Contents

This Report is in two volumes: Volume 1 contains Part A (Introduction), Part B (Child care, education and training), Part C (Justice), Part D (Emergency Management) and Appendix A (Statistical appendix); Volume 2 contains Part E (Health), Part F (Community Services) and Part G (Housing and Homelessness).

<table>
<thead>
<tr>
<th>Volume 1</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Foreword</td>
<td>iii</td>
</tr>
<tr>
<td>Contents</td>
<td>iv</td>
</tr>
<tr>
<td>Steering Committee</td>
<td>xii</td>
</tr>
<tr>
<td>Acronyms and abbreviations</td>
<td>xiv</td>
</tr>
<tr>
<td>Glossary</td>
<td>xxxi</td>
</tr>
<tr>
<td>Terms of reference</td>
<td>xxxiv</td>
</tr>
</tbody>
</table>

**PART A INTRODUCTION**

1. **The approach to performance measurement**
   1.1 Aims of the Review and the Report on Government Services 1.1
   1.2 The role of government in delivering services 1.3
   1.3 Reasons for measuring comparative performance 1.5
   1.4 Scope 1.7
   1.5 Approach 1.11
   1.6 Using the data in RoGS 1.22
   1.7 Other performance measurement exercises 1.24
   1.8 References 1.30

2. **Recent developments in the Report**
   2.1 Developments in reporting 2.1
   2.2 Key data issues 2.2
   2.3 ‘Cross-cutting’ issues 2.24
   2.4 References 2.27
PART B CHILD CARE, EDUCATION AND TRAINING

B  Child care, education and training sector overview

B.1 Introduction
B.2 Sector performance indicator framework
B.3 Future directions in performance reporting
B.4 List of attachment tables
B.5 References

3  Early childhood education and care

3.1 Profile of early childhood education and care
3.2 Framework of performance indicators
3.3 Key performance indicator results
3.4 Future directions in performance reporting
3.5 Jurisdictions’ comments
3.6 Definitions of key terms
3.7 List of attachment tables
3.8 References

4  School education

4.1 Profile of school education
4.2 Framework of performance indicators
4.3 Key performance indicator results
4.4 Future directions in performance reporting
4.5 Jurisdictions’ comments
4.6 Definitions of key terms
4.7 List of attachment tables
4.8 References

5  Vocational education and training

5.1 Profile of vocational education and training
5.2 Framework of performance indicators
5.3 Key performance indicator results
5.4 Future directions in performance reporting
5.5 Jurisdictions’ comments
5.6 Definitions of key terms
5.7 List of attachment tables
5.8 References
PART C JUSTICE

C Justice sector overview
C.1 Introduction C.1
C.2 Sector performance indicator framework C.12
C.3 Cross-cutting and interface issues C.42
C.4 Future directions in performance reporting C.42
C.5 List of attachment tables C.43
C.6 References C.43

6 Police services
6.1 Profile of police services 6.2
6.2 Framework of performance indicators 6.7
6.3 Indicators relevant to all police services 6.9
6.4 Community safety 6.21
6.5 Crime 6.28
6.6 Road safety 6.44
6.7 Judicial services 6.50
6.8 Future directions in performance reporting 6.57
6.9 Jurisdictions’ comments 6.58
6.10 Definitions of key terms 6.67
6.11 List of attachment tables 6.72
6.12 References 6.74

7 Courts
7.1 Profile of court services 7.1
7.2 Framework of performance indicators 7.22
7.3 Key performance indicator results 7.24
7.4 Future directions in performance reporting 7.61
7.5 Jurisdictions’ comments 7.62
7.6 Definitions of key terms 7.71
7.7 List of attachment tables 7.74
7.8 References 7.75

8 Corrective services
8.1 Profile of corrective services 8.3
8.2 Framework of performance indicators 8.11
8.3 Key performance indicator results 8.13
PART D EMERGENCY MANAGEMENT

D Emergency management sector overview
D.1 Introduction D.1
D.2 Sector performance indicator framework D.17
D.3 Cross-cutting and interface issues D.30
D.4 Future directions in performance reporting D.31
D.5 List of attachment tables D.32
D.6 References D.33

9 Fire and ambulance services
9.1 Profile of emergency services for fire events 9.2
9.2 Framework of performance indicators for fire events 9.5
9.3 Key performance indicator results for fire events 9.8
9.4 Profile of emergency services for ambulance events 9.37
9.5 Framework of performance indicators for ambulance events 9.43
9.6 Key performance indicator results for ambulance events 9.45
9.7 Future directions in performance reporting 9.69
9.8 Jurisdictions’ comments 9.70
9.9 Definitions of key terms 9.79
9.10 List of attachment tables 9.83
9.11 References 9.85

A Statistical appendix
A.1 Introduction A.1
A.2 Population A.2
A.3 Family and household A.7
A.4 Income, education and employment A.10
A.5 Statistical concepts used in the Report A.19
A.6 List of attachment tables A.38
A.7 References A.40
<table>
<thead>
<tr>
<th>Page</th>
<th>Section</th>
</tr>
</thead>
<tbody>
<tr>
<td>iii</td>
<td>Foreword</td>
</tr>
<tr>
<td>iv</td>
<td>Contents</td>
</tr>
<tr>
<td>xii</td>
<td>Steering Committee</td>
</tr>
<tr>
<td>xiv</td>
<td>Acronyms and abbreviations</td>
</tr>
<tr>
<td>xxxi</td>
<td>Glossary</td>
</tr>
<tr>
<td>xxxiv</td>
<td>Terms of reference</td>
</tr>
</tbody>
</table>

**PART E HEALTH**

<table>
<thead>
<tr>
<th>E.1</th>
<th>Introduction</th>
</tr>
</thead>
<tbody>
<tr>
<td>E.9</td>
<td>Sector performance indicator framework</td>
</tr>
<tr>
<td>E.57</td>
<td>Cross cutting and interface issues</td>
</tr>
<tr>
<td>E.58</td>
<td>Future directions in performance reporting</td>
</tr>
<tr>
<td>E.58</td>
<td>Jurisdictions’ comments</td>
</tr>
<tr>
<td>E.68</td>
<td>List of attachment tables</td>
</tr>
<tr>
<td>E.70</td>
<td>References</td>
</tr>
</tbody>
</table>

**10 Public hospitals**

<table>
<thead>
<tr>
<th>10.2</th>
<th>Profile of public hospitals</th>
</tr>
</thead>
<tbody>
<tr>
<td>10.14</td>
<td>Framework of performance indicators for public hospitals</td>
</tr>
<tr>
<td>10.17</td>
<td>Key performance indicator results for public hospitals</td>
</tr>
<tr>
<td>10.58</td>
<td>Profile of maternity services</td>
</tr>
<tr>
<td>10.60</td>
<td>Framework of performance indicators for maternity services</td>
</tr>
<tr>
<td>10.62</td>
<td>Key performance indicator results for maternity services</td>
</tr>
<tr>
<td>10.77</td>
<td>Future directions in performance reporting</td>
</tr>
<tr>
<td>10.79</td>
<td>Definitions of key terms</td>
</tr>
<tr>
<td>10.84</td>
<td>List of attachment tables</td>
</tr>
<tr>
<td>10.89</td>
<td>References</td>
</tr>
</tbody>
</table>

**11 Primary and community health**

<table>
<thead>
<tr>
<th>11.2</th>
<th>Profile of primary and community health</th>
</tr>
</thead>
<tbody>
<tr>
<td>11.14</td>
<td>Framework of performance indicators</td>
</tr>
<tr>
<td>11.17</td>
<td>Key performance indicator results</td>
</tr>
<tr>
<td>11.88</td>
<td>Future directions in performance reporting</td>
</tr>
<tr>
<td>11.90</td>
<td>Definitions of key terms</td>
</tr>
<tr>
<td>11.94</td>
<td>List of attachment tables</td>
</tr>
</tbody>
</table>
11.7 References 11.98

12 Mental health management 12.2
12.1 Framework for measuring health management performance 12.2
12.2 Profile of mental health management 12.3
12.3 Framework of performance indicators for mental health management 12.16
12.4 Key performance indicators for mental health management 12.20
12.5 Future directions in performance reporting 12.65
12.6 Definitions of key terms 12.66
12.7 List of attachment tables 12.72
12.8 References 12.76

PART F COMMUNITY SERVICES 12.76
F Community services sector overview 12.76
F.1 Introduction F.1
F.2 Sector performance indicator framework F.13
F.3 Cross-cutting and interface issues F.37
F.4 Future directions in performance reporting F.41
F.5 List of attachment tables F.42
F.6 References F.43

13 Aged care services 13.2
13.1 Profile of aged care services 13.2
13.2 Framework of performance indicators 13.34
13.3 Key performance indicator results 13.37
13.4 Future directions in performance reporting 13.82
13.5 Jurisdictions’ comments 13.82
13.6 Definitions of key terms 13.92
13.7 List of attachment tables 13.96
13.8 References 13.101

14 Services for people with disability 14.3
14.1 Profile of disability services 14.3
14.3 Key performance indicator results 14.23
14.4 Future directions in performance reporting 14.76
14.5 Jurisdictions’ comments 14.78
14.6 Service user data quality and other issues 14.88
<table>
<thead>
<tr>
<th>Chapter</th>
<th>Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>14.7</td>
<td>Definitions of key terms</td>
<td>14.93</td>
</tr>
<tr>
<td>14.8</td>
<td>List of attachment tables</td>
<td>14.101</td>
</tr>
<tr>
<td>14.9</td>
<td>References</td>
<td>14.108</td>
</tr>
<tr>
<td>15</td>
<td>Child protection and youth justice services</td>
<td></td>
</tr>
<tr>
<td>15.1</td>
<td>Profile of child protection and out-of-home care services</td>
<td>15.3</td>
</tr>
<tr>
<td>15.2</td>
<td>Framework of performance indicators for child protection and out-of-home care services</td>
<td>15.18</td>
</tr>
<tr>
<td>15.3</td>
<td>Key child protection and out-of-home care services performance indicator results</td>
<td>15.21</td>
</tr>
<tr>
<td>15.4</td>
<td>Future directions in child protection and out-of-home care services performance reporting</td>
<td>15.59</td>
</tr>
<tr>
<td>15.5</td>
<td>Profile of youth justice services</td>
<td>15.61</td>
</tr>
<tr>
<td>15.6</td>
<td>Framework of performance indicators for youth justice services</td>
<td>15.69</td>
</tr>
<tr>
<td>15.7</td>
<td>Future directions in youth justice performance reporting</td>
<td>15.96</td>
</tr>
<tr>
<td>15.8</td>
<td>Jurisdictions’ comments</td>
<td>15.96</td>
</tr>
<tr>
<td>15.9</td>
<td>Definitions of key terms</td>
<td>15.105</td>
</tr>
<tr>
<td>15.10</td>
<td>List of attachment tables</td>
<td>15.112</td>
</tr>
<tr>
<td>15.11</td>
<td>References</td>
<td>15.123</td>
</tr>
<tr>
<td>PART G</td>
<td>HOUSING AND HOMELESSNESS</td>
<td></td>
</tr>
<tr>
<td>G</td>
<td>Housing and homelessness services sector overview</td>
<td></td>
</tr>
<tr>
<td>G.1</td>
<td>Introduction</td>
<td>G.1</td>
</tr>
<tr>
<td>G.2</td>
<td>Sector performance indicator framework</td>
<td>G.9</td>
</tr>
<tr>
<td>G.3</td>
<td>Cross-cutting and interface issues</td>
<td>G.24</td>
</tr>
<tr>
<td>G.4</td>
<td>Future directions in performance reporting</td>
<td>G.26</td>
</tr>
<tr>
<td>G.5</td>
<td>List of attachment tables</td>
<td>G.27</td>
</tr>
<tr>
<td>G.6</td>
<td>Definitions of key terms</td>
<td>G.29</td>
</tr>
<tr>
<td>G.7</td>
<td>Appendix – Private housing market contextual information</td>
<td>G.31</td>
</tr>
<tr>
<td>G.8</td>
<td>References</td>
<td>G.34</td>
</tr>
<tr>
<td>16</td>
<td>Housing</td>
<td></td>
</tr>
<tr>
<td>16.1</td>
<td>Profile of housing assistance</td>
<td>16.5</td>
</tr>
<tr>
<td>16.3</td>
<td>Key performance indicator results</td>
<td>16.16</td>
</tr>
<tr>
<td>16.4</td>
<td>Future directions in performance reporting</td>
<td>16.49</td>
</tr>
<tr>
<td>16.5</td>
<td>Jurisdictions’ comments</td>
<td>16.49</td>
</tr>
<tr>
<td>16.6</td>
<td>Definitions of key terms</td>
<td>16.59</td>
</tr>
</tbody>
</table>
17 Homelessness services

17.1 Profile of homelessness services 17.3
17.2 Framework of performance indicators for government funded specialist homelessness services 17.6
17.3 Key performance indicator results for government funded specialist homelessness services 17.9
17.4 Key performance indicator results for government funded specialist homelessness services, SAAP, 2010-11 17.36
17.5 Future directions in homelessness services performance reporting 17.38
17.6 Jurisdictions’ comments 17.38
17.7 Definition of key terms 17.48
17.8 List of attachment tables 17.52
17.9 References 17.55
## Acronyms and abbreviations

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>AACR</td>
<td>Australasian Association of Cancer Registries</td>
</tr>
<tr>
<td>AAGR</td>
<td>average annual growth rates</td>
</tr>
<tr>
<td>AAT</td>
<td>Administrative Appeals Tribunal</td>
</tr>
<tr>
<td>ABS</td>
<td>Australian Bureau of Statistics</td>
</tr>
<tr>
<td>ACAM</td>
<td>Australian Centre for Asthma Monitoring</td>
</tr>
<tr>
<td>ACAP</td>
<td>Aged Care Assessment Program</td>
</tr>
<tr>
<td>ACAT</td>
<td>aged care assessment team</td>
</tr>
<tr>
<td>ACARA</td>
<td>Australian Curriculum and Assessment Reporting Authority</td>
</tr>
<tr>
<td>ACE</td>
<td>adult community education</td>
</tr>
<tr>
<td>ACECQA</td>
<td>Australian Children's Education and Care Quality Authority</td>
</tr>
<tr>
<td>ACER</td>
<td>Australian Council for Educational Research</td>
</tr>
<tr>
<td>ACFI</td>
<td>aged care funding instrument</td>
</tr>
<tr>
<td>ACHS</td>
<td>Australian Council on Healthcare Standards</td>
</tr>
<tr>
<td>ACIR</td>
<td>Australian Childhood Immunisation Register</td>
</tr>
<tr>
<td>ACOSS</td>
<td>Australian Council of Social Services</td>
</tr>
<tr>
<td>ACRRM</td>
<td>Australian College of Rural and Remote Medicine</td>
</tr>
<tr>
<td>ACSAA</td>
<td>Aged Care Standards and Accreditation Agency</td>
</tr>
<tr>
<td>ACSES</td>
<td>The Australian Council of State Emergency Services</td>
</tr>
<tr>
<td>ACSQHC</td>
<td>Australian Commission for Safety and Quality in Health Care</td>
</tr>
<tr>
<td>------------</td>
<td>-------------------------------------------------------------</td>
</tr>
<tr>
<td>ACT</td>
<td>Australian Capital Territory</td>
</tr>
<tr>
<td>ADL</td>
<td>activities of daily living</td>
</tr>
<tr>
<td>ADR</td>
<td>Alternative Dispute Resolution</td>
</tr>
<tr>
<td>AEDI</td>
<td>Australian Early Development Index</td>
</tr>
<tr>
<td>AFAC</td>
<td>Australasian Fire and Emergency Services Authorities Council</td>
</tr>
<tr>
<td>AFP</td>
<td>Australian Federal Police</td>
</tr>
<tr>
<td>AGCCC</td>
<td>Australian Government Census of Child Care Services</td>
</tr>
<tr>
<td>AGCCPS</td>
<td>Australian Government Child Care Provider Survey</td>
</tr>
<tr>
<td>AGPAL</td>
<td>Australian General Practice Accreditation Limited</td>
</tr>
<tr>
<td>AGPN</td>
<td>Australian General Practice Network</td>
</tr>
<tr>
<td>AGSRC</td>
<td>Average Government School Recurrent Costs</td>
</tr>
<tr>
<td>AHCA</td>
<td>Australian Health Care Agreements</td>
</tr>
<tr>
<td>AHMAC</td>
<td>Australian Health Ministers’ Advisory Council</td>
</tr>
<tr>
<td>AHMC</td>
<td>Australian Health Ministers’ Conference</td>
</tr>
<tr>
<td>AHV</td>
<td>Aboriginal Housing Victoria</td>
</tr>
<tr>
<td>AIC</td>
<td>Australian Institute of Criminology</td>
</tr>
<tr>
<td>AIFS</td>
<td>Australian Institute of Family Studies</td>
</tr>
<tr>
<td>AIHW</td>
<td>Australian Institute of Health and Welfare</td>
</tr>
<tr>
<td>AIJA</td>
<td>Australian Institute of Judicial Administration</td>
</tr>
<tr>
<td>AIPAR</td>
<td>Australian Institute for Population Ageing Research</td>
</tr>
<tr>
<td>AJJA</td>
<td>Australasian Juvenile Justice Administrators</td>
</tr>
<tr>
<td>Acronym</td>
<td>Full Form</td>
</tr>
<tr>
<td>---------</td>
<td>-----------</td>
</tr>
<tr>
<td>ALLS</td>
<td>Adult Literacy and Life Skills</td>
</tr>
<tr>
<td>ANZEMC</td>
<td>Australia-New Zealand Emergency Management Committee</td>
</tr>
<tr>
<td>ANZPAA</td>
<td>Australia and New Zealand Police Advisory Agency</td>
</tr>
<tr>
<td>ANZSCO</td>
<td>Australian and New Zealand Standard Classification of Occupations</td>
</tr>
<tr>
<td>ANZSIC</td>
<td>Australian and New Zealand Standard Industrial Classification</td>
</tr>
<tr>
<td>AODTS-NMDS</td>
<td>Alcohol and Other Drug Treatment Services National Minimum Data Set</td>
</tr>
<tr>
<td>AQF</td>
<td>Australian Qualifications Framework</td>
</tr>
<tr>
<td>AQFC</td>
<td>Australian Qualifications Framework Council</td>
</tr>
<tr>
<td>AQTF</td>
<td>Australian Quality Training Framework</td>
</tr>
<tr>
<td>AR-DRG v 5.1</td>
<td>Australian refined diagnosis related group, version 5.1</td>
</tr>
<tr>
<td>AR-DRGs</td>
<td>Australian refined diagnosis related groups</td>
</tr>
<tr>
<td>ARHP</td>
<td>Aboriginal Rental Housing Program</td>
</tr>
<tr>
<td>ARIA</td>
<td>Accessibility and Remoteness Index for Australia</td>
</tr>
<tr>
<td>ARO</td>
<td>Authorised Review Officer</td>
</tr>
<tr>
<td>ASCED</td>
<td>Australian Standard Classification of Education</td>
</tr>
<tr>
<td>ASGC</td>
<td>Australian Standard Geographical Classification</td>
</tr>
<tr>
<td>ASGS</td>
<td>Australian Statistical Geography Standard</td>
</tr>
<tr>
<td>ASM</td>
<td>Active Service Model</td>
</tr>
<tr>
<td>ASO</td>
<td>ambulance service organisation</td>
</tr>
<tr>
<td>ASOC</td>
<td>Australian Standard Offence Classification</td>
</tr>
<tr>
<td>ASR</td>
<td>Age-standardised rate</td>
</tr>
<tr>
<td>Acronym</td>
<td>Description</td>
</tr>
<tr>
<td>---------</td>
<td>-------------</td>
</tr>
<tr>
<td>ASSNP</td>
<td>core activity need for assistance</td>
</tr>
<tr>
<td>ASQA</td>
<td>Australian Skills Quality Authority</td>
</tr>
<tr>
<td>ATC</td>
<td>Australian Transport Commission</td>
</tr>
<tr>
<td>Aust</td>
<td>Australia</td>
</tr>
<tr>
<td>AVETMISS</td>
<td>Australian Vocational Education and Training Management Information Statistical Standard</td>
</tr>
<tr>
<td>BBF</td>
<td>Building a Better Future</td>
</tr>
<tr>
<td>BEACH</td>
<td>Bettering the Evaluation and Care of Health</td>
</tr>
<tr>
<td>BMI</td>
<td>Body Mass Index</td>
</tr>
<tr>
<td>C&amp;K</td>
<td>Crèche and Kindergarten</td>
</tr>
<tr>
<td>CAA</td>
<td>Council of Ambulance Authorities</td>
</tr>
<tr>
<td>CACP</td>
<td>Community Aged Care Package</td>
</tr>
<tr>
<td>CAD</td>
<td>computer aided dispatch</td>
</tr>
<tr>
<td>CAEPR</td>
<td>Centre for Aboriginal Economic Policy Research</td>
</tr>
<tr>
<td>CALD</td>
<td>culturally and linguistically diverse</td>
</tr>
<tr>
<td>CAP</td>
<td>conditional adjustment payment</td>
</tr>
<tr>
<td>CAP</td>
<td>Crisis Accommodation Program</td>
</tr>
<tr>
<td>Cat. no.</td>
<td>Catalogue number</td>
</tr>
<tr>
<td>CAWG</td>
<td>Court Administration Working Group</td>
</tr>
<tr>
<td>CCB</td>
<td>Child Care Benefit</td>
</tr>
<tr>
<td>CCET</td>
<td>Child care, education and training</td>
</tr>
<tr>
<td>CCMS</td>
<td>Child Care Management System</td>
</tr>
<tr>
<td>CCR</td>
<td>Child Care Rebate</td>
</tr>
<tr>
<td>CCTR</td>
<td>Child Care Tax Rebate</td>
</tr>
<tr>
<td>Acronym</td>
<td>Description</td>
</tr>
<tr>
<td>---------</td>
<td>-------------</td>
</tr>
<tr>
<td>CDC</td>
<td>Community Directed Care</td>
</tr>
<tr>
<td>CDC</td>
<td>consumer directed care</td>
</tr>
<tr>
<td>CD-ROM</td>
<td>Compact Disc Read Only Memory</td>
</tr>
<tr>
<td>CDSMAC</td>
<td>Community and Disability Services Ministers’ Advisory Council</td>
</tr>
<tr>
<td>CEaCS</td>
<td>Childhood Education and Care Survey</td>
</tr>
<tr>
<td>CFA</td>
<td>Country Fire Authority</td>
</tr>
<tr>
<td>CFCs</td>
<td>Child and Family Centres</td>
</tr>
<tr>
<td>CGC</td>
<td>Commonwealth Grants Commission</td>
</tr>
<tr>
<td>CGRIS</td>
<td>Coordinator-General for Remote Indigenous Services</td>
</tr>
<tr>
<td>CHDSMC</td>
<td>Community, Housing and Disability Services Ministers’ Conference</td>
</tr>
<tr>
<td>CHIP</td>
<td>Community Housing and Infrastructure Program</td>
</tr>
<tr>
<td>CHOS</td>
<td>Canadian National Occupancy Standard</td>
</tr>
<tr>
<td>CI</td>
<td>confidence interval</td>
</tr>
<tr>
<td>CIS</td>
<td>Complaints Investigation Scheme</td>
</tr>
<tr>
<td>CMHC</td>
<td>Community Mental Health Care</td>
</tr>
<tr>
<td>COAG</td>
<td>Council of Australian Governments</td>
</tr>
<tr>
<td>CPG</td>
<td>Court Practitioners Group</td>
</tr>
<tr>
<td>CRA</td>
<td>Commonwealth Rent Assistance</td>
</tr>
<tr>
<td>CRC</td>
<td>COAG Reform Council</td>
</tr>
<tr>
<td>CR</td>
<td>Crude rate</td>
</tr>
<tr>
<td>CRS</td>
<td>Commonwealth Rehabilitation Services</td>
</tr>
<tr>
<td>CRS</td>
<td>Complaints Resolution Scheme</td>
</tr>
<tr>
<td>CRYPAR</td>
<td>Coordinated Response to Young People at Risk</td>
</tr>
<tr>
<td>Acronym</td>
<td>Description</td>
</tr>
<tr>
<td>---------</td>
<td>-------------</td>
</tr>
<tr>
<td>CSASAW</td>
<td>Commonwealth-State Agreement for Skilling Australia’s Workforce</td>
</tr>
<tr>
<td>CSHA</td>
<td>Commonwealth State Housing Agreement</td>
</tr>
<tr>
<td>CSMAC</td>
<td>Community Services Ministers’ Advisory Council</td>
</tr>
<tr>
<td>CSTDA</td>
<td>Commonwealth State/Territory Disability Agreement</td>
</tr>
<tr>
<td>CURF</td>
<td>confidentialised unit record file</td>
</tr>
<tr>
<td>DDHCS</td>
<td>Department of Disability, Housing and Community Services</td>
</tr>
<tr>
<td>DEEWR</td>
<td>Department of Education, Employment and Workplace Relations</td>
</tr>
<tr>
<td>DET</td>
<td>Department of Education (NSW)</td>
</tr>
<tr>
<td>DGP</td>
<td>Divisions of General Practice</td>
</tr>
<tr>
<td>DGPP</td>
<td>Divisions of General Practice Program</td>
</tr>
<tr>
<td>DHAC</td>
<td>Department of Health and Aged Care</td>
</tr>
<tr>
<td>DHS</td>
<td>Department of Human Services</td>
</tr>
<tr>
<td>DSHS</td>
<td>Department of Human Services and Health</td>
</tr>
<tr>
<td>DIISRTE</td>
<td>Department of Industry, Innovation, Science, Research and Tertiary Education</td>
</tr>
<tr>
<td>DiRCS</td>
<td>Differences in Recorded Crime Statistics</td>
</tr>
<tr>
<td>DoCS</td>
<td>Department of Community Services (NSW)</td>
</tr>
<tr>
<td>DoHA</td>
<td>Department of Health and Ageing</td>
</tr>
<tr>
<td>DPEM</td>
<td>Department of Police and Emergency Management (Tas)</td>
</tr>
<tr>
<td>DPIE</td>
<td>Department of Primary Industries and Energy</td>
</tr>
<tr>
<td>DQI</td>
<td>data quality information</td>
</tr>
<tr>
<td>DSE</td>
<td>Department of Sustainability and Environment</td>
</tr>
<tr>
<td>Acronym</td>
<td>Full Form</td>
</tr>
<tr>
<td>----------</td>
<td>-----------</td>
</tr>
<tr>
<td>DVA</td>
<td>Department of Veterans’ Affairs</td>
</tr>
<tr>
<td>EACH</td>
<td>Extended Aged Care at Home</td>
</tr>
<tr>
<td>EACH-D</td>
<td>EACH Dementia</td>
</tr>
<tr>
<td>ECDSG</td>
<td>Early Childhood Data Sub Group</td>
</tr>
<tr>
<td>ECEC</td>
<td>Early Childhood Education and Care</td>
</tr>
<tr>
<td>ECEC NMDS</td>
<td>Early Childhood Education and Care National Minimum Data Set</td>
</tr>
<tr>
<td>EMA</td>
<td>Emergency Management Australia</td>
</tr>
<tr>
<td>EMS</td>
<td>emergency medical service</td>
</tr>
<tr>
<td>ERP</td>
<td>estimated resident population</td>
</tr>
<tr>
<td>ESO</td>
<td>emergency services organisation</td>
</tr>
<tr>
<td>FaCS</td>
<td>Department of Family and Community Services</td>
</tr>
<tr>
<td>FaCSIA</td>
<td>Department of Families, Community Services and Indigenous Affairs</td>
</tr>
<tr>
<td>FaHCSIA</td>
<td>Department of Families, Housing, Community Services and Indigenous Affairs</td>
</tr>
<tr>
<td>FDC</td>
<td>family day care</td>
</tr>
<tr>
<td>FDCQA</td>
<td>Family Day Care Quality Assurance</td>
</tr>
<tr>
<td>FSO</td>
<td>fire services organisation</td>
</tr>
<tr>
<td>FTE</td>
<td>full time equivalent</td>
</tr>
<tr>
<td>FWE</td>
<td>full time workload equivalent</td>
</tr>
<tr>
<td>FYA</td>
<td>Foundation for Young Australians</td>
</tr>
<tr>
<td>GDP</td>
<td>gross domestic product</td>
</tr>
<tr>
<td>GFS</td>
<td>Government Finance Statistics</td>
</tr>
<tr>
<td>GP</td>
<td>general practitioner</td>
</tr>
<tr>
<td>Acronym</td>
<td>Definition</td>
</tr>
<tr>
<td>---------</td>
<td>------------</td>
</tr>
<tr>
<td>GPII</td>
<td>General Practice Immunisation Incentives Scheme</td>
</tr>
<tr>
<td>GSP</td>
<td>gross state product</td>
</tr>
<tr>
<td>GSS</td>
<td>General Social Survey</td>
</tr>
<tr>
<td>GST</td>
<td>goods and services tax</td>
</tr>
<tr>
<td>HACC</td>
<td>Home and Community Care</td>
</tr>
<tr>
<td>HAF</td>
<td>Housing Affordability Fund</td>
</tr>
<tr>
<td>HDSC</td>
<td>Health Data Standards Committee</td>
</tr>
<tr>
<td>HECS</td>
<td>Higher Education Contribution Scheme</td>
</tr>
<tr>
<td>HELP</td>
<td>Higher Education Loan Program</td>
</tr>
<tr>
<td>HHWR</td>
<td>Hospitals and Health Workforce Reform</td>
</tr>
<tr>
<td>HILDA</td>
<td>Household Income and Labour Dynamic Australia</td>
</tr>
<tr>
<td>HIP</td>
<td>Home Independence Project</td>
</tr>
<tr>
<td>HMAC</td>
<td>Housing Ministers’ Advisory Council</td>
</tr>
<tr>
<td>HOIST</td>
<td>New South Wales Population Health Survey 2007</td>
</tr>
<tr>
<td>HoTS</td>
<td>Heads of Treasuries</td>
</tr>
<tr>
<td>HREOC</td>
<td>Human Rights and Equal Opportunity Commission</td>
</tr>
<tr>
<td>HRSEET</td>
<td>House of Representatives Standing Committee on Employment, Education and Training</td>
</tr>
<tr>
<td>ICD</td>
<td>International Classification of Diseases</td>
</tr>
<tr>
<td>ICD-10-AM</td>
<td>Australian modification of the International Standard Classification of Diseases and Related Health Problems, version 10</td>
</tr>
<tr>
<td>ICH</td>
<td>Indigenous community housing</td>
</tr>
<tr>
<td>ICHO</td>
<td>Indigenous Community Housing Organisation</td>
</tr>
<tr>
<td>ICT</td>
<td>information and communication technologies</td>
</tr>
<tr>
<td>Acronym</td>
<td>Description</td>
</tr>
<tr>
<td>---------</td>
<td>-------------</td>
</tr>
<tr>
<td>IER</td>
<td>Indigenous Expenditure Report</td>
</tr>
<tr>
<td>IGA</td>
<td>Intergovernmental Agreement</td>
</tr>
<tr>
<td>IMR</td>
<td>Infant mortality rate</td>
</tr>
<tr>
<td>IPD</td>
<td>Implicit Price Deflator</td>
</tr>
<tr>
<td>IRG</td>
<td>Independent Reference Group</td>
</tr>
<tr>
<td>IRSD</td>
<td>Index of Relative Socio-economic Disadvantage</td>
</tr>
<tr>
<td>ISO</td>
<td>International Organisation for Standardisation</td>
</tr>
<tr>
<td>ISS</td>
<td>Inclusion Support Subsidy</td>
</tr>
<tr>
<td>JCHE</td>
<td>Joint Committee on Higher Education</td>
</tr>
<tr>
<td>JJ NMDS</td>
<td>Juvenile Justice National Minimum Data Set</td>
</tr>
<tr>
<td>JJ RIG</td>
<td>Juvenile Justice Research and Information Group</td>
</tr>
<tr>
<td>K10</td>
<td>Kessler Psychological Distress Scale</td>
</tr>
<tr>
<td>KPIs</td>
<td>key performance indicators</td>
</tr>
<tr>
<td>LBOTE</td>
<td>Language background other than English</td>
</tr>
<tr>
<td>LCL</td>
<td>lower confidence limit</td>
</tr>
<tr>
<td>LDC</td>
<td>long day care</td>
</tr>
<tr>
<td>LGCSA</td>
<td>Local Government Community Services Association of Australia</td>
</tr>
<tr>
<td>LMO</td>
<td>local medical officer</td>
</tr>
<tr>
<td>LOTE</td>
<td>Language other than English</td>
</tr>
<tr>
<td>LSOP</td>
<td>Long Stay Older Patients</td>
</tr>
<tr>
<td>LSAC</td>
<td>Longitudinal Study of Australian Children</td>
</tr>
<tr>
<td>LSAY</td>
<td>Longitudinal Surveys of Australian Youth</td>
</tr>
<tr>
<td>MBI</td>
<td>Modified Barthel Index</td>
</tr>
<tr>
<td>Acronym</td>
<td>Definition</td>
</tr>
<tr>
<td>------------</td>
<td>-----------------------------------------------------------------------------</td>
</tr>
<tr>
<td>MBS</td>
<td>Medicare Benefits Schedule</td>
</tr>
<tr>
<td>MCATSIA</td>
<td>Ministerial Council on Aboriginal and Torres Strait Islander Affairs</td>
</tr>
<tr>
<td>MCEECDYA</td>
<td>Ministerial Council for Education, Early Childhood Development and Youth Affairs</td>
</tr>
<tr>
<td>MCEETYA</td>
<td>Ministerial Council on Education, Employment, Training and Youth Affairs</td>
</tr>
<tr>
<td>MCFFR</td>
<td>Ministerial Council on Federal Financial Relations</td>
</tr>
<tr>
<td>MCTEE</td>
<td>Ministerial Council of Tertiary Education and Employment</td>
</tr>
<tr>
<td>MECS</td>
<td>Mobile Early Childhood Services</td>
</tr>
<tr>
<td>MFS</td>
<td>Metropolitan Fire Service</td>
</tr>
<tr>
<td>MHE</td>
<td>Mental Health Establishments</td>
</tr>
<tr>
<td>MHS</td>
<td>mental health services</td>
</tr>
<tr>
<td>MPS</td>
<td>multi-purpose services</td>
</tr>
<tr>
<td>NA</td>
<td>National Agreement</td>
</tr>
<tr>
<td>na</td>
<td>not available</td>
</tr>
<tr>
<td>NAHA</td>
<td>National Affordable Housing Agreement</td>
</tr>
<tr>
<td>NAP</td>
<td>National Assessment Program</td>
</tr>
<tr>
<td>NAPLAN</td>
<td>National Assessment Program — Literacy and Numeracy</td>
</tr>
<tr>
<td>NASWD</td>
<td>National Agreement for Skills and Workforce Development</td>
</tr>
<tr>
<td>NATESE</td>
<td>National Advisory for Tertiary Education. Skills and Employment</td>
</tr>
<tr>
<td>NMVTRC</td>
<td>National Motor Vehicle Theft Reduction Council</td>
</tr>
<tr>
<td>Acronym</td>
<td>Full Name</td>
</tr>
<tr>
<td>---------</td>
<td>-----------</td>
</tr>
<tr>
<td>NATSISS</td>
<td>National Aboriginal and Torres Strait Islander Social Survey</td>
</tr>
<tr>
<td>NBCC</td>
<td>National Breast Cancer Centre</td>
</tr>
<tr>
<td>NCAC</td>
<td>National Childcare Accreditation Council</td>
</tr>
<tr>
<td>NCAG</td>
<td>National Corrections Advisory Group</td>
</tr>
<tr>
<td>NCCH</td>
<td>National Centre for Classification in Health</td>
</tr>
<tr>
<td>NCIRS</td>
<td>National Centre for Immunisation Research and Surveillance of Vaccine Preventable Diseases</td>
</tr>
<tr>
<td>NCJSF</td>
<td>National Criminal Justice Statistical Framework</td>
</tr>
<tr>
<td>NCPASS</td>
<td>National Child Protection and Support Services data working group</td>
</tr>
<tr>
<td>NCSIMG</td>
<td>National Community Services Information Management Group</td>
</tr>
<tr>
<td>NCVER</td>
<td>National Centre for Vocational Education Research</td>
</tr>
<tr>
<td>NDA</td>
<td>National Disability Agreement</td>
</tr>
<tr>
<td>NDIS</td>
<td>National Disability Insurance Scheme</td>
</tr>
<tr>
<td>NEA</td>
<td>National Education Agreement</td>
</tr>
<tr>
<td>NEAT</td>
<td>Department of Natural Resources Environment and the Arts</td>
</tr>
<tr>
<td>NESB</td>
<td>non-English speaking background</td>
</tr>
<tr>
<td>NGOs</td>
<td>non-government organisations</td>
</tr>
<tr>
<td>NHA</td>
<td>National Healthcare Agreement</td>
</tr>
<tr>
<td>NHIMPC</td>
<td>National Health Information Management Principal Committee</td>
</tr>
<tr>
<td>NHMP</td>
<td>National Homicide Monitoring Program</td>
</tr>
<tr>
<td>NHMRC</td>
<td>National Health and Medical Research Council</td>
</tr>
<tr>
<td>Abbreviation</td>
<td>Description</td>
</tr>
<tr>
<td>--------------</td>
<td>-------------</td>
</tr>
<tr>
<td>NHPAC</td>
<td>National Health Priority Action Council</td>
</tr>
<tr>
<td>NHPC</td>
<td>National Health Performance Committee</td>
</tr>
<tr>
<td>NHS</td>
<td>National Health Survey</td>
</tr>
<tr>
<td>NIA ECEC</td>
<td>National Information on Agreement on Early Childhood Education and Care</td>
</tr>
<tr>
<td>NIDP</td>
<td>National Information Development Plan</td>
</tr>
<tr>
<td>NIHEC</td>
<td>National Indigenous Health Equality Council</td>
</tr>
<tr>
<td>NIRA</td>
<td>National Indigenous Reform Agreement</td>
</tr>
<tr>
<td>NISC</td>
<td>National Industry Skills Committee</td>
</tr>
<tr>
<td>NMDS</td>
<td>national minimum data set</td>
</tr>
<tr>
<td>NMHS</td>
<td>National Mental Health Strategy</td>
</tr>
<tr>
<td>NNDSS</td>
<td>National Notifiable Diseases Surveillance System</td>
</tr>
<tr>
<td>no.</td>
<td>number</td>
</tr>
<tr>
<td>NOOSR</td>
<td>National Office of Overseas Skills Recognition</td>
</tr>
<tr>
<td>NP</td>
<td>National Partnership</td>
</tr>
<tr>
<td>np</td>
<td>not published</td>
</tr>
<tr>
<td>NPAs</td>
<td>National Partnership Agreements</td>
</tr>
<tr>
<td>NPC</td>
<td>National Preschool Census</td>
</tr>
<tr>
<td>NP ECE</td>
<td>National Partnership for Early Childhood Education</td>
</tr>
<tr>
<td>NQC</td>
<td>National Quality Council</td>
</tr>
<tr>
<td>NQF</td>
<td>National Quality Framework</td>
</tr>
<tr>
<td>NQS</td>
<td>National Quality Standard</td>
</tr>
<tr>
<td>NRCP</td>
<td>National Respite for Carers Program</td>
</tr>
<tr>
<td>NRF</td>
<td>National Reporting Framework</td>
</tr>
<tr>
<td>ACRONYM</td>
<td>FULL FORM</td>
</tr>
<tr>
<td>---------</td>
<td>-----------</td>
</tr>
<tr>
<td>NRSS</td>
<td>National Road Safety Strategy</td>
</tr>
<tr>
<td>NSCSP</td>
<td>National Survey of Community Satisfaction with Policing</td>
</tr>
<tr>
<td>NSOC</td>
<td>National Senior Officials Committee</td>
</tr>
<tr>
<td>NSSC</td>
<td>National Schools Statistics Collection</td>
</tr>
<tr>
<td>NSMHS</td>
<td>National Standards for Mental Health Services</td>
</tr>
<tr>
<td>NSW RFS</td>
<td>New South Wales Rural Fire Service</td>
</tr>
<tr>
<td>NSW</td>
<td>New South Wales</td>
</tr>
<tr>
<td>NSWFB</td>
<td>New South Wales Fire Brigade</td>
</tr>
<tr>
<td>NT</td>
<td>Northern Territory</td>
</tr>
<tr>
<td>NTCE</td>
<td>Northern Territory Certificate of Education</td>
</tr>
<tr>
<td>NTES</td>
<td>National Territory Emergency Services</td>
</tr>
<tr>
<td>NVEAC</td>
<td>National VET Equity Advisory Council</td>
</tr>
<tr>
<td>NYPR</td>
<td>National Youth Participation Requirement</td>
</tr>
<tr>
<td>OCYFS</td>
<td>Office for Children, Youth and Family Support (ACT)</td>
</tr>
<tr>
<td>OECD</td>
<td>Organisation for Economic Co-operation and Development</td>
</tr>
<tr>
<td>OID</td>
<td>Overcoming Indigenous Disadvantage</td>
</tr>
<tr>
<td>OMP</td>
<td>other medical practitioner</td>
</tr>
<tr>
<td>OSHC</td>
<td>outside school hours care</td>
</tr>
<tr>
<td>OSHCQA</td>
<td>Outside School Hours Care Quality Assurance</td>
</tr>
<tr>
<td>OSR</td>
<td>Online services report</td>
</tr>
<tr>
<td>PBS</td>
<td>Pharmaceutical Benefits Scheme</td>
</tr>
<tr>
<td>PC</td>
<td>Productivity Commission</td>
</tr>
<tr>
<td>PDF</td>
<td>Portable Document Format</td>
</tr>
<tr>
<td>Acronym</td>
<td>Description</td>
</tr>
<tr>
<td>---------</td>
<td>-------------</td>
</tr>
<tr>
<td>PDWG</td>
<td>Performance and Data Working Group</td>
</tr>
<tr>
<td>PEP</td>
<td>Personal Enablement Program</td>
</tr>
<tr>
<td>PES</td>
<td>Post Enumeration Survey</td>
</tr>
<tr>
<td>PhARIA</td>
<td>Pharmacy Access/Remoteness Index of Australia</td>
</tr>
<tr>
<td>PHCRIS</td>
<td>Primary Health Care Research and Information Service</td>
</tr>
<tr>
<td>PIF</td>
<td>performance indicator framework</td>
</tr>
<tr>
<td>PIP</td>
<td>Practice Incentives Program</td>
</tr>
<tr>
<td>PIRP</td>
<td>Preschool Investment and Reform Plan</td>
</tr>
<tr>
<td>PISA</td>
<td>Program for International Student Assessment</td>
</tr>
<tr>
<td>PKI</td>
<td>Public Key Infrastructure</td>
</tr>
<tr>
<td>PSM</td>
<td>ABS Population Survey Monitor</td>
</tr>
<tr>
<td>PWI</td>
<td>personal wellbeing index</td>
</tr>
<tr>
<td>QE</td>
<td>Qualification Equivalents</td>
</tr>
<tr>
<td>QFRS</td>
<td>Queensland Fire and Rescue Service</td>
</tr>
<tr>
<td>QIAS</td>
<td>Quality Improvement and Accreditation System</td>
</tr>
<tr>
<td>Qld</td>
<td>Queensland</td>
</tr>
<tr>
<td>QMP</td>
<td>Quality Management Framework</td>
</tr>
<tr>
<td>RACGP</td>
<td>Royal Australian College of General Practitioners</td>
</tr>
<tr>
<td>RAV</td>
<td>Rural Ambulance Victoria</td>
</tr>
<tr>
<td>RCS</td>
<td>resident classification scale</td>
</tr>
<tr>
<td>RFDS</td>
<td>Royal Flying Doctor Service</td>
</tr>
<tr>
<td>RISS</td>
<td>Remote and Indigenous Service Support</td>
</tr>
<tr>
<td>RoGS</td>
<td>Report on Government Services</td>
</tr>
<tr>
<td>ROSC</td>
<td>return of spontaneous circulation</td>
</tr>
<tr>
<td>Acronym</td>
<td>Description</td>
</tr>
<tr>
<td>---------</td>
<td>-------------</td>
</tr>
<tr>
<td>RPBS</td>
<td>Repatriation Pharmaceutical Benefits Scheme</td>
</tr>
<tr>
<td>RPL</td>
<td>recognition of prior learning</td>
</tr>
<tr>
<td>RRMA</td>
<td>Rural, Remote and Metropolitan Areas</td>
</tr>
<tr>
<td>RSE</td>
<td>relative standard error</td>
</tr>
<tr>
<td>RTO</td>
<td>Registered Training Organisation</td>
</tr>
<tr>
<td>S/TES</td>
<td>State/Territory Emergency Service</td>
</tr>
<tr>
<td>SA</td>
<td>South Australia</td>
</tr>
<tr>
<td>SAAP CAD</td>
<td>SAAP Coordination and Development Committee</td>
</tr>
<tr>
<td>SAAP NDCA</td>
<td>SAAP National Data Collection Agency</td>
</tr>
<tr>
<td>SAAP</td>
<td>Supported Accommodation Assistance Program</td>
</tr>
<tr>
<td>SAAS</td>
<td>SA Ambulance Service</td>
</tr>
<tr>
<td>SAT</td>
<td>school-based apprenticeships and traineeships</td>
</tr>
<tr>
<td>SCCHDS</td>
<td>Standing Council on Community, Housing and Disability Services</td>
</tr>
<tr>
<td>SCOTESE</td>
<td>Standing Council on Tertiary Education, Skills and Employment</td>
</tr>
<tr>
<td>SCRCSSP</td>
<td>Steering Committee for the Review of Commonwealth/State Service Provision</td>
</tr>
<tr>
<td>SCRGSP</td>
<td>Steering Committee for the Review of Government Service Provision</td>
</tr>
<tr>
<td>SCSEEC</td>
<td>Standing Council for School Education and Early Childhood</td>
</tr>
<tr>
<td>SDAC</td>
<td>Survey of Disability, Ageing and Carers</td>
</tr>
<tr>
<td>SE</td>
<td>standard error</td>
</tr>
<tr>
<td>SEIFA</td>
<td>Socio Economic Indexes for Areas</td>
</tr>
<tr>
<td>SEM</td>
<td>standard error of the mean</td>
</tr>
<tr>
<td>Acronym</td>
<td>Description</td>
</tr>
<tr>
<td>---------</td>
<td>-------------</td>
</tr>
<tr>
<td>SES</td>
<td>socioeconomic status</td>
</tr>
<tr>
<td>SES</td>
<td>State Emergency Services</td>
</tr>
<tr>
<td>SEWB</td>
<td>National Framework for Aboriginal and Torres Strait Islander Mental Health and Social and Emotional Wellbeing 2004-05</td>
</tr>
<tr>
<td>SEWB</td>
<td>Social and Emotional Wellbeing</td>
</tr>
<tr>
<td>SHSC</td>
<td>Specialist Homelessness Services collection</td>
</tr>
<tr>
<td>SIQ</td>
<td>standard Indigenous question</td>
</tr>
<tr>
<td>SLA</td>
<td>statistical local area</td>
</tr>
<tr>
<td>SMHWB</td>
<td>National Survey of Mental Health and Wellbeing</td>
</tr>
<tr>
<td>SMR</td>
<td>standardised mortality ratios</td>
</tr>
<tr>
<td>SOMIH</td>
<td>State-owned and managed Indigenous housing</td>
</tr>
<tr>
<td>SPP</td>
<td>specific purpose payment or special purpose payment</td>
</tr>
<tr>
<td>SPRC</td>
<td>Social Policy Research Centre</td>
</tr>
<tr>
<td>SSAT</td>
<td>Social Security Appeals Tribunal</td>
</tr>
<tr>
<td>SWPE</td>
<td>standardised whole patient equivalent</td>
</tr>
<tr>
<td>TAFE</td>
<td>technical and further education</td>
</tr>
<tr>
<td>Tas</td>
<td>Tasmania</td>
</tr>
<tr>
<td>TAS</td>
<td>Tasmanian Ambulance Service</td>
</tr>
<tr>
<td>TCP</td>
<td>Transition Care Program</td>
</tr>
<tr>
<td>TEQPPC</td>
<td>Tertiary Education Quality and Pathways Committee</td>
</tr>
<tr>
<td>TFS</td>
<td>Tasmania Fire Service</td>
</tr>
<tr>
<td>TGR</td>
<td>total growth rate</td>
</tr>
<tr>
<td>TIMSS</td>
<td>Trends in International Mathematics and Science Study</td>
</tr>
<tr>
<td>UCC</td>
<td>user cost of capital</td>
</tr>
<tr>
<td>Acronym</td>
<td>Description</td>
</tr>
<tr>
<td>---------</td>
<td>-------------</td>
</tr>
<tr>
<td>UCL</td>
<td>upper confidence limit</td>
</tr>
<tr>
<td>UK</td>
<td>United Kingdom</td>
</tr>
<tr>
<td>URTI</td>
<td>upper respiratory tract infection</td>
</tr>
<tr>
<td>USAR</td>
<td>Urban Search and Rescue</td>
</tr>
<tr>
<td>USA</td>
<td>United States of America</td>
</tr>
<tr>
<td>U-Turn</td>
<td>U-Turn diversionary program for young motor vehicle offenders</td>
</tr>
<tr>
<td>VCAT</td>
<td>Victorian Civil and Administrative Tribunal</td>
</tr>
<tr>
<td>VET</td>
<td>vocational education and training</td>
</tr>
<tr>
<td>VF</td>
<td>ventricular fibrillation</td>
</tr>
<tr>
<td>VHC</td>
<td>Veterans’ Home Care</td>
</tr>
<tr>
<td>Vic</td>
<td>Victoria</td>
</tr>
<tr>
<td>VT</td>
<td>ventricular tachycardia</td>
</tr>
<tr>
<td>WA</td>
<td>Western Australia</td>
</tr>
<tr>
<td>WGIR</td>
<td>Working Group on Indigenous Reform</td>
</tr>
<tr>
<td>WHO</td>
<td>World Health Organisation</td>
</tr>
<tr>
<td>YAT</td>
<td>Youth Attainment and Transitions</td>
</tr>
<tr>
<td>YPIRAC</td>
<td>Younger people in residential aged care</td>
</tr>
</tbody>
</table>
## Glossary

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Access</strong></td>
<td>Measures how easily the community can obtain a delivered service (output).</td>
</tr>
<tr>
<td><strong>Appropriateness</strong></td>
<td>Measures how well services meet client needs and also seeks to identify the extent of any underservicing or overservicing.</td>
</tr>
<tr>
<td><strong>Constant prices</strong></td>
<td>See ‘real dollars’.</td>
</tr>
<tr>
<td><strong>Cost effectiveness</strong></td>
<td>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.</td>
</tr>
<tr>
<td><strong>Current prices</strong></td>
<td>See ‘nominal dollars’.</td>
</tr>
<tr>
<td><strong>Descriptors</strong></td>
<td>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.</td>
</tr>
<tr>
<td><strong>Effectiveness</strong></td>
<td>Reflects how well the outputs of a service achieve the stated objectives of that service (also see program effectiveness).</td>
</tr>
<tr>
<td><strong>Efficiency</strong></td>
<td>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’.)</td>
</tr>
<tr>
<td><strong>Equity</strong></td>
<td>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).</td>
</tr>
<tr>
<td>------------</td>
<td>--------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td><strong>Inputs</strong></td>
<td>The resources (including land, labour and capital) used by a service area in providing the service.</td>
</tr>
<tr>
<td><strong>Nominal dollars</strong></td>
<td>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.</td>
</tr>
<tr>
<td><strong>Output</strong></td>
<td>The service delivered by a service area, for example, a completed episode of care is an output of a public hospital.</td>
</tr>
<tr>
<td><strong>Outcome</strong></td>
<td>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.</td>
</tr>
<tr>
<td><strong>Process</strong></td>
<td>Refers to the way in which a service is produced or delivered (that is, how inputs are transformed into outputs).</td>
</tr>
<tr>
<td><strong>Program effectiveness</strong></td>
<td>Reflects how well the outcomes of a service achieve the stated objectives of that service (also see effectiveness).</td>
</tr>
<tr>
<td><strong>Quality</strong></td>
<td>Reflects the extent to which a service is suited to its purpose and conforms to specifications.</td>
</tr>
<tr>
<td>Term</td>
<td>Definition</td>
</tr>
<tr>
<td>--------------------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td><strong>Real dollars</strong></td>
<td>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.</td>
</tr>
<tr>
<td><strong>Technical efficiency</strong></td>
<td>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.</td>
</tr>
<tr>
<td><strong>Unit costs</strong></td>
<td>Measures average cost, expressed as the level of inputs per unit of output. This is an indicator of efficiency.</td>
</tr>
</tbody>
</table>
Part E

Health
E Health sector overview

CONTENTS
E.1 Introduction E.1
E.2 Sector performance indicator framework E.9
E.3 Cross cutting and interface issues E.57
E.4 Future directions in performance reporting E.58
E.5 Jurisdictions’ comments E.58
E.6 List of attachment tables E.68
E.7 References E.70

Attachment tables
Attachment tables are identified in references throughout this sector overview by an ‘EA’ prefix (for example, table EA.1). A full list of attachment tables is provided at the end of this sector overview, and the attachment tables are available from the Review website at www.pc.gov.au/gsp.

E.1 Introduction
This sector overview provides an introduction to the Public hospitals (chapter 10), Primary and community health (chapter 11), and Mental health management (chapter 12) chapters of this Report. It provides an overview of the health sector, presenting both contextual information and high level performance information.

Major improvements in reporting in health this year are identified in each of the service-specific health chapters.

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. 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.

Policy context

All levels of government in Australia fund, deliver and regulate health services, with most of the activity performed by the Australian, State and Territory governments. The Australian Government’s health services activities include:

- funding State and Territory governments to assist with the cost of providing public hospital services in line with the National Health Reform Agreement and the National Healthcare Agreement (NHA)
- providing rebates to patients and regulating medical services provided by General Practitioners (GPs) and specialists, practice nurses, and some services provided by allied health professionals (such as Medicare), and delivering public health programs
- funding and regulating the Pharmaceutical Benefits Scheme (PBS)
- funding and regulating private health insurance rebates
- funding improved access to primary health care, including Indigenous-specific primary health, specialist services and infrastructure for rural and remote communities
- 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 hearing services for eligible Australians through the Australian Government Hearing Services Program
- funding the Medicare Safety Net.

State and Territory governments contribute funding for, and deliver, a range of health care services (including services specifically for Indigenous Australians) such as:

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

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) and private hospitals.

**Sector scope**

Health services in Australia are delivered by a variety of government and non-government providers in a range of service settings. This Report primarily concentrates on the performance of public hospitals (chapter 10), primary and community health services (including general practice) (chapter 11) and mental health management (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 expenditure on healthcare
• have common objectives across jurisdictions.

High level residential aged care services and patient transport (ambulance) services are not covered in the health chapters in this Report, but are reported separately in chapter 13 (‘Aged care services’) and chapter 9 (‘Fire, road rescue and ambulance’).

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 mental health
• funding for specialist medical practitioners.
Profile of health sector

Detailed profiles for the services within the health sector are reported in chapters 10, 11 and 12, and cover health service funding and expenditure as well as the size and scope of the individual service types.

Descriptive statistics

Descriptive statistics for the health sector are included in this section. Additional descriptive data for each jurisdiction are presented in tables EA.5–EA.6.

Total expenditure (recurrent and capital) on health care services in Australia was estimated to be $130.3 billion in 2010–11 (figure E.1). This total was estimated to account for 9.3 per cent of gross domestic product in 2010–11 an increase of 0.9 percentage points from the 8.4 per cent of GDP in 2001–02 (AIHW 2012).

Figure E.1  **Total health expenditure, by source of funds (2010–11 dollars)**a, b, c, d

<table>
<thead>
<tr>
<th></th>
<th>Australian Government</th>
<th>State, Territory and local</th>
<th>Non-government</th>
</tr>
</thead>
<tbody>
<tr>
<td>2001-02</td>
<td>60.2</td>
<td>33.8</td>
<td>26.4</td>
</tr>
<tr>
<td>2002-03</td>
<td>61.1</td>
<td>34.0</td>
<td>26.0</td>
</tr>
<tr>
<td>2003-04</td>
<td>67.1</td>
<td>39.1</td>
<td>23.8</td>
</tr>
<tr>
<td>2004-05</td>
<td>71.1</td>
<td>41.2</td>
<td>20.8</td>
</tr>
<tr>
<td>2005-06</td>
<td>75.1</td>
<td>43.1</td>
<td>19.9</td>
</tr>
<tr>
<td>2006-07</td>
<td>80.8</td>
<td>46.3</td>
<td>19.3</td>
</tr>
<tr>
<td>2007-08</td>
<td>86.3</td>
<td>49.2</td>
<td>19.5</td>
</tr>
<tr>
<td>2008-09</td>
<td>91.0</td>
<td>52.1</td>
<td>19.9</td>
</tr>
<tr>
<td>2009-10</td>
<td>95.5</td>
<td>54.6</td>
<td>20.9</td>
</tr>
<tr>
<td>2010-11</td>
<td>100.3</td>
<td>57.3</td>
<td>22.4</td>
</tr>
</tbody>
</table>

a Includes recurrent and capital expenditure. b Includes expenditure on 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.


In 2010–11, the health expenditure of the Australian, State and Territory, and local governments was $90.1 billion health expenditure, which represented 69.1 per cent of total health expenditure within Australia. The Australian Government accounted
for the largest proportion of health care expenditure — $55.6 billion or 42.7 per cent of the total in 2010-11. State and Territory, and local governments contributed $34.4 billion or 26.4 per cent of total health expenditure in that year (AIHW 2012). The remainder was paid by individuals, health insurance funds, workers compensation and compulsory motor vehicle third party insurance providers (tables EA.1 to EA.7).

Between 2001-02 and 2010-11, the average annual rate of growth in real expenditure was 5.0 per cent for the Australian Government, 6.5 per cent for State, Territory and local governments, and 4.8 per cent for non-government sources (table EA.1).

The Health chapters (Part E) provide performance information on Australian, State and Territory, and local governments government health services that account for $72.0 billion of total recurrent health expenditure (or 84.4 per cent of all government recurrent expenditure on health in 2010-11) (table EA.4). The services covered are:

- public hospitals (chapter 10)
- primary and community health (chapter 11) — medical services (including payments to general practitioners [GPs] and other specialist practitioners), community and public health, medications and public dental services
- specialist mental health services (chapter 12) — recurrent expenditure estimated to be $6.6 billion in 2010-11 (tables 12A.1 and 12A.6). Some of this expenditure was on psychiatric care provided by public (non-psychiatric) hospitals (chapters 10 and 12).

Health expenditure per person in each jurisdiction is affected by different policy initiatives and socioeconomic and demographic characteristics. Nationally, total health expenditure per person in Australia increased from $4177 in 2001-02 to $5796 in 2010-11 (expressed in 2010-11 dollars) (table EA.5). Government real recurrent health expenditure per person in Australia increased from $2709 in 2001-02 to $3795 in 2010-11 (expressed in 2010-11 dollars). Non-government recurrent expenditure per person in Australia rose from $1253 in 2001-02 to $1707 in 2010-11 (expressed in 2010-11 dollars) (figure E.2 and table EA.6).

1 There was a break in series due to differences in definitions of public hospital and public hospital services between 2002-03 and 2003-04.
Figure E.2  
Recurrent health expenditure per person, by source of funds, excluding high level residential aged care, 2010-11\(^a\), \(^b\), \(^c\)

\[\text{\includegraphics[width=\textwidth]{recurrent-health-expenditure.png}}\]

\(^a\) Includes expenditure on 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 expenditure for NSW residents, and the ACT population is not the appropriate denominator.


Direct expenditure on health services to Indigenous Australians made up $4.7 billion (5.1 per cent) of the total, and 19 per cent of all government expenditure on services to Indigenous Australians (box E.1).

**Box E.1  Government health expenditure for Indigenous Australians**

The 2012 *Indigenous Expenditure Report* (SCRGSP 2012) is the second in a series that provides estimates of expenditure on government services to Indigenous Australians. It provides information on the levels and patterns of expenditure on targeted and mainstream services for Indigenous Australians across 86 expenditure categories (including Health), mapped to the COAG National Indigenous Reform Agreement building blocks.

The report estimates that government direct expenditure on health services for all Australians was $92.8 billion in 2010-11. Direct expenditure on health services to Indigenous Australians made up $4.7 billion (5.1 per cent) of the total, and 19 per cent of all government expenditure on services to Indigenous Australians.

- State and Territory governments provided $3.1 billion (66 per cent) of direct Indigenous expenditure — the Australian Government provided the remaining 34 per cent, plus significant indirect expenditure ‘to’ and ‘through’ the State and Territory governments.
Box E.1 continued

- most Indigenous expenditure related to mainstream services (74 per cent, $3.5 billion) — but Indigenous specific (targeted) expenditure (such as Indigenous child and maternity health services and the Remote Aboriginal Health Services Program) accounted for $1.2 billion (26 per cent) of direct health expenditure.

In total, $2.02 was spent per Indigenous person in the population for every dollar spent per non-Indigenous person. Indigenous expenditure per person was:

- higher for public and community health services (a ratio of $4.89 to 1) — which includes expenditure on Aboriginal Community Controlled Health Organisation services

- lower for health care subsidies and support (a ratio of $0.66 to 1) — which includes expenditure on Medicare rebates, pharmaceutical benefits subsidies (such as the PBS) and private health insurance rebates.

In addition to the Indigenous Expenditure Report, detailed information on health expenditure (including by the non-government sector) and drivers of health costs are available from Expenditure on Health for Aboriginal and Torres Strait Islander People 2008-09 (AIHW 2011). The AIHW methodology is similar to the Indigenous Expenditure Report methodology, but undertakes the estimation of expenditure at a more detailed level. This provides greater scope for analysis at lower levels, and also allows the case-mix characteristics of health services to be reflected more precisely in the aggregated estimates.

Source(s): SCRGSP (2012); AIHW (2011).

Social and economic factors affecting demand for services

There is a complex relationship between social and economic factors and demand for health services.

It has been well documented that people who experience social and economic disadvantage are at risk of negative health outcomes. Compared with those who have social and economic advantages, disadvantaged Australians are more likely to have shorter lives (AIHW 2010). Those who are disadvantaged tend to have greater health risks such as smoking more and higher rates of obesity (SCRGSP 2009). Burden-of-disease studies indicate greater burden among people who are relatively disadvantaged in society (Begg et al. 2007). Those who are disadvantaged are more likely to report their health as fair or poor than those that do not suffer the same disadvantage as measured by the Socio Economic Indexes for Areas (SEIFA) (table EA.50).

While social and economic disadvantage can be linked to negative health outcomes, the effect on demand is less clear. Poor health could increase demand for health
services, however, poor health could be the result of not accessing health services when required because of financial, educational or geographic barriers:

- Higher income and wealth are associated with better health. People with higher income are better able to access health services in a timely manner, and are also able to access goods and services that have health benefits such as better housing, food and other healthy pursuits (AIHW 2010).

- People with higher education levels are likely to have better health. Those with higher education levels have better prospects of employment and higher incomes, allowing greater access to health care. Higher education levels are also likely to help people gain the knowledge and confidence to look after their health and obtain the best care (AIHW 2010).

- Geographic distance to health services, particularly in remote and very remote areas, can contribute to poor health. People living in rural and remote areas tend to have higher levels of disease risk factors and illness than those in major cities (AIHW 2010). Those in remote areas are more likely to report their health as fair or poor and less likely to report their health as excellent, very good or good than those in major cities (table EA.49).

Indigenous Australians are generally less healthy than other Australians, die at much younger ages, and have more disability and a lower quality of life (AIHW 2010 and tables EA.32–EA.34). Many Indigenous Australians live in conditions of social and economic disadvantage. Indigenous Australians have low employment and income levels when compared to non-Indigenous Australians (see statistical appendix tables AA.2, AA.23–AA.25, and AA.34–AA.36, and SCRGSP 2011). Indigenous Australians have relatively high rates for many health risk factors and are more likely to smoke and to consume alcohol at risky levels (ABS 2006a and SCRGSP 2011). Indigenous Australians are more likely to live in inadequate and overcrowded housing (SCRGSP 2011) and in remote areas with more limited access to health services. In 2006, 51,992 Indigenous Australians were living in discrete Indigenous communities that were 100 kilometres or more from the nearest hospital (ABS 2007).

**Service-sector objectives**

Government involvement in health services is predicated on the desire to improve the health of all Australians and to ensure equity of access and the sustainability of the Australian health system. Box E.2 presents the overall objectives of the health system as summarised for this Report, which are consistent with the objectives outlined in the National Healthcare Agreement (MCFFR 2012). Governments provide a variety of services in different settings to fulfil these objectives.
Overall objectives of the health system

Government involvement in the health system is aimed at efficiently and effectively improving health outcomes for all Australians and ensuring the sustainability of the Australian health system, achieving the following outcomes:

- Australians are born and remain healthy
- Australians receive appropriate high quality and affordable primary and community health services
- Australians receive appropriate high quality and affordable hospital and hospital related care
- Australians have positive health care experiences which take account of individual circumstances and care needs
- Australians have a health system that promotes social inclusion and reduces disadvantage, especially for Indigenous Australians
- Australians have a sustainable health system.

Measuring the equity, effectiveness 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 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) plays 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.

E.2 Sector performance indicator framework

This sector overview is based on a sector performance indicator framework (figure E.3). This framework is made up of the following elements:

- Sector objectives — three sector objectives are a précis of the key objectives of the health system and reflect the outcomes in the NHA (box E.2).
- Sector-wide indicators — seven sector-wide indicators relate to the overarching service sector objectives identified in the NHA.
- Information from the service-specific performance indicator frameworks that relate to health services. Discussed in more detail in chapters 10, 11 and 12, the service-specific frameworks provide comprehensive information on the equity, effectiveness and efficiency of these services.
This sector overview provides an overview of relevant performance information. Chapters 10, 11 and 12 and their associated attachment tables provide more detailed information.

Figure E.3  **Health services sector performance indicator framework**

**Sector objectives**

<table>
<thead>
<tr>
<th>Objective</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Australians are born and remain healthy</td>
<td></td>
</tr>
<tr>
<td>Australians have a sustainable health system</td>
<td></td>
</tr>
<tr>
<td>Australians have a health system that promotes social inclusion and reduces disadvantage, especially for Indigenous Australians*</td>
<td></td>
</tr>
</tbody>
</table>

**Sector-wide indicators**

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Babies born of low birthweight*</td>
<td></td>
</tr>
<tr>
<td>Prevalence of risk factors to the health of Australians*</td>
<td></td>
</tr>
<tr>
<td>Selected potentially preventable diseases*</td>
<td></td>
</tr>
<tr>
<td>Potentially avoidable deaths*</td>
<td></td>
</tr>
<tr>
<td>Mortality and life expectancy*</td>
<td></td>
</tr>
</tbody>
</table>

* Selected indicators disaggregated by: Indigenous status; disability status; remoteness area; and socio-economic status, where appropriate.

**Service-specific performance indicator frameworks**

<table>
<thead>
<tr>
<th>Chapter</th>
<th>Description</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chapter 10 Public hospitals</td>
<td>Public hospitals</td>
<td>p. 10.16</td>
</tr>
<tr>
<td></td>
<td>Maternity services</td>
<td>p. 10.61</td>
</tr>
<tr>
<td>Chapter 11 Primary and community health</td>
<td>Primary and community health</td>
<td>p. 11.16</td>
</tr>
<tr>
<td>Chapter 12 Mental health management</td>
<td>Mental health management</td>
<td>p. 12.19</td>
</tr>
</tbody>
</table>
Data quality information (DQI) is being progressively introduced for all indicators in the Report. The purpose of DQI is to provide structured and consistent information about quality aspects of data used to report on performance indicators. DQI in this Report cover the seven dimensions in the ABS’ data quality framework (institutional environment, relevance, timeliness, accuracy, coherence, accessibility and interpretability) in addition to dimensions that define and describe performance indicators in a consistent manner, and note key data gaps and issues identified by the Steering Committee. All DQI for the 2013 Report can be found at www.pc.gov.au/gsp/reports/rogs/2013.

**Sector-wide performance indicators**

This section includes high level indicators of health outcomes. Many factors are likely to influence outcomes — not solely the performance of government services. However, these outcomes inform the development of appropriate policies and delivery of government services.

*Babies born of low birth weight*

‘Babies born of low birth weight’ is an indicator of governments’ objective that Australians are born and remain healthy (box E.3). The birth weight of a baby is an important indicator of its health status and future wellbeing. Low birth weight babies have a greater risk of poor health and dying, require a longer period of hospitalisation after birth, and are more likely to develop significant disabilities (Goldenberg & Culhane 2007).

<table>
<thead>
<tr>
<th>Box E.3</th>
<th><strong>Low birth weight of babies</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Babies’ birth weight is defined as low if they weigh less than 2500 grams, very low if they weigh less than 1500 grams and extremely low if they weigh less than 1000 grams (Li et al. 2011).</td>
<td></td>
</tr>
<tr>
<td>A low or decreasing number of low birth weight babies is desirable.</td>
<td></td>
</tr>
<tr>
<td>Factors external to the health system also have a strong influence on the birth weight of babies. Some factors contributing to low birth weight include socioeconomic status, size of parents, age of mother, number of babies previously born, mother’s nutritional status, smoking and alcohol intake, and illness during pregnancy (Li et al. 2011).</td>
<td></td>
</tr>
<tr>
<td>Data reported for this indicator are comparable.</td>
<td></td>
</tr>
</tbody>
</table>
In 2010, 91.9 per cent of liveborn babies in Australia weighed between 2500 and 4499 grams (Li et al. 2012). The average birth weight for all live births was 3369 grams in 2010 (table EA.8).

Nationally, rates of low birth weight babies increased with remoteness, from 4.5 per cent in major cities, rising to 5.3 per cent in outer regional areas, then 8.9 per cent in very remote areas in 2010 (table EA.11).

In 2010, 6.2 per cent of all liveborn babies in Australia weighed less than 2500 grams. This included 1.0 per cent of babies with a very low birth weight (who weighed less than 1500 grams) (table EA.8).

Nationally, the average birth weight for liveborn babies of Indigenous mothers was 3190 grams in 2010 (table EA.9). Among live-born singleton babies born to Indigenous mothers in 2010, the proportion with low birth weight was over twice that of those born to non-Indigenous mothers (figure E.4).

Figure E.4 Proportion of live-born singleton babies of low birthweight, by maternal Indigenous status, 2010a, b, c, d, e

<table>
<thead>
<tr>
<th></th>
<th>Indigenous mothers</th>
<th>Non-Indigenous mothers</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>NSW</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vic</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Qld</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>WA</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SA</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tas</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ACT</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NT</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Aust</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

a Low birth weight is defined as less than 2500 grams. b Disaggregation by State/Territory is by place of usual residence of the mother. c Data excludes Australian non-residents, residents of external territories and where State/Territory of residence was not stated. d Excludes stillbirths and multiple births. Births were included if they were at least 20 weeks gestation or at least 400 grams birth weight. e Birth weight data on babies born to Indigenous mothers residing in the ACT and Tasmania should be viewed with caution as they are based on small numbers of births.

Prevalence of risk factors to the health of Australians

‘Prevalence of risk factors to the health of Australians’ is an indicator of governments’ objective that Australians are born and remain healthy (box E.4).

A number of behaviours create risks to health outcomes; for example, lack of exercise, smoking, excessive alcohol consumption, sun exposure and unhealthy dietary habits. Health services are concerned with promoting, restoring and maintaining a healthy society. An important part of this activity is reducing health risk factors through activities that raise awareness of health issues to reduce the risk and onset of illness and injury.

Box E.4 Prevalence of risk factors to the health of Australians

‘Prevalence of risk factors to the health of Australians’ is defined by the following measures:

- Prevalence of overweight and obesity — the number of people with a Body Mass Index (BMI) in the categories of either overweight or obese, as a percentage of the population. BMI is calculated as weight (kg) divided by the square of height (m). BMI values are grouped according to World Health Organization and National Health and Medical Research Council guidelines.
  
  Among adults, a BMI of 25 to less than 30 is considered overweight and a BMI of 30 and over is considered to be obese (WHO 2000; NHMRC 2003).
  
  Children are defined as people aged 5–17 years. For children, obesity is defined as BMI (appropriate for age and sex) that is likely to be 30 or more at age 18 years.

- Rates of current daily smokers — number of people aged 18 years or over who smoke tobacco every day as a percentage of the population aged 18 years or over.

- Risk of alcohol related harm over a lifetime — people aged 18 years or over assessed as having an alcohol consumption pattern that puts them at risk of long-term alcohol related harm, as a percentage of the population aged 18 years or over.
  
  ‘Lifetime risk of alcohol related harm’ is defined according to the 2009 National Health and Medical Research Council guidelines: for males and females, no more than two standard drinks on any day. This has been operationalised as: for both males and females, an average of more than 2 standard drinks per day in the last week.

Rates for all three measures are age standardised.

A low or decreasing rate is desirable for each health risk factor.

Data reported for this indicator are comparable.

Prevalence of overweight and obesity

Being overweight or obese increases the risk of an individual developing, among other things, heart disease, stroke and Type 2 diabetes. In 2011-12, over a third of Australians’ measured BMI was in the overweight range and over a quarter were obese (table EA.12).

The percentage of adults who were overweight or obese tended to be higher in remote (72.8 per cent) and outer regional areas (68.4 per cent), than in major cities (61.6 per cent) in 2011-12 (table EA.13). The percentage of people who were overweight or obese increased from 2007-08 in all areas of Australia (table EA.13).

Figure E.5  Proportion of adults in BMI categories\(a, b, c, d\)

![Figure E.5](image)

\(a\) Adults are defined as people aged 18 years and over. Children are defined as people aged 5–17 years. 
\(b\) Obesity for adults is defined as BMI equal to or greater than 30. 
\(c\) Measured people only. 
\(d\) Rates are age standardised by State and Territory, to the 2001 Estimated Resident Population. 


The percentage of people who were overweight or obese tended to be higher in older age groups, peaking at age 70–74 for males and females (82.6 per cent and 75.1 per cent respectively) in 2011-12. Overall, the percentage of males and females that were overweight or obese increased from 2007-08 (by 2.5 percentage points for males and 1.4 percentage points for females) although the change varied by age category (table EA.15).

Nationally, there were almost twice as many obese Indigenous adults (33.6 per cent) as non-Indigenous obese adults (17.7 per cent) in 2004-05 (table EA.16).
Rates of current daily smokers

Smoking is an important risk factor for heart disease, stroke and lung cancer. These were the three leading causes of death in Australia in 2009 (ABS 2012). Smoking is responsible for around 80 per cent of all lung cancer deaths and 20 per cent of all cancer deaths (HealthInsite 2011).

The proportion of adult daily smokers aged 18 years and over accounted for 16.5 per cent of the population in 2011-12, a decrease of 2.6 percentage points from 2007-08 (figure E.6 and table EA.18).

Nationally, people from lower socioeconomic backgrounds have a higher propensity to smoke (age standardised). In 2011-12, 24.5 per cent of adults living in areas from the first quintile of the SEIFA were daily smokers, compared with 10.2 per cent from the fifth quintile (figure E.6 and table EA.18).

Figure E.6  Proportion of adults who are daily smokers, by State and Territorya, b, c, d

![Graph showing proportion of daily smokers by State and Territory]

a Rates for total are age standardised by State and Territory to the 2001 Estimated Resident Population (5 year ranges from 18 years). b A lower SEIFA quintile indicates relatively greater disadvantage and a lack of advantage in general. A higher SEIFA quintile indicates a relative lack of disadvantage and greater advantage in general. c Total includes persons for whom an Index of disadvantage of residence score was not known. d Estimates with RSEs between 25 per cent and 50 per cent should be used with caution. Estimates with RSEs greater than 50 per cent are considered too unreliable for general use.


Adults from more remote locations also had a higher propensity to smoke (age standardised). Daily smokers accounted for 26.5 per cent of the population in remote geographical areas, gradually decreasing as remoteness of residence
decreases, accounting for 22.9 per cent of the population in outer regional areas, 19.9 per cent in inner regional areas and 14.8 per cent in major cities (table EA.17).

Nationally, Indigenous Australians had higher age standardised rates of daily smoking (44.8 per cent) than non-Indigenous Australians (18.9 per cent) in 2007-08 (table EA.19).

*Levels of risky alcohol consumption*

The National Health and Medical Research Council (NHMRC) reports that excessive long term alcohol consumption increases the risk of heart disease, diabetes, liver cirrhosis and some types of cancers. It can contribute to injury and death through accidents, violence, suicide and homicide, and also to financial problems, family breakdown, and child abuse and neglect (NHMRC 2009).

Rates are based on the 2009 NHMRC guidelines for reducing risks from drinking alcohol (NHMRC 2009). Across Australia, 19.4 per cent of adults were at risk of alcohol related harm over a lifetime in 2011-12, although the age standardised rates varied among jurisdictions (table EA.20). Adults who are at risk of alcohol related harm over a lifetime gradually decreased as remoteness of residence decreased in 2011-12 (figure E.7). There is no statistically significant difference between socioeconomic categories of the proportion of Australians at risk of alcohol related harm over a lifetime (table EA.21).
Figure E.7  **Proportion of adults at risk of alcohol related harm over a lifetime, by remoteness, 2011-12**

Nationally, the age standardised proportion of adults at risk of alcohol related harm over a lifetime (2001 NHMRC guidelines) was slightly higher for Indigenous Australians (15.4 per cent) than for non-Indigenous Australians (13.5 per cent) in 2004-05, although results varied across jurisdictions (table EA.22).

**Selected potentially preventable diseases**

‘Selected potentially preventable diseases’ is an indicator of governments’ objective that Australians are born and remain healthy (box E.5).
Box E.5  **Selected potentially preventable diseases**

‘Selected potentially preventable diseases’ is defined by the following measures:

- **Incidence of selected cancers** — incidence of selected cancers of public health importance.
  - For melanoma, lung and bowel cancer, the measure is defined as the number of new cases in the reported year expressed as a directly age standardised rate.
  - For breast and cervical cancer in females, the measure is defined as the number of new cases in women in the reported year expressed as a directly age standardised rate.

Calculated separately for each type of cancer.

- **Incidence of heart attacks** — the number of deaths recorded as acute coronary heart disease deaths plus the number of non-fatal hospitalisations for acute myocardial infarction or unstable angina not ending in a transfer to another acute hospital, as a percentage of the total population.

- **Prevalence of type 2 diabetes** — the number of people recorded as having Type 2 diabetes as a percentage of the total population.

A low or decreasing rate is desirable for each incidence/prevalence rate.

Data reported for this indicator are comparable.


As well as addressing health risk factors, well-planned disease prevention and early intervention programs help prevent a number of diseases (or more successfully treat through early identification). A number of programs form an important element of preventing disease and improving the health of Australians (NPHT 2009), such as:

- immunisation
- cancer screening and early treatment
- early detection and intervention (box E.6)
- individual disease risk assessments and early intervention for biomedical risk factors such as: high blood pressure, high blood cholesterol, or impaired glucose tolerance
- childhood infectious diseases control
- sexually transmitted infections control.
Stroke is the second single greatest cause of premature death and one of the leading causes of disability in Australia. The risk of having a stroke following a Transient Ischaemic Attack (TIA) (commonly referred to as a ‘mini-stroke’) is around 10 per cent within the first 30 days, rising to 15 per cent in high risk patients. Most occur within the first 48 hours of a TIA.

The Transient Ischaemic Attack Rapid Assessment Clinic (TIA RAC) was established at the Queen Elizabeth Hospital in Adelaide's West to rapidly assess patients and implement treatment to prevent subsequent stroke. Facilitated by a dedicated TIA nurse, the Clinic provides comprehensive assessment, continuous blood pressure and cardiac rhythm monitoring and cerebrovascular imaging to patients with suspected TIA. Patients are identified through the Stroke Unit via the Emergency Department (ED) or are directly referred by their general practitioner (GP). All patients are reviewed by a stroke physician following investigation.

The design of the TIA RAC is based on published peer-reviewed evidence. This includes findings from the ‘Express study’ which concluded that rapid assessment and initiation of treatment within 24 hours can reduce the risk of early recurrent stroke after TIA or minor stroke by 80 per cent. Furthermore, the National Stroke Foundation Clinical Guidelines for Stroke Management 2010 recommend that high risk TIA patients be seen within 24 hours and low risk patients within 7 days.

Prior to its establishment, a patient presenting to the ED with suspected TIA was admitted for inpatient workup with an average length of stay of 6.75 days. For such patients presenting to their GP, referral to a neurologist was common, with an average waiting time of at least three months.

During the first two years of its operation, 200 patients were assessed by the TIA RAC with none of them having a recurrent stroke at 30 days. Of this group, only 18 patients (9 per cent) were admitted to the Stroke Unit, indicating that up to 182 admissions were avoided. Given an average length of stay for TIA of 6.75 days, up to 1,230 inpatient bed days were averted. The cost associated with these averted bed days equates to over 3 times the financial investment in the TIA RAC Program over the two year period. Furthermore, the 18 patients who still required admission had a markedly shorter hospitalisation, since a comprehensive diagnostic assessment had already been completed through the TIA RAC prior to admission.

Patient case studies also suggest that the rapid investigation of patients in the TIA RAC results in positive patient outcomes by avoiding subsequent stroke:

Continued next page
Box E.6  continued

- Patient 1 presented to the ED with left-sided sensory impairment which lasted for 10 minutes and resolved spontaneously. The patient was reviewed in the ED and discharged 2 hours later with a referral to the TIA RAC for a comprehensive work up. The patient was assessed within 48 hours and MRI revealed an ulcerated plaque in the right carotid artery. The patient was admitted to the Stroke Unit and a carotid endarterectomy performed and discharged 2 days post-surgery without any residual weakness. While hospital admission was not avoided, early intervention prevented the reoccurrence of stroke and potentially an extended hospital stay and ongoing disability.

- Patient 2 presented to the ED with left-sided numbness and slurred speech lasting for approximately one hour. The patient was referred to the TIA RAC and seen within 24 hours. Investigations revealed Atrial Fibrillation, which was subsequently managed with anticoagulation without further recurrence. Early assessment and management prevented major stroke in this patient.

The South Australian Statewide Stroke Clinical Network has recommended the establishment of a centralised TIA service for metropolitan South Australia.

Source(s): SA Government.

Incidence of selected cancers

Health service efforts to control cancer involve (AIHW 2012a):

- public health programs — programs to reduce the major risk factors; tobacco consumption, poor diet, insufficient physical activity, being overweight or obese, unsafe alcohol use, infectious diseases and exposure to ultraviolet radiation

- early detection — screening programs for cancers in Australia have contributed to substantial declines in associated mortality. Screening can also help prevent the development of cancer if changes can be found before they become cancer

- research support — such as provided through the National Health and Medical Research Council.

Nationally, the age standardised rate of lung cancer was 43.2 new cases per 100 000 people in 2009. Bowel cancer, which has been linked to diet, occurred at a rate of 61.0 new cases per 100 000 people in 2009 (table EA.23). Other cancers such as melanoma are also preventable. The incidence of these cancers for 2009, along with breast and cervical cancer, are reported in figure E.8. Tables EA.24–26 report the incidence of the selected cancers by remoteness, SEIFA IRSD quintiles and Indigenous status.
Figure E.8  **Incidence of selected cancers, per 100 000 people, 2009**

Incidence of heart attacks

Cardiovascular disease is the largest cause of premature death in Australia. Although death rates for cardiovascular disease have declined considerably in recent decades, it continues to be one of the biggest health problems requiring attention in Australia (AIHW 2012a).

The major, preventable risk factors for cardiovascular disease are: tobacco smoking; high blood pressure; high blood cholesterol; insufficient physical activity; overweight and obesity; poor nutrition; and diabetes.

Nationally, the rate of heart attacks was 443.1 new cases per 100 000 people in 2010 (table EA.28). The incidence of heart attacks was greater for Indigenous Australians (table EA.27). Caution should be taken in interpreting these data as they have been estimated using an algorithm that is under AIHW development. It should be considered an interim measure until current validation work is complete.
**Prevalence of type 2 diabetes**

Diabetes mellitus is a chronic condition in which the body makes too little of the hormone insulin or cannot use it properly. Type 2 diabetes is the most common form of diabetes, occurring mostly in people aged 50 years and over, and accounting for 85-90 per cent of all cases (AIHW 2012a).

Diabetes mellitus and its complications contribute significantly to ill health, disability, poor quality of life and premature death. It also increases the risk of a variety of complications including end-stage kidney disease, coronary heart disease, stroke and other vascular diseases. Type 2 diabetes is more common in people who do insufficient physical activity and are overweight or obese. It is strongly associated with high blood pressure, high cholesterol and excess weight carried around the waist (Better Health Channel 2012). Thus, early intervention and treatment programs have the potential to reduce the cases and severity of the disease.

Definitions and data are yet to be developed for reporting on a nationally comparable basis.

**Potentially avoidable deaths**

‘Potentially avoidable deaths’ is an indicator of governments’ objective that Australians are born and remain healthy (box E.7). Avoidable deaths reflect the effectiveness of current and past preventative health activities.

Indigenous Australians had significantly higher death rates from potentially avoidable deaths (preventable and treatable) over the period 2006–2010, comprising higher potentially preventable deaths per 100 000 people and higher treatable deaths per 100 000 people (figure E.9 and table EA.30). Single year data for all Australians are presented in table EA.29.
Box E.7 **Potentially avoidable deaths**

‘Potentially avoidable deaths’ is defined as potentially preventable deaths (deaths amenable to screening and primary prevention, such as immunisation) and deaths from potentially treatable conditions (deaths amenable to therapeutic interventions) for those aged less than 75 years per 100,000 people aged less than 75 years.

A low or decreasing potentially avoidable death rate is desirable.

Most components of the health system can influence potentially avoidable death rates, although there can be decades between the action and the effect. Factors external to the health system also have a strong influence on potentially avoidable death rates.

Data reported for this indicator are comparable.

Figure E.9  Age standardised mortality rates of potentially avoidable deaths, under 75 years, 2006–2010a, b, c, d, e, f, g, h

<table>
<thead>
<tr>
<th></th>
<th>Indigenous</th>
<th>Non-Indigenous</th>
</tr>
</thead>
<tbody>
<tr>
<td>NSW</td>
<td>[Graph]</td>
<td>[Graph]</td>
</tr>
<tr>
<td>Qld</td>
<td>[Graph]</td>
<td>[Graph]</td>
</tr>
<tr>
<td>WA</td>
<td>[Graph]</td>
<td>[Graph]</td>
</tr>
<tr>
<td>SA</td>
<td>[Graph]</td>
<td>[Graph]</td>
</tr>
<tr>
<td>NT</td>
<td>[Graph]</td>
<td>[Graph]</td>
</tr>
<tr>
<td>Total</td>
<td>[Graph]</td>
<td>[Graph]</td>
</tr>
</tbody>
</table>

a Standardised death rates (SDRs) are expressed per 1000 or 100 000 persons. SDRs in this table have been calculated using the direct method, age-standardised by 5 year age groups to less than 75 years. b Avoidable mortality has been defined in the Public Health Information Development Unit’s report, Australian and New Zealand Atlas of Avoidable Mortality (2006), and in reports by NSW Health and the Victorian Department of Human Services as mortality before the age of 75 years, from conditions which are potentially avoidable within the present health system. c Data based on reference year. See data quality statements for a more detailed explanation. d Data are reported by jurisdiction of residence for NSW, Queensland, WA, SA and the NT only. Only these five states and territories have evidence of a sufficient level of Indigenous identification and sufficient numbers of Indigenous deaths to support mortality analysis. e Care should be taken when interpreting deaths data for Queensland as they are affected by recent changes in the timeliness of birth and death registrations. Queensland deaths data for 2010 have been adjusted to minimise the impact of late registration of deaths on mortality indicators. See data quality statements for a more detailed explanation. f Total includes data for NSW, Queensland, WA, SA and the NT only. g Preventable deaths are those which are amenable to screening and primary prevention such as immunisation, and reflect the effectiveness of the current preventative health activities of the health sector. h Deaths from potentially treatable conditions are those which are amenable to therapeutic interventions, and reflect the safety and quality of the current treatment system.

The mortality and life expectancy of Australians

‘The mortality and life expectancy of Australians’ is an indicator of governments’ objective that Australians are born and remain healthy (box E.8).

Comparing mortality and life expectancy data across populations, including cause, age, sex, population group and geographical distribution, provide important insights into the overall health of Australians (AIHW 2012d). Trends over time in mortality and life expectancy data can signal changes in the health status of the population, as well as provide a baseline indicator for the effectiveness of the health system.

**Box E.8  The mortality and life expectancy of Australians**

‘The mortality and life expectancy of Australians’ is defined by the following measures:

- ‘Life expectancy’ — the average number of additional years a person of a given age and sex might expect to live if the age-specific death rates of the given period continued throughout his/her lifetime.
  
  A high or increasing life expectancy is desirable.

- ‘Median age at death’ — 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.
  
  A high or increasing median age at death is desirable.

- ‘Mortality rates’ — the number of deaths compared to the total population (expressed as a rate). Rates are provided for:
  - Australian mortality rate — age standardised mortality per 1000 people
  - infant and child mortality rates — the number of deaths of children under one year of age in a calendar year per 1000 live births in the same year (infant mortality rate) and the number of deaths of children between one and four years of age in a calendar year per 100 000 children (child mortality rate)
  - mortality rates by major cause of death — age standardised deaths, by cause of death compared to the total population (expressed as a rate).
  
  A low or decreasing mortality rate is desirable.

Most components of the health system can influence the mortality and life expectancy of Australians, although there can be decades between the action and the effect. Factors external to the health system also have a strong influence.

Data reported for this indicator are comparable.

Life expectancy

The life expectancy of Australians improved dramatically during the twentieth century and so far during the 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 2011a). It has risen steadily in each decade since, reaching 79.7 years for males and 84.2 years for females in 2009–2011 (figure E.10).

Figure E.10  All Australians average life expectancy at birth, 2009–2011

The life expectancies of Indigenous Australians are considerably lower than those of non-Indigenous Australians. ABS experimental estimates indicate a life expectancy at birth of 67.2 years for Indigenous males and 72.9 years for Indigenous females born from 2005 to 2007. In the same time period, life expectancy at birth for non-Indigenous males was 78.7 years and for non-Indigenous females was 82.6 years (figure E.11 and table EA.32).

\(^{a}\) Data for Australia include ‘other territories’.

Figure E.11  **Estimated life expectancies at birth, by Indigenous status and sex, 2005–2007 (years)**\(^a, b, c\)

![Graph showing life expectancies](image)

\(^a\) Indigenous estimates of life expectancy are not available for Victoria, SA, Tasmania or the ACT due to the small number of Indigenous deaths in these jurisdictions. \(^b\) Life tables are constructed separately for Males and Females. \(^c\) Australian total includes all states and territories.

**Source:** ABS (2009) *Experimental Life Tables for Aboriginal and Torres Strait Islander Australians 2005–2007*, Australia, Cat. no. 3302, Canberra; table EA.32.

**Median age at death**

The median age at death in 2011 was 78.5 years of age for Australian males and 84.5 years of age for Australian females (table EA.33).

Comparisons of the median age at death for Indigenous and non-Indigenous Australians 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 falls significantly in older age groups. The median age of death for Indigenous Australians is, therefore, likely to be an underestimate.

Caution should be taken when comparing median age at death between Indigenous and non-Indigenous populations. Coory and Baade (2003) note that:

- the relationship between a change in median age at death and a change in death rate depends upon the baseline death rate. So comparison of trends in median age at death for Indigenous and non-Indigenous Australians is difficult to interpret
- changes in the median age at death of public health importance might be difficult to distinguish from statistical noise.
In the jurisdictions for which data were available for Indigenous Australians, the median age at death for male Indigenous Australians was 55.4 years of age. The median age at death for female Indigenous Australians was 58.5 years of age (figure E.12 and table EA.33).

Figure E.12  **Median age at death, by sex and Indigenous status, 2011**

![Median age at death, by sex and Indigenous status, 2011](image_url)

*Victoria, Tasmania and the ACT are excluded due to small numbers of registered Indigenous deaths. The accuracy of Indigenous mortality data is 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 (2012a) *Deaths Australia, 2011*, Cat. no. 3302.0, Canberra; table EA.33.

**Mortality rates**

There were 146,932 deaths in Australia in 2011 (ABS 2012a), which translated into an age standardised mortality rate of 5.6 deaths per 1000 people (figure E.13). Death rates over the last 20 years have declined for all states and territories (ABS 2012a).

**Mortality rates — Infant and child**

The infant mortality rate in Australia declined from an average of 5.2 deaths per 1000 live births over the period 2000–2002 to 4.1 deaths per 1000 live births over the period 2009–2011 (figure E.14 and table EA.35).
Figure E.13  **Mortality rates, age standardised**a, b, c, d  

![Graph showing mortality rates](image)

*a* Deaths are based on year of registration of death.  
*b* Deaths per 1000 standard population. Standardised death rates use total people in the 2001 Australian population as the standard population.  
*c* Death rates data for 2007 have been revised.  
*d* Australian totals includes all states and territories.  

Source: ABS (2011) *Deaths 2010*, Australia, Cat. no. 3302.0, AusInfo, Canberra; table EA.34.

Figure E.14  **Infant mortality rate, three year average**a, b  

![Graph showing infant mortality rates](image)

*a* Infant deaths per 1000 live births.  
*b* Data for Australia include all states and territories.  

Source: ABS (2011) *Deaths Australia, 2010*, Australia, Cat. no. 3302.0, Canberra; table EA.35.

The Australian child mortality rate was 18.6 deaths per 100 000 of the child population in 2009–2011 (children aged 1 to 4 years). The mortality rate for infants and children combined (those aged 0 to 4 years) was 97.9 deaths per 100 000 of the population in 2009–2011 (table EA.36).
Mortality rates — by remoteness

Mortality indicators showed that very remote areas of Australia have had consistently higher mortality rates than the other remoteness areas. For the period 2007 to 2011 the age standardised mortality rates were highest in very remote areas (8.2 deaths per 1000 people), while major cities had the lowest mortality rates (5.6 deaths per 1000 people) (ABS 2012a).

Mortality rates — Indigenous

Data on Indigenous mortality are collected through State and Territory death registrations. The completeness of identification of Indigenous Australians in these collections varies significantly across states and territories so care is required when making comparisons.

For the period 2007–2011, NSW, Queensland, WA, SA and the NT have been assessed as having adequate identification of Indigenous deaths for mortality analysis. For these five jurisdictions combined, the overall rates of mortality for Indigenous Australians were nearly twice as high as mortality rates for non-Indigenous Australians based on data for 2007–2011 (figure E.15 and table EA.34). Due to identification completeness issues, mortality rates presented here are likely to be under-estimates of the true mortality of Indigenous Australians (ABS and AIHW 2008).

Data on longer-term trends for WA, SA and the NT suggest that the mortality rate for Indigenous infants decreased by 62 per cent between 1991 and 2010 (AHMAC 2012). Despite this significant improvement, infant mortality rates for Indigenous children are still markedly higher than for non-Indigenous children in Australia.

For the period 2007–2011, the average infant mortality rate for Indigenous infants (less than one year) was higher than for non-Indigenous infants in the jurisdictions (NSW, Queensland, WA, SA and NT) for which there were data available (table EA.37). For the same period, the average child mortality rate for Indigenous children (1–4 years) was also higher for these jurisdictions (table EA.37). The combined infant and child average mortality rate for Indigenous infants and children (0–4 years) was 211.9 deaths per 100 000 of the infant and child population in NSW, Queensland, WA, SA and NT. This compared with 95.4 deaths per 100 000 of the infant and child population for non-Indigenous infants and children (table EA.37).
**Figure E.15**  Mortality rates, age standardised, by Indigenous status, five year average, 2007–2011\(^{a, b, c, d}\)

![Mortality rates chart](chart.png)

\(^{a}\) Deaths are based on year of registration of death. \(^{b}\) Deaths per 1000 population. Standardised death rates use total people in the 2001 Australian population as the standard population. \(^{c}\) Calculations of rates for the Indigenous population are based on ABS Experimental Projections, Aboriginal and Torres Strait Islander Australians 1991 to 2009 (ABS Cat. no. 3238.0, low series, 2001 base). There are no comparable population data for the non-Indigenous population. Calculations of rates for comparison with the Indigenous population are derived by subtracting Indigenous population projections from total Estimated Resident Population (ERP) and should be used with care, as these data include deaths and population units for which Indigenous status were not stated. ERP used in calculations are final ERP based on 2006 Census. \(^{d}\) Total includes NSW, Queensland, SA, WA, and NT combined, based on State or Territory of usual residence. Victoria, Tasmania and the ACT are excluded due to small numbers of registered Indigenous deaths.


**Mortality rates — by major cause of death**

The most common causes of death among Australians in 2010 were cancers, diseases of the circulatory system (including heart disease, heart attack and stroke), and diseases of the respiratory system (including influenza, pneumonia and chronic lower respiratory diseases) (tables E.1 and EA.38).

In the jurisdictions for which age standardised death rates are available by Indigenous status (NSW, Queensland, WA, SA and the NT), death rates were significantly higher for Indigenous Australians than for non-Indigenous Australians in 2006–10. For these jurisdictions the leading age-standardised cause of death for Indigenous Australians was circulatory diseases followed by neoplasms (cancer) (tables E.2 and EA.39).
### Table E.1
Age standardised mortality rates by major cause of death (deaths per 100 000 people), 2010a, b

<table>
<thead>
<tr>
<th>Cause of Death</th>
<th>NSW</th>
<th>Vic</th>
<th>Qld</th>
<th>WA</th>
<th>SA</th>
<th>Tas</th>
<th>ACT</th>
<th>NT</th>
<th>Aust</th>
</tr>
</thead>
<tbody>
<tr>
<td>Certain infectious and parasitic diseases</td>
<td>9.9</td>
<td>7.4</td>
<td>6.5</td>
<td>8.7</td>
<td>9.9</td>
<td>7.9</td>
<td>7.5</td>
<td>np</td>
<td>8.5</td>
</tr>
<tr>
<td>Neoplasms</td>
<td>174.8</td>
<td>173.7</td>
<td>181.4</td>
<td>170.9</td>
<td>176.4</td>
<td>196.3</td>
<td>157.7</td>
<td>207.2</td>
<td>175.9</td>
</tr>
<tr>
<td>Diseases of the bloodc</td>
<td>1.6</td>
<td>1.6</td>
<td>1.5</td>
<td>1.7</td>
<td>1.6</td>
<td>np</td>
<td>np</td>
<td>np</td>
<td>1.6</td>
</tr>
<tr>
<td>Endocrine, nutritional and metabolic diseases</td>
<td>19.1</td>
<td>23.5</td>
<td>22.0</td>
<td>23.8</td>
<td>24.6</td>
<td>35.4</td>
<td>20.2</td>
<td>50.0</td>
<td>22.3</td>
</tr>
<tr>
<td>Mental and behavioural disorders</td>
<td>25.4</td>
<td>26.3</td>
<td>23.7</td>
<td>25.1</td>
<td>29.3</td>
<td>37.7</td>
<td>27.0</td>
<td>44.6</td>
<td>26.0</td>
</tr>
<tr>
<td>Diseases of the:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- nervous system</td>
<td>22.2</td>
<td>26.0</td>
<td>22.3</td>
<td>27.6</td>
<td>28.2</td>
<td>25.1</td>
<td>24.0</td>
<td>31.4</td>
<td>24.3</td>
</tr>
<tr>
<td>- eye and adnexa</td>
<td>np</td>
<td>–</td>
<td>–</td>
<td>np</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>np</td>
</tr>
<tr>
<td>- ear and mastoid process</td>
<td>–</td>
<td>np</td>
<td>np</td>
<td>–</td>
<td>np</td>
<td>–</td>
<td>np</td>
<td>–</td>
<td>np</td>
</tr>
<tr>
<td>- circulatory system</td>
<td>174.3</td>
<td>164.3</td>
<td>180.4</td>
<td>158.8</td>
<td>182.8</td>
<td>215.4</td>
<td>168.7</td>
<td>186.3</td>
<td>173.5</td>
</tr>
<tr>
<td>- respiratory system</td>
<td>48.2</td>
<td>44.5</td>
<td>46.6</td>
<td>40.8</td>
<td>48.3</td>
<td>53.9</td>
<td>41.2</td>
<td>70.3</td>
<td>46.5</td>
</tr>
<tr>
<td>- digestive system</td>
<td>19.6</td>
<td>20.7</td>
<td>20.6</td>
<td>20.2</td>
<td>18.6</td>
<td>23.3</td>
<td>16.2</td>
<td>39.2</td>
<td>20.2</td>
</tr>
<tr>
<td>- skin and subcutaneous tissue</td>
<td>1.8</td>
<td>1.5</td>
<td>1.2</td>
<td>1.0</td>
<td>np</td>
<td>np</td>
<td>np</td>
<td>np</td>
<td>1.5</td>
</tr>
<tr>
<td>- musculoskeletal system and connective tissue</td>
<td>4.3</td>
<td>4.8</td>
<td>4.9</td>
<td>4.0</td>
<td>3.6</td>
<td>8.0</td>
<td>np</td>
<td>np</td>
<td>4.5</td>
</tr>
<tr>
<td>- genitourinary system</td>
<td>12.2</td>
<td>13.7</td>
<td>11.8</td>
<td>12.2</td>
<td>14.3</td>
<td>13.4</td>
<td>12.8</td>
<td>25.2</td>
<td>12.8</td>
</tr>
<tr>
<td>Pregnancy, childbirth and the puerperium</td>
<td>np</td>
<td>np</td>
<td>np</td>
<td>np</td>
<td>np</td>
<td>–</td>
<td>–</td>
<td>np</td>
<td>np</td>
</tr>
<tr>
<td>Certain conditions originating in the perinatal period</td>
<td>3.0</td>
<td>2.2</td>
<td>3.3</td>
<td>2.1</td>
<td>2.6</td>
<td>np</td>
<td>np</td>
<td>np</td>
<td>2.8</td>
</tr>
<tr>
<td>Congenital conditionsd</td>
<td>2.7</td>
<td>2.7</td>
<td>2.8</td>
<td>2.2</td>
<td>2.2</td>
<td>np</td>
<td>np</td>
<td>np</td>
<td>2.7</td>
</tr>
<tr>
<td>Abnormal findings nec</td>
<td>5.4</td>
<td>1.7</td>
<td>3.8</td>
<td>3.4</td>
<td>3.1</td>
<td>np</td>
<td>np</td>
<td>np</td>
<td>3.7</td>
</tr>
<tr>
<td>External causes of morbidity and mortality</td>
<td>33.5</td>
<td>35.6</td>
<td>40.1</td>
<td>45.4</td>
<td>38.4</td>
<td>40.6</td>
<td>39.8</td>
<td>78.5</td>
<td>37.6</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>558.0</strong></td>
<td><strong>550.3</strong></td>
<td><strong>573.1</strong></td>
<td><strong>548.0</strong></td>
<td><strong>585.2</strong></td>
<td><strong>669.6</strong></td>
<td><strong>529.9</strong></td>
<td><strong>774.8</strong></td>
<td><strong>564.5</strong></td>
</tr>
</tbody>
</table>

---

**a** Age standardised to the Australian population as at 30 June 2001. **b** Australian total includes ‘Other territories’. **c** Diseases of the blood and blood-forming organs and certain disorders involving the immune mechanism. **d** Congenital malformations, deformations and chromosomal abnormalities. **e** Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified. – Nil or rounded to zero. np Not published.

*Source: ABS (2012) Causes of Death Australia, 2010, Cat. no. 3303.0; table EA.38.*

Compared to non-Indigenous Australians, Indigenous Australians died at higher rates from ‘endocrine, metabolic and nutritional disorders’, ‘kidney diseases’, ‘digestive diseases’, and ‘conditions originating in perinatal period’ (tables E.2 and EA.39).
## Table E.2

<table>
<thead>
<tr>
<th>Category</th>
<th>NSW</th>
<th>Qld</th>
<th>WA</th>
<th>SA</th>
<th>NT</th>
<th>Total</th>
<th>Rate difference — Indigenous rate less non-Indigenous rate</th>
<th>Rate ratio — Indigenous rate divided by non-Indigenous rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Circulatory diseases</td>
<td>137.3</td>
<td>130.4</td>
<td>235.0</td>
<td>117.8</td>
<td>194.6</td>
<td>151.4</td>
<td>1.7</td>
<td>1.6</td>
</tr>
<tr>
<td>Cancer</td>
<td>49.5</td>
<td>70.5</td>
<td>88.8</td>
<td>31.3</td>
<td>80.1</td>
<td>67.5</td>
<td>1.3</td>
<td>1.4</td>
</tr>
<tr>
<td>External causes</td>
<td>19.1</td>
<td>26.9</td>
<td>97.1</td>
<td>56.4</td>
<td>70.6</td>
<td>47.4</td>
<td>1.6</td>
<td>1.7</td>
</tr>
<tr>
<td>Endocrine and other disorders</td>
<td>38.1</td>
<td>115.2</td>
<td>142.1</td>
<td>44.0</td>
<td>176.3</td>
<td>96.3</td>
<td>2.9</td>
<td>6.2</td>
</tr>
<tr>
<td>Respiratory diseases</td>
<td>55.9</td>
<td>45.2</td>
<td>80.6</td>
<td>56.8</td>
<td>106.1</td>
<td>64.1</td>
<td>2.1</td>
<td>1.9</td>
</tr>
<tr>
<td>Digestive diseases</td>
<td>20.8</td>
<td>33.9</td>
<td>52.4</td>
<td>35.9</td>
<td>69.6</td>
<td>37.7</td>
<td>2.0</td>
<td>2.7</td>
</tr>
<tr>
<td>Kidney diseases</td>
<td>11.9</td>
<td>23.3</td>
<td>45.3</td>
<td>34.9</td>
<td>68.9</td>
<td>29.2</td>
<td>2.0</td>
<td>3.2</td>
</tr>
<tr>
<td>Conditions originating in perinatal period</td>
<td>1.6</td>
<td>3.0</td>
<td>3.4</td>
<td>np</td>
<td>7.9</td>
<td>3.3</td>
<td>1.5</td>
<td>2.0</td>
</tr>
<tr>
<td>Infectious and parasitic diseases</td>
<td>10.1</td>
<td>15.3</td>
<td>21.9</td>
<td>np</td>
<td>34.4</td>
<td>16.8</td>
<td>2.0</td>
<td>3.3</td>
</tr>
<tr>
<td>Nervous system diseases</td>
<td>-0.6</td>
<td>-2.6</td>
<td>13.8</td>
<td>9.8</td>
<td>7.5</td>
<td>2.6</td>
<td>1.0</td>
<td>0.9</td>
</tr>
<tr>
<td>Other causes</td>
<td>19.6</td>
<td>30.6</td>
<td>81.8</td>
<td>43.6</td>
<td>79.8</td>
<td>42.6</td>
<td>1.4</td>
<td>1.8</td>
</tr>
<tr>
<td><strong>All causes</strong></td>
<td><strong>363.4</strong></td>
<td><strong>491.9</strong></td>
<td><strong>862.2</strong></td>
<td><strong>445.4</strong></td>
<td><strong>895.5</strong></td>
<td><strong>558.8</strong></td>
<td><strong>1.6</strong></td>
<td><strong>1.8</strong></td>
</tr>
</tbody>
</table>

**a** All causes of death data from 2006 onward are subject to a revisions process - once data for a reference year are ‘final’, they are no longer revised. Affected data in this table are: 2006 (final), 2007 (final), 2008 (final), 2009 (revised), 2010 (preliminary). See Cause of Death, Australia, 2010 (cat. no. 3303.0) Explanatory Notes 35-39 and Technical Notes, Causes of Death Revisions, 2006 and Causes of Death Revisions, 2008 and 2009. **b** Age standardised death rates enable the comparison of death rates between populations with different age structures by relating them to a standard population. The current ABS standard population is all persons in the Australian population at 30 June 2001. Standardised death rates (SDRs) are expressed per 100 000 persons. SDRs in this table have been calculated using the direct method, age standardised by 5 year age group to 75 years and over. Rates calculated using the direct method are not comparable to rates calculated using the indirect method. **c** Data are reported by jurisdiction of residence for NSW, Queensland, WA, SA and the NT only. Only these five states and territories have evidence of a sufficient level of Indigenous identification and sufficient numbers of Indigenous deaths to support mortality analysis. **d** Endocrine, metabolic and nutritional disorders. np not published.

**Source:** ABS (unpublished) Causes of Death Australia, 2010 cat. No. 3301.0; table EA.39.

---

**Profile of employed health workforce**

‘Profile of employed health workforce’ is an indicator of governments’ objective that Australians have a sustainable health system (box E.9).
Box E.9  Profile of employed health workforce

‘Profile of employed health workforce’ is defined by three measures:

- the full time equivalent employed health workforce divided by the population
- the proportion of the full time equivalent employed health workforce under the age of 45
- the net growth in the full time equivalent employed health workforce.

High or increasing rates in the health workforce measures can give an indication of the sustainability of the health system and its ability to respond and adapt to future needs.

Data reported for this indicator are comparable.


In 2011, the majority of employed medical practitioners (commonly referred to as doctors) that were employed in medicine were clinicians (93.8 per cent), of whom 33.9 per cent were general practitioners), 33.1 per cent specialists, 16.9 per cent were specialists-in-training, 12.9 per cent hospital non-specialists and 3.2 per cent were other clinicians. The proportion of women increased from 34.0 per cent in 2007 to 37.6 per cent in 2011 (AIHW 2012b). The number of full time equivalent (FTE) practitioners per 100 000 people for 2011, is illustrated in figure E.16.

In 2011, the number of nurses and midwives registered in Australia was 330 680. The majority of employed nurses and midwives were clinicians (79.4 per cent). The principal area of the main job of employed registered and enrolled nurses and midwives was aged care (14.3 per cent) followed by critical care and emergency (9.6 per cent). The average age of employed nurses and midwives increased between 2007 and 2011 (from 43.7 to 44.4 years). The proportion of employed nurses and midwives aged 50 or older increased from 33.0 per cent to 38.3 per cent over this period (AIHW 2012c). The number of FTE nurses and midwives per 100 000 people by jurisdiction is illustrated in figure E.17.
Figure E.16  **Full time equivalent employed medical practitioners, 2007–2011**

- **a** FTE rate (FTE per 100,000 people) is based on standard full-time working week of 40 hours.
- **b** Number of ‘employed medical practitioners’ does not include medical practitioners on extended leave.
- **c** Care must be taken when interpreting the ACT’s data as the ACT’s medical practitioners provide a large number of services to NSW residents. This rate used the ACT resident population as the denominator, hence a high rate for the ACT. The rate will reduce if the NSW population within the catchment area of Southern NSW is included in the denominator.
- **d** Jurisdictional differences between the previous survey questions prior to 2010, as well as the introduction of the new collection tool in 2010, have resulted in a slight change in the pattern of responses to the employment-related questions. As such, comparing data over time should be done with caution. (See Data Quality Information for further details.)
- **e** Comparisons with NT data should be made with caution. From 2010, doctors’ registration requirements have changed (in particular, doctors providing fly in fly out services are no longer required to register in the NT where they are registered nationally).
- **f** 2010 data for Queensland and Western Australia are not available.
- **g** In 2010, state and territory is derived from state and territory of principal practice where available; otherwise state and territory of residence is used as a proxy. If residence details are unavailable, state and territory of main job is used. Records with no information on all three locations are coded to ‘Not stated’.


---

**Note:** The diagram shows the full time equivalent (FTE) practitioners per 100,000 people for various states and territories from 2007 to 2011.
At the national level, 50.9 per cent of employed medical practitioners were under the age of 45 in 2011. The medical practitioner workforce grew at an average annual rate of 4.1 per cent from 2007 to 2011 (figure E.18). The nursing and midwifery workforce grew at an average rate of 1.7 per cent annually from 2007 to 2011 (figure E.18), and 47.2 per cent of employed nurses were under the age of 45 in 2011.

Nationally, 1.6 per cent of people employed in health-related occupations were Indigenous in 2011. Within health related occupations in 2011, the occupations with the highest percentage of Indigenous Australians were health and welfare support officers, which includes the occupation Indigenous Health Workers (tables EA.44–EA.46).
Figure E.18  **Annual average growth in selected workforces, 2007–2011**\(^a, b, c, d, e\)

![Bar chart showing annual average growth in selected workforces, 2007–2011](chart.png)

\(^a\) Net growth measures the change in the FTE number in the workforce in the reference year compared to the year prior to the reference year. \(^b\) FTEs calculated based on a 40-hour standard working week for medical practitioners and a 38-hour week for nurses/midwives. \(^c\) Jurisdictional differences between the previous survey questions prior to 2010, as well as the introduction of the new collection tool in 2010, have resulted in a slight change in the pattern of responses to the employment-related questions. As such, comparing data over time should be done with caution. (See Data Quality Information for further information.) \(^d\) In 2011, state and territory is derived from state and territory of main job where available; otherwise state and territory of principal practice is used as a proxy. If principal practice details are unavailable, state and territory of residence is used. Records with no information on all three locations are coded to ‘Not stated’. \(^e\) Data for 2007, 2008 and 2009 are for the workforce (i.e. including those employed, on extended leave and looking for work in the workforce). Data for 2010 and 2011 are only for those employed in the workforce. Therefore, comparisons should be made with caution.


**Access to services compared to need by type of service**

‘Access to services compared to need by type of service’ is an indicator of governments’ objective that Indigenous Australians and those living in rural and remote areas or on low incomes achieve health outcomes comparable to the broader population (box E.10).

Results from the 2007-08 National Health Survey indicate that the majority of Australians (85 per cent) aged 15 years or over reported their health as either good, very good or excellent (ABS 2009c). In the 2008 National Aboriginal and Torres Strait Islander Social Survey, 78 per cent of Indigenous Australians reported their health as either good, very good or excellent (ABS 2009b).
The latest available data comparing the health outcomes of Indigenous and non-Indigenous Australians are from the National Aboriginal and Torres Strait Islander Health Survey 2004-05 (ABS 2006a) and National Health Survey 2004-05 (ABS 2006b).

**Box E.10  Access to services compared to need by type of service**

‘Access to services compared to need by type of service’ is defined as the number of people aged 15 years or over who accessed a particular health service in the past 12 months (for hospital admissions) or 2 weeks (for other health services) divided by the population aged 15 years or over, expressed as a percentage. Rates are age standardised and calculated separately for each type of service and by categories of self-assessed health status. Service types are: admitted hospitalisations, casualty/outpatients, GP and/or specialist doctor consultations, consultations with other health professional and dental consultation. Self-assessed health status is categorised as excellent/very good/good and fair/poor and are reported by Indigenous status, remoteness and Socio Economic Indexes for Areas (SEIFA).

High or increasing rates of ‘access to services compared to need by type of service’ are desirable, as are rates for those in disadvantaged groups being close to the rates for those who are not disadvantaged.

Data reported for this indicator are comparable.

Data quality information for this indicator/measure is under development.

The surveys show that Indigenous Australians were less likely than non-Indigenous Australians to report very good or excellent health and the difference between the two populations was greatest in the older age groups. Taking into account differences in age structure between the Indigenous and non-Indigenous populations, Indigenous Australians overall were almost twice as likely to report their health as fair or poor than non-Indigenous Australians in 2004-05 (ABS 2006b).

Data from the surveys show that 41.8 per cent of Australians who reported their health status as being excellent/very good/good accessed health services in 2004-05, while health services were accessed by 62.6 per cent of people who reported their health status as being fair/poor (tables EA.47). There was little difference between the percentages of Indigenous and non-Indigenous Australians reporting excellent/very good/good health status who accessed health services or between Indigenous and non-Indigenous Australians reporting fair/poor health status who accessed health services in 2004-05 (figure E.19).
Data on the proportion of people who accessed health services by remoteness and SEIFA and data on the types of health services people accessed are reported in tables EA.47–EA.50.

**Figure E.19** Proportion of people who accessed health services by health status and Indigenous status, 2004-05a, b, c, d, e

<table>
<thead>
<tr>
<th>Number</th>
<th>Indigenous - Health status (excellent/very good/good)</th>
<th>Indigenous - Health status (fair/poor)</th>
<th>Non-Indigenous - Health status (excellent/very good/good)</th>
<th>Non-Indigenous - Health status (fair/poor)</th>
</tr>
</thead>
<tbody>
<tr>
<td>NSW</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vic</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Qld</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>WA</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SA</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tas</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ACT</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NT</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Aust</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Notes:**

a Rates are age standardised by State/Territory to the 2001 estimated resident population (5 year ranges from 15+).  
b People who accessed at least one of the health services noted in tables EA.19 and EA.20 in the last two weeks or were admitted to hospital in the last 12 months.  
c Limited to people aged 15 years or over.  
d Total people accessing any of the selected health services. Components may not add to total because people may have accessed more than one type of health service.  
e Estimates with RSEs between 25 per cent and 50 per cent should be used with caution. Estimates with RSEs greater than 50 per cent are considered too unreliable for general use.


**Service-specific performance indicator frameworks**

The health service specific frameworks in chapters 10, 11 and 12 reflect both the general Report framework and the National Health Performance Framework. They differ from the general Report framework (see chapter 1) in two respects. First, they include three subdimensions of quality — safety, responsiveness and continuity —

---

2 The former National Health Performance Committee developed the National Health Performance Framework to guide the reporting and measurement of health service performance in Australia. The National Health Performance Framework was reviewed by the National Health Performance Committee and a revised framework was agreed by the National Health Information Standards and Statistics Committee in 2009. A number of groups involved in health performance indicator development have adopted this framework for use within specific project areas and in publications.
and, second, they include an extra dimension of efficiency — sustainability. 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 Report 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
- **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.

This section summarises information from the following specific indicator frameworks:

- public hospitals (see chapter 10 for more detail)
- maternity services (see chapter 10 for more detail)
- primary and community health (see chapter 11 for more detail)
- mental health management (see chapter 12 for more detail).

Additional information is available to assist the interpretation of these results:

- indicator interpretation boxes, which define the measures used and indicate any significant conceptual or methodological issues with the reported information (chapters 10, 11 and 12)
- caveats and footnotes to the reported data (chapters 10, 11 and 12 and Attachments 10A, 11A and 12A)
- additional measures and further disaggregation of reported measures (for example, by Indigenous status, remoteness, disability, language background, sex) (chapters 10, 11 and 12 and Attachments 10A, 11A and 12A)
- data quality information for many indicators, based on the ABS Data Quality Framework (chapters 10, 11 and 12 Data quality information).
A full list of attachment tables and available data quality information is provided at the end of chapters 10, 11 and 12.

*Public hospitals*

The performance indicator framework for public hospitals is presented in figure E.20. This framework provides comprehensive information on the equity, effectiveness, efficiency and the outcomes of public hospitals.
An overview of the public hospital performance indicator results are presented in table E.3. Information to assist the interpretation of these data can be found in the indicator interpretation boxes in chapter 10 and the footnotes in attachment 10A.
Table E.3  Performance indicators for public hospitals

<table>
<thead>
<tr>
<th>Effectiveness — Access indicators</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Emergency department waiting times, 2011-12</strong></td>
</tr>
<tr>
<td>Data for this indicator not complete or not directly comparable (chapter 10)</td>
</tr>
<tr>
<td>Proportion of patients seen on time (per cent)</td>
</tr>
<tr>
<td>NSW</td>
</tr>
<tr>
<td>Resuscitation</td>
</tr>
<tr>
<td>Urgent</td>
</tr>
<tr>
<td>Semi-urgent</td>
</tr>
<tr>
<td>Non-urgent</td>
</tr>
<tr>
<td>Total</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Effectiveness — Appropriateness indicators</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Separation rates for selected procedures, all hospitals, per 1000 people (age-standardised), 2010-11</strong></td>
</tr>
<tr>
<td>Data for this indicator comparable, subject to caveats (chapter 10)</td>
</tr>
<tr>
<td>Cataract extraction</td>
</tr>
<tr>
<td>Cholecystectomy</td>
</tr>
<tr>
<td>Coronary angioplasty</td>
</tr>
<tr>
<td>Coronary artery bypass graft</td>
</tr>
<tr>
<td>Cystoscopy</td>
</tr>
<tr>
<td>Haemorrhoidectomy</td>
</tr>
<tr>
<td>Hip replacement</td>
</tr>
<tr>
<td>Hysterectomy</td>
</tr>
<tr>
<td>Inguinal herniorrhaphy</td>
</tr>
<tr>
<td>Knee replacement</td>
</tr>
<tr>
<td>Myringotomy</td>
</tr>
<tr>
<td>Prostatectomy</td>
</tr>
<tr>
<td>Septoplasty</td>
</tr>
<tr>
<td>Tonsillectomy</td>
</tr>
<tr>
<td>Varicose veins, stripping and ligation</td>
</tr>
</tbody>
</table>

Source: table 10A.42.
Table E.3  (continued)

<table>
<thead>
<tr>
<th></th>
<th>NSW</th>
<th>Vic</th>
<th>Qld</th>
<th>WA</th>
<th>SA</th>
<th>Tas</th>
<th>ACT</th>
<th>NT</th>
<th>Aust</th>
</tr>
</thead>
<tbody>
<tr>
<td>Effectiveness — Quality — Safety indicators</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unplanned hospital readmissions within 28 days of selected surgical admissions, 2010-11</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Surgical, procedure prior to separation, rate per 1000 separations</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Knee replacement</td>
<td>21.7</td>
<td>22.0</td>
<td>37.5</td>
<td>31.1</td>
<td>19.6</td>
<td>31.7</td>
<td>np</td>
<td>np</td>
<td>24.4</td>
</tr>
<tr>
<td>Hip replacement</td>
<td>16.5</td>
<td>20.8</td>
<td>14.2</td>
<td>14.2</td>
<td>10.3</td>
<td>np</td>
<td>np</td>
<td>16.5</td>
<td></td>
</tr>
<tr>
<td>Tonsillectomy and adenoidectomy</td>
<td>22.9</td>
<td>23.9</td>
<td>31.0</td>
<td>34.4</td>
<td>31.3</td>
<td>37.6</td>
<td>19.3</td>
<td>np</td>
<td>26.3</td>
</tr>
<tr>
<td>Hysterectomy</td>
<td>29.1</td>
<td>28.9</td>
<td>34.7</td>
<td>33.5</td>
<td>28.1</td>
<td>40.1</td>
<td>np</td>
<td>np</td>
<td>30.5</td>
</tr>
<tr>
<td>Prostatectomy</td>
<td>27.2</td>
<td>20.9</td>
<td>25.8</td>
<td>38.0</td>
<td>21.9</td>
<td>np</td>
<td>np</td>
<td>np</td>
<td>25.1</td>
</tr>
<tr>
<td>Cataract surgery</td>
<td>3.2</td>
<td>3.9</td>
<td>4.0</td>
<td>4.3</td>
<td>4.0</td>
<td>–</td>
<td>–</td>
<td>np</td>
<td>3.5</td>
</tr>
<tr>
<td>Appendicectomy</td>
<td>24.8</td>
<td>25.6</td>
<td>19.6</td>
<td>30.8</td>
<td>19.9</td>
<td>37.7</td>
<td>40.2</td>
<td>24.2</td>
<td></td>
</tr>
<tr>
<td>Accreditation, proportion of accredited beds, public hospitals 2010-11</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>%</td>
<td>95</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>98</td>
<td>87</td>
<td>100</td>
<td>100</td>
<td>98</td>
</tr>
<tr>
<td>Healthcare associated infections in acute care hospitals, 2011-12</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Infections per 10 000 patient days</td>
<td>1.0</td>
<td>0.9</td>
<td>0.9</td>
<td>0.7</td>
<td>0.9</td>
<td>0.8</td>
<td>1.1</td>
<td>1.3</td>
<td>0.9</td>
</tr>
<tr>
<td>Separations with an adverse event, public hospitals, 2010-11</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Events per 100 separations</td>
<td>Total: 6.1</td>
<td>5.8</td>
<td>5.7</td>
<td>6.0</td>
<td>6.6</td>
<td>7.1</td>
<td>6.0</td>
<td>np</td>
<td>5.9</td>
</tr>
<tr>
<td>Source: tables 10A.43–10A.47.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Efficiency sustainability indicators

Workforce sustainability

Data for this indicator comparable, subject to caveats (chapter 10)

Nursing workforce by age group (per cent), 2011

<table>
<thead>
<tr>
<th></th>
<th>&lt;30</th>
<th>30-39</th>
<th>40-49</th>
<th>50-59</th>
<th>60+</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;30</td>
<td>13.3</td>
<td>20.3</td>
<td>25.4</td>
<td>30.5</td>
<td>10.5</td>
</tr>
<tr>
<td>30-39</td>
<td>17.0</td>
<td>21.4</td>
<td>26.6</td>
<td>26.1</td>
<td>8.9</td>
</tr>
<tr>
<td>40-49</td>
<td>14.7</td>
<td>21.0</td>
<td>28.6</td>
<td>26.3</td>
<td>9.3</td>
</tr>
<tr>
<td>50-59</td>
<td>15.9</td>
<td>19.6</td>
<td>27.6</td>
<td>26.7</td>
<td>10.3</td>
</tr>
<tr>
<td>60+</td>
<td>13.8</td>
<td>19.3</td>
<td>27.8</td>
<td>30.7</td>
<td>8.4</td>
</tr>
</tbody>
</table>

Medical practitioner workforce by age group, 2011

<table>
<thead>
<tr>
<th></th>
<th>&lt;30</th>
<th>30-39</th>
<th>40-49</th>
<th>50-59</th>
<th>60+</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;30</td>
<td>9.0</td>
<td>27.3</td>
<td>24.1</td>
<td>21.1</td>
<td>18.5</td>
</tr>
<tr>
<td>30-39</td>
<td>12.0</td>
<td>30.6</td>
<td>23.6</td>
<td>20.6</td>
<td>15.5</td>
</tr>
<tr>
<td>40-49</td>
<td>10.5</td>
<td>28.9</td>
<td>25.4</td>
<td>20.0</td>
<td>13.5</td>
</tr>
<tr>
<td>50-59</td>
<td>12.4</td>
<td>27.6</td>
<td>24.9</td>
<td>19.9</td>
<td>13.9</td>
</tr>
<tr>
<td>60+</td>
<td>11.7</td>
<td>26.3</td>
<td>23.7</td>
<td>20.4</td>
<td>16.7</td>
</tr>
</tbody>
</table>

Source: tables 10A.48–10A.51. (Continued next page)
### Table E.3 (continued)

#### Efficiency indicators

**Recurrent cost per casemix adjusted separation, dollars, 2010-11**

Data for this indicator comparable, subject to caveats (chapter 10)

<table>
<thead>
<tr>
<th></th>
<th>NSW</th>
<th>Vic</th>
<th>Qld</th>
<th>WA</th>
<th>SA</th>
<th>Tas</th>
<th>ACT</th>
<th>NT</th>
<th>Aust</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total recurrent</td>
<td>4904</td>
<td>4508</td>
<td>5323</td>
<td>4996</td>
<td>4854</td>
<td>5913</td>
<td>5401</td>
<td>5645</td>
<td>4918</td>
</tr>
<tr>
<td>Capital</td>
<td>503</td>
<td>536</td>
<td>448</td>
<td>521</td>
<td>414</td>
<td>335</td>
<td>581</td>
<td>666</td>
<td>445</td>
</tr>
</tbody>
</table>

**Relative stay index, 2010-11**

Data for this indicator comparable, subject to caveats (chapter 10)

<table>
<thead>
<tr>
<th></th>
<th>NSW</th>
<th>Vic</th>
<th>Qld</th>
<th>WA</th>
<th>SA</th>
<th>Tas</th>
<th>ACT</th>
<th>NT</th>
<th>Aust</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>1.04</td>
<td>0.91</td>
<td>0.93</td>
<td>0.99</td>
<td>1.02</td>
<td>1.09</td>
<td>0.97</td>
<td>1.16</td>
<td>0.98</td>
</tr>
</tbody>
</table>

#### Outcome indicators

**Patient satisfaction, 2011-12**

Data for this indicator not complete or not directly comparable (chapter 10).

Proportion (%) of persons who went to an emergency department in the last 12 months reporting:

<table>
<thead>
<tr>
<th></th>
<th>Doctors/specialists</th>
<th>Nurses</th>
</tr>
</thead>
<tbody>
<tr>
<td>ED doctors</td>
<td>86.1</td>
<td>87.8</td>
</tr>
<tr>
<td>specialists</td>
<td>82.8</td>
<td>87.7</td>
</tr>
<tr>
<td>or nurses</td>
<td>85.2</td>
<td>88.5</td>
</tr>
<tr>
<td>always or</td>
<td>86.7</td>
<td>88.9</td>
</tr>
<tr>
<td>often listened</td>
<td>84.2</td>
<td>88.0</td>
</tr>
<tr>
<td>carefully to</td>
<td>86.2</td>
<td>90.5</td>
</tr>
<tr>
<td>them</td>
<td>86.3</td>
<td>93.2</td>
</tr>
<tr>
<td></td>
<td>87.6</td>
<td>87.2</td>
</tr>
<tr>
<td></td>
<td>85.1</td>
<td>88.2</td>
</tr>
</tbody>
</table>

Proportion (%) of persons who were admitted to hospital in the last 12 months reporting:

<table>
<thead>
<tr>
<th></th>
<th>Doctors/specialists</th>
<th>Nurses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital</td>
<td>86.6</td>
<td>89.8</td>
</tr>
<tr>
<td>doctors</td>
<td>88.2</td>
<td>90.9</td>
</tr>
<tr>
<td>specialists</td>
<td>91.6</td>
<td>92.1</td>
</tr>
<tr>
<td>or nurses</td>
<td>90.2</td>
<td>88.6</td>
</tr>
<tr>
<td>always or</td>
<td>93.0</td>
<td>93.2</td>
</tr>
<tr>
<td>often listened</td>
<td>86.0</td>
<td>91.7</td>
</tr>
<tr>
<td>carefully to</td>
<td>90.8</td>
<td>88.5</td>
</tr>
<tr>
<td>them</td>
<td>88.4</td>
<td>89.5</td>
</tr>
<tr>
<td></td>
<td>89.6</td>
<td>89.8</td>
</tr>
<tr>
<td></td>
<td>88.9</td>
<td>90.3</td>
</tr>
</tbody>
</table>

Proportion (%) of persons who were admitted to hospital in the last 12 months reporting:

<table>
<thead>
<tr>
<th></th>
<th>Doctors/specialists</th>
<th>Nurses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital</td>
<td>89.8</td>
<td>90.4</td>
</tr>
<tr>
<td>doctors</td>
<td>90.2</td>
<td>91.4</td>
</tr>
<tr>
<td>specialists</td>
<td>90.8</td>
<td>92.5</td>
</tr>
<tr>
<td>or nurses</td>
<td>90.1</td>
<td>91.2</td>
</tr>
<tr>
<td>always or</td>
<td>91.8</td>
<td>93.1</td>
</tr>
<tr>
<td>often showed</td>
<td>85.5</td>
<td>91.6</td>
</tr>
<tr>
<td>respect to</td>
<td>89.5</td>
<td>91.5</td>
</tr>
<tr>
<td>them</td>
<td>89.8</td>
<td>86.5</td>
</tr>
<tr>
<td></td>
<td>90.3</td>
<td>91.4</td>
</tr>
</tbody>
</table>

Sentinel events, 2010-11

Data for this indicator not complete or not directly comparable (chapter 10).

Data are available in tables 10A.82–10A.90.

Source: tables 10A.52–10A.65.

*a Caveats for these data are available in chapter 10 and attachment 10A. Refer to the indicator interpretation boxes in chapter 12 for information to assist with the interpretation of data presented in this table. – Nil or rounded to zero. na Not available. np Not published.
Maternity services

The performance indicator framework for maternity services is presented in figure E.21. This framework provides comprehensive information on the equity, effectiveness, efficiency and the outcomes of maternity services.

Figure E.21  Maternity services performance indicator framework

An overview of the maternity services performance indicator results are presented in table E.4. Information to assist the interpretation of these data can be found in the indicator interpretation boxes in chapter 10 and the footnotes in attachment 10A.
Table E.4  Performance indicators for maternity services

<table>
<thead>
<tr>
<th></th>
<th>NSW</th>
<th>Vic</th>
<th>Qld</th>
<th>WA</th>
<th>SA</th>
<th>Tas</th>
<th>ACT</th>
<th>NT</th>
<th>Aust</th>
</tr>
</thead>
</table>

**Effectiveness — Appropriateness indicators**

*Caesareans for selected primiparae — Proportion (%) of births that were caesareans, 2011*

Data for this indicator not complete or not directly comparable (chapter 10)

<table>
<thead>
<tr>
<th></th>
<th>Public hospitals</th>
<th>Private hospitals</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>23.3</td>
<td>31.0</td>
</tr>
<tr>
<td></td>
<td>23.9</td>
<td>31.0</td>
</tr>
<tr>
<td></td>
<td>22.7</td>
<td>36.2</td>
</tr>
<tr>
<td></td>
<td>26.4</td>
<td>33.2</td>
</tr>
<tr>
<td></td>
<td>27.4</td>
<td>31.8</td>
</tr>
<tr>
<td></td>
<td>na</td>
<td>na</td>
</tr>
<tr>
<td></td>
<td>24.2</td>
<td>38.1</td>
</tr>
<tr>
<td></td>
<td>28.0</td>
<td>np</td>
</tr>
<tr>
<td></td>
<td>24.0</td>
<td>33.1</td>
</tr>
</tbody>
</table>

*Inductions for selected primiparae — Proportion (%) of births that were induced, rate, 2011*

Data for this indicator not complete or not directly comparable (chapter 10)

<table>
<thead>
<tr>
<th></th>
<th>Public hospitals</th>
<th>Private hospitals</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>35.4</td>
<td>35.7</td>
</tr>
<tr>
<td></td>
<td>32.6</td>
<td>35.5</td>
</tr>
<tr>
<td></td>
<td>28.5</td>
<td>34.2</td>
</tr>
<tr>
<td></td>
<td>34.4</td>
<td>40.4</td>
</tr>
<tr>
<td></td>
<td>39.3</td>
<td>41.5</td>
</tr>
<tr>
<td></td>
<td>na</td>
<td>na</td>
</tr>
<tr>
<td></td>
<td>21.4</td>
<td>25.5</td>
</tr>
<tr>
<td></td>
<td>35.0</td>
<td>np</td>
</tr>
<tr>
<td></td>
<td>33.1</td>
<td>35.9</td>
</tr>
</tbody>
</table>

**Vaginal birth following a previous caesarean, 2010**

Data for this indicator comparable, subject to caveats (chapter 10)

<table>
<thead>
<tr>
<th></th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vaginal delivery</td>
<td>17.2</td>
</tr>
<tr>
<td>Caesarean</td>
<td>82.8</td>
</tr>
<tr>
<td></td>
<td>16.9</td>
</tr>
<tr>
<td></td>
<td>83.2</td>
</tr>
<tr>
<td></td>
<td>15.6</td>
</tr>
<tr>
<td></td>
<td>84.4</td>
</tr>
<tr>
<td></td>
<td>13.3</td>
</tr>
<tr>
<td></td>
<td>86.7</td>
</tr>
<tr>
<td></td>
<td>18.2</td>
</tr>
<tr>
<td></td>
<td>81.8</td>
</tr>
<tr>
<td></td>
<td>17.4</td>
</tr>
<tr>
<td></td>
<td>82.6</td>
</tr>
<tr>
<td></td>
<td>19.3</td>
</tr>
<tr>
<td></td>
<td>80.7</td>
</tr>
<tr>
<td></td>
<td>23.8</td>
</tr>
<tr>
<td></td>
<td>76.2</td>
</tr>
<tr>
<td></td>
<td>16.5</td>
</tr>
<tr>
<td></td>
<td>83.5</td>
</tr>
</tbody>
</table>

Source: table 10A.94–10A.103.

**Effectiveness — Quality — Safety indicators**

*Perineal status after vaginal birth — Mothers with third or fourth degree lacerations after vaginal births, 2010*

Data for this indicator not complete or not directly comparable (chapter 10)

<table>
<thead>
<tr>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.7</td>
</tr>
<tr>
<td>1.8</td>
</tr>
<tr>
<td>1.7</td>
</tr>
<tr>
<td>1.9</td>
</tr>
<tr>
<td>2.1</td>
</tr>
<tr>
<td>1.1</td>
</tr>
<tr>
<td>3.0</td>
</tr>
<tr>
<td>2.2</td>
</tr>
<tr>
<td>1.8</td>
</tr>
</tbody>
</table>

Source: table 10A.104.

**Efficiency indicators**

*Cost per maternity separation, without complications, dollars, 2010-11,*

Data for this indicator not complete or not directly comparable (chapter 10)

<table>
<thead>
<tr>
<th>Cost (dollars)</th>
<th>Caesarean</th>
<th>Vaginal delivery</th>
</tr>
</thead>
<tbody>
<tr>
<td>8 689</td>
<td>8 947</td>
<td>5 304</td>
</tr>
<tr>
<td>8 947</td>
<td>13 196</td>
<td>4 359</td>
</tr>
<tr>
<td>–</td>
<td>9 917</td>
<td>5 096</td>
</tr>
<tr>
<td>9 197</td>
<td>12 010</td>
<td>5 669</td>
</tr>
<tr>
<td>12 010</td>
<td>12 328</td>
<td>4 495</td>
</tr>
<tr>
<td>12 328</td>
<td>11 257</td>
<td>5 829</td>
</tr>
<tr>
<td>9 681</td>
<td>6 919</td>
<td>6 919</td>
</tr>
<tr>
<td>11 257</td>
<td>5 137</td>
<td>5 137</td>
</tr>
</tbody>
</table>

*Mother’s average length of stay, days, 2010-11*

Data for this indicator not complete or not directly comparable (chapter 10)

<table>
<thead>
<tr>
<th>Average length (days)</th>
<th>Caesarean</th>
<th>Vaginal delivery</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.9</td>
<td>3.9</td>
<td>2.7</td>
</tr>
<tr>
<td>3.9</td>
<td>3.9</td>
<td>2.5</td>
</tr>
<tr>
<td>–</td>
<td>3.9</td>
<td>2.8</td>
</tr>
<tr>
<td>4.2</td>
<td>4.0</td>
<td>2.6</td>
</tr>
<tr>
<td>4.0</td>
<td>3.7</td>
<td>2.7</td>
</tr>
<tr>
<td>3.7</td>
<td>4.8</td>
<td>2.8</td>
</tr>
<tr>
<td>4.8</td>
<td>3.9</td>
<td>2.8</td>
</tr>
<tr>
<td>3.9</td>
<td>3.9</td>
<td>3.0</td>
</tr>
<tr>
<td>3.9</td>
<td>3.9</td>
<td>2.7</td>
</tr>
</tbody>
</table>

Source: table 10A.105.

(Continued next page)
Table E.4  (continued)

<table>
<thead>
<tr>
<th>Outcome indicators</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>NSW</td>
<td>Vic</td>
<td>Qld</td>
<td>WA</td>
<td>SA</td>
<td>Tas</td>
<td>ACT</td>
<td>NT</td>
<td>Aust</td>
</tr>
<tr>
<td><strong>Apgar score at 5 minutes, 2011</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Data for this indicator not complete or not directly comparable (chapter 10)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Percentage of live births with an Apgar score of 3 or lower by birthweight</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt;1500g</td>
<td>18.0</td>
<td>16.5</td>
<td>15.9</td>
<td>7.8</td>
<td>6.8</td>
<td>na</td>
<td>21.0</td>
<td>9.1</td>
<td>na</td>
</tr>
<tr>
<td>1500g–1999g</td>
<td>1.5</td>
<td>1.4</td>
<td>1.1</td>
<td>0.3</td>
<td>0.8</td>
<td>na</td>
<td>6.7</td>
<td>–</td>
<td>na</td>
</tr>
<tr>
<td>2000g–2499g</td>
<td>0.9</td>
<td>0.9</td>
<td>1.1</td>
<td>0.5</td>
<td>0.1</td>
<td>na</td>
<td>–</td>
<td>–</td>
<td>na</td>
</tr>
<tr>
<td>2500g+</td>
<td>0.2</td>
<td>0.2</td>
<td>0.2</td>
<td>0.2</td>
<td>0.1</td>
<td>na</td>
<td>0.3</td>
<td>–</td>
<td>na</td>
</tr>
<tr>
<td><strong>Perinatal death rates — deaths per ‘000 total births, 2010</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Data for this indicator comparable, subject to caveats (chapter 10)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fetal deaths</td>
<td>5.2</td>
<td>5.7</td>
<td>6.8</td>
<td>5.9</td>
<td>3.9</td>
<td>8.4</td>
<td>13.8</td>
<td>7.9</td>
<td>5.9</td>
</tr>
<tr>
<td>Neonatal deaths</td>
<td>2.9</td>
<td>2.3</td>
<td>3.8</td>
<td>2.2</td>
<td>2.2</td>
<td>2.5</td>
<td>2.9</td>
<td>4.6</td>
<td>2.8</td>
</tr>
<tr>
<td>Perinatal deaths</td>
<td>8.1</td>
<td>8.0</td>
<td>10.5</td>
<td>8.0</td>
<td>6.1</td>
<td>10.9</td>
<td>16.7</td>
<td>12.5</td>
<td>8.7</td>
</tr>
<tr>
<td>Source: tables 10A.106–10A.111.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a Caveats for these data are available in chapter 10 and attachment 10A. Refer to the indicator interpretation boxes in chapter 12 for information to assist with the interpretation of data presented in this table. – Nil or rounded to zero. na Not available.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Primary and community health**

The performance indicator framework for primary and community health is presented in figure E.22. This framework provides comprehensive information on the equity, effectiveness, efficiency and the outcomes of primary and community health.
An overview of the primary and community health performance indicator results are presented in table E.5. Information to assist the interpretation of these data can be found in the indicator interpretation boxes in chapter 11 and the footnotes in attachment 11A.
Table E.5  Performance indicators for Primary and community health\textsuperscript{a,b}

<table>
<thead>
<tr>
<th>NSW</th>
<th>Vic</th>
<th>Qld</th>
<th>WA</th>
<th>SA</th>
<th>Tas</th>
<th>ACT</th>
<th>NT</th>
<th>Aust</th>
</tr>
</thead>
</table>

**Equity — Access indicators**

**Availability of PBS medicines — PBS prescriptions filled at concessional rate (per cent), 2011-12**
Data for this indicator comparable, subject to caveats (chapter 11)
Proportion of total

<table>
<thead>
<tr>
<th>NSW</th>
<th>Vic</th>
<th>Qld</th>
<th>WA</th>
<th>SA</th>
<th>Tas</th>
<th>ACT</th>
<th>NT</th>
<th>Aust</th>
</tr>
</thead>
<tbody>
<tr>
<td>86.9</td>
<td>87.0</td>
<td>86.2</td>
<td>82.7</td>
<td>88.6</td>
<td>89.8</td>
<td>73.8</td>
<td>75.9</td>
<td>86.5</td>
</tr>
</tbody>
</table>

**Equity of access to GPs, 2011-12**
Data for this indicator comparable, subject to caveats (chapter 11)
Full time workload equivalent GPs by region per 100 000 people

<table>
<thead>
<tr>
<th>Urban areas, rate</th>
<th>Rural areas, rate</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>103.2</td>
<td>90.9</td>
<td>64.7</td>
</tr>
<tr>
<td>95.5</td>
<td>87.6</td>
<td>58.3</td>
</tr>
<tr>
<td>96.1</td>
<td>92.4</td>
<td>43.2</td>
</tr>
<tr>
<td>73.2</td>
<td>70.9</td>
<td>55.2</td>
</tr>
<tr>
<td>98.1</td>
<td>98.1</td>
<td>60.0</td>
</tr>
<tr>
<td>93.6</td>
<td>83.8</td>
<td>55.5</td>
</tr>
<tr>
<td>68.8</td>
<td>..</td>
<td>56.1</td>
</tr>
<tr>
<td>73.1</td>
<td>88.0</td>
<td>59.3</td>
</tr>
</tbody>
</table>

**Equity of access to GPs, 2011-12 — Proportion of total**

<table>
<thead>
<tr>
<th>NSW</th>
<th>Vic</th>
<th>Qld</th>
<th>WA</th>
<th>SA</th>
<th>Tas</th>
<th>ACT</th>
<th>NT</th>
<th>Aust</th>
</tr>
</thead>
<tbody>
<tr>
<td>86.9</td>
<td>87.0</td>
<td>86.2</td>
<td>82.7</td>
<td>88.6</td>
<td>89.8</td>
<td>73.8</td>
<td>75.9</td>
<td>86.5</td>
</tr>
</tbody>
</table>

**Availability of public dentists — per 100 000 people, 2011**
Data for this indicator comparable, subject to caveats (chapter 11)
Proportion

<table>
<thead>
<tr>
<th>NSW</th>
<th>Vic</th>
<th>Qld</th>
<th>WA</th>
<th>SA</th>
<th>Tas</th>
<th>ACT</th>
<th>NT</th>
<th>Aust</th>
</tr>
</thead>
<tbody>
<tr>
<td>4.9</td>
<td>5.1</td>
<td>6.9</td>
<td>5.8</td>
<td>7.4</td>
<td>3.6</td>
<td>7.7</td>
<td>10.7</td>
<td>5.7</td>
</tr>
</tbody>
</table>

**Early detection and early treatment for Indigenous Australians — Proportion of Older Indigenous Australians who received a health assessment, 2011-12**
Data for this indicator comparable, subject to caveats (chapter 11)
Proportion

<table>
<thead>
<tr>
<th>NSW</th>
<th>Vic</th>
<th>Qld</th>
<th>WA</th>
<th>SA</th>
<th>Tas</th>
<th>ACT</th>
<th>NT</th>
<th>Aust</th>
</tr>
</thead>
<tbody>
<tr>
<td>25.1</td>
<td>14.6</td>
<td>32.9</td>
<td>23.5</td>
<td>18.5</td>
<td>14.0</td>
<td>18.6</td>
<td>28.6</td>
<td>25.5</td>
</tr>
</tbody>
</table>

**Children receiving a fourth year developmental health check, 2011-12**
Data for this indicator comparable, subject to caveats (chapter 11)
Proportion

<table>
<thead>
<tr>
<th>NSW</th>
<th>Vic</th>
<th>Qld</th>
<th>WA</th>
<th>SA</th>
<th>Tas</th>
<th>ACT</th>
<th>NT</th>
<th>Aust</th>
</tr>
</thead>
<tbody>
<tr>
<td>51.4</td>
<td>24.1</td>
<td>67.0</td>
<td>41.9</td>
<td>37.7</td>
<td>49.9</td>
<td>26.0</td>
<td>57.2</td>
<td>45.8</td>
</tr>
</tbody>
</table>

Source: tables 11A.7–11A.25.

**Effectiveness — Access indicators**

**Effectiveness of access to GPs**
Data comparability and completeness vary for this indicator.

**Bulk billing rates for non-referred patients, 2011-12**
Proportion (%)

<table>
<thead>
<tr>
<th>NSW</th>
<th>Vic</th>
<th>Qld</th>
<th>WA</th>
<th>SA</th>
<th>Tas</th>
<th>ACT</th>
<th>NT</th>
<th>Aust</th>
</tr>
</thead>
<tbody>
<tr>
<td>86.1</td>
<td>80.8</td>
<td>81.0</td>
<td>72.8</td>
<td>80.8</td>
<td>75.4</td>
<td>50.2</td>
<td>73.7</td>
<td>81.5</td>
</tr>
</tbody>
</table>

**GP waiting times for urgent appointment, 2011-12 — less than 4 hours**
Proportion (%)

<table>
<thead>
<tr>
<th>NSW</th>
<th>Vic</th>
<th>Qld</th>
<th>WA</th>
<th>SA</th>
<th>Tas</th>
<th>ACT</th>
<th>NT</th>
<th>Aust</th>
</tr>
</thead>
<tbody>
<tr>
<td>63.5</td>
<td>63.5</td>
<td>65.2</td>
<td>63.1</td>
<td>68.4</td>
<td>54.3</td>
<td>48.0</td>
<td>46.6</td>
<td>63.6</td>
</tr>
</tbody>
</table>

**People deferring treatment due to cost, 2011-12 — deferring visits to GPs**
Proportion (%)

<table>
<thead>
<tr>
<th>NSW</th>
<th>Vic</th>
<th>Qld</th>
<th>WA</th>
<th>SA</th>
<th>Tas</th>
<th>ACT</th>
<th>NT</th>
<th>Aust</th>
</tr>
</thead>
<tbody>
<tr>
<td>5.5</td>
<td>7.8</td>
<td>7.4</td>
<td>9.2</td>
<td>6.0</td>
<td>11.4</td>
<td>12.9</td>
<td>12.2</td>
<td>7.2</td>
</tr>
</tbody>
</table>

**Selected potentially avoidable GP-type presentations to emergency departments, 2011-12**

<table>
<thead>
<tr>
<th>'000</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>684.9</td>
<td>545.1</td>
<td>378.0</td>
<td>283.1</td>
<td>103.9</td>
<td>59.8</td>
<td>47.8</td>
<td>40.9</td>
<td>2143.6</td>
</tr>
</tbody>
</table>

**Financial barriers to PBS medicines**

**People deferring treatment due to cost, 2011-12 — deferring purchase of medicines**
Data for this indicator comparable, subject to caveats (chapter 11)
Proportion (%)

<table>
<thead>
<tr>
<th>NSW</th>
<th>Vic</th>
<th>Qld</th>
<th>WA</th>
<th>SA</th>
<th>Tas</th>
<th>ACT</th>
<th>NT</th>
<th>Aust</th>
</tr>
</thead>
<tbody>
<tr>
<td>8.9</td>
<td>9.2</td>
<td>11.5</td>
<td>8.2</td>
<td>10.1</td>
<td>10.8</td>
<td>11.7</td>
<td>11.0</td>
<td>9.6</td>
</tr>
</tbody>
</table>

**Public dentistry waiting times, 2011-12 — less than 1 month**
Data for this indicator comparable, subject to caveats (chapter 11)
Proportion (%)

<table>
<thead>
<tr>
<th>NSW</th>
<th>Vic</th>
<th>Qld</th>
<th>WA</th>
<th>SA</th>
<th>Tas</th>
<th>ACT</th>
<th>NT</th>
<th>Aust</th>
</tr>
</thead>
<tbody>
<tr>
<td>47.8</td>
<td>30.4</td>
<td>42.2</td>
<td>53.1</td>
<td>35.0</td>
<td>38.3</td>
<td>23.0</td>
<td>66.3</td>
<td>41.3</td>
</tr>
</tbody>
</table>

Source: tables 11A.26–11A.36.
Table E.5  (continued)

<table>
<thead>
<tr>
<th>Effectiveness — Appropriateness indicators</th>
</tr>
</thead>
<tbody>
<tr>
<td><em>GP</em> <em>with vocational registration</em>, 2011-12</td>
</tr>
<tr>
<td>Data for this indicator comparable, subject to caveats (chapter 11)</td>
</tr>
<tr>
<td>Proportion (%)</td>
</tr>
<tr>
<td>----------------</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td><em>General practices with accreditation, at 30 June 2011</em></td>
</tr>
<tr>
<td>Data for this indicator comparable, subject to caveats (chapter 11)</td>
</tr>
<tr>
<td>Proportion (%)</td>
</tr>
<tr>
<td>----------------</td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>

*Management of upper respiratory tract infections*  
Data for this indicator comparable, subject to caveats (chapter 11)  
Prescriptions for oral antibiotics used to treat upper respiratory tract infections per 1000 concession card holders, 2011-12  
Rate | 1 297.8 | 1 228.0 | 1 293.6 | 1 015.9 | 1 095.3 | 1 053.4 | 1 179.1 | 435.3 | 1 220.0 |
Proportion (%) | 35.0 | 30.1 | 33.7 | 28.7 | 30.1 | 25.3 | 33.0 | 22.8 | 32.5 |

*Management of chronic disease*  
Data for this indicator comparable, subject to caveats (chapter 11)  
People with diabetes mellitus who have received an annual cycle of care within general practice, 2011-12  
Proportion (%) | 22.4 | 23.4 | 22.0 | 19.4 | 27.1 | 29.0 | 15.7 | 19.4 | 22.7 |
People with asthma who have a written asthma action plan, 2007-08  
Proportion (%) | 20.4 | 22.9 | 19.7 | 17.4 | 21.9 | 17.1 | 21.8 | 40.9 | 20.8 |

*Pathology tests and diagnostic imaging — Medicare benefits for pathology tests, 2011-12*  
Data for this indicator comparable, subject to caveats (chapter 11)  
$ per person | 65.7 | 60.2 | 67.3 | 54.9 | 62.1 | 58.0 | 59.1 | 58.1 | 62.9 |


**Effectiveness — Quality — Safety indicators**

**Electronic health information systems — general practices using electronic systems, May 2012**  
Data for this indicator comparable, subject to caveats (chapter 11)  
Proportion (%) | 86.6 | 89.8 | 89.3 | 89.2 | 87.8 | 89.7 | 90.9 | 77.8 | 88.3 |

Source: tables 11A.52–11A.53.

**Effectiveness — Quality — Responsiveness indicators**

*Patient satisfaction, 2011-12*  
Data for this indicator comparable, subject to caveats (chapter 11)  
Proportion (%) of people who saw a practitioner in the previous 12 months where the practitioner always or often: listened carefully to them  
GP | 89.1 | 87.6 | 87.5 | 87.0 | 88.9 | 88.3 | 90.0 | 86.5 | 88.1 |
Dental practitioner | 93.8 | 93.6 | 93.8 | 94.4 | 95.8 | 91.4 | 93.9 | 92.3 | 93.9 |

Source: tables 11A.54–11A.57.

(Continued next page)
Table E.5  (continued)

<table>
<thead>
<tr>
<th>NSW</th>
<th>Vic</th>
<th>Qld</th>
<th>WA</th>
<th>SA</th>
<th>Tas</th>
<th>ACT</th>
<th>NT</th>
<th>Aust</th>
</tr>
</thead>
</table>

**Effectiveness — Quality — Continuity indicators**

*Health assessments for older people — proportion of older people assessed, 2011-12*

Data for this indicator comparable, subject to caveats (chapter 11)

| Proportion (%) | 28.0 | 26.1 | 31.5 | 25.1 | 25.7 | 31.2 | 19.6 | 21.9 | 27.6 |

Source: table 11A.58.

**Efficiency indicators**

*Cost to government of general practice per person, 2011-12*

Data for this indicator comparable, subject to caveats (chapter 11)

| $ per person | 320.5 | 301.7 | 308.2 | 228.6 | 314.5 | 292.3 | 216.9 | 189.8 | 299.4 |

Source: table 11A.2.

**Outcome indicators**

*Child immunisation coverage — Children aged 60 to 63 months fully immunised, 30 June 2012*

Data for this indicator comparable, subject to caveats (chapter 11)

| Proportion (%) | 90.6 | 91.6 | 91.0 | 87.6 | 88.8 | 90.8 | 90.4 | 90.2 |

*Notifications of selected childhood diseases — notifications per 100 000 children, 2011-12*

Data for this indicator comparable, subject to caveats (chapter 11)

| Measles | 1.5 | np | – | np | – | – | np | 0.6 |

*Participation rates for women in breast cancer screening — Ages 50–69, 1 January 2010 to 31 December 2011*

Data for this indicator comparable, subject to caveats (chapter 11)

| Rate | 49.6 | 54.3 | 56.4 | 58.2 | 57.4 | 57.0 | 51.1 | 40.7 | 53.9 |

*Participation rates for women in cervical screening — Ages 20–69, 1 January 2010 to 31 December 2011*

Data for this indicator comparable, subject to caveats (chapter 11)

| Rate | 56.1 | 60.3 | 55.3 | 55.6 | 59.7 | 55.6 | 57.6 | 53.5 | 57.2 |

*Influenza vaccination coverage for older people — 65 years or over, 2009*

Data for this indicator comparable, subject to caveats (chapter 11)

| Rate | 72.7 | 75.0 | 74.6 | 72.9 | 81.3 | 77.5 | 78.0 | 69.3 | 74.6 |

*Separations for selected potentially preventable hospitalisations, 2010-11, per 1000 people*

Data for this indicator comparable, subject to caveats (chapter 11)

| Vaccine-preventable | 0.6 | 0.8 | 0.8 | 0.6 | 1.0 | 0.4 | 0.5 | 3.0 | 0.8 |
| Acute conditions excluding dehydration and gastroenteritis | 10.6 | 11.6 | 12.3 | 12.6 | 12.4 | 8.4 | 9.0 | 18.0 | 11.5 |
| Chronic conditions excluding additional diagnoses of diabetes complications | 10.1 | 11.9 | 12.0 | 10.6 | 11.5 | 9.1 | 8.5 | 22.0 | 11.1 |


---

* Caveats for these data are available in Chapter 11 and Attachment 11A. Refer to the indicator interpretation boxes in chapter 11 for information to assist with the interpretation of data presented in this table. *b* Some data are derived from detailed data in Chapter 11 and Attachment 11A. – Nil or rounded to zero. *na* Not available. *np* Not published.

Source: Chapter 11 and Attachment 11A.
Mental health management

The performance indicator framework for mental health management is presented in figure E.23. This framework provides comprehensive information on the equity, effectiveness, efficiency and the outcomes of mental health management.

Figure E.23  Mental health management performance indicator framework

Key to indicators

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

<table>
<thead>
<tr>
<th>Output</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>New client index</td>
<td>Rates of licit and illicit drug use</td>
</tr>
<tr>
<td>Mental health service use by selected community groups</td>
<td>Prevalence of mental illness</td>
</tr>
<tr>
<td>Mental health service use by total population</td>
<td>Mortality due to suicide</td>
</tr>
<tr>
<td>Primary mental health care for children and young people</td>
<td>Social and economic inclusion of people with a mental illness</td>
</tr>
<tr>
<td>Services reviewed against the National Standards</td>
<td>Mental health outcomes of consumers of specialised public mental health services</td>
</tr>
<tr>
<td>Services provided in the appropriate setting</td>
<td>Collection of information on consumers outcomes</td>
</tr>
<tr>
<td>Consumer and carer experiences of services</td>
<td>Mental health outcomes of consumers of specialised public mental health services</td>
</tr>
<tr>
<td>Consumer and carer involvement in decision making</td>
<td>Specialised public mental health consumers with nominated GP</td>
</tr>
<tr>
<td>Post discharge community care</td>
<td>Prevalence of mental illness</td>
</tr>
<tr>
<td>Readmission to hospital within 28 days of discharge</td>
<td>Mortality due to suicide</td>
</tr>
<tr>
<td>Cost for inpatient care</td>
<td>Social and economic inclusion of people with a mental illness</td>
</tr>
<tr>
<td>Cost for community-based residential care</td>
<td>Mental health outcomes of consumers of specialised public mental health services</td>
</tr>
<tr>
<td>Cost for ambulatory care</td>
<td>Prevalence of mental illness</td>
</tr>
</tbody>
</table>

---

**HEALTH SECTOR**

**OVERVIEW**

E.53
An overview of the mental health management performance indicator results are presented in table E.6. Information to assist the interpretation of these data can be found in the indicator interpretation boxes in chapter 12 and the footnotes in attachment 12A.

**Table E.6 Performance indicators for Mental health management**

<table>
<thead>
<tr>
<th>Equity — Access indicators</th>
</tr>
</thead>
<tbody>
<tr>
<td>New client index — Proportion of clients under the care of State or Territory specialised public mental health services who were new clients, 2010-11</td>
</tr>
<tr>
<td>Data for this indicator comparable, subject to caveats (chapter 12)</td>
</tr>
<tr>
<td>Proportion (%)</td>
</tr>
<tr>
<td>----------------</td>
</tr>
<tr>
<td>Access indicators</td>
</tr>
</tbody>
</table>

**Mental health service use by selected community groups**

Data for this indicator comparable, subject to caveats (chapter 12)

| Proportion (%) of the Indigenous population using State and Territory mental health services, compared with the proportion for non-Indigenous population, 2010-11 |
| Indigenous | 4.8 | 3.1 | 4.4 | 4.8 | 5.8 | 1.9 | 6.4 | 3.7 | 4.4 |
| Non-Indigenous | 1.2 | 1.0 | 1.6 | 1.7 | 1.6 | 1.6 | 1.8 | 2.0 | 1.4 |

| Proportion (%) of the Indigenous population using MBS and DVA funded mental health services, compared with the proportion for non-Indigenous population, 2010-11 |
| Indigenous | 10.1 | 11.3 | 5.9 | 4.0 | 7.8 | 8.9 | 11.5 | 1.5 | 6.9 |
| Non-Indigenous | 6.9 | 7.6 | 6.6 | 5.7 | 6.9 | 6.3 | 5.5 | 3.4 | 6.8 |


**Effectiveness — Access indicators**

**Mental health service use by total population, 2010-11**

Data for this indicator comparable, subject to caveats (chapter 12)

| Proportion (%) of the population in a State and Territory using a specialised public mental health service or a MBS-subsidised service |
| Specialised public mental health | 1.6 | 1.1 | 1.7 | 1.9 | 2.0 | 1.8 | 2.2 | 2.4 | 1.6 |
| MBS and DVA subsidised service | 7.1 | 7.7 | 6.7 | 5.7 | 7.1 | 6.4 | 5.7 | 2.9 | 6.9 |

**Primary mental health care for children and young people, 2011-12**

Data for this indicator comparable, subject to caveats (chapter 12)

| Proportion of young people aged under 25 years who had contact with primary mental health care services subsidised through the MBS |
| Proportion (%) | 4.7 | 5.3 | 4.4 | 3.5 | 4.9 | 4.5 | 4.0 | 1.7 | 4.6 |

Source: tables 12A.30 and 12A.33.

**Effectiveness — Appropriateness indicators**

**Services reviewed against national standards, June 2011**

Data for this indicator not complete or not directly comparable (chapter 12)

| Proportion of specialised public mental health services that had completed an external review against national standards and were assessed as meeting ‘all Standards’ (level 1) |
| Proportion (%) | 82.1 | 95.6 | 96.4 | 43.6 | 85.6 | 28.0 | 100.0 | 100.0 | 84.9 |

(Continued next page)
Table E.6  (Continued)

<table>
<thead>
<tr>
<th></th>
<th>NSW</th>
<th>Vic</th>
<th>Qld</th>
<th>WA</th>
<th>SA</th>
<th>Tas</th>
<th>ACT</th>
<th>NT</th>
<th>Aust</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Services provided in the appropriate setting, 2010-11</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Data for this indicator comparable, subject to caveats (chapter 12)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Recurrent expenditure on community-based services as a proportion of total expenditure on mental health services</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Proportion (%)</td>
<td>44.3</td>
<td>63.3</td>
<td>55.5</td>
<td>53.4</td>
<td>56.5</td>
<td>73.2</td>
<td>64.3</td>
<td>53.9</td>
<td></td>
</tr>
<tr>
<td><strong>Collection of information on consumers outcomes, 2010-11</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Data for this indicator comparable, subject to caveats (chapter 12)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Proportion of episodes with completed consumer outcomes measures collected for people in specialised public mental health services — ongoing community care</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Proportion (%)</td>
<td>19.0</td>
<td>35.0</td>
<td>37.0</td>
<td>45.0</td>
<td>39.0</td>
<td>32.0</td>
<td>14.0</td>
<td>39.0</td>
<td>31.0</td>
</tr>
<tr>
<td><strong>Source:</strong> tables 12A.34-36.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Effectiveness — Quality — Responsiveness indicators**

**Consumer and carer involvement in decision making, 2010-11**

Data for this indicator comparable, subject to caveats (chapter 12)

Paid consumer consultants (FTE) per 1000 paid direct care, consumer and carer staff (FTE)

| no.   | 2.7 | 3.0 | 3.8 | 1.2 | 4.0 | 0.7 | –   | –   | 2.8 |

**Source:** tables 12A.37.

**Effectiveness — Quality — Continuity indicators**

**Community follow up for people within the first 7 days of discharge from hospital, 2010-11**

Data for this indicator not complete or not directly comparable (chapter 12)

Proportion of overnight separations from psychiatric inpatient acute services with a community mental health service contact recorded in the 7 days following separation

| Proportion (%) | 47.6 | 71.8 | 52.6 | 58.8 | 45.5 | 43.8 | 78.6 | 19.5 | 54.3 |

**Readmissions to hospital within 28 days of discharge, 2010-11**

Data for this indicator not complete or not directly comparable (chapter 12)

Proportion of overnight separations from psychiatric inpatient acute services that were followed by a readmission to a psychiatric inpatient service within 28 days of discharge

| Proportion (%) | 15.8 | 15.0 | 16.3 | 13.0 | 8.9  | 15.1 | 5.3  | 12.0 | 14.7 |

**Source:** tables 12A.38–39.

**Efficiency indicators**

**Cost of inpatient care**

Data for this indicator comparable, subject to caveats (chapter 12)

Cost per inpatient bed day, 2010-11

| General mental health services (acute units) | $ per bed day | 898 | 790 | 826 | 1 101 | 886 | 1 106 | 870 | 1 242 | 892 |
| Public acute hospital with a psychiatric unit or ward (acute units) | $ per bed day | 921 | 794 | 858 | 1 041 | 873 | 1 289 | 809 | 1 242 | 897 |
## Table E.6  (Continued)

<table>
<thead>
<tr>
<th>NSW</th>
<th>Vic</th>
<th>Qld</th>
<th>WA</th>
<th>SA</th>
<th>Tas</th>
<th>ACT</th>
<th>NT</th>
<th>Aust</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Average recurrent cost per patient day for community residential services, 2010-11

*Data for this indicator comparable, subject to caveats (chapter 12)*

- General adult units — 24-hour staffed units
  - $ per patient day
    - NSW: 291
    - Vic: 531
    - Qld: ..
    - WA: 511
    - SA: 451
    - Tas: 469
    - ACT: 637
    - NT: 352
    - Aust: 492

### Average cost of ambulatory care — Average cost per episode of ambulatory care 2010-11

*Data for this indicator comparable, subject to caveats (chapter 12)*

- $ per episode
  - NSW: 1 895
  - Vic: 2 455
  - Qld: 2 320
  - WA: 2 011
  - SA: 1 756
  - Tas: 1 794
  - ACT: 2 016
  - NT: 2 050
  - Aust: 2 089

### Outcome indicators

#### Rates of licit and illicit drug use, 2010

*Data for this indicator comparable, subject to caveats (chapter 12)*

- Proportion of people aged 14 years or over who used any illicit drug in the preceding 12 months
  - Proportion (%): 11.4

#### Prevalence of mental illness, 2007

*Data for this indicator comparable, subject to caveats (chapter 12)*

- Proportion of people with a lifetime mental disorders among adults aged 16–85 years
  - Proportion (%): 20.1
  - Proportion (%): 20.7
  - Proportion (%): 19.2
  - Proportion (%): 21.4
  - Proportion (%): 19.1
  - Proportion (%): 14.1
  - Proportion (%): np
  - Proportion (%): np
  - Proportion (%): np

#### Mortality due to suicide — Suicide rate per 100 000 people 2006–2010

*Data for this indicator comparable, subject to caveats (chapter 12)*

- Rate: 8.4

#### Social and economic inclusion of people with a mental illness, 2011-12

*Data for this indicator comparable, subject to caveats (chapter 12)*

- Proportion of people discharged from a State or Territory public hospital psychiatric inpatient unit who had a significant improvement in their clinical mental health outcomes
  - Proportion (%): 69
  - Proportion (%): 74
  - Proportion (%): 74
  - Proportion (%): 75
  - Proportion (%): 72
  - Proportion (%): 76
  - Proportion (%): np
  - Proportion (%): 77
  - Proportion (%): 72

#### Mental health outcomes of consumers of specialised public mental health services, 2010-11

*Data for this indicator comparable, subject to caveats (chapter 12)*

- Proportion of people aged 16–64 years with a mental illness who are employed
  - Proportion (%): 65.2
  - Proportion (%): 59.4
  - Proportion (%): 57.7
  - Proportion (%): 65.0
  - Proportion (%): 61.2
  - Proportion (%): 51.6
  - Proportion (%): 72.5
  - Proportion (%): 63.2
  - Proportion (%): 61.7
  - Proportion (%): ± 7.7
  - Proportion (%): ± 6.4
  - Proportion (%): ± 6.7
  - Proportion (%): ± 5.9
  - Proportion (%): ± 7.2
  - Proportion (%): ± 8.7
  - Proportion (%): ± 8.2
  - Proportion (%): ± 10.3
  - Proportion (%): ± 3.1

Source: tables 12A.41, 12A.43, 12A.44-45.

