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Suggestions:

The Steering Committee welcomes suggestions on the performance indicators contained in this Report. Please direct your suggestions to the Productivity Commission Secretariat at the above address.

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Foreword

This constitutes the seventh edition of the annual *Report on Government Services*, a product of the Review of Commonwealth/State Service Provision. A Steering Committee comprising representatives from central agencies in the Commonwealth, States and Territories oversees the collaboration of more than 80 government agencies. The Review was the initiative of heads of government in 1993 and continues under the auspices of the Council of Australian Governments.

The services covered by the Review span education, health, justice, community services and housing. Collectively they represented approximately \$64.3 billion of government expenditure in 2000-01 or 9.6 per cent of gross domestic product.

There has been a general improvement in the data presented in the Report this year. The advances in reporting fall into three broad groups. The first relates to existing performance indicators and encompasses improved comparability, timeliness and quality of data; as well as enhanced reporting on special needs groups; and reporting on full costs to government. In this category, there were improvements to the reporting for chapters on health, court administration, police services, corrective services, emergency management, child protection and support services, and disability services and housing.

The second area of improvement relates to new performance indicators reported for the first time this year. These include indicators for the health (maternity services and general practitioners), court administration (Federal Magistrates' Services), aged care (compliance with service standards for residential care), disability services (social participation) and housing (Aboriginal Rental Housing Program) chapters.

The third area of improvements is in the quality of descriptive data and contextual information in the emergency management, juvenile justice and veterans' home care in the aged care services chapters.

Particularly noteworthy is the inclusion of reporting on the Aboriginal Rental Housing Program. This is the first *targeted* Indigenous program that the Review has reported – until now all Indigenous data have been disaggregated from mainstream

program data. The Steering Committee's aim is to expand its reporting on targeted programs in other chapters as data become available.

The Review's underlying philosophy is one of continuous improvement. Sometimes that means starting from a fairly low base and improving the comparability and quality of data over time. The Review has undertaken a number of research projects over the years directed at improving aspects that are important for data comparability. It has conducted, for example, an examination of payroll tax and superannuation in the costing of government services, and of the use of activity surveys by police services. Over the past year, in response to concerns, the Review undertook a study to examine the extent to which differences in asset measurement techniques applied by participating agencies affected the comparability of reported unit costs. The benefits of these research projects have been manifest in the incremental improvements that have been made every year.

Producing a report of this size and scope each year depends on the cooperation and support of many participants. The Review's 12 working groups constitute the 'engine room' of this project and the Steering Committee relies on the assistance and advice from the service agencies represented in these groups. In addition, the Review draws on a Secretariat from the Productivity Commission, and on bodies such as the Australian Bureau of Statistics and the Australian Institute of Health and Welfare, amongst others. The working groups and the Secretariat also work closely with a range of other groups involved in government performance measurement.

I would like to thank everyone involved for their continuing contribution to this important joint undertaking.

Gary Banks
Chairman

Contents

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

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Acronyms and abbreviations

AADWA	Aboriginal Affairs Department of Western Australia
ABS	Australian Bureau of Statistics
ACAT	Aged Care Assessment Team
ACCCHS	Aboriginal Community Controlled Health Services
ACHS	Australian Council on Healthcare Standards
ACIR	Australian Child Immunisation Register
ACSQHC	Australian Council for Safety and Quality in Health Care
ACT	Australian Capital Territory
AEMC	Australian Emergency Management Committee
AFAC	Australasian Fire Authorities Council
AGPS	Australian Government Publishing Service
AGPAL	Australian General Practice Accreditation Limited
AHMAC	Australian Health Ministers' Advisory Council
AIC	Australian Institute of Criminology
AIHW	Australian Institute of Health and Welfare
AIMS	Australian Patient Safety Foundation Australian Incident Monitoring System
AN-DRG	Australian national diagnosis related group
ANTA	Australian National Training Authority
APMC	Australian Police Ministers Council
AR-DRG	Australian revised diagnosis related group
ARHP	Aboriginal Rental Housing Program
ARIA	Accessibility and Remoteness Index for Australia
ASQHC	Australian Council for Safety and Quality in Health Care
ATSI	Aboriginal and Torres Strait Islander

ATSIC	Aboriginal and Torres Strait Islander Commission
Aust	Australia
BEACH	Bettering the Evaluation and Care of Health
CAA	Convention of Ambulance Authorities
CACP	Community Aged Care Package
CCB	Child Care Benefit
CCCCS	Commonwealth Census of Child Care Services
CD-ROM	Compact Disc Read Only Memory
COAG	Council of Australian Governments
CRA	Commonwealth Rent Assistance
CSDA	Commonwealth–State Disability Agreement
CSDA MDS	Commonwealth–State Disability Agreement Minimum Data Set
CSHA	Commonwealth–State Housing Agreement
CSI	Consumer Survey Instrument
CSMAC	Community Services Ministers’ Advisory Council (formally Standing Committee on Community Services and Income Security Administrators (SCCSISA))
DALE	Disability Adjusted Life Expectancy
DALY	Disability Adjusted Life Years
DEA	data envelopment analysis
DETYA	Department of Education, Training and Youth Affairs
DEWRSB	Department of Employment, Work Place Relations and Small Business
DFaCS	Commonwealth Department of Family and Community Services
DHAC	Department of Health and Aged Care
DHFS	Department of Health and Family Services
DHS	Department of Human Services (Victoria)
DPS	Drug Policy Subcommittee
DRG	Diagnosis related group

DVA	Department of Veterans' Affairs
EACH	Extended Aged Care at Home pilot
ESB	English speaking background
FMD	Foot and Mouth Disease
FTE	full time equivalent
FWE	full time workload equivalent
GDP	gross domestic product
GP	general practitioner
GPMoU	General Practice Memorandum of Understanding
GST	goods and services tax
HACC	Home and Community Care (program)
HACC MDS	Home and Community Care (program) Minimum Data Set
HRSCEET	House of Representatives Standing Committee on Employment, Education and Training
ICD-9-CM	international classification of diseases, 9 th revision, clinical modification
ICD-10-AM	international statistical classification of diseases and related health problems, 10 th revision, Australian modification
ICF	International Classification of Functioning, Disabilities and Health
ICIDH	International Classification of Impairments, Disabilities and Handicaps
IDDM	insulin-dependent diabetes mellitus
IESIP	Indigenous Education Strategic Initiatives Programme
IMP	Information Management Plan
LAC	local area command
LBOTE	language background other than English
LPP	Local Priority Policing
MBS	Medicare Benefits Schedule
MCEETYA	Ministerial Council on Education, Employment, Training and Youth Affairs
MDS	minimum data set

MH-CASC	Mental Health Classification and Service Costs project
NAC	National Advisory Committee to BreastScreen Australia
NBCC	National Breast Cancer Centre
NCIRS	National Centre for Immunisation Research and Surveillance of Vaccine Preventable Diseases
NCJSF	National Crime and Justice Statistical Framework
NCPASS	National Child Protection and Support Services
NCSMIG	National Community Services Information Management Group
NCVER	National Centre for Vocational Education Research
NEPI	National Exchange of Police Information
NESB	non-English speaking background
NESO	non-English speaking origin
NHCDC	Commonwealth Department of Health and Aged Care, National Hospital Cost Data Collection
NHMRC	National Health and Medical Research Council
NHPC	National Health Performance Committee
NIDDM	Non-insulin-dependent diabetes mellitus
NMDS	national minimum data set
NMHS	National Mental Health Strategy
NOOSR	National Office of Overseas Skills Recognition
NPS	National Prescribing Service
NRCP	National Respite for Carers Program
NSW	New South Wales
NT	Northern Territory
OATSIH	Office of Aboriginal and Torres Strait Islander Health
OECD	Organisation for Economic Cooperation and Development
OMP	Other Medical Practitioner
PBS	Pharmaceutical Benefits Scheme
PDF	Postscript Document Format
PHOFA	Public Health Outcome Funding Agreements

PIP	Practice Incentives Program
PMRT	Performance Measurement and Reporting Taskforce
PSM	Population Survey Monitor
Qld	Queensland
RACGP	Royal Australian College of General Practitioners
RCS	Resident Classification Scheme
Review	Review of Commonwealth/State Service Provision
RFDS	Royal Flying Doctor Service
RRMA	Rural Remote Classification System
SA	South Australia
SAAP	Supported Accommodation Assistance Program
SCRCSSP	Steering Committee for the Review of Commonwealth/State Service Provision
SDA	service delivery area
SES/TES	State Emergency Service/Territory Emergency Service
SLA	statistical local area
SMART	SAAP Management and Reporting Tool
SRCSSP	Secretariat for the Review of Commonwealth/State Service Provision
SWPE	Standardised whole patient equivalent
TAFE	technical and further education
Tas	Tasmania
ULN	upper limit of normal
VET	vocational education and training
VHC	Veterans' Home Care
Vic	Victoria
WA	Western Australia
WHO	World Health Organization
YLD	Years of life lost due to disability
YLL	Years of life lost due to premature mortality

Glossary

Descriptors	Statistics included in the Report that relate to the size of the service system, its client mix and the environment within which government services are delivered. They are provided to highlight and make more transparent the differences among jurisdictions.
Effectiveness	A reflection of how well the outputs of a service achieve the stated objectives of that service
Efficiency	A reflection of how well organisations use their resources to produce services
Unit costs	An indicator of efficiency, as used throughout this Report
Inputs	The resources (including land, labour and capital) used by a service area in providing the service
Process	The way in which a service is produced or delivered
Output	The service provided by a service area — for example, a treated case is an output of a public acute care hospital
Outcome	The impact of the service on the status of individuals or a group. A service provider can influence an outcome but external factors can also apply. 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.

Definitions of the indicators and terminology used in each chapter can be found in the relevant attachments.

Terms of reference

The Review, to be conducted by a joint Commonwealth/State and Territory government working party, is to undertake the following:

- establish the collection and publication of data that will enable ongoing comparisons of the efficiency and effectiveness of Commonwealth and State government services, including intra-government services. This will involve:
 - establishing performance indicators for different services which would assist comparisons of efficiency and effectiveness. The measures should, to the maximum extent possible, focus on the cost effectiveness of service delivery, as distinct from policy considerations that determine the quality and level of services; and
 - collecting and publishing data that are consistent with these measures. The Review should also address the procedures for the ongoing collection and publication of benchmark data; and
- compile and assess service provision reforms that have been implemented or are under consideration by Commonwealth and State Governments.

The Review will cover all major types of reform, including those involving the separation of policy development from service provision. Case studies of particular reforms could be provided where appropriate.

The Review will need to keep abreast of developments in other relevant reviews and working parties, including the Commonwealth/State Government working party (initiated by the Council of Australian Governments), investigating Commonwealth/State government roles and responsibilities.

1 The approach to performance measurement

1.1 Aims of the Review

Australian governments established the Review of Commonwealth/State Service Provision (the Review) to provide information on the effectiveness and efficiency of Commonwealth, State and Territory government services (see terms of reference, p. XVII).

There are two functions of the Review:

- to provide ongoing comparisons of the performance of government services (the role of this Report); and
- to report on service provision reforms that governments have implemented or that are under consideration.

A Steering Committee, comprising senior representatives from the central agencies of all governments, was established to manage the Review with the assistance of a Secretariat provided by the Productivity Commission.

Over time, the Report has become an important tool for government. It has been used for strategic budget and policy planning, and for policy evaluation. Some users have found the Report to be instrumental in assessing the resource needs and resource performance of departments. Others have used the Report for identifying other jurisdictions with whom to share information on services.

For governments, the data in this Report can be an incentive to improve performance by fostering improvements in government services through:

- helping jurisdictions identify where there is scope for improvement;
- promoting greater transparency and informed debate about comparative performance; and
- enhancing measurement approaches and techniques in relation to aspects of performance such as unit costs and service quality.

In June 2001, a survey of users and producers of the Report was undertaken. The feedback survey achieved a response rate of nearly 40 per cent, which was somewhat lower than for the survey undertaken in 1998. The results have been made available to Review participants and will be used in assessing how to enhance reporting. Some of the key findings are outlined in box 1.1.

Box 1.1 Key results of the feedback survey

In June 2001, the Secretariat undertook a survey of users of, and contributors to, the Report to obtain feedback on the success of the Report in meeting the objectives of the Review.

Overall, around three-quarters of respondents rated the Report as 'good' or 'very good' on a range of criteria — credibility, relevance and objectivity — and nearly 60 per cent of respondents similarly rated the timeliness of its data.

In addition, respondents were asked to rate the usefulness of the various types of information presented in the Report by service area.

More than 80 per cent of respondents considered the profiles provided on the individual sectors (such as school education, public hospitals, child protection and aged care) to be 'useful' or 'very useful' and about three-quarters of respondents similarly rated the Report's coverage of policy developments and key performance results.

The Steering Committee will use the survey results to continue to improve the Report.

1.2 Scope

This seventh *Report on Government Services* contains performance information on 12 key service areas (box 1.2). These government services have two features:

- their key objectives are common or similar across jurisdictions; and
- they make an important contribution to the economy and/or community.

Why governments deliver services

Governments deliver services for a number of reasons, and all services included in this Report affect the community in significant ways. Some services form an important part of the nation's social welfare system (for example, public housing), some are provided to people with specific needs (for example, aged care and disability services), while other services are typically used by each person in the

Box 1.2 Services covered in the 2000 Report

Education and training	— School education (chapter 3) — Vocational education and training (chapter 4)
Health	— Public hospitals (chapter 5) — General practice (chapter 6) — Breast cancer control and mental health (chapter 7)
Justice	— Police (chapter 8) — Court administration (chapter 9) — Corrective services (chapter 10)
Emergency services	— Emergency management (chapter 11)
Community services	— Aged care (chapter 12) — Services for people with a disability (chapter 13) — Children's services (chapter 14) — Protection and support services (chapter 15)
Housing	— Public and community housing, and Commonwealth Rent Assistance (chapter 16)

community at some stage during their life (for example, school education, police services and emergency services). More generally, the services included in this Report are largely concerned with:

- providing public goods, including:
 - creating a legal framework that determines the rules for ownership of property and the operation of markets (for example, enforcing property rights, checking abuses of power and upholding the rule of law). This reduces transaction costs (Messick 1999), and encompasses the work of the courts in maintaining law and order, including the work of police and corrective services; and
 - managing adverse events, including the work of emergency services such as fire and flood control, and some aspects of the health system; and
- enabling the consumption of particular goods and services that governments see as having particular merits or reflecting significant spillover effects in society. Examples include health services, ambulance services, community services and housing.

How governments deliver services

Governments deliver services to the community by:

- providing the services directly (a ‘provider’ role);
- managing and funding external providers of the services through grants or the purchase of services (a ‘purchaser’ role);
- subsidising users (through vouchers or cash payments) who then purchase services from external providers;
- creating community service obligations on public and private providers;
- reducing tax obligations in particular circumstances (known as tax expenditures); or
- using a mix of these delivery methods.

Funding from government may not meet the full cost of delivering a service to the community, and not-for-profit organisations or users may also contribute funding and other resources (box 1.3).

Box 1.3 **Cost to government and to non-government organisations**

The Report seeks, where possible, to provide information about the cost of services to government. Some argue that where non-government groups such as charities, not-for-profit organisations and private providers also contribute resources for the services covered by the Report, those costs should be taken into account.

The purpose of the Report is to provide information to assist government decision making, and the relevant information required depends on the type of assessment that needs to be made to support a decision. When government provides the service directly it may wish to assess the internal management of the service. On other occasions it may wish to assess the decision of whether to provide the service directly or to purchase, part fund or subsidise the service. Alternatively, it may wish to assess from which organisation to purchase the service.

If a government provides services directly, it is accountable for all resources used and the Report includes the full costs. When focusing on government decision making in the role of direct service provider, the Report aims to compare the full cost to government of service delivery, including the cost of capital, where possible, in each State and Territory. This allows governments to compare the internal management of their services with that of their counterparts in other jurisdictions. If a government decides to purchase, part fund or subsidise services, it should aim to maximise the benefit to the community from this use of government funds.

(Continued next page)

Box 1.3 (continued)

The Report also compares the cost to government of services delivered by non-government and government service providers; this information allows governments to assess their purchase decisions. This Report has not sought to facilitate comparisons between the internal management of government providers and non-government providers, and there are difficulties in collecting data to make such comparisons. As a result, it has not attempted to compare the full cost of delivery by non-government organisations with the full cost of delivery by government service providers. Consequently, for services delivered by non-government agencies, this Report emphasises the costs to government, along with outputs, outcomes and service quality.

Sometimes, a private organisation will offer to deliver a service at a lower price to government than offered by an equivalent government provider, even though it may use at least as many resources as used by the government provider. This can typically arise for not-for-profit organisations such as charities, which may be able to charge less because they operate the service as an adjunct to another activity, or because they have access to resources such as donations, church buildings and volunteers that are not costed at market rates.

Funding government services

The services covered in the Report absorb a significant level of government expenditure. They accounted for approximately \$64.3 billion in 2000-01 (figure 1.1), representing around 27.5 per cent of government expenditure in that year (equivalent to about 9.6 per cent of gross domestic product).

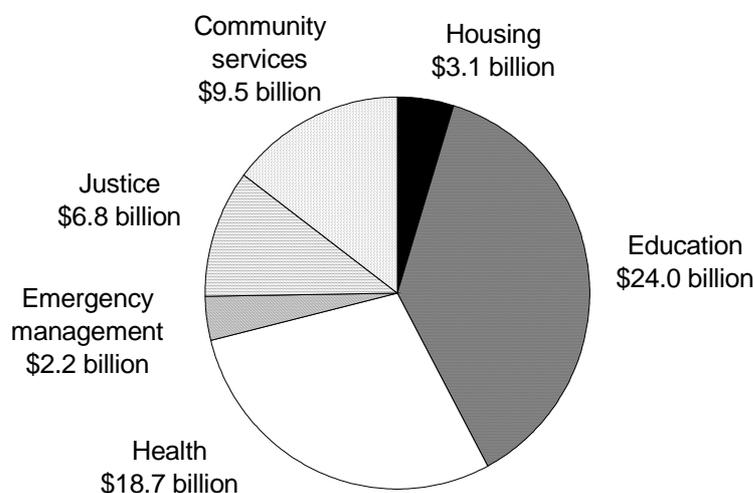
1.3 Approach

Guiding principles

The aim of the Report is to provide objective government performance information to facilitate informed policy judgments and sound outcomes. The following guiding principles apply:

- *a focus on outcomes* — performance indicators should focus on outcomes from the provision of government services, reflecting whether service objectives have been met;

Figure 1.1 **Estimated government recurrent expenditure on services covered by the Report, 2000-01^{a, b, c, d, e, f}**



^a Data for 2000-01 were not available for all services. The Report uses 1998-99 data for breast cancer screening and non-inpatient mental health care; 1999-2000 data for school education, public hospitals and general practice services; and 2000 data for vocational education and training. ^b These figures are not directly comparable to those reported in SCRCSSP (2001) because some service areas have used different data sources. ^c Health expenditure includes data for public hospitals, general practice, public health expenditure on breast cancer screening services and non-inpatient mental health services. ^d Increased housing expenditure in 2000-01 was partly due to an 8.0 per cent real increase in the maximum rate of Commonwealth Rent Assistance as compensation for the goods and services tax (GST), and \$89.7 million of GST compensation paid by the Commonwealth to State and Territory governments under the Commonwealth State Housing Agreement. ^e Health expenditure excludes patient transport. ^f Community services expenditure excludes juvenile justice.

Sources: relevant chapters.

- *comprehensiveness* — the performance indicator framework should be as comprehensive as possible, assessing performance against all important objectives;
- *comparability* — data should be comparable across jurisdictions wherever possible. Reporting comparable information has a higher priority than using a better indicator that allows no comparison. Where data are not yet comparable, they can still provide a useful basis for evaluating performance. Data for many services have been published in each of the seven reports; and
- *progressive data availability* — while the ultimate aim is comparable data for all jurisdictions, progress may differ across jurisdictions, so data are generally presented for those jurisdictions that can currently report (rather than waiting until the data are available for all jurisdictions).

Why measure performance?

The Steering Committee defines ‘performance’ in terms of how well a service meets its objectives, recognising the influence of external factors. Measuring the performance of government services is important for a number of reasons. The services covered in this Report are vital to the community’s wellbeing. Improving them will result in major social and economic benefits. Governments are continually re-evaluating whether the community is receiving the appropriate service mix and whether the services are getting to those most in need. Moreover, governments need to know whether their policies are effective and whether they are being implemented efficiently.

Performance measurement can:

- make performance more transparent, allowing assessment of whether program objectives are being met;
- help clarify government objectives and responsibilities;
- inform the wider community about government performance;
- encourage ongoing performance improvement;
- encourage efficient service delivery; and
- promote analysis of the relationship between agencies and between programs, allowing governments to coordinate policy within and across agencies.

Why report comparative performance?

There are two main reasons that comparative performance information across jurisdictions is reported:

- to facilitate yardstick competition which enhances incentives for agencies to address substandard performance; and
- to allow agencies to identify peer agencies that are delivering better or more cost-effective services from which they can learn.

Comparative performance measurement is important for government services because the limited information is available to those deciding what services to supply and to whom. Each jurisdiction has, for example, only one police service, one protection and support service and one public hospital system. As a result, choices are always constrained for consumers of these services, and those responsible for delivering the services do not have access to the same level of information that is available to providers in markets with more providers.

Reporting comparative performance measures can facilitate surrogate competition across jurisdictions. Governments and the community can assess service delivery and policy development in the context of the performance of other jurisdictions.

Comparative performance information can promote a process of learning from the diversity of experience, particularly as governments implement different policy approaches. Governments have considered a range of general policy approaches when deciding how to deliver services in recent years. These approaches include:

- moving from historical or input based funding to output based funding (for example, casemix funding in public hospitals in Victoria);
- separating the purchaser and provider roles for government organisations (for example, the separation of functions and corporatisation);
- outsourcing the provider roles (for example, competitive tendering for correctional services in Queensland);
- devolving and decentralising decision making on how to provide services by government service providers (for example, devolving decision making in Victorian government schools to local school communities);
- examining alternative delivery mechanisms (for example, deinstitutionalising community services and offering direct consumer funding and choice in disability services in WA);
- examining interactions between services; and
- implementing user charging (for example, pricing court reporting services for Commonwealth courts).¹

Comparisons that draw on reliable performance information can help governments better understand the strengths and weaknesses of each approach, and the circumstances in which each may best work.

Providing performance information across jurisdictions can encourage innovation (and thus performance improvement). Traditionally, much of the effort to improve the effectiveness of government services has focused on increasing the level of resources devoted to them. This overlooks another important means of enhancing services — that is, finding better and more cost effective ways in which to use existing resources. Productivity growth has had an important influence on living standards in Australia, accounting for the majority of the increase in real average annual income over the past decade (Bland and Will 2001). Innovation (the

¹ The implementation issues associated with these types of reform are examined in SCRCSSP (1997b) and SCRCSSP (1998).

introduction of new products or processes) can be important to productivity growth in all sectors, including government services.

While the Report does not establish best practice benchmarks, the information in the Report could be used to help jurisdictions identify appropriate benchmarks (box 1.4).

Box 1.4 Benchmarking

Benchmarking service delivery involves a systematic process of searching for and encouraging the introduction of best practice in the use of scarce resources, so as to deliver more efficient and effective services. There are three main forms of benchmarking: results benchmarking (comparing performances within and between organisations using performance indicators of effectiveness and efficiency); process benchmarking (analysing activities and tasks that turn resource inputs and outputs into outcomes); and best practice standards (establishing goals and standards to which organisations can aspire).

Benchmarking typically involves a number of steps. Whatever the chosen approach or focus, the steps usually include:

- deciding why, when and what to benchmark;
- analysing plans and performance (reviewing objectives and identifying performance indicators and own performance);
- establishing benchmarking partners;
- obtaining the data and analysing differences;
- identifying best practices and the most useful improvements;
- implementing improvements in practice; and
- assessing improvements and re-benchmarking (MAB/MIAC 1996).

The performance information in the *Report on Government Services* can contribute to many of the above steps in a results benchmarking cycle, including by identifying better approaches adopted by agencies' peers and thus implementing best practice.

Publishing performance comparisons across services in a single annual report has a number of benefits, namely:

- data are drawn from a range of sources;
- a common method is used across services, which is convenient and useful for people interested in more than one service area;
- there are opportunities to share insights into approaches to performance assessment across services;

-
- progress in performance reporting in any one service area is demonstrated to reinforce what is possible and to encourage improved reporting by other services;
 - there is the capacity to address efficiently issues that arise across all service areas (for example, how to measure timeliness, how to assess other aspects of quality and how to cost superannuation); and
 - there is a response to issues with links between service areas (for example, recidivism and justice services).

A number of the services covered by the Report are also subject to other comparative performance measurement across jurisdictions. Advantages of the approach taken in the Report are that there is a focus on non-technical information, making it accessible to non-specialists, and that the Report is produced on a regular basis.

This Report examines performance of the service elements for which government is responsible and accountable. The focus is on reporting performance information on the effectiveness and efficiency of government expenditure, linked to the purchase or supply of specific services rather than to general government income support. Thus, the Report covers aged care (but not the aged pension), disability services (but not disability pensions) and children's services (but not family payments), although some descriptive information on income support is provided in some cases. An exception is the reporting of performance information on Commonwealth Rent Assistance (chapter 16).

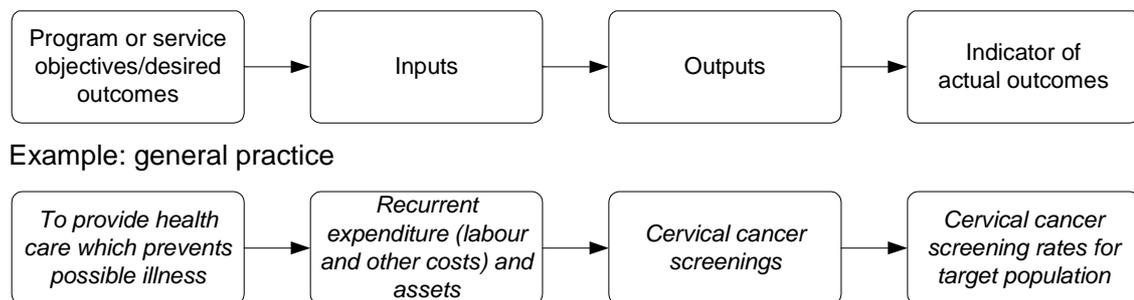
The service process

The basic relationship between objectives, inputs, outputs and outcomes is set out in figure 1.2. Governments have a number of objectives/desired outcomes for the community. To achieve these objectives or desired outcomes, governments fund service providers and products and/or provide services. Service providers transform these funds/resources (inputs) into services (outputs), and the outputs contribute to the achievement of a government's actual outcomes.

The general framework

A number of the objectives (or desired outcomes) for each government funded service are similar across jurisdictions, although the priority that jurisdictions give to each objective may differ. The Steering Committee's approach to performance

Figure 1.2 **Service process**



reporting is to focus on the extent to which each *shared* objective for a service has been met. Objectives for each service area are outlined and performance indicators consistent with those objectives are reported.

The Steering Committee has developed a general framework for performance indicators (figure 1.3).² Within the framework, performance is assessed in terms of effectiveness and efficiency. *Effectiveness* is a reflection of how well the outputs of a service achieve the stated objectives. *Efficiency* is a reflection of how well governments use their resources to produce units of services.

Service provision can sometimes involve a tradeoff between elements of effectiveness and efficiency.³ A change in service delivery may increase the level of resources per unit of output (a decrease in measured efficiency) but lead to better outcomes. A standard unit of service may be, for example, more costly to produce but more effective in meeting each client's specific needs. Thus, performance assessment should consider both efficiency and effectiveness indicators.

Effectiveness indicators in this Report include indicators of:

- actual outcomes;
- access and equity;
- appropriateness; and
- quality.

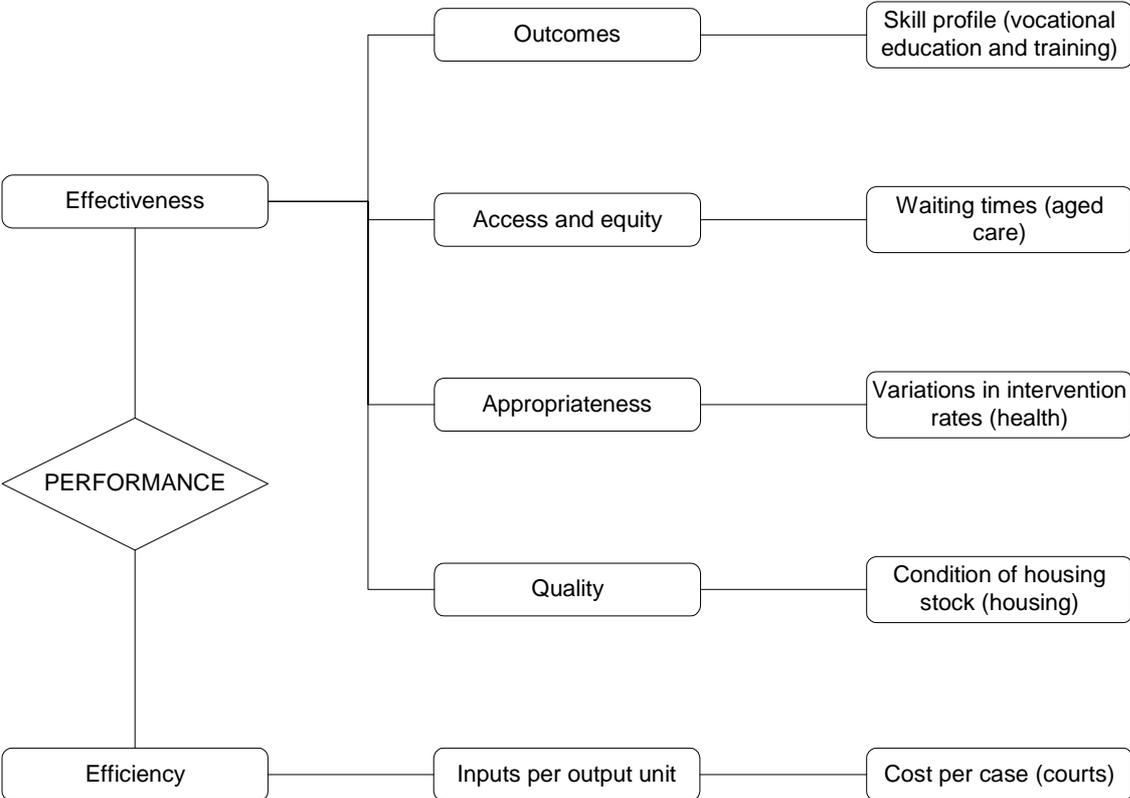
The indicator of efficiency generally used is the level of government inputs per unit of output. Each chapter of the Report includes descriptive information about

² The performance indicator framework for schools, used for the first time in the 2001 Report, is a departure from the general framework.

³ The Review has adopted the effectiveness and efficiency terms common to the program evaluation literature.

services and the context of their delivery, recent policy developments, a discussion of future directions in performance reporting, and comments from each jurisdiction.

Figure 1.3 A general framework and examples of performance indicators



Outcomes

The actual outcomes of a service area should reflect the objectives of the service area; it is important, therefore, to report outcome indicators (or their proxies) when measuring performance. Outcome indicators provide information on the impact of a service on the status of an individual or a group, although other factors may affect actual outcomes for an individual or group. Outputs are the services delivered by the service area.

Some indicators could be described as both outcome and output indicators. In corrective services, for example, the secure housing of prisoners is a prison output but also an outcome indicator (linked to the objective of containment and supervision). If there is an established link between the indicator and the objective, then the indicator has validity as a performance indicator regardless of whether it is output or outcome related.

Outcomes of a service range from immediate and specific (short term) results to long term or broad changes in the community. Short term specific outcomes often lead to broader outcomes. As outcomes become less specific and more broad, it becomes increasingly difficult to assess the separate role that a particular service area has had relative to other factors. One of the broad outcomes (objectives) for maternity services, for example, is that services are safe and of high quality. While one of the outcome indicators — rate of neonatal deaths per 1000 births — indicates the effectiveness of the service area, external factors (such as general health and wellbeing of the mother) will also affect the indicator.

The approach in this Report is to:

- use, where possible, both short term (or intermediate) and long term (or final) outcome indicators; and
- make clear that the service is only one contributing factor and, where possible, point to data on other factors. (Appendix A contains detailed statistics and short profiles on each State and Territory, which may assist in interpreting the performance indicators presented in this Report).

Access and equity

Enabling appropriate access to key services is an important reason for governments to fund services. The objective may be to ensure access to a service by everyone in the community (for example, to school education and police services) or access by a target group (for example, to housing services for those having difficulties accessing housing in the private sector).

Access has three main dimensions — preventing discrimination, undue delay, and undue cost. This Report focuses on:

- service provision to those who may have special difficulties accessing services; and
- service timeliness and affordability.

Groups with special difficulties

A number of criteria can be used to classify those who may have special difficulties in accessing government services. These include:

- language or literacy proficiency;
- gender;
- age;

-
- physical or mental capacity;
 - race or ethnicity; and
 - geographic location.

In addition to reporting access indicators for individual service areas, the Report has devoted a chapter to examining the effectiveness and efficiency of services for people with a disability (chapter 13).

In May 1997, the Prime Minister (with the support of the Premiers and Chief Ministers) requested that the Review give particular attention to the performance of mainstream services in relation to Indigenous Australians. Chapter 2 provides more detail on the progress in this area.

Identifying service recipients as members of groups with special access difficulties poses challenges, particularly when relying on client self identification. If members of such groups are required to identify themselves, then the accuracy of the data will partly depend on how a group perceives the advantages (or disadvantages) of identification and whether such perceptions change over time. Varying definitions of these groups in data collections across jurisdictions and service areas may also create comparability problems.

The Report often uses the proportion of each target group in the broader community as a proxy indicator of the group's need for a particular service. This simple assumption is clearly sensible for some services (for example, schools), but it should be treated with caution for other services (for example, aged care). Another option is to collect more direct indicators of need (for example, the Supported Accommodation Assistance Program (SAAP) collects data on the characteristics of those seeking assistance).

Where geographic location is used to identify groups with access difficulties, access is normally compared for metropolitan, rural and remote areas. These classifications are based on population density and distances to large population centres (DPIE and DSHS 1994). Such comparison by location has been criticised because it is an imperfect indicator of the time and cost of reaching the point of service. Further, it does not consider the client's capacity to bear the cost of receiving the service (Griffith 1998). To improve the model, service centre locations would need to be reclassified according to the services they provide and the client's cost of receiving the service.

Timeliness and affordability

Timeliness and affordability can also be important access issues for those in the community who rely on publicly funded services. Timeliness indicators used to measure access in this Report include waiting times (for example, in public hospitals and for aged care services). Affordability indicators relate to the proportion of income spent on particular services (for example, out-of-pocket expenses in children's services).

Appropriateness

Appropriateness indicators measure how well service delivery directly meets client needs. An appropriateness indicator for SAAP, for example, is the proportion of clients receiving the services they are judged to need. Appropriateness indicators also seek to identify the extent, if any, of underservicing or overservicing (Renwick and Sadkowsky 1991).

Some services have developed measurable standards of service need against which the current levels of service can be assessed. The 'overcrowding' measure in housing, for example, measures the appropriateness of the size of the dwelling relative to the size of the tenant household. Other services have few measurable standards of service need; for example, the appropriate number of particular medical treatments for particular populations is not known. However, data on differences in service levels can indicate where further work could identify possible underservicing or overservicing.

Quality

The Review highlights indicators of service quality because they are important to performance assessment and policy formulation. Information about quality is particularly important for performance assessment when there is a strong emphasis on increasing efficiency (as indicated by lower unit costs). Moreover, there is usually more than one way in which to deliver a service, and each alternative has different implications for cost and quality. Information about service quality is needed to ensure that governments fairly consider all useful delivery alternatives.

One definition of quality is fitness for the purpose. A comprehensive assessment of fitness for purpose requires a range of indicators. Ideally, such indicators directly capture the achievement of outcomes — that is, whether the service achieves the objectives of government. Assessment may also involve seeking the views of clients and others with a legitimate interest in service quality.

Data generated for quality control can often be a useful source of information about likely outcomes. Information about the incidence of complaints or adverse outcomes (such as the number of escapes from prison), for example, is often used as an indicator of outcome quality. Another test of fitness for purpose is the extent to which aspects of the service delivery process (such as inputs, processes and outputs) conform to specifications — for example, the level of accreditation of public hospitals and facilities for aged care.

The framework of indicators for this Report treats quality as one aspect of effectiveness and distinguishes it from outcomes, access and appropriateness (figure 1.3). This distinction, however, is somewhat artificial because other aspects of service provision also have the potential to contribute to a meaningful picture of quality.

No perfect indicator of service quality exists; each has its own strengths and weaknesses. Selecting an indicator requires trading off desirable characteristics (such as timeliness, cost and validity). The approach here is to consider the use of acceptable (albeit imperfect) quality indicators that are already in use or available in Australia or internationally. Adopting these indicators can lower the costs of, and reduce delays in, performance reporting. Although the Steering Committee values time series data as a means of evaluating developments in service delivery, performance indicators will sometimes change from one Report to another when better or more appropriate ones are developed.

Efficiency

Efficiency relates to how well organisations use their resources to produce units of services. This Report mostly focuses on achieving better value for the broader community from the use of government resources, so government funding per unit of service is typically used as the efficiency indicator — for example, recurrent funding per annual curriculum hour for vocational education and training. However, such an efficiency indicator is not to be interpreted as encompassing a service's full cost to society.

Where possible, full unit costs are used as the indicator of efficiency. Where there are shortcomings in the data, other indicators of efficiency are used (including partial productivity ratios such as staff level per student in government schools and staff per prisoner in corrective services). Comparisons of unit cost of a service are a more meaningful input to public policy when they use the full cost to government, accounting for all resources consumed in providing the service. Problems can occur when some costs of providing services are overlooked or treated inconsistently (for example, superannuation or overheads). The Steering Committee believes, where

full cost information is not available in the short term, that data should at least be calculated consistently across jurisdictions. Further, treatment should be fully transparent.

Using the data in this Report

Data comparability

For each service area, the performance indicator framework shows which data are provided on a comparable basis and which are not strictly comparable. Qualifications for data that are not strictly comparable are also noted within the text. Data may not be strictly comparable if:

- definitions or counting rules differ or are so broad that they result in different interpretations (for example, depreciation rules);
- the scope of measurement varies (for example, the waiting time for elective surgery); and
- benchmarks differ (for example, literacy standards).

These differences may result in biased estimates, but it is not always clear whether biases will necessarily be material. Even where they are significant, relatively simple adjustments may resolve the differences in many cases. As noted earlier, payroll tax exemption has an influence on the comparability of unit cost indicators, and the payroll tax amount can be readily calculated from payroll data. Differences in the marginal tax rates of payroll tax systems, conversely, are not likely to have a material impact on unit costs. Such differences are likely to be outweighed by other factors affecting comparisons.

Validation

Data contained in this Report vary in the extent to which they have been reviewed or validated; at a minimum, all data have been subject to peer review by the working group for each service. Some data are supplied by data collection agencies such as the Australian Bureau of Statistics (ABS) and the Australian Institute of Health and Welfare.

Timeliness and accuracy

Timeliness of data is an important consideration for policy decision making. Sometimes, however, there is a tradeoff between the accuracy of data and its timely

availability; data that are provided in a timely fashion may have had fewer opportunities to undergo rigorous processes of validation.

The Review recognises the importance of both timely and accurate data. The Review's process of iterative data collection is intended to manage this tradeoff. The Review publishes data that jurisdictions have provided, with appropriate qualifications. This provides an opportunity for the Review to improve the data accuracy and comparability over time. This approach has increased scrutiny of the data and led to timely improvements in data quality.

Improving the timeliness and accuracy of the data — an ongoing task — requires a high level of cooperation between the Steering Committee and participating agencies from all jurisdictions. Users of the Report are also an important source of feedback on issues relating to the improvement of performance reporting. The Steering Committee welcomes feedback, which can be forwarded to the Secretariat (see the contact details inside the front cover of the Report).

Effects of factors beyond the control of agencies

The Report aims to present indicators that help users assess performance. Many government objectives involve tradeoffs, such as choosing whether to improve the average level of service or better target services to those most in need. Each government's priorities, tradeoffs or targets may be unknown and may change over time. Presenting a range of performance indicators encourages users to consider overall performance, rather than performance against a single indicator. Moreover, each user is left to judge the appropriate tradeoffs between objectives.

Readers must also account for other important issues. The broader environment in which a service operates affects the performance of each service in each jurisdiction. There may be significant differences in clients, available inputs, prices and geography, and any comparison of performance across jurisdictions needs to consider these differences.

To help identify and account for environmental differences, the Report includes a descriptive statistical appendix (appendix A). This appendix provides a range of general descriptive information for each jurisdiction, including age profile, population distribution, income levels, education levels, tenure of dwellings and cultural heritage (such as Indigenous and ethnic status). It has two parts: a description of the main distinguishing characteristics of each jurisdiction and a set of source tables (which will help users to compare jurisdictional performances).

The Report does not adjust results provided by jurisdictions for differences that may affect service delivery. Rather, it leaves this task to users who can better make the necessary judgments, perhaps with the benefit of additional information about their jurisdiction's circumstances or priorities. The Commonwealth Grants Commission adopts a different approach, but this reflects its different role (SCRCSSP 2000).

When comparing performance information across jurisdictions, users also need to consider the effect of differences in the quality of data collection methods and systems. Definitions of terms may also vary, such as the definitions of notification in child protection. Notes to tables or figures highlight differences in data collection methods or definitions.

The Report aims to provide a comprehensive set of performance information. Nevertheless, given the complex nature of government services and the cost of collecting information, some important but secondary aspects of government services may not be reported. Reforms in government services may impose unmeasured costs on clients of those services (for example, when the closure of schools force some students to travel further). This highlights the importance of using performance indicators as part of a broader set of tools when assessing policy choices.

1.4 Other approaches and exercises

Efficiency measures

The approach to developing indicators of efficiency used in the Report is primarily that of unit cost (although some chapters contain other measures of efficiency). Data envelopment analysis (DEA) is another measurement technique that appears to be well suited to assessing efficiency in the delivery of government services. Typically using linear programming, DEA calculates the efficiency of an organisation within a group relative to observed best practice (not actual best practice) within that group. The approach operates by identifying best performers, in terms of input use and output production. Other service providers are allocated a single efficiency score based on their performance relative to these best performers.

Data envelopment analysis is capable of handling multi-input, multi-output production processes, as often exist in areas of government service provision. Moreover, this technique, unlike other more sophisticated tools, does not require outputs to be priced, which has obvious application to government services. It should be noted, however, that like any efficiency measurement tool, outputs (and units of measure) still need to be identified for estimation purposes.

Such analysis requires accurate data on all relevant input and output levels. Service providers that do not have a typical relationship between their inputs and outputs can have a significant impact on the results. In addition, a fairly large sample of service providers is required. This approach has been used to measure the performance of a range of service providers internationally, and its applicability in the Australian context has been examined.

The Steering Committee published a report in 1997, *Data Envelopment Analysis — A Technique for Measuring the Efficiency of Government Service Delivery* (SCRCCSP 1997a), that explains DEA's conceptual underpinnings, how to interpret the output from DEA models and its strengths and weaknesses. Also, through the use of case studies on hospitals, dental services, police, motor registries and corrective services, the report provides a practical guide to developing and refining a DEA model and interpreting of results. The DEA report is directed at those responsible for providing government services and those accountable for their delivery in a cost effective manner. It aims to encourage people to think about how more detailed and rigorous analysis of performance can assist in improving the efficiency with which resources are used to provide essential services to the community.

Another efficiency measurement technique was used in the World Health Organisation report *The World Health Report 2000 — Health Systems: Improving Performance*. This report outlines an approach to performance measurement by identifying two important aspects needed to judge performance. The first is attainment — that is, achievement of the objectives of good health, responsiveness and fair financial contribution. The second is performance — that is, the comparison between what has been achieved (attainment) and the best that could be achieved with the same resources (potential attainment). A frontier corresponding to the most that could be expected of a health system (a level of attainment that a country may achieve but that no country surpasses) was derived using information from many countries. Performance is measured on how far from this frontier actual attainment lies (WHO 2000).

Programme for International Student Assessment

The Organisation for Economic Cooperation and Development (OECD) launched the Programme for International Assessment to monitor the outcomes for students in 29 member countries and several other countries. The results will be published every three years, along with other indicators of education systems, allowing countries to compare the performance of their education systems with those of other countries.

Between 4500 and 10 000 students from each participating country will be surveyed in an internationally standardised assessment. The program covers three broad areas: reading literacy, mathematical literacy and scientific literacy. The first assessment took place in 2000 and results were published in late 2001 (Lokan, Greenwood and Cresswell 2001).

The assessments will provide various types of indicators, including:

- indicators of a baseline profile of the knowledge and skills of students;
- indicators showing how such skills relate to important demographic, social, economic and educational variables; and
- trends from ongoing data collection and showing changes in outcome levels, outcome distribution and outcomes over time (OECD 1999).

Australia's survey was undertaken by the Australian Council for Educational Research on behalf of the OECD.

Measuring Australia's progress

The ABS has indicated it will produce a new publication, *Measuring Australia's Progress (MAP)*, in April 2002. The publication will present data on measures (or indicators) that relate to progress in three general areas; economic, social and environment. The approach adopted is to present a suite of indicators of key aspects of progress, side by side, and to discuss the links between them. The aim is to provide 15 headline indicators and to track progress over time, allowing readers to draw their own conclusions about overall progress (ABS 2001).

Performance monitoring in other countries

Performance reporting exercises are undertaken using various approaches in other countries. In the United Kingdom, agency performance is measured in respect to the achievement of targets set out in Public Service Agreements. These agreements set out the aim of the department or program, the supporting objectives and the related performance targets that are to be achieved during a specified period. There has been a shift in emphasis of targets towards an outcome focus (The Comptroller and Auditor-General 2001).

In the United States, the *Government Performance and Results Act 1993* requires agencies to develop multi-year strategic plans, annual performance plans and annual performance reports. Performance measures are targets set by the departments (GAO 2000).

In Canada, performance information is organised around 200 key results commitments that federal departments and agencies have made. These commitments state what departments intend to achieve with the resources they have been allocated. Each department produces an annual performance report and the Treasury Board of Canada Secretariat produces an annual report, *Managing for Results*, which provides an overview. Performance frameworks and the types of indicators used vary across departments (Treasury Board of Canada 2000).

2 Recent developments in the Report

2.1 Developments in reporting in 2001

This is the seventh *Report on Government Services* produced by the Review. Reporting is an iterative process and each year the Review endeavours to build on developments of previous years. Since the Review published its first Report in 1995, there has been a general improvement in the data collected for the Report. Improvements in the 2002 Report can be categorised into three broad areas:

- improvements to the data used in performance indicators:
 - comparability, timeliness and quality of data;
 - increased reporting for special needs groups (in particular, Indigenous Australians and people living in rural and remote areas); and
 - reporting full costs to government;
- improvements to performance indicator frameworks to include new indicators and to report against others for the first time; and
- improvements to the quality of descriptive data and contextual information.

Improvements in reporting for the 2002 Report

Health

Improvements in reporting of existing performance indicators for health services include:

- reporting of standardised Indigenous hospitalisation ratios based on new definitions endorsed by the Australian Health Ministers' Advisory Council;
- reporting of public hospital efficiency by peer group to facilitate comparisons across hospitals providing similar services;
- refining the reporting of participation rates for special needs groups in breast cancer screening;

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- improved reporting of quality of mental health care to reflect review against National Standards for Mental Health Services; and
 - presentation of unit cost data for community based mental health care.

Refinements to both the maternity services and the general practice performance indicator frameworks have been made:

- the maternity services framework has been expanded to include four new performance indicators and each has been reported in this Report; and
- the addition of two new appropriateness indicators for general practice that illustrate the performance of general practitioners (GPs) in appropriate prescribing practices and in managing chronic illness, and the discontinuation of reporting of two indicators that were not closely and transparently related to the activities of GPs.

Justice

Improvements in reporting of existing performance indicators for justice services include:

- work on improving comparability of indicators in the following areas: juvenile diversions, costs awarded against police, outcomes of court cases, and recurrent expenditure by key service delivery area;
- the inclusion of a preliminary case study on the impact of rural/remoteness on the cost of delivering police services in NSW;
- separate reporting of children's and electronic court results from those of magistrates' courts, which has increased the meaningfulness of the data reported in the court administration chapter;
- the inclusion of the Federal Magistrates Service in the court administration chapter; and
- reporting for the first time fully comparable data for the completion of community orders indicator in the corrective services chapter.

To assist in improving the comparability of data in the court administration chapter, a Courts Practitioner Group has been established.

Emergency management

Improvements in reporting of existing performance indicators for emergency management services include refining:

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- the way ambulance services are referred to in the Report to accommodate future expansion of event type services reporting;
 - revenue data items (for both fire and ambulance services) to clarify reporting of revenue received directly and indirectly by agencies; and
 - a number of definitions to improve data comparability.

In addition, the descriptive data and contextual information has been improved by:

- including text boxes detailing specific programs focused on Indigenous communities;
- providing information on the activities of the various agencies involved in the sector to improve understanding of the scope of emergency management;
- presenting information on the scope and type of State and Territory emergency services activities; and
- providing data on revenue sources for event type services.

Community services

Improvements in reporting of existing performance indicators for disability services include reporting:

- geographic indicators of access;
- Indigenous indicators of day activity services;
- cost per place for employment services by jurisdiction; and
- social participation indicators (community, cultural and leisure participation; use of public and private transport; educational attainment; and level of schooling).

Efficiency reporting for child protection and out-of-home care in protection and support services has been improved with the introduction of new efficiency indicators. For child protection, total expenditure on child protection is compared with notifications, investigations and substantiations across jurisdictions. For out-of-home care, the actual expenditure on residential care is related to the number of children in residential care at 30 June, and the actual expenditure on non-residential care is related to the number of children in non-residential care at 30 June.

For the first time, the quality indicator — compliance with service standards for residential care — has been reported against in aged care services. This indicator provides information on the number of services that have been accredited under the new Commonwealth regulatory framework for aged care services. Data on the four standards considered for each accreditation decision are also presented.

The performance indicator framework for children's services has been revised. Two additional quality indicators — staff qualifications and licensing, and accreditation and registration — have been added. No data for these indicators were available for this Report.

Improvements in descriptive data and contextual information include:

- reporting of descriptive data relating to juvenile justice in the community services preface for the first time in this Report; and
- the inclusion of descriptive data on veterans' home care in aged care services.

Housing

Improvements in reporting of existing performance indicators for housing services include:

- performance reporting of the Aboriginal Rental Housing Program (ARHP) for the first time;
- simplifying some community housing indicators to promote better response rates from community providers;
- reporting for the first time information on access and on the extent to which affordability outcomes are improved by Commonwealth Rent Assistance for Indigenous Australians and those in rural and remote areas; and
- improving financial reporting for public housing with deduction of interest payments from capital costs to avoid double counting.

In addition, the contextual information has been improved with the reporting of descriptive data on the location of public housing, community housing and the ARHP.

2.2 Progress on key data issues

The Review has identified key data issues that bear on the Report: the comparability of data; full costing of government services; reporting of data for particular target population groups; and accounting for the goods and services tax (GST). There are also some issues associated with changes to administrative data collections on which the Review relies to publish the Report.

Changes to administrative data collections

There are some instances where reporting has stalled in the past year because data sets used by the Review have been discontinued. One example is the 2001 Commonwealth Census of Child Care Services, which was substantially scaled back during the year. This significantly limited the comparable data available for reporting in the 2002 Report. Review requirements are sometimes not a priority in the development or refinement of national minimum data sets or other types of information infrastructure. There is, for example, sometimes significant delay between the first data collection period and the availability of data from a new data set. This is due in part to implementation problems that can affect data quality for several years. In other cases, collection of data is staged so that comprehensive data sets are not available immediately. For the purposes of the Review, these delays can mean that reporting scope and data quality are diminished for some time until the new data sets are fully operational. The Steering Committee has taken steps to minimise the occurrence and effect of data time lags on the Report.

Comparability of data

To facilitate informed policy making, the Steering Committee has adopted the basic principle that, where feasible, data should be reported on a comparable basis across service areas and jurisdictions. Table 2.1 summarises the Review's progress in reporting comparable performance indicators for efficiency and for each of the four categories of effectiveness — overall outcomes, access and equity, appropriateness and quality. Client views are also reported where they are collected as proxies for effectiveness indicators. Data are considered to be comparable when they are collected using the same definition across jurisdictions.

Some service areas have not explicitly adopted the above categories in their frameworks. Where services have adopted their own headings (for example, breast cancer management and emergency management), the service's performance indicators have been allocated to the most suitable broad heading. Response times, for example, are a 'response' performance indicator in emergency management, but in table 2.1 they are reported as a 'quality' performance indicator.

Inclusion of indicators in table 2.1 does not infer an assessment of the quality of the indicator (for example, whether they are necessarily the most appropriate indicators). Rather, it indicates the first year when at least one indicator under each broad heading was reported across all jurisdictions on a comparable basis and sourced from a regularly published report or data collection and not from a one-off collection.

The pace of improvements in reporting across services is also illustrated in table 2.1. All services report on an accrual basis (except in the NT) to measure outputs and to demonstrate the maintenance of quality in purchaser/provider and contracting arrangements. Some service areas, however, are still unable to provide comparable data for a number of performance indicators. The housing chapter, for example, still does not report nationally comparable data on community housing for any performance indicators six years after its inclusion in the Review.

Costing of services

In addition to the Review's objective that costs for the funding or delivery of services be measured and reported on a comparable basis, a further objective is that they reflect the full costs to government. The Review has identified three priority areas for improving the comparability of unit costs:

- including superannuation on an accrual basis;
- accounting for differences in the treatment of payroll tax; and
- including the full range of capital costs.

Other issues also potentially affect the comparability of cost estimates. Where possible, the Review has sought to apply the same principles to:

- reporting accrued benefits to employees (such as recreation and long service leave);
- apportioning overhead department costs, where relevant; and
- reporting non-government sourced revenue.

Recent reforms to treasury and finance department accounting guidelines in most jurisdictions require government agencies to adopt accrual accounting rather than cash accounting methods in their financial reporting frameworks. Accrual accounting is based on the principle that the agency recognises revenue and expenses when they are earned and incurred. Cash accounting, in contrast, recognises revenue and expenses when they are collected and paid. Not all agencies and jurisdictions, however, have adopted or fully implemented accrual accounting. The NT Government is in transition to accrual accounting.

Table 2.1 First reporting of at least one comparable indicator^{a, b}

<i>Framework service</i>	<i>First coverage of service</i>	<i>When at least one nationally comparable indicator was first reported^c</i>					
		<i>Overall outcomes</i>	<i>Access and equity</i>	<i>Appropriateness</i>	<i>Quality</i>	<i>Client views</i>	<i>Efficiency</i>
<i>Education</i>							
School education	1995	1995	2001	na	na	na	1995
VET	1995	1995	1995	1995	1995	1995	1997
<i>Health</i>							
Public hospitals	1995	na	1995	1995	1995	na	1995
Maternity services	2001	2001	na	na	na	na	na
General practice	1999	1999	1999	2000	2000	na	2000
Breast cancer	1998	2000	na	na	2000	na	na
Mental health	1999	1999	na	1999	2000	na	1999
<i>Justice</i>							
Police services	1995	1995	1999	na	1995	1997	1997
Court administration	1995	na	1995	na	1995	na	1995
Corrective services	1995	1995	1998	na	1995	na	1995
<i>Emergency management</i>							
Fire services	1998	1999	na	na	na	2000	2001
Ambulance services	1998	na	na	na	na	2000	2001
<i>Community services</i>							
Aged care services	1997	na	1999	2000	2000	2000	2000
Services for people with a disability	1997	1997	1997	1997	2000	2000	na
Children's services	1997	na	1997	na	na	na	na
Child protection and out-of-home care	1995	na	na	na	1997	na	na
Supported Accommodation	1995	1998	na	1999	1998	na	na
<i>Housing assistance</i>							
Public housing	1995	1995	1995	1995	1997	1997	1997
Community housing	1997	na	na	na	na	na	na
Aboriginal Rental Housing Program	2002	2002	2002	2002	na	na	2002
Commonwealth Rent Assistance	1999	2000	2000	2000	2000	2000	2000

^a In the *Report on Government Services*. ^b Not all frameworks in this Report necessarily follow the general framework set out in chapter 1. However, all services report indicators that cover these general areas. Where this framework is not followed, the service's performance indicators have been allocated to the most suitable broad heading. ^c Refers to year in which Report was published, not year of data. **na** Nationally comparable data are not available.

Sources: SCRCSSP (1995, 1997b, 1998b, 1999c, 2000 and 2001a).

Accrual accounting has assisted the Review in meeting its full costing principle, but has reduced the comparability of some data over time. Government finance statistics data published by the Australian Bureau of Statistics (ABS) for 1998-99 are based on accrual methods, but are not consistent with earlier data collected on cash accounting methods. Care needs to be taken when comparing 1998-99 financial data collected for this Report with earlier data.

Table 2.2 provides an overview of the Review's progress in reporting on an accrual basis, meeting the principle of reporting full cost to government and adjusting for differences in superannuation and payroll tax.

Table 2.2 Progress of unit cost comparability in the 2002 Report

Framework/service	What is the accounting regime? ^a	Full cost to government			
		Is depreciation included?	Is the user cost of capital included?	Is super-annuation included on an accrual basis?	Is payroll tax treated in a consistent manner?
<i>Education</i>					
School education	Accrual	✓	✓	✓	✓
VET	Accrual	✓	✓	✓	✓
<i>Health</i>					
Public hospitals	Accrual	✓	✓	✓	✓
Maternity	Accrual	✓	x	✓	✓
General practice ^b	Accrual	..	..	..	..
Breast cancer	Accrual	✓	x	✓	✓
Mental health	Accrual	x	x	x	x
<i>Justice</i>					
Police services	Accrual	✓	✓	✓	✓
Court administration	Accrual	✓	✓	✓	✓
Corrective services	Accrual	✓	?	✓	✓
<i>Emergency management</i>					
Fire services	Accrual	✓	✓	✓	x
Ambulance services	Accrual	✓	✓	✓	x
<i>Community services</i>					
Aged care ^c	Accrual	..	..	..	..
Services to people with a disability	Accrual	✓	x	✓	✓
Children's services	Accrual	✓	x	✓	✓
Child protection and out-of-home care ^c	Accrual	✓	x	✓	✓
Supported accommodation and assistance ^c	Accrual	..	..	..	..
<i>Housing assistance</i>					
Public housing	Accrual	✓	✓	na	✓
Community housing	Transition	x	x	x	x
Aboriginal Rental Housing Program	Accrual	x	x	na	✓
Commonwealth Rent Assistance ^b	Accrual	..	..	..	..

^a **Accrual** = majority of jurisdictions reported in accrual terms for the data in the 2002 Report. **Transition** = majority of jurisdictions did not report on either a pure cash or accrual basis. ^b Costs comprise mostly Commonwealth transfer payments to private service providers or households. ^c Costs comprise mostly Commonwealth, State or Territory transfer payments to private service providers or households. ✓ Majority of jurisdictions have included this item or reported it separately, or have included it on an accrual basis. x Majority of jurisdictions have not included or reported this item, or not included it on an accrual basis. na Not available. .. Not applicable.

Source: 2002 Report.

Superannuation

The treatment of superannuation is a significant issue when measuring the unit cost of many services because it often makes up a major component of overall costs and can be treated differently across services and jurisdictions. The Review researched the current treatment of superannuation costs and developed approaches to improve its treatment (SCRCSSP 1998c). This helps service providers to improve the consistency of treatment of superannuation in cost estimates. The extent to which individual agencies consistently report actuarial estimates of superannuation costs depends on jurisdictions' implementation of accrual accounting systems.

Payroll tax

Payroll tax makes up a small but significant part of the reported cost of many government funded and delivered services. It is particularly significant for services with a high proportion of labour costs, and can be around 5 per cent of total service costs. Consequently, differences in the treatment of payroll tax can affect the comparability of unit costs across jurisdictions and services. Differences occur in payroll tax exemptions, marginal tax rates, tax-free thresholds and clawback arrangements. Accounting for the effect of payroll tax on unit costs can be important for improving the comparability of the unit costs of private and public service providers.

A Steering Committee paper (SCRCSSP 1999b) recommended two approaches for improving the comparability of cost data. The first is to include a hypothetical payroll tax amount in cost estimates for exempt services. The hypothetical amount is to be based on the payroll tax liability had the service not been exempt from payroll tax. This approach would be used when the majority of services are taxable, and is most appropriate where private sector providers are also subject to payroll tax. This has the benefit of improving comparability of data with private sector providers, and is the recommended strategy for reporting on vocational education and training, emergency management, and public and community housing services. It is also the strategy adopted for police services and court administration, to ensure comparability with the corrective services sector.

The second approach involves deducting the payroll tax amount from the costs of those government services that are taxable. This approach would be used where the majority of services are tax exempt, and is most appropriate where private sector providers are either exempt from payroll tax or fall below the payroll tax-free threshold, or where there are no private providers. This is the recommended strategy for reporting on schools, health services, police, courts administration, aged care services, disability services, children's services, and protection and support services.

(It is noted in individual chapters whether these two approaches were implemented for this Report.)

Capital costs

Capital costs in an accrual sense comprise two distinct cost elements — depreciation and the user cost of capital. The focus is on the capital used in a particular year rather than the cash expenditure incurred in its purchase (for example, the purchase costs of a new building). Depreciation is defined as the annual consumption of non-current physical assets used in providing government services. The user cost of capital is the opportunity cost of funds tied up in the capital used to deliver services (for example, rental properties in public housing).

It is important to fully incorporate capital costs in cost comparisons wherever possible. Capital can be a significant component of service costs and is costed in full for contracted elements of service delivery. Unit costs estimated on the basis of cash based recurrent expenditures underestimate the underlying costs to governments. Including capital expenditures alone does not guarantee accurate or complete estimates of unit costs.

To improve the comparability of unit costs, the Steering Committee decided that both depreciation and the user cost of capital should be included in unit cost estimates (although the user cost of capital for land is to be reported separately). The user cost of capital rate should be applied to all non-current physical assets, less any capital charges and interest on borrowings already reported by the agency (to avoid double counting). The user cost of capital rate is based on a weighted average of rates nominated by jurisdictions (currently 8 per cent).

Other costing issues

Other costing issues include the apportionment of costs that are shared across services (mainly overhead department costs) and the treatment of non-government sourced revenue. Full apportionment of departmental overheads is not necessarily consistent with the concept of marginal cost, but is consistent with the concept of full cost recovery. The practice of apportioning overhead costs varies across the services in the Report. Some services deduct their non-government sourced revenue from their estimates of unit costs where the revenues are relatively small (for example, police services). This provides an estimate of net cost to government. However, where revenue from non-government sources is significant (as with public hospitals, and fire and ambulance services), the net cost to government does not provide an adequate measure of cost efficiency. In these instances, it is

appropriate to report both the gross cost (cost efficiency) and net costs to government.

Costs associated with non-current physical assets (such as depreciation and the user cost of capital) are potentially important components of the total costs of many services delivered by government agencies. Differences in the techniques for measuring non-current physical assets (such as valuation methods) may reduce the comparability of cost estimates across jurisdictions. In response to concerns regarding data comparability, the Steering Committee initiated a study: *Asset Measurement in the Costing of Government Services* (SCRCSSP 2001b). The aim of the study was to examine the extent to which differences in asset measurement techniques applied by participating agencies affect the comparability of reported unit costs.

The study considered the likely materiality of differences in asset measurement techniques in the areas of corrective services, housing, police services and public hospitals. These service areas were selected for their differing degrees of capital intensity. The importance of capital costs as a proportion of total costs for the particular service areas suggest that housing can be considered highly capital intensive, while police tends to be highly labour intensive. Public hospitals and corrective services fall between these in terms of capital intensity.

While the study collected data for a range of assets, property assets were the major focus of the study because they account for the greater part of the total value of non-current assets in each area studied. Ostensibly, comparable property assets were selected for analysis (the largest correctional facilities, average value dwellings, police complexes in larger urban areas, and principal referral hospitals).

The study found differences in asset measurement techniques can have a major impact on reported capital costs, with their influence on total unit cost dependent on the importance of capital costs as a proportion of total costs for the particular service area being studied. Results of the study suggest that the differences created by these asset measurement effects were generally relatively small in the context of total unit costs as, except for housing, capital costs represent a relatively small proportion of total cost. In housing, where the potential for asset measurement techniques to influence total unit costs is greater, the adoption under the Commonwealth State Housing Agreement of a uniform accounting framework has largely prevented this occurring. The adoption of national uniform accounting standards across all service areas would be a desirable outcome from the perspective of the Review.

The results of the study suggested that for those service areas covered, the potential impact of asset measurement factors on reported total unit costs averaged around

5 per cent of total unit costs. Therefore, if using reported total unit costs for comparison purposes, the potential for asset measurement factors to have an impact of this magnitude should be taken into account. These differences may affect cost rankings between jurisdictions. As a result of the difficulties in fully isolating accounting factors from other factors affecting asset valuations (such as size, location and age of assets), the analysis, if anything, overstated the impact on unit costs of differences in asset valuation methods.

