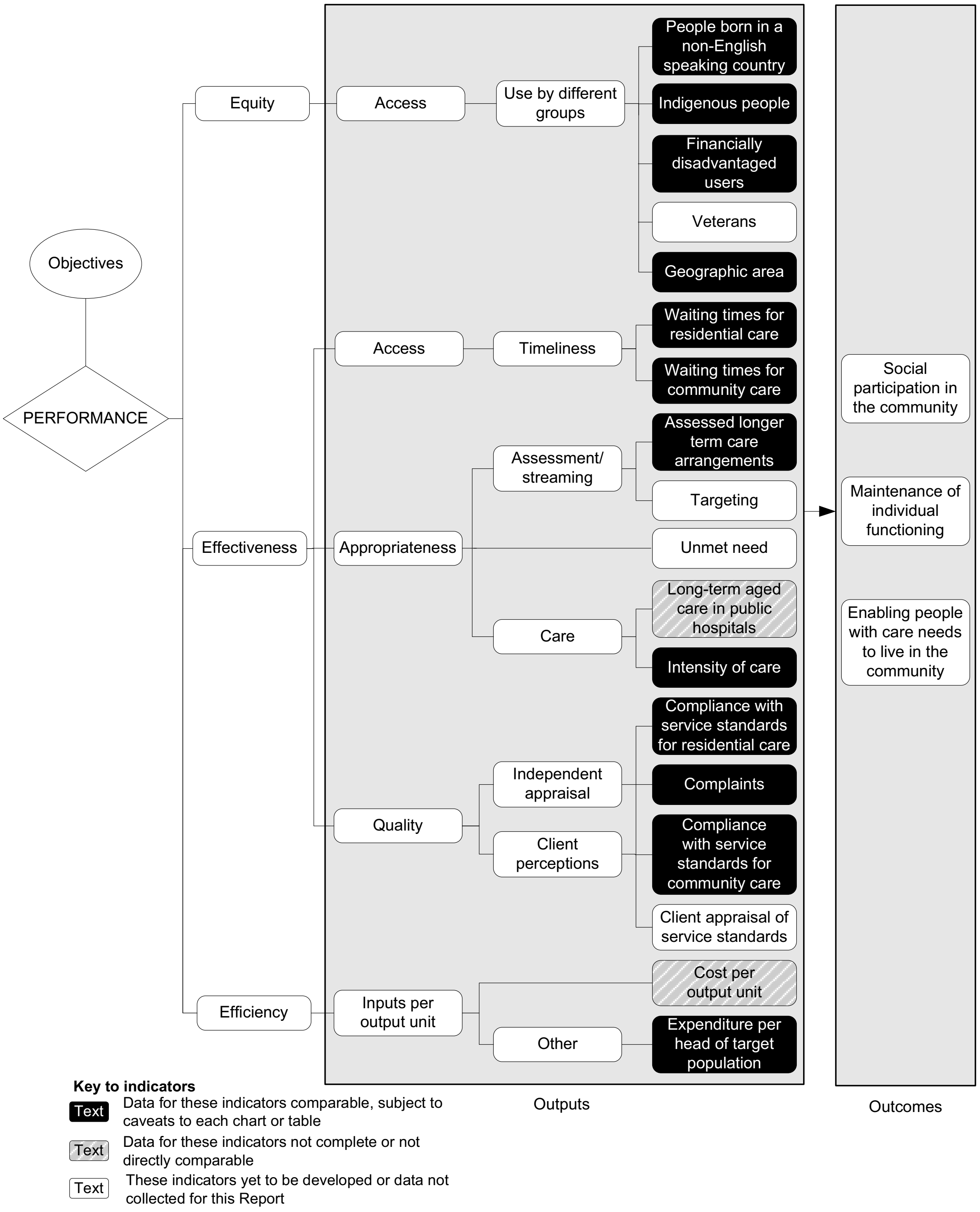
- accessible
- appropriate to needs
- high quality
- efficient.

The performance indicator framework shows which data are comparable in the 2008 Report (figure 13.12). For data that are not considered strictly comparable, the text includes relevant caveats and supporting commentary. Chapter 1 discusses data comparability from a Report-wide perspective (see section 1.6).

13.3 Key performance indicator results

Different delivery contexts, locations and types of client may affect the effectiveness and efficiency of aged care services. Appendix A contains detailed statistics and short profiles on each State and Territory, which may assist in interpreting the performance indicators presented in this chapter.

Figure 13.12 **Performance indicators for aged care services**



Outputs

Outputs are the actual services delivered (while outcomes are the impact of these services on the status of an individual or group) (see chapter 1, section 1.5).

Equity — Access

Use by different groups

‘Use by different groups’ is an indicator of the equity of aged care services (box 13.8).

Box 13.8 **Use by different groups**

A key national objective of the aged care system is to provide equitable access to aged care services for all people who require these services. ‘Use by different groups’ is a proxy indicator of equitable access. Various groups are identified by the Aged Care Act and its principles (regulations) as having special needs, including people from Indigenous communities, people born in non-English speaking countries, people who live in rural or remote areas, people who are financially or socially disadvantaged, and veterans (including widows and widowers of veterans). The indicator is reported for each special needs group except veterans, using the following definitions:

- the number of people born in non-English speaking countries using residential services, CACPs, EACH and HACC services, divided by the number of people born in non-English speaking countries aged 70 years or over, benchmarked against the rate at which the general population accesses the service
- the number of Indigenous people using residential services, CACP, EACH and HACC services, divided by the number of Indigenous people aged 50 years or over (because Indigenous people tend to require aged care services at a younger age than the general population) benchmarked against the rate at which the general population accesses the service
- the rate of contacts with Commonwealth Carelink Centres for Indigenous people compared with all people
- access to residential services for financially disadvantaged users, defined as the number of new residents classified as concessional or assisted divided by the number of new residents
- access to HACC services for people living in rural and remote areas — the number of hours of HACC service received (and, separately, meals provided) divided by the number of people aged 70 years or over plus Indigenous people aged 50–69 years for major cities, inner regional areas, outer regional areas, remote areas and very remote areas.

(Continued on next page)

Box 13.8 **(Continued)**

In general, usage rates for special needs groups similar to those for the broader aged care population are desirable, but interpretation of results differs for some special needs groups because:

- there is evidence that Indigenous people have higher disability prevalence rates than those of the general population, which suggests a greater level of need for services compared with those in the broader aged care population
- for financially disadvantaged users, Australian Government planning guidelines require that services allocate a minimum proportion of residential places for concessional or assisted residents. These targets range from 16 per cent to 40 per cent of places, depending on the service's region. Usage rates equal to or higher than the minimum rates are desirable.

Several factors need to be considered in interpreting the results for this set of indicators:

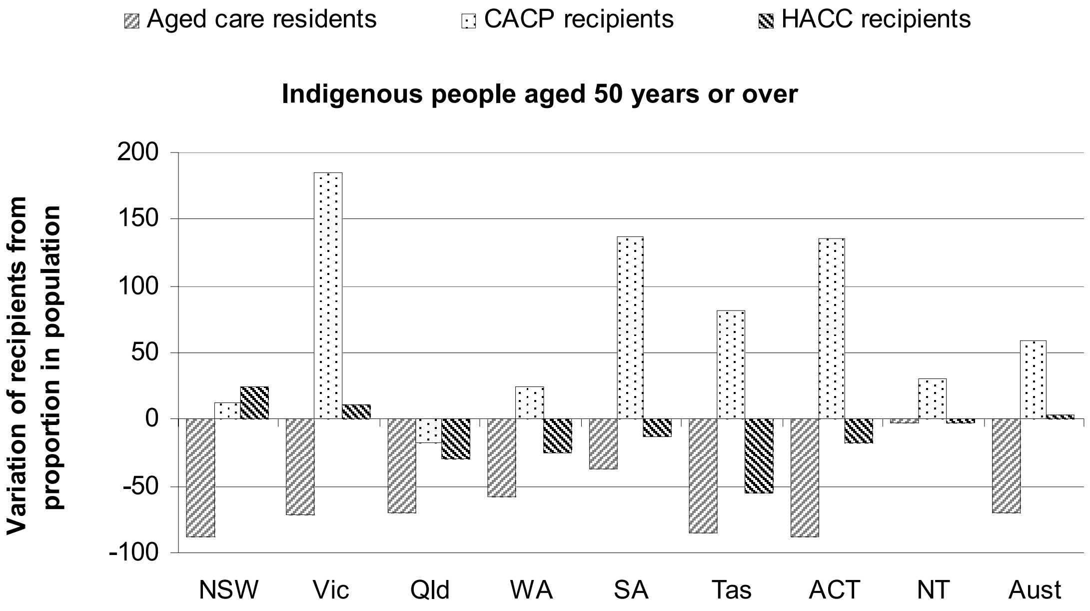
- Cultural differences may influence the extent to which people born in non-English speaking countries use different types of services.
- Cultural differences and geographic location may influence the extent to which Indigenous people use different types of services.
- The availability of informal care and support may influence the use of aged care services in different population groups.

Data presented for this indicator are organised by the type of service provided, with sub-sections for the relevant special needs groups reported against that service.

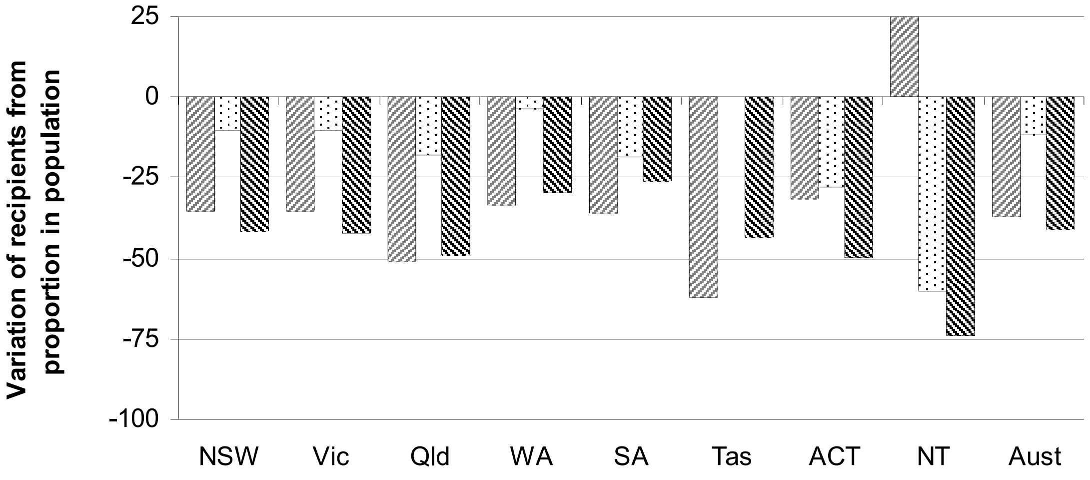
Access to residential care services, CACP and HACC services by Indigenous people and people born in a mainly non-English speaking country

In general, Indigenous people and people born in a mainly non-English speaking country are under-represented in some aspects of access to residential care, CACP and HACC services in comparison to their proportion of the population as a whole. However, in relation to the CACP program in almost all jurisdictions and nationally, Indigenous people are over-represented, compared to the proportion of this group in the population. In relation to HACC services, Indigenous people are represented similarly to the total population on a national basis. Figure 13.13 demonstrates this over- and under-representation by reflecting the variation in the rate of access of the special needs target population from their proportion in the population as a whole. If the special needs group accessed services in proportion to their general representation in the population, no percentage variation would be observed. If they access services at a greater rate, a positive percentage from the benchmark rate will be observed, or, if services are accessed at a lower rate, the bar would be negative (figure 13.13).

Figure 13.13 **Variation in the proportions of special needs target population accessing aged care services from their proportion in the population as a whole, June 2007 (per cent)**[a, b]



People born in a mainly non-English speaking country aged 70 years or over[c]



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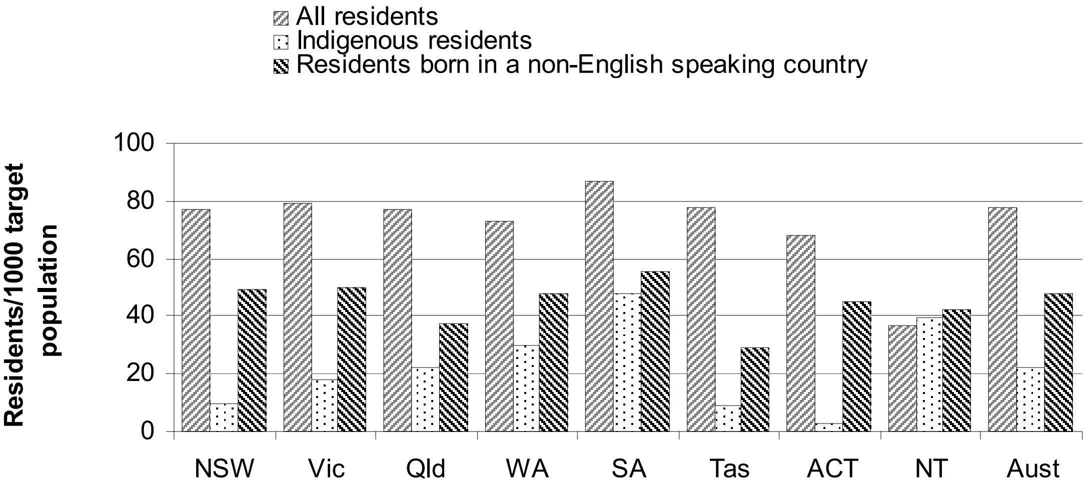
[a] The proportion of a HACC agencies that submitted data for the year varied between jurisdictions and actual service levels were higher than stated. [b] Reports provisional HACC data that have not been validated and may be subject to revision. [c] There is no variation between the proportion of Tasmanian CACP recipients for this group and their proportion in the population.

Source: DoHA (unpublished); tables 13A.19.

In all jurisdictions at 30 June 2007, on average, Indigenous people and people born in non-English speaking countries had lower rates of use of aged care residential services (22.2 and 48.1 per thousand of the relevant target populations respectively), compared with the population as a whole (77.7 per thousand) (figure 13.14).

Figure 13.14 **Residents per 1000 target population, 30 June 2007**[a, b, c]



[a] All residents data are per 1000 people aged 70 years or over plus Indigenous people aged 50–69 years. [b] Indigenous residents data are per 1000 Indigenous people aged 50 years or over. [c] Data for residents from a non-English speaking country are per 1000 people from non-English speaking countries aged 70 years or over.

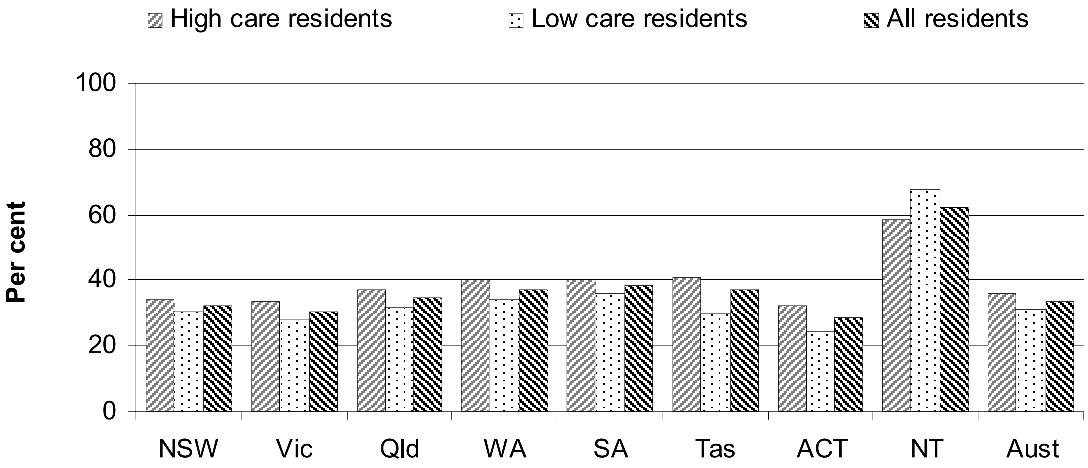
Source: DoHA (unpublished); tables 13A.13, 13A.15 and 13A.17.

Age specific usage rates for these services, by jurisdiction and remoteness are included in the Report. These data suggest there is significant variation in usage rates by remoteness area. In general, differences amongst jurisdictions are less marked than differences between remoteness area (tables 13A.14, 13A.16, 13A.18, 13A.59, 13A.61, 13A.62, 13A.64 and 13A.65).

Access to residential services by financially disadvantaged users

The proportion of all new residents classified as concessional or assisted residents during 2006-07 was 33.6 per cent nationally but varied across jurisdictions (figure 13.15).

Figure 13.15 **New residents classified as concessional or assisted residents, 30 June 2007[a]**



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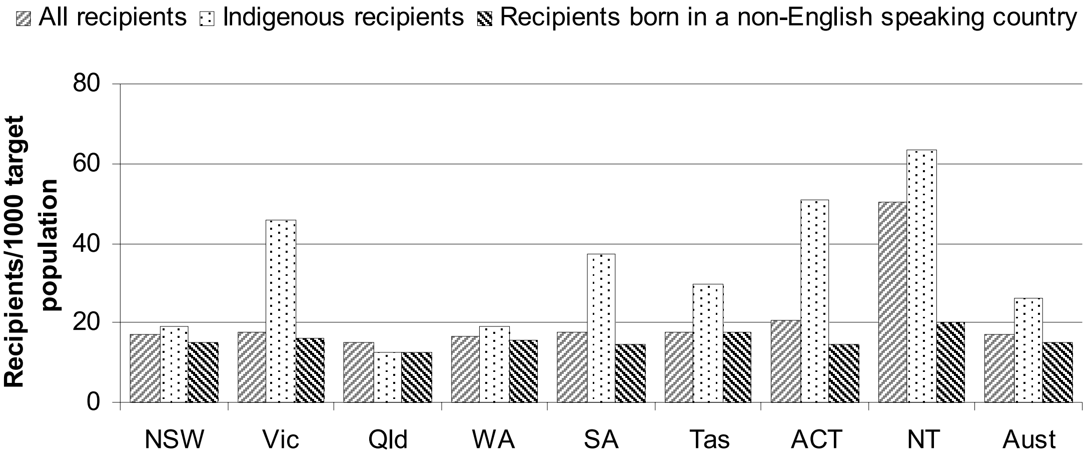
[a] Concessional residents are those who receive an income support payment and have not owned a home for the previous two or more years (or whose home is occupied by a ‘protected’ person, such as the care recipient’s spouse or long term carer), and have assets of less than 2.5 times the annual single basic age pension. Assisted residents are those meeting the above criteria, but with assets between 2.5 and 4.0 times the annual single basic age pension.

Source: DoHA (unpublished); table 13A.20.

Access to community aged care packages by Indigenous people and people born in a mainly non-English speaking country

The number of Indigenous CACP recipients per 1000 Indigenous people aged 50 years or over was 25.9 nationally and the numbers of CACP recipients from non-English speaking countries per 1000 of the relevant target population was 15.1 nationally. These figures compare to a total of 17.1 per 1000 of the target population (people aged 70 years or over plus Indigenous people aged 50–69 years) (figure 13.16).

Figure 13.16 **Community Aged Care Package recipients per 1000 target population, 30 June 2007**[a, b, c, d, e]



[a] All recipients data are per 1000 people aged 70 years or over plus Indigenous people aged 50–69 years. [b] Indigenous recipients data are per 1000 Indigenous people aged 50 years or over. [c] Data for recipients from non-English speaking countries are per 1000 people from non-English speaking countries aged 70 years or over. [d] The ACT has a very small Indigenous population aged 50 years or over (table 13A.2), and a small number of packages result in a very high provision ratio. [e] CACPs provide a more flexible model of care more suitable to remote Indigenous communities, so areas such as the NT have a higher rate of CACP recipients per 1000 people.

Source: DoHA (unpublished); tables 13A.13, 13A.15 and 13A.17.

Age-sex specific usage rates for CACP and EACH, by jurisdiction, remoteness and Indigenous usage vary between jurisdictions and remoteness categories for CACP. For EACH, the differences are less marked. However, the EACH program is small and growing rapidly (tables 13A.60-61 and 13A.63-65).

Access to the HACC program by Indigenous people and by remoteness area

HACC services are provided in the client’s home or community for people with a moderate, severe or profound disability and their carers. The focus of this chapter is people 70 years and over and Indigenous people aged over 50. The proportion of HACC recipients aged 70 years or over during 2006-07 was 68.8 per cent (table 13A.33).

The number of service hours per 1000 people aged 70 years or over plus Indigenous people aged 50–69 years was 18 599 nationally, and the number of meals provided per 1000 people aged 70 years or over plus Indigenous people aged 50–69 was 6126 nationally (table 13.8). HACC agencies that submitted the data as a proportion of all HACC agencies varies across jurisdictions and comparisons between jurisdictions should be made with care.

Table 13.8 **HACC services received, 2006-07 (per 1000 people aged 70 years or over plus Indigenous people aged 50–69 years)**[a, b, c]

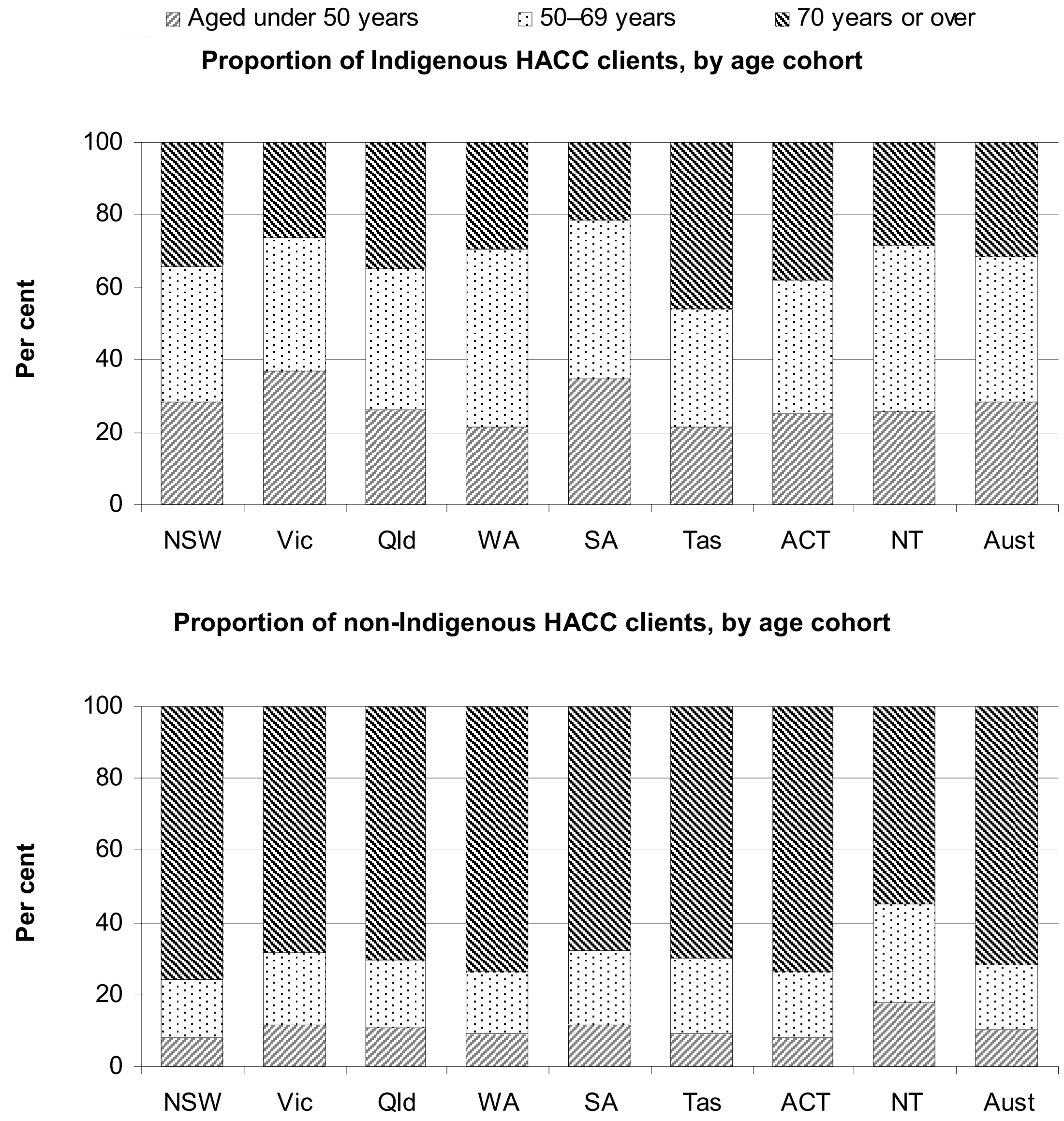
	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Percentage of agencies that reported Minimum Data Set data	%	75	89	92	91	94	81	100	92	83
Total hours[d]										
Major cities	hrs.	11 998	19 591	21 278	22 863	23 333	..	22 637	..	17 854
Inner regional	hrs.	11 736	23 601	17 357	20 749	17 009	17 022	..	..	17 063
Outer regional	hrs.	13 221	28 858	18 830	25 166	21 930	15 854	..	19 772	19 331
Remote	hrs.	22 774	34 353	20 912	23 563	25 066	20 750	..	32 606	24 037
Very remote	hrs.	16 276	..	19 926	20 935	30 629	33 975	..	35 463	25 502
All areas	**hrs.**	**12 847**	**21 446**	**20 304**	**23 852**	**23 328**	**17 333**	**23 110**	**28 852**	**18 599**
Total meals[e]										
Major cities	no.	4 379	5 247	6 696	6 599	7 042	..	5 229	..	5 453
Inner regional	no.	5 519	8 010	6 036	6 658	3 838	6 288	..	..	6 281
Outer regional	no.	7 259	7 292	7 467	7 841	7 770	7 903	..	8 272	7 493
Remote	no.	7 690	6 777	8 319	9 713	5 843	7 667	..	32 426	9 962
Very remote	no.	12 540	..	10 661	21 438	21 111	4 088	..	46 219	24 040
All areas	**no.**	**4 974**	**6 056**	**6 761**	**7 321**	**6 846**	**6 864**	**5 234**	**28 430**	**6 126**

[a] Data represent HACC services received divided by people aged 70 years or over, plus Indigenous people aged 50–69 years (tables 13A.21–13A.26) as distinct from HACC services received divided by HACC target population in all age groups (tables 13A.27–13A.32). [b] The proportion of HACC agencies that submitted data for the year varied between jurisdictions and actual service levels may be higher than stated. [c] Reports provisional HACC data that have not been validated and may be subject to revision. [d] See table 13A.21 for a full list of categories. [e] Includes home meals and centre meals. .. Not applicable.

Source: DoHA (unpublished); tables 13A.21–13A.26.

Reported use of HACC services showed a substantial difference between all users and Indigenous users across all age groups in 2006-07. This reflects the difference in morbidity and mortality trends between Indigenous people and the general population. The proportion of Indigenous HACC clients who are aged 70 years and over is 31.4 per cent and the proportion of non-Indigenous HACC clients who are aged 70 years and over is 71.2 per cent (figure 13.17).

Figure 13.17 **Recipients of HACC services by age and Indigenous status, 2006-07**[a]



[a] Reports provisional HACC data that have not been validated and may be subject to revision.

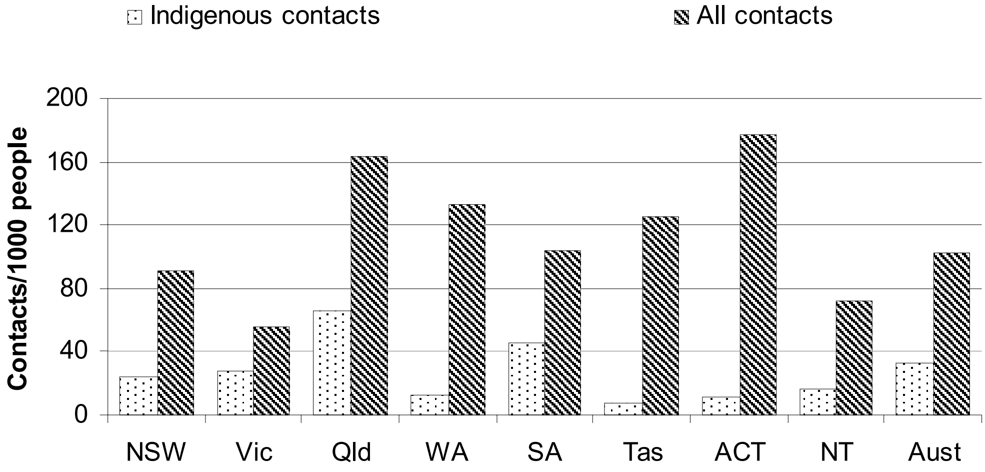
Source: DoHA (unpublished); table 13A.34.

Access by Indigenous people to Commonwealth Carelink Centres

Commonwealth Carelink Centres are information centres for older people, people with disabilities, carers and service providers. Information is provided on community services and aged care, disability and other support services available locally or anywhere in Australia, the costs of services, assessment processes and eligibility criteria. The national rate at which Indigenous people contacted Carelink

Centres at 30 June 2007, was 33.4 people per 1000 Indigenous people in the Indigenous target population (Indigenous people aged 50 years and over). The rate for all Australians was 102.2 per 1000 people in the target population (people aged 70 years and over plus Indigenous people aged 50–69). These figures varied across jurisdictions (figure 13.18). Data presented against this measure vary from previous Reports, where the entire population was used as the denominator. For this Report, the target populations for this chapter have been used, resulting in higher rates than in previous Reports.

Figure 13.18 **Commonwealth Carelink Centres, contacts per 1000 target population, by Indigenous status, 30 June 2007**[a, b, c]



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[a] Contacts with Carelink include phone calls, visits, emails and facsimiles. [b] Indigenous contacts refer to contacts by Indigenous people per 1000 Indigenous people in the target population. [c] All contacts refers to contacts per 1000 target population.

Source: DoHA (unpublished); table 13A.57.

Effectiveness

Timeliness of access — waiting times for residential care

The indicator ‘waiting times for residential care’ is an indicator of the effectiveness of aged care services (box 13.9).

Box 13.9 **Waiting times for residential care**

'Waiting times for residential care' is an indicator of the timeliness with which people are able to access residential care.

The measure 'elapsed time between ACAT approval and entry into high care residential care service' measures the period between a client's approval for high care and his or her entry into care, and is defined as the percentage of people who are admitted to high care residential care within three months of their ACAT approval. Shorter elapsed times (measured by higher rates of admission to high care residential care within three months of ACAT approval) are desirable.

The relevant terms are defined as follows:

- ACAT approval — the approval date of an ACAT assessment
- entry into a residential care service — the date of admission to a residential care service.

This indicator needs to be interpreted with care. The measure of 'elapsed time' is utilised because the period of time between the ACAT assessment and entry into residential care may be due to factors which cannot be categorised as 'waiting' time. These include:

- clients with ACAT approvals who do not enter residential care (for example, who die before entering care)
- residential placement offers that are not accepted
- the availability of alternative community care, informal care and respite services
- the availability and distribution of operational residential care services
- building quality and perceptions about quality of care, which influence client choice of preferred service
- delays between the date of ACAT assessments and their approval
- priority allocations (for example, special needs groups)
- hospital discharge policies and practices
- impact on clients of programs which provide alternatives to residential care, such as EACH and EACH Dementia.

The measure focuses on high care services because, as a proxy for waiting time, the link between entry to residential care and elapsed time is stronger for high care residents than low care residents. This is due to the urgency for high care residents, and the greater number of alternatives for people with ACAT approvals for low care only. Waiting time measures for low care are included in the attachment tables.

The Steering Committee acknowledges the limitations of the current indicator (box 13.10) and supports redevelopment for improvement. The current indicator will continue to be reported until improved data are available.

Box 13.10 **Entry period for residential care**

The Australian Institute of Health and Welfare (AIHW) conducted a detailed study of 1999-2000 ACAT assessment data and entry into residential care (AIHW 2002*)*. The 'entry period' is the time between ACAT assessment of a person as eligible for residential aged care, and that person's entry into a residential aged care service.

The study found that one of the main determinants of a short entry period is whether the resident has an ACAT assessment performed while in hospital rather than when living at home. A longer entry period is also strongly related to whether the resident used a CACP or residential respite care before admission.

Recommendations for residential care remain active for 12 months. Some people assessed by an ACAT and recommended for residential aged care may not take up a residential place within this period. People often do not act on the recommendation immediately. They may believe they are capable of continuing to manage at home and that they do not need admission. Others receive recommendations for both residential aged care and a CACP, and take up the latter.

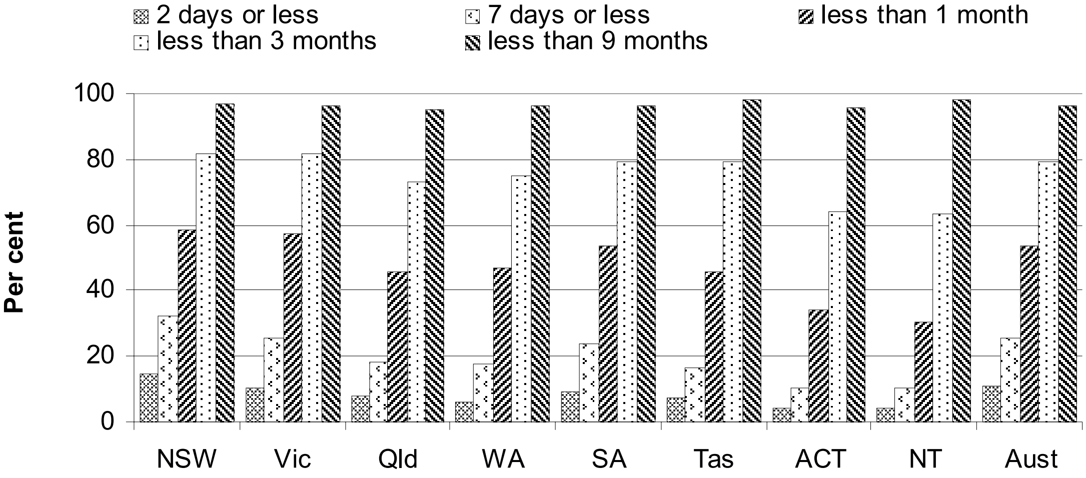
The AIHW found that many factors affect the entry period but are not linked to the performance of the aged care system. It recommended that the entry period for residential care not be used as a performance indicator.

Source: AIHW (2002).

Overall, 25.4 per cent of all people entering high care residential care during 2006-07 did so within seven days of being approved by an ACAT, 53.9 per cent entered within one month of their ACAT approval and 79.1 per cent entered within three months of their approval. These times varied across jurisdictions (figure 13.19). In the calculation of entry period, the most recent ACAT approval prior to entry is used. The median time for entry into high care residential care was 26 days (table 13A.37).

Nationally, a greater proportion of people entering high care residential services entered within three months of approval (79.1 per cent), compared with the proportion entering low care residential services within that time (60.4 per cent). These proportions varied across jurisdictions (table 13A.37).

Figure 13.19 **People entering high care residential care within specified time periods of their ACAT approval, 2006-07**



Source: DoHA (unpublished); table 13A.37.

Timeliness of access — waiting times for community care

'Waiting times for community care' is an indicator of the effectiveness of aged care services (box 13.11).

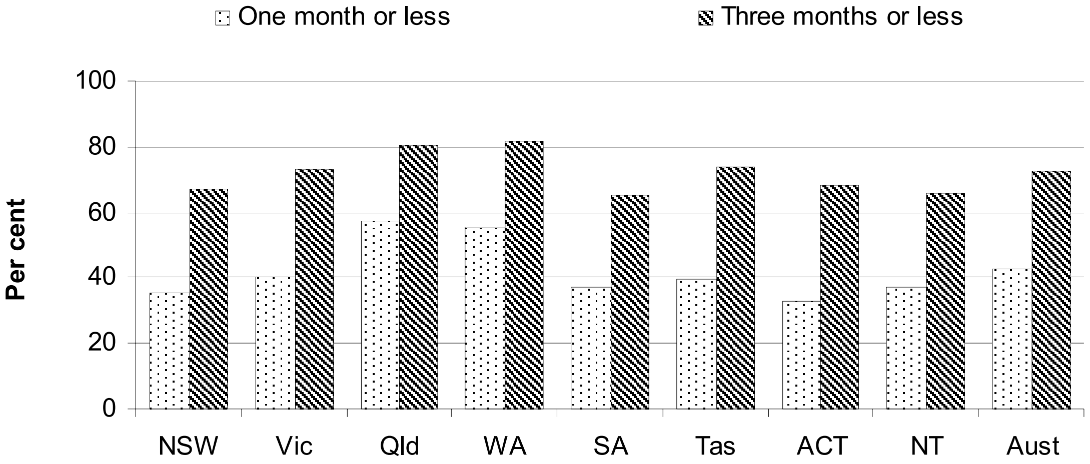
Box 13.11 **Waiting times for community care**

'Waiting times for community care' is an indicator of effectiveness and reflects the timeliness with which people are able to access CACPs. The indicator measures the period between a client's approval for care and his or her receipt of care, and is defined as the elapsed time between an ACAT approval and receipt of a CACP. Shorter waiting times (or higher rates of receipt of a CACP within one month or within three months of an ACAT approval) are considered desirable.

This indicator needs to be interpreted with care. Some ACAT assessed clients may choose not to receive a CACP, alternative community care options may be available, or varying fee regimes might influence choice.

Overall, 72.5 per cent of all people receiving a CACP during 2006-07 received it within three months of being assessed by an ACAT. This proportion varied across jurisdictions. On average, 42.9 per cent started receiving a CACP within one month of their ACAT assessment (figure 13.20).

Figure 13.20 **People commencing a CACP within one or three months of their ACAT assessment, 2006-07**



Source: DoHA (unpublished); table 13A.37.

Appropriateness — assessed longer term care arrangements

'Assessed longer term arrangements' is an indicator of the appropriateness of aged care services (box 13.12) and measures the proportion of clients referred to community care, compared with residential care.

Box 13.12 **Assessed longer term living arrangements**

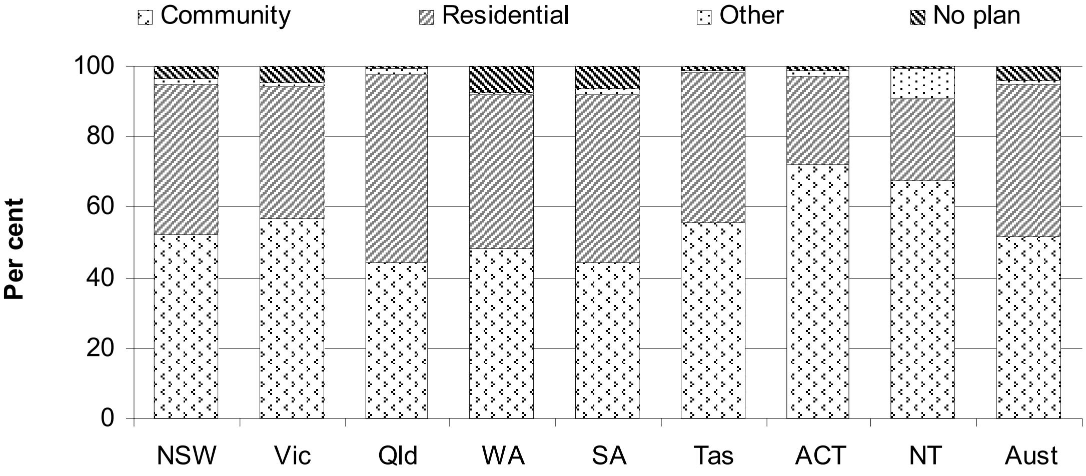
'Assessed longer term living arrangements' is an indicator of the appropriateness of aged care services in referrals. The indicator measures how effectively clients are allocated to the services that best meet their needs.

This indicator is defined as the proportion of ACAT clients recommended to remain at home or in residential care (permanent or respite). (Aged care assessments are mandatory for admission to residential care or for receipt of a CACP or an EACH package.)

The results for this indicator show the distribution of recommended living arrangements of ACAT clients in each jurisdiction. Differences in recommendations across jurisdictions may reflect external factors such as geographic dispersion of clients and service availability, but also client preferences and views on the types of client best served by community-based services. The distribution of ACAT recommendations for various living arrangements are influenced by the degree to which any pre-selection process refers people requiring residential care to ACATs for assessment. Jurisdictions with lower overall assessment rates may operate a filtering process to focus assessments on individuals who are more likely to require residential care.

The national proportion of ACAT clients approved for residential care in 2005-06 was 43.0 per cent and the proportion recommended to remain in the community was 51.8 per cent. No long term plan was made for 3.7 per cent, which included deaths, cancellations and transfers. These proportions varied across jurisdictions (figure 13.21).

Figure 13.21 **Recommended longer term living arrangements of ACAT clients, 2005-06**[a]



[a] 'No plan' includes deaths, cancellations and transfers.

Source: Aged Care Assessment Program National Data Repository (unpublished); table 13A.38.

Appropriateness — targeting

A 'targeting' indicator has not yet been developed (box 13.13).

Box 13.13 **Targeting**

The Steering Committee has identified 'targeting' as an indicator of appropriateness. It will be developed for reporting in the future.

Appropriateness — unmet need

'Unmet need' is an indicator of the appropriateness of aged care services in meeting clients needs (box 13.14).

Box 13.14 **Unmet need**

‘Unmet need’ is an indicator of the appropriateness of aged care services. The indicator measures the extent to which demand for services to support older people requiring assistance with daily activities is met.

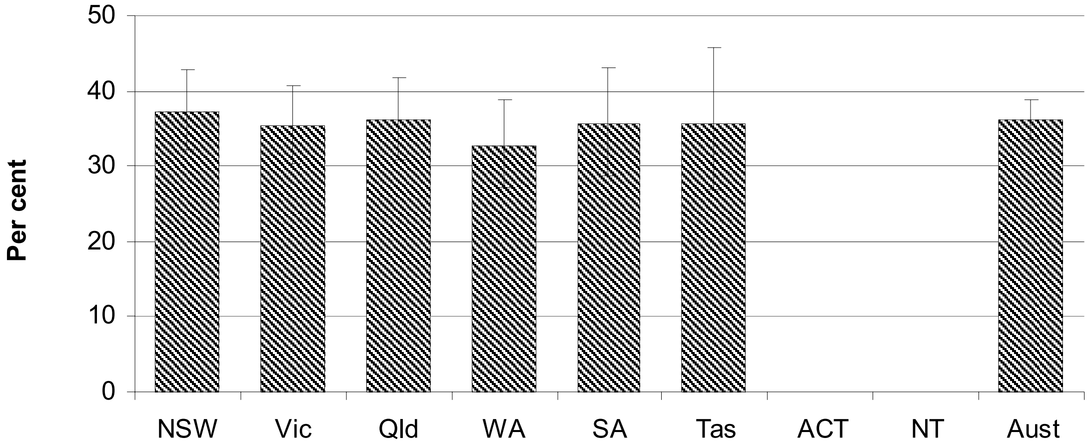
Defining and determining the level of need at an individual level, let alone at a population level, is complex. Perceptions of need and unmet need are often subjective. Data for this indicator are drawn from the ABS 2003 Survey of Disability, Ageing and Carers and reflect people aged over 70 years who self-identified as having a need for assistance with at least one everyday activity, and the extent to which that need was met (fully, partly or not at all).

While low rates of unmet need are desirable, direct inferences about the demand for services from these data need to be made with care, because the data do not:

- reveal the intensity of care required by those who identify an unmet need — there is no indication of whether the need can readily be met informally or by formal home care, or whether the person may require residential care
- reflect the degree of unmet demand for a specific type of service. Differences across jurisdictions in the proportion of unmet need can reflect different policy approaches to targeting services. Some governments may choose to focus on those with the greatest degree of need for care and on fully meeting their needs. By contrast, other governments may choose to provide a lower level of service to a greater number of people, while only partly meeting the needs of those with the greatest need for care. Both policy approaches to the targeting of services are valid
- reflect the past and possible future duration of the need — that is, whether it is long term or transitory
- reflect whether the need relates to a disability support service, aged care service or health care.

Of those persons aged 70 years or over in 2003, who were living in households and who self-identified as having a need for assistance with at least one everyday activity, over one third (36.1 per cent) reported that their needs for assistance were not fully met (figure 13.22).

Figure 13.22 **Percentage of older persons needing assistance with at least one everyday activity whose need was not fully met, 2003[a, b, c, d]**



[a] Aged 70 years or over, living in households. [b] Australian total includes data for the ACT and the NT. [c] Data for ACT and NT not available. [d] Error bars represent the 95 per cent confidence interval associated with each point estimate.

Source: ABS 2003 Survey of Disability, Ageing and Carers (unpublished); table 13A.67.

Appropriateness — long term aged care in public hospitals

'Long term aged care in public hospitals' is an indicator of the appropriateness of aged care services (box 13.15).

Box 13.15 **Long term aged care in public hospitals**

‘Long term aged care in public hospitals’ is an indicator of the appropriateness of care. Hospital inpatient services are geared towards shorter periods of care aimed at addressing serious illness or injury, or diagnosis, and are a less effective form of care for older people who cannot live independently in the long term.

The proxy measure for this indicator is defined as the proportion of completed hospital separations for people aged 70 years and over plus Indigenous people aged 50–69 years where:

- the care type was maintenance and
- the diagnosis (either principal or additional) was either ‘awaiting admission to residential aged care’ or ‘no-one to provide care at home’ and
- where the length of stay was 35 days or longer

as a proportion of all such separations.

A low proportion of stays of 35 days or more is desirable.

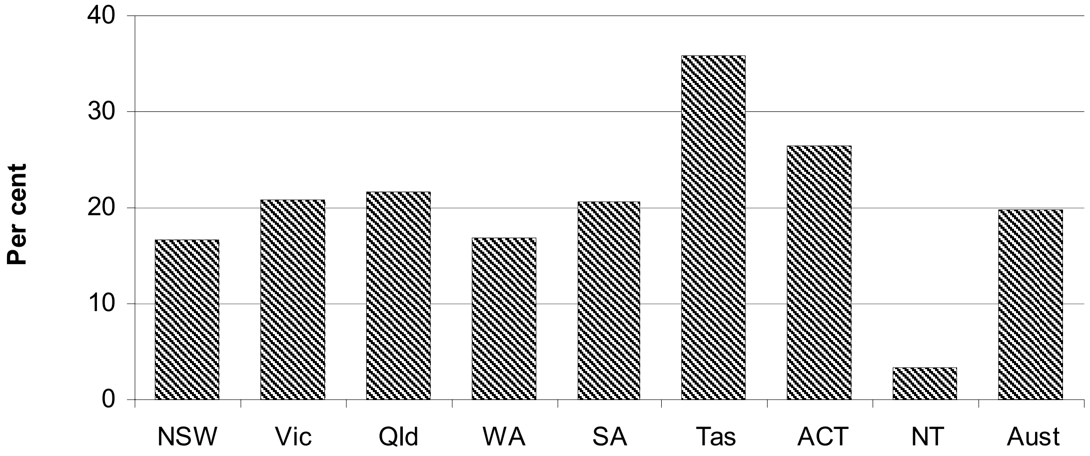
These data should be interpreted with care.

- Patients who have not completed their hospital stay are not reported in these data.
- Although the diagnosis codes reflect a care type, they do not determine a person’s eligibility for residential aged care (this is determined by an ACAT assessment) or necessarily reliably reflect access issues for residential aged care from the acute care sector.
- Diagnosis codes may not be applied consistently across jurisdictions or over time.
- Data about hospital separations do not necessarily reflect the full length of hospital stay for any individual patient. If a change in the type of care occurs during a patient’s hospital stay (for example, from acute to maintenance) then the data report two separations for that patient.
- The code ‘no-one to provide care at home’ may also be used for respite care for aged care residents or those receiving community care and some jurisdictions may have a high proportion of this type of use. This is particularly relevant in some rural areas where there are few alternative options for these clients.
- These data do not necessarily reflect alternative strategies in place by states and territories to manage the older person into appropriate residential aged care facilities from acute care hospitals.

The measure above is regarded as a proxy measure, as the desired measures (utilising appropriate linked hospital separations and ACAT approvals) are not available at this time. Work is underway to improve available data sets and the Steering Committee will continue to develop the indicator and associated measures for future Reports.

The proportion of separations for patients aged 70 years and over plus Indigenous people aged 50–69 years who had a care type of maintenance with a diagnosis (either principal or additional) of either 'awaiting admission to residential aged care' or 'no-one to provide care at home', and whose separation was 35 days or longer was 19.9 per cent nationally in 2005-06. This proportion varied across jurisdictions (figure 13.23). These data reflect only a small proportion of all public hospital separations for patients aged 70 years and over plus Indigenous people aged 50–69 years (11 222 separations of a total of 1.3 million nationally) (table 13A.70).

Figure 13.23 **Proportion of long term separations for aged care patients, in public hospitals, 2005-06**[a, b, c, d, e, f, g]



[a] Data are for hospital separations with a care type of maintenance and a diagnosis (either principal or additional) of either 'awaiting admission to residential aged care' or 'no-one to provide care at home' and where the separation lasted 35 days or longer. [b] Age of patients is 70 years and over, plus Indigenous patients 50–69 years. [c] Although the diagnosis codes reflect a care type, they do not determine a persons eligibility for residential aged care. [d] Diagnosis codes may not be applied consistently across jurisdictions or over time. [e] These data only account for completed unlinked separations. [f] The code 'no-one to provide care at home' may also be used for respite care for either residential or community care patients. [g] An individual patient may have multiple hospital separations during a single hospital stay – for example, if a change in the type of care occurs during a patient's hospital stay. Data on length of stay relate to each separation and not the whole hospital stay.

Source: AIHW (unpublished); table 13A.70.

Appropriateness — intensity of care

'Intensity of care' is an indicator of the appropriateness of aged care services (box 13.16).

Box 13.16 **Intensity of care**

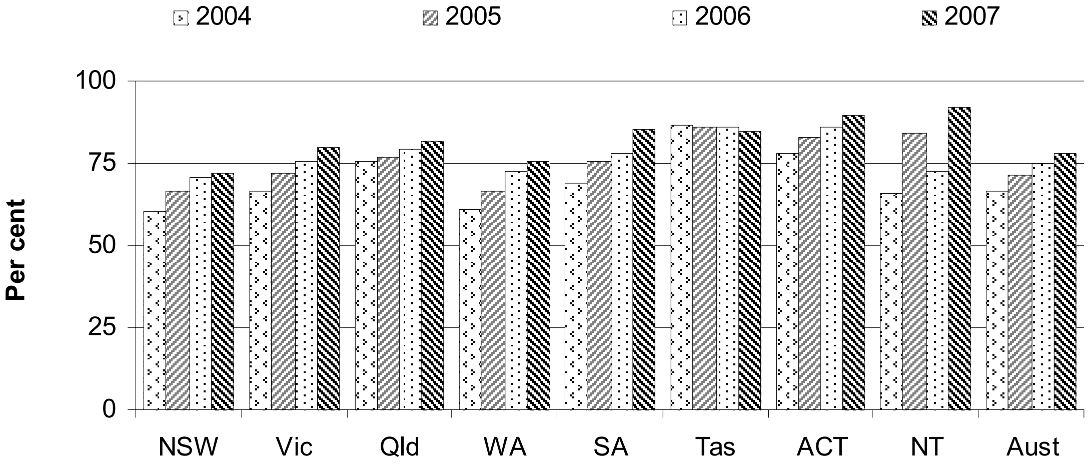
'Intensity of care' is an indicator of appropriateness, reflecting the proportion of residents who remain in the same residential aged care facility as their care needs increase from low care to high care. The Aged Care Act aims explicitly to encourage 'ageing in place' to increase choice and flexibility in residential aged care service provision (box 13.5).

This indicator needs to be viewed from the perspective of the system as a whole. The implication of ageing in place is that some places that were allocated for low care will be occupied by high care residents (or, conversely, allocated for high care and occupied by low care residents). Information about the use of operational residential aged care places is provided to demonstrate the impact of ageing in place on the aged care service system over time.

Higher rates of ageing in place are desirable, in the context of a flexible system that also meets the need for low level care either in residential facilities or in the community.

From June 2004 to June 2007 there was a steady increase in the proportion of people who stayed in the same residential aged care service when changing from low care to high care, from 66.7 per cent to 77.8 per cent nationally (figure 13.24). In June 2007 the proportion was higher in inner regional areas (81.5 per cent), outer regional areas (79.8 per cent) and remote areas (88.3 per cent) than in major cities (76.1 per cent) and very remote areas (39.3 per cent) (table 13A.55).

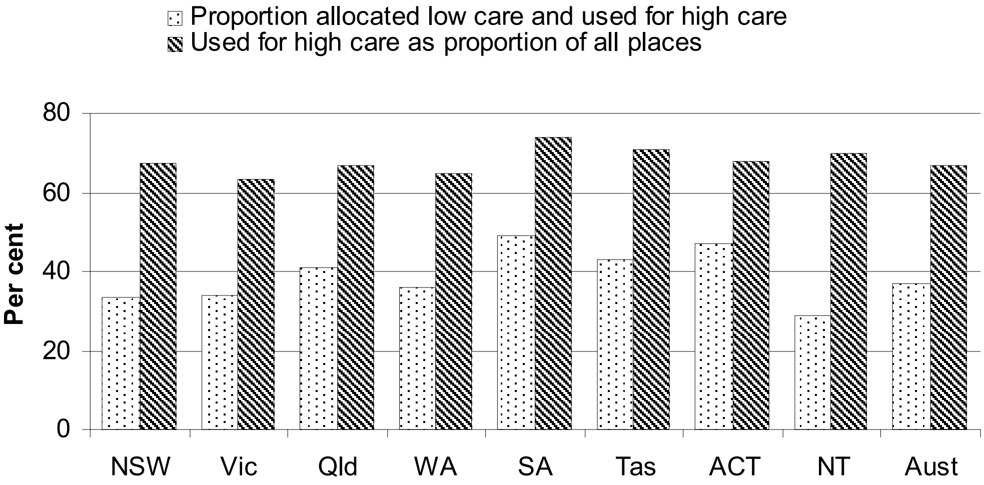
Figure 13.24 **Proportion of residents who changed from low care to high care and remained in the same aged care service, June**



Source: DoHA (unpublished); table 13A.55.

Nationally, 36.9 per cent of low care places in 2006-07 were occupied by residents with high care needs. The proportion of all operational places taken up by residents with high care needs made up 66.7 per cent (figure 13.25). These data are provided by remoteness area in table 13A.58.

Figure 13.25 **Utilisation of operational residential places, 30 June 2007**



Source: DoHA (unpublished); table 13A.58.

Quality — compliance with service standards for residential care

'Compliance with service standards for residential care' is an indicator of quality of aged care services (box 13.17).

Box 13.17 **Compliance with service standards for residential care**

'Compliance with service standards for residential care' is an indicator of the quality of care. The purpose of the indicator is to monitor the extent to which residential care facilities are complying with accreditation or certification standards. The extent to which they comply implies a certain level of care and service quality.

Two measures are reported against this indicator:

- the extent to which accreditation standards are met
- the number of residents per room.

(Continued on next page)

Box 13.17 **(Continued)**

Accreditation standards

Since 2001, each Australian Government funded residential service has been required to meet accreditation standards (which comprise 44 expected outcomes). The accreditation indicator reflects the period of accreditation granted. High rates of approval for three year accreditation are desirable.

The accreditation process is managed by the Aged Care Standards and Accreditation Agency (ACSAA). A Service must apply to ACSAA for accreditation and its application is based on a self-assessment of performance against the accreditation standards.

Following a residential service applying for accreditation, a team of registered quality assessors reviews the application, conducts an onsite assessment and prepares a report based on these observations, interviews with residents, relatives, staff and management, and relevant documentation.

An authorised decision maker from ACSAA then considers the report, in conjunction with any submission from the residential service and other relevant information (including information from DoHA) and decides whether to accredit and, if so, for how long.

Number of residents per room

The number of residents per room is an output indicator of quality. Lower rates of residents per room are generally desirable because they imply a higher service quality of accommodation.

As part of the Australian Government’s certification requirements for residential aged care buildings, by 31 December 2008 every service that existed prior to July 1999 will be required to have no more than four residents accommodated in any room, no more than six residents sharing each toilet and no more than seven residents sharing each shower. For new buildings planned or built since July 1999, an average for the whole service of not more than 1.5 residents per room is required. No room may accommodate more than two residents, there must be no more than three residents per toilet and no more than four residents per shower or bath.

Accreditation decisions and other information relating to the accreditation standards, the aged care standards and ACSAA are publicly available via the ACSAA’s web site (www.accreditation.aust.com). The accreditation process is summarised in box 13.17.

At 30 June 2007, 92.2 per cent of residential aged care services had been granted an accreditation approval for a period of three years or more. This proportion varied across jurisdictions (table 13.9).

Table 13.9 Accreditation decisions on residential aged care services, 30 June 2007[a]

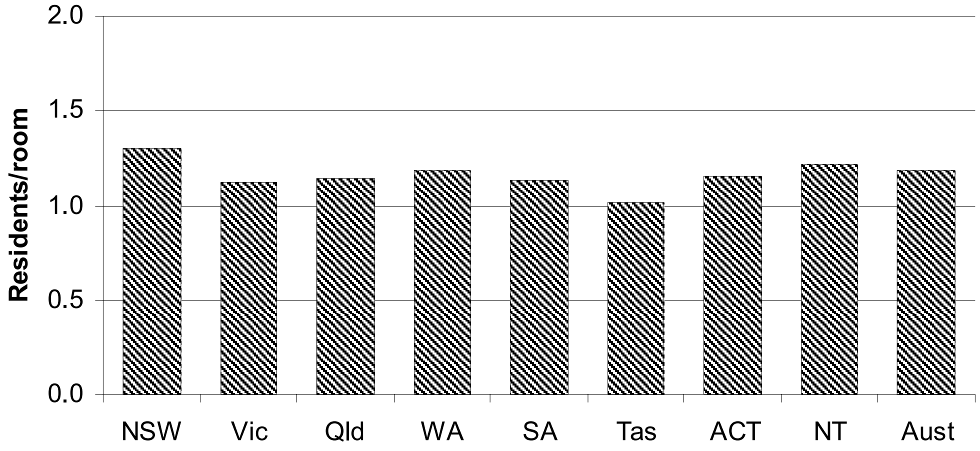
	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Accreditation period										
<2 years	%	2.0	4.1	8.0	3.9	4.2	4.5	8.7	–	4.1
2 years or more (but <3 years)	%	2.3	2.4	8.6	3.5	3.8	3.4	–	6.7	3.7
3 years or more	%	95.8	93.5	83.5	92.5	92.0	92.1	91.3	93.3	92.2
Total	%	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**
Accredited services	no.	918	805	490	255	288	89	23	15	2 886

[a] NT data will be variable due to small numbers. – Nil or rounded to zero.

Source: ACSAA (unpublished); table 13A.41.

Existing services are required to meet privacy and space requirements by 2008. Since 2001, all new services must meet these targets from the time of construction. The average number of residents per room at December 2006 was 1.19 nationally (figure 13.26).

Figure 13.26 Average residents per room in residential aged care facilities, December 2006



Source: DoHA (unpublished); table 13A.42.

Quality — complaints

‘Complaints’ is an indicator of the quality of aged care services (box 13.18).

Box 13.18 **Complaints**

'Complaints' is a proxy indicator of the quality of care. The indicator monitors the level of complaints received by the Complaints Resolution Scheme (after 30 April 2007, the Complaints Investigation Scheme) in each state and territory. If service recipients make official complaints, they may be dissatisfied with an element of the service provided.

All aged care services are required to have an internal complaints system. Until 30 April 2007, the Aged Care Complaints Resolution Scheme (ACCRS) was the Australian Government system for managing complaints. It was a complaints system run by the DoHA and overseen by the Commissioner for Complaints. The scheme was available to anyone who wished to make a complaint about an Australian Government funded aged care service, including residents of aged care facilities and their families, staff and people receiving CACPs and EACH packages. The indicator presented for this Report measures the number of complaints to the ACCRS per 1000 residents, for the period July 2006–April 2007, and for previous years. A low rate of complaints is desirable.

The rate at which complaints occur can be influenced by the propensity of clients and their families or service staff to complain, their knowledge of the complaints system, and perceptions of the effectiveness of the complaints system. In many cases, complaints may be resolved without the need to involve complaints systems.

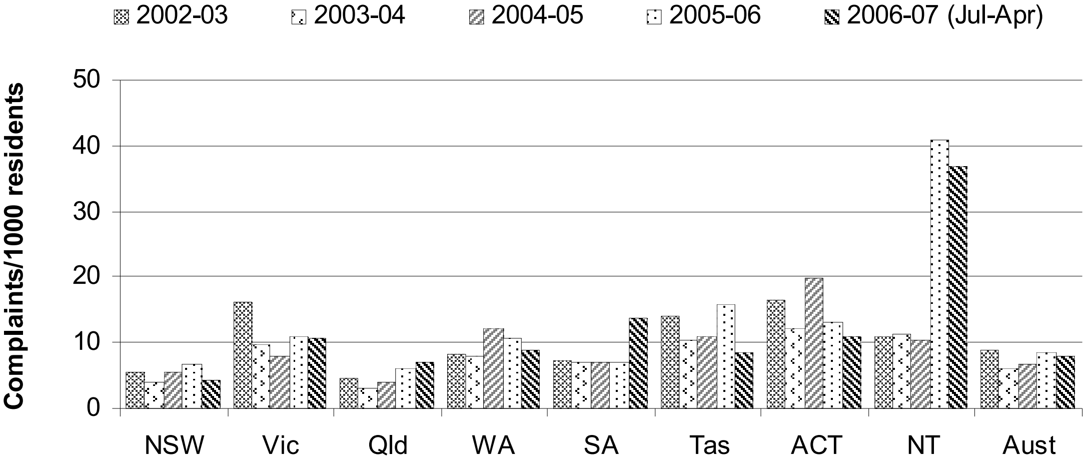
From 1 July 2006 to 30 April 2007, the Complaints Resolution Scheme received approximately 1229 new complaints, compared with 1260 in 2005-06 (table 13A.43). The number of complaints registered per 1000 residents from 1 July 2006 to 30 April 2007 was 8.0 nationally. This varied across jurisdictions (figure 13.27).

From 1 May 2007, the ACCRS was replaced by the Complaints Investigation Scheme (CIS), which has a greater capacity to accept complaints and other aged care related information. The CIS is a service which investigates any potential breach of an approved provider's responsibilities in residential and community care; requires the service provider, where appropriate, to take action; and is able to refer issues that may be more appropriately dealt with by others (for example, police, nurses and medical registration boards).

Also from 1 May 2007 a new independent Aged Care Commissioner was appointed to examine certain decisions made by the CIS, to examine complaints made about the CIS's process and the conduct of the Aged Care Standards and Accreditation Agency as well as any persons carrying out audits or making support contacts under the Accreditation Grant Principles 1999.

In the period 1 May–30 June 2007, DoHA dealt with 1170 matters which were within the scope of the CIS, not all of which were complaints. The increased number of calls reflects the broader nature of the new scheme, which deals with information from a range of sources (DoHA, unpublished).

Figure 13.27 **Aged Care Complaints Resolution Scheme complaints per 1000 residents**[a, b]



[a] 2006-07 data represent complaints for the period July 2006 – April 2007. Therefore data for rates per 1000 residents for 2006-07 are not comparable with earlier years. [b] NT data will be variable due to small numbers. The number of complaints varied from 4 to 16 between 2002-03 and 2006-07.

Source: DoHA (unpublished); table 13A.43.

Quality — compliance with service standards for community care

The indicator 'compliance with service standards for community care' is an indicator of the quality of aged care services (box 13.19).

Box 13.19 **Compliance with service standards for community care**

'Compliance with service standards for community care' is an indicator of quality. The indicator monitors the extent to which individual agencies are complying with service agreement standards.

The HACC national service standards provide HACC funded agencies with a common reference point for internal quality control by defining aspects of service quality and expected outcomes for consumers. States and territories are required to include the standards in all service agreements. The HACC national service standards instrument has been developed to measure through a service appraisal process the extent to which individual agencies are complying with the standards. Monitoring and compliance with the standards are now a major part of service reviews.

(Continued on next page)

Box 13.19 **(Continued)**

The indicator measures the number of HACC agencies appraised against the standards divided by the total number of HACC agencies. This indicator also measures the percentage of individual agencies that comply with the service standards, through data on the outcomes of service standard appraisals. It should be noted that the standards are not an accreditation system.

A total of 3207 HACC agencies were identified for appraisal over the three year cycle 2001-02 to 2003-04. The number of these agencies appraised was 2711 (85 per cent). This proportion varied across jurisdictions (table 13.10). The outcomes of these appraisals was a national average score of 16.0 out of 20 (table 13.11). In the course of the initial three year appraisal process, in the absence of detailed national implementation guidelines, each State and Territory adopted individual approaches when assessing agencies against the National Service Standards Instrument (State and Territory governments unpublished).

The next appraisal cycle will cover the period 2005-06 to 2007-08. Data from this appraisal cycle are anticipated to be available for the 2009 Report.

Table 13.10 **HACC National Service Standards appraisals over the three year cycle ending 2003-04[a]**

	Unit	*NSW*[b]	*Vic*	*Qld*[c]	*WA*[d]	*SA*[e]	*Tas*[f]	*ACT*	*NT*[g]	*Aust*
Appraisals	no.	1 095	481	706	168	161	58	31	11	2 711
HACC agencies	no.	1 487	481	730	178	161	58	31	81	3 207
Proportion of agencies assessed	%	74	100	97	94	100	100	100	14	85

[a] Reports provisional data that have not been validated and may be subject to revision. Not all HACC agencies were required to undergo external assessment, and some are exempt, so the number of HACC agencies may be higher than those reported. [b] The total number of agencies identified for NSW are those targeted in the appraisal plan as at 2001-02. The Integrated Monitoring Framework implemented by NSW in 2005-06 will cover new agencies since that time. NSW completed all remaining appraisals in 2004-05. [c] Reviews in Queensland are conducted by an external agency on a three year contract. In Queensland there were 730 agencies at the beginning of the contract period. There were 808 agencies in Queensland at the commencement of the 2004-05 contract. [d] The number of WA agencies appraised is lower than expected because some agencies amalgamated. [e] SA has an additional 21 exempt agencies. [f] Two agencies were exempt from the appraisal process in Tasmania. [g] NT data are variable due to small numbers.

Source: State and Territory governments (unpublished).

Table 13.11 **HACC National Service Standards results of appraisals over the three year cycle ending 2003-04**[a, b, c]

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
High (17.5 – 20)	no.	607	157	276	108	51	12	25	na	1 236
Good (15 – 17.4)	no.	337	168	191	28	37	11	2	na	774
Basic (10 -14.9)	no.	132	123	142	34	50	24	3	na	508
Poor (less than 10)	no.	19	33	97	4	23	11	1	na	188
Average score	no.	17.2	15.5	14.8	17.0	14.5	13.2	17.9	na	16.0

[a] Reports provisional data that have not been validated and may be subject to revision. Not all HACC agencies were required to undergo external assessment, and some are exempt, so the number of HACC agencies may be higher than those listed. [b] The results of the appraisals will reflect the individual approaches adopted by each State and Territory. [c] For details about the method of determining the average score, see table 13A.66. **na** Not available.

Source: State and Territory governments (unpublished); table 13A.66.

Quality — client appraisal of service standards

The indicator ‘client appraisal of service standards’ has not yet been developed (box 13.20).

Box 13.20 **Client appraisal of service standards**

‘Client appraisal of service standards’ is an indicator of the quality of aged care services. This indicator aims to monitor client satisfaction with services received. The Steering Committee has identified this indicator for development and reporting in future.

Efficiency

Inputs per output unit — cost per ACAT assessment

‘Cost per ACAT assessment’ is an indicator of the efficiency of aged care services (box 13.21).

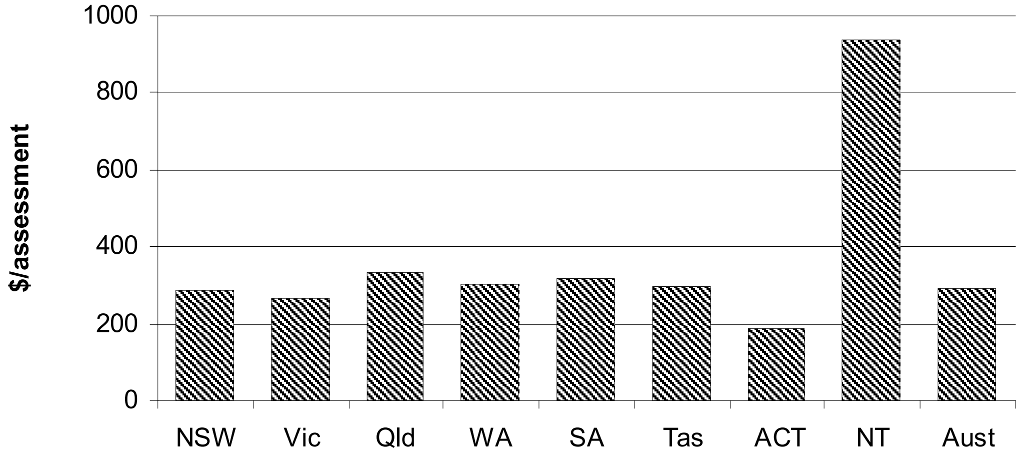
Box 13.21 **Cost per ACAT assessment**

A proxy efficiency indicator, 'cost per ACAT assessment', has been developed as work in progress to measure efficiency for ACATs. It is defined as expenditure on ACATs divided by the number of ACAT assessments completed.

This indicator needs to be interpreted with care. While high or increasing expenditure per assessment may reflect deteriorating efficiency, it may also reflect changes in aspects of the service (such as greater time spent with clients) or changes in the characteristics of clients (such as their geographic location). Similarly, low or declining expenditure per assessment may reflect improving efficiency or less time spent with clients (for example). This indicator includes only Australian Government expenditure, although states and territories also contribute to the cost of ACAT assessments.

Australian Government expenditure per aged care assessment during 2005-06 averaged $294 nationally (figure 13.28). The cost per assessment is calculated using the total number of assessments and therefore includes clients aged less than 70 years.

Figure 13.28 **Australian Government expenditure on aged care assessments, per assessment, 2005-06 (dollars)**[a, b, c]



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[a] Only includes Australian Government expenditure on ACAT. [b] ACAT referrals and operations vary across jurisdictions. [c] The high cost for each assessment in the NT may be influenced by the remoteness of people requiring assessments, clients having English as a second or third language, and a lack of supporting health and community services infrastructure to assist with assessments.

Source: DoHA (unpublished); table 13A.56.

Inputs per output unit — expenditure per head of target population

'Expenditure per head of target population' is a proxy indicator of the efficiency of aged care services (box 13.22).

Box 13.22 **Expenditure per head of target population**

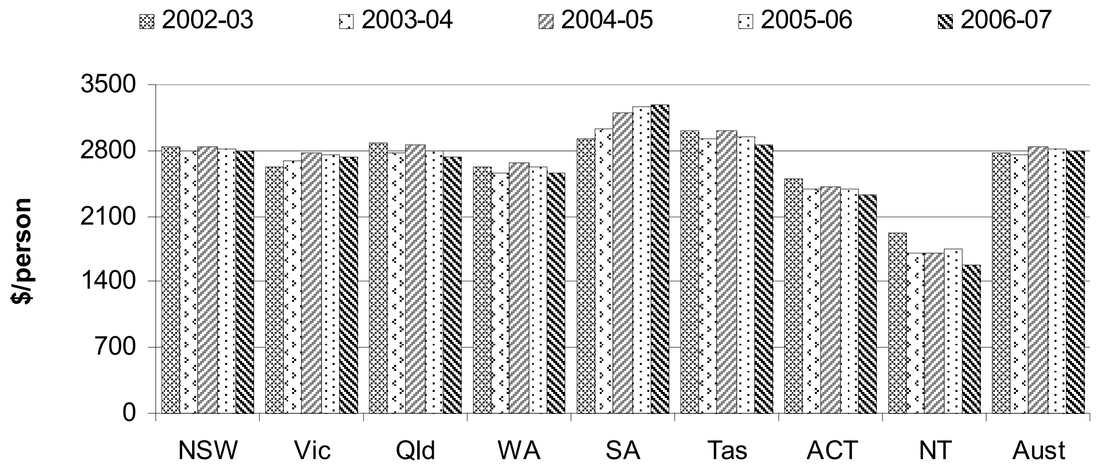
A proxy indicator of efficiency is 'expenditure per head of target population'. The indicator is defined as government inputs (expenditure) divided by the number of people aged 70 years or over plus Indigenous people aged 50–69 years. Expenditure per person in the target population is reported for three main service types: residential services, CACP and HACC services.

This indicator needs to be interpreted with care. While high or increasing expenditure per person may reflect deteriorating efficiency, it may also reflect changes in aspects of the service (such as better quality of services) or in the characteristics of clients receiving the service (such as their geographic location or level of care need). Similarly, low or declining expenditure per assessment may reflect improving efficiency or a decrease in service standards.

Australian Government real expenditure by both DoHA and DVA on residential care services per person aged 70 years or over plus Indigenous people aged 50–69 years was little changed between 2002-03 ($2775) and 2006-07 ($2788) (figure 13.29). If the payroll tax supplement paid by the Australian Government is excluded, this expenditure decreased nationally from $2800 in 2004-05 (the earliest year the payroll tax supplement is included in the Report for this service) to $2734 in 2006-07 (table 13A.51).

DoHA expenditure on residential care per person aged 70 years or over plus Indigenous people aged 50–69 years in 2006-07 was $2359 including the payroll tax supplement and $2312 excluding the payroll tax supplement (table 13A.50). DVA expenditure on residential care per person aged 70 years or over plus Indigenous people aged 50–69 years in 2006-07 was $429 including the payroll tax supplement and $422 excluding the payroll tax supplement (table 13A.46).

Figure 13.29 Australian Government (DoHA and DVA) real expenditure on residential services per person aged 70 years or over plus Indigenous people aged 50–69 years (2006-07 dollars)[a]



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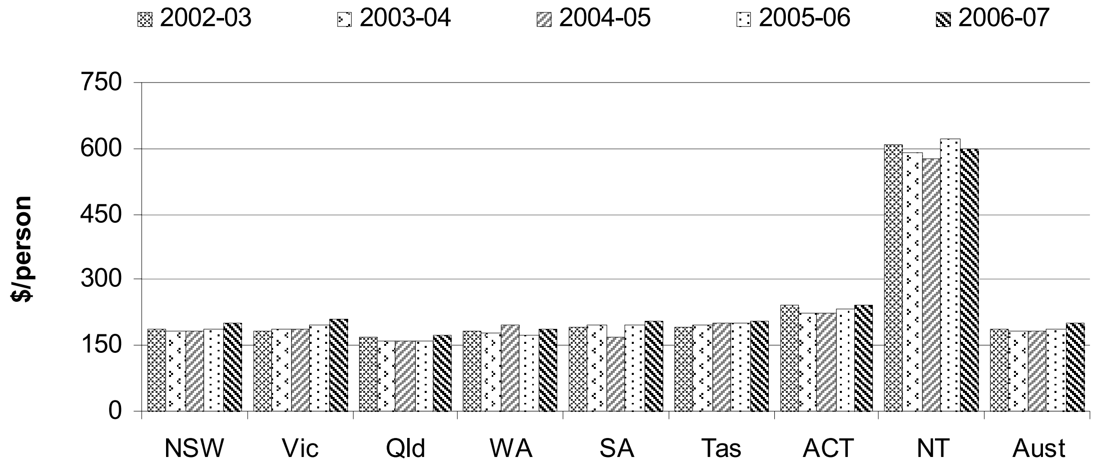
[a] Includes a payroll tax supplement provided by the Australian Government. Actual payroll tax paid may differ.

Source: DoHA (unpublished); DVA (unpublished); table 13A.51.

Australian Government expenditure on CACPs per person aged 70 years or over plus Indigenous people aged 50–69 years was similar in most jurisdictions except the NT in 2006-07. Nationally, real expenditure per person aged 70 years or over plus Indigenous people aged 50–69 years increased from $186 in 2002-03 to $200 in 2006-07 (figure 13.30).

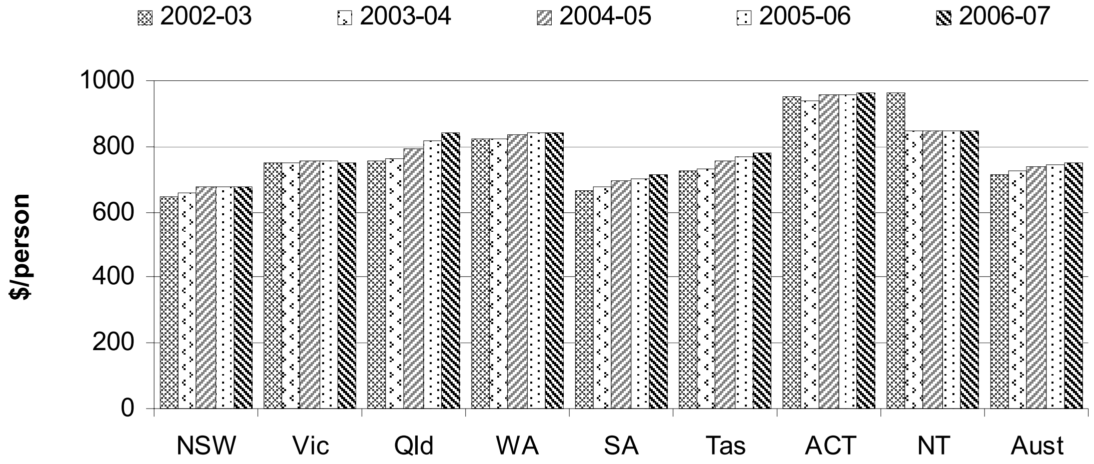
Figure 13.30 Australian Government real expenditure on CACP services per person aged 70 years or over plus Indigenous people aged 50–69 years (2006-07 dollars)



Source: DoHA (unpublished); table 13A.54.

Australian, State and Territory government expenditure on HACC services per person aged 70 years or over plus Indigenous people aged 50–69 years varied across jurisdictions. Nationally, real expenditure increased from $715 in 2002-03 to $751 in 2006-07 (figure 13.31). These figures reflect expenditure against the population regarded as the proxy for this chapter (see section 13.1), which is not the same as the HACC target population. Expenditure per person in the HACC target population is reported in table 13A.52.

Figure 13.31 **Australian, State and Territory government real expenditure on HACC services per person aged 70 years or over plus Indigenous people aged 50–69 years (2006-07 dollars)**[a, b, c]



[a] People aged 70 years or over plus Indigenous people aged 50–69 years are not the HACC target population. Expenditure per person and definition of the HACC target population are contained in table 13A.52. [b] This figure only represents expenditure under HACC Amending Agreements. [c] Reports provisional HACC data that have not been validated and may be subject to revision.

Source: DoHA (unpublished); table 13A.53.

Outcomes

Outcomes are the impact of services on the status of an individual or group (while outputs are the actual services delivered) (see chapter 1, section 1.5).

Three outcomes indicators have been identified for development and reporting in future:

- social participation in the community (box 13.23)
- maintenance of individual functioning (box 13.24)
- enabling people with care needs to live in the community (box 13.25).

Social participation in the community

Box 13.23 **Social participation in the community**

‘Social participation in the community’ is an indicator of the wellbeing and independence of frail older people. An indicator will be developed to show the extent to which older people participated in community, cultural or leisure activities. Higher rates of participation in the community are more desirable.

The Steering Committee has identified this indicator for development and reporting in future.

Maintenance of individual functioning

Box 13.24 **Maintenance of individual functioning**

‘Maintenance of individual functioning’ is an indicator that reflects the objective for aged care services to promote the health, wellbeing and independence of frail older people. The indicator is defined as:

- maintenance of, or minimised decline in, residents’ level of functioning reflected by a movement of clients to a higher level of need as indicated by a change in classification on the resident classification scale
- length of stay in residential care for a given level of frailty or age at entry.

The Steering Committee has identified this indicator for development and reporting in future.

Enabling people with care needs to live in the community

Box 13.25 **Enabling people with care needs to live in the community**

‘Enabling people with care needs to live in the community’ is an indicator that reflects the objective of community care to delay entry to residential care and will measure levels of dependency on entry to residential care for those who have been receiving community care.

The Steering Committee has identified this indicator for development and reporting in future.

13.4 Future directions in performance reporting

For several aspects of aged care services, indicators are not fully developed and there is little performance reporting. Priorities for the future include:

- continued improvement of efficiency indicators, including for HACC services and assessment services
- improved reporting of waiting times for residential aged care
- improved reporting of long term aged care in public hospitals
- development of outcome measures.

13.5 Jurisdictions' comments

This section provides comments from each jurisdiction on the services covered in this chapter. Appendix A contains data about each jurisdiction that may assist in interpreting the performance indicators presented in this chapter. These data cover a range of demographic and geographic characteristics, including age profile, geographic distribution of the population, income levels, education levels, tenure of dwellings and cultural heritage (including Indigenous and ethnic status).

Australian Government comments

The Commonwealth is keen to develop a stronger focus in the Review on the people for whom services are provided. In round numbers, 800 000 older people received aged care services in 2006-07. Of these, over half a million received support while still living at home through the HACC Program, jointly funded by the Commonwealth, states and territories. HACC also provided services to another quarter of a million people aged less than 70, most of whom are younger people with disabilities. These are not counted in the 800 000 people receiving aged care.

Some 55 373 people received Commonwealth CACPs or EACH packages – equivalent to 2.9 per cent of people aged 70 years or over (as at 30 June 2006 from the 2006 Census).

A further 202 502 people received permanent residential aged care at some stage during 2006-07 — equivalent to 10.6 per cent of people aged 70 years or over. 38 806 people received residential respite care during 2006-07 — equivalent to 2.0 per cent of people aged 70 years or over.

Some 6511 people received care in 2006-07 under the Transition Care Program, jointly funded by the Commonwealth and the states and territories.

During the 2006-07 financial year, over 80 000 veterans and war widows/widowers received either domestic assistance, personal care, home and garden maintenance, respite care or a combination of these services through the VHC program.

In accordance with the Commonwealth Procurement Guidelines, and to ensure the continuation of VHC services, the Department of Veterans' Affairs conducted an open procurement processes in 2006 for the selection of assessment agencies and service providers, with the result that the Department now contracts with over 190 organisations around Australia to assess clients for VHC services or deliver those services.

The Department also contracted with the University of Wollongong in early 2007 to conduct an independent review of the VHC program to identify what adjustments, if any, may be necessary to ensure the program continues to meet the needs of veterans and war widows/widowers over the coming years. In addition to VHC, eligible veterans, serving and former defence force members, their war widows/widowers and dependents have access to a wide range of health and other care services that promote and maintain self-sufficiency, wellbeing and quality of life.

New South Wales Government comments

“ The NSW Government is committed to providing quality services for older people and their carers which promote their health and wellbeing, optimise their independence and participation in community life, and facilitate their timely access to appropriate care and support.

This commitment is strongly reflected in both the State Plan and the State Health Plan (‘A New Direction for NSW — Towards 2010’) which were developed after extensive community consultation.

NSW is pursuing a number of strategies to improve the planning and delivery of care for frail older people. A key priority is to strengthen the integration of services across a range of providers and settings to improve the older person’s journey through the health and aged care continuum.

An *Interagency Protocol for Responding to Abuse of Older People* was developed which emphasised the principle that older people are entitled to the same level of protection as any other member of the community. The Protocol details a framework and provides information and resources for agencies and staff to assist them to better respond to the abuse of older people.

Additional resources have been allocated to services that enable older people with multiple care needs to return home from hospital safely and without unnecessary delay. These same services also provide support in the home to minimise the risk of avoidable re-admission to hospital.

The specialised aged care services that have been established in public hospital Emergency Departments continue to support the appropriate care and management of older people in these busy, high pressured settings.

The NSW Carers Program funds Non Government Organisations Grants, Carers Support Services in Area Health Services, services for carers of people with mental illness, peak body funding to Carers NSW through NSW Department of Health and a young carers project through the NSW Department of Ageing Disability and Home Care.

In 2006-07 the NSW HACC program continued to expand with the allocation of over $31 million in additional funding, bringing the total budget to more than $479 million.

Planning for the HACC program in 2006-07 continued toward a more strategic approach with the identification of regional priorities and strategies over the long, medium and short term. NSW priorities for growth funding in 2006-07 included an emphasis on basic support services and improved delivery to the HACC special needs groups. Growth funding highlights included increases in social support and transport services to improve clients’ and carers’ access to the community and reduce social isolation.

Following major reviews, guidelines for the HACC service types of case management, social support, respite, centre-based day care, home maintenance and home modification were developed. ”

Victorian Government comments

In 2006-07, Victoria has emphasised the individual at the centre of the care domain in further developing innovative approaches to meeting the challenges of providing aged care across the State. As in the past, Victoria continues to build its community-based services to meet the growing care needs of frail older people.

Victoria has been working with the Commonwealth to implement the 2006 COAG agreement *to simplify entry and assessment processes for the HACC Program*. Two Access Point Demonstration Projects have been established. The Access Point capacity in Victoria will be an easily identifiable and highly visible and well recognised point of contact for those frail older people, younger people with disabilities, their carers, families and friends who do not know where to go for initial information and assistance, including (if required) a referral for an assessment.

Younger people in residential aged care will benefit from alternative accommodation and support through the *my future my choice* initiative. A 10-bed unit to give younger people with a disability an alternative to living in residential aged care will be the first specialist home to be provided under this initiative.

Residents in Victoria's public sector residential aged care facilities are being supported to maintain their social connections with their community through the Victorian Government's *Count Us In!* initiative. This initiative promotes social inclusion for people living in residential aged care, helping to ensure that older citizens who move into this type of care can continue throughout their lives as valued members of their communities.

Residential aged care residents also benefited from new legislation and guidelines for medication management. The provisions extend coverage to all high care residents without regard to the type of facility, providing protection to a wider group while at the same time making better use of professional resources.

A number of innovative programs that provide outreach services have been funded. Outreach eye care and oral health services for people living in Supported Residential Services (SRS) facilities will be provided in a van fitted out with optometrical equipment to enable vision tests to be done on location at each SRS facility. Oral health services will involve local community health centre staff, with oral assessments, being completed on site at SRS facilities.

Innovation has continued to occur in the area of support for people with dementia and their families and carers. Funds have been made available for projects to develop dementia care information and/or services to meet the needs of people from Aboriginal and culturally and linguistically diverse backgrounds.

Queensland Government comments

Queensland has continued to support the programs and services that improve the quality of life of older people and has worked closely with the Australian Government and negotiated the HACC Amending Agreement during 2006-07.

Queensland received its final provisional approval of 78 transition care places bringing its allocation of places to 351. As at 30 June 2007, 249 of these places were operational across both residential and community settings. State government expenditure for the Transition Care Program in 2006-07 was $2.4 million.

With funding provided by the Australian Government through COAG, Queensland Health implemented a number of local based initiatives through the Long Stay Older Patients Program. These initiatives included capital works at the Gatton Hospital, interim care at Cairns and Townsville and Hospital in the Nursing Home at Bundaberg. Significant planning has also been undertaken in a number of sites across Queensland to expand the Multi-Purpose Health Service (MPHS) program.

Queensland continues to support 21 State owned and operated residential aged care facilities. In 2006-07, the State government contribution to the operations of these facilities was $48.4 million from an overall expenditure of $121.8 million. Other revenue was received from the Australian Government, resident charges and other miscellaneous sources to supplement the Queensland Government contribution. In addition as part of its $120 million redevelopment program, $20.7 million was expended on the upgrade of 10 of its residential aged care facilities.

During 2006-07, 37 365 aged care assessments were undertaken in Queensland through the Aged Care Assessment Teams jointly funded by both levels of government. In addition four projects have been progressed under funding provided through COAG in relation to the improvement of consistency and timeliness of aged care assessments. These projects are the development of a business case model for ACATs, supporting the ACAT workforce, developing of protocols to improve access by Indigenous and people from culturally and linguistically diverse background to ACAT assessments and the provision of infrastructure to improve the collection and quality of data.

In recognition of the need to protect older residents in residential aged care facilities from elder abuse, Queensland Health has ensured that criminal history checks are undertaken on all staff in these facilities. A training program including protocols and mechanisms to improve the identification and reporting of cases of elder abuse in residential aged care facilities is being developed.

Western Australian Government comments

“The approach to services for older people continues to develop in line with the ongoing reform agenda occurring across the WA health system. The WA health system change and redesign incorporates the shared principles outlined in *A Healthy Future for Western Australians: Report of the Health reform Committee.*

In response to the change in policy direction an Aged Care Network has been set up to develop the *Model of Care for Older Persons* that relates to the continuum of care service delivery across the WA health system and beyond. The conceptual and strategic framework for the State Aged Care Plan for WA 2003–2008 has guided the work of the Aged Care Network since its inception in February 2006.

The *Model of Care for Older Persons* focuses on the need to promote independence, well-being and quality of life for the older person with a greater emphasis on prevention and promotion programs that encourage self management. It includes a partnership approach across the community, acute and residential aged care sectors, including improved coordination and communication processes. It is also being used to inform the development of the service specific models with the initial focus on Dementia, Delirium, Falls, Parkinson’s, Amputees, Rehabilitation, Ortho-Geriatrics and Geriatric Evaluation Management.

Implementation of the National Action Plan (NAP), (Health Care of Older Australians Standing Committee) in WA is another key component of work being undertaken to progress system wide coordination for older people accessing aged care services thorough the establishment of an eldercare pathway. This work is being supported in part by strengthening existing hospital strategies, including safe and effective discharge from emergency departments, improved patient and carer health outcomes, early identification, assessment and care planning for older people at risk and implementing best practice clinical resources developed as part of the NAP.

The WA HACC Program continues to progress development of Access Networks in Esperance (rural), Derby (remote) and the Swan Local Government Area (metropolitan) that will simplify client access, eligibility and assessment processes into community care. Agencies that form part of the Access Network will provide information, initial screening and data collection, with the goal of assisting clients/carers to access the most appropriate referral and support into community care services. Access Network agencies will form part of an interconnected network of community care agencies that deliver services and/or support to frail aged and younger people with disabilities living in the community.

An ‘ACAP Quality Framework’ has been developed and implemented along with some work around strengthening communication with ACATs and ACAT management. These initiatives are expected to provide an effective environment to progress the ACAP COAG initiatives.”

South Australian Government comments

> “The Department for Families and Communities through the Office for the Ageing (OFTA) has led the development and implementation of *Improving with Age: Our Ageing Plan for South Australia*. *Improving with Age* is the State Government’s blueprint for its response to an increasingly ageing population. Since its launch in February 2006, OFTA has provided over $4 million to kick-start over 40 innovative projects to implement the Ageing Plan. Currently, over 135 State Government initiatives are operating across the state, which are making a difference to the lives of older South Australians.
>
> SA actively participated in the trialling of the Australian Community Care Needs Assessment and the Carers Eligibility Needs Assessment in 2006, with the involvement of non-government and government, country and metropolitan agencies. In 2007, SA identified two sites, one country and one metropolitan, to demonstrate access points for community care. The demonstration sites build on existing infrastructure, but will expand their role across the broader sector.
>
> ACAP projects developed under the COAG initiative of improving timeliness and consistency of assessments have included a review of assessment practices across ACATs, and the development of a Mobile Assessment Response (MAR). The MAR aims to provide support and back-up to teams especially in unforseen circumstances, to improve the availability of particular areas of expertise, and to respond to assessment needs in remote communities.
>
> OFTA is reforming the way that it allocates growth funding to services for frail older people, people with disabilities and carers through the HACC Program. In 2007-08, new funding allocation processes including invited submission and direct allocation were introduced in country regions and for Aboriginal and culturally and linguistically diverse community organisations. The new funding allocation processes have introduced more appropriate and targeted methods of funding disadvantaged groups and have streamlined and simplified administrative processes with benefits to both OFTA and the sector. In 2008-09, new funding allocation processes will be rolled out to metropolitan regions.
>
> SA is currently developing a Triennial Plan for the HACC Program which will commence in 2008-09. The Plan will outline the agreed Australian Government and State Government strategic directions, priorities and allocation of funds for the HACC Program over the triennium. SA has undertaken extensive consultation processes to inform the Triennial Plan, including with peak bodies, key stakeholders, special needs groups, service providers and consumers at a regional and sub-regional level. In particular, the Council on the Ageing SA has been engaged by OFTA to facilitate statewide consumer consultations with older people.”

Tasmanian Government comments

“ *Tasmania’s Health Plan*, released in May 2007, is an integrated strategy incorporating both acute health services and primary health services. The key focus and objective of *Tasmania’s Health Plan* is sustainability. This seeks to ensure that health services are safe, effective and accessible and make the best use of available resources. Aged care and rehabilitation are a defined area for development in the Plan.

A separate and interlinking statewide Rehabilitation Services Review was also commissioned and conducted during 2006-07. It is anticipated that the reforms will enhance specialised health service delivery for older people.

Tasmania’s Health Plan includes a greater focus on primary health, increasing health promotion and better management of chronic illnesses. It establishes a new tiered service structure for both primary and acute health, with a change of role for some facilities including reconfiguring under-used and unsustainable district hospital and residential aged care services, with resources redirected to primary health care and home based care services.

Service development and redesign initiatives during 2007 have included:

- ongoing management of the *Tasmanian Post Acute Support Program* providing services to eligible HACC clients
- projects funded under the *Pathways Home Program* supporting education, step down and rehabilitation services
- ongoing implementation of recommended service changes from the *Palliative Care in Tasmania: Current Situation and Future Directions Report*
- implementation of the national Transition Care Program and the COAG Long Stay Older Patient initiative have supported quality development of age friendly principles and practices
- development of a HACC data repository which will include a range of service and client data and be capable of linking and communicating with HACC service providers
- the establishment of a demonstration site, in collaboration with the Australian Government, for simplified entry to community care, including HACC.

The removal of the legacy requiring State governments to supplement non-government operators in respect of former State operated residential aged care places is a welcome initiative. The Tasmanian Government looks forward to continuing to work with the Australian Government in removing the burden associated with those beds that the Tasmanian Government itself continues to operate. The reduced subsidy and consequent need by the Tasmanian Government to top-up funding, increases the financial pressures on those services that, due to their small size and remote location, make them non-viable for other providers. ”

Australian Capital Territory Government comments

“ During 2006-07 the ACT Government has remained committed to assisting older people and their carers by providing better access to appropriate services and promoting independence and participation in community life.

access health was launched in 2006-07 by the Minister for Health as a key document to set the future direction of ACT health services for the next three years. *access health* is about ensuring that people have access to the right type of health care. The ACT Government identified priorities include:

- timely access to care
- aged care
- mental health
- chronic disease management
- early childhood and vulnerable families
- Aboriginal & Torres Strait Islander health.

A new purpose built sub and non-acute and psycho-geriatric facility was officially opened in February 2007 boosting the bed and service capacity of ACT public hospitals. The new facility added 28 new sub and non-acute beds to the existing 12 geriatric evaluation management beds at the Calvary Hospital. The facility also provides 20 new psycho-geriatric beds to meet the needs of older people with a mental illness in the ACT and enhance care options.

The Medical Assessment and Planning Unit opened in May 2007. The new Unit aims to improve the older persons experience through the Emergency Department by streamlining admission and intervention processes, facilitating early consultant review, expediting multidisciplinary review and providing better access to more appropriate services.