---

1 Caveats for these data are available in chapter 12 and attachment 12A. Refer to the indicator interpretation boxes in chapter 12 for information to assist with the interpretation of data presented in this table.

- Nil or rounded to zero.
- .. Not applicable.
- np Not published.
E.3 Cross cutting and interface issues

Many determinants affect Australian’s health (AIHW 2010). They include the delivery of an efficient, effective and equitable health service, but also factors such as individuals’ and communities’ social and economic conditions and background.

Major improvements in health outcomes therefore depend on strong partnerships between components of the health system and relationships between the health sector and other government services:

- **Early childhood, education and training services** play an important role in shaping a child’s development, which has consequences for overall health and wellbeing in later life (AIHW 2011a).

  Good health is critical to a child’s educational development. Impaired hearing, malnutrition, poor general health, including poor eyesight, anaemia, skin diseases, and sleep deprivation have been identified as having adverse effects on the educational attainment of Indigenous children (AMA 2001).

- **Justice services** have a critical role in providing a safe and secure society, free from violence. They also enforce laws designed to improve public health such as to prevent road traffic accidents and the use of illicit drugs.

  A person’s health can also be a critical factor in a persons interaction with the justice system. Research shows that prisoners have significantly worse health, with generally higher levels of diseases, mental illness and illicit drug use than Australians overall (AIHW 2010).

- **Emergency management services** have an important role in the preparation and response to emergency events providing emergency first aid, protection and shelter. Ambulance services are an integral part of a jurisdiction’s health service providing emergency as well as non-emergency patient care and transport.

- **Community services** and health services interact at many levels. People with disability are more likely than others to have poor physical and mental health, and higher rates of risk factors such as smoking and obesity (AIHW 2010). Aged care services can keep people living independently and healthily, without undue call on the health sector. Child protection services act to protect children and ensure their good health (while medical professionals are the source of many child protection notifications).

- **Housing and homelessness services** play an important role in ensuring the health of Australians. Living conditions (particularly poor housing and infrastructure) are a major contributor to health and well being. People with unmet housing needs tend to experience higher death rates, poor health, and are more likely to have serious chronic illnesses (Garner 2006).
E.4  Future directions in performance reporting

This health sector overview will continue to be developed in future reports.

It is anticipated that work undertaken to achieve the COAG aspirations will lead to improvements in performance reporting for the health sector. There are several important national initiatives currently underway. COAG has agreed to the National Health Reform Agreement (COAG 2011). The Agreement includes a commitment to introduce clear and transparent performance reporting against the new Performance and Accountability Framework that will include:

• a subset of the national performance indicators already agreed by COAG through the NHA
• reference to national clinical quality and safety standards developed by the Australian Commission on Safety and Quality in Health Care
• design principles for the new Hospital Performance Reports and Healthy Communities Reports.

Performance reporting will be through the establishment of the National Health Performance Authority. The Authority will:

• provide clear and transparent quarterly public reporting of the performance of every Local Hospital Network, private hospital and Medicare Local
• monitor the performance of Local Hospital Networks, Medicare Locals and hospitals
• develop additional performance indicators as appropriate
• maintain the MyHospitals website.

The COAG Reform Council will continue its role of reviewing the national performance indicators at a State and Territory level. It will report on the performance of the Australian and State and Territory governments in achieving the jurisdictional level outcomes and performance benchmarks included in the NHA.

The Public hospitals, Primary and community health and Mental health management chapters contain a service-specific section on future directions in performance reporting.

E.5  Jurisdictions’ comments

This section provides comments from each jurisdiction on the services covered in this sector overview.
New South Wales Government comments

The 2011-12 New South Wales Budget saw a record $17.3 billion invested in NSW public health care. This investment supports the NSW health strategic planning framework that will guide the development of services and investments in the NSW public health system over the next 10 to 20 years.

*NSW 2021: A Plan to Make NSW Number One* was launched in September 2011 and is the NSW Government’s new 10-year plan to rebuild the economy, return quality services, renovate infrastructure, strengthen our local environment and communities, and restore accountability to Government.

The Plan sets immediate priorities for action and guides NSW Government resource allocation in conjunction with the NSW Budget. The Plan includes specific health-related targets.

- NSW Health is the lead for the following ‘NSW 2021’ Goals:
  - Keep people healthy and out of hospital (Goal 11)
  - Provide world-class clinical services with timely access and effective infrastructure (Goal 12).

The past year has seen a concerted effort across the system to deliver on these. Keeping people healthy and out of hospital will improve our quality of life and is the best way to manage rising health costs.

We will provide timely access to world-class health care through increased investment in infrastructure, and by establishing Local Health Districts and new governance arrangements for the NSW health system. We are restoring local decision-making so that our hospitals and health services can be managed by those closest to the patient.

Key achievements against these two goals in 2011-12 include:

- 5186 more elective surgery procedures have been performed
- Aboriginal infant mortality rates have fallen from 6.8 (2007–2009) to 4.5 (2009-2011) deaths per 1000 live births
- *Staphylococcus aureus* bloodstream infection rates remain well below the national benchmark of 2 per 10 000 patient bed days.

This year has also seen the introduction of a new collaborative performance management framework, which operates in conjunction with the revised funding and purchasing model for NSW Health. This framework actively engages the Local Health Districts and Specialist Health Networks in the management of performance and more clearly articulates the responsibilities of the Ministry of Health, the Pillar organisations and the Local Health Districts and Specialist Health Networks and their Boards.
Victorian Government comments

The Victorian Government is committed to building and maintaining a high quality and sustainable health system. Recent population health studies show that there have been important gains in the health profile of the Victorian population and that Victorians are benefiting from advice delivered by public health campaigns. Life expectancy and survival rates from heart disease and cancer continue to improve. However, increasing demand and an ageing population are significant sources of pressure on the health system, while global and national factors impacting on the Victorian economy have required greater focus on efficiencies in government spending.

The Victorian government is increasing health spending to $13.68 billion in 2012-13, including an additional $618 million for health services. Additional funding has been committed to increase the number of organ transplants, improve security and safety in hospitals, and implement a range of initiatives to further develop and support the rural maternity workforce and improve maternity service sustainability. A Perinatal Services Advisory Committee has also been established to provide advice and support a coordinated focus on improving the maternity and neonatal service systems.

The Victorian government is committed to significant mental health reform with the development of a new Mental Health Act and reform of the Psychiatric Disability Rehabilitation Support Services program being at the forefront. Investment of over $1.14 billion has been allocated in 2012-13 for specialist mental health services to deliver better targeted, planned and coordinated services. This includes investment in community based mental health services, new and redeveloped acute and sub-acute mental health beds and new specialist services, such as mother and baby units and eating disorder services.

The establishment of a new Health Innovation and Reform Council and the Commission for Hospital Improvement will drive further innovation and reform across Victoria’s health service system. The Council will provide advice to the Minister for Health and the Department of Health on the effective and efficient delivery of quality health services, with an increased focus on quality and safety, and the Commission will facilitate improvement through a range of initiatives in partnership with the sector. In the first instance the Council is reviewing hospital readmission rates and will provide advice on innovative models of care that can be provided through telehealth services in rural areas.

Victoria’s primary health services are promoting good health and early intervention to maximise health outcomes, and Primary Care Partnerships are working together to develop a more responsive and integrated service system. The establishment of clinical networks to assist people with chronic illnesses such as heart disease, diabetes, stroke and respiratory disease demonstrate the commitment to innovation in patient care while also planning for the growing demand for health services. Improved coordination, consistency and continuity of care, better access to health and human services, and improved planning and delivery of services now and into the future remain strong priorities.
Queensland Government comments

Queensland Health has been working hard to implement health reforms that will change the way health services are managed. On 17 May 2012 the Minister for Health introduced the Health and Hospital Network and Other Legislation Amendment Bill to strengthen the decentralisation of healthcare delivery in Queensland, and implement the revised national health funding arrangements under the National Health Reform Agreement. This enabled the establishment of the 17 Hospital and Health Services, which are statutory bodies with Hospital and Health Boards accountable to the local community and Queensland Parliament. The commencement of these 17 Hospital and Health Services occurred on 1 July 2012.

Another major reform for Queensland has been the introduction of Activity Based Funding (ABF). ABF is a funding framework used to manage how we deliver public healthcare services across Queensland. The ABF framework allocated health funding to Queensland Health hospitals based on the cost of healthcare services referred to as activities delivered. The framework promotes smarter healthcare choices and better care by placing greater focus on the value of healthcare we deliver for the amount of money we expend.

Queensland has been making progress with Closing the Gap. The most recent data shows that performance against the two COAG headline indicators show that between 2002–2004 and 2005–2007 the gap in Indigenous life expectancy has reduced from 10.36 to 9.39 for females and 11.37 to 10.42 for males (reduction of 0.95 years for both) and that mortality rates for children less than five years of age have dropped by more than 30 per cent from 2005 to 2007.

Queensland continues to have the shortest waiting times for elective surgery in the country, with the median wait of 27 days in 2011-2012, compared to 36 days nationally. Queensland will also continue to strive to reduce emergency department waiting times.

Queensland Health has also had the largest health building program in Australia in 2011–2012. This includes the development of the new Sunshine Coast University Hospital and the Gold Coast University Hospital and expanded healthcare services. This means importantly that patients will be treated closer to home. The development of the Queensland Children’s Hospital will offer children, young people, and their families access to the best paediatric care in Queensland. This has in turn created jobs across Queensland along with the rural and remote rectification works and various upgrades to existing infrastructure.

Within the eHealth program a clinical data repository known as ‘The Viewer’ has been implemented across the state to allow the sharing of patient information taken from various clinical systems. This important initiative supports improved patient care through easier access to more information.
Western Australian Government comments

WA Health has had one of its busiest years yet with hospital activity, emergency department presentations and elective surgery numbers reaching all time highs. Despite escalating demands, WA Health has performed strongly in the key areas of safety and quality through a consistent focus on forward planning, continuous improvement and innovative reform. Efforts are aligned to, and given focus by, the four pillars of the WA Health Strategic Intent 2010-2015:

- **Caring for individuals and the community**
  WA Health is working hard to provide access to safe and high quality healthcare for all Western Australian communities. Despite emergency department attendances increasing (by 8.2 per cent) since 2010-11, the percentage of patients waiting eight hours or more for admission (access block) fell by three percentage points at our tertiary hospitals. A focus on safety and quality has seen the implementation of key initiatives, such as, the public reporting of hand hygiene compliance across WA public hospitals. These initiatives foster continuous improvement aligned to the WA Strategic Plan for Safety and Quality Care 2008-2013.

- **Caring for those who need it most**
  Aboriginal health remains a top priority and WA Health is continuing to deliver new programs and expand existing programs under the national health reform’s Closing the Gap and Indigenous Early Childhood Development.
  In addition, WA Health has increased sub-acute care (rehabilitation, palliative care, mental health and geriatric services) in both hospitals and the community to help reduce the number of older Australians unnecessarily admitted to hospitals due to a lack of appropriate options to help support or restore their health and independence.

- **Making the best use of fund and resources**
  WA Health’s overarching focus on safety and quality in health care has enabled a smooth transition into the national health reform initiatives including the implementation of the Activity Based Funding and Management (ABF/M) Program, National Emergency Access Targets (NEAT) and National Elective Surgery Targets (NEST) across WA public hospitals.

- **Supporting our team**
  WA Health is committed to supporting and strengthening the skills and potential of its employees. A record number of medical graduates began internships in public hospitals and a refreshed recruitment drive was launched to attract new people in the nursing field. The WA Health Aboriginal Cultural Learning Framework and Aboriginal Workforce Strategic Intent have been launched to increase Aboriginal leadership in the health workforce, and concurrently contribute to improve understanding and health outcomes for all Aboriginal people.
South Australian Government comments

SA Health is progressing implementation of South Australia’s Health Care Plan 2007–2016 to meet health challenges including an ageing population and increasing incidence of chronic diseases.

South Australia is fast becoming a leader in the field of digital health care, investing in the $408 million Enterprise Patient Administration System (EPAS). Partnering with the Commonwealth Government, SA Health will deliver a better integrated health record system that will connect public hospitals and health care sites with each other and with the national eHealth records system.

The $36.7 million roll-out of digital breast screening across South Australia began in 2011-12. All eight analogue screening units are expected to be converted from analogue to digital by 2013, with as many as 23 000 more South Australian women able to be screened by 2015.

More Emergency Department patients were seen more quickly in 2011-12 and the median waiting time was 15 minutes. Elective Surgery median waiting time reduced to 34 days — four days fewer than the previous year. Online dashboards delivering real-time patient information are now available on the SA Health website for ambulance services, Emergency Department, inpatient and elective surgery at metropolitan and some of the larger country public hospitals.

Key elements of South Australia’s state-wide health reform advanced well in 2011-12. Work for the new Royal Adelaide Hospital began in September 2011 and is due to open in 2016. The $163 million redevelopment of the Flinders Medical Centre Emergency Department progressed well and in May 2012, the Royal Adelaide Hospital’s Acute Assessment Area opened. In April 2012, the new Children’s Cancer Centre at the Women’s and Children’s Hospital opened. Work also began on a new $11.5 million specialist cancer centre at the Lyell McEwin Hospital.

Major capital investment in our network of country hospitals continued, with the completion of the $36 million Ceduna District Health Service redevelopment in September 2011. The Riverland’s $41 million Berri Hospital is being redeveloped on time and under budget. In February 2012, work began on the $69 million state and federally funded Whyalla Hospital redevelopment.

The network of GP Plus and GP Plus Super Clinics steadily increased their hours and services in 2011-12. Construction of the Modbury and Noarlunga GP Plus Super Clinics was completed in December 2011 and March 2012 respectively. The Ceduna GP Plus commenced services in September 2011 and the Port Pirie GP Plus Centre is due to open by 2014.

SA Health’s $34 million Community Mental Health Centres initiative continues to progress well. In total there will be six Community Mental Health Centres, which will offer treatment and care for people who need mental health services.

In 2011-12, South Australia reported a dramatic fall in smoking and was ranked the highest in Australia for its leadership and action on tobacco control.
Tasmanian Government comments

The Tasmanian Government continued to deliver high quality health services to the population of Tasmania in 2011-2012. Major organisational changes were made in response to national and state health reforms, and this resulted in the establishment of three Tasmanian Health Organisations, each with an independent governing council responsible for providing local health services.

The number of Statewide emergency department presentations fell in 2011-2012, and there was an increase in the percentage of Triage category 1 and 2 patients seen within the recommended timeframe. There was also an improvement in the percentage of category 1 elective surgery patients who were seen within the clinically recommended time.

Among capital works completed during 2011-2012 were the Launceston General Hospital Emergency Department and Holman Clinic Bunker, the Northern Integrated Care Service, and the redevelopment of the Mersey Community Hospital Emergency Department. Work on the $585 million Royal Hobart Hospital redevelopment is progressing, and planning works are advanced for North West Regional Hospital’s Regional Cancer Care Centre.

2011 saw budget measures in response to the difficult financial environment faced by the Government as a result of the Global Financial Crisis. The Department of Health and Human Services (DHHS) was a focus for this effort with savings targets of $100.2m identified for 2011-12 and $150m for 2012-13. These health savings strategies resulted in significant agency realignment and a strong focus on efficiency.

In late 2012 the DHHS will begin working with Tasmania’s Lead Clinicians Group to update Tasmania’s Health Plan to take account of the changes that have occurred since the Plan was first published in 2007, and to address the new challenges to health service provision that continue to emerge.

Explicitly, Tasmania’s Health Plan 2013 will:

- Quantify the changes that have occurred in public health services in Tasmania over the last 5 years
- Update the 15-year vision for Tasmania’s health system in the light of changing circumstances and trends
- Provide a coherent strategic framework for decision making over the next 5 years
- Deliver the National Health and Hospital Reforms within a broader Statewide healthcare strategy
- Produce a Statewide General Practice and Primary Care Plan in partnership with Tasmania’s Medicare Local
- Deliver a health sector that contributes effectively to other cross-governmental strategies.
Australian Capital Territory Government comments

The ACT Government provides health services through two major hospitals: the Canberra Hospital and Health Services (CHHS) and Calvary Public Hospital. Both hospitals are teaching hospitals in cooperation with the Australian National University’s Medical School and University of Canberra.

In line with the national health reform agenda, the ACT has established a Local Hospital Network comprising the CHHS, Calvary Public Hospital, Clare Holland House, and Queen Elizabeth II Family Centre (a mothercraft facility). This network provides a comprehensive range of acute, sub-acute, emergency, non-admitted, primary, and community-based health services to residents of the ACT and the surrounding parts of NSW. CHHS is the major trauma referral hospital for the region.

The ACT government has continued to boost service provision and enhance quality of care. Hospital capacity continued to grow with bed numbers increasing from 907 in 2009-10 to 926 in 2010-11, and 939 in 2011-12. Australia’s first public, nurse-led Walk-in-Centre based at CHHS saw 17,540 presentations in 2011-12 (an increase of 15 per cent on 2010-11). Of these, 9 per cent were redirected to their GP and 5 per cent to the emergency department. The Centre provides the community with access to free treatment and care for minor illnesses.

In May 2008 the Government announced a ‘$1 billion plus’ commitment to a 10 year program of capital works known at the time as the Capital Asset Development Program (CADP). In 2012 the project name changed to the Health Infrastructure Program (HIP) to better reflect the vision and objectives of the project. HIP is designed to assist the ACT deliver the health services required to meet future increases in demand. In the 2008–09 Budget, the Government allocated $300 million as the first tranche toward the program. Further allocations in subsequent Budgets have brought the total financial commitment to date to $685.6 million. This has allowed several projects to be completed since the program commenced, including many enhancements to services and facilities at the Canberra Hospital campus.

In 2012 HIP has seen the completion of the Adult Mental Health Unit; Stage One of the Centenary Hospital for Women and Children; ‘Duffy House’ – a home-away-from-home for regional cancer patients and their carers staying in Canberra for treatment; and the Gungahlin Community Health Centre.

Other projects including the Belconnen Enhanced Community Health Centre; the Canberra Region Cancer Centre; and Stage Two of the Centenary Hospital for Women and Children continue their construction phase while projects, including the expansion of ED/ICU at Canberra Hospital, and the expansion and refurbishment of the Tuggeranong Community Health Centre are in final planning and design phases.

The ACT Health Directorate continues to work with the Commonwealth Government to achieve the national health reform agenda.
Northern Territory Government comments

During 2011-12, Northern Territory Department of Health services provided care to 258,000 Territorians and visitors in a range of settings, including remote health centres and our five hospitals.

Northern Territory statistics reflect the challenges of geography and a population widely distributed across remote and very remote areas. This contributes to significant socioeconomic disadvantage for some sectors of the population which often results in limited life and health choices and poorer wellbeing. These challenges require different approaches to service provision and make some areas of performance difficult to implement, measure, or accurately represent. For example, the reducing number of local medical registrations could be interpreted as a shrinking medical workforce when, in fact, it reflects increased use of fly-in fly-out medical services where doctors only need national registration. Small numbers of patients can also create difficulties with reporting for reasons of statistical interpretation as well as privacy.

The Northern Territory has pursued a range of strategies over the past year to manage increasing service demand. These have involved significant investment in remote service delivery and the expansion and upgrading of health facilities:

- the Territory’s ehealth strategy culminated in the first Telehealth Outpatient Clinic between specialists at Alice Springs Hospital and patients located at the Tennant Creek Hospital enabling delivery of services closer to home;
- home based dialysis options were accessed by 66 people;
- a new $24 million Emergency Department at Alice Springs Hospital is being built;
- major upgrades continue at Royal Darwin Hospital to provide increased beds in the Emergency Department (ED) and Short Stay Unit and two extra operating theatres;
- there are new works or upgrades at the hospitals in Gove (ED and staff accommodation), Katherine (ED) and Tennant Creek (Renal Unit);
- construction of 16-bed group homes in both Darwin and Alice Springs provide specialised, secure care and support for adults and young people with complex care needs requiring assessment and intensive intervention.

As part of the National Health Reform process, our five Hospital Boards transitioned into two Hospital Network Governing Councils, and the Northern Territory Medicare Local was created through a partnership between the Department, the Aboriginal Medical Services Alliance Northern Territory and the General Practice Network Northern Territory.

Continuity of care was strengthened through the sign-up of 54,000 people to My eHealth Record which, with client consent, securely stores and shares health information. This includes an estimated 75 per cent of the targeted Aboriginal and Torres Strait Islander rural and remote population.
The implementation of national reforms to the public hospital system continued throughout 2012. On 8 June 2012, the Independent Hospital Pricing Authority published the Pricing Framework for Australian Public Hospital Services and the National Efficient Price Determination 2012-13 to underpin new activity based funding (ABF) arrangements.

Funding structures to support ABF and governance arrangements to improve local responsiveness and accountability were in place by 1 July 2012; Local Hospital Networks were established by state and territory governments; and the Australian Government established a national network of Medicare Locals. The National Health Funding Pool was set up to transfer Commonwealth and state public hospital funding to Local Hospital Networks. All governments agreed to the appointment of an acting Administrator of the Pool. The Australian Government established the National Health Funding Body to assist the acting Administrator.

Key mental health reform achievements in 2012 include: significantly increased funding to Medicare Locals to provide access to psychological services for hard to reach groups; the establishment of the online mental health portal, mindhealthconnect; and support in all states and territories for people with severe and persistent mental illness who frequently use hospital emergency departments and need stable accommodation to keep well and to break the cycle of hospitalisation and homelessness.

Strengthening accountability and transparency across Government was progressed with the establishment of the new National Mental Health Commission. The Commission will promote best practice and measure the performance of the mental health system, including through the production of an Annual Report Card on Mental Health and Suicide Prevention.

The introduction of plain packaging was implemented through the Tobacco Plain Packaging Act 2011 and the Trade Marks Amendment (Tobacco Plain Packaging) Act 2011. All tobacco products manufactured or packaged in Australia from 1 October 2012 for domestic consumption must be in plain packaging, and all tobacco products must now be sold in plain packaging with new larger health warnings, effective 1 December 2012. The Australian Government has defended two constitutional challenges to the legislation, which were rejected by the High Court on 15 August 2012; and is continuing to defend international legal challenges to the plain packaging measures.

The Australian Government has finalised the compliance and enforcement framework for plain packaging which will be supported by extensive communication activities including the nationwide distribution of an Information Kit to tobacco suppliers, and advertising in the metropolitan, regional and rural press and online to ensure tobacco suppliers are aware of their obligations under the legislation. The Australian Government has also established a complaints line and email address for public complaints regarding compliance with the legislation.
E.6 List of attachment tables

Attachment tables are identified in references throughout this appendix by an ‘EA’ prefix (for example, table EA.1). Attachment tables are available on the Review website (www.pc.gov.au/gsp).

**Table EA.1** Total health expenditure, by broad source of funds (2010-11 dollars)
**Table EA.2** Government recurrent health expenditure, by area of expenditure (2010-11 dollars)
**Table EA.3** Non-government recurrent health expenditure by area of expenditure (2010-11 dollars)
**Table EA.4** Recurrent health expenditure, by source of funds and area of expenditure, 2010-11
**Table EA.5** Total health expenditure per person (2010-11 dollars)
**Table EA.6** Recurrent health expenditure per person by source of funds, excluding high level residential aged care (2010-11 dollars)
**Table EA.7** Total health price index
**Table EA.8** Birthweights, live births, all mothers, 2010
**Table EA.9** Birthweights, live births, Indigenous mothers, 2010
**Table EA.10** Proportion of live-born singleton babies of low birthweight, by maternal Indigenous status
**Table EA.11** Proportion of live-born singleton babies of low birthweight, by remoteness and SEIFA quintiles, and SEIFA deciles, National, 2010
**Table EA.12** Proportion of live-born singleton babies of low birthweight, by Indigenous status, 2007-08
**Table EA.13** Proportion of adults and children in BMI categories
**Table EA.14** Rates of overweight and obesity for adults and children, by remoteness
**Table EA.15** Rates of overweight and obesity for adults and children, by SEIFA IRSD quintiles
**Table EA.16** Rates of overweight and obesity for adults, by Indigenous status, 2004-05
**Table EA.17** Proportion of adults who are daily smokers, by remoteness
**Table EA.18** Proportion of adults who are daily smokers, by SEIFA IRSD quintiles
**Table EA.19** Proportion of adults who are daily smokers, by Indigenous status, 2007-08
**Table EA.20** Proportion of adults at risk of long term harm from alcohol (2009 NHMRC guidelines), by remoteness
**Table EA.21** Proportion of adults at risk of long term harm from alcohol (2009 NHMRC guidelines), by SEIFA IRSD quintiles
**Table EA.22** Proportion of adults at risk of long term harm from alcohol (2001 NHMRC guidelines), by Indigenous status, 2004-05
**Table EA.23** Incidence of selected cancers
**Table EA.24** Incidence of selected cancers by remoteness area
Table EA.25  Incidence of selected cancers, by SEIFA IRSD quintiles
Table EA.26  Incidence of selected cancers, by Indigenous status
Table EA.27  Age standardised rate of heart attacks, people 25 years and over, by Indigenous status, 2007 to 2010
Table EA.28  Rate of heart attacks, by age and sex, people aged 25 years and over, 2007 to 2010
Table EA.29  Age-standardised mortality rates of potentially avoidable deaths, under 75 years
Table EA.30  Age standardised mortality rates of potentially avoidable deaths, under 75 years, by Indigenous status, NSW, Queensland, WA, SA, NT, 2006–2010
Table EA.31  All Australians average life expectancy at birth (years)
Table EA.32  Estimated life expectancies at birth, by Indigenous status and sex, 2005–2007 (years)
Table EA.33  Median age at death (years)
Table EA.34  Mortality rates, age standardised for all causes (per 1000 people)
Table EA.35  Infant mortality rate, three year average (per 1000 live births)
Table EA.36  All causes infant and child mortality, by age group, by State and Territory
Table EA.37  All causes infant and child mortality, by Indigenous status, NSW, Queensland, WA, SA, NT, 2007–2011
Table EA.38  Age standardised mortality rates by cause of death (with variability bands), by State and Territory
Table EA.39  Age standardised mortality rates by major cause of death, by Indigenous status, 2006–2010
Table EA.40  Employed medical practitioners
Table EA.41  Employed nurses
Table EA.42  Net growth in health workforce, selected professions
Table EA.43  Employed health workforce, by Indigenous status and state and territory of principal practice
Table EA.44  Indigenous health workforce, by State/Territory, 2011
Table EA.45  Indigenous people in health workforce as a proportion of total health workforce, by age group and sex, 2011
Table EA.46  Indigenous persons employed in selected health-related occupations, 2011
Table EA.47  Proportion of people who accessed health services by health status, 2004-05
Table EA.48  Proportion of people who accessed health services by health status, by Indigenous status, 2004-05
Table EA.49  Proportion of people who accessed health services by health status, by remoteness of residence, 2004-05
Table EA.50  Proportion of people who accessed health services by health status, by SEIFA, 2004-05
E.7 References

ABS (Australian Bureau of Statistics) 2006a, *National Aboriginal and Torres Strait Islander Health Survey 2004-05, Australia*, Cat. no. 4715.0, Canberra.

—— 2006b, *National Health Survey: Summary of Results, 2004-05*, Cat. no. 4364.0, Canberra.

—— 2007, *Housing and Infrastructure in Aboriginal and Torres Islander Communities 2006, Australia, (Reissue)*, Cat. no. 4710.0, Canberra.

—— 2009a, *Experimental Life Tables for Aboriginal and Torres Strait Islander Australians 2005–2007*, Australia, Cat. no. 3302.0.55.003, Canberra.

—— 2009b, *National Aboriginal and Torres Strait Islander Social Survey, 2008, Australia*, Cat. no. 4714.0, Canberra.

—— 2009c, *National Health Survey: Summary of Results, Australia (Reissue)*, Cat. no. 4364.0, Canberra.

—— 2012, *Causes of Death Australia, 2010*, Cat. no. 3303.0, Canberra.

—— 2012a, *Deaths Australia 2010*, Cat. no. 3302.0, Canberra.


—— 2011, *Expenditure on health for Aboriginal and Torres Strait Islander people 2008-09*, Health and welfare expenditure series no. 44, Cat. no. HWE 53, Canberra.


—— 2012b, *Medical Workforce 2010*, National health workforce series no. 1, Cat. no. HWL 47, Canberra.

—— 2012c, *Nursing and Midwifery Workforce 2011*, National health workforce series no. 2, Cat. no. 48, Canberra.


Li Z, Zeki R, Hilder L & Sullivan EA 2012, Australia’s mothers and babies 2010, Perinatal statistics series no. 27, Cat. no. PER 56, Sydney, AIHW National Perinatal Epidemiology and Statistics Unit.


NHMRC (National Health and Medical Research Council) 2003, Dietary Guidelines for Australian Adults, Canberra.

—— 2009, Australian Guidelines to Reduce Health Risks from Drinking Alcohol, Commonwealth of Australia, Canberra.


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.

Major improvements in reporting on public hospitals this year include:

- a new measure adverse events treated in hospitals is reported under the ‘adverse events in public hospitals’ indicator
• time series data are reported, or have been extended, for a number of indicators and descriptive data items

• data quality information (DQI) is available for the first time for the indicators ‘accreditation’, ‘relative stay index’, ‘patient satisfaction’, ‘vaginal delivery following a previous caesarean’, ‘perineal status after vaginal birth’ and ‘Apgar score at five minutes’.

10.1 Profile of public hospitals

Definition

A key objective of Australian governments 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, irrespective of geographic location. Public hospitals provide a range of services, including:

• acute care services to admitted patients

• subacute and non-acute services to admitted patients (for example, rehabilitation, palliative care, and 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 relative to other hospitals data. Data in the chapter include subacute and non-acute care services.

In some instances, data for stand-alone psychiatric hospitals are included in this chapter. However, under the National Mental Health 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 the ‘Mental health management’ chapter (chapter 12).
**Funding**

Total recurrent expenditure on public hospitals (excluding depreciation) was $37.0 billion in 2010-11 (table 10A.1).

The majority of public hospital recurrent expenditure is spent on admitted patients. Non-admitted patients account for a much smaller share. For selected public hospitals, in 2010-11, the proportion of total public hospital recurrent expenditure that related to the care of admitted patients (based on the admitted patient cost proportion) was 70.0 per cent across Australia (AIHW 2012a).

Funding for public hospitals comes from a number of sources. The Australian, State and Territory governments contributed 91.6 per cent of funding for public hospital services in 2010-11 (figure 10.1). Public hospital services accounted for 41.8 per cent of government recurrent expenditure on health services in 2010-11 (AIHW 2012b).

**Figure 10.1 Recurrent expenditure, public hospital services, by source of funds, 2010-11**

<table>
<thead>
<tr>
<th>Source</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Australian Government</td>
<td>39.7%</td>
</tr>
<tr>
<td>State and local governments</td>
<td>51.9%</td>
</tr>
<tr>
<td>Non-government</td>
<td>8.4%</td>
</tr>
</tbody>
</table>

*Source: AIHW (unpublished), Health expenditure database.*

Non-government sources contributed 8.4 per cent of all recurrent expenditure on public hospital services in 2010-11 (including depreciation) (figure 10.2 and table 10A.2). Non-government expenditure comprised revenue from health insurance funds, individuals, workers’ compensation and compulsory third-party motor vehicle insurers and other sources. The proportion of hospitals’ revenue per person funded from non-government sources varied across jurisdictions in 2010-11 (figure 10.2).
In 2010-11, government real recurrent expenditure on public hospitals was $1645 per person for Australia, up from $1407 in 2006-07 (in 2010-11 dollars) (figure 10.3). It is difficult to make comparisons across jurisdictions based on these recurrent expenditure data, due to differences in the data coverage. The main 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.

Expenditure data in figures 10.1 and 10.2 are sourced from unpublished data from the AIHW Health Expenditure Australia database, and are not directly comparable with other expenditure data used in this chapter, which are drawn from Australian Hospital Statistics 2010-11 (AIHW 2012a). The AIHW publication Health Expenditure Australia 2010-11 provides information about the differences in the expenditure data between the two sources (AIHW 2012b).
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 type of public hospital separations; the proportion of separations by age group of the patient; the number of separations and incidence of treatment, by procedure and Indigenous status of the patient; the number of hospital staff; and types of public hospital activity.

Hospitals

In 2010-11, Australia had 752 public hospitals (including 17 psychiatric hospitals) (table 10A.4 and AIHW 2012a). Although 71.0 per cent of hospitals had 50 or fewer beds, these smaller hospitals represented only 15.2 per cent of total available beds (figure 10.4 and table 10A.4).
Figure 10.4  **Public hospitals, by size, 2010-11**\(^a, b, c, d, e\)

<table>
<thead>
<tr>
<th>Per cent</th>
<th>NSW</th>
<th>Vic</th>
<th>Qld</th>
<th>WA</th>
<th>SA</th>
<th>Tas</th>
<th>ACT</th>
<th>NT</th>
<th>Aust</th>
</tr>
</thead>
<tbody>
<tr>
<td>10 or fewer beds</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
</tr>
<tr>
<td>more than 10 to 50 beds</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>more than 50 to 100 beds</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>more than 100 beds</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

\(^a\) 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. \(^e\) The ACT did not have hospitals with more than 10 to 50 beds or more than 50 to 100 beds. The NT did not have hospitals with 10 or fewer beds.

*Source: AIHW (2012), *Australian Hospital Statistics 2010-11*, Health Services Series No. 43, Cat no. HSE 117; table 10A.4.*

**Hospital beds**

There were 57,772 available beds for admitted patients in public hospitals in 2010-11, equivalent to 2.6 beds per 1000 people (figures 10.5 and table 10A.4). The concept of an available bed is becoming less important in the overall context of hospital activity, particularly given the increasing significance of same day hospitalisations and hospital-in-the-home care (AIHW 2011a).
Figure 10.5  **Available beds, public hospitals**

An ‘available bed’ is one that is immediately available for exclusive or predominate use by admitted patients. 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 (HDSC 2008).

Source: AIHW (various years), *Australian hospital statistics*, Health Services Series, Cat. nos HSE 55, 71, 84, 107 and 117; table 10A.5.

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 admission practices and how available beds are counted, both across jurisdictions and over time.

Nationally, more beds were available per 1000 people in remote areas (figure 10.6). The patterns of bed availability can reflect a number of factors, including patterns of availability of other healthcare services, patterns of disease and injury and the relatively poor health of Indigenous Australians, who have higher population concentrations in remote areas. These data also need to be viewed in the context of the age and sex structure (reported in appendix A) and the morbidity and mortality (reported in the ‘Health sector overview’) of the population in each State and Territory.
Figure 10.6  **Available beds, public hospitals, by location, 2010-11**

*a, b, c, d*

An ‘available bed’ is one that is immediately available for exclusive or predominate use by admitted patients. 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 (HDSC 2008).

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 2012a).

Tasmania and the NT do not have major cities and the ACT does not have remote areas.

There were no available beds in regional areas in the ACT.

Source: AIHW (2012), *Australian Hospital Statistics 2010-11*, Health Services Series No. 43, Cat no. HSE 117; table 10A.5.

**Admitted patient care**

There were approximately 5.3 million separations from public (non-psychiatric) hospitals in 2010-11 (table 10A.6). Nationally, this translates into 225.5 separations per 1000 people (figure 10.7). Acute separations accounted for 95.9 per cent of separations from public hospitals, newborns excluding unqualified days accounted for 1.0 per cent (newborn qualification status is defined in section 10.8) and rehabilitation care accounted for 1.6 per cent (table 10A.13). Palliative care, non-acute care and other care constitute the remainder. Of the total number of separations in public (non-psychiatric) hospitals, 50.9 per cent were for same day patients. Public psychiatric hospitals accounted for around 0.2 per cent of total separations in public hospitals in 2010-11 (table 10A.6).
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 2010-11 (figure 10.8). 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.
People aged 55 years and over accounted for half of the separations in public hospitals (52.0 per cent) in 2010-11, even though they accounted for only 24.9 per cent of the estimated resident population at 30 June 2010 (table 10A.9 and AIHW 2012a).

The 10 AR-DRGs that accounted for the most overnight acute separations in public hospitals (19.7 per cent of all overnight acute separations recorded) in 2010-11 are shown in table 10A.14. Giving birth by vaginal delivery accounted for the most overnight acute separations (5.7 per cent) followed by chest pain (2.4 per cent).

The 10 AR-DRGs that accounted for the most patient days (19.4 per cent of all patient days recorded) in 2010-11 are shown in table 10A.15. Schizophrenic disorders accounted for the largest number of patient days (5.0 per cent), followed by birth by vaginal delivery (3.0 per cent) (table 10A.15).

**Admitted patient care for Indigenous Australians**

The completeness of Indigenous identification in hospital admitted patient data varies across states and territories. Efforts to improve Indigenous identification are ongoing. In 2010-11, on an age standardised basis, 848.0 public hospital separations (including same day separations) for Indigenous Australians were reported per 1000 Indigenous people in NSW, Victoria, Queensland, WA, SA and the NT combined.
This rate was markedly higher than the corresponding rate of 227.9 per 1000 for these jurisdictions’ combined total population (figure 10.9).

**Figure 10.9** Estimates of public hospital separations, by Indigenous status of patient, 2010-11\(^a, b, c\)

<table>
<thead>
<tr>
<th></th>
<th>Indigenous</th>
<th>All Australians</th>
</tr>
</thead>
<tbody>
<tr>
<td>NSW</td>
<td>400</td>
<td>1600</td>
</tr>
<tr>
<td>Vic</td>
<td>800</td>
<td>1200</td>
</tr>
<tr>
<td>Qld</td>
<td>1200</td>
<td>800</td>
</tr>
<tr>
<td>WA</td>
<td>2000</td>
<td>2000</td>
</tr>
<tr>
<td>SA</td>
<td>1600</td>
<td>1600</td>
</tr>
<tr>
<td>Tas</td>
<td>1200</td>
<td>1200</td>
</tr>
<tr>
<td>ACT</td>
<td>800</td>
<td>800</td>
</tr>
<tr>
<td>NT</td>
<td>400</td>
<td>400</td>
</tr>
<tr>
<td>Total</td>
<td>400</td>
<td>400</td>
</tr>
</tbody>
</table>

\(^a\) The rates are directly age standardised to the Australian population at 30 June 2001. \(^b\) Identification of Indigenous Australians is incomplete and completeness varies across jurisdictions. \(^c\) Data are reported for NSW, Victoria, Queensland, WA, SA and the NT. These six jurisdictions are considered to have an acceptable quality of Indigenous identification. The total comprises these jurisdictions only.

*Source:* AIHW (unpublished), National Hospital Morbidity Database; table 10A.11.

Hospital episodes of care involving dialysis accounted for 44 per cent of all hospitalisations for Indigenous Australians (compared with 12 per cent for non-Indigenous Australians) in the period July 2008 to June 2010. The hospitalisation rate for Indigenous Australians for dialysis was 11 times as high as the rate for non-Indigenous Australians. After adjusting for age differences, the hospitalisation rate (excluding dialysis) for Indigenous Australians in the two years to June 2010 was 435 per 1000 of the population compared with 305 per 1000 of the population for non-Indigenous Australians (1.4 times as high) (AHMAC 2012).

In 2010-11, separations for Indigenous Australians accounted for around 3.8 per cent of total separations and 5.9 per cent of separations in public hospitals in NSW, Victoria, Queensland, WA, SA and the NT combined (table 10A.10). Indigenous Australians made up only around 3.0 per cent of the population in these jurisdictions (tables AA.2 and AA.15). Most separations involving Indigenous Australians (91.9 per cent) in these jurisdictions occurred in public hospitals (table 10A.10).
Non-admitted patient services

There is considerable variation among states and territories and across reporting years in the way in which non-admitted patient occasions of service are collected. Differing admission practices across states and territories also lead to variation among jurisdictions in the services reported (AIHW 2012a).

A total of 50.2 million individual occasions of service were provided to non-admitted patients in public acute hospitals in 2010-11 (table 10.1). In addition, public hospitals delivered 317,764 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.16). In public acute hospitals in 2010-11, accident and emergency services comprised 15.2 per cent of all individual occasions of service to non-admitted patients. ‘Other medical, surgical and obstetric services’ (23.5 per cent), ‘pathology services’ (17.7 per cent) and ‘pharmacy’ (9.7 per cent) were other common types of non-admitted patient care (table 10.1).
### Table 10.1 Non-admitted patient occasions of service, by type of non-admitted patient care, public acute hospitals, 2010-11a

<table>
<thead>
<tr>
<th></th>
<th>NSW</th>
<th>Vic</th>
<th>Qld</th>
<th>WA</th>
<th>SA</th>
<th>Tas</th>
<th>ACT</th>
<th>NTb</th>
<th>Aust</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accident and emergency</td>
<td>11.6</td>
<td>19.7</td>
<td>14.9</td>
<td>16.4</td>
<td>26.0</td>
<td>28.4</td>
<td>16.6</td>
<td>26.8</td>
<td>15.2</td>
</tr>
<tr>
<td>Pathology</td>
<td>15.1</td>
<td>10.0</td>
<td>36.6</td>
<td>10.2</td>
<td>..</td>
<td>..</td>
<td>5.3</td>
<td>21.9</td>
<td>17.7</td>
</tr>
<tr>
<td>Radiology and organ imaging</td>
<td>4.2</td>
<td>7.9</td>
<td>9.1</td>
<td>8.7</td>
<td>11.1</td>
<td>..</td>
<td>13.1</td>
<td>16.1</td>
<td>6.9</td>
</tr>
<tr>
<td>Pharmacyc</td>
<td>16.4</td>
<td>5.7</td>
<td>5.4</td>
<td>4.9</td>
<td>..</td>
<td>..</td>
<td>0.2</td>
<td>7.2</td>
<td>9.7</td>
</tr>
<tr>
<td>Other medical/surgical/obstetric</td>
<td>23.0</td>
<td>20.7</td>
<td>23.7</td>
<td>15.6</td>
<td>43.1</td>
<td>43.8</td>
<td>53.2</td>
<td>25.6</td>
<td>23.5</td>
</tr>
<tr>
<td>Mental health</td>
<td>4.4</td>
<td>9.1</td>
<td>0.6</td>
<td>1.5</td>
<td>0.7</td>
<td>0.3</td>
<td>0.2</td>
<td>..</td>
<td>3.7</td>
</tr>
<tr>
<td>Dental</td>
<td>1.9</td>
<td>5.5</td>
<td>..</td>
<td>0.2</td>
<td>0.4</td>
<td>..</td>
<td>..</td>
<td>..</td>
<td>1.8</td>
</tr>
<tr>
<td>Allied health</td>
<td>3.1</td>
<td>13.6</td>
<td>5.3</td>
<td>21.9</td>
<td>8.2</td>
<td>22.2</td>
<td>4.7</td>
<td>2.4</td>
<td>7.8</td>
</tr>
<tr>
<td>Other non-admitted services</td>
<td>6.0</td>
<td>3.9</td>
<td>1.2</td>
<td>15.4</td>
<td>0.1</td>
<td>5.3</td>
<td>3.2</td>
<td>..</td>
<td>5.2</td>
</tr>
<tr>
<td>Community health</td>
<td>5.8</td>
<td>2.8</td>
<td>1.3</td>
<td>2.9</td>
<td>0.3</td>
<td>..</td>
<td>..</td>
<td>..</td>
<td>3.5</td>
</tr>
<tr>
<td>District nursingd</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Most common types of non-admitted patient care (%)</strong></td>
<td>91.6</td>
<td>98.8</td>
<td>98.1</td>
<td>97.6</td>
<td>89.9</td>
<td>100.0</td>
<td>96.5</td>
<td>100.0</td>
<td>95.1</td>
</tr>
<tr>
<td><strong>Total occasions of service for non-admitted patients ('000)</strong></td>
<td>21 334</td>
<td>8 383</td>
<td>11 191</td>
<td>5 358</td>
<td>2 163</td>
<td>543</td>
<td>679</td>
<td>526</td>
<td>50 177</td>
</tr>
</tbody>
</table>

---

**a** Individual non-admitted patient care services. Excludes group sessions. Reporting arrangements vary significantly across jurisdictions. **b** Radiology data for the NT are underestimated and pathology data relate to only three of the five hospitals. **c** Justice Health in NSW reported a large number of occasions of service that may not be typical of pharmacy. **d** Justice Health in NSW reported a large number of occasions of service that may not be typical of district nursing. – Nil or rounded to zero. .. Not applicable.

**Source:** AIHW (2012), *Australian Hospital Statistics 2010-11*, Health Services Series No. 43, Cat no. HSE 117; table 10A.16.

---

### Staff

In 2010-11, nurses comprised the single largest group of full time equivalent (FTE) staff employed in public hospitals (5.3 per 1000 people) (figure 10.10). Comparing data on FTE staff across jurisdictions should 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 and can explain some of the differences in FTE staff in some staffing categories across jurisdictions (AIHW 2011a).
Figure 10.10  **Average FTE staff per 1000 people, public hospitals, 2010-11**\(^{a, b, c, d, e}\)

![Graph showing average FTE staff per 1000 people for public hospitals in different jurisdictions.]

**Source** AIHW (2012), *Australian Hospital Statistics 2010-11*, Health Services Series No. 43, Cat no. HSE 117; ABS (unpublished), *Australian Demographic Statistics, December Quarter 2010*, Cat. no. 3101.0; tables 10A.12 and AA.2.

10.2 **Framework of performance indicators for public hospitals**

Performance is reported against objectives that are common to public hospitals in all jurisdictions (box 10.1). The Health sector overview 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.

COAG has agreed six National Agreements to enhance accountability to the public for the outcomes achieved or outputs delivered by a range of government services (see chapter 1 for more detail on reforms to federal financial relations).

The National Healthcare Agreement (NHA) covers the area of health and aged care, and health indicators in the National Indigenous Reform Agreement (NIRA) establish specific outcomes for reducing the level of disadvantage experienced by Indigenous Australians. Both agreements include sets of performance indicators, for which the Steering Committee collates performance information for analysis by the
COAG Reform Council (CRC). Performance indicators reported in this chapter are aligned with the health performance indicators in the NHA. The NHA was reviewed in 2011 and 2012 resulting in changes that have been reflected in this Report, as relevant.

### Box 10.1 Objectives for public hospitals

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

- safe and of high quality
- appropriate and responsive to individual needs
- affordable, timely and accessible
- equitably and efficiently delivered.

The performance indicator framework provides information on equity, efficiency and effectiveness, and distinguishes the outputs and outcomes of public hospital services (figure 10.11). The performance indicator framework shows which data are comparable in the 2013 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 Report’s statistical appendix 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) (appendix A).
Data quality information (DQI) is being progressively introduced for all indicators in the Report. The purpose of DQI is to provide structured and consistent information about quality aspects of data used to report on performance indicators. DQI in this Report cover the seven dimensions in the ABS’ data quality framework (institutional environment, relevance, timeliness, accuracy, coherence, accessibility and interpretability) in addition to dimensions that define and describe performance indicators in a consistent manner, and note key data gaps and issues identified by the Steering Committee. All DQI for the 2013 Report can be found at www.pc.gov.au/gsp/reports/rogs/2013.
10.3 Key performance indicator results for public hospitals

Different delivery contexts, locations and types of client can affect the equity, effectiveness and efficiency of health services.

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

Outputs

Outputs are the 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 important for people of low socioeconomic status (and others) who can have difficulty in accessing alternative services, such as those provided by private hospitals.

Equity of access by special needs groups

‘Equity of access by special needs groups’ is an indicator of governments’ objective to provide accessible services (box 10.2).
Box 10.2  **Equity of access by special needs groups**

‘Equity of access by special needs groups’ measures the performance of agencies providing services for three identified special needs groups: Indigenous Australians; 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.

Equity of access by special needs groups has been identified as a key area for development in future Reports. Data for the emergency department waiting times and waiting times for admitted patient services indicators are reported by Indigenous status and remoteness.

**Effectiveness — access**

*Emergency department waiting times*

‘Emergency department waiting times’ is an indicator of governments’ objective to provide accessible services (box 10.3).

Box 10.3  **Emergency department waiting times**

‘Emergency department waiting times’ is defined as the proportion of patients seen within the benchmarks set by the Australasian Triage Scale. The Australasian Triage Scale is a scale for rating clinical urgency, designed for use in hospital-based emergency services in Australia and New Zealand.

These waiting times are measured using the nationally agreed method of calculation 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, 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 (HDSC 2008).

(Continued next page)
Box 10.3 (Continued)

A high or increasing proportion of patients seen within the benchmarks set for each triage category is desirable.

Data reported for this indicator are not directly comparable.


The comparability of emergency department waiting times data across jurisdictions can be influenced by differences in data coverage (table 10.2) and clinical practices — in particular, the allocation of cases to urgency categories. The proportion of patients in each triage category who were subsequently admitted can indicate the comparability of triage categorisations across jurisdictions and thus the comparability of the waiting times data (table 10A.17).

Nationally, in 2011-12, 100 per cent of patients in triage category 1 were seen within the clinically appropriate timeframe, and 80 per cent of patients in triage category 2 were seen within the clinically appropriate timeframe. For all triage categories combined, 72 per cent of patients were seen within triage category timeframes (table 10.2).

Emergency department waiting times by Indigenous status and remoteness, for peer group A and B hospitals are reported in the attachment (tables 10A.19 and 10A.20). Nationally, there was little difference between Indigenous and non-Indigenous Australians in the percentages of patients treated within national benchmarks across the triage categories, although there were variations across states and territories for some triage categories (table 10A.19). At the national level, there was variation in waiting times across triage categories by remoteness, although there was less variation for the most serious category, resuscitation (table 10A.20).

Under the National Health Reform Agreement – National Partnership Agreement on Improving Public Hospital Services (NPA), an expert panel reviewed the implementation of emergency department and elective surgery targets. Fifteen recommendations were made, which were approved by COAG and are incorporated into the revised NPA signed by all jurisdictions in August 2011. Recommendations included the new National Emergency Access Target (NEAT), to remove clinically appropriate; and other exclusions from the NEAT by incorporating them into the revised target of 90 per cent of patients leaving the emergency department within four hours of presentation — either by admission, transfer to another hospital, or discharge.
The NEAT program commenced from 1 January 2012 with staged annual interim targets until the full NEAT target is to be achieved in 2015.

Table 10.2  Emergency department patients seen within triage category timeframes, public hospitals (per cent)\textsuperscript{a}

<table>
<thead>
<tr>
<th>Triage category</th>
<th>NSW</th>
<th>Vic</th>
<th>Qld</th>
<th>WA</th>
<th>SA</th>
<th>Tas</th>
<th>ACT</th>
<th>NT</th>
<th>Aust</th>
</tr>
</thead>
<tbody>
<tr>
<td>2010-11</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 — Resuscitation\textsuperscript{b}</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>99</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
</tr>
<tr>
<td>2 — Emergency</td>
<td>83</td>
<td>81</td>
<td>78</td>
<td>71</td>
<td>78</td>
<td>72</td>
<td>78</td>
<td>65</td>
<td>79</td>
</tr>
<tr>
<td>3 — Urgent</td>
<td>71</td>
<td>70</td>
<td>60</td>
<td>50</td>
<td>66</td>
<td>55</td>
<td>48</td>
<td>53</td>
<td>65</td>
</tr>
<tr>
<td>4 — Semi-urgent</td>
<td>73</td>
<td>65</td>
<td>67</td>
<td>65</td>
<td>70</td>
<td>63</td>
<td>48</td>
<td>54</td>
<td>68</td>
</tr>
<tr>
<td>5 — Non-urgent</td>
<td>88</td>
<td>86</td>
<td>90</td>
<td>92</td>
<td>88</td>
<td>83</td>
<td>75</td>
<td>90</td>
<td>88</td>
</tr>
<tr>
<td>Total</td>
<td>76</td>
<td>71</td>
<td>67</td>
<td>63</td>
<td>71</td>
<td>62</td>
<td>55</td>
<td>58</td>
<td>70</td>
</tr>
<tr>
<td>Data coverage\textsuperscript{c}</td>
<td>na</td>
<td>na</td>
<td>na</td>
<td>na</td>
<td>na</td>
<td>na</td>
<td>na</td>
<td>na</td>
<td>na</td>
</tr>
<tr>
<td>2011-12</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 — Resuscitation\textsuperscript{b}</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>99</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
</tr>
<tr>
<td>2 — Emergency</td>
<td>82</td>
<td>83</td>
<td>82</td>
<td>76</td>
<td>79</td>
<td>77</td>
<td>76</td>
<td>64</td>
<td>80</td>
</tr>
<tr>
<td>3 — Urgent</td>
<td>71</td>
<td>72</td>
<td>63</td>
<td>52</td>
<td>70</td>
<td>64</td>
<td>50</td>
<td>49</td>
<td>66</td>
</tr>
<tr>
<td>4 — Semi-urgent</td>
<td>74</td>
<td>67</td>
<td>69</td>
<td>67</td>
<td>77</td>
<td>71</td>
<td>47</td>
<td>49</td>
<td>70</td>
</tr>
<tr>
<td>5 — Non-urgent</td>
<td>89</td>
<td>87</td>
<td>90</td>
<td>94</td>
<td>92</td>
<td>88</td>
<td>81</td>
<td>89</td>
<td>89</td>
</tr>
<tr>
<td>Total</td>
<td>76</td>
<td>72</td>
<td>69</td>
<td>65</td>
<td>76</td>
<td>71</td>
<td>55</td>
<td>54</td>
<td>72</td>
</tr>
<tr>
<td>Data coverage\textsuperscript{c}</td>
<td>na</td>
<td>na</td>
<td>na</td>
<td>na</td>
<td>na</td>
<td>na</td>
<td>na</td>
<td>na</td>
<td>na</td>
</tr>
</tbody>
</table>

\textsuperscript{a} Percentages are derived from all hospitals that reported to the Non-admitted Patient Emergency Department Care Database, including all principal referral and specialist women's and children's hospitals, large hospitals and public hospitals that were classified to other peer groups. \textsuperscript{b} Resuscitation patients whose waiting time for treatment was less than or equal to two minutes are considered to have been seen on time. \textsuperscript{c} 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 can underestimate coverage because some occasions of service are for other than emergency presentations. 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.


Waiting times for admitted patient services

‘Waiting times for admitted patient services’ is an indicator of governments’ objective to provide accessible services (box 10.4). Elective surgery patients who wait longer are likely to suffer discomfort and inconvenience, and more urgent patients can experience poor health outcomes as a result of extended waits.
Box 10.4  **Waiting times for admitted patient services**

‘Waiting times for admitted patient services’ is defined by three measures:

- ‘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 12 months is also shown.
  - For overall elective surgery waiting times, a low or decreasing number of days waited at the 50th and 90th percentiles, and a low or decreasing proportion of people waiting more than 365 days are desirable.

- ‘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 clinical urgency categories for elective surgery are:
  - category 1 — 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 — admission is desirable within 90 days for a condition causing some pain, dysfunction or disability but which is not likely to deteriorate quickly or become an emergency
  - category 3 — admission at some time in the future is acceptable for a condition causing minimal or no pain, dysfunction or disability, which is unlikely to deteriorate quickly and which does not have the potential to become an emergency. The desirable timeframe for this category is admission within 365 days.

  The term ‘extended wait’ is used for category 3 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.
  - For elective surgery waiting times by clinical urgency category, a low or decreasing 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 10.3).

(Continued on next page)
Box 10.4  (Continued)

- Waiting times for admission following emergency department care is currently expected to measure the percentage of patients who present to a public hospital emergency department and are admitted to the same hospital, whose time in the emergency department was less than 8 hours. This indicator is being developed as part of the NHA reporting process. Waiting times for admission following emergency department care has been identified as a key area for development in future Reports.

Data reported for this indicator are not directly comparable.

Waiting times for elective surgery

Elective surgery waiting times data are provided for waiting lists managed by public acute hospitals. The data collection covers most public hospitals that undertake elective surgery, and in 2011-12 covered 92 per cent of separations for elective surgery in public acute hospitals (table 10A.21).

Patients on waiting lists who were not subsequently admitted to hospital are excluded. Patients can be removed from waiting lists because they no longer need the surgery, die, are treated at another location, decline to have the surgery, or cannot be contacted by the hospital (AIHW 2012c). In 2011-12, 12.6 per cent of patients who were removed from waiting lists were removed for reasons other than elective or emergency admission (AIHW 2012c).

Comparisons across jurisdictions should be made with caution, due to differences in clinical practices and classification of patients across Australia. The measures are also 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 another 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 in NSW, SA and the NT. This approach can have the effect of increasing the apparent waiting times for admissions in these jurisdictions compared with other jurisdictions (AIHW 2012c).

Nationally in 2011-12, 50 per cent of patients were admitted within 36 days and 90 per cent of patients were admitted within 251 days. The proportion of patients who waited more than a year was 2.7 per cent. Nationally, waiting times at the 50th percentile increased by two days between 2007-08 and 2011-12, from 34 to 36 days. However, there were different trends for different jurisdictions and for different sized hospitals over that period (figure 10.12 and table 10A.21).
Figure 10.12 *Waiting times for elective surgery, public hospitals*

**Days waited at the 50th percentile**

**Days waited at the 90th percentile**

**Percentage who waited more than 365 days**


Attachment 10A includes data on elective surgery waiting times by hospital peer group, specialty of surgeon and indicator procedure. It also includes waiting times
by remoteness and by Indigenous status (tables 10A.21–10A.25). Those living in regional areas had longer waiting times than those in major cities at the 50th and 90th percentiles at the national level (table 10A.24). Nationally, Indigenous Australians had longer waiting times for elective surgery than non-Indigenous Australians at the 50th percentile and 90th percentile (table 10A.23).

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 2010-11 are shown in table 10.3. The states and territories with lower proportions of patients in category 1 tended to have smaller proportions of patients in this category who were ‘not seen on time’. NSW, Victoria and the ACT, for example, had the lowest proportions of patients in category 1 and also had low proportions of patients in category 1 who had extended waits (tables 10.3, 10A.26, 10A.28 and 10A.38).

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 of providing 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.

Under the National Health Reform Agreement — National Partnership Agreement on Improving Public Hospital Services (NPA), an expert panel reviewed the implementation of emergency department and elective surgery targets. Fifteen recommendations were made, which were incorporated into the revised NPA signed by all jurisdictions in August 2011. These recommendations included adoption of the new National Elective Surgery Target (NEST), and agreement to develop national definitions for elective surgery categories, including ‘not ready for care’.

The NEST program commenced from 1 January 2012. The aim is to progressively increase and measure the number of elective surgeries performed within the clinically recommended time and to reduce long waits for patients, so that 100 per cent of patients receive their elective surgery within clinically recommended times across all urgency categories. The AIHW, with the Royal Australasian College of Surgeons, has submitted a proposal to Health Ministers to seek endorsement for nationally agreed elective surgery urgency category definitions, including consistent treatment of patients ‘not ready for care’.
Table 10.3  Classification of elective surgery patients, by clinical urgency category, 2010-11 (per cent)

<table>
<thead>
<tr>
<th></th>
<th>NSW</th>
<th>Vic</th>
<th>Qld</th>
<th>WA</th>
<th>SA</th>
<th>Tas</th>
<th>ACT</th>
<th>NT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients on waiting lists</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Category 1</td>
<td>3.1</td>
<td>4.0</td>
<td>10.1</td>
<td>6.4</td>
<td>6.4</td>
<td>9.8</td>
<td>4.1</td>
<td>7.7</td>
</tr>
<tr>
<td>Category 2</td>
<td>16.8</td>
<td>45.8</td>
<td>48.0</td>
<td>30.6</td>
<td>25.0</td>
<td>54.9</td>
<td>54.9</td>
<td>38.7</td>
</tr>
<tr>
<td>Category 3</td>
<td>80.2</td>
<td>50.2</td>
<td>41.9</td>
<td>62.9</td>
<td>68.6</td>
<td>35.3</td>
<td>41.0</td>
<td>53.6</td>
</tr>
<tr>
<td>Total</td>
<td>100.0</td>
<td>100.0</td>
<td>100.0</td>
<td>100.0</td>
<td>100.0</td>
<td>100.0</td>
<td>100.0</td>
<td>100.0</td>
</tr>
<tr>
<td>Patients admitted from waiting lists</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Category 1</td>
<td>26.9</td>
<td>28.2</td>
<td>39.0</td>
<td>26.1</td>
<td>33.6</td>
<td>40.8</td>
<td>29.1</td>
<td>42.3</td>
</tr>
<tr>
<td>Category 2</td>
<td>32.3</td>
<td>47.6</td>
<td>45.6</td>
<td>35.3</td>
<td>34.2</td>
<td>42.5</td>
<td>48.6</td>
<td>38.3</td>
</tr>
<tr>
<td>Category 3</td>
<td>40.8</td>
<td>24.2</td>
<td>15.4</td>
<td>38.6</td>
<td>32.2</td>
<td>16.7</td>
<td>22.3</td>
<td>19.4</td>
</tr>
<tr>
<td>Total</td>
<td>100.0</td>
<td>100.0</td>
<td>100.0</td>
<td>100.0</td>
<td>100.0</td>
<td>100.0</td>
<td>100.0</td>
<td>100.0</td>
</tr>
</tbody>
</table>

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. 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.26, 10A.28, 10A.30, 10A.32, 10A.34, 10A.36, 10A.38 and 10A.40. The proportion of patients on waiting lists who already had an extended wait at the date of the census does not represent the completed waiting times of patients. This is represented by the proportion of patients with extended waits at admission.

Of patients admitted from waiting lists in NSW in 2010-11:
- 26.9 per cent were classified to category 1, of whom 7.4 per cent had an extended wait
- 32.3 per cent were classified to category 2, of whom 10.3 per cent had an extended wait
- 40.8 per cent were classified to category 3, of whom 8.8 per cent had an extended wait.

Overall in NSW, 8.9 per cent of all patients experienced extended waits (table 10.3 and table 10A.26).

Of patients admitted from waiting lists in Victoria in 2010-11:
- 28.2 per cent were classified to category 1, of whom zero per cent had an extended wait
- 47.6 per cent were classified to category 2, of whom 25.4 per cent had an extended wait
• 24.2 per cent were classified to category 3, of whom 7.4 per cent had an extended wait.

Overall in Victoria, 13.9 per cent of all patients experienced extended waits (table 10.3 and table 10A.28).

Of patients admitted from waiting lists in Queensland in 2010-11:
• 39.0 per cent were classified to category 1, of whom 13.5 per cent had an extended wait
• 45.6 per cent were classified to category 2, of whom 24.9 per cent had an extended wait
• 15.4 per cent were classified to category 3, of whom 6.2 per cent had an extended wait.

Overall in Queensland, 17.6 per cent of all patients experienced extended waits (table 10.3 and table 10A.30).

Of patients admitted from waiting lists in WA in 2010-11:
• 26.1 per cent were classified to category 1, of whom 12.7 per cent had an extended wait
• 35.3 per cent were classified to category 2, of whom 19.3 per cent had an extended wait
• 38.6 per cent were classified to category 3, of whom 3.2 per cent had an extended wait.

Overall in WA, 11.3 per cent of all patients experienced extended waits (table 10.3 and table 10A.32).

Of patients admitted from waiting lists in SA in 2010-11:
• 33.6 per cent were classified to category 1, of whom 13.2 per cent had an extended wait
• 34.2 per cent were classified to category 2, of whom 12.7 per cent had an extended wait
• 32.2 per cent were classified to category 3, of whom 6.1 per cent had an extended wait.

Overall in SA, 10.7 per cent of all patients experienced extended waits (table 10.3 and table 10A.34).

Of patients admitted from waiting lists in Tasmania in 2010-11:
• 40.8 per cent were classified to category 1, of whom 28.0 per cent had an extended wait

• 42.5 per cent were classified to category 2, of whom 39.0 per cent had an extended wait

• 16.7 per cent were classified to category 3, of whom 28.0 per cent had an extended wait.

Overall in Tasmania, 33.0 per cent of all patients experienced extended waits (table 10.3 and table 10A.36).

Of patients admitted from waiting lists in the ACT in 2010-11:
• 29.1 per cent were classified to category 1, of whom 9.8 per cent had an extended wait

• 48.6 per cent were classified to category 2, of whom 55.1 per cent had an extended wait

• 22.3 per cent were classified to category 3, of whom 23.6 per cent had an extended wait.

Overall in the ACT, 34.9 per cent of all patients experienced extended waits (table 10.3 and table 10A.38).

Of patients admitted from waiting lists in NT in 2010-11:
• 42.3 per cent were classified to category 1, of whom 18.6 per cent had an extended wait

• 38.3 per cent were classified to category 2, of whom 41.2 per cent had an extended wait

• 19.4 per cent were classified to category 3, of whom 17.9 per cent had an extended wait.

Overall in the NT, 27.1 per cent of all patients experienced extended waits (table 10.3 and table 10A.40).

All jurisdictions also provided data on urgency category waiting times by clinical specialty (tables 10A.27, 10A.29, 10A.31, 10A.33, 10A.35, 10A.37, 10A.39 and 10A.41).
Effectiveness — appropriateness

Separation rates for selected procedures

‘Separation rates for selected procedures’ is an indicator of the appropriateness of hospital services (box 10.5).

Box 10.5  Separation rates for selected procedures

‘Separation rates for selected procedures’ is defined as separations per 1000 people for certain procedures. The procedures are selected for their frequency, for sometimes being elective and discretionary, and because alternative treatments are sometimes available.

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

Care needs to be taken when interpreting the differences in the separation rates for the selected procedures. Variations in rates can be attributable to variations in the prevalence of the conditions being treated, or to differences in clinical practice across states and territories. Higher rates can be acceptable for certain conditions and not for others. Higher rates of angioplasties, for example, can represent appropriate levels of care, whereas higher rates of hysterectomies or tonsillectomies can represent an over-reliance on procedures. Some of the selected procedures, such as angioplasty and coronary artery bypass graft, are alternative treatment options for people diagnosed with similar conditions.

Data reported for this indicator are comparable.


The separation rates for selected procedures reported here include all hospitals and reflect the activities of both the public and private health systems. Table 10A.42 reports the proportion of separations that were for public patients for each procedure by State and Territory. This proportion ranged from 58 per cent nationally for cholecystectomy to 27 per cent for septoplasty.

The most common procedures of those reported in 2010-11 were cataract extraction, cystoscopy, prostatectomy, hysterectomy and tonsillectomy. For all procedures, separation rates varied across jurisdictions (table 10.4).
Table 10.4  Separations for selected procedures per 1000 people, all hospitals, 2010-11a

<table>
<thead>
<tr>
<th>Procedure</th>
<th>NSW</th>
<th>Vic</th>
<th>Qld</th>
<th>WA</th>
<th>SA</th>
<th>Tas</th>
<th>ACT</th>
<th>NT</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cataract extraction</td>
<td>8.5</td>
<td>8.1</td>
<td>8.5</td>
<td>10.3</td>
<td>8.0</td>
<td>9.6</td>
<td>6.7</td>
<td>8.5</td>
<td>8.6</td>
</tr>
<tr>
<td>Cholecystectomy</td>
<td>2.2</td>
<td>2.3</td>
<td>2.4</td>
<td>2.1</td>
<td>2.4</td>
<td>2.4</td>
<td>2.5</td>
<td>1.8</td>
<td>2.2</td>
</tr>
<tr>
<td>Coronary angioplasty</td>
<td>1.5</td>
<td>1.6</td>
<td>1.5</td>
<td>1.7</td>
<td>1.5</td>
<td>1.2</td>
<td>3.0</td>
<td>np</td>
<td>1.6</td>
</tr>
<tr>
<td>Coronary artery bypass graft</td>
<td>0.5</td>
<td>0.6</td>
<td>0.6</td>
<td>0.4</td>
<td>0.6</td>
<td>0.4</td>
<td>0.6</td>
<td>0.6</td>
<td>0.6</td>
</tr>
<tr>
<td>Cystoscopy</td>
<td>4.0</td>
<td>5.4</td>
<td>5.2</td>
<td>7.0</td>
<td>5.8</td>
<td>5.7</td>
<td>5.6</td>
<td>3.3</td>
<td>5.1</td>
</tr>
<tr>
<td>Haemorrhoidectomy</td>
<td>2.7</td>
<td>1.6</td>
<td>1.5</td>
<td>1.1</td>
<td>1.3</td>
<td>2.0</td>
<td>1.3</td>
<td>2.1</td>
<td>1.9</td>
</tr>
<tr>
<td>Hip replacement</td>
<td>1.4</td>
<td>1.5</td>
<td>1.3</td>
<td>1.7</td>
<td>1.7</td>
<td>1.9</td>
<td>2.5</td>
<td>0.7</td>
<td>1.5</td>
</tr>
<tr>
<td>Hysterectomy, females aged 15–69 years</td>
<td>2.1</td>
<td>2.1</td>
<td>2.5</td>
<td>2.4</td>
<td>2.6</td>
<td>2.6</td>
<td>2.6</td>
<td>2.0</td>
<td>2.3</td>
</tr>
<tr>
<td>Inguinal herniorrhaphy</td>
<td>2.2</td>
<td>2.1</td>
<td>2.2</td>
<td>2.3</td>
<td>2.0</td>
<td>2.2</td>
<td>2.7</td>
<td>1.8</td>
<td>2.2</td>
</tr>
<tr>
<td>Knee replacement</td>
<td>1.8</td>
<td>1.5</td>
<td>1.8</td>
<td>2.0</td>
<td>2.0</td>
<td>1.7</td>
<td>2.9</td>
<td>0.8</td>
<td>1.8</td>
</tr>
<tr>
<td>Myringotomy (with insertion of tube)</td>
<td>1.6</td>
<td>2.0</td>
<td>1.6</td>
<td>2.2</td>
<td>3.2</td>
<td>1.4</td>
<td>2.5</td>
<td>0.8</td>
<td>1.9</td>
</tr>
<tr>
<td>Prostatectomy</td>
<td>2.8</td>
<td>3.2</td>
<td>2.6</td>
<td>2.6</td>
<td>2.6</td>
<td>3.0</td>
<td>3.7</td>
<td>1.7</td>
<td>2.9</td>
</tr>
<tr>
<td>Septoplasty</td>
<td>1.0</td>
<td>1.4</td>
<td>0.8</td>
<td>0.9</td>
<td>1.3</td>
<td>0.5</td>
<td>1.1</td>
<td>0.5</td>
<td>1.1</td>
</tr>
<tr>
<td>Tonsillectomy</td>
<td>2.2</td>
<td>2.3</td>
<td>2.2</td>
<td>2.7</td>
<td>2.7</td>
<td>1.7</td>
<td>3.9</td>
<td>1.0</td>
<td>2.3</td>
</tr>
<tr>
<td>Varicose veins, stripping and ligation</td>
<td>0.5</td>
<td>0.8</td>
<td>0.5</td>
<td>0.6</td>
<td>0.6</td>
<td>0.6</td>
<td>1.1</td>
<td>0.4</td>
<td>0.6</td>
</tr>
</tbody>
</table>

a Rates are standardised to the Australian population as at 30 June 2001 and are calculated for the total population for all procedures except prostatectomy (rates calculated for the male population only) and hysterectomy (rates calculated for females aged 15–69 years). .. Not applicable. np Not published.

Source: AIHW (2012), Australian Hospital Statistics 2010-11, Health Services Series No. 43, Cat no. HSE 117; table 10A.42.

**Effectiveness — quality**

There is no single definition of quality in healthcare, but the Australian Commission on Safety and Quality in Health Care (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 approach is to identify and report on aspects of quality of care. The aspects of quality recognised in the performance indicator framework are safety, responsiveness and continuity. This Report includes indicators of safety, but no indicators have yet been developed for responsiveness or continuity.

There has been considerable debate and research to develop suitable indicators of the quality of healthcare both in Australia and overseas. 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 has maintained the Council’s focus on improving the safety and quality in health care provided in hospitals (including private hospitals) and sought to improve the quality of primary healthcare.

Various governments publicly report performance indicators for service quality of public hospitals. Some have adopted the same indicators reported in this chapter. For example:

- The Australian Government’s MyHospitals website, which is managed by the National Health Performance Authority, reports *staphylococcus aureus* bacteraemia (SAB) infections as counts and rates per 10,000 occupied bed days, and compares the rate to the national benchmark. Data are provided for most public hospitals and a number of private hospitals.

- In NSW, reporting of surgical site infection rates for hip and knee surgery is mandatory for public hospitals.

- 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, pressure wound monitoring and prevention, patient satisfaction and consumer participation in health care decision making.

- In addition to the Queensland Health annual report, Queensland Health publishes regular online public hospitals performance reports, which, among other measures, include patient satisfaction results.

- Both the WA and Tasmanian health departments’ annual reports include information on unplanned re-admission rates and WA also includes a section on patient evaluation of health services.

- SA Health publishes an annual patient safety report, which provides a summary of the types of incidents that occurred in public hospitals and a comprehensive overview of the major patient safety programs being conducted by SA Health. It links the programs to the safety issues identified by analysis of data from the incident management system (Safety Learning System), Coroner’s recommendations and other sources, to help explain what actions are being taken to address these safety issues. A Measuring Consumer Experience SA Public Hospital Inpatient Annual Report, which details the key findings from the SA Consumer Experience Surveillance System, is also published.

- The ACT Government Health Directorate publishes quarterly reports that include data on unplanned readmissions, unplanned returns to operating theatre and hospital acquired infection rates. Information about quality and safety
activities and consumer feedback management is also included in an annual report.

- The NT Health Department Annual Report publishes information on unplanned re-admission rates after discharge for acute mental health episodes.

**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 Eshani et al. 2006). These adverse events can result in serious consequences for individual patients, and the associated costs to individuals and the health care system can be considerable (Van den Bos et al. 2011).

**Safety — unplanned hospital readmission rates**

‘Unplanned hospital readmission rates’ is an indicator of governments’ objective to provide public hospital services that are safe and of high quality (box 10.6). Patients might be re-admitted unexpectedly if the initial care or treatment was ineffective or unsatisfactory, if post discharge planning was inadequate, or for reasons outside the control of the hospital (for example poor post-discharge care).

---

**Box 10.6 Unplanned hospital readmission rates**

‘Unplanned hospital readmission rates’ is defined as the rate at which patients unexpectedly return to hospital within 28 days for further treatment of the same condition. It is calculated as the number of separations that were unplanned or unexpected readmissions to the same hospital following a separation in which a selected surgical procedure was performed and which occurred within 28 days of the previous date of separation, expressed per 1000 separations in which one of the selected surgical procedures was performed. Selected surgical procedures are knee replacement, hip replacement, tonsillectomy and adenoidectomy, hysterectomy, prostatectomy, cataract surgery and appendectomy. Unplanned readmissions are those having a principal diagnosis of a post-operative adverse event for which a specified ICD-10-AM diagnosis code has been assigned.

Low or decreasing rates for this indicator are desirable. Conversely, 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.

Data reported for this indicator are not complete or directly comparable.

There are some difficulties in identifying re-admissions that were unplanned. The indicator is likely to be an under-estimate because:

- it identifies only those patients re-admitted to the same hospital, so does not include patients who go to another hospital
- episodes of non-admitted patient care provided in outpatient clinics or emergency departments which may have been related to a previous admission are not included
- the unplanned and/or unexpected readmissions are limited to those having a principal diagnosis of a post-operative adverse event. This does not include all possible unplanned/unexpected readmissions.

Unplanned re-admission rates are not adjusted for casemix or patient risk factors, which can vary across hospitals and across jurisdictions. This indicator is currently under review nationally and it is expected that it will be revised for the 2014 Report.

Unplanned hospital readmission rates in public hospitals in 2010-11 are reported in table 10.5. Unplanned hospital readmission rates are reported by Indigenous status and remoteness in table 10A.44.

### Table 10.5  **Unplanned hospital readmission rates, per 1000 separations, 2010-11**

<table>
<thead>
<tr>
<th>Surgical procedure prior to separation</th>
<th>NSW</th>
<th>Vic</th>
<th>Qld</th>
<th>WA^a</th>
<th>SA</th>
<th>Tas</th>
<th>ACT</th>
<th>NT</th>
<th>Total^a</th>
</tr>
</thead>
<tbody>
<tr>
<td>Knee replacement</td>
<td>21.7</td>
<td>22.0</td>
<td>37.5</td>
<td>31.1</td>
<td>19.6</td>
<td>31.7</td>
<td>np</td>
<td>np</td>
<td>24.4</td>
</tr>
<tr>
<td>Hip replacement</td>
<td>16.5</td>
<td>20.8</td>
<td>14.2</td>
<td>14.7</td>
<td>10.3</td>
<td>np</td>
<td>np</td>
<td>np</td>
<td>16.5</td>
</tr>
<tr>
<td>Tonsillectomy and Adenoidectomy</td>
<td>22.9</td>
<td>23.9</td>
<td>31.0</td>
<td>34.4</td>
<td>31.3</td>
<td>37.6</td>
<td>19.3</td>
<td>np</td>
<td>26.3</td>
</tr>
<tr>
<td>Hysterectomy</td>
<td>29.1</td>
<td>28.9</td>
<td>34.7</td>
<td>33.5</td>
<td>28.1</td>
<td>40.1</td>
<td>np</td>
<td>np</td>
<td>30.5</td>
</tr>
<tr>
<td>Prostatectomy</td>
<td>27.2</td>
<td>20.9</td>
<td>25.8</td>
<td>38.0</td>
<td>21.9</td>
<td>np</td>
<td>np</td>
<td>np</td>
<td>25.1</td>
</tr>
<tr>
<td>Cataract surgery</td>
<td>3.2</td>
<td>3.9</td>
<td>4.0</td>
<td>4.3</td>
<td>4.0</td>
<td>–</td>
<td>–</td>
<td>np</td>
<td>3.5</td>
</tr>
<tr>
<td>Appendectomy</td>
<td>24.8</td>
<td>25.6</td>
<td>19.6</td>
<td>30.8</td>
<td>22.8</td>
<td>19.9</td>
<td>37.7</td>
<td>40.2</td>
<td>24.2</td>
</tr>
</tbody>
</table>

^a Total rates for Australia do not include WA. For all jurisdictions except WA, this indicator is calculated by the AIHW using data from the National Hospital Morbidity Database, based on the national minimum data set for Admitted patient care. For WA, the indicator was calculated and supplied by WA Health and was not independently verified by the AIHW. np Not published. – Nil or rounder to zero.

Source: AIHW (unpublished) Admitted Patient Care National Minimum Data Set; WA Health (unpublished); table 10A.43.

### Safety — hospital accreditation

‘Accreditation’ is an indicator of governments’ objective to provide public hospital services that are of high quality (box 10.7). Data for this indicator are shown in figure 10.13.
Box 10.7 Accreditation

‘Accreditation’ is defined as the ratio of accredited beds to all beds in public hospitals. The number of beds indicates the level of hospital capacity or activity. ‘Accreditation’ signifies professional and national recognition awarded to hospitals and other healthcare facilities that meet defined industry standards. Public hospitals can seek accreditation through the Australian Council on Healthcare Standards (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 Organisation 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.

A high or increasing rate of accreditation is desirable. However, 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 mandatory for all public hospitals (excluding those that provide only dental or mothercraft services). The costs of preparing a hospital for accreditation are significant, and a low level of accreditation can 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).

Data reported for this indicator are comparable.

Figure 10.13  **Proportion of accredited beds, public hospitals**\textsuperscript{a, b}

\textbf{Source:}  AIHW (various years),  
Australian Hospital Statistics, Health Services Series, Cat nos. HSE 55, 71, 84, 107 and 117; table 10A.45.

*Safety — adverse events in public hospitals*

‘Adverse events in public hospitals’ is an indicator of governments’ objective to provide public hospital services that are safe and of high quality (box 10.8). Adverse events in public hospitals 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. Sentinel events, which are a subset of adverse events that result in death or very serious harm to the patient, are reported separately in this chapter as an outcome indicator.
Box 10.8 **Adverse events in public hospitals**

‘Adverse events in public hospitals’ is defined by the following two measures:

- healthcare associated infections
- adverse events treated in hospitals.

**Healthcare associated infections**

Healthcare associated infections is the number of *Staphylococcus aureus* (including Methicillin-resistant *Staphylococcus aureus* [MRSA]) bacteraemia (SAB) patient episodes associated with acute care public hospitals, expressed as a rate per 10 000 patient days for public acute care hospitals reporting for the SAB indicator.

A patient episode of SAB is defined as a positive blood culture for SAB. Only the first isolate per patient is counted, unless at least 14 days has passed without a positive blood culture, after which an additional episode is recorded.

SAB is considered to be healthcare-associated if the first positive blood culture is collected more than 48 hours after hospital admission or less than 48 hours after discharge, or if the first positive blood culture is collected 48 hours or less after admission and one or more of the following key clinical criteria was met for the patient-episode of SAB:

- SAB is a complication of the presence of an indwelling medical device
- SAB occurs within 30 days of a surgical procedure where the SAB is related to the surgical site
- an invasive instrumentation or incision related to the SAB was performed within 48 hours
- SAB is associated with neutropenia (<1x10^9/L) contributed to by cytotoxic therapy.

Cases where a known previous blood culture has been obtained within the last 14 days are excluded. Patient days for unqualified newborns are included. Patient days for hospital boarders and posthumous organ procurement are excluded.

A low or decreasing healthcare associated infections rate is desirable.

Data reported for this measure are not directly comparable.


**Adverse events treated in hospitals**

Adverse events treated in hospitals are incidents in which harm resulted to a person receiving healthcare. They include infections, falls resulting in injuries and problems with medication and medical devices.

(Continued on next page)
Box 10.8 (Continued)

Some of these adverse events may be preventable. It is measured by separations with an adverse event that have diagnoses, places of occurrence and external causes of injury and poisoning that can indicate that an adverse event was treated and/or occurred during the hospitalisation.

Low or decreasing adverse events treated in hospitals is desirable.

Data reported for this measure are not directly comparable.

Data quality information for this measure is under development.

Safety — healthcare associated infections

Healthcare associated infections in acute care hospitals per 10 000 patient days is reported in figure 10.14.

Figure 10.14 Healthcare associated infections, public acute care hospitals\(^a, b, c\)

\[^a\] Comprises both Methicillin resistant \textit{Staphylococcus aureus} and Methicillin sensitive \textit{Staphylococcus aureus}. \[^b\] The SAB patient episodes were associated with both admitted patient care and with non-admitted patient care (including emergency departments and outpatient clinics). The comparability of the SAB rates across jurisdictions and over time is limited, because of coverage differences and because the count of patient days reflects the amount of admitted patient activity, but does not necessarily reflect the amount of non-admitted patient activity. \[^c\] Queensland data for 2010-11 only include patients 14 years of age and over.

\textit{Source: AIHW unpublished; table 10A.46.}
Safety — adverse events treated in hospitals

This measure is reported for the first time in the 2013 Report. In 2010-11, 5.9 per cent of separations in public hospitals reported an ICD-10-AM code indicating an adverse event (table 10.6). Around 54 per cent of separations with an adverse event reported procedures causing abnormal reactions/complications and 36 per cent reported adverse effects of drugs, medicaments and biological substances (table 10A.47). Data for 2009-10 are reported in table 10A.47.

Table 10.6 Separations with an adverse event, per 100 separations, public hospitals, 2010-11a, b

<table>
<thead>
<tr>
<th>External cause of injury and poisoning</th>
<th>NSW</th>
<th>Vic</th>
<th>Qld</th>
<th>WA</th>
<th>SA</th>
<th>Tas</th>
<th>ACT</th>
<th>NT</th>
<th>Aust</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adverse effects of drugs, medicaments and biological substances</td>
<td>2.3</td>
<td>2.1</td>
<td>1.9</td>
<td>2.2</td>
<td>2.4</td>
<td>2.2</td>
<td>1.8</td>
<td>np</td>
<td>2.1</td>
</tr>
<tr>
<td>Misadventures to patients during surgical and medical care</td>
<td>0.2</td>
<td>0.3</td>
<td>0.3</td>
<td>0.3</td>
<td>0.3</td>
<td>0.3</td>
<td>0.3</td>
<td>np</td>
<td>0.3</td>
</tr>
<tr>
<td>Procedures causing abnormal reactions/complications</td>
<td>3.1</td>
<td>3.1</td>
<td>3.2</td>
<td>3.2</td>
<td>3.6</td>
<td>4.1</td>
<td>3.5</td>
<td>np</td>
<td>3.2</td>
</tr>
<tr>
<td>Other external causes of adverse events</td>
<td>0.1</td>
<td>0.1</td>
<td>0.1</td>
<td>0.1</td>
<td>0.2</td>
<td>0.1</td>
<td>0.2</td>
<td>np</td>
<td>0.1</td>
</tr>
<tr>
<td>Place of occurrence of injury and poisoning: Health service area</td>
<td>5.9</td>
<td>5.7</td>
<td>5.5</td>
<td>5.8</td>
<td>6.3</td>
<td>7.0</td>
<td>5.8</td>
<td>np</td>
<td>5.7</td>
</tr>
<tr>
<td>Diagnoses</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Selected post-procedural disorders</td>
<td>0.9</td>
<td>0.6</td>
<td>0.7</td>
<td>0.9</td>
<td>1.1</td>
<td>1.1</td>
<td>1.1</td>
<td>np</td>
<td>0.8</td>
</tr>
<tr>
<td>Haemorrhage and haematoma complicating a procedure</td>
<td>0.4</td>
<td>0.5</td>
<td>0.4</td>
<td>0.5</td>
<td>0.4</td>
<td>0.5</td>
<td>0.5</td>
<td>np</td>
<td>0.5</td>
</tr>
<tr>
<td>Infection following a procedure</td>
<td>0.5</td>
<td>0.4</td>
<td>0.4</td>
<td>0.4</td>
<td>0.4</td>
<td>0.5</td>
<td>0.5</td>
<td>np</td>
<td>0.4</td>
</tr>
<tr>
<td>Complications of internal prosthetic devices</td>
<td>1.2</td>
<td>1.2</td>
<td>1.3</td>
<td>1.2</td>
<td>1.2</td>
<td>1.2</td>
<td>1.3</td>
<td>np</td>
<td>1.2</td>
</tr>
<tr>
<td>Other diagnoses of complications of medical and surgical care</td>
<td>0.7</td>
<td>1.0</td>
<td>0.8</td>
<td>0.8</td>
<td>0.8</td>
<td>0.9</td>
<td>0.8</td>
<td>np</td>
<td>0.8</td>
</tr>
<tr>
<td>Total (any of the above)c</td>
<td>6.1</td>
<td>5.8</td>
<td>5.7</td>
<td>6.0</td>
<td>6.6</td>
<td>7.1</td>
<td>6.0</td>
<td>np</td>
<td>5.9</td>
</tr>
</tbody>
</table>

a Separations that included ICD-10-AM diagnosis and/or external cause codes that indicated an adverse event was treated and/or occurred during the hospitalisation. b Age standardised rate. c Categories do not sum to the totals because multiple diagnoses and external causes can be recorded for each separation and external cause codes and diagnosis codes can be used together to describe an adverse event. np Not published.

Source: AIHW (unpublished), National Hospital Morbidity Database; AIHW (2012), Australian Hospital Statistics 2010-11, Health Services Series No. 43, Cat no. HSE 117; table 10A.47.

Separations with an adverse event have diagnoses, places of occurrence and external causes of injury and poisoning that can indicate that an adverse event was treated and/or occurred during the hospitalisation. However, some adverse events
are not identifiable using these codes, and some other diagnosis codes may also suggest that an adverse event has occurred.

These data can be interpreted as representing selected adverse events in health care that have resulted in, or have affected, hospital admissions, rather than all adverse events that occurred in hospitals. Some of the adverse events included in these tables may represent events that occurred before admission.

A separation may be recorded against more than one category in table 10.6, as some adverse events are reported as diagnoses and others as external causes or places of occurrence (of the injury or poisoning).

**Responsiveness**

The Steering Committee has identified the responsiveness of public hospitals as an area for development in future Reports.

**Continuity — continuity of care**

‘Continuity of care’ is an indicator of governments’ objective to provide public hospital services that are of high quality (box 10.9).

---

**Box 10.9 Continuity of care**

‘Continuity of care’ measures the provision of uninterrupted, timely, coordinated healthcare, interventions and actions across programs, practitioners and organisations. Continuity of care has been identified as a key area for development in future Reports.

---

**Sustainability**

**Workforce sustainability**

‘Workforce sustainability’ is an indicator of governments’ objective to provide sustainable public hospital services (box 10.10). Labour, particularly nurses and medical practitioners, is the most significant and costly resource used in providing public hospital services (figure 10.21), and the sustainability of the workforce helps determine whether sustainability problems might arise in the future delivery of public hospital services.
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 that is close to retirement.

Box 10.10 **Workforce sustainability**

‘Workforce sustainability’ reports age profiles for nurse and medical practitioner workforces. It shows the proportions of registered nurses and medical practitioners in ten year age brackets, by jurisdiction and by region.

A high or increasing proportion of the workforce that are new entrants and/or a low or decreasing proportion of the workforce that is close to retirement is desirable.

All nurses (including midwives) and medical practitioners in the workforce 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.

Data reported for this indicator are comparable.

The age profile of the nursing workforce (which includes midwives) for 2011 for each jurisdiction is shown in figure 10.15. Nursing workforce data by remoteness area for 2011 are shown in figure 10.16.
Figure 10.15  **Nursing workforce, by age group, 2011**\textsuperscript{a, b}

<table>
<thead>
<tr>
<th>Age Group</th>
<th>NSW</th>
<th>Vic</th>
<th>Qld</th>
<th>WA</th>
<th>SA</th>
<th>Tas</th>
<th>ACT</th>
<th>NT</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;30</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>30–39</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>40–49</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>50–59</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>60+</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

\textsuperscript{a} Includes registered and enrolled nurses (including midwives) who are employed in nursing, nurses who are registered but on extended leave and nurses who are registered and looking for work in nursing. \textsuperscript{b} State and territory is derived from state and territory of main job where available; otherwise state and territory of principal practice is used as a proxy. If principal practice details are unavailable, state and territory of residence is used. Records with no information on all three locations are coded to 'Not stated'.

*Source: AIHW (unpublished) National Health Workforce Data Set; table 10A.49.*

Figure 10.16  **Nursing workforce, by age group and remoteness area, 2011**\textsuperscript{a, b}

<table>
<thead>
<tr>
<th>Area</th>
<th>&lt;30</th>
<th>30–39</th>
<th>40–49</th>
<th>50–59</th>
<th>60+</th>
</tr>
</thead>
<tbody>
<tr>
<td>Major cities</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inner regional</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outer regional</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Remote and very remote</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All areas</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

\textsuperscript{a} Includes registered and enrolled nurses (including midwives) who are employed in nursing, nurses who are registered but on extended leave and nurses who are registered and looking for work in nursing. \textsuperscript{b} Remote and very remote areas include migratory areas.

*Source: AIHW (unpublished) National Health Workforce Data Set; table 10A.48.*
The age profile of the medical practitioner workforce in 2011 for each jurisdiction is shown in figure 10.17. Medical practitioner workforce data for 2011 by remoteness area are shown in figure 10.18.

**Figure 10.17** Medical practitioner workforce, by age group, 2011\(^a, b\)

\(\begin{array}{cccccc}
\hline
& <30 & 30–39 & 40–49 & 50–59 & 60+ \\
\hline
NSW & \text{includes employed medical practitioners, registered medical practitioners on extended leave and registered medical practitioners looking for work in medicine.} & \text{State and territory is derived from state and territory of main job where available; otherwise state and territory of principal practice is used as a proxy. If principal practice details are unavailable, state and territory of residence is used. Records with no information on all three locations are coded to ‘Not stated’.} \\
\hline
\end{array}\)

**Source**: AIHW (unpublished) National Health Workforce Data Set; table 10A.51.

**Figure 10.18** Medical practitioner workforce, by age group and remoteness area, 2011\(^a, b\)

\(\begin{array}{cccccc}
\hline
& <30 & 30–39 & 40–49 & 50–59 & 60+ \\
\hline
\text{Major cities} & \text{includes employed medical practitioners, registered medical practitioners on extended leave and registered medical practitioners looking for work in medicine.} & \text{Remote and very remote areas include migratory areas.} \\
\text{Inner regional} & \text{State and territory is derived from state and territory of main job where available; otherwise state and territory of principal practice is used as a proxy. If principal practice details are unavailable, state and territory of residence is used. Records with no information on all three locations are coded to ‘Not stated’.} & \\
\text{Outer regional} & \text{Source: AIHW (unpublished) National Health Workforce Data Set; table 10A.50.} & \\
\text{Remote and very remote} & \text{Remote and very remote areas include migratory areas.} & \\
\text{All areas} & \text{State and territory is derived from state and territory of main job where available; otherwise state and territory of principal practice is used as a proxy. If principal practice details are unavailable, state and territory of residence is used. Records with no information on all three locations are coded to ‘Not stated’.} & \\
\hline
\end{array}\)
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’. Length of stay is correlated with costs 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) can 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 can 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 can 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.

Care needs to be taken, therefore, in comparing unit costs 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 can 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.

Cost per casemix-adjusted separation

‘Cost per casemix-adjusted separation’ is an indicator of governments’ objective to deliver services in a cost effective manner (box 10.11).

Box 10.11  Cost per casemix-adjusted separation

‘Cost per casemix-adjusted separation’ is defined by the following two measures:

- Recurrent cost per casemix-adjusted separation is 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 (4.1 per cent of total separations in 2010-11 (table 10A.13)), so the acute care cost weights are applied to non-acute separations. The admitted patient cost proportion is an estimate only.
  - Some jurisdictions have developed experimental cost estimates for acute, non-psychiatric patients, which are 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.

- Total cost per casemix-adjusted separation is 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. This measure allows the full cost of hospital services to be considered. The hospitals included in this measure are the same as for recurrent cost per casemix-adjusted separation.

(Continued on next page)
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 services or to retire debt. Interest payments represent a user cost of capital, so are deducted from capital costs to avoid double counting.

A low or decreasing cost per casemix-adjusted separation can 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 decreasing cost could also be associated with decreasing quality and effectiveness.

A low or decreasing cost per casemix-adjusted separation can 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 decreasing cost could also be associated with decreasing quality and effectiveness.


**Recurrent cost per casemix-adjusted separation**

‘Recurrent cost per casemix-adjusted separation’ data are presented in figure 10.19.

**Figure 10.19  Recurrent cost per casemix-adjusted separation, 2010-11**

![Recurrence graph](image)

- **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 Cost Data Collection, based on acute and unspecified separations and newborn episodes of care with qualified days, using the 2008-09 AR-DRG v 5.2 cost weights.
- **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, ungeared 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.

**Source:** AIHW (2012), *Australian Hospital Statistics 2010-11*, Health Services Series No. 43, Cat no. HSE 117; table 10A.52.
Experimental estimates of ‘recurrent cost per casemix-adjusted separation’ for acute non-psychiatric patients are reported for NSW, Victoria and WA (figure 10.20). (These estimates relate to a subset of the selected public hospitals reported in figure 10.19 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 10.11). The effect of restricting the analysis to acute, non-psychiatric admitted patients was to decrease the estimated recurrent cost per casemix adjusted separation for the subset of hospitals by 4.0 per cent for NSW, 13.5 per cent for Victoria and 4.9 per cent for WA (AIHW 2012a).

Figure 10.20 Recurrent cost per acute non-psychiatric casemix-adjusted separation, subset of hospitals, 2010-11\(^a, b, c, d\)

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’.

---

\(^a\) Excludes psychiatric hospitals, subacute, 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 Cost Data Collection, based on acute, newborn with at least one qualified day, or not reported, using the 2008-09 AR-DRG version 5.2 cost weights.  
\(^d\) These estimates are not available for Queensland, SA, Tasmania, the ACT or the NT.

Source: AIHW (2012), Australian Hospital Statistics 2010-11, Health Services Series No. 43, Cat no. HSE 117; table 10A.52.
The dominant peer classification is the ‘Principal referral and Specialist women’s and children’s’ category. The 88 hospitals in this group had an average of 44,209 separations each at an average cost of $4,904 per person (table 10A.53 and table 10.7). Data for each of the hospital peer groups are presented in table 10.7. Detailed data for all peer groups are presented in table 10A.53.

Table 10.7  **Recurrent cost per casemix-adjusted separation, by hospital peer group, 2010-11**a, b, c

<table>
<thead>
<tr>
<th>Hospital peer group</th>
<th>NSW</th>
<th>Vic</th>
<th>Qld</th>
<th>WA</th>
<th>SA</th>
<th>Tas</th>
<th>ACT</th>
<th>NT</th>
<th>Aust</th>
</tr>
</thead>
<tbody>
<tr>
<td>Principal referral and Specialist women's and children's</td>
<td>4,897</td>
<td>4,477</td>
<td>5,420</td>
<td>4,720</td>
<td>4,929</td>
<td>5,779</td>
<td>5,401</td>
<td>5,595</td>
<td>4,904</td>
</tr>
<tr>
<td>Large</td>
<td>4,576</td>
<td>4,667</td>
<td>4,230</td>
<td>5,180</td>
<td>4,944</td>
<td>np</td>
<td>..</td>
<td>..</td>
<td>4,754</td>
</tr>
<tr>
<td>Medium</td>
<td>5,115</td>
<td>4,403</td>
<td>5,138</td>
<td>5,336</td>
<td>4,530</td>
<td>np</td>
<td>..</td>
<td>..</td>
<td>4,942</td>
</tr>
<tr>
<td>Small acute</td>
<td>6,112</td>
<td>5,556</td>
<td>5,183</td>
<td>7,516</td>
<td>4,158</td>
<td>5,773</td>
<td>..</td>
<td>6,027</td>
<td>5,920</td>
</tr>
<tr>
<td>All hospitalsd</td>
<td>4,904</td>
<td>4,508</td>
<td>5,323</td>
<td>4,996</td>
<td>4,854</td>
<td>5,913</td>
<td>5,401</td>
<td>5,645</td>
<td>4,918</td>
</tr>
</tbody>
</table>

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.

Source: AIHW (2012), *Australian Hospital Statistics 2010-11*, Health Services Series No. 43, Cat no. HSE 117; table 10A.53.

**Total cost per casemix-adjusted separation**

Total cost includes both the recurrent costs (as discussed above) and the capital costs associated with hospital services. Results for this measure in 2010-11 are reported in figure 10.21. Labour costs accounted for the majority of costs in most jurisdictions. The user cost of capital for land is not included in figure 10.21 but is reported in table 10A.54.
Figure 10.21  **Total cost per casemix-adjusted separation, public hospitals, 2010-11**

<table>
<thead>
<tr>
<th>State</th>
<th>Labour</th>
<th>Material</th>
<th>Capital</th>
</tr>
</thead>
<tbody>
<tr>
<td>NSW</td>
<td>3500</td>
<td>4000</td>
<td>3000</td>
</tr>
<tr>
<td>Vic</td>
<td>3700</td>
<td>4200</td>
<td>3500</td>
</tr>
<tr>
<td>Qld</td>
<td>3900</td>
<td>4500</td>
<td>3800</td>
</tr>
<tr>
<td>WA</td>
<td>4000</td>
<td>4800</td>
<td>3700</td>
</tr>
<tr>
<td>SA</td>
<td>4100</td>
<td>4900</td>
<td>3900</td>
</tr>
<tr>
<td>Tas</td>
<td>4200</td>
<td>5000</td>
<td>4000</td>
</tr>
<tr>
<td>ACT</td>
<td>4300</td>
<td>5100</td>
<td>4100</td>
</tr>
<tr>
<td>NT</td>
<td>4400</td>
<td>5200</td>
<td>4200</td>
</tr>
<tr>
<td>Aust</td>
<td>4500</td>
<td>5300</td>
<td>4300</td>
</tr>
</tbody>
</table>

\[a\] Labour includes medical and non-medical labour costs. Material includes other non-labour recurrent costs, such as repairs and maintenance (table 10A.52). \[b\] 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.54). \[c\] 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 (2012), Australian Hospital Statistics 2010-11, Health Services Series No. 43, Cat no. HSE 117; State and Territory governments (unpublished); tables 10A.52 and 10A.54.*

**Relative stay index**

‘Relative stay index’ is an indicator of governments’ objective to deliver services efficiently (box 10.12). Data for this indicator are reported in figure 10.22. The relative stay index is reported by patient election status and by medical, surgical and other AR DRGs in tables 10A.55 and 10A.56 respectively.
Box 10.12  **Relative stay index**

‘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 index.

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 or decreasing 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.

Data reported for this indicator are comparable.


---

**Figure 10.22  Relative stay index, public hospitals, 2010-11**

---

*a* Separations exclude newborn with unqualified days, organ procurement posthumous and hospital boarders.  
*b* The relative stay index is based on all hospitals and is estimated using the indirect standardisation method and AR-DRG version 5.2. 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 (2012), Australian Hospital Statistics 2010-11, Health Services Series No. 43, Cat no. HSE 117; table 10A.55.*
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 (box 10.13).

Box 10.13  Recurrent cost per non-admitted occasion of service

‘Recurrent cost per non-admitted occasion of service’ is defined as 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. Non-admitted occasions of service (including emergency department presentations and outpatient services) account for a significant proportion of hospital expenditure.

A low or decreasing recurrent cost per non-admitted occasion of service can reflect more efficient service delivery in public hospitals. However, this indicator should be viewed in the context of the set of performance indicators as a whole, as decreasing cost could also be associated with decreasing quality and effectiveness. 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).

Data reported for this indicator are not complete or directly comparable.

Data quality information for this indicator is under development.

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 can be included in expenditure on non-admitted services, but not in the count of occasions of service. Jurisdictions able to supply 2010-11 data for this indicator reported the following results for non-admitted patient services:

- In NSW, the emergency department cost per occasion of service was $245 for 2.4 million occasions, the outpatient cost per occasion of service was $122 for 15.6 million occasions and the overall cost per occasion of service (emergency plus outpatient plus other) was $136 for 20.4 million occasions (table 10A.57).
- In WA, the emergency department cost per occasion of service was $476 for 902 000 occasions, the outpatient cost per occasion of service was $190 for 2.2 million occasions and the overall cost per occasion of service (emergency plus outpatient plus other) was $275 for 3.1 million occasions (table 10A.59).
- In SA, the emergency department cost per occasion of service was $460 for 544 000 occasions, the outpatient cost per occasion of service was $334 for
1.5 million occasions and the overall cost per occasion of service (emergency plus outpatient) was $368 for 2.0 million occasions (table 10A.60).

- In Tasmania, the emergency department cost per occasion of service was $355 for 123,000 occasions. The outpatient cost per occasion of service was $250 for 484,000 occasions. An overall cost per occasion of service was not available (table 10A.61).

- In the ACT, the emergency department cost per occasion of service was $723 for 112,000 occasions, the outpatient cost per occasion of service was $255 for 314,000 occasions and the overall cost per occasion of service (emergency plus outpatient) was $340 for 426,000 occasions (table 10A.62).

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. The average cost per encounter was $179 for 1.4 million encounters in 2010-11 (table 10A.58).

Given the lack of a nationally consistent non-admitted patient classification system, this Report includes national data from the Independent Hospital Pricing Authority’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.

Emergency department data were contributed by 228 public hospitals. These data suggest that the cost per emergency department presentation for the public hospitals sector in 2010-11 was $498 per presentation for 5.5 million presentations (table 10A.63). The cost per presentation for emergency departments by triage class are shown in table 10A.64. Cost per non-admitted clinic occasion of service data were provided by 203 public hospitals with an average cost of $340 per occasion of service for 8.1 million occasions of service (table 10A.65).
Outcomes

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

Patient satisfaction

‘Patient satisfaction’ provides a proxy measure of governments’ objective to deliver services that are high quality and responsive to individual patient needs (box 10.14). Patient satisfaction surveys are different from other sources of hospital quality data, because they provide information on hospital quality from the patient’s perspective. 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).
Box 10.14  **Patient satisfaction**

‘Patient satisfaction’ is defined by the following six measures:

- Proportion of people who went to an emergency department in the last 12 months reporting the emergency department doctors, specialists or nurses always or often listened carefully to them
- Proportion of people who went to an emergency department in the last 12 months reporting the emergency department doctors, specialists or nurses always or often showed respect to them
- Proportion of people who went to an emergency department in the last 12 months reporting the emergency department doctors, specialists or nurses always or often spent enough time with them
- Proportion of people who were admitted to hospital in the last 12 months reporting the hospital doctors, specialists or nurses always or often listened carefully to them
- Proportion of people who were admitted to hospital in the last 12 months reporting the hospital doctors, specialists or nurses always or often showed respect to them
- Proportion of people who were admitted to hospital in the last 12 months reporting the hospital doctors, specialists or nurses always or often spent enough time with them.

A high or increasing proportion of patients who were satisfied is desirable, because it suggests the hospital care received was of high quality and better met the expectations and needs of patients.

Data reported for this indicator are comparable.

Descriptive information on patient surveys undertaken by states and territories is also reported. The descriptive information includes the survey time period, method, sample size, response rate and a selection of results where available. Information on how jurisdictions have used patient satisfaction surveys to improve public hospital quality in recent years is also reported. If public hospitals respond to patient views and modify services, service quality can be improved to better meet patients’ needs. As State and Territory based surveys differ in content, timing and scope across jurisdictions, it is not possible to compare their results nationally.


Patient satisfaction data for emergency department and admitted hospital patients are reported in table 10.8. Relative standard errors and confidence intervals are reported in attachment tables 10A.66—10A.73. These tables also report patient satisfaction by remoteness.
Table 10.8  **Patient satisfaction, public hospitals, 2011-12**a

<table>
<thead>
<tr>
<th></th>
<th>NSW</th>
<th>Vic</th>
<th>Qld</th>
<th>WA</th>
<th>SA</th>
<th>Tas</th>
<th>ACT</th>
<th>NT</th>
<th>Aust</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Emergency department patients</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Proportion of people who went to an emergency department in the last 12 months reporting the ED doctors, specialists or nurses always or often listened carefully to them</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Doctors or specialists</td>
<td>86.1</td>
<td>82.8</td>
<td>85.2</td>
<td>86.7</td>
<td>84.2</td>
<td>86.2</td>
<td>86.3</td>
<td>87.6</td>
<td>85.1</td>
</tr>
<tr>
<td>Nurses</td>
<td>87.8</td>
<td>87.7</td>
<td>88.5</td>
<td>88.9</td>
<td>88.0</td>
<td>90.5</td>
<td>93.2</td>
<td>87.2</td>
<td>88.2</td>
</tr>
<tr>
<td>Proportion of people who went to an emergency department in the last 12 months reporting the ED doctors, specialists or nurses always or often showed respect to them</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Doctors or specialists</td>
<td>88.7</td>
<td>84.2</td>
<td>86.1</td>
<td>88.2</td>
<td>87.6</td>
<td>84.8</td>
<td>87.4</td>
<td>86.6</td>
<td>86.9</td>
</tr>
<tr>
<td>Nurses</td>
<td>88.9</td>
<td>87.5</td>
<td>87.9</td>
<td>90.0</td>
<td>88.2</td>
<td>90.7</td>
<td>91.7</td>
<td>88.4</td>
<td>88.7</td>
</tr>
<tr>
<td>Proportion of people who went to an emergency department in the last 12 months reporting the ED doctors, specialists or nurses always or often spent enough time with them</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Doctors or specialists</td>
<td>80.7</td>
<td>76.5</td>
<td>81.4</td>
<td>85.5</td>
<td>77.5</td>
<td>77.7</td>
<td>82.5</td>
<td>83.7</td>
<td>80.3</td>
</tr>
<tr>
<td>Nurses</td>
<td>84.1</td>
<td>82.9</td>
<td>84.0</td>
<td>85.1</td>
<td>82.6</td>
<td>87.4</td>
<td>90.6</td>
<td>85.1</td>
<td>84.1</td>
</tr>
<tr>
<td><strong>Admitted hospital patients</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Proportion of people who were admitted to hospital in the last 12 months reporting the hospital doctors, specialists or nurses always or often listened carefully to them</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Doctors or specialists</td>
<td>88.6</td>
<td>88.2</td>
<td>91.6</td>
<td>90.2</td>
<td>93.0</td>
<td>86.0</td>
<td>90.8</td>
<td>88.4</td>
<td>89.6</td>
</tr>
<tr>
<td>Nurses</td>
<td>89.8</td>
<td>90.9</td>
<td>92.1</td>
<td>88.6</td>
<td>93.2</td>
<td>91.7</td>
<td>88.5</td>
<td>80.7</td>
<td>90.7</td>
</tr>
<tr>
<td>Proportion of people who were admitted to hospital in the last 12 months reporting the hospital doctors, specialists or nurses always or often showed respect to them</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Doctors or specialists</td>
<td>89.8</td>
<td>90.2</td>
<td>90.8</td>
<td>90.1</td>
<td>91.8</td>
<td>85.5</td>
<td>89.5</td>
<td>89.8</td>
<td>90.3</td>
</tr>
<tr>
<td>Nurses</td>
<td>90.4</td>
<td>91.4</td>
<td>92.5</td>
<td>91.2</td>
<td>93.1</td>
<td>91.6</td>
<td>91.5</td>
<td>86.5</td>
<td>91.4</td>
</tr>
<tr>
<td>Proportion of people who were admitted to hospital in the last 12 months reporting the hospital doctors, specialists or nurses always or often spent enough time with them</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Doctors or specialists</td>
<td>85.7</td>
<td>86.5</td>
<td>88.7</td>
<td>84.1</td>
<td>87.0</td>
<td>80.5</td>
<td>91.3</td>
<td>86.4</td>
<td>86.3</td>
</tr>
<tr>
<td>Nurses</td>
<td>86.3</td>
<td>88.7</td>
<td>89.5</td>
<td>88.1</td>
<td>89.3</td>
<td>84.5</td>
<td>89.2</td>
<td>81.4</td>
<td>87.9</td>
</tr>
</tbody>
</table>

a Rates are age standardised to the 2001 estimated resident population (5 year ranges). ED=Emergency department.


State and Territory survey approaches differed markedly across jurisdictions, so it is not possible to compare results:

- All jurisdictions provided details of surveys conducted in 2010 and/or 2011, with the exception of Tasmania and the NT, which did not update survey details for this Report.
- The length of time that the survey was conducted varied from a 12 month period to a two month period.
Survey methods ranged from Computer Assisted Telephone Interviewing used by Queensland, WA and SA, while other jurisdictions used a combination of mail and internet surveys.

Most jurisdictions surveyed admitted patients, but one jurisdiction surveyed hospital inpatients and outpatients, non-admitted emergency patients, mental health inpatients and outpatients, and one jurisdiction surveyed emergency departments only.

Sample sizes varied from 194,000 to around 1,500.

More information on the survey methods and results are in tables 10A.74–10A.81.

All jurisdictions reported that they use survey results in some way to improve services. All jurisdictions provide survey results or feedback to hospitals. Most jurisdictions have a formalised approach to prioritising the areas in need of improvement identified by the surveys and then implementing quality improvements. One jurisdiction reported that key performance measure results from its survey are included in its area health service performance agreements. More information on how survey results are used to improve services are in tables 10A.74–10A.81.

**Sentinel events**

‘Sentinel events’ is an indicator of governments’ objective to deliver public hospital services that are safe and of high quality (box 10.15). Sentinel events can indicate hospital system and process deficiencies that compromise quality and safety. Sentinel events are a subset of adverse events that result in death or very serious harm to the patient. Adverse events are reported in this chapter as an output indicator.
Box 10.15  **Sentinel events**

'Sentinel events’ is defined as the number of reported adverse events that occur because of hospital system and process deficiencies, and which result 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 resulting in death or major permanent loss of function.
2. Suicide of a patient in an inpatient unit.
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.

A low or decreasing number of sentinel events is desirable.

Over time, an increase in the number of sentinel events reported might reflect improvements in incident reporting mechanisms 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).

Data reported for this indicator are not complete or directly comparable.

Data quality information for this indicator is under development.

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 events data for 2004-05 (AIHW and ACSQHC 2007). The report identified that reporting practices differ across jurisdictions and, as a result, the data are not comparable across jurisdictions.
Numbers of sentinel events for 2010-11 are reported below. As larger states and territories will tend to have more sentinel events than smaller jurisdictions, the numbers of separations and individual occasions of service are also presented to provide context.

- In NSW public hospitals in 2010-11, there were around 1.6 million separations (table 10A.6) and around 21.3 million individual occasions of service (table 10A.16). In NSW in 2010-11, there was 1 procedure involving the wrong patient or body part, 12 suicides of patients in inpatient units, 10 cases of retained instruments or other material after surgery requiring re-operation or further surgical procedure, 1 intravascular gas embolism resulting in death or neurological damage, 2 medication errors leading to the death of a patient reasonably believed to be due to incorrect administration of drugs and 3 maternal deaths or cases of serious morbidity associated with labour delivery. Sentinel events in all other categories were reported as zero (table 10A.82).

- In Victorian public hospitals in 2010-11, there were around 1.5 million separations (table 10A.6) and around 8.4 million individual occasions of service (table 10A.16). In Victoria in 2010-11, there was 1 procedure involving the wrong patient or body part, 9 suicides of a patient in an inpatient unit, 5 retained instruments or other material after surgery requiring re-operation or further surgical procedure, 1 intravascular gas embolism resulting in death or neurological damage, 1 haemolytic blood transfusion reaction resulting from ABO incompatibility, 2 medication errors leading to the death of a patient reasonably believed to be due to incorrect administration of drugs and 2 maternal deaths or cases of serious morbidity associated with labour or delivery. Sentinel events in all other categories were reported as zero (table 10A.83).

- In Queensland public hospitals in 2010-11, there were around 964,000 separations (table 10A.6) and around 11.2 million individual occasions of service (table 10A.16). In Queensland in 2010-11, there was 1 suicide of a patient in an inpatient unit, 5 retained instruments or other material after surgery requiring re-operation or further surgical procedure, 4 medication errors leading to the death of a patient reasonably believed to be due to incorrect administration of drugs and 1 maternal death or case of serious morbidity associated with labour or delivery. Sentinel events in all other categories were reported as zero (table 10A.84).

- In WA public hospitals in 2010-11, there were around 548,000 separations (table 10A.6) and around 5.4 million individual occasions of service (table 10A.16). In WA in 2010-11, there was 1 procedure involving the wrong patient or body part, 5 suicides of patients in inpatient units, 1 retained instrument or other material after surgery requiring re-operation or further surgical procedure, 2 medication errors leading to the death of a patient
reasonably believed to be due to incorrect administration of drugs and 3 maternal
deaths or cases of serious morbidity associated with labour or delivery. Sentinel
events in all other categories were reported as zero (table 10A.85).

- In SA public hospitals in 2010-11, there were around 390 000 separations
  (table 10A.6) and around 2.2 million individual occasions of service
  (table 10A.16). In SA in 2010-11, there were 2 suicides of a patient in an
  inpatient unit, 3 retained instruments or other material after surgery requiring
  re-operation or further surgical procedure, 1 medication error leading to the
  death of a patient reasonably believed to be due to incorrect administration of
  drugs and 4 maternal deaths or cases of serious morbidity associated with labour
  or delivery. Sentinel events in all other categories were reported as zero
  (table 10A.86).

- In Tasmanian public hospitals in 2010-11, there were around 99 000 separations
  (table 10A.6) and around 543 000 individual occasions of service (table 10A.16).
  In Tasmania in 2010-11, sentinel events in all categories were reported as zero
  (table 10A.87).

- In ACT public hospitals in 2010-11, there were around 94 000 separations
  (table 10A.6) and around 679 000 individual occasions of service (table 10A.16).
  In the ACT in 2010-11, there were a total of 2 sentinel events. Data for each of
  the nationally agreed categories have not been published (table 10A.88).

- In NT public hospitals in 2010-11, there were around 104 000 separations
  (table 10A.6) and around 526 000 individual occasions of service (table 10A.16).
  In the NT in 2010-11, there was 2 retained instruments or other material after
  surgery requiring re-operation or further surgical procedure. Sentinel events in
  all other categories were reported as zero (table 10A.89).

Data for 2006-07 to 2009-10 are reported in tables 10A.82–10A.90. Australian
totals are in table 10A.90.

*Mortality in hospitals*

‘Mortality in hospitals’ is an indicator of governments’ objective to deliver public
hospital services that are safe and of high quality (box 10.16).
Box 10.16  **Mortality in hospitals**

‘Mortality in hospitals’ is defined by the following three measures:

- Hospital standardised mortality ratio
- Death in low-mortality diagnostic related groups
- In hospital mortality rates.

Mortality in hospitals has been identified as a key area for development in future Reports.

### 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 8.0 per cent of total acute separations in public hospitals (table 10A.92) and around 10.9 per cent of the total cost of all acute separations in public hospitals in 2010-11 (table 10A.91). Figure 10.23 shows the rate of acute separations per 1000 people for maternity services across jurisdictions in 2010-11.

**Figure 10.23  Separation rates for maternity services, public hospitals, 2010-11**

- The puerperium refers to the period of confinement immediately after labour (around six weeks).
- 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.
- Includes separations for which the type of episode of care was reported as ‘acute’, or ‘newborn with qualified patient days’.

*Source: AIHW (2012), *Australian Hospital Statistics 2010-11*, Health Services Series No. 43, Cat no. HSE 117; ABS (unpublished), Australian Demographic Statistics, December Quarter 2010, Cat. no. 3101.0; tables AA.2 and 10A.92.*
In Australian public hospitals in 2010-11, 42.4 per cent of the separations for pregnancy, childbirth and the puerperium had a DRG of vaginal delivery (tables 10A.92 and 10A.93). In the context of all AR-DRGs in public hospitals, vaginal deliveries comprised the largest number of overnight acute separations (5.7 per cent of all separations) (table 10A.14) and the highest cost of all separation categories ($850.5 million) (table 10A.93).

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 (table 10.9).

Table 10.9  Mean age of mothers at time of giving birth, public hospitals

<table>
<thead>
<tr>
<th>Year</th>
<th>NSW</th>
<th>Vic&lt;sup&gt;a&lt;/sup&gt;</th>
<th>Qld</th>
<th>WA</th>
<th>SA&lt;sup&gt;b&lt;/sup&gt;</th>
<th>Tas</th>
<th>ACT&lt;sup&gt;c&lt;/sup&gt;</th>
<th>NT</th>
</tr>
</thead>
<tbody>
<tr>
<td>2007</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>First birth</td>
<td>28.1</td>
<td>27.8</td>
<td>25.6</td>
<td>26.0</td>
<td>26.9</td>
<td>26.0</td>
<td>27.7</td>
<td>24.1</td>
</tr>
<tr>
<td>Second birth</td>
<td>30.2</td>
<td>30.0</td>
<td>28.0</td>
<td>28.5</td>
<td>29.4</td>
<td>28.5</td>
<td>30.2</td>
<td>26.4</td>
</tr>
<tr>
<td>Third birth</td>
<td>31.4</td>
<td>31.5</td>
<td>29.7</td>
<td>30.0</td>
<td>31.1</td>
<td>29.9</td>
<td>31.4</td>
<td>27.8</td>
</tr>
<tr>
<td>All births</td>
<td>29.1</td>
<td>29.6</td>
<td>27.9</td>
<td>28.1</td>
<td>29.0</td>
<td>28.1</td>
<td>29.6</td>
<td>26.6</td>
</tr>
<tr>
<td>2008</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>First birth</td>
<td>27.9</td>
<td>27.7</td>
<td>25.5</td>
<td>26.0</td>
<td>26.9</td>
<td>27.0</td>
<td>28.0</td>
<td>24.5</td>
</tr>
<tr>
<td>Second birth</td>
<td>30.2</td>
<td>30.0</td>
<td>28.1</td>
<td>28.6</td>
<td>29.5</td>
<td>29.6</td>
<td>30.2</td>
<td>26.4</td>
</tr>
<tr>
<td>Third birth</td>
<td>31.5</td>
<td>31.5</td>
<td>29.7</td>
<td>30.1</td>
<td>31.0</td>
<td>31.7</td>
<td>31.9</td>
<td>28.5</td>
</tr>
<tr>
<td>All births</td>
<td>29.8</td>
<td>29.6</td>
<td>27.9</td>
<td>28.2</td>
<td>29.1</td>
<td>29.2</td>
<td>29.8</td>
<td>26.8</td>
</tr>
<tr>
<td>2009</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>First birth</td>
<td>27.9</td>
<td>28.2</td>
<td>25.6</td>
<td>26.2</td>
<td>27.0</td>
<td>24.9</td>
<td>28.0</td>
<td>24.2</td>
</tr>
<tr>
<td>Second birth</td>
<td>30.4</td>
<td>30.7</td>
<td>28.3</td>
<td>28.6</td>
<td>29.6</td>
<td>29.6</td>
<td>30.4</td>
<td>26.8</td>
</tr>
<tr>
<td>Third birth</td>
<td>31.6</td>
<td>32.0</td>
<td>29.8</td>
<td>30.1</td>
<td>31.1</td>
<td>29.0</td>
<td>31.3</td>
<td>28.6</td>
</tr>
<tr>
<td>All births</td>
<td>29.9</td>
<td>30.1</td>
<td>28.0</td>
<td>28.3</td>
<td>29.1</td>
<td>27.3</td>
<td>29.8</td>
<td>26.9</td>
</tr>
<tr>
<td>2010</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>First birth</td>
<td>28.2</td>
<td>28.2</td>
<td>25.6</td>
<td>26.3</td>
<td>27.1</td>
<td>26.3</td>
<td>28.0</td>
<td>24.6</td>
</tr>
<tr>
<td>Second birth</td>
<td>30.3</td>
<td>30.7</td>
<td>28.2</td>
<td>28.8</td>
<td>29.6</td>
<td>28.6</td>
<td>30.4</td>
<td>27.1</td>
</tr>
<tr>
<td>Third birth</td>
<td>31.6</td>
<td>32.0</td>
<td>29.8</td>
<td>30.3</td>
<td>31.3</td>
<td>29.9</td>
<td>31.9</td>
<td>28.9</td>
</tr>
<tr>
<td>All births</td>
<td>29.9</td>
<td>30.1</td>
<td>28.0</td>
<td>28.4</td>
<td>29.2</td>
<td>28.8</td>
<td>29.8</td>
<td>27.0</td>
</tr>
<tr>
<td>2011</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>First birth</td>
<td>28.2</td>
<td>27.9</td>
<td>25.9</td>
<td>26.5</td>
<td>27.3</td>
<td>na</td>
<td>28.4</td>
<td>24.7</td>
</tr>
<tr>
<td>Second birth</td>
<td>30.4</td>
<td>30.2</td>
<td>28.2</td>
<td>28.8</td>
<td>29.8</td>
<td>na</td>
<td>30.5</td>
<td>27.2</td>
</tr>
<tr>
<td>Third birth</td>
<td>31.6</td>
<td>31.7</td>
<td>30.1</td>
<td>30.4</td>
<td>31.3</td>
<td>na</td>
<td>32.2</td>
<td>28.7</td>
</tr>
<tr>
<td>All births</td>
<td>29.9</td>
<td>29.7</td>
<td>28.2</td>
<td>28.5</td>
<td>29.3</td>
<td>na</td>
<td>30.0</td>
<td>27.1</td>
</tr>
</tbody>
</table>

<sup>a</sup> Data for Victoria for 2011 are preliminary.  
<sup>b</sup> Data for SA for 2011 are preliminary.  
<sup>c</sup> ACT 2011 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.  
<sup>na</sup> Not available.  

Source: State and Territory governments (unpublished).
10.5 Framework of performance indicators for maternity services

The performance indicator framework provides information on equity, efficiency and effectiveness, and distinguishes the outputs and outcomes of maternity services (figure 10.24). The performance indicator framework shows which data are comparable in the 2013 Report. For data that are not considered directly comparable, the text includes relevant caveats and supporting commentary. Chapter I discusses data comparability from a Report-wide perspective (see section 1.6). The Health sector overview 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.

The Report’s statistical appendix 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) (appendix A).
Data quality information (DQI) is being progressively introduced for all indicators in the Report. The purpose of DQI is to provide structured and consistent information about quality aspects of data used to report on performance indicators. DQI in this Report cover the seven dimensions in the ABS’ data quality framework (institutional environment, relevance, timeliness, accuracy, coherence, accessibility and interpretability) in addition to dimensions that define and describe performance indicators in a consistent manner, and note key data gaps and issues identified by the Steering Committee. All DQI for the 2013 Report can be found at www.pc.gov.au/gsp/reports/rogs/2013.
10.6 Key performance indicator results for maternity services

Outputs

Outputs are the 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 Australians 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 10.17).
Box 10.17  **Caesareans and inductions for selected primiparae**

'Caesareans and inductions for selected primiparae' are defined as the number of inductions or caesareans for the selected primiparae divided respectively by the number of the selected primiparae who gave birth. High intervention rates can indicate a need for investigation, although 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. Rates 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, so caesarean or induction rates should be low in their population.

Data reported for this indicator are not complete or directly comparable.

Data quality information for this indicator is under development.

a Primiparae refers to pregnant women who have had no previous pregnancy resulting in a live birth or stillbirth (Laws and Hilder 2008). b Parturient means 'about to give birth'.

Caesarean rates for selected primiparae in public hospitals are reported in figure 10.25. Caesarean rates for private hospitals are shown in table 10A.94 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.95–10A.102.

**Figure 10.25  Caesareans for selected primiparae, public hospitals**

<table>
<thead>
<tr>
<th></th>
<th>2007</th>
<th>2008</th>
<th>2009</th>
<th>2010</th>
<th>2011</th>
</tr>
</thead>
<tbody>
<tr>
<td>NSW</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vic</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Qld</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>WA</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SA</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tas</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ACT</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NT</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

a Data for 2011 for Victoria are preliminary. b Data for SA for 2011 are preliminary. c Data for Tasmania are not available. 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. e Total includes only jurisdictions for which data are available.

Source: State and Territory governments (unpublished); tables 10A.95–10A.102.
Induction rates for selected primiparae in public hospitals are reported in figure 10.26. Induction rates for private hospitals are shown in table 10A.94 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.95–10A.102.

Figure 10.26  **Inductions for selected primiparae, public hospitals**

![Inductions for selected primiparae, public hospitals](image)

<table>
<thead>
<tr>
<th>Year</th>
<th>NSW</th>
<th>Vic</th>
<th>Qld</th>
<th>WA</th>
<th>SA</th>
<th>Tas</th>
<th>ACT</th>
<th>NT</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>2007</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2008</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2009</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2010</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2011</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Source:** State and Territory governments (unpublished); tables 10A.95–10A.102.

**Vaginal delivery following previous caesarean**

‘Vaginal delivery following a previous caesarean’ is an indicator of the appropriateness of maternity services in public hospitals (box 10.18).
Box 10.18  **Vaginal delivery following a previous caesarean**

‘Vaginal delivery following a previous caesarean’ is defined as the percentage of multiparous\(^a\) mothers who have had a previous caesarean, whose current method of birth was either an instrumental or non-instrumental vaginal delivery.

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 caesarean. Low rates of vaginal birth following a previous caesarean may warrant investigation, or on the other hand, they can indicate appropriate clinical caution. When interpreting this indicator, emphasis needs to be given to the potential for improvement.

Data reported for this indicator are comparable.


\(^a\) Multiparous means a pregnant woman who had at least one previous pregnancy resulting in a live birth or stillbirth.

Nationally in 2010, of women that had a previous caesarean section, 16.5 per cent had either an instrument or non-instrumental vaginal delivery as their current method of birth, while 83.5 per cent had another caesarean section (figure 10.27 and table 10A.103).
Multiparous mothers who had a vaginal birth after a previous caesarean section \(^a, b, c, d\)

Vaginal birth comprises both instrument and non-instrument vaginal births. \(^b\) For multiple births, the method of birth of the first born baby was used. \(^c\) For NSW, Victoria, WA and the NT non-instrumental vaginal birth includes all women who had a vaginal breech birth, whether or not instruments were used. For the remaining jurisdictions, vaginal breech births are only included where instruments were not used. \(^d\) Instrumental vaginal birth includes forceps and vacuum extraction.

Source: Li, Z., McNally, L., Hilder, L. and Sullivan, EA. (various years), Australia’s mothers and babies, Perinatal statistics series Cat nos. PER 50, 52 and 56; table 10A.103.

**Effectiveness — quality**

The performance indicator framework for maternity services identifies three subdimensions of quality for health services: safety; responsiveness 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 governments’ objective to provide safe and high quality services (box 10.19). Perineal lacerations caused by childbirth are painful, take time to heal and can result in ongoing discomfort and debilitating conditions such as faecal incontinence.
Box 10.19  **Perineal status after vaginal birth**

'Perineal status after vaginal birth' is defined as the state of the perineum following a vaginal birth (HDSC 2008). 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 2008). It is measured by the proportion of mothers with third or fourth degree lacerations to their perineum following vaginal birth.

A low or decreasing rate of mothers with third or fourth degree lacerations after vaginal birth is desirable. Maternity services staff aim to minimise lacerations, particularly more severe lacerations (third and fourth degree), through labour management practices. 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.

Data reported for this indicator are not directly comparable.


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.104.

**Figure 10.28  Perineal status — mothers with third or fourth degree lacerations after vaginal births**

\[\begin{align*}
\text{0.0} & \quad \text{0.5} & \quad \text{1.0} & \quad \text{1.5} & \quad \text{2.0} & \quad \text{2.5} & \quad \text{3.0} & \quad \text{3.5} \\
\text{NSW} & \quad \text{Vic} & \quad \text{Qld} & \quad \text{WA} & \quad \text{SA} & \quad \text{Tas} & \quad \text{ACT} & \quad \text{NT} & \quad \text{Aust}
\end{align*}\]

\[2006 \quad 2007 \quad 2008 \quad 2009 \quad 2010\]

\[\text{Per cent}\]

\[\text{0.0} \quad \text{0.5} \quad \text{1.0} \quad \text{1.5} \quad \text{2.0} \quad \text{2.5} \quad \text{3.0} \quad \text{3.5}\]

\[\text{NSW} \quad \text{Vic} \quad \text{Qld} \quad \text{WA} \quad \text{SA} \quad \text{Tas} \quad \text{ACT} \quad \text{NT} \quad \text{Aust}\]

\[\begin{align*}
\text{a} & \quad \text{For multiple births, the perineal status after birth of the first child was used.} \\
\text{b} & \quad \text{Data include all women who gave birth vaginally, including births in public hospitals, private hospitals and outside of hospital, such as homebirths.}
\end{align*}\]

Responsiveness, continuity

The Steering Committee has identified the responsiveness and continuity of care of maternity services as an area for development in future Reports.

Efficiency — 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 governments’ objective to deliver cost effective services (box 10.20).

Box 10.20  Recurrent cost per maternity separation

‘Recurrent cost per maternity separation’ is presented for the two AR-DRGs 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.

Low or decreasing recurrent costs per maternity separation can reflect high or increasing 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 reported for this indicator are not directly comparable.

Data quality information for this indicator is under development.

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.105. Data are sourced from the NHCDC. The NHCDC is a voluntary annual collection, the purpose of which is to calculate 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, 2010-11a, b, c

<table>
<thead>
<tr>
<th>$/separation</th>
<th>NSW</th>
<th>Vic</th>
<th>Qld</th>
<th>WA</th>
<th>SA</th>
<th>Tas</th>
<th>ACT</th>
<th>NT</th>
<th>Aust</th>
</tr>
</thead>
<tbody>
<tr>
<td>O01C caesarean delivery</td>
<td>8000</td>
<td>8000</td>
<td>8000</td>
<td>8000</td>
<td>8000</td>
<td>8000</td>
<td>8000</td>
<td>8000</td>
<td>8000</td>
</tr>
<tr>
<td>O60B vaginal delivery</td>
<td>6000</td>
<td>6000</td>
<td>6000</td>
<td>6000</td>
<td>6000</td>
<td>6000</td>
<td>6000</td>
<td>6000</td>
<td>6000</td>
</tr>
</tbody>
</table>

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. Caution must be used in making direct comparisons between jurisdictions, because of differences in hospital costing systems. c Average cost for Queensland for O01C caesarean delivery was zero.

Source: IHPA (unpublished), National Hospital Cost Data Collection; table 10A.105.

Mother’s average length of stay

‘Mother’s average length of stay’ is an indicator of governments’ objective to deliver services efficiently (box 10.21).

Box 10.21  Mother’s average length of stay

‘Mother’s average length of stay’ is defined as the total number of patient days for the selected maternity AR-DRG, 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 can, for example, have an adverse effect on the health of some mothers and result in additional costs for in-home care and potential readmissions. The indicator is not adjusted for multiple births born vaginally and without complications but requiring a longer stay to manage breastfeeding.

Data reported for this indicator are not directly comparable.

Data quality information for this indicator is under development.
Data are sourced from the NHCDC and 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).

Figure 10.30  **Average length of stay for selected maternity-related AR-DRGs, public hospitals, 2010-11**a, b

<table>
<thead>
<tr>
<th>Days</th>
<th>NSW</th>
<th>Vic</th>
<th>Qld</th>
<th>WA</th>
<th>SA</th>
<th>Tas</th>
<th>ACT</th>
<th>NT</th>
<th>Aust</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- **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 length of stay for Queensland for O01C caesarean delivery was zero.

*Source: IHPA (unpublished), National Hospital Cost Data Collection; table 10A.105.*

### Outcomes

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

#### Baby’s Apgar score

‘Baby’s Apgar score at five minutes’ is an indicator of governments’ objective to deliver maternity services that are safe and of high quality (box 10.22). The future health of babies with lower Apgar scores is often poorer than those with higher scores.
Box 10.22  **Baby’s Apgar score at five minutes**

Baby’s Apgar score at five minutes is defined as the number of live births with an Apgar score of 3 or less, at 5 minutes post-delivery, as a proportion of the total number of live births by specified birthweight categories. 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 1 and 5 minutes after birth, and subsequently at 5 minute intervals if it is still low at 5 minutes (Day et al. 1999).

A high or increasing Apgar score is desirable.

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

Data reported for this indicator are not complete or directly comparable.


‘Low’ (less than 4) Apgar scores for babies by birthweight category are contained in table 10.10. The full range of Apgar scores for 2006 to 2011 are reported in table 10A.106.

**Table 10.10  Live births with an Apgar score of 3 or lower, 5 minutes post-delivery, public hospitals, 2011**

<table>
<thead>
<tr>
<th>Birthweight (grams)</th>
<th>Unit</th>
<th>NSW</th>
<th>Vic&lt;sup&gt;a&lt;/sup&gt;</th>
<th>Qld</th>
<th>WA</th>
<th>SA&lt;sup&gt;b&lt;/sup&gt;</th>
<th>Tas</th>
<th>ACT&lt;sup&gt;c&lt;/sup&gt;</th>
<th>NT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than 1500</td>
<td>no.</td>
<td>884</td>
<td>601</td>
<td>558</td>
<td>283</td>
<td>204</td>
<td>na</td>
<td>81</td>
<td>55</td>
</tr>
<tr>
<td>Low Apgar</td>
<td>%</td>
<td>18.0</td>
<td>16.5</td>
<td>15.9</td>
<td>7.8</td>
<td>6.8</td>
<td>na</td>
<td>21.0</td>
<td>9.1</td>
</tr>
<tr>
<td>1500-1999</td>
<td>no.</td>
<td>941</td>
<td>730</td>
<td>635</td>
<td>290</td>
<td>242</td>
<td>na</td>
<td>105</td>
<td>64</td>
</tr>
<tr>
<td>Low Apgar</td>
<td>%</td>
<td>1.5</td>
<td>1.4</td>
<td>1.1</td>
<td>0.3</td>
<td>0.8</td>
<td>na</td>
<td>6.7</td>
<td>–</td>
</tr>
<tr>
<td>2000-2499</td>
<td>no.</td>
<td>2 955</td>
<td>2 148</td>
<td>1 729</td>
<td>847</td>
<td>752</td>
<td>na</td>
<td>215</td>
<td>196</td>
</tr>
<tr>
<td>Low Apgar</td>
<td>%</td>
<td>0.9</td>
<td>0.9</td>
<td>1.1</td>
<td>0.5</td>
<td>0.1</td>
<td>na</td>
<td>–</td>
<td>–</td>
</tr>
<tr>
<td>2500 and over</td>
<td>no.</td>
<td>68 594</td>
<td>48 033</td>
<td>40 492</td>
<td>17 387</td>
<td>13 958</td>
<td>na</td>
<td>3 889</td>
<td>2 748</td>
</tr>
<tr>
<td>Low Apgar</td>
<td>%</td>
<td>0.2</td>
<td>0.2</td>
<td>0.2</td>
<td>0.2</td>
<td>0.1</td>
<td>na</td>
<td>0.3</td>
<td>–</td>
</tr>
</tbody>
</table>

<sup>a</sup> Data for Victoria are preliminary.  
<sup>b</sup> Data for SA are preliminary.  
<sup>c</sup> 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.  
<sup>na</sup> Not available. – Nil or rounded to zero.

*Source: State and Territory governments (unpublished); table 10A.106.*
Perinatal death rate

‘Perinatal death rate’ is an indicator of governments’ objective to deliver maternity services that are safe and of high quality (box 10.23).

Box 10.23  Perinatal death rate

‘Perinatal death rate’ is defined by the following three measures:

- 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. 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). The rate of fetal deaths is expressed per 1000 total births, by State or Territory of usual residence of the mother.

- 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). 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.

- A perinatal death is a fetal or neonatal death. 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). It is expressed per 1000 total births, by State or Territory of usual residence of the mother.

Low or decreasing death rates are desirable and can indicate high quality maternity services. The neonatal death rate tends to be higher among premature babies, so a lower neonatal death rate can also indicate a lower percentage of pre-term births.

Differences in the fetal death rate between jurisdictions are likely to be due to factors outside the control of admitted patient maternity services (such as the health of mothers and the progress of pregnancy before hospital admission). To the extent that the health system influences fetal death rates, the health services that can have an influence include outpatient services, general practice services and 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.

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.

Data reported for this indicator are comparable.

Fetal death rate

Fetal death rates are reported in figure 10.31. Nationally, fetal death rates have generally been steady over the period 2006–2010. National time series for fetal death rates for the period 1998 to 2010 are included in table 10A.109.

Figure 10.31  Fetal death rate\textsuperscript{a, b}

\begin{figure}[h]
\centering
\includegraphics[width=\textwidth]{figure10.31.png}
\caption{Fetal death rate by state and territory, Australia, 2006 to 2010.}
\end{figure}

\textsuperscript{a} Annual rates fluctuate (in particular, for smaller jurisdictions) as a result of a low incidence of fetal deaths and small populations. \textsuperscript{b} The ACT and Australian total may exclude stillbirth data which were not received or processed by the ABS in time for the finalisation of the 2008 reference year. According to scope rules, these 2008 data were included in the 2010 reference year.

Source: ABS (unpublished) Perinatal deaths, Australia, Cat. no. 3304.0; table 10A.107.

Fetal deaths data by the Indigenous status of the mother are available for NSW, Queensland, WA, SA and the NT only. Data for other jurisdictions are not included due to small numbers or poor coverage rates (ABS 2004). For three of the five jurisdictions for which data are available, the fetal death rates for Indigenous Australians are higher than those for non-Indigenous Australians (figure 10.32).

Neonatal deaths data by the Indigenous status of the mother are available for NSW, Queensland, WA, SA and the NT only. Data for other jurisdictions are not included due to small numbers or poor coverage rates (ABS 2004). In the jurisdictions for which data are available, the neonatal death rates for Indigenous Australians are higher than those for non Indigenous Australians (figure 10.34).
Figure 10.33 Neonatal death rate

*Annual rates fluctuate (in particular, for smaller jurisdictions) as a result of a low incidence of neonatal deaths and small populations.*

*Source: ABS (unpublished) Perinatal deaths, Australia, Cat. no. 3304.0; table 10A.108.*

Figure 10.34 Neonatal death rate by Indigenous status of mother 2006–2010

*Data are reported individually by jurisdiction of residence for NSW, Queensland, WA, SA and the NT only. These jurisdictions have evidence of sufficient levels of identification and sufficient numbers of deaths. The total relates to those jurisdictions for which data are published. Data are not available for other jurisdictions.*

*Source: ABS (unpublished) Perinatal deaths, Australia, Cat. no. 3304.0; table 10A.111.*
Perinatal death rate

Perinatal death rates are shown in figure 10.35. National time series for perinatal death rates for the period 1998 to 2010 are included in table 10A.109.

Figure 10.35  Perinatal death rate\textsuperscript{a, b}

\textsuperscript{a} Annual rates fluctuate (in particular, for smaller jurisdictions) as a result of a low incidence of perinatal deaths. \textsuperscript{b} The ACT and Australian total may exclude stillbirth data which were not received or processed by the ABS in time for the finalisation of the 2008 reference year. According to scope rules, these 2008 data were included in the 2010 reference year.

Source: ABS (unpublished) \textit{Perinatal deaths, Australia}, Cat. no. 3304.0; table 10A.110.

Perinatal deaths data by the Indigenous status of the mother are available for NSW, Queensland, WA, SA and the NT only. Data for other jurisdictions are not included due to small numbers or poor coverage rates (ABS 2004). In the jurisdictions for which data are available, perinatal death rates for Indigenous Australians are higher than those for non-Indigenous Australians in all but one jurisdiction (figure 10.36).
Figure 10.36  **Perinatal death rate by Indigenous status of mother**  
*2006–2010*\(^a\)

\(^a\) Data are reported individually by jurisdiction of residence for NSW, Queensland, WA, SA and the NT only. These jurisdictions have evidence of sufficient levels of identification and sufficient numbers of deaths. The total relates to those jurisdictions for which data are published. Data are not available for other jurisdictions.

*Source*: ABS (unpublished) *Perinatal deaths, Australia*, Cat. no. 3304.0; table 10A.111.

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, and indicators of continuity of care. Gaps in the maternity services framework include equity of access, effectiveness of access, two aspects of quality — responsiveness and continuity — and the efficiency 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.

- Improving the reporting of elective surgery waiting times by urgency category to achieve greater comparability across jurisdictions and improving timeliness of the data.
• Improving the reporting of quality and safety indicators in both the public hospitals’ and maternity services’ frameworks.

• Improving the quality of data on Indigenous Australians. Work on improving Indigenous identification in hospital admitted patient data across states and territories is ongoing.
### 10.8 Definitions of key terms

**Accreditation**  
Professional recognition awarded to hospitals and other healthcare facilities that meet defined industry standards. Public hospitals can 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 can receive acute, subacute 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 5.1 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 can be radical and is frequently costly.

**Community health**  
Health services for individuals and groups delivered in a community
services 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
Recruent 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
Recruent expenditure divided by the inpatient fraction and divided by the total number of non-admitted occasions of service.

Cost per casemix-adjusted separation
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.

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 can 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.

Hospital boarder
A person who is receiving food and/or accommodation but for whom the hospital does not accept responsibility for treatment and/or care.

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.

**Newborn qualification status**
A newborn qualification status is assigned to each patient day within a newborn episode of care.

A newborn patient day is qualified if the infant meets at least one of the following criteria:

- is the second or subsequent live born infant of a multiple birth, whose mother is currently an admitted patient,
- is admitted to an intensive care facility in a hospital, being a facility approved by the Commonwealth Minister for the purpose of the provision of special care,
- is admitted to, or remains in hospital without its mother.

A newborn patient day is unqualified if the infant does not meet any of the above criteria.

The day on which a change in qualification status occurs is counted as a day of the new qualification status.

If there is more than one qualification status in a single day, the day is counted as a day of the final qualification status for that day.

**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.

**Multiparous**
A pregnant woman who had at least one previous pregnancy resulting in a live birth or stillbirth.

**Non-acute care**
Includes maintenance care and newborn care.

**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 can 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.
<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Perinatal death rate</td>
<td>Perinatal deaths divided by the total number of births (that is, live births registered and fetal deaths combined).</td>
</tr>
<tr>
<td>Perineal laceration (third or fourth degree)</td>
<td>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 2008).</td>
</tr>
<tr>
<td>Perineal status</td>
<td>The state of the perineum following a birth.</td>
</tr>
<tr>
<td>Primary care</td>
<td>Essential healthcare based on practical, scientifically sound and socially acceptable methods made universally accessible to individuals and families in the community.</td>
</tr>
<tr>
<td>Primipara</td>
<td>Pregnant woman who has had no previous pregnancy resulting in a live birth or a still birth.</td>
</tr>
<tr>
<td>Public hospital</td>
<td>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 can provide (and charge for) treatment and accommodation services to private patients. Charges to non-admitted patients and admitted patients on discharge can be levied in accordance with the Australian Health Care Agreements (for example, aids and appliances).</td>
</tr>
<tr>
<td>Puerperium</td>
<td>The period or state of confinement after labour.</td>
</tr>
<tr>
<td>Real expenditure</td>
<td>Actual expenditure adjusted for changes in prices.</td>
</tr>
<tr>
<td>Relative stay index</td>
<td>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.</td>
</tr>
<tr>
<td>Same day patients</td>
<td>A patient whose admission date is the same as the separation date.</td>
</tr>
<tr>
<td>Sentinel events</td>
<td>Adverse events that cause serious harm to patients and that have the potential to undermine public confidence in the healthcare system.</td>
</tr>
<tr>
<td>Separation</td>
<td>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).</td>
</tr>
<tr>
<td>Separation rate</td>
<td>Hospital separations per 1000 people or 100 000 people.</td>
</tr>
<tr>
<td>Selected primiparae</td>
<td>Primiparae with no previous deliveries, aged 25–29 years, singleton, vertex presentation and gestation of 37–41 weeks (inclusive).</td>
</tr>
<tr>
<td>Subacute care</td>
<td>Interdisciplinary therapeutic clinically-intense and goal-directed care in which the need for care depends primarily on the patient’s functional status and quality of life rather than the underlying medical diagnosis or the patient’s prospects of recovery from illness. Subacute care includes rehabilitation, palliative care and some mental health care, as well as geriatric evaluation and management.</td>
</tr>
</tbody>
</table>
and psychogeriatric care. Common to all is the patient no longer meets criteria for classification as ‘acute’, but still requires therapeutic, clinically-intense and goal-directed care.

**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).

**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 can 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.
List of attachment tables

Attachment tables are identified in references throughout this chapter by a ‘10A’ prefix (for example, table 10A.1). Attachment tables are available from the Review website (www.pc.gov.au/gsp).

Table 10A.1 Recurrent expenditure, public hospitals (including psychiatric hospitals), (2010-11 dollars, million)
Table 10A.2 Recurrent expenditure, public hospitals, by source of funding, (2010-11 dollars)
Table 10A.3 Recurrent expenditure per person, public hospitals (including psychiatric) (2010-11 dollars)
Table 10A.4 Public hospitals (including psychiatric hospitals) by hospital size
Table 10A.5 Available beds per 1000 people, by region, public hospitals (including psychiatric) (number)
Table 10A.6 Summary of separations, public hospitals
Table 10A.7 Separations, public (non-psychiatric) hospitals
Table 10A.8 Separations, public (non-psychiatric) hospitals
Table 10A.9 Separations in public hospitals, by age group
Table 10A.10 Separations by hospital sector and Indigenous status of patient
Table 10A.11 Separations per 1000 people, by Indigenous status of patient (number)
Table 10A.12 Average full time equivalent (FTE) staff per 1000 persons, public hospitals (including psychiatric hospitals)
Table 10A.13 Separations, by type of episode of care, public hospitals (including psychiatric), 2010-11
Table 10A.14 Australian refined diagnosis related groups (AR-DRGs) version 6.0 with the highest number of overnight acute separations, public hospitals, 2010-11
Table 10A.15 Top 10 AR-DRGs (version 6.0) with the most patient days, excluding same day separations, public hospitals, 2010-11
Table 10A.16 Non-admitted patient occasions of service, by type of non-admitted patient care, public hospitals, 2010-11
Table 10A.17 Emergency department waiting times, by triage category, public hospitals
Table 10A.18 Patients treated within national benchmarks for emergency department waiting time, by hospital peer group, by State and Territory
Table 10A.19 Patients treated within national benchmarks for emergency department waiting time, by Indigenous status, by State and Territory
Table 10A.20 Patients treated within national benchmarks for emergency department waiting time, by remoteness, by State and Territory
| Table 10A.21 | Elective surgery waiting times for patients admitted from waiting lists, by hospital peer group, public hospitals |
| Table 10A.22 | Elective surgery waiting times, by specialty of surgeon |
| Table 10A.23 | Waiting times for elective surgery in public hospitals, by Indigenous status and procedure, by State and Territory (days) |
| Table 10A.24 | Waiting times for elective surgery in public hospitals, by remoteness area, by State and Territory, 2010-11 (days) |
| Table 10A.25 | Elective surgery waiting times, by indicator procedure |
| Table 10A.26 | NSW elective surgery waiting times by clinical urgency category, public hospitals (per cent) |
| Table 10A.27 | NSW elective surgery waiting times, public hospitals, by clinical urgency category and surgical specialty, 2010-11 |
| Table 10A.28 | Victorian elective surgery waiting times by clinical urgency category, public hospitals (per cent) |
| Table 10A.29 | Victorian elective surgery waiting times, public hospitals, by clinical urgency category and surgical specialty, 2010-11 |
| Table 10A.30 | Queensland elective surgery waiting times, by clinical urgency category, public hospitals (per cent) |
| Table 10A.31 | Queensland elective surgery waiting times, public hospitals, by clinical urgency category and surgical specialty, 2010-11 |
| Table 10A.32 | WA elective surgery waiting times, by clinical urgency category, public hospitals (per cent) |
| Table 10A.33 | WA elective surgery waiting times, public hospitals, by clinical urgency category and surgical specialty, 2010-11 |
| Table 10A.34 | SA elective surgery waiting times, by clinical urgency category, public hospitals |
| Table 10A.35 | SA elective surgery waiting times, public hospitals, by clinical urgency category and surgical specialty, 2010-11 |
| Table 10A.36 | Tasmanian elective surgery waiting times, by clinical urgency category, public hospitals |
| Table 10A.37 | Tasmania elective surgery waiting times, public hospitals, by clinical urgency category and surgical specialty, 2010-11 |
| Table 10A.38 | ACT elective surgery waiting times, by clinical urgency category, public hospitals |
| Table 10A.39 | ACT elective surgery waiting times, public hospitals, by clinical urgency category and surgical specialty, 2010-11 |
| Table 10A.40 | NT elective surgery waiting times, by clinical urgency category, public hospitals |
| Table 10A.41 | NT elective surgery waiting times, public hospitals, by clinical urgency category and surgical specialty, 2010-11 |
| Table 10A.42 | Separation statistics for selected hospital procedures, all hospitals, states and territories, 2010-11 |
| Table 10A.43 | Unplanned hospital readmissions rates, per 1000 separations |
Table 10A.44  Unplanned hospital readmission rates, by State and Territory, by Indigenous status, hospital peer group, remoteness and SEIFA IRSD quintiles, 2010-11
Table 10A.45  Proportion of accredited beds in public hospitals (per cent)
Table 10A.46  Episodes of Staphylococcus aureus (including MRSA) bacteraemia (SAB) in acute care hospitals, by State and Territory, by MRSA and MSSA, 2011-12
Table 10A.47  Separations with an adverse event, public hospitals
Table 10A.48  Nursing workforce (includes midwives), by age group and region
Table 10A.49  Nursing workforce (includes midwives), by age group
Table 10A.50  Medical practitioner workforce, by age group and region
Table 10A.51  Medical practitioner workforce, by age group
Table 10A.52  Recurrent cost per casemix-adjusted separation, selected public acute hospitals 2010-11
Table 10A.53  Costs and utilisation by hospital peer group, public hospitals, 2010-11
Table 10A.54  Capital cost per casemix-adjusted separation — indicative estimates for inpatient services at major public acute hospitals, 2010-11
Table 10A.55  Relative stay index for patients in public hospitals, by patient election status 2010-11
Table 10A.56  Relative stay index, indirectly standardised, patients in public hospitals, by medical, surgical and other type of diagnosis related group 2010-11
Table 10A.57  NSW recurrent cost per non-admitted patient occasion of service, public hospitals
Table 10A.58  Victorian recurrent cost per encounter, public hospitals
Table 10A.59  WA recurrent cost per non-admitted patient occasion of service, public hospitals
Table 10A.60  SA recurrent cost per non-admitted patient occasion of service, public hospitals
Table 10A.61  Tasmania recurrent cost per non-admitted patient occasion of service, public hospitals
Table 10A.62  ACT recurrent cost per non-admitted patient occasion of service, public hospitals
Table 10A.63  Emergency department number of presentations and actual average cost per presentation
Table 10A.64  Emergency department presentation by Urgency Related Groupings (URG) codes - presentations and average cost per presentation, 2009-10
Table 10A.65  Non-admitted clinic number of occassions of service and actual average cost per occasion of service
Table 10A.66  Proportion of persons who went to an emergency department in the last 12 months reporting the ED doctors or specialists always or often: listened carefully, showed respect, and spent enough time with them, by State and Territory, by remoteness, 2011-12
Table 10A.67  Proportion of persons who went to an emergency department in the last 12 months reporting the ED doctors or specialists always or often: listened carefully, showed respect, and spent enough time with them, by remoteness, 2011-12
<table>
<thead>
<tr>
<th>Table 10A.68</th>
<th>Proportion of persons who went to an emergency department in the last 12 months reporting the ED nurses always or often: listened carefully, showed respect, and spent enough time with them, by remoteness, by State and Territory, 2011-12</th>
</tr>
</thead>
<tbody>
<tr>
<td>Table 10A.69</td>
<td>Proportion of persons who went to an emergency department in the last 12 months reporting the ED nurses always or often: listened carefully, showed respect, and spent enough time with them, by remoteness, 2011-12</td>
</tr>
<tr>
<td>Table 10A.70</td>
<td>Proportion of persons who were admitted to hospital in the last 12 months reporting the hospital doctors or specialists always or often: listened carefully, showed respect, and spent enough time with them, by remoteness, by State and Territory, 2011-12</td>
</tr>
<tr>
<td>Table 10A.71</td>
<td>Proportion of persons who were admitted to hospital in the last 12 months reporting the hospital doctors or specialists always or often: listened carefully, showed respect, and spent enough time with them, by remoteness, 2011-12</td>
</tr>
<tr>
<td>Table 10A.72</td>
<td>Proportion of persons who were admitted to hospital in the last 12 months reporting the hospital nurses always or often: listened carefully, showed respect, and spent enough time with them, by State and Territory, by remoteness, 2011-12</td>
</tr>
<tr>
<td>Table 10A.73</td>
<td>Proportion of persons who were admitted to hospital in the last 12 months reporting the hospital nurses always or often: listened carefully, showed respect, and spent enough time with them, by remoteness, 2011-12</td>
</tr>
<tr>
<td>Table 10A.74</td>
<td>NSW patient evaluation of hospital services</td>
</tr>
<tr>
<td>Table 10A.75</td>
<td>Victorian patient evaluation of hospital services</td>
</tr>
<tr>
<td>Table 10A.76</td>
<td>Queensland patient evaluation of hospital services</td>
</tr>
<tr>
<td>Table 10A.77</td>
<td>WA patient evaluation of hospital services</td>
</tr>
<tr>
<td>Table 10A.78</td>
<td>SA patient evaluation of hospital services</td>
</tr>
<tr>
<td>Table 10A.79</td>
<td>Tasmanian patient evaluation of hospital services</td>
</tr>
<tr>
<td>Table 10A.80</td>
<td>ACT patient evaluation of hospital services</td>
</tr>
<tr>
<td>Table 10A.81</td>
<td>NT patient evaluation of hospital services</td>
</tr>
<tr>
<td>Table 10A.82</td>
<td>NSW selected sentinel events (number)</td>
</tr>
<tr>
<td>Table 10A.83</td>
<td>Victoria selected sentinel events (number)</td>
</tr>
<tr>
<td>Table 10A.84</td>
<td>Queensland selected sentinel events (number)</td>
</tr>
<tr>
<td>Table 10A.85</td>
<td>WA selected sentinel events (number)</td>
</tr>
<tr>
<td>Table 10A.86</td>
<td>SA selected sentinel events (number)</td>
</tr>
<tr>
<td>Table 10A.87</td>
<td>Tasmania selected sentinel events (number)</td>
</tr>
<tr>
<td>Table 10A.88</td>
<td>ACT selected sentinel events (number)</td>
</tr>
<tr>
<td>Table 10A.89</td>
<td>NT selected sentinel events (number)</td>
</tr>
<tr>
<td>Table 10A.90</td>
<td>Australia selected sentinel events (number)</td>
</tr>
<tr>
<td>Table 10A.91</td>
<td>Separations, same day separations, patient days, average length of stay and costs for MDC 14 and MDC 15, public hospitals, Australia, 2010-11</td>
</tr>
<tr>
<td>Table 10A.92</td>
<td>Separations by major diagnostic category (AR-DRGs) version 6.0, public hospitals, 2010-11</td>
</tr>
</tbody>
</table>
Table 10A.93  10 Diagnosis related groups with highest cost, by volume, public hospitals, Australia, 2010-11
Table 10A.94  Intervention rates for selected primiparae, 2011
Table 10A.95  Intervention rates for selected primiparae, NSW
Table 10A.96  Intervention rates for selected primiparae, Victoria
Table 10A.97  Intervention rates for selected primiparae, Queensland
Table 10A.98  Intervention rates for selected primiparae, WA
Table 10A.99  Intervention rates for selected primiparae, SA
Table 10A.100 Intervention rates for selected primiparae, Tasmania
Table 10A.101 Intervention rates for selected primiparae, ACT
Table 10A.102 Intervention rates for selected primiparae, NT
Table 10A.103  Multiparous mothers who have had a previous caesarean section by current method of birth
Table 10A.104  Perineal status after vaginal births
Table 10A.105  Separations, patient days, ALOS and estimated cost per separation for selected maternity AR-DRG (version 6.0) in selected public hospitals, 2009-10
Table 10A.106  Baby's Apgar scores at five minutes, by birthweight, public hospitals
Table 10A.107  Fetal deaths
Table 10A.108  Neonatal deaths
Table 10A.109  Neonatal, fetal and perinatal death rates, Australia
Table 10A.110  Perinatal deaths
Table 10A.111  Perinatal, neonatal and fetal deaths
10.10 References

ABS (Australian Bureau of Statistics) 2004, Deaths, Australia 2003, Cat. no. 3302.0, Canberra.


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


—— 2009b, Health expenditure Australia 2007–08, AIHW Cat. no. HWE 37, Health and Welfare Expenditure Series No.30, Canberra.


—— 2011b, Health expenditure Australia 2009–10, Health and Welfare Expenditure Series No. 46, Cat. no. HWE 55. Canberra, AIHW.

—— 2012b, Health expenditure Australia 2010–11, Health and Welfare Expenditure Series No. 47, Cat. no. HWE 56. Canberra, AIHW.


AIHW (Australian Institute of Health and Welfare) and ACSQHC (Australian Commission on Safety and Quality in Health Care) 2007, Sentinel events in Australian public hospitals 2004–05, Cat. no. HSE. 51 Canberra: AIHW.


Primary and community health services include general practice, allied health services, dentistry, alcohol and other drug treatment, maternal and child health, the Pharmaceutical Benefits Scheme (PBS) and a range of other community health services. Reporting in this chapter focuses mainly on general practice, primary healthcare services targeted to Indigenous Australians, public dental services, drug and alcohol treatment and the PBS. The scope of this chapter does not extend to:

- public hospital emergency departments and outpatient services (reported in chapter 10, ‘Public hospitals’)
- community mental health services (reported in chapter 12, ‘Mental health management’)
- Home and Community Care program services (reported in chapter 13, ‘Aged care’ and chapter 14, ‘Services for people with a disability’).
The primary and community health sector is the part of the healthcare system most frequently used by Australians. It is important in preventative healthcare and in the detection and management of illness and injury, through direct service provision and through referral to acute (hospital) or other healthcare services, as appropriate.

Major improvements in reporting on primary and community health in this edition include:

- data are available for the first time for reporting against ‘public dentistry waiting times’
- improved data for reporting of ‘management of acute upper respiratory tract infection’
- reporting time series for the first time for some indicators, and extending time series for several others
- data quality information (DQI) available for the first time for the indicators ‘use of pathology tests and diagnostic imaging’ and ‘cost to government of general practice per person’.

11.1 Profile of primary and community health

Definitions, roles and responsibilities

Primary and community healthcare services are delivered by a range of health and allied health professionals in various private, not-for-profit and government service settings. Those funded largely by governments include general practice, community health services, the PBS and public dental services. The Australian Government provides some funding for private dental and allied health services through the private health insurance rebate and, through the Department of Human Services, Medicare (DHS, Medicare), for people with long-term health conditions and/or mental health problems. Funding of private dental services for people with long-term health conditions through DHS, Medicare ceased 1 December 2012.

Definitions for common health terms are provided in section 11.5.

General practice

General practice is a major provider of primary healthcare in Australia. It is defined by the Royal Australian College of General Practitioners (RACGP) as providing ‘person centred, continuing, comprehensive and coordinated whole person health..."
care to individuals and families in their communities’ (RACGP 2011). General practice is the business structure within which one or more general practitioners (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 GPs or corporate entities.

General practitioners must be registered with the Medical Board of Australia. General practice data reported in this chapter relate mainly to services provided by those general practitioners who are recognised for Medicare as defined below:

- vocationally registered GPs — GPs who are recognised under s.3F of the *Health Insurance Act 1973* (Cwlth), hold Fellowship of the RACGP or equivalent, or hold a recognised training placement
- other medical practitioners (OMP) — medical practitioners who are not vocationally registered GPs.

Services provided in general practice include:

- diagnosis and treatment of illness (both chronic and acute) and injury
- preventative care through to palliative care
- referrals to consultants, allied health professionals, community health services and hospitals.

The Australian Government provides the majority of general practice income through DHS, Medicare, including fee-for-service payments via the Medicare Benefits Schedule (MBS) and other payments. Through its funding role, the Australian Government seeks to influence the supply, regional distribution and quality of general practice services. State and Territory governments also provide some funding to influence general practice services, particularly regional distribution, within jurisdictions.

While the majority of GPs provide services as part of a general practice, some are employed by hospitals, community health services or other organisations.

*Pharmaceutical Benefits Scheme and Repatriation Pharmaceutical Benefits Scheme*

The Australian Government subsidises the cost of around 80 per cent of prescription medicines through the PBS (DoHA 2010). The PBS aims to provide affordable, reliable and timely access to prescription medicines for all Australians. Users make a co-payment, which in 2012 was $5.80 for concession card holders and up to $35.40 for general consumers (DoHA 2012a). The Australian Government pays the
remaining cost of medicines eligible for the subsidy. Co-payment amounts are normally adjusted by the rate of inflation on 1 January each year. (DoHA 2012a).

Co-payments are also subject to a safety net threshold. Once consumer spending within a calendar year has reached the threshold, PBS medicines are generally cheaper or fully subsidised for the rest of the calendar year. The 2012 safety net threshold was $1363.30 for general consumers and $348.00 for concession card holders (DoHA 2012a).

The Repatriation Pharmaceutical Benefits Scheme (RPBS) provides subsidised pharmaceutical medicines, dressings and other items to war veterans and war widows. The RPBS is administered by the Department of Veterans’ Affairs (DVA). Drugs eligible for subsidy under the RPBS may not be eligible under the PBS.

Community health services

Community health services usually comprise multidisciplinary teams of salaried health and allied health professionals, who aim to protect and promote the health of particular communities (Quality Improvement Council 1998). The services may be provided directly by governments (including local governments) or indirectly, through a local health service or community organisation funded by government. State and Territory governments are responsible for most community health services. The Australian Government’s main role in the community health services covered in this chapter is in health services for Indigenous Australians. In addition, the Australian Government provides targeted support to improve access to community health services in rural and remote areas. There is no national strategy for community health and there is considerable variation in the services provided across jurisdictions.

Allied health services

Allied health services include, but are not limited to, physiotherapy, psychology, occupational therapy, audiology, podiatry and osteopathy. While some allied health professionals are employed in community health services, allied health services are delivered mainly in the private sector. Governments provide some funding for private allied health services through insurance schemes and private insurance rebates. The Australian Government also makes some allied health services available under the MBS to patients with chronic conditions and complex care needs, and improves access to allied health services in rural and remote areas.
Dental services

The Australian Government and the State and Territory governments have different roles in supporting dental services in Australia’s mixed system of public and private dental healthcare. State and Territory governments have the main responsibility for the delivery of major public dental programs, primarily directed at children and disadvantaged adults. The Australian Government supports the provision of dental services primarily through the private health insurance rebate and, through DHS, Medicare, for a limited range of oral surgical procedures. Private dental services were also funded through DHS, Medicare for people with chronic conditions and complex care needs until 1 December 2012. In addition, the Australian Government provides funding for the dental care of war veterans and members of the Australian Defence Force and has a role in the provision of dental services through Indigenous Primary Health Care Services. 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

The Australian Government funds the majority of general practice services, primarily through DHS, Medicare and the DVA. The remainder comes from insurance schemes, patient contributions, and State and Territory government programs. The annual Bettering the Evaluation and Care of Health (BEACH) survey of general practice activity in Australia found that 95.0 per cent of all general practice encounters in 2011-12 were for services at least partly funded by DHS, Medicare or the DVA (Britt et al. 2012) (table 11.1).
Table 11.1  General practice encounters and funding sources, April 2011 to March 2012a, b

<table>
<thead>
<tr>
<th>Numberc</th>
<th>Per cent of all encountersd</th>
<th>95% LCL</th>
<th>95% UCL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total encounters for which BEACH data were recordedb</td>
<td>91 956</td>
<td>100.0</td>
<td>..</td>
</tr>
<tr>
<td>Direct encounters</td>
<td>90 429</td>
<td>98.3</td>
<td>98.1</td>
</tr>
<tr>
<td>No charge</td>
<td>450</td>
<td>0.5</td>
<td>0.3</td>
</tr>
<tr>
<td>DHS, Medicare or DVA paid</td>
<td>87 264</td>
<td>94.9</td>
<td>94.4</td>
</tr>
<tr>
<td>Workers compensation paid</td>
<td>1 853</td>
<td>2.0</td>
<td>1.8</td>
</tr>
<tr>
<td>Other paid (for example, hospital, State)</td>
<td>862</td>
<td>0.9</td>
<td>0.7</td>
</tr>
<tr>
<td>Indirect encountersf</td>
<td>1 522</td>
<td>1.7</td>
<td>1.4</td>
</tr>
</tbody>
</table>

LCL = lower confidence limit. UCL = upper confidence limit. DHS = Department of Human Services. DVA = Department of Veterans’ Affairs. a  An encounter is any professional interchange between a patient and a GP or other health professional (other health professionals include practice nurses, Aboriginal health workers and allied health service professionals). b Data from the BEACH survey may not be directly comparable with other data on medical practitioners in this Report. c Number of encounters after post stratification weighting for GP activity and GP age and sex. d Missing data removed from analysis (n = 7074). e Includes 5 encounters for which direct/indirect was not specified. f For indirect encounters, the patient is not seen but a service is provided (for example, a prescription or referral). .. Not applicable.