People with special needs

For some chapters, the Report contains data on the performance of agencies in catering to special needs groups. The chapters on breast cancer management, aged care services, services to people with a disability and children's services examine the performance of government services in addressing the needs of particular groups in society. Data is presented on the performance of services for two groups — Indigenous Australians and people living in communities outside the capital cities (that is, people living in other metropolitan areas, rural and remote communities) for all services areas, where available.

Indigenous Australians

In May 1997, the Prime Minister asked the Review to give particular attention to the performance of mainstream services in meeting the needs of Indigenous Australians. This was reinforced by the Council of Australian Governments (COAG) at its 3 November 2000 meeting where heads of government agreed that ministerial councils will develop action plans, performance reporting strategies and benchmarks to review progress in this area.

The Review will be assisted by work being undertaken by the Ministerial Council of Aboriginal and Torres Strait Islander Affairs (MCATSIA), which, as part of its action plan, sets out the foundations for pursuing sustainable improvements in the lives of Indigenous people into the future. The Plan includes agreed benchmarks and performance reporting strategies to assist in assessing progress towards meeting the objectives of the COAG Reconciliation Commitment. One of the principles underpinning MCATSIA's work is accountability — that is, recognising the importance of a national, whole-of-government framework for measuring and publicly reporting performance. The Council has also agreed on a strategy of monitoring the overall performance of governments and ministerial councils in achieving outcomes under the COAG Reconciliation Commitment.

To measure performance in advancing the COAG Reconciliation Commitment, MCATSIA will use whole-of-government lead indicators, Aboriginal and Torres Strait Islander portfolio-specific indicators, and indicators of the extent to which actions under MCATSIA's action plan have been completed. Of relevance to the Review are a number of whole-of-government lead indicators of social and economic disadvantage with a focus on those issues requiring successful interventions spanning more than one ministerial council. These include indicators of:

- family violence (care and protection orders per 1000 population, and hospital separations for homicide and interpersonal violence);
- law and justice (recidivism by adult, juvenile and gender; imprisonment rates; and deaths in custody);
- health, housing and community wellbeing (life expectancy at birth; overcrowding; and substance abuse); and
- education (attendance; literacy and numeracy attainment; and year 10 and 12 retention).

The Review collects data on services to Indigenous clients, although the extent and quality of reporting varies significantly across both services and jurisdictions. Table 2.3 provides a stocktake, indicating which services have reported at least one comparable performance indicator or descriptive data for all jurisdictions. It does not signify the quality of that data.

The important task of collecting data is complicated by the administrative nature of many data collections that do not distinguish between Indigenous and non-Indigenous clients. The method and level of identification of Indigenous people appear to vary across jurisdictions; overall, it seems clear that not all Indigenous people seeking access to government services are recorded.

The ABS has an important role in this area. Some of the work being undertaken by the ABS includes:

- an ongoing program to develop and improve Indigenous data flowing from Commonwealth, State and Territory administrative systems;
- work with other agencies to ensure that Indigenous people are identified in relevant systems and that statistics are of adequate quality. Priority is initially being given to the improvement of births and deaths statistics in all States and Territories. Other priorities include hospitals, community services, education, housing, and law and justice statistics; and

- work with other agencies to develop and support national Indigenous information plans, Indigenous performance indicators and Indigenous taskforces on a number of topics.

Table 2.3 Reporting of at least one comparable data item on Indigenous Australians for the 2002 Report

<i>Framework/service</i>	<i>Descriptive data</i>	<i>Overall outcomes</i>	<i>Access and equity</i>	<i>Appropriateness</i>	<i>Quality</i>	<i>Client views</i>	<i>Efficiency</i>
<i>Education</i>							
School education	✓	x	✓	x	x	x	x
VET	✓	x	✓	x	x	x	x
<i>Health</i>							
Public hospitals	✓	x	x	x	x	x	x
Maternity services							
General practice	x	x	x	x	x	x	x
Breast cancer	x	x	x	x	x	x	x
Mental health	x	✓	x	x	x	x	x
<i>Justice</i>							
Police services	x	✓	✓	x	x	x	x
Court administration	x	x	x	x	x	x	x
Corrective services	✓	✓	x	x	x	x	x
<i>Emergency management</i>							
Fire services	x	x	x	x	x	x	x
Ambulance services	✓	x	x	x	x	x	x
<i>Community services</i>							
Juvenile justice	✓	x	x	x	x	x	x
Aged care services	x	x	✓	x	x	x	x
Services for people with a disability	x	x	✓	x	x	x	x
Children's services	✓	x	x	x	x	x	x
Child protection and out-of-home care	x	✓	✓	x	x	x	x
Supported accommodation	x	x	x	x	x	x	x
<i>Housing assistance</i>							
Public housing	x	x	x	x	x	x	x
Community housing	x	x	x	x	x	x	x
Aboriginal Rental Housing Program	✓	✓	✓	✓	x	x	✓
Commonwealth Rent Assistance	✓	x	✓	x	x	x	x

✓ At least one nationally comparable data item is available. x No nationally comparable data are available (although jurisdictions may report data specific to their jurisdiction).

Source: 2002 Report.

The ABS is also working towards improving the quality of Indigenous data from the 2001 Census of Population and Housing. At the same time, it is expanding its Household Survey Program to collect more regular Indigenous statistics, including regular Indigenous general social surveys, Indigenous sample supplementation in

regular health surveys and annual Indigenous labour force estimates. The Review will draw on these initiatives in future reports.

People living in rural and remote areas

The Steering Committee has agreed to selectively report data on the performance of governments in delivering services to people in communities outside the capital cities. The Review undertook a stocktake of its data and examined existing classifications of ‘remoteness’ used in the Report. A number of service sectors report data on services delivered to rural and remote communities.

Table 2.4 Reporting of at least one comparable data item on rural and remote communities for the 2002 Report

<i>Framework/service</i>	<i>Descriptive data</i>	<i>Overall outcomes</i>	<i>Access and equity</i>	<i>Appropriateness</i>	<i>Quality</i>	<i>Client views</i>	<i>Efficiency</i>
<i>Education</i>							
School education	x	x	x	X	x	x	✓
VET	x	✓	✓	x	x	x	x
<i>Health</i>							
Public hospitals	✓	x	x	x	x	x	x
General practice	x	x	✓	x	✓	x	x
Breast cancer	x	x	✓	x	x	x	x
Mental health	x	✓	x	x	x	x	x
<i>Justice</i>							
Police services	x	x	x	x	x	x	x
Court administration	x	x	✓	x	x	x	x
Corrective services	x	x	x	x	x	x	x
<i>Emergency management</i>							
Fire services	x	x	x	x	x	x	x
Ambulance services	x	x	x	x	x	x	x
<i>Community services</i>							
Aged care services	✓	x	✓	x	x	x	x
Services for people with a disability	x	x	✓	x	x	x	x
Children’s services	x	x	x	x	x	x	x
Child protection and out-of-home care	x	x	x	x	x	x	x
Supported accommodation	x	x	x	x	x	x	x
<i>Housing assistance</i>							
Public housing	✓	x	x	x	x	x	x
Community housing	✓	x	x	x	x	x	x
Aboriginal Rental Housing Program	✓	x	x	x	x	x	x
Commonwealth Rent Assistance	✓	x	x	x	x	x	x

✓ At least one nationally comparable data item is available. x No nationally comparable data are available (although jurisdictions may report data specific to their jurisdiction).

Source: 2002 Report.

The Rural Remote Metropolitan Areas classification (or a variant) is used in the majority of services in the Report, although some services are considering reporting future data using the Accessibility/Remoteness Index of Australia. The ABS is revising its Australian Geographic Classification System for the 2001 Census of Population and Housing. The new classification system is expected to include measures of remoteness that are partly based on the Accessibility/Remoteness Index of Australia. The Review expects to draw on this initiative in future reports.

Table 2.4 provides a stocktake, indicating which services and jurisdictions have collected at least one comparable data item for this Report. The table also shows whether the data are descriptive information or a performance indicator.

Cross-cutting issues

The management of issues that cover more than one service area ('cross-cutting issues') is an area of increasing interest for governments. These are issues that can not solely be addressed within any particular service area or ministerial portfolio. They include policies aimed at specific client constituencies or social groups (such as the elderly, women, children, Indigenous Australians, people in rural and remote areas and people from backgrounds other than English) whose needs are seen to merit comprehensive, integrated services and programs.

Improving the management of these issues can contribute to more cost effective (that is, more efficient, higher quality, and client focused) service provision. Greater efficiency is expected to come from more clearly defined priorities, and the elimination of duplicated or contradictory programs. Improved quality and user friendliness is expected to come from a greater and more holistic client focus.

While data limitations to date have meant that the Review is yet to develop a performance indicator framework that cuts across more than one service area, work is progressing that may lead to improved data in this area. The National Community Services Data Committee is undertaking work to match relevant data elements in existing national data sets to common classifications and to promote consistency of definitions. It is anticipated that this will lead to better identification of the extent to which target groups use services and may provide greater nationally comparable data in the future. The Australian Institute of Health and Welfare is also developing a performance indicator framework for juvenile justice, which draws on aspects of education, justice, community services and numerous other factors. The 2002 Report includes descriptive information on juvenile justice for the first time in the Community services preface.

Impact of the GST

There were major changes to the Australian tax system from 1 July 2000 with the introduction of The New Tax System. A major component of The New Tax System is the GST. The GST replaced wholesale sales tax, the temporary arrangements for the taxation of liquor, petrol and tobacco under the safety net arrangements, and a number of State and Territory taxes. Several measures contained in The New Tax System impact on government service provision, including the GST that commenced on 1 July 2000.

Under the GST, government agencies are treated in the same manner as other businesses. That is, government agencies are not exempt from paying the GST on their purchases, and they are able to claim input tax credits for the GST paid on inputs. Data reported in this Report are net of GST paid and input tax credits received, unless otherwise specified.

It appears that the GST has had little quantifiable impact on the performance indicators in this Report. The most significant impact of the GST on the Report is on the deflator used throughout the Report to derive real expenditure and cost data.

The deflator used is the ABS gross domestic product (GDP) implicit price deflator. The level of indirect taxes is a component of GDP at current prices, and because the GST collects more revenue than the taxes it has replaced, the current price estimate of GDP increased after the introduction of the GST on 1 July 2000.

Household consumption expenditure is another component of GDP at current prices that increased with the introduction of the GST. The approach of recording the GST as payable by purchasers, rather than by sellers, means that the GST is recorded as being paid on final uses — mainly household consumption. While other components of GDP at current prices may be affected by the GST, the two components identified appear to have had the largest impact. The increase in the current price estimate of GDP can be seen in the change in the GDP price deflator between 1999-2000 and 2000-01 (4.7 per cent) compared to changes between 2.2 per cent and 0.3 per cent since 1991-92. For a more detail description of the impact of the GST on GDP refer to the *Australian National Accounts: Concepts, Sources and Methods. Appendix 5 — Australian National Accounts and the GST* (ABS 2000).

2.3 Related Review projects

The Steering Committee has undertaken research into other issues relevant to the performance of government services. As noted, this year the Steering Committee

published a paper that examined the extent to which differences in asset measurement techniques applied by participating agencies affect the comparability of reported unit costs (SCRCSSP 2001b).

In previous years, the Steering Committee published reports on:

- a survey of satisfaction of clients of disability services jointly with the National Disability Administrators (Equal and Donovan Research 2000);
- the use of activity surveys by police services in Australia and New Zealand (SCRCSSP 1999a) as a means of drawing lessons for other areas of government considering activity measurement in output costing and internal management;
- an examination of payroll tax (SCRCSSP 1999b) and superannuation (SCRCSSP 1998c) in the costing of government services; and
- a report on a technique for measuring the efficiency of government services delivery (SCRCSSP 1997c).

Earlier research has involved case studies of issues and options in the implementation of government service reforms. The Steering Committee has published a case study report (SCRCSSP 1997a) that covers:

- purchasing community services in SA;
- using output based funding of public acute hospital care in Victoria; and
- implementing competitive tendering and contracting for Queensland prisons.

Another case study report (SCRCSSP 1998a) covers:

- devolving decision making in Victorian Government schools;
- using competitive tendering for NSW public hospital services;
- offering consumer funding and choice in WA disability services; and
- pricing court reporting services in Commonwealth courts.

The Steering Committee has also developed checklists for some common issues in implementing these reforms, such as:

- timing program implementation;
- decentralising decision making;
- measuring and assessing performance;
- measuring quality;
- directly linking funding to performance; and
- charging users (SCRCSSP 1998a).

The Steering Committee will continue to focus on research that is related to performance measurement to enhance efforts to improve reporting for individual services.

B Education preface

Education is a lifelong activity, delivered both informally (for example, by family, by the community or at work) and formally by the education system (for example, by schools, technical and further education [TAFE] institutes, registered training providers and universities). The education sector has a range of objectives — some of which are common across all levels of education (for example, to increase knowledge) and others which are more specific to a particular level of education (for example, with vocational education and training [VET], to provide skills and knowledge directly related to work related competencies).

Both government and non-government providers deliver formal education services. Government education agencies include government primary and secondary schools, and TAFE institutes. Governments also fund services delivered by universities and non-government providers in the preschool, school and VET sectors.

The education section of this Report covers the performance of the school and VET sectors. Preschool programs, which provide a variety of educational and developmental experiences for children before full time schooling, are covered in the children's services chapter (chapter 14).

Areas of government involvement in education that are not covered in the following chapters include:

- universities (although some information is included in this preface);
- the transportation of students;
- income support payments for students; and
- adult and community education (except VET programs).

Factors external to the education sector — including other government services (such as health and community services) — influence education outcomes. These factors are not formally part of Australia's education system and are not covered in the following chapters, but are discussed in other sections of the Report. Indigenous status, socioeconomic status and geographic location are also potential influences on education outcomes. It is a priority of the Review to improve the reporting of

data for these factors in relation to the education outputs reported in the following chapters.

The remainder of this preface provides a systemwide picture of Australia's education system and its broad outcomes.

Profile of education

Roles and responsibilities

The roles and responsibilities of administering, funding and determining the objectives of the education sector encompass different levels of government and non-government authorities and stakeholders. The Ministerial Council on Education, Employment, Training and Youth Affairs (MCEETYA) coordinates strategic policy at the national level, develops national agreements on shared objectives and interests, and negotiates the scope and format of national reporting for the school sectors. Membership of MCEETYA includes Commonwealth, State and Territory ministers with responsibility for education, employment, training and youth affairs.

The Australian National Training Authority (ANTA) Ministerial Council is comprised of Australia's Commonwealth, State and Territory ministers with responsibility for vocational education and training. The ANTA Ministerial Council decides strategic policy, national objectives and priorities for the training system.

The Commonwealth Government's roles and responsibilities in providing education services include:

- providing funding to State and Territory governments and non-government schools to support agreed priorities and strategies;
- providing funding through the ANTA to States and Territories for the delivery of VET programs;
- being the primary funding source for, and provider of, related policy to the higher education sector; and
- providing financial assistance for students.

State and Territory governments' roles and responsibilities in providing education services include:

-
- having constitutional responsibility for the provision of schooling to all children of school age;
 - administering and delivering VET and school education in government schools;
 - administering and funding TAFE institutes;
 - having regulatory responsibilities for both private and publicly provided VET programs, including the registration of training organisations and the accreditation of nationally recognised training;
 - being responsible for legislation relating to the establishment of universities and the accreditation of higher education courses by registered training organisations;
 - regulating non-government school activities and policies;
 - determining school curricula; regulating school activities and policies, course accreditation, student assessment and awards; having the major financial responsibility for government school education; and contributing funds to non-government schools;
 - funding VET programs; and
 - delivering schooling through non-government schools.

More detailed descriptions of the roles and responsibilities in the school and VET sectors can be found in the respective chapters 3 and 4.

Funding

Education is a major area of expenditure and activity. Total operating expenses for all governments in 1999-2000 were approximately \$34.0 billion, which was equivalent to 5.4 per cent of gross domestic product. Private final consumption expenditure on education in 1999-2000 was approximately \$8.8 billion, or 1.4 per cent of gross domestic product (GDP) (ABS 2001b).

Commonwealth Government operating expenses on education in 1999-2000 were \$10.3 billion, with \$7.8 billion (75.7 per cent) comprising grants to other levels of government. The next largest component of Commonwealth expenditure, current transfers to households amounted to \$1.8 billion (17.5 per cent). This expenditure included payment of income support payments for students. State and Territory (including local government) operating expenditure was \$23.2 billion for the same year. Multi-jurisdictional (university) operating expenses were \$8.7 billion. The inter-sector transfers, such as grants, were \$8.1 billion (table B.1).

Between 1998-99 and 1999-2000, the annual real growth rate of total government expenditure on education was 3.6 per cent. With the introduction of accrual accounting, the education expenditure series between 1998-99 and earlier years is not comparable.

Table B.1 Commonwealth, State and Territory (including local) government expenditure on primary, secondary and tertiary education (1999-2000\$ million)^a

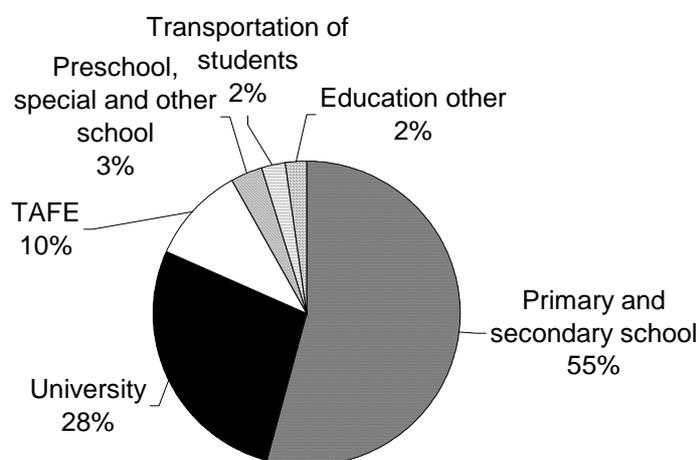
	1998-99 ^c	1999-2000	Annual real growth (%)
Commonwealth operating expenses	9 895	10 299	4.1
Transfers to other levels of government ^b	(7 364)	(7 787)	5.7
Commonwealth expenses after transfers	2 532	2 512	- 0.8
State and Territory (including local) operating expenses	22 268	23 225	4.3
Transfers to other levels of government ^b	(123)	(107)	- 13.0
State and territory (including local) expenses after transfers	22 145	23 118	4.4
Multi-jurisdictional (university) operating expenses	8 433	8 659	2.7
Transfers to other levels of government ^b	(249)	(254)	2.0
Multi-jurisdictional (university) expenses after transfers	8 184	8 405	2.7
Total operating expenses	32 861	34 035	3.6

^a Based on accrual operating expenses for education. ^b Payments between levels of government within the public sector. ^c Calculated using the GDP price deflator.

Source: ABS (2000a, 2001b).

In 1999-2000, schools accounted for the highest proportion of education expenditure (55 per cent), followed by universities (28 per cent) and TAFE (10 per cent) (figure B.1).

Figure B.1 Total government expenditure on education, 1999-2000^{a, b}



^a Based on accrual operating expenses for education. ^b 'Education other' includes 'tertiary other'.

Source: ABS (2001b).

The breakdown of State and Territory government expenditure across the education sector varied across jurisdictions in 1999-2000. The proportion of State and Territory expenditure allocated to total school education (including primary, secondary, preschool and special education) ranged from 86.6 per cent in Queensland to 74.5 per cent in the NT. The ACT had the highest proportion of expenditure on technical and further education (15.3 per cent) and the NT had the lowest (6.9 per cent). There was little difference between jurisdictions in the proportion of expenditure on university education, except in the NT, which had the highest proportion (7.4 per cent) (table B.2).

Table B.2 State and Territory (including local) government expenditure, 1999-2000

	Unit	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total
Total school ^a	%	78.9	76.2	86.6	84.0	84.7	84.2	79.7	74.5	80.7
Technical and further	%	15.2	14.3	10.3	13.3	14.1	12.3	15.3	6.9	13.6
University	%	0.1	0.5	0.2	–	–	0.3	1.5	7.4	0.4
Other Tertiary	%	–	0.6	–	0.6	–	–	–	3.6	0.3
Other ^b	%	5.8	8.4	2.8	2.1	1.3	3.3	3.3	7.4	5.1
Total	%	100	100	100	100	100	100	100	100	100
Total	\$m	7 458	5 657	4 125	2 494	1 936	676	459	420	23 225

^a Includes preschool, special and other school, and primary and secondary school. ^b Refers to transportation of students and education not elsewhere classified.

Source: ABS (2001b).

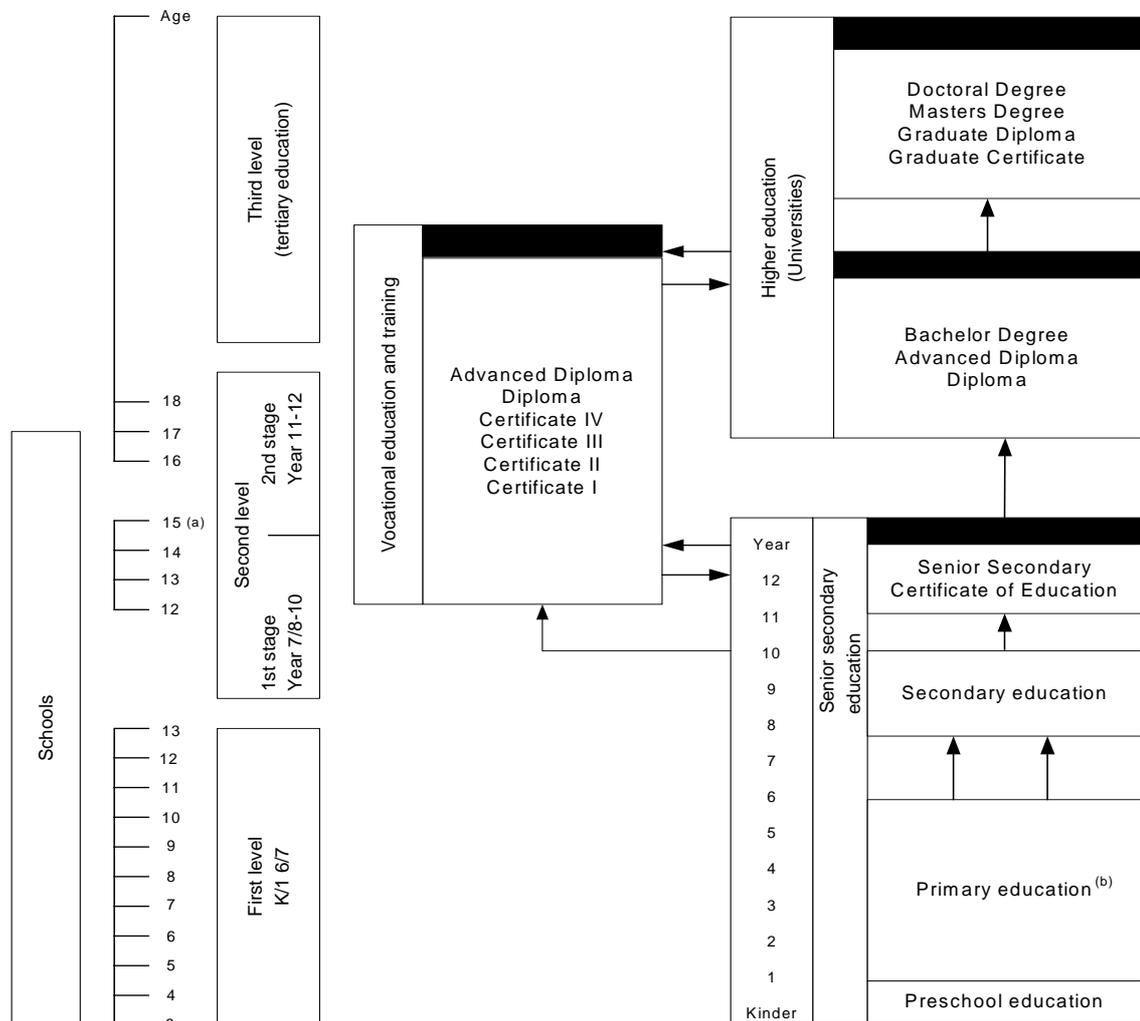
Size and scope

In 2000, approximately 5.6 million people participated in some form of formal education and training. Approximately 58.1 per cent of these people participated in school education, 29.5 per cent participated in VET and 12.4 per cent participated in university education (ABS 2001a).

In 2000, there were 9595 schools in Australia, including 6961 government schools (ABS 2001c). Vocational Education and Training programs were provided by 86 TAFE and other government institutions, 1139 community education providers and 3388 other registered training providers (NCVER 2001). There were 42 higher education institutions which received funds for operating purposes through the Commonwealth Department of Education, Training and Youth Affairs (DETYA). Most of these, plus two others, were eligible for funds for research purposes through DETYA. In addition, three other higher education institutions received funds for operating purposes through other portfolios.

Box B.1 illustrates the Australian education system, indicating the compulsory years of schooling and the range of pathways and options available to students. In addition to the arrangements outlined in box B.1, TAFE institutes and registered training providers deliver graduate certificates, graduate diplomas and undergraduate degrees.

Box B.1 Outline of the Australian education system



^a End of compulsory schooling. ^b Year 7 is part of primary school in some States and Territories and part of secondary education in others.

Source: NOOSR (2000).

Australian Qualifications Framework

The Australian Qualifications Framework was developed to provide a comprehensive, nationally consistent framework for all qualifications in post-compulsory education and training. It was introduced in 1995 and was fully implemented by the end of 1999 (box B.2).

The framework encourages flexible learning pathways; for example, modules from VET certificates are able to be integrated with the senior secondary certificate, and

both VET and higher education diplomas, and advanced diplomas gain credit towards a bachelors degree. Equally the VET sector recognises some higher education qualifications.

Box B.2 Australian Qualifications Framework

This outline shows nominally the qualifications delivered in each sector, although qualifications may be delivered across sectors.

<i>School sector</i>	<i>Vocational education and training sector</i>	<i>Higher education sector</i>
		Doctorate
		Masters degree
		Graduate diploma
		Graduate certificate
		Bachelor degree
	Advanced diploma	Advanced diploma
	Diploma	Diploma
Senior Secondary Certificate of Education	Certificate IV	
	Certificate III	
	Certificate II	
	Certificate I	

^a The Australian Qualifications Framework Advisory Board members are discussing the relationship between the senior secondary certificate and VET qualifications.

Source: Australian Qualifications Framework Advisory Board (1998).

Expanded options for students

One of the major objectives of schooling is to provide students with general education, employment related skills, career options, and skills for further education and training. Since 1996, the ANTA Ministerial Council has allocated \$20.0 million of ANTA funds each year (for four years from 1997 to 2000) and a further \$20.0 million in 2001 to support VET in schools. This funding, together with Commonwealth, State and Territory funding, supports the delivery of VET programs as part of the senior secondary curriculum, including school based, part time New Apprenticeships. This program involves Commonwealth, State and Territory education and training departments and agencies, and the non-government schooling sectors working in partnership with industry.

Under the Australian Qualification Framework, VET certificates (mainly certificates I and II) may be achieved in schools and may contribute towards the

Senior Secondary Certificate of Education, resulting in a dual qualification. Approximately 153 616 students were enrolled in VET in schools programs in 2000, with over 90 per cent of schools that offered a senior secondary curriculum also offering VET. Enrolments were highest in tourism and hospitality programs (21.0 per cent). In 2000, approximately 53 per cent of students participating in VET in schools programs undertook workplace learning (MCEETYA 2001). By the end of 2000, nearly 6000 students were involved in a schools based New Apprenticeship.

Australia's post-school sectors (VET and higher education) have expanded in recent years. Both sectors offer courses at the diploma and advanced diploma level, and an evolving system of credit transfer arrangements between VET providers and universities has facilitated pathways for students from one sector to the other (box B.2).

The number of students in post-school vocational programs increased by 6.2 per cent between 1999 and 2000 to reach 1.75 million. The participation rate in VET was 28 per cent for people aged 15–19 years and 19 per cent for people aged 20–24 years (NCVER 2001).

Measuring the performance of the education system

Measuring the effectiveness and efficiency of the Australian education sector is a complex task. Individual performance indicator frameworks for the schools and VET sectors have been developed for the purposes of the Review, although there is significant interaction between the two sectors. Socioeconomic factors, geographic location, age, racial characteristics and the performance of other service sectors (particularly, the health and housing sectors) also contribute to an individual's overall education outcomes.

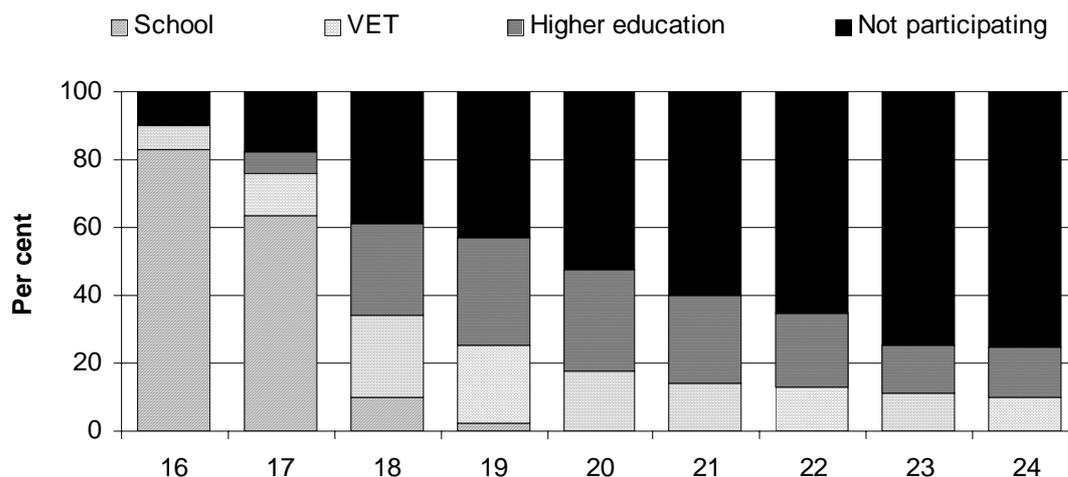
Effectiveness

Participation in education and training

Successive Australian governments have viewed education as a key means to improve economic and social outcomes and equity across all sections of society. They have sought, therefore, to increase rates of participation in education. In 2000, approximately 5.6 million people participated in some form of education and training. Participation in school education accounted for 3.3 million people, or 58.1 per cent of the total participants in formal education in that year.

Beyond the age of compulsory school education (16 years in Tasmania and 15 years in all other jurisdictions), the percentage of people participating in education and training declines. In 2000, participation was 61.4 per cent for 18 year olds and 24.6 per cent for 24 year olds (figure B.2).

Figure B.2 **Participation in education and training by people aged 16–24 years, by sector, 2000^{a, b, c, d}**



^a Participation in school for persons aged 20–24 years has a relative standard error greater than 50 per cent and is considered too unreliable for general use. ^b As defined under the Australian Bureau Statistics (ABS) Classification of Qualification. ^c Includes persons who never attended school. ^d Includes persons whose study was not intended to result in a recognised educational qualification.

Source: ABS (unpublished).

Progress towards Finn targets

In 1991, ministers responsible for VET set ‘Finn targets’ for the participation of young people in post-compulsory education and training (box B.3). The targets relate to national participation and qualification attainment for 19 and 22 year olds in schools, VET and higher education, and provide overall measures for the education sector (figure B.3).

The Australian National Training Authority has noted that progress for 19 and 22 year olds, while improving, is not yet in line with Finn targets. It projects, if the current participation and attainment trends continue for 19 and 22 year olds, that the achievement of the Finn target for these age groups by 2001 will not be reached (ANTA 2001).

Box B.3 Finn targets

By 2001, 95 per cent of 19 year olds will:

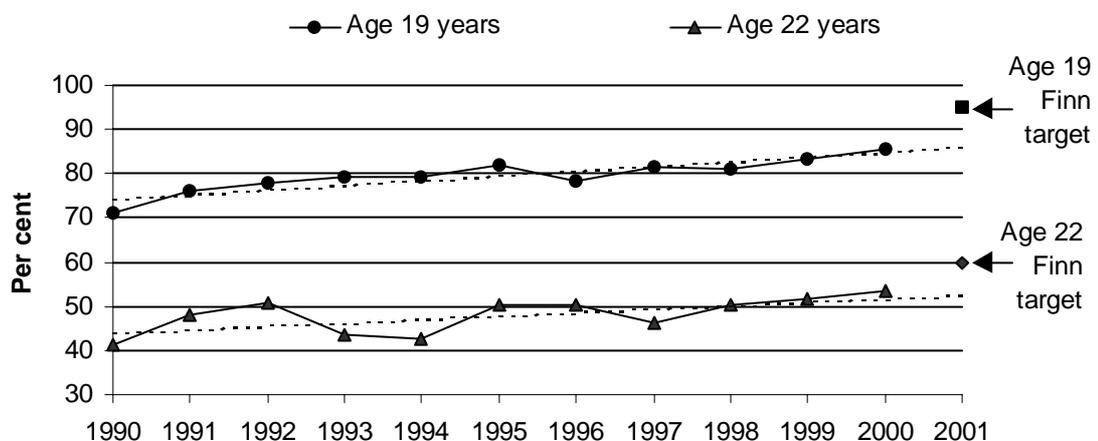
- be participating in, or have completed, year 12; or
- have completed years 10 or 11 and be participating in, or have completed, some formally recognised education and training.

By 2001, 60 per cent of 22 year olds will:

- be participating in education or training programs that lead to level 3 awards; or
- have attained level 3 or above qualifications; or
- be participating in, or have completed, higher education studies such as diplomas and degrees.

Source: ANTA (2001).

Figure B.3 Participation and qualifications attainment by 19 and 22 year olds in post-compulsory education^{a, b, c}



^a Targets for the participation of young people in post-compulsory education and training are also known as Finn targets. ^b The dotted lines show the trend. ^c The approach adopted to monitor Finn targets was revised in 1999. Some previous data used to measure attainment against the targets have been revised.

Source: ANTA (2001).

Enrolment in a post-school education and training institution

From 1996 through to 2000, the proportion of the population aged 15–64 years applying for enrolment in post-school education and training was fairly stable at 20.0 per cent, while 1.5 per cent deferred their studies. The number that applied to enrol but did not gain placements declined from 1999 to 2000 (table B.3).

Table B.3 Applications to enrol in a post-school education and training institution, by people aged 15–64 years ('000)^a

	1996	1997	1998	1999	2000
All persons studying in May that year	2 128.2	2 131.8	2 143.1	2 257.2	2 256.4
Gained placement but deferred study	199.3	182.5	176.2	188.0	185.4
Unable to gain placement	106.4	75.1	83.5	92.3	86.0
Total VET	67.3	44.0	47.7	59.2	53.4
TAFE institutes	48.3	35.3	35.2	45.8	40.5
Other VET ^b	19.0	8.7	12.5	13.4	12.9
Higher education	25.3	18.3	22.9	20.0	18.8
Study not for a recognised qualification	13.8	12.8	12.9	13.1	13.8
Applied to enrol for that year	2 433.9	2 389.3	2 402.8	2 537.5	2 527.8
Total population	12 042.1	12 187.0	12 340.9	12 482.6	12 652.7

^a Reasons for applicants not receiving a place in post-secondary education include: the course was full; the course was cancelled; they were not eligible/their entry score was too low; they applied too late; or other reasons. ^b Includes other educational institutions not separately listed.

Source: ABS (2000b).

School leaver destinations

Approximately 303 000 students left school in the year to May 2000 to work, to attend university or vocational training, or to undertake combinations of work and education. Of these students, 33.4 per cent were early school leavers. Higher education institutions attracted around 90 000 school leavers in 2000, or 29.6 per cent of all school leavers. Institutes of TAFE attracted 77 000 school leavers (25.3 per cent). Sixty nine per cent of year 12 leavers went on to post-school education and training, while 41.7 per cent of early school leavers went on to post school education and training (table B.4).

Table B.4 School leaver destination (15–25 year olds), May 2000^a

Type of institution attended in May 2000	Unit	Year 12 leavers			Early school leavers ^b			All school leavers		
		Male	Female	Total	Male	Female	Total	Male	Female	Total
Higher education	%	41.9	45.3	43.7	0.6	2.7	1.3	24.7	35.2	29.6
TAFE institutes	%	22.1	17.2	19.5	43.5	23.4	36.9	31.0	18.7	25.3
Other study ^c	%	3.6	8.0	5.9	2.0	6.7	3.5	2.9	7.7	5.1
Not attending	%	32.4	29.5	30.9	54.0	67.2	58.3	41.4	38.4	40.0
Total	'000	94.8	107.3	202.0	67.9	33.2	101.2	162.7	140.5	303.2

^a Comprises people who attended school in 1999 and were not attending school in May 2000. Includes those studying in May 2000 for non-recognised qualifications. ^b Those who left school earlier than year 12.

^c Includes business colleges, industry skills centres and other educational institutions.

Source: ABS (unpublished).

Skill profile of Australia

Another important objective of the education system is to improve the skill base of the economy. In turn, this may facilitate higher productivity growth by enhancing the country's overall ability to adapt to technological change. The education attainment of the labour force is used as an indicator for the skill profile of Australia.

There were 4.7 million people in the labour force aged 15–64 years with recognised post-school qualifications in 2000 (of whom 4.5 million were employed representing 51.1 per cent of employed people aged 15–64 years). In the labour force, 18.5 per cent of people had a higher degree, postgraduate diploma or bachelor degree as their highest qualification, 9.1 per cent had an undergraduate diploma or associate diploma, 13.4 per cent had a skilled vocational qualification and 8.8 per cent had a basic vocational qualification (ABS 2000b). Generally, a greater proportion of those with post-school qualifications at May 2000 were employed as managers, administrators and professionals (51.8 per cent), while a greater proportion of those without post-school qualifications were employed as clerical, sales and service workers (40.1 per cent) (table B.5).

Table B.5 Education attainment of employed persons aged 15–64 years, May 2000 ('000)^a

<i>Occupation in current job</i>	<i>Total with post-school qualifications</i>	<i>Total without post-school qualifications^b</i>	<i>Completion of highest level of secondary school</i>	<i>Non-completion of highest level of secondary school</i>	<i>Total^c</i>
Professional ^d	2 332.6	868.9	436.7	432.0	3 207.9
Trades people and related workers	772.2	411.8	133.0	278.2	1 187.6
Clerical, sales and service workers ^e	995.1	1 639.7	770.5	868.3	2 785.4
Intermediate production and transport workers	214.5	563.5	157.9	405.0	790.9
Labourers and related workers	191.4	605.9	167.1	437.4	852.6
Total	4 505.8	4 089.8	1 665.2	2 421.0	8 824.5

^a Educational attainment as defined under the ABS Classification of Qualifications. ^b Includes persons who never attended school. ^c Includes persons still at school. ^d Includes managers, administrators, professionals and associate professionals. ^e Includes advanced, intermediate and elementary clerical, sales and services workers.

Source: ABS (2000b).

International comparison of education levels

In 2000, the proportion of Australia's labour force (population aged 25–64 years) with a post-compulsory school qualification had increased by 4 percentage points (to 63 per cent) from the level reported in 1995 (59 per cent) (OECD 2001). Australia had a lower proportion of the labour force with a post-compulsory school qualification than that of many other industrialised countries in that year, such as France (67 per cent), Germany (85 per cent) and Denmark (83 per cent) (table B.6). The relative qualification level of a country's labour force does not directly reflect its relative skill base, because skills are acquired at different educational levels in different countries.

Table B.6 Highest completed level of education — international comparisons, 2000 (per cent of labour force aged 25–64 years)^a

	Post-compulsory school				
	Less than upper secondary	Upper secondary ^b	Non-university tertiary education ^c	University level education	Total post-compulsory school
Czech Republic	10	78	..	12	90
United States	10	51	9	30	90
United Kingdom	13	60	9	19	88
Norway	13	57	2	27	87
Germany	15	54	11	15	85
Canada	15	28	22	21	84
Switzerland	16	58	10	16	84
Denmark	16	54	22	7	83
Sweden	21	49	16	15	80
New Zealand	22	41	14	14	77
Finland	24	41	19	16	76
Netherlands	28	45	3	24	72
France	32	43	12	12	67
Australia	37	33	10	20	63
Italy	47	34	..	13	53
Portugal	77	12	3	8	23
Country mean^d	31	42	8	16	69

^a The differences in data definitions and variations in collection methods across countries needs to be noted when measuring the gap between Australia's skill base and that of other countries. ^b Includes vocational equivalents such as apprenticeships and traineeships. ^c Several definitional and data issues that may influence the ranking of countries include: the definition used for non-university tertiary (particularly for VET courses); the OECD education classification levels, which are based on UNESCO's International Standard Classification for Education (for example, primary education is defined as beginning at age 5, 6 or 7 years and lasting for four to six years); and variations in survey data (for example, Denmark's 24–64 year old group actually includes all ages). ^d The country mean includes the countries in the table plus the Republic of Korea, Austria, Belgium, Greece, Ireland, Luxembourg, Spain, Poland and Turkey. .. Not applicable or included within another column of this table.

Source: OECD (2001).

Efficiency

Comparing unit costs across jurisdictions

Comparing unit costs of a particular service for a specified outcome across jurisdictions can help to identify whether States or Territories have the scope to improve their performance. However, special characteristics within jurisdictions mean it would be hard for all jurisdictions to attain the same level of unit costs, while achieving similar outcomes. One way of better understanding how special circumstances may affect costs is to compare the variations in the unit costs across jurisdictions for services that have some similarities in outcomes, such as government school education and VET (table B.7). The greater variation in the unit costs of VET than in those of schools raises questions about the likely causes. Further analysis would be necessary to identify, for example, whether the effects of scale or dispersion are greater for VET than for schools, whether the mix of costly and inexpensive courses differs (although the ANTA has adjusted data on recurrent costs to allow for that difference), and whether the quality or efficiency of the services differs.

Table B.7 Education institution recurrent unit costs, 1999-2000^a

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>AUST</i>
Government primary schools										
In-school cost per FTE student	\$	5 783	5 576	6 057	5 455	6 077	6 583	5 974	9 813	5 866
Difference from national average	%	-1.4	-4.9	3.3	-7.0	3.6	12.2	1.8	67.3	-
Government secondary schools										
In-school cost per FTE student	\$	7 805	7 306	7 691	7 722	8 135	7 501	8 097	13 568	7 729
Difference from national average	%	1.0	-5.5	-0.5	-0.1	5.3	-2.9	4.8	75.6	-
VET ^b										
Cost per adjusted annual curriculum hour ^c	\$	13.82	9.51	15.15	12.84	12.20	14.99	13.64	20.67	12.68
Difference from national average	%	8.9	-25.0	19.4	1.2	-3.8	18.1	7.5	62.9	-

^a Based on accrual data. ^b Vocational education and training data are based on 2000 calendar year.

^c Includes payroll tax estimates for the ACT. FTE = full time equivalent

Sources: chapters 3 and 4.

Unit cost differences across education sectors should be used for further analysis rather than interpreted in isolation from other performance indicators such as

outcomes and outputs (chapters 3 and 4). Further, comparing the performance of education sectors requires a cross-sectoral approach to measuring and classifying educational participation and attainment, and such a system does not yet exist in Australia.

The Australian Bureau of Statistics (ABS) has been partly addressing this issue by reviewing its Classification of Qualifications and developing an Australian Standard Classification of Education that covers all education sectors and can be used in both administrative systems and surveys. This classification was expected to be finalised by early 2000 and introduced into the ABS statistical collections from 2001. In addition, the development of a conceptual framework for education and training statistics is planned following the establishment of a National Centre for Education and Training Statistics.

3 School education

This chapter focuses on the performance information — efficiency, effectiveness, access and equity — for government funded school education in Australia. Reporting relates to government funding only, not to the full cost to the community of providing school education. Descriptive information and performance indicators are generally available for:

- government primary and secondary schools;
- non-government primary and secondary schools; and
- school education as a whole (government and non-government primary and secondary schools).

Schooling aims to provide education for all young people. The main purposes of school education are to assist students in:

- developing their talents, capacities, self-confidence, self-esteem and respect for others;
- attaining knowledge, skills and understanding in key learning areas; and
- developing their capacity to contribute to Australia’s social, cultural and economic development.

This year, the Report has been enhanced to include:

- nationally comparable learning outcomes for year 5 reading benchmark results using 1999 data; and
- improved reporting on the performance of Indigenous students.

Following a discussion of the profile of school education in Australia in section 3.1, recent policy developments are discussed in section 3.2. These two sections provide the context for the assessment of performance indicators in the subsequent sections. Section 3.3 includes the framework of performance indicators for school education and section 3.4 presents and discusses the available data relating to this framework. Section 3.5 discusses future directions in the development and reporting of performance indicators for school education. The chapter concludes with jurisdictions’ comments in section 3.6 and definitions of terms in section 3.7.

Supporting tables

Supporting tables for chapter 3 are provided on the CD-ROM enclosed with the Report. The files are provided in Microsoft Excel 97 format as \Publications\Reports\2002\Attach3A.xls and in Adobe PDF format as \Publications\Reports\2002\Attach3A.pdf.

Supporting tables are identified in references throughout this chapter by an 'A' suffix (for example, table 3A.3 is table 3 in the electronic files). They may be subject to revision. The most up-to-date versions of these files can be found on the Review's web page (www.pc.gov.au/gsp/). Users without Internet access can contact the Secretariat to obtain up-to-date versions of these tables (see details inside the front cover of the Report).

3.1 Profile of school education

Service overview

Schools are the institutions within which organised school education takes place. They are differentiated by the type and level of education they provide, their ownership and management, and the characteristics of their student body.

The formal statistical definition of schools used for this chapter is:

... an establishment that satisfies all of the following criteria:

- its major activity is the provision of full time day primary, secondary or special school education or primary or secondary distance education;
- it is headed by a principal (or equivalent) responsible for its internal operation; and
- it is possible for students to enrol for a minimum of four continuous weeks (excluding breaks for school vacations) (ABS 2001a).

Student performance can be affected by factors that may be partly or totally outside the influence of the school, including student commitment, family income and commitment to education, the proximity of the school to other educational facilities, and the resources available to the school. It is beyond the scope of this Report to consider the effect of all factors, but this section provides some contextual background for the performance information presented later in the chapter. Further information is provided in appendix A.

Roles and responsibilities

The State and Territory governments have constitutional responsibility to ensure the delivery of schooling to all children of school age. They determine curricula, regulate school activities and provide most of the funding. State and Territory governments are directly responsible for the administration of government schools for which they provide the majority of government expenditure. Non-government schools operate under conditions determined by State and Territory government registration authorities and receive significant Commonwealth, State and Territory government funding.

The Commonwealth funds government and non-government schools through specific purpose payments. The Ministerial Council on Education, Employment, Training and Youth Affairs (MCEETYA) — comprising Commonwealth, State and Territory education ministers — is the principal forum for developing national priorities and strategies for schooling.

Funding

Commonwealth, State and Territory government expenditure on school education in 1999-2000 was \$20.7 billion (table 3.1). Expenditure on government schools was \$16.6 billion, or 80.2 per cent of the total. Government schools account for most of the expenditure by State and Territory governments, but these governments also contribute to the funding of non-government schools and provide services used by both government and non-government schools. This figure may not be totally comparable to that in the 2001 Report because it now includes Commonwealth funding on Indigenous-specific programs. More information, including on Commonwealth spending on Indigenous-specific programs, can be found in tables 3A.8 and 3A.9.

These expenditure figures are based on accrual accounting and are not comparable with expenditure figures included in previous reports (which were based on cash accounting).

Some data are presented on government funding of non-government schools. Caution needs to be taken in examining data on the efficiency of government and non-government schools because governments provide only part of the funding for non-government schools. Governments provided 57 per cent of the non-government school funding in 1999, with the remaining 43 per cent sourced from private fees and fundraising (MCEETYA 2001a).

Table 3.1 Government expenditure on school education, 1999-2000
(\$ million)^{a, b, c}

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
Government schools									
Commonwealth	604	410	329	183	142	51	29	40	1 846
States and Territories	4 671	3 558	3 040	1 360	1 160	427	270	321	14 747
Total	5 274	3 968	3 368	1 543	1 301	478	299	360	16 592
Non-government schools									
Commonwealth	958	765	529	279	216	59	60	35	2 900
States and Territories	434	245	233	137	72	26	25	22	1 195
Total	1 392	1 010	762	415	289	85	85	57	4 096
All schools									
Commonwealth	1 561	1 175	857	462	358	110	89	75	4 746
States and Territories	5 105	3 803	3 273	1 497	1 232	453	295	342	15 942
Total	6 667	4 978	4 130	1 959	1 590	563	384	417	20 688

^a See notes to table 3A.11 for definitions and data caveats. ^b Based on accrual accounting (whereas financial data in previous reports are based on cash accounting). ^c Includes Commonwealth specific purpose payments to schools provided under Indigenous education programs. These payments were excluded in previous reports.

Source: table 3A.11.

Size and scope

Descriptive information on the numbers of students, staff and schools can be found in tables 3A.1– 3A.5.

Structure

The structure of school education varies among States and Territories. These differences can influence the interpretation of data presented under common classifications. Formal schooling begins with six to seven years of primary school education followed by five to six years of secondary school education, depending on the State or Territory (figure 3.1). All States and Territories divide school education into compulsory and non-compulsory components based on age, not grade. School education is compulsory in all States and Territories for people between 6 and 15 years of age (and to 16 years of age in Tasmania).

Figure 3.1 Structure of primary and secondary schooling, 2000

<i>Level</i>	<i>NSW, Vic, Tas, ACT</i>	<i>SA, NT</i>	<i>WA, Qld</i>
Year 12	SECONDARY	SECONDARY	SECONDARY
Year 11			
Year 10			
Year 9			
Year 8			
Year 7			
Year 6	PRIMARY	PRIMARY	PRIMARY
Year 5			
Year 4			
Year 3			
Year 2			
Year 1			
Pre-year 1 ^a	Kindergarten (NSW, ACT) Preparatory (Vic, Tas)	Reception (SA) Transition (NT)	

^a Pre-year 1 is not included in the pattern of study in Queensland. Pre-year 1 is called 'pre-primary' in WA (where students attended on a four-day week basis in 2000). From 2002, pre-primary students in WA will be attending five days a week, at which time students and staff will be included within the scope of MCEETYA's National School Statistics Collection.

Source: MCEETYA (2001a).

Schools

At the beginning of August 2000, there were 9595 schools in Australia. The majority of schools were government owned and managed (72.5 per cent) (table 3.2).

Settlement patterns (population dispersion), the age distribution of the population, and educational policy influence the distribution of schools by size and level in different jurisdictions. For school education as a whole in August 2000, the NT had the highest proportions of very small primary and secondary schools (those having 20 or fewer students) at 15.1 per cent and 5.6 per cent respectively. Nationally, 62.1 per cent of all secondary schools enrolled over 600 students (table 3A.17). A breakdown of primary and secondary schools by size for government, non-government and all schools is reported in tables 3A.15, 3A.16 and 3A.17 respectively.

Table 3.2 Summary of school characteristics, August 2000

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
Government schools (no.)									
Primary	1 648	1236	985	517	452	142	67	91	5 138
Combined ^a	64	48	75	88	74	26	3	42	420
Secondary	393	266	188	95	75	39	22	12	1090
Special schools ^b	82	79	49	66	20	8	4	5	313
Total	2 187	1629	1297	766	621	215	96	150	6 961
Non-government schools (no.)									
Primary	535	449	235	155	119	33	26	15	1 567
Combined ^a	192	129	110	82	52	26	9	11	611
Secondary	141	103	74	38	25	7	6	6	400
Special schools ^b	33	14	2	2	3	1	1	0	56
Total	901	695	421	277	199	67	42	32	2 634
All schools (no.)									
Primary	2 183	1 685	1220	672	571	175	93	106	6 705
Combined ^a	256	177	185	170	126	52	12	53	1 031
Secondary	534	369	262	133	100	46	28	18	1 490
Special schools ^b	115	93	51	68	23	9	5	5	369
Total	3 088	2 324	1 718	1 043	820	282	138	182	9 595
Proportion of government schools (%)									
Primary	75.5	73.4	80.7	76.9	79.2	81.1	72.0	85.8	76.6
Combined ^a	25.0	27.1	40.5	51.8	58.7	50.0	25.0	79.2	40.7
Secondary	73.6	72.1	71.8	71.4	75.0	84.8	78.6	66.7	73.2
Special schools ^b	71.3	84.9	96.1	97.1	87.0	88.9	80.0	100.0	84.8
All schools	70.8	70.1	75.5	73.4	75.7	76.2	69.6	82.4	72.5
Proportion of primary schools (%) ^c									
Government	75.4	75.9	75.9	67.5	72.8	66.0	69.8	60.7	73.8
Non-government	59.4	64.6	55.8	56.0	59.8	49.3	61.9	46.9	59.5
All schools	70.7	72.5	71.0	64.4	69.6	62.1	67.4	58.2	69.9

^a Combined primary and secondary schools. ^b Special schools provide special instruction for students with physical or intellectual disabilities and students with social problems. ^c Excludes combined primary and secondary schools.

Source: ABS (2001a).

Student body

There were 3.3 million full time equivalent student enrolments in primary and secondary schools in August 2000 (table 3.3). The proportion of students enrolled in government schools was greater in primary schools (72.8 per cent) than in secondary schools (64.5 per cent). The proportion of students in government schools was highest in the NT (77.6 per cent) and lowest in the ACT (63.5 per cent).

Differences in schooling structures influence enrolment patterns. Primary school education, for example, goes to year 7 in Queensland, WA, SA and the NT and to year 6 in all other jurisdictions, and involves an additional year of schooling in SA

and the NT. As a result, the proportion of students enrolled in primary school education would be expected to be higher in these jurisdictions than others (table 3.3).

Total full time student equivalent enrolments in schools in Australia were relatively stable over the five years to 2000 — up by about 0.9 per cent each year between August 1996 and August 2000. Enrolments in individual jurisdictions grew at different rates, with total enrolments increasing by 1.6 per cent each year in Queensland and declining by 0.4 per cent each year in the ACT (table 3A.18).

Table 3.3 Full time equivalent student enrolments, August 2000

	<i>NSW</i>	<i>Vic</i>	<i>Qld^a</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
Total full time equivalent student enrolments at level of education ('000)									
Primary schools	629.0	451.7	366.2	192.0	159.3	47.2	32.3	26.1	1 903.9
Secondary schools	467.7	351.3	238.2	126.9	93.4	38.1	28.2	11.7	1 355.5
All schools	1 096.6	803.1	604.3	318.9	252.8	85.3	60.5	37.8	3 259.4
Proportion of full time equivalent students who were enrolled in government schools (%)									
Primary schools	72.5	69.4	76.0	75.0	72.4	77.9	66.3	80.1	72.8
Secondary schools	65.4	61.5	64.5	65.3	66.4	72.9	60.3	72.0	64.5
All schools	69.5	65.9	71.5	71.2	70.2	75.7	63.5	77.6	69.3
Proportion of full time equivalent students in all schools who were female (%)									
Primary schools	48.7	48.6	48.7	48.6	48.5	48.8	48.8	48.8	48.6
Secondary schools	49.9	50.1	49.7	49.8	50.4	50.8	49.4	50.3	50.0
All schools	49.2	49.3	49.1	49.1	49.2	49.7	49.1	49.2	49.2
Proportion of full time equivalent students who were enrolled in primary education (%)									
Government schools	59.8	59.2	64.4	63.5	65.0	56.9	55.7	71.3	61.3
Non-government schools	51.7	50.6	51.0	52.1	58.4	50.3	49.3	61.3	51.8
All schools	57.4	56.2	60.6	60.2	63.0	55.3	53.4	69.1	58.4

^a Students enrolled in special schools are included in this table, with special school students of primary school age included in the primary figures and those of secondary school age included in the secondary figures.

Source: ABS (2001a).

The proportion of students enrolled in non-government schools increased between August 1996 and August 2000 in all States and Territories except Tasmania. Total non-government school enrolments expanded by about 2.1 per cent each year — nearly seven times greater than the average annual growth rate in government school enrolments (table 3A.18). The expansion of enrolments in non-government schools, however, is from a lower base than that for government schools.

The Australian Bureau of Statistics (ABS) publishes data on part time students at only the secondary level. Part time courses are available to secondary students, including mature-age students attending colleges and those studying year 11 or year 12 short courses (lasting 5–22 weeks).

The proportion of secondary school students who were part time in 2000 varied considerably among jurisdictions, partly because each education authority had different policy and organisational arrangements for part time study. The number of part time courses available also varied considerably among jurisdictions. South Australia, Tasmania and the NT had the highest proportion of part time government secondary school students in 2000 (table 3.4).

Table 3.4 Part time secondary school students in government schools^a

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
Number of part time secondary school students in government schools										
1996	no.	1 776	1 758	5 280	4 518	5 698	2 475	13	869	22 387
1997	no.	2 204	2 185	6 911	4 447	6 054	2 824	3	663	25 291
1998	no.	3 029	2 044	4 276	4 157	5 909	2 607	10	961	22 993
1999	no.	3 323	2 495	4 063	4 199	6 545	3 203	6	1 032	24 866
2000	no.	3 638	2 489	3 868	4 154	7 015	3 538	7	977	25 686
Proportion of part time secondary school students in government schools										
1996	%	0.6	0.8	3.5	5.4	9.1	8.5	0.1	10.3	2.6
1997	%	0.7	1.0	4.7	5.2	9.5	9.4	–	7.7	2.8
1998	%	1.0	0.9	2.8	4.8	9.2	8.7	0.1	10.9	2.6
1999	%	1.1	1.1	2.6	4.8	9.9	10.7	–	11.6	2.8
2000	%	1.2	1.1	2.5	4.8	10.7	12.0	–	10.9	2.9

^a Absolute number of part time secondary students, not full time equivalent and proportion (part time) students, as a proportion of all full time and part time secondary students (absolute numbers) in government schools).

– Nil or rounded to zero.

Source: ABS (2001a).

Special needs groups

Certain groups of students have been identified as having special needs in education. These special needs groups include:

- Indigenous students;
- students from language backgrounds other than English (LBOTE);
- students with disabilities;
- students from families of low socioeconomic status; and
- students who are geographically isolated.

Government schools provide education for a high proportion of students from special needs groups. Around 80 per cent of students with disabilities and nearly 90 per cent of Indigenous students, for example, attend government schools (AIHW 1999). This chapter reports on the proportion of Indigenous students and

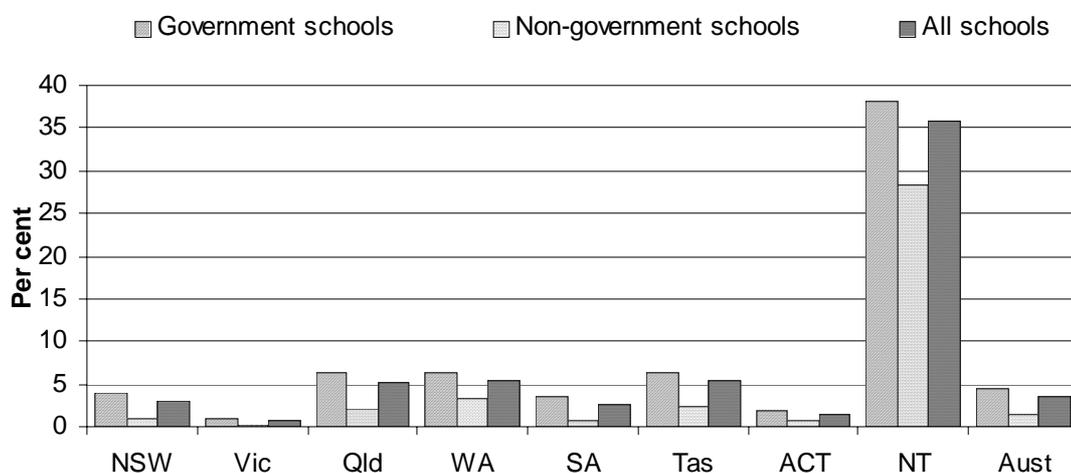
students with disabilities. Care needs to be taken in interpreting this information because some definitions of ‘special needs’ differ across States and Territories.

Indigenous students

Reflecting its population profile, the NT had the highest proportion (35.9 per cent) of Indigenous students in 2000. The jurisdictions with the next highest proportions of Indigenous students were WA and Tasmania (5.4 per cent), and Queensland (5.1 per cent) (figure 3.2). In absolute terms, NSW had the largest number of Indigenous students (32 354), accounting for 29.0 per cent of all Indigenous students enrolled in Australian schools.

In all jurisdictions, the proportion of Indigenous students was higher in government schools than in non-government schools. Nationally, the proportion of Indigenous students was 4.3 per cent for government schools and 1.4 per cent for non-government schools. Table 3A.12 provides additional information on Indigenous enrolments.

Figure 3.2 Indigenous full time students as a proportion of all students, 2000



Source: table 3A.12.

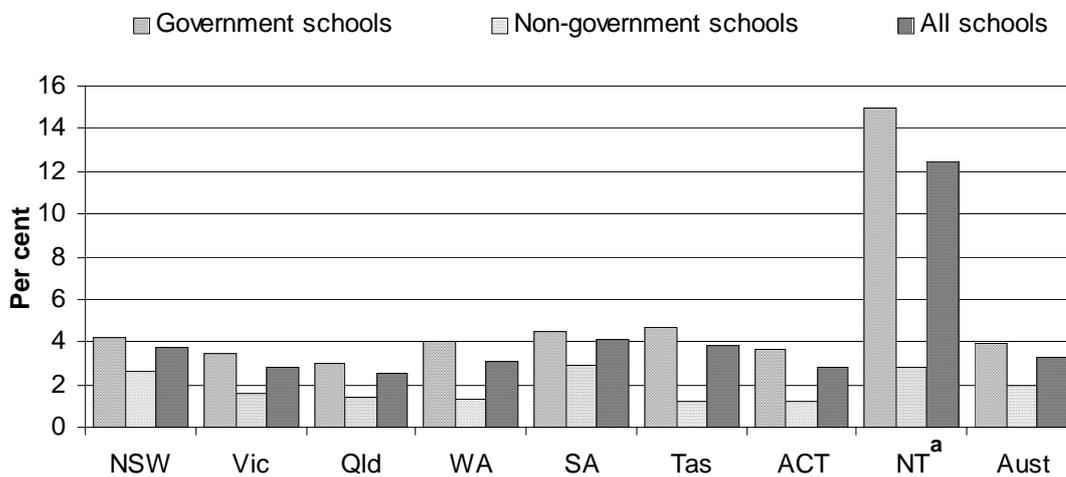
Students from language backgrounds other than English

The proportion of LBOTE students in government schools and all schools, based on data from the 1996 Census, was published in the 2000 and 2001 reports (SCRCSSP 2000 and 2001) and are at table 3A.13. The Census is conducted every five years, so no new data are available for this Report.

Students with disabilities

Students with disabilities are educated in both mainstream and special schools. In figure 3.3, students with disabilities are those that satisfy the criteria for enrolment in special education services provided in the State or Territory in which they reside. The NT had the highest proportion (12.4 per cent) of students with disabilities in 2000, while Queensland had the lowest (2.5 per cent) (figure 3.3). The proportion of students with disabilities in government schools was around twice as high as those in non-government schools in all jurisdictions, and more than five times as high in the NT.

Figure 3.3 **Students with disabilities as a proportion of all students, 2000**



^a The NT advises caution regarding these figures. Source data are being examined for accuracy.

Source: table 3A.14.

3.2 Policy developments in schools education

MCEETYA taskforces

At its July 2001 meeting, MCEETYA endorsed the formation of seven new schools based taskforces to support its deliberations on achieving the National Goals for Schooling in the Twenty First Century. These taskforces will enhance national collaboration and advance the national schooling agenda in the following key areas:

- schools resourcing;
- teacher quality and educational leadership;

-
- student learning and support services;
 - information and communication technologies in schools;
 - Indigenous students and other targeted initiatives of national significance;
 - transition from school; and
 - performance measurement and reporting

Indigenous students

Launched in March 2000 by the Prime Minister, the National Indigenous English Literacy and Numeracy Strategy is aimed at improving education outcomes for Indigenous people. Funding for the strategy is provided under the Indigenous Education Strategic Initiatives Programme (IESIP). Recipients of the IESIP are required to enter into an Indigenous Education Agreement with the Commonwealth, which includes baseline and annual performance targets for improvement. Annual performance reports detail the outcomes achieved. A set of standard performance indicators has been developed for all jurisdictions to use in IESIP reporting for the 2001–04 quadrennium.

3.3 Framework of performance indicators

This chapter provides comparable indicators on the effectiveness and efficiency of government expenditure for all schools in Australia. It does not compare the efficiency of government and non-government schools.

Governments own and operate government schools and have a direct interest in the efficiency and effectiveness of their operation. In addition, governments are committed to providing access to education for all students (box 3.1). The reporting framework for schools (figure 3.4) is consistent with government goals for the school system. All indicators are defined in section 3.7.

Box 3.1 National goals for school education in Australia, 1999

The Ministerial Council on Education, Employment, Training and Youth Affairs endorsed in April 1999 the following set of national goals for school education.

Preamble

Australia's future depends upon each citizen having the necessary knowledge, understanding, skills and values for a productive and rewarding life in an educated, just and open society. High quality schooling is central to achieving this vision.