The ACT also added the Rapid Assessment of the Deteriorating Aged at Risk (RADAR) program to support older people in the community in 2006-07. RADAR provides short term assistance with medical management to an older persons own GP to prevent a hospital admission.

The HACC program was enhanced by an additional $1.8 million in 2006-07 to provide support services to assist people to remain in the community. The focus of additional HACC funding provided additional levels of personal care, social support, home maintenance and domestic assistance. The enhanced service delivery of HACC services in the ACT has provided more options for older people and their carers, and helps avoid premature entry into residential aged care. ”

Northern Territory Government comments

“The unique environmental and socio economic factors in the Northern Territory create specific challenges in the provision of aged care services for both the Northern Territory and Australian Governments, particularly in providing appropriate and sustainable aged care services to remote Indigenous communities. The high proportion of people living in remote settings creates increased cost structures for all services, particularly due to the cost of travel, staff retention and recruitment, and in providing a service to small numbers over large geographical areas.

Data quality remains an ongoing challenge for providers in the Northern Territory, given the need to integrate funds across aged care and disability programs to create viable services, especially in remote communities. Data quality issues can distort results in individual programs. During 2006-07 the Northern Territory consolidated the effort of the previous year in improving the participation rates as well as the quality of the HACC National Minimum Data Set (MDS) from providers. There remains an ongoing challenge of ensuring good data quality from the large number of small and dispersed providers, particularly given that these providers receive funds from multiple funding sources.

In 2006-07 the quality focus was the development of a number of standardised initiatives supporting Territory-wide approaches, while retaining flexibility in region specific HACC services.

During 2006-07 the new *Carers’ Recognition Act* with a specific Carers’ Charter came into effect. Subsidies and concessions on cost of essential services similar to those available to pensioners was extended to carers in the Northern Territory and $1.05 million was allocated for this purpose by the Northern Territory Government in 2006-07. The Pensioner Concession and Carer’s Scheme was further consolidated by the linking of the Northern Territory Senior’s Card administratively with the above schemes.

Aged care services in remote areas face real challenges in terms of sustainability and viability of service contributed by remoteness, limited economies of scale, staff recruitment and retention issues. Innovative service models, which include pooling resources from a range of programs, and closer links with health services, provide opportunities for addressing these issues.

Projections of future Northern Territory potential population estimates in the report are based on small sample sizes and subsequently have high standard error rates.

Indicators based on these estimates need to be interpreted with caution. Similarly small variations in Northern Territory aged care data appear magnified in the report.”

13.6 Definitions of key terms and indicators

Adjusted subsidy reduction supplement	Payments made to equalise the recurrent funding paid by the Australian Government as adjusted subsidy reduction places to public sector residential care operators. The states and territories provide top-up funding for residential aged care places at a rate set by the Minister for Health from 1 July each year.
Aged care	Formal services funded and/or provided by governments, that respond to the functional and social needs of frail older people, and the needs of their carers. Community aged care services aim to optimise independence and to assist frail older people to stay in their own homes, while residential care services provide accommodation and care for those who can no longer be assisted to stay at home. The majority of aged care services assist in activities of daily living such as personal care (for example, bathing and dressing), housekeeping and meal provision, and are delivered by trained aged care workers. However, aged care services may also be delivered by health professionals such as nurses and occupational therapists. These services generally aim to maintain function rather than treat illness or rehabilitate, and are distinguished from the health services described in Part E of this Report. Assessment of care needs is also an important component of aged care. Aged care services may be funded through programs specifically or mainly directed to older people, or through programs that address the needs of people of different ages. Generally, the target groups of aged care services are people over the age of 70 years and Indigenous people aged over 50 years.
Ageing in place in residential care	An approach that aims to provide residents with appropriate care and increased choice by allowing them to remain in the same facility regardless of changes in their level of care needs. It also allows couples with different levels of care needs to be cared for in the same facility. The main facet of 'ageing in place' is that funding is tied to the assessed care needs of the client rather than to the services provided by the facility. One of the objectives of Australian Government aged care legislation is 'to promote ageing in place through the linking of care and support services to the places where older people prefer to live' (*Aged Care Act 1997* (Cwlth), s.2-1 [1j]).
Capital expenditure on residential services	Expenditure on building and other capital items, specifically for the provision of Australian government funded residential aged care.
Centre day care	Respite care provided from a facility such as a day care or health centre. Respite care is usually combined with social support services to maintain the functional capabilities of the person receiving care.
Complaint	A complaint by the affected care recipient or his or her representative, or anyone else, to the Secretary about anything that: • may be a breach of the relevant approved provider's responsibilities under the *Aged Care Act 1997* or the Aged Care Principles • the complainant thinks is unfair or makes the affected care recipient dissatisfied with the service.

Dementia services program	Includes flexible and innovative support, respite, counselling, information and referral services, education and leisure. The program includes meeting individual and immediate needs which cannot be met by other services, through carer respite services and other carer support agencies. Inpatient services are excluded.
Disability	A limitation, restriction or impairment that has lasted, or is likely to last, for at least six months and restricts everyday activities.
EBA supplement	Payments made to supplement services for the extra costs associated with public sector enterprise bargaining agreements over and above those required by other wage Awards.
Elapsed time between ACAT approval and entry into a residential care service	The measure of the elapsed time between ACAT approval and entry into a residential care service. It has been used in past years as an indicator of access to residential care.
HACC target population	The HACC Target population is people in the Australian community who, without basic maintenance and support services provided under the scope of the HACC Program, would be at risk of premature or inappropriate long term residential care, including (i) older and frail people with moderate, severe or profound disabilities; (ii) younger people with moderate, severe or profound disabilities; and (iii) such other classes of people as are agreed upon, from time to time, by the Commonwealth Minister and the State Minister; and the unpaid Carers of people assessed as being within the National Program's target population. The HACC Target Population is estimated by applying the proportion of people in households with a moderate, severe, or profound disability as reported in the ABS 2003 Survey of Disability, Ageing and Carers to the ABS Population Projections by SLA 2002–2022.
High/low care recipient	Recipient of a high level of residential care (that is, a level to RCS levels 1–4) or a recipient of a low level of residential care (that is, a level corresponding to RCS levels 5–8). If the person is approved as a recipient of a high level of care, that person can receive care at any care classification level (*Approval of Care Recipients Principles 1997*, s.5-9). A person approved as a recipient of a low level of care can be classified on entry only as RCS 5–8 (*Classification Principles 1997*, s.9-19).
In-home respite	A short term alternative for usual care.
People from non-English speaking countries	People who were born in non-English speaking countries. English-speaking countries are defined as Australia, New Zealand, the United Kingdom, Ireland, the United States, Canada and South Africa.
People with a moderate disability	Where a person does not need assistance, but has difficulty with self care, mobility or communication.
People with a profound disability	Where a person is unable to perform self-care, mobility and/or communication tasks, or always needs assistance.
People with a severe disability	Where a person sometimes needs assistance with self-care, mobility or communication.
Personal care	Assistance in undertaking personal tasks (for example, bathing).
Places	A capacity within an aged care service for the provision of residential care, community care or flexible care in the residential care context to an individual (*Aged Care Act 1997* (Cwlth)); also refers to 'beds' (*Aged Care (Consequential Provisions) Act 1997* (Cwlth), s.16).
Real expenditure	Actual expenditure adjusted for changes in prices, using the GDP(E)

	price deflator and expressed in terms of final year prices.
Resident	For the purposes of the *Aged Care Act 1997*, a person who is being provided with residential care through an aged care service conducted by an approved provider under the Act.
Respite care	Alternative care arrangements for dependent people living in the community, with the primary purpose of giving their carer a short term break from their usual caring commitments.
Rural small nursing home supplement	Payments made by states and territories to small sized high care public sector residential aged care facilities (up to 30 places) that are located in rural areas. Three levels of supplement are paid to facilities varying in size from 10 to 20 and 30 places.
Special needs groups	Section 11-3 of the Aged Care Act, specifies the following people as people with special needs: people from Aboriginal and Torres Strait Islander communities; people from non-English speaking countries; people who live in rural or remote areas; and people who are financially or socially disadvantaged. Principles (Regulations) made under s. 11-3 also specify veterans as a special needs group.
State-only HACC expenditure	Additional to state matching amount already reported but not including local government.
Veterans	Veterans, their war widows, widowers and dependents who are eligible for treatment through the Department of Veterans' Affairs under the provisions of the *Veterans' Entitlements Act 1986* (Cwlth).

13.7 Attachment tables

Attachment tables are identified in references throughout this chapter by an 'A' suffix (for example, table 13A.3 is table 3 in the attachment). Attachment tables are provided on the CD-ROM enclosed with the Report and on the Review website (www.pc.gov.au/gsp). On the CD-ROM, the files containing the attachment tables are provided in Microsoft Excel format as \Publications\Reports\2008\Attach13A.xls and in Adobe PDF format as \Publications\Reports\2008\Attach13A.pdf. Users without access to the CD-ROM or the website can contact the Secretariat to obtain the attachment tables (see contact details on the inside front cover of the Report).

13.8 References

ABS (Australian Bureau of Statistics) 2003, *Australian Standard Geographic Classification,* Cat no. 1216.0, Canberra.

—— 2004a, *Survey of Disability, Ageing and Carers, 2003,* Cat no. 4430.0, Canberra.

—— 2004b, *Experimental Estimates and Projections, Aboriginal and Torres Strait Islander Australians,* Cat no. 3238.0, Canberra.

—— 2006a, *Australian Historical Population Statistics, 2006,* Cat. no. 3105.0.65.001, Canberra.

—— 2006b, *Population Projections Australia 2004–2101,* Cat. no. 3222.0, Canberra.

AIHW (Australian Institute of Health and Welfare) 2002, *Entry Period for Residential Aged Care*, Cat. no. AGE 24, AIHW Aged Care Series no. 7, Canberra.

COAG (Council of Australian Governments), 2006, Better Health For All Australians Action Plan Attachment D to COAG meeting, 10 February 2006, http://www.coag.gov.au/meetings/100206/attachment_d_better_health.rtf

14 Services for people with a disability

The Australian, State and Territory governments aim to maximise opportunities for people with a disability to participate actively in the community, by providing services and support for people with a disability, their families and carers.

This chapter focuses on services covered by the third Commonwealth State/Territory Disability Agreement (CSTDA), which applied to the period 1 July 2002 to 30 June 2007. The Australian Government and State and Territory governments are currently negotiating a fourth CSTDA.

The CSTDA forms the basis for the provision and funding of services for people with a disability, where the person’s disability manifests before the age of 65 years and for which they require ongoing or long term episodic support. Specialist psychiatric disability services are excluded from the chapter to improve data comparability across jurisdictions.

Services for people with a disability can be grouped into income support, disability support services and relevant generic services provided to the community as a whole. This Report generally does not report performance information on income support. Disability support services are primarily delivered under the CSTDA, as well as through programs such as Home and Community Care (HACC) and Commonwealth Rehabilitation Services (CRS) Australia. Performance information on the HACC program is provided in the ‘Aged care services’ chapter (chapter 13). CRS Australia’s services are not covered in this Report.

Some generic services provided to the community as a whole are covered elsewhere in this Report — for example, school education (chapter 4), vocational education and training (VET) (chapter 5), public hospital care (chapter 10), specialised mental health services (chapter 12) and public housing (chapter 16). Other generic services provided to people with a disability — such as transport and utility services at concessional rates — are outside the scope of this Report.

Results in this chapter that are derived using the service user data collected under the CSTDA National Minimum Data Set (NMDS) need to be interpreted with caution. These service user data have a number of quality issues, which are discussed in section 14.6.

Significant improvements in the reporting of services for people with a disability in this year's Report are the inclusion of:

- jurisdictional data on people with a disability aged 0–49 years in residential aged care
- a new section on informal carers that reports data on the:
  - age distribution of carers of CSTDA service users, by geographic location
  - impact that the primary caring role has on informal carers' labour force participation
- data on the proportion of people with a disability who had difficulty accessing government and other services as a result of their disability.

A profile of services provided under the CSTDA for people with a disability appears in section 14.1. A framework of performance indicators is outlined in section 14.2. The performance of jurisdictions is discussed in section 14.3 and future directions for performance reporting are discussed in section 14.4. Section 14.5 contains jurisdictions' comments and section 14.6 contains an appendix on service user data quality and other issues. Section 14.7 provides definitions of the data descriptors and indicators and section 14.8 lists the attachment tables for this chapter. Attachment tables are identified in references throughout the chapter by an 'A' suffix (for example, table 14A.3 is table 3 in the attachment). Attachment tables are available on the CD-ROM enclosed with the Report or from the Review website (www.pc.gov.au/gsp). Section 14.9 lists references used in this chapter.

14.1 Profile of specialist disability services

Service overview

The CSTDA defines 'specialist disability services' as 'services or initiatives specially designed from time to time to meet the needs of people with disabilities' (CSTDA 2003, p. 10). A definition of disability is provided in box 14.1.

Box 14.1 **Definition of disability**

The International Classification of Functioning, Disability and Health defines disability as being an experience for the person involved that may include the impairment of their body structure and function, limitation of their activity and restriction of their participation in life areas. The International Classification of Functioning, Disability and Health also recognises the role of physical and social environmental factors in affecting disability (WHO 2001).

The Australian Bureau of Statistics (ABS) Survey of Disability, Ageing and Carers (SDAC) was conducted in 1981, 1988, 1993, 1998 and 2003, and was based on the International Classification of Functioning, Disability and Health and its predecessor. The 2003 survey defined a disability as a limitation, restriction or impairment that has lasted, or is likely to last, for at least six months and restricts everyday activities.

Self care, mobility and communication are defined as core activities. The ABS defines levels of core activity limitation as follows:

- mild — where a person does not need assistance and has no difficulty with self care, mobility and/or communication, but uses aids or equipment
- moderate — where a person does not need assistance, but has difficulty with self care, mobility and/or communication
- severe — where a person sometimes needs assistance with self care, mobility and/or communication tasks; 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
- profound — where a person is unable, or always needs assistance, to perform self care, mobility and/or communication tasks.

The CSTDA (2003, p. 9) defines ‘people with disabilities’ as those whose disability manifests itself before the age of 65 years and for which they require significant ongoing and/or long term episodic support. For these people, the disability will be attributable to an intellectual, psychiatric, sensory, physical or neurological impairment or acquired brain injury (or some combination of these) which is likely to be permanent and results in substantially reduced capacity in at least one of the following:

- self-care/management
- mobility
- communication.

Source: ABS (2004c); WHO (2001); CSTDA (2003).

Details of the specialist disability services provided under the CSTDA are outlined in the following section on roles and responsibilities. Mechanisms for the funding and delivery of these services differ across jurisdictions as a result of policy differences. Further contextual information is provided in appendix A.

Roles and responsibilities

Australian, State and Territory governments

The CSTDA defines the roles and responsibilities of the Australian, State and Territory governments in the provision of services to people with a disability. Its agreed purposes are listed in box 14.2.

Box 14.2 **The purposes of the CSTDA**

The purposes of the CSTDA are to:

- provide a national framework to underpin the provision of specialist disability services across Australia, and outline a means for measuring and publicising the progress of governments towards achieving this national framework
- outline the respective and collective roles and responsibilities of governments in the planning, policy setting and management of specialist disability services
- provide for accountability to funders in respect of funds contributed by one government which are expended by another government
- establish the financial arrangements for making funds available for the provision of specialist disability services
- define the persons eligible for services under this Agreement and acknowledge they may require services provided outside the Agreement
- provide for a nationally consistent approach to quality across specialist disability services
- provide for funds to address key national and strategic research, development and innovation priorities.

Source: CSTDA (2003, pp. 4–5).

The Australian Government administers the following services:

- open employment services that provide assistance to people with a disability in obtaining and/or retaining paid employment in the open labour market
- supported employment services that provide support to, and employment for, people with a disability within the same organisation.

Prior to 1 December 2004, the Australian Government also administered services that provided both open and supported employment assistance.

State and Territory governments administer the following services:

- accommodation support services that provide support to people with a disability in accommodation settings (hostels, institutions and group homes), and in their own home (including attendant/personal care, in home support and alternative family placements)
- community access services that provide opportunities for people with a disability to gain and use their abilities to enjoy their full potential for social independence — including learning and life skills development and recreation/holiday programs
- community support services that help people with a disability to integrate and participate in the community, including case management, counselling, early intervention therapy and other therapy services
- respite care services that provide relief or support (for limited periods) to families and carers of people with a disability who are living in the community.

Australian, State and Territory governments share responsibility for administering the following services:

- advocacy services that enable people with a disability to increase their control over their lives by representing their interests and views in the community
- information services that provide accessible information to people with a disability, their carers, families and related professionals about disabilities, specific and generic services and equipment; and promote the development of community awareness
- print disability services that produce alternative communication formats for people who, by reason of their disability, are unable to access information provided in a print medium
- research and development projects relating to:
  - the provision of services funded under the CSTDA
  - the achievement of the national framework under the CSTDA for people with a disability.

The CSTDA does not apply to the provision of:

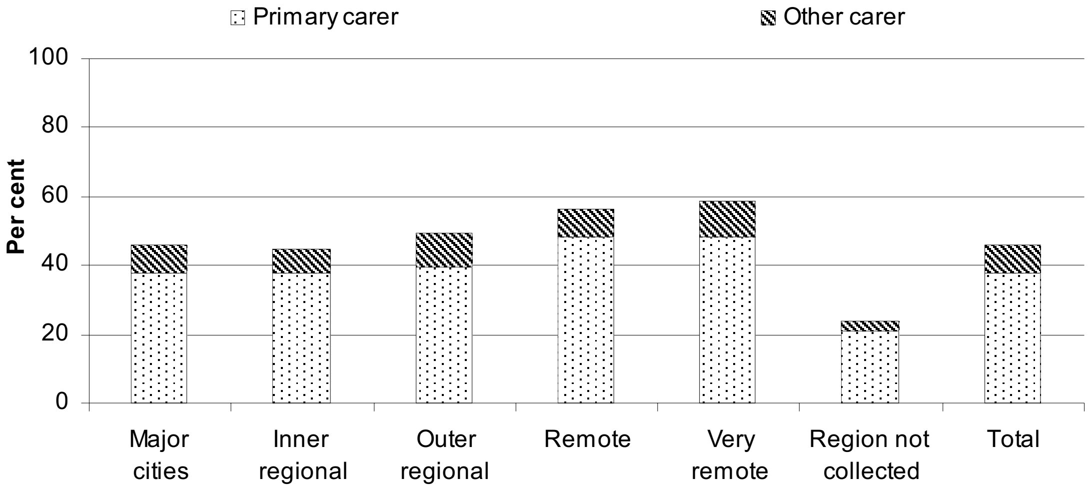
- disability services and activities provided under the *Veterans' Entitlements Act 1986* (Cwlth)
- services with a specialist clinical focus, regardless of whether those services are provided to people eligible to receive services under the CSTDA.

Informal carers

Family and friends provide the most assistance in meeting the needs of people with a disability. An informal carer is a person of any age who provides any informal assistance, in terms of help or supervision, to people with a disability. This assistance has to be ongoing, or likely to be ongoing, for at least six months. A 'primary carer' is the informal carer who provides the most informal assistance. This assistance has to be provided for one or more of the three core activities — self-care, mobility or communication (ABS 2004c). In 2003, an estimated 474 600 primary carers provided the majority of informal help with self care, mobility and communication for people with a disability — an increase of 5.3 per cent since 1998 (ABS 1999, 2004c).

Of people with a disability who accessed CSTDA funded services in 2005-06, 45.8 per cent reported having an informal carer and 37.9 per cent reported having an informal carer who was a primary carer (figure 14.1)[1]. Service users in remote or very remote locations were more likely to report having an informal carer than those in other areas.

Figure 14.1 **Users of CSTDA-funded services who reported having an informal carer, by primary carer status and geographic location, 2005-06**[a, b, c]



[a] Total includes data for service users whose location was not collected/identified. [b] These data need to be interpreted with caution due to a number of factors impacting on data quality. See section 14.6 for further information on these quality issues. [c] Data relating to primary carers are not reported for all service users. Some service types are not required to collect all service user data items. For example, employment services are not required to collect selected informal carer information, including primary status.

Source: AIHW (2007).

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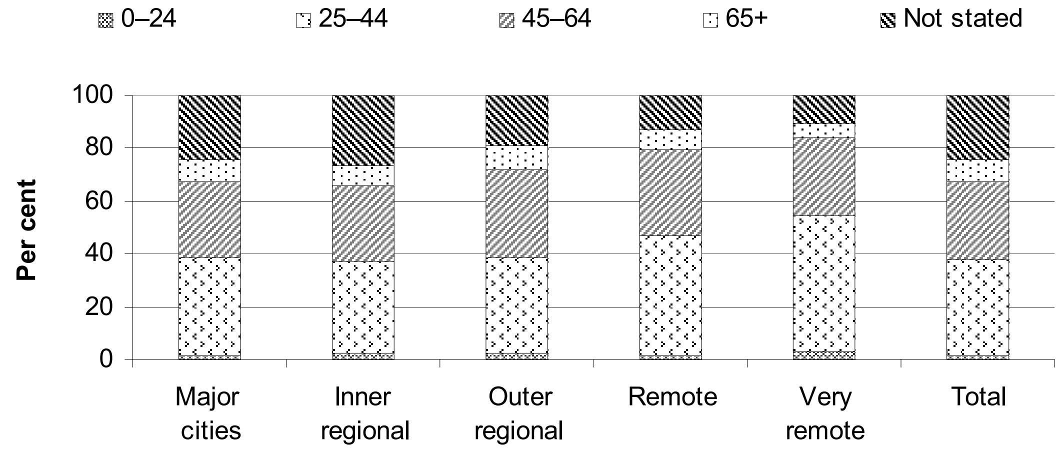
[1] The definition of informal carers used in the CSTDA NMDS differs slightly from the definition used in the SDAC. See section 14.7 for these definitions.

Information about the age distribution of primary carers enables governments to plan ahead with respect to the future demand for services that may arise as carers age. As the proportion of primary carers who are over 65 years increases, for example, there may be a greater need for access to respite or in home accommodation support services. Figure 14.2 shows the proportions of informal primary carers who are in different age groups by location.

Figure 14.2 **Age distribution of informal carers who are primary carers of people accessing CSTDA funded services, by location, 2005-06**[a]



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[a] These data need to be interpreted with caution due to a number of factors impacting on data quality. See section 14.6 for further information on these quality issues.

Source: AIHW (2007).

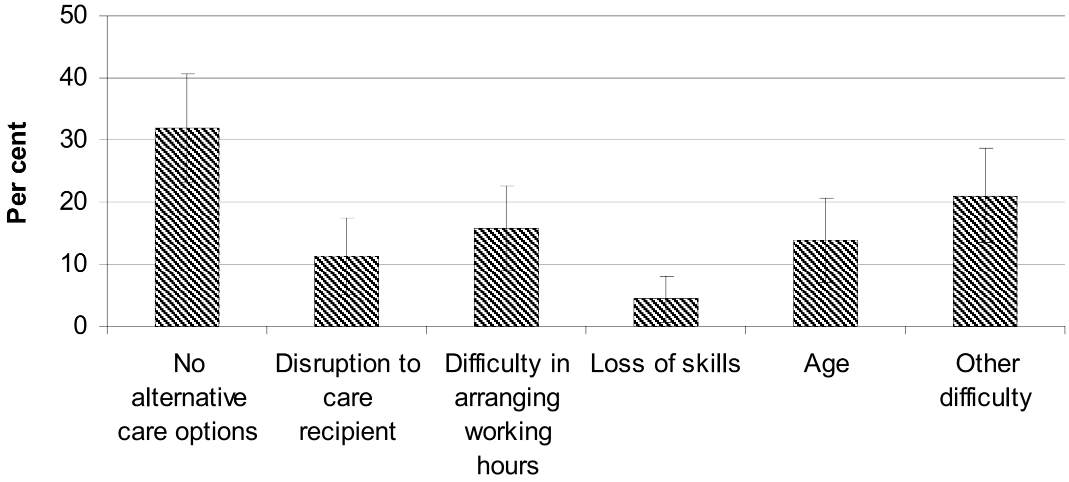
Under the human capital stream of the national reform agenda, the Council of Australian Governments (COAG) is seeking to reduce the proportion of the working age population not participating or who are under-participating in paid employment. One indicative progress measure identified is the proportion of people of working age who are not participating or who are under-participating in the labour force due to disability — including those providing informal care for people with a disability.

The ABS SDAC 2003 provides information regarding the impact that the primary caring role has on informal carers' labour force participation.

- An estimated 37.8 per cent of primary carers were employed — of these 23.0 per cent had reduced their working hours to take on their caring role.
- The remaining 62.2 per cent of primary carers were either unemployed or not in the labour force — of these, 30.8 per cent had worked before commencing their caring role.

- For those primary carers who were unemployed or not in the labour force and not yet retired (60.5 per cent of all primary carers), 24.1 per cent wanted to return to work. Figure 14.3 shows the most significant perceived barriers for primary carers who wanted to return to work.

Figure 14.3 **Perceived barriers to returning to work for primary carers who want to return to work, 2003[a]**



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[a] Estimates for ‘disruption to care recipient’ and for ‘loss of skills’ have relative standard errors between 25–50 per cent and should be used with caution.

Source: ABS (2003c).

The Australian Government provides income support in the form of the Carer Payment and other financial assistance through the Carer Allowance to carers of people with a disability (box 14.3). This financial assistance is not included under the CSTDA funding arrangements.

Box 14.3 **Australian Government supplementary and income support arrangements**

The Australian Government funds income support payments for people with a disability, those caring for people with a disability and those temporarily incapacitated from work as a result of illness. These payments include the Disability Support Pension, the Carer Payment, the Carer Allowance, the Sickness Allowance and the Mobility Allowance. Outlays on payments to people with a disability in 2006-07 (on an accrual basis) amounted to $8.7 billion for the Disability Support Pension, $1.4 billion for the Carer Payment (includes expenditure on carer bonus), $1.3 billion for the Carer Allowance (includes expenditure on carer bonus), $85.2 million for the Sickness Allowance and $106.4 million for the Mobility Allowance (Department of Family, Community Services and Indigenous Affairs (FaCSIA) (unpublished) and Department of Employment and Workplace Relations (DEWR) (unpublished)). These income support arrangements do not constitute a CSTDA service.

At 30 June 2007, there were around 714 200 recipients of the Disability Support Pension, 116 600 recipients of the Carer Payment, 407 900 recipients of the Carer Allowance, and around 54 900 recipients of the Mobility Allowance. There were also around 7600 recipients of the Sickness Allowance (table 14A.2).

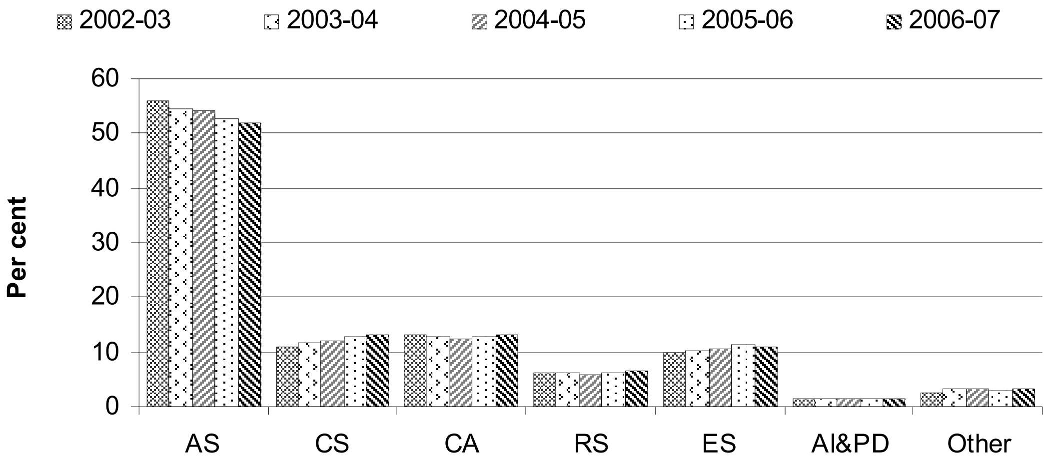
Source: FaCSIA (unpublished); DEWR (unpublished); table 14A.2.

Funding

Under the CSTDA, Australian and State and Territory governments fund both government and non-government providers of services for people with a disability. Total government expenditure on CSTDA funded services was $4.3 billion in 2006-07 — a real increase of 6.7 per cent on the expenditure in 2005-06 ($4.1 billion) (table 14A.5). State and Territory governments funded the majority of this expenditure in 2006-07 (74.2 per cent, or $3.2 billion). The Australian Government funded the remainder (25.8 per cent, or $1.1 billion), which included $624.6 million in transfer payments to states and territories (tables 14A.6 and 14A.7).

Direct government expenditure on CSTDA funded services (that is, excluding expenditure on administration) was $3.9 billion in 2006-07 (table 14A.3). The distribution of direct government expenditure varied across jurisdictions in 2006-07. The main areas of State and Territory government expenditure were accommodation support services (51.8 per cent of total direct service expenditure), and community support services (13.2 per cent of total direct service expenditure) (figure 14.4). Employment services were the main area of Australian Government expenditure in 2006-07 (11.0 per cent of total direct service expenditure and 93.4 per cent of Australian Government direct service expenditure) (table 14A.4).

Figure 14.4 **Direct expenditure on CSTDA funded services, by service type**[a]



AS = accommodation support; CS = community support; CA = community access; RS = respite services; ES = employment services; AI&PD = advocacy, information and print disability. [a] See table 14A.3 for detailed notes accompanying expenditure data.

Source: Australian, State and Territory governments (unpublished); table 14A.4.

Size and scope

Disability prevalence

The ABS estimated that one in five people in Australia (3 958 300 or 20.0 per cent) had a reported disability (that is a core activity limitation, a schooling or employment restriction or an impairment) in 2003 (ABS 2004c). Of the population aged 5–64 years in 2003, an estimated 13.0 per cent had a core activity limitation or specific restriction. This proportion comprised 4.0 per cent who had a profound or severe core activity limitation, a further 6.6 per cent who had a mild to moderate core activity limitation, and 2.4 per cent who had a schooling or employment restriction only (ABS 2004c). Table 14A.9 contains additional information on disability prevalence, and table 14A.10 contains information on the proportion of those with a profound or severe core activity limitation who needed help that received help.

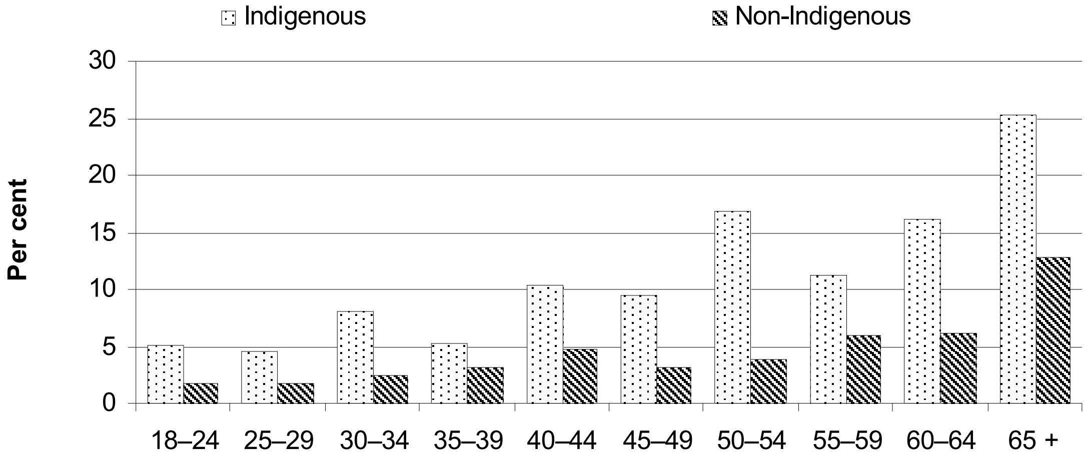
Aboriginal and Torres Strait Islander people

Indigenous people have significantly higher rates of profound or severe core activity limitation than non-Indigenous people. The Australian Institute of Health and Welfare (AIHW) estimated that the proportion of Indigenous people aged over 18 years who had a profound or severe core activity limitation was approximately 2.4 times that of non-Indigenous people in 2002 (AIHW 2006b). This estimate is based on data from the ABS's General Social Survey (GSS) and National Aboriginal and Torres Strait Islander Social Survey (NATSISS) and takes into account differences in the:

- age structure of the Indigenous and non-Indigenous populations
- method that was applied in remote areas for the two surveys (for further details on the difference in method see AIHW 2006b).

The difference (in rate ratio terms) between the populations is most marked for people aged 50–54 years and those aged 30–34 years (figure 14.5).

Figure 14.5 **Proportion of age groups who have a profound or severe core activity limitation, by Indigenous status, 2002[a]**



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[a] For the NATSISS, there were a number of differences in the 'screening' questions used to establish disability status and disability type for persons living in remote and non-remote areas. While a 'common' set of questions was asked in both remote and non-remote areas, some additional questions were asked in non-remote areas only. The expanded set of screening questions asked in non-remote areas is referred to as the 'broader criteria', the smaller set is referred to as the 'common criteria'. For the reported proportions, the relative impact of the broader criteria on the Indigenous estimate in non-remote areas was calculated and applied as a weight to the estimate for remote areas. The non-Indigenous estimates from the GSS are based on the broader criteria only (AIHW 2006b).

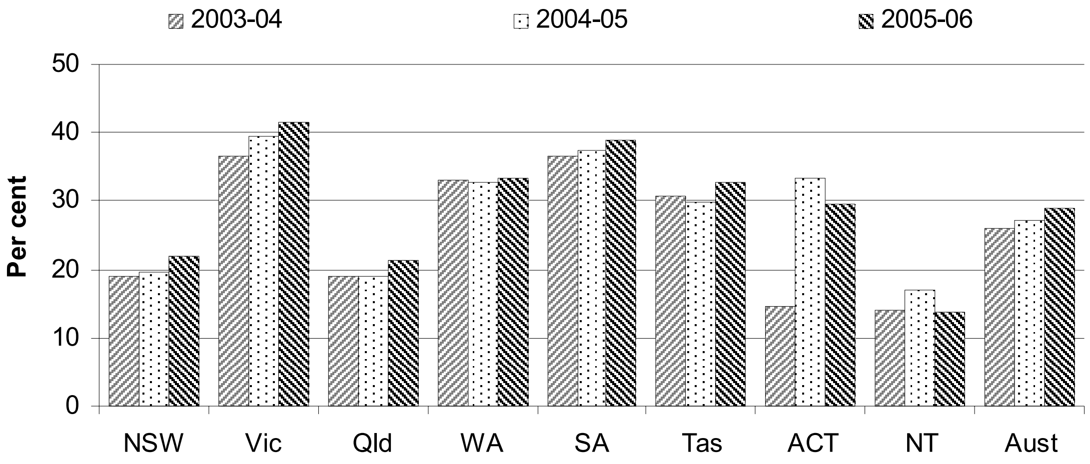
Source: AIHW (2006b).

The *Overcoming Indigenous Disadvantage: Key Indicators 2007* contains additional data from the GSS and NATSISS, including a comparison of the Indigenous and non-Indigenous peoples rates of selected long-term health conditions (SCRGSP 2007).

Use of CSTDA funded services

In 2005-06, 205 283 people were reported as using services provided under the CSTDA (excluding users who received specialist psychiatric disability services only) (table 14A.1). Nationally, this is 29.1 per cent of the estimated potential population (that is, people aged under 65 years who meet the service eligibility criteria for specialist disability services (see section 4.7 for a definition)) (figure 14.6).

Figure 14.6 **Users of CSTDA funded services as a proportion of the estimated potential population**[a, b]

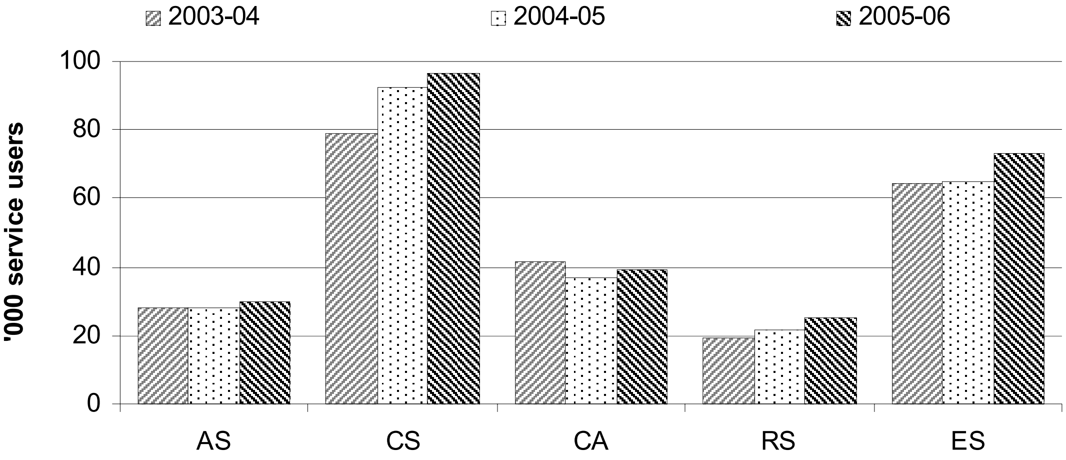


[a] These data need to be interpreted with caution due to a number of factors impacting on data quality. See section 14.6 for further information on these quality issues and for service type outlet response rates across jurisdictions. [b] For the ACT, the decreased service user rate for 2005-06 was due to the data collection for therapy services being incomplete.

Source: ABS (2003a, 2004a, 2005a, 2004d); AIHW (2005, 2006a, 2006b, 2007); AIHW analysis of the ABS SDAC 2003; table 14A.1.

Service user numbers varied across service types (figure 14.7). Accommodation support, community access, community support and respite services reported 143 890 users and employment services reported 73 157 users.

Figure 14.7 **Users of CSTDA funded services, by service type**[a, b]

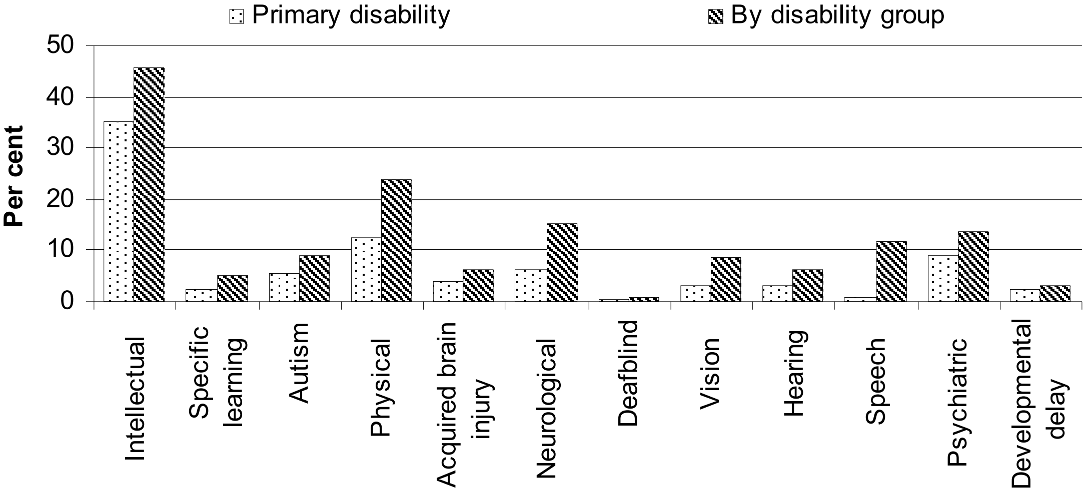


AS = accommodation support; CS = community support; CA = community access; RS = respite services; ES = employment services. [a] These data need to be interpreted with caution due to a number of factors impacting on data quality. See section 14.6 for further information on these quality issues. [b] See table 14A.1 for detailed notes relating to these data.

Source: AIHW (2005, 2006a, 2007); table 14A.1.

In 2005-06, 45.6 per cent of CSTDA service users reported an intellectual disability, including 35.2 per cent who reported an intellectual disability as their primary disability (figure 14.8).

Figure 14.8 **Service users by disability group, 2005-06**[a, b]



[a] These data need to be interpreted with caution due to a number of factors impacting on data quality. See section 14.6 for further information on these quality issues. [b] See tables 14A.11 and 14A.12 for detailed notes relating to these data.

Source: AIHW (2007); tables 14A.11 and 14A.12.

Younger people with a disability in residential aged care

At its February 2006 meeting, COAG made a commitment to reduce the number of younger people with a disability living in residential aged care. COAG agreed to establish a five-year program, beginning in July 2006. Funding for this program is separate and in addition to the general funding provided under the CSTDA. The Australian Government has signed bilateral agreements with all states and territories.

There are three elements to the program:

- Move younger people with a disability currently accommodated in residential aged care into appropriate supported disability accommodation where it can be made available and if this is what clients choose.
- Divert future admission of younger people with a disability who are at risk of admission to residential aged care into more appropriate forms of accommodation.
- Enhance the delivery of specialist disability services to those younger people with a disability who choose to remain in residential aged care or for whom residential aged care remains the only available suitable supported accommodation option.

The initial priority for the program is people aged under 50, and participation is voluntary. On 30 June 2007, there were 943 people aged under 50 years living in permanent residential aged care nationally (excluding the ACT) (table 14.1). This was a 6.3 per cent decrease on the number of people aged under 50 years living in permanent residential aged care on 30 June 2006 nationally (excluding the ACT).

Table 14.1 **Younger people (aged under 50 years) in residential aged care, 30 June (number)[a, b]**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*[c]	*NT*	*Aust (excluding ACT)*[d]
2006	392	221	245	65	61	15	np	7	1006
2007	374	210	226	63	53	12	np	5	943

[a] Data are for permanent residents in aged care. [b] These data should be interpreted with caution (particularly for the NT). There may be issues related to the age of Indigenous residents being incorrectly recorded. An assessment of the data set in the NT has previously shown that approximately half of Indigenous peoples' ages were incorrectly recorded. [c] Data are not published due to small numbers. The number is between 1–4 inclusive. [d] The total is for jurisdictions for which data are published only.

Source: Department of Health and Ageing (unpublished).

14.2 Framework of performance indicators

The framework of performance indicators is based on the Australian, State and Territory governments' shared objectives under the third CSTDA (box 14.4).

Box 14.4 **Objectives of government funded services for people with a disability**

The performance data for this Report cover services provided under the third CSTDA. Through that CSTDA, governments strive to enhance the quality of life experienced by people with a disability by assisting them to live as valued and participating members of the community.

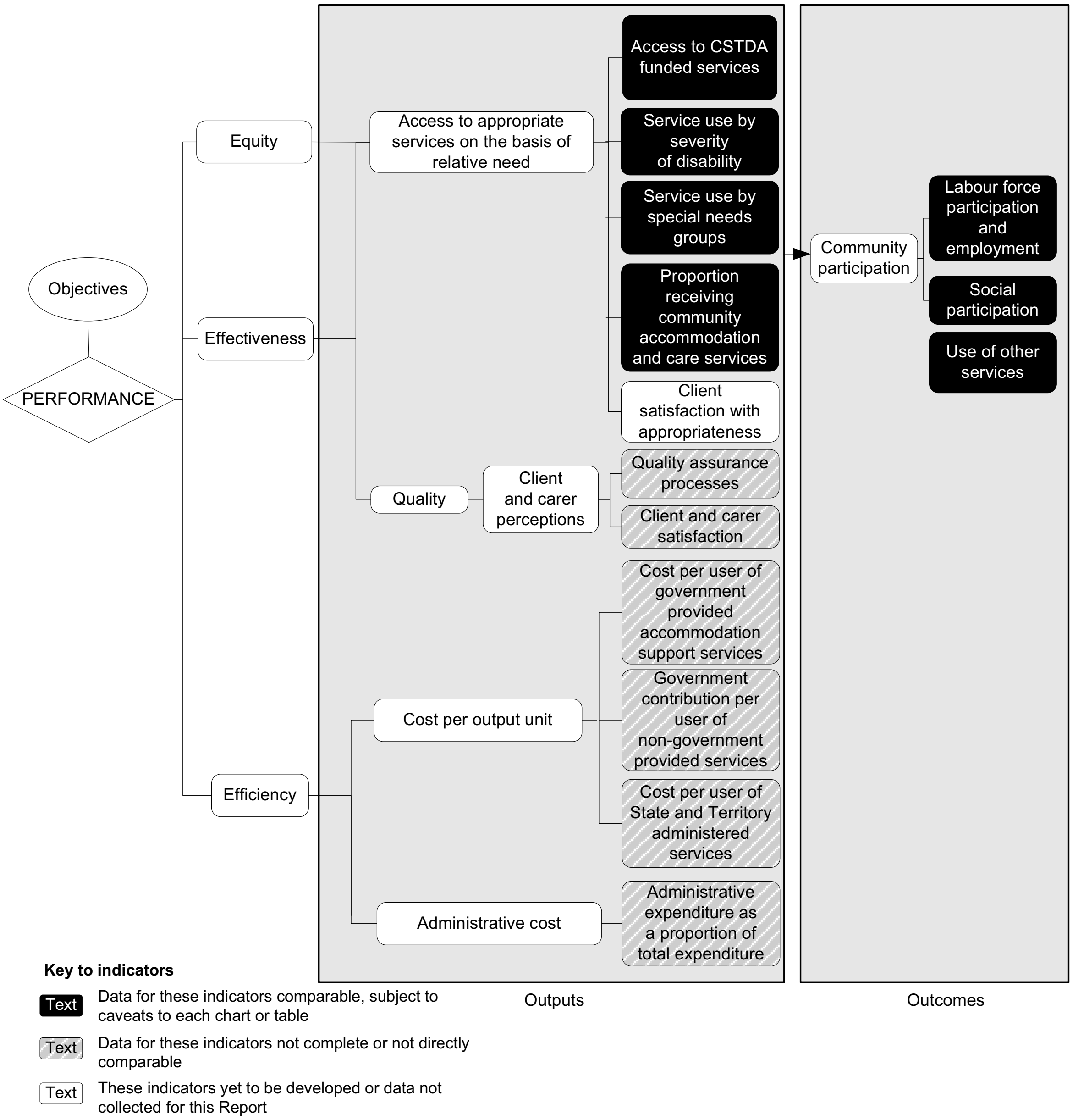
In working towards this objective, governments have five policy priorities, to:

- strengthen access to generic services for people with a disability
- strengthen across government linkages — bilateral agreements between the Australian Government and each State and Territory have been negotiated to improve services
- strengthen individuals, families and carers
- improve long term strategies to respond to, and manage, demand for specialist disability services
- improve accountability, performance reporting and quality.

Source: CSTDA (2003).

The performance indicator framework shows which specialist disability services data are comparable in the 2008 Report (figure 14.9). For data that are not considered directly comparable, the text includes relevant caveats and supporting commentary. Chapter 1 discusses data comparability from a Report-wide perspective (see section 1.6).

Figure 14.9 **Performance indicators for services for people with a disability**



The performance indicator framework provides information on equity, efficiency and effectiveness, and distinguishes the outputs and outcomes of government funded services for people with a disability. This is consistent with the general performance indicator framework and service process diagram (figures 1.2 and 1.3, chapter 1) on which the Steering Committee has agreed.

Proxy efficiency indicators focus on unit costs and administrative costs. Effectiveness and equity indicators focus on access to appropriate services and service quality. Outcome indicators focus on the participation of people with a disability in the community.

14.3 Key performance indicator results

Different delivery contexts, locations and client characteristics may affect the equity, effectiveness and efficiency of specialist disability services. Appendix A contains data that may assist in interpreting the performance indicators presented in this chapter.

The performance indicator results reported in this chapter generally relate to CSTDA funded services. This Report includes service user data for 2005-06. These data were sourced from the CSTDA NMDS collection, which is managed by individual jurisdictions and coordinated by the AIHW. The CSTDA NMDS collection was implemented in 2002-03, with national data from the first collection available for the period 1 January 2003 to 30 June 2003. Other information on the implementation of the CSTDA NMDS is contained in box 13.6 of the 2006 Report (SCRGSP 2006) and in AIHW (2003).

When considering the indicator results derived from service user data, comparisons between jurisdictions and across years should be undertaken with care. While the implementation of the CSTDA NMDS continues to improve, data quality is still affected by a number of factors including that:

- the proportion of service users and service outlets that provided data (response rates) and the ‘not stated’ rates of particular data items vary across jurisdictions and years (see section 14.6 for further details)
- the interpretation of CSTDA NMDS service definitions can differ across jurisdictions (for example, the target group for services classified as ‘early intervention’ can differ).

Outputs

Outputs are the actual services delivered (while outcomes are the impact of these services on the status of an individual or group) (see chapter 1, section 1.5).

Equity and effectiveness — access to appropriate services on the basis of relative need

The following equity and effectiveness access indicators are reported:

- ‘access to CSTDA funded services’
- ‘service use by severity of disability’
- ‘service use by special needs groups’

- ‘proportion of accommodation support service users receiving community accommodation and care services’.

Access to CSTDA funded services

‘Access to CSTDA funded services’ is an indicator of access to specialist disability services on the basis of relative need (box 14.5).

Box 14.5 **Access to CSTDA funded services**

The proportion of the estimated potential population using CSTDA funded services is an indicator of governments’ objective to provide access to government funded or provided specialist disability services on the basis of relative need and available resources. Measures are reported for accommodation support, employment, community access, community support and respite services.

This indicator is defined as the number of people using a particular CSTDA funded service divided by the ‘potential population’ for that service. The potential population is an estimate that broadly indicates the number of people with the potential to require specialist disability services at some time.

The potential population estimate for *accommodation support*, *community access* and *community support services* is the number of people aged under 65 years with profound or severe core activity limitations, multiplied by the Indigenous factor for a jurisdiction. The potential population estimate for *employment services* is the number of people aged 15–64 years with severe or profound core activity limitations, multiplied by both the Indigenous factor and the labour force participation rate for a jurisdiction. The potential population estimate for *respite services* is the number of people aged under 65 years with profound or severe core activity limitations who also reported a primary carer, multiplied by the Indigenous factor for a jurisdiction. The potential populations are further defined in section 14.7.

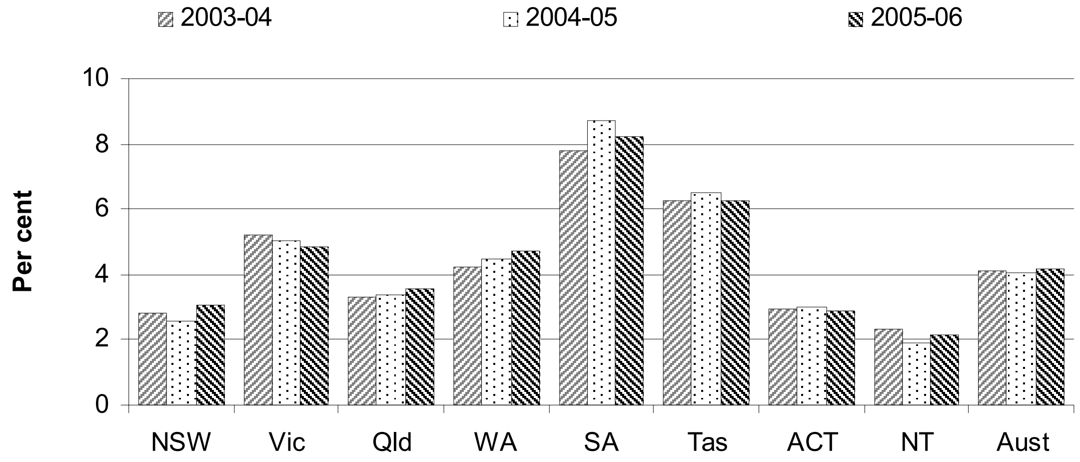
A higher proportion of the relevant estimated potential population using a particular CSTDA service suggests greater access to this service.

This indicator does not provide information on whether the services are appropriate for the needs of the people receiving them, or accessed by those most in need. In addition, not all people in the estimated ‘potential population’ will need the service or seek to access the service in the relevant period.

The numerators and denominators of the access measures do not match fully. The numerator of an access measure includes service users of all ages who have profound, severe, or moderate to no core activity limitations. The denominator, which is the ‘potential population’, is an estimate of the number of people who have a profound or severe core activity limitation and are aged under 65 years. Although the numerator includes people who are aged 65 and over and/or people who have moderate to no core activity limitations, this is not the case for the denominator. It would be helpful, therefore, to consider the results of this indicator in conjunction with the 'service use by severity of disability' indicator. The 'service use by severity of disability' indicator reports the proportion of service users who have different levels of core activity limitations (profound, severe and moderate to no). Therefore, it provides information about access to specialist disability services on the basis of relative need, where the level of core activity limitation is used as a proxy for relative need.

Nationally, 4.2 per cent of the estimated potential population were using CSTDA funded accommodation support services in 2005-06 (figure 14.10).

Figure 14.10 **Users of CSTDA funded accommodation support services as a proportion of the estimated potential population[a, b]**

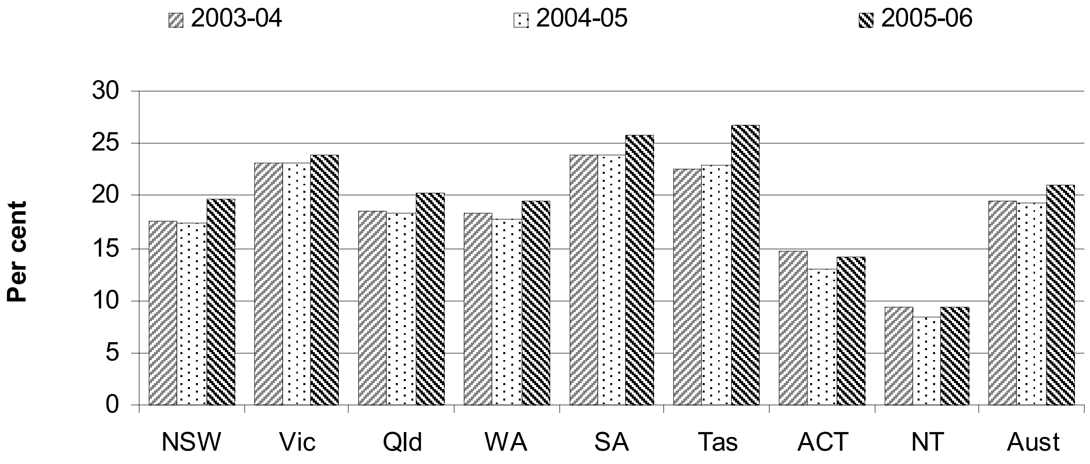


[a] See table 14A.13 for detailed notes relating to service user data. [b] These data need to be interpreted with caution due to a number of factors impacting on data quality. See section 14.6 for further information on these quality issues.

Source: ABS (2003a, 2004a, 2004d, 2005a); AIHW (2005, 2006a, 2006b, 2007); AIHW analysis of the 2003 ABS SDAC data; table 14A.13.

During the reporting period, the Australian Government had responsibility for employment services under the CSTDA and provided most employment services (99.8 per cent) by funding non-government organisations. Nationally, 21.1 per cent of the estimated potential population for CSTDA funded employment services were using these services in 2005-06 (figure 14.11).

Figure 14.11 **Users of CSTDA funded employment services as a proportion of the estimated potential population for employment services**[a]



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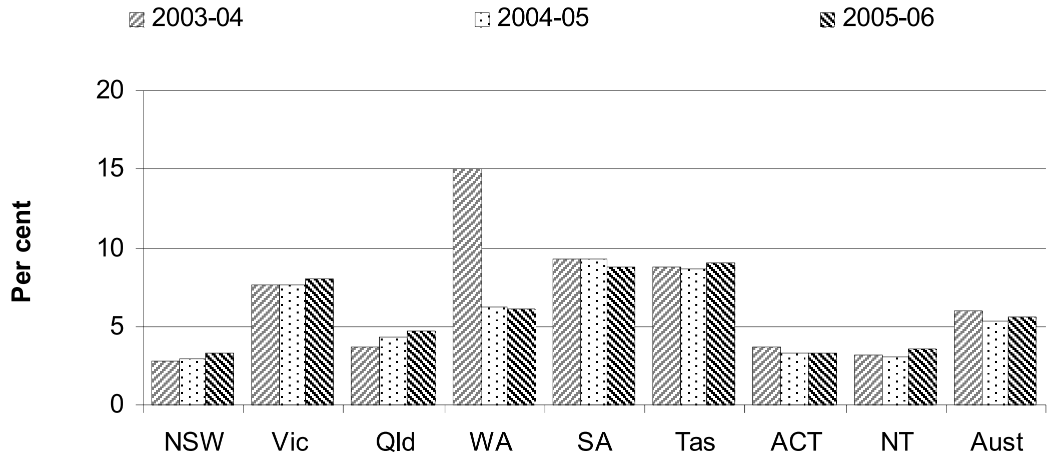
[a] See table 14A.14 for detailed notes relating to these data.

Source: ABS (2003a, 2003b, 2004a, 2004b, 2004d, 2005a, 2005b); AIHW (2005, 2006a, 2006b, 2007); AIHW analysis of the ABS SDAC 2003; table 14A.14.

Nationally, in 2005-06, 5.6 per cent and 13.7 per cent of the estimated potential population were using CSTDA funded community access and community support services respectively (figures 14.12 and 14.13).

Nationally, 11.5 per cent of the estimated potential population (who reported having a primary carer) were using CSTDA funded respite services in 2005-06 (figure 14.14).

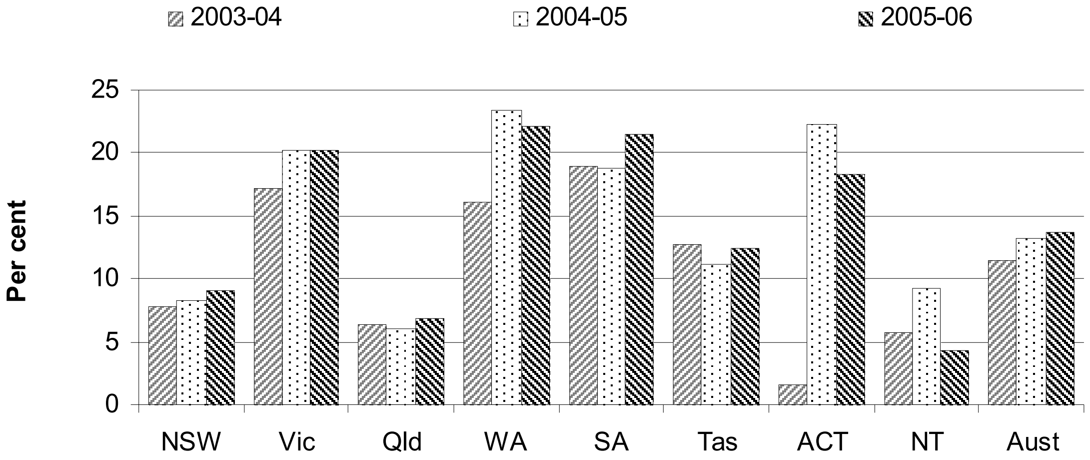
Figure 14.12 **Users of CSTDA funded community access services as a proportion of the estimated potential population**[a, b, c]



[a] See table 14A.15 for detailed notes relating to these data. [b] These data need to be interpreted with caution due to a number of factors impacting on data quality. See section 14.6 for further information on these quality issues. [c] The decrease in the number of WA service users between 2003-04 and 2004-05 is due to a change in reporting by one recreation agency.

Source: ABS (2003a, 2004a, 2004d, 2005a); AIHW (2005, 2006a, 2006b, 2007); AIHW analysis of the ABS SDAC 2003; table 14A.15.

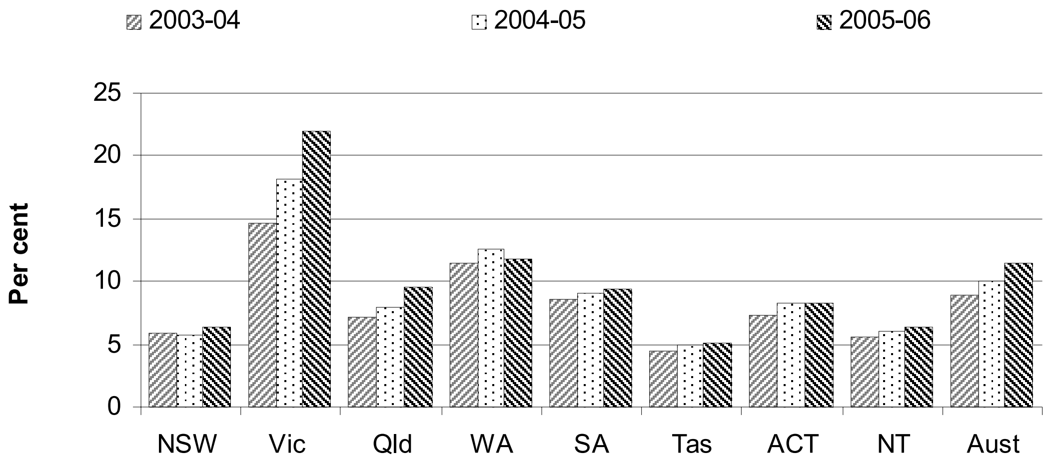
Figure 14.13 **Users of CSTDA funded community support services as a proportion of the estimated potential population**[a, b, c, d]



[a] See table 14A.16 for detailed notes relating to service user data. [b] These results need to be interpreted with caution due to a number of factors impacting on data quality. See section 14.6 for further information on these quality issues. [c] The increase in the number of WA service users between 2003-04 and 2004-05 is due to the inclusion of data from a new electronic database for the first time. [d] For the ACT, the decreased community support services rate for 2005-06 was due to the data collection for therapy services being incomplete.

Source: ABS (2003a, 2004a, 2004d, 2005a); AIHW (2005, 2006a, 2006b, 2007); AIHW analysis of the ABS SDAC 2003; table 14A.16.

Figure 14.14 **Users of CSTDA funded respite services as a proportion of the estimated potential population for respite services**[a, b]



[a] See table 14A.17 for detailed notes relating to these data. [b] These data need to be interpreted with caution due to a number of factors impacting on data quality. See section 14.6 for further information on these quality issues.

Source: ABS (2003a, 2004a, 2004d, 2005a); AIHW (2005, 2006a, 2006b, 2007); AIHW analysis of the ABS SDAC 2003; table 14A.17.

Service use by severity of disability

'Service use by severity of disability' is an indicator of access to specialist disability services on the basis of relative need (box 14.6). This indicator provides additional information for interpreting the access to CSTDA funded accommodation support, employment, community access, community support and respite services measures reported above.

Severity of disability (core activity limitation) is derived using data on the level of support needed in one or more of the support areas: self-care, mobility, and communication. Service users with a profound core activity limitation reported always needing support in one or more of these areas. Service users with a severe core activity limitation reported sometimes needing support in one or more of these areas. Service users with a moderate to no core activity limitation reported needing no support in all three of these areas.

Box 14.6 **Service use by severity of disability**

The proportion of people accessing CSTDA funded services by severity of core activity limitation is an indicator of governments' objective to use available resources to target services to people with the greatest level of need.

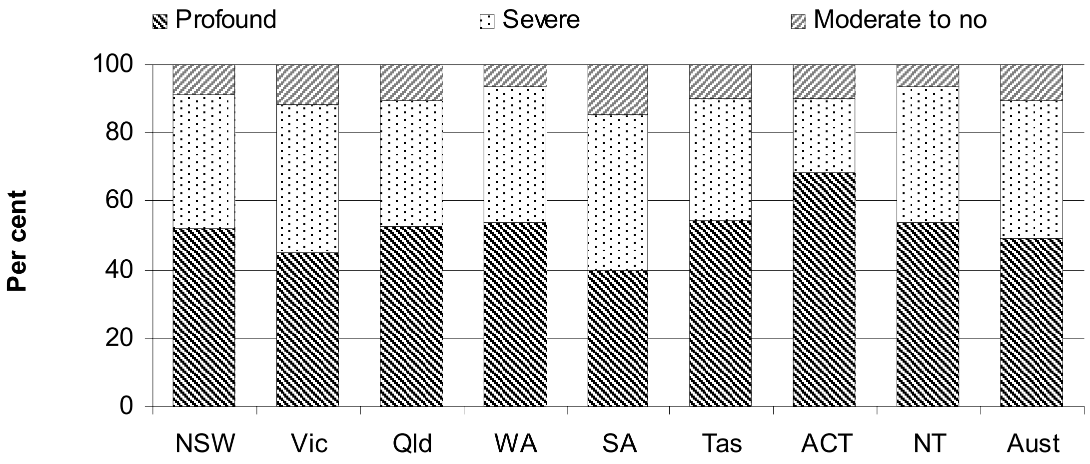
This indicator is defined as the proportion of people who access CSTDA funded services, by severity of core activity limitation. Three categories of core activity limitation are reported: profound, severe, and moderate to no core activity limitation. Measures are reported for accommodation support, employment, community access, community support and respite services.

A higher proportion of people with a profound or severe core activity limitation using a particular service type suggests greater access to this service type for those with the greatest level of need.

This indicator does not provide information on whether services are appropriate for the needs of the people receiving them or appropriately targeted to those with the greatest level of need in terms of access to other formal and informal support. The need for services is assumed to vary according to the level of core activity limitation and so core activity limitation is used as one proxy for relative need. Core activity limitation data are self/carer identified, not based on formal clinical assessments of individual limitations. In addition, there are other factors that may also be important in determining relative need, such as the complexity of a service user's needs.

Nationally, 49.1 per cent of users of CSTDA funded accommodation support services in 2005-06 had a profound core activity limitation, 40.5 per cent had a severe core activity limitation and 10.4 per cent had moderate to no core activity limitations (figure 14.15).

Figure 14.15 **Users of CSTDA funded accommodation support services, by severity of core activity limitation, 2005-06[a, b]**



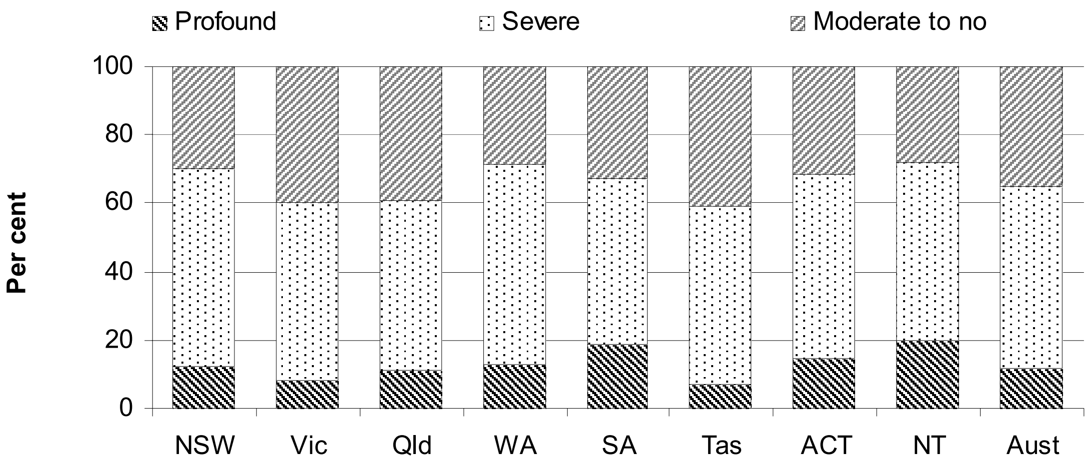
[a] See table 14A.18 for detailed notes relating to these data. [b] These data need to be interpreted with caution due to a number of factors impacting on data quality. See section 14.6 for further information on these quality issues.

Source: AIHW (2007); table 14A.18.

Nationally, 11.5 per cent of users of CSTDA funded employment services in 2005-06 had a profound core activity limitation, 53.5 per cent had a severe core activity limitation and 35.0 per cent had moderate to no core activity limitations (figure 14.16).

Nationally, 41.3 per cent of users of CSTDA funded community access services in 2005-06 had a profound core activity limitation, 43.5 per cent had a severe core activity limitation and 15.2 per cent had moderate to no core activity limitations (figure 14.17).

Figure 14.16 Users of CSTDA funded employment services, by severity of core activity limitation, 2005-06[a, b, c]



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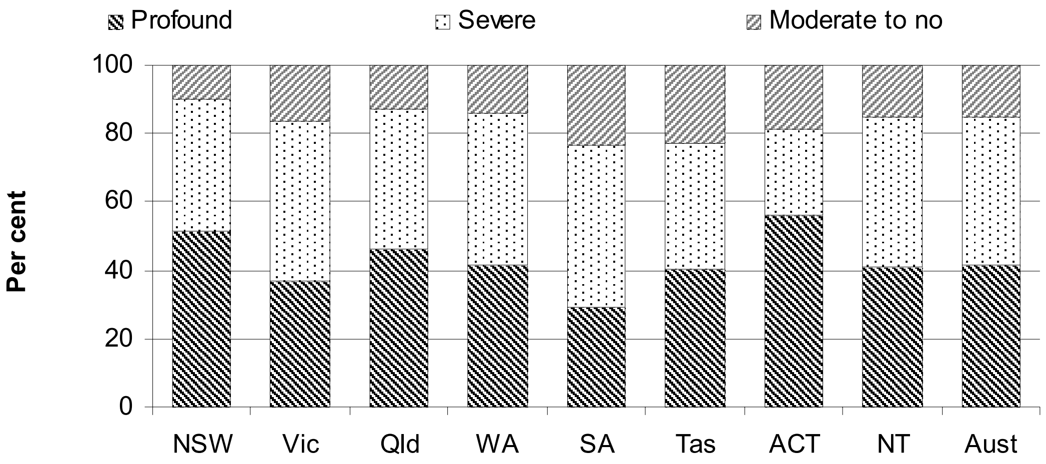
[a] Severity of core activity limitation relates to the level of support needed in the areas of self care, mobility and communication. It does not necessarily relate to the level of support needed to find or maintain employment. [b] See table 14A.19 for detailed notes relating to these data. [c] These data need to be interpreted with caution due to a number of factors impacting on data quality. See section 14.6 for further information on these quality issues.

Source: AIHW (2007); table 14A.19.

Figure 14.17 Users of CSTDA funded community access services, by severity of core activity limitation, 2005-06[a, b]



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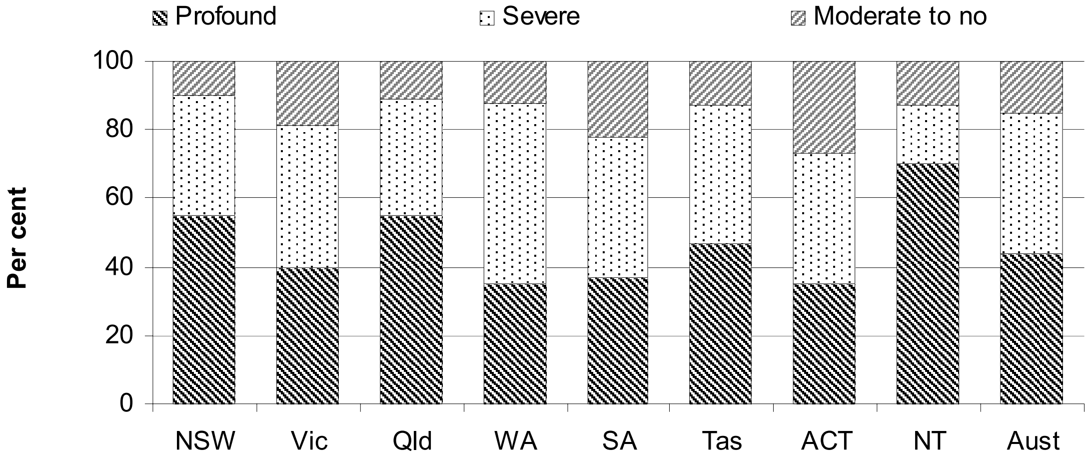
[a] See table 14A.20 for detailed notes relating to these data. [b] These data need to be interpreted with caution due to a number of factors impacting on data quality. See section 14.6 for further information on these quality issues.

Source: AIHW (2007); table 14A.20.

Nationally, 44.1 per cent of users of CSTDA funded community support services in 2005-06 had a profound core activity limitation, 40.6 per cent had a severe core activity limitation and 15.3 per cent had moderate to no core activity limitations (figure 14.18). Care should be taken when interpreting this measure due to the high rate of missing data. Data exclude 27 382 community support service users (out of a total of 96 469) who did not report on a need for support with any of the areas: self-care; mobility; or communication.

Figure 14.18 **Users of CSTDA funded community support services, by severity of core activity limitation, 2005-06**[a, b]

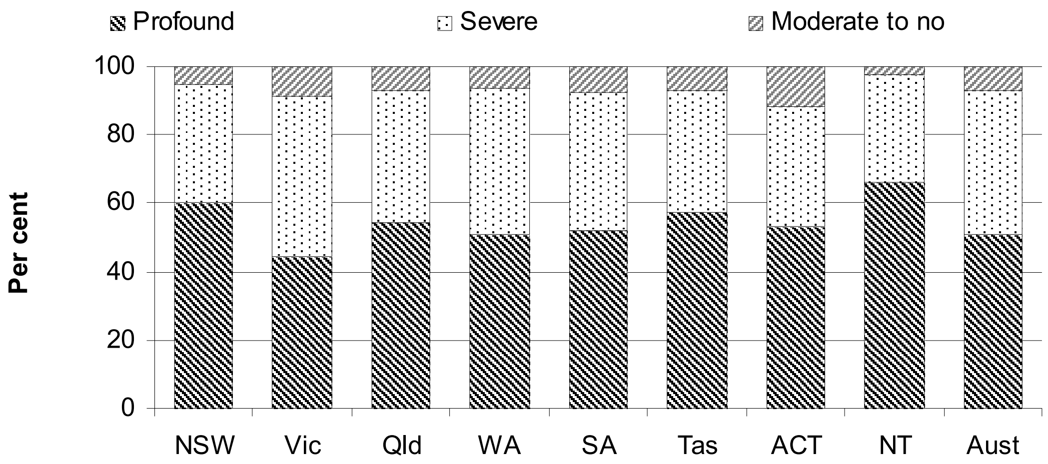


[a] See table 14A.21 for detailed notes relating to these data. [b] These data need to be interpreted with caution due to a number of factors impacting on data quality. See section 14.6 for further information on these quality issues.

Source: AIHW (2007); table 14A.21.

Nationally, 51.0 per cent of users of CSTDA funded respite services in 2005-06 had a profound core activity limitation, 41.7 per cent had a severe core activity limitation and 7.3 per cent had moderate to no core activity limitations (figure 14.19).

Figure 14.19 Users of CSTDA funded respite services, by severity of core activity limitation, 2005-06[a, b]



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[a] See table 14A.22 for detailed notes relating to these data. [b] These data need to be interpreted with caution due to a number of factors impacting on data quality. See section 14.6 for further information on these quality issues.

Source: AIHW (2007); table 14A.22.

Service use by special needs groups

An additional indicator of access is the comparison between the representation of all people with a disability who use CSTDA funded services and the representation of people with a disability from special needs groups (box 14.7). The numerators and denominators of the 'service use by special needs groups' measures do not match fully. The numerators of the measures include service users of all ages whereas the denominators (populations) include people aged under 65 years only.

Box 14.7 Service use by special needs groups

The proportion of people from special needs groups accessing CSTDA funded services is an indicator of governments' objective that access to appropriate services should be equitable for all members of the community. The three special needs groups reported here are:

- people from outer regional and remote/very remote locations
- people identified as Indigenous
- people who were born in a non-English speaking country (that is, not born in Australia, New Zealand, Canada, the United Kingdom, South Africa, Ireland, the United States or Zimbabwe).

(Continued on next page)

Box 14.7 **(Continued)**

This indicator compares the proportion of service users per 1000 people from a particular special needs group with the proportion of service users per 1000 people outside the special needs group. The disability service types reported are accommodation support, employment, community access, community support and respite services. For accommodation support, community access, community support and respite services, people aged under 65 years are included in the population counts for both the special needs groups and the people outside the special needs groups. For employment, only people aged 15–64 years are included in these population counts.

Holding other factors constant, the proportion of service users per 1000 people from a special needs group should not vary significantly from the proportion of service users per 1000 people outside the special needs group. While a markedly lower proportion may represent reduced access for a special needs group, it may also represent strong alternative support networks (and thus a lower level of need), or the individual choice of people with a disability not to access CSTDA funded services. Similarly, while a higher proportion may suggest poor service targeting or the lack of alternative support networks, it may also reflect the special needs group having a greater prevalence of disability.

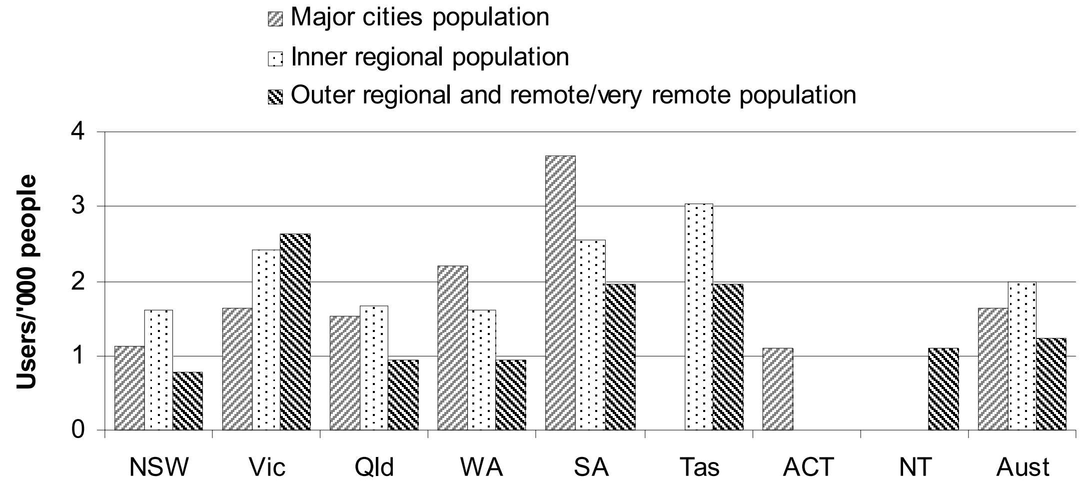
The CSTDA funded services are provided on the basis of need and available resources. This indicator does not provide information on whether the services are appropriate for the needs of the people receiving them, or correctly targeted to those most in need. The indicator also does not take into account differences in:

- the prevalence of disability between people in the special needs group and people outside the special needs groups — for example, this may be a significant issue when comparing Indigenous and non-Indigenous populations’ access to services
- the level of informal assistance that is available for people in special needs groups and outside the special needs groups. Results for outer regional and remote/very remote users of accommodation support services, for example, need to be considered with care because alternatives to government funded accommodation support services may be more readily available in these areas. Specifically, accommodation support services in outer regional and remote/very remote areas are largely provided informally, making use of local area coordinators and local community resources.

Service use by special needs groups — people in outer regional and remote/very remote areas

Nationally, the proportion of the outer regional and remote/very remote population who used CSTDA funded accommodation support services in 2005-06 (1.2 service users per 1000 people aged under 65 years) was lower than that of the major cities and inner regional populations (1.6 and 2.0 service users per 1000 people aged under 65 years, respectively) (figure 14.20). Comparisons between the outer regional and remote/very remote populations' and major cities and inner regional populations' access to CSTDA funded services should be undertaken with care. Outer regional and remote/very remote areas have a higher proportion of Indigenous people than major cities and inner regional areas and therefore the prevalence of disability may differ for these populations.

Figure 14.20 **Users of CSTDA funded accommodation support services per 1000 people, by geographic location, 2005-06**[a, b, c, d, e]



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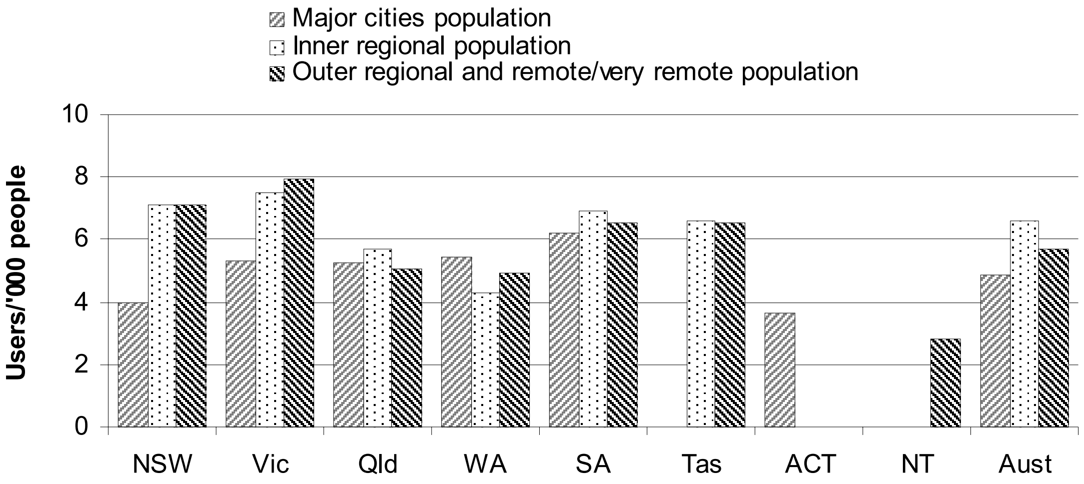
[a] See table 14A.23 for detailed notes relating to these data. [b] These data need to be interpreted with caution due to a number of factors impacting on data quality. See section 14.6 for further information on these quality issues. [c] Tasmania does not have major cities. [d] The ACT does not have outer regional and remote/very remote areas. ACT data for service users per 1000 people in inner regional areas are not published as they are based on a small number of service users. [e] The NT does not have major cities or inner regional areas.

Source: AIHW analysis of ABS SLA population estimates for June 2005; AIHW (unpublished); table 14A.23.

Nationally, the proportion of the outer regional and remote/very remote population who used CSTDA funded employment services in 2005-06 (5.7 service users per 1000 people aged 15–64 years) was higher than the proportion of the major cities population (4.9 service users per 1000 people aged 15–64 years) and lower than the proportion of the inner regional population (6.6 service users per 1000 people aged 15–64 years) (figure 14.21).

Figure 14.21 **Users of CSTDA funded employment services per 1000 people, by geographic location, 2005-06**[a, b, c]



[a] See table 14A.24 for detailed notes relating to these data. [b] Tasmania does not have major cities. The NT does not have major cities or inner regional areas. [c] The ACT does not have outer regional and remote/very remote areas, and the rate for the inner regional population in the ACT is not reported as nearly all users of ACT services who are from inner regional areas are from NSW residential postcodes.

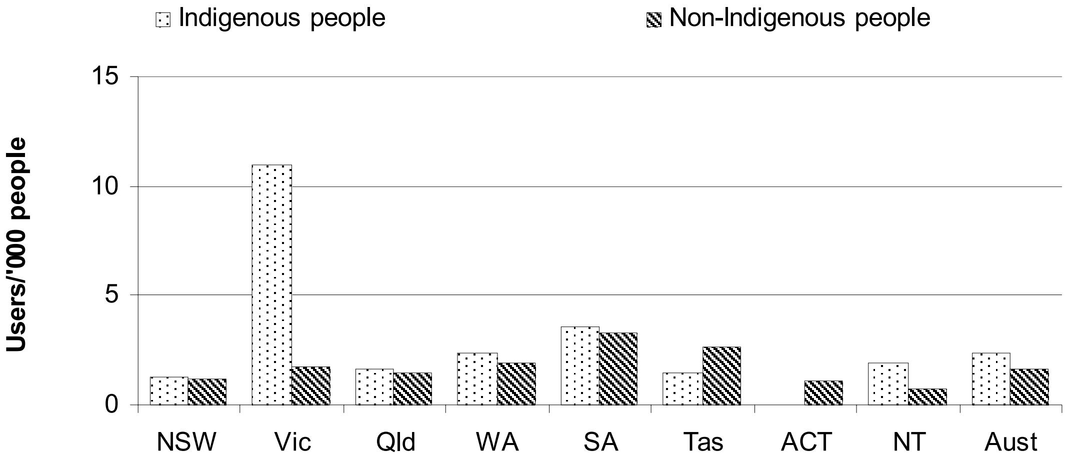
Source: AIHW analysis of ABS SLA population estimates for June 2005; AIHW (unpublished); table 14A.24.

Service use by special needs groups — Indigenous people

Comparisons between Indigenous and non-Indigenous populations' access to services need to be undertaken with care as the prevalence of disability is significantly different for these two populations (figure 14.5).

Nationally, the proportion of the Indigenous population who used CSTDA funded accommodation support services in 2005-06 (2.4 Indigenous service users per 1000 Indigenous people aged under 65 years) was higher than the proportion of the non-Indigenous population who used these services (1.6 service users per 1000 non-Indigenous people aged under 65 years) (figure 14.22). Nationally, the proportion of the Indigenous population who used CSTDA funded employment services in 2005-06 (5.9 Indigenous service users per 1000 Indigenous people aged 15–64 years) was higher than the proportion of the non-Indigenous population who used these services (5.2 service users per 1000 non-Indigenous people aged 15–64 years) (figure 14.23).

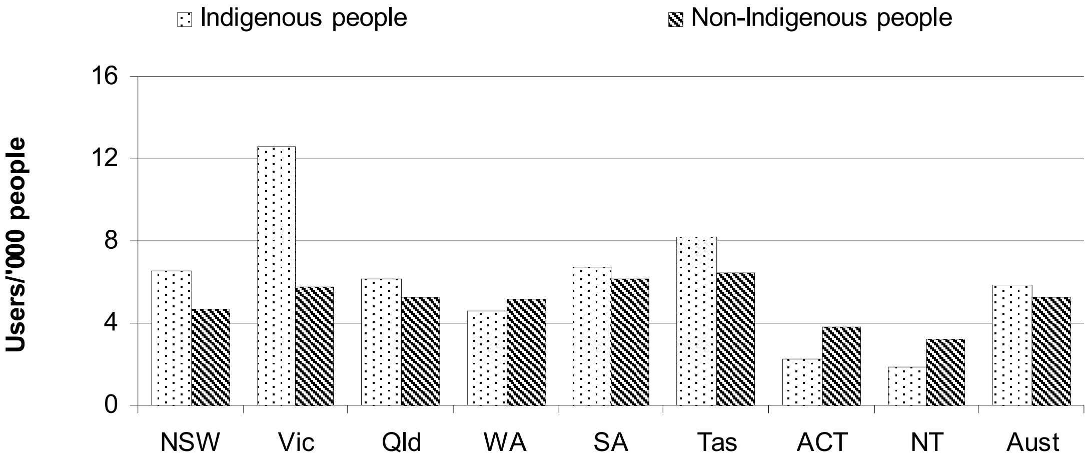
Figure 14.22 Users of CSTDA funded accommodation support services per 1000 people, by Indigenous status, 2005-06[a, b, c]



[a] See table 14A.25 for detailed notes relating to these data. [b] These data need to be interpreted with caution due to a number of factors impacting on data quality. See section 14.6 for further information on these quality issues. [c] ACT data for service users per 1000 Indigenous people are not published as they are based on a small number of service users.

Source: ABS (2004d, 2005a); AIHW (unpublished); table 14A.25.

Figure 14.23 Users of CSTDA funded employment services per 1000 people, by Indigenous status, 2005-06[a]

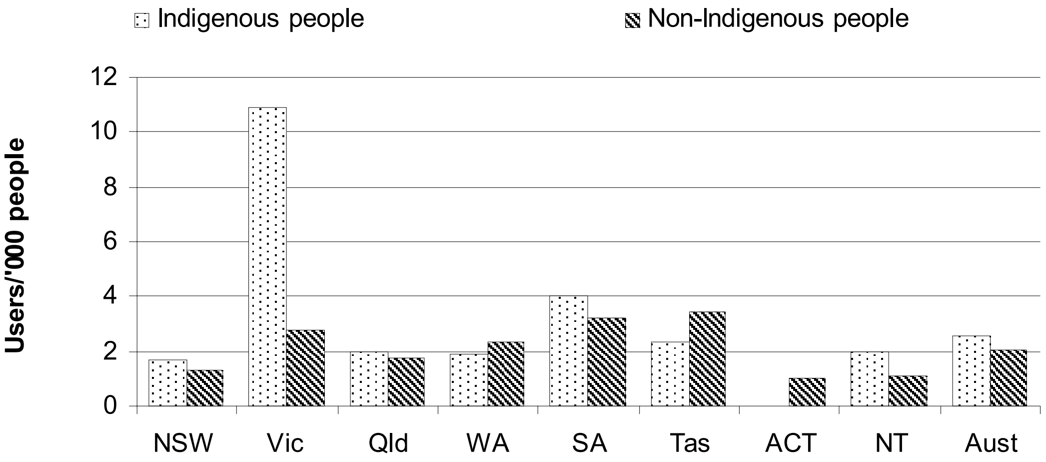


[a] See table 14A.26 for detailed notes relating to these data.

Source: ABS (2004d, 2005a); AIHW (unpublished); table 14A.26.

Nationally, the proportion of the Indigenous population who used CSTDA funded community access services in 2005-06 (2.5 Indigenous service users per 1000 Indigenous people aged under 65 years) was higher than the proportion of the non-Indigenous population who used these services (2.0 service users per 1000 people aged under 65 years) (figure 14.24).

Figure 14.24 **Users of CSTDA funded community access services per 1000 people, by Indigenous status, 2005-06**[a, b, c]



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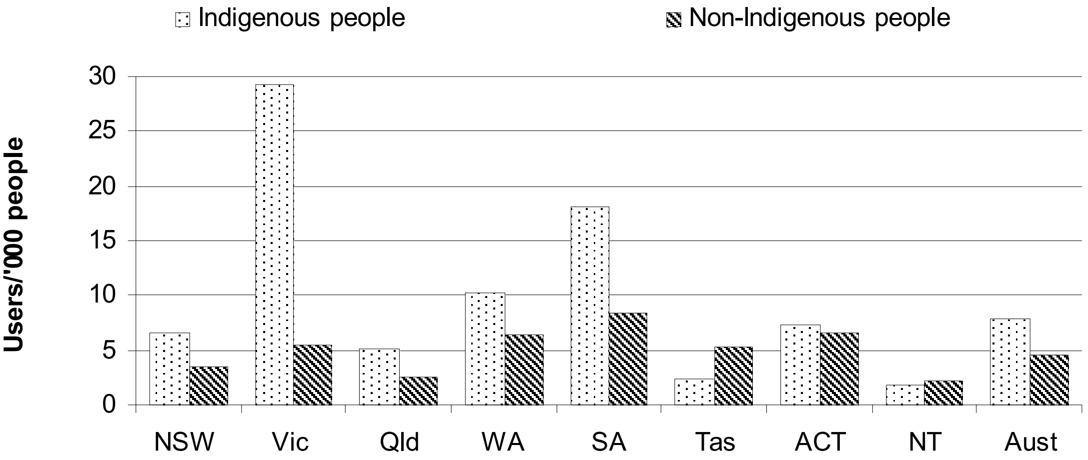
[a] See table 14A.27 for detailed notes relating to these data. [b] These data need to be interpreted with caution due to a number of factors impacting on data quality. See section 14.6 for further information on these quality issues. [c] ACT data for service users per 1000 Indigenous people are not published as they are based on a small number of service users.

Source: ABS (2004d, 2005a); AIHW (unpublished); table 14A.27.

Nationally, the proportion of the Indigenous population who used CSTDA funded community support services in 2005-06 (8.0 Indigenous service users per 1000 Indigenous people aged under 65 years) was higher than the proportion of the non-Indigenous population who used these services (4.5 service users per 1000 people aged under 65 years) (figure 14.25). Due to the relatively high rate of missing data, care should be taken when interpreting this measure. Data exclude 15 013 service users (out of a total of 96 469) whose Indigenous status was not reported.

Nationally, the proportion of the Indigenous population who used CSTDA funded respite services in 2005-06 (2.9 Indigenous service users per 1000 Indigenous people aged under 65 years) was higher than the proportion of the non-Indigenous population who used these services (1.3 service users per 1000 people aged under 65 years) (figure 14.26).

Figure 14.25 **Users of CSTDA funded community support services per 1000 people, by Indigenous status, 2005-06**[a, b]



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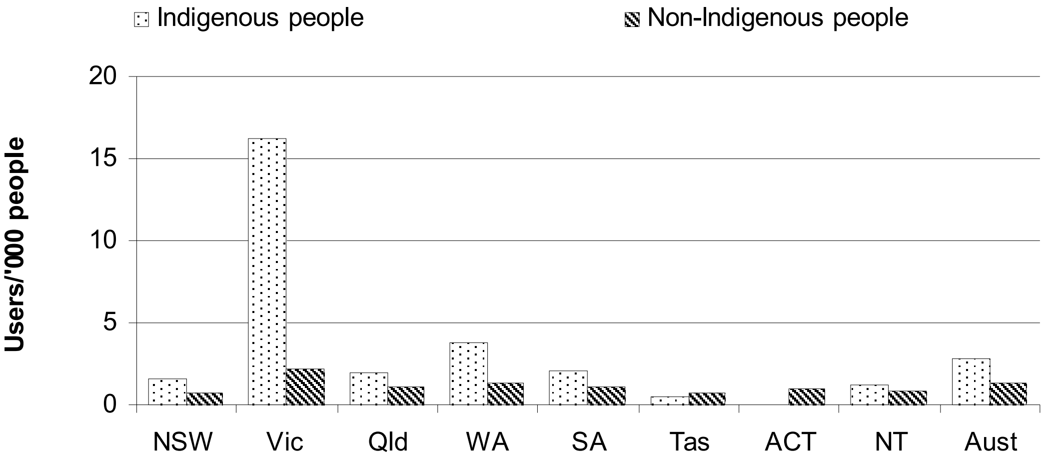
[a] See table 14A.28 for detailed notes relating to these data. [b] These data need to be interpreted with caution due to a number of factors impacting on data quality. See section 14.6 for further information on these quality issues.

Source: ABS (2004d, 2005a); AIHW (unpublished); table 14A.28.

Figure 14.26 **Users of CSTDA funded respite services per 1000 people, by Indigenous status, 2005-06**[a, b, c]



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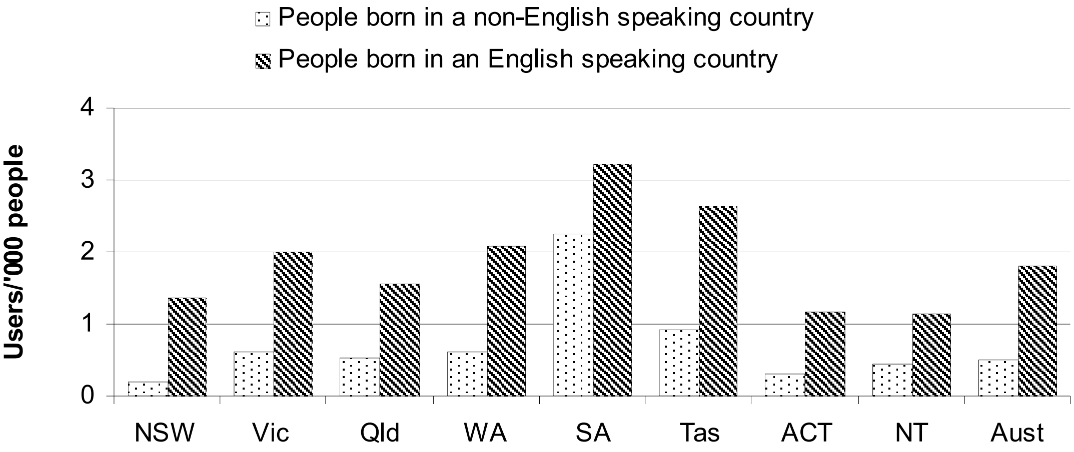
[a] See table 14A.29 for detailed notes relating to these data. [b] These data need to be interpreted with caution due to a number of factors impacting on data quality. See section 14.6 for further information on these quality issues. [c] ACT data for service users per 1000 Indigenous people are not published as they are based on a small number of service users.