The Australian Government also provides funding for general practice services under initiatives such as:

- the Practice Incentives Program (PIP)
- the General Practice Immunisation Incentives Scheme (GPII)
- the Divisions of General Practice Program (DGPP) — from 30 June 2012, Medicare Locals assumed responsibility for general practice support initiatives previously funded under the DGPP.

Australian Government expenditure on general practice in 2011-12 was $6.7 billion, or $299 per person (figure 11.36, table 11A.2).

Not all Australian Government funding of primary healthcare services is captured in these data. Funding is also provided for services delivered in non-general practice settings, particularly in rural and remote areas, for example, in hospital emergency departments, Indigenous primary healthcare and other community health services and the Royal Flying Doctor Service. Thus, expenditure on general practice understates expenditure on primary healthcare, particularly in jurisdictions with large populations of Indigenous Australians and people living in rural and remote areas.
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, workers compensation and third party insurance) and private individuals — also provide payments to GPs.

Pharmaceutical Benefits Scheme and Repatriation Pharmaceutical Benefits Scheme

Australian Government expenditure on the PBS and RPBS was around $8.0 billion in 2011-12. Expenditure on the PBS was around $7.5 billion — or $335 per person — in 2011-12, of which 77.8 per cent was for concessional patients (table 11.2). Government expenditure on pharmaceuticals data are also presented in the Health sector overview.

Table 11.2  PBS and RPBS expenditure, 2011-12 ($ million)a

<table>
<thead>
<tr>
<th></th>
<th>NSW</th>
<th>Vic</th>
<th>Qld</th>
<th>WA</th>
<th>SA</th>
<th>Tas</th>
<th>ACT</th>
<th>NT</th>
<th>Aust</th>
</tr>
</thead>
<tbody>
<tr>
<td>PBS generalb</td>
<td>538.6</td>
<td>400.3</td>
<td>322.0</td>
<td>200.3</td>
<td>118.9</td>
<td>37.5</td>
<td>34.3</td>
<td>10.0</td>
<td>1 661.9</td>
</tr>
<tr>
<td>PBS concessiona</td>
<td>2 040.2</td>
<td>1 450.3</td>
<td>1 127.5</td>
<td>1 127.5</td>
<td>503.4</td>
<td>170.8</td>
<td>754.1</td>
<td>15.7</td>
<td>5 866.3</td>
</tr>
<tr>
<td>PBS doctor’s bag</td>
<td>4.3</td>
<td>3.3</td>
<td>2.8</td>
<td>1.0</td>
<td>1.0</td>
<td>0.3</td>
<td>0.2</td>
<td>0.1</td>
<td>13.0</td>
</tr>
<tr>
<td>PBS totald</td>
<td>2 583.1</td>
<td>1 853.9</td>
<td>1 452.3</td>
<td>503.4</td>
<td>170.8</td>
<td>754.1</td>
<td>15.7</td>
<td>5 866.3</td>
<td></td>
</tr>
<tr>
<td>RPBS totale</td>
<td>156.3</td>
<td>88.7</td>
<td>108.3</td>
<td>35.8</td>
<td>33.5</td>
<td>13.6</td>
<td>6.8</td>
<td>0.9</td>
<td>444.0</td>
</tr>
<tr>
<td>PBS and RPBS Total</td>
<td>2 739.4</td>
<td>1 942.6</td>
<td>1 560.7</td>
<td>736.8</td>
<td>656.8</td>
<td>222.3</td>
<td>98.7</td>
<td>27.9</td>
<td>7 985.1</td>
</tr>
<tr>
<td>PBS $ per personf</td>
<td>355.8</td>
<td>332.0</td>
<td>321.2</td>
<td>293.2</td>
<td>378.3</td>
<td>247.5</td>
<td>116.1</td>
<td>334.8</td>
<td></td>
</tr>
</tbody>
</table>

a State and Territory data are only available on a cash basis for general and concessional categories. Data 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 s.100 of the National Health Act 1953 [Cwlth]). b Includes PBS general ordinary and safety net. c Includes PBS concessional ordinary and concessional free safety net. d Funding for supplies to prescribers for use in a medical emergency. e Includes RPBS general ordinary and safety net. f Excludes PBS doctor’s bag.


Community health services

Overall government expenditure data relating only to the services covered in this chapter are not available. Expenditure data reported here also cover services such as
food safety regulation and media campaigns to promote health awareness, as well as private dental services (funded by health insurance premium rebates and non-government expenditure) (table 11.3).

In 2010-11, government expenditure on community and public health was $7.9 billion, of which State, Territory and local governments provided 73.8 per cent, and the Australian Government 26.2 per cent (table 11.3). In that year, Australian Government direct outlay expenditure on dental services, predominantly through the DVA and DoHA, was $908 million. State, Territory and local government expenditure on dental services was $699 million in 2010-11. Additional expenditure is incurred by some states and territories through schemes that fund the provision of dental services to eligible people by private practitioners.

Table 11.3 **Estimated funding on community and public health, and dental services, 2010-11 ($ million)**

<table>
<thead>
<tr>
<th></th>
<th>DVA</th>
<th>DoHA and other&lt;sup&gt;a&lt;/sup&gt; Insurance premium rebates&lt;sup&gt;b&lt;/sup&gt;</th>
<th>Total&lt;sup&gt;c&lt;/sup&gt;</th>
<th>State, Territory and local government</th>
<th>Total&lt;sup&gt;c&lt;/sup&gt; Non-government</th>
<th>Total government and non-government&lt;sup&gt;c&lt;/sup&gt;</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community and public health&lt;sup&gt;d&lt;/sup&gt;</td>
<td>1 2066</td>
<td>– 2 068</td>
<td>5 822</td>
<td>7 890</td>
<td>351</td>
<td>8 242</td>
</tr>
<tr>
<td>Dental services</td>
<td>105</td>
<td>803</td>
<td>528</td>
<td>1 437</td>
<td>699</td>
<td>2 136</td>
</tr>
</tbody>
</table>

<sup>a</sup> ‘Other’ comprises Australian Government expenditure on the NHA and health-related NPs, capital consumption, estimates of the medical expenses tax offset and health research not funded by DoHA.  
<sup>b</sup> Government expenditure on insurance premium rebates relates to private health and dental services that are not within the scope of this chapter.  
<sup>c</sup> Totals may not add due to rounding.  
<sup>d</sup> Includes expenditure on other recurrent health services (not elsewhere classified) in addition to expenditure on community and public health services. – Nil or rounded to zero.  

*Source: AIHW (2012) Health Expenditure Australia 2010-11, Cat. no. HWE 56.*

**Size and scope**

**General practice**

There were 29 011 vocationally registered GPs and OMPs billing Medicare Australia, based on MBS claims data, in 2011-12. On a full time workload equivalent (FWE) basis, there were 21 119 vocationally registered GPs and OMPs (see section 11.5 for a definition of FWE). This was equal to 93.9 FWE registered GPs and OMPs per 100 000 people (table 11A.5). These data exclude services
provided by GPs working in Indigenous primary healthcare services, public hospitals and the Royal Flying Doctor Service. In addition, for some GPs — particularly in rural areas — MBS claims provide income 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 DHS, Medicare. The numbers of FWE vocationally registered 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)**

![Bar chart showing availability of GPs from 2007-08 to 2011-12 by jurisdiction]

*a  Data include vocationally registered GPs and OMPs billing Medicare who are allocated to a jurisdiction based on the postcode of their major practice.  
*b  Historical data may differ from data in previous reports due to a change in the methodology used to derive population estimates.


Nationally, around 5763 general practitioner-type services were provided per 1000 population under DHS, Medicare in 2011-12 (figure 11.2).
GP type service use\textsuperscript{a, b}

\begin{figure}
\centering
\includegraphics[width=\textwidth]{gp_type_service_use}
\caption{GP type service use\textsuperscript{a, b}}
\end{figure}

\textsuperscript{a} Rates are age standardised to the Australian population at 30 June 2001 for 2010-11 and previous years. Data for 2011-12 are preliminary and are not directly comparable with data for previous years. \textsuperscript{b} Includes non-referred attendances by vocationally registered GPs and OMPs, and practice nurses.


\textbf{Pharmaceutical Benefits Scheme and Repatriation Pharmaceutical Benefits Scheme}

Around 195 million services — 86.5 per cent of them concessional — were provided under the PBS in 2011-12 (table 11.4). This amounted to 8.7 filled prescriptions per person. A further 13 million services were provided under the RPBS in the same period.
### Table 11.4  PBS and RPBS services, 2011-12 (million services)

<table>
<thead>
<tr>
<th></th>
<th>NSW</th>
<th>Vic</th>
<th>Qld</th>
<th>WA</th>
<th>SA</th>
<th>Tas</th>
<th>ACT</th>
<th>NT</th>
<th>Aust</th>
</tr>
</thead>
<tbody>
<tr>
<td>PBS generala</td>
<td>8.5</td>
<td>6.3</td>
<td>5.2</td>
<td>2.9</td>
<td>1.9</td>
<td>0.6</td>
<td>0.6</td>
<td>0.2</td>
<td>26.1</td>
</tr>
<tr>
<td>PBS concessionalb</td>
<td>57.2</td>
<td>42.8</td>
<td>32.7</td>
<td>14.2</td>
<td>14.6</td>
<td>5.0</td>
<td>1.6</td>
<td>0.5</td>
<td>168.5</td>
</tr>
<tr>
<td>PBS doctor's bagc</td>
<td>0.1</td>
<td>0.1</td>
<td>0.1</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>0.3</td>
</tr>
<tr>
<td><strong>PBS total</strong></td>
<td>65.9</td>
<td>49.2</td>
<td>37.9</td>
<td>17.1</td>
<td>16.4</td>
<td>5.6</td>
<td>2.1</td>
<td>0.6</td>
<td>194.9</td>
</tr>
<tr>
<td>RPBS totald</td>
<td>4.4</td>
<td>2.8</td>
<td>3.1</td>
<td>1.0</td>
<td>1.0</td>
<td>0.4</td>
<td>0.2</td>
<td>–</td>
<td>13.0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>70.3</td>
<td>52.0</td>
<td>41.0</td>
<td>18.1</td>
<td>17.5</td>
<td>6.0</td>
<td>2.3</td>
<td>0.7</td>
<td>207.8</td>
</tr>
<tr>
<td>PBS services per person e</td>
<td>9.1</td>
<td>8.8</td>
<td>8.4</td>
<td>7.2</td>
<td>10.0</td>
<td>10.9</td>
<td>5.7</td>
<td>2.8</td>
<td>8.7</td>
</tr>
</tbody>
</table>

a Includes PBS general ordinary and safety net. b Includes PBS concessional ordinary and concessional free safety net. c Supplies to prescribers for use in a medical emergency. d Includes RPBS general ordinary and safety net. e Excludes PBS doctor’s bag. – Nil or rounded to zero.

Source: DoHA (unpublished) PBS Statistics; tables 11A.7 and 11A.8.

### Community health services

The range of community health services available varies considerably across jurisdictions. Tables 11A.88–11A.96 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 (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 (Mental health management) and 13 (Aged care services).

### 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 (tables 11A.88–11A.96).

State and Territory governments also provide some general dental services and a limited range of specialist dental services to disadvantaged adults who are 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). Most jurisdictions provided public dental services in 2011-12 targeted at disadvantaged people (tables 11A.88–11A.96). As updated data were not available for use of public dental services for the 2013 Report, data for 2010 are reported again.

Nationally, 74.4 public dental services were provided per 1000 people in 2010. Of these, around 19.5 per cent were emergency services (table 11.5).

Table 11.5 Use of public dental services by service type, per 1000 people, 2010a, b, c, d

<table>
<thead>
<tr>
<th>Service Type</th>
<th>NSW</th>
<th>Vic</th>
<th>Qld</th>
<th>WA</th>
<th>SA</th>
<th>Tas</th>
<th>ACT</th>
<th>NT</th>
<th>Aust</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency services</td>
<td>9.6</td>
<td>10.4</td>
<td>26.9</td>
<td>12.4</td>
<td>13.3</td>
<td>29.3</td>
<td>14.6</td>
<td>25.6</td>
<td>14.5</td>
</tr>
<tr>
<td>General services</td>
<td>34.1</td>
<td>45.0</td>
<td>71.0</td>
<td>113.6</td>
<td>84.1</td>
<td>106.2</td>
<td>81.7</td>
<td>157.7</td>
<td>59.9</td>
</tr>
<tr>
<td>All services</td>
<td>43.7</td>
<td>55.4</td>
<td>97.9</td>
<td>126.0</td>
<td>97.3</td>
<td>135.4</td>
<td>96.3</td>
<td>183.3</td>
<td>74.4</td>
</tr>
</tbody>
</table>

a Rates are age standardised to the Australian population at 30 June 2001. b Limited to dentate people aged 5 years or over. c Data are for the number of people who used a public dental service at least once in the preceding 12 months, not for the number of services provided. d Type of service at the most recent visit. e Emergency visit is a visit for relief of pain.


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 (AODTS–NMDS) — a collection of data from publicly funded government and non-government treatment services (AIHW 2012a). Treatment activities excluded from that collection include treatment with medication for dependence on opioid drugs such as heroin (opioid pharmacotherapy treatment) where no other treatment is provided, the majority of services for Indigenous Australians 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 666 alcohol and other drug treatment agencies reported 2010-11 data to the AODTS–NMDS. Of these, 309 (46.4 per cent) identified as government providers and 357 (53.6 per cent) as non-government providers (table 11A.10). There were 150 488 reported closed treatment episodes in 2010-11 (see section 11.5 for a definition of a closed treatment episode). Clients seeking treatment for their own substance use, 67.9 per cent of whom were male, accounted for 144 002 closed treatment episodes (AIHW 2012a).

Alcohol was the most commonly reported principal drug of concern in closed treatment episodes for clients seeking treatment for their own substance abuse (47.3 per cent). Cannabis was the next most common drug of concern (22.1 per cent), followed by heroin (9.3 per cent) and amphetamines (8.7 per cent) (AIHW 2012a). Further information on alcohol and other drug treatment services funded by governments is included in tables 11A.88–11A.96.

**Indigenous community healthcare services**

Indigenous Australians use a range of primary healthcare services, including private GPs 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 2011-12, 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.88–11A.96).

From the 2008-09 reporting period, data on Indigenous primary healthcare services that receive funding from the Australian Government have been collected through the Online Services Report (OSR) (previously the OATSIH Services Report)
questionnaire. Many of these services receive additional funding from State and Territory governments and other sources. The OSR data reported here represent the health-related activities, episodes and workforce funded from all sources.

For 2010-11, OSR data are reported for 235 Indigenous primary healthcare services (table 11A.11). Of these services, 90 (38.3 per cent) were located in remote or very remote areas (table 11A.12). 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.13). An episode of healthcare is defined in the OSR data collection as contact between an individual client and staff of a service to provide healthcare. Around 2.5 million episodes of healthcare were provided by participating services in 2010-11 (table 11.6). Of these, around 1.2 million (47.6 per cent) were in remote or very remote areas (table 11A.12).

Table 11.6  Estimated episodes of healthcare for Indigenous Australians by services for which OSR data are reported (‘000)¹

<table>
<thead>
<tr>
<th>Year</th>
<th>NSW</th>
<th>Vic</th>
<th>Qld</th>
<th>WA</th>
<th>SA</th>
<th>Tas</th>
<th>ACT</th>
<th>NT</th>
<th>Aust</th>
</tr>
</thead>
<tbody>
<tr>
<td>2008-09</td>
<td>452.1</td>
<td>160.2</td>
<td>335.7</td>
<td>305.7</td>
<td>191.3</td>
<td>34.7</td>
<td>23.2</td>
<td>593.0</td>
<td>2 095.9</td>
</tr>
<tr>
<td>2009-10</td>
<td>542.4</td>
<td>184.8</td>
<td>378.8</td>
<td>408.8</td>
<td>191.6</td>
<td>36.2</td>
<td>25.7</td>
<td>614.6</td>
<td>2 382.9</td>
</tr>
<tr>
<td>2010-11</td>
<td>521.8</td>
<td>200.5</td>
<td>309.7</td>
<td>473.1</td>
<td>221.8</td>
<td>37.7</td>
<td>29.7</td>
<td>703.8</td>
<td>2 498.1</td>
</tr>
</tbody>
</table>

¹ 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 and/or information by staff. Outreach provision is included, for example episodes at outstation visits, park clinics and satellite clinics. Episodes of healthcare delivered over the phone are included.

Source: AIHW (2012 and previous issues) Aboriginal and Torres Strait Islander health services report: OATSIH services reporting - key results, Cat. no.s IHW 31, 56 and 79; table 11A.11.

The services included in the OSR data collection employed around 3644 full time equivalent health staff (as at 30 June 2011). Of these, 1934 were Indigenous Australians (53.1 per cent). The proportions of doctors and nurses employed by surveyed services who were Indigenous Australians were relatively low (7.2 per cent and 9.1 per cent, respectively) (table 11A.14).

11.2 Framework of performance indicators

The performance indicator framework is based on shared government objectives for primary and community health (box 11.1). 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.
COAG has agreed six National Agreements to enhance accountability to the public for the outcomes achieved or outputs delivered by a range of government services (see chapter 1 for more detail on reforms to federal financial relations).

The National Healthcare Agreement (NHA) covers the areas of health and aged care services, and health indicators in the National Indigenous Reform Agreement establish specific outcomes for reducing the level of disadvantage experienced by Indigenous Australians. Both agreements include sets of performance indicators, for which the Steering Committee collates performance information for analysis by the COAG Reform Council (CRC). Performance indicators reported in this chapter are aligned with health performance indicators in the NHA. The NHA was reviewed in 2011 and 2012 resulting in changes that have been reflected in this Report, as relevant.

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

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

- providing a universally accessible point of entry to the healthcare system
- promoting health and preventing illness
- providing timely and high quality healthcare that meets individual needs, throughout the lifespan — directly, and/or by facilitating access to the appropriate service(s)
- coordinating service provision to ensure continuity of care where more than one service type, and/or ongoing service provision, is required to meet individuals’ healthcare needs.

In addition, governments aim to ensure that interventions provided by primary and community health services are based on best practice evidence and delivered in an equitable and efficient manner.

The performance indicator framework provides information on equity, efficiency and effectiveness, and distinguishes the outputs and outcomes of health services (figure 11.3). The performance indicator framework shows which data are comparable in the 2013 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 Report’s statistical appendix 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) (appendix A).

Figure 11.3 **Primary and community health performance indicator framework**

Key to indicators
- **Text** Data for these indicators are comparable, subject to caveats to each chart or table
- **Text** Data for these indicators are not complete and/or not directly comparable
- **Text** These indicators are yet to be developed or data are not collected for this Report
Data quality information (DQI) is being progressively introduced for all indicators in the Report. The purpose of DQI is to provide structured and consistent information about quality aspects of data used to report on performance indicators. DQI in this Report cover the seven dimensions in the ABS’ data quality framework (institutional environment, relevance, timeliness, accuracy, coherence, accessibility and interpretability) in addition to dimensions that define and describe performance indicators in a consistent manner, and note key data gaps and issues identified by the Steering Committee. All DQI for the 2013 Report can be found at www.pc.gov.au/gsp/reports/rogs/2013.

11.3 Key performance indicator results

Different delivery contexts, locations and client factors may affect the equity, effectiveness and efficiency of health services.

Outputs

Outputs are the 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. Access to primary and community health services can be affected through factors such as disability, socioeconomic circumstance, age, geographic distance, cultural issues and English language proficiency (see chapter 1). Such issues have contributed to the generally poor health status of Indigenous Australians relative to other Australians (SCRGSP 2011).

Access

Availability of PBS medicines

‘Availability of PBS medicines’ is an indicator of governments’ objective to provide equitable access to PBS medicines (box 11.2).
Box 11.2  **Availability of PBS medicines**

‘Availability of PBS medicines’ is defined by three measures:

- People per pharmacy by region, defined as the estimated resident population (ERP), divided by the number of pharmacies, in urban and in rural regions.
- PBS expenditure per person by region, defined as expenditure on PBS medicines, divided by the ERP, in urban and in rural regions.
- Proportion of PBS prescriptions filled at a concessional rate, defined as the number of PBS prescriptions filled at a concessional rate, divided by the total number of prescriptions filled.

This indicator is difficult to interpret. A low or decreasing number of people per pharmacy may indicate greater availability of PBS medicines. High or increasing PBS expenditure per person may indicate improved availability of PBS medicines. A high or increasing proportion of PBS prescriptions filled at a concessional rate may indicate improved availability of PBS prescriptions to disadvantaged people. It is also important that there are not large discrepancies in these measures by region.

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 residential geolocation or socioeconomic circumstance.

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

Data for this indicator are comparable.

Data quality information for this indicator is under development.

Access to PBS medicines is primarily governed by the distribution of pharmacies. Across Australia, there were 4082 people per pharmacy in urban areas and 4148 in rural areas in 2011-12. In most states and territories, the number of people per pharmacy was higher in rural areas than in urban areas (figure 11.4, table 11A.15).

Medical practitioners and hospitals can also be approved to supply PBS medicines to the community, improving access for people in some locations. There were 41 medical practitioners and 246 hospitals — 91 private and 155 public — approved to supply PBS medicines to the community in 2011-12. The approved medical practitioners and 51 of the approved public hospitals were located in rural areas (table 11A.15).

---

1 PBS approved private hospitals supply medicines to patients of the hospital (inpatients and outpatients), while public hospitals provide medicines only to patients on discharge.
Figure 11.4 **People per pharmacy**\(^{a,b}\)

![Graph showing people per pharmacy over years in different regions](image)

\(^{a}\) Geolocation based on the Pharmacy Access/Remoteness Index of Australia (PhARIA). Urban = PhARIA 1. Rural = PhARIA 2–6. The ACT has no rural PhARIA areas. \(^{b}\) Excludes RPBS and doctor’s bag.


Nationally, PBS expenditure per person increased from $319 in 2007-08 to $335 in 2011-12 (in 2011-12 dollars) (figure 11.5). PBS expenditure per person was lower in capital cities than in other metropolitan, rural and remote areas for the period.
Locality level data are only available on a cash basis for general and concessional categories. Data 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 s.100 of the *National Health Act 1953* [Cwlth]).


The proportion of PBS prescriptions filled at a concessional rate is reported by State and Territory in table 11A.7. These data are not available by regional location. Nationally, 86.5 per cent of prescriptions subsidised under the PBS were concessional in 2011-12.

**Equity of access to GPs**

‘Equity of access to GPs’ is an indicator of governments’ objective to provide equitable access to primary healthcare services (box 11.3).
**Box 11.3  Equity of access to GPs**

‘Equity of access to GPs’ is defined by two measures:

- availability of GPs by region, defined as the number of FWE GPs per 100 000 people, by region
- availability of female GPs, defined as the number of female FWE GPs, per 100 000 females.

High or increasing availability of GPs can indicate improved access to GP services. Low availability of GPs by region can be associated with an increase in distance travelled and waiting times to see a GP, and increased difficulty in booking long consultations. Reduced competition for patients can also reduce bulk billing rates. State and Territory governments seek to influence the availability of GPs through incentives to recruit and retain GPs in rural and remote areas.

High or increasing availability of female GPs means it is more likely that female patients who prefer to visit female GPs will have their preference met. Low availability of female GPs can similarly be associated with increased waiting times to see a GP, for women who prefer to discuss health matters with, and to receive primary healthcare from, a female GP.

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.

Data for this indicator are comparable.


---

**Equity of access to GPs — availability of GPs by region**

In terms of FWE GPs per 100 000 people, there were more GPs available in urban areas than in rural areas in almost all states and territories in 2011-12 (figure 11.6). The bulk billed proportion of non-referred attendances was lower in remote centres and, to a lesser extent, rural areas than in capital cities, other metropolitan centres and ‘other remote’ areas (table 11A.26).
Figure 11.6 Availability of GPs (full time workload equivalent), 2011-12a, b, c

<table>
<thead>
<tr>
<th>Year</th>
<th>NSW</th>
<th>Vic</th>
<th>Qld</th>
<th>WA</th>
<th>SA</th>
<th>Tas</th>
<th>ACT</th>
<th>NT</th>
<th>Aust</th>
</tr>
</thead>
<tbody>
<tr>
<td>2007-08</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2008-09</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2009-10</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2010-11</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2011-12</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

a Geographical locations are based on the Rural, Remote and Metropolitan Areas (RRMA) classification. 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 registered GPs and OMPs billing DHS, Medicare, who are allocated to a jurisdiction based on the postcode of their major practice. c The ACT has no rural areas.

Source: DoHA (unpublished) MBS Statistics; table 11A.17.

**Equity of access to GPs — availability of female GPs**

In 2011-12, 41.7 per cent of Australia’s GPs — 31.7 per cent of FWE GPs — were female (tables 11A.5 and 11A.18). The number of FWE GPs per 100 000 females increased from 49.8 to 59.3 in the period 2007-08 to 2011-12 (figure 11.7).
Availability of female GPs (full time workload equivalent)\textsuperscript{a}

\begin{figure}
\centering
\includegraphics[width=\textwidth]{figure11.7}
\caption{Availability of female GPs (full time workload equivalent)\textsuperscript{a}}
\end{figure}

\textsuperscript{a} Data relate to vocationally registered GPs and OMPs billing DHS, Medicare, who are allocated to a jurisdiction based on the postcode of their major practice.


Availability of public dentists

‘Availability of public dentists’ is an indicator of governments’ objective to provide equitable access to dental services (box 11.4).

\begin{box}
\textbf{Box 11.4 Availability of public dentists}

‘Availability of public dentists’ is defined as the number of full time equivalent (FTE) public dentists per 100 000 people by region.

High or increasing availability of public dentists can indicate improved access to public dental services. The availability 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.

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.

Data for this indicator are comparable.


\end{box}

Nationally, there were more FTE public dentists per 100 000 people in remote and very remote areas combined than in major cities or regional areas in
2011 (figure 11.8, table 11A.19). Data for FTE dental therapists are presented in table 11A.20.

Figure 11.8  Availability of public dentists, 2011\textsuperscript{a, b, c, d}

\begin{figure}[h]
\centering
\includegraphics[width=\textwidth]{figure11_8}
\caption{Availability of public dentists, 2011\textsuperscript{a, b, c, d}}
\end{figure}

\textsuperscript{a} FTE based on 40 hours per week. \textsuperscript{b} Public dentists include those working in public dental hospitals, school dental services, general dental services, defence forces, tertiary education and 'other public' areas. \textsuperscript{c} 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. \textsuperscript{d} Tasmania has no major cities. The ACT has no outer regional, or remote and very remote, areas. The NT has no major cities or inner regional areas.

Source: AIHW (unpublished) National Health Workforce Data Set; table 11A.19.

Early detection and early treatment for Indigenous Australians

‘Early detection and early treatment for Indigenous Australians’ is an indicator of governments’ objective to provide equitable access to primary and community healthcare services for Indigenous Australians (box 11.5).

Box 11.5  Early detection and early treatment for Indigenous Australians

‘Early detection and early treatment for Indigenous Australians’ is defined as:
- the identification of individuals who are at high risk for, or in the early stages of, preventable and/or treatable health conditions (early detection)
- the provision of appropriate prevention and intervention measures in a timely fashion (early treatment).

(Continued next page)
Four measures of early detection and early treatment for Indigenous Australians are reported:

- The proportion of older people who received a health assessment by Indigenous status, where
  - older people are defined as non-Indigenous Australians aged 75 years or over and Indigenous Australians aged 55 years or over, excluding hospital inpatients and people living in aged care facilities. The relatively young age at which Indigenous Australians become eligible for ‘older’ people’s services 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 sector overview)
  - health assessments are MBS items that allow comprehensive examinations of patient health, including physical, psychological and social functioning. The assessments are intended to facilitate timely prevention and intervention measures to improve patient health and wellbeing.
- The proportion of older Indigenous Australians who received a health assessment in successive years of a five year period.
- The proportion of Indigenous Australians who received a health assessment or check by age group — health assessment/checks are available for Indigenous children (0–14 years), adults (15–54 years) and older people (55 years or over).
- The proportion of Aboriginal and Torres Strait Islander primary healthcare services that provided early detection services.

A low or decreasing gap between the proportion of all older people and older Indigenous Australians who received a health assessment can indicate more equitable access to early detection and early treatment services for Indigenous Australians. An increase over time in the proportion of older Indigenous Australians who received a health assessment is desirable as it indicates improved access to these services. A low or decreasing gap between the proportion of Indigenous Australians in different age groups who received a health assessment/check can indicate more equitable access to early detection and treatment services within the Indigenous population. An increase in the proportion of Aboriginal and Torres Strait Islander primary healthcare services that included early detection activities is desirable as it indicates improved access to early detection and treatment services for Indigenous Australians.

This indicator provides no information about the proportion of people who receive early detection and early treatment services that are not listed in the MBS. Such services are provided by salaried GPs in community health settings, hospitals and Aboriginal and Torres Strait Islander primary healthcare services, particularly in rural and remote areas. Accordingly, this indicator understates the proportion of people who received early detection and early treatment services.

Data for this indicator are comparable.

Data quality information for this indicator is under development.
The high prevalence of preventable and/or treatable health conditions in the Indigenous population is strongly associated with relatively poor health outcomes for Indigenous Australians (AIHW 2008a; SCRGSP 2011). The availability and uptake of early detection and early treatment services is understood to be a significant determinant of people’s health.

In 2011-12, the proportion of Indigenous older Australians who received an annual health assessment was lower than the proportion of non-Indigenous older Australians who received an annual health assessment in all jurisdictions except the NT and Queensland (figure 11.9). This suggests that access to early detection and early treatment services may not be equitable.

**Figure 11.9 Older people who received an annual health assessment by Indigenous status, 2011-12**

![Graph showing health assessment data by state and Indigenous status for 2011-12](image)

---


The proportion of older Indigenous Australians who received an annual health assessment increased in nearly all jurisdictions between 2007-08 and 2011-12 (figure 11.10).
Older Indigenous Australians who received an annual health assessment

Health check MBS items were introduced for Indigenous Australians aged 15–54 years in May 2004. Initially available biennially, since 1 May 2010 they have been available annually. Also available annually are health checks for Indigenous children aged 0–14 years, introduced in May 2006.

The proportion of the eligible Indigenous population who received a health assessment or check was highest for older people and lowest for children aged 0–14 years in most jurisdictions (figure 11.11). This can, in part, reflect differences in how long the items have been available, as factors such as awareness and administrative requirements affect the uptake of new MBS items (AIHW 2008a).
Indigenous Australians who received a health check or assessment by age, 2011-12

Indigenous status is determined by self-identification. Indigenous Australians 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 overall proportions due to the relatively low average life expectancy of Indigenous Australians.


Nationally, the proportion of Indigenous primary healthcare services providing early detection services varied little in the period 2008-09 to 2010-11 (figure 11.12).
Figure 11.12  Indigenous primary healthcare services for which OSR data are reported that provided early detection services$^a$

$^a$ The OSR data collection replaces the previous Service Activity Reporting (SAR) data collection from the 2008-09 reporting period. Historical SAR data are published in previous reports.

Source: AIHW (2012 and previous issues) Aboriginal and Torres Strait Islander health services report: OATSIH services reporting - key results, 2008-09, 2009-10 and 2010-11, Cat. no.s IHW 31, 56 and 79; table 11A.24.

**Developmental health checks**

‘Developmental health checks’ is an indicator of governments’ objective to provide equitable access to early detection and intervention services for children (box 11.6).
Box 11.6 Developmental health checks

‘Developmental health checks’ is defined as the proportion of children who received a fourth year developmental health check under DHS, Medicare, by health check type. Health check type is considered as a proxy for Indigenous status. The ‘Healthy Kids Check’ MBS health assessment item is available to children aged 3 or 4 years, while the ‘Aboriginal and Torres Strait Islander Peoples Health Assessment’ item is available to Indigenous Australians.

A high or increasing proportion of children receiving a fourth year developmental health check is desirable as it suggests improved access to these services.

The proportion of Indigenous children aged 3 or 4 years who received the Aboriginal and Torres Strait Islander Peoples Health Assessment is considered as a proxy for the proportion of Indigenous children who received a fourth year developmental health check. This should be considered a minimum estimate as the data exclude checks received by Indigenous children under the Healthy Kids Check item.

Fourth year developmental health checks are intended to assess children’s physical health, general wellbeing and development. They enable identification of children who are at high risk for or, have early signs of, delayed development and/or illness. Early identification provides the opportunity for timely prevention and intervention measures that can ensure that children are healthy, fit and ready to learn when they start schooling.

This indicator provides no information about developmental health checks for children that are provided outside DHS, Medicare, as comparable data for such services are not available for all jurisdictions. These checks are provided in the community, for example, maternal and child health services, community health centres, early childhood settings and the school education sector. Accordingly, this indicator understates the proportion of children who receive a fourth year developmental health check.

Data for this indicator are comparable.


Nationally, 45.8 per cent of children received a fourth year developmental health check under DHS, Medicare in 2011-12. The proportion of Indigenous children who received an Aboriginal and Torres Strait Islander Peoples Health Assessment in their fourth year was higher than the proportion of children who received a Healthy Kids Check in most jurisdictions (figure 11.13).
Effectiveness

Access

Effectiveness of access to GPs

‘Effectiveness of access to GPs’ is an indicator of governments’ objective to provide effective access to primary healthcare services (box 11.7). The effectiveness of services can vary according to the affordability and timeliness of services that people can access.
Box 11.7  **Effectiveness of access to GPs**

‘Effectiveness of access to GPs’ is defined by four measures:

- **bulk billing rates**, defined as the number of GP visits that were bulk billed as a proportion of all GP visits
- **people deferring visits to GPs due to financial barriers**, defined as the proportion of people who delayed seeing or did not see a GP due to cost
- **GP waiting times**, defined as the number of people who saw a GP for urgent medical care within specified waiting time categories in the previous 12 months, divided by the number of people who saw a GP for urgent medical care in the previous 12 months. Specified waiting time categories are:
  - less than 4 hours
  - 4 to 24 hours
  - more than 24 hours
- **selected potentially avoidable GP-type presentations to emergency departments**, defined as the number of ‘GP-type presentations’ to emergency departments divided by the total number of presentations to emergency departments, where GP-type presentations are those:
  - allocated to triage category 4 or 5
  - not arriving by ambulance, with police or corrections
  - not admitted or referred to another hospital
  - who did not die.

A high or increasing proportion of bulk billed attendances can indicate more affordable access to GP services. GP visits that are bulk billed do not require patients to pay part of the cost of the visit, while GP visits that are not bulk billed do. This measure does not provide information on whether the services are appropriate for the needs of the people receiving them.

A low or decreasing proportion of people deferring visits to GPs due to financial barriers indicates more widely affordable access to GPs. A high or increasing proportion of people who saw a GP within 4 hours for urgent medical care indicates more timely access to GPs. A low or decreasing proportion of GP-type presentations to emergency departments can indicate better access to primary and community health care.

Data for the first three measures of this indicator are comparable, while data for the fourth measure — selected potentially avoidable GP-type presentations to emergency departments — are not directly comparable.

Effectiveness of access to GPs — bulk billing rates

Patient visits to GPs are either bulk billed, or the patient is required to pay part of the cost of the visit. GP visits are classed as non-referred attendances under DHS, Medicare. Where a patient is bulk billed they make no out-of-pocket contribution; the GP bills DHS, Medicare directly and, since 1 January 2005, receives 100 per cent of the Schedule fee (the patient rebate) as full payment for the service. The 100 per cent DHS, Medicare rebate applies to most GP services.

Nationally, the bulk billed proportion of non-referred attendances, including those by practice nurses, was 81.5 per cent in 2011-12. For most jurisdictions, this proportion increased in the period 2007-08 to 2011-12 (figure 11.14). The bulk billed proportion of non-referred attendances was highest in ‘other remote areas’, ‘capital cities’ and ‘other metropolitan centres’ (table 11A.26). The bulk billed proportion of non-referred attendances was higher for children under 16 years and older people than for people aged 16 to 64 years (table 11A.27).

Figure 11.14  GP visits that were bulk billeda, b

<table>
<thead>
<tr>
<th></th>
<th>2007-08</th>
<th>2008-09</th>
<th>2009-10</th>
<th>2010-11</th>
<th>2011-12</th>
</tr>
</thead>
<tbody>
<tr>
<td>NSW</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vic</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Qld</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>WA</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SA</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tas</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ACT</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NT</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Aust</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Source: DoHA (unpublished) MBS Statistics; table 11A.27.

a Includes attendances by practice nurses. b Allocation to State/Territory based on patients’ DHS, Medicare enrolment postcode.
Effectiveness of access to GPs — people deferring visits to GPs due to financial barriers

Timely access to healthcare services is important to people’s health and wellbeing. Deferring or not visiting a GP can result in poorer health. Nationally, in 2011-12, 7.2 per cent of respondents reported that they delayed or did not visit a GP in the previous 12 months because of cost (figure 11.15).

Figure 11.15  People deferring visits to GPs due to cost\(^a\), \(^b\), \(^c\), \(^d\)

![Graph showing people deferring visits to GPs due to cost for different regions and years (2009, 2010-11, 2011-12)].

\(^a\) People aged 15 years or over. \(^b\) Delayed visiting or did not visit a GP at any time in the previous 12 months due to cost. \(^c\) Rates are age standardised to the Australian population at 30 June 2001. \(^d\) Error bars represent the 95 per cent confidence interval associated with each point estimate.


Effectiveness of access to GPs — GP waiting times

Nationally, 63.6 per cent of people who saw a GP for urgent care waited less than 4 hours in 2011-12 (figure 11.16). Around 12.0 per cent waited from 4 to less than 24 hours, and 24.4 per cent waited for 24 hours or more. For visits to GPs not requiring urgent care, 27.4 per cent of people waited longer than they felt was acceptable to get an appointment (table 11A.30).
**Effectiveness of access to GPs — GP-type presentations to emergency departments**

GP-type presentations to emergency departments are presentations for conditions that could be appropriately managed in the primary and community health sector (Van Konkelenberg, Esterman and Van Konkelenberg 2003). One of several factors contributing to GP-type presentations at emergency departments is perceived or actual lack of access to GP services. Other factors include proximity of emergency departments and trust for emergency department staff.

Nationally, there were around 2.1 million GP-type presentations to public hospital emergency departments in 2011-12 (table 11.7). Data are presented by Indigenous status and remoteness in table 11A.31.
Table 11.7  **GP-type presentations to emergency departments**

<table>
<thead>
<tr>
<th></th>
<th>NSW</th>
<th>Vic</th>
<th>Qld</th>
<th>WA</th>
<th>SA</th>
<th>Tas</th>
<th>ACT</th>
<th>NT</th>
<th>Aust</th>
</tr>
</thead>
<tbody>
<tr>
<td>2011-12</td>
<td>684.9</td>
<td>545.1</td>
<td>378.0</td>
<td>283.1</td>
<td>103.9</td>
<td>59.8</td>
<td>47.8</td>
<td>40.9</td>
<td>2 143.6</td>
</tr>
</tbody>
</table>

*a* GP-type emergency department presentations are defined as presentations for which the type of visit was reported as emergency presentation, which did not arrive by ambulance or by police or other correctional vehicle, with a triage category of semi-urgent or non-urgent, and where the episode end status was not admitted to the hospital, or referred to another hospital, or died. This is an interim definition, pending development of new methodology to more closely approximate the population that could receive services in the primary care sector.  

*b* Data are presented by State/Territory of usual residence of the patient.  

*c* Data are for peer group A and B public hospitals only.  


**Financial barriers to PBS medicines**

‘Financial barriers to PBS medicines’ is an indicator of governments’ objective to ensure effective access to prescribed medicines (box 11.8).

---

**Box 11.8  Financial barriers to PBS medicines**

‘Financial barriers to PBS medicines’ is defined as the proportion of people who delayed getting or did not get a prescription filled due to cost.

A low or decreasing proportion of people deferring treatment due to financial barriers indicates more widely affordable access to medications.

Data for this indicator are comparable.


---

Nationally, in 2011-12, 9.6 per cent of respondents delayed or did not purchase prescribed medicines due to cost in the previous 12 month period (figure 11.17).
People deferring purchase of prescribed medicines due to cost\textsuperscript{a, b, c}

\textbf{Box 11.9 Public dentistry waiting times}

‘Public dentistry waiting times’ is defined as the time waited between being placed on a public dentistry waiting list and being seen by a dental professional. It is measured as the proportion of people on a public dental waiting list who saw a dental professional at a government dental clinic for non-urgent treatment, within specified waiting time categories.

A high or increasing proportion of people waiting shorter periods to see a dental professional indicates more timely access to public dental services.

Data for this indicator are comparable.

Nationally, 24.3 per cent of people who were on a public dental waiting list for non-urgent treatment waited less than 2 weeks to see a dental professional at a government dental clinic in 2011-12 (table 11A.35). Around 41.3 per cent waited less than one month for treatment (figure 11.18).

Figure 11.18  Time waited for public dentistry services, 2011-12a, b, c, d, e

<table>
<thead>
<tr>
<th></th>
<th>Less than 1 month</th>
<th>1 month or more</th>
</tr>
</thead>
<tbody>
<tr>
<td>NSW</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vic</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Qld</td>
<td></td>
<td></td>
</tr>
<tr>
<td>WA</td>
<td></td>
<td></td>
</tr>
<tr>
<td>SA</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tas</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ACT</td>
<td></td>
<td></td>
</tr>
<tr>
<td>NT</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Aust</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

a Time waited for treatment at a government dental clinic for people 15 years or over who were on a public dental waiting list in the last 12 months. Excludes treatment for urgent dental care.  
b Rates are age standardised to the Australian population at 30 June 2001.  
c Error bars represent the 95 per cent confidence interval associated with each point estimate.  

Appropriateness

GPs with vocational registration

‘GPs with vocational registration’ is an indicator of governments’ objective to ensure the GP workforce has the capability to deliver high quality services (box 11.10).
Box 11.10  **GPs with vocational registration**

‘GPs with vocational registration’ is defined as the proportion of FWE GPs with vocational registration. Vocationally registered GPs are considered to have the values, skills and knowledge necessary for competent unsupervised general practice within Australia (RACGP 2007).

A high or increasing proportion of FWE GPs with vocational registration can indicate an improvement in the capability of the GP workforce to deliver high quality services. GPs without vocational registration may deliver services of equally high quality, however, their access to DHS Medicare rebates for the general practice services they provide is limited compared to vocationally registered GPs.

Data for this indicator are comparable.

Data quality information for this indicator is under development.

Since 1996, a GP can only achieve vocational registration by attaining Fellowship of the RACGP or (from April 2007) the Australian College of Rural and Remote Medicine (ACRRM) or equivalent, or hold a recognised training placement. 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 meet mandated registration standards which include Continuing Professional Development (CPD) in order to maintain registration.

The proportion of FWE GPs with vocational registration remained relatively constant over the five years to 2011-12 (figure 11.19). The proportion of FWE GPs with vocational registration was highest in capital cities and other metro centres, and lowest in remote areas, in 2011-12 (table 11A.37).
General practices with accreditation

‘General practices with accreditation’ is an indicator of governments’ objective to ensure the general practitioner workforce has the capability to provide high quality services (box 11.11).

Box 11.11 General practices with accreditation

‘General practices with accreditation’ is defined as the number of general practices that are accredited as a proportion of all general practices in Australia. 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.

(Continued next page)
Box 11.11  (Continued)
A high or increasing proportion of practices with accreditation can indicate an improvement in the capability of general practice 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.

Data for this indicator are comparable.

Data quality information for this indicator is under development.

The two providers of general practice accreditation services are Australian General Practice Accreditation Limited (AGPAL) and Quality Practice Accreditation Pty Ltd.

Updated data for the number of general practices were not available for the 2013 Report. In June 2011, 4783 general practices — representing 67.4 per cent of general practices — were accredited nationally (figure 11.20).

Figure 11.20  General practices with accreditation, at 30 June

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.
Nationally, the proportion of general practice patient care — measured as standardised whole patient equivalents (SWPEs) — provided by PIP practices has been relatively constant in the period from 2006-07 to 2010-11 (figure 11.21).

Figure 11.21 Proportion of general practice patient care provided by PIP practices

Management of upper respiratory tract infection

‘Management of acute upper respiratory tract infection’ is an indicator of governments’ objective to ensure that antibiotics are used appropriately and effectively (box 11.12).
Management of upper respiratory tract infection

‘Management of acute upper respiratory tract infection’ (URTI) is defined by two measures:

- number of prescriptions by GPs for selected antibiotics (those oral antibiotics most commonly prescribed to treat URTI) that are provided to PBS concession card holders, per 1000 PBS concession card holders
- proportion of visits to GPs for acute URTI where systemic antibiotics are prescribed.

A low or decreasing rate of prescriptions for the selected antibiotics and of the proportion of GP visits where systemic antibiotics are prescribed to treat acute URTI, can indicate that GPs’ management of URTI more closely follows guidelines. Information about data quality for this measure is at www.pc.gov.au/gsp/reports/rogs/2013.

A low or decreasing proportion of GP visits where systemic antibiotics are prescribed to treat acute URTI can indicate that GPs’ management of URTI more closely follows guidelines. Data quality information for this indicator is under development.

URTI without complication (acute URTI or the ‘common cold’) is most often caused by a virus. Antibiotics have no efficacy in the treatment of viral infections, but are nevertheless often prescribed for their treatment. Unnecessarily high rates of antibiotic prescription have the potential to increase pharmaceutical costs and to increase antibiotic resistance in the community.

Data for this indicator are comparable.

Reporting against this indicator has improved for the 2013 Report with the availability for the first time at State/Territory level of data for the additional measure proportion of GP visits for acute URTI where antibiotics are prescribed.

Rate of prescription of selected antibiotics

Caution should be used in the interpretation of this measure as the oral antibiotics most commonly prescribed to treat acute URTI are also prescribed for other illnesses. Information about the condition for which the antibiotics are prescribed is not available. Data are reported for PBS concession card holders because complete data are not available for prescriptions provided to non-holders of PBS concession cards. Caution should be used in interpretation of the measure over time, as the pharmaceutical needs of concession card holders can increase in complexity due to the effects of population ageing.

Nationally, the prescription rate for the oral antibiotics most commonly used to treat acute URTI was 1220 per 1000 PBS concession card holders in 2011-12 (figure 11.22).
Figure 11.22  **Rate of prescription of the oral antibiotics used most commonly to treat acute upper respiratory tract infection**

<table>
<thead>
<tr>
<th>Year</th>
<th>NSW</th>
<th>Vic</th>
<th>Qld</th>
<th>WA</th>
<th>SA</th>
<th>Tas</th>
<th>ACT</th>
<th>NT</th>
<th>Aust</th>
</tr>
</thead>
<tbody>
<tr>
<td>2007-08</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2008-09</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2009-10</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2010-11</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2011-12</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Prescriptions** ordered by vocationally registered GPs and other medical practitioners (OMPs) and dispensed to PBS concession card holders. **Data** are not limited to prescriptions for treatment of upper respiratory tract infection.

Source: DoHA (unpublished) PBS Statistics; table 11A.41.

**Proportion of GP visits for acute URTI where systemic antibiotics are prescribed**

Data for the proportion of GP visits for acute URTI where systemic antibiotics are prescribed are for the first time available at State/Territory level, from the annual BEACH survey of general practice activity in Australia.

The BEACH survey collects information on the reason for the GP visit as well as the treatment prescribed or provided. This allows derivation of the proportion of visits to GPs for acute URTI for which systemic antibiotics were prescribed or supplied. Each year, the national BEACH sample comprises around 1000 GPs, each providing data for around 100 patient visits. Aggregation of data for a period of 5 years allows publication of data for all States and Territories (figure 11.23). This has some limitations — short-term change will be reflected only if substantive when averaged over a 5 year period, and proximate causes of change will not be directly identifiable. These limitations are to a degree mitigated by the reporting of data for each year in the reference period at the national level. This will assist in interpreting whether change reflected over rolling 5 year periods is due to substantive short-term change or to incremental change over several years.

Nationally, for the 5 years April 2007 to March 2012, the proportion of people presenting to GPs for acute URTI where the GP prescribed systemic antibiotics for
its treatment was 32.5 per cent (figure 11.23). This proportion was 32.8 per cent for the period April 2011 to March 2012 (figure 11.24). The higher proportion for the 5 year reference period reflects an increase in use of systemic antibiotics for treatment of acute URTI associated with the swine flu outbreak in 2009 (figure 11.24).

Figure 11.23 Proportion of acute URTI managements where systemic antibiotics were prescribed

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Per cent</td>
<td></td>
<td></td>
</tr>
<tr>
<td>NSW</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vic</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Qld</td>
<td></td>
<td></td>
</tr>
<tr>
<td>WA</td>
<td></td>
<td></td>
</tr>
<tr>
<td>SA</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tas</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ACT</td>
<td></td>
<td></td>
</tr>
<tr>
<td>NT</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Aust</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

\* Error bars represent the 95 per cent confidence interval associated with each point estimate. Participation in the survey is voluntary. Data are not necessarily representative of the prescribing behaviour of non-participating GPs.

Figure 11.24  Proportion of acute URTI managements where systemic antibiotics were prescribed, Australia\textsuperscript{a, b}

\textsuperscript{a} Error bars represent the 95 per cent confidence interval associated with each point estimate. \textsuperscript{b} Participation in the survey is voluntary. Data are not necessarily representative of the prescribing behaviour of non-participating GPs.


\textit{Chronic disease management}

‘Chronic disease management’ is an indicator of governments’ objective to ensure appropriate and effective management of chronic disease in the primary and community health sector (box 11.13).

\textbf{Box 11.13  Chronic disease management}

‘Chronic disease management’ is defined by three measures:

- Management of diabetes, defined as:
  - the proportion of people with diabetes mellitus who have received an annual cycle of care within general practice (the number of MBS items claimed for completion of a cycle of care for patients with established diabetes mellitus, divided by the estimated number of people with diabetes mellitus)
  - the proportion of people with diabetes with HbA1c (glycosolated haemoglobin) below 7 per cent (the number of people with diabetes mellitus with HbA1c below 7 per cent, divided by the estimated number of people with diabetes mellitus)

(Continued next page)
Management of asthma, defined as the proportion of people with asthma who have a written asthma action plan

Care planning/case conferencing, defined as the proportion of GPs who used the MBS chronic disease management items for care planning or case conferencing at least once during a 12 month period.

A high or increasing proportion of people with diabetes mellitus who have received an annual cycle of care within general practice is desirable. The MBS annual cycle of care for patients with diabetes is generally based on RACGP clinical guidelines for the appropriate management of Type 2 diabetes in general practice. Appropriate management of diabetes in the primary and community health sector can prevent or minimise the severity of complications (AIHW 2008c). Patient compliance with management measures is also a critical determinant of the occurrence and severity of complications. Data should be considered as minimum estimates as appropriate management of diabetes mellitus by GPs who do not claim the rebates is not captured. Various factors influence the uptake of MBS items by GPs. Information about data quality for this measure is at www.pc.gov.au/gsp/reports/rogs/2013.

A high or increasing proportion of people with diabetes with HbA1c below 7 per cent is desirable. HbA1c measures the level of glucose in the blood averaged over the preceding three months. Data for this measure were not available for the 2013 Report.

A high or increasing proportion of people with asthma who have a written asthma action plan is desirable. Written asthma action plans have been included in clinical guidelines for asthma management for nearly 20 years. They enable people with asthma to recognise and respond quickly and appropriately to deteriorating asthma symptoms, and thereby preventing or reducing the severity of acute asthma episodes (ACAM 2008). Information about data quality for this measure is at www.pc.gov.au/gsp/reports/rogs/2013.

A high or increasing proportion of GPs who use chronic disease management items can indicate an improvement in the continuity of care provided to people with complex, multidisciplinary care needs. Chronic disease management items in the MBS allow for the preparation and regular review of care plans for individuals with complex, multidisciplinary care needs due to chronic or terminal medical conditions, through GP managed or multidisciplinary team based care. Individual compliance with management measures is also a critical determinant of the occurrence and severity of complications for patients with chronic disease. Data quality information for this indicator is under development.

Data reported against this indicator are comparable.

Chronic diseases are generally long term and often progressive conditions, for example, diabetes and asthma. Chronic disease is estimated to be responsible for more than 80 per cent of the burden of disease and injury suffered by Australians (Australian Government 2010).
Appropriate and effective management in the primary and community health sector can delay the progression of many chronic diseases as well as prevent or minimise the severity of complications (AIHW 2008c, NHPAC 2006). Effective management requires the provision of timely, high quality healthcare to meet individual needs and provide continuity of care (Australian Government 2010). Effective management can have profound effects on individuals and on the broader health system. Individuals benefit from improved health and wellbeing, and the capacity for greater economic and social participation. Reduced demand for treatment in the acute health sector can reduce the burden on the broader health system.

Patient compliance with management measures is also a critical determinant of the occurrence and severity of complications.

**Chronic disease management — diabetes**

Diabetes mellitus, a chronic disease of increasing prevalence, is an identified National Health Priority Area for Australia. People with diabetes (‘diabetes’ refers to diabetes mellitus; this Report does not consider diabetes insipidus) are at high risk of serious complications such as cardiovascular, eye and kidney disease. Type 2 diabetes is the most common form of diabetes and is largely preventable.

Appropriate management in the primary and community health sector can prevent or minimise the severity of diabetes complications (AIHW 2008c). Patient compliance with management measures is also a critical determinant of the occurrence and severity of complications.

Since 2001, rebates have been available to GPs under the MBS on completion of an annual cycle of care for diabetes. The ‘required annual cycle of care’ is generally based on the RACGP’s clinical guidelines for the management of Type 2 diabetes in general practice (but requires less frequent testing of glycosolated haemoglobin). Clinical guidelines represent the minimum required level of care. The need for a standard definition of ‘annual cycle of care’ has been identified (AIHW 2007).

Nationally, 22.7 per cent of people with diabetes received the annual cycle of care in 2011-12 (figure 11.25). Data for historical years are reported by geographical region in table 11A.45.
Figure 11.25  **People with diabetes mellitus who have received an annual cycle of care within general practice, 2011-12**

![Bar chart showing percentage of people with diabetes mellitus who received annual cycle of care within general practice by state and Australia.](image)

a GPs may provide the annual cycle of care but not claim the MBS rebate. Various factors influence the uptake of MBS items by GPs. b Error bars represent the 95 per cent confidence interval associated with each point estimate.

Source: DoHA (unpublished) MBS Statistics; ABS (2012) *Australian Health Survey: First Results, 2011-12*, Cat. no. 4364.0.55.001; table 11A.44.

**Chronic disease management — asthma**

Asthma, an identified National Health Priority Area for Australia, is a common chronic disease among Australians — particularly children — and is associated with wheezing and shortness of breath. Asthma can be intermittent or persistent, and varies in severity.

Updated data were not available for the 2013 Report for the proportion of people with current asthma reporting that they have a written asthma action plan. Nationally, this proportion was 20.8 per cent for all ages and 47.8 per cent for children aged 0–14 years in 2007-08 (figure 11.26). Data are reported by geographical region in table 11A.47. Data for 2004-05 are reported by Indigenous status in table 11A.48.
Figure 11.26 Proportion of people with asthma who have a written asthma action plan, 2007-08\textsuperscript{a,\,b,\,c}

\begin{figure}
\centering
\includegraphics[width=\textwidth]{proportion_0-14_all_ages.png}
\caption{Proportion of people with asthma who have a written asthma action plan, 2007-08\textsuperscript{a,\,b,\,c}}
\end{figure}

\textsuperscript{a} Rates for 'all ages' are age standardised to the Australian population at 30 June 2001. \textsuperscript{b} Separate estimates for 0–14 years are not available for the NT, but the NT sample contributes to the national estimates. \textsuperscript{c} Error bars represent the 95 per cent confidence interval associated with each point estimate.


Chronic disease management — care planning and case conferencing

Individuals with chronic or terminal medical conditions commonly have complex, multidisciplinary care needs. Coordination of service provision to provide continuity of care and meet the changing needs of individuals over time is important in the effective management of such conditions. Chronic disease management items in the MBS allow for the preparation and regular review of care plans for individuals with complex, multidisciplinary care needs due to chronic or terminal medical conditions, through GP managed or multidisciplinary team based care planning and case conferencing.

Individual compliance with management measures is also a critical determinant of the occurrence and severity of complications for patients with chronic disease.

Nationally, the proportion of GPs who used chronic disease management MBS items for care planning or case conferencing increased from 93.1 in 2007-08 to 97.0 per cent in 2011-12 (figure 11.27). The proportion increased steadily in almost all jurisdictions in the period 2007-08 to 2011-12.
Use of pathology tests and diagnostic imaging

‘Use of pathology tests and diagnostic imaging’ is an indicator of governments’ objective to ensure that primary healthcare services are appropriate (box 11.14).
Box 11.14 Use of pathology tests and diagnostic imaging

‘Use of pathology tests and diagnostic imaging’ is defined by four measures:

- MBS items rebated through DHS, Medicare for pathology tests requested by vocationally registered GPs and OMPs, per person
- Diagnostic imaging services provided on referral from vocationally registered GPs and OMPs and rebated through DHS, Medicare, per person
- DHS, Medicare benefits paid per person for pathology tests
- DHS, Medicare benefits paid per person for diagnostic imaging.

This indicator cannot be interpreted as appropriate levels of use of pathology tests and diagnostic imaging cannot be determined. A high or increasing level of use can reflect overreliance on tools to support the diagnostic process. A low or decreasing level of use can contribute to misdiagnosis of disease and to relatively poor treatment decisions. Reporting differences across jurisdictions and over time contributes to consideration of these issues. Pathology tests and diagnostic imaging are important tools used by GPs in the diagnosis of many diseases, and in monitoring response to treatment.

Data for this indicator are comparable.


Pathology and diagnostic imaging services performed at the request of vocationally registered GPs and OMPs and rebated through DHS, Medicare is used as a proxy in reporting against this indicator. The available data do not exactly reflect the services requested and performed. For example, rebates are provided for a maximum of three MBS pathology items — additional pathology tests can be requested and performed, but are excluded from the data because rebates are not provided. A radiologist can identify the need for and perform more or different diagnostic imaging services than requested. DHS, Medicare data reflect only those services provided and rebated.

Nationally, the number of rebated MBS items for pathology tests requested by GPs ranged from 3.3 to 3.6 per person in the period 2007-08 to 2011-12 (figure 11.28).
Australian Government expenditure under DHS, Medicare for pathology tests requested by vocationally registered GPs and OMPs amounted to $1.4 billion, or around $63 per person, in 2011-12. Nationally, Medicare benefits worth $1.3 billion — around $59 per person — were paid for diagnostic imaging services provided on referral from vocationally registered GPs and OMPs, in 2011-12 (figure 11.29).
Figure 11.29  **Benefits paid for pathology tests and diagnostic imaging, 2011-12**

![Pathology benefits paid vs Imaging benefits paid](chart)

**Source:** DoHA (unpublished) MBS and DVA data collections; tables 11A.50 and 11A.51.

Nationally, the number of rebated MBS items for diagnostic imaging performed on referral from GPs ranged from 0.49 to 0.54 per person in the period 2007-08 to 2011-12 (figure 11.30).

Figure 11.30  **Diagnostic imaging services referred by GPs and rebated through DHS, Medicare**

![Graph showing diagnostic imaging services referred by GPs](chart)

**Source:** DoHa (unpublished) MBS and DVA data collections; table 11A.51.
Quality — safety

Electronic health information systems

‘Electronic health information systems’ is an indicator of governments’ objective to improve patient safety through enhanced access to patient health information at the point of care and the more efficient coordination of care across multiple providers and services (box 11.15).

Box 11.15  Electronic health information systems

‘Electronic health information systems’ is defined as the proportion of general practices enrolled in the Practice Incentives Program (PIP) that are registered for the PIP eHealth incentive.

A high or increasing proportion can indicate that patient health information at the point of care and coordination of care across multiple providers and services are desirable or are improved, minimising the likelihood of patient harm due to information gaps.

The PIP does not include all practices in Australia. PIP practices provided around 83.0 per cent of general practice patient care in Australia (measured as standardised whole patient equivalents) in 2010-11 (DoHA unpublished; table 11A.40).

Data for this indicator are comparable.

Data quality information for this indicator is under development.

The use of electronic health information systems can, for example, facilitate best practice chronic disease management as well as minimise errors of prescribing and dispensing that can cause adverse drug reactions (Hofmarcher, Oxley and Rusticelli 2007).

The PIP provides financial incentives to general practices to support quality care, and improve access and health outcomes. The PIP promotes activities such as:

- use of electronic health information systems
- the provision of after hours care
- teaching medical students
- improving management for patients with diabetes and/or asthma.

The PIP eHealth Incentive aims to encourage general practices to keep up to date with the latest developments in electronic health information systems. It replaced, in August 2009, the PIP Information Management, Information Technology Incentive that had commenced in November 2006.
To be eligible for the PIP eHealth Incentive, practices must:

- have a secure messaging capability provided by an eligible supplier
- have (or have applied for) a location/site Public Key Infrastructure (PKI) certificate for the practice and each practice branch, and make sure that each medical practitioner from the practice has (or has applied for) an individual PKI certificate
- provide practitioners from the practice with access to a range of key electronic clinical resources.

Nationally, 88.3 per cent of PIP practices used electronic health systems in May 2012, an increase from 78.5 per cent in May 2010 (figure 11.31).

**Figure 11.31  PIP practices using electronic health systems**

![Bar chart showing the percentage of PIP practices using electronic health systems in May 2010, 2011, and 2012 for various states in Australia.](image)

Source: DoHA (unpublished) MBS and PIP data collections; table 11A.52.

The proportion of PIP practices using electronic health systems in remote areas was lower than in urban and rural areas in May 2012 (figure 11.32).
Figure 11.32  PIP practices using electronic health systems by area\(^a\)

\(^a\) Geographical locations are based on the Rural, Remote and Metropolitan Areas (RRMA) classification. 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) MBS and PIP data collections; table 11A.53.

**Quality — responsiveness**

**Patient satisfaction**

‘Patient satisfaction’ is an indicator of governments’ objective to ensure primary and community health services are high quality and account for individual patient needs (box 11.16).
Box 11.16  **Patient satisfaction**

‘Patient satisfaction’ is defined as the quality of care as perceived by the patient. It is measured as patient experience of and/or satisfaction around ‘key aspects of care’ — that is, aspects of care that are key factors in patient outcomes and can be readily modified. Two measures of patient experience of communication with health professionals — a key aspect of care — are reported:

- experience with selected key aspects of GP care, defined as the number of people who saw a GP in the previous 12 months where the GP always or often: listened carefully to them; showed respect; and spent enough time with them, divided by the number of people who saw a GP in the previous 12 months

- experience with selected key aspects of dental professional care, defined as the number of people who saw a dental professional in the previous 12 months where the dental practitioner always or often: listened carefully to them; showed respect; and spent enough time with them, divided by the number of people who saw a dental practitioner in the previous 12 months.

High or increasing proportions can indicate that more patients experienced communication with health professionals as satisfactory.


---

**Patient satisfaction — experience with selected key aspects of GP care**

Nationally, the majority of respondents reported that the GP always or often (figure 11.33):

- listened carefully to them (88.1 per cent)
- showed respect (91.5 per cent)
- spent enough time with them (86.4 per cent).

Data are presented by remoteness area in tables 11A.54 and 11A.55.
Figure 11.33 Proportion of people whose GP always or often listened carefully, showed respect, spent enough time, 2011-12\textsuperscript{a, b}

\begin{figure}
\centering
\includegraphics[width=\textwidth]{chart.png}
\end{figure}

\textsuperscript{a} People aged 15 years or over who or over who saw a GP in the last 12 months. \textsuperscript{b} Rates are age standardised to the Australian population at 30 June 2001.

Source: ABS (unpublished) Patient Experience Survey 2011-12, Cat. no. 4839.0; tables 11A.54, 11A.55.

Patient satisfaction — experience with selected key aspects of dental professional care

Nationally, the majority of respondents reported that the dental professional always or often (figure 11.34):

- listened carefully to them (93.9 per cent)
- showed respect (94.9 per cent)
- spent enough time with them (95.0 per cent).

Data are presented by remoteness area in tables 11A.56 and 11A.57.
Figure 11.34 Proportion of people whose dental professional always or often listened carefully, showed respect, spent enough time, 2011-12 a, b

<table>
<thead>
<tr>
<th></th>
<th>Listened carefully</th>
<th>Showed respect</th>
<th>Spent enough time</th>
</tr>
</thead>
<tbody>
<tr>
<td>NSW</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vic</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Qld</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>WA</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SA</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tas</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ACT</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NT</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Aust</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

a People aged 15 years or over who saw a dental professional in the last 12 months. b Rates are age standardised to the Australian population at 30 June 2001.

Source: ABS (unpublished) Patient Experience Survey 2011-12, Cat. no. 4839.0; tables 11A.56, 11A.57.

Quality — continuity

Health assessments for older people

‘Health assessments for older people’ is an indicator of governments’ objective to improve population health outcomes through the provision of prevention as well as early detection and treatment services (box 11.17).

Box 11.17 Health assessments for older people

‘Health assessments for older people’ is defined as the proportion of older people who received a health assessment. Older people are defined as non-Indigenous Australians aged 75 years or over and Indigenous Australians aged 55 years or over, excluding hospital inpatients and people living in aged care facilities. Annual health assessments for older people are MBS items that allow 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 11.5).

(Continued next page)
A high or increasing proportion of eligible older people who received a health assessment can indicate a reduction in health risks for older people, through early and timely prevention and intervention measures to improve and maintain health.

Data for this indicator are comparable.

Data quality information for this indicator is under development.

The targeted age range for Indigenous Australians of 55 years or over 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 sector overview). Results for Indigenous Australians are reported under equity indicators (box 11.5).

There has been an increase in the proportion of older people receiving a health assessment in all jurisdictions in the period 2007-08 to 2011-12. Nationally, this proportion increased from 21.3 per cent in 2007-08 to 27.6 per cent in 2011-12 (figure 11.35).

Figure 11.35 Older people who received a health assessment

---

**Note:**

Older people are defined as non-Indigenous Australians aged 75 years or over and Indigenous Australians aged 55 years or over, excluding hospital inpatients and people living in aged care facilities. Data may differ from previous reports due to revision of denominator data according to a change in methodology.

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

‘Cost to government of general practice per person’ is an indicator of governments’ objective to provide primary healthcare services in an efficient manner (box 11.18).

Box 11.18  Cost to government of general practice per person

‘Cost to government of general practice per person’ is defined as the cost to government of general practice per person in the population.

A low or decreasing cost per person can indicate higher efficiency. However, this is likely to be the case only where the low or decreasing cost is associated with services of equal or superior effectiveness.

This indicator needs to be interpreted with care. A low or decreasing cost per person can reflect service substitution between primary healthcare and hospital or specialist services — potentially at greater expense. This indicator does not include costs for primary healthcare services provided by salaried GPs in community health settings, particularly in rural and remote areas, through emergency departments, and Indigenous-specific primary healthcare 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.

Data for this indicator are comparable.


Nationally, the recurrent cost to the Australian Government of general practice was $299 per person in 2011-12 (figure 11.36).
Figure 11.36  **Australian Government real expenditure per person on GPs (2011-12 dollars)**

<table>
<thead>
<tr>
<th></th>
<th>2007-08</th>
<th>2008-09</th>
<th>2009-10</th>
<th>2010-11</th>
<th>2011-12</th>
</tr>
</thead>
<tbody>
<tr>
<td>NSW</td>
<td>310.0</td>
<td>310.0</td>
<td>310.0</td>
<td>310.0</td>
<td>310.0</td>
</tr>
<tr>
<td>Vic</td>
<td>290.0</td>
<td>290.0</td>
<td>290.0</td>
<td>290.0</td>
<td>290.0</td>
</tr>
<tr>
<td>Qld</td>
<td>270.0</td>
<td>270.0</td>
<td>270.0</td>
<td>270.0</td>
<td>270.0</td>
</tr>
<tr>
<td>WA</td>
<td>250.0</td>
<td>250.0</td>
<td>250.0</td>
<td>250.0</td>
<td>250.0</td>
</tr>
<tr>
<td>SA</td>
<td>230.0</td>
<td>230.0</td>
<td>230.0</td>
<td>230.0</td>
<td>230.0</td>
</tr>
<tr>
<td>Tas</td>
<td>210.0</td>
<td>210.0</td>
<td>210.0</td>
<td>210.0</td>
<td>210.0</td>
</tr>
<tr>
<td>ACT</td>
<td>200.0</td>
<td>200.0</td>
<td>200.0</td>
<td>200.0</td>
<td>200.0</td>
</tr>
<tr>
<td>NT</td>
<td>190.0</td>
<td>190.0</td>
<td>190.0</td>
<td>190.0</td>
<td>190.0</td>
</tr>
<tr>
<td>Aust</td>
<td>180.0</td>
<td>180.0</td>
<td>180.0</td>
<td>180.0</td>
<td>180.0</td>
</tr>
</tbody>
</table>

**Source**: DoHA (unpublished) MBS, PIP, GPII, DGPP and DVA data collections; table 11A.2.

**Outcomes**

Outcomes are the impact of services on the status of an individual or group (while outputs are the services delivered) (see chapter 1, section 1.5). Intermediate outcomes (such as vaccination coverage within a target group) moderate final outcomes (such as the incidence of vaccine preventable diseases). Both intermediate and final primary and community health outcome indicators are reported.

**Child immunisation coverage**

‘Child immunisation coverage’ is an indicator of governments’ objective to achieve high immunisation coverage levels for children to prevent selected vaccine preventable diseases (box 11.19).
Box 11.19  Child immunisation coverage

‘Child immunisation coverage’ is defined by three measures:

- the proportion of children aged 12 months to less than 15 months who are fully immunised, where children assessed as fully immunised at 12 months are immunised against diphtheria, tetanus, whooping cough, polio, *Haemophilus influenzae* type b and hepatitis B
  - data quality information for this measure is under development

- the proportion of children aged 24 months to less than 27 months who are fully immunised, where 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
  - data quality information for this measure is under development

- the proportion of children aged 60 months to less than 63 months who are fully immunised, where children assessed as fully immunised at 60 months are immunised against diphtheria, tetanus, whooping cough, polio, and measles, mumps and rubella

A high or increasing proportion of children who are fully immunised indicates a reduction in the risk of children contracting a range of vaccine preventable diseases, including measles, whooping cough and *Haemophilus influenzae* type b.

Data for this indicator are comparable.

Many providers deliver child immunisation services (table 11.8). 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 7 years of age.
Table 11.8  Valid vaccinations supplied to children under 7 years of age, by provider type, 2007–2012 (per cent)a, b, c

<table>
<thead>
<tr>
<th>Provider</th>
<th>NSW</th>
<th>Vic</th>
<th>Qld</th>
<th>WA</th>
<th>SA</th>
<th>Tas</th>
<th>ACT</th>
<th>NT</th>
<th>Aust</th>
</tr>
</thead>
<tbody>
<tr>
<td>GP</td>
<td>84.4</td>
<td>53.4</td>
<td>82.8</td>
<td>64.4</td>
<td>69.2</td>
<td>87.1</td>
<td>42.4</td>
<td>4.4</td>
<td>71.3</td>
</tr>
<tr>
<td>Council</td>
<td>5.6</td>
<td>45.3</td>
<td>7.0</td>
<td>6.4</td>
<td>18.4</td>
<td>12.1</td>
<td>–</td>
<td>–</td>
<td>16.8</td>
</tr>
<tr>
<td>State or Territory health department</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>6.1</td>
<td>0.1</td>
<td>0.1</td>
<td>19.1</td>
<td>0.3</td>
<td>0.9</td>
</tr>
<tr>
<td>Public hospital</td>
<td>2.0</td>
<td>0.5</td>
<td>3.0</td>
<td>4.4</td>
<td>2.6</td>
<td>0.2</td>
<td>0.8</td>
<td>7.5</td>
<td>2.1</td>
</tr>
<tr>
<td>Private hospital</td>
<td>0.1</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>9.0</td>
<td>–</td>
</tr>
<tr>
<td>Indigenous health service</td>
<td>0.5</td>
<td>–</td>
<td>1.1</td>
<td>0.6</td>
<td>0.5</td>
<td>–</td>
<td>0.2</td>
<td>10.8</td>
<td>0.7</td>
</tr>
<tr>
<td>Community health centre</td>
<td>7.3</td>
<td>0.7</td>
<td>5.7</td>
<td>18.1</td>
<td>9.1</td>
<td>0.5</td>
<td>37.5</td>
<td>76.0</td>
<td>8.0</td>
</tr>
<tr>
<td>Otherd</td>
<td>–</td>
<td>–</td>
<td>0.3</td>
<td>–</td>
<td>0.1</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>0.1</td>
</tr>
<tr>
<td>Total</td>
<td>100.0</td>
<td>100.0</td>
<td>100.0</td>
<td>100.0</td>
<td>100.0</td>
<td>100.0</td>
<td>100.0</td>
<td>100.0</td>
<td>100.0</td>
</tr>
</tbody>
</table>

a Data are for the period 1 July 2007 to 30 June 2012.  
b Data are based on State/Territory in which the immunisation provider was located.  
c 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.  
d Other includes Divisions of GP, Flying Doctors Services, Indigenous Health Workers, Community nurses and unknown. – Nil or rounded to zero.


Around 91.9 per cent of Australian children aged 12 months to less than 15 months at 30 June 2012 were assessed as fully immunised (figure 11.37).
Figure 11.37  **Children aged 12 months to less than 15 months who were fully immunised**\(^a, b, c, d\)

- Coverage measured at 30 June for children turning 12 months of age by 31 March, by State or Territory in which the child resided. 
- The Australian Childhood Immunisation Register (ACIR) includes all children under 7 years of age who are registered with DHS, Medicare. By the age of 12 months, over 98 per cent of Australian children have been registered with DHS, Medicare. 
- There can be some under-reporting by providers, so vaccination coverage estimates based on ACIR data are considered minimum estimates (NCIRS 2000). 
- Relatively low coverage rates for the June 2011 quarter are associated with parents not receiving immunisation reminders due to administrative error.

Source: DoHA (unpublished) ACIR data collection; table 11A.60.

Nationally, 92.3 per cent of children aged 24 months to less than 27 months at 30 June 2012 were assessed as being fully immunised (figure 11.38).
Figure 11.38  **Children aged 24 months to less than 27 months who were fully immunised\(^a, b, c\)**

\[\text{\begin{tabular}{|c|c|c|c|c|c|}
\hline
\text{Year} & \text{NSW} & \text{Vic} & \text{Qld} & \text{WA} & \text{SA} & \text{Tas} & \text{ACT} & \text{NT} & \text{Aust} \\
\hline
2008 & 80 & 90 & 95 & 85 & 90 & 85 & 90 & 95 & 90 \\
2009 & 85 & 90 & 95 & 85 & 90 & 85 & 90 & 95 & 90 \\
2010 & 90 & 95 & 98 & 90 & 95 & 90 & 95 & 98 & 90 \\
2011 & 95 & 98 & 98 & 95 & 98 & 95 & 98 & 98 & 95 \\
2012 & 98 & 98 & 98 & 98 & 98 & 98 & 98 & 98 & 98 \\
\hline
\end{tabular}}\]

\(^a\) Coverage measured at 30 June for children turning 24 months of age by 31 March, by State or Territory in which the child resided. \(^b\) The ACIR includes all children under 7 years of age who are registered with DHS, Medicare. By the age of 12 months, over 98 per cent of Australian children have been registered with DHS, 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) ACIR data collection; table 11A.61.

Nationally, 90.2 per cent of Australian children aged 60 months to less than 63 months at 30 June 2012 were assessed as fully immunised (figure 11.39).
Figure 11.39  **Children aged 60 months to less than 63 months who were fully immunised**\(^a\), \(^b\), \(^c\)

\[\begin{array}{cccccc}
\text{Per cent} \\
\hline
0 & 20 & 40 & 60 & 80 & 100 \\
\hline
\text{NSW} & 85 & 83 & 82 & 81 & 80 \\
\text{Vic} & 87 & 86 & 85 & 84 & 83 \\
\text{Qld} & 84 & 83 & 82 & 81 & 80 \\
\text{WA} & 86 & 85 & 84 & 83 & 82 \\
\text{SA} & 88 & 87 & 86 & 85 & 84 \\
\text{Tas} & 89 & 88 & 87 & 86 & 85 \\
\text{ACT} & 90 & 89 & 88 & 87 & 86 \\
\text{NT} & 91 & 90 & 89 & 88 & 87 \\
\text{Aust} & 92 & 91 & 90 & 89 & 88 \\
\end{array}\]

\(^a\) Coverage measured at 30 June for children turning 60 months of age by 31 March, by State or Territory in which the child resided. \(^b\) The ACIR includes all children under 7 years of age who are registered with DHS, Medicare. By the age of 12 months, over 98 per cent of Australian children have been registered with DHS, 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) ACIR data collection; table 11A.62.

**Notifications of selected childhood diseases**

‘Notifications of selected childhood diseases’ is an indicator of governments’ objective to improve population health outcomes through the prevention of selected vaccine preventable childhood diseases (box 11.20).

**Box 11.20  Notifications of selected childhood diseases**

‘Notifications of selected childhood diseases’ is defined as the number of notifications of measles, pertussis and invasive *Haemophilus influenzae* type b reported to the National Notifiable Diseases Surveillance System (NNDSS) by State and Territory health authorities for children aged 0–14 years, per 100 000 children in that age group.

(Continued next page)
A low or reducing notification rate for the selected diseases indicates that the immunisation program is more effective. Measles, pertussis (whooping cough) and invasive *Haemophilus influenzae* type b are nationally notifiable vaccine preventable diseases. Notification of the relevant State or Territory authority is required when a nationally notifiable disease is diagnosed. 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 in 1 in 25 cases. The activities of GPs and community health services can reduce the prevalence of these diseases through immunisation (and consequently the notification rates).

Data for this indicator are comparable.

Data quality information for this indicator is under development.

In 2011-12 the national notification rate for measles was 0.6 per 100 000 children aged 0–14 years (figure 11.40). There were 27 notifications for this age group in 2011-12, lower than the 61 notifications for the previous year (table 11A.63).

![Figure 11.40](image)

*Notifications of measles per 100 000 children aged 0–14 years*  

*Data are suppressed where there are fewer than 5 notifications. Data have been revised and differ from data published in the 2012 Report.*

*Nationally, there were over 15 000 notifications for pertussis (whooping cough) for children aged 0–14 years in 2011-12 — a rate of 356 notifications per 100 000 children in this age group (figure 11.41).*
In 2011-12, the national notification rate for invasive *Haemophilus influenzae* type b — 0.2 per 100,000 children aged 0–14 years — remained low, consistent with recent years (figure 11.42).

**Figure 11.41**  
**Notifications of pertussis (whooping cough) per 100,000 children aged 0–14 years**

Data are suppressed where there are fewer than 5 notifications. Data have been revised and differ from data published in the 2012 Report.

Source: DoHA (unpublished) NNDSS, ABS *Population by Age and Sex, Australian States and Territories* (various years), Cat. No. 3201.0; table 11A.64.

**Figure 11.42**  
**Notifications of invasive *Haemophilus influenzae* type b per 100,000 children aged 0–14 years, Australia**

Data have been revised and differ from data published in the 2012 Report.

Source: DoHA (unpublished) NNDSS, ABS *Population by Age and Sex, Australian States and Territories* (various years), Cat. No. 3201.0; table 11A.65.
Participation for women in breast cancer screening

‘Participation for women in breast cancer screening’ is an indicator of governments’ objective to reduce morbidity and mortality attributable to breast cancer through the provision of early detection services (box 11.21).

Box 11.21 Participation for women in breast cancer screening

‘Participation for women in breast cancer screening’ is defined as the number of women aged 50–69 years who are screened in the BreastScreen Australia Program over a 24 month period, divided by the estimated population of women aged 50–69 years and reported as a rate.

A high or increasing participation rate is desirable.

Data reported for this indicator are comparable.


Early detection of breast cancer is associated with improved morbidity and mortality outcomes. Early detection allows a wider range of treatment options — including less invasive procedures — and a higher likelihood of survival, than does later detection (AIHW and NBCC 2007). The BreastScreen Australia Program is jointly funded by the Australian, State and Territory governments to undertake nationwide breast cancer screening. It aims to achieve at least 70 per cent participation in screening over a period of 24 months in the target group of women aged 50–69 years. Women aged 40–49 years and 70 years or over can also access the program.

An evaluation of the BreastScreen Australia Program found that it has been successful in reducing mortality from breast cancer in the target age group (women aged 50–69 years) by approximately 21–28 per cent since screening commenced in 1991 (DoHA 2009). Further, the relatively high proportion of cancers that are detected early, and treated by breast conserving surgery, was associated with reduced treatment related morbidity for Program participants.

The national participation rate for women aged 50–69 years in BreastScreen Australia screening programs decreased from 56.1 per cent in the 24 month period 2006 and 2007 to 53.9 per cent in the 24 month period 2010 and 2011 (figure 11.43). These rates remain below the National Accreditation Standards aim of participation by 70 per cent women in this age group.
Figure 11.43 **Age standardised participation rate for women aged 50–69 years in BreastScreen Australia screening programs (24 month period)**\(^a, b, c, d\)

<table>
<thead>
<tr>
<th>Year</th>
<th>Per cent</th>
</tr>
</thead>
<tbody>
<tr>
<td>2006–2007</td>
<td></td>
</tr>
<tr>
<td>2007–2008</td>
<td></td>
</tr>
<tr>
<td>2008–2009</td>
<td></td>
</tr>
<tr>
<td>2009–2010</td>
<td></td>
</tr>
<tr>
<td>2010–2011</td>
<td></td>
</tr>
</tbody>
</table>

\(^a\) The participation rate is the number of women aged 50–69 years resident in the jurisdiction who were screened during the reference period, divided by the estimated number of women aged 50–69 years resident in the jurisdiction midway through the reference period. \(^b\) In general, women resident in the jurisdiction represent over 99 per cent of the women screened in each jurisdiction, except for the ACT (where residents accounted for 91.3 per cent of those screened in the 2010–2011 reference period). \(^c\) The estimated resident population (ERP) is computed as the average of the ERP in each calendar year of the reference period. \(^d\) Rates are standardised to the 2001 Australian population standard.


Indigenous women, women from non-English speaking backgrounds (NESB) and women living in outer regional, remote and very remote areas can experience particular language, cultural and geographic barriers to accessing breast cancer screening. Participation rates for community groups at or close to those for the total population indicate equitable access to early detection services.

Participation rates in the BreastScreen Australia Program for women from selected community groups are shown in table 11.9. In the 24 month period 2010 and 2011, the national age standardised participation rate for Indigenous women aged 50–69 years (36.1 per cent) was below the total participation rate in that age group (53.9 per cent), although this can in part reflect under-reporting of Indigenous status in screening program records (table 11A.68). For NESB women for the same 24 month period and age group, the national participation rate of 51.1 per cent was also lower than that of the national total female population (table 11A.69). Care needs to be taken when comparing data across jurisdictions as there is variation in the collection of Indigenous and NESB identification data, and in the collection of residential postcodes data. Updated State and Territory data for participation rate by
remoteness area were not available for the 2013 Report — data for previous years as well as national data for 2010–2011 are reported in table 11A.70.

Table 11.9  **Age standardised participation rate for women aged 50–69 years from selected communities in BreastScreen Australia programs, 2010 and 2011 (24 month period) (per cent)***

<table>
<thead>
<tr>
<th></th>
<th>NSW</th>
<th>Vic</th>
<th>Qld</th>
<th>WA</th>
<th>SA</th>
<th>Tas</th>
<th>ACT</th>
<th>NT</th>
<th>Aust</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indigenous</td>
<td>34.5</td>
<td>29.8</td>
<td>46.4</td>
<td>33.4</td>
<td>33.3</td>
<td>46.1</td>
<td>47.5</td>
<td>24.8</td>
<td>36.1</td>
</tr>
<tr>
<td>NESB</td>
<td>52.5</td>
<td>43.6</td>
<td>67.8</td>
<td>67.1</td>
<td>51.3</td>
<td>45.0</td>
<td>14.7</td>
<td>38.7</td>
<td>51.1</td>
</tr>
<tr>
<td>All women aged 50–69 years</td>
<td>49.6</td>
<td>54.3</td>
<td>56.4</td>
<td>58.2</td>
<td>57.4</td>
<td>57.0</td>
<td>51.1</td>
<td>40.7</td>
<td>53.9</td>
</tr>
</tbody>
</table>

*a First and subsequent rounds.  
b Rates are standardised to the Australian population at 30 June 2001.  
c Data reported for this measure are not directly comparable.  
d Women resident in the jurisdiction represent over 99 per cent of women screened in each jurisdiction except the ACT (91.3 per cent in 2010–2011).  
e Women who self-identify as being of Aboriginal and/or Torres Strait Islander descent.  
f NESB is defined as speaking a language other than English at home.

*Source: State and Territory governments (unpublished); ABS (2011) Population by Age and Sex, Australian States and Territories, June 2011, Cat. no. 3201.0; ABS (unpublished) Experimental Estimates And Projections, Aboriginal And Torres Strait Islander Australians, 1991 to 2021, Cat. no. 3238.0; ABS (unpublished) 2006 Census of Population and Housing; tables 11A.66–11A.69.*

**Participation for women in cervical screening**

‘Participation for women in cervical screening’ is an indicator of governments’ objective to reduce morbidity and mortality attributable to cervical cancer through the provision of early detection services (box 11.22).

**Box 11.22  Participation for women in cervical screening**

‘Participation for women in cervical screening’ is defined as the number of women aged 20–69 years who are screened over a two year period, divided by the estimated population of eligible women aged 20–69 years and reported as a rate. Eligible women are those who have not had a hysterectomy.

A high or increasing proportion of eligible women aged 20–69 years who have been screened is desirable.

Data for this indicator are comparable.


It is estimated that up to 90 per cent of the most common type of cervical cancer (squamous cervical cancer) can be prevented if cell changes are detected and treated.
early (DoHA 2012b; Mitchell, Hocking and 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.

The national age-standardised participation rate for women aged 20–69 years in cervical screening dropped from 59.4 per cent for the 24 month period 1 January 2006 to 31 December 2007 to 57.2 per cent for the 24 months 1 January 2010 to 31 December 2011 (figure 11.44). For most jurisdictions, participation rates have dropped slightly since the screening period of 2006 and 2007. Data for Indigenous women for 2004-05 are presented in table 11A.72.

Figure 11.44 Participation rates for women aged 20–69 years in cervical screening

<table>
<thead>
<tr>
<th>2006 and 2007</th>
<th>2008 and 2009</th>
<th>2010 and 2011</th>
</tr>
</thead>
<tbody>
<tr>
<td>%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>NSW</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vic</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Qld</td>
<td></td>
<td></td>
</tr>
<tr>
<td>WA</td>
<td></td>
<td></td>
</tr>
<tr>
<td>SA</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tas</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ACT</td>
<td></td>
<td></td>
</tr>
<tr>
<td>NT</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Aust</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

a Rates are the number of women screened as a proportion of the eligible female population, calculated as the average of the ABS ERP in each calendar year in the reference period and age standardised to the 2001 Australian population. b Eligible female population adjusted for estimated proportion who have had a hysterectomy. c Excludes women who have opted off the cervical cytology register. d Data include all women screened except for Victoria and the ACT, where data are based on residence.

Source: AIHW (unpublished) State and Territory Cervical Cytology Registry data collections; table 11A.71.

Influenza vaccination coverage for older people

‘Influenza vaccination coverage for older people’ is an indicator of governments’ objective to reduce the morbidity and mortality attributable to vaccine preventable disease (box 11.23).
Box 11.23  **Influenza vaccination coverage for older people**

‘Influenza vaccination coverage for older people’ is defined as the proportion of people aged 65 years or over who have been vaccinated against seasonal influenza. This does not include pandemic influenza such as H1N1 Influenza (commonly known as ‘swine flu’).

A high or increasing proportion of older people vaccinated against influenza reduces the risk of older people contracting influenza and suffering consequent complications. Each year, influenza and its consequences result in the hospitalisation of many older people, as well as a considerable number of deaths.

Data for this indicator are comparable.

Data quality information for this indicator is under development.

Influenza vaccinations for older people have been demonstrated to reduce hospitalisations and deaths (DoHA and NHMRC 2008). Free vaccines for Australians aged 65 years or over have been funded since 1999 by the Australian Government through the National Influenza Vaccine Program for Older Australians. GPs provide the majority of these vaccinations.

Updated data were not available for the 2013 Report. Nationally, 74.6 per cent of eligible people were fully vaccinated against influenza in 2009 (table 11A.73).

Pneumococcal disease is also a vaccine preventable disease that can result in hospitalisation and/or death. Free vaccinations against pneumococcal disease became available to older Australians in 2005. Data for 2009 for older adults fully vaccinated against both influenza and pneumococcal disease are presented by remoteness in table 11A.74. Data for Indigenous Australians fully vaccinated against influenza and pneumococcal disease in 2004-05 are presented in table 11A.75.

**Selected potentially preventable hospitalisations**

‘Selected potentially preventable hospitalisations’ is an indicator of governments’ objective to reduce potentially preventable hospitalisations through the delivery of effective primary healthcare services (box 11.24).
Box 11.24 Selected potentially preventable hospitalisations

‘Selected potentially preventable hospitalisations’ is defined as hospital admissions that may be avoided by effective management of illness and injury in the primary and community healthcare sector or, in some cases, by preventing illness and injury altogether.

Three measures of selected potentially preventable hospitalisations are reported:

- potentially preventable hospitalisations for selected vaccine preventable, acute and chronic conditions, as defined in the Victorian Ambulatory Care Sensitive Conditions Study (AIHW 2012b; DHS 2002)
- potentially preventable hospitalisations for diabetes
- potentially preventable hospitalisations of older people for falls.

Low or decreasing separation rates for selected potentially preventable hospitalisations can indicate improvements in the effectiveness of preventative programs and/or more effective management of selected conditions in the primary and community healthcare sector.

Factors outside the control of the primary and community healthcare sector also influence hospitalisation rates for these conditions (AIHW 2008b, 2012b). For example, the underlying prevalence of conditions, patient compliance with treatment and older people’s access to aged care services and other support.

Data for this indicator are comparable.


Potentially preventable hospitalisations for selected vaccine preventable, acute and chronic conditions

Studies have shown that hospitalisation rates for selected vaccine preventable, acute and chronic conditions are significantly affected by the availability of care in the primary and community healthcare sector (DHS 2002). These are conditions for which hospitalisation can potentially be avoided, through prevention of the condition — for example, through vaccination — or, prevention of exacerbations or complications requiring hospitalisation — through effective management of the condition in the primary and community healthcare sector. While not all hospitalisations for the selected conditions can be prevented, strengthening the effectiveness of primary and community healthcare has considerable potential to reduce the need for hospitalisation for these conditions.

Variation in hospitalisation rates data can also be affected by differences in hospital protocols for clinical coding and admission between and within jurisdictions. This
particularly affects diagnoses of dehydration and gastroenteritis and diabetes complications. The effect is exacerbated for diabetes hospitalisations data disaggregated by Indigenous status because of the high prevalence of diabetes in Indigenous communities. Caution should also be used in time series analysis because of revisions to clinical coding standards and improvements in data quality over time, as well as changes in hospital coding and admission protocols.

Data presented by Indigenous status are adjusted to account for differences in the age structures of these populations across states and territories.

Nationally, the age standardised hospital separation rate for the selected vaccine preventable, acute and chronic conditions reported here was 23.3 per 1000 people in 2010-11 (table 11.10). Of these, 47.7 per cent were for chronic and 49.4 per cent for acute conditions (table 11A.76). Data are presented disaggregated by Indigenous status in table 11A.77 and remoteness in table 11A.78. National data by Indigenous status and remoteness are presented in table 11A.79.

Table 11.10 Separations for selected potentially preventable hospitalisations per 1000 people, 2010-11a, b

<table>
<thead>
<tr>
<th></th>
<th>NSW</th>
<th>Vic</th>
<th>Qld</th>
<th>WA</th>
<th>SA</th>
<th>Tas</th>
<th>ACT</th>
<th>NT</th>
<th>Austc</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vaccine preventable conditions</td>
<td>0.6</td>
<td>0.8</td>
<td>0.8</td>
<td>0.6</td>
<td>1.0</td>
<td>0.4</td>
<td>0.5</td>
<td>3.0</td>
<td>0.8</td>
</tr>
<tr>
<td>Selected acute conditionsd</td>
<td>10.6</td>
<td>11.6</td>
<td>12.3</td>
<td>12.6</td>
<td>12.4</td>
<td>8.4</td>
<td>9.0</td>
<td>18.0</td>
<td>11.5</td>
</tr>
<tr>
<td>Selected chronic conditionse</td>
<td>10.1</td>
<td>11.9</td>
<td>12.0</td>
<td>10.6</td>
<td>11.5</td>
<td>9.1</td>
<td>8.5</td>
<td>22.0</td>
<td>11.1</td>
</tr>
<tr>
<td>Totalf, g</td>
<td>21.2</td>
<td>24.2</td>
<td>25.0</td>
<td>23.7</td>
<td>24.7</td>
<td>17.7</td>
<td>17.9</td>
<td>42.5</td>
<td>23.3</td>
</tr>
</tbody>
</table>

*a Separation rates are directly age standardised to the Australian population at 30 June 2001. 
*b Rates are based on State/Territory of usual residence. 
*c Includes other territories. Excludes overseas residents and unknown state of residence. 
*d Selected acute conditions excluding dehydration and gastroenteritis. 
*e Selected chronic conditions excluding diabetes complications (additional diagnoses only). 
*f Total is all potentially preventable hospitalisations excluding dehydration and gastroenteritis and diabetes complications (additional diagnoses only). 
*g Totals may not add as more than one condition may be reported for a separation. 

Source: AIHW (2012b) Australian Hospital Statistics 2010-11, Cat. no. HSE 117; table 11A.76.

Nationally, the age standardised hospital separation rate for all vaccine preventable conditions was 0.8 per 1000 people in 2010-11 (table 11.11). Nationally, influenza and pneumonia accounted for 73.8 per cent of hospital separations for vaccine preventable conditions in 2010-11 (AIHW 2012).
The age standardised hospital separation rate for vaccine preventable conditions was higher for Indigenous Australians than for non-Indigenous Australians in 2010-11, in most jurisdictions (figure 11.45).

### Table 11.11  **Separations for vaccine preventable conditions per 1000 people, 2010-11**^{a,b}

<table>
<thead>
<tr>
<th>Condition</th>
<th>NSW</th>
<th>Vic</th>
<th>Qld</th>
<th>WA</th>
<th>SA</th>
<th>Tas</th>
<th>ACT</th>
<th>NT</th>
<th>Aust^{c}</th>
</tr>
</thead>
<tbody>
<tr>
<td>Influenza and pneumonia</td>
<td>0.5</td>
<td>0.5</td>
<td>0.6</td>
<td>0.5</td>
<td>0.7</td>
<td>0.3</td>
<td>0.4</td>
<td>2.5</td>
<td>0.6</td>
</tr>
<tr>
<td>Other conditions</td>
<td>0.1</td>
<td>0.3</td>
<td>0.2</td>
<td>0.1</td>
<td>0.2</td>
<td>0.1</td>
<td>0.1</td>
<td>0.5</td>
<td>0.2</td>
</tr>
<tr>
<td><strong>Total</strong>^{d}</td>
<td>0.6</td>
<td>0.8</td>
<td>0.8</td>
<td>0.6</td>
<td>1.0</td>
<td>0.4</td>
<td>0.5</td>
<td>3.0</td>
<td>0.8</td>
</tr>
</tbody>
</table>

^{a} Separation rates are directly age standardised to the Australian population at 30 June 2001. ^{b} Rates are based on State/Territory of usual residence. ^{c} Includes other territories and excludes overseas residents and unknown State of residence. ^{d} Totals may not add due to rounding.

*Source: AIHW (2012b) *Australian Hospital Statistics 2010-11*, Cat. no. HSE 117; table 11A.80.*
Figure 11.45  Separations for vaccine preventable conditions by Indigenous status\textsuperscript{a, b, c, d, e}

\textsuperscript{a} Separation rates are directly age standardised to the Australian population at 30 June 2001. \textsuperscript{b} Caution should be used in the interpretation of these data because of jurisdictional differences in data quality. \textsuperscript{c} Separation rates are based on State/Territory of usual residence. \textsuperscript{d} NT data for Indigenous Australians are for public hospitals only. \textsuperscript{e} Total comprises NSW, Victoria, Queensland, WA, SA and the NT (public hospitals only), for which Indigenous status data are of sufficient quality for statistical reporting purposes. Indigenous status data reported for Tasmania and the ACT should be interpreted with caution until further assessment of Indigenous identification is completed.

Source: AIHW (unpublished) National Hospital Morbidity Database; table 11A.77.

Of the selected acute conditions, dental conditions, dehydration and gastroenteritis, and pyelonephritis recorded the highest rates of hospitalisation nationally in 2010-11 (table 11.12).
Table 11.12  Separations for selected acute conditions per 1000 people, 2010-11\textsuperscript{a, b}

<table>
<thead>
<tr>
<th>Condition</th>
<th>NSW</th>
<th>Vic</th>
<th>Qld</th>
<th>WA</th>
<th>SA</th>
<th>Tas</th>
<th>ACT</th>
<th>NT</th>
<th>Aust\textsuperscript{c}</th>
</tr>
</thead>
<tbody>
<tr>
<td>Appendicitis</td>
<td>0.1</td>
<td>0.1</td>
<td>0.1</td>
<td>0.1</td>
<td>0.1</td>
<td>0.1</td>
<td>0.1</td>
<td>0.1</td>
<td>0.1</td>
</tr>
<tr>
<td>Cellulitis</td>
<td>1.8</td>
<td>1.8</td>
<td>2.3</td>
<td>1.7</td>
<td>1.7</td>
<td>1.3</td>
<td>1.4</td>
<td>3.9</td>
<td>1.9</td>
</tr>
<tr>
<td>Convulsions and epilepsy</td>
<td>1.5</td>
<td>1.5</td>
<td>1.6</td>
<td>1.5</td>
<td>1.6</td>
<td>1.1</td>
<td>1.3</td>
<td>3.2</td>
<td>1.5</td>
</tr>
<tr>
<td>Dehydration and gastroenteritis</td>
<td>2.7</td>
<td>3.5</td>
<td>2.8</td>
<td>2.8</td>
<td>2.8</td>
<td>2.1</td>
<td>1.7</td>
<td>2.4</td>
<td>2.9</td>
</tr>
<tr>
<td>Dental conditions</td>
<td>2.3</td>
<td>2.9</td>
<td>2.7</td>
<td>3.7</td>
<td>3.3</td>
<td>2.3</td>
<td>2.1</td>
<td>2.9</td>
<td>2.8</td>
</tr>
<tr>
<td>Ear, nose and throat infections</td>
<td>1.6</td>
<td>1.6</td>
<td>1.9</td>
<td>1.9</td>
<td>2.3</td>
<td>1.1</td>
<td>1.0</td>
<td>2.3</td>
<td>1.7</td>
</tr>
<tr>
<td>Gangrene</td>
<td>0.2</td>
<td>0.3</td>
<td>0.3</td>
<td>0.2</td>
<td>0.2</td>
<td>0.3</td>
<td>0.1</td>
<td>0.9</td>
<td>0.3</td>
</tr>
<tr>
<td>Pelvic inflammatory disease</td>
<td>0.2</td>
<td>0.2</td>
<td>0.3</td>
<td>0.2</td>
<td>0.2</td>
<td>0.1</td>
<td>0.2</td>
<td>0.1</td>
<td>0.2</td>
</tr>
<tr>
<td>Perforated/bleeding ulcer</td>
<td>0.2</td>
<td>0.2</td>
<td>0.2</td>
<td>0.2</td>
<td>0.2</td>
<td>0.2</td>
<td>0.3</td>
<td>0.3</td>
<td>0.2</td>
</tr>
<tr>
<td>Pyelonephritis\textsuperscript{d}</td>
<td>2.5</td>
<td>2.7</td>
<td>2.8</td>
<td>2.7</td>
<td>2.4</td>
<td>1.6</td>
<td>2.3</td>
<td>3.7</td>
<td>2.6</td>
</tr>
<tr>
<td><strong>Total</strong>\textsuperscript{e}</td>
<td>13.0</td>
<td>14.9</td>
<td>14.8</td>
<td>15.1</td>
<td>14.9</td>
<td>10.2</td>
<td>10.4</td>
<td>20.3</td>
<td>14.2</td>
</tr>
<tr>
<td>Total excluding dehydration and gastroenteritis\textsuperscript{b}</td>
<td>10.6</td>
<td>11.6</td>
<td>12.3</td>
<td>12.6</td>
<td>12.4</td>
<td>8.4</td>
<td>9.0</td>
<td>18.0</td>
<td>11.5</td>
</tr>
</tbody>
</table>

\textsuperscript{a} Separation rates are directly age standardised to the Australian population at 30 June 2001. \textsuperscript{b} Rates are based on State/Territory of usual residence. \textsuperscript{c} Includes other territories and excludes overseas residents and unknown State of residence. \textsuperscript{d} Kidney inflammation caused by bacterial infection. \textsuperscript{e} Totals may not add as more than one acute condition may be reported for a separation.

Source: AIHW (2012b) Australian Hospital Statistics 2010-11, Cat. no. HSE 117; table 11A.81.

The age standardised hospital separation rate for the selected acute conditions was higher for Indigenous Australians than for non-Indigenous Australians in all jurisdictions in 2010-11 (figure 11.46).
Figure 11.46  Separations for selected acute conditions by Indigenous status\textsuperscript{a, b, c, d, e, f}

\begin{itemize}
  \item \textsuperscript{a} Excludes separations for dehydration and gastroenteritis.
  \item \textsuperscript{b} Separation rates are directly age standardised to the Australian population at 30 June 2001.
  \item \textsuperscript{c} Caution should be used in the interpretation of these data because of jurisdictional differences in data quality.
  \item \textsuperscript{d} Separation rates are based on State/Territory of usual residence.
  \item \textsuperscript{e} NT data for Indigenous Australians are for public hospitals only.
  \item \textsuperscript{f} Total comprises NSW, Victoria, Queensland, WA, SA and the NT (public hospitals only), for which Indigenous status data are of sufficient quality for statistical reporting purposes. Indigenous status data reported for Tasmania and the ACT should be interpreted with caution until further assessment of Indigenous identification is completed.
\end{itemize}

Source: AIHW (unpublished) National Hospital Morbidity Database; table 11A.77.

Of the selected chronic conditions, diabetes complications, chronic obstructive pulmonary disease, congestive cardiac failure and asthma recorded the highest rates of hospitalisation nationally in 2010-11 (table 11.13).
Table 11.13  Separations for selected chronic conditions per 1000 people, 2010-11\textsuperscript{a, b}

<table>
<thead>
<tr>
<th>Condition</th>
<th>NSW</th>
<th>Vic</th>
<th>Qld</th>
<th>WA</th>
<th>SA</th>
<th>Tas</th>
<th>ACT</th>
<th>NT</th>
<th>Aust\textsuperscript{c}</th>
</tr>
</thead>
<tbody>
<tr>
<td>Angina</td>
<td>1.1</td>
<td>1.3</td>
<td>1.8</td>
<td>1.5</td>
<td>1.3</td>
<td>0.9</td>
<td>0.7</td>
<td>2.5</td>
<td>1.3</td>
</tr>
<tr>
<td>Asthma</td>
<td>1.7</td>
<td>2.0</td>
<td>1.6</td>
<td>1.3</td>
<td>2.1</td>
<td>1.0</td>
<td>1.2</td>
<td>2.0</td>
<td>1.7</td>
</tr>
<tr>
<td>Chronic obstructive pulmonary disease</td>
<td>2.6</td>
<td>2.6</td>
<td>3.1</td>
<td>2.4</td>
<td>2.8</td>
<td>2.5</td>
<td>2.0</td>
<td>7.1</td>
<td>2.7</td>
</tr>
<tr>
<td>Congestive cardiac failure</td>
<td>1.9</td>
<td>2.2</td>
<td>2.0</td>
<td>2.0</td>
<td>1.9</td>
<td>1.5</td>
<td>2.0</td>
<td>3.7</td>
<td>2.0</td>
</tr>
<tr>
<td>Diabetes complications</td>
<td>2.5</td>
<td>3.1</td>
<td>4.2</td>
<td>8.7</td>
<td>3.0</td>
<td>2.4</td>
<td>2.3</td>
<td>7.5</td>
<td>3.7</td>
</tr>
<tr>
<td>Diabetes complications (except as additional diagnosis)\textsuperscript{d}</td>
<td>1.4</td>
<td>1.7</td>
<td>1.7</td>
<td>1.5</td>
<td>1.7</td>
<td>1.4</td>
<td>1.4</td>
<td>4.2</td>
<td>1.6</td>
</tr>
<tr>
<td>Hypertension</td>
<td>0.3</td>
<td>0.3</td>
<td>0.4</td>
<td>0.2</td>
<td>0.3</td>
<td>0.2</td>
<td>0.1</td>
<td>0.3</td>
<td>0.3</td>
</tr>
<tr>
<td>Iron deficiency anaemia</td>
<td>1.1</td>
<td>1.7</td>
<td>1.1</td>
<td>1.6</td>
<td>1.3</td>
<td>1.5</td>
<td>1.0</td>
<td>1.3</td>
<td>1.4</td>
</tr>
<tr>
<td>Nutritional deficiencies</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>0.1</td>
<td>–</td>
</tr>
<tr>
<td>Rheumatic heart disease\textsuperscript{e}</td>
<td>0.1</td>
<td>0.1</td>
<td>0.1</td>
<td>0.1</td>
<td>0.1</td>
<td>0.1</td>
<td>0.1</td>
<td>0.8</td>
<td>0.1</td>
</tr>
</tbody>
</table>

| Total\textsuperscript{f} | 11.0 | 13.0 | 14.1 | 17.4 | 12.5 | 9.7 | 9.1 | 24.3 | 12.9 |
| Total excluding diabetes complications as additional diagnosis\textsuperscript{f} | 10.1 | 11.9 | 12.0 | 10.6 | 11.5 | 9.1 | 8.5 | 22.0 | 11.1 |
| Total excluding diabetes complications (all diagnoses)\textsuperscript{f} | 8.7  | 10.3 | 10.2 | 9.1  | 9.8  | 7.6 | 7.1 | 17.7 | 9.5  |

\textsuperscript{a} Separation rates are directly age standardised to the Australian population at 30 June 2001. \textsuperscript{b} Rates are based on State/Territory of usual residence. \textsuperscript{c} Includes other territories. Excludes overseas residents and unknown State of residence. \textsuperscript{d} Excludes diabetes complications as additional diagnosis. \textsuperscript{e} Includes acute rheumatic fever as well as the chronic disease. \textsuperscript{f} Totals may not add as more than one chronic condition may be reported for a separation.

Source: AIHW (2012b) Australian Hospital Statistics 2010-11, Cat. no. HSE 117; table 11A.82.

The age standardised hospital separation rate for the selected chronic conditions was higher for Indigenous Australians than for non-Indigenous Australians in all jurisdictions in 2010-11 (figure 11.47).
Figure 11.47  Separations for selected chronic conditions by Indigenous status\textsuperscript{a, b, c, d, e, f}

\textbf{Indigenous Australians}

\begin{figure}[h]
\centering
\includegraphics[width=\textwidth]{indigenous_separations.png}
\end{figure}

\textbf{Non-Indigenous Australians}

\begin{figure}[h]
\centering
\includegraphics[width=\textwidth]{non_indigenous_separations.png}
\end{figure}

\textsuperscript{a} Excludes separations for diabetes complications (all diagnoses). \textsuperscript{b} Separation rates are directly age standardised to the Australian population at 30 June 2001. \textsuperscript{c} Caution should be used in the interpretation of these data because of jurisdictional differences in data quality. \textsuperscript{d} Separation rates are based on State/Territory of usual residence. \textsuperscript{e} Total comprises NSW, Victoria, Queensland, WA, SA and the NT (public hospitals only), for which Indigenous status data are of sufficient quality for statistical reporting purposes. \textsuperscript{f} Indigenous status data reported for Tasmania and the ACT should be interpreted with caution until further assessment of Indigenous identification is completed.

\textit{Source: AIHW (unpublished) National Hospital Morbidity Database; table 11A.77.}

\textbf{Potentially preventable hospitalisations for diabetes}

Diabetes is a chronic disease of increasing prevalence, and is an identified National Health Priority Area for Australia. People with diabetes are at high risk of serious
complications such as cardiovascular, eye and kidney disease. Type 2 diabetes is the most common form of diabetes and is largely preventable.

The provision of high quality, appropriate and effective management of diabetes in the primary and community health sector can prevent or minimise the severity of diabetes complications, thereby reducing demand for hospitalisation (AIHW 2008c). Patient compliance with management measures is also a critical determinant of the occurrence and severity of complications.

Nationally, the age standardised hospital separation rate for Type 2 diabetes mellitus as principal diagnosis was 95.5 separations per 100,000 people in 2010-11 (figure 11.48).

Figure 11.48  **Separations for Type 2 diabetes mellitus as principal diagnosis, all hospitals, 2010-11**

<table>
<thead>
<tr>
<th></th>
<th>Separations/100,000 people</th>
</tr>
</thead>
<tbody>
<tr>
<td>NSW</td>
<td></td>
</tr>
<tr>
<td>Vic</td>
<td></td>
</tr>
<tr>
<td>Qld</td>
<td></td>
</tr>
<tr>
<td>WA</td>
<td></td>
</tr>
<tr>
<td>SA</td>
<td></td>
</tr>
<tr>
<td>Tas</td>
<td></td>
</tr>
<tr>
<td>ACT</td>
<td></td>
</tr>
<tr>
<td>NT</td>
<td></td>
</tr>
<tr>
<td>Aust</td>
<td></td>
</tr>
</tbody>
</table>

**Source:** AIHW (unpublished) National Hospital Morbidity Database; table 11A.84.

The three complications of Type 2 diabetes most commonly leading to hospitalisation in 2010-11 were ophthalmic, renal and circulatory complications. Across all jurisdictions for which data were published, the highest hospital separation rates were for ophthalmic complications (figure 11.49).
Figure 11.49  Separations for principal diagnosis of Type 2 diabetes mellitus by selected complication, all hospitals, 2010-11\textsuperscript{a, b, c, d, e}

\begin{figure}[h]
\centering
\includegraphics[width=\textwidth]{figure11.49.png}
\caption{Separations for principal diagnosis of Type 2 diabetes mellitus by selected complication, all hospitals, 2010-11.}
\end{figure}

\textsuperscript{a} Results for individual complications can be affected by small numbers, and need to be interpreted with care. \textsuperscript{b} Patients can have one or more complication(s) for each separation. \textsuperscript{c} 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. \textsuperscript{d} Morbidity data are coded under coding standards that can differ over time and across jurisdictions. \textsuperscript{e} 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) National Hospital Morbidity Database; table 11A.84.

Treatment for Type 2 diabetes and related conditions is also provided in ambulatory care settings but these data are 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 variation in the proportion of separations that are ‘same day’ across jurisdictions. Nationally, 21.9 per cent of separations for Type 2 diabetes were same day separations in 2010-11 (table 11A.85).

Serious circulatory complications of diabetes can necessitate amputation of a lower limb. In 2010-11, there were 13.3 hospital separations per 100 000 people (age standardised) for lower limb amputations where Type 2 diabetes mellitus was a principal or additional diagnosis (figure 11.50).
Separations for lower limb amputation with principal or additional diagnosis of Type 2 diabetes, all hospitals, 2010-11\textsuperscript{a, b, c}

\begin{figure}
\centering
\includegraphics[width=\textwidth]{figure11.50.png}
\caption{Separations for lower limb amputation with principal or additional diagnosis of Type 2 diabetes, all hospitals, 2010-11\textsuperscript{a, b, c}}
\end{figure}

\textsuperscript{a} Separation rates are directly age standardised to the Australian population at 30 June 2001. \textsuperscript{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, 44367-01 and 44367-02 for lower limb amputation. \textsuperscript{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) National Hospital Morbidity Database; table 11A.86.

Age standardised hospital separation ratios for diabetes (excluding separations for diabetes complications as an additional diagnosis) illustrate differences between the rate of hospital admissions for Indigenous Australians and that for all Australians, taking into account differences in the age structures of the two populations. Rate ratios close to one indicate that Indigenous Australians have similar separation rates to all people, while higher rate ratios indicate relative disadvantage. A reduction in the gap in hospital separation rates between Indigenous and all people can indicate greater equity of access to primary healthcare services.

There was a marked difference in 2010-11 between the separation rates for Indigenous Australians and those for the total population for diabetes diagnoses. The quality of Indigenous identification is considered acceptable for analysis only for NSW, Victoria, Queensland, WA, SA and the NT. For these jurisdictions combined, the separation rate for Indigenous Australians was 4.4 times as high as the separation rate for all Australian people (figure 11.51).
**Figure 11.51**  
Ratio of separation rates of Indigenous Australians to all people for diabetes, 2010-11\(^a, b, c, d, e, f, g\)

<table>
<thead>
<tr>
<th>Region</th>
<th>Ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>NSW</td>
<td>3.0</td>
</tr>
<tr>
<td>Vic</td>
<td>3.5</td>
</tr>
<tr>
<td>Qld</td>
<td>4.0</td>
</tr>
<tr>
<td>WA</td>
<td>6.5</td>
</tr>
<tr>
<td>SA</td>
<td>5.5</td>
</tr>
<tr>
<td>Tas</td>
<td>4.0</td>
</tr>
<tr>
<td>ACT</td>
<td>3.0</td>
</tr>
<tr>
<td>NT</td>
<td>4.0</td>
</tr>
<tr>
<td>Total</td>
<td>4.0</td>
</tr>
</tbody>
</table>

\(^a\) Excludes separations with diabetes complications as an additional diagnosis.  
\(^b\) Ratios are directly age standardised to the Australian population at 30 June 2001.  
\(^c\) Indigenous separation rates are based on state of hospitalisation while all person rates are based on state of usual residence.  
\(^d\) Patients aged 75 years or over are excluded.  
\(^e\) Caution should be used in the interpretation of these data because of jurisdictional differences in data quality.  
\(^f\) NT data are for public hospitals only.  
\(^g\) Total comprises NSW, Victoria, Queensland, WA, SA and the NT. Data are not published for Tasmania and the ACT.

*Source:* AIHW (unpublished) National Hospital Morbidity Database; table 11A.83.

**Potentially preventable hospitalisations of older people for falls**

For people over 65 years, injurious falls accounted for one in ten days spent in hospital in 2008-09 (AIHW 2012c). 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, increased in the period 2006-07 to 2010-11 in most jurisdictions (figure 11.52).
Figure 11.52  **Separations for older people with a reported external cause of falls**\(^a, b, c\)

\[ \begin{align*}
\text{0} & \quad \text{NSW} & \quad \text{Vic} & \quad \text{Qld} & \quad \text{WA} & \quad \text{SA} & \quad \text{Tas} & \quad \text{ACT} & \quad \text{NT} & \quad \text{Aust} \\
\text{2006-07} & \quad \text{2007-08} & \quad \text{2008-09} & \quad \text{2009-10} & \quad \text{2010-11} \\
\end{align*} \]

\(^a\) Older people are defined as people aged 65 years or over. \(^b\) Separation rates are age standardised to the Australian population aged 65 years or over at 30 June 2001. \(^c\) Excludes separations records for hospital boarders and posthumous organ procurement. \(^d\) Data are not published for the NT for 2010-11.

**Source:** AIHW (unpublished) National Hospital Morbidity Database; table 11A.87.

### 11.4 Future directions in performance reporting

The topic of this chapter is all primary and community health services. However, the indicators remain heavily focused on general practice services. This partly reflects the lack of nationally consistent data available to report potential indicators for other primary and community health services. Allied health professional workforce data are anticipated to be available for the 2015 Report from the new National Registration and Accreditation Scheme. Priorities for future reporting on primary and community health services include:

- further improving the reporting of public dental health services
- reporting of community-based drug and alcohol treatment services
- reporting of additional indicators relating to the use of the MBS chronic disease management items

The scope of this chapter can 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 Australians compared to other Australians (see the Health sector overview). The Steering Committee has identified primary and community health services for Indigenous Australians as a priority area for future reporting and 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 for Indigenous Australians.

Continued efforts to improve the quality of Indigenous data, particularly Indigenous identification and completeness, are necessary to better measure the performance of primary and community health services in relation to the health of Indigenous Australians. Work being undertaken by the ABS and AIHW includes an ongoing program to improve identification of Indigenous status in Australian, State and Territory government administrative systems. Work on improving Indigenous identification in hospital admitted patient data across states and territories is ongoing, with the inclusion of data for Tasmania and the ACT in national totals a priority.
### 11.5 Definitions of key terms

<table>
<thead>
<tr>
<th>Term</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age standardised</td>
<td>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.</td>
</tr>
<tr>
<td>Annual cycle of care for people with diabetes mellitus within general practice</td>
<td>The annual cycle of care comprises the components of care, delivered over the course of a year, that are minimum requirements for the appropriate management of diabetes in general practice. MBS items can be claimed on completion of the annual cycle of care according to MBS requirements for management, which are based on but not identical to the RACGP guidelines.</td>
</tr>
</tbody>
</table>
| Asthma Action Plan                                        | An asthma action plan is an individualised, written asthma action plan incorporating information on how to recognise the onset of an exacerbation of asthma and information on what action to take in response to that exacerbation, developed in consultation with a health professional.  
  *Source*: ACAM (Australian Centre for Asthma Monitoring) 2007, Australian asthma indicators: Five-year review of asthma monitoring in Australia. Cat. no. ACM 12, AIHW, Canberra. |
| Cervical screening rates for target population            | Proportion of eligible women aged 20–69 years who are screened for cervical cancer over a 2 year period. Eligible women are those who have not had a hysterectomy.                                                                                                                                                           |
| 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 a 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 active until end June 2012. There were 109 Divisions of General Practice (DGP), 8 State Based Organisations and a peak national body, the Australian General Practice Network (AGPN). The DGPP’s aims were to contribute to improved health outcomes for communities by working with GPs and other health service providers to improve the quality and accessibility of healthcare at the local level. From 30 June 2012, Medicare Locals assumed responsibility for general practice support initiatives previously funded under the DGPP. |
| Full time workload equivalents (FWE)                      | A measure of medical practitioner supply based on claims processed by DHS, Medicare in a given period, calculated by dividing the practitioner’s DHS, Medicare billing by the mean billing of full time practitioners for that period.                                                                                                                                           |
Full time equivalents (FTE) are calculated in the same way as FWE except that FTE are capped at 1 per practitioner.

<table>
<thead>
<tr>
<th>Immunisation Coverage</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fully immunised at 12 months</td>
<td>A child who has completed three doses of diphtheria, tetanus, pertussis vaccine, three doses of polio vaccine, three doses of Hepatitis B vaccine and three doses of <em>Haemophilus influenzae</em> type B vaccine.</td>
</tr>
<tr>
<td>Fully immunised at 24 months</td>
<td>A child who has received four doses of diphtheria, tetanus, pertussis vaccine, three doses of polio vaccine, three doses of Hepatitis B vaccine, four doses of <em>Haemophilus influenzae</em> type B and one dose of measles, mumps and rubella vaccine.</td>
</tr>
<tr>
<td>Fully immunised at 60 months</td>
<td>A child who has received the necessary doses of diphtheria, tetanus, whooping cough, polio, and measles, mumps and rubella vaccines.</td>
</tr>
</tbody>
</table>

**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 registered GPs — medical practitioners who are vocationally registered under s.3F of the *Health Insurance Act 1973* (Cwlth), hold Fellowship of the RACGP or the Australian College of Rural and Remote Medicine (ACRRM) or equivalent, or hold a recognised training placement. From 1996 vocational registration is available only to GPs who attain Fellowship of the RACGP or (from April 2007) the ACRRM, or hold a recognised training placement. Other medical practitioners (OMP) — medical practitioners who are not vocationally registered GPs.

**GP-type services**
Non-referred attendances by vocationally registered GPs and OMPs, and practice nurses.

**Haemophilus influenzae type b**
A bacterium which causes bloodstream infection, meningitis, epiglottitis, and pneumonia (DoHA 2008).

**Immunisation coverage**
The proportion of a target population fully immunised with National Immunisation Program specified vaccines 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.

**Medicare Locals**
Medicare Locals (MLs) are not-for profit regional primary health care organisations with responsibility for supporting improved co-ordination of primary health care service delivery, as well as identifying and addressing gaps in primary health care services, across their region (http://www.amlalliance.com.au/about-us, accessed 27 November 2012).

Established as part of the National Health Reform agenda, a national network comprising 61 MLs and a national body, the Australian Medicare Local Alliance (AML Alliance), were operational at 1 July 2012.

**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 DHS, Medicare reimbursement.
<table>
<thead>
<tr>
<th>Term</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-referred attendances that are bulk billed</td>
<td>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.</td>
</tr>
<tr>
<td>Nationally notifiable disease</td>
<td>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.</td>
</tr>
<tr>
<td>Notifications of selected childhood diseases</td>
<td>Number of cases of measles, pertussis and <em>Haemophilus influenzae</em> type b reported to the National Notifiable Diseases Surveillance System by State and Territory health authorities.</td>
</tr>
<tr>
<td>Other medical practitioner (OMP)</td>
<td>A medical practitioner other than a vocationally registered GP who has at least half of the schedule fee value of his/her DHS Medicare billing from non-referred attendances. These practitioners are able to access only the lower A2 DHS, Medicare rebate for general practice services they provide, unless the services are provided through certain Departmental incentive programs.</td>
</tr>
<tr>
<td>Pap smear</td>
<td>A procedure for the detection of cancer and pre-cancerous conditions of the female cervix.</td>
</tr>
<tr>
<td>PBS doctor’s bag</td>
<td>Emergency drug supplies provided without charge to prescribers for use in medical emergencies in the clinic or the community at no charge to the patient.</td>
</tr>
<tr>
<td>Per person benefits paid for GP ordered pathology</td>
<td>Total benefits paid under DHS, Medicare for pathology tests requested by GPs, divided by the population.</td>
</tr>
<tr>
<td>Per person benefits paid for GP referred diagnostic imaging</td>
<td>Total benefits paid for diagnostic imaging services performed on referral by GPs, divided by the population.</td>
</tr>
</tbody>
</table>
| 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. |
<p>| Prevalence | The proportion of the population suffering from a disorder at a given point in time (point prevalence) or 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 registered, divided by the total number of FWE GPs. |
| Proportion of general practices registered for accreditation | Number of practices registered for accreditation through either of the two accreditation bodies (AGPAL and Quality Practice Accreditation Pty Ltd), divided by the total number of practices in the DGP. |
| Proportion of general practices with electronic health information systems | Number of PIP-registered practices that have taken up the eHealth PIP incentive, divided by the total number of practices registered. |</p>
<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public health</td>
<td>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.</td>
</tr>
<tr>
<td>Recognised immunisation provider</td>
<td>A provider recognised by DHS, Medicare as a provider of immunisation to children.</td>
</tr>
<tr>
<td>Recognised specialist</td>
<td>A medical practitioner classified as a specialist by the Medical Board of Australia and on the DHS, 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.</td>
</tr>
<tr>
<td>Screening</td>
<td>The performance of tests on apparently well people to detect a medical condition earlier than would otherwise be possible.</td>
</tr>
<tr>
<td>Triage category</td>
<td>The urgency of the patient’s need for medical and nursing care:</td>
</tr>
<tr>
<td></td>
<td>• category 1 — resuscitation (immediate within seconds)</td>
</tr>
<tr>
<td></td>
<td>• category 2 — emergency (within 10 minutes)</td>
</tr>
<tr>
<td></td>
<td>• category 3 — urgent (within 30 minutes)</td>
</tr>
<tr>
<td></td>
<td>• category 4 — semi-urgent (within 60 minutes)</td>
</tr>
<tr>
<td></td>
<td>• category 5 — non-urgent (within 120 minutes).</td>
</tr>
<tr>
<td>Vocationally registered</td>
<td>A medical practitioner who is vocationally registered 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 DHS, Medicare billing from non-referred attendances.</td>
</tr>
</tbody>
</table>
11.6 List of attachment tables

Attachment tables are identified in references throughout this chapter by a ‘11A’ prefix (for example, table 11A.1). Attachment tables are available on the Review website (www.pc.gov.au/gsp).

Table 11A.1 Types of encounter, 2011-12
Table 11A.2 Australian Government real expenditure on GPs ($ million) (2011-12 dollars)
Table 11A.3 Australian government expenditure on the Pharmaceutical Benefits Scheme
Table 11A.4 Australian government expenditure on the Pharmaceutical Benefits Scheme, by type of service
Table 11A.5 Medical practitioners billing Medicare and full time workload equivalent (FWE) GPs
Table 11A.6 Number of GP-type services used per 1000 people
Table 11A.7 PBS services
Table 11A.8 PBS services, by service type (‘000)
Table 11A.9 Use of public dental services, by service type, 2010
Table 11A.10 Alcohol and other drug treatment agencies, by sector, 2010-11 (number)
Table 11A.11 Indigenous primary healthcare services and episodes of healthcare (number)
Table 11A.12 Indigenous primary healthcare services and episodes of healthcare, by remoteness category (number)
Table 11A.13 Proportion of Indigenous primary healthcare services that undertook selected health related activities (per cent)
Table 11A.14 Full time equivalent (FTE) health staff employed by Indigenous primary healthcare services for which OATSIH Services Reporting (OSR) data are reported, as at 30 June 2011 (number)
Table 11A.15 Approved providers of PBS medicines, by urban and rural location
Table 11A.16 PBS expenditure per person, by urban and rural location (2011-12 dollars)
Table 11A.17 Availability of GPs by region
Table 11A.18 Availability of female GPs
Table 11A.19 Availability of public dentists (per 100 000 people)
Table 11A.20 Availability of public dental therapists (per 100 000 people)
Table 11A.21 Annual health assessments for older people by Indigenous status (per cent)
Table 11A.22 Older Indigenous people who received an annual health assessment (per cent)
Table 11A.23 Indigenous people who received a health check or assessment, by age (per cent)
Table 11A.24 Early detection activities provided by Indigenous primary healthcare services for which OATSIH Services Reporting (OSR) data are reported
Table 11A.25 Proportion of children receiving a fourth year developmental health check, by type of health check (per cent)
| Table 11A.26 | Non-referred attendances that were bulk billed, by region and age (per cent) |
| Table 11A.27 | Non-referred attendances that were bulk billed by age (per cent) |
| Table 11A.28 | People deferring access to GPs due to cost (per cent) |
| Table 11A.29 | Waiting time for GPs for an urgent appointment (per cent) |
| Table 11A.30 | Proportion of people who saw a GP in the previous 12 months who waited longer than felt acceptable to get an appointment (per cent) |
| Table 11A.31 | Selected potentially avoidable GP-type presentations to emergency departments by Indigenous status and remoteness, 2011-12 (number) |
| Table 11A.32 | Selected potentially avoidable GP-type presentations to emergency departments (number) |
| Table 11A.33 | Emergency department presentations, 2011-12 (number) |
| Table 11A.34 | People deferring access to prescribed medication due to cost (per cent) |
| Table 11A.35 | Waiting time for public dentistry (per cent) by remoteness, by State and Territory, 2011-12 |
| Table 11A.36 | Waiting time for public dentistry (per cent) by remoteness, Australia, 2011-12 |
| Table 11A.37 | Proportion of full time workload equivalent (FWE) GPs with vocational registration, by region (per cent) |
| Table 11A.38 | Number and proportion of full time workload equivalent (FWE) GPs with vocational registration |
| Table 11A.39 | General practices that are accredited at 30 June |
| Table 11A.40 | General practice activity in PIP practices (per cent) |
| Table 11A.41 | Prescriptions for oral antibiotics used most commonly in the treatment of upper respiratory tract infections ordered by GPs and provided to PBS concession card holders |
| Table 11A.42 | Proportion of GP encounters for the management of acute URTI where systemic antibiotics were prescribed or supplied |
| Table 11A.43 | Proportion of GP encounters for the management of acute URTI where systemic antibiotics were prescribed or supplied, Australia |
| Table 11A.44 | Proportion of people with diabetes who had a GP annual cycle of care, 2011-12 (per cent) |
| Table 11A.45 | Proportion of people with diabetes who had a GP annual cycle of care, by region (per cent) |
| Table 11A.46 | Proportion of people with asthma with a written asthma action plan, by age (per cent) |
| Table 11A.47 | Proportion of people with asthma with a written asthma plan, by region, 2007-08 |
| Table 11A.48 | Proportion of people with asthma with a written asthma plan, by Indigenous status, 2004-05 |
| Table 11A.49 | GP use of chronic disease management Medicare items for care planning or case conferencing |
| Table 11A.50 | Pathology tests requested by vocationally registered GPs and other medical practitioners (OMPs), real benefits paid (2011-12 dollars) and number of rebated MBS pathology items |
Table 11A.51 Diagnostic imaging referred by vocationally registered GPs and other medical practitioners (OMPs) and rebated through Medicare, real benefits paid (2011-12 dollars) and number of rebated MBS imaging items

Table 11A.52 Practices in the Practice Incentives Program (PIP) using computers for clinical purposes

Table 11A.53 Practices in the Practice Incentives Program (PIP) using computers for clinical purposes, by region

Table 11A.54 Client experience of GPs by remoteness, by State and Territory area

Table 11A.55 Client experience of GPs by remoteness area

Table 11A.56 Client experience of dental professionals by remoteness area, by State and Territory

Table 11A.57 Client experience of dental professionals by remoteness area

Table 11A.58 Annual health assessments for older people

Table 11A.59 Valid vaccinations supplied to children under seven years of age, by type of provider, 2007–2012

Table 11A.60 Children aged 12 months to less than 15 months who were fully immunised (per cent)

Table 11A.61 Children aged 24 months to less than 27 months who were fully immunised (per cent)

Table 11A.62 Children aged 60 months to less than 63 months who were fully immunised (per cent)

Table 11A.63 Notifications of measles, children aged 0–14 years

Table 11A.64 Notifications of pertussis (whooping cough), children aged 0–14 years

Table 11A.65 Notifications of Haemophilus influenzae type b, children aged 0–14 years

Table 11A.66 Participation rates for women in BreastScreen Australia (24 month period)

Table 11A.67 Participation rates for women in BreastScreen Australia by residential status, 2010 and 2011 (24 month period)

Table 11A.68 Participation rates for Indigenous women screened by BreastScreen Australia (24 month period) (first and subsequent rounds) (per cent)

Table 11A.69 Participation rates for NESB women screened by BreastScreen Australia (24 month period) (first and subsequent rounds) (per cent)

Table 11A.70 Participation rates for women screened by BreastScreen Australia, by geographic location (24 month period) (first and subsequent rounds) (per cent)

Table 11A.71 Participation rates for women in cervical screening programs, by age group (per cent) (24 month period)

Table 11A.72 Cervical screening rates among Indigenous women aged 20 to 69 years, who reported having a Pap smear at least every 2 years, 2004-05 (per cent)

Table 11A.73 Influenza vaccination coverage, people aged 65 years or over

Table 11A.74 Proportion of adults 65 years or over fully vaccinated against influenza and pneumococcal disease, by remoteness, 2009

Table 11A.75 Proportion of Indigenous Australians aged 50 years or over who were fully vaccinated against influenza and pneumococcal disease, 2004-05
Table 11A.76  Separations for selected potentially preventable hospitalisations, by State and Territory (per 1000 people)
Table 11A.77  Separations for selected potentially preventable hospitalisations by Indigenous status (per 1000 people)
Table 11A.78  Separations for selected potentially preventable hospitalisations by remoteness, 2010-11 (per 1000 people)
Table 11A.79  Separations for selected potentially preventable hospitalisations by Indigenous status and remoteness, Australia (per 1000 people)
Table 11A.80  Separations for selected vaccine preventable conditions by Indigenous status, 2010-11 (per 1000 people)
Table 11A.81  Separations for selected acute conditions by Indigenous status, 2010-11 (per 1000 people)
Table 11A.82  Separations for selected chronic conditions by Indigenous status, 2010-11 (per 1000 people)
Table 11A.83  Ratio of separations for Indigenous Australians to all Australians, diabetes, 2010-11
Table 11A.84  Separations for Type 2 diabetes mellitus as principal diagnosis by complication, all hospitals, 2010-11 (per 100 000 people)
Table 11A.85  Proportion of separations for principal diagnosis of Type 2 diabetes mellitus that were same day by complication, all hospitals, 2010-11 (per cent)
Table 11A.86  Separations for lower limb amputation with principal or additional diagnosis of Type 2 diabetes, all hospitals, 2010-11
Table 11A.84  Separations for Type 2 diabetes mellitus as principal diagnosis by complication, all hospitals, 2010-11 (per 100 000 people)

Community health programs
Table 11A.88  Australian Government, community health services programs
Table 11A.89  New South Wales, community health services programs
Table 11A.90  Victoria, community health services programs
Table 11A.91  Queensland, community health services programs
Table 11A.92  Western Australia, community health services programs
Table 11A.93  South Australia, community health services programs
Table 11A.94  Tasmania, community health services programs
Table 11A.95  Australian Capital Territory, community health services programs
Table 11A.96  Northern Territory, community health services programs
11.7 References


—— 2008a, *Aboriginal and Torres Strait Islander Health Performance Framework, 2008 report: detailed analyses*, AIHW Cat. no. IHW 22, Canberra.


—— 2008c, *Diabetes: Australian facts*, Cat. no. CVD 40, Diabetes series no. 8, Canberra.


AIHW and NBCC (National Breast Cancer Centre) 2007, *Breast cancer survival by size and nodal status in Australia*, Cat. no. CAN 34, Cancer series no. 39, AIHW, Canberra.


12 Mental health management

CONTENTS

12.1 Framework for measuring health management performance 12.2
12.2 Profile of mental health management 12.3
12.3 Framework of performance indicators for mental health management 12.16
12.4 Key performance indicators for mental health management 12.20
12.5 Future directions in performance reporting 12.65
12.6 Definitions of key terms 12.66
12.7 List of attachment tables 12.72
12.8 References 12.76

Attachment tables
Attachment tables are identified in references throughout this chapter by a '12A' prefix (for example, table 12A.1). A full list of attachment tables is provided at the end of this chapter, and the attachment tables are available from the Review website at www.pc.gov.au/gsp.

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 Australian, State and Territory governments’ management of mental health and mental illnesses through a variety of service types and delivery settings.

The following improvements have been made to the chapter this year:

• a new measure on the average length of stay has been included for the ‘cost of inpatient care’ indicator
• the cost per inpatient bed day measures have been disaggregated by program type (acute and non-acute)

• time series data reporting in some attachment tables has been expanded, in particular, six years are now reported for most data for State and Territory governments’ specialised mental health services

• data quality information (DQI) available for the first time for the indicators ‘services reviewed against the National Standards’, ‘services provided in an appropriate setting’, ‘consumer and carer involvement in decision making’, ‘post discharge community care’, ‘cost for inpatient care’, ‘cost for community-based residential care’ and ‘cost for ambulatory care’.

### 12.1 Framework for measuring health management performance

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.

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 service providers in specific settings, and the overall management of diseases, illnesses and injuries across a spectrum of services, including prevention, early detection and treatment programs. The measurement approach is summarised in figure 12.1.

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. The ‘Health sector overview’ in 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 mental health management performance framework provides information on the interaction and integration arrangements between GPs (as the key providers of primary health), community-based and hospital-based providers in meeting the needs of people with a mental illness.
12.2 Profile of mental health management

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). The World Health Organization (WHO) describes positive mental health as:

... a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community (WHO 2001).

Mental health is identified by governments as a national health priority area as are cancer, asthma, cardiovascular health, diabetes mellitus, injury prevention and control, arthritis and musculoskeletal conditions and obesity. The national health priority areas represented over 70 per cent of the total burden of disease and injury in Australia in 2003 and mental illnesses contribute significantly to this total burden (13.3 per cent) (Begg et al. 2007). The total burden comprises the number of ‘years’
lost due to fatal events (years of life lost due to premature death) and non-fatal events (years of ‘healthy’ life lost due to disability). Mental illness is the leading cause of ‘healthy’ life years lost due to disability (24 per cent of the total non-fatal burden in 2003) (Begg et al. 2007).

‘Mental illness’ is a term that describes a diverse range of behavioural and psychological conditions. These conditions can affect an individual’s mental health, functioning and quality of life. Each mental illness is unique in its incidence across the lifespan, causal factors and treatments. The most common mental illnesses are anxiety, affective (mood) and substance use disorders. Mental illness also includes ‘low prevalence’ conditions such as schizophrenia, bipolar disorder and other psychoses, and severe personality disorder (DoHA 2010). While of lower prevalence, these conditions can severely affect people’s ability to function in their daily lives (Morgan et al. 2011).

Specialised mental health management services offered by a range of government and non-government service providers include promotion, prevention, treatment, 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 specialised psychiatric units and stand-alone psychiatric hospitals all provide specialised mental health care. In addition, a number of health services provide care to mental health patients in a non-specialised health setting — for example, general practitioners (GPs), Aboriginal community controlled health services, public hospital emergency departments and outpatient departments, and public hospital general wards (as distinct from specialist psychiatric wards). Some people with a mental illness are cared for in residential aged care services.

Mental health is also the subject 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 reported in chapter 10 and the performance of primary and community health services generally is reported in chapter 11.

This chapter focuses on the performance of State and Territory specialised public mental health services that treat the mostly low prevalence, but severe mental illnesses. It also includes performance data on the services provided by GPs, psychiatrists and other allied health professionals under the Medicare Benefits Schedule (MBS).
Other health and related services are also important for people with a mental illness, including 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. Mental health patients often have complex needs that can also affect other government services they receive, such as those covered in chapter 4 (‘School education’), chapter 8 (‘Corrective services’), chapter 9 (‘Fire and ambulance services’), chapter 14 (‘Services for people with disability’) and chapter 17 (‘Homelessness services’).

Some key terms used in mental health management are outlined in section 12.6.

**Roles and responsibilities**

State and Territory governments are responsible for the funding, delivery and management of specialised public mental health services including admitted patient care in hospitals, community-based ambulatory care services and community-based residential care (for further details see the sector scope section later in this chapter). State and Territory governments also fund not-for-profit, non-government organisations (NGOs) to provide a range of support services for people with psychiatric disability arising from a mental illness.

The Australian Government is responsible for the funding of the following mental health services and related programs:

- MBS-subsidised services provided by GPs (both general and specific mental health items), private psychiatrists and allied mental health professionals (psychologists, social workers, occupational therapists, mental health nurses and Aboriginal health workers)

- Pharmaceutical Benefits Scheme (PBS) funded mental health-related medications

- other specific programs, including those provided by the non-government sector, designed to increase the level of social support and community-based care for people with a mental illness and to prevent suicide.

In addition, the Australian Government provides funding for mental health-related services through the Medicare Safety Net, the Department of Veterans’ Affairs (DVA) and the Private Health Insurance Premium Rebates.

The Australian Government also provides a specific purpose payment (SPP) to State and Territory governments for health services under the National Healthcare
Agreement (NHA). According to the *Intergovernmental Agreement on Federal Financial Relations*, under which this SPP is provided, State and Territory governments must expend the SPP on the health sector, but they have budget flexibility to allocate funds within that sector as they deem appropriate. Consequently, specific mental health funding cannot be separately identified in the Australian Government funding provided to State and Territory governments under the NHA.

The Australian, State and Territory governments also fund and/or provide other services that people with mental illnesses can access, such as employment, accommodation, income support, rehabilitation, residential aged care and other services for older people and people with disability (see chapters 13 and 14, respectively).

**Funding**

Real government recurrent expenditure of around $6.6 billion was allocated to mental health services in 2010-11 (table 12A.4). State and Territory governments made the largest contribution ($4.1 billion, or 62.5 per cent), although this includes Australian Government funding under the NHA SPP. The Australian Government spent $2.5 billion or 37.5 per cent of total government recurrent expenditure on mental health services (table 12A.4). Real average governments’ expenditure per person on specialised mental health services in 2010-11 was $294.2, an increase from $240.9 in 2006-07 (figure 12.2).

The largest component of Australian Government expenditure on mental health services in 2010-11 was expenditure under the PBS for mental health-related medications ($808.8 million) (table 12A.1). Real expenditure on PBS mental health-related medications increased by an annual average rate of 2.2 per cent between 2006-07 and 2010-11. This average annual growth rate was lower than the overall Australian Government mental health services average annual expenditure growth rate of 8.5 per cent. Expenditure on PBS mental health-related medications decreased as a share of real expenditure from 42.5 per cent in 2006-07 to 33.4 per cent in 2010-11 (table 12A.1).

In 2010-11, the next largest component of Australian Government expenditure for mental health services was MBS payments for psychologists and other allied health professionals (social workers and occupational therapists) (14.6 per cent), followed by expenditure on consultant psychiatrists (11.3 per cent) (table 12A.1). For details on the remainder of the Australian Government’s expenditure for mental health services see table 12A.1.
Real recurrent governments’ expenditure on mental health services, by funding source (2010-11 dollars)$^{a, b, c, d}$

$^a$ Real expenditure for all years (2010-11 dollars), using the implicit price deflators for general government final consumption expenditure on hospitals and nursing homes (tables 12A.71 and 12A.72). $^b$ State and Territory governments’ expenditure includes expenditure sourced from ‘other revenue’ that includes patient fees and reimbursement by third party compensation insurers and from Australian Government funding provided under the Australian Health Care Agreement base grants/NHASS. $^c$ Australian Government expenditure includes funding provided for State and Territory governments’ specialised mental health services, see table 12A.3 for details. $^d$ The quality of the NSW Mental Health Establishments (MHE) National Minimum Data Set (NMDS) 2010-11 data has been affected by the reconfiguration of the service system during the year. Delays caused by this change have also meant that the validation process for the data used in this Report was not completed.


Real expenditure per person on State and Territory governments’ specialised public mental health services has increased over time (figure 12.3). Recurrent expenditure on State and Territory governments’ specialised public mental health services in figure 12.3 includes expenditure funded from all sources, including the Australian Government. Expenditure on State and Territory governments’ specialised public mental health services by source of funding are in table 12A.3.
Figure 12.3  **Real recurrent expenditure on State and Territory governments’ specialised public mental health services (2010-11 dollars)**\(^a, b, c, d, e\)

\[
\begin{array}{cccccc}
\hline
NSW & & & & & \\
Vic & & & & & \\
Qld & & & & & \\
WA & & & & & \\
SA & & & & & \\
Tas & & & & & \\
ACT & & & & & \\
NT & & & & & \\
Aust & & & & & \\
\end{array}
\]

\(^a\) Real expenditure (2010-11 dollars), using State and Territory implicit price deflators for general government final consumption on hospitals and nursing homes (table 12A.71). \(^b\) Estimates of State and Territory governments’ spending include funding from other revenue (including patient fees and reimbursement by third party compensation insurers) and Australian Government funds. \(^c\) Depreciation is excluded for all years. Depreciation estimates are reported in table 12A.5. \(^d\) Expenditure data on State and Territory governments’ specialised public mental health services by source of funding are presented in table 12A.3. \(^e\) The quality of the NSW MHE NMDS 2010-11 data has been affected by the reconfiguration of the service system during the year. Delays caused by this change have also meant that the validation process for the data used in this Report was not completed.

Source: DoHA (unpublished); State and Territory governments (unpublished); AIHW (unpublished) MHE NMDS; table 12A.2.

Figure 12.4 shows how recurrent expenditure on State and Territory governments specialised public mental health services was distributed across the different service types in 2010-11.
Recurrent expenditure on State and Territory governments’ specialised public mental health services, by service category, 2010-11a, b, c, d, e

- Hospital inpatient
- Ambulatory
- Community residential
- Non-government organisations

<table>
<thead>
<tr>
<th>Percent</th>
<th>NSW</th>
<th>Vic</th>
<th>Qld</th>
<th>WA</th>
<th>SA</th>
<th>Tas</th>
<th>ACT</th>
<th>NT</th>
<th>Aust</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>100</td>
<td>80</td>
<td>60</td>
<td>40</td>
<td>20</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

**Source:** AIHW (unpublished) MHE NMDS; table 12A.6.

### Size and scope of sector

**Prevalence of mental illness and high/very high levels of psychological distress**

According to the National Survey of Mental Health and Wellbeing (SMHWB), in 2007, 20.0 ± 1.1 per cent of adults aged 16–85 years (or approximately 3.2 million adults) met the criteria for diagnosis of a lifetime mental disorder and had symptoms in the 12 months before the survey. A further 25.5 ± 1.4 per cent of adults aged 16–85 years had experienced a mental disorder at some point in their life, but did not have symptoms in the previous 12 months (table 12A.55).

A proxy measure of the overall mental health and wellbeing of the population is the Kessler 10 (K10) psychological distress scale. Data from the 2007 SMH WB show that people with a lifetime mental disorder who had symptoms in the previous...
12 months (20.0 ± 1.1 per cent of the total population), were significantly overrepresented in the populations who had high or very high levels of psychological distress — 57.1 ± 5.1 per cent and 79.6 ± 7.2 per cent of these populations respectively (table 12A.7). Analysis of the 1997 SMHWB showed a strong association between a high/very high K10 score and a current diagnosis of anxiety and affective disorders (ABS 2012).

According to the ABS, which use the K10 instrument in the SMHWB and National Health Surveys, the K10:

….is a scale designed to measure non-specific psychological distress, based on questions about negative emotional states experienced in the past 30 days. ….it is not a diagnostic tool, but an indicator of current psychological distress, where very high levels of distress may signify a need for professional help. It is also useful for estimating population need for mental health services (ABS 2012).

Females had higher proportions of very high levels of psychological distress than males in 2011-12 (figure 12.5). People with disability or restrictive long-term health condition and people in low socio-economic areas also reported higher proportions of very high levels of psychological distress than other community groups (table 12A.9). In 2008, 31.2 per cent of Indigenous Australians aged 18 years or over reported high/very high levels of psychological distress (table 12A.15). After adjusting for age, this was 2.5 times the rate for non-Indigenous adults. Tables 12A.8–16 contain additional data on high/very high levels of psychological distress from National Health Surveys conducted in 2004-05, 2007-08 and 2011-12.
**Mental health services**

There are a range of government provided or funded mental health services; the key services are the following:

- MBS-subsidised mental health services — services provided by a GP, psychiatrist, psychologist or another allied health professional on a fee-for-service basis that are partially or fully funded under Medicare.
- Admitted patient care in hospitals — services provided to admitted patients in stand-alone psychiatric hospitals or in specialised psychiatric units in acute hospitals.
- Community-based mental health services, comprising:
  - ambulatory care services provided by outpatient clinics (hospital and clinic based), mobile assessment and treatment teams, day programs and other services dedicated to the assessment, treatment, rehabilitation and care
  - specialised residential services that provide beds in the community, staffed on-site (24 hour and non-24 hour) by mental health professionals
  - not-for-profit, NGO services, funded by the Australian, State and Territory governments to provide community support for people with psychiatric disability, including accommodation, outreach to people living in their own...
homes, residential rehabilitation units, recreational programs, self-help and mutual support groups, carer respite services and system-wide advocacy (DoHA 2010).

**MBS-subsidised GP mental health services**

GPs are often the first type of service accessed by people seeking help when suffering from a mental illness (AIHW 2012). GPs can diagnose, manage and treat mental illnesses and they also refer patients to more specialised service providers such as psychiatrists and psychologists (see other MBS-subsidised services below).

According to the *Bettering the Evaluation and Care of Health* (BEACH) (an annual survey collected from a sample of 1000 GPs), 11.7 per cent of GP encounters (an estimated 13.9 million MBS-subsidised services) were mental health-related in 2010-11 (AIHW 2012). Under the BEACH, a mental health-related encounter is defined as one at which a mental health-related problem is managed. Problems managed reflect the GP’s understanding of the health problem presented by the patient. These encounters comprise those billed as general surgery consultations and those billed under specific mental health MBS items.

A GP can manage more than one problem at a single encounter. In 2010-11, 12.4 mental health-related problems were managed per 100 encounters. Depression was the most frequently reported mental health-related problem managed (4.2 per 100 GP encounters) and of all problems was the fifth most frequently managed (Britt et al. 2011). Anxiety (1.9 per 100 GP encounters) and sleep disturbance (1.5 per 100 GP encounters) were the next most common mental health-related problems. The most common form of GP management for a mental health-related problem was the prescription, supply or recommendation of a medication (AIHW 2012).

Another measure of GP mental-health related activity is the number of services provided under specific mental health MBS items (GP Mental Health Treatment Plan, Focussed Psychological Strategies and Family Group Therapy). In 2010-11, 2.1 million MBS-subsidised specific mental health MBS items (93.6 per 1000 population) were provided by GPs and Other Medical Practitioners (OMPs) (table 12A.17).

**Other MBS-subsidised services**

In 2010–11, 5.6 million other MBS-subsidised mental health-related services were provided by psychiatrists, psychologists and other allied health professionals to an
estimated 916,719 patients (AIHW 2012). This comprised 3.4 million provided by psychologists, 2.0 million services provided by psychiatrists, and 230,972 services provided by other allied health professionals (table 12A.17). This was equivalent to 150.2 psychologist services, 90.7 psychiatrist services, and 10.3 other allied health services per 1000 people (table 12A.17).

Admitted patient care and community-based mental health services — service use, patient days, beds and staffing

Estimating activity across the publicly funded specialised mental health services sector, which comprises admitted patient care and community-based mental health services, is problematic as the service types differ. Service activity is reported by separations for admitted patient care, episodes for community-based residential care and contacts for community-based ambulatory care. Service use data for the NGO sector are not available.

There were 80,506 separations with specialised psychiatric care in public acute hospitals and 10,997 specialised psychiatric care separations in public psychiatric hospitals in 2009-10 (table 12A.19). Schizophrenia accounted for a large proportion of separations with specialised psychiatric care in public hospitals (21.3 per cent in public acute hospitals and 22.2 per cent in public psychiatric hospitals) (table 12A.19). There were a further 5,193 ambulatory equivalent same day separations with specialised psychiatric care in public acute hospitals and 132 in public psychiatric hospitals (AIHW 2012).

There were 3,964 episodes of community-based residential care in 2009-10 (table 12A.21). Schizophrenia, schizotypal and delusional disorders as a principal diagnosis accounted for the largest proportion of these episodes (61.9 per cent) (AIHW 2012). There were 6.6 million community-based ambulatory care patient contacts, equivalent to 299.9 contacts per 1000 people, in 2009-10 (table 12A.21). For those contacts in 2009-10 where a principal diagnosis was available, the largest proportion was for schizophrenia (30.1 per cent) (AIHW 2012).

Data on service use by the Indigenous status of patients are available, but comparisons not necessarily accurate because Indigenous patients are not always correctly identified. Differences in rates of service use could also reflect other factors, including the range of social and physical infrastructure services available to Indigenous Australians, and differences in the complexity, incidence and prevalence of illnesses. Table 12A.21 contains information on use of these services by Indigenous status.
Activity can also be measured across specialised public mental health services by accrued mental health patient days, mental health beds and full time equivalent (FTE) direct care staff. Admitted patient care and community-based residential (24 hour staffed) accrued patient days per 1000 people for 2010-11 are included in figure 12.6.

Figure 12.6  **Accrued mental health patient days, 2010-11**\(^{a,b,c}\)

---

\(^a\) Queensland does not fund community-based residential services, but funds a number of campus-based and non-campus-based extended treatment services. Data from these services are included as non-acute.

\(^b\) The ACT and the NT did not provide mental health care in non-acute hospital units.

\(^c\) The quality of the NSW MHE NMDS 2010-11 data has been affected by the reconfiguration of the service system during the year. Delays caused by this change have also meant that the validation process for the data used in this Report was not completed.

*Source: AIHW (unpublished) MHE NMDS; table 12A.18.*

Beds are counted as those that can provide overnight accommodation for patients admitted to hospital or (see section 12.6 for more details). Figure 12.7 presents the number of beds per 100 000 people by service setting, in 2010-11. These data show the differences in service mix across states and territories.

Figure 12.8 reports FTE direct care staff per 100 000 people employed across the admitted patient and community-based services (ambulatory and residential). Nursing staff comprise the largest FTE component of direct care staff employed in specialised public mental health services. Across Australia in 2010-11, there were 65.8 nurses per 100 000 people, compared with 24.9 allied health care staff, 12.8 medical staff and 4.8 other personal care staff (table 12A.23). FTE direct care staff employed in specialised public mental health services, by service setting, are reported in table 12A.24.
Figure 12.7  
**Mental health beds in public hospitals and community-based residential units, 2010-11**

<table>
<thead>
<tr>
<th></th>
<th>Public psychiatric hospitals</th>
<th>Public acute hospitals</th>
<th>Community-based residential units</th>
</tr>
</thead>
<tbody>
<tr>
<td>NSW</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vic</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Qld</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>WA</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SA</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tas</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ACT</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NT</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Aust</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

---

a Includes beds in public hospitals and publicly funded community-based residential units.  
b Queensland does not fund community-based residential services, but funds campus-based and non-campus-based extended treatment services.  
c Beds data in WA include publicly funded mental health beds in private hospitals.  
d Tasmania, the ACT and the NT do not have public psychiatric hospitals.  
e The quality of the NSW MHE NMDS 2010-11 data has been affected by the reconfiguration of the service system during the year. Delays caused by this change have also meant that the validation process for the data used in this Report was not completed.

Source: AIHW (unpublished) MHE NMDS; table 12A.22.

---

Figure 12.8  
**FTE health professional direct care staff**

<table>
<thead>
<tr>
<th></th>
<th>2006-07</th>
<th>2007-08</th>
<th>2008-09</th>
<th>2009-10</th>
<th>2010-11</th>
</tr>
</thead>
<tbody>
<tr>
<td>NSW</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vic</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Qld</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>WA</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SA</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tas</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ACT</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NT</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Aust</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

---

a Includes staff within the health professional categories of ‘medical’, ‘nursing’, ‘allied health’ and ‘other personal care’. Section 12.6 provides detailed definitions for these staffing categories.  
b The quality of the NSW MHE NMDS 2010-11 data has been affected by the reconfiguration of the service system during the year. Delays caused by this change have also meant that the validation process for the data used in this Report was not completed.

Source: AIHW (unpublished) MHE NMDS; table 12A.23.
12.3 Framework of performance indicators for mental health management

Preventing the onset of mental illness is challenging, primarily because individual illnesses 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 draws on governments’ broad objectives for national mental health policy, as encompassed in the National Mental Health Policy 2008 (box 12.1). The performance indicator framework reports on the equity, effectiveness and efficiency of mental health services. It covers a number of service delivery types (MBS-subsidised, admitted patient and community-based services) and includes outcome indicators of system-wide performance.

Box 12.1 Broad objectives and policy directions of National Mental Health Policy

The National Mental Health Policy 2008 has an emphasis on whole-of-government mental health reform and commits the Australian, State and Territory governments to the continual improvement of Australia's mental health system. The key broad objectives are to:

- promote the mental health and well-being of the Australian community and, where possible, prevent the development of mental health problems and mental illness
- reduce the impact of mental health problems and mental illness, including the effects of stigma on individuals, families and the community
- promote recovery from mental health problems and mental illness
- assure the rights of people with mental health problems and mental illness, and enable them to participate meaningfully in society.

The key policy directions are summarised as follows:

- Rights and responsibilities of people with mental health problems and mental illness will be acknowledged and respected.
- Mental health promotion will support destigmatisation and assist people to be emotionally resilient, cope with negative experiences and participate in the community.
- The proportion of people with mental health problems, mental illness and people at risk of suicide will be reduced.

(Continued next page)
Box 12.1  (continued)

- Emerging mental health problems or mental illnesses will receive early intervention
to minimise the severity and duration of the condition and to reduce its broader
impacts.
- People will receive timely access to high quality, coordinated care appropriate to
their conditions and circumstances.
- People with mental health problems and mental illness will enjoy full social, political
and economic participation in their communities.
- The crucial role of carers will be acknowledged and respected and they will be
provided with appropriate support to enable them to fulfil their role.
- The mental health workforce will be appropriately trained and adequate in size and
distribution to meet the need for care.
- Across all sectors, mental health services should be monitored and evaluated to
ensure they are of high quality and achieving positive outcomes.
- Research and evaluation efforts will generate new knowledge about mental health
problems and mental illness that can reduce the impact of these conditions.

National Mental Health Strategy

In 1991, Australian Health Ministers signed the Mental Health Statement of Rights and Responsibilities. This Statement seeks to ensure that consumers, carers, advocates, service providers and the community are aware of their rights and responsibilities and can be confident in exercising them (Australian Health Ministers 1991). The Statement underpins the National Mental Health Strategy (NMHS) endorsed by Australian, State and Territory governments in 1992 (AIHW 2008). During 2011-12, the Statement was updated to align with the National Mental Health Policy 2008 and Australia’s international obligations with respect to the United Nations Convention on the Rights of Persons with Disabilities and the United Nations Convention on the Rights of the Child.

The NMHS was established to guide the reform agenda for mental health in Australia across the whole-of-government. The NMHS 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 NMHS. The National Mental Health Plan describes the approach to implementing the aims and objectives of the Policy. A fourth plan (2009–2014) was endorsed by all Australian Health Ministers in September 2009. The fourth plan aims to strengthen the accountability framework with Australian, State and Territory governments by developing targets and data sources for a set of indicators and to provide annual progress reports to COAG (AHMC 2009). These indicators will be the primary vehicle for monitoring
the progress of these governments in achieving national mental health reform under the fourth plan.

**COAG National Healthcare Agreement**

COAG has agreed six National Agreements to enhance accountability to the public for the outcomes achieved or outputs delivered by a range of government services, (see chapter 1 for more detail on reforms to federal financial relations).

The NHA covers the areas of health and aged care services. The NHA includes sets of performance indicators, for which the Steering Committee collates performance information for analysis by the COAG Reform Council (CRC). Performance indicators reported in this chapter are aligned with the mental health-related performance indicators in the NHA. The NHA was reviewed in 2011 and 2012 resulting in changes that have been reflected in this Report, as relevant.

**Performance indicator framework**

The performance indicator framework provides information on equity, efficiency and effectiveness, and distinguishes the outputs and outcomes of mental health management services (figure 12.9). The performance indicator framework shows which data are comparable in the 2013 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 Report’s statistical appendix 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) (appendix A).

Some changes to the names of indicators have been made in the mental health management framework for the 2013 Report:

- ‘mental health service use by special needs groups’ has changed to ‘mental health service use by selected community groups’
- ‘cost per inpatient bed day’ has changed to ‘cost of inpatient care’ as this indicator now has a measure of the average length of inpatient stay.
Data quality information is being progressively introduced for all indicators in the Report. The purpose of DQI is to provide structured and consistent information about quality aspects of data used to report on performance indicators. DQI in this Report cover the seven dimensions in the ABS’ data quality framework.

Text Data for these indicators are comparable, subject to caveats to each chart or table

Text Data for these indicators are not complete and/or not directly comparable

Text These indicators are yet to be developed or data are not collected for this Report
(institutional environment, relevance, timeliness, accuracy, coherence, accessibility and interpretability) in addition to dimensions that define and describe performance indicators in a consistent manner, and note key data gaps and issues identified by the Steering Committee. All DQI for the 2013 Report can be found at www.pc.gov.au/gsp/reports/rogs/2013.

12.4 Key performance indicators for mental health management

Outputs

Outputs are the 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 — new client index

‘New client index’ is an indicator of governments’ objective to provide mental health services in an equitable manner (box 12.2). Population treatment rates are relatively low and it might be difficult for a new client to access specialised public mental health services if resources are already utilised by existing clients.

Box 12.2 New client index

‘New client index’ is defined as the proportion of total clients under the care of State or Territory specialised public mental health services who were new clients. A new client is a consumer who has not been seen by a specialised public mental health service in the five years preceding the initial contact with a service in the relevant reference period.

A high or increasing proportion of total clients who are new might be desirable, as it suggests it is easier for new clients to access specialised public mental health services. However, results are difficult to interpret. The appropriate balance between providing ongoing care to existing clients who have continuing needs and meeting the needs of new clients is unknown.

This indicator does not provide information on whether the services are appropriate or adequate for the needs of the people receiving them (new or existing clients), or correctly targeted to those clients who are most in need.

(Continued next page)
The proportions of total clients of specialised public mental health services who are new are reported in figure 12.10.

Figure 12.10  **Proportion of total clients of specialised public mental health services who are new**\(^a, \, b, \, c\)

*a Clients in receipt of services include all people who received one or more community-based ambulatory service contact or had one or more day of inpatient or community-based residential care in the data period.

*b A new client is a consumer who had not been seen in the five years preceding the first contact with a State or Territory specialised public mental health service.

*c The approach to identifying unique clients differs across jurisdictions. Some have a State-wide unique patient identifier, others use a statistical linkage key. For SA, the client counts are not unique, but are an aggregation of three separate databases.

*Source*: State and Territory governments (unpublished); table 12A.25.

**Equity — mental health service use by selected community groups**

‘Mental health service use by selected community groups’ is an indicator of governments’ objective to provide mental health services in an equitable manner, including access to services by selected community groups such as Indigenous Australians (box 12.3).
Box 12.3  Mental health service use by selected community groups

‘Mental health service use by selected community groups’ is defined by two measures:

- proportion of the population in a selected community group using State and Territory specialised public mental health services, compared with the proportion of the population outside the selected community group using State and Territory specialised public mental health services
- proportion of the population in a selected community group using MBS-subsidised ambulatory mental health services provided by private psychiatrists, GPs and allied health providers (psychologists, social workers, occupational therapists, mental health nurses and Aboriginal health workers), compared with the proportion of the population outside the selected community group using MBS-subsidised ambulatory mental health services.

The selected community groups reported are Indigenous Australians, people from outer regional, remote and very remote locations and people residing in low socio-economic areas.

This indicator is difficult to interpret. It does not measure access according to need, that is, according to the prevalence of mental illness across the selected community group. Variations in use could be due to variations in access, but could also be a result of differences in the prevalence of mental illness. It also 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.

Data reported for this indicator are comparable.


The proportions of the population using State and Territory specialised public mental health services in 2010-11, by selected community group are reported in figure 12.11. The results at the national level show that the proportion of the population using these services is higher:

- for Indigenous Australians, than for non-Indigenous Australians (figure 12.11a)
- in remote and very remote locations, than in other locations (figure 12.11b)
- for people in the three most disadvantaged Socio-Economic Indexes for Areas (SEIFA) quintiles (1, 2 and 3), than the more advantaged quintiles (figure 12.11c).
These results, which are derived using community-based ambulatory care data, should be interpreted with care, as:

- people receiving only admitted and/or community-based residential services are not included in the proportion of people accessing services or in rates of service use
- there is no identifier to distinguish ‘treatment’ versus ‘non-treatment’ service contacts in the community mental health care data set
- jurisdictions differ in their collection and reporting of community-based ambulatory care data — there are variations in local business rules and in the interpretation of the national definitions.

The proportions of the population using MBS-subsidised ambulatory mental health services, by selected community group are reported in figure 12.12. The results at the national level show that the proportion of the population using MBS-subsidised ambulatory mental health services is similar for Indigenous Australians, than for non-Indigenous Australians (figure 12.12a), but lower:

- in remote and very remote locations than in other locations (figure 12.12b)
- for those in the most disadvantaged SEIFA quintile 1, than for those in the more advantaged quintiles (figure 12.12c).

Data on the use of State and Territory community-based specialised public mental health services and MBS-subsidised ambulatory mental health services by age group are in table 12A.29. Data on the use of private hospital mental health services are also contained in tables 12A.26–29.
Figure 12.11 Population using State and Territory specialised public mental health services, by selected community group, 2010-11

(a) Indigenous status

<table>
<thead>
<tr>
<th>Region</th>
<th>Indigenous</th>
<th>Non-Indigenous</th>
</tr>
</thead>
<tbody>
<tr>
<td>NSW</td>
<td>3.2%</td>
<td>2.5%</td>
</tr>
<tr>
<td>Vic</td>
<td>2.8%</td>
<td>2.3%</td>
</tr>
<tr>
<td>Qld</td>
<td>3.0%</td>
<td>2.6%</td>
</tr>
<tr>
<td>WA</td>
<td>3.5%</td>
<td>2.9%</td>
</tr>
<tr>
<td>SA</td>
<td>3.8%</td>
<td>3.1%</td>
</tr>
<tr>
<td>Tas</td>
<td>4.2%</td>
<td>3.5%</td>
</tr>
<tr>
<td>ACT</td>
<td>4.7%</td>
<td>4.1%</td>
</tr>
<tr>
<td>NT</td>
<td>3.8%</td>
<td>2.9%</td>
</tr>
<tr>
<td>Aust</td>
<td>3.5%</td>
<td>2.6%</td>
</tr>
</tbody>
</table>

(b) Geographic location

<table>
<thead>
<tr>
<th>Region</th>
<th>Major cities</th>
<th>Inner regional</th>
<th>Outer regional</th>
<th>Remote</th>
<th>Very remote</th>
</tr>
</thead>
<tbody>
<tr>
<td>NSW</td>
<td>2.0%</td>
<td>2.3%</td>
<td>2.6%</td>
<td>2.9%</td>
<td>3.1%</td>
</tr>
<tr>
<td>Vic</td>
<td>2.2%</td>
<td>2.5%</td>
<td>2.8%</td>
<td>3.1%</td>
<td>3.3%</td>
</tr>
<tr>
<td>Qld</td>
<td>2.5%</td>
<td>2.8%</td>
<td>3.1%</td>
<td>3.4%</td>
<td>3.6%</td>
</tr>
<tr>
<td>WA</td>
<td>3.0%</td>
<td>3.3%</td>
<td>3.6%</td>
<td>3.9%</td>
<td>4.1%</td>
</tr>
<tr>
<td>SA</td>
<td>3.5%</td>
<td>3.8%</td>
<td>4.1%</td>
<td>4.4%</td>
<td>4.6%</td>
</tr>
<tr>
<td>Tas</td>
<td>3.8%</td>
<td>4.1%</td>
<td>4.4%</td>
<td>4.7%</td>
<td>4.9%</td>
</tr>
<tr>
<td>ACT</td>
<td>4.3%</td>
<td>4.6%</td>
<td>4.9%</td>
<td>5.2%</td>
<td>5.4%</td>
</tr>
<tr>
<td>NT</td>
<td>2.6%</td>
<td>2.9%</td>
<td>3.2%</td>
<td>3.5%</td>
<td>3.7%</td>
</tr>
<tr>
<td>Aust</td>
<td>2.9%</td>
<td>3.2%</td>
<td>3.5%</td>
<td>3.8%</td>
<td>4.0%</td>
</tr>
</tbody>
</table>

(c) SEIFA

<table>
<thead>
<tr>
<th>Quintile</th>
<th>Region</th>
<th>Indigenous</th>
<th>Non-Indigenous</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>NSW</td>
<td>2.0%</td>
<td>1.5%</td>
</tr>
<tr>
<td></td>
<td>Vic</td>
<td>2.3%</td>
<td>1.8%</td>
</tr>
<tr>
<td></td>
<td>Qld</td>
<td>2.5%</td>
<td>2.0%</td>
</tr>
<tr>
<td></td>
<td>WA</td>
<td>3.0%</td>
<td>2.5%</td>
</tr>
<tr>
<td></td>
<td>SA</td>
<td>3.5%</td>
<td>3.0%</td>
</tr>
<tr>
<td></td>
<td>Tas</td>
<td>4.0%</td>
<td>3.5%</td>
</tr>
<tr>
<td></td>
<td>ACT</td>
<td>4.5%</td>
<td>4.0%</td>
</tr>
<tr>
<td></td>
<td>NT</td>
<td>3.6%</td>
<td>3.1%</td>
</tr>
<tr>
<td></td>
<td>Aust</td>
<td>3.9%</td>
<td>3.4%</td>
</tr>
</tbody>
</table>

SEIFA = Socio-Economic Indexes for Areas. a Proportions are age-standardised to the Australian population as at 30 June 2001. b Counts for State and Territory specialised public mental health services are counts of people receiving one or more service contacts provided by community-based ambulatory services. c SA submitted data that were not based on unique patient identifiers or data matching approaches. Therefore, caution needs to be taken when making jurisdictional comparisons. d Victoria does not have very remote locations. e Tasmania does not have major cities. SEIFA Quintile 5 is not applicable for Tasmania. f The ACT does not have outer regional, remote or very remote locations. ACT data are not published for inner regional areas. Data for quintile 1 are not published for the ACT. g The NT does not have major cities or inner regional locations.