(Continued on next page)

Box 3.1 (Continued)

This statement of national goals for schooling provides broad directions to guide schools and education authorities in securing these outcomes for students.

It acknowledges the capacity of all young people to learn, and the role of schooling in developing that capacity. It also acknowledges the role of parents as the first educators of their children and the central role of teachers in the learning process.

Schooling provides a foundation for young Australians' intellectual, physical, social, moral, spiritual and aesthetic development. By providing a supportive and nurturing environment, schooling contributes to the development of students' sense of self-worth, enthusiasm for learning and optimism for the future.

Governments set the public policies that foster the pursuit of excellence, enable a diverse range of educational choices and aspirations, safeguard the entitlement of all young people to high quality schooling, promote the economic use of public resources, and uphold the contribution of schooling to a socially cohesive and culturally rich society.

Common and agreed goals for schooling establish a foundation for action among State and Territory governments with their constitutional responsibility for schooling, the Commonwealth, non-government school authorities and all those who seek the best possible educational outcomes for young Australians, to improve the quality of schooling nationally.

The achievement of these common and agreed national goals entails a commitment to collaboration for the purposes of:

- further strengthening schools as learning communities where teachers, students and their families work in partnership with business, industry and the wider community;
- enhancing the status and quality of the teaching profession;
- continuing to develop curriculum and related systems of assessment, accreditation and credentialling that promote quality and are nationally recognised and valued;
- increasing public confidence in school education through explicit and defensible standards that guide improvement in students' levels of educational achievement and through which the effectiveness, efficiency and equity of schooling can be measured and evaluated.

These national goals provide a basis for investment in schooling to enable all young people to engage effectively with an increasingly complex world. This world will be characterised by advances in information and communication technologies, population diversity arising from international mobility and migration, and complex environmental and social challenges.

(Continued on next page)

Box 3.1 (Continued)

The achievement of the national goals for schooling will assist young people to contribute to Australia's social, cultural and economic development in local and global contexts. Their achievement will also assist young people to develop a disposition towards learning throughout their lives so that they can exercise their rights and responsibilities as citizens of Australia.

Goals

1. Schooling should develop fully the talents and capacities of all students. In particular, when students leave schools they should:

- 1.1 have the capacity for, and skills in, analysis and problem solving and the ability to communicate ideas and information, to plan and organise activities and to collaborate with others;
- 1.2 have qualities of self-confidence, optimism, high self-esteem, and a commitment to personal excellence as a basis for their potential life roles as family, community and workforce members;
- 1.3 have the capacity to exercise judgment and responsibility in matters of morality, ethics and social justice, and the capacity to make sense of their world, to think about how things got to be the way they are, to make rational and informed decisions about their own lives and to accept responsibility for their own actions;
- 1.4 be active and informed citizens with an understanding and appreciation of Australia's system of government and civic life;
- 1.5 have employment related skills and an understanding of the work environment, career options and pathways as a foundation for, and positive attitudes towards, vocational education and training, further education, employment and life-long learning;
- 1.6 be confident, creative and productive users of new technologies, particularly information and communication technologies, and understand the impact of those technologies on society;
- 1.7 have an understanding of, and concern for, stewardship of the natural environment, and the knowledge and skills to contribute to ecologically sustainable development; and
- 1.8 have the knowledge, skills and attitudes necessary to establish and maintain a healthy lifestyle, and for the creative and satisfying use of leisure time.

2. In terms of curriculum, students should have:

- 2.1 attained high standards of knowledge, skills and understanding through a comprehensive and balanced curriculum in the compulsory years of schooling encompassing the agreed eight key learning areas:
 - the arts
 - English

(Continued on next page)

Box 3.1 (Continued)

- health and physical education
- languages other than English
- mathematics
- science
- studies of society and environment
- technology

and the interrelationships between them;

- 2.2 attained the skills of numeracy and English literacy, such that every student should be numerate, able to read, write, spell and communicate at an appropriate level;
- 2.3 participated in programs of vocational learning during the compulsory years and have had access to vocational education and training programs as part of their senior secondary studies; and
- 2.4 participated in programs and activities which foster and develop enterprise skills, including those skills which will allow them maximum flexibility and adaptability in the future.

3. Schooling should be socially just, so that:

- 3.1 students' outcomes from schooling are free from the effects of negative forms of discrimination based on sex, language, culture and ethnicity, religion or disability; and of differences arising from students' socioeconomic background or geographic location;
- 3.2 the learning outcomes of educationally disadvantaged students improve and, over time, match those of other students;
- 3.3 Aboriginal and Torres Strait Islander students have equitable access to, and opportunities in, schooling so that their learning outcomes improve and, over time, match those of other students;
- 3.4 all students understand and acknowledge the value of Aboriginal and Torres Strait Islander cultures to Australian society and possess the knowledge, skills and understanding to contribute to, and benefit from, reconciliation between Indigenous and non-Indigenous Australians;
- 3.5 all students understand and acknowledge the value of cultural and linguistic diversity, and possess the knowledge, skills and understanding to contribute to, and benefit from, such diversity in the Australian community and internationally; and
- 3.6 all students have access to the high quality education necessary to enable the completion of school education to year 12 or its vocational equivalent and that provides clear and recognised pathways to employment and further education and training.

Source: MCEETYA (1999).

3.4 Key performance indicator results

Different delivery contexts and locations affect the effectiveness and efficiency of school education services. Appendix A contains detailed statistics and short profiles on each State and Territory, which may help in interpreting the performance indicators presented in this chapter. Figure 3.4 contains a framework for performance indicators. This section reports on what jurisdictions currently collect and assess in terms of the performance indicators.

Effectiveness

The effectiveness indicators for school education in this chapter are based on the achievement of the national goals for school education.

State and Territory specific learning outcomes

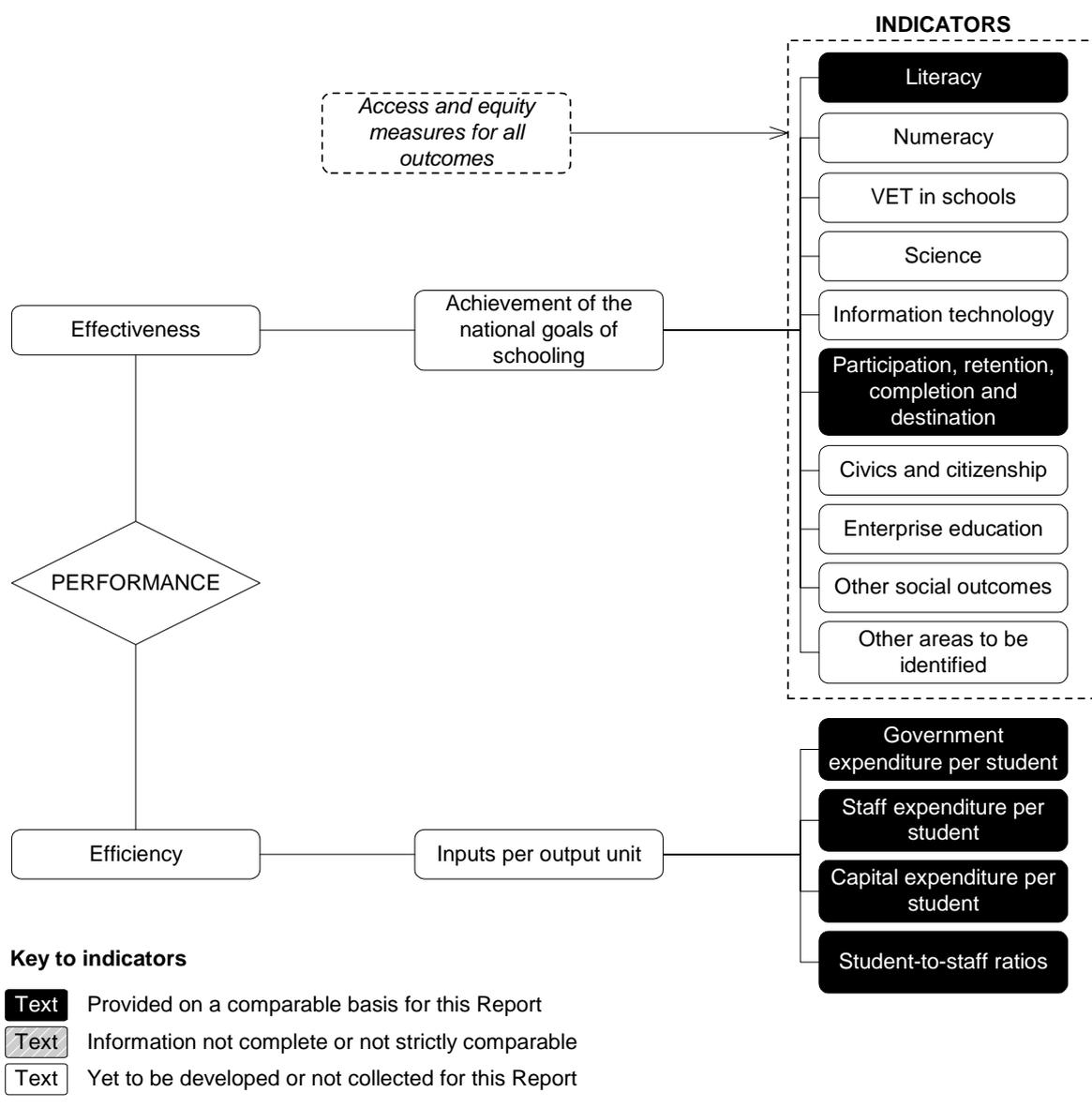
The reporting of test result data by jurisdictions provides some insight into how learning outcomes are measured and may help an understanding of trends within jurisdictions over time, although the general non-comparability of data across States and Territories reduces the usefulness of this information.

Jurisdictions are in the process of aligning jurisdiction-specific testing with benchmarks for nationally comparable learning outcomes for a range of indicators. As a result, some jurisdictions have stopped collecting the jurisdiction-specific learning outcomes data published in previous reports. Where jurisdictions provided updated information on jurisdiction-specific learning outcomes, that information is reported in attachment 3A.

Access and equity

Access and equity objectives of school education can be assessed by comparing outcomes for special needs groups to those for the mainstream student population through indicators such as completion rates, apparent retention rates, age participation rates and learning outcomes. Outcomes are compared for special needs groups for available indicators where possible. Learning outcomes for Indigenous students and LBOTE students are also reported for Victoria, Queensland, WA and the NT in tables 3A.54–3A.57, 3A.67, 3A.76, 3A.78 and 3A.126.

Figure 3.4 Performance indicators for all schools



Performance benchmarks

In July 1996, Commonwealth, States and Territory education ministers agreed to develop national benchmarks for use in reporting years 3, 5 and 7 students' performance. Benchmarks have been developed for reading, writing, spelling and numeracy. These benchmarks describe the nationally agreed minimum acceptable standard in the aforementioned areas of study, at a particular year level — that is, the standard without which a student will have difficulty making sufficient progress at school. Given that the benchmarks represent *minimum* acceptable standards, education ministers have determined that the national goal is that all students achieve at least the benchmark level of performance.

Literacy

An indicator of performance is the proportion of students who reach a benchmark standard. Table 3.5 shows the percentage of assessed year 5 students who achieved the reading benchmark in 1999 reported by gender, Indigenous status and LBOTE status. (For further information and caveats to table 3.5, see tables 3A.25, 3A.26 and 3A.27.) Data on year 3 reading in 1999 can be found in the 2001 Report.

Table 3.5 Proportion of year 5 students who achieved the reading benchmark, 1999 (per cent)^a

<i>State/Territory</i>					
<i>1. Average age^b</i>	<i>All</i>	<i>Male</i>	<i>Female</i>	<i>Indigenous</i>	<i>LBOTE</i>
<i>2. Years of schooling^c</i>	<i>students</i>	<i>students</i>	<i>students</i>	<i>students^d</i>	<i>students^d</i>
NSW	90.3	88.6	92.0	72.5	89.1
1. 10 yrs, 9 mths	± 1.4	± 1.6	± 1.3	± 3.6	± 1.8
2. 5 yrs, 7 mths					
Victoria	88.0	85.6	90.5	64.8	83.4
1. 10 yrs, 11 mths	± 1.9	± 2.1	± 1.7	± 6.7	± 2.6
2. 5 yrs, 7 mths					
Queensland ^e	80.0	78.2	84.3	54.4	75.2
1. 10 yrs, 3 mths	± 3.0	± 3.5	± 2.6	± 5.6	± 3.8
2. 4 yrs, 8 mths					
WA	79.5	75.5	83.6	42.2	73.1
1. 10 yrs, 2 mths	± 2.7	± 3.1	± 2.3	± 4.1	± 3.2
2. 5 yrs, 7 mths					
SA	82.8	80.2	85.8	58.7	na
1. 10 yrs, 6 mths	± 1.5	± 1.8	± 1.4	± 2.9	
2. 5 yrs, 3 mths					
Tasmania	78.7	76.2	81.3	63.3	63.3
1. 11 yrs, 0 mths	± 2.1	± 2.2	± 1.9	± 2.3	± 3.3
2. 5 yrs, 7 mths					
ACT	90.4	88.6	92.1	69.1	77.6
1. 10 yrs, 9 mths	± 1.6	± 2.2	± 1.9	± 27.5	± 4.9
2. 5 yrs, 6 mths					
NT	78.4	77.3	80.0	46.2	37.5
1. 10 yrs, 7 mths	± 1.7	± 2.0	± 1.5	± 2.4	± 2.2
2. 5 yrs, 3 mths					
Australia	85.6	83.4	88.4	58.6	na

^a The achievement percentages reported in this table include 95 per cent confidence intervals (for example, 80 per cent ± 2.7 per cent). Table 3A.26 contains details of test populations in all States and Territories. ^b The typical average age of students at the time of testing (expressed in years and months). Table 3A.25 contains more information. ^c The typical average time that students had spent in schooling at the time of testing (expressed in years and months). Table 3A.25 contains more information. ^d The methods used to identify Indigenous students and LBOTE students varied across jurisdictions. Definitions can be found at section 3.7. Table 3A.27 contains more information. ^e Data for the proportions of male, female, Indigenous and LBOTE students do not include students who were formally exempted from testing. **na** Not available.

Source: MCEETYA (2001a).

Participation, retention, completion and school leaver destination

Participation rate

The participation rate of 15–19 year olds (for whom school attendance is no longer compulsory) measures the number of full time school students in that age group, as a proportion of the estimated resident population of the same age. Care needs to be taken in interpreting participation rates in school education because rates are influenced by differences across jurisdictions in:

- year and age/grade structures;
- other options for delivering post-compulsory education and training (for example, work based training and enrolment in technical and further education [TAFE] delivered programs);
- the extent of part time enrolment in schools (see table 3.4 for part time student enrolments).

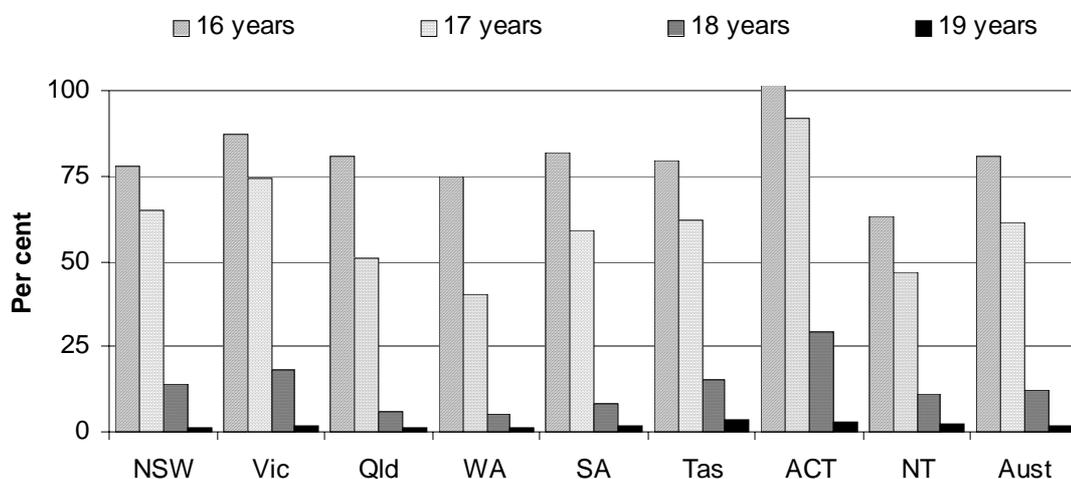
The participation rate may understate the extent of participation in post-compulsory schooling for these reasons. Further work to improve the comparability of the participation rate is discussed in section 3.5.

Nationally, 49.8 per cent of 15–19 year olds were enrolled in schools in 2000 (table 3A.19). Actual participation rates varied by jurisdiction, age and gender.

- The ACT had the highest overall participation rate of 15–19 year olds (63.4 per cent) and the NT had the lowest overall participation rate (41.7 per cent).
- Participation rates for females were typically 2–4 percentage points higher than those for males in all jurisdictions.
- Participation rates declined significantly as students exceeded the maximum compulsory school age (16 years for Tasmania and 15 years for other jurisdictions) (figure 3.5).

Participation rates in the ACT in 2000, as in the past, were higher than those in other jurisdictions for all ages (exceeding 100 per cent for 16 year olds). This is a result of the enrolment in the ACT of NSW residents from surrounding areas.

Figure 3.5 **School participation rates by age of students, all schools, August 2000^{a, b}**



^a Proportion of the population who were not of compulsory school age but were enrolled as full time students in August 2000. ^b School is compulsory for 16 year olds in Tasmania.

Source: table 3A.19.

Apparent retention rate

The apparent retention rate is derived by measuring the number of full time school students enrolled in year 12 in 2000 and expressing this as a proportion of the number of full time school students enrolled in year 10 in 1998. Progression to final years of schooling is influenced by a wide range of factors, including student perceptions of the benefits of schooling, the availability of employment and further educational alternatives, socioeconomic status and population movements. Apparent retention is a long-standing measure which is presented as an indicator of the extent to which students progress to their final year of education. It has been consistently reported over time, but, it does not reflect factors such as:

- students repeating a year of education or returning to education after a period of absence and hence being included in the year 10 cohort in 1998 but not in the year 12 cohort in 2000;
- differing enrolment policies across jurisdictions (which contribute to different age/grade structures);
- students enrolled in year 12 on a part time basis (see table 3.4 for the proportions of part time students in government schools in each jurisdiction);
- interstate movement of students;

-
- movement from the government to non-government schools sector;
 - impacts of migration and full-fee paying overseas students; and
 - varying enrolment patterns in which students choose to complete their secondary schooling in TAFE institutes.

All these factors can combine to result in a year 12 cohort that is significantly different in composition from the corresponding year 10 cohort — for example:

- in SA in 2000, 85.2 per cent of all students, including part time students, had continued their schooling from year 10 to year 12, compared with 69.5 per cent for full time students only (ABS 1999, 2001a); and
- in NSW, a significant number of students use the TAFE system to complete their post-compulsory schooling in preference to enrolling in years 11 and 12 in the school system. In 2000, around 4000 students aged 15–19 years who undertook higher schools certificate studies in NSW did so through TAFE institutes.

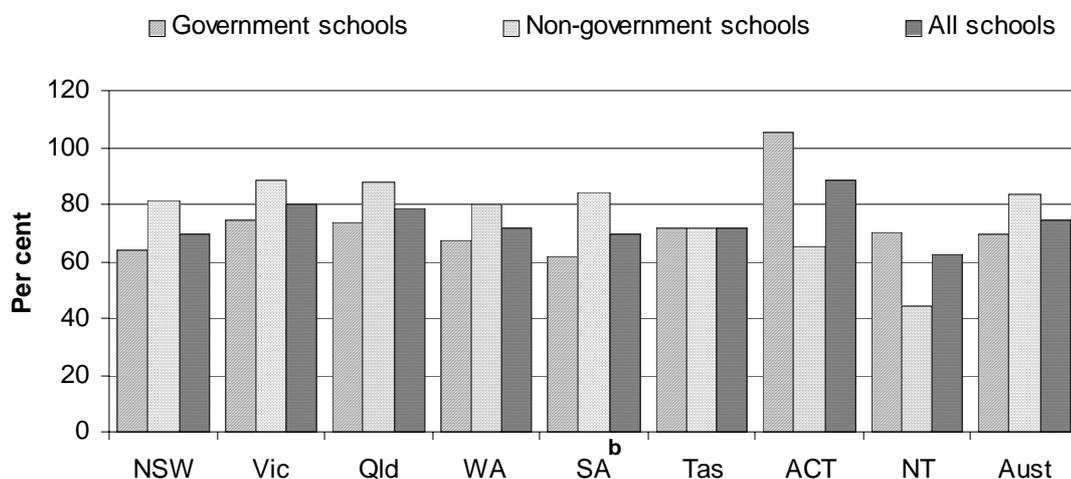
Work being undertaken to improve this measure is discussed in section 3.5.

The ABS publishes two separate measures of apparent retention rates: the first indicates student progression from years 7 and 8 to year 12, while the second indicates student progression from year 10 to year 12. This Report uses retention from year 10 to year 12 because that measure is less affected than the former measure by factors such as inter-sector transfers and interstate movement.

Apparent retention rates from year 10 to year 12 in all schools ranged from 88.7 per cent in the ACT to 62.2 per cent in the NT in 2000. The apparent retention rates for government schools ranged from 105.0 per cent in the ACT to 61.9 per cent in SA (figure 3.6). One reason for the ACT rate for government schools exceeding 100 per cent is that a number of non-government schools do not enrol students beyond year 10 and students need to change schools to continue to years 11 and 12. This has the effect of reducing the retention rate for non-government schools and increasing the retention rate for government schools.

For all schools, apparent retention rates from year 10 to year 12 for Indigenous students in 2000 ranged from 70.0 per cent in the ACT to 28.1 per cent in WA in 2000 (figure 3.7). This indicator may need to be interpreted with regard to retention rates to year 10 for Indigenous students. Nationally, Indigenous retention to year 10 for all schools in 2000 was 14.6 percentage points lower than the retention rate for all students, although this varied across jurisdictions (table 3A.20).

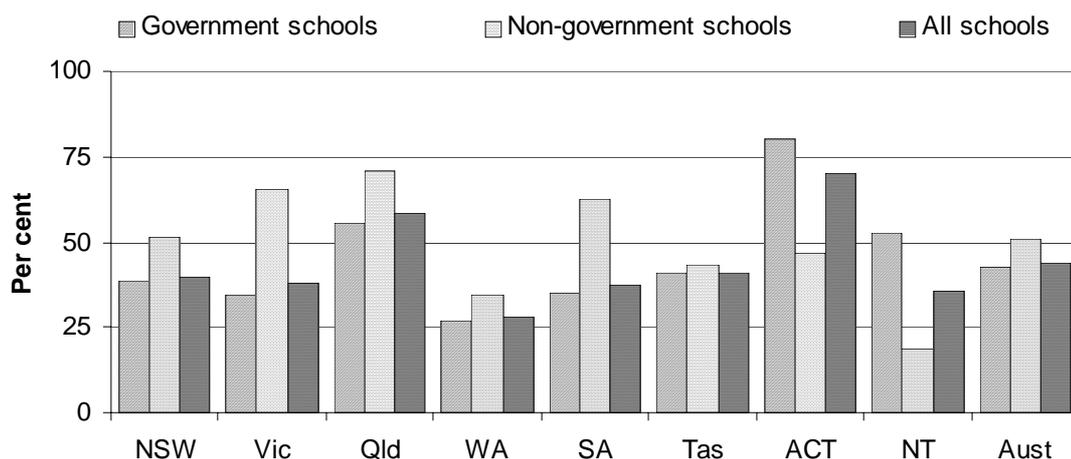
Figure 3.6 Apparent retention rates of full time secondary students from year 10 to year 12, 2000^a



a Retention rates are affected by a number of factors that vary across jurisdictions. For these reasons, variations in apparent retention rates over time within jurisdictions may be more useful than comparisons across jurisdictions. Retention rates can exceed 100 per cent because student transfers between government and non-government schools occurred after the base year. **b** The exclusion of part time students from standard apparent retention rate calculations has particular implications for the interpretation of results for SA.

Source: table 3A.21.

Figure 3.7 Apparent retention rates of Indigenous full time secondary students from year 10 to year 12, 2000

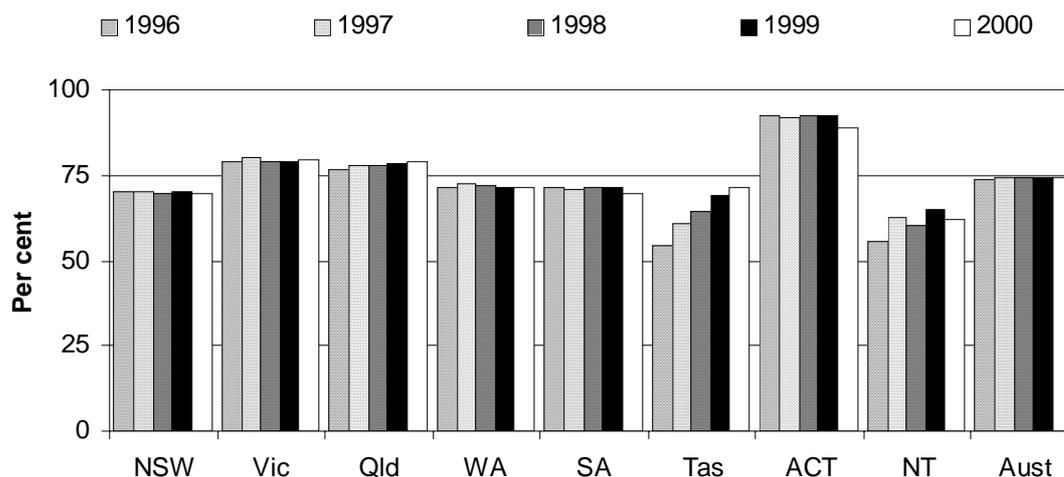


a Retention rates are affected by a number of factors that vary across jurisdictions. For these reasons, variations in apparent retention rates over time within jurisdictions may be more useful than comparisons across jurisdictions. Retention rates can exceed 100 per cent because student transfers between government and non-government schools occurred after the base year. **b** The exclusion of part time students from standard apparent retention rate calculations has particular implications for the interpretation of results for SA.

Source: table 3A.21.

Between 1996 and 2000, apparent retention rates from year 10 to year 12 in all schools increased in Tasmania and the NT, and remained fairly steady in all other jurisdictions (figure 3.8). Other information on apparent retention rates can be found in table 3A.20.

Figure 3.8 Apparent retention rates of full time secondary students from year 10 to year 12, all schools



Sources: ABS (2001a); table 3A.21.

Completion of secondary schooling

The Commonwealth Government has developed a method for estimating the proportion of young Australians who complete year 12, disaggregated by locality, socioeconomic background and gender. Completion rates are estimated by calculating the number of students who obtain a year 12 certificate expressed as a percentage of the potential year 12 population (for the definition of the potential year 12 population, see section 3.7).

The Commonwealth uses the completion rates in the absence of participation or retention data by socioeconomic background or geographic location. Completion rates are primarily used as indicators of trends. Small changes in population or completions can affect rates quite significantly, particularly for smaller States and the Territories. Also, assessment, reporting and certification methods for year 12 vary across States and Territories. Given these differences, comparisons among jurisdictions need to be made with care.

Geographic isolation is determined using the method developed by the former Department of Primary Industry and Energy. Socioeconomic status is determined

according to the Index of Relative Socioeconomic Disadvantage developed by the ABS. Low socioeconomic status is the average of the three lowest deciles and high socioeconomic status is the average of the three highest deciles. The aggregation of all postcode locations into three categories — high, medium and low — means that there may be significant variation within the categories. Low deciles, for example, will include locations ranging from those of extreme disadvantage to those of moderate disadvantage.

Year 12 completion rates in 2000 by socioeconomic background, location and gender are provided in tables 3.6 and 3.7. The data show that students in capital cities had the highest completion rates in 2000, while students in rural or remote areas other than rural centres generally had the next highest completion rates. Gender differences are also evident, with the completion rates for females consistently higher than those for males in 2000, regardless of location or socioeconomic background.

Table 3.6 highlights differences in completion rates on the basis of socioeconomic background. Completion rates for students from a low socioeconomic background were 17 percentage points below those for students from a high socioeconomic background in 2000. The completion rates in both socioeconomic categories were higher for female students; female completion rates in the low socioeconomic category were only 4 percentage points behind males in the high socioeconomic category in 2000.

Table 3.6 also indicates that the 2000 completion rates varied substantially across jurisdictions. Rates in the low socioeconomic status deciles ranged from 70 per cent in Queensland to 14 per cent in the NT. Rates for the high socioeconomic status deciles (for jurisdictions with available data) ranged from 95 per cent in Tasmania to 76 per cent in Victoria.

Gender differences are also evident in table 3.7. In other rural and remote areas there was a 21 percentage point difference between male and female completion rates in 2000. In capital cities, there was an 11 percentage point gender difference.

Time series data on completion rates are shown in tables 3A.22 and 3A.23.

Table 3.6 Year 12 estimated completion rates by socioeconomic status and gender, 2000 (per cent)^a

	NSW	Vic	Qld	WA	SA	Tas	ACT ^b	NT ^c	Aust
Low socioeconomic status deciles									
Male	53	54	63	45	48	58	..	11	54
Female	69	71	77	54	68	69	..	16	69
All students	61	62	70	50	58	63	..	14	61
High socioeconomic status deciles									
Male	71	71	78	74	77	90	78	na	73
Female	83	82	79	82	93	99	86	na	83
All students	77	76	78	78	85	95	82	na	78
Total									
Male	59	61	68	57	59	68	77	23	61
Female	72	76	77	68	78	81	85	35	74
All students	65	68	73	63	68	74	81	28	67

^a The ABS Index of Relative Socioeconomic Disadvantage has been used to calculate socioeconomic status on the basis of students' home addresses. Low socioeconomic status is the average of the three lowest deciles and high socioeconomic status is the average of the three highest deciles. ^b On the basis of this index, the ACT has only medium and high socioeconomic status deciles. ^c Small increases in the estimated resident population can cause significant fluctuations in the data. As a result, high socioeconomic status rates for the NT are unreliable and have been excluded. **na** Not available. **..** Not applicable.

Source: DETYA (unpublished).

School leaver destinations

The Education preface of this Report discusses the destinations of year 12 leavers and early school leavers in 2000 at the national level, and examines the proportions of male and female students attending other educational institutions in 2000 after leaving school in the previous year (table B.4, which also shows the proportion of students who were not attending any educational institution in 2000).

Social objectives of schooling

In 1996, the Commonwealth Department of Education, Training and Youth Affairs, on behalf of MCEETYA, commissioned an investigation 'to define and describe aspects of the social objectives of schooling'. The purpose of this investigation was to obtain baseline data on achievements against the selected social objectives and to investigate the role and influence of schools in this regard (Ainley *et al.* 1998, p. xiii). The 1999 Report includes a summary of these results.

Table 3.7 Year 12 estimated completion rates by locality and gender, 2000 (per cent)

	NSW	Vic	Qld	WA ^a	SA ^a	Tas ^a	ACT ^b	NT ^c	Aust
Capital city									
Male	63	63	71	61	62	79	77	30	64
Female	75	76	78	69	79	88	85	51	75
All students	68	70	74	65	70	83	81	40	70
Other metropolitan									
Male	53	53	65	..	..	..	..	..	57
Female	63	69	72	..	..	..	..	..	66
All students	58	61	69	..	..	..	..	..	62
Rural centres									
Male	53	55	66	53	44	67	..	..	58
Female	66	72	74	61	62	80	..	..	70
All students	59	63	70	57	53	73	..	..	64
Other rural and remote areas									
Male	55	54	66	46	53	52	..	17	55
Female	76	80	84	65	83	71	..	21	76
All students	65	66	74	55	67	61	..	19	65
All areas									
Male	59	61	68	57	59	68	77	23	61
Female	72	76	77	68	78	81	85	35	74
All students	65	68	73	63	68	74	81	28	67

^a There are no Other Metropolitan Areas in this jurisdiction. ^b All of the ACT is defined as a Capital City. ^c There are no Other Metropolitan or Rural Centres in the NT. .. Not applicable.

Source: DETYA (unpublished).

Efficiency

Governments have an interest in achieving the best results from their expenditure on schooling, both as owners and operators of government schools, and as the major providers of funds to the non-government school sector. An objective for the Review is to publish comparable estimates of costs. Ideally, such comparison includes the full range of costs to government. Where the full costs cannot be measured, cost is best estimated on a consistent basis. Significant effort has been made to improve the method for calculating the indicators in this Report and to document any differences. However, some concerns remain over the comparability of the results because jurisdictions use somewhat different methods of data collection. Table 3.8 summarises these differences and table 3A.24 contains more information.

Table 3.8 Comparability of expenditure — items included, 1999-2000

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT
Superannuation	✓	✓	✓	✓	✓	✓	✓	na
<i>Basis of estimate</i>	Accrual	Accrual	Accrual	Accrual	Accrual	Accrual	Accrual	na
Workers compensation	✓	✓	✓	✓	✓	✓	✓	na
Payroll tax ^a	✓	X	✓	X ^a	✓	✓	X	na
<i>Basis of estimate</i>	Accrual	..	Accrual	..	Accrual	Accrual	..	na
Termination and long service leave	✓	X	✓	✓	✓	✓	✓	na
<i>Basis of estimate</i>	Accrual	..	Accrual	Accrual	Accrual	Accrual	Accrual	na
Sick leave	X	X	X	X	✓	✓	✓	na
<i>Basis of estimate</i>	..	..	..	..	Accrual	Accrual	Accrual	na
Depreciation	✓	X	✓	✓	✓	✓	✓	na
Rent	✓	✓	✓	✓	✓	✓	✓	na
<i>Basis of estimate</i>	Accrual	Accrual	Accrual	Accrual	Accrual	Accrual	Accrual	na
Utilities	✓	✓	✓	✓	✓	✓	✓	na
<i>Basis of estimate</i>	Accrual	Accrual	Accrual	Accrual	Accrual	Accrual	Accrual	na
Umbrella department costs	✓	✓	✓	✓	✓	✓	✓	na
<i>Basis of apportionment^b</i>	Formula	Formula	Formula	Formula	Per student	Per FTE student	Formula	na

^a Education departments in WA and the ACT are exempt from payroll tax. ^b Umbrella department costs are apportioned according to: departmental program structure in NSW; use (including enrolment) in Victoria; and activity based costing in the ACT. **na** Not available. **..** Not applicable. **✓** Included. **X** Excluded. FTE = full time equivalent.

Source: Commonwealth, State and Territory governments.

Government recurrent expenditure per student

A number of factors may influence government recurrent expenditure per student (box 3.2).

Box 3.2 Factors that may influence the level of expenditure per student

Differences in the costs of educating students can be driven by:

- influences beyond the control of governments, such as a high proportion of geographically isolated population and/or a dispersed population;
- policy changes in education, such as tradeoffs between reducing costs and improving the quality of education, or between reducing costs and increasing the accessibility of education; and
- how well the education department and schools manage resources.

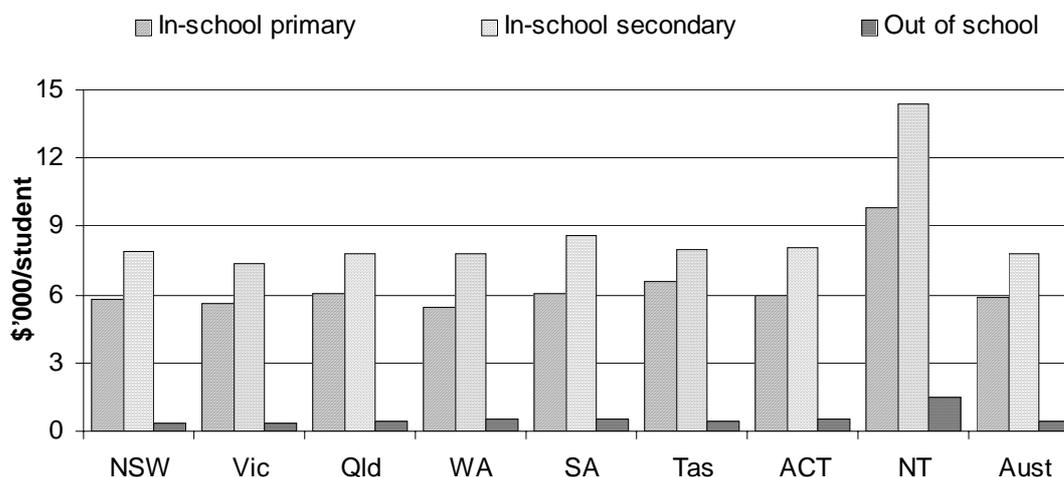
The Commonwealth Grants Commission, when calculating relativities between States and Territories to distribute Commonwealth general purpose grants, accounts for influences beyond a jurisdiction's control (called disabilities) that affect its cost of providing services and its capacity to raise revenue. In relation to education, the assessment includes 'service delivery scale' disability factors. These factors allow for the effects on relative cost differences among jurisdictions that have to service small and remote schools because they have a small and dispersed population. However, this Report does not make any cost adjustments based on any of the above factors. These factors may need to be considered when examining each jurisdiction's expenditure per student.

The introduction of accrual accounting was completed for the 1999-2000 financial year for all jurisdictions except the NT. Accrual accounts for 1998-99 were also constructed and are included in this Report (tables 3A.30 and 3A.31). These financial data are not comparable with financial data from earlier years which were calculated on a cash accounting basis. This also means that the 1998-99 financial data in the 2001 Report (which was prepared on a cash basis) may not be comparable with the 1998-99 data in this Report. Tables 3A.28 and 3A.29 contain more information.

A proxy indicator of efficiency is the level of government inputs per unit of output (unit cost). In-school government expenditure per full time equivalent student in government primary schools ranged from \$9813 in the NT to \$5455 in WA in 1999-2000. In-school government expenditure per full time equivalent secondary student in government secondary schools ranged from \$13 568 in the NT to \$7306

in Victoria. Out-of-school departmental overheads per full time equivalent student in government schools ranged from \$1453 in the NT to \$308 in NSW (figure 3.9).

Figure 3.9 Total government expenditure per full time equivalent student, government schools, 1999-2000^{a, b}

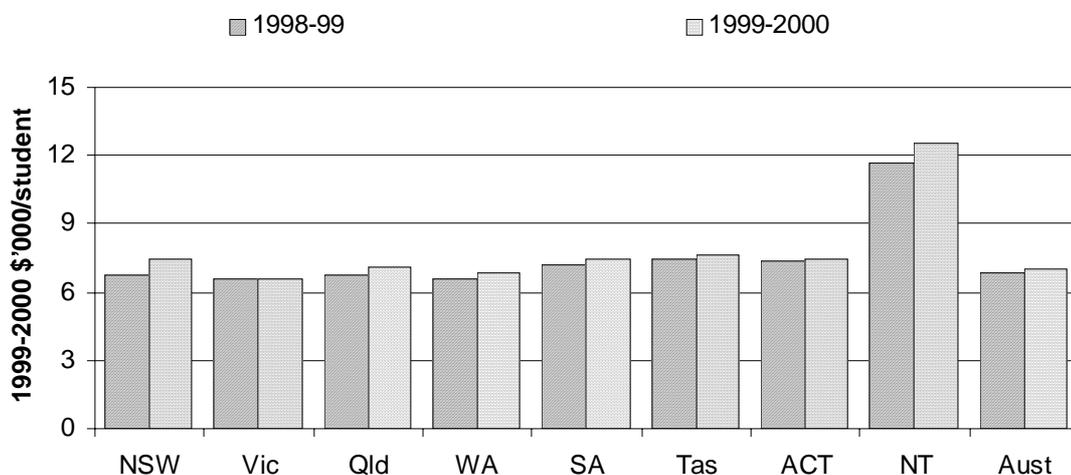


^a See notes to table 3A.9 and 3A.10 for definitions and data caveats. ^b Capital charges have been excluded for comparability reasons.

Source: table 3A.10.

Figure 3.10 shows that total government expenditure per full time equivalent student in government schools increased (in real terms) between 1998-99 and 1999-2000 in all jurisdictions.

Figure 3.10 **Total government expenditure per full time equivalent student, government schools^{a, b, c}**

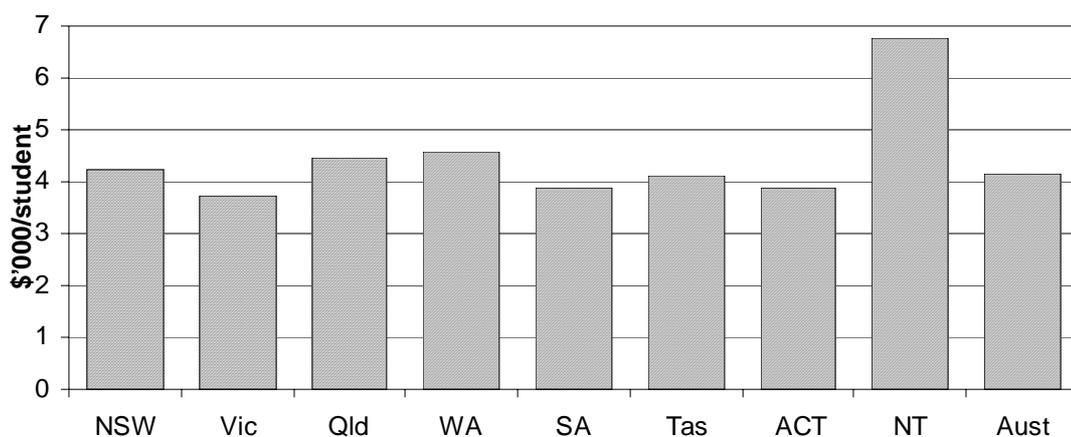


^a See notes to table 3A.9 for definitions and data caveats. ^b Data for 1998-99 have been adjusted to 1999-2000 dollars using the gross domestic product deflator. ^c Capital charges have been excluded for comparability reasons.

Source: table 3A.11.

In 1999-2000, government expenditure per full time equivalent student in non-government schools in Australia ranged from \$6764 in the NT to \$3719 in Victoria (figure 3.11).

Figure 3.11 **Total government expenditure per full time equivalent student, non-government schools, 1999-2000^a**



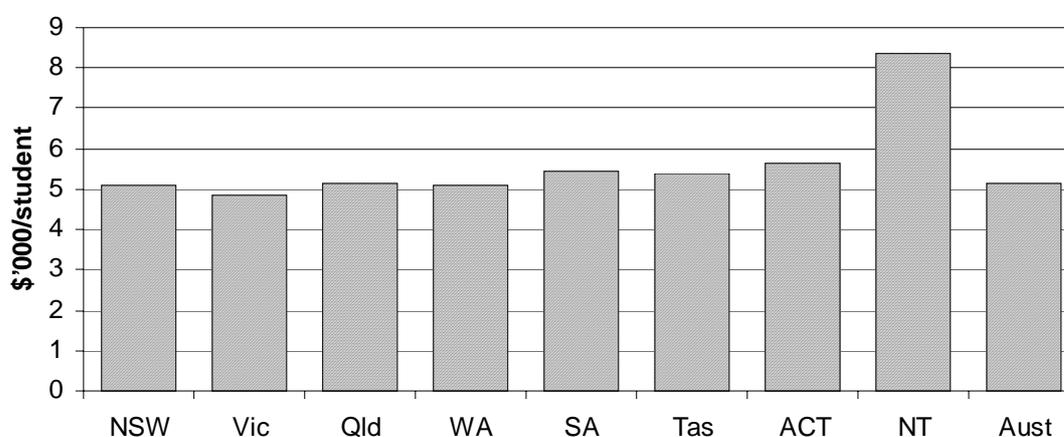
^a The sum of Commonwealth specific purpose payments for non-government schools, and State and Territory payments to non-government schools.

Source: table 3A.11.

Staff expenditure per student

Expenditure on staff is the major component of government expenditure on government schools, accounting for 69.4 per cent of the total in 1999-2000. Of this expenditure on staff, 81.3 per cent was expenditure on in-school teachers (table 3A.9). Government expenditure on staff per full time equivalent student ranged from \$8201 in the NT to \$4826 in Victoria (figure 3.12).

Figure 3.12 Government expenditure on staff per full time equivalent student, government schools, 1999-2000



Source: table 3A.10.

User cost of capital of school education

The user cost of capital for government services is the cost of funds tied up in capital used to produce services (for example, land and buildings owned by government schools). The user cost of capital makes explicit the opportunity cost of using the funds to provide services rather than investing elsewhere or retiring debt.

When comparing costs of government services, it is important to account for the user cost of capital because:

- it is often a significant component of the cost of services; and
- it is often treated inconsistently (that is, it is included in the costs of services delivered by many non-government service providers, but effectively costed at zero for most budget sector agencies).

An indicative user cost of capital for government schools in 1999-2000 was calculated for all jurisdictions except the NT (which has yet to introduce accrual

accounting). This was done by applying a nominal cost of capital rate of 8 per cent to the value of government assets used in the delivery of education in government schools. The indicative user cost of capital per full time equivalent government school student in 1999-2000 was highest in NSW (\$1780) and lowest in SA (\$654) (table 3A.11).

The Steering Committee accepts that asset valuation data are imperfect. However, it also recognises that the treatment of costs has not fully recognised the cost of public capital used by departments to deliver services — that is, capital has generally been considered ‘free’. This can lead to significant underestimation of costs for those services for which government capital is a major input. Thus, using an imperfect costing is preferable to not costing government capital and also provides an incentive to improve data over time.

Student-to-staff ratios¹

The student-to-teacher ratio presents the number of students per person classified as a teacher in a way that can be compared across jurisdictions. A low ratio means that there are a small number of students per teacher. (The ratio is not a measure of class size.) Table 3A.6 contains student-to-staff ratios for 2000.

The ratio needs to be interpreted with care because it can be affected by a number of factors, including:

- the proportion of small rural schools. A large proportion of small rural schools, for example, can significantly lower the overall average student-to-teacher ratio. Conversely, a large proportion of students in metropolitan schools can raise the ratio;
- the degree to which administrative work is undertaken by people classified as teachers (such as principals, deputy principals and senior teachers); and
- other inputs to school education (for example, non-teaching staff, computers, books and laboratory equipment).

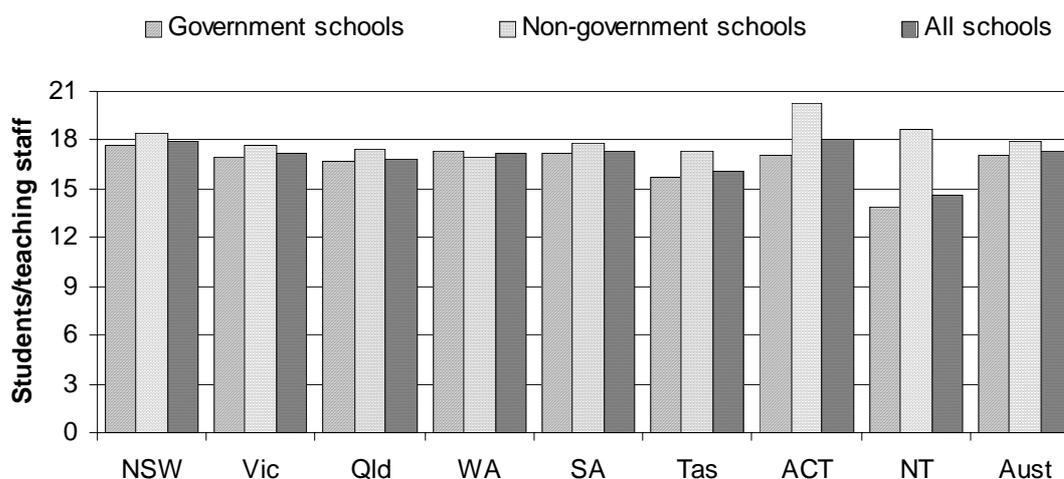
¹ Teaching staff have teaching duties (that is, they are engaged to impart the school curriculum) and spend the majority of their time in contact with students. They support students, either by direct class contact or on an individual basis. Teaching staff include principals, deputy principals and senior teachers mainly involved in administrative duties, but not specialist support staff (who may spend the majority of their time in contact with students but are not engaged to impart the school curriculum). Rather, the latter provide benefits to students or teaching staff in the development of the school curriculum. Full time equivalent students are defined as the sum of full time students and full time equivalent part time secondary students.

Interpretation of student-to-teacher ratios is usually accompanied by assumptions about efficiency and quality.

- A high ratio could indicate an efficient school system, because desired outputs are produced with a small number of inputs. However, lower inputs per unit of output indicate efficiency only when output units and outcomes are the same across all systems being compared. It is not possible to determine how changes in teaching staff numbers influence school outcomes until better indicators of those outcomes are available. There is no clear agreement in international literature that smaller class sizes necessarily improve outcomes.
- A low ratio could indicate a higher quality education system, if it is assumed that teachers have more time for each student. The ratio is not an indicator of class size; further, it does not reflect the quality, experience or qualifications of teachers. The ratio is also an aggregate across all subjects and year levels, so does not reflect the fact that a lower ratio may not be so important for certain subjects or year levels. Further, there is no clear agreement in international literature that smaller class sizes necessarily improve outcomes. It will not be possible to determine how different ratios influence quality in Australian schools until better indicators of school outcomes are available.

For primary schools in both government and non-government sectors combined, the ACT had the highest (18.0) student-to-teacher ratio and the NT had the lowest (14.6) (figure 3.13).

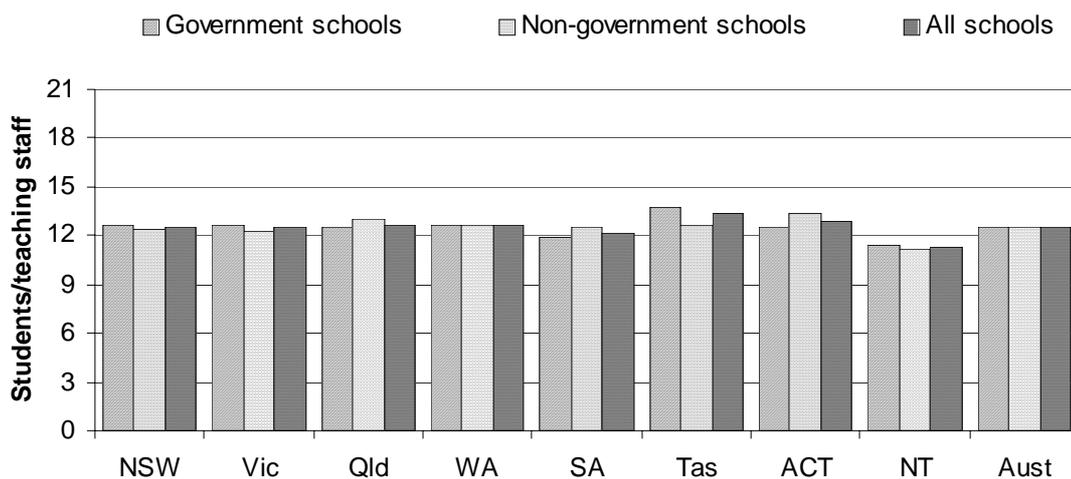
Figure 3.13 Ratio of full time equivalent students to full time equivalent teaching staff, primary schools, 2000



Source: table 3A.6.

For secondary schools in both government and non-government sectors combined, Tasmania had the most students per teacher in 2000 (13.4) and the NT had the least (11.3) (figure 3.14).

Figure 3.14 **Ratio of full time equivalent students to full time equivalent teaching staff, secondary schools, 2000**



Source: table 3A.6.

Student-to-non-teaching, in-school staff ratio²

The ratio of full time equivalent students to full time equivalent non-teaching, in-school staff needs to be interpreted with care because it can be affected by:

- the amount of administrative work undertaken by staff nominally classified as teachers (such as principals, assistant principals and senior teachers);
- the proportion of administrative work undertaken outside the school (because administrative tasks such as personnel management are centralised in some jurisdictions but undertaken at the school level in others);
- the extent to which technology is applied to teaching, learning and school administration;
- the extent to which there are support staff in the class room setting; and
- the degree to which schools contract out services.

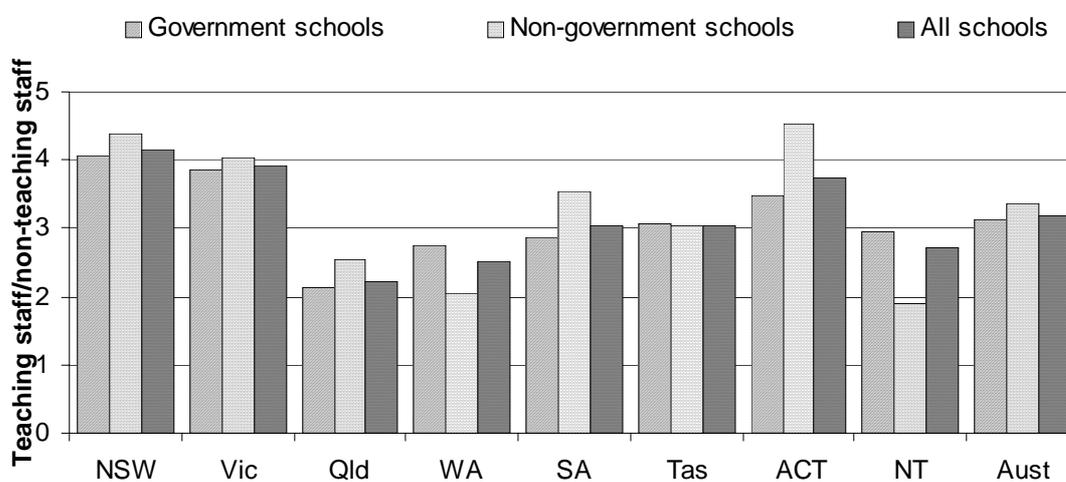
² Non-teaching staff include administrative and clerical staff (teacher aides and assistants who perform functions that are of benefit to students and teaching staff, including assisting in the development of school curriculum); building operations, general maintenance and other staff; and special support staff. In-school staff include staff who spend more than half their time actively engaged in duties in one or more schools.

For all schools, the ratio of students to non-teaching, in-school staff in 2000 ranged from 62.4 in NSW to 34.9 in Queensland (table 3A.6).

Teaching staff-to-non-teaching staff ratio

For primary schools in both government and non-government sectors combined, NSW had the most number of teachers per non-teaching staff (4.1) and Queensland had the least (2.2) (figure 3.15).

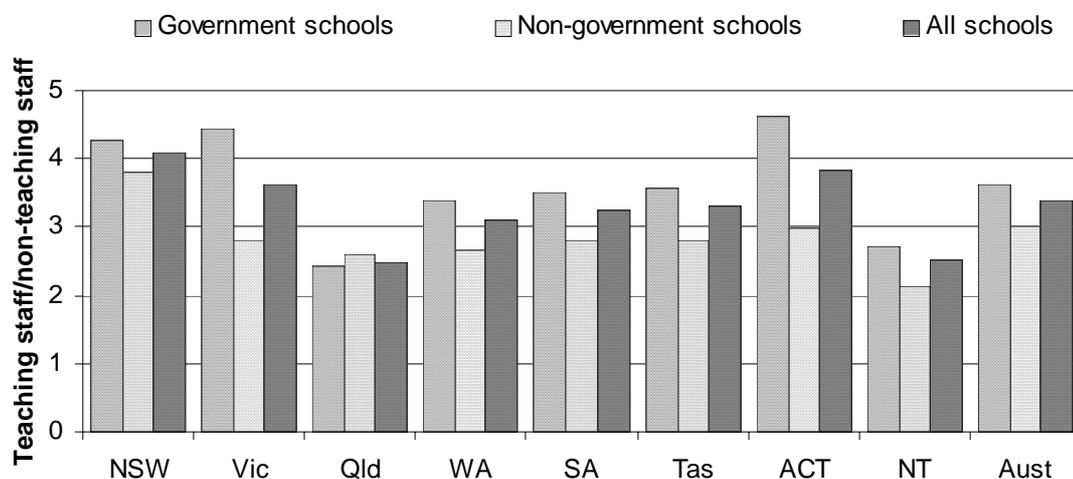
Figure 3.15 Ratio of teaching staff to non-teaching, in-school staff, primary schools, 2000



Source: table 3A.7.

For secondary schools in both government and non-government sectors combined, NSW had the highest ratio on 2000 (4.1) and Queensland and the NT had the lowest (2.5) (figure 3.16).

Figure 3.16 **Ratio of teaching staff to non-teaching, in-school staff, secondary schools, 2000**



Source: table 3A.7.

3.5 Future directions in performance reporting

Retention and participation rates

It is important that any measure of the extent to which students progress through the post-compulsory education system captures the impact of the significant changes that are occurring in the Australian education system. The participation and apparent retention rates reported in this Report may not reflect changes such as increased part time enrolments and moves to undertake post-compulsory schooling in TAFE institutes. During 2002, other measures, including new measures of participation and attainment developed by MCEETYA, will be examined.

Nationally comparable reporting of learning outcomes

The National Education Performance Monitoring Taskforce, under the auspices of MCEETYA, coordinated the development of definitions for, and approaches to, collecting nationally comparable data on performance indicators. This additional information will align with the performance indicator framework. While the taskforce completed its work at the end of 2001, the work will continue under a new taskforce, the Performance Measurement and Reporting Taskforce (PMRT), established by MCEETYA.

Nationally consistent definitions

Collecting nationally comparable data depends on, among other factors, nationally consistent definitions of groups against which educational achievement and outcomes can be reported. To date, education ministers have:

- endorsed national definitions for sex and Indigenous status; and
- agreed in principle to definitions of socioeconomic status, an approach to the measurement of language background, culture and ethnicity, and an approach to measurement of geographic location.

Progress has also been made towards the development of a common definition of, and approach to, the measurement of outcomes for students with disabilities.

Vocational education and training in schools

Education ministers agreed in July 2001 on key measures for reporting on the performance of vocational education and training (VET) in schools. The PMRT is also developing further measures of attainment in VET in schools. Data are expected to be collected and reported annually from 2003.

Science

Education ministers have agreed in principle to an approach to measuring student knowledge, skills in, and understanding of, science at primary school which involves a sample assessment of year 6 students every two or three years. This agreement is subject to assessment instruments and measures being trialed for consideration by ministers in the second half of 2002, with a view to data starting to be collected and published in 2003.

In 2000, a sample of school students aged 15 years participated in the Organisation for Economic Cooperation and Development Program for International Student Assessment, which provided internationally comparable indicators of student achievement in scientific literacy. Results from this study were published in December 2001.

Information and communications technology

Education ministers have agreed in principle to data collection via an assessment of a national sample of students at two stages of schooling at years 5 or 6 and years 9 or 10, every two or three years. The PMRT will develop assessment instruments and

key performance measures for consideration by ministers in the second half of 2002, with a view to a full assessment cycle taking place no later than 2003.

Civics and citizenship

Ministers have endorsed a process of:

- collecting information on what can be expected of students in late primary and late compulsory schooling;
- developing draft key performance measures to monitor student learning outcomes; and
- trialing these measures to validate them before recommending a full national sample assessment.

A report on the outcomes of the process will be available in late 2001.

Enterprise education

The PMRT will work with the Transition from School Taskforce on developing key performance measures and program measures for vocational learning and enterprise education.

3.6 Jurisdictions' comments

This section provides comments from each jurisdiction on the services covered in this chapter and attachment 3A on the CD-ROM. Appendix A contains detailed statistics and short profiles on each State and Territory, which may assist in interpreting the performance indicators presented in this chapter. The information covers aspects such as age profile, geographic distribution of the population, income levels, education levels, tenure of dwellings and cultural heritage (such as Indigenous and ethnic status).

Commonwealth Government comments

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New Commonwealth funding arrangements for non-government schools were introduced in 2001. Under these arrangements need is assessed according to a measure of the socioeconomic status of a school's community rather than a school's own resource levels.

Under the new arrangements, the lower the socioeconomic status of a school's students, the higher the funding received from the Commonwealth Government. Funding ranges from 13.7 per cent of average government school recurrent costs to 70 per cent, which is 14 per cent higher than the previous maximum funding rate for primary schools.

The Commonwealth has guaranteed that schools will not be financially disadvantaged by the introduction of the new arrangements by guaranteeing maintenance of the 2000 funding levels for those schools that would have received less funding under the socioeconomic measure.

Stronger reporting and accountability arrangements have been introduced for Commonwealth schools funding for the quadrennium 2001–04. Under the *States Grants (Primary and Secondary Education Assistance) Act 2000*, all education authorities are required, as a condition of funding from 2001, to make a commitment to the *National Goals for Schooling in the 21st Century*. Authorities are also called on as a condition of funding to make a commitment to achieve any performance measures, including targets, incorporated in the legislation. These commitments form part of the funding agreements between the Commonwealth and each authority.

Performance targets and measures may be determined by the Commonwealth Minister and incorporated into the legislation through regulations, though wherever possible national targets and measures would be agreed by State and Commonwealth education ministers through MCEETYA. Reporting takes place through the *Annual National Report on Schooling in Australia* (the ANR).

The first targets, now incorporated in the Act through regulations, are that all year 3 students will meet the national benchmarks in reading, writing, spelling and in numeracy each year.

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New South Wales Government comments

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There were many highlights in 2000 as a consequence of the substantial involvement of the Department of Education and Training in Olympic and Paralympic Games-related events. Around 90 000 students from the State's city and country public schools were directly involved in test events such as the Pacific School Games, official venue openings or special Olympic functions in the lead-up to the Olympic and Paralympic Games.

Approximately 6500 students performed in the Opening and Closing Ceremonies of the Olympic and Paralympic Games. Hundreds of teachers acted as trainers, chaperones, backstage production crew and stage management crew at both events.

There was a continued focus on literacy and numeracy through the implementation of the State Literacy and Numeracy Plan with a particular focus in 2000 on the writing aspect of literacy. Through State-wide testing in the Basic Skills Tests (BST) in the primary years and the English Language and Literacy Assessment (ELLA) in the secondary years, the department was able to measure and provide to schools and parents quality student performance data in the key areas of literacy and numeracy. The performance of Aboriginal and Torres Strait Islander (ATSI) students shows that as a group their average gain in Basic Skills Test scores since 1996 matches that of the State as a whole. NSW years 3 and 5 students achieved high levels of performance on the national benchmarks.

Significant progress was made to improve the quality of secondary educational provision by developing new multi-campus colleges that take advantage of partnership opportunities between schools, TAFE and university institutions.

There was continued expansion of opportunities for secondary students to undertake vocational education and training (VET) courses. One in three senior school students studied a VET course as part of the Higher School Certificate. More than 13 000 students were involved in the School-to-Work Program, with significant expansion planned for 2001 on the basis of the program's success. This program focuses on the needs of students as they prepare to make the transition from school to further education, training or employment.

In 2001–02 the Government will continue to build for the future through record expenditure on quality education and training. Total recurrent and capital funding for schools is \$6 billion, up 6.2 per cent on last year's budget. There will be a major commitment to improving education facilities through increased funding for capital works and school maintenance.

Administrative costs in NSW remain among the lowest in Australia.

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Victorian Government comments

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The aim of school education is for all students to leave school literate, numerate and socially skilled, and progress to further education and employment. To achieve this, the Government recognises the importance of a robust, well-resourced public education and training system linked to social and economic development goals. To this end, the 2000-01 State Budget allocated an additional \$258 million to schools for the 2001 school year. A further \$654 million was allocated to promote excellence and innovation in government school education in the 2001-02 State Budget brought down in May 2001.

The Government's goals are quantified in three crucial targets, namely: by 2005 Victorian primary students will be at or above the national benchmarks for reading, writing and numeracy; by 2010 90 per cent of young people will complete year 12 or its equivalent; and by 2005 there will be a 6 per cent rise in the percentage of young people aged 15–19 in rural and regional Victoria engaged in education and training.

Significant progress towards the achievement of the first target has already been made, with 93.0 per cent of Victorian students at year 3 in 2000 performing at or above the national benchmarks in reading. Initiatives in early years numeracy will lift numeracy learning in government primary schools to the same high standards attained through the literacy program.

Victoria's apparent retention rate for the year 2000 for students from years 7 to 12 was 77.2 per cent, which was above the national average of 72.3 per cent. Similarly, the level of participation in schooling of 15–19 year olds was higher than the national average and the highest of any State or Territory (except the ACT). Together with the further growth in the number of students participating in the VET in Schools program and additional places for apprentices, these indicators, although not actually measuring completion rates, signal the positive progress the Government is making towards achieving its completion target.

Initiatives implemented to support the third target include the Managed Individual Pathways program, which aims to provide one-to-one support for students in the post-compulsory years, Local Learning and Employment Networks (LLENS) and Precincts. The LLENS bring together all relevant providers and employer representatives at the local level in order to maximise employment and training outcomes for students. Precincts will provide broad options and alternative pathways for students.

In terms of assistance for students with special needs, the Victorian Government has supported over 100 locally based projects through regional Koorie educational committees. Additionally, in 2001 approximately \$25.3 million was allocated to primary and secondary schools for the provision of English as a Second Language programs and 237.3 full time equivalent multicultural aides were allocated across all sectors of the school system. Funding is also provided through the School Global Budget for students with special learning needs with an additional \$35 million being committed over four years.

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Queensland Government comments

“ Education Queensland’s vision is for all Queensland students to become active citizens in a learning society: the Smart State.