Source: ABS (2004d, 2005a); AIHW (unpublished); table 14A.29.

Service use by special needs groups — people born in a non-English speaking country

Nationally, the proportion of people born in a non-English speaking country who used CSTDA funded accommodation support services in 2005-06 (0.5 service users per 1000 people aged under 65 years) was lower than the proportion of people born in an English speaking country who used these services (1.8 service users per 1000 people aged under 65 years) (figure 14.27).

Figure 14.27 **Users of CSTDA funded accommodation support services per 1000 people, by country of birth, 2005-06**[a, b]



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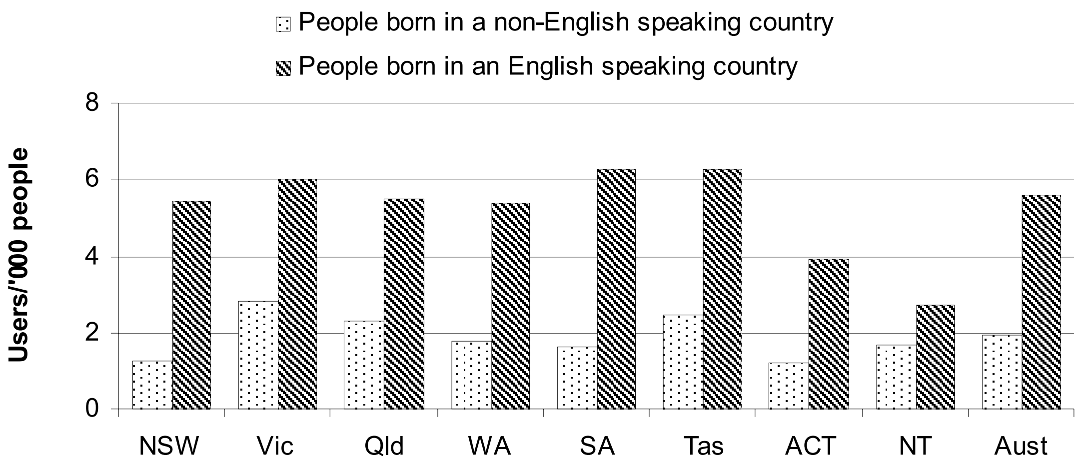
[a] See table 14A.30 for detailed notes relating to these data. [b] These data need to be interpreted with caution due to a number of factors impacting on data quality. See section 14.6 for further information on these quality issues.

Source: ABS (2005a; 2005c); ABS (unpublished) *2001 Census of Population and Housing*; AIHW (unpublished); table 14A.30.

Nationally, the proportion of people born in a non-English speaking country who used CSTDA funded employment services in 2005-06 (1.9 service users per 1000 people aged 15–64 years) was lower than the proportion of people born in an English speaking country who used these services (5.6 service users per 1000 people aged 15–64 years) (figure 14.28).

Figure 14.28 **Users of CSTDA funded employment services per 1000 people, by country of birth, 2005-06**[a, b]



[a] See table 14A.31 for detailed notes relating to these data. [b] These data need to be interpreted with caution due to a number of factors impacting on data quality. See section 14.6 for further information on these quality issues.

Source: ABS (2005a; 2005c); ABS (unpublished) *2001 Census of Population and Housing*; AIHW (unpublished); table 14A.31.

Proportion of CSTDA funded accommodation support service users receiving community accommodation and care services

The 'proportion of accommodation support service users receiving community accommodation and care services' is an indicator of access to appropriate services (box 14.8). Governments provide or fund accommodation support services to people with a disability in institutional/residential settings and through community accommodation and care services. Institutional or residential accommodation support services are provided in both institutions and hostels. Community accommodation and care services are provided in group homes and other community settings. The accommodation support services provided in other community settings are attendant care/personal care, in-home accommodation support, alternative family placement and other accommodation support.

Nationally, 83.9 per cent of users of CSTDA funded accommodation support service received community accommodation and care services in 2005-06 (figure 14.29).

Box 14.8 **Proportion of CSTDA funded accommodation support service users receiving community accommodation and care services**

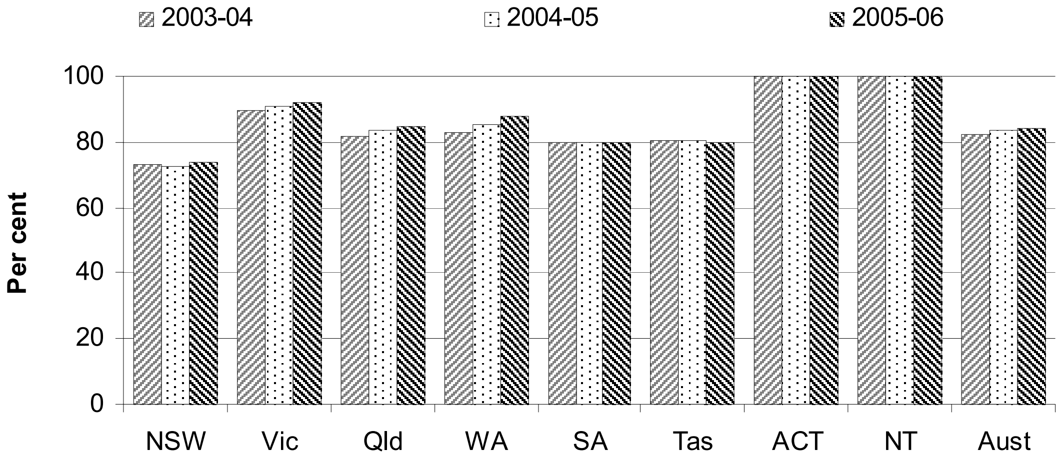
It is an objective of governments to assist people with a disability to live as valued and participating members of the community. State and Territory governments generally seek, if possible, to provide accommodation support services to people with a disability outside of institutional/residential settings. Community accommodation and care services are considered to provide better opportunities for people with a disability to be involved in their community.

This indicator is defined as the number of people using a CSTDA funded community accommodation and care service divided by the total number of people using CSTDA funded accommodation support services (excluding people who use specialist psychiatric disability services only).

A higher proportion of people accessing CSTDA funded community accommodation and care services is likely to provide better opportunities for people with a disability (who need accommodation support) to be involved in their community.

The CSTDA funded services are provided on the basis of need and available resources. This indicator does not provide information on whether the services are appropriate for the needs of the people receiving them, or correctly targeted to those most in need.

Figure 14.29 **Users of community accommodation and care services as a proportion of all CSTDA funded accommodation support service users[a, b]**



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[a] See table 14A.32 for detailed notes relating to these data. [b] These data need to be interpreted with caution due to a number of factors impacting on data quality. See section 14.6 for further information on these quality issues.

Source: AIHW (2005, 2006a, 2007); table 14A.32.

Client satisfaction with appropriateness

The Steering Committee has identified ‘client satisfaction with appropriateness’ as an indicator of access to services that are appropriate to client needs (box 14.9). This indicator is for development in future reports. Data for this indicator are currently not available.

Box 14.9 **Client satisfaction with appropriateness**

‘Client satisfaction with appropriateness’ will provide an indicator of governments’ objective to provide services to people with a disability that are appropriate to their needs. This indicator will measure the appropriateness of these services relative to the service user’s need, from the service user’s perspective.

Equity and effectiveness — quality of services

The following equity and effectiveness quality indicators are reported:

- ‘Quality assurance processes’
- ‘Client and carer satisfaction’.

Information on quality assurance processes for providers of specialist disability services in 2006-07 are available for six jurisdictions — the Australian Government, NSW, Victoria, Queensland, WA and SA. Client and/or carer satisfaction data are included for Queensland (2006 data), WA (2006 data), Tasmania (2006-07 data) and the ACT (2007 data).

Quality assurance processes

‘Quality assurance processes’ are an indicator of the quality of specialist disability services (box 14.10). All services funded under the CSTDA are required to comply with national standards, and most jurisdictions have been examining ways of implementing quality assurance monitoring systems for these services.

Box 14.10 **Quality assurance processes**

‘Quality assurance processes’ are an indicator related to governments’ objective to deliver and fund services for people with a disability that meet a certain standard of quality.

This indicator is defined as the proportion of government and non-government disability service outlets that have been assessed (either by an assessing agency or through a self-assessment process) against service standards or performance indicators.

A higher proportion of disability service outlets that have been accredited against service standards or performance indicators suggests an improvement in the quality of specialist disability services delivered or funded by government.

This indicator does not provide information on whether the standards and performance indicators of the quality assurance processes are appropriate. In addition, service outlets that are not quality assessed do not necessarily deliver services of lower quality.

Data on quality assurance processes in 2006-07 are reported in box 14.11. These quality assurance processes data relate to service providers from all disability service types provided under the CSTDA. Data come from service quality reviews and self-assessment processes. The jurisdictions implementing monitoring of quality assurance processes expect to review all service providers in a rolling process over several years.

Box 14.11 **Quality assurance processes for specialist disability services**

The quality assurance processes data reported below relate to CSTDA funded services.

Australian Government

Australian Government funded disability employment assistance organisations are required to meet quality standards as a prerequisite for continued funding. The disability employment services quality assurance standards comprise 12 standards and 26 key performance indicators. Since 31 December 2004 around 466 services (100 per cent) have been required to be assessed by independent accredited certification bodies and have achieved certification against the revised standards. Services' compliance with the quality standards continue to be monitored by certification bodies through a program of surveillance audits.

(Continued on next page)

Box 14.11 **(Continued)**

NSW, Victoria, Queensland, WA and SA

In 2006-07, different quality assurance processes were in place in NSW, Victoria, Queensland, WA and SA but these jurisdictions collected data on similar indicators. Specialist disability services providers (outlets and organisations) refer to providers of accommodation support; community support; community access; respite; advocacy, information and print disability; and other support services. The evaluation processes relate to both government and non-government service outlets.

In NSW, the Integrated Monitoring Framework (IMF) provides an integrated approach to compliance, quality and performance reporting for all funded services. Each year service providers are required to report their compliance with contractual obligations including adherence to legislation, policy and program guidelines. The quality component of the IMF includes a provider self assessment and a desk top review, followed by an on-site service review of the provider's outlets. As part of the on-site review, service providers are required to demonstrate adherence to 23 Key Performance Indicators (KPIs). By June 2007, 647 outlets had been assessed for the on-site review.

On 1 July 2007, the Quality Framework for Disability Services was implemented in Victoria. This new Framework includes an independent quality monitoring mechanism (results of this independent monitoring are not yet available). In the interim, self-assessment against the Standards for Disability Services continues, with annual reporting of quality plans and improvement initiatives. For 2006-07, 93 per cent of disability service providers had reported on their plans and initiatives. In addition, relevant disability service providers are assessed under the monitoring framework for the health, housing and community services sectors. Under this framework, two cycles of desktop review have been completed.

In Queensland, the Disability Sector Quality System was introduced in 2004. Disability services that are recurrently funded or provided by Disability Services Queensland have four years from 1 July 2004 to become certified against service standards. As at 30 June 2007, approximately 70 services (out of a possible 250 non-government and government services) had undertaken an external assessment with the remaining services scheduled to be externally assessed by 30 June 2008.

In WA, 27.8 per cent (194 of 698) of total service outlets had been independently monitored (comprehensive and abridged monitoring) against the service standards, and 83.5 per cent (162 of 194) of the assessed disability service outlets had been quality assured against all assessed service standards. Outlets that are not independently assessed are required to provide a self-assessment. The number of outlets that completed self assessments was 595.

(Continued on next page)

Box 14.11 **(Continued)**

In SA, service providers are required to meet quality assurance criteria before they can provide CSTDA funded services. From 2006-07 the criteria have been further enhanced to include participation in an independently audited quality assurance system. As of June 2007, 53 per cent (71 of 134) of agencies are engaged in the Service Excellence Framework, however, a number of agencies are involved in other independently assessed quality assurance programs.

Source: Australian, NSW, Victorian, Queensland, WA and SA governments (unpublished).

Client and carer satisfaction

'Client and carer satisfaction' is an indicator of the quality of specialist disability services (box 14.12). Data are available for reporting for Queensland, WA and Tasmania only. It is anticipated that data for other jurisdictions will be included in future reports.

Box 14.12 **Client and carer satisfaction**

'Client and carer satisfaction' is an indicator designed to provide information on satisfaction with the quality of services received. It is an indicator of governments' objective to deliver and fund quality services for people with a disability that meet the needs and goals of the client (or carer of the client) receiving them.

Overall client and carer satisfaction ratings and satisfaction with individual services are reported. Results are taken from a client and carer satisfaction survey and are expressed in percentage terms.

A higher proportion of clients and carers satisfied is desirable, because it suggests the service received was of a higher quality and better met the needs and goals of the client (or carer).

This indicator will be further developed over time as data become available from more jurisdictions.

Queensland conducted a consumer satisfaction survey and carer satisfaction survey of specialist disability services during November and December 2006. Overall, of the 2450 consumers, proxies and carers who were surveyed, 83 per cent of consumers and proxies and 72 per cent of carers identified that they were satisfied with the services they received. The survey provided results according to the type of disability services received and showed the following:

- 89 per cent of consumers and their proxies and 72 per cent of carers were satisfied with accommodation support services

- 79 per cent of consumers and their proxies and 67 per cent of carers were satisfied with community support services
- 83 per cent of consumers and their proxies and 78 per cent of carers were satisfied with community access services
- 80 per cent of consumers and their proxies and 70 per cent of carers were satisfied with respite services (Queensland Government (unpublished)).

The survey also contained three qualitative questions. The questions and associated responses are as follows:

- 'How do disability services make a difference in life?' — respondents expressed very strong recognition that disability services add value and enrich the lives of people with a disability and their carers.
- 'What factors are considered important about the services received?' — respondents consistently considered 'improved social connection and interaction' as the most important factor about the disability services they received.
- 'How could the disability services be improved?' — the most common response was there was 'no need' to improve disability services; however, a strong secondary theme indicated a need for 'more' disability services followed by a 'need for greater personalisation of services' (Queensland Government (unpublished)).

Western Australia conducted a carer and client satisfaction study in 2006. In this study, 1250 disability services clients of all ages (or their carers) were asked whether they were satisfied with services. Questions about specific services were combined with two global satisfaction questions. Overall, 77 per cent of respondents were happy with their quality of life. The following results show the proportions of clients/carers who were satisfied with individual services:

- residential services — 93 per cent
- supported community living — 83 per cent
- community support — 72 per cent
- respite — 85 per cent
- recreation/day option — 79 per cent
- local area coordination — 65 per cent (WA Government (unpublished)).

In the WA carer and client satisfaction study, questions were also included in relation to the personal wellbeing of service users. Each respondent was asked to rate their level of satisfaction with seven key wellbeing domains (standard of living, personal health, achieving in life, personal relationships, personal safety, community connectedness and future security). The results of the seven domains were averaged to give an overall personal wellbeing index (PWI). The overall PWI score for the total sample for the seven domains was 74 per cent. The PWI scores for the six CSTDA service types were as follows:

- hostel/community residential — 74 per cent
- supported community living — 71 per cent
- community support — 74 per cent
- respite — 74 per cent
- recreation/day option — 73 per cent
- local area coordination — 73 per cent (WA Government (unpublished)).

Clients of all Tasmanian centre-based respite services (8 service type outlets) participated in a satisfaction survey during 2006-07. Surveys were conducted with 25 clients and 152 family members/significant others. Each participating service provider was given a report specific to their service. The report details satisfaction ratings and provides direction for continuous quality improvement activities within the service.

Overall, 87 per cent of clients and 81 per cent of family members/significant others were satisfied with these respite services. Other results included:

- 69 per cent of clients felt safe at respite and 91 per cent of family members/significant others perceived respite to be safe
- 86 per cent of clients indicated that they were free from abuse and 88 per cent of family members/significant others indicated that they felt that their family member is free from abuse
- 69 per cent of clients and 72 per cent of family members/significant others indicated that staff communicate effectively
- 65 per cent of clients indicated that they are free from restrictive practices and 76 per cent of family members/significant others indicated that they feel their family member is free from restrictive practices
- 79 per cent of clients indicated that they felt comfortable reporting complaints
- 76 per cent of clients indicated that they are able to make choices about important life decisions and 74 per cent of family members/significant others indicated that the service respects their family member’s choices and preferences (Tasmanian Government (unpublished)).

The ACT conducted two client satisfaction surveys in 2007 regarding CSTDA services. Both these surveys asked clients to rate their overall satisfaction levels with a range of programs. These satisfaction levels ranged from 75–100 per cent and for reporting purposes have been combined into the four main CSTDA service types. Each satisfaction level has been weighted according to the number of respondents commenting on each service and are as follows:

- For accommodation services, 90.2 per cent of service users were satisfied.
- For respite services, 84.8 per cent of service users were satisfied.
- For community access services, 78.9 per cent of service users were satisfied.
- For community support services, 89.7 per cent of service users were satisfied with the services that they received (ACT Government (unpublished)).

Efficiency — cost per output unit

The following cost per output unit efficiency indicators are reported:

- 'Cost per user of government provided accommodation support services'
- 'Government contribution per user of non-government provided services'
- 'Cost per user of State and Territory administered services'.

This Report includes 2006-07 expenditure data provided by Australian, State and Territory governments. However, as 2006-07 service user data from the CSTDA NMDS collection were not available for this Report, the cost per service user efficiency indicators are reported for 2005-06. Expenditure data might differ from information reported elsewhere (such as in departmental annual reports) because the financial counting rules and definitions used to calculate expenditure may differ. Data in this Report may also differ from information reported elsewhere because the data here exclude users of specialist psychiatric disability services.

It is an objective of the Review to report comparable estimates of costs. Ideally, such comparisons would include the full range of costs to government. Where the full costs cannot be counted, costs are estimated on a consistent basis. The jurisdictional expenditure data included in this chapter do not yet include the user cost of capital, and so do not reflect the full costs of government funded services. (User cost of capital is defined in chapter 2.)

Considerable effort has been made to document any differences in calculating the reported efficiency indicators. Concerns remain over the comparability of the results, because jurisdictions use somewhat different methods of data collection (table 14.2). Expenditure data reported in this section are from individual jurisdictions' collections and may differ from cost per service user data reported elsewhere.

Table 14.2 **Comparability of expenditure estimates for government provided specialist disability services, by items included**

Expenditure	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aus Gov*
Superannuation	✓	✓	✓	✓	✓	✓	✓	✓	✓
Basis of estimate	Accrual	Accrual	Accrual	Accrual	Cash	Cash	Accrual	Accrual	Accrual
Workers compensation	✓	✓	✓	✓	✓	✓	✓	✓	✓
Payroll tax[a]									
Actual	✓	✓	✓	x	x	✓	x	✓	..
Imputed	x	✓	x	✓	✓	x	✓	x	..
Apportioned umbrella department costs	✓	✓	✓	..	✓	✓	✓	✓	✓
Basis of apportioning									
Departmental formula	✓	✓	✓	..	✓	✓	x	✓	✓
% of FTE employees	x	x	x	..	x	✓	✓	x	x
Long service leave									
Entitlements	✓	✓	✓	✓	✓	✓	✓	✓	✓
Basis of estimate	Accrual	Accrual	Accrual	Accrual	Cash	Cash	Accrual	Accrual	Accrual
Depreciation	✓	✓	✓	✓	x	x	✓	x	✓

FTE = full time equivalent. [a] Actual payroll tax amounts are included in cost (expenditure) per user data for NSW, Victoria, Tasmania and the NT because the actual payroll tax amounts are not separately identified at the service delivery area level. For the other jurisdictions, no payroll tax amounts (actual or imputed) are included. .. Not applicable.

Source: Australian, State and Territory governments (unpublished).

Government and non-government provided services

Efficiency indicators are reported for both government and non-government provided services. Government provision means that a service is both funded and directly provided by a government department, agency or local government. Non-government provision is a service purchased or part-funded by a government department or agency, but provided by a non-government organisation. Non-government service providers may receive funds from the private sector and the general public in addition to funding, grants and input tax concessions (such as payroll tax exemptions) from governments. Data on funds received by non-government service providers from the private sector and the general public are not included in this Report.

Accommodation support services

Governments provide or contribute funding to accommodation support services for people with a disability in institutional/residential settings and through community accommodation and care. In recent years, there has been an ongoing process of relocating people with a disability from institutional/residential accommodation to community accommodation (including group homes and other community accommodation). As a result, total government expenditure on accommodation support services in institutional/residential settings has decreased, with a corresponding increase in expenditure on community accommodation and care services.

Cost per user of government provided accommodation support services

'Cost per user of government provided accommodation support services' is an indicator of the efficiency of specialist disability services (box 14.13). The service user data used to derive this indicator have quality issues, so estimates of jurisdictional efficiency need to be interpreted with care.

Box 14.13 **Cost per user of government provided accommodation support services**

'Cost per user of government provided accommodation support services' is an output (efficiency) indicator of governments' objective to provide specialist disability services in an efficient manner. A set of indicators is reported under this heading for a range of service types.

This indicator is defined as the net government expenditure per user of government provided accommodation support services in institutional/residential settings, group homes and other community settings.

Holding other factors constant (such as service quality and accessibility), a decrease in government expenditure per service user reflects a more efficient provision of this service.

(Continued on next page)

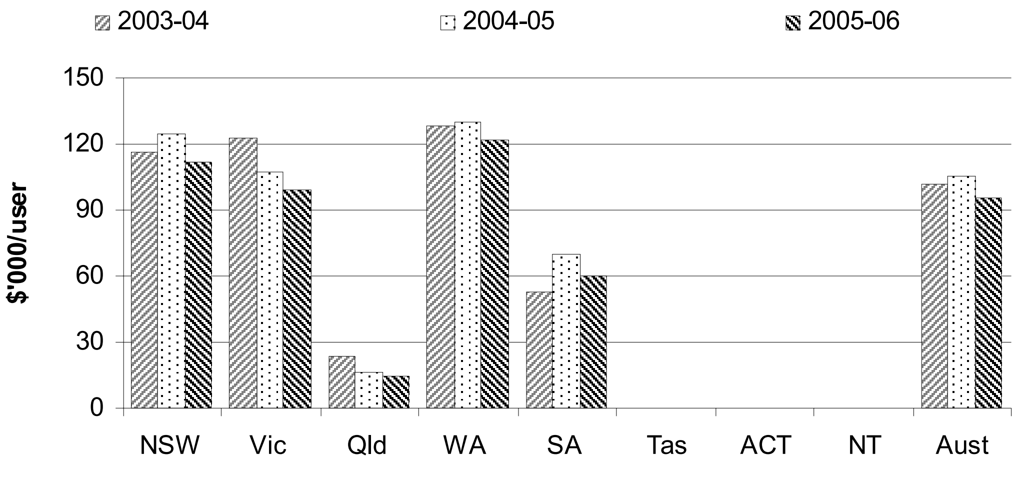
Box 14.13 **(Continued)**

Efficiency data are difficult to interpret. While high or increasing expenditure per unit of output may reflect deteriorating efficiency, it may also reflect improvements in the quality or attributes of the services provided. Increasing expenditure may also reflect the changing needs of service users — for example, as the population of accommodation support service users ages, their support needs are also likely to increase. Similarly, low or declining expenditure per unit of output may reflect improving efficiency, or lower quality and less effective services. Efficiency data therefore should be interpreted within the context of the effectiveness and equity indicators to derive a holistic view of performance.

Cost per user of government provided accommodation support services — institutional/residential settings

Nationally, estimated annual government expenditure on accommodation support services in institutional/residential settings was $95 466 per service user in 2005-06 (figure 14.30).

Figure 14.30 **Estimated annual government expenditure per user of government provided accommodation support services in institutional/residential settings (2005-06 dollars)**[a, b, c]



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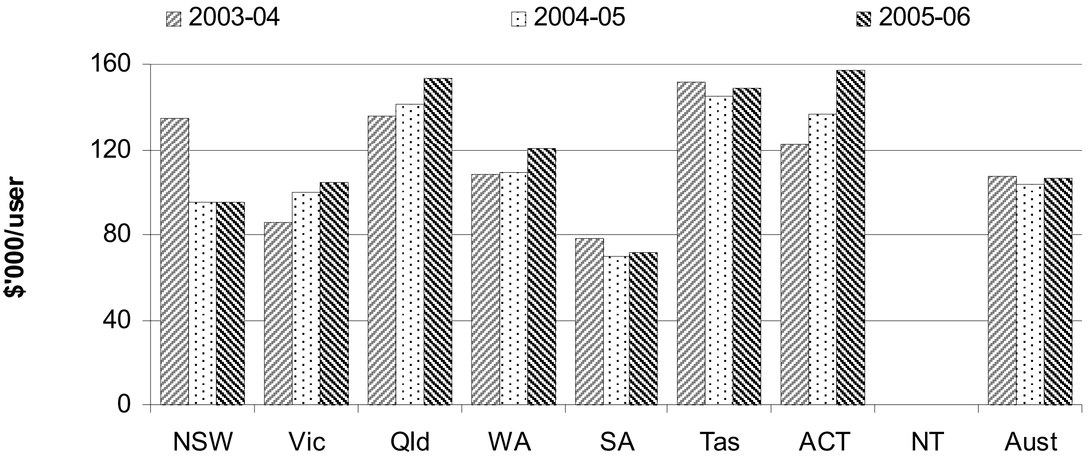
[a] See table 14A.33 for detailed notes relating to these data. [b] The service user data used to derive this indicator have quality issues, so estimates of jurisdictional efficiency need to be interpreted with care. See section 14.6 for further information on these quality issues. [c] There were no government provided accommodation support services in institutional/residential settings in Tasmania, the ACT or the NT.

Source: AIHW (unpublished); State and Territory governments (unpublished); table 14A.33.

Cost per user of government provided accommodation support services — group homes

Nationally, estimated annual government expenditure on government provided accommodation support services in group homes was $106 671 per service user in 2005-06 (figure 14.31). For 2003-04 and 2004-05, service user data used to derive this measure include users of services provided by local government, while NSW, Victorian, WA and SA expenditure data exclude services provided by local governments. Thus historical data for this measure need to be interpreted with care.

Figure 14.31 **Estimated annual government expenditure per user of government provided accommodation support services in group homes (2005-06 dollars)**[a, b, c, d]



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[a] See table 14A.33 for detailed notes relating to these data. [b] The service user data used to derive this indicator have quality issues, so estimates of jurisdictional efficiency need to be interpreted with care. See section 14.6 for further information on these quality issues. [c] In the ACT, the increase in expenditure between 2004-05 to 2005-06 was the result of a combination of factors including service user information being excluded as a result of data cleansing analyses of the NMDS forms or being reclassified to 'other community settings'. [d] There were no government providers of accommodation support services in group homes in the NT.

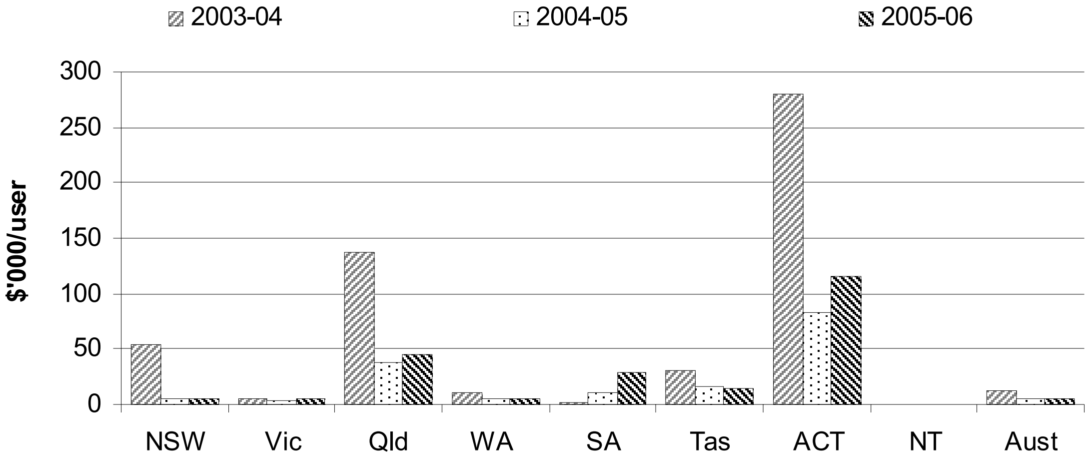
Source: AIHW (unpublished); State and Territory governments (unpublished); table 14A.33.

Cost per user of government provided accommodation support services — other community settings

Nationally, estimated annual government expenditure on government provided accommodation support services in other community settings was $5930 per service user in 2005-06 (figure 14.32). For 2003-04 and 2004-05, service user data used to derive this measure include users of services provided by local government, while

NSW, Victorian, WA and SA expenditure data exclude services provided by local governments. Thus historical data for this measure need to be interpreted with care.

Figure 14.32 **Estimated annual government expenditure per user of government provided accommodation support services in other community settings (2005-06 dollars)**[a, b, c, d]



[a] See table 14A.33 for detailed notes relating to these data. [b] The service user data used to derive this indicator have quality issues, so estimates of jurisdictional efficiency need to be interpreted with care. See section 14.6 for further information on these quality issues. [c] In the ACT, the increase in cost per user between 2004-05 and 2005-06 was the result of data cleansing as some services users were not counted. [d] There were no government providers of accommodation support services in other community settings in the NT.

Source: AIHW (unpublished); State and Territory governments (unpublished); table 14A.33.

Government contribution per user of non-government provided services

'Government contribution per user of non-government provided services' is an indicator of the efficiency of specialist disability services (box 14.14). The service user data used to derive this indicator have quality issues, so estimates of jurisdictional efficiency need to be interpreted with care.

Box 14.14 Government contribution per user of non-government provided services

Governments directly provide services to service users and also fund non-government service providers to deliver these services. The government contribution per user of non-government provided services is an indicator of governments' objective to provide specialist disability services in an efficient manner. The focus on the contribution of governments reflects the Steering Committee's terms of reference, which require it to report on services funded and/or delivered by government.

A set of measures is reported under this indicator for a range of government funded service types. The measures are defined as the net government expenditure per user of the following non-government provided services:

- accommodation support services in:
  - institutional/residential settings
  - group homes
  - other community settings
- employment services (reported per employment service user assisted).

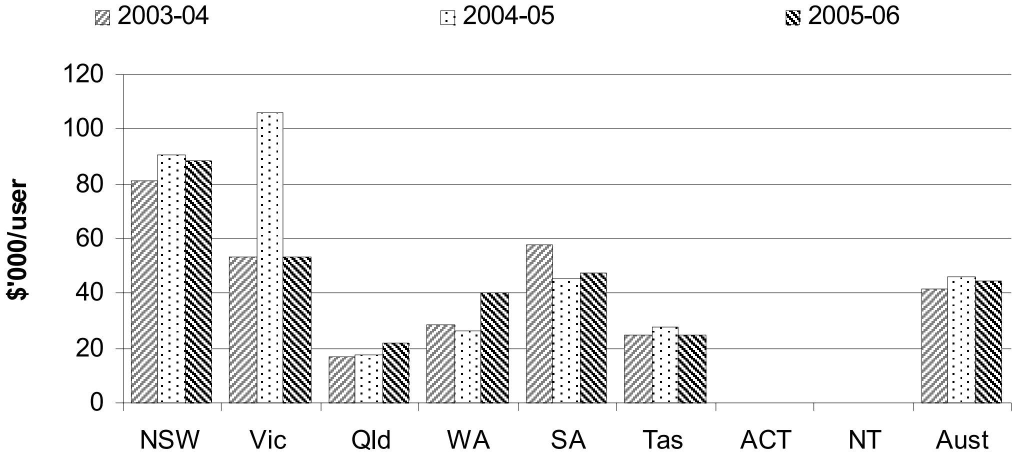
Holding other factors constant (such as service quality and accessibility), a decrease in government expenditure per service user reflects a more efficient provision of this service. However, efficiency data are difficult to interpret.

Although high or increasing expenditure per unit of output may reflect deteriorating efficiency, it may also reflect improvements in the quality or attributes of the services provided, or an increase in the service needs of users. Similarly, low or declining expenditure per unit of output may reflect improving efficiency, or lower quality less effective services. Efficiency data therefore should be interpreted within the context of the effectiveness and equity indicators to derive a holistic view of performance.

Government contribution per user of non-government provided services — accommodation support services in institutional/residential settings

Nationally, estimated annual government funding of non-government provided accommodation support services in institutional/residential settings was $44 653 per service user in 2005-06 (figure 14.33).

Figure 14.33 **Estimated annual government funding per user of non-government provided accommodation support services in institutional/residential settings (2005-06 dollars)**[a, b, c, d]



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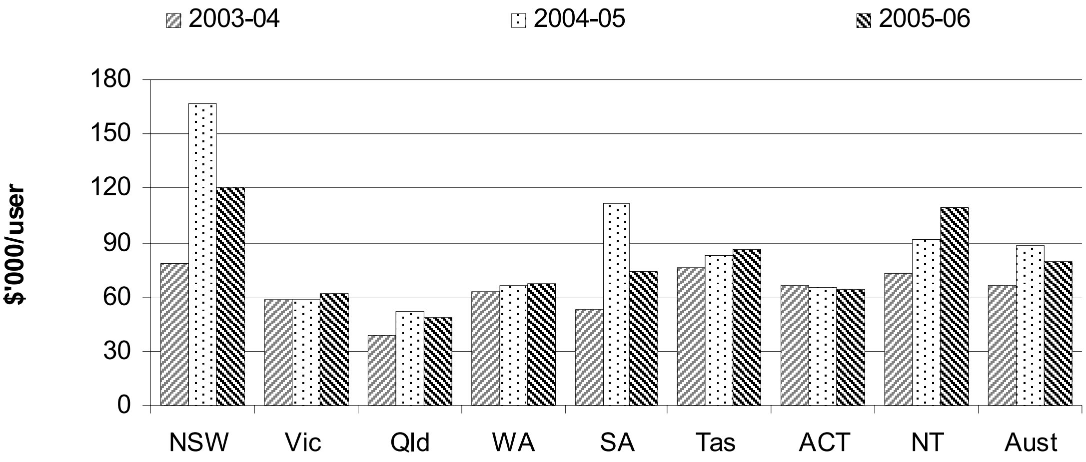
[a] See table 14A.33 for detailed notes relating to these data. [b] The service user data used to derive this indicator have quality issues, so estimates of jurisdictional efficiency need to be interpreted with care. See section 14.6 for further information on these quality issues. [c] The Victorian cost per service user for 2004-05 is overstated due to a move towards community based and individualised settings, which was not reflected in the expenditure data. [d] There were no non-government provided accommodation support services in institutional/residential settings in the ACT and the NT.

Source: AIHW (unpublished); State and Territory governments (unpublished); table 14A.33.

Government contribution per user of non-government provided services — accommodation support services in group homes

Nationally, estimated annual government funding of non-government provided accommodation support services in group homes was $80 059 per service user in 2005-06 (figure 14.34). For 2003-04 and 2004-05, service user data used to derive this indicator exclude users of services provided by local government, while NSW, Victorian, WA and SA expenditure data include services provided by local governments. Thus historical data for this measure need to be interpreted with care.

Figure 14.34 **Estimated annual government funding per user of non-government provided accommodation support services in group homes (2005-06 dollars)**[a, b]



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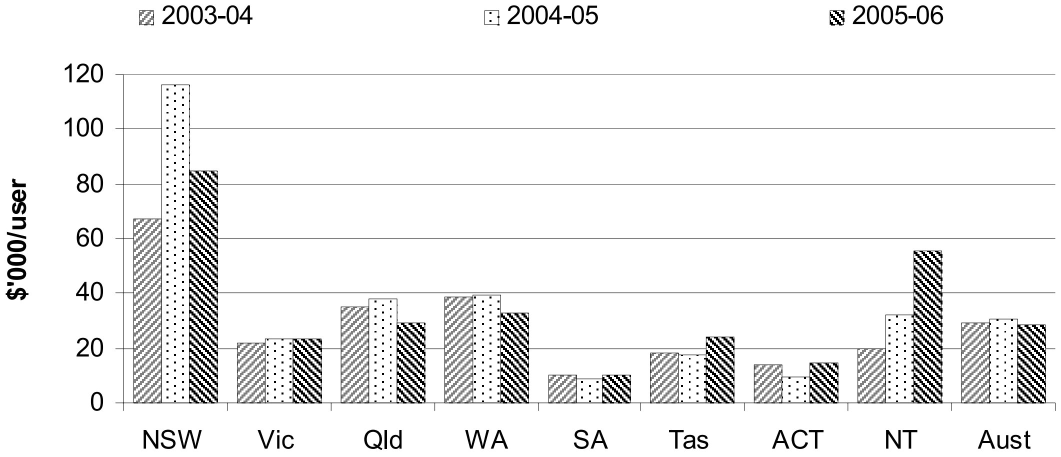
[a] See table 14A.33 for detailed notes relating to these data. [b] The service user data used to derive this indicator have quality issues, so estimates of jurisdictional efficiency need to be interpreted with care. See section 14.6 for further information on these quality issues.

Source: AIHW (unpublished); State and Territory governments (unpublished); table 14A.33.

Government contribution per user of non-government provided services — accommodation support services in other community settings

Nationally, estimated annual government funding of non-government provided accommodation support services in other community settings was $28 245 per service user in 2005-06 (figure 14.35). For 2003-04 and 2004-05, service user data used to derive this indicator exclude users of services provided by local government, while NSW, Victorian, WA and SA expenditure data include services provided by local governments. Thus historical data for this measure need to be interpreted with care.

Figure 14.35 **Estimated annual government funding per user of non-government provided accommodation support services in other community settings (2005-06 dollars)[a, b]**



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[a] See table 14A.33 for detailed notes relating to these data. [b] The service user data used to derive this indicator have quality issues, so estimates of jurisdictional efficiency need to be interpreted with care. See section 14.6 for further information on these quality issues.

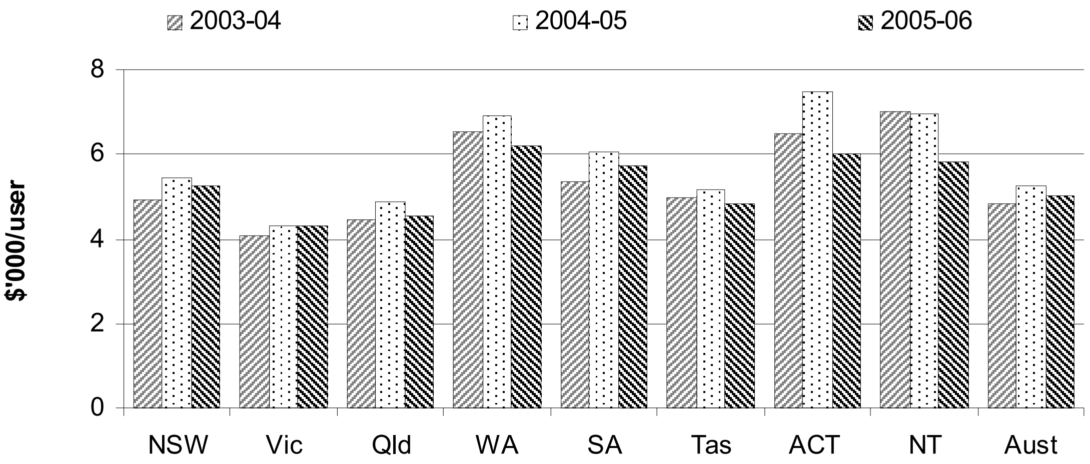
Source: AIHW (unpublished); State and Territory governments (unpublished); table 14A.33.

Government contribution per employment service user assisted

Assistance with employment for people with a disability was the responsibility of the Australian Government under the CSTDA in 2005-06. Nationally, for all employment services, government expenditure per service user assisted was $5014 in 2005-06 (figure 14.36).

Nationally, estimated annual government expenditure per service user in 2005-06, by employment service type, was $3760 on open services (employed or seeking employment in the open labour market) and $7971 on supported services (employed by the service provider) (table 14A.35).

Figure 14.36 **Government contribution per employment service user assisted (2005-06 dollars)**[a, b]



[a] See table 14A.34 and 14A.35 for detailed notes relating to these data. [b] This indicator is derived using service user data provided by the AIHW. Cost per employment service user data may differ from those reported in the Australian Government's annual report, as the Australian Government and the AIHW use different rules to count the number of employment service users. Where a person has used more than one service outlet during the reporting period, the person is counted more than once by the Australian Government, whereas the AIHW counts each person only once. In addition, the Australian Government includes independent workers (1004 persons in 2003-04, 804 persons in 2004-05 and 266 persons in 2005-06) in calculating service user numbers, whereas the AIHW does not.

Source: Australian Government (unpublished); AIHW (unpublished); table 14A.34.

Cost per user of State and Territory administered services

'Cost per user of State and Territory administered services' is an indicator of the efficiency of specialist disability services (box 14.15).

Box 14.15 **Cost per user of State and Territory administered services**

'Cost per user of State and Territory administered services' is an indicator of governments' objective to provide specialist disability services in an efficient manner.

This indicator is defined as government expenditure on CSTDA State and Territory administered services per service user. Data are reported separately for government expenditure net of payroll tax and for government expenditure including actual and/or imputed payroll tax.

Holding other factors constant (such as service quality and accessibility), a decrease in government expenditure per service user reflects a more efficient provision of this service.

(Continued on next page)

Box 14.15 **(Continued)**

Efficiency data are difficult to interpret. Although high or increasing expenditure per unit of output may reflect deteriorating efficiency, it may also reflect improvements in the quality or attributes of the services provided, or an increase in the service needs of service users. Similarly, low or declining expenditure per unit of output may reflect improving efficiency, or lower quality and less effective services. Efficiency data therefore should be interpreted within the context of the effectiveness and equity indicators to derive a holistic view of performance.

Total estimated government expenditure per user of CSTDA State and Territory administered specialist disability services in 2005-06 is reported both net of payroll tax and including actual and/or imputed payroll tax. Nationally, estimated expenditure per service user was $23 512 excluding payroll tax and $23 962 including actual and/or imputed payroll tax (figure 14.37).

Figure 14.37 **Estimated annual government expenditure per user of CSTDA State and Territory administered services, 2005-06**[a, b, c, d]

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[a] In some jurisdictions (NSW, Victoria and SA in part, Queensland, Tasmania and the NT), payroll tax data is actual; in other jurisdictions (Victoria and SA in part, WA, and the ACT), payroll tax data is imputed. [b] Government expenditure per service user for Australia excludes Australian Government expenditure on State and Territory administered services that was not provided as transfer payments. [c] Payroll tax data for Queensland includes paid payroll tax and accrued payroll tax. [d] In the NT, payroll tax relates to government service provision and excludes expenditure for program management and administration.

Source: AIHW (unpublished); State and Territory governments (unpublished); table 14A.36.

Efficiency — administrative cost

Administrative expenditure as a proportion of total expenditure

‘Administrative expenditure as a proportion of total expenditure’ is an indicator of the efficiency of the administration of specialist disability services (box 14.16). The proportion of total expenditure on administration is not yet comparable across jurisdictions because they apportion it using different methods. However, administrative expenditure data can indicate trends within jurisdictions over time.

Box 14.16 **Administrative expenditure as a proportion of total expenditure**

‘Administrative expenditure as a proportion of total expenditure’ is an indicator of governments’ objective to provide specialist disability services in an efficient manner. Administrative expenditure in this context represents the costs incurred by government agencies in administering CSTDA funded services.

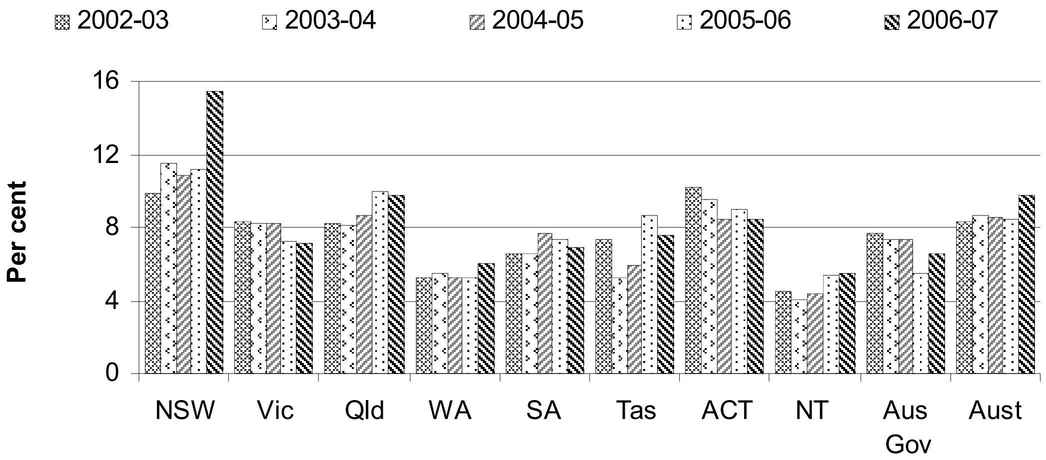
This indicator is defined as government expenditure on administration as a proportion of total CSTDA expenditure.

Holding other factors constant (such as service quality and accessibility), a decrease in administrative expenditure as a proportion of total CSTDA expenditure may reflect an increase in administrative efficiency.

Efficiency data are difficult to interpret. Although high or increasing administrative expenditure as a proportion of total expenditure may reflect deteriorating efficiency, it may also reflect improvements in the quality or attributes of the administrative services provided. Similarly, low or declining administrative expenditure as a proportion of total expenditure may reflect improving efficiency, or lower quality less effective services. Efficiency data therefore should be interpreted within the context of the effectiveness and equity indicators to derive a holistic view of performance.

Nationally, administrative expenditure as a proportion of total government expenditure on specialist disability services (excluding payroll tax) increased from 8.4 per cent in 2005-06 to 9.8 per cent in 2006-07 (figure 14.38). When actual or imputed payroll tax is included, the average national administrative expenditure as a proportion of total CSTDA expenditure was 9.6 per cent in 2006-07 (table 14A.37). Payroll tax data need to be interpreted with caution because some jurisdictions (NSW, Victoria (in part), Queensland, SA (in part), Tasmania and the NT) have provided payroll or payroll tax data on the basis of direct service delivery expenditure for government provided services, and others (WA and the ACT) have provided the data on the basis of total expenditure for government provided services. Real total CSTDA expenditure is reported in table 14A.8, both excluding and including actual or imputed payroll tax amounts.

Figure 14.38 **Administrative expenditure as a proportion of total expenditure**[a, b, c, d, e]



[a] See table 14.2 for an explanation of different methods of apportioning departmental costs. [b] Data exclude payroll tax. [c] Australian Government administrative expenditure is an estimate, based on average staffing levels. [d] NSW administrative expenditure in 2006-07 included $55 million of capital grants. If this $55 million is excluded from expenditure, the percentage in 2006-07 is at a similar level to the previous two years. [e] In Tasmania, the Department administering Disability Services underwent a restructure in 2006-07. Disability Services now falls under the umbrella of a smaller management team. This resulted in a reduction in administration expenditure in 2006-07.

Source: Australian, State and Territory governments (unpublished); table 14A.37.

Outcomes

Outcomes are the impact of services on the status of an individual or group (while outputs are the actual services delivered) (see chapter 1, section 1.5).

The following outcome indicators are reported:

- 'Labour force participation and employment of people with a disability'
- 'Social participation of people with a disability'
- 'Use of other services'.

Labour force participation and employment rate data from the ABS *2006 Census of Population and Housing* are reported for all jurisdictions. The ABS 2006 Census contained questions in relation to people's need for assistance with core activities. Using these questions, individuals with a 'core activity need for assistance' can be identified. The population identified in this way is conceptually comparable to the SDAC population of people with a profound or severe core activity limitation. These data derived from the Census are not suitable for updating the prevalence estimates for the population of people with a profound or severe core activity limitation, but can be used to provide information on their characteristics (ABS 2006a).

Social participation from the GSS 2006 are reported for all jurisdictions. In addition, data on the participation in voluntary work from the ABS 2006 Census are also included. For WA, 2006 social participation data from a jurisdiction specific survey are also included.

For the ‘use of other services’ indicator, the participation of people with a disability in education and training in 2006 and their levels of attainment are included. These data are sourced from ABS 2006 Census. Data are also reported for the first time in relation to the proportion of people with a disability who reported difficulties accessing government and other services as a result of their disability. These data are from the GSS 2006.

Interpreting data for some outcome indicators

For the outcome indicators derived using survey data, 95 per cent confidence intervals are presented These intervals assist with making comparisons between jurisdictions, and between different disability status groups. Confidence intervals are a standard way of expressing the degree of uncertainty associated with survey estimates. An estimate of 80 with a confidence interval of ± 2, for example, means that if another sample had been drawn, or if another combination of test items had been used, there is a 95 per cent chance that the result would lie between 78 and 82. If one jurisdiction’s results ranges from 78–82 and another’s from 77–81, then it is not possible to say with confidence that one differs from the other (because there is unlikely to be a statistically significant difference). Where ranges do not overlap, there is a high likelihood that there is a statistically significant difference. To say that there is a statistically significant difference means there is a high probability that there is an actual difference — it does not imply that the difference is necessarily large or important.

Labour force participation and employment of people with a disability

‘Labour force participation and employment of people with a disability’ is an indicator of outcomes for specialist disability services (box 14.17).

Box 14.17 **Labour force participation and employment of people with a disability**

‘Labour force participation and employment of people with a disability’ is an indicator of governments’ objective of assisting people with a disability to participate fully in the community. Participation in the labour force and employment is important to the overall wellbeing of people with a disability, particularly in terms of the opportunity for self-development and interaction with people outside the home.

This indicator is defined as the labour force participation and employment rates of people aged 15–64 years with a profound or severe core activity limitation. Labour force participation rates and employment rates of people aged 15–64 years without a profound or severe core activity limitation are also reported.

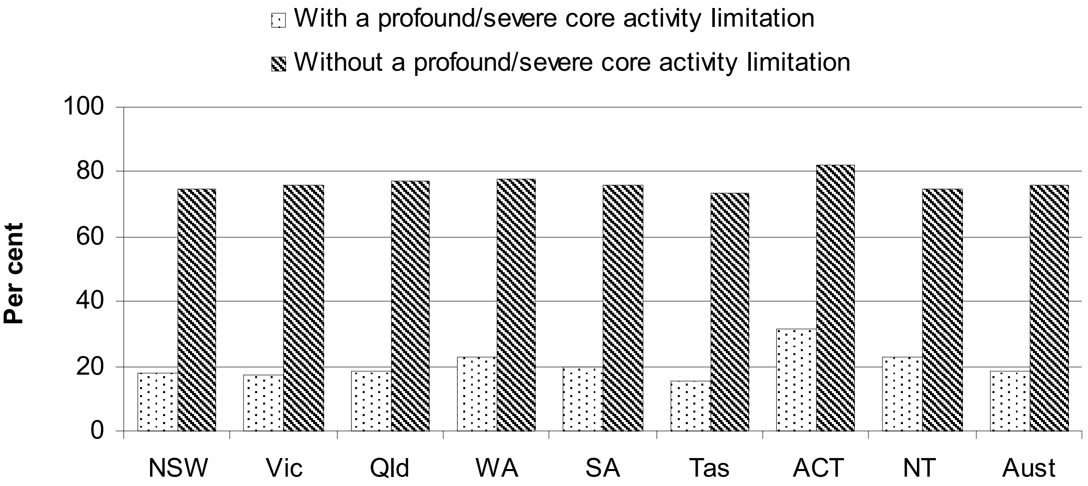
A higher labour force participation or employment rate for people with a profound or severe core activity limitation is likely to increase the quality of life of people by providing greater opportunities for self-development and interaction with people outside the home.

This indicator does not provide information on why people choose not to participate in the labour force and why people are not employed. Finally, it does not provide information on whether the jobs that people find are appropriate or fulfilling.

Labour force participation

Nationally, the estimated labour force participation rate of people aged 15–64 years with a profound or severe core activity limitation in 2006 (18.4 per cent) was below the rate for people without a profound or severe core activity limitation (76.1 per cent) (figure 14.39). The detailed definition of the labour force participation rate and its calculation method is provided in section 14.7.

Figure 14.39 **Estimated labour force participation rates of people aged 15–64 years, by need for assistance status, 2006[a, b]**



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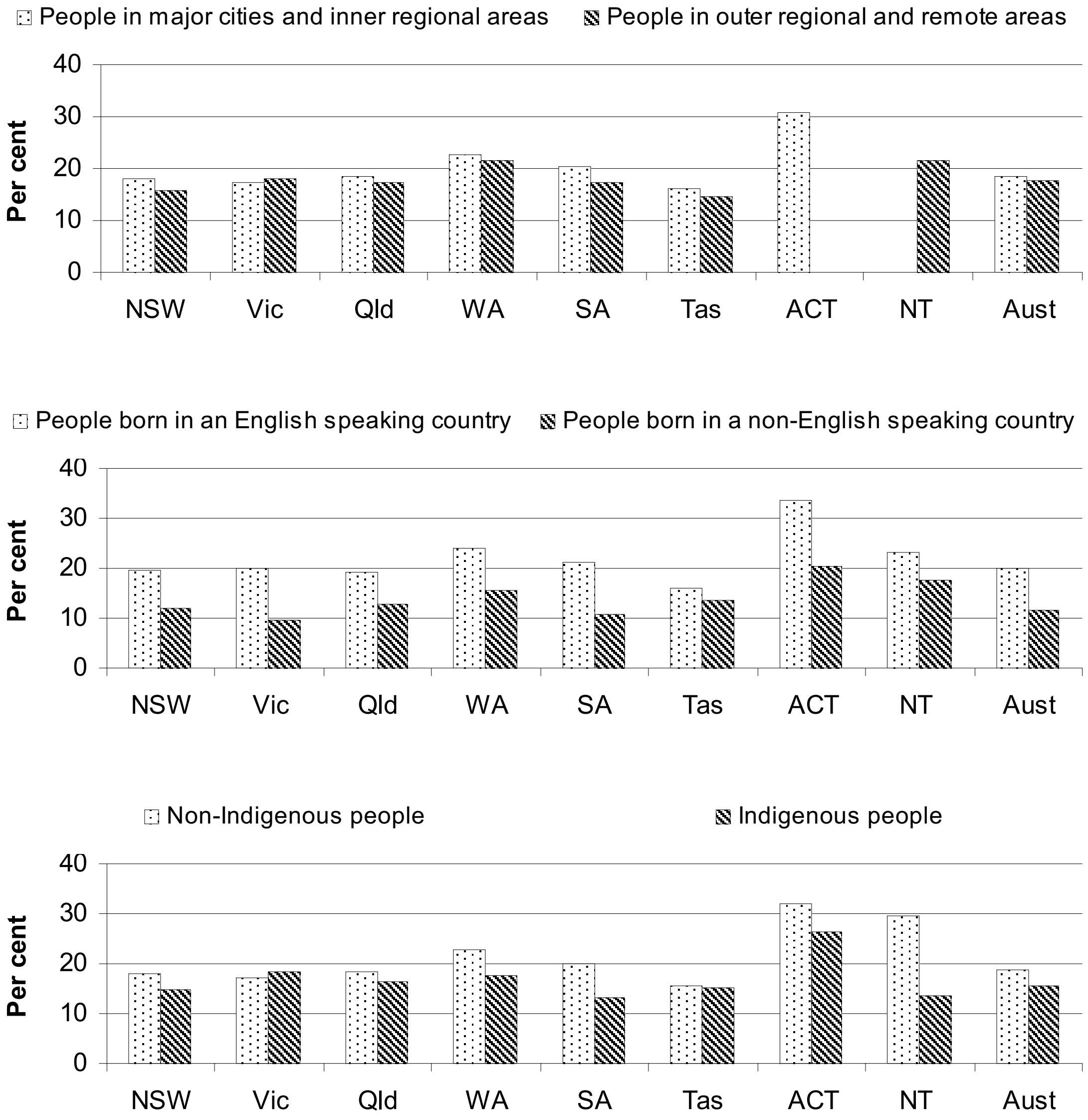
[a] People with a profound or severe core activity limitation are those who need assistance with core activities: self-care, mobility and communication because of a disability or long term health condition (lasting six months or more). [b] The ABS 2006 Census module, used to source these data, was designed to measure 'Core Activity Need for Assistance' (ASSNP). In previous years, the data were sourced from the SDAC and the ABS disability module. The ASSNP is conceptually comparable with the SDAC and ABS disability module population of people who have a profound or severe core activity limitation, but due to the different collection methodology and shortening of the question set used, the population identified is smaller (but displays very similar characteristics). It is likely that the reduction is at the less severe end of the profound or severe core activity limitation population. As such, these data will differ from those of previous years.

Source: ABS (unpublished) *2006 Census of Population and Housing*; table 14A.38.

The labour force participation rates of people aged 15–64 years with a profound or severe core activity limitation by geographic location, country of birth and Indigenous status, in 2006 are reported in figure 14.40. Nationally, the estimated labour force participation rate of people with a profound or severe core activity limitation was:

- 17.5 per cent for those living in outer regional and remote areas, lower than the rate for those living in major cities and inner regional areas (18.6 per cent)
- 11.5 per cent for those born in a non-English speaking country, lower than the rate for those born in an English speaking country (20.1 per cent)
- 15.7 per cent for Indigenous people, lower than the rate for non-Indigenous people (18.6 per cent) (figure 14.40).

Figure 14.40 **Estimated labour force participation rates of people with profound or severe core activity limitation aged 15–64 years, by special needs groups, 2006**[a, b, c, d]



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[a] People with a profound or severe core activity limitation are those who need assistance with core activities: self-care, mobility and communication because of a disability or long term health condition (lasting six months or more). [b] The ABS 2006 Census module, used to source these data, was designed to measure ASSNP. In previous years, the data were sourced from the SDAC and the ABS disability module. The ASSNP is conceptually comparable with the SDAC and ABS disability module population of people who have a profound or severe core activity limitation, but due to the different collection methodology and shortening of the question set used, the population identified is smaller (but displays very similar characteristics). It is likely that the reduction is at the less severe end of the profound or severe core activity limitation population. As such, these data will differ from those of previous years. [c] The ACT does not have outer regional and remote/very remote areas. [d] The NT does not have major cities or inner regional areas.

Source: ABS (unpublished) *2006 Census of Population and Housing*; table 14A.41.

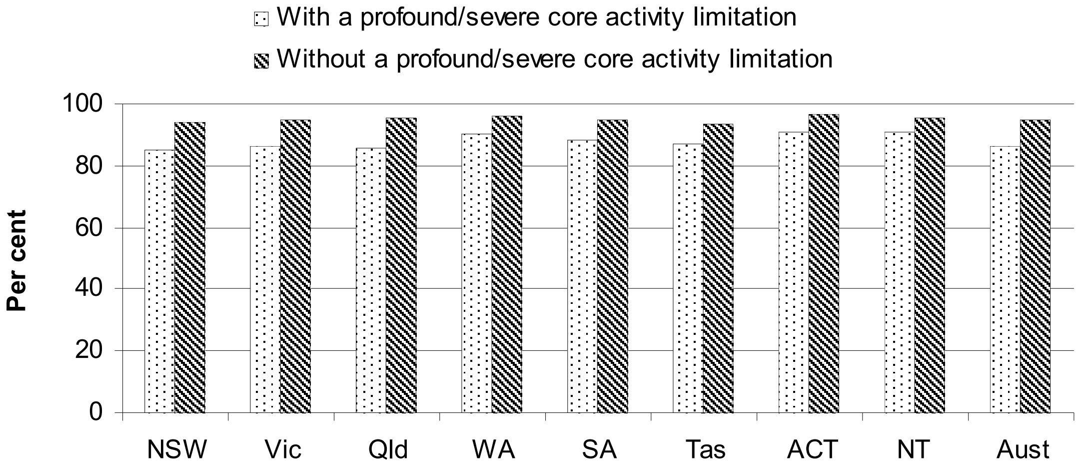
Additional labour force participation data for 2003 and 2005 are shown in tables 14A.39, 14A.40, 14A.42 and 14A.43.

Employment

Nationally, the estimated employment rate of people aged 15–64 years with a profound or severe core activity limitation in 2006 (86.6 per cent) was below the rate for people without a profound or severe core activity limitation (94.7 per cent) (figure 14.41).

The detailed definition of the employment rate and its calculation method is provided in section 14.7. Employment rates should be interpreted in conjunction with labour force participation rates (figures 14.39 and 14.40).

Figure 14.41 **Estimated employment rates of people aged 15–64 years, by need for assistance status, 2006**[a, b]



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[a] The ABS 2006 Census contained a variable ‘core activity need for assistance’. This variable is conceptually comparable with the SDAC population of people with a profound or severe core activity limitation. Data derived from this variable are not suitable for updating the prevalence estimates for this population, but can be used to provide information on the characteristics of this population. [b] People with a profound or severe core activity limitation are those who need assistance with core activities: self-care, mobility and communication because of a disability or long term health condition (lasting six months or more).

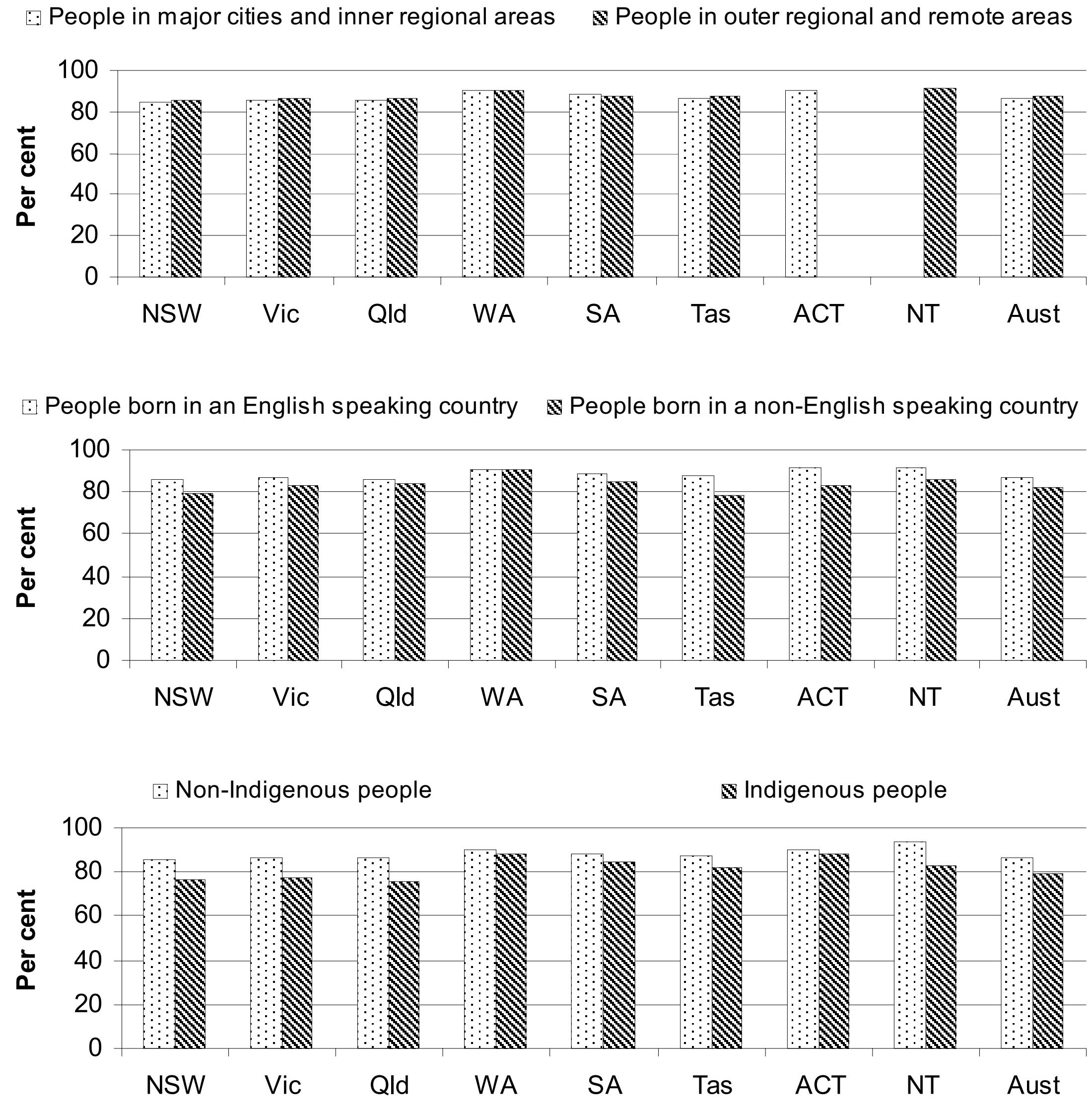
Source: ABS (unpublished) *2006 Census of Population and Housing*; table 14A.38.

The employment rates of people aged 15–64 years with a profound or severe core activity limitation by geographic location, country of birth and Indigenous status, in 2006 are reported in figure 14.42. Nationally, the estimated employment rate of people with a profound or severe core activity limitation was:

- 87.5 per cent for those living in outer regional and remote areas, above the rate for those living in major cities and inner regional areas (86.4 per cent)

- 82.3 per cent for those born in a non-English speaking country, below the rate for those born in an English speaking country (87.1 per cent)
- 79.3 per cent for Indigenous people, below the rate for non-Indigenous people (86.9 per cent) (figure 14.42).

Figure 14.42 **Estimated employment rates of people with profound or severe core activity limitation aged 15–64 years, by special needs groups, 2006**[a, b, c, d]



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[a] The ABS 2006 Census contained a variable 'core activity need for assistance'. This variable is conceptually comparable with the SDAC population of people with a profound or severe core activity limitation. Data derived from this variable are not suitable for updating the prevalence estimates for this population, but can be used to provide information on the characteristics of this population. [b] People with a profound or severe core activity limitation are those who need assistance with core activities: self-care, mobility and communication because of a disability or long term health condition (lasting six months or more). [c] The ACT does not have outer regional and remote/very remote areas. [d] The NT does not have major cities or inner regional areas.

Source: ABS (unpublished) *2006 Census of Population and Housing*; table 14A.41.

Additional employment rate data for 2003 and 2005 are shown in tables 14A.39, 14A.40, 14A.42 and 14A.43.

Social participation of people with a disability

'Social participation of people with a disability' is an indicator of outcomes for specialist disability services (box 14.18).

Box 14.18 **Social participation of people with a disability**

'Social participation of people with a disability' is an indicator of governments' objective to assist people with a disability to live as valued and participating members of the community.

This indicator is defined as the proportion of people with a limitation or specific restriction who participate in selected social or community activities. The proportion of people without a limitation or specific restriction who participate in these activities is also reported. The following measures are reported:

- Estimated proportion of people aged 18–64 years (by level of core activity limitation/restriction) who:
  - attended selected cultural venues/events in the last 12 months
  - attended a sporting event in the last 12 months
  - were actively involvement in a social or support group in the last 12 months
  - had face-to-face contact with family and friends at least once a month.
- Proportion of people aged 15–64 years who spent time doing unpaid voluntary work through an organisation or group, in the last 12 months.

A higher proportion of people aged 15–64 years with a limitation or specific restriction who participate in social or community activities reflects their greater integration in the community.

This indicator does not provide information on the degree to which the identified types of social or community activities contribute to people's quality of life. It also does not provide information on why some people did not participate.

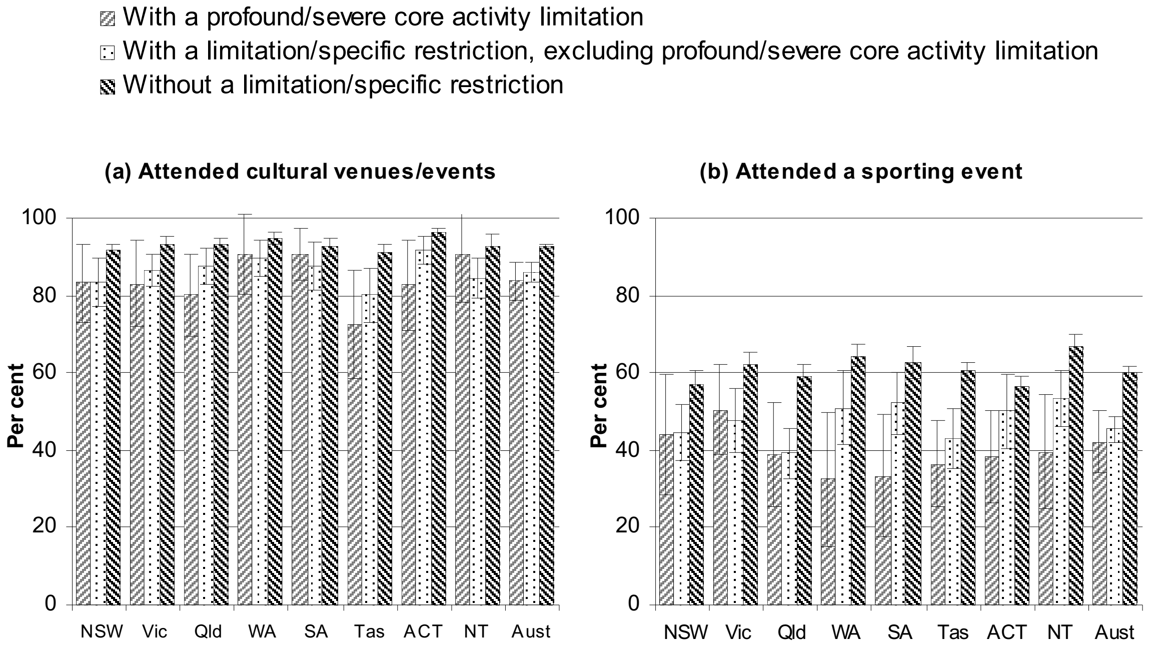
Nationally, the estimated proportion of people with a profound or severe core activity limitation aged 18–64 years who participated in social and community activities were as follows:

- 83.7 ± 4.9 per cent attended selected cultural venues/events, no different to the proportion for other people with a limitation or specific restriction, excluding profound or severe core activity limitation (86.1 ± 2.7 per cent), but below the proportion for people without a limitation or specific restriction (92.9 ± 0.5 per cent) (figure 14.43a)

- 42.2 ± 7.9 per cent attended a sporting event, no different to the proportion for other people with a limitation or specific restriction, excluding profound or severe core activity limitation (45.5 ± 3.5 per cent), but below the proportion for people without a limitation or specific restriction (60.0 ± 1.8 per cent) (figure 14.43b)
- 53.9 ± 6.9 per cent were involved in a social/support group, no different to the proportion for other people with a limitation or specific restriction, excluding profound or severe core activity limitation (58.9 ± 3.5 per cent), but below the proportion for people without a limitation or specific restriction (64.2 ± 1.5 per cent) (figure 14.43c)
- 91.9 ± 3.2 per cent had face-to-face contact with family and friends at least once a month, no different to the proportion for other people with a limitation or specific restriction, excluding profound or severe core activity limitation (91.7 ± 2.0 per cent) or the proportion for people without a limitation or specific restriction (94.4 ± 0.6 per cent) (figure 14.43d).

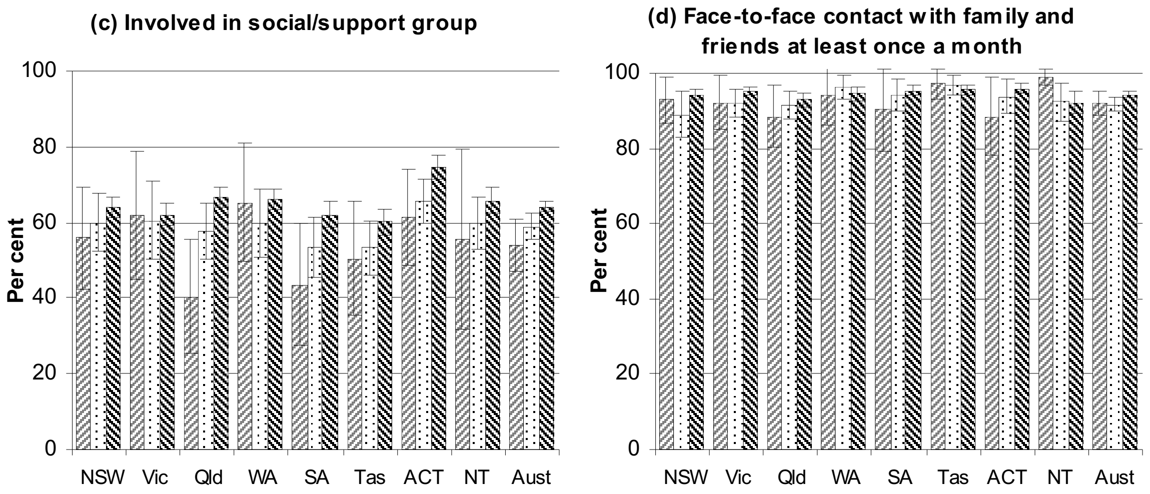
Nationally, the proportion of people with a profound or severe core activity limitation aged 15–64 years who participated in voluntary work for an organisation or group in 2006 was 14.3 per cent, below the proportion for people without a profound or severe core activity limitation (19.4 per cent) (figure 14.44).

Figure 14.43 **Estimated proportion of people aged 18–64 years who participated in social and community activities, by disability status, 2006**[a, b, c]



(a) Attended cultural venues/events

(b) Attended a sporting event



(c) Involved in social/support group

(d) Face-to-face contact with family and friends at least once a month

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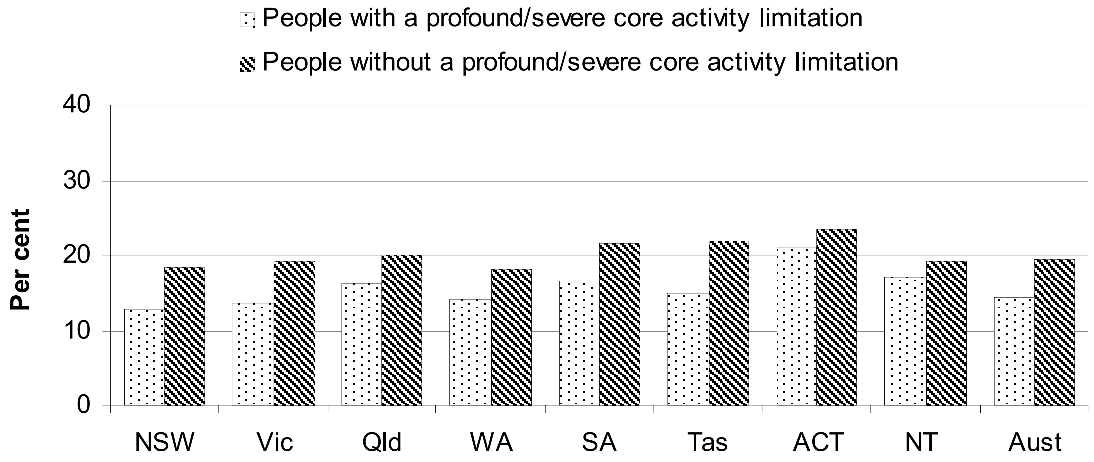
[a] Due to differences in collection methodology, the data collected by the GSS relate to a broader 'disability and long-term health condition' population than the 'disability' population obtained from the much more detailed SDAC — however, the characteristics of the populations are similar. The data are suitable for population comparisons, but not for prevalence updates between SDAC surveys. [b] Profound or severe core activity limitation refers to always or sometimes needing assistance with one or more of the core activities. Core activities comprise communication, mobility and self-care. [c] Error bars represent the 95 per cent confidence interval associated with each point estimate.

Source: ABS (2006b); table 14A.44.

Figure 14.44 **Estimated proportion of people aged 15–64 years who participated in voluntary work for an organisation or group, by need for assistance status, 2006**[a, b]



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[a] The ABS 2006 Census contained a variable 'core activity need for assistance'. This variable is conceptually comparable with the SDAC population of people with a profound or severe core activity limitation. Data derived from this variable are not suitable for updating the prevalence estimates for this population, but can be used to provide information on the characteristics of this population. [b] People with a profound or severe core activity limitation are those who need assistance with core activities: self-care, mobility and communication because of a disability or long term health condition (lasting six months or more).

Source: ABS (unpublished) *2006 Census of Population and Housing*; table 14A.45.

In 2006, WA conducted a survey of users of disability services (or their carers) on their participation in various social activities. Results of this survey are provided in box 14.19. Additional data from on the social participation of people with a disability are in tables 14A.46 and 14A.47.

Box 14.19 **Social participation of people with a disability in WA**

In 2006, 1250 randomly selected users of disability services (or their carers) were surveyed on their participation in a range of social activities. The questions used in the survey were based largely on previous surveys but were modified to align with the International Classification of Functioning categorisation of functions.

The surveyed service users (or carers) were asked if they participated in the activities 'often', 'sometimes', 'rarely' or 'never'. The 'often' and 'sometimes' categories were combined to indicate participation in these activities. Surveyed service users were also asked whether they wanted to participate in the activities 'more often', 'less often' or 'not change'.

(Continued on next page)

Box 14.19 **(Continued)**

The following are the reported results of service users' participation, where:

- 70 per cent reported going out to entertainment (for example, movies, restaurants and concerts), 15 per cent reported never going out to entertainment and 54 per cent reported wanting to participate in these activities more often
- 57 per cent reported being involved in group leisure or sport, 36 per cent reported never being involved in group leisure or sport and 48 per cent reported wanting to participate in these activities more often
- 82 per cent reported being involved in individual activities such as going to the park, walking or swimming, 10 per cent reported never being involved in individual activities and 42 per cent reported wanting to participate in these activities more often
- 41 per cent reported attending cultural, religious or community events, 47 per cent reported never being involved in these events and 17 per cent reported wanting to participate in these activities more often
- 66 per cent reported communicating with people other than carers, friends or family members, 19 per cent reported never communicating with these people and 34 per cent reported wanting to communicate with these people more often.

Source: WA Government (unpublished).

Use of other services

'Use of other services' is an indicator of outcomes for specialist disability services (box 14.20).

Box 14.20 **Use of other services**

'Use of other services' is an indicator of governments' objective of enhancing the quality of life experienced by people with a disability by assisting them to gain access to generic government and community services and facilities.

This indicator has the following two measures:

- The proportion of people with a profound or severe core activity limitation who:
  - participated in pre-schools (aged 3–5 years), secondary schools (aged 15–24 years), technical or further education and universities (aged 15–64 years)
  - reached certain levels of educational and training attainment.

  Data are also reported for those without a profound or severe core activity limitation.

(Continued on next page)

Box 14.20 **(Continued)**

- The proportion of people with a profound or severe core activity limitation aged 18–64 years who reported difficulties accessing government and other services as a result of their disability.

Higher proportions of people with a disability participating in education and training or reaching higher levels of educational and training attainment is desirable as it suggests greater access to generic government educational and training services.

Lower proportions of people with a profound or severe core activity limitation who reported difficulties accessing services as a result of their disability is desirable as it suggests greater access to generic government and community services.

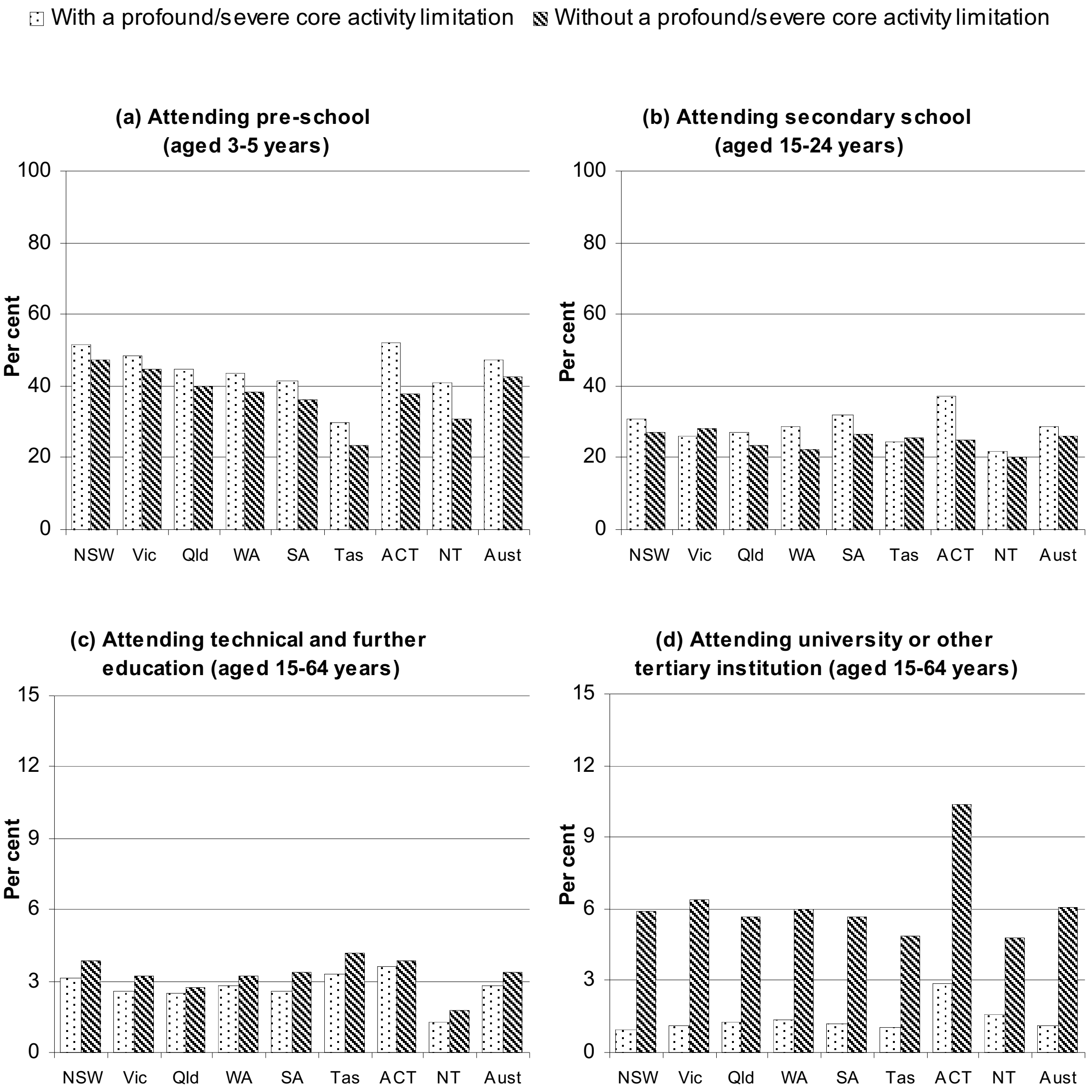
This indicator does not provide information on the degree to which the services contribute to people's quality of life. It also does not provide information on why some people do not access these services.

Education and training

Nationally in 2006, the proportion of children/people with a profound or severe core activity limitation:

- aged 3–5 who participated in pre-schools was 47.3 per cent, above the proportion for those without a profound or severe core activity limitation (42.6 per cent) (figure 14.45a)
- aged 15–24 who participated in secondary schools was 28.7 per cent, above the proportion for those without a profound or severe core activity limitation (26.0 per cent) (figure 14.45b)
- aged 15–64 who participated in technical or further education was 2.8 per cent, below the proportion for those without a profound or severe core activity limitation (3.4 per cent) (figure 14.45c)
- aged 15–64 who participated in university was 1.1 per cent, below the proportion for those without a profound or severe core activity limitation (6.0 per cent) (figure 14.45d).

Figure 14.45 **Estimated proportion of people who participated in education and training, by need for assistance status, 2006**[a, b]



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[a] The ABS 2006 Census contained a variable ‘core activity need for assistance’. This variable is conceptually comparable with the SDAC population of people with a profound or severe core activity limitation. Data derived from this variable are not suitable for updating the prevalence estimates for this population, but can be used to provide information on the characteristics of this population. [b] People with a profound or severe core activity limitation are those who need assistance with core activities: self-care, mobility and communication because of a disability or long term health condition (lasting six months or more).

Source: ABS (unpublished) *2006 Census of Population and Housing*; table 14A.48.

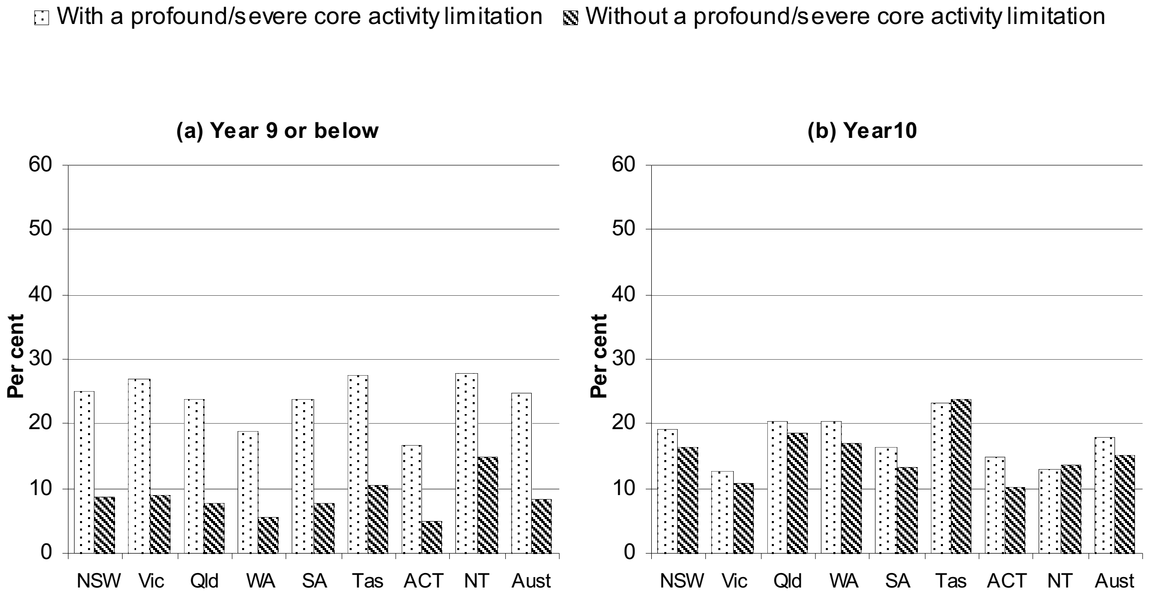
Nationally in 2006, the proportion of people with a profound or severe core activity limitation aged 15–64 whose highest level of educational attainment was:

- year 9 was 24.6 per cent, above the proportion for people without a profound or severe core activity limitation (8.2 per cent) (figure 14.46a)

- year 10 was 17.8 per cent, above the proportion for people without a profound or severe core activity limitation (15.2 per cent) (figure 14.46b)
- year 11/12 was 17.8 per cent, below the proportion for people without a profound or severe core activity limitation (26.2 per cent) (figure 14.46c)
- diploma, certificate, bachelor degree or above was 21.8 per cent, below the proportion for people without a profound or severe core activity limitation (42.9 per cent) (figure 14.46d).

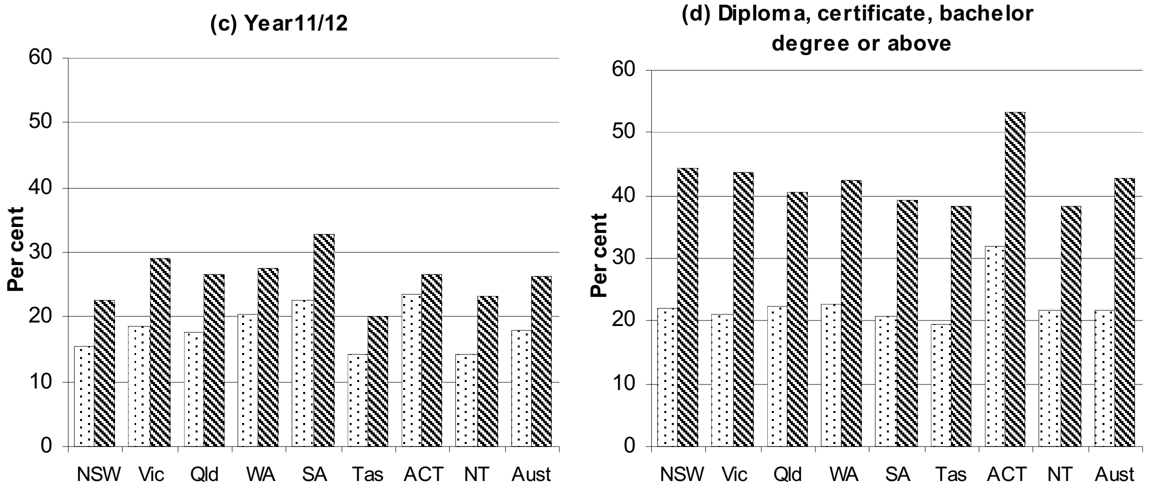
Additional education and training participation and attainment data for 2005 are shown in tables 14A.49 and 14A.51.

Figure 14.46 **Level of highest educational attainment of people aged 15–64, by need for assistance status, 2006[a, b]**



(a) Year 9 or below

(b) Year10



(c) Year11/12

(d) Diploma, certificate, bachelor degree or above

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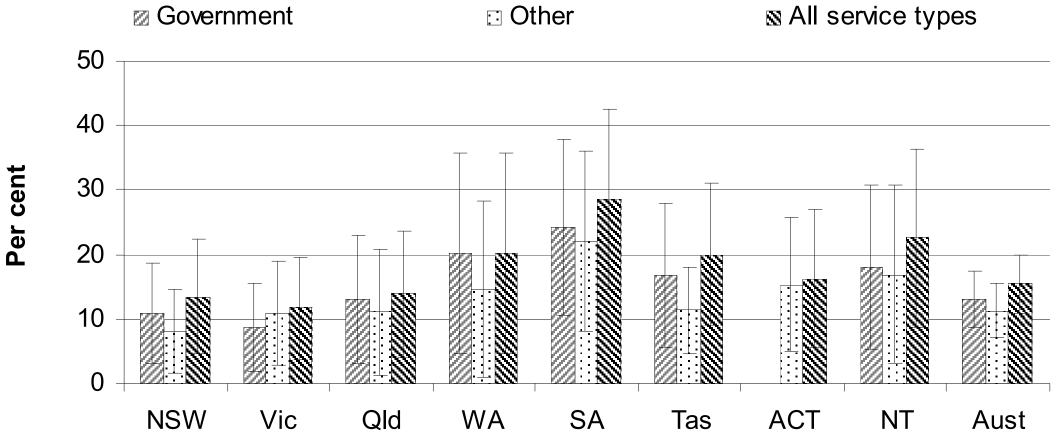
[a] The ABS 2006 Census contained a variable 'core activity need for assistance'. This variable is conceptually comparable with the SDAC population of people with a profound or severe core activity limitation. Data derived from this variable are not suitable for updating the prevalence estimates for this population, but can be used to provide information on the characteristics of this population. [b] People with a profound or severe core activity limitation are those who need assistance with core activities: self-care, mobility and communication because of a disability or long term health condition (lasting six months or more).

Source: ABS (unpublished) *2006 Census of Population and Housing*; table 14A.50.

Difficulties accessing services

Nationally in 2006, the proportion of people with a profound or severe core activity limitation aged 18–64 years who reported difficulties accessing government, other and all service types as a result of their disability was 12.9 ± 4.3 per cent, 11.3 ± 4.2 per cent and 15.4 ± 4.5, respectively (figure 14.47). Results for people with a limitation or specific restriction, excluding profound or severe core activity limitation, are reported in table 14A.52.

Figure 14.47 **People with a profound or severe core activity limitation aged 18–64 who reported difficulties accessing services as a result of their disability, by service sector, 2006 (per cent)**[a, b, c, d]



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[a] Due to differences in collection methodology, the data collected by the GSS relate to a broader 'disability and long-term health condition' population than the 'disability' population obtained from the much more detailed SDAC — however, the characteristics of the populations are similar. The data are suitable for population comparisons, but not for prevalence updates between SDAC surveys. [b] Other relates to private and not-for-profit services. [c] Profound or severe core activity limitation refers to always or sometimes needing assistance with one or more of the core activities. Core activities comprise communication, mobility and self-care. [d] Error bars represent the 95 per cent confidence interval associated with each point estimate. Data with relative standard errors over 50 per cent are not published (this is the case for government services in the ACT).

Source: ABS (2006b); table 14A.52.

Other data

Data on the participation of people with a disability in various government services are also incorporated in the performance indicator frameworks for other chapters of this Report. Participation is reported for children's services (see chapter 3), VET (see chapter 5), and public, community and State owned and managed Indigenous housing (see chapter 16). In addition, the following chapters include data on services provided to people with a disability:

- ‘School education’ (see chapter 4) reports data on students with a disability in the student body mix.
- ‘Health management issues’ (see chapter 12) reports performance data on specialised mental health services.
- ‘Aged care services’ (see chapter 13) reports data on HACC services received, including those received by people with a profound, severe or moderate core activity limitation, disaggregated by jurisdiction and geographic location.

14.4 Future directions in performance reporting

There is scope for further improvements in reporting against the current framework, including improvements to the data on service quality. The Steering Committee intends to address limitations over time by:

- considering whether the most recent year’s service user data are available for reporting
- considering the development of an indicator on quality of life
- considering complimenting the descriptive data on younger people with a disability in residential aged care facilities with a performance indicator
- reporting national client and carer satisfaction with service quality
- reporting more complete, current, ongoing quality assurance processes data — reporting on quality assurance processes is expected to become more complete and comparable over time, with refinements to performance indicators and data collections.

14.5 Jurisdictions’ comments

This section provides comments from each jurisdiction on the services covered in this chapter. Appendix A contains data that may assist in interpreting the performance indicators presented in this chapter. These data cover a range of demographic and geographic characteristics, including age profile, geographic distribution of the population, income levels, education levels, tenure of dwellings and cultural heritage (including Indigenous and ethnic status).

Australian Government comments

- In 2006-07 the Australian Government expanded upon the gains made through reforms to the business service sector, assisting services to operate as commercially viable enterprises and increasing the provision of quality support available to over 20 000 individuals with more severe disability.
- The 2006 Business Services Case Based Funding Review confirmed the implementation of the case based funding model has resulted in increased employment opportunities and outcomes for individuals with disability. Under the new model more individuals are being supported and the number of employees reaching a sustainable employment outcome has also increased, with an employment outcome rate of 83 per cent for workers commencing in 2005.
- Business services continue to benefit from the flexible assistance available through the Security, Quality Services and Choice for People with Disabilities package announced in April 2004. Participation of business services in the package remains at over 90 per cent and so far $43.9 million in funding has been approved to boost the viability of business services.
- In 2006-07, several new initiatives commenced to promote the business services sector, building upon the significant gains established by flexible business assistance.
- The Australian Government continues to build on the successful implementation of full case based funding, implement initiatives related to Welfare to Work reforms and improve accountability and performance reporting.
- The successful implementation of uncapped DEN services in July 2006 resulted in over 8000 commencements in the first year of operation. 106 organisations began delivering uncapped services from 529 sites.
- 208 organisations delivered the DEN capped stream from 325 sites and provided employment assistance to over 52 000 clients.
- Over 28 000 new job seekers entered into assistance with DEN services.
- Key performance indicators and their weightings in the Disability Employment Network Star Ratings performance framework for the 2006-09 funding period were finalised after significant consultation with the disability employment sector.
- 36.3 per cent of DEN capped jobseekers who completed 18 months from entering assistance during 2006-07 achieved a sustainable employment outcome (8 hours of work per week for 26 weeks).
- A new remote servicing model was introduced in 2006-07 to provide a suite of employment services, including DEN, to communities in 16 Remote Employment Service Areas. Job seekers with disability in the most remote parts of Australia will benefit from the new model, which allows employment service providers to more effectively tailor services to suit local conditions.