Figure 12.12 Population using MBS-subsidised ambulatory mental health services, by selected community group, 2010-11a, b, c, d

(a) Indigenous status

(b) Geographic location

(c) SEIFA

SEIFA = Socio-Economic Indexes for Areas. a Proportions are age-standardised to the Australian population as at 30 June 2001. b MBS-subsidised services are those mental health-specific services provided under the general MBS and by DVA. The specific Medicare items included are detailed in table 12A.30. c Victoria does not have very remote areas. Tasmania does not have major cities. The ACT does not have outer regional, remote or very remote locations. The NT does not have major cities or inner regional locations. d SEIFA Quintile 5 is not applicable for Tasmania.

**Effectiveness — access — mental health service use by total population**

‘Mental health service use by total population’ is an indicator of governments’ objective to provide equitable access to mental health services for all people who need them (box 12.4). An estimate of the population who need mental health services is not available, so the indicator is reported as a proportion of the total population.

**Box 12.4  Mental health service use by total population**

‘Mental health service use by total population’ is defined as the proportion of the population in a State or Territory using a specialised public mental health service or a MBS-subsidised service. Data are reported separately for State and Territory specialised public mental health services and MBS-subsidised services. Data from the 2007 SMHWB on the proportion of people who had a lifetime mental disorder with symptoms in the 12 months before the survey who used any service for mental health are also reported in tables 12A.31–32.

This indicator is difficult to interpret. It does not measure access according to need, that is, according to the prevalence of mental illness across jurisdictions. Variations in use could be due to variations in access, but could also be a result of differences in the prevalence of mental illness.

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. People with a mental illness can have low rates of service use due to them choosing not to access services, appropriate services are unavailable, lack of awareness that services are available and negative experiences associated with the previous use of services (AHMC 2008). In addition, it might not be appropriate for all people with a mental illness to use a service, for example, some can seek and receive assistance from outside the health system (AHMC 2008).

Data reported for this indicator are comparable.


In 2010-11, 1.6 per cent and 6.9 per cent of the total population received State and Territory specialised public mental health services and MBS-subsidised (MBS general and DVA), respectively (figure 12.13).
Figure 12.13  **Population receiving mental health services, by service type, 2010-11**, a, b, c

<table>
<thead>
<tr>
<th>State/Territory specialised public mental health services</th>
<th>Medicare-subsidised services</th>
</tr>
</thead>
<tbody>
<tr>
<td>NSW</td>
<td>Vic</td>
</tr>
<tr>
<td>6</td>
<td>4</td>
</tr>
</tbody>
</table>

a Rates are age-standardised to the Australian population as at 30 June 2001. b Counts for State and Territory specialised public mental health services are counts of people receiving one or more service contacts provided by community-based ambulatory services (most people who have received an inpatient service or residential care service have also received a service contact with a community-based ambulatory service). c MBS-subsidised services are those specific mental health services provided under the general MBS and DVA by psychiatrists, clinical psychologists, GPs and other allied health services. The specific MBS items included are detailed in table 12A.30. People seen by more than one provider type are counted only once.

*Source:* State and Territory governments (unpublished) CMHC data; DoHA (unpublished) MBS Statistics data; DVA (unpublished); table 12A.30.

**Effectiveness — access — primary mental health care for children and young people**

‘Primary mental health care for children and young people’ is an indicator of governments’ objective to prevent, where possible, the development of mental health problems and mental illness and undertake early intervention for mental health problems and mental illness (box 12.5). Early identification of and intervention in mental illnesses for children and young people can result in better outcomes.
Box 12.5  **Primary mental health care for children and young people**

‘Primary mental health care for children and young people’ is defined as the proportion of young people aged under 25 years who had contact with primary mental health care services subsidised through the MBS. Data are also reported by four age cohorts: pre-school (0–<5 years), primary school (5–<12 years), secondary school (12–<18 years) and youth/young adult (18–<25 years).

High or increasing proportions of young people who had contact with primary mental health care services subsidised through the MBS is desirable. This indicator does not provide information on whether the services are appropriate for the needs of the young people receiving them, or correctly targeted to those young people most in need. It also does not measure access according to need, that is, according to the prevalence of mental illness across jurisdictions. Variations in use could be due to variations in access, but could also be a result of differences in the prevalence of mental illness.

Data reported for this indicator are comparable.

Data quality information for this indicator is under development.

Results for this indicator should be interpreted with caution. Primary mental health care for children and young people can be accessed from services other than those that are MBS subsidised. Other providers of primary mental health care to young people include community health centres, Aboriginal Community Controlled Health Services, school counsellors and health nurses and university and Technical and Further Education counselling services. A component of the mental health care provided by State and Territory specialised public mental health services could also be considered primary mental health care for young people, but this cannot be reliably differentiated from other care types (NMHPSC 2011).

In 2011-12, 4.6 per cent of all children and young people aged under 25 years had contact with MBS-subsidised primary mental health care services (figure 12.14).
Figure 12.14 **Children and young people who received MBS-subsidised primary mental health care, 2011-12**

Source: DoHA (unpublished); table 12A.33.

**Appropriateness — services reviewed against the National Standards**

‘Services reviewed against the National Standards’ is an indicator of governments’ objective to provide mental health services that are appropriate (box 12.6). It is a process indicator of appropriateness, reflecting progress made in meeting the national standards for mental health care (see box 12.7 for details on the relevant standards).

**Box 12.6 Services reviewed against the National Standards**

‘Services reviewed against the National Standards’ is defined as the proportion of specialised public mental health services that had completed a review by an external accreditation agency against the National Standards for Mental Health Services (NSMHS). Services were assessed as level 1, level 2, level 3, or level 4 where these levels are defined as:

- **Services at level 1** — the number of specialised public mental health services that have been reviewed by an external accreditation agency and judged to have met all National Standards.
- **Services at level 2** — the number of specialised public mental health services that have been reviewed by an external accreditation agency and judged to have met some but not all National Standards.

(Continued next page)
Box 12.6 (continued)

- **Services at level 3** — the number of specialised public mental health services that are (i) in the process of being reviewed by an external accreditation agency but the outcomes are not known, or (ii) booked for review by an external accreditation agency.

- **Services at level 4** — the number of specialised public mental health services that do not meet criteria detailed under levels 1 to 3.

A high or increasing proportion of specialised public mental health services that had completed a review by an external accreditation agency against the NSMHS and that had been assessed as level 1 or level 2 is desirable. It suggests an improvement in the quality of services.

The indicator does not provide information on whether the standards or assessment process are appropriate. In addition, services that had not been assessed do not necessarily deliver services of lower quality. Some services that had not completed an external review included those that were undergoing a review and those that had booked for review and were engaged in self-assessment preparation.

Data reported for this indicator are not directly comparable.


Revised *National Standards for Mental Health Services* (NSMHS) were released in September 2010 and provide a blueprint for new and existing services to guide quality improvement and service enhancement activities. The standards have been broadened to include non-government community mental health services and private office-based services as well as specialised public mental health services. Implementation guidelines have also been released.

Box 12.7 outlines the 2010 NSMHS against which public mental health services are now assessed. External accreditation agencies, such as the Australian Council on Healthcare Standards, undertake accreditation of a parent health organisation (for example, a hospital) that can cover a number of specialised 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 12.7  **The 2010 National Standards for Mental Health Services**

The first National Standards for Mental Health Services (NSMHS) were developed under the *First National Mental Health Plan 1993–1998*. Revised NSMHS were released in September 2010 and provide a blueprint for new and existing services to guide quality improvement and service enhancement activities. The 2010 NSMHS comprise 10 overarching standards:

1. Rights and responsibilities
2. Safety
3. Consumer and carer participation
4. Diversity responsiveness
5. Promotion and prevention
6. Consumers
7. Carers
8. Governance, leadership and management
9. Integration
10. Delivery of care.

In future, services will be required to undergo accreditation against the ten new national safety and quality health service standards mandated by the Australian Commission on Safety and Quality in Health Care (ACSQHC) and the revised 2010 NSMHS. Reaccreditation against the 2010 NSMHS was expected to be undertaken by 2014 and services have indicated their preference to undertake this in conjunction with the accreditation against the ACSQHC standards which must be implemented from January 2013 onwards.

*Source: AHMC (2010) and DoHA (unpublished).*

Table 12.1 shows the proportion of specialised public mental health services that had completed an external review against the NSMHS and were assessed as meeting ‘all standards’ (level 1) or as meeting ‘some but not all standards’ (level 2). Table 12.1 also shows the proportion of specialised public mental health services that are either in the process of being reviewed by an external accreditation agency but the outcomes are not known, or booked for review by an external accreditation agency (level 3) and those that do not meet criteria detailed under levels 1 to 3 (level 4).
### Table 12.1 Specialised public mental health services reviewed against the NSMHS, 30 June 2011 (per cent)a

<table>
<thead>
<tr>
<th>Level</th>
<th>NSWb</th>
<th>Vic</th>
<th>Qld</th>
<th>WA</th>
<th>SA</th>
<th>Tas</th>
<th>ACT</th>
<th>NT</th>
<th>Aust</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level 1</td>
<td>82.1</td>
<td>95.6</td>
<td>96.4</td>
<td>43.6</td>
<td>85.6</td>
<td>28.0</td>
<td>100.0</td>
<td>100.0</td>
<td>84.9</td>
</tr>
<tr>
<td>Level 2</td>
<td>16.6</td>
<td>0.3</td>
<td>–</td>
<td>–</td>
<td>72.0</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>8.9</td>
</tr>
<tr>
<td>Level 3</td>
<td>0.1</td>
<td>2.0</td>
<td>1.0</td>
<td>32.1</td>
<td>12.0</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>3.4</td>
</tr>
<tr>
<td>Level 4</td>
<td>1.2</td>
<td>2.0</td>
<td>2.6</td>
<td>24.4</td>
<td>2.4</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>2.9</td>
</tr>
</tbody>
</table>

a Data are based on counts of individual service units within mental health organisations, not at the whole organisation level. However, there is variation across jurisdictions in the method used to assign an assessment level (1, 2, 3 or 4) to a service unit. In some jurisdictions, if an organisation with multiple service units is assessed at a particular level all the organisation’s units are ‘counted’ at that assessment level. In other jurisdictions, service units are ‘counted’ individually at assessment levels and assessment levels may or may not be consistent across the units within an organisation. The approach can also vary across organisations within a single jurisdiction. b The quality of the NSW MHE NMDS 2010-11 data has been affected by the reconfiguration of the service system during the year. Delays caused by this change have also meant that the validation process for the data used in this Report was not completed.

– Nil or rounded to zero.

Source: AIHW (unpublished) MHE NMDS; table 12A.34.

**Appropriateness — services provided in the appropriate setting**

‘Services provided in the appropriate setting’ is an indicator of governments’ objective to provide mental health services in mainstream or community-based settings wherever possible (box 12.8).

**Box 12.8 Services provided in the appropriate setting**

‘Services provided in the appropriate setting’ is defined as recurrent expenditure on community-based services as a proportion of State and Territory governments’ expenditure on specialised mental health services (excluding aged care community residential expenditure). Community-based services are defined as ambulatory care, adult residential services and non-government organisations. Aged residential care is excluded to improve comparability.

A high or increasing proportion of recurrent expenditure spent on community-based services is desirable, reflecting a greater reliance on services that are based in community settings.

Data reported for this indicator are comparable.


The development of local, comprehensive mental health service systems is advocated by the NMHS. Mental health services must be capable of responding to the individual needs of people with mental illnesses and of providing continuity of
care to enable consumers to move between services as their needs change. More appropriate mental health treatment options can be provided by encouraging the treatment of patients in community-based settings, rather than in stand-alone psychiatric hospitals and public (non-psychiatric) hospitals.

Figure 12.15 shows recurrent expenditure on community-based services as a proportion of total expenditure on specialised public mental health services.

**Figure 12.15** Recurrent expenditure on community-based services as a proportion of total expenditure on specialised public mental health services\(^a, b, c, d\)

![Graph showing recurrent expenditure on community-based services as a proportion of total expenditure on specialised public mental health services](image)

\(^a\) Community-based expenditure includes expenditure on ambulatory, NGO and adult residential services. Aged care residential expenditure is excluded to improve comparability. \(^b\) Total expenditure on specialised public mental health services excludes indirect/residual expenditure that could not be apportioned directly to services and aged care community residential expenditure. \(^c\) Queensland does not fund community-based residential services, but funds extended treatment (campus-based and non-campus-based) services that provide longer term inpatient treatment and rehabilitation services with clinical staffing for 24 hours a day, 7 days a week. \(^d\) The quality of the NSW MHE NMDS 2010-11 data has been affected by the reconfiguration of the service system during the year. Delays caused by this change have also meant that the validation process for the data used in this Report was not completed.

Source: AIHW (unpublished) MHE NMDS; table 12A.35.

**Appropriateness — collection of information on consumers’ outcomes**

‘Collection of information on consumers’ outcomes’ is an indicator of governments’ objective that consumer outcomes be monitored (box 12.9). It is a process indicator, reflecting the capability of services in establishing systems to collect information on consumers’ mental health outcomes.
Box 12.9 **Collection of information on consumers’ outcomes**

‘Collection of information on consumers’ outcomes’ is defined as the proportion of specialised public mental health service episodes with completed clinical mental health outcome measures data, by client type (people in ongoing community-based care, people discharged from community-based care and people discharged from hospital).

High or increasing proportions of episodes for which information on consumers’ mental health outcomes is collected is desirable.

This indicator monitors the uptake of the routine National Outcomes Casemix Collection (NOCC). It does not provide information on whether consumers had appropriate outcomes.

Data reported for this indicator are not directly comparable.

Data quality information for this indicator is under development.

The estimated proportions of specialised public mental health service episodes for which information on consumers’ mental health outcomes is collected are shown in figure 12.16.
Figure 12.16  **Estimated proportion of episodes for which ‘complete’ consumer outcome measures were collected, 2010-11**\(^a\), \(^b\), \(^c\)

![Bar chart showing estimated proportion of episodes for which 'complete' consumer outcome measures were collected, 2010-11.](image)

\(^a\) These data were prepared by the Australian Mental Health Outcomes and Classification Network, using data submitted by State and Territory governments to the Australian Government (DoHA). To be counted as an episode for which consumer outcome measures are collected, data need to be completed correctly (a specified minimum number of items completed) and have a ‘matching pair’ — that is, a beginning and end rating are needed to enable an outcome score to be determined. \(^b\) For the ACT, due to a technical issue, the proportion of matched pairs for people discharged from a community episode of care (Group B) was below the statistical threshold for a meaningful comparison. \(^c\) Estimates of coverage for State and Territory services are crude and made by DoHA based on available data.


**Quality — consumer and carer experiences of services**

‘Consumer and carer experiences of services’ is an indicator of governments’ objective that services are of a high quality and responsive to the needs of consumers and their carers (box 12.10). Consumers and their carers should have positive experiences in all mental health service areas with clinicians and services provided. Both are important aspects of the NMHS.

**Box 12.10  Consumer and carer experiences of services**

‘Consumer and carer experiences of services’ is yet to be defined.

Data for this indicator were not available for the 2013 Report.
Quality — consumer and carer involvement in decision making

‘Consumer and carer involvement in decision making’ is an indicator of governments’ objective that consumers and carers are involved at the service delivery level, where they have the opportunity to influence the services they receive (box 12.11). Consumer and carer involvement is an important aspect of the NMHS.

Box 12.11  Consumer and carer involvement in decision making

‘Consumer and carer involvement in decision making’ is defined by two measures:

- the number of paid FTE consumer staff per 1000 FTE direct care, consumer and carer staff
- the number of paid FTE carer staff per 1000 FTE direct care, consumer and carer staff.

High or increasing proportions of paid FTE direct care, consumer and carer staff who are consumer/carer staff implies better opportunities for consumers and carers to be involved at the service delivery level, where they can influence the services received.

Data reported for this indicator are comparable.


Table 12.2 reports the number of paid FTE consumer and carer staff per 1000 paid FTE direct care, consumer and carer staff.
Table 12.2  Number of paid FTE consumer and carer staff per 1000 FTE
direct care, consumer and carer staff\textsuperscript{a}

<table>
<thead>
<tr>
<th>Year</th>
<th>NSW</th>
<th>Vic</th>
<th>Qld</th>
<th>WA</th>
<th>SA</th>
<th>Tas</th>
<th>ACT</th>
<th>NT</th>
<th>Aust</th>
</tr>
</thead>
<tbody>
<tr>
<td>2006-07</td>
<td>3.7</td>
<td>3.6</td>
<td>2.7</td>
<td>0.3</td>
<td>1.2</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>2.7</td>
</tr>
<tr>
<td>2007-08</td>
<td>4.1</td>
<td>3.7</td>
<td>2.3</td>
<td>0.5</td>
<td>2.4</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>2.9</td>
</tr>
<tr>
<td>2008-09</td>
<td>3.3</td>
<td>3.0</td>
<td>3.1</td>
<td>1.4</td>
<td>3.2</td>
<td>0.8</td>
<td>–</td>
<td>–</td>
<td>2.8</td>
</tr>
<tr>
<td>2009-10</td>
<td>2.9</td>
<td>3.1</td>
<td>3.2</td>
<td>1.9</td>
<td>2.8</td>
<td>0.7</td>
<td>–</td>
<td>–</td>
<td>2.8</td>
</tr>
<tr>
<td>2010-11</td>
<td>2.7</td>
<td>3.0</td>
<td>3.8</td>
<td>1.2</td>
<td>4.0</td>
<td>0.7</td>
<td>–</td>
<td>–</td>
<td>2.8</td>
</tr>
</tbody>
</table>

Paid FTE carer staff per 1000 paid FTE direct care, consumer and carer staff

<table>
<thead>
<tr>
<th>Year</th>
<th>NSW</th>
<th>Vic</th>
<th>Qld</th>
<th>WA</th>
<th>SA</th>
<th>Tas</th>
<th>ACT</th>
<th>NT</th>
<th>Aust</th>
</tr>
</thead>
<tbody>
<tr>
<td>2006-07</td>
<td>1.3</td>
<td>2.5</td>
<td>0.2</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>1.1</td>
</tr>
<tr>
<td>2007-08</td>
<td>1.0</td>
<td>2.9</td>
<td>0.4</td>
<td>0.3</td>
<td>0.9</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>1.2</td>
</tr>
<tr>
<td>2008-09</td>
<td>1.5</td>
<td>2.5</td>
<td>0.6</td>
<td>0.2</td>
<td>1.2</td>
<td>0.8</td>
<td>–</td>
<td>–</td>
<td>1.3</td>
</tr>
<tr>
<td>2009-10</td>
<td>1.9</td>
<td>2.8</td>
<td>1.1</td>
<td>0.4</td>
<td>0.8</td>
<td>0.7</td>
<td>–</td>
<td>–</td>
<td>1.6</td>
</tr>
<tr>
<td>2010-11</td>
<td>1.8</td>
<td>3.0</td>
<td>1.1</td>
<td>0.4</td>
<td>2.4</td>
<td>0.7</td>
<td>–</td>
<td>–</td>
<td>1.8</td>
</tr>
</tbody>
</table>

\textsuperscript{a} Data up to 2009-10 were restricted to consumer/carer consultants. In 2010-11, the definitions were altered to include a broader range of roles in the contemporary mental health environment, transitioning to mental health consumer and carer workers. Comparisons between data up to 2009-10 with data for 2010-11 should not be made. \textsuperscript{b} The quality of the NSW MHE NMDS 2010-11 data has been affected by the reconfiguration of the service system during the year. Delays caused by this change have also meant that the validation process for the data used in this Report was not completed. \textsuperscript{c} WA has advised that this information does not represent the full range of consumer and carer participation (see table 12A.37 for further details). – Nil or rounded to zero.

Source: AIHW (unpublished) MHE NMDS; table 12A.37.

Quality — specialised public mental health service consumers with nominated GP

‘Specialised public mental health service consumers with nominated GP’ is an indicator of governments’ objective to provide continuity of care in the delivery of mental health services. GPs can be an important point of contact for those with a mental illness (box 12.12).

Box 12.12  Specialised public mental health service consumers with
nominated GP

‘Proportion of specialised public mental health service consumers with nominated GP’ is yet to be defined.

Data for this indicator were not available for the 2013 Report.

Quality — post discharge community care

‘Post discharge community care’ is an indicator of governments’ objective to provide continuity of care in the delivery of mental health services (box 12.13).
Box 12.13  Post discharge community care

‘Post discharge community care’ is defined as the proportion of admitted patient overnight acute separations from psychiatric inpatient services for which a community-based ambulatory mental health care contact was recorded in the seven days following separation.

A high or increasing rate of community follow up within the first seven days of discharge from hospital is desirable.

This indicator does not measure the frequency of contacts recorded in the seven days following separation. It also does not distinguish qualitative differences between phone and face-to-face community contacts. Only community-based ambulatory contact made by State and Territory specialised public mental health services are included. Where clinical follow up is managed outside these services (for example, by private psychiatrists or GPs), these contacts are not included.

Data reported for this indicator are not directly comparable.


Continuity of care involves prompt community follow up in the vulnerable period following discharge from hospital (AHMC 2012). A community support system for people who are discharged from hospital after an acute psychiatric episode is essential to maintain clinical and functional stability and to minimise the need for hospital readmission (NMHPSC 2011).

Data on the rates of community follow up for people within the first seven days of discharge from an acute inpatient psychiatric unit are reported in figure 12.17. Specifications for this indicator have been revised for the current report to focus on follow up care for people discharged from acute psychiatric inpatient units only, rather than discharges from all psychiatric inpatient units. Data have been revised for 2006-07 to 2009-10.
**Figure 12.17** Community follow up for people within the first seven days of discharge from acute inpatient psychiatric units\(^a, b, c\)

\(\begin{array}{c}
2006-07 \\
2007-08 \\
2008-09 \\
2009-10 \\
2010-11
\end{array}\)

\(\begin{array}{c}
\text{NSW} \\
\text{Vic} \\
\text{Qld} \\
\text{WA} \\
\text{SA} \\
\text{Tas} \\
\text{ACT} \\
\text{NT} \\
\text{Aust}
\end{array}\)

\(^a\) Community-based ambulatory mental health contacts counted for determining whether follow up occurred are restricted to those in which the consumer participated, except for the NT where the data include all contacts (the NT has advised that the effect on the indicator is immaterial). Contacts made on the day of discharge are also excluded. \(^b\) Data are not comparable across jurisdictions. SA and Tasmania are not able to accurately track post discharge follow up between hospitals and community service organisations, due to the lack of unique patient identifiers or data matching systems. Results for these jurisdictions could appear ‘lower’ relative to jurisdictions that are able to track utilisation across services. \(^c\) Tasmanian data for 2006-07 are not available.


**Quality — readmissions to hospital within 28 days of discharge**

‘Readmissions to hospital within 28 days of discharge’ is an indicator of governments’ objective to provide effective care and continuity of care in the delivery of mental health services (box 12.14).
Box 12.14  Readmissions to hospital within 28 days of discharge

‘Readmissions to hospital within 28 days of discharge’ is defined as the proportion of admitted patient overnight separations from public psychiatric acute inpatient services that were followed by readmission to public psychiatric acute inpatient services within 28 days of discharge.

A low or decreasing rate of readmissions to hospital within 28 days of discharge from hospital is desirable. Readmissions following a recent discharge can indicate that inpatient treatment was either incomplete or ineffective, or that follow-up care was inadequate to maintain people out of hospital (NMHPSC 2011).

Readmission rates are affected by factors other than deficiencies in specialised public mental health services, such as the cyclic and episodic nature of some illnesses or other issues that are beyond the control of the mental health system (NMHWG 2005).

Data reported for this indicator are not directly comparable.

Data quality information for this indicator is under development.

Data on the rates of readmission to hospital within 28 days of discharge are reported in figure 12.18. Specifications for this indicator have been revised for the current report to focus on readmissions of people discharged from acute psychiatric inpatient units only, rather than discharges from, and readmissions to, all psychiatric inpatient units. Data have been revised for 2006-07 to 2009-10.
Readmissions to hospital within 28 days of discharge from acute psychiatric units

No distinction is made between planned and unplanned readmissions because data collection systems in most Australian mental health services do not include a reliable and consistent method to distinguish a planned from an unplanned admission to hospital.


Sustainability

The Steering Committee has identified sustainability as an area for reporting but no indicators have yet been identified.

Efficiency — cost for inpatient care

‘Cost for inpatient care’ is an indicator of governments’ objective that specialised public mental health services are delivered in an efficient manner (box 12.15).
Box 12.15  **Cost for inpatient care**

‘Cost for inpatient care’ is defined by two measures:

- ‘Cost per inpatient bed day’ is defined as the cost of providing inpatient services per inpatient bed day — data are disaggregated by hospital and care type (psychiatric hospitals [acute units and non-acute units] and general hospitals [acute and non-acute units]) and by inpatient target population (acute units only).

- ‘Average length of stay’ is defined as the average number of inpatient patient days per separation — data are disaggregated by inpatient target population (acute units only).

These measures are considered together for the inpatient acute units by target population to provide a ‘proxy’ measure to improve understanding of service efficiency. Average inpatient bed day costs can be reduced with longer lengths of stay because the costs of admission, discharge and more intensive treatment early in a stay are spread over more days of care.

A low or decreasing cost per inpatient bed day combined with similar or shorter average lengths of stay can indicate more efficient service delivery, although efficiency data need to be interpreted with care as they do not provide any information on the quality of service provided.

This indicator does not account for differences in the client mix. The client mix in inpatient settings can differ — for example, some jurisdictions treat a higher proportion of less complex patients in inpatient settings as distinct from treating them in the community. More suitable measures for mental health services would be cost per casemix adjusted separation, for which cost is adjusted to take into account the type and complexity of cases, and the relative stay index (that also adjusts for casemix) similar to those presented for public hospitals (chapter 10). Data for these measures are not yet available, as casemix funding has not been applied to specialised mental health services.

Data reported for this indicator are comparable.


Data on average recurrent cost per inpatient bed day by hospital (psychiatric and public acute) and care type (acute or non-acute) are reported in figure 12.19. Costs per inpatient bed day and average length of stay data for acute units by inpatient target population (for psychiatric and public acute hospitals combined) are presented in figure 12.20. Data for forensic services are included for costs per inpatient bed day only as the length of stay is dependent on factors outside the control of the specialised public mental health services. Data for cost per inpatient bed day for all units by target population are included in table 12A.40.
**Figure 12.19** Average recurrent cost per inpatient bed day, public hospitals, by hospital and care type, 2010-11\(^a\), \(^b\), \(^c\), \(^d\), \(^e\), \(^f\), \(^g\)

<table>
<thead>
<tr>
<th>Health Care Type</th>
<th>NSW</th>
<th>Vic</th>
<th>Qld</th>
<th>WA</th>
<th>SA</th>
<th>Tas</th>
<th>ACT</th>
<th>NT</th>
<th>Aust</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychiatric hospitals (acute units)</td>
<td>600</td>
<td>800</td>
<td>800</td>
<td>800</td>
<td>800</td>
<td>1200</td>
<td>1200</td>
<td>1200</td>
<td>1200</td>
</tr>
<tr>
<td>Psychiatric hospitals (non-acute units)</td>
<td>400</td>
<td>600</td>
<td>600</td>
<td>600</td>
<td>600</td>
<td>1000</td>
<td>1000</td>
<td>1000</td>
<td>1000</td>
</tr>
<tr>
<td>Public acute hospitals (acute units)</td>
<td>200</td>
<td>400</td>
<td>400</td>
<td>400</td>
<td>400</td>
<td>800</td>
<td>800</td>
<td>800</td>
<td>800</td>
</tr>
<tr>
<td>Public acute hospitals (non-acute units)</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

\(^a\) Depreciation is excluded. \(^b\) Costs are not adjusted for differences in the complexity of cases across jurisdictions and can reflect differences in the rate of institutional change (that is, the mainstreaming of mental health services). \(^c\) Mainstreaming has occurred at different rates across jurisdictions. Victorian 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. \(^d\) The quality of the NSW MHE NMDS 2010-11 data has been affected by the reconfiguration of the service system during the year. Delays caused by this change have also meant that the validation process for the data used in this Report was not completed. \(^e\) Queensland data for public acute hospitals include costs associated with extended treatment services (campus-based and non-campus-based) 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. \(^g\) SA, the ACT and the NT do not have non-acute units in general hospitals.

*Source: AIHW (unpublished) MHE NMDS; table 12A.43.*

Data on ‘average length of stay’ should be considered with caution:

- The quality of the separations data used to derive them is variable across jurisdictions. Until recently, these separations data were not subject to in depth scrutiny. It is expected that the quality of these data will improve over time.

- There is a mismatch between the inpatient bed days and the separations in the reference period (2010-11).
  - Patients days for clients who separated in the reference period that were during the previous period (2009-10) are excluded.
  - Patient days for clients who remain in hospital (that is, are not included in the separations data) are included.

The ‘average length of stay’ data reported here may not match data reported elsewhere (such as the AIHW’s *Mental Health Services in Australia* publication) for these and other scope related reasons.
Figure 12.20  Costs for inpatient care in acute units of public hospitals, by target population, 2010-11a, b, c, d, e, f, g

Cost per inpatient bed day

- General mental health services
- Child and adolescent mental health services
- Older people’s mental health services
- Forensic mental health services

Average length of stay

- General mental health services
- Child and adolescent mental health services
- Older people’s mental health services

---

a Depreciation is excluded. b Costs are not adjusted for differences in the complexity of cases across jurisdictions and can reflect differences in the rate of institutional change (that is, the mainstreaming of mental health services). c The quality of the NSW MHE NMDS 2010-11 data has been affected by the reconfiguration of the service system during the year. Delays caused by this change have also meant that the validation process for the data used in this Report was not completed. d Queensland provides older people’s mental health services using a variety of different service models, including extended treatment services co-located with other services. These different service models are all reported as older people’s mental health services, which lowers the average patient day costs, and limits comparability with the costs of jurisdictions that report these services differently. e Tasmania does not provide, or cannot separately identify, child and adolescent mental health services or older people’s mental health services. f The ACT does not have separate forensic or child and adolescent mental health inpatient services. g The NT has general mental health services only.

Source: AIHW (unpublished) MHE NMDS; tables 12A.41-42.
Efficiency — cost for community-based residential care

‘Cost for community-based residential care’ is an indicator of governments’ objective that mental health services be delivered in an efficient manner (box 12.16).

Box 12.16  Cost for community-based residential care

‘Cost for community-based residential care’ is defined as the average cost per day for specialised public mental health services of providing community-based residential care.

A low or decreasing average cost can indicate efficiency, although efficiency data need to be interpreted with care as they do not provide any information on the quality of service provided.

The indicator does not account for differences in the client mix. The client mix in community-based services can differ across jurisdictions — for example, some State and Territory governments treat a higher proportion of more complex patients in community-based residential settings.

Data reported for this indicator are comparable.


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). Differences across jurisdictions in the types of patient admitted to community-based 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.

The average recurrent cost per patient day for community-based residential care services is presented in table 12.3. For general adult units in 2010-11, the average cost per patient day for 24 hour staffed community-based residential care was an estimated $492 nationally. For non-24 hour staffed community-based residential units, the average cost per patient day was $157 nationally. For State or Territory governments that had community-based older people’s residential care units in 2010-11, the average recurrent cost per patient day for 24 hour staffed services was $354 nationally (table 12.3).
## Table 12.3  
**Average recurrent cost per inpatient day for community-based residential services, by target population and staffing provided, 2010-11**

<table>
<thead>
<tr>
<th></th>
<th>NSW</th>
<th>Vic</th>
<th>Qld</th>
<th>WA</th>
<th>SA</th>
<th>Tas</th>
<th>ACT</th>
<th>NT</th>
<th>Aust</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>General adult units</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>24 hour staffed</td>
<td>291</td>
<td>531</td>
<td>..</td>
<td>511</td>
<td>451</td>
<td>469</td>
<td>637</td>
<td>352</td>
<td>492</td>
</tr>
<tr>
<td>Non-24 hour staffed</td>
<td>177</td>
<td>155</td>
<td>..</td>
<td>134</td>
<td>262</td>
<td>220</td>
<td>108</td>
<td>..</td>
<td>157</td>
</tr>
<tr>
<td><strong>Older people’s care units</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>24 hour staffed</td>
<td>226</td>
<td>343</td>
<td>..</td>
<td>..</td>
<td>..</td>
<td>686</td>
<td>206</td>
<td>..</td>
<td>354</td>
</tr>
<tr>
<td>Non-24 hour staffed</td>
<td>277</td>
<td>..</td>
<td>..</td>
<td>..</td>
<td>..</td>
<td>..</td>
<td>..</td>
<td>..</td>
<td>277</td>
</tr>
</tbody>
</table>

a Depreciation is excluded.  
b Costs are not adjusted for differences in the complexity of cases across states and territories and can reflect differences in the rate of institutional change (that is, the mainstreaming of mental health services).  
c The quality of the NSW MHE NMDS 2010-11 data has been affected by the reconfiguration of the service system during the year. Delays caused by this change have also meant that the validation process for the data used in this Report was not completed.  
d Victoria, Tasmania and the ACT do not have any community-based residential services that are non-24 hour older people’s units.  
e Queensland does not fund community-based residential services, although it funds a number of campus-based and non-campus-based extended treatment services.  
f WA, SA and the NT do not have any community-based residential services that are older people’s units.  
.. Not applicable.

*Source: AIHW (unpublished) MHE NMDS; table 12A.44.*

### Efficiency — Cost for ambulatory care

‘Cost for ambulatory care’ is an indicator of governments’ objective that mental health services be delivered in an efficient manner (box 12.17).
Box 12.17  **Cost for ambulatory care**

'Cost for ambulatory care’ is defined by two measures:

- average cost per episode of ambulatory care provided by community-based specialised public mental health services
- average number of community treatment days per episode of ambulatory care provided by community-based specialised public mental health services. This measure is provided along with average costs as frequency of servicing is the main driver of variation in care costs. It is equivalent to the 'length of stay' efficiency measure for public hospitals.

An episode of ambulatory care is a three month period of ambulatory care for an individual registered patient where the patient was under ‘active care’ (one or more treatment days in the period). Community-based periods relate to the following four fixed three monthly periods: January to March, April to June, July to September, and October to December. Treatment day refers to any day on which one or more community contacts (direct or indirect) are recorded for a registered client during an ambulatory care episode.

Low or decreasing average cost or fewer community treatment days can indicate greater efficiency although, efficiency data need to be interpreted with care as they do not provide any information on the quality of service provided.

The measures do not account for differences in the client mix. The client mix in community-based services can differ across jurisdictions — for example, some State and Territory governments treat a higher proportion of more complex patients in community-based ambulatory settings.

Data reported for this indicator are comparable.


Average recurrent cost per episode of ambulatory care data are shown in figure 12.21.
Average recurrent cost per episode of ambulatory care (2010-11 dollars)$^{a, b, c, d}$

$^{a}$ Real expenditure (2010-11 dollars), using State and Territory implicit price deflators for general government final consumption on hospital and nursing home services (table 12A.71). $^{b}$ Recurrent expenditure data used to derive this measure have been adjusted (that is, reduced) to account for the proportion of clients in the CMHC NMDS that were defined as ‘non-uniquely identifiable consumers’. Therefore, it does not match recurrent expenditure on ambulatory care reported elsewhere. $^{c}$ ‘Non-uniquely identifiable consumers’ have been excluded from the episodes of ambulatory care. $^{d}$ The quality of the NSW MHE NMDS 2010-11 data has been affected by the reconfiguration of the service system during the year. Delays caused by this change have also meant that the validation process for the data used in this Report was not completed.

Source: AIHW (unpublished) CMHC NMDS; AIHW (unpublished) MHE NMDS; table 12A.45.

Average treatment days per episode of ambulatory care data are shown in figure 12.22.
Figure 12.22  **Average treatment days per episode of ambulatory care**<sup>a, b</sup>

![Bar chart showing treatment days per episode of care across different years and states/territories.](image)

<sup>a</sup> ‘Non-uniquely identifiable consumers’ have been excluded from the episodes of ambulatory care and treatment days data.  
<sup>b</sup> The quality of the NSW MHE NMDS 2010-11 data has been affected by the reconfiguration of the service system during the year. Delays caused by this change have also meant that the validation process for the data used in this Report was not completed.

Source: AIHW (unpublished) CMHC NMDS; AIHW (unpublished) MHE NMDS; table 12A.45.

**Outcomes**

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

The output indicators reported above focus on specialised public mental health services provided by State and Territory governments (although the indicators ‘mental health service use by selected community groups’, ‘mental health service use by total population’ and ‘primary mental health care for children and young people’ include measures of access to MBS-subsidised services). The outcome indicators identified and/or reported here reflect the performance of governments (including the mental health sector) against the broad objectives of the NMHS.

The whole-of-government approach within the *Fourth National Mental Health Plan 2009–2014* acknowledges that many of the determinants of good mental health, and of mental illness, are influenced by factors beyond the health system. The fourth plan identifies that the mental health sector must form partnerships with other sectors in order to develop successful interventions (AHMC 2009).
‘Rates of licit and illicit drug use’ is an indicator of governments’ objective under the NMHS to prevent the development of mental health problems and mental illness where possible, by reducing the prevalence of risk factors that contribute to the onset of mental illness and prevent longer term recovery (box 12.18). High rates of substance use and abuse in young people can contribute to the onset of, and poor recovery from, mental illness (NMHPSC 2011).

Box 12.18 Rates of licit and illicit drug use

‘Rates of licit and illicit drug use’ is defined as the proportion of people aged 14 years or over who use specific licit and illicit drugs in the preceding 12 months. The specific drugs are: alcohol, cannabis, ecstasy, cocaine, meth/amphetamine, hallucinogens, Gamma-hydroxybutyrate (GHB), inhalants, and heroin.

A low or decreasing proportion of people aged 14 years or over using specific licit and illicit drugs is desirable. It suggests a reduction in the risk factors that contribute to the onset of mental illness and prevent longer term recovery.

Many of the risk and protective factors that impact on a person’s propensity to use licit or illicit drugs lie outside the ambit of the mental health system. These include environmental, sociocultural and economic factors — for example, adverse childhood experiences (such as sexual abuse) and exposure to domestic violence can increase the risk of substance abuse. A reduction in the prevalence of drugs use, therefore, will be a result of a coordinated response across a range of collaborating agencies including education, justice and community services.

Data reported for this indicator are comparable.

Data quality information for this indicator is under development.

Alcohol is the substance most commonly used and abused, and is a major cause of death, injury and illness in Australia (AHMC 2011). In 2010, of people aged 14 years or over, 80.5 per cent drank alcohol over the last 12 months (table 12A.46) and 20.1 per cent drank alcohol at levels considered ‘risky’ for developing long-term health problems (figure 12.23). Data from the 2007 National Drug Strategy Household Survey Report on alcohol use and risk status are in table 12A.50.
Figure 12.23 Recent use of alcohol, in last 12 months, by people aged 14 years or over, life time risk status, 2010\textsuperscript{a, b, c}

\begin{figure}
\centering
\includegraphics[width=\textwidth]{figure1223.png}
\caption{Recent use of alcohol, in last 12 months, by people aged 14 years or over, life time risk status, 2010\textsuperscript{a, b, c}}
\end{figure}

\textsuperscript{a} Abstainers — people who did not consume alcohol in the previous 12 months. \textsuperscript{b} Low risk — people who on average, had no more than two standard drinks per day. \textsuperscript{c} Risky — people who on average, had more than two standard drinks per day.


Cannabis, ecstasy, cocaine and meth/amphetamines are the most widely used illicit drugs in Australia (figure 12.24). Younger people’s usage of cannabis and meth/amphetamines is of particular concern for their associated mental health problems (AHMC 2011). Cannabis use can precipitate schizophrenia in people who have a family history of the disorder, increase the risk of symptoms for those vulnerable to psychosis and also exacerbate the symptoms of schizophrenia (AHMC 2011). Cannabis use can also pose a moderate risk for depression in later life and heavy cannabis use can pose a small additional risk of suicide (AHMC 2011).
Figure 12.24  Recent use of alcohol, in last 12 months, by people aged 14 years or over, life time risk status, 2010\textsuperscript{a}

Symptoms of psychosis are also one of the consequences of meth/amphetamine use and dependent meth/amphetamine users can also suffer from a range of co-morbid mental health problems (AHMC 2011). For meth/amphetamine users who use the drug once a month or more, the psychosis prevalence is 11 times higher than for the general population (AHMC 2011). Figure 12.25 shows the rates of use of cannabis and meth/amphetamines by young people.

Data on self-reported health conditions including mental illness and level of psychological distress by whether a person had used an illicit drug in the previous 12 months are included in table 12A.49. Data from the 2007 National Drug Strategy Household Survey Report on illicit drug use are in tables 12A.51–53.
Figure 12.25  Recent use of cannabis and meth/amphetamines, in last 12 months, by young people, 2010a, b

M/A = meth/amphetamine. a The following estimates have RSEs of between 25 per cent and 50 per cent and should be considered with caution: for people aged 14–19 years, cannabis use in SA, the ACT and the NT and meth/amphetamine use in Victoria and Queensland; and for people aged 20–29 years, meth/amphetamine use in SA and the NT. The following estimates are subject to RSEs greater than 50 per cent and are considered too unreliable for general use: for people aged 14–19 years, meth/amphetamine use in NSW, WA, SA and the NT, and cannabis use in Tasmania; and for people aged 20–29 years, meth/amphetamine use in the Tasmania and the NT. b The proportion of people aged 14–19 years in Tasmania and the ACT who used meth/amphetamine was zero.


Prevalence of mental illness

‘Prevalence of mental illness’ is an indicator of governments’ objective under the NMHS to prevent the development of mental health problems and mental illness where possible (box 12.19).
Prevalence of mental illness data are from the 2007 SMHWB, the latest prevalence estimates available. The 2007 SMHWB was designed to provide reliable estimates at the national level, not at the State and Territory level; however, jurisdictional data are available in 12A.54. National data on the prevalence of mental illness by disorder, age and sex are reported in tables 12A.55-56.

The SMHWB provided prevalence estimates for the mental disorders that are considered to have the highest incidence rates in the population — anxiety disorders, affective disorders and substance use disorders, but did not measure the prevalence of some severe mental disorders, such as schizophrenia and bipolar disorder. The National Survey of Psychotic Illness 2010 provides information on the one-month treated prevalence of these and other psychotic illnesses. In 2010, there were an estimated 3.1 cases of psychotic illness per 1000 adult population (aged 18–64 years), for which there was a contact with public specialised mental health services. Males had a higher treated prevalence rate than females (3.7 cases compared to 2.4 cases per 1000 adult population). Males aged 25–34 years had the highest rate at 5.2 cases per 1000 population (Morgan et. al 2011).
Mortality due to suicide

‘Mortality due to suicide’ is an indicator of governments’ objective under the NMHS to prevent mental health problems, mental illness and suicide, and identify and intervene early with people at risk (box 12.20).

Box 12.20  Mortality due to suicide

‘Mortality due to suicide’ is defined as the suicide rate per 100 000 people. The suicide rate is reported for all people, for males and females, for people of different ages (including those aged 15–24 years), people living in capital cities, people living in other urban areas, people living in rural areas, Indigenous and non-Indigenous Australians.

A low or decreasing suicide rate per 100 000 people is desirable.

While mental health services contribute to reducing suicides, other government services also have a significant role. Public mental health programs are primarily concerned with providing treatment and support services for individual clients affected by severe mental illness, some of whom have either attempted, or indicated an intention, to commit suicide. Suicide prevention targeted at the wider population is also addressed through the initiatives of other government agencies, non-government organisations and other special interest groups. Any effect on suicide rates, therefore, will be a result of a coordinated response across a range of collaborating agencies, including education, housing, justice and community services.

Many factors outside the control of mental health services can 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.

Data reported for this indicator are comparable.


People with a mental illness are at higher risk of suicide than are the general population. They are also at higher risk of death from other causes, such as cardiovascular disease (Coghlan et al. 2001; Joukamaa et al. 2001; Sartorius 2007).

All Coroner certified deaths registered after 1 January 2006 are subject to a revisions process. The revisions process enables the use of additional information relating to Coroner certified deaths either 12 or 24 months after initial processing. This increases the specificity of the assigned ICD-10 codes over time (ABS 2010).
Each year of data is now released as preliminary, revised and final. For further information on this revisions process see the DQI for this indicator.

In the period 2006–2010, 11 335 deaths by suicide were recorded in Australia (table 12A.58) — equivalent to 10.4 deaths per 100 000 people (figure 12.26). The rate for males (16.3 per 100 000 males) was around three times that for females (4.8 per 100 000 females) in that period — a ratio that was relatively constant over all age groups, except for those aged 75–84 years and aged 85 years or over where the male suicide rate was over six times the female rate (figure 12.27). Table 12A.60 shows suicide death rates per 100 000 people aged 15–24 years for all jurisdictions.

Figure 12.26 Suicide rates, 5 year average, 2006–2010

Table 12A.60 shows suicide death rates per 100 000 people aged 15–24 years for all jurisdictions.

Suicide deaths include ICD-10 codes X60-X84 and Y87.0. The death rate is age standardised to the mid-year 2001 population. Causes of death data for 2006, 2007 and 2008 have undergone revision/s and are now considered final. Causes of death data for 2009 have been revised and are subject to further revisions. Causes of death data for 2010 are preliminary and subject to a revisions process.

Source: ABS (unpublished) Causes of Deaths, Australia, Cat. no. 3303.0; table 12A.59.
Figure 12.27  **Suicide rates, by age and sex, 2006–2010**\(^a, b, c\)

- **Suicide deaths include ICD-10 codes X60-X84 and Y87.0.**  
- **Age specific death rates are calculated as the number of suicides for an age group per 100 000 population in the same age group, for the period 2006–2010.**  
- **Causes of death data for 2006, 2007 and 2008 have undergone revisions and are now considered final. Causes of death data for 2009 have been revised and are subject to further revisions. Causes of death data for 2010 are preliminary and subject to a revisions process.**

*Source: ABS (unpublished) Causes of Deaths, Australia, Cat. no. 3303.0; table 12A.58.*

Nationally the suicide rate in the period 2006–2010 was higher in rural areas. There were 9.8 suicides per 100 000 people in capital cities and 11.8 suicides per 100 000 people in urban centres, compared with 13.2 suicides per 100 000 people in rural areas in Australia (figure 12.28).

Tables 12A.57 and 12A.59–61 contain single year time series suicide data.

Indigenous suicide rates are presented for NSW, Queensland, WA, SA and the NT (figure 12.29). After adjusting for differences in the age structure of the two populations, the suicide rate for Indigenous Australians during the period 2006–2010, for the reported jurisdictions, was higher than the corresponding rate for non-Indigenous Australians.
Care needs to be taken when interpreting these data because data for Indigenous Australians are incomplete and data for some jurisdictions are not published. Indigenous Australians 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.
Figure 12.29  Suicide rates, by Indigenous status, 2006–2010* a, b, c, d, e, f

* Deaths from suicides are deaths with ICD-10 codes X60–X84 and Y87.0. b Suicide rate are age-standardised. c Data on deaths of Indigenous Australians are affected by differing levels of coverage of deaths identified as Indigenous across states and territories. Care should be exercised in analysing these data, particularly in making comparisons across states and territories and between Indigenous and non-Indigenous data. d Deaths with a ‘not stated’ Indigenous status are included in the data for non-Indigenous. e Causes of death data for 2006, 2007 and 2008 have undergone revisions and are now considered final. Causes of death data for 2009 have been revised and are subject to further revisions. Causes of death data for 2010 are preliminary and subject to a revisions process. f Total data are for NSW, Queensland, WA, SA, and the NT combined, based on State or Territory of usual residence. These four states and one Territory have been included due to there being evidence of sufficient levels of identification and sufficient numbers of deaths to support Indigenous mortality analysis. Victoria, Tasmania and the ACT are excluded due to insufficient levels of identification or numbers of deaths.

Source: ABS (unpublished) Causes of Deaths, Australia, Cat. no. 3303.0; table 12A.62.

Social and economic inclusion of people with a mental illness

‘Social and economic inclusion of people with a mental illness’ is an indicator of governments’ objective to improve mental health and facilitate recovery from illness through encouraging meaningful participation in recreational, social, employment and other activities in the community (box 12.21).
Box 12.21  **Social and economic inclusion of people with a mental illness**

‘Social and economic inclusion of people with a mental illness’ is defined by two measures:

- proportion of people aged 16–64 years with a mental illness who are employed, compared with the equivalent proportion for people without a mental illness
- proportion of people aged 16–30 years with a mental illness who are employed and/or are enrolled for study in a formal secondary or tertiary qualification (studying full or part-time), compared with the equivalent proportion for people without a mental illness.

A high or increasing proportion of people with a mental illness aged 16–64 years who are employed is desirable. A high or increasing proportion of people aged 16–30 years with a mental illness who are employed and/or are enrolled for study is also desirable.

This indicator measures employment participation relative to the total population aged 16–64 years, as distinct from the labour force (that is, people who are employed or unemployed, but actively looking for work). Some people can choose not to participate in the labour force (that is, they are not working or actively looking for work). Data on the proportion of people aged 16–64 years who are unemployed or not in the labour force (by mental illness status) are in table 12A.63. It also does not provide information on whether for those employed or enrolled for study, their jobs/studies are appropriate or meaningful.

Data reported for this indicator are comparable.


Mental illness can act as a barrier to gaining and maintaining employment (AHMC 2012). Nationally, in 2011-12, the proportion of people with a mental illness who were employed was 61.7 ± 3.1 per cent, compared to 80.3 ± 0.9 per cent for those without a mental illness (figure 12.30).
People aged 16–64 years who are employed, by mental illness status, 2011-12\textsuperscript{a, b}

\begin{figure}
\centering
\includegraphics[width=\textwidth]{chart.png}
\caption{Figure 12.30 People aged 16–64 years who are employed, by mental illness status, 2011-12\textsuperscript{a, b}}
\end{figure}

\textsuperscript{a} People with a mental illness are defined as those who self-reported mental and behavioural problems that have lasted for six months, or which the respondent expects to last for six months or more. Includes organic mental conditions, alcohol and drug conditions, mood conditions and other mental and behavioural conditions. \textsuperscript{b} Estimates have been age standardised to the 2001 estimated resident population.


Data from the 2007-08 National Health Survey and the 2007 SMHWB on the labour force and employment participation of people who had a mental illness/disorder are in tables 12A.65 and 12A.67.

Mental illness in early adult years can lead to disrupted education and premature exit from school or tertiary training, or disruptions in the transition from school to work (AHMC 2012). The effect of these disruptions can be long term, restricting the person’s ability to participate in a range of social and vocational activities over their lifetime (AHMC 2012). Nationally, in 2011-12, the proportion of people aged 16–30 years with a mental illness who were employed and/or are enrolled for study in a formal secondary or tertiary qualification was 79.2 ± 4.2 per cent, compared to 90.2 ± 1.2 per cent for those without a mental illness (figure 12.31).
People aged 16-30 years who were employed and/or are enrolled for study in a formal secondary or tertiary qualification, by mental illness status, 2011-12

People with a mental illness are defined as those who self-reported mental and behavioural problems that have lasted for six months, or which the respondent expects to last for six months or more. Includes organic mental conditions, alcohol and drug conditions, mood conditions and other mental and behavioural conditions. Estimates have been age standardised to the 2001 estimated resident population.

Source: ABS (unpublished) Australian Health Survey 2011-13 (2011-12 NHS component), Cat. no. 4364.0; table 12A.64.

Data from the 2007-08 National Health Survey and the 2007 SMHWB on the participation of people aged 16–30 years in the labour force and/or in education or training are in tables 12A.66 and 12A.68-69.

Mental health outcomes of consumers of specialised public mental health services

‘Mental health outcomes of consumers of specialised public mental health services’ is an indicator of governments’ objective to improve the effectiveness and quality of service delivery and outcomes and promote recovery from mental health problems and mental illness (box 12.22).
Mental health outcomes of consumers of specialised public mental health services

‘Mental health outcomes of consumers of specialised public mental health services’ is defined as the proportion of people receiving care in specialised public mental health services who had a significant improvement in their clinical mental health outcomes. Data are also reported on the proportion who experienced no significant change or a significant deterioration in their mental health outcomes. Data are reported by three service user types: people in ongoing community-based care, people discharged from community-based care and people discharged from a hospital psychiatric inpatient unit.

Results are difficult to interpret as there are a range of mental health clinical outcomes for people treated in specialised public mental health services and ‘best practice’ outcomes are unknown (AHMC 2012). A high or increasing proportion of people receiving care in specialised public mental health services who had a significant improvement in their clinical mental health outcomes is desirable.

The assessment of a consumer’s clinical mental health outcomes is based on the changes reported in a consumer’s ‘score’ on a rating scale known as the Health of the Nation Outcomes Scale (HoNOS), or for children and adolescents, the Health of the Nation Outcome Scales for Children and Adolescents (HoNOSCA) (AHMC 2012). Outcome scores are classified based on effect size — a statistic used to assess the magnitude of a treatment effect (AHMC 2012). The effect size is based on the ratio of the difference between the pre- and post- scores to the standard deviation of the pre-score (AHMC 2012). Individual episodes are classified as ‘significant improvement’ if the effect size index is greater than or equal to positive 0.5; ‘no change’ if the index is between -0.5 and zero; and ‘significant deterioration’ if the effect size index is less than or equal to -0.5 (AHMC 2012).

This indicator has many technical and conceptual issues. The outcome measurement tool is imprecise. A single ‘average score’ does not reflect the complex service system in which services are delivered across multiple settings (inpatient, community and residential) and provided as both discrete, short term episodes of care and prolonged care over indefinite periods (AHMC 2012). The approach separates a consumer’s care into segments (hospital versus the community) rather than tracking the person’s overall outcomes across treatment settings. In addition, consumers’ outcomes are measured from the clinician’s perspective and not as the ‘lived experience’ from the consumer’s viewpoint (AHMC 2012).

Data reported for this indicator are not directly comparable.

Data quality information for this indicator is under development.

Nationally, in 2010-11, 26 per cent of people in ongoing community-based care, 50 per cent of people discharged from community-based care and 72 per cent of people discharged from a hospital psychiatric inpatient unit showed a significant improvement in their mental health clinical outcomes (figures 12.32-33). Caution is required in interpreting results across states and territories. Data are of variable
quality and there are different levels of coverage across states and territories (AHMC 2012).

Figure 12.32  Mental health outcomes of consumers of State or Territory community-based specialised public mental health services, 2010-11

- **People in ongoing community-based care**
  - Data comprise people receiving relatively long term community-based care. Data include people who were receiving care for the whole of 2010-11, and those who commenced community-based care sometime after 1 July 2010 who continued under care for the rest of the year. The defining characteristic of the group is that all remained in ongoing care when the year ended (30 June 2011). Outcome scores were calculated as the difference between the total score recorded on the first occasion rated and the last occasion rated in the year.

- **People discharged from community-based care**
  - Data comprise people who received relatively short term community-based care. The defining characteristic of the group is that the episode of community-based care commenced, and was completed, within 2010-11. Outcome scores were calculated as the difference between the total score recorded at admission to, and discharge, from community-based care. People whose episode of community-based care was completed because they were admitted to hospital are not included.

- **ACT data are not published due to insufficient observations.**
- **NT data are not published due to insufficient observations.**

Figure 12.33 Mental health outcomes of consumers discharged from State or Territory inpatient mental health services, 2010-11\(^a\), \(^b\)

\(^a\) The ACT data are not published due to insufficient observations. \(^b\) Data comprise people who received a discrete episode of inpatient care within a psychiatric unit. The defining characteristic of the group is that the episode of inpatient care commenced, and was completed, within the year. Outcome scores were calculated as the difference between the total score recorded at admission and discharge. The analysis excludes episodes where the length of stay was three days or less because it is not meaningful to compare admission and discharge ratings for short duration episodes.


12.5 Future directions in performance reporting

Key challenges for improving the reporting on mental health include:

- improving the reporting of effectiveness and efficiency indicators for Indigenous Australians, rural/remote and other selected community groups
- developing an estimate of the number of people who need mental health services so that access to services can be measured in terms of need
- identifying indicators that relate to the performance framework dimensions of quality — safety and sustainability
- improving reporting on outcomes to include indicators that relate to the participation of people with a mental illness in meaningful social and recreational activities
- further developing the measurement and reporting on the clinical mental health outcomes of consumers of specialised public mental health services.
12.6 Definitions of key terms

**General terms**

**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.

**Mental health**

**Acute services**
Services that primarily provide specialised psychiatric care for people with acute episodes of mental illness. These episodes are characterised by recent onset of severe clinical symptoms of mental illness 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 can:
- focus on assisting people who have had no prior contact or previous psychiatric history, or individuals with a continuing psychiatric illness for whom there has been an acute exacerbation of symptoms
- target the general population or be specialised in nature, targeting specific clinical populations. The latter group include psychogeriatric, child and adolescent, youth and forensic mental health services.

**Accrued mental health patient days**
Mental health care days are days of admitted patient care provided to admitted patients in psychiatric hospitals, designated psychiatric units and days of residential care provided to residents in residential mental health services. Accrued mental health care days can also be referred to as occupied bed days in specialised mental health services. The days to be counted are only those days occurring within the reference period, that is from 1 July to the following 30 June for the relevant period, even if the patient/resident was admitted prior to the reference period or discharged after the reference period.

The key basic rules to calculate the number of accrued mental health care days are as follows:
- For a patient admitted and discharged on different days, all days are counted as mental health care days except the day of discharge and any leave days.
- Admission and discharge on the same day are equal to one patient day.
• Leave days involving an overnight absence are not counted.
• A patient day is recorded on the day of return from leave.

**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.

**Average available beds**
The number of beds available to provide overnight accommodation for patients admitted to hospital (other than neonatal cots [non-special-care] and beds occupied by hospital-in-the-home patients) or to specialised residential mental health care, averaged over the counting period. Beds are available only if they are suitably located and equipped to provide care and the necessary financial and human resources can be provided.

**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 can 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 illness or psychiatric disability. To be defined as community-based residences, the services must: provide residential care to people with mental illnesses 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 illnesses such as depressive illness 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 can be affected.

**Forensic mental health services**
Services principally providing assessment, treatment and care of mentally ill 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
General mental health services

Services that principally target the general adult population (18–65 years old) but that can provide services to children, adolescents or older people. Includes, therefore, those services that cannot be described as specialised child and adolescent, youth, older people’s 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 illness

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 illness.

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 an illness to prevent its development. The goal of prevention interventions is to reduce the incidence and prevalence of mental health problems and mental illnesses.

Mortality rate from suicide

The proportion of the population who die as a result of suicide.

Non-acute services

Non-acute services are defined by 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 can include high levels of severe unremitting symptoms of mental illness. 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 can include supported accommodation services (including community-based crisis and respite beds), vocational rehabilitation programs, advocacy programs...
Older people’s 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 people. These services can 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 can 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 can include outreach or domiciliary care as an adjunct to services provided from the clinic base.

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 illnesses.

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 can 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 specialised 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 illness 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 non-24 or 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 specialised categories of registered nurses.

Enrolled nurses: refers to people 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 (allied 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 Health establishments that are primarily devoted to the treatment and
hospitals  

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 can 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 can be psychological (as in substance misuse) or physiological (as in substance dependence).

Youth mental health services  

Services principally targeting children and young people generally aged 16-25 years. The classification of a service into this category requires recognition by the regional or central funding authority of the special focus of the service. These services may include a forensic component.
12.7 List of attachment tables

Attachment tables are identified in references throughout this chapter by a ‘12A’ prefix (for example, table 12A.1). Attachment tables are available on the Review website (www.pc.gov.au/gsp).

Table 12A.1 Real estimated Australian Government expenditure on mental health services (2010-11 dollars) ($'000)
Table 12A.2 Real estimated recurrent expenditure on State and Territory governments specialised mental health services (2010-11 dollars)
Table 12A.3 Real estimated expenditure on State and Territory governments’ specialised mental health services, by funding source (2010-11 dollars) ($000s),
Table 12A.4 Real Australian, State and Territory governments expenditure on specialised mental health services (2010-11 dollars) ($000s),
Table 12A.5 Depreciation (current prices) ($'000s)
Table 12A.6 Total state and territory recurrent expenditure on specialised mental health services (current prices)
Table 12A.7 Functioning and quality of life measures, by 12-month mental disorder status, 2007 (per cent)
Table 12A.8 Age standardised rate of adults with very high levels of psychological distress, by State and Territory, 2011-12
Table 12A.9 Age standardised rate of adults with very high levels of psychological distress, by remoteness, SEIFA IRSD quintiles, SEIFA IRSD deciles, and disability status, 2011-12
Table 12A.10 Age standardised rate of adults with high/ very high levels of psychological distress, by State and Territory, 2011-12
Table 12A.11 Age standardised rate of adults with very high levels of psychological distress, by State and Territory, 2007-08
Table 12A.12 Age standardised rate of adults with very high levels of psychological distress, by remoteness, SEIFA IRSD quintiles, SEIFA IRSD deciles, and disability status, 2007-08
Table 12A.13 Age standardised rate of adults with high/ very high levels of psychological distress, by State and Territory, 2007-08
Table 12A.14 Level of psychological distress K10, 2007-08 (per cent)
Table 12A.15 Age standardised rate of adults with high/very high levels of psychological distress, by State and Territory, by Indigenous status, 2008
Table 12A.16 Level of psychological distress K10, 2004-05 (per cent)
Table 12A.17 Mental health care specific MBS items processed
Table 12A.18 Mental health patient days
Table 12A.19 Admitted patient mental health-related separations with specialised psychiatric care, by principal diagnosis in ICD-10-AM and hospital type
<p>| Table 12A.20  | Community mental health service contacts, by sex and age group |
| Table 12A.21  | Specialised mental health care reported, by Indigenous status |
| Table 12A.22  | Available beds in specialised mental health services |
| Table 12A.23  | Full time equivalent (FTE) direct care staff employed in specialised mental health services by staff type (per 100 000 people) |
| Table 12A.24  | Full time equivalent (FTE) direct care staff employed in specialised mental health services, by service setting (per 100 000 people) |
| Table 12A.25  | New clients as a proportion of total clients under the care of State or Territory specialised public mental health services, |
| Table 12A.26  | Proportion of people receiving clinical mental health services by service type and Indigenous status |
| Table 12A.27  | Proportion of people receiving clinical mental health services by service type and remoteness area |
| Table 12A.28  | Proportion of people receiving clinical mental health services by service type and SEIFA |
| Table 12A.29  | Proportion of people receiving clinical mental health services by service type and age, 2010-11 |
| Table 12A.30  | Proportion of people receiving clinical mental health services by service type |
| Table 12A.31  | Services used for mental health problems, Australia, 2007 (per cent) |
| Table 12A.32  | Services used for mental health, by mental disorder status, 2007 (per cent) |
| Table 12A.33  | Young people who had contact with MBS-subsidised primary mental health care services, by age group |
| Table 12A.34  | Specialised public mental health services reviewed against National Standards for Mental Health Services, 30 June |
| Table 12A.35  | Recurrent expenditure on community-based services as a proportion of total spending on mental health services (per cent) |
| Table 12A.36  | Specialised public mental health services episodes with completed consumer outcomes measures collected |
| Table 12A.37  | Consumer and carer participation |
| Table 12A.38  | Rates of community follow up for people within the first seven days of discharge from hospital |
| Table 12A.39  | Readmissions to hospital within 28 days of discharge |
| Table 12A.40  | Average recurrent costs per inpatient bed day, public hospitals, by target population (2010-11 dollars) |
| Table 12A.41  | Average recurrent costs per inpatient bed day, public hospitals, by target population and care type (2010-11 dollars) |
| Table 12A.42  | Average length of stay, public hospitals acute units, by target population, 2010-11 |
| Table 12A.43  | Average recurrent cost per inpatient bed day, by public hospital type (2010-11 dollars) |
| Table 12A.44  | Average recurrent cost per patient day for community residential services (2010-11 dollars) |</p>
<table>
<thead>
<tr>
<th>Table No.</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>12A.45</td>
<td>Average cost of ambulatory care</td>
</tr>
<tr>
<td>12A.46</td>
<td>Risk status recent drinkers (in last 12 months) aged 14 years or over, 2010 (per cent)</td>
</tr>
<tr>
<td>12A.47</td>
<td>Recent alcohol and illicit drug use, people aged 14 years or over, by substance, 2010 (per cent)</td>
</tr>
<tr>
<td>12A.48</td>
<td>Selected illicit drug use, by substance and age group, 2010 (per cent)</td>
</tr>
<tr>
<td>12A.49</td>
<td>Selected illicit drug use by people aged 18 years or over, by level of psychological distress and mental illness status, 2010 (per cent)</td>
</tr>
<tr>
<td>12A.50</td>
<td>Risk status recent drinkers aged 14 years or over, 2007 (per cent)</td>
</tr>
<tr>
<td>12A.51</td>
<td>Recent alcohol and illicit drug use, people aged 14 years or over, by substance, 2007 (per cent)</td>
</tr>
<tr>
<td>12A.52</td>
<td>Use of cannabis and any illicit drug excluding cannabis, by age group, 2007 (per cent)</td>
</tr>
<tr>
<td>12A.53</td>
<td>Selected illicit drug use by people aged 18 years or over, by level of psychological distress and mental illness status, 2007 (per cent)</td>
</tr>
<tr>
<td>12A.54</td>
<td>Prevalence of lifetime mental disorders among adults aged 16–85 years, 2007 (per cent)</td>
</tr>
<tr>
<td>12A.55</td>
<td>Prevalence of lifetime mental disorders among adults aged 16–85 years, by sex, 2007 (per cent)</td>
</tr>
<tr>
<td>12A.56</td>
<td>Prevalence of lifetime mental disorders among adults, by age, 2007 (per cent)</td>
</tr>
<tr>
<td>12A.57</td>
<td>Suicides and mortality rate, by sex, Australia</td>
</tr>
<tr>
<td>12A.58</td>
<td>Suicides and mortality rate, by age and sex, Australia</td>
</tr>
<tr>
<td>12A.59</td>
<td>Suicide deaths and death rate</td>
</tr>
<tr>
<td>12A.60</td>
<td>Suicide deaths and death rate of people aged 15–24 years</td>
</tr>
<tr>
<td>12A.61</td>
<td>Suicide deaths and suicide death rate, by area</td>
</tr>
<tr>
<td>12A.62</td>
<td>Suicide deaths, by Indigenous status, 2006–2010</td>
</tr>
<tr>
<td>12A.63</td>
<td>Age standardised proportion of people aged 16–64 years who are employed, by mental illness status, 2011–12 (per cent)</td>
</tr>
<tr>
<td>12A.64</td>
<td>Age standardised proportion of the population aged 16–30 years who are employed and/or are enrolled for study in a formal secondary or tertiary qualification (full or part-time), by mental health status, 2011–12 (per cent)</td>
</tr>
<tr>
<td>12A.65</td>
<td>Age standardised proportion of people aged 16–64 years who are employed, by mental illness status, 2007-08 (per cent)</td>
</tr>
<tr>
<td>12A.66</td>
<td>Population aged 16–30 years who are employed and/or are enrolled for study in a formal secondary or tertiary qualification (full or part-time), by mental health status, 2007-08 (per cent)</td>
</tr>
<tr>
<td>12A.67</td>
<td>Labour force and employment participation among adults aged 16–64 years, by mental disorder status, 2007 (per cent)</td>
</tr>
<tr>
<td>12A.68</td>
<td>Education, training and employment participation among adults aged 16–30 years, by mental disorder status, 2007 (per cent)</td>
</tr>
<tr>
<td>Table 12A.69</td>
<td>Labour force and employment participation among adults aged 16–30 years, by mental disorder status, 2007 (per cent)</td>
</tr>
<tr>
<td>---------------</td>
<td>------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Table 12A.70</td>
<td>Clinical outcomes of people receiving various types of mental health care provided by State and Territory public mental health services (per cent)</td>
</tr>
<tr>
<td>Table 12A.71</td>
<td>Deflators used to calculate real state and territory mental health expenditure</td>
</tr>
<tr>
<td>Table 12A.72</td>
<td>Deflator used to calculate real Australian Government mental health expenditure</td>
</tr>
<tr>
<td>Table 12A.73</td>
<td>Estimated resident populations used in mental health per head calculations</td>
</tr>
</tbody>
</table>
12.8 References


—— 2012, Information Paper: Use of the Kessler Psychological Distress Scale in ABS Health Surveys, Australia, 2007-08, Cat. no. 4817.0.55.001, Canberra.


—— 2010, National Standards for Mental Health Services 2010, Canberra.


AIHW (Australian Institute of Health and Welfare) 2008, Mental Health Services in Australia 2005–06, Mental health series no. 10, Cat. no. HSE 56, Canberra.


Coghlan, R., Lawrence D., Holman D. and Jablensky A. 2001, *Duty to Care: Physical Illness in People with Mental Illness*, University of Western Australia, Perth.


PART F

COMMUNITY SERVICES
F Community services sector overview

CONTENTS

F.1 Introduction F.1
F.2 Sector performance indicator framework F.13
F.3 Cross-cutting and interface issues F.37
F.4 Future directions in performance reporting F.41
F.5 List of attachment tables F.42
F.6 References F.43

Attachment tables
Attachment tables are identified in references throughout this sector overview by a 'FA' prefix (for example, table FA.1). A full list of attachment tables is provided at the end of this sector overview, and the attachment tables are available from the Review website at www.pc.gov.au/gsp.

F.1 Introduction

This sector overview provides an introduction to the Aged care services (chapter 13), Services for people with disability (chapter 14) and Child protection and youth justice services (chapter 15) chapters of this Report. It provides an overview of the community services sector, presenting both contextual information and high level performance information.

Major improvements in reporting on community services this year are identified in each of the service-specific community services chapters.
Policy context

Families are the principal providers of care for children, older people and people with disability (ABS 2010; Australian Government 2008). Community services aim to:

- support families to fulfil their caring roles
- provide care when families are unable to
- provide interventions when a person’s needs are not able to be met within the community without special intervention.

Community services provide support to sustain and nurture the functioning of individuals, families and groups, to maximise their potential and to enhance community wellbeing (Australian Council of Social Service 2009). Although community services generally target individuals, they can be delivered at an institutional level. 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).

Sector scope

Although there is a broad understanding of the nature of community services, the sector is complex, and consistent aggregate reporting across the community services sector is not possible at this time.

Definitions of the sector vary in their scope and can change over time. Community service activities typically include activities that support individual and family functioning. They can include financial assistance and relief to people in crisis but exclude acute health care services and long term housing assistance. Some of these interventions are included elsewhere in this Report; for example, Public hospitals (chapter 10), Mental health management (chapter 12), Housing (chapter 16), and Homelessness services (chapter 17).

The definition of community services activities in this sector overview is based on the National Classification of Community Services developed by the Australian Institute of Health and Welfare (AIHW 2003) (box F.1). The scope of the sector overview is therefore somewhat broader than the three service-specific chapters in this section of the Report (Aged care services, Services for people with disability, and Child protection and youth justice services).
Box F.1  **Community services activities**

Community services activities include:

**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, social and systemic 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 is 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 promote child and family welfare by supporting families and protecting children from abuse and neglect or harm through statutory intervention.

**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 that are 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** — activities in relation to young people and people with intellectual and psychiatric disabilities on court orders 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 Report uses the term ‘youth 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 (chapter 15).

*Source: AIHW (2003); State and Territory governments (unpublished).*
Other definitions of community services have even 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 2008). Other definitions include activities such as advocacy, public transport, community safety and emotional support.

Profile of the community services sector

This section examines the size and scope of the community services sector and the role of government in providing community services. Detailed profiles for the services within the community services sector are reported in chapters 13, 14 and 15, and cover:

- size and scope of the individual service types
- funding and expenditure.

Roles and responsibilities

The Australian, State and Territory governments have major roles in the provision of community services. These roles are based on mandates to ensure basic rights and an acceptable standard of living, and a requirement to protect and support vulnerable people in society.

Local governments are also funders and providers of community services (AIHW 2005). However, community services funded solely by local government are not included in this Report.

Roles and responsibilities for the health sector were confirmed by COAG under the National Health Reform Agreement during 2011. Under that Agreement, changes in roles and responsibilities for the Home and Community Care (HACC) program across the aged care and disability services’ sectors also came into effect on 1 July 2011 (for more detail see section F.3, box 13.1 and box 14.5).

Government involvement in community services includes:

- providing services directly to clients
- funding non-government community service providers (which then provide services to clients)
- legislating for, and regulating, government and non-government providers
- undertaking strategic planning, policy development and administration
- undertaking monitoring and evaluation of community services programs.
The roles and funding arrangements for community services vary across service areas and programs:

- statutory child protection, out-of-home care services, intensive family support services and youth justice services are funded and delivered primarily by State and Territory governments, with some non-government sector involvement, particularly in the delivery of out-of-home care services. Family support and early intervention (assessment and referral) services are funded by State and Territory governments and services are delivered primarily by non-government organisations.

- specialist disability services, excluding employment services, are funded primarily by State and Territory governments (with some Australian Government contribution) and are delivered primarily by State and Territory governments and the non-government sector. Employment services are funded and provided primarily by the Australian Government.

- residential aged care is funded primarily by the Australian Government and services are delivered primarily by the non-government sector.

- the funding and program responsibilities for HACC services across states and territories (except in Victoria and WA) are split — the Australian Government funds services for older people and State and Territory governments fund services for younger people. HACC services for older people and younger people are jointly funded by the Australian and Victorian governments in Victoria and the Australian and WA governments in WA. Services are delivered by a combination of local government, non-government community organisations, religious or charitable bodies, State and Territory government agencies, and private (for profit) organisations.

Effective regulation of non-government agencies (through licensing, accreditation and quality assurance) enables agencies to provide services within a framework of agreed standards. Examples include the accreditation of residential aged care services and the new Community Care Common Standards that came into effect on 1 March 2011. The Community Care Common Standards apply for the HACC program, Community Aged Care Packages (CACP), Extended Aged Care at Home (EACH), EACH-Dementia (EACH-D) and National Respite for Carers Program (NRCP).
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.

*Australia’s welfare 2011* (AIHW 2011) analyses community services expenditure incurred by governments, non-government organisations and individual households in providing services to assist members of the community with special needs (families and children, older people, people with disability and other disadvantaged groups). It estimates that:

- welfare expenditure broadly comprises spending on welfare services and cash payments. In 2008–09, welfare expenditure was estimated to be $136.6 billion, $94.4 billion of this was for cash payments while $42.2 billion was for welfare services (AIHW 2011)

- expenditure on welfare services, excluding welfare payments ($42.2 billion) in 2008–09 represented 3.4 per cent of Gross Domestic Product (GDP). The amount spent on welfare services between 1998–99 and 2008-09 increased on average each year by 4.9 per cent, much higher than GDP growth of 3.2 per cent (AIHW 2011)

- governments were the source of 73.0 per cent ($30.9 billion) of all funding of welfare services in 2008–09, with the non-government sector providing the remaining 27.0 per cent ($11.2 billion) (AIHW 2011).

*Community Services Australia, 2008-09* (ABS 2010) provides data on community services expenditure incurred by governments and non-government organisations (for-profit and not-for-profit) in providing services to assist members of the community with special needs, including personal and social support, residential care and other social assistance services. These data apply to organisations engaged in providing a wide variety of social support services directly to clients, including (but not limited to), welfare services, disabilities assistance and the operation of adult day care centres.

Community Services Australia estimates that, during 2008-09, $25.2 billion was spent on direct community services activities and a further $4.0 billion on non-direct and related community services activities. The majority of services were provided by the not-for-profit sector, which received most of its funding from government. Total expenditure on direct activities comprised $13.8 billion by
not-for-profit organisations, $6.7 billion by for-profit organisations, $3.8 billion by Australian, State and Territory governments and $0.9 billion by local government. In addition, Australian, State and Territory governments provided funding of $9.5 billion to other private organisations and self-employed contractors for the direct provision of community services:

- Personal and social support comprises activities relating to information, advice and referral, individual and family support, independent and community living support, and support in the home. During 2008–09, total expenditure on personal and social support was $5.9 billion, which accounted for 24 per cent of all direct community services expenditure. Not-for-profit organisations received the majority of this ($4.3 billion). The main components of personal and social support expenditure were $1.6 billion for individual and family support, $1.5 billion for support in the home, and $1.5 billion for other personal and social support.

- Direct expenditure on residential care across the community services sector was $12.6 billion in 2008–09. Not-for-profit organisations had the largest allocation with $7.2 billion, followed by for-profit organisations with $3.3 billion, and government organisations with $2.0 billion. Aged and disability care was the most significant activity within residential care, accounting for $10.3 billion of total expenditure. The main components of this were high level care ($6.8 billion or 66 per cent), and low level care ($3.5 billion or 34 per cent). Not-for-profit organisations accounted for $3.3 billion (48 per cent) of the high level care expenditure and $2.5 billion (73 per cent) of the low level care expenditure.

Community services expenditure included in this Report

The following analysis relates only to expenditure on programs reported in the community services chapters of this Report (box F.2).
Box F.2  **Major programs included in community services expenditure in the Report**

The major programs reported on include:

- aged care services — aged care assessment, residential care and community care, including HACC services
- services for people with disability — services as outlined in the National Disability Agreement
- child protection and youth justice services — child protection, out-of-home care, family support services and intensive family support services, and youth justice services, including community and detention-based supervision and group conferencing.

Each chapter includes more detailed analysis of expenditure items reported.

**Recurrent expenditure included in the Report**

Total Australian, State and Territory government recurrent expenditure on community services covered by this Report was estimated to be $24.2 billion in 2011-12 (table F.1). This was equivalent to 1.7 per cent of GDP in that year, and 9.3 per cent of total government outlays (table F.1 and ABS 2012).

Between 2007-08 and 2011-12, real government recurrent expenditure on these services increased by $5.9 billion or 32.1 per cent. The largest proportional increase in real expenditure was on child protection and youth justice services, which increased by 87.3 per cent between 2007-08 and 2011-12. However, in part this increase is explained by the addition in 2011-12 of expenditure data for two new services: family support services and youth justice services. The largest absolute dollar increase for a particular service between 2007-08 and 2011-12 was $2.3 billion for aged care services (table F.1).
<table>
<thead>
<tr>
<th>Year</th>
<th>Unit</th>
<th>Aged care services</th>
<th>Services for people with disability</th>
<th>Child protection and youth justice</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>2007-08</td>
<td>$m</td>
<td>10,562.3</td>
<td>5,408.9</td>
<td>2,391.1</td>
<td>18,362.3</td>
</tr>
<tr>
<td>2008-09</td>
<td>$m</td>
<td>10,967.7</td>
<td>5,710.3</td>
<td>2,705.5</td>
<td>19,383.4</td>
</tr>
<tr>
<td>2009-10</td>
<td>$m</td>
<td>11,868.1</td>
<td>6,193.7</td>
<td>3,044.2</td>
<td>21,106.0</td>
</tr>
<tr>
<td>2010-11</td>
<td>$m</td>
<td>12,371.2</td>
<td>6,301.9</td>
<td>3,172.1</td>
<td>21,845.2</td>
</tr>
<tr>
<td>2011-12</td>
<td>$m</td>
<td>12,861.3</td>
<td>6,914.2</td>
<td>4,479.0</td>
<td>24,254.5</td>
</tr>
</tbody>
</table>

Increase 2007-08 to 2011-12 % 21.8 27.8 87.3 32.1

**Note:**
- Data for 2007-08 to 2010-11 have been adjusted to 2011-12 dollars using the gross domestic product (GDP) price deflator in table AA.51 of appendix A.
- Totals may not add as a result of rounding.
- See box F.2 for the major programs included in expenditure for each service.
- Total expenditure includes a transfer of $131 million from NSW to the Australian Government for the notional support costs for younger people receiving residential and packaged aged care, as required under the National Partnership Agreement on Transitioning Responsibilities for Aged Care and Disability Services. This expenditure is included in both the Aged Care expenditure and Services for people with disability expenditure.
- More detailed expenditure data can be found in the relevant chapters of the Report.

Source: Australian, State and Territory governments (unpublished); tables 13A.6, 14A.4, 15A.1, 15A.179 and AA.51.

**Expenditure available for reporting at a State and Territory level**

Table F.2 identifies expenditure on community services included in this Report by State and Territory governments and the Australian Government, available for reporting by State and Territory for 2011-12.
Table F.2  Government recurrent expenditure on community services, 2011-12\(^{a, b, c, d, e, f, g}\)

<table>
<thead>
<tr>
<th>Unit</th>
<th>NSW</th>
<th>Vic</th>
<th>Qld</th>
<th>WA</th>
<th>SA</th>
<th>Tas</th>
<th>ACT</th>
<th>NT</th>
<th>Aust</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACS</td>
<td>$m</td>
<td>4 176.0</td>
<td>3 251.8</td>
<td>2 436.8</td>
<td>1 146.8</td>
<td>1 214.0</td>
<td>345.3</td>
<td>146.4</td>
<td>72.2</td>
</tr>
<tr>
<td>SPWD</td>
<td>$m</td>
<td>2 065.2</td>
<td>1 504.8</td>
<td>990.7</td>
<td>655.4</td>
<td>433.1</td>
<td>151.3</td>
<td>90.6</td>
<td>64.0</td>
</tr>
<tr>
<td>CPYJS</td>
<td>$m</td>
<td>1 774.9</td>
<td>823.3</td>
<td>920.8</td>
<td>471.9</td>
<td>235.3</td>
<td>89.8</td>
<td>49.4</td>
<td>113.6</td>
</tr>
<tr>
<td>Total</td>
<td>$m</td>
<td>8 016.1</td>
<td>5 579.9</td>
<td>4 348.3</td>
<td>2 274.0</td>
<td>1 882.4</td>
<td>586.4</td>
<td>286.4</td>
<td>249.8</td>
</tr>
</tbody>
</table>

Proportion of recurrent expenditure by service

<table>
<thead>
<tr>
<th>Unit</th>
<th>NSW</th>
<th>Vic</th>
<th>Qld</th>
<th>WA</th>
<th>SA</th>
<th>Tas</th>
<th>ACT</th>
<th>NT</th>
<th>Aust</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACS</td>
<td>%</td>
<td>52.1</td>
<td>58.3</td>
<td>56.0</td>
<td>50.4</td>
<td>64.5</td>
<td>58.9</td>
<td>51.1</td>
<td>28.9</td>
</tr>
<tr>
<td>SPWD</td>
<td>%</td>
<td>25.8</td>
<td>27.0</td>
<td>22.8</td>
<td>28.8</td>
<td>23.0</td>
<td>25.8</td>
<td>31.6</td>
<td>25.6</td>
</tr>
<tr>
<td>CPYJS</td>
<td>%</td>
<td>22.1</td>
<td>14.8</td>
<td>21.2</td>
<td>20.8</td>
<td>12.5</td>
<td>15.3</td>
<td>17.2</td>
<td>45.5</td>
</tr>
<tr>
<td>Total</td>
<td>%</td>
<td>100.0</td>
<td>100.0</td>
<td>100.0</td>
<td>100.0</td>
<td>100.0</td>
<td>100.0</td>
<td>100.0</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Recurrent expenditure on community services per person in the population\(^{f}\)

<table>
<thead>
<tr>
<th>Unit</th>
<th>NSW</th>
<th>Vic</th>
<th>Qld</th>
<th>WA</th>
<th>SA</th>
<th>Tas</th>
<th>ACT</th>
<th>NT</th>
<th>Aust</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACS</td>
<td>$</td>
<td>576.2</td>
<td>583.3</td>
<td>540.0</td>
<td>480.4</td>
<td>738.0</td>
<td>674.8</td>
<td>394.9</td>
<td>310.7</td>
</tr>
<tr>
<td>SPWD</td>
<td>$</td>
<td>285.0</td>
<td>269.9</td>
<td>219.5</td>
<td>274.5</td>
<td>263.3</td>
<td>295.7</td>
<td>244.5</td>
<td>275.4</td>
</tr>
<tr>
<td>CPYJS</td>
<td>$</td>
<td>244.9</td>
<td>147.7</td>
<td>204.0</td>
<td>197.7</td>
<td>143.0</td>
<td>175.5</td>
<td>133.3</td>
<td>488.9</td>
</tr>
<tr>
<td>Total</td>
<td>$</td>
<td>1 106.0</td>
<td>1 001.0</td>
<td>963.5</td>
<td>952.6</td>
<td>1 144.3</td>
<td>1 145.9</td>
<td>772.7</td>
<td>1 075.0</td>
</tr>
</tbody>
</table>

ACS = Aged care services. SPWD = Services for people with disability. CPYJS = Child protection and youth justice services.

\(^{a}\) For aged care services and services for people with disability, Australian Government expenditure not allocated to a State or Territory is included in the totals ($72.1 million in aged care services and $959.9 million in services for people with disability). \(^{b}\) Collection and reporting methods may vary across jurisdictions and services, therefore, these data should be interpreted with care. \(^{c}\) See box F.2 for the major programs included in expenditure for each service. More detailed expenditure data can be found in the relevant chapters of the Report. \(^{d}\) Totals may not sum due to rounding. \(^{e}\) Expenditure for aged care does not include capital expenditure. \(^{f}\) Population at 31 December 2011. \(^{g}\) Total expenditure includes a transfer of $131 million from NSW to the Australian Government for the notional support costs for younger people receiving residential and packaged aged care, as required under the National Partnership Agreement on Transitioning Responsibilities for Aged Care and Disability Services. This expenditure is included in both the Aged Care expenditure and Services for people with disability expenditure.

Source: Australian, State and Territory governments (unpublished); tables 13A.5, 14A.4, and 15A.1

Size and scope

Current data on the size and scope of the community services sector are limited. The ABS survey of community services collected data on the number of organisations that provided community services in 2009. Almost 11 000 organisations were providing community services. These included 5 809 not-for-profit organisations, 4 638 for-profit organisations and 520 government organisations (ABS 2010).

Social and economic factors affecting demand for services

In general, relatively disadvantaged members of the community live shorter lives and have higher rates of illness and disability than those whose circumstances are advantageous. For example, higher levels of education and income are associated
with a lower prevalence of health risk factors such as smoking and obesity, and better health outcomes generally (AIHW 2010).

Disadvantage also limits the extent to which individuals and families can participate in society. Economic participation conveys financial, health and social benefits to individuals, households and families and is central to population welfare. Economic participation can be described as a person’s engagement in education and employment, and access to economic resources including income and wealth. The various aspects of economic participation are inter-related, and are also associated with positive social and health outcomes (AIHW 2011).

*Child protection and youth justice services*

No single factor can predict whether a child will require child protection services. Factors commonly associated with child protection involvement include: early child bearing, parental alcohol and drug use, family violence, adult mental illness, social isolation, children with health, disability or behavioural problems, and families under financial stress (families who are reliant on pensions and benefits are overrepresented in the child protection system) (Bromfield and Holzer 2008; Allen Consulting Group 2003).

Similarly, no single factor can predict which children will come into contact with the justice system or be subject to youth justice supervision. A range of factors are associated with youth justice system involvement, including a young person’s lack of maturity, his or her propensity to take risks and susceptibility to peer influence, intellectual disability, and mental illness (Richards 2011).

*Disability services*

The Productivity Commission report (PC 2011a) into the disability care and support sector describes the sector as underfunded, unfair, fragmented, and inefficient, which gives people with disability little choice and no certainty of access to appropriate supports. The disability sector reflects social barriers such as prejudice, out-of-date practices, and poorly designed infrastructure. On 13 February 2011, COAG formally endorsed the National Disability Strategy 2010-2020. The Strategy outlines a ten-year national policy framework to improve the lives of people with disability, promote participation, and create a more inclusive society. It guides public policy across governments and aims to bring about change in all mainstream and specialist services and programs, as well as community infrastructure, to ensure they are accessible and responsive to the needs of people with disability. This change is important to ensuring that people with disability have the same
opportunities as other Australians – a quality education, health care, a job where possible and access to buildings, transport and social activities.

**Aged care services**

The National Health and Hospitals Reform Commission noted a number of challenges facing the aged care sector including significant shifts in the type of care demanded, due to reduced access to carers and family support caused by changes in social and economic circumstances (NHHRC 2009). The Productivity Commission report (PC 2011b) into caring for older Australians highlighted the increasing numbers of older people who are likely to require care (by 2050 it is estimated the 3.5 million Australians will use aged care services), along with their increasing expectations of care and the relative fall in the number of informal carers. The Australian Government’s *Living Longer, Living Better* aged care reform package, announced during 2012, includes a focus on increased consumer choice and control; more affordable and easier access to a full range of services; improved and expanded home care, support and residential care; better information; and more sustainable financing arrangements.

**Service-sector objectives**

The overarching service sector objectives in box F.3 draw together the objectives from each of the specific services detailed in this Report. More detailed objectives can be found in chapters 13 (Aged care services), 14 (Services for people with disability) and 15 (Child protection and youth justice services).
The overarching objective of the community services sector is to ensure that older people, people with disability and vulnerable children are supported or assisted and have the opportunity to fully participate in the community.

The specific objectives of the services that comprise the community services sector are summarised below:

- Aged care services (chapter 13) aim 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, and person-centred. These objectives are consistent with the Australian, State and Territory governments' long-term aged care objectives articulated under the NHA: that 'older Australians receive appropriate high quality and affordable health and aged care services' (COAG 2009).

- Services for people with disability (chapter 14) aim to enhance the quality of life experienced by people with disability by assisting them to live as valued and participating members of the community.

- Child protection and youth justice services (chapter 15) aim to support families to care for their children and to protect children who are at risk of harm. Youth justice services aim to contribute to a reduction in the frequency and severity of youth offending, recognise the rights of victims, and promote community safety.

Source: Chapters 13, 14 and 15.

F.2 Sector performance indicator framework

This sector overview is based on a sector performance indicator framework (figure F.1). This framework is made up of the following elements:

- Sector objectives — three sector objectives are a précis of the key objectives of the community services sector (box F.3)

- Sector-wide indicators — sector-wide indicators are high level indicators which cut across community services

- Service-specific indicators — information from the service-specific performance indicator frameworks that relate to community services. Discussed in more detail in chapters 13, 14 and 15, the service-specific frameworks provide comprehensive information on the equity, effectiveness and efficiency of these services.

This sector overview provides an overview of relevant performance information. Chapters 13, 14 and 15 and their associated attachment tables provide more detailed information.
Figure F.1  Community services performance indicator framework

Sector objectives

- Promote the wellbeing and independence of older people and their carers
- People with disability and their carers have an enhanced quality of life and participate as valued members of the community
- Australia’s children and young people are safe and well

Sector-wide indicators

- Wellbeing of older people
- Quality of life
- Jobless families with children as a proportion of all families
- Independence of older people and their carers
- Participation of people with disability and their carers in the community
- Improving child development

Service-specific performance indicator frameworks

- Chapter 13 – Aged care services
  - Aged care services p. 13.36
- Chapter 14 – Services for people with disability
  - Services for people with disability p. 14.22
- Chapter 15 – Protection and support services
  - Child protection and out-of-home care services p. 15.20
  - Juvenile justice services p. 15.70
Sector-wide indicators

This section includes high level indicators of community services’ outcomes. Many factors are likely to influence these outcomes — not solely the performance of government services. However, these outcomes inform the development of appropriate policies and the delivery of government services.

Wellbeing of older people

‘Wellbeing of older people’ is an indicator of governments’ objective to promote the wellbeing and independence of older people and their carers (box F.4).

Box F.4  Wellbeing of older people

‘Wellbeing of older people’ is defined as overall life satisfaction of older people and is measured by the proportion of people aged 65 years or over who were mostly satisfied with their lives.

A high proportion of people who are mostly satisfied with their lives is desirable.

Data reported for this indicator are comparable.

Data quality information for this indicator is under development.

Nationally in 2010, 83.3 per cent of people aged 65–74 years were mostly satisfied with their lives, 77.3 per cent of people aged 75–84 years were mostly satisfied with their lives and 82.2 per cent of people aged 85 years and over were mostly satisfied with their lives (figure F.2).
Figure F.2  Proportion of people aged 65 years or over who were mostly satisfied with their lives, 2010\(^a\), \(^b\), \(^c\)

![Bar chart showing the proportion of people aged 65 years or over who were mostly satisfied with their lives in 2010 for males, females, and all people, categorized by age groups 65-74, 75-84, and 85+.

\(^a\) People who felt delighted, pleased or mostly satisfied with their lives as a proportion of all people who provided a response to overall life satisfaction.

\(^b\) Excludes those who did not provide a response or did not know how they felt.

\(^c\) Error bars represent the 95 per cent confidence interval associated with each point estimate.

Source: ABS 2011 (unpublished), General Social Survey 2010, Cat. no. 4159.0, Canberra; table FA.7.

Independence of older people and their carers

‘Independence of older people and their carers’ is an indicator of governments’ objective to promote the wellbeing and independence of older people and their carers (box F.5).

Box F.5  Independence of older people and their carers

‘Independence of older people and their carers’ is defined as participation in the community by older people and their carers and is measured by the number of people living in households aged 65 or over who participated in social or community activities away from home in the past 3 months divided by the number of people aged 65 years or over living in households.

A high proportion of people aged 65 years or over who participate in the community is desirable.

Data reported for this indicator are comparable.

Data quality information for this indicator is under development.
Nationally, in 2009, among people aged 65 years or over living in households:

- 52.6±1.3 per cent participated once or twice in social or community activities in the past 3 months
- 32.8±1.3 per cent participated 3 or 4 times in social or community activities in the past 3 months
- 16.5±0.6 per cent participated 5 times or more in social or community activities in the past 3 months
- 8.0±1.3 per cent did not participate in social or community activities in the past 3 months (figure F.3).

Figure F.3  Proportion of all people living in households aged 65 years or over, who participated in social or community activities away from home in the past 3 months, 2009a

![Graph showing participation in social or community activities](image)

a Error bars represent the 95 per cent confidence interval associated with each point estimate.

Source: DoHA analysis of ABS Survey of Disability, Ageing and Carers 2009 Confidentialised Unit Record File (unpublished); table FA.1.

Quality of life

‘Quality of life’ is an indicator of governments’ objective for people with disability and their carers to have an enhanced quality of life and participate as valued members of the community (box F.6).
Quality of life

‘Quality of life’ is defined as overall life satisfaction of people with disability and their carers, and is measured by the number of people with disability who were mostly satisfied or better with their lives divided by the total number of people with a mild, moderate, severe or profound disability who provided a response.

A high proportion of people with disability who were mostly satisfied with their lives is desirable.

Overall life satisfaction is a summary indicator of subjective wellbeing. A number of circumstances may influence overall life satisfaction, such as health, education, employment, income, personality, family and social connections, civil and human rights, levels of trust and altruism, and opportunities for democratic participation (Diener 1984; Stutzer and Frey 2010).

Data reported for this indicator are comparable.

Data quality information for this indicator is under development.

Nationally, in 2010, about 78.0 per cent of people with a disability described their satisfaction with their lives as mostly satisfied or better, compared with 16.8±1.1 per cent who described their satisfaction as mixed, 2.1±0.4 per cent mostly dissatisfied, 2.1±0.4 per cent unhappy and 0.9±0.3 per cent terrible (figure F.4).

Figure F.4 Proportion of people with disability who were satisfied with their lives, 2010 a,b

<table>
<thead>
<tr>
<th>Per cent</th>
<th>Delighted</th>
<th>Pleased</th>
<th>Mostly satisfied</th>
<th>Mixed</th>
<th>Mostly dissatisfied</th>
<th>Unhappy</th>
<th>Terrible</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

a Excludes those who did not provide a response or did not know how they felt. b Error bars represent the 95 per cent confidence interval associated with each point estimate.

Participation of people with disability and their carers in the community

‘Participation of people with disability and their carers in the community’ is an indicator of governments’ objective for people with disability and their carers to participate as valued members of the community and have an enhanced quality of life (box F.7).

Box F.7  Participation of people with disability and their carers in the community

‘Participation of people with disability and their carers in the community’ is defined as social and community participation of people with disability and their carers’ and is measured by:

- the proportion people with disability and their carers who participated in social or community activities (away from home or at home) in the past 3 months
- the proportion of primary carers who participated in social or community activities (away from home or at home) in the past 3 months.

A high proportion of people with disability and their carers who participated in social or community activities is desirable.

Data reported for this indicator are comparable.

Data quality information for this indicator is under development.

Nationally in 2006, 65.1±8.9 per cent of people with a profound/severe disability attended selected cultural venues and events in the past 12 months. This was significantly less than all people with disability (85.4±2.3 per cent) and for people with disability (91.2±1.9 per cent) (see table 14A.133).

Other data on participation of people with disability in selected social and community activities are reported in chapter 14 attachment tables 14A.119–148.

Nationally in 2009, 71.6±5.6 per cent of primary carers participated in social or community activities away from home and without the recipient of care in the past 3 months, while 28.1±3.2 per cent of primary carers did not participate in social or community activities away from home without the recipient of care in the past 3 months (figure F.5).
Figure F.5  Proportion of primary carers who participated in social or community activities away from home and without the recipient of care in the past 3 months 2009\textsuperscript{a, b}

\begin{center}
\includegraphics[width=\textwidth]{figure_F_5.png}
\end{center}

\textsuperscript{a} Excludes carers who were disabled or aged 60 years and over. \textsuperscript{b} Error bars represent the 95 per cent confidence interval associated with each point estimate.


\textbf{Jobless families with children as a proportion of all families}

‘Jobless families with children as a proportion of all families’ is an indicator of governments’ objective to ensure positive family environments for Australia’s children and young people (box F.8). This indicator is consistent with the Australian Government’s Social Inclusion Agenda, and the activities of the Australian Social Inclusion Board, which identifies a reduction in family joblessness as a key priority for addressing the barriers and entrenched disadvantage faced by some households (Australian Government 2011).

The Australian Social Inclusion Board notes that a reduction in the number of jobless families is important, as there are many costs to the country of family joblessness, including:

- the direct costs of lost national output and supporting families who are not participating in the workforce
- the indirect costs of reduced labour market attachment of children from jobless families, poorer health outcomes, and reduced income and overall wellbeing arising from joblessness (Commonwealth of Australia 2011).
Box F.8  **Jobless families with children as a proportion of all families**

‘Jobless families with children as a proportion of all families’ is defined as the number of families with children without jobs as a proportion of all families. Family is defined as two or more people, one of whom is at least 15 years of age, who are related by blood, marriage (registered or de facto), adoption, step or fostering, and who are usually resident in the same household. 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 will, therefore, contain more than one family (ABS 2007).

The jobless rate is reported for:
- all families as a proportion of all families
- families with dependants (including children aged under 15 years) as a proportion of all families with dependants (including children aged under 15 years)
- families with children aged under 15 years as a proportion of all families with children aged under 15 years

A low or decreasing number of jobless families as a proportion of all families is desirable.

Data reported for this indicator are comparable.

Data quality information for this indicator is under development.

Nationally, at 30 June 2011:
- 19.0 per cent of all families were jobless
- 10.5 per cent of families with dependants (including children under 15) were jobless
- 11.6 per cent of families with children aged under 15 years were jobless (figure F.6).
Figure F.6  **Jobless families as a proportion of all families, at June**

Source: ABS, Labour Force, Australia: Labour Force Status and Other Characteristics of Families, June 2011, Cat. no. 6224.0.55.001; table FA.4

**Improving child development**

‘Improving child development’ is an indicator of governments’ objective to ensure that Australia’s children and young people are safe and well (box F.9).
Box F.9  **Improving child development**

‘Improving child development’ is defined as the proportion of children who are developmentally vulnerable on one or more Australian Early Development Index (AEDI) domains.

A low or decreasing proportion of children who are developmentally vulnerable on one or more AEDI domains is desirable.

The AEDI is a population measure of young children’s development as they enter school. A population measure places the focus on all children in the community and therefore the AEDI reports on early childhood development across the whole community. Every three years, teachers complete a checklist for children in their first year of full-time school. The checklist measures five key areas, or domains, of early childhood development:

- physical health and wellbeing
- social competence
- emotional maturity
- language and cognitive skills (school-based)
- communication skills and general knowledge.

These areas are closely linked to the predictors of good adult health, education and social outcomes.

The next data collection for the AEDI will take place from May to July 2012, with results expected to be available in 2013.

Data reported for this indicator are comparable.

Data quality information for this indicator is under development.

Nationally, in 2009, 23.6 per cent of children were developmentally vulnerable on one or more AEDI domain/s, while 11.8 per cent of children were developmentally vulnerable on two or more AEDI domains (F.7).
Service-specific performance indicator frameworks

This section summarises information from the Aged care services’ service-specific indicator framework in chapter 13, the Services for people with disability service-specific indicator framework in chapter 14 and the Child protection and youth justice services’ service-specific indicator framework in chapter 15.

Additional information is available to assist the interpretation of these results:

- indicator interpretation boxes, which define the measures used and indicate any significant conceptual or methodological issues with the reported information (chapters 13, 14 and 15)
- caveats and footnotes to the reported data (chapters 13, 14 and 15 and attachments 13A, 14A and 15A)
- additional measures and further disaggregation of reported measures, for example, by Indigenous status, remoteness, language background, sex and age (chapters 13, 14 and 15 and attachments 13A, 14A and 15A)
- data quality information for many indicators (chapters 13, 14 and 15 Data Quality Information)
Aged care services

The performance indicator framework for aged care services is presented in figure F.8. This framework provides comprehensive information on the equity, effectiveness, efficiency and the outcomes of aged care services.

**Figure F.8  Aged care services performance indicator framework**

Key to indicators

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

**Objectives**

- Equity
- Access
- Use by different groups
- Operational aged care places
- Elapsed times for aged care services
- Assessed longer term care arrangements
- Unmet need
- Hospital patient days used by aged care type patients
- Intensity of care

**Performance**

- Appropriateness
- Assessment/streaming
- Care
- Social participation in the community
- Maintenance of individual physical function

**Effectiveness**

- Access
- Timeliness
- Hospital leave days for preventable causes
- Compliance with service standards for residential care
- Complaints resolution
- Compliance with service standards for community care
- Client appraisal of service standards
- Enabling people with care needs to live in the community

**Quality**

- Safety
- Hospital leave days for preventable causes
- Client perceptions
- Improving independence of target population
- Compliance with service standards for community care
- Client appraisal of service standards

**Efficiency**

- Equity
- Access
- Use by different groups
- Operational aged care places
- Elapsed times for aged care services
- Assessed longer term care arrangements
- Unmet need
- Hospital patient days used by aged care type patients
- Intensity of care

**Outputs**

- Appropriateness
- Assessment/streaming
- Care
- Social participation in the community
- Maintenance of individual physical function

**Outcomes**

- Efficiency
- Inputs per output unit
- Cost per output unit
- Expenditure per head of target population
- Hospital leave days for preventable causes
- Enabling people with care needs to live in the community

**Text** Data for these indicators are comparable, subject to caveats to each chart or table.
An overview of aged care performance indicator results are presented in table F.3. Information to assist the interpretation of these data can be found in the indicator interpretation boxes in chapter 13 and the footnotes in attachment 13A.

**Table F.3  Performance indicators for aged care services**

<table>
<thead>
<tr>
<th>Equity — access indicators</th>
<th>NSW</th>
<th>Vic</th>
<th>Qld</th>
<th>WA</th>
<th>SA</th>
<th>Tas</th>
<th>ACT</th>
<th>NT</th>
<th>Aust</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Access to residential aged care services by all people — aged care recipients per 1000 in the target population, 2011-12</td>
<td>no.</td>
<td>54.3</td>
<td>54.2</td>
<td>48.5</td>
<td>47.5</td>
<td>60.1</td>
<td>50.2</td>
<td>44.9</td>
<td>30.8</td>
<td>52.6</td>
</tr>
<tr>
<td>Access to residential aged care services by Indigenous Australians — Indigenous aged care recipients per 1000 Indigenous people aged 50 years or over, 2011-12</td>
<td>no.</td>
<td>12.7</td>
<td>25.2</td>
<td>19.5</td>
<td>26.6</td>
<td>43.2</td>
<td>7.6</td>
<td>10.6</td>
<td>34.3</td>
<td>21.2</td>
</tr>
<tr>
<td>Veterans in residential care per 1000 eligible veterans 70 years or over, 2011-12</td>
<td>no.</td>
<td>162.2</td>
<td>169.1</td>
<td>135.1</td>
<td>133.7</td>
<td>166.3</td>
<td>132.8</td>
<td>99.1</td>
<td>62.2</td>
<td>153.2</td>
</tr>
<tr>
<td>Access to the HACC program — service hours per 1000 people aged 65 years or over and Indigenous people aged 50–64 years, 2011-12 (no.)</td>
<td>Major cities</td>
<td>8 738</td>
<td>10 673</td>
<td>11 079</td>
<td>10 666</td>
<td>10 958</td>
<td>..</td>
<td>8 835</td>
<td>..</td>
<td>10 069</td>
</tr>
<tr>
<td>Inner regional</td>
<td>7 323</td>
<td>12 046</td>
<td>9 813</td>
<td>9 309</td>
<td>9 463</td>
<td>10 838</td>
<td>..</td>
<td>..</td>
<td>9 497</td>
<td>13A.52</td>
</tr>
<tr>
<td>Outer regional</td>
<td>9 098</td>
<td>15 113</td>
<td>10 569</td>
<td>12 699</td>
<td>11 565</td>
<td>8 506</td>
<td>..</td>
<td>5 453</td>
<td>10 797</td>
<td>13A.54</td>
</tr>
<tr>
<td>Remote</td>
<td>12 240</td>
<td>25 968</td>
<td>15 123</td>
<td>10 469</td>
<td>12 792</td>
<td>7 204</td>
<td>..</td>
<td>8 122</td>
<td>12 434</td>
<td>13A.56</td>
</tr>
<tr>
<td>Very remote</td>
<td>13 315</td>
<td>..</td>
<td>15 714</td>
<td>16 376</td>
<td>29 877</td>
<td>13 244</td>
<td>..</td>
<td>14 476</td>
<td>16 752</td>
<td>13A.58</td>
</tr>
<tr>
<td>All areas</td>
<td>8 440</td>
<td>11 286</td>
<td>10 805</td>
<td>10 729</td>
<td>11 025</td>
<td>9 977</td>
<td>8 835</td>
<td>8 417</td>
<td>10 083</td>
<td>13A.48</td>
</tr>
</tbody>
</table>

**Effectiveness — access indicators**

Total operational aged care places per 1000 people aged 70 years or over (excluding transition care), 2011-12

| Elapsed times for aged care services — proportion of people entering high care residential services entered within 3 months of approval, 2011-12 | % | 74.8 | 77.9 | 67.9 | 69.4 | 70.8 | 76.2 | 68.7 | 49.5 | 73.2 | 13A.83 |

**Effectiveness — appropriateness indicators**

Assessed longer term care arrangements — proportion of clients recommended to remain in the community, 2010-11

| % | 47.5 | 58.0 | 39.0 | 51.8 | 40.6 | 58.6 | 65.9 | 69.0 | 49.4 | 13A.87 |
### Table F.3  
(continued)

<table>
<thead>
<tr>
<th></th>
<th>NSW</th>
<th>Vic</th>
<th>Qld</th>
<th>WA</th>
<th>SA</th>
<th>Tas</th>
<th>ACT</th>
<th>NT</th>
<th>Aust</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Hospital patient days used by aged care type patients</strong> —— proportion of separations for ‘aged care type’ public hospitals patients that were 35 days or longer, 2010-11</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Intensity of care</strong> — proportion of people who stayed in the same residential aged care service when changing from low care to high care, 2011-12</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Effectiveness — quality indicators</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Compliance with service standards for residential care — proportion of re-accredited residential aged care services that were granted a re-accreditation approval for a period of three years, 2011-12</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Efficiency indicators</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cost per ACAT assessment — Australian Government expenditure on aged care assessments, per assessment, 2010-11</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Outcome indicators</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maintenance of individual functioning — improvement in Transition Care Program (TCP) client’s level of functioning, reflected in the movement from the average Modified Barthel Index (MBI) score on entry to the average MBI score on exit, 2011-12</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
**Services for people with disability**

The performance indicator framework for services for people with disability is presented in figure F.9. This framework provides comprehensive information on the equity, effectiveness, efficiency and the outcomes of disability services.

**Figure F.9 Services for people with disability performance indicator framework**

---

### Key to indicators

- **Text**: Data for these indicators are comparable, subject to caveats to each chart or table.
- **Text**: Data for these indicators are not complete and/or not directly comparable.
- **Text**: These indicators are yet to be developed or data are not collected for this Report.

---

F.28 REPORT ON GOVERNMENT SERVICES 2013
An overview of services for people with disability performance indicator results for 2010-11 are presented in table F.4. Information to assist the interpretation of these data can be found in the indicator interpretation boxes in chapter 14 and the footnotes in attachment 14A.

Table F.4  Performance indicators for services for people with disability, 2010-11a, b, c, d

<table>
<thead>
<tr>
<th>Equity — access indicators</th>
<th>NSW</th>
<th>Vic</th>
<th>Qld</th>
<th>WA</th>
<th>SA</th>
<th>Tas</th>
<th>ACT</th>
<th>NT</th>
<th>Aust</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Access to NDA specialist disability services</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Proportion of potential population (aged 0-64 years) who used disability support services</td>
<td>%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>31.0</td>
<td>45.9</td>
<td>23.0</td>
<td>30.4</td>
<td>51.7</td>
<td>53.2</td>
<td>51.9</td>
<td>22.2</td>
<td>34.9</td>
<td>14A.16</td>
</tr>
<tr>
<td>Service use by severity of disability</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Proportion of users of NDA services (aged 0-64 years), by severity of disability who need help with Assisted Daily Living</td>
<td>%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>72.5</td>
<td>46.5</td>
<td>81.3</td>
<td>84.6</td>
<td>81.0</td>
<td>85.1</td>
<td>80.8</td>
<td>45.0</td>
<td>67.9</td>
<td>14A.28</td>
</tr>
<tr>
<td>Service use by special needs groups</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Proportion of Indigenous potential population who use disability support services</td>
<td>%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>36.2</td>
<td>63.6</td>
<td>26.0</td>
<td>53.0</td>
<td>65.5</td>
<td>19.9</td>
<td>64.7</td>
<td>55.3</td>
<td>40.5</td>
<td>14A.45</td>
</tr>
<tr>
<td>Access to community accommodation and care services</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Users of NDA community accommodation and care services as a proportion of all accommodation support service users</td>
<td>%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>85.3</td>
<td>96.2</td>
<td>88.8</td>
<td>91.2</td>
<td>88.9</td>
<td>83.7</td>
<td>100.0</td>
<td>100.0</td>
<td>89.9</td>
<td>14A.62</td>
</tr>
<tr>
<td>Assistance for younger people with disability in residential aged care</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rate of younger people admitted to permanent residential aged care per 10 000 potential population (2011-12)</td>
<td>%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>40.1</td>
<td>38.6</td>
<td>32.9</td>
<td>26.0</td>
<td>46.9</td>
<td>56.1</td>
<td>24.6</td>
<td>8.1</td>
<td>36.9</td>
<td>14A.68</td>
</tr>
<tr>
<td>Efficiency indicators</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Government contribution per user of non-government provided services</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Government funding per user of non-government provided accommodation support services in institutional/residential setting</td>
<td>$</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>59 106</td>
<td>36 185</td>
<td>51 967</td>
<td>83 852</td>
<td>58 101</td>
<td>38 445</td>
<td>.. .</td>
<td>54 556</td>
<td>14A.81</td>
<td></td>
</tr>
</tbody>
</table>
Table F.4  (continued)

<table>
<thead>
<tr>
<th></th>
<th>NSW</th>
<th>Vic</th>
<th>Qld</th>
<th>WA</th>
<th>SA</th>
<th>Tas</th>
<th>ACT</th>
<th>NT</th>
<th>Aust</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cost per user of State and territory administered services</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Total estimated expenditure per service user, State and Territory government administered programs*

Data for this indicator not complete or not directly comparable (chapter 14)

$ 35 663  23 229  37 717  32 958  17 764  23 414  19 179  24 053  33 128  14A.84

Administrative expenditure as a proportion of total recurrent expenditure

*Administration expenditure as a proportion of total expenditure (excluding actual and imputed payroll tax) (2011-12)*

Data for this indicator not complete or not directly comparable (chapter 14)

% 8.8  8.4  7.6  4.2  4.4  5.5  8.3  4.7  7.3  14A.85

Outcome indicators

Labour force participation and employment of people with disability

*Employment rate for people with a profound/severe core activity limitation (2009)*

Data for this indicator are comparable, subject to caveats (chapter 14)

% 90.4  89.0  87.9  88.1  89.3  89.7  96.6  96.3  89.4  14A.86

Labour force participation of primary carers of people with disability

*Labour force participation rate for primary carers aged 15-64 years (2009)*

Data for this indicator are comparable, subject to caveats (chapter 14)

% 56.0  51.7  52.4  53.5  52.8  52.9  63.7  60.1  53.7  14A.104

Social participation of people with disability

*People with a profound/severe disability aged 5-64 years who have had face to face contact with ex-household family or friends in the previous week (2009)*

Data for this indicator are comparable, subject to caveats (chapter 14)

% 69.5  76.0  71.5  76.9  71.1  70.1  77.8  78.6  72.5  14A.119

Use of other services by people with disability

*People with a profound/severe disability (children aged 3-5 years) who attended pre-school*

% 51.1  45.5  30.4  36.8  41.6  25.3  48.4  44.1  42.6  14A.144

---

*a* Caveats for these data are available in Chapter 14 and Attachment 14A. Refer to the indicator interpretation boxes in Chapter 14 for information to assist with the interpretation of data presented in this table.  
*b* Some data are derived from detailed data in Chapter 14 and Attachment 14A.  
*c* Data are for 2011 except where noted.  
*d* Data are as at 30 June 2011 except where noted.  
*na* Not available.  
.. Not applicable.  

*Source: Chapter 14 and Attachment 14A.*
Child protection and youth justice services

The performance indicator framework for child protection and out-of-home care services is presented in figure F.10. This framework provides comprehensive information on the equity, effectiveness, efficiency and the outcomes of child protection and youth justice services.

Figure F.10  Child protection and out-of-home care services performance indicator framework

---

Key to indicators

- **Text** Data for these indicators are comparable, subject to caveats to each chart or table
- **Text** Data for these indicators are not complete and/or not directly comparable
- **Text** These indicators are yet to be developed or data are not collected for this Report
An overview of child protection and out-of-home care services performance indicator results for 2011-12 are presented in table F.5. Information to assist the interpretation of these data can be found in the indicator interpretation boxes in chapter 15 and the footnotes in attachment 15A.

**Table F.5  Performance indicators for child protection and out of home care services, 2011-12**

<table>
<thead>
<tr>
<th></th>
<th>NSW</th>
<th>Vic</th>
<th>Qld</th>
<th>WA</th>
<th>SA</th>
<th>Tas</th>
<th>ACT</th>
<th>NT</th>
<th>Aust</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Effectiveness — child protection indicators</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Response times</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Proportion of investigations completed within 28 days of notification</td>
<td>%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>46.5</td>
<td>30.3</td>
<td>20.0</td>
<td>29.7</td>
<td>41.5</td>
<td>44.9</td>
<td>58.1</td>
<td>57.2</td>
<td>..</td>
<td>15A.15</td>
</tr>
<tr>
<td></td>
<td>30.8</td>
<td>27.1</td>
<td>36.7</td>
<td>33.6</td>
<td>19.4</td>
<td>10.9</td>
<td>3.1</td>
<td>14.1</td>
<td>..</td>
<td>15A.15</td>
</tr>
<tr>
<td>Substantiation rate</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Proportion of finalised child protection investigations that were substantiated</td>
<td>%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>46.8</td>
<td>60.2</td>
<td>34.9</td>
<td>31.4</td>
<td>50.4</td>
<td>41.7</td>
<td>48.6</td>
<td>..</td>
<td>Fig.15.6</td>
<td></td>
</tr>
<tr>
<td><strong>Effectiveness — out-of-home care indicators</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Safety in out-of-home care</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Children in care who were the subject of a substantiation as a proportion of all children in care</td>
<td>%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>0.3</td>
<td>1.0</td>
<td>3.7</td>
<td>0.3</td>
<td>0.3</td>
<td>2.1</td>
<td>1.0</td>
<td>na</td>
<td>..</td>
<td>15A.26</td>
</tr>
<tr>
<td>Stability of placement</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Proportion of children on a care and protection order exiting care after less than 12 months in 1 or 2 placements</td>
<td>%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>90.0</td>
<td>88.4</td>
<td>81.8</td>
<td>na</td>
<td>77.4</td>
<td>94.4</td>
<td>81.1</td>
<td>83.0</td>
<td>86.7</td>
<td>15A.25</td>
</tr>
<tr>
<td></td>
<td>52.7</td>
<td>53.9</td>
<td>38.2</td>
<td>na</td>
<td>44.4</td>
<td>51.3</td>
<td>47.9</td>
<td>40.5</td>
<td>48.0</td>
<td>15A.25</td>
</tr>
<tr>
<td>Children aged under 12 years in home-based care</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Proportion of children aged under 12 years in out-of-home care who were in a home-based placement at 30 June</td>
<td>%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>99.5</td>
<td>98.0</td>
<td>97.4</td>
<td>93.1</td>
<td>91.0</td>
<td>97.8</td>
<td>99.2</td>
<td>90.2</td>
<td>97.5</td>
<td>15A.24</td>
</tr>
<tr>
<td>Placement with extended family</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(continued on next page)
### Table F.5  (continued)

<table>
<thead>
<tr>
<th>NSW</th>
<th>Vic</th>
<th>Qld</th>
<th>WA</th>
<th>SA</th>
<th>Tas</th>
<th>ACT</th>
<th>NT</th>
<th>Aust</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Proportion of children in out-of-home care placed with relatives/kin at 30 June**

<table>
<thead>
<tr>
<th>%</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>55.8</td>
<td>45.6</td>
<td>34.6</td>
<td>43.1</td>
<td>43.3</td>
<td>30.3</td>
<td>51.6</td>
<td>23.3</td>
<td>46.7</td>
<td>15A.22</td>
</tr>
</tbody>
</table>

Placement in accordance with Aboriginal Child Placement Principle

Data for this indicator are comparable, subject to caveats (chapter 15)

**Proportion of Indigenous children placed in accordance with the Aboriginal Child Placement Principle**

<table>
<thead>
<tr>
<th>%</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>81.6</td>
<td>56.3</td>
<td>53.7</td>
<td>69.3</td>
<td>74.4</td>
<td>45.7</td>
<td>65.4</td>
<td>38.1</td>
<td>68.8</td>
<td>15A.23</td>
</tr>
</tbody>
</table>

### Efficiency – child protection services

Total expenditure on all child protection activities, per notification, investigation and substantiation

Data for this indicator are not complete or not directly comparable (chapter 15)

**Expenditure per notification**

<table>
<thead>
<tr>
<th>$</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>3118</td>
<td>2886</td>
<td>12337</td>
<td>8191</td>
<td>2651</td>
<td>1927</td>
<td>954</td>
<td>5175</td>
<td>..</td>
<td>15A.2</td>
</tr>
</tbody>
</table>

**Expenditure per investigation**

<table>
<thead>
<tr>
<th>$</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>5913</td>
<td>11462</td>
<td>12337</td>
<td>10971</td>
<td>9940</td>
<td>13196</td>
<td>5376</td>
<td>10295</td>
<td>..</td>
<td>15A.2</td>
</tr>
</tbody>
</table>

**Expenditure per substantiation**

<table>
<thead>
<tr>
<th>$</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>13358</td>
<td>20300</td>
<td>39870</td>
<td>40806</td>
<td>23617</td>
<td>22247</td>
<td>13755</td>
<td>24189</td>
<td>..</td>
<td>15A.2</td>
</tr>
</tbody>
</table>

### Efficiency – out-of-home care services

Total expenditure on all out-of-home care divided by the number of children in all out-of-home care at 30 June

Data for this indicator are not complete or not directly comparable (chapter 15)

<table>
<thead>
<tr>
<th>$</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>43393</td>
<td>56652</td>
<td>49515</td>
<td>60493</td>
<td>55569</td>
<td>39333</td>
<td>47438</td>
<td>80256</td>
<td>..</td>
<td>15A.3</td>
</tr>
</tbody>
</table>

Out-of-home care expenditure per placement night

Data for this indicator are not complete or not directly comparable (chapter 15)

<table>
<thead>
<tr>
<th>$</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>120.2</td>
<td>149.7</td>
<td>140.7</td>
<td>167.5</td>
<td>155.8</td>
<td>108.0</td>
<td>131.9</td>
<td>226.2</td>
<td>136.9</td>
<td>15A.3</td>
</tr>
</tbody>
</table>

### Outcomes

**Improved safety**

Data for this indicator are not complete or not directly comparable (chapter 15)

**Substantiation rate after decision not to substantiate, 3 months**

<table>
<thead>
<tr>
<th>%</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>4.1</td>
<td>2.0</td>
<td>3.2</td>
<td>1.2</td>
<td>5.8</td>
<td>7.4</td>
<td>7.1</td>
<td>4.3</td>
<td>..</td>
<td>15A.9</td>
</tr>
</tbody>
</table>

**Substantiation rate after decision not to substantiate, 12 months**

<table>
<thead>
<tr>
<th>%</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>12.7</td>
<td>12.8</td>
<td>9.6</td>
<td>7.0</td>
<td>13.1</td>
<td>17.4</td>
<td>16.7</td>
<td>15.5</td>
<td>..</td>
<td>15A.9</td>
</tr>
</tbody>
</table>

**Substantiation rate after a prior substantiation, 3 months**

<table>
<thead>
<tr>
<th>%</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>8.2</td>
<td>1.2</td>
<td>8.8</td>
<td>1.5</td>
<td>12.0</td>
<td>7.7</td>
<td>11.8</td>
<td>7.6</td>
<td>..</td>
<td>15A.10</td>
</tr>
</tbody>
</table>

**Substantiation rate after a prior substantiation, 12 months**

<table>
<thead>
<tr>
<th>%</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>19.7</td>
<td>10.1</td>
<td>19.0</td>
<td>8.1</td>
<td>22.9</td>
<td>18.6</td>
<td>31.9</td>
<td>20.5</td>
<td>..</td>
<td>15A.10</td>
</tr>
</tbody>
</table>

---

a Caveats for these data are available in Chapter 15 and Attachment 15A. Refer to the indicator interpretation boxes in Chapter 15 for information to assist with the interpretation of data presented in this table. b Some data are derived from detailed data in Chapter 15 and Attachment 15A. .. Not applicable. na Not available. – Nil or rounded to zero.

Source: Chapter 15 and Attachment 15A.
The performance indicator framework for youth justice services is presented in figure F.11. This framework provides comprehensive information on the equity, effectiveness, efficiency and the outcomes of youth justice services.

Figure F.9  Youth justice services performance indicator framework

An overview of youth justice services performance indicator results for 2011-12 are presented in table F.6. Information to assist the interpretation of these data can be found in the indicator interpretation boxes in chapter 15 and the footnotes in attachment 15A.
Table F.6  Performance indicators for youth justice services, 2011-12\textsuperscript{a, b}

<table>
<thead>
<tr>
<th></th>
<th>NSW</th>
<th>Vic</th>
<th>Qld</th>
<th>WA</th>
<th>SA</th>
<th>Tas</th>
<th>ACT</th>
<th>NT</th>
<th>Aust</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Effectiveness — diversion</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Group conferencing outcomes</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Proportion of group conferences resulting in an agreement</td>
<td>%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Effectiveness — rehabilitation</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Education and training attendance</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Proportion of young people in detention of compulsory school age attending an education course</td>
<td>%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Effectiveness — safe and secure environment</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Deaths in custody</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Escapes</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rate of escapes from detention per 10 000 custody nights</td>
<td>%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rate of escapes from escorted movement per 10 000 escorted movements</td>
<td>%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Absconds from unescorted leave</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Assaults in custody</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rate of young people and staff injured as a result of a serious assault per 10 000 custody nights</td>
<td>%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rate of young people and staff injured as a result of an assault per 10 000 custody nights</td>
<td>%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(continued on next page)
Table F.6  (continued)

<table>
<thead>
<tr>
<th>Source</th>
<th>NSW</th>
<th>Vic</th>
<th>Qld</th>
<th>WA</th>
<th>SA</th>
<th>Tas</th>
<th>ACT</th>
<th>NT</th>
<th>Aust</th>
<th>Rate of incidents of self-harm in custody requiring hospitalisation per 10 000 custody nights</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>%</td>
<td>%</td>
<td>%</td>
<td>%</td>
<td>%</td>
<td>%</td>
<td>%</td>
<td>%</td>
<td>%</td>
<td>0.2</td>
</tr>
<tr>
<td></td>
<td>%</td>
<td>%</td>
<td>%</td>
<td>%</td>
<td>%</td>
<td>%</td>
<td>%</td>
<td>%</td>
<td>%</td>
<td>2.6</td>
</tr>
</tbody>
</table>

**Effectiveness – statutory responsibilities**

**Pre-sentence reports completed**

Data for this indicator are not complete or not directly comparable (chapter 15)

Proportion of pre-sentence reports completed by youth justice agencies

| % | 100.0 | 100.0 | 100.0 | 99.6 | na | 100.0 | 100.0 | 100.0 | 99.9 | 15A.190 |

**Completion of orders**

Data for this indicator are not complete or not directly comparable (chapter 15)

Proportion of community-based orders successfully completed

| % | 87.6 | 86.0 | 81.7 | 67.3 | 85.8 | 92.2 | na | 57.6 | 83.0 | 15A.199 |

**Case plans prepared**

Data for this indicator are not complete or not directly comparable (chapter 15)

Proportion of case plans prepared or reviewed within 6 weeks of commencing a sentenced detention order

| % | 100.0 | 90.3 | 77.4 | 100.0 | na | na | 72.2 | 100.0 | 91.6 | 15A.200 |

Proportion of case plans prepared or reviewed within 6 weeks of commencing a sentenced community-based order

| % | 98.5 | 95.0 | 75.0 | 73.1 | na | na | 95.1 | 9.1 | 84.0 | 15A.200 |

**Efficiency indicators**

**Centre utilisation**

Data for this indicator are comparable, subject to caveats (chapter 15)

| % | 73.3 | 81.6 | 76.7 | 82.9 | 74.2 | 58.8 | 57.1 | 59.1 | 75.2 | 15A.201 |

---

*a* Caveats for these data are available in Chapter 15 and Attachment 15A. Refer to the indicator interpretation boxes in Chapter 15 for information to assist with the interpretation of data presented in this table. *b* Some data are derived from detailed data in Chapter 15 and Attachment 15A. .. Not applicable. na Not available. np Not published. – Nil or rounded to zero.

**Source:** Chapter 15 and Attachment 15A.
F.3 Cross-cutting and interface 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 different services to individuals at different stages of life. Other services are not as strictly, or not at all, age-specific, and some individuals may receive multiple services at the same time — for example, a child who is in receipt of youth justice services together with homelessness, child protection or disability services. Disability services can continue throughout an individual’s lifetime and overlap with the provision of aged care services.

The sequence of interventions or services can be referred to as ‘pathways’ of community service provision. However, there is a paucity of 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 help to inform government social policy.

Examples of relevant research include:

- a cohort study carried out in Queensland, which found a correlation between contact with child protection services and the youth 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 being undertaken by the AIHW involving the linkage of available Supported Accommodation Assistance Program data, youth justice data and child protection data. This project involves analysing the characteristics and pathways of children and young people who are involved in these sectors
• a FaHCSIA 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 health, culture, education, housing and family relationships (FaHCSIA 2008)

• the Australian Community Sector Survey (ACSS) is an annual national survey which collects data about the non-government, non-profit community services and welfare sector (Australian Council of Social Service 2011).

In September 2009, the Australian Government launched the Australian Institute for Population Ageing Research (AIPAR), based at the University of New South Wales. The AIPAR brings together cross-disciplinary research on the issue of population ageing to inform economic and social policy. The AIPAR also maintains a ‘Longevity Index’ to track the extent to which Australians are able to maintain their living standards over their lifetime (UNSW 2009).

On 30 April 2009, COAG endorsed *Protecting Children is Everyone’s Business: National Framework for Protecting Australia’s Children 2009–2020* (the National Framework). The National Framework emphasises that protecting children should be seen as a community and cross-sector responsibility. The National Framework is intended to deliver a more integrated response to protecting Australia’s children and emphasises the role of government, the non-government sector, and the community in achieving these aims. The Second Action Plan 2012–15 was released in 2012. It prioritises early intervention, prevention and collaboration with mental health, domestic and family violence, drug and alcohol, education, health and other services. As reporting for the National Framework progresses, the Steering Committee will further consider the suitability of some of the high-level, cross-sector performance indicators in the National Framework for inclusion in the Community services sector overview in future Reports.

There are also links between community services and other government services. Access to effective community services can influence outcomes for clients of education, health, housing and justice sector services. In turn, access to these other service areas can affect community services outcomes.

A recent report, *Children and young people at risk of social exclusion* (AIHW 2012), presents findings from analysis of linked client data across three service areas: homelessness, youth justice, and child protection. This analysis revealed that people with involvement in one of these three services are more likely to be involved in another of these services than the general population. For example:
• approximately 15 per cent of young people under youth justice supervision received specialist homelessness support the year before their most recent period of supervision, and 8 per cent received specialist homelessness support in the year after their most recent period of youth justice supervision. Approximately 6 per cent of children who were the subject of a child protection notification received specialist homelessness support in the year prior to the notification, and 7 per cent received specialist homelessness support in the year after their most recent substantiated notification. These figures are in stark contrast to the general population, where approximately 1 per cent of people aged 10 and older receive specialist homelessness support in a year, and approximately 2 per cent receive specialist homelessness support as an accompanying child in a year.

• approximately 10 per cent of adult specialist homelessness clients had a history of youth justice supervision, compared to approximately 1 per cent of the general population aged 16 or 17 years (the peak age for youth justice supervision).

The results of this analysis highlight the extent of multiple-sector involvement across these service areas. Further analysis of pathways through these services, and common factors giving rise to contact with these services, is likely to assist governments in targeting prevention and rehabilitation activities.

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 closely linked to health services by the needs of clients, as people with disability tend to have a larger number of poor health conditions than the general population (AIHW 2006). Other links, such as the role of medical and other health professional 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**

Historically within the Report, HACC services have been included in the Aged care services chapter, but the scope of the program is wider than aged care. Provision of HACC services is primarily to older people, but younger people with disability and carers are also recipients of HACC assistance.

In previous editions, HACC data were reported in the Aged care services chapter only. For this Report onwards, information on HACC clients outside the Aged care services chapter’s target population (65 years and older and Indigenous Australians 50–64 years) will be reported in the Disability services chapter. Expenditure data
for this group were not available for this Report, but are expected to be reported in future editions.

The Australian, State and Territory governments committed to the National Health Reform Agreement (NHRA) on 2 August 2011. The NHRA reaffirmed previous commitments on health and aged care (and their implications for services for people with disability) under the National Health and Hospitals Network Agreement and the Heads of Agreement — National Health Reform.

Changes to roles and responsibilities under the National Health Reform Agreement are aimed at creating a national aged care system and a national disability services system. Under the National Health Reform Agreement:

- the Australian Government is responsible for:
  - regulating packaged community (CACP, EACH and EACH-D) and residential aged care
  - funding packaged community and residential aged care for people aged 65 years or over (50 years or over for Indigenous Australians)
  - funding and regulating basic community care services (previously delivered under the HACC program) for people aged 65 years or over (50 years or over for Indigenous Australians)
  - funding specialist disability services delivered by the State and Territory governments under the NDA for people aged 65 years or over (50 years or over for Indigenous Australians).

- the State and Territory governments are responsible for:
  - regulating specialist disability services delivered under the NDA
  - funding and regulating basic community care services (previously delivered under the HACC program) for people aged under 65 years, except for Indigenous Australians aged 50 years or over
  - funding packaged community (CACP, EACH and EACH-D) and residential aged care for people aged under 65 years, except for Indigenous Australians aged 50 years or over.

The basic community care reforms (HACC reforms) occurred over two phases (except in Victoria and WA). On 1 July 2011, the Australia Government assumed funding and policy responsibility for basic community care services for people aged 65 years or over (50 years or over for Indigenous Australians), and on 1 July 2012 they also assumed operational responsibility for these services. On 1 July 2011, State and Territory governments (except in Victoria and WA) assumed full funding
and program responsibility for basic community care services provided to younger people aged under 65 years (or under the age of 50 for Indigenous Australians).

The changes to roles and responsibilities for basic community care, aged care and specialist disability services do not apply to Victoria and WA. In these states, basic community care continues to be delivered under HACC as a joint Australian and State governments’ funded program. The Australian Government and the Victorian and WA governments have maintained bilateral agreements for that purpose.

**Housing**

Livable Housing Australia (LHA) is a not-for-profit organisation established to encourage Australians constructing new homes to comply with design standards to meet the changing needs of home occupants across their lifetime. LHA promotes greater understanding of the value of universal housing design practices and has developed guidelines to help guide the residential and building industry and all levels of government. The Livable Housing Design guidelines seek to raise national awareness about the benefits of designing homes for everyone, irrespective of their abilities.

The housing industry, the disability and the ageing sectors are working towards having all new homes built to reflect the new standards by 2020. They have also committed to a strategic plan that provides a pathway over the next decade to work towards this target.

The Australian Government is investing $1 million to drive this innovative partnership with the building and property sectors to promote universal housing design.

**F.4 Future directions in performance reporting**

This community services sector overview will continue to be developed in future reports.

The Aged care services, Service for people with disability, and Child protection and youth justice services chapters contain a service-specific section on future directions in performance reporting.
### F.5 List of attachment tables

Attachment tables are identified in references throughout this appendix by an ‘FA’ prefix (for example, table FA.1). Attachment tables are available on the Review website (www.pc.gov.au/gsp).

<table>
<thead>
<tr>
<th>Table FA.1</th>
<th>All people living in households aged 65 and over, number of social or community activities participated in away from home in the past 3 months (‘000)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Table FA.2</td>
<td>Primary carers living in households, whether participated in social activities at home in past 3 months without the recipient of care (‘000)</td>
</tr>
<tr>
<td>Table FA.3</td>
<td>Self-assessed health status of disabled people aged 18 years and over (000's)</td>
</tr>
<tr>
<td>Table FA.4</td>
<td>Jobless families, at June</td>
</tr>
<tr>
<td>Table FA.5</td>
<td>Australian Early Development Index (AEDI) Data</td>
</tr>
<tr>
<td>Table FA.6</td>
<td>Overall life satisfaction, by sex, 2010 (per cent)</td>
</tr>
<tr>
<td>Table FA.7</td>
<td>Adults at least satisfied with their lives, by age, 2010 (per cent)</td>
</tr>
</tbody>
</table>
F.6 References


—— 2010, Community Services Australia, 2008-09, Cat. no. 8696.0, Canberra.


—— 2010b, A stronger, fairer Australia — a new social inclusion strategy, Commonwealth of Australia, Canberra.


AIHW (Australian Institute of Health and Welfare) 2003 (and previous issues), National Classifications of Community Services, Version 2.0, Cat. no. HWI 40, Canberra.


—— 2006, Disability and disability services in Australia. Cat. no. DIS 43. Canberra.

—— 2010, Australia’s health 2010, Cat. no. AUS 122, Canberra.

—— 2011, Australia’s welfare 2011, Australia’s welfare series no. 10. Cat. no. AUS 142, Canberra.

—— 2012, Children and young people at risk of social exclusion: Links between homelessness, child protection and juvenile justice, Data linkage series no. 13 Cat. no. CSI 13. Canberra: AIHW.

—— 2010b, *National Health and Hospitals Network Agreement*,


The aged care system comprises all services specifically designed to meet the care and support needs of older people living in Australia. 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.

Major improvements in reporting on aged care services this year include:

- alignment of the aged care target population with the funding arrangements specified under the *National Health Reform Agreement* — the aged care target population for this year’s Report is all people 65 years or over and Indigenous...
Australians 50–64 years, revised from all people aged 70 years or over and Indigenous Australians 50–69 years

- replacement of a Home and Community Care (HACC) equity—access measure for the ‘use by different groups’ indicator with one that is easier to understand
- inclusion of additional data for the:
  - ‘elapsed times for aged care services’ indicator, by remoteness areas, socio-economic index for areas (SEIFA) and Indigenous status
  - ‘compliance with service standards for residential aged care’ indicator on three year re-accreditation, by remoteness areas and size of facility
- reporting of revised measures for the ‘compliance with service standards for community care’ and ‘complaints resolution’ indicators to reflect changes to the relevant programs
- data quality information (DQI) available for the first time for the indicators ‘elapsed times for aged care services’, ‘compliance with service standards for residential care’ and ‘maintenance of individual physical function’.

Older Australians are also users of other government services covered in this Report, including specialised mental health services (chapter 12), disability services (chapter 14), and housing assistance (chapter 16). Understanding the relationship between the health system and the aged care system is of particular importance (sector overview E and chapters 10–12), given that people aged 65 years or over account for around 50 per cent of all patient days in public hospitals (AIHW 2010). Interactions between health and aged care services are critical for the performance of both systems, for example, the number of operational residential aged care places can affect demand for public hospital beds, and throughput of older patients in acute and sub-acute care has a substantial effect on the demand for residential and community aged care.

### 13.1 Profile of aged care services

#### Service overview

To align with the funding arrangements as specified under the National Health Reform Agreement (box 13.1), this year’s Report defines the aged care target population as all people aged 65 years or over and Indigenous Australians aged 50–64 years. This aged care target population differs to previous reports, where it aligned with the Australian Government’s aged care ‘planning population’ (people aged 70 years or over) used to allocate residential care places and community care
packages under the *Aged Care Act 1997*, and also included Indigenous Australians aged 50–69 years. Where relevant, data are presented in the attachment tables for 2010-11 and 2011-12 using both the previous aged care target population (people aged 70 years or over and Indigenous Australians 50–69 years) and the new aged care target population (people aged 65 years or over and Indigenous Australians 50–64 years).

Services for older people are provided on the basis of frailty or functional disability. 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 services covered include:

- assessment and information services, which are largely provided by the Aged Care Assessment Program (ACAP)
- residential care services, which provide permanent high and low level care, and respite high and low level care
- community care services, including home-based care and assistance to help older people remain, or return to, living independently in the community as long as possible. These services include:
  - HACC program services
  - Community Aged Care Packages (CACP)
  - flexible care packages provided under the Extended Aged Care at Home (EACH) and the EACH-Dementia (EACH-D) programs
  - services provided by the Department of Veterans’ Affairs (DVA) under the Veterans’ Home Care (VHC)\(^1\) and Community Nursing programs
- community care respite services, which include HACC respite and centre-based day care services and services provided under the National Respite for Carers Program (NRCP)
- services provided in mixed delivery settings, which are designed to provide flexible care or specific support:
  - flexible care services, which address the needs of care recipients in ways other than that provided through mainstream residential and community care — services are provided under the Transition Care Program (TCP), Multi-purpose Service (MPS) Program, Innovative Care Pool and National Aboriginal and Torres Strait Islander Flexible Aged Care Program

\(^1\) Unless otherwise stated, HACC expenditure excludes the DVA expenditure on VHC.
specific support services, which are provided to address particular needs such as those under the Long Stay Older Patients (LSOP) initiative and in Day Therapy Centres.

The formal publicly funded services covered represent only a small proportion of total assistance provided to 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 2009 who required help with self-care, mobility or communications received assistance from the informal care network of family, friends and neighbours (ABS 2011). 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**

From 1 July 2011, the roles and responsibilities that apply under the aged care and disability service systems changed under the *National Health Reform Agreement* (box 13.1). The roles and responsibilities outlined in this section reflect that Agreement and differ to those that were in previous reports (see the 2012 Report for previous arrangements).

The funding and regulation of aged care services are predominantly the role of the Australian Government (although all three levels of government are involved). The *Aged Care Act 1997*, together with the accompanying *Aged Care Principles*, are the main regulatory instruments establishing the aged care framework. Key provisions covered include service planning, user rights, eligibility for care, funding, quality assurance and accountability (Productivity Commission 2010).

**Box 13.1 National Health Reform Agreement**

The changes to the relevant roles and responsibilities under the *National Health Reform Agreement* are aimed at creating a national aged care system and national disability services system. Under the *National Health Reform Agreement* the agreed policy and funding responsibilities of Australian, State and Territory governments (other than for Victoria and WA) are as follows:

- The Australian Government is responsible for:
  - regulating packaged community (CACP, EACH and EACH-D) and residential aged care

(Continued next page)
Box 13.1 (continued)

- funding packaged community and residential aged care for people aged 65 years or over (50 years or over for Indigenous Australians)
- funding and regulating basic community care services (previously delivered under the HACC program) for people aged 65 years or over (50 years or over for Indigenous Australians)
- funding specialist disability services delivered by the State and Territory governments under the National Disability Agreement (NDA) for people aged 65 years or over (50 years or over for Indigenous Australians).

- State and Territory governments are responsible for:
  - regulating specialist disability services delivered under the NDA
  - funding and regulating basic community care services (previously delivered under the HACC program) for people aged under 65 years, except for Indigenous Australians aged 50 years or over
  - funding packaged community (CACP, EACH and EACH-D) and residential aged care for people aged under 65 years, except Indigenous Australians aged 50 years or over.

The basic community care reforms for aged care occurred over two phases (except in Victoria and WA). On 1 July 2011, the Australian Government assumed funding and policy responsibility for basic community care services for people aged 65 years or over (50 years or over for Indigenous Australians), and on 1 July 2012 they also assumed operational responsibility for these services.

Unless otherwise agreed, the changes to roles and responsibilities for basic community care, aged care and specialist disability services and the reconciliation arrangements do not apply to Victoria and WA. In these States, basic community care will continue to be delivered under the HACC Program as a joint Australian and State governments' funded program. The Australian Government and these State governments will maintain bilateral agreements for that purpose.

A key objective in implementing the new arrangements is to minimise disruption for care recipients and providers in both the aged care and disability support systems. In 2011-12, for aged care the Australian Government developed and implemented the program framework and information technology systems needed to support these changes. During the transition, care recipients continued to receive services from their current providers.

**Aged Care Assessment Program**

The Australian Government established the ACAP in 1984. Under the ACAP, assessments are undertaken by an Aged Care Assessment Team (ACAT) and an approval is mandatory to be eligible for admission to Australian Government subsidised residential care (including respite) or to receive a CACP, EACH package,
EACH-D package or enter the TCP. People can also be referred by an ACAT to other services, such as those funded by the HACC program (although an ACAT referral is not mandatory for receipt of these other services).

The Australian Government has oversight of policy and guidelines, and provides funding to State and Territory governments specifically to operate ACATs. State and Territory governments are responsible for the day to day operation and administration of the ACAP. The scope and practice of the ACATs differ across and within jurisdictions, partly reflecting the service setting and location (for example, whether the team is attached to a hospital or a community service) and this has an effect on program outputs.

From 2010-11, Australian Government funding for the ACAP was provided to the State and Territory governments under the ACAP Implementation Plan 2010–2012 of the National Partnership Agreement on Health Services. The Implementation Plan sets Key Performance Indicators for the State and Territory governments, and allowed for payments to be made to the State and Territory governments on achievement of program milestones up until June 2012. From 1 July 2012 (up to 30 June 2014), the National Partnership Agreement has been replaced by an Agreement between the Australian Government and State and Territory governments.

**Residential care services**

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 13.2).
Box 13.2  **Examples of regulatory arrangements for residential services**

The Australian Government controls the number of subsidised residential care places. The current provision ratio for residential aged care is 86 operational places per 1000 people aged 70 years or over. More detail on the provision ratios across aged care services is provided in box 13.9.

Under the arrangements:

- services are expected to meet regional targets for places for concessional, assisted and supported residents. These targets range from 16 per cent to 40 per cent of places and are intended to ensure that residents who cannot afford to pay an accommodation bond or charge have equal access to care. (The criteria for being deemed a concessional or assisted resident are based on the date of the resident’s entry to care, home ownership and occupancy, receipt of income support and the level of assets held at entry. The criteria for being deemed a supported resident are based on the resident’s entry date and 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 1997* as a provider of aged care

- principles (regulations) created under the *Aged Care Act 1997* 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 administration of medicines and/or certain medical procedures, occupational health and safety, workers compensation requirements, building standards, and fire prevention and firefighting measures. Industrial relations arrangements and outcomes vary between and within jurisdictions.


Religious and private for-profit organisations were the main providers of residential care at June 2012, accounting for 27.2 per cent and 35.9 per cent respectively of all Australian Government subsidised residential aged care places. Community-based organisations and charitable organisations accounted for a further 13.4 per cent and 17.5 per cent respectively. State, Territory and local governments provided the remaining 5.9 per cent (figure 13.1).
Community care services

The main community care programs reported in this chapter are the HACC, CACP, EACH, EACH-D and the DVA VHC and Veterans’ community nursing programs. The Australian Government assumed full funding and policy responsibility for HACC aged care services on 1 July 2011 and operational responsibility on 1 July 2012 (box 13.1). The HACC program in Victoria and WA continues as a joint Australian Government, and State governments’ initiative administered under the Home and Community Care Review Agreement 2007. HACC service providers vary from small community-based groups to large charitable and public sector organisations.

The Australian Government (Department of Health and Ageing [DoHA]) is responsible for the policy oversight and regulation of the CACP, EACH and EACH-D programs. Religious and charitable organisations were the main providers of Australian Government subsidised community care places across the three programs at June 2012 (figure 13.2). EACH and EACH-D services are considered flexible care under the Aged Care Act 1997, but because of their nature are classified in this chapter as community care.
Figure 13.2  Operational CACP, EACH and EACH-D places, by provider type, June 2012a, b

*Figure 13.2 Operational CACP, EACH and EACH-D places, by provider type, June 2012a, b*

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>CACP</th>
<th>EACH</th>
<th>EACH-D</th>
</tr>
</thead>
<tbody>
<tr>
<td>Religious</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Charitable</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Community-based</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Private for-profit</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>State and local governments</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*a Community-based organisations provide a service for an identifiable community based on locality or ethnicity, not for financial gain.  
b Charitable organisations provide a service for the general community or an appreciable section of the public, not for financial gain.

Source: DoHA (unpublished).

The Australian Government (DVA) is primarily responsible for policy oversight and provision of the VHC programs and community nursing services for veterans and war widows/widowers. These services are delivered primarily by organisations contracted by DVA. There were 69 714 people aged 65 years or over approved for VHC services in 2011-12 and 30 115 people receiving community nursing services (table 13A.13), including services provided to assist carers.

**Services provided in mixed delivery setting**

Two categories of services are defined in this Report as being provided in mixed delivery settings:

- flexible care services provided under the:
  - *Aged Care Act 1997*
  - National Aboriginal and Torres Strait Islander Flexible Aged Care Program

- specific support services.
Flexible care services under the Aged Care Act 1997

Flexible care services provided in mixed delivery settings that are included under the *Aged Care Act 1997* comprise the TCP, MPS and innovative care places.

- The TCP is jointly funded by the Australian, State and Territory governments. Its implementation is overseen by the Transition Care Working Group, which includes representatives from all State and Territory governments and the Australian Government. Within the framework of the program, State and Territory governments, as the approved providers, develop their own service delivery models.

- The MPS program is a joint initiative between the Australian Government and State and Territory governments, which aims to deliver flexible and integrated health and aged care services to small rural and remote communities. Australian Government aged care funding is combined with State and Territory governments’ health services funding. State governments are the major providers of MPS, which are primarily located in small rural hospital settings (DoHA 2012).

- The Aged Care Innovative Pool is designed to test new approaches to providing aged care. At the beginning of each financial year, the Australian Government’s Minister for Ageing determines the flexible care subsidy rates for the Innovative Pool pilots. Further information on the TCP, MPS, and innovative care pool is provided in box 13.3.

---

**Box 13.3  Flexible care programs provided under the Aged Care Act**

**Transition care**

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 prematurely 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.

Transition care can be provided either in 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 around 8 weeks (62 days for completed episodes), with a maximum duration of 12 weeks that may in some circumstances be extended by a further 6 weeks.

(Continued next page)
Box 13.3 (continued)

The TCP operates with some differences across jurisdictions including differences in health and aged care service systems, local operating procedures and client groups, which are reflected in national data collections. In the six years from the introduction of the program until 2010-11, over 60 per cent of care recipients left the program with improved functioning and over half returned to live in the community (AIHW 2012).

Multi-purpose services (MPS)

The MPS Program supports the integration and provision of health and aged care services for small rural and remote communities. Some health, aged and community care services may not be viable in a small community if provided separately. By bringing the services together, economies of scale are achieved to support the services. Services are also able to be innovative in delivery and to offer more choices specific to the needs of the local community.

Innovative pool

The Aged Care Innovative Pool supports the development and testing of flexible models of service delivery in areas where mainstream aged care services might not appropriately meet the needs of a location or target group. In 2010-11, 500 places were allocated to selected approved providers for a two-year consumer directed packaged care pilot. Two hundred packages were also allocated to selected Commonwealth Respite and Carelink Centres to trial consumer directed respite care. In 2011-12, a further 500 consumer directed packaged care places and 200 consumer directed respite care packages were allocated.

National Aboriginal and Torres Strait Islander Flexible Aged Care Program

Flexible models of care are also provided under the National Aboriginal and Torres Strait Islander Flexible Aged Care Program. Services funded under the Program operate outside the regulatory framework of the Aged Care Act 1997. Aboriginal and Torres Strait Islander people also access mainstream services under the Aged Care Act 1997, including those managed by Aboriginal and Torres Strait Islander organisations.

The National Aboriginal and Torres Strait Islander Flexible Aged Care Program funds organisations to provide quality, flexible, culturally appropriate aged care to older Aboriginal and Torres Strait Islander people close to home and community. Flexible Aged Care services can deliver a mix of residential and community aged care services to meet the needs of the community.

In addition to the National Aboriginal and Torres Strait Islander Flexible Aged Care Program, some services managed by non-Indigenous approved providers also have
significant numbers of Aboriginal and Torres Strait Islander clients. All aged care services that are funded under the Aged Care Act 1997 are required to provide culturally appropriate care. Whether they are provided in a community or residential setting, services can 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.

Specific support services

A range of programs designed to meet the specific support needs of older people across care settings are funded and operate outside the regulatory framework of the Aged Care Act 1997. The Day Therapy Centre Program, for example, provides a wide range of therapy services to older people living in the community and to low care residents of Australian Government funded residential aged care facilities.

The Australian Government established, funds and oversees most of these programs. The LSOP Initiative was one exception (box 13.4). This program was established as part of the COAG national health and aged care agenda in 2006 and ceased on 30 June 2012. A new National Partnership Agreement on Financial Assistance for LSOP that applies from 2011-12 to 2013-14, is now in place.

**Box 13.4 Long Stay Older Patients**

**COAG LSOP Initiative — 2006-07 to 2011-12**

From July 2006, a four-year program commenced to improve care for older patients in public hospitals, and particularly those who no longer required hospital care and were awaiting alternative/long term care. This initiative was continued for a further two years in the 2010-11 Budget (to June 2012) and operated under the National Partnership Agreement on Health Services.

States and territories have completed a range of activities under the program to ensure that older Australians at risk of unnecessary and prolonged hospital stays receive appropriate and quality health care that better meets their needs, through:

- reduction in unnecessary admissions
- improvement in hospital services for older people

(Continued next page)
Box 13.4 (continued)

- improved transition to appropriate long term care
- improvement in the flexibility and capacity of rural hospitals to provide more age-appropriate services.

National Partnership Agreement (NPA) on Financial Assistance for LSOP — 2011-12 to 2013-14

Under the NPA on Financial Assistance for LSOP, which commenced 1 July 2011, funding is provided to improve care outcomes for older patients in public hospitals who no longer require acute or subacute care and who are waiting for residential aged care. The funding enables states and territories to provide a range of services relevant to their own service systems.


Funding

Recurrent expenditure on aged care services reported in this chapter was $12.9 billion in 2011-12 (table 13.1). Table 13.1 does not include all Australian, State and Territory government expenditure on caring for older people, for example, the experimental estimates of expenditure on non-HACC post-acute packages of care and funding provided for older people in specialist disability services (table 13A.11), and Australian, State or Territory government capital expenditure are excluded (table 13A.12). Data on Australian, State and Territory governments’ expenditure per person in the aged care target population by program, jurisdiction and over time are in table 13A.6.
## Table 13.1  
**Recurrent expenditure on aged care services, 2011-12**  
($ million)

<table>
<thead>
<tr>
<th></th>
<th>NSW</th>
<th>Vic</th>
<th>Qld</th>
<th>WA</th>
<th>SA</th>
<th>Tas</th>
<th>ACT</th>
<th>NT</th>
<th>Austa</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assessment and</td>
<td>34.8</td>
<td>25.6</td>
<td>18.1</td>
<td>10.9</td>
<td>10.3</td>
<td>2.9</td>
<td>1.3</td>
<td>1.7</td>
<td>108.7</td>
</tr>
<tr>
<td>information services</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Residential care</td>
<td>3 000.8</td>
<td>2 341.9</td>
<td>1 651.8</td>
<td>727.3</td>
<td>873.2</td>
<td>232.2</td>
<td>91.0</td>
<td>29.0</td>
<td>8 939.9</td>
</tr>
<tr>
<td>services</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Community care</td>
<td>941.3</td>
<td>744.0</td>
<td>651.1</td>
<td>332.6</td>
<td>238.5</td>
<td>88.0</td>
<td>48.4</td>
<td>29.7</td>
<td>3 086.9</td>
</tr>
<tr>
<td>servicesd</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Services provided in</td>
<td>199.1</td>
<td>140.3</td>
<td>115.8</td>
<td>76.0</td>
<td>92.0</td>
<td>22.1</td>
<td>5.7</td>
<td>11.8</td>
<td>725.9</td>
</tr>
<tr>
<td>mixed delivery</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>settings</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>4 176.0</td>
<td>3 251.8</td>
<td>2 436.8</td>
<td>1 146.8</td>
<td>1 214.0</td>
<td>345.3</td>
<td>146.4</td>
<td>72.2</td>
<td>12 861.3</td>
</tr>
</tbody>
</table>

a Australian total includes ‘other’ Australian Government expenditure that cannot be attributed to individual states or territories. b Assessment and information services include only Australian Government expenditure on the ACAP, additional COAG funding for ACATs, Commonwealth Carelink Centres and Carers Information and Support. c Residential care services include DoHA and DVA (including payroll tax supplement) and State and Territory governments’ expenditure and funding. d Community care services include HACC, CACP, EACH, EACH-D, NRCP, VHC, DVA Community Nursing and Assistance with Care and Housing for the Aged. Expenditure on HACC in Victoria and WA includes only that under the HACC Review Agreement. e Services provided in mixed delivery settings include MPS, TCP, National Aboriginal and Torres Strait Islander Flexible Aged Care Program, Day Therapy Centres, Continence Aids Assistance Scheme, Continence Aids Payment Scheme, National Continence Program, Innovative Care Pool, Dementia Education and Support, LSOP Initiative, Financial Assistance for LSOP, Community Visitors Scheme and Culturally and Linguistically Diverse expenditure.

Source: DoHA (unpublished); State and Territory governments (unpublished); table 13A.5.

### Assessment services

There were 108 ACATs (107 Australian Government funded) at 30 June 2012 (DoHA unpublished). In 2011-12, the Australian Government provided funding of $91.3 million nationally for the ACAP (table 13A.7). Australian Government ACAP expenditure per person aged 65 years or over and Indigenous Australians aged 50–64 years was $28 nationally during 2011-12 (table 13A.7). State and Territory governments also contribute funding for ACATs, but this expenditure is not included in the chapter.

Aged care assessment program activities and expenditure for 2010-11 and costs per person for 2004-05 to 2010-11 are reported in table 13A.100.

### Residential care services

The Australian Government provides most of the recurrent funding for residential aged care services. State and Territory governments provide funding for residential aged care for younger people with disability and some public sector beds. Residents provide most of the remaining service revenue, with some income derived from...
charitable sources and donations. Total expenditure on residential aged care was $8.9 billion in 2011-12 (table 13A.5).

**Australian Government expenditure**

Australian Government expenditure (including payroll tax) on residential aged care was $8.5 billion in 2011-12, comprising DoHA expenditure of $7.2 billion (table 13A.8) and DVA expenditure of $1.3 billion (table 13A.8).

**Australian Government basic subsidy**

The Australian Government annual basic subsidy for each occupied place varies according to clients’ levels of dependency and includes the Conditional Adjustment Payment (CAP). The amount of CAP payable in respect of a resident is calculated as a percentage of the basic subsidy amount. Since 2008-09, the percentage has been set at 8.75 per cent.

At 30 June 2012, the average annual subsidy per residential place, including the CAP, was $47 123 nationally (figure 13.3). Variations across jurisdictions in average annual subsidies reflect differences in the dependency of residents. Rates for aged care services by the level of high and low care places are in table 13A.17.

**Figure 13.3 Average annual Australian Government real basic subsidy (all levels) per occupied place, at June (2011-12 dollars)a**

![Graph showing average annual subsidy per occupied place across different states and territories]

*a See footnotes to table 13A.17 for further information.

*Source*: DoHA (unpublished); table 13A.17.
The dependency levels of permanent residents are shown in table 13.2. Each permanent resident has a dependency level for each of three domains. These dependency levels vary across jurisdictions. These data, categorised by the proportion of high and low care places provided, are included in table 13A.17.

Table 13.2  Dependency levels of permanent residents, 30 June 2012a, b, c

<table>
<thead>
<tr>
<th></th>
<th>NSW</th>
<th>Vic</th>
<th>Qld</th>
<th>WA</th>
<th>SA</th>
<th>Tas</th>
<th>ACT</th>
<th>NT</th>
<th>Aust</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aged Care Funding Instrument</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Activities of daily living</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>High</td>
<td>%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Proportions of residents</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medium</td>
<td>%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Low</td>
<td>%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nil</td>
<td>%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>%</td>
<td>100.0</td>
<td>100.0</td>
<td>100.0</td>
<td>100.0</td>
<td>100.0</td>
<td>100.0</td>
<td>100.0</td>
<td>100.0</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>NSW</th>
<th>Vic</th>
<th>Qld</th>
<th>WA</th>
<th>SA</th>
<th>Tas</th>
<th>ACT</th>
<th>NT</th>
<th>Aust</th>
</tr>
</thead>
<tbody>
<tr>
<td>Behaviours</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>High</td>
<td>%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medium</td>
<td>%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Low</td>
<td>%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nil</td>
<td>%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>%</td>
<td>100.0</td>
<td>100.0</td>
<td>100.0</td>
<td>100.0</td>
<td>100.0</td>
<td>100.0</td>
<td>100.0</td>
<td>100.0</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>NSW</th>
<th>Vic</th>
<th>Qld</th>
<th>WA</th>
<th>SA</th>
<th>Tas</th>
<th>ACT</th>
<th>NT</th>
<th>Aust</th>
</tr>
</thead>
<tbody>
<tr>
<td>Complex health care</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>High</td>
<td>%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medium</td>
<td>%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Low</td>
<td>%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nil</td>
<td>%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>%</td>
<td>100.0</td>
<td>100.0</td>
<td>100.0</td>
<td>100.0</td>
<td>100.0</td>
<td>100.0</td>
<td>100.0</td>
<td>100.0</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>NSW</th>
<th>Vic</th>
<th>Qld</th>
<th>WA</th>
<th>SA</th>
<th>Tas</th>
<th>ACT</th>
<th>NT</th>
<th>Aust</th>
</tr>
</thead>
<tbody>
<tr>
<td>Numbers of permanent residents</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total High</td>
<td>no.</td>
<td>45266</td>
<td>33972</td>
<td>24218</td>
<td>10907</td>
<td>13181</td>
<td>3363</td>
<td>1449</td>
<td>404</td>
</tr>
<tr>
<td>Total Low</td>
<td>no.</td>
<td>12168</td>
<td>9102</td>
<td>6114</td>
<td>3096</td>
<td>2415</td>
<td>865</td>
<td>397</td>
<td>92</td>
</tr>
<tr>
<td>All</td>
<td>no.</td>
<td>57434</td>
<td>43074</td>
<td>30332</td>
<td>14003</td>
<td>15596</td>
<td>4228</td>
<td>1846</td>
<td>496</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>NSW</th>
<th>Vic</th>
<th>Qld</th>
<th>WA</th>
<th>SA</th>
<th>Tas</th>
<th>ACT</th>
<th>NT</th>
<th>Aust</th>
</tr>
</thead>
<tbody>
<tr>
<td>High/Low</td>
<td>no.</td>
<td>57434</td>
<td>43074</td>
<td>30332</td>
<td>14003</td>
<td>15596</td>
<td>4228</td>
<td>1846</td>
<td>496</td>
</tr>
</tbody>
</table>

a See footnotes to table 13A.17 for further information.  
b Totals may not add as a result of rounding.  
c Information on the Aged Care Funding Instrument (ACFI) and the characteristics of residents is provided in box 13.5.

Source: DoHA (unpublished); table 13A.17.

State and Territory government recurrent expenditure

State and Territory government expenditure has been collected for four categories of residential care expenditure/funding (adjusted subsidy reduction supplement, enterprise bargaining agreement supplement, rural small nursing home supplement and funding of younger people with disability in residential care). Reported expenditure in the first three categories was $201.5 million in 2011-12 (table 13A.8)
and State and Territory governments (excluding Victoria and WA) provided $231.0 million in funding for younger people with disability in residential aged care.

Capital expenditure

The Australian Government provided $27.5 million in 2011-12 to fund the Rural and Regional Building Fund and Targeted Capital Assistance programs (table 13A.12), $7.9 million under the Aged Care Service Improvement and Healthy Ageing Grants Fund and $150 million for the Zero Real Interest Loans initiative (DoHA unpublished). These programs offer a range of financial assistance to address the capital needs (including for essential maintenance, repairs and upgrades) of services that are located in rural or remote areas, provide care to Aboriginal and Torres Strait Islander people or are in areas of high need.

State governments also provided $21.5 million in 2011-12 for capital expenditure on residential aged care services (table 13A.12). Capital expenditure on aged care services in 2011-12 is summarised in table 13A.12. These capital funds are in addition to the total recurrent expenditure reported in table 13.1.

Community care services

Total government expenditure on HACC services to older people was $1.6 billion in 2011-12, consisting of $1.4 billion from the Australian Government and $228.9 million from the Victorian and WA governments. In Victoria and WA, the Australian Government contributed 60.2 per cent, while these State governments funded the remainder (table 13A.9). For details on total HACC program expenditure under the HACC Review Agreement in Victoria and WA see tables 13A.5 and 13A.9. Recipients of HACC services also contribute towards the cost of these services.

Total government expenditure on the CACP program was $561.8 million in 2011-12 (table 13.3). This was largely funded by the Australian Government (97.8 per cent) with the remaining funding contributed by the State and Territory governments for younger people with disability (except in Victoria and WA). CACPs are also partly funded by client contributions. Similarly, the Australian Government also largely funds flexible care services under the EACH and EACH-D programs, spending $330.3 million and $157.6 million respectively on these programs in 2011-12 and the State and Territory governments (except for Victoria and WA) contributing $8.5 million for younger people (table 13A.9). EACH and EACH-D packages are also partly funded by client contributions.
The NRCP provides community respite services and is funded by the Australian Government. Expenditure on this program was $198.7 million in 2011-12 (table 13.3). The NRCP assisted 109,210 people in 2011-12 (table 13A.15).

Table 13.3  Governments’ expenditure on selected community aged care programs, 2011-12 ($million)

<table>
<thead>
<tr>
<th></th>
<th>NSW</th>
<th>Vic</th>
<th>Qld</th>
<th>WA</th>
<th>SA</th>
<th>Tas</th>
<th>ACT</th>
<th>NT</th>
<th>Aust</th>
</tr>
</thead>
<tbody>
<tr>
<td>HACC aged care services expenditure by the Australian, Victorian and WA governments&lt;sup&gt;a&lt;/sup&gt;</td>
<td>462.3</td>
<td>402.2</td>
<td>377.3</td>
<td>172.7</td>
<td>127.0</td>
<td>45.0</td>
<td>18.6</td>
<td>8.3</td>
<td>1,613.4</td>
</tr>
<tr>
<td>Aged care services expenditure&lt;sup&gt;b&lt;/sup&gt;</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CACP</td>
<td>192.0</td>
<td>146.2</td>
<td>93.1</td>
<td>49.9</td>
<td>48.0</td>
<td>14.8</td>
<td>8.0</td>
<td>9.7</td>
<td>561.8</td>
</tr>
<tr>
<td>EACH</td>
<td>94.1</td>
<td>74.5</td>
<td>71.5</td>
<td>55.3</td>
<td>18.3</td>
<td>7.8</td>
<td>10.5</td>
<td>4.6</td>
<td>336.5</td>
</tr>
<tr>
<td>EACH-D</td>
<td>43.6</td>
<td>36.9</td>
<td>36.6</td>
<td>23.9</td>
<td>9.9</td>
<td>4.4</td>
<td>3.1</td>
<td>1.5</td>
<td>159.9</td>
</tr>
<tr>
<td>NRCP&lt;sup&gt;c&lt;/sup&gt;</td>
<td>60.5</td>
<td>43.1</td>
<td>33.1</td>
<td>16.4</td>
<td>17.0</td>
<td>6.0</td>
<td>4.1</td>
<td>5.2</td>
<td>198.7</td>
</tr>
</tbody>
</table>

HACC = Home and Community Care. CACP = Community Aged Care Packages. EACH = Extended Aged Care at Home. EACH-D = EACH-Dementia. <sup>a</sup>Estimated Australian Government, Victorian and WA governments’ HACC expenditure on people aged 65 years or over and Indigenous Australians aged 50–64 years. For total program expenditure in Victoria and WA see table 13A.5. <sup>b</sup>Includes total program expenditure, including expenditure on services provided for younger people with disability. <sup>c</sup>Australian total includes ‘other’ Australian Government expenditure that cannot be attributed to individual states or territories.

Source: DoHA (unpublished); tables 13A.5 and 13A.9.

The DVA also provided $86.3 million for the VHC program and $125.6 million for veterans community nursing services during 2011-12 (table 13A.9). VHC recipients also contribute towards the cost of these services. In 2011-12, $17.7 million was also spent on veterans accessing HACC services (table 13A.11), but this expenditure is not included in table 13.1.