In April 2000, Queensland State Education – 2010 was adopted by Government as the strategic response to the broad economic and social change. The strategy is based on research undertaken in Queensland and reflects the views about the future expressed by people involved in public education in Queensland. The purpose of education in Queensland is to create a safe, tolerant and disciplined environment within which young people prepare to be active and reflective Australian citizens with a disposition to lifelong learning. They will be able to participate in and shape community, economic and political life in Queensland and the nation. They will be able to engage confidently with other cultures at home and abroad

The first stage initiatives for implementing Queensland State Education – 2010 have commenced. The Secondary Schools Renewal Program, a \$114 million, three-year commitment, will reinvigorate secondary school as part of the move towards establishing distinctive State schools. The New Basics, a new approach to teaching and learning that focuses on essential areas of learning, is being trialled in 38 schools.

Strategies to maximise student learning continue to be implemented. Learning Technology grants totalling more than \$22 million were provided to schools for maintenance and purchase of computers, training and software. A comprehensive review of literacy teaching in Queensland state schools was conducted and the report launched in November. It complements and builds on the already significant achievements of schools in improving literacy standards.

Interest in vocational subjects continued to grow, broadening the career opportunities of all students, especially those who might leave school early. In 2000, 61 per cent of students in State secondary schools were studying at least one vocational subject. More than 2200 students combined schoolwork with an apprenticeship.

Confidence in public schools is an important indicator as to whether schools are providing what the public want. The majority of parents rated their school a good school and indicated satisfaction with their child’s progress at school. The demand for school places continues to increase as a result of Queensland’s high population growth rate, which has tapered but remains the highest in the country, at 1.6 per cent after account is taken of interstate movements.

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Western Australian Government comments

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Following the State election in February 2001, the new Minister for Education made clear the Government's view of the importance of school education and its determination to introduce a range of reforms to ensure that public schools offered a world-class education to all Western Australians, with the following objectives:

- students who are more literate and numerate;
- students who stay at school longer;
- students and staff who enjoy better learning environments;
- students who learn from teachers who know how best they learn;
- teachers who are held in respect by the community; and
- students who are able to use quality information technology to learn about their world.

This determination to improve the image and quality of government schooling was demonstrated by the Minister's decision to establish an immediate review of the provision of resources and services to government schools. Chaired by Professor Alan Robson, Deputy Vice Chancellor of the University of Western Australia, the review made a range of recommendations for achieving these objectives.

The *School Education Act 1999* and Regulations 2000 came into force. They are the most significant legislative changes affecting school education in Western Australia in more than 70 years.

A later starting age for kindergarten students was introduced, creating a new cohort of older students who will be able to undertake thirteen years of education and aligning this State more closely with other Australian jurisdictions, while at the same time improving provisions in early childhood education: from 2001, only children whose fourth birthday falls on or before 30 June are eligible to enter K programs. Western Australia is the only State that provides universal access to government-funded kindergarten and pre-primary programs

In August 2001, 70.2 per cent of all school students in Western Australia attended government schools. There were 252 784 students, compared with 261 286 in August 2000: 28 488 kindergarten and pre-primary, 142 527 primary and 81 769 secondary. The one-off reduction in enrolments was due to this change to the age of entry to kindergarten.

Schools continued to progress successfully through the Curriculum Improvement Program (CIP), which involves implementation of the Curriculum Framework by 2004 and implementation of the Outcomes and Standards Framework, of which the Student Outcome Statements are the major part, by 2005.

There were 19 200 computers in primary schools (one per eight students) and 15 100 in secondary schools (one per five students).

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South Australian Government comments



The Department of Education, Training and Employment provides for a range of services including children's services, education (preschools and schools), vocational education and training, youth and employment. At the end of 2000 the department employed 14 545 teachers in government schools of which 88.8 per cent were permanent employees with 11.2 per cent having temporary employment status.

During 2000, Partnerships 21, a local management model specific to South Australia, was implemented in government schools and preschools on a voluntary basis. By the end of the year it featured in approximately 75 per cent of schools and preschools.

The South Australian Curriculum, Standards and Accountability framework, which provides for curriculum continuity and reporting against standards from birth to year 12, was launched in November 2000. It is organised around eight learning areas in which essential learnings, equity cross-curriculum perspectives and enterprise and vocational education are interwoven. The four bands for the early, primary, middle and senior years, describe the curriculum scope and standards for learners in each group.

The Literacy and Numeracy Strategy 2000–2005 was launched in October to support improved literacy and numeracy outcomes for all students, in the early to post compulsory years. In 2000 a total of 12 677 year 3 students and 12 828 year 5 students participated in the Basic Skills Test in aspects of literacy and numeracy. This represented a steady rise from 81 per cent when the test started in 1995 to 98 per cent in 2000. The marked growth from 1998 to 1999 (up by 6 per cent) was maintained in year 3 literacy, this was also reflected in the year 5 Aboriginal students literacy performance. International student enrolments in secondary schools continued their upward rise throughout 2000 with the total figure for term 4 being 438 students, a 62 per cent increase on 1999 figures.

Improved pathways for young people to undertake education and training are supported by the Vocational Education in Schools Strategy. VET in Schools provides parity of esteem for vocational education and accredited courses of study, enabling young people undertaking VET to have their course included in their TER. School-to-work transitions for young people at the local level were supported through the establishment of 19 regional partnerships across South Australia. A total of \$10 million was approved through the strategy for disbursement over a three-year period for Regional Networks.

The new Education Development Centre, a \$12.8 million State initiative, commenced operations in 2000 to provide the latest technology and professional training and development. The Technology School of the Future, on site with the Centre, supports seamless learning opportunities for student and adults. A Pathways framework was developed to support staff gaining tertiary accredited qualifications. Educational leadership is supported by the Centre for Leaders through workshops, online programs, tertiary accredited courses and master classes in a range of areas.



Tasmanian Government comments

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The Tasmanian Department of Education is responsible for the provision of public education, vocational education and training, information and library and archive services throughout the State. In addition, it is responsible for the regulation and licensing of child care and provision of policy advice across Government on youth affairs. This allows for development of highly integrated strategies across the delivery of services to children and young people and a focus on developing a culture of lifelong learning.

During 2000 the Minister for Education launched a vision for education, training and information titled Learning Together. This plan contains a vision for the public education, training and information system in Tasmania with underpinning values and goals. It sets out a comprehensive set of initiatives designed to realise the goals with a set of indicators that will be used to measure progress towards the stated goals. Two major areas for action within the plan were a comprehensive review of the Tasmanian school curriculum and the continuing development of strategies to enhance the use of ICT in teaching and learning.

The process of curriculum review has been initiated through a comprehensive Curriculum Consultation. A broad consultation process was established engaging many individuals and groups in the discussion of what the Tasmanian school system stands for. The outcome, a Statement of Values and Purposes, was launched in December 2000. This statement made clear the values that should underpin the provision of education and the purposes that should be served by our learning and curriculum frameworks. It established a platform of belief that will significantly affect decisions about content, teaching and assessment.

The continuing development of ICT in teaching and learning was strengthened through the establishment of a Centre of Excellence in Online Learning. The Centre of Excellence in Online Learning has a key role in leading and supporting the development of online learning throughout the State. Services provided by the Centre include:

- provision of professional learning relating to the application of ICT to teaching and learning;
- promotion of online learning as a teaching and learning tool and the increasing provision of on-line learning;
- the development of a network of Innovation Schools throughout the State to develop innovative practices in the integration of online services and online learning modules into classroom practice;
- development of research programs focused on ICT in teaching and learning; and
- the coordination and facilitation of the development of online learning materials and services.

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Australian Capital Territory Government comments



The ACT Department of Education and Community Services is responsible for school and vocational education, children's, family, youth, sport and recreational services. The provision of government school education is part of the seamless provision of services to children and youth in the ACT.

A significant development was the implementation of a professional appraisal program for principals, to align professional performance with system and school strategic directions, within an accountability and continuous improvement framework.

The High Schools for the New Millennium Project is now in its second year. The three year project is addressing the needs and priorities for a new generation of ACT public high schools.

Drug education remains a high priority. Partnerships with parents/carers and community organisations continue to be strengthened through the Drug Education Framework for ACT Government Schools (1999), the National School Drug Education Strategy (1999), the Drug Education Project for School Communities in the ACT and Local School Community Drug Summits.

The department has achieved stronger connection with the Indigenous community following two Indigenous Education Forums in August 2000. The forums initiated the development of an Indigenous Compact between the department and the ACT Aboriginal and Torres Strait Islander community. The compact aims to improve education outcomes for Aboriginal and Torres Strait Islander students. An Indigenous teacher has joined the Literacy and Numeracy Team to assist teachers in continuing to improve the performance of Indigenous students in the early years of schooling. The Consultation Draft Strategic Plan 2001–04 Services to Indigenous People, released in April 2001, outlines the department's commitment to improving services and outcomes for Indigenous children, young people and their families.

Information technology continues to be a high priority for the department. The appointment of the Chief Information Officer has provided strategic vision and direction for the next phase of IT development. This direction includes access to the corporate intranet by all staff at work and at home.

Work commenced on: the ACT Government Schools Plan 2002–04 to provide the department with a cohesive framework to improve services and outcomes for all students in ACT government schools; and Within Reach of Us All: Action Plan for the Achievement of Educational Success for All Students 2002–04, a framework for all students to complete a meaningful education to the end of year 12.



Northern Territory Government comments

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The Northern Territory Department of Education continues to focus on the particular needs of a vastly distributed student population, including the unique needs of Indigenous students. The department has identified as a particular focus, the provision of educational services to secondary aged Indigenous students. The NT has 1022 secondary aged Indigenous students enrolled in schools other than secondary schools. In the year 2000 the Northern Territory recorded 33 258 full time equivalent enrolments in government schools. This continues to be the highest proportion of students enrolled in government schools in Australia, with no indications that this proportion will change significantly in the near future. The NT has 79 per cent of students in government schools compared to a national average of 69 per cent. In primary school 42 per cent of our student population is Indigenous.

The NT continues to face significant challenges delivering educational services to Indigenous students and non-indigenous students in remote locations. These challenges are being met in part through the use of information and communication technology and the development of a new curriculum framework.

The Learning and Technology in Schools (LATIS) program aims to bring to all Territory schools a minimum standard of connectivity and with reasonable access to the world wide web. The program has provided information and communication technology infrastructure to schools, where in many cases it may not have been available. This technology brings with it significant opportunities to ‘add value’ to the educational process both educationally and administratively. Students attending remotely located schools make up 26.7 per cent of all students —government and non-government — in the NT. These students attend 54 per cent of our schools. Small, remote schools are a feature of the NT educational landscape. LATIS as a program aims to reduce the divide between technology rich and poor locations, by providing equipment and training enabling a standard level of access to information technology and internet connection.

Along with the LATIS program the Northern Territory has made significant progress in developing an NT outcomes focused curriculum framework to enable better reporting of student outcomes and to guide teacher programming.

Improving national benchmark achievement levels continues to be a priority target for the NT. In 2000, 81 per cent the Territory’s year 3 non-Indigenous students and 26 per cent of the Indigenous students at the year 3 level achieved the national benchmark for reading. For year 5, 86 per cent of the non-Indigenous students and 34 per cent of the Indigenous students achieved the national benchmark for reading.

For mathematics, 95 per cent of the Territory’s non-Indigenous year 3 students and 48 per cent of the year 3 level Indigenous students achieved the national benchmark. At the year 5 level, 89 per cent of the non-Indigenous students and 37 per cent of the Indigenous students achieved the national benchmark for mathematics.”

3.7 Definitions

Data for this chapter were sourced from *Schools Australia* (ABS 2001a), the *National Schools Statistics Collection* (MCEETYA 2001b), unpublished Commonwealth, State and Territory governments data, and unpublished DETYA data. More information on definitions and explanatory notes can be found in *National Schools Statistics Collection (Government Schools Sector) Notes Instructions and Tabulations 2000* (ABS 2001b).

Table 3.9 **Terms**

<i>Term</i>	<i>Definition</i>
Apparent retention rates	The percentage of full time students who continued to year 12 in 2000 from respective cohort groups at year 10. The rate is calculated by dividing the total number of full time students in year 12 in 2000 by the sum of full time students in year 10 in 1998.
Average expenditure per full time equivalent student	Total expenditure (excluding capital charges) divided by the total number of full time equivalent students. It is based on the <i>National School Statistics Collection</i> definitions (MCEETYA 2001b). Expenditure figures are in financial years and student numbers are in calendar years, so the total number of students is taken as the average of two years. When calculating 1999-2000 average expenditure per student, for example, the total expenditure figure is at 1999-2000 but the total student number figure is the average of student numbers from 1999 and 2000.
Full time equivalent student	The full time equivalent of a full time student is 1.0. The method of converting part time student numbers into full time equivalents should be based on the student's workload compared with the workload usually undertaken by a full time student.
Full time student	A person who satisfies the definition of a student and undertakes a workload equivalent to, or greater than, that usually undertaken by a student of that year level. The definition of full time student varies across jurisdictions.
Indigenous student	A student of Aboriginal or Torres Strait Islander origin who identifies as an Aboriginal or Torres Strait Islander or as being from an Aboriginal and Torres Strait Islander background. Administrative processes for determining Indigenous status varies across jurisdictions.
Language background other than English (LBOTE)	Administrative processes for determining LBOTE status varies across jurisdictions.

(Continued on next page)

Table 3.9 (Continued)

<i>Term</i>	<i>Definition</i>
Locality	<p>Where a school is located (either in a metropolitan or nonmetropolitan area) based on the jurisdiction's own definitions/classifications. In this Report, the definitions are:</p> <ul style="list-style-type: none"> • capital city, as defined by the former Department of Primary Industry and Energy (DPIE); • other metropolitan as defined by the former DPIE; • rural centres (the summation of large and small rural centres), as defined by the former DPIE; and • other rural and remote centres (the summation of other rural areas, remote centres and other remote areas), as defined by the former DPIE. <p>Further classifications are: capital city and other metropolitan as urban; large rural centres, small rural centres and other rural as rural; and other remote as remote.</p> <p>Metropolitan may be defined as capital city and other metropolitan, while nonmetropolitan may be defined as rural centres and other rural and remote areas.</p> <ul style="list-style-type: none"> • Capital cities consists of State and Territory capital city statistical divisions. • Other metropolitan centres consist of one or more statistical subdivisions that have an urban centre of population of 100 000 or more. • Large rural centres are statistical local areas where most of the population resides in urban centres of population of 25 000 or more. • Small rural centre are statistical local areas in rural zones that contain urban centres of population of between 10 000 and 24 999. • Other rural areas are the remaining statistical local areas within the rural zone. • Remote centres are statistical local areas in the remote zone that contain urban centres of population of 5000 or more. • Other remote areas are the remaining statistical local areas within the remote zone.
Part time student	A student undertaking a workload that is less than that specified as being full time in their jurisdiction.
Participation (15–19 years)	Number of full time students of a particular age and sex, expressed as a proportion in government schools of a particular age group, multiplied by the published participation rate for all schools of that particular age group.
Potential year 12 population	An estimate of a single year age group which could have participated in year 12 that year, defined as: the estimated resident population aged 15–19 years divided by 5.
Real expenditure	Nominal expenditure adjusted for changes in prices, using the GDP(E) price deflator and expressed in terms of final year prices.
Socioeconomic status	Administrative processes for determining socioeconomic status varies across jurisdictions.

(Continued on next page)

Table 3.9 (Continued)

<i>Term</i>	<i>Definition</i>
Source of income	Income from a level of government as a percentage of total government expenditure. Income in this Report may come from any of the three levels of government: Commonwealth, State and Territory, and local governments. Commonwealth expenditure is derived from specific purpose payments (current and capital) for government schools. This funding indicates the level of monies allocated, not necessarily the level of expenditure incurred in any given financial year. The data provide, therefore, only a broad indication of the level of Commonwealth funding.
Staff	Full time equivalent of staff who are generally active in government schools and ancillary education establishments.
Student-to-staff ratios	Number of full time equivalent students per full time equivalent teaching and non-teaching staff. Students at special schools are allocated to primary and secondary. The full time equivalent of staff includes those who are generally active in government schools and ancillary education establishments.
Student	Full time student only. A student is a person who is formally (officially) enrolled or registered at a school, and who is also active in a primary, secondary or special education program at that school. Students at special schools are allocated to primary and secondary on the basis of age, unless otherwise identified.
Student, primary	Student in primary education, which covers pre-year 1 to year 6 in NSW, Victoria, Tasmania and the ACT, pre-year 1 to year 7 in WA, SA and the NT, and year 1 to year 7 in Queensland.
Student, secondary	Student in secondary education, which commences at year 7 in NSW, Victoria, Tasmania and the ACT, and at year 8 in Queensland, SA, WA and the NT.
Students with disabilities	Students included in the annual system reports to DETYA. The definitions of students with disabilities are based on individual State criteria, so data are not comparable across jurisdictions.

4 Vocational education and training

This chapter focuses on the education and training system that delivers employment related skills. The vocational education and training (VET) system provides Australians with the skills to enter and re-enter the labour force, to retrain for a new job and to upgrade skills for an existing job. It includes publicly and privately funded VET delivered by a wide range of training institutions and enterprises through a number of delivery methods. This chapter reports on VET services that receive government funding — that is, only vocational programs of study, not non-vocational programs (see definitions in table 4.14). The scope of VET in this Report aligns with the annual VET data collected by the National Centre for Vocational Education Research (NCVER). Most of the information is derived from Volume 3 of the Australian National Training Authority's (ANTA) Annual National Report (ANTA 2001).

This chapter covers the provision of VET in publicly owned technical and further education (TAFE) institutes and universities with TAFE divisions, other government and community institutions and publicly funded activity by private registered training organisations. Data on the provision of VET services on a fee-for-service basis by TAFE institutes are also included in the general data collection. Revenue from fees received from individuals and organisations for fee-for-service programs, as well as from Commonwealth programs, such as Adult Migrant English Services, are excluded from recurrent expenditure for unit cost calculations.

This chapter does not cover higher education, although some descriptive information can be found in the Education preface. Vocational education and training services provided in schools fall within the scope of chapter 3 of this Report.

A profile of VET is presented in section 4.1, followed by a brief discussion of recent policy developments in section 4.2. Together, these provide a context for assessing the performance indicators presented later in the chapter (see box 4.1 for a description of some of the common terms used in the chapter). All jurisdictions have agreed to develop and report comparable indicators. A framework of performance indicators is outlined in section 4.3. The indicators are discussed in section 4.4 and future directions in performance reporting are discussed in 4.5. The chapter concludes with jurisdictions' comments in section 4.6 and definitions of terms in section 4.7.

Box 4.1 **Some common VET terms**

nominal hours — supervised: the anticipated hours of supervised learning or training deemed necessary to adequately present the education material associated with the delivery of a training program delivered in standard classroom delivery mode. These hours are generally specified in the curriculum documentation and do not include hours associated with work experience, industry placement or field placement.

course: a structured program of study including, where appropriate, practical experience. A course may lead to a recognised qualification. Where a program is a nationally recognised accredited course, the term 'course' is used; where a program is designed to lead to a qualification in a national training package, the term 'qualification' is used. See table 4.18 for the definition of qualification.

module: a unit of training in which a student can enrol and be assessed.

module completers: identified in the 2000 Student Outcomes Survey (NCVER 2000) as a student who is not a graduate and who successfully completed some training in a vocational program of study at a TAFE institute in Australia in 2000 and then left the TAFE system. Students who did not have an Australian address were excluded from the survey.

unit of competency: the basic unit in the competency standards framework. A unit of competency is the smallest component that can be assessed and recognised in the VET system.

training package: a package of industry competency standards, guidelines for assessment and qualifications that result from successful assessment, and sometimes training and assessment resources. As they are developed, training packages are becoming the basis for all government funded training. New apprenticeships are based on training packages. An integrated set of nationally endorsed standards, guidelines and qualifications for training, assessing and recognising people's skills have been developed by industry to meet the training needs of an industry or group of industries. Training packages consist of endorsed competency standards, assessment guidelines and qualifications, and optional non-endorsed support materials, such as learning strategies, assessment resources and professional development materials.

Source: ANTA (2001).

Supporting tables

Supporting tables for chapter 4 are provided on the CD-ROM enclosed with the Report. The files are provided in *Microsoft Excel 97* format as \Publications\Reports\2002\Attach4A.xls and in Adobe PDF format as \Publications\Reports\2002\Attach4A.pdf.

Supporting tables are identified in references throughout this chapter by an 'A' suffix (for example, table 4A.3 is table 3 in the electronic files). They may be subject to revision. The most up-to-date versions of these files can be found on the

Review's web page (www.pc.gov.au/gsp). Users without Internet access can contact the Secretariat to obtain up-to-date versions of these tables (see details on the inside front cover of the Report).

4.1 Profile of vocational education and training

Service overview

The general roles of the system and the main reasons that students participate in VET programs are to:

- develop skills, including general education skills such as literacy and numeracy, that enhance ability to enter the labour force;
- retrain or update labour force skills; and
- provide a pathway to further tertiary education, including entrance to higher education.

In any dynamic economy there will be some mismatch between skills demanded by employers and those possessed by people looking for work. Some employers in Australia in the second half of 2000 found it difficult to fill employment vacancies in a recognised occupation or specialisation at the existing level of remuneration and conditions of employment, including location (box 4.2). A perfect match is never possible and many factors (including working conditions, career choices, industry profile and employer attitudes) influence both the supply of, and demand for, skills at regional, State and Territory and national levels.

Box 4.2 National skill shortage list (second half of 2000)

The Department of Employment, Workplace Relations and Small Business (DEWRSB) compiles a list of skill shortages at the national level. There may be regional skill shortages that are not reflected in this list.

Professionals

Accountant
Child care coordinator
Computing professional
Electronics engineer
Registered nurses

Associate professionals

Chef (selected Asian cuisines such as Indian, Japanese and regional Chinese)

Tradespersons

Metal machinist	Toolmaker	Metal fitter
Welder	Sheetmetal worker	Motor mechanic
Automotive electrician	Panel beater	Vehicle painter
Furniture upholsterer	Pastry cook	Hairdresser
	Cook	
	Refrigeration and air-conditioning mechanic	

Source: DEWRSB (2001).

Diversity of the VET system

The VET system involves the interaction of employers, Commonwealth, State, Territory and local governments (as both purchasers and providers) and an increasing number of specialist private registered training organisations. The system provides a diverse range of programs and qualification levels, with course durations varying from a module (a stand-alone course component or subject) of a few hours to full courses of up to four years (box 4.3).

Box 4.3 Diversity of the VET system

The levels of training range from a single module or unit of competency (which can involve fewer than 10 contact hours) to advanced diplomas (which can involve up to four years of full time study). All training levels in the VET system need to be assessed because many students complete modules or units of competency (which do not provide a course award) without intending to complete a course.

The types of training range from formal classroom learning to workplace based learning and may include flexible, self paced learning and/or online training. The availability of distance education has increased with off-campus options, such as correspondence, Internet study and interactive teleconferencing.

The types of training institution range from institutions specialising in VET delivery (such as publicly owned TAFE institutes and agricultural colleges, private registered training organisations and adult and community education providers) to secondary schools and universities. These institutions have started to provide dual award courses that combine traditional studies with VET, with an award from both the VET provider and the secondary school or university. In addition to specialist institutions, employers in the workplace deliver much informal on-the-job training that does not lead to a qualification.

Funding

Total recurrent expenditure on VET by governments in 2000 totalled \$3.3 billion, a real increase of 0.6 per cent from 1999 (table 4A.1). Government recurrent VET expenditure excludes revenue from fees recovered from individuals and organisations for fee-for-service programs, ancillary trading revenue, other operating revenue and revenue from Commonwealth specific purpose funds. Accrual expenditure data are available from 1997 to 2000. Recurrent government VET expenditure per person aged 15–64 years ranged from \$508.2 in the NT to \$219.8 in Victoria in 2000. Expenditure per person in NSW, WA, the ACT and the NT was higher than the national average (table 4A.2).

Size and scope

The VET system is an integral part of Australia's education system. It plays an important role in providing and updating the skills of the labour force. The target population for VET is people aged 15–64 years and this group is used in this chapter for per person comparisons across jurisdictions where possible. There were 4.7 million people in the labour force aged 15–64 years with recognised post-school qualifications in 2000 (of which 4.5 million were employed representing 51.1 per cent of employed people aged 15–64 years). In the labour force, 13.4 per cent of

people had a skilled vocational qualification as their highest qualification and 8.8 per cent had a basic vocational qualification (ABS 2000).

Over 1.7 million people participated in publicly funded and/or provided VET programs in 2000 (up by 102 200 students or 6.2 per cent from the 1999 level), comprising about 12.1 per cent of the Australian population aged 15–64 years (ANTA 2001).

Over 346.1 million hours of VET programs were publicly funded or delivered on a fee-for-service basis by public providers in 2000, ranging from 118.4 million hours in NSW to 4.8 million hours in the NT (table 4A.3). This represents an increase of 4.5 per cent from 1999. The number of annual hours delivered per student ranged from 316.4 in the ACT to 167.3 in SA. The national average was 197.9 hours per student, compared to 201 in 1999. These programs were delivered by 86 public training institutions, 1139 community based providers and 3388 publicly funded private registered training organisations (NCVER 2001a, 2001c).

State and Territory TAFE institutes and universities with TAFE divisions provide the majority of publicly funded VET services, delivering approximately 84.1 per cent of all VET hours in 2000 (compared with about 84.6 per cent in 1999). Adult and community education providers and private registered training organisations delivered the remaining 15.9 per cent of VET hours in 2000 (compared with about 15.4 per cent in 1999) (NCVER 2001a).

The infrastructure (net assets) of government owned TAFE institutes and universities with TAFE divisions was worth over \$5.7 billion at 31 December 2000, of which 90.9 per cent comprised the value of land and buildings (NCVER 2001b). The value of these assets per person aged 15–64 years varied across jurisdictions, ranging from \$871.4 in the NT to \$353.7 in Queensland (table 4A.4).

Students studying in rural and remote locations

The proportion of students studying in rural and remote locations varied across jurisdictions in 2000. The proportion of students studying in rural locations ranged from 58.2 per cent in Tasmania to none in the ACT, while the proportion in remote locations ranged from 54.9 per cent in the NT to less than 1 per cent of students in NSW and Victoria (table 4A.3).

Roles and responsibilities

The national VET system is a cooperative arrangement between Commonwealth, State and Territory governments, State training boards, industry (represented by

Industry Training Advisory Bodies) and service providers. Different bodies may provide services, funds, advice and decisions (figure 4.1). State and Territory governments play dual roles as both purchasers of VET services (from private and community providers) and direct providers of services (through TAFE institutes and universities with TAFE divisions). In addition, each State and Territory government is responsible for administering its training system, setting fees and determining exemption, concession and loan arrangements for students.

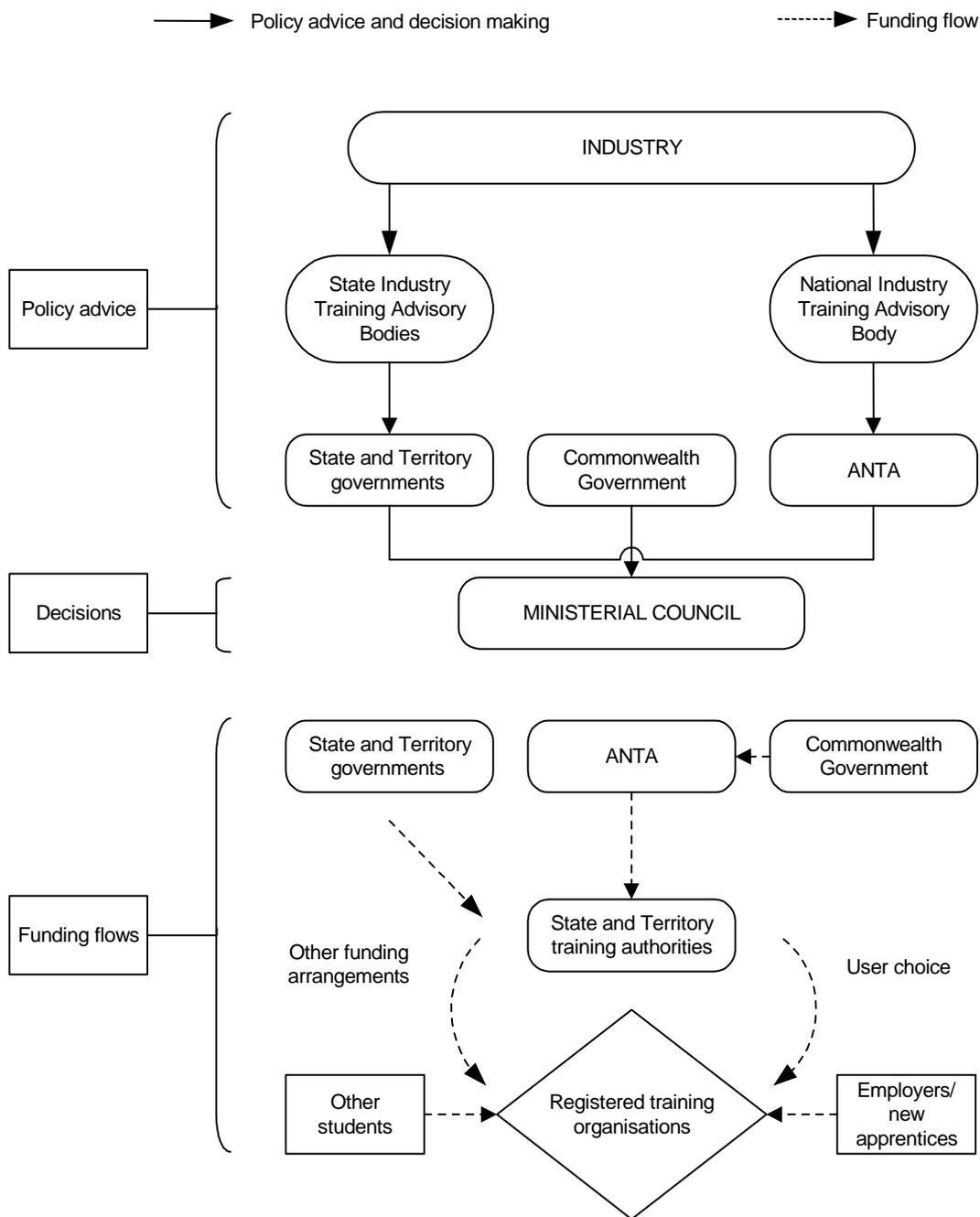
Public VET funding comes from Commonwealth, State and Territory governments. State and Territory governments provided 73.1 per cent of recurrent funding in 2000 while the Commonwealth provided the remainder (NCVER 2001b). These proportions are the same as those in 1999.

The proportion of government funding allocated to private and adult community providers varied across jurisdictions — Queensland had the highest proportion in 2000 (9.1 per cent) and NSW the lowest (4.4 per cent) (table 4A.5).

Allocation of VET funding

The majority of government VET funds are allocated to major public providers based on the planned activity of State and Territory training authorities (which plan the amount of annual curriculum hours to be delivered in each field of study). Competitive tendering was introduced in the early 1990s to allocate \$21 million of additional Commonwealth funds to public and private registered training organisations (HRSCEET 1998).

Figure 4.1 Decisions, advice and funding flows within the VET system



Commonwealth, State and Territory ministers agree to pursue a more effective training market with public and private provision of training as a key objective of the national VET system. This approach is reflected in the ANTA Agreement. In line with this objective, States and Territories have made greater use of competitive funding arrangements, which have increased the provision of publicly funded

training by other providers, including private training providers. Processes used to allocate funds on a competitive basis include:

- *competitive tendering* — where public and private registered training organisations compete for funding contracts from State and Territory training authorities (based on one or more selection criteria) in response to government offers (tenders);
- *user choice* — where the employer and apprentice/trainee choose a registered training provider and negotiate key aspects of their training. Public funds flow to that provider; and
- *preferred supplier arrangements* — an extension of competitive tendering, where a contract is awarded to a provider (chosen by the tender process) to provide training on a longer term basis.

Competitive tendering mechanisms for allocating funds to VET providers are designed to expose the sector to greater competition by facilitating the entry of new providers and the expansion of existing providers. Competitive tendering may also have an effect, either positive or negative, on other dimensions of VET service provision, including quality and access by equity target groups. Some jurisdictions are pursuing efficiency and effectiveness gains through competitive tendering mechanisms.

An estimated \$725.3 million of public VET funding was allocated on a competitive basis in 2000 (including user choice arrangements) — 26.5 per cent more than the amount in 1999 (table 4A.6). The degree of competition in the tendering process varies across jurisdictions. Some funds are potentially available to both public and private registered training organisations (open competitive tendering) whereas some tendering is restricted to either public or private registered training organisations (limited competitive tendering). Similarly, the potential for competition, in terms of the size of the market of potential providers, varies across jurisdictions.

Institutes of TAFE and universities with TAFE divisions may be subject to factors that affect their ability to compete effectively for funding allocated by competitive tendering (box 4.4).

Box 4.4 TAFE institutes and competitive tendering

The House of Representatives Standing Committee on Employment, Education and Training (HRSCEET) argues that the following factors impede the competitive position of TAFE institutes:

- Many publicly owned TAFE institutes and universities with TAFE divisions cannot retain revenue earned from fee-for-service activity;
- Governments set concessional fees but do not necessarily compensate TAFE institutes and universities with TAFE divisions for the revenue lost in meeting this community service obligation;
- Governments set mainstream course fees that may not reflect course costs; and
- Governments require publicly owned TAFE institutes and universities with TAFE divisions to operate in higher cost regional and remote areas.

However, TAFE institutes and universities with TAFE divisions have some competitive advantages over other VET providers. The HRSCEET notes that a main advantage is the size and value of the public infrastructure to which they have access.

Source: HRSCEET (1998).

4.2 Policy developments in vocational education and training

As part of the planning and accountability arrangements for the national VET system, ministers agreed in June 2001 to five annual national priorities for 2002.

- *A quality national training system that provides value for money* — to achieve quality outcomes in a cost effective way which would include the implementation of national training arrangements within the National Training Framework . Quality assurance and risk management processes will underpin the success in this area, while States and Territories will contribute to improvements in national consistency, having regard to their own priorities.
- *Industry commitment to skill development* — to foster a learning culture within enterprises, to increase industry participation and investment in training to add to the existing skill base, and to expand new apprenticeships.
- *Individuals as learners* — to target products and services that meet learner needs, increase opportunities and improve outcomes for targeted groups. There will also be a focus on improving and increasing pathways for VET learners, consistent with the National Training Framework. Pathways in VET include learning opportunities in the workplace as well as off-the-job and VET programs in schools, facilitated using different modes of delivery.

-
- *VET professionalism* — to build the capabilities of VET professional staff.
 - *Support for regional development* — to target skill development to meet the needs of local enterprise, small business and communities.

The five priorities will apply in 2002 under the ANTA Agreement for 2001–2003, endorsed in August 2001.

4.3 Framework of performance indicators

The framework of performance indicators for VET used in this Report (figure 4.2) is built around a set of shared VET objectives (box 4.5). The performance indicators reflect the national VET objectives — for example, participation by target groups indicates the access to and equity of VET outcomes; skill profile is an indicator of the mobility of the labour market; overall employer satisfaction with VET indicates the preparedness of people for work; and recurrent expenditure per annual curriculum hour indicates the extent to which the value of public VET expenditure is maximised.

Box 4.5 Objectives for VET services

Ministers agreed in 1997 on four objectives for VET services:

- to achieve equitable outcomes in VET;
- to enhance mobility in the labour market;
- to equip Australians for the world of work; and
- to maximise the value of public VET expenditure.

A fifth objective — to increase investment in training — was added in early 1998.

Source: ANTA (1998).

Government recurrent expenditure was reported on an accrual basis for the first time in 1998. While the move to accrual reporting represents a break in the series, both accrual and cash data are available for 1997, which will facilitate comparisons over time from 1997. Ongoing work to provide a more comprehensive set of performance indicators and to improve existing indicators and data is discussed in section 4.5.

4.4 Key performance indicator results

Different delivery contexts, locations and types of client may affect the effectiveness and efficiency of VET services. Appendix A contains detailed

statistics and short profiles on each State and Territory, which may help in interpreting the performance indicators presented in this chapter. Figure 4.2 contains a framework for performance indicators.

Access and equity

This section provides data on the extent to which the general population, young people and the ANTA-designated equity target groups have access to, and participate in, the publicly funded VET system. ANTA-designated equity target groups are women, Indigenous people, people with a disability, residents of rural and remote communities and people from non-English speaking backgrounds.

VET participation of the general population

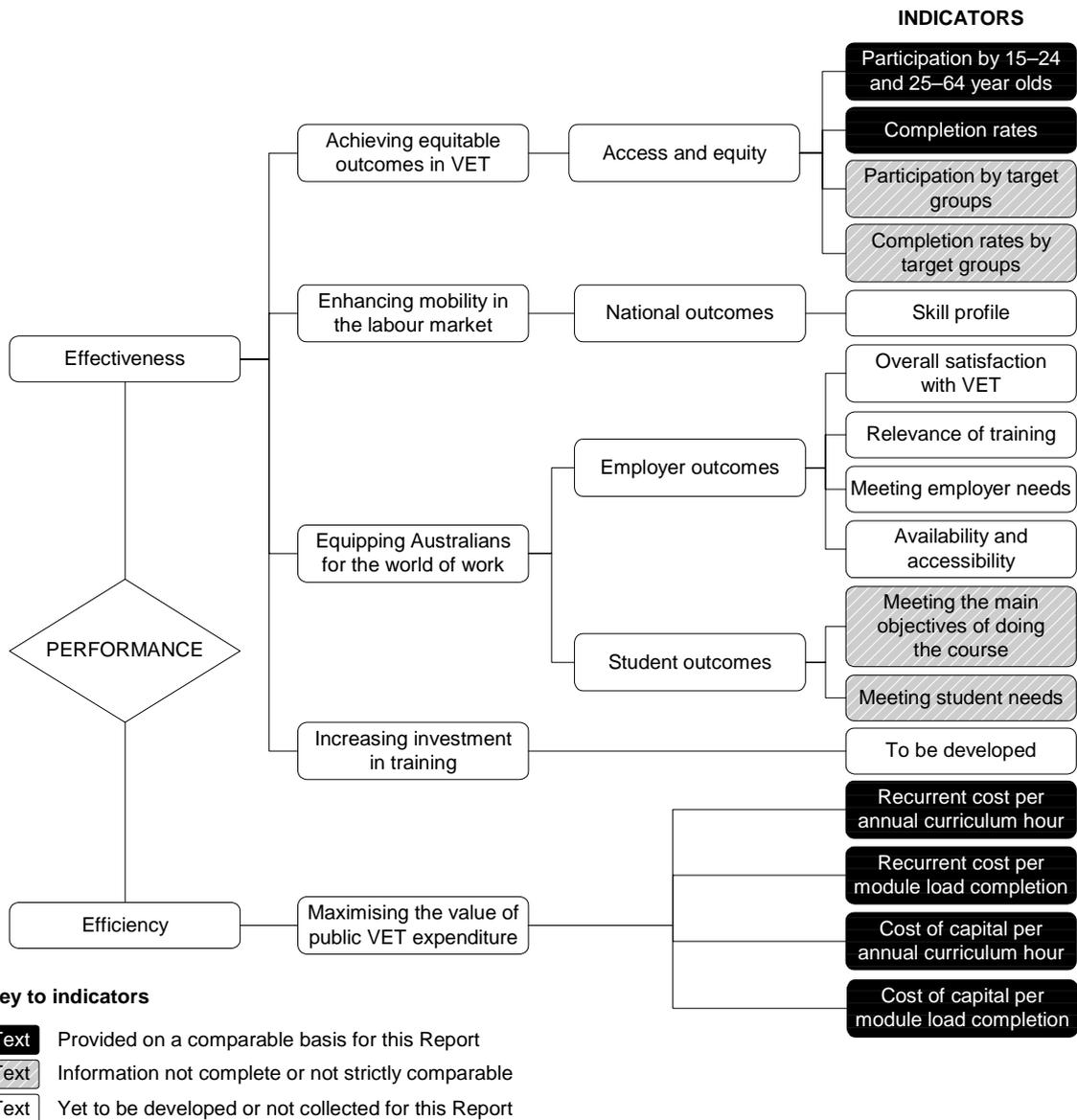
Males represented 50.8 per cent of all VET students in 2000 and females represented 49.2 per cent (NCVER 2001a). The national VET participation rate for people aged 15–64 years was 12.1 per cent in 2000. The NT reported the highest participation rates (14.1 per cent) and the ACT reported the lowest (8.9 per cent). The participation rate was lower for females than for males in all jurisdictions, except NSW and the NT (figure 4.3).

Males aged 15–29 years had higher participation rates than those of their female counterparts, with the reverse being true for the group aged 30–59 years. Males and females of 60–64 years of age had the same participation rates (table 4A.7).

VET participation of young people (15–24 years of age)

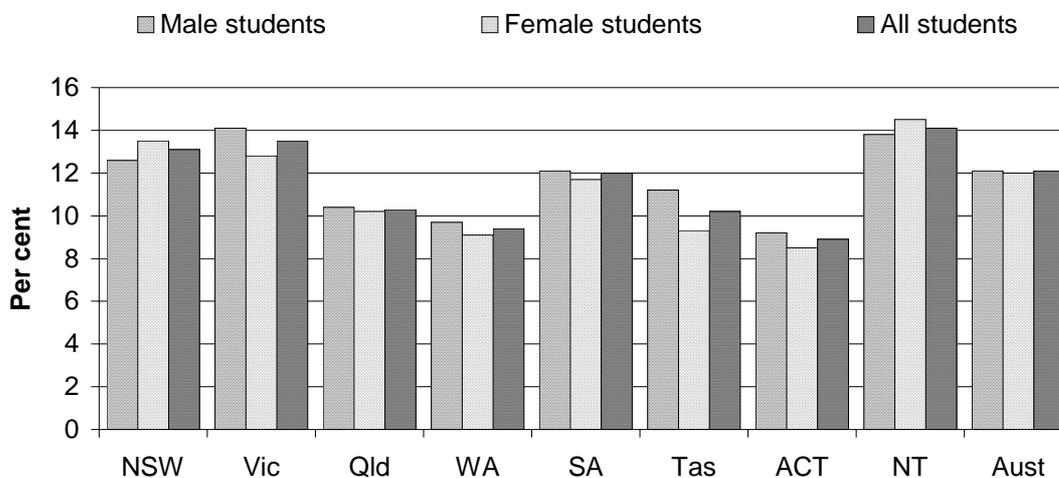
In 2000, 638 100 young people (27.1 per cent of people aged 15–24 years of age) participated in VET (table 4A.7). Traditionally, young males (15–24 years of age) have had a higher participation rate than young females and this pattern continued in 2000. The majority (75.5 per cent) of young people undertook their training at TAFE or other government providers, with the remainder divided between community education and other registered providers (NCVER 2001a).

Figure 4.2 Performance indicators for VET services a, b



^a The depicted relationship between the performance indicators and objectives for VET is imperfect. In some cases, the performance indicators may relate to more than one of the objectives for VET (for example, the indicator, 'Meeting the main objectives of doing the course' also reports on results for target groups that fall under the equity objective, and the access and equity indicators also relate to the objective of enhancing mobility in the labour market). ^b The VET sector has identified total investment in VET as a key performance measure, but this is included as descriptive (not performance) information in this Report.

Figure 4.3 VET participation rates for people aged 15–64 years, 2000



Source: table 4A.8.

Load pass rate for the general population

Load pass rates report the extent to which students pass assessment in an assessable module or unit of competency. Comparisons should be made with care because average module durations and competencies achieved by students vary across jurisdictions. This chapter provides load pass rates (the ratio of students who passed assessment in an assessable module or unit of competency to all students who were assessed and either passed, failed or withdrew) for all students and ANTA-designated equity target groups. The calculation is based on the nominal hours supervised for each assessable module or unit of competency.

Load pass rates in 2000 ranged from 86.9 per cent in SA to 69.2 per cent in the NT. South Australia, Tasmania and the ACT reported rates above the national average of 75.4 per cent. In general, there was little difference in the completion rates of males and females (table 4.1).

Table 4.1 Load pass rates, 2000 (per cent)^a

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust
Male	73.6	73.6	74.4	72.8	86.9	81.6	79.3	71.9	74.9
Female	74.1	76.2	74.9	72.4	87.1	84.2	81.9	66.2	75.8
All people	73.9	74.8	74.6	72.6	86.9	82.8	80.6	69.2	75.4

^a Care needs to be taken in comparing data across jurisdictions because average module durations and competencies achieved by students vary.

Source: table 4A.9.

Participation by target groups

A key national goal of the VET system is to increase opportunities and outcomes for disadvantaged groups. Participation by these groups, compared with their representation in the general population, may reflect the effectiveness of current strategies to achieve this objective. For people with special needs, participation rates need to be interpreted with care because the data generally depended on self identification at the time of enrolment, and non-responses (that is, students who did not indicate whether they had special needs) were both high and varied across jurisdictions. The VET participation rate of people with a disability was below this group's representation in the population in all jurisdictions, although there were high non-response rates for several jurisdictions (table 4A.10).

The national participation rate of people identifying themselves as being born in a non-English speaking country was below this group's representation in the population. Queensland, SA and Tasmania reported a participation rate above this group's representation in the population. The highest non-response rate (31.7 per cent) was reported by WA and the lowest (4.5 per cent) by Tasmania. Given such high non-response rates, care needs to be taken in making comparisons across jurisdictions (table 4.2).

Table 4.2 VET participation by people from a non-English speaking background, 2000 (per cent)

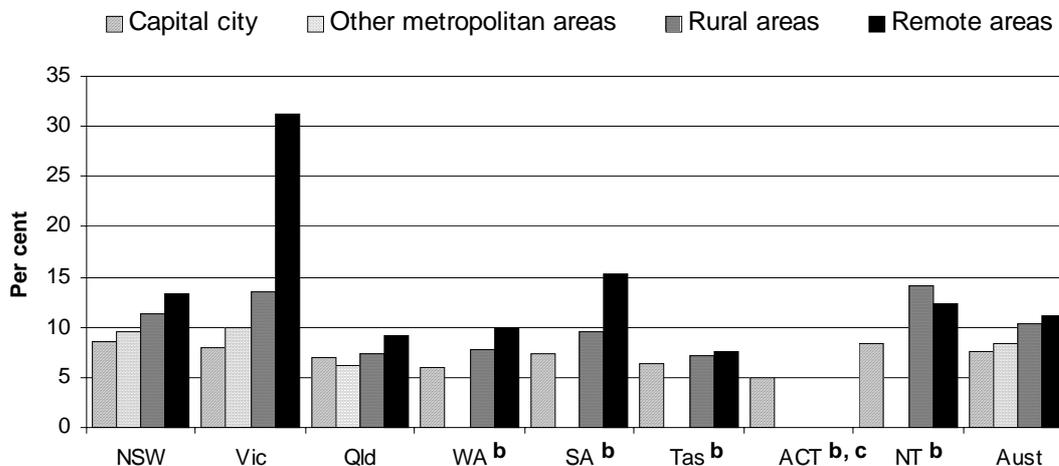
	NSW ^a	Vic	Qld	WA	SA	Tas	ACT	NT	Aust
Students who reported being born in a non-English speaking country	13.2	12.7	8.0	10.2	14.0	4.7	13.4	7.1	11.9
Proportion of population born in a non-English speaking country	15.8	17.1	7.3	11.8	10.6	3.9	13.8	8.1	13.3
Non-response rate ^b	27.0	18.8	11.5	31.7	16.5	4.5	16.5	9.1	21.1

^a The proportion of respondents who did not indicate whether they belong to this client group was higher in 2000 than in previous years. ^b Students who did not indicate the country in which they were born.

Source: table 4A.11.

The participation rate for rural areas was highest in the NT (14.1 per cent) and lowest in Tasmania (7.1 per cent). The participation rate for remote areas was highest in Victoria (31.3 per cent) and lowest in Tasmania (7.6 per cent) (figure 4.4). Interpretation of rural and remote area participation rates should consider both the target population and the proportion of students from these regional areas (table 4A.3 and appendix A).

Figure 4.4 VET participation by region, 2000^a



^a Interpretation of rural and remote participation rates should consider the absolute number of students from these regional areas (table 4A.3 and appendix A). ^b The number of students from other metropolitan areas is too small to calculate meaningful rates. ^c The numbers of students from rural, remote and other metropolitan areas are too small to calculate meaningful rates.

Source: table 4A.12.

The proportion of VET students who identified as Indigenous ranged from 33.6 per cent in the NT to 0.9 per cent in Victoria. The proportion of VET students who identified as Indigenous was greater than the Indigenous representation in the population in all jurisdictions except Tasmania, where the two rates were similar (table 4.3).

Table 4.3 VET participation by Indigenous people, 2000 (per cent)

	NSW ^a	Vic	Qld	WA	SA	Tas	ACT	NT	Aust
Students who reported being Indigenous	2.5	0.9	4.3	5.6	2.7	2.9	1.1	33.6	3.0
Indigenous people as a proportion of total population	1.7	0.5	2.9	3.0	1.4	3.0	1.0	24.4	2.0
Non-response rate ^b	28.2	16.2	12.7	29.0	18.3	10.7	2.1	10.6	20.9

^a The proportion of respondents who did not indicate whether they belonged to this client group was higher in 2000 than in previous years. ^b Students who did not indicate if they were Indigenous.

Source: table 4A.13.

Load pass rates for target groups

The load pass rate for all students was highest in SA (86.9 per cent), which also reported the highest load pass rates for Indigenous students (74.2 per cent), for students from rural and remote areas (91.8 per cent and 88.8 per cent respectively), students with a disability (82.4 per cent) and for students from a non-English

speaking country (82.5 per cent) (table 4.4). Care needs to be taken in comparing rates across jurisdictions because average module duration and competencies achieved by students vary across jurisdictions.

Table 4.4 Load pass rates by target groups, 2000 (per cent)^a

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
All people	73.9	74.8	74.6	72.6	86.9	82.8	80.6	69.2	75.4
Target groups									
Students who reported being Indigenous	58.0	60.3	59.3	54.7	74.2	67.6	73.1	64.0	60.1
Students who reported having a disability	66.2	66.4	65.1	64.4	82.4	69.1	72.2	67.0	67.1
Students who reported being born in a non-English speaking country	71.7	70.8	63.7	67.3	82.5	80.1	75.7	65.1	70.9
Rural area students	74.4	78.6	76.5	75.2	91.8	80.9	–	73.1	77.5
Remote area students	72.4	79.2	75.6	67.7	88.8	81.8	–	65.5	71.3

^a Care needs to be taken in comparing rates across jurisdictions because average module durations and competencies achieved by students vary. – Numbers too small to calculate a meaningful rate.

Source: table 4A.9.

Employer outcomes

Employer satisfaction is an important indicator of the quality of VET services. No new data are available for this indicator and readers should refer to last year's Report for data from the NCVET 1999 Survey of Employer Views on VET. The 2001 survey was not available in time to be included in this Report, however, the data will be included in the 2003 Report. The 2001 survey is available in *Australian Vocational Education and Training Statistics 2001 Survey of Employer Views on Vocational Education and Training* (NCVER 2001d).

Student outcomes

In 2000, ANTA commissioned the Student Outcomes Survey for the second time. Its aim was to ascertain training outcomes for students who completed VET at TAFE institutes or universities with TAFE divisions in Australia in 1999. The survey targeted students who graduated with a qualification from a course (graduates) and students who had successfully completed some training below the level of full qualification and who were no longer engaged in training at the time the survey was undertaken (module completers). The data collected about TAFE graduates and TAFE module completers describe their general characteristics, fields of study, employment outcomes, occupations, industries of employment, satisfaction with their course of study and further study outcomes.

The 2000 Student Outcomes Survey involved the mailing of questionnaires to a randomly selected sample of graduates and module completers. The sample was stratified by TAFE institute, field of study, gender and age. Responses have been weighted to population benchmarks to minimise non-response bias. The questionnaires for graduates and module completers were slightly different in their layout and questions. Both student groups are distinctive segments of the student market in terms of their demographic and training characteristics.

Care needs to be taken when comparing State and Territory information as each jurisdiction has different economic, demographic and social profiles that are likely to have an effect on a range of training related outcomes. In particular, employment related VET outcomes are predominantly affected by economic parameters that are beyond the control of the TAFE system.

Main reason for undertaking VET course

The 2000 Student Outcomes Survey (NCVER 2000) asked 1999 TAFE institute graduates to nominate their main reason for undertaking a VET course. Nationally, 77 per cent of surveyed graduates indicated that they enrolled for vocational reasons (for example, to obtain a job or promotion). This proportion ranged from 84 per cent in Tasmania to 71 per cent in the NT (table 4.5).

Table 4.5 TAFE graduates' main reason for undertaking a VET course, 2000 (per cent)^{a, b, c}

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
Vocational reason	76 (0.8)	78 (0.8)	78 (0.9)	73 (1.2)	82 (1.5)	84 (2.0)	75 (2.5)	71 (4.1)	77 (0.4)
Non-vocational reason	24 (0.8)	22 (0.8)	22 (0.9)	27 (1.2)	18 (1.5)	16 (2.0)	25 (2.5)	29 (4.1)	23 (0.4)

^a The standard errors corresponding to a 95 per cent confidence interval for the percentage estimate are reported in parentheses under the estimate. ^b Includes 'to get into another course of study', which could ultimately be vocational. ^c 'Not stated/refused' represented the balance of responses in each jurisdiction.

Source: table 4A.14.

The proportion of TAFE institute graduates who reported that their course helped or partly helped them achieve their main reason for doing the course ranged from 84.7 per cent in Queensland to 76.1 per cent in Tasmania (table 4.6).

Table 4.6 Whether VET course helped TAFE institute graduates achieve their main reason for doing the course, 2000 (per cent)^{a, b}

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
Course helped to achieve main reason	62.3 (0.9)	64.0 (1.0)	73.7 (1.0)	64.7 (1.3)	70.1 (1.7)	62.0 (2.5)	65.8 (3.0)	71.0 (4.2)	65.5 (0.5)
Course partly helped to achieve main reason	16.1 (0.7)	16.3 (0.7)	11.0 (0.7)	14.8 (1.0)	13.6 (1.3)	14.1 (1.8)	13.5 (2.2)	11.4 (2.9)	14.8 (0.4)
Course did not help to achieve main reason	8.0 (0.5)	7.1 (0.5)	7.2 (0.6)	8.8 (0.8)	8.4 (1.1)	11.3 (1.6)	7.4 (1.7)	6.3 (2.3)	7.9 (0.3)
Do not know yet	13.5 (0.6)	12.5 (0.7)	8.1 (0.6)	11.7 (0.9)	7.9 (1.0)	12.6 (1.7)	13.2 (2.1)	11.2 (2.9)	11.8 (0.3)

^a The standard errors corresponding to a 95 per cent confidence interval for the percentage estimates are reported in parentheses under the estimates. ^b 'Not stated/refused' represented the balance of responses in each jurisdiction.

Source: table 4A.15.

The extent to which students achieved their main reason for doing a course not only varied across jurisdictions but also across target groups. Nationally, 66.8 per cent of TAFE institute graduates who enrolled in a VET course to obtain a job achieved this outcome. This outcome was lower for people identifying as Indigenous (59.6 per cent) and for people from non-English speaking backgrounds (63.0 per cent) (table 4.7).

Table 4.7 Whether VET course helped TAFE institute graduates achieve their main reason for doing the course by reason and special needs group, 2000 (per cent)^{a, b}

<i>Reason for course</i>	<i>All graduates</i>	<i>Graduates born in a non-English speaking country</i>	<i>Indigenous graduates</i>
To obtain a job (or own business)	66.8 (0.5)	63.0 (0.9)	59.6 (4.3)
To try for a different career	67.8 (0.8)	66.8 (1.4)	64.9 (5.5)
To obtain a better job or promotion	71.8 (0.8)	69.6 (1.4)	59.9 (7.9)
To fulfil requirements of the job	94.1 (0.3)	93.8 (0.8)	88.7 (3.2)
To learn extra skills for the job	91.4 (0.4)	88.8 (1.0)	89.7 (3.6)
To qualify for another course	86.4 (0.8)	85.5 (11.2)	73.1 (7.9)
Interest or personal development	89.9 (0.5)	88.4 (0.9)	87.9 (2.9)
Other	79.9 (1.2)	77.5 (2.1)	68.0 (8.5)

^a Includes respondents who indicated that their VET course helped or partly helped them achieve their main reason for doing the course. ^b The standard errors corresponding to a 95 per cent confidence interval for the percentage estimate are reported in parentheses to the right of the estimate.

Source: table 4A.16.

Meeting student needs — employment outcomes of VET graduates

Of the surveyed TAFE institute graduates who completed a VET program during 1999, 76 per cent indicated that they were employed. Graduates from Queensland, SA, Tasmania, the ACT and the NT reported better than average employment outcomes (table 4.8). Interpretation of employment outcomes must take account of the general economic conditions in each jurisdiction (appendix A) and the enrolment of some students for non-vocational reasons.

Table 4.8 Labour force status of 1999 TAFE institute graduates, 2000 (per cent)^{a, b, c}

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
Employed	74 (0.9)	76 (0.9)	79 (0.9)	74 (1.2)	83 (1.5)	80 (2.0)	82 (2.4)	80 (3.6)	76 (0.4)
Unemployed	12 (0.6)	12 (0.6)	9 (0.7)	11 (0.8)	9 (1.1)	11 (1.5)	8 (1.8)	8 (2.7)	11 (0.3)
Not in labour force	13 (0.6)	11 (0.6)	11 (0.7)	14 (0.8)	8 (1.1)	9 (1.5)	9 (1.8)	11 (2.7)	12 (0.3)

^a At 28 May. ^b The standard errors corresponding to a 95 per cent confidence interval for the percentage estimates are reported in parentheses under the estimates. ^c 'Not stated/refused' represented the balance of responses in each jurisdiction.

Source: table 4A.17.

There was little difference across jurisdictions in the proportion of employed TAFE institute graduates who reported that their course was highly relevant to their job (table 4.9). The proportion of TAFE institute graduates who received a pay increase after completing their course ranged from 33.0 per cent in the ACT to 19.1 per cent in Queensland. The proportion who received a promotion (or increased status at work) as a result of doing their VET course ranged from 25.1 per cent in the NT to 14.0 per cent in Queensland (table 4.10).

Table 4.9 Employed 1999 TAFE institute graduates who undertook their course for vocational reasons — relevance of course to main job, 2000 (per cent)^{a, b}

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
Highly relevant	55.3 (1.2)	57.2 (1.3)	56.3 (1.4)	59.6 (1.8)	59.4 (2.3)	59.9 (3.1)	60.1 (3.9)	59.3 (6.0)	56.6 (0.6)
Some relevance	25.4 (1.1)	24.3 (1.1)	28.3 (1.3)	19.9 (1.4)	26.3 (2.0)	24.3 (2.7)	20.7 (3.2)	24.5 (5.2)	25.3 (0.6)
Total	80.7 (1.0)	81.6 (1.0)	84.6 (1.0)	79.5 (1.5)	85.7 (1.6)	84.2 (2.3)	80.8 (3.2)	83.8 (4.5)	81.9 (0.5)

^a Totals may not add as a result of rounding. ^b The standard errors corresponding to a 95 per cent confidence interval for the percentage estimates are reported in parentheses under the estimates.

Source: table 4A.18.

Table 4.10 Employed 1999 TAFE institute graduates who undertook their course for vocational reasons — benefits of course, 2000 (per cent)^a

<i>Benefit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
An increase in earnings	26.9 (1.0)	28.5 (1.1)	19.1 (1.0)	26.2 (1.4)	24.5 (1.9)	32.2 (2.8)	33.0 (3.4)	29.8 (4.9)	25.7 (0.5)
A promotion (or increased status at work)	21.0 (0.9)	18.7 (0.9)	14.0 (0.9)	16.7 (1.2)	22.1 (1.8)	17.7 (2.3)	24.3 (3.1)	25.1 (4.6)	18.8 (0.5)
Obtained a job	26.3 (1.0)	29.4 (1.1)	21.6 (1.1)	35.3 (1.6)	25.1 (1.9)	29.6 (2.7)	30.9 (3.3)	21.9 (4.4)	26.7 (0.5)
Change of job or new job	17.9 (0.9)	18.5 (0.9)	12.9 (0.9)	16.7 (1.2)	17.3 (1.6)	17.5 (2.2)	21.7 (2.9)	23.8 (4.6)	17.0 (0.4)
Benefit in some way ^b	75.1 (1.0)	77.0 (1.0)	61.7 (1.3)	75.5 (1.4)	75.9 (1.9)	76.5 (2.5)	78.3 (2.9)	75.6 (4.6)	72.9 (0.5)

^a The standard errors corresponding to a 95 per cent confidence interval for the percentage estimates are reported in parentheses under the estimates. ^b 'Benefit in some way' may not equal the sum of the benefits because graduates could report more than one type of benefit.

Source: table 4A.19.

Efficiency

The ANTA Agreement requires States and Territories to demonstrate improved efficiency in the provision of publicly funded VET. As a result, unit cost performance assumes greater significance over this period (ANTA 1999a).

A proxy indicator of efficiency is the level of government inputs per unit of output (unit cost). Two unit cost indicators are reported here:

- recurrent cost per annual curriculum hour; and
- recurrent cost per government funded successful module load completion.

The factors that have the greatest impact on efficiency include:

- training-related factors, such as class sizes, teaching salaries, teaching hours per full time equivalent staff member and differences in the length of training programs of similar types;
- differences between States and Territories, including socio-demographic composition, administrative scale, course mix and dispersion and scale of service delivery;
- the mix of industry in a jurisdiction and its effect on the nature of courses required; and
- VET policies and practices, including the level of fees and charges paid by students.

The Steering Committee decided in 1998 that a user cost of capital should be included, where possible, as part of the costs for each government service reported here, and that this should be calculated by applying a jurisdiction cost of capital rate to the value of government assets. The cost of capital is included in estimates of the cost of government services because it reflects the opportunity cost of government assets that could be used to provide other services or to retire debt. Not reporting the user cost of capital underestimates the opportunity cost to government (box 4.6).

Box 4.6 Comparability of cost estimates

It is an objective of the Review to report comparable estimates of costs. Ideally, the full range of costs to government is counted on a comparable basis. Where the full costs cannot be counted, costs should be estimated on a consistent basis.

The Steering Committee has identified four areas that could diminish the comparability of costs across government and private providers.

- Superannuation costs are included in cost estimates for VET. It is recommended that superannuation be costed on an accrued actuarial basis (SCRCSSP 1998).
- Depreciation costs are included in cost estimates for all VET services.
- The user cost of capital is not included in estimates of recurrent expenditure, although it is reported separately (as the cost of capital per adjusted annual curriculum hour and the cost of capital per adjusted module load completion). The user cost of capital represents the opportunity cost to government of the funds tied up in VET assets. Excluding the user cost of capital from accrued costs lowers the costs per annual curriculum hour and the costs per government funded module load completion. Comparability can be improved by adding the reported user cost of capital to accrued costs if debt servicing costs and State and Territory based capital asset charges are deducted from accrual costs.
- Payroll tax is payable by all jurisdictions (except the ACT) for VET. A payroll tax estimate has been included in cost estimates for the ACT. It is recommended that payroll tax be costed to unit cost estimates to achieve comparability across government and private providers and across jurisdictions (SCRCSSP 1999).

Source: SCRCSSP (1998, 1999).

Unit cost — government expenditure per hour of delivery

Unit costs are reported in terms of total recurrent government expenditure per annual curriculum hours, adjusted to account for course mix differences across jurisdictions.¹ Financial and activity data from States and Territories are reported

¹ Other unaccounted external influences on the unit cost of VET provision include the population density and the provision of VET for disadvantaged groups (see appendix A).

within an agreed scope and boundary to ensure unit costs accurately reflect the relative efficiency of government service provision across jurisdictions.

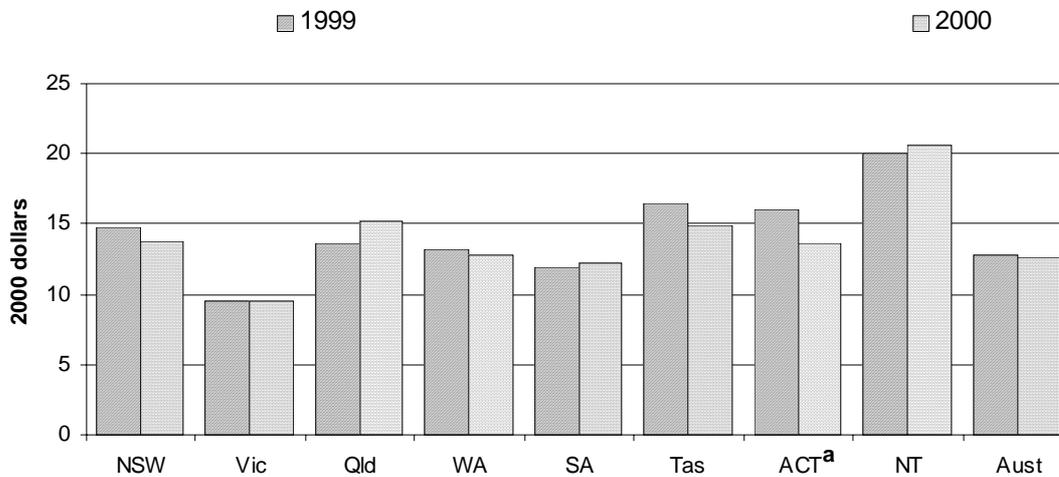
Data used in the calculation of unit cost are largely derived from the Australian Vocational Education and Training Management Information Statistic Standard. Both activity (nominal hours — supervised) and financial data are audited under arrangements with the States and Territories.