New South Wales Government comments

The NSW Government continued its commitment to providing services to people with a disability and their carers to assist them to live independently and participate in community life. The total expenditure for the disability services reported in this chapter has doubled during the past ten years, reaching over $1.3 billion in 2006-07.

In 2006, the NSW Government announced its 10-year Plan, *Stronger Together: a new direction for disability services: 2006–2016*. Stronger Together represents an historic investment in disability services that will provide long term and practical solutions to support people with a disability and their families. In 2006-07, an investment of $154 million delivered a wide range of new services.

Significant progress has been made to support the growing need for disability services during the year. These include 1138 new respite places made up of flexible respite places and centre-based respite places to provide short-term breaks for carers of children and people with a disability; 95 new Attendant Care places at a cost of $5.3 million per annum as part of the significant expansion of intensive in-home support for people with a disability; 1200 new therapy places; 110 general specialist support places allocated to regions; 36 long-term specialist support places to support people with a disability who are leaving custody and an additional 74 long-term accommodation or support arrangements for young people leaving care and 19 support coordination services to support older parent carers.

Substantial changes to the Community Participation Program were introduced by the NSW Government after extensive consultation, resulting in greater choices and increased funding and service hours.

Other new initiatives included the establishment of the Office of the Senior Practitioner to oversight behaviour support practices and psychology services for people with a disability in NSW. The University of NSW was selected to host the new Chair in Disability Mental Health with the aim of enhancing mental health services to people with an intellectual disability.

In March 2007, the NSW Government launched *Better Together: A new direction to make NSW Government services work better for people with a disability and their families 2007–2011. Better Together* identifies how government agencies will coordinate their efforts across all services so that people with a disability can participate fully in education, employment and community life. This whole-of-government plan had extensive input from 12 other NSW Government agencies. Key themes include early intervention, improving access to therapy and strengthening services and support for children with autism and their families. The plan will complement the work of Stronger Together in delivering better services for people with a disability, their families and carers.

Victorian Government comments

The Victorian Government continues the implementation of the *Victorian State Disability Plan 2002–2012*, which emphasises that people with a disability have the same rights, responsibilities and opportunities to participate in the life of the community as other citizens in Victoria. The *Disability Act 2006* became operational on 1 July 2007 and in 2006-07 the department achieved significant milestones in implementing the new legislation. Key activities included:

- establishing the Office of the Senior Practitioner to lead best practice in behaviour management and to protect the rights of people subject to compulsory treatment and restrictive interventions
- establishing the Office of the Disability Services Commissioner to address complaints raised by and on behalf of people with a disability, their families and carers
- introducing revised standards and performance measures for service delivery and proposals for independent monitoring of service providers
- creating a policy framework to support the legislation and provide the structure for implementation of the Act; amending relevant polices and procedures to reflect the requirements of the new Act; and providing resources to inform service providers of their responsibilities and service users of their rights under the Act.

Other key achievements for 2006-07 included:

- continuing to broaden implementation of the Individualised Planning and Support approach by trialling a direct payments model in which people with a disability can choose and directly pay for their own support. Victoria provided an additional 170 Support and Choice packages, and 200 new support packages for ongoing day activities to Futures for Young Adults participants
- publishing *Partnering for the future: The Victorian industry development plan for the provision of support for people with a disability.* Developed in partnership with industry stakeholders, the plan focuses on establishing new practices and contemporary approaches to the way support for people with a disability is provided in the future
- the Changing Days initiative funded ten projects in both metropolitan and rural areas to assist day service providers in the transition to new service delivery approaches that promote individualised planning and support as well as broader, more innovative partnerships within the community sector
- Through the *My future, My choice* initiative, working with young people living in aged care facilities and their families to find them better homes and care. New support options include a new high care service which is expected to be operational in 2008 and new services in Southern and Eastern regions
- developing a strategy to improve the health and wellbeing of people with a disability in department-managed accommodation services.

Queensland Government comments

“The successful implementation of the *Disability Services Act 2006* demonstrates Queensland’s continued commitment to improving legislation and policy for disability services throughout the state. The *Disability Services Act 2006* is a vital part of strengthening and safeguarding the rights of people with a disability. Each Queensland Government department is implementing a Disability Service Plan to ensure it applies the human rights and service delivery principles outlined in the Act. From 1 July 2007, these plans will help to ensure that policies for people with a disability are embedded into the business of each Queensland Government department.

As a result of feedback received from the disability sector through initiatives such as the *Have Your Say* community consultation project; conferences; and the Disability Council of Queensland and Regional Disability Councils, Queensland developed and launched a $52 million, four-year program of reform, *Growing Stronger*. The program of reform will improve the way specialist disability services are delivered and create a better, fairer, disability service system. In association with the *Growing Stronger* initiative, Queensland announced its four-year, $113 million Specialist Response Service initiative which details a legislative framework and service model to better protect the human rights of and deliver improved outcomes for adults with an intellectual/cognitive disability who exhibit challenging behaviour. Supporting the information requirements arising from these initiatives, Queensland launched the Disability Services Queensland Information System, an information system to support service delivery to people with a disability, their families and carers.

We have continued to meet our responsibilities under the *Commonwealth State/Territory Disability Agreement 2002–2007* with additional investment from $239 million in 2002-03 to an estimated $523 million in 2006-07, increasing service provision in the areas of accommodation support, community support, community access, respite, and information and print disability services.

In August 2006, Queensland committed $23.9 million over five years to the joint Younger People with a Disability in Residential Aged Care Initiative with the Commonwealth Government. Queensland progressed this initiative with the commencement of assessment and planning for individuals, and program design for a continuum of appropriate models for living and support arrangements. We also allocated additional funding to existing programs, for example, $3 million for the Post School Services Program. Through this funding, we supported an additional 188 young people with high support needs to make the transition from student to adult life in their community. The total number of young people assisted through this program since its inception is 1914.

Throughout 2006-07, the Queensland Government, together with funded non-government service providers, increased support to approximately 18 480 people with a disability with access to an increased number of services of around 35 700. Queensland has continued its ongoing commitment to improving the quality of disability services through the Disability Sector Quality System.”

Western Australian Government comments

“The WA Government has continued to develop and sustain services for people with disabilities and their carers. A review of disability services through the Disability Services Sector Health Check was completed to evaluate the sector and to determine whether Government resources were being used effectively, efficiently and in the best interests of people with disabilities in WA. There were 67 recommendations arising from the review including: the development of a long-term (15 years minimum) WA State Disability Plan; making all aspects of the WA community accessible, inclusive and responsive to the needs, requirements and aspirations of people with disabilities, their families and carers; the development of a Community Living Plan to promote a range of alternative pathways to enable people with disabilities to live within the community; improving responses to the changing needs of people with rapidly degenerating conditions; and the development of an outcomes framework to evaluate the outcomes of the programs and services provided.

There has been a major statewide focus on making local communities more accessible and inclusive, with State Government departments and local government authorities lodging Disability Access and Inclusion Plans with the Commission. The WA Government has continued to raise community awareness on disability issues through the Count Us In campaign, which included media advertising and a new website; distribution of the Count Us In! curriculum support package which promotes disability awareness to all WA schools; and the distribution of grants to local governments to develop and implement You’re Welcome — Western Australian Access Strategy packages.

The Getting Services Right information package for Aboriginal people with disabilities, their families and service providers was actively promoted across WA. The first year of the Commission’s Substantive Equality Five Year Plan for people from Aboriginal and culturally and linguistically diverse backgrounds was completed. Development of a Memorandum of Agreement with South West Area Health was undertaken to complete the implementation of a consistent, statewide model of therapy services for people with disabilities living in regional areas.

The role of carers was also widely promoted to staff, funded agencies, carers and individuals through the promotion of the *Carers Recognition Act 2004* which recognises the crucial role that carers play in supporting people with disabilities and the Carers Charter.

The Annual Client and Service Data Collection system was redeveloped, following extensive consultation with the non-government agencies and internal service providers, to an internet web-based system which will provide an efficient data collection system that will enable ready and ongoing access for all service providers to electronically enter data for the CSTDA NMDS data.”

South Australian Government comments

“ *Disability SA* was formed as a result of merging three government providers of disability services into a single government disability service. The new service is designed to deliver an integrated, streamlined and accountable system of government-provided services. The *Office of Disability and Client Services* leads strategic planning and policy and resource allocation across the disability sector.

Some key achievements for 2006-07 include:

- *South Australia’s Strategic Plan* was revised to include three major disability targets relating to increased community based accommodation, day options programs and employment of people with a disability
- significant progress achieved in relation to government agencies’ provision of disability awareness training consistent with a whole of government *Disability Awareness and Discrimination Training Framework*
- continued the provision of community accommodation for *people exiting institutions*
- developed and implemented a *Supported Accommodation Strategy* aimed at delivering a streamlined system of accommodation and personal support incorporating: a single waiting list; a single entry point for services; an increased Disability Housing Program; standardised approaches to the assessment of client needs and the allocation of services; and monitoring of data and planning for future need
- the Child and Youth Teams within Disability SA provided case management for all *children and young people* under Guardianship of the Minister with a disability up to 25 years of age in recognition of transition stressor factors. In addition:
  - the *Richard Llewellyn Trust Fund* specifically for children and young people with disabilities to undertake Arts related projects was finalised with the fund administered by Arts SA
  - the *Dame Roma Mitchell Trust Fund* for children and young people who are or have been under Guardianship of the Minister was established with the first round of grants approved in May 2007
- a new service was implemented in 2006 to address the needs of people with complex needs including psychiatric disability. The service focuses on addressing homelessness and social exclusion among this population
- transferred the Supported Residential Facilities Program to Disability Services SA to further improve service provision, such as personal support services to residents
- developed service agreements to extend the Supported Accommodation Demonstration Project for a further 12 months and undertook a review of some projects. ”

Tasmanian Government comments

During 2006-07, Disability Services implemented a new organisational structure, as part of the Tasmanian Department of Health and Human Services organisational reform agenda. The new structure is designed to reduce the number of management layers, provide additional support to operational managers through increased resources and accountability, and emphasising the need to work in close partnership with associated service areas across the Department and the broader community.

Workforce planning for the disability services sector was progressed in collaboration with representatives from the community services sector throughout 2006-07. The *Disability Services Sector Workforce Development Strategy 2007-08–2011-12* was released in June 2007. The strategy is the beginning of a collaborative partnership between government and non-government disability service providers, and is underpinned by a five year framework which includes three focus areas: professional learning, human resources; and health and safety. Key activities will be workforce planning, including learning and development activities and sustainable recruitment and retention initiatives. The Strategy is aligned to national and state workforce research.

Other notable achievements during 2006-07 included:

- development and opening of three new group homes providing ongoing accommodation support for 12 people
- continuation of the *Living Independently* project. Under this project management of all group homes managed by the Government will be transferred to the non-government sector. During 2006-07 two sites were transferred with the remainder to be transferred during 2007-08
- implementation of satisfaction surveys as part of Disability Services Quality Review and Improvement System. Client and family satisfaction surveys were undertaken within all centre based respite services in Tasmania
- formation of a Joint Working Group to facilitate discussion and collaboration between the department and the non-government sector on the provision of disability services. In December 2006 the working group provided the Minister for Health and Human Services with an interim report containing 13 recommendations covering major policy and service delivery issues
- the announcement of an independent review of Disability Services in Tasmania to be undertaken during 2007-08.

Australian Capital Territory Government comments

The Department of Disability, Housing and Community Services, through Disability ACT (DACT), continued to advance its strategic plan as outlined in *Future Directions: a framework for the ACT 2004–2008* to:

- promote an inclusive society
- strengthen the capacity of individuals with a disability and their families to maximise control over their lives
- improve planning and use of available resources
- in partnership with the community sector, strengthen the sustainability and responsiveness of the service delivery sector.

Recent initiatives have included:

- Local Area Co-ordination was established in 2006 to build and maintain relationships with individuals of all ages and families enabling them to connect with their local areas. The service model includes community development strategies to support the inclusion of people with disabilities into mainstream activities, as well as co-ordinating assistance to people with disabilities accessing formal support services
- in October 2006, the ACT Disability Advisory Council convened a Citizens Jury as a means of generating a scorecard for *Challenge 2014 — a ten year vision for disability in the ACT*. The Jury's report acknowledged the work that had been done in recent years in developing a better ACT Government disability policy framework and move towards improved community partnerships
- in February 2007, DACT released a revised Individual Support Package Policy, incorporating feedback following a development process with individuals, families and community organisations
- in 2007, DACT commissioned Dr Michael Kendrick to conduct a mid-term evaluation of Future Directions, with a focus on the implementation of a shared governance approach
- in 2007, DACT continued consultations on the Review of the Role of Government as a disability service provider. A summit will be conducted in late 2007 to agree a number of in-principle options and recommendations to be put forward to the ACT Government for consideration
- stage one of the ACT Disability Sector Workforce Strategy that was developed in consultation with community providers has been completed. Stage two of the strategy will include the development of an implementation plan and the establishment of new programs
- DACT has continued its strategy for continuous improvement in the disability sector. The process includes the monitoring of organisations' quality improvement action plans and compliance with contractual requirements.

Northern Territory Government comments

“ The unique environmental and socio-economic factors in the NT create specific challenges in the provision of specialist disability services for both the NT Government and Australian Government, particularly in providing appropriate and sustainable disability services to remote Indigenous communities. Promoting access to disability services in remote communities and for Indigenous people remains a priority for the NT Government with the Review of Disability Services undertaken in 2006-07 highlighting the need to develop an integrated service delivery model, and a need to allocate resources in remote areas.

Data quality remains an ongoing challenge for providers in the NT, given the need to integrate funds across aged care and disability programs to create viable services, especially in remote communities. Data quality issues can distort results in individual programs. During 2006-07 the NT consolidated the effort of the previous year in improving the participation rates as well as the quality of National Minimum Data Set (MDS) from providers. There remains an ongoing challenge of ensuring good data quality from the large number of small and dispersed providers, particularly given that these providers receive funds from multiple funding sources.

During 2006-07 the new *Carers' Recognition Act* with specific Carers' Charter came into effect. Subsidies and concessions on cost of essential services similar to those available to pensioners was extended to carers in the NT and $1.05 million was allocated by NT Government for these concessions in 2006-07.

An additional $25.77 million over five years was announced as part of the 2007-08 Budget in May 2007 to implement the Disability Services Review. The Disability Services Review will provide a whole of service system framework for disability services in the NT, with the development of an implementation plan for the next 5 years. Current projects underway in 2006-07, with a focus on planning and service quality include:

- a new resource allocation policy to ensure funding is available for services close to home for all Territorians with a disability
- developing a better intake and assessment process so that people with disability have a single point of entry into the service system
- developing a Graduate Allied Health program to encourage graduates to the Territory.

Indicators based on the estimated number of people with severe, profound and/or severe core activity limitations in the NT need to be interpreted with caution. Small variations in services data appears in magnified proportions due to the small population in the NT. ”

14.6 Service user data quality and other issues

Data quality

Data quality considerations should be taken into account when interpreting the CSTDA NMDS service user data used in this chapter. In particular, data quality should be considered when making comparisons across jurisdictions and across years.

There are three aspects of quality that affect the accuracy and reliability of the data reported in this chapter:

- service type outlet response rates
- service user response rates
- ‘not stated’ rates for individual data items.

The first two of these affect the service user counts — nationally, by jurisdiction and service type — and all three affect the accuracy of analyses of individual data items (AIHW 2006a).

Service type outlet response rates

Response rates are based on the number of service type outlets responding out of the total number of outlets in the jurisdiction. Service user data are collected quarterly from service type outlets. A service type outlet is considered a responding outlet even if they provide service use data for one quarter only.

The overall national service type outlet response rate for the 2005-06 collection was 94 per cent (table 14.3). This was the same as for the 2004-05 collection.

Table 14.3 **Service type outlet response rates**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aus Gov*	*Aust*
2003-04	80	94	97	100	100	100	93	95	100	93
2004-05	85	92	99	100	100	96	98	70	100	94
2005-06	89	90	99	100	100	100	100	100	100	94

Source: AIHW (2005, 2006a, 2007).

Service user response rates

Service user information may be missing from the data set for a number of reasons. There are outlets that do not respond (table 14.3) and outlets that, through administrative or other error, neglect to report on all of their service users (AIHW 2006a). Estimates of the total number of service users who may be missing from the data set are not available.

Response rates based on the number of service type outlets responding who provided service user data are available for accommodation support services by type and government sector for 2003-04, 2004-05 and 2005-06 (table 14.4). While helpful, these response rates do not account for service users who received services from:

- responding outlets, but whose data were not included
- non-responding outlets.

Table 14.4 **Service user data response rates for CSTDA funded accommodation support service type outlets (per cent)**[a]

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
2003-04									
Institutions/large residential or hostel									
Government	92.3	85.7	66.7	100.0	80.0	–	–	–	88.6
Non-government	83.3	84.0	98.6	100.0	100.0	100.0	–	–	94.4
Group homes									
Government	97.8	98.5	99.5	100.0	93.5	100.0	98.0	–	98.2
Non-government	95.8	97.6	100.0	100.0	95.7	100.0	100.0	100.0	97.5
Community based									
Government	100.0	82.4	100.0	100.0	100.0	75.0	100.0	–	88.9
Non-government	95.6	84.6	93.7	100.0	94.7	97.5	100.0	100.0	92.8
2004-05									
Institutions/large residential or hostel									
Government	100.0	100.0	100.0	100.0	100.0	–	–	–	100.0
Non-government	100.0	100.0	100.0	100.0	100.0	100.0	–	–	100.0
Group homes									
Government	100.0	100.0	100.0	100.0	100.0	100.0	98.0	100.0	100.0
Non-government	99.7	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Community based									
Government	100.0	100.0	100.0	100.0	50.0	100.0	–	100.0	98.7
Non-government	100.0	100.0	100.0	100.0	100.0	100.0	87.5	100.0	99.9
2005-06									
Institutions/large residential or hostel									
Government	100.0	100.0	100.0	100.0	100.0	–	–	–	100.0
Non-government	100.0	100.0	100.0	100.0	100.0	100.0	–	–	100.0
Group homes									
Government	100.0	100.0	100.0	100.0	100.0	100.0	98.0	100.0	100.0
Non-government	99.7	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Community based									
Government	100.0	100.0	100.0	100.0	50.0	100.0	–	100.0	98.7
Non-government	100.0	100.0	100.0	100.0	100.0	100.0	87.5	100.0	99.9

[a] Percentages are based on the number of service type outlets providing service user data. The denominator is the total number of outlets that provided service type outlet data; the numerator is the number of outlets that provided service user data. – Nil or rounded to zero.

Source: AIHW (unpublished).

'Not stated' rates

'Not stated' rates for individual data items vary between jurisdictions (AIHW 2006a). One reason for the higher level of 'not stated' responses to some data items may be the increased efforts to improve the coverage and completeness of the CSTDA NMDS collection overall. For example, therapy services (a community support service) in the ACT participated for the first time in the 2004-05 collection. In an effort to include all users of these services, provisional data collection processes were used that meant minimal data were provided for each user (AIHW 2006a).

Table 14.5 shows the total 'not stated' rates for the relevant individual data items used in this chapter. Results are not adjusted to account for these 'not stated' rates.

Table 14.5 **'Not stated' rates for individual data items (per cent)**

Data item	*Accommodation support*	*Employment*	*Community access*	*Community support*	*Respite*
2003-04					
Severity of core activity limitation	17.4	3.2	32.3	..	..
Indigenous status	3.4	7.0	17.5	..	..
Country of birth	3.6	3.9	..	..	..
Geographic location	1.0	0.0	..	..	..
2004-05					
Severity of core activity limitation	5.1	3.1	12.2	32.7	13.0
Indigenous status	8.6	4.1	14.1	29.5	16.8
Country of birth	3.1	3.5	..	..	..
Geographic location	1.0	–	..	..	..
2005-06					
Severity of core activity limitation	3.9	14.5	11.8	28.4	12.8
Indigenous status	2.3	1.8	7.8	15.6	7.1
Country of birth	2.8	6.8	..	..	..
Geographic location	0.7	0.3	..	..	..

.. Not applicable. – Nil or rounded to zero.

Source: AIHW (unpublished).

Other issues

Service user data/data items not collected

Service user data are not collected for certain CSTDA funded service types. These service types are as follows: advocacy, information/referral, combined information/advocacy, mutual support/self-help groups, print disability/alternative formats of communication, research and evaluation, training and development, peak bodies and other support services. In addition, some service types are not required to collect all service user data items. In particular:

- ‘recreation/holiday programs’ (service type 3.02) are required to collect only information related to the statistical linkage key (selected letters of name, date of birth and sex)
- employment services (service types 5.01 and 5.02) are not required to collect selected informal carer information, including primary status (AIHW 2007).

Specialist psychiatric disability services

Data for specialist psychiatric disability services are excluded to improve the comparability of data across jurisdictions. People with psychiatric disability may use a range of CSTDA-funded service types. In some jurisdictions (Victoria, Queensland and WA), specialist psychiatric disability services are funded specifically to provide such support (AIHW 2006a). Nationally, there were 11 860 users of specialist psychiatric disability services in 2005-06.

Data for these services are included in other publications on the CSTDA NMDS such as AIHW 2007. Therefore, service user data for Victoria, Queensland and WA in this chapter will differ to other publications.

Statistical linkage key

A statistical linkage key is used to derive the service user counts in this chapter. The statistical linkage key enables the number of service users to be estimated from data collected from different service outlets and agencies (AIHW 2006a). Using the linkage key minimises double counting of service users who use more than one service outlet during the reporting period.

The statistical linkage key components of each service record are compared with the statistical linkage key components of all other records. Records that have matching statistical linkage keys are assumed to belong to the same service user.

- As the statistical linkage key is not a unique identifier, some degree of false linking is expected. A small probability exists that some of the linked records do not actually belong to the same service user and, conversely, that some records that did not link do belong to the same service user. The statistical linkage key does not enable the linking of records to the extent needed to be certain that a ‘service user’ is one individual person.

- Missing or invalid statistical linkage keys cannot be linked to other records and so must be treated as belonging to separate service users. This may result in the number of service users being overestimated (AIHW 2006a).

14.7 Definitions of key terms and indicators

Accommodation support service users receiving community accommodation and care services	People using the following CSTDA accommodation support services: group homes; attendant care/personal care; in-home accommodation support; alternative family placement and other accommodation support (types 1.04–1.08), as a proportion of all people using CSTDA accommodation support services (excludes specialist psychiatric disability services). See AIHW (2007) for more information on service types 1.04–1.08.
Administration expenditure as a proportion of total expenditure	The numerator — expenditure (accrual) by jurisdictions on administering the disability service system as a whole (including the regional program management and administration, the central policy and program management and administration, and the disability program share of corporate administration costs under the umbrella department, but excluding administration expenditure on a service that has been already counted in the direct expenditure on the service) — divided by the denominator — total government expenditure on services for people with a disability (including expenditure on both programs and administration, direct expenditure and grants to government service providers, and government grants to non-government service providers).
Core activities as per the 2003 ABS SDAC	Self-care — showering or bathing, dressing, eating, toileting and bladder or bowel control; mobility — getting into or out of a bed or chair, moving about the usual place of residence, going to or getting around a place away from the usual residence, walking 200 metres, walking up and down stairs without a handrail, bending and picking up an object from the floor, using public transport (the first three tasks contribute to the definitions of profound and severe core-activity limitation); and communication — understanding and being understood by strangers, family and friends.
Cost per user of government provided accommodation support services — group homes	The numerator — government expenditure (accrual) on government provided accommodation support services in group homes (as defined by CSTDA NMDS service type 1.04) — divided by the denominator — the number of users of government provided accommodation support services in group homes.
Cost per user of government provided accommodation support services — institutional/residential settings	The numerator — government expenditure (accrual) on government provided accommodation support services in institutional/residential settings (as defined by CSTDA NMDS service types 1.01, 1.02 and 1.03) — divided by the denominator — the number of users of accommodation support services in institutional/residential settings. See AIHW (2007) for more information on service types 1.01–1.03.
Cost per user of government provided accommodation support services — other community settings	The numerator — government expenditure (accrual) on government provided accommodation support services in other community settings (as defined by CSTDA NMDS service types 1.05–1.08) divided by the denominator — the number of users of government provided accommodation support services in other community settings.
Disability	A multidimensional experience that may involve effects on organs or body parts, and effects on a person's participation in areas of life. Correspondingly, three dimensions of disability are recognised in the International Classification of Functioning, Disability and Health: body structure and function (and impairment thereof), activity (and activity

	limitations) and participation (and participation restriction). (WHO 2001). The classification also recognises the role of physical and social environmental factors in affecting disability outcomes. The ABS SDAC 2003 defined ‘disability’ as the presence of one or more of 17 limitations, restrictions or impairments, which have lasted, or are likely to last, for a period of six months or more: loss of sight (not corrected by glasses or contact lenses); loss of hearing where communication is restricted; or an aid to assist with, or substitute for, hearing is used; speech difficulties; shortness of breath or breathing difficulties causing restriction; chronic or recurrent pain or discomfort causing restriction; 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; nervous or emotional condition causing restriction; restriction in physical activities or in doing physical work; disfigurement or deformity; mental illness or condition requiring help or supervision; long term effects of head injury; stroke or other brain damage causing restriction; receiving treatment or medication for any other long term conditions or ailments and still restricted; any other long term conditions resulting in a restriction.
Employment rate for people with a profound or severe core activity limitation	Total estimated number of people aged 15–64 years with a profound or severe core activity limitation who are employed, divided by the total estimated number of people aged 15–64 years with a profound or severe core activity limitation in the labour force, multiplied by 100.
Employment rate for total population	Total estimated number of people aged 15–64 years who are employed, divided by the total number of people aged 15–64 years in the labour force, multiplied by 100.
Funded agency	An organisation that delivers one or more CSTDA service types (service type outlets). Funded agencies are usually legal entities. They are generally responsible for providing CSTDA NMDS data to jurisdictions. Where a funded agency operates only one service type outlet, the service type outlet and the funded agency are the same entity.
Geographic location	Geographic location is based on the ABS’s Australian Standard Geographical Classification of Remoteness Areas, which categorises areas as ‘major cities’, ‘inner regional’, ‘outer regional’, ‘remote’, ‘very remote’ and ‘migratory’. The criteria for Remoteness Areas are based on the Accessibility/Remoteness Index of Australia, which measures the remoteness of a point based on the physical road distance to the nearest urban centre in each of five size classes (ABS 2001). The ‘outer regional and remote/very remote’ classification used in this Report was derived by adding outer regional, remote and very remote data.
Government contribution per user of non-government provided employment services	The numerator — Australian Government grant and case based funding expenditure (accrual) on specialist disability employment services (as defined by CSTDA NMDS service types 5.01 [open] and 5.02 [supported]) — divided by the denominator — number of service users who received assistance. (For data prior to 2005-06, service type 5.03 [combined open and supported] is also included.) See AIHW (2006a) for more information on service types 5.01–5.03.

Government contribution per user of non-government provided services — accommodation support in group homes	The numerator — government expenditure (accrual) on non-government provided accommodation support services in group homes (as defined by CSTDA NMDS service type 1.04) — divided by the denominator — the number of users of non-government provided accommodation support services in group homes.
Government contribution per user of non-government provided services — accommodation support in institutional/residential settings	The numerator — government expenditure (accrual) on non-government provided accommodation support services in institutional/residential settings (as defined by CSTDA NMDS service types 1.01, 1.02 and 1.03) — divided by the denominator — the number of users of non-government provided accommodation support services in institutional/residential settings.
Government contribution per user of non-government provided services — accommodation support in other community settings	The numerator — government expenditure (accrual) on non-government provided accommodation support services in other community settings (as defined by CSTDA NMDS service types 1.05–1.08) — divided by the denominator — the number of users of non-government provided accommodation support services in other community settings.
Indigenous factor	The potential populations were estimated by applying the 2003 national age- and sex- specific rates of profound or severe core activity limitation to the age and sex structure of each jurisdiction in the current year. As Indigenous people have significantly higher disability prevalence rates and greater representation in some CSTDA funded services than non-Indigenous people, and there are differences in the share of different jurisdictions' populations who are Indigenous, a further Indigenous factor adjustment was undertaken. The Indigenous factor was multiplied by the 'expected current population estimate' of people with a profound or severe core activity limitation in each jurisdiction to derive the 'potential population'. The following steps were undertaken to estimate the Indigenous factors. • Data for all people (weighted) were calculated by multiplying the data for Indigenous Australians by 2.4 and adding the data for non-Indigenous Australians. Hence Indigenous Australians are weighted at 2.4 and non-Indigenous Australians at one. • Data for all people (weighted per person) were calculated by dividing the all people (weighted) data by the sum of the Indigenous Australians data and the non-Indigenous Australians data. • The Indigenous factors were then calculated by multiplying the all people (weighted per person) data by 100 and dividing by the all people (weighted per person) total for Australia (AIHW 2007).

Informal carer	*ABS informal carer:* A person of any age who provides any informal assistance, in terms of help or supervision, to people with a disability. This assistance has to be ongoing, or likely to be ongoing, for at least six months. Assistance to a person in a different household relates to 'everyday types of activities', without specific information on the activities. Where the care recipient lives in the same household, the assistance is for one or more of the following activities (cognition or emotion, communication, health care, housework, meal preparation, mobility, paperwork, property maintenance, self care and transport) (ABS 2004c). *CSTDA NMDS informal carer*: an informal carer is someone such as a family member, friend or neighbour, who has been identified as providing regular and sustained care and assistance to the person. Each service user can only record one informal carer (it is expected that the carer recorded will be the one who provides the most significant care and assistance related to the service user's capacity to remain living in their current environment). Informal carers include those people who receive a pension or benefit for their caring role but do not include paid or volunteer carers organised by formal services. See also primary carer.
Labour force participation rate for people with a profound or severe core activity limitation	The total number of people with a profound or severe core activity limitation in the labour force (where the labour force includes employed and unemployed people), divided by the total number of people with a profound or severe core activity limitation who are aged 15–64 years, multiplied by 100. An employed person is a person who, in his or her main job during the remuneration period (reference week): • worked one hour or more for pay, profit, commission or payment in kind in a job or business, or on a farm (including employees, employers and self-employed persons) • worked one hour or more without pay in a family business, or on a farm (excluding persons undertaking other unpaid voluntary work), or • was an employer, employee or self-employed person or unpaid family helper who had a job, business or farm, but was not at work. An unemployed person is a person aged 15–64 years who was not employed during the remuneration period, but was looking for work.
Labour force participation rate for the total population	Total number of people aged 15–64 years in the labour force (where the labour force includes both employed and unemployed people) divided by the total number of people aged 15–64 years, multiplied by 100.
Mild core activity limitation	Not needing assistance with, and has no difficulty performing, core activity tasks, but uses aids and equipment (as per the ABS 2003 SDAC).
Moderate core activity limitation	Not needing assistance but having difficulty performing a core activity task (as per the ABS 2003 SDAC).

Non-English speaking country of birth

People with a country of birth other than Australia and classified in English proficiency groups 2, 3 or 4 (DIMA 1999, 2003). For 2003-04 and 2004-04 data these countries include countries other than New Zealand, Canada, the United Kingdom, South Africa, Ireland and the United States. For 2005-06, data include Zimbabwe as an ‘English-speaking country’.

Payroll tax

A tax levied on employers based on the value of wages and certain supplements paid or payable to, or on behalf of, their employees (SCRCSSP 1999). Payroll tax arrangements for government funded and delivered services differ across jurisdictions. Differences in the treatment of payroll tax can affect the comparability of unit costs across jurisdictions and services. These differences include payroll tax exemptions, marginal tax rates, tax-free thresholds and clawback arrangements (see SCRCSSP 1999).

There are two forms of payroll tax reported:

- *actual* — payroll tax actually paid by non-exempt services
- *imputed* — a hypothetical payroll tax amount estimated for exempt services. A jurisdiction’s estimate is based on the cost of salaries and salary related expenses, the payroll tax threshold and the tax rate.

Potential population

Potential population estimates are used as the denominators for the performance measures reported under the indicator ‘access to CSTDA funded services’.

The term ‘potential population’ is not the same as the population needing the services. Rather, it indicates those with the potential to require disability support services, including individuals who meet the service eligibility criteria but who do not demand the services.

The potential population for CSTDA funded accommodation support, community access and community support services is the number of people aged under 65 years who have a profound or severe core activity limitation, adjusted for the Indigenous factor. The potential population for CSTDA funded employment services is the number of people aged 15–64 years with a profound or severe core activity limitation, adjusted for the Indigenous factor and the labour force participation rate. The potential population for CSTDA funded respite services data is the number of people under 65 years with a profound or severe core activity limitation who have a primary carer, adjusted for the Indigenous factor.

The ABS concept of a ‘profound or severe’ core activity limitation that relates to the need for assistance with everyday activities of self-care, mobility and communication identifies the most relevant population for specialist disability services. The relatively high standard errors in the prevalence rates for smaller jurisdictions, as well as the need to adjust for the Indigenous population necessitated the preparation of special estimates of the ‘potential population’ for specialist disability services.

Briefly, the potential population was estimated by applying the 2003 national age- and sex- specific rates of profound or severe core activity limitation to the age and sex structure of each jurisdiction in the current year, to give an ‘expected current estimate’ of people with a profound or severe core activity limitation in that jurisdiction. These estimates were adjusted by the Indigenous factor to account for differences in the proportion of jurisdictions’ populations who are

	Indigenous. Indigenous people have been given a weighting of 2.4 in these estimates, in recognition of their greater prevalence rates of disability and their relatively greater representation in CSTDA funded services (AIHW 2006b).
Primary carer	*ABS primary carer*: a person who provides the most informal assistance, in terms of help or supervision, to a person with one or more disabilities. The assistance has to be ongoing, or likely to be ongoing, for at least six months and be provided for one or more of the core activities (communication, mobility and self-care) (ABS 2004c). *CSTDA NMDS primary carer*: an informal carer who assists the person requiring support, in one or more of the following activities of daily living: self-care, mobility or communication. See also informal carer.
Primary disability group	Disability group that most clearly expresses the experience of disability by a person. The primary disability group can also be considered as the disability group causing the most difficulty to the person (overall difficulty in daily life, not just within the context of the support offered by a particular service).
Profound core activity limitation	Unable to, or always needing assistance to, perform a core activity task (as per the ABS 2003 SDAC).
Real expenditure	Actual expenditure (accrual) adjusted for changes in prices, using the Gross Domestic P(E) price deflator, and expressed in terms of current year dollars.
Schooling or employment restriction	*Schooling restriction*: as a result of disability, being unable to attend school; having to attend a special school; having to attend special classes at an ordinary school; needing at least one day a week off school on average; and/or having difficulty at school. *Employment restriction*: as a result of disability, being permanently unable to work; being restricted in the type of work they can do; needing at least one day a week off work on average; being restricted in the number of hours they can work; requiring an employer to provide special equipment, modify the work environment or make special arrangements; needing to be given ongoing assistance or supervision; and/or finding it difficult to change jobs or to get a preferred job.
Service	A service is a support activity provided to a service user, in accord with the CSTDA. Services within the scope of the collection are those for which funding has been provided during the specified period by a government organisation operating under the CSTDA.
Service type	The support activity that the service type outlet has been funded to provide under the CSTDA. The NMDS classifies services according to ‘service type’. The service type classification groups services into seven categories: accommodation support; community support; community access; respite; employment; advocacy, information and print disability; and other support services. Each of these categories has subcategories.
Service type outlet	A service type outlet is the unit of the funded agency that delivers a particular CSTDA service type at or from a discrete location. If a funded agency provides, for example, both accommodation support and respite services, it is counted as two service type outlets. Similarly, if an agency is funded to provide more than one accommodation support service type (for example, group homes and

	attendant care), then it is providing (and is usually separately funded for) two different service types — that is, there are two service type outlets for the funded agency.
Service user	A service user is a person with a disability who receives a CSTDA funded service. A service user may receive more than one service over a period of time or on a single day.
Service users with different levels of severity of core activity limitation	Data on service users with different levels of severity of core activity limitation are derived by the AIHW based on the level of support needed in one or more of the three areas of daily living: self-care, mobility and communication. Service users with: • a profound core activity limitation reported ‘always needing support’ in one or more of these areas • a severe core activity limitation reported ‘sometimes needing support’ in one or more of these areas • moderate to no core activity limitations reported needing ‘no support’ (including needing no support but using aids) in all of these areas.
Severe core activity limitation	Sometimes needing assistance to perform a core activity task (as per the ABS SDAC 2003).
Users of CSTDA accommodation support services	People using one or more accommodation support services that correspond to the following CSTDA NMDS service types: 1.01 large residentials/institutions (more than 20 places); 1.02 small residentials/institutions (7–20 places); 1.03 hostels; 1.04 group homes (less than seven places); 1.05 attendant care/personal care; 1.06 in-home accommodation support; 1.07 alternative family placement; and 1.08 other accommodation support.
Users of CSTDA community access services	People using one or more services that correspond to the following CSTDA NMDS service types: 3.01 learning and life skills development; 3.02 recreation/holiday programs; and 3.03 other community access. See AIHW (2007) for more information on service types 3.01–3.03.
Users of CSTDA community support services	People using one or more services that correspond to the following CSTDA NMDS service types: 2.01 therapy support for individuals; 2.02 early childhood intervention; 2.03 behaviour/specialist intervention; 2.04 counselling; 2.05 regional resource and support teams; 2.06 case management, local coordination and development; and 2.07 other community support. See AIHW (2006a) for more information on service types 2.01–2.07.
Users of CSTDA employment services	People using one or more services that correspond to the following CSTDA NMDS service types: 5.01 open employment and 5.02 supported employment. (For data prior to 2005-06, people using service type 5.03 [combined open and supported] are also included.)
Users of CSTDA respite services	People using one or more services that correspond to the following CSTDA NMDS service types: 4.01 own home respite; 4.02 centre-based respite/respite homes; 4.03 host family respite/peer support respite; 4.04 flexible/combination respite; and 4.05 other respite. See AIHW (2007) for more information on service types 4.01–4.05.

14.8 Attachment tables

Attachment tables are identified in references throughout this chapter by an ‘A’ suffix (for example, table 14A.3 is table 3 in the attachment). Attachment tables are provided on the CD-ROM enclosed with the Report and on the Review website (www.pc.gov.au/gsp). On the CD-ROM, the files containing the attachment tables are provided in Microsoft Excel format as \Publications\Reports\2008\ Attach14A.xls and in Adobe PDF format as \Publications\Reports\2008\ Attach14A.pdf. Users without access to the CD ROM or the website can contact the Secretariat to obtain the attachment tables (see contact details on the inside front cover of the Report).

14.9 References

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15 Protection and support services

Protection and support services aim to assist individuals and families who are in crisis or experiencing difficulties that hinder personal or family functioning. These services assist by alleviating the difficulties and reducing the potential for their recurrence.

This chapter reports on:

- *child protection services*: the functions of government that receive and assess allegations of child abuse and neglect, and/or harm to children and young people, provide and refer clients to family support and other relevant services, and intervene to protect children
- *out-of-home care services*: care for children placed away from their parents for protective or other family welfare reasons
- *juvenile justice services*: services that aim to promote community safety and reduce youth offending by assisting young people to address their offending behaviour
- *supported accommodation and assistance services*: services to assist young people, adults and families who are homeless or at imminent risk of becoming homeless. (Only limited updated data were available for this section for this Report).

Several improvements to the chapter have been made this year including:

- reporting on juvenile justice services has moved from the Community services preface to this chapter, in recognition of the important role of juvenile justice services in assisting young people experiencing difficulties that involve contact with the criminal justice system
- four jurisdictions are now reporting experimental results for the ‘pathways’ project, and indicative unit costs (program dollars per placement day) for out-of-home care services are reported for the first time for most jurisdictions
- a partial measure for the outcome indicator ‘Improved education, health and wellbeing of the child’ is included this year.

A profile of child protection and out-of-home care services appears in section 15.1. A framework of performance indicators is outlined in section 15.2 and data are discussed in section 15.3. Future directions in child protection and out-of-home care performance reporting are outlined in section 15.4.

A profile of juvenile justice services appears in section 15.5. Section 15.6 notes the ongoing development of a performance indicator framework and future directions in juvenile justice performance reporting are discussed in 15.7.

A profile of supported accommodation and assistance services funded under the Supported Accommodation Assistance Program (SAAP) appears in section 15.8. A framework of performance indicators for these services is outlined in section 15.9. The limited updated data available are discussed in section 15.10. Future directions in SAAP performance reporting are discussed in section 15.11.

Jurisdictions' comments on child protection and out-of-home care services, juvenile justice services and supported accommodation and assistance services are reported in section 15.12. Definitions of data descriptors and indicators are provided in section 15.13. A list of supporting tables is provided in section 15.14. Attachment tables are identified in references throughout this chapter by an 'A' suffix (for example, table 15A.3 is table 3 in the attachment). Attachment tables are provided on the CD-ROM enclosed with the Report and on the Review website: http://www.pc.gov.au/gsp/reports/rogs/2008. Section 15.15 lists references used in this chapter.

15.1 Profile of child protection and out-of-home care services

Service overview

Child protection services

Child protection services are provided to protect children and/or young people aged 0–17 years who are at risk of harm within their families, or whose families do not have the capacity to protect them. These services include:

- receiving and responding to reports of concern about children or 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 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 (in some jurisdictions, restoration may occur in voluntary placements as well)
- 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.

Research suggests that children and families who come into contact with the protection and support services system often share common social and demographic characteristics. Families with low incomes or that are reliant on pensions and benefits, those that experience alcohol and substance abuse, or a psychiatric disability, and those that have a family history of domestic violence are over-represented in the families that came into contact with the protection and support services system (Department of Human Services 2002).

Child protection concerns and Indigenous communities

Studies have highlighted the high incidence of child abuse and neglect within some Indigenous communities, compared with non-Indigenous communities. Indigenous families across Australia have been found to experience high levels of violence, compared with non-Indigenous families (AIHW 2006a). 'Little Children are Sacred', the final report of the Northern Territory Board of Inquiry into the Protection of Aboriginal Children from Sexual Abuse (2007), identified child sexual abuse as a significant issue for many of the remote NT Aboriginal communities consulted as part of the Inquiry. The final report of the WA Inquiry into Response by Government Agencies to Complaints of Family Violence and Child Abuse in Aboriginal Communities (Gordon Report 2002), also found high levels of violence and child abuse within Aboriginal communities in WA.

Out-of-home care services

Out-of-home care services provide care for children and young people aged 0–17 years who are placed away from their parents or family home for reasons of safety or family crisis. These reasons include abuse, neglect or harm, illness of a parent and the inability of parents to provide adequate care. The placements may be voluntary or made in conjunction with care and protection orders.

Out-of-home care services are either home-based care (for example, foster care, care with the child's extended family or other home-based arrangements), facility-based care (for example, community residential care) or independent living (which is often intensively supported) as a transition to full independence or supported placements. Across jurisdictions, there has been a shift away from the use of facility-based (or residential) care towards foster care and other forms of home-based care, including relative/kinship care.

Intensive family support services are increasingly perceived as an alternative to the removal of the child from his or her home for child protection reasons (box 15.1).

Box 15.1 **Intensive family support services**

Intensive family support services are specialist services, established in each jurisdiction, that aim to:

- prevent the imminent separation of children from their primary caregivers as a result of child protection concerns
- reunify families where separation has already occurred.

Intensive family support services differ from other types of child protection and family support services referred to in this chapter, in that they:

- are funded or established explicitly to prevent the separation of, or to reunify, families
- provide a range of services as part of an integrated strategy focusing on improving family functioning and skills, rather than providing a single type of service
- are intensive in nature, averaging at least four hours of service provision per week for a specified short term period (usually less than six months)
- generally receive referrals from a child protection service.

Intensive family support services may use some or all of the following strategies: assessment and case planning; parent education and skill development; individual and family counselling; anger management; respite and emergency care; practical and financial support; mediation, brokerage and referral services; and training in problem solving.

(Continued on next page)

Box 15.1 **(Continued)**

Expenditure on intensive family support services

Recurrent expenditure on intensive family support services across all jurisdictions was at least $148.3 million in 2006-07. This expenditure has increased in real terms each year from $81.8 million in 2002-03 (table 15A.24). This represents an average annual increase in expenditure of 16.1 per cent over this four year period. Tables 15A.24–27 provide additional information about families and children who were involved with intensive family support services, including the cost of providing these services per child commencing intensive family support services.

Child protection treatment and support services

A complementary suite of services not currently included in this Report, but intended for inclusion in future Reports, are known as child protection treatment and support services. These are targeted to at-risk families where there are concerns about the safety and wellbeing of children. They may be less intensive in nature and include services that strengthen family relationships in response to concerns about the welfare of a child and may focus on either early intervention or reunification support.

Child protection treatment and support services provide educational services, clinical services including counselling, group work and other therapeutic interventions, and domestic violence services, where the child is the direct recipient of the service and s/he is, has, or is likely to become, a client of child protection.

The Australian Institute of Health and Welfare (AIHW), with the support of the States and Territories, is studying the feasibility of a national data collection for child protection treatment and support services.

Source: AIHW (unpublished).

Roles and responsibilities

State and Territory governments fund child protection, out-of-home care, family support (including intensive family support) and other relevant services. These services may be delivered by the government or the non-government sector. State and Territory departments responsible for child protection are responsible for investigating and assessing reports to the department, providing, or referring families to, support services, and intervening where necessary (including making court applications when an order is required to protect a child, and placing children in out-of-home care).

Other areas of government also have roles in child protection and provide services for children who have come into contact with relevant departments for protective reasons. These include:

- police services, which investigate serious allegations of child abuse and neglect, particularly criminal matters, and may also work on child protection assessments with State and Territory departments responsible for child protection
- courts, which decide whether a child will be placed on an order
- education and child care services, which provide services for these children and also conduct mandatory reporting and protective behaviours education in some jurisdictions
- health services, which support the assessment of child protection matters and deliver therapeutic, counselling and other services.

A range of appointments, schemes and charters have been introduced by jurisdictions in recent years, to enable additional protection for clients of the child protection system. Examples of these are listed in box 15.2.

Box 15.2 **Initiatives to enable additional protection for clients**

NSW	The Commission for Children and Young People initiates and influences broad and positive change for children and young people. The Office of the Children's Guardian promotes the best interests and rights of all children in out-of-home care, through accreditation and monitoring of out-of-home care agencies to ensure services are of the highest standard.
VIC	The Child Safety Commissioner promotes child safe practices and environments across the community. Part of the Commissioner's role is to monitor the quality of out-of-home care services. A charter of rights for children has been completed and was launched on 28 November 2007.
QLD	The Commission for Children and Young People and the Child Guardian monitors and reports on child protection services, investigates complaints and conducts a Community Visitor Program to regularly visit children and young people in out-of-home care. The Department of Child Safety has also established a departmental complaints system which is available to clients, family members, advocates and members of the public.
WA	The Advocate for Children in Care provides advocacy and complaints management services for children and young people in care. The Department's general Consumer Advocacy Service has been redesignated as a Complaints Management Unit from January 2008 and is available to all customers. Formal monitoring of protection and care service standards by a Standards Monitoring Unit began on 1 July 2007. Sixteen Districts are monitored on a two-year cycle and the monitoring regime will be extended across all care providers in due course.

(Continued on next page)

Box 15.2 **(Continued)**

SA	The Office of the Guardian monitors and assesses care, advocates for, and advises on, the circumstances and needs of children and systemic issues affecting the quality of out-of-home care.
TAS	The Commissioner for Children's functions include promoting the rights and wellbeing of children, examining the policies, practices and services provided for children and any laws affecting the health, welfare, care, protection and development of children.
ACT	The ACT Public Advocate’s functions include monitoring the provision of services, and protecting and acting as an advocate for the rights of children and young people. The Public Advocate must refer systemic issues concerning young people to the Human Rights Commission for consideration. The Official Visitors’ role is to investigate complaints made by or on behalf of children and young people in institutions or shelters concerning their care. The Commissioner for Human Rights and Discrimination ensures the rights of children and young people are upheld.
NT	A review of the *NT Community Welfare Act* has resulted in the development of a new *Care and Protection of Children Act* — which was introduced in late 2007. The Act includes provisions for a Children’s Commissioner and a child death review committee.

Source: State and Territory governments (unpublished).

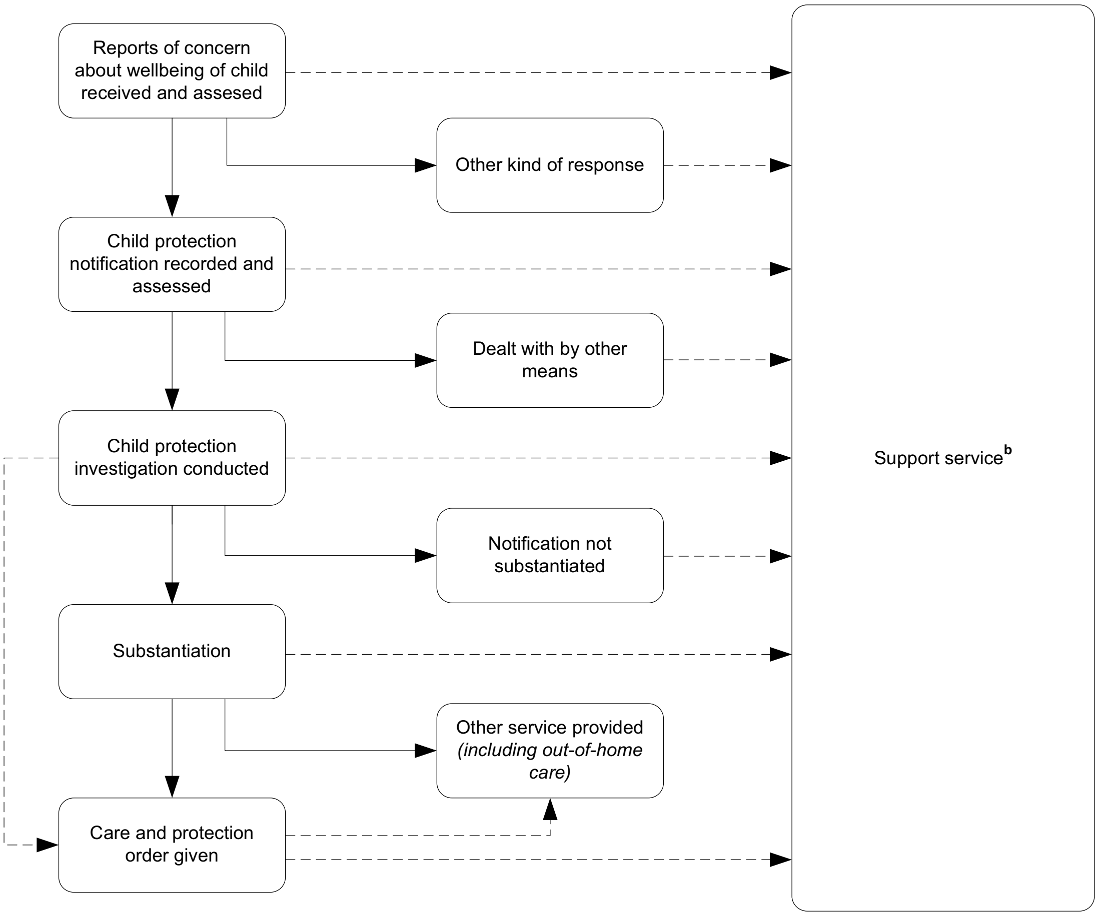
Size and scope

The child protection system

Child protection legislation, policies and practices vary across jurisdictions, but the broad processes in child protection systems are similar (figure 15.1).

State and Territory departments with responsibility for child protection are advised of concerns about the wellbeing of children through reports to these departments. Reports may be made by people mandated to report or by other members of the community. Individuals and organisations mandated to report vary across the states and territories, and may include medical practitioners, police services, school teachers and principals. These reports are assessed and classified as child protection notifications, child concern reports, or matters requiring some other kind of response. The most common sources of notification for finalised investigations in 2006-07 were school personnel, police, hospitals and other health centres (AIHW 2008).

Figure 15.1 **The child protection system**[a]



[a] Dashed lines indicate that clients may or may not receive these services, depending on need. [b] Support services include family support or family preservation services provided by departments responsible for child protection and referrals to other agencies.

Notification

Jurisdictions count notifications at different points in the response to a report, ranging from the point of initial contact with the source of the report to the end of a screening and decision making process. This means the number of notifications is not strictly comparable across jurisdictions.[1]

All jurisdictions except Tasmania and the ACT screen incoming reports before deciding whether they will be counted as a notification, thus reducing the proportion of reports that become notifications.

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[1] Child protection services, care and protection orders and out-of-home care relate to children aged 0–17 years. However, rates of children subject to notifications, investigations and substantiations, are calculated for children aged 0–16 years, given differences in jurisdictions' legislation, policies and practices regarding children aged 17 years. Rates of children on care and protection orders and in out-of-home care are calculated for children aged 0–17 years.

In all jurisdictions, notifications are investigated, based on the policies and practices in that jurisdiction. Once it has been decided that an investigation is required, the investigation process is similar across jurisdictions. The department responsible for child protection may obtain further information about the child and his or her family by checking information systems for any previous history, undertaking discussion/case planning with agencies and individuals, interviewing/sighting the child and/or interviewing the caregivers/parents. At a minimum, the child is sighted whenever practicable, and the child's circumstances and needs are assessed. This investigation process determines whether the notification is substantiated or not substantiated (figure 15.1).

Nationally, 186 335 children aged 0–16 years were the subject of child protection notifications in 2006-07. The rate of notifications per 1000 children in the population aged 0–16 years was 40.2 in 2006-07 (table 15A.8). The total number of notifications for each jurisdiction for 2006-07 (including cases where a child is the subject of more than one child protection notification) by Indigenous status of the child is reported in table 15A.5.

Data on the number of notifications are collected early in the child protection process and often before the agency has full knowledge of the child's family circumstances. This lack of information and the inherent difficulties in identifying Indigenous status mean that data on the number of notifications by Indigenous status need to be interpreted with care.

Substantiation

The criteria for substantiation vary across jurisdictions. In the past, child protection legislation and policy focused on the identification and investigation of narrowly defined incidents that were broadly grouped as types of abuse or neglect. Across all jurisdictions, the focus is now shifting away from the actions of parents and guardians, toward the desired outcomes for the child, the identification and investigation of actual and/or likely harm to the child, and the child's needs.

If an investigation results in substantiation, intervention by the relevant department may be needed to protect the child. This intervention can take a number of forms, including one or more of: referral to other services; supervision and support; an application to court; and a placement in out-of-home care.

Nationally, 32 423 children aged 0–16 years were the subject of a substantiation in 2006-07. The rate of children who were the subject of a substantiation per 1000 children in the population aged 0–16 years was 7.0 (table 15A.8). The number and rate of children aged 0–16 years who were the subject of a substantiation has increased since 2002-03. Nationally, 30 784 children were the subject of a substantiation in 2002-03. This represented a rate of 6.8 per 1000 children in the population aged 0–16 years (SCRGSP 2004).

Nationally, 6554 Indigenous and 25 869 non-Indigenous children were the subject of a substantiation in 2006-07. The rate of children who were the subject of a substantiation per 1000 children in the target population aged 0–16 years was 31.8 for Indigenous children and 5.8 for non-Indigenous children (table 15A.8).

Care and protection orders

Although child protection substantiations are often resolved without the need for a court order (which is usually a last resort), recourse to the court may take place at any point in the child protection investigation process. The types of order available vary across jurisdictions and may include guardianship or custody orders, supervisory orders, and interim and temporary orders.

Nationally, 29 406 children aged 0–17 years were on care and protection orders at 30 June 2007. The rate of children on care and protection orders per 1000 children in the population aged 0–17 years was 6.0 (table 15A.8). The number and rate of children aged 0–17 years who were the subject of a care and protection order has increased since 2002–03. At 30 June 2003, 22 130 children were the subject of a care and protection order, which represented a rate of 4.6 per 1000 children in the population aged 0–17 years (SCRGSP 2004).

Nationally, 7301 Indigenous and 22 105 non-Indigenous children were on care and protection orders at 30 June 2007. The rate of children on care and protection orders per 1000 children in the target population aged 0–17 years was 33.4 for Indigenous children and 4.7 for non-Indigenous children (table 15A.8).

Further information on children on care and protection orders is included in the attachment tables to this Report. Table 15A.6 identifies the number of children admitted to, and discharged from care and protection orders by Indigenous status, 2006-07. Table 15A.7 identifies the number of children on care and protection orders by type of order and Indigenous status at 30 June 2007.

Out-of-home care

Out-of-home care is one of a range of services provided to families and children where there is a need to provide safe care for a child. The services are intended to place a child in out-of-home care only if this will improve the outcome for the child and only when it is not possible to maintain the child within their family. If it is necessary to remove the child from his or her home, then placement with the wider family or community is sought where possible, particularly in the case of Indigenous children (AIHW 2006b). Continued emphasis is placed on improving case planning and case management processes to facilitate the safe return home of children in out-of-home care and to maximise case workers' contact time with children and families.

Nationally, 28 441 children were in out-of-home care at 30 June 2007. The rate of children in out-of-home care per 1000 children in the population aged 0–17 years was 5.8 (table 15A.14). The number and rate of children aged 0–17 years in out-of-home care has increased since 2002-03. At 30 June 2003, 20 297 children were in out-of-home care. This represented a rate of 4.2 per 1000 children in the population aged 0–17 years (SCRGSP 2004).

Nationally, 7892 Indigenous children and 20 549 non-Indigenous children were in out-of-home care at 30 June 2007. The rate of children in out-of-home care per 1000 children in the target population aged 0–17 years was 36.1 for Indigenous children and 4.4 for non-Indigenous children (table 15A.14).

Further information on children in out-of-home care is included in the attachment tables to this Report. Table 15A.15 identifies the number of children in out-of-home care by Indigenous status and placement type at 30 June 2007. Table 15A.16 identifies the number of children in out-of-home care by Indigenous status and whether they were on a care and protection order at 30 June 2007. Table 15A.17 identifies the number of children in out-of-home care by Indigenous status and length of time in continuous out-of-home care as at 30 June 2007. Table 15A.18 identifies the number of children who exited care during 2006-07, by Indigenous status and length of time spent in care.

Funding

Recurrent expenditure on child protection and out-of-home care services was approximately $1.7 billion across Australia in 2006-07 — a real increase of $199.8 million (13.7 per cent) from 2005-06. Of this expenditure, out-of-home care services accounted for the majority (63.7 per cent, or $1.1 billion). Nationally, annual real expenditure on child protection and out-of-home care services has increased by $597.1 million from $1.1 billion since 2002-03, an average annual increase over the four year period of 11.8 per cent (table 15A.1).

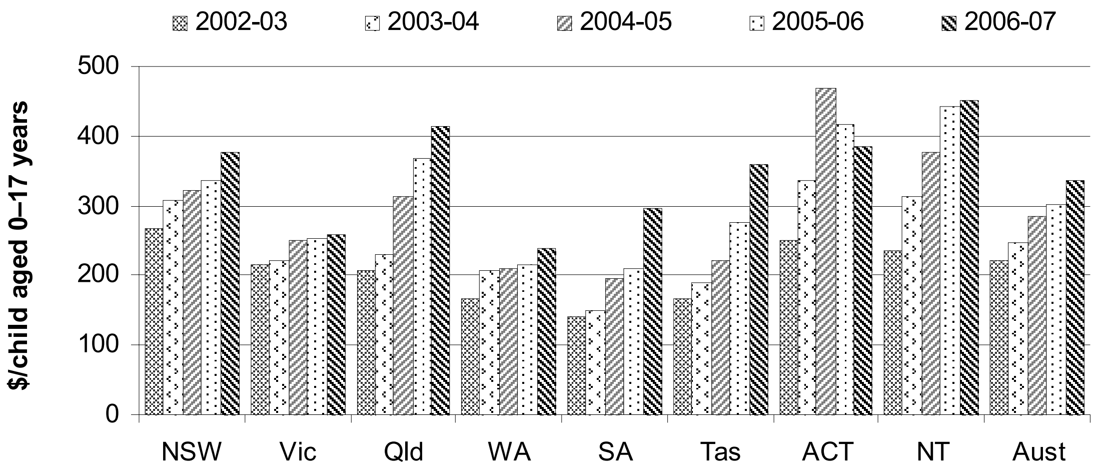
In 2006-07, real recurrent expenditure per child aged 0–17 years in child protection and out-of-home care services was $336 nationally (figure 15.2). Real recurrent expenditure per child aged 0–17 years increased in all jurisdictions between 2002-03 and 2006-07 and has increased nationally each year since 2002-03. In

2002-03 the real recurrent expenditure per child aged 0–17 years was $221 (table 15A.1). This represents an average annual increase over the four year period of 11.0 per cent.

It is an objective of the Review to report comparable estimates of costs. Ideally, the full range of costs to government would be determined on a comparable basis across jurisdictions. Where full costs cannot be counted, costs should be estimated on a consistent basis across jurisdictions. However, in the area of child protection, there are differences across jurisdictions in the calculation of expenditure.

Table 15A.4 identifies the level of consistency across jurisdictions for a number of expenditure items. The scope of child protection systems also varies across jurisdictions, and expenditure on some services may be included for some jurisdictions, but not for others.

Figure 15.2 **Real recurrent expenditure on child protection and out-of-home care services per child (2006-07 dollars)**[a]



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[a] Refer to table 15A.1 for detailed jurisdiction-specific footnotes on expenditure data and table 15.A4 for information on the comparability of expenditure data.

Source: State and Territory governments (unpublished); table 15A.1.

15.2 Framework of performance indicators for child protection and out-of-home care services

The framework of performance indicators for child protection and out-of-home care services is based on shared government objectives (box 15.3).

Box 15.3 **Objectives for child protection and out-of-home care services**

The aims of child protection services are to:

- protect children and young people at risk of harm within their family or in circumstances in which the family of the child or young person does not have the capacity to protect them
- assist families to protect children and young people.

The aim of out-of-home care services is to provide quality care for children and young people aged 0–17 years who cannot live with their parents for reasons of safety or family crisis.

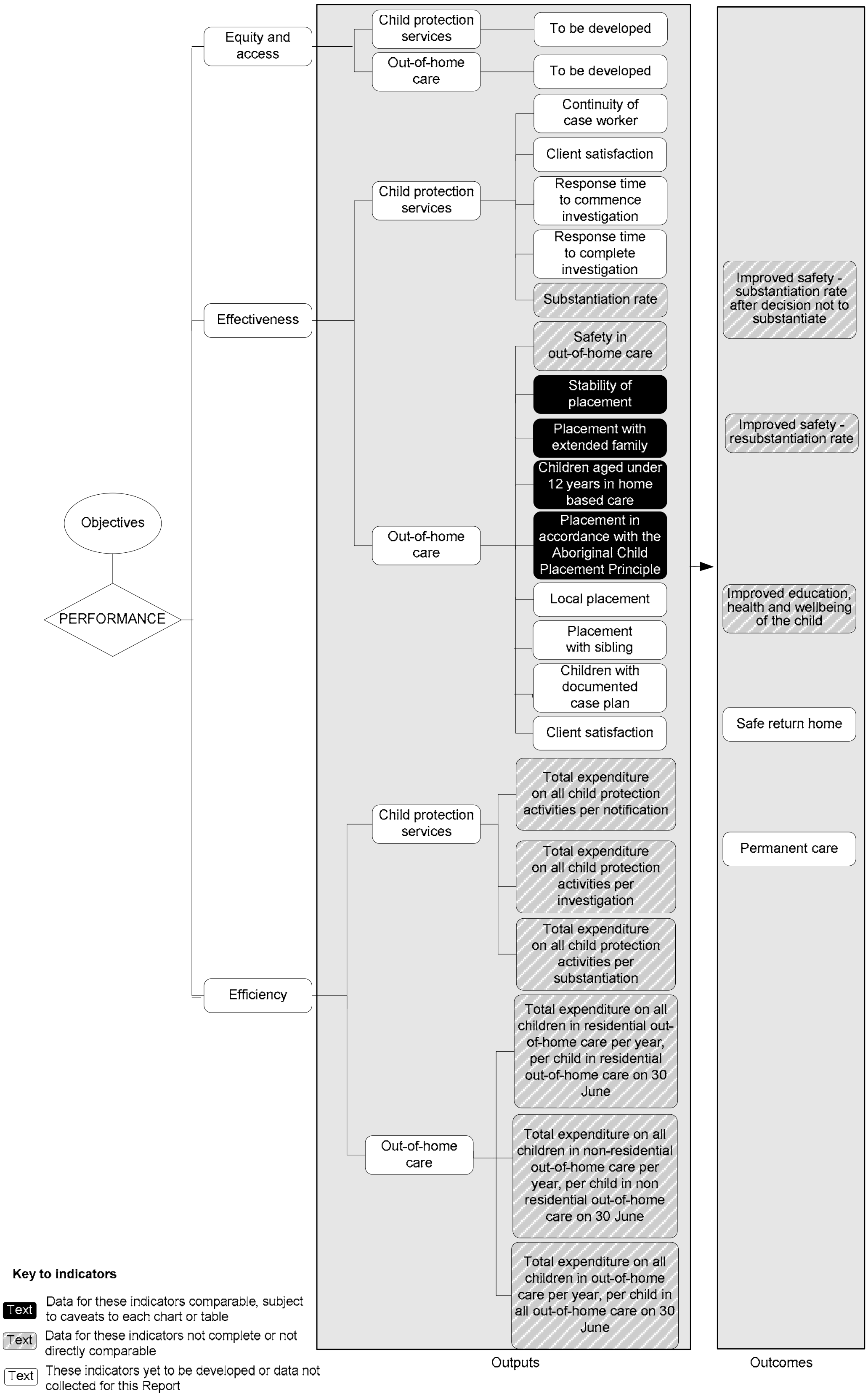
Child protection and out-of-home care services should be provided in an efficient and effective manner.

The performance indicator framework shows which data are comparable in the 2008 Report (figure 15.3). For data that are not considered directly comparable, the text includes relevant caveats and supporting commentary. Chapter 1 discusses data comparability from a Report-wide perspective (see section 1.6).

15.3 Key child protection and out-of-home care services performance indicator results

Different delivery contexts, locations and types of client may affect the equity/access, effectiveness and efficiency of child protection services. Appendix A contains detailed statistics that may assist in interpreting the performance indicators.

Figure 15.3 Performance indicators for child protection and out-of-home care services



Outputs

Outputs are the actual services delivered (while outcomes are the impact of these services on the status of an individual or group) (see chapter 1, section 1.5).

Equity and access

Equity and access indicators are a key area for further development in future reports (box 15.4).

Box 15.4 **Access to child protection and out-of-home care services by equity groups**

These will be indicators of governments' objective to ensure that all clients have fair and equitable access to services on the basis of relative need and available resources. These indicators are under development.

Effectiveness

Child protection services — continuity of case worker

'Continuity of case worker' is an indicator of the effectiveness of the delivery of child protection services (box 15.5).

Box 15.5 **Continuity of case worker**

'Continuity of case worker' is an indicator of governments' objective to ensure child protection services are delivered in an effective manner. The turnover of workers is a frequent criticism of the quality of child protection services. Effective intervention requires a productive working relationship between the worker and the child and family.

This indicator has been identified for development and reporting in future. Data were not available for the 2008 Report.

Child protection services — client satisfaction

'Client satisfaction' is an indicator of the effectiveness of child protection services (box 15.6).

Box 15.6 **Client satisfaction**

Client satisfaction is an indicator of governments' objective to provide high quality services that meet the needs of recipients.

This indicator has been identified for development and reporting in future. Data were not available for the 2008 Report.

Box 15.7 provides examples of steps taken in seven jurisdictions to monitor, assess and promote client satisfaction in relation to child protection and out-of-home care.

Box 15.7 **Developments in client satisfaction**

NSW An evaluation of the Early Intervention Program is planned. This program targets vulnerable families with children aged 0–8 years. A sample of families and children receiving services will be surveyed during the evaluation to determine whether they are satisfied the program is meeting their needs.

VIC A survey of child protection clients and families in 2001 was designed to gather information on the clients' and families' experience of child protection, in order to enhance future service delivery, and to improve client and family outcomes. The survey findings identified a range of specific strengths in child protection practice, including that in the majority of cases, child protection intervention improved the safety and life circumstances of young people. The survey also identified a range of areas for practice improvement.

Qld The Commission for Children and Young People and Child Guardian undertakes regular surveys of children in out-of-home care to seek their views and opinions about their current placement, their Child Safety Officer and their experience with the child protection system. Information collected from these surveys forms important measures about the performance of the child protection system. CREATE is also funded to engage samples of children and young people to gain more detailed information about how child protection services affect them.

WA The Department of Child Protection administers an annual customer perception survey across the majority of its provided and funded services. For ethical and practical reasons, children and young people in care are not routinely surveyed. However, the Department includes foster carers and young people receiving leaving care services in the survey. Children and young people in care are also interviewed as part of the standards monitoring process described in box 15.2.

(Continued on next page)

Box 15.7 **(Continued)**

TAS	A Quality Improvement Unit dedicated to service development and improvement has recently been established within Children and Family Services. A key priority of this unit will be investigating and responding to complaints and serious incidents relating to child protection services and developing structured processes to address identified issues. Once complaint and incident management processes are successfully embedded in the services, the Quality Improvement Unit will also develop and implement a process to monitor client satisfaction.
ACT	CREATE released a report in July 2004 based on qualitative interviews of children and young people in out-of-home care in the ACT. This report recommended the development of a charter of rights for children and young people in care in the ACT. The Government will develop a charter in consultation with children and young people.
NT	A participation survey of children and young people in care was funded in 2005 and an evaluation of case work attitudes was also undertaken. As a result, out-of-home care core training for staff has been restructured to incorporate the participation of young people in care planning.

Source: State and Territory governments (unpublished).

Child protection services — response time to commence investigation

'Response time to commence investigation' is an indicator of the effectiveness of child protection services through the timely response to a notification (box 15.8).

Box 15.8 **Response time to commence investigation**

'Response time to commence investigation' is an indicator of governments' objective to minimise the risk of harm to the child by responding to notifications of possible child protection incidents and commencing investigations in a timely manner.

This indicator has been identified for reporting in future, with data anticipated to be available for the 2009 Report.

Significant developmental work has occurred on the counting rules for this indicator, with progress underway to complete a third pilot collection of these data in early 2008.

Child protection services — response time to complete investigation

'Response time to complete investigation' is an indicator of the effectiveness of child protection services through the timely completion of investigations (box 15.9).

Box 15.9 **Response time to complete investigation**

'Response time to complete investigation' is an indicator of governments' objective to minimise the risk of harm to the child by responding to notifications of possible child protection incidents and completing investigations in a timely manner.

This indicator has been identified for reporting in future, with data anticipated to be available for the 2009 Report.

Significant developmental work has occurred on the counting rules and output categories for this indicator, with progress underway to complete a third pilot collection of these data in early 2008.

Child protection services — substantiation rate

'Substantiation rate' is an indicator of the effectiveness of child protection services in targeting investigations (box 15.10).

Box 15.10 **Substantiation rate**

The 'substantiation rate' is an indicator of governments' objective to target investigations to those notifications where a substantive child abuse/neglect incident has occurred. It also provides an indication of the extent to which government has avoided the human and financial costs of an investigation where no harm has occurred.

This indicator is defined as the proportion of finalised investigations where harm or risk of harm was substantiated.

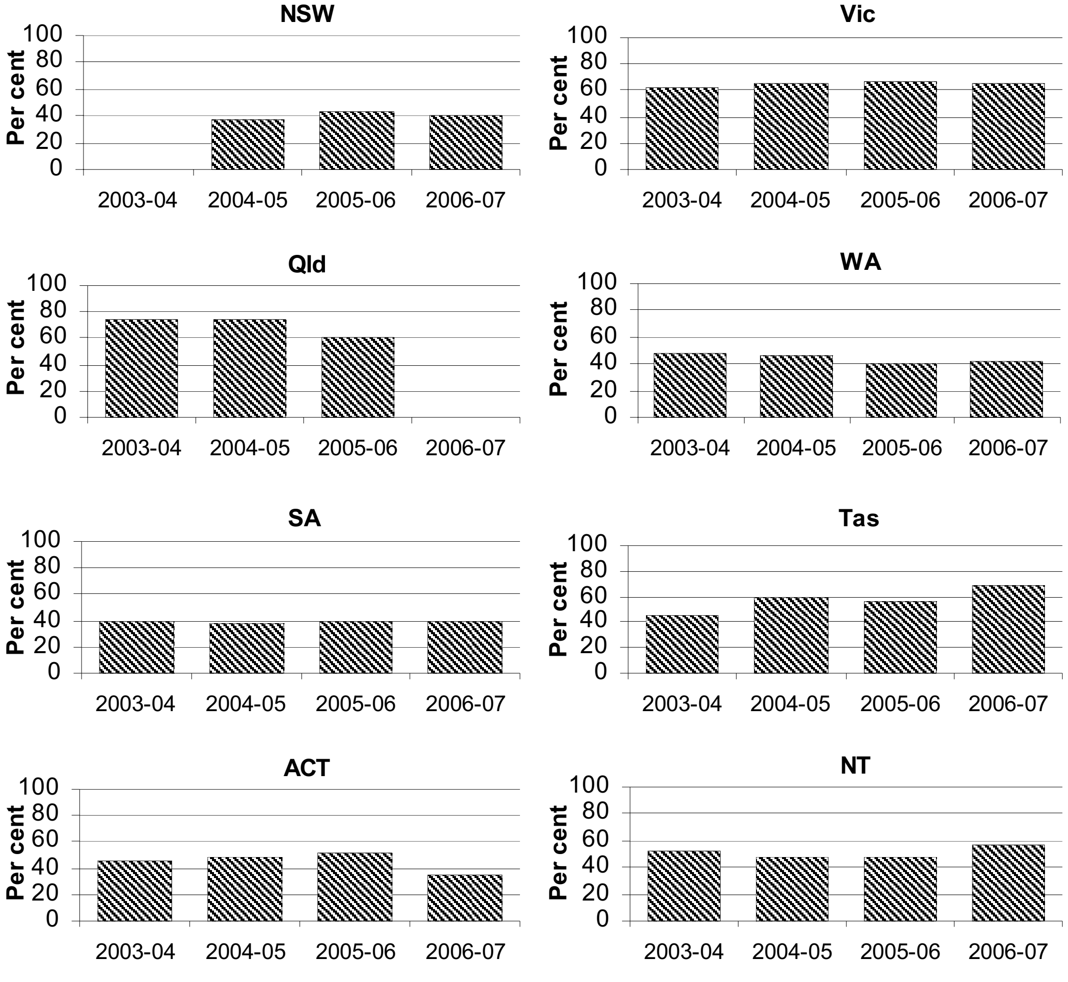
The substantiation rate should be neither 'very high' nor 'very low'. A very low substantiation rate may suggest that notifications and investigations are not accurately targeted at appropriate cases, with the undesirable consequence of distress to families and undermining the chances that families will voluntarily seek support. Very low substantiation rates may also indicate that the scarce resources of the child protection system are being overwhelmed and that screening should be tightened. A very high substantiation rate may indicate that either some appropriate cases are being overlooked at notification and investigation, or that the criteria for substantiation are bringing 'lower risk' families into the statutory system.

Finalised investigations that were substantiated may fluctuate because of policy, funding and practice change, such as better targeting of investigative resources, the impact of mandatory reporting or other factors such as increased community awareness and willingness to notify suspected instances of child abuse, neglect or harm.

Data that are comparable across jurisdictions are not available for this indicator because definitions of substantiation vary across jurisdictions, but data are comparable within each jurisdiction over time unless otherwise stated (figure 15.4).

Due to the difficulties in identifying the source of annual fluctuations in substantiation rates, changes over time within jurisdictions are more appropriately used to prompt further analysis, rather than used as definitive performance information.

Figure 15.4 **Proportion of finalised child protection investigations that were substantiated**[a, b, c, d]



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[a] Data are not comparable across jurisdictions because definitions of substantiation vary significantly. Consequently, rates should not be compared across jurisdictions. [b] NSW was unable to provide data for 2003-04 due to the introduction of a new client information system. [c] During 2006-07 Victoria introduced new service and data reporting arrangements. Therefore data for 2006-07 may not be fully comparable to previous years' data. See table 15A.54 for more details on these arrangements. [d] Queensland data for 2006-07 have not been provided due to the recent transition to a new information management system.

Source: AIHW *Child protection notifications, investigations and substantiations, Australia* data collection (unpublished); tables 15A.37, 15A.54, 15A.71, 15A.88, 15A.105, 15A.122, 15A.139 and 15A.156.

Out-of-home care — safety in out-of-home care

'Safety in out-of-home care' is an indicator of the effectiveness of out-of-home care services in providing a safe home environment for children (box 15.11).

Box 15.11 **Safety in out-of-home care**

'Safety in out-of-home care' is an indicator of governments' objective to provide children who are under the care of the State with a safe home environment. The indicator reflects the safety of clients in care situations.

This indicator is defined as the proportion of substantiations where those responsible for harm or risk were carers or other people living in households providing out-of-home care.

A low proportion of substantiations is desirable.

Three jurisdictions (WA, SA and ACT) provided 2006-07 data on the incidence of child protection substantiations where the person believed responsible for harm or risk to the child was either the carer or another person living in the household providing out-of-home care. The proportion of children who were the subject of a child protection substantiation and the person believed responsible was in the household was 0.4 per cent in each reporting jurisdiction. WA provided data on abuse by foster carers or workers in placement services, but not abuse by others living in the household (table 15A.23).

Out-of-home care — stability of placement

'Stability of placement' is an indicator of the effectiveness of out-of-home care services (box 15.12).

Box 15.12 **Stability of placement**

'Stability of placement' is an indicator of governments' objective to provide high quality services that meet the needs of recipients on the basis of relative need and available resources.

This indicator is defined as the proportion of children who had 1 or 2 placements during a period of continuous out-of-home care.

(Continued on next page)

Box 15.12 **(Continued)**

A low number of child placements (one or two) per period of care is desirable, but must be balanced against other placement quality indicators, such as placements in compliance with the Aboriginal Child Placement Principle, local placements and placements with siblings.

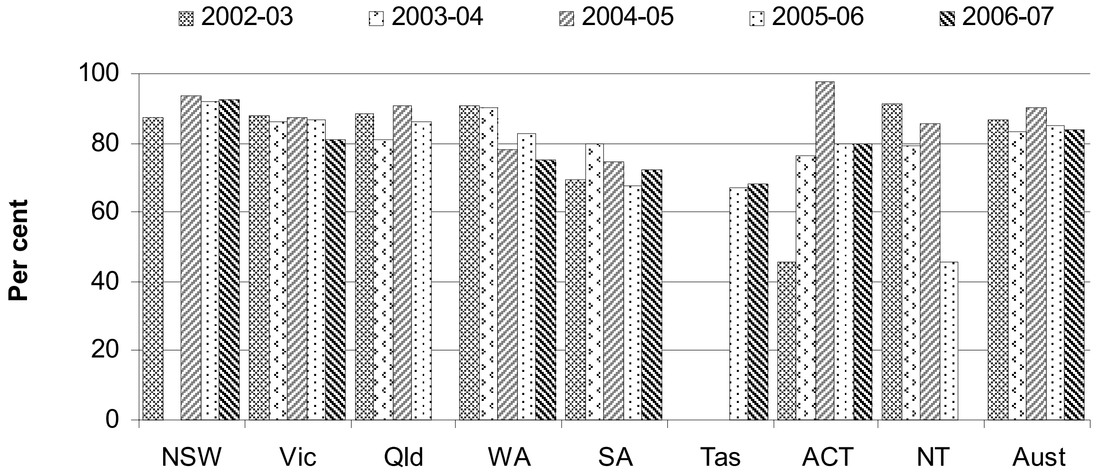
Children may have multiple placements for good reasons, (for example, an initial placement followed by a longer term placement) or it may be desirable to change placements to achieve better child–family compatibility. It is not desirable for a child to stay in an unsatisfactory or unsupportive placement. Also, older children are more likely to have multiple placements as they move towards independence and voluntarily seek alternate placements.

Data are collected only for children who are on orders and who exit care during the reporting period. There are limitations to counting placement stability using an exit cohort rather than entry cohort longitudinal data, because the sample is biased to children from recent entry cohorts with relatively short stays in care, and these children are likely to have experienced fewer placements.

For children placed away from their family for protective reasons, stability of placement is an important indicator of service quality, particularly for those children who require long term placements. Data are collected on the number of different placements for children on a care and protection order who exited out-of-home care in 2006-07. Data are grouped according to the length of time in care (less than 12 months and 12 months or more).

Nationally, 83.9 per cent of the children on a care and protection order who exited care after less than 12 months in 2006-07 experienced only one or two placements. This proportion varied across jurisdictions (figure 15.5).

Figure 15.5 **Proportion of children on a care and protection order exiting care after less than 12 months, who had 1 or 2 placements**[a, b, c, d, e, f]



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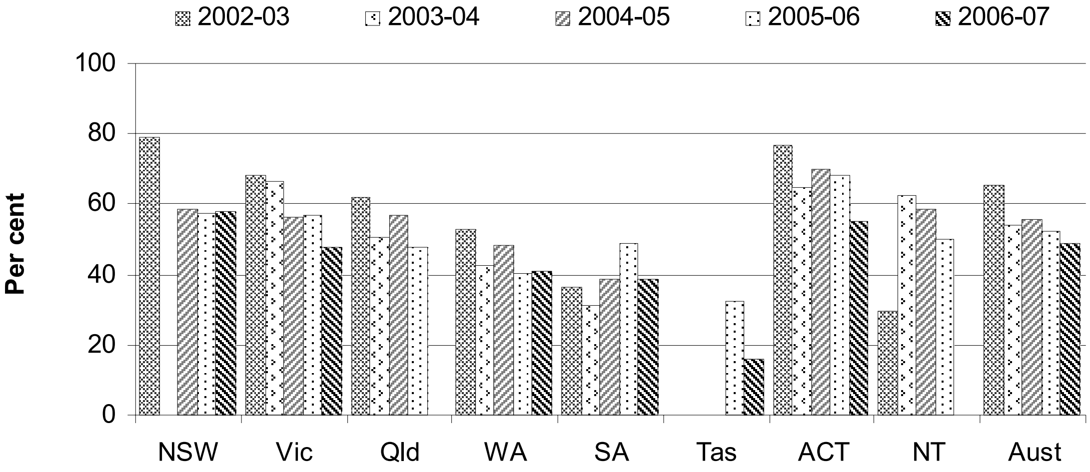
[a] Data refer to children exiting care during the relevant financial year. [b] Refer to footnotes in the source tables for information about what each jurisdiction's data include. [c] NSW was unable to provide data for 2003-04 due to the introduction of a new client information system. [d] During 2006-07 Victoria introduced new service and data reporting arrangements. Therefore data for 2006-07 may not be fully comparable to previous years' data. [d] Queensland data for 2006-07 have not been provided due to the recent transition to a new information management system. [e] Data for Tasmania were not available prior to 2005-06. [f] NT data for 2006-07 were not available at the time of publication.

Source: AIHW *Children in out-of-home care, Australia* data collection (unpublished); table 15A.22.

Across jurisdictions, children who had been in out-of-home care longer tended to have had more placements. The proportion of children exiting care in 2006-07 after 12 months or more who had experienced one or two placements was 49.0 per cent nationally but varied across jurisdictions (figure 15.6).

Figure 15.6 **Proportion of children on a care and protection order exiting care after 12 months or more, who had 1 or 2 placements**[a, b, c, d, e, f]



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[a] Data refer to children exiting care during the relevant financial year. [b] Refer to footnotes in the source table for information about what each jurisdiction's data include. [c] NSW was unable to provide data for 2003-04 due to the introduction of a new client information system. [d] During 2006-07 Victoria introduced new service and data reporting arrangements. Therefore data for 2006-07 may not be fully comparable to previous years' data. [d] Queensland data for 2006-07 have not been provided due to the recent transition to a new information management system. [e] Data for Tasmania were not available prior to 2005-06. [f] NT data for 2006-07 were not available at the time of publication.

Source: AIHW *Children in out-of-home care, Australia* data collection (unpublished); table 15A.22.

Out-of-home care — placement with extended family

'Placement with extended family' is an indicator of the effectiveness of out-of-home care services (box 15.13).

Box 15.13 **Placement with extended family**

‘Placement with extended family’ is an indicator of governments’ objective to provide services that meet the needs of the recipients on the basis of relative need and available resources.

This indicator is defined as the proportion of all children in out-of-home care who are placed with relatives or kin who receive government financial assistance to care for that child.

A reasonably high rate for this indicator is considered desirable.

This needs to be considered with other factors in the placement decision.

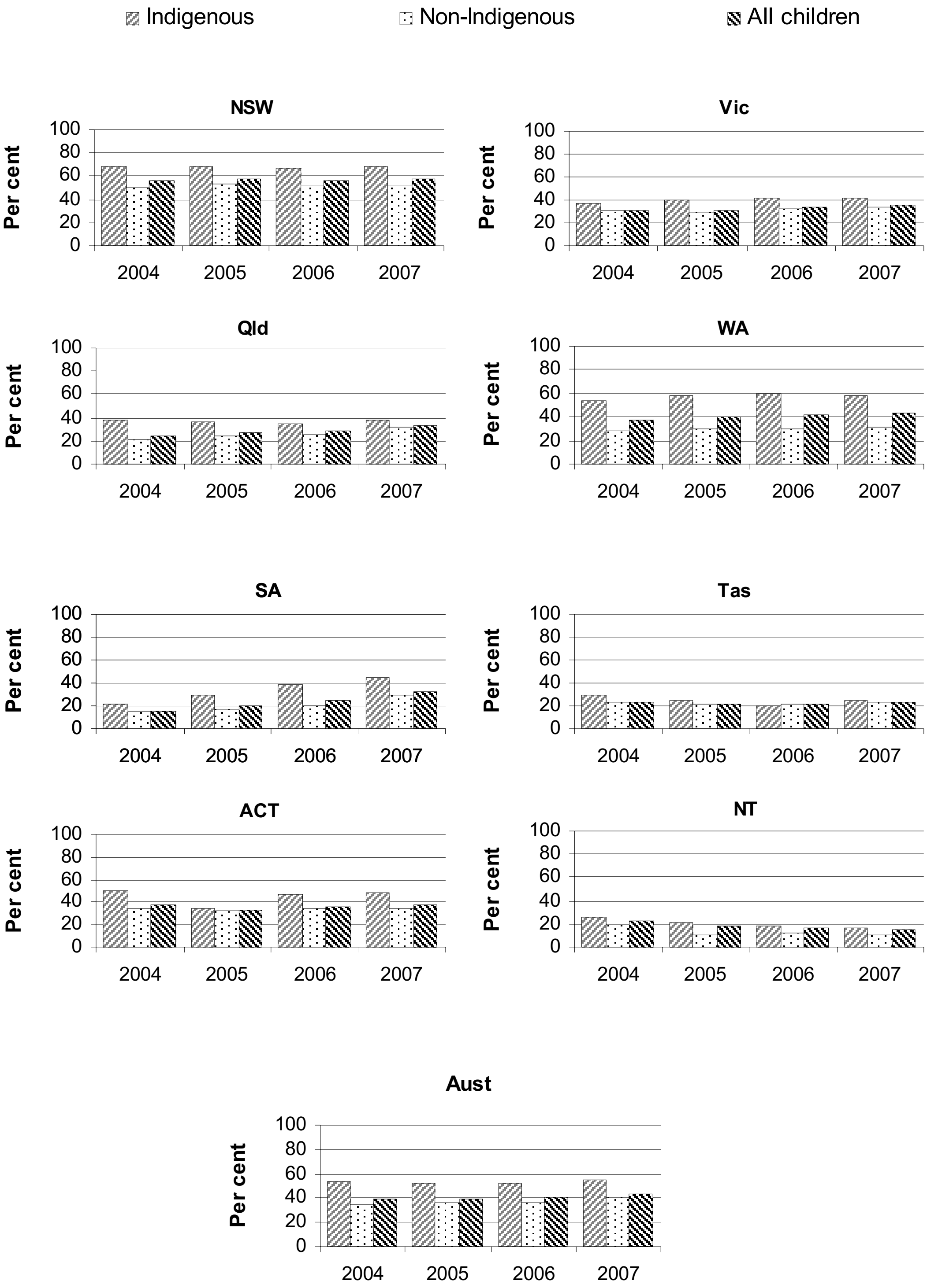
Placing children with their relatives or kin is generally the preferred out-of-home care placement option. This option is generally associated with better long term outcomes due to increased continuity, familiarity and stability for the child. Relatives are more likely to have or form long term emotional bonds with the child. Placement with familiar people can help to overcome the loss of attachment and belonging that can occur when children are placed in out-of-home care.

Placements with extended family may not always be the best option. Long standing family dynamics may undermine the pursuit of case goals such as reunification, and the possibility of intergenerational abuse needs to be considered. In addition, depending on the individual circumstances of children, it may be more important to have a local placement that enables continuity at school, for example, rather than a distant placement with relatives.

Figure 15.7 shows the proportion of children placed with relatives or kin by Indigenous status for the past 4 years. Although these data are comparable, each jurisdiction is shown separately for simpler presentation. The proportion of children placed with relatives or kin at 30 June 2007 was greater for Indigenous children than for non-Indigenous children in all jurisdictions and nationally (figure 15.7).

In addition, the Aboriginal Child Placement Principle places additional emphasis on the placement of Indigenous children with extended family. This principle is discussed in box 15.15.

Figure 15.7 Proportion of children in out-of-home care placed with relatives/kin, by Indigenous status, 30 June



Source: AIHW *Children in out-of-home care, Australia* data collection (unpublished); table 15A.19.

Out-of-home care — children aged under 12 years in home-based care

‘Children aged under 12 years in home-based care’ is an indicator of the effectiveness of out-of-home care services (box 15.14).

Box 15.14 **Children aged under 12 years in home-based care**

‘Children aged under 12 years in home-based care’ is an indicator of governments’ objective to provide services which meet the needs of the recipients. This indicator is defined as the number of children under 12 years of age placed in home-based care divided by the total number of children under 12 years in out-of-home care.

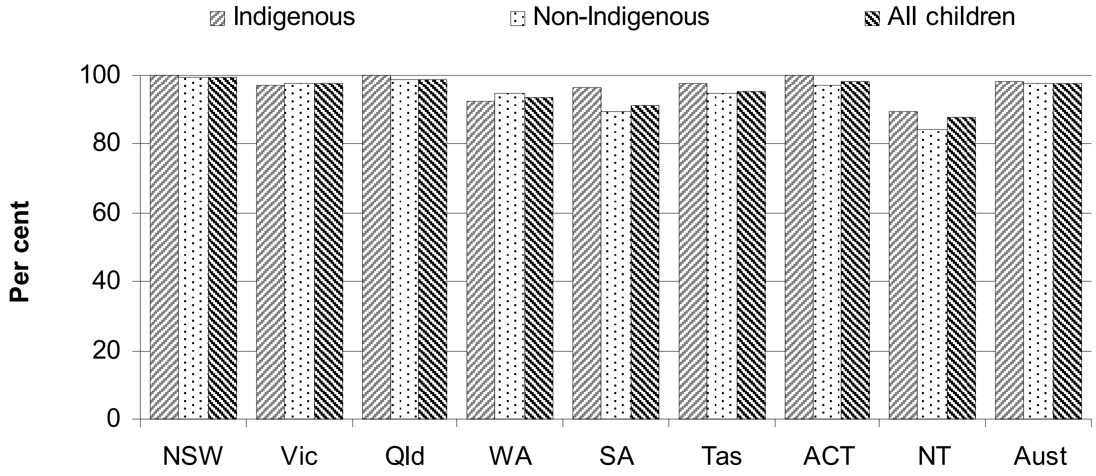
A high rate for this indicator is considered desirable.

Placing children in home-based care is generally considered to be in their best interests, particularly for younger children. Children will generally make better developmental progress (and have more ready access to normal childhood experiences) in family settings rather than in residential care.

This indicator should be interpreted in conjunction with other placement indicators.

The proportion of all children aged under 12 years in care who were placed in home-based care (excluding family group homes) at 30 June 2007 was 97.9 per cent nationally. In all jurisdictions the proportion of Indigenous children aged under 12 years who were placed in home-based care was similar to that of non-Indigenous children, within seven percentage points (figure 15.8).

Figure 15.8 **Proportion of children aged under 12 years in out-of-home care and in a home-based placement, by Indigenous status, 30 June 2007**[a]



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[a] Family group homes are not classified as being home-based care.

Source: AIHW *Children in out-of-home care, Australia* data collection (unpublished); table 15A.21.

Out-of-home care — placement in accordance with the Aboriginal Child Placement Principle

'Placement in accordance with the Aboriginal Child Placement Principle' is an indicator of the effectiveness of out-of-home care services (box 15.15). Subject to an over-riding concern for the safety and wellbeing of Indigenous children, the principle supports the maintenance of the Indigenous child's cultural ties and identity while in out-of-home care.

According to the Aboriginal Child Placement Principle (NSW Law Reform Commission 1997), the following hierarchy or placement preference should be pursued in protecting the safety and welfare of Indigenous children:

- placement with the child's extended family (which includes Indigenous and non-Indigenous relatives/kin)
- placement within the child's Indigenous community
- placement with other Indigenous people.

All jurisdictions have now adopted this principle in both legislation and policy.

Box 15.15 Placement in accordance with the Aboriginal Child Placement Principle

‘Placement in accordance with the Aboriginal Child Placement Principle’ is an indicator of governments’ objective to protect the safety and welfare of Indigenous children while maintaining the cultural ties and identity of Indigenous children in out-of-home care.

Placing Indigenous children in circumstances consistent with the Aboriginal Child Placement Principle is considered to be in their best interests. However, it is one factor among many considerations for the child’s safety and wellbeing that must be carefully considered in the placement decision. In the application of this principle, consultation with and involvement of appropriate Indigenous individuals or organisations occurs in the placement decision.

If the preferred options are not available, the child may be placed (after appropriate consultation) with a non-Indigenous family or residential setting. The principle does not preclude the possibility that in some instances, placement in a non-Indigenous setting, where arrangements are in place for the child’s cultural identity to be preserved, may be the most appropriate placement for the child.

This indicator is defined as the number of Indigenous children placed with the child’s extended family, Indigenous community or other Indigenous people, divided by the total number of Indigenous children in out-of-home care. Data are reported separately for children placed (i) with relative/kin, (ii) with other Indigenous carer or Indigenous residential care, and (iii) not placed with relative/kin, other Indigenous carer or Indigenous residential care.

A high proportion of children placed in accordance with the principle is desirable.

This indicator needs to be interpreted with care as the current measure is a proxy measure for compliance with the principle, as it reports the placement outcome of the Indigenous child rather than compliance with the principle. The indicator does not report whether the hierarchy was followed in the consideration of the best placement for the child, nor whether consultation was held with appropriate Indigenous individuals or organisations.