**Services provided in mixed delivery settings**

Five types of flexible care are provided under the *Aged Care Act 1997* (EACH and EACH-D packages, TCP, MPS and innovative care places). Expenditure relating to EACH and EACH-D is reported in table 13.3. The Australian, State and Territory governments fund the TCP. In 2011-12, the Australian Government spent $202.4 million and the State and Territory governments spent $105.3 million on the TCP (table 13A.10). The Australian Government also funds the MPS program (in conjunction with State and Territory governments) and the Innovative Care Pool. In 2011-12, the Australian Government spent $116.2 million and $19.9 million on these programs, respectively (table 13A.10). In addition to expenditure on these flexible care programs, the Australian Government spent $26.9 million on Indigenous specific services delivered under the National Aboriginal and Torres Strait Islander Flexible Aged Care Program and other aged care services funded...
under the *Aged Care Act 1997* that provide care to a significant number of older Aboriginal and Torres Strait Islander people.

Australian Government expenditure on two programs related to supporting older people in hospitals (LSOP and Financial Assistance for LSOP) was $143.3 million in 2011-12 (table 13A.5). Australian Government expenditure data by jurisdiction on a range of other services provided in mixed delivery settings targeting older people are in table 13A.10. Australian Government expenditure was $111.9 million in 2011-12 on these programs which comprise Day Therapy Centres, Continence Aids Payment Scheme, Continence Aids Assistance Scheme, National Continence Program, Dementia Education and Support, Community Visitors Scheme and support for people from Culturally and Linguistically Diverse (CALD) backgrounds (table 13A.10).

**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 older people (aged 65 years or over) in the total population. This trend is expected to continue, and the proportion of older people is expected to increase dramatically during this century (figure 13.4). The proportion of older people in the population is 14.4 per cent nationally, but varies across jurisdictions (figure 13.5). A disaggregation by remoteness categorisation is provided in table 13A.3. Higher life expectancy for females resulted in all jurisdictions having a higher proportion of older females than older males in the total population (except the NT) (table 13A.1).

The demand for aged care services is driven by the size and health of the older population. Females comprise a larger proportion of the older population and are more likely to utilise aged care services than males (partly because they are more likely to live alone). Based on the current age-sex specific utilisation rates for residential aged care and packaged community care combined, and projected growth in the size of the aged care planning population for these services, it is estimated that the demand for aged care services for people aged 70 years or over will more than treble by 2056 (DoHA unpublished estimate, based on ABS population projections series B in Cat. no. 3222.0).
Figure 13.4  People aged 65 years or over as a proportion of the total population\(^a\)

\[\text{Figure 13.5  Estimated proportion of population aged 65 years or over, by sex, June 2012}\]

\(\text{Source: Population projections prepared by the ABS using preliminary rebased estimated resident populations based on the 2006 Census according to assumptions agreed to by the Treasury and DoHA (unpublished); table 13A.1.}\)
**Characteristics of older Indigenous Australians**

DoHA estimates that about 80,091 Indigenous Australians were aged 50 years or over in Australia at 30 June 2012 (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 show life expectancy at birth in the Indigenous population is around 11.5 years less for males and 9.7 years less for females when compared with the total Australian population (ABS 2009). Indigenous Australians aged 50 years or over are used in this Report as a proxy for the likelihood of requiring aged care services, compared to 65 years or over for the general population.

**Figure 13.6  Age profile and aged care target population differences between Indigenous and other Australians, June 2011**

![Age profile and aged care target population differences between Indigenous and other Australians, June 2011](source)


**Aged Care Assessments**

Aged care assessments are designed to assess the care needs of older people and assist them to gain access to the most appropriate type of care. Nationally, the number of assessments per 1000 people aged 65 years or over and Indigenous Australians aged 50–64 years was 54.3 assessments, but this varied across jurisdictions. The rate for Indigenous Australians was 33.0 per 1000 Indigenous Australians aged 50 years or over (figure 13.7). Data on the numbers and rates of assessment for people of all ages by age group, Indigenous status and remoteness of residence are in table 13A.82.
ACAT assessments that 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-D). The approval rates for both residential and community care services vary across jurisdictions and increase with age (table 13A.81 and figure 13.8). 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.
Figure 13.8 Age-specific approval rates, per 1000 people in the population, 2010-11a,b

Permanent residential aged care

Community care (CACP, EACH and EACH-D) programs

a Population numbers and the proportions of the population for older age groups in the ACT and the NT are smaller than other jurisdictions, and may show variation between years, so results should be interpreted with caution. b The age category population data for this figure are derived from ABS population estimates as at 30 June 2011.

Source: DoHA (unpublished); table 13A.81.
Residential care services

Residential care services provide permanent high level and low level care and respite high/low level care:

- high care combines services such as nursing care, continence aids, basic medical and pharmaceutical supplies and therapy services with the types of services provided in low care such as accommodation, support services (cleaning, laundry and meals) and personal care services

- low care focuses on personal care services, accommodation, support services (cleaning, laundry and meals) and some allied health services such as physiotherapy — nursing care can be given when required

- respite provides short term residential high/low care on a planned or emergency basis (DoHA 2012).

At June 2012, there were 2725 residential aged care services (table 13A.18). There were generally fewer places in low care services than high care services. At June 2012, 80.8 per cent of low care services had 60 or fewer places (table 13A.20), compared with 28.1 per cent of high care services (table 13A.19).

The size and location of residential services — which can influence the costs of service delivery — vary across jurisdictions. Nationally, there were 184 570 mainstream operational places (excluding flexible care places) in residential care services (97 395 in predominantly high care services, 3048 in predominantly low care services, 84 095 in services with a mix of high care and low care residents2) at June 2012 (tables 13A.18–21). Box 13.5 contains information on the planning and allocation of residential aged care places and how the Aged Care Funding Instrument (ACFI) is used to appraise a resident’s needs as high or low care.

---

2 One service could not be classified to high, low or mixed care and therefore the sum of operational places across the high, low and mixed care service types will not add to the total.
Planning and allocation of residential aged care places and the Aged Care Funding Instrument

Planning and allocating of places

The Aged Care Act 1997 (part 2.2) details the processes for planning and allocating Australian Government subsidised services to meet residential aged care needs and community care needs. Planning for residential aged care is based on a national ratio of places per 1000 people aged 70 years or over (see box 13.9). High care places are planned to meet the needs of residents equivalent to high care. Low care places are planned to meet the needs of residents equivalent to low care.

Although a needs match is expected when residents enter vacant places (that is, for example, 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.

Aged Care Funding Instrument and the characteristics of residents

Aged Care Assessment Teams (ACATs) assess and approve clients as eligible for residential and community care. ACAT approvals for residential care can limit the approval for some residents to low care. Following this, approved providers of aged care homes appraise the level of a resident’s care needs using the ACFI.

The ACFI measures each resident’s need for care (high, medium, low or nil) in each of three domains: Activities of Daily Living, Behaviours and Complex Health Care. The ACFI was introduced on 20 March 2008 and replaced the Resident Classification Scale (RCS).

Residents are classified as high or low care based on the resident’s level of approval for care (determined by an ACAT) and on the approved provider’s appraisal of the resident’s care needs against the ACFI, in the following manner:

- Residents who have not yet received an ACFI appraisal are classified using their ACAT assessment.
- Residents whose ACAT approval is not limited to low care, are classified as high care if they are appraised under the ACFI as:
  - High in Activities of Daily Living, or
  - High in Complex Health Care, or
  - High in Behaviour, together with low or medium in at least one of the Activities of Daily Living or Complex Health Care domains; or
  - Medium in at least two of the three domains.
- All other residents appraised under the ACFI are classified as low care residents.
- In addition, residents whose ACAT approval is limited to low care, but whose first ACFI appraisal rates them in a high care range are classified as ‘interim low’ until the ACAT low care restriction is removed, or the ACFI High status is confirmed by a subsequent assessment or review.

(Continued next page)
Residents' care needs may change over time. Under ‘ageing-in-place’, a low care resident who becomes high care at a later date is able to remain within the same service.

From 1 January 2010, the definition for high care under the ACFI changed to make it similar to what it was before the ACFI was introduced (see www.health.gov.au/internet/main/publishing.nsf/Content/ageing-acfi-factsheets.htm).

The combined number of all operational high care and low care residential places per 1000 people in the aged care planning population (aged 70 years or over) at June 2012 was 84.4 (42.0 high care and 42.4 low care) on a national basis (table 13.4). Nationally, the proportion of low care places relative to high care places has remained relatively constant between 2007 and 2012 (table 13A.24).

Table 13.4  Operational high care and low care residential places, 30 June 2012a, b, c, d, e

<table>
<thead>
<tr>
<th>Unit</th>
<th>NSW</th>
<th>Vic</th>
<th>Qld</th>
<th>WA</th>
<th>SA</th>
<th>Tas</th>
<th>ACT</th>
<th>NT</th>
<th>Aust</th>
</tr>
</thead>
<tbody>
<tr>
<td>High care places no.</td>
<td>44.5</td>
<td>40.8</td>
<td>38.9</td>
<td>36.1</td>
<td>49.3</td>
<td>44.7</td>
<td>32.3</td>
<td>48.8</td>
<td>42.0</td>
</tr>
<tr>
<td>Low care places no.</td>
<td>41.7</td>
<td>44.3</td>
<td>42.3</td>
<td>40.9</td>
<td>42.4</td>
<td>38.3</td>
<td>42.5</td>
<td>39.6</td>
<td>42.4</td>
</tr>
<tr>
<td>Total places no.</td>
<td>86.2</td>
<td>85.1</td>
<td>81.2</td>
<td>77.0</td>
<td>91.7</td>
<td>83.0</td>
<td>74.8</td>
<td>88.4</td>
<td>84.4</td>
</tr>
<tr>
<td>Proportion of places</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>High care places %</td>
<td>51.6</td>
<td>48.0</td>
<td>47.9</td>
<td>46.9</td>
<td>53.8</td>
<td>53.9</td>
<td>43.2</td>
<td>55.2</td>
<td>49.8</td>
</tr>
<tr>
<td>Low care places %</td>
<td>48.4</td>
<td>52.0</td>
<td>52.1</td>
<td>53.1</td>
<td>46.2</td>
<td>46.1</td>
<td>56.8</td>
<td>44.8</td>
<td>50.2</td>
</tr>
</tbody>
</table>

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 in the NT).

c Includes residential places categorised as high care or low care.

d See table 13A.24 for further information regarding the calculation of provision ratios, which vary from corresponding data published in the DoHA Annual Report 2011-12.

e Data in this table may not add due to rounding.

Source: DoHA (unpublished); table 13A.24.

Age specific usage rates for permanent residential aged care services, by jurisdiction and remoteness, at 30 June 2012 are included in tables 13A.37 and 13A.44, respectively. Age specific usage rates for these permanent residential services combined with community care program services (CACP, EACH and EACH-D) are reported in tables 13A.42 and 13A.46. National, Indigenous age specific usage rates for all these services by remoteness category are in table 13A.47.

During 2011-12, the number of older clients (aged 65 years or over and Indigenous Australians aged 50–64 years) who received either high or low care in a residential
aged care facility was 215 156 nationally for permanent care and 45 592 nationally for respite care (table 13A.4). These figures reflect the number of older individuals who utilised these services during the year, for any length of time. Data on the number of younger people aged under 65 years who used permanent residential care during 2011-12 are in table 13A.43.

**Community care services**

Changing government policies over the past decade — shifting the balance of care away from the more intensive types of residential care towards community-based care — have meant that the HACC, CACP, EACH, EACH-D and DVA VHC and community nursing programs have become increasingly important components of the aged care system.

**HACC, CACP, EACH and EACH-D programs**

The distinctions between the HACC, CACP, EACH and EACH-D programs are summarised in table 13.5. DVA VHC and Veterans’ community nursing program services are described below.

Services provided under the HACC program are basic maintenance and support services, including allied health care, assessment, case management and client care coordination, centre-based day care, counselling, support, information and advocacy, domestic assistance, home maintenance, nursing, personal care and respite care, social support, meals, home modification, linen service, goods and equipment and transport. During 2011-12, the HACC program delivered approximately 10 083 hours per 1000 people aged 65 years or over and Indigenous Australians aged 50–64 years (table 13A.48).

CACPs provide community-based low level care to older people who are assessed by ACATs as having complex low care needs, but who are able to live at home with assistance. The total number of CACPs per 1000 people aged 70 years or over and Indigenous Australians aged 50–69 years increased between June 2007 and June 2012, from 18.6 to 20.8 (table 13A.25).

EACH and EACH-D provide community-based high level care to older people who are assessed by ACATs as having complex high care needs, but who have expressed a preference to live at home and are able to do so with assistance (EACH-D provides this care to people with the complex care needs associated with dementia). The total combined number of EACH and EACH-D packages per 1000 people aged
70 years or over and Indigenous Australians aged 50–69 years increased between June 2007 and June 2012, from 2.2 to 5.7 (table 13A.25).

Table 13.5 Distinctions between the HACC, CACP, EACH and EACH-D programs, 2011-12

<table>
<thead>
<tr>
<th>HACC</th>
<th>CACPs</th>
<th>EACH and EACH-D</th>
</tr>
</thead>
<tbody>
<tr>
<td>Type of services&lt;sup&gt;a&lt;/sup&gt;</td>
<td>Maintenance and support services for people in the community whose independence is at risk</td>
<td>Package of low level care tailored to client needs</td>
</tr>
<tr>
<td>Relationship to residential care</td>
<td>Aims to prevent premature or inappropriate admission</td>
<td>Substitutes for a low care residential place</td>
</tr>
<tr>
<td>Eligibility</td>
<td>ACAT assessment not required</td>
<td>ACAT assessment mandatory</td>
</tr>
<tr>
<td>Funding</td>
<td>Cost shared by the Australian, Victorian and WA governments and client contributions</td>
<td>Funded by the Australian, State and Territory governments and client contributions</td>
</tr>
<tr>
<td>Target client groups&lt;sup&gt;b&lt;/sup&gt;</td>
<td>Available to people with profound, severe and moderate disability and their carers. Not age specific in Victoria and WA</td>
<td>Targets older people with care needs similar to low level residential care</td>
</tr>
<tr>
<td>Size of program</td>
<td>$1.6 billion funding in 2011-12 for older clients</td>
<td>$561.8 million total funding in 2011-12</td>
</tr>
<tr>
<td></td>
<td>At least 746,859 older clients in 2011-12&lt;sup&gt;c&lt;/sup&gt;</td>
<td>47,826 operational places&lt;sup&gt;d&lt;/sup&gt; in 2011-12</td>
</tr>
</tbody>
</table>

<sup>a</sup> HACC services such as community nursing, which are not available under CACPs, can be supplied to someone receiving a CACP. <sup>b</sup> Most HACC clients 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 needs that would exceed the level available under CACPs and EACH. <sup>c</sup> The proportion of HACC funded agencies that submitted Minimum Data Set data for 2011-12 differed across jurisdictions and ranged from 93 per cent to 100 per cent. Consequently, the total number of clients will be higher than those reported. <sup>d</sup> The number of operational places includes CACPs, low level consumer directed care (CDC) places and flexible community places. See note (d) to table 13A.15. <sup>e</sup> The number of operational places includes EACH and EACH-D and high level CDC places.

Source: DoHA (unpublished); tables 13A.4, 13A.5 and 13A.15.

Age specific usage rates for CACP, EACH and EACH-D, by jurisdiction and remoteness, at 30 June 2012 are included in tables 13A.41 and 13A.45 respectively. Age specific usage rates for these community care program services (CACP, EACH and EACH-D) combined with permanent residential services are in tables 13A.42 and 13A.46. National, Indigenous age specific usage rates for all these services by remoteness category are in table 13A.47.
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 can lead to apparently large fluctuations in growth rates. This can be seen from some of the usage rates identified for the EACH and EACH-D programs, which, whilst growing rapidly, are doing so from a relatively small base.

Data on the number of older clients (aged 65 years or over and Indigenous Australians aged 50–64 years) who received HACC, CACP, EACH and EACH-D services in 2011-12 are included in table 13.6. These data reflect the number of individuals who utilised these services during the year, for any length of time, as distinct from the number of places available. Data on the number of younger people aged under 65 years who used CACP, EACH and EACH-D services during 2011-12 are in table 13A.43.

**Table 13.6  Number of community aged care older clients, by program, 2011-12**

<table>
<thead>
<tr>
<th></th>
<th>NSW</th>
<th>Vic</th>
<th>Qld</th>
<th>WA</th>
<th>SA</th>
<th>Tas</th>
<th>ACT</th>
<th>NT</th>
<th>Aust</th>
</tr>
</thead>
<tbody>
<tr>
<td>HACC</td>
<td>217 252</td>
<td>209 634</td>
<td>147 919</td>
<td>56 192</td>
<td>80 911</td>
<td>22 624</td>
<td>9 729</td>
<td>2 598</td>
<td>746 859</td>
</tr>
<tr>
<td>CACP</td>
<td>20 812</td>
<td>14 811</td>
<td>10 275</td>
<td>5 737</td>
<td>5 176</td>
<td>1 525</td>
<td>911</td>
<td>790</td>
<td>59 991</td>
</tr>
<tr>
<td>EACH</td>
<td>3 302</td>
<td>2 365</td>
<td>2 516</td>
<td>2 147</td>
<td>598</td>
<td>236</td>
<td>388</td>
<td>152</td>
<td>11 689</td>
</tr>
<tr>
<td>EACH-D</td>
<td>1 462</td>
<td>1 195</td>
<td>1 363</td>
<td>966</td>
<td>359</td>
<td>155</td>
<td>112</td>
<td>40</td>
<td>5 649</td>
</tr>
</tbody>
</table>

Source: DoHA (unpublished); table 13A.4.

_Veterans' Home Care and Community Nursing programs_

The services of the VHC program target veterans and war widows/widowers with low care needs. There were 71 870 people approved for VHC services in 2011-12 (table 13A.13)³. 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.

Eligibility for VHC services is not automatic, but based on assessed need. The average number of hours provided per year for veterans who were eligible to receive home care services was 50.0 nationally in 2011-12 (figure 13.9).

The DVA also provides community nursing services to veterans and war widows/widowers. These services include acute/post-acute support and maintenance, personal care, medication management and palliative care. In 2011-12, 30 647 veterans received these services (table 13A.13) and the average

---

³ DVA data include veterans of all ages.
number of hours provided for each recipient was 8.1 per 28 day period (figure 13.10).

Figure 13.9  **Average number of hours approved for Veterans’ Home Care, 2011-12**

![Graph showing average number of hours approved for Veterans’ Home Care, 2011-12](image)

*Source: DVA (unpublished); table 13A.13.*

Figure 13.10  **Average number of hours provided for DVA Community Nursing, 2011-12**

![Graph showing average number of hours provided for DVA Community Nursing, 2011-12](image)

*Source: DVA (unpublished); table 13A.13.*
Information on the size/scope of a selection of the programs delivering services in mixed delivery settings is outlined below:

- At 30 June 2012, the Australian Government had allocated 4000 places to transition care, all of which were operational, across 100 services nationally. The average length of stay in 2011-12 was 62 days nationally for completed episodes (table 13A.106).

- At 30 June 2012, there were 137 operational MPS services with a total of 3337 operational flexible aged care places. Some of the MPS services serve more than one location (DoHA unpublished).

- At 30 June 2012, there were 29 aged care services funded to deliver 675 flexible aged care places under the National Aboriginal and Torres Strait Islander Flexible Aged Care Program (DoHA unpublished).

- During 2011-12, 106,150 people were assisted through the Continence Aids Payment Scheme (DoHA unpublished).

- During 2011-12, 56,315 people received Day Therapy Centre Program services from 137 centres (DoHA unpublished).

**Case study**

Box 13.6 contains a case study of the performance and evaluation of Wellness and reablement approaches in HACC.

---

**Box 13.6  Case study — Wellness and reablement approaches in HACC: the Victorian and WA experience**

Wellness and reablement approaches in Home and Community Care (HACC) seek to support older people to maintain or regain their capacity to live as independently as possible at home and in the community. The overall aim is to improve functional and psychosocial independence, quality of life and social participation.

Wellness and reablement approaches involve redesigning the service delivery model so that services work with clients in ways that serve to:

- prevent loss of independence by focusing on the retention of existing skills
- minimise the negative impact of service support by avoiding an emphasis on task completion and instead support the client to do as much as possible for themselves

(Continued next page)
where appropriate, focus on regaining skills and a subsequent increased level of independence and well-being as opposed to a continuing or increasing dependence on services being provided by others

• actively involve clients in setting goals and making decisions about their care
  provide timely and flexible services that support people to reach their goals

• promote active participation in society, social connections and family-centred care.

The foundation for the development of this approach in Australia has been two reablement projects. The Home Independence Project (HIP) targets older home care clients (without dementia) when first referred for assistance or when referred for additional services because of increased need. The Personal Enablement Program (PEP) is designed to meet the needs of eligible clients who are exiting an acute episode of care in hospital.

The evidence base for these approaches has been building since 1999 when HIP was developed, piloted and made operational, followed by a randomised controlled trial of HIP between 2005—2009, an evaluation of Wellness implementation in 2009 and in 2012 a retrospective cohort study. The retrospective study followed older individuals who received HIP, PEP or ‘usual HACC’ support for five years post-intervention to ascertain their use of home care services during the period July 2004 – December 2009. The cohort included a total of 11 316 individuals, 2724 HIP, 6105 PEP and 2487 ‘usual HACC’ clients.

Results of the retrospective study suggest that the HIP and PEP groups were less likely to use HACC funded home care services of any type over the next three years following the intervention compared to the ‘usual HACC’ group. When the use of specific HACC service types was examined, it was found that the HIP and PEP groups were less likely to be receiving personal care support at the five year follow up. In addition, the cumulative cost of all services were significantly lower in those receiving HIP/PEP compared to ‘usual HACC’. The study concluded that participation in a short term restorative home care program is likely to reduce an individual’s need for subsequent home care services for up to five years and represents an excellent return on investment for government funded aged care services.

The implementation of Wellness and reablement approaches in the WA HACC Program has been a key driver for a major reform in the way in which assessments for HACC are conducted. Implementation of the WA Assessment Framework (WAAF) in 2011 has not only separated assessment from service provision by the establishment of Regional Assessment Services (RAS), but has led to the development of an assessment tool that is client strength and ability based, embedded a holistic person centred approach into assessment protocols and ensures that, as a person ages and support needs change, assessment processes are progressive and recursive.

(Continued next page)
With the consolidation of Wellness and reablement approaches within HACC service delivery and the implementation of the WAAF, the need for further reform and development work to ensure that the approaches are integrated and become part of normal practice has become more evident. An example of this is the need to improve the interface and increase the collaboration between the RAS and ACATs. A professional development module for ACATs is currently being trialled and evaluated which aims to support ACATs to develop a greater understanding of Wellness and commitment to promoting client abilities and independence, and reduce duplication of assessment by ensuring ACAT assessment information is also strength and ability based.

In Victoria, the approach has been developed as the Active Service Model (ASM). After significant work in researching, piloting and developing the approach, nearly 500 HACC funded agencies commenced implementation in mid-2010. The ASM is a significant change management project, especially given the size and complexity of HACC services in Victoria.

Evidence shows that most HACC agencies now understand the ASM and have started implementing the approach in practice. They see ASM as core business, a new way of delivering HACC service. Practice is still developing and not yet consistent across the State. Elements of a reablement and restorative care approach are apparent in a range of ways. These include: how organisations describe and conceptualise their approach to HACC services; the case studies they share; more flexible and focussed service responses with higher rates of episodic rather than ongoing care; a more health promoting and preventive approach from intake through the client pathway; higher staff and client satisfaction and greater coordination with other agencies. These elements combine to produce better client outcomes and use of resources.

One key focus has been on building partnerships and understanding between agencies to enhance service provision, particularly assessment services and allied health. An example has been collocating Occupational Therapists from Community Health Services with HACC Assessment Services. This has increased referrals, reduced waiting times, reduced duplication of assessment, and improved responsiveness to clients’ needs. Another area of focus has been in developing a more strength based and expanded range of service options in personal care and domestic assistance, which has enabled community care workers to ‘work with’ their clients and use their relationships with clients to inform more effective care planning and review processes and to build clients’ confidence in developing and maintaining social connections.

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 indicator framework for aged care services is based on a set of shared government objectives in the aged care sector (box 13.7).

COAG has agreed six National Agreements to enhance accountability to the public for the outcomes achieved or outputs delivered by a range of government services (see chapter 1 for more detail on reforms to federal financial relations).

The NHA covers the area of health and aged care. The Agreement includes sets of performance indicators, for which the Steering Committee collates performance information for analysis by the COAG Reform Council (CRC). Performance indicators reported in this chapter are aligned with the aged care performance indicators in the NHA. The NHA was reviewed in 2011 and 2012 resulting in changes that have been reflected in this Report, as relevant.

Box 13.7 Objectives for aged care services

The aged care system aims to promote the wellbeing and independence of older people and their carers through the funding and delivery of care services that are:

- accessible
- appropriate to needs
- high quality
- efficient
- person-centred.

These objectives are consistent with the Australian, State and Territory governments’ long term aged care objectives articulated under the NHA that ‘older Australians receive appropriate high quality and affordable health and aged care services’ (COAG 2009).

The performance indicator framework provides information on equity, efficiency and effectiveness, and distinguishes the outputs and outcomes of aged care services (figure 13.11). The performance indicator framework shows which data are comparable in the 2013 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 Report’s statistical appendix 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) (appendix A).

Some changes have been made to the aged care framework for the 2013 Report.

- The ‘selected adverse events in residential aged care’ indicator has been replaced by the outcome indicator ‘hospital leave days for preventable causes’. Measures for this replacement indicator are under development.
- The names of the following indicators have changed:
  - ‘waiting times for aged care services’ to ‘elapsed times for aged care services’
  - ‘long term aged care in public hospitals’ to ‘hospital patient days used by aged care type patients’
  - ‘complaints’ to ‘complaints resolution’
  - ‘maintenance of individual functioning’ to ‘maintenance of individual physical function’.

Data quality information is being progressively introduced for all indicators in the Report. The purpose of DQI is to provide structured and consistent information about quality aspects of data used to report on performance indicators. DQI in this Report cover the seven dimensions in the ABS’ data quality framework (institutional environment, relevance, timeliness, accuracy, coherence, accessibility and interpretability) in addition to dimensions that define and describe performance indicators in a consistent manner, and note key data gaps and issues identified by the Steering Committee. All DQI for the 2013 Report can be found at www.pc.gov.au/gsp/reports/rogs/2013.
Figure 13.11  Aged care services performance indicator framework

Key to indicators

Text Data for these indicators are comparable, subject to caveats to each chart or table
Text Data for these indicators are not complete and/or not directly comparable
Text These indicators are yet to be developed or data are not collected for this Report
13.3 Key performance indicator results

Different delivery contexts, locations and types of client may affect the effectiveness and efficiency of aged care services.

Outputs

Outputs are the 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 governments’ objective for the aged care system to provide equitable access to aged care services for all people who require these services (box 13.8).

Box 13.8 Use by different groups

‘Use by different groups’ has six measures defined as follows:

- the number of people born in non-English speaking countries using residential services, CACPs, EACH, EACH-D and HACC services divided by the number of people born in non-English speaking countries aged 65 years or over, compared with the rates at which the total aged care target population (people aged 65 years or over and Indigenous Australians aged 50–64 years) access these services
- the number of Indigenous Australians using residential services, CACP, EACH, EACH-D and HACC services, divided by the number of Indigenous Australians aged 50 years or over (because Indigenous Australians tend to require aged care services at a younger age than the general population), compared with the rates at which the total aged care target population (people aged 65 years or over and Indigenous Australians aged 50–64 years) access these services
- the number of veterans aged 65 years or over in residential care divided by the total number of eligible veterans aged 65 years or over, where a veteran is defined as a DVA Gold or White card holder

(Continued next page)
Box 13.8  (continued)

- access to HACC services for people living in rural or remote areas — the number of hours of HACC service received (and, separately, meals provided) divided by the number of people aged 65 years or over and Indigenous Australians aged 50–64 years for major cities, inner regional areas, outer regional areas, remote areas and very remote areas
- the rate of contacts with Commonwealth Respite and Carelink Centres for Indigenous Australians compared with the rate for all people
- access to residential aged care services for financially disadvantaged people
  - the proportion of new residents classified as supported
  - the proportion of permanent resident care days classified as concessional, assisted or supported.

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 Australians have higher disability 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, assisted or supported 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.

Use by different groups is a proxy indicator of equitable access. Various groups are identified by the Aged Care Act 1997 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, veterans (including widows and widowers of veterans), people who are homeless or at risk of becoming homeless, or who are care leavers. A care leaver is a person who was in institutional care (such as an orphanage or mental health facility) or other form of out-of-home care, including foster care, as a child or youth (or both), at some time during their lifetime (DoHA 2012).

Several factors need to be considered in interpreting the results for this set of measures:

- Cultural differences can influence the extent to which people born in non-English speaking countries use different types of services.
- Cultural differences and geographic location can influence the extent to which Indigenous Australians use different types of services.

(Continued next page)
Box 13.8 (continued)

- The availability of informal care and support can influence the use of aged care services in different population groups.

Data reported for this indicator are comparable.

Information about data quality for four measures defined for this indicator is at www.pc.gov.au/gsp/reports/rogs/2013. Data quality information for the other measures is under development.

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 aged care services by Indigenous Australians and people born in a non-English speaking country*

In all jurisdictions at 30 June 2012, on average, Indigenous Australians and people born in non-English speaking countries had lower rates of use of aged care residential services (21.2 and 42.5 per 1000 of the relevant aged care target populations respectively), compared with the population as a whole (52.6 per 1000) (figure 13.12).
Figure 13.12 **Residents per 1000 aged care target population, 30 June 2012**\(^{a, b, c}\)

![Bar chart showing residents per 1000 aged care target population by state and category.]

---

\(^a\) All residents data are per 1000 people aged 65 years or over and Indigenous Australians aged 50–64 years. \(^b\) Indigenous residents data are per 1000 Indigenous Australians 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 65 years or over.

*Source: DoHA (unpublished); tables 13A.28, 13A.32 and 13A.35.*

Age specific usage rates for these services, by jurisdiction (tables 13A.37 and 13A.42) and nationally by remoteness (tables 13A.44 and 13A.46-47), suggest there is greater variation in usage rates by remoteness area than amongst jurisdictions.

**Access to CACP services by Indigenous Australians and people born in a non-English speaking country**

Nationally, the number of Indigenous CACP recipients per 1000 Indigenous Australians aged 50 years or over was 24.5 and the numbers of CACP recipients from non-English speaking countries per 1000 of the relevant aged care target population was 14.3. These numbers compare to a total of 13.3 per 1000 of the aged care target population (people aged 65 years or over and Indigenous Australians aged 50–64 years) (figure 13.13).
Figure 13.13  Community Aged Care Package recipients per 1000 aged care target population, 30 June 2012\textsuperscript{a, b, c, d, e}

\begin{itemize}
\item All recipients data are per 1000 people aged 65 years or over and Indigenous Australians aged 50–64 years.
\item Indigenous recipients data are per 1000 Indigenous Australians aged 50 years or over.
\item Data for recipients from non-English speaking countries are per 1000 people from non-English speaking countries aged 65 years or over.
\item 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.
\item 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.
\end{itemize}

Source: DoHA (unpublished); tables 13A.28, 13A.32 and 13A.35.

Age–sex specific usage rates vary between jurisdictions (tables 13A.41-42) and by remoteness categories nationally (tables 13A.45-46) for CACP, EACH and EACH-D.

\textit{Access to HACC aged care services by Indigenous Australians and people born in a non-English speaking country}

Nationally, the number of Indigenous HACC recipients per 1000 Indigenous Australians aged 50 years or over was 219.1 and the numbers of HACC recipients from non-English speaking countries per 1000 people aged 65 years or over was 220.8. These numbers compare to a total of 225.3 per 1000 of the aged care target population (people aged 65 years or over and Indigenous Australians aged 50–64 years) (figure 13.14).

**Figure 13.14** HACC recipients per 1000 aged care target population, 30 June 2012\(^{a, b, c}\)

<table>
<thead>
<tr>
<th>Recipients per 1000 aged care target population</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
</tr>
<tr>
<td>100</td>
</tr>
<tr>
<td>200</td>
</tr>
<tr>
<td>300</td>
</tr>
<tr>
<td>400</td>
</tr>
<tr>
<td>NSW</td>
</tr>
<tr>
<td>All recipients</td>
</tr>
</tbody>
</table>

\(^{a}\) All recipients data are per 1000 people aged 65 years or over and Indigenous Australians aged 50–64 years.

\(^{b}\) Indigenous recipients data are per 1000 Indigenous Australians aged 50 years or over.

\(^{c}\) Data for recipients from non-English speaking countries are per 1000 people from non-English speaking countries aged 65 years or over.

*Source:* DoHA (unpublished); table 13A.31.

**Access by veterans**

The total number of veterans 65 years or over who were in the DVA treatment population (that is, eligible veterans) at 30 June 2012 was 179,378 (table 13A.14). The number of veterans in residential care per 1000 eligible veterans aged 65 years or over at 30 June 2012 was 153.2 (figure 13.15). Nationally, total DVA expenditure on residential aged care subsidy per person aged 65 years or over was $405 (including payroll tax) in 2011-12 (table 13A.14). Total DVA expenditure per 1000 eligible veterans was $7.3 million (figure 13.15).
Figure 13.15 **Number of veterans aged 65 years or over in residential care and total DVA expenditure on residential aged care subsidy, per 1000 eligible veterans aged 65 years or over, 2011-12**

<table>
<thead>
<tr>
<th>Service use</th>
<th>Total expenditure</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Data are subject to a time lag and may be subject to revision. b The number of eligible veterans are veterans with a DVA Gold and White card holder residents as at June 2012. c Veterans 65 years or over includes those whose age is unknown. d The expenditure measure ‘$m/1000 eligible veterans’ is derived using data in table 13A.14.

**Source:** DVA (unpublished); DoHA (unpublished); table 13A.14.

**Access to the HACC program, by location**

HACC services are provided in the client’s home or community for people with moderate, severe or profound disability and their carers. The focus of this chapter is older people 65 years or over and Indigenous Australians aged 50–64 years. Nationally, the number of service hours per 1000 people aged 65 years or over and Indigenous Australians aged 50–64 years was 10 083 and the number of meals provided per 1000 people aged 65 years or over and Indigenous Australians aged 50–64 was 3012 in 2011-12 (table 13.7). The proportion of HACC agencies that submitted data vary across jurisdictions so comparisons between jurisdictions should be made with care.
Table 13.7  HACC services received per 1000 people aged 65 years or over and Indigenous Australians aged 50–64 years, 2011–12\textsuperscript{a, b, c}

<table>
<thead>
<tr>
<th></th>
<th>NSW</th>
<th>Vic</th>
<th>Qld</th>
<th>WA</th>
<th>SA</th>
<th>Tas</th>
<th>ACT</th>
<th>NT</th>
<th>Aust</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage of agencies that reported Minimum Data Set data</td>
<td>99</td>
<td>99</td>
<td>99</td>
<td>100</td>
<td>96</td>
<td>98</td>
<td>100</td>
<td>93</td>
<td>99</td>
</tr>
<tr>
<td>Total hours (no.)\textsuperscript{d}</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Major cities</td>
<td>8 738</td>
<td>10 673</td>
<td>11 079</td>
<td>10 666</td>
<td>10 958</td>
<td>..</td>
<td>8 835</td>
<td>..</td>
<td>10 069</td>
</tr>
<tr>
<td>Inner regional</td>
<td>7 323</td>
<td>12 046</td>
<td>9 813</td>
<td>9 309</td>
<td>9 463</td>
<td>10 838</td>
<td>..</td>
<td>..</td>
<td>9 497</td>
</tr>
<tr>
<td>Outer regional</td>
<td>9 098</td>
<td>15 113</td>
<td>10 569</td>
<td>12 699</td>
<td>11 565</td>
<td>8 506</td>
<td>..</td>
<td>5 453</td>
<td>10 797</td>
</tr>
<tr>
<td>Remote</td>
<td>12 240</td>
<td>25 968</td>
<td>15 123</td>
<td>10 469</td>
<td>12 792</td>
<td>7 204</td>
<td>..</td>
<td>8 122</td>
<td>12 434</td>
</tr>
<tr>
<td>Very remote</td>
<td>13 315</td>
<td>..</td>
<td>15 714</td>
<td>16 376</td>
<td>29 877</td>
<td>13 244</td>
<td>..</td>
<td>14 476</td>
<td>16 752</td>
</tr>
<tr>
<td>All areas</td>
<td>8 440</td>
<td>11 286</td>
<td>10 805</td>
<td>10 729</td>
<td>9 977</td>
<td>8 835</td>
<td>8 417</td>
<td>10 083</td>
<td></td>
</tr>
<tr>
<td>Total meals (no.)\textsuperscript{e}</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Major cities</td>
<td>2 071</td>
<td>2 691</td>
<td>3 024</td>
<td>1 925</td>
<td>4 558</td>
<td>..</td>
<td>1 679</td>
<td>..</td>
<td>2 609</td>
</tr>
<tr>
<td>Inner regional</td>
<td>3 020</td>
<td>3 443</td>
<td>3 421</td>
<td>2 335</td>
<td>2 521</td>
<td>3 041</td>
<td>..</td>
<td>..</td>
<td>3 142</td>
</tr>
<tr>
<td>Outer regional</td>
<td>4 691</td>
<td>4 143</td>
<td>3 348</td>
<td>3 558</td>
<td>5 300</td>
<td>3 088</td>
<td>..</td>
<td>2 400</td>
<td>3 991</td>
</tr>
<tr>
<td>Remote</td>
<td>10 812</td>
<td>6 957</td>
<td>5 929</td>
<td>5 043</td>
<td>4 955</td>
<td>3 211</td>
<td>..</td>
<td>9 218</td>
<td>6 520</td>
</tr>
<tr>
<td>Very remote</td>
<td>17 863</td>
<td>..</td>
<td>8 639</td>
<td>14 596</td>
<td>25 311</td>
<td>6 730</td>
<td>..</td>
<td>25 474</td>
<td>16 399</td>
</tr>
<tr>
<td>All areas</td>
<td>2 577</td>
<td>2 960</td>
<td>3 285</td>
<td>2 451</td>
<td>4 544</td>
<td>3 081</td>
<td>1 679</td>
<td>9 979</td>
<td>3 012</td>
</tr>
</tbody>
</table>

\textsuperscript{a} Data represent HACC services received by people aged 65 years or over and Indigenous Australians aged 50–64 years, divided by people aged 65 years or over and Indigenous Australians aged 50–64 years (tables 13A.48, 13A.50, 13A.52, 13A.54, 13A.56 and 13A.58) as distinct from HACC services received divided by HACC target population in older or all age groups (tables 13A.61–72). \textsuperscript{b} The proportion of HACC funded agencies that submitted Minimum Data Set data for 2011-12 differed across jurisdictions and ranged from 93 per cent to 100 per cent. Consequently, actual service levels were higher than stated. \textsuperscript{c} Reports provisional HACC data that have not been validated and may be subject to revision. \textsuperscript{d} See table 13A.48 for a full list of categories. \textsuperscript{e} Includes home meals and centre meals. .. Not applicable.


There are substantial differences in the age profile across the Indigenous and non-Indigenous populations. This reflects the difference in morbidity and mortality trends between Indigenous Australians and the general population. The proportion of older Indigenous HACC clients (aged 65 years or over) who are aged 80 years or over is 25.5 per cent and the proportion of non-Indigenous HACC clients who are aged 80 years or over is 54.7 per cent (figure 13.16).
Figure 13.16 Older recipients of HACC aged care services by age and Indigenous status, 2011-12\textsuperscript{a, b, c}

\textsuperscript{a} Reports provisional HACC data that have not been validated and may be subject to revision. \textsuperscript{b} The proportion of HACC clients with unknown Indigenous status differed across jurisdictions. Nationally, the proportion of HACC clients with unknown or null Indigenous status was 6.1 per cent (table 13A.73). \textsuperscript{c} The Indigenous proportions are derived using data contained in table 13A.75.

Source: DoHA (unpublished); table 13A.75.
**Access by Indigenous Australians to Commonwealth Respite and Carelink Centres**

Commonwealth Respite and 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 Australians contacted Respite and Carelink Centres at 30 June 2012, was 55.6 people per 1000 Indigenous Australians in the Indigenous target population (Indigenous Australians aged 50 years or over). The rate for all Australians was 151.5 per 1000 people in the target population (people aged 65 years or over and Indigenous Australians aged 50–64 years). These figures varied across jurisdictions (figure 13.17).

**Figure 13.17** Commonwealth Respite and Carelink Centres, contacts per 1000 aged care target population, by Indigenous status, 30 June 2012

![Bar chart showing contacts per 1000 aged care target population for Indigenous and all contacts.]

- **Contacts include phone calls, visits, emails and facsimiles.**
- **Indigenous contacts refer to contacts by Indigenous Australians per 1000 Indigenous Australians aged 50 years or over.**
- **All contacts refers to contacts per 1000 aged 65 years of over and Indigenous Australians aged 50-64 years.**
- **Indigenous status is determined through people making contact self-identifying themselves as Indigenous. Therefore, there is likely to be substantial under-reporting of Indigenous status.**

*Source: DoHA (unpublished); table 13A.79.*

**Access to residential services by financially disadvantaged users**

New residents who are assessed as eligible to receive subsidised accommodation costs are known as supported residents. Residents who entered care prior to 20 March 2008 are still subject to the eligibility criteria for ‘concessional’ or ‘assisted’ resident status.
The proportion of all new residents classified as supported residents during 2011-12 was 38.2 per cent nationally but varied across jurisdictions (figure 13.18). Targets for financially disadvantaged users range from 16 per cent to 40 per cent of places, depending on the service’s region.

Figure 13.18 New residents classified as supported residents, 2011-12\textsuperscript{a}

\begin{figure}
\centering
\includegraphics[width=\textwidth]{figure13_18.png}
\caption{New residents classified as supported residents, 2011-12\textsuperscript{a}}
\end{figure}

\textsuperscript{a} Supported residents are those who have entered permanent residential care on or after 20 March 2008 (or who re-entered care on or after 20 March 2008 after a break in care of more than 28 days) and have assets of up to a set value (from 20 March 2011 to 19 September 2011 — $102,544.00, from 20 September 2011 to 19 March 2012 — $107,850.40 and from 20 March 2012 to 30 June 2012 — $108,266.40.)

Source: DoHA (unpublished); table 13A.38.

The proportion of all permanent resident care days classified as concessional, assisted or supported during 2011-12 was 40.7 per cent nationally, but varied across jurisdictions (figure 13.19).
Concessional residents are those who entered permanent residential care before 20 March 2008, receive an income support payment and have not owned a home for the last two or more years (or whose home is occupied by a protected person, for example, the care recipient’s partner), and have assets of less than 2.5 times the annual single basic age pension (or for a transfer from 20 September 2009 less than 2.25). Assisted residents are those meeting the above criteria, but with assets between 2.5 and 4.0 times the annual single basic age pension (or for a transfer from 20 September 2009 between 2.25 and 3.61). Supported residents are those who have entered permanent residential care on or after 20 March 2008 (or who re-enter care on or after 20 March 2008 after a break in care of more than 28 days) and have assets of up to a set value (from 20 March 2011 to 19 September 2011 — $102 544.00, from 20 September 2011 to 19 March 2012 — $107 850.40 and from 20 March 2012 to 30 June 2012 — $108 266.40.)

Source: DoHA (unpublished); table 13A.38.

Effectiveness — level of access

Operational aged care places

‘Operational aged care places’ is an indicator of governments’ objective to provide older Australians with access to a range of aged care services that can meet their care needs (box 13.9). This indicator does not include places that have been approved, but are not yet operational.
Box 13.9  Operational aged care places

'Operational aged care places' is defined by two measures, the number of operational places (by type) per 1000 people in the aged care planning population:

- aged 70 years or over
- aged 70 years or over and Indigenous Australians aged 50–69 years.

The planning framework for services provided under the *Aged Care Act 1997* aims to keep the growth in the number of Australian Government subsidised aged care places in line with growth in the aged population, and to ensure a balance of services across Australia, including services for people with lower levels of need and in rural and remote areas. The current national provision ratio is 113 operational aged care places per 1000 of the population aged 70 years or over.\(^a\) Within this overall target provision ratio of 113 places:

- 42 places (37 per cent) should be residential high care — designed to meet the needs of residents equivalent to high care
- 44 places (39 per cent) should be residential low care — designed to meet the needs of residents equivalent to low care
- 27 places (24 per cent) should be community care, with 6 of these places (around 5.3 per cent of total places) being for high level community care — designed to enable those with high/low care needs to continue living in, or return to, the community (DoHA unpublished).\(^a\)

In recognition of poorer health among Indigenous communities and that planning in some cases also takes account of the Indigenous population aged 50–69 years, the provision ratio is also reported for operational places per 1000 people aged 70 years or over and Indigenous Australians aged 50–69 years. A 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).

In general, provision ratios across states and territories, and across regions, that are broadly similar to the overall target provision ratios are desirable as it indicates that older Australians have access to a similar level and mix of services to meet their care needs.

This indicator does not provide information on whether the overall target provision ratios are adequate or provide an appropriate mix of services relative to need.

Data reported for this indicator are comparable.


\(^a\) By 30 June 2022, the operational planning target ratio will be: 45 Home Care Packages per 1000 people aged 70 years or over and 80 residential care places per 1000 people aged 70 years or over, for a total 125 Australian Government subsidised aged care places.

Nationally, the combined number of high care residential places, low care residential places, CACPs, flexible care places (including EACH and EACH-D, but
excluding Transition Care places) and places under the National Aboriginal and Torres Strait Islander Flexible Aged Care Program at 30 June 2012, was 111.8 per 1000 people aged 70 years or over (figure 13.20). Transition Care places add an additional 1.8 per 1000 people aged 70 years or over, however, these places are not included in the target of 113 places (table 13A.24). The number of operational aged care places per 1000 people aged 70 years or over by care type was:

- 42.0 places (37.6 per cent of total) for residential high care
- 42.4 places (37.9 per cent of total) for residential low care
- 27.4 places (24.5 per cent of total) for community care — 21.5 places for CACPs and 5.9 places for EACH and EACH-D combined (5.3 per cent of total places) (figure 13.20).

**Figure 13.20** Operational residential places, CACPs, EACH and EACH-D packages per 1000 people aged 70 years or over, 30 June 2012

---

**Source:** DoHA (unpublished); table 13A.24.

The number of operational aged care places can also be shown using an aged care planning population that incorporates Indigenous Australians aged 50–69 years.
Use of this ‘adjusted’ aged care planning population has a noticeable effect on the NT, which has a large proportion of Indigenous Australians.

Figure 13.21  **Operational residential places, CACPs, EACH and EACH-D packages per 1000 people aged 70 years or over and Indigenous Australians aged 50–69 years, 30 June 2012**

- Excludes places that have been approved but are not yet operational.
- Ageing in place may result in some low care places being filled by high care residents.
- CACPs, EACH and EACH-D packages are included in the Australian Government planning targets.
- Includes residential places categorised as high care or low care.
- 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.
- CACP data include flexible community low care places under the National Aboriginal and Torres Strait Islander Flexible Aged Care Program, Multi-Purpose Service Program and Innovative Pool Program (including CDC low care places). EACH data includes CDC high care places and EACH-D data includes CDC high care dementia places.
- TCP places are not shown, see table 13A.25.

Source: DoHA (unpublished); table 13A.25.

Data on the number of residential and community care operational aged care places per 1000 people aged 70 years or over and Indigenous Australians aged 50–69 years by planning region and remoteness are in tables 13A.26-27.
Effectiveness — timeliness of access

Elapsed times for aged care services

‘Elapsed times for aged care services’ is an indicator of governments’ objective to maximise the timeliness with which people are able to access aged care services (box 13.10).

Box 13.10  Elapsed times for aged care services

‘Elapsed times for aged care services’ is defined by two measures.

- The proportion of people who entered residential high care within three months of their ACAT approval. Entry into a residential care service refers to the date of admission to a residential aged care service. ACAT approval refers to the approval date of the most recent ACAT assessment prior to admission into care.
- The proportion of people who commenced a CACP who did so within three months of their ACAT approval. ACAT approval refers to the approval date of the most recent ACAT assessment prior to commencement of care.

Data are also presented for these service types on the proportions who enter/receive these services within other periods of time. Data on ‘elapsed’ times for EACH and EACHD services are also included in table 13A.83.

Higher proportions of admission to residential high care or of commencement of a CACP service within three months of ACAT approval are desirable.

This indicator needs to be interpreted with care. The measure of ‘elapsed time’ is utilised, rather than ‘waiting times’, because the period of time between the ACAT approval and entry into residential care or commencement of a CACP may be affected by factors other than time spent ‘waiting’ to enter/receive a service, for example:

- hospital discharge policies and practices
- client choice not to enter residential care immediately, but to take up the option at a later time
- variations in building quality, perceived quality of care and care fee regimes, which influence client choice of preferred service and delays their take up of care.

In addition, the measure does not include clients who have received an ACAT approval and who may have spent time waiting, but who:

- do not enter residential care or commence a CACP (for example, who die before entering care)
- ultimately decide not to take-up a care placement offer
- choose to take-up an alternative care option due to, for example, varying fee regimes.

(Continued next page)
Elapsed time needs to be interpreted locally and may vary in relevance according to individual circumstances. A client’s decision to take-up care at a particular point in time can be influenced by the location of residential care services; the availability of alternatives to residential care, such as EACH and EACH-D; and for community care, the availability of informal care and respite services.

For residential aged care, this indicator focuses on high care services because the link between ‘elapsed time’ before entry to residential care and actual ‘waiting time’ is stronger for high care residents than for low care residents. This is due to the urgency of high care residents’ needs, and the greater number of alternatives for people with ACAT approvals for low residential aged care only. Where there is some urgency because of a client’s high care needs, it is clearly desirable to minimise the time elapsing between ACAT approval and entry to high level residential aged care. However, there is an equally strong argument for ensuring all options are explored, including Transition Care, to ensure that premature entry to residential aged care is avoided or at least postponed for as long as practical given individual circumstances.

It is recognised that this indicator has limitations and work is underway to review the data. This indicator will continue to be reported until improved data are available.

Data reported for this indicator are comparable.


Overall, 22.6 per cent of all people entering residential high care during 2011-12 did so within seven days of being approved by an ACAT compared with 23.0 per cent in 2010-11. In 2011-12, 51.2 per cent entered within one month of their ACAT approval and 73.2 per cent entered within three months of their approval (figure 13.22), compared with 51.0 per cent and 74.0 per cent respectively in 2010-11 (table 13A.83). The median time for entry into high care residential services was 28 days in 2011-12, the same as the median time in 2010-11 (table 13A.83).

Nationally in 2011-12, a greater proportion of people entering high care residential services entered within three months of approval (73.2 per cent), compared with the proportion entering low care residential services within that time (65.0 per cent). Further data on elapsed time by remoteness, SEIFA and Indigenous status are included in table 13A.84–86.
Overall, 69.5 per cent of all people commencing a CACP during 2011-12 received it within three months of being approved by an ACAT. This proportion varied across jurisdictions. On average, 39.1 per cent started receiving a CACP within one month of their ACAT approval (figure 13.23).
Effectiveness — appropriateness

Assessed longer term care arrangements

‘Assessed longer term care arrangements’ is an indicator of governments’ objective to meet clients’ needs through provision of appropriate aged care services (box 13.11).

Box 13.11  **ACAT recommended longer term living arrangements**

‘Assessed longer term care arrangements’ is defined as the proportions of ACAT clients recommended to reside in the community (private residence or other community), or in residential care (high or low level), or in another location (such as, hospital) or for clients whom ACATs do not develop a long term plan for reasons such as death or cancellation. A recommendation does not mean that the person will be approved for the care recommended, and an approval does not mean that the person will take up the care approved. Aged care assessments are mandatory for admission to Australian Government subsidised residential care or for receipt of a CACP, EACH, EACH-D or TCP package.

High or increasing proportions of clients recommended to remain in the community (assuming this is appropriate) are desirable.

The results for this indicator show the distribution of recommended living arrangements of ACAT clients in each jurisdiction. Differences in recommendations across jurisdictions can 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.

Data reported for this indicator are comparable.

Data quality information for this indicator is under development.

The national proportion of ACAT clients approved for residential care in 2010-11 was 39.7 per cent and the proportion recommended to remain in the community was 49.4 per cent (figure 13.24). No long term plan was made for 10.3 per cent, which included deaths, cancellations and transfers.
Figure 13.24  **Recommended longer term living arrangements of ACAT clients, 2010-11**

![Recommended longer term living arrangements of ACAT clients, 2010-11](image)

*a* Other includes hospital and other institutional care.  
*b* No plan includes deaths, cancellations and transfers.

**Source:** DoHA (unpublished) Ageing and Aged Care Data Warehouse from Aged Care Assessment Program Minimum Data Set; table 13A.87.

**Unmet need**

‘Unmet need’ is an indicator of governments’ objective of ensuring aged care services are allocated to meet clients’ needs (box 13.12).

**Box 13.12 Unmet need**

‘Unmet need’ is defined as the extent to which demand for services to support older people requiring assistance with daily activities is not met.

Low rates of unmet need are desirable, however, defining and determining the level of need at an individual level is complex and at a population level is highly complex. Perceptions of need and unmet need are often subjective.

Data for this indicator are drawn from the ABS 2009 Survey of Disability, Ageing and Carers. Data are for people aged 65 years or over who self-identified as having a need for assistance with at least one everyday activity, and the extent to which that need was being met (fully, partly or not at all).

(Continued next page)
Box 13.12  (continued)

Direct inferences about the demand for services need to be made with care, because the measure used does 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 are valid policy approaches
- 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.

Although data are included, this indicator is regarded as yet to be developed, because of the extent of the caveats.

Of those people aged 65 years or over in 2009, who were living in households and who self-identified as having a need for assistance with at least one everyday activity, 30.2 per cent reported that their need for assistance was not fully met (table 13A.88).

*Hospital patient days used by aged care type patients*

‘Hospital patient days used by aged care type patients’ is an indicator of governments’ objective to minimise the incidence of older people staying in hospitals for extended periods of time when their care needs may be met more appropriately through residential or community care services (box 13.13).
Box 13.13  **Hospital patient days used by aged care type patients**

‘Hospital patient days used by aged care type patients’ has two measures:

- the proportion of completed aged care type public hospital separations for people aged 65 years or over and Indigenous Australians aged 50–64 years for which the length of stay was 35 days or longer, where ‘aged care type’ hospital separations are defined as:
  - the care type was maintenance, and
  - the diagnosis (either principal or additional) was either person awaiting admission to residential aged care service or need for assistance at home and no other household member able to render care

- the proportion of all patient days (for overnight separations only) used by patients who are waiting for residential aged care, where the:
  - care type was maintenance, and
  - diagnosis (either principal or additional) was person awaiting admission to residential aged care service, and
  - separation mode was discharge/transfer to another acute hospital or to residential aged care (unless this is usual place of residence); statistical discharge, that is a change in care type; the patient died; discharge/transfer to other health care accommodation (including mother craft hospitals and another psychiatric hospital); left against medical advice/discharge at own risk or statistical discharge from leave.

Low or decreasing proportions of hospital stays of 35 days or more and low or decreasing proportions of patient days used by people waiting for residential aged care are desirable.

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.

These measures should be interpreted with care, because:

- patients who have not completed their period of care in a hospital are not included
- 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
- reported hospital separations and patient days do not necessarily reflect the full length of hospital stay for an individual patient. If a change in the type of care occurs during a patient’s hospital stay (for example, from acute to maintenance) then two separations are reported for that patient

(Continued next page)
for the first measure, the code ‘need for assistance at home and no other household member able to render care’ 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

• the measures 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 measures are regarded as proxies, as the desired measures (utilising appropriate linked hospital separations and ACAT approvals) are not available at this time. Further development is underway to improve available data sets and associated measures for future reports.

Data reported for this indicator are not directly comparable.

Information about data quality for one measure defined for this indicator is at www.pc.gov.au/gsp/reports/rogs/2013. Data quality information for the other measure is under development.

The proportion of separations for ‘aged care type’ patients (as defined in box 13.13) aged 65 years or over and Indigenous Australians aged 50–64 years whose separation was 35 days or longer was 13.3 per cent nationally in 2010-11 (figure 13.25). The number of ‘aged care type’ patient separations for people aged 65 years or over and Indigenous Australians aged 50–64 years was 12 425, of a total 2.1 million nationally (table 13A.89).
Figure 13.25  Proportion of separations for ‘aged care type’ public hospitals patients that were 35 days or longer\textsuperscript{a, b, c, d, e, f, g}

\begin{figure}
\centering
\includegraphics[width=0.5\textwidth]{figure13_25.png}
\caption{Proportion of separations for ‘aged care type’ public hospitals patients that were 35 days or longer\textsuperscript{a, b, c, d, e, f, g}}
\end{figure}

\textsuperscript{a} Data are for hospital separations with a care type of maintenance and a diagnosis (either principal or additional) of either ‘person awaiting admission to residential aged care service’ or ‘need for assistance at home and no other household member able to render care’ and where the separation lasted 35 days or longer. \textsuperscript{b} Age of patients is 65 years or over and Indigenous patients 50–64 years. \textsuperscript{c} Although the diagnosis codes reflect a care type, they do not determine a person’s eligibility for residential aged care. \textsuperscript{d} Diagnosis codes may not be applied consistently across jurisdictions or over time. \textsuperscript{e} These data only account for completed unlinked separations. \textsuperscript{f} The code ‘need for assistance at home and no other household member able to render care’ may also be used for respite care for either residential or community care patients. \textsuperscript{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 to the whole hospital stay.

Source: AIHW (unpublished); table 13A.89.

The proportion of all hospital patient days (for overnight separations only) used by patients who are waiting for residential aged care (as defined in box 13.13) was 11.7 per 1000 patient days nationally in 2010-11 (figure 13.26).
Figure 13.26  **Hospital patient days used by patients waiting for residential aged care**\(^a, b, c, d, e, f\)

\[\text{Figure 13.26: Hospital patient days used by patients waiting for residential aged care.}\]

\[\text{Source: AIHW (unpublished); table 13A.90.}\]

**Intensity of care**

‘Intensity of care’ is an indicator of governments’ objective to encourage ‘ageing in place’ to increase choice and flexibility in residential aged care service provision (box 13.14). (See box 13.15 for background information on the ‘ageing in place’ policy.)
Box 13.14 **Intensity of care**

‘Intensity of care’ is defined by two measures:

- the proportion of people who stayed in the same residential aged care service when changing from low care to high care
- the proportion of low care places occupied by residents with high care needs, compared with the proportion of all operational places taken up by residents with high care needs.

High or increasing 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.

These measures reflect 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 1997* aims explicitly to encourage ageing in place to increase choice and flexibility in residential aged care service provision (box 13.15).

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 services system over time.

Data reported for this indicator are comparable.

Data quality information for this indicator is under development.

Nationally, from June 2004 to June 2012, 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 92.1 per cent (figure 13.27). For June 2012, the proportion was highest in remote areas (93.4 per cent), compared to other areas: major cities (92.2 per cent), inner regional areas (91.8 per cent), outer regional areas (91.7 per cent) and very remote areas (78.9 per cent) (table 13A.39).
In its Objects, the *Aged Care Act 1997* 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 1997* 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 1997* 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.

*Source: DoHA (unpublished).*

Nationally, 54.6 per cent of low care places in 2011-12 were occupied by residents with high care needs. The proportion of all operational places taken up by residents with high care needs was 73.0 per cent (figure 13.28). These data are provided by remoteness area in table 13A.40.
Figure 13.27  Proportion of residents who changed from low care to high care and remained in the same aged care service, June\textsuperscript{a}

![Figure 13.27](image1)

\textsuperscript{a} Ten years of annual data for this indicator are in table 13A.39.
Source: DoHA (unpublished); table 13A.39.

Figure 13.28  Utilisation of operational residential places, 30 June 2012\textsuperscript{a}

![Figure 13.28](image2)

\textsuperscript{a} Includes residential places categorised as high care or low care.
Source: DoHA (unpublished); table 13A.40.
Effectiveness — quality

Compliance with service standards for residential care

‘Compliance with service standards for residential care’ is an indicator of governments’ objective to ensure residential care services attain high levels of service quality, through compliance with certification and accreditation standards (box 13.16).

<table>
<thead>
<tr>
<th>Box 13.16  Compliance with service standards for residential care</th>
</tr>
</thead>
<tbody>
<tr>
<td>‘Compliance with service standards for residential care’ is defined by two measures:</td>
</tr>
<tr>
<td>• the proportion of accredited services which have received three year re-accreditation, by meeting accreditation standards</td>
</tr>
<tr>
<td>• the proportion of aged care services that are compliant with building certification, fire safety and privacy and space requirements.</td>
</tr>
</tbody>
</table>

High or increasing proportions of approval for three year re-accreditation and services that are compliant with building certification, fire safety and privacy and space requirements are desirable. The extent to which residential care services comply with service standards and other requirements implies a certain level of care and service quality.

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. The accreditation process is managed by the Aged Care Standards and Accreditation Agency Ltd (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 an existing 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. Commencing services are subject to a desk audit only, and are accredited for one year.

(Continued next page)
A home must be certified to be able to receive accommodation payments and extra service charges. Residents expect high quality and safe accommodation in return for their direct and indirect contributions. Certification provides a mechanism to encourage provision of safe and high quality accommodation within the regulatory frameworks for buildings legislated by State and Territory governments. Aged care homes are required to meet building certification, fire safety, privacy and space requirements to be eligible to receive the maximum level of the accommodation supplement.

Under the privacy and space requirements, all new buildings constructed since July 1999, are required to have an average, for the whole aged care home, of no more than 1.5 residents per room. No room may accommodate more than two residents. There is also a mandatory standard of no more than three residents per toilet, including those off common areas, and no more than four residents per shower or bath.

Data reported for this indicator are comparable.


Accreditation decisions and further information relating to the accreditation standards and ACSAA are publicly available (ACSA 2009). The accreditation process is summarised in box 13.16.

At 30 June 2012, of residential aged care services that were re-accredited during 2011-12, 93.5 per cent were granted re-accreditation approval for a period of three years (table 13.8).

Table 13.8 Re-accreditation decisions on residential aged care services, 30 June 2012\(^a, b\)

<table>
<thead>
<tr>
<th>Re-accreditation period</th>
<th>NSW</th>
<th>Vic</th>
<th>Qld</th>
<th>WA</th>
<th>SA</th>
<th>Tas</th>
<th>ACT</th>
<th>NT</th>
<th>Aust</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;2 years</td>
<td>%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>3.1</td>
</tr>
<tr>
<td>2 years or more (but &lt;3 years)</td>
<td>%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>3.4</td>
</tr>
<tr>
<td>3 years or more</td>
<td>%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>93.5</td>
</tr>
<tr>
<td>Total</td>
<td>%</td>
<td>100.0</td>
<td>100.0</td>
<td>100.0</td>
<td>100.0</td>
<td>100.0</td>
<td>100.0</td>
<td>100.0</td>
<td>100.0</td>
</tr>
</tbody>
</table>

| Total re-accredited services | no. | 451 | 309 | 165 | 125 | 165 | 42  | 12  | 9    | 1 278 |
| Total services             | no. | 884 | 755 | 460 | 243 | 264 | 78  | 26  | 15   | 2 725 |

\(^{a}\) Data at 30 June 2012 relate only to re-accreditations, and do not include accreditation periods for 22 commencing services. \(^{b}\) Note that ‘accreditation period’ shows the decision in effect at 30 June 2012. Data in this table will not necessarily be consistent with the accreditation decisions made in 2011-12, because those decisions may not yet have taken effect, or may have been superseded. – Nil or rounded to zero.

Source: ACSAA (unpublished); tables 13A.18 and 13A.91.
Nationally, as at 30 June 2011, 99.9 per cent of residential aged care services were compliant with building certification, fire safety, and privacy and space requirements (table 13.9).

Table 13.9  Residential aged care services compliant with building certification, fire safety and privacy and space requirements, at 30 June 2012

<table>
<thead>
<tr>
<th></th>
<th>Unit</th>
<th>NSW</th>
<th>Vic</th>
<th>Qld</th>
<th>WA</th>
<th>SA</th>
<th>Tas</th>
<th>ACT</th>
<th>NT</th>
<th>Aust</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total residential</td>
<td>no</td>
<td>884</td>
<td>755</td>
<td>460</td>
<td>243</td>
<td>264</td>
<td>78</td>
<td>26</td>
<td>15</td>
<td>2725</td>
</tr>
<tr>
<td>services</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total compliant</td>
<td>no</td>
<td>884</td>
<td>755</td>
<td>458</td>
<td>243</td>
<td>264</td>
<td>78</td>
<td>26</td>
<td>15</td>
<td>2723</td>
</tr>
<tr>
<td>services</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Proportion of</td>
<td>%</td>
<td>100.0</td>
<td>100.0</td>
<td>99.6</td>
<td>100.0</td>
<td>100.0</td>
<td>100.0</td>
<td>100.0</td>
<td>100.0</td>
<td>99.9</td>
</tr>
<tr>
<td>compliant services</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>


Complaints resolution

‘Complaints resolution’ is an indicator of governments’ objective to ensure aged care services provide a high quality of care (box 13.17). From 1 September 2011, the Aged Care Complaints Scheme (the Scheme) changed and now focuses on the resolution of complaints in the interests of the care recipient.
Box 13.17 Complaints resolution

‘Complaints resolution’ has two measures:

- the number of complaints received by the Scheme which are within the scope of the Scheme to handle (that is, relate to the responsibilities of an approved provider of residential or community care under the Aged Care Act 1997) per 1000 permanent care recipients

- the proportion of complaints that were resolved without the need for a direction.

This indicator is a proxy of the quality of care and of the responsiveness of approved providers where issues about the quality of care or services are raised through complaints. A low or decreasing rate of complaints received and high proportion of complaints that that were resolved without the need for a direction are desirable.

From 1 September 2011, the Scheme assesses the risk associated with a complaint and the most appropriate method for resolving the complaint. This may mean encouraging resolution at a local provider level, conciliating an outcome between the complainant and the provider, or the Scheme investigating the complaint. Where the Scheme decides that an approved provider is not meeting its responsibilities, it has the power to issue the provider with directions. Prior to issuing a direction, the Scheme will typically give the provider other opportunities to remedy the issues, including giving the provider the opportunity to respond to a Notice of Intention to Issue Directions. Where issues are addressed, directions may not be issued.

Data reported for this indicator are comparable across states and territories, but are not comparable with previous years due to the change in the complaints management arrangements from 1 September 2011.

Data quality information for this indicator is under development.

From 1 September 2011 to 30 June 2012, the Scheme received 3204 complaints that were within the scope of the Scheme to handle. The number of complaints per 1000 care recipients from 1 September 2011 to 30 June 2012 was 19.3 nationally (figure 13.29).
Of the complaints dealt with by the Scheme, 93.1 per cent related to residential care services and 6.9 related to community/flexible care services (CACP, EACH and EACHD) (DoHA unpublished).

In the period 1 September 2011 to 30 June 2012, 65.3 per cent of complaints were resolved through early resolution and 34.7 per cent progressed to resolution, utilising the range of techniques available to Scheme officers including approved provider resolution, conciliation, and investigation (DoHA unpublished). Of those complaints that progressed to resolution, 99.2 per cent were resolved without the need for a direction to the approved provider (figure 13.30).

Data relating to the previous Complaints Investigation Scheme are in table 13A.96.
‘Compliance with service standards for community care’ is an indicator of governments’ objective to ensure that community aged care programs provide a high quality of service (box 13.18). On 1 March 2011, across Australia, new Community Care Common Standards came into effect and apply to the HACC program (replacing the HACC program National Service Standards), CACP, EACH, EACHD and NRCP. Data for 2011-12 are the first year for which the new Community Care Common Standards applied across the full reporting year.
Compliance with service standards for community care

'Compliance with service standards for community care’ is defined as the proportion of community aged care services which received ratings for:

- Outcome 1 — effective process and systems in place
- Outcome 2 — some concerns about effectiveness of processes and systems in place
- Outcome 3 — significant concerns about effectiveness of processes and systems in place.

The number of reviews against program standards for community aged care services that were completed is also provided for information. Data are reported for the CACP, EACH, EACH-D and NRCP programs combined and separately for the HACC program. HACC review numbers and outcomes are reported separately as they may be undertaken at a different organisational level to the other programs.

A high or increasing proportion of community aged care services reviewed and a high or increasing proportion reviewed who achieved an outcome 1 (effective processes and systems in place) are desirable.

The indicator monitors the extent to which agencies are being reviewed over a three year cycle by identifying what proportion of services targeted for review have been reviewed in a particular year. This indicator also measures the proportion of individual agencies that comply with the service standards, through the outcomes of service standard appraisals. It should be noted that a review against the standards is not an accreditation process.

Data reported for this indicator are comparable across states and territories, but not comparable with results for previous years due to the introduction of the New Community Care Common Standards from 1 March 2011.

Data quality information for this indicator is under development.

Nationally, a total of 361 reviews of HACC services were completed in 2011-12 (table 13.10). Outcome 1 — effective processes and systems in place — was achieved in 72.9 per cent of these reviews (table 13.10).
Table 13.10  **Compliance with service standards for HACC, 2011-12**

<table>
<thead>
<tr>
<th></th>
<th>NSW</th>
<th>Vic&lt;sup&gt;a&lt;/sup&gt;</th>
<th>Qld</th>
<th>WA</th>
<th>SA</th>
<th>Tas</th>
<th>ACT</th>
<th>NT&lt;sup&gt;a&lt;/sup&gt;</th>
<th>Aust</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Number of reviews completed (no.)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>105</td>
<td>.</td>
<td>111</td>
<td>49</td>
<td>45</td>
<td>19</td>
<td>32</td>
<td></td>
<td>361</td>
</tr>
<tr>
<td><strong>Proportion of reviews achieving relevant outcomes (%)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outcome 1&lt;sup&gt;b&lt;/sup&gt;</td>
<td>67.6</td>
<td>.</td>
<td>97.3</td>
<td>57.1</td>
<td>64.4</td>
<td>63.2</td>
<td>46.9</td>
<td>.</td>
<td>72.9</td>
</tr>
<tr>
<td>Outcome 2&lt;sup&gt;c&lt;/sup&gt;</td>
<td>22.9</td>
<td>.</td>
<td>0.9</td>
<td>22.4</td>
<td>28.9</td>
<td>36.8</td>
<td>34.4</td>
<td>.</td>
<td>18.6</td>
</tr>
<tr>
<td>Outcome 3&lt;sup&gt;d&lt;/sup&gt;</td>
<td>9.5</td>
<td>.</td>
<td>1.8</td>
<td>20.4</td>
<td>6.7</td>
<td>–</td>
<td>18.8</td>
<td>.</td>
<td>8.6</td>
</tr>
</tbody>
</table>

<sup>a</sup> Victoria began implementing the Community Care Common Standards for HACC funded organisations in 2011-12. Pilot reviews only have been conducted. Reviews will commence early in 2012-13 and be completed by June 2014. The NT has not yet conducted any reviews. <sup>b</sup> Outcome 1 — effective processes and systems in place. <sup>c</sup> Outcome 2 — some concerns about effectiveness of processes and systems in place. <sup>d</sup> Outcome 3 — significant concerns about effectiveness of processes and systems in place. .. Not applicable. – Nil or rounded to zero.

*Source: DoHA (unpublished); tables 13A.99.*

Nationally, a total of 374 reviews of community aged care organisations providing CACP, EACH, EACH-D and NRCP services were completed in 2011-12 (table 13.11). Outcome 1 — effective processes and systems in place — was achieved in 73.3 per cent of these reviews (table 13.11).

Table 13.11  **Compliance with service standards for Community Aged Care Services — CACP, EACH, EACH-D and NRCP, 2011-12**

<table>
<thead>
<tr>
<th></th>
<th>NSW</th>
<th>Vic</th>
<th>Qld</th>
<th>WA</th>
<th>SA</th>
<th>Tas</th>
<th>ACT</th>
<th>NT</th>
<th>Aust</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Number of reviews completed (no.)</strong></td>
<td></td>
<td>76</td>
<td>88</td>
<td>106</td>
<td>41</td>
<td>24</td>
<td>13</td>
<td>9</td>
<td>17</td>
</tr>
<tr>
<td><strong>Proportion of reviews achieving relevant outcomes (%)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outcome 1&lt;sup&gt;a&lt;/sup&gt;</td>
<td>73.7</td>
<td>92.0</td>
<td>67.9</td>
<td>68.3</td>
<td>79.2</td>
<td>53.8</td>
<td>44.4</td>
<td>41.2</td>
<td>73.3</td>
</tr>
<tr>
<td>Outcome 2&lt;sup&gt;b&lt;/sup&gt;</td>
<td>7.9</td>
<td>5.7</td>
<td>17.0</td>
<td>24.4</td>
<td>20.8</td>
<td>46.2</td>
<td>22.2</td>
<td>47.1</td>
<td>16.0</td>
</tr>
<tr>
<td>Outcome 3&lt;sup&gt;c&lt;/sup&gt;</td>
<td>18.4</td>
<td>2.3</td>
<td>15.1</td>
<td>7.3</td>
<td>–</td>
<td>–</td>
<td>33.3</td>
<td>11.8</td>
<td>10.7</td>
</tr>
</tbody>
</table>

<sup>a</sup> Outcome 1 — effective processes and systems in place. <sup>b</sup> Outcome 2 — some concerns about effectiveness of processes and systems in place. <sup>c</sup> Outcome 3 — significant concerns about effectiveness of processes and systems in place. – Nil or rounded to zero.

*Source: DoHA (unpublished); tables 13A.97-98.*

**Client appraisal of service standards**

‘Client appraisal of service standards’ is an indicator of governments’ objective to ensure high levels of client satisfaction with aged care services (box 13.19).
Client appraisal of service standards

'Client appraisal of service standards' is yet to be defined. Data for this indicator were not available for the 2013 Report.

Efficiency — inputs per output unit

Cost per output unit

'Cost per output unit' is an indicator of governments’ objective to deliver efficient aged care services (box 13.20).

Cost per output unit

'Cost per output unit' is defined by two measures:

- cost per ACAT assessment — Australian Government expenditure on ACATs divided by the number of ACAT assessments completed
- cost per hour of service for HACC — State and Territory governments expenditure on services (some of this expenditure is funded by the Australian Government), divided by the number of hours of service provided (by service type domestic assistance, personal care, nursing and allied health service).

This is a proxy indicator of efficiency and needs to be interpreted with care. While high or increasing expenditure per assessment or hour of service 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 or hour of service may reflect improving efficiency or less time spent with clients, for example.

Cost per ACAT assessment and cost per hour of HACC service have been developed as proxies. For cost per ACAT assessment, only Australian Government expenditure is included, although State and Territory governments also contribute to the cost of ACAT assessments. Similarly only State and Territory governments’ expenditure on HACC services is included and expenditure funded by non-government sources is excluded.

Data reported for this indicator are not directly comparable.

Data quality information for this indicator is under development.

Australian Government expenditure per aged care assessment during 2010-11 averaged $388 nationally (figure 13.31). The cost per assessment is calculated using the total number of assessments and therefore includes clients aged 64 years or under.
State and Territory governments’ expenditure per hour of HACC service during 2010-11 was higher for nursing and allied health than for domestic assistance and personal care across the states and territories for which data are available (figure 13.32). These results are for HACC services to younger and older clients as they relate to the arrangements for HACC before the changes to roles and responsibilities on 1 July 2011 (see box 13.1).
‘Expenditure per head of aged care target population’ is an indicator of governments’ objective to deliver efficient aged care services (box 13.21).

Box 13.21  Expenditure per head of aged care target population

‘Expenditure per head of aged care target population’ is defined as government inputs (expenditure) divided by the number of people aged 65 years or over and Indigenous Australians aged 50–64 years. Expenditure per person in the aged care target population is reported for residential care, selected community aged care programs (CACP, EACH and EACH-D) and multi-purpose and Indigenous specific services combined and reported separately for the three main service types: residential care services, HACC and CACP services.

(Continued next page)
Box 13.21  (continued)

This is a proxy indicator of efficiency and needs to be interpreted with care as it measures cost per target population, not cost per unit of service. While high or increasing expenditure per person can reflect deteriorating efficiency, it can 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 can reflect improving efficiency or a decrease in service standards.

Data reported for this indicator are comparable.

Data quality information for this indicator is under development.

Australian Government real expenditure on residential care, selected community care programs (CACP, EACH, EACH-D), and on multipurpose and Indigenous specific services combined per person aged 65 years or over and Indigenous Australians aged 50–64 years was $2922 nationally in 2011-12 (figure 13.33).

Figure 13.33  Australian Government (DoHA and DVA) real expenditure on selected programs, per person in the aged care target population, 2011-12\(^a\),\(^b\)

\begin{figure}
\centering
\includegraphics[width=\textwidth]{chart.png}
\caption{Australian Government (DoHA and DVA) real expenditure on selected programs, per person in the aged care target population, 2011-12\(^a\),\(^b\)}
\end{figure}

\(^a\) Population data are from population projections by SLA for 2007–2027 based on the 2006 Census prepared by the ABS for DoHA according to assumptions agreed by DoHA. See footnotes to table 13A.2 for more information.

\(^b\) Results exclude State and Territory governments funding of younger people with disability (people aged under 65 years and Indigenous aged under 50 years) in residential and community aged care.

Source: DoHA (unpublished); tables 13A.8–10.
Nationally, Australian Government real expenditure by both DoHA and DVA on residential care services per person aged 65 years or over and Indigenous Australians aged 50–64 years was $2566 in 2011-12 (figure 13.34). If the payroll tax supplement paid by the Australian Government is excluded, this expenditure nationally was $2522 in 2011-12 (table 13A.102).

Nationally, DoHA expenditure on residential care per person aged 65 years or over and Indigenous Australians aged 50–64 years in 2011-12 was $2168 including the payroll tax supplement and $2131 excluding the payroll tax supplement (table 13A.8). DVA expenditure on residential care per person aged 65 years or over was $405 including the payroll tax supplement and $398 excluding the payroll tax supplement in 2011-12 (table 13A.14).

Figure 13.34 Australian Government (DoHA and DVA) real expenditure on residential services per person in the aged care target population, 2011-12a, b, c

---

a Includes a payroll tax supplement provided by the Australian Government. Actual payroll tax paid may differ.

b Population data are from population projections by SLA for 2007–2027 based on the 2006 Census prepared by the ABS for DoHA according to assumptions agreed by DoHA. See footnotes to table 13A.2 for more information.

c Results exclude State and Territory governments’ funding for younger people with disability (people aged 64 years or under and Indigenous aged 49 years or under) in residential aged care (see tables 13A.5 and 13A.8 for details).

Source: DoHA (unpublished); DVA (unpublished); table 13A.102.

Australian Government expenditure on CACPs per person aged 65 years or over and Indigenous Australians aged 50–64 years was similar in most jurisdictions except the NT. Nationally, expenditure per person aged 65 years or over and Indigenous Australians aged 50–64 years was $166 in 2011-12 (figure 13.35).
Australian, Victorian and WA governments’ real expenditure on HACC services per person aged 65 years or over and Indigenous Australians aged 50–64 years was $487 nationally in 2011-12 (figure 13.36). These data reflect expenditure against the aged care target population (see section 13.1), which is not the same as the HACC target population for older people. Expenditure per person in the HACC target population for older people is reported in table 13A.103. Total HACC program expenditure per person in the total HACC target population (including younger people with disability) is also reported for Victoria and WA in table 13A.103.
Figure 13.36 Australian, Victorian and WA governments’ real expenditure on HACC services per person in the aged care target population, 2011-12\textsuperscript{a, b, c, d}

\begin{figure}[h]
\centering
\includegraphics[width=\textwidth]{figure13.36.png}
\caption{Australian, Victorian and WA governments’ real expenditure on HACC services per person in the aged care target population, 2011-12\textsuperscript{a, b, c, d}}
\end{figure}

\textsuperscript{a} Expenditure per person in the HACC older target population (people aged 65 years or over and Indigenous Australians aged 50-64 years) and for the total HACC target population in Victoria and WA is contained in table 13A.103. HACC target population (older and total, for Victoria and WA) data are in table 13A.60.\textsuperscript{b} These data represent expenditure on those aged 65 years or over and Indigenous Australians aged 50–64 years. Total program expenditure data for Victoria and WA are in table 13A.5.\textsuperscript{c} Reports provisional HACC data that have not been validated and may be subject to revision.\textsuperscript{d} Population data are from population projections by SLA for 2007–2027 based on the 2006 Census prepared by the ABS for DoHA according to assumptions agreed by DoHA. See footnotes to table 13A.2 for more information.

\textit{Source:} DoHA (unpublished); table 13A.104.

\section*{Outcomes}

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

\subsection*{Social participation in the community}

‘Social participation in the community’ has been identified for development as an indicator of governments’ objective to encourage the wellbeing and independence of older people (box 13.22).
Box 13.22 **Social participation in the community**

‘Social participation in the community’ is yet to be defined.

High or increasing rates of participation in the community are desirable.

When developed for future reports, this indicator will show the extent to which older people participated in community, cultural or leisure activities.

---

**Maintenance of individual physical function**

‘Maintenance of individual physical function’ is an indicator of governments’ objective for aged care services to promote the health, wellbeing and independence of older people (box 13.23).

Box 13.23 **Maintenance of individual physical function**

‘Maintenance of individual physical function’ is defined as the improvement in the TCP client’s level of physical function, reflected in the difference between the average Modified Barthel Index (MBI) score on entry to the TCP to the average MBI score on exit from the TCP. The minimum MBI score is 0 (fully dependent) and the maximum score is 100 (fully independent).

This indicator needs to be interpreted with care. The TCP is one aged care program where it is possible to measure a change in a client’s level of physical function. Variation in the average MBI scores on entry and exit from the program may reflect a range of target client groups for the program across jurisdictions. An increase in the score from entry to exit is desirable.

The TCP is a small program at the interface of the health and aged care systems. It may be possible to develop measures for other aged care programs such as residential aged care and community aged care services which would be indicators of maintenance of individual physical function.

Data reported for this indicator are comparable.


The average MBI score on entry to the TCP in 2011-12 was 72.4 nationally. The average MBI score on exit from the TCP was 82.9 nationally (figure 13.37). This was an average increase in the score of 10.5 nationally.
Figure 13.37  Transition Care Program — average Modified Barthel Index score on entry and exit, 2011-12\textsuperscript{a, b}

\begin{figure}[h]
\centering
\includegraphics[width=\textwidth]{figure13_37}
\caption*{MBI = Modified Barthel Index. \textsuperscript{a} The MBI is a measure of functioning in the activities of daily living, ranging from 0 (fully dependent) to 100 (fully independent). Data are reported for TCP recipients who completed a transition care episode. \textsuperscript{b} Different health and aged care service systems, local operating procedures and client groups can affect the outcomes of the Transition Care Program across jurisdictions.}
\end{figure}

Source: DoHA (unpublished); table 13A.106.

\textit{Hospital leave days for preventable causes}

‘Hospital leave days for preventable causes’ has been identified for development as an indicator of governments’ objective to provide high quality and safe residential aged care services (box 13.24).

\begin{stripbox}
\textbf{Box 13.24  Hospital leave days for preventable causes}

‘Hospital leave days for preventable causes’ is yet to be defined.

Low or decreasing proportions of residential aged care days on hospital leave due to selected preventable causes are desirable.

When developed for future reports, this indicator will show the proportion of residential aged care days that are taken as hospital leave for selected preventable causes.
\end{stripbox}
Enabling people with care needs to live in the community

‘Enabling people with care needs to live in the community’ has been identified for development as an indicator of governments’ objective to delay entry to residential care when a person care needs can be met in the community (box 13.25).

Box 13.25  Enabling people with care needs to live in the community

‘Enabling people with care needs to live in the community’ is yet to be defined.
High or increasing rates of people with care needs remaining and participating in the community are desirable.
When developed for future reports, this indicator will show the extent to which older people’s entry to residential care is delayed.

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 available. Priorities for the future include:

- continued improvement of efficiency indicators
- improved reporting of elapsed times for aged care
- improved reporting of hospital patient days used by aged care type patients
- inclusion of data on hospital leave days for preventable causes as they become available
- further development of outcome indicators.

13.5  Jurisdictions’ comments

This section provides comments from each jurisdiction on the services covered in this chapter.
Australian Government comments

On 20 April 2012 the Government announced a comprehensive 10 year package to reshape aged care. The Living Longer Living Better aged care reform package provides $3.7 billion over five years. It encompasses a 10 year reform program to create a flexible and seamless system that provides older Australians with more choice, control and easier access to a full range of services, where they want it and when they need it.

Under the reforms, the Australian Government is expanding and improving the support and care options available for older people who want to stay in their own homes, committing $880.1 million over the next five years to expand care in the home, reducing the emphasis on residential care. From 1 July 2012, the Australian Government is directly funding and administering home support services for older people previously provided under the Home and Community Care (HACC) Program (except in Victoria and WA where joint funding arrangements continue). The Government will also more than double the number of Home Care packages available across Australia over the next 10 years — more than 80 000 new packages by 2021-22.

The reforms will also strengthen residential aged care by encouraging greater investment, strengthening the sustainability of the sector, and providing consumers with more choice and greater protections. Increasing the incentives for investment in aged care is vital to ensure there is sufficient supply of aged care services to meet the needs of an ageing population, so that older Australians who are no longer able to stay in their own home can access affordable and timely residential care. While the reform package has a strong emphasis on the expansion of home care, in line with the expectations and wishes of older Australians, the residential aged care sector will also significantly increase over the next 10 years — providing more than 65 200 new residential places by 2021-22, on top of the 191 500 residential places currently available.

Importantly, the reforms also ensure Australia’s aged care system is underpinned by fairer and more sustainable financing arrangements. These arrangements reflect a shared commitment to meeting the costs of aged care, protect the most vulnerable in the community and do not involve any changes to the current treatment of the family home. These reforms support the financial viability of the aged care system into the future, and ensure that older Australians will continue to be able to access the care that they need, when they need it.

These very significant improvements to care provision and financing are integrated with a large range of other measures under the package which support and safeguard older Australians and their carers. These include better access to information, strengthened quality assurance arrangements, expanded advocacy services and additional support for people with dementia and those from diverse backgrounds.
New South Wales Government comments

In 2011-12 the NSW Home and Community Care (HACC) Program had a budget of $675.9 million, which included NSW’s contribution of $216 million. From 1 July 2011 the NSW and the Australian Governments have separate funding responsibilities for basic community care services for younger people with a disability and frail older people, respectively, in accordance with the National Partnership Agreement on Transitioning Responsibilities for Aged Care and Disability Services (2011).

The Program provided services to over 270,000 people across NSW. Over 18 million units of service outputs were delivered in this year, including hours of service, transport trips and meals. The services receiving most investment were domestic assistance, personal care, respite, nursing care and transport provided by over 600 government and non-government organisations.

The 2010-15 Dementia Services Framework, a commitment between ADHC and NSW Ministry of Health to improve the experiences of people with dementia and their carers, remained a key focus for the older cohort in the HACC Program. Growth funding of $3.4 million was given to 65 dementia specific programs, such as dementia advisory services, dementia focused centre based day care and dementia monitoring services. Additionally, $1.4 million of non-recurrent funding was invested in related research and development activities.

While anticipating the Commonwealth assuming full funding and policy responsibility for aged care from 1 July 2014, NSW Health is maintaining ACAT service delivery through to 30 June 2014 under a 2-year transition arrangement.

Under the COAG National Health Reform Agreement, NSW Health has implemented new organisational arrangements including a streamlined central Ministry for Health, 16 Local Health Districts and four key Pillars responsible for key support functions. It is also working collaboratively with the Commonwealth on effective implementation of aged care reform under the Living Long Living Better strategy released in April 2012.

As part of the NSW Government’s Ageing Strategy, a whole of government response to the challenges of an ageing population, NSW Health is actively pursuing the strategic goal of keeping people healthy and out of hospital.

As Approved Provider, NSW Health has operationalised all 1378 Transition Care places allocated to NSW. There are 51 Transition Care services across NSW providing 161 (12 per cent) residential places and 1217 (88 per cent) community places. NSW has been leading the way nationally in providing Transition Care to Indigenous Australians in 2011-12 with 38 of 138 discharges nationally.

NSW Health continues to address issue of long stay older patients (LSOP) in its public hospitals. Initiatives such as Aged Care Services in Emergency Teams (ASETs) and Acute to Aged Related Care Services (AARCS) have contributed to significant reductions in NSW in the numbers of LSOP demonstrated in the 2011-12 national LSOP census. Efforts continue to ensure services are responsive to the changing needs of older people across the continuum of care.
Victorian Government comments

In 2011–12, Victoria strengthened its work in promoting the health, wellbeing and participation of older people. This year it has become one of just two jurisdictions continuing to jointly manage the HACC program with the Commonwealth. In that context Victoria is working closely with the Commonwealth as it implements its aged care program changes announced in the Living Longer Living Better package this year.

The HACC program continues to be strengthened through ongoing development including of the HACC Assessment Framework, which is delivering quality, consistent living at home assessments as the cornerstone of the HACC active service model. HACC Assessment services work in partnership with key agencies such as community health and Aged Care Assessment Services (ACAS) to provide a streamlined, coordinated approach to assessment and care planning.

Victoria has also indicated that it proposes to continue management of ACAS and has continued to strengthen that program. Victoria completed the roll-out of the Victorian Comprehensive Assessment Form (VCAF) — the first electronic aged care assessment form in Australia, which is designed to promote greater consistency in recording assessments across the State. Victoria has also developed an ACAS Locum Bank. This centralised pool of qualified, trained assessors is designed to minimise assessment waiting times by providing temporary backfill during periods of unplanned leave and gaps in recruitment.

Wound Care has been a focus across Victoria’s aged care programs in community and residential settings. A key project has focused on targeted strategies to support more consistent and quality wound care practice with nursing staff in high care public sector aged care facilities, district nursing services and bush nursing centres.

This is an example of the sort of structured, deliberate links between health and aged care that aids the effectiveness of the aged care system and the care delivered to older people.

Other programs commenced or further developed this year to assist older people include; support for increased participation and access to services for older Victorians from culturally and linguistically diverse backgrounds, additional resources for palliative care, delivery of spectacles to disadvantaged Victorians and outreach eye care services to residents of Supported Residential Services and public sector residential aged care facilities. Additional resources were also provided to assist people with dementia, providing access to early diagnosis for people concerned by cognitive loss, supporting younger people with dementia and their families and carers to live well at home for as long as possible and improving public sector residential aged care environments to provide better care for people with dementia.
Queensland Government comments

The Queensland Government commenced the development of a new Senior’s Strategy in 2012, to provide a whole-of-Government framework identifying priority areas and actions to address the needs of older people, including mature age employment, recognition of seniors and health.

In October 2011, the Queensland Carer Action Plan 2011–2014 was launched. The Plan focuses on meeting the varying needs of carers through the priority areas: recognition and respect for carers; support for carers; and participation of carers. The Plan will be revised in 2012-13.

In 2011-12, the Queensland Government assisted the service delivery sector to make the operational transition from the previous Home and Community Care (HACC) Program as part of the transitioning of responsibilities for aged care and disability services commencing 1 July 2012. This included consultation with organisations to determine the appropriate funding split between the aged and disability cohorts, the preparation of new Service Agreements, the provision of funding to all HACC organisations to cover costs associated with the transition, and an information and communication management program. These activities facilitated a smooth transition for service providers. New agreements commenced 1 July 2012 to ensure the continued delivery of services to existing clients in both age groups. The opportunity was also taken to increase the flexibility of service delivery and further align and simplify reporting requirements for funded organisations.

To improve access to HACC services, the Queensland Government continued to fund the Community Care Access Point in the Central and Wide Bay regions. In 2011–12, 2028 calls were received with 891 people referred to HACC service providers.

In August 2011, a two-day Aboriginal and Torres Strait Islander statewide gathering was held in Cairns. The event attracted almost 160 Aboriginal and Torres Strait Islander delegates, including 89 specialist Aboriginal and Torres Strait Islander service providers as well as peak bodies, consumer and government representatives. The gathering enabled participants to identify key issues and share ways to continue improving service delivery and planning strategies including improving access to services for people living in remote communities.

In 2011-12, the Queensland Government continued to investigate the use of smart assistive technologies to enhance the safety and independence of HACC clients by funding research into methods of incorporating smart assistive technologies into service delivery models. Trials of various technologies have resulted in positive outcomes for clients, including reduced need for formal assistance to live independently and improved social connectedness.
Western Australian Government comments

In December 2011, a Western Australian Dementia Working Group (WADWG) was established to focus on:

- Recommendations from the WA Dementia Model of Care
- Alignment with the Australian Health Minister’s Advisory Council’s (AHMAC) Dementia Working Group and a renewed National Framework for Action on Dementia.

The WADWG is providing expert advice and direction to inform the development and implementation of a project to identify and assess current dementia services and pathways in WA.

Work has also continued on consolidating and improving the range of subacute care services including two dedicated Geriatric Evaluation and Management Units at tertiary hospital sites and an additional secondary stroke rehabilitation unit in the metropolitan area.

The establishment of a State-wide Subacute Care Training and development Centre (TRACS) also marked an important milestone for the state. TRACS is the first of its kind in WA and will improve the quality of services provided to Western Australians in the areas of rehabilitation, geriatric evaluation and management and psycho-geriatric care by supporting staff who work in these areas.

Further expansion has continued in the areas of community based psycho-geriatric programs, Rehabilitation in the Home, Falls Specialists and additional in-patient rehabilitation beds in rural and metropolitan Perth.

Rollout of the Transition Care Program has been completed resulting in a total of 346 places available across the State, with 256 metropolitan residential care places and 90 community care places (35 metropolitan and 55 rural).

The National Transitional Care Program Quality Improvement Framework came into effect from 1 July 2012. WA has engaged an external consultant to review residential and community care Transition Care Services.

A metropolitan wide electronic Transition Care referral system has been implemented in all public hospitals resulting in a reduced workload for clinical staff associated with the previous paper based system.

With the consolidation of the Wellness Approach within Home and Community Care (HACC) service delivery and the continuing rollout of the WA Assessment Framework in the South West and the Kimberley, a formal partnership has been developed with the Aged Care Assessment Program. This partnership has resulted in the development and implementation of a professional development module for staff working in the Aged Care Assessment Teams to:

- ensure greater understanding and commitment to promoting client independence, and
- streamlining referral pathways and reducing duplication of assessment.
South Australian Government comments

In 2011-12, the Government of South Australia undertook a Machinery of Government change that transferred ageing policy to the Department for Health and Ageing whilst the disability sector was aligned to the Department for Communities and Social Inclusion (DCSI). DCSI continued to administer the Home and Community Care (HACC) Program in 2011-12 as this realignment better reflects administrative responsibilities resulting from the implementation of the HACC split from 1 July 2012.

In 2011-12, the South Australian HACC Annual Plan was developed which outlined funding priorities for HACC Real Growth Funding for people aged 65 years or over (Aboriginal 50 or over) and their carers. This included funding to ensure growth and sustainability of the Better Practice Project and additional funding to ensure all South Australian regions had access to a regional collaborative project officer able to promote their needs and priorities.

South Australia, in conjunction with the Commonwealth Department of Health and Ageing, finalised the process of transitioning the HACC program to the appropriate jurisdictions. The transition process involved consultations with all HACC service providers on funding levels and service outputs. By 30 June 2012 all service providers had agreed with both jurisdictions to enter into a service level agreement for three years.

DCSI released three significant reports that will assist the sector for future planning and development in HACC sector in South Australia. The Culturally and Linguistically Diverse (CALD) Emerging Needs Scoping Study focuses on emerging CALD groups who will require funding as their community ages whilst the CALD Meals Scoping Study examines trends and issues in developing culturally appropriate meals for CALD communities. The Carers Project Report was a comprehensive study of carers and explores ways to respond to the needs and choices of HACC eligible carers.

As part of the recent Machinery of Government changes in South Australia, from 1 January 2012 responsibility for ageing policy, including the Aged Care Assessment Program and the Adelaide Aged Care Assessment Teams (AACAT) transferred to the South Australian Department for Health and Ageing. The nine country ACATs were already auspiced by the Country Health SA Local Health Network (CHSALHN).

The expansion of A2HC across the metropolitan region is now consolidated; the client experience has been enhanced with improved linkages to appropriate services as well as improved referrer knowledge regarding access to the aged care sector. Current figures indicate around 30 per cent of current referrals for an ACAT assessment are actually linked to more appropriate services, typically the HACC Program.
Tasmanian Government comments

Demographic change is a major issue for Tasmania. The state’s population is ageing more rapidly than any other Australian jurisdiction and the median age is the highest in the nation. Over the next 20 years, the proportion of Tasmanians aged 65 years and over is projected to grow by 80 per cent, with the number aged 85 years and over doubling during that period. In line with these projections, it is anticipated that future demand for aged care services will increase at a significantly faster rate than planned increases in their supply.

Tasmania is also likely to have more people with dementia, per head of population, than any other state. In 2010, about 6000 Tasmanians had dementia. By 2030, it is anticipated that this will increase out to over 15 000. Over 2011-12, the Tasmanian Government strongly supported the designation of dementia as the 9th National Health Priority Area and advocated for a national strategic approach to the promotion and advancement of dementia care development across all states and territories.

It is inevitable that population ageing will continue to have a significant impact on hospitalisation rates in Tasmania. The rate of hospitalisation doubles between people aged 40 and 59 years and those aged 60-79 years, with a further rate increase (greater than 50 per cent) for persons aged 80 years and over. On average during 2011-12, Tasmania’s public hospitals had 30 long stay older patients each day with an average wait, after they had completed their treatment, of 16 days until discharge.

With increasing demand, it is important that avoidable hospitalisations and long-stays by older people are minimised and well managed. Tasmania has continued to make a considerable investment in 2011-12, with both the jointly-funded Transition Care and the Long Stay Older Patients programs, successfully diverting older people away from, or reducing their stay, in hospital care. Tasmania’s hospitals have also continued to utilise strategies, such as the purchase of temporary beds in private aged care facilities, to facilitate the transition for older people from hospital to home or into residential care.

While, during 2011-12, the Australian Government continued its progress towards assuming full funding and management responsibility for the provision of aged care services to people over 65 years of age, the Tasmanian Government retains a strong interest in the planning and provision of those services and their impact on those parts of the broader health and human services system for which it retains whole or partial responsibility.

There will continue to be a degree of complexity at the interface between aged care and health services for older people and their families. The Australian Government’s Living Longer Living Better package is a welcome initiative in its plan to widen care choices for older people and expand aged care services capacity. In supporting those directions, the Tasmanian Government will continue to focus on better connecting its health and hospital care services for older people and simplifying pathways through aged and health care services and across settings.
Australian Capital Territory Government comments

- The current ACT Ministerial Advisory Council on Ageing was appointed February 2012 to provide strategic advice to the Minister for Ageing on issues affecting older citizens in the ACT. The Council has had a key role in developing the ACT Strategic Plan for Positive Ageing 2010-14: Towards an Age-Friendly City and continues to provide advice on its implementation. The Plan provides a blueprint for a coordinated approach across ACT Government and the Community to support positive ageing and an age-friendly city where older people are respected, valued and supported to actively participate.

- **Breaking Down the Wall: Barriers to Social Inclusion Amongst Older Australians;** was a 12-month research project which explored the key factors preventing social and community participation by older people living in Inner North of Canberra. The results focused on social outings through ‘out and about’ activities and showed that the frequency and popularity of outings increased by 50 per cent.

- The Falls Injury Prevention Service is a multidisciplinary team which assesses people aged 65 and over or 55 and over for Aboriginal and Torres Strait Islander People for a range of fall risk factors. The Service also ran a 7 week evidence based program ‘Stepping On’ aimed at people aged 70 years and over living independently in the community. Topics covered were balance and strengthening exercises, environmental hazards, vision and eye care, medication management, nutrition and bone health, foot care and footwear.

- The GP Aged Day Service (GPADS) provides an in-hours locum service to support people who are homebound or in residential aged care facilities when their GP is unable to make house calls. GPADS is operated by the ACT Medicare Local under a Service Funding Agreement with the Health Directorate.

- MoUs have been established with 58 general practices. The service is successfully meeting a significant need in the community and has received excellent feedback from patients, carers, families and GPs.

- The Residential Aged Care Liaison Nurse (RACLN) continues to support timely discharge from Canberra Hospital and Health Services for public and private patients requiring residential care placement and the Rapid Assessment of the Deteriorating Aged at Risk (RADAR) program continues to provide short term assessment and management services to elderly clients living in the community or in a residential aged care facility.
**Northern Territory Government comments**

In accordance with the National Partnership Agreement on Transitioning Aged Care and Disability Services significant activity occurred throughout 2011-12 to prepare for the transition of the Home and Community Care Program (HACC). The NT worked collaboratively with the Australian Government to transition the HACC Program to ensure minimal impact on service providers and clients. On 1 July 2012, the Australian Government assumed funding and administration responsibility for people 65 years of age and over, and Indigenous people 50 years and over.

The NT continued to provide comprehensive aged care assessments, under the final year of the Aged Care Assessment Program (ACAP) Implementation Plan. The NT has both urban and remote Aged Care Assessment Teams (ACAT). Urban ACAT conduct the majority of assessments within the major towns and cities of the NT. The remote ACAT operate in smaller towns and deliver outreach services to remote and very remote Indigenous communities across the NT. The ACAP is planned to transition to the Australian Government as part of aged care reforms by 30 June 2014.

The Transition Care Program (TCP) is a jointly funded Australian and Northern Territory Government program. There are 29 allocated places under the TCP of which 19 are community based places and 10 residential based. The allocation of community and residential places was reviewed and varied in 2011-12 to improve the usage of the TCP in the NT. In 2011-12, three were 105 admissions to TCP across the Northern Territory with 98 resulting in successful discharge; 34 from residential care settings and 64 from the community.

The NT population and geographic profile is unique when compared with other parts of Australia. The population of people aged 65 years and over comprise approximately 5.4 per cent of the NT population in comparison to 12.2 per cent of the Australian average. The NT also has a large geographic region with very remote communities that deliver aged care services. The NT is committed as part of the transition of aged care services to the Australian Government to conduct appropriate planning that recognises unique factors impacting service delivery in the NT.

As in previous years, indicators based on the estimated number of people with severe, profound and/or core activity limitations in the NT need to be interpreted with caution. Small variations in service and population data appears in magnified proportions to the small population of the NT.
### 13.6 Definitions of key terms

<table>
<thead>
<tr>
<th>Term</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Adjusted subsidy reduction supplement</strong></td>
<td>An adjusted subsidy reduction supplement is a payment made by State governments to some public sector residential care operators to offset the effect of the Australian Government's adjusted subsidy reduction. The adjusted subsidy reduction reduces the daily rate of Residential Care Subsidy paid by the Australian Government in respect of certain residential aged care places owned by State governments or State public sector organisations. The rate of the reduction is determined by the relevant Commonwealth Minister from 1 July each year, in accordance with section 44-19 of the <em>Aged Care Act 1997</em>.</td>
</tr>
<tr>
<td><strong>Accreditation</strong></td>
<td>Accreditation is a key component of the Australian Government’s quality framework for federally funded residential aged care and is a quality assurance system for residential aged care services — based on the principle of continuous improvement. Accreditation requires assessment against the 44 expected outcomes used for accreditation assessment — grouped into four standards: management systems, staffing and organisational development; health and personal care; residential lifestyle; and physical environment and safety systems.</td>
</tr>
<tr>
<td><strong>Aged care</strong></td>
<td>Formal services funded and/or provided by governments that respond to the functional and social needs of older people, and the needs of their carers. Community aged care services aim to optimise independence and to assist 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. Assessment of care needs is an important component of aged care. 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. Other services aim to promote social participation and connectedness. These services are delivered by trained aged care workers and volunteers. However, aged care services may also be delivered by health professionals such as nurses and occupational therapists. Aged care services generally aim to promote wellbeing and foster function rather than to treat illness. Although some aged care services such as transition care have a specific restorative role, they are distinguished from the health services described in Part E of this Report. 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.</td>
</tr>
<tr>
<td><strong>Aged care target population</strong></td>
<td>The Aged care target population is defined as people aged 65 years or over and Indigenous Australians aged 50–64 years. This is the population specified in the <em>National Health Reform Agreement</em> who are within the scope of, and funded for services under, the national aged care system (except in Victoria and WA).</td>
</tr>
<tr>
<td><strong>Aged care planning population</strong></td>
<td>The Aged care planning population is defined as people aged 70 years or over. This is the population used by the Australian Government for its needs-based planning framework to ensure sufficient supply of both low-level and high-level residential and community care places by matching the growth in the number of aged care places with growth in the aged population. It also seeks to</td>
</tr>
</tbody>
</table>
ensure balance in the provision of services between metropolitan, regional, rural and remote areas, as well as between people needing differing levels of care (DoHA 2012).

Under the framework, the Australian Government seeks to achieve and maintain a specified national provision level of subsidised operational aged care places for every 1000 people aged 70 years or over. This provision level is known as the aged care provision ratio (DoHA 2012).

**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](http://www.agedcare.gov.au)), 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.

**Care leaver**

A care leaver is a person who was in institutional care (such as an orphanage or mental health facility) or other form of out-of-home care, including foster care, as a child or youth (or both) at some time during their lifetime (DoHA 2012).

**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 of the Department of Health and Ageing about anything that:

- may be a breach of the relevant approved provider’s responsibilities under the [Aged Care Act 1997](http://www.agedcare.gov.au) 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.

**HACC target population (all people and older people)**

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 older and frail people with moderate, severe or profound disabilities and younger people with moderate, severe or profound disabilities. The [HACC target population for all people](http://www.agedcare.gov.au) (Victoria and WA only) is estimated by applying the 2009 national age- and sex- specific rates of profound, severe or moderate disability for people in households.
(from the Survey of Disability Ageing and Carers) to the age and sex structure of each jurisdiction in the current year, to give an ‘expected current estimate’ of people with a profound, severe or moderate disability in the community in that jurisdiction.

The HACC target population for older people (all jurisdictions) is derived using a similar method, but it is restricted to the older age groups (that is, all people aged 65 years or over and Indigenous Australians aged 50–64 years). For Indigenous Australians aged 50–64 years, the disability rates for all people aged 50–64 years are first increased by an additional Indigenous factor and then applied to the Indigenous population in this age group.

On entry, a resident is classified as high or low care based on their ACAT assessment and their approved provider's appraisal of their care needs under the ACFI.

Residents whose ACAT approval is not limited to low care are classified as high care if they have an ACFI appraisal of:

- high in Activities of Daily Living, or
- high in Complex Health Care, or
- high in Behaviour, together with low or medium in at least one of the Activities of Daily Living or Complex Health Care domain, or
- medium in at least two of the three domains.

All other ACAT approval and ACFI appraisal combinations result in a classification of low level care.

A resident's care needs may change over time resulting in a change in classification from low to high level care (ageing in place).

A short term alternative for usual care.

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.

Where a person does not need assistance, but has difficulty with self-care, mobility or communication.

Where a person is unable to perform self-care, mobility and/or communication tasks, or always needs assistance.

Where a person sometimes needs assistance with self-care, mobility or communication.

Assistance in undertaking personal tasks (for example, bathing).

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).

Actual expenditure adjusted for changes in prices, using the GDP(E) price deflator and expressed in terms of final year prices.

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.

Alternative care arrangements for dependent people living in the community, with the primary purpose of giving a carer or a care recipient a short term break from their usual care arrangement.

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.

Section 11-3 of the Aged Care Act 1997, specifies the following
groups
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, people who are homeless or at risk of becoming homeless, and care leavers as special needs groups.

Veterans

Waiting times
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.
13.7 List of attachment tables

Attachment tables are identified in references throughout this chapter by a ‘13A’ prefix (for example, table 13A.1). Attachment tables are available on the Review website (www.pc.gov.au/gsp).

**Table 13A.1**  Older people as a share of the total population, by gender, June 2012
**Table 13A.2**  Target population data, by location (‘000)
**Table 13A.3**  Proportion of all people who are older, by region, June 2012
**Table 13A.4**  People receiving aged care services, 2011-12
**Table 13A.5**  Government expenditure on aged care services, 2011-12 ($ million)
**Table 13A.6**  Government real expenditure on aged care services, by program type (2011-12$)
**Table 13A.7**  Australian Government (DOHA) real expenditure on assessment and information services (2011-12$)
**Table 13A.8**  Government real expenditure on residential aged care services (2011-12$)
**Table 13A.9**  Government real expenditure on community care services (2011-12$)
**Table 13A.10**  Government real expenditure on aged care services provided in mixed delivery settings (2011-12$)
**Table 13A.11**  Australian, State and Territory governments' other aged care related expenditure not included in Aged care services estimates 2011-12 ($ million)
**Table 13A.12**  Real capital expenditure on aged care services (2011-12 $million)
**Table 13A.13**  Australian Government (DVA) Veterans' Home Care (VHC) and Community Nursing programs, 2011-12
**Table 13A.14**  Australian Government (Department of Veterans' Affairs) residential aged care clients
**Table 13A.15**  Australian Government Activity Measures on selected Aged Care Programs
**Table 13A.16**  Ownership of operational aged care residential places
**Table 13A.17**  Average annual Australian Government basic subsidy amount, including Conditional adjustment payment, per occupied place and the dependency level of aged care residents
**Table 13A.18**  Size and distribution of all residential aged care services
**Table 13A.19**  Size and distribution of residential aged care services with over 80 per cent high care residents
**Table 13A.20**  Size and distribution of residential aged care services with over 80 per cent low care residents
**Table 13A.21**  Size and distribution of mixed residential aged care services with less than 80 per cent high care residents and more than 20 per cent low care residents
**Table 13A.22**  Proportion of residential aged care places, by location in high care, low care and mixed care services
<table>
<thead>
<tr>
<th>Table 13A.23</th>
<th>Operational number of aged care places, 30 June ('000)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Table 13A.24</td>
<td>Operational number of aged care places per 1000 people aged 70 years or over, 30 June</td>
</tr>
<tr>
<td>Table 13A.25</td>
<td>Operational number of aged care places per 1000 people aged 70 years or over and Indigenous Australians aged 50–69 years, 30 June</td>
</tr>
<tr>
<td>Table 13A.26</td>
<td>Operational number of residential and community aged care services per 1000 people aged 70 years or over and Indigenous Australians aged 50–69 years, by planning region</td>
</tr>
<tr>
<td>Table 13A.27</td>
<td>Operational number of residential and community aged care services per 1000 people aged 70 years or over and Indigenous Australians aged 50–69 years, by remoteness</td>
</tr>
<tr>
<td>Table 13A.28</td>
<td>Aged care recipients per 1000 people, 30 June</td>
</tr>
<tr>
<td>Table 13A.29</td>
<td>Aged care recipients per 1000 people aged 65 years or over and Indigenous Australians aged 50–64 years by locality, 30 June</td>
</tr>
<tr>
<td>Table 13A.30</td>
<td>Aged care recipients per 1000 people aged 70 years or over and Indigenous Australians aged 50–69 years by locality, 30 June</td>
</tr>
<tr>
<td>Table 13A.31</td>
<td>HACC recipients per 1000 people in a special needs group</td>
</tr>
<tr>
<td>Table 13A.32</td>
<td>Aged care recipients from a non-English speaking country, 30 June</td>
</tr>
<tr>
<td>Table 13A.33</td>
<td>Aged care recipients from a non-English speaking country per 1000 people from a non-English speaking country aged 65 years and over by locality, 30 June</td>
</tr>
<tr>
<td>Table 13A.34</td>
<td>Aged care recipients from a non-English speaking country per 1000 people from a non-English speaking country aged 70 years and over by locality, 30 June</td>
</tr>
<tr>
<td>Table 13A.35</td>
<td>Indigenous aged care recipients per 1000 Indigenous Australians aged 50 years or over and as a proportion of all recipients, 30 June</td>
</tr>
<tr>
<td>Table 13A.36</td>
<td>Indigenous aged care recipients per 1000 Indigenous Australians aged 50 years or over by locality, 30 June</td>
</tr>
<tr>
<td>Table 13A.37</td>
<td>Permanent aged care residents at June 2012: age-sex specific usage rates per 1000 people by jurisdiction</td>
</tr>
<tr>
<td>Table 13A.38</td>
<td>Proportion of permanent residents/resident care days classified as concessional, assisted or supported (per cent)</td>
</tr>
<tr>
<td>Table 13A.39</td>
<td>Ageing in place: residents changing from low care to high care in the same facility</td>
</tr>
<tr>
<td>Table 13A.40</td>
<td>Utilisation of residential aged care places, by remoteness category, June 2012</td>
</tr>
<tr>
<td>Table 13A.41</td>
<td>CACP EACH and EACH-D recipients at June 2012: age-sex specific usage rates per 1000 people</td>
</tr>
<tr>
<td>Table 13A.42</td>
<td>Permanent aged care residents, CACP, EACH and EACH-D recipients at June 2012: age-sex specific usage rates per 1000 people by jurisdiction</td>
</tr>
<tr>
<td>Table 13A.43</td>
<td>Number of younger people with a disability using residential, CACP, EACH and EACH-D aged care services</td>
</tr>
<tr>
<td>Table 13A.44</td>
<td>Permanent aged care residents at June 2012: age-sex specific usage rates per 1000 people by remoteness</td>
</tr>
<tr>
<td>Table 13A.45</td>
<td>CACP, EACH and EACH-D recipients at June 2012: age-sex specific usage rates per 1000 people by remoteness</td>
</tr>
<tr>
<td>Table</td>
<td>Description</td>
</tr>
<tr>
<td>-------</td>
<td>-------------</td>
</tr>
<tr>
<td>13A.46</td>
<td>Permanent aged care residents, CACP, EACH and EACH-D recipients at June 2012: age-sex specific usage rates per 1000 people by remoteness</td>
</tr>
<tr>
<td>13A.47</td>
<td>Indigenous permanent residents classified as high or low care and Indigenous CACP, EACH and EACH-D at June 2012: age-sex specific usage rates per 1000 people by remoteness</td>
</tr>
<tr>
<td>13A.48</td>
<td>HACC services received per 1000 people aged 65 years or over and Indigenous Australians aged 50–64 years</td>
</tr>
<tr>
<td>13A.49</td>
<td>HACC services received per 1000 people aged 70 years or over and Indigenous Australians aged 50–69 years</td>
</tr>
<tr>
<td>13A.50</td>
<td>HACC services received within major cities per 1000 people aged 65 years or over and Indigenous Australians aged 50–64 years</td>
</tr>
<tr>
<td>13A.51</td>
<td>HACC services received within major cities per 1000 people aged 70 years or over and Indigenous Australians aged 50–69 years</td>
</tr>
<tr>
<td>13A.52</td>
<td>HACC services received within inner regional areas per 1000 people aged 65 years or over and Indigenous Australians aged 50–64 years</td>
</tr>
<tr>
<td>13A.53</td>
<td>HACC services received within inner regional areas per 1000 people aged 70 years or over and Indigenous Australians aged 50–69 years</td>
</tr>
<tr>
<td>13A.54</td>
<td>HACC services received within outer regional areas per 1000 people aged 65 years or over and Indigenous Australians aged 50–64 years</td>
</tr>
<tr>
<td>13A.55</td>
<td>HACC services received within outer regional areas per 1000 people aged 70 years or over and Indigenous Australians aged 50–69 years</td>
</tr>
<tr>
<td>13A.56</td>
<td>HACC services received within remote areas per 1000 people aged 65 years or over and Indigenous Australians aged 50–64 years</td>
</tr>
<tr>
<td>13A.57</td>
<td>HACC services received within remote areas per 1000 people aged 70 years or over and Indigenous Australians aged 50–69 years</td>
</tr>
<tr>
<td>13A.58</td>
<td>HACC services received within very remote areas per 1000 people aged 65 years or over and Indigenous Australians aged 50–64 years</td>
</tr>
<tr>
<td>13A.59</td>
<td>HACC services received within very remote areas per 1000 people aged 70 years or over and Indigenous Australians aged 50–69 years</td>
</tr>
<tr>
<td>13A.60</td>
<td>HACC target population</td>
</tr>
<tr>
<td>13A.61</td>
<td>HACC services received per 1000 HACC target population aged 65 years or over and Indigenous Australians aged 50-64 years</td>
</tr>
<tr>
<td>13A.62</td>
<td>HACC services received per 1000 HACC target population</td>
</tr>
<tr>
<td>13A.63</td>
<td>HACC services received within major cities per 1000 HACC target population aged 65 years or over and Indigenous Australians aged 50-64 years</td>
</tr>
<tr>
<td>13A.64</td>
<td>HACC services received within major cities per 1000 HACC target population</td>
</tr>
<tr>
<td>13A.65</td>
<td>HACC services received within inner regional areas per 1000 HACC target population aged 65 years or over and Indigenous Australians aged 50-64 years</td>
</tr>
<tr>
<td>13A.66</td>
<td>HACC services received within inner regional areas per 1000 HACC target population</td>
</tr>
<tr>
<td>13A.67</td>
<td>HACC services received within outer regional areas per 1000 HACC target population aged 65 years or over and Indigenous Australians aged 50-64 years</td>
</tr>
<tr>
<td>Table 13A.68</td>
<td>HACC services received within outer regional areas per 1000 HACC target population</td>
</tr>
<tr>
<td>Table 13A.69</td>
<td>HACC services received within remote areas per 1000 HACC target population aged 65 years or over and Indigenous Australians aged 50-64 years</td>
</tr>
<tr>
<td>Table 13A.70</td>
<td>HACC services received within remote areas per 1000 HACC target population</td>
</tr>
<tr>
<td>Table 13A.71</td>
<td>HACC services received within very remote areas per 1000 HACC target population aged 65 years or over and Indigenous Australians aged 50-64 years</td>
</tr>
<tr>
<td>Table 13A.72</td>
<td>HACC services received within very remote areas per 1000 HACC target population</td>
</tr>
<tr>
<td>Table 13A.73</td>
<td>Older HACC client characteristics</td>
</tr>
<tr>
<td>Table 13A.74</td>
<td>HACC client characteristics — total program</td>
</tr>
<tr>
<td>Table 13A.75</td>
<td>Distribution of older HACC clients, by age and Indigenous status (per cent)</td>
</tr>
<tr>
<td>Table 13A.76</td>
<td>Distribution of all HACC clients, by age and Indigenous status (per cent)</td>
</tr>
<tr>
<td>Table 13A.77</td>
<td>Comparative characteristics of Indigenous HACC clients</td>
</tr>
<tr>
<td>Table 13A.78</td>
<td>Comparative characteristics of Indigenous HACC clients</td>
</tr>
<tr>
<td>Table 13A.79</td>
<td>Access to Commonwealth Respite and Carelink Centres, 2011-12</td>
</tr>
<tr>
<td>Table 13A.80</td>
<td>Aged care assessments</td>
</tr>
<tr>
<td>Table 13A.81</td>
<td>Aged care assessments per 1000 people – age specific approvals</td>
</tr>
<tr>
<td>Table 13A.82</td>
<td>Aged care assessments completed under the ACAP for people of all ages</td>
</tr>
<tr>
<td>Table 13A.83</td>
<td>Elapsed time between ACAT approval and entry into residential, EACH, EACH-D or CACP service</td>
</tr>
<tr>
<td>Table 13A.84</td>
<td>Elapsed times for aged care services, by remoteness, 2011-12</td>
</tr>
<tr>
<td>Table 13A.85</td>
<td>Elapsed times for aged care services, by SEIFA IRSD quintiles, 2011-12</td>
</tr>
<tr>
<td>Table 13A.86</td>
<td>Elapsed times for aged care services, by State and Territory, by Indigenous status, 2011-12</td>
</tr>
<tr>
<td>Table 13A.87</td>
<td>Recommended location of longer term living arrangements of Aged Care Assessment Teams (ACAT) clients</td>
</tr>
<tr>
<td>Table 13A.88</td>
<td>Older people needing assistance with at least one everyday activity: extent to which need was met, 2009</td>
</tr>
<tr>
<td>Table 13A.89</td>
<td>Public hospital separations for care type &quot;maintenance&quot; for older people</td>
</tr>
<tr>
<td>Table 13A.90</td>
<td>Hospital patient days used by those eligible and waiting for residential aged care</td>
</tr>
<tr>
<td>Table 13A.91</td>
<td>Re-accreditation decisions on residential aged care services at 30 June 2012</td>
</tr>
<tr>
<td>Table 13A.92</td>
<td>Proportion of residential aged care services that are three year re-accredited, 2011-12</td>
</tr>
<tr>
<td>Table 13A.93</td>
<td>Proportion of residential aged care services that are three year re-accredited, by remoteness, 2011-12</td>
</tr>
<tr>
<td>Table 13A.94</td>
<td>Proportion of residential aged care services that are three year re-accredited, by State and Territory, by size of facility (places), 2011-12</td>
</tr>
<tr>
<td>Table 13A.95</td>
<td>Aged Care Complaints Scheme, 1 September 2011 to 30 June 2012</td>
</tr>
<tr>
<td>Table 13A.96</td>
<td>Aged Care Complaints Investigation Scheme</td>
</tr>
</tbody>
</table>
Table 13A.97 Compliance with service standards for community aged care services — CACP, EACH, EACH-D and National Respite for Carers Program

Table 13A.98 Outcomes for community aged care services — CACP, EACH, EACH-D and National Respite for Carers Program — reviewed against standards

Table 13A.99 Compliance with service standards for community aged care services — HACC, 2011-12

Table 13A.100 Aged care assessment program — activity and costs

Table 13A.101 Home and Community Care — cost per hour of service (2010-11 $)

Table 13A.102 Australian Government (DoHA and DVA) real expenditure on residential services, per older person (2011-12 dollars)

Table 13A.103 Australian, State and Territory governments' real expenditure on HACC services per person in the HACC target population (2011-12 dollars)

Table 13A.104 Australian, State and Territory government total real expenditure on HACC services, per older person (2011-12 dollars)

Table 13A.105 Australian Government real expenditure on CACPs, per older person (2011-12 dollars)

Table 13A.106 Transition Care Program
13.8 References

ABS 2009, *Experimental Life Tables for Aboriginal and Torres Strait Islander Australians, Australia, 2005-2007*, Cat. no. 3302.0.55.003, Canberra.


14 Services for people with disability

CONTENTS

14.1 Profile of disability services 14.3
14.3 Key performance indicator results 14.23
14.4 Future directions in performance reporting 14.76
14.5 Jurisdictions’ comments 14.78
14.6 Service user data quality and other issues 14.88
14.7 Definitions of key terms 14.93
14.8 List of attachment tables 14.101
14.9 References 14.108

Attachment tables
Attachment tables are identified in references throughout this chapter by a ‘14A’ prefix (for example, table 14A.1). A full list of attachment tables is provided at the end of this chapter, and the attachment tables are available from the Review website at www.pc.gov.au/gsp.

The Australian, State and Territory governments aim to ensure that people with disability and their carers have an enhanced quality of life and participate as valued members of the community. The National Disability Agreement (NDA), effective from 1 January 2009, provides the national framework and key areas of reform for the provision of government support and services for people with disability. Box 14.1 provides an overview of the NDA. The NDA replaced the third Commonwealth, State and Territory Disability Agreement (CSTDA), which was due to expire on 30 June 2007 but was extended to 31 December 2008. Funding to the State and Territory governments is provided through the National Disability Services Specific Purpose Payment (ND SPP), not the NDA.
Box 14.1 **National Disability Agreement and the National Disability Services Specific Purpose Payment**

Funding to the State and Territory governments is provided through the National Disability Services Specific Purpose Payment (ND SPP), associated with the National Disability Agreement (NDA). The focus of the NDA is on the provision of specialist disability services. However, the NDA acknowledges that specialist disability services are complemented by mainstream services and income support measures.

Reforms under the NDA are directed at creating a disability services system that is effective, efficient and equitable, and has a focus on: early intervention; timely, person-centred approaches; and lifelong planning. Five priority areas to underpin the policy directions and achieve these reforms are:

- build the evidence base for disability policies and strategies
- enhance family and carer capacity
- develop strategies for increased choice, control and self-directed decision making
- maintain innovative and flexible support models for people with high and complex needs
- develop employment opportunities for people with disability.

Other specific details relating to the NDA (such as roles and responsibilities of different governments) are provided throughout this chapter.

*Source: COAG (2009).*

This chapter provides information on the assistance provided by governments to people with disability and their carers, focusing on specialist disability services provided under the NDA and funded by the ND SPP. The chapter reports NDA and ND SPP data for 2010-11 and 2009-10, a combination of NDA and CSTDA data for 2008-09, and CSTDA data for earlier years.

- Specialist psychiatric disability services are excluded to improve data comparability across jurisdictions. Further information regarding specialist psychiatric services are reported in chapter 12, Mental health management.

- Performance information on access by people with disability to mainstream services is excluded. Further information on access by people with disability to mainstream services is included elsewhere in this Report — for example, School education (chapter 4), Vocational education and training (VET) (chapter 5), Public hospitals (chapter 10), Mental health management (chapter 12) and Public housing (chapter 16). Other mainstream services and supports provided to people with disability — such as transport and utility services at concessional rates — are outside the scope of this Report.
• Descriptive information on income support to people with disability and their carers is included, for context. This Report generally does not include performance information on income support.

Major improvements in the reporting of services for people with disability in this edition include:

• reporting a new, more accurate, single potential population and backcasting this for two historical years of data

• inclusion for the first time of HACC service user data for the age range of the target population of people with disability using specialist disability services

• inclusion for the first time of open employment services (Disability Management Services) measures and data

• inclusion of new carers’ measures and data from the NDA

14.1 Profile of disability services

Service overview

Government assistance for people with disability and their carers comprises provision of specialist disability services, access to mainstream services and provision of income support. Definitions of disability are provided in box 14.2.
Box 14.2 **Definitions of disability**

The United Nation’s *Convention on the Rights of Persons with Disabilities*, ratified by Australia on 17 July 2008, defines ‘persons with disabilities’ as those who have long-term physical, mental, intellectual or sensory impairments which, in interaction with various barriers, may hinder their full and effective participation in society on an equal basis with others.

The World Health Organisation (WHO) defines ‘disabilities’ as impairments, activity limitations and participation restrictions: an impairment is a problem in body function or structure; an activity limitation is a difficulty encountered by an individual in executing a task or action; and a participation restriction is a problem experienced by an individual in involvement in life situations. Disability is a complex phenomenon, reflecting an interaction between features of a person’s body and features of the society in which he or she lives (WHO 2009).

The third Commonwealth, State and Territory Disability Agreement ([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.

The NDA does not include a specific definition of ‘people with disability’.

The Australian Bureau of Statistics (ABS) *Survey of Disability, Ageing and Carers* (SDAC) 2009 defines ‘disability’ as a limitation, restriction or impairment, which has lasted, or is likely to last, for at least 6 months and restricts everyday activities. Examples range from hearing loss that requires the use of a hearing aid, to difficulty dressing due to arthritis, to advanced dementia requiring constant help and supervision. The SDAC reports on the spectrum of disability experiences using three main ‘categories’ of disability:

- with a specific core activity limitation (mild, moderate, severe and profound)
- with a schooling or employment restriction
- with a disability, but without a specific limitation or restriction — includes people who need assistance with health care, cognition and emotion, paperwork, transport, housework, property maintenance or meal preparation.

(Continued on next page)
Box 14.2  (Continued)

Self care, mobility and communication are defined as core activities. The ABS defines levels of core activity limitation as:

- mild — where a person does not need assistance and has no difficulty with self care, mobility and/or communication, but uses aids or equipment. They may also not be able to easily walk 200m, walk up and down stairs without a handrail, bend to pick up objects from the floor or use public transport easily or without help or supervision
- 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.


Specialist disability services

Specialist disability services are services designed to meet the needs of people with disability. These services tend to be targeted at those who have profound or severe core activity limitations. The seven broad categories of specialist disability services are outlined below. These categories underpin the collection of the Disability Services National Minimum Data Set (DS NMDS) and expenditure data on specialist disability services:

- accommodation support services, which provide support to people with disability in accommodation settings (hostels, institutions and group homes), and in their own homes (including attendant/personal care, in home support and alternative family placements)
- community support services, which provide the support needed for a person with disability to live in a non-institutional setting — including therapy support, counselling and early childhood intervention
- community access services, which provide opportunities for people with 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
• *respite care services*, which provide a short-term and time-limited break for families and other voluntary caregivers of people with disability, to assist in supporting and maintaining the primary care-giving relationship, while providing a positive experience for the person with disability

• *employment services* for people with disability, which provide:
  – open employment services — assistance in obtaining and/or retaining paid employment in the open labour market
  – supported employment services — support and employment within the same organisation

• *advocacy, information and alternative forms of communication*, which provide
  – advocacy services to enable people with disability to increase their control over their lives by representing their interests and views in the community
  – information services to provide accessible information to people with disability, their carers, families and related professionals about disabilities, specific and mainstream services and equipment; and promote the development of community awareness
  – alternative forms of communication for people who are, by reason of their disability, unable to access information provided in standard formats

• *other support services*, which include research and evaluation, and training and development projects.

*Mainstream services*

Mainstream services are services provided to the community as a whole. Governments acknowledge that specialist disability services are complemented by mainstream services. Under the NDA, all Australian governments have agreed to strive to ensure that all people with disability have access to mainstream government services within their jurisdictions. It is recognised that improved outcomes for people with disability, their families and their carers, are contingent upon the effective coordination of efforts across government services. Some mainstream services give priority to people with disability (for example, public housing) or have programs to meet the special needs of people with disability (for example, school education).

*Income support and allowances*

Income support for people with disability and their carers contributes to the outcomes of the NDA. The Australian Government is responsible for the provision
of income support targeted to the needs of people with disability, their families and carers (box 14.3). Income support is provided to those who meet the relevant eligibility criteria. Income support payments and allowances include the Disability Support Pension, Carer Payment, Carer Allowance, Sickness Allowance, Mobility Allowance, Child Disability Assistance Payment and Carer Supplement.

Details of the roles and responsibilities of the Australian, State and Territory governments in relation to assistance for people with disability are outlined in the following section.

**Box 14.3 Australian Government supplementary and income support arrangements**

Under the NDA, provision of income support for people with disability, their families and carers is a key responsibility of the Australian Government (see ‘roles and responsibilities’ section). Outlays on income support payments and allowances to people with disability and their carers in 2011-12 (on an accrual basis) amounted to $20.4 billion, comprising $14.6 billion for the Disability Support Pension, $3.2 billion for the Carer Payment, $1.7 billion for the Carer Allowance, $91.6 million for the Sickness Allowance, $138.9 million for the Mobility Allowance, $163.6 million for the Child Disability Assistance Payment and $480.4 million for Carer Supplement (Australian Government unpublished).

At 30 June 2012, there were around 827,500 recipients of the Disability Support Pension, 205,600 recipients of the Carer Payment, 570,800 recipients of the Carer Allowance (including Health Care Card only recipients), 61,300 recipients of the Mobility Allowance, 7,200 recipients of the Sickness Allowance, 148,900 recipients of the Child Disability Assistance Payment and 557,200 recipients of Carer Supplement (table 14A.1).

*Source: Australian Government (unpublished); table 14A.1.*

**Roles and responsibilities**

**Australian, State and Territory governments**

The NDA defines the roles and responsibilities of the Australian, State and Territory governments in the provision of services and supports to people with disability and their carers.

The Australian Government is responsible for:

- provision of employment services for people with disability (which includes regulation, service quality and assurance, assessment, policy development,
service planning, and workforce and sector development) in a manner that most effectively meets the needs of people with disability consistent with local needs and priorities

- provision of income support targeted to the needs of people with disability, their families and carers
- provision of funds to states and territories to contribute to the achievement of the NDA objective and outcomes
- where appropriate, investing in initiatives to support nationally agreed policy priorities, in consultation with State and Territory governments
- ensuring that Commonwealth legislation and regulations are aligned with the national policy reform directions and the United Nations Convention on the Rights of Persons with Disabilities.

State and Territory governments are responsible for:

- the provision of specialist disability services, except disability employment services (which include regulation, service quality and assurance, assessment, policy development, service planning, and workforce and sector development) in a manner which most effectively meets the needs of people with disability, their families and carers, consistent with local needs and priorities
- ensuring that State and Territory legislation and regulations are aligned with the national policy and reform directions
- where appropriate, investing in initiatives to support nationally agreed policy priorities, in consultation with the Australian Government.

Australian, State and Territory governments are jointly responsible for:

- development of national policy and reform directions to meet the agreed objectives and outcomes of the NDA
- funding and pursuing research that provides an evidence base for national policy and reform directions
- developing and implementing reforms to improve outcomes for Indigenous Australians with disability
- the provision of data, including a commitment to providing data for the DS NMDS and a commitment to the improvement of data.
Funding

Australian and State and Territory governments fund both government and non-government providers of specialist disability services under the NDA. Total government expenditure on these services was $6.9 billion in 2011-12 — a real increase of 1.7 per cent on the expenditure in 2010-11 ($6.3 billion) (table 14A.4). State and Territory governments funded the majority of this expenditure in 2011-12 (68.7 per cent, or $4.7 billion). The Australian Government funded the remainder (31.3 per cent, or $2.2 billion), which included $1.2 billion in transfer payments to states and territories (tables 14A.5 and 14A.6). Table 14A.7 provides data on total government expenditure including and excluding payroll tax.

Direct government expenditure on specialist disability services under the NDA (excluding expenditure on administration) was $6.4 billion in 2011-12 (table 14A.8). The distribution of direct government expenditure varied across jurisdictions. The main areas of State and Territory government expenditure were accommodation support services (48.4 per cent of total direct service expenditure) and community support (16.0 per cent of total direct service expenditure) (figure 14.1). Employment services were the main area of Australian Government expenditure in 2011-12 (11.6 per cent of total direct service expenditure and 82.7 per cent of Australian Government direct service expenditure) (table 14A.9).

Figure 14.1 Direct expenditure on NDA specialist disability services, by service type

<table>
<thead>
<tr>
<th>Year</th>
<th>AS</th>
<th>CS</th>
<th>CA</th>
<th>RS</th>
<th>ES</th>
<th>AI&amp;PD</th>
<th>OS</th>
</tr>
</thead>
<tbody>
<tr>
<td>2007-08</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2008-09</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2009-10</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2010-11</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2011-12</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

AS = accommodation support; CS = community support; CA = community access; RS = respite services; ES = employment services; AI&PD = advocacy, information and print disability. "See table 14A.8 for detailed notes accompanying expenditure data."

Source: Australian, State and Territory governments (unpublished); table 14A.9.
Size and scope

Disability prevalence

The ABS estimates that 1 in 5 people in the Australian population (4 026 213 people) had one or more disabilities (that is, a core activity limitation, a schooling or employment restriction or an impairment) in 2009 (ABS 2011), compared with 3 958 300 in 2003 (ABS 2004). Of the population aged 5–64 years in 2009, an estimated 11.8 per cent had a core activity limitation or specific restriction (ABS 2011) compared with 13.0 per cent in 2003 (ABS 2004). In 2009, 3.7 per cent of 5–64 year olds had a profound or severe core activity limitation, 8.6 per cent had a mild to moderate core activity limitation and 1.6 per cent had a schooling or employment restriction only (ABS 2011). Tables 14A.10 and 14A.11 contain additional information on disability prevalence, and table 14A.12 contains information on the estimated number of people with a profound or severe core activity limitation who received help as a proportion of those who needed help.

Aboriginal and Torres Strait Islander people

Indigenous Australians have significantly higher rates of disability than non-Indigenous Australians. Data on disability status for Indigenous people are available from the ABS 2008 National Aboriginal and Torres Strait Islander Social Survey (NATSISS). Data for non-Indigenous people with disability are from the ABS National Health Survey (ABS 2009a). There are differences in the scope of these surveys which affect direct comparability.

Nationally, 10.3 per cent of Indigenous Australians aged 18 years and over reported a profound or severe core activity restriction in 2008, around twice the rate for non-Indigenous Australians (4.7 per cent) (ABS 2009b). The disparity between Indigenous and non-Indigenous Australians is consistent across ages or age groups (as applicable) (figure 14.2).
Figure 14.2  People with profound or severe core activity restrictions by age group and Indigenous status, non-remote areas of Australia, 2008

Potential population

The potential population is an estimate, derived using a range of data sources, of the number of people with the potential to require disability support services, including individuals who meet the service eligibility criteria but who do not demand the services. Results are reported on the basis of the potential population to account for differences in the prevalence of disability between people in the special needs group and people outside the special needs group. For open employment services, the potential population is not used; instead, an estimate of all people with a disability and who have an employment restriction aged 15–64 is used. For information on how the potential populations for the special needs groups were derived see section 14.6.

A review of the scope and method for calculating the potential population for disability services was undertaken in 2012 (box 14.4). Outcomes of this review for the 2013 Report are:

- a single, more accurate potential population method is used in denominators, replacing the two different potential population methods used in previous reports
- the potential population has been backcast for rates in reference years 2008-09 and 2009-10

as a result of the method, the potential population for disability services has been revised downward significantly for 30 June 2008 and 2009 (for use in rates for reference years 2008-09 and 2009-10).

Box 14.4  Scope and calculation of potential population for disability services

In previous Reports, two potential populations have been reported, the revised method (to align with NDA data) and the unrevised method (historically used in this Report).

In 2012, the Disability Policy and Research Working Group (DPRWG) formed a sub-group to determine a single, nationally agreed method for calculating potential population for disability services.

The primary aim of this work was to redefine and identify the scope and method for calculating the potential population of people most appropriately supported by, and/or eligible for, disability services.

Re-identifying the scope of the potential population was based on a combination of interconnected components, including:

- people with disability aged 64 years and under (and Indigenous Australians aged 49 years and under) who are Australian citizens or permanent residents
- people who are most appropriately supported by disability services
- people who require ongoing and/or long-term episodic support
- people with a permanent/chronic impairment
- people with substantially reduced capacity in one or more core activities.

Identifying people with disability who are potentially most appropriately supported by and/or are eligible for disability services significantly decreased the number of people previously included in the potential population. This is due to a narrowing of the definitions of the abovementioned components. This has had the effect of significantly increasing reported rates of usage for specialist disability services.

The new nationally agreed method adopted for calculating the potential population is outlined in section 14.7.

Source: Disability Policy and Research Working Group (DPRWG) unpublished.

Informal carers

Family and friends provide most help and/or care assistance to people with disability. Information about informal carers enables governments to plan ahead for the future demand for services that support carers and the people they assist. Support services that assist people with disability to live in the community, such as in-home accommodation support and community support, often complement and are contingent upon the availability of informal care. In turn, the provision of
informal care may rely on access to formal support services, including carer respite services and a range of services for the person with disability.

Information on informal carers is available from the ABS SDAC and for NDA service users from the DS NMDS. The definition of informal carers differs slightly across these data collections:

- the ABS SDAC defines an informal primary carer as a person who provides the most informal assistance, in terms of help or supervision, to a person with one or more disabilities. The assistance has to be ongoing, or likely to be ongoing, for at least six months and be provided for one or more of the core activities (communication, mobility and self care)

- the DS NMDS defines an informal carer as someone, such as a family member, friend or neighbour, who is identified as providing regular and sustained care and assistance to a person with disability (see section 14.7 for further details). Informal carers who provide assistance with core activities (self care, mobility and communication) are defined as primary carers.

An estimated 575,500 informal primary carers aged 15–64 years provided the majority of assistance with self care, mobility and communication for people with disability, including older people in 2009 (ABS 2011). Of people with disability who accessed NDA specialist disability services in 2010-11, 41.2 per cent reported having an informal carer and 33.6 per cent reported having an informal carer who was a primary carer (figure 14.3). Service users in remote or very remote locations were more likely to report having an informal carer than those in other areas. Figure 14.4 shows the proportions of informal primary carers who are in different age groups, by location.
Figure 14.3  Users of NDA specialist disability services, by whether they had an informal carer and geographic location, 2010-11\textsuperscript{a, b, c}

\textsuperscript{a} Total includes data for service users whose location was not collected/identified. \textsuperscript{b} Data need to be interpreted with care due to a number of factors affecting data quality. Section 14.6 contains further information on these quality issues. \textsuperscript{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.

In 2010-11, 301,016 people were reported as using specialist disability services provided under the NDA (excluding service users who received specialist psychiatric disability services only) (table 14A.13). Nationally, this is 61.2 per cent of the estimated potential population (see section 14.7 for information on how the potential population is defined) (figure 14.5).
Users of NDA specialist disability services as a proportion of the estimated potential population

Service user numbers varied across service types. Accommodation support (34 838 users), community access (51 353 users), community support (139 725 users) and respite services (33 980) reported a combined total of 189 388 users (table 14A.13) and employment services reported a total of 128 321 users, in 2010-11 (figure 14.6).
In 2010-11, the most commonly reported disability of NDA service users was an intellectual disability (33.7 per cent of service users, including 28.8 per cent who reported it as their primary disability) (figure 14.7).

**Figure 14.6 Users of NDA specialist disability services, by service type**

**Figure 14.7 NDA specialist disability service users, by disability group, 2010-11**

Intellect = intellectual disability; SL = Specific Learning; ABI = Acquired brain injury; DB = Deafblind; Psych = Psychiatric; Neuro = Neurological. a Data need to be interpreted with care due to a number of factors affecting data quality. b See tables 14A.14 and 14A.15 for detailed notes relating to these data.

*Source: AIHW (unpublished) DS NMDS; tables 14A.14 and 14A.15.*
Home and Community Care

The Home and Community Care (HACC) program is a joint Australian Government and State and Territory government initiative administered under the *Home and Community Care Act 1985* (DoHA 2011). The State and Territory governments provide the day to day management and the Australian Government provides national oversight for the program. HACC service providers vary from small community-based groups to large charitable and public sector organisations (box 14.5).

Box 14.5  Home and Community Care services

Changes to the Australian, State and Territory governments’ roles and responsibilities specified in the National Health Reform Agreement (NHRA) for the Home and Community Care (HACC) program make it appropriate to report on people aged under 65 years (and Indigenous Australians aged under 50 years) with disability who use HACC services in this chapter.

The changes to the relevant roles and responsibilities under the NHRA are aimed at creating a national aged care system and national disability services system.

Under the NHRA, from 13 July 2011 the Australian Government has:

- full policy and funding responsibility for aged care services (for people aged 65 years or over and Indigenous Australians aged 50–64 years), including basic community care (previously provided under the HACC program)
- funding responsibility for specialist disability services delivered under the National Disability Agreement (NDA) for people aged 65 years or over and for Indigenous Australians aged 50–64 years

Under the NHRA from 13 July 2011 the State and Territory governments have:

- full policy and funding responsibility for specialist disability services for people aged under 65 years and for Indigenous Australians aged 49 years or under, including basic community care (previously provided under the HACC program)
- funding responsibility for packaged community care and residential care delivered through aged care programs to people aged 64 years or under, except for Indigenous Australians aged 50–64 years.

The changes to roles and responsibilities for basic community care, aged care and specialist disability services and the reconciliation arrangements do not apply to Victoria and WA. In these states, basic community care continues to be delivered under HACC as a joint Australian and State government funded program. The under HACC as a joint Australian and State government funded program. The Australian Government and the Victorian and WA governments have maintained bilateral agreements for that purpose.

(Continued on next page)
Nationally in 2011-12, 207,315 people aged 64 years and under (and Indigenous Australians aged 49 years and under) received HACC services (table 14.1).

Table 14.1  **Number of people receiving HACC services aged 64 years and under and Indigenous Australians aged 49 years and under, 2011-12**

<table>
<thead>
<tr>
<th></th>
<th>NSW</th>
<th>Qld</th>
<th>SA</th>
<th>Tas</th>
<th>ACT</th>
<th>NT</th>
<th>Aust</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indigenous Australians aged 49 years and under</td>
<td>3,338</td>
<td>1,273</td>
<td>772</td>
<td>116</td>
<td>67</td>
<td>413</td>
<td>7,563</td>
</tr>
<tr>
<td>People born in non-English speaking countries aged 64 years and under</td>
<td>6,539</td>
<td>2,250</td>
<td>2,057</td>
<td>239</td>
<td>478</td>
<td>93</td>
<td>23,065</td>
</tr>
<tr>
<td>All people aged 64 years and under and Indigenous Australians aged 49 years and under</td>
<td>50,605</td>
<td>37,366</td>
<td>22,711</td>
<td>6,179</td>
<td>3,775</td>
<td>1,217</td>
<td>20,7315</td>
</tr>
</tbody>
</table>

*The proportion of HACC clients with an unknown or invalid date of birth differed across jurisdictions and ranged from 0.1 per cent to 5.1 per cent. Nationally, the proportion of HACC clients with an unknown or invalid date of birth was 0.3 per cent.  The proportion of HACC clients aged 49 years and under with unknown or null Indigenous status differed across jurisdictions and ranged from 5.4 per cent to 11.1 per cent. Nationally, the proportion of HACC clients aged 49 years and under with unknown or null Indigenous status was 8.2 per cent. The proportion of HACC clients aged 64 years and under with an unknown or null country of birth differed across jurisdictions and ranged from 2.0 per cent to 7.1 per cent. Nationally, the proportion of HACC clients aged 64 years and under with an unknown or null country of birth was 5.0 per cent. The proportion of HACC funded agencies that submitted HACC MDS 2011-12 data differed across jurisdictions and ranged from 93 per cent to 100 per cent. The proportion of HACC clients aged 49 years and under with unknown or null Indigenous status differed across jurisdictions and ranged from 5.4 per cent to 11.1 per cent. Nationally, the proportion of HACC clients aged 49 years and under with unknown or null Indigenous Status was 8.2 per cent. Data for Vic and WA are not available. See box 14.5 for details.*

*Source: DoHA (unpublished) Home and Community Care Minimum Data Set 2011-12.; table 14A.154.*

Further data on HACC services received by people aged 64 years and under and Indigenous Australians aged 49 years and under are available by geographical location (tables 14A.148–153).
14.2 Framework of performance indicators

The performance framework and related indicators reflect governments’ shared objectives and priorities under the NDA (box 14.6).

COAG has agreed six National Agreements to enhance accountability to the public for the outcomes achieved or outputs delivered by a range of government services (see chapter 1 for more detail on reforms to federal financial relations).

The NDA covers the area of disability services. The agreement includes sets of performance indicators, for which the Steering Committee collates performance information for analysis by the COAG Reform Council (CRC). Performance indicators reported in this chapter are aligned with performance indicators in the NDA. The NDA was reviewed in 2011 and 2012, resulting in changes that have been reflected in this Report, as relevant.

Box 14.6 Objectives of government funded services for people with disability

The following long-term objective under the NDA is similar to the previous broad objective under the third CSTDA:

People with disability and their carers have an enhanced quality of life and participate as valued members of the community.

All aspects of the NDA contribute to or measure progress towards this objective. The objective is enhanced by three specific outcomes as well as a set of revised priority reform areas (outlined in box 14.1). The outcomes are that:

- people with disability achieve economic participation and social inclusion
- people with disability enjoy choice, wellbeing and the opportunity to live as independently as possible
- families and carers are well supported.

In support of the agreed NDA outcomes, governments will contribute to the following outputs:

- services that provide skills and support to people with disability to enable them to live as independently as possible
- services that assist people with disability to live in stable and sustainable living arrangements
- income support for people with disability and their carers
- services that assist families and carers in their caring role

Source: COAG (2012).

The performance indicator framework provides information on equity, efficiency and effectiveness, and distinguishes outputs and outcomes of government funded
services for people with disability (figure 14.8). The performance indicator framework shows which data are comparable in the 2013 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 Report’s statistical appendix 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) (appendix A).

Data quality information (DQI) is being progressively introduced for all indicators in the Report. The purpose of DQI is to provide structured and consistent information about quality aspects of data used to report on performance indicators. DQI in this Report cover the seven dimensions in the ABS’ data quality framework (institutional environment, relevance, timeliness, accuracy, coherence, accessibility and interpretability) in addition to dimensions that define and describe performance indicators in a consistent manner, and note key data gaps and issues identified by the Steering Committee. All DQI for the 2013 Report can be found at www.pc.gov.au/gsp/reports/rogs/2013.
Figure 14.8  Services for people with disability performance indicator framework

Key to indicators

- Text: Data for these indicators are comparable, subject to caveats to each chart or table
- Text: Data for these indicators are not complete and/or not directly comparable
- Text: These indicators are yet to be developed or data are not collected for this Report
14.3 Key performance indicator results

The performance indicator results reported in this chapter relate to NDA specialist disability services. These data were sourced from the DS NMDS collection, which is managed by Australian, State and Territory governments at the service and jurisdictional level and by the AIHW at the national level. Under the NDA, governments have committed to the ongoing improvement of and the ongoing provision of data for the DS NMDS.

When considering the performance indicator results derived from service user data, comparisons between jurisdictions and across years should be undertaken with care. While the implementation of the DS NMDS continues to improve, data quality is still affected by a number of factors, including:

- differences across jurisdictions and over time in the participation of service users and service outlets in the collection, and in the ‘not stated’ response rates of particular data items (see section 14.6 for further details)
- differences across jurisdictions in the interpretation of DS NMDS service definitions (for example, the target group for services classified as ‘early intervention’ can differ)
- differences across jurisdictions in whether particular activities are defined as specialist disability services or are funded under other programs.

Outputs

Outputs are the 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

Access to NDA specialist disability services

‘Access to NDA specialist disability services’ is an indicator of governments’ objective to provide access to government funded services including specialist disability services on the basis of relative need and available resources. Measures are reported for accommodation support, community support, community access, respite services and employment (box 14.7).
Box 14.7  **Access to National Disability Agreement specialist disability services**

‘Access to NDA specialist disability services’ is defined as the number of people using a particular NDA specialist disability service divided by the ‘potential population’ for that service. The potential population is an estimate of the number of people with the potential to require specialist disability services at some time.

The scope of the potential population for 2008-09, 2009-10 and 2010-11 has changed and is substantially lower than the potential population reported in the 2012 Report and earlier editions. Data for 2008-09, 2009-10 and 2010-11 are not comparable to those for previous years. See details in box 14.4.

The potential population is the number of people aged 0–64 years (and Indigenous Australians aged 49 years and under) who are most appropriately supported by disability services, require ongoing and/or long-term episodic support, have a permanent or chronic impairment and who have a substantially reduced capacity in one or more core activities. For respite services, only those people with a primary carer are included. For supported employment services, only the potential population aged 15–64 years participating in the labour force are included. For open employment services, the potential population is not used; instead, an estimate of all people with a disability and who have an employment restriction aged 15–64 is used. The potential population has been recalculated based on available data from the 2009 SDAC. The potential population has been backcast to the 2008-09 year. Data published in the 2011 and 2012 Reports have been recalculated for this Report.

A high or increasing proportion of the relevant estimated potential population using a particular NDA service suggests greater access to that service.

Not all people in the estimated potential population will need the service or seek to access the service in the relevant period. In addition, 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.

Data reported for this indicator are comparable.


The numerators and denominators of this access measure apply to different age groups. The numerator of an access measure is service users of all ages. The denominator is the estimated potential population:

- of people aged under 65 years for accommodation support, community support, community access and respite services
- of people aged 15–64 years for employment services.
Data on users of NDA specialist disability services as a proportion of the estimated potential population are also available disaggregated by service group, age and sex (table 14A.16).

Nationally, 4.8 per cent of the estimated potential population were using NDA accommodation support services in 2010-11 (figure 14.9).

**Figure 14.9** Users of NDA accommodation support services as a proportion of the estimated potential population\(^{a, b, c, d}\)

\(^a\) See table 14A.17 for detailed notes relating to service user data. See section 14.7 for information on how the potential population is defined. \(^c\) Data need to be interpreted with care due to a number of factors affecting data quality. Section 14.6 contains further information on these quality issues. \(^d\) The scope of the potential population for 2008-09, 2009-10 and 2010-11 has changed and is substantially lower than the potential population reported in the 2012 Report and earlier editions. Data for 2008-09, 2009-10 and 2010-11 are not comparable to those for previous years. See details in box 14.4.


Data on users of NDA accommodation support services as a proportion of the estimated potential population are also available disaggregated by service group, age and sex (table 14A.18).

Nationally, 28.4 per cent of the estimated potential population were using NDA community support in 2010-11 (figure 14.10).
Data on users of NDA community support as a proportion of the estimated potential population are also available disaggregated by service group, age and sex (table 14A.20).

Nationally, 10.4 per cent of the estimated potential population were using NDA community access services in 2010-11 (figure 14.11).
Data on users of NDA community access services as a proportion of the estimated potential population are also available disaggregated by service group, age and sex (table 14A.22).

Nationally, 15.5 per cent of the estimated potential population who reported having a primary carer were using NDA respite services in 2010-11 (figure 14.12).
Figure 14.12 Users of NDA respite services as a proportion of the estimated potential population for respite services\textsuperscript{a, b, c, d}

\begin{figure}[h]
\centering
\includegraphics[width=\textwidth]{figure14.12.png}
\caption{Users of NDA respite services as a proportion of the estimated potential population for respite services.}
\end{figure}

\textsuperscript{a} See table 14A.23 for detailed notes relating to these data. \textsuperscript{b} See section 14.7 for information on how the potential population is defined. \textsuperscript{c} Data need to be interpreted with care due to a number of factors affecting data quality. Section 14.6 contains further information on these quality issues. \textsuperscript{d} The scope of the potential population for 2008-09, 2009-10 and 2010-11 has changed and is substantially lower than the potential population reported in the 2012 Report and earlier editions. Data for 2008-09, 2009-10 and 2010-11 are not comparable to those for previous years. See details in box 14.4.


Data on users of NDA respite services as a proportion of the estimated potential population are also available disaggregated by service group, age and sex (table 14A.24).

Nationally in 2010-11, 7.1 per cent of the people with disability with employment restriction were using NDA open employment services (Employment Support Services) (figure 14.13).
Figure 14.13  Users of NDA open employment services (Employment Support Services) as a proportion of the estimated number of people with an employment restrictiona, b

![Bar chart showing the percentage of users of NDA open employment services (Employment Support Services) as a proportion of the estimated number of people with an employment restriction from 2008-09 to 2010-11, by state and territory.]

a See table 14A.25 for detailed notes relating to these data. b See section 14.7 for further information on employment services.


Further data on users of NDA open employment services (Disability Management Services) as a proportion of the estimated population are also available (14A.14.26).

Data on users of NDA supported employment services as a proportion of the potential population are also available disaggregated by age and sex (table 14A.27).

**Service use by severity of disability**

‘Service use by severity of disability’ is an indicator of governments’ objective to use available resources to provide services to people on the basis of relative need, where need for services is assumed to vary according to the need for help with the activities of daily living (ADL) and for help with activities of independent living (AIL) or activities of work, education and community living (AWEC) (box 14.8). This indicator provides additional information for interpreting the access to NDA services measures reported.
Data on the need for assistance are derived using information on the level of support needed in one or more of the following support areas for:

- activities of daily living (ADL) – self care, mobility, and communication (the core support areas)(conceptually comparable to people who have a profound or severe core activity limitation)
- activities of independent living (AIL) – interpersonal interactions and relationships, learning, applying knowledge and general tasks and demands; and domestic life
- activities of work, education and community living (AWEC) – education, community (civic) and economic life; and work.

<table>
<thead>
<tr>
<th>Box 14.8 Service use by severity of disability</th>
</tr>
</thead>
<tbody>
<tr>
<td>‘Service use by severity of disability’ is defined as the proportion of people who access NDA specialist disability services, by need for help with ADL, or AIL, or AWEC. Four categories are reported:</td>
</tr>
<tr>
<td>- need help with ADL</td>
</tr>
<tr>
<td>- need help with AIL or AWEC but not ADL</td>
</tr>
<tr>
<td>- does not need assistance or information on ADL, AIL or AWEC</td>
</tr>
<tr>
<td>- not stated/collected.</td>
</tr>
</tbody>
</table>

Measures are reported for accommodation support, community support, community access, employment and respite services.

A high or increasing proportion of people using a particular service type who need help with ADL suggests greater access 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 based on relative need taking into account access to other formal and informal support. The need for services is assumed to vary according to the need for help with ADL, or AIL, or AWEC. Data on ADL, AIL and AWEC are self/carer identified, not based on formal clinical assessments of individual limitations. Other factors may also be important in determining relative need, such as the complexity of a service user’s needs in other activity areas.

Data reported for this indicator are comparable.

Nationally, in 2010-11:

- 81.5 per cent of users of NDA accommodation support services needed help with ADL, 9.0 per cent required assistance with AIL or AWEC but not with ADL, 2.0 per cent did not report need for any assistance in major life areas and for 7.5 per cent information on need for assistance was not collected/not stated (figure 14.14a)

- 64.6 per cent of users of NDA community support services needed help with ADL, 6.6 per cent required assistance with AIL or AWEC, but not with ADL, 1.9 per cent did not report need for any assistance in major life areas and for 26.9 per cent information on need for assistance was not collected/not stated (figure 14.14b)

- 70.9 per cent of users of NDA community access services needed help with ADL, 8.2 per cent required assistance with AIL or AWEC, but not with ADL, 3.5 per cent did not report need for any assistance in major life areas and for 17.4 per cent information on need for assistance was not collected/not stated (figure 14.14c)

- 81.6 per cent of users of NDA respite services needed help with ADL, 5.0 per cent required assistance with AIL or AWEC, but not with ADL, 0.6 per cent did not report need for any assistance in major life areas and for 12.8 per cent information on need for assistance was not collected/not stated (figure 14.14d)

- 37.2 per cent of users of NDA employment services needed help with ADL, 17.0 per cent required assistance with AIL or AWEC, but not with ADL, 17.1 per cent did not report need for any assistance in major life areas and for 28.8 per cent information on need for assistance was not collected/not stated (figure 14.14e).

Data on users of NDA specialist disability services as a proportion of the estimated potential population are also available (tables 14A.28, 14A.30, 14A.32, 14A.34, 14A.36, 14A.38 and 14A.39).
Figure 14.14 Users of NDA specialist disability services, by need for help with Activities of Daily Living, 2010-11a, b, c, d

- Need help with ADL
- Need help with AIL or AWEC
- Do not need help
- Not stated/not collected

(a) Accommodation support
(b) Community support
(c) Community access
(d) Respite
(e) Employment

---

a Need for help with ADL relates to the level of support needed in self care, mobility and communication. It does not necessarily relate to the level of support needed to find or maintain employment or with other activities.
b See tables 14A.29, 14A.31, 14A.33, 14A.35 and 14A.37 for detailed notes about these data.
c Data need to be interpreted with care due to factors affecting data quality. Section 14.6 contains further information on these quality issues.
d Need help with AIL or AWEC does not include people who also need help with ADL.

Service use by special needs groups

‘Service use by special needs groups’ is an indicator of governments’ objective that access to services should be equitable for all members of the community and provided on the basis of relative need (box 14.9). This indicator compares access for people from special needs groups with access for people from outside the special needs group of the total population and the potential population.

Box 14.9 Service use by special needs groups

‘Service use by special needs groups’ is defined by two measures:

- the proportion of service users per 1000 total population in a particular special needs group, compared to the proportion of service users per 1000 total population outside the special needs group
- the proportion of service users per 1000 potential population in a particular special needs group, compared to the proportion of service users per 1000 potential population outside the special needs group.

Both measures are reported for accommodation support, community support, community access and employment services. For respite services, data are reported per 1000 total population only, due to data limitations.

Data are reported for three special needs groups:

- people from outer regional and remote/very remote locations
- people identified as Indigenous Australians
- 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).

For both measures, while a lower proportion can indicate reduced access for a special needs group, it can also represent strong alternative informal support networks (and a consequent lower level of otherwise unmet need), or a lower tendency of people with disability in a special needs group to choose to access NDA specialist disability services. Similarly, a higher proportion can suggest poor service targeting, the lack of alternative informal support networks or a greater tendency of people with disability in a special needs group to choose to access NDA specialist disability services. For the measure that compares access per 1000 population, significant differences in access can also reflect the special needs group having a higher/lower prevalence of disability.

This indicator does not provide information on whether the services are appropriate for the needs of the people receiving them, or correctly targeted on the basis of relative need. The indicator does not take into account differences in 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

(Continued on next page)
The numerators and denominators of these measures use different age groups. The numerators include service users of all ages. The denominators are based on specific age groups:

- people aged under 65 years for accommodation support, community support, community access and respite services
- people aged 15–64 years for employment services.

The measures of access per 1000 potential population should be interpreted with care, due to a number of factors affecting data quality. Potential sources of error include:

- the existence of service users for whom ‘special needs group’ status (for example, Indigenous status) is not stated or not collected — poor and/or inconsistent levels of identification across states and territories would affect comparisons
- the assumptions underlying the method used to derive the potential populations
- for the Indigenous estimates, differential Census undercount across states and territories that could introduce bias in the results.

Section 14.6 contains more detailed information on these quality issues.

*Service use by special needs groups — people in outer regional and remote/very remote areas*

Nationally in 2010-11, the proportion of the outer regional and remote/very remote population who used NDA:

- accommodation support services was 1.4 service users per 1000 population, lower than the proportion of the major cities and inner regional population who used these services (1.9 service users per 1000 population) (figure 14.15a). The proportion of the outer regional and remote/very remote potential population
who used NDA accommodation support services (50.3 service users per 1000 potential population) was lower than that of the major cities and inner regional potential population who used these services (73.0 service users per 1000 potential population) (figure 14.16a).

- community support services was 6.8 service users per 1000 population, only slightly lower than the proportion of the major cities and inner regional population who used these services (7.0 service users per 1000 population) (figure 14.15b). The proportion of the outer regional and remote/very remote potential population who used NDA community support services (238.6 service users per 1000 potential population) was lower than the proportion of the major cities and inner regional potential population who used these services (275.7 service users per 1000 potential population) (figure 14.16b).

- community access services was 2.1 service users per 1000 population, lower than the proportion of the major cities and inner regional population who used these services (2.7 service users per 1000 population) (figure 14.15c). The proportion of the outer regional and remote/very remote potential population who used NDA community access services (74.8 service users per 1000 potential population) was lower than the proportion of the major cities and inner regional potential population who used these services (104.3 service users per 1000 potential population) (figure 14.16c).

- respite services was 1.8 service users per 1000 population, higher than the proportion of the major cities and inner regional population who used these services (1.7 service users per 1000 population) (figure 14.15d). Access to respite as a proportion of the potential population is not reported. Potential population data for respite services is not calculated at these levels because of conceptual, definitional and quality issues with carer data for special needs groups from the 2011 Census.
Figure 14.15  Users of State and Territory administered NDA specialist disability services per 1000 people, by geographic location, 2010-11\(^a, b, c, d\)

(a) Accommodation support

(b) Community support

(c) Community access

(d) Respite

\(^a\) See tables 14A.40, 14A.41, 14A.42 and 14A.43 for detailed notes relating to these data. \(^b\) Data need to be interpreted with care due to a number of factors affecting data quality. Section 14.6 contains further information on these quality issues. \(^c\) The ACT does not have outer regional and remote/very remote areas. \(^d\) The NT does not have major cities and inner regional areas.

Source: AIHW (unpublished) DS NMDS; AIHW (2012) Disability support services 2010-11: Services provided under the National Disability Agreement. DIS 60. Canberra; AIHW; AIHW (unpublished), derived from ABS 2011, 2009 Survey of Disability, Ageing and Carers, Cat. no. 4430.0; tables 14A.40, 14A.41, 14A.42 and 14A.43.
Figure 14.16 Users of State and Territory administered NDA specialist disability services per 1000 potential population, by geographic location, 2010-11a, b, c, d, e, f

- **(a) Accommodation support**
- **(b) Community support**
- **(c) Community access**

**Source:** AIHW (unpublished) DS DMDS; AIHW (2012) Disability support services 2010-11: Services provided under the National Disability Agreement. DIS 60. Canberra; AIHW; AIHW (unpublished), derived from ABS 2011, 2009 Survey of Disability, Ageing and Carers, Cat. no. 4430.0; tables 14A.40, 14A.41 and 14A.42.

---

*a* See tables 14A.40, 14A.41 and 14A.42 for detailed notes relating to these data. *b* See section 14.7 for information on how the potential population is defined. *c* Data need to be interpreted with care due to a number of factors affecting data quality. Section 14.6 contains further information on these quality issues. *d* The ACT does not have outer regional and remote/very remote areas. *e* The NT does not have major cities and inner regional areas. *f* ACT data for service users per 1000 Indigenous potential population are not published as they are based on a small number of service users.
Nationally in 2010-11, the proportion of the outer regional and remote/very remote population who used NDA employment services (8.9 service users per 1000 population) was higher than that of the major cities and inner regional population (8.3 service users per 1000 population) (figure 14.17a). The proportion of the outer regional and remote/very remote potential population who used NDA employment services (358.6 service users per 1000 potential population) was lower than that of the major cities and inner regional potential population (403.2 service users per 1000 potential population) (figure 14.17b).

Figure 14.17 Users of NDA employment services, by geographic location, 2010-11

- Major cities and inner regional
- Outer regional and remote/very remote

(a) Use per 1000 population
(b) Use per 1000 potential population

(a) Users/1000 people
(b) Users/1000 potential population

<table>
<thead>
<tr>
<th>Major cities and inner regional</th>
<th>Outer regional and remote/very remote</th>
</tr>
</thead>
</table>

Source: AIHW (unpublished) DS NMDS; AIHW (2012) Disability support services 2010-11: Services provided under the National Disability Agreement. DIS 60. Canberra; AIHW; AIHW (unpublished), derived from ABS 2011, 2009 Survey of Disability, Ageing and Carers, Cat. no. 4430.0; table 14A.44.

Service use by special needs groups — Indigenous Australians

Nationally in 2010-11, the proportion of the Indigenous population who used NDA:

- accommodation support services was 3.3 service users per 1000 population, higher than the proportion of the non-Indigenous population who used these services (1.7 service users per 1000 population) (figure 14.18a). The proportion
of the Indigenous potential population who used NDA accommodation support services (67.7 service users per 1000 potential population) was slightly lower than the non-Indigenous potential population who used these services (68.3 service users per 1000 potential population) (figure 14.19a).

- Community support services was 17.4 service users per 1000 population, higher than the proportion of the non-Indigenous population who used these services (6.6 service users per 1000 population) (figure 14.18b). The proportion of the Indigenous potential population who used NDA community support services (356.4 service users per 1000 potential population) was higher than the proportion of the non-Indigenous potential population who used these services (262.5 service users per 1000 potential population) (figure 14.19b).

- Community access services was 4.0 service users per 1000 population, higher than the proportion of the non-Indigenous population who used these services (2.4 service users per 1000 population) (figure 14.18c). The proportion of the Indigenous potential population who used NDA community access services (81.4 service users per 1000 potential population) was lower than the proportion of the non-Indigenous potential population who used these services (95.2 service users per 1000 potential population) (figure 14.19c).

- Respite service was 3.6 users per 1000 population, higher than the proportion of the non-Indigenous population who used these services (1.6 service users per 1000 population) (figure 14.18d). Access to respite as a proportion of the potential population is not reported. Potential population data for respite services is not calculated at these levels because of conceptual, definitional and quality issues with carer data for the special needs groups from the 2011 Census.