Recurrent expenditure per annual curriculum hour of government funded VET programs in 2000 ranged from \$20.67 in the NT to \$9.51 in Victoria. Only Victoria and SA reported unit costs below the national average of \$12.68. Queensland, SA and the NT reported a real increase in unit cost from 1999; all other jurisdictions reported close to no change (Victoria) or a real decrease (NSW, WA, Tasmania and the ACT) (figure 4.5).

The full cost of providing VET services includes both the cost of capital and recurrent costs. To integrate these costs to make up total cost, it is necessary to convert the cost of capital to a year-by-year charge. The Steering Committee has adopted a nominal 8 per cent user cost of capital rate to reflect the income that might have been earned if the funds had been invested elsewhere rather than in the capital item, although the actual rate may vary across jurisdictions. The basis for the 8 per cent capital charge is discussed in chapter 2.

The Steering Committee acknowledges the potential for differences in some input costs (for example, land values) to affect reported costs across jurisdictions without necessarily reflecting the efficiency of service delivery. The costs of capital for land and other assets are presented separately to allow users to consider any differences in land values among jurisdictions when assessing the results (table 4.11).

Figure 4.5 Government recurrent expenditure per adjusted annual hours of curriculum



^a The ACT is the only jurisdiction not to levy payroll tax on its VET employees. A payroll tax estimate based on the ACT payroll tax rate has been included in the expenditure data. The payroll tax estimate has increased real recurrent government VET expenditure per adjusted annual curriculum hour in the ACT by \$0.62 in 1999 and by \$0.53 in 2000.

Source: table 4A.21.

Table 4.11 Cost of capital, 2000^a

	Unit	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust
Non-current physical assets										
Land	\$m	311.9	256.7	118.5	75.4	35.6	8.8	7.4	4.5	818.8
Other	\$m	1 701.7	1 121.7	764.4	404.6	398.7	132.9	113.7	115.8	4 754.4
Total	\$m	2 013.6	1 378.4	882.9	480.0	434.3	141.7	121.1	120.3	5 573.2
Capital charge	%	8.0	8.0	8.0	8.0	8.0	8.0	8.0	8.0	8.0
Cost of capital										
Land	\$m	25.0	20.5	9.5	6.0	2.8	0.7	0.6	0.4	65.5
Other	\$m	136.1	89.7	61.2	32.4	31.9	10.6	9.1	9.3	380.3
Total	\$m	161.1	110.3	70.6	38.4	34.7	11.3	9.7	9.6	445.9

^a Totals may not add as a result of rounding.

Source: table 4A.22.

The total cost of government owned capital per annual curriculum hour varied across jurisdictions in 2000, ranging from \$2.84 in the NT to \$1.48 in WA. Excluding land assets, the government cost of other capital per annual curriculum hour ranged from \$2.73 in the NT to \$1.21 in Victoria. The cost of government owned land capital per annual curriculum hour ranged from \$0.28 in NSW and Victoria to \$0.11 in the NT in 2000 (table 4.12).

Table 4.12 Cost of capital per annual curriculum hour, 2000^a

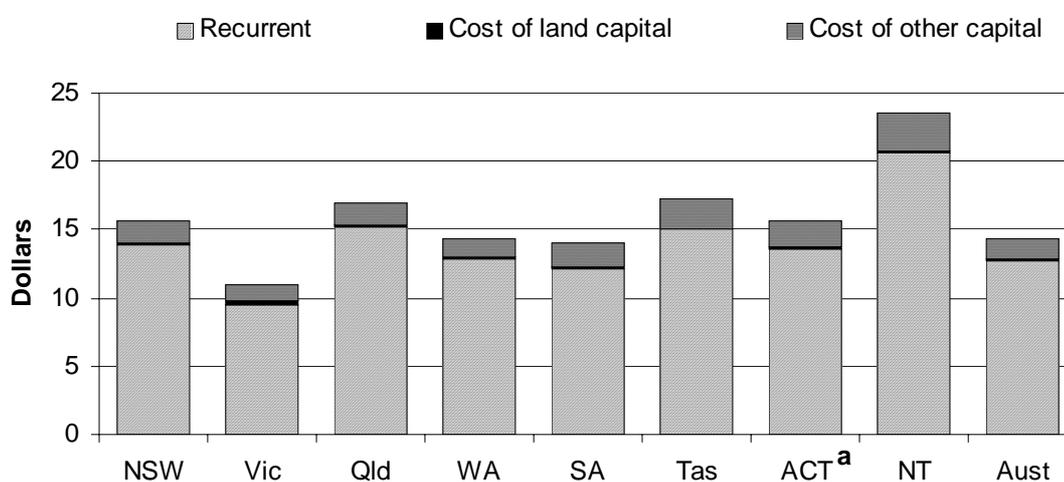
	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
Adjusted annual curriculum hours	millions	88.8	74.2	38.5	25.9	19.6	5.1	4.8	3.4	260.1
Cost of capital per adjusted annual curriculum hour										
Land	\$	0.28	0.28	0.25	0.23	0.15	0.14	0.12	0.11	0.25
Other	\$	1.53	1.21	1.59	1.25	1.63	2.08	1.88	2.73	1.46
Total	\$	1.81	1.49	1.84	1.48	1.77	2.22	2.00	2.84	1.71

^a Totals may not add as a result of rounding.

Source: table 4A.22.

The national full cost to government of funding VET per adjusted annual curriculum hour in 2000 was \$14.40 (recurrent cost of \$12.68, plus cost of land capital of \$0.25, plus cost of other capital of \$1.46). Across jurisdictions, the full cost per adjusted annual curriculum hour ranged from \$23.50 in the NT to \$11.00 in Victoria (figure 4.6). Care needs to be taken in interpreting these results because the asset data used to calculate cost of capital are not as reliable as the recurrent cost data.

Figure 4.6 Total government VET costs per annual curriculum hour, 2000



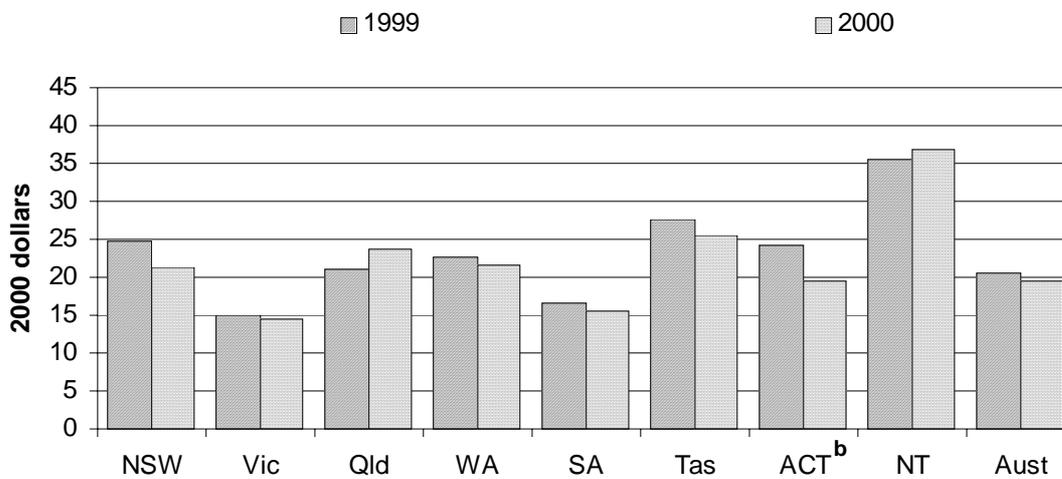
^a The ACT is the only jurisdiction not to levy payroll tax on its VET employees. A payroll tax estimate based on the ACT payroll tax rate has been included in the expenditure data presented. The payroll tax estimate has increased real recurrent government VET expenditure per adjusted annual curriculum hour in the ACT by \$0.53 in 2000.

Source: table 4A.23.

Unit cost — government expenditure per publicly funded module load completion

Government expenditure per publicly funded module load completion is the cost to government of each successfully completed VET module (that is, the cost per output produced). The cost of producing successful publicly funded outputs decreased in all jurisdictions except Queensland and the NT between 1999 and 2000 (figure 4.7).

Figure 4.7 **Government recurrent expenditure per hour of successful publicly funded module load completion^a**



^a Care needs to be taken in comparing data across jurisdictions because average module durations and competencies achieved by students vary. ^b The ACT is the only jurisdiction not to levy payroll tax on its VET employees. A payroll tax estimate, based on the ACT payroll tax rate, has been included in the expenditure data presented. The payroll tax estimate has increased real recurrent government VET expenditure per publicly funded successful module load completion in the ACT by \$0.94 in 1999 and \$0.76 in 2000.

Source: table 4A.24.

Total government cost of capital per module load completion in 2000 ranged from \$5.06 in the NT to \$2.25 in Victoria. Excluding land assets, the government cost of capital per module load completion ranged from \$4.87 in the NT to \$1.83 in Victoria in 2000 (table 4.13).

Table 4.13 Cost of capital per module load completion, 2000^{a, b}

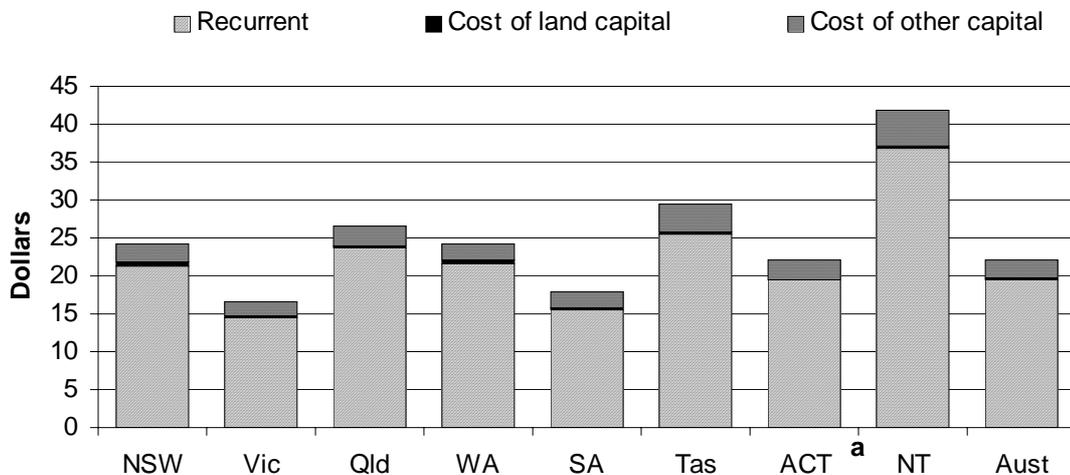
Unit	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust
Adjusted module load completions									
mill.	57.4	48.9	24.7	15.3	15.4	3.0	3.4	1.9	169.7
Cost of capital per adjusted module load completion									
Land	\$ 0.44	0.42	0.38	0.39	0.19	0.24	0.17	0.19	0.39
Other	\$ 2.37	1.83	2.48	2.11	2.07	3.56	2.66	4.87	2.24
Total	\$ 2.81	2.25	2.86	2.50	2.26	3.79	2.84	5.06	2.63

^a Care needs to be taken in comparing data across jurisdictions because average module durations and competencies achieved by students vary. ^b Totals may not add as a result of rounding.

Source: table 4A.22.

The national full cost per module load completion in 2000 was \$22.07 (recurrent cost of \$19.45 plus cost of land capital of \$0.39, plus cost of other capital of \$2.24). Across jurisdictions, this ranged from \$41.87 in the NT to \$16.67 in Victoria (figure 4.8). Care needs to be taken in interpreting these results because the asset data used to calculate cost of capital are not as reliable as the recurrent cost data.

Figure 4.8 Total government VET costs per module load completion, 2000



^a The ACT is the only jurisdiction not to levy payroll tax on its VET employees. A payroll tax estimate, based on the ACT payroll tax rate, has been included in the expenditure data presented. The payroll tax estimate has increased real recurrent government VET expenditure per publicly funded successful module load completion in the ACT by \$0.76 in 2000.

Source: table 4A.25.

4.5 Future directions in performance reporting

Indicator development

A complete assessment of the outcomes achieved under the terms of the ANTA Agreement 1998–2000 will be provided in the report, *Directions and Resources Allocations 2002*.

Work is continuing on improvements to the VET output measures that capture the diversity of the VET system. Progress has been made in developing a system for determining the number of students who are eligible to receive a VET qualification. It is now anticipated that this performance information will be reported for the first time in 2002 and will be available for the 2003 Report. Establishment of a standardised output measure for measuring all VET outputs on a single scale remains outstanding and an approach to implementation is still to be developed.

The NCVER has reviewed the Survey of Employer Views on VET to improve the survey's usefulness for performance measurement purposes. The survey, which is the key data source used to assess employers' views on the relevance of skills acquired through VET, was undertaken in its revised form in the second half of 2001. Some results were available at the end of 2001 but were not available in time to be included in the 2002 Report. These results will be included in the 2003 Report.

The NCVER has undertaken pilot studies that assess the outcomes achieved by students who participate in training outside of the publicly owned TAFE institutes. These studies are intended to complement the survey instrument that assesses the employment outcomes and prospects of both graduates and module load completers from within the TAFE system.

The Australian Bureau of Statistics will conduct a survey of employer training expenditure and practices in 2002. The results will inform a number of key performance measures and are expected to be available in March 2003.

Reporting new indicators

Implementation of a new accountability framework for VET infrastructure commenced in 2001. The framework includes three performance measures:

- public expenditure per publicly funded output (incorporating both recurrent spending and an agreed approach for determining the user cost of capital);
- ratio of operating and maintenance costs to capital value (including the value of the maintenance backlog); and

-
- a measure of the utilisation of infrastructure.

It is anticipated that full implementation, including national reporting against these performance measures, will be achieved by 2003 and be available for the 2004 Report.

4.6 Jurisdictions' comments

This section provides comments from each jurisdiction on the services covered in this chapter and attachment 4A on the CD-ROM. Appendix A contains short profiles on each State and Territory, which may assist in interpreting the performance indicators presented in this chapter. Detailed statistics covering aspects such as age profile, geographic distribution of the population, income levels, education levels, tenure of dwellings and cultural heritage (such as Indigenous and ethnic status) are also found in appendix A.

New South Wales Government comments

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Enrolments in TAFE NSW during the year exceeded 544 000, with two thirds of enrolment growth over the past five years occurring in 1999-2000. Almost one in 10 residents of NSW attends TAFE. The participation rate was highest among 15–19 year olds with almost one in four residents aged 15–19 attending TAFE.

TAFE NSW had a major profile as Official Training Services Supporter of the 2000 Olympic Games and as Official Partner of the Paralympic Games. TAFE NSW trained a total of 110 000 volunteers and contractors in preparation for the Olympic Games.

TAFE NSW made significant progress in relation to the participation of targeted groups in training programs. Almost 16 000 Indigenous people enrolled in TAFE courses, an increase of more than 20 per cent compared to 1996. More than 25 000 people with disabilities enrolled in TAFE courses, with enrolments showing a 25 per cent increase since 1996. Some 60 000 people from non-English speaking backgrounds enrolled in TAFE courses. Almost 260 000 women enrolled in TAFE courses, reflecting an increase of almost 40 per cent in enrolments for women since 1996 compared to the overall TAFE enrolment growth rate of 30.4 per cent. Almost 180 000 enrolments were from rural areas, an increase of more than 37 per cent since 1996.

TAFE NSW has made great progress in the implementation of flexible delivery initiatives, including the provision of short courses and modules tailored to specific industry and employee needs. TAFE NSW Online was supported in 2000 by the development of 300 modules of online course materials, significantly enhancing the organisation's flexible delivery capacity. TAFE Global Pty Ltd was established to take advantage of emerging opportunities in the international training market. Recognition and credit transfer arrangements between ACE and TAFE NSW were successfully established in the fields of information technology, business, hospitality, health and community services.

There was continued growth in apprenticeships and traineeships with 58 000 apprentices and trainees commencing training in 2000, an increase of 13 per cent. In the March 2000 quarter, 72 340 apprentices and trainees were in training and employment. By the end of December 2000, the number had grown to 85 670, an increase of 18.5 per cent.

In the 2000-01 budget the government is spending \$1 506.6 million in recurrent and capital funding for TAFE NSW and other vocational education and training services. The budget takes into account Commonwealth government funding and the need for greater efficiencies in an increasingly competitive training market.”

Victorian Government comments



Collectively, 14 TAFE institutes, five TAFE divisions within universities and over 1000 other registered training organisations provided skills training across all major industries and occupational levels, as well as further education and personal development programs, to over 578 000 students — a 2.8 per cent increase on 1999.

Performance information in this Report indicates that the Victorian training system performed well across a range of indicators, particularly participation in VET, especially in rural and remote areas.

In its 2000-01 Budget, the Victorian Government provided an additional \$177.4 million over four years to training providers, including \$127 million to TAFE institutes. It also provided \$84.7 million for targeted employment programs to support the employment of apprentices and trainees in the public and private sectors and \$65 million to extend and improve post-compulsory education and training pathways.

This investment provided immediate benefits for Victoria's community and industry. In particular, Victorian TAFE institutes are better placed to provide quality education and training, there are record numbers of apprentices and trainees and facilities and resources in the Adult Community Education sector have been enhanced.

In its 2001-02 Budget, the Victorian Government built on this investment in education and training to renew and improve the skills base of Victoria by providing an additional \$110 million in new initiatives focusing on innovation, community building and infrastructure.

The Government also established goals and targets to increase participation and attainment in education and training in Victoria. Four of the goals will impact directly on the provision of vocational education and training in 2001 and beyond. They are:

- to increase the percentage of young people who successfully complete year 12 or the equivalent;
- to increase adults' participation in education and training and hence the overall level of educational attainment and literacy levels in Victoria;
- to increase the level of participation and achievement in education and training in rural and regional Victoria and among groups where it is presently low; and
- to make near-universal participation in post compulsory education and training the norm in our society.



Queensland Government comments

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Queensland continues to improve the quality of vocational education and training outcomes through the development of a range of objectives articulated in *Skilling Queensland: A strategy for vocational education and training (2001–2004)*. This strategy aims to increase the skills and qualifications of Queenslanders; embrace the information and biotechnology age; expand innovation and collaborative business practices; and build on the quality of vocational education and training.

The *Training and Employment Act 2000* proclaimed on 28 September 2000, strengthened Queensland's commitment to quality vocational education and training and national consistency within the vocational education and training sector across Australia. The *Training and Employment Act 2000* introduced multiple improvements based on the findings of the 1999 Independent Investigation into the Quality of Training in Queensland's Traineeship System.

Through an innovative approach aimed at ensuring that training meets the needs at a community level, Queensland implemented a \$10 million (per year) community training partnership program in 2000-01. Experience has shown that community based, not-for-profit organisations need time and support to develop the necessary infrastructure to effectively enable the implementation of accredited training programs. While outcomes for training are yet to be realised there has been significant development of community capacity which will ensure the sustainability of these programs over time.

In addition, the competitive purchasing program was, for the first time, highly targeted at identified skills gaps in each region. Providers experienced significant difficulty attracting students in contract timeframes resulting in cancellation of contracts late in the financial year or extension of end dates that will result in a delay in delivery achieved.

The department has now established mechanisms to continually monitor delivery on all programs and to proactively negotiate alternative training where community response has been inadequate or emergent priorities identified.

Importantly, more realistic targets have been negotiated with the Australian National Training Authority for Queensland's vocational education and training system for 2001-02.

Queensland 2000 expenditure was affected by abnormal expenses totalling approximately \$23 million. These expenses relate to changes in depreciation/amortisation, due to asset revaluation, losses on asset sales and the treatment of information technology capital expenditure as recurrent expenditure. This has now been addressed by a policy change. These items are accounting treatments that should be considered in determining improvements in the operational efficiency of the vocational education and training system.

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Western Australian Government comments

“ The Western Australian Vocational Education and Training system consists of 14 publicly funded providers (TAFE Colleges) and in excess of 900 private providers, some 100 of which receive public funding through contestable means. In 2000, delivery exceeded 25 million student contact hours to around 102 000 (ANTA scope) students at a recurrent and capital cost of approximately \$320 million.

The Department's strong industry focus provided by the State Training Board and its principal planning mechanism, the State Training Strategy, provides government, industry and training providers with short, medium and long term directions and advice on the training priorities and skill needs of Western Australia. This is an important feature of the Western Australian vocational education and training system and one that places the State at the forefront in actively seeking industry involvement in the identification and planning of VET.

By focusing on industry, student and community requirements within a managed competitive training market, a more demand-driven and responsive system for publicly funded training effort has been developed with a commitment to system monitoring and the development of quality processes.

This report highlights some of the Western Australian VET sector accomplishments for 2000 including:

- 79.5 per cent of WA graduates said that they achieved or partly achieved their main reason for doing their course;
- 59.6 per cent of employed TAFE graduates in WA said that their course was highly relevant to their job, compared to 56.6 per cent nationally.
- 75.5 per cent of employed graduates who undertook their course for vocational reasons said that they benefited in some way;
- Indigenous people in WA participated in VET at almost twice the rate (5.6 per cent) of their representation in the population (3.0 per cent);
- Total VET costs per adjusted annual curriculum hour in WA for 2000 was \$14.32, down from \$14.52 in 1999 — the third lowest of all States and Territories.

Demand for VET in WA will continue to increase due to a variety of factors, including increased workforce demand for new and higher skill levels due to ongoing structural changes in the labour market. These changes include developments in information technology, globalisation of markets and the move to knowledge based industries. By recognising these factors and planning to effectively meet the training needs that will flow from these structural changes, the WA VET system will ensure that it continues to offer timely, effective and efficient training solutions that continue to meet the needs of industry, the community and individuals.

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South Australian Government comments

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South Australia continued to develop an efficient, high quality vocational education and training (VET) system that plays a significant role in providing and updating the skills of our workforce. The Report highlights some of the achievements during 2000, when South Australia:

- increased the number of contract of training commencements from 18 700 in 1999 to 22 300 in 2000;
- maintained the efficiency of publicly funded VET at a rate significantly lower than the Australian average (\$12.20 versus \$12.70). The total government VET cost in South Australia per hour of successful module completion has improved from \$16.00 in 1999 to \$15.50 in 2000 and the cost remains lower than the national average cost of \$19.40;
- increased the participation rate for 15-64 year olds from 11.4 per cent in 1999 to 12.0 per cent in 2000;
- had the highest load pass rate (86.9 per cent) in the country, which considerably exceeds the national average of 75.4 per cent;
- had the equal highest employer satisfaction for recent VET graduates (87 per cent versus the 83 per cent national average) in the 1999 Survey of Employer Views on Vocational Education and Training;
- recorded 91.4 per cent of recent TAFE graduates employed or in further study after their course, higher than the national average of 89.2 per cent;
- recorded 67.9 per cent of recent TAFE graduates who rated the quality of their TAFE training as 8 or more on a 10 point scale, higher than the national average of 66.7 per cent;
- increased funding to the Adult Community Education sector for delivery of non accredited pathways programs; and
- increased the funding allocation to rural/remote areas of the state for delivery of Adult Community Education general education and language, literacy and numeracy programs.

South Australia has continued to closely align the VET system to the economic and social needs of our community, including the emerging training needs of SA enterprises. Results from the 1997 and 1999 employer satisfaction surveys and the *2000 Student Outcomes Survey* indicate that TAFE provides high quality training, while TAFE qualifications consistently improve the chances of finding work, advancing careers and changing occupations.

The outcomes and initiatives shown in this Report demonstrate the efforts by the South Australian Department of Education, Training and Employment to continually improve the training system in the State. South Australia continues to support improvements in service and performance and the value of measuring this through reliable performance information.

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Tasmanian Government comments



A commitment to lifelong learning together with a strong focus on integrating vocational education and training with State industry planning mechanisms complement the continuing improvement in efficiency and quality in VET in Tasmania.

This Report highlights progress made in the delivery of VET in Tasmania despite the constraints specific to the State. The constraints include the small, widely dispersed population; the comparatively low proportion of the population residing in the capital city compared to other States; and the broad but thin composition of Tasmanian industry which necessitates provision of a wide range of services to small groups of students. Within these and fiscal constraints, key goals have been achieved, including increased participation and cost effectiveness and demonstrated responsiveness to client needs.

- Tasmania's participation rate in VET continued to rise in 2000. The proportion of Tasmanians aged 15 to 64 participating in VET has risen consistently and at a greater rate than the national average, from 8.7 per cent in 1997 to 10.2 per cent in 2000.
- The continuing improvement in efficiency of the State's VET system is demonstrated by the unit cost (recurrent) of Tasmanian VET activity, which has reduced from \$19.00 in 1997 to \$15.00 in 2000.
- The 2000 Student Outcomes Survey shows good employment outcomes for TAFE graduates, 80 per cent being employed after graduation compared with 76 per cent nationally. The Survey shows 57 per cent of those who were unemployed at the commencement of their training subsequently being employed compared with 50 per cent nationally.
- The Student Outcomes Survey also shows 84 per cent of graduates in Tasmania cited vocational reasons as the main reason for undertaking their course compared with 77 per cent nationally.
- Results of the 2001 national Survey of Employer Views on VET, not included in this Report, show Tasmanian employers having the highest proportion of employers (84 per cent) very satisfied or satisfied with VET providers.
- The Institute of TAFE Tasmania's standard of performance was acknowledged with recognition in 2000 as the Australian National Training Authority's Training Provider of the Year.

Tasmania's improved efficiency and participation rate in 2000 was linked to implementation of its three year plan for growth derived through efficiencies, covering the period 1998 to 2000. Tasmania has increased participation significantly, achieved substantial gains in efficiency (22 per cent since 1997) and achieved targets for ANTA Agreement funded nominal hours with a 27 per cent growth in hours since 1997.



Australian Capital Territory Government comments

“

The ACT VET system is strongly committed to expanding vocational education and training to enhance economic and social opportunities for people and businesses in the ACT. ACT VET aims to be responsive to the changing vocational aspirations of the community and the skills needs of ACT commerce and industry.

In the ACT there is one public provider of Technical and Further Education, the Canberra Institute of Technology (CIT), which is a Registered Training Organisation (RTO). Seventeen government and non-government secondary colleges are also RTOs, and there are 87 private or community RTOs in the ACT. Of these 105 RTOs, 66 were in receipt of government training funds in 2000.

Some of the key initiatives and objectives for 2000 were to:

- maintain high levels of training activity. In the period 1998–2000, participation has increased by 20 per cent compared with 13 per cent nationally. Similarly, there was considerable growth as shown in the ANTA audited Annual Hours Curriculum, adjusted for invalid enrolments. (15 per cent growth over 1997). Over the same period, ACT VET delivery has been more successful with a greater proportion of training hours resulting in successful completion (rose from 76.5 in 1998 to 80.6 in 2000);
- increase the uptake of school-based New Apprenticeships. The number of school based New Apprenticeships (SNAPs) increased significantly in 2000 with commencements nearly doubling from 46 in 1999 to 107 in 2000. This trend is expected to continue into 2001;
- continue to improve efficiency. The ACT's efficiency improvement over the period of 1997 to 2000 was 26 per cent, with the real cost of training dropping from \$18.35 per Annual Hours Curriculum in 1997 to \$13.64 in 2000;
- increase the uptake of training for people from equity groups. In 2000, several programs that provided training opportunities and support for people from equity groups were funded. For example, the Adult English Language and Numeracy Program, which addresses the English language, literacy and numeracy needs of people, enabled 169 students from a wide range of disadvantaged groups to participate in 38,860 hours of training;
- increase training in information technology skills areas. Information Technology was a priority training area for 2000. Under the Industry Training Program, 37 per cent of total funds was allocated to the Information and Communications Technology area; and
- continue the growth of training delivery through Training Packages. In 2000, ACT RTOs delivered qualifications from 32 Training Packages. It is a requirement in the ACT that government-funded training is delivered through training packages, where they exist.

”

4.7 Definitions

Table 4.14 Terms

<i>Term</i>	<i>Definition</i>
Annual curriculum hours	The anticipated hours of supervised learning or training deemed necessary to adequately present the education material. These hours are generally specified in the curriculum documentation and do not include hours associated with field work or work experience. Changed in 1999 to nominal hours – supervised.
Adjusted annual curriculum hours	Annual curriculum hours that are adjusted to account for module enrolments reported with an outcome of recognition of prior learning and invalid module enrolments.
Adjusted module load completion rate	Module load completions that are adjusted to account for module enrolments reported with an outcome of recognition of prior learning and invalid module enrolments.
AVETMISS	Australian Vocational Education and Training Management Information Statistical Standard. This is a specification of information standards for recording and reporting VET inputs (resource module) and activity and outputs (business module). This standard was observed in the collection and preparation of data for this Report.
Community education providers	Community education training organisations that have provided information to the NCVET data collection.
Completions	Fulfilment of all of the requirements of a course enrolment or module enrolment.
Contract of training	A contractual agreement between an employer and employee (apprentice or trainee) specifying the competencies to be developed over the period of the contract and the rights and obligations of each party.
Cost per curriculum hour (average)	Total government recurrent expenditure per total adjusted annual curriculum hours.
Course	A structured sequence of vocational education and training that leads to the acquisition of identified competencies and includes assessment leading to a qualification or statement of attainment.
Employer perception of the level of VET graduates' work skills	Descriptions of graduates' work skills range from 'they do not show any better skills' to 'they have significantly improved their skills and productivity'.
Employer satisfaction with VET value for money	Employer satisfaction with VET value for money is reported as a spectrum of views ranging from 'the VET course being mostly a waste of money' to 'the VET course being an excellent return on investment' (that is, productivity increases greatly exceed the costs of the course).
Enrolment	The registration of a student with a training provider for the purpose of doing a course or module. The enrolment is considered valid only if all fee obligations have been met and the student has attended at least one lesson or submitted at least one piece of work.

(Continued on next page)

Table 4.14 (Continued)

<i>Term</i>	<i>Definition</i>
Fee-for-service activity	Activity that is funded by fees received from individuals and organisations, other than regulatory student fees. This includes Commonwealth and State-specific funded programs (such as Labour Market Programs and Adult Migrant English Services).
Geographic region	A geographic classification (based on statistical local areas) devised by the former Department of Primary Industry and Energy and the Department of Employment, Education, Training and Youth Affairs. <i>Remote</i> : regions that contain urban centres with a population of less than 5000 and that are more than 150 kilometres from an urban centre with a population of 10 000 or more <i>Rural</i> : regions that consist of statistical local areas associated with urban centres of population of 5000 to 100 000 and that are not classified as remote.
Government cost of capital per hour of successful publicly funded module load completions	Cost to the government of using capital (physical non-current assets) per adjusted publicly funded successful module load completions.
Government costs of capital per adjusted annual curriculum hours	Cost to the government of using capital (physical non-current assets) for delivering VET services.
Graduate	A person who has completed a vocational program.
Government funding to private and adult and community providers	Government recurrent expenditure to private and adult and community providers for the delivery of VET services. Expenditure includes payments to secondary schools, other government providers, enterprises, private registered training organisations, ACE providers, industry and local government providers.
Hours delivered per campus	The ratio of unadjusted VET hours delivered to the number of campuses in each jurisdiction.
Load pass rate	The ratio of students who pass assessment in an assessable module or unit of competency to all students who are assessed and pass, fail or withdraw. The calculation is based on the nominal hours supervised for each assessable module or unit of competency.
Module	A unit of training in which a student can enrol and be assessed.
Module completers	Students who successfully completed at least one module in a vocational program of study.
Net assets of public VET providers per person aged 15–64	Net assets (total assets less liabilities) of publicly owned VET providers per person aged 15–64 years.
Nominal hours – supervised	The anticipated hours of learning or training deemed necessary to adequately present the educational material associated with the delivery of a training program when delivered in standard classroom delivery mode. These hours are generally specified in the curriculum documentation and do not include hours associated with work experience, industry placement, or field placement. See also annual curriculum hours.

(Continued on next page)

Table 4.14 (Continued)

<i>Term</i>	<i>Definition</i>
Non-English speaking background (by country of birth)	Born in a country that is non-English speaking.
Non-response rate	Proportion of VET students who did not indicate on their enrolment form whether they were a member of a target group.
Number of campuses	The number of locations at which VET providers delivered VET programs or modules.
Occupational group	Occupations that are linked to particular Australian Bureau of Statistics Standard Occupational Classification (ASCO) groups. Category A courses have a direct link to an individual ASCO, category B have multiple links to ASCOs and category C courses potentially link across all ASCO areas.
Occupational level	Classified as 'general/unspecified', 'operative/clerical', 'trades/skilled' and 'para-professional/professional'. These are also linked to the Australian Bureau of Statistics' ASCO group.
Overall employer satisfaction with VET providers	Employer satisfaction with VET training providers (including both TAFE and non-TAFE). It is rated on a scale from 1 to 10, with 1 being 'very dissatisfied' and 10 being 'very satisfied'.
Private provider	A commercial organisation that provides training to individuals and industry.
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 Commonwealth and State and Territory governments to cover operating costs, salaries and rent.
Recurrent government VET expenditure per person aged 15–64 years	Total State and Commonwealth recurrent expenditure (based on 'maintenance of effort' cash expenditure as reported by ANTA 1998a) per person aged 15–64 years.
State Training Profile	An annual publication by the State training authorities, which outlines the planned training in terms of annual hours, by occupational groupings, for the year ahead (with indicative estimates for the next two years). It also outlines initiatives to meet State and national strategies.
Non-vocational program of study	Recreation, leisure and personal enrichment courses directed towards the encouragement and development of creative, social and personal pursuits and skills that enable people to make more effective use of leisure time.
Vocational program of study	A program of study that is intended to develop competency in skills relevant to the workplace or entry to further education; initial vocational courses and courses subsequent to initial vocational courses. These are typically associated with preparatory, operative, trades/skilled and para-professional education and training.
Students per campus	The ratio of the number of students who undertook vocational programs to the number of campuses in each jurisdiction.
Students studying in remote areas	The ratio of the number of students who studied in campuses located in remote areas to the total number of VET students.

(Continued on next page)

Table 4.14 (Continued)

<i>Term</i>	<i>Definition</i>
Students studying in rural areas	The ratio of the number of students who studied in campuses located in rural areas to the total number of VET students.
TAFE	Technical and Further Education colleges and institutes, which are the primary providers of publicly funded VET.
TAFE institute graduates' main reason for undertaking VET course	Either vocational reasons (to get a job, to try for a different career, to meet job requirements, to get extra job skills) or non-vocational reasons (for to get into another course, personal interest, for other reasons).
Training packages	Provide the basic building blocks for vocational education and training programs under the National Training Framework. They are developed by industry and create national standards, programs, qualifications and learning resources.
VET costs per adjusted annual curriculum hours	Government recurrent expenditure per adjusted publicly funded annual curriculum hours.
VET participation by Indigenous people	The proportion of Indigenous VET students compared with the proportion of Indigenous people aged 15–64 years.
VET participation by people from a non-English speaking background by country of birth	The proportion of VET students who report being born in a non-English speaking country compared with the proportion of people in the population who were born in a mainly non-English speaking country.
VET participation rate for people aged 15–64 years	The ratio of the number of people who undertake a VET program or module to the number of people in Australia (or each jurisdiction) aged 15–64 years.
VET participation rate for people of all ages by region (capital city, rural, remote and other metropolitan areas)	The ratio of the number of people who undertake VET programs or modules in specified geographic areas (that is, capital cities, rural areas, remote areas and other metropolitan areas) to the total population of people in those geographic areas.
VET program	A course or module offered by a training organisation in which clients may enrol.
Whether the VET course helped graduates achieve their main reason for doing the course	Whether 'the course helped', 'the course partly helped', 'the course did not help' or the graduates 'cannot say'.

C Health preface

Health care services are concerned with promoting, restoring and maintaining a healthy society. They involve illness prevention, health promotion, detection and treatment of illness and injury and the rehabilitation and palliative care of individuals who experience illness and injury. More broadly defined, the health system includes a range of activities that raise awareness, thereby reducing the risk and onset of illness and injury (box C.1).

Health care services in Australia are delivered by a variety of government and non-government providers in a range of service settings. The Report concentrates on the performance of public hospitals (particularly, the provision of acute care services to admitted patients and emergency department services) and general practitioners (GPs) because they represent a significant component of government expenditure on health care. According to the most recent comparative data, Australian governments expended \$20.5 billion on public hospitals (including psychiatric hospitals) and medical services (which includes payments to GPs and other specialist practitioners) in 1998-99 — 70.2 per cent of recurrent health expenditure¹ (table 5A.54 and AIHW 2001a). The Report also examines the interactions between different service mechanisms for dealing with two health management issues: mental health and breast cancer.

Areas of government involvement in health care provision not covered in the health chapters include:

- community health services (although reporting on community health services for patients with mental disorders is increasing);
- nursing home services (these are reported in chapter 12, ‘Aged care services’);
- patient transport services (these are reported in chapter 11, ‘Emergency management’);
- public health programs, other than those for breast cancer and mental health;
- funding for specialist medical practitioners; and
- government support for pharmaceuticals.

¹ Excludes aged care and ambulance services as these areas are covered in other chapters of the Report.

A range of government services, such as public housing, sanitation and water supply, also influence health outcomes. These are not formally part of Australia's health system and are not the subject of the following health chapters. A range of other factors, such as Indigenous status, socioeconomic status and residential location are potential influences on the health outcomes in this Report. It is a priority of the Review to improve the reporting of data on health outcomes and access to health care services for Indigenous people and residents in nonmetropolitan regions of Australia.

Box C.1 Some common health terms

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

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

Medicare: Commonwealth Government funding of private medical and optometrical services (Medicare Benefits Schedule). Some users use the term to include other forms of Commonwealth Government funding — for example, funding of selected pharmaceuticals (Pharmaceutical Benefits Scheme) and public hospital funding (Australian Health Care Agreements) — which is aimed at providing public hospital services free of charge to public patients.

public health: an organised social response to protect and promote health and to prevent illness, injury and disability. The starting point for identifying public health issues, problems and priorities, and for designing and implementing medical interventions, is the population 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 hospital: a hospital that provides free treatment and accommodation to eligible admitted persons who elect to be treated as public patients. It also provides free services to eligible non-admitted patients and may provide (and charge for) treatment and accommodation services to private patients. However, charges to non-admitted patients and admitted patients on discharge may be levied in accordance with the Australian Health Care Agreements (for example, charges for aids and appliances).

Sources: AIHW (2000); DHAC (1999).

The remainder of this preface is a summary of the nature of Australia's health care system and a report on the broad outcomes under that system.

Supporting tables for the 'Health preface' are provided on the CD-ROM enclosed with the Report. The files are provided in Microsoft Excel 97 format at

\Publications\Reports\2002\Attach5A.xls or in Adobe PDF format at
\Publications\Reports\2002\Attach5A.pdf.

Supporting tables are identified in references throughout this chapter by an 'A' suffix (for example, table 5A.3 is table 3 in the electronic files). They may be subject to revision. The most up-to-date versions of these files can be found on the Review's web page (www.pc.gov.au/gsp/). Users without Internet access can contact the Secretariat to obtain up-to-date versions of these tables (see details on the inside front cover of the Report).

Profile of health services

Roles and responsibilities

The Commonwealth Government's health services activities include:

- funding public hospital services, GPs, some specialist medical services, and public health programs;
- the Pharmaceutical Benefits Scheme (PBS);
- funding and providing nursing home services;
- funding the Commonwealth private health insurance rebate;
- promulgating and coordinating health regulations; and
- undertaking health policy research and policy coordination across the Commonwealth, States and Territories.

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

- public hospital services;
- public health programs, including those for mental health;
- home and community care;
- child, adolescent and family health services;
- patient transport;
- health promotion; and
- 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 hospital and nursing home services.

Funding

Funding the various components of the health care system is a complicated process. The Commonwealth Government subsidises many of the services provided by the non-government sector (mostly through the Medicare Benefits Schedule, the PBS and the private health insurance rebate) and funds a number of nationally coordinated public health programs. It also provides funding to the States and Territories for public hospital services under the Australian Health Care Agreements.

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

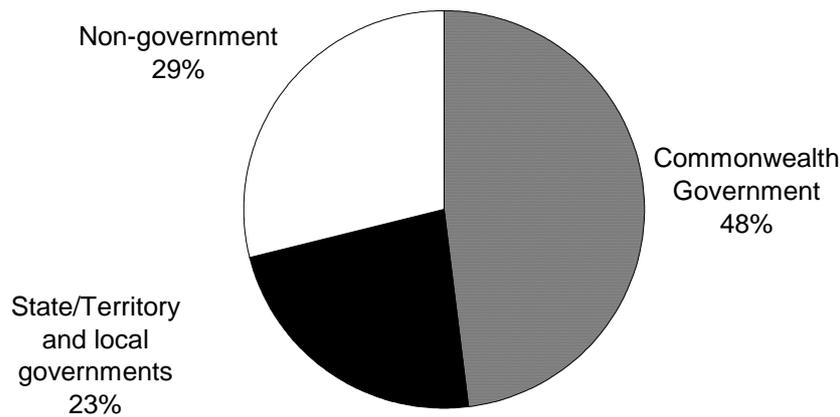
Governments (at all levels) funded approximately 71.2 per cent of total expenditure on health care services during 1999-2000, with the remainder coming from individuals, health insurance funds, and workers' compensation and compulsory motor vehicle third party insurance providers (figure C.1). (The latter two are treated as non-government funding because funds are obtained on the basis of fee-for-service). The Commonwealth Government accounted for the largest proportion of total health care expenditure in Australia (48.0 per cent) in 1999-2000.

Size and scope of sector

Total expenditure (recurrent and capital) on health care services in Australia was estimated to be \$53.7 billion in 1999-2000. This was equivalent to 8.5 per cent of gross domestic product (GDP), up from 7.5 per cent in 1989-90. This implies that health care expenditure grew faster than the economy over the last decade. The ratio

of health expenditure to GDP fell slightly from 8.6 per cent in 1998-99 to 8.5 per cent in 1999-2000, however this was primarily due to GDP having faster real growth than health expenditure — 4.3 per cent and 3.0 per cent respectively (AIHW 2001a).

Figure C.1 **Total health expenditure by source, 1999-2000**^{a, b, c, d, e}



^a Expenditure by the Commonwealth Government and the non-government sector has been adjusted for tax expenditures. ^b Based on preliminary estimates by the Australian Institute of Health and Welfare and the Australian Bureau of Statistics. ^c 'Non-government' includes expenditure by individuals, health insurance funds, workers' compensation and compulsory motor vehicle third party insurers. ^d Includes expenditure on nursing homes and patient transport services. ^e Includes recurrent and capital expenditure.

Source: AIHW (2001a); table 5A.53.

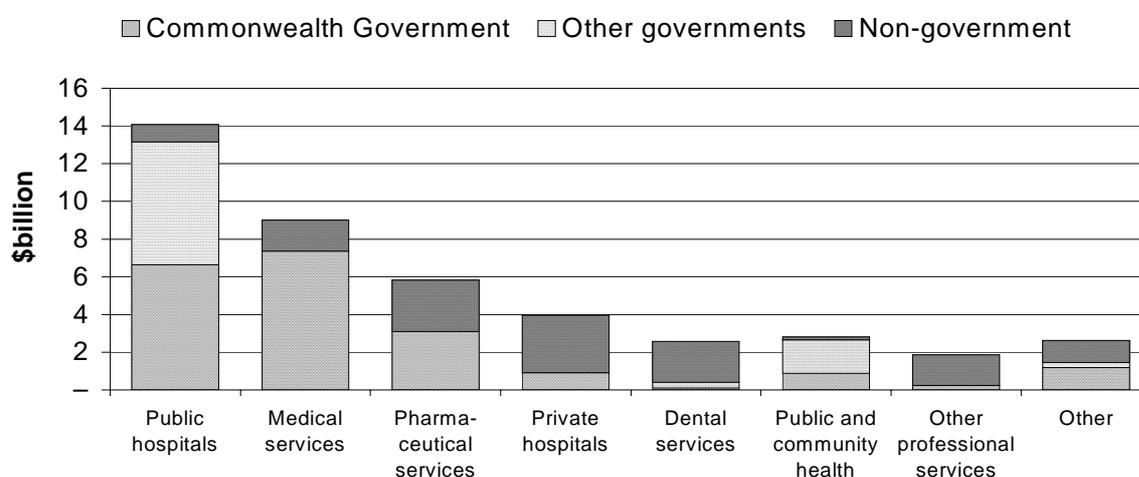
The growth of total expenditure over the last decade was partly the result of an increase in expenditure by the Commonwealth Government. Expenditure by the Commonwealth grew proportionally faster than expenditure by State and Territory governments and non-government sources. Between 1989-90 and 1999-2000 the real average annual rate of growth in expenditure was 5.7 per cent for the Commonwealth Government, 3.0 per cent for State, Territory and local governments and 2.5 per cent for non-government sources (AIHW 2001a). A significant factor was the introduction of Commonwealth programs supporting private health insurance.

On 1 January 1998, the Commonwealth Government replaced the Private Health Insurance Incentive Scheme with a 30 per cent rebate on private health insurance premiums. Total expenditure on the rebate for 1999-2000 was \$1.6 billion (AIHW 2001a).

The single largest item of recurrent health care expenditure by government and non-government sources in 1998-99 (the year for which the most recent data are

available) was on public (non-psychiatric) hospitals. Expenditure of \$13.7 billion funded 3.9 million separations and 33.7 million non-admitted occasions of service (AIHW 2001a). Government recurrent expenditure on public (non-psychiatric) hospitals of \$12.8 billion accounted for 43.7 per cent of total government recurrent expenditure on health care services in that year. Medical services accounted for \$7.4 billion of government expenditure (25.2 per cent of all government recurrent expenditure) and pharmaceutical services accounted for \$3.1 billion (10.6 per cent) (figure Error! Not a valid link.).

Figure C.2 Total health services recurrent expenditure, 1998-99^{a, b, c, d}



^a 'Public hospitals' includes funding for public psychiatric hospitals. ^b 'Medical services' are defined as those provided on a fee-for-service basis, including those provided to private patients in hospitals. They also include some expenditure on private medical services that is not based on a fee for service. ^c 'Pharmaceutical services' include (but are not limited to) those provided under the PBS. ^d 'Other' includes funding for aids and appliances, administration and research.

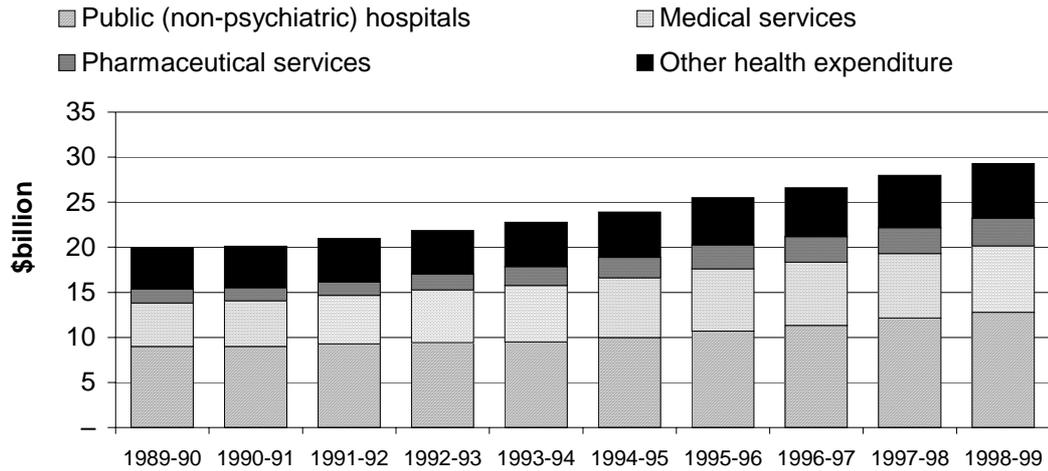
Source: AIHW (2001a); table 5A.54.

Recurrent expenditure on public (non-psychiatric) hospitals by all governments grew by \$3.8 billion (in 1998-99 dollars) between 1989-90 and 1998-99. This accounted for 40.7 per cent of growth in government expenditure on health services (figure C.3 and table 5A.55). The public (non-psychiatric) hospital share, however, fell slightly from 45.0 per cent in 1989-90 to 43.7 per cent in 1998-99.

The decline in the proportion of government expenditure on public hospitals reflected the rapid growth of expenditure on medical and pharmaceutical services (figure C.3). The real average annual growth rate of recurrent expenditure on medical services was 4.6 per cent between 1989-90 and 1998-99 and on pharmaceuticals was 7.5 per cent between 1989-90 and 1998-99 (AIHW 2001a). The growth in medical and pharmaceutical services expenditure reflected an

increase in the number of services delivered. The average number of medical services processed under the Medicare scheme rose from 8.5 in 1989 to 10.6 per person in 1999 (ABS 2001).

Figure C.3 **Total government recurrent health expenditure (constant prices 1998-99)**^{a, b, c, d}



^a 'Medical services' are defined as those provided on a fee-for-service basis, including those provided to private patients in hospitals. They also include some expenditure on private medical services that is not based on a fee for service. ^b 'Pharmaceutical services' include (but are not limited to), those provided under the PBS. ^c Excludes expenditure on nursing homes and patient transport services. ^d 'Other' includes psychiatric hospitals, aids and appliances, administration, research and other institutional expenditure not identified elsewhere.

Source: AIHW (2001a); table 5A.55.

The rapid growth of expenditure on medical and pharmaceutical services meant that their proportion of government health care expenditure rose over the period 1989-90 to 1998-99. Expenditure on medical services increased from 24.2 per cent of government expenditure in 1989-90 to 27.6 per cent in 1993-94 and 1994-95, and has since decreased to 25.2 per cent in 1998-99. The share devoted to pharmaceutical services increased from 7.8 per cent in 1989-90 to 10.6 per cent in 1998-99 (table 5A.55). This strong growth placed pressure on the Commonwealth Government in 1996-97 to restrict Medicare provider numbers and to encourage the use of generic pharmaceutical brands. These initiatives had the effect of slowing the growth of expenditure in real terms.

Policy developments

A number of recent policy developments in Australia and abroad have been aimed at improving the performance measurement of health systems and health care

providers. One development was the establishment by the Australian Health Ministers' Conference of the National Health Performance Committee (NHPC) in August 1999 to replace the National Health Ministers' Benchmarking Working Group. The NHPC is responsible for developing and maintaining a national performance measurement framework for the whole of the health system to support benchmarking for health system improvement and to provide information on national health system performance. The Committee has developed a new health performance framework that provides a structure for appraising the health system. The framework is adapted from work by the Canadian Institute for Health Information and consists of three tiers, each with a number of dimensions:

- health status and outcomes (comprising the dimensions of health conditions, human function, life expectancy and wellbeing, and deaths);
- determinants of health (grouped into environmental factors, socioeconomic factors, community capacity, health behaviours and person-related factors); and
- the performance of health systems (grouped into nine dimensions comprising effectiveness, appropriateness, efficiency, responsiveness, accessibility, safety, continuity, capability and sustainability).

Criteria for the selection of performance indicators have been proposed and the first report on performance is due for publication in 2002 (NHPC 2001).

Policy developments in Indigenous health

A National Aboriginal Health Strategy was developed in 1989 to guide the delivery of Indigenous health services and to improve the health status of Indigenous Australians. The Strategy focused on collaboration and partnership between health and other sectors and increased involvement of Indigenous people in service delivery. Initiatives under the Strategy addressed accessibility of services, workforce issues, risk factors, appropriateness of services and intersectoral collaboration.

A review of the 1989 Strategy undertaken by the National Aboriginal and Torres Strait Islander Health Council indicated that implementation of the Strategy had not been supported and it was suggested that various initiatives failed to improve health outcomes as a result of a lack of cultural security, insufficient resources, failure to adopt recommended strategies, a lack of comprehensive and coordinated action and a lack of recognition and measurement of the intermediate outcomes and critical success factors. A *2001 National Aboriginal and Torres Strait Islander Health Strategy* has been developed based on the same principles as the 1989 Strategy, but reflecting structural changes in health policy and planning and incorporating

recommendations from the review of the previous Strategy. Governments have also tested health reforms to improve Indigenous health outcomes via the Aboriginal and Torres Strait Islander Coordinated Care Trials (box C.2).

Over a number of years, the Australian Health Ministers' Advisory Council (AHMAC) has commissioned the development of specific indicators to review its efforts and achievements in Indigenous health. A refined set of national performance indicators for Aboriginal and Torres Strait Islander health was endorsed by AHMAC in October 2000 and the first performance report will be based on 2000 data. Reports for 1998 and 1999 were released against an interim set of national performance indicators using data submitted by all jurisdictions, although reporting was limited by a paucity of data and difficulties resulting from the small numbers of cases. The last interim report for 1999 noted that:

While some improvements in the ability to report against the indicators are evident in this year's report, the gaps and deficiencies noted in the first report remain: data quality problems affecting most jurisdictions (although to varying degrees); definitional problems associated with many of the performance indicators; and lack of available data or methods for collecting data for several of the indicators (NHIMG 2001).

The refined indicator set incorporates improved definitions and methods for many of the indicators and also covers gaps, including indicators for Indigenous mental health. Reporting over time should also improve (this was not previously possible for many of the interim indicators). Data for the refined indicators are not yet publicly available, although the public hospitals chapter (chapter 5) reports unpublished Australian Institute of Health and Welfare (AIHW) data for standardised Indigenous hospital separation ratios for selected causes (refined indicators 40 to 46).

Box C.2 The Aboriginal and Torres Strait Islander Coordinated Care Trials

Four Aboriginal and Torres Strait Islander Coordinated Care Trials — held in the NT, NSW and WA — ran concurrently with the general trials (box C.6). Their overall objective was to improve the health status of targeted Indigenous communities through a more coordinated approach to delivery of health care. These outcomes were to be facilitated by improving access to, and appropriateness of, health care services, and by establishing or improving local organisational capacity and improved (more flexible) financial and administrative arrangements. The process was to be driven by clients and their communities to create a sense of empowerment.

It was not envisaged that quantifiable improvements in the health status of Indigenous people would be achieved over the trial period given the relatively short duration of the trials in the context of the underlying social, economic and cultural factors that contribute to the ill health of Indigenous people. Evaluation was therefore based on the intermediate objectives: access, appropriateness, organisational capacity, financial and administrative arrangements, client empowerment, and community empowerment.

There were particular differences between the Indigenous and general trials.

- Most Aboriginal trials targeted the whole of the population rather than just people with a complex illness. They engaged all persons in a designated geographical area, facilitating population based health initiatives and a strong focus on community empowerment.
- Since Indigenous people have relatively low levels of access to Medicare and PBS services, the funds pool was based on average per capita Australian use of Medicare/PBS and therefore generally represented additional money for Aboriginal trials.
- A major common aim of the Aboriginal and Torres Strait Islander trials was to increase access to comprehensive primary health care services and to services that were more relevant to the holistic health care needs of Indigenous people.

The evaluation found that the trials made considerable progress in all aspects of the intended program of reforms. The reported outcomes include significantly improved access to services, health care planning, population health programs targeting priority needs at the community level, and building the skills and resources of local communities and organisations so that improvements can be made and sustained into the future.

Financial reform and enhanced community capacity — that is, the combination of the funds pooling and its administration by community based organisations — were the key factors in improving the capacity of the health care system to achieve enhanced health outcomes for Indigenous people.

Source: DHAC (2001b).

Policy developments in regional, rural and remote health

Australians living in rural and remote areas have generally not had the same access to health services as those in metropolitan centres. Initiatives have been introduced by Commonwealth, State and Territory governments to improve health services for non-metropolitan areas in Australia. For example, in 2000-01, the Commonwealth introduced a Regional Health Strategy: *More doctors, better services* — an integrated package of programs worth more than \$560 million over four years. The package included funding for enhanced education and training for health professionals, incentives to retain doctors in rural areas and allowances to sustain or increase the number of pharmacies in more remote areas. Chapter 6 outlines some State and Territory government programs to encourage GPs to practice in rural and remote areas.

Underpinning all of this activity is the need for strong research to report on the efficiency, effectiveness and appropriateness of the Commonwealth Government's rural health programs. Reviews of the early impact of some of the rural programs will be conducted with a view to determining progress of the initiatives, including identifying barriers to the provision of new services in rural areas. In addition, the Department of Health and Aged Care has engaged the AIHW to undertake a major rural health information project which will lead to the provision of a range of reports on rural health performance indicators and selected rural health issues.

Framework for measuring the performance of the health system

Government involvement in health services is predicated on the desire to improve the health of all Australians (box C.3) and governments use a variety of services in different settings to fulfil this objective.

Box C.3 Overall objectives of the health system

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

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

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

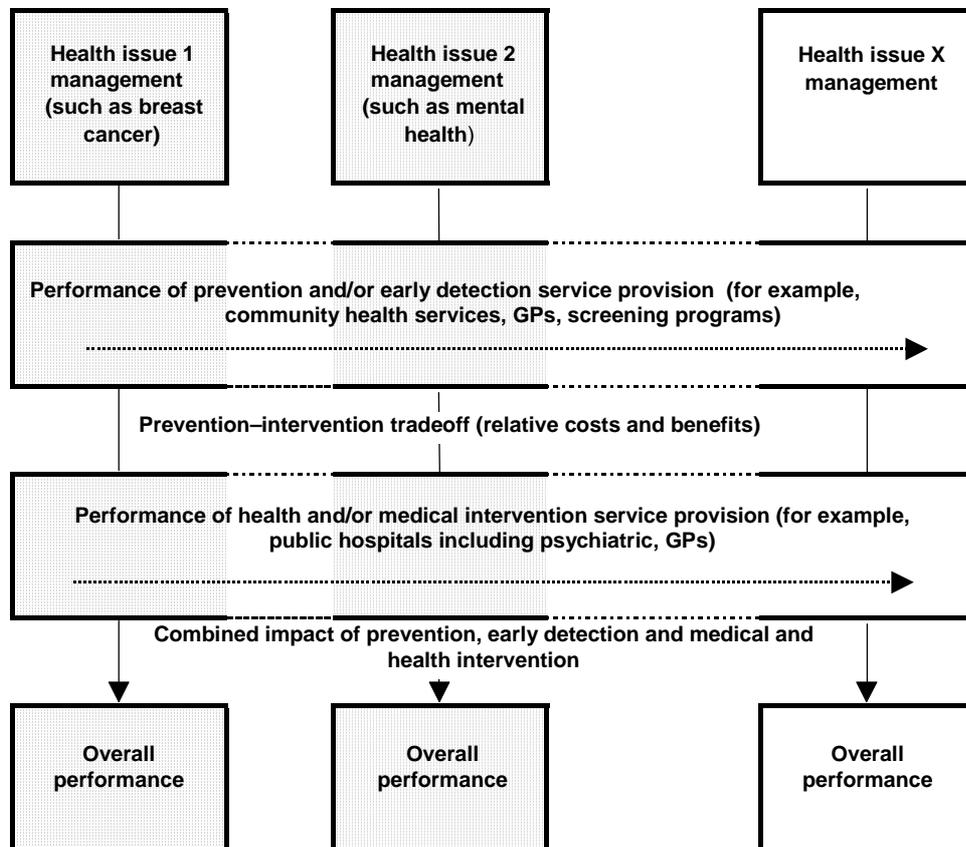
- reduce a person's risk of getting a disease or illness by increasing protective factors; and
- delay the onset of illness.

Medical intervention strategies are implemented after a diagnosis.

Measuring the effectiveness and efficiency of Australia's health system is a complex task. It must account for the performance of a range of services delivered (such as prevention and medical intervention), and for the performance of service providers (such as community health centres, GPs and public hospitals), as well as for the overall outcomes generated by the health system. The Steering Committee has not sought to develop a single unifying performance indicator framework that captures all these aspects of the health system. Instead, it has adopted performance indicator frameworks for each component of the system. The frameworks report on two key aspects of the health system — health care providers and health issues. A complete set of performance indicator frameworks can contribute to an improved understanding of the performance of health care service systems in each jurisdiction.

The measurement approach adopted in this Report is represented diagrammatically (figure C.4). Frameworks of indicators measuring the performance of health service providers across a range of health care issues (represented by the horizontal arrows) are presented for two service delivery mechanisms used in Australia: public hospitals and GPs.

Figure C.4 Australian health system — measurement diagram



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 (hospital based versus community based), are measured by focusing on a health management issue (represented by the vertical arrows). As in previous years, the Report covers breast cancer management and mental health services. The breast cancer management framework integrates the early detection and medical intervention strategies, which should inform the tradeoffs in the allocation of resources between these two strategies. The mental health framework provides information on the interaction and integration arrangements between community based and hospital based providers in meeting the needs of Australians with a mental illness. Performance indicator frameworks are discussed in more detail in chapters 5, 6 and 7.

Measuring health system performance

It is difficult to isolate the effect of health care services on the general health of the population. Socioeconomic factors (such as ethnicity, residential location, income levels and employment rates) and the provision of non-health care government services (such as clean water, sewerage, nutrition, education and public housing) each contribute to overall health outcomes. Indicators of aggregate health outcomes used in this Report include: the prevalence of illness and injury; mortality rates (for infants and all persons, as well as for the leading causes of death); average life expectancy; and the burden of disease and injury (as measured by the years of life lost to mortality or disability).

Where possible, indicators include both Indigenous people as well as the Australian population as a whole. As discussed elsewhere, reporting indicators of performance for Indigenous people is a priority for the Review. Aggregate health outcomes for Indigenous people in Tasmania are discussed in box C.4.

Similarly, the efforts of governments to address health care needs are influenced by factors external to their control, including geographic dispersion, age profiles, racial characteristics and socioeconomic status. Statistical Appendix A provides a summary of some factors that could influence health outcomes and government expenditure. Measures of the efficiency of government and non-government service provision include the per person expenditure on health care services. It is important to remember the limits of these measures, given the effects of other non-health related factors.

Prevalence of illness and injury

One method for measuring overall health outcomes is to use data outlining the prevalence and incidence of illness and injury. The Australian Bureau of Statistics (ABS) published data on the prevalence of illness and injury in 1997 based on the 1995 National Health Survey (table 5A.56). A discussion of the data was included in previous editions of the *Report on Government Services* (including the 2001 Report) and consequently, has not been reproduced here.

Box C.4 Tasmanian Healthy Communities Survey, 1998

Data from the Healthy Communities Survey conducted by the Tasmanian Government in 1998 identify key health and wellbeing differences between Aboriginal and non-Aboriginal adults. As well as health status and risk behaviours, the survey addressed determinants which have been found in previous research to influence health and wellbeing gain. While the survey did not attempt to compile a comprehensive picture of the determinants of Aboriginal health in Tasmania, it improved the population level data available on the social, economic, behavioural, psychological, cultural and attitudinal correlates of Aboriginal people's health status in Tasmania. The report on the survey cautions that it is not possible to derive conclusions about causal links from the data, but that the data do provide an evidence base for input to future research, policy and planning processes.

Detailed data from the survey are presented in table 5A.67. In brief, the survey suggested that, in 1998, Aboriginal people had a greater likelihood than the non-Aboriginal population of experiencing a range of health and socioeconomic disadvantages. Aboriginal people tended to be less satisfied with their mental and physical wellbeing, reported poorer socioeconomic status, had more concerns about their community participation, interaction and respect, tended to exhibit more health related risk behaviours and were more likely to report concerns about their family cohesion. Importantly, there were no statistically significant differences in belief in the effectiveness of immunisation, or reported frequency of problems caused by gambling. However, there was also evidence that many Aboriginal people were achieving at the highest levels. For example, there were similar proportions of Aboriginal and non-Aboriginal people who reported having excellent health, affectionate and non-violent family relationships, and high levels of satisfaction with job security and overall standard of living.

The survey highlights that in order to achieve health gain, the challenge for Aboriginal people and policy makers is to identify the strengths that can be built on, and the factors of disadvantage that can be mediated at population, community, family and individual levels.

Key issues in the health and wellbeing of Aboriginal people have emerged. These include the different demographic profile of Aboriginal people, the need for more information about the prevalence of specific illnesses and injuries experienced by Aboriginal people, of the lifestyle and psychosocial factors that contribute to poorer health and wellbeing, and of Aboriginal family and social support structures. There is also a need for more detailed information about education and work trends, economic capability, community capacity, and cultural issues, such as involvement in community activities, respect and recognition, and the importance of place.

Source: Tasmanian Government.