Nationally, at 30 June 2007, 55.6 per cent of Indigenous children in out-of-home care were placed with a relative/kin, 20.3 per cent placed with other Indigenous carer or Indigenous residential care, and 24.1 per cent were not placed with relative/kin, or other Indigenous residential care (figure 15.9).

The proportion of Indigenous children in out-of-home care at 30 June 2007 who were placed with Indigenous or non-Indigenous relatives or kin or with another Indigenous carer or in Indigenous residential care varied across jurisdictions (figure 15.9).

Figure 15.9 **Placement of Indigenous children in out-of-home care, 30 June 2007**[a, b, c, d]

Relative/Kin = Placed with relative/kin. Other Indigenous = Placed with other Indigenous carer or Indigenous residential care. Other = Not placed with relative/kin, other Indigenous carer or Indigenous residential care. [a] Excludes Indigenous children living independently and those whose living arrangements were unknown. [b] During 2006-07 Victoria introduced new service and data reporting arrangements. Therefore data for 2006-07 may not be fully comparable to previous years' data. [c] 2006-07 data for Queensland are preliminary and will be revised in 2008. [d] Data for Tasmania and the ACT relate to a small number of Indigenous children (113 and 89 respectively) in care at 30 June 2007.

Source: AIHW *Children in out-of-home care, Australia* data collection (unpublished); table 15A.20.

Out-of-home care — local placement

'Local placement' is an indicator of the effectiveness of out-of-home care services (box 15.16).

Box 15.16 **Local placement**

Local placement is an indicator of governments' objective to provide services which meet the needs of the recipients.

A high rate of 'local placement' is desirable.

A placement close to where a child lived prior to entering out-of-home care is considered to enhance the stability, familiarity and security of the child. It enables some elements of the child's life to remain unchanged (for example, they can continue attending the same school and retain their friendship network). It may also facilitate family contact if the child's parents continue to live nearby.

(Continued on next page)

Box 15.16 **(Continued)**

This indicator is defined as the proportion of children attending the same school after entering out-of-home care. Data will be provided for 3 and 12 months after entering care. Data collections for local placement are being developed. Data were not available for the 2008 Report.

This indicator should be balanced against other quality indicators. This is one factor among many that must be considered in the placement decision. For example, placement with a sibling or relative might preclude a local placement. Also, a child might move from a primary school to a secondary school.

Out-of-home care — placement with sibling

'Placement with sibling' is an indicator of the effectiveness of out-of-home care services (box 15.17).

Box 15.17 **Placement with sibling**

'Placement with sibling' is an indicator of governments' objective to provide services which meet the needs of the recipients.

This indicator is defined as the proportion of children who are on orders and in out-of-home care at 30 June who have siblings also on orders and in out-of-home care, who are placed with at least one of their siblings.

A high rate of placement with siblings is desirable.

Placement of siblings together promotes stability and continuity. It is a long standing placement principle that siblings should be placed together, where possible, in the interests of their emotional wellbeing. Children are likely to be more secure and have a sense of belonging within their family when placed with siblings.

This is one factor among many that must be considered in the placement decision. In circumstances of sibling abuse, or when a particular child in a family has been singled out as the target for abuse or neglect, keeping siblings together may not be appropriate.

Data collections for placement with sibling are being developed. Data were not available for the 2008 Report.

Out-of-home care — children with documented case plan

'Children with documented case plan' is an indicator of the effectiveness of out-of-home care services (box 15.18).

Box 15.18 **Children with documented case plan**

‘Children with documented case plan’ is an indicator of governments’ objective to provide services that meet the needs of the recipients.

This indicator is defined as the proportion of children on an order and in out-of-home care who have a documented case plan.

A high rate is desirable because all children should have a case plan.

The quality of the case plan must also be considered and the mere existence of a case plan does not guarantee that appropriate case work is occurring that meets the child’s needs.

Case planning is essential to structured and purposeful work to support children’s optimal development. Case plans outline intervention goals such as improved parent–child attachments, reunification or other forms of permanency, and set out the means to achieve these goals, such as frequency of family contact and any remedial or special services considered appropriate for the individual child. Case plans also allow for the monitoring of a child’s time in care.

Data collections for children with a documented case plan are being developed. Data were not available for the 2008 Report.

Out-of-home care — client satisfaction

‘Client satisfaction’ is an indicator of the effectiveness of out-of-home care services (box 15.19).

Box 15.19 **Client satisfaction**

Client satisfaction is an indicator of governments’ objective to provide high quality services that meet the needs of recipients.

This indicator has been identified for development and reporting in future. Data were not available for the 2008 Report.

Some information on jurisdictions’ development of initiatives which may assist to measure client satisfaction in the future is included in box 15.7.

Efficiency

Understanding the efficiency of the child protection systems that they administer helps State and Territory governments to identify the key cost drivers of their systems and to weigh the efficacy of options for addressing child protection issues.

Challenges in reporting efficiency for child protection systems

Current efficiency data for child protection services has several limitations, including:

- *different systems and priorities across jurisdictions* — child protection systems in Australia have evolved independently under the auspices of State and Territory governments. This has resulted in variations in the processes and emphases placed on different service delivery paradigms, such as different approaches to diversionary options
- *limitations of current information systems* — in most jurisdictions, it is difficult to identify explicit resources expended on child protection services, out-of-home care services and other support services for families. This is due in part to the historic structure of information systems and the embedding of the government agencies responsible for child protection issues within larger community services departments. Table 15A.4 identifies the level of consistency in expenditure data across jurisdictions.

As a result of these limitations, cost allocations reflect the historic nature of information systems and do not necessarily provide an accurate reflection of the costs involved in provision of various child protection and out-of-home care services.

In April 2002, the Review initiated a project to improve efficiency data for a national framework of protection and support pathways (box 15.20). Until this can be fully implemented, reporting on efficiency has been limited to relatively poor proxy indicators (box 15.21 and box 15.22).

Box 15.20 **The pathways project**

The pathways project developed and tested a model that will ultimately allow jurisdictions to calculate more meaningful, comparable and robust efficiency measures (the ‘pathways method’). The model is based on a top-down application of the activity-based costing method. A set of eight national pathways has been developed as a high level representation of the services that a protection and support client could receive in any jurisdiction. Each pathway consists of common activity groups which act as the ‘building blocks’ for each of the pathways. The aggregate cost of each activity group within the pathway will allow for the unit cost of an individual pathway to be determined.

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Box 15.20 **(Continued)**

These activity groups and pathways will provide additional utility for jurisdictions in managing the business of child protection services. Implementation of the model has the potential to improve the quality of national reporting of protection and support services efficiency measures. Activity-based data can also result, over time, in measures of the cost savings associated with early intervention strategies.

The activity groups are:

- Activity Group 1 Receipt and assessment of initial information about a potential protection and support issue
- Activity Group 2 Provision of generic/non-intensive family support services
- Activity Group 3 Provision of intensive family support services
- Activity Group 4 Secondary information gathering and assessment
- Activity Group 5 Provision of short term protective intervention and coordination services
- Activity Group 6 Seeking a court order
- Activity Group 7 Provision of longer term protective intervention, support and coordination services
- Activity Group 8 Provision of out-of-home care services.

Detailed definitions of activity groups are included in section 15.13.

Before jurisdictional reporting against the activity groups can be undertaken with confidence, further refinement of activity group definitions and counting rules is required. Development work, including further data testing in these areas will continue.

Source: SCRCSSP (2003).

Experimental results from the Pathways model, provided by four jurisdictions, are included in table 15.1. These data are preliminary and are subject to further analysis and refinement for future Reports. The data do not represent unit costs and should be interpreted with caution. Due to differing internal management systems across jurisdictions, there may be significant variation between jurisdictions in relation to specific activities or expenditures that are included in each activity group.

The data reflect a combination of allocation of direct costs (those costs which can be clearly identified by a jurisdiction to a particular activity group) and indirect costs (which form part of the overall expenditure base, but which cannot be identified in a specific activity group and hence have been allocated amongst the activity groups). These indirect allocations have been approximated by each jurisdiction amongst the eight activity groups.

Table 15.1 provides an approximation of the proportionate allocation of expenditure amongst the eight activity groups for each participating jurisdiction. The expenditure base used for the pathways project differs from the expenditure base used to calculate the existing proxy efficiency indicators for child protection and out-of-home care services (box 15.21 and box 15.22).

The proportion of expenditure allocated to Activity group 8 (Out-of-home care) is the most significant and varies from 41 per cent to 46 per cent across reporting jurisdictions. The proportions allocated to Activity groups 1 (Receipt and assessment of initial information about a potential protection and support issue), 6 (Seeking a court order) and 7 (Provision of longer term protective intervention, support and coordination services) each accounted for 10 per cent or less across all reporting jurisdictions.

Table 15.1 **Proportion of expenditure by activity group – experimental estimates (per cent)[a, b, c, d]**

	AG1	*AG2*[e]	*AG3*	*AG4*	*AG5*	*AG6*	*AG7*	*AG8*	*Total*
NSW	7	17	18	6	2	3	2	46	**100**
Vic	3	24	4	5	4	7	8	44	**100**
SA	4	8	4	13	10	8	7	45	**100**
Tas	6	2	4	12	17	9	10	41	**100**

AG = Activity Group. AG1 Receipt and assessment of initial information about a potential protection and support issue. AG2 Provision of generic/non-intensive family support services. AG3 Provision of intensive family support services. AG4 Secondary information gathering and assessment. AG5 Provision of short term protective intervention and coordination services. AG6 Seeking a court order. AG7 Provision of longer term protective intervention, support and coordination services. AG8 Provision of out-of-home care services. [a] Includes direct and indirect expenditure. [b] These experimental data have been derived from expenditure allocations in different years by the various participating jurisdictions, but may be applied indicatively to 2006-07. [c] These experimental percentage allocations are derived from total expenditure allocations which vary from totals used to derive costs presented elsewhere in the chapter. [d] Totals may not add to 100 as a result of rounding. [e] Expenditure items included in calculating proportional expenditure for Activity Group 2 may vary across jurisdictions.

Source: NSW, Victoria, SA and Tasmanian governments (unpublished).

Out-of-home care services unit costs – program expenditure per placement day

Indicative unit costs for out-of-home care services are provided in table 15.2. Out-of-home care program expenditure per placement day varied across jurisdictions (table 15.2).

Table 15.2 **Indicative unit costs of out-of-home care services, 2006-07**[a, b]

	NSW[c]	*Vic*	*Qld*[d]	*WA*	*SA*	*Tas*[e]	*ACT*	*NT*
Real expenditure on out-of-home care services ($m)	364.7	199.7	263.2	89.0	73.1	28.8	18.7	19.2
Placement days in out-of-home care (no. ‘000)[f]	na	1 900.1	na	783.6	594.5	235.8	141.6	134.1
Out-of-home care program expenditure per placement day ($)	na	105.1	na	113.6	123.0	122.3	132.0	143.1

[a] These data should not be interpreted as unit costs for Activity Group 8 as they are derived using reported program expenditure and not activity group expenditure. [b] Caution should be used when interpreting results due to the variability of activities that are included in out-of-home care services. [c] Comparable data for NSW were not available. [d] Data on placement days were unable to be reported due to the recent transition to a new information management system. [e] Children in facility-based care placements contribute to a significant proportion of out-of-home care expenditure and may inflate the average unit cost. [f] A placement day in out-of-home care only counts children who stay overnight in an out-of-home care placement. **na** Not available.

Source: State and Territory Governments (unpublished); table 15A.30.

These indicative costs are derived using total real recurrent program expenditure on out-of-home care services (table 15A.1) and not expenditure allocated to an activity group. It is anticipated that unit costs on out-of-home care services derived from Activity group 8 expenditure will be available in future Reports, as development work continues on definitions and counting rules for the pathways project.

Child protection services proxy efficiency indicators

There are three proxy indicators of the efficiency of child protection services (box 15.21).

Box 15.21 **Child protection services proxy efficiency indicators**

Three child protection efficiency measures are reported as proxy indicators of governments' objective to maximise the benefit to the community through the efficient use of taxpayer resources: 'total expenditure on all child protection activities, per notification', 'total expenditure on all child protection activities, per investigation', and 'total expenditure on all child protection activities, per substantiation'.

These indicators are defined, respectively, as:

- total expenditure on all child protection activities divided by the number of notifications
- total expenditure on all child protection activities divided by the number of investigations
- total expenditure on all child protection activities divided by the number of substantiations.

These indicators are imperfect proxy indicators and need to be interpreted with care.

Because each of these proxy indicators is based on total expenditure on child protection activities, they do not represent, and cannot be interpreted as, unit costs for notifications, investigations or substantiations.

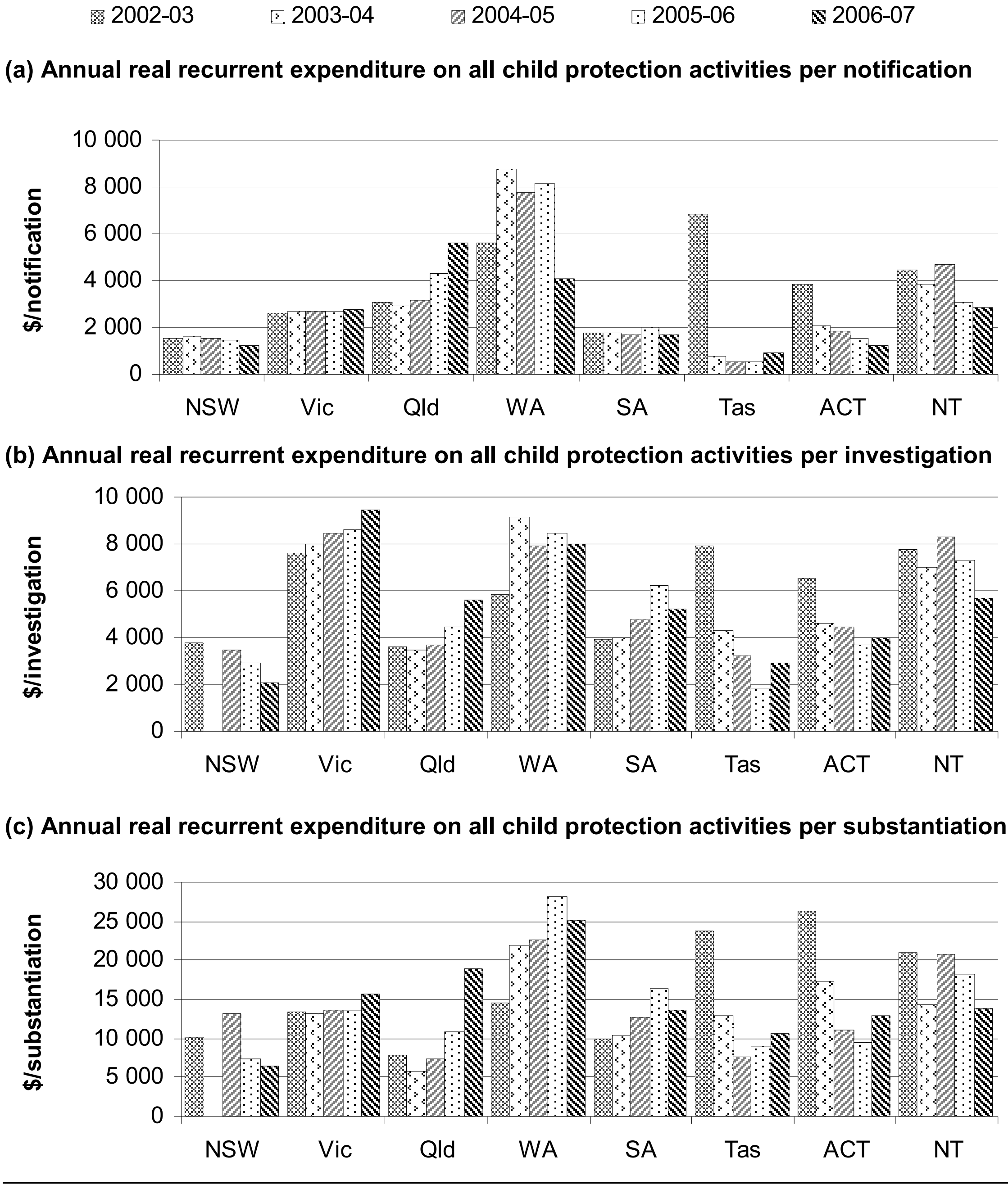
These proxy indicators cannot be added together to determine overall cost of child protection services.

Lower expenditure per notification/investigation/substantiation may suggest more efficient services but may indicate lower quality or different service delivery models.

Better efficiency indicators would relate expenditure on particular child protection activities to a measure of output of those activities. Work is in progress to develop an activity-based costing method that will allow this type of reporting from existing information systems (box 15.20).

Total expenditure on all child protection activities per notification, per investigation and per substantiation from 2002-03 to 2006-07 varied between jurisdictions (figure 15.10).

Figure 15.10 **Child protection efficiency indicators (2006-07 dollars)**[a, b, c, d]



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[a] Real expenditure based on ABS gross domestic product price deflator (2006-07 = 100) (table AA.26). [b] These data are derived from proxy indicators and cannot be interpreted as the unit costs for 'expenditure per notification', 'expenditure per investigation' or 'expenditure per substantiation' because each is based on the total expenditure of all child protection activities. They cannot be added together to derive a total cost for child protection activities. Differences across jurisdictions reflect the quantity of the three activities rather than a difference in unit costs. [c] 2006-07 data for some jurisdictions for 'annual real expenditure per notification' and 'annual real expenditure per investigation' may not be strictly comparable with previous years, due to the introduction of a new investigation category 'Investigation closed—no outcome possible'. [d] See table 15A.2 for detailed jurisdiction-specific footnotes.

Source: State and Territory governments (unpublished); table 15A.2.

Out-of-home care proxy efficiency indicators

There are three proxy indicators of the efficiency of out-of-home care services (box 15.22).

Box 15.22 **Out-of-home care proxy efficiency indicators**

Three out-of-home care efficiency measures are reported as proxy indicators of governments' objective to maximise the benefit to the community through the efficient use of taxpayer resources: 'total expenditure on all children in residential out-of-home care per year, per child in residential out-of-home care on 30 June', 'total expenditure on all children in non-residential out-of-home care per year, per child in non-residential out-of-home care on 30 June', and 'total expenditure on all children in out-of-home care per year, per child in all out-of-home care on 30 June'.

These indicators are defined respectively as:

- total annual expenditure on residential out-of-home care divided by the number of children in residential out-of-home care at 30 June
- total annual expenditure on non-residential out-of-home care divided by the number of children in non-residential out-of-home care at 30 June
- total annual expenditure on all out-of-home care divided by the number of children in all out-of-home care at 30 June.

These indicators are imperfect proxy indicators and need to be interpreted with care. Low expenditure per child in care may suggest more efficient services but may also indicate lower service quality.

These indicators should be interpreted with care because they do not represent unit cost measures. Expenditure per child in care at 30 June overstates the cost per child because significantly more children are in care during a year than at a point in time. In addition, the indicator does not reflect the length of time that a child spends in care.

Better efficiency indicators would relate expenditure on particular out-of-home care activities to a measure of output of those activities. Work is currently in progress to develop an activity-based costing method which will allow this type of reporting from existing information systems (box 15.20).

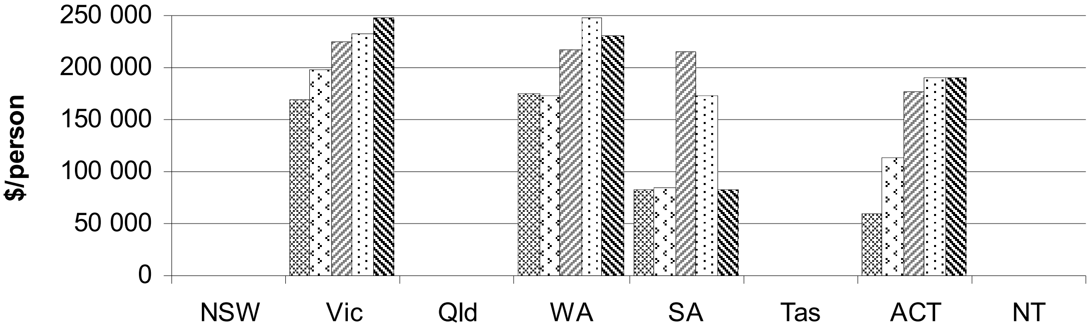
Victoria, WA, SA and the ACT were able to separate expenditure on out-of-home care into residential care and non-residential care. This annual expenditure to 30 June for 2002-03 to 2006-07 per child in residential care and non-residential care at 30 June, varied across these jurisdictions (figures 15.11(a) and figure 15.11(b)).

All jurisdictions provided data on total expenditure on out-of-home care per child in care at 30 June for 2002-03 to 2006-07, which varied across jurisdictions (figure 15.11(c)).

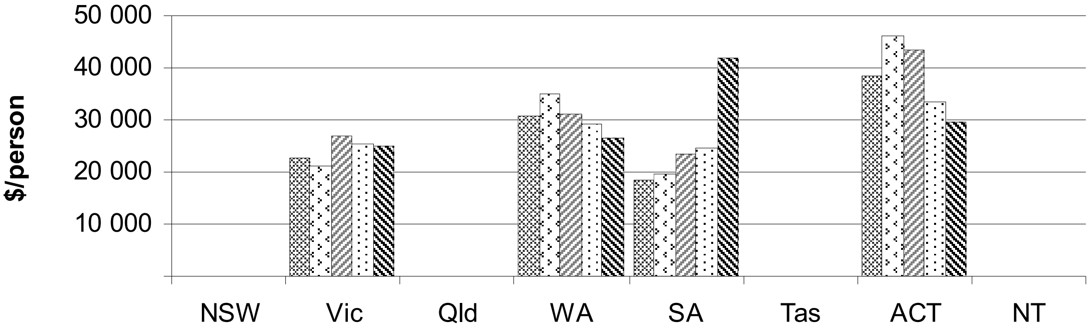
Figure 15.11 **Out-of-home care efficiency indicators (2006-07 dollars)**[a, b, c]

▩ 2002-03 ▫ 2003-04 ▨ 2004-05 ▫ 2005-06 ▧ 2006-07

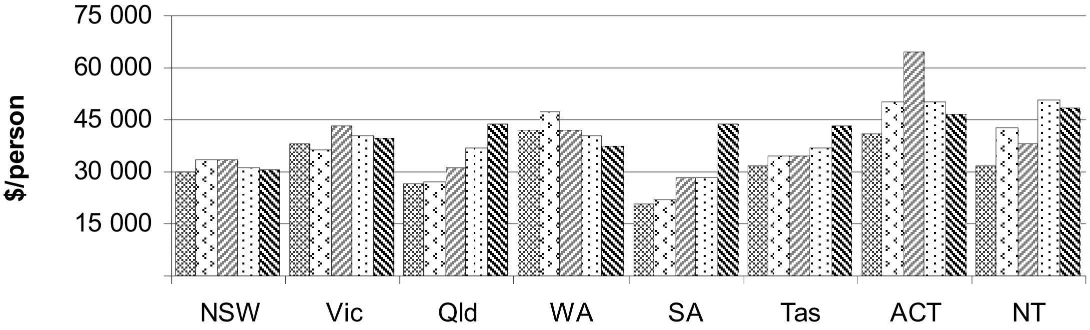
(a) Annual real expenditure on residential out-of-home care per child in residential out-of-home care at 30 June



(b) Annual real expenditure on non-residential out-of-home care per child in non-residential out-of-home care at 30 June



(c) Annual real expenditure on all out-of-home care per child in out-of-home care at 30 June



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[a] Real expenditure based on ABS gross domestic product price deflator (2006-07 = 100) (table AA.26). [b] These data do not represent unit costs of providing out-of-home care services. [c] NSW, Qld, Tasmania and the NT could not disaggregate expenditure on out-of-home care into residential care and non-residential care.

Source: State and Territory governments (unpublished); table 15A.3.

Outcomes

Outcomes are the impact of services on the status of an individual or group (while outputs are the actual services delivered) (see chapter 1, section 1.5).

Improved safety — substantiation rate after decision not to substantiate

'Substantiation rate after decision not to substantiate' is an indicator of the outcomes of child protection and out-of-home care services (box 15.23).

Box 15.23 **Improved safety — substantiation rate after decision not to substantiate**

'Improved safety — substantiation rate after decision not to substantiate' is an indicator of governments' objective to reduce the risk of harm to children by appropriately assessing notifications of possible child protection incidents.

This indicator is defined as the proportion of children who were the subject of an investigation in the previous financial year that led to a decision not to substantiate, and who were later the subject of a substantiation within three or 12 months of the initial decision not to substantiate. The year reported relates to the year of the initial decision not to substantiate.

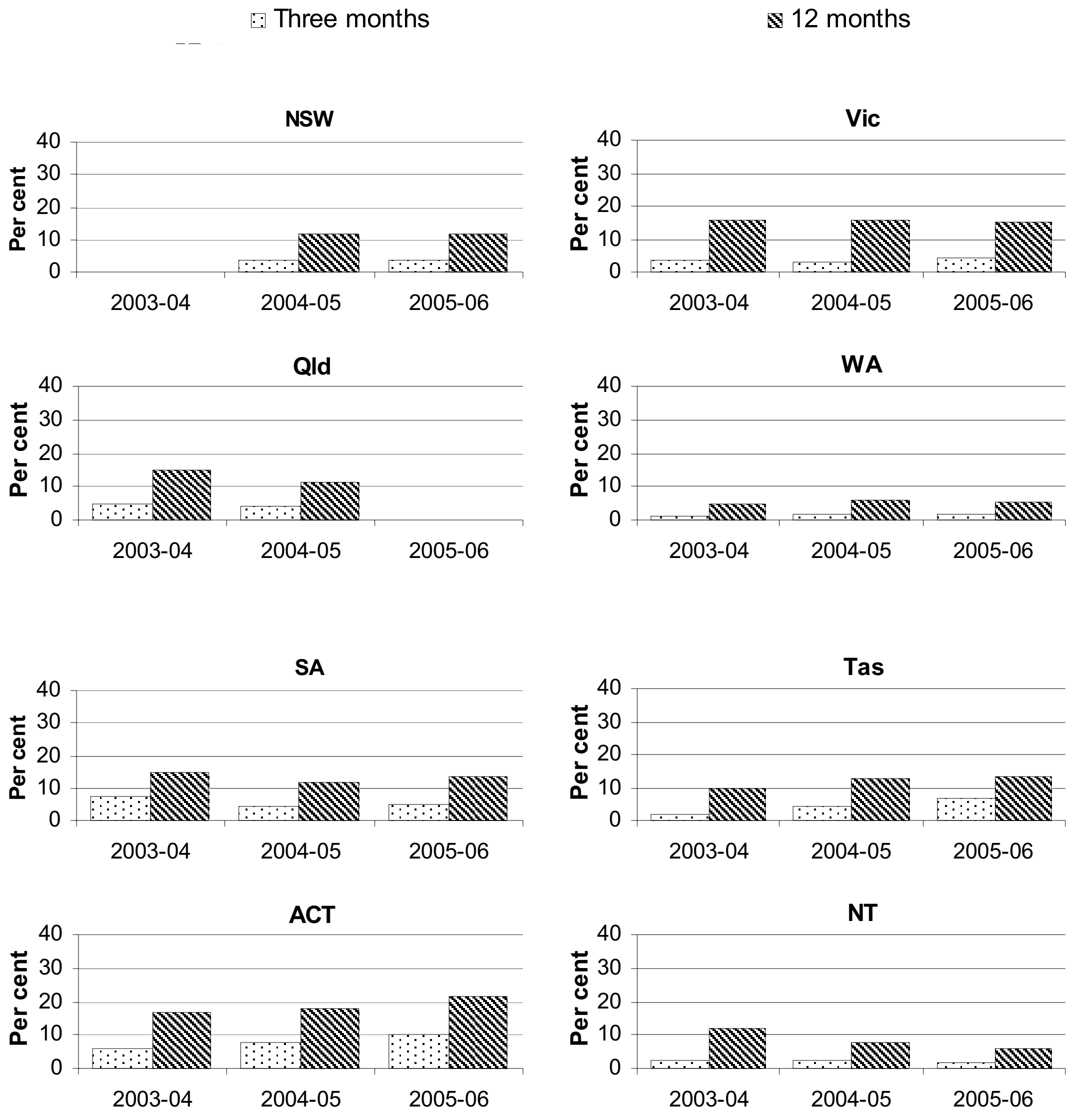
This indicator partly reveals the extent to which an investigation has not succeeded in identifying the risk of harm to a child who is subsequently the subject of substantiated harm. It also provides a measure of the adequacy of intervention offered to children in terms of protecting them from further harm.

A low rate for this indicator is generally desirable. However, reported results may be affected by the finalisation of investigations, factors beyond the control of child protection services, or a change in circumstances after the initial decision not to substantiate was made. A demonstrable risk of harm might not have existed in the first instance. In addition, this indicator does not distinguish between subsequent substantiations which are related to the initial notification (that is, the same source of risk of harm), and those which are unrelated to the initial notification (that is, a different source of risk of harm).

This indicator should be considered with other outcome indicators.

Data that are comparable across jurisdictions are not available for this indicator, because definitions of substantiations vary across jurisdictions. Data are comparable within each jurisdiction over time unless otherwise stated (figure 15.12).

Figure 15.12 **Improved safety — substantiation rate within 3 and/or 12 months after a decision not to substantiate**[a, b, c, d, e, f, g]



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[a] Data are not comparable across jurisdictions because definitions of substantiation vary significantly. Consequently, rates cannot be compared across jurisdictions. [b] Jurisdictions have provided the denominator for this indicator for this Report. In previous Reports the denominator was derived by the AIHW. Data in this Report may therefore differ from previous Reports. [c] NSW was unable to provide data for 2003-04 due to the introduction of a new client information system. [d] The counting rule for this indicator changed from 2003-04 onwards. SA applied the earlier counting rule up to and including 2004-05. [e] During 2006-07 Victoria introduced new service and data reporting arrangements. Therefore data for 2006-07 may not be fully comparable to previous years' data. See source table 15A.52 for more details on these arrangements. [f] Queensland data have not been provided due to the recent transition to a new information management system. As this indicator is calculated using two years of data, 2005-06 rates are not available for Queensland. [g] Data relating to substantiations after a decision not to substantiate in Tasmania for 2006-07 should be interpreted carefully due to the high proportion of investigations in process at 31 August 2007.

Source: AIHW *Child protection notifications, investigations and substantiations, Australia* data collection (unpublished); tables 15A.9, 15A.35, 15A.52, 15A.69, 15A.86, 15A.103, 15A.120, 15A.137 and 15A.154.

Improved safety — resubstantiation rate

The ‘resubstantiation rate’ is an indicator of the outcomes of child protection and out-of-home care services (box 15.24).

Box 15.24 **Improved safety — resubstantiation rate**

‘Resubstantiation rate’ is an indicator of governments’ objective to reduce the risk of harm and to prevent the recurrence of abuse and neglect or harm to children. This indicator also partly reveals the extent to which intervention by child protection services has succeeded in preventing further harm.

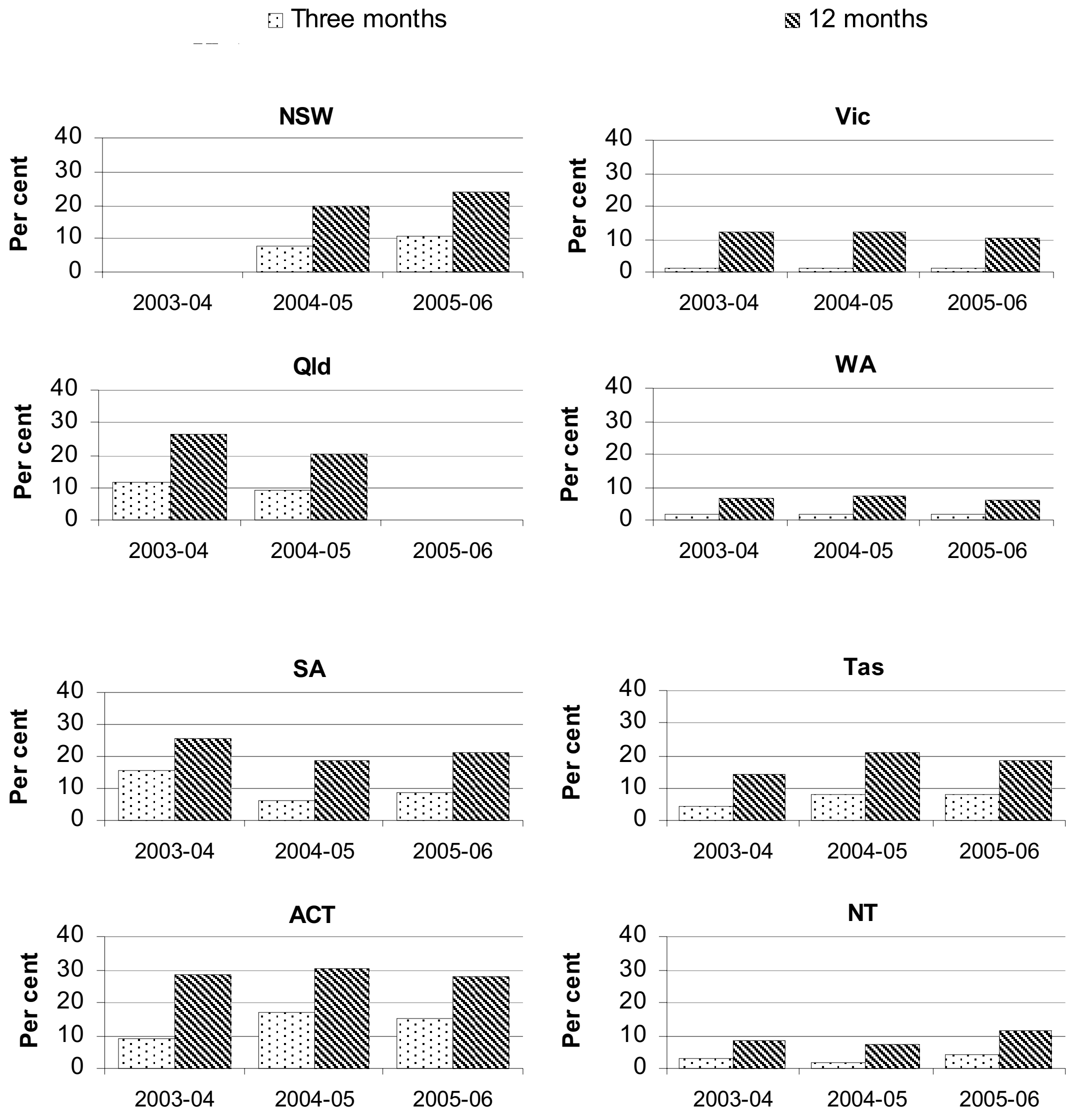
This indicator is defined as the proportion of children who were the subject of a substantiation in the previous financial year, who were subsequently the subject of a further substantiation within the following three or 12 months. The year reported relates to the year of the original substantiation.

A low rate for this indicator is generally desirable. However, reported results may be affected by the finalisation of investigations, factors beyond the control of child protection services, such as changes in the family situation (for example, illness, unemployment or a new partner). In addition, this indicator does not distinguish between subsequent substantiations that are related to the initial notification (that is, the same source of risk of harm) and those that are unrelated to the initial notification (that is, a different source of risk of harm).

This indicator should be considered with other outcome indicators.

Data that are comparable across jurisdictions are not available for this indicator, because definitions of substantiations vary across jurisdictions. Data are comparable within each jurisdiction over time unless otherwise stated (figure 15.13).

Figure 15.13 **Improved safety — resubstantiation rate within 3 and/or 12 months after a substantiation**[a, b, c, d, e, f, g]



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[a] Data are not comparable across jurisdictions because definitions of substantiation vary significantly. Consequently, rates cannot be compared across jurisdictions. [b] Jurisdictions have provided the denominator for this indicator for this Report. In previous Reports the denominator was derived by the AIHW. Data in this Report may therefore differ from previous Reports. [c] NSW was unable to provide data for 2003-04 due to the introduction of a new client information system. [d] The counting rule for this indicator changed from 2003-04 onwards. SA applied the earlier counting rule up to and including 2004-05. [e] During 2006-07 Victoria introduced new service and data reporting arrangements. Therefore data for 2006-07 may not be fully comparable to previous years' data. See source table 15A.53 for more details on these arrangements. [f] Queensland data have not been provided due to the recent transition to a new information management system. As this indicator is calculated using two years of data, 2005-06 rates are not available for Queensland. [g] Data relating to resubstantiations in Tasmania for 2006-07 should be interpreted carefully due to the high proportion of investigations in process at 31 August 2007.

Source: AIHW *Child protection notifications, investigations and substantiations, Australia* data collection (unpublished); tables 15A.10, 15A.36, 15A.53, 15A.70, 15A.87, 15A.104, 15A.121, 15A.138 and 15A.155.

Improved education, health and wellbeing of the child

'Improved education, health and wellbeing of the child' is an indicator of the outcomes of child protection and out-of-home care services (box 15.25).

Box 15.25 **Improved education, health and wellbeing of the child**

'Improved education, health and wellbeing of the child' is an indicator of governments' objective to maximise children's life chances by ensuring children in care have their educational, health and wellbeing needs met.

Information on the change over time in learning outcomes for children on guardianship or custody orders provides a partial measure against this outcome indicator. An increase in learning outcomes over time for children on guardianship or custody orders indicates that their educational outcomes are improving.

However, factors outside the control of protection and support services may also influence the educational outcomes of children on guardianship or custody orders, and care needs to be exercised when interpreting results.

For the 2008 Report, data are available on the proportion of children in years 3, 5 and 7 on guardianship or custody orders (attending government schools) achieving the national reading and numeracy benchmarks in 2003, relative to all children (attending government and non-government schools) achieving these benchmarks over the same period (see tables 15A.11–15A.13). Until information on the learning outcomes for these children is available at a later point in time, changes over time are not able to be presented.

Development is currently under way to produce information on the educational outcomes for these same children two years after their assessment in 2003. These data are anticipated to be available for the 2010 Report.

Safe return home

'Safe return home' is an indicator of the outcomes of child protection and out-of-home care services (box 15.26).

Box 15.26 **Safe return home**

‘Safe return home’ is an indicator of governments’ objective to remove the risk of harm to the child while maintaining family cohesion. For children who cannot be protected within their family and are removed from home, often the best outcome is when effective intervention to improve their parents’ skills or capacity to care for them enables them to return home.

This indicator has been identified for development and reporting in future. Data were not available for the 2008 Report.

Permanent care

‘Permanent care’ is an indicator of the outcomes of child protection and out-of-home care services (box 15.27).

Box 15.27 **Permanent care**

‘Permanent care’ is an indicator of governments’ objective to provide appropriate care for children who cannot be safely reunified with their families. Appropriate services are those that minimise the length of time before stable, permanent placement is achieved.

This indicator has been identified for development and reporting in future. Data were not available for the 2008 Report.

15.4 Future directions in child protection and out-of-home care services performance reporting

Improving national child protection data

Between 2000 and 2003, the National Child Protection and Support Services (NCPASS) Data Working Group, under the auspices of the National Community Services Information Management Group, reviewed the reporting framework used to collect the national child protection data.

The review resulted in the development of a broader framework to count responses to calls received by departments responsible for child protection about the safety and wellbeing of children. The responses include those that occur outside the formal child protection system. The new framework incorporates data elements such as the provision of advice and information, the assessment of needs, and the provision of general and intensive family support services.

The AIHW, in conjunction with the NCPASS, has developed data dictionaries to support the new reporting framework. These dictionaries have undergone initial data testing and it is envisaged that they will be used by jurisdictions to provide unit record data. This will provide more detailed child protection and out-of-home care data than is currently available with aggregated data.

Further development of the pathways activity-based costing project will reduce the reliance on proxy efficiency indicators for child protection and out-of-home care and enable more detailed and comparative analysis of efficiency indicators. Developments planned for the next Report include the implementation of revised definitions for some activity groups and the development of a common survey tool to facilitate greater consistency across reporting jurisdictions.

Significant progress is underway to develop comparative data in relation to two effectiveness indicators (response times to commence and complete investigations) for inclusion in the 2009 Report. Further work is occurring on the collection of additional material relating to the educational outcomes for children on orders for potential inclusion in the 2010 Report.

15.5 Profile of juvenile justice services

Service overview

Juvenile justice services aim to promote community safety and reduce youth offending by assisting young people to address their offending behaviour and take responsibility for the effect their behaviour has on victims and the wider community. In doing this, juvenile justice services recognise the importance of the families and communities of young offenders, particularly Indigenous communities, in the provision of services. Consequently, services are designed to maximise opportunities to maintain offending free lifestyles by rehabilitating young people who commit offences and reintegrating them into their community.

The juvenile justice system is responsible for dealing with young people (predominantly aged 10–17 years) who have committed or allegedly committed an offence while considered by law to be a juvenile. Key elements of juvenile justice systems in all jurisdictions include:

- the diversion of young people from the more formal criminal justice system (courts) where appropriate
- detention as a last resort
- victims' rights
- ensuring a young person fulfils their sentencing obligations
- responsibility appropriate to the developmental stage of the young person
- community safety.

The juvenile justice information in the Report is sourced from the Juvenile Justice National Minimum Data Set (JJ NMDS), the Australian Institute of Criminology (AIC) and the AIHW.

Roles and responsibilities

The responsibility for juvenile justice in Australia resides with State and Territory governments. Each jurisdiction has its own legislation that determines the policies and practices of its juvenile justice system. While this legislation varies in detail, its intent is similar across jurisdictions. National coordination takes place through the Australasian Juvenile Justice Administrators (AJJA). AJJA is a Standing Committee of the Community and Disability Services Ministerial Advisory Council.

The juvenile justice system in each jurisdiction comprises several organisations, each with a different primary role and responsibility in dealing with young people. These include:

- police, who are usually the young person's first point of contact with the system
- courts (usually a special children's or youth court), where matters relating to the charges against the young person are heard. The courts are largely responsible for decisions regarding bail (and remand) and sentencing options
- juvenile justice agencies, which are responsible for the supervision and case management of young people on a range of community-based legal arrangements and in detention, and for the provision of a wide range of services aimed at crime prevention and reduction. Many of the services provided by juvenile justice agencies are aimed at: rehabilitating young people; minimising the level and future involvement of young people in the juvenile justice system; reducing the over representation of Indigenous young people in the justice system; maintaining the young person's connection with family, culture and community; providing young people with an appropriate level of care and safety (duty of care); increasing young people's accountability to victims; and improving community safety.

Diversion of young offenders

In most jurisdictions, the majority of young people who come into contact with the juvenile justice system are diverted through a range of mechanisms such as police cautions, conferences and unsupervised orders, and do not generally become clients of juvenile justice agencies. These mechanisms are now part of the spectrum of legislated responses to juvenile crime.

Responsibility for administering the options available for more minor offences — warnings (informal cautions), formal cautions, and infringement notices — rests mainly with police in all jurisdictions. Responsibility for administering the diversionary processes available for more serious offences lies with juvenile justice authorities and courts in each jurisdiction.

Diverting appropriate young people from the formal court system, or minimising the involvement of young people with the justice system through a conferencing process, can take considerable resources, depending on the judicial system in the jurisdiction and the number of young people involved. While comparable national data are not yet available to illustrate the level of diversion, the juvenile justice agencies in NSW and Queensland have provided information on the number of young people dealt with by means of diversion. These data are not comparable across the two jurisdictions.

The 2005-06 data from the NSW Bureau of Crime Statistics and Research that are available to the NSW Department of Juvenile Justice show that 19 349 warnings were administered to young people, 9449 cautions were given and 978 police referrals to youth justice conferences were made. The NSW Department of Juvenile Justice data show 1111 conferences (from 1555 police and court referrals) were convened for young people in 2005-06 (NSW Department of Juvenile Justice 2007). In Queensland, 2040 conferences were held for people aged 10–17 years in 2006-07, representing an increase of 6 per cent from 1927 in 2005-06 (Queensland Department of Communities unpublished).

Juvenile justice agencies in all jurisdictions provide pre-sentence reports for young people (who may or may not subsequently become clients) to the courts as required.

Funding

Data on Australian, State and Territory government expenditure on juvenile justice services are not currently available. This information is anticipated to be available for future Reports.

Size and scope

Clients of juvenile justice agencies

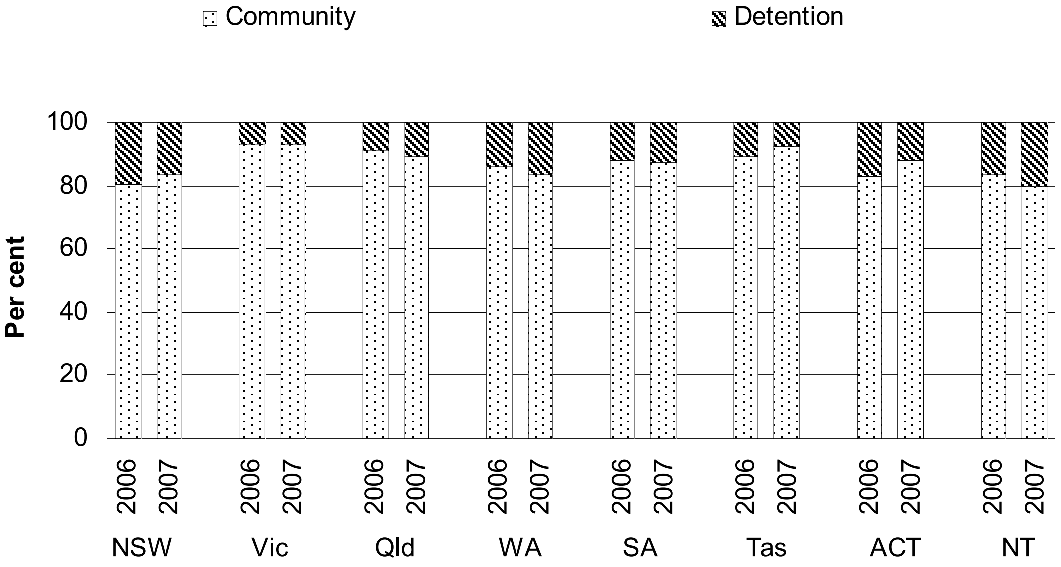
The third report of the JJ NMDS covers the period 2005-06 and was released in August 2007 (AIHW 2007a). The JJ NMDS provides information about young people who are supervised by juvenile justice agencies. Pre-sentenced and sentenced supervision both within the community and in detention are included in the JJ NMDS. Elements of the juvenile justice system which do not require juvenile justice agency supervision (such as police and court actions) are not within the scope of the JJ NMDS.

Of those young people who become clients of juvenile justice agencies, most are supervised on community-based orders, including parole. The JJ NMDS shows that, during 2005-06, 13 254 young people experienced juvenile justice supervision in Australia. Of these young people, 11 150 had community-based supervision, 5137 had detention-based supervision, with some young people experiencing both (AIHW 2007a).

The majority of young people aged 10–17 years supervised by juvenile justice jurisdictions (between 79.8 per cent and 92.8 per cent) were in the community, rather than in detention (figure 15.14). These figures do not include any juveniles aged 10–17 years who were supervised in the adult correctional system.

These data were collected at a point in time, so they need to be interpreted with care, particularly for jurisdictions with smaller populations where a small change to the number of young people in detention can make a significant difference to their relative proportion.

Figure 15.14 **Proportion of juvenile justice clients aged 10–17 years who were supervised in the community and in detention centres, at 30 June[a, b, c, d]**



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[a] Includes only those young people who were under the supervision or case management of juvenile justice agencies on a pre- or post-sentence legal arrangement or order (for example, supervised bail, remand, a community services order, parole and detention). [b] Juvenile justice agencies also have additional clients in detention and community supervision who are over 17 years of age. The figure does not include juvenile justice clients over 17 years of age at 30 June 2006 or 30 June 2007. [c] Clients may be on multiple orders at any one time. The distribution in the figure, therefore, is based not on order type but on where the client was located at 30 June 2006 or 30 June 2007. [d] Refer to source table 15A.167 for detailed footnotes.

Source: AIHW unpublished (data supplied by State and Territory governments); table 15A.167.

Juvenile detention

As outlined above, the majority of juvenile offenders are supervised in community-based services. The following data relate to juvenile detention only. As jurisdictions have different definitions of a juvenile, this may affect the number and rates reported for young people aged 10–17 years.

The data from the AIC cover young people aged 10–17 years in juvenile justice centres at the end of each quarter. They include young people in detention, both on remand or sentenced.

Nationally, the daily average number of people aged 10–17 years detained in juvenile detention centres increased from 590 to 634 between 2001-02 and 2005-06 (table 15.3).

Table 15.3 **Daily average population of people aged 10–17 years in juvenile detention (number)[a, b]**

	NSW[c]	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
2001-02	217	62	89	108	56	27	17	16	590
2002-03	220	64	96	106	65	25	17	24	616
2003-04	209	62	91	122	50	26	18	13	590
2004-05	218	53	89	110	58	33	15	22	596
2005-06	244	53	127	115	39	27	13	17	634

[a] Average based on population of juvenile detention centres on the last day of each quarter of the financial year. [b] Due to rounding, the Australian total may differ from the combined total of all jurisdictions. [c] NSW data from 31 March 2005 include Kariong Juvenile Correction Centre detainees, sourced from the NSW Department of Corrective Services. Numbers for NSW in each quarter in 2005-06 and the quarters of 31 March and 30 June 2005 include young people in the care of both the NSW Department of Juvenile Justice and the Department of Corrective Services.

Source: AIC (unpublished); table 15A.168.

The average rate of detention of young people aged 10–17 years per 100 000 in the population aged 10–17 years increased from 27.2 per 100 000 in 2001-02 to 28.4 per 100 000 in 2005-06, although rates varied across jurisdictions (table 15A.169).

Nationally, females made up 7.7 per cent of the total population of juvenile detention centres at 30 June 2006. Males made up 92.3 per cent of the national population of juvenile detention centres at 30 June 2006 (table 15A.170).

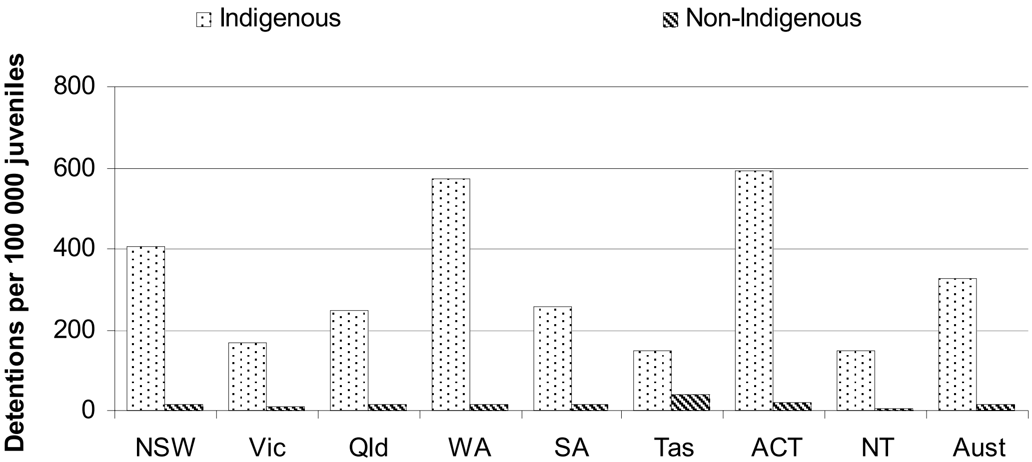
Numbers and rates of Indigenous young people placed in detention

The daily average number of Indigenous young people aged 10–17 years detained in juvenile detention centres was 334 in 2005-06 (table 15A.171). Nationally, the daily average detention rate for Indigenous people aged 10–17 years in 2005-06 was 324.1 per 100 000 Indigenous people aged 10–17 years. This rate compared to 14.1 per 100 000 for the non-Indigenous population aged 10–17 years (table 15A.172).

Jurisdictional comparisons need to be treated with caution, especially for those states and territories with low Indigenous populations, where small number effects can introduce statistical variations that do not accurately represent trends over time or consistent differences from other jurisdictions. The AIC uses ABS experimental projections for its estimates of the Indigenous population (ABS 2004). These data include a range of estimates (low and high). The AIC data are based on high level estimates, unlike other sections of this Report, which use the low level estimates.

The over-representation of Indigenous young people in detention across jurisdictions in 2005-06 is shown in figure 15.15.

Figure 15.15 **Average rate of detention of Indigenous and non-Indigenous people aged 10–17 years in juvenile detention, per 100 000 people, 2005-06**[a]



[a] Rates of detention for Indigenous and non-Indigenous people in NSW in each quarter in 2005-06 include young people in the care of both the NSW Department of Juvenile Justice and the Department of Corrective Services.

Source: AIC (unpublished); table 15A.172.

15.6 Framework of performance indicators for juvenile justice services

A framework of performance indicators for juvenile justice services is under development. It is anticipated that this framework will be available for the 2010 Report.

15.7 Future directions in juvenile justice reporting

The AJJA have formed a working group to develop national performance indicators for juvenile justice. Two types of measures, relating to the performance of juvenile justice agencies and the performance of the broader juvenile justice system, are being considered by this group.

When available, the Steering Committee will consider these indicators for inclusion in future editions of this Report.

15.8 Profile of supported accommodation and assistance services

Service overview

Supported accommodation and assistance services aim to assist people who are homeless or at imminent risk of becoming homeless as a result of a crisis, including women and children escaping domestic violence.

The Supported Accommodation and Assistance Program (SAAP) was established in 1985 to bring homelessness programs funded by individual State and Territory governments and the Australian Government under one nationally coordinated program. The current program (SAAP V) is governed by the *Supported Accommodation Assistance Act 1994*. This specifies that the overall aim of SAAP is to provide transitional supported accommodation and related support services to assist homeless people achieve the maximum degree of self-reliance and independence (AIHW 2007b).

Clients are offered a range of services through SAAP. These include:

- supported accommodation
- counselling
- advocacy
- links to housing
- health, education and employment services
- outreach support
- brokerage and meals services
- financial and employment assistance.

The main source of SAAP information in this Report is the SAAP National Data Collection (NDC). In 2005-06, the Client Collection of the SAAP NDC underwent some significant changes resulting from the introduction of a new Core Data Set and statistical linkage key. Some of the data items in the Client Collection subsequently changed. These changes mean that some SAAP data for 2005-06 are not directly comparable to those in previous years. In addition, since 2004-05 there has been a change in the definition of a SAAP support period. This may have an effect on the reported number of support periods.

The Steering Committee anticipated that SAAP data for 2006-07 would be available for this Report. Unfortunately, the majority of 2006-07 data were not available.

Financial data for 2006-07 are included, and the 2005-06 demand for SAAP accommodation and turn-away updates the 2004-05 data provided in the 2007 Report. All other data for 2005-06 have been revised from the preliminary data provided in the 2007 Report, and these are included in the attachment tables of this Report (tables 15A.173–202).

The Steering Committee is disappointed that the remaining 2006-07 data were not available for this Report. It is anticipated that SAAP data for 2006-07 and 2007-08 will be available for the 2009 Report.

Size and scope

Support services funded by SAAP are provided by agencies to a range of groups. These include homeless families, single men and women, young people and adults and children escaping domestic violence.

At least 1300 agencies were funded under the SAAP program in 2005-06 and included non-government, community or local government agencies (AIHW 2007b), the most recent year for which data are available.

SAAP agencies vary in their service delivery model. Common models include the provision of medium term to long term supported accommodation and the provision of crisis or short term supported accommodation. Agencies also provide services other than accommodation, such as outreach support, day support, and telephone information and referral. Agencies may also provide multiple types of services and agency support. The proportions of agencies delivering particular service models have remained relatively stable since 2002-03 (table 15A.175).

SAAP and the link with other services

Families and children in crisis (such as those escaping domestic violence or experiencing homelessness) are often subject to considerable stress, violence and transience, all of which have a negative impact on children. As a result, some children assisted by SAAP may have also had contact with child protection and out-of-home care services or may have been subject to a current or past care and protection order.

Close links also exist with other forms of housing assistance reported in the Housing chapter of the Report (chapter 16), which focuses on the performance of government in providing public, Indigenous and community housing under the Commonwealth State Housing Agreement (CSHA), and the Commonwealth Rent Assistance (CRA) program. The Crisis Accommodation Program (CAP) is a special purpose program funded under the CSHA which provides funding to State and Territory housing authorities to support SAAP agencies, by providing infrastructure funding for SAAP accommodation.

Some individuals and families utilise both SAAP services and services described in the Housing chapter, as people tend to move from homelessness to social housing, or may be in receipt of SAAP services and accommodated in social housing.[2]

Roles and responsibilities

SAAP is jointly funded by the Australian, State and Territory governments. The Coordination and Development Committee (CAD) of senior Australian and State government officials oversight the development and implementation of the program at the national level. The State and Territory governments are responsible for the day-to-day management of the program including the distribution of funding to SAAP funded agencies. Non-government agencies, with some local government participation, deliver most SAAP services.

Research, strategy, and other planning and development activities are coordinated at the national level by the SAAP National Coordination and Development Committee (which comprises representatives of the Australian Government and each State and Territory government).

Funding

Recurrent funding of SAAP services was approximately $356.1 million in 2006-07 (table 15A.177), of which the Australian Government contributed 51.1 per cent and the State and Territory governments contributed 48.9 per cent (table 15A.176). These proportions have remained relatively stable since 2002-03. An additional $0.5 million was provided to allow the Australian Government to manage and administer national research and evaluation projects.

Nationally, real recurrent SAAP funding per person has decreased from $18 in 2002-03 to $17 in 2006-07 (table 15A.178). These figures varied across jurisdictions (figure 15.16).

In 2006-07, in addition to the amounts determined in agreements between jurisdictions and the Australian Government, some jurisdictions made recurrent allocations to SAAP services (for example, to assist service viability), and/or SAAP

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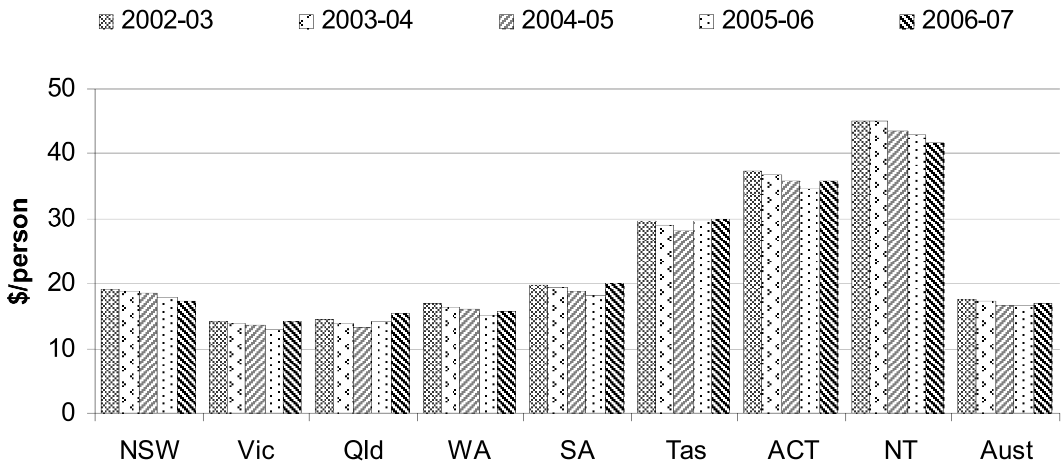
[2] Social housing is generally understood to include public and community housing. For further information on these forms of housing assistance, see chapter 16 (box 16.2).

like activities. These additional funds are not included in the above figures, but may be included in future Reports.

Figure 15.16 **Real recurrent SAAP funding per person in the residential population (2006-07 dollars)**[a, b, c]



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[a] Includes total recurrent allocations (including State and Territory level allocations for program administration). [b] The total population figure used to derive program funding per person in the total population has changed from previous Reports. The total population figure uses a mid-point estimate for 31 December at the end of each year. In previous Reports, the financial year average was used. The total population figure is not indicative of the demand for SAAP services. [c] Real recurrent funding is calculated using ABS gross domestic product expenditure implicit price deflator (2006-07=100) (table AA.26).

Source: Department of Families, Community Services and Indigenous Affairs (FaCSIA) (unpublished); table 15A.178.

15.9 Framework of performance indicators for supported accommodation and assistance services

The framework of performance indicators for supported accommodation and assistance services is based on the shared government objectives for SAAP services (box 15.28).

Box 15.28 **Objectives for SAAP services**

The overall aim of SAAP is to provide transitional supported accommodation and a range of related support services, to help people who are homeless or at imminent risk of homelessness to achieve the maximum possible degree of self-reliance and independence. Within this aim, the goals are to:

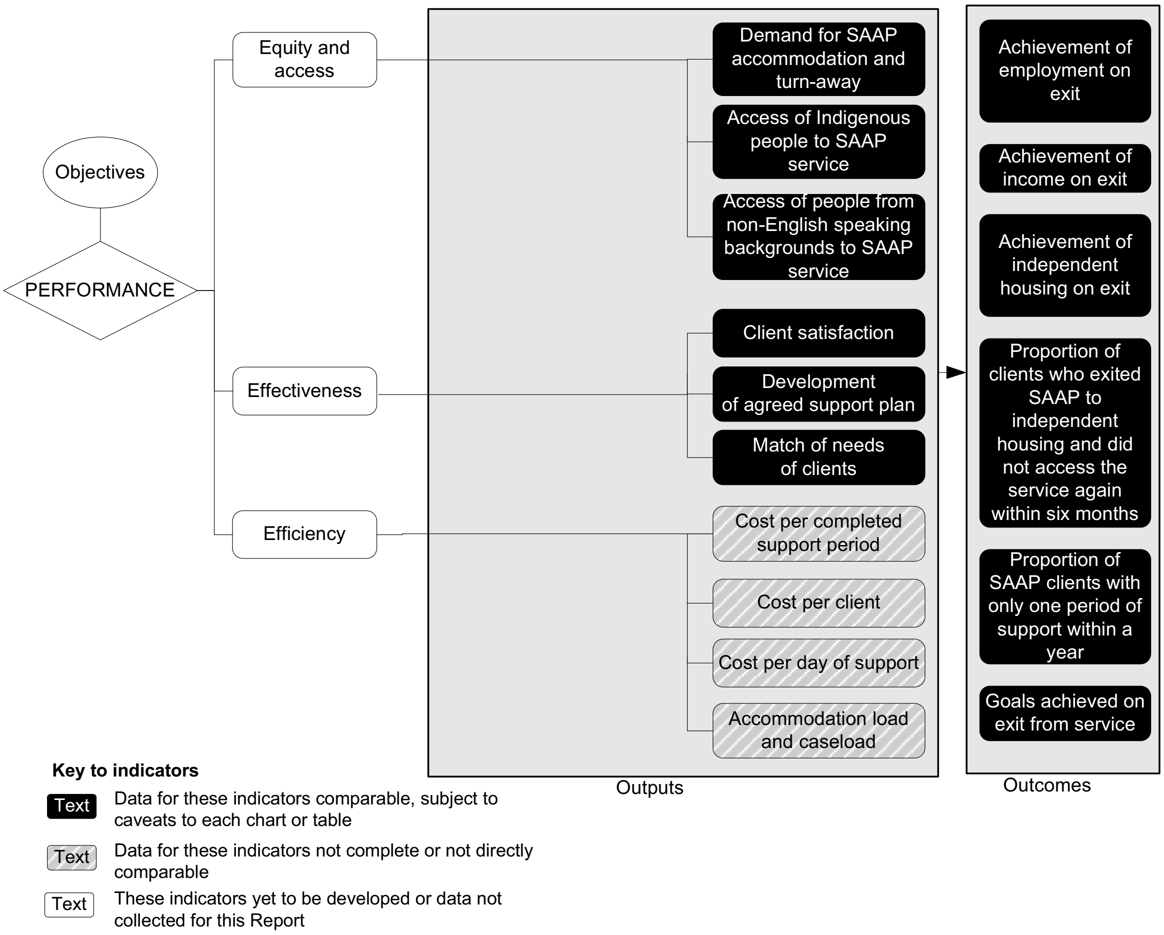
- resolve crises
- re-establish family links where appropriate
- re-establish the capacity of clients to live independently of SAAP.

SAAP services should be provided in an equitable and efficient manner.

The performance indicator framework provides information on equity, efficiency and effectiveness, and distinguishes the outputs and outcomes of SAAP services (figure 15.17).

The performance indicator framework shows which data are comparable in the 2008 Report. For data that are not considered directly comparable, the text includes relevant caveats and supporting commentary. Chapter 1 discusses data comparability from a Report-wide perspective (see section 1.6).

Figure 15.17 **Performance indicators for SAAP services**



15.10 Key supported accommodation and assistance performance indicator results

Preliminary data for 2005-06 were presented in the 2007 Report. Updated data for 2005-06, which includes substantial revisions to some data items, are included in the attachment tables of this Report (15A.173–202).

The data collection for SAAP allows for the measurement of the number of clients and of the number and types of services provided to clients, but is subject to some limitations (box 15.29).

Box 15.29 **Information to be considered when analysing SAAP data**

The following information needs to be considered when analysing SAAP data.

- Informed consent is an essential component of the integrity of the data. The principle of client/consumer rights (which underpins informed consent) recognises that clients do not receive services under a mandatory order. They have the right to accept or reject the services offered and they have the right to provide or not provide information while receiving SAAP services.
- Clients consented to provide personal details for the SAAP client collection for 86.6 per cent of support periods in 2005-06. A weighting system has been developed to adjust for agency non-participation (92.9 per cent of agencies participated in the client collection) and non-consent (SAAP NDCA *Administrative Data and Client Collection*, unpublished).

Outputs

Outputs are the actual services delivered (while outcomes are the impact of these services on the status of an individual or group) (see chapter 1, section 1.5).

Equity and access

Demand for SAAP accommodation and turn-away

'Demand for SAAP accommodation and turn-away' is an indicator of the equity of access to SAAP services (box 15.30).

Box 15.30 **Demand for SAAP accommodation and turn-away**

'Demand for SAAP accommodation and turn-away' is an indicator of governments' objective to ensure all Australians have equitable access to SAAP services on the basis of relative need. The indicator measures the extent to which the demand for accommodation is met or unmet. Unmet demand occurs when a homeless person expressly asking for supported accommodation cannot be provided with that assistance (although one-off assistance may be provided).

Two measures of the proportion of people whose valid request for immediate SAAP accommodation cannot be met are reported: turn-away as the proportion of people requiring new SAAP accommodation; and turn-away as the proportion of total demand for SAAP accommodation.

(Continued on next page)

Box 15.30 **(Continued)**

Turn-away as the proportion of people requiring new accommodation is defined as the average daily percentage of people who could not be accommodated relative to all people making valid requests for immediate SAAP accommodation. This provides an indication of a person's likelihood of obtaining SAAP accommodation.

Turn-away as the proportion of total demand for SAAP accommodation is defined as the average daily percentage of people who could not be accommodated relative to all people who required new and immediate SAAP accommodation or who were continuing their accommodation from the previous day. This provides a measure of the overall ability of SAAP to meet the demand for accommodation on an average day during the Demand for Accommodation Collection period.

A higher proportion of valid requests receiving accommodation is desirable.

Data for assessing access to SAAP services are sourced from the Demand for Accommodation Collection and the Client Collection. The Demand for Accommodation Collection measures the levels of met and unmet demand for SAAP accommodation by collecting information about requests for accommodation by individuals or groups over two weeks each year. These data are used in conjunction with Client Collection data to calculate the 'turn-away' rate for demand for SAAP accommodation.

The Demand for Accommodation Collection collects data on 'valid unmet requests' for immediate accommodation. 'Valid unmet requests' excludes requests made at an agency, where the person or group is determined to be inappropriate for the agency, where there is no fee-free accommodation available at that time[3], or where offered assistance is refused. For the Client Collection, the accommodation status of a client on a particular day is based on the reported periods of accommodation within a support period.

As only data from agencies that participated in both the Client Collection and the Demand for Accommodation Collection are used for the calculations, data included in this Report may understate activities of SAAP agencies. Additionally, the two week sample period over which data are collected may not be representative of the eventual success of clients accessing SAAP services over the full year (see notes to tables 15A.179-180).

Data on the proportion of people with valid requests for SAAP accommodation who were turned away are included for the years 2002-03 to 2005-06. Data provided for

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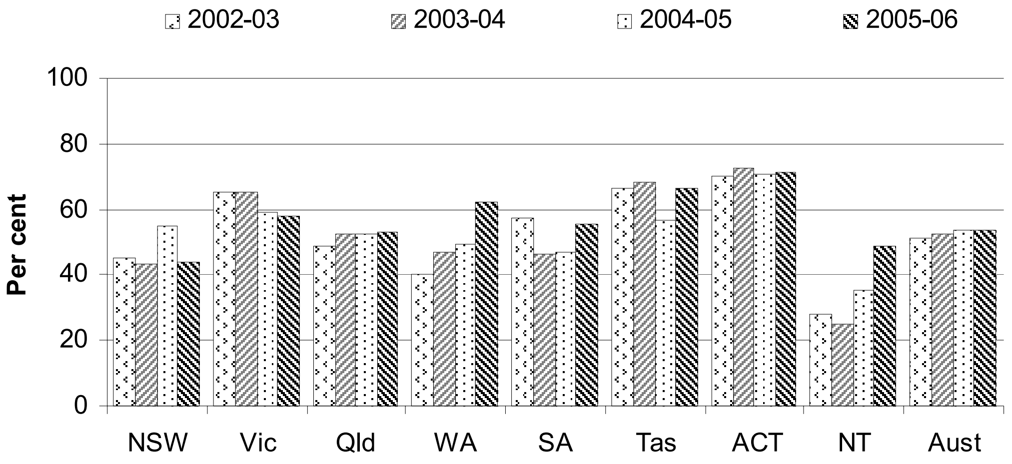
[3] 'No fee-free accommodation available' refers to situations where the person/group is not given accommodation because they cannot meet the financial requirements (for example, fees) for that accommodation.

2005-06 are new for this Report. Nationally, 53.6 per cent of adults and unaccompanied children requesting immediate new SAAP accommodation on a given day were turned away in 2005-06. This proportion varied across jurisdictions (figure 15.18).

Figure 15.18 **Turn-away of adults and unaccompanied children as the proportion of people requiring new SAAP accommodation**[a, b, c]

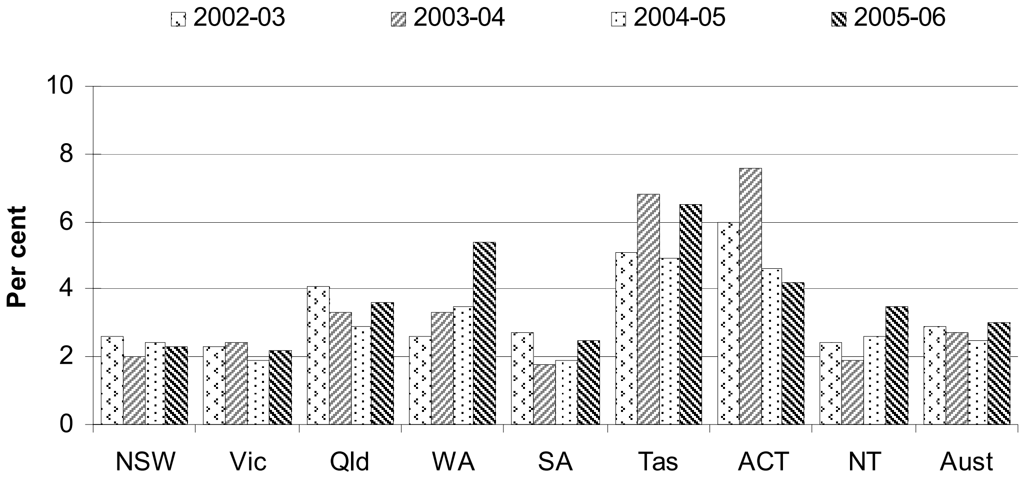


[a] A two-week Demand for Accommodation Collection is conducted annually to gather information about homeless people whose requests for accommodation were unable to be met by SAAP agencies. The collections were held in December and May of each financial year. [b] Comparisons between years should be treated with caution, due to variation in participation rates, differing imputation methods and because the collections were held on different dates each year. [c] See notes to table 15A.179 for more detailed data caveats.

Source: AIHW (2004, 2006, 2007); SAAP NDCA *Client and Demand for Accommodation Collections* (unpublished); table 15A.179.

Nationally, the number of adults and unaccompanied children who made valid requests for SAAP accommodation but could not be accommodated accounted for 3.0 per cent of the total demand for SAAP accommodation in 2005-06. This proportion varied across jurisdictions. Total demand for SAAP accommodation is measured by the total number of people who made requests for immediate SAAP accommodation, and those who were continuing their accommodation from the previous day (figure 15.19).

Figure 15.19 **Turn-away of adults and unaccompanied children as the proportion of total demand for SAAP accommodation**[a, b, c]



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[a] A two-week Demand for Accommodation Collection is conducted annually to gather information about homeless people whose requests for accommodation were unable to be met by SAAP agencies. The collections were held in December and May of each financial year. [b] Comparisons between years should be treated with caution, due to variation in participation rates, differing imputation methods and because the collections were held on different dates each year. [c] See notes to table 15A.180 for more detailed data caveats.

Source: AIHW (2004, 2006, 2007); SAAP NDCA *Client and Demand for Accommodation Collections* (unpublished); table 15A.180.

'Access of Indigenous people to SAAP service' is an indicator of the equity of access of Indigenous people to SAAP services (box 15.31).

Box 15.31 **Access of Indigenous people to SAAP service**

'Access of Indigenous people to SAAP service' is an indicator of governments' objective to ensure all Australians have equitable access to SAAP services on the basis of relative need. The indicator measures the extent to which the demand for assistance from Indigenous people is met or unmet. Unmet demand occurs when a homeless person expressly asking for supported accommodation, or support, cannot be provided with that assistance (although one-off assistance may be provided).

This indicator is defined as the comparison between the representation of Indigenous people among all people whose valid requests for SAAP accommodation were unmet and their representation among SAAP clients who were accommodated during the year.

Supported accommodation and assistance services target homeless people in general, but access by special needs groups (such as Indigenous people) is particularly important.

A high and equivalent proportion of valid requests receiving assistance is desirable.

Data for this indicator for 2006-07 were not available for the 2008 Report. Revised data for 2005-06 are reported in table 15A.181.

Access of people from non-English speaking backgrounds to SAAP service

'Access of people from non-English speaking backgrounds to SAAP service' is an indicator of the equity of access of people from non-English speaking backgrounds to SAAP services (box 15.32).

Box 15.32 **Access of people from non-English speaking backgrounds to SAAP service**

'Access of people from non-English speaking backgrounds to SAAP service' is an indicator of governments' objective to ensure all Australians have equitable access to SAAP services on the basis of relative need. The indicator measures the extent to which the demand for assistance from people from non-English speaking backgrounds is met or unmet. Unmet demand occurs when a homeless person expressly asking for supported accommodation, or support, cannot be provided with that assistance (although one-off assistance may be provided).

This indicator is defined as the comparison between the representation of people from non-English speaking backgrounds among all people whose valid requests for SAAP accommodation were unmet, and their representation among SAAP clients who were accommodated during the year.

Supported accommodation and assistance services target homeless people in general, but access by special needs groups (such as people from non-English speaking backgrounds) is particularly important.

A high and equivalent proportion of valid requests receiving assistance is desirable.

Data for this indicator for 2006-07 were not available for the 2008 Report. Revised data for 2005-06 are reported in table 15A.182.

Effectiveness

Client satisfaction

'Client satisfaction' is an indicator of the effectiveness of SAAP services (box 15.33).

Box 15.33 **Client satisfaction**

‘Client satisfaction’ is an indicator of governments’ objective to provide high quality services that meet the needs of SAAP recipients.

This indicator is defined as the proportion of clients whose overall satisfaction with the assistance they had received from the SAAP service was either ‘good’ or ‘really good’.

A higher proportion suggests greater client satisfaction with the overall SAAP service.

Data for the client satisfaction indicator are sourced from the national SAAP client satisfaction survey, which is conducted periodically. As a result, new data for this indicator are not available for this Report. Data on client satisfaction relating to a four week period beginning 11 November 2003 were included in the 2005 Report (SCRGSP 2005, pp. 15.47-48; CBSR 2004).

Development of agreed support plan

‘Development of agreed support plan’ is an indicator of the effectiveness of SAAP services (box 15.34).

Box 15.34 **Development of agreed support plan**

‘Development of agreed support plan’ is an indicator of governments’ objective to provide high quality services that are appropriately targeted to meet the needs of SAAP clients.

This indicator is defined as the number of closed support periods with an agreed support plan divided by the total number of support periods. Data are reported for all SAAP clients, and separately for Indigenous clients.

A higher proportion of support periods with agreed support plans is desirable. However, in some instances, a support plan may be judged to be inappropriate (such as when a support period is short term).

Data for this indicator for 2006-07 were not available for the 2008 Report. Revised data for 2005-06 are reported for all SAAP clients and separately for Indigenous clients in tables 15A.183-184 respectively.

Match of needs of clients

‘Match of needs of clients’ is an indicator of the effectiveness of SAAP services (box 15.35).

Box 15.35 **Match of needs of clients**

‘Match of needs of clients’ is an indicator of governments’ objective to ensure that SAAP services meet their client’s individual needs. This is a measure of appropriateness. The range of services needed is broad (ranging from meals to laundry facilities to long term accommodation), so the effect of not providing these services varies.

This indicator is defined as the number of clients who were provided with the services they needed and clients who were referred to another agency, divided by the total number of SAAP clients.

Data are reported for all SAAP clients, and separately for Indigenous people and people from non-English speaking backgrounds.

A higher proportion of clients who received services they needed, or who were referred to another agency, is desirable.

Data for this indicator for 2006-07 were not available for the 2008 Report. Revised data for 2005-06 for all SAAP clients, Indigenous clients and clients from non-English speaking backgrounds are reported in tables 15A.185-187 respectively.

Efficiency

Across jurisdictions, there are varying treatments of expenditure items (for example, superannuation) and different counting and reporting rules for generating financial data. Results reported on efficiency indicators may reflect these differences.

The funding figures used to calculate the following efficiency indicators include recurrent allocations to agencies provided by some jurisdictions in addition to the amounts determined in the agreements between these jurisdictions and the Australian Government.

Cost per completed support period

‘Cost per completed support period’ is an indicator of the efficiency of SAAP services (box 15.36).

Box 15.36 **Cost per completed support period**

'Cost per completed support period' is an indicator of governments' objective to maximise the availability and quality of services through the efficient use of taxpayer resources. This is a proxy indicator of efficiency, measuring government inputs per unit of output (unit cost).

This indicator is defined as total expenditure on SAAP services divided by the number of completed support periods (excluding casual clients, and adults and accompanying children with a valid unmet request for accommodation).

A lower cost per completed support period is desirable, but may also indicate lesser service quality.

Unit cost analyses include only expenditure by service delivery providers. Unit cost indicators should also include administration costs borne by State and Territory departments in administering services, but this is not yet possible. In addition, capital costs are excluded because capital funding for SAAP is provided under the CSHA through a special purpose program (the CAP).

As data on completed support periods were unavailable for 2006-07, the 'cost per completed support period' was unable to be derived for 2006-07. Revised data for 2005-06 are reported in table 15A.189.

Cost per client

'Cost per client' is an indicator of the efficiency of SAAP services (box 15.37).

Box 15.37 **Cost per client**

'Cost per client' is an indicator of governments' objective to maximise the availability and quality of services through the efficient use of taxpayer resources. This is a proxy indicator of efficiency, measuring government inputs per unit of output (unit cost).

This indicator is defined as total expenditure on SAAP services divided by the number of clients accessing a bed or place over the year.

A lower cost per client is desirable, but may also indicate lesser service quality.

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Box 15.37 **(Continued)**

Unit cost analyses include only expenditure by service delivery providers. Unit cost indicators should also include administration costs borne by State and Territory departments in administering services, but this is not yet possible. In addition, capital costs are excluded because capital funding for SAAP is provided under the CSHA through a special purpose program (the CAP).

As data on the number of clients accessing a bed or place over the year were unavailable for 2006-07, the 'cost per client' was unable to be derived for 2006-07. Revised data for 2005-06 are reported in table 15A.190.

Cost per day of support

'Cost per day of support' is an indicator of the efficiency of SAAP services (box 15.38).

Box 15.38 **Cost per day of support**

'Cost per day of support' is an indicator of governments' objective to maximise the availability and quality of services through the efficient use of taxpayer resources. This indicator provides a proxy indicator of efficiency, measuring government inputs per unit of output (unit cost).

This indicator is defined as total expenditure on SAAP services divided by the number of days of support for SAAP clients receiving support and/or supported accommodation (excluding casual clients, and adults and accompanying children with a valid unmet request for accommodation).

A lower cost per day of support is desirable, but may also indicate lesser service quality.

Unit cost analyses include only expenditure by service delivery providers. Unit cost indicators should include administration costs borne by State and Territory departments in administering services, but this is not yet possible. In addition, capital costs are excluded because capital funding for SAAP is provided under the CSHA through a special purpose program (the CAP).

As data on the number of days of support were unavailable for 2006-07, the 'cost per day of support' was unable to be derived for 2006-07. Revised data for 2005-06 are reported in table 15A.191.

Accommodation load and caseload

‘Accommodation load’ and ‘caseload’ are indicators of the efficiency of SAAP services (box 15.39).

Box 15.39 **Accommodation load and caseload**

‘Accommodation load’ and ‘caseload’ are indicators of governments’ objective to maximise the availability and quality of services through the efficient use of taxpayer resources. Average accommodation load and caseload are indicators of efficiency as they indicate levels of output by agencies.

The average accommodation load is defined as the average number of people accommodated per day per agency. The average caseload is defined as the average number of people being supported per day per agency.

Accommodation load and caseload are likely to be affected by the size of the agencies funded under the SAAP Program.

Data for this indicator for 2006-07 were not available for the 2008 Report. Revised data for 2005-06 are reported in table 15A.192.

Outcomes

Outcomes are the impact of services on the status of an individual or group (while outputs are the actual services delivered) (see chapter 1, section 1.5).

An important outcome of SAAP services is clients’ achievement of self-reliance and independence. Characteristics that may indicate whether clients can live independently include their income, housing status and workforce status. These characteristics are recorded at the end of a client’s support period.

Achievement of employment on exit

‘Achievement of employment on exit’ is an indicator of the outcomes of SAAP services (box 15.40).

Box 15.40 **Achievement of employment on exit**

‘Achievement of employment on exit’ is an indicator of governments’ objective to enable clients to participate as productive and self-reliant members of society at the end of their support period.

Achievement of employment is defined as the number of SAAP clients who sought assistance to obtain or maintain employment and training, and achieved employment after SAAP support, divided by the total number of clients who sought assistance to obtain or maintain employment. Support periods reported relate to these clients only.

This indicator compares these clients’ employment status before and after they requested SAAP support. Data are reported for all SAAP clients, and separately for Indigenous clients.

This indicator relates to relatively short term outcomes — that is, outcomes for clients immediately after their support period. Longer term outcomes are important, but more difficult to measure.

Higher proportions of achievement of employment are desirable.

Data for this indicator for all SAAP clients and Indigenous SAAP clients for 2006-07 were not available for the 2008 Report. Clients who provided no information or provided a ‘Don’t know’ response have been removed from 2005-06 data. Revised data for 2005-06 are reported in tables 15A.195-196.

Achievement of income on exit

‘Achievement of income on exit’ is an indicator of the outcomes of SAAP services (box 15.41).

Box 15.41 **Achievement of income on exit**

'Achievement of income on exit' is an indicator of governments' objective to enable clients to participate independently in society at the end of their support period. This indicator compares these clients' income status before and after they received SAAP support. A client's independence and self-reliance is enhanced when the client experiences a positive change in income source (for example, from having no income support to obtaining some income, including wages and/or benefits) on exit from SAAP services.

This indicator is defined as the number of clients who requested assistance to obtain or maintain a pension or benefit and exited SAAP with an income source, divided by the total number of clients who requested assistance to obtain or maintain a pension or benefit. Data are reported for all SAAP clients, and separately for Indigenous clients.

A high proportion of clients who requested income assistance and exited SAAP with an income source is desirable.

Data for this indicator for all SAAP clients and Indigenous SAAP clients for 2006-07 were not available for the 2008 Report. Clients who provided no information or provided a 'Don't know' response have been removed from 2005-06 data. Revised data for 2005-06 are reported in tables 15A.200-201.

Achievement of independent housing on exit

'Achievement of independent housing on exit' is an indicator of the outcomes of SAAP services (box 15.42).

Box 15.42 **Achievement of independent housing on exit**

'Achievement of independent housing on exit' is an indicator of governments' objective to enable clients to participate as productive and self-reliant members of society at the end of their support period. This indicator compares the proportion of clients who were in independent housing before and after they received SAAP support.

Achievement of independent housing is defined as the number of support periods of clients who requested assistance with obtaining or maintaining independent housing achieving independent housing at the end of a support period, divided by the total number support periods of clients who requested assistance with obtaining or maintaining independent housing.

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Box 15.42 **(Continued)**

This indicator relates to relatively short term outcomes — that is, outcomes for clients immediately after their support period. Longer term outcomes are important, but more difficult to measure. Data are reported for all SAAP clients, and separately for Indigenous clients.

Higher proportions of clients who are in independent housing are desirable.

Data for this indicator for all SAAP clients and Indigenous SAAP clients for 2006-07 were not available for the 2008 Report. Revised data for 2005-06 are reported in tables 15A.193-194.

Proportion of SAAP clients who exited SAAP to independent housing and did not access the service again within six months

'Proportion of SAAP clients who exited SAAP to independent housing and did not access the service again within six months' is an indicator of the outcomes of SAAP services (box 15.43).

Box 15.43 **Proportion of SAAP clients who exited SAAP to independent housing and did not access the service again within six months**

'Proportion of SAAP clients who exited SAAP to independent housing and did not access the service again within six months' is an indicator of governments' objective to enable clients to participate independently in society at the end of their support period.

This indicator is defined as the number of clients who exit to independent housing and do not return to SAAP within six months, divided by the total number of SAAP clients.

A higher proportion of clients not returning to the program within six months is desirable.

A number of SAAP clients who need long term assistance may access SAAP services a number of times before their needs are met on a permanent basis. Ongoing contact with SAAP agencies may also lead to an improvement in living skills and self-reliance.

Data for this indicator for 2005-06 and 2006-07 were not available for the 2008 Report. Final data for 2004-05 are reported in table 15A.199.

Proportion of SAAP clients with only one period of support within a year

'Proportion of SAAP clients with only one period of support within a year' is an indicator of the outcomes of SAAP services (box 15.44).

Box 15.44 **Proportion of SAAP clients with only one period of support within a year**

'Proportion of SAAP clients with only one period of support within a year' is an indicator of governments' objective to enable clients to participate independently in society at the end of their support period.

This indicator is defined as the number of clients with only one support period during the year, divided by the total number of SAAP clients. Data are reported for all SAAP clients, and separately for Indigenous clients.

A higher proportion of clients with only one support period during the year is desirable.

It may be appropriate for some clients to receive more than one support period in a given period of time (for example, moving from crisis accommodation to medium term accommodation). One group that makes multiple use of SAAP is single adults, especially older single men. A number of SAAP clients who need long term assistance may access SAAP services a number of times before their needs are met on a permanent basis. Ongoing contact with SAAP agencies may also lead to an improvement in living skills and self-reliance.

Data for this indicator for 2006-07 were not available for the 2008 Report. Revised data for 2005-06 are reported separately for all SAAP clients and Indigenous clients in tables 15A.197-198 respectively.

Goals achieved on exit from service

'Goals achieved on exit from service' is an indicator of the outcomes of SAAP services (box 15.45).

Box 15.45 **Goals achieved on exit from service**

'Goals achieved on exit from service' is an indicator of governments' objective to ensure SAAP services meet the needs and expectations of users.

This indicator is defined as the number of clients whose case management goals are fully or mostly achieved by the end of the support period, divided by the total number of clients with case management goals in a given period.

The data is identified from a questionnaire completed by clients.

A high proportion of achieved goals is desirable.

Data for this indicator for 2006-07 were not available for the 2008 Report. Revised data for 2005-06 are reported in table 15A.202.

15.11 Future directions in supported accommodation and assistance performance reporting

The Steering Committee is disappointed that SAAP data for 2006-07 were not available for this Report. The Steering Committee anticipates that SAAP data for 2006-07 and 2007-08 will be available for the 2009 Report.

Under SAAP V (2005–2010), a new performance framework was developed and incorporated into the multilateral agreement. The new performance framework contains some of the same performance indicators as SAAP IV but new emphases have been placed on client outcome information. Four levels of client outcomes are identified in the SAAP V Program Logic developed by a working group of the CAD. Information on some client outcome indicators can be obtained from the SAAP National Data Collection and reported on a regular basis, but information on some higher level client outcome indicators can only be obtained from targeted research. Three specific research projects will be carried out under SAAP V to obtain this information. These projects are: SAAP Impact on client self-reliance; measuring the number of clients with high and complex needs; and Client Satisfaction survey.

An Evaluation Working Group (EWG) consisting of representatives from the Australian and State and Territory governments has been established to develop and manage the SAAP V National Evaluation on behalf of CAD. Additional data and research activities identified by the EWG as necessary for input to the national evaluation of SAAP V include: research on longer term housing outcomes for SAAP clients entering public and community housing and private rental housing; a survey of SAAP agencies to determine views on the achievement of SAAP V strategic priorities; an analysis of the evaluations undertaken on each of the Innovation and Investment Fund projects; the three client outcome projects mentioned above; and other data and research projects. These developments are likely to provide improved outcome focussed data for future Reports. The CAD is undertaking a mid-term review of SAAP V. The SAAP V Mid-term Review Report will be published in early 2008.

Improving data from Indigenous clients

An Indigenous data training package has been developed by the National Data Collection Agency (NDCA) at the AIHW in collaboration with the Information Sub-committee of the CAD. Members of the Indigenous Reference Group consist of SAAP Indigenous representatives from NSW, Victoria, Queensland, WA and NT, together with staff from the NDCA, Queensland Department of Communities, and FaCSIA. The Reference Group provided input to develop the package based on current SAAP data training content but with an Indigenous-specific focus. It is expected that the package will encourage more Indigenous agencies to participate in the SAAP data collection and demonstrate to Indigenous agencies the value of collecting SAAP data for Indigenous clients. This development will improve the quality and coverage of Indigenous data in future Reports.

15.12 Jurisdictions’ comments

This section provides comments from each jurisdiction on the services covered in this chapter. Appendix A contains data that may assist in interpreting the performance indicators presented in this chapter. These data cover a range of demographic and geographic characteristics, including age profile, geographic distribution of the population, income levels, education levels, tenure of dwellings and cultural heritage (including Indigenous and ethnic status).

Australian Government comments

Child protection and supported placements

The Australian Government provides funding for early intervention and prevention initiatives and specifically addresses better outcomes for vulnerable children and families. These include the $490 million Stronger Families and Communities Strategy 2004–09 initiatives such as Communities for Children and the 'Every Child is Important' initiatives. National projects include the National Child Protection Clearinghouse, which researches, draws together and disseminates information on child protection activities and research to professionals and organisations in this field; National Child Protection Week; and national conferences that focus on child abuse and neglect. Each year the Australian Institute of Health and Welfare collects and reports on child protection and out-of-home care data from each of the states and territories.

The Australian Government contributes to the wellbeing of children and young people in foster and grandparent/relative care, mainly through the provision of Australian Government payments for eligible carers. In particular, the Government provides Family Tax Benefit and Child Care Benefit and provides all children in foster or grandparent/relative care with access to a Health Care concession card.

Supported Accommodation Assistance Program (SAAP)

In 2006-07, the Australian Government spent approximately $231.4 million on programs for homeless persons. These include the Supported Accommodation Assistance Program (SAAP), the Household Organisational Management Expenses (HOME) Advice Program, the National Homelessness Strategy, Reconnect and other related programs.

The Australian Government contributed $182.4 million to SAAP during 2006-07. This amount represented 51 per cent of total SAAP funding for the financial year.

Through the HOME Advice Program, the Government provides assistance to families who are at risk of homelessness. This program builds on the success of the Family Homelessness Prevention Pilots (FHPP) which is an Australian Government initiative under the National Homelessness Strategy. The recent evaluation of the program found that it had been highly effective in preventing family homelessness.

An extension of the National Homelessness Strategy (NHS) was announced in the 2005-06 budget with funding of $10 million over four years. The NHS includes demonstration projects which trial innovative models to prevent or respond to homelessness and communication activities to disseminate the knowledge base on homelessness.

New South Wales Government comments

Child protection and supported placements

- In December 2002, the NSW Government announced a $1.2 billion reform program for the child protection system to run over five full years from 2002-03 to 2007-08. The Department of Community Services (DoCS) is progressively implementing a suite of reforms across early intervention, child protection and out-of-home care in an environment of increasing demand for services.
- Amendments to the *Children and Young Persons (Care and Protection) Act 1998*, effective 30 March 2007, enable information to be exchanged about an unborn child who is the subject of a pre-natal report, and enable a primary care-giver of a child or young person to enter into a Parent Responsibility Contract with DoCS, where they voluntarily agree to accept support to improve their parenting skills.
- DoCS Brighter Futures program is a voluntary, targeted program that supports vulnerable children and families to prevent them from entering or escalating in the child protection system. This Program will deliver $150 million for early intervention services and the employment of 350 new dedicated early intervention caseworkers. Families in the Brighter Futures Program can access core funded services, which include parenting programs and quality childcare.
- Approximately $613 million has been committed to expanding and improving the out-of-home care (OOHC) system. A key aim of this process is to develop an integrated OOHC service system that allows children and young people to move seamlessly through a continuum of services that responds to their changing needs.

Juvenile justice

- The NSW Government is committed to providing restorative justice services to young offenders, victims and the community through administering youth justice conferences. The Department of Juvenile Justice supervises juvenile offenders on community-based or custodial orders or young people remanded into custody pending finalisation of their court matters. The Government’s commitment to reducing re-offending is reflected in the programs across the department including Community Intervention and Intensive Bail Supervision Programs.

Supported Accommodation Assistance Program (SAAP)

- During the second year of the SAAP V Agreement in New South Wales, each of the seven DoCS regions developed a regional plan in line with the SAAP V strategic priorities to improve early intervention and post crisis strategies. These plans also identified priorities for funding under the national Innovation and Investment Fund.
- DoCS began the implementation of funding reforms with increased accountability. This involves service agreements that reflect Program priorities; results-based service specifications, and implementation of a performance monitoring framework.

Victorian Government comments

Child protection and supported placements

The *Children, Youth and Families Act 2005* came into effect during 2007 and implementation of the legislation and its associated *every child every chance* reforms have dominated the year.

As part of the reforms, significant additional resources have been provided to Family Services to create a greater system capacity to provide prevention and early intervention services, and confidential referrals can now be made directly to those services. As a result the Child Protection service will be able to focus more exclusively on children at risk of significant harm.

In out-of-home care, the focus has been on developing new models of therapeutic home-based and residential care. Emerging models of care combine a focus on better assessment and treatment, consistent and stable relationships and improving access to social, educational and cultural opportunities that all children need for their healthy development.