Data on users of NDA disability support services as a proportion of the Indigenous estimated potential population are also available disaggregated by age (table 14A.45).
Figure 14.18  Users of State and Territory administered NDA specialist disability services per 1000 people, by Indigenous status, 2010-11a, b

- (a) Accommodation support
- (b) Community support
- (c) Community access
- (d) Respite

Source: AIHW (unpublished) DS NMDS; AIHW (2012) Disability support services 2010-11: Services provided under the National Disability Agreement. DIS 60. Canberra; AIHW; AIHW (unpublished), derived from ABS 2011, 2009 Survey of Disability, Ageing and Carers, Cat. no. 4430.0; tables 14A.46, 14A.47, 14A.48 and 14A.49.

a See tables 14A.46, 14A.47, 14A.48 and 14A.49 for detailed notes relating to these data. b Data need to be interpreted with care due to a number of factors affecting data quality. Section 14.6 contains further information on these quality issues.
Figure 14.19 Users of State and Territory administered NDA specialist disability services per 1000 potential population, by Indigenous status, 2010-11\(^a\), \(^b\), \(^c\), \(^d\)

\(^a\) See tables 14A.46, 14A.47 and 14A.48 for detailed notes relating to these data. \(^b\) See section 14.7 for information on how the potential population is defined. \(^c\) Data need to be interpreted with care due to a number of factors affecting data quality. Section 14.6 contains further information on these quality issues. \(^d\) ACT data for service users per 1000 Indigenous potential population are not published for accommodation support and community access as they are based on a small number of service users.

Nationally in 2010-11, the proportion of the Indigenous population who used NDA employment services (15.7 service users per 1000 population) was higher than that of the non-Indigenous population (8.4 service users per 1000 population) (figure 14.20a). The proportion of the Indigenous potential population who used NDA employment services (442.8 service users per 1000 potential population) was lower than that of the non-Indigenous potential population (523.4 service users per 1000 potential population) (figure 14.20b).

Data on users of NDA open and supported employment services as a proportion of the Indigenous estimated potential population are also available disaggregated by age (tables 14A.51–53).

Figure 14.20  **Users of NDA employment services, by Indigenous status, 2010-11**

<table>
<thead>
<tr>
<th></th>
<th>Indigenous</th>
<th>Non- Indigenous</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>4</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>8</td>
<td>8</td>
<td>8</td>
</tr>
<tr>
<td>12</td>
<td>12</td>
<td>12</td>
</tr>
<tr>
<td>16</td>
<td>16</td>
<td>16</td>
</tr>
<tr>
<td>20</td>
<td>20</td>
<td>20</td>
</tr>
<tr>
<td>24</td>
<td>24</td>
<td>24</td>
</tr>
</tbody>
</table>

(a) Use per 1000 population

(b) Use per 1000 potential population

<table>
<thead>
<tr>
<th></th>
<th>NSW</th>
<th>Vic</th>
<th>Qld</th>
<th>WA</th>
<th>SA</th>
<th>Tas</th>
<th>ACT</th>
<th>NT</th>
<th>Aust</th>
</tr>
</thead>
<tbody>
<tr>
<td>Users/1000 people</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NSW</td>
<td>0</td>
<td>4</td>
<td>8</td>
<td>12</td>
<td>16</td>
<td>20</td>
<td>24</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vic</td>
<td>0</td>
<td>4</td>
<td>8</td>
<td>12</td>
<td>16</td>
<td>20</td>
<td>24</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Qld</td>
<td>0</td>
<td>4</td>
<td>8</td>
<td>12</td>
<td>16</td>
<td>20</td>
<td>24</td>
<td></td>
<td></td>
</tr>
<tr>
<td>WA</td>
<td>0</td>
<td>4</td>
<td>8</td>
<td>12</td>
<td>16</td>
<td>20</td>
<td>24</td>
<td></td>
<td></td>
</tr>
<tr>
<td>SA</td>
<td>0</td>
<td>4</td>
<td>8</td>
<td>12</td>
<td>16</td>
<td>20</td>
<td>24</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tas</td>
<td>0</td>
<td>4</td>
<td>8</td>
<td>12</td>
<td>16</td>
<td>20</td>
<td>24</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ACT</td>
<td>0</td>
<td>4</td>
<td>8</td>
<td>12</td>
<td>16</td>
<td>20</td>
<td>24</td>
<td></td>
<td></td>
</tr>
<tr>
<td>NT</td>
<td>0</td>
<td>4</td>
<td>8</td>
<td>12</td>
<td>16</td>
<td>20</td>
<td>24</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Aust</td>
<td>0</td>
<td>4</td>
<td>8</td>
<td>12</td>
<td>16</td>
<td>20</td>
<td>24</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Service use by special needs groups — people born in a non-English speaking country

Nationally, in 2010-11, the proportion of people born in a non-English speaking country who used NDA:

- accommodation support services was 0.6 users per 1000 population, lower than the proportion of people born in an English speaking country (2.0 service users per 1000 population) (figure 14.21a). The proportion of the potential population born in a non-English speaking country who used NDA accommodation support services (24.6 users per 1000 potential population) was lower than the proportion of people born in an English speaking country who used these services (75.3 service users per 1000 potential population) (figure 14.22a)

- community support services was 2.6 service users per 1000 population, lower than the proportion of people born in an English speaking country who used these services (7.6 service users per 1000 population) (figure 14.21b). The proportion of the potential population born in a non-English speaking country who used community support services (112.7 service users per 1000 potential population) was lower than the proportion of people born in an English speaking country who used these services (290.7 service users per 1000 potential population) (figure 14.22b)

- community access services was 1.0 users per 1000 population, lower than the proportion of people born in an English speaking country who used these services (2.7 service users per 1000 population) (figure 14.21c). The proportion of the potential population born in a non-English speaking country who used community access services (43.1 service users per 1000 potential population) was lower than the proportion of people born in an English speaking country who used these services (101.1 service users per 1000 population) (figure 14.22c)

- respite services was 0.6 service users per 1000 population, lower than the proportion of people born in an English speaking country who used these services (1.9 service users per 1000 population) (figure 14.21d). Access to respite as a proportion of the potential population is not reported. Potential population data for respite services is not calculated at these levels because of conceptual, definitional and quality issues with carer data for the special needs groups from the 2011 Census.
Figure 14.21 Users of State and Territory administered NDA specialist disability services per 1000 people (aged 0–64 years), by country of birth, 2010-11

- (a) Accommodation support
- (b) Community support
- (c) Community access
- (d) Respite

Legend:
- People born in an English speaking country
- People born in a non-English speaking country

*a* See tables 14A.54, 14A.55, 14A.56 and 14A.57 for detailed notes relating to these data. *b* Data need to be interpreted with care due to a number of factors affecting data quality. Section 14.6 contains further information on these quality issues.

Figure 14.22  **Users of State and Territory administered NDA specialist disability services per 1000 potential population, by country of birth, 2010-11**  

- People born in an English speaking country
- People born in a non-English speaking country

### (a) Accommodation support

- **NSW**: 180
- **Vic**: 150
- **Qld**: 120
- **WA**: 90
- **SA**: 60
- **Tas**: 30
- **ACT**: 0
- **NT**: 0
- **Aust**: 0

### (b) Community support

- **NSW**: 600
- **Vic**: 500
- **Qld**: 400
- **WA**: 300
- **SA**: 200
- **Tas**: 100
- **ACT**: 0
- **NT**: 0
- **Aust**: 0

### (c) Community access

- **NSW**: 200
- **Vic**: 160
- **Qld**: 120
- **WA**: 80
- **SA**: 40
- **Tas**: 0
- **ACT**: 0
- **NT**: 0
- **Aust**: 0

---


---

Nationally in 2010-11, the proportion of people born in a non-English speaking country who used NDA employment services (6.7 service users...
per 1000 population) was lower than that of people born in an English speaking country (8.9 service users per 1000 population) (figure 14.23a). The proportion of the potential population of people born in a non-English speaking country who used NDA employment services (304.1 service users per 1000 potential population) was lower than that of the potential population of people born in an English speaking country (414.2 service users per 1000 potential population) (figure 14.23b).

**Figure 14.23 Users of NDA employment services, by country of birth, 2010-11**

(a) Use per 1000 population  
(b) Use per 1000 potential population

Data on users of NDA open and supported employment services are also available disaggregated by country of birth and remoteness (tables 14A.59–61).

**Access to community accommodation and care services**

‘Access to community accommodation and care services’ is an indicator of governments’ objective to assist people with disability to live as valued and
participating members of the community (box 14.10). Governments provide or fund accommodation support services to people with 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 services provided in other community settings are attendant care/personal care, in home accommodation support, alternative family placement and other accommodation support.

State and Territory governments generally seek, if possible, to provide accommodation support services to people with disability outside of institutional/residential settings. Community accommodation and care services are considered to provide better opportunities for people with disability to be involved in their community.

Box 14.10 **Access to community accommodation and care services**

‘Access to community accommodation and care services’ is defined as the number of people using a NDA community accommodation and care service divided by the total number of people using NDA accommodation support services (excluding people who use specialist psychiatric disability services only).

A higher proportion of people accessing NDA community accommodation and care services might provide better opportunities for people with disability (who need accommodation support) to be involved in their community.

NDA specialist disability 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 on the basis of relative need.

Data reported for this indicator are comparable.

Data quality information for this indicator is under development.

Nationally, 89.9 per cent of users of NDA accommodation support services received community accommodation and care services in 2010-11 (figure 14.24).
**Figure 14.24 Users of community accommodation and care services as a proportion of all NDA accommodation support service users**

### Data Analysis

- **Per cent of users**: The graph shows the percentage of users in different states from 2006-07 to 2010-11.
- **States**: NSW, Vic, Qld, WA, SA, Tas, ACT, NT, Aust.

**Source**: AIHW (unpublished) DS NMDS; table 14A.62.

---

**Assistance for younger people with disability in, or at risk of entering, residential aged care**

'Assistance for younger people with disability in, or at risk of entering, residential aged care' (renamed for this Report from young people in residential aged care) is an indicator of governments’ objective to provide access to services to people with disability that are appropriate to their needs (box 14.11).
Box 14.11  **Assistance for younger people with disability in, or at risk of entering, residential aged care**

‘Assistance for younger people in, or at risk of entering, residential aged care’ is defined by two measures:

- the percentage change in numbers of younger people in residential aged care
- the proportion of service users in the Younger People in Residential Aged Care program (YPIRAC) who have achieved program objectives since its inception.

At its February 2006 meeting, COAG made a commitment to reduce the number of younger people with disability living in or at risk of entering residential aged care, and agreed to establish a 5 year initiative — YPIRAC. The initial priority group was younger people with disability aged less than 50 years in or at risk of entering residential aged care. Individuals participate in the YPIRAC initiative voluntarily.

The YPIRAC initiative has three main objectives:

- Objective 1 — People moving out of residential aged care to more appropriate supported disability accommodation.
- Objective 2 — People at risk, diverted from inappropriate admission to residential aged care.
- Objective 3 — People provided with enhanced services within a residential aged care setting, for whom residential aged care is the only available, suitable supported accommodation option.

To meet these objectives, the YPIRAC initiative provides three broad categories of services:

- YPIRAC assessment, individual care planning and/or client monitoring
- Alternative accommodation
- Support services packages.

On 1 January 2009, the NDA replaced the CSTDA. The NDA provides the framework for the provision of government support for people with disability. Australian Government funding for the YPIRAC initiative was rolled into funding provided to the State and Territory governments for the NDA. However, the YPIRAC initiative targets remain as agreed in the previous bilateral agreements.

Data reported for this indicator are comparable.

Nationally on 30 June 2011, there were 657 people aged under 50 years living in permanent residential aged care (table 14A.63). This is a 34.8 per cent decrease on the number of people aged under 50 years living in permanent residential aged care on 30 June 2006 (figure 14.25). These data should to be interpreted with care, as some younger people choose to remain in residential aged care for a variety of reasons, such as:

- their physical and nursing needs can be best met in residential aged care
- they are satisfied with their current living situation (that is, it is the preferred facility)
- the facility is located close to family and friends
- it is a familiar home environment.

Figure 14.25 Younger people in residential aged care, percentage change in numbers between 2006 and 2011, by age group\textsuperscript{a, b, c}

\begin{figure}
\centering
\includegraphics[width=\textwidth]{figure14_25.png}
\caption{Younger people in residential aged care, percentage change in numbers between 2006 and 2011, by age group.}
\end{figure}

\textsuperscript{a} Data are for permanent residents in aged care. \textsuperscript{b} These data should be interpreted with care (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 Australian’s ages were incorrectly recorded. \textsuperscript{c} The percentage change for the number of people aged 0–49 years in the ACT is not reported due to confidentiality.


An estimated 1432 younger people with disability have been assisted with YPIRAC services since its inception in 2006:

- 17.5 per cent (250 service users) have achieved objective 1 — people moving out of residential aged care to more appropriate supported disability accommodation (figure 14.26, table 14A.67)
- 17.0 per cent (244 service users) have achieved objective 2 — people at risk, diverted from inappropriate admission to residential aged care (figure 14.26, table 14A.67)

- 31.8 per cent (456 service users) have achieved objective 3 — people provided with enhanced services within a residential aged care setting, for whom residential aged care is the only available, suitable supported accommodation option (figure 14.26, table 14A.67).

**Figure 14.26 Proportion YPIRAC service users who have achieved program objectives since its inception to June 2010**

<table>
<thead>
<tr>
<th>Objective</th>
<th>Per cent</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>NSW</th>
<th>Vic</th>
<th>Qld</th>
<th>WA</th>
<th>SA</th>
<th>Tas</th>
<th>ACT</th>
<th>NT</th>
<th>Aust</th>
</tr>
</thead>
<tbody>
<tr>
<td>20</td>
<td>15</td>
<td>10</td>
<td>30</td>
<td>15</td>
<td>45</td>
<td>30</td>
<td>10</td>
<td>15</td>
</tr>
</tbody>
</table>


Additional data on younger people admitted to residential aged care, YPIRAC service users, YPIRAC programme objectives by age, younger people who separated from permanent residential aged care and the number of younger people with disability receiving residential aged care are available in the attachment tables (see tables 14A.63–70).
Equity and effectiveness — quality of services

The following equity and effectiveness quality indicators are reported:

- ‘Quality assurance processes’
- ‘Client and carer satisfaction’.

Quality assurance processes

‘Quality assurance processes’ is related to governments’ objective to deliver and fund disability services that meet a particular standard of quality (box 14.12).

Box 14.12 Quality assurance processes

‘Quality assurance processes’ is defined as the proportion of NDA disability service outlets that have been assessed (either by an external agency or through a self-assessment process) against service standards.

A high or increasing proportion of disability service outlets that have been assessed against the standards (and are found to be compliant) suggests an improvement in the quality of government delivered or funded specialist disability services.

This indicator does not provide information on whether the standards or the quality assurance processes are appropriate. In addition, service outlets that are not quality assessed do not necessarily deliver services of lower quality.

Data reported for this indicator are neither complete nor directly comparable.

Data quality information for this indicator is under development.

A set of eight minimum National Disability Service Standards were developed in 1992 under the first Commonwealth State Disability Agreement (box 14.13). The Australian Government and all State and Territory governments agreed to implement these minimum standards:

- The Australian Government has implemented a quality assurance system for funded disability employment and rehabilitation services, which requires service providers to be certified as compliant against 12 standards (which include the eight minimum standards). Each standard has a least one key performance indicator (table 14A.79).
- Most State and Territory governments have undertaken work to interpret the standards (such as developing supporting standards) and to develop related performance indicators and/or guidance on how to meet the standards. Most State and Territory governments have adopted additional standards to the eight minimum National Standards. Five jurisdictions have adopted a specific standard
relating to ‘Protection of human rights and freedom from abuse’, for example. Some have also introduced specific outcome standards for service users or generic standards that apply to all community sector organisations including, disability services (tables 14A.71–78).

- All State and Territory governments have developed, or are in the process of developing/re-developing, mechanisms for assessing compliance with standards (tables 14A.71–78).

**Box 14.13 National Disability Service Standards**

**Standard 1 Service access**
Each consumer seeking a service has access to a service on the basis of relative need and available resources.

**Standard 2 Individual needs**
Each person with disability receives a service which is designed to meet, in the least restrictive way, his or her individual needs and personal goals.

**Standard 3 Decision making and choice**
Each person with disability has the opportunity to participate as fully as possible in making decisions about the events and activities of his or her daily life in relation to the services he or she receives.

**Standard 4 Privacy, dignity and confidentiality**
Each consumer's right to privacy, dignity and confidentiality in all aspects of his or her life is recognised and respected.

**Standard 5 Participation and integration**
Each person with disability is supported and encouraged to participate and be involved in the life of the community.

**Standard 6 Valued status**
Each person with disability has the opportunity to develop and maintain skills and to participate in activities that enable him or her to achieve valued roles in the community.

**Standard 7 Complaints and disputes**
Each consumer is free to raise and have resolved, any complaints or disputes he or she may have regarding the agency or the service.

**Standard 8 Service management**
Each agency adopts sound management practices which maximise outcomes for consumers.
Quality assurance processes differ across jurisdictions. Most processes include some form of self-assessment. Many include, or are working toward implementing, an external third party audit/certification process.

Data on quality assurance processes are reported in box 14.14. These results should be interpreted with reference to tables 14A.71–78, which contain information on the legislation under which jurisdictions implement standards, the relevant disability service standards and how quality is monitored.

**Box 14.14 Quality assurance processes for NDA specialist disability services**

**Australian Government**

The Australian Government funded a total of 348 disability employment organisations, comprising 1814 outlets, operating across Australia at 30 June 2012. Of these:

- Disability Employment Services (DES) funded by the Department of Education, Employment and Workplace Relations (DEEWR) made up 150 (43 per cent) of the organisations but accounted for 1496 (82 per cent) of total outlets
- Australian Disability Enterprises (ADEs) funded by the Department of Families, Housing, Community Services and Indigenous Affairs (FaHCSIA) made up 131 (38 per cent) of the organisations, with 318 (18 per cent) of total outlets
- of the 348 organisations, 67 (19 per cent) organisations operated as dual funded (both DEEWR and FaHCSIA) employment services
- in the year ending 30 June 2012, there were a total of 356 quality assurance audits performed at 153 DES organisations, 129 ADE organisations and 74 dual funded organisations. FaHCSIA paid a total of $2,182,750 in contributions towards the cost of these audits.

Of the 153 audits performed at DES organisations, 48 were certification audits and 105 were surveillance audits.

Of the 129 audits performed at ADE organisations, 16 were certification audits and 113 were surveillance audits.

**NSW, Victoria, Queensland, WA, SA, Tasmania and the ACT**

Different quality assurance processes were in place in NSW, Victoria, Queensland, WA, SA and the ACT in 2010-11. The evaluation processes related to both government and non-government service outlets, although in some jurisdictions the requirements are different across service sectors.

(Continued on next page)
Box 14.14  (Continued)

**NSW** — All NSW non-government providers are required annually to revalidate ongoing compliance with Standards. In 2010-11, 97 per cent of providers reported compliance with Standards. An action plan is developed for any required remedial action. The information return provided is assessed using a risk monitoring tool to determine the level of intervention required to support the provider. The extent of intervention is based on a range of factors, including output and financial reporting, complaints, self assessments and implementation of agreed plans for improvement.

To further strengthen this approach, NSW is implementing a Quality Management Framework, which requires funded service providers to implement a range of new quality requirements over the course of the three year funding cycle up to 30 June 2015. Over time, this will enhance the level of information available on the quality of services provided by funded providers. Compliance with the NSW Disability Services Standards, which have been streamlined from ten standards to six to closely align with the revised National Disability Standards, will also be a feature of the new requirements on quality and will involve an independent verification process by a certified third party.

**Victoria** — In 2011-12, organisations providing disability supports were required to report annually against a quality improvement indicator of their intention to undertake two or more quality improvement activities over the forthcoming year.

In 2011-12, 97 per cent of agencies in the sample reported at least two planned quality improvements activities in the next 12 months.

**Queensland** — The Disability Sector Quality System, introduced on 1 July 2004, requires all disability service providers recurrently funded by the Department of Communities, to achieve certification through an external certification body accredited by the Joint Accreditation System of Australia and New Zealand (JAS-ANZ). Each year service providers undergo annual surveillance audits to ensure that certification is maintained and that a continuous improvement plan has been developed. The quality system also provides a framework to support service providers to develop, implement and maintain their own quality management system. The assessment process relates to both government and non-government service providers.

Of the established 256 recurrently funded service providers, 100 per cent have achieved certification and undergo annual surveillance audits to ensure that certification is maintained and that a continuous improvement plan has been developed. Currently there are 14 new service providers who are in the process of implementing their quality management systems in preparation for external audit. Evaluation processes relate to both government and non-government service outlets.

(Continued on next page)
Box 14.14  (Continued)

WA — The Quality Management Framework (QMF) adopted in 2010 places an emphasis on outcomes achieved for people with disability via the evaluation of service points that comprise a number of service outlets.

Independent Evaluation is conducted for each service point on a three yearly cycle and includes an evaluation of agreed program outcomes and the Standards.

In 2011-12, 64 service points were evaluated against nine Disability Service Standards. All nine standards were met by 40 service points (63 per cent).

SA — In SA, non-government service providers are required to meet quality assurance criteria before they can provide NDA specialist services. From 2006-07, this included participation in an independent audit quality assurance program. In 2011-12, changes in contracting arrangements significantly increased the number of non-government service providers needing to participate. Currently, 90 per cent of grant and brokerage funded organisations are required to be engaged in an approved quality improvement program with the remaining 10 per cent exempt. It is anticipated that 85 per cent of all organisations will have met quality improvements by December 2012.

Tasmania — During 2011-12, Tasmania continued to implement the Quality and Safety Standards Framework across all Department of Health and Human Services funded community sector organisations, including specialist services for people with disability. The requirement to adhere to, and engage with the Standards Framework is included in the contractual arrangement between the Agency and the community sector organisation.

Engagement with the Standards Framework requires community sector organisations to demonstrate continuous quality improvement, on a six monthly basis, or continue with their current accreditation framework or, if seeking accreditation, select an appropriate framework that is inclusive of relevant national standards. To date, 100 per cent of funded community sector organisations delivering specialist disability services have engaged with the Standards Framework.

An independent consultant was engaged to complete an evaluation of the Standards Framework in mid-2011. Feedback from the evaluation was generally very positive and highlighted some major achievements. The Evaluation Report identified a need for change in the way the Agency monitors the quality and safety of services provided by the funded community sector. It also identified a need to strengthen the contract management relationship between the Agency and community sector organisations. The implementation of the recommendations will be transitional, commencing from July 2012.

(Continued on next page)
In 2011-12, the ACT continued the implementation of the quality improvement framework for all services delivered by government and community sector service providers. All individual organisations have begun work into business continuity management practices.

All individual organisations are required to undertake an annual baseline self-assessment against the National Disability Service Standards, with quality improvement action plans being developed and implemented on the basis of any identified issues.

All organisations have commenced work on a prequalification framework to come into effect from January 2013. The Community Services Directorate Prequalification Framework is designed to provide the ACT Government with assurance that each Community Services Directorate funded organisation meets the acceptable level of quality, capability and governance to secure recurrent funding for the services specified in a tender and/or under an existing Service Funding Agreement. The Prequalification Framework sets out standards of good practice in governance, management and service delivery in the human services sector. Organisations are submitting applications during 2012, which are being processed through the Prequalification Assessment Teams.

Further, as part of a regular process in the quality improvement framework, the ACT engaged an external contractor to conduct an independent compliance, quality assurance and financial audit on 15 Disability ACT funded non-government organisations. This audit has been completed. A series of ongoing audits will have involved at least 42 funded non-government organisations over a period of three years up to 2013.


**Client and carer satisfaction**

‘Client and carer satisfaction’ is an indicator of governments’ objective to deliver and fund quality disability services that meet the needs and goals of the client (or carer of the client) receiving them (box 14.15).
Box 14.15  **Client and carer satisfaction**

‘Client and carer satisfaction’ is defined as reported overall ratings and satisfaction with individual services. Results are taken from a client and carer satisfaction survey and are expressed in percentage terms.

A high or increasing proportion of clients and carers satisfied is desirable, as it suggests the service received was of a higher quality and better met the needs and goals of the client (or carer).

Data reported for this indicator are neither complete nor directly comparable.

Data quality information for this indicator is under development.

Data are available for reporting for only Victoria, Queensland, WA, SA, Tasmania and the ACT (box 14.16). It is anticipated that data for other jurisdictions will be included in future reports.

Box 14.16  **Client and carer satisfaction**

‘Client and carer satisfaction’ data reported relate to NDA specialist disability services.

**Victoria**

Since 2007-08, the Victorian Department of Human Services has surveyed a sample of carers using disability respite services to determine carer satisfaction with services.

The survey results inform program directions and, until 2011-12, were also reported to the Department of Treasury and Finance as part of the Department of Human Services’ budget paper performance reporting.

The Respite Carer Satisfaction Survey for 2011-12 found that:

- 69 per cent of carers responded that they were satisfied with the respite support service they received
- 11 per cent of carers reported being dissatisfied with respite services (down from 13 per cent in 2010-11)
- responses indicated that reported satisfaction may be influenced by factors such as the availability of services, rather than the quality of the services delivered.

DHS has committed to undertake a range of projects aimed at improving respite supports in Victoria, including the development of a plan to ensure that a wide range of supports are able to meet the diversity of families/carers needs into the future.

(Continued on next page)
Box 14.16  (Continued)

Queensland

No survey was conducted in Queensland in 2011-12. Queensland’s most recent *Disability and Mental Health Service Users and Carers Satisfaction Survey* was conducted during February to April 2009. Overall, of the 2147 service users, service users’ proxies, and carers who were surveyed, 73 per cent of service users and proxies and 66 per cent of carers reported that they were satisfied with the services they received. The survey provides results according to the type of disability and mental health services received and shows:

- 80 per cent of service users and their proxies and 74 per cent of carers were satisfied with accommodation support services
- 66 per cent of service users and their proxies and 61 per cent of carers were satisfied with community support services
- 76 per cent of service users and their proxies and 65 per cent of carers were satisfied with community access services
- 81 per cent of service users and their proxies and 77 per cent of carers were satisfied with respite services.

WA

Western Australia conducted a carer and client satisfaction survey in March 2012. In this survey, a total of 739 structured telephone interviews were completed from a sample of 1421 individuals with a disability or their carers, which was stratified to ensure that it contained individuals representing users across all services funded by the Disability Services Commission. Of the 739 respondents, 163 (22 per cent) were service users and 576 (78 per cent) were carers responding on behalf of service users. This survey was previously undertaken biennially but from 2011 will be undertaken annually.

Overall service user satisfaction was 81 per cent. For individual services, reported satisfaction was:

- 84 per cent for accommodation
- 87 per cent for individual support (includes Disability Professional Services and Day Options)
- 71 per cent for local area coordination
- 86 per cent for family and carer support.

SA

No update is available for the 2013 Report. A survey was conducted in 2011 but, due to issues with the sample size, data are not reported.

(Continued on next page)
Box 14.16  (Continued)

Tasmania

No update is available for the 2013 Report. No survey was conducted in Tasmania in 2011-12.

ACT

In 2012, the ACT conducted a client satisfaction survey that measured client satisfaction with all disability services funded through Disability ACT, including government provided services as well as services provided through non-government agencies. Overall, 76 per cent of respondents to the survey reported that they were satisfied or very satisfied with disability services funded through Disability ACT.

These surveys asked clients to rate their overall level of satisfaction with the quality of the main Disability ACT services they had received over the past 12 months. Overall, factoring responses recorded as either ‘satisfied’ or ‘very satisfied’, a satisfaction rating of 76 per cent was reported. The proportion of service users reporting that they were satisfied or very satisfied was:

- 78.9 per cent for accommodation support services — group home
- 77.8 per cent for accommodation support services — in my own home
- 69.2 per cent for community access — recreation
- 88.0 per cent for community access — support to participate in my community
- 75.0 per cent for community support — case management/support
- 50.0 per cent for community support — counselling
- 62.5 per cent for respite — centre based respite
- 78.6 per cent for respite — in home respite
- 100.0 per cent for information referral.


Efficiency — cost per output unit

The following cost per output unit efficiency indicators are reported:

- ‘government contribution per user of non-government provided services’
- ‘cost per user of State and Territory administered services’.

This Report includes 2011-12 expenditure data provided by Australian, State and Territory governments. However, as 2011-12 service user data from the DS NMDS collection were not available for this Report, the cost per service user efficiency indicators are reported using expenditure and service use data for 2010-11. Expenditure data in this Report might differ from information reported elsewhere (such as in departmental annual reports), because the financial counting rules and
definitions used to calculate expenditure can differ, and 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 different methods of service use data collection (table 14A.80).

Financial data — expenditure items included/excluded

Financial data reported in this chapter include/exclude various expenditure items depending on the context in which the data are reported. When specific service types are discussed, only direct recurrent expenditure on those specific services is included (this may include administrative costs that can be directly attributed to a specific service/s). When the disability services system as a whole is discussed, expenditure includes general administrative overheads that cannot be allocated to a specific service/s and major capital grants to non-government service providers. Capital grants to non-government service providers are excluded from total recurrent expenditure for the indicator ‘administrative expenditure as a proportion of total recurrent expenditure’, as they are not strictly a ‘recurrent’ expense. Exclusion of these grants improves the comparability of the indicator across jurisdictions and over time.

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 that non-government
service providers receive from the private sector and the general public are outside the scope of this Report.

Government contribution per user of non-government provided services

‘Government contribution per user of non-government provided services’ is an indicator of governments’ objective to provide specialist disability services in an efficient manner (box 14.17).

Box 14.17  Government contribution per user of non-government provided services

‘Government contribution per user of non-government provided services’ is defined as the net government expenditure per user of non-government provided NDA services. Measures are reported for 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 low or decreasing government expenditure per service user reflects a more efficient provision of this service.

Efficiency data are difficult to interpret. Although high or increasing expenditure per unit of output can reflect deteriorating efficiency, it can 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 can 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.

Data reported for this indicator are not directly comparable.

Data quality information for this indicator is under development.

The service user data used to derive this indicator have quality issues, so estimates of jurisdictional efficiency should be interpreted with care.
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 $73 328 per service user in 2010-11 (figure 14.27).

Figure 14.27 Estimated annual government funding per user of non-government provided accommodation support services in institutional/residential settings (2010-11 dollars)\(^a, b, c, d, e\)

---

\(^a\) See table 14A.81 for detailed notes relating to these data. \(^b\) Service user data used to derive this indicator have quality issues, so estimates of jurisdictional efficiency need to be interpreted with care. Section 14.6 contains further information on these quality issues. \(^c\) Government and non-government sectors have not been accurately recorded in the NSW DS MDS over the years. Some non-government providers have been coded as government and this will affect the comparability of the number of service users from government and non-government sectors over time. \(^d\) There were no non-government provided accommodation support services in institutional/residential settings in the ACT and the NT. \(^e\) Real dollars are previous years’ expenditure in current year’s dollars after basing expenditure on the ABS GDP price deflator 2010-11=100 (table AA.51).

Source: AIHW (unpublished) DS NMDS; State and Territory governments (unpublished); table 14A.81.

Estimated annual government funding per user of non-government provided accommodation support services in group homes and other community settings for 2010-11 are reported in table 14A.81.
Government contribution per user of non-government provided services —
government contribution per employment service user assisted

Nationally, for all employment services, estimated government expenditure per
service user assisted was $5060 in 2010-11 (figure 14.28). Nationally, estimated
annual government expenditure per service user in 2010-11, by employment service
type, was $4430 on open services (employed or seeking employment in the open
labour market) and $9892 on supported services (employed by the service provider)
(table 14A.83).

Figure 14.28 Government contribution per employment service user
assisted (2010-11 dollars)a, b, c

![Graph showing government contribution per employment service user assisted (2010-11 dollars)]

a See table 14A.82 for detailed notes relating to these data. b Cost per employment service user data
reported here might differ from those reported in the Australian Government's annual report, where different
rules are used to count the number of employment service users. c Real dollars are previous years’
expenditure in current year’s dollars after basing expenditure on the ABS GDP price deflator 2010-11 =100
(table AA.51).

Source: Australian Government (unpublished); AIHW (unpublished) DS NMDS; table 14A.82.

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 (box 14.18).
Box 14.18  **Cost per user of State and Territory administered services**

'Cost per user of State and Territory administered services' is defined as government expenditure on NDA State and Territory administered services per service user. The following two measures are reported:

- estimated government expenditure per user of NDA State and Territory administered services (data are reported separately for government expenditure net of payroll tax and for government expenditure including actual and/or imputed payroll tax)
- cost per user of government provided accommodation support services in:
  - institutional/residential settings
  - group homes
  - other community settings.

Holding other factors constant (such as service quality and accessibility), a low or decreasing government expenditure per service user reflects a more efficient provision of this service.

Efficiency data are difficult to interpret. Although high or increasing expenditure per unit of output can reflect deteriorating efficiency, it can 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 can 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.

Data reported for this indicator are not directly comparable.

Data quality information for this indicator is under development.

Total estimated government expenditure per user of NDA State and Territory administered specialist disability services in 2010-11 is reported both net of payroll tax and including actual and/or imputed payroll tax. Nationally, estimated expenditure per service user was $32 701 excluding payroll tax and $33 128 including actual and/or imputed payroll tax (figure 14.29).
Figure 14.29  Estimated annual government expenditure per user of NDA State and Territory administered services, 2010-11a, b, c, d

<table>
<thead>
<tr>
<th>State/Region</th>
<th>Total expenditure excluding payroll tax</th>
<th>Actual and/or imputed payroll tax</th>
</tr>
</thead>
<tbody>
<tr>
<td>NSW</td>
<td>30</td>
<td>10</td>
</tr>
<tr>
<td>Vic</td>
<td>20</td>
<td>5</td>
</tr>
<tr>
<td>Qld</td>
<td>30</td>
<td>15</td>
</tr>
<tr>
<td>WA</td>
<td>25</td>
<td>10</td>
</tr>
<tr>
<td>SA</td>
<td>20</td>
<td>5</td>
</tr>
<tr>
<td>Tas</td>
<td>20</td>
<td>5</td>
</tr>
<tr>
<td>ACT</td>
<td>20</td>
<td>5</td>
</tr>
<tr>
<td>NT</td>
<td>30</td>
<td>10</td>
</tr>
<tr>
<td>Aust</td>
<td>30</td>
<td>10</td>
</tr>
</tbody>
</table>

a In some jurisdictions (NSW, Victoria, SA, Queensland, Tasmania and the NT), payroll tax data are actual; in other jurisdictions (WA and ACT), payroll tax data are 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) DS NMDS; State and Territory governments (unpublished); table 14A.84.

Cost per user of State and Territory administered services — government provided accommodation support services – institutional/residential settings

Nationally, estimated annual government expenditure on accommodation support services in institutional/residential settings was $128,919 per service user in 2010-11 (figure 14.30).
Estimated annual government expenditure per user of government provided accommodation support services in institutional/residential settings (2010-11 dollars)\(^a, b, c, d, e, f\)

\(^a\) See table 14A.81 for detailed notes relating to these data. \(^b\) Service user data used to derive this measure have quality issues, so estimates of jurisdictional efficiency need to be interpreted with care. Section 14.6 contains further information on these quality issues. \(^c\) Government and non-government sectors have not been accurately recorded in the NSW DS MDS over the years. Some non-government providers have been coded as government and this will affect the comparability of the number of service users from government and non-government sectors over time. \(^d\) Queensland data include funding provided by the Department of Communities only. \(^e\) There were no government provided accommodation support services in institutional/residential settings in Tasmania, the ACT or the NT. \(^f\) Real dollars are previous years’ expenditure in current year’s dollars after basing expenditure on the ABS GDP price deflator 2070-11 =100 (table AA.51).

Source: AIHW (unpublished) DS NMDS; State and Territory governments (unpublished); table 14A.81.

Estimated annual government expenditure per user of government provided accommodation support services in group homes and other community settings for 2010-11 are reported in table 14A.81.

**Efficiency — administrative cost**

**Administrative expenditure as a proportion of total recurrent expenditure**

‘Administrative expenditure as a proportion of total recurrent expenditure’ is an indicator of governments’ objective to provide specialist disability services in an efficient manner (box 14.19). The proportion of total expenditure on administration is not yet comparable across jurisdictions, as it is apportioned by jurisdictions using different methods (table 14A.81). However, administrative expenditure data can indicate trends within jurisdictions over time.
Box 14.19  
**Administrative expenditure as a proportion of total recurrent expenditure**

‘Administrative expenditure as a proportion of total recurrent expenditure’ is defined as government expenditure on administration as a proportion of total recurrent NDA expenditure. Major capital grants to non-government service providers are excluded to improve comparability across jurisdictions and over time.

Holding other factors constant (such as service quality and accessibility), lower or decreasing administrative expenditure as a proportion of total recurrent NDA expenditure might 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 and less effective administrative services. This may in turn affect service delivery effectiveness. Efficiency data therefore should be interpreted within the context of the effectiveness and equity indicators to derive a holistic view of performance.

Data reported for this indicator are not directly comparable.

Data quality information for this indicator is under development.

Nationally, administrative expenditure as a proportion of total government expenditure on specialist disability services (excluding payroll tax) decreased slightly from 7.6 per cent in 2010-11 to 7.3 per cent in 2011-12 (figure 14.31). When actual or imputed payroll tax is included, the average national administrative expenditure as a proportion of total NDA expenditure was 7.2 per cent in 2011-12 (table 14A.85). Real total NDA expenditure is reported in table 14A.7, both excluding and including actual or imputed payroll tax amounts.
Outcomes

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

The following outcome indicators are included in the performance framework:

- ‘Labour force participation and employment of people with disability’
- ‘Labour force participation of primary carers of people with disability’
- ‘Social participation of people with disability’
- ‘Use of other services by people with disability’.

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 across
jurisdictions, and across 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 ± 4, for example, means that if another sample had been drawn there is a 95 per cent chance that the result would lie between 76 and 84. Where ranges do not overlap, there is a statistically significant difference. If one jurisdiction’s results range from 78–80 and another’s from 82–89, then it is possible to say that one differs from the other (because 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 disability

‘Labour force participation and employment of people with disability’ is an indicator of governments’ objective of assisting people with disability to participate fully in the community (box 14.20). Participation in the labour force and employment is important to the overall wellbeing of people with disability, providing opportunities for personal development and financial independence.

Box 14.20 Labour force participation and employment of people with disability

‘Labour force participation and employment of people with disability’ 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.

High or increasing labour force participation and employment rates for people with disability are desirable. Higher rates are likely to increase the quality of life of people with disability by providing greater opportunities for self-development and for economic and social participation.

This indicator does not provide information on why people choose not to participate in the labour force and why people are not employed. It also does not provide information on whether the employment positions are appropriate or fulfilling.

Data for this indicator were not available for the 2013 Report.


Data for 2009 and previous years are available in attachment tables 14A.86–103.
Labour force participation of primary carers of people with disability

‘Labour force participation of primary carers of people with disability’ is an indicator of governments’ objective of assisting primary carers of people with disability to participate fully in the community (box 14.21). Participation in the labour force is important to the overall wellbeing of carers, providing opportunities for personal development and financial independence.

Box 14.21  Labour force participation of primary carers of people with disability

‘Labour force participation of primary carers of people with disability’ is defined as labour force participation rate for primary carers aged 15–64 years of people with disability.

Primary carer is defined as a person who provides the most informal assistance, in terms of help or supervision, to a person with one or more disabilities. A detailed definition is provided in section 14.7.

Higher or increasing labour force participation rates for primary carers of people with disability are desirable. Higher rates are likely to increase the quality of life of primary carers of people with disability by providing greater opportunities for self-development.

This indicator does not provide information on why people choose not to participate in the labour force. It also does not provide information on whether the participation in the labour force is fulfilling.

Data reported for this indicator are comparable.


Nationally in 2009, the estimated labour force participation rate of primary carers aged 15–64 years for people with disability (53.7 ± 3.7 per cent) was less than both the estimated labour force participation rate for all carers (68.7 ± 1.9 per cent) and the estimated labour force participation rate for non-carers (79.9 ± 3.8 per cent) (figure 14.32).

Detailed definitions of the labour force participation rate and its calculation method are provided in section 14.7. Other data on the labour force participation for primary carers of people with disability are reported in tables 14A.104–111.
Social participation of people with disability

‘Social participation of people with disability’ is an indicator of governments’ objective to assist people with disability to live as valued and participating members of the community (box 14.22).

**Box 14.22  Social participation of people with disability**

‘Social participation of people with disability’ is defined as the proportion of people who participate in selected social or community activities by disability status:

- Profound or severe core activity limitation
- Other disability
- No disability.

A high or increasing proportion of people with disability who participate in social or community activities reflects their greater inclusion 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.

Contact with family and friends

Nationally in 2010, the estimated proportion of people with disability aged 18-64 years with a profound or severe disability who had face-to-face contact with family or friends at least once a month or more (89.2 ± 5.5 per cent) was lower than the rate for other people with disability (without a profound or severe core activity limitation) (93.6 ± 1.5 per cent) and the rate for people without disability (95.2 ± 0.8 per cent) (figure 14.36).

Figure 14.33 People with disability aged 18–64 years who had face-to-face contact with family or friends at least once a month or more, 2010a, b, c

---

Use of other services by people with disability

‘Use of other services by people with disability’ is an indicator of governments’ objective of enhancing the quality of life experienced by people with disability by assisting them to gain access to mainstream government services (box 14.23).
Box 14.23  Use of other services by people with disability

This indicator is reported using different measures in different Reports, depending on the data available.

For this Report ‘Use of other services by people with disability’ is defined by the following measures:

- people with a profound or severe core activity limitation aged 3–5 years who attended pre-school divided by the total population of people aged 3–5 years with a profound or severe core activity limitation
- people with a profound or severe core activity limitation aged 15–24 years who attended secondary schools divided by the total population of people aged 15–24 years with a profound or severe core activity limitation
- people with a profound or severe core activity limitation aged 15–64 years who attended technical or further education divided by the total population of people aged 15–64 years with a profound or severe core activity limitation
- people with a profound or severe core activity limitation aged 15–64 years who attended university or other tertiary institutions divided by the total population of people aged 15–64 years with a profound or severe core activity limitation.

For each measure, rates for people with disability are compared with rates for people without disability.

A high proportion of people with disability who use the selected mainstream government services suggests greater access to these services.

This indicator does not provide information on whether the service accessed is the most appropriate, or the degree to which the service contributes to people’s quality of life. It also does not provide information on why some people do not access these services.

Data quality information for this indicator is under development.

Education and training

Nationally in 2011, the proportion of children/people who need assistance with a core activity limitation:

- aged 3–5 years who attended pre-schools was 42.6 per cent, higher than those without a disability (40.5 per cent) (figure 14.37a)
- aged 15–24 years who attended secondary schools was 33.0 per cent, higher than those without a disability (26.5 per cent) (figure 14.37b)
- aged 15–64 years who attended technical or further education was 2.7 per cent, lower than those without a disability (3.3 per cent) (figure 14.37c)
• aged 15–64 years who attended university or other tertiary institutions was 1.4 per cent, less than the those without a disability (6.6 per cent) (figure 14.37d).

Figure 14.34 People with a core activity limitation who need assistance participating in education and training, 2011a, b

(a) Attending pre-school

(b) Attending secondary school

(c) Attending Technical or Further Education

(d) Attending University or other Tertiary Institution

---

a The ABS 2011 Census module, used to source these data, was designed to measure ‘Core Activity Need for Assistance’ (ASSNP). 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). 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.

Other data on participation of people with disability in selected social and community activities are reported in tables 14A.118–147.

‘Use of other services’ data reported elsewhere in this Report

Data on the participation of people with disability in various government services are incorporated in the performance indicator frameworks for other chapters of this Report. Participation is reported for children’s services (chapter 3); VET (chapter 5); social, community and State owned and managed Indigenous housing (chapter 16) and Commonwealth Rent Assistance (sector overview G). In addition, the following chapters include data on services provided to people with disability:

- ‘School education’ (chapter 4) reports data on students with disability in the student body mix
- ‘Mental health management’ (chapter 12) reports performance data on specialised mental health services
- ‘Aged care services’ (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 for people 65 years and over.

14.4 Future directions in performance reporting

Scope for further improvements to 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 the development of an indicator on quality of life
- reporting improved service user data, as a result of anticipated improvements in data quality and comparability
- reporting more comprehensive social and community participation data, when available
- reporting nationally consistent client and carer satisfaction with service quality for all jurisdictions
- reporting improved quality assurance processes data, which are expected to become more complete and comparable under the NDA.
COAG developments

The Steering Committee is committed to ensuring this chapter remains aligned with the significant reforms being implemented by COAG.

Indicators in the chapter will continue to be aligned with indicators in the NDA, and the chapter will reflect development in the National Disability Strategy and the National Disability Insurance Scheme.

National Disability Strategy

The National Disability Strategy 2010–2020 was formally endorsed by COAG on 13 February 2011 and launched by the Australian Government on 18 March 2011. This represents the first time in Australia’s history that all governments have committed to a unified, national approach to improving the lives of people with disability, their families and carers.

The Strategy will guide public policy across governments and aims to bring about changes to all mainstream services and programs, as well as community infrastructure, to ensure they are accessible and responsive to the needs of people with disability.

A first report on the Strategy will be presented to COAG in late 2012. Every two years, a high level progress report will track achievements under the Strategy and provide a picture of how people with disability are faring. The first biennial progress report will be presented to COAG in 2014.

National Disability Insurance Scheme

The first stage of the National Disability Insurance Scheme (NDIS) will commence on 1 July 2013, with sites in NSW, Victoria, South Australia, Tasmania and the ACT.

The first stage includes the establishment of a new National Disability Transition Agency to run the delivery of care and support to people with disability, their families and carers. The establishment of the NDIS has the potential to influence the future direction of the DS NMDS and data in future editions of the Report.

National Health Reform Agreement

COAG agreed the National Health Reform Agreement out of session in August 2011. The Agreement gives effect to the commitment made by the Council of
Australian Governments (COAG) on 13 February 2011, and in doing so, supersedes the National Health and Hospitals Network Agreement and the Heads of Agreement on National Health Reform.

The Agreement will deliver major reforms to the organisation, funding and delivery of health and aged care. It sets out the shared intention of the Commonwealth and State and Territory governments to work in partnership to improve health outcomes for all Australians and ensure the sustainability of the Australian health system. The reforms aim to achieve better access to services, improved local accountability and transparency, greater responsiveness to local communities and a stronger financial basis for our health system into the future.

### 14.5 Jurisdictions’ comments

This section provides comments from each jurisdiction on the services covered in this chapter.
Australian Government comments

• During 2011-12 the Australian Government funded supported employment for over 22,300 people with disability in 319 Australian Disability Enterprise (ADE) outlets across Australia.

• In May 2012, the Australian Government released Inclusive Employment 2012-2022: a vision for supported employment. It recognises that the time has come, in line with other Australian Government commitments, to put people with disability front and centre of program delivery. The Vision articulates a significant change in the way the Australian Government supports people with disability in employment by ensuring they have control of the assistance they get.

• Work was undertaken in collaboration with State and Territory jurisdictions in 2011 to test retirement planning options for ageing workers in ADEs. The Transition to Retirement Evaluation Report into these activities was released by the Australian Government in May 2012. The report highlights that person-centred individualised planning to identify issues and possible options for retirement is crucial, along with activities which enable potential retirees to try out and experience what life might be like when they stop work.

• A draft report on the review of costs the Australian Government pays to service providers to deliver supported employment was delivered in 2011. A series of national validation and information workshops were held in May/June 2012. The workshops highlighted the need for further data collection to better determine an appropriate funding structure. The second data collection round closed at the end of September 2012.

• The Disability Employment Services (DES) – Employment Support Service (ESS) program was in operation during the entire 2011-12 year. ESS assists job seekers with permanent disability and an assessed need for long-term, regular support in the workplace. Job seekers receive tailored services that are flexible and responsive to both their needs and those of employers.

• As at 30 June 2012 there were 194 organisations delivering ESS from 1130 sites and for the 2011-12 financial year there were around 127,000 participants referred to the program.

• The proportion of ESS job seekers who achieved a sustainable employment outcome (at their assessed benchmark hours of 8, 15 or 30 hours of work per week for 26 weeks) was 28.8 per cent as at 30 June 2012.

• It should be noted that comparisons to Disability Employment Network (DEN was the previous program) outcome rates should be done with care. The requirements regarding the payment of outcome fees have been tightened under DES to reward genuine sustainable employment at the participants work capacity with assistance.
New South Wales Government comments

NSW continued the implementation of Stronger Together, the NSW Government’s 10 year plan to make the specialist disability service system more responsive to the needs of people with a disability, their families and carers. In 2011-12, disability funding in NSW increased by 13.7 per cent over the previous year, reaching $2.1 billion.

Over $2 billion in new growth funding has been committed over five years to 2015-16 under the second phase of Stronger Together. This is the largest investment in disability services in NSW history. The number of places planned for delivery totals 47 200, 63 per cent more than the 29 000 places delivered in the first five years.

Stronger Together Two delivered 5336 new places in 2011-12, excluding Ability Links. This exceeded the place targets by over 10 per cent. Total expenditure to deliver these new services was $137.9 million. Over 300 new accommodation places were delivered, including 107 through the Supported Living Fund, a new individualised approach to accommodation support. There was major expansion of flexible respite, with 1393 places delivered. In addition 61 new attendant care places for people with a primary physical or sensory disability or acquired brain injury were provided.

Throughout 2011-12 approximately 4000 people participated in the Living Life My Way consultations on how people with a disability can be supported to be at the centre of decision making about how their support needs are met. The $5 million Consumer Development Fund, an initiative of the consultations, was introduced to assist people with a disability make the most of the opportunities presented by individualised funding.

A new range of innovative, specialist supports to the most complex clients in the disability service system and their families, carers and staff became available through the Specialist Training and Resource Team.

As part of the ongoing commitment to reduce red tape, an enhanced client management system service portal was implemented to streamline engagement with service providers.

Development of the disability services sector continued through ongoing rollout of the $17 million Industry Development Fund and implementation of the Sector Planning Framework to promote local capacity to deliver the commitments under Stronger Together Two.

NSW is enhancing actuarial modelling to predict and monitor need and supply for disability services. The annual update of Stronger Together Two modelling found that the new data reinforces the assumptions of the original modelling. It also found that changes underway were consistent with the outcomes expected.
Victorian Government comments

In 2011-12, Victoria has continued to extend its achievements in disability reform and increase the availability of disability support services. Victoria is committed to putting clients’ needs at the centre of service delivery and to work with communities and individuals to provide greater choice and opportunities.

Notable achievements in 2011-12 include:

- The Disability Amendment Act 2012 came into effect on 1 July 2012 to address technical and administrative issues that have arisen since the introduction of the Disability Act 2006. The issues amended include clarifying the jurisdiction of the Victorian Disability Services Commissioner, empowering the Victorian Civil and Administrative Council to review assessment orders made by the Victorian Senior Practitioner and modifying definitions to cover all intended services under the Disability Act 2006.

- A commitment was made to deliver a total of 118 new supported accommodation options through two separate programs. The government encouraged community service organisations to develop new and innovative models of supported accommodation through the IDEAS initiative, to be delivered through funding from the 2011-12 Victorian State Budget. The government assisted nine community service organisations to secure 53 new accommodation options from the Commonwealth Government’s Supported Accommodation Initiative Fund, announced in April 2012.

- The Carers Recognition Act 2012 came into effect on 1 July 2012. The Act raises the status of carers and care relationships in the community and sets out clear expectations for organisations covered by the Act. In addition, Victoria expanded practical supports for carers with better access, greater flexibility and more choice in respite support services for people with a disability, their families and carers. In 2011-12, more than 30 service providers were funded to deliver respite support and school holiday respite support as part of Victoria’s plan to improve disability respite and carer support services across the State.

- A new top-up fund was established in May 2012 to assist children with the cost of manual and powered wheelchairs, pressure cushions and walking aids.

- Victoria commenced a series of projects focussed on improving access for Aboriginal people with a disability to mainstream and Aboriginal disability, health and other programs to improve their whole-of-life outcomes.

- Victoria continued work to develop support for self-directed approaches through a learning and development program where facilitators work with people to plan for and design their support arrangements. Victoria released a number of publications to assist people with a disability and those supporting them to better understand how individual support packages can be used in different, choice-based ways as well as providing funding to an advocacy organisation to deliver a number of forums on choice across Victoria.
Queensland Government comments

In 2011-12, the Queensland Government implemented the new specialist disability service system to provide consistent access and referral pathways to disability services, and fairer and more equitable processes by which to make decisions regarding the allocation of funding. From the release of the reforms in July 2011 to 30 June 2012, 6262 new clients have been assessed.

The Disability Assistance Package capital funding, a partnership between the Queensland Government and the Commonwealth Government, completed 30 houses supporting 118 people of which 76 transitioned from being cared for by older carers. In addition, the Queensland Government provided $1 million as part of a $3 million commitment over three years (2012—2015) for ongoing support for residents at a state-of-the-art accommodation complex built on the Gold Coast, accommodating seven young people with high and complex disability support needs.

In 2011-12, the Queensland Government provided specialist services to more than 8500 children aged 0–17 years through initiatives such as Family and Early Childhood Services, the Autism Early Intervention Initiative, All Abilities Playgrounds and the Evolve Behaviour Support Service. The Queensland Government also delivered additional respite to more than 500 families of young children with disability, aged 0–12 years through 15 non-government service providers across Queensland to support families in their caring role.

In February 2012, the Queensland Government commenced My Future: My Life, an early intervention strategy to support young people with a disability encouraging eligible students to engage in meaningful opportunities to assist them to plan ahead for their transition from school. These students may access to up to $1000 in Year 11 and up to $2000 in Year 12.

In July 2011, as part of the Positive Futures initiative, the Forensic Disability Act 2011 commenced establishing and regulating the new Forensic Disability Service operated by the department to provide a secure, therapeutic service for up to 10 people placed on forensic disability orders by the Mental Health Court. The Queensland Government also commenced providing $2 million in recurrent funding to assist non-government organisations to implement the Positive Futures reforms on an ongoing basis.

The Disability Act 2006 has a strong focus on protecting clients from abuse, neglect and exploitation and also focuses on improving practices across the disability sector by encouraging the use of positive behaviour support practices. A review of the legislative provisions around restrictive practices commenced in 2010 and a Position Paper outlining proposed reforms was released in January 2012 and distributed to key service providers and disability advocates. Two information forums on the Position Paper for key stakeholders were held in February 2012.
Western Australian Government comments

The WA Government supports the introduction of the National Disability Insurance Scheme and has made a significant contribution to the design of the emerging scheme. Western Australia will be supporting a federated governance approach that achieves local control and decision making to achieve better outcomes for people with disability. The new My Way project sites will be used to commence the NDIS in WA.

Key initiatives implemented in 2011-2012 include:

- Four trial sites for the My Way project were announced — Goldfields, Lower South West, Cockburn/Kwinana and Perth Hills. My Way aims to increase the level of control that individuals and families have over their supports and services. The outcomes from this project are expected to contribute to the development of the National Disability Insurance Scheme.

- More than $1 million of recurrent funding was allocated to respite centres in York and Gosnells to provide support for people with disability who also have high support needs.

- The Commission’s Reconciliation Action Plan was endorsed for 2012—2014. Increasing Aboriginal employment rates, developing an Aboriginal employment strategy to explore alternative employment options as well as to promote and understand Aboriginal culture, and building stronger Aboriginal community networks and partnerships are key components of the plan.

- The State Government committed $18 million to establish two secure community based accommodation centres for people with an intellectual or cognitive disability who are accused of offences but have been deemed not fit to plead. New legislation will enable the Commission to establish and operate the disability justice centres. The Commission has progressed work on the model of service for the centres and for an in-reach prison program.

- In November, the Liveable Homes project was launched including design guidelines aimed at increasing the number of private dwellings built using universal design.

- The Commission commenced work on a comprehensive sector development plan. The plan will provide analysis of current services and supports for people with disability across WA according to local government areas. It will provide a base for identifying current services and demand, and in partnership with local stakeholders will define opportunities for development.

- The Commission allocated $3.3 million to increase the number of places available for its Early Childhood Intervention, School Aged Intervention and Adult Intervention services to support independence and participation in the community for people with disability.

- The Commission led a collaborative partnership across the disability sector to implement the Positive Behaviour Strategy. This resulted in the completion of the Effective Service Design project and its expansion into regional WA.
South Australian Government comments

The South Australian Government has commenced implementation of a major reform agenda underpinned by Strong Voices: A Blueprint to Enhance Life and Claim the Rights of People with Disability in South Australia (2010-2020). Reforms focus on accessible and inclusive communities and services, choice and control for people with disability, strengthening rights and safeguards, investing early and diversifying housing choices.

The explicit aim is to bring people with disability to the forefront in determining how they live their lives, pursue aspirations and contribute to our society.

Highlights for 2011-12 include:

- Review of the Promoting Independence Strategy to further improve accessibility and inclusion for people with disability.
- Successful evaluation of the Self-Managed Funding Initiative – Phase One.
- Government commitment to the expansion of individualised funding, so that everyone in receipt of six hours or more of specialist disability support per week through Disability Services will receive a personalised budget.
- Continued progress, including consultation with people with disability, to progress the development of a new Disability Act.
- Announcement of a $212.5 million funding boost to disability services in the 2012-13 State Budget, the largest in more than 25 years.
- Establishment of the Disability Community Visitor Scheme to protect the rights and wellbeing of people with disabilities who live in disability accommodation or in Supported Residential Facilities.
- Agreement for State and Commonwealth funding for the National Disability Insurance Scheme launch across South Australia for about 5000 children aged up to 15 years, commencing in July 2013.
- Establishment of the Child and Youth Services directorate within Disability Services to provide a dedicated focus on the needs of children and young people with disability. Implementation of a revised service delivery model aimed at maximising developmental outcomes for children and young people and strengthening families to assist them in the care of children.

Continued progress in meeting the South Australian Strategic Plan Target 11 to increase the number of people with disability in stable, supported community accommodation to 7000 by 2020. This includes construction of 47 client places as part of the Supported Accommodation for People with Disability with Ageing Carers Program.
Tasmanian Government comments

In 2011-2012 Tasmania continued to support people with disability to achieve economic participation and social inclusion through the continuing implementation of the Operational Framework for Disability Services, Tasmania’s high level strategic plan launched in 2009.

Work has focussed on embedding the outsourcing of the government specialist disability support services from 2011 and reviewing its progress to ensure that the range of services available continue to provide flexible and person centred support to people with disability, their families and carers.

Following a review and extensive community consultation in 2010, the Tasmanian Disability Services Bill 2011 was passed by the Tasmanian Parliament in September 2011 and proclaimed on the 1 January 2012. Changes under the Disability Services Act 2011 have been communicated to the Tasmanian sector through workshops, information sessions and the publication of a number of fact sheets. The new position of Senior Practitioner has been filled and work has begun to establish this position and its requirements under the Act.

A discussion paper on self-directed funding in Tasmania was developed in late 2011 with the aim of introducing a self-directed funding pilot in Tasmania in 2012. Tasmania has obtained a Class Ruling from the Australian Tax Office and will begin directly funding a small number of people with disability who choose to manage their own funding packages in 2013 with the aim of extending this as the pilot progresses.

Continuing on from the reform period in Tasmania, additional recurrent funding has been provided to advocacy services to support Tasmanians with disability.

A new service model for the provision of equipment and assistive technology has been endorsed by the Tasmanian Minister for Human Services. Implementation of the new State-wide program, TasEquip, has commenced.

The Resource Allocation and Unit Pricing Framework developed as part of the Tasmanian Integrated Service System reforms began the first stage of a three year implementation in July 2011. This pricing mechanism is applied to a range of services (including specialist disability support services) and will continue to respect sector diversity, promote client choice, promote equity between Tasmania’s regions and encourage innovative service delivery models.

Tasmania undertook a project within the Department of Health and Human Services to manage the changes under the age care reform program.

Tasmania has been working with the Australian Government on a number of major areas for reform in preparation for the launch of the National Disability Insurance Scheme.
Australian Capital Territory Government comments

In 2011-2012, the Community Services Directorate, through Disability ACT continued to operate under a national framework of reforms and priorities and the ACT Government Policy Framework, Future Directions: Towards Challenge 2014. The Directorate implemented new and significant programs to improve the life outcomes and opportunities for people with disability in the ACT.

- The Disability Information and Support Hub (DISH) was launched in February 2012. The DISH co-locates some existing ACT Government and community sector programs to centralise resources which support people with disability and their families. The DISH operates within a strengths-based framework that reflects our approach to working with the community and how we provide people with the tools to bring about change in their lives.

- Two new after-school programs for teens and four vacation care programs for young people with disability commenced in 2012; 20 after-school care places focus on supporting individuals to develop life skills and social development; 40 vacation care places focus on creating inclusive holiday opportunities for children in primary school and young people attending high school.

- Disability ACT continued to assist people with disability to identify housing options that best meet their individual need. Since August 2011, the Housing Options Facilitator has completed housing options plans with over 40 individuals and families and has provided presentations in housing options planning to over 200 individuals who sought support and advice.

- Everyone, Everyday is a disability awareness program for ACT schools which promotes inclusion and raising awareness about disability issues with school students. A trial of the Everyone, Everyday curriculum resource has begun at five ACT primary schools. The Education and Training Directorate are providing teaching time and resource support for this initiative. An evaluation of the pilot program will be completed at the end of the 2012 school year.

- Disability ACT continued to deliver services under the National Disability Agreement (NDA). Disability ACT worked across government as part of a national review of the NDA to better align with national reforms through the launch of the National Disability Strategy (NDS) and the National Carers Strategy (NCS); and new responsibilities with the National Health Reform Agreement (NHRA); and the National Disability Insurance Scheme (NDIS).

- During 2011-12, ACT officials participated in national working groups progressing the design elements of the NDIS for the launch in July 2013.

- The ACT will participate as a launch site for the NDIS from July 2013. In August 2012, the Minister for Community Services established an expert panel to provide strategic advice on the impact of the NDIS on people with disability, their supports and the ACT Community. The ACT NDIS Taskforce will work with the Commonwealth on implementing the scheme in the ACT.
Northern Territory Government comments

The Northern Territory Government’s ongoing commitment and vision is for a society where people with a disability have productive and fulfilling lives as valued members of their communities. The Northern Territory Government aims to continue to improve access to support services for Territorians with a disability, while ensuring that their carers also enjoy good health, wellbeing, and resilience.

Key initiatives undertaken towards these aims in 2011-12 include:

- The number of disability supported accommodation places in the Northern Territory increased by 14. The new total of 178 places provide care and support to people with a disability and high support needs.

- Construction of two secure residential facilities in Darwin and Alice Springs. The secure group homes will provide an intensive therapeutic environment in order to stabilise resident behaviour, increase their daily living skills and decrease their high risk behaviours, thus allowing them to transition to less restrictive service options. The group homes will begin scaled operations following successful recruitment to the facilities.

- The continuation of the pilot Remote Intensive Therapy Program provides specialised and intensive allied health treatment and support for children with a significant disability living in a remote location. The Program is designed to maximise function, participation and quality of life.

- The development of the Disability In-Home Support Service which continues the provision of support services to support younger people with a disability, their families and carers. The service was previously delivered through the Home and Community Care Programs (HACC). The NT continues to fund HACC type services for non-Indigenous people aged 64 years and under and 49 years and under for Indigenous people.

- As in previous years, indicators based on the estimated number of people with severe, profound and/or core activity limitations in the NT need to be interpreted with caution. Small variations in service and population data appears in magnified proportions to the small population of the NT.
14.6 Service user data quality and other issues

Data quality

Data quality considerations should be taken into account when interpreting the DS 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 participation rates
- service user participation rates
- ‘not stated’ response 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 2012a).

‘Not stated’ rates for individual data items vary between jurisdictions (AIHW 2012a). Reasons 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 DS 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 2012a)
- changes in collection practices, such as data on new users of open employment services not being collected in 2010–11. This change resulted in high overall non-response rates for these items and data not being strictly comparable with previous years.
Other issues

Service user data/data items not collected

Service user data are not collected for the following NDA specialist disability service types: 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, sex, commencement date and date of last service)
- 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 NDA specialist disability service types. In some jurisdictions (Victoria, Queensland and WA), specialist psychiatric disability services are funded specifically to provide such support (AIHW 2011a). Nationally, in 2010-11, 13 236 people used only specialist psychiatric disability services (AIHW unpublished). Data for these services are included in other publications on the DS NMDS, such as AIHW (2011a). Therefore, service user data for Victoria, Queensland, WA and Australia 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 2011a). 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 2011a).

**Deriving potential populations for the special needs groups**

Potential populations have been estimated for each of the special needs groups (outer regional and remote/very remote areas, Indigenous and people born in a non-English speaking country) and for those outside of the special needs groups (major cities and inner regional areas, non-Indigenous and people born in an English speaking country). These potential populations are estimates of the number of people with the potential to require disability support services in the relevant group, including individuals who meet the service eligibility criteria but who do not demand the services.

The approach used to derive the potential population estimates by country of birth and geographic location involved the following steps:

- Deriving State/Territory based 10-year age and sex specific proportions of people with ASSNP by geographic location and country of birth using the 2006 Census
- Multiplying these State/Territory based 10-year age and sex specific proportions by the 10-year age specific estimates of the number of people with severe/profound core activity limitations in each State/Territory
- Summing the resultant 10-year age and sex group counts to derive the total potential populations for the geographic locations, people born in Australia, people born in another English speaking country and people born in a non-English speaking country. Summing the potential populations for people born in Australia and people born in another English speaking country to derive the total potential population for people born in an English speaking country
- For employment, repeating the above steps, but restricting the calculations to those people aged 15–64 years, then multiplying each State/Territory total by State/Territory specific labour force participation rates for people aged 15–64 years.
The approach used to derive the potential populations by Indigenous status involved the following steps:

- Deriving current State/Territory based 10-year age and sex specific rate ratios of people with ASSNP by Indigenous status using the 2006 Census

- Multiplying the current State/Territory Indigenous and non-Indigenous 10-year age and sex population estimates by national 10-year age and sex specific rates of severe/profound core activity limitation from the 2009 SDAC. Then multiplying the Indigenous and non-Indigenous counts for each 10-year age and sex group by the 10-year age and sex specific rate ratios of people with ASSNP to obtain an Indigenous/non-Indigenous potential population within each age and sex group

- Summing the 10-year age and sex group counts to derive a total Indigenous and non-Indigenous potential population for each State/Territory

- For employment, repeating the above steps, but restricting the calculations to those people aged 15–64 years, then multiplying each State/Territory total by State/Territory specific labour force participation rates for people aged 15–64 years.

Data quality issues

Data measuring the potential populations of the special needs groups are not explicitly available for the required time periods and have been estimated using several different data sources (as noted above), under several key assumptions. Some issues with this approach are outlined below:

- The method used to estimate the potential populations assumes:
  - that disability rates vary only by age and sex, and there is no effect of remoteness, disadvantage, or any other variable — this is likely to affect the reliability of comparisons across states and territories, however, it is currently not possible to detect the size or direction of any potential bias
  - that age- and sex-specific disability rates do not change significantly over time.

- The rate ratio/proportion adjustments (that is, multiplication) assumes consistency between the rate ratio/proportion as calculated from the 2006 Census and the corresponding information if it were collected from the 2009 SDAC. Two particular points to note with this assumption are that:
  - information about people with ASSNP is based on the self-enumeration (interview in Indigenous communities) of four questions under the 2006 Census, whereas in SDAC 2009 people are defined as having a
severe/profound core activity limitation on the basis of a comprehensive interviewer administered module of questions — the two populations are different, but are conceptually related

– the special needs groups identification may not be the same between the 2006 Census and the 2009 SDAC (ABS research indicates, for example, that the Indigenous identification rate differs across the Census and interviewer administered surveys)

• It is not known if the data collection instruments are culturally appropriate for all special needs groups; nor is it known how this, combined with different data collection methods, impacts on the accuracy of the estimated potential population

• There are a number of potential sources of error related to the Census that stem from failure to return a Census form or failure to answer every applicable question. Information calculated from 2011 Census data exclude people for whom data item information is not available. As with any collection, should the characteristics of interest (for example, ASSNP and/or special needs group status) of the people excluded differ from those people included, a potential for bias is introduced. In particular, for Indigenous estimates, differential undercount of Indigenous Australians across states and territories may introduce bias into the results that would affect the comparability of estimates across jurisdictions, if those missed by the Census had a different rate of disability status to those included.
### 14.7 Definitions of key terms

**Accommodation support service users receiving community accommodation and care services**

People using the following NDA 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 NDA accommodation support services (excludes service users of specialist psychiatric disability services only). See AIHW (2009) 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 disability (including expenditure on both programs and administration, direct expenditure and grants to government service providers, and government grants to non-government service providers (except major capital grants).

**Core activities as per the 2009 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 DS 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 DS 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 (2009) 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 DS 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

The United Nation's Convention on the Rights of Persons with Disabilities, ratified by Australia on 17 July 2008, defines ‘persons with disabilities’ as those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others.

The WHO defines ‘disabilities’ as impairments, activity limitations, and participation restrictions: an impairment is a problem in body function or structure; an activity limitation is a difficulty encountered by an individual in executing a task or action; and a participation restriction is a problem experienced by an individual in involvement in life situations. Disability is a complex phenomenon, reflecting an interaction between features of a person's body and features of the society in which he or she lives (WHO 2009).

The ABS SDAC 2009 defined ‘disability’ as the presence of at least one of 17 limitations, restrictions or impairments, which have lasted or are likely to last for a period of 6 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.

The third CSTDA (2003, p. 9) defined '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 and communication.

Employment services

Employment services comprise open employment services and supported employment services. Where users of employment services are described without further qualification, this includes people who use either or both open and supported employment services.

All open employment services are now included in the Disability Employment Services (DES) program administered by the Department of Education, Employment and Workplace Relations (DEEWR). Disability Employment Services has two parts: Disability Management Service is for job seekers with disability, injury or health condition who need assistance to find a job and occasional support to keep a job; and Employment Support Service provides assistance to people with permanent disability and who need regular, ongoing support to keep a job. Supported employment services are administered by FaHCSIA under the Australian Disability Enterprise program. Australian Disability Enterprises are commercial businesses that provide employment for people with disability in a supportive
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 NDA service types (service type outlets). Funded agencies are usually legal entities. They are generally responsible for providing DS 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 DS 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 (2009) 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 DS 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 DS 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 DS 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 2009 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 Australians have significantly higher disability prevalence rates and greater representation in some NDA specialist disability services than non-Indigenous Australians, 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 2011a).

Informal carer

ABS informal carer: A person of any age who provides any informal assistance, in terms of help or supervision, to persons with disabilities or long-term conditions, or older persons (that is, aged 60 years and over). This assistance has to be ongoing, or likely to be ongoing, for at least 6 months. 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 2011a).

DS NMDS informal carer: an informal carer is a person such as a family member, friend or neighbour who provides regular and sustained care and assistance to the person requiring support (AIHW 2012a). This includes people who may receive a pension or benefit associated with their caring role, but does not include people, either paid or voluntary, whose services are arranged by a formal service organisation. Informal carers can be defined as primary if they help with one or more of the activities of daily living: self-care, mobility or communication.

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 2009 SDAC).

**Moderate core activity limitation**

Not needing assistance but having difficulty performing a core activity task (as per the 2009 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 2004-05 data these countries include countries other than New Zealand, Canada, the United Kingdom, South Africa, Ireland and the United States. For 2005-06 onwards, 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 NDA specialist disability services’.

The ‘potential population’ is the number of people 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 is the number of people aged 0–64 years who are most appropriately supported by disability services, require ongoing and/or long-term episodic support, have a permanent or chronic impairment and with a substantially reduced capacity in one or more core activities. For respite services, only those people with a primary carer were included. For supported employment services, only the potential population aged 15–64 years participating in the labour force are included. For open employment services, the potential population is not used; instead, an estimate of all people with a disability and an employment restriction aged 15–64 is used.

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 national age- and sex-specific distribution of the potential population identified in the 2009 SDAC to the age and sex structure of each jurisdiction in the current year, to give an ‘expected current estimate’ of the potential population 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 Australians 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 NDA specialist disability services (AIHW 2006).

The potential populations for 2004-05 to 2006-07 were calculated using national age- and sex-specific rates of severe or profound core activity limitation from the ABS Survey of Disability, Ageing and Carers (SDAC) conducted in 2003. In 2011, the 2009 SDAC was released, recalculation of the potential population has resulted in a break in series between the 2003 and 2009 surveys.

**Primary carer**

*ABS SDAC primary carer*: A primary carer is a person who provides the most informal assistance, in terms of help or supervision, to a person with one or more disabilities. The assistance has to be ongoing, or likely to be ongoing, for at least 6 months and be provided for one or more of the core activities (communication, mobility and self care). In the SDAC, primary carers only include persons aged 15 years and over for whom a personal interview was conducted. Persons aged 15 to 17 years were only interviewed personally if parental permission was granted (ABS 2011a).

*DS NMDS primary carer*: an informal carer who assists the person requiring support, in one or more of the following ADL: 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 2009 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 NDA. 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 NDA.

**Service type**
The support activity that the service type outlet has been funded to provide under the NDA. The DS 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 NDA 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 disability who receives a NDA specialist disability 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 need for assistance with ADL**
Data on service users with different levels of need for assistance with ADL are derived using information on the level of support needed in one or more of the core support areas: self care, mobility, and communication. Service users who need help with ADL reported always/sometimes needing help in one or more of these areas (people who need help with ADL are ‘conceptually comparable’ with people who have a profound or severe core activity limitation). Service users who did not need with ADL reported needing no support in all the core activity support areas.

**Severe core activity limitation**
Sometimes needing assistance to perform a core activity task (as per the SDAC 2009).

**Users of NDA accommodation support services**
People using one or more accommodation support services that correspond to the following DS NMDS service types: 1.01 large residential/institutions (more than 20 places); 1.02 small residential/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 NDA community access services**
People using one or more services that correspond to the following DS NMDS service types: 3.01 learning and life skills development; 3.02 recreation/holiday programs; and 3.03 other community access. See AIHW (2009) for more information on service types 3.01–3.03.

**Users of NDA community support services**
People using one or more services that correspond to the following DS 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 (2009) for more information on service types 2.01–2.07.
<table>
<thead>
<tr>
<th>Users of NDA employment services</th>
<th>People using one or more services that correspond to the following DS 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.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Users of NDA respite services</td>
<td>People using one or more services that correspond to the following DS 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 (2009) for more information on service types 4.01–4.05.</td>
</tr>
</tbody>
</table>
14.8 List of attachment tables

Attachment tables are identified in references throughout this chapter by a ‘14A’ prefix (for example, table 14.1). Attachment tables are available on the Review website (www.pc.gov.au/gsp).

Table 14A.1 Recipients of Disability Support Pension, Mobility Allowance, Carer Payment, Carer Allowance, Sickness Allowance, Child Disability Assistance Payment and Carer Supplement ('000)
Table 14A.2 Users of National Disability Agreement (NDA) specialist disability services, existence of an informal/primary carer, by geographic location
Table 14A.3 Users of NDA specialist disability services, age of primary carers, by geographic location
Table 14A.4 Government expenditure, by type ($'000)
Table 14A.5 Total real government expenditure, by source of funding (2011-12 dollars) ($'000)
Table 14A.6 Government expenditure, by source of funding (per cent)
Table 14A.7 Real government direct service delivery and total expenditure adjusted for payroll tax (2011-12 dollars) ($'000)
Table 14A.8 Real government direct service delivery expenditure, by service type (2011-12 dollars) ($'000)
Table 14A.9 Government expenditure, by service type (per cent)
Table 14A.10 People aged 5–64 years with disability
Table 14A.11 People aged 0–4 years with disability, 2009
Table 14A.12 Estimated number of people aged 0–64 years with a profound or severe core activity limitation who received help as a proportion of those who needed help (per cent)
Table 14A.13 Users of NDA government and non-government provided services, by service type
Table 14A.14 Users of NDA services, by primary disability group
Table 14A.15 Users of NDA services, by disability group (all disability groups reported) as a proportion of total users
Table 14A.16 Users of total NDA State/Territory delivered disability support services (aged 0-64 years) as a proportion of the total estimated potential population, by sex and age group
Table 14A.17 Users of NDA accommodation support services (all ages), as a proportion of the total estimated potential population for accommodation support services
Table 14A.18 Users of NDA accommodation support services (aged 0-64 years), as a proportion of the total estimated potential population for accommodation support services, by sex and age group
Table 14A.19 Users of NDA community support services (all ages), as a proportion of the total potential population for community support services
Table 14A.20  Users of NDA community support services (aged 0-64 years), as a proportion of the total potential population for community support services, by sex and age group

Table 14A.21  Users of NDA community access services (all ages), as a proportion of the total potential population for community access services

Table 14A.22  Users of NDA community access services (aged 0-64 years), as a proportion of the total potential population for community access services, by sex and age group

Table 14A.23  Users of NDA respite services (aged 0-64 years), as a proportion of the total potential population for respite services

Table 14A.24  Users of NDA respite services (aged 0-64 years), as a proportion of the total potential population for respite services, by sex and age group

Table 14A.25  People with disability (aged 15–64 years with an employment restriction) accessing Disability Employment Services/Open Employment Services (Employment Support Services), by sex and age group

Table 14A.26  People with disability (aged 15–64 years with an employment restriction) accessing Disability Employment Services/Open Employment Services (Disability Management Services), by sex and age group

Table 14A.27  Users of NDA supported employment services/Australian Disability Enterprises (aged 15–64 years), as a proportion of the total estimated potential population for supported employment services, by sex and age group

Table 14A.28  Users of total NDA disability support services (aged 0-64 years), by severity of disability

Table 14A.29  Users of NDA accommodation support services (all ages), by severity of disability

Table 14A.30  Users of NDA accommodation support services (aged 0-64 years), by severity of disability

Table 14A.31  Users of NDA community support services (all ages), by severity of disability

Table 14A.32  Users of NDA community support services (aged 0-64 years), by severity of disability

Table 14A.33  Users of NDA community access services (all ages), by severity of disability

Table 14A.34  Users of NDA community access services (aged 0-64 years), by severity of disability

Table 14A.35  Users of NDA respite services (all ages), by severity of disability

Table 14A.36  Users of NDA respite services (aged 0-64 years), by severity of disability

Table 14A.37  Users of NDA employment services (aged 15-64 years), by severity of disability

Table 14A.38  Users of NDA open employment services (aged 15-64 years), by severity of disability

Table 14A.39  Users of NDA supported employment services (aged 15-64 years), by severity of disability

Table 14A.40  Users of NDA accommodation support services, by geographic location

Table 14A.41  Users of NDA community support services, by geographic location

Table 14A.42  Users of NDA community access services, by geographic location

Table 14A.43  Users of NDA respite services, by geographic location

Table 14A.44  Users of NDA employment services, by geographic location
### Table 14A.45
Indigenous users of total NDA disability support services (aged 0-64 years) as a proportion of the indigenous estimated potential population, by age group

### Table 14A.46
Users of NDA accommodation support services, by Indigenous status

### Table 14A.47
Users of NDA community support services, by Indigenous status

### Table 14A.48
Users of NDA community access services, by Indigenous status

### Table 14A.49
Users of NDA respite services, by Indigenous status

### Table 14A.50
Users of NDA employment services (aged 15-64 years), by Indigenous status

### Table 14A.51
Proportion of Indigenous users of NDA open employment services (Employment Support Services) aged 15-64 years, by age group

### Table 14A.52
Proportion of Indigenous users of NDA open employment services (Disability Management Services) aged 15-64 years, by age group

### Table 14A.53
Proportion of Indigenous people (aged 15–64 years) accessing Australian Disability Enterprises/Supported Employment Services, by age group

### Table 14A.54
Users of NDA accommodation support services (aged 0-64 years), by country of birth

### Table 14A.55
Users of NDA community support services (aged 0-64 years), by country of birth

### Table 14A.56
Users of NDA community access services (aged 0-64 years), by country of birth

### Table 14A.57
Users of NDA respite services (aged 0-64 years), by country of birth

### Table 14A.58
Users of NDA employment services (aged 15-64 years), by country of birth

### Table 14A.59
Users of NDA open employment services (Employment Support Services) aged 15-64 years, by country of birth and remoteness, Australia

### Table 14A.60
Users of NDA open employment services (Disability Management Services) aged 15-64 years, by country of birth and remoteness, Australia

### Table 14A.61
Users of NDA supported employment services (aged 15-64 years), by country of birth and remoteness, Australia

### Table 14A.62
Users of NDA community accommodation and care services as a proportion of all accommodation support service users (per cent)

### Table 14A.63
Permanent aged care residents aged under 65, 30 June

### Table 14A.64
People admitted to permanent residential aged care aged under 65

### Table 14A.65
YPIRAC service users

### Table 14A.66
Estimated number of YPIRAC service users who have achieved program objectives since entry to the program, 30 June 2011

### Table 14A.67
Estimated number of YPIRAC service users who have achieved program objectives since entry to the program, by state and territory, 30 June

### Table 14A.68
Rate of younger people admitted to permanent residential aged care per 10 000 potential population

### Table 14A.69
Younger people who separated from permanent residential aged care to return to home/family

### Table 14A.70
Number of younger people receiving permanent residential aged care

### Table 14A.71
NSW quality assurance processes

### Table 14A.72
Victorian quality assurance processes

### Table 14A.73
Queensland quality assurance processes

### Table 14A.74
WA quality assurance processes

### Table 14A.75
SA quality assurance processes

### Table 14A.76
Tasmanian quality assurance processes
Table 14A.77  ACT quality assurance processes
Table 14A.78  NT quality assurance processes
Table 14A.79  Aust Government quality assurance processes
Table 14A.80  Comparability of expenditure estimates for government provided specialist disability services, by items included
Table 14A.81  Real government expenditure per user of NDA accommodation support services (2010-11 dollars)
Table 14A.82  Australian Government funding per user of non-government provided employment services
Table 14A.83  Real Australian Government funding per user of non-government provided employment services (2010-11 dollars)
Table 14A.84  Total estimated expenditure per service user, State and Territory government administered programs, 2010-11
Table 14A.85  Government administration expenditure as a proportion of total recurrent expenditure on services (per cent)
Table 14A.86  Labour force participation and employment, 2009 (per cent)
Table 14A.87  Labour force participation rate for people with disability aged 15–64 years, by disability status, by State/Territory, 2009 ('000)
Table 14A.88  Employment to population rate for people with disability aged 15–64 years, by disability status, by State/Territory, 2009 ('000)
Table 14A.89  Unemployment rate for people with disability aged 15–64 years, all with reported disability, by disability status, by State/Territory, 2009 ('000)
Table 14A.90  Labour force participation and employment of people aged 15-64 years, 2009 (per cent)
Table 14A.91  Labour force participation and employment, 2007-08 (per cent)
Table 14A.92  Labour force participation and employment, 2010 (per cent)
Table 14A.93  Labour force participation and employment of all people with disability, by special needs groups, 2009 (per cent)
Table 14A.94  Labour force participation and employment of people with a profound or severe core activity limitation, by special needs groups, 2009 (per cent)
Table 14A.95  Labour force participation and employment of people with a profound or severe core activity limitation, by special needs groups, 2006 (per cent)
Table 14A.96  Labour force participation and employment of people with a profound or severe core activity limitation, by special needs groups, 2003 (per cent)
Table 14A.97  Labour force participation rate for people with disability aged 15–64 years, all with reported disability, by remoteness area, by State/Territory, 2009 ('000)
Table 14A.98  Labour force participation rate for people with disability aged 15–64 years, all with reported disability, by country of birth, by State/Territory, 2009 ('000)
Table 14A.99  Labour force participation rate for people with disability aged 15–64 years, all with reported disability, by sex by age group, by State/Territory, 2009 ('000)
Table 14A.100 Employment to population rate for people with disability aged 15–64 years, all with reported disability, by remoteness area, by State/Territory, 2009 ('000)
Table 14A.101 Employment to population rate for people with disability aged 15–64 years, all with reported disability, by country of birth, by State/Territory, 2009 ('000)
Table 14A.102 Employment to population rate for people with disability aged 15–64 years, all with reported disability, by sex, by State/Territory, 2009 ('000)
Table 14A.103 Employment to population rate for people with disability aged 15–64 years, all with reported disability, by age group, by State/Territory, 2009 ('000)
<table>
<thead>
<tr>
<th>Table 14A.104</th>
<th>Labour force participation rate for primary carers (carers of people with disability) aged 15–64 years, by carer sex, by State/Territory, 2009 (000's)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Table 14A.105</td>
<td>Labour force participation rate for primary carers (carers of people with disability) aged 15–64 years, by carer age group, by State/Territory, 2009 ('000)</td>
</tr>
<tr>
<td>Table 14A.106</td>
<td>Labour force participation rate for all carers and non-carers aged 15–64 years, by carer sex, by carer age group, by State/Territory, 2009</td>
</tr>
<tr>
<td>Table 14A.107</td>
<td>Labour force participation rate for primary carers (carers of people aged 0–64 with disability) aged 15–64 years, 2009 (000's)</td>
</tr>
<tr>
<td>Table 14A.108</td>
<td>Employment rate for primary carers (carers of people with disability) aged 15–64 years, by carer sex, by carer age group, by State/Territory, 2009</td>
</tr>
<tr>
<td>Table 14A.109</td>
<td>Labour force participation rate for primary carers (carers of people with disability) aged 15–64 years, by carer remoteness area, by State/Territory, 2009 ('000)</td>
</tr>
<tr>
<td>Table 14A.110</td>
<td>Employment rate for primary carers (carers of people with disability) aged 15–64 years, by carer remoteness area, by State/Territory, 2009</td>
</tr>
<tr>
<td>Table 14A.111</td>
<td>Labour force participation rate for primary carers (carers of people with disability) aged 15–64 years, by carer age group, by State/Territory, 2009 ('000)</td>
</tr>
<tr>
<td>Table 14A.112</td>
<td>Proportion of primary carers (carers of people with disability aged 0–64 years) who do not experience negative impacts on their wellbeing due to caring role, by carer sex, by carer age group, by State/Territory, 2009 ('000's)</td>
</tr>
<tr>
<td>Table 14A.113</td>
<td>Proportion of primary carers (carers of people with disability aged 0–64 years) who do not experience negative impacts on their wellbeing due to their caring role, by carer remoteness area, by State/Territory, 2009 ('000)</td>
</tr>
<tr>
<td>Table 14A.114</td>
<td>Proportion of primary carers (carers of people with disability aged 0–64 years) who do not experience negative impacts on their wellbeing due to their caring role, by main recipient of care age group, by State/Territory, 2009 ('000)</td>
</tr>
<tr>
<td>Table 14A.115</td>
<td>Proportion of primary carers (carers of people with disability aged 0–64 years) who report a need for further assistance in their caring roles, by carer sex, by carer age group, by State/Territory, 2009 ('000's)</td>
</tr>
<tr>
<td>Table 14A.116</td>
<td>Proportion of primary carers (carers of people with disability aged 0–64 years) who report a need for further assistance in their caring roles, by carer remoteness area, by State/Territory, 2009 ('000's)</td>
</tr>
<tr>
<td>Table 14A.117</td>
<td>Proportion of primary carers (carers of people with disability aged 0–64 years) who report a need for further assistance in their caring roles, by main recipient of care age group, by State/Territory, 2009 ('000)</td>
</tr>
<tr>
<td>Table 14A.118</td>
<td>Social activities participated in by people with a profound or severe core activity limitation 2009 (per cent)</td>
</tr>
<tr>
<td>Table 14A.119</td>
<td>People with disability aged 5–64 years who have had face-to-face contact with ex-household family or friends in the previous week, by disability status, by State/Territory, 2009 ('000)</td>
</tr>
<tr>
<td>Table 14A.120</td>
<td>People with disability aged 5–64 years who have had face-to-face contact with ex-household family or friends in the previous week, all with reported disability, by remoteness area, by State/Territory, 2009 ('000)</td>
</tr>
<tr>
<td>Table 14A.121</td>
<td>People with disability aged 15–64 years who have had face-to-face contact with ex-household family or friends in the previous week, all with reported disability, by country of birth, by State/Territory, 2009 ('000)</td>
</tr>
<tr>
<td>Table 14A.122</td>
<td>People with disability aged 15–64 years who have had face-to-face contact with ex-household family or friends in the previous week, all with reported disability, by country of birth, by State/Territory, 2009 ('000)</td>
</tr>
<tr>
<td>Table</td>
<td>Description</td>
</tr>
<tr>
<td>-------</td>
<td>-------------</td>
</tr>
<tr>
<td>14A.123</td>
<td>People with disability aged 5–64 years who travelled to a social activity in the last two weeks, by disability status, by State/Territory, 2009 ('000)</td>
</tr>
<tr>
<td>14A.124</td>
<td>People with disability aged 5–64 years who travelled to a social activity in the last two weeks, all with reported disability, by remoteness area, by State/Territory, 2009 ('000)</td>
</tr>
<tr>
<td>14A.125</td>
<td>People with disability aged 5–64 years who travelled to a social activity in the last two weeks, all with reported disability, by country of birth, by State/Territory, 2009 ('000)</td>
</tr>
<tr>
<td>14A.126</td>
<td>People with disability aged 5–64 years who travelled to a social activity in the last two weeks, all with reported disability, by sex by age group, by State/Territory, 2009 ('000)</td>
</tr>
<tr>
<td>14A.127</td>
<td>People with disability aged 5–64 years who report the main reason for not leaving home as often as they would like is their disability or condition, all with reported disability, by country of birth, by State/Territory, 2009 ('000)</td>
</tr>
<tr>
<td>14A.128</td>
<td>People with disability aged 5–64 years who report the main reason for not leaving home as often as they would like is their disability or condition, all with reported disability, by disability status, by State/Territory, 2009 ('000)</td>
</tr>
<tr>
<td>14A.129</td>
<td>People with disability aged 5–64 years who report the main reason for not leaving home as often as they would like is their disability or condition, all with reported disability, by remoteness area, by State/Territory, 2009 ('000)</td>
</tr>
<tr>
<td>14A.130</td>
<td>People with disability aged 5–64 years who report the main reason for not leaving home as often as they would like is their disability or condition, all with reported disability, by sex by age group, by State/Territory, 2009 ('000)</td>
</tr>
<tr>
<td>14A.131</td>
<td>People who have contact with friends and family in whom they can confide or on whom they can rely, by disability status, 2007 (per cent)</td>
</tr>
<tr>
<td>14A.132</td>
<td>Social participation, by disability status, 2010 (per cent)</td>
</tr>
<tr>
<td>14A.133</td>
<td>Social participation, by limitation or restriction status, 2006 (per cent)</td>
</tr>
<tr>
<td>14A.134</td>
<td>Participation in voluntary work for an organisation or group, by disability status, 2010 (per cent)</td>
</tr>
<tr>
<td>14A.135</td>
<td>Person living in dwellings, by tenure type, core activity need for assistance status and age, 2006</td>
</tr>
<tr>
<td>14A.136</td>
<td>People aged 0–64 years in potential population who have taken action in the last twelve months to get more formal assistance but who still need more formal assistance, by sex, by State/Territory, 2009 ('000)</td>
</tr>
<tr>
<td>14A.137</td>
<td>People aged 0–64 years in potential population who have taken action in the last twelve months to get more formal assistance but who still need more formal assistance, by age group, by State/Territory, 2009 ('000)</td>
</tr>
<tr>
<td>14A.138</td>
<td>People aged 0–64 years in potential population who have taken action in the last twelve months to get more formal assistance but who still need more formal assistance, by remoteness area, by State/Territory, 2009 ('000)</td>
</tr>
<tr>
<td>14A.139</td>
<td>People aged 0–64 years in potential population who have taken action in the last twelve months to get more formal assistance but who still need more formal assistance, by country of birth, by State/Territory, 2009 ('000)</td>
</tr>
<tr>
<td>14A.140</td>
<td>People aged 0–64 years in potential population who need more formal assistance than they are currently receiving, by sex, by State/Territory, 2009 ('000)</td>
</tr>
<tr>
<td>14A.141</td>
<td>People aged 0–64 years in potential population who need more formal assistance than they are currently receiving, by age group, by State/Territory, 2009 ('000)</td>
</tr>
<tr>
<td>14A.142</td>
<td>People aged 0–64 years in potential population who need more formal assistance than they are currently receiving, by remoteness area, by State/Territory, 2009 ('000)</td>
</tr>
<tr>
<td>Table 14A.143</td>
<td>People aged 0–64 years in potential population who need more formal assistance than they are currently receiving, by country of birth, by State/Territory, 2009 ('000)</td>
</tr>
<tr>
<td>Table 14A.144</td>
<td>Participation in education and training, by need for assistance status, 2011 (per cent)</td>
</tr>
<tr>
<td>Table 14A.145</td>
<td>Participation in education and training, by disability status, 2009 (per cent)</td>
</tr>
<tr>
<td>Table 14A.146</td>
<td>Educational and training attainment, by need for assistance status, 2010 (per cent)</td>
</tr>
<tr>
<td>Table 14A.147</td>
<td>Educational and training attainment, by disability status, 2009 (per cent)</td>
</tr>
<tr>
<td>Table 14A.148</td>
<td>HACC services received by people aged 64 years and under and Indigenous Australians aged 49 years and under, 2011-12</td>
</tr>
<tr>
<td>Table 14A.149</td>
<td>HACC services received within major cities by people aged 64 years and under and Indigenous Australians aged 49 years and under, 2011-12</td>
</tr>
<tr>
<td>Table 14A.150</td>
<td>HACC services received within inner regional areas by people aged 64 years and under and Indigenous Australians aged 49 years and under, 2011-12</td>
</tr>
<tr>
<td>Table 14A.151</td>
<td>HACC services received within outer regional areas by people aged 64 years and under and Indigenous Australians aged 49 years and under, 2011-12</td>
</tr>
<tr>
<td>Table 14A.152</td>
<td>HACC services received within remote areas by people aged 64 years and under and Indigenous Australians aged 49 years and under, 2011-12</td>
</tr>
<tr>
<td>Table 14A.153</td>
<td>HACC services received within very remote areas by people aged 64 years and under and Indigenous Australians aged 49 years and under, 2011-12</td>
</tr>
<tr>
<td>Table 14A.154</td>
<td>HACC services received by people aged 64 years and under and Indigenous Australians aged 49 years and under, 2011-12</td>
</tr>
</tbody>
</table>
14.9 References


—— 2010, *Disability Support Services 2007-08: National Data on Services Provided under the CSTDA*, Cat. no. DIS 56, Canberra.


—— 2012, *Disability support services 2010-11: Services provided under the National Disability Agreement*. DIS 60. Canberra.


15 Child protection and youth justice services

CONTENTS

15.1 Profile of child protection and out-of-home care services 15.3
15.2 Framework of performance indicators for child protection and out-of-home care services 15.18
15.3 Key child protection and out-of-home care services performance indicator results 15.21
15.4 Future directions in child protection and out-of-home care services performance reporting 15.59
15.5 Profile of youth justice services 15.61
15.6 Framework of performance indicators for youth justice services 15.69
15.7 Future directions in youth justice performance reporting 15.96
15.8 Jurisdictions’ comments 15.96
15.9 Definitions of key terms 15.105
15.10 List of attachment tables 15.112
15.11 References 15.123

Attachment tables
Attachment tables are identified in references throughout this chapter by a ‘15A’ prefix (for example, table 15A.1). A full list of attachment tables is provided at the end of this chapter, and the attachment tables are available from the Review website at www.pc.gov.au/gsp.
Child protection and youth justice services aim to assist individuals and families who are in crisis or experiencing difficulties that hinder personal or family functioning, promote community safety, and reduce youth offending.

This chapter reports on:

- **child protection services** — 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 primary caregivers for protective or other family welfare reasons
- **intensive family support services** — specialist services that aim to prevent the imminent separation of children from their primary caregivers as a result of child protection concerns and to reunify families where separation has already occurred. (Performance data for intensive family support services are not yet available, and reporting for intensive family support services is limited to expenditure data and information on the numbers of children commencing intensive family support services)
- **family support services** — activities associated with the provision of lower level (that is, non-intensive) services to families in need, including identification and assessment of family needs, provision of support and diversionary services, some counselling, and active linking and referrals to support networks. These services are typically delivered via voluntary arrangements (as distinct from court orders) between the relevant agency and family. (Performance data for family support services are not yet available, and reporting for family support services is limited to expenditure data)
- **youth justice services** — services to promote community safety and reduce youth offending by assisting young people to address their offending behaviour.

Improvements to the reporting of child protection and youth justice services in this edition include:

- the inclusion for the first time of expenditure data for family support services (data are reported for seven jurisdictions)
- the inclusion for the first time of case plans prepared data (data are reported for four jurisdictions)
- the inclusion of a new measure ‘children in out-of-home care who were the subject of a notification, which was substantiated’ for the ‘safety in out-of-home care’ indicator
- reporting on the unit costs of seven child protection ‘Pathways’ activity groups, compared with five previously
- the inclusion for the first time of experimental educational outcomes data for children on orders (data are reported for two jurisdictions)
- the inclusion for the first time of expenditure data for youth justice services
- data quality information (DQI) documentation for a further eight indicators:
  - Child protection DQI
    - Response times (to commence and to complete investigation)
    - Improved safety (substantiation after a decision not to substantiate and re-substantiation after a prior substantiation)
    - Improved education, health and wellbeing of the child
  - Youth justice DQI
    - Education and training attendance
    - Deaths in custody
    - Absconds from unescorted leave
    - Completion of orders
    - Case plans prepared.

### 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 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 and young people, including investigation and assessment where appropriate
- providing support services (directly or through referral) 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 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 child protection system often share common social and demographic characteristics. Families with a history of domestic violence, alcohol and substance abuse, psychiatric disability, and families with low incomes or that are reliant on pensions and benefits are over-represented in the families that come into contact with the child protection system (Department of Human Services 2002; The Allen Consulting Group 2008).

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 higher levels of violence, compared with non-Indigenous families (AIHW 2006). 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.

The Report of the Board of Inquiry into the Child Protection System in the NT (2010) Growing them strong, together also observed the presence of multiple risk factors in Aboriginal communities, including lack of adequate housing, financial security and education. However, Aboriginal communities also possessed protective factors that can safeguard children and families from psychological...
distress, such as spirituality and connection to land, family and culture (Bamblett, Bath and Roseby 2010).

**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/or the inability of parents to provide adequate care. Placements may be voluntary or made in conjunction with care and protection orders.

Out-of-home care services comprise home-based care (for example, foster care, care with a 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**

Intensive family support services are an alternative to the removal of a 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 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 respond to referrals from a child protection service.

(Continued on next page)
Box 15.2 (Continued)

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.

Child protection treatment and support services
A complementary suite of services not included in this Report, but intended for inclusion in future editions, are known as child protection treatment and support services. These services target at-risk families where there are concerns about the safety and wellbeing of children. They may be less intensive in nature and focus on 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 include educational services, clinical services including counselling, group work and other therapeutic interventions, and domestic violence services.

State and Territory governments, with the Australian Institute of Health and Welfare (AIHW), are studying the feasibility of a national data collection for child protection treatment and support services.


Family support services

Family support services are activities typically associated with the provision of lower level (that is, non-intensive) services to families in need, including identification and assessment of family needs, provision of support and diversionary services, some counselling, and active linking and referrals to support networks. These types of services are funded by government but can be delivered by the relevant child protection agency or a non-government organisation. This suite of services does not typically involve planned follow-up by the relevant child protection agency after initial service referral or delivery. These types of services are delivered via voluntary arrangements (as distinct from court orders) between the relevant agency and family.

For the first time, this Report includes expenditure information for family support services (table 15A.1). Corresponding family support service activity data (for example, numbers of clients or numbers of referrals) are not yet available nationally. The Steering Committee considers the development of a data collection to quantify the extent of family support service activity, and the effectiveness of family support service activity, as an important future development.
Roles and responsibilities

State and Territory governments fund child protection, out-of-home care, family support (including intensive family support) and other relevant services (box 15.2 identifies State and Territory government departments responsible for these services during 2011-12). These services may be delivered by the government, non-government organisations, and in some cases, by for-profit providers. Child protection services investigate and assess reports, provide or refer families to support services, and intervene where necessary (including making court applications when an order is required to protect a child, and placing children in out-of-home care).

Box 15.3  Government agencies responsible for child protection and out-of-home care services

<table>
<thead>
<tr>
<th>State</th>
<th>Agency Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>NSW</td>
<td>Department of Family and Community Services</td>
</tr>
<tr>
<td>Vic</td>
<td>Department of Human Services</td>
</tr>
<tr>
<td>Qld</td>
<td>Department of Communities, Child Safety and Disability Services</td>
</tr>
<tr>
<td>WA</td>
<td>Department for Child Protection</td>
</tr>
<tr>
<td>SA</td>
<td>Department for Education and Child Development</td>
</tr>
<tr>
<td>Tas</td>
<td>Department of Health and Human Services</td>
</tr>
<tr>
<td>ACT</td>
<td>Community Services Directorate</td>
</tr>
<tr>
<td>NT</td>
<td>Office of Children and Families</td>
</tr>
</tbody>
</table>

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:

- education and child care services, some of which have mandatory reporting responsibilities and conduct education on protective behaviours’ in some jurisdictions
- health services, which support the assessment of child protection matters and deliver therapeutic, counselling and other services
- police, 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.
A range of appointments, schemes and charters have been introduced by jurisdictions in recent years, to provide additional protection for clients of child protection systems. Examples of these are listed in box 15.3.

<table>
<thead>
<tr>
<th>Box 15.3</th>
<th>Initiatives to provide additional protection for child protection clients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aus Gov</td>
<td>In April 2012, the Australian Government announced the introduction of a new national Children’s Commissioner to champion the rights of Australia’s young people (Attorney General 2012).</td>
</tr>
<tr>
<td>NSW</td>
<td>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.</td>
</tr>
<tr>
<td>Vic</td>
<td>The Child Safety Commissioner promotes child safe practices and environments across the community through a charter of rights for children in care. Part of the Commissioner’s role is to monitor the quality of out-of-home care services.</td>
</tr>
<tr>
<td>Qld</td>
<td>The Commission for Children and Young People and Child Guardian has a range of legislated monitoring and overseeing functions for children in the child protection system, including regular visits to children in out-of-home care, receiving and investigating complaints, monitoring child outcomes, and screening foster carers and adult members in the foster carer household through its Blue card screening system. The Department of Communities, Child Safety and Disability Services has a complaints management system through which clients, family members, advocates and members of the Queensland public can raise enquiries, concerns, or complaints about their contact and interactions with the department.</td>
</tr>
<tr>
<td>WA</td>
<td>The Advocate for Children in Care provides advocacy and complaints management services for children and young people in care. In 2011-12, the Advocate also implemented a state-wide rollout of ‘Viewpoint’, an interactive online program for children in care aged 4 to 17 years to express their views, wishes and experiences to contribute to developing meaningful care plans. The Department’s Complaints Management Unit is available to all customers. Formal monitoring of protection and care service standards by a Standards Monitoring Unit began on 1 July 2007. Seventeen districts are monitored on a two-year cycle and the monitoring regime has been extended across all placement service providers.</td>
</tr>
</tbody>
</table>
**Box 15.3 (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 and young people, and examining the policies, practices, services and laws affecting the health, welfare, care, protection and development of children and young people.

**ACT**  The Public Advocate of the ACT monitors the provision of services, and protects and advocates for the rights of children and young people. Systemic issues are referred by the Public Advocate to the Commissioner for Children and Young People. The Commissioner consults with and promotes the interests of children. The Official Visitor's role is to visit and inspect places of care, of detention or therapeutic protection, and receive and inquire about complaints made concerning the care provided to children and young people at these locations. In addition, an ACT Charter of Rights for children and young people in out-of-home care was launched in November 2009. The Charter is consistent with the United Nations Convention on the Rights of the Child, the ACT *Human Rights Act 2004*, and the *Children and Young People Act 2008*, all of which emphasise the basic human rights to which children and young people are entitled.

**NT**  The Office of the Children's Commissioner was established in 2008 to independently monitor the child protection system through the investigation of complaints and reporting against the Office of Children and Families’ administration of the *Care and Protection of Children Act*. In July 2011, the powers of the Children's Commissioner were extended to allow the initiation of investigations without receiving a formal complaint. The scope of the Children’s Commissioner's powers was expanded beyond children involved in the child protection system with 'protected children' changing to 'vulnerable children'. An Aboriginal Peak body Stronger Aboriginal Families, Together (SAF,T) has been established to represent Aboriginal children, young people and their families. SAF,T has established an Aboriginal Child Care Agency to deliver services in support of vulnerable Aboriginal children and their families in the Top End.

*Source: State and Territory governments (unpublished).*
Size and scope

The child protection system

Child protection legislation, policies and practices vary across jurisdictions, which has some implications for the comparability of child protection data (Holzer and Bromfield 2008). However, the broad processes in child protection systems are similar (figure 15.1).

State and Territory government departments with responsibility for child protection are advised of concerns about the wellbeing of children through reports to these agencies. Reports may be made by people mandated to report or by other members of the community. Individuals and organisations mandated to report vary across states and territories, and may include medical practitioners, police officers, 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. Nationally, police were the most common source of notifications in 2011-12 (AIHW forthcoming).

Figure 15.1 is a simplified representation of the statutory child protection system. It depicts the common pathways through the statutory system and referrals to support services, which can take place at any point along the statutory service system. Children might or might not move sequentially along these pathways and in some instances children might move through these pathways quite rapidly (for example, on the same day). There are a range of other services and programs which work to meet the needs of children and families that are not depicted in this diagram, including health, education and early childhood services.
Figure 15.1  The child protection service

- Dashed lines indicate that clients may or may not receive these services, depending on need, service availability, and client willingness to participate in what are voluntary services.
- Support services include family preservation and reunification services provided by government departments responsible for child protection and other agencies. Children and families move in and out of these services and the statutory child protection system, and might also be in the statutory child protection system while receiving support services.
- Shaded boxes are those for which data are available.
- AG = Activity Group.
- AG1 = Receipt and assessment of initial information about a potential protection and support issue; AG2 = Provision of generic 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 for children not on an order; AG6 = Seeking an order; AG7 = Provision of protective intervention, support and coordination services for children on an order; AG8 = Provision of out-of-home care services.

Source: State and Territory governments (unpublished).
**Notification**

Notifications are reports lodged by members of the community with the appropriate statutory child protection department to signify that they have reason to believe that a child is in need of protection. Depending on the circumstances, not all reports received by child protection departments will be recorded as notifications. Most jurisdictions assess incoming reports to determine whether they meet the threshold for recording a notification. Where, for example, a determination is made that the alleged behaviour does not meet the definition of a child in need of protection, a child concern report or equivalent might be recorded instead. If the alleged behaviour does not meet the threshold for recording a notification or a child concern report, the person reporting the matter might be provided with general advice and/or a referral.

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. Notifications are subsequently investigated based on the policies and practices in each jurisdiction (figure 15.1).

Prior to 2009-10, the rates of children subject to notifications, investigations and substantiations were calculated for children aged 0–16 years, while the rates of children on care and protection orders and in out-of-home care were calculated for children aged 0–17 years. From the 2009-10 period onwards, all child protection data are reported for the age range 0–17 years.

Nationally, 173,502 children aged 0–17 years were the subject of child protection notifications in 2011-12. The rate of notifications per 1000 children in the population aged 0–17 years was 34.0 in 2011-12 (table 15A.8). The total number of notifications for each jurisdiction for 2011-12 (including cases where a child was the subject of more than one child protection notification) by Indigenous status of the child is reported in table 15A.5.

Notifications data are collected early in the child protection process and often before an agency has full knowledge of a child’s 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.
Investigation

An investigation is the process whereby the relevant department obtains more detailed information about a child who is the subject of a notification and makes an assessment about the harm or risk of harm to the child, and his or her protective needs. Not all notifications are investigated in all jurisdictions. For example, if a determination is made that a child and family are better served by family support services rather than a child protection response, children and families might be referred to diversionary and support services. 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 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. Where possible, an investigation determines whether a notification is substantiated or not substantiated.

Nationally, 82,401 children aged 0–17 years who were the subject of a notification in 2011-12 were subsequently the subject of an investigation in 2011-12 (table 15A.8). The rate per 1000 children in the population aged 0–17 years was 16.2 in 2011-12 (table 15A.8). The total number of notifications investigated for each jurisdiction in 2011-12, by Indigenous status, is reported in table 15A.5.

Substantiation

The legal definition of harm or risk of harm, abuse or risk of abuse are similar across jurisdictions. Traditionally, 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 has now shifted 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 or risk to the child, and the child’s needs. While the legal criteria for substantiating such matters are now similar across jurisdictions, there remain some differences in practice, including different thresholds for recording a substantiation related to risk of harm.

If an investigation results in a substantiation, intervention by child protection services might 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, 37 781 children aged 0–17 years were the subject of a substantiation in 2011-12. The rate of children who were the subject of a substantiation per 1000 children in the population aged 0–17 years was 7.4 (table 15A.8). The number and rate of children who were the subject of a substantiation has fluctuated within jurisdictions since 2007-08. Nationally, 31 915 children aged 0–16 were the subject of a substantiation in 2007-08. This represented a rate of 6.8 per 1000 children in the population aged 0–16 years (prior to 2009-10, substantiations data were collected for children aged 0–16 years) (table 15A.8).

Nationally, 10 058 Indigenous children, 26 183 non-Indigenous children and 1540 children of unknown Indigenous status were the subject of substantiations in 2011-12. The rate of children who were the subject of a substantiation per 1000 children in the target population aged 0–17 years was 41.9 for Indigenous children and 5.4 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 a court may take place at any point in the child protection investigation process. The types of orders available vary across jurisdictions and may include finalised guardianship or custody orders, finalised supervisory orders, and interim and temporary orders.

Nationally, 40 962 children aged 0–17 years were on care and protection orders at 30 June 2012. The rate of children on care and protection orders per 1000 children in the population aged 0–17 years was 8.0 (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 2008. At 30 June 2008, 32 642 children were the subject of a care and protection order, which represented a rate of 6.6 per 1000 children in the population aged 0–17 years (table 15A.8).

Nationally, 13 268 Indigenous, 27 531 non-Indigenous and 163 children of unknown Indigenous status were on care and protection orders at 30 June 2012. The rate of children on care and protection orders per 1000 children in the target population aged 0–17 years was 54.9 for Indigenous children and 5.6 for non-Indigenous children (table 15A.8).

Further information regarding children on care and protection orders is included in the attachment tables. Table 15A.6 identifies the number of children admitted to and discharged from care and protection orders by Indigenous status in 2011-12. Table 15A.7 identifies the number of children on care and protection orders by type of order and Indigenous status at 30 June 2012.
Out-of-home care

Out-of-home care is one of a range of services provided to children and families where there is a need to provide safe care for a child. Children are placed in out-of-home care as a last resort when it is not in their best interests to remain with their family (for example, because there is no one to provide care). Where children are placed in out-of-home care, placement with the extended family or community is sought where possible, particularly in the case of Indigenous children (AIHW 2006). 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, 39,621 children were in out-of-home care at 30 June 2012. The rate of children in out-of-home care per 1000 children in the population aged 0–17 years was 7.7 (table 15A.17). The number and rate of children aged 0–17 years in out-of-home care has increased since 2008. At 30 June 2008, 31,166 children were in out-of-home care. This represented a rate of 6.3 per 1000 children in the population aged 0–17 years (table 15A.17).

Nationally, 13,299 Indigenous children and 26,127 non-Indigenous children were in out-of-home care at 30 June 2012. The rate of children in out-of-home care per 1000 children in the target population aged 0–17 years was 55.1 for Indigenous children and 5.4 for non-Indigenous children (table 15A.17).

Further information on children in out-of-home care is included in the attachment tables. Table 15A.18 identifies the number of children in out-of-home care by Indigenous status and placement type at 30 June 2012. Table 15A.19 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 2012. Table 15A.20 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 2012. Table 15A.21 identifies the number of children who exited care during 2011-12, by Indigenous status and length of time spent in care.

Funding

Recurrent expenditure on child protection and out-of-home care services was approximately $3.0 billion across Australia in 2011-12 — a real increase of $100.8 million (3.5 per cent) from 2010-11. Of this expenditure, out-of-home care services accounted for the majority (65.3 per cent, or $1.9 billion). Nationally, annual real expenditure on child protection and out-of-home care services has...
increased by $748.4 million from $2.2 billion since 2007-08, an average increase of 7.5 per cent per year for the past four years (table 15A.1).

Recurrent expenditure on intensive family support services across all jurisdictions was $375.3 million in 2011-12. This expenditure has increased in real terms each year from $148.0 million in 2007-08 (table 15A.28). This represents an average increase in expenditure of 26.2 per cent per year for the past four years. Table 15A.1 and tables 15A.30–33 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.

For the first time, this Report includes expenditure on family support services for all jurisdictions except South Australia. Family support services are less intensive in nature and do not typically involve planned follow up and case management by child protection agencies (as is often the case with intensive family support services). With the exception of South Australia, in 2011-12, expenditure on family support services amounted to $472.2 million nationally (table 15A.1).

In 2011-12, real recurrent expenditure on child protection, out-of-home care, intensive family support services and family support services per child aged 0–17 years in the population was $750 nationally. In previous reports, this figure has excluded the cost of family support services. Excluding family support services, the real recurrent expenditure on child protection, out-of-home care and intensive family support services per child aged 0–17 years in the population was $658 nationally. Real recurrent expenditure per child aged 0–17 years increased in most jurisdictions between 2007-08 and 2011-12 and has increased nationally each year since 2007-08. In 2007-08 the real recurrent expenditure on child protection, out-of-home care and intensive family support services per child aged 0–17 years was $480 (table 15A.1). This represents an average increase of 8.2 per cent per year for the past four years.

Figure 15.2 depicts total real recurrent expenditure per child aged 0–17 years in the population for the period 2007-08 to 2011-12, excluding expenditure on family support services in 2011-12 (for consistency across the time series). Figure 15.3 depicts expenditure on child protection services, out-of-home care services, intensive family support services and family support services per child aged 0–17 years in the population in 2011-12.
Figure 15.2  **Real recurrent expenditure on child protection, out-of-home care, and intensive family support services per child (total) (2011-12 dollars)**\(^a, b\)

\[\text{\textbullet\quad 2007-08  
\textbullet\quad 2008-09  
\textbullet\quad 2009-10  
\textbullet\quad 2010-11  
\textbullet\quad 2011-12}\]

\[\text{\$child aged 0-17 years}\]

\[\text{NSW  
Vic  
Qld  
WA  
SA  
Tas  
ACT  
NT  
Aust}\]

\(^a\) Refer to table 15A.1 for detailed jurisdiction-specific footnotes on expenditure data and table 15A.4 for information on the comparability of expenditure data. \(^b\) This figure excludes expenditure on family support services for consistency across the time series.

*Source*: State and Territory governments (unpublished); table 15A.1.

Figure 15.3  **Real recurrent expenditure on child protection, out-of-home care, family support services and intensive family support services per child, 2011-12**\(^a, b, c\)

\[\text{\textbullet\quad Child protection  
\textbullet\quad Out-of-home care  
\textbullet\quad Intensive family support services  
\textbullet\quad Family support services}\]

\[\text{\$child aged 0-17 years}\]

\[\text{NSW  
Vic  
Qld  
WA  
SA  
Tas  
ACT  
NT  
Aust}\]

\(^a\) Refer to table 15A.1 for detailed jurisdiction-specific footnotes on expenditure data and table 15A.4 for information on the comparability of expenditure data. \(^b\) Expenditure data for family support services were included for the first time in the 2013 Report. As a result of this addition, total expenditure for 2011-12, including family support services expenditure, is not comparable to total expenditure in previous years. \(^c\) Family support services expenditure data were not available for SA in 2011-12.

*Source*: State and Territory governments (unpublished); table 15A.1.
It is a Steering Committee objective 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 calculated, 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 are included for some jurisdictions, but not for others.

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 15.4).

Box 15.4 Objectives for child protection and out-of-home care services

The aims of child protection services are to:
- protect children and young people who are at risk of harm within their families or whose families do not have the capacity to provide care and protection
- 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 provides information on equity, efficiency and effectiveness, and distinguishes the outputs and outcomes of child protection and out-of-home care services (figure 15.4). The performance indicator framework shows which data are comparable in the 2013 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 Report’s statistical appendix 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) (appendix A). The statistical appendix also notes that the large populations of the eastern mainland states — NSW, Victoria and Queensland — have a significant effect on national averages, as approximately three quarters of Australia’s population live in these states.

Data quality information (DQI) is being progressively introduced for all indicators in the Report. The purpose of DQI is to provide structured and consistent information about quality aspects of data used to report on performance indicators. DQI in this Report cover the seven dimensions in the ABS’ data quality framework (institutional environment, relevance, timeliness, accuracy, coherence, accessibility and interpretability) in addition to dimensions that define and describe performance indicators in a consistent manner, and note key data gaps and issues identified by the Steering Committee. All DQI for the 2013 Report can be found at www.pc.gov.au/gsp/reports/rogs/2013.
Figure 15.4 Child protection and out-of-home care services performance indicator framework

Key to indicators
- Text: Data for these indicators are comparable, subject to caveats to each chart or table.
- Text: Data for these indicators are not complete and/or not directly comparable.
- Text: These indicators are yet to be developed or data are not collected for this Report.
15.3 Key child protection and out-of-home care services performance indicator results

Different delivery contexts, locations and clients can affect the equity/access, effectiveness and efficiency of child protection and out-of-home care services.

**Outputs**

Outputs are the 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 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 (box 15.5).

<table>
<thead>
<tr>
<th>Box 15.5</th>
<th>Access to child protection and out-of-home care services by equity groups</th>
</tr>
</thead>
<tbody>
<tr>
<td>‘Access to child protection and out-of-home care services by equity groups’ is yet to be defined.</td>
<td></td>
</tr>
<tr>
<td>These indicators have been identified for development and reporting in future.</td>
<td></td>
</tr>
</tbody>
</table>

**Effectiveness**

Child protection services — 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 (box 15.6).

<table>
<thead>
<tr>
<th>Box 15.6</th>
<th>Continuity of case worker</th>
</tr>
</thead>
<tbody>
<tr>
<td>‘Continuity of case worker’ is yet to be defined.</td>
<td></td>
</tr>
<tr>
<td>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.</td>
<td></td>
</tr>
<tr>
<td>This indicator has been identified for development and reporting in future.</td>
<td></td>
</tr>
</tbody>
</table>
Child protection services — client satisfaction

‘Client satisfaction’ is an indicator of governments’ objective to provide high quality services that meet the needs of recipients (box 15.7).

Box 15.7  **Client satisfaction**

‘Client satisfaction’ is yet to be defined.

This indicator has been identified for development and reporting in future.

Box 15.8 provides examples of steps taken across jurisdictions to monitor, assess and promote client satisfaction with child protection and out-of-home care services.

Box 15.8  **Developments in client satisfaction**

**NSW**  A large scale evaluation is being undertaken of the Brighter Futures early intervention program, which targets vulnerable families with children under 9 years of age. As part of the evaluation, a sample of 2484 families participated in the family survey, which assessed satisfaction with the services provided. The survey was conducted from August 2007 to 30 June 2009. Interviewed families were overwhelmingly positive about the Brighter Futures program, and generally satisfied with the services they received. Respondents were asked (using a scale from 1 to 5, with 1 being ‘completely dissatisfied’ and 5 ‘completely satisfied’), their degree of service satisfaction. Respondents consistently reported a high level of satisfaction (on average, 5 or ‘completely satisfied’) with the quality of services and the amount of help they received from Brighter Futures, which was sustained over the three waves of surveys.

**Vic**  Child Protection clients and families were surveyed in 2001 about their experience of child protection intervention. Findings identified areas for practice improvement and also a range of strengths in child protection practice, including that in the majority of cases, child protection intervention improved the safety and life circumstances of children and young people. A more comprehensive survey commenced in 2011 (the Child and Family Services Outcomes Survey, or CAFSOS). An independent survey of the parents and carers of children receiving child protection, out-of-home care and intensive family support services was completed in 2012. A survey of young people who are clients of these services will be undertaken in 2013. Both surveys will be repeated after a 2 year interval. Client feedback is also routinely sought by Community Services Organisations as part of meeting Victorian out-of-home care service registration standards.

(Continued on next page)
Box 15.8  (Continued)

Qld  Children in State care are visited regularly by the Commission for Children and Young People and Child Guardian’s Community Visitors (CVs) to independently assess their safety and wellbeing. CVs work to resolve issues locally and are able to escalate more serious concerns. Children are surveyed every two years by the Commission. Several age-appropriate questionnaires are used to determine satisfaction with current placements, case workers and the child protection system. Information is also gathered on placement histories, education and health needs, participation in decision-making, and planning for transition to independent living for those aged 16 and over. Results from surveys undertaken during 2011 of children and young people in foster care and residential care are available at: http://www.ccypcg.qld.gov.au/resources/publications/reports.html.

WA  WA's first Commissioner for Children and Young People was appointed in December 2007 and has legislative powers to consult, investigate, research, advise and report independently to the Parliament about issues that concern children and young people and those supporting them. In late 2011, the Department for Child Protection undertook a paper-based survey of foster carers to ascertain their level of satisfaction with the Foster Care Partnership launched in March 2009. Findings have provided a basis for further development of a positive and constructive relationship with the Department’s foster carers. In summary, 60 per cent of people who became approved carers from 2009 reported that they were satisfied with the support they received from the Department. Overall, 70 per cent of carers reported they were satisfied with the level of support they received, their level of involvement in the decision making process, and that they felt acknowledged for their efforts in providing support to the children in their care. The Department introduced new complaints policy and procedures in March 2008. Formal monitoring of service standards has continued and all districts were assessed by June 2009. A pilot standards monitoring regime for residential and non-government placement services was completed in June 2009. As a result of a positive outcome for 2009-10, residential and placement services completed a self-assessment. External on-site monitoring commenced in July 2010.

SA  Client complaints, compliments and suggestions are reported to the Families SA client feedback system, ‘RiskMan’. This information is assessed for appropriate follow up, and is reported to the Health and Community Services Complaints Commissioner on a quarterly basis, and the Families SA Executive Director. In addition, Create SA is contracted as the peak body representing the voices of all children in care. Children have the opportunity to provide evaluation feedback on training and programs they are involved in through formal surveys, and are encouraged to provide feedback on their experiences with Create SA through various media. Young people also complete an annual ‘Report Card Survey’ to provide feedback on their experiences in care and with Create SA.

(Continued on next page)
Box 15.8 (Continued)

Recently, the Office of the Guardian for Children and Young People (the Office) sought the views of children in care about contact with their siblings. The report was released in November 2011. The findings highlight how important sibling relationships are to children in the child protection system (for example, sibling relationships often helped to ameliorate the trauma children experience prior to and on entering the child protection system). In 2012-13, the Office will seek the views and experiences of children on moving while in care.

Tas An independent evaluation of the pilot Children’s Visitors scheme for children and young people in out-of-home care was completed following the completion of the pilot scheme in 2011. The pilot program involved children meeting regularly with their visitor, to participate in activities and answer questions relating to their experience in out-of-home care. The evaluation report confirmed the overall benefit of the pilot and recommended that a new, ongoing model for a children’s visitors program be developed. A new youth mentoring/visitor program is now being sought. The program will be based on providing long term, independent mentoring relationships for young people currently in care, preparing to leave care, and beyond. Major aims of the program include improving the engagement of young people with the care planning process and the associated decisions that affect them and consistently supporting clients to achieve their goals throughout their transition to independent living and beyond. Client participation is the most significant component of the new model.

ACT The ACT Government, Community Services Directorate entered into a research partnership Community Capacity Building in Child Protection Through Responsive Regulation. This research, which commenced in 2006, seeks to develop a regulatory framework for child protection that effectively manages escalating notification rates and addresses the challenge of how and when governments can intervene in individuals’ lives without undermining the goodwill essential for such interventions to be successful. One of the studies undertaken as part of this research partnership examines parents’ experiences of their encounters with the child protection system. Descriptive analysis from the parent study has been completed and further results are expected to be published in 2012.

NT A Practice Integrity and Complaints Management Branch has been established within the Office of Children and Families and reports directly to the Office of the Chief Executive. This branch provides a clear point of contact for clients wishing to provide feedback or raise concerns. The Children’s Commissioner’s powers have also been strengthened to allow the Commissioner to investigate concerns relating to vulnerable children without having to receive a formal complaint.

Source: State and Territory governments (unpublished).
Child protection services — response times

‘Response times’ is an indicator of governments’ objective to minimise the risk of harm to children by responding to notifications of possible child protection incidents and completing investigations in a timely manner (box 15.9). Notifications and investigations are defined on pages 15.11 and 15.12.

**Box 15.9  Response times**

‘Response times’ is defined by two measures:

- response time to commence investigations, defined as the length of time (measured in days) between the date a child protection department records a notification and the date an investigation is subsequently commenced
- response time to complete investigations, defined as the length of time (measured in days) between the date a child protection department records a notification and the date an investigation is completed (that is, the date an investigation outcome is determined by a department).

A short or decreasing length of time between recording a notification and commencing an investigation, and between recording a notification and completing an investigation, is desirable.

The length of time between recording a notification and commencing an investigation indicates a department’s promptness in effectively responding to child protection concerns. The length of time between recording a notification and completing an investigation indicates a department’s effectiveness in conducting investigations in a timely manner.

This indicator needs to be interpreted with care, as jurisdictions record notifications at different stages in response to a report, and jurisdictions have different policies and legislation outlining the time recommended for commencing investigations, based on the seriousness of the child protection concern. Furthermore, while investigations should be conducted in a timely manner, it is important that expediency does not undermine a thorough and accurate assessment of the case. In addition, a number of factors outside the control of a department can affect the timeliness of investigations, including involvement by external parties (for example, police and schools) and an inability to locate a child and/or family.

Data reported for this indicator are neither directly comparable nor complete.


For most jurisdictions, the majority of investigations were commenced within seven days of notification in 2011-12 (figure 15.5(a)). Response times to complete investigations varied across jurisdictions in 2011-12. Nationally, 37.4 per cent of investigations were completed in 28 days or less, 20.4 per cent were completed in 29 to 62 days, 12.2 per cent were completed in 63 to 90 days, and 30.0 per cent were completed in more than 90 days (figure 15.5(b)).
Figure 15.5  Proportion of investigations commenced and completed, by time taken (2011-12)\textsuperscript{a, b}

\textbf{(a) Response time to commence investigations}

\begin{table}[h]
\centering
\begin{tabular}{|c|c|c|c|c|c|}
\hline
& Up to 7 days & 8 to 14 days & 15 to 21 days & 22 to 28 days & 29 days or more \\
\hline
NSW & & & & & \\
Vic & & & & & \\
Qld & & & & & \\
WA & & & & & \\
SA & & & & & \\
Tas & & & & & \\
ACT & & & & & \\
NT & & & & & \\
Aust & & & & & \\
\hline
\end{tabular}
\end{table}

\textbf{(b) Response time to complete investigations}

\begin{table}[h]
\centering
\begin{tabular}{|c|c|c|c|c|}
\hline
& 28 days or less & 29 to 62 days & 63 to 90 days & More than 90 days \\
\hline
NSW & & & & \\
Vic & & & & \\
Qld & & & & \\
WA & & & & \\
SA & & & & \\
Tas & & & & \\
ACT & & & & \\
NT & & & & \\
Aust & & & & \\
\hline
\end{tabular}
\end{table}

\textsuperscript{a} For the response time to complete investigations measure, the NT’s data differ from the national counting rule — the NT counts the number of days from the start of investigations to the completion of investigations, as distinct from the number of days from recording notifications to the completion of investigations. \textsuperscript{b} See source table for detailed footnotes.

\textit{Source: AIHW data collection (unpublished); tables 15A.14 and 15A.15.}
Child protection services — substantiation rate

‘Substantiation rate’ is an indicator of governments’ objective to target investigations to those notifications where a substantive child abuse/neglect incident has occurred or is at risk of occurring (box 15.10).

Box 15.10  Substantiation rate

‘Substantiation rate’ is defined as the proportion of finalised investigations where harm or risk of harm was confirmed.

The substantiation rate provides an indication of the extent to which government avoided the human and financial costs of an investigation where no harm had occurred or was at risk of occurring. Neither a very high nor very low substantiation rate is desirable. A very low substantiation rate might indicate that notifications and investigations are not accurately targeted to appropriate cases, with the undesirable consequence of distress to families and undermining the likelihood that families will voluntarily seek support. It might also reflect a greater propensity to substantiate abuse incidents rather than situations of risk. A very high substantiation rate might indicate that the criteria for substantiation are unnecessarily bringing ‘lower risk’ families into the statutory system.

The rate of finalised investigations that were substantiated is influenced by a range of factors and might fluctuate because of policy, funding and practice changes, 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 reported for this indicator are not directly comparable.


Data for this indicator are not comparable across jurisdictions because definitions of substantiation vary. Data are comparable within each jurisdiction over time unless otherwise stated (figure 15.6).
Figure 15.6  **Proportion of finalised child protection investigations that were substantiated**\(^a, b\)

---

\(^a\) Data are not comparable across jurisdictions because definitions of substantiation vary significantly. Consequently, rates should not be compared across jurisdictions. \(^b\) See source tables for detailed footnotes.


**Out-of-home care — 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 (box 15.11).
Box 15.11  **Safety in out-of-home care**

'Safety in out-of-home care' is defined by two measures:

- the proportion of children in out-of-home care who were the subject of a notification while in out-of-home care, which was substantiated
- the proportion of children in out-of-home care who were the subject of a substantiation where the person responsible was living in the household providing out-of-home care.

The scope of these measures differs. For the first measure, the person responsible can be anyone who comes into contact with the child while the child is in out-of-home care. For the second measure, the person responsible is limited to someone in the household providing out-of-home care.

A low or decreasing proportion of substantiations for both measures is desirable.

The proportion of children in out-of-home care who were the subject of a notification while in out-of-home care, which was substantiated, assesses the overall safety of children in care. The proportion of children in out-of-home care who were the subject of a substantiation where the person responsible was living in the household providing out-of-home care assesses the extent to which authorised carers specifically provide safe care to children in care.

Care should be taken when interpreting this indicator as the threshold for substantiating harm or risk involving children in care is generally lower than that for substantiating harm or risk involving a child in the care of his or her own parents. This is because governments assume a duty of care for children removed from the care of their parents for protective reasons. In addition, care should be taken when interpreting these data as the scope of information captured by jurisdictions differs. For example, some jurisdictions substantiate carer requests to cease caring for a child, incidents or risk of self-harm or violence by a child, children absconding from out-of-home care placements, and abuse or risk of abuse during family contact visits.

Data reported for this indicator are neither complete nor directly comparable.


This Report includes for the first time a measure of children in out-of-home care who were the subject of a substantiated notification while in out-of-home care — regardless of whether the person responsible was living in the household (table 15.1). These data are experimental and will be improved over time, but available data suggest the proportion of children in out-of-home care who were the subject of a notification, which was substantiated, varied across jurisdictions (table 15.1).

The proportion of children in out-of-home care who were the subject of a substantiation where the person responsible was living in the household also varied across jurisdictions (table 15.2).
Table 15.1  Proportion of children in out-of-home care who were the subject of a notification, which was substantiated (experimental data), 2011-12a, b

<table>
<thead>
<tr>
<th>Unit</th>
<th>NSWc</th>
<th>Vicd</th>
<th>Qle</th>
<th>WA</th>
<th>SA</th>
<th>Tas</th>
<th>ACT</th>
<th>NT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children in care who were the subject of a notification, which was substantiated</td>
<td>no.</td>
<td>1 200</td>
<td>na</td>
<td>316</td>
<td>80</td>
<td>na</td>
<td>26</td>
<td>16</td>
</tr>
<tr>
<td>Children aged 0–17 in at least one care placement during the year</td>
<td>no.</td>
<td>20 018</td>
<td>9 103</td>
<td>8 560</td>
<td>4 260</td>
<td>2 986</td>
<td>1 249</td>
<td>797</td>
</tr>
<tr>
<td>Proportionf</td>
<td>%</td>
<td>6.0</td>
<td>na</td>
<td>3.7</td>
<td>1.9</td>
<td>na</td>
<td>2.1</td>
<td>2.0</td>
</tr>
</tbody>
</table>

a Data are not comparable due to differences across jurisdictions in policies, practices and reporting methods. b See source table for detailed footnotes. c NSW data are not comparable to data supplied by other jurisdictions because NSW data encompass a more inclusive set of substantiated issues, for example, children who abscond from out-of-home care placements and reported incidents of self-harm. In addition, NSW has a significantly lower threshold for investigating notifications relating to children in care compared with children in the general population. d Data are not available for Victoria, as the Victorian Child Protection Service does not record the required data for children who are in out-of-home care. e Queensland's data comprise matter of concern substantiations, which refer to children in the custody or guardianship of the Chief Executive only where a breach of the standards of care is indicated. Therefore, Queensland's data are narrower than the scope of the national counting rule and should not be compared to other jurisdictions' data. f As a proportion of all children in at least one care placement. na Not available. .. Not applicable.

Source: AIHW data collection (unpublished); table 15A.27.

Table 15.2  Proportion of children in out-of-home care who were the subject of a substantiation and the person responsible was living in the household, 2011-12a, b

<table>
<thead>
<tr>
<th>Unit</th>
<th>NSW</th>
<th>Vicc</th>
<th>Qld</th>
<th>WA</th>
<th>SA</th>
<th>Tas</th>
<th>ACT</th>
<th>NT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children in care who were the subject of a substantiation and the person responsible was in the household</td>
<td>no.</td>
<td>58</td>
<td>90</td>
<td>316</td>
<td>14</td>
<td>10</td>
<td>26</td>
<td>8</td>
</tr>
<tr>
<td>Children aged 0–17 in at least one care placement during the year</td>
<td>no.</td>
<td>20 018</td>
<td>9 103</td>
<td>8 560</td>
<td>4 260</td>
<td>2 986</td>
<td>1 249</td>
<td>797</td>
</tr>
<tr>
<td>Proportione</td>
<td>%</td>
<td>0.3</td>
<td>1.0</td>
<td>3.7</td>
<td>0.3</td>
<td>0.3</td>
<td>2.1</td>
<td>1.0</td>
</tr>
</tbody>
</table>

a Data are not comparable due to differences across jurisdictions in policies, practices and reporting methods. b See source table for detailed footnotes. c Victorian data comprise completed investigations where quality of care concerns were substantiated and action taken in response. d Queensland's data comprise matter of concern substantiations, which refer to children in the custody or guardianship of the Chief Executive only. Queensland's consideration of the 'person believed responsible' relates to the overall safety and risk experienced by a child in care. It includes allegations of actual harm inflicted by members of a household and also whether the carer's action or inaction contributed to the risk or harm even if the person believed responsible did not reside in the household. Therefore, Queensland's data are broader than the scope of the national counting rule and should not be compared to other jurisdictions' data. e As a proportion of all children in at least one care placement. na Not available.

Source: AIHW data collection (unpublished); table 15A.26.
‘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 (box 15.12).

Stability of placement is an important indicator of service quality for children placed away from their family for protective reasons, particularly for those 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 2011-12. Data are grouped according to the length of time in care (less than 12 months and 12 months or more).

**Box 15.12 Stability of placement**

‘Stability of placement’ is defined as the proportion of children who had 1 or 2 placements during a period of continuous out-of-home care.

A low number of child placements (1 or 2) 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 can have multiple short term placements for appropriate reasons (for example, an initial placement followed by a longer term placement) or it may be desirable to change placements to achieve better compatibility between a child and family. 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 a cohort of children on exit from care rather than longitudinally tracking a cohort of children on their entry into care: an exit cohort is biased to children who stayed a relatively short time in care and thus were more likely to have experienced fewer placements.

Data reported for this indicator are comparable.


Nationally, 86.7 per cent of children on a care and protection order who exited care after less than 12 months in 2011-12 experienced 1 or 2 placements. Proportions varied across jurisdictions (figure 15.7).
Figure 15.7  Proportion of children on a care and protection order exiting care after less than 12 months, who had 1 or 2 placements\textsuperscript{a, b, c, d, e}

\begin{figure}[h]
\centering
\includegraphics[width=\textwidth]{figure15.7}
\caption{Proportion of children on a care and protection order exiting care after less than 12 months, who had 1 or 2 placements\textsuperscript{a, b, c, d, e}}
\end{figure}

\textsuperscript{a} Data refer to children exiting care during the relevant financial year. \textsuperscript{b} The apparent decline in the proportion for the ACT in 2007-08 was affected by the small number of children involved and the placement of large sibling groups. \textsuperscript{c} NT data for 2007-08 to 2008-09 were not available. WA data for 2010-11 and 2011-12 were not available. \textsuperscript{d} In Tasmania, it was not possible to identify respite placements prior to 2011-12 and as such all respite placements were counted as distinct placements. Respite placements lasting less than seven days have been excluded for 2011-12. \textsuperscript{e} See source table for detailed footnotes.

Source: AIHW data collection (unpublished); table 15A.25.

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 2011-12 after 12 months or more who had experienced 1 or 2 placements was 48.0 per cent nationally but varied across jurisdictions (figure 15.8).
**Figure 15.8** Proportion of children on a care and protection order exiting care after 12 months or more, who had 1 or 2 placements$^{a, b, c, d}$

<table>
<thead>
<tr>
<th>Year</th>
<th>NSW</th>
<th>Vic</th>
<th>Qld</th>
<th>WA</th>
<th>SA</th>
<th>Tas</th>
<th>ACT</th>
<th>NT</th>
<th>Aust</th>
</tr>
</thead>
<tbody>
<tr>
<td>2007-08</td>
<td>40</td>
<td>45</td>
<td>35</td>
<td>32</td>
<td>28</td>
<td>30</td>
<td>35</td>
<td>30</td>
<td>32</td>
</tr>
<tr>
<td>2008-09</td>
<td>45</td>
<td>48</td>
<td>38</td>
<td>33</td>
<td>29</td>
<td>31</td>
<td>36</td>
<td>31</td>
<td>33</td>
</tr>
<tr>
<td>2009-10</td>
<td>42</td>
<td>46</td>
<td>36</td>
<td>31</td>
<td>27</td>
<td>30</td>
<td>34</td>
<td>30</td>
<td>32</td>
</tr>
<tr>
<td>2010-11</td>
<td>40</td>
<td>44</td>
<td>34</td>
<td>30</td>
<td>26</td>
<td>29</td>
<td>33</td>
<td>29</td>
<td>31</td>
</tr>
<tr>
<td>2011-12</td>
<td>38</td>
<td>42</td>
<td>32</td>
<td>28</td>
<td>24</td>
<td>27</td>
<td>31</td>
<td>27</td>
<td>29</td>
</tr>
</tbody>
</table>

$^a$ Data refer to children exiting care during the relevant financial year. $^b$ In Tasmania, it was not possible to identify respite placements prior to 2011-12 and such all respite placements were counted as distinct placements. Respite placements lasting less than seven days have been excluded for 2011-12; however, this figure is still likely to be under-reported as historical respite placements have not been excluded for children exiting care during 2011-10. $^c$ NT data for 2007-08 to 2008-09 are not available. WA data for 2010-11 and 2011-12 are not available. $^d$ See source table for detailed footnotes.

Source: AIHW data collection (unpublished); table 15A.25.

**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 governments’ objective to provide services which meet the needs of recipients (box 15.13).

**Box 15.13  Children aged under 12 years in home-based care**

‘Children aged under 12 years in home-based care’ is defined as the number of children aged under 12 years placed in home-based care divided by the total number of children aged under 12 years in out-of-home care.

A high or increasing rate for this indicator is desirable. This indicator should be interpreted in conjunction with other placement indicators.

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 or institutional care environments.

Data reported for this indicator are comparable.

Nationally, the proportion of all children aged under 12 years in care who were placed in home-based care at 30 June 2012 was 97.5 per cent. In most 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 (figure 15.9).

Figure 15.9 Proportion of children aged under 12 years in out-of-home care who were in a home-based placement, by Indigenous status, 30 June 2012

![Bar chart showing proportions of children in home-based care by Indigenous status and location]

*See source table for detailed footnotes.*

*Source: AIHW data collection (unpublished); table 15A.24.*

**Out-of-home care — placement with extended family**

‘Placement with extended family’ is an indicator of governments’ objective to provide services that meet the needs of recipients (box 15.14).
Box 15.14  **Placement with extended family**

‘Placement with extended family’ 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 high or increasing rate for this indicator is desirable. 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.

Placement with extended family needs to be considered with other factors in the placement decision, placements with extended family may not always be the best option. Long standing family dynamics can 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 the child, it may be more important to have a local placement that enables continuity at school, for example, rather than a distant placement with relatives.

Data reported for this indicator are comparable.


Figure 15.10 shows the proportion of children placed with relatives or kin by Indigenous status. The proportion of children placed with relatives or kin at 30 June 2012 was greater for Indigenous children than for non-Indigenous children in most jurisdictions (figure 15.10).

The Aboriginal Child Placement Principle gives considerable emphasis to the placement of Indigenous children with extended family. This principle is discussed in box 15.15.
Figure 15.10 Proportion of children in out-of-home care placed with relatives/kin, by Indigenous status, 30 June 2012\(^a\)

\(^a\) See table 15A.22 for detailed footnotes.

\textit{Source}: AIHW data collection (unpublished); table 15A.22.

\textit{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 governments’ objective to protect the safety and welfare of Indigenous children while maintaining their cultural ties and identity (box 15.15).
Box 15.15 Placement in accordance with the Aboriginal Child Placement Principle

‘Placement in accordance with the Aboriginal Child Placement Principle’ 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 a non-relative Indigenous carer or in Indigenous residential care, and (iii) not placed with relative/kin, a non-relative Indigenous carer or in Indigenous residential care.

A high or increasing proportion of children placed in accordance with the principle is desirable. This indicator needs to be interpreted with care as it is a proxy for compliance with the principle. This indicator reports the placement outcomes of Indigenous children rather than compliance with the principle. The indicator does not reflect whether the hierarchy was followed in the consideration of the best placement for the child, nor whether consultation was had with appropriate Indigenous individuals or organisations.

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, departments consult with and involve appropriate Indigenous individuals and/or organisations. If the preferred options are not available, the child may be placed (after appropriate consultation) with a non-Indigenous family or in a 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, might be the most appropriate placement for the child.

Data reported for this indicator are comparable.

According to the Aboriginal Child Placement Principle (NSW Law Reform Commission 1997) the following hierarchy of placement options 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 adopted this principle in both legislation and policy.

Nationally, at 30 June 2012, 52.4 per cent of Indigenous children in out-of-home care were placed with relatives/kin (38.2 per cent with Indigenous relatives/kin and 14.1 per cent with non-Indigenous relatives/kin). A further 16.4 per cent of Indigenous children in out-of-home care were placed with other Indigenous carers or in Indigenous residential care (figure 15.11).

The proportion of Indigenous children in out-of-home care at 30 June 2012 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 15.11).

As noted above, the placement of Indigenous children in out-of-home care is a proxy measure for compliance with the Aboriginal Child Placement Principle. The proxy measure reports the placement outcomes of Indigenous children rather than compliance with the hierarchy of placement options to be considered when finding suitable out-of-home care environments for Indigenous children. Work is underway to develop a more robust measure of compliance with the Aboriginal Child Placement Principle as part of the National framework for protecting Australia’s children: Second three year action plan, 2012-15 (Commonwealth of Australia, 2012).
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. \(^b\) Data for Tasmania and the ACT relate to a small number of Indigenous children. \(^c\) In Tasmania, it was not possible to confirm the Indigenous status of all carers, as such it is likely that the ‘Other Indigenous’ category was under-counted and the ‘Other’ category correspondingly over-counted. \(^d\) See source table for detailed footnotes.

Source: AIHW data collection (unpublished); table 15A.23.

**Out-of-home care — local placement**

‘Local placement’ is an indicator of governments’ objective to provide services which meet the needs of the recipients (box 15.16).
Box 15.16  **Local placement**

‘Local placement’ is defined as the proportion of children attending the same school that they were attending before entering out-of-home care as after entering out-of-home care.

A high or increasing 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.

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 or to a different local school at the same level.

Data will be provided for 3 and 12 months after entering care. Data collection for this indicator is under development. Data were not available for the 2013 Report.

Data quality information for this indicator is under development.

---

*Out-of-home care — placement with sibling*

‘Placement with sibling’ is an indicator of governments’ objective to provide services which meet the needs of the recipients (box 15.17).
Box 15.17  Placement with sibling

‘Placement with sibling’ 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 or increasing 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 collection for this indicator is under development. Data were not available for the 2013 Report.

Data quality information for this indicator is under development.

Out-of-home care — children with documented case plans

‘Children with documented case plans’ is an indicator of governments’ objective to provide services that meet the needs of the recipients (box 15.18). Experimental data for this indicator are included for the first time in this Report. These data are under development and will be improved over time.
Box 15.18  **Children with documented case plans**

‘Children with documented case plans’ is defined as the number of children who have a current documented and approved case plan as a proportion of all children who are required to have a current documented and approved case plan.

A case plan is an individualised, dynamic written plan (or support agreement) that includes information on a child in need of protection, including his or her needs, risks, health, education, living and family arrangements, goals for ongoing intervention and actions required to achieve identified goals. A case plan is usually developed between a family and an agency on the basis of an assessment process. Case planning is essential to structured and purposeful work to support children’s optimal development.

A current case plan is one that has been approved and/or reviewed within the previous 12 months. Individual jurisdictions’ timeframes for ongoing review may vary and reviews may be more frequent when young children or infants are involved, the child has just entered care, and certain orders are in place (for example, assessment orders). Reviews may also be required when circumstances have changed (for example, the death of a parent or carer and placement changes) and significant new decisions are needed.

A high or increasing rate of children with documented case plans is desirable.

The quality of case plans, and the extent to which identified needs and actions are put into place, should also be taken into account when considering this indicator. The existence of a case plan does not guarantee that appropriate case work to meet a child’s needs is occurring.

Data reported for this indicator are neither complete nor directly comparable.

Data quality information for this indicator is under development.

The proportion of children with documented case plans at 30 June 2012 varied across jurisdictions (figure 15.12).
Figure 15.12  Proportion of children with documented case plans, 30 June 2012<sup>a, b, c</sup>

<table>
<thead>
<tr>
<th></th>
<th>NSW</th>
<th>Vic</th>
<th>Qld</th>
<th>WA</th>
<th>SA</th>
<th>Tas</th>
<th>ACT</th>
<th>NT</th>
<th>Aust</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>100</td>
<td>90</td>
<td>100</td>
<td>80</td>
<td>70</td>
<td>60</td>
<td>80</td>
<td>70</td>
<td>80</td>
</tr>
</tbody>
</table>

<sup>a</sup> Data were not available for NSW, Victoria, SA and the NT. <sup>b</sup> In Tasmania, a child with a populated case plan has not been counted as having a ‘documented case plan’ if the case plan was not approved or if the review date was overdue. <sup>c</sup> See source table for detailed footnotes.

Source: AIHW data collection (unpublished); State and Territory governments (unpublished); table 15A.16.

Out-of-home care — client satisfaction

‘Client satisfaction’ is an indicator of governments’ objective to provide high quality services that meet the needs of recipients (box 15.19).

Box 15.19  Client satisfaction

‘Client satisfaction’ is yet to be defined.

This indicator has been identified for development and reporting in future.

Some information on jurisdictions’ development of initiatives which may assist to measure client satisfaction in the future is included in box 15.8.

Efficiency

Understanding the efficiency of child protection systems broadly — and the different components of child protection systems, such as early intervention and out-of-home care services — enables State and Territory governments to identify key service cost drivers. Efficiency measures coupled with outcome measures ultimately enable State and Territory governments to compare the relative cost
effectiveness of broad system approaches and the cost effectiveness of different components of child protection systems.

Challenges in reporting efficiency for child protection systems

Current efficiency data for child protection services have 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 resources directed specifically to 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 government agencies responsible for child protection services 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 Steering Committee initiated a project to improve efficiency data for a national framework of child protection and family support pathways (the ‘Pathways’ project) (box 15.20). Until this can be fully implemented, reporting on efficiency has been limited to proxy indicators (boxes 15.21 and 15.23).

Experimental data relating to the proportion of expenditure across each Pathways activity group are included in table 15.3. These data are preliminary and are subject to further analysis and refinement for future Reports. Due to different internal management systems, there can be significant variation across jurisdictions in the activities or expenditures that are included in each activity group. However, for all jurisdictions, the proportion of expenditure allocated to Activity group 8 (out-of-home care) is the most significant and varies from 47.8 per cent to 70.3 per cent across jurisdictions (table 15.3).
These 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). Indirect allocations have been approximated by jurisdictions across the eight activity groups.

**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. Eight national pathways have been developed as a high level representation of the services that a child protection 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 the unit cost (including direct and indirect expenditure) of an individual pathway to be determined.

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 child protection 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 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 for children not on an order
- **Activity Group 6** Seeking an order
- **Activity Group 7** Provision of protective intervention, support and coordination services for children on an order
- **Activity Group 8** Provision of out-of-home care services

Detailed definitions of activity groups are included in section 15.9 Definitions of key terms and indicators.

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).*
Table 15.3  Proportion of expenditure by activity group — experimental estimates (per cent), 2011-12\(^a, b\)

<table>
<thead>
<tr>
<th>Activity Group</th>
<th>Unit</th>
<th>NSW</th>
<th>Vic</th>
<th>Qld</th>
<th>WA</th>
<th>SA</th>
<th>Tas</th>
<th>ACT</th>
<th>NT</th>
</tr>
</thead>
<tbody>
<tr>
<td>AG1</td>
<td>%</td>
<td>3.5</td>
<td>6.4</td>
<td>3.0</td>
<td>7.4</td>
<td>6.5</td>
<td>7.5</td>
<td>6.7</td>
<td>10.0</td>
</tr>
<tr>
<td>AG2(^c)</td>
<td>%</td>
<td>17.6</td>
<td>13.4</td>
<td>7.2</td>
<td>9.8</td>
<td>4.2</td>
<td>7.5</td>
<td>6.5</td>
<td>1.9</td>
</tr>
<tr>
<td>AG3</td>
<td>%</td>
<td>14.7</td>
<td>9.8</td>
<td>4.2</td>
<td>7.4</td>
<td>4.6</td>
<td>7.8</td>
<td>3.2</td>
<td>0.5</td>
</tr>
<tr>
<td>AG4</td>
<td>%</td>
<td>3.6</td>
<td>4.4</td>
<td>7.0</td>
<td>5.0</td>
<td>3.5</td>
<td>5.1</td>
<td>4.6</td>
<td>6.8</td>
</tr>
<tr>
<td>AG5</td>
<td>%</td>
<td>4.3</td>
<td>0.3</td>
<td>4.5</td>
<td>0.3</td>
<td>1.6</td>
<td>0.3</td>
<td>0.3</td>
<td>0.5</td>
</tr>
<tr>
<td>AG6</td>
<td>%</td>
<td>4.6</td>
<td>2.5</td>
<td>4.3</td>
<td>2.9</td>
<td>1.5</td>
<td>3.0</td>
<td>2.6</td>
<td>3.9</td>
</tr>
<tr>
<td>AG7</td>
<td>%</td>
<td>3.8</td>
<td>12.8</td>
<td>19.9</td>
<td>14.7</td>
<td>7.7</td>
<td>15.0</td>
<td>13.4</td>
<td>20.1</td>
</tr>
<tr>
<td>AG8</td>
<td>%</td>
<td>47.8</td>
<td>50.4</td>
<td>50.0</td>
<td>52.4</td>
<td>70.3</td>
<td>53.7</td>
<td>62.6</td>
<td>56.3</td>
</tr>
<tr>
<td>Total</td>
<td>%</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
</tr>
</tbody>
</table>

\(\text{AG} = \text{Activity Group (box 15.20)}\). \(^a\) Totals may not add to 100 due to rounding. \(^b\) Experimental percentage allocations are derived from total expenditure allocations which vary from totals used to derive costs presented elsewhere in this chapter. \(^c\) Expenditure items included in calculating proportional expenditure for AG2 can vary across jurisdictions, for example the inclusion/exclusion of expenditure on services outsourced to non-government organisations.

Source: State and Territory governments (unpublished).

Table 15.4 presents experimental unit cost data for all activity groups for all jurisdictions, where data are available. A more complete collection of unit cost data will be provided once all jurisdictions are able to report appropriate denominators (that is, activity counts).
Table 15.4  Activity group unit costs — experimental data, 2011-12\textsuperscript{a, b}

<table>
<thead>
<tr>
<th>Unit</th>
<th>NSW</th>
<th>Vic</th>
<th>Qld</th>
<th>WA</th>
<th>SA</th>
<th>Tas</th>
<th>ACT</th>
<th>NT</th>
</tr>
</thead>
<tbody>
<tr>
<td>AG1–Cost per report to child protection</td>
<td>$236</td>
<td>na</td>
<td>na</td>
<td>316</td>
<td>315</td>
<td>na</td>
<td>na</td>
<td>967</td>
</tr>
<tr>
<td>AG1-Cost per notification\textsuperscript{c}</td>
<td>$547</td>
<td>704</td>
<td>956</td>
<td>1 989</td>
<td>682</td>
<td>468</td>
<td>232</td>
<td>1 257</td>
</tr>
<tr>
<td>AG2-Cost per child commencing family support services\textsuperscript{d}</td>
<td>na</td>
<td>na</td>
<td>na</td>
<td>na</td>
<td>na</td>
<td>na</td>
<td>na</td>
<td>na</td>
</tr>
<tr>
<td>AG3-Cost per child commencing intensive family support services</td>
<td>$25 679</td>
<td>11 756</td>
<td>9 941</td>
<td>27 120</td>
<td>15 926</td>
<td>na</td>
<td>na</td>
<td>4 364</td>
</tr>
<tr>
<td>AG4-Cost per notification investigated\textsuperscript{e}</td>
<td>$795</td>
<td>1 925</td>
<td>2 236</td>
<td>1 808</td>
<td>1 405</td>
<td>2 175</td>
<td>886</td>
<td>1 697</td>
</tr>
<tr>
<td>AG5-Cost per child commencing protective intervention and coordination services who is not on an order</td>
<td>$6 101</td>
<td>na</td>
<td>na</td>
<td>789</td>
<td>na</td>
<td>627</td>
<td>385</td>
<td>na</td>
</tr>
<tr>
<td>AG6-Cost per order issued</td>
<td>$14 255</td>
<td>3 757</td>
<td>4 709</td>
<td>5 501</td>
<td>na</td>
<td>1 722</td>
<td>1 903</td>
<td>1 566</td>
</tr>
<tr>
<td>AG7-Cost per child commencing protective intervention and coordination services who is on an order</td>
<td>$19 471</td>
<td>na</td>
<td>na</td>
<td>15 660</td>
<td>5 805</td>
<td>7 817</td>
<td>12 840</td>
<td>25 040</td>
</tr>
<tr>
<td>AG8-Cost per placement night\textsuperscript{f}</td>
<td>$120</td>
<td>150</td>
<td>141</td>
<td>167</td>
<td>156</td>
<td>108</td>
<td>136</td>
<td>226</td>
</tr>
</tbody>
</table>

\textsuperscript{a} AG = Activity Group (box 15.20). \textsuperscript{b} Data are rounded to the nearest whole number. \textsuperscript{c} Experimental unit costs are based on jurisdictions’ total expenditure for each activity group, including direct and indirect costs such as staffing and other overheads. \textsuperscript{d} Jurisdictions count notifications at different points in 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 and hence the unit costs for notifications are not comparable across jurisdictions. \textsuperscript{e} Unit costs for AG2 will be included when jurisdictions are better able to capture family support service activity data (that is, the required denominator). \textsuperscript{f} Jurisdictions differ in the way notifications and investigations are defined and the requirements for conducting an investigation. \textsuperscript{g} Cost per placement night should be interpreted with caution due to the effect of different proportions of children in residential out-of-home care across jurisdictions. \textsuperscript{na} Not available.

Source: State and Territory governments (unpublished).

**Total expenditure on all child protection activities per notification, investigation and substantiation**

‘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’ are reported as proxy indicators of governments’ objective to maximise the benefit to the community through the efficient use of public resources (box 15.21).
Box 15.21  **Total expenditure on all child protection activities per notification, investigation and substantiation**

‘Total expenditure on all child protection activities per notification, investigation and substantiation’ is defined by three measures:

- 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.

Low or decreasing expenditure per notification/investigation/substantiation can suggest more efficient services but may indicate lower quality or different service delivery models. These indicators are 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.

More comprehensive and accurate efficiency indicators would relate expenditure on particular child protection activities to a measure of output of those activities. Work is underway to develop a national activity-based costing method, the Pathways project, which will allow this type of reporting from existing information systems (box 15.20). Experimental data using the Pathways method are included in table 15.3. The following proxy data will be replaced by Pathways unit cost data when the Pathways method is refined and implemented nationally.

Data reported for this indicator are not directly comparable.

Data quality information for this indicator is under development.

Total expenditure on all child protection activities per notification, per investigation and per substantiation from 2007-08 to 2011-12 varied across jurisdictions (figure 15.13).
Figure 15.13  Child protection efficiency indicators (2011-12 dollars)a, b, c

(a) Annual real recurrent expenditure on all child protection activities per notification

(b) Annual real recurrent expenditure on all child protection activities per investigation

(c) Annual real recurrent expenditure on all child protection activities per substantiation

---

a Real expenditure based on ABS gross domestic product price deflator (2011-12 = 100) (table AA.51). b See source table for detailed footnotes. c In Queensland, all notifications are required to be investigated. As such, the annual real recurrent expenditure on all child protection activities per notification is equivalent to the annual real recurrent expenditure on all child protection activities per investigation.

Source: AIHW data collection (unpublished); State and Territory governments (unpublished); table 15A.2.
Out-of-home care expenditure per placement night

‘Out-of-home care expenditure per placement night’ is an indicator of governments’ objective to maximise the availability and quality of services through the efficient use of public resources (box 15.22).

Box 15.22  Out-of-home care expenditure per placement night

‘Out-of-home care expenditure per placement night’ is defined as total real recurrent expenditure on out-of-home care services divided by the total number of placement nights in out-of-home care.

Low or decreasing expenditure per placement night can suggest more efficient services but may indicate lower service quality or different service delivery models. Further, in some cases, efficiencies may not be able to be realised due to remote geographic locations that limit opportunities to reduce overheads through economies of scale.

Data reported for this indicator are not directly comparable.

Data quality information for this indicator is under development.

Out-of-home care expenditure per placement night varied across jurisdictions (figure 15.14).

Figure 15.14 Real out-of-home care expenditure per placement night (2011-12 dollars)a, b, c, d

<table>
<thead>
<tr>
<th>Year</th>
<th>NSW</th>
<th>Vic</th>
<th>Qld</th>
<th>WA</th>
<th>SA</th>
<th>Tas</th>
<th>ACT</th>
<th>NT</th>
<th>Aust</th>
</tr>
</thead>
<tbody>
<tr>
<td>2007-08</td>
<td>105</td>
<td>110</td>
<td>120</td>
<td>130</td>
<td>140</td>
<td>150</td>
<td>160</td>
<td>170</td>
<td>180</td>
</tr>
<tr>
<td>2008-09</td>
<td>105</td>
<td>110</td>
<td>120</td>
<td>130</td>
<td>140</td>
<td>150</td>
<td>160</td>
<td>170</td>
<td>180</td>
</tr>
<tr>
<td>2009-10</td>
<td>105</td>
<td>110</td>
<td>120</td>
<td>130</td>
<td>140</td>
<td>150</td>
<td>160</td>
<td>170</td>
<td>180</td>
</tr>
<tr>
<td>2010-11</td>
<td>105</td>
<td>110</td>
<td>120</td>
<td>130</td>
<td>140</td>
<td>150</td>
<td>160</td>
<td>170</td>
<td>180</td>
</tr>
<tr>
<td>2011-12</td>
<td>105</td>
<td>110</td>
<td>120</td>
<td>130</td>
<td>140</td>
<td>150</td>
<td>160</td>
<td>170</td>
<td>180</td>
</tr>
</tbody>
</table>

a Real expenditure based on ABS gross domestic product price deflator (2011-12 = 100) (table AA.51).

c These data should not be interpreted as unit costs for Activity Group 8 as they are derived using reported program expenditure, not activity group expenditure. Caution should be used when interpreting results due to the variety of activities included in out-of-home care services.

Source: AIHW data collection (unpublished); State and Territory governments (unpublished); table 15A.34.
These indicative unit 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.

_Total expenditure on all children in residential and non-residential out-of-home care per child in residential and non-residential out-of-home care_

‘Total expenditure on all out-of-home care services per child in out-of-home care, by residential and non-residential care’ are reported as proxy indicators of governments’ objective to maximise the benefit to the community through the efficient use of public resources (box 15.23).

<table>
<thead>
<tr>
<th>Box 15.23</th>
<th><strong>Total expenditure on children in residential and non-residential out-of-home care per child in residential and non-residential out-of-home care</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total expenditure on children in residential and non-residential out-of-home care per child in residential and non-residential out-of-home care</strong></td>
<td>Total expenditure on children in residential and non-residential out-of-home care per child in residential and non-residential out-of-home care is defined by three measures:</td>
</tr>
<tr>
<td><strong>Total expenditure on children in residential and non-residential out-of-home care per child in residential and non-residential out-of-home care</strong></td>
<td>total expenditure on residential out-of-home care divided by the number of children in residential out-of-home care at 30 June</td>
</tr>
<tr>
<td><strong>Total expenditure on children in residential and non-residential out-of-home care per child in residential and non-residential out-of-home care</strong></td>
<td>total expenditure on non-residential out-of-home care divided by the number of children in non-residential out-of-home care at 30 June</td>
</tr>
<tr>
<td><strong>Total expenditure on children in residential and non-residential out-of-home care per child in residential and non-residential out-of-home care</strong></td>
<td>total expenditure on all out-of-home care divided by the number of children in all out-of-home care at 30 June.</td>
</tr>
</tbody>
</table>

Low or decreasing expenditure per child in care can suggest more efficient services but may indicate lower quality or different service delivery models. These indicators are proxy indicators and need to be interpreted with care as they do not represent a measure of unit costs. 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.

Data reported for this indicator are not directly comparable.

Data quality information for this indicator is under development.

Total expenditure on residential care and non-residential care for the period 2007-08 to 2011-12, per child in residential care and non-residential care at 30 June, varied across jurisdictions (figures 15.15(a) and figure 15.15(b)). Total expenditure on all out-of-home care per child in care at 30 June for 2007-08 to 2011-12 also varied across jurisdictions (figure 15.15(c)).
Figure 15.15  Out-of-home care efficiency indicators (2011-12 dollars)\textsuperscript{a, b, c}

(a) Annual real recurrent 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

\textsuperscript{a} Real expenditure based on ABS gross domestic product price deflator (2011-12 = 100) (table AA.51).
\textsuperscript{b} NSW, Queensland, and the NT could not disaggregate expenditure on out-of-home care. Tasmania could only disaggregate these data from 2008-09 onwards. \textsuperscript{c} See source table for detailed footnotes.

Source: AIHW data collection (unpublished); 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 services delivered) (see chapter 1, section 1.5).

Improved safety — substantiation rate after decision not to substantiate

‘Improved safety’ is an indicator of governments’ objective to reduce the risk of harm to children by appropriately assessing notifications of possible child protection incidents (box 15.24).

<table>
<thead>
<tr>
<th>Box 15.24  Improved safety</th>
</tr>
</thead>
<tbody>
<tr>
<td>‘Improved safety’ is defined by two measures:</td>
</tr>
<tr>
<td>• substantiation rate after a decision not to substantiate, 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 3 or 12 months of the initial decision not to substantiate. The year reported relates to the year of the initial decision not to substantiate</td>
</tr>
<tr>
<td>• substantiation rate after a prior substantiation, 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 3 or 12 months. The year reported relates to the year of the original substantiation.</td>
</tr>
<tr>
<td>A low or decreasing rate for these measures is desirable. However, reported results can 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 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 interventions offered to children to protect them from further harm. This indicator should be considered with other outcome indicators.</td>
</tr>
<tr>
<td>Data reported for this indicator are not directly comparable.</td>
</tr>
</tbody>
</table>

Data are not comparable across jurisdictions for this indicator because definitions of substantiation vary. Data are comparable within each jurisdiction over time unless otherwise stated.
The proportion of substantiations that occurred within 3 and 12 months of a decision not to substantiate are provided in figure 15.16. The proportion of substantiations that occurred within 3 and 12 months of a prior substantiation are provided in figure 15.17.

Figure 15.16 Improved safety — substantiation rate within 3 and/or 12 months after a decision not to substantiatea, b

---

a Data are not comparable across jurisdictions because definitions of substantiation vary significantly. Consequently, rates cannot be compared across jurisdictions. b See source tables for detailed footnotes.

Source: AIHW data collection (unpublished); tables 15A.9.
Data are not comparable across jurisdictions for this indicator because definitions of substantiation vary. Data are comparable within each jurisdiction over time unless otherwise stated (figure 15.17).

Figure 15.17 **Improved safety — resubstantiation rate within 3 or 12 months of a prior substantiation**

\[ \text{Data are not comparable across jurisdictions because definitions of substantiation vary significantly. Consequently, rates cannot be compared across jurisdictions.} \]

\[ \text{See source table for detailed footnotes.} \]

*Source*: AIHW data collection (unpublished); tables 15A.10.
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 (box 15.25).

**Box 15.25  Improved education, health and wellbeing of the child**

‘Improved education, health and wellbeing of the child’ is defined as the change over time in the learning outcomes of children on guardianship or custody orders.

A high or increasing rate at which children’s educational outcomes are improving is desirable.

Factors outside the control of child protection services can also influence the educational outcomes of children on guardianship or custody orders, and care needs to be exercised when interpreting results. Change over time in the learning outcomes of children on guardianship or custody orders is a partial measure of this outcome indicator, which also includes health and wellbeing.

Educational outcomes data reported for this indicator are not complete.

The health and wellbeing components of this indicator have been identified for development and reporting in future.


Tables 15A.11 to 15A.13 provide data on the proportion of children in years 3, 5 and 7 on guardianship or custody orders (attending government schools) achieving national reading and numeracy benchmarks in 2003, 2004, 2005 and 2006 relative to all children (attending government and non-government schools). The proportion of children on guardianship or custody orders achieving national reading and numeracy benchmarks in 2003, 2004, 2005 and 2006 varied significantly across jurisdictions. However, with few exceptions, the proportion of children on orders achieving national reading and numeracy benchmarks was less — at times significantly less — than all students.

Data contained in tables 15A.11 to 15A.13 in this Report were sourced from a pilot study conducted by the AIHW. Data were not available for all jurisdictions. Work is underway to improve reporting for this indicator using National Assessment Program — Literacy and Numeracy (NAPLAN) data. NAPLAN testing is conducted each year for all students across Australia in years 3, 5, 7 and 9. All students in the same year level are assessed on the same test items in the assessment domains of reading, writing, language conventions (spelling, grammar and punctuation) and numeracy.
During 2012, an experimental collection was undertaken by the Protection and Support Services Working Group (PSSWG) to assess jurisdictions’ capacity to report NAPLAN data for children on orders. The experimental collection sought aggregate counts of the number of year 5 children on guardianship and custody orders who achieved at or above the national minimum standards in the NAPLAN domains ‘reading’ and ‘numeracy’, as well as the NAPLAN participation rates of children in these categories.