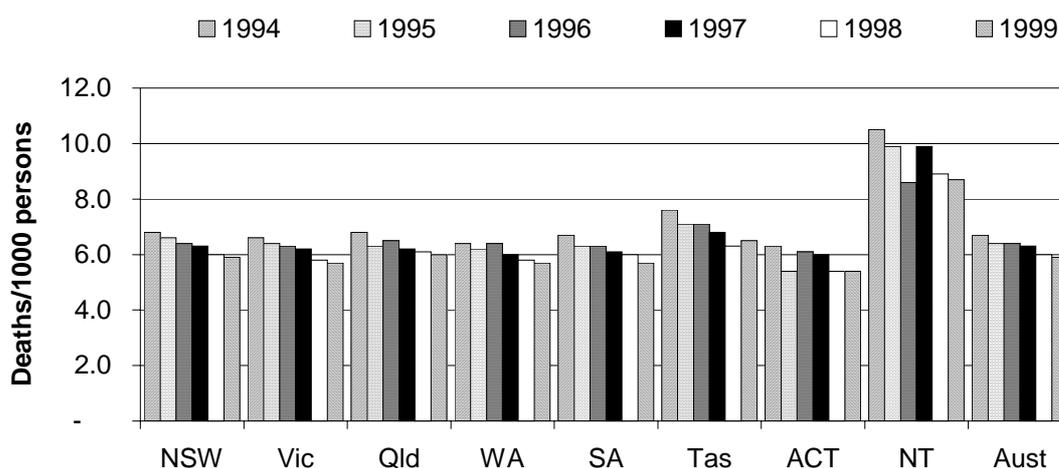
Mortality rates

A second method for measuring overall health outcomes is to use mortality rates among all persons and infants. There were 128 102 deaths in Australia in 1999 (ABS 2000a) which translated into a mortality rate (standardised for age differences across jurisdictions) of 5.9 per 1000 population (figure C.5). Across jurisdictions, mortality rates in 1999 were highest in the NT (8.7 per 1000) and lowest in the ACT (5.4 per 1000).

Mortality rates for Indigenous Australians are reported again this year. In 1999, Indigenous mortality rates in jurisdictions with reliable data were approximately two to three times that of the national average (table 5A.57).

Indigenous mortality, infant mortality, life expectancy, and median age at death need to be interpreted with care. The coverage of Indigenous deaths (and births) in Australia is imperfect. Not every Indigenous registered death (or birth) is appropriately identified as Indigenous. This can result in the underestimation of the number of Indigenous deaths (or births) occurring and, by extension, an underestimation of the mortality (or birth) rate of Indigenous persons (ABS 2000b). The ABS now publishes the Indigenous mortality data for all jurisdictions except Tasmania and the ACT. Changes are being made that will improve the coverage of Indigenous death registrations in these jurisdictions (ABS 2000a).

Figure C.5 **Mortality rate per 1000 persons, age standardised**

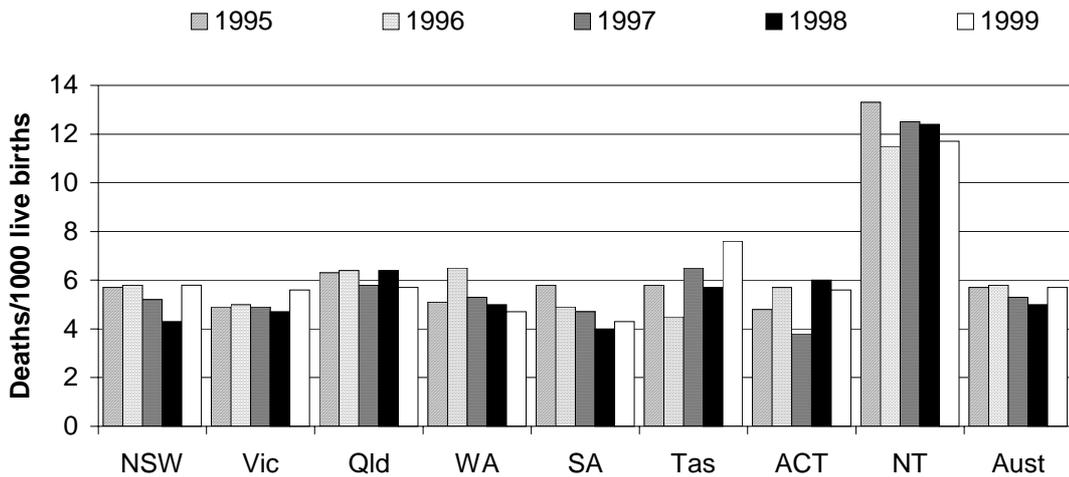


Source: ABS (1997, 2000a and unpublished); table 5A.57.

Infant mortality rates in Australia declined between 1994 and 1998 — from 5.9 to 5.0 per 1000 live births. Between 1998 and 1999, infant mortality rates rose in NSW, Victoria, SA and Tasmania. These increases are reflected in a higher national

infant mortality rate — 5.7 in 1999 (figure C.6). Across jurisdictions, infant mortality rates in 1999 were highest in the NT (11.7 per 1000 live births) and lowest in SA (4.3 per 1000 live births).

Figure C.6 **Infant mortality rate**



Source: ABS (1997, 2000a and unpublished); table 5A.58.

Infant mortality rates for Indigenous Australians are reported for all jurisdictions except Tasmania and the ACT this year. The Indigenous infant mortality rate was between two and three times that of the national average for Indigenous and non-Indigenous Australians in 1999 (table 5A.58). Care must be taken in interpreting these data, given the systematic under-reporting of both infant deaths and births.

Principal causes of death

The main causes of death among Australians in 1999, when measured in terms of broad categories of disease and injury, were diseases of the circulatory system (heart diseases, heart attacks and strokes), neoplasms (tumours and malignant cancers), diseases of the respiratory system (such as chronic obstructive pulmonary disease) and external causes (including accidents and suicide). These accounted for 83.7 per cent of all deaths among males and 80.3 per cent of all deaths among females (table 5A.59).

Table C.1 Principal causes of deaths, 1999 (per cent)

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
Male									
Heart disease ^a	22.6	21.0	23.5	20.3	23.0	21.3	19.5	17.9	22.1
Acute myocardial infarction ^b	11.9	11.4	13.4	10.8	12.6	11.6	10.4	5.7	11.9
Stroke ^c	7.7	6.9	7.3	7.1	7.5	7.6	5.1	3.5	7.3
Lung cancer ^d	6.8	6.9	7.2	7.6	6.9	6.7	5.0	5.7	6.9
Prostate cancer	3.5	4.1	3.7	3.4	4.2	3.9	3.1	0.8	3.7
Suicide	2.9	2.7	3.3	3.3	2.7	3.5	5.1	5.3	3.0
Motor vehicle accidents	1.9	2.1	2.2	3.0	2.0	2.9	1.9	6.1	2.1
Female									
Heart disease ^a	21.3	19.8	23.0	19.6	21.2	20.0	17.7	9.9	20.9
Acute myocardial infarction ^b	11.8	11.1	12.8	10.4	13.2	9.7	10.2	4.3	11.7
Stroke ^c	12.9	11.5	12.1	11.5	12.3	10.4	13.7	7.4	12.1
Lung cancer ^d	3.4	3.6	3.6	4.1	3.3	3.0	3.4	3.1	3.5
Breast cancer	3.8	4.4	4.0	4.8	3.6	4.7	5.1	8.0	4.1
Suicide	0.8	0.7	0.8	0.9	0.8	0.5	1.5	1.5	0.8
Motor vehicle accidents	0.9	0.9	0.9	1.3	0.9	1.2	1.1	2.5	0.9

^a Ischaemic heart disease. ^b Heart attack. ^c Cerebrovascular disease. ^d Cancer of the trachea, bronchus and lung.

Source: ABS (2000a); table 5A.59.

Table C.1 summarises the seven most significant individual causes of mortality among Australian males and females. Ischaemic heart disease, acute myocardial infarction, cerebrovascular disease, lung cancer, prostate and breast cancer, suicide and motor vehicle accidents accounted for 57.1 per cent of all male deaths in Australia in 1999 and 54.1 per cent of all female deaths.

Indigenous Australians in 1999 experienced quite different patterns of mortality than those of the Australian population as a whole. The four major categories of mortality (circulatory diseases, neoplasms, respiratory diseases and external causes²) accounted for between 65.9 per cent (WA) and 75.1 per cent (NSW) of deaths among Indigenous males and between 72.1 per cent (Victoria) and 55.6 per cent (WA) of deaths among Indigenous females (table 5A.60). Diabetes mellitus and external causes accounted for between 33.9 per cent (SA) and 20.6 per cent

² 'External causes' includes transport accidents, intentional self harm, assault and all other external causes of mortality.

(NSW) of all deaths among Indigenous males and 25.4 per cent (WA) and 8.0 per cent (Victoria) of all deaths among Indigenous females.

Burden of disease and injury

The Australian Burden of Disease and Injury Study (Mathers, Vos and Stephenson 1999) provides a comprehensive assessment of the amount of ill health and disability in Australia — the ‘burden of disease’. The burden of disease is measured in terms of the total years of life lost to premature mortality or disability (box C.5). In 1996, premature mortality was responsible for 1.35 million years of life lost in Australia. When adjusted to include the number of years lost to disability resulting from disease or injury, the AIHW estimated the total burden to be 2.5 million Disability-Adjusted Life Years (DALY) in 1996.

Box C.5 Disability- adjusted life expectancy and adjusted life years

Both Disability Adjusted Life Expectancy (DALE) and Disability Adjusted Life Years (DALY) are summary measures of population health.

DALE = Life expectancy adjusted for the average time spent in states of less than full health weighted for severity.

$DALY = YLL + YLD$

YLL = Years of life lost due to premature mortality

YLD = Years of life lost due to disability

The DALE measure estimates the number of years that a person could expect to live in a defined state of health, and is therefore a health expectancy measure. It is a measure of years lived in full health combined with years lived in states of less than full health weighted for severity of disability.

The DALY measure is the number of years lost due to premature mortality (relative to a standard life expectancy) combined with years lived in states of less than full health and is known as a health gap measure. At the population level, it can be interpreted as the gap between current health status and an ideal in which everyone lives into old age free of disease.

‘Disability’ in this context is defined as any departure from full health, and can include a short-term disability from a common cold, through to a long-term disability such as quadriplegia. This is a broader definition of disability than that often used in common language.

(Continued on next page)

Box C.5 (Continued)

Over reliance on aggregated measures such as DALE and DALY can obscure information on the impact of particular disabilities. However, both the mortality and disability components of DALYs can be scrutinised separately.

The definition for YLD shown above is the definition used by the World Health Organisation. The definition that is more commonly used in Australia is 'years of life lost due to disability'.

There may be issues around the acceptability to some groups of people with a disability of both the DALE and DALY concepts in general and the specific weights assigned to various disabilities. There is a need for discussion within the community as to how well the weights (especially those derived from overseas research) reflect the views of both the people most affected by disability and Australian society as a whole. The technical application of the terms from a statistical and data measurement perspective will also be subject to further debate within Australia.

Source: NHPC (2001).

The leading causes of DALYs in Australia in 1996 were ischaemic heart disease and stroke. Together, these accounted for 17.8 per cent of the total disease burden. Chronic obstructive pulmonary disease and lung cancer (also smoking-related diseases) are the third and fifth leading causes of disease burden, accounting for 7.3 per cent of the total. Depression is the fourth leading cause of disease. If the burden attributable to suicide and self inflicted injury is included, then depression rises to third place, accounting for an overall 5 per cent of the total (table C.2).

Table C.2 Leading causes of disease and injury in Australia, 1996

	<i>% of DALYs</i>
Ischaemic heart disease	12.4
Stroke	5.4
Chronic obstructive pulmonary disease ^a	3.7
Depression	3.7
Lung cancer	3.6
Dementia	3.5
Diabetes mellitus	3.0
Colorectal cancer	2.7
Asthma	2.6
Osteoarthritis	2.2

^a Chronic bronchitis and emphysema.

Source: Mathers *et al.* (1999).

Life expectancy

The life expectancy of Australians has improved dramatically since the turn of the century. The average life expectancy at birth in the period 1901–10 was 58.8 years for females and 55.2 years for males. It then rose steadily until it reached 81.8 for females and 76.2 years for males in 1999 (table 5A.61).

Life expectancy at birth varies across jurisdictions. Average life expectancy for males at birth was 77.9 years in the ACT in 1999, compared with 70.6 years in the NT (table C.3). The average for females in WA and SA was 82.1 years, which was seven years longer than that for females in the NT. These differences reflect the large number of Indigenous people living in the NT (compared with other jurisdictions) and the shorter life expectancy of Indigenous people generally (table 5A.61).

Table C.3 **Average life expectancy at birth (years)**

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
Males									
1994–96	75.0	75.6	75.1	75.4	75.3	74.1	76.6	69.2	75.2
1995–97	75.4	75.8	75.4	75.7	75.7	74.8	77.1	70.0	75.6
1996–98	75.8	76.3	75.6	76.1	76.0	75.1	77.5	70.6	75.9
1997–99	76.1	76.7	76.0	76.4	76.4	75.4	77.9	70.6	76.2
Females									
1994–96	80.9	81.2	80.9	81.3	81.3	80.0	81.6	75.0	81.1
1995–97	81.2	81.4	81.3	81.6	81.5	80.1	81.3	74.7	81.3
1996–98	81.6	81.7	81.5	81.9	81.6	80.4	81.6	75.0	81.5
1997–99	81.7	82.0	81.7	82.1	82.1	80.7	81.8	75.1	81.8

Source: ABS 2001; table 5A.61.

Indigenous Australians had considerably worse health than non-Indigenous Australians in 1999 and earlier years. The ABS has published experimental estimates of life expectancy for Indigenous Australians for 1997–99. Based on these estimates, the life expectancy at birth of Indigenous Australians was between 56.3 years in the NT and 54.4 years in SA for males and between 65.2 years in Victoria and 61.4 years in the NT for females (table 5A.61). Care needs to be taken when interpreting these figures as they are estimates only.

Concerns with the under-reporting of Indigenous deaths also affect estimates of life expectancies (ABS 2000b). An alternative measure of longevity is the median age at death, although this does not indicate the current health status of living persons. In 1999, the median age at death in Australia among all Australians was 77.8 years.

Across jurisdictions, median age at death was highest in SA (78.5 years) and lowest in the NT (57.7 years) (ABS 2000a). In contrast, the median age at death for Indigenous Australians was highest among females in Victoria (65.0 years) and lowest among males in SA (46.5 years) (table 5A.62).

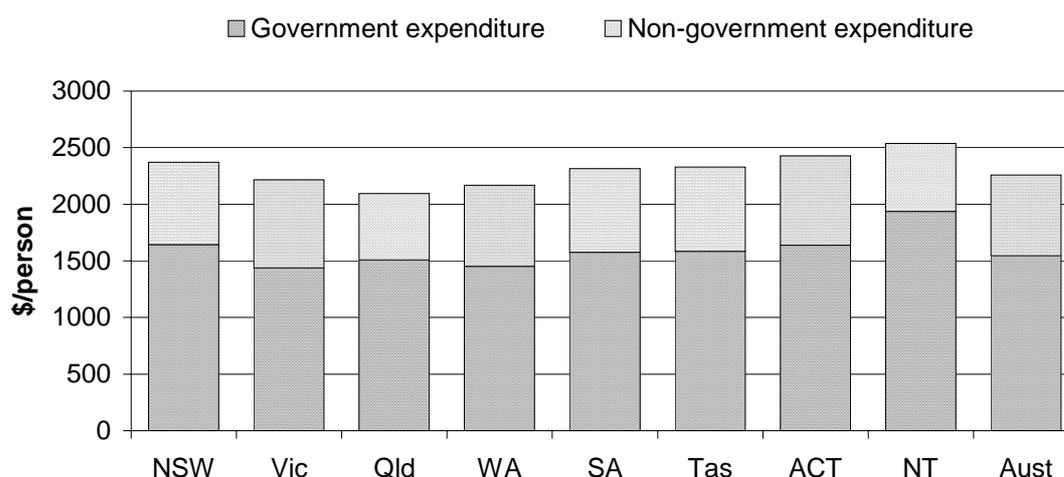
Efficiency of service provision

Total (government and non-government) recurrent expenditure per person can be considered as an imperfect proxy for the efficiency with which health services are provided. As mentioned, a number of factors influence this indicator, including geographic dispersion, differences in population mix and differences in the types of outputs delivered by agencies.

Real government recurrent expenditure on health (excluding nursing homes and ambulance services) rose from \$1379 per person in 1995-96 to \$1545 in 1998-99 in Australia (table 5A.63). Expenditure in 1998-99 was highest in the NT (\$1938) and lowest in Victoria (\$1439 per person). Non-government expenditure was highest in the ACT (\$790 per person) and lowest in Qld (\$585 per person) in 1998-99 (figure C.7).

Real total recurrent expenditure on health care services rose from \$2079 per person in 1995-96 to \$2259 per person in 1998-99 (excluding expenditure on nursing homes and ambulance services) (table 5A.63).

Figure C.7 Total recurrent expenditure per person, 1998-99^a



^a Excludes expenditure on nursing homes and ambulance services.

Source: AIHW (2001a); table 5A.63.

Expenditures on health services for Aboriginal and Torres Strait Islander people

Consistent with a decision by the Australian Health Ministers' Conference that regular estimates should be made of health services expenditure for Aboriginal and Torres Strait Islander people, the Office of Aboriginal and Torres Strait Islander Health commissioned the AIHW to report on health services expenditure to Indigenous people for the 1998-99 financial year (AIHW 2001b). This follows a previous report based on 1995-96 data (Deeble *et al.* 1998).

The report outlines the distribution of expenditure across different levels of government and across different types of health care, but does not attempt to measure performance of the current health system in relation to Indigenous people. In particular, it is not possible to draw conclusions from these data about whether the current balance of services provided to Indigenous people across the health service spectrum is appropriate in terms of both health and culture.

Data and method of estimation

Health expenditure data for Indigenous people are often difficult to obtain or are incomplete. Medicare and PBS data do not include an Indigenous identifier and the Department of Veterans' Affairs also does not identify Aboriginal and Torres Strait Islander status on its records. In other data sets, formal measures have been taken to record Indigenous status, but identification of Indigenous people remains incomplete.

Information on primary care, including use by Indigenous people of Medicare and the PBS, was obtained from a survey of general practitioner activity (the *Bettering the Evaluation and Care of Health* survey, which is discussed in more detail in chapter 6). These data remain subject to incomplete identification of Indigenous people.

The results of the study are based on 'low' Indigenous population estimates calculated on the assumption that the propensity to identify as an Aboriginal and/or Torres Strait Islander person applying at the time of the 1996 census did not change. High population estimates were also calculated based on the assumption that the propensity to identify as Indigenous increased in line with the increase occurring between the 1991 and 1996 Census. Basing the results of the study on the high population estimates reduces the Indigenous/non-Indigenous health expenditure and morbidity ratios by around 8 per cent.

Findings

The vast majority of Indigenous health expenditure is allocated through mainstream health programs, such as admitted and non-admitted patient services, community health services, medical and pharmaceutical health services and public health services. A small proportion of health expenditure is allocated through health programs directly targeting Indigenous people. The most significant targeted programs are the Aboriginal Community Controlled Health Services (ACCHSs), which provide services relating to general and specialist health, eye health, hearing, substance use, mental health, remote health, sexual health, and services fostering emotional and social wellbeing and transport. ACCHSs also provide non-health related services. It should be noted that the report definition excludes welfare services from the expenditure estimates. Other targeted programs include infectious diseases and substance misuse programs and Coordinated Care Trials for Aboriginal communities (box C.2).

Total recurrent expenditure on health services for Indigenous people was estimated at around \$1.2 billion in 1998-99.³ This was equivalent to \$3065 per Indigenous person compared with \$2518 per non-Indigenous person; a ratio of 1.22:1 (table C.4).⁴

Indigenous people were on average much higher users of publicly funded health services but used fewer privately funded services, such as doctors in private practice, private hospitals, dentists and other allied health professionals. Governments funded 90.8 per cent of Indigenous recurrent health costs compared with 67.5 per cent of the recurrent health care costs of non-Indigenous Australians (table C.4). For public funding, the ratio of Indigenous to non-Indigenous expenditures per person was 1.64:1, reflecting their relatively poor health and socioeconomic status (table C.4). Public expenditures on the health of Indigenous people appear to have been similar to those for non-Indigenous people in low income groups, when their relative income position is taken into account.

The Commonwealth, State and Territory governments contributed very similar amounts to the funding of health services for Indigenous people in 1998-99 — the Commonwealth contributed \$566 million and State and Territory governments spent \$559 million.

³ The Report examines recurrent expenditure only. Capital costs are not included in expenditure estimates.

⁴ If the higher costs of providing services in remote areas were factored in, the ratio of Indigenous to non-Indigenous health expenditure would be lower.

Table C.4 Estimated expenditures by source of funds and by Indigenous status, 1998-99 (per person)^a

Source of funds	Indigenous		Non-Indigenous		Indigenous/ other
	\$	%	\$	%	Ratio
Government funding					
<i>State government funding of State government programs</i>	1 376	44.9	484	19.2	2.84
<i>Commonwealth Government funding</i>					
Indigenous-specific	298	9.7	1	–	..
Medicare/PBS	196	6.4	506	20.1	0.39
Other Commonwealth programs	163	5.3	366	14.5	0.45
Payments to States	735	24.0	334	13.2	2.20
<i>Total Commonwealth funding</i>	1 393	45.5	1 206	47.9	1.15
<i>Local government funding</i>	15	0.5	9	0.4	1.67
Total government	2 783	90.8	1 700	67.5	1.64
Patient and other private payments					
State government programs	94	3.1	101	4.0	0.93
Commonwealth Government programs	40	1.3	141	5.6	0.29
Local government programs	5	0.2	2	0.1	2.21
Private sector programs	141	4.6	574	22.8	0.25
<i>Total private funding^b</i>	281	9.2	819	32.5	0.34
Total health funding	3 065	100.0	2 518	100.0	1.22

^a Totals may not add as a result of rounding. ^b Private funding includes funding from out-of-pocket payments by patients, health insurance funding and other funding sources such as workers' compensation. – Zero or close to zero.

Source: AIHW (2001b).

Administrative responsibility and expenditure by program

The majority of health services provided to Indigenous people were administered by State and Territory governments (around 72.0 per cent) (table C.5). Programs delivered directly by the Commonwealth Government accounted for 22.5 per cent of total health expenditure per Indigenous person — a significant proportion through grants to ACCHSs.

Table C.5 Estimated health expenditure by Indigenous status, 1998-99 (per person)^{a, b}

<i>Administrative responsibility</i>	<i>Per person Indigenous</i>		<i>Per person non-Indigenous</i>		<i>Ratio Indigenous/non-Indigenous</i>
	\$	%	\$	%	Ratio
<i>Programs administered by State and Territory governments</i>					
Admitted patient expenditure	1 115	36.4	548	21.8	2.04
Other	1 090	35.6	372	14.8	2.93
Total	2 205	72.0	920	36.6	2.40
<i>Programs administered by Commonwealth</i>					
Indigenous-specific programs	298	9.7	1	..	..
Medicare/PBS	224	7.3	601	23.9	0.37
Other	169	5.5	336	13.3	0.50
Total	691	22.5	937	37.2	0.74
Programs administered by local government	20	0.7	11	0.4	1.78
Programs administered by private sector	148	4.8	650	25.8	0.23
Total recurrent expenditure	3 065	100.0	2 518	100.0	1.22

^a Includes Medicare optometrical and dental as well as medical services. ^b Totals may not add as a result of rounding.

Source: AIHW (2001b).

Around half of government expenditure per Indigenous person was allocated to public hospitals in 1998-99. Community and public health also accounted for a significant proportion (table C.6).

Compared with other Australians, government expenditure per head for Indigenous people was higher for hospital services (both admitted and non-admitted), patient transport and community health services (such as State government community health services, ACCHSs and the Aboriginal and Torres Strait Islander Coordinated Care Trials). On the other hand, expenditure on Medicare and the PBS was much lower for Indigenous people — around 37 per cent of that per non-Indigenous person.

Table C.6 **Estimated expenditures by program and by Indigenous status, 1998-99 (dollars/person)^a**

	<i>Per person Indigenous</i>	<i>Per person non- Indigenous</i>	<i>Ratio Indigenous/non- Indigenous</i>
Expenditure through Commonwealth, State and Territory government programs			
Acute care institutions			
Admitted patient services	1 125	558	2.02
Non-admitted patient services	307	139	2.21
Mental health institutions	64	25	2.53
<i>Public hospitals</i>	1 496	722	2.07
High-care residential aged care	99	209	0.47
Community and public health	874	170	5.14
Patient transport	106	31	3.39
Medicare and other medical ^b	179	468	0.38
PBS medicines	61	195	0.31
Administration and research	101	72	1.40
Total government program expenditure	2 917	1 868	1.56
Expenditures on private sector services			
Private hospitals	25	222	0.11
Dental and other professional	42	213	0.20
Non-PBS medicines and appliances	66	144	0.46
Medical (compensable etc)	11	37	0.30
Administration	5	34	0.14
Total private sector services expenditure	148	650	0.23
Total	3 065	2 518	1.22

^a Totals may not add as a result of rounding. ^b Includes Medicare optometrical and dental as well as medical services.

Source: AIHW (2001b).

Expenditure by jurisdiction

Table C.7 shows expenditure per person by jurisdiction and type of service for the 80 per cent of expenditures on Indigenous people administered by State and Territory governments and provided through the ACCHSs. The data include Commonwealth payments to States and Territories.

More detailed data are included for each jurisdiction in attachments 5A.64 - 5A.71. Any comparisons across jurisdictions need to be made with care as different methods were used to collect the data and the estimates are based on projections of under-identification of Indigenous people, which have significant scope for error.

Table C.7 Estimated government expenditures for Indigenous people 1998-99 (dollars/person)^{a, b, c}

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total
<i>State government</i>									
Admitted patient care	945	793	1 068	1 516	1 434	836	1 206	1 219	1 115
Other health services	884	650	946	1 257	916	809	1 226	1 989	1 090
<i>Commonwealth</i>									
ACCHSs	151	392	157	439	700	a	b	432	287
Total Commonwealth and local government	na	na	na	na	na	na	na	na	711
Total expenditure through government programs	na	na	na	na	na	na	na	na	2917

^a Tasmanian ACCHS funding is included with Victoria. ^b ACT ACCHS funding is included with NSW. ^c Totals may not add as a result of rounding. **na** Not available.

Source: AIHW (2001b).

Comparisons of expenditure on Indigenous health over time

The two reports (AIHW 2001b and Deeble *et al.* 1998) cannot be easily compared because the two sets of estimates are based on different data sources and some of the methods of estimation and costing changed. In addition, under-identification of Indigenous status means that it is difficult to isolate statistical artefacts from real changes over time.

Future directions

The 2001 Report noted that the key challenge for improving the efficiency and effectiveness of the health care system is to improve our understanding of whether health care services are appropriately addressing Australia's health needs. This will continue to be a key challenge over the next decade. The 'appropriateness' of service provision includes:

- the appropriate sequence of events in promoting health care issues and preventing disease and injury in the population, and in treating an individual patient;
- the appropriate level and mix of treatments (for example, the level and mix of separations);

-
- the appropriate mix of service types (for example, the mix of promotion and prevention, and medical intervention); and
 - the appropriate mix of service providers (for example, the mix of public/private health organisations, community based services and hospital based services).

There is already relatively good coverage of performance indicators in some areas where the processes of data specification and capture have been continually refined over a number of years, particularly in hospital care. However, major gaps remain in other areas of the health system, such as primary health and community care. In order to gradually achieve more comprehensive reporting on how well high-level objectives are being met in these areas, there is an ongoing need to develop:

- indicators that cover health services more comprehensively;
- indicators that show the relationship or links between primary health, community care and other sectors; and
- processes to upgrade the quality of the data available for reporting.

Primary health and community care are currently an important focus within health care. As a result, there is increasing recognition of the importance and value of developing and continually refining performance indicators in these areas. An important challenge will be to ensure that reporting on indicators has the potential to lead to action and is highly relevant to policy and practice.

In developing more comprehensive sets of indicators, it is important to focus on the significant aspects of public health or the performance of the health system that are worth measuring. The Review and AHMAC have both commissioned work to consider future directions within the existing range of primary health, and community care services, including general practice, community care, population health, as well as the interfaces between services.

In particular, work is underway that aims to improve and strengthen understanding of the contribution of primary health and community care to overall health system performance, including:

- the refinement of existing performance indicators and/or development of new indicators in areas such as community health and population health;
- improved reporting of the effectiveness of service delivery to specific client groups, including Indigenous people and people in regional, rural and remote areas; and
- work to improve understanding of the interface between services.

Notably, for some years governments have been examining the scope to improve health system performance through service substitution via the Coordinated Care Trials (box C.6).

Work commenced in 2001 on a long term strategy to enhance the capacity of the Review's reporting frameworks to reflect inter-relationships between services. In the first instance, this analysis is focusing on the nexus between general practice and aged care. The Review also instigated the development of a long term strategy (with a five to 10 year view) to improve reporting of the performance of governments in providing health services to Indigenous people.

Box C.6 Coordinated Care Trials

In the mid-1990s, the Council of Australian Governments initiated Coordinated Care Trials to develop and test different service delivery and funding arrangements with a view to more appropriately meeting individual care needs within existing resources.

Nine trials were established to conduct a live phase test of coordinated care over a time span ranging from 761 to 944 days. The live phase was completed by 31 December 1999. The trials operated in five States and one Territory.

The trials were aimed at people with chronic illness and complex care needs that involved access to multiple services. Each client in the trial had a care coordinator — often their GP — who developed a care plan. The Commonwealth, State and Territory governments pooled their funds for health and community services for each participant in the trial. The amount of money placed in each pool was based on an estimate of what would otherwise have been spent on services used by trial participants. The care coordinator used money from the pool to buy services set out in the care plan.

One of the original intentions of care coordination was to promote opportunities for service substitution between:

- acute and sub-acute and community based services;
- community based services and residential care; and
- a range of other community based services.

It was hypothesised that the success of coordinated care to improve health outcomes within existing resources would be affected by the extent of substitution between services. In practice, the scope of service substitution across the trials varied and the structure of the trials in some cases hindered substitution activities. Difficulties were also experienced with the complex data needs associated with evaluating the trials. The evaluation report released in 2001 was unable to reach a conclusion about the extent to which service substitution had occurred and noted that the anticipated reductions in Medicare, PBS and hospitalisation that were intended to cover the costs

(Continued on next page)

Box C.6 (Continued)

of care coordination were not apparent. However, there may have been changes in service use beyond the period of the trials that were not able to be measured. Overall, while some clients may have experienced some improvement in their sense of wellbeing, this was not achieved within existing resources.

A further round of Coordinated Care Trials targeting the frail aged; those with chronic conditions such as asthma, diabetes, and heart conditions; and Aboriginal communities experiencing problems associated with chronic disease, commenced in early 2001 and will run for three years.

Source: DHAC (2001a).

5 Public hospitals

Public hospitals are important providers of government funded health care services in Australia. This chapter reports on the performance of States' and Territories' public hospitals, with a focus on acute care services. The chapter also reports on a significant component of the services provided by public hospitals — maternity services.

Public hospital systems, including provision by public hospitals of maternity services, are described in section 5.1. A framework of performance indicators and the key performance indicator results for public hospitals are outlined in section 5.2. The performance indicator framework and key results for maternity services provided by public hospitals are discussed in section 5.3. Future directions in reporting are discussed in section 5.4. Terms and definitions are summarised in section 5.5.

This year, improvements have been made in the reporting of public hospital efficiency to facilitate comparisons across hospitals providing similar services. Descriptive data on non-government sources of funding for public hospitals are also presented to aid interpretation of the efficiency data. This is consistent with the focus of the Review on services provided by government. In addition, national averages compiled by the Commonwealth National Hospital Cost Data Collection are provided for the costs of emergency department visits and occasions of service to outpatients. Reporting on hospital services to non-admitted patients is hampered by the lack of a nationally agreed classification system for these data. Lastly, the maternity services indicator framework has been expanded to include four new performance indicators which are reported for the first time this year.

In line with the Review's focus on improving reporting for Indigenous Australians, a number of new Indigenous data are reported this year: hospitalisation ratios for circulatory diseases, injury and poisoning, respiratory diseases, diabetes, tympanoplasty for otitis media, and mental disorders. These are similar to data included in previous reports, but rely on new definitions endorsed by the Australian Health Ministers' Advisory Council (AHMAC). These data do not reflect the performance of public hospitals, but have been included in the chapter to expand information on the utilisation of public hospitals by Indigenous people.

Supporting tables

Supporting tables for chapter 5 are provided on the CD-ROM enclosed with the Report. The files are provided in Microsoft Excel 97 format as \Publications\Reports\2002\Attach5A.xls and in Adobe PDF format as \Publications\Reports\2002\Attach5A.pdf.

Supporting tables are identified in references throughout this chapter by an 'A' suffix (for example, table 5A.3 is table 3 in the electronic files). They may be subject to revision. The most up-to-date versions of these files can be found on the Review's web page (www.pc.gov.au/gsp). Users without Internet access can contact the Secretariat to obtain up-to-date versions of these tables (see details on the inside front cover of the Report).

5.1 Profile of public hospital systems

Definition

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

- acute care services to admitted patients;
- sub-acute and non-acute services to admitted patients (for example, rehabilitation or palliative care, or long stay maintenance care);
- emergency, outpatient and other services to non-admitted patients;¹
- mental health services, including services provided to admitted patients by designated psychiatric/psychogeriatric units;
- public health services; and
- teaching and research activities.

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

¹ Other services to non-admitted patients include community health services such as baby clinics and immunisation units, district nursing services and other outreach services. Definitions are provided in AIHW (2001a).

reliable data available. Some data in the chapter include sub-acute and non-acute care services where they cannot yet be separately identified from acute care. In some instances, stand-alone psychiatric hospitals are also included, although their role is diminishing in accordance with the National Mental Health Strategy. Under the strategy, the provision of psychiatric treatment is shifting away from specialised psychiatric hospitals to mainstream public hospitals and the community sector. The performance of psychiatric hospitals and psychiatric units of public hospitals is examined more closely in chapter 7. Some common health terms relating to hospitals are defined in box 5.1.

Box 5.1 **Some common health terms**

Patients

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

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

Types of care

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

acute care: clinical services provided to 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.

ambulatory services: services provided by hospitals to non-admitted patients.

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

Hospital outputs

separation: the discharge, transfer, death or change of episode of care of an admitted patient. For measuring a hospital's activity, separations are used in preference to admissions because diagnoses and procedures can be more accurately recorded at the end of a patient's stay and patients may undergo more than one separation from the time of admission. Admitted patients who receive same day procedures (for example, renal dialysis) are recorded in separation statistics.

(Continued on next page)

Box 5.1 (Continued)

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

non-admitted occasions of service: clinical services provided by hospitals to non-admitted patients. Services may include emergency department visits, outpatient services (such as pathology, radiology and imaging, 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.

Other common health terms

comorbidity: the simultaneous occurrence of two or more diseases or health problems that affect the care of the patient.

AR-DRG v4.1 (Australian Revised Diagnosis Related Group, version 4.1): a patient classification system that hospitals use to match their patient services (hospital procedures and diagnoses) with their resource needs. AR-DRG v4.1 is based on the ICD-10-AM classification and replaces the earlier AN-DRG v3.0/3.1.

ICD-10-AM: a classification of diseases and injuries, the Australian Modification (AM) of the International Standard Classification of Diseases and Related Health Problems, Revision 10 (ICD-10). ICD-10-AM replaces the earlier ICD-9-CM (Australian Version of the International Classification of Diseases, Revision 9, Clinical Modification).

Sources: AIHW (2001a); DHAC (1998); National Centre for Classification in Health (1998).

Funding

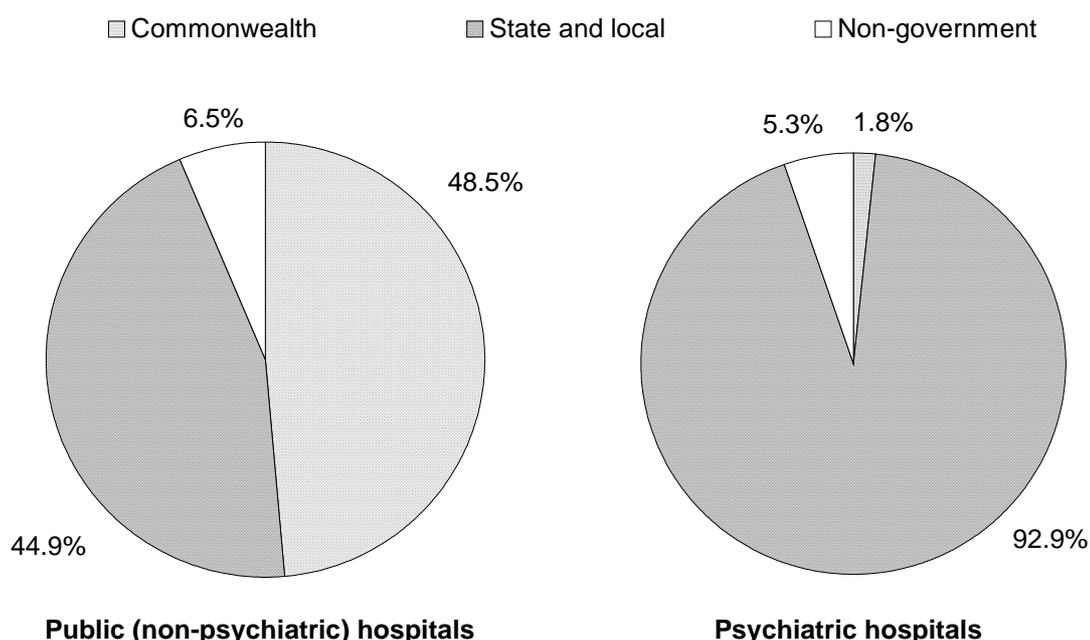
Total recurrent expenditure on public hospitals (excluding depreciation) was \$14.4 billion in 1999-2000 (1999-2000 dollars) (table 5A.1).² In real terms, expenditure increased 2.6 per cent in 1999-2000 (in 1998-99 dollars) (AIHW 2001b).

Commonwealth, State and Territory governments, health insurance funds, individuals, workers' compensation and compulsory motor vehicle third party insurance cover, finance the expenditure on public hospitals. The most recent comparative data available on hospital expenditure by source of funds are for

² This figure includes spending on patient transport.

1998-1999.³ In that year, around \$13.7 billion was spent on public (non-psychiatric) hospitals and \$397 million was spent on public psychiatric hospitals (AIHW 2001c). Governments contributed about 93.5 per cent of funding for public (non-psychiatric) hospitals and 94.7 per cent of funding for public psychiatric hospitals (figure 5.1).

Figure 5.1 Recurrent expenditure on public hospitals, by source of funds, 1998-1999 (per cent)



Source: AIHW (2001c); table 5A.54.

Public hospitals accounted for 69.3 per cent of recurrent expenditure on health services by State and Territory governments in 1998-99. In contrast, public hospitals accounted for only 32.5 per cent of Commonwealth Government recurrent spending on health services (table 5A.54).⁴

For selected public hospitals, expenditure on admitted patients (based on the inpatient fraction) comprised 70–80 per cent of total recurrent expenditure in 1999-2000 (table 5A.27). Acute non-psychiatric admitted patients accounted for

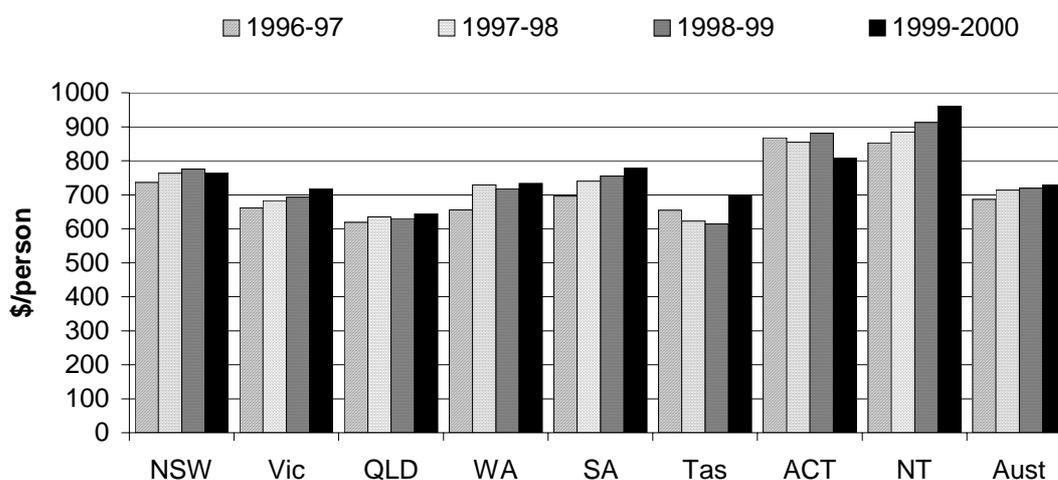
³ The 1998-99 expenditure data (figure 5.1) are from the AIHW's *Health Expenditure Bulletin* and are not directly comparable with the 1999-2000 expenditure data which are drawn from the AIHW's *Australian Hospital Statistics*. The *Health Expenditure Bulletin* data have a broader scope. The *Australian Hospital Statistics* data exclude expenditure for population health, primary and community based services administered by NSW hospitals and trust fund expenditure (AIHW 2001).

⁴ Excludes expenditure on nursing homes and ambulance services as these are discussed elsewhere in the Report.

66.8 per cent of hospital expenditure in NSW and 61.6 per cent in Victoria (table 5A.29).

In 1999-2000, per capita government recurrent expenditure on public hospitals was \$729 for Australia, ranging from \$962 in the NT to \$643 in Queensland (1998-99 dollars). Real expenditure per head across Australia increased over time, from \$686 to \$729 between 1996-97 and 1999-2000 (figure 5.2). Not all jurisdictions followed this trend.

Figure 5.2 Recurrent expenditure per person, public hospitals (1998-99 dollars)^{a, b}

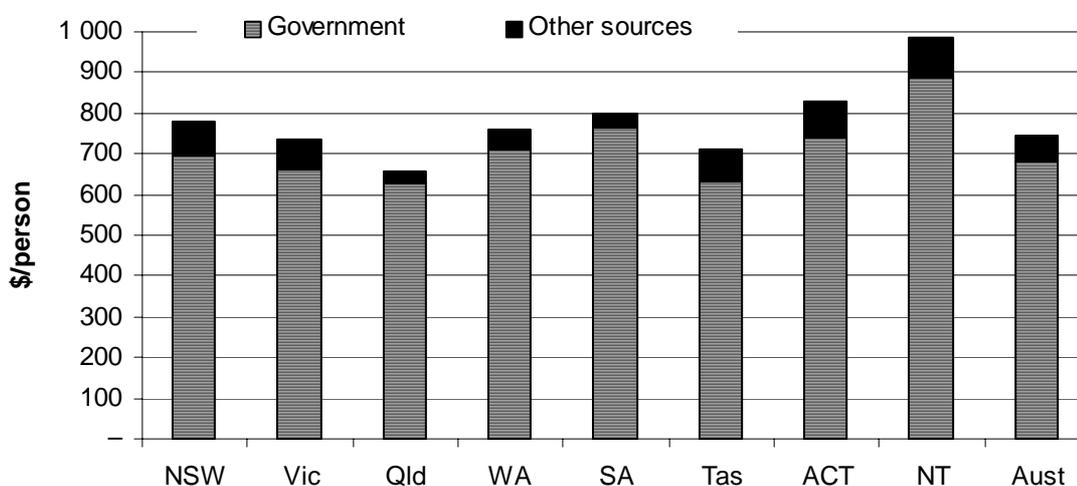


^a Data include psychiatric hospitals. ^b Depreciation and interest payments excluded.

Source: AIHW (2001b, 2001c); table 5A.2.

In 1999-2000, public hospitals received \$1.2 billion revenue from non-government sources, which accounted for 8.5 per cent of all recurrent expenditure. Total revenue in each State and Territory comprised patient revenues (including income from private and compensable patients), recoveries (including fees from private practitioners treating private patients in public hospitals, staff meals and accommodation) and other revenue (investment income, charities and bequests). It should be noted that some Commonwealth health insurance subsidy payments are indirectly included in total income via health insurance payments received as part of patient revenue. The proportion of hospital expenditure from non-government sources varies across jurisdictions (figure 5.3).

Figure 5.3 **Source of funds per person, public hospitals, 1999-2000 (current prices)^a**



^a Data include psychiatric hospitals.

Source: AIHW (2001b); tables 5A.30 and 5A.1.

Size and scope of sector

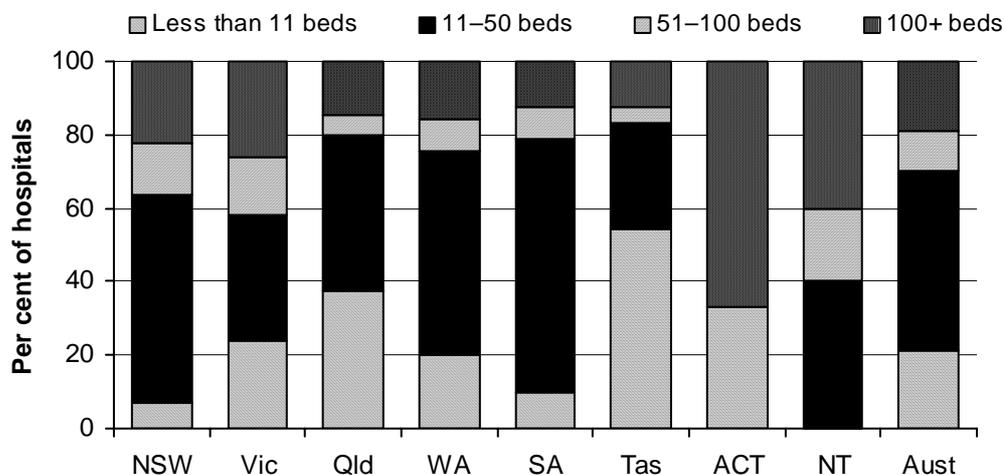
Hospitals

In 1999-2000, Australia had 748 public hospitals (including 24 psychiatric hospitals) with 52 947 beds (AIHW 2001b). There were 679 fewer beds in public (non-psychiatric) hospitals in 1999-2000 than in 1998-99. Although 69.9 per cent of hospitals had fewer than 50 beds, these smaller hospitals represented only 18.5 per cent of total available beds (figure 5.4).

Beds

On average, there were 2.9 beds per 1000 people in 1999-2000 (figure 5.5). The number of beds per 1000 people was highest in SA (3.4) and lowest in the ACT (2.2). More beds were available per 1000 people in remote areas, however, this does not provide an indication of regional access to particular types of service or the distance required to travel to access these services. These data should be viewed in the context of the age and sex structure of the population in each jurisdiction. This information is included in appendix A.

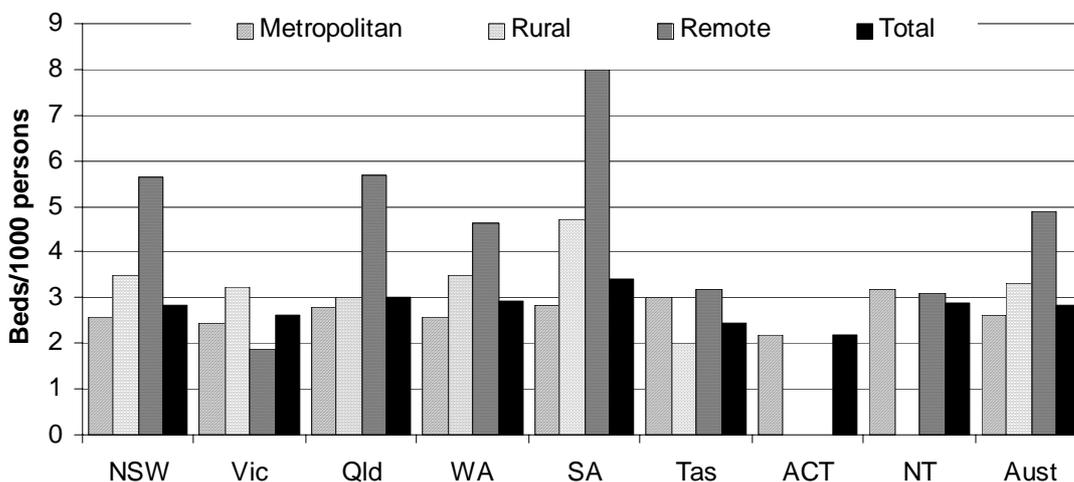
Figure 5.4 Public hospitals by size, 1999-2000^{a, b, c}



^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 physical hospital buildings or campuses. ^b Size is based on the number of available beds. ^c The count of hospitals in Victoria is a count of the campuses that separately report data to the Victorian Admitted Episodes Database.

Source: AIHW (2001b); table 5A.3.

Figure 5.5 Number of available beds by region, public hospitals, 1999-2000^a



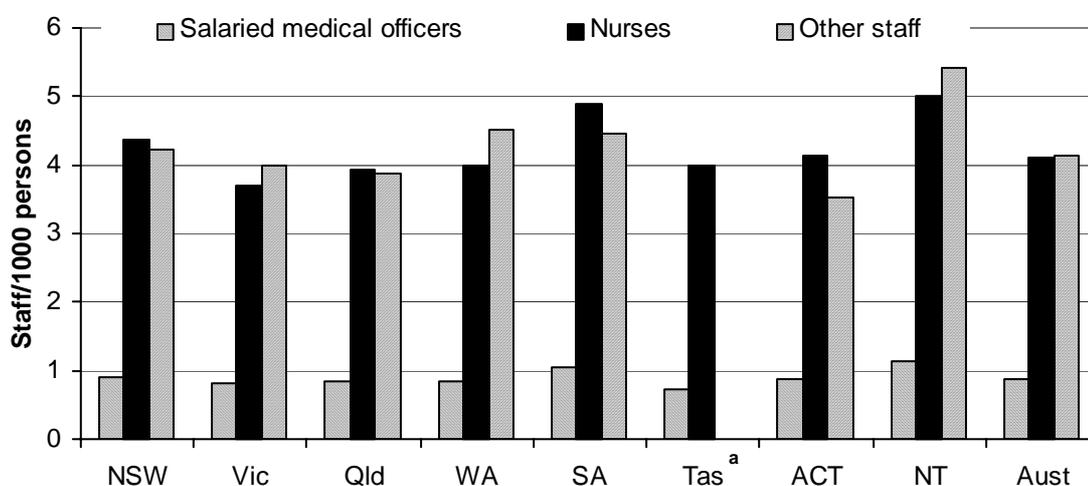
^a An 'available bed' is immediately available to be used by an admitted patient. A bed is immediately available if located in a suitable place for care, with nursing and auxiliary staff available within a reasonable period. Surgical tables, recovery trolleys, delivery beds, cots for normal neonates, emergency stretchers/beds not normally authorised or funded, and beds designated for same day non-admitted patient care are excluded (AIHW 2001a).

Source: AIHW (2001b); table 5A.4.

Staff

There were 175 291 full time equivalent (FTE) staff employed in Australian public hospitals in 1999-2000 (based on the average number of staff available for the year). This represents a reduction of 244 since 1998-99. Nurses comprised 45.1 per cent and salaried medical officers represented 9.5 per cent of FTE staff. Other staff (diagnostic and allied health professionals, other personal care staff, administrative and clerical staff, and domestic and other staff) made up the remaining 45.4 per cent (AIHW 2001b). The NT had the most FTE staff per 1000 people (11.6) while Victoria and the ACT had the least (8.5) (figure 5.6). It is important to note that the collection of data by staffing category is not consistent across jurisdictions — for some jurisdictions, best estimates only are reported. In some jurisdictions there has been an increase in the outsourcing of services with a large labour related component (for example, food services and domestic services). Increased outsourcing may explain some of the apparent decline in full time equivalent staff in some staffing categories and also some of the differences between the jurisdictions (AIHW 2000a).

Figure 5.6 Average full time equivalent staff, public hospitals, 1999-2000



^a Data for the 'other' staff category for Tasmania were not available.

Source: AIHW (2001b); table 5A.5.

Activity

Admitted patient care

There were around 3.9 million acute, sub-acute and non-acute separations in public hospitals in 1999-2000 (table 5A.6). Of these, acute separations accounted for 95.7 per cent, newborns with some qualified days 1.1 per cent, and rehabilitation care 1.8 per cent (see table 5A.8). (Palliative care, non-acute care and other care made up the residual.) Public psychiatric hospitals accounted for around 0.5 per cent of total separations in public hospitals. Of the total number of separations in public (non-psychiatric) hospitals, 45.8 per cent were for same day patients (table 5A.6).

Table 5.1 shows the 10 AR-DRGs with the highest number of acute separations in public hospitals (excluding same day separations) for 1999-2000. These 10 AR-DRGs accounted for 16.1 per cent of all acute separations nationally. In the NT, which reported the highest jurisdictional percentage, these 10 AR-DRGs accounted for around 19.3 per cent. If same day separations were included, renal dialysis and chemotherapy would form a large proportion (15.6 per cent) of the total national number of separations. In 1999-2000, 1.7 million same day separations occurred in Australia (AIHW 2001b). Renal dialysis accounted for 26.9 per cent of these and chemotherapy 6.7 per cent.

Table 5.1 Ten AR-DRGs with the highest number of non-same day acute separations, public hospitals, 1999-2000 (per cent)^{a, b, c}

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
Vaginal delivery W/O CD	5.5	5.5	5.7	4.6	3.8	5.1	6.1	5.7	5.3
Chest pain	1.5	1.3	1.7	1.0	1.4	0.9	1.1	1.4	1.4
Oesophagitis, gastroenteritis and miscellaneous digestive system disorders Age>9 W/O Cat/Sev CC	1.5	1.2	1.5	1.5	1.5	1.2	0.7	0.8	1.4
Bronchitis and asthma aged<50 W/O CC	1.4	1.2	1.4	1.5	1.6	0.8	1.0	1.0	1.3
Cellulitis aged>59 W/O Cat/Sev CC	1.2	1.0	1.5	1.5	0.9	1.0	0.8	3.8	1.2
Caesarean delivery W/O CD	1.1	1.2	1.3	1.0	1.0	1.0	1.2	1.1	1.1
Vaginal delivery W Sev CD	1.2	1.1	1.0	1.0	0.8	1.0	1.3	1.3	1.1
Heart failure and shock W/O Cat CC	1.2	1.0	1.0	1.1	1.1	1.0	0.8	0.8	1.1
Unstable angina W/O Cat/Sev CC	1.2	1.1	1.3	0.6	0.9	1.2	0.8	1.0	1.1
Respiratory infection/inflammation W/O CC	1.1	0.9	1.0	1.2	0.7	0.9	1.2	2.5	1.1
Per cent of acute separations accounted for by 10 AR-DRGs with most acute separations	16.8	15.6	17.3	15.0	13.9	14.1	15.0	19.3	16.1
Total acute separations (non same day) ('000)	706	478	368	187	183	40	29	28	2019

^a Cat=Catastrophic, CC=complications and comorbidities, CD=complicating diagnosis, Sev=Severe, W/O=without, W=with. ^b Separations for which the type of episode of care was reported as acute or was not reported and the length of stay was less than 366 days. ^c Totals may not add as a result of rounding.

Source: AIHW (2001b); table 5A.9.

Table 5.2 lists the 10 AR-DRGs that accounted for the largest number of patient days for overnight stays in 1999-2000. These account for 17.4 per cent of all patient days recorded. Vaginal delivery without complicating diagnosis accounted for the largest number of patient days, followed by schizophrenic disorders and major affective disorders.

Table 5.2 Ten AR-DRGs with the most patient days, excluding same day separations, public hospitals, 1999-2000 (per cent)^{a, b}

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
Vaginal delivery W/O CD	3.1	3.1	3.2	2.7	2.2	2.7	2.9	3.8	3.0
Schizophrenic disorders W/O legal status	3.4	1.5	1.2	1.2	1.5	3.1	2.9	1.6	2.2
Major affective disorder Aged<70 W/O Cat/Sev CC	1.8	1.8	2.3	3.1	3.0	2.5	5.1	1.1	2.2
Tracheostomy, any age, any condition	1.9	2.2	2.0	1.7	1.9	2.0	2.1	2.0	2.0
Schizophrenia disorders W legal status	0.1	2.8	3.1	3.1	1.8	0.6	1.9	0.0	1.7
Chronic obstruction airway Disorder W Cat/Sev CC	1.6	1.4	1.6	1.2	1.3	1.7	0.5	1.3	1.4
Dementia and chronic disturb Crbrl Fn	1.0	1.5	0.9	2.8	1.8	1.1	0.4	0.2	1.3
Heart failure and shock W/O Cat CC	1.5	1.2	1.2	1.2	1.3	1.3	0.8	0.9	1.3
Stroke with Sev CD/proc	1.2	1.3	1.0	1.6	1.3	1.2	1.1	0.5	1.2
Respiratory infection/inflammation W Smcc	1.2	1.1	0.9	0.8	0.9	1.0	0.7	2.8	1.1
Total patient days accounted for by top ten AR-DRGs (%)	16.6	17.9	17.4	19.6	17.1	17.2	18.6	14.2	17.4
Total days (excluding same day separations) ('000)	3940	2622	1805	1047	985	250	177	153	10 981

^a Cat=Catastrophic, CC=complications and comorbidities, CD=complicating diagnosis, Sev=Severe, W/O=without, W=with. ^b Separations for which the type of episode of care was reported as acute or was not reported and the length of stay was less than 366 days.

Source: AIHW (unpublished); table 5A.31.

Non-admitted patient services

There is no agreed classification system for services to non-admitted patients, so activity is difficult to measure and cannot be compared across jurisdictions. In particular, SA hospitals reported non-admitted patient services using a different set of categories than those used by other States and Territories. Differing admission practices will lead to variation among jurisdictions in the services reported. In addition, States and Territories may also differ in the extent to which these types of services are outsourced or provided in non-hospital settings (such as community health centres) (AIHW 2000a). Over the past few years, NSW, Queensland, WA, SA and Tasmania have all made changes in the reporting arrangements used for non-admitted occasions of service (AIHW 2000a). The complexity of the occasion of service is also not taken into account (for example, simple urine glucose test treated equally with complete biochemical analysis of all body fluids) (AIHW

2001a). Table 5.3 presents data from the AIHW Australian Hospital Statistics publication and can be considered a 'best available estimate' of activity in this area.

A total of 33.7 million occasions of service were provided to individual non-admitted patients in public hospitals in 1999-2000 (table 5A.10). In addition to services provided to individuals, 473 449 group sessions were also delivered by public hospitals during this time (where a group session is defined as a service provided to two or more patients, but excludes services provided to two or more family members). In public hospitals in 1999-2000, accident and emergency services comprised 15.5 per cent of all occasions of service to non-admitted patients. Pathology services and other medical, surgical and obstetric services were the most common types of outpatient care.

Table 5.3 Seven most common types of non-admitted patient care, public hospitals, 1999-2000 (per cent)^{a, b}

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
Accident and emergency	13.4	16.0	15.5	17.3	19.3	13.5	23.3	28.6	15.5
<i>Outpatient services</i>									
Other medical/surgical/obstetric ^c	50.9	19.5	28.9	14.6	40.3	29.1	45.2	23.0	34.2
Pathology	16.2	9.6	13.4	9.1	..	24.8	8.4	19.7	12.4
Radiology and organ imaging	6.7	6.9	11.0	9.1	9.5	11.6	14.6	20.6	8.4
Pharmacy	3.5	4.7	10.3	4.9	..	6.2	0.1	4.3	5.2
Allied health ^d	..	14.3	8.4	18.4	11.1	12.6	2.4	3.9	7.8
<i>Other non-admitted</i>									
Community health ^e	7.4	7.2	2.5	17.0	..	..	..	..	6.5
Seven most common as a per cent of total (%)	98	78	90	90	80	98	94	100	90
Total occasions of service ('000)	11 993	6994	7380	3540	2397	678	365	337	33 684

^a The count of pathology occasions of service in WA is considerably lower than last year due to a changed method of counting at a major hospital. ^b Non-admitted patient occasions of service data are not reliable, and in addition, significant differences occur between States and Territories due to different counting methods. The overall comparability of these data is poor. ^c Other medical/surgical/obstetric refers to occasions of service to non-admitted patients not covered by other National Health Data Dictionary categories for outpatient services (dialysis, pathology, radiology and organ imaging, endoscopy and related procedures, mental health, drug and alcohol, dental pharmacy and allied health). ^d Allied health includes services to non-admitted patients where services are provided at clinics or units providing treatment or counselling such as physiotherapy, speech therapy etc ^e Community health refers to services provided by designated community health units within the establishment such as baby clinics, immunisation units, aged care assessment teams and so on. .. Not applicable.

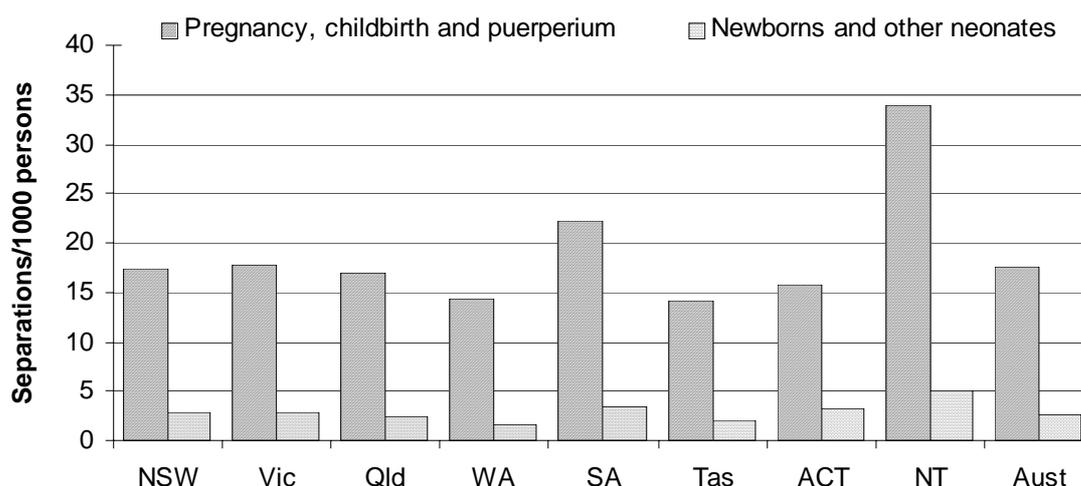
Source: AIHW (2001b); table 5A.10.

Maternity services

Maternity services (specifically, AR-DRGs relating to pregnancy, childbirth and the puerperium) accounted for the third highest number of separations in public hospitals in Australia in 1999-2000 after diseases and disorders of the kidney and urinary tract, and diseases and disorders of the digestive system (AIHW 2001b). Maternity services separations accounted for 9.0 per cent of total acute separations in public hospitals (table 5A.37) and contributed around 7.9 per cent to the total cost of all acute separations in public hospitals in 1999-2000 (table 5A.37).

Figure 5.7 shows that the NT had the highest number of acute separations per 1000 persons for pregnancy, childbirth and the puerperium (33.9) in 1999-2000 and Tasmania had the lowest (14.1).

Figure 5.7 **Separation rates for maternity services in public hospitals, 1999-2000^{a, b, c}**



^a The puerperium refers to the period of confinement immediately after labour (around six weeks).

^b Newborns and other neonates include babies aged less than 28 days or babies aged less than one year with admission weight less than 2500 grams. ^c Separations for which the type of episode of care was reported as acute, or newborn with qualified patient days.

Source: AIHW (2001b); table 5A.38.

Vaginal deliveries without complicating diagnosis accounted for a substantial proportion of the separations for pregnancy, childbirth and the puerperium (31.8 per cent) in 1999-2000. Excluding same day separations, vaginal deliveries without complicating diagnosis accounted for the largest number of acute separations and patient days in public hospitals (table 5.1 and table 5.2) and the second highest cost in 1999-2000 (\$254.7 million) (table 5A.39) (AIHW 2001b).

The complexity of cases across jurisdictions for maternity services is in part related to the mother's age at the time of giving birth. On average, women in the ACT reported the oldest mean birthing age (29.0) and NT the youngest (27.1) (table 5.4).

Table 5.4 Mean age of mothers at time of first, second and third births in public hospitals, 1998 (years)

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>
<i>Mean age of mothers at the following:</i>								
First birth	26.7	26.7	24.9	25.6	25.9	na	27.0	25.0
Second birth	29.2	29.1	27.4	27.9	28.5	na	29.0	27.5
Third birth	30.7	30.8	29.2	29.8	30.1	na	31.0	28.7
All confinements	28.9	28.9	27.2	27.7	28.2	na	29.0	27.1

na Not available.

Source: State and Territory governments (unpublished).

5.2 Public hospitals

Framework of performance indicators

The performance indicator framework is based on the shared government objective for public hospitals (box 5.2).