Juvenile Justice

The Youth Justice Group Conferencing Program was rolled out statewide in Victoria in 2006-07. This program is an intervention based on restorative justice principles and is available as a community rehabilitation intervention to the Children's Court at the pre-sentence stage. The aim of the program is to divert young people from more intensive supervisory court outcomes, to increase their sense of responsibility for offending and to encourage reparation to the victim and community.

Other rehabilitative initiatives implemented this year include CHART – Changing Habits And Reaching Targets – an offending behaviour change program using a skills-oriented, cognitive-behavioural focus, BRAVE (Be Real About ViolencE) and RAVE (Relationships and ViolencE) which are cognitive behavioural violence prevention group programs for young men and women respectively who have displayed or threatened physical violence in familial or community settings.

Supported Accommodation Assistance Program (SAAP)

Victoria has continued to implement enhanced services in line with the three key directions of the SAAP V agreement. In 2006-07 additional funding of $12 million over four years was allocated to implement enhanced integrated services for young people and increased services for people with mental health issues who are at risk of homelessness when exiting from mental health accommodation services and acute mental health services. In conjunction with this initiative Victoria has also implemented new services through the Innovation and Investment funds for intensive case management for young people and single adults, assistance for young people to access education, training and employment opportunities and support for young parents. Victoria has also begun initiatives to consolidate the service sector including integrated family violence services, accreditation, workforce strategy, funding model review and access, assessment and referral frameworks.

Queensland Government comments

Child protection and supported placements

Major achievements during 2006-07 included completion of the most widespread child protection reforms in Queensland’s history, with implementation of all 110 recommendations from the Crime and Misconduct Commission report *Protecting children: an inquiry into abuse of children in care* (2004), and launching of a world class child protection information management system across the state, providing frontline staff with comprehensive, up-to-date information about children and their families. Children’s wellbeing was enhanced by the introduction of Child Health Passports and Education Support Plans to give children in care access to quality health and education services, as well as through creation of behavioural and therapeutic support services for children with challenging behaviours. Improvements to workforce planning, development and training as well as strategies to recruit, retain and support staff and carers were progressed and statewide Indigenous organisations to inform decision making for Indigenous children in the child protection system were established.

Juvenile justice

As at 30 June 2007, Indigenous young people represented 61 per cent of young people in detention. The Department of Communities is committed to reducing the numbers of Indigenous young people in custody by exploring community-based options such as the Young Offender Community Response Service and the introduction of Indigenous Service Support workers at targeted locations in the state.

Remanded males accounted for 71 per cent of the total male population (143) as at 30 June 2007, whilst they accounted for 64 per cent of the total population (159). The Department of Communities is currently investigating options to address the current high level of remanded young people in the Queensland. The Department is also undertaking a review of the *Juvenile Justice Act 1992* to ensure a best practice framework for youth justice in Queensland.

Supported Accommodation Assistance Program (SAAP)

In 2006-07, the Queensland Government continued to address homelessness as a whole-of-government issue requiring an integrated response. Work is continuing on the implementation of the ‘Responding to Homelessness’ initiative which will provide a continuum of integrated responses to the needs of homeless people.

The continuum of services ranges from Homelessness Early Intervention Services right through to Integrated Service Hubs and Crisis Accommodation and Support services for rough sleepers. Over the year, Queensland continued to experience the fastest population growth of any state or territory, with an increase of 2.3 per cent over the past year, compared with national population growth of 1.25 per cent. This level of growth continues to put pressure on demand for services in Queensland and this is particularly evident in South East Queensland.

Western Australian Government comments

Child protection and supported placements

The Department for Child Protection was created on 1 May 2007 in response to the Review of the Department for Community Development by Ms Prudence Ford. The Department for Child Protection provides a strengthened focus on the protection of vulnerable children, young people and families. 69 of the 70 recommendations from the Review are being implemented. A child safety director has been appointed in each key state government agency. In March 2007, the State Government announced the development of legislation for the mandatory reporting of child sexual abuse by doctors, nurses, teachers and police. The legislation was introduced into State Parliament on 28 November 2007. In the past 18 months the State Government has invested more than $300 million in the new Department for Child Protection, including funding for additional field staff and the implementation of review recommendations.

Juvenile justice

The Department of Corrective Services is responsible for delivering juvenile justice services in Western Australia. During 2006-07, the Department on average managed 139 juveniles in detention and 710 juveniles in the community.

Significant achievements during the year saw the expansion of the Intensive Supervision Program, the development of the Regional Youth Justice Strategy, funding for the development of the Young Women and Girls accommodation precinct, participation in an interagency round table to address the increasing number of young people held in custody on remand and an increased focus on staff development to ensure a better delivery of services to young people. A range of group and individual development and therapeutic programs was delivered to young people in detention and in the community throughout the year. Work has commenced on the development of an integrated juvenile justice service delivery model to ensure the system is able to meet future demand.

Supported Accommodation Assistance Program (SAAP)

SAAP continues to operate under the SAAP V Multilateral Agreement, signed 30 September 2005 and the Western Australian Bilateral Agreement, signed 25 January 2006. In recognition of SAAP service viability concerns, the State Budget of 2006-07 included an allocation of $5 million over four years. Additionally, funding of $1.5 million was allocated over four years for a new refuge for women and children experiencing domestic violence. Ten pilot projects commenced in 18 SAAP services throughout the State as part of the SAAP V Innovation and Investment Fund. The projects cover all SAAP target groups and address the three strategic priorities of SAAP V. The Department for Child Protection conducted a review which enabled strategic reform of eight SAAP non-accommodation youth services. The sector is challenged by affordable housing issues and difficulty in recruiting and retaining trained staff.

South Australian Government comments

Child protection and supported placements

Child protection notifications increased in South Australia, with neglect and emotional abuse being the predominant issues bringing children to the attention of the Department. Across government, partnerships are increasingly important in the provision of relevant and effective support to children and their families. Under the government's *Keeping them Safe* child protection policy reform, the Department for Families and Communities (DFC) and the Department of Health Child Protection Information Sharing protocol was launched in February 2007, to provide a framework for sharing information. The number of children in out-of-home care has increased by 12.1 per cent over the past twelve months, placing pressure on placement capacity. *The Keeping Them Safe — In Our Care* strategy for building the capacity and quality of alternative care services into the future has been welcomed both by young people in care, and by people who work with them.

Juvenile justice

The South Australian Government has formed a Youth Justice Cabinet Committee and established a Taskforce made up of all major divisions of the public sector (for example justice, families and communities, health, education, police and statutory order management agencies). The Task force is implementing a whole of government approach to recommendations arising from the *To Break the Cycle Report* (2007) developed by the South Australian Commissioner for Social Inclusion.

Families SA Youth Justice Directorate administers statutory supervision of orders made by the Youth Court. Priority reform areas currently being addressed by Families SA as part of the whole of government approach arising from the Taskforce include development of a new case management system, formation of Youth Justice Teams in metropolitan Adelaide and development of service models to increase supervision and surveillance of serious and repeat offenders.

Supported Accommodation Assistance Program (SAAP)

During 2006-07 a comprehensive consultation process across metropolitan and rural South Australia has been undertaken to engage all SAAP service providers in the development of strategies to meet the SAAP reform agenda.

Achievements for South Australia in 2006-07 included:

- Amalgamation of two domestic violence services in Ceduna to create a single regional response for women and children escaping domestic/family violence.
- Four Inner City centres were allocated extra funding to modify their service delivery to meet the priority directions of the SAAP V agreement and the Inner City Strategic Directions for DFC.

The data for SA in 2006-07 indicates that the number of Indigenous people who are homeless and Indigenous accompanying children continues to increase in significant numbers.

Tasmanian Government comments

Child Protection and Support Services

The Tasmanian Government is currently engaged in a wide-ranging reform of the child protection system as part of *A Way Forward — the Implementation of Actions in Response to the Review of Child Protection Services in Tasmania*. Considerable progress has been made during 2006-07 against the recommendations of the review including:

- the establishment of a new structure for Children and Family Services to focus on the development of local area networks and provide greater access to services for vulnerable families
- the redevelopment of the Child Protection Information System.

Work is also advanced in the implementation of improvements to business practices, service delivery models, professional development and practice, quality improvement mechanisms, legislative amendments and the liaison with key stakeholders such as the Departments of Police and Education. The Tasmanian Government will provide an additional $9 million in 2007-08 to continue this reform of child protection services.

Juvenile Justice

In Juvenile Justice, current service reforms address a range of recommendations for improvement as proposed within the *Legislative Council Review of Ashley, Youth Justice and Detention (2007)*; the *Review of Resident Safety at Ashley Youth Detention Centre (2005)* and the *Review of Juvenile Remandees in Detention in Tasmania (2006)*. Reviews of both the Community Service Orders programs and the Community Conferencing services were completed with implementation of recommendations having commenced. A Service Delivery Framework will be published with operational guidelines and standard operating procedures being drafted. An evaluation of the Collaborative Case Conferencing program for management of clients with complex and exceptional needs has been finalised. In addition it is planned to further develop a framework to strengthen community capacity and engagement to support young offenders. Work has commenced on a quality and safety framework as part of the Service's risk management strategy.

Supported Accommodation Assistance Program (SAAP)

Ensuring the flexible delivery of SAAP services was a focus in 2006-07 by continuing to decentralise immediate emergency accommodation. Shifting the focus from a shelter-based model in a number of agencies to a range of units dispersed within the wider community has improved privacy for clients, enabled more families to stay together, and improved outcomes for clients. In 2006-07 three significant projects began to improve SAAP service delivery in Tasmania. The first of these is developing an early intervention and referral training and information package for professionals who may come in contact with families and individuals with complex needs at risk of homelessness. The second is addressing the transitional support needs of children accompanying parents, and the third is a research project to identify and eliminate exclusionary practices within the sector.

Australian Capital Territory Government comments

Child protection and supported placements

During 2006-07 the ACT experienced significant changes in practice in working with vulnerable children and young people particularly in relation to infants and toddlers, drug related issues and family violence. Policy changes and practice initiatives that were introduced included: improved working relations with health; an increased focus on earlier intervention with children and families at risk; and improved multi-agency case conferencing.

The ACT has continued to focus on improving supported placements for children and young people on orders. Changes and initiatives include:

- In August 2006 an amendment was made to the *Children and Young People Act 1999* to ensure that all Aboriginal and Torres Strait Islander children on orders have a cultural plan.
- In 2006-07 a review of children and young people in long-term care was conducted to establish if Enduring Parental Responsibility is an option for them.

Juvenile Justice Services

Construction of a new youth detention centre commenced in 2006-07. When Bimberi Youth Justice Centre opens in mid-2008 it will be the first human rights compliant youth detention centre in Australia.

Significant work was initiated to enhance the range of education and vocational programs available to young people in detention.

Reviews of the 26 Standing Orders, which set out the minimum standards for staff when carrying out their duties in a detention centre, were completed. The Standing Orders were reduced to 11 new Human Rights compliant Standing Orders, and were notified in January 2007.

Supported Accommodation Assistance Program (SAAP)

The ACT Homelessness strategy entered its final year of implementation and is currently being reviewed. Associated reforms of the sector continue, with all services participating in a pathways process to develop common operational principles and practices. This work includes the development of a Service Guarantee that outlines the rights of all SAAP clients to an agreed standard of service.

The establishment of a transitional housing program has enabled the ACT to utilise hard to let public housing properties and properties which are soon to be redeveloped. This increase in transitional accommodation allows crisis places to be targeted to those people most in need of intensive crisis support.

The ACT has worked with SAAP agencies to improve data collection, to ensure that the ACT data more accurately captures the experience of SAAP services and clients in the Territory.

Northern Territory Government comments

Child protection and supported placements

The Northern Territory Government continued the development of the Family and Children’s Services (FACS) program in 2007. Increased funding commenced in December 2003 with the intent of improving child protection services and systems over a period of 5 years. The increased funding has been primarily used to expand the child protection workforce, and investment to develop the capacity and quality of the out-of-home care system. In 2007 the *Care and Protection of Children Act* was passed and will replace the *Community Welfare Act 1983*.

An enhanced training program has been established to increase the opportunities for new and existing staff. This is achieved via mandatory induction training, specialist training, and opportunistic training in line with the FACS Training Framework.

A combined Police/FACS Child Abuse Task Force has been fully implemented to respond to systemic maltreatment and severe physical and sexual abuse notifications across the NT. The Child Abuse Taskforce is co-located with the Centralised Intake Team which receives all notifications across the NT.

Family and Children’s Services actively contributed to the Inquiry into Child Sexual Abuse resulting in the ‘Little Children are Sacred’ report. The subsequent “Closing the Gap” announcement by the NT Government has given further increased funding to FACS in the areas of Child Protection Workforce, Aboriginal Community Workers, Residential and Therapeutic Care, the expansion of Sexual Assault Services, and investment in the Child Abuse Taskforce.

Supported Accommodation Assistance Program (SAAP)

During 2006-07, NT Shelter was funded to provide a Mentor who would work with individual SAAP agencies to improve their human and financial management. Most agencies requested assistance with governance, management including strategic planning, and staff retention as well as service delivery. The intervention was well received by the sector.

Projects approved for the SAAP Innovation and Investment Fund in 2006-07 include the Tenancy Support Service in Alice Springs, Family Violence projects in Milikapati and Borroloola, and a project aimed at providing therapeutic interventions for children in SAAP. Interest in providing these services has been low, as providers appear to find it more challenging to implement innovative projects than to deliver more familiar services. It appears that the SAAP sector is approaching capacity and the skills shortage in Central and Northern Australia is having a substantial effect on the capacity of organisations to provide both mainstream and innovative services.

15.13 Definitions of key terms and indicators

Child protection and out-of-home care services

Activity Group 1 (pathways) Receipt and assessment of initial information about a potential protection or support issue	Activities that are typically associated with receipt and assessment of initial information including receipt and recording of information, review of department databases, initial assessment of information and decisions about the appropriate response. This activity can also include consultation, with possible provision of advice. Activities by non-government organisations (NGO) may be included if appropriate.
Activity Group 2 (pathways) Provision of generic/non-intensive family support services	Activities that are typically associated with provision of lower level family support services at various stages including identification of family needs, provision of support services and diversionary services, some counselling and active linking of the family to support networks. Services are funded by government but can be delivered by either the relevant agency or a NGO. This bundle of services does not involve planned follow-up by the relevant agency after initial service delivery. The services will be delivered under voluntary arrangements between the relevant agency and family. Clients may receive these services more than once.
Activity Group 3 (pathways) Provision of intensive family support services	Activities that are typically associated with provision of complex or intensive family support services including provision of therapeutic and in-home supports such as counselling and mediation, modelling of positive parenting strategies, referrals to intensive support services that may be provided by NGOs, advocacy on behalf of clients and intensive support for a family in a residential setting. This includes protection and treatment support services. These activities services may be provided if diversionary services are inappropriate to the case and may lead to statutory services being provided to the client.
Activity Group 4 (pathways) Secondary information gathering and assessment	Activities that are typically associated with secondary information gathering and assessment are currently counted as 'investigations' in the Report on Government Services. As part of this activity group a decision may be made to substantiate or not substantiate. Information gathering activities include: • sighting the child • contacting people with relevant information about the child or family (for example, teachers, police, support services) • interviewing the child, sibling(s) and parents • observing family interactions • obtaining assessments of the child and/or family • conducting family group conferences • liaising with agencies providing services to the child and family • recording a substantiation or non-substantiation decision • case conferences with partners and contributors in the investigation and assessment process.
Activity Group 5 (pathways) Provision of short-term protective intervention and coordination services	Activities that are typically associated with provision of short-term protective intervention and coordination services including: • working with the family to address protective issues • developing networks of support for the child • monitoring and reviewing the safety of the child • monitoring and reviewing family progress against case planning

	goals • case conferences with agencies providing services to the child and/or family, internal discussions and reviews • specialist child-focused therapeutic support.
Activity Group 6 (pathways) Seeking a court order	Activities that are typically associated with seeking court orders including: • preparing applications for the order • preparing reports for the court • obtaining assessment reports to submit to the court • informing parties to the court proceedings, including parents, the child, and lawyers • informing and briefing legal counsel or internal court groups • going through internal pre-court review processes • attending court • conducting family group conferences.
Activity Group 7 (pathways) Provision of longer-term protective intervention and coordination services	Activities that are typically associated with provision of longer-term protective intervention and coordination services including: • monitoring the child or young person's progress and development (for example, social development and education progress) and undertaking activities that facilitate progress and development • meeting any specific requirements of any court order • reviewing appropriateness of the order for the circumstances of the child or young person. This usually occurs at intervals established by the court or in legislation • reporting back to court • long term cases involving out-of-home care.
Activity Group 8 (pathways) Provision of out-of-home care services	Activities that are typically associated with provision of out-of-home care services including: • finding suitable placement(s) for the child • assisting the child or young person to maintain contact with his/her family • in some cases, staff payments for recruiting and training carers • assessing suitability of potential kinship carers • assisting the child or young person to maintain contact with their family • working to return the child home • assisting the child or young person as they prepare to leave care as the end of the order approaches.
Care and protection orders	Legal orders or administrative/voluntary arrangements involving the community services department, issued in respect of an individual child who is deemed to be in need of care and/or protection. Community services department involvement may include: • total responsibility for the welfare of the child (for example, guardianship) • responsibility for overseeing the actions of the person or authority caring for the child • responsibility for providing or arranging accommodation, or reporting or considering the child's welfare. The order may have been from a court, children's panel, minister of the Crown, authorised community services department officer or similar tribunal or officer. Care and protection orders are categorised as:

- finalised guardianship and finalised custody orders sought through a court
- finalised supervision and other finalised court orders that give the department some responsibility for the child’s welfare (excluding interim orders)
- interim and temporary orders (including orders that are not finalised)
- administrative or voluntary arrangements with the community services department, for the purpose of child protection.

Children are counted only once, even if they are on more than one care and protection order.

Child	A person aged 0–17 years.
Child at risk	A child for whom no abuse or neglect can be substantiated but where there are reasonable grounds to suspect the possibility of prior or future abuse or neglect, and for whom continued departmental involvement is considered warranted.
Child concern reports	Reports to departments responsible for child protection regarding concerns about a child, as distinct from notifications of child abuse and neglect. The distinction between the two differs across and within jurisdictions.
Children in out-of-home care during the year	The total number of children who are in at least one out-of-home care placement at any time during the year. A child who is in more than one placement is counted only once.
Dealt with by other means	A notification that is responded to by means other than an investigation, such as the provision of advice or referral to services.
Exited out-of-home care	Where a child does not return to care within two months.
Family based care	Home-based care (see ‘placement types’).
Family group homes	Residential child care single dwelling establishments that have as their main purpose the provision of substitute care to children. They are typically run like family homes, with a limited number of children who eat together as a family group and are cared for around the clock by resident substitute parents.
Foster care	Care of a child who is living apart from his or her natural or adoptive parents in a private household, by one or more adults who act as ‘foster parents’ and are paid a regular allowance by a government authority or non-government organisation for the child’s support. The authorised department or non-government organisation provides continuing supervision or support while the child remains in the care of foster parents.
Foster parent	Any person (or such a person’s spouse) who is being paid a foster allowance by a government or non-government organisation for the care of a child (excluding children in family group homes).
Guardian	Any person who has the legal and ongoing care and responsibility for the protection of a child.
Indigenous person	Person of Aboriginal or Torres Strait Islander descent who identifies as being an Aboriginal or Torres Strait Islander and is accepted as such by the community with which he or she is associated. If Indigenous status is unknown, then a person is considered to be non-Indigenous.
Investigation	An investigation of child abuse and neglect that involves identifying

	harm or risk of harm to the child, determining an outcome and assessing protective needs. It includes the interviewing or sighting of the subject child where practicable.
Investigation finalised	Where an investigation is completed and an outcome of ‘substantiated’ or ‘not substantiated’ is recorded by 31 August.
Investigation in process	Where an investigation is commenced but an outcome is not recorded by 31 August.
Investigation closed – no outcome possible	Where an investigation is commenced but is not able to be finalised in order to reach the outcome of ‘substantiated’ or ‘not substantiated’. These files would be closed for administrative purposes. This may happen in instances where the family have relocated.
Length of time in continuous out-of-home care	The length of time for which a child is in out-of-home care on a continuous basis. A return home of less than seven days is not considered to break the continuity of placement.
Non-respite care	Out-of-home care for children for child protection reasons.
Notification	Contact with an authorised department by persons or other bodies making allegations of child abuse or neglect, or harm to a child. Notifications can be counted at different points in the response to a report, ranging from the point of initial contact with the source of the report to the end of a screening and decision making process.
Other relative	A grandparent, aunt, uncle or cousin, whether the relationship is half, full, step or through adoption, and can be traced through or to a person whose parents were not married to each other at the time of the child’s birth. This category includes members of Aboriginal communities who are accepted by that community as being related to the child.
Out-of-home care	Overnight care, including placement with relatives (other than parents) where the government makes a financial payment. Includes care of children in legal and voluntary placements (that is, children on and not on a legal order) but excludes placements made in disability services, psychiatric services, juvenile justice facilities and overnight child care services.
Placement types	Four main categories: • facility-based care (placement in a residential building where the purpose is to provide placement for children and where there are paid staff, including placements in family group homes) • home-based care (placement in the home of a carer who is reimbursed for expenses for the care of the child). The three subcategories of home-based care are foster care/community care, relative/kinship care and other • independent living (including private board) • other (including unknown).
Relatives/kin	Family members other than parents, or a person well known to the child and/or family (based on an existing relationship).
Respite care	Out-of-home care on a temporary basis for reasons other than child protection — for example, when parents are ill. Excludes emergency care provided to children who are removed from their homes for protective reasons.
Safety in out-of-home care	The proportion of children in out-of-home care who are the subject of a child protection substantiation, where the person believed

	responsible for the child abuse, neglect or harm is living in the household (or was a worker in a residential care facility).
Stability of placement	Number of placements for children who have exited out-of-home care and do not return within two months. Placements exclude respite or temporary placements lasting less than seven days. Placements are counted separately where there is: • a change in the placement type — for example, from a home-based to a facility-based placement • within placement type, a change in venue or a change from one home-based placement to a different home-based placement. A particular placement is counted only once, so a return to a previous placement is another placement.
Substantiation	Notification for which an investigation concludes there is reasonable cause to believe that the child has been, is being or is likely to be abused, neglected or otherwise harmed. It does not necessarily require sufficient evidence for a successful prosecution and does not imply that treatment or case management is, or is to be, provided.

Juvenile justice services

Juvenile justice centre	A place administered and operated by a juvenile justice department, where young people are detained whilst under the supervision of the relevant juvenile justice department on a remand or sentenced detention episode.
Juvenile justice department	Refers to those departments in each State and Territory that are responsible for juvenile justice matters.
Supervision period	A period of time during which a young person is continuously under juvenile justice supervision of one type or another. A supervision period is made up of one or more contiguous episodes.
Police caution	Refers to when a police officer administers a caution to the child instead of bringing the child before a court for the offence.
Pre-sentence community	Pre-sentence arrangements where the juvenile justice department is responsible for the case management or supervision of a young person (such as supervised or conditional bail where the juvenile justice department is involved with monitoring or supervising a young person).
Pre-sentence detention	Remanded or held in a juvenile justice centre or police watch house prior to appearing in court or to being sentenced.
Sentenced community-based supervision	Includes probation, recognisance and community service orders which are supervised or case managed by the juvenile justice department. May be supervision with or without additional mandated requirements, requiring some form of obligation or additional element that a young person is required to meet. This obligation could be community work such as in a community service order, a developmental activity or program attendance. The juvenile justice department may or may not directly supervise any additional mandated requirements, but remains responsible for the overall case management of a young person.
Youth justice conference	A youth justice conference is a facilitated meeting resulting in a formal agreement to repair the harm caused by the offence. Participants can include the victim, offender, convenor, police and

other key stakeholders. Referrals may be initiated by the police or the courts.

Supported accommodation and assistance services

Accommodation	Crisis or short term accommodation, medium term to long term accommodation, and other SAAP funded accommodation (which comprises accommodation at hostels, motels and hotels, accommodation in caravans, community placements and other SAAP funded arrangements).
Accommodation load (of agencies)	The number of accommodation days divided by the number of days for which the agency is operational during the reporting period, where the number of accommodation days equals the sum of accommodation days for all clients of an agency who are supported during the reporting period. The average accommodation load is the mean value of all agencies' accommodation loads. Support periods without valid accommodation dates are assigned the interquartile modal duration of accommodation for agencies of the same service delivery model in the same jurisdiction.
Agency	The body or establishment with which the State or Territory government or its representative agrees to provide a SAAP service. The legal entity has to be incorporated. Funding from the State or Territory government could be allocated directly (that is, from the government department) or indirectly (that is, from the auspice of the agency). The SAAP service could be provided at the agency's location or through an outlet at a different location.
Caseload (of agencies)	The number of support days (the sum of support days for all clients of the agency who are supported during the reporting period) divided by the number of days for which the agency is operational during the reporting period. The average caseload is the mean value of all agencies' caseloads. Support periods without valid support dates are assigned the interquartile modal duration of support for agencies of the same service delivery model in the same jurisdiction.
Casual client	A person who is in contact with a SAAP agency and receives one-off assistance for generally not more than one hour, and who does not establish an ongoing relationship with an agency.
Client	A person who receives supported accommodation or support.
Crisis or short term supported accommodation	Supported accommodation for periods of generally not more than three months (short term), and for persons needing immediate short term accommodation (crisis).
Cross target/multiple/ general services	SAAP services targeted at more than one primary client group category — for example, SAAP services for single persons regardless of their gender.
Day support	Support provided only on a walk-in basis — for example, an agency that provides a drop-in centre, showering facilities and a meals service at the location of the SAAP agency.
Homeless person	A person who does not have access to safe, secure and adequate housing. A person is considered to not have such access if the only housing to which he or she has access: • is damaged, or is likely to damage, the person's health

	• threatens the person’s safety • marginalises the person by failing to provide access to adequate personal amenities or the economic and social supports that a home normally affords • places the person in circumstances that threaten or adversely affect the adequacy, safety, security and affordability of that housing • is of unsecured tenure. A person is also considered homeless if living in accommodation provided by a SAAP agency or some other form of emergency accommodation.
Indigenous person	A person who is of Aboriginal and/or Torres Strait Island descent, who identifies as being an Aboriginal and/or Torres Strait Islander, and who is accepted as such by the community with which they are associated.
Medium term to long term supported accommodation	Supported accommodation for periods over three months. Medium term is around three to six months and long term is longer than six months.
Multiple service delivery model	SAAP agencies that use more than one service delivery model to provide SAAP services — for example, crisis or short term accommodation and support, as well as day support (that is, the provision of meals).
Non-English speaking background services	Services that are targeted at persons whose first language is not English.
One-off assistance	Assistance provided to a person who is not a client, such as the provision of a meal, a shower, transport, money, clothing, telephone advice, information or a referral.
Ongoing support period	A support period for which, at the end of the reporting period, no support end date and no after-support information are provided.
Outlet	A premise owned/managed/leased by an agency at which SAAP services are delivered. Excludes accommodation purchased using SAAP funds (for example, at a motel).
Outreach support services	Services that exist to provide support and other related assistance specifically to homeless people. These clients may be isolated and able to receive services and support from a range of options that enhance their flexibility (for example, advocacy, life skills and counselling). Generalist support and accommodation services may also provide outreach support in the form of follow-up to clients where they are housed. In this context, support is provided ‘off site’.
Providers	Agencies that supply support and accommodation services.
Real expenditure	Actual expenditure adjusted for changes in prices. Adjustments are made using the GDP(E) price deflator and expressed in terms of final year prices.
Recurrent funding	Funding provided by the Australian, State and Territory governments to cover operating costs, salaries and rent.
Referral	When a SAAP agency contacts another agency and that agency accepts the person concerned for an appointment or interview. A referral is not provided if the person is not accepted for an appointment or interview.

SAAP service	Supported accommodation, support or one-off assistance that is provided by a SAAP agency and intended to be used by homeless persons.
Service delivery model	The mode or manner in which a service is provided through an agency. The modes of service delivery could be described as crisis or short term accommodation and support; medium term to long term accommodation and support; day support; outreach support; telephone information; and referral or agency support. An agency may deliver its services through one or more of these means of delivery.
Service provider	A worker or volunteer employed and/or engaged by a SAAP agency, who either directly provides a SAAP service or in some way contributes to the provision of a SAAP service. Includes administrative staff of an agency, whether paid or not paid.
Single men services	Services provided for males who present to the SAAP agency without a partner or children.
Single women services	Services provided for females who present to the SAAP agency without a partner or children.
Support	SAAP services, other than supported accommodation, that are provided to assist homeless people or persons at imminent risk of becoming homeless to achieve the maximum possible degree of self-reliance and independence. Support is ongoing and provided as part of a client relationship between the SAAP agency and the homeless person.
Support period	The period that commences when a SAAP client establishes or re-establishes (after the cessation of a previous support period) an ongoing relationship with a SAAP agency. The support period ends when: • support ceases because the SAAP client terminates the relationship with the SAAP agency • support ceases because the SAAP agency terminates the relationship with the SAAP client • no support is provided to the SAAP client for a period of three months. A support period is relevant to the provision of supported accommodation or support, not the provision of one-off assistance.
Supported accommodation	Accommodation provided by a SAAP agency in conjunction with support. The accommodation component of supported accommodation is provided in the form of beds in particular locations or accommodation purchased using SAAP funds (for example, at a motel). Agencies that provide accommodation without providing support are considered to provide supported accommodation.
Telephone information and referral	Support delivered via telephone without face-to-face contact. Support provided may include information and/or referral.
Total funding	Funding for allocation to agencies (not available at the individual client group level) for training, equipment and other administration costs.
Unmet demand	A homeless person who seeks supported accommodation or support, but is not provided with that supported accommodation or

	support. The person may receive one-off assistance.
Women escaping domestic violence services	Services specifically designed to assist women and women accompanied by their children, who are homeless or at imminent risk of becoming homeless as a result of violence and/or abuse.
Youth/young people services	Services provided for people who are independent and above the school leaving age for the State or Territory concerned, and who present to the SAAP agency unaccompanied by a parent/guardian.

15.14 Attachment tables

Attachment tables are identified in references throughout this chapter by an 'A' suffix (for example, table 15A.3 is table 3 in the attachment). Attachment tables are provided on the CD-ROM enclosed with the Report and on the Review website (www.pc.gov.au/gsp). On the CD-ROM, the files containing the attachment tables are provided in Microsoft Excel format as \Publications\Reports\2008\Attach15A.xls and in Adobe PDF format as \Publications\Reports\2008\Attach15A.pdf. Users without access to the CD-ROM or the website can contact the Secretariat to obtain the attachment tables (see contact details on the inside front cover of the Report).

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15.15 References

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PART G

HOUSING

16 Housing

Governments play a significant role in the Australian housing market, directly through housing assistance and indirectly through policies associated with land planning and taxation. The Australian, State and Territory governments share responsibility for housing assistance. Direct assistance includes public and community housing, home purchase and home ownership assistance, Indigenous housing, State and Territory private rental assistance (such as State and Territory provided bond loans, guarantees and assistance with rent payments and advance rent payments, relocation expenses and other one-off grants) and Commonwealth Rent Assistance (CRA).

This chapter focuses on the performance of governments in providing public, State owned and managed Indigenous housing (SOMIH) and community housing under the Commonwealth State Housing Agreement (CSHA) (box 16.1), Indigenous community housing and CRA. Close links exist between the housing services covered in this chapter and other government programs and support services discussed elsewhere in the Report, such as:

- the Supported Accommodation Assistance Program (SAAP), which provides accommodation and other services for homeless people or those at imminent risk of becoming homeless (chapter 15)
- services delivered by the Australian, State and Territory governments and community organisations to promote independent living, including services for people with a disability (chapter 14), mental health services (chapter 12) and aged care services, such as the Home and Community Care program (chapter 13).

A profile of housing and housing assistance is presented in section 16.1. This provides the context for assessing the performance indicators presented later in the chapter. All jurisdictions have agreed to develop and report comparable indicators, and a framework of performance indicators is outlined in section 16.2. The data are discussed in section 16.3, and future directions for performance reporting are discussed in section 16.4. Jurisdictions’ comments are reported in section 16.5 and definitions are listed in section 16.6. Section 16.7 lists the attachment tables for this chapter and section 16.8 lists references used in the chapter.

Box 16.1 **Commonwealth State Housing Agreement**

The CSHA is an agreement made between the Australian, State and Territory governments under the *Housing Assistance Act 1996* (Cwlth) to provide strategic direction and funding certainty for the provision of housing assistance. The aim of this agreement is to provide appropriate, affordable and secure housing assistance for those who most need it, for the duration of their need.

The 2003 CSHA came into effect on 1 July 2003 and will run until 30 June 2008, and includes bilateral agreements between the Australian Government and each State and Territory government and an overarching multilateral agreement. There are generally separate bilateral agreements for mainstream and Indigenous housing in each jurisdiction. Bilateral agreements are intended to provide greater flexibility for states and territories to respond to their particular housing needs.

A national ten year strategy to improve Indigenous housing, Building a Better Future, was agreed in 2001 by Australian, State and Territory ministers. State Indigenous Bilateral Agreements are the primary vehicle for implementing the national Building a Better Future strategy. The desired strategy outcomes are better housing and housing services, more housing, improved partnerships, greater effectiveness and efficiency, and improved performance linked to accountability and coordination of services.

Funding arrangements

The majority of funding under the 2003 CSHA is provided by the Australian Government, taking the form of general assistance funding (public housing, home purchase assistance and private rental assistance) and specified funding for identified programs: the Aboriginal Rental Housing Program (ARHP), the Crisis Accommodation Program (CAP) and the Community Housing Program. The majority of CSHA funding is distributed to State and Territory governments on a modified per person basis, with the State and Territory governments contributing additional funding from their own resources to ‘match’ (in part) Australian Government funding allocations.

Roles and responsibilities

Under the CSHA, the Australian Government has responsibility for:

- ensuring the outcomes pursued through the agreement are consistent with broader national objectives, particularly in relation to support for individuals and communities
- advising State and Territory governments of Australian Government objectives to be achieved under the agreement
- reporting to the Commonwealth Parliament on performance against agreed outcomes and targets of housing assistance provided under the agreement.

State and Territory governments have responsibility for:

- developing housing assistance strategies that are consistent with Australian, State and Territory government objectives and that best meet the circumstances of the State or Territory
- developing, implementing and managing services and programs to deliver agreed outcomes
- reporting on a basis that enables performance assessment by the Australian, State or Territory governments, based on agreed performance indicators.

Source: CSHA (2003).

Public housing, SOMIH, community housing and Indigenous community housing information has been obtained from the State and Territory governments, except where otherwise indicated. The Australian Institute of Health and Welfare (AIHW) collects and collates these data and produces annual data collection manuals and reports. The data reports are available from the AIHW web site at www.aihw.gov.au. CRA data were obtained from the Department of Families, Community Services and Indigenous Affairs (FaCSIA). Data on satisfaction, amenity and location were obtained from national social housing surveys of public housing, community housing and SOMIH tenants.

Housing assistance not covered

This chapter does not cover a number of government funded and provided housing services, including:

- the CAP, including the Victorian Transitional Housing Management Program under the CSHA, which provides capital funding for accommodation for homeless people
- non-CSHA programs, including those provided by the Department of Veterans' Affairs (DVA)
- CRA paid by the DVA or paid to Abstudy recipients on behalf of the Department of Education, Science and Training (DEST)
- some Indigenous housing and infrastructure assistance
- non-Indigenous community housing not funded under the CSHA
- home purchase assistance, including the First Home Owners Grant, a Commonwealth initiative administered by State and Territory governments
- private rent assistance funded by States and Territories.

16.1 Profile of housing and housing assistance

Service overview

The Australian Bureau of Statistics (ABS) 2006 Census of Population and Housing (ABS 2007) identified just under 7.1 million households in Australia, where 'household' is classified as 'a person living alone' or as 'a group of related or unrelated people who usually reside and eat together'. Of these households, 68.1 per cent owned or were purchasing their own home, 19.0 per cent rented in the private sector, 3.6 per cent were in public rental accommodation, 0.7 per cent lived in community housing,[1] 2.6 per cent resided in other tenure types and 6.0 per cent did not state their tenure type (table 16A.72). For a number of reasons, including non-response and misunderstanding, Census data are likely to underestimate the number of tenants in public housing.[2]

The composition of Australian households is changing. There is an increasing number of smaller households, including a rising number of single person households. The average Australian household size fell from 3.3 people to 2.8 people between 1971 and 2006, while the proportion of single person households increased from 18.1 per cent to 24.4 per cent over this period (ABS 2007).

The average Indigenous household is larger than the average non-Indigenous household. In 2006, the average non-Indigenous Australian household size was 2.6 people, whereas the average household with at least one Indigenous person was 3.4 people (ABS 2007).

Why government provides housing assistance

Australia's private housing stock houses the majority of the population. Most Australian households can access accommodation either through owner occupation or by renting from a private landlord. Many households, however, face problems in acquiring or accessing suitable private accommodation, for reasons of cost, discrimination, availability, location and/or adequacy. The price of rental dwellings can be prohibitive for people on lower incomes. Further, stock may not be available in the private rental market for households with special accommodation needs. Housing assistance from the Australian, State and Territory governments can help these households.

Roles and responsibilities

Each level of government has different roles and responsibilities in housing and housing assistance:

- The Australian Government provides CRA and shares responsibility with State and Territory governments for housing assistance provided under the CSHA (box 16.1). It also provides funding for the Community Housing and

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[1] This estimate is based on data received from jurisdictions regarding the number of community housing dwellings in each jurisdiction, combined with data from the ABS 2006 Census on the total number of dwellings in each jurisdiction.

[2] Public housing tenants appear to be undercounted in the 2006 Census (and in previous censuses).

Infrastructure Program (CHIP). The Australian Government also influences the housing market through other direct and indirect means, including taxation and home purchase assistance.

- State and Territory governments provide housing assistance, such as homeless assistance, public housing, community housing, SOMIH, private rental assistance and home purchase assistance. Some jurisdictions also contribute to the delivery of housing assistance through mechanisms such as home lending programs and joint ventures with the private sector. State and Territory governments are also responsible for land taxes, stamp duties and residential tenancy legislation.
- In the States, local governments implement planning regulations and are sometimes involved in providing community housing.

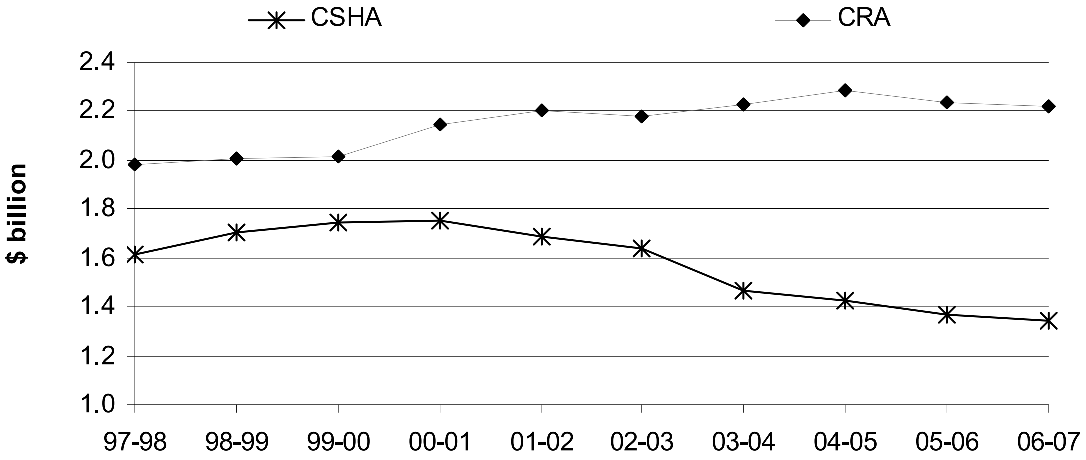
Funding

The Australian, State and Territory governments provided $1.3 billion for housing programs under the CSHA in 2006-07 (figure 16.1). Of this, the Australian Government provided $970.6 million or 72.2 per cent, and State and Territory governments were collectively required to provide minimum matching funds of $374.6 million or 27.8 per cent (FaCSIA 2007). In addition, most jurisdictions provided additional funding above the minimum matching requirements. Public and community housing accounted for the majority of CSHA funding in 2006-07. Real expenditure on CSHA assistance declined by 16.7 per cent between 1997-98 and 2006-07 (figure 16.1).

Some of the funding for Indigenous community housing comes through the ARHP under the CSHA and through the CHIP. Indigenous community housing is also funded by the Australian, State and Territory governments.

The Australian Government also provided $2.2 billion for CRA in 2006-07 (figure 16.1). Real expenditure on CRA increased by 12.0 per cent over the ten year time period (table 16A.79).

Figure 16.1 **Real government expenditure on CSHA assistance and CRA (2006-07 dollars)**[a]



[a] Data may not be comparable over time and comparisons could be misleading. Reasons for this are provided in table 16A.79.

Source: CSHA (1999); FaCS (various years); FaCSIA (2007); FaCSIA (unpublished); table 16A.79.

Public housing is the largest form of assistance provided under the CSHA. Given the capital intensive nature of provision of social housing, additional assistance to annual funding is provided through the use of $68 billion of housing stock owned by housing authorities in 2005-06 (calculated from 2005-06 State and Territory CSHA national financial statements).

Table 16.1 is a summary table that presents government expenditure including and excluding capital costs, on a per capita and per dwelling basis. It also includes CRA expenditure per capita and per income unit to present the overall level of government housing assistance covered in this chapter. More detailed analysis of the cost components for public housing is presented in table 16.15. Nationally, net recurrent cost per capita on public housing was approximately $98 in 2006-07. Cost including capital costs per capita on public housing was $373 (table 16.1). Nationally, net recurrent cost per dwelling on public housing was approximately $5956 in 2006-07. Average cost including capital cost per dwelling on public housing was $22 717 (table 16.1).

It is important to note the differences in housing assistance operations across jurisdictions when discussing expenditure per capita on public housing. It is also important to note that the per capita data could have been influenced by historic arrangements (such as previous years' investment) that might have influenced the overall size of the public housing sector relative to the size of the population. Reporting direct cost per public housing dwelling addresses some of these issues.

Table 16.1 **Government housing assistance, 2006-07 (dollars)**[a]

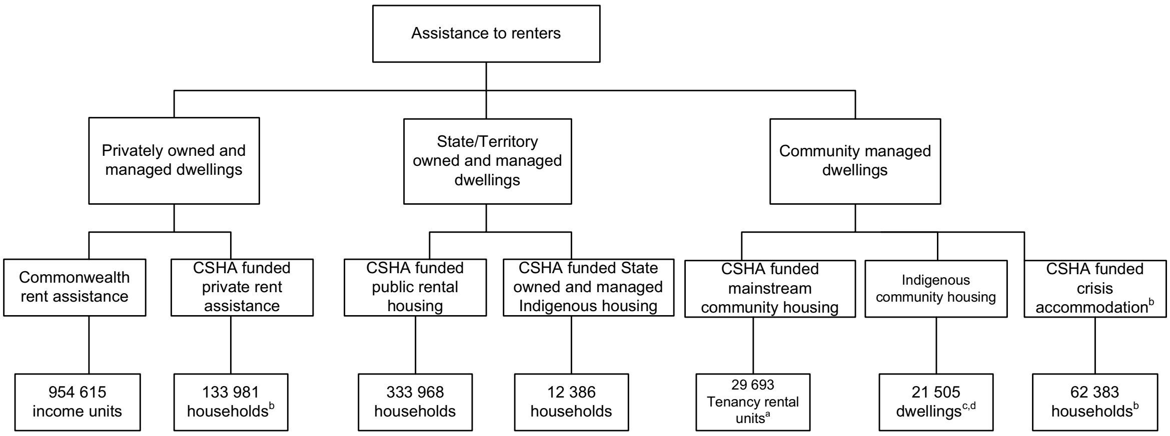
	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Government expenditure on public housing									
Per capita[b]									
Net recurrent cost	103	57	63	115	167	161	221	241	98
Cost including capital cost	420	248	271	465	490	437	1 020	635	373
Per dwelling									
Net recurrent cost	5 778	4 541	5 162	7 553	5 990	6 752	6 842	9 502	5 956
Cost including capital cost	23 497	19 584	22 093	30 568	17 538	18 323	31 616	25 011	22 717
CRA expenditure									
Per capita[b]	112	94	134	90	99	116	50	58	107
Per income unit	2 341	2 303	2 378	2 303	2 257	2 304	2 154	2 302	2 328

[a] Data may not be comparable between jurisdictions and over time and comparisons could be misleading. Reasons for this are provided in table 16A.86. [b] Data are expressed as per capita of Australian population.

Source: FaCSIA (unpublished); State and Territory governments (unpublished); table 16A.86.

Figure 16.2 illustrates the range of government assistance to renters.

Figure 16.2 **Assistance across the rental sector, 2007**[a]



[a] Additional dwellings are funded under programs other than CSHA. Data about these dwellings are not available. [b] For year ending 30 June 2006. [c] At 30 June 2006. [d] Includes permanent dwellings managed by funded/actively registered or unfunded Indigenous community housing organisations. 19 512 of these dwellings were managed by organisations administered by the State governments and 1993 were managed by organisations administered by the Australian Government.

Source: Adopted from AIHW (2007e).

CSHA funding data for 2005-06 and 2006-07 financial years are presented in table 16.2.

Table 16.2 **CSHA funding, 2005-06 and 2006-07 ($ million)[a]**

Funding arrangements	**2005-06**	**2006-07**
Base funding grants	743.9	752.5
Aboriginal Rental Housing Program	93.3	94.4
Crisis Accommodation Program	40.7	41.2
Community Housing Program	65.6	66.4
State matching grants — minimum funding required	364.1	368.4
Total	**1 307.6**	**1 323.0**

[a] Includes Public Housing, Home Purchase Assistance and Private Rental Assistance Programs.

Source: FaCSIA (2007); FaCSIA (unpublished).

Size and scope

Housing assistance is provided in various forms, and models for delivering assistance can vary within and across jurisdictions. The main forms of assistance are outlined in box 16.2. This chapter focuses on five forms of assistance: public housing, SOMIH, community housing, Indigenous community housing and CRA.

Box 16.2 **Forms of housing assistance**

There are several significant forms of housing assistance.

- *Public housing*: dwellings owned (or leased) and managed by State and Territory housing authorities to provide affordable rental accommodation. The CSHA is the main source of funding for public housing along with internally generated rental revenues and the proceeds of asset sales.
- *Community housing*: rental housing provided for low to moderate income or special needs households, managed by community-based organisations that are at least partly subsidised by government. Community housing models vary across jurisdictions, and the housing stock may be owned by a variety of groups including government.
- *Indigenous housing*: State owned housing targeted at Indigenous households (referred to as 'SOMIH' in this report) and houses owned or leased and managed by Indigenous community housing organisations and community councils in major cities, regional and remote areas.
- *Crisis accommodation*: accommodation services to help people who are homeless or in crisis. Services are generally provided by non-government organisations and many are linked to support services funded through SAAP. Sources of government funding include CAP through the CSHA, which provides funding for accommodation, and SAAP funding for live-in staff, counselling and other support services.

(Continued on next page)

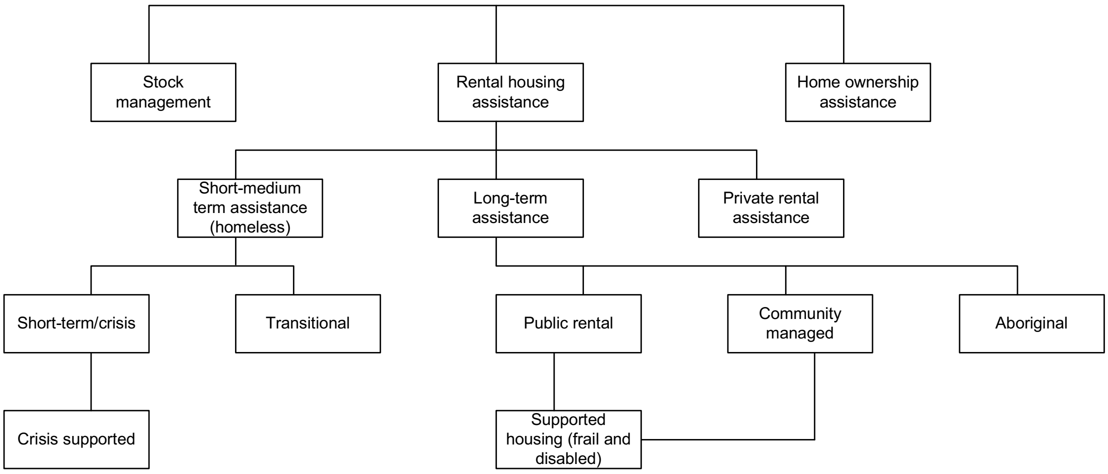
Box 16.2 **(Continued)**

- *Home purchase assistance*: assistance provided by State and Territory governments to low income households to help with home purchases or mortgage repayments; for example, the grant provided under the First Home Owner's Scheme, a Commonwealth initiative administered by State and Territory governments.
- *Private rental assistance*: assistance funded by State and Territory governments to low income households experiencing difficulty in securing or maintaining private rental accommodation. This assistance may include ongoing or one-off payments to help households meet rent payments, one-off payments for relocation costs, guarantees or loans to cover the cost of bonds and housing assistance advice and information services. Assistance may be provided by community-based organisations funded by government.
- The chapter also reports on CRA, which is a non-taxable income support supplement paid by the Australian Government to income support recipients or people who receive more than the base rate of the Family Tax Benefit Part A and who rent in the private rental market.

Source: CSHA (2003); FaCS (2003).

A snapshot presenting different forms of CSHA housing assistance for vulnerable people is presented through the example for Victoria (figure 16.3).

Figure 16.3 **Forms of CSHA housing assistance for low income Victorians**



Source: VDHS (2001, p. 4).

Public housing

Public housing comprises those dwellings owned (or leased) and managed by State and Territory housing authorities. The CSHA is the main source of funding for public housing. A total of 333 139 public housing dwellings were occupied at 30 June 2007 (table 16A.1). Public housing is available to people on low incomes and those with special needs. In 2006-07, 29.1 per cent of public housing tenants were people with a disability (AIHW 2007e).

Public housing rents are generally set at market levels, and rebates are granted to low income tenants (so they generally pay no more than 25 per cent of their assessable income in rent), to provide affordable housing. Public housing allocations are constrained by the amount of housing stock available and are income tested. The proportion of total households residing in public housing in 2006 (4.3 per cent nationally) is presented for all jurisdictions in table 16A.75. Information on the proportion of income paid in rent by public housing tenants is contained in table 16A.80. Details of multiple family composition, non-rebated and other public households excluded from data in this chapter are presented in table 16A.87.

Community housing

Community housing is generally managed by not-for-profit organisations or local governments, which perform asset and tenancy management functions. A major objective of community housing is to increase social capital by encouraging local communities to take a more active role in planning and managing appropriate and affordable transitional and long term rental accommodation. Community housing is also intended to provide a choice of housing location, physical type and management arrangements. Some forms of community housing also allow tenants to participate in the management of their housing.

Community housing programs aim to achieve links between housing and services that are best managed at the community level, including services for people with a disability, and home and community care. Notwithstanding their common objectives, community housing programs vary within and across jurisdictions in their administration and types of accommodation (box 16.3).

Box 16.3 **Models of community housing**

Community housing models vary across jurisdictions in terms of their scale, organisational structure and financing arrangements, and the extent to which the community or government has management responsibility and ownership of the housing stock. Table 16A.76 lists the relevant community housing programs in each jurisdiction.

Some community housing models are:

- *regional or local housing associations,* whereby the associations provide property and tenancy management services, and community groups provide support services to tenants
- *joint ventures and housing partnerships,* whereby a range of church, welfare, local government agencies and other organisations provide resources in cooperation with State and Territory governments
- *housing cooperatives*, which are responsible for tenant management and maintenance, while government, a central finance company or an individual cooperative owns the housing stock
- *community management and ownership,* whereby not-for-profit or community housing associations both own and manage housing
- *local government housing associations,* which provide low cost housing within a particular municipality, are closely involved in policy, planning, funding and/or monitoring roles, and may directly manage the housing stock
- *equity share rental housing,* whereby housing cooperatives wholly own the housing stock and lease it to tenants (who are shareholders in the cooperative and, therefore, have the rights and responsibilities of cooperative management).

Source: State and Territory governments (unpublished).

Funding for community housing is typically either fully or partly provided by governments to not-for-profit organisations or local governments. Australian Government funding for community housing amounted to 7.0 per cent ($67.5 million) of total CSHA funding provided by the Australian Government in 2006-07 (FaCSIA unpublished). There were 34 672 CSHA community housing dwellings in Australia at 30 June 2007 (table 16A.25).[3] Table 16A.77 presents the proportion of all households residing in community housing in each jurisdiction in 2006 (0.7 per cent nationally).

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[3] Data are based on a combination of survey and administrative data. Results, therefore, are affected by survey non-response. Details of community housing survey response rates and associated information are presented in table 16A.89.

Indigenous housing

There are a number of different government programs that provide housing assistance to Indigenous people — both Indigenous-specific programs and mainstream programs. The two main Indigenous-specific forms of social housing are:

- SOMIH — managed by State governments with funding provided by the CSHA
- Indigenous community housing (ICH) — managed by Indigenous community housing organisations (ICHOs) with funding provided by the State, Territory and Australian governments.

In addition to these Indigenous-specific programs, Indigenous people are also eligible for assistance through mainstream housing programs such as public housing, community housing and CRA.

State owned and managed Indigenous housing

SOMIH dwellings are defined as those rental housing dwellings owned and managed by government and allocated only to Indigenous Australians (AIHW 2006c). They include dwellings managed by government Indigenous housing agencies for allocation to Indigenous tenants. There were 13 098 dwellings identified in the 2006-07 SOMIH collection (table 16A.14).

The ACT and the NT are not included in the SOMIH data collection. The ACT does not receive funding for, or administer, any Territory owned and managed Indigenous housing programs; in the NT, ARHP funding is directed to Indigenous community housing.

In NSW, a separate statutory organisation — the Aboriginal Housing Office — is responsible for planning, administering and expanding policies, programs and the asset base for Aboriginal housing in that State. Funding for the office comes from the CSHA and the State Government (in addition to its CSHA commitments).

Some other jurisdictions are increasingly pooling funding but currently report SOMIH data separately. Queensland administers a separate Aboriginal and Torres Strait Islander Housing Program, which includes ARHP funds, untied CSHA funds and State funds, and does not report separately against the ARHP component of the program funds (which forms more than one third of total funding).

Indigenous community housing

ICH is delivered by Indigenous community housing organisations who perform asset and tenancy management functions. The funding and administrative arrangements for ICH, vary across jurisdictions. In some jurisdictions, only the states are involved in the administration of ICH; in some only the Australian Government is involved; and in others both the State or Territory and the Australian governments are involved.

The Australian Government, through FaCSIA, formerly through Aboriginal and Torres Strait Islander Services (ATSIS), is directly responsible for the funding and administration of ICH in three jurisdictions — Queensland, Victoria and Tasmania. In Victoria and Tasmania there is only Australian Government administered ICH housing, while in Queensland, some ICH housing is administered by the Australian Government and some by the State government. In the five remaining jurisdictions — NSW, WA, SA, the ACT and NT — funding from the relevant State or Territory and the Australian governments is pooled and the State or Territory government has sole responsibility for the administration of ICH.

There has been considerable progress in the development of national Indigenous community housing data to report against the National Reporting Framework (NRF) for Indigenous housing (AIHW 2007b). For the first time, this Report includes a performance indicator framework and data for Indigenous community housing.

CRA

CRA is a non-taxable supplementary payment provided by the Australian Government to help with the cost of private rental housing. It is available to recipients of income support payments, including those who receive more than the base rate of the Family Tax Benefit Part A and who pay private rent above minimum thresholds. Private rent includes rent paid under both formal tenancy agreements and informal arrangements, such as board and lodging paid to a family member. It also includes mooring and site fees (for boats and caravans) and payments for retirement village services.

CRA is paid at 75 cents for every dollar above the threshold until a maximum rate is reached. The maximum rates and thresholds vary according to a customer's family situation and number of children (table 16.3). For single people without dependent children, the maximum rate may also vary according to whether accommodation is shared with others. Rent thresholds and maximum rates are indexed twice per year (March and September) to reflect changes in the consumer price index.

Because CRA is a national payment, FaCSIA seeks to ensure that CRA recipients who have the same income unit characteristics and who pay the same amount of rent receive the same amount of assistance wherever they live. There were 943 718 income units (where an income unit is defined as either a single person or a couple with or without dependents)[4] entitled to receive CRA at 8 June 2007 (table 16A.48). The proportion of CRA recipients by income unit type is presented in table 16A.49. Data on the number and proportion of Indigenous income units receiving CRA by income unit type are presented in tables 16A.50 and 16A.51, respectively.

The maximum rate of assistance was received by 67.2 per cent of CRA recipients at 8 June 2007 (table 16A.63). There was little variation in the average level of assistance across locations at 8 June 2007 (table 16A.62), even though rents varied considerably by location. At 8 June 2007, the average payment across Australia was $87.34 per fortnight (approximately $2277 per year) (table 16A.62).

Table 16.3 **Eligibility and payment scales for CRA, 20 March to 19 September 2007 ($ per fortnight)[a]**

Income unit type	*Minimum rent to be eligible for CRA*	*Minimum rent to be eligible for maximum CRA*	*Maximum CRA*
Single, no dependent children	92.60	231.27	104.00
Single, no children, sharer	92.60	185.04	69.33
Couple, no dependent children	150.60	281.53	98.20
Single, one or two dependent children	121.80	284.76	122.22
Single, three or more dependent children	121.80	306.04	138.18
Partnered, one or two dependent children	180.18	343.14	122.22
Partnered, three or more dependent children	180.18	364.42	138.18
Partnered, illness separated, no dependent children	92.60	231.27	104.00
Partnered, temporarily separated, no dependent children	92.60	223.53	98.20

[a] Further information pertinent to the data included in this table and/or its interpretation is provided in table 16A.47.

Source: FaCSIA (unpublished); table 16A.47.

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[4] Dependents are defined as young persons for whom the person or partner receives the Family Tax Benefit. The benefit is not payable for children receiving Youth Allowance or any other income security payment. Children aged over 16 years for whom the Family Tax Benefit is not payable are regarded as separate income units.

Diversity of State and Territory housing assistance operations

State and Territory governments have similar broad objectives for providing housing assistance. Individual jurisdictions, however, emphasise different objectives depending on their historical precedents and ways of interacting with community sector providers. Jurisdictions also have different private housing markets. These differences lead to a variety of policy responses and associated forms of assistance. It is important to be aware of all the housing assistance operations in each State and Territory when analysing performance information.

Appendix A contains information on each State and Territory that may help in interpreting the performance indicators presented in this chapter.

Public housing and State owned and managed Indigenous housing

Eligibility criteria for access to public housing, such as income and asset definitions and limits, vary across jurisdictions. In most cases, jurisdictions require that applicants be Australian citizens or permanent residents and not own or part-own residential property. All jurisdictions require eligible applicants to be resident in the respective State or Territory. All State and Territory governments prioritise access to public housing by segmenting their waiting lists in some way. Segments are defined differently across jurisdictions, but generally reflect urgent need/homelessness and an inability to access appropriate private market accommodation. Most jurisdictions provide security of tenure after an initial probationary period. Most jurisdictions also have periodic reviews of eligibility. Rebated rents result in the majority of households paying no more than 25 per cent of their assessable income in rent (the rent-to-income ratio). Definitions of assessable income vary across jurisdictions (table 16.4).

Table 16.4 Public housing policy context, 2007[a]

	NSW[b]	*Vic*[c]	*Qld*	*WA*[d]	*SA*[e]	*Tas*[f]	*ACT*	*NT*[g]
Eligibility								
Income limit per week ($)[h]	410	423	609	430	674	423	514	595
'Other' asset limits ($)[h]	None	30 000	None	36 400 cash	278 500	35 000	40 000 liquid assets	41 800
Minimum age	18	16	None	18	None	16	16	16
Waiting list[i]								
Segmented by:	Wait turn and priority (two segments)	Priority (four segments)	Priority (two segments)	Priority (three segments)	Need (four segments)	Need (four segments)	Need (three segments)	Wait turn and priority (two segments)
Tenure								
Probationary period	None	None	None	None	6 months	3–6 months	None	3–6 months
Fixed term	3, 6, 12 or 18 months 2, 5 and 10 years	5 years for tenancies commencing before November 1997	None	3 months	None	1–3 years	None	2 year then 5 year
Ongoing	Yes	Lifetime after age 65 for tenancies commencing after November 1997	Subject to review	Ongoing	Ongoing after probation	In some cases, particularly older persons	Lifetime tenure	Leases extended
Tenancy review	Prior to the end of the tenancy	To commence in 2008	Review at 4 or 10 years	Annual	None	Fixed term leases reviewed at end of each term	None	Prior to each lease extension

(Continued on next page)

Table 16.4 **(Continued)**

	NSW[b]	*Vic*[c]	*Qld*	*WA*[d]	*SA*[e]	*Tas*[f]	*ACT*	*NT*[g]
Rebated rent setting								
Rent-to-income ratio	25-30	25	25	23 or 25	25	23–25	25	18 or 23

[a] At 30 June. [b] Interest accrued from cash assets is assessed as income less the first $5000 of each person’s savings. Applicants under the age of 18 years must demonstrate living skills to be eligible for housing. Tenants housed prior to 1 July 2005 were generally provided with a continuous lease. New tenants housed since 1 July 2005 are generally provided with a fixed term lease. New tenancies from 1 July 2005 to 22 October 2006 were signed as 18 month interim tenancies. Tenants on an 18 month fixed term lease are reviewed prior to the end of lease, and if eligible, are offered a 2, 5 or 10 year lease. If ineligible, they are offered a 12 month fixed term lease. From 23 October 2006 the Department began to offer 2, 5 or 10 year leases to new tenants and ceased to offer the 18 month interim leases. From 5 December 2005 new thresholds and rules determine whether a tenant is eligible for a rent subsidy and the percentage of income they will pay as rent. Their household’s gross assessable income, household size and age of household members are used when assessing the household’s eligibility for a rent subsidy. For rebated rents, varied concessional rates are applicable to certain age groups and some pensioners. For households whose tenancy commenced on or after 5 December 2005, the Family Tax Benefit Part A and Part B received are assessed at 15 per cent. Where the tenancy commenced prior to 5 December 2005 the Family Tax Benefit Part A and Part B received was assessed at 12 per cent from 5 December 2005, with an increase of 1 per cent every 6 months until the assessment rate reaches 15 per cent. [c] Public housing tenancies in Victoria are ongoing tenancies (not fixed term) that are subject to review after 5 years. For households that require major disability modifications, discretion may be applied to extend the asset limit to $60 000. [d] Income limit for those in north west remote areas is $550 per week. Those aged over 60 years are subject to a cash asset limit of $80 000. A rent-to-income ratio of 23 per cent can apply for groups such as seniors, people with disabilities and people living in remote locations. [e] The same definition as the Centrelink asset test threshold for a single person who does not own their own home is used. Most households pay a rent-to-income ratio of 25 per cent of assessable income in rent, except aged residents in cottage flat and bedsitter flat accommodation (for whom the ratio is 19 per cent and 17 per cent respectively) and households receiving less than the single Newstart Allowance (for whom the ratio is 19.5 per cent). [f] The rent-to-income ratio is indicative only. The majority of households pay amounts within this range, but some pay lesser or higher amounts, depending on household composition and the relationship of household members to the tenant, for example, boarder, parent, independent child. [g] There is discretion to accept applications for people under 16 years. The rent-to-income ratio is 18 per cent for aged pension recipients. [h] Limits are for a single person. [i] Two segment lists generally consist of ‘priority’ and ‘wait turn’.

Source: State and Territory governments (unpublished).

The proportion of public housing located in regional and remote areas using the Australian Standard Geographical Classification remoteness area structure (ASGC remoteness areas) is shown in table 16.5.

Table 16.5 **Public housing — regional and remote area concentrations, 2006-07 (per cent)**[a]

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Major cities	81.0	72.1	61.6	70.7	77.4	–	99.9	–	71.6
Inner regional	15.0	22.5	19.5	9.7	7.0	73.0	0.1	–	16.8
Outer regional	3.6	5.4	16.5	9.4	13.7	26.2	–	69.0	9.4
Remote	0.3	–	1.8	7.0	1.8	0.6	–	27.2	1.7
Very remote	0.1	–	0.6	3.3	0.2	0.3	–	3.8	0.5

[a] Further information pertinent to the data included in this table and/or its interpretation is provided in table 16A.1. – Nil or rounded to zero.

Source: AIHW (2007a); table 16A.1.

Eligibility criteria for access to SOMIH are generally consistent with those for public housing once an applicant has been confirmed as Indigenous. The management of waiting lists varies across jurisdictions — for example, a number of jurisdictions use the same list for both public housing and SOMIH. Terms of tenure are the same as those for public housing for a number of jurisdictions (table 16.6).

Table 16.6 **SOMIH housing policy context, 2007**[a]

	NSW[b]	*Vic*[c]	*Qld*	*WA*[d]	*SA*[e]	*Tas*[f]
Eligibility						
Income limit per week ($)[g]	410	423	609	430	674	423
‘Other’ asset limits ($)[g]	None	30 000	None	36 400 in cash	278 500	35 000
Minimum age	18	16	None	18	None	16
Waiting list						
Details	Combined with public housing	Combined with public housing	Combined with public housing	Combined with public housing	Need (Four segment)	Priority, similar to public housing
Tenure						
Probationary period	None	None	None	None	6 months	3–6 months
Fixed term	3, 6, 12 or 18 months 2, 5 and 10 years	5 years for tenancies commencing before November 1997	None	3 months	None	1–3 years
Ongoing	Yes	Lifetime after age 65 for tenancies commencing after November 1997	Subject to review	Ongoing	Ongoing after probation	Dependant on housing history
Tenancy review	Prior to the end of the tenancy	To commence in 2008	Review at 4 or 10 years	Annual	None	Fixed term leases reviewed at end of each term
Rebated rent setting						
Rent-to-income ratio	25–30	25	25	23 or 25	25	23–25

(Continued on next page)

Table 16.6 **(Continued)**

[a] At 30 June. [b] Interest accrued from cash assets is assessed as income less the first $5000 of each person’s savings. Applicants under the age of 18 years must demonstrate living skills to be eligible for housing. Tenants housed prior to 1 July 2005 were generally provided with a continuous lease. New tenants housed since 1 July 2005 are generally provided with a fixed term lease. New tenancies from 1 July 2005 to 22 October 2006 were signed to 18 month interim tenancies. Tenants on an 18 month fixed term lease are reviewed prior to the end of lease, and if eligible, are offered a 2, 5 or 10 year lease. If ineligible, they are offered a 12 month fixed term lease. From 23 October 2006 the Department began to offer 2, 5 or 10 year leases to new tenants and ceased to offer the 18 month interim leases. From 5 December 2005 new thresholds and rules determine whether a tenant is eligible for a rent subsidy and the percentage of income they will pay as rent. Their household’s gross assessable income, household size and age of household members are used when assessing the household’s eligibility for a rent subsidy. For rebated rents, varied conssessional rates are applicable to certain age groups and some pensioners. For households whose tenancy commenced on or after 5 December 2005, the Family Tax Benefits Part A and Part B received are assessed at 15 per cent. Where the tenancy commenced prior to 5 December 2005 the Family Tax Benefits Part A and Part B received was assessed at 12 per cent from 5 December 2005, with an increase of 1 per cent every six months until the assessment rate reaches 15 per cent. CRA is assessed at 100 per cent. [c] Tenancies in Victoria are ongoing tenancies (not fixed term) that are subject to review after 5 years. For households that require major disability modifications, discretion may be applied to extend the asset limit to $60 000. Indigenous households generally access long term accommodation through the General Rental program or housing managed by the Aboriginal Housing Board of Victoria. [d] The income limit for those in north west remote areas is $550 per week. Those aged over 60 years are subject to a cash asset limit of $80 000. [e] The same definition as the Centrelink asset test threshold for a single person who does not own their own home is used. Most households pay a rent-to-income ratio of 25 per cent of assessable income in rent. However, households receiving less than the single Newstart Allowance pay rent-to-income ratio of 19.5 per cent. [f] The rent-to-income ratio is indicative only. The majority of households pay amounts within this range, but some pay lesser or higher amounts, depending on household composition and the relationship of household members to the tenant, for example, boarder, parent, independent child. [g] Limits are for a single person.

Source: State and Territory governments (unpublished).

The proportions of SOMIH located by ASGC remoteness areas are shown in table 16.7.

Table 16.7 **SOMIH — regional and remote area concentrations, 2006-07 (per cent)[a]**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*Total*
Major cities	40.5	37.8	13.9	28.4	60.9	–	33.9
Inner regional	32.2	37.3	15.3	7.9	7.8	82.3	22.4
Outer regional	20.7	24.5	44.3	21.3	17.7	17.7	26.1
Remote	5.1	0.4	10.0	20.4	5.9	–	8.4
Very remote	1.5	–	16.6	22.0	7.7	–	9.3

[a] Further information pertinent to the data included in this table and/or its interpretation is provided in table 16A.14. – Nil or rounded to zero.

Source: AIHW (2007c); table 16A.14.

Community housing

Eligibility criteria for community housing are generally consistent with those for public housing in each jurisdiction. Most jurisdictions do not require community housing organisations to segment waiting lists.

For the data that are available, the proportions of community housing located in regional and remote areas using (using ASGC remoteness areas) are shown in table 16.8.

Table 16.8 **Community housing — regional and remote area concentrations, 2006-07 (per cent)[a]**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Major cities	70.1	72.5	44.2	66.6	84.8	–	100.0	–	66.6
Inner regional	24.0	23.5	23.0	12.4	9.3	51.2	–	–	20.4
Outer regional	5.4	3.7	23.3	13.0	4.5	46.7	–	69.6	9.8
Remote	0.4	0.3	3.7	6.5	1.3	2.1	–	23.9	1.9
Very remote	–	–	5.9	1.5	0.1	–	–	6.5	1.3

[a] Further information pertinent to the data included in this table and/or its interpretation is provided in table 16A.25. – Nil or rounded to zero.

Source: AIHW (2008); table 16A.25.

Private rental markets

Tight private rental markets (vacancy rates below 3.0 per cent) were evident in all states in June 2007. Capital city vacancy rates in the private rental market for all jurisdictions are reported in table 16A.73. Capital city median rents varied across jurisdictions. Median rents for three bedroom houses and two bedroom flats or units are reported in table 16A.74.

16.2 Framework of performance indicators

Prior to the 2007 Report, separate performance indicator frameworks for public, SOMIH and community housing were presented. Increasing convergence between the frameworks over time has meant that, since the 2007 Report, public and SOMIH have adopted a common performance indicator framework, while the CSHA funded community housing data are presented in a separate framework because of data comparability issues. The Indigenous community housing framework has been included in the Report for the first time this year. This framework is also separate because of data comparability issues. A separate performance indicator framework is adopted for reporting on CRA.

The performance indicator frameworks are consistent with the general performance indicator framework agreed by the Steering Committee (see chapter 1). They also draw on the framework developed for the 1999 CSHA and reflect the national objectives of that agreement (and of the new CSHA that took effect in 2003 (box 16.4). The new CSHA places greater emphasis on Australian, State and Territory governments improving housing outcomes for Indigenous people, and governments have committed to improving access to mainstream housing options for Indigenous people living in urban and regional areas. This is the fourth year that data are reported under the current agreement. Work is being undertaken on the performance indicators to improve the quality and scope of national performance information.

Box 16.4 **Objectives for public and community housing under the 2003 CSHA**

The principles guiding the 2003 CSHA are to:

1. maintain a core Social Housing sector to assist people unable to access alternative suitable housing options
2. 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

(Continued on next page)

Box 16.4 **(Continued)**

3. provide assistance in a manner that is non-discriminatory and has regard to consumer rights and responsibilities, including consumer participation
4. commit to improving housing outcomes for Indigenous people in urban, regional 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
5. ensure housing assistance links effectively with other programs and provides better support for people with complex needs, and has a role in preventing homelessness
6. promote innovative approaches to leverage additional resources into Social Housing, through community, private sector and other partnerships
7. ensure that housing assistance supports access to employment and promotes social and economic participation
8. establish greater consistency between housing assistance provision and outcomes, and other social and economic objectives of government, such as welfare reform, urban regeneration, and community capacity-building
9. undertake efficient and cost-effective management which provides best value to governments
10. adopt a cooperative partnership approach between levels of government towards creating a sustainable and more certain future for housing assistance
11. promote a national, strategic, integrated and long term vision for affordable housing in Australia through a comprehensive approach by all levels of government.

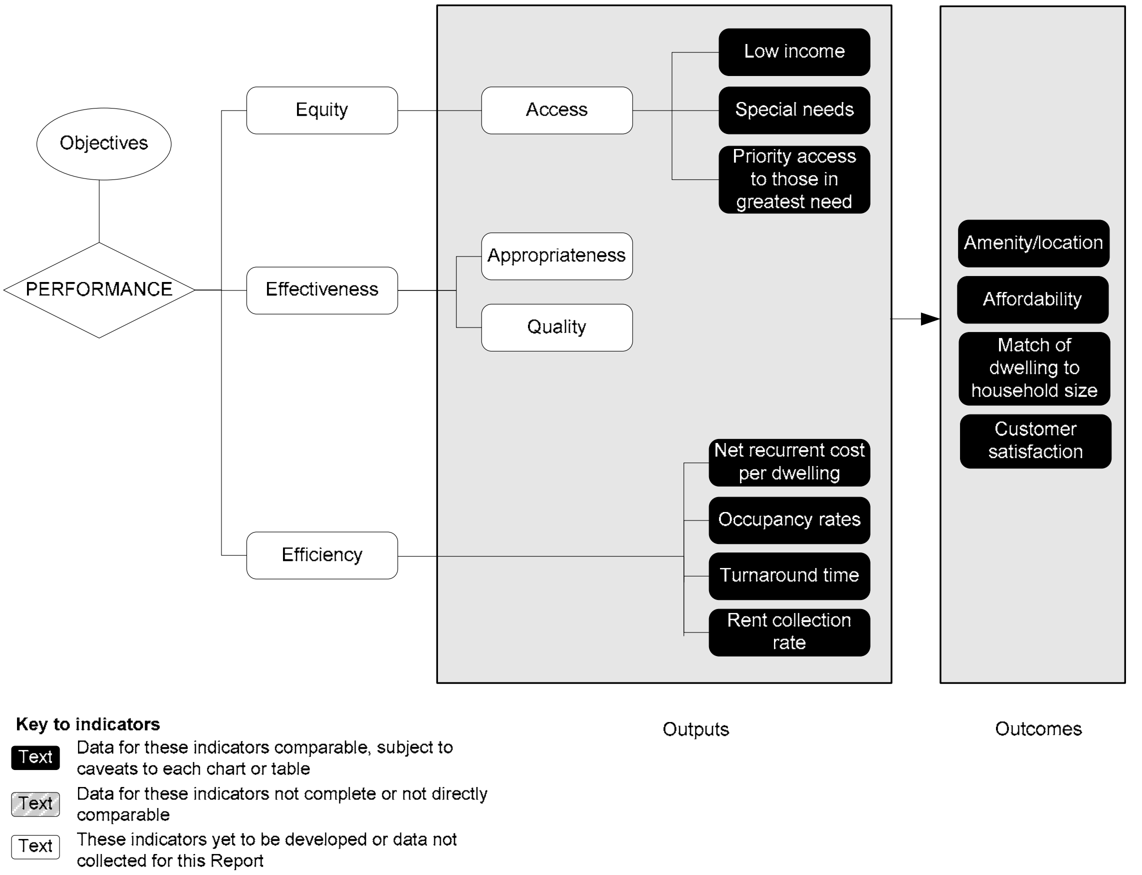
Source: CSHA (2003, p. 4).

The performance indicator frameworks show which data are comparable in the 2008 Report (figures 16.4, 16.5, 16.6 and 16.7). For data that are not considered directly comparable, the text includes relevant caveats and supporting commentary. Chapter 1 discusses data comparability from a Report-wide perspective (see section 1.6).

The frameworks reflect the adoption by governments of accrual accounting and depict the Review’s focus on outcomes, consistent with demand by governments for outcome oriented performance information. The frameworks also accentuate the importance of equity. More detail on the general report framework, along with the differences between outputs and outcomes, can be found in chapter 1.

Comparable data are presented for the full range of indicators in the performance measurement framework for public housing and SOMIH (figure 16.4).

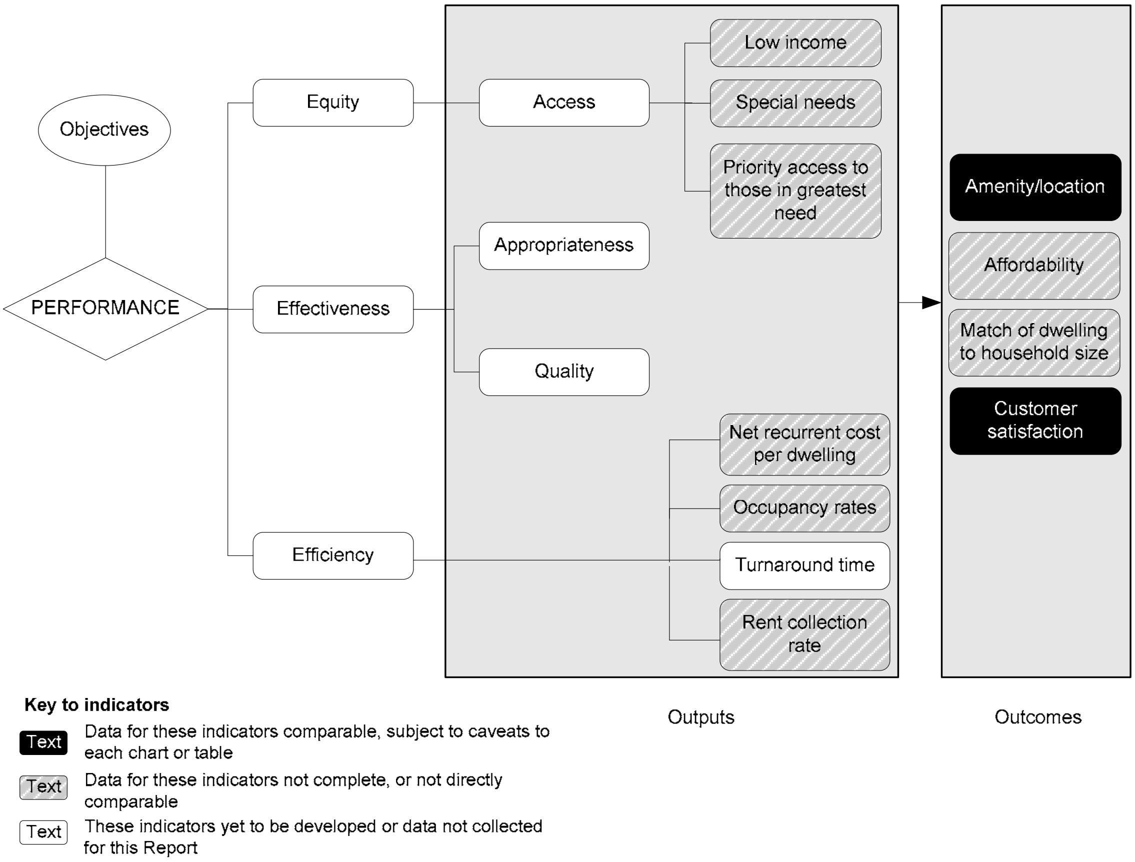
Figure 16.4 **Performance indicators for public housing and SOMIH**



While public, SOMIH and community and Indigenous community housing use a common framework, the delivery method for public housing and SOMIH differs from that for community and Indigenous community housing. State and Territory governments deliver public housing and SOMIH, while community organisations and sometimes local government deliver community and Indigenous community housing.

The performance indicator framework for CSHA funded community housing is presented in figure 16.5. The turnaround time performance indicator has been removed from the CSHA community housing data collection by the National Housing Data Agreement Management Group following their review of the national performance reporting framework, and so no data were available for this Report.

Figure 16.5 **Performance indicators for CSHA funded community housing**



Indigenous housing aims to achieve the outcomes listed in box 16.5 as part of the Building a Better Future: Indigenous Housing to 2010. The aims also relate to Indigenous community housing.

Box 16.5 **Indigenous housing**

The guiding principles and objectives for achieving better Indigenous housing are:

1. provide better housing that meets agreed standards, is appropriate to the needs of Aboriginal and Torres Strait Islander people, and contributes to their health and well being
2. provide better housing services that are well managed and sustainable
3. ensure housing growth in the number of houses to address both the backlog of Indigenous housing need and emerging needs of a growing Indigenous population
4. ensure improved partnerships in a way that Indigenous people are fully involved in the planning, decision making and delivery of services by governments

(Continued on next page)

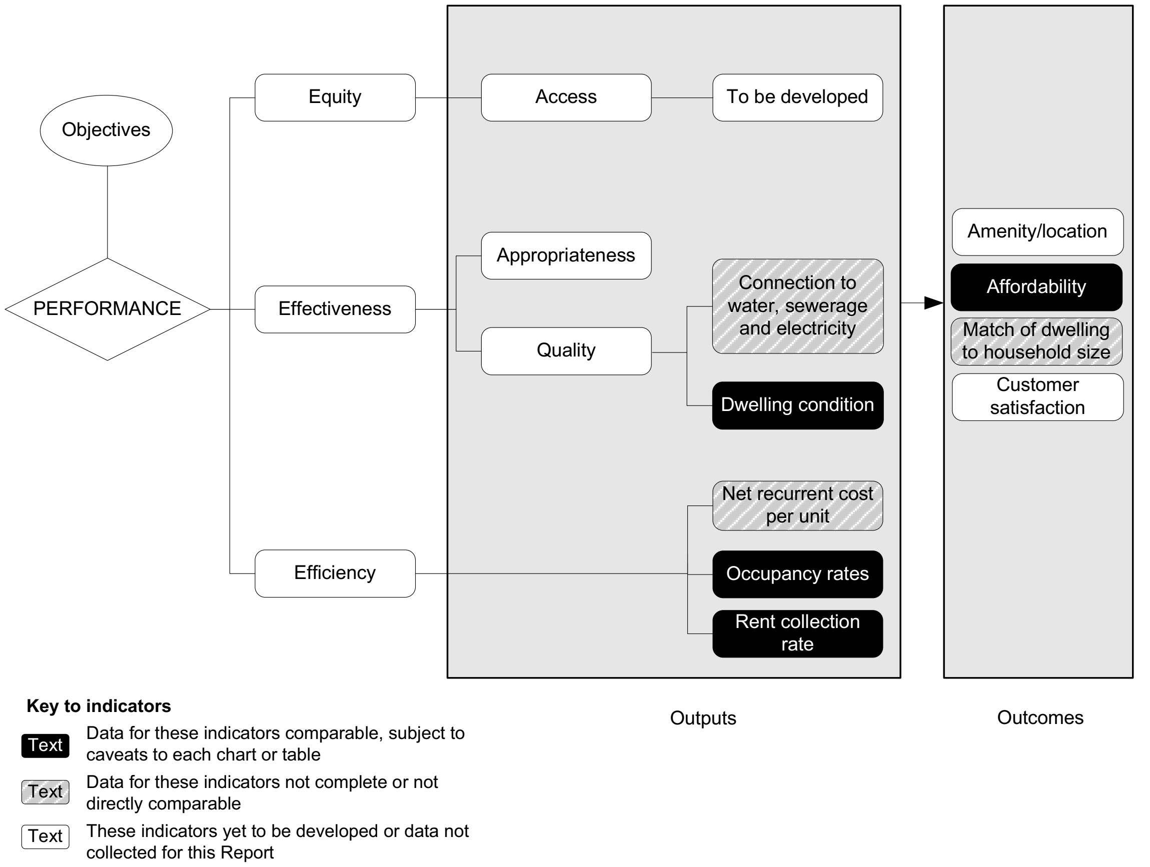
Box 16.5 **(Continued)**

5. ensure greater effectiveness and efficiency in a way that that assistance is properly directed to meeting objectives, and that resources are being used to best advantage
6. commit to improved performance linked to accountability for the program performance reporting based on national data collection systems and good information management
7. promote the a 'whole of government' coordination of services approach that ensures greater coordination of housing and housing-related services linked to improved health and well being outcomes.

Source: FaCSIA (2001).

The performance indicator framework for Indigenous community housing is shown in figure 16.6.

Figure 16.6 **Performance indicators for Indigenous community housing**

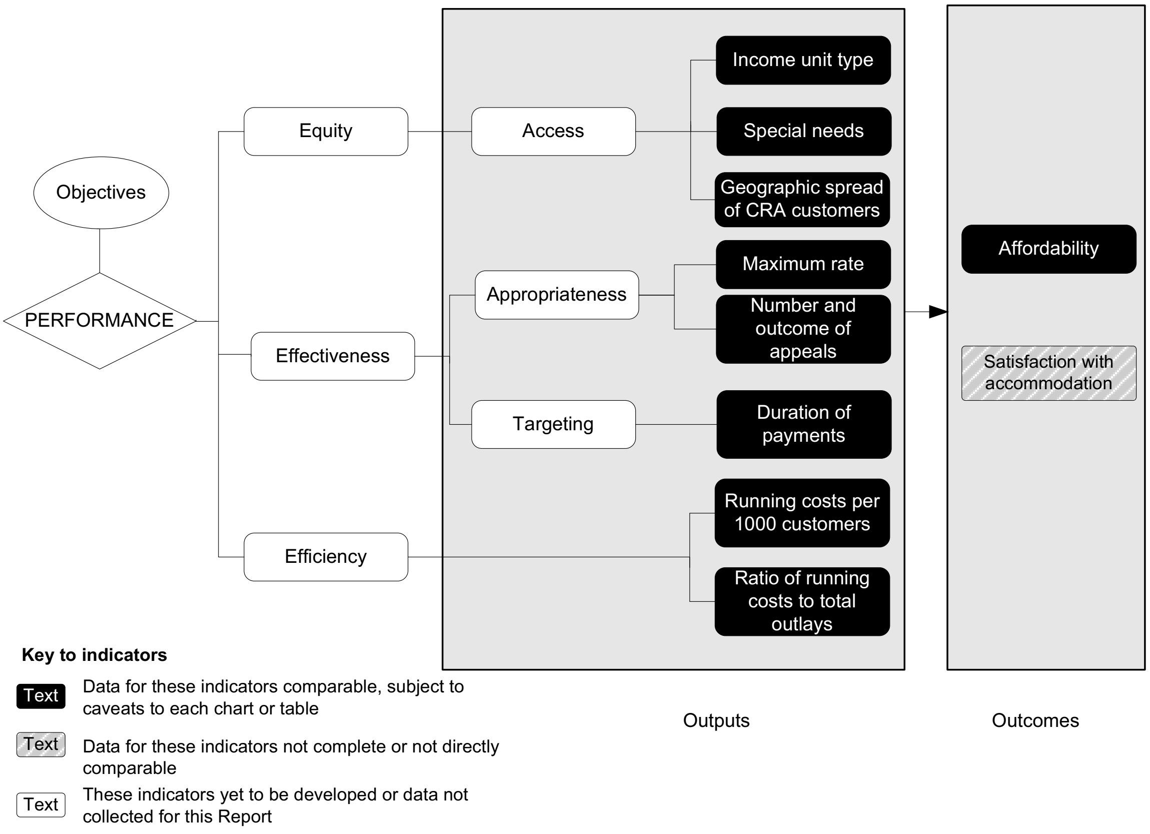


The performance indicators for CRA differ from those for public, SOMIH, CSHA funded and Indigenous community housing because CRA has different objectives and delivery methods. The CRA performance indicator framework in figure 16.7 is based on the CRA objective outlined in box 16.6.

Box 16.6 **Objective of CRA**

The objective of CRA is to provide income support recipients and low income families in the private rental market with additional financial assistance, in recognition of the housing costs that they face (Newman 1998). This assistance should be delivered in an equitable and efficient manner. CRA is also governed by other objectives relating to the primary income support payment.

Figure 16.7 **Performance indicators for CRA**



16.3 Key performance indicator results

Performance indicator results are comparable between public housing and SOMIH, but are not comparable to CSHA funded community housing and Indigenous community housing because data quality and coverage can differ. More information on definitions is provided in a box for each indicator.

Public housing and SOMIH

The performance indicator framework for public housing and SOMIH is presented in figure 16.4.

Different delivery contexts, locations and types of tenant may affect the performance of public housing and SOMIH reported in this chapter. For example, SOMIH housing dwellings are slightly more likely than mainstream public or community housing dwellings to be located in regional or remote areas (tables 16.5, 16.7 and 16.8). Care therefore needs to be taken in comparing performance indicator results, and the qualifications presented with the data need to be considered.

Some contextual information on public housing can be found in table 16A.1. Some descriptive data on SOMIH are included in table 16A.14. As outlined in section 16.1, the ACT and the NT are not included in the SOMIH data collection.

Outputs

The following indicators measure the outputs of public housing and SOMIH. Outputs are the actual services delivered (while outcomes are the impact of these services on the status of an individual or group) (see chapter 1, section 1.5).

Equity — low income

The first equity indicator reported for public housing and SOMIH is ‘low income’ (box 16.7).

Box 16.7 **Equity — low income**

‘Low income’ is an indicator of the CSHA guiding principle to assist people unable to access alternative suitable housing options. The ‘low income’ performance indicator measures the number of new low income households as a proportion of all new households. Two measures of low income performance indicator are reported:

- the proportion of new households with low income A — households where all members receive an income equivalent to or below 100 per cent of the government income support benefits at the pensioner rate (pension rates have been selected for calculating this indicator because they are higher than allowance rates)
- the proportion of new households with low income B — households with an income above 100 per cent of the government income support benefits at the pensioner rate, but below the effective cut-off for receiving any government support benefits.

High values for these measures indicate a high degree of access for low income households.

The proportion of new tenancies allocated to low income A households for public housing in 2006-07 is presented in table 16.9. The proportion of new tenancies allocated to low income B households is reported in the attachment (table 16A.2).

Table 16.9 **Public housing — low income A households as a proportion of all new households (per cent)[a]**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
New low income A households as proportion of all new households									
2002-03	92.9	90.4	90.3	86.8	89.6	90.6	88.9	87.4	90.4
2003-04	94.7	92.4	90.5	87.9	87.5	89.1	87.7	87.6	91.2
2004-05	94.0	92.5	88.1	85.8	87.1	80.8	89.4	85.6	90.0
2005-06	94.5	93.3	87.3	88.2	87.6	89.8	87.1	85.3	90.9
2006-07	93.6	92.5	72.9	83.6	89.5	88.9	90.2	85.2	87.7

[a] Data may not be comparable between jurisdictions and over time and comparisons could be misleading. Reasons for this are provided in table 16A.2.

Source: AIHW (2003c, 2004c, 2005c, 2006d, 2007a); table 16A.2.

The proportion of new tenancies allocated to low income A households for SOMIH in 2006-07 is presented in table 16.10. The proportion of new tenancies allocated to low income B households is reported in the attachment (table 16A.15).

Table 16.10 **SOMIH — low income A households, as a proportion of all new households (per cent)**[a]

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*Total*
New low income A households as proportion of all new households							
2002-03	91.5	87.8	89.7	89.1	86.5	87.2	89.2
2003-04	94.4	90.5	83.3	93.5	89.2	89.5	90.6
2004-05	94.2	87.7	76.1	92.9	86.0	86.0	88.0
2005-06	95.9	88.2	89.2	88.6	86.5	93.3	90.4
2006-07	95.5	89.9	76.5	87.9	88.7	100.0	87.7

[a] Data may not be comparable between jurisdictions and over time and comparisons could be misleading. Reasons for this are provided in table 16A.15.

Source: AIHW (2003a, 2004a, 2005a, 2006a, 2007c); table 16A.15.

The ratio of low income households to all new households was similar for public housing and SOMIH. There were some variations across jurisdictions.

Equity — special needs

The second equity indicator reported for public housing and SOMIH is ‘special needs’ (box 16.8).

Box 16.8 **Equity — special needs**

‘Special needs’ is an indicator of the CSHA guiding principle to provide appropriate, affordable and secure housing assistance to people who are unable to access suitable housing. It measures the proportion of new tenancies allocated to special needs households. The proportion of new tenancies with special needs are reported as a proxy for measuring all households with special needs. Special needs households are defined as those households that have either a household member with a disability, a principal tenant aged 24 years or under, or 75 years or over, or one or more Indigenous members. Special needs households for SOMIH are defined as those households that have either a household member with a disability or a principal tenant aged 24 years or under, or 50 years or over. A high proportion indicates a high degree of access by these special needs households. Data for public housing and SOMIH are not comparable.

New public housing tenancies allocated to households with special needs are presented in table 16.11.

Table 16.11 Public housing — new tenancies allocated to households with special needs (per cent)[a]

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
2002-03	52.4	43.7	38.9	44.7	59.0	49.9	35.3	62.8	48.1
2003-04	53.6	45.9	58.2	49.9	58.9	65.7	33.0	73.0	53.5
2004-05	55.7	47.1	62.7	64.8	63.2	67.6	48.4	100.0	58.2
2005-06	55.7	58.9	61.9	67.7	61.1	66.1	52.7	63.1	59.8
2006-07	52.3	54.5	64.6	56.2	65.8	63.9	48.5	66.0	57.8

[a] Data may not be comparable between jurisdictions and over time and comparisons could be misleading. Reasons for this are provided in table 16A.3.

Source: AIHW (2003c, 2004c, 2005c, 2006d, 2007a); table 16A.3.

The proportion of new tenancies allocated to special needs households for SOMIH is presented in table 16.12.

Table 16.12 SOMIH — new tenancies allocated to households with special needs (per cent)[a]

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*Total*
2002-03	35.8	49.7	41.0	37.4	37.8	50.6	39.5
2003-04	44.6	44.2	46.3	40.8	39.5	60.3	43.6
2004-05	51.5	45.4	45.2	49.2	42.1	66.7	48.1
2005-06	48.8	42.8	46.8	53.2	45.3	62.3	48.8
2006-07	47.6	52.9	47.0	44.6	45.6	65.6	47.4

[a] Data may not be comparable between jurisdictions and over time and comparisons could be misleading. Reasons for this are provided in table 16A.16.

Source: AIHW (2003a, 2004a, 2005a, 2006a, 2007c); table 16A.16.

The proportion of new tenancies allocated to households with special needs decreased in 2006-07 at the national level for both public housing and SOMIH, but there were variations among the jurisdictions.

Equity — priority access to those in greatest need

The final equity indicator reported for public housing and SOMIH is 'priority access to those in greatest need' (box 16.9). Differences in State and Territory housing assessment policies can influence comparability for this indicator.

Box 16.9 **Priority access to those in greatest need**

'Priority access to those in greatest need' is an output indicator of the CSHA guiding principle to provide appropriate, affordable and secure housing to assist people who are unable to access suitable housing. This indicator provides information on whether allocation processes are such that those in greatest need have first access to housing. It measures the proportion of new allocations to those in greatest need. Greatest need households are defined as households that at the time of allocation were either homeless, in housing inappropriate to their needs, or in housing that is adversely affecting their health or placing their life and safety at risk, or that have very high rental housing costs.