Experimental data were available for Queensland and South Australia for children under the guardianship of the Minister in government schools. These data indicate that the proportion of year 5 children on orders achieving at or above the national minimum standards in the NAPLAN domains ‘reading’ and ‘numeracy’ are significantly lower than the results for all students in year 5. For example, in 2010:

- 57 per cent of year 5 students on orders in Queensland and 60 per cent of year 5 students on orders in South Australia achieved at or above the national minimum standard in the NAPLAN domain ‘reading’, compared with 91.3 per cent of all year 5 students
- 69 per cent of year 5 students on orders in Queensland and 59 per cent of year 5 students on orders in South Australia achieved at or above the national minimum standard in the NAPLAN domain ‘numeracy’, compared with 93.7 per cent of all year 5 students (Australian Curriculum, Assessment and Reporting Authority 2010; Queensland Government 2012; South Australia Government unpublished).

It is important to take student participation rates into account when analysing NAPLAN data. Participation rates are calculated as all assessed and exempt students as a percentage of the total number of students in the year level, including students who were absent or withdrawn. In 2010:

- the participation rates for year 5 students on orders in the NAPLAN ‘reading’ domain was 94 per cent in Queensland and 93 per cent in South Australia, compared with 96.2 per cent of all year 5 students
- the participation rates for year 5 students on orders in the NAPLAN ‘numeracy’ domain was 92 per cent in Queensland and 91 per cent in South Australia, compared with 95.9 per cent of all year 5 students (Australian Curriculum, Assessment and Reporting Authority 2010; Queensland Government 2012; South Australia Government unpublished).

The NAPLAN results of children on orders are indicative of the high needs of children in the child protection system and the disadvantage often faced by children in the child protection system (for example, children’s experiences of trauma, mental illness, disability, and family violence). However, it is also important to note
that children exempted from NAPLAN testing are recorded as being below the national minimum standard. Data from Queensland and South Australia indicate that children on guardianship and custody orders are exempted from NAPLAN testing at significantly higher rates than the general student population, which also contributes to poorer NAPLAN results for children on orders than the general student population.

The experimental collection will assist the PSSWG to identify the type of education data that would be meaningful to include in this chapter in the future, and methodological issues that need to be accounted for in educational outcomes reporting for children on orders. Further information on NAPLAN testing generally can be found in chapter 4 School education of this Report.

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 (box 15.26).

Box 15.26 Safe return home

‘Safe return home’ is yet to be defined.

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.

Permanent care

‘Permanent care’ is an indicator of governments’ objective to provide appropriate care for children who cannot be safely reunified with their families (box 15.27).

Box 15.27 Permanent care

‘Permanent care’ is yet to be defined.

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.
15.4 Future directions in child protection and out-of-home care services performance reporting

Improving national child protection data

The Performance and Data Working Group has initiated a number of national projects to address the gaps in child protection reporting and to improve the comparability of child protection data. Such projects, approved by the National Community Services Information Management Group (NCSIMG) and funded by the Community and Disability Services Ministerial Council (CDSMC; now the Standing Council on Community, Housing and Disability Services), include: Educational Outcomes for Children on Orders; Scoping of a Treatment and Support Services data collection; and the development of a unit-record based Carer data module. It is expected that these projects, along with the development of a child based unit-record data collection, will improve child protection reporting.

COAG developments

National framework for protecting Australia’s children 2009–2020


The Report’s child protection and out-of-home care performance indicator framework already includes and reports upon several National Framework performance indicators. In addition, the Steering Committee has previously identified developments for the Report’s child protection and out-of-home care performance indicator framework which are complementary to many of the measures in the National Framework. In further developing the Report’s child protection and out-of-home care performance indicator framework, the Steering Committee will align with applicable National Framework developments.
National standards for out-of-home care

Under the National Framework, Australian governments have committed to implementing National Standards for Out-of-Home Care (the National Standards). The National Standards relate to areas affecting the outcomes and experiences of children in out-of-home care, including: health; education; case planning; connection to family; transitioning from care; training and support for carers; belonging and identity; and stability and safety. The Steering Committee will keep a watching brief on the development of performance indicators for the National Standards and align with applicable National Standard developments.
15.5 Profile of youth justice services

Service overview

Youth justice systems are responsible for attending to young people (predominantly aged 10–17 years) who have committed or allegedly committed an offence while considered by law to be a juvenile. In so doing, youth justice systems 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.

The youth justice system in each State and Territory comprises:

- police, who are usually a young person’s first point of contact with the system, and are typically responsible for administering the options available for diverting young people from further involvement in the youth justice system
- courts (usually a special children’s or youth court), where matters relating to the charges against young people are heard. The courts are largely responsible for decisions regarding bail, remand and sentencing
- statutory youth justice agencies, which are responsible for the supervision and case management of young people on a range of legal and administrative orders, and for the provision of a wide range of services intended to reduce and prevent crime
- non-government and community service providers, who may work with youth justice agencies to provide services and programs for young people under supervision.

The majority of young people who come into contact with the youth justice system do not become clients of statutory youth justice agencies. Instead, young people are diverted through a range of mechanisms, including contact with police (who have the authority to issue warnings, formal cautions and infringement notices for minor offences) and the courts (which can issue non-supervised orders for minor offences).

This chapter reports on services provided by statutory youth justice agencies that are responsible for the supervision and case management of young people who have committed or allegedly committed an offence.
Roles and responsibilities

Responsibility for the provision of youth justice services in Australia resides with State and Territory governments. The relevant department in each State and Territory responsible for funding and/or providing youth justice services in 2011-12 is listed in box 15.28. Each jurisdiction has its own legislation that determines the policies and practices of its youth justice system. While this legislation varies in detail, its intent is similar across jurisdictions.

Legislation in all jurisdictions (except Queensland) requires that the offence giving rise to youth justice involvement be committed while a young person is aged between 10–17 years (in Queensland, it is 10–16 years). However, youth justice agencies might continue their involvement with these young people after they reach adulthood, for example, where young people turn 18 years of age while on an order. In five jurisdictions, there is no upper age limit for youth justice involvement (Victoria, Queensland, Western Australia, South Australia, and Tasmania). In the Northern Territory, the Australian Capital Territory, and New South Wales the upper age limits for youth justice involvement are 18 years, 21 years, and 21.5 years respectively.

Most of the youth justice information contained in the ‘size and scope’ section of this chapter is sourced from the Juvenile Justice National Minimum Data Set (JJ NMDS), which is maintained by the Australian Institute of Health and Welfare (AIHW). This data set comprises information about the number of young people under youth justice supervision aged 10–17 years of age. The remaining information in the chapter is sourced directly from State and Territory governments and concerns all young people subject to youth justice supervision (that is, including those young people who remain on an order who are 18 years and older).

The Australasian Juvenile Justice Administrators (AJJA) is responsible for national coordination of youth justice services and is a committee of the Standing Council on Community, Housing and Disability Services (SCCHDS), which in turn provides support to the Community, Housing and Disability Services Ministers’ Conference (CHDSMC).
Box 15.28  **Government departments responsible for the delivery of youth justice services**

**NSW**  Department of Attorney General and Justice  
**Vic**  Department of Human Services  
**Qld**  Department of Justice and Attorney-General  
**WA**  Department of Corrective Services  
**SA**  Department for Communities and Social Inclusion  
**Tas**  Department of Health and Human Services  
**ACT**  Community Services Directorate  
**NT**  Department of Justice and Office of Children and Families

**Diversion of young offenders**

In all jurisdictions, police have responsibility for administering options for diverting young people who have committed (or allegedly committed) relatively minor offences from further involvement in the youth justice system. Diversionary options include warnings (informal cautions), formal cautions, and infringement notices. Responsibility for administering the diversionary processes available for more serious offences lies with youth justice authorities, courts and in some cases, other agencies. Comparable and extensive national data are not yet available to illustrate the nature or level of diversion undertaken by Australian jurisdictions. However, Police services (chapter 6) provides data on the number of juveniles who are diverted by police, as a proportion of all juvenile offenders formally dealt with by police (table 6.2).

**Size and scope**

**Clients of youth justice agencies**

Data in the following section of the chapter are sourced from the Juvenile Justice National Minimum Data Set (JJ NMDS), which contains information on the number of young people under youth justice supervision aged 10–17 years of age. While the JJ NMDS focuses on young people aged 10–17 years, youth justice agencies across all jurisdictions supervise young people over the age of 17 years. Most young people who are supervised by youth justice agencies are on community-based orders, which include supervised bail, probation and parole. During 2010-11, 14 555 young people aged 10–17 years experienced youth justice supervision in
Australia (AIHW 2012). Nationally, 86.2 per cent of young people aged 10–17 years who were supervised by youth justice services on an average day during 2010-11 were in the community, with the remainder in detention (figure 15.18). These data do not include juveniles aged 10–17 years who were supervised in the adult correctional system or young people over 17 years of age who continue to be supervised by youth justice agencies.

![Daily average proportion of youth justice clients aged 10–17 years supervised in the community and in detention centres](image)

---

**Table 15.5**  
**Daily average population of young people aged 10–17 years in youth justice detention (number)**

<table>
<thead>
<tr>
<th>Year</th>
<th>NSW</th>
<th>Vic</th>
<th>Qld</th>
<th>WA</th>
<th>SA</th>
<th>Tas</th>
<th>ACT</th>
<th>NT</th>
<th>Aust</th>
</tr>
</thead>
<tbody>
<tr>
<td>2010-11</td>
<td>331</td>
<td>84</td>
<td>136</td>
<td>164</td>
<td>58</td>
<td>24</td>
<td>23</td>
<td>39</td>
<td>859</td>
</tr>
<tr>
<td>2009-10</td>
<td>371</td>
<td>85</td>
<td>127</td>
<td>156</td>
<td>57</td>
<td>27</td>
<td>15</td>
<td>29</td>
<td>867</td>
</tr>
<tr>
<td>2008-09</td>
<td>382</td>
<td>73</td>
<td>104</td>
<td>137</td>
<td>55</td>
<td>28</td>
<td>14</td>
<td>27</td>
<td>822</td>
</tr>
<tr>
<td>2007-08</td>
<td>343</td>
<td>68</td>
<td>144</td>
<td>161</td>
<td>59</td>
<td>29</td>
<td>16</td>
<td>35</td>
<td>855</td>
</tr>
</tbody>
</table>

---

*Due to rounding, Australian totals may differ from the combined totals of all jurisdictions.  
Refer to table 15A.181 for detailed footnotes.*

The daily average rate of detention of young people aged 10–17 years per 100 000 in the population aged 10–17 years decreased from 37.9 per 100 000 in 2009-10 to 37.6 per 100 000 in 2010-11, with rates varying across jurisdictions (table 15A.181).

Nationally, on an average day, females comprised 9.0 per cent of the total population of youth justice detention centres during 2010-11, while males comprised 90.9 per cent of the youth justice detention population (table 15A.184).

Community-based supervision

As outlined above, the majority of young offenders are supervised in the community. Nationally, the daily average number of young people aged 10–17 years supervised in the community increased from 5274 to 5353 between 2009-10 and 2010-11 (table 15.6).

<table>
<thead>
<tr>
<th></th>
<th>NSW</th>
<th>Vic</th>
<th>Qld</th>
<th>WA</th>
<th>SA</th>
<th>Tas</th>
<th>ACT</th>
<th>NT</th>
<th>Aust</th>
</tr>
</thead>
<tbody>
<tr>
<td>2010-11</td>
<td>1591</td>
<td>956</td>
<td>1265</td>
<td>718</td>
<td>305</td>
<td>226</td>
<td>110</td>
<td>182</td>
<td>5353</td>
</tr>
<tr>
<td>2009-10</td>
<td>1566</td>
<td>936</td>
<td>1219</td>
<td>685</td>
<td>384</td>
<td>236</td>
<td>90</td>
<td>157</td>
<td>5274</td>
</tr>
<tr>
<td>2008-09</td>
<td>1543</td>
<td>845</td>
<td>1246</td>
<td>629</td>
<td>430</td>
<td>228</td>
<td>93</td>
<td>172</td>
<td>5185</td>
</tr>
<tr>
<td>2007-08</td>
<td>1397</td>
<td>777</td>
<td>1322</td>
<td>619</td>
<td>399</td>
<td>169</td>
<td>97</td>
<td>73</td>
<td>4854</td>
</tr>
</tbody>
</table>

*Due to rounding, the Australian total may differ from the combined total of all jurisdictions. *Refer to table 15A.181 for detailed footnotes.


The daily average rate of young people aged 10–17 years supervised in the community per 100 000 in the population aged 10–17 years increased from 230.8 per 100 000 in 2009-10 to 234.2 per 100 000 in 2010-11, with rates varying across jurisdictions (table 15A.181).

Nationally, on an average day, females comprised 19.0 per cent of the total population of young people supervised in the community during 2010-11, while males comprised 80.8 per cent (table 15A.185).

Numbers and rates of young Indigenous Australians subject to youth justice supervision

The daily average number of Indigenous Australians aged 10–17 years detained in youth justice detention centres was 454 in 2010-11, compared with 396 non-Indigenous Australians aged 10–17 years (table 15A.186). Nationally, the daily
average detention rate for Indigenous Australians aged 10–17 years in 2010-11 was 437.5 per 100 000 Indigenous Australians aged 10–17 years, compared with 18.2 per 100 000 non-Indigenous young people (table 15A.186). The over-representation of Indigenous Australians aged 10–17 years in detention across jurisdictions in 2010-11 is shown in figure 15.19.

In 2011, the House of Representatives Standing Committee on Aboriginal and Torres Strait Islander Affairs released the report *Doing Time — Time for Doing: Indigenous youth in the criminal justice system*, which highlighted that, although 20 years have passed since the *Royal Commission into Aboriginal Deaths in Custody Report* (Commonwealth of Australia 1991), the incarceration rate of Indigenous Australians, including Indigenous youth, has worsened (Commonwealth of Australia 2011). Indigenous young people are far more likely to come into contact with the criminal justice system and to be incarcerated than non-Indigenous young people, despite Indigenous people representing approximately 2.5 per cent of the Australian population.

![Figure 15.19: Average daily rate of detention of Indigenous and non-Indigenous young people aged 10–17 years, per 100 000 young people aged 10–17 years, 2010-11](image)

Indigenous young people are also over-represented in community-based supervision (figure 15.20). The daily average number of Indigenous young people aged 10–17 years supervised in the community was 2125 in 2010-11, compared with
3043 non-Indigenous young people aged 10–17 years (table 15A.187). Nationally, the daily average rate of Indigenous young people aged 10–17 years subject to community-based supervision in 2010-11 was 2045.8 per 100 000 Indigenous young people aged 10–17 years, compared with 139.5 per 100 000 non-Indigenous young people aged 10–17 years (table 15A.187).

Figure 15.20 **Average daily rate of Indigenous and non-Indigenous young people aged 10–17 years subject to community supervision, per 100 000 young people aged 10-17 years, 2010-11**


### Funding

Data on government expenditure for youth justice services are included in this Report for the first time. Expenditure data are based on the total costs incurred by governments in supervising young offenders of any age, where the offence giving rise to youth justice supervision was committed while the young person was aged 10–17 years. Total recurrent expenditure on detention-based supervision, community-based supervision and group conferencing was approximately $640.1 million across Australia in 2011-12. Detention-based supervision accounted for the majority of government expenditure (59.7 per cent, or $382.2 million). Nationally, in 2011-12, recurrent expenditure on youth justice services per child in the population aged 10–17 years (as distinct from per youth justice client) was $285 (figure 15.21).
The population of all children aged 10–17 years is used in figure 15.21 to calculate a per head of population cost, as this age range notionally represents the potential population of youth justice agencies’ clients. The 10–17 year age range is considered the potential population of youth justice agencies’ clients, as legislation in all jurisdictions (except Queensland) requires that the offence giving rise to youth justice involvement be committed while a young person is aged between 10–17 years (in Queensland, it is 10–16 years). However, youth justice agencies often continue their involvement with young people after they reach adulthood; for example, where young people turn 18 years of age while on a supervision order.

It is an objective of the Steering Committee 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 calculated, costs should be estimated on a consistent basis across jurisdictions. It is expected that the quality and comparability of juvenile justice expenditure data will be improved over time. At present, there are differences across jurisdictions in the calculation of youth justice expenditure. Tables 15A.179 and 15A.180 identify the level of consistency across jurisdictions.

It is anticipated that suitable activity counts will be identified to use in conjunction with the expenditure data to report unit cost efficiency indicators in future Reports.

**Figure 15.21** Recurrent expenditure on youth justice services (comprising detention-based and community-based supervision and group conferencing), per child aged 10–17 years in the population, 2011-12\(^a, b\)

---

\(^a\) Group conferencing expenditure data were not available for SA or the NT. \(^b\) Refer to tables 15A.179 and 15A.180 for detailed footnotes and explanations of the consistency of expenditure data across states and territories.

*Source:* State and Territory governments (unpublished); table 15A.179.
15.6 Framework of performance indicators for youth justice services

The performance indicator framework for youth justice services is based on a set of shared government objectives (box 15.29).

Box 15.29 Objectives for youth justice services

Youth justice services aim to contribute to a reduction in the frequency and severity of youth offending, recognise the rights of victims and promote community safety. Youth justice services seek to achieve these aims by:

- assisting young people to address their offending behaviour and take responsibility for the effect their behaviour has on victims and the wider community
- enabling the interests and views of victims to be heard
- contributing to the diversion of young offenders to alternative services
- recognising the importance of the families and communities of young offenders, particularly Indigenous communities, in the provision of services and programs
- providing services that are designed to rehabilitate young offenders and reintegrate them into their community.

Youth justice services should be provided in an equitable, efficient and effective manner.

The performance indicator framework provides information on equity, efficiency and effectiveness, and distinguishes the outputs and outcomes of youth justice services (figure 15.22). The performance indicator framework shows which data are comparable in the 2013 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 Report’s statistical appendix 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) (appendix A).

The performance data that follow concern all young people under the supervision of youth justice agencies, including those aged 18 years and over where the offence that gave rise to youth justice involvement was committed while the young person was aged 10–17 years (or 10–16 years in Queensland).
Data quality information (DQI) is being progressively introduced for all indicators in the Report. The purpose of DQI is to provide structured and consistent information about quality aspects of data used to report on performance indicators. DQI in this Report cover the seven dimensions in the ABS’ data quality framework (institutional environment, relevance, timeliness, accuracy, coherence, accessibility and interpretability) in addition to dimensions that define and describe performance indicators in a consistent manner, and note key data gaps and issues identified by the Steering Committee. All DQI for the 2013 Report can be found at www.pc.gov.au/gsp/reports/rogs/2013.

Figure 15.22 Youth justice services performance indicator framework
Outputs

Outputs are the 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. 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

Diversion — group conferencing outcomes

‘Group conferencing outcomes’ is an indicator of governments’ objective to divert young people from the youth justice system and address their offending needs (box 15.30).

Box 15.30  Group conferencing outcomes

‘Group conferencing outcomes’ is defined as the number of young people who receive group conferencing and who as a result reach an agreement, as a proportion of all young people who receive group conferencing.

Typically, a group conference involves the young offender and victim (or victims) and their families, police, and a youth justice agency officer, all of whom attempt to agree on a course of action required of the young offender to make amends for his or her offence. Group conferences are decision-making forums that aim to minimise the progression of young people into the youth justice system, and provide restorative justice.

Data for this indicator should be interpreted with caution as the provision of group conferencing differs across jurisdictions in relation to: (a) its place in the court process (for example, whether young people are referred by police before court processes begin, or by the court as an alternative to sentencing), (b) the consequences for young people if they do not comply with the outcome plans of a conference, and (c) eligibility.

A high or increasing rate for this indicator is desirable.

Data reported for this indicator are not complete.

Nationally, 96.8 per cent of all concluded group conferences resulted in an agreement, with proportions varying across jurisdictions (figure 15.23).

Figure 15.23  Proportion of young people who receive group conferencing and reach an agreement, by Indigenous status, 2011-12

a Queensland data could not be disaggregated by Indigenous status for the number of group conferences resulting in an agreement. Therefore, proportions are calculated only for the total number of group conferences resulting in agreement, and with the exception of the total Queensland proportion, Queensland data are excluded from national totals. b Data were not available for WA or SA. c Queensland and Victoria count the number of group conferences resulting in an agreement, as a proportion of all concluded group conferences, as distinct from young people who receive group conferencing and reach an agreement. d Refer to table 15A.191 for detailed footnotes.

Source: State and Territory governments (unpublished); table 15A.191.

Rehabilitation — offending-specific programs completed

‘Offending-specific programs completed’ is an indicator of governments’ objective to provide program interventions that are designed to rehabilitate young offenders and reintegrate them into their community (for example, the Changing Habits and Reaching Targets program, drug counselling programs and sex offender treatment programs) (box 15.31).
Box 15.31  **Offending-specific programs completed**

'Offending-specific programs completed' is defined as the percentage of young people who completed an offending-specific program while completing a supervised sentenced order (whether a community-based order or a detention order) as a proportion of all young people completing a supervised sentenced order who were assessed as requiring an offending-specific program to address their criminogenic behaviour.

A high or increasing rate of offending-specific programs completed is desirable.

Data for this indicator were not available for the 2013 Report. Offending-specific programs data are expected to be available for inclusion in the 2014 Report.

Data quality information for this indicator is under development.

Box 15.32 provides information regarding offending-specific programs in operation in each jurisdiction.
## Box 15.32 Offending-specific programs

### NSW

The Violence Offender Program (VOP) addresses the criminogenic needs of violent offenders, thereby reducing their offending behaviours, contact with the justice system and rates of recidivism. The Sexual Offending Program (SOP) provides comprehensive, individualised assessment for adolescents convicted of offences of a sexual nature, as well as individual and group interventions. The Alcohol and Other Drug (AOD) Program aims to address the needs of clients whose pattern of alcohol and other drug use is related to their offending behaviour. The Intensive Supervision Program (ISP) focuses on juveniles who commit serious and/or repeat offences, or whose severe antisocial behaviour increases their likelihood of offending. ISP is based on the Multisystemic Therapy Model that has delivered significant reductions in the long-term rates of re-offending in WA, New Zealand, the United States, Canada and nine countries throughout Europe. ‘Dthina Yuwali’ is an Aboriginal-specific staged AOD program based on the relationship between substance use and pathways to offending.

### Vic

Victoria offers a range of offending-specific programs in conjunction with a comprehensive individualised case planning framework (including assessment and client service planning). ‘Changing Habits and Reaching Targets’ (CHART) is a structured intervention program which challenges offending behaviour. CHART is used as part of casework intervention with individuals or in small groups. The ‘Male Adolescent Program for Positive Sexuality’ is an intensive individual, group and family treatment program for young people found guilty of sexual offences. The ‘Be Real About Violence’ and ‘Relationships and Violence’ programs address violent offending and related behaviours by increasing offenders’ understanding of patterns of violence and their pro-social coping skills. The ‘Motor Vehicle Offending Program’ is provided in conjunction with the Transport Accident Commission and Road Trauma Support Unit. It addresses specific behaviours related to motor vehicle offences. Better Outcomes Result in Valuable Outcomes (BRAVO) is a behaviour change program developed in consultation with the community service organisations selected to provide the Youth Support Service focused on knife crime or knife related behaviours. BRAVO is a strength based program consisting of six modules covering motivational interviewing, education, young people and the law, personal development, goal setting, goal planning, revisit and review.

(Continued on next page)
Box 15.32  (Continued)

Qld

In the Queensland youth justice system, a young person’s risk, needs and protective factors are assessed using the Youth Level of Service Case Management Inventory (YLS-CMI) to determine both suitability for programs and outcome efficacy. Youth justice staff throughout Queensland deliver two offence-focussed programs to young offenders in regional service centres and in youth detention — Changing Habits and Reaching Targets (CHART) and Aggression Replacement Training (ART). Additionally, Queensland’s two youth detention centres and 16 youth justice service centres deliver tailored offending-specific programs that address individual and local needs and align with the Queensland Youth Justice Intervention Framework. This framework details an evidence-based process for the development, implementation and evaluation of programs. To ensure the provision of holistic and effective responses to young offenders, the framework encompasses the delivery of offence-focussed and developmental interventions and support services alongside the supervision of court orders.

WA

WA offers a range of offending-specific programs to address the needs of young offenders. Programs are run on an as needs basis according to suitability criteria for specific programs. Examples of the offending-specific programs provided in WA include: ‘Healthy Relationships’, which explores adolescent relationships and issues such as sexism, stereotypes and consent; ‘Protective Behaviours’, which examines safety warning signs and discusses who young people can turn to for help; ‘Drumbeat’, a therapeutic program which incorporates music; and other conflict, parenting and sex education programs. These programs can be conducted in community settings, but are most commonly conducted in custodial settings.

SA

SA offers offending-specific programs in addition to individualised case management programs to address assessed client risk and need. ‘Systematic Training for Anger Reduction’ (STAR) is based on principles of cognitive behaviour therapy. The program seeks to assist young people to develop awareness about anger and skills of self-control. The ‘Problem-solving: Learning Usable Skills’ program (Plus+) employs cognitive-behavioural methods of problem solving, skill-training and self-management, which have been shown to be effective in reducing juvenile offending. The Victim Awareness program raises awareness of the effects of crime on individuals and the community. The ‘Alcohol and Other Drug’ (AOD) program explores the risks of offending while under the influence of AOD. Moral Reconation Therapy (Little and Robinson 1988), which seeks to develop concern for social rules and others, is also used. The SA Police Safe Driving program targets ‘high speed’ drivers with the aim of reducing motor vehicle crime.

(Continued on next page)
**Box 15.32  (Continued)**

**Tas**  In December 2011, Tasmania implemented the Youth Level of Service/Case Management Inventory (YLS/CMI) risk assessment tool and the Changing Habits and Reaching Targets (CHART) offending behaviour program on a state-wide basis. The tools support a modular and structured approach to working with young people who are at a high risk of reoffending. Tasmania also sources expertise from a range of government, non-government and private services to provide offending-specific programs to young people based on their assessed risk and need. The community based Targeted Youth Support Service (TYSS) provides intensive case management and therapeutic interventions for vulnerable young people and their families. The target groups for this service are young people identified as having significant and/or multiple risk issues and without intensive support, young people known to child protection, and young people at risk of entry and/or escalation within the youth justice system. U-Turn delivers a motor vehicle offending program which involves engaging participants with a history of motor vehicle theft in ‘hands on’ mechanical training while addressing life skills and personal development issues. One of the objectives of the U-Turn program is to redirect the thrill seeking behaviour associated with motor vehicle theft into positive, legal, safe and fun motor sport activities.

**ACT**  The ACT’s main offending-specific program is CHART, which is designed specifically for young people assessed as moderate to high-risk of re-offending. This behaviour program is used by youth justice staff as part of their casework intervention either with individuals or with small groups of two to three clients. CHART is evidence-based and is informed by the ‘What Works’ approach to offender rehabilitation. This approach is characterised by the application of five basic principles of good practice for effective interventions: risk, needs, responsiveness, program integrity and professional discretion.

**NT**  The NT’s main offending-specific programs are the ‘Anger Management Program’ and ‘Cognitive Skills Program’. Both programs are based on cognitive behavioural therapy and are designed to provide a basic understanding of thoughts, feelings, actions and consequences. In facilitating these programs, caseworkers use a ‘hands on’ approach incorporating role plays and artwork to discuss issues. Caseworkers take this approach because the vast majority of juveniles undertaking these programs are Indigenous with low literacy levels. Other treatment programs which address sexual offending and alcohol and drug use are also provided either by caseworkers or by external agencies.

*Source: State and Territory governments (unpublished).*
Rehabilitation — education and training attendance

‘Education and training attendance’ is an indicator of governments’ objective to provide program interventions in education and training to rehabilitate young offenders and increase their chances of successfully re-integrating into the community (box 15.33).

Box 15.33 Education and training attendance

‘Education and training attendance’ is defined by two measures:

- the number of young people of compulsory school age in detention attending an education course, as a percentage of all young people of compulsory school age in detention
- the number of young people not of compulsory school age in detention attending an education or training course, as a percentage of all young people not of compulsory school age in detention.

Compulsory school age refers to specific State and Territory governments’ requirements for a young person to participate in school, which are based primarily on age (see chapter 4 School education for further information). Education or training course refers to school education or an accredited education or training course under the Australian Qualifications Framework.

A high or increasing percentage of young people attending education and training is desirable.

Exclusions include young people not under youth justice supervision (for example, in police custody) and young people whose situation might exclude their participation in education programs (including young people who are: on temporary leave such as work release, medically unable to participate, in isolation, and on remand or sentenced for fewer than 7 days).

Data reported for this indicator are comparable.


Nationally, 97.8 per cent of young people of compulsory school age in detention were attending an education course in 2011-12, while 96.5 per cent of young people in detention not of compulsory school age were attending an accredited education or training course (figure 15.24). Proportions varied across jurisdictions.
Figure 15.24 Proportion of young people in detention attending an accredited education or training course, by Indigenous status 2011-12

(a) Proportion of young people of compulsory school age in detention attending an accredited education or training course

(b) Proportion of young people not of compulsory school age in detention attending an accredited education or training course

Source: State and Territory governments (unpublished); table 15A.193.

Safe and secure environment — deaths in custody

‘Deaths in custody’ is an indicator of governments’ objective to ensure that youth justice agencies provide a safe and secure environment for young people in custody (box 15.34).
Box 15.34  **Deaths in custody**  

‘Deaths in custody’ is defined as the number of young people who died while in custody.  

A zero or decreasing deaths in custody rate is desirable.  

The scope of this indicator is restricted to those young people who died while in the legal and/or physical custody of a youth justice agency and those who died in, or en route to, an external medical facility as a result of becoming ill or being injured in custody (even if not escorted by youth justice agency workers).  

Data reported for this indicator are comparable.  


No young people died while in the legal or physical custody of an Australian youth justice agency in 2011-12 (table 15A.192).

**Safe and secure environment — escapes**

‘Escapes’ is an indicator of governments’ objective to ensure that youth justice agencies provide a safe and secure environment for young people in custody, and the community (box 15.35).

Box 15.35  **Escapes**  

‘Escapes’ is defined by two measures:

- the number of escapes from a youth justice detention centre, as a proportion of all young people in custody
- the number of escapes during periods of escorted movement, as a proportion of all periods of escorted movement.

An escape from a youth justice detention centre is defined as a breach of a secure perimeter or defined boundary of a youth justice detention centre by a young person under the supervision of the centre.

(Continued on next page)
A period of escorted movement is defined as a period of time during which a young person is in the custody of the youth justice agency while outside a detention centre. The period of escorted movement ends when the young person is returned to the detention centre, or is no longer in the legal or physical custody of the youth justice agency. An escape from an escorted movement is defined as the failure of a young person to remain in the custody of a supervising youth justice worker or approved service provider during a period of escorted movement. An escape is counted each time a young person escapes. For example, if a young person escapes three times in a counting period, three escapes are recorded. If three young people escape at the same time, three escapes are recorded.

A zero or decreasing escape rate is desirable.

Data reported for this indicator are comparable but not complete.


Nationally, there were 20 escapes from youth justice detention in 2011-12, which was equivalent to 0.6 escapes per 10,000 custody nights in 2011-12 (table 15.7). The number of escapes from detention varied across jurisdictions.

### Table 15.7  Number and rate of escapes from youth justice detention centres, by Indigenous status, 2011-12\[^{a,b}\]

<table>
<thead>
<tr>
<th></th>
<th>NSW</th>
<th>Vic</th>
<th>Qld</th>
<th>WA</th>
<th>SA</th>
<th>Tas</th>
<th>ACT</th>
<th>NT</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Number of escapes</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Indigenous</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>4.0</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>9.0</td>
</tr>
<tr>
<td>Non-Indigenous</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>4.0</td>
<td>2.0</td>
<td>–</td>
<td>–</td>
<td>–</td>
</tr>
<tr>
<td>Unknown</td>
<td>–</td>
<td>1.0</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>–</td>
</tr>
<tr>
<td>Total</td>
<td>–</td>
<td>1.0</td>
<td>–</td>
<td>8.0</td>
<td>2.0</td>
<td>–</td>
<td>–</td>
<td>9.0</td>
</tr>
<tr>
<td><strong>Rate per 10,000 custody nights</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Indigenous</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>3.9</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>6.7</td>
</tr>
<tr>
<td>Non-Indigenous</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>3.5</td>
<td>3.0</td>
<td>–</td>
<td>–</td>
<td>–</td>
</tr>
<tr>
<td>Unknown</td>
<td>–</td>
<td>3333.3</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>–</td>
</tr>
<tr>
<td>Total</td>
<td>–</td>
<td>0.2</td>
<td>–</td>
<td>3.6</td>
<td>2.6</td>
<td>–</td>
<td>–</td>
<td>6.5</td>
</tr>
</tbody>
</table>

\[^{a}\] Victoria’s high rate of escapes from youth justice detention for young people of unknown Indigenous status is the result of having very few young people in detention of unknown Indigenous status.

\[^{b}\] Refer to table 15A.194 for detailed footnotes. – Nil or rounded to zero.

Source: State and Territory governments (unpublished); table 15A.194.

Nationally, there were six escapes from escorted movements in 2011-12 (table 15.8). The number of escapes from escorted movement varied across jurisdictions.
Table 15.8  Number and rate of escapes from escorted movement, by Indigenous status, 2011-12a

<table>
<thead>
<tr>
<th></th>
<th>NSW</th>
<th>Vic</th>
<th>Qld</th>
<th>WA</th>
<th>SA</th>
<th>Tas</th>
<th>ACT</th>
<th>NT</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Number of escapes</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Indigenous</td>
<td>3.0</td>
<td>–</td>
<td>–</td>
<td>na</td>
<td>–</td>
<td>na</td>
<td>–</td>
<td>na</td>
</tr>
<tr>
<td>Non-Indigenous</td>
<td>1.0</td>
<td>1.0</td>
<td>–</td>
<td>na</td>
<td>–</td>
<td>1.0</td>
<td>na</td>
<td>–</td>
</tr>
<tr>
<td>Unknown</td>
<td>–</td>
<td>–</td>
<td>na</td>
<td>–</td>
<td>–</td>
<td>na</td>
<td>–</td>
<td>na</td>
</tr>
<tr>
<td>Total</td>
<td>4.0</td>
<td>1.0</td>
<td>na</td>
<td>–</td>
<td>1.0</td>
<td>na</td>
<td>–</td>
<td>na</td>
</tr>
<tr>
<td><strong>Rate per 10 000 periods of escorted movement</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Indigenous</td>
<td>12.5</td>
<td>–</td>
<td>na</td>
<td>–</td>
<td>–</td>
<td>na</td>
<td>–</td>
<td>–</td>
</tr>
<tr>
<td>Non-Indigenous</td>
<td>3.5</td>
<td>7.2</td>
<td>na</td>
<td>–</td>
<td>na</td>
<td>na</td>
<td>na</td>
<td>–</td>
</tr>
<tr>
<td>Unknown</td>
<td>–</td>
<td>–</td>
<td>na</td>
<td>–</td>
<td>–</td>
<td>na</td>
<td>–</td>
<td>na</td>
</tr>
<tr>
<td>Total</td>
<td>7.4</td>
<td>6.4</td>
<td>na</td>
<td>–</td>
<td>18.9</td>
<td>na</td>
<td>–</td>
<td>–</td>
</tr>
</tbody>
</table>

a Refer to table 15A.194 for detailed footnotes. na Not available. – Nil or rounded to zero.

Source: State and Territory governments (unpublished); table 15A.194.

Safe and secure environment — absconds from unescorted leave

‘Absconds from unescorted leave’ is an indicator of governments’ objective to appropriately manage young people while they are in the legal custody of a youth justice detention centre (box 15.36). Management of young people includes the provision of appropriate assessment, planning and supervision to enable young people to undertake unescorted temporary leave from detention centres. Unescorted leave may be undertaken for the purposes of providing rehabilitation interventions and activities such as education, training and employment.

Box 15.36  Absconds from unescorted leave

‘Absconds from unescorted leave’ is defined as the number of young people who have unescorted temporary leave and fail to return to custody, as a proportion of all young people who have unescorted temporary leave.

A zero or low, or decreasing rate of absconds from unescorted leave is desirable.

Data reported for this indicator are comparable but not complete.


One young person absconded from unescorted leave in 2011-12 (table 15.9).
Table 15.9  Number and rate of absconds from unescorted leave, by Indigenous status, 2011-12<sup>a, b, c</sup>

<table>
<thead>
<tr>
<th></th>
<th>NSW</th>
<th>Vic</th>
<th>Qld</th>
<th>WA</th>
<th>SA</th>
<th>Tas</th>
<th>ACT</th>
<th>NT</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Number of escapes</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Indigenous</td>
<td>–</td>
<td>–</td>
<td>..</td>
<td>na</td>
<td>–</td>
<td>–</td>
<td>na</td>
<td>–</td>
</tr>
<tr>
<td>Non-Indigenous</td>
<td>1.0</td>
<td>–</td>
<td>..</td>
<td>na</td>
<td>–</td>
<td>–</td>
<td>na</td>
<td>–</td>
</tr>
<tr>
<td>Unknown</td>
<td>–</td>
<td>–</td>
<td>..</td>
<td>na</td>
<td>–</td>
<td>–</td>
<td>na</td>
<td>–</td>
</tr>
<tr>
<td>Total</td>
<td>1.0</td>
<td>–</td>
<td>..</td>
<td>na</td>
<td>–</td>
<td>–</td>
<td>na</td>
<td>–</td>
</tr>
<tr>
<td><strong>Rate per 10 000 periods of escorted movement</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Indigenous</td>
<td>–</td>
<td>–</td>
<td>..</td>
<td>na</td>
<td>–</td>
<td>–</td>
<td>na</td>
<td>–</td>
</tr>
<tr>
<td>Non-Indigenous</td>
<td>0.5</td>
<td>–</td>
<td>..</td>
<td>na</td>
<td>–</td>
<td>–</td>
<td>na</td>
<td>–</td>
</tr>
<tr>
<td>Unknown</td>
<td>–</td>
<td>–</td>
<td>..</td>
<td>na</td>
<td>–</td>
<td>–</td>
<td>na</td>
<td>–</td>
</tr>
<tr>
<td>Total</td>
<td>0.3</td>
<td>–</td>
<td>..</td>
<td>na</td>
<td>–</td>
<td>–</td>
<td>na</td>
<td>–</td>
</tr>
</tbody>
</table>

<sup>a</sup> Data were not available WA and the ACT.  
<sup>b</sup> Queensland does not currently use unescorted leave.  
<sup>c</sup> Refer to table 15A.195 for detailed footnotes.  

na Not available. – Nil or rounded to zero.  

Source: State and Territory governments (unpublished); table 15A.195.

Safe and secure environment — assaults in custody

‘Assaults in custody’ is an indicator of governments’ objective to provide a custodial environment that is safe and secure in order to rehabilitate young offenders and reintegrate them into their community (box 15.37).

Youth justice agencies have a heightened duty of care to young people in detention, because of their age and vulnerability. The duty of care required for young people is greater than might be the case in adult custodial facilities. In discharging their duty of care to young people in detention, youth justice agencies aim to create safe and secure environments in which typical adolescent development can occur and in which young people can socialise with others in a positive and constructive way prior to their release back into their families and communities.
Box 15.37  **Assaults in custody**

‘Assaults in custody’ is defined by two measures:

- the rate of detainees and staff (by Indigenous status) who are seriously assaulted (that is, sustain an injury that requires overnight hospitalisation and any act of sexual assault) due to an act perpetrated by one or more detainees, as a proportion of the number of detainees in custody
- the rate of detainees and staff (by Indigenous status) who are assaulted (that is, sustain an injury, but do not require hospitalisation) due to an act perpetrated by one or more detainees, as a proportion of the number of detainees in custody.

A zero or low, or decreasing assaults in custody rate is desirable.

Data reported for this indicator are not complete.


Nationally, 10 detainees were reported as injured in custody due to a serious assault in 2011-12 (table 15.10). Nationally, no staff were reported as injured due to a serious assault in 2011-12. The proportion of young people injured in custody due to a serious assault varied across jurisdictions.

<table>
<thead>
<tr>
<th>Table 15.10  <strong>Number and rate of young people injured as a result of a serious assault, by Indigenous status, 2011-12</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>NSW</strong></td>
</tr>
<tr>
<td>Number of young people injured as a result of a serious assault</td>
</tr>
<tr>
<td>Indigenous</td>
</tr>
<tr>
<td>Non-Indigenous</td>
</tr>
<tr>
<td>Unknown</td>
</tr>
<tr>
<td>Total</td>
</tr>
<tr>
<td>Rate per 10 000 custody nights</td>
</tr>
<tr>
<td>Indigenous</td>
</tr>
<tr>
<td>Non-Indigenous</td>
</tr>
<tr>
<td>Unknown</td>
</tr>
<tr>
<td>Total</td>
</tr>
</tbody>
</table>

\[ Data were not available for WA and SA. na Not available. – Nil or rounded to zero.\]

Source: State and Territory governments (unpublished); table 15A.196.

Nationally, 79 detainees were reported as injured in custody due to an assault in 2011-12 (table 15.11). Proportions varied across jurisdictions.
### Table 15.11  Number and rate of detainees injured as a result of an assault, by Indigenous status, 2011-12\textsuperscript{a, b}

<table>
<thead>
<tr>
<th></th>
<th>NSW</th>
<th>Vic</th>
<th>Qld</th>
<th>WA</th>
<th>SA</th>
<th>Tas</th>
<th>ACT</th>
<th>NT</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Number of detainees</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Indigeneous</td>
<td>5.0</td>
<td>na</td>
<td>10.0</td>
<td>na</td>
<td>na</td>
<td>np</td>
<td>2.0</td>
<td>48.0</td>
</tr>
<tr>
<td>Non-Indigeneous</td>
<td>7.0</td>
<td>na</td>
<td>6.0</td>
<td>na</td>
<td>na</td>
<td>np</td>
<td>–</td>
<td>–</td>
</tr>
<tr>
<td>Unknown</td>
<td>1.0</td>
<td>na</td>
<td>–</td>
<td>na</td>
<td>na</td>
<td>–</td>
<td>–</td>
<td>–</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>13.0</td>
<td>na</td>
<td>16.0</td>
<td>na</td>
<td>na</td>
<td>np</td>
<td>2.0</td>
<td>48.0</td>
</tr>
<tr>
<td><strong>Rate per 10 000 custody nights</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Indigeneous</td>
<td>0.8</td>
<td>na</td>
<td>3.2</td>
<td>na</td>
<td>na</td>
<td>np</td>
<td>6.5</td>
<td>35.5</td>
</tr>
<tr>
<td>Non-Indigeneous</td>
<td>1.1</td>
<td>na</td>
<td>3.2</td>
<td>na</td>
<td>na</td>
<td>np</td>
<td>–</td>
<td>–</td>
</tr>
<tr>
<td>Unknown</td>
<td>4.2</td>
<td>na</td>
<td>–</td>
<td>na</td>
<td>na</td>
<td>–</td>
<td>–</td>
<td>–</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>1.0</td>
<td>na</td>
<td>3.2</td>
<td>na</td>
<td>na</td>
<td>np</td>
<td>2.4</td>
<td>34.7</td>
</tr>
</tbody>
</table>

\textsuperscript{a} Data reported for this indicator are not comparable and need to be interpreted with caution. Methods of data collection vary across jurisdictions (for example, manual case file review compared to the collation of electronic incident reports) and jurisdictions’ ability to report on this measure is dependent on relevant incidents having first been documented. \textsuperscript{b} Data were not available for Victoria, WA, and SA. \textsuperscript{np} Not published. – Nil or rounded to zero.

Source: State and Territory governments (unpublished); table 15A.197.

Nationally, 47 staff were reported as injured due to an assault while supervising detainees in 2011-12 (table 15.12). Proportions varied across jurisdictions.

### Table 15.12  Number and rate of staff injured as a result of an assault, by Indigenous status, 2011-12\textsuperscript{a, b, c}

<table>
<thead>
<tr>
<th></th>
<th>NSW</th>
<th>Vic</th>
<th>Qld</th>
<th>WA</th>
<th>SA</th>
<th>Tas</th>
<th>ACT</th>
<th>NT</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Number of staff injured as a result of an assault</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Indigeneous</td>
<td>na</td>
<td>na</td>
<td>8.0</td>
<td>na</td>
<td>na</td>
<td>–</td>
<td>–</td>
<td>–</td>
</tr>
<tr>
<td>Non-Indigeneous</td>
<td>na</td>
<td>na</td>
<td>18.0</td>
<td>na</td>
<td>na</td>
<td>–</td>
<td>2.0</td>
<td>2.0</td>
</tr>
<tr>
<td>Unknown</td>
<td>17.0</td>
<td>na</td>
<td>–</td>
<td>na</td>
<td>na</td>
<td>np</td>
<td>–</td>
<td>–</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>17.0</td>
<td>na</td>
<td>26.0</td>
<td>na</td>
<td>na</td>
<td>np</td>
<td>2.0</td>
<td>2.0</td>
</tr>
<tr>
<td><strong>Rate per 10 000 custody nights</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Indigeneous</td>
<td>na</td>
<td>na</td>
<td>2.6</td>
<td>na</td>
<td>na</td>
<td>–</td>
<td>–</td>
<td>–</td>
</tr>
<tr>
<td>Non-Indigeneous</td>
<td>na</td>
<td>na</td>
<td>9.7</td>
<td>na</td>
<td>na</td>
<td>–</td>
<td>3.8</td>
<td>66.0</td>
</tr>
<tr>
<td>Unknown</td>
<td>71.7</td>
<td>na</td>
<td>–</td>
<td>na</td>
<td>na</td>
<td>np</td>
<td>–</td>
<td>–</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>1.3</td>
<td>na</td>
<td>5.2</td>
<td>na</td>
<td>na</td>
<td>np</td>
<td>2.4</td>
<td>1.4</td>
</tr>
</tbody>
</table>

\textsuperscript{a} Data reported for this indicator are not comparable and need to be interpreted with caution. Methods of data collection vary across jurisdictions (for example, manual case file review compared to the collation of electronic incident reports) and jurisdictions’ ability to report on this measure is dependent on relevant incidents having first been documented. \textsuperscript{b} Data report the Indigenous status of staff who were reported as injured due to an assault. \textsuperscript{c} Data were not available for Victoria, WA, and SA. \textsuperscript{na} Not available. \textsuperscript{np} Not published. – Nil or rounded to zero.

Source: State and Territory governments (unpublished); table 15A.197.
Safe and secure environment — self-harm and attempted suicide in custody

‘Self-harm and attempted suicide in custody’ is an indicator of governments’ objective to provide a custodial environment that is safe and secure in order to rehabilitate young offenders and reintegrate them into their community (box 15.38).

Box 15.38  **Self-harm and attempted suicide in custody**

‘Self-harm and attempted suicide in custody’ is defined by four measures:

- the number of incidents of self-harm or attempted suicide in custody requiring hospitalisation
- the number of incidents of self-harm or attempted suicide in custody not requiring hospitalisation
- the number of detainees who self-harmed or attempted suicide in custody requiring hospitalisation
- the number of detainees who self-harmed or attempted suicide in custody not requiring hospitalisation.

An incident of self-harm or attempted suicide is counted each time a young person self-harms or attempts suicide. For example, if one young person self-harms or attempts suicide three times in a counting period, three incidents are recorded. Therefore, the number of incidents of self-harm or attempted suicide and the number of detainees who self-harm or attempt suicide will differ when one detainee has self-harmed on two or more occasions, as each occasion will be counted as a separate incident.

A zero, low, or decreasing self-harm and attempted suicide in custody rate is desirable.

Data reported for this indicator are not complete.


Nationally, five detainees in five separate incidents were reported as having self-harmed or attempted suicide in custody requiring hospitalisation in 2011-12. Proportions varied across jurisdictions (table 15.13).
Table 15.13  Number and rate of detainees who self-harmed or attempted suicide in custody requiring hospitalisation, by Indigenous status, 2011-12\textsuperscript{a, b}

<table>
<thead>
<tr>
<th></th>
<th>NSW</th>
<th>Vic</th>
<th>Qld</th>
<th>WA</th>
<th>SA</th>
<th>Tas</th>
<th>ACT</th>
<th>NT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of detainees who self-harmed or attempted suicide in custody requiring hospitalisation</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Indigenous</td>
<td>1.0</td>
<td>–</td>
<td>–</td>
<td>na</td>
<td>na</td>
<td>–</td>
<td>–</td>
<td>1.0</td>
</tr>
<tr>
<td>Non-Indigenous</td>
<td>1.0</td>
<td>1.0</td>
<td>–</td>
<td>na</td>
<td>na</td>
<td>–</td>
<td>–</td>
<td>–</td>
</tr>
<tr>
<td>Unknown</td>
<td>1.0</td>
<td>na</td>
<td>–</td>
<td>na</td>
<td>na</td>
<td>–</td>
<td>–</td>
<td>–</td>
</tr>
<tr>
<td>Total</td>
<td>3.0</td>
<td>1.0</td>
<td>–</td>
<td>na</td>
<td>na</td>
<td>–</td>
<td>–</td>
<td>1.0</td>
</tr>
<tr>
<td>Rate per 10 000 custody nights</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Indigenous</td>
<td>0.2</td>
<td>–</td>
<td>–</td>
<td>na</td>
<td>na</td>
<td>–</td>
<td>–</td>
<td>0.7</td>
</tr>
<tr>
<td>Non-Indigenous</td>
<td>0.2</td>
<td>0.2</td>
<td>–</td>
<td>na</td>
<td>na</td>
<td>–</td>
<td>–</td>
<td>–</td>
</tr>
<tr>
<td>Unknown</td>
<td>4.2</td>
<td>na</td>
<td>–</td>
<td>na</td>
<td>na</td>
<td>–</td>
<td>–</td>
<td>–</td>
</tr>
<tr>
<td>Total</td>
<td>0.2</td>
<td>0.2</td>
<td>–</td>
<td>na</td>
<td>na</td>
<td>–</td>
<td>–</td>
<td>0.7</td>
</tr>
</tbody>
</table>

\textsuperscript{a} Data were not available for WA and SA. \textsuperscript{b} Refer to table 15A.198 for detailed footnotes. \textsuperscript{na} Not available.

- Nil or rounded to zero.

Source: State and Territory governments (unpublished); table 15A.198.

Nationally, 49 detainees were reported as having self-harmed or attempted suicide in 65 separate incidents during 2011-12, none of which required hospitalisation (tables 15.14 and 15.15). Proportions varied across jurisdictions.
Table 15.14  **Number and rate of detainees who self-harmed or attempted suicide in custody not requiring hospitalisation, by Indigenous status, 2011-12**

<table>
<thead>
<tr>
<th></th>
<th>NSW</th>
<th>Vic</th>
<th>Qld</th>
<th>WA</th>
<th>SA</th>
<th>Tas</th>
<th>ACT</th>
<th>NT</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Number of detainees who self-harmed or attempted suicide in custody not requiring hospitalisation</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Indigenous</td>
<td>14.0</td>
<td>–</td>
<td>1.0</td>
<td>na</td>
<td>na</td>
<td>–</td>
<td>1.0</td>
<td>7.0</td>
</tr>
<tr>
<td>Non-Indigenous</td>
<td>12.0</td>
<td>1.0</td>
<td>4.0</td>
<td>na</td>
<td>na</td>
<td>–</td>
<td>1.0</td>
<td>–</td>
</tr>
<tr>
<td>Unknown</td>
<td>8.0</td>
<td>na</td>
<td>–</td>
<td>na</td>
<td>na</td>
<td>–</td>
<td>–</td>
<td>–</td>
</tr>
<tr>
<td>Total</td>
<td>34.0</td>
<td>1.0</td>
<td>5.0</td>
<td>na</td>
<td>na</td>
<td>–</td>
<td>2.0</td>
<td>7.0</td>
</tr>
<tr>
<td><strong>Rate per 10 000 custody nights</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Indigenous</td>
<td>2.2</td>
<td>–</td>
<td>0.3</td>
<td>na</td>
<td>na</td>
<td>–</td>
<td>3.3</td>
<td>5.2</td>
</tr>
<tr>
<td>Non-Indigenous</td>
<td>1.9</td>
<td>0.2</td>
<td>2.2</td>
<td>na</td>
<td>na</td>
<td>–</td>
<td>1.9</td>
<td>–</td>
</tr>
<tr>
<td>Unknown</td>
<td>33.7</td>
<td>na</td>
<td>–</td>
<td>na</td>
<td>na</td>
<td>–</td>
<td>–</td>
<td>–</td>
</tr>
<tr>
<td>Total</td>
<td>2.6</td>
<td>0.2</td>
<td>1.0</td>
<td>na</td>
<td>na</td>
<td>–</td>
<td>2.4</td>
<td>5.1</td>
</tr>
</tbody>
</table>

* Data were not available for WA and SA.  
* Data reported for this indicator are not comparable and need to be interpreted with caution. Methods of data collection vary across jurisdictions (for example, manual case file review, the collation of electronic incident reports) and jurisdictions’ ability to report on this measure is dependent on relevant incidents having first been documented.  
* na Not available. – Nil or rounded to zero.

**Source:** State and Territory governments (unpublished); table 15A.198.

Table 15.15  **Number and rate of incidents of self-harm or attempted suicide in custody not requiring hospitalisation, by Indigenous status, 2011-12**

<table>
<thead>
<tr>
<th></th>
<th>NSW</th>
<th>Vic</th>
<th>Qld</th>
<th>WA</th>
<th>SA</th>
<th>Tas</th>
<th>ACT</th>
<th>NT</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Number of incidents of self-harm or attempted suicide in custody not requiring hospitalisation</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Indigenous</td>
<td>14.0</td>
<td>–</td>
<td>1.0</td>
<td>na</td>
<td>na</td>
<td>–</td>
<td>1.0</td>
<td>22.0</td>
</tr>
<tr>
<td>Non-Indigenous</td>
<td>12.0</td>
<td>1.0</td>
<td>4.0</td>
<td>na</td>
<td>na</td>
<td>–</td>
<td>2.0</td>
<td>–</td>
</tr>
<tr>
<td>Unknown</td>
<td>8.0</td>
<td>na</td>
<td>–</td>
<td>na</td>
<td>na</td>
<td>–</td>
<td>–</td>
<td>–</td>
</tr>
<tr>
<td>Total</td>
<td>34.0</td>
<td>1.0</td>
<td>5.0</td>
<td>na</td>
<td>na</td>
<td>–</td>
<td>3.0</td>
<td>22.0</td>
</tr>
<tr>
<td><strong>Rate per 10 000 custody nights</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Indigenous</td>
<td>2.2</td>
<td>–</td>
<td>0.3</td>
<td>na</td>
<td>na</td>
<td>–</td>
<td>3.3</td>
<td>16.3</td>
</tr>
<tr>
<td>Non-Indigenous</td>
<td>1.9</td>
<td>0.2</td>
<td>2.2</td>
<td>na</td>
<td>na</td>
<td>–</td>
<td>3.8</td>
<td>–</td>
</tr>
<tr>
<td>Unknown</td>
<td>33.7</td>
<td>na</td>
<td>–</td>
<td>na</td>
<td>na</td>
<td>–</td>
<td>–</td>
<td>–</td>
</tr>
<tr>
<td>Total</td>
<td>2.6</td>
<td>0.2</td>
<td>1.0</td>
<td>na</td>
<td>na</td>
<td>–</td>
<td>3.6</td>
<td>15.9</td>
</tr>
</tbody>
</table>

* Data reported for this indicator are not comparable and need to be interpreted with caution. Methods of data collection vary across jurisdictions (for example, manual case file review compared to the collation of electronic incident reports) and jurisdictions’ ability to report on this measure is dependent on relevant incidents having first been documented.  
* Data were not available for WA and SA.  
* na Not available. – Nil or rounded to zero.

**Source:** State and Territory governments (unpublished); table 15A.198.
Statutory responsibilities — pre-sentence reports completed

‘Pre-sentence reports completed’ is an indicator of governments’ objective to ensure that accurate and timely advice is provided to courts to inform decision-making (box 15.39).

Box 15.39  Pre-sentence reports completed

‘Pre-sentence reports completed’ is defined as the number of written reports provided by youth justice agencies to a court in response to a request for a pre-sentence report, as a proportion of all court requests to youth justice agencies for written pre-sentence reports.

A pre-sentence report is a written report that provides a court with pertinent information about the assessed factors that contributed to a young person’s offence and explores programs and services that could be provided to address a young person’s offending behaviour. A pre-sentence report is prepared when ordered by a court after a young person has pleaded or been found guilty of an offence.

A high or increasing percentage of pre-sentence reports completed is desirable.

Data reported for this indicator are comparable but not complete.


The percentage of pre-sentence reports completed varied slightly across jurisdictions (figure 15.25). Nationally, in 2011-12, 99.9 per cent of all court requests for pre-sentence reports were completed.
Figure 15.25  Proportion of pre-sentence reports completed by youth justice agencies, by Indigenous status, 2011-12\textsuperscript{a, b, c, d, e}

\begin{figure}
\centering
\includegraphics[width=\textwidth]{proportion.png}
\end{figure}

\textsuperscript{a} Victoria was not able to provide the numerator or denominator for this indicator and instead provided a total proportion based on a survey of managers. Victoria’s data are excluded from the national total. \textsuperscript{b} WA data could not be disaggregated by Indigenous status. \textsuperscript{c} SA was not able to provide the numerator or denominator for this indicator and instead provided a total proportion by Indigenous and non-Indigenous status. As a result, a total proportion could not be calculated for SA and SA data are excluded from the national total. \textsuperscript{d} The proportion of pre-sentence reports completed by youth justice agencies in Tasmania includes some cases where the report was not provided by the initial request and the court extended the required date of the report. \textsuperscript{e} Refer to table 15A.190 for detailed footnotes.

Source: State and Territory governments (unpublished); table 15A.190.

Statutory responsibilities — case plans prepared

‘Case plans prepared’ is an indicator of governments’ objective to ensure that youth justice agencies support young people to minimise the likelihood of re-offending by addressing their offending-related needs (box 15.41).
Box 15.41  **Case plans prepared**

‘Case plans prepared’ is defined as the number of eligible young people who had a documented case plan prepared or reviewed within 6 weeks of commencing:

- a sentenced detention order, as a proportion of all young people commencing a sentenced detention order
- a sentenced community-based order, as a proportion of all young people commencing a sentenced community-based order.

An eligible young person is one who is serving a sentenced order that requires case management.

A high or increasing rate of case plans prepared is desirable.

Data reported for this indicator are comparable but not complete.


Nationally, 84.0 per cent of case plans were prepared within 6 weeks of commencing a sentenced community-based order in 2011-12 (figure 15.27(a)). Nationally, 91.6 per cent of case plans were prepared within 6 weeks of commencing a sentenced detention order in 2011-12 (figure 15.27(b)). Proportions varied across jurisdictions.
Figure 15.27 Proportion of case plans prepared within 6 weeks of commencing sentenced detention orders and sentenced community-based orders, by Indigenous status, 2011-12a, b, c, d

(a) Proportion of case plans prepared within 6 weeks of commencing a sentenced community-based order

(b) Proportion of case plans prepared within 6 weeks of commencing a sentenced detention order

---

For community-based case plans, WA could not disaggregate the numerator by Indigenous status. Therefore, a proportion is only calculated for the total number of case plans prepared in WA. b Data were not available for SA and Tasmania. c In the NT, case plans for young people on community-based orders are prepared within 8 weeks of order commencement. Community-based data for the NT have been manually collated and data integrity cannot be assured. d Refer to table 15A.200 for detailed footnotes.

Source: State and Territory governments (unpublished); table 15A.200.
Statutory responsibilities — completion of community-based orders

‘Completion of community-based orders’ is an indicator of governments’ objective to rehabilitate young offenders (box 15.40).

Box 15.40  Completion of community-based orders

‘Completion of community-based orders’ is defined as the proportion of sentenced community-based supervision orders successfully completed. An order is counted as successfully completed where the earliest order expiry date or the order termination date is reached and breach is neither pending nor finalised.

A high or increasing proportion of orders successfully completed is desirable. However, where offenders are non-compliant and pose a risk, breach action (an unsuccessful completion) may be warranted. As a result, a completion rate less than 100 per cent may not necessarily indicate poor performance, and may reflect appropriate supervision of young people on community-based supervision orders.

Data reported for this indicator are comparable but not complete.


Nationally, 83.0 per cent of community-based orders were successfully completed in 2011-12. The proportion of community-based orders successfully completed varied across jurisdictions (figure 15.26).
Figure 15.26 Proportion of community-based orders successfully completed, by Indigenous status, 2011-12\textsuperscript{a, b}

\[\text{Per cent}\]

\begin{tabular}{cccccccc} 
\hline
 & NSW & Vic & Qld & WA & SA & Tas & ACT & NT & Aust \\
\hline
Indigenous & 70 & 70 & 70 & 70 & 70 & 70 & 70 & 70 & 70 \\
Non-Indigenous & 70 & 70 & 70 & 70 & 70 & 70 & 70 & 70 & 70 \\
Unknown & 70 & 70 & 70 & 70 & 70 & 70 & 70 & 70 & 70 \\
Total & 60 & 60 & 60 & 60 & 60 & 60 & 60 & 60 & 60 \\
\hline
\end{tabular}

\textsuperscript{a} Data were not available for the ACT due to information system limitations. \textsuperscript{b} Refer to table 15A.199 for detailed footnotes.

Source: State and Territory governments (unpublished); table 15A.199.

Efficiency

Cost per offender

‘Cost per offender’ is an indicator of governments’ objective to provide youth justice services in an efficient manner (box 15.42). Youth justice expenditure data are reported in the profile section of the chapter (p. 15.68).

Box 15.42 Cost per offender

‘Cost per offender’ is yet to be defined.

Data for this indicator were not available for the 2013 Report. Cost per offender data are expected to be available for inclusion in the 2014 Report.

Data quality information for this indicator is under development.

Offender-to-staff ratio

‘Offender-to-staff ratio’ is an indicator of governments’ objective to provide youth justice services in an efficient manner (box 15.43).
Box 15.43 **Offender-to-staff ratio**

‘Offender-to-staff ratio’ is defined by two measures:

- the number of young people requiring community-based supervision relative to the number of community-based staff
- the number of young people in detention relative to the number of detention centre staff.

The number of offenders relative to the number of staff provides a measure of efficient resource management by youth justice agencies. A high or increasing ratio (that is, a higher number of offenders per staff member) suggests better performance towards achieving efficient resource management. However, this indicator needs to be interpreted with caution, as a low or decreasing offender-to-staff ratio may result in more effective performance, particularly with high risk young offenders who possess significant offence-related needs. Further, in some cases, efficiencies may not be possible due to remote geographic locations that limit opportunities to reduce overheads through economies of scale.

Data for this indicator were not available for the 2013 Report. Offender-to-staff ratio data are expected to be available for inclusion in the 2014 Report.

Data quality information for this indicator is under development.

---

**Centre utilisation**

‘Centre utilisation’ is an indicator of governments’ objective to provide youth justice services in an efficient manner (box 15.44).
Box 15.44  **Centre utilisation**

‘Centre utilisation’ is defined as the number of detainees in all detention centres as a proportion of the number of permanently funded beds.

This indicator partially measures both effective and efficient performance. Detention centres operating at higher capacities is desirable from an efficient resource management perspective. However, detention centres operating at or above capacity might be ineffective due to the consequences for rehabilitation when centres are overcrowded. Centres also need to make provision for separately detaining various classes of young offenders (for example, males and females, offenders requiring different security levels, offenders of different ages, and young people on remand and young people who have been sentenced). In order to make provision for separately detaining various classes of young people, detention centres require utilisation rates that are below full capacity.

This indicator also reflects the efficient use of publicly funded resources. Centres that are built at a point in time need to be able to justify significant under use, if that occurs in future years, where that under use cannot reasonably be explained by the need to make provision for detaining different classes of young offenders.

Data reported for this indicator are comparable and complete.


Nationally, 75.2 per cent of centre capacity (that is, permanently funded beds) was utilised in 2011-12. Proportions varied across jurisdictions (figure 15.28).

**Figure 15.28 Centre utilisation rate, 2011-12**

![Bar chart showing centre utilisation rates for different jurisdictions in 2011-12.]

*Source: State and Territory governments (unpublished); table 15A.201.

---

*a Refer to table 15A.201 for detailed footnotes.
Outcomes

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

Outcome indicators for youth justice services are yet to be developed. The Steering Committee has identified outcome indicators as an important element of the youth justice performance indicator framework to develop for future reports.

15.7 Future directions in youth justice performance reporting

Further development of the framework and reporting for indicators included in the framework is being undertaken according to a staged process. Data for 11 performance indicators are included in this Report. The remaining performance indicators in the youth justice performance indicator framework, and additional efficiency and outcome indicators, will be developed for inclusion in future Reports.

15.8 Jurisdictions’ comments

This section provides comments from each jurisdiction on the services covered in this chapter.
New South Wales Government comments

Child protection and out-of-home care

The NSW Government is committed to repositioning the child protection system to put families, not systems, at the centre. The State Plan, NSW 2021, reflects our commitment to “better protect the most vulnerable members of our community and break the cycle of disadvantage”. NSW 2021 commits this government to reducing the rate of children and young people reported as at risk of significant harm, reducing the rate of children and young people in statutory out-of-home care (OOHC) and increasing the proportion of NSW children who are developmentally on track in Australian Early Development Index domains.

Since 2010, the government has invested in early intervention programs such as Families NSW and Brighter Futures to divert families to services earlier.

We are working to improve and deliver a seamless service system that works for families. FACS now co-delivers with our partner government agencies and non-government organisations (NGO) integrated services across the child protection spectrum, from early intervention to leaving OOHC. The non-government sector’s capacity to deliver services has grown exponentially, as has its expertise and ability.

Youth justice

Youth justice saw consistently lower numbers of young people in custody, from an average of 391 per day in 2010-11, to 353 per day in 2011-12. The agency continued to work to improve its response to Aboriginal and Torres Strait Islander (ATSI) overrepresentation through the development and implementation of the ATSI Cultural Respect Framework, the Aboriginal Mentoring Program and the ATSI Recruitment and Retention Strategy 2011–15.

Youth justice received $2.9 million to expand its remand reduction (bail) services, which established 24.5 full time positions responsible for reducing the number of young people in custody on remand. The agency also rolled out Changing Habits and Reaching Targets (CHART), a new cognitive-behavioural approach for community-based offenders which helps young people change their thinking and decision-making processes and, ultimately, their offending behaviour.

A number of research projects were commissioned including reviews of the Detainee Behaviour Intervention Framework and Youth Justice Conferencing, and an analysis of staff supervision skills. Quality assurance reviews were completed on all Youth Justice Centres and community offices, including Youth Justice Conferencing and court logistics.
Victorian Government comments

Child protection and out-of-home care

An independent inquiry into Victoria’s child protection system, Protecting Victoria’s Vulnerable Children, chaired by the Hon P.D. Cummins was tabled in February 2012. The Inquiry made 90 recommendations to strengthen the child protection system. The Victoria’s Vulnerable Children Directions paper outlines the first phase and next steps of the Government’s response to the inquiry and commits to the development of an independent commission for children and young people, a new child protection operating model, the building of effective and connected services, making a child friendly legal system and the development of a whole of Government Vulnerable children’s strategy.

The Victorian Government is also developing a five year plan for out-of-home care, as per the recommendation from the Protecting Victoria Vulnerable Children’s Inquiry. The plan will set out actions across government to improve outcomes and achieve the targets that will be articulated in the final vulnerable children and families strategy. A long term goal will also be a reduction in the growth in the number of children in care to match and not exceed Victoria’s overall population growth.

A complementary five year plan for Aboriginal children in out-of-home care will also be developed, which will take into account the importance of maintaining strong connections to family and community.

The Victorian Government also committed:

- $29.6 million over four years to significantly expand therapeutic residential care across the State
- $27.9 million to increase residential care placement capacity
- $29.7 million over four years to further develop and expand the Stronger Families placement prevention initiative.

Youth Justice

The Victorian Government committed $62.1 million over four years in the 2012-13 budget to improve youth justice outcomes and better tailor services to young offenders, including:

- $54.5 million over three years for an additional 45 beds at the Malmsbury Youth Justice Centre to increase capacity across Victoria’s youth justice centres to meet medium to long term demand. The initiative will also support improvements to infrastructure at Malmsbury Youth Justice Centre and at the Parkville Youth Justice Precinct
- $7.6 million over four years to provide drug and alcohol, health and rehabilitative services for young offenders through coordinated case management.
Queensland Government comments

Child protection and out-of-home care

The March 2012 Queensland State election resulted in a change of government. The Department of Communities is now the Department of Communities, Child Safety and Disability Services. Juvenile justice has moved to the Department of Justice and Attorney-General (DJAG).

The Government announced an Inquiry to review progress made since the 1999 inquiry into abuse of children in Queensland institutions and the 2004 inquiry into abuse of children in foster care and to chart a new road map for child protection for the next decade.

Amendments to the Child Protection Act 1999 have been completed enhancing the administration of the Act to focus on children’s immediate safety, long term wellbeing and best interests. Key changes include:

- extending the definition of harm so it is clear that harm can be the cumulative result of a number of incidents of abuse and neglect
- introducing temporary custody orders and introducing a new transition order
- introducing more flexible arrangements for case planning and work with families where a child has a long term guardian who is not the chief executive
- clarifying the obligations to inform police of suspected criminal offences.

Youth justice

With the change in responsibility for youth justice to DJAG, there has been a renewed commitment to strengthen responses to youth crime, including:

- The trial of two youth boot camps — one targeted at young offenders facing a custodial sentence (these young people will be sentenced to a Boot Camp Order); and another targeted at young people deemed at-risk of entering the justice system. The trial will commence in early 2013 and deliver education, physical training and therapeutic programs that involve the family and mentors.
- Mandatory Graffiti Removal Order is planned for all offenders (juvenile and adult) found guilty of a graffiti offence.
- Review of the publication and naming of young offenders legislation with a view to expanding the law and a review of breach of bail legislation to determine how laws can be strengthened to make young offenders more accountable.

Current initiatives in youth detention centres include: further development of behaviour management programs, a review of the Youth Detention Centre Practice Manual and enhancement of safety and security of young people and staff by providing a contemporary approach to the use of protective actions. Cleveland Youth Detention Centre will double in capacity from 48 to 96 beds by mid-2013 and will include accommodation for young women north of Rockhampton.
**Western Australian Government comments**

*Child protection and out-of-home care*

The Department for Child Protection’s (the Department) focus is on consolidating reforms from the 2007 Ford Review, building on partnerships to further integrate its work with the community sector and other government agencies, while streamlining its business and administrative systems, wherever practicable.

The Department’s work is guided by a number of sound theoretical and practice frameworks including Signs of Safety, Foster Care Partnership and Residential Care (Sanctuary) Framework, Permanency Planning Policy, Leaving Care and Transitioning to Independent Living Policy, and the Family Support (Responsible Parenting) Framework. During 2011-12, WA’s first Family Support Network was established to assist families to address serious problems and reduce the need for child protection interventions, wherever possible.

Responsible Parenting Services and the Best Beginnings programs have expanded to regional districts, supported through Royalties for Regions funding. A statutory review of the Working with Children (Criminal Record Checking) Act 2004 was undertaken in 2011-12, resulting in 23 recommendations to improve the implementation of the Act.

*Youth justice*

Through its Youth Justice Services (YJS), the Department of Corrective Services administers the *Young Offenders Act 1994*. Its primary focus is the management of young people sentenced to community orders or detention for offences committed while 10-17 years of age. YJS also works to prevent and divert young people from entering the formal justice system, abiding by the Act's principles of detention as a last resort.

During 2011-12, YJS completed the expansion of the Regional Youth Justice Services (RYJS) to the Pilbara region, now allowing service delivery in the East Kimberley, West Kimberley, Pilbara, Midwest Gascoyne and the Goldfields regions. These service areas consist of youth justice teams which steer at-risk youth away from the justice system, after-hours outreach family support services and after-hours bail services.

Work continued on the redevelopment of Banksia Hill Detention Centre as the single youth detention facility for Western Australia. The Department assumed full responsibility for regional youth transport services from the WA Police, upon expiry of the 12 month pilot. The Metropolitan Youth Bail Services underwent a second phase of expansion and now provides additional services including point of arrest intervention, WA Police caution follow up and seven days a week operations with extended hours.
South Australian Government comments

Child protection and out-of-home care

In 2011-12, SA brought together education, early years, child protection and child development services into one agency, the Department for Education and Child Development (DECD). DECD provides SA with an opportunity for integrated service reform. These reforms will be underpinned by: (a) new overarching child development enabling legislation, which is currently being drafted; (b) the *Every Chance for Every Child* state-wide policy that seeks to build on SA’s proud history as a leader in early childhood by creating a stronger, child-friendly state and generate lasting opportunities for every child; and (c) the Strategic Agenda for the Safety and Wellbeing of Children and Young People, which provides a framework for collaboration to ensure children grow up in safe and nurturing environments, and emphasises the need for a more cohesive and innovative child development workforce, which embraces knowledge from a range of professions, families, cultures and communities.

Alongside these developments, the care and protection system has continued to strengthen a wide range of practices for working with vulnerable children and their families, including the development of a multi-disciplinary team approach to reunification, the continued roll out of the Connected Client Case Management System (C3MS), the continuing implementation of the Directions for Alternative Care, and strengthening across government engagement with children in care through the Rapid Response initiative.

Youth justice

The completion of a new 60 bed youth training centre facility was a major initiative for SA; the first young person was admitted to the centre on 31 August 2012. The open campus design of the centre is innovative and complies with human rights obligations. It incorporates accommodation units, an education centre, a health centre, a pool and gym, a visitor centre and a multi-faith facility. The centre is an integral component of the new Adelaide Youth Training Centre (AYTC) service model, which now delivers services across two campuses.

As part of the establishment of the AYTC, work continues with sector partners to reshape service delivery models, including (a) moving education provision to a service-based ‘Centre of Innovation’ and developing a new health service model to increase support for young people while in custody; (b) expanding and creating opportunities for enhanced involvement of Aboriginal communities and other cultural communities to provide children and young people with transitional support and cultural connection; (c) involving government and community service providers and social support systems (parents, guardians, carers or partners) in exit planning and goal setting; (d) promoting more effective collaboration with departmental colleagues responsible for social housing and disability services to enhance responsiveness and across-system service provision to common clients; and (e) identifying new strategies with co-located service providers and external partners to strengthen family/carer engagement to support young people’s education, training, and work participation opportunities.
Tasmanian Government comments

Child protection and out-of-home care

The Tasmanian Government has developed a strategic whole-of-government approach to the recently tabled report of the Select Committee of Enquiry on Child Protection. Action will take place across six key areas: Continue System Reform; Build and Strengthen Relationships; Improve the Legislative Framework; Ensure Transparency and Accountability; Reform Out-of-Home Care and Increase Education, Training and Professional Development. The most significant recommendation calls for the introduction of a public health model approach to child wellbeing and safety.

A project to ensure children have clarity and certainty regarding the ways in which they will be cared for in the future is currently underway. This permanency planning project is initially focusing on modifications to support the recruitment and assessment of carers and the development of a decision making framework.

Child and Family Centres continue to be developed throughout Tasmania. They represent a major policy shift towards the integration of early childhood services in health, early education and care for children aged 0 to 5 years.

Youth justice

From January 2011 a single dedicated magistrate has been presiding in the Youth Justice Specialist Magistrate Pilot in Hobart. The Pilot aims to better achieve the objectives of the Youth Justice Act 1997 with a more holistic, consistent, timely and collaborative approach to young offenders. A “special list” which uses a therapeutic, bail-based approach to cases has been developed for young people who are at real risk of detention and reoffending. The Pilot is currently under evaluation.

A major project over the last 12 months has seen the transformation of the Ashley Youth Detention Centre (AYDC) Health Service. This change has joined AYDC to a robust system of clinical governance and has seen increased investment in clinical services including increased nursing capacity; the establishment of telehealth services; the introduction of a web based healthcare information system; the refurbishment of the health facility and purchase of new clinical equipment. A complementary project focusing on broader custodial services has commenced; this will see the implementation of continuous quality improvement, self-assessment against the AJJA standards and external validation.

An On-boarding and Induction program for new recruits in Community Youth Justice has been finalised. The program provides a thorough grounding in Youth Justice theory, as well as practical training in the Tasmanian specific legislation, policies and practice.

The Youth Justice (Miscellaneous Amendment) Bill 2012 was tabled in Parliament on the 23 October 2012, this will deliver effective, far reaching and continuing reforms across the Tasmanian Youth Justice System.
Australian Capital Territory Government comments

Child protection and out-of-home care

In 2011-12, there was a focus on improving service models and quality in ACT Care and Protection Services. During this period ACT Care and Protection achieved 100 per cent staffing capacity after an internal and overseas recruitment process. A restructure of funding arrangements for youth and family support programs was implemented, a systematic review of all Care and Protection policies and procedures commenced, and an additional out-of-home care service provider was introduced. There was also significant external scrutiny of Care and Protection Services, with two reviews conducted by the ACT Public Advocate, resulting in twelve system recommendations. Processes are underway to implement the majority of the recommendations.

There continues to be a focus on early intervention. The prenatal Care and Protection services team has expanded services to pregnant mothers, and a Child Protection Case Conferencing model has been implemented which requires that teenagers (13 to 16 years of age) identified as being at risk of family breakdown have a case conference before consideration is given to placing them in out-of-home care. This work is resulting in a decrease in the number of young people of this age entering out-of-home care and positive outcomes for babies and their mothers, children and young people.

Youth justice

The ACT Government delivered key reforms to improve the youth justice system and outcomes for young people over the past 12 months:

- Responding to the Human Rights Commission report, The ACT Youth Justice System 2011: A Report to the ACT Legislative Assembly. Substantial progress has been made completing the majority of recommendations.

- Releasing the Blueprint for Youth Justice in the ACT 2012–22 as a key platform of the ACT Government’s response to the Human Rights Commission’s report. The Blueprint sets the strategic reform for the youth justice system over the next 10 years.

- Commencing a major change management program that will embed an Integrated Management System at Bimberi Youth Justice Centre.

- Implementing a single case management model for youth justice that provides a seamless service for young people who move between custodial and community settings.

- Initiating a two-year trial of a Youth Drug and Alcohol Court Program. The program is an intensive and diversionary option for young people with a drug or alcohol problem who are at high risk of being sentenced to imprisonment.

- Establishing the After Hours Bail Support Service to assist young people in police custody by arranging suitable, community-based alternatives to custody and assisting young people to comply with their bail conditions.
Northern Territory Government comments

Child protection and out-of-home care

To strengthen service delivery to children and families the Northern Territory (NT) Government has established an Office of Children and Families that will offer a broader range of complimentary functions with a stronger focus on children in the 0–4 years age group. A strategic plan across the Office and the Department of Education and Children’s Services will be established, providing better coordination and integration of key early years, child protection, out-of-home care, family and parent support and family violence services, as well as broader education services.

Significant progress has been made to reform the Northern Territory’s child protection system over the last 18 months. Highlights include:

- regionalisation of child protection services
- implementation of four Structured Decision-Making Tools across all service centres
- introduction of legislation providing for authorised bodies and individuals to share information relating to the safety and wellbeing of children
- implementation of a cross-agency Child Safety and Wellbeing Plan
- placement of child protection professionals in remote Aboriginal communities for the first time under the Community Child Safety and Wellbeing Teams initiative
- delivery of a Supervision Framework and comprehensive package of accredited and non-accredited training for the frontline
- introduction of a new tiered system of foster carer payments recognising complexity, age and remoteness.

Future priorities for child protection include reform of out-of-home care, service delivery guided by an Aboriginal Child Safety and Wellbeing Framework and family decision making, and overhauling the Care and Protection of Children Act.

Youth Justice

A review of the Youth Justice System has been completed. The nine recommendations were endorsed by the Government in October 2011. A new Youth Justice Unit was established in November 2011 as the central coordination unit for youth justice policy and service delivery. The Unit is leading the implementation of the nine recommendations which include: a new Youth Justice Strategy; workforce development reforms; improved monitoring and evaluation mechanisms; and new and improved services to young people across the youth justice continuum incorporating expanded diversion services, family support and responsibility, bail support and supervision, enhanced community corrections and detention, and reintegration support.
15.9 Definitions of key terms

**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 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 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 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
intervention and coordination services for children not on an order

• 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 an order
Activities that are typically associated with seeking orders (court orders or voluntary/administrative 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 protective intervention, support and coordination services for children on an order
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
Care and protection orders are legal orders or arrangements which give child protection departments some responsibility for a child’s welfare. The scope of departmental involvement mandated by a care and protection order is dependent on the type of order, and can include:

• responsibility for overseeing the actions of the person or authority caring for the child
• reporting or giving consideration to the child’s welfare (for example, regarding the child’s education, health, religion, accommodation and financial matters).
Types of care and protection orders:

- **Finalised guardianship or custody orders** – involve the transfer of legal guardianship to the relevant state or territory department or non-government agency. These orders involve considerable intervention in a child’s life and that of his or her family, and are sought only as a last resort. Guardianship orders convey responsibility for the welfare of a child to a guardian (for example, regarding a child’s education, health, religion, accommodation and financial matters). Guardianship orders do not necessarily grant the right to the daily care and control of a child, or the right to make decisions about the daily care and control of a child, which are granted under custody orders. Custody orders generally refer to orders that place children in the custody of the state or territory, or department responsible for child protection or non-government agency. These orders usually involve the child protection department being responsible for the daily care and requirements of a child, while his or her parent retains legal guardianship. Custody alone does not bestow any responsibility regarding the long-term welfare of the child.

- **Finalised third party parental responsibility orders** – transfer all duties, powers, responsibilities and authority parents are entitled to by law, to a nominated person(s) considered appropriate by the court. The nominated person may be an individual such as a relative or an officer of a state or territory department. Third party parental responsibility may be ordered when a parent is unable to care for a child, and as such parental responsibility is transferred to a relative. ‘Permanent care orders’ are an example of a third party parental responsibility order and involve the transfer of guardianship to a third party carer. It can also be applied to the achievement of a stable arrangement under a long-term guardianship order to 18 years without guardianship being transferred to a third party. These orders are only applicable in some jurisdictions.

- **Finalised supervisory orders** – give the department responsible for child protection some responsibility for a child’s welfare. Under these orders, the department supervises and/or directs the level and type of care that is to be provided to the child. Children under supervisory orders are generally under the responsibility of their parents and the guardianship or custody of the child is unaffected. Finalised supervisory orders are therefore less interventionist than finalised guardianship orders but require the child’s parent or guardian to meet specified conditions, such as medical care of the child.

- **Interim and temporary orders** – generally cover the provision of a limited period of supervision and/or placement of a child. Parental responsibility under these orders may reside with the parents or with the department responsible for child protection. Orders that are not finalised (such as an application to a court for a care and protection order) are also included in this category, unless another finalised order is in place.

- **Administrative arrangements** – are agreements with relevant child protection departments, which have the same effect as a court order in transferring custody or guardianship. These arrangements can also allow a child to be placed in out-of-home care without going through the courts.

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, where there is no indication that a child may have been, or is at risk of being, harmed through abuse or neglect. This may include concerns about a child’s welfare related to the quality of his or her home environment or the standard of care that he or she is receiving.

Children in out-of-home care during the year
The total number of children who were 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. This category can also include notifications where the decision to investigate has not been reached (that is, notifications ‘in process’).

Exited out-of-home care
Where a child does not return to care within 60 days.

Family based care
Home-based care (see ‘Out-of-home care’).

Family group homes
Family group homes are care settings that provide care to children in a departmentally or community sector agency provided home. These homes have live-in, non-salaried carers who are reimbursed and/or subsidised for the provision of care.

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 parents are chosen from a list of people registered, licensed or approved as foster parents by an authorised department or non-government organisation.

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 lives.

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 has 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. Any break of 60 days or more is considered to break the continuity of the placement. Where a child returns home for less than 60 days and then returns to the former placement or to a different placement, this does not affect the length of time in care. Holidays or authorised absences (less than 60 days) in a placement do not 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 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 solely funded by disability services, psychiatric services, youth justice facilities and overnight child care services.

There are five main out-of-home care placement types:

- **Residential care** – where placement is in a residential building with paid staff.
- **Family group homes** – provide care to children in a departmentally or community sector agency provided home. These homes have live-in, non-salaried carers who are reimbursed and/or subsidised for the provision of care.
- **Home-based care** – where placement is in the home of a carer who is reimbursed (or who has been offered but declined reimbursement) for expenses for the care of the child. This is broken down into three subcategories: (1) **relative/kinship care** – where the caregiver is a relative (other than parents), considered to be family or a close friend, or is a member of the child or young person’s community (in accordance with their culture) who is reimbursed (or who has been offered but declined reimbursement) by the State/Territory for the care of the child. For Aboriginal and Torres Strait Islander children, a kinship carer may be another Indigenous person who is a member of their community, a compatible community or from the same language group; (2) **foster care** – where the care is authorised and carers are reimbursed (or were offered but declined reimbursement) by the state/territory and supported by an approved agency. There are varying degrees of reimbursement made to foster carers; (3) **other** – home-based care which does not fall into either of the above categories.
- **Independent living** – including private board and lead tenant.
households.

- Other – includes placements that do not fit into the above categories and unknown living arrangements. This includes boarding schools, hospitals, hotels/motels and defence force.

### Relatives/kin

People who are family or close friends, or are members of a child or young person’s community (in accordance with their culture) who are reimbursed (or who have been offered but declined reimbursement) by the State/Territory for the care of a child. For Aboriginal and Torres Strait Islander children, a kinship carer may be another Indigenous person who is a member of their community, a compatible community or from the same language group.

### Respite care

Respite care is a form of out-of-home care that is used to provide short-term accommodation for children and young people where the intention is for the child to return to their prior place of residence. Respite placements include: respite from birth family, where a child is placed in out-of-home care on a temporary basis for reasons other than child protection (for example, the child’s parents are ill or unable to care for them on a temporary basis; or as a family support mechanism to prevent entry into full time care, as part of the reunification process, as a shared care arrangement); respite from placement, where a child spends regular, short and agreed periods of time with another carer other than their primary carer.

### Stability of placement

Number of placements for children who exited out-of-home care and did not return within 60 days. Placements exclude respite or temporary placements lasting less than 7 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.

Each placement should only be counted once. A return to a previous placement is not included as a different placement. A return home is not counted as a placement, although if a child returns home for 60 days or more they are considered to have exited care.

### 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.

### Youth justice services

#### Youth justice centre

A place administered and operated by a youth justice department, where young people are detained whilst under the supervision of the relevant youth justice department on a remand or sentenced detention episode.

#### Youth justice department

Refers to those departments in each State and Territory that are responsible for youth justice matters.

#### Supervision period

A period of time during which a young person is continuously under youth 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 youth justice department is responsible for the case management or supervision of a young person (such as supervised or conditional bail where the youth justice department is involved with monitoring or supervising a young person).

**Pre-sentence detention**

Remanded or held in a youth 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 youth 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 youth 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 / group 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.
15.10 List of attachment tables

Attachment tables are identified in references throughout this chapter by a ‘15A’ prefix (for example, table 15A.1). Attachment tables are available on the Review website (www.pc.gov.au/gsp).

All jurisdictions data

Table 15A.1 State and Territory Government real recurrent expenditure on child protection and out-of-home care services, (2011-12 dollars)
Table 15A.2 State and Territory Government real recurrent expenditure on child protection services, per notification, per investigation and per substantiation, (2011-12 dollars)
Table 15A.3 State and Territory Government real recurrent expenditure on out-of-home care services, (2011-12 dollars)
Table 15A.4 Comparability of government recurrent expenditure — items included, 2011-12
Table 15A.5 Child protection notifications, investigations and substantiations by Indigenous status
Table 15A.6 Number of children admitted to and discharged from care and protection orders by Indigenous status
Table 15A.7 Number of children on care and protection orders by type of order and Indigenous status, at 30 June
Table 15A.8 Children in notifications, investigations and substantiations and children on care and protection orders: number and rate per 1000 children in the target populations by Indigenous status
Table 15A.9 Children who were the subject of a decision not to substantiate during the year and who were also the subject of a subsequent substantiation within 3 and/or 12 months, 2010-11
Table 15A.10 Children who were the subject of a substantiation during the year and who were also the subject of a subsequent substantiation within 3 and/or 12 months, 2010-11
Table 15A.11 Proportion of children on guardianship/custody orders achieving the national reading and numeracy benchmarks, Year 3 level (per cent)
Table 15A.12 Proportion of children on guardianship/custody orders achieving the national reading and numeracy benchmarks, Year 5 level (per cent)
Table 15A.13 Proportion of children on guardianship/custody orders achieving the national reading and numeracy benchmarks, Year 7 level (per cent)
Table 15A.14 Response time to commence investigation
Table 15A.15 Response time to complete investigation
Table 15A.16 Children with documented case plans, by Indigenous status, at 30 June
Table 15A.17 Children in out-of-home care: number and rate per 1000 children aged 0–17 years by Indigenous status
Table 15A.18 Children in out-of-home care by Indigenous status and placement type, 30 June
<table>
<thead>
<tr>
<th>Table</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>15A.19</td>
<td>Children in out-of-home care by Indigenous status and whether on a care and protection order, 30 June (number)</td>
</tr>
<tr>
<td>15A.20</td>
<td>Children in out-of-home care by Indigenous status and length of time in continuous out-of-home care, 30 June (number)</td>
</tr>
<tr>
<td>15A.21</td>
<td>Children who exited care during the year by Indigenous status and length of time spent in care (number)</td>
</tr>
<tr>
<td>15A.22</td>
<td>Children in out-of-home care placed with relatives/kin by Indigenous status, 30 June</td>
</tr>
<tr>
<td>15A.23</td>
<td>Indigenous children in out-of-home care by relationship of caregiver, 30 June</td>
</tr>
<tr>
<td>15A.24</td>
<td>Children aged under 12 years in out-of-home care and in a home-based placement by Indigenous status, 30 June</td>
</tr>
<tr>
<td>15A.25</td>
<td>Children on a care and protection order and exiting out-of-home care during the year by number of placements, by the length of time in out-of-home care (number)</td>
</tr>
<tr>
<td>15A.26</td>
<td>Children in out-of-home care by whether they were the subject of a child protection substantiation and the person believed responsible was living in the household providing out-of-home care</td>
</tr>
<tr>
<td>15A.27</td>
<td>Children in out-of-home care who were the subject of a notification, which was substantiated</td>
</tr>
<tr>
<td>15A.28</td>
<td>Intensive family support services: total real recurrent expenditure, number of children aged 0-17 years commencing intensive family support services and real recurrent expenditure per child (2011-12 dollars)</td>
</tr>
<tr>
<td>15A.29</td>
<td>Intensive family support services: number of children aged 0–17 years commencing intensive family support services by Indigenous status and gender</td>
</tr>
<tr>
<td>15A.30</td>
<td>Intensive family support services: number of children aged 0–17 years commencing intensive family support services by age</td>
</tr>
<tr>
<td>15A.31</td>
<td>Intensive family support services: number of children aged 0–17 years in intensive family support services by living situation at commencement of the program</td>
</tr>
<tr>
<td>15A.32</td>
<td>Target population data used for annual data, December ('000)</td>
</tr>
<tr>
<td>15A.33</td>
<td>Target population data used for end of financial year data, March ('000)</td>
</tr>
<tr>
<td>15A.34</td>
<td>Out-of-home care expenditure per placement night</td>
</tr>
<tr>
<td><strong>Single jurisdiction data NSW</strong></td>
<td></td>
</tr>
<tr>
<td>15A.35</td>
<td>Child protection notifications, investigations and substantiations by Indigenous status, NSW</td>
</tr>
<tr>
<td>15A.36</td>
<td>Number of children admitted to and discharged from care and protection orders by Indigenous status, NSW</td>
</tr>
<tr>
<td>15A.37</td>
<td>Number of children on care and protection orders at 30 June by type of order and Indigenous status, NSW</td>
</tr>
<tr>
<td>15A.38</td>
<td>Children in notifications, investigations and substantiations and children on care and protection orders: Number and rate per 1000 children in the target populations by Indigenous status, NSW</td>
</tr>
<tr>
<td>15A.39</td>
<td>Children who were the subject of a decision not to substantiate during the year and who were also the subject of a subsequent substantiation within 3 and/or 12 months, NSW</td>
</tr>
<tr>
<td>15A.40</td>
<td>Children who were the subject of a substantiation during the year and who were also the subject of a subsequent substantiation within 3 and/or 12 months, NSW</td>
</tr>
</tbody>
</table>
Table 15A.41  Resubstantiation rate, substantiation rate after a decision not to substantiate and substantiation rate, NSW

Table 15A.42  Children in out-of-home care at 30 June: number and rate per 1000 children aged 0–17 years, by Indigenous status, NSW

Table 15A.43  Number of children in out-of-home care at 30 June, by Indigenous status and placement type, NSW

Table 15A.44  Number of children in out-of-home care at 30 June, by Indigenous status and whether on a care and protection order, NSW

Table 15A.45  Number of children in out-of-home care at 30 June, by Indigenous status and length of time in continuous out-of-home care, NSW

Table 15A.46  Number of children who exited care during the year by Indigenous status and length of time spent in care, NSW

Table 15A.47  Children in out-of-home care at 30 June placed with relatives/kin, by Indigenous status, NSW

Table 15A.48  Indigenous children in out-of-home care at 30 June by Indigenous status and relationship of caregiver, NSW

Table 15A.49  Children aged under 12 years in out-of-home care in a home based placement at 30 June, by Indigenous status, NSW

Table 15A.50  Number of children exiting out-of-home care during the year, who were on a care and protection order, by number of different placements, by length of time in out-of-home care, NSW

Table 15A.51  Children in out-of-home care by whether they were the subject of a child protection substantiation and the person believed responsible was in the household, NSW

Table 15A.52  Children in out-of-home care who were the subject of a notification, which was substantiated NSW

Single jurisdiction data Vic

Table 15A.53  Child protection notifications, investigations and substantiations by Indigenous status, VIC

Table 15A.54  Number of children admitted to and discharged from care and protection orders by Indigenous status, VIC

Table 15A.55  Number of children on care and protection orders at 30 June by type of order and Indigenous status, VIC

Table 15A.56  Children in notifications, investigations and substantiations and children on care and protection orders: Number and rate per 1000 children in the target populations by Indigenous status, Vic

Table 15A.57  Children who were the subject of a decision not to substantiate during the year and who were also the subject of a subsequent substantiation within 3 and/or 12 months, VIC

Table 15A.58  Children who were the subject of a substantiation during the year and who were also the subject of a subsequent substantiation within 3 and/or 12 months, VIC

Table 15A.59  Resubstantiation rate, substantiation rate after a decision not to substantiate and substantiation rate, VIC

Table 15A.60  Children in out-of-home care at 30 June: number and rate per 1000 children aged 0–17 years, by Indigenous status, VIC
Table 15A.61  Number of children in out-of-home care at 30 June, by Indigenous status and placement type, VIC
Table 15A.62  Number of children in out-of-home care at 30 June, by Indigenous status and whether on a care and protection order, VIC
Table 15A.63  Number of children in out-of-home care at 30 June, by Indigenous status and length of time in continuous out-of-home care, VIC
Table 15A.64  Number of children who exited care during the year by Indigenous status and length of time spent in care, VIC
Table 15A.65  Indigenous children in out-of-home care at 30 June by Indigenous status and relationship of caregiver, VIC
Table 15A.66  Children in out-of-home care at 30 June placed with relatives/kin, by Indigenous status, VIC
Table 15A.67  Children aged under 12 years in out-of-home care in a home based placement at 30 June, by Indigenous status, VIC
Table 15A.68  Number of children exiting out-of-home care during the year, who were on a care and protection order, by number of different placements, by length of time in out-of-home care, VIC
Table 15A.69  Children in out-of-home care by whether they were the subject of a child protection substantiation and the person believed responsible was in the household, VIC
Table 15A.70  Children in out-of-home care who were the subject of a notification, which was substantiated, VIC

Single jurisdiction data Qld
Table 15A.71  Child protection notifications, investigations and substantiations by Indigenous status, Qld
Table 15A.72  Number of children admitted to and discharged from care and protection orders by Indigenous status, Qld
Table 15A.73  Number of children on care and protection orders at 30 June by type of order and Indigenous status, Qld
Table 15A.74  Children in notifications, investigations and substantiations and children on care and protection orders: Number and rate per 1000 children in the target populations by Indigenous status, Qld
Table 15A.75  Children who were the subject of a decision not to substantiate during the year and who were also the subject of a subsequent substantiation within 3 and/or 12 months, Qld
Table 15A.76  Children who were the subject of a substantiation during the year and who were also the subject of a subsequent substantiation within 3 and/or 12 months, Qld
Table 15A.77  Resubstantiation rate, substantiation rate after a decision not to substantiate and substantiation rate, Qld
Table 15A.78  Children in out-of-home care at 30 June: number and rate per 1000 children aged 0–17 years, by Indigenous status, Qld
Table 15A.79  Number of children in out-of-home care at 30 June, by Indigenous status and placement type, Qld
| Table 15A.80 | Number of children in out-of-home care at 30 June, by Indigenous status and whether on a care and protection order, Qld |
| Table 15A.81 | Number of children in out-of-home care at 30 June, by Indigenous status and length of time in continuous out-of-home care, Qld |
| Table 15A.82 | Number of children who exited care during the year by Indigenous status and length of time spent in care, Qld |
| Table 15A.83 | Children in out-of-home care at 30 June placed with relatives/kin, by Indigenous status, Qld |
| Table 15A.84 | Indigenous children in out-of-home care at 30 June by Indigenous status and relationship of caregiver, Qld |
| Table 15A.85 | Children aged under 12 years in out-of-home care in a home based placement at 30 June, by Indigenous status, Qld |
| Table 15A.86 | Number of children exiting out-of-home care during the year, who were on a care and protection order, by number of different placements, by length of time in out-of-home care, Qld |
| Table 15A.87 | Children in out-of-home care by whether they were the subject of a child protection substantiation and the person believed responsible was in the household, Qld |
| Table 15A.88 | Children in out-of-home care who were the subject of a notification, which was substantiated, Qld |

**Single jurisdiction data WA**

| Table 15A.89 | Child protection notifications, investigations and substantiations by Indigenous status, WA |
| Table 15A.90 | Number of children admitted to and discharged from care and protection orders by Indigenous status, WA |
| Table 15A.91 | Number of children on care and protection orders at 30 June by type of order and Indigenous status, WA |
| Table 15A.92 | Children in notifications, investigations and substantiations and children on care and protection orders: Number and rate per 1000 children in the target populations by Indigenous status, WA |
| Table 15A.93 | Children who were the subject of a decision not to substantiate during the year and who were also the subject of a subsequent substantiation within 3 and/or 12 months, WA |
| Table 15A.94 | Children who were the subject of a substantiation during the year and who were also the subject of a subsequent substantiation within 3 and/or 12 months, WA |
| Table 15A.95 | Resubstantiation rate, substantiation rate after a decision not to substantiate and substantiation rate, WA |
| Table 15A.96 | Children in out-of-home care at 30 June: number and rate per 1000 children aged 0–17 years, by Indigenous status, WA |
| Table 15A.97 | Number of children in out-of-home care at 30 June, by Indigenous status and placement type, WA |
| Table 15A.98 | Number of children in out-of-home care at 30 June, by Indigenous status and whether on a care and protection order, WA |
Table 15A.99  Number of children in out-of-home care at 30 June, by Indigenous status and length of time in continuous out-of-home care, WA

Table 15A.100  Number of children who exited care during the year by Indigenous status and length of time spent in care, WA

Table 15A.101  Children in out-of-home care at 30 June placed with relatives/kin, by Indigenous status, WA

Table 15A.102  Indigenous children in out-of-home care at 30 June by Indigenous status and relationship of caregiver, WA

Table 15A.103  Children aged under 12 years in out-of-home care in a home based placement at 30 June, by Indigenous status, WA

Table 15A.104  Number of children exiting out-of-home care during the year, who were on a care and protection order, by number of different placements, by length of time in out-of-home care, WA

Table 15A.105  Children in out-of-home care by whether they were the subject of a child protection substantiation and the person believed responsible was in the household, WA

Table 15A.106  Children in out-of-home care who were the subject of a notification, which was substantiated WA

Single jurisdiction data SA

Table 15A.107  Child protection notifications, investigations and substantiations by Indigenous status, SA

Table 15A.108  Number of children admitted to and discharged from care and protection orders by Indigenous status, SA

Table 15A.109  Number of children on care and protection orders at 30 June by type of order and Indigenous status, SA

Table 15A.110  Children in notifications, investigations and substantiations and children on care and protection orders: Number and rate per 1000 children in the target populations by Indigenous status, SA

Table 15A.111  Children who were the subject of a decision not to substantiate during the year and who were also the subject of a subsequent substantiation within 3 and/or 12 months, SA

Table 15A.112  Children who were the subject of a substantiation during the year and who were also the subject of a subsequent substantiation within 3 and/or 12 months, SA

Table 15A.113  Resubstantiation rate, substantiation rate after a decision not to substantiate and substantiation rate, SA

Table 15A.114  Children in out-of-home care at 30 June: number and rate per 1000 children aged 0–17 years, by Indigenous status, SA

Table 15A.115  Number of children in out-of-home care at 30 June, by Indigenous status and placement type, SA

Table 15A.116  Number of children in out-of-home care at 30 June, by Indigenous status and whether on a care and protection order, SA

Table 15A.117  Number of children in out-of-home care at 30 June, by Indigenous status and length of time in continuous out-of-home care, SA
Table 15A.118 Number of children who exited care during the year by Indigenous status and length of time spent in care, SA

Table 15A.119 Children in out-of-home care at 30 June placed with relatives/kin, by Indigenous status, SA

Table 15A.120 Indigenous children in out-of-home care at 30 June by Indigenous status and relationship of caregiver, SA

Table 15A.121 Children aged under 12 years in out-of-home care in a home based placement at 30 June, by Indigenous status, SA

Table 15A.122 Number of children exiting out-of-home care during the year, who were on a care and protection order, by number of different placements, by length of time in out-of-home care, SA

Table 15A.123 Children in out-of-home care by whether they were the subject of a child protection substantiation and the person believed responsible was in the household, SA

Table 15A.124 Children in out-of-home care who were the subject of a notification, which was substantiated SA

Single jurisdiction data Tas

Table 15A.125 Child protection notifications, investigations and substantiations by Indigenous status, TAS

Table 15A.126 Number of children admitted to and discharged from care and protection orders by Indigenous status, TAS

Table 15A.127 Number of children on care and protection orders at 30 June by type of order and Indigenous status, TAS

Table 15A.128 Children in notifications, investigations and substantiations and children on care and protection orders: Number and rate per 1000 children in the target populations by Indigenous status, Tas

Table 15A.129 Children who were the subject of a decision not to substantiate during the year and who were also the subject of a subsequent substantiation within 3 and/or 12 months, TAS

Table 15A.130 Children who were the subject of a substantiation during the year and who were also the subject of a subsequent substantiation within 3 and/or 12 months, TAS

Table 15A.131 Resubstantiation rate, substantiation rate after a decision not to substantiate and substantiation rate, TAS

Table 15A.132 Children in out-of-home care at 30 June: number and rate per 1000 children aged 0–17 years, by Indigenous status, TAS

Table 15A.133 Number of children in out-of-home care at 30 June, by Indigenous status and placement type, TAS

Table 15A.134 Number of children in out-of-home care at 30 June, by Indigenous status and whether on a care and protection order, TAS

Table 15A.135 Number of children in out-of-home care at 30 June, by Indigenous status and length of time in continuous out-of-home care, TAS

Table 15A.136 Number of children who exited care during the year by Indigenous status and length of time spent in care, TAS
| Table 15A.137 | Children in out-of-home care at 30 June placed with relatives/kin, by Indigenous status, TAS |
| Table 15A.138 | Indigenous children in out-of-home care at 30 June by Indigenous status and relationship of caregiver, TAS |
| Table 15A.139 | Children aged under 12 years in out-of-home care in a home based placement at 30 June, by Indigenous status, TAS |
| Table 15A.140 | Number of children exiting out-of-home care during the year, who were on a care and protection order, by number of different placements, by length of time in out-of-home care, TAS |
| Table 15A.141 | Children in out-of-home care by whether they were the subject of a child protection substantiation and the person believed responsible was in the household, TAS |
| Table 15A.142 | Children in out-of-home care who were the subject of a notification, which was substantiated, TAS |
| **Single jurisdiction data ACT** | |
| Table 15A.143 | Child protection notifications, investigations and substantiations by Indigenous status, ACT |
| Table 15A.144 | Number of children admitted to and discharged from care and protection orders by Indigenous status, ACT |
| Table 15A.145 | Number of children on care and protection orders at 30 June by type of order and Indigenous status, ACT |
| Table 15A.146 | Children in notifications, investigations and substantiations and children on care and protection orders: Number and rate per 1000 children in the target populations by Indigenous status, ACT |
| Table 15A.147 | Children who were the subject of a decision not to substantiate during the year and who were also the subject of a subsequent substantiation within 3 and/or 12 months, ACT |
| Table 15A.148 | Children who were the subject of a substantiation during the year and who were also the subject of a subsequent substantiation within 3 and/or 12 months, ACT |
| Table 15A.149 | Resubstantiation rate, substantiation rate after a decision not to substantiate and substantiation rate, ACT |
| Table 15A.150 | Children in out-of-home care at 30 June: number and rate per 1000 children aged 0–17 years, by Indigenous status, ACT |
| Table 15A.151 | Number of children in out-of-home care at 30 June, by Indigenous status and placement type, ACT |
| Table 15A.152 | Number of children in out-of-home care at 30 June, by Indigenous status and whether on a care and protection order, ACT |
| Table 15A.153 | Number of children in out-of-home care at 30 June, by Indigenous status and length of time in continuous out-of-home care, ACT |
| Table 15A.154 | Number of children who exited care during the year by Indigenous status and length of time spent in care, ACT |
| Table 15A.155 | Children in out-of-home care at 30 June placed with relatives/kin, by Indigenous status, ACT |
Table 15A.156 Indigenous children in out-of-home care at 30 June by Indigenous status and relationship of caregiver, ACT

Table 15A.157 Children aged under 12 years in out-of-home care in a home based placement at 30 June, by Indigenous status, ACT

Table 15A.158 Number of children exiting out-of-home care during the year, who were on a care and protection order, by number of different placements, by length of time in out-of-home care, ACT

Table 15A.159 Children in out-of-home care by whether they were the subject of a child protection substantiation and the person believed responsible was in the household, ACT

Table 15A.160 Children in out-of-home care who were the subject of a notification, which was substantiated ACT

Single jurisdiction data NT

Table 15A.161 Child protection notifications, investigations and substantiations by Indigenous status, NT

Table 15A.162 Number of children admitted to and discharged from care and protection orders by Indigenous status, NT

Table 15A.163 Number of children on care and protection orders at 30 June by type of order and Indigenous status, NT

Table 15A.164 Children in notifications, investigations and substantiations and children on care and protection orders: Number and rate per 1000 children in the target populations by Indigenous status, NT

Table 15A.165 Children who were the subject of a decision not to substantiate during the year and who were also the subject of a subsequent substantiation within 3 and/or 12 months, NT

Table 15A.166 Children who were the subject of a substantiation during the year and who were also the subject of a subsequent substantiation within 3 and/or 12 months, NT

Table 15A.167 Resubstantiation rate, substantiation rate after a decision not to substantiate and substantiation rate, NT

Table 15A.168 Children in out-of-home care at 30 June: number and rate per 1000 children aged 0–17 years, by Indigenous status, NT

Table 15A.169 Number of children in out-of-home care at 30 June, by Indigenous status and placement type, NT

Table 15A.170 Number of children in out-of-home care at 30 June, by Indigenous status and whether on a care and protection order, NT

Table 15A.171 Number of children in out-of-home care at 30 June, by Indigenous status and length of time in continuous out-of-home care, NT

Table 15A.172 Number of children who exited during the year by Indigenous status and length of time spent in care, NT

Table 15A.173 Children in out-of-home care at 30 June placed with relatives/kin, by Indigenous status, NT

Table 15A.174 Indigenous children in out-of-home care at 30 June by Indigenous status and relationship of caregiver, NT
Table 15A.175  Children aged under 12 years in out-of-home care in a home based placement at 30 June, by Indigenous status, NT

Table 15A.176  Number of children exiting out-of-home care during the year, who were on a care and protection order, by number of different placements, by length of time in out-of-home care, NT

Table 15A.177  Children in out-of-home care by whether they were the subject of a child protection substantiation and the person believed responsible was in the household, NT

Table 15A.178  Children in out-of-home care who were the subject of a notification, which was substantiated NT

Youth justice data
Table 15A.179  State and Territory Government real recurrent expenditure on youth justice services, 2011-12 dollars

Table 15A.180  Comparability of government recurrent expenditure — items included, 2011-12

Table 15A.181  Daily average number and rate of young people aged 10–17 years who were supervised in the community and in detention centres

Table 15A.182  Daily average number and rate of males and females aged 10–17 years in detention

Table 15A.183  Daily average number and rate of males and females aged 10–17 years subject to community-based supervision

Table 15A.184  Males and females as a proportion of the total population aged 10–17 years in detention (per cent)

Table 15A.185  Males and females as a proportion of the total population aged 10–17 years subject to community based supervision (per cent)

Table 15A.186  Daily average number and rate of Indigenous young people aged 10–17 years in detention

Table 15A.187  Daily average number and rate of Indigenous young people aged 10–17 years subject to community-based supervision

Table 15A.188  Average rates of detention and Indigenous rate ratio, young people aged 10-17 years in juvenile detention, per 100 000 people

Table 15A.189  Custody nights, by Indigenous status

Table 15A.190  Proportion of pre-sentence reports completed by youth justice agencies, by Indigenous status

Table 15A.191  Proportion of group conferences resulting in an agreement, by Indigenous status

Table 15A.192  Deaths in custody, by Indigenous status

Table 15A.193  Young people in detention attending education and training, by Indigenous status

Table 15A.194  Escapes from detention and escorted movement, by Indigenous status

Table 15A.195  Absconds from unescorted leave, by Indigenous status

Table 15A.196  Serious assaults in custody, by Indigenous status

Table 15A.197  Assaults in custody, by Indigenous status

Table 15A.198  Self-harm and attempted suicide in custody, by Indigenous status
Table 15A.199  Completion of community-based orders, by Indigenous status
Table 15A.200  Case plans prepared/reviewed within 6 weeks of commencing a sentenced order, by Indigenous status
Table 15A.201  Centre utilisation
15.11 References


AIHW (Australian Institute of Health and Welfare) 2006, Family violence among Aboriginal and Torres Strait Islander peoples, Cat. No. IHW 17, Canberra.

—— 2012, Juvenile Justice in Australia 2010-11, Cat. no. JUV 10, Canberra.

—— forthcoming, Child Protection Australia 2011-12, Child Welfare series no. 53. Cat. no. CWS 41, Canberra: AIHW.


PART G

HOUSING AND HOMELESSNESS SERVICES
G  Housing and homelessness services
sector overview

CONTENTS
G.1 Introduction G.1
G.2 Sector performance indicator framework G.9
G.3 Cross-cutting and interface issues G.24
G.4 Future directions in performance reporting G.26
G.5 List of attachment tables G.27
G.6 Definitions of key terms G.29
G.7 Appendix – Private housing market contextual information G.31
G.8 References G.34

Attachment tables
Attachment tables are identified in references throughout this sector overview by a ‘GA’ prefix (for example, table GA.1). A full list of attachment tables is provided at the end of this sector overview, and the attachment tables are available on the Review website at www.pc.gov.au/gsp.

G.1  Introduction

This sector overview provides an introduction to the ‘Housing’ (chapter 16) and ‘Homelessness services’ (chapter 17) chapters of this Report. It provides an overview of the housing and homelessness sector, presenting both contextual information and high level performance information.
This sector overview also includes descriptive information on Commonwealth Rent Assistance (CRA).

Major improvements in reporting on housing and homelessness this year are identified in each of the service-specific housing and homelessness chapters.

**Policy context**

Shelter is a fundamental human need, and housing and homelessness assistance plays an important role in enabling social and economic participation. This assistance is an important element of governments’ social policy and welfare frameworks.

Housing assistance and services to people who are homeless and at risk of homelessness are closely interconnected:

> The concepts of ‘homelessness’ and ‘housing’ are culturally bound, and … in order to define homelessness it is necessary to identify shared community standards about minimum housing (Homelessness Australia 2010).

Australian, State and Territory governments assist people to meet their housing needs through direct services, funding support and other initiatives, including assistance for people who are homeless or at risk of homelessness. Many non-government organisations also provide housing assistance and services to people who are homeless or at risk of homelessness.

The National Affordable Housing Agreement (NAHA) provides the current framework for Australian, State and Territory governments’ housing and homelessness policy, and funds many housing and homelessness services. The NAHA provides the framework for the parties to improve housing affordability and homelessness outcomes for Australians (COAG 2008). Commencing on 1 January 2009, the NAHA replaced the Commonwealth State Housing Agreement (CSHA) and Supported Accommodation Assistance Program (SAAP) V Agreement.

**Sector scope**

This Report includes detailed information on two specific services: social housing and homelessness services. Social housing broadly encompasses public housing, State owned and managed Indigenous housing (SOMIH), community housing and Indigenous community housing, and is reported in chapter 16 (box G.1).
Homelessness services in this Report encompass government funded specialist homelessness services, and are reported in chapter 17 (box G.2).

This report focuses on social housing and homelessness services funded under the National Affordable Housing Specific Purpose Payment (NAH SPP) and related National Partnership Agreements (NPAs), and provided through the policy framework of the NAHA and the related NPAs which support it.

Governments provide other forms of support for housing and homelessness, including home purchase assistance and private rental assistance, but these are not considered in detail in this Report.

Housing and homelessness outcomes are influenced by many factors apart from government assistance. Section G.6 (Appendix) presents contextual information on some of these factors, including housing affordability, private rental markets and home ownership.

**Box G.1 Scope of social housing**

Social housing is rental housing provided by government or non-government organisations (including not-for-profit) to assist people who are unable to access suitable accommodation in the private rental market (AIHW 2010). The forms of social housing included in this Report are:

- **Public housing** (PH): dwellings owned (or leased) and managed by State and Territory housing authorities to provide affordable rental accommodation.
- **State owned and managed Indigenous housing** (SOMIH): dwellings owned and managed by State housing authorities that are allocated only to Indigenous households.
- **Community housing** (CH): rental housing provided to low to moderate income or special needs households, managed by community based organisations that have received capital or recurrent subsidy from government. Community housing models vary across jurisdictions, and the housing stock may be owned by a variety of groups, including local government.
- **Indigenous community housing** (ICH): dwellings owned or leased and managed by ICH organisations and community councils in major cities, regional areas and remote areas. Indigenous community housing models vary across jurisdictions and can also include dwellings funded or registered by government.

*Crisis and transitional housing* is an additional form of social housing, but it is not separately identified in this Report. Crisis and transitional housing might be indirectly reported through the other forms of social housing described above. Development work is underway to enable better reporting on this form of housing assistance.

*Source: Chapter 16.*
Box G.2 **Scope of homelessness services**

Under the NAHA, governments have committed to undertake reforms in the housing sector to improve integration between homelessness services and mainstream services, and reduce the rate of homelessness.

*Government funded specialist homelessness services* provide assistance to individuals and families who are homeless or at risk of becoming homeless.

Data reported in Chapter 17 of this Report are for government funded specialist homelessness services delivered under the NAHA and NPAH. Data for 2010-11 are sourced from the SAAP Client Collection and Demand for Accommodation Collection. Data for 2011-12 are sourced from the Specialist Homelessness Services collection (SHSC), which measures the number of clients and the number and types of services provided to clients.

**Definition of homelessness**

Definitions of homelessness range from objective measures in which homelessness means having ‘no roof’, to broader, more subjective definitions founded on culturally and historically determined ideas of ‘home’.

The ABS definition of homelessness is informed by a broader understanding of homelessness as ‘homelessness, not ‘rooflessness’. Data on homelessness from the 2011, 2006 and 2001 censuses are based on the ABS methodology (ABS 2012a) and a statistical definition of homelessness (ABS 2012b), which were both developed following consultation with the homelessness sector.

Data on homeless people are categorised by the ABS (2012b) according to their living situation. When a person does not have suitable accommodation alternatives they are considered homeless if their current living arrangement either:

- is in a dwelling that is inadequate
- has no tenure, or if their initial tenure is short and not extendable
- does not allow them to have control of, and access to space for social relations.

The definition has been constructed from a conceptual framework centred around the following elements:

- Adequacy of the dwelling or security of tenure in the dwelling
- Control of, and access to space for social relations.

(Source: ABS (2012); Chapter 17.)

---

**Profile of the housing and homelessness sector**

Detailed profiles for the services within the housing and homelessness services sector are reported in chapters 16 and 17, and cover:

- size and scope of the individual service types
• roles and responsibilities of each level of government and non-government organisations
• funding and expenditure.

Roles and responsibilities

The Australian, State and Territory governments share responsibility for housing and homelessness assistance provided under the NAHA.

• The Australian, State and Territory governments jointly fund specialist homelessness services
• The Australian Government provides funding for housing and homelessness services to State and Territory governments through the NAH SPP and related National Partnership Agreements. The Australian Government influences the housing market through direct and indirect means, including providing CRA, home purchase assistance, financial sector regulations and taxation
• State and Territory governments fund, administer and deliver social housing and homelessness services, and provide financial support to renters through private rental assistance. State and Territory governments are also responsible for land use and supply policy, urban planning and development policy, housing related taxes and charges (such as land taxes and stamp duties) and residential tenancy legislation and regulation
• Local governments are mostly responsible for most building approvals, urban planning and development processes, and may be involved in providing community housing
• Non-government organisations provide housing through the community housing sector and deliver most homelessness services with some local government participation.

Government funding and expenditure

Most government funding for housing and homelessness services is provided through the NAH SPP. This funding is based on outcomes rather than tied to programs, so it is not possible to identify NAH SPP funding used for specific programs.

In 2011-12, the Australian Government provided $2.2 billion to State and Territory governments for housing and homelessness services through the NAH SPP and related NPAs covering social housing; homelessness; and Remote Indigenous
Housing (table GA.1). In addition, the Australian Government provided a further $3.4 billion for CRA in 2011-12 (table GA.12). The Australian Government provided a further $162 million in 2011-12 for the social housing initiative component of the National Building Economic Stimulus Package to aid the construction of new social housing dwellings, and repairs and maintenance of existing dwellings (table GA.1).

Australian, State and Territory governments’ total expenditure on social housing and homelessness services was $3.1 billion in 2010-11 (table G.1). Other descriptive data for social housing and homelessness services for 2010-11 are presented in table G.1, and data for each jurisdiction are reported in tables GA.3 and GA.4. Further information, including 2010-11 and 2011-12 financial data for public housing, SOMIH and homelessness services, is presented in chapters 16 and 17.

Table G.1  
**Housing and homelessness services sector, selected descriptive statistics, Australia, 2010-11**

<table>
<thead>
<tr>
<th></th>
<th>Net recurrent expenditure</th>
<th>No. units</th>
<th>No. households</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$m  Dwellings (’000)</td>
<td>’000</td>
<td></td>
</tr>
<tr>
<td><strong>Social housing</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Public housing</td>
<td>2 394.7</td>
<td>331 371</td>
<td>324 908</td>
</tr>
<tr>
<td>SOMIH</td>
<td>92.4</td>
<td>9 820</td>
<td>9 564</td>
</tr>
<tr>
<td>Community housing</td>
<td>501.9</td>
<td>59 777</td>
<td>54 911</td>
</tr>
<tr>
<td>Indigenous community housing</td>
<td>80.9</td>
<td>17 543</td>
<td>..</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>3069.9</td>
<td>418 511</td>
<td>389 383</td>
</tr>
<tr>
<td></td>
<td>$m  Clients (’000)</td>
<td>..</td>
<td>..</td>
</tr>
<tr>
<td><strong>Homelessness services</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>491.1</td>
<td>142.5</td>
<td>..</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>3 561.0</td>
<td>..</td>
<td>..</td>
</tr>
</tbody>
</table>

- Data may not be comparable across jurisdictions or service areas and comparisons could be misleading. Chapters 16 and 17 provide further information.
- The total number of dwellings at 30 June.
- Data for ICH are likely to be underestimated because complete data were not available for all jurisdictions. The number of ICH dwellings are ‘funded, permanent dwellings’.
- Data for homelessness services are based on the 2010-11 SAAP data collection. Not applicable.

*Source:* Chapters 16 and 17; table GA.2.

**Commonwealth Rent Assistance**

CRA is an Australian Government payment to people on low and moderate incomes who are renting in the private housing market, to assist with the cost of housing. It is a non-taxable income supplement, paid 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 market. CRA may be payable to people living in SOMIH (in NSW
only), community housing or Indigenous community housing but it is not payable to people renting housing from State or Territory housing authorities [that is, people living in public housing, or SOMIH (other than NSW)], as housing authorities separately subsidise rent for eligible tenants.

CRA is paid at 75 cents for every dollar above a minimum rental threshold until a maximum rate is reached. The minimum threshold and maximum rates vary according to an income unit’s family situation and number of children. Information on the eligibility and payment rates for CRA are presented in table GA.14.

Australian Government expenditure on CRA was $3.4 billion in 2011-12, increasing from $2.6 billion in 2007-08 (in real terms) (table GA.12). The average government expenditure per income unit receiving CRA was $2874 in 2011-12 (table GA.13).

At 1 June 2012:
- there were 1 188 467 income units receiving CRA (table GA.15)
- the median CRA payment was $116 per fortnight (table GA.22)
- 75 per cent of all CRA recipients were paying enough rent to be eligible to receive the maximum rate of CRA (table GA.23).

Though funded separately to the NAH SPP, CRA contributes to NAHA outcomes relating to rental affordability. CRA assists with reducing the cost of rental housing and the incidence of rental stress (defined as more than 30 per cent of household income being spent on rent) for people on low incomes. Nationally in June 2012, 68.2 per cent of CRA recipients would have paid more than 30 per cent of their gross income on rent if CRA were not provided. However, with CRA, 40.3 per cent of CRA recipients spent more than 30 per cent of their income on rent (table GA.24).

Tables GA.12–34 present a range of detailed data on CRA, including Australian Government expenditure; CRA recipients, including Indigenous recipients and those with special needs; and the amount of rent paid and the proportion of income spent on rent by CRA recipients.

**Social and economic factors affecting demand for services**

Demand for housing and homelessness services is influenced by a shortage of affordable housing, long term unemployment and financial hardship, mental health issues, substance abuse, and family and relationship breakdown. Among women,
domestic and family violence is the main reason for seeking help from specialist homelessness services (Homelessness Taskforce 2008).

Research shows the pathways to homelessness are varied and complex. For Indigenous people, longitudinal factors (for example, influences from early childhood) can compound with situational factors, leading to homelessness. For young people, factors such as family conflict or abuse, drug use, unstable employment, participating in education and training, combining work and study, and financial pressure (for example, tension between paying rent, food and utility costs) can potentially lead to unstable housing and increase the risk of homelessness (Memmott and Chambers 2010; CHP 2005).

Pathways through the homelessness, child protection and juvenile justice sectors have been explored in an analysis of linked client data across the three sectors. The analysis suggests that children and young people who are involved with one of the three areas have an increased risk of being involved in the other two areas. For example, in 2009-10, approximately 15 per cent of young people under youth justice supervision received specialist homelessness support the year before their most recent period of supervision and 10 per cent of adult specialist homelessness clients had a history of youth justice supervision. This type of analysis assists government and non-government agencies to provide more targeted prevention and support services (AIHW 2012).

Demand for housing assistance may continue even after recipients have gained stable employment and financial circumstances are improved. A study of workforce participation of women living in public housing in Australia found that job insecurity and low wages are the main incentives for tenants to continue to live in public housing (Saugeres and Hulse 2010).

**Service-sector objectives**

The overarching service sector objectives in box G.3 draw together the objectives from each of the specific services (described in chapters 16 and 17), as well as reflecting the objectives set out in the NAHA.
The overarching objective of housing and homelessness services is that all Australians have access to affordable, safe and sustainable housing that contributes to social and economic participation. Further, government services are to be provided in a collaborative, equitable and efficient manner.

The specific objectives of the services that comprise the housing and homelessness services sector are summarised below:

- **Social housing** aims to assist people unable to access alternative suitable housing options, through the delivery of affordable, appropriate, flexible and diverse social housing. Some forms of social housing specifically aim to contribute to Indigenous community wellbeing, by improving housing outcomes for Indigenous people, especially those living in remote communities (chapter 16).

- **Government funded specialist homelessness services** aim 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 stable and long term independent housing (chapter 17).

**Box G.3 Objectives for housing and homelessness services**

The specific objectives of the services that comprise the housing and homelessness services sector are summarised below:

- **Social housing** aims to assist people unable to access alternative suitable housing options, through the delivery of affordable, appropriate, flexible and diverse social housing. Some forms of social housing specifically aim to contribute to Indigenous community wellbeing, by improving housing outcomes for Indigenous people, especially those living in remote communities (chapter 16).

- **Government funded specialist homelessness services** aim 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 stable and long term independent housing (chapter 17).

**Source**: COAG (2008); Chapters 16 and 17.

### G.2 Sector performance indicator framework

This sector overview is based on a sector performance indicator framework (figure G.1). This framework is made up of the following elements:

- **Sector objectives** — three sector objectives are a précis of the key objectives of housing and homelessness services and reflect the outcomes in the NAHA (box G.3).

- **Sector-wide indicators** — three sector-wide indicators relate to the overarching service sector objectives.

- **Information from the service-specific performance indicator frameworks that relate to housing and homelessness services.** Discussed in more detail in chapters 16 and 17, the service-specific frameworks provide comprehensive information on the equity, effectiveness and efficiency of these services.

This sector overview provides an overview of relevant performance information. Chapters 16 and 17 and their associated attachment tables provide more detailed information.
**Figure G.1  Housing and homelessness services sector performance indicator framework**

**Sector objectives**

- People are able to rent housing that meets their needs
- Indigenous people have improved amenity and reduced overcrowding
- People who are homeless or at risk of homelessness achieve sustainable housing and social inclusion

**Sector-wide indicators**

- Low income households in rental stress
- Appropriateness of Indigenous Housing
- Australians who are homeless

**Service specific performance indicator frameworks**

- **Chapter 16 – Housing**
  - Social housing p. 16.16

- **Chapter 17 – Homelessness services**
  - Government funded specialist homelessness services p. 17.8

**Sector-wide indicators**

This section includes high level indicators of housing and homelessness outcomes. Many factors are likely to influence these outcomes — not solely the performance of government services. However, these outcomes inform the development of appropriate policies and the delivery of government services.
Low income households in rental stress

‘Low income households in rental stress’ is an indicator of governments’ objective to provide affordable housing to assist people who are unable to access suitable housing (box G.4).

Box G.4 Low income households in rental stress

‘Low income households in rental stress’ is defined as the proportion of low income renter households spending more than 30 per cent of their gross household income on rent.

Low income renter households are defined as those in the bottom 40 per cent of equivalised disposable household incomes (that is, the bottom two income quintiles). Equivalised disposable income is an indicator of disposable household income after taking into account household size and composition (ABS 2010a). Household income and rent expenditure exclude CRA.

A low or decreasing proportion of households in rental stress implies greater housing affordability.

The social housing outcome indicator ‘affordability’ provides additional information on rental stress (chapter 16).

Data reported for this indicator are comparable and complete.


Nationally, the proportion of low income households in rental stress increased from 37.2 per cent in 2007-08 to 41.7 per cent in 2009-10, though this varied across jurisdictions (figure G.2).
Figure G.2  Proportion of low income households in rental stress

<table>
<thead>
<tr>
<th>Region</th>
<th>2007-08</th>
<th>2009-10</th>
</tr>
</thead>
<tbody>
<tr>
<td>NSW</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vic</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Qld</td>
<td></td>
<td></td>
</tr>
<tr>
<td>WA</td>
<td></td>
<td></td>
</tr>
<tr>
<td>SA</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tas</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ACT</td>
<td></td>
<td></td>
</tr>
<tr>
<td>NT</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Aust</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

\[ a \] See notes to source tables for more detailed caveats about the data.


Appropriateness of Indigenous housing

‘Appropriateness of Indigenous housing’ is an indicator of governments’ objective to ensure all Australians have access to affordable, safe, appropriate and sustainable housing (box G.5). Governments have a specific interest in improving amenity and reducing overcrowding for Indigenous people, particularly those living in remote and discrete communities (COAG 2008).
Box G.5 **Appropriateness of Indigenous housing**

‘Appropriateness of Indigenous housing’ is an indicator of the effectiveness and quality of Indigenous housing. Two measures are reported:

- proportion of Indigenous households living in overcrowded conditions
- proportion of Indigenous households living in houses of an acceptable standard.

Overcrowding is defined and measured using the Canadian National Occupancy Standard (CNOS) under which overcrowding is deemed to have occurred if one or more additional bedrooms are required to meet the standard.

For all housing tenures, acceptable standard is defined as a household with four working facilities (for washing people, for washing clothes/bedding, for storing/preparing food and sewerage) and not more than two major structural problems.

A low proportion of households living in overcrowded conditions is desirable. A high proportion of Indigenous households living in houses of an acceptable standard is desirable.

Data comparability and completeness vary for this indicator:

- data for overcrowding are not comparable or complete
- data for housing of acceptable standard are comparable but not complete.

Related information on the appropriateness of social housing is presented for the outcome indicators ‘match of dwelling to household size’ ‘and amenity/location’ in chapter 16.


*Indigenous households living in overcrowded conditions*

Overcrowding is deemed to occur if one or more bedrooms are required to meet the Canadian National Occupancy Standard (explained in chapter 16). Overcrowding is a significant issue for many Indigenous people.

The proportion of Indigenous households living in overcrowded conditions varied across jurisdictions in 2012 (figure G.3).
Indigenous households living in houses of an acceptable standard

Data for this indicator are sourced from the National Social Housing Survey. Data from the 2012 survey are reported for public housing, SOMIH and community housing. Nationally in 2012, the NSHS found that:

- for public housing, 61.3 per cent of Indigenous households were living in houses of an acceptable standard
- for SOMIH, 61.4 per cent of Indigenous households were living in houses of an acceptable standard
- for community housing, 71.5 per cent of Indigenous households were living in houses of an acceptable standard (figure G.4).
Figure G.4  Proportion of Indigenous households living in houses of an acceptable standard, 2012a, b, c, d, e

![Proportion of Indigenous households living in houses of an acceptable standard, 2012a, b, c, d, e](image)

a Error bars represent the 95 per cent confidence intervals associated with each point estimate. b There are no SOMIH data reported for Victoria, WA, the ACT or the NT as the SOMIH program does not exist in these jurisdictions. c Public housing and community housing data are not published for Victoria, WA, SA and the ACT. d Community housing data are not published for Tasmania. e Community housing data are not available for the NT.


**Australians who are homeless**

‘Australians who are homeless’ is an indicator of governments’ objective to ensure all Australians have access to affordable, safe and sustainable housing (box G.6).

**Box G.6  Australians who are homeless**

‘Australians who are homeless’ is defined as the proportion of Australians who are homeless. For this indicator, people are defined as homeless when a person does not have suitable accommodation alternatives and their current living arrangement:

- is in a dwelling that is inadequate; or
- has no tenure, or if their initial tenure is short and not extendable; or
- does not allow them to have control of, and access to space for social relations (see box G.2).

A low proportion of Australians who are homeless is desirable.

Data for this indicator are comparable.

Nationally in 2011, approximately 49 Australians per 10,000 people in the population were homeless on Census night (figure G.5).

Figure G.5  Rate of homelessness, 2011 (per 10,000 population)


Service-specific performance indicator frameworks

This section summarises information from the performance indicator frameworks for social housing (chapter 16) and government funded specialist homelessness services (chapter 17). Additional information is available to assist the interpretation of these results:

- indicator interpretation boxes, which define the measures used and indicate any significant conceptual or methodological issues with the reported information (chapters 16 and 17)
- caveats and footnotes to the reported data (chapter 16 and attachment 16A; chapter 17 and attachment 17A)
- additional measures and further disaggregation of reported measures (for example, by Indigenous status, remoteness, disability and age data (chapter 16 and attachment 16A; chapter 17 and attachment 17A)
- data quality information for many indicators, based on the ABS Data Quality Framework.

A full list of attachment tables and available data quality information is provided at the end of chapters 16 and 17.
Social housing

The performance indicator framework for social housing is presented in figure G.6. This framework provides information on equity, efficiency, effectiveness, and outcomes of social housing.

Figure G.6 Social housing performance indicator framework

An overview of the performance indicator results for the most recent reporting period is presented in table G.2. Results are reported separately for public housing, SOMIH, community housing and Indigenous community housing. Data for Indigenous community housing are not reported for a number of performance indicators due to issues with data quality and availability. Information to assist the
interpretation of these data can be found in the indicator interpretation boxes in chapter 16 and in the footnotes in attachment 16A.
### Performance indicators for social housing<sup>a, b</sup>

<table>
<thead>
<tr>
<th></th>
<th>NSW</th>
<th>Vic</th>
<th>Qld</th>
<th>WA</th>
<th>SA</th>
<th>Tas</th>
<th>ACT</th>
<th>NT</th>
<th>Aust</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Equity (access) indicators</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><em>Special needs</em> – proportion of new tenancies allocated to households with special needs (%)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Data comparability and completeness vary for this indicator.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PH 2011-12</td>
<td>72.6</td>
<td>62.1</td>
<td>71.9</td>
<td>61.1</td>
<td>71.9</td>
<td>64.0</td>
<td>54.1</td>
<td>57.8</td>
<td>67.5</td>
</tr>
<tr>
<td>SOMIH 2011-12</td>
<td>56.7</td>
<td>..</td>
<td>45.2</td>
<td>..</td>
<td>52.0</td>
<td>77.4</td>
<td>..</td>
<td>..</td>
<td>54.0</td>
</tr>
<tr>
<td>CH 2011-12</td>
<td>71.3</td>
<td>50.7</td>
<td>58.0</td>
<td>47.4</td>
<td>73.9</td>
<td>67.7</td>
<td>61.5</td>
<td>na</td>
<td>60.3</td>
</tr>
<tr>
<td>Source: tables 16A.9–16A.11.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><em>Priority access to those in greatest need</em> – proportion of new allocations of housing to those in greatest need (%)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Data comparability and completeness vary for this indicator.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PH 2011-12</td>
<td>65.6</td>
<td>70.8</td>
<td>96.4</td>
<td>55.2</td>
<td>83.1</td>
<td>94.9</td>
<td>94.0</td>
<td>56.5</td>
<td>74.2</td>
</tr>
<tr>
<td>SOMIH 2011-12</td>
<td>31.0</td>
<td>..</td>
<td>93.8</td>
<td>..</td>
<td>90.5</td>
<td>na</td>
<td>..</td>
<td>..</td>
<td>55.7</td>
</tr>
<tr>
<td>CH 2011-12</td>
<td>69.7</td>
<td>83.5</td>
<td>62.4</td>
<td>75.4</td>
<td>45.3</td>
<td>86.6</td>
<td>97.8</td>
<td>na</td>
<td>72.0</td>
</tr>
<tr>
<td><strong>Effectiveness indicators</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><em>Dwelling condition</em></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Proportion of households with at least four working facilities and not more than two major structural problems (%)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Data for this indicator are not directly comparable.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PH 2012</td>
<td>67.7</td>
<td>73.7</td>
<td>83.5</td>
<td>75.9</td>
<td>81.7</td>
<td>76.2</td>
<td>76.6</td>
<td>81.6</td>
<td>74.7</td>
</tr>
<tr>
<td>± 1.3</td>
<td>± 4.0</td>
<td>± 3.0</td>
<td>± 3.8</td>
<td>± 3.6</td>
<td>± 3.9</td>
<td>± 3.3</td>
<td>± 3.3</td>
<td>± 0.9</td>
<td></td>
</tr>
<tr>
<td>SOMIH 2012</td>
<td>56.4</td>
<td>..</td>
<td>69.9</td>
<td>..</td>
<td>56.9</td>
<td>64.9</td>
<td>..</td>
<td>..</td>
<td>61.4</td>
</tr>
<tr>
<td>± 3.6</td>
<td>± 4.6</td>
<td>± 6.6</td>
<td>± 8.2</td>
<td>± 3.3</td>
<td>± 3.3</td>
<td>± 2.5</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CH 2012</td>
<td>81.4</td>
<td>87.1</td>
<td>89.4</td>
<td>89.1</td>
<td>86.1</td>
<td>84.4</td>
<td>80.2</td>
<td>na</td>
<td>85.2</td>
</tr>
<tr>
<td>± 2.3</td>
<td>± 3.5</td>
<td>± 3.1</td>
<td>± 3.2</td>
<td>± 3.6</td>
<td>± 3.6</td>
<td>± 7.7</td>
<td>± 1.3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Source: tables 16A.15–16A.17.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><em>Dwellings in need of repair (%)&lt;sup&gt;c&lt;/sup&gt;</em></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ICH 2006</td>
<td>18.8</td>
<td>24.7</td>
<td>26.3</td>
<td>27.9</td>
<td>22.4</td>
<td>30.6</td>
<td>..</td>
<td>21.0</td>
<td>23.4</td>
</tr>
<tr>
<td><em>Dwellings in need of replacement (%)&lt;sup&gt;c&lt;/sup&gt;</em></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ICH 2006</td>
<td>2.7</td>
<td>4.5</td>
<td>5.9</td>
<td>10.1</td>
<td>5.8</td>
<td>–</td>
<td>..</td>
<td>10.2</td>
<td>7.2</td>
</tr>
<tr>
<td>Source: table 16A.18.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Efficiency indicators</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><em>Net recurrent cost per dwelling ($)</em></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Data comparability and completeness vary for this indicator.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PH 2011-12</td>
<td>7 429</td>
<td>5 884</td>
<td>8 294</td>
<td>9 762</td>
<td>7 604</td>
<td>8 194</td>
<td>8 736</td>
<td>14 912</td>
<td>7 707</td>
</tr>
<tr>
<td>SOMIH 2011-12</td>
<td>7 913</td>
<td>..</td>
<td>13 515</td>
<td>..</td>
<td>13 180</td>
<td>7 390</td>
<td>..</td>
<td>..</td>
<td>10 682</td>
</tr>
<tr>
<td>CH 2010-11</td>
<td>9 356</td>
<td>9 417</td>
<td>5 345</td>
<td>5 400</td>
<td>6 629</td>
<td>15 699</td>
<td>10 971</td>
<td>na</td>
<td>8 149</td>
</tr>
<tr>
<td>ICH 2010-11</td>
<td>10 656</td>
<td>4 851</td>
<td>5 538</td>
<td>9 063</td>
<td>na</td>
<td>4 960</td>
<td>na</td>
<td>na</td>
<td>7 327</td>
</tr>
<tr>
<td>Source: tables 16A.20–16A.23.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(Continued)
### Table G.2 (continued)

<table>
<thead>
<tr>
<th></th>
<th>NSW</th>
<th>Vic</th>
<th>Qld</th>
<th>WA</th>
<th>SA</th>
<th>Tas</th>
<th>ACT</th>
<th>NT</th>
<th>Aust</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Occupancy rates (%)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Data comparability and completeness vary for this indicator.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PH 2011-12</td>
<td>98.9</td>
<td>96.9</td>
<td>98.6</td>
<td>96.3</td>
<td>96.0</td>
<td>97.3</td>
<td>98.6</td>
<td>95.4</td>
<td>97.7</td>
</tr>
<tr>
<td>SOMIH 2011-12</td>
<td>97.7</td>
<td>..</td>
<td>95.2</td>
<td>..</td>
<td>96.0</td>
<td>96.8</td>
<td>..</td>
<td>..</td>
<td>96.5</td>
</tr>
<tr>
<td>CH 2011-12</td>
<td>98.1</td>
<td>94.4</td>
<td>95.7</td>
<td>92.8</td>
<td>97.0</td>
<td>90.9</td>
<td>92.7</td>
<td>100.0</td>
<td>96.2</td>
</tr>
<tr>
<td>ICH 2010-11</td>
<td>96.2</td>
<td>95.4</td>
<td>97.0</td>
<td>79.8</td>
<td>78.8</td>
<td>89.8</td>
<td>na</td>
<td>na</td>
<td>91.6</td>
</tr>
<tr>
<td><strong>Turnaround time (days)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Data for this indicator are comparable and complete, subject to caveats.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PH 2011-12</td>
<td>28.9</td>
<td>31.9</td>
<td>28.6</td>
<td>22.3</td>
<td>24.6</td>
<td>37.0</td>
<td>37.1</td>
<td>60.1</td>
<td>28.8</td>
</tr>
<tr>
<td>SOMIH 2011-12</td>
<td>23.1</td>
<td>..</td>
<td>47.2</td>
<td>..</td>
<td>24.7</td>
<td>53.5</td>
<td>..</td>
<td>..</td>
<td>29.9</td>
</tr>
<tr>
<td><strong>Rent collection rate (%)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Data comparability and completeness vary for this indicator.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PH 2011-12</td>
<td>99.1</td>
<td>98.5</td>
<td>99.4</td>
<td>100.7</td>
<td>100.3</td>
<td>98.6</td>
<td>99.7</td>
<td>99.0</td>
<td>99.3</td>
</tr>
<tr>
<td>SOMIH 2011-12</td>
<td>100.0</td>
<td>..</td>
<td>100.6</td>
<td>..</td>
<td>100.7</td>
<td>98.6</td>
<td>..</td>
<td>..</td>
<td>100.5</td>
</tr>
<tr>
<td>CH 2010-11</td>
<td>96.5</td>
<td>99.2</td>
<td>101.6</td>
<td>99.1</td>
<td>98.1</td>
<td>na</td>
<td>99.1</td>
<td>na</td>
<td>97.9</td>
</tr>
<tr>
<td>ICH 2010-11</td>
<td>100.7</td>
<td>100.1</td>
<td>93.0</td>
<td>88.7</td>
<td>na</td>
<td>98.2</td>
<td>na</td>
<td>71.2</td>
<td>94.9</td>
</tr>
<tr>
<td><strong>Amenity/location (%)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Data comparability and completeness vary for this indicator.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PH 2012</td>
<td>80.1</td>
<td>82.1</td>
<td>89.1</td>
<td>84.7</td>
<td>84.5</td>
<td>82.6</td>
<td>82.9</td>
<td>87.2</td>
<td>83.4</td>
</tr>
<tr>
<td>SOMIH 2012</td>
<td>79.6</td>
<td>..</td>
<td>85.4</td>
<td>..</td>
<td>81.6</td>
<td>82.0</td>
<td>..</td>
<td>..</td>
<td>82.2</td>
</tr>
<tr>
<td>CH 2012</td>
<td>84.2</td>
<td>82.5</td>
<td>84.7</td>
<td>85.1</td>
<td>89.0</td>
<td>88.6</td>
<td>82.5</td>
<td>na</td>
<td>84.7</td>
</tr>
<tr>
<td><strong>Location important and meeting needs (%)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PH 2012</td>
<td>85.8</td>
<td>87.3</td>
<td>91.0</td>
<td>87.6</td>
<td>90.9</td>
<td>85.9</td>
<td>88.0</td>
<td>90.1</td>
<td>87.9</td>
</tr>
<tr>
<td>SOMIH 2012</td>
<td>86.9</td>
<td>..</td>
<td>85.2</td>
<td>..</td>
<td>89.8</td>
<td>85.2</td>
<td>..</td>
<td>..</td>
<td>86.8</td>
</tr>
<tr>
<td>CH 2012</td>
<td>86.3</td>
<td>88.1</td>
<td>87.7</td>
<td>87.5</td>
<td>87.9</td>
<td>91.5</td>
<td>90.6</td>
<td>na</td>
<td>87.3</td>
</tr>
<tr>
<td><strong>Affordability – proportion of low income households spending more than 30 per cent of their gross income on rent (%)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Data comparability and completeness vary for this indicator.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PH 2011-12</td>
<td>0.2</td>
<td>0.7</td>
<td>1.3</td>
<td>0.1</td>
<td>0.7</td>
<td>1.8</td>
<td>0.4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>SOMIH 2011-12</td>
<td>0.5</td>
<td>..</td>
<td>1.1</td>
<td>..</td>
<td>..</td>
<td>..</td>
<td>0.7</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CH 2011-12</td>
<td>3.8</td>
<td>na</td>
<td>5.0</td>
<td>3.6</td>
<td>26.5</td>
<td>na</td>
<td>3.5</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Source: tables 16A.24–16A.27.

(Continued)
Table G.2  (continued)

| Match of dwelling to household size – proportion of overcrowded households (%) |
|-----------------|-----------------|-----------------|-----------------|-----------------|-----------------|-----------------|-----------------|-----------------|
|                  | NSW             | Vic             | Qld             | WA              | SA              | Tas             | ACT             | NT              | Aust            |
| PH 2011-12       | 4.4             | 4.2             | 4.8             | 4.9             | 2.3             | 4.4             | 4.9             | 8.0             | 4.3             |
| SOMIH 2011-12    | 7.6             | ..              | 13.2            | ..              | 9.5             | 6.0             | ..              | ..              | 9.8             |
| CH 2011-12       | 3.3             | 2.9             | na              | 1.7             | 2.5             | 1.4             | 0.4             | na              | 2.8             |
| ICH 2010-11      | na              | 5.7             | 13.9            | 32.9            | 52.0            | na              | na              | na              | na              |

Source: tables 16A.47–16A.50.

Customer satisfaction (%) – proportion of tenants who were satisfied or very satisfied with the services provided by their State or Territory housing authority or community housing organisation.

<table>
<thead>
<tr>
<th></th>
<th>PH 2012</th>
<th>SOMIH 2012</th>
<th>CH 2012</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>± 1.4</td>
<td>± 3.6</td>
<td>± 2.7</td>
</tr>
<tr>
<td></td>
<td>± 4.1</td>
<td>± 4.5</td>
<td>± 4.5</td>
</tr>
<tr>
<td></td>
<td>± 3.1</td>
<td>± 6.4</td>
<td>± 3.9</td>
</tr>
<tr>
<td></td>
<td>± 4.3</td>
<td>± 8.1</td>
<td>± 4.2</td>
</tr>
<tr>
<td></td>
<td>± 3.9</td>
<td>± 2.5</td>
<td>± 3.5</td>
</tr>
<tr>
<td></td>
<td>± 4.2</td>
<td>± 3.7</td>
<td>± 3.7</td>
</tr>
<tr>
<td></td>
<td>± 3.5</td>
<td>± 1.0</td>
<td>± 1.0</td>
</tr>
<tr>
<td></td>
<td>± 3.7</td>
<td>± 58.5</td>
<td>± 58.5</td>
</tr>
<tr>
<td></td>
<td>± 4.1</td>
<td>± 6.4</td>
<td>± 6.4</td>
</tr>
<tr>
<td></td>
<td>± 3.9</td>
<td>± 8.1</td>
<td>± 8.1</td>
</tr>
<tr>
<td></td>
<td>± 4.2</td>
<td>± 3.7</td>
<td>± 3.7</td>
</tr>
<tr>
<td></td>
<td>± 3.5</td>
<td>± 1.0</td>
<td>± 1.0</td>
</tr>
</tbody>
</table>

Source: tables 16A.36, 16A.55 and 16A.56.

a Caveats for these data are available in Chapter 16 and Attachment 16A. Refer to the indicator interpretation boxes in chapter 16 for information to assist with the interpretation of data presented in this table. b Some data are derived from detailed data in Chapter 16 and Attachment 16A. c NSW data includes ACT. na Not available. .. Not applicable. – Nil or rounded to zero.

Source: Chapter 16 and Attachment 16A.

Homelessness services

The performance indicator framework for government funded specialist homelessness services is presented in figure G.7. This framework provides information on equity, efficiency, and outcomes of homelessness services.

The introduction of the new specialist homelessness services collection (SHSC) from 1 July 2011 has presented an opportunity to review and re-develop the framework of performance indicators and supporting measures for government funded specialist homelessness services.

The key changes from the SAAP-based framework (see Chapter 17) are:

- the introduction of a new indicator in the framework’s ‘outcomes’ domain (‘repeat periods of homelessness’)
- the consolidation of indicators for special needs groups (Indigenous and NESB) as performance measures under a single indicator ‘access of special needs groups to homelessness services’.
Although some indicator names remain the same, many supporting measures have been revised. While there is broad consistency in the aspects of homelessness on which data are collected, many of the differences between the two collections limit the ability to directly compare data across these collections.

Figure G.7  
**Government funded specialist homelessness services performance indicator framework**

An overview of the performance indicator results for 2011-12 is presented in table G.3. Data reported are for homelessness services provided under the NAHA and NPAH and are sourced from the SHSC. Information to assist the interpretation of these data can be found in the indicator interpretation boxes in chapter 17 and in the footnotes in attachment 17A.

Data from the last year of the SAAP data collection (2010-11) are also included in the Homelessness services attachment tables (tables 17A.30–59).
Table G.3  **Performance indicators for government funded specialist homelessness services, 2011-12.**

<table>
<thead>
<tr>
<th>Equity (access) indicators</th>
<th>NSW</th>
<th>Vic</th>
<th>Qld</th>
<th>WA</th>
<th>SA</th>
<th>Tas</th>
<th>ACT</th>
<th>NT</th>
<th>Aust</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Access of special needs groups to homelessness services</strong> — <strong>Access of Indigenous people to homelessness services and their representation in the community</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Data for this indicator comparable, subject to caveats.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Representation among clients whose accommodation needs were met</td>
<td>2011-12</td>
<td>%</td>
<td>23.3</td>
<td>10.3</td>
<td>30.3</td>
<td>41.0</td>
<td>na</td>
<td>14.8</td>
<td>16.9</td>
</tr>
<tr>
<td>Representation among clients whose need for services other than accommodation was met</td>
<td>2011-12</td>
<td>%</td>
<td>21.1</td>
<td>7.0</td>
<td>27.4</td>
<td>31.9</td>
<td>na</td>
<td>14.8</td>
<td>14.1</td>
</tr>
<tr>
<td>Representation in the community</td>
<td>2011</td>
<td>%</td>
<td>2.9</td>
<td>0.9</td>
<td>4.2</td>
<td>3.8</td>
<td>2.3</td>
<td>4.7</td>
<td>1.7</td>
</tr>
</tbody>
</table>

Source: table 17A.4 and 17A.6.

| **Access of special needs groups to homelessness services** — **Access of people from non-English speaking backgrounds to homelessness services and their representation in the community** | | | | | | | | | |
| Data for this indicator comparable, subject to caveats. | | | | | | | | | |
| Representation among clients whose accommodation needs were met | 2011-12 | % | 11.0 | 12.5 | 6.8 | 10.5 | na | 4.0 | 14.9 | 4.2 | 9.9 |
| Representation among clients whose need for services other than accommodation was met | 2011-12 | % | 9.9 | 11.0 | 6.6 | 10.9 | na | 4.1 | 14.8 | 3.8 | 9.6 |
| Representation in the community | 2011 | % | 18.6 | 19.6 | 9.5 | 14.4 | 12.7 | 5.1 | 16.8 | 10.3 | 15.7 |

Source: table 17A.5 and 17A.6.

| Effectiveness indicators | | | | | | | | | |
| **Development of a case management plan** | | | | | | | | | |
| Data for this indicator comparable, subject to caveats. | | | | | | | | | |
| 2011-12 | % | 71.5 | 50.8 | 72.3 | 72.1 | 54.5 | 68.5 | 72.3 | 72.4 | 63.1 |

| **Match of needs of clients (provided and referred)** | | | | | | | | | |
| Data for this indicator comparable, subject to caveats. | | | | | | | | | |
| 2011-12 | % | 98.9 | 96.6 | 96.7 | 99.2 | na | 97.1 | 93.0 | 98.4 | 97.4 |

Source: tables 17A.9 and 17A.11.

| Efficiency indicators | | | | | | | | | |
| **Cost per completed support period** | | | | | | | | | |
| Data for this indicator not complete or not directly comparable. | | | | | | | | | |
| 2011-12 | $ | 2 123 | 901 | 1 733 | 2 502 | 2 388 | 2 282 | 3 418 | 1 395 | 1 632 |

| **Cost per client** | | | | | | | | | |
| Data for this indicator not complete or not directly comparable. | | | | | | | | | |
| 2011-12 | $ | 2 462 | 1 459 | 2 116 | 3 126 | 2 972 | 2 747 | 3 562 | 1 624 | 2 212 |

(Continued)
Table G.3  (continued)

<table>
<thead>
<tr>
<th>Cost per day of support</th>
</tr>
</thead>
<tbody>
<tr>
<td>NSW  Vic  Qld  WA  SA  Tas  ACT  NT  Aust</td>
</tr>
<tr>
<td>2011-12</td>
</tr>
</tbody>
</table>

Data for this indicator not complete or not directly comparable.

Source: Tables 17A.15, 17A.16 and 17A.17.

Outcome indicators

Achievement of employment on exit (proportion of clients who needed employment and/or training assistance who were employed after support)

Data for this indicator comparable, subject to caveats.

| 2011-12 | % | 18.1 | 12.0 | 13.5 | 16.9 | na | 10.3 | 16.4 | 23.5 | 15.9 |

Source: table 17A.22.

Achievement of income on exit (proportion of clients who needed income assistance who had an income source after support)

Data for this indicator comparable, subject to caveats.

| 2011-12 | % | 96.0 | 97.0 | 95.9 | 95.3 | na | 93.3 | 95.2 | 96.0 | 96.0 |

Source: table 17A.27.

Achievement of independent housing on exit (proportion of clients who needed assistance to obtain or maintain independent housing who obtained or maintained independent housing after support)

Data for this indicator comparable, subject to caveats.

| 2011-12 | % | 43.1 | 36.4 | 43.3 | 57.1 | na | 39.4 | 37.3 | 38.6 | 41.9 |

Source: table 17A.18.

Proportion of people experiencing repeat periods of homelessness

Data for this indicator comparable, subject to caveats.

| 2011-12 | % | 8.8 | 7.5 | 7.8 | 6.9 | 4.8 | 8.4 | 13.2 | 7.1 | 7.3 |

Source: table 17A.25.

Case management goals achieved on exit of service (proportion of clients who achieved some or all case management goals)

Data for this indicator comparable, subject to caveats.

| 2011-12 | % | 91.4 | 92.0 | 91.0 | 90.5 | 69.9 | 89.7 | 90.1 | 95.3 | 89.7 |

Source: table 17A.29.

\(^{a}\) Caveats for these data are available in Chapter 17 and Attachment 17A. Refer to the indicator interpretation boxes in chapter 17 for information to assist with the interpretation of data presented in this table. \(^{b}\) Some data are derived from detailed data in Chapter 17 and Attachment 17A. \(^{na}\) Not available. – Nil or rounded to zero.

Source: Chapter 17 and Attachment 17A.

G.3 Cross-cutting and interface issues

Australian and international research identifies a strong association between housing, health status, living standards and well-being (Morris 2010; Bridge et al. 2003; Quine et al. 2004; Waters 2001). A lack of adequate and affordable
housing contributes to housing stress and homelessness, and is detrimental to people’s physical and mental health. People who are homeless have a much higher prevalence of mental illness than the general population (Mental Health Council of Australia 2009). Homelessness affects life expectancy, with homeless people estimated to live 15–20 years less than the mainstream population (Quine et al 2004).

The provision of housing assistance and homelessness services can improve people’s education, health and employment outcomes, community cohesion and reduce crime (King 2002; Bridge et al 2003; AHURI 2008; Morris 2010).

Studies have found that housing assistance affects education outcomes by reducing housing costs and increasing financial resources available for education and training, and providing security of tenure to create stable learning environment (Bridge et al 2003). Conversely, housing assistance may reduce the incentives to participate in the labour market, with security of tenure reducing willingness to relocate for employment purposes (Bridge et al 2003).

There is evidence to suggest that effective housing assistance programs reduce the burden on health and justice services, leading to reduced expenditure for hospital, ambulance, police and court services (AHURI 2008).

**National research developments**

The National Homelessness Research Agenda 2009–2013 was released on 20 November 2009. The Agenda provides a framework for building an evidence base to prevent and respond to homelessness. It reflects the Australian Government’s strategic research priorities and lists key research questions for the development of an evidence base to drive reform (FaHCSIA 2010).

The Australian Housing and Urban Research Institute’s (AHURI) 2013 national research agenda is structured around five high priority topics for housing policy development, including the integration of housing assistance and social support; and comparing cost effectiveness and client outcomes in the multi-provider social housing system. In addition, eight strategic research issues are identified and research responding to these strategic issues will assist national housing policy development.
G.4 Future directions in performance reporting

This housing and homelessness sector overview will continue to be developed in future reports.

The Housing and Homelessness services chapters contain a service-specific section on future directions in performance reporting.
G.5 List of attachment tables

Attachment tables are identified in references throughout this service sector overview by a ‘GA’ prefix (for example, table GA.1). Attachment tables are provided on the Review website (www.pc.gov.au/gsp). Users without access to the website can contact the Secretariat to obtain the attachment tables (see contact details on the inside front cover of the Report).

Table GA.1  Australian Government nominal expenditure relating to the National Affordable Housing Agreement (NAHA) and Nation Building Economic Stimulus Package ($million)
Table GA.2  Housing and homelessness services sector, descriptive statistics, Australia, 2010-11
Table GA.3  Social housing descriptive statistics, 2010-11
Table GA.4  Homelessness services descriptive statistics, 2010-11
Table GA.5  Proportion of low income households in rental stress
Table GA.6  Proportion of Indigenous households living in overcrowded conditions
Table GA.7  Proportion of Indigenous households living in houses of an acceptable standard, 2012
Table GA.8  Australians who are homeless, 2011
Table GA.9  Supplementary contextual data
Table GA.10 Moving annual vacancy rates in the private housing market, by capital city, June (per cent)
Table GA.11 Median market rents in the private housing market, by capital city, June quarter (dollars/week)
Table GA.12 Australian Government expenditure for Commonwealth Rent Assistance, 2007-08 to 2011-12 ($ million)
Table GA.13 Australian Government real expenditure for CRA, per person, 2007-08 to 2011-12 (2011-12 dollars)
Table GA.14 Eligibility and payment scales for CRA, 2012 ($ per fortnight)
Table GA.15 Income units receiving CRA, 2012
Table GA.16 Number of income units receiving CRA, by age, 2012
Table GA.17 Indigenous income units receiving CRA, 2012
Table GA.18 CRA income units, by payment type, 2012
Table GA.19 Indigenous CRA recipients, by payment type, 2012
Table GA.20 Geographic location of income units receiving CRA, 2012
Table GA.21 Income units receiving CRA, by special needs and geographic location, 2012
Table GA.22 Median CRA entitlement, by location, 2012
Table GA.23 Income units receiving CRA paying enough rent to be eligible for maximum assistance, by jurisdiction, 2008 to 2012 (per cent)
| Table GA.24 | Number and proportion of income units receiving CRA paying more than 30 per cent of income on rent, with and without CRA, by geographic location, 2007 to 2012 (per cent) |
| Table GA.25 | Proportion of income units receiving CRA, paying more than 30 per cent of income on rent, with and without CRA, 2003 to 2012 (per cent) |
| Table GA.26 | Proportion of Indigenous income units receiving CRA, paying more than 30 per cent of income on rent, with and without CRA, by geographic location, 2007 to 2012 (per cent) |
| Table GA.27 | Proportion of Indigenous income units receiving CRA, paying more than 30 per cent of income on rent, with and without CRA, 2003 to 2012 (per cent) |
| Table GA.28 | Proportion of income units receiving Disability Support Pension and CRA paying more than 30 per cent of income on rent, with and without CRA, by geographic location, 2007 to 2012 (per cent) |
| Table GA.29 | Proportion receiving a Disability Support Pension and CRA, paying more than 30 per cent of income on rent, with and without CRA, 2003 to 2012 (per cent) |
| Table GA.30 | Proportion of income units receiving CRA aged 24 years or under paying more than 30 per cent of income on rent, with and without CRA, by geographic location, 2007 to 2012 (per cent) |
| Table GA.31 | Proportion of income units receiving CRA aged 24 years or under paying more than 30 per cent of income on rent, with and without CRA, 2005 to 2012 (per cent) |
| Table GA.32 | Proportion of income units receiving CRA aged 75 years or over paying more than 30 per cent of income on rent, with and without CRA, by geographic location, 2007 to 2012 (per cent) |
| Table GA.33 | Proportion of income units receiving CRA aged 75 years or over paying more than 30 per cent of income on rent, with and without CRA, 2005 to 2012 (per cent) |
| Table GA.34 | Number and proportion of income units receiving CRA with more than 50 per cent of income spent on rent, with and without CRA, by special needs and geographic location, 2012 (per cent) |
G.6 Definitions of key terms

Commonwealth Rent Assistance

Affordability
Affordability (without CRA) is calculated for all income units receiving CRA by dividing Rent by Total Income from all sources. The CRA entitlement for the reference fortnight in June is included in Total Income from all sources for the calculation of affordability with CRA.

Dependent child
Dependent child has a wider meaning under Social Security and Family Assistance law than is used in this chapter in relation to CRA. In this chapter, a dependent child is one in respect of whom an adult member of the income unit receives Family Tax Benefit Part A (FTB (A)) at more than the base rate. Prior to 1 January 2012, children aged 16 or older attracted the base rate of FTB (A) so are not included in the count of dependent children. From January 2012 children aged 16 to 19 years attending secondary school may now receive more than the base rate of FTB (A). Figures for June 2012 do not include 16 to 19 years olds who receive more than the base rate of FTB (A). Some children aged under 16 years may also attract only the base rate of FTB (A) because of the maintenance income test, the maintenance action test, or because they are overseas.

Income support recipient
Recipients in receipt of a payment made under social security law. The main income support payments administered by FaHCSIA are Age Pension, Disability Support Pension and Carer Payment, while the main income support payments administered by Department of Education, Employment and Workplace Relations are Newstart Allowance, Youth Allowance, Austudy, Parenting Payment (Single) and Parenting Payment (Partnered).

Family Tax Benefit is paid under family assistance law and is not an income support payment.

Income unit
An income unit may consist of:
- a single person with no dependent children
- a sole parent with one or more dependent children
- a couple (married, registered or defacto) with no dependent children
- a couple (married, registered or defacto) with one or more dependent children.

A non-dependent child living at home, including one who is receiving an income support payment in their own right, is regarded as a separate income unit. Similarly, a group of non-related adults sharing accommodation are counted as separate income units.

Low and moderate incomes
Individuals and families receive CRA with either an income support payment or FBT Part A. While income support recipients are generally thought of as low income, those receiving FBT (A) can have higher incomes and still be eligible for a part rate of Rent Assistance. For this reason, CRA recipients are not defined as those on low incomes.

Primary payment type
Each income unit receiving CRA is assigned a primary payment type, based on the payment(s) received by each member. The primary payment is determined using a hierarchy of payment types, with precedence given to pensions, then other social security payments and then the Family Tax Benefit part A. No extra weight is given to the payment type with which CRA is paid. Specifically, the hierarchy for the main payments is:
- Disability Support Pension
- Carer Payment
- Age Pension
- Parenting Payment (Single)
- Newstart Allowance
- Youth Allowance
- Austudy
- Parenting Payment (Partnered)
- Family Tax Benefit part A.

**Rent**

Amount payable as a condition of occupancy of a person's home. Rent 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.

**Sharer**

Some single people are subject to a lower maximum (sharer) rate of CRA. The lower rate may apply to a single person (with no dependent children) who shares a major area of accommodation. The lower rate does not apply to those receiving Disability Support Pension or Carer Payment, those in nursing homes or boarding house accommodation, or those paying for both board and lodgings.

**Special needs**

Individuals and families with at least one member who either self-identifies as Indigenous; receives a Disability Support Pension; is aged 24 years or under; or is aged 75 years or over.

**Total income from all sources**

Income received by the recipients or partner, excluding income received by a dependent. It includes regular social security payments and any maintenance and other private income taken into account for income testing purposes. It does not include:

- one-time payments
- arrears payments
- advances
- Employment or Education Entry Payments
- Mobility Allowance
- Baby Bonus
- Child Care Tax 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 part A but no income support payment.
G.7 Appendix – Private housing market contextual information

Housing market demand, supply and affordability

The private housing market encompasses rented accommodation, home ownership and housing investment. A range of factors influence demand and supply in the private housing market:

- Factors affecting the demand for housing include population growth, household formation, household income and employment, investor demand, household preferences for size, quality and location of housing, the price and availability of housing, government taxes, concessions and transfers, and the cost and availability of finance (NHSC 2010).

- Factors affecting the supply of housing include land tenure arrangements, land release and development processes, construction and infrastructure costs, government taxes, concessions and transfers, and the availability and price of land (NHSC 2010). The availability of credit to finance the development of new housing can also affect the supply of housing (RBA 2009).

An efficient housing market refers to achieving a balance between housing supply and demand (CRC 2010). Nationally in 2009, there was an estimated cumulative gap between underlying demand for housing and housing supply, as a proportion of growth in underlying demand, of 14.7 per cent. A estimated 178 400 dwellings were required in Australia to meet growth in demand (NHSC 2012: tables 7.2 and 7.3).

Housing affordability

A shortage of affordable housing is likely to affect demand for housing and homelessness services. Governments provide support to ensure people can access affordable rental housing, either in the private market or in social housing, and many governments provide support to those purchasing houses, particularly first home buyers (box G.7).
Box G.7 **Government assistance for affordable housing**

A range of government initiatives and programs are designed to help households to pay for housing, and to increase the supply of affordable housing. These initiatives include:

- direct assistance to first home buyers through schemes such as the First Home Owners Grant and the First Home Owners Boost. These schemes are funded by the Australian Government and administered by State and Territory governments
- funding for Indigenous home ownership programs (the Home Ownership Program funded and administered by Indigenous Business Australia and the Home Ownership on Indigenous Land Program jointly funded by FaHCSIA and IBA)
- stamp duty concessions or exemptions for first home buyers
- incentives to save for first home ownership through First Home Saver Accounts
- State and Territory Government funding to assist low income households with home purchases or mortgage repayments
- Commonwealth Rent Assistance paid on an ongoing basis to income support and family tax benefit recipients in the private rental market and community housing
- funding for provision and management of social (public and community) housing and related reforms through the National Affordable Housing Agreement
- incentives for institutional investors and community housing providers to build new affordable rental properties
- Commonwealth, State and Territory land and planning measures to increase the supply of affordable housing
- Housing Affordability Fund grants to improve planning and infrastructure provision.

*Source: Australian, State and Territory Governments (unpublished).*

The Housing chapter (chapter 16) reports on government assistance for social housing, but does not report on government assistance for purchasing housing or other forms of housing assistance. Information on housing affordability by region in Australia is available in the State of the Regions Report 2011–12: the housing shortage and housing affordability (ALGA 2011). The Steering Committee’s annual report to the COAG Reform Council on NAHA performance information includes a range of housing data, some of which are reported below.

**Affordable housing for low and moderate income households**

Low income households are more likely to be adversely affected by relatively high housing costs than households with higher disposable incomes (Yates and Gabriel 2006; Yates and Milligan 2007).
Housing stress is considered to occur when households spend more than 30 per cent of their income on rent or mortgage payments. Nationally in 2009-10, 41.7 per cent of low income households were experiencing rental stress (tables GA.5).

The number of homes sold that are affordable by low and moderate income households per 1,000 low or moderate income households indicates the level of home purchase affordability. Nationally in 2009-10, 35.5 homes sold were affordable by low and moderate income households per 1000 low or moderate income households (table GA.9).

**Private rental markets**

Tight private rental markets were evident in June 2012, with vacancy rates in capital cities ranging between 1.6 per cent and 3.7 per cent (table GA.10). Capital city median rents in the private market varied across jurisdictions. Data for median rents for three bedroom houses and two bedroom flats or units in capital cities in the June quarter of 2012 are reported in table GA.11.