Box 5.2 Objective for public hospitals

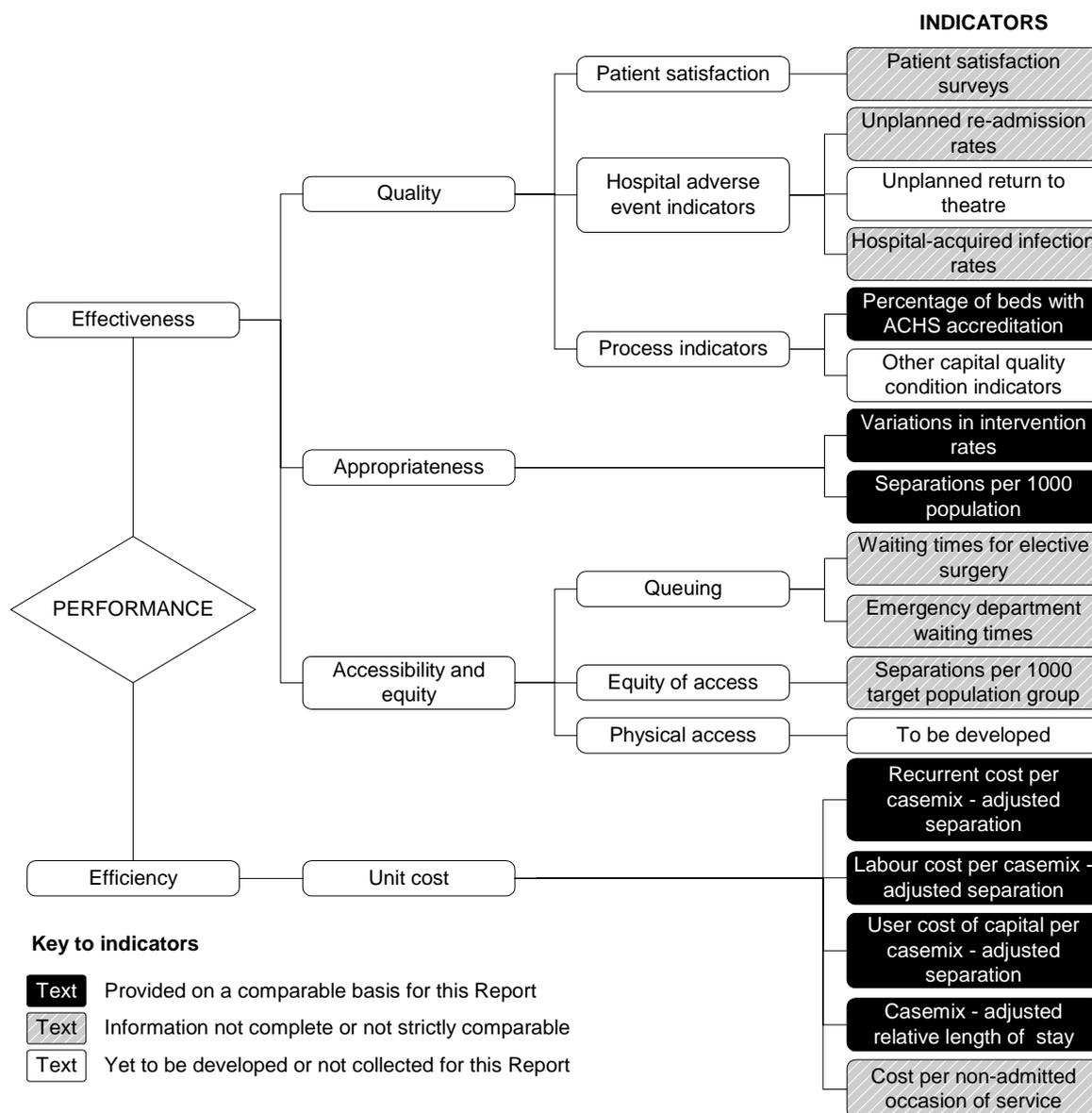
The common government objective for public hospitals is to provide cost effective acute and specialist services that are:

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

The framework captures general aspects of the performance of public hospitals in providing health care services (figure 5.8). The effectiveness of services provided is reflected in terms of quality (as indicated by patient satisfaction, hospital infections and re-admissions and accreditation), appropriateness (as indicated by the total separation rate and the rate for certain procedures) and access and equity (as indicated by emergency department and elective surgery waiting times and by

information on access by Indigenous people to services provided by public hospitals). Efficiency indicators include the cost per casemix-adjusted separation, the cost per non-admitted occasion of service and the casemix-adjusted relative length of stay. The framework is subject to regular review. Ongoing work to improve reporting on public hospitals is discussed in section 5.4.

Figure 5.8 Performance indicators for public hospitals



Key performance indicator results

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

As discussed in section 5.1, public hospitals provide a range of services to admitted patients, including some non-acute services, such as rehabilitation and palliative care. The extent to which these non-acute treatments can be identified and excluded from the analysis differs across jurisdictions. Similarly, psychiatric treatments are being transferred to public hospitals at rates that differ across jurisdictions.

Quality

All Australian governments and users of health care services are interested in assessing and improving quality of care. There is no single definition of quality in health care, but the Institute of Medicine in the United States defines quality as ‘the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge’ (Lohr and Shroeder 1990). No single indicator can measure quality across all providers; an alternative strategy is to identify and report on *aspects* of quality of care.

There has been considerable debate and research to develop suitable indicators of the quality of health care both in Australia and overseas. The Steering Committee reports data on the accreditation of public hospital beds, patient satisfaction and unplanned re-admission rates and hospital-acquired infection rates.

The value of clinical indicators, such as re-admissions and infection rates, was evaluated in a research project undertaken in 1998 (box 5.3). The Steering Committee acknowledges the limitations of the current indicators, particularly given non-representative samples and other caveats for interpretation of the indicators outlined below, and agrees with the project’s recommendations for improving these indicators. Until improved data are available, the Steering Committee has decided to continue to report collected data on these indicators at the jurisdiction level, on the understanding that doing so is better than reporting nothing at all. As Boyce *et al.* (1997, p. 3) state:

Most existing quality and outcome indicators are imperfect. ...We see the current generation of indicators as stepping stones to future better indicators. It will only be by their application in the health sector that indicators will improve.

The quality indicators presented here are also reported elsewhere, including in the annual reports of the WA and Tasmanian health departments (Health Department of WA 1998; Tasmanian Department of Health and Human Services 1998). The ACT Department of Health and Community Care has included a range of clinical indicators in its purchase agreements with its major public hospitals.

Accreditation

Public hospitals may seek accreditation through the Australian Council on Healthcare Standards (ACHS) Evaluation and Quality Improvement Program, ISO 9000 Quality Management System or other equivalent programs. Jurisdictions apply specific criteria to determine which accreditation programs are suitable. The ACHS requires hospitals to demonstrate continual adherence to quality improvement standards to gain and retain accreditation. Accreditation is not limited to the ACHS process, but comparable data on proportions of hospital beds with ACHS accreditation are one of the few nationally available indicators of hospital quality.

Accreditation is an imperfect indicator of quality for several reasons. While it indicates that accredited parties have passed a series of quality tests, it is not possible to draw conclusions about the quality of care in those hospitals that do not have accreditation. Public hospital accreditation is voluntary in all jurisdictions except Victoria, where it is now mandatory for all public hospitals (excluding those which provide dental or mothercraft services). The costs of preparing a hospital for accreditation are significant, so a low level of accreditation may reflect cost constraints rather than indicate 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 ACHS accreditation (because it is relatively less costly for them) than actually offering superior care. That said, accreditation provides some information about the proportion of hospital beds in institutions that have been subject to some independent evaluation.

Seventy-nine per cent of public hospital beds were in ACHS accredited hospitals at 30 June 2000. Across jurisdictions, the proportion ranged from 98.5 per cent in the ACT to 47.1 per cent in the NT (figure 5.9). In some jurisdictions, hospitals sought (and obtained) alternative forms of accreditation not reflected in figure 5.9.

Box 5.3 **The Pilot Hospital-wide Clinical Indicators Project**

The Commonwealth Department of Health and Family Services funded the Pilot Hospital-wide Clinical Indicators Project as part of the National Hospital Outcomes Program in 1998. The project investigated the link between the selected clinical indicators (used in this Report) and an overall assessment of all aspects of the quality of clinical care, as determined by a panel of medical experts. The indicators evaluated were:

- the rate of unplanned hospital re-admission within 28 days of separation;
- the rate of hospital-acquired bacteraemia;
- the rates of post-operative wound infection following clean and contaminated surgery; and
- the rate of unplanned return to an operating room.

The last indicator could not be extracted from available databases easily, so was not included in the project's more detailed analysis.

The project set a high standard for each indicator, requiring it to reflect hospital-wide medical care accurately. The final report concluded that a clinically weak and statistically insignificant relationship existed between the indicators and the overall assessment of quality of care, and therefore that the indicators were unsuited as national performance measures of hospital quality. Thus, the indicators were not validated as measures of hospital-wide care.

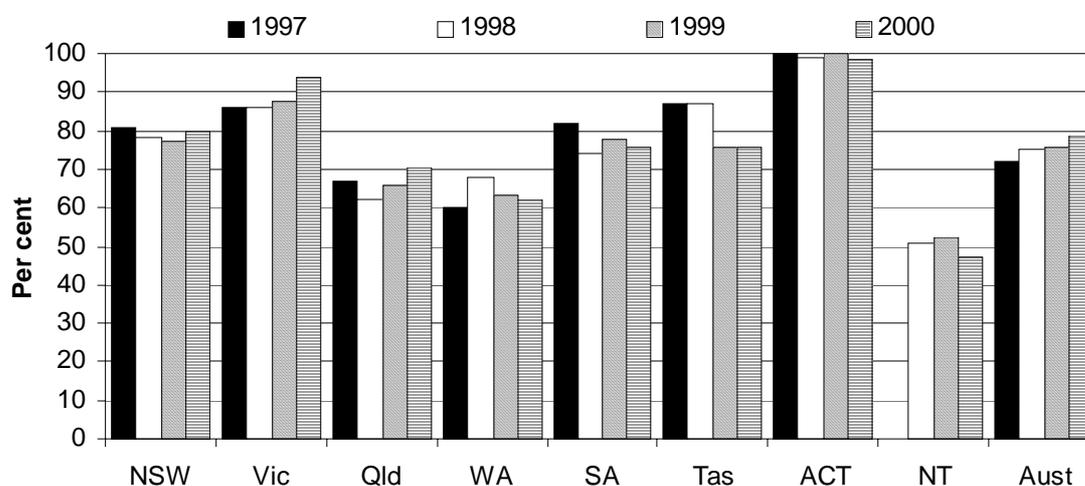
Questions remain about whether the indicators reflect the quality of more limited aspects of care — for example, do unplanned re-admissions reflect discharge planning procedures? Do wound infection rates reflect the standards of wound care during and immediately after surgery?

The project report recommended that 'there is a strong rationale for individual institutions to continue to monitor these indicators as part of a quality improvement program' (Ibrahim *et al.* 1998). It urged caution in using these indicators for benchmarking purposes, but suggested that the indicators may be useful for identifying outliers or comparing the performance of hospitals with similar patient mix, rather than making close comparisons. The final report concluded that '(a) low incidence of surgical wound infection is highly desirable ... wound infection rates should continue to be monitored Institutions whose rates are very high compared with the average should seek an explanation for this' (Ibrahim *et al.* 1998, p. 43).

The project identified the lack of appropriate and widely recognised definitions and the absence of structured data collections as significant shortcomings of the indicators. The final report recommended that ideally, future indicators should be constructed from planned collections of clinical data and that clinical data collection within hospitals should be improved.

Source: Ibrahim *et al.* (1998).

Figure 5.9 Proportion of ACHS accredited public hospital beds, public hospitals^{a, b, c}



^a At 30 June. ^b The NT commenced accreditation in September 1997. ^c Includes public psychiatric hospitals.
Source: AIHW (2001b); table 5A.11.

Patient survey results

Patient surveys have been used to assess the performance of hospitals in their delivery of clinical and non-clinical services. In the absence of other comparable indicators of quality, they provide a useful means of assessing the outcomes of hospital care. There is no agreement among jurisdictions on the best method of undertaking patient surveys and reporting the results. The timing and scope of patient satisfaction surveys also differ, so it is not possible to compare results across jurisdictions. Table 5.5 reflects the years in which patient satisfaction data have been provided by jurisdictions to the Review.

Table 5.5 Patient satisfaction data provided by jurisdictions to each edition of the *Report on Government Services*

Report edition	NSW	Vic	Qld	WA	SA	Tas	ACT	NT
1995	✓	✓	✓	✓	✗	✗	✓	✗
1999	✗	✓	✗	✓	✗	✓	✓	✓
2000	✓	✓	✓	✓	✗	✓	✓	✗
2001	✓	✗	✗	✓	✗	✓	✓	✗
2002	✗	✓	✗	✓	✓	✓	✓	✗

Source: SCRSCCP (1995, 1999, 2000 and 2001a).

Jurisdictions reported the following developments this year.

- The Victorian Government is conducting a State-wide Patient Satisfaction Monitor in all public hospitals over three years. Patients completed a total of 18 000 questionnaires in the first 12 months of surveying. This is an overall response rate of 46 per cent. The survey indicated 95 per cent of all patients were either very or fairly satisfied, with 72 per cent indicating that they were very satisfied with their hospital treatment (Victorian Department of Human Services 2001).
- Queensland Health has commenced a mail out patient satisfaction survey of the 60 largest hospitals around the State. It is anticipated that results of the survey will be available by late 2001 and an evaluation of the survey is planned for early 2002.
- Annual State-wide patient surveys are conducted in WA. The 2001 survey covered admitted and non-admitted patients in public hospitals and public patients in private hospitals in both metropolitan and rural areas. Overnight admitted patients, maternity patients, outpatients, emergency patients were asked to assess clinical outcomes. The results are outlined in table 5A.77.
- In 2001, SA undertook a telephone based survey of 2079 discharged patients from all major teaching hospitals and two country regions in SA. The overall response rate for the survey was 70.9 per cent, with 85.2 per cent of the respondents rating the health care provided by the hospital as excellent or good.
- Tasmania conducted a mail-out survey of 1300 hospital patients during 2000-01. The response rate for the mail-out was 52.6 per cent. Overall, 93 per cent of hospital patients were either very or mostly satisfied, with 61 per cent reporting that they were very satisfied with the care and treatment they received (table 5A.82).
- The ACT surveyed its inpatients, emergency and day surgery patients using mail-out surveys. A total of 1646 patients completed a survey representing a 54 per cent response rate for inpatients, a 39 per cent rate for emergency patients, and a 69 per cent rate for day surgery patients. Inpatients reported an overall satisfaction rate of 86 per cent, emergency patients an overall satisfaction rate of 76 per cent and day surgery patients an 86 per cent overall satisfaction rate (ACT Department of Health and Community Care unpublished, 2001).
- No NT-wide patient satisfaction data are collected. Hospitals conduct their own hospital-specific patient satisfaction surveys. Development of a Territory-wide survey is planned for 2003.

Unplanned re-admission rates

The unplanned re-admission rate is the total number of unplanned and unexpected re-admissions within 28 days of separation as a percentage of the total number of separations (excluding patient deaths) (table 5.6). (There is a more detailed definition of this indicator in table 5.18.)

The data for this indicator are sourced from the ACHS Comparative Report Service (Clinical Indicators). The data are collected for the purposes of internal clinical review by individual hospitals. State-wide conclusions cannot be drawn from the data as participation in the Comparative Report Service (Clinical Indicators) is voluntary and so the data are not necessarily drawn from representative samples. Sample sizes for each jurisdiction are contained in the attachment (table 5A.12). In 2000, 167 public and 182 private health care organisations Australia-wide contributed unplanned re-admissions data.

There are a number of caveats for the interpretation of this indicator. First, it is not clear to what extent differences between jurisdictions are due to casemix of hospitals or patient risk factors (ACHS 2000a). Second, there are some difficulties in identifying re-admissions that were unplanned (Ibrahim *et al.* 1998). A re-admission is considered 'unplanned' or 'unexpected' if there was no documentation to verify that the re-admission was 'planned' and if the re-admission occurred through the accident and emergency department of a hospital (Ibrahim *et al.* 1998). Third, this indicator identifies only those patients re-admitted to the same hospital, which may not always be the case. Box 5.3 outlines some limitations to this indicator.

Data for the NT, and in some cases the ACT and Tasmania, were not provided by the ACHS because of the small number of hospitals in those jurisdictions. South Australia requested that its data not be published because as mentioned above, the data are drawn from samples that do not necessarily reflect all hospitals in each jurisdiction. Among all organisations participating in the ACHS Service in 2000, the mean rate of unplanned re-admissions was 2.3 per cent (table 5A.12). While the rate was highest among organisations participating in Victoria (2.51) and lowest in organisations participating in WA (1.93), these estimates should be viewed in the context of the statistical (standard) errors (table 5.6).

Table 5.6 Unplanned re-admissions, all hospitals, per 100 admissions^a

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT^b</i>	<i>NT^b</i>	<i>Public</i>	<i>All</i>
1998										
Rate	2.27	3.06	2.55	1.41	na	0.98	2.85	na	3.23	2.50
Standard error	0.15	0.18	0.22	0.22	na	0.43	0.47	na	0.11	na
1999										
Rate	2.22	2.10	2.24	1.99	na	1.68	2.86	na	2.97	2.20
Standard error	0.12	0.14	0.22	0.32	na	0.41	0.39	na	0.09	na
2000										
Rate	2.27	2.51	1.79	1.93	na	2.41	na	na	na	2.30
Standard error	0.20	0.16	0.27	0.37	na	0.44	na	na	na	0.01

^a Health organisations contribute data voluntarily to the ACHS and the samples are not therefore necessarily representative of all hospitals in each jurisdiction. SA requested its data be removed for this reason. ^b ACT and NT data are not available for some years because of the small number of hospitals. na Not available.

Source: ACHS (unpublished); table 5A.12.

Hospital-acquired infection rates

Three measures of hospital-acquired infection rates are reported here. Rates of post-operative wound infection are defined for both clean and contaminated surgery. They are derived by dividing the number of inpatients with evidence of wound infection on or after the fifth post-operative day following clean (or contaminated) surgery, by the number of inpatients undergoing clean (or contaminated) surgery with a post-operative stay of at least five days. The ‘rate of hospital-acquired bacteraemia’ is the number of inpatients who acquired bacteraemia during the period under study, as a percentage of the total number of separations with a hospital length of stay of 48 hours or more during the time period under study. (There is a more detailed definition of this indicator in table 5.18). This indicator does not reflect infections that do not become apparent until post-discharge.

The infections data, like the unplanned re-admissions data, are sourced from the ACHS Comparative Report Service (Clinical Indicators) and are collected for the purposes of internal clinical review by individual hospitals. State-wide conclusions cannot be drawn from the data as health care organisations contribute to the ACHS on a voluntary basis and so the data are not necessarily drawn from representative samples. Sample sizes for each jurisdiction are contained in the attachment (table 5A.13) and in 2000 ranged from 188 to 259 health care organisations across Australia. It should be noted that the data are not adjusted for differences across cases in the risk of infection or differences across hospitals in casemix. Box 5.3 outlines limitations associated with this indicator.

Data for the ACT, the NT and in some cases Tasmania, were not provided by the ACHS because of the small number of hospitals in those jurisdictions. South

Australia requested that its data not be published because the data are drawn from samples that do not necessarily reflect all hospitals in each jurisdiction. Estimated infection rates for the other jurisdictions are shown in table 5.7 and should be viewed in the context of the statistical (standard) errors.

Data are also disaggregated by region (metropolitan and rural) — although again may be affected by the potential for samples to be non-representative (table 5A.13). Among organisations participating in the ACHS Service, those in rural areas generally experienced higher levels of post-operative infection rates, but lower levels of bacteraemia infection.

Appropriateness

Two indicators are presented for the appropriateness of care provided by public hospitals: the number of separations per 1000 people (also known as the separation rate) and separation rates for certain procedures. Both indicators, however, are problematic. First, the measures do not reflect differences in casemix across jurisdictions. Second, there is no benchmark as to the appropriate share of same day separations. Third, the appropriate mix/level is unclear (for example, a relatively high level of separations may reflect better access *or* over-servicing). Fourth, variations in admission rates also reflect different practices in classifying patients as either admitted same day patients or outpatients. This is a particular issue for non-surgical same day admissions. States that apply lower thresholds for treating a patient as an admitted patient will tend to have higher separation rates. Comparisons are also complicated by different access to substitutable services (for example, private hospitals). Jurisdictional comparisons, therefore, are most useful for highlighting differences, noting that more detailed analysis may be required.

Total separation rates

There were approximately 3.9 million separations from public hospitals in 1999-2000 (table 5A.7). Nationally, this translated into 196.5 separations per 1000 people, ranging from 360.3 per 1000 in the NT to 154.3 per 1000 in Tasmania (figure 5.10).

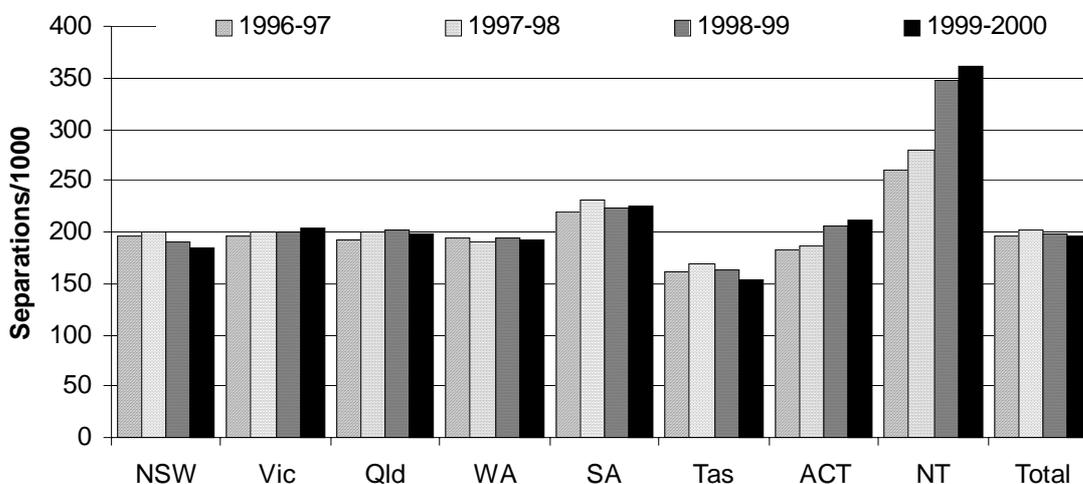
Table 5.7 Hospital-acquired infection, per 100 separations^a

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas^b</i>	<i>ACT^b</i>	<i>NT^{b, c}</i>
Post-operative infection, following clean surgery								
1999								
Public hospitals								
Rate	1.99	1.88	3.02	2.38	na	na	na	na
Standard error	0.18	0.18	0.32	0.46	na	na	na	na
All hospitals								
Rate	1.19	0.71	1.67	1.14	na	1.00	na	na
Standard error	0.11	0.09	0.17	0.33	na	0.37	na	na
2000								
All hospitals								
Rate	0.92	0.69	1.47	1.01	na	na	na	na
Standard error	0.09	0.08	0.17	0.28	na	na	na	na
Post-operative infection, following contaminated surgery								
1999								
Public hospitals								
Rate	2.98	1.94	3.36	2.17	na	na	na	na
Standard error	0.23	0.19	0.37	0.50	na	na	na	na
All hospitals								
Rate	1.66	1.56	2.43	1.60	na	3.05	na	na
Standard error	0.13	0.13	0.21	0.44	na	0.67	na	na
2000								
All hospitals								
Rate	1.54	1.48	2.56	2.01	na	na	na	na
Standard error	0.16	0.14	0.22	0.52	na	na	na	na
Hospital-acquired bacteraemia								
1999								
Public hospitals								
Rate	0.49	0.48	0.30	0.25	na	na	na	na
Standard error	0.04	0.05	0.06	0.13	na	na	na	na
All hospitals								
Rate	0.41	0.29	0.28	0.22	na	0.31	0.39	na
Standard error	0.03	0.04	0.05	0.10	na	0.12	0.13	na
2000								
All hospitals								
Rate	0.35	0.16	0.27	0.25	na	0.26	na	na
Standard error	0.03	0.02	0.03	0.07	na	0.08	na	na

^a Health organisations contribute data voluntarily to the ACHS and the samples are not therefore necessarily representative of all hospitals in each jurisdiction. SA requested its data be removed for this reason. ^b Not all data for Tasmania and the ACT are available and no data are available for the NT because of the small number of hospitals. ^c The NT government provided public hospital data for post-operative wound infection following clean surgery (0.84 per cent), contaminated surgery (4.87 per cent) and hospital-acquired bacteraemia (0.33 per cent). **na** Not available

Source: ACHS (unpublished); table 5A.13.

Figure 5.10 Separation rates in public hospitals, 1999-2000^a



^a 1998-99 and 1999-2000 figures directly age standardised to the Australian population at 30 June 1991. Pre-1998-99 data are not standardised, and so should not be compared with the more recent data.

Source: AIHW (2001b); table 5A.7.

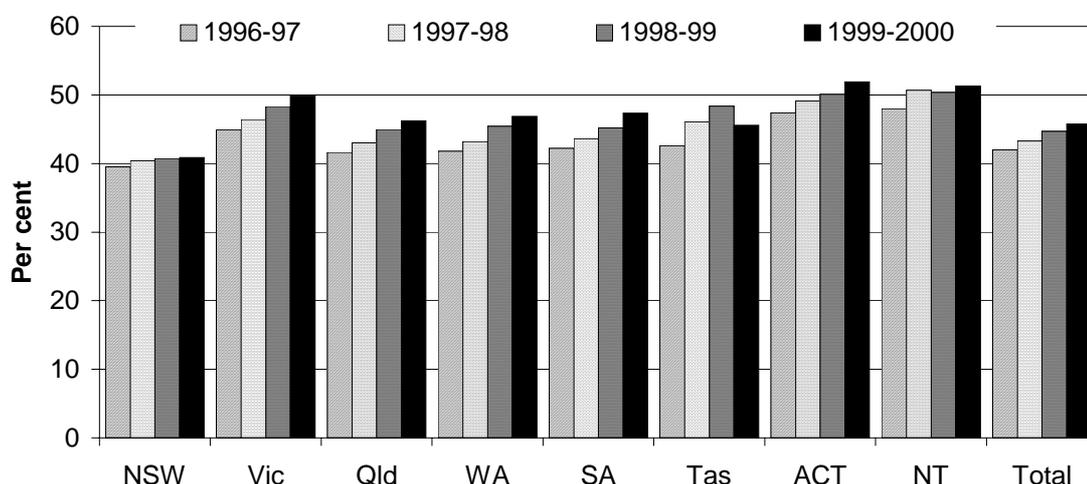
Nationally, 45.8 per cent of separations were same day separations in 1999-2000. The ACT reported the highest percentage rate of same day separations (51.9) and NSW reported the lowest (40.9) (figure 5.11). As indicated previously, variations between States in the thresholds applied for classifying patients as either same day admitted patients or outpatients will affect this indicator. New South Wales reports that over recent years there have been changes in this threshold. These issues apply mainly to non-surgical same day admissions and a better indicator of appropriateness may be the percentage of surgical separations performed on a same day basis.

Separation rates for certain procedures

Separation rates for certain procedures are used to indicate the appropriateness of hospital care, with procedures selected for their frequency and for being elective and discretionary (given the availability of alternative treatments) (table 5.8). Care needs to be taken when interpreting the differences in the separation rates of the selected procedures. Variations in rates may be attributable to variations in the prevalence of the conditions being treated or to differences in clinical practice among States and Territories. Higher/lower rates are not necessarily associated with inappropriate care. Higher rates may be acceptable for certain conditions and not for others. For example, higher rates of angioplasties and lens insertions may represent appropriate levels of care, whereas higher rates of hysterectomies or tonsillectomies

may represent an over-reliance on procedures, and no clear inference can be drawn on the basis of higher rates of arthroscopies or endoscopies.

Figure 5.11 **Proportion of separations that were same day, public hospitals**



Source: AIHW (2001b); table 5A.7.

The data reported includes all hospitals, so are reflective of the activities of both public and private health systems.⁵ For the first time in this Report, all States and Territories are using the latest version of disease classification (the International Statistical Classification of Diseases and Related Health Problems, Revision 10, Australian Modification — ICD-10-AM) so that data can be compared across jurisdictions without any definitional caveats.

The most common procedures in 1999-2000 were endoscopies, lens insertions and arthroscopic procedures (table 5.8). Separation rates for all procedures varied across jurisdictions, in some cases considerably (for example, endoscopy and myringotomy). Table 5A.14 outlines which State or Territory separation rates are statistically significantly different to the collective separation rate for all other jurisdictions.

Some of the selected procedures, such as angioplasty and coronary artery bypass graft, are alternative treatment options for people diagnosed with similar conditions. Statistically significant and material differences in the separation rates for these procedures may highlight variations in treatment methods across jurisdictions.

⁵ Data include public acute, public psychiatric, private acute, private psychiatric and private free standing day hospital facilities. Some private hospitals are excluded resulting in underreporting of some procedures, particularly those more likely to be performed in private hospitals. Thus, these types of procedure will be undercounted for some jurisdictions (AIHW 2000a).

Statistically significant differences from the average rate for procedures of interest for all jurisdictions are contained in table 5A.14.

Table 5.8 **Separations per 1000 people, public and private hospitals by selected procedure, 1999-2000^{a, b, c}**

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total ^d
Angioplasty	0.97	1.14	0.81	1.02	1.02	1.00	1.13	0.79	1.00
Coronary artery bypass	0.97	0.83	0.85	0.63	0.66	0.74	0.74	0.58	0.84
Hip replacement	1.01	1.09	0.87	1.22	1.15	1.19	1.31	0.36	1.04
Lens insertion	6.05	5.27	6.58	6.32	4.64	4.04	3.96	4.97	5.76
Hysterectomy	1.51	1.55	1.69	1.89	1.96	2.06	1.61	0.81	1.63
Tonsillectomy	1.73	1.92	1.81	2.10	2.13	1.36	1.40	0.60	1.83
Myringotomy	1.65	2.29	1.69	2.41	2.94	1.44	1.40	0.61	1.96
Caesarean section separation rate	2.96	3.03	3.54	3.27	3.37	2.95	2.40	2.41	3.13
Caesarean section separations per 100 in-hospital births	20.75	23.02	24.51	24.09	24.37	29.40	18.80	19.59	
Appendicectomy	1.33	1.42	1.61	1.69	1.36	1.46	1.21	0.89	1.44
Cholecystectomy	2.19	2.18	2.32	2.16	2.41	2.06	1.90	1.32	2.21
Arthroscopic procedures (includes arthroscopies)	4.89	5.63	4.42	7.10	8.42	4.95	5.28	3.49	5.47
Diagnostic gastrointestinal endoscopy	24.52	26.16	27.71	25.05	21.64	17.63	11.80	12.32	24.87

^a The procedures are defined using ICD-10-AM codes. Procedures include National Health Ministers' Benchmarking Working Group sentinel procedures and additional procedures requested by States and Territories. ^b Some private hospitals are not included. ^c Rate per 1000 population was directly age- and sex-standardised to the Australian population at 30 June 1991. ^d Includes Other Territories.

Source: AIHW (2001b); table 5A.14.

Accessibility and equity

Emergency department waiting times

This indicator measures the proportion of patients seen within the time limits set according to the urgency of treatment required. Waiting times measure the time elapsed from presentation to the emergency department to commencement of service by a treating medical officer or nurse. A 1997 study recommended two emergency department waiting time indicators for national reporting (Whitby *et al.* 1997). One of these indicators relates waiting times to the urgency of treatment required (the triage category):

- triage category 1: patients needing resuscitation — 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; and
 - triage category 5: non-urgent — patients seen within 120 minutes.

Data for all jurisdictions for 1999-2000 are presented in table 5.9. The data include both public and private patients. There are nationally agreed definitions but, as with the elective surgery data, differences in how the data are collected may exist, and great care needs to be taken in interpreting these data. Data may vary across jurisdictions as a result of differences in clinical practices (for example, the allocation of cases to urgency categories).

Other data issues to be investigated include any differences in when the elapsed time commences (for example, when the patient arrives at the triage desk, or when a triage category is allocated) and the precision with which the starting time of treatment is recorded. States have also adopted different approaches to identifying when a patient has been seen. A new national standard has now been adopted that allows being seen by either a nurse or a doctor to be used in this measure. For 1999-2000 data, however, NSW and Queensland have reported only on the basis of time to being seen by a doctor. Other issues arise with the use of benchmarks. A patient in triage category 2 who waits 11 minutes, for example, would be recorded the same as one waiting 18 minutes, even though the latter event may be of much greater concern.

In 1999-2000, Victoria and the NT had the highest proportion of patients seen within the triage timeframe for category 1 (100.0 per cent) and Tasmania had the lowest proportion (87.6 per cent). For triage category 2, the ACT had the highest proportion of patients seen with the relevant timeframe (88.9 per cent) and the NT had the lowest (47.9 per cent) (table 5.9).

Waiting times for elective surgery

The three generally accepted urgency categories for elective surgery are:

- category 1, for which admission is desirable within 30 days;
- category 2, for which admission is desirable within 90 days; and
- category 3, for which admission at some time in the future is acceptable.

Table 5.9 Emergency department waiting time to service delivery, 1999-2000 (per cent of patients seen within triage category)^a

<i>Triage category</i>	<i>NSW^b</i>	<i>Vic</i>	<i>Qld^b</i>	<i>WA^c</i>	<i>SA^d</i>	<i>Tas</i>	<i>ACT</i>	<i>NT^e</i>
1 – Resuscitation	98	100	95	99	99	88	98	100
2 – Emergency	76	77	68	75	71	63	89	48
3 – Urgent	63	71	61	64	65	59	82	62
4 – Semi-urgent	67	60	68	60	66	66	75	50
5 – Non-urgent	89	86	89	83	91	88	89	67
<i>Data coverage</i>								
Estimated proportion of emergency visits (per cent)	79	100	80	100	64	100	100	55
Hospitals (number)	51	29	20	4	8	4	2	2

^a Care needs to be taken in interpreting these data. Nationally agreed definitions exist but there may be differences in how data are collected. Data may vary across jurisdictions as a result of differences in clinical practices (for example, on the allocation of cases to urgency categories). States have also adopted different approaches to identifying when a patient has been seen. A new national standard has now been adopted that allows being seen by either a nurse or a doctor to be used in this measure. For 1999-2000 data, however, NSW and Queensland have reported on the basis of time to being seen by a doctor only. ^b Waiting time is measured from arrival to time seen by a doctor (not a doctor or a nurse). ^c Data provided for metropolitan teaching hospitals. ^d Data provided for metropolitan hospitals only. ^e Category 2 rate is the result of a data entry issue which has now been rectified. 2000-2001 data for the NT show that 68.9 per cent of Category 2 patients were seen within 10 minutes.

Source: State and Territory governments (unpublished); table 5A.15.

A complete definition of these categories is provided in table 5.18. Category 1 and category 2 patients waiting longer than desirable are usually described as ‘overdue’, while category 3 patients waiting longer than one year are subject to an ‘extended wait’ (AIHW 1999a). For simplicity, the term ‘extended wait’ is also used here to describe ‘overdue’ patients. There is no specified or agreed desirable wait for category 3 patients, so the term ‘extended wait’ is used for patients waiting for longer than 12 months. Under the 1998–2003 Australian Health Care Agreements, the States and Territories report to the Commonwealth the number of category 3 patients who, on admission, have waited longer than 12 months for elective surgery.

Where patients experience a change in their clinical condition leading to a review of their urgency category, waiting times are recorded as the period in the most recent urgency category and in any previous more urgent categories. South Australia records waiting times in the most recent urgency category only.

Elective surgery waiting times are difficult to measure objectively, and the data can be complex to interpret. The two widely accepted measures of waiting times are the proportion of patients on waiting lists with extended waits (at a census date) and the proportion of patients admitted after extended waits (based on throughput data). Both present conceptual and data issues.

From a patient's perspective, the relevant question is, 'If I need surgery, what is the likelihood that I will have to wait longer than is considered desirable?' To develop strictly comparable data to answer this question, clinical judgements about need for surgery, and allocations by surgeons into the three categories of urgency, would need to be consistent across jurisdictions. Current data collections assume there is some standardisation across Australia in how these ratings are allocated, but the definitions remain relatively broad (Clover *et al.* 1998). As a result, systematic differences in clinical practices across jurisdictions (such as differences in the complexity of cases) and in the judgements applied by clinicians about the urgency of particular cases, as well as in the performance of hospital systems, may affect reported results. Differences in the scope of the collections (including the proportion of hospitals and elective admissions covered) may also affect comparisons across jurisdictions. In a recent appraisal of waiting lists, the AIHW noted that, while there has been some harmonisation of definitions and waiting list management practice across jurisdictions, the issue of medical staff putting similar cases into different urgency categories due to differing practices would not be easily resolved (Healthdata Services 2001).

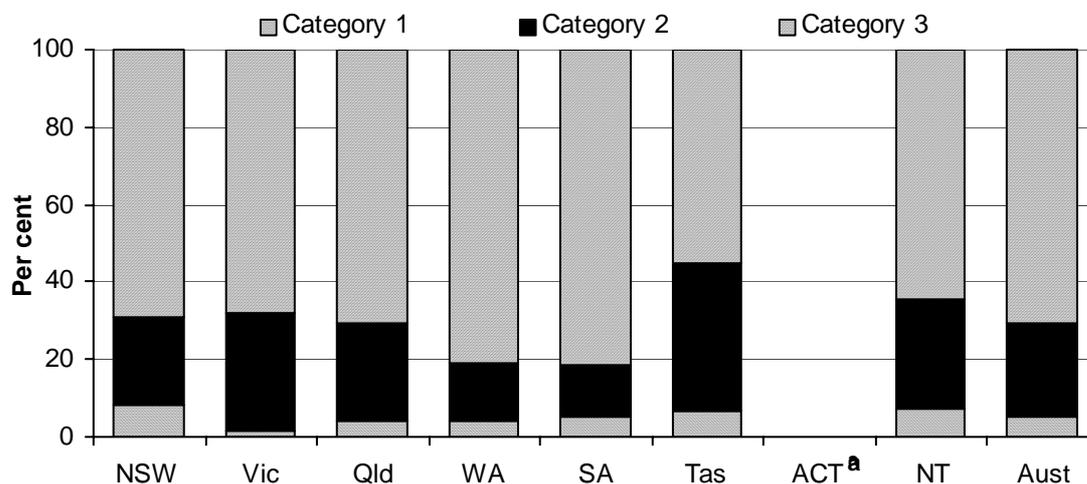
Figures 5.12 and 5.13 illustrate these differences across jurisdictions in the classification of patients to urgency categories. On 30 June 1999, NSW had the highest proportion of patients on waiting lists allocated to category 1 and Victoria the lowest (figure 5.12). For patients admitted from waiting lists in 1998-99, Tasmania had the highest proportion in category 1 and Victoria the lowest (figure 5.13). States and Territories with large proportions of patients in category 1 are also the States and Territories that have relatively large proportions of patients 'not seen on time'. Thus, the apparent variation in performance is likely to be significantly due to variation in the classification practices employed. There have also been substantial differences in the proportion of hospitals in each jurisdiction that contribute data to the Report. This may introduce systematic biases into the data. Finally, there have been variations between States in the measurement of waiting times, with several different methods applied (AIHW 2001e).

In light of these important issues, work is currently being undertaken under the auspices of AHMAC to improve this indicator. The Steering Committee will modify reporting in future according to the outcomes of the AHMAC work. Indeed, it is likely that more comparable data will be available for the 2003 Report.

Elective surgery waiting time data provide some information on access, but public hospital services are provided on the basis of clinical need, and elective surgery is only one aspect of the care they provide. Therefore, the assessment of access would not be based on only the waiting lists for elective surgery because these do not

capture the needs of patients requiring services for acute and chronic medical conditions (Hall 1999).

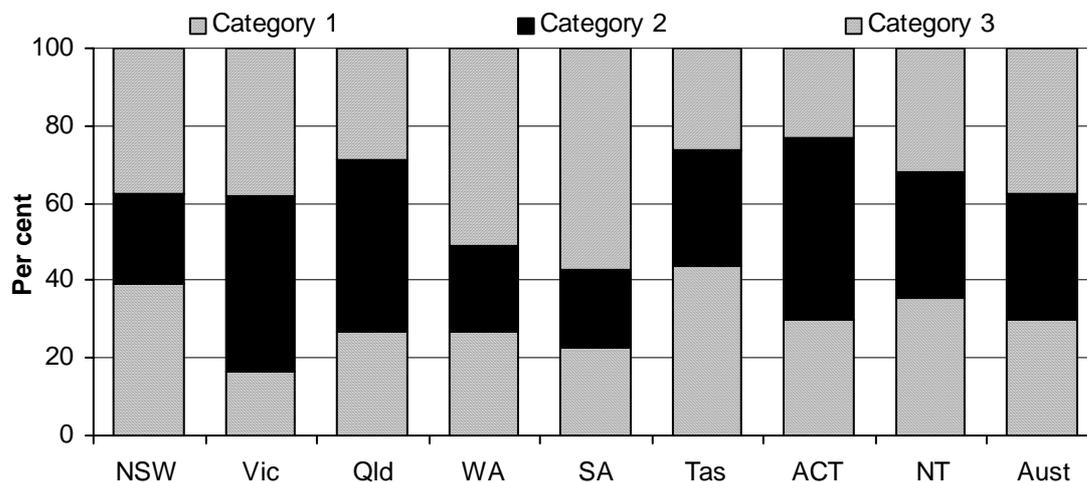
Figure 5.12 Patients on waiting lists by clinical urgency, 30 June 1999^b



^a No ACT data available. ^b Category 1=admission is desirable within 30 days; Category 2=admission is desirable within 90 days; and Category 3=admission at some time in the future is acceptable.

Source: AIHW (2001e); table 5A.17.

Figure 5.13 Admissions from waiting lists by clinical urgency, 1998-1999^a



^a Category 1=admission is desirable within 30 days; Category 2=admission is desirable within 90 days; and Category 3=admission at some time in the future is acceptable.

Source: AIHW (2001e); table 5A.18.

The proportion of patients subject to extended waits for elective surgery at public hospitals is reported for each urgency category in table 5.10. It indicates the proportion of those patients waiting on that date, who have been waiting an

extended time. Generally, it will overstate the likelihood of an extended wait, because patients who wait for long periods are more likely to be counted at census points (Moon 1996).

Table 5.10 Proportion of elective surgery patients with extended waits, 1999-2000^a

<i>Clinical urgency category</i>	<i>NSW^b</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SAC^c</i>	<i>Tas^d</i>	<i>ACT^e</i>	<i>NT^f</i>
Per cent of patients on waiting lists with extended waits, 30 June 2000								
Category 1	na	0.0	2.7	40.0	24.8	na	8.7	40.0
Category 2	na	38.1	8.3	41.0	23.3	na	41.4	38.8
Category 3	na	27.3	32.4	26.0	14.2	na	19.7	14.5
All patients	na	32.9	25.0	29.0	15.9	na	28.3	23.0
Per cent of patients admitted from waiting lists with extended waits, 1999-2000								
Category 1	na	0.0	5.3	15.0	12.6	na	na	8.9
Category 2	na	18.4	8.2	25.0	14.7	na	na	15.3
Category 3	na	9.4	11.1	10.0	3.7	na	na	3.7
All patients	na	12.1	8.2	15.0	7.9	na	na	9.3
Data coverage								
% of elective admissions	na	71.0	95.0	69.0	15.0	na	100.0	16.9

^a These data should be viewed with caution as systematic differences in clinical practices across jurisdictions (such as differences in the complexity of cases), in the judgements applied by clinicians about the urgency of particular cases, and in the performance of hospital systems, may affect reported results. Figures 5.12 and 5.13 show differences across jurisdictions in classification to urgency categories. There are also substantial differences in the proportion of hospitals in each jurisdiction that contribute data to the Report. This may introduce systematic biases into the data. Finally, there have been variations between States in the measurement of waiting times, with several different methods applied. In light of these issues, work is currently being undertaken under the auspices of AHMAC to improve this indicator. The Steering Committee will modify reporting in future according to the outcomes of the AHMAC work. ^b NSW did not provide data for this indicator because of concerns that the data are not comparable across jurisdictions. ^c Data from Department of Human Services Booking List Information System data (BLIS); data created through an ad hoc report. Unknown categories are included with category 3. Cosmetic surgery is excluded. Data from Department of Human Services Integrated South Australian Activity Collection (ISAAC). Per cent of acute admissions is calculated as: number of elective surgery booking list separations in 1999-2000 divided by total number of acute (including qualified newborns) separations in 1999-2000 for all hospitals. An alternative calculation may be the total number of acute (including qualified newborns) separations in 1999-2000 for the seven booking list hospitals / total number of acute (including qualified newborns) separations in 1999-2000 for all hospitals. This figure is 69.5 per cent. The seven major metropolitan hospitals maintain elective surgery waiting lists. These are: Women's and Children's Hospital, Flinders Medical Centre, The Queen Elizabeth Hospital, Lyell McEwin Health Service, Modbury Hospital, Repatriation General Hospital and Royal Adelaide Hospital. ^d Tasmania was unable to provide data in time for publication. ^e One of the two hospitals in the ACT was unable to provide these data. Data were not therefore submitted for the other hospital as it would be identifiable. ^f NT data may not reflect reality. A project has been established to undertake an administrative and clinical audit of NT waiting time data.

Source: State and Territory governments (unpublished); table 5A.16.

An alternative indicator based on admissions data — that is, the proportion of patients admitted with extended waits — also has some shortcomings. Those who were on a waiting list but were never admitted (because they became emergency cases, decided to be treated in a private hospital or died) are not counted (Moon

1996). In addition, some waiting patients may not be admitted because their condition improved sufficiently to make treatment unnecessary, or because they declined treatment for other reasons (Lee *et al.* 1987).

Victoria, Queensland, WA, SA, the ACT and the NT provided data on patients on waiting lists by clinical speciality for 1999-2000 (tables 5A.73, 5A.76, 5A.78, 5A.80, 5A.84 and 5A.86). Victoria, Queensland, WA, SA and the NT also provided data on elective surgery waiting lists at time of admission by clinical speciality for this period (tables 5A.73, 5A.76, 5A.78, 5A.80 and 5A.86).

Separations by target group

Equity of access to hospital services is another measure of accessibility and hence, of the effectiveness of the health sector. Without appropriate access to hospital services, the consequences of any injury or illness are more likely to be either permanent disability or premature death for a patient. Equity of access has been measured using data on Indigenous and non-Indigenous separations.

Data on Indigenous people are limited by the extent to which Indigenous people are identified in hospital records and completeness is likely to vary across States and Territories. The Australian Bureau of Statistics (ABS) (2000a) noted that studies of a limited number of individual hospitals suggest that the proportion of Indigenous people correctly identified in hospital records ranges from less than 50 per cent to close to 100 per cent. It found that for 1998-99, the quality of data on Indigenous hospitalisations was considered acceptable only in the NT, SA and WA (ABS 2000a). National reporting on data quality in hospitals is expected in 2002. In the meantime, few jurisdictions have data of consistent quality — with the exception of the NT (ABS 2000a, *Condon et al.* 1998). In addition, difficulties in estimating the size of the Indigenous population limits the comparability of data over time.

Descriptive data on Indigenous and non-Indigenous separations in public hospitals in 1999-2000 are provided in table 5.11. Indigenous separations accounted for around 3 per cent of total separations in 1999-2000, although Indigenous people represented around 2 per cent of the total population in 1998 (AIHW 2001b). Most Indigenous separations occurred in public hospitals (97 per cent). The low proportion of private hospital separations for Indigenous people may be partly due to a lower proportion of Indigenous patients being correctly identified in private hospitals and partly to a lower use of private hospitals (ABS 2000). Data in table 5.11 need to be interpreted with care.

Table 5.11 Separations by Indigenous status, 1999-2000^a

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT^b</i>	<i>NT^c</i>	<i>Aust</i>
Number of public hospital separations ('000)									
Indigenous	30	7	47	34	12	1	1	34	166
Non-Indigenous	1216	997	637	326	338	70	59	23	3665
Not reported	0	0	25	0	10	5	1	0	41
Total	1246	1004	708	360	360	76	61	58	3872
Number of private hospital separations ('000)									
Indigenous	3	0	1	1	0	0	0	na	5
Non-Indigenous	601	520	362	214	152	43	23	na	1915
Not reported	0	0	90	0	8	8	0	na	106
Total	604	520	452	215	160	51	23	na	2026
Separations in public hospitals as a proportion of separations in all hospitals (%)									
Indigenous	91	97	99	98	99	99	100	na	97
Non-Indigenous	74	66	64	60	69	62	72	na	66

^a Identification of Indigenous patients is not considered to be complete and completeness varies across jurisdictions. ^b Rates reported for the Aboriginal and Torres Strait Islander population in the ACT are subject to variability due to the small population of Aboriginal and Torres Strait Islanders in the jurisdiction. ^c Includes only public hospitals.

Source: AIHW (2001b); table 5A.19.

A performance indicator of Indigenous access to hospitals is given by the rate of separations per 1000 people. Data on separation rates for Indigenous people and all people by State and Territory for all public hospitals are presented in table 5.12. Data regarding private hospital separation rates are contained in table 5A.20. This is a change from the 2001 Report when data for public hospitals were not available separately and so data for all hospitals were presented.

In 1999-2000, on an age-standardised basis, 592 separations (including same day separations) for Indigenous patients were reported per 1000 Indigenous population in Australian public hospitals. This was markedly higher than the corresponding figure for the total population of 199 per 1000. Excluding the ACT data which fluctuate markedly over time because of the small Indigenous population, Indigenous separation rates were highest in the NT (963 separations per 1000 Indigenous people) and lowest in Tasmania (132). The Australian Institute of Health and Welfare (AIHW) has revised the data for private hospitals in table 5A.20. The new data were not available in time for publication but will be placed on the Review web page early in 2002.

Table 5.12 Estimates of separations per 1000 people by reported Indigenous status, public hospitals^{a, b}

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA^c</i>	<i>SA</i>	<i>Tas</i>	<i>ACT^d</i>	<i>NT</i>	<i>Aust</i>
1997-98									
Indigenous people	316	340	503	na	604	153	369	828	505
Total population	195	191	193	192	214	162	204	326	195
1998-99									
Indigenous people	336	331	590	na	673	23	33	887	550
Total population	194	201	205	198	224	165	208	352	201
1999-2000									
Indigenous people	344	380	631	na	771	132	1815	963	592
Total population	187	205	201	196	227	156	215	365	199

^a The rates were directly age-standardised to the Australian population at 30 June 1991. ^b Identification of Aboriginal and Torres Strait Islander patients is not considered to be complete and completeness varies across jurisdictions. ^c WA data for Indigenous people were revised by the AIHW and were not available in time for publication of this Report. ^d Rates reported for the Aboriginal and Torres Strait Islander population in the ACT are subject to variability due to the small population of Aboriginal and Torres Strait Islanders in the jurisdiction.

Source: AIHW (unpublished); table 5A.20.

The reporting of Indigenous separations for selected conditions has changed this year. Data are presented for one of the refined national health performance indicators for Aboriginal and Torres Strait Islanders endorsed by AHMAC in 2000 — Standardised Hospital Separation Ratios. It should be noted, however, that the ratios are included in this chapter for descriptive purposes only. The data do not signal the performance of hospitals, but reflect a range of factors, such as the spectrum of public, primary care and post hospital care available; Indigenous access to these as well as hospital services, social and physical infrastructure services for Indigenous people; and differences in the complexity, incidence and prevalence of disease between the Indigenous and non-Indigenous populations.

The Standardised Hospital Separation Ratios are calculated by dividing Indigenous separations by 'expected' separations. Expected separations are calculated as the product of the all Australian separation rate and the Indigenous population. They therefore illustrate differences between the rates of Indigenous hospital admissions and those of the total Australian population, taking into account differences in age distributions. Ratios are presented for six major conditions — circulatory diseases, injury and poisoning, respiratory diseases and lung cancer, diabetes, tympanoplasty associated with otitis media and mental health conditions and selected associated ICD-9 and ICD-10 codes (tables 5A.21 and 5A.22).

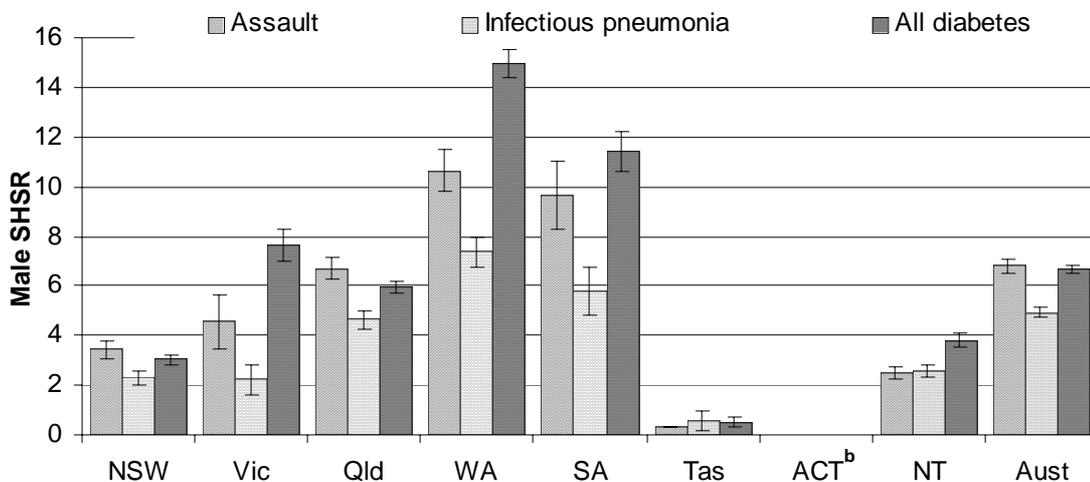
There was variation across jurisdictions in the proportion of Indigenous people who were identified as such in the hospital morbidity data collections and/or in the total

population. The data should, therefore, be used with care as only the NT and SA data were considered of acceptable quality by the AIHW.

In 1999-2000, for all causes and across all hospitals, Indigenous people were close to twice as likely to be hospitalised as all Australians. For males, there was a marked difference between Indigenous separation rates and those of the total population for assault (Indigenous separation rates were 6.8 times higher than for all Australians), all diabetes (Indigenous separation rates were 6.7 times higher than for all Australians), and infectious pneumonia (Indigenous separation rates were 4.9 times higher than for all Australians) (figure 5.14). (While the standardised rates for Indigenous males for rheumatic heart disease and tympanoplasty associated with otitis media also appear markedly higher than for the Australian population, the number of separations for these conditions was very small [table 5A.21].)

The AIHW has revised these data, but the new data were not available in time for publication. The new data will be placed on the Review web page early in 2002.

Figure 5.14 Indigenous males: standardised hospital separation ratios for selected conditions, 1999-2000^{a, c}



^a The ratios were indirectly age-standardised to the Australian population 0–74 years at 30 June 1999. ^b The ACT data are not of high enough quality to be published. ^c It should be noted that these data do not signal the performance of hospitals, but reflect a range of factors such as the spectrum of public, primary care and post hospital care available; Indigenous access to these as well as hospital services, social and physical infrastructure services for Indigenous people; and differences in the complexity, incidence and prevalence of disease between the Indigenous and non-Indigenous populations.

Source: AIHW (unpublished); table 5A.21.

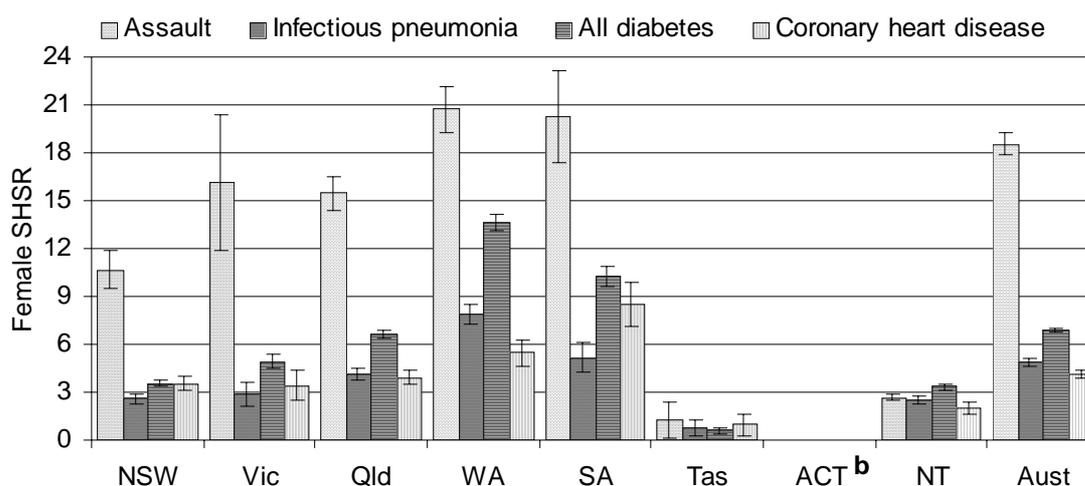
Indigenous females' separation rates were markedly higher than those for all females for assault (the rate for Indigenous females was 18.5 times the rate for all females), all diabetes (the rate for Indigenous females was 6.9 times the rate for all females), infectious pneumonia (the rate for Indigenous females was 4.9 times the

rate for all females) and coronary heart disease (the rate for Indigenous females was 4.1 times the rate for all females) (figure 5.15). (While the standardised rates for Indigenous females for rheumatic heart disease and tympanoplasty associated with otitis media also appear markedly higher than for the Australian population, the number of separations for these conditions was very small [table 5A.22].)

The AIHW have revised these data, but the new data were not available in time for publication. The new data will be placed on the Review web page early in 2002.

By way of completeness, Indigenous separation rates for selected conditions are also presented in the format used in the 2001 Report. These data can be found in table 5A.23.

Figure 5.15 Indigenous females: standardised hospital separation ratios for selected conditions, 1999-2000^{a, c}



^a The ratios were indirectly age-standardised to the Australian population 0–74 years at 30 June 1999. ^b The ACT data are not of high enough quality to be published. ^c It should be noted that these data do not signal the performance of hospitals, but reflect a range of factors such as the spectrum of public, primary care and post hospital care available; Indigenous access to these as well as hospital services, social and physical infrastructure services for Indigenous people; and differences in the complexity, incidence and prevalence of disease between the Indigenous and non-Indigenous populations.

Source: AIHW (unpublished); table 5A.22.

Efficiency

Two approaches to measuring the efficiency of public hospital services are used in this Report. One is the cost per casemix-adjusted unit of output (the unit cost) and the other is the casemix-adjusted relative length of stay index, because costs are

correlated with the length of stay at aggregate levels of reporting. Both indicators represent marked improvements since efficiency indicators were first reported in the 1995 Report.

The Review's approach is to report the full costs of a service where they are available. Where the full costs of a service cannot be measured accurately, the Review seeks to report estimated costs that are comparable. Where differences in comparability remain, the differences are documented.

The Review has identified a range of financial reporting issues that have affected the accuracy and comparability of unit costs for acute care services. These include the treatment of payroll tax, superannuation, depreciation and the user cost of capital associated with buildings and equipment. A number of issues remain to further improve the quality of these estimates.

Costs associated with non-current physical assets (such as depreciation and the user cost of capital) are potentially important components of the total costs of many services delivered by government agencies. Differences in the techniques for measuring non-current physical assets (such as valuation methods) may reduce the comparability of cost estimates across jurisdictions.

In response to concerns regarding data comparability, the Steering Committee initiated a study, *Asset Measurement in the Costing of Government Services* (SCRCSSP 2001b). The aim of the study was to examine the extent to which differences in asset measurement techniques applied by participating agencies affect the comparability of reported unit costs.

The 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. Considered in the context of total unit costs, however, the differences created by these asset measurement effects were relatively small as capital costs represent a relatively small proportion of total cost — although the differences may affect cost rankings between jurisdictions. A key message from the study was that the adoption of national uniform accounting standards across all service areas would be a desirable outcome from the perspective of the Review. The results are discussed in more detail in chapter 2.

Thus, care needs to be taken in comparing the available indicators of efficiency across jurisdictions. Differences in counting rules, the treatment of various expenditure items (for example, superannuation) and the allocation of overhead costs have the potential to hinder such comparisons. In addition, differences in the use of salary packaging may allow hospitals to lower their wage bills (and thus State or Territory government expenditure) while maintaining the after-tax income

of their staff. No data were available for reporting on the effect of salary packaging and any variation in its use across jurisdictions.

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

Recurrent costs per casemix-adjusted separation

The recurrent cost per casemix-adjusted separation is an indicator of hospitals' cost performance for admitted patients. This indicator measures the average cost of providing care for an admitted patient (whether overnight stay or same day), adjusted for the relative complexity of the patient's clinical condition and of the hospital services provided (AIHW 2000a).

While all admitted patient separations and their costs are included in the calculations, cost weights are not available for non-acute admitted patients which now comprise approximately 3 per cent of total admitted patient episodes. An approximation of the cost per separation for the acute separations is therefore applied to the non-acute patients. Average cost weights for acute patients typically underestimate the costs of non-acute separations, however, as these patients typically have very long lengths of stay (AIHW 2001b).

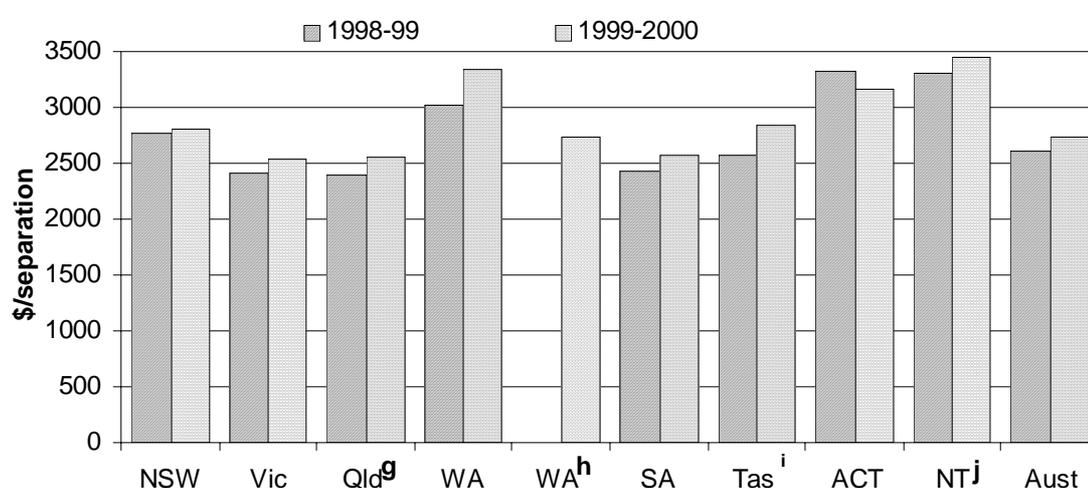
The AIHW (2001d) has shown that hospital recurrent expenditures on Indigenous and non-Indigenous people may differ (box 5.4). This may also influence unit cost outcomes.

The data exclude spending on non-admitted patient care, the user cost of capital and depreciation, research costs and payroll tax. Overnight stays, same day separations and private patient separations in public hospitals and private patient recurrent costs are included. The institutional scope excludes psychiatric hospitals, drug and alcohol services, mothercraft hospitals, unpeered and other hospitals, hospices, rehabilitation facilities, small non-acute and multi-purpose services. Separations in the excluded hospitals comprised 3.5 per cent of separations (on average) in 1998-99 and 1999-2000 — although the proportion of separations excluded varies across jurisdictions (table 5A.27).

Recurrent cost per casemix-adjusted separation for each jurisdiction for 1998-99 and 1999-2000 is presented in figure 5.16. It should be noted that the data for 1999-2000 are based on 1998-99 cost weights, rather than 1999-2000 cost weights. These data are currently being revised by the AIHW and the new data will be placed on the Review web page in early 2002.

The additional data for 1999-2000 for WA in figure 5.16 were provided by the WA Department of Health and do not correspond with the estimates for WA for that year calculated by the AIHW. For the other States and Territories, in 1999-2000, recurrent cost per casemix-adjusted separation was highest in the NT (\$3444) and lowest in Victoria (\$2529) (figure 5.16). The NT Government advise that the apparent high unit cost for the NT may reflect inclusion of some non-admitted patient services and that work is currently being undertaken to clearly identify the inpatient fraction of recurrent hospital cost.

Figure 5.16 Recurrent cost per casemix-adjusted separation (current prices)^{a, b, c, d, e, f}



^a Excludes depreciation. ^b Psychiatric hospitals, drug and alcohol services, mothercraft hospitals, unpeered and other hospitals, hospices, rehabilitation facilities, small non-acute and multi-purpose services are excluded from the data. ^c Separations from the National Hospital Morbidity Database whose type of episode of care is acute, newborn with qualified days or unspecified. ^d Average cost weight from the National Hospital Morbidity Database, based on acute and unspecified separations and newborn episodes of care with qualified days, using the 1998-99 AR-DRG v 4.0/4.1 combined cost weights (DHAC unpublished). ^e Casemix-adjusted separations are the product of total separations and average cost weight. ^f Estimated private patient medical costs calculated as the sum of salary/sessional and VMO payments divided by the number of public patient days multiplied by the number of private patient days. This is a notional estimate of the medical costs for all non-medical costs. ^g Queensland pathology services are now being purchased from the State-wide pathology service rather than being provided by each hospitals' employees. ^h Revised WA data provided by WA Department of Health. These data do not accord with the Australian Institute of Health and Welfare (2001), *Australian Hospital Statistics 1999-00*. WA used a morbidity extract of September 2001 for 1999-2000 data, and changed the inpatient fraction. Excluded hospitals are those with <200 separations; all MPSs and drug and psychiatric hospitals. Weights are NHCDC round 3 population weights for public hospitals. WA data for 1998-99 were not revised unlike the data for 1999-2000, thus, any apparent drop in average cost is the result methodological differences rather than fluctuations in cost. ⁱ Tasmania is the only jurisdiction with a significant payroll tax burden. As a result, payroll tax has been estimated at 6.7 per cent of salary plus superannuation and removed from the above. ^j These figures need to be interpreted in conjunction with the consideration of cost disabilities associated with hospital service delivery in the NT.

Sources: AIHW (2001b); WA Department of Health; table 5A.27.

Box 5.4 Admitted patient costs for Indigenous people, 1998-99

The AIHW (2001d) notes that there are a number of factors driving differences in admitted patient expenditures between Indigenous people and non-Indigenous people.

- The average DRG cost weight for Indigenous patients is lower than for non-Indigenous patients due to their higher numbers of low-cost DRGs, such as dialysis, and lower numbers of high cost surgical DRGs.
- The average length of hospital stay for Indigenous people tends to be longer than for non-Indigenous people within the same DRG. This leads to higher costs per episode and can be attributed to case complexity, hospital and regional cost variations, differences in clinical practice and post-discharge support.
- A high proportion of Indigenous people live in areas where the hospitals are relatively high-cost, such as those in remote parts of Australia. On the other hand, in some cases, a high proportion of Indigenous people live in the vicinity of lower cost hospitals, such as small non-remote rural hospitals and remote Queensland hospitals.⁶
- In addition, there is evidence that cost per separation for Indigenous people is higher due to the higher costs of caring for patients with greater comorbidities. These costs are in addition to those associated with longer lengths of stay. The AIHW (2001d) added a five per cent cost loading for Indigenous admitted patients to account for this affect.

Overall, after adjusting for length of stay and differences in hospital costs due to locational factors, costs per separation within DRGs for Indigenous patients were 6 per cent higher than for non-Indigenous patients. This varied across jurisdictions. Costs per separation for Indigenous patients in NSW were 4 per cent lower and Queensland costs 6 per cent lower, whereas, WA, SA and NT costs per separation for Indigenous patients were respectively 5 per cent, 13 per cent and 6 per cent higher. Higher costs in SA were the result of treatment of Indigenous patients that are many hundreds of kilometres from home. Many of the high-cost NT patients are treated in SA hospitals.

Source: AIHW (2001d).

To address the problem associated with a lack of cost weights for non-acute admitted patients, Victoria and NSW also report recurrent cost per casemix-adjusted separation for acute patients only. Psychiatric care days in designated psychiatric units in acute hospitals are also removed from these calculations because the AR-DRG casemix classification is recognised to be a poor predictor of the cost of psychiatric episodes. Capital costs (the user cost of capital and depreciation expenses), research costs and payroll tax are excluded from these estimates of unit

⁶ In 1998-99, over a quarter of the Indigenous population (27.5 per cent) lived in remote areas, compared with only 2.6 per cent of the total Australian population (AIHW 2001d).

costs (figure 5.17). Other jurisdictions are expected to also be able to isolate acute care costs in the near future.

Figure 5.17 Recurrent cost per casemix-adjusted acute non-psychiatric separation (current prices)^{a, b, c, d, e}



^a Excludes psychiatric; mothercraft; hospices; small non-acute, unpeered and other hospitals; rehabilitation facilities; and multi-purpose services. ^b Acute separations are separations where the type of episode of care is acute, newborn with qualified days, or unspecified. Psychiatric unit separations are those psychiatric separations with at least some days in designated psychiatric units. ^c The acute non-psychiatric admitted patient fraction is that portion of recurrent costs which are for acute admitted patients and which exclude the costs of psychiatric care in a designated psychiatric unit. ^d Average cost weight from the National Hospital Morbidity Database, based on acute and unspecified separations and newborn episodes of care with qualified days, using the 1998–99 AR-DRG version 4.0/4.1 combined cost weights. ^e The cost per non-acute separation and including psychiatric unit separations is \$5769 for NSW and \$6347 for Victoria.

Source: AIHW (2001b); table 5A.29 and table 5A.28.

Comparisons across jurisdictions are affected by differences in the mix of outputs (or admitted patient services) produced by hospitals in each jurisdiction. Hospitals have therefore been categorised according to a set of ‘peer groups’ — developed by the National Health Performance Committee (and its predecessor, the National Health Ministers’ Benchmarking Working Group) — to enable hospitals with similar activities to be compared. The data by peer group are presented in detail in table 5A.32. The dominant peer classification is the principal referral and specialist women’s and children’s category. In 1999–2000, these hospitals accounted for 66 per cent of public hospital expenditure and 63 per cent of separations (AIHW 2001b). The data for principal referral hospitals (excluding specialist women’s and children’s) are presented in table 5.13. Australia-wide, recurrent cost per casemix-adjusted separation for principal referral hospitals in 1999–2000 was \$2789 — highest in NSW (\$2940) and lowest in Victoria (\$2577). It should be noted that the data for 1999–2000 are based on 1998–99 cost weights, rather than 1999–2000 cost

weights. These data are being revised by the AIHW and the new data will be placed on the Review web page in early 2002.

Table 5.13 Recurrent cost per casemix-adjusted separation, principal referral hospitals (public), 1999-2000^{a, b, c}

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT^d</i>	<i>Aust</i>
No. of hospitals	18	11	11	3	3	2	1	1	50
Av. beds per hospital	418	771	421	593	461	364	503	268	506
Separations per hospital	36 615	65 590	35 514	58 394	55 466	30 939	48 368	32 046	45 102
Av. cost weight	1.08	1.01	1.07	1.00	1.05	1.06	0.89	0.75	1.04
Cost per casemix-adjusted separation (\$)	2940	2577	2703	na	na	2608	na	na	2789
Expenditure									
Principal referral hospitals (\$m)	2780	2618	1330	na	na	249	na	na	8554
Total (\$m)	5071	3507	2348	1442	1197	334	259	197	14 354

^a Principal referral hospitals are classified as metropolitan hospitals with greater than 20 000 acute casemix-adjusted separations and rural hospitals with greater than 16 000 acute casemix-adjusted separations per annum. ^b Expenditure data exclude depreciation. ^c Average cost weight from the National Hospital Morbidity Database, based on acute and unspecified separations and newborn episodes of care with qualified days, using the 1998-99 AR-DRG v 4.0/4.1 combined cost weights (DHAC unpublished). ^d The NT average cost weight of 0.75 reflects the high number of patients receiving renal dialysis treatments and the low average cost of this treatment compared with other DRGs. If treatment for renal dialysis is excluded, the NT average cost weight is 1.11.

Source: AIHW (2001b); table 5A.32.

Inclusion of capital costs

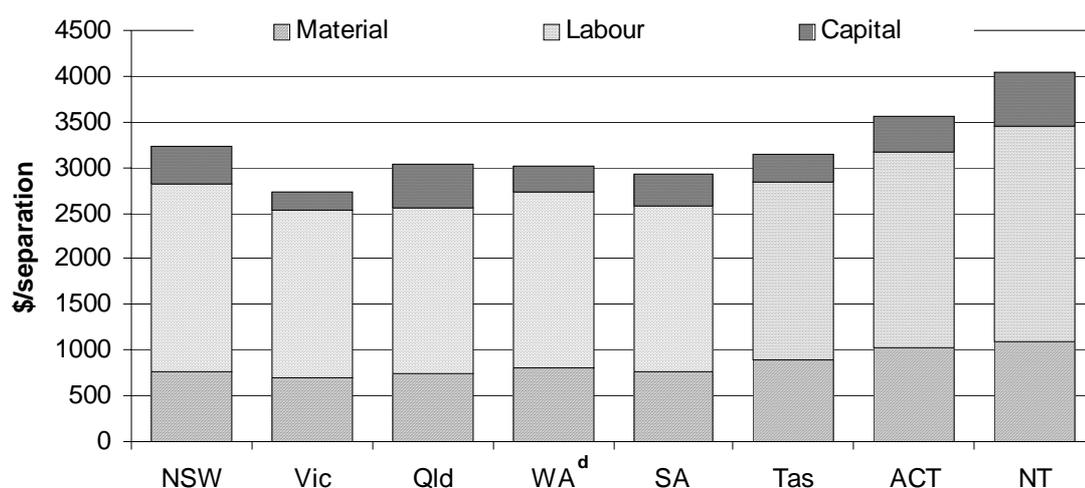
The estimated unit cost of admitted care services inclusive of capital costs is reported below. Total cost per casemix-adjusted separation is defined as the recurrent cost per casemix-adjusted separation plus the capital costs (depreciation and the user cost of capital of buildings and equipment) per casemix-adjusted separation. The indicator is reported only for admitted patients.

Depreciation is defined as the cost of consuming an asset's services, and 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 and is equivalent to the return forgone from not using the funds to deliver other government services or to retire debt. Interest payments represent a user cost of capital and so should be excluded from recurrent expenditure where user costs of capital are calculated separately and added to recurrent costs. Interest payments were not separately identified in the data

for the select group of hospitals included in this indicator. For all public hospitals in 1999-2000, however, reported interest expenses were effectively zero for all jurisdictions except WA (where interest expenses were 1.6 per cent of recurrent expenditure) and the NT (where they were not reported) (AIHW 2001b). Interest expenses were therefore deducted directly from capital costs in WA to avoid double counting.

Total cost per casemix-adjusted separation by jurisdiction (including capital costs) are presented in figure 5.18. *It is important to note that all of the material and labour costs data were calculated by the AIHW, except the data for WA — its data were provided by the WA Department of Health and do not correspond with the estimates for WA calculated by the AIHW (2001b) (see figure 5.16).* When the revised data for casemix-adjusted separations based on 1999-2000 cost weights are available from the AIHW, total cost per casemix-adjusted separation will be recalculated. The new data will be placed on the Review web page early in 2002.

Figure 5.18 Total cost per casemix-adjusted separation, 1999-2000^{a, b, c, e}



^a 'Labour' includes medical and non-medical labour costs. 'Material' includes other non-labour recurrent costs. 'Capital' is defined to include the user cost of capital plus depreciation associated with the delivery of inpatient services in the public hospitals described in the data for recurrent cost per casemix-adjusted separation. ^b Excludes the user cost of capital associated with land. This is reported in table 5A.24. ^c Variation across jurisdictions in the collection of capital related data suggests that the data should be treated as indicative. ^d WA data for material and labour costs are based on data provided by the WA Department of Health and do not correspond with the estimates for WA calculated by the AIHW (2001b) (see figure 5.16). For other jurisdictions, these data were calculated by the AIHW. ^e Data based on 1998-99 cost weights.

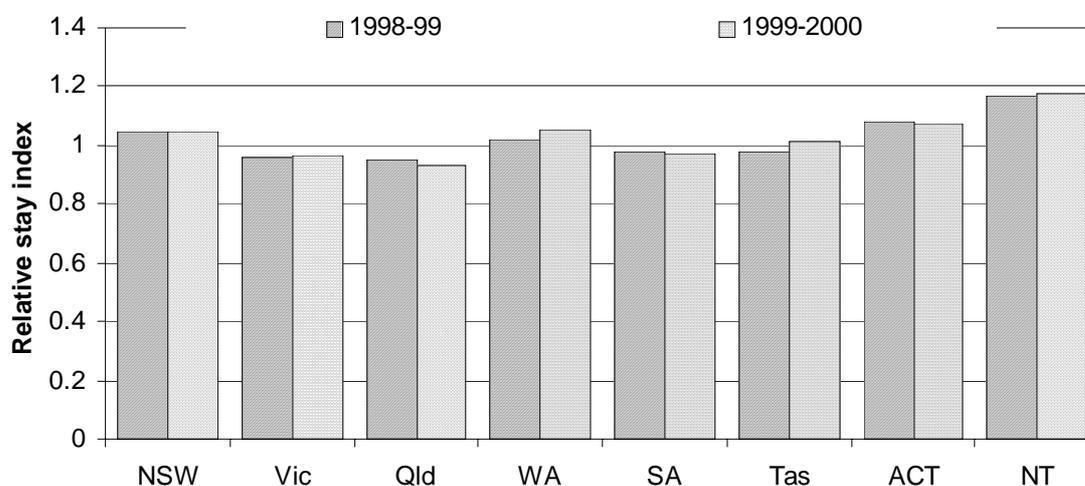
Source: AIHW (2001b); State and Territory governments; table 5A.24 and table 5A.27.

Casemix-adjusted relative stay index

The casemix-adjusted length of stay — or ‘relative stay index’ — is defined as the actual number of acute bed days divided by the expected number of acute bed days adjusted for casemix. Casemix-adjustment is important, since hospitals with more complex patients will appear to have relatively higher lengths of stay, and may erroneously appear less efficient. As indicated, States and Territories vary in the thresholds applied for classifying patients as either same day admitted patients or outpatients. These variations will affect this indicator.

The relative length of stay for Australia is one. A relative stay index greater than one indicates that an average patient’s length of stay is higher than would be 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 would have been expected. Same day dialysis and chemotherapy patients have been excluded from the calculations for this indicator. The relative stay index for acute patients in public hospitals in 1999-2000 was highest in the NT (1.17) and lowest in Queensland (0.93) (figure 5.19).

Figure 5.19 Casemix-adjusted relative stay index, public hospitals^a



^a Stays of 200 days and over are excluded. Index includes acute patients only (including unknowns and newborns with qualified days). Same day dialysis and chemotherapy are excluded.

Source: AIHW (unpublished); table 5A.26.

Recurrent cost per non-admitted occasion of service

The cost per non-admitted occasion of service is the proportion of 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.

These data are not comparable across jurisdictions because, to date, there is no agreed non-admitted patient classification system. There is variation in reporting categories across jurisdictions and inconsistencies arise because of differences in outsourcing practices. (In some cases, for example, outsourced occasions of service may be included in expenditure on non-admitted services, but not in the count of occasions of service.) In addition, this indicator does not adjust for complexity of service — for example, a simple urine glucose test is treated equally with a complete biochemical analysis of all body fluids (AIHW 2000b).

Jurisdictions able to supply 1999-2000 data for this indicator reported the following results:

- in NSW, emergency department cost per occasion of service was \$83 for 7.7 million occasions of service, and outpatient cost per occasion of service was \$160 for 1.6 million occasions of service (table 5A.72).
- in WA, emergency department cost per occasion of service was \$92; outpatient cost per occasion of service was \$104; and overall, cost per occasion of service was \$95. In total, there were 3.6 million occasions of service (table 5A.79).
- in SA in 1999-2000, emergency department cost per occasion of service was \$214; outpatient cost per occasion of service was \$147; and overall, cost per occasion of service was \$149. In total, there were 283 514 occasions of service (table 5A.81).
- in Tasmania, emergency department cost per occasion of service was \$178 for 72 501 occasions of service and outpatient cost per occasion of service was \$165 for 260 567 occasions of service (table 5A.83).
- in the ACT, emergency department cost per occasion of service was \$138; outpatient cost per occasion of service was \$42 and overall, cost per occasion of service was \$59. In total, there were 496 304 occasions of service (table 5A.85).

Victoria collects data on the basis of cost per encounter. An encounter includes the clinic visit and all ancillary services provided within a 30-day period either side of the clinic visit. Based on cost data from 13 major hospitals in 1999-2000, the average cost per encounter was \$109, compared with \$104 in 1998-99. This compared with an average cost per encounter of \$105 in 1997-98 (based on cost data from nine major hospitals) and \$104 in 1996-97 (based on cost data from seven major hospitals) (table 5A.74).

In light of the difficulties associated with the lack of a nationally consistent non-admitted patient classification system, the Review has included national data from

the Commonwealth Department of Health and Aged Care, National Hospital Cost Data Collection (NHCDC) for cost per emergency department visit (table 5.14) and cost per occasion of service for outpatients (table 5.15) for the first time in this Report. The NHCDC collects data on a consistent basis across a sample of hospitals which is expanding over time. The samples for each jurisdiction are, however, not necessarily representative since hospitals contribute data on a voluntary basis. The emergency department data are based on figures provided by 128 hospitals across Australia, whereas the outpatient (tier 1) data are based on figures provided by 17 hospitals. (Outpatient tier 2 data are included in the attachment and were contributed by 27 hospitals (attachment table 5A.36).) The NHCDC data are affected by differences in costing and admission practices across jurisdictions and hospitals.

Table 5.14 Emergency department average cost per presentation by triage class, public sector, Australia, 1999-2000^{a, b, c, d, e, f, g}

<i>Triage category</i>	<i>Population estimated</i>	<i>Actual</i>
	<i>Average cost per presentation (\$)</i>	<i>Average cost per presentation (\$)</i>
Admitted triage 1	539	562
Admitted triage 2	358	369
Admitted triage 3	335	345
Admitted triage 4	290	302
Admitted triage 5	188	218
Non-admitted triage 1	399	448
Non-admitted triage 2	310	317
Non-admitted triage 3	265	275
Non-admitted triage 4	191	202
Non-admitted triage 5	116	138
Did not wait ^h	70	79
Total	211	233

^a Population estimates are derived as not all hospitals submit emergency department data to the NHCDC. The emergency department national database differs from the acute national database in that acute hospitals without emergency department cost and activity are excluded from this database. ^b Based on data from 128 hospitals across Australia. ^c Cost and activity emergency department (ED) data for Victoria was only captured for cost-modelled sites representing approximately 10 per cent of the available ED data for that State. ^d The NT did not submit emergency department data. ^e Queensland data are incomplete. Queensland did not report cost and activity data for the emergency department component of admitted triage category for eight major costing sites. ^f Costing and admission practices vary across jurisdictions and hospitals. ^g Depreciation and interest costs are included. ^h 'Did not wait' means those presentations to an emergency department who were triaged but did not wait until the completion of their treatment, at which time they would have been either admitted to hospital or discharged home.

Source: DHAC, National Hospital Cost Data Collection, Round 4; table 5A.33.

Table 5.15 **Non-admitted clinic occasions of service for tier 1 clinics, actual results, public sector, 1999-2000^{a, b}**

<i>Tier 1 clinic</i>	<i>Occasions of service (no.)</i>	<i>Average cost per occasion of service (\$)</i>
Allied health and/or clinical nurse spec.	830 464	58
Dental	62 171	93
Medical	706 229	196
Obstetrics and gynaecology	264 332	137
Paediatric	48 542	204
Psychiatric	69 623	260
Surgical	533 180	108
Total	2 514 541	125

^a Depreciation and interest costs are included. ^b A total of 17 hospitals contributed tier one data.

Source: DHAC, National Hospital Cost Data Collection, Round 4; table 5A.35.

5.3 Maternity services performance framework

Framework of performance indicators

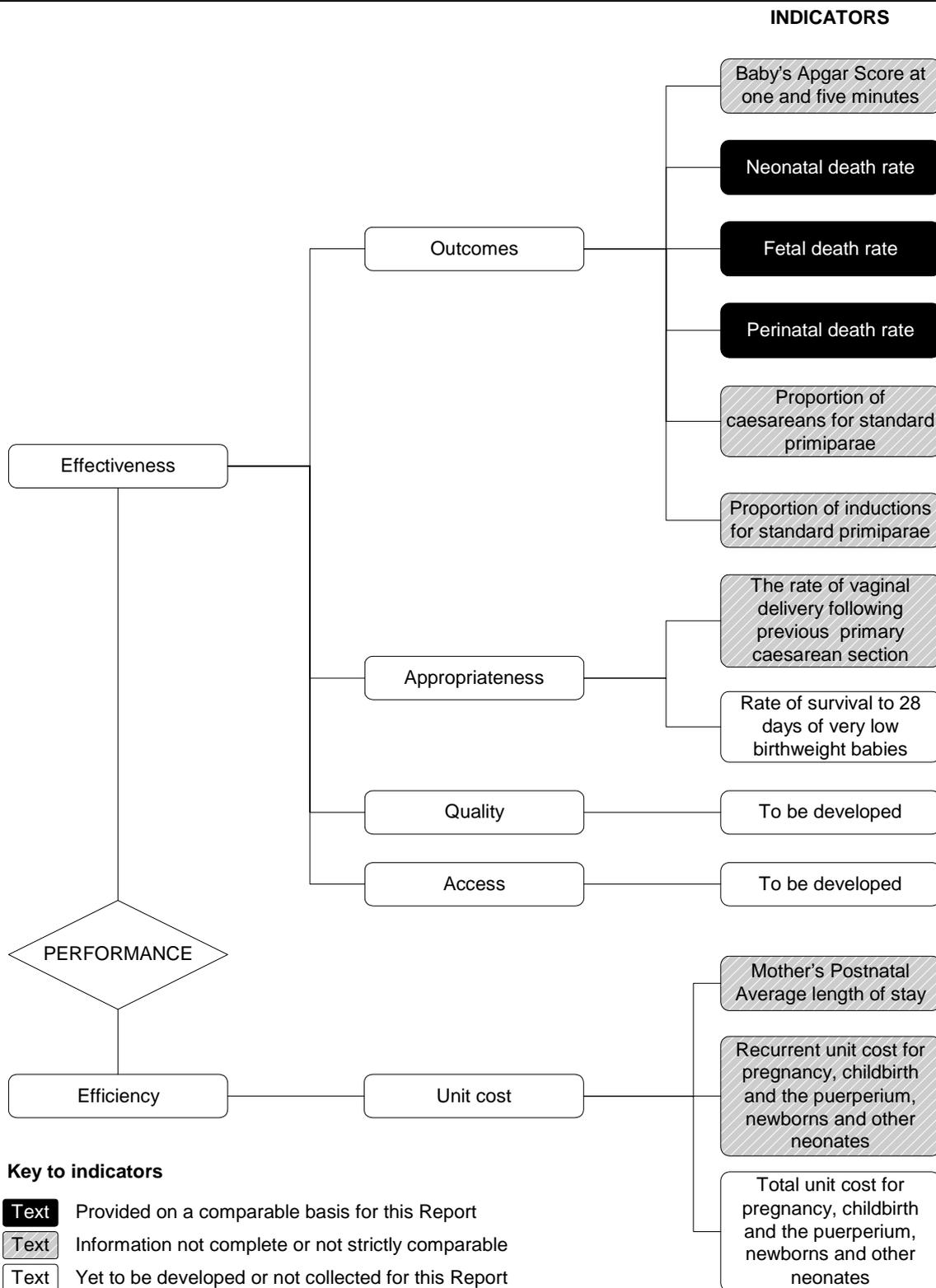
The performance framework for maternity services is outlined in figure 5.20, and has the same objectives as for public hospitals in general. The framework is under development by the Steering Committee and, as is the case with all the performance indicator frameworks, will be subject to regular review.

Key performance indicator results

Outcomes

Six maternity service outcome indicators are included in the Report this year: the Apgar score (which indicates a baby's wellbeing soon after birth); fetal, perinatal and neonatal death rates; and caesarean and induction rates for standard primiparae.

Figure 5.20 Proposed performance framework for maternity services



Apgar score

The Apgar score is a numerical score used to evaluate a baby's condition shortly after birth. It is based on an assessment of the baby's heart rate, breathing, colour, muscle tone and reflex irritability. Between zero and two points are given for each of these five characteristics, and the total score may vary between zero and 10. The Apgar score is routinely assessed at one and five minutes after birth, and subsequently at five-minute intervals if it is still low at five minutes (Day *et al.* 1999). Low Apgar scores of less than four are strongly associated with babies' birthweights.

This year, jurisdictions provided Apgar scores by birth weight (table 5A.40) for the first time. The Review will clarify the definitions underlying the data over time. Table 5.16 illustrates the relationship between low birth weight and low Apgar score. In 1999, Victoria had the highest proportion of babies weighing 0–1499 grams reporting an Apgar score of three or less five minutes after delivery (17.6 per cent) while SA reported the smallest proportion (7.7 per cent). For babies weighing 1500–1999 grams, NSW reported the highest proportion of babies with Apgar scores of three or less (8.1 per cent) and Victoria reported the lowest (0.8 per cent). For other birthweights, Apgar scores of three or less were relatively rare and the proportion was fairly similar across jurisdictions.

Table 5.16 Number of live births and proportion of babies with an Apgar score of three or less, five minutes post-delivery, public hospitals, 1999^a

<i>Birthweight (grams)</i>	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>
0–1499	No. live births	815	556	485	244	194	na	na	51
	%	15.9	17.7	14.6	10.6	7.7	na	na	10.0
1500–1999	No. live births	933	611	464	255	198	na	na	71
	%	8.1	0.8	1.7	1.6	1.5	na	na	0.0
2000–2499	No. live births	2 857	2 034	1440	711	604	na	na	150
	%	0.4	0.5	0.4	0.4	0.2	na	na	0.0
2500 and over	No. live births	66 185	43 047	33 614	15 720	13 255	na	na	2 524
	%	0.2	0.1	0.2	0.1	0.2	na	na	0.0

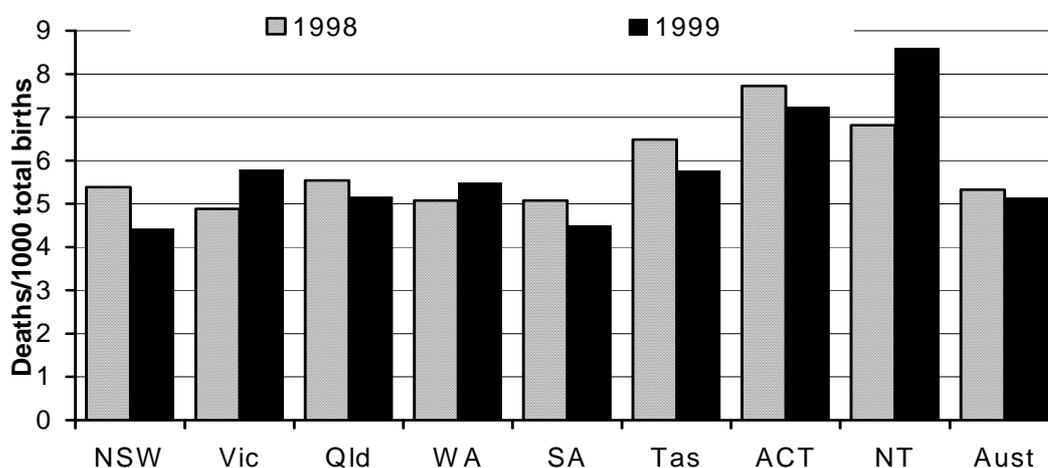
^a There are minor discrepancies in the data provided by Victoria and WA. The Review will clarify the definitions underlying the data over time. **na** Not available.

Source: State and Territory governments (unpublished); table 5A.40.

Fetal deaths

The fetal death rate is presented for the first time in this Report. Fetal death (stillbirth) is the delivery of a child who did not at any time after delivery breathe or show any other evidence of life, such as heartbeat. Fetal deaths by definition only include infants weighing at least 400 grams or of a gestational age of at least 20 weeks. The rate of fetal deaths is expressed per 1000 total births. In 1999, the national rate was 5.1 per 1000 births. This rate was slightly lower than the 1998 rate (5.3). In 1999, the fetal death rate was highest in the NT (8.6 deaths per 1000 births) and lowest in NSW (4.4 deaths per 1000 births) (figure 5.21).

Figure 5.21 **Fetal death rate^a**



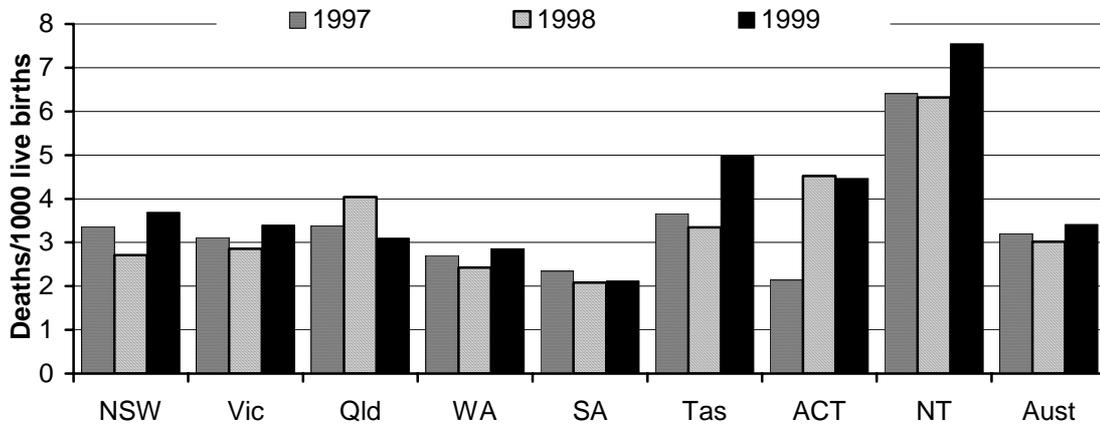
^a Rate expressed as a proportion of total births in Australia.

Source: ABS (2000); table 5A.44.

Neonatal deaths

Neonatal death is the death of a live born infant within 28 days of birth. The rate of neonatal deaths is expressed per 1000 live births. In 1999, the national rate was 3.4 deaths per 1000 live births. This was higher than the 1998 rate (3.0). In 1999, the neonatal death rate was highest in the NT (7.6 deaths per 1000 live births) and lowest in SA (2.1 deaths per 1000 live births) (figure 5.22).

Figure 5.22 Neonatal death rate^a



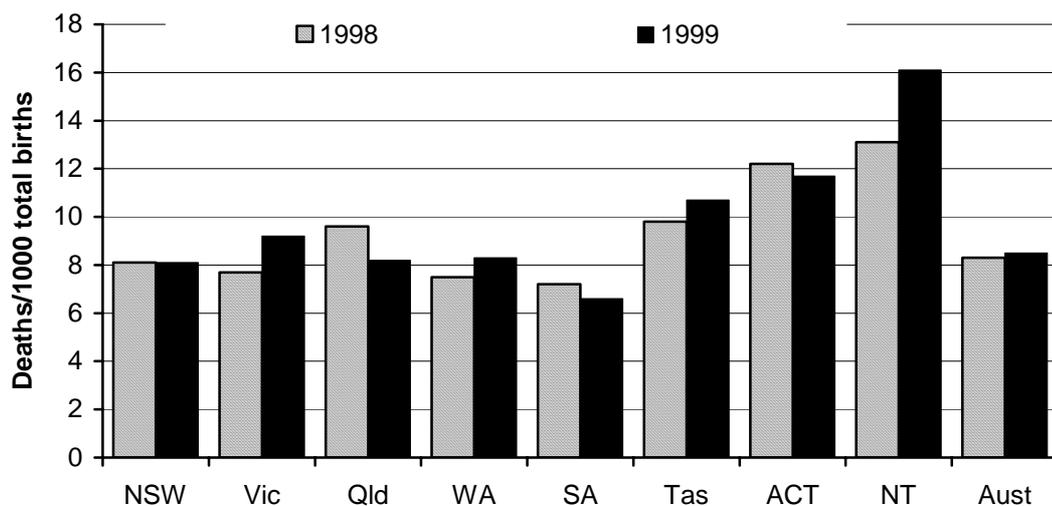
^a Rate expressed as a proportion of live births in Australia.

Source: ABS (2000); table 5A.42.

Perinatal deaths

A perinatal death is a fetal death or neonatal death of an infant weighing at least 400 grams or of gestational age of at least 20 weeks. The rate of perinatal deaths is expressed per 1000 total births. In 1999, the perinatal death rate Australia-wide was 8.5 deaths per 1000 total births — highest in the NT (16.1 deaths per 1000 total births) and lowest in SA (6.6 deaths per 1000 total births) (figure 5.23).

Figure 5.23 Perinatal death rate^a



^a Rate expressed as a proportion of total births in Australia.

Source: ABS (2000); table 5A.43.

Intervention rates for standard primiparae

Caesarean and induction rates for standard primiparae are being developed as an indicator by the Review and preliminary data are presented for the first time in this Report. It is important to note that at present, there is no nationally agreed definition of standard primiparae so the data are not comparable across jurisdictions. Standard primiparae are by definition considered low risk parturients.⁷ Intervention (caesarean or induction) rates should therefore be low in this population. High rates may indicate a need for investigation. A general definition (provided by Victoria) refers to standard primiparae as mothers of between 20–34 years of age, babies that are not small for gestational age (greater than the 10th percentile), singleton pregnancy, at term (37–41 weeks gestation), with a cephalic presentation and free of medical complications of pregnancy. This definition, however, leaves scope for differences in application across States and Territories.

Preliminary data for induction and caesarean rates for standard primiparae for the jurisdictions supplying data are outlined below. As stated earlier, the data are not comparable across jurisdictions. The data are for public hospitals and definitions are included where they differ to that provided by Victoria.

- NSW defined standard primiparae as mothers between 20–34 of years of age, not small for gestational age, singleton pregnancy, at term, cephalic presentation and without hypertension (essential or pregnancy induced), and without diabetes (pre-existing or gestational). The 2000 rate of inductions for standard primiparae was 18.3 per cent. The 2000 rate of caesareans for standard primiparae was 12.9 per cent (table 5A.45).
- Data for 2000 for WA were not provided. The 1999 rate of inductions for standard primiparae was 22.7. The 1999 rate of caesareans for standard primiparae was 13.7 (table 5A.46).
- Victoria's 2000 rate of inductions for standard primiparae was 19.1. The 2000 rate of caesareans for standard primiparae was 13.9 (table 5A.47).
- The 2000 rate of inductions for standard primiparae for SA was 20.1. The 2000 rate of caesareans for standard primiparae was 15.9. (South Australia used the Victorian definition, taking medical complications to include obstetric complications as well.) (Refer to table 5A.48.)
- The NT defined a standard primipara as a mother between 20–34 years of age, with no previous pregnancies resulting in a live or still birth, singleton birth, carrying a child whose gestational age was between 37 and 41 weeks, where the

⁷ Parturient means 'about to give birth'. Primipara refers to a pregnant woman, who has had no previous pregnancy resulting in a live birth or stillbirth (AIHW 1998).

presentation is vertex, there are no medical complications, and where there are no indicators for intrauterine growth retardation. The NT was not able to provide a rate for 2000. The 1999 rate of inductions for standard primiparae was 19.1. The 1999 rate of caesareans for standard primiparae was 12.4 (table 5A.49).

- The ACT provided some data for 1998. The 1998 rate of caesareans for standard primiparae was 10.5 (table 5A.50).

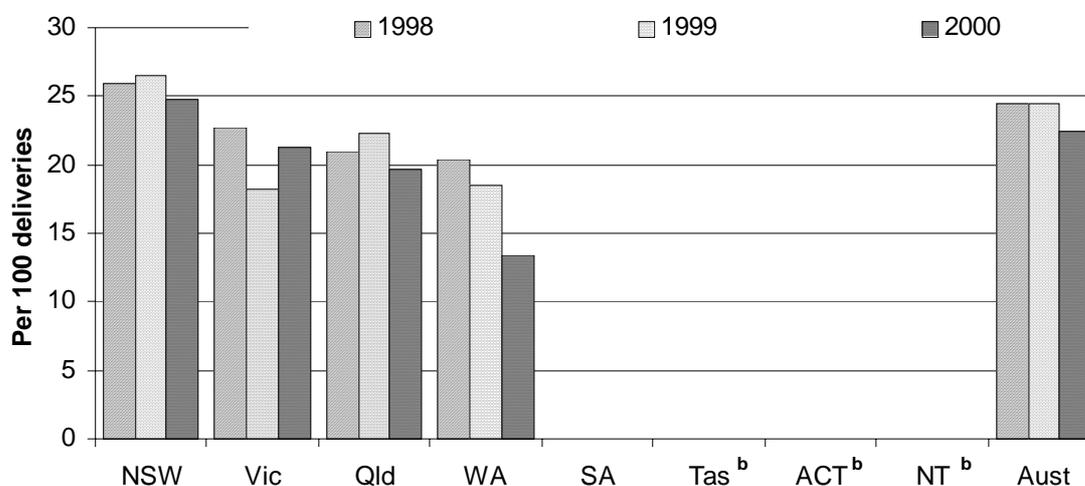
Appropriateness

One appropriateness indicator is reported this year: the rate of vaginal delivery following previous primary caesarean section. Variations in rates across jurisdictions may highlight differences in intervention rates that require more detailed analysis. The rate of vaginal delivery following primary caesarean section is defined as the number of patients delivering vaginally following a previous primary (first) caesarean section, as a proportion of the total number of patients delivering who have had a previous primary caesarean section and no intervening pregnancies of greater than 20 weeks gestation (ACHS 2000b).

The data are sourced from the ACHS Comparative Report Service (Clinical Indicators) and are collected for the purposes of internal clinical review by individual hospitals. State-wide conclusions cannot be drawn from the data as health care organisations contribute to the ACHS on a voluntary basis and so the data are not necessarily drawn from representative samples. Sample sizes for each jurisdiction are contained in the attachment (table 5A.51). Across Australia, 139 health care organisations contributed data in 2000.

Data for the ACT, the NT and in some cases Tasmania were not provided by the ACHS because of the small number of hospitals in those jurisdictions. South Australia requested that its data not be published because the data are drawn from samples that do not necessarily reflect all hospitals in each jurisdiction. Estimated rates for the other jurisdictions are shown in figure 5.24 and should be viewed in the context of the statistical (standard) errors. Data are also disaggregated by region (metropolitan and rural) — although again, may be affected by the potential for samples to be non-representative (table 5A.51).

Figure 5.24 **Rate of vaginal delivery following primary caesarean (all hospitals)^{a, c}**



^a Defined as the number of patients delivering vaginally following a previous primary caesarean section divided by the total number of patients delivering who have had a previous primary caesarean section and no intervening pregnancies of greater than 20 weeks gestation. ^b Data for Tasmania, the ACT and the NT are not available because of the small number of hospitals. ^c Health organisations contribute data voluntarily to the ACHS and the samples are not therefore necessarily representative of all hospitals in each jurisdiction. SA requested its data be removed for this reason.

Source: ACHS (unpublished); table 5A.51.

Efficiency

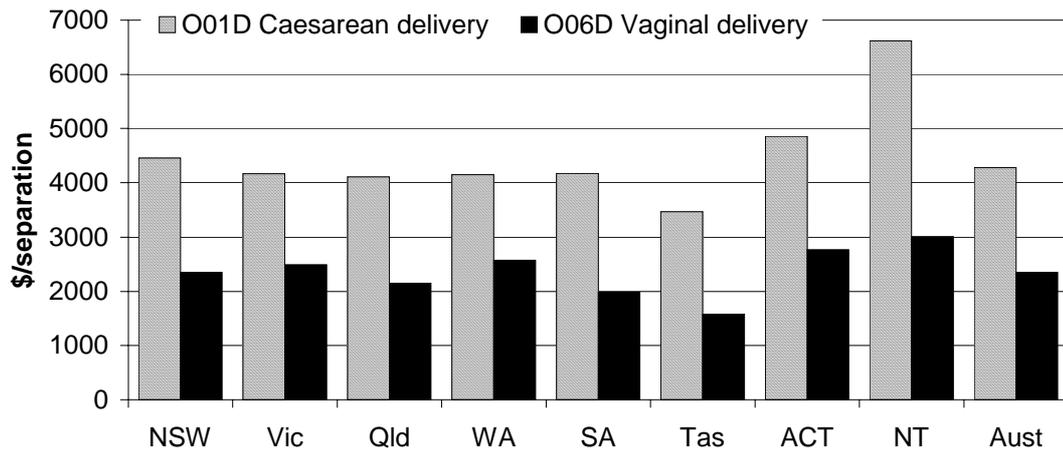
Two efficiency indicators are reported for maternity services — the cost per separation and the average length of stay. Figures 5.25 and 5.26 present data for the two largest DRGs that account for the largest number of maternity separations. Data for a number of other delivery-related DRGs are shown in table 5A.52.

Data are sourced from the NHCDC and are based on the AR-DRG classification version 4.1. The NHCDC is a voluntary annual collection coordinated by the Commonwealth Department of Health and Aged Care hospital cost and activity data — including national and jurisdiction cost weights — covering the financial year prior to the collection period. Survey respondents comprise mostly larger hospitals, and as such, cost estimates may tend to underestimate the real costs to a jurisdiction because of their scale economies. Since participation in the NHCDC collection is voluntary, the samples are not necessarily representative of the set of hospitals in each jurisdiction.

The average cost per separation for caesarean delivery without complications was \$4278 for Australia in 1999-2000 (figure 5.25). The highest average cost was in the NT (\$6615) and the lowest was in Tasmania (\$3466). The average cost per

separation for a vaginal delivery without complications was \$2349 for Australia. The highest average cost was in the NT (\$3010) and the lowest cost was in Tasmania (\$1582).

Figure 5.25 **Average cost per separation for selected DRGs public hospitals, 1999-2000^a**

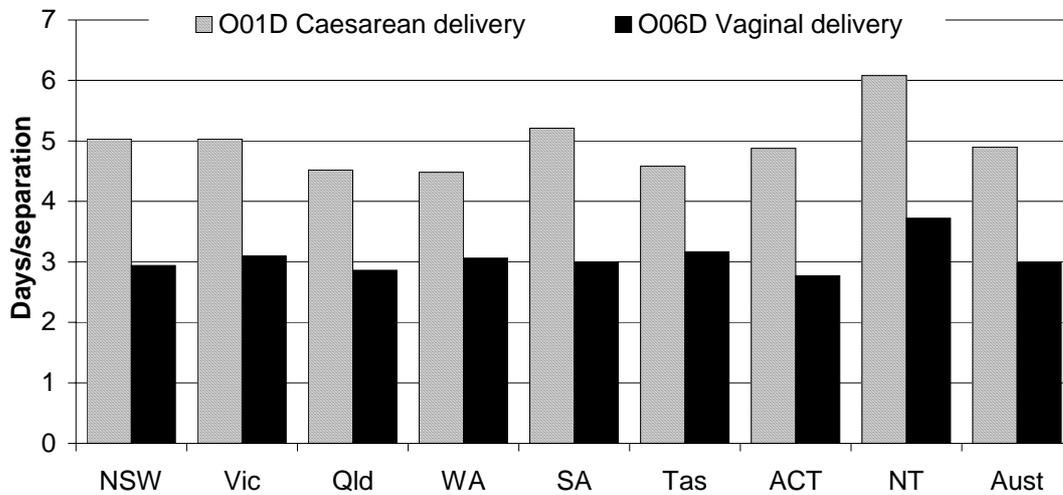


^a Includes O01D caesarean delivery without complicating diagnosis and O060D vaginal delivery without complicating diagnosis.

Source: DHAC, National Hospital Cost Data Collection, Round 4; table 5A.52

The average length of stay for caesarean delivery without complications was 4.90 days for Australia — the longest stay in the NT (6.08 days) and the shortest in WA (4.48 days). The average length of stay for vaginal delivery without complications was 2.99 days for Australia. The longest length of stay was in the NT (3.72) and the shortest in the ACT (2.77) (figure 5.26).

Figure 5.26 Average length of stay per DRG, public hospitals, 1999-2000^a



^a Includes O01D caesarean delivery without complicating diagnosis and O060D vaginal delivery without complicating diagnosis.

Source: DHAC, National Hospital Cost Data Collection, Round 4; table 5A.52

5.4 Future directions in performance reporting

Key challenges for the Steering Committee in future years are to:

- continue to improve the reporting of hospital services (including maternity services) delivered to special needs groups, particularly Indigenous people;
- improve the reporting of indicators in the performance frameworks for public hospitals and maternity services where data are not complete or not strictly comparable; and
- continue to improve the frameworks for reporting.

Quality

Reporting on quality in previous years has been constrained by a paucity of data, creating an important gap in information. Policy developments, in particular the establishment of the Australian Council for Safety and Quality in Health Care (ACSQHC) in 2000, are likely to create scope for improved reporting in this area in the medium to long term.

Patient safety monitoring

As discussed in previous reports, patient safety is an important policy issue for the health system, including public hospitals. A number of studies have indicated that the incidence of adverse events (sometimes referred to as ‘iatrogenic harm’⁸) is potentially high (Brennan *et al.* 1991, Wilson *et al.* 1995, Thomas *et al.* 2000). The costs of adverse events can be considerable (Kohn *et al.* 1999).

Estimating the prevalence of adverse events is hampered by difficulties with recognising when such events have occurred and determining what is preventable, taking the risk of a given outcome into account. Reliability of reporting can also be a problem (McNeil *et al.* 2000). The ACSQHC examined sources of data about adverse events in acute health care settings in Australia and found that there is no single system that provides comprehensive quantitative measurement of the nature and frequency of preventable adverse events (ACSQHC 2001b).

Estimates of hospital separations associated with an adverse event were produced by Hargreaves (2001) (table 5.17). The data are affected by changes in scope and coverage of the collection and improvements to the quality of data recording and coding over time, so it cannot be concluded that the rate of adverse events increased over time. The data in table 5.17 underestimate the number of separations associated with adverse events as they are based on the International Classification of Disease (ICD) codes specific to adverse events. There are other ICD categories that can be used to reflect both adverse events and non-adverse events (for example, ‘accidental poisoning by drugs, medicaments and biologicals’ may reflect both medical mistakes and a drug taken inadvertently by a child). These have been excluded from the data (Hargreaves 2001). Comparisons across States and Territories are affected by differences across jurisdictions in the capacity of data systems to record the necessary codes for adverse events.

The ACSQHC (2001b) concluded that:

Hospital separations data in their current form cannot be used to estimate the number of patient days or levels of disability attributable to the injuries, nor the proportion of injuries that may be amenable to preventive measures. Nor can the data at present reliably distinguish those events occurring during the episode of care from those present on admission (ACSQHC 2001b, p. 22).

⁸ ‘Iatrogenic harm’ refers to harm arising from health care, rather than from the patient’s underlying disease or injury.

Table 5.17 Hospital separations with an adverse event, 1993-94 to 1997-98

<i>Year</i>	<i>Misadventures</i>	<i>Complications</i>	<i>Drug adverse events</i>	<i>Total^a</i>	<i>Per cent of all separations</i>
1993-94	2 898	133 516	28 890	182 858	3.97
1994-95	3 582	152 584	35 816	209 305	4.29
1995-96	3 928	164 181	41 714	226 563	4.38
1996-97	4 532	178 837	48 202	246 948	4.64
1997-98	4 877	190 739	53 388	264 347	4.75

^a The data are affected by changes in scope and coverage of the collection and improvements to the quality of data recording and coding over time, so it cannot be concluded that the rate of adverse events increased over time. ^b Total includes separations with no external cause.

Source: ACSQHC (2001b).

The Council has foreshadowed further work on promoting better use of data to identify, learn from, and prevent error and system failure as a priority (ACSQHC 2001a). In particular, it plans to lead the development of a more comprehensive national approach to monitoring incidents and adverse events in order to provide a stronger information base to support coordinated and consistent action for improving patient safety (ACSQHC 2001a).

Victoria has established a State-wide system for reporting of a subset of adverse events, called 'sentinel events'. Sentinel events are defined as relatively infrequent clear-cut events that occur independently of a patient's condition, commonly reflect hospital system and process deficiencies and result in unnecessary outcomes for patients (DHS [Victoria] 2001).⁹ Data collection commenced in 2001-02. Given the relative infrequency of sentinel events, data collected will not be used as a measure of hospital performance to compare hospitals or be reported publicly. Any future release of sentinel event information is subject to review and analysis of data received and to consultation with hospitals and other stakeholders, but would be likely to be descriptive rather than statistical in nature.

The ACT is also investigating patient safety initiatives that may be suitable for inclusion in future reports. The ACT, for example, has implemented the Australian

⁹ The specified events to be reported are: procedures involving the wrong patient or body part; unexpected/unexplained serious neurological damage following spinal procedures (anaesthetic/surgical/medical) that is likely to be permanent; inadvertent perforation of a viscus during endoscopic procedure; inadvertent perforation or ligation of duct or major vessel during laparoscopic procedure; intravascular gas embolism resulting in serious neurological damage or mortality; haemolytic blood transfusion reaction resulting from ABO incompatibility; patient suicide in hospital; retained instruments or other material after surgery requiring re-operation or further surgical procedure; hypoxic brain damage probably attributable to anaesthesia, airway management or ventilation techniques; post-partum haemorrhage requiring hysterectomy.

Patient Safety Foundation Australian Incident Monitoring System (AIMS) as a Territory-wide initiative. The AIMS is an incident monitoring system established by the Australian Patient Safety Foundation. It uses a standardised reporting instrument and classification scheme. Reporting is voluntary and anonymous if desired. In addition to the ACT, the AIMS has been or is being introduced across the public health care system in SA, WA, and the NT. It is also used in some health services in other states and New Zealand. There are approximately 50 000 records in the AIMS database. A recent analysis of the AIMS database of incidents routinely reported by the health care facilities found that falls were the main type of event recorded (28.9 per cent) followed by injuries other than falls (13.0 per cent) and medication errors (11.6 per cent). Several examples of use of the data in studies to improve services have been published.

Appropriateness

As foreshadowed in the 2001 Report, reporting of appropriateness is another area with scope for improvement. Acute care services are increasingly delivered in non-hospital settings (box 5.5). For any given procedure, alternative forms of delivery may better suit certain types of patients. For example, Caplan *et al.* (1999) found that hospital-in-the-home may be preferable for older people. Changing the delivery environment can increase the patient's welfare and/or lead to improved cost effectiveness without affecting outcomes for patients.

Box 5.5 Selected service delivery alternatives to hospital care

hospital-in-the home: provision of acute care in non-hospital accommodation, such as the patient's own residence.

step-down facilities: patients are transferred out of the acute ward into an adjacent facility where their progress can be monitored in a less intensive setting.

coordinated care programs: recognise patients at high risk of hospital admission (for example, asthmatics, diabetics, patients with heart disease) and intervene to lower hospital admission rates by providing strategies for better patient management.

Source: DHAC (1999).

In addition, the performance of acute care services is influenced by the operation of pre- and post-acute health care, such as health prevention and promotion, primary care, rehabilitation and chronic illness management. Developing an appropriate mix of services across the spectrum of health and community care has the potential to enhance outcomes for patients and possibly, efficiency. Experiments to test the scope of different service delivery and funding arrangements to improve health care outcomes within existing resources were undertaken as part of the Coordinated Care

Trials (box C.6 in the Health preface). The Review is developing long term strategies to address these issues.

Efficiency

Non-admitted patient classification

National data for cost per visit for emergency departments and cost per occasion of service for outpatients are reported this year as an initial step towards reflecting these data consistently across jurisdictions. While there is significant scope for improvement in reporting for non-admitted patients, progress depends on the development of a non-admitted patient classification system. Several States are working on systems for improved reporting of non-admitted patients. National agreement on definitions, such as those for acute admitted patients with AN-DRGs, will be needed before comparable reporting can commence. The Australian Health Care Agreements specify that the Commonwealth, State and Territory governments will develop and implement a non-admitted patient morbidity data set by 30 June 2003.

Maternity services

Two of the new outcomes indicators for maternity services reported this year — the proportion of caesareans and the proportion of inductions for standard primiparae — are not able to be compared across jurisdictions as a result of differences in the definition of standard primiparae. It is an aim of the Review to contribute to the development of a nationally consistent definition for these indicators in conjunction with the AIHW, the ACHS and Women's Hospitals Australia. In addition, the Review plans to work on development of an indicator reflecting appropriateness of service delivery for maternity services in public hospitals.

5.5 Definitions

Table 5.18 Terms

<i>Term</i>	<i>Definition</i>
Aboriginal concept of health	'Not just the physical wellbeing of an individual, but ... the social, emotional and cultural wellbeing of the whole community in which each individual is able to achieve their full potential as a human being, thereby bringing about the total wellbeing of their community. It is a whole-of-life view and includes the cyclical concept of life-death-life (NACCHO 1997).
Aboriginal concept of community control	'A process which allows the local Aboriginal community to be involved in its affairs in accordance with whatever protocols or procedures are determined by the Community' (NACCHO 1997).
Accessibility index	A measure of hospital access equity, primarily for Indigenous people.
Acute care episode	Clinical services provided to patients, including 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, although acute care services may also be provided to non-admitted patients.
Admission	The process by which an admitted patient commences an episode of care.
Allied health (non-admitted)	All occasions of service to non-admitted patients where services are provided at units/clinics providing treatment/counselling to patients. These include units primarily concerned with physiotherapy, speech therapy, family planning, dietary advice, optometry, occupational therapy.
Ambulatory services	Services provided by an acute care hospital to non-admitted patients
Apgar score	Numerical score used to evaluate a baby's condition after birth. The definition of the indicator is the number of babies born with an Apgar score of four or below at five minutes post-delivery as a proportion of the total number of babies born. Foetal death in utero prior to commencement of labour is excluded.
Average length of stay	Equal to the arithmetic mean of the length of stay for all patient episodes, estimated by dividing total occupied bed days by total episodes.
Bulk billed services	Attendances for which the medical practitioner bills the Commonwealth Government directly.
Caesarean section	Operative birth through an abdominal incision.
Casemix-adjustment	Adjustment of data on cases treated to account for the number and type of cases. Cases are sorted into diagnosis related groups (AN-DRGs) which represent a category of patients with similar clinical conditions requiring similar hospital services.
Catastrophic	An acute or prolonged illness usually considered to be life threatening or with the threat of serious residual disability. Treatment may be radical and is frequently costly.
Case weight	The relative costliness of a particular AN-DRG, determined so that the average case weight for all AN-DRGs is 1.00.

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Table 5.18 (Continued)

<i>Term</i>	<i>Definition</i>
Comorbidity	The simultaneous occurrence of two or more diseases or health-problems.
Community health services	Health services for individuals and groups delivered in a community setting, rather than via hospitals or private facilities.
Community health (non-admitted)	Occasions of service to non-admitted patients provided by designated community health units within the establishment. Such units include baby clinics, immunisation units, aged care assessment teams etc. Some community health care may involve a hospital employee providing a service away from his or her hospital establishment.
Complication	Additional medical problems that develop following a procedure, treatment or illness. Complications are usually directly or indirectly related to a procedure (risk of the procedure), treatment (side effect or toxicity) or illness.
Condition of capital	Ratio of depreciated replacement value to total replacement value.
Cost per casemix-adjusted separation	Recurrent expenditure * inpatient fraction/total number of casemix-adjusted separations + estimated private patient medical costs.
Cost per non-admitted occasion of service	Recurrent expenditure * (1–inpatient fraction)/total number of non-admitted occasions of service.
Elective surgery waiting times	The time elapsed for a patient on the elective surgery waiting list, from the date he or she was added to the waiting list for a procedure to a designated census date.
Emergency department waiting times to service delivery	The time elapsed for each patient from presentation to the emergency department to 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.
Fetal death	Delivery of a child who did not at any time after delivery breathe or show any other evidence of life, such as heartbeat. Excludes infants weighing less than 400 grams or of gestational age less than 20 weeks.
Fetal death rate	Fetal deaths (400 grams/20 weeks) by usual residence divided by the total number of births (ie. live births registered and fetal deaths combined).
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 and Indigenous health.
Hospital-acquired infection — bacteraemia	The total number of inpatients who acquire bacteraemia during the time period under study, divided by the total number of separations with a length of stay of 48 hours or more during the time period under study. Hospital-acquired bacteraemia is defined as positive blood culture for inpatients who were afebrile on admission — that is, those with a temperature less than 37.4 degrees Celsius, who become febrile 48 hours or more after admission.

(Continued on next page)

Table 5.18 (Continued)

<i>Term</i>	<i>Definition</i>
Hospital-acquired infection — wound infection	The number of inpatients having evidence of wound infection on or after the fifth post-operative day following clean (contaminated) surgery during the time period under study, divided by the total number of inpatients undergoing clean (contaminated) surgery with a post-operative length of stay equal to or greater than five days. All endoscopies are excluded, as are intra-cavity procedures such as oral, aural, nasal, urethral, vaginal and anal operations. Clean surgery refers to those operations performed in a sterile field. Contaminated surgery, includes traumatic wounds and those operations which breach the gastro-intestinal, respiratory and genito-urinary tracts or where a break in aseptic technique occurs.
Inpatient fraction (IFRAC)	The ratio of inpatient costs to total hospital costs.
Labour cost per casemix-adjusted separations	([Salary and wages]*[inpatient fraction] + visiting medical officer payments)/total 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. All registered live births regardless of birthweight.
Medicare	The Commonwealth Government funding of private medical and optometrical services (Medicare Benefits Schedule). Some users use the term to include other forms of Commonwealth Government funding: selected pharmaceuticals (Pharmaceutical Benefits Scheme) and public hospital funding (Australian Health Care Agreements), which provide public hospital services free of charge to public patients.
Mortality rate	The number of deaths per 100 000 people.
Neonate	A live birth less than 28 days old. The neonatal period is exactly 28 completed days commencing on the date of birth (day 0) and ending on the completion of day 27.
Neonatal death	Death of a live born infant within 28 days of birth (defined in Australia as deaths of infants weighing at least 400 grams or of gestational age of at least 20 weeks).
Neonatal death rate	Neonatal deaths (400 grams/20 weeks) by usual residence, divided by the number of live births registered.
Non-acute episode of care	Involves clinical services provided to admitted and non-admitted patients, including planned geriatric respite, palliative care, geriatric evaluation and management and services for nursing home-type patients. Clinical services delivery by designated psychiatric or psychogeriatric units, designated rehabilitation units and mothercraft services are also considered non-acute.
Non-admitted patient services	Services provided to non-admitted patients of the kind defined in the <i>National Health Data Dictionary</i> version 6, data element no. 231 'Type of non-admitted patient care'. Services include: emergency services; outpatient services; and other non-admitted patient services.

(Continued on next page)

Table 5.18 (Continued)

<i>Term</i>	<i>Definition</i>
Opportunity cost	The return forgone on the next best investment, calculated as eight per cent of depreciated replacement value of buildings, equipment and land.
Overdue patient	A patient whose wait has exceeded the time determined as clinically desirable in relation to the urgency category to which he or she has been assigned for elective surgery.
Percentage of facilities accredited with the Australian Council on Healthcare Standards	The ratio of accredited beds to all hospital beds in the jurisdiction.
Perinatal death	Fetal death or neonatal death of infant weighing at least 400 grams or of gestational age of at least 20 weeks.
Perinatal death rate	Perinatal deaths (400 grams/20 weeks) by usual residence divided by the total number of births (that is live births registered and fetal deaths combined).
Primary care	Essential health care based on practical, scientifically sound and socially acceptable methods made universally accessible to individuals and families in the community.
Primipara	Pregnant woman who has had no previous pregnancy resulting in a live birth or a still birth.
Private patient medical costs (estimated)	The sum of salary/sessional and visiting medical officer payments divided by the number of public patient days multiplied by the number of private patient days.
Public hospital	A hospital that provides free treatment and accommodation to eligible admitted persons who elect to be treated as public patients. It also provides free services to eligible non-admitted patients and may provide (and charge for) treatment and accommodation services to private patients. Charges to non-admitted patients and admitted patients on discharge may be levied in accordance with the Australian Health Care Agreements (for example, aids and appliances).
Puerperium	The period or state of confinement after labour.
Qualified/unqualified newborn	A newborn patient day is qualified if the infant: is the second or subsequent live born infant of a multiple birth whose mother is an admitted patient; is admitted to an intensive care facility in a hospital; or is admitted to, or remains in, hospital without its mother. A newborn patient day is unqualified if the infant does not meet any of these three criteria. Unqualified patient days are excluded from measurement of patient days for newborn episodes of care.
Real expenditure	Actual expenditure adjusted for changes in prices.
Same day patients	A patient whose admission date is the same as the separation date.
Sentinel procedures	Procedures that are the most common surgical operations, provided by acute care hospitals during a given period of time.
Separation	The discharge, transfer or death of a patient admitted to hospital.
Separations per 1000 population	The rates of hospital separations per 1000 population.
Spontaneous vertex	Vaginal birth without intervention in which the baby's head is the presenting part.

(Continued on next page)

Table 5.18 (Continued)

<i>Term</i>	<i>Definition</i>
Standard primipara	Victoria defines this as follows: 20–34 years of age, not small for gestational age (SGA greater than the 10th percentile), singleton pregnancy, at term (37–41 weeks gestation), with a cephalic presentation and free of medical complications of pregnancy.
Triage category	The urgency of the patient's need for medical and nursing care: category 1 — resuscitation (immediate within seconds) category 2 — emergency (within 10 minutes) category 3 — urgent (within 30 minutes) category 4 — semi-urgent (within 60 minutes) category 5 — non-urgent (within 120 minutes).
Unplanned hospital re-admissions	The total number of unplanned and unexpected re-admissions within 28 days of separation, during the time period under study, divided by the total number of separations (excluding deaths) for the same time period. Unplanned hospital re-admission refers to an unexpected admission for further treatment of the same condition for which the patient was previously hospitalised; an unexpected admission for treatment of a condition related to one for which the patient was previously hospitalised; or an unexpected admission for a complication of the condition for which the patient was previously hospitalised. Day stay patients are included in both the numerator and the denominator. This indicator addresses patients readmitted to the same organisation.
Unreferred attendances	GP services, emergency attendances after hours, other prolonged attendances, group therapy and acupuncture.
Urgency category for elective surgery	category 1 patients — admission within 30 days is desirable for a condition that has the potential to deteriorate quickly to the point that it may become an emergency. category 2 patients — admission desirable within 90 days for a condition 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 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.
User cost of capital per casemix-adjusted separation	(Depreciation + opportunity cost)/casemix-adjusted separations.
Vaginal delivery following primary caesarean section	The number of patients delivering vaginally following a previous primary (first) caesarean section as a proportion of the total number of patients delivering who have had a previous primary caesarean section and no intervening pregnancies greater than 20 weeks gestation.

6 General practice

General practice is a major component of Australia's healthcare system and plays an important role in the delivery of health services. General practitioners (GPs) form part of the primary health care system and are at the interface between primary care and other parts of the health system. Consequently, support for general practice is an important part of government strategy to improve health outcomes in Australia.

Descriptive information about services provided in general practice is contained in section 6.1. Policy developments in general practice are discussed in section 6.2, a framework of performance indicators is presented in section 6.3 and key results are discussed in section 6.4. Future directions for reporting are covered in section 6.5 and relevant terms are defined at section 6.6.

A number of significant changes have been made to enhance the general practice chapter this year. These include:

- reporting new appropriateness indicators. Two indicators have been discontinued and replaced by indicators that better reflect the activities of GPs;
- enhanced data on expenditure are reported including non-Medicare data, Department of Veterans' Affairs (DVA) and State and Territory government contributions; and
- improved definitions to better reflect the supply of general practice services.

These changes are discussed in more detail in sections 6.1 – 6.4.

Supporting tables

Supporting tables for chapter 6 are provided on the CD-ROM enclosed with the Report. The files are provided in Microsoft Excel 97 format as `\Publications\Reports\2002\Attach6A.xls` and in Adobe PDF format as `\Publications\Reports\2002\Attach6A.pdf`.

Supporting tables are identified in references throughout this chapter by an 'A' suffix (for example, table 6A.3 is table 3 in the electronic files). They may be

subject to revision. The most up-to-date versions of these files can be found on the Review web page (www.pc.gov.au/gsp/). Users without Internet access can contact the Secretariat to obtain up-to-date versions of these tables (see details on the inside front cover of the Report).

6.1 Profile of general practice

Definitions, roles and responsibilities

General Practitioners form part of the medical practitioner workforce. The medical practitioner workforce comprises doctors trained in a specialty — including general practice — and other medical practitioners (OMPs). All GPs trained since 1996 must undertake the general practice specialist training program. The Royal Australian College of General Practitioners (RACGP) defines a GP as: “a medical practitioner who provides primary, comprehensive and continuing care to patients and their families within the community” (Britt *et al.* 1999, p. XXXV). For the purposes of Medicare, ‘recognised’ GPs are those who are vocationally registered under section 3F of the *Health Insurance Act 1973 (Cth)*, hold fellowship of the RACGP or equivalent, or hold a recognised training placement (Britt *et al.* 1999). A summary of common health terms is provided at section 6.6.

In Australia, GPs are an important source of primary health care.¹ The services provided by GPs include: diagnosing and treating illness (both chronic and acute); providing preventive care through to palliative care; referring patients to consultants, allied health professionals, community health services, and hospitals; and acting as gatekeepers for other health care services (DHFS 1996). They may also be involved in teaching and research.

While the majority of GPs are private practitioners who provide services as part of a general practice (funded largely by the Commonwealth Government’s Medicare Benefits Schedule, supplemented by patient contributions), they may also be employed by hospitals. Over recent years there has also been an emerging trend of corporate entities purchasing general practices and in some cases, amalgamating these practices into medical centres that include other health services. In some parts of rural Australia, GPs provide a range of services to admitted patients, and rural and urban GPs staff emergency departments, although this latter role is declining

¹ Primary care refers to the care provided at the patient’s first point of contact with the health care system. Other examples of primary care include services provided by community health centres, pharmacists in local pharmacies, nurses in the home and a number of other health providers in non-institutional settings.

(DHAC 2000a). State and Territory governments fund services provided by visiting medical officers or salaried doctors to public patients in public hospitals, and visiting medical and other primary health care services provided in rural and remote areas. State and Territory governments are also responsible for registering and licensing GPs in their jurisdiction. Commonwealth, State and Territory governments provide incentives for GPs to locate in rural and remote areas.

Funding

Almost all of the services provided by private GPs are funded in part by the Commonwealth Government through Medicare and the DVA. This is illustrated by the *Bettering the Evaluation and Care of Health* (BEACH) study of general practice activity in Australia (Britt *et al.* 2000). About 1000 GPs participate in the BEACH study each year, with each participant recording details of 100 consecutive encounters. (Britt *et al.* (2000) define an 'encounter' as any professional interchange between a patient and a GP.) The BEACH study found that, in 2000-01, 94.6 per cent of all encounters with GPs were for services funded by Medicare or DVA (table 6.1).

Table 6.1 Encounters by source of funding