Reported measures reflect the percentages of new allocations to greatest need households overall, and for greatest need households waiting for periods of less than three months, three months to less than six months, 6 months to less than one year, one year to less than two years, and two years or more. As time to allocation reflects greatest need allocations as a percentage of all new allocations for the time period, these percentages are not cumulative.

High values for these measures, particularly for short time frames, indicate a high degree of access for those households in greatest need.

The proportion of new allocations to those in greatest need in 2006-07 for public housing is presented in table 16.13.

Table 16.13 **Public housing — proportion of new allocations to those in greatest need, 2006-07 (per cent)**[a]

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Total for year ending 30 June	**29.8**	**68.1**	**26.3**	**31.6**	**46.5**	**93.6**	**87.3**	**25.0**	**42.8**
Proportion of new allocations to those in greatest need, by time to allocation									
<3 months	59.8	76.0	74.7	51.1	67.0	95.2	94.6	18.4	68.5
3–<6 months	46.9	68.8	77.7	70.6	64.9	95.7	91.9	40.0	64.6
6 months–<1 year	30.4	71.3	55.0	46.5	64.6	93.5	86.1	43.9	53.5
1–<2 years	16.0	67.0	18.5	6.1	41.2	85.6	78.6	23.8	31.0
2+ years	2.7	31.1	3.8	–	3.0	80.4	61.2	3.6	5.6

[a] Further information pertinent to the data included in this table and/or its interpretation is provided in table 16A.4. – Nil or rounded to zero.

Source: AIHW (2007a); table 16A.4.

The proportion of new allocations to those in greatest need for 2006-07 for SOMIH is presented in table 16.14.

Table 16.14 **SOMIH — proportion of new allocations to those in greatest need, 2006-07 (per cent)**[a]

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*Total*
Total for year ending 30 June	**10.5**	**19.3**	**20.2**	**28.2**	**74.4**	**na**	**25.8**
Proportion of greatest need allocations to new allocations, by time to allocation							
<3 months	17.5	34.4	32.1	32.2	78.8	na	33.3
3–<6 months	15.5	50.0	56.3	50.0	88.2	na	40.2
6 months–<1 year	10.2	14.3	37.3	41.3	89.7	na	36.4
1–<2 years	3.1	11.1	14.3	15.9	66.7	na	19.2
2+ years	–	2.1	4.1	–	59.6	na	8.8

[a] Further information pertinent to the data included in this table and/or its interpretation is provided in table 16A.17. **na** Not available. – Nil or rounded to zero.

Source: AIHW (2007c); table 16A.17.

Efficiency — net recurrent cost per dwelling

The efficiency indicator reported for public housing and SOMIH is ‘net recurrent cost per dwelling’ (box 16.10).

Box 16.10 **Net recurrent cost per dwelling**

‘Net recurrent cost per dwelling’ is an indicator of the CSHA guiding principle to undertake efficient and cost-effective management. It measures the average cost of providing assistance per dwelling.

‘Net recurrent cost per dwelling’ is defined as the total recurrent expenses, including administration and operational costs, less rents received from tenants, divided by the total number of dwellings. The ‘cost of providing assistance (including capital) per dwelling’ is also reported. Holding other factors equal, a lower net recurrent cost per dwelling suggests an improvement in efficiency.

The cost per dwelling indicators do not provide any information on the quality of service provided (for example, the standard of dwellings).

Due to a high level of capital expenditure in housing, costs per dwelling are predominantly driven by the user cost of capital (box 16.11). Caution must therefore be used when interpreting the indicator because the user cost of capital and service delivery models differ across the jurisdictions.

The costs incurred by jurisdictions in providing public housing and SOMIH include:

- administration costs (the cost of the administration offices of the property manager and tenancy manager)

- operating costs (the costs of maintaining the operation of the dwelling, including repairs and maintenance, rates, the costs of disposals, market rent paid and interest expenses)
- depreciation costs
- the user cost of capital (the cost of the funds tied up in the capital used to provide public housing and SOMIH). Box 16.11 provides a discussion of the user cost of capital.

In 2001, the Steering Committee completed a research project to assess the impact of asset measurement factors (such as depreciation and asset valuation methods) on the comparability of cost data in the Report. The results of this study are summarised in chapter 2. Box 16.12 summarises the results relating to housing.

Treatment of assets by housing agencies for each jurisdiction is presented in table 16A.78.

Box 16.11 **The user cost of capital**

The 'user cost of capital' for government services is the cost of having funds tied up in the capital used to deliver services (for example, houses and land in public housing). It makes explicit the opportunity cost of using the funds to deliver services rather than investing them elsewhere or using them to retire debt. It is calculated by applying a jurisdictional cost of capital rate to the value of government assets (see chapter 2 for details of the determination of a cost of capital rate). The costs of capital for land and other assets are shown separately, to allow users to consider any differences in land values across jurisdictions when assessing the results. Land values make up a large part of the user cost of capital and are largely beyond the control of jurisdictions.

When comparing costs of government services, it is important to account for the user cost of capital because it is often:

- a significant component of the cost of services
- treated inconsistently (that is, included in the costs of services delivered by many non-government service providers, but effectively costed at zero for most budget sector agencies).

The Steering Committee accepts that asset valuation data are imperfect. It also considers that non-recognition of the cost of capital used by departments to deliver services can result in a significant underestimation of costs for those services for which government capital is a major input. While the measurement of capital costs in this Report is not perfect, using an imputed costing is preferable to not costing government capital at all. The rate used for the user cost of capital is based on a weighted average of rates nominated by jurisdictions (currently 8 per cent).

Box 16.12 **Asset measurement in the costing of government services**

Differences in the techniques for measuring non-current physical assets (such as valuation methods) may reduce the comparability of capital cost estimates across jurisdictions. In response to concerns regarding data comparability, the Steering Committee initiated the study, *Asset Measurement in the Costing of Government Services* (SCRCSSP 2001). The aim of the study was to examine the extent to which differences in asset measurement techniques applied by participating agencies affect the comparability of reported unit costs.

The relative capital intensity associated with the provision of public housing increases the potential for differences in asset measurement techniques to have a material impact on total unit costs. However, the results of this study suggest, however, that the adoption under the CSHA of a uniform accounting framework has largely avoided this impact. The results are discussed in more detail in chapter 2.

Source: SCRCSSP (2001).

Care needs to be taken in interpreting the cost of delivering public housing. Cost data for some jurisdictions are either more complete than for other jurisdictions or collected on a more consistent basis. Administration costs and operating costs, for example, may not capture all costs incurred by government, so could understate the total costs of public housing. In addition, some jurisdictions have difficulty separating costs for public housing from those for other housing assistance activities. There may also be double counting of some expenditure items in the cost calculations for some jurisdictions. The user cost of capital, for example, is intended to capture all the costs of funding assets used to produce the services, but reported operating costs (apart from interest payments, which have been adjusted for) may already include some of these costs.

Payroll tax is excluded from total recurrent cost for public housing. This was done for the first time in the 2004 Report, making the cost data not comparable with the data published in past reports. (Chapter 2 elaborates on the reasons for excluding payroll tax from the cost calculations.)

Nationally, net recurrent costs per dwelling (excluding the cost of capital) were $5956 in 2006-07 (table 16.15). Direct cost per dwelling including capital costs were $22 717 in 2006-07 (table 16A.5).

Table 16.15 **Public housing — cost of providing assistance per dwelling (2006-07 dollars)**[a, b]

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Net recurrent cost of providing assistance (excluding the cost of capital) per dwelling									
2002-03	5 344	3 829	4 915	5 021	5 351	7 538	7 517	10 949	5 195
2003-04	5 504	4 013	5 016	5 358	5 261	6 873	8 843	11 476	5 360
2004-05	5 206	4 100	4 913	5 619	5 362	6 779	8 949	10 401	5 270
2005-06	5 369	4 437	4 946	5 641	5 538	7 141	8 056	9 753	5 393
2006-07	5 778	4 541	5 162	7 553	5 990	6 752	6 842	9 502	5 956
Cost of providing assistance (including the cost of capital) per dwelling									
2002-03	24 588	18 145	17 885	16 279	12 223	13 201	28 761	21 855	19 656
2003-04	26 714	20 224	20 668	17 252	13 734	14 057	33 208	23 926	21 754
2004-05	25 165	20 088	20 728	18 642	15 912	19 619	33 240	26 363	21 830
2005-06	23 817	19 916	21 386	20 394	16 864	19 047	31 947	25 340	21 619
2006-07	23 497	19 584	22 093	30 568	17 538	18 323	31 616	25 011	22 717

[a] Further information pertinent to the data included in this table and/or its interpretation is provided in table 16A.5. [b] Data are presented in real dollars based on the ABS Gross Domestic Product price deflator (index) (2006-07 = 100) table AA.26.

Source: AIHW (2007a); State and Territory governments (unpublished); table 16A.5.

The net recurrent cost of providing assistance (excluding the cost of capital) per dwelling for SOMIH is presented in table 16.16. Capital cost data for SOMIH are not available for this Report. As with other indicators, it is not appropriate to compare the net recurrent cost of providing assistance per dwelling for public housing with the net recurrent cost of providing assistance per dwelling for SOMIH, because there is greater scope for economies of scale in administration costs with public housing, which is a much larger program overall.

SOMIH dwellings are also slightly more concentrated in regional and remote areas, where the cost of providing housing assistance is potentially greater. The need to construct culturally appropriate housing (possibly requiring different amenities) may also affect the cost per dwelling. Finally, different cost structures may apply to the programs. Construction of dwellings under SOMIH, for example, may involve a skills development element to allow for training of apprentices in regional areas.

Table 16.16 **SOMIH — net recurrent cost of providing assistance per dwelling (2006-07 dollars)**[a, b]

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*Total*
Net recurrent cost of providing assistance (excluding the cost of capital) per dwelling							
2002-03	5 962	5 522	7 108	6 364	9 336	4 346	6 710
2003-04	6 489	5 408	7 188	6 917	6 243	3 910	6 509
2004-05	5 551	5 263	6 734	7 527	4 518	5 363	5 984
2005-06	5 623	6 507	6 900	7 955	7 265	5 819	6 660
2006-07	5 818	4 078	7 471	7 627	6 674	6 430	6 476

[a] Data may not be comparable between jurisdictions and over time and comparisons could be misleading. Reasons for this are provided in table 16A.18. [b] Data are presented in real dollars based on the ABS Gross Domestic Product price deflator (index) (2006-07 = 100) table AA.26.

Source: AIHW (2003a, 2004a, 2005a, 2006a, 2007c); table 16A.18.

Efficiency — occupancy rate

The second efficiency indicator reported for public housing and SOMIH is the 'occupancy rate' (box 16.13).

Box 16.13 **Occupancy rate**

The 'occupancy rate' is an indicator of the CSHA guiding principle to measure the efficiency of housing utilisation. It represents the proportion of rental housing stock occupied by households. The term 'occupied' refers to rental housing stock occupied by tenants who have a tenancy agreement with the relevant housing authority.

A high value for this indicator suggests higher efficiency of housing utilisation. Occupancy is influenced by both turnover and housing supply and demand.

The national average proportion of public rental stock occupied at 30 June 2007 was 98.0 per cent. There were only slight variations across jurisdictions or over time (table 16.17).

Table 16.17 **Public housing — occupancy rates (per cent)**[a]

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
2003	98.3	96.5	97.9	95.7	94.9	96.8	98.7	93.9	97.1
2004	98.7	96.6	98.7	95.3	95.4	97.4	97.2	93.8	97.4
2005	98.7	97.3	98.6	95.6	96.1	98.0	98.1	94.1	97.7
2006	98.6	97.5	98.9	96.2	96.2	98.4	98.7	95.6	97.8
2007	98.6	97.6	99.1	96.5	97.1	98.7	98.6	95.7	98.0

[a] Data may not be comparable between jurisdictions and over time and comparisons could be misleading. Reasons for this are provided in table 16A.6.

Source: AIHW (2003c, 2004c, 2005c, 2006d, 2007a); table 16A.6.

The proportion of total SOMIH stock occupied at 30 June 2007 is presented in table 16.18. The national average proportion of SOMIH stock occupied at 30 June 2007 was 96.4 per cent.

Table 16.18 **SOMIH — occupancy rates (per cent)**[a]

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*Total*
2003	97.6	96.1	94.2	94.4	91.8	95.8	95.2
2004	98.0	96.7	96.8	94.1	92.2	98.2	96.0
2005	97.4	95.8	96.1	94.2	91.8	97.7	95.5
2006	97.4	96.7	96.8	94.1	93.5	98.3	96.1
2007	97.7	96.4	97.2	94.5	94.1	97.7	96.4

[a] Data may not be comparable between jurisdictions and over time and comparisons could be misleading. Reasons for this are provided in table 16A.19.

Source: AIHW (2003a, 2004a, 2005a, 2006a, 2007c); table 16A.19.

Efficiency — turnaround time

The third efficiency indicator reported for public housing and SOMIH is ‘turnaround time’ (box 16.14).

Box 16.14 **Turnaround time**

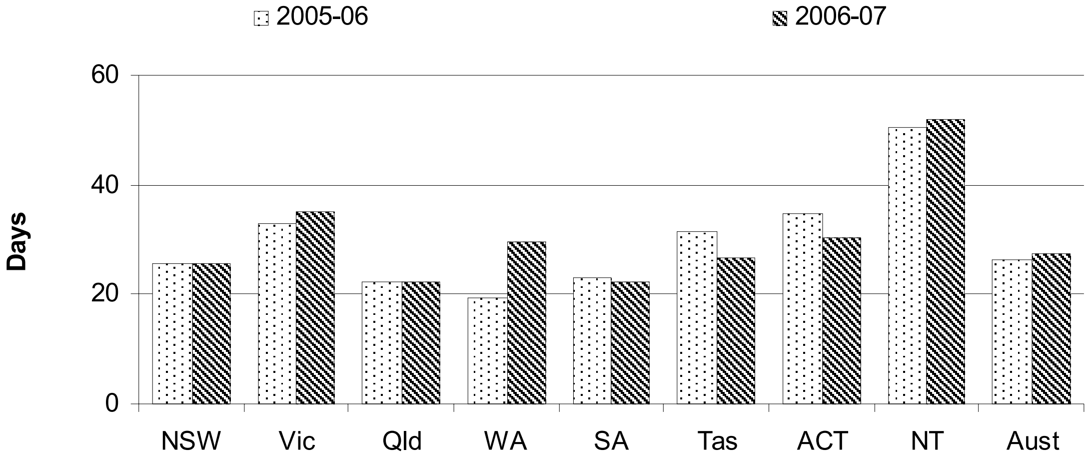
‘Turnaround time’ is an indicator of the CSHA guiding principle to undertake efficient and cost-effective management. It measures the average time taken for occupancy of available dwelling stock to rent through normal processes. A low turnaround time suggests efficient housing allocation.

‘Normal’ vacancies exclude properties that are offline or are undergoing major redevelopment and where there is no suitable applicant but include hard-to-let properties as this relates to tenancy management.

This indicator may be affected by changes in maintenance programs and stock allocation processes, and some jurisdictions may have difficulty excluding stock upgrades. Cultural factors may also influence the national average turnaround time for SOMIH dwellings relative to public housing dwellings. Following the death of a significant person, for example, a dwelling may need to be vacant for a longer period of time (Morel and Ross 1993). A higher proportion of SOMIH dwellings in regional and remote areas may also contribute to delays in completing administrative tasks and maintenance before dwellings can be re-tenanted.

The average number of days for vacant stock to remain unallocated in 2006-07 is presented in figure 16.8 for public housing and figure 16.9 for SOMIH.

Figure 16.8 **Public housing — average turnaround time**[a]



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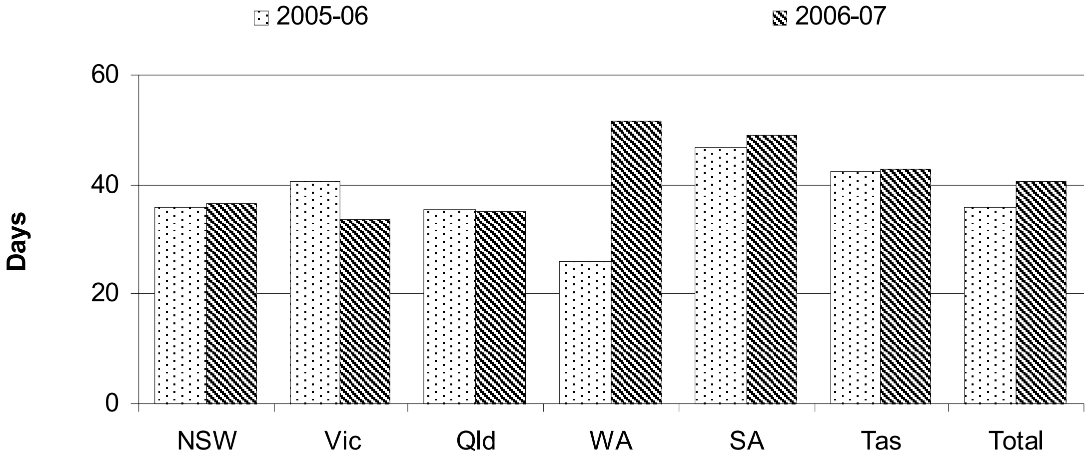
[a] Data may not be comparable between jurisdictions and comparisons could be misleading. Reasons for this are provided in table 16A.7.

Source: AIHW (2007a); table 16A.7.

Figure 16.9 **SOMIH — average turnaround time**[a]



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[a] Data may not be comparable between jurisdictions and comparisons could be misleading. Reasons for this are provided in table 16A.20.

Source: AIHW (2007c); table 16A.20.

Efficiency — rent collection rate

The final efficiency indicator reported for public housing and SOMIH is 'rent collection rate' (box 16.15).

Box 16.15 **Rent collection rate**

‘Rent collection rate’ is an indicator of the CSHA guiding principle to undertake efficient and cost-effective management. It is the total rent actually collected as a percentage of the total rent charged. A high percentage suggests efficiency in collecting rent. All jurisdictions aim to maximise the rent collected as a percentage of the rent charged.

Differences in recognition policies, write-off practices, the treatment of disputed amounts, and the treatment of payment arrangements may affect the comparability of this indicator’s reported results. Further, payment arrangements for rent in some jurisdictions mean that rent collected over a 12 month period may be higher than rent charged over that period.

‘Rent collection rate’ in 2006-07 is presented in table 16.19 for public housing and table 16.20 for SOMIH.

Table 16.19 **Public housing — rent collection rate (per cent)**[a]

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
2002-03	100.5	99.8	99.3	101.0	98.3	99.7	99.9	97.5	99.8
2003-04	99.7	99.3	99.8	101.9	100.0	102.2	99.3	99.9	99.9
2004-05	101.2	101.1	100.6	103.2	100.5	99.7	100.0	102.8	101.1
2005-06	100.1	100.1	100.2	101.7	100.8	103.8	99.8	100.7	100.4
2006-07	97.8	97.0	99.4	102.1	100.3	101.5	100.1	100.9	98.8

[a] Data may not be comparable between jurisdictions and over time and comparisons could be misleading. Reasons for this are provided in table 16A.8.

Source: AIHW (2003c, 2004c, 2005c, 2006d, 2007a); table 16A.8.

Table 16.20 **SOMIH — rent collection rate (per cent)**[a]

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*Total*
2002-03	102.3	98.1	97.2	101.9	107.9	98.8	101.4
2003-04	104.1	99.8	101.3	103.1	97.0	102.2	101.8
2004-05	97.7	100.6	100.4	103.9	93.8	99.6	99.2
2005-06	100.5	99.0	99.7	104.3	94.7	103.8	100.0
2006-07	101.8	92.8	97.3	105.3	103.0	102.1	100.6

[a] Data may not be comparable between jurisdictions and over time and comparisons could be misleading. Reasons for this are provided in table 16A.21.

Source: AIHW (2003a, 2004a, 2005a, 2006a, 2007c); table 16A.21.

Outcomes

The following indicators measure the outcomes of public housing and SOMIH. Outcomes are the impact of services on the status of an individual or group (while outputs are the actual services delivered) (see chapter 1, section 1.5).

Amenity/location

'Amenity/location' is an indicator of success in meeting tenants' needs (box 16.16).

Box 16.16 **Amenity/location**

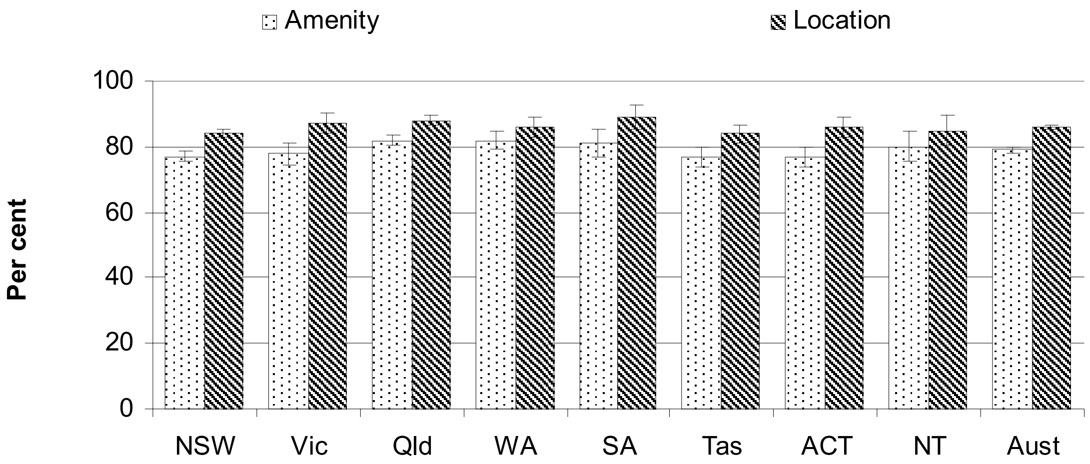
'Amenity/location' is an indicator of the CSHA guiding principle to provide housing assistance that is appropriate to the needs of different households. The amenity/location indicator is a survey-based measure of the percentage of tenants rating amenity/location aspects of their dwelling as important and as meeting their needs.

A higher level of satisfaction with amenity and location suggests the provision of housing assistance satisfies household needs.

The data for public housing are taken from the *2007 National Social Housing Survey* for public rental housing. Tenants were asked whether particular aspects of the amenity and location of their dwellings were important to them and, if so, whether they felt their needs were met. The error bars in the figures show the range of potential values that might be expected, based on the sample size. Further information on the sample size is provided in tables 16A.9 and 16A.10.

The proportion of public housing tenants rating their current home as meeting their needs is reported in figure 16.10.

Figure 16.10 **Public housing — proportion of tenants rating their current home as meeting their amenity and location needs, 2007**[a]



[a] Further information pertinent to the data included in this table and/or its interpretation is provided in tables 16A.9 and 16A.10.

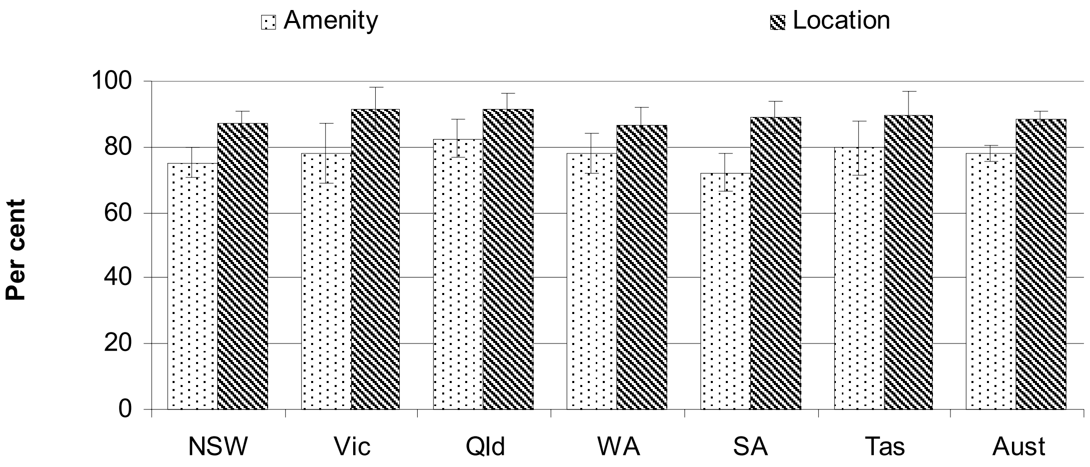
Source: AIHW (2007a); tables 16A.9 and 16A.10.

Nationally, 70.0 per cent of Indigenous and 79.0 per cent of non-Indigenous public housing tenants rated amenity aspects as important and meeting their needs. Similarly, at the national level, 80.0 per cent of Indigenous and 86.0 per cent of non-Indigenous public housing tenants rated location aspects as important and meeting their needs (AIHW 2007a).

During 2006-07, all states participated in the *National Social Housing Survey* of SOMIH. As for the National Social Housing Survey undertaken biennially for public and community housing, the survey seeks to determine tenants' level of satisfaction with various aspects of service and measure housing outcomes.

SOMIH tenants were asked whether particular aspects of the amenity and location of their dwellings were important to them and, if so, whether they felt their needs were met. Nationally, 78.1 per cent of tenants for whom amenity was important felt that their needs were met, and of those tenants for whom location was important, 88.7 per cent felt that their needs were met (figure 16.11). Caution should be used when comparing the SOMIH survey results with the public housing survey results, due to the different demographic profile of Indigenous tenants and the different survey methodologies used. A mail-out survey is used for the public housing survey and interviews for the SOMIH survey. These differences may affect the comparability of the results.

Figure 16.11 **SOMIH — proportion of tenants rating their current home as meeting their amenity and location needs, 2007**[a]



[a] Further information pertinent to the data included in this table and/or its interpretation is provided in table 16A.22.

Source: AIHW (2007c); table 16A.22.

Customer satisfaction

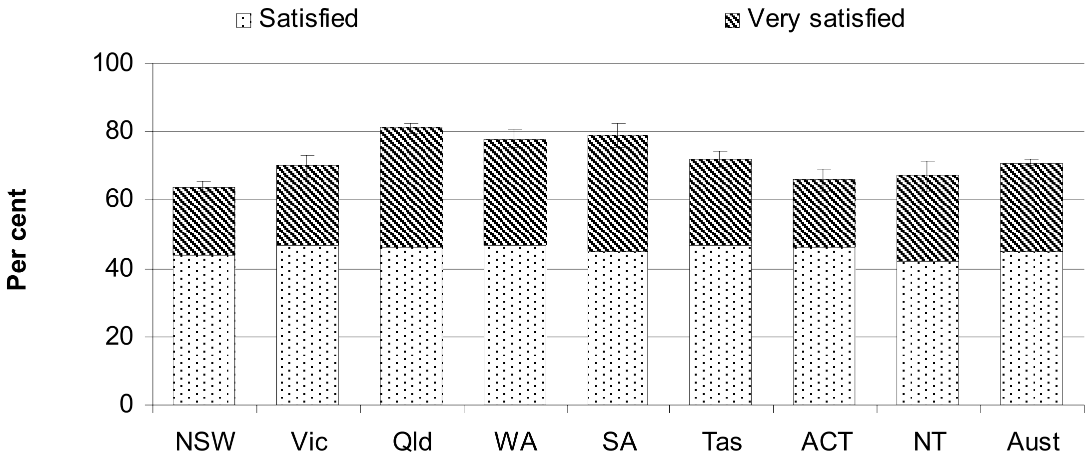
'Customer satisfaction' is an indicator of tenants' satisfaction with the overall service provided (box 16.17).

Box 16.17 **Customer satisfaction**

'Customer satisfaction' is an indicator of the CSHA guiding principle to provide housing assistance that is appropriate for different households. Customer satisfaction is a survey-based measure of satisfaction with the overall service provided by the State or Territory housing authority. A higher percentage for customer satisfaction may imply better housing assistance provision.

Data for public housing are sourced from the *2007 National Social Housing Survey* for public rental housing. Nationally in 2007, 71.0 per cent of tenants were either satisfied or very satisfied with the service provided (figure 16.12).

Figure 16.12 **Public housing — customer satisfaction, 2007**[a]



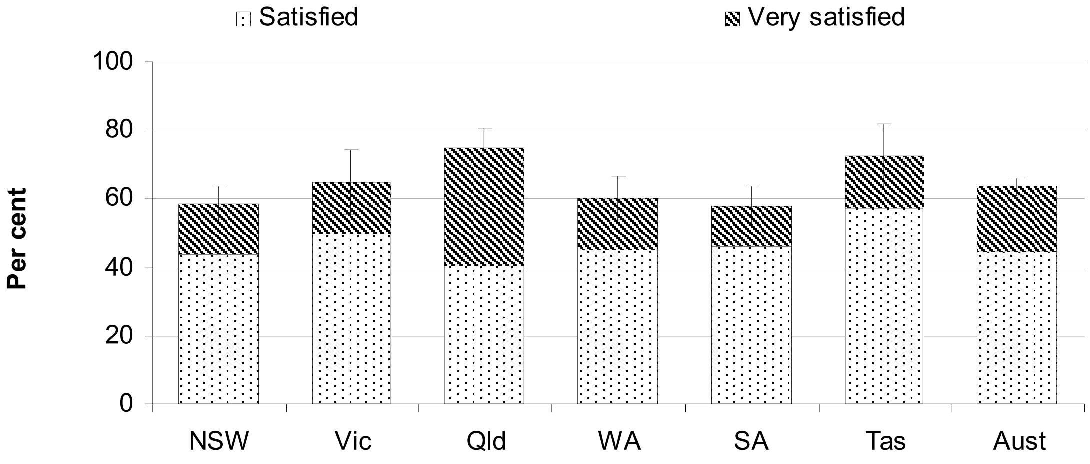
[a] Further information pertinent to the data included in this table and/or its interpretation is provided in table 16A.11.

Source: AIHW (2007a); table 16A.11.

Nationally, 57 per cent of Indigenous and 72 per cent of non-Indigenous public housing tenants were either satisfied or very satisfied with the overall service provided by their State housing authority in 2007 (AIHW 2007a).

Results for SOMIH are taken from the 2007 National Social Housing Survey for SOMIH. Nationally, 64 per cent of respondents were either satisfied or very satisfied with the overall service provided by their State housing authority (figure 16.13).

Figure 16.13 **SOMIH — customer satisfaction, 2007**[a]



[a] Further information pertinent to the data included in this table and/or its interpretation is provided in table 16A.22.

Source: AIHW (2007c); table 16A.22.

Affordability

'Affordability' is an indicator of tenants' ability to access suitable housing (box 16.18).

Box 16.18 **Affordability**

'Affordability' is an indicator of the level of housing affordability for CSHA housing tenants. Two measures are reported:

- average weekly rental subsidy per household, derived by dividing the total rental rebate amount by the total number of households
- the proportion of rebated households spending less than 30 per cent of their income in rent.

Higher values of these measures imply greater housing affordability.

The average weekly subsidy per household and the proportion of households spending less than 30 per cent of their income in rent for public housing at 30 June 2007 are presented in table 16.21. Information on the amount of income paid in rent by households as a proportion of income can be found in table 16A.80.

Table 16.21 **Public housing — average weekly subsidy per household and proportion of households spending 30 per cent or less of their income in rent**[a]

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Average weekly subsidy per household ($)									
2007	108.5	68.0	96.1	49.6	64.0	46.0	131.1	95.9	86.3
Proportion of rebated households spending 30 per cent or less of their income in rent									
2007	100.0	99.9	100.0	99.5	99.9	100.0	99.3	98.9	99.8

[a] Data may not be comparable between jurisdictions and comparisons could be misleading. Reasons for this are provided in table 16A.12.

Source: AIHW (2003c, 2004c, 2005c, 2006d, 2007a); table 16A.12.

The average weekly subsidy per household and the proportion of rebated households spending less than 30 per cent of their income in rent for SOMIH at 30 June 2007 are presented in table 16.22. Information on the amount of income paid in rent by SOMIH tenants as a proportion of income can be found in table 16A.81.

Table 16.22 **SOMIH — average weekly subsidy per household and proportion of households spending 30 per cent or less of their income in rent**[a]

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*Total*
Average weekly subsidy per household ($)							
2007	85.5	81.2	88.5	61.7	78.2	54.4	79.8
Proportion of rebated households spending 30 per cent or less of their income in rent							
2007	100.0	100.0	99.9	99.6	99.1	100.0	99.1

[a] Data may not be comparable between jurisdictions and comparisons could be misleading. Reasons for this are provided in table 16A.23.

Source: AIHW (2003a, 2004a, 2005a, 2006a, 2007c); table 16A.23.

Match of dwelling to household size

'Match of dwelling to household size' is an indicator of housing appropriateness (box 16.19).

Box 16.19 **Match of dwelling to household size**

'Match of dwelling to household size' is an indicator of the CSHA guiding principle to provide housing assistance that is appropriate to the needs of different households, such as household size. It measures the proportion of households where dwelling size is not appropriate due to overcrowding. The indicator uses a proxy occupancy standard based on the size of the dwelling and household structure (see table below). Overcrowding is deemed to have occurred where two or more additional bedrooms are required to satisfy the proxy occupancy standard.

The proxy occupancy standard was revised in 2005-06 to remove the four bedroom cap. Data prior to 2005–06 should not be compared with data from later years.

Proxy occupancy standard for appropriate sized dwelling, by household structure

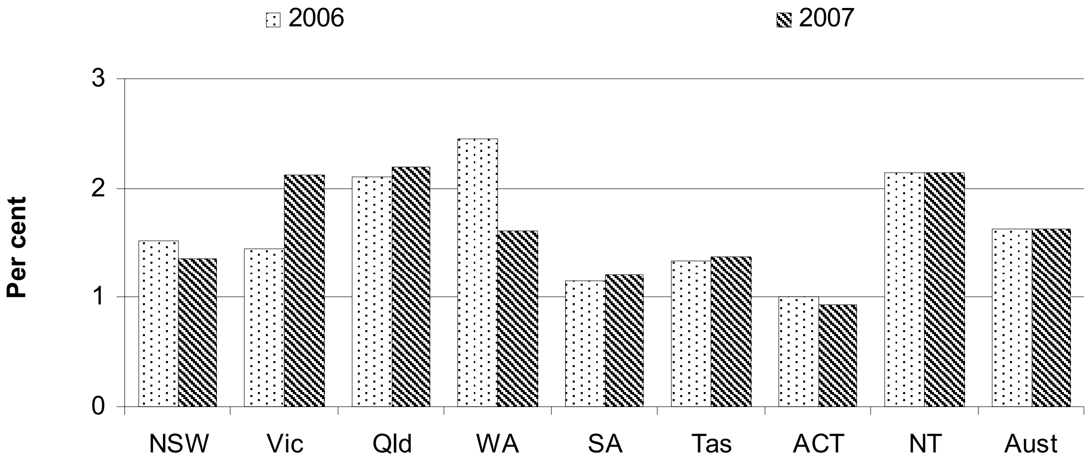
Household structure	*Bedrooms required*
Single adult only	1 bedroom
Single adult (group)	1 bedroom (per adult)
Couple with no children	2 bedrooms
Sole parent or couple with one child	2 bedrooms
Sole parent or couple with two or three children	3 bedrooms
Sole parent or couple with four children	4 bedrooms
Sole parent or couple with more than four children	equal to number of children

Source: AIHW (2006b).

A low proportion indicates a low proportion of overcrowded households.

Multi-income unit households are now included for all jurisdictions except Tasmania and the NT. The proportion of households with overcrowding for public housing is illustrated in figure 16.14. Information on moderate overcrowding and underutilisation for public housing can be found in table 16A.83.

Figure 16.14 **Public housing — proportion of households with overcrowding**[a, b]



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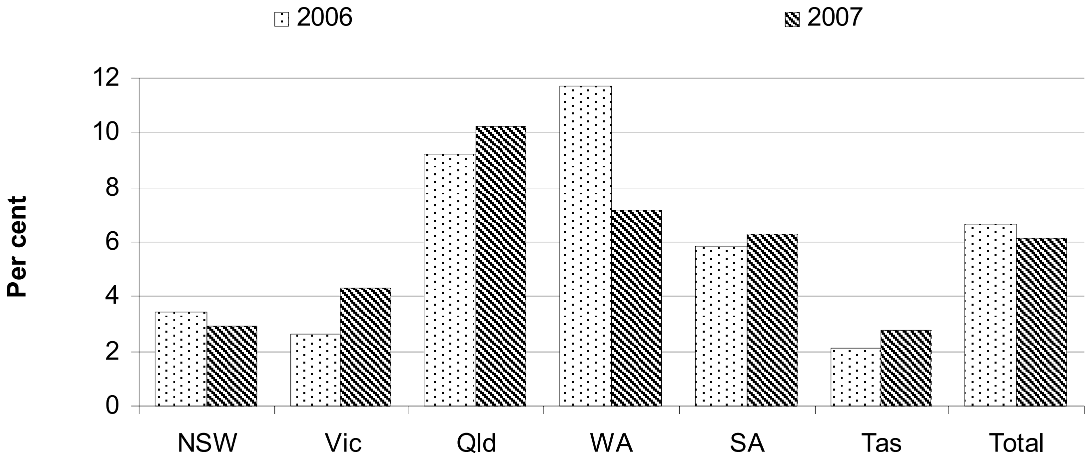
[a] Data may not be comparable between jurisdictions and over time and comparisons could be misleading. Reasons for this are provided in table 16A.13. [b] The proxy occupancy standard was revised to remove the four bedroom cap for the 2006 data. Data from previous years can not be compared.

Source: AIHW (2007a); table 16A.13.

The proportion of households with overcrowding for SOMIH is illustrated in figure 16.15. Information on moderate overcrowding and underutilisation for SOMIH can be found in table 16A.84.

Figure 16.15 **SOMIH — proportion of households with overcrowding**[a, b]



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[a] Data may not be comparable between jurisdictions and over time and comparisons could be misleading. Reasons for this are provided in table 16A.24. [b] The proxy occupancy standard was revised to remove the four bedroom cap for the 2006 data. Data from previous years can not be compared.

Source: AIHW (2007c); table 16A.24.

CSHA funded community housing

The performance indicator framework for CSHA funded community housing is presented in figure 16.5.

This section includes data on 10 performance indicators in the framework (figure 16.5).

CSHA funded community housing data have three sources:

- Jurisdictions' administrative data, provided by the State or Territory government body with responsibility for administering the community housing program in the jurisdiction. The NT provided only administrative data, as they currently do not survey their providers.
- Community housing provider survey data, collected from the community organisations (providers) that manage the service delivery.
- Survey data collected via the National Social Housing Survey.

For the CSHA funded community housing provider survey data, response rates, along with changes to the definitions and counting rules used over time, can influence the comparability of the data. Comparisons over time therefore need to be made with care. Table 16A.89 outlines the survey response rates and associated information for each jurisdiction for each year from 2001-02 to 2006-07. Performance indicator results are not comparable between public, community housing, SOMIH and Indigenous community housing sections.

Some descriptive data on community housing are contained in table 16A.25. Table 16A.76 lists State and Territory programs included in the CSHA funded community housing data collection.

Outputs

The following indicators measure the outputs of CSHA funded community housing. Outputs are the actual services delivered (while outcomes are the impact of these services on the status of an individual or group) (see chapter 1, section 1.5).

Equity — low income

The first equity indicator reported for CSHA funded community housing is 'low income' (box 16.20).

Box 16.20 **Low income**

‘Low income’ is an indicator of the CSHA guiding principle to provide appropriate, affordable and secure housing assistance to people who are unable to access suitable housing. This indicator assesses the low income need status of all households receiving assistance. It measures the number of low income households as a proportion of all households (new and existing). A high proportion indicates a high degree of access by low income households.

The low income indicator is measured differently for CSHA funded community housing than for public housing. The CSHA funded community housing indicator is based on the low income B cut-offs used in the public rental housing data collection. Data are reported on all households, rather than just new households.

At 30 June 2007, across those jurisdictions able to provide data, the number of low income households as a proportion of all households is presented in table 16.23.

Table 16.23 **Community housing — the number of low income households as a proportion of all households**[a]

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
2003	96.6	100.0	95.7	37.4	89.8	53.3	92.4	na	88.2
2004	96.6	99.5	93.3	95.7	94.0	72.2	95.6	na	95.6
2005	88.9	98.5	98.2	87.5	91.6	93.5	97.5	na	91.8
2006	89.8	93.8	81.9	97.8	97.3	95.1	97.7	na	90.3
2007	89.2	98.2	95.3	99.6	99.7	91.5	97.9	na	93.6

a Data may not be comparable between jurisdictions and over time and comparisons could be misleading. Reasons for this are provided in table 16A.26. **na** Not available.

Source: AIHW (2003b, 2004b, 2005b, 2007d, 2008); table 16A.26.

Equity — special needs

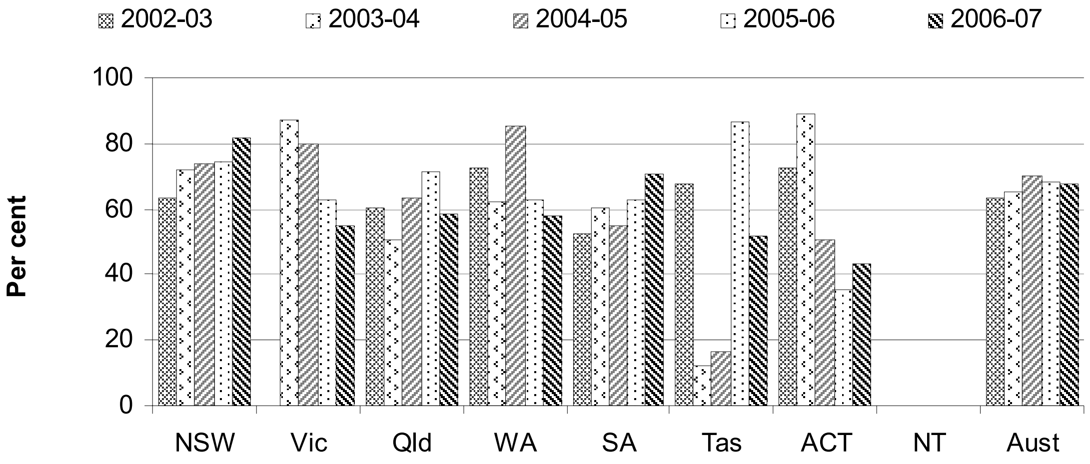
The second equity indicator reported for CSHA funded community housing is ‘special needs’ (box 16.21).

Box 16.21 **Special needs**

‘Special needs’ is an indicator of the CSHA guiding principle to provide appropriate, affordable and secure housing assistance to people who are unable to access suitable housing. It measures the proportion of new tenancies allocated to special needs households. The proportion of new tenancies with special needs are reported as a proxy for measuring all households with special needs. Special needs households are defined as those households that have either a household member with a disability, a principal tenant aged 24 years or under, or 75 years or over, or one or more Indigenous members. A high proportion indicates a high degree of access by these special needs households.

The proportion of new tenancies allocated to special needs households in 2006-07 is presented in figure 16.16.

Figure 16.16 **Community housing — new tenancies allocated to households with special needs**[a, b]



[a] Data may not be comparable between jurisdictions and over time and comparisons could be misleading. Reasons for this are provided in table 16A.27. [b] Data for Victoria for 2002-03 and the NT are not available.

Source: AIHW (2003b, 2004b, 2005b, 2007d, 2008); table 16A.27.

Equity — priority access to those in greatest need

The final equity indicator reported for CSHA funded community housing is ‘priority access to those in greatest need’ (box 16.22).

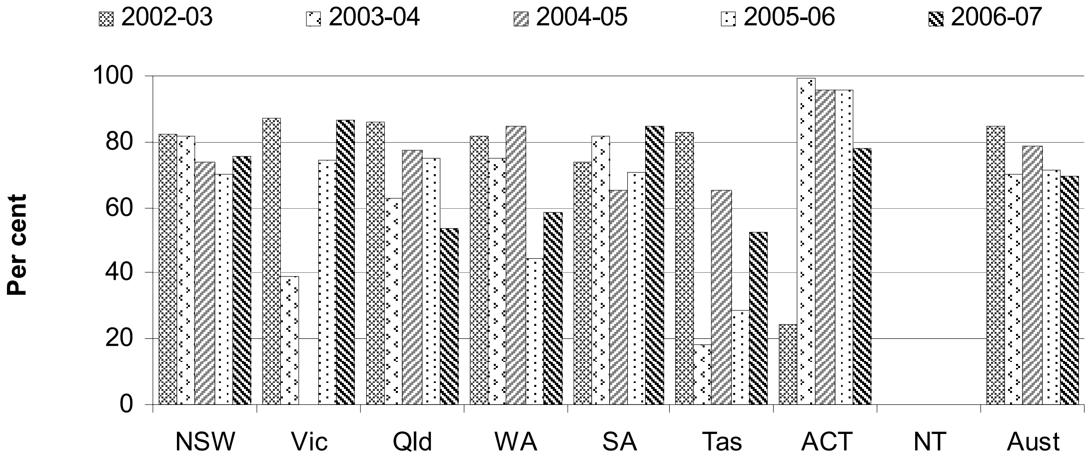
Box 16.22 **Priority access to those in greatest need**

'Priority access to those in greatest need' is an indicator of the CSHA guiding principle to provide appropriate, affordable and secure housing to assist people who are unable to access suitable housing. This indicator provides information on whether allocation processes are such that those in greatest need have first access to housing. It measures the proportion of new allocations to those in greatest need.

Greatest need households are defined as low income households that at the time of allocation are homeless, in housing inappropriate to their needs, or in housing that is adversely affecting their health or placing their life and safety at risk, or that have very high rental housing costs. High values for this indicator represent a high degree of access by those in greatest need.

The proportion of new allocations to those in greatest need is presented in figure 16.17. Differences in community housing allocation policies can influence comparability for this indicator across jurisdictions.

Figure 16.17 **Community housing — proportion of new allocations to those in greatest need**[a, b]



[a] Data may not be comparable between jurisdictions and over time and comparisons could be misleading. Reasons for this are provided in table 16A.28. [b] Data for Victoria for 2004-05 and the NT are not available.

Source: AIHW (2003b, 2004b, 2005b, 2007d, 2008); table 16A.28.

Efficiency — net recurrent cost per dwelling

The first efficiency indicator for CSHA funded community housing is 'net recurrent cost per dwelling' (box 16.23).

Box 16.23 **Net recurrent cost per dwelling**

‘Net recurrent cost per dwelling’ is an indicator of the CSHA guiding principle to undertake efficient and cost-effective management. It measures the average cost of providing assistance per dwelling. ‘Net recurrent cost per dwelling’ can be defined as the total administration costs and the costs of maintaining operation of dwellings. It does not include any cost of capital.

Holding other factors equal, a lower net recurrent cost per unit suggests an improvement in efficiency. The cost per dwelling indicators do not provide any information on the quality of service provided (for example, the standard of dwellings).

Capital cost data for CSHA community housing are not included in the 2008 Report as no data on value of assets are available.

The ‘net recurrent cost per dwelling’ at 30 June 2006 is presented in table 16.24. For community housing, data on direct cost per unit are reported with a one year lag to allow community housing providers an extra year to collate financial data.

Table 16.24 **Community housing — net recurrent cost per dwelling (2006-07 dollars)[a, b]**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Net recurrent cost of providing assistance (excluding the cost capital) per dwelling									
2001-02	3 209	na	3 798	4 534	4 262	8 533	na	na	3 786
2002-03	9 174	4 200	4 779	5 762	4 979	5 906	na	na	6 433
2003-04	10 125	5 672	4 710	8 629	4 118	8 466	na	na	7 167
2004-05	9 854	6 988	5 774	8 399	7 332	11 913	na	na	8 118
2005-06	8 326	6 764	4 459	9 415	7 512	9 547	na	na	7 411

a Data may not be comparable between jurisdictions and comparisons could be misleading. Reasons for this are provided in table 16A.29. **b** Data are presented in real dollars based on the ABS Gross Domestic Product price deflator (index) (2006-07 = 100) table AA.26. **na** Not available.

Source: AIHW (2003b, 2004b, 2005b, 2007d, 2008); table 16A.29.

Efficiency — occupancy rate

A second efficiency indicator reported for CSHA funded community housing is the ‘occupancy rate’ (box 16.24).

Box 16.24 **Occupancy rate**

The ‘occupancy rate’ is an indicator of the CSHA guiding principle to measure the efficiency of housing utilisation. It is the proportion of dwellings occupied. The term ‘occupied dwelling’ refers to dwellings occupied by tenants who have a tenancy agreement with the relevant CSHA funded community housing organisation. A higher occupancy rate suggests higher efficiency of housing utilisation. Occupancy is influenced by both turnover and housing supply.

The proportion of community housing dwellings occupied at 30 June 2007 is presented in table 16.25. The NT occupancy rates are based on the assumption that all dwellings are occupied.

Table 16.25 **Community housing — occupancy rates (per cent)**[a]

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
2003	97.8	96.3	96.1	100.4	95.6	98.3	97.4	100.0	97.0
2004	98.6	98.1	95.0	99.8	95.4	99.8	95.8	100.0	97.5
2005	98.2	94.5	95.7	98.0	95.1	98.9	89.8	100.0	96.5
2006	98.4	93.7	97.2	94.1	96.5	99.8	89.8	100.0	96.6
2007	97.2	96.6	96.6	96.1	96.8	98.5	90.4	100.0	96.7

[a] Data may not be comparable between jurisdictions and over time and comparisons could be misleading. Reasons for this are provided in table 16A.30.

Source: AIHW (2003b, 2004b, 2005b, 2007d, 2008); table 16A.30.

Efficiency — turnaround time

The third efficiency indicator for CSHA funded community housing is ‘turnaround time’ (box 16.25). Current data for turnaround time are not available for community housing due data quality issues. Data for this indicator were last reported in the 2006 Report.

Box 16.25 **Turnaround time**

‘Turnaround time’ is an indicator of the CSHA guiding principle to undertake efficient and cost-effective management of the time taken to reallocate normally vacant properties after they have been vacated, acquired or newly constructed. The indicator measures the average time taken in days for normal vacant dwellings to be occupied. The length of time taken to rent untenanted dwellings affects allocations of housing, waiting times, the length of waiting lists and rent foregone. A low turnaround time suggests efficient housing allocation. All jurisdictions aim to minimise turnaround times.

‘Normal’ vacancies exclude properties that are offline or are undergoing major redevelopment and where there is no suitable applicant but include hard-to-let properties as this relates to tenancy management.

Efficiency — rent collection rate

The fourth efficiency indicator reported for community housing is ‘rent collection rate’ (box 16.26).

Box 16.26 **Rent collection rate**

‘Rent collection rate’ is an indicator of the CSHA guiding principle to undertake efficient and cost-effective management. It is the total rent actually collected as a proportion of the rent charged. A high proportion suggests efficiency in collecting rent. All jurisdictions aim to maximise the rent collected as a proportion of the rent charged.

Differences in recognition policies, write-off practices, the treatment of disputed amounts, and the treatment of payment arrangements may affect the comparability of this indicator’s reported results. Payment arrangements for rent in some jurisdictions mean that rent collected over a 12 month period may be higher than rent charged over that period.

For CSHA funded community housing, data on the rent collection rate are reported with a one year lag to allow CSHA funded community housing providers an extra year to collate financial data (table 16.26). As with public housing, payment arrangements for rent in some jurisdictions mean the rent collected over a 12 month period may be higher than rent charged over that period.

Table 16.26 **Community housing — rent collection rate (per cent)**[a]

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
2001-02	98.5	na	92.6	97.5	97.9	98.7	98.9	na	97.1
2002-03	98.8	98.6	83.8	100.5	97.3	98.9	99.7	na	95.7
2003-04	99.4	96.1	98.6	98.0	97.8	101.2	92.6	na	98.3
2004-05	99.5	96.3	98.3	102.6	97.8	100.4	100.3	na	99.0
2005-06	98.8	99.6	99.6	100.5	98.0	98.5	97.3	na	99.1

[a] Data may not be comparable between jurisdictions and over time and comparisons could be misleading. Reasons for this are provided in table 16A.31. **na** Not available.

Source: AIHW (2003b, 2004b, 2005b, 2007d, 2008); table 16A.31.

Outcomes

The following indicators measure the outcomes of CSHA funded community housing. Outcomes are the impact of services on the status of an individual or group (while outputs are the actual services delivered) (see chapter 1, section 1.5).

Amenity/location

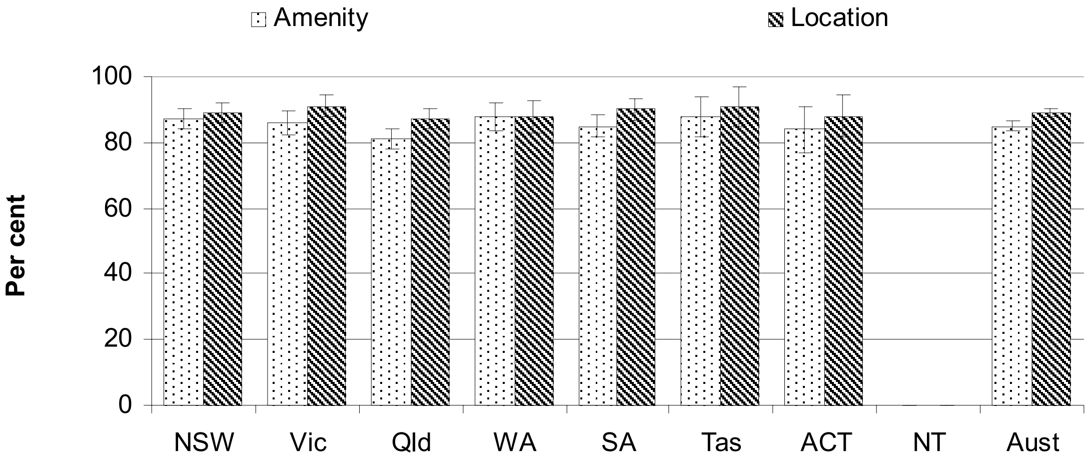
‘Amenity/location’ is an outcome indicator of success in meeting tenants’ needs (box 16.27).

Box 16.27 **Amenity/location**

‘Amenity/location’ is an indicator of the CSHA guiding principle to provide housing assistance that is appropriate to the needs of different households. The amenity/location indicator is a survey-based measure of the percentage of tenants rating amenity/location aspects of their dwelling as important and as meeting their needs. A higher level of satisfaction with amenity and location suggests the provision of housing assistance satisfies household needs.

The data for this indicator are from the *2007 Community Housing National Social Housing Survey*. CSHA funded community housing tenants were asked whether particular aspects of the amenity and location of their dwellings were important to them and, if so, whether they felt their needs were met. The proportions of tenants satisfied with the amenity and location of their dwelling in March/April 2007 are presented in figure 16.18. As with public housing, the precision of survey estimates depends on the survey sample size (see the discussion of amenity/location for public housing). More information on the sample size is provided in tables 16A.32 and 16A.33.

Figure 16.18 **Community housing — proportion of tenants rating their current home as meeting their amenity and location needs, 2007**[a, b]



[a] Further information pertinent to the data included in this table and/or its interpretation is provided in tables 16A.32 and 16A.33. [b] Data for the NT are not available.

Source: AIHW (2008); tables 16A.32 and 16A.33.

Affordability

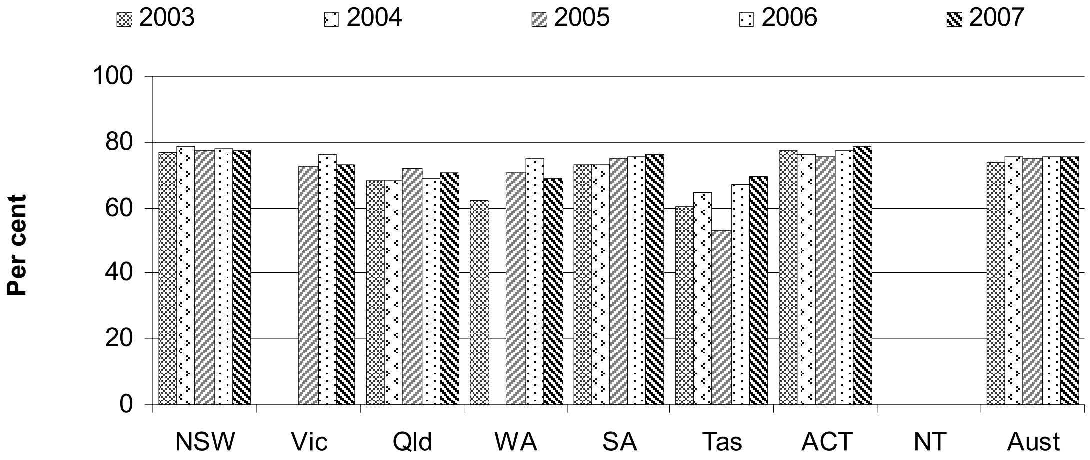
'Affordability' is an indicator of tenants' ability to access suitable housing (box 16.28).

Box 16.28 **Affordability**

'Affordability' is an indicator of the CSHA guiding principle to provide affordable housing to assist people who are unable to access suitable housing. It measures the proportion of household income left after paying rent. A high proportion indicates that housing is affordable. This affordability measure differs from that reported for public housing and SOMIH.

The proportion of household income left after paying rent is presented in figure 16.19. Differences in the definition of assessable income, including the treatment of CRA in rent assessment, may affect the comparability of this indicator's reported result. More information on affordability for community housing can be found in table 16A.82.

Figure 16.19 **Community housing — proportion of income left after paying rent**[a, b, c]



[a] Data may not be comparable between jurisdictions and over time and comparisons could be misleading. Reasons for this are provided in table 16A.34. [b] Data for the NT and Victoria for 2003 and 2004 are not available. [c] Data for WA for 2004 are not published.

Source: AIHW (2003b, 2004b, 2005b, 2007d, 2008); table 16A.34.

Match of dwelling to household size

'Match of dwelling to household size' is an indicator of appropriateness of community housing (box 16.29).

Box 16.29 **Match of dwelling to household size**

'Match of dwelling to household size' is an indicator of the CSHA guiding principle to provide housing assistance that is appropriate to the needs of different households, such as household size. It measures the proportion of households where dwelling size is not appropriate due to overcrowding. The indicator uses a proxy occupancy standard based on the size of the dwelling and household structure (see table below). Overcrowding is deemed to have occurred where two or more additional bedrooms are required to satisfy the proxy occupancy standard.

The proxy occupancy standard was revised in 2005-06 to remove the four bedroom cap. Data prior to 2005–06 should not be compared with data from later years.

Proxy occupancy standard for appropriate sized dwelling, by household structure

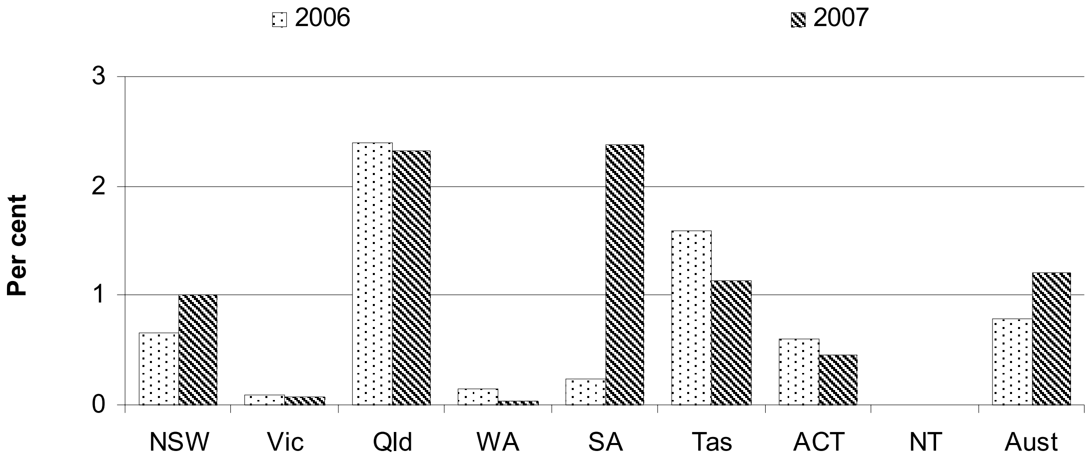
Household structure	*Bedrooms required*
Single adult only	1 bedroom
Single adult (group)	1 bedroom (per adult)
Couple with no children	2 bedrooms
Sole parent or couple with one child	2 bedrooms
Sole parent or couple with two or three children	3 bedrooms
Sole parent or couple with four children	4 bedrooms
Sole parent or couple with more than four children	equal to number of children

Source: AIHW (2006b).

A low proportion indicates a low proportion of overcrowded households.

The proportion of community households with overcrowding is illustrated in figure 16.20. Information on moderate overcrowding and underutilisation for CSHA funded community housing can be found in table 16A.85.

Figure 16.20 **Community housing — proportion of households with overcrowding**[a, b]



[a] Data may not be comparable between jurisdictions and over time and comparisons could be misleading. Reasons for this are provided in table 16A.35. [b] Data for the NT are not available.

Source: AIHW (2003b, 2004b, 2005b, 2007d, 2008); table 16A.35.

Customer satisfaction

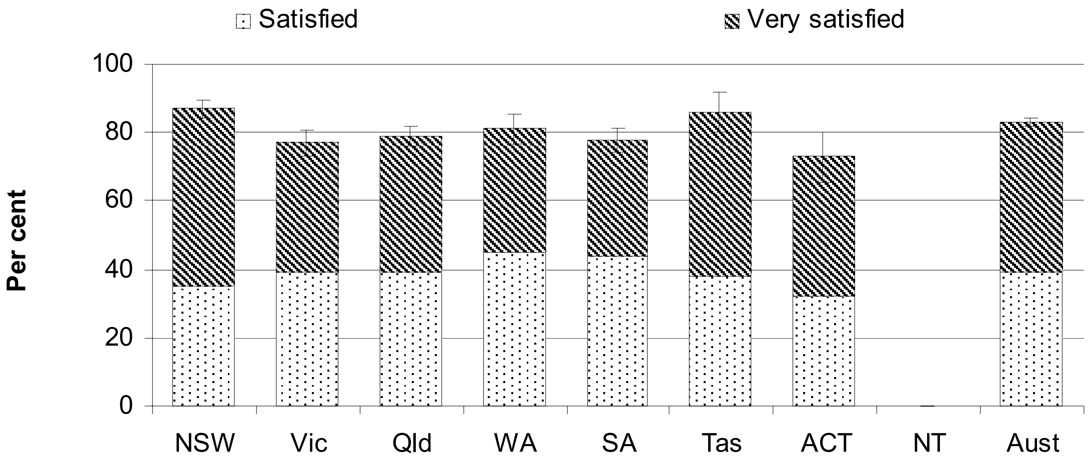
'Customer satisfaction' is an indicator of tenants' satisfaction with CSHA funded community housing (box 16.30).

Box 16.30 **Customer satisfaction**

'Customer satisfaction' is an indicator of the CSHA guiding principle to provide housing assistance that is appropriate to different households. Customer satisfaction is a survey measure of satisfaction with the overall service provided by the State or Territory housing authority. A higher proportion of satisfied customers may imply better housing assistance provision.

Data for this indicator are from the 2007 Community Housing National Social Housing Survey. Nationally, in March/April 2007, 83.0 per cent of tenants were satisfied or very satisfied with the services provided by their community housing organisation (figure 16.21).

Figure 16.21 **Community housing — customer satisfaction, 2007**[a, b]



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[a] Further information pertinent to the data included in this table and/or its interpretation is provided in table 16A.36. [b] Data for the NT are not available.

Source: AIHW (2008); table 16A.36.

Indigenous community housing

This section includes data on a number of performance indicators in the ICH framework (figure 16.6). The ICH data have been developed over the past few years but this is the first time a separate performance indicator framework for ICH has been included in the Report. The framework was based on the one used for public housing, but with some indicators developed specifically for ICH.

This section of the chapter focuses on the ICH performance indicator framework. The definition of Indigenous community housing is presented in box 16.31.

Box 16.31 **Indigenous community housing**

Indigenous community housing refers to housing funded by State or Federal governments that is managed and delivered by Indigenous community housing organisations. These organisations are responsible for asset and tenancy management functions.

Funding for Indigenous community housing comes through Australian Government programs such as the ARHP, CHIP and the National Aboriginal Health Strategy. State governments also provide funding for Indigenous community housing. In most jurisdictions (NSW, SA, WA, NT and the ACT), State and Federal funding is pooled and administered by the State governments. In Victoria and Tasmania only the Australian Government is involved in the administration of Indigenous community housing. In Queensland, some Indigenous community housing is administered by the State government and some by the Australian Government.

In May 2001, housing ministers endorsed a 10-year statement of new directions for Indigenous housing, *Building a Better Future: Indigenous housing to 2010* (BBF). BBF recognised that Indigenous housing was a major national issue requiring priority action and sought to improve housing and environmental health outcomes for Indigenous Australians. The focus of BBF was on: identifying and addressing outstanding need; improving the viability of Indigenous community housing organisations; establishing safe, healthy and sustainable housing for Indigenous Australians, especially in rural and remote communities; and establishing a national framework for the development and delivery of improved housing outcomes for Indigenous Australians by State, Territory and community housing providers.

The National Reporting Framework (NRF) for Indigenous Housing was developed to provide a framework for reporting across all Indigenous housing programs and on the implementation and outcomes of BBF. The NRF comprises a set of 38 performance indicators for national reporting and the AIHW collects annual data for reporting on these indicators. The latest report on the NRF is *Indigenous housing indicators 2005-06*.

Source: AIHW (2007b).

Outputs

The following indicators measure the outputs of Indigenous community housing. Outputs are the actual services delivered (while outcomes are the impact of these services on the status of an individual or group) (see chapter 1, section 1.5).

Equity — access

There are currently no equity — access indicators in the framework. Equity indicators may be included as the data are further developed.

Effectiveness — quality — connection to water, sewerage and electricity

The first effectiveness indicator of the quality of Indigenous community housing is 'connection to water, sewerage and electricity' (box 16.32).

Box 16.32 **Connection to water, sewerage and electricity**

'Connection to water, sewerage and electricity' is an output indicator of the Indigenous community housing guiding principle to provide quality housing. It measures the proportion of Indigenous community housing dwellings not connected to essential services. The indicator is defined as the number of permanent Indigenous community housing dwellings not connected to an organised water, sewerage and electricity system as a percentage of the total number of permanent dwellings. A lower percentage suggests higher housing quality.

The percentage of Indigenous community houses not connected to water, sewerage and electricity at 30 June 2006 is presented in table 16.27.

Table 16.27 Indigenous community housing — proportion not connected to water, sewerage and electricity, at 30 June 2006[a]

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aus Gov*	*Aust*
Water	–	..	–	–	–	..	–	4.7	0.1	1.7
Sewerage	–	..	–	–	–	..	–	6.4	0.5	2.4
Electricity	–	..	–	–	–	..	–	5.4	0.1	2.0

[a] Data may not be comparable between jurisdictions and comparisons could be misleading. Reasons for this are provided in tables 16A.38, 16A.39 and 16A.40. .. Not applicable. – Nil or rounded to zero.

Source: AIHW (2007b); tables 16A.38, 16A.39 and 16A.40.

Effectiveness — quality — dwelling condition

The second effectiveness indicator of the quality of Indigenous community housing is ‘dwelling condition’ (box 16.33).

Box 16.33 **Dwelling condition**

‘Dwelling condition’ is an output indicator of the Indigenous community housing guiding principle to provide quality housing. It shows the proportion of Indigenous community housing dwellings in poor condition and in need of major repair or replacement.

This indicator is defined as the number of permanent Indigenous community housing dwellings in need of either major repair or replacement as a percentage of the total number of permanent dwellings.

A lower proportion suggests higher housing quality.

The ‘dwelling condition’ indicator for Indigenous community housing in 2006 is presented in table 16.28.

Table 16.28 **Indigenous community housing — dwelling condition, 2006**[a]

	NSW (include ACT)[b]	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aus Gov*	*Aust*
Dwellings in need of major repair	18.8	24.7	26.3	27.9	22.4	30.6	..	21.0	..	23.4
Dwellings in need of replacement	2.7	4.5	5.9	10.1	5.8	–	..	10.2	..	7.2

[a] Data may not be comparable between jurisdictions and comparisons could be misleading. Reasons for this are provided in table 16A.41. [b] Data for the ACT data had been included with NSW due to low numbers. .. Not applicable. – Nil or rounded to zero.

Source: ABS (2007); table 16A.41.

Efficiency — net recurrent cost per unit

The first efficiency indicator reported for Indigenous community housing is ‘net recurrent cost per unit’ (box 16.34).

Box 16.34 **Net recurrent cost per unit**

‘Net recurrent cost per unit’ is an output indicator of the Indigenous community housing guiding principle to provide efficient and cost-effective management of housing. It measures the cost of providing assistance per dwelling. This indicator is total recurrent costs for Indigenous community housing divided by the total number of permanent dwellings. It includes the recurrent cost of delivering Indigenous community housing, but excludes capital cost.

A lower proportion suggests higher housing efficiency. The cost per dwelling indicators do not provide any information on the quality of service provided (for example, the standard of dwellings).

Data on net recurrent costs will be collected for 2006-07 onwards. For 2005-06, data are reported on direct cost per unit. The direct cost per unit for 2005-06 is presented in table 16.29.

Table 16.29 **Indigenous community housing — direct cost per unit, 2005-06**[a]

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aus Gov	Aust
2005-06	6 964.0	..	na	na	6 428.0	..	22 391.0	567.0	6 879.0	na

[a] Data may not be comparable between jurisdictions and comparisons could be misleading. Reasons for this are provided in table 16A.42. **na** Not available. .. Not applicable.

Source: AIHW (2007b); table 16A.42.

Efficiency — occupancy rate

A second efficiency indicator for Indigenous community housing is the 'occupancy rate' (box 16.35).

Box 16.35 **Occupancy rate**

The 'occupancy rate' is an indicator of the Indigenous community housing guiding principle to provide efficient housing utilisation. It is the proportion of dwellings occupied. The term 'occupied dwelling' refers to dwellings occupied by tenants who have a tenancy agreement with the relevant Indigenous community housing organisation. A higher occupancy rate suggests higher efficiency of housing utilisation. Occupancy is influenced by both turnover and housing supply.

The proportion of Indigenous community housing occupied at 30 June 2006 is presented in table 16.30.

Table 16.30 **Indigenous community housing — occupancy rates, at 30 June 2006 (per cent)**[a]

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aus Gov	Aust
2006	96.6	..	95.7	77.9	88.3	..	95.7	87.0	94.1	89.6

[a] Data may not be comparable between jurisdictions and comparisons could be misleading. Reasons for this are provided in table 16A.43. .. Not applicable.

Source: AIHW (2007b); table 16A.43.

Efficiency — rent collection rate

The third efficiency indicator for Indigenous community housing is the 'rent collection rate' (box 16.36).

Box 16.36 **Rent collection rate**

'Rent collection rate' is an indicator of the Indigenous community housing guiding principle to provide efficient and cost-effective management of housing. It is the total rent actually collected as a proportion of the rent charged. A high proportion suggests efficiency in collecting rent. All jurisdictions aim to maximise the rent collected as a proportion of the rent charged.

As with CSHA funded community housing, payment arrangements for rent in some jurisdictions mean the rent collected over a 12 month period may be higher than rent charged over that period.

'Rent collection rate' in 2005-06 is presented in table 16.31.

Table 16.31 **Indigenous community housing — rent collection rate (per cent)**[a]

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aus Gov*	*Aust*
2005-06	89.4	..	97.4	94.1	102.7	..	100.0	103.8	84.7	94.2

[a] Data may not be comparable between jurisdictions and comparisons could be misleading. Reasons for this are provided in table 16A.44. .. Not applicable.

Source: AIHW (2007b); table 16A.44.

Outcomes

The following indicators measure the outcomes of Indigenous community housing. Outcomes are the impact of services on the status of an individual or group (while outputs are the actual services delivered) (see chapter 1, section 1.5).

Amenity/location

The Steering Committee has identified 'amenity/location' as an indicator of the appropriateness of Indigenous community housing (box 16.37). Data for this indicator were not available for this Report.

Box 16.37 **Amenity/location**

‘Amenity/location’ is an indicator of the Indigenous community housing guiding principle to provide housing assistance that is appropriate to the needs of different households. The location/amenity indicator is a survey-based measure of the proportion of tenants rating location and amenity aspects as important and as meeting their needs. Higher levels of satisfaction with location and amenity imply the provision of housing assistance that satisfies household needs.

Affordability

‘Affordability’ is an indicator of access to Indigenous community housing (box 16.38).

Box 16.38 **Affordability**

‘Affordability’ is an indicator of the Indigenous community housing guiding principle to provide affordable housing to assist people who are unable to access suitable housing. The indicator provides a measure of the extent to which households are paying a large share of their income in rent.

This indicator is the number of Indigenous and mainstream community housing households in the bottom 40 per cent of equivalised incomes paying more than 25 per cent or more of their income in rent, divided by the total number of Indigenous community households.

A low proportion indicates that housing is more affordable. No administrative data are currently collected for this indicator, so ABS survey data from 2001 are reported.

The proportion of Indigenous community households in the bottom 40 per cent of equivalised incomes paying 25 per cent or more of their income on rent in 2001 is presented in table 16.32.

Table 16.32 **Indigenous community housing — proportion of households paying 25 per cent or more of their income on rent, 2001**[a]

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aus Gov*	*Aust*
2001	28.9	31.1	20.2	12.4	12.3	20.9	..	5.2	..	15.8

[a] Data may not be comparable between jurisdictions and comparisons could be misleading. Reasons for this are provided in table 16A.45. .. Not applicable.

Source: ABS (2002); table 16A.45.

Match of dwelling to household size

'Match of dwelling to household size' is an indicator of the appropriateness of Indigenous community housing (box 16.39).

Box 16.39 **Match of dwelling to household size**

'Match of dwelling to household size' is an outcome indicator of the Indigenous community housing guiding principle to provide housing assistance that is appropriate to the needs of different households, such as household size. It measures the proportion of households where dwelling size is not appropriate due to overcrowding. The indicator uses a proxy occupancy standard based on the size of the dwelling and household structure (see table below). Overcrowding is deemed to have occurred where two or more additional bedrooms are required to satisfy the proxy occupancy standard.

Proxy occupancy standard for appropriate sized dwelling, by household structure

Household structure	*Bedrooms required*
Single adult only	1 bedroom
Single adult (group)	1 bedroom (per adult)
Couple with no children	2 bedrooms
Sole parent or couple with one child	2 bedrooms
Sole parent or couple with two or three children	3 bedrooms
Sole parent or couple with four children	4 bedrooms
Sole parent or couple with more than four children	equal to number of children

Source: AIHW (2006b).

A low proportion indicates a low proportion of overcrowded households.

The proportion of Indigenous community households with overcrowding at 30 June 2006 is illustrated in table 16.33.

Table 16.33 **Indigenous community housing — proportion of households with overcrowding**[a]

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aus Gov*	*Aust*
2006	na	..	36.6	na	5.6	..	4.5	na	19.3	na

[a] Data may not be comparable between jurisdictions and comparisons could be misleading. Reasons for this are provided in table 16A.46. **na** Not available. .. Not applicable.

Source: AIHW (2007b); table 16A.46.

Customer satisfaction

The Steering Committee has identified ‘customer satisfaction’ as an outcome indicator of Indigenous community housing (box 16.40). Data for this indicator were not available for this Report.

Box 16.40 **Customer satisfaction**

‘Customer satisfaction’ is an outcome indicator of the Indigenous community housing guiding principle to provide housing assistance that is appropriate to different households. Customer satisfaction is a survey measure of satisfaction with the overall quality of service provided. A higher proportion of satisfied tenants may imply better housing assistance provision.

Commonwealth Rent Assistance

Data for CRA recipients are for individuals and families paid CRA by Centrelink under the *Social Security Act 1991* or family assistance law. It does not include equivalent payments made by the Department of Veterans Affairs, or payments made with Abstudy on behalf of DEST.

Data are generally for those entitled to CRA at 8 June 2007. Centrelink recorded 943 718 individuals and families as being entitled to CRA with a social security or family assistance payment for that day. Other published figures may include individuals and families who were paid CRA in the previous fortnight, some of whom were only entitled to payment for an earlier period (table 16.34).

Important eligibility requirements for CRA (which is paid automatically once eligibility has been established) are (1) the receipt of an income support payment or more than the base rate of the Family Tax Benefit Part A, and (2) liability to pay rent.

The performance indicator framework for CRA is presented in figure 16.7.

Outputs

The following indicators measure the outputs of CRA. Outputs are the actual services delivered (while outcomes are the impact of these services on the status of an individual or group) (see chapter 1, section 1.5).

Equity — access — income unit type

The first indicator of equitable access to CRA is ‘income unit type’ (box 16.41).

Box 16.41 **Income unit type**

Access to CRA by ‘income unit type’ is an indicator of the objective of CRA to provide financial assistance in an equitable manner. This indicator measures the number and proportion of eligible income support recipients receiving CRA by income unit type. The level of access experienced by different income unit types across states and territories is influenced by a number of factors, including (but not restricted to) the size of their respective base populations and the levels of home ownership. CRA is a demand driven payment that has no benchmark in terms of the mix of customers. This indicator provides descriptive information only.

Of the 943 718 income units entitled to receive CRA at 8 June 2007, 30 609 (approximately 3.2 per cent) self-identified as Indigenous. Single people with no children represented approximately 51.1 per cent of income units receiving CRA and 37.2 per cent of Indigenous income units receiving CRA (table 16.34). The figures for the total number and proportion of income units by the income unit type disaggregated at the jurisdiction level are presented in tables 16A.48, 16A.49, 16A.50 and 16A.51.

Table 16.34 **Income units receiving CRA, by income unit type, 2007**[a]

Type of income unit	*Income units*	*Proportion of CRA recipients*	*Indigenous income units*	*Proportion of Indigenous CRA recipients*
	no.	%	no.	%
Single, no dependent children aged under 16	364 673	38.6	9 001	29.4
Single, no children, sharer	117 874	12.5	2 395	7.8
Single, one or two dependent children aged under 16	185 871	19.7	7 916	25.9
Single, three or more dependent children aged under 16	36 501	3.9	2 736	8.9
Partnered, no dependent children aged under 16	82 048	8.7	1 752	5.7
Partnered, one or two dependent children aged under 16	106 530	11.3	4 060	13.3
Partnered, three or more dependent children aged under 16	47 394	5.0	2 607	8.5
Partnered, illness or temporarily separated	2 827	0.3	142	0.5
Unknown income unit	..	..	..	..
Total	943 718	100.0	30 609	100.0

[a] Further information pertinent to the data included in this table and/or its interpretation is provided in tables 16A.48, 16A.49, 16A.50 and 16A.51. .. Not applicable.

Source: FaCSIA (unpublished); tables 16A.48, 16A.49, 16A.50 and 16A.51.

Equity — access — special needs

The second indicator of equitable access to CRA is 'special needs' (box 16.42).

Box 16.42 **Special needs**

'Special needs' access to CRA is an indicator of the objective of CRA to provide income support recipients and low income families with financial assistance. This indicator provides the proportions of special needs income units receiving CRA, including Indigenous income units, those with a member receiving a Disability Support Pension and CRA recipients by geographic classification. This indicator provides an overview of the level of assistance provided to disadvantaged groups and facilitates comparison with special needs groups in public housing. CRA is a demand driven payment that has no benchmark in terms of the level of assistance provided to special needs customers. Additional measures of special need, which include a geographic dimension, are reported under 'affordability'.

Table 16.35 illustrates the number and proportion of income units receiving CRA at 8 June 2007 by jurisdiction, Indigenous status and geographic location.

Overall, 57.8 per cent of all income units receiving CRA at 8 June 2007 were in capital cities, while 42.2 per cent were in the rest of the State or Territory (FaCSIA unpublished). For Indigenous income units receiving CRA, 34.0 per cent were located in capital cities, while 66.0 per cent lived in the rest of the State or Territory. For non-Indigenous income units receiving CRA, 58.7 per cent were located in capital cities, while 41.3 per cent lived in the rest of the State or Territory (table 16.35).

People who own their own home are not entitled to CRA. Indigenous people receiving social security benefits are less likely to own their own home, and therefore are more likely to receive CRA. Nationally, 6.7 per cent of Indigenous income units receiving social security or family payments are homeowners, while 44.0 per cent of non-Indigenous income units receiving benefits are home owners (FaCSIA unpublished).[5]

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[5] Home ownership rate refers to the proportion of income units receiving a social security payment or more than the base rate Family Tax Benefit Part A recorded as owning or purchasing a home. It excludes those identified as living in special residences such as nursing homes, aged care and retirement villages, those residing overseas or living in caravan parks.

Table 16.35 Income units receiving CRA, by Indigenous status, disability support pension and geographic location, 2007[a]

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Non-Indigenous										
Income units	no.	312 242	206 091	217 063	74 518	67 170	23 535	na	4 276	912 371
In capital city	%	54.8	69.3	42.6	75.5	76.6	42.7	na	81.3	58.7
In rest of State	%	45.2	30.7	57.4	24.5	23.4	57.3	na	18.7	41.3
Non-Indigenous income units as proportion of all CRA recipient income units	%	96.2	98.9	95.4	96.7	97.9	95.4	na	81.3	96.7
Non-Indigenous population, as proportion of total population	%	97.9	99.4	96.6	96.5	98.2	96.2	98.7	70.9	97.6
Indigenous										
Income units	no.	12 129	2 133	10 150	2 484	1 443	1 131	138	960	30 578
In capital city	%	27.1	45.7	27.9	52.8	59.9	38.4	100.0	57.0	34.0
In rest of State	%	72.9	54.3	72.1	47.2	40.1	61.6	–	43.0	66.0
Indigenous income units as proportion of all CRA recipient income units	%	3.7	1.0	4.5	3.2	2.1	4.6	1.8	18.3	3.2
Indigenous population, as proportion of total population	%	2.1	0.6	3.4	3.5	1.8	3.8	1.3	29.1	2.4
Total income units	**no.**	**324 528**	**208 289**	**227 511**	**77 051**	**68 634**	**24 668**	**7 615**	**5 260**	**943 718**
Disability Support Pension										
In capital city	%	47.3	67.2	41.6	74.0	76.6	43.2	100.0	74.6	55.3
In rest of State	%	52.7	32.7	58.3	26.0	23.3	56.8	na	25.2	44.7
Total income units	**no.**	**61 039**	**42 590**	**43 964**	**14 828**	**13 993**	**5 054**	**1 005**	**1 137**	**183 638**

[a] Further information pertinent to the data included in this table and/or its interpretation is provided in table 16A.52. **na** Not available. – Nil or rounded to zero.

Source: FaCSIA (unpublished); table 16A.52.

Equity — access — geographic spread of CRA customers

The third indicator of equitable access to CRA is the 'geographic spread of CRA customers' (box 16.43).

Box 16.43 **Geographic spread of CRA customers**

The 'geographic spread of CRA recipients' provides descriptive information about rents, average levels of assistance, and the proportion of private rental stock occupied by CRA recipients within regions. This information is useful in examining differences across states and territories, and capital cities/rest of State. The indicator can provide some insight into the responsiveness of CRA to regional variations in rent and the extent to which recipients are able to exercise choice in where to live.

Two measures are presented:

- maps showing CRA recipients as a proportion of private rental stock (from 2006 Census) across Australia and within each capital city
- the average CRA entitlement across locations.

Additional measures of geographic spread are reported under 'affordability'.

Results for income units receiving CRA as a proportion of income units in each capital city receiving a social security income support benefit or more than the base rate of the Family Tax Benefit are mapped in tables 16A.53–16A.61. Information on the average CRA entitlement across locations is contained in table 16A.62.

The ratio of CRA recipients to private rental stock between and within capital cities varies but the patterns are complex. The maps should be interpreted with caution because they compare CRA recipients at 8 June 2007 with 2006 Census data and make no allowance for changes in private rental stock over that period (FaCSIA unpublished).

Effectiveness — appropriateness — maximum rate

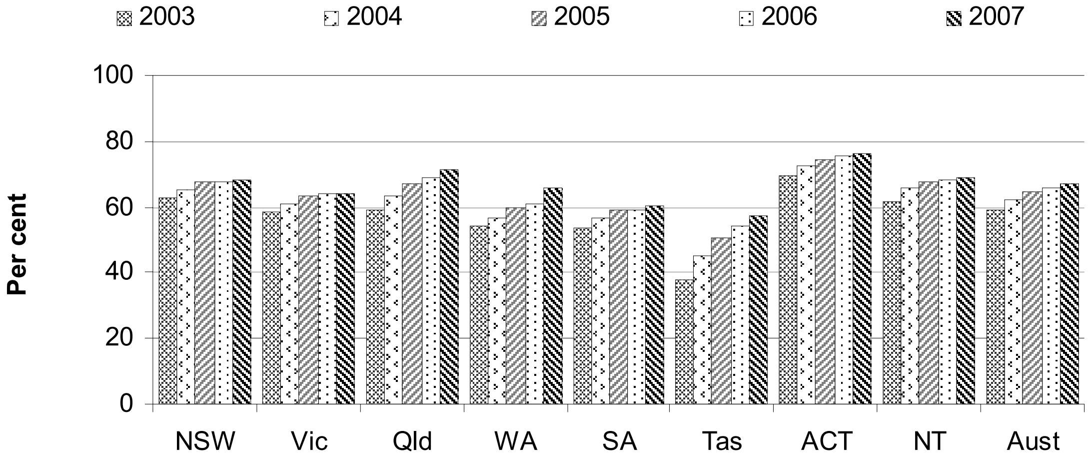
The first indicator of the effectiveness of CRA is the proportion of income units receiving the 'maximum rate of CRA', by jurisdiction and payment type (box 16.44).

Box 16.44 **Maximum rate of CRA**

The 'maximum rate of CRA' indicator is an indicator of the appropriateness of CRA. It measures the proportion of income units receiving the maximum rate of CRA, and can be used to monitor the adequacy of CRA over time. The effectiveness of the payment against rents is reflected in increasing/decreasing proportions of units on the maximum rates of assistance. An increasing proportion of income units receiving the maximum rate of assistance suggests that CRA is becoming less effective against rent increases. A decreasing proportion suggests that CRA is increasing faster than rents.

At 8 June 2007, 67.2 per cent of income units receiving CRA across Australia qualified for the maximum rate of CRA payments (figure 16.22). The figure indicates an upward trend in the measure over recent years.

Figure 16.22 **Proportion of income units receiving CRA paying enough rent to receive maximum assistance[a]**



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[a] Further information pertinent to the data included in this table and/or its interpretation is provided in table 16A.63.

Source: FaCSIA (unpublished); table 16A.63.

Effectiveness — appropriateness — number and outcome of appeals

The second indicator of the effectiveness of CRA is the 'number and outcome of appeals' (box 16.45).

Box 16.45 **Number and outcome of appeals**

The 'number and outcome of appeals' is an indicator of the appropriateness of decisions related to the payment of CRA. There is a formal review process for decisions related to the payment of CRA. Recipients who are dissatisfied with a decision are encouraged to discuss the matter with the original decision maker before taking the matter further, although this is not a necessary step. Authorised review officers conduct a quick and informal internal review of the decision. Generally, recipients who are dissatisfied with the authorised review officer's decision can appeal to the Social Security Appeals Tribunal, which is an independent body with decision making powers. Either the recipients or FaCSIA, the Department of Employment and Workplace Relations (DEWR) or DEST can seek an Administrative Appeals Tribunal review of the Social Security Appeals Tribunal's decisions. The indicator measures the outcomes of all CRA appeals finalised. A high proportion of original decisions affirmed would imply that the original decisions were appropriate.

There were 351 finalised appeals to an authorised review officer in 2006-07, which represented approximately 0.04 per cent of income units receiving CRA. The original decision was affirmed or appeal dismissed for approximately 59.5 per cent of finalised appeals to an authorised review officer, 72.7 per cent of appeals to the Social Security Appeals Tribunal and 60.0 per cent of appeals to the Administrative Tribunal (table 16.36).

Table 16.36 **Outcome of all CRA appeals finalised in 2006-07**[a]

Outcome	*Appeals to ARO*		*Appeals to SSAT*		*Appeals to AAT*	
	no.	%	no.	%	no.	%
Original decision affirmed or appeal dismissed	209	59.5	48	72.7	6	60.0
Original decision set aside	82	23.4	15	22.7	–	0.0
Original decision varied	47	13.4	–	–	2	20.0
Appeal withdrawn	13	3.7	3	4.6	2	20.0
Total finalised	**351**	**100.0**	**66**	**100.0**	**10**	**100.0**

ARO = Authorised Review Officer. SSAT = Social Security Appeals Tribunal. AAT = Administrative Appeals Tribunal

[a] Further information pertinent to the data included in this table and/or its interpretation is provided in table 16A.64. – Nil or rounded to zero.

Source: FaCSIA (unpublished); table 16A.64.

Effectiveness — targeting — duration of payments

'Duration of payments' is an indicator of the effectiveness of targeting of CRA (box 16.46).

Box 16.46 **Duration of payments**

'Duration of payments' is a targeting indicator which provides information on the level of long-term and short-term dependence on CRA payments. The indicator presents the number of recipients receiving CRA benefits at the beginning and at the end of the year, as well as the number of CRA recipients who were in receipt of CRA benefits at the beginning of the year and still in receipt a year later.

Nationally, 947 336 income units were entitled to receive CRA payments at March 2006, and 943 718 income units were entitled to receive CRA at 8 June 2007. Out of those, 674 185 income units were receiving CRA at both times, implying a high degree of dependence on CRA (table 16.37). The remaining 269 533 income units started to receive CRA during the year and were receiving assistance at the end of the year. Other families received assistance for only part of the year. Unpublished FaCSIA data show that while CRA was paid on average to just over one million individuals each fortnight in 2006-07, over 1.4 million individuals were entitled to assistance during the financial year (FaCSIA unpublished).

Table 16.37 **Duration of CRA payments, by State and Territory, 2007**[a]

State/Territory	*Number of Income units at the beginning of the year*	*Number of Income units at the end of the year*	*Number of same Income units at the beginning and the end of the year*
	no.	no.	no.
NSW	321 864	324 528	235 829
Victoria	208 367	208 289	148 522
Queensland	230 219	227 511	162 142
WA	81 222	77 051	55 251
SA	67 928	68 634	48 530
Tasmania	24 357	24 668	16 910
ACT	7 814	7 615	4 233
NT	5 335	5 260	2 691
Total	**947 336**	**943 718**	**674 185**

[a] Further information pertinent to the data included in this table and/or its interpretation is provided in table 16A.65.

Source: FaCSIA (unpublished); table 16A.65.

Efficiency — running costs per 1000 customers

The first efficiency indicator for CRA is 'running costs per 1000 customers' (box 16.47).

Box 16.47 **Running costs per 1000 customers**

‘Running costs per 1000 customers’ is an indicator of CRA’s guiding principle to provide financial assistance in an efficient manner. Low running costs per 1000 customers would imply high efficiency for a given service level.

Nationally, the running costs per 1000 customers were $57 300 for 2006-07 and $54 000 for 2005-06 (table 16A.66).

Efficiency — ratio of running costs to total outlays

The second efficiency indicator reported for CRA is the ‘ratio of running costs to total outlays’ (box 16.48).

Box 16.48 **Ratio of running costs to total outlays**

The ‘ratio of running costs to total outlays’ is an indicator of CRA’s guiding principle to provide financial assistance in an efficient manner. A low ratio would imply high efficiency for a given service level.

Nationally, the ratio of running costs to total outlays was 2.46 per cent for 2006-07 and 2.42 per cent for 2005-06 (table 16A.67).

Outcomes

The following indicators measure the outcomes of CRA. Outcomes are the impact of services on the status of an individual or group (while outputs are the actual services delivered) (see chapter 1, section 1.5).

Affordability

The first outcome indicator for CRA relates to ‘affordability’ (box 16.49).

Box 16.49 **Affordability**

‘Affordability’ is an indicator of the CRA objective to provide income support recipients and low income families in the private rental market with financial assistance. CRA is intended to improve affordability, not to achieve a particular benchmark. Program performance is best judged by trends over a number of years. This indicator measures the proportions of income units spending more than 30 per cent and 50 per cent of their income on rent with and without CRA. A lower proportion of recipients spending 30 per cent and 50 per cent of income on rent with CRA implies improved affordability.

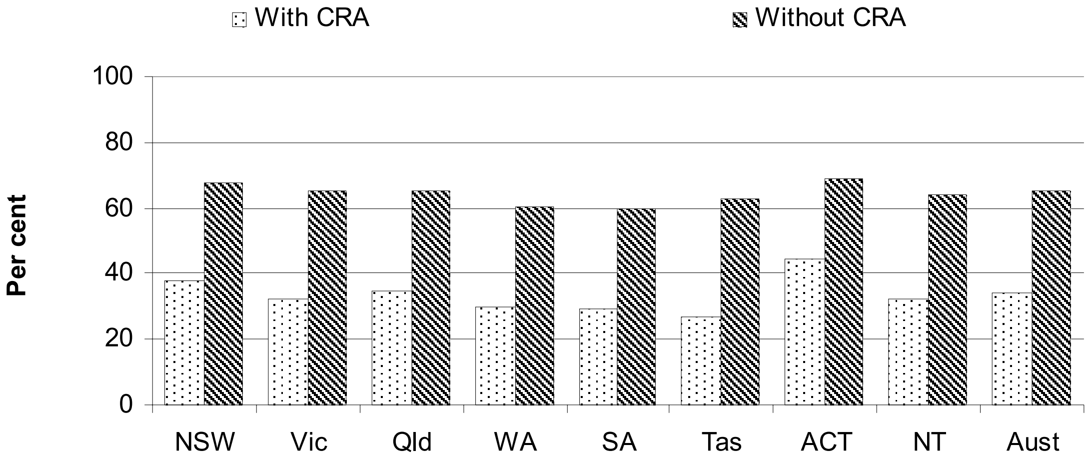
Affordability outcomes (with and without CRA) have been provided for all income units receiving CRA, Indigenous income units receiving CRA, and Disability Support Pension income units receiving CRA.

Information on the proportion of income spent on rent (with and without CRA) by Australians living in State capital cities and rest of State regions, income units where one or more members’ self-identify as Indigenous Australians and income units where one or more members receive a Disability Support Pension is presented in tables 16A.68–16A.70.

Nationally, if CRA were not payable, then at 8 June 2007, 65.3 per cent of income units receiving CRA would have paid more than 30 per cent of their income on rent. Accounting for CRA payments (thereby reducing the rent paid by the amount of the assistance) this proportion falls to 34.4 per cent (figure 16.23).

Without CRA, 25.2 per cent of recipients across Australia would have spent more than 50 per cent of their income on rent, while with CRA the proportion is 8.8 per cent (table 16A.71).