**Home ownership and government assistance to home buyers**

In 2009-10, 68.8 per cent of Australian households owned or were purchasing a home (table GA.9). Home ownership is not necessarily an aspiration for all Australian households, but is often considered desirable because of the benefits associated with home ownership, including wealth accumulation and security of tenure (CRC 2010, p. 60). The rate of home ownership in Australia is similar to many developed countries, but is comparatively higher than some European countries, which may reflect different cultural and economic incentives, such as income security for retirement (ABS 2010b; Frick and Headey 2009).

Governments provide financial assistance to people purchasing homes, particularly first home owners and low income home owners. Nationally in 2011-12, 100 879 people received the First Home Owner Scheme grant (table GA.9).


G.8 References


—— 2012, *Children and young people at risk of social exclusion: links between homelessness, child protection and juvenile justice*, Data linkage series no. 13 Cat. no. CSI 13, Canberra.


Waters, A.M., 2001, *Do housing conditions impact on health inequalities between Australia’s rich and poor?* Final Report no.4, Australia Housing and Urban Research Institute, Melbourne.


16 Housing

CONTENTS

16.1 Profile of housing assistance 16.5
16.3 Key performance indicator results 16.16
16.4 Future directions in performance reporting 16.49
16.5 Jurisdictions’ comments 16.49
16.6 Definitions of key terms 16.59
16.7 List of attachment tables 16.62
16.8 References 16.65

Attachment tables
Attachment tables are identified in references throughout this chapter by a ‘16A’ prefix (for example, table 16A.1). A full list of attachment tables is provided at the end of this chapter, and the attachment tables are available on the Review website at www.pc.gov.au/gsp.

Governments play a significant role in the Australian housing market, directly through housing assistance and indirectly through policies associated with land planning and taxation. Direct assistance includes social housing, home purchase assistance and rent assistance. Housing assistance is provided by governments because many Australian households face problems in acquiring or accessing suitable private accommodation — either through renting from a private landlord or through owner occupation — for reasons of cost, discrimination, availability, location and/or adequacy. The Australian, State and Territory governments share responsibility for housing assistance.
This chapter focuses on the performance of governments in providing social housing, which broadly encompasses public housing, State owned and managed Indigenous housing, community housing, and Indigenous community housing. These services are outlined in box 16.1.

Box 16.1 Forms of social housing

Social housing is rental housing provided by not-for-profit, non-government or government organisations to assist people who are unable to access suitable accommodation in the private rental market. The forms of social housing included in this Report are:

- **Public housing (PH):** dwellings owned (or leased) and managed by State and Territory housing authorities to provide affordable rental accommodation.
- **State owned and managed Indigenous housing (SOMIH):** dwellings owned and managed by State housing authorities that are allocated only to Indigenous households.
- **Community housing (CH):** rental housing provided for low to moderate income and/or special needs households, managed by community-based organisations that have received a capital or recurrent subsidy from government. Community housing models vary across jurisdictions, and the housing stock may be owned by a variety of groups including government.
- **Indigenous community housing (ICH):** dwellings owned or leased and managed by ICH organisations and community councils in major cities, regional and remote areas. Indigenous community housing models vary across jurisdictions and can also include dwellings funded or registered by government.

*Crisis and transitional housing* is an additional form of social housing, but it is not separately identified in this Report. Crisis and transitional housing might be indirectly reported through the other forms of social housing described above. Development work is underway to enable better reporting on this form of housing assistance.

Social housing is provided under the National Affordable Housing Agreement (NAHA). The NAHA is the overarching agreement between Australian, State and Territory governments for providing assistance to improve housing outcomes for Australian people. Prior to commencement of the NAHA on 1 January 2009, social housing was provided under the Commonwealth State Housing Agreement (CSHA) (box 16.2).
The NAHA commenced on 1 January 2009 as part of the Intergovernmental Agreement on Federal Financial Relations. It is a broad, ongoing agreement that provides a framework to improve housing affordability and homelessness outcomes for Australians. The objective of the NAHA is that all Australians have access to affordable, safe and sustainable housing that contributes to social and economic participation (COAG 2009).

In relation to housing assistance, the parties to the NAHA agreed to the achievement of a range of outcomes including:

• people who are homeless or at risk of homelessness achieve sustainable housing and social inclusion
• people are able to rent housing that meets their needs
• people can purchase affordable housing
• people have access to housing through an efficient and responsive housing market
• Indigenous people have improved housing amenity and reduced overcrowding, particularly in remote areas and discrete communities

The NAHA replaced the CSHA, which concluded on 31 December 2008.

Source: FaCS (2003); COAG (2009).

Links to other government services

Close links exist between social housing and other government programs and support services discussed elsewhere in the Report, such as:

• assistance to people who are homeless or at risk of homelessness, in the Homelessness services chapter (chapter 17)
• Commonwealth Rent Assistance (CRA), in the Housing and Homelessness sector overview G
• various health and community services, including Mental health management (chapter 12), Aged care services (chapter 13) and Services for people with disability (chapter 14).
Improvements in the 2013 Report

Major improvements in the chapter this year are:

- data for public housing, SOMIH and community housing for the indicator 'dwelling condition' are published for the first time based on the 2012 National Social Housing Survey (NSHS)
- updated data for the indicator ‘amenity/location’. These are also based on the 2012 NSHS and were last updated for the 2011 Report
- ‘data quality information’ (DQI) is available for the first time for the indicators ‘net recurrent cost per dwelling’ and ‘rent collection rate’ for public housing and SOMIH.

Data sources

This Report presents data for up to 10 years, reflecting housing assistance provided under the NAHA and the CSHA. Data from 2009-10 onward relate to the NAHA, data for 2008-09 relate to both the NAHA and CSHA, and data for 2007-08 and preceding years relate to the CSHA.

Social housing data reported in this chapter were obtained from State and Territory governments, except where otherwise indicated. The Australian Institute of Health and Welfare (AIHW) collects, collates and publishes these data in the Housing assistance in Australia publication.

Housing assistance not reported

The focus of this chapter is social housing. A range of government housing assistance is not reported in this chapter, including:

- services and programs for people who are homeless or at risk of homelessness, including CRA, reported in Chapter 17 and in the Housing and homelessness sector overview G
- crisis and transitional housing (unless it is indirectly reported through the other forms of social housing)
- community housing and other housing programs not provided under the NAHA, such as 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, Employment and Workplace Relations (DEEWR)
- private rent assistance funded by State and Territory governments
• the National Rental Affordability Scheme (NRAS) and the Housing Affordability Fund (although some NRAS dwellings are included in the community housing data collection because they are owned and managed by the community housing sector)

• some Indigenous specific housing and infrastructure assistance (such as the Home Ownership Program funded and administered by Indigenous Business Australia (IBA) and the Home Ownership on Indigenous Land Program jointly funded by FaHCSIA and IBA)

• home purchase assistance, such as first home owner grants.

16.1 Profile of housing assistance

Service overview

The Australian Bureau of Statistics (ABS) Survey of Income and Housing 2009-10 identified 8.4 million households in Australia, where ‘household’ is classified as ‘a person living alone’ or as a group of people who usually live in the same private dwelling (ABS 2011). Of these households, 68.8 per cent owned or were purchasing their own home, 23.7 per cent rented in the private sector, and 3.9 per cent rented from public rental accommodation (table 16A.57).

The composition of Australian households is changing. There are 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 2.6 people between 1971 and 2011, while the proportion of single person households increased from 18.1 per cent to 24.3 per cent over this period (ABS 2012).

The average Indigenous household is larger than the average non-Indigenous household. In 2011, the average household with at least one Indigenous Australian was 3.3 people, whereas the average non-Indigenous household was 2.6 people (ABS 2012).

Roles and responsibilities

Australian, State and Territory governments share responsibility for housing assistance provided under the NAHA, as they did under the CSHA. Each level of government has different roles and responsibilities:
• The Australian Government influences the housing market through direct and indirect means, including providing CRA, home purchase assistance, financial sector regulations and taxation. Further information on CRA can be found in the Housing and homelessness sector overview G and attachment GA (tables GA.12–GA.34).

• State and Territory governments administer and deliver housing services, such as public housing, community housing, SOMIH and other Indigenous housing. They also provide financial support to renters through private rental assistance and to buyers through home purchase assistance, and some jurisdictions provide home finance lending programs. State and Territory governments are also responsible for land use and supply policy, urban planning and development policy, housing-related taxes and charges (such as land taxes and stamp duties) and residential tenancy legislation and regulation.

• Local governments are mostly responsible for building approval, urban planning and development processes and may be involved in providing community housing.

**Government funding and expenditure**

State and Territory government net recurrent expenditure on social housing was $3.9 billion in 2011-12, decreasing from $5.1 billion in 2010-11 (2011-12 dollars) (table 16.1). In 2011-12, this expenditure included $2.6 billion for public housing and $107.3 million for SOMIH (table 16A.1).

The Australian Government provided $2.2 billion in 2011-12 to State and Territory governments for housing assistance through the National Affordable Housing Specific Purpose Payment (NAH SPP) and related National Partnership agreements. NAH SPP funding is outcome based and not tied to specific programs, and Australian Government funding is reflected in data for State and Territory government net recurrent expenditure.

The Australian Government also provided $3.4 billion for CRA (table GA.11). Further information on CRA can be found in the Housing and homelessness sector overview G and attachment GA (tables GA.12–GA.34).
Governments provide funding for the construction of social housing dwellings. The Australian Government provided $162 million for the social housing initiative component of the Nation Building Economic Stimulus Package, to aid the construction of new social housing dwellings, and repairs and maintenance of existing dwellings in 2011-12 (table GA.1). State and Territory government capital expenditure for social housing was $2.2 billion in 2011-12, which was partly funded by the Australian Government through the NAH SPP and the Nation Building Economic Stimulus Package (table 16A.1).

Size and scope

Public housing

Public housing comprises those dwellings owned (or leased) and managed by State and Territory housing authorities. Public housing is generally provided to people on low incomes and to those with special needs, and aims to provide a choice of housing location, physical type and management arrangements. Nationally at 30 June 2012, there were 323 423 households occupying 330 906 public housing dwellings (tables 16A.3 and 16A.4). Table 16A.58 presents the proportion of all households residing in public housing in each jurisdiction (3.9 per cent nationally in 2009-10).

The NAHA provides the current framework for Australian, State and Territory governments’ housing policy. The NAHA is supported by a national Specific Purpose Payment (SPP) that provides funding to the states and territories for the housing sector. State and Territory government net recurrent expenditure on public housing was $3.9 billion nationally (table 16A.1).
Public housing rents are generally set at market levels. To provide affordable housing, public housing rents are subsidised (or rebated) for eligible low income tenants so that they pay no more than 30 per cent of their gross income on rent. Information on the proportion of income paid in rent by public housing tenants is contained in table 16A.44.

State owned and managed Indigenous housing

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 2006). They include dwellings managed by government Indigenous housing agencies for allocation to Indigenous tenants. Nationally at 30 June 2012, there were 9,692 households occupying 10,047 SOMIH dwellings (tables 16A.3 and 16A.4).

The SOMIH program is partly funded under the NAHA, but because NAHA funding is not tied to specific programs, the amount attributed to SOMIH cannot separately identified. In 2011-12, State and Territory government net recurrent expenditure on SOMIH was $107.3 million nationally (table 16A.1).

The SOMIH program does not operate in all jurisdictions. In 2011-12, SOMIH is reported for NSW, Queensland, South Australia and Tasmania.

- In Victoria, the SOMIH program ended on 30 September 2010, when management of tenancies in SOMIH properties was transferred to Aboriginal Housing Victoria. These dwellings are now classified as Indigenous community housing. A small number of SOMIH tenants and properties transferred to public housing. No SOMIH dwellings are reported for Victoria for 2009-10 onwards.
- In WA, from 2010-11 SOMIH dwellings ceased to be funded separately and were combined with public housing. From 2010-11, SOMIH dwellings in WA are reported as public housing.
- The ACT does not have a separately identified or funded Indigenous housing program. Social housing assistance for Indigenous people is provided through public housing and Indigenous community housing.
- In the NT, Indigenous housing was provided through community housing (prior to 2010-11) or public housing (2010-11 onwards). During 2008-09, approximately 4,000 dwellings were transferred from Indigenous housing to remote public housing. These dwellings are not included in either the community housing data collection or the public housing data collection.
In NSW, a separate statutory organisation — the Aboriginal Housing Office (AHO) — is responsible for planning, administering and expanding policies, programs and the asset base for Aboriginal housing.

**Community housing**

Community housing is delivered by not-for-profit organisations that develop, own and/or manage affordable rental housing for people on low or moderate incomes. Community housing organisations typically receive some form of government assistance, such as direct funding or the provision of land and property, but a number of community housing organisations are entirely self-funded. Increasingly, community housing organisations are seeking funding through alternative, non-government means, such as leveraging and partnership arrangements.

A major objective of community housing is to increase social capital by encouraging local communities to take a more active role in providing affordable housing. Community housing programs may also establish links between housing and services managed at the community level, including services for people with disability, and home and community care. It 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. Notwithstanding their common objectives, community housing programs vary within and across jurisdictions in their administration and types of accommodation (box 16.3).

The role of community housing in the housing sector is expanding, driven primarily by changes in government policy that encourage the sector to play a larger role in the provision of affordable housing (Productivity Commission 2010). Community housing organisations are working in partnership with the Australian, State and Territory governments, and the private sector, to increase the supply of affordable housing, and many of the new dwellings constructed under the NRAS and other Australian Government social housing initiatives are or will be owned or managed by community housing organisations.
Box 16.3 **Models of community housing**

Community housing models vary across jurisdictions in scale, organisational structure and financing arrangements, and the extent to which community organisations or government has management responsibility and ownership of the housing stock. Table 16A.64 lists the community housing programs in each jurisdiction.

Some models of community housing are:

- **housing cooperatives**, providing tenancy management and maintenance of housing that is owned by government, a central finance company or an individual cooperative
- **local government housing associations**, providing low cost housing within a particular municipality, are closely involved in policy, planning, funding and/or monitoring roles, and can directly manage the housing stock
- **regional or local housing associations**, providing property and tenancy management services, and support services to tenants
- **State and Territory government housing entities** are community housing organisations established and controlled by State and Territory governments
- **specialist providers** are organisations with a specific purpose or function, such as tenancy management, housing development, or for specific target groups
- **broad service delivery** are organisations that provide housing and other welfare services, such as aged care and disability services
- **vertically integrated providers of affordable housing** are involved in all stages of providing affordable housing, from construction to property and tenancy management
- **community management and ownership**, where housing is owned and managed by not-for-profit or community housing associations
- **joint ventures and housing partnerships**, where church and welfare entities, local government, private sector and other organisations provide resources in cooperation with State and Territory governments; or where groups of community housing providers form partnerships to maximise growth opportunities, share resources and/or manage risk
- **equity share rental housing**, where 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: Australian, State and Territory governments (unpublished).*
At 30 June 2012, 61 033 households were assisted with community housing and there were 61 563 community housing tenancy rental units in Australia (tables 16A.3 and 16A.4). Table 16A.59 presents the proportion of all households residing in community housing in each jurisdiction in 2011 (0.7 per cent nationally).

**Indigenous community housing**

Indigenous community housing (ICH) is housing funded by Australian, State and Territory governments that are generally managed and delivered by ICH organisations (although some ICH dwellings are managed by State and Territory housing authorities). The commencement of the NAHA on 1 January 2009 resulted in changes to the funding and administrative arrangements for ICH.

From 1 January 2009, ICH was funded through the NAHA SPP and the associated National Partnership Agreement on Remote Indigenous Housing (NPA RIH), and delivered by State and Territory governments. State and Territory governments assumed responsibility for administering ICH in urban and regional areas, and arrangements varied across jurisdictions. Some ICH dwellings were transferred to other social housing programs.

Descriptive information on ICH is contained in table 16A.8.

**Diversity of State and Territory government social housing**

State and Territory governments have similar broad objectives for providing social housing. 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 consider the various levels and types of assistance provided in each State and Territory, the differences in urban, regional and remote area concentration, and the various eligibility criteria for the different assistance types when analysing performance information. Some information on the context for public housing and SOMIH are included at tables 16A.60 and 16A.61.

**Urban, regional and remote concentrations**

The proportion of social housing located in urban, regional and remote areas, for public housing, SOMIH and community housing, using the Australian Standard Geographical Classification remoteness area structure (ASGC remoteness areas) is
shown in table 16.2. Data for Indigenous community housing may be included in future reports.

Table 16.2  **Regional and remote area concentrations of social housing, at 30 June 2012 (per cent)**

<table>
<thead>
<tr>
<th></th>
<th>NSW</th>
<th>Vic</th>
<th>Qld</th>
<th>WA</th>
<th>SA</th>
<th>Tas</th>
<th>ACT</th>
<th>NT</th>
<th>Aust</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Public housing</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Major cities</td>
<td>83.4</td>
<td>72.4</td>
<td>67.3</td>
<td>66.8</td>
<td>77.3</td>
<td>..</td>
<td>99.9</td>
<td>..</td>
<td>72.7</td>
</tr>
<tr>
<td>Inner regional</td>
<td>13.3</td>
<td>22.4</td>
<td>16.5</td>
<td>10.0</td>
<td>6.7</td>
<td>73.3</td>
<td>0.1</td>
<td>..</td>
<td>15.8</td>
</tr>
<tr>
<td>Outer regional</td>
<td>3.0</td>
<td>5.2</td>
<td>14.1</td>
<td>10.6</td>
<td>13.9</td>
<td>26.0</td>
<td>..</td>
<td>71.0</td>
<td>9.0</td>
</tr>
<tr>
<td>Remote</td>
<td>0.3</td>
<td>–</td>
<td>1.6</td>
<td>8.2</td>
<td>1.8</td>
<td>0.5</td>
<td>..</td>
<td>25.4</td>
<td>1.8</td>
</tr>
<tr>
<td>Very remote</td>
<td>–</td>
<td>..</td>
<td>0.5</td>
<td>4.5</td>
<td>0.2</td>
<td>0.2</td>
<td>..</td>
<td>..</td>
<td>3.6</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>100.0</td>
<td>100.0</td>
<td>100.0</td>
<td>100.0</td>
<td>100.0</td>
<td>100.0</td>
<td>100.0</td>
<td>100.0</td>
<td>100.0</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>NSW</th>
<th>Vic</th>
<th>Qld</th>
<th>WA</th>
<th>SA</th>
<th>Tas</th>
<th>ACT</th>
<th>NT</th>
<th>Aust</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>SOMIH</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Major cities</td>
<td>43.7</td>
<td>..</td>
<td>13.3</td>
<td>..</td>
<td>60.8</td>
<td>..</td>
<td>..</td>
<td>..</td>
<td>35.1</td>
</tr>
<tr>
<td>Inner regional</td>
<td>31.5</td>
<td>..</td>
<td>18.6</td>
<td>..</td>
<td>7.8</td>
<td>82.9</td>
<td>..</td>
<td>..</td>
<td>24.6</td>
</tr>
<tr>
<td>Outer regional</td>
<td>18.3</td>
<td>..</td>
<td>39.6</td>
<td>..</td>
<td>18.2</td>
<td>17.1</td>
<td>..</td>
<td>..</td>
<td>25.4</td>
</tr>
<tr>
<td>Remote</td>
<td>5.6</td>
<td>..</td>
<td>10.2</td>
<td>..</td>
<td>5.4</td>
<td>–</td>
<td>..</td>
<td>..</td>
<td>6.9</td>
</tr>
<tr>
<td>Very remote</td>
<td>0.8</td>
<td>..</td>
<td>18.2</td>
<td>..</td>
<td>7.8</td>
<td>–</td>
<td>..</td>
<td>..</td>
<td>8.0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>100.0</td>
<td>..</td>
<td>100.0</td>
<td>..</td>
<td>100.0</td>
<td>100.0</td>
<td>..</td>
<td>..</td>
<td>100.0</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>NSW</th>
<th>Vic</th>
<th>Qld</th>
<th>WA</th>
<th>SA</th>
<th>Tas</th>
<th>ACT</th>
<th>NT</th>
<th>Aust</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Community housing</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Major cities</td>
<td>67.2</td>
<td>71.8</td>
<td>51.0</td>
<td>71.6</td>
<td>84.5</td>
<td>..</td>
<td>99.7</td>
<td>..</td>
<td>64.9</td>
</tr>
<tr>
<td>Inner regional</td>
<td>26.3</td>
<td>24.5</td>
<td>22.0</td>
<td>19.3</td>
<td>8.9</td>
<td>72.3</td>
<td>0.3</td>
<td>..</td>
<td>24.0</td>
</tr>
<tr>
<td>Outer regional</td>
<td>6.4</td>
<td>3.5</td>
<td>20.5</td>
<td>7.7</td>
<td>5.4</td>
<td>26.5</td>
<td>..</td>
<td>42.6</td>
<td>9.3</td>
</tr>
<tr>
<td>Remote</td>
<td>0.1</td>
<td>0.1</td>
<td>2.9</td>
<td>1.1</td>
<td>1.1</td>
<td>1.1</td>
<td>..</td>
<td>55.8</td>
<td>1.1</td>
</tr>
<tr>
<td>Very remote</td>
<td>–</td>
<td>..</td>
<td>3.5</td>
<td>0.2</td>
<td>0.1</td>
<td>0.1</td>
<td>..</td>
<td>1.6</td>
<td>0.7</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>100.0</td>
<td>100.0</td>
<td>100.0</td>
<td>100.0</td>
<td>100.0</td>
<td>100.0</td>
<td>100.0</td>
<td>100.0</td>
<td>100.0</td>
</tr>
</tbody>
</table>

*a* Further information pertinent to these data is provided in tables 16A.5–16A.7. Data are calculated as the proportion of total dwellings. na Not available. .. Not applicable. – Nil or rounded to zero.

Source: AIHW (unpublished); tables 16A.5–16A.7.

### Eligibility criteria for access to social housing

Eligibility criteria for access to social housing varies across the forms of social housing and across jurisdictions.

For public housing, in most cases, jurisdictions require that applicants are Australian citizens or permanent residents and do not own or partially own residential property. All jurisdictions require eligible applicants to reside in the respective State or Territory. Most jurisdictions provide security of tenure after an initial probationary period and most jurisdictions have periodic reviews of eligibility. Rebated rents generally result in the majority of households paying no more than 30 per cent of their gross income in rent (the rent to income ratio).
Tenants who do not provide updated income information may forfeit their rebate and be required to pay market rent. Information on the eligibility criteria for income and asset limits for each jurisdiction is presented in table 16A.63.

Eligibility criteria for access to SOMIH (table 16A.61) are generally consistent with those for public housing (table 16A.60), once an applicant has been confirmed as Indigenous. Terms of tenure are the same as those for public housing in most jurisdictions.

Eligibility criteria for community housing are generally consistent with those for public housing in each jurisdiction.

**Waiting lists**

All State and Territory governments prioritise access to social housing by segmenting their waiting lists in some way. Segments are defined differently across jurisdictions, but generally reflect urgent need to avoid homelessness and an inability to access appropriate private market accommodation.

The management of waiting lists varies across jurisdictions. NSW, Queensland, WA, the ACT and the NT have adopted an integrated social housing waiting list and do not segment by public housing, SOMIH and community housing. Progress towards adopting an integrated waiting list varies for the remaining jurisdictions. For this report, data for integrated waiting lists are not yet available and waiting list data are reported separately for public housing, SOMIH and community housing.

### 16.2 Framework of performance indicators

The performance indicator framework provides information on equity, efficiency and effectiveness, distinguishes the outputs and outcomes and reflects the objectives of social housing (box 16.4).

The performance indicator framework shows which data are comparable in the 2013 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 Report’s statistical appendix 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) (appendix A).

COAG has agreed six National Agreements to enhance accountability to the public for the outcomes achieved or outputs delivered by a range of government services, (see chapter 1 for more detail on reforms to federal financial relations).

The NAHA covers the area of housing and homelessness, and housing and homelessness indicators in the National Indigenous Reform Agreement (NIRA) establish specific outcomes for reducing the level of disadvantage experienced by Indigenous Australians. Both agreements include sets of performance indicators, for which the Steering Committee collates performance information for analysis by the COAG Reform Council (CRC). Performance indicators reported in this chapter are aligned with performance indicators in the NAHA. The NAHA was reviewed in 2011 and 2012 resulting in changes that have been reflected in this Report, as relevant.

A review of the NAHA was completed in 2012 and a revised suite of performance indicators agreed by COAG. No changes to reporting on housing services in this Report are required to align with the revised suite of NAHA performance indicators.

Different delivery contexts and locations influence the equity, effectiveness and efficiency of social housing. The Report’s statistical appendix 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) (appendix A).
Social housing aims to assist people unable to access alternative suitable housing options through the delivery of affordable, appropriate, flexible and diverse social housing. Some forms of social housing aim specifically to contribute to Indigenous community wellbeing by improving housing outcomes for Indigenous people, especially those living in remote communities.

The NAHA and previously the CSHA provide the overarching framework for the delivery of social housing in Australia:

- The objective of the NAHA (2009) is that all Australians have access to affordable, safe and sustainable housing that contributes to social and economic participation.
- The guiding principles of the CSHA (2003) included maintaining a social housing sector and providing appropriate housing assistance, improving housing outcomes for Indigenous people, improving links with other programs and support to people with complex needs, promoting social and economic participation, managing housing programs efficiently and effectively, ensuring cooperative relationships between levels of governments, and promoting a national approach to affordable housing.

Source: FaCS (2003); COAG (2009).

The performance indicator framework for social housing is presented in figure 16.1.
16.3 Key performance indicator results

Results for each performance indicator are presented separately for public housing, SOMIH, community housing and Indigenous community housing. Generally, performance indicator results are comparable between public housing and SOMIH. Public housing and SOMIH results are not comparable to community housing and Indigenous community housing because of differences in data quality, timing and coverage.

Data presented in this Report are collected from a variety of sources and the quality and coverage of each collection varies.
• Public housing and SOMIH data are sourced from State and Territory government unit record datasets extracted from administrative databases. The data are complete and comparable. As outlined in section 16.1, Victoria (from 2009-10), WA (from 2010-11), the ACT and the NT are not included in the SOMIH data collection.

• Community housing data are sourced from jurisdictions’ administrative data (provided by State and Territory governments), community housing provider surveys and the National Social Housing Survey (NSHS). Queensland and the NT do not survey their community housing providers, and provide administrative data. Data are not directly comparable across jurisdictions or over time, due to varying response rates and changes to the definitions and counting rules used over time for the provider surveys. Table 16A.66 and related data quality information outline the survey response rates and associated information for each jurisdiction.

• Indigenous community housing data are a combination of administrative data and survey data collected from ICH organisations. Complete data for all jurisdictions are not available, and ICH data should be interpreted with caution. Details of all ICH dwellings were not known and ICH data reflect only those dwellings for which details were known. ICH data are not reported for a number of the social housing performance indicators due to issues with data quality and availability.

Data quality information (DQI) is being progressively introduced for all indicators in the Report. The purpose of DQI is to provide structured and consistent information about quality aspects of data used to report on performance indicators. DQI in this Report covers the seven dimensions in the ABS’ data quality framework (institutional environment, relevance, timeliness, accuracy, coherence, accessibility and interpretability) in addition to dimensions that define and describe performance indicators in a consistent manner, and note key data gaps and issues identified by the Steering Committee.


This Report includes additional descriptive data for social housing in tables 16A.5 (public housing), 16A.6 (SOMIH), 16A.7 (community housing) and 16A.8 (ICH).

Outputs

The following indicators measure the outputs of social housing. Outputs are the services delivered, while outcomes are the impact of those services on the status of an individual or group (see chapter 1, section 1.5).
Special needs

‘Special needs’ is an indicator of governments’ objective to provide appropriate, affordable and secure housing assistance to people who are unable to access suitable housing (box 16.5).

Box 16.5 Special needs

‘Special needs’ is defined as the proportion of new tenancies allocated to households with special needs. The proportion of new tenancies with special needs is reported as a proxy for measuring all households with special needs.

Households with special needs are defined as:

- for public and community housing — those households that have either a household member with disability, a principal tenant aged 24 years or under, or 75 years or over, or one or more Indigenous members
- for SOMIH — those households that have either a household member with disability or a principal tenant aged 24 years or under, or 50 years or over.

A high or increasing proportion indicates a high degree of access by these special needs households.

Data for this indicator are reported for public housing, SOMIH and community housing. Data comparability and completeness vary for this indicator. Data reported:

- are not comparable across public housing, SOMIH and community housing
- for public housing and SOMIH are comparable across jurisdictions, but not over time
- for community housing are neither comparable nor complete.


The proportions of new housing tenancies that were allocated to households with special needs varies across the forms of social housing, across jurisdictions and over time. Nationally in 2011-12:

- 67.5 per cent of new public housing tenancies were allocated to households with special needs, increasing from 59.0 per cent in 2007-08
- 54.0 per cent of new tenancies for SOMIH were allocated to households with special needs, increasing from 47.2 per cent in 2007-08
- 60.3 per cent of new community housing tenancies were allocated to households with special needs, decreasing from 62.4 per cent in 2007-08 (figure 16.2).
Figure 16.2  **New tenancies allocated to households with special needs (per cent)**

- **Public housing**

- **SOMIH**

- **Community housing**

---

**Public housing**

- 2008
- 2009
- 2010
- 2011
- 2012

**SOMIH**

- 2008
- 2009
- 2010
- 2011
- 2012

**Community housing**

- 2008
- 2009
- 2010
- 2011
- 2012

---

**Data** may not be comparable across jurisdictions and over time and comparisons could be misleading. Tables 16A.9–16A.11 provide further information. **b** There are no SOMIH data reported for Victoria (from 2009-10) or WA (from 2010-11) as SOMIH was transferred to other housing programs. **c** Data for the NT are not available.

**Source**: AIHW (unpublished); AIHW (various years) CSHA national data report; AIHW (various years) Housing assistance in Australia (Cat. no. HOU 236); tables 16A.9–16A.11.
Priority access to those in greatest need

‘Priority access to those in greatest need’ is an indicator of governments’ objective 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 ensure that those in greatest need have priority access to housing (box 16.6).

Box 16.6 Priority access to those in greatest need

‘Priority access to those in greatest need’ is defined as the proportion of new allocations of housing to households in greatest need.

Greatest need households are defined as households that at the time of allocation are either homeless, in housing inappropriate to their needs, in housing that is adversely affecting their health or placing their life and safety at risk, or that has very high rental housing costs.

The following measures are reported:

- the proportion of new allocations that were to households in greatest need
- the proportion of new allocations to households in greatest need (of all new allocations) that were waiting for periods of: less than three months; three months to less than six months; six months to less than one year; one year to less than two years; two years or more. These percentages are not cumulative, because time to allocation for this measure reflects greatest need allocations as a percentage of all new allocations for the time period.

High or increasing values for these measures, particularly for short timeframes, indicate a high degree of access for those households in greatest need.

Data for this indicator are reported for public housing, SOMIH and community housing. Data comparability and completeness vary for this indicator. Differences in State and Territory housing assessment policies and community housing allocation policies can influence comparability for this indicator. Data reported:

- for public housing and SOMIH are comparable across jurisdictions, but not over time
- for community housing are neither comparable nor complete.


The proportions of new allocations to those households in greatest need for public housing, SOMIH and community housing are reported in figure 16.3. Nationally in 2011-12, 74.2 per cent of new public housing allocations, 55.7 per cent of new SOMIH allocations and 72.0 per cent of new community housing allocations were to those households in greatest need (figure 16.3).
Figure 16.3  Proportion of new allocations to those in greatest need\(^a\)

\(^a\) Data may not be comparable across jurisdictions and over time and comparisons could be misleading. Tables 16A.12–14 provide further information. \(^b\) There are no SOMIH data reported for Victoria (from 2009-10) or WA (2010-11) as SOMIH was transferred to other housing programs. Data for Tasmania were not available. \(^c\) Data for the NT are not available.

Source: AIHW (unpublished); AIHW (various years) CSHA national data report; AIHW (various years) Housing assistance in Australia (Cat. no. HOU 236); tables 16A.12–16A.14.
Table 16.3 presents information on the proportion of new public housing and SOMIH allocations made to households in greatest need for the year ending 30 June 2012, within particular timeframes. Nationally, of all new households that were allocated public housing within three months at 30 June 2012, 83.1 per cent were households in greatest need. Nationally, of all new households that were allocated SOMIH within three months at 30 June 2012, 70.4 per cent were households in greatest need (table 16.3).

<table>
<thead>
<tr>
<th></th>
<th>NSW</th>
<th>Vic</th>
<th>Qld</th>
<th>WA</th>
<th>SA</th>
<th>Tas</th>
<th>ACT</th>
<th>NT</th>
<th>Aust</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Public housing</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Under 3 months</td>
<td>78.1</td>
<td>67.3</td>
<td>96.8</td>
<td>63.0</td>
<td>90.1</td>
<td>94.0</td>
<td>97.6</td>
<td>47.5</td>
<td>83.1</td>
</tr>
<tr>
<td>3 &lt; 6 months</td>
<td>77.0</td>
<td>70.2</td>
<td>97.4</td>
<td>75.8</td>
<td>90.6</td>
<td>95.9</td>
<td>94.7</td>
<td>67.6</td>
<td>84.0</td>
</tr>
<tr>
<td>6 months to &lt; 1 year</td>
<td>67.5</td>
<td>78.2</td>
<td>96.4</td>
<td>77.9</td>
<td>88.1</td>
<td>97.2</td>
<td>90.5</td>
<td>73.6</td>
<td>82.1</td>
</tr>
<tr>
<td>1 &lt; 2 years</td>
<td>66.3</td>
<td>80.5</td>
<td>94.8</td>
<td>72.2</td>
<td>85.5</td>
<td>96.7</td>
<td>83.6</td>
<td>67.0</td>
<td>77.9</td>
</tr>
<tr>
<td>2+ years</td>
<td>47.3</td>
<td>63.9</td>
<td>95.3</td>
<td>34.0</td>
<td>59.5</td>
<td>83.7</td>
<td>91.3</td>
<td>42.0</td>
<td>46.2</td>
</tr>
<tr>
<td><strong>Overall</strong></td>
<td>65.6</td>
<td>70.8</td>
<td>96.4</td>
<td>55.2</td>
<td>83.1</td>
<td>94.9</td>
<td>94.0</td>
<td>56.5</td>
<td>74.2</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>NSW</th>
<th>Vic</th>
<th>Qld</th>
<th>WA</th>
<th>SA</th>
<th>Tas</th>
<th>ACT</th>
<th>NT</th>
<th>Aust</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>SOMIH</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Under 3 months</td>
<td>45.3</td>
<td>..</td>
<td>95.9</td>
<td>..</td>
<td>89.5</td>
<td>na</td>
<td>..</td>
<td>..</td>
<td>70.4</td>
</tr>
<tr>
<td>3 &lt; 6 months</td>
<td>38.2</td>
<td>..</td>
<td>91.2</td>
<td>..</td>
<td>100.0</td>
<td>na</td>
<td>..</td>
<td>..</td>
<td>60.9</td>
</tr>
<tr>
<td>6 months to &lt; 1 year</td>
<td>28.1</td>
<td>..</td>
<td>94.7</td>
<td>..</td>
<td>100.0</td>
<td>na</td>
<td>..</td>
<td>..</td>
<td>58.1</td>
</tr>
<tr>
<td>1 &lt; 2 years</td>
<td>19.3</td>
<td>..</td>
<td>90.9</td>
<td>..</td>
<td>100.0</td>
<td>na</td>
<td>..</td>
<td>..</td>
<td>42.3</td>
</tr>
<tr>
<td>2+ years</td>
<td>21.4</td>
<td>..</td>
<td>90.0</td>
<td>..</td>
<td>44.4</td>
<td>na</td>
<td>..</td>
<td>..</td>
<td>28.8</td>
</tr>
<tr>
<td><strong>Overall</strong></td>
<td>31.0</td>
<td>..</td>
<td>93.8</td>
<td>..</td>
<td>90.5</td>
<td>na</td>
<td>..</td>
<td>..</td>
<td>55.7</td>
</tr>
</tbody>
</table>

a Further information on these data is provided in tables 16A.12 and 16A.13. na Not available. .. Not applicable.

Source: AIHW (unpublished); table 16A.12 and 16A.13.

Effectiveness — quality

**Dwelling condition**

‘Dwelling condition’ is an indicator of governments’ objective to provide quality housing (box 16.7).
Box 16.7  **Dwelling condition**

'Dwelling condition' is defined as the proportion of households living in houses of an acceptable standard for public housing, SOMIH and community housing. A house is assessed as being of an acceptable standard if it has at least four working facilities (for washing people, for washing clothes/bedding, for storing/preparing food, and sewerage) and not more than two major structural problems.

A high proportion for this indicator suggests higher or increasing housing quality.

'Dwelling condition' is defined as the proportion of dwellings in need of either major repair or replacement for ICH.

A low proportion for dwelling condition suggests higher or increasing housing quality.

Data for this indicator are reported for Public housing, SOMIH, Community housing and ICH.

Data reported for this indicator are not comparable.


Nationally in 2012, the NSHS found that:

- for public housing, 74.7 per cent of all households and 61.3 per cent of Indigenous households had four working facilities and not more than two major structural problems
- for SOMIH, 61.4 per cent of all households had four working facilities and not more than two major structural problems
- for community housing, 85.2 per cent of all households and 71.5 per cent of Indigenous households had four working facilities and not more than two major structural problems (figure 16.4).

Information for Indigenous households is available in tables 16A.15–17.

95 per cent confidence intervals for these data are in the attachment tables.
Figure 16.4  Proportion of households with at least four working facilities and not more than two major structural problems, 2012\(^a, b\)

\(^{a}\) Error bars represent the 95 per cent confidence intervals associated with each point estimate. \(^{b}\) Data may not be comparable across jurisdictions and over time and comparisons could be misleading. Tables 16A.15–17 provide further information. \(^{b}\) There are no SOMIH data reported for Victoria, WA, ACT and the NT as SOMIH program does not exist in these jurisdictions. \(^{c}\) Includes a small proportion of non-Indigenous households. \(^{d}\) Data for the NT are not available.
Nationally in 2006, 23.4 per cent of Indigenous community housing dwellings were in need of major repair and 7.2 per cent of dwellings were in need of replacement (table 16A.18) (figure 16.5).

**Figure 16.5** Proportion of Indigenous community housing dwellings in need of major repair and dwellings in need of replacement, 2006\(^a,b\)

\[^a\] The proportion of dwellings in need of replacement in Tasmania was nil, or rounded to zero. \[^b\] ACT data have been included with NSW due to low numbers.

**Efficiency**

**Net recurrent cost per dwelling**

‘Net recurrent cost per dwelling’ is an indicator of governments’ objective to undertake efficient and cost effective management of social housing (box 16.8).
Box 16.8  **Net recurrent cost per dwelling**

'Net recurrent cost per dwelling' is defined as the cost of providing assistance per dwelling — total recurrent expenses (including administration and operational costs), divided by the total number of dwellings.

Measures are reported for public housing, SOMIH, community housing and Indigenous community housing. Net recurrent cost per dwelling for public housing is reported, both including and excluding the user cost of capital. Reporting for SOMIH, community housing and Indigenous community housing excludes the user cost of capital.

The total number of dwellings for Indigenous community housing is the number of permanent dwellings.

Holding other factors equal, a low or decreasing net recurrent cost per dwelling suggests an improvement in efficiency.

Cost per dwelling measures do not provide any information on the quality of service provided (for example, the standard of dwellings).

Data comparability and completeness vary for this indicator. Data reported:
- for public housing and SOMIH are comparable
- for community housing and Indigenous community housing are neither comparable nor complete


The cost incurred by jurisdictions in providing social housing includes:
- 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 social housing). For this Report, information on the user cost of capital was only available for public housing.

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, and could therefore understate the total cost of public housing. In addition, some jurisdictions are unable to separate costs for public housing from those for other housing and homelessness 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.

Due to a high level of capital expenditure in housing, cost per dwelling is predominantly driven by the user cost of capital. There are different user cost of capital and service delivery models across jurisdictions, and user cost of capital data reported should be interpreted with caution. Information on the treatment of assets by housing agencies for each jurisdiction is presented in table 16A.65.

Payroll tax is excluded from total recurrent cost for public housing to improve comparability across jurisdictions. (Chapter 2 elaborates on the reasons for excluding payroll tax from the cost calculations.)

Nationally in 2011-12, net recurrent cost per dwelling (excluding the user cost of capital) for public housing was $7707 and the cost per dwelling including capital costs was $29,527 (figure 16.6). More detailed information on public housing expenditure is reported in nominal terms in table 16A.19 and in real terms in table 16A.20, including data from 2002-03 to 2011-12.
Figure 16.6  Net recurrent cost per dwelling — public housing (2011-12 dollars)\textsuperscript{a, b}

\begin{figure}
\centering
\includegraphics[width=\textwidth]{figure166.png}
\caption{Net recurrent cost per dwelling — public housing (2011-12 dollars)\textsuperscript{a, b}}
\end{figure}

\textsuperscript{a} Further information pertinent to these data is provided in table 16A.20.  \textsuperscript{b} Data are adjusted to 2011-12 dollars using the gross domestic product (GDP) price deflator (2011-12 = 100) (table AA.51). Recent volatility in the GDP deflator series affects annual movements of real expenditure. See the Statistical appendix (section A.5) for details.

Source: State and Territory governments (unpublished); tables 16A.20 and AA.51.

Nationally, the net recurrent cost of providing assistance (excluding the cost of capital) per dwelling for SOMIH was $10,682 in 2011-12 (figure 16.7). Table 16A.21 contains data for the years 2002-03 to 2011-12. 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 per dwelling for public housing with that for SOMIH, because:

- SOMIH dwellings are 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) can affect the cost per dwelling for SOMIH
- different cost structures can apply to the programs. For example, construction of dwellings under SOMIH can involve a skills development element to allow for training of Indigenous apprentices in regional areas
- in jurisdictions where SOMIH is managed separately from public housing, there is greater scope for economies of scale in administration costs with public housing, which is a much larger program.

Figure 16.7  **Net recurrent cost per dwelling — SOMIH (2011-12 dollars)\(^{a,b,c}\)**

Data on net recurrent cost per dwelling for community and Indigenous community housing are reported with a one year lag to allow community housing providers an extra year to collate financial data. Capital cost data for community housing are not available for this Report.
Nationally, the net recurrent cost per tenancy at 30 June 2011 was $8149 (figure 16.8). Table 16A.22 contains data from 2002-03 to 2010-11.

Figure 16.8  Net recurrent cost per tenancy — community housing (2010-11 dollars)\(^{a, b, c}\)

Excluding the cost of capital

<table>
<thead>
<tr>
<th>$/dwelling</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
</tr>
<tr>
<td>4000</td>
</tr>
<tr>
<td>8000</td>
</tr>
<tr>
<td>12000</td>
</tr>
<tr>
<td>16000</td>
</tr>
<tr>
<td>20000</td>
</tr>
<tr>
<td>24000</td>
</tr>
</tbody>
</table>

\(^a\) Data may not be comparable across jurisdictions and comparisons could be misleading. Table 16A.22 provides further information. \(^b\) Data are adjusted to 2010-11 dollars using the gross domestic product (GDP) price deflator (2010-11 = 100) (table AA.51). Recent volatility in the GDP deflator series affects annual movements of real expenditure. See the Statistical appendix (section A.5) for details. \(^c\) Data for the NT are not available.

Source: AIHW (unpublished); AIHW (various years) CSHA national data report; AIHW (various years) Housing assistance in Australia (Cat. no. HOU 236); tables 16A.22 and AA.51.

Nationally in 2010-11, the net recurrent cost per Indigenous community housing dwelling was $7327 (table 16.4). However, complete data were not available for all jurisdictions, and these figures may be an underestimate.
Table 16.4  
Net recurrent cost per dwelling (excluding the cost of capital) — Indigenous community housing (2010-11 dollars)a, b, c, d

<table>
<thead>
<tr>
<th></th>
<th>NSW</th>
<th>Vic</th>
<th>Qld</th>
<th>WA</th>
<th>SA</th>
<th>Tas</th>
<th>ACT</th>
<th>NT</th>
<th>Aus Gov</th>
<th>Aust</th>
</tr>
</thead>
<tbody>
<tr>
<td>2006-07</td>
<td>9 350</td>
<td>..</td>
<td>3 854</td>
<td>na</td>
<td>3 829</td>
<td>..</td>
<td>na</td>
<td>na</td>
<td>na</td>
<td>5 862</td>
</tr>
<tr>
<td>2007-08</td>
<td>7 417</td>
<td>3 392</td>
<td>7 676</td>
<td>14 827</td>
<td>2 903</td>
<td>..</td>
<td>7 686</td>
<td>na</td>
<td>8 896</td>
<td>8 405</td>
</tr>
<tr>
<td>2008-09</td>
<td>6 409</td>
<td>6 318</td>
<td>3 967</td>
<td>6 786</td>
<td>3 507</td>
<td>..</td>
<td>10 801</td>
<td>na</td>
<td>8 031</td>
<td>5 627</td>
</tr>
<tr>
<td>2009-10</td>
<td>15 086</td>
<td>9 534</td>
<td>4 750</td>
<td>7 211</td>
<td>4 207</td>
<td>11 465</td>
<td>na</td>
<td>na</td>
<td>..</td>
<td>7 944</td>
</tr>
<tr>
<td>2010-11</td>
<td>10 656</td>
<td>4 851</td>
<td>5 538</td>
<td>9 063</td>
<td>na</td>
<td>4 960</td>
<td>na</td>
<td>na</td>
<td>..</td>
<td>7 327</td>
</tr>
</tbody>
</table>

a Data may not be comparable across jurisdictions and over time and comparisons could be misleading. Table 16A.23 provides further information. b Data are adjusted to 2010-11 dollars using the gross domestic product (GDP) price deflator (2010-11 = 100) (table AA.51). Recent volatility in the GDP deflator series affects annual movements of real expenditure. See the Statistical appendix (section A.5) for details. c Results for this indicator are based on the total number of dwellings for which details were known (not the total number of dwellings). d Includes data from Victoria, Queensland and Tasmania not published separately, and includes dwellings managed by funded and unfunded organisations responding to the FaHCSIA survey. na Not available. .. Not applicable.

Source: AIHW (2012) Housing Assistance in Australia (Cat No. HOU 236); AIHW (various years) Indigenous Community Housing; table 16A.23.

Occupancy rate

‘Occupancy rate’ is an indicator of governments’ objective to ensure efficient housing utilisation (box 16.9).

Box 16.9  Occupancy rate

‘Occupancy rate’ is defined as the proportion of dwellings occupied. The term ‘occupied’ refers to rental housing stock occupied by tenants who have a tenancy agreement with the relevant housing authority (for public housing and SOMIH) or community housing organisation (for community housing and Indigenous community housing).

A high or increasing proportion suggests greater efficiency of housing utilisation.

Occupancy is influenced by both turnover and housing supply and demand.

Data for this indicator are reported for public housing, SOMIH, community housing and Indigenous community housing. Data comparability and completeness vary for this indicator. Data reported:

- for public housing and SOMIH are comparable
- for community housing and Indigenous community housing are neither comparable nor complete.

Nationally at 30 June 2012, the proportion of total rental stock occupied was 97.7 per cent for public housing, 96.5 per cent for SOMIH, and 96.2 per cent for community housing (figure 16.9).
Figure 16.9  Occupancy rates, at 30 June (per cent)a

Data may not be comparable across jurisdictions and over time and comparisons could be misleading. Tables 16A.24–16A.26 provide further information. b There are no SOMIH data reported for Victoria (from 2009-10) or WA (from 2010-11) as SOMIH was transferred to other housing programs. c Occupancy rates in the NT are based on the assumption that all dwellings are occupied.

Source: AIHW (unpublished); AIHW (various years) CSHA national data report; AIHW (various years) Housing assistance in Australia Cat. no. HOU 236; tables 16A.24–16A.26.
Nationally, 91.6 per cent of Indigenous community housing was occupied at 30 June 2011, though this varied across jurisdictions (table 16.5). However, complete data were not available for all jurisdictions, and these figures may be an underestimate.

Table 16.5  **Occupancy rates for Indigenous community housing, at 30 June (per cent)**<sup>a</sup>,<sup>b</sup>

<table>
<thead>
<tr>
<th>Year</th>
<th>NSW</th>
<th>Vic</th>
<th>Qld</th>
<th>WA</th>
<th>SA</th>
<th>Tas</th>
<th>ACT</th>
<th>NT</th>
<th>Aus Gov&lt;sup&gt;c&lt;/sup&gt;</th>
<th>Aust</th>
</tr>
</thead>
<tbody>
<tr>
<td>2007</td>
<td>98.3</td>
<td>..</td>
<td>100.0</td>
<td>91.0</td>
<td>89.0</td>
<td>..</td>
<td>100.0</td>
<td>na</td>
<td>94.9</td>
<td>96.2</td>
</tr>
<tr>
<td>2008</td>
<td>96.0</td>
<td>99.1</td>
<td>98.1</td>
<td>na</td>
<td>93.3</td>
<td>..</td>
<td>100.0</td>
<td>100.0</td>
<td>96.6</td>
<td>98.3</td>
</tr>
<tr>
<td>2019</td>
<td>99.2</td>
<td>97.9</td>
<td>96.8</td>
<td>89.8</td>
<td>87.7</td>
<td>..</td>
<td>100.0</td>
<td>na</td>
<td>95.3</td>
<td>96.5</td>
</tr>
<tr>
<td>2010</td>
<td>97.0</td>
<td>95.7</td>
<td>96.4</td>
<td>73.7</td>
<td>87.8</td>
<td>90.2</td>
<td>na</td>
<td>na</td>
<td>..</td>
<td>90.8</td>
</tr>
<tr>
<td>2011</td>
<td>96.2</td>
<td>95.4</td>
<td>97.0</td>
<td>79.8</td>
<td>78.8</td>
<td>89.8</td>
<td>na</td>
<td>na</td>
<td>..</td>
<td>91.6</td>
</tr>
</tbody>
</table>

<sup>a</sup> Data may not be comparable across jurisdictions and over time and comparisons could be misleading. Table 16A.27 provides further information. <sup>b</sup> Results for this indicator are based on those dwellings for which occupancy status was known. <sup>c</sup> Includes data from Victoria, Queensland and Tasmania not published separately, and includes dwellings managed by funded and unfunded organisations responding to the FaHCSIA survey. na Not available. .. Not applicable.

*Source: AIHW (2012) *Housing Assistance in Australia* (Cat No. HOU 236); AIHW (various years) *Indigenous Community Housing*, table 16A.27.*
**Turnaround time**

‘Turnaround time’ is an indicator of governments’ objective to undertake efficient and cost effective management (box 16.10).

<table>
<thead>
<tr>
<th>Box 16.10</th>
<th><strong>Turnaround time</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>‘Turnaround time’ is defined as the average time taken for vacant stock, that is available to rent through normal processes, to be occupied.</td>
<td></td>
</tr>
<tr>
<td>A low or decreasing turnaround time suggests efficient housing allocation.</td>
<td></td>
</tr>
<tr>
<td>Properties that are unavailable, undergoing major redevelopment or for which there was no suitable applicant are excluded from the calculation. Hard-to-let properties are included.</td>
<td></td>
</tr>
<tr>
<td>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.</td>
<td></td>
</tr>
<tr>
<td>Data for this indicator are reported for public housing and SOMIH.</td>
<td></td>
</tr>
<tr>
<td>Data reported for this indicator are comparable and complete.</td>
<td></td>
</tr>
</tbody>
</table>

Nationally, vacant stock remained unallocated for an average of 28.8 days for public housing and 29.9 days for SOMIH in 2011-12 (figure 16.10).
There are no SOMIH data reported for Victoria (from 2009-10) or WA (2010-11) as SOMIH was transferred to other housing programs.

Source: AIHW (unpublished); AIHW (various years) CSHA national data report; AIHW (various years) Housing assistance in Australia (Cat. no. HOU 236); tables 16A.28 and 16A.29.
Rent collection rate

‘Rent collection rate’ is an indicator of governments’ objective to undertake efficient and cost effective management of social housing (box 16.11).

Box 16.11 Rent collection rate

‘Rent collection rate’ is defined as the total rent collected as a percentage of the total rent charged.

A high or increasing percentage suggests higher 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 can affect the comparability of reported results. Payment arrangements for rent in some jurisdictions mean that rent collected over a 12 month period can be higher than rent charged over that period.

Data for this indicator are reported for public housing, SOMIH, community housing and Indigenous community housing.

Data comparability and completeness vary for this indicator. Data reported:
- for public housing and SOMIH are comparable
- for community housing and Indigenous community housing are not comparable or complete.


In 2011-12, the national rent collection rate was 99.3 per cent for public housing and 100.5 per cent for SOMIH. In 2010-11, the national rent collection rate was 97.9 per cent for community housing, and 94.9 per cent for Indigenous community housing (table 16.6). However, complete data for ICH were not available for all jurisdictions, and these figures may be an underestimate.
Table 16.6  Rent collection rate (per cent)\textsuperscript{a}

<table>
<thead>
<tr>
<th></th>
<th>NSW</th>
<th>Vic</th>
<th>Qld</th>
<th>WA</th>
<th>SA</th>
<th>ACT</th>
<th>NT</th>
<th>Aus Gov\textsuperscript{b}</th>
<th>Aust</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Public housing</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2007-08</td>
<td>100.0</td>
<td>97.2</td>
<td>98.9</td>
<td>101.0</td>
<td>99.6</td>
<td>101.9</td>
<td>99.9</td>
<td>101.7</td>
<td>..</td>
</tr>
<tr>
<td>2008-09</td>
<td>100.2</td>
<td>98.5</td>
<td>99.3</td>
<td>101.3</td>
<td>100.0</td>
<td>99.0</td>
<td>99.9</td>
<td>100.8</td>
<td>..</td>
</tr>
<tr>
<td>2009-10</td>
<td>100.0</td>
<td>99.0</td>
<td>100.3</td>
<td>101.2</td>
<td>99.8</td>
<td>99.0</td>
<td>99.5</td>
<td>103.8</td>
<td>..</td>
</tr>
<tr>
<td>2010-11</td>
<td>99.2</td>
<td>98.7</td>
<td>100.9</td>
<td>100.7</td>
<td>100.0</td>
<td>99.0</td>
<td>99.5</td>
<td>102.7</td>
<td>..</td>
</tr>
<tr>
<td>2011-12</td>
<td>99.1</td>
<td>98.5</td>
<td>99.4</td>
<td>100.7</td>
<td>100.3</td>
<td>98.6</td>
<td>99.7</td>
<td>99.0</td>
<td>99.3</td>
</tr>
<tr>
<td><strong>SOMIH\textsuperscript{c}</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2007-08</td>
<td>96.8</td>
<td>99.6</td>
<td>99.6</td>
<td>104.3</td>
<td>103.7</td>
<td>99.8</td>
<td>..</td>
<td>..</td>
<td>..</td>
</tr>
<tr>
<td>2008-09</td>
<td>99.8</td>
<td>97.2</td>
<td>97.2</td>
<td>103.6</td>
<td>99.7</td>
<td>99.0</td>
<td>..</td>
<td>..</td>
<td>..</td>
</tr>
<tr>
<td>2009-10</td>
<td>101.5</td>
<td>..</td>
<td>101.5</td>
<td>104.5</td>
<td>100.7</td>
<td>101.7</td>
<td>..</td>
<td>..</td>
<td>..</td>
</tr>
<tr>
<td>2010-11</td>
<td>104.0</td>
<td>..</td>
<td>99.3</td>
<td>..</td>
<td>99.9</td>
<td>99.0</td>
<td>..</td>
<td>..</td>
<td>..</td>
</tr>
<tr>
<td>2011-12</td>
<td>100.0</td>
<td>..</td>
<td>100.6</td>
<td>..</td>
<td>100.7</td>
<td>98.6</td>
<td>..</td>
<td>..</td>
<td>..</td>
</tr>
<tr>
<td><strong>Community housing</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2006-07</td>
<td>99.8</td>
<td>99.5</td>
<td>100.3</td>
<td>100.3</td>
<td>98.4</td>
<td>95.7</td>
<td>98.1</td>
<td>na</td>
<td>..</td>
</tr>
<tr>
<td>2007-08</td>
<td>98.3</td>
<td>99.2</td>
<td>98.6</td>
<td>100.9</td>
<td>98.6</td>
<td>97.9</td>
<td>97.0</td>
<td>na</td>
<td>..</td>
</tr>
<tr>
<td>2008-09</td>
<td>96.6</td>
<td>99.1</td>
<td>99.0</td>
<td>98.8</td>
<td>100.3</td>
<td>99.7</td>
<td>95.8</td>
<td>na</td>
<td>..</td>
</tr>
<tr>
<td>2009-10</td>
<td>96.1</td>
<td>98.1</td>
<td>99.3</td>
<td>99.6</td>
<td>99.7</td>
<td>100.2</td>
<td>101.6</td>
<td>na</td>
<td>..</td>
</tr>
<tr>
<td>2010-11</td>
<td>96.5</td>
<td>99.2</td>
<td>101.6</td>
<td>99.1</td>
<td>98.1</td>
<td>na</td>
<td>99.1</td>
<td>na</td>
<td>..</td>
</tr>
<tr>
<td><strong>Indigenous community housing</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2006-07</td>
<td>90.0</td>
<td>..</td>
<td>96.6</td>
<td>96.8</td>
<td>65.5</td>
<td>..</td>
<td>100.0</td>
<td>111.5</td>
<td>92.0</td>
</tr>
<tr>
<td>2007-08</td>
<td>89.8</td>
<td>95.4</td>
<td>90.8</td>
<td>101.1</td>
<td>63.5</td>
<td>..</td>
<td>100.4</td>
<td>114.4</td>
<td>93.2</td>
</tr>
<tr>
<td>2008-09</td>
<td>90.4</td>
<td>94.1</td>
<td>115.8</td>
<td>64.2</td>
<td>60.3</td>
<td>..</td>
<td>100.0</td>
<td>115.6</td>
<td>97.9</td>
</tr>
<tr>
<td>2009-10</td>
<td>90.3</td>
<td>92.3</td>
<td>83.5</td>
<td>84.7</td>
<td>na</td>
<td>97.0</td>
<td>na</td>
<td>93.6</td>
<td>..</td>
</tr>
<tr>
<td>2010-11</td>
<td>100.7</td>
<td>100.1</td>
<td>93.0</td>
<td>88.7</td>
<td>na</td>
<td>98.2</td>
<td>na</td>
<td>71.2</td>
<td>..</td>
</tr>
</tbody>
</table>

\textsuperscript{a} Data may not be comparable across jurisdictions and over time and comparisons could be misleading. Tables 16A.30--33 provide further information. \textsuperscript{b} Includes data from Victoria, Queensland and Tasmania not published separately, and includes dwellings managed by funded and unfunded organisations responding to the FaHCSIA survey. \textsuperscript{c} There are no SOMIH data reported for Victoria (from 2009-10) or WA (2010-11) as SOMIH was transferred to other housing programs. na Not available. .. Not applicable.

Source: State and Territory Governments (unpublished); AIHW (various years) CSHA national data report; AIHW (various years) Housing assistance in Australia Cat. no. HOU 236; AIHW (various years) Indigenous Community Housing; tables 16A.30--16A.33.

Outcomes

The following indicators measure the outcomes of social housing. Outcomes are the impact of services on the status of an individual or group, while outputs are the services delivered (see chapter 1, section 1.5).

Amenity/location

‘Amenity/location’ is an indicator of governments’ objective to provide housing assistance that is appropriate to the needs of different households (box 16.12).
Box 16.12  **Amenity/location**

‘Amenity/location’ is defined as the percentage of tenants rating amenity/location aspects of their dwelling as important and as meeting their needs.

A high or increasing level of satisfaction with amenity and location suggests that the provision of housing assistance satisfies household needs.

Data for this indicator are reported for public housing, SOMIH and community housing. There are no data available for Indigenous community housing for the 2013 Report.

Data comparability and completeness vary for this indicator. Data reported:

- for public housing and SOMIH are comparable
- for community housing are neither comparable nor complete.


Data for this indicator are sourced from the National Social Housing Survey (NSHS), which measures tenants’ level of satisfaction with various aspects of service, and to measure housing outcomes. Public housing, SOMIH and 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. Data from the 2012 survey are reported for public housing, community housing and SOMIH. Data from earlier surveys (2010 [public housing and community housing] and 2007 [public housing, community housing and SOMIH]) were included in earlier reports.

Caution should be used when comparing the public housing, SOMIH and community housing results, due to the different demographic profile of Indigenous tenants and the method of data collection.

Nationally in 2012, the NSHS found that:

- for public housing, 83.4 per cent of tenants rated amenity as important and meeting their needs, and 87.9 per cent rated location as important and meeting their needs (tables 16A.34 and 16A.35)
- for SOMIH, 82.2 per cent of tenants rated amenity as important and meeting their needs and 86.8 per cent of tenants rated location as important and meeting their needs (table 16A.36)
- for community housing, 84.7 per cent of tenants rated amenity as important and meeting their needs, and 87.3 per cent rated location as important and meeting their needs (tables 16A.37 and 16A.38).
The precision of survey estimates depends on the survey sample size and further information, including 95 per cent confidence intervals, is presented tables 16A.36, 16A.55 and 16A.56.

Affordability

‘Affordability’ is an indicator of governments’ objective to provide affordable housing to assist people who are unable to access suitable housing (box 16.13).
Box 16.13  **Affordability**

`Affordability` is defined as tenants’ financial ability to access suitable housing. Two measures of affordability are reported:

- **Average weekly rental subsidy per rebated household.**
  - This measure is reported for public housing and SOMIH. It is calculated as the total rental rebate amount divided by the total number of rebated households.
  - The amount of a rental rebate is influenced by market rent. High market rents will result in high rental rebates and low market rents will result in low rental rebates. A high or increasing value of the subsidy might imply that governments are spending more to ensure housing affordability.

- **Proportion of low income households in social housing spending more than 30 per cent of their gross income on rent.**
  - This measure is reported for public housing, SOMIH and community housing. It is calculated as number of low income rental households spending more than 30 per cent of their gross income on rent, divided by the total number of low income rental households.
  - Low income households are defined as those in the bottom 40 per cent of equivalised gross household incomes (that is, the bottom two income quintiles). Low income households are more likely to be adversely affected by relatively high housing costs than households with higher disposable incomes (Yates and Gabriel 2006; Yates and Milligan 2007).
  - Households in public housing and SOMIH who do not receive rental rebates are included in this measure. A low or decreasing proportion of households spending more than 30 per cent of their income on rent implies greater housing affordability.

Data for this indicator are reported for public housing, SOMIH and community housing. No data were available for reporting on `affordability` for Indigenous community housing. New measures of affordability is a key area for development in future reports.

Data comparability and completeness vary for this indicator. Data reported:

- for public housing and SOMIH are comparable
- for community housing are not comparable or complete.


---

**Average weekly rental subsidy**

Nationally, the average weekly subsidy per rebated household in public housing was $143 at 30 June 2012, increasing from $124 at 30 June 2008 (in real terms). For SOMIH, the average weekly subsidy per rebated household was $136 at 30 June 2012, increasing from $128 at 30 June 2008 (in real terms) (figure 16.11). These subsidies varied across jurisdictions.
Figure 16.11 **Average weekly subsidy per rebated household at 30 June (2011-12 dollars)**\(^a, b\)

\(^a\) Data may not be comparable across jurisdictions and comparisons could be misleading. Tables 16A.39 and 16A.40 provide further information. \(^b\) Data are adjusted to 2011-12 dollars using the gross domestic product (GDP) price deflator (2011-12 = 100) (table AA.51). Recent volatility in the GDP deflator series affects annual movements of real expenditure. See the Statistical appendix (section A.5) for details. \(^c\) There are no SOMIH data reported for Victoria (from 2009-10) or WA (2010-11) as SOMIH was transferred to other housing programs.

*Source: AIHW (unpublished); AIHW (various years) CSHA national data report; AIHW (various years) Housing assistance in Australia (Cat. no. HOU 236); tables 16A.39, 16A.40 and AA.51.*
Proportion of low income households spending more than 30 per cent of their income on rent

Information on the proportion of low income households in social housing are presented in table 16A.41.

At 30 June 2012:

- 97.8 per cent of all households in public housing were low income households, of which 0.4 per cent were spending more than 30 per cent of their gross income on rent
- 94.4 per cent of all households in SOMIH were low income households, of which 0.7 per cent were spending more than 30 per cent of their gross income on rent
- 91.5 per cent of all households in community housing were low income households, of which 3.5 per cent were spending more than 30 per cent of their gross income on rent (table 16A.41 and table 16.7).

Further information on the proportion of income paid in rent by low income households is provided in tables 16A.43–16A.46.

These results should be interpreted with care, as income data for some public housing and SOMIH households are not updated annually and this may result in overestimating the proportion of household income spent on rent. Further, differences in the treatment of CRA in rent assessment can affect the comparability of the results reported for community housing (CRA should be excluded from household income, but data for some households may include CRA in household income). Further information on CRA can be found in the Housing and homelessness sector overview G and attachment GA (tables GA.12–GA.34).
### Table 16.7 Proportion of low income households spending more than 30 per cent of their gross income on rent, at 30 June (per cent)

<table>
<thead>
<tr>
<th></th>
<th>NSW</th>
<th>Vic</th>
<th>Qld</th>
<th>WA</th>
<th>SA</th>
<th>Tas</th>
<th>ACT</th>
<th>NT</th>
<th>Aust</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Public housing</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2010</td>
<td>0.1</td>
<td>3.9</td>
<td>–</td>
<td>1.1</td>
<td>1.7</td>
<td>–</td>
<td>0.9</td>
<td>5.8</td>
<td>1.3</td>
</tr>
<tr>
<td>2011</td>
<td>0.2</td>
<td>np</td>
<td>0.1</td>
<td>1.4</td>
<td>–</td>
<td>np</td>
<td>0.8</td>
<td>1.8</td>
<td>0.3</td>
</tr>
<tr>
<td>2012</td>
<td>0.2</td>
<td>–</td>
<td>0.7</td>
<td>1.3</td>
<td>–</td>
<td>np</td>
<td>0.7</td>
<td>1.8</td>
<td>0.3</td>
</tr>
<tr>
<td><strong>SOMIH</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2010</td>
<td>0.1</td>
<td>..</td>
<td>0.1</td>
<td>2.0</td>
<td>2.2</td>
<td>–</td>
<td>..</td>
<td>..</td>
<td>0.8</td>
</tr>
<tr>
<td>2011</td>
<td>0.3</td>
<td>..</td>
<td>0.2</td>
<td>..</td>
<td>–</td>
<td>–</td>
<td>..</td>
<td>..</td>
<td>0.2</td>
</tr>
<tr>
<td>2012</td>
<td>0.5</td>
<td>..</td>
<td>1.1</td>
<td>..</td>
<td>–</td>
<td>–</td>
<td>..</td>
<td>..</td>
<td>0.7</td>
</tr>
<tr>
<td><strong>Community housing</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2009-10</td>
<td>12.9</td>
<td>20.3</td>
<td>na</td>
<td>59.9</td>
<td>6.9</td>
<td>28.0</td>
<td>23.6</td>
<td>na</td>
<td>18.4</td>
</tr>
<tr>
<td>2010-11</td>
<td>10.8</td>
<td>12.2</td>
<td>na</td>
<td>32.7</td>
<td>1.2</td>
<td>35.5</td>
<td>2.0</td>
<td>na</td>
<td>12.6</td>
</tr>
<tr>
<td>2011-12</td>
<td>3.8</td>
<td>–</td>
<td>na</td>
<td>5.0</td>
<td>3.6</td>
<td>26.5</td>
<td>–</td>
<td>na</td>
<td>3.5</td>
</tr>
</tbody>
</table>

*a Data may not be comparable across jurisdictions and comparisons could be misleading. Table 16A.42 provides further information. b There are no SOMIH data reported for Victoria (from 2009-10) or WA (2010-11) as SOMIH was transferred to other housing programs. na Not available. .. Not applicable. – Nil or rounded to zero. np Not published.

*Source: AIHW (unpublished); AIHW (various years) Housing assistance in Australia (Cat. no. HOU 236); table 16A.42.*

**Match of dwelling to household size**

‘Match of dwelling to household size’ is an indicator of governments’ objective to provide housing assistance that is appropriate to the needs of different households (box 16.14). The objectives of community housing providers in providing housing assistance may be different to those of governments.
'Match of dwelling to household size' is defined as the proportion of households that are overcrowded. Overcrowding is defined and measured using the Canadian National Occupancy Standard (CNOS) since 2010 under which overcrowding is deemed to have occurred if one or more additional bedrooms are required to meet the standard.

The CNOS specifies that:
- no more than two people shall share a bedroom
- parents or couples may share a bedroom
- children under 5 years, either of the same sex or opposite sex may share a bedroom
- children under 18 years of the same sex may share a bedroom
- a child aged 5 to 17 years should not share a bedroom with a child under 5 of the opposite sex
- single adults 18 years and over and any unpaired children require a separate bedroom.

Households living in dwellings where this standard cannot be met are considered to be overcrowded. The CNOS enables a comparison of the number of bedrooms required with the actual number of bedrooms in the dwelling and is sensitive to both household size and household composition.

A low or decreasing proportion of overcrowded households is desirable.

State and Territory governments’ housing authorities bedroom entitlement policies may differ from the CNOS.

Data for this indicator are reported for public housing, SOMIH, community housing and Indigenous community housing. The comparability and completeness of data reported for the indicator vary. Data reported:
- for public housing and SOMIH are comparable
- for community housing and Indigenous community housing are neither comparable nor complete.


The proportion of overcrowded households varied across social housing programs and across jurisdictions. At 30 June 2012, 4.3 cent of households in public housing were overcrowded, 9.8 per cent of SOMIH households were overcrowded and 2.8 per cent of households in community housing were overcrowded (figure 16.12). Information on underutilisation in public housing, SOMIH and community housing dwellings is reported at table 16A.54.
Figure 16.12 Proportion of overcrowded households, at 30 June\textsuperscript{a}

\begin{figure}
\begin{center}
\includegraphics[width=\textwidth]{figure16_12}
\end{center}
\end{figure}

\textsuperscript{a} Data may not be comparable across jurisdictions and comparisons could be misleading. Tables 16A.47–16A.49 provide further information. \textsuperscript{b} There are no SOMIH data reported for Victoria (from 2009-10) or WA (2010-11) as SOMIH was transferred to other housing programs. \textsuperscript{c} Data for Queensland (from 2010) and the NT are not available. \textsuperscript{d} Proportions for Victoria in 2008 and the ACT in 2009 were nil or rounded to zero.

Source: AIHW (unpublished); AIHW (various years) Housing assistance in Australia (Cat. no. HOU 236); tables 16A.47–16A.49.
Table 16.8 illustrates the proportion of overcrowded households in Indigenous community housing. However, complete data were not available for all jurisdictions, and these figures may be an underestimate.

Table 16.8  Proportion of overcrowded households in Indigenous community housing, at 30 June (per cent)a, b

<table>
<thead>
<tr>
<th></th>
<th>NSW</th>
<th>Vic</th>
<th>Qld</th>
<th>WA</th>
<th>SA</th>
<th>Tas</th>
<th>ACT</th>
<th>NT</th>
<th>Aus Gov</th>
<th>Aust</th>
</tr>
</thead>
<tbody>
<tr>
<td>2007</td>
<td>na</td>
<td>..</td>
<td>27.2</td>
<td>na</td>
<td>24.1</td>
<td>..</td>
<td>na</td>
<td>na</td>
<td>24.5</td>
<td>na</td>
</tr>
<tr>
<td>2008</td>
<td>29.1</td>
<td>–</td>
<td>36.6</td>
<td>na</td>
<td>na</td>
<td>..</td>
<td>–</td>
<td>na</td>
<td>10.2</td>
<td>na</td>
</tr>
<tr>
<td>2009</td>
<td>25.1</td>
<td>0.8</td>
<td>32.5</td>
<td>na</td>
<td>31.8</td>
<td>..</td>
<td>–</td>
<td>na</td>
<td>13.7</td>
<td>na</td>
</tr>
<tr>
<td>2010</td>
<td>na</td>
<td>6.3</td>
<td>43.8</td>
<td>28.4</td>
<td>48.4</td>
<td>na</td>
<td>na</td>
<td>na</td>
<td>..</td>
<td>na</td>
</tr>
<tr>
<td>2011</td>
<td>na</td>
<td>5.7</td>
<td>13.9</td>
<td>32.9</td>
<td>52.0</td>
<td>na</td>
<td>na</td>
<td>na</td>
<td>..</td>
<td>na</td>
</tr>
</tbody>
</table>

a Data may not be comparable across jurisdictions and comparisons could be misleading. Table 16A.50 provides further information. b Australian totals may not represent national totals because data were not available for all jurisdictions. na Not available. — nil or rounded to zero. .. not applicable.

Source: AIHW (various years) Housing Assistance in Australia (Cat No. HOU 236); table 16A.50.

Other information relating to overcrowding of Indigenous people in social housing, includes:

- Indigenous people living in overcrowded conditions in public housing and SOMIH, by remoteness area (tables 16A.51 and 16A.52)
- the number of bedrooms required for people living in overcrowded conditions in Indigenous community housing (table 16A.53).

Customer satisfaction

‘Customer satisfaction’ is an indicator of governments’ objective to provide housing assistance that is appropriate for different households (box 16.15).
Box 16.15  **Customer satisfaction**

‘Customer satisfaction’ is defined as tenants’ satisfaction with the overall service provided.

A high or increasing percentage for customer satisfaction can imply better housing assistance provision.

Data are reported for public housing, SOMIH and community housing. There were no data available for Indigenous community housing for the 2013 Report.

Data comparability and completeness vary for this indicator:
- data reported for public housing and SOMIH are comparable
- data reported for community housing are neither comparable nor complete.


Data for this indicator are sourced from the National Social Housing Survey (NSHS). Data from the 2012 survey are reported for public and community housing and SOMIH. Data from earlier surveys (2010 and 2007) were included in earlier reports.

Nationally in 2012, the NSHS found that:
- for public housing, 65.2 per cent of tenants in public housing were either satisfied (34.2 per cent) or very satisfied (31.0 per cent) with the service provided by the State or Territory housing authority (table 16A.55)
- for SOMIH, 58.5 per cent of SOMIH respondents were either satisfied (36.6 per cent) or very satisfied (21.9 per cent) with the service provided by the State housing authority (table 16A.36)
- for community housing, 73.9 per cent of tenants were either satisfied (35.1 per cent) or very satisfied (38.8 per cent) with the services provided by their community housing organisation (table 16A.56).

95 per cent confidence intervals for these data are in the attachment tables.

The levels of satisfaction varied across jurisdictions.
16.4 Future directions in performance reporting

Further developing indicators and data

The Housing and Homelessness Working Group will continue to improve the quality of community housing, Indigenous community housing and financial data in this Report.

Development work is underway to enable better reporting on crisis and transitional housing.

16.5 Jurisdictions’ comments

This section provides comments from each jurisdiction on the services covered in this chapter.
**Australian Government comments**

The NAHA is a framework for governments to work together to improve housing affordability, reduce homelessness and reduce Indigenous housing disadvantage. As part of the Agreement, governments have committed to undertake a number of reforms in the housing sector. The NAHA is supported by three National Partnership Agreements:

- the $400 million National Partnership Agreement on Social Housing will deliver around 1950 dwellings – by 30 June 2012 over 1800 had been completed
- the $1.1 billion National Partnership Agreement on Homelessness will deliver new expanded services to reduce homelessness across Australia. A Place to Call Home, a joint initiative under the National Partnership Agreement on Homelessness, will deliver over 600 new homes in conjunction with wrap-around support services. At 30 June 2012, 468 were completed
- the $5.5 billion National Partnership on Remote Indigenous Housing will help address significant overcrowding, homelessness and poor housing conditions over 10 years. Up to 4200 new houses will be constructed and up to 4800 existing houses will be rebuilt or refurbished. At 30 June 2012, over 1400 new houses had been delivered and 4707 existing dwellings refurbished.

In addition, the $5.6 billion Social Housing Initiative under the Nation Building — Economic Stimulus Plan will deliver around 19 700 social housing dwellings and has completed repairs and maintenance to around 80 000 existing social housing dwellings. As at 30 June 2012 construction had been completed for nearly 19 000 dwellings.

Commonwealth Rent Assistance (CRA) is a non-taxable income support supplement payable to individuals and families who rent accommodation in the private rental market and community housing. CRA rates are based on a customer's family situation and the amount of rent they pay. At 1 June 2012 1 188 467 individuals and families were receiving CRA. In 2011-12 Australian Government expenditure on CRA was $3.35 billion.

The National Rental Affordability Scheme (NRAS) is a long-term commitment by the Australian Government to invest in affordable rental housing. The Scheme offers financial incentives to the business sector and community organisations to build and rent dwellings to low and moderate income households at a rate that is at least 20 per cent below prevailing market rates. As at 30 June 2012 more than 8500 dwellings had been built.

The Australian Government has continued to implement several other initiatives to improve housing affordability and help Australians buy their first home. These include the Housing Affordability Fund, First Home Savers Accounts, releasing surplus Commonwealth land and the Building Better Regional Cities initiative. Commonwealth Financial Counselling and Centrelink’s Financial Information Service also help people in financial difficulty to make informed choices to address their problems.
New South Wales Government comments

A strong and sustainable social housing system is a key priority for the NSW Government. The Government’s plan for New South Wales, *NSW 2021*, outlines its commitment to deliver well-coordinated services to support those who need it most, including social housing services. Through early intervention and collaboration across different areas of government and with the non–government sector, NSW can design and deliver tailored support services to vulnerable individuals and families.

The NSW Government manages approximately 112,000 public housing properties – the largest number of public housing assets in Australia. As well as public housing, the community housing sector’s role in the provision of social housing continues to grow, with almost 26,000 properties now being managed in this sector. The Aboriginal Housing Office owns nearly 4,500 properties and Aboriginal housing providers manage more than 4,700 properties.

The NSW Government is committed to building a flexible and responsive community housing sector, well integrated into the broader NSW social housing system, and capable of providing an increased supply of affordable housing tailored to tenants’ needs. The Registrar of Community Housing registers and regulates community housing providers, and has a focus on ensuring a viable and diverse community housing sector that supports people in need in NSW.

The NSW Government’s Build and Grow Aboriginal Community Housing Strategy is designed to better meet the needs of Aboriginal tenants and communities. Key features of the Strategy include addressing the backlog of maintenance in community-owned homes, developing an Aboriginal community housing provider registration system, introducing a new rent policy and providing time-limited capacity subsidies for registered providers.

NSW is also working to ensure that Aboriginal clients are offered culturally appropriate social housing products and services, are supported to sustain their tenancies, and experience less homelessness, overcrowding and housing affordability stress.

As well as delivering a strong and sustainable social housing system, the NSW Government is committed to tackling the underlying causes of rising housing costs by increasing the supply of affordable housing in the private market. Planning reforms are underway to support more private sector investment in new, affordable housing. This includes providing councils with planning tools to encourage housing development for low and moderate income households.

NSW is also working with the Commonwealth through the National Rental Affordability Scheme. The NSW Government has allocated more than $260 million to support the delivery of over 6,500 new affordable rental homes for lower income families in NSW, of which 1,400 have been constructed to date.
Victorian Government comments

During 2011-12, Victoria continued its effort to provide housing and services to families and individuals who require assistance to access and maintain safe and stable housing as well as offer support for homeless people.

Through the Commonwealth Government’s Nation Building Economic Stimulus Plan, over 900 new homes were completed in 2011-12 across Victoria, taking the total number of homes built through this program to 4503 in Victoria. The majority of these homes have been allocated to the homeless or those at risk of homelessness, with the rest provided to other Victorians in need of support such as those with a disability and the elderly.

In addition to this, Victoria has progressed on many of its redevelopment projects which aim to redevelop outdated public housing neighbourhoods to offer an integrated mix of public, social and private homes with landscaped parks and gardens in well located areas.

For example, 152 new homes were delivered in 2011-12 as part of the Fitzroy renewal project with three retail spaces and a family and children’s hub. Additional benefits were delivered such as local children art projects and youth sport programs as a result of the government’s strong partnership with the development team and collaboration with residents.

Two new Work and Learning centres were set up in Carlton and North Geelong which offer people experiencing disadvantage, particularly public housing tenants, access to career guidance, training and links to employment services and employers. In 2011-12, the two centres developed support plans for 225 clients and placed 146 people into employment and training.

The Public Tenant Employment Program has also helped housing tenants from disadvantage areas in Victoria to develop skills and work readiness to break the cycle of disadvantage. Job opportunities to public tenants were provided during the construction phase of three housing affordability projects in Richmond, Prahran and Fitzroy. A place-based work and learning broker was engaged at each of the projects to support tenants, including linking them to training and/or employment opportunities with public housing work contractors and community enterprises.

Victoria is also committed to maintaining and improving public housing. In 2011-12 major upgrades to 1832 homes were completed, extending the life of these ageing properties and making them more comfortable for residents to live in.

Victoria has contributed to reducing its environmental footprint by implementing environmentally sustainable initiatives. The government has assisted housing tenants to reduce their energy and water consumption by retrofitting 250 public housing properties with energy and water efficient facilities.

A minimum 6 Star Nationwide House Energy Rating Scheme rating was achieved through building renewal projects delivered at Richmond, Prahran and Fitzroy housing estates.
Queensland Government comments

Queensland continues to be committed to delivering a social housing system that provides safe, affordable and appropriate housing for Queenslanders.

In addition, Queensland is progressing a significant reform agenda at the State and national levels to ensure the best long-term use of assets and to improve client outcomes.

During 2011-12, social housing assistance was provided to more than 70,000 households across Queensland. New households with a very high or high housing need comprised 95 per cent of households provided with government-managed social rental housing. A total of 202,372 households were assisted to access or sustain private market tenure.

Under the Nation Building Jobs Plan – Social Housing Initiative, during 2011-12 Queensland expended $145.5 million and completed 994 dwellings. The final 287 dwellings for delivery under this program will be completed in 2012-13.

Under the National Rental Affordability Scheme (life of program to 30 June 2012) 11,284 incentives were approved, 2,472 new dwellings became available and 2,191 dwellings were tenanted.

The range of State reform initiatives commenced in 2011-12 in Queensland are significant and aim to:

- leverage the extensive asset base worth over $15 billion to facilitate redevelopment and/or create additional housing better aligned to current needs
- create a stronger role for not-for-profit housing providers, who currently manage 20 per cent of Queensland’s social housing stock, to pursue options for alternative service delivery models through land, stock and management transfers of public housing to not-for-profit housing providers.

In particular, the Logan Renewal Initiative aims to renew and realign an ageing public housing portfolio to meet current and future demand for housing assistance in Logan City, and will deliver a new supply of affordable housing both for rent and sale in response to anticipated population growth over the next 20 years. It will also transition management of the existing public housing portfolio in Logan (approximately 5000 tenancies) to one or more registered community housing organisations.
Western Australian Government comments

In 2011-12, the Housing Authority launched the SharedStart shared equity home ownership scheme, which provides shared equity loans to low to moderate income households. We assisted more than 190 applicants to buy newly built and off-the-plan properties under this scheme. The purchase of these is made affordable by the Authority taking an equity stake as a ‘silent partner’ and through the provision of low-deposit Keystart mortgage finance. A further 601 properties have been contracted.

The Government continues to address the affordability issue through its 10-year Affordable Housing Strategy, which was announced last year. The Authority is implementing the Strategy through the building and sale of houses, the provision of mortgage finance, the supply of rental properties, the sale of land and through the our partnerships with the community, private sector and other State Government agencies. The Authority has already delivered more than 6200 housing opportunities under this Strategy.

In March 2012, Cabinet acknowledged the impact of high housing in regional areas by approving a funding allocation over five years to deliver increased affordable housing opportunities for key workers in regional Western Australia. To date, 58 properties have been made available to staff of non-government organisations.

The State Government has increased its investment in NRAS to fund an extra 1000 new affordable rental homes, in conjunction with the Commonwealth Government. More than 500 new NRAS properties in WA were occupied this year.

Major activities for 2011-12 included the shifting away from public housing for life. This aims to transition tenants out of public housing and into other affordable housing options as their circumstances improve and includes the provision of affordable shared equity loan finances as well as support to access private rental opportunities. This not only encourages tenants to enter the wider housing market, but is also as an important part of our strategy to free up public housing for those on the waiting list who are in greater housing need.

The Authority has continued to work closely with the community housing sector to maximise the benefits being delivered to low and moderate income earners through the Asset Transfer Program.

We met our targets under the National Partnership Agreement on Remote Indigenous Housing for the third consecutive year, and improved housing and development opportunities by building workers’ hostels for Aboriginal trainees in regional areas.

This year we celebrated 100 years of providing affordable housing for Western Australians. The Housing Authority traces its roots to the Workers’ Homes Board, which was established to provide housing for workers on low to moderate incomes.
South Australian Government comments

Seventy-five years after becoming Australia’s first public housing authority, the role of Housing SA continues to evolve to deliver better housing outcomes for South Australian communities. The creation of a new urban renewal authority, Renewal SA, in March 2012 has consolidated some activities conducted by South Australian agencies responsible for land and housing development including Housing SA’s medium and high density housing developments, urban renewal activities and the affordable housing program.

Housing SA remains responsible for housing policy, community housing regulation, remote Indigenous and homelessness services, specialist social housing, tenancy management and maintenance functions. Housing SA also continues its new build programs for public, Aboriginal and community housing construction.

Housing SA continued to maintain 43 705 rental dwellings as at 30 June 2012. During 2011-12, 2592 properties were newly allocated to public and Aboriginal housing tenants with 95 per cent allocated to high needs households. The changing needs of our tenants has led to the employment of social workers to meet the growing demand for case management skills within our workforce.

Our Private Rental Assistance Program saw a 14.3 per cent increase in the total number of households assisted over the past financial year with 19 727 bonds, including cash bonds, guaranteed. The value of bonds guaranteed also increased, up to $19.6 million, a 23.0 per cent increase from 2010-11.

New investment in Aboriginal housing under the National Partnership Agreement on Remote Indigenous Housing saw the construction of 58 new dwellings (above the target of 54) and 39 houses refurbished. Of these capital works, 38 new builds and 19 refurbishments were undertaken on the Anangu Pitjantjatjara Yankunytjatjara communities (APY Lands). A new information technology system, Chintaro, was rolled out across Housing SA to support the management of tenancies and properties across South Australia’s Aboriginal communities.

Through the Nation Building – Economic Stimulus Plan (NBESP), Housing SA has continued to deliver affordable housing opportunities with the practical completion of 1367 new dwellings with a further 103 currently under construction as at 30 June 2012. We have been working towards increasing the growth of the not-for profit sector by transferring ownership of 617 NBESP properties. As at 30 June 2012, the legal transfer of 607 properties had occurred.

All properties funded through the National Partnership Agreement on Social Housing have been completed. Under the National Rental Affordability Scheme, South Australia has 1200 dwellings completed that are either tenanted or available for rent.
Tasmanian Government comments

The landscape of social and affordable housing is changing in Tasmania. Public housing still represents the overwhelming proportion of social housing for the most vulnerable in the community. However in 2011-2012, the Tasmanian Government agreed to major reform of the State’s social housing sector via the transfer of management of 4000 public housing properties, and the title ownership of vacant land, to three community housing organisations by June 2014. Tasmania released its first portfolio of 500 tenancies in early 2012 under the Better Housing Futures program.

In 2011-12 Housing Tasmania continued its strong performance in housing people in greatest need; managed an occupancy rate of 97.3 per cent; and reduced the waiting list from 2983 to 2670. There was a significant improvement in utilisation. However the ageing portfolio means that maintenance requirements between tenancies are high and this may have contributed to the disappointing increase in the number of days dwellings were vacant, the time to occupy and the number of dwellings unable to be tenanted.

During this period, there has also been a significant focus on implementing the Cost of Living Energy Efficiency Strategy. This has included initiatives such as thermal installations, window treatments, more efficient lighting and space heating, and solar hot water.

In October 2011, Tasmania began the progressive introduction of a new rent setting method whereby all tenants moved from a variable proportion of income to the flat 25 per cent used elsewhere in Australia. This major and complex change required detailed individual tenant communication, but the effect has been to create policy equivalence in rent conditions between public and community housing. It was the forerunner of a number of policy changes which are now being made. These changes afford greater policy equity so there is no disincentive for tenants to choose between social housing providers.

Tasmania’s community housing picture validates efforts to foster growth in that sector. There was an improved response rate and better data quality than in previous years and there has been a sizeable increase in households and dwellings, together with a substantial decrease in net recurrent costs. On the National Social Housing Survey, satisfaction increased to 88 per cent for community housing. The sector in Tasmania is performing better than it has since collections started.

Throughout the year, there was a continuing effort to increase supply and by June 2012 the target of 1400 new homes had been built. This achievement was enabled by a range of Australian and Tasmanian Government programs including the Nation Building Economic Stimulus Plan and the National Rental Affordability Scheme. Tasmania expects to deliver a further 1000 homes and release 200 land lots for residential development by June 2016.
Australian Capital Territory Government comments

A wide range of policy and operational reforms to the social and broader housing system have been delivered in response to the National Affordable Housing Agreement. Work in establishing a housing continuum and in addressing housing affordability has ensured that the ACT Government has delivered the majority of its commitments under the National Affordable Housing Agreement.

The ACT was the first jurisdiction to complete its commitments under the Nation Building and Jobs Plan. The ACT delivered 421 properties, which was well above the Commonwealth’s requirement to construct 297 properties. The final 27 dwellings were completed in 2011-12.

In keeping with the ACT’s commitment to a strong and viable community housing sector, a total of 124 dwellings constructed under the stimulus program were transferred to a range of community housing providers, including three providers who are new to the ACT.

The ACT continued the re-alignment of the public housing portfolio to improve the quality of the stock and to better meet the needs of applicants and tenants. In addition, all newly constructed properties were built to a minimum 6 star energy rating.

In 2011-12, Housing ACT continued to integrate its specialist homelessness responses providing better support for vulnerable Canberrans. Notably, the implementation of the Central Access Point (CAP) has streamlined access to housing and homelessness services by ensuring that clients do not have to negotiate with multiple agencies access services. The CAP co-locates Housing ACT’s Gateway Services, the central intake service for homelessness services, the Supportive Tenancy Service and CARE financial counselling service. Other evidence of Housing ACT working to assist vulnerable and marginalised people to participate in and enjoy the benefits of the community, include:

- The establishment of the Improved Support/Stronger Communities Initiative a specialist approach to anti-social and disruptive behaviour.
- The provision of support to 147 young tenants through the Youth Housing Program; and
- The ongoing support of the Joint Champions group, providing an opportunity for ACT public housing tenants to contribute to the planning and delivery of social housing services in the ACT.

A new Total Facilities Management contract came into effect on 1 July 2012. The new contract implemented several new initiatives aimed at further improving service delivery. Under the new contract the Total Facilities Manager is also required to achieve employment targets and to provide training to groups, such as public housing tenants, youth, people with a disability and Aboriginal and Torres Straight Islanders.
Northern Territory Government comments

In 2011-12 the Northern Territory continued to focus on land release and access to safe, affordable and appropriate housing.

Land release continued across the Palmerston suburbs of Bellamack, Johnston and Zuccoli. In addition, planning continued on the new suburbs of Mitchell in Palmerston and Kilgariff in Alice Springs. A minimum of 15 per cent of all new crown land releases were reserved for social and affordable housing.

In 2011-12, 443 new dwellings for low and middle income earners were constructed including:

- 356 new houses and 805 refurbishments in remote and urban Indigenous living areas as part of the $1.7 billion ten year National Partnership Agreement on Remote Indigenous Housing
- 87 new social housing dwellings and significant upgrade works to existing facilities. This included the completion of the Bellamack Seniors Village, a jointly funded initiative of the Northern Territory and Commonwealth governments, which provided 40 one and two bedroom dwellings for seniors.

In early 2012, Venture Housing Company was formally established as the Territory’s first affordable housing rental company. Venture will provide rental properties for low to moderate income earners in the Territory having difficulties affording market rental prices, with an initial focus on the Darwin region.

In 2011-12, the NT Home Ownership Business Division helped Territorians achieve homeownership by:

- issuing 166 loans through the HomestartNT shared equity scheme
- assisting with the sale of 21 new affordable housing units for low-to-middle-income earners, priced between $320 000 and $390 000.

Other NT home ownership measures included the continued provision of stamp duty concessions for first home buyers, senior Territorians, veterans and carers looking to purchase or build a new home. There were also 162 grants of $10 000 each provided to encourage investment in, and construction of, homes and units across the Territory.

In an effort to sustain public housing tenancies, in 2011-12 the Northern Territory introduced Public Housing Safety Officers who are employed by the Department of Housing to work proactively with tenants, neighbours and visitors to resolve and reduce antisocial behaviour at public housing sites.
16.6 Definitions of key terms

Social housing

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.

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.

Canadian National Occupancy Standard (CNOS)
A measure of the appropriateness of housing which is sensitive to both household size and composition. The CNOS specifies that:

- no more than two people shall share a bedroom
- parents or couples may share a bedroom
- children under 5 years, either of the same sex or opposite sex may share a bedroom
- children under 18 years of the same sex may share a bedroom
- a child aged 5 to 17 years should not share a bedroom with a child under 5 of the opposite sex
- single adults 18 years and over and any unpaired children require a separate bedroom.

Depreciation costs
Depreciation calculated on a straight-line basis at a rate that realistically represents the useful life of the asset (as per the Australian Accounting Standards 13–17).

Disability (as per the ABS Survey of Disability Ageing and Carers)
A person has a disability if they report they have a limitation, restriction or impairment, which has lasted, or is likely to last, for at least six months and restricts everyday activities.

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** Low income households are generally defined in this Report as those in the bottom 40 per cent of equivalised gross household incomes (that is, the bottom two income quintiles). Equivalised gross income is an indicator of disposable household income after taking into account household size and composition.

**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.

**New household** Households that commence receiving assistance during the relevant reporting period (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 one or more bedrooms are required to meet the Canadian National 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 standard** A measure of the appropriateness of housing related to the household size and tenancy composition. The measure specifies the bedroom requirements of a household.

<table>
<thead>
<tr>
<th>Household structure</th>
<th>Bedrooms required</th>
</tr>
</thead>
<tbody>
<tr>
<td>Single adult only</td>
<td>1</td>
</tr>
<tr>
<td>Single adult (group)</td>
<td>1 (per adult)</td>
</tr>
<tr>
<td>Couple with no children</td>
<td>2</td>
</tr>
<tr>
<td>Sole parent or couple with one child</td>
<td>2</td>
</tr>
<tr>
<td>Sole parent or couple with two or three children</td>
<td>3</td>
</tr>
<tr>
<td>Sole parent or couple with four children</td>
<td>4</td>
</tr>
</tbody>
</table>

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.

**Rebated household** A household that receives housing assistance and pays less than the market rent value for the dwelling.

**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.

**Special needs household** Low income households that have either a household member with disability, a principal tenant aged 24 years or under, or 75 years or over, or one or more Indigenous members.

For SOMIH, special needs households are those that have either a
<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Household member with disability or a principal tenant aged 24 years or under, or 50 years or over.</td>
<td></td>
</tr>
<tr>
<td>Tenancy rental unit</td>
<td>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.</td>
</tr>
<tr>
<td>Tenantable dwelling</td>
<td>A dwelling where maintenance has been completed, whether occupied or unoccupied at 30 June. All occupied dwellings are tenantable.</td>
</tr>
<tr>
<td>Total gross household income</td>
<td>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. CRA payments are not included as income.</td>
</tr>
<tr>
<td>Transfer household</td>
<td>A household, either rebated or market renting, that relocates (transfers) from one dwelling to another within the same social housing program.</td>
</tr>
<tr>
<td>Turnaround time</td>
<td>The average time taken in days for vacant dwellings, which are available for letting, to be occupied.</td>
</tr>
<tr>
<td>Underutilisation</td>
<td>Where there are two or more bedrooms additional to the number required in the dwelling to satisfy CNOS.</td>
</tr>
<tr>
<td>Untenantable dwelling</td>
<td>A dwelling not currently occupied by a tenant, where maintenance has been either deferred or not completed at 30 June.</td>
</tr>
</tbody>
</table>
### 16.7 List of attachment tables

Attachment tables are identified in references throughout this chapter by a ‘16A’ prefix (for example, table 16A.1). Attachment tables are available on the Review website (www.pc.gov.au/gsp).

| Table 16A.1 | State and Territory Government nominal expenditure on social housing |
| Table 16A.2 | State and Territory Government real expenditure on social housing (2011-12 dollars) |
| Table 16A.3 | Descriptive data — number of social housing dwellings, at 30 June |
| Table 16A.4 | Descriptive data — number of households in social housing, at 30 June |
| Table 16A.5 | Descriptive data — public housing |
| Table 16A.6 | Descriptive data — State owned and managed Indigenous housing |
| Table 16A.7 | Descriptive data — community housing |
| Table 16A.8 | Descriptive data — Indigenous community housing |
| Table 16A.9 | Proportion of new tenancies allocated to households with special needs — public housing (per cent) |
| Table 16A.10 | Proportion of new tenancies allocated to households with special needs — SOMIH (per cent) |
| Table 16A.11 | Proportion of new tenancies allocated to households with special needs — community housing (per cent) |
| Table 16A.12 | Greatest need allocations as a proportion of all new allocations — public housing (per cent) |
| Table 16A.13 | Greatest need allocations as a proportion of all new allocations — SOMIH (per cent) |
| Table 16A.14 | Greatest need allocations as a proportion of all new allocations — community housing (per cent) |
| Table 16A.15 | Dwelling condition — Public housing (per cent) |
| Table 16A.16 | Dwelling condition — SOMIH (per cent) |
| Table 16A.17 | Dwelling condition — Community housing (per cent) |
| Table 16A.18 | Dwelling condition — Indigenous community housing (per cent) |
| Table 16A.19 | Nominal government expenditure on public housing, 2002-03 to 2011-12 ($ per dwelling) |
| Table 16A.20 | Real government expenditure on public housing, 2002-03 to 2011-12 (2011-12 dollars) ($ per dwelling) |
| Table 16A.21 | Net recurrent cost of providing assistance per dwelling (excluding the cost of capital) — SOMIH ($ per dwelling) |
| Table 16A.22 | Net recurrent cost per tenancy — community housing ($ per dwelling) |
| Table 16A.23 | Net recurrent cost per dwelling — Indigenous community housing (2010-11 dollars) |
| Table 16A.24 | Public housing occupancy rates as at 30 June (per cent) |
Table 16A.25  SOMIH occupancy rates as at 30 June (per cent)
Table 16A.26  Community housing occupancy rates at 30 June (per cent)
Table 16A.27  Indigenous community housing occupancy rates (per cent)
Table 16A.28  Average turnaround times for vacant stock — public housing (days)
Table 16A.29  Average turnaround times for vacant stock — SOMIH (days)
Table 16A.30  Public housing rent collection rate (per cent)
Table 16A.31  SOMIH rent collection rate (per cent)
Table 16A.32  Community housing rent collection rate (per cent)
Table 16A.33  Indigenous community housing rent collection rate (per cent)
Table 16A.34  Proportion of public housing tenants rating amenity aspects as important and meeting their needs, 2012 (per cent)
Table 16A.35  Proportion of public housing tenants rating location aspects as important and meeting their needs, 2012 (per cent)
Table 16A.36  Amenity, location and customer satisfaction with SOMIH, 2012 (per cent)
Table 16A.37  Proportion of community housing tenants rating amenity aspects as important and meeting their needs, 2012 (per cent)
Table 16A.38  Proportion of community housing tenants rating location aspects as important and meeting their needs, 2012 (per cent)
Table 16A.39  Average weekly subsidy per rebated household, at 30 June — public housing ($ per week)
Table 16A.40  Average weekly subsidy per rebated household, at 30 June — SOMIH ($ per week)
Table 16A.41  Low income households in social housing, at 30 June
Table 16A.42  Proportion of low income households in social housing spending more than 30 per cent of their gross income on rent, at 30 June (per cent)
Table 16A.43  Proportion of income remaining after paying rent, as at 30 June — community housing (per cent)
Table 16A.44  Proportion of household gross income spent on rent — low income households in public housing, at 30 June (per cent)
Table 16A.45  Proportion of household gross income spent on rent — low income households in SOMIH, at 30 June (per cent)
Table 16A.46  Proportion of household income spent on rent — community housing, at 30 June (per cent)
Table 16A.47  Proportion of overcrowded households at 30 June — public housing (per cent)
Table 16A.48  Proportion of overcrowded households at 30 June — SOMIH (per cent)
Table 16A.49  Proportion of overcrowded households at 30 June — community housing (per cent)
Table 16A.50  Proportion of overcrowded households in Indigenous community housing (per cent)
Table 16A.51  Proportion of Indigenous households in public housing living in overcrowded conditions, by remoteness (per cent)
Table 16A.52  Proportion of Indigenous households in SOMIH living in overcrowded conditions, by remoteness (per cent)
Table 16A.53  Proportion of Indigenous households in Indigenous community housing living in overcrowded conditions, by number of bedrooms needed (per cent)
Table 16A.54  Underutilisation in social housing at 30 June (per cent)
Table 16A.55  Customer satisfaction — public housing
Table 16A.56  Customer satisfaction — community housing
Table 16A.57  Housing composition by tenure type (per cent)
Table 16A.58  Households residing in public housing (per cent)
Table 16A.59  Households residing in community housing (per cent)
Table 16A.60  Public housing policy context, 2012
Table 16A.61  SOMIH housing policy context, 2012
Table 16A.62  State and Territory programs included in the community housing data collection, 2011-12
Table 16A.63  Treatment of assets by housing agencies, 2011-12
Table 16A.64  Community housing survey response rates and associated information
16.8 References

—— 2011, *Household Income and Income Distribution, Australia 2009-10*, Cat. no. 6523.0, Canberra

—— 2011, *Housing Assistance in Australia*, Cat. No. HOU 236, Canberra


FaCS (Department of Family and Community Services) 2003, *Commonwealth State Housing Agreement*, Australian Government, Department of Family and Community Services, Canberra


16.8 References


—— 2011, *Household Income and Income Distribution, Australia 2009-10*, Cat. no. 6523.0, Canberra


—— 2011, *Housing Assistance in Australia*, Cat. No. HOU 236, Canberra


FaCS (Department of Family and Community Services) 2003, *Commonwealth State Housing Agreement*, Australian Government, Department of Family and Community Services, Canberra


17 Homelessness services

CONTENTs

17.1 Profile of homelessness services 17.3
17.2 Framework of performance indicators for government funded specialist homelessness services 17.6
17.3 Key performance indicator results for government funded specialist homelessness services 17.9
17.4 Key performance indicator results for government funded specialist homelessness services, SAAP, 2010-11 17.36
17.5 Future directions in homelessness services performance reporting 17.38
17.6 Jurisdictions’ comments 17.38
17.7 Definitions of key terms 17.48
17.8 List of attachment tables 17.52
17.9 References 17.55

Attachment tables
Attachment tables are identified in references throughout this chapter by a ‘17A’ prefix (for example, table 17A.1). A full list of attachment tables is provided at the end of this chapter, and the attachment tables are available from the Review website at www.pc.gov.au/gsp.

Homelessness has multiple causes. Some of the social and personal factors associated with homelessness include a shortage of affordable housing, family and relationship breakdown, unemployment and financial hardship, mental health problems, and drug and alcohol abuse (COAG Reform Council 2010).

Australian, State and Territory governments fund services to assist people who are homeless or at risk of homelessness.
Between 1985 and 2009, the Australian Government and State and Territory governments funded the Supported Accommodation Assistance Program (SAAP) to alleviate the difficulties of people who are homeless or at risk of homelessness and reduce the potential for their recurrence. SAAP services provided assistance to individuals and families who were in crisis or experienced difficulties that hindered personal or family functioning. The SAAP concluded on 31 December 2008 at the expiry of the SAAP V Multilateral Agreement.

The National Affordable Housing Agreement (NAHA) commenced on 1 January 2009 as part of the Intergovernmental Agreement on Federal Financial Relations. To support the NAHA, the National Partnership Agreement on Homelessness (NPAH) commenced on 1 July 2009. Government funding for specialist homelessness services is provided through the NAHA and NPAH.

The NAHA and NPAH provide the framework for Australian Government and State and Territory governments to reduce homelessness and improve housing outcomes for Australians. Under the NAHA, governments have committed to undertake reforms in the housing sector to improve integration between homelessness services and mainstream services, and reduce the rate of homelessness.

Under the NAHA, and the NPAH in particular, Australian, State and Territory governments agreed to a number of outcomes relating to homelessness, including that:

- fewer people will become homeless and fewer of these will sleep rough
- fewer people will become homeless more than once
- people at risk of or experiencing homelessness will maintain or improve connections with their families and communities, and maintain or improve their education, training or employment participation
- people at risk of or experiencing homelessness will be supported by quality services, with improved access to sustainable housing.

The NPAH contributes to achieving the NAHA homelessness outcomes and outlines the roles and responsibilities of the Australian Government and State and Territory governments to reduce and prevent homelessness.

This chapter presents data on government-funded specialist homelessness services and the people accessing these services. Homelessness services that do not receive government funding are excluded from this Report.

Previous editions of this Report have included data from the SAAP collection. Although the SAAP concluded on 31 December 2008, the SAAP data collection
continued until 30 June 2011 to enable reporting on homelessness services while a new Specialist Homelessness Services collection was developed. For completeness of time series, attachment tables 17A.30–59 of this Report present the final year of data sourced from the SAAP National Data Collection (NDC) (2010-11).

A performance indicator framework for specialist homelessness services, based on the new Specialist Homelessness Services collection (SHSC), is included for the first time in this Report (section 17.2) and data for the new collection for 2011-12 year are in this chapter and attachment tables 17A.1–29.

### 17.1 Profile of homelessness services

**Services to assist people who are homeless or at imminent risk of becoming homeless**

Specialist homelessness services aim to provide support to 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 SAAP was the main governmental response to homelessness between 1985 and 2009. It provided emergency accommodation as well as support services to people experiencing, or at risk of, homelessness. Some of the main developments of this program that have influenced the current service environment include:

- expansion of target groups and increasing specialisation of services
- the provision of non-accommodation support services
- responding to the individual needs of clients. This was associated with an emphasis on case management, a form of service delivery that involves an assessment process to identify the specific needs of clients and to connect them with appropriate services. (AIHW 2011).

Government and non-government service providers (including community organisations) deliver a variety of homelessness services to clients, including supported accommodation, counselling, advocacy, links to housing, health, education and employment services, outreach support, brokerage and meals services, and financial and employment assistance.
**Homelessness services and the link with other services**

Close links exist between homelessness services and other forms of housing assistance reported in the Housing chapter of this Report (chapter 16). Some individuals and families used both homelessness and housing services, as people can move from homelessness to social housing, or might be in receipt of homelessness services and accommodated in social housing. The Housing and homelessness sector overview provides some information on the interconnections between these services.

**Size and scope**

Data on homelessness from the 2011, 2006 and 2001 Census are based on the Australian Bureau of Statistics (ABS) methodology (ABS 2012b) and statistical definition of homelessness (ABS 2012c), which were both developed following consultation with the homelessness sector.

When a person does not have suitable accommodation alternatives they are considered homeless if their current living arrangement:

- is in a dwelling that is inadequate
- has no tenure, or if their initial tenure is short and not extendable
- does not allow them to have control of, and access to space for social relations (ABS 2012c).

This definition applies to the general population and includes aspects of adequacy, security, stability and privacy (ABS 2012c).

In 2011, 105,237 people were estimated to be homeless on Census night (ABS 2012a).

Data on homeless people are categorised by the ABS according to homelessness operational groups. The majority of homeless people in 2011 were ‘persons living in severely crowded dwellings’ (39 per cent). Homeless people who were staying in supported accommodation accounted for 20 per cent of the homeless population. Similar proportions of homeless people were staying temporarily in other households (17 per cent) and in boarding houses (17 per cent). Only 6 per cent of

---

1 Social housing includes public and community housing. For further information on these forms of housing assistance, see chapter 16 (box 16.1).

2 The ABS categorises a dwelling as severely overcrowded if it requires four or more extra bedrooms to accommodate the number of people who usually live there based on the Canadian National Occupancy Standard (ABS 2012b).
homeless people were in improvised dwellings, tents or sleepers out and 1 per cent were in other temporary lodgings on Census night.

Estimates of homelessness from the Census provide a point-in-time prevalence measure of homelessness and information about the characteristics of those who were likely to have been homeless. However, estimates of people who are homeless on Census night may be over- or under-estimated if the data collected about a person is not sufficient to be certain about whether or not they were homeless on Census night, or under-enumerated (not counted in the Census at all). Rough sleepers and people staying in supported accommodation for the homeless are at particular risk of being under-enumerated, and Aboriginal and Torres Strait Islander people are more likely to be both under-enumerated and overrepresented in the homeless population (ABS 2012b)\(^3\).

Nationally, specialist homelessness services agencies provided support to 229,247 people in 2011-12 (AIHW 2012). Besides general services (89.8 per cent), services commonly provided included accommodation (37.7 per cent), assistance to sustain housing (23.8 per cent), domestic violence services (23.0 per cent), and other specialist services (15.7 per cent) (figure 17.1).

![Figure 17.1 Composition of support provided, all clients, 2011-12](image)


\(^3\) The Post Enumeration Survey (PES) only covers people in private dwellings at the time of the PES and therefore cannot be used to estimate underenumeration of the homeless population in the Census (ABS 2012b).
Funding

Government funded specialist homelessness services are jointly funded by the Australian Government and State and Territory governments, through the NAHA and NPAH.

Direct expenditure on specialist homelessness services is undertaken by State and Territory governments. Recurrent government expenditure on specialist homelessness services for 2011-12 was $507.0 million. Most of this expenditure (97.0 per cent) was funding provided to agencies to deliver services for people who are homeless or at risk of homelessness, while the remaining expenditure (3.0 per cent) was attributed to State and Territory governments’ administration costs (table 17A.2).

Nationally, real recurrent funding per person in the population was $23 in 2011-12, though the amount of funding per person varied across jurisdictions (table 17A.3).

In addition to funding provided under the NAHA and NPAH, State and Territory governments contribute extra funding to specialist homelessness services. Where available, the additional funding is included in reporting from 2008-09.

17.2 Framework of performance indicators for government funded specialist homelessness services

The performance indicator framework for government funded specialist homelessness services is based on shared government objectives for homelessness services delivered under the NAHA (box 17.1).
Box 17.1 **Objectives for government funded specialist homelessness services**

The overall aim of specialist homelessness services 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
- provide homelessness services in an equitable and efficient manner.

COAG has agreed six National Agreements to enhance accountability to the public for the outcomes achieved or outputs delivered by a range of government services (see chapter 1 for more detail on reforms to federal financial relations). The NAHA covers the area of housing and homelessness and includes performance indicators for which the Steering Committee collates performance information for analysis by the COAG Reform Council (CRC). Performance indicators reported in this chapter are aligned with homelessness performance indicators in the NAHA.

The performance indicator framework provides information on equity, efficiency and effectiveness, and distinguishes the outputs and outcomes of government funded specialist homelessness services (figure 17.2). The performance indicator framework shows which data are comparable in the 2013 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 Report’s statistical appendix 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) (appendix A).

The introduction of the new specialist homelessness services collection (SHSC) from 1 July 2011 has presented an opportunity to review and re-develop the framework of performance indicators and supporting measures for government funded specialist homelessness services.

A performance indicator framework based on the SHSC is presented in figure 17.2. The key changes from the SAAP-based framework (figure 17.24) are:
- the introduction of a new indicator ‘Repeat periods of homelessness’ in the framework’s ‘Outcomes’ domain
- the consolidation of indicators for special needs groups — Indigenous Australians and people from a non-English speaking background (NESB) as performance measures under a single indicator ‘Access of special needs groups to homelessness services’.

Although some indicator names remain the same, many supporting measures have been revised. While there is broad consistency in the aspects of homelessness covered in the two collections, differences in the construction of the measures mean that data are not directly comparable between the two collections.

Figure 17.2 **Government funded specialist homelessness services performance indicator framework**
17.3 Key performance indicator results for government funded specialist homelessness services

Data reported in this section are for government funded specialist homelessness services delivered under the NAHA and NPAH for 2011-12. Data are sourced from the SHSC, which reports the number of clients and the number and types of services provided to clients (box 17.2).

Data quality information (DQI) is being progressively introduced for all indicators in the Report. The purpose of DQI is to provide structured and consistent information about quality aspects of data used to report on performance indicators. DQI in this Report covers the seven dimensions in the ABS’ data quality framework (institutional environment, relevance, timeliness, accuracy, coherence, accessibility and interpretability) in addition to dimensions that define and describe performance indicators in a consistent manner, and note key data gaps and issues identified by the Steering Committee.


**Box 17.2 Specialist homelessness services collection (SHSC)**

SHSC data are collected by specialist homelessness agencies for all clients, and reported each month to the Australian Institute of Health and Welfare (AIHW). Data are collected about the characteristics and circumstances of a client when they first present at an agency, and further data — on the assistance the client receives and the client’s circumstances at the end of the month — are collected at the end of every month in which the client receives services, and at the end of the support period.

Specialist homelessness agencies that are funded under the National Affordable Housing Agreement (NAHA) and the National Partnership Agreement on Homelessness (NPAH) are in scope for the collection. Those agencies that are expected to participate in the SHSC are identified by State and Territory departments responsible for the delivery of services.

There have been many changes between the SAAP NDC and the SHSC. While there is broad consistency in the aspects of homelessness on which data are collected, many of the changes limit the ability to directly compare data across these collections. Changes include new and revised data items, changes in the scope of agencies and changes to key concepts and definitions.

**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 and access indicators are 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.

Access of special needs groups to homelessness services

‘Access of special needs groups to homelessness services’ is an indicator of governments’ objective to ensure all Australians have equitable access to accommodation services on the basis of relative need (box 17.3).

Box 17.3 Access of special needs groups to homelessness services

‘Access of special needs groups to homelessness services’ is the comparison between the representation of Indigenous people and people from a non-English speaking background (NESB) among all people whose needs for accommodation and other services were met, and the representation of these groups in the community.

This indicator is defined by three measures:

- the number of Indigenous/NESB clients whose demand for accommodation was met divided by the total number of clients whose demand for accommodation was met
- the number of Indigenous/NESB clients whose demand for services other than accommodation was met divided by the total number of clients whose demand for services other than accommodation was met
- the representation of Indigenous/NESB clients in specialist homelessness services compared with their representation in the community

Use by special needs groups is a proxy indicator of equitable access. In general, usage rates for special needs groups similar or higher to those for the broader service population are desirable. Several factors need to be considered in interpreting the results for this set of measures. In particular, cultural differences can influence the extent to which Indigenous/NESB people use different types of services.

Data reported for this indicator are not directly comparable across jurisdictions.

Data quality information for this indicator is under development.

Access of Indigenous people to homelessness services

Nationally, Indigenous people had a higher representation amongst all people accessing specialist homelessness services (22.4 per cent) than their representation in the community (3.0 per cent) (table 17.1).
Nationally, Indigenous people made up 25.5 per cent of all clients whose request for accommodation resulted in accommodation assistance, and 19.5 per cent of all clients whose request for services other than accommodation resulted in assistance in 2011-12. These results varied across jurisdictions (figure 17.3).

Figure 17.3  **Proportion of Indigenous clients among all clients whose needs for accommodation and services other than accommodation were met, 2011-12**

![Proportion of Indigenous clients among all clients whose needs for accommodation and services other than accommodation were met, 2011-12](image)

Nationally, people from non-English speaking backgrounds had a lower representation amongst all people accessing specialist homelessness services (9.1 per cent) than this group’s representation in the community (15.7 per cent) (table 17.1).

Nationally, people from a non-English speaking background (NESB) made up 9.9 per cent of all clients whose request for accommodation resulted in accommodation assistance and 9.6 per cent of all clients whose request for services other than accommodation resulted in assistance in 2011-12. These results varied across jurisdictions (figure 17.4).

Additional data on representation of special needs groups in specialist homelessness services are presented in tables 17A.4 to 17A.6.
Proportion of clients from a NESB among all clients whose needs for accommodation and services other than accommodation were met, 2011-12

SA collection methodology for 2011-12 does not allow for this type of analysis.


Table 17.1 Proportion of Indigenous and NESB people represented in specialist homelessness services and in the community, 2011-12 (per cent)

<table>
<thead>
<tr>
<th></th>
<th>NSW</th>
<th>Vic</th>
<th>Qld</th>
<th>WA</th>
<th>SA</th>
<th>Tas</th>
<th>ACT</th>
<th>NT</th>
<th>Aust</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Indigenous people</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>In specialist homelessness services</td>
<td>23.7</td>
<td>8.4</td>
<td>30.9</td>
<td>35.2</td>
<td>22.3</td>
<td>15.5</td>
<td>15.8</td>
<td>72.6</td>
<td>22.4</td>
</tr>
<tr>
<td>In the community, 2011</td>
<td>2.9</td>
<td>0.9</td>
<td>4.2</td>
<td>3.8</td>
<td>2.3</td>
<td>4.7</td>
<td>1.7</td>
<td>29.8</td>
<td>3.0</td>
</tr>
<tr>
<td><strong>People from non-English speaking backgrounds (NESB)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>In specialist homelessness services</td>
<td>9.8</td>
<td>10.9</td>
<td>6.4</td>
<td>10.8</td>
<td>5.4</td>
<td>3.9</td>
<td>14.5</td>
<td>3.9</td>
<td>9.1</td>
</tr>
<tr>
<td>In the community, 2011</td>
<td>18.6</td>
<td>19.6</td>
<td>9.5</td>
<td>14.4</td>
<td>12.7</td>
<td>5.1</td>
<td>16.8</td>
<td>10.3</td>
<td>15.7</td>
</tr>
</tbody>
</table>


Unmet demand for homelessness services

‘Unmet demand for homelessness services’ is an indicator of governments’ objective to ensure all Australians have equitable access to accommodation services on the basis of relative need (box 17.4).
Unmet demand occurs when a homeless person or a person at risk of homelessness expressly asking for assistance cannot be provided with that assistance.

**Box 17.4 Unmet demand for homelessness services**

Unmet demand for homelessness services occurs when a homeless person or a person at risk of homelessness expressly asking for assistance cannot be provided with that assistance.

‘Unmet demand’ is defined by two measures:

- the number of clients who requested short-term or emergency accommodation or medium or long term housing who were not provided or referred to these services, divided by the number of clients who had a need for short-term or emergency accommodation or medium or long term housing
- the number of clients who did not request accommodation but did request another type of service who were not provided or referred to any of these services, divided by the number of clients who had a need for a service other than accommodation.

Specialist homelessness agencies in Australia provide a range of services to a large number of people every day. However, agencies cannot always meet the requests for assistance they receive.

Information on unmet need is collected for people who seek services from specialist homeless agencies but receive no assistance (unassisted requests for services), and for the clients who have had some, but not all, of their needs met. These two components are part of the overall picture of unmet demand for specialist homelessness services. Indicators and associated measures for these components are under development.

A low or decreasing proportion of clients with unmet demand is desirable.

Data reported for this indicator are comparable across jurisdictions.

Data quality information for this indicator is under development.

Nationally in 2011-12, the number of clients with unmet need for accommodation accounted for 19.4 per cent of the total demand for accommodation. This result varied across jurisdictions (figure 17.5).

Nationally, the number of clients with unmet demand for services other than accommodation accounted for 1.2 per cent of the total demand for services other than accommodation in 2011-12. This result varied across jurisdictions (figure 17.5).
Certain data items could not be implemented in SA’s Homeless 2 Home (H2H) system before the collection for the SHSC commenced. Consequently, SHSC data about clients’ needs for assistance where associated services have not been provided do not include data from SA. The relatively higher proportion of unmet need for accommodation services in Victoria and ACT could be due to the role of central intake service models in these jurisdictions. See notes to table 17A.8 for more details.


The number of average daily unassisted requests for accommodation and services other than accommodation are included in table 17A.7.

**Effectiveness — appropriateness**

Effectiveness indicators measure how well the outputs of a service reflect the stated objectives of that service. The reporting framework groups effectiveness indicators according to characteristics that are considered important to the service. These characteristics may include access, appropriateness and/or quality.

**Development of a case management plan**

‘Development of a case management plan’ is an indicator of governments’ objective to provide high quality services that are appropriately targeted to the needs of clients (box 17.5).
Box 17.5  **Development of a case management plan**

‘Development of a case management plan’ is defined as the number of clients with an agreed case management plan divided by the total number of clients. Data are reported for all clients, and separately for Indigenous clients.

A high or increasing proportion of clients with agreed case management 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, for example 24 hours).

Data reported for this indicator are comparable across jurisdictions.

Data quality information for this indicator is under development.

Nationally, there was an agreed case management plan for 63.1 per cent of clients in 2011-12 (compared with 69.5 per cent for Indigenous clients). These proportions varied across jurisdictions (figure 17.6 and tables 17A.9 and 17A.10).

**Figure 17.6  Proportion of clients with a case management plan, all clients, 2011-12**

![Bar chart showing the proportion of clients with a case management plan across different jurisdictions.](chart.png)

Match of needs of clients

‘Match of needs of clients’ is an indicator of governments’ objective to ensure that services meet clients’ individual needs (box 17.6).

**Box 17.6  Match of needs of clients**

‘Match of needs of clients’ is defined by two measures:

- the number of clients who required services that were provided, as well as those referred to another agency, as a proportion of the total number of clients
- the number of young clients (aged 12 to 18 years) who needed education and/or training assistance, and maintained or achieved education and/or training after support, as a proportion of the total number of young clients (aged 12 to 18 years) who sought education and/or training assistance.

The range of services needed by clients is broad (ranging from meals to laundry facilities to long term accommodation), so the effect of not providing these services varies.

Holding other factors constant, a high or increasing proportion of clients who received services they needed, or who were referred to another agency, is desirable.

Data reported for this indicator are comparable across jurisdictions.

Data quality information for this indicator is under development.

Nationally in 2011-12, 97.4 per cent of clients received the services they needed (including services provided by the initially approached agencies and/or referrals to another agency) (figure 17.7).
The proportions for Indigenous clients (98.3 per cent) and clients from a NESB (97.8 per cent) who received services they needed in 2011-12 were higher than that for all clients (97.4 per cent). These proportions varied across jurisdictions (figures 17.8 and 17.9).
Figure 17.8  **Support needs of Indigenous clients, provided and referred by agencies, 2011-12**

SA collection methodology for 2011-12 does not allow for this type of analysis.


Figure 17.9  **Support needs of NESB clients, provided and referred by agencies, 2011-12**

SA collection methodology for 2011-12 does not allow for this type of analysis.

Nationally, of young clients (aged 12—18 years) who needed assistance to obtain or maintain education and/or training when entering homelessness services in 2011-12, 51.9 per cent were undertaking formal study or training after support. Amongst this 51.9 per cent, the proportion of clients who were in secondary school increased from 23.2 per cent before support to 33.5 per cent after support. The proportion of clients who were in vocational education/training increased from 4.1 per cent before support to 11.7 per cent after support. These proportions varied across jurisdictions (figure 17.10).

Figure 17.10 Proportion of clients aged 12 to 18 years who needed education and/or training assistance who were undertaking formal study or training after support, status before and after support, 2011-12\textsuperscript{a}

\begin{table}[h]
\centering
\begin{tabular}{|c|c|c|c|c|c|c|c|}
\hline
 & Primary school & Secondary school & Vocational education/training \\
\hline
NSW & Before & After & Before & After & Before & After & Before & After \\
Vic & Before & After & Before & After & Before & After & Before & After \\
Qld & Before & After & Before & After & Before & After & Before & After \\
WA & Before & After & Before & After & Before & After & Before & After \\
SA & Before & After & Before & After & Before & After & Before & After \\
Tas & Before & After & Before & After & Before & After & Before & After \\
ACT & Before & After & Before & After & Before & After & Before & After \\
NT & Before & After & Before & After & Before & After & Before & After \\
Aust & Before & After & Before & After & Before & After & Before & After \\
\hline
\end{tabular}
\end{table}

\textsuperscript{a}SA collection methodology for 2011-12 does not allow for this type of analysis.


Additional data on the education and training status of clients before and after support are presented in table 17A.14.

Effectiveness — quality

Client satisfaction

‘Client satisfaction’ is an indicator of governments’ objective to provide high quality services that meet the needs of clients (box 17.7).
Box 17.7  **Client satisfaction**  
‘Client satisfaction’ is defined as the extent to which clients find homelessness services and programs to be helpful and of a high standard.  
This indicator and associated measures are under development.

**Efficiency**

Expenditure data for these indicators are provided by State and Territory governments, while data on the number of support periods, support days and clients are drawn from the SHSC.

Across jurisdictions, there may be varying treatments of expenditure items (for example, superannuation) and different counting and reporting rules for generating financial data. Differences in expenditure data across jurisdictions may reflect to some extent differences in the way in which these data are compiled rather than true variations in expenditure.

**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 public resources (box 17.8).

Box 17.8  **Cost per completed support period**

‘Cost per completed support period’ is defined as total recurrent expenditure on homelessness services divided by the number of completed support periods.

- A low or decreasing cost per completed support period may represent an improvement in efficiency, but may also indicate lower service quality.
- Data reported for this indicator are not comparable across jurisdictions.
- Data quality information for this indicator is under development.

Nationally, the recurrent cost per completed support period was $1632 in 2011-12. This cost varied significantly across jurisdictions (figure 17.11).
Figure 17.11  **Recurrent cost per completed support period, 2011-12**

![Graph showing recurrent cost per completed support period, 2011-12](image)

*See notes to table 17A.15 for more information.*


**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 public resources (box 17.9).

<table>
<thead>
<tr>
<th>Box 17.9  <strong>Cost per client</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>‘Cost per client’ is defined as total recurrent expenditure on homelessness services divided by the number of clients provided with a service.</td>
</tr>
<tr>
<td>A low or decreasing cost per client may represent an improvement in efficiency, but may also indicate lower service quality.</td>
</tr>
<tr>
<td>Data reported for this indicator are not comparable across jurisdictions.</td>
</tr>
<tr>
<td>Data quality information for this indicator is under development.</td>
</tr>
</tbody>
</table>

Nationally, the recurrent cost per client accessing homelessness services was $2212 in 2011-12. This cost varied significantly across jurisdictions (figure 17.12).
Figure 17.12  Recurrent cost per client accessing homelessness services, 2011-12\textsuperscript{a}

\begin{figure}
\centering
\includegraphics[width=\textwidth]{figure17.12.png}
\caption{Recurrent cost per client accessing homelessness services, 2011-12\textsuperscript{a}}
\end{figure}

\textsuperscript{a} See notes to table 17A.16 for more information.

\textit{Source: AIHW (unpublished) Specialist Homelessness Services Collection: 2011-12 National Data Collection annual report, Australia; Australian, State and Territory governments (unpublished); table 17A.16.}

\textbf{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 public resources (box 17.10).

\begin{center}
\begin{verbatim}
Box 17.10  Cost per day of support

‘Cost per day of support’ is defined as total recurrent expenditure on homelessness services divided by the number of days of support for clients receiving support and/or supported accommodation.

A low or decreasing cost per day of support may represent an improvement in efficiency, but may also indicate lower service quality.

Data reported for this indicator are not comparable across jurisdictions.

Data quality information for this indicator is under development.
\end{verbatim}
\end{center}

Nationally, the recurrent cost per day of support for clients averaged $28 in 2011-12. This cost varied significantly across jurisdictions (figure 17.13).
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 homelessness 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 independent housing on exit

‘Achievement of independent housing’ 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 (box 17.11).
Achievement of independent housing on exit

‘Achievement of independent housing’ is defined by three measures:

- the proportion of clients who needed assistance with obtaining or maintaining independent housing and achieved independent housing
- the proportion of clients who needed assistance with obtaining independent housing and were in non-independent housing at the start of the support period and obtained independent housing after support
- the proportion of clients who needed assistance with obtaining or maintaining independent housing, and had independent housing after support, who did not present for accommodation within twelve months of receiving support.

Data are reported for all clients, and separately for Indigenous clients.

A high or increasing proportion of closed support periods in which clients achieve independent housing is desirable.

This indicator compares the proportion of clients who were in independent housing before and after they received support from homelessness services. It 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 reported for this indicator are comparable across jurisdictions.

Data quality information for this indicator is under development.

Nationally, of clients who needed assistance with obtaining or maintaining independent housing 41.9 per cent achieved independent housing in 2011-12 (figure 17.18). This included clients who moved or returned to private rental housing (18.7 per cent), and to public or community rental housing (14.4 per cent). (table 17A.18).

Nationally, of Indigenous clients who needed assistance with obtaining or maintaining independent housing 39.2 per cent achieved independent housing in 2011-12 (figure 17.15). This included clients who moved or returned to private rental housing (12.3 per cent), and to public or community rental housing (18.0 per cent). (table 17A.19).

Clients who did not achieve independent housing included those who moved to, or continued to live in, short to medium term accommodation provided by homelessness services and other forms of non-independent accommodation (tables 17A.18 and 17A.19).
Figure 17.14 Proportion of clients who needed assistance to obtain or maintain independent housing and who obtained or maintained independent housing after support, 2011-12a, b


Figure 17.15 Proportion of Indigenous clients who needed assistance to obtain or maintain independent housing who obtained or maintained independent housing after support, 2011-12a, b

Amongst clients who were living in non-independent housing and who needed assistance to obtain independent housing, 23.5 per cent achieved independent housing in 2011-12. This included clients who moved to private rental housing (7.7 per cent), and to public or community rental housing (11.1 per cent) (figure 17.16).

Figure 17.16 Proportion of clients who were living in non-independent housing before support who obtained independent housing after support, by tenure type, 2011-12a, b

a SA collection methodology for 2011-12 does not allow for this type of analysis. b See notes to table 17A.20 for more information.

Nationally, of clients who needed assistance to obtain or maintain independent housing and that achieved independent housing after support and did not present again for accommodation in 2011-12, 40.5 per cent were in private rental after support (figure 17.17).

Figure 17.17 Proportion of clients who needed assistance to obtain or maintain independent housing who achieved independent housing after support, and did not present again with a need for accommodation, by tenure type, 2011-12\(^a,\ b\)

\(\text{\textsuperscript{a} SA collection methodology for 2011-12 does not allow for this type of analysis.} \textbf{\textsuperscript{b} See notes to table 17A.21 for more information.}\)


**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 the community at the end of their support period (box 17.12).
Box 17.12  **Achievement of employment on exit**

‘Achievement of employment on exit’ is defined by three measures:

- the proportion of clients who needed employment and/or training assistance, who achieved or maintained employment after support
- the proportion of clients who needed employment and/or training assistance, who were unemployed at the start of the support period, who achieved employment after support
- the proportion of clients who needed employment and/or training assistance and who were not in the labour force at the start of the support period, who achieved employment after support.

Holding other factors constant, a high or increasing proportion of clients achieving employment after support is desirable.

Data are reported for all clients, and separately for Indigenous clients.

This indicator compares clients’ employment status before and after they needed support. 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 reported for this indicator are comparable across jurisdictions.

Data quality information for this indicator is under development.

Nationally, of those clients who needed assistance to obtain or maintain employment and training when entering homelessness services in 2011-12, 15.9 per cent were employed either part-time or full-time after support, compared to 5.2 per cent before support. Amongst the 15.9 per cent employed after support, 4.9 per cent were employed full-time and 11.0 per cent were employed part time after support. Proportions varied across jurisdictions (figure 17.18).

Nationally, of those Indigenous clients who needed assistance to obtain or maintain employment and training when entering homelessness services in 2011-12, 11.0 per cent were employed either part-time or full-time after support, compared to 3.9 per cent before support. Amongst the 11.0 per cent employed after support, 3.9 per cent were employed full time and 7.1 per cent were employed part time after support. These proportions varied across jurisdictions (table 17A.23).
Figure 17.18  Proportion of clients who needed employment and/or training assistance and who were employed after support, by labour force status, 2011-12\textsuperscript{a, b}

(a) Before support

(b) After support

\textsuperscript{a} SA collection methodology for 2011-12 does not allow for this type of analysis. \textsuperscript{b} See notes to table 17A.22 for more information.


Nationally, of those clients who needed assistance to obtain or maintain employment and training when entering homelessness services in 2011-12, and were unemployed before support, 4.2 per cent were employed full time and 8.0 per cent were employed part time after support (figure 17.19 (a)).
Nationally, of those clients who needed assistance to obtain or maintain employment and training when entering homelessness services in 2011-12, and were not in the labour force before support, 2.6 per cent were employed full time and 7.7 per cent were employed part time after support (figure 17.19 (b)).

Figure 17.19 Labour force status of clients after support who were unemployed or not in the labour force before support, 2011-12

(a) Unemployed before support

(b) Not in the labour force before support

Proportion of people experiencing repeat periods of homelessness

‘Proportion of people experiencing repeat periods of homelessness’ is an indicator of governments’ objective to enable clients to participate independently in society at the end of their support period (box 17.13).

Box 17.13 Proportion of people experiencing repeat periods of homelessness

‘Proportion of people experiencing repeat periods of homelessness’ is defined as the number of clients who change status from ‘homeless’ to ‘not homeless’ and back to ‘homeless’; or have repeat periods where housing situation is identified as ‘homeless’.

A low or decreasing proportion of clients who more than once required housing or accommodation support specifically is desirable.

Data reported for this indicator are comparable across jurisdictions.

Data quality information for this indicator is under development.

Nationally, 7.3 per cent of all clients and 8.0 per cent of Indigenous clients who experienced homelessness at some time in 2011-12, had more than one period of homelessness in 2011-12. This proportion varied across jurisdictions (figure 17.20).

Figure 17.20 Clients who had more than one period of homelessness, all clients and Indigenous clients, 2011-12

Achievement of income on exit

Achievement of income on exit’ is an indicator of governments’ objective to enable clients to participate independently in the community at the end of their support period (box 17.14).

Box 17.14  Achievement of income on exit

‘Achievement of income on exit’ is defined as the proportion of clients who needed assistance to obtain or maintain income assistance who exited homelessness services with an income source.

Data are reported for all clients, and separately for Indigenous clients.

A high or increasing proportion of clients who needed income assistance and exited homelessness services with an income source is desirable.

This indicator compares these clients’ income status before and after they received support. It is assumed that 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 services.

Data reported for this indicator are comparable across jurisdictions.

Data quality information for this indicator is under development.

Nationally, of clients who needed income assistance when entering homelessness services in 2011-12, 96.0 per cent had an income source after support. Amongst the 96.0 per cent, the proportion whose source of income was a government pension/allowance increased from 60.1 per cent before support to 68.6 per cent after support and the proportion of clients whose source of income was employee/business income increased from 4.5 per cent before support to 5.7 per cent after support. Proportions varied across jurisdictions (figure 17.21).

Nationally, of Indigenous clients who needed income assistance when entering homelessness services in 2011-12, 96.9 per cent had an income source after support. Amongst the 96.9 per cent, the proportion whose source of income was a government pension/allowance increased from 64.8 per cent before support to 72.0 per cent after support. The proportion of clients whose source of income was employee/business income increased from 2.8 per cent before support to 3.3 per cent after support. Proportions varied across jurisdictions (figure 17.22).
Figure 17.21 Proportion of clients who needed income assistance and who had an income source after support, by income source, 2011-12\textsuperscript{a, b}

(a) Source of income before support

- No income
- Awaiting benefit
- Government pension/allowance (incl. DVA)
- Employee/Business income

(b) Source of income after support

- No income
- Awaiting benefit
- Government pension/allowance (incl. DVA)
- Employee/Business income

\textsuperscript{a} SA collection methodology for 2011-12 does not allow for this type of analysis. \textsuperscript{b} See notes to table 17A.27 for more information.

Figure 17.22 Proportion of Indigenous clients who needed income assistance and who had an income source after support, by income source, 2011-12\textsuperscript{a, b}

(a) Income source before support\textsuperscript{c}

(b) Income source after support\textsuperscript{c}

\textsuperscript{a} SA collection methodology for 2011-12 does not allow for this type of analysis. \textsuperscript{b} See notes to table 17A.28 for more information. \textsuperscript{c} ‘No income’ is nil or rounded to zero for ACT. ‘Employee/business income is nil or rounded to zero for Queensland, Tasmania the ACT and the NT.

Goals achieved on exit from service

‘Goals achieved on exit’ is an indicator of governments’ objective to ensure homelessness services meet the needs and expectations of clients (box 17.15).

Box 17.15  Goals achieved on exit from service

‘Goals achieved on exit from service’ is defined as the proportion of clients in a given period who reported that their case management goals were ‘all’, ‘some’ or ‘none’ achieved by the end of their support period.

This indicator should be interpreted in conjunction with the ‘Match of needs of clients’ indicator which identifies the proportion of case management plans developed.

A high or increasing proportion of achieved goals is desirable.

Data reported for this indicator are comparable across jurisdictions.

Data quality information for this indicator is under development.

Nationally, some or all case management goals were achieved by the end of the support period for 89.7 per cent of clients in 2011-12 (figure 17.23).

Figure 17.23  Goals achieved on exit from homelessness services, 2011-12

17.4 **Key performance indicator results for government funded specialist homelessness services, SAAP, 2010-11**

The SAAP program concluded on 31 December 2008 but the SAAP data collection continued to enable reporting on homelessness services while the new specialist homelessness services (SHS) data collection was developed.

For reference, the performance indicator framework for government funded specialist homelessness services delivered under the SAAP V Agreement is presented in figure 17.24.

Attachment tables 17A.30–59 of this Report present the final year of data from the SAAP National Data Collection (NDC) (data for 2010-11).
Figure 17.24 Government funded specialist homelessness services performance indicator framework, SAAP

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
17.5 Future directions in homelessness services performance reporting

Homelessness data developments

From 1 July 2011, the SAAP data collection was replaced by the Specialist homelessness services collection (SHSC) which will continue to be the primary source for reporting on the performance indicators for homelessness services in the future editions of the Report.

The 2014 Report and later editions will continue:

- developing and refining performance measures
- lengthening time series data in attachment tables
- developing data quality information for performance indicators.

17.6 Jurisdictions’ comments

This section provides comments from each jurisdiction on the services covered in this chapter.
Australian Government comments

The Australian Government continues to deliver, develop, and assess initiatives to achieve the goals of the White Paper on Homelessness: The Road Home.

FaHCSIA, through the Reconnect program, provides community-based and family focused early intervention program supporting young people who are homeless, or at risk of homelessness. In partnership with Centrelink, FaHCSIA delivers the ‘HOME Advice’ program to assist families facing difficulty to maintain tenancies or home ownership. FaHCSIA manages A Place to Call Home, a $311 million joint program by the Commonwealth and states and territories to build over 600 dwellings for people who are experiencing or, at risk of, homelessness, beginning in July 2008.

FaHCSIA also manages Research Partnership Agreements worth $4 million. These agreements aim to contribute to the design and implementation of evidence-based policy and support for the homeless and the development of services that meet their needs. In addition, 16 National Homelessness Research Projects worth $1.4 million support a ‘bottom up’ approach to strengthen understanding of factors leading to homelessness and inform service improvements, future policies and programs.

FaHCSIA is also funding Journeys Home: Longitudinal Study of Factors Affecting Housing Stability which aims to improve the understanding of, and policy response to, the diverse social, economic and personal factors relating to homelessness and the risk of becoming homeless. The survey has four waves, running from September 2011 to the first half of 2013. Three waves have been completed and the research report for Wave 2 is due in late 2012.

FaHCSIA is developing the Homelessness Bill 2012 which will provide greater recognition of the needs of homeless people. Together with States and Territories, FaHCSIA is developing a National Quality Framework to improve the quality and integration of services delivered to people experiencing or at risk of homelessness. In 2012, the National Homelessness Services Achievement Awards were presented to seven inaugural winners in recognition of the outstanding contributions that community organisations and services around Australia make to supporting homeless people or those at risk of homelessness.

As the National Partnership Agreement on Homelessness (NPAH) is in its final year of implementation, the Government is working with all jurisdictions to collect evidence about services and programs that are making a difference to reducing homelessness. This evidence will inform future policy directions. The significant additional investment in homelessness provided by the NPAH has been an opportunity for states and territories to undertake strategic reforms and position themselves to reduce homelessness into the future.

The Prime Minister’s Council on Homelessness (established 2009) continues to provide advice to government on progress, risks and emerging issues in homelessness, as well as to monitor the implementation of White Paper goals and targets.
New South Wales Government comments

NSW 2021, the Government’s plan for New South Wales, outlines the Government’s commitment to deliver well-coordinated services to support those who need it most, including homeless people. This includes actions to reduce homelessness by 7 per cent, reduce rough sleeping by 25 per cent and reduce the number of people experiencing repeat periods of homelessness.

Under the National Affordable Housing Agreement (NAHA), Specialist Homelessness Services (SHS) in NSW received funding of $134 million in 2011/12 to assist people who are homeless or at risk of homelessness. This provided SHS to 65,400 people, including crisis and transitional support and practical assistance to help break the cycle of repeat homelessness.

In addition to homelessness funding under the NAHA, the National Partnership Agreement on Homelessness (NPAH) provides a joint Commonwealth and NSW Government commitment to tackle the issue of homelessness, including Aboriginal homelessness. The NPAH is supported by a total funding commitment of up to $392.5 million over the life of the agreement - $101 million in Commonwealth funding and a NSW Government contribution of up to $241 million. The NPAH includes A Place to Call Home, and in 2011-12, $6.4 million was committed for new accommodation places under this initiative.

NSW’s investment under the NPAH focuses on continued interagency collaboration, driving service reform and priorities and the ongoing implementation of regional homelessness action plans, to deliver streamlined services for clients to prevent, reduce and respond effectively to homelessness.

The NSW Homelessness Action Plan (HAP) puts NSW and national homelessness policy into action. The HAP reinforces NSW’s commitment to the targets in the NSW 2021 plan and the NPAH, and provides the direction for both new and existing effort in NSW. A key initiative of the HAP is reform of the delivery of homeless services, shifting the focus away from crisis services towards early intervention services.

To this end, NSW has committed to a two-year $5.3 million reform program, Going Home, Staying Home, in order to improve the capacity of the Specialist Homelessness Services sector to deliver better and more cost effective outcomes for people who are homeless.

NSW’s service delivery achievements are evidence of the strong consolidation of projects that have taken place over the life of the NPAH. All projects have established service delivery regimes and built referral networks and strong interagency partnerships. Significantly, in 2011/12, NSW exceeded the total agreed client target across all NPAH funded projects by some 60 per cent.
Victorian Government comments

Together with our funded service providers, Victoria provides support to people who are homeless, at risk of homelessness or experiencing family violence to get their lives back on track.

Planning and development of a new type of student accommodation that supports young people at risk of homelessness is well underway. Based on a successful early intervention model, Youth Foyers will give vulnerable young people stable accommodation with support to achieve their education goals and move into employment, empowering them to reach their full potential and make a pathway out of homelessness.

The Government has already committed $30.1 million for the development of three new youth foyers for up to 40 disadvantaged students. The first of the youth foyers will be built on Kangan Institute land in Broadmeadows in partnership with two community service providers. Developing the Youth Foyers on Tertiary and Further Education (TAFE) provider land supports the collaborative relationship between the Youth Foyer and the TAFE and will increase access to educational activities by foyer participants.

After significant policy work at the acute end of the social housing system, the $76.7 million Victorian Homelessness Action Plan 2011–15 was released by the Minister for Housing in October 2011. The plan focuses on supporting innovative approaches to homelessness, investigating early intervention and prevention models and better targeting resources. The plan includes ten Innovation Action Projects that demonstrate new ways to tackle homelessness through partnerships with the sector. A newly established Ministerial Advisory Council on Homelessness will also provide advice to Government on longer-term service system reforms.

The Australian Institute of Health and Welfare’s (AIHW) new Specialist Homelessness Services Collection (SHSC) commenced 1 July 2011. Victoria contributed significant effort in training over 1,500 specialist homelessness services agency staff in the new SHSC and the associated Information Platform (SHIP) which has contributed to Victoria’s higher than the national average agency reporting compliance. This is expected to improve the capacity of the department and the agency to monitor the impact of initiatives. The AIHW has adopted nationally the E-Learning modules developed by Victoria for the SHSC.

The Victorian Government continued to work in close partnership with other organisations in 2011-12 to support homeless people. For example, a trial working with Centrelink and HomeGround (a community service organisation supporting homeless people) worked to put in place an innovative model to better integrate assistance to clients in resolving their housing issues at earlier stages and assisting them to reconnect with education and employment pathways. Clients of all three agencies were involved in the design of the project, and nearly 100 clients have been referred to the project. Many have been assisted with long term accommodation, returning to employment and assisted to stay in school.
Queensland Government comments

In 2011-12, Queensland allocated over $100 million to support the delivery of 246 specialist homelessness services for target groups including young people, families, adults and women and children escaping domestic and family violence.

Through the NPA on Homelessness, the Australian and Queensland Governments are providing an additional $284.6 million over five years (2008-09 to 2012-13) to reduce homelessness in Queensland, including $149.5 million state funds and $135.1 million Australian Government funds.

Several initiatives and reform activities have helped people who are homeless or at risk of homelessness. These include:

- Five Street to Home services, which assisted 1,552 instances of rough sleepers and chronically homeless people to transition to stable housing.

- The Micah Projects Supportive Housing Service, which assisted 132 chronically homeless people.

- HomeStay Support services, which provided early intervention assistance to 3,932 instances of clients to maintain their tenancies.

Progress was made in service integration which includes:

- Seven Homelessness Community Action Plans to provide better coordinated local responses to homelessness were developed and commenced implementation.

- Introduction of a Vacancy Capacity Management System to manage access to supported accommodation, providing real time vacancy information for specialist homelessness services.

Significant efforts were also made to address homelessness at key points such as the transition from statutory or institutional care settings back to the community. Several initiatives were in place for clients at risk of homelessness to have appropriate transition/discharge arrangements before exiting health facilities, child safety arrangements, prisons and youth detention facilities.

Examples of services include:

- Youth Housing and Reintegration Services provided support in six locations to 400 young people aged 12-21 years to transition to stable housing and develop skills to live independently.

- Five After Care Services provided support to 244 young people leaving out-of-home care at risk of becoming homeless. These persons were supported to find accommodation and connect with the education system.

Emergency Department Homeless Liaison officers, located at four hospital sites provided support on 742 occasions to people who were identified as homeless or at risk of homelessness.
Western Australian Government comments

The Western Australian (WA) Department for Child Protection (the Department) has lead agency responsibility for homelessness, and contracts community sector organisations across the state to provide a range of specialist homelessness services (SHSs). Through the National Affordable Housing Agreement (NAHA), the Department provides recurrent funding to 115 specialist homelessness services, and through the National Partnership Agreement on Homelessness (NPAH), 81 additional specialist homelessness services are currently operating across the state.

The roll out of the WA Implementation Plan for the NPAH enabled specialist homelessness services to further integrate and provide a continuum of homelessness services for people who are at risk of, or experiencing, homelessness.

The NPAH has been an important mechanism in leveraging reform in the response to homelessness by mainstream and specialist homelessness services. As part of this reform, the reporting requirements of community sector organisations have been reduced through streamlined contracting arrangements. Ongoing collaboration between community services sector organisations and government agencies has resulted in the development of new innovative programs such as the Safe at Home and Street to Home programs that require a partnership approach to ensure successful outcomes. The provision of brokerage funding and incorporation of assertive case management models in the majority of NPAH programs have been effective strategies to ensure purposeful, client centred support is provided to specific cohorts.

The WA Council on Homelessness was instrumental in developing the Western Australia Homelessness State Plan: Opening Doors 2010-13 (State Plan) which ensured continuation in the implementation of state-wide integrated responses to homelessness by Government agencies and community sector organisations. To complement the State Plan, 16 regional homelessness plans have also been implemented to provide relevant location specific responses to homelessness. The regional plans were developed collaboratively by communities, government, and non-government stakeholders in regional and remote locations across the state.

The Department and the Western Australian Council on Homelessness continue to promote continuous quality improvement and best practice in service delivery by mainstream, agencies and specialist homelessness services through best practice forums. The Specialist Homelessness Services Conference: Leading The Road Home held in May 2012 attracted 450 specialist and mainstream service providers. The Department continues to provide SHS training to NPAH and NAHA services to ensure compliance and accuracy in data collection. An independent external evaluation of all NPAH programs is currently under way and will inform future policies, processes and funding to ensure a range of homelessness services is provided on a continuum across the state for people who are homeless or at risk of homelessness.
South Australian Government comments

As a result of the National Partnership Agreement on Homelessness (NPAH), the Specialist Homelessness Service (SHS) sector in South Australia has been significantly restructured and retendered.

The SHS sector now delivers a consistent and integrated suite of services to priority population groups throughout South Australia. Each region is served by generic homelessness, youth, Aboriginal and Torres Strait Islander and Domestic/Aboriginal family violence services. Each of these services deliver individualised case managed support to adults/young people aged over 15 years as well as children. Complementing this is a state wide network of services to improve access to specialist regional services and to respond to groups at particular risk of homelessness, including young people, adults exiting custodial institutions, children with complex needs and people of Aboriginal and Torres Strait Islander background who are transient.

The reform has also ensured that homeless people are able to receive support to help them sustain the transition from homelessness to sustainable housing via a ‘housing first’ principle. This has included formalising funding and service arrangements to enable structured, outreach based case management.

In 2011-12, 41 government and non-government organisations provided 75 specialist homelessness programs/services that assisted over 19 000 people. The services provided by the SHS sector are complemented by a portfolio of 146 properties used for crisis accommodation and 611 Community Tenancy properties that provide transitional accommodation.

635 properties were allocated to people that were homeless or at risk of homelessness with 484 of these properties coupled with support packages. The funding under the NPAH is to assist households to maintain their tenancies by building their capacity to address issues impacting on their housing stability. A further 48 supportive accommodation dwellings are operated through a dedicated Aged Homeless Persons Program.

The South Australian SHS sector responds to clients as a holistic, integrated sector, ensuring that clients encounter ‘no wrong door and only need to tell their story once’. This capacity is facilitated by the new Homeless to Home (H2H) system, a web-based client information and case management system that enables agencies to coordinate referrals and joint case work for clients.
Tasmanian Government comments

2011-12 saw the consolidation of the new initiatives of the National Partnership Agreement on Homelessness, and the continuation of strong relationships between the specialist homelessness sector and Housing Tasmania.

Tasmania's ambitious and multi-faceted approach to homelessness is focused through three priorities: new services; new supply; and new ways of working.

The leading new services - “Keys” and “Stay” and are provided through two non-government agencies. The service model relies on the separation of tenancy management and casework support. It is also based on the ‘housing first’ principle of long-term housing with wrap-around intensive services as the best solution to homelessness, especially for people with complex needs. Next year’s evaluation will provide important insights into how this worked, although the anecdotal evidence to date, is very positive.

Since 2009, the Tasmanian Government has invested more than $200 million to increase the supply of social and affordable housing through a range of Australian and Tasmanian funding sources and delivered 1400 new homes for Tasmanians. A key focus of this new supply was on housing for people who are homeless or at risk.

This financial year has seen the completion and tenanting of supported accommodation facilities in Ulverstone (Grove Street), Launceston (Thistle Street and Thyne House). In Hobart, the two Common Ground facilities are in the process of being tenanted. Between them, these facilities will provide 165 beds.

Within the theme “new ways of working” are common trends: integration, accessibility, and collaboration. Significant work included establishment of a common assessment framework and tools and an integrated social housing application list which will mature next year into a knowledge base about people with a housing need and accessible to all providers.

Housing Tasmania undertook the most comprehensive review of support and accommodation assistance which started in July 2011 and was characterised by intensive sector engagement throughout the year.

Tasmania's data reinforces both reviews' findings: many people have unmet needs for accommodation (21.4 per cent against the national average of 19.4 per cent), while case management goals are well met (89.7 per cent) and there is a high proportion of clients (68.5 per cent) with a case management plan.

The outcome is new social housing and homelessness service system model that will deliver improved services to Tasmanians in need and will commence from July 2013.
Australian Capital Territory Government comments

The ACT has undertaken a program of reform aimed at the development of a suite of service responses that either respond to or prevent homelessness.

The reform of the Youth Housing and Homelessness Service delivery model in the ACT was finalised during the year. The reform resulted in six community organisations selected to deliver seven new services as part of the new service delivery model. All services under the model commenced operation in March/April 2012. Housing ACT worked with the outgoing services to transition young people to appropriate accommodation and support to ensure no young person entered into homelessness.

The implementation of the new national data collection system for specialist homelessness services was undertaken with 35 ACT agencies commencing on 1 July 2011. This included the use of the Specialist Homelessness Information Platform (SHIP), an online client information management tool provided by AIHW which will result in an increase in consistency of recording and reporting of Homelessness data. The data collected supports the ACT participation in national reporting under the National Affordable Housing Agreement (NAHA) and the National Partnership Agreement on Homelessness (NPAH) and their focus on outcomes based reporting. A number of agencies commenced in the Collection in 2012, including First Point – the ACT centralised access service for persons requiring homelessness support.

The establishment of First Point is a significant initiative in the homelessness reform program in the ACT and a substantial advance in managing demand for and access to homelessness services. All persons experiencing or at risk of homelessness in the ACT are referred to First Point for assistance. It is important to understand the impacts of this centralised access service on the service delivery system in the ACT. The inclusion of First Point in ACT data for the Specialist homelessness services collection raises unique issues in the interpretation of performance indicators results for the ACT including those that relate to outcomes for clients. Direct comparison of ACT results with those of other jurisdictions may be inappropriate except where comparisons are understood in the light of this substantially different service model.

The Common Ground feasibility study which was conducted throughout 2011-2012 has been completed. The feasibility study report identified a proposed service model, potential locations, and design considerations. The 2012 budget allocates $130,000 for the forward design and planning for a Common Ground. The Snow Foundation has also pledged $500 000 to the project over four years.

The Joint Pathways Group continued to provide an effective forum for senior non-government and government representatives to work in partnership to propose the future structure of the homelessness service system in the ACT following the review of the NAHA and NPAH programs.
Northern Territory Government comments

During 2011-12 the Northern Territory Government consolidated and supported the non-government sector to improve and expand existing services under the National Affordable Housing Agreement (NAHA) and the National Partnership Agreement on Homelessness (NPAH). Nineteen non-government organisations were funded $10.8 million to deliver 40 specialist homelessness services across the Northern Territory under the NAHA. This represents a joint contribution from the Australian and Northern Territory governments.

In addition, $19.32 million was invested to deliver 22 initiatives under the NPAH. During this year significant achievement was made under the NPAH by services focussed on young people and women and children affected by domestic and family violence, including:

- establishing a youth crisis accommodation service in Katherine and a medium term transitional youth accommodation service in Palmerston
- providing safe places to stay for women and children escaping domestic and family violence in remote indigenous communities through the ongoing establishment of remote safe houses in Wadeye and Gunbalanya
- establishing a medium term transitional housing program for women and children in Darwin.

In 2011-12, three new service providers commenced under the A Place to Call Home initiative, providing much needed support for households in Katherine and more households in Darwin. The Northern Territory continued to strengthen its NPAH initiatives aimed at decreasing indigenous homelessness through:

- Percy Court, providing an additional 75 beds in 28 accommodation units for transitional accommodation in Alice Springs
- South Terrace managed accommodation facility providing 66 beds for short term accommodation to people who would otherwise sleep rough or stay in overcrowded households in Alice Springs
- The Apmere Mwerre accommodation park in Alice Springs provided a mix of units, cabins, tents and open camping areas for short term accommodation for up to 150 people.

2011-12 saw the development of ShelterMe, a web-based directory of services for homeless Territorians containing up to date information on housing and homelessness services throughout the NT. ShelterMe is funded by the NT Government under the NPAH and is managed by NT Shelter, the Territory’s housing and homelessness peak body.

The NT Government continued to provide hands-on support to agencies participating in the Specialist Homelessness Services Collection across urban and remote areas of the Territory. This continued support included group training and one-on-one training tailored to the specific needs of individual services.
17.7 Definitions of key terms

*Based on the SHS client collection*

**Age**

Age is calculated as age of the client on the start date of their first support period of the reporting period or the first date of the reporting period, whichever of the two is the later date.

**Client**

A person who receives a specialist homelessness service. A client can be of any age—children are also clients if they receive a service from a specialist homelessness agency.

To be a client, the person must directly receive a service and not just be a beneficiary of a service. Children who present with a parent or guardian and receive a service are considered to be a client. This includes a service that they share with their parent or guardian such as meals or accommodation.

Children who present with a parent or guardian but do not directly receive a service are not considered to be clients. This includes situations where the parent or guardian receives assistance to prevent tenancy failure or eviction. Clients can be counted differently according to the data item that is being reported:

- **Clients (demographic)**—For clients with multiple support periods, reported data is determined based on the information at the start date of the client’s first support period in the reporting period or the first date of the reporting period, whichever is later.

- **Clients (counted by support periods)**—For each data item, clients are counted based on support periods with distinct client information. The same client can be counted more than once if they have multiple support periods with a different response for the data item. The result is that percentages do not add up to 100.

- **Clients (outcomes)**—Clients are counted based on closed support periods where a valid response is recorded both when presenting to an agency and at the end of support.

**Closed support period**

A support period that had finished on or before the end of the reporting period — 30 June 2012.

**Homelessness**

A person is homeless if they are either:

- living in non-conventional accommodation or ‘sleeping rough’, or
- living in short-term or emergency accommodation due to lack of other options.

**Indigenous status**

In practice, it is not realistic to collect information on the community acceptance of part of ‘The Commonwealth Definition’ and therefore standard questions on Indigenous status relate to descent and self-identification only.

Where Indigenous status is not stated, the ‘not stated’ figure includes clients where contradictory Indigenous status were reported across multiple support periods as well as, missing, ‘not applicable’ and ‘don’t know’ responses.

**Labour force status**

Reported data excludes clients aged under 15.

**Main source of income**

Reported data excludes clients aged under 15.
Non-English speaking background services
Services that are targeted at persons whose first language is not English.

No tenure
A type of housing tenure recorded for clients who are sleeping rough or do not have a legal right to occupy a dwelling and may be asked to leave at any time. Includes couch surfing, living in an institutional setting, living on the streets, sleeping in parks, squatting, using cars or railway carriages, improvised dwellings or living in long grass.

Non-conventional accommodation
Non-conventional accommodation is defined as:
- living on the streets
- sleeping in parks
- squatting
- staying in cars or railway carriages
- living in improvised dwellings
- living in long grass.

Ongoing support period
A support period is considered ongoing at the end of the reporting period if each of the following conditions is met:
- no support end-date is provided
- no after-support information is provided
- corresponding client data was received in the month following the end of the reporting period.

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 an 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.

Reporting period
For the purposes of this report the reporting period is the financial year-to-date (FYTD): 1 July 2011 to 30 June 2012.

Short-term or emergency accommodation
Short-term or emergency accommodation includes:
- refuges
- crisis shelter
- couch surfing
- living temporarily with friends and relatives
- insecure accommodation on a short-term basis
- emergency accommodation arranged by a specialist homelessness agency (e.g. in hotels, motels etc.).

The following short-term accommodation options are not included:
- hotels, motels, caravan parks and other temporary accommodation used when a person is on holiday or travelling
- custodial and care arrangements, such as prisons and hospitals
- temporary accommodation used by a person while renovating usual residence or building a new residence (e.g. weekenders, caravans).
Specialist homelessness agency
An organisation that receives government funding to deliver specialist homelessness services. Assistance is provided to clients aimed at responding to or preventing homelessness. Agencies may also receive funding from other sources. Inclusion of agencies in the SHSC is determined by the state and territory departments responsible for administering the government response to homelessness. Not all funded agencies are required to participate in data collection.

Specialist homelessness service(s)
Assistance provided by a specialist homelessness agency to a client aimed at responding to or preventing homelessness. The specialist homelessness services that are in scope for this collection and that may be provided during a support period are:

Housing/accommodation services:
- short-term or emergency accommodation
- medium-term/transitional housing
- long-term housing
- assistance to sustain tenancy or prevent tenancy failure or eviction
- assistance to prevent foreclosures or for mortgage arrears.

General assistance and support:
- assertive outreach
- assistance to obtain/maintain government allowance
- employment assistance
- training assistance
- educational assistance
- financial information
- material aid/brokerage
- assistance for incest/sexual
- assistance for domestic/family violence
- family/relationship assistance
- assistance for trauma
- assistance with challenging social/behavioural problems
- living skills/personal development
- legal information
- court support
- advice/information
- retrieval/storage/removal of personal belongings
- advocacy/liaison on behalf of client
- school liaison
- child care
- structured play/skills development
- child contact and residence arrangements
- meals
- laundry/shower facilities
- recreation
- transport
- other basic assistance.

Specialised services:
- child protection services
- parenting skills education
- child-specific specialist counselling services
- psychological services
- psychiatric services
- mental health services
- pregnancy assistance
- family planning support
- physical disability services
- intellectual disability services
- health/medical services
- professional legal services
- financial advice and counselling
- counselling for problem gambling
- drug/alcohol counselling
- specialist counselling services
- interpreter services
- assistance with immigration services
- culturally specific services
- assistance to connect culturally
- other specialised services.

**Support period**

The period of time a client receives services from an agency is referred to as a support period. A support period starts on the day the client first receives a service from an agency. A support period ends when:

- the relationship between the client and the agency ends
- the client has reached their maximum amount of support the agency can offer
- a client has not received any services from the agency for a whole calendar month
- and there is no ongoing relationship.

Where a client has an appointment with the agency which is more than a calendar month in the future then it is not necessary to close the support period. This is because it is expected that there is an ongoing relationship with the client. The end of the support period is the day the client last received services from an agency.

**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.
17.8 List of attachment tables

Attachment tables are identified in references throughout this chapter by an ‘17A’ prefix (for example, table 17A.1 is table 1). Attachment tables are provided on the Review website (www.pc.gov.au/gsp).

2011-12 (SHSC)

Table 17A.1 Composition of support provided, all clients, 2011-12
Table 17A.2 Nominal expenditure on homelessness services, 2011-12
Table 17A.3 Real recurrent homelessness expenditure per person in the residential population (2011-12 dollars)
Table 17A.4 Proportion of Indigenous clients among all clients whose needs for accommodation and services other than accommodation were met, 2011-12
Table 17A.5 Proportion of clients from a non-English speaking background among all clients whose needs for accommodation and services other than accommodation were met, 2011-12
Table 17A.6 Representation of special needs groups accessing specialist homelessness services (per cent)
Table 17A.7 Average daily unassisted requests for accommodation and services other than accommodation, 2011-12
Table 17A.8 Proportion of clients with unmet needs for accommodation and services other than accommodation, 2011-12
Table 17A.9 Proportion of clients with a case management plan, all clients, 2011-12
Table 17A.10 Proportion of Indigenous clients with a case management plan, 2011-12
Table 17A.11 Support needs of all clients, provided and referred by agencies, 2011-12
Table 17A.12 Support needs of Indigenous clients, provided and referred by agencies, 2011-12
Table 17A.13 Support needs of clients from non-English speaking backgrounds, provided and referred, 2011-12
Table 17A.14 Proportion of clients aged 12 to 18 years who needed education and/or training assistance who were undertaking formal study or training after support, before and after support, 2011-12
Table 17A.15 Recurrent cost per completed support period, 2011-12
Table 17A.16 Recurrent cost per client accessing homelessness services, 2011-12
Table 17A.17 Recurrent cost per day of support for clients, 2011-12
Table 17A.18 Proportion of clients who needed assistance to obtain or maintain independent housing and who obtained or maintained independent housing after support, 2011-12
Table 17A.19 Proportion of Indigenous clients who needed assistance to obtain or maintain independent housing and who obtained or maintained independent housing after support, 2011-12
Table 17A.20 Proportion of clients who were living in non-independent housing before support and who obtained independent housing after support, 2011-12
Table 17A.21 Proportion of clients who needed assistance to obtain or maintain independent housing and who achieved independent housing after support, and did not present again with a need for accommodation within the reporting period, by tenure type after support, 2011-12

Table 17A.22 Proportion of clients who needed employment and/or training assistance who were employed after support, labour force status, 2011-12

Table 17A.23 Proportion of Indigenous clients who needed employment and/or training assistance who were employed after support, by labour force status, 2011-12

Table 17A.24 Proportion of clients who needed employment and/or training assistance and who were unemployed and not in the labour force before support, who were employed after support, by labour force status, 2011-12

Table 17A.25 Proportion of clients experiencing homelessness who had repeat periods of homelessness, 2011-12

Table 17A.26 Proportion of Indigenous clients experiencing homelessness who had repeat periods of homelessness, 2011-12

Table 17A.27 Proportion of clients who needed income assistance and who had an income source after support, 2011-12

Table 17A.28 Proportion of Indigenous clients who needed income assistance and who had an income source after support, 2011-12

Table 17A.29 The extent that case management goals have been achieved after support, all clients, 2011-12

2010-11 SAAP

Table 17A.30 Composition of support provided in support periods

Table 17A.31 Agencies by primary target group

Table 17A.32 Agencies by service delivery model

Table 17A.33 Nominal expenditure on homelessness services

Table 17A.34 Total recurrent expenditure on homelessness services

Table 17A.35 Real recurrent homelessness expenditure per person in the residential population (2011-12 dollars)

Table 17A.36 Turn-away of adults and unaccompanied children as a proportion of people requiring new immediate accommodation

Table 17A.37 Turn-away of adults and unaccompanied children as the proportion of total demand for accommodation

Table 17A.38 Proportion of Indigenous people among all accommodated clients and among people whose valid requests for accommodation were unmet

Table 17A.39 Proportion of people from non-English speaking backgrounds among all accommodated clients and among people whose valid requests for accommodation were unmet

Table 17A.40 Closed support periods, by the existence of a support plan, all clients

Table 17A.41 Closed support periods, by the existence of a support plan, Indigenous clients

Table 17A.42 Support needs of all clients, met and unmet

Table 17A.43 Support needs of Indigenous clients, met and unmet

Table 17A.44 Support needs of clients from non-English speaking backgrounds, met and unmet
Table 17A.45  Valid unmet requests for accommodation, main reason for support not provided, Australia

Table 17A.46  Recurrent cost per completed support period (2010-11 dollars)

Table 17A.47  Recurrent cost per client accessing services (2010-11 dollars)

Table 17A.48  Real recurrent cost per day of support for clients (2010-11 dollars)

Table 17A.49  Average accommodation load and caseload per day

Table 17A.50  Closed support periods in which clients needed assistance to obtain/maintain independent housing, by type of tenure

Table 17A.51  Closed support periods in which Indigenous clients needed assistance to obtain/maintain independent housing, by type of tenure

Table 17A.52  Closed support periods: Labour force status of clients who needed employment and training assistance, before and after support

Table 17A.53  Closed support periods: Labour force status of Indigenous clients who needed employment and training assistance, before and after support

Table 17A.54  Clients who exited from the service and who returned to agencies before the end of that year

Table 17A.55  Indigenous clients who exited from the service and who returned to agencies before the end of that year

Table 17A.56  Proportion of clients who more than once had a housing/accommodation need identified by an agency worker, by Indigenous status

Table 17A.57  Source of income immediately before and after support of all clients who needed assistance to obtain/maintain a pension or benefit

Table 17A.58  Source of income immediately before and after support of Indigenous clients who needed assistance to obtain/maintain a pension or benefit

Table 17A.59  The extent that clients case management goals have been achieved
17.9 References