Figure 16.23 **Income units paying more than 30 per cent of income on rent, with and without CRA, 2007**[a]

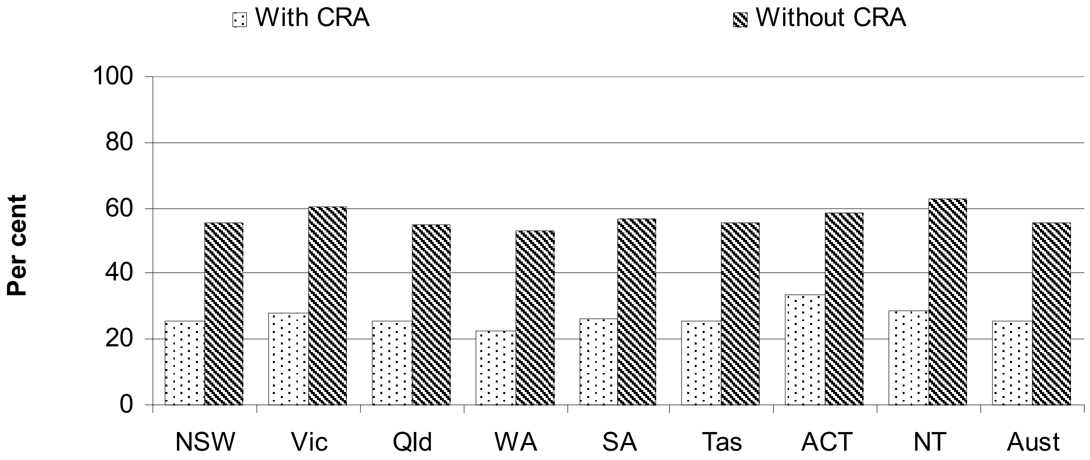


[a] Further information pertinent to the data included in this table and/or its interpretation is provided in table 16A.68.

Source: FaCSIA (unpublished); table 16A.68.

Nationally, if CRA were not payable, then 55.7 per cent of the Indigenous income units receiving CRA would have spent more than 30 per cent of income on rent at 8 June 2007. Taking CRA into account, this proportion falls to 25.7 per cent (figure 16.24). Similarly, if CRA were not payable, then 18.9 per cent of Indigenous income units across Australia would have spent more than 50 per cent of income on rent at 8 June 2007. Accounting for CRA payments this proportion decreases to 5.9 per cent (table 16A.71).

Figure 16.24 **Indigenous income units receiving CRA paying more than 30 per cent of income on rent, with and without CRA, 2007**[a]

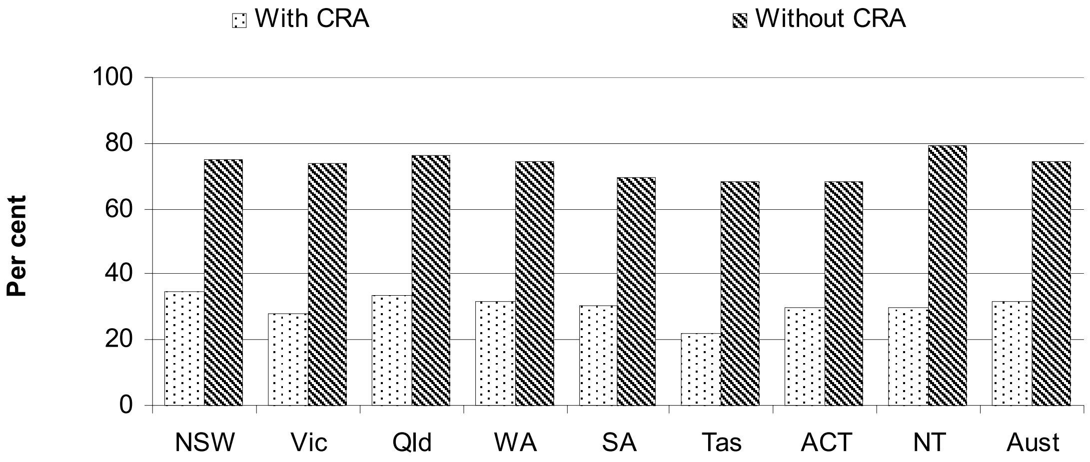


[a] Further information pertinent to the data included in this table and/or its interpretation is provided in table 16A.69.

Source: FaCSIA (unpublished); table 16A.69.

Nationally, if CRA were not payable, then 74.2 per cent of all income units with a member receiving a Disability Support Pension would have spent more than 30 per cent of income on rent at 8 June 2007. Accounting for CRA payments this proportion decreases to 31.8 per cent (figure 16.25). Similarly, if CRA were not payable, then 26.7 per cent of income units receiving a Disability Support Pension would have spent more than 50 per cent of income on rent at 8 June 2007. Accounting for CRA payments, this proportion decreases to 6.1 per cent (table 16A.71).

Figure 16.25 **Income units receiving a Disability Support Pension paying more than 30 per cent of income on rent, with and without CRA, 2007**[a]



[a] Further information pertinent to the data included in this table and/or its interpretation is provided in table 16A.70.

Source: FaCSIA (unpublished); table 16A.70.

Satisfaction with accommodation

'Satisfaction with location' and 'satisfaction with quality' are indicators of whether housing is appropriate to the needs of CRA recipients (box 16.50).

Box 16.50 **Satisfaction with accommodation**

'Satisfaction with location' and 'satisfaction with quality' are outcome indicators of customer satisfaction, and proxy measures of whether the housing is appropriate to the needs of CRA recipient.

Information about CRA recipients' satisfaction with their housing was obtained from a voluntary mail survey conducted in 2006. The overall response rate was approximately 38 per cent from the 10 000 recipients who were invited to participate. Results have been adjusted to compensate for differences in the response rates by age, payment type and family type.

Overall, 71 per cent of CRA recipients expressed a preference to stay in the area in which they live, while 10 per cent expressed a preference to leave the area. When asked about the adequacy of their home in meeting housing needs in general, 14 per cent considered their housing to be either less than adequate or much less than adequate, while 22 per cent considered it to be more than adequate or much more than adequate (table 16.38).

Table 16.38 **Satisfaction with location and quality of housing (per cent)**[a, b]

	Strong preference to stay	*Preference to stay*	*Unsure/no preference to stay or leave*	*Preference to leave*	*Strong preference to leave*
Satisfaction with location	43.3	27.6	19.2	5.6	4.3
	Much more than adequate	More than adequate	Adequate	Less than adequate	Much less than adequate
Satisfaction with quality	3.6	18.3	64.6	9.0	4.6

[a] Satisfaction with location of housing data were based on 3745 valid responses. [b] Satisfaction with quality of housing data were based on 3725 valid responses.

Source: FaCSIA (unpublished).

16.4 Future directions in performance reporting

Further developing indicators and data

Improved reporting on housing provision to Indigenous Australians continues to be a priority. All states, territories and the Australian Government have committed to improve reporting against the NRF, the nationally endorsed performance indicator framework for Indigenous housing.

Jurisdictions have implemented action plans to improve the availability and reliability of data on Indigenous Australians accessing mainstream housing assistance.

The Working Group will continue to improve the quality of mainstream community housing and financial data that are published in the Report.

16.5 Jurisdictions' comments

This section provides comments from each jurisdiction on the services covered in this chapter. Appendix A contains data that may assist in interpreting the performance indicators presented in this chapter. These data cover a range of demographic and geographic characteristics, including age profile, geographic distribution of the population, income levels, education levels, tenure of dwellings and cultural heritage (including Indigenous and ethnic status).

Australian Government comments

The 2003 Commonwealth State Housing Agreement (CSHA) aims to maintain a core Social Housing sector to assist people unable to access alternative housing options in the private rental market. The performance framework introduced under the 1999 CSHA continues to support the measurement of the guiding principles of the 2003 CSHA. The 2003 CSHA has a particular emphasis on timely reporting and demonstrated progress in achieving performance objectives.

A total of around $4.75 billion over five years to 2007-08 provides strategic direction and funding certainty. Programs funded include public housing, Aboriginal rental housing program (ARHP) community housing program (CHP) and CAP.

Over $232 million was also allocated in the 2006-07 budget through the CHIP to increase access to safe, healthy and sustainable housing and related services for Indigenous families and communities. CHIP provides for community housing and housing related environmental health infrastructure in rural and remote areas, and for community housing in urban areas. This funding was either directed through State and Territory governments or to specific community organisations.

Rent Assistance is provided as a financial supplement and has the flexibility to cope with changing demand and provide recipients with more choice about where to live and the quality of their housing. This choice can involve a trade-off with other expenses and with the consumer’s after-housing income.

The Rent Assistance program has no specific benchmark for affordability. The adoption of an affordability benchmark would fail to recognise the element of choice exercised by recipients who place a higher value on some aspects of their housing than others in comparable circumstances. Recipients may, for example, choose to pay higher rent for a property that is well-located, thus making a trade-off between housing and transport costs.

New South Wales Government comments

“

The Department of Housing manages the largest portfolio of public housing in Australia with over 126 000 properties. The community housing sector’s integral role in the provision of social housing continues to expand with over 14 000 properties now being managed in this sector. The Aboriginal Housing Office currently owns over 4200 properties, and funded/actively registered and non-actively registered Aboriginal housing providers manage about 5000 properties.

The Reshaping Public Housing reforms announced in 2005 are being progressively implemented. From October 2006, new tenants in public housing and Aboriginal Housing Office properties are given two, five or ten year fixed term leases matched to the duration of their housing need. Leases are renewed if need is ongoing. To support workforce participation, lease review income limits are higher than those applied when applying for public housing.

Growth and sustainability of community housing are key features of a five year draft strategy, NSW Planning for the Future: Community Housing released for consultation in April 2007. The sector is expected to more than double in size over the next ten years, increasing to 30 000 homes and expanding its role in affordable housing provision. Improving sustainability in the Aboriginal community managed housing sector is a key focus for the NSW Aboriginal Housing Office to build capacity and improve viability and governance of providers.

Social housing in NSW assists a growing number of clients with special needs often requiring support services to maintain tenancies. The Housing and Human Services Accord, a formal agreement between human service agencies launched in April 2007, is being implemented through a range of partnerships between government and non-government agencies to improve the sustainability of tenancies for mutual clients with complex needs.

The changing profile of clients assisted in social housing and the need to provide cost-effective services is driving a major reconfiguration of NSW public housing in terms of size, location and condition. The Department of Housing is also committed to environmentally sustainable housing design and is incorporating energy saving measures in new homes, retrofitting homes with water saving devices and encouraging tenants to use water and power efficiently.

Homeownership in NSW has become increasingly unaffordable for first home buyers, particularly over the last five years, and private rental has become a long term tenure for an increasing number of households. The NSW Government does not control the main levers to address this complex issue, but is committed to supporting a strong and viable social housing sector with innovative approaches to respond to changing needs and priorities in both mainstream and Aboriginal housing.

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Victorian Government comments

Victoria continued to expand the supply of social housing for low income Victorians in 2006-07, acquiring 930 social housing units (including leases). Of these, 839 were for long-term housing, including 51 for Indigenous housing and 91 properties for short-term housing provided through the Crisis and Supported Accommodation and Transitional Housing Management programs. Significant improvements were also made to 2933 existing social housing properties in line with the Government's commitment for Victorian tenants to have a decent home.

Expanding and strengthening the Housing Association sector is being used as a key vehicle to drive the provision of affordable housing in an environment of diminishing housing affordability in the private sector, declining grant funding under the Commonwealth State Housing Agreement and the ageing of social housing properties. Following the establishment of the Office of the Registrar of Housing Agencies in 2005-06, a registration pilot was launched in 2006-07 inviting agencies to register as Housing Associations or Providers under the *Housing Act 1983*. By June 2007, six agencies were registered as Housing Associations.

In 2006-07, partnership approaches led to the delivery of 326 new homes in collaboration with local government, community organisations, rental housing cooperatives and Housing Associations. The majority of these (251) were delivered through the State Government funded *Strategy for Growth for Low Income Victorians*.

During 2006-07, works commenced on the redevelopment of the Carlton public housing estate demonstrating Victoria's commitment to find new ways of improving public housing. Developers and financiers were publicly invited to lodge an Expression of Interest in the project.

In an environment of strong demand for public housing, Victoria has adopted a highly targeted approach to housing allocations, ensuring priority is given to people who are homeless, those with specific medial or support needs and those experiencing family violence. This has led to growing complexity of need and disadvantage among the public housing population. In response, the State Government funded Neighbourhood Renewal program is promoting economic participation in disadvantaged communities. Neighbourhood Renewal involves a whole-of-government approach, where the Office of Housing works with the Commonwealth and local governments, as well as the not-for-profit sector to assist public housing tenants in disadvantaged communities.

Neighbourhood Renewal is currently occurring in 19 areas in metropolitan Melbourne and regional Victoria. In 2006-07 the Neighbourhood Renewal program was fully rolled out in four new sites in West Heidelberg, East Reservoir, Delacombe (Ballarat) and Hastings.

Queensland Government comments

“ In response to the increasing demand for social housing, resulting from population growth and higher rents and house prices, Queensland is implementing an integrated system for providing people in housing need with simpler and fairer access to the range of housing assistance. A consolidation strategy is also being implemented, to encourage registered community housing providers to amalgamate, thereby creating a stronger and more integrated service delivery network.

The Housing Improvement Program has been implemented in the 34 Indigenous communities, to increase the supply and improve the standard of housing. In 2006-07, 91 new and replacement dwellings were constructed, 190 existing properties were upgraded, and significant maintenance was undertaken on more than 4000 properties, resulting in a marked improvement in the standard of living of the Indigenous residents.

Following the success of the Brisbane Housing Company, the Gold Coast Housing Company has been established (in collaboration with the Gold Coast City Council) to add to the housing options of low to moderate income households on the Gold Coast.

During 2006-07, more than 56 000 households received assistance through Home Assist Secure and the Home and Community Care Home Modification Service. These programs provide low-income clients with information and/or financial assistance for home maintenance, repairs and modifications to improve their personal security around the home.

Grant funding was also provided to 22 organisations which provide advice and advocacy to private renters, thereby assisting almost 70 000 households.

With many areas of Queensland affected by the drought, water has become a precious and increasingly scarce resource. To help tenants save water, water-efficient devices have been installed in 26 021 dwellings and information provided on ways to conserve water.

As part of the Responding to Homelessness initiative, Queensland has purchased and constructed additional dwellings and provided grant funding to community organisations to deliver housing related services to clients who are homeless or at risk of homelessness.

People with a mental illness have been assisted to live in the community, through the provision of housing combined with support. To date 53 clients with a mental illness who were previously residing in extended treatment or acute inpatient facilities have been assisted. Appropriate housing, community services and support have also been provided to 17 patients with spinal cord injuries exiting health facilities. ”

Western Australian Government comments

“Western Australia is currently experiencing an unprecedented economic growth with the 2.7 per cent unemployment figure being the lowest on record. The building industry is working at capacity with demand for housing and infrastructure outstripping supply. This presents a great challenge because it has resulted in significant increases in building costs. It has also led to reductions in the number of contractors tendering for building projects.

Western Australia’s economic success has resulted in unparalleled housing market conditions. Continued increases in the median house price and the median weekly rent in the private sector have continued to place pressure on the public housing waiting list and waiting times. During 2006-07 the waiting list for public housing increased from 13 780 to 15 438. The average waiting time increased from 74 weeks to 83 weeks. As well as being impacted by increases in house prices and private rents there has been a decrease in the number of people vacating public housing, which has been a contributing factor to the increase in waiting times. In addition, every effort is made to house priority applicants in three months. The increase in applicants with an urgent housing need, thus requiring priority assistance, has meant that other applicants with less urgent circumstances can expect extended waiting times for public rental housing.

A number of strategies have been developed to contribute to meeting the housing needs of Western Australians now and in the future. Areas being looked at include community housing, affordable private rental accommodation through expansion of the bonds assistance loans scheme, access to home ownership and strategies to sustain and grow social housing stock.

It is intended to address the increasing demand for social housing by implementing policies that will capacity build the community housing sector. This will allow unprecedented growth in the number of properties managed by the sector, while at the same time reducing the waiting list for public housing.

This year has seen a renewed focus on stock growth to help meet the ongoing demand for public rental housing. 861 new properties were purchased or constructed during 2006-07. The State Government is committed to providing more public housing — 1124 additional rental housing properties will be delivered in the next four years.

In February 2007, the First Start Shared Equity Scheme was launched. This scheme assists low to moderate income earners to own their own homes. With families and couples the Housing Authority will purchase up to 40 per cent equity in the home with the client purchasing 60 per cent. With single applicants the Authority will purchase up to 30 per cent equity with the client buying 70 per cent. Clients can increase their share when circumstances permit.”

South Australian Government comments

2006-07 has been an important year as we have implemented Housing Reforms to meet the targets of SA’s Strategic Plan and the Housing Plan for SA. Services were delivered through Housing SA under a Service Level Agreement between the South Australian Housing Trust, Aboriginal Housing Authority and South Australian Community Housing Authority Boards and the Department for Families and Communities.

During the year a number of significant initiatives were undertaken including:

- Announcement of the Affordable Homes Program to improve the financial viability of the social housing system by selling stock in a targeted way to create affordable housing outcomes (both rental and home ownership) for low to moderate income South Australians and to eliminate the debt the social housing system currently experiences.
- Development of a new Housing SA service delivery model based on offering the full continuum of housing options and coordinating effective packages of support for Housing SA customers with high needs.
- Commitment to three affordable and high need partnership projects to produce 87 houses. The three projects involve management by Not-For-Profit Organisations, various needs groups and combinations of partner equity, borrowing and CRA inclusive rent models.
- Management of approximately 50 000 properties and allocation of approximately 3300 properties to new public and Aboriginal tenants.
- Construction of 452 new social housing properties. All achieved 5 star energy ratings and met the Department’s Adaptability Standards.
- Provision of private rental accommodation assistance to approximately 17 000 low income South Australians through bond assistance and advance rental payments.
- Allocation of short term accommodation to 254 Aboriginal adults and 116 Aboriginal children in Wangka Wilurrara Accommodation Centre at Ceduna and 225 Aboriginal adults and 101 Aboriginal children in Lakeview Accommodation Centre at Port Augusta.
- Launch of the Vision Plan for Community Housing to progress the development of new models for Community Housing, new directions in regulation, and other new initiatives to build the capacity of the sector.

Tasmanian Government comments

The housing market in Tasmania continues to be characterised by declining affordability associated with increasing house prices and private rental costs. Demographically, Tasmania has an ageing population, a high proportion of lone person households and a high proportion of people with disabilities. These influences continue to shape the strategic development of a viable and sustainable social housing sector.

Working from the premise that housing plays a vital role in ensuring social, health and economic wellbeing, Housing Tasmania implemented a range of initiatives to increase the number of affordable housing options available for people on low incomes during 2006-07.

Five Community Housing grants totalling $3 million were provided to organisations providing accommodation options for refugees and displaced persons, people with disabilities and elderly people in need of affordable housing.

A new affordable housing organisation, Tasmanian Affordable Housing Limited (TAHL), was established to increase the supply of affordable housing in Tasmania. TAHL will be provided with up to $6 million per annum to establish up to 700 new affordable housing dwellings that will be leased to people on Housing Tasmania's wait list.

Also in 2006-07, an additional supported residential facility, Indigo Lodge was established in Northern Tasmania, providing supported accommodation for up to 30 people on low incomes.

The Service Delivery Review (SDR) was initiated as a priority project for Housing Tasmania in 2005 to address key issues identified by stakeholders in the context of a changing service environment. Stage 1 of the SDR has been completed and Stage 2 of the SDR has commenced and will introduce a new service delivery model, the Housing Implementation Project (HIP).

Under the HIP, a Supported Tenancies Framework and Tools project was introduced to increase access to support for clients with complex needs, a telephone enquiry service trialled, and an interactive website developed to increase access to information about housing options and support services.

Utilising Affordable Housing Strategy funding, the Private Rental Tenancy Support Service (PRTSS) continued to play an integral role in providing non-financial support to low income Tasmanians with complex needs to access and maintain private rental tenancies. The Private Rental Support Scheme (PRSS) also continued to provide rental, bond and removals assistance to people experiencing difficulty within the private rental market. While the number of people assisted through PRSS has declined over the past few years due to low vacancy rates of affordable private rental and greater client costs, the number of people accessing PRTSS almost doubled compared to last year. These trends reflect a tight private rental market, increasing private rental costs and increasing complexity of client need.

Australian Capital Territory Government comments

During 2006-07 the ACT Government introduced a number of reforms to improve service delivery to tenants and applicants whilst reducing operating costs to national benchmarks. This has resulted in a significant improvement in the average costs of public housing provision in the ACT as reflected in this report.

The ACT Government has made a capital investment of $30 million over 3 years for new housing stock. In the first year, 25 properties have been acquired for families at risk. Housing ACT has also continued to drive improved outcomes in the management of the housing portfolio, including greater value for money on repairs and maintenance.

In early June 2006 a range of amendments were made to the Public Rental Housing Assistance Program (PRHAP) to further sharpen its focus on people most in need of public housing assistance, including a new priority allocation system. The key objective of the new system has been to ensure timely allocations to those with priority needs. The new system includes a multi-disciplinary panel with human services expertise from government and non-government agencies to make assessment for priority housing applications.

The changes have resulted in significantly reduced waiting times for those most in need. The average waiting times for priority housing applications have reduced from 9 months to less than 3 months. The public housing waiting list now also accurately reflects the number of people who need public housing.

To build on these reforms, the Government announced policy changes to ensure the provision of public housing for the duration of need. Under the policy, Housing ACT will assess the circumstances of tenants with a sustained household income exceeding $80 000 and those with 2 or more spare bedrooms to identify the most appropriate housing option. The individual circumstances of affected tenants will be fully considered, with Housing ACT working with tenants who wish to explore alternative housing. These changes will be phased in over a number of years, commencing with properties with four or more bedrooms.

The ACT Legislative Assembly passed the *Housing Assistance Act 2007* in May 2007 to modernise the legislative framework for social housing in the ACT. The new Act replaces legislation that which was first enacted in 1987. The ACT Government has also introduced the Affordable Housing Action Plan to provide a range of solutions to support affordable home ownership and private rental, an expansion of the community housing sector, and additional public/private partnerships to increase the supply of affordable housing, including joint ventures between Housing ACT and the private sector. Under the Plan a shared equity scheme will be introduced that will allow public housing tenants to purchase a majority share of their home, with Housing ACT retaining the remaining equity.

Northern Territory Government comments

Under Closing the Gap, the Northern Territory's Indigenous generational plan of action, aimed at closing the gap in outcomes between Indigenous and non-Indigenous Territorians, the NT Government has decided to reform the funding, delivery and management of remote housing, and to roll-out an additional $100 million over five years to improve housing outcomes for Indigenous people living in remote communities. *Closing the Gap* also includes an additional $42.32 million investment in Government Employee Housing to underpin the delivery of important services in remote Indigenous communities.

The key objectives the NT Government's reforms to remote housing are to:

- deliver more housing at less cost
- manage housing better
- support more Indigenous employment and economic development
- support health and education outcomes.

The reform agenda will be supported by significant additional funding commitments from the Australian Government for remote housing.

Territory Housing has made significant progress developing the strategic directions of these reforms as well as developing new program approaches to ensure the reforms will commence implementation on 1 July 2008.

Territory Housing has completed a trial and is preparing to roll-out a new best practice housing management model. Territory Housing's operational functions within the model will be divided into the following three streams:

- tenancy management (focus on tenancy)
- clients services (focus on providing support to tenants)
- property management (focus on maintaining/improving assets).

This new management model will be implemented across the Territory, including in remote areas. This will ensure parity of service for all public housing clients.

HomeNorth Xtra is the NT Government's primary vehicle to assist low to medium income households in the Territory into home-ownership. Since 1991, the scheme has assisted over 2000 Territorians into home ownership. In 2007, HomeNorth Xtra was updated and both the income and upper purchase limits were revised to ensure that the scheme remains accessible for families. The fixed upper house price threshold was removed and replaced with variable regional price caps based on local median house prices. Additionally, the house price cap was removed for tenants wanting to buy their public housing dwelling.

The NT Government has announced the release of land for Bellamack, a new suburb of Palmerston. Bellamack will be an affordable suburb with fifteen per cent of the land set aside for affordable and social housing, including for first home buyers.

16.6 Definitions of key terms and indicators

Public, community, Indigenous community housing and SOMIH

Administration costs	Those costs associated with the administration offices of the property manager and tenancy manager. They include the general accounting and personnel function costs relating to: • employee expenses (for example, superannuation, compensation, accrued leave and training) • supplies and services expenses (including stationery, postage, telephone, office equipment, information systems and vehicle expenses) • rent • grants and subsidies (excluding rental subsidies) • expenditure incurred by other government agencies on behalf of the public housing agency • contracted public housing management services.
Affordability	‘Affordability’ is an outcome indicator that aims to measure housing affordability for CSHA housing tenants. Two measures are reported: • a subsidy per tenant derived by dividing the total rebated amount by the total number of households • the proportion of households spending less than 30 per cent of their income in rent.
Amenity/location (satisfaction)	A survey-based measure of the proportion of tenants rating amenity and location aspects as important and meeting their needs.
Assessable income	The income used to assess eligibility for housing assistance and to calculate the rental housing rebate that allows a household to pay a rent lower than the market rent. Definition may vary across jurisdictions.
Customer satisfaction	A survey measure of the proportion of customers expressing different degrees of satisfaction with the overall service provided.
Depreciation costs (as per the Australian Accounting Standards 13–17)	Depreciation calculated on a straight-line basis at a rate that realistically represents the useful life of the asset.
Direct costs	Total administration costs and the costs of maintaining the operation of dwellings.
Disability (as per the ABS Survey of Disability Ageing and Carers)	Any restriction or lack of ability (resulting from an impairment) to perform an action in the manner or within the range considered normal for a human being.
Dwelling	A structure or a discrete space within a structure intended for people to live in or where a person or group of people live. Thus a structure that people actually live in is a dwelling regardless of its intended purpose, but a vacant structure is only a dwelling if intended for human residence. A dwelling may include one or more rooms used as an office or workshop provided the dwelling is in residential use.
Greatest need	Low income households that at the time of allocation were subject to one or more of the following circumstances: • homelessness • their life or safety being at risk in their accommodation • their health condition being aggravated by their housing • their housing being inappropriate to their needs

	• their rental housing costs being very high.
Household	For the purpose of the public, community, SOMIH and ICH collections, the number of tenancy agreements is the proxy for counting the number of households. A tenancy agreement is defined as a formal written agreement between a household (a person or group of people) and a housing provider, specifying details of a tenancy for a particular dwelling.
Indigenous household	A household with one or more members (including children) who identify as Aboriginal and/or Torres Strait Islander.
Low income household	A public housing or SOMIH household whose members are assessed as having a low income according to the following definitions. Households are assigned an income status based on total household gross income and the composition of the household: • low income A households are those in which all household members have incomes at or below the maximum pension rate • low income B households are those that have incomes that would enable them to receive government income support benefits below the maximum pension. A community housing household which has a gross weekly income equivalent to or below the income cut-off specified for their household composition is classified as low income. The community housing low income measure is based on the low income B cut-offs as outlined above.
Maintenance costs	Costs incurred to maintain the value of the asset or to restore an asset to its original condition. The definition includes day-to-day maintenance reflecting general wear and tear, cyclical maintenance, performed as part of a planned maintenance program and other maintenance, such as repairs as a result of vandalism.
Market rent	Aggregate market rent that would be collected if the public rental housing properties were available in the private market.
Match of dwelling to household size	The proportion of households where dwelling size is not appropriate due to overcrowding. The indicator uses a proxy occupancy standard based on the size of the dwelling and household structure. Overcrowding is deemed to have occurred where two or more additional bedrooms are required to satisfy the proxy occupancy standard.
Moderate overcrowding	Where one additional bedroom is required to satisfy the proxy occupancy standard.
Net recurrent cost	The average cost of providing assistance (excluding the cost of capital) per dwelling. The formula is ‘total net recurrent costs for the year ending 30 June’ divided by ‘total number of dwellings at 30 June’.
New household	Households that commence receiving assistance for the financial year.
Occupancy rate	The proportion of dwellings occupied.
Occupied dwelling	Dwellings occupied by tenants who have a tenancy agreement with the relevant housing authority.
Overcrowding	Where two or more additional bedrooms are required to meet the proxy occupancy standard.
Priority access to those in greatest need	Allocation processes to ensure those in greatest need have first access to housing. This is measured as the proportion of new allocations to those in greatest need.
Principal tenant	The person whose name appears on the tenancy agreement. Where this is not clear, it should be the person who is responsible for rental payments.
Proxy occupancy	A measure of the appropriateness of housing related to the household

standard	size and tenancy composition. The measure specifies the bedroom requirements of a household.

Household structure	*Bedrooms required*
Single adult only	1
Single adult (group)	1 (per adult)
Couple with no children	2
Sole parent or couple with one child	2
Sole parent or couple with two or three children	3
Sole parent or couple with four children	4

	For sole parent or couple households with four or more children the dwelling size in terms of bedrooms should be the same value as the number of children in the household.
Rent charged	The amount in dollars that households are charged based on the rents they are expected to pay. The rents charged to tenants may or may not have been received.
Rent collection rate	The total rent actually collected as a proportion of the total rent charged.
Special needs household	A household with a member(s) who has a disability or is aged 24 years or under, or 75 years or over (50 years or over for SOMIH), or (except for SOMIH) is Indigenous.
Tenancy rental unit	A tenancy (rental) unit is defined as the unit of accommodation on which a tenancy agreement can be made. It is a way of counting the maximum number of distinct rentable units that a dwelling structure can contain.
Tenantable dwelling	A dwelling where maintenance has been completed, whether occupied or unoccupied at 30 June. All occupied dwellings are tenantable.
Total gross household income	The value of gross weekly income from all sources (before deductions for income tax, superannuation etc.) for all household members, expressed as dollars per week. The main components of gross income are current usual wages and salary; income derived from self-employment, government pensions, benefits and allowances; and other income comprising investments and other regular income.
Transfer household	A household, either rebated or market renting, that relocates (transfers) from one public or community rental dwelling to another.
Turnaround time	The average time taken in days for normally vacant dwellings to be occupied.
Underutilisation	Where there are two or more bedrooms additional to the number required in the dwelling to satisfy the proxy occupancy standard.
Untenantable dwelling	A dwelling not currently occupied by a tenant, where maintenance has been either deferred or not completed at 30 June.

Commonwealth Rent Assistance

Affordability	The proportions of recipients spending more than 30 per cent and 50 per cent of their income on rent with and without CRA.
Dependent child	A person under 18 years who is the dependant of another person (an adult) if the adult is legally responsible for the day-to-day care, welfare and development of the child, if the child is not a dependent child of another person, and if the child is wholly or substantially in the adult's care. A young person aged 18–24 years may be regarded as the dependant of another person if he or she is wholly or substantially dependent on that other person. A young person aged 21 years or over cannot be

	regarded as a dependant unless undertaking full time study. A young person cannot be regarded as a dependant if he or she receives an income support payment. Operationally, a child is regarded as a dependant of another person (the parent) if the parent receives the Family Tax Benefit for the care of the child. A dependent child is regarded as a member of the parental income unit. The maximum rate of CRA depends on the number of children for whom the recipient or partner receives more than the base rate of the Family Tax Benefit Part A. Although the Family Tax Benefit may be paid for a child aged 16 years or over, it cannot be paid at more than the base rate. It may also be paid at not more than the base rate if a parent has not taken appropriate steps to obtain maintenance from a child's other parent.
Duration of payments	Broadly presents dependence on CRA by showing the percentage of people who are in receipt of CRA payments at a given point in time and who are still dependent on the CRA payments a year later.
Eligible income support recipient	Recipients in receipt of an income support payment or more than the base rate of the Family Tax Benefit Part A. CRA is automatically paid once eligibility is established. The only eligible recipients who are not paid are those affected by Centrelink errors in recording information or by program errors.
Geographic spread of CRA recipients	Two measures are presented: • CRA recipients as a proportion of income units in each capital city receiving a social security income support benefit or more than the base rate of the Family Tax Benefit • the average CRA entitlement across locations.
Income unit	One person or a group of related people within a household who share command over income. The only recognised relationships are (1) marriage (registered or defacto) and (2) adult and dependent child. Operationally, an income unit may consist of: • a single person with no dependent child • a sole parent with a dependent child • a couple (registered or defacto) with no dependent child • a couple (registered or defacto) and any dependent children. A non-dependent child, including any child receiving Youth Allowance or some other income support payment, is not regarded as part of the parental income unit. Rather, he or she is regarded as a separate income unit.
Income unit type	The number and proportion of eligible income support recipients receiving CRA, by income unit type.
Low income	Income of CRA recipients, by quintiles of family income received per week.
Maximum rate	Proportion of CRA recipients receiving the maximum rate of CRA.
Number and outcome of appeals	The outcomes of all CRA appeals finalised: (1) the number of customers who appealed to an authorised review officer, and (2) the proportions of appeals where the decision was affirmed, set aside or varied, or the appeal was withdrawn.
Number and proportion of CRA recipients, by income unit type	A point-in-time indicator showing the number of CRA recipients by income unit type, and the proportion of recipients within each income unit category. Includes data on Indigenous recipients.
Number and proportion of CRA recipients, by payment type	A point-in-time indicator showing the number of CRA recipients by the type of primary payments received, and the proportion of recipients within each payment type category.

Payment type	The number and proportion of income support recipients receiving CRA, by the primary payment type received.
Primary payment type	Each income unit receiving CRA is assigned a primary payment type, based on the payment(s) received by each member. This is used to monitor the extent to which assistance is provided to families and individuals that primarily depend on different forms of assistance. The primary payment is determined using a hierarchy of payment types, precedence being given to pensions, then other social security payments that attract CRA, and then the Family Tax Benefit. Within this overall structure a lower precedence is given to payments that are made only to the partners of a social security payment. If both members of a couple receive a payment of the same rating, the male is regarded as the primary member of the couple. No extra weight is given to the payment type with which CRA is paid.
Proportion of income spent on rent with and without CRA	A point-in-time indicator, measuring the proportion of income units spending more than 30 per cent and 50 per cent of their income on rent, both with and without CRA. The proportion of income spent on rent is calculated as follows: • with CRA: rent (minus CRA) divided by total income from all sources, excluding CRA • without CRA: rent divided by total income from all sources, excluding CRA.
Ratio of running costs to total outlay for CRA	Total running costs for the CRA program as a proportion of total outlay.
Rent	Amount payable as a condition of occupancy of a person's home. Includes site fees for a caravan, mooring fees and payment for services provided in a retirement village. Rent encompasses not only a formal tenancy agreement, but also informal agreements between family members, including the payment of board or board and lodgings. Where a person pays board and lodgings and cannot separately identify the amount paid for lodgings, two thirds of the payment is deemed to be for rent. There is no requirement that rent be paid; a person whose rent is in arrears may remain eligible for assistance, provided Centrelink is satisfied that the liability is genuine.
Running costs per 1000 CRA customers	Total running costs for the CRA program per 1000 CRA customers.
Sharer	Some single people are subject to a lower maximum (sharer) rate of CRA. The lower rate may apply to only a single person (with no dependent child) who shares a major area of accommodation. The lower rate does not apply to those receiving the Disability Support Pension or Carer Payment, those in nursing homes or boarding house accommodation, or those paying for both board and lodgings. A person is not regarded as a sharer solely because he or shares with a child (of any age) if the child does not receive CRA.
Satisfaction with location of housing	Satisfaction with the location of housing rather than with the CRA payment, as measured by the FaCSIA General Customer Survey. The indicator measures the proportion of respondents satisfied with the quality of their housing, broken down into categories of 'poor', 'just okay', 'good' and 'great'.
Satisfaction with quality of housing	Satisfaction with the quality of housing rather than with the CRA payment, as measured by the FaCSIA General Customer Survey. The indicator measures the proportion of respondents satisfied with the quality of their housing, broken down into categories of 'poor', 'just okay', 'good' and 'great'.
Special needs	The proportions of special needs income units receiving CRA, such as regional and remote Australians and Indigenous recipients, by benefit

type.

Total income from all sources

Income received by the recipients or partner, excluding income received by a dependent. Includes regular social security payments and any maintenance and other private income taken into account for income testing purposes. Excludes:

- one-time payments
- arrears payments
- advances
- Employment or Education Entry Payments
- the Mobility Allowance
- the Maternity Allowance
- the Child Care Assistance Rebate.

In most cases, private income reflects the person’s current circumstances. Taxable income for a past financial year or an estimate of taxable income for the current financial year is used where the income unit receives more than the minimum rate of the Family Tax Benefit but no other income support payment.

16.7 Attachment tables

Attachment tables are identified in references throughout this chapter by an 'A' suffix (for example, table 16A.3 is table 3 in the attachment). Attachment tables are provided on the CD-ROM enclosed with the Report and on the Review website (www.pc.gov.au/gsp). On the CD-ROM, the files containing the attachment tables are provided in Microsoft Excel format as \Publications\Reports\2008\Attach16A Housing.xls and in Adobe PDF format as \Publications\Reports\2008\Attach16A Housing.pdf. Users without access to the CD-ROM or the website can contact the Secretariat to obtain the attachment tables (see contact details on the inside front cover of the Report).

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Table 16A.88	State owned and managed Indigenous housing, non-rebated and multiple family households excluded
Table 16A.89	Community housing survey response rates and associated information

16.8 References

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A Statistical appendix

A.1 Introduction

This appendix contains contextual information to assist the interpretation of the performance indicators presented in the Report. The following six key factors in interpreting the performance data are addressed:

- *Australia's population*. Section A.2 presents data on population characteristics, including age and sex, ethnicity, geographic location, and a profile of Indigenous Australians.
- *Family and household*. Section A.3 provides an overview of the family and household environments in which Australians live.
- *Income, education and employment*. Section A.4 summarises the income and employment characteristics of Australians, including educational attainment and workforce participation, and gross domestic product.
- *Statistical concepts used in the Report*. Section A.5 provides technical information on the key statistical concepts used in the Report.
- *List of attachment tables*. Section A.6 lists the attachment tables for this appendix. Attachment tables are identified in references throughout the appendix by an 'AA' suffix (for example, table AA.3 is table AA.3 in the attachment tables). Attachment tables are provided on the CD-ROM enclosed with the Report and on the Review website (www.pc.gov.au/gsp).
- *References*. Section A.7 lists references used in this appendix.

A.2 Population

The Australian people are the principal recipients of the government services covered by this Report. The size, trends and characteristics of the population can have a significant influence on the demand for government services and the cost of delivery. This section provides a limited description of the Australian population to support the interpretation of government services provided in the Report. More detail is provided in the Australian Bureau of Statistics (ABS) annual publication *Australian Social Trends* (ABS 2007b).

In this appendix and associated attachment tables, population totals for the same year can vary because they are drawn from different ABS sources depending on the information required — for example, some data are from the *Census of Population and Housing* (ABS 2006b) and others from the *Australian Demographic Statistics* (ABS 2007a).

Most of the service areas covered by the Report use population data from tables AA.1 and AA.2 for descriptive information (such as expenditure per person in the population) or performance indicators (such as participation rates for vocational education and training [VET]).

Population size and trends

More than three quarters of Australia's 20.7 million people lived in the eastern mainland states as at 30 June 2006, with NSW, Victoria and Queensland accounting for 32.9 per cent, 24.8 per cent and 19.8 per cent, respectively, of the nation's population. Western Australia and SA accounted for a further 9.9 per cent and 7.6 per cent, respectively, of the population, while Tasmania, the ACT and the NT accounted for the remaining 2.4 per cent, 1.6 per cent and 1.0 per cent, respectively (table AA.1).

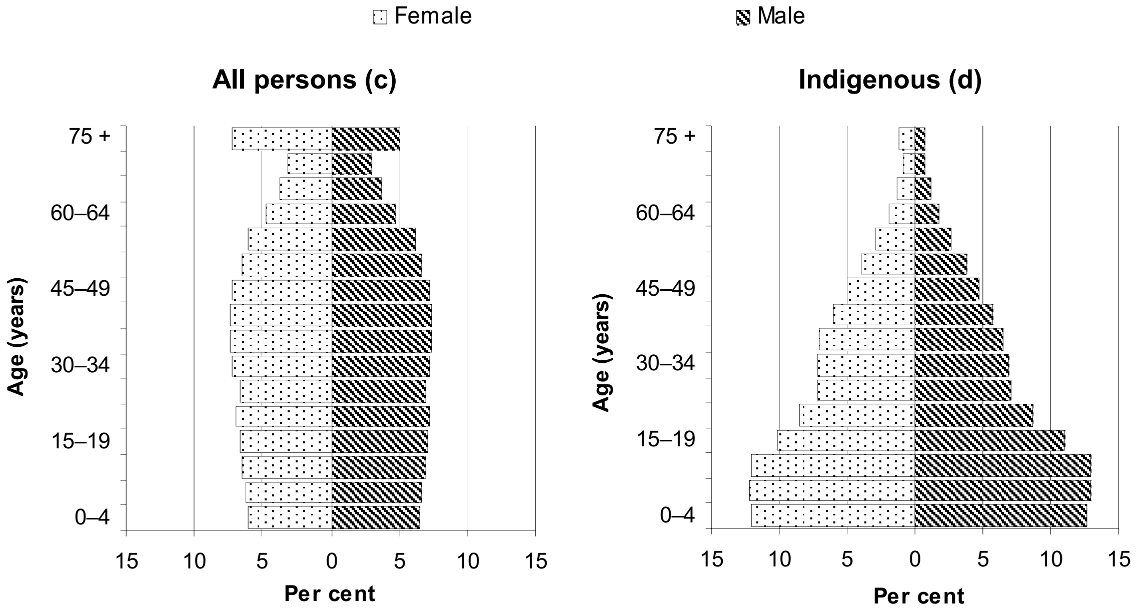
Nationally, the average annual growth rate of the population between 2002 and 2006 was approximately 1.3 per cent. The growth across jurisdictions ranged from 2.3 per cent in Queensland to 0.8 per cent in NSW and SA (table AA.2, 31 December estimates).

Population, by age and sex

As in most other developed economies, greater life expectancy and declining fertility have contributed to an 'ageing' of Australia's population. However, the age distribution of Indigenous Australians is markedly different (figure A.1). At 30 June 2006, 9.2 per cent of Australia's population was aged 70 years or over, in contrast to 1.8 per cent of Australia's Indigenous population (tables AA.1 and AA.7). Across jurisdictions, the proportion of people aged 70 years or over ranged from 11.0 per cent in SA to 2.6 per cent in the NT (table AA.1).

Half of the population at June 2006 was female (50.3 per cent). This distribution was similar across all jurisdictions except the NT, which had a lower representation of women in its population (48.1 per cent) (table AA.1). The proportion of women in the population varies noticeably by age. Nationally, approximately 56.7 per cent of people aged 70 or over were female, compared with 48.7 per cent of people aged 14 years or younger (table AA.1).

Figure A.1 **Population distribution, Australia, by age and sex, 30 June 2006[a, b]**



[a] Totals may not add as a result of rounding. [b] Includes other territories. [c] Estimated resident population (ERP) figures as at 30 June 2006 are preliminary and rebased on the *2006 Census of Population and Housing*. [d] Experimental estimates at 30 June 2006 are preliminary rebased estimates and are based on the *2006 Census of Population and Housing*.

Source: ABS (unpublished) *Australian Demographic Statistics, December Quarter 2006*; ABS (2007) *Australian Demographic Statistics, March Quarter 2007*; tables AA.1 and AA.7.

Population, by ethnicity and proficiency in English

New Australians face specific problems when accessing government services. Language and culture can be formidable barriers for otherwise capable people. Cultural backgrounds can also have a significant influence on the support networks offered by extended families. People born outside Australia accounted for 22.2 per cent of the population in August 2006 (8.4 per cent from the main English speaking countries and 13.8 per cent from other countries).[1] Across jurisdictions, the proportion of people born outside Australia ranged from 27.1 per cent in WA to 10.6 per cent in Tasmania. The proportion from countries other than the main

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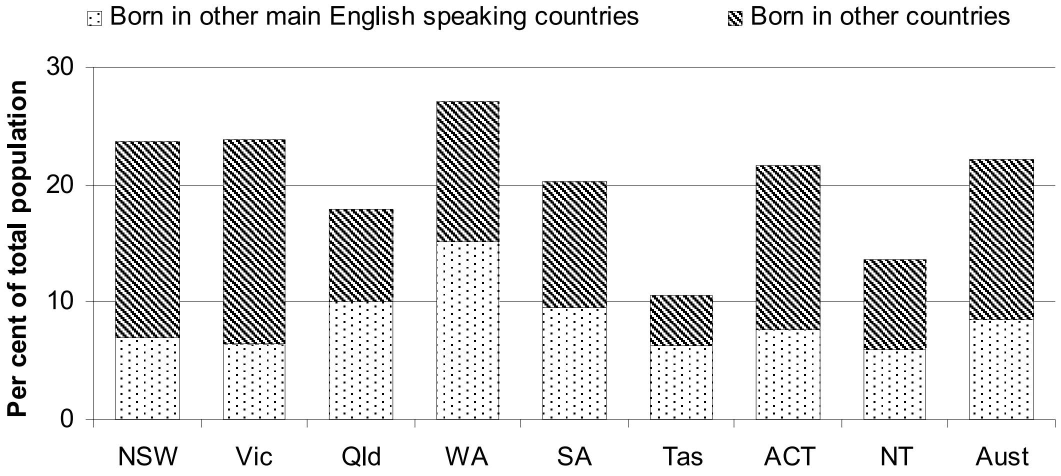
[1] The ABS defines the other main English speaking countries as Canada, Ireland, New Zealand, South Africa, the United States of America and the United Kingdom.

English speaking countries ranged from 17.3 per cent in Victoria to 4.2 per cent in Tasmania (figure A.2).

Figure A.2 **People born outside Australia, by country of birth, August 2006**[a, b]



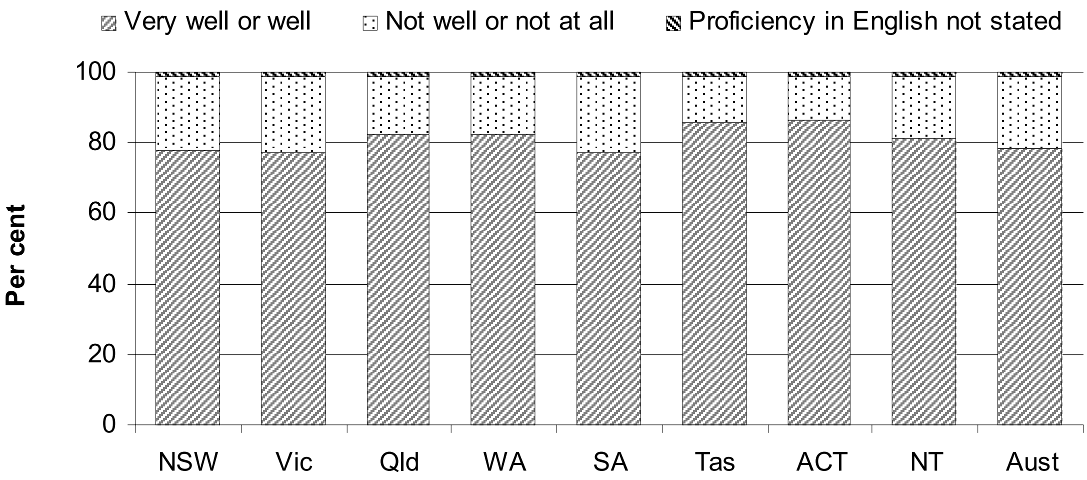
[a] 'Australia' includes other territories. [b] The ABS defines the other main English speaking countries as Canada, Ireland, New Zealand, South Africa, the United States of America and the United Kingdom.

Source: ABS (unpublished) *2006 Census of Population and Housing*; table AA.4.

Of the population born outside Australia, in August 2006, 89.0 per cent spoke only English, or spoke another language as well as speaking English very well or well. Figure A.3 shows proficiency in English of people born overseas who speak another language. Of those people born overseas who spoke another language, 78.6 per cent also spoke English very well or well. The proportion of people born overseas who spoke another language, who did not speak English well or at all, ranged from 21.9 per cent in Victoria to 12.8 per cent in Tasmania (table AA.3).

The proportion of all people born overseas who did not speak English well or at all was 10.0 per cent nationally, and ranged from 12.9 per cent in Victoria to 3.1 per cent in Tasmania (table AA.3).

Figure A.3 **People born overseas who spoke another language, by proficiency in English, August 2006[a]**



[a] Excludes persons who did not state their country of birth.

Source: ABS (unpublished) *2006 Census of Population and Housing*, Cat. no. 2068.0; table AA.3.

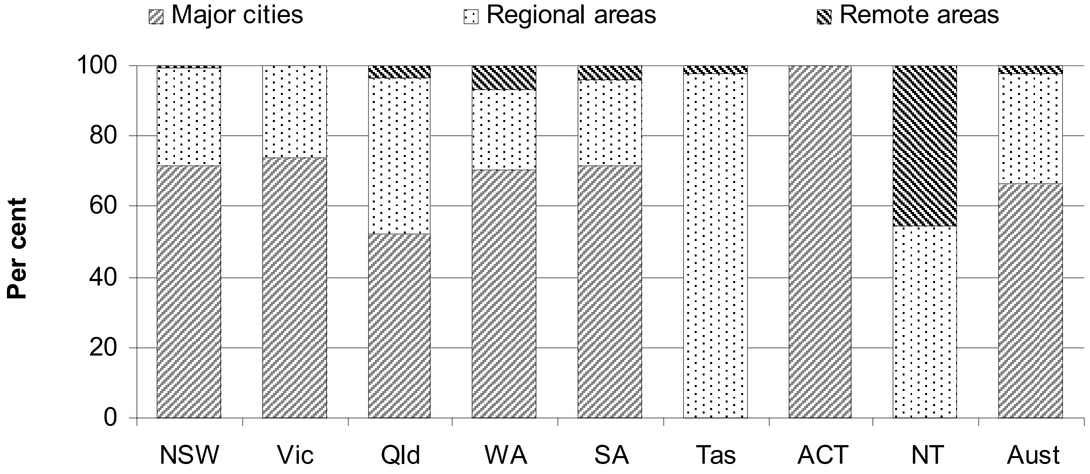
Approximately 15.8 per cent of Australians spoke a language other than English at home in August 2006. Across jurisdictions, this proportion ranged from 23.2 per cent in the NT to 3.5 per cent in Tasmania (table AA.5). The most common languages spoken were Chinese languages, Italian, Greek and Arabic.

The most and least common languages other than English spoken in people's homes varied across jurisdictions in August 2006. The most extreme variation was in the NT, where 15.1 per cent of people spoke an Australian Indigenous language (65.3 per cent of the total persons in the NT who spoke a language other than English in their homes) (table AA.5).

Population, by geographic location

The Australian population is highly urbanised, with 66.2 per cent of the population located in major cities as at 30 June 2006 (figure A.4). Across jurisdictions, this proportion ranged from 99.8 per cent in the ACT to 52.2 per cent in Queensland (table AA.6). Tasmania and the NT by definition have no major cities. In Tasmania, 97.8 per cent of the population lived in regional areas. Australia-wide, 2.4 per cent of people lived in remote areas. The NT was markedly above this average, with 45.7 per cent of people living in remote areas.

Figure A.4 **Population, by remoteness area, June 2006**[a, b]



[a] Preliminary rebased ERP based on the *2006 Census of Population and Housing* by 2001 remoteness areas. [b] ‘Australia’ includes other territories.

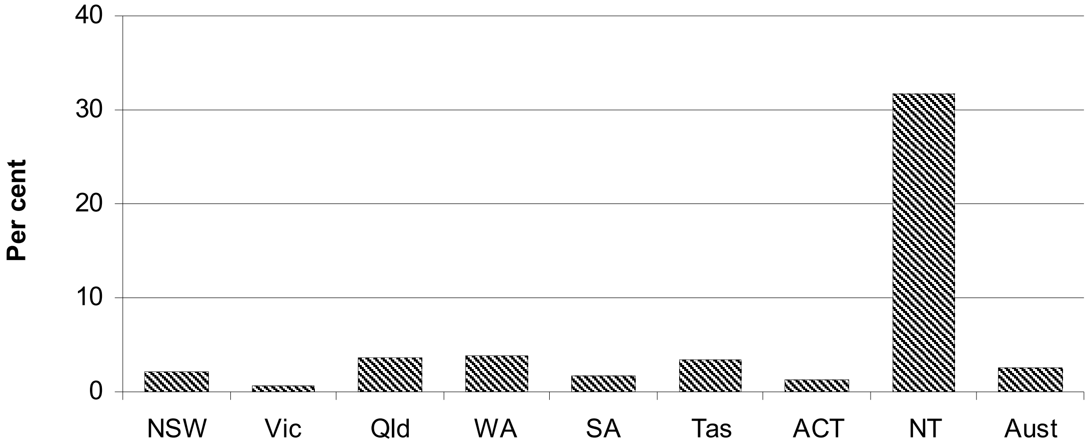
Source: ABS (unpublished) *Australian Demographic Statistics, March Quarter 2007*; table AA.6.

Indigenous population profile

There were an estimated 517 174 Indigenous people (259 693 female and 257 481 male) in Australia at 30 June 2006, accounting for approximately 2.5 per cent of the total population (tables AA.2 and AA.7). The proportion of people who were Indigenous was significantly higher in the NT (31.6 per cent) than in any other jurisdiction. Across the other jurisdictions, the proportion ranged from 3.8 per cent in WA to 0.6 per cent in Victoria (figure A.5). Nationally, the Indigenous population is projected to grow to 528 645 people in 2009 (table AA.8).

The majority of Indigenous people (81.8 per cent) at August 2006 spoke only English at home, while a further 9.0 per cent spoke an Indigenous language and English very well or well. However, 2.2 per cent spoke English not well or not at all (up to 12.2 per cent in the NT). Nationally, 5.2 per cent did not state proficiency in any specific language (table AA.9).

Figure A.5 **Indigenous people as a proportion of the population, 30 June 2006[a, b, c]**



[a] 'Australia' includes other territories. [b] Experimental estimates of the Australian Indigenous population at 30 June 2006 are preliminary rebased estimates and are based on the *2006 Census of Population and Housing*. [c] The ERP at 30 June 2006 is preliminary and rebased on the *2006 Census of Population and Housing*.

Source: ABS (December Quarter 2006, March Quarter 2007) *Australian Demographic Statistics*; tables AA.2 and AA.7.

A.3 Family and household

Family structure

There were 5.7 million families in Australia in 2006.[2] Across jurisdictions, the number of families ranged from 1.9 million in NSW to 40 000 in the NT. The average family size across Australia was 3.0 people (unchanged since 2002). Across jurisdictions, the average family size was the same as the national average except for SA and Tasmania, where the average family size was 2.9 people. Nationally, 39.9 per cent of families had at least one child under 15 years, and 17.7 per cent of families had at least one child under 5 years (table AA.10).

Lone parent families may have a greater need for government support and particular types of government services (such as child care for respite reasons). Nationally, 19.0 per cent of children aged under 15 years lived in one parent families in 2006.

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[2] The ABS *Census Dictionary* (ABS 2006a) defines a family as two or more persons, one of whom is aged 15 years or over, who are related by blood, marriage (registered or de facto), adoption, step or fostering; and who are usually resident in the same household. The basis of a family is formed by identifying the presence of a couple relationship, lone parent-child relationship or other blood relationship. Some households contain more than one family.

Lone mother families made up 18.0 per cent of families with children aged under 15 years. Lone father families made up 2.7 per cent of families with children under 15 years. Across jurisdictions, the proportion of children aged under 15 years living in one parent families ranged from 23.1 per cent in SA to 17.4 per cent in Victoria and the NT (table AA.11).

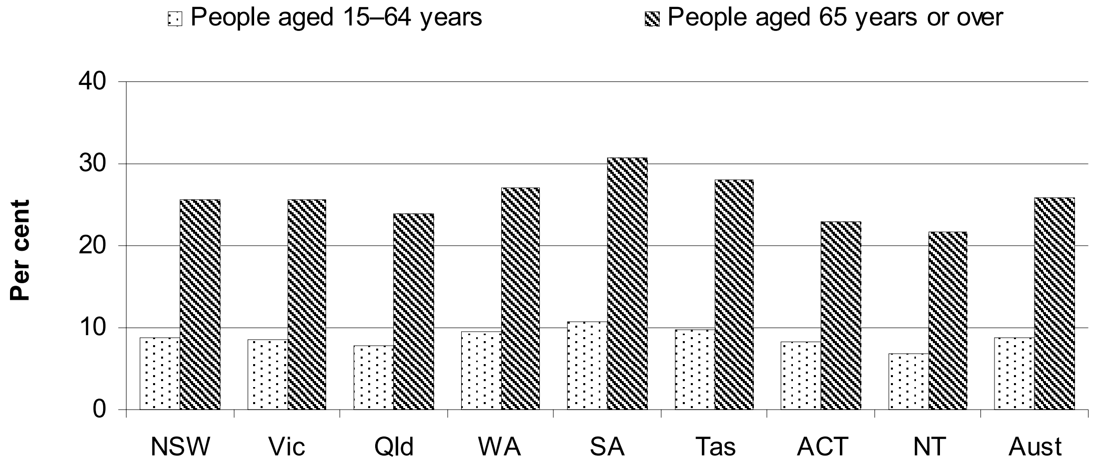
Employment status also has implications for the financial independence of families. Nationally, 15.7 per cent of children aged under 15 years in 2003-04 lived in families where no parent was employed (table AA.12).

Household profile

There were 8.1 million households in Australia in 2006 (table AA.14). Over one quarter (26.5 per cent) of these were lone person households. Across jurisdictions, the proportion of lone person households ranged from 30.7 per cent in Tasmania to 23.5 per cent in the NT.

In June 2006, the proportion of people aged 65 years or over who lived alone (25.9 per cent) was considerably higher than that for people aged 15–64 years (8.8 per cent). Across jurisdictions, the proportion of people aged 65 years or over who lived alone ranged from 30.8 per cent in SA to 21.6 per cent in the NT (figure A.6).

Figure A.6 **Proportion of population who lived alone, by age group, June 2006**



Source: ABS (2007) *Australian Social Trends 2007*, Cat. no. 4102.0; table AA.14.

Home ownership can reflect on a family's wealth and savings, and is often positively related to employment and income. Approximately 15.4 million people in families lived in private dwellings in August 2006 (table AA.13).[3]

Nationally, the majority of occupied private dwellings (68.1 per cent, or 4.9 million dwellings) in August 2006 were owned or were being purchased. Home ownership was highest in Victoria (71.6 per cent) and lowest in the NT (47.6 per cent). Australians rented 2.0 million dwellings, or 28.1 per cent of dwellings (of these, 50.9 per cent were from real estate agents and 15.1 per cent from state or territory housing authorities) (table AA.15). Across jurisdictions, the proportion of dwellings that were rented was highest in the NT (47.8 per cent) and lowest in Victoria (24.6 per cent) (figure A.7).

Figure A.7 **Occupied private dwellings, by tenure type, August 2006[a, b, c]**

[a] 'Australia' includes other territories. [b] 'Owned or being purchased' includes dwellings being purchased under a rent/buy scheme. [c] 'Other tenure type' includes dwellings being occupied under a life tenure scheme.

Source: ABS (unpublished) *2006 Census of Population and Housing*, Cat. no. 2068.0; table AA.15.

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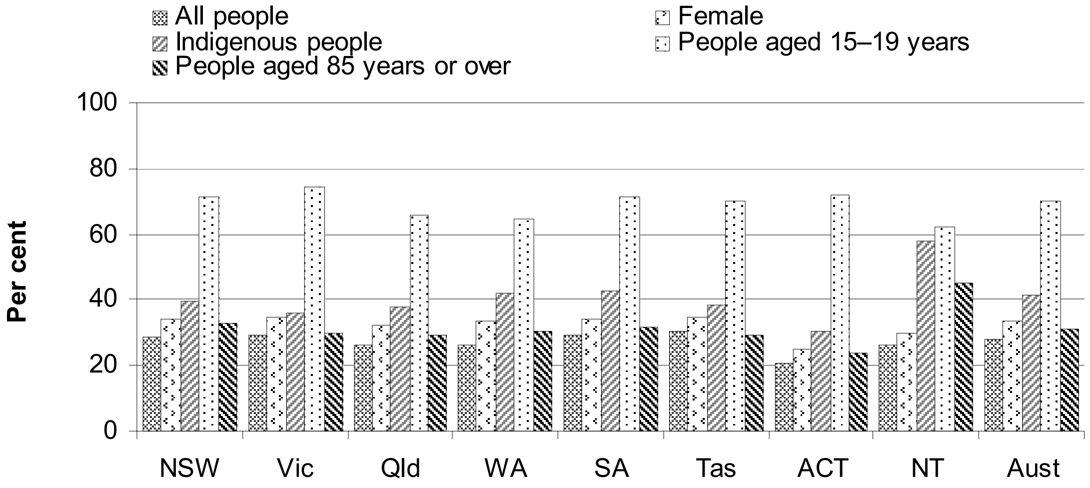
[3] The ABS *Census Dictionary* (ABS 2006a) defines an occupied private dwelling as a private dwelling occupied by one or more people. A private dwelling is normally a house, flat, or even a room. It can also be a caravan, houseboat, tent or a house attached to an office, or rooms above a shop.

A.4 Income, education and employment

Income

Nationally, 28.0 per cent of people aged 15 years or over in August 2006 had a relatively low weekly individual income of $249 or less (table AA.16). The proportion was considerably higher for younger people (70.3 per cent for people aged 15–19 years), Indigenous people (41.4 per cent), females (33.5 per cent) but similar for older people (30.9 per cent for people aged 85 years or over) (figure A.8).

Figure A.8 **Weekly individual income of $249 or less, by sex, Indigenous status and age, August 2006[a]**



[a] 'Australia' includes other territories.

Source: ABS (unpublished) *2006 Census of Population and Housing*; ABS (unpublished) *2006 Census of Population and Housing*, Cat. no. 2068.0; tables AA.16–AA.18.

Nationally, 17.3 per cent of the total population was receiving income support in 2006. The age pension was received by 9.3 per cent of the population, while 3.4 per cent received a disability support pension and 2.1 per cent received a single parent payment. A further 2.5 per cent of the population received some form of labour market allowance in 2006 (figure A.9).

Figure A.9 **Proportion of total population on income support, June 2006**[a, b]

[a] Components do not add to Australian total because total for Australia includes payments to people living overseas and where valid geographic data were not available. [b] Excludes Newstart customers who received a nil rate of payment.

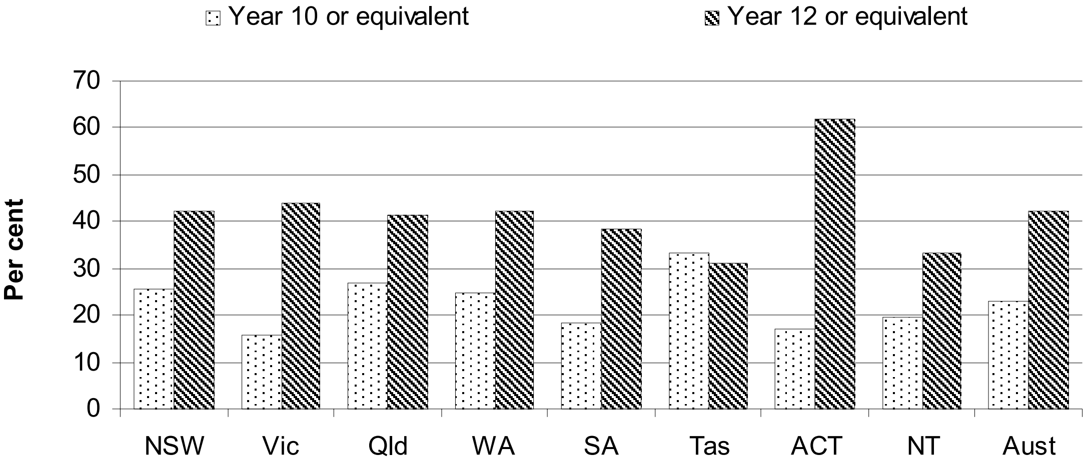
Source: ABS (2007) *Australian Social Trends 2007*, Cat. no. 4102.0; table AA.19.

The proportion of the population receiving the age pension in 2006 ranged from 11.2 per cent in SA to 2.8 per cent in the NT; the proportion receiving a disability support pension ranged from 5.1 per cent in Tasmania to 2.1 per cent in the ACT; and the proportion receiving a single parent payment ranged from 2.8 per cent in the NT to 1.4 per cent in the ACT. The proportion receiving a labour market allowance in 2006 ranged from 6.0 per cent in the NT to 1.4 per cent in the ACT.

Educational attainment

Employment outcomes and income are closely linked to the education and skill levels of individuals. At August 2006, 42.2 per cent of people aged 15 years and over (approximately 6.7 million people) had completed year 12 or equivalent as the highest level of schooling. A further 22.9 per cent (3.6 million people) had completed year 10 or equivalent schooling. Across jurisdictions, the proportion of people aged 15 years and over who had completed year 12 or equivalent schooling ranged from 62.1 per cent in the ACT to 31.3 per cent in Tasmania (figure A.10).

Figure A.10 **People aged 15 years or over, by highest year of school completed, August 2006[a]**

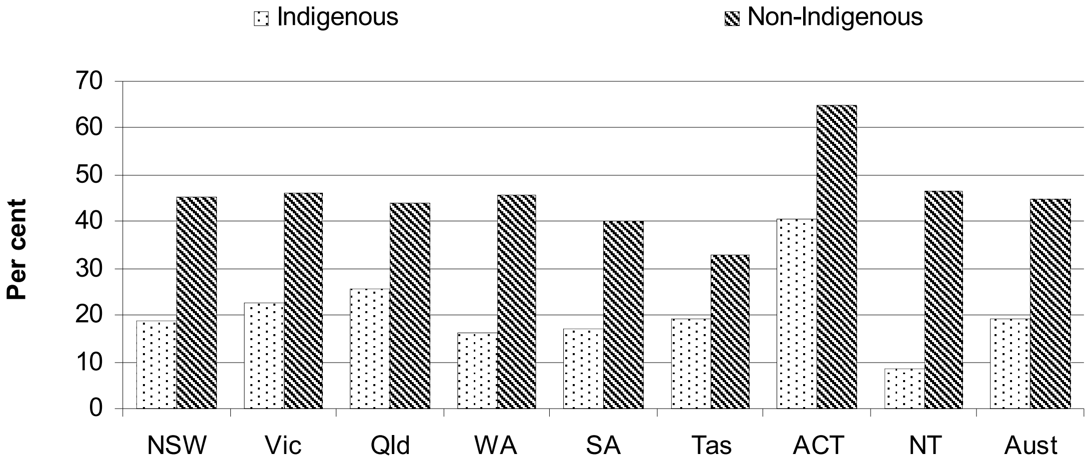


[a] 'Australia' includes other territories.

Source: ABS (unpublished) *2006 Census of Population and Housing*, Cat. no. 2068.0; table AA.20.

The proportion of non-Indigenous people aged 15 years or over who had completed year 12 or equivalent schooling as the highest level of schooling (44.9 per cent) was considerably higher than the proportion of Indigenous people (19.4 per cent) in August 2006. Across jurisdictions, the proportion of Indigenous people aged 15 years or over who had completed year 12 or equivalent schooling ranged from 40.7 per cent in the ACT to 8.5 per cent in the NT. The proportion of non-Indigenous people who had completed year 12 or equivalent was highest in the ACT (65.0 per cent) and lowest in Tasmania (33.0 per cent) (figure A.11).

Figure A.11 **People aged 15 years or over who had completed year 12 or equivalent as highest level of schooling, by Indigenous status, August 2006**[a]



[a] 'Australia' includes other territories.

Source: ABS (unpublished) *2006 Census of Population and Housing*, Cat. no. 2068.0; table AA.20.

Tertiary education in Australia is principally provided by universities and technical and further education (TAFE) institutes. Nationally, 18.9 per cent of those attending an educational institution[4] were attending university or TAFE in August 2006 (12.0 per cent at university and 6.9 per cent at TAFE). Across jurisdictions, the proportion of students attending TAFE ranged from 8.7 per cent in Tasmania to 3.2 per cent in the NT; the proportion attending university ranged from 21.1 per cent in the ACT to 8.5 per cent in the NT (figure A.12).

In August 2006, the proportion of the Indigenous tertiary students who were attending TAFE was highest in Tasmania (9.5 per cent) and lowest in the NT (2.0 per cent). At August 2006, the proportion of non-Indigenous students (14.4 per cent) attending university was considerably higher than the proportion of Indigenous students (3.7 per cent). Across jurisdictions, the proportion of non-Indigenous students attending university ranged from 24.0 per cent in the ACT to 11.7 per cent in Tasmania. For Indigenous students the proportion ranged from 10.0 per cent in the ACT to 2.2 per cent in the NT (figure A.13).

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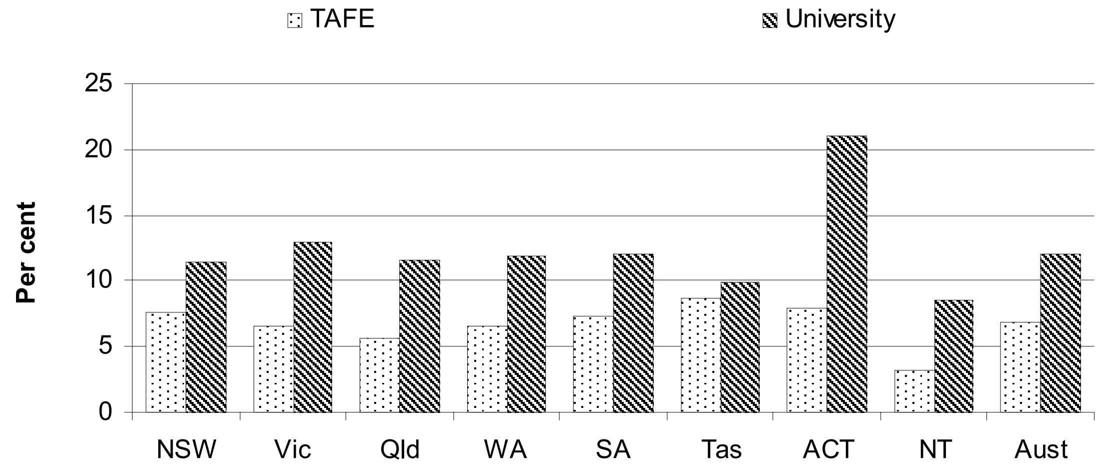
[4] Educational institutions include pre-school, infants/primary school, secondary school, tertiary institutions and other educational institutions.

Figure A.12 **Proportion of students attending tertiary education institutions, August 2006[a, b]**



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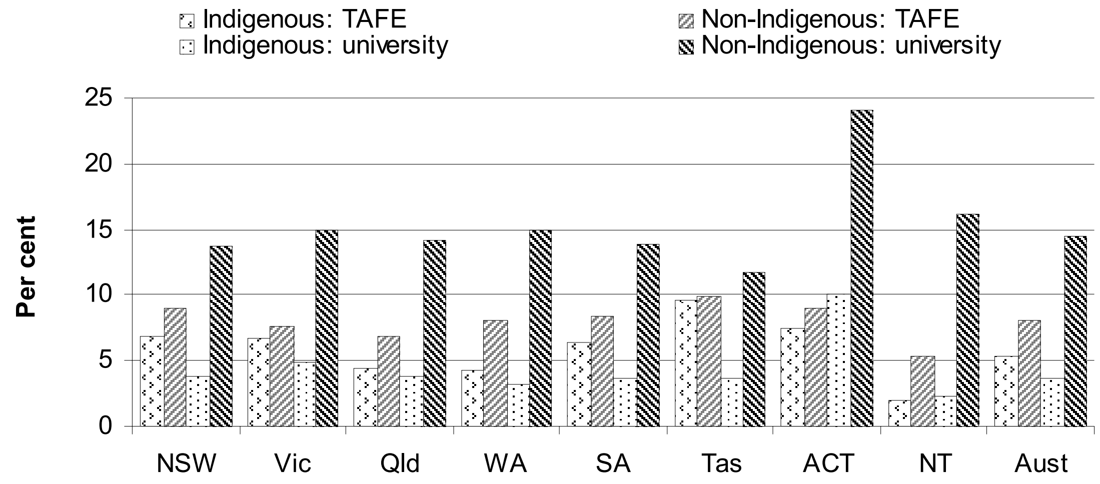
[a] 'Australia' includes other territories. [b] Includes 'technical and further educational institution (including TAFE colleges)'.

Source: ABS (unpublished) *2006 Census of Population and Housing*, Cat. no. 2068.0; table AA.21.

Figure A.13 **Proportion of students attending tertiary education institutions, by Indigenous status, August 2006[a, b]**



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[a] 'Australia' includes other territories. [b] Includes 'technical and further educational institution (including TAFE colleges)'.

Source: ABS (unpublished) *2006 Census of Population and Housing*, Cat. no. 2068.0; table AA.21.

Employment and workforce participation

There were 10.9 million people aged 15 years or over in the labour force in Australia in June 2007. Of these, 95.8 per cent were employed. This means 4.2 per cent of the participating labour force were unemployed at June 2007. The majority of employed persons (71.1 per cent) were in full time employment. A further 460 000 people were looking for work (70.9 per cent for full time work and 29.1 per cent for part time work) (table AA.22).

Across jurisdictions, the proportion of employed people in full time employment in June 2007 ranged from 80.0 per cent in the NT to 68.2 per cent in SA. The unemployment rate ranged from 4.9 per cent in Tasmania to 3.0 per cent in the ACT. The proportion of unemployed people looking for full time work ranged from 74.5 per cent in SA to 48.0 per cent in the NT (tables AA.22 and AA.24).

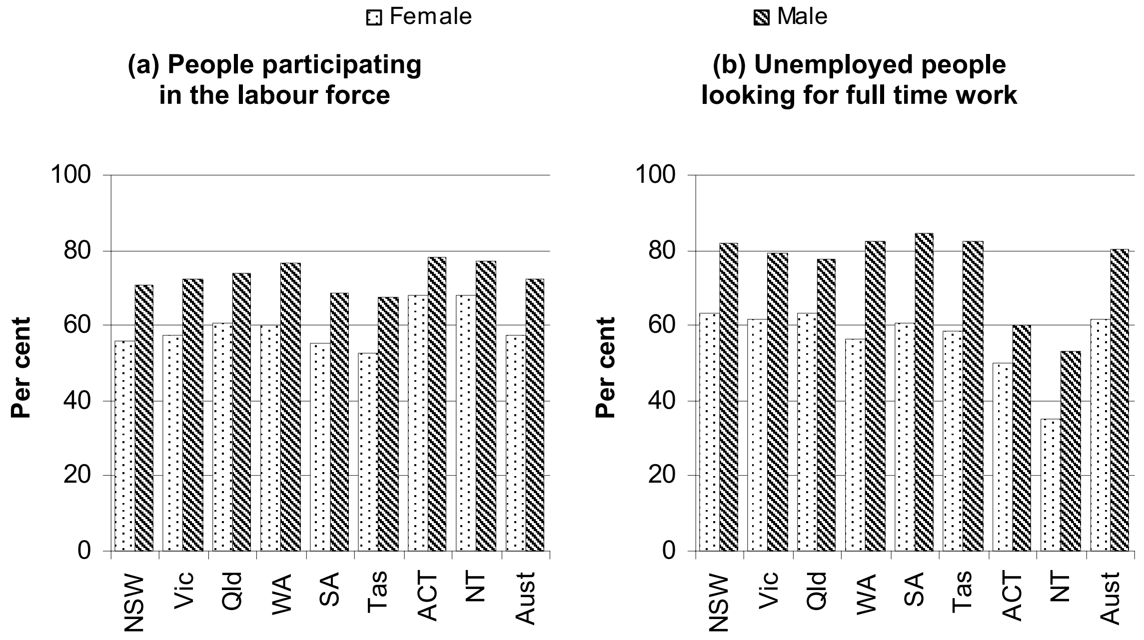
The unemployment rate needs to be interpreted within the context of labour force participation rates, which were higher for males than for females in all jurisdictions (figure A.14a). Nationally, fewer unemployed females were looking for full time work than males (61.5 per cent and 80.3 per cent respectively) (figure A.14b).

The unemployment rate for females was higher than that for males in all jurisdictions except SA and the NT. Male and female unemployment rates were the same in the ACT (figure A.14c). A greater proportion of employed males than of employed females had full time employment in all jurisdictions. The difference between male and female full time employment ranged from 34.4 percentage points in Tasmania to 13.1 percentage points in the NT (figure A.14d).

General economic indicators

Gross Domestic Product (GDP) is the total market value of goods and services produced in Australia within a given period. Australia's GDP is the total of all State and Territory Gross State Product (GSP). In 2005-06, the GSP for NSW accounted for 33.1 per cent of national gross product, compared with 1.3 per cent for the NT. Growth from the previous year's GSP (in 2005-06 dollars) was highest for WA (10.7 per cent) and lowest for NSW (-0.2 per cent). Across Australia, the GSP per person was $47 181 in 2005-06 (table AA.25).

Figure A.14 Labour force outcomes for people aged 15 years or over, by sex, June 2007

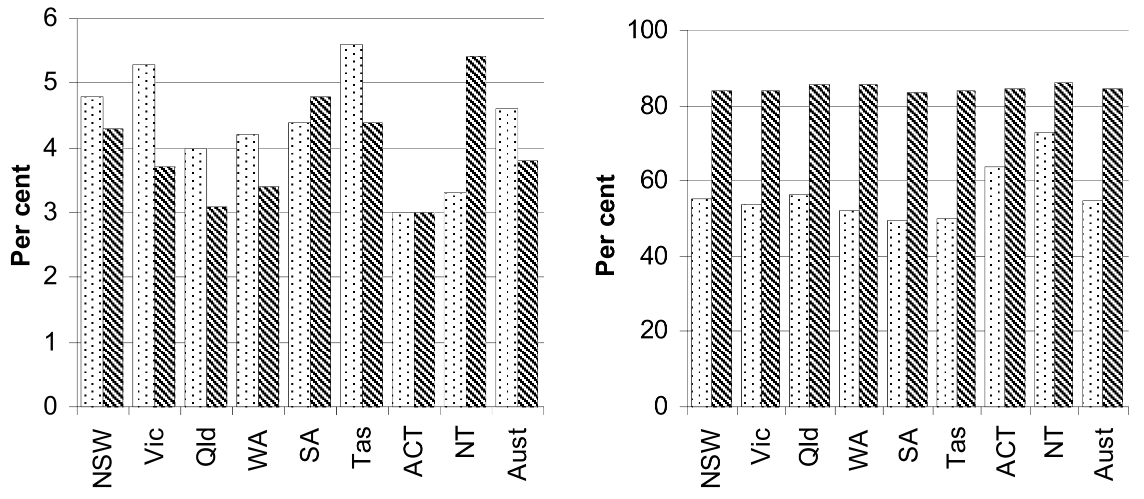


(a) People participating in the labour force

(b) Unemployed people looking for full time work

(c) Labour force unemployed

(d) Employed people in full time employment



Source: ABS (unpublished) *Labour Force, Australia*, (data cube ST LM8) Cat. no. 6291.0; tables AA.22–AA.24.

A.5 Statistical concepts used in the Report

Reliability of estimates

Outcome and quality indicators for some services covered in this Report are reported from surveys (including surveys of client and community perception). Police services, for example, use a survey to obtain an indicative level of community satisfaction with the services that police agencies provide. The potential for sampling error — that is, the error that occurs by chance because the data are obtained from only a sample and not the entire population — means that the reported responses may not indicate the true responses.

Standard error

The standard error (SE) is one measure of the variability that occurs as a result of surveying a sample of the population. There are two chances in three (67 per cent) that a survey estimate is within one SE of the figure that would have been obtained if the entire population had been surveyed, and about 19 chances in 20 (95 per cent) that it is within approximately two SEs. There is a 95 per cent probability that the true value of a survey estimate (x) lies within:

$$x - 1.96\,\mathrm{SE}(x) \text{ and } x + 1.96\,\mathrm{SE}(x)$$

where x is the estimate (for example, the number of persons responding either 'satisfied' or 'very satisfied'). The SE of an estimate can be obtained from either (1) the tables in chapters reporting the estimates and relative standard errors (RSEs) or (2) the RSE tables produced at the end of each of the relevant attachments. Linear interpolation needs to be used to calculate the SEs of estimates falling between the sizes of estimates listed in these tables.

Relative standard error

The SE can be expressed as a proportion of the estimate — known as the RSE, which is determined by dividing the SE of the estimate SE(x) by the estimate x and expressing it as a percentage:

$$\mathrm{RSE}(x) = \frac{\mathrm{SE}(x)}{x}$$

If, for example, 4.3 million people in NSW were estimated to be satisfied with a service, and the SE was approximately ±34 100 people, then the RSE(x) would be equal to 0.0078, or 0.78 per cent. The RSE is a useful measure that provides an immediate indication of the percentage errors likely to have occurred as a result of sampling.

Proportions and percentages formed from the ratio of two estimates are also subject to sampling error, as when estimating the proportion of a population that is 'satisfied' or 'very satisfied' with a service. The size of the error depends on the accuracy of both the numerator (the estimated number of persons responding as 'satisfied' or 'very satisfied') and the denominator (the estimated size of the population). The formula for the RSE of a proportion is:

$$\mathrm{RSE}\left(\frac{x_1}{\mathrm{X}}\right) = \sqrt{[\mathrm{RSE}(x_1)]^2 - [\mathrm{RSE}(\mathrm{X})]^2}$$

where x_1 is estimated as the number of persons from jurisdiction x responding as 'satisfied' or 'very satisfied', and X is the estimated population of jurisdiction x.

Testing for statistical differences

The chance that an estimate falls within a certain range of the true value is known as the *confidence* of the estimate. For any particular survey, there is a tradeoff between the confidence of the estimate and the range of error (in terms of SEs) attached to the estimate. The appropriate level of reliability chosen depends on the purpose of obtaining the estimate. The lower the level of confidence required, the smaller the range the estimate will fall within (for example, we might be able to be 90 per cent confident the true result lies between 18 and 20, but if we want to be 95 per cent confident, we might have to increase the possible range to between 16 and 22).

Confidence intervals (CIs) — the value ranges within which estimates are likely to fall — can be used to test whether the results reported for two jurisdictions are statistically different. If the CIs for the results overlap, then there can be little confidence that the estimated results differ from each other.

For example, assume survey data estimated a result of 60 per cent for NSW, with a 95 per cent CI of ± 3.2 per cent, and a result of 58 per cent for Queensland, with a 95 per cent confidence interval of ± 1.15 per cent. These results imply that we can be 95 per cent sure the true result for NSW lies between 56.8 and 62.3 per cent, and the true result for Queensland lies between 56.5 and 59.5 per cent. As these two ranges overlap, we cannot be sure that the true results for NSW and Queensland are statistically different.

Expressed mathematically, the estimated response is within the 95 per cent confidence interval:

$$\left(\frac{x_1}{\mathrm{X}}-\frac{y_1}{\mathrm{Y}}\right)-1.96\sqrt{\mathrm{RSE}\left(\frac{x_1}{\mathrm{X}}\right)\times\frac{x_1}{\mathrm{X}}+\mathrm{RSE}\left(\frac{y_1}{\mathrm{Y}}\right)\times\frac{y_1}{\mathrm{Y}}}$$

and

$$\left(\frac{x_1}{\mathrm{X}}-\frac{y_1}{\mathrm{Y}}\right)+1.96\sqrt{\mathrm{RSE}\left(\frac{x_1}{\mathrm{X}}\right)\times\frac{x_1}{\mathrm{X}}+\mathrm{RSE}\left(\frac{y_1}{\mathrm{Y}}\right)\times\frac{y_1}{\mathrm{Y}}}$$

where x_1, X, y_1 and Y represent the estimated number of respondents and estimated populations of jurisdictions x and y respectively. If none of the values in this interval is zero, then the difference between jurisdiction x's response and jurisdiction y's response is statistically significant.

Growth rates

Average annual growth rates

Given that data in the Report cover different periods, compound annual averages have been used to facilitate more meaningful comparisons of changes over time.

The formula for calculating a compound annual growth rate (AGR) is:

$$\mathrm{AGR}=\left[\left(\frac{\mathrm{P_v}}{\mathrm{P_0}}\right)^{\left(\frac{1}{n-1}\right)}-1\right]\times 100$$

where AGR is the annual growth rate
$\mathrm{P_v}$ is the present value
$\mathrm{P_0}$ is the beginning value
n is the number of periods.

Summing and taking averages of growth rates

Total growth rate

The formula for calculating a total growth rate (TGR) from AGRs is:

$$\text{TGR} = \Pi_t \ (1+r)_t - 1$$

that is, the total growth over the period, TGR, is found by taking the product (Π) of each $(1+r)_t$ and deducting 1. If, for example, the sample ranges of growth rates are:

6 per cent in 2002-03 to 2003-04
6 per cent in 2003-04 to 2004-05
8 per cent in 2004-05 to 2005-06

where TGR is the total growth rate
t is the year (2002, 2003, 2004…n)
n is the final period

then the total growth over the period 2002-03 to 2005-06 can be calculated as:

$$\begin{aligned} r_{\mathrm{T}} &= [\Pi_t (1+r)_t - 1] \times 100 \\ &= [(1.06) \times (1.06) \times (1.08) - 1] \times 100 \\ &= (1.213488 - 1) \times 100 \\ &= 21.3 \text{ per cent.} \end{aligned}$$

Average growth rates

The formula for the average of growth rates is:

$$r_{\mathrm{A}} = \left\{ [\Pi_t (1+r)_t]^{\left[\frac{1}{t}\right]} - 1 \right\} \times 100$$

This involves first finding the total growth over the period, then finding the average. Note that t is the count of growth rates being averaged, not the years. For example:

$$\begin{aligned} r_{A} &= \{ [(1.06 \times 1.06 \times 1.08)^{(1/3)} - 1] \times 100\} \\ &= \{ [(1.213488\,)^{(1/3)} - 1] \times 100\} \\ &= [(1.066625) - 1] \times 100 \\ &= 6.66 \text{ per cent.} \end{aligned}$$

Gross domestic product deflators

Table AA.26 in the attachment contains GDP deflators for 1997-98 to 2006-07. Financial data in the Report are often deflated by the GDP deflator (except in some health chapters and chapter 5 on VET, which use service–specific deflators) to calculate real dollars.

The general formula used to re-base GDP deflators is as follows:

$$\mathrm{N}_t = 100 \times \frac{\mathrm{O}_t}{\mathrm{B}}$$

where N_t is the new index based in year t
O_t is the current index for year t
B is the current index for the year that will be the new base.

Age standardisation of data

How age profiles can distort observed service usage patterns

The age profile of Australians varies across jurisdictions and across different cultural and linguistic backgrounds (see for example the different age profiles of Indigenous and all Australians, figure A.1). Variations in age profiles are important because the likelihood of needing certain services (such as aged care services) increases with age. As a result, observed differences in service usage rates by different cohorts within the community may arise from different age profiles, rather than from different usage patterns. One method of eliminating this distortion from the data is to standardise for the age profiles of different groups.

Method of standardisation

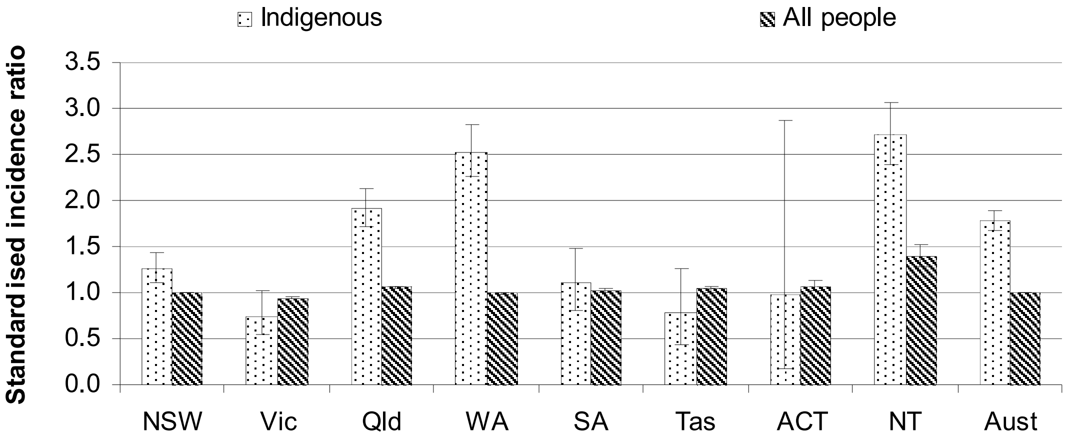
Either direct or indirect standardisation can be used. Indirect standardisation is presented here because it is more appropriate when comparing small populations. This method applies standard age-specific usage rates (in this case, average Australian rates) to actual populations (different groups within states and territories), and compares observed numbers of clients with the numbers that would have been expected if average rates had applied. Comparisons are made via the standardised incidence ratio. A value greater than 1.0 in this ratio means that use is higher than would be expected if the particular group had the same usage rate as that of the Australian population as a whole. A value below 1.0 means use is lower than would be expected. Age standardisation generally covers use by all age groups, so the resulting standardised incidence ratios compare use by complete population groups.

Application of indirect standardisation

In the following illustration, the combined use of permanent residential aged care and Community Aged Care Packages (CACPs) by Indigenous people is compared with average service use by all Australians (using 2001 data). The resulting standardised incidence ratios are presented in figure A.15. The error bars in the figure show how accurate the comparisons are—if an error bar goes across the value of 1.0, then the usage rate by Indigenous people in that jurisdiction is not significantly different from the average use by all Australians.

Figure A.15 shows that Indigenous people had a higher than average combined use of CACPs and permanent residential aged care — nationally, about 80 per cent higher. This result reflects the higher age-specific usage rates of CACPs for Indigenous people at all ages, and of permanent residential aged care for those Indigenous people aged under 75 years (table A.1). Results vary across jurisdictions.

Figure A.15 **Standardised incidence ratio for use of CACP and permanent residential aged care (combined), 30 June 2001**[a, b, c]



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[a] The Indigenous ratio is per 1000 Indigenous people aged 50 or over, the all people ratio is per 1000 Indigenous people aged 50 or over and non-Indigenous people aged 70 or over. [b] The calculations use indirect age standardisation against use by all people Australia-wide. [c] ACT data are based on a very small Indigenous population and have high standard errors.

Source: AIHW (unpublished); table AA.27.

Table A.1 Age-specific usage rates of CACPs and permanent residential aged care, 30 June 2005, (per 1000 people)[a, b]

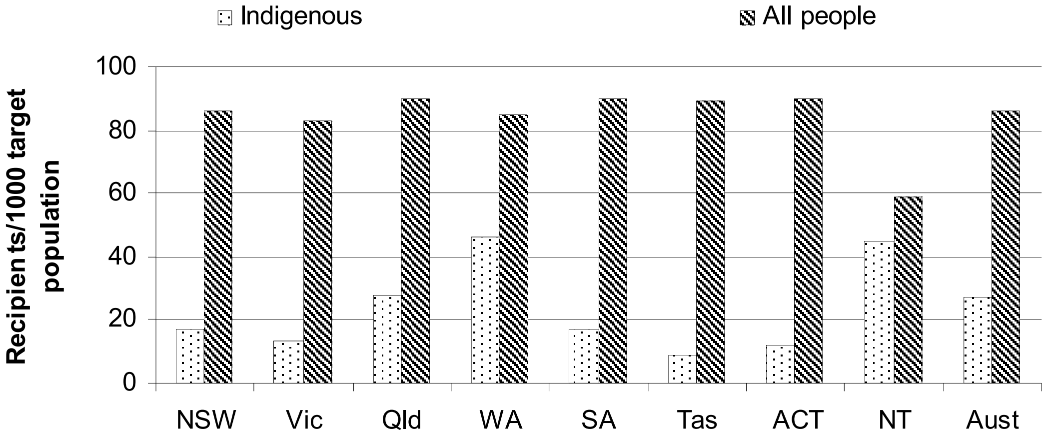
	CACP recipients		*Permanent aged care residents*	
Age (years)	*Indigenous*	*Non-Indigenous*	*Indigenous*	*Non-Indigenous*
50–54	4.1	0.1	2.5	0.7
55–59	9.8	0.3	5.8	1.4
60–64	19.2	0.8	8.8	2.8
65–69	36.3	1.8	15.4	5.9
70–74	48.5	3.9	28.7	13.5
75+	82.1	17.8	106.8	102.0

[a] Excludes clients of multipurpose and flexible services. [b] Cases with missing data on Indigenous status have been pro-rated within gender/age groups.

Source: AIHW (2006) *Residential Aged Care in Australia 2004–05: A Statistical Overview*, Cat. no. AGE 45, Aged Care Statistics Series no. 22; AIHW (2006) *Community Aged Care Packages in Australia 2004–05: A Statistical Overview,* Cat. no. AGE 47, Aged Care Statistics Series no. 23.

The age standardised rates are quite different from those that result from comparing use with the target group population (clients per 1000 in the target group). The target group measure (figure A.16) suggests that combined use of CACPs and permanent residential aged care is much lower for Indigenous people than for all people. Figure A.16 also suggests that use of the two services for all people is much lower in the NT than in other jurisdictions; this difference is not apparent after age standardisation (figure A.15), indicating that the difference in this measure is the result of the relatively young age structure of the NT (even within the two subgroups of people 70 years and over, and Indigenous people 50 years and over).

Figure A.16 Ratio of CACP recipients and permanent residents (combined) to 1000 persons in target population, 30 June 2001[a]



[a] Indigenous ratio is per 1000 Indigenous people aged 50 years or over, ‘all people’ ratio is per 1000 Indigenous people aged 50 years or over and non-Indigenous people aged 70 years or over.

Source: AIHW (unpublished); table AA.27.

A.6 Attachment tables

Attachment tables are identified in references throughout this appendix by an 'AA' suffix (for example, table AA.3 is table 3 in the attachment). Attachment tables are provided on the CD-ROM enclosed with the Report and on the Review website (www.pc.gov.au/gsp). On the CD-ROM, the files containing the attachment tables are provided in Microsoft Excel format as \Publications\Reports\2008\Attach_stat_app.xls and in Adobe PDF format as \Publications\Reports\2008\Attach_stat_app.pdf. Users without access to the CD-ROM or the website can contact the Secretariat to obtain the attachment tables (see contact details on the inside front cover of the Report).

Population

Table AA.1	Estimated resident population by age and sex, 30 June 2006 ('000)
Table AA.2	Estimated resident population by calendar and financial year
Table AA.3	Proficiency in spoken English of people born overseas, August 2006 ('000)
Table AA.4	Persons by country of birth, August 2006 ('000)
Table AA.5	Persons by language spoken at home, August 2006 ('000)
Table AA.6	Estimated resident population by remoteness area, 30 June 2006
Table AA.7	Experimental estimated resident Australian Indigenous population, 30 June 2006
Table AA.8	Experimental projection of the Indigenous population, 2000 to 2009 (number)
Table AA.9	Language spoken at home by Indigenous people and proficiency in spoken English, by sex, August 2006 (number)

Family and household

Table AA.10	Family structure, 2002–2006
Table AA.11	Family structure: lone parents, 2002–2006 (per cent)
Table AA.12	Families and work (per cent)
Table AA.13	Families and persons in families in occupied private dwellings by Indigenous status and family/household composition, August 2006
Table AA.14	Household structure, 2002–2006
Table AA.15	Occupied private dwellings by tenure type and landlord type, August 2006 ('000)

Income, education and employment

Table AA.16	Persons aged 15 years and over, by weekly individual income and sex, August 2006

General economic indicators

Statistical concepts

A.7 References

ABS (Australian Bureau of Statistics) 2006a (Reissue), *Census Dictionary*, Cat. no. 2901.0, Canberra.

——2006b, *Census of Population and Housing*, Cat. no. 2068.0, Canberra.

——2007a, *Australian Demographic Statistics March Quarter 2007*, Cat. no. 3101.0, Canberra.

——2007b, *Australian Social Trends 2007*, Cat. no. 4102.0, Canberra.

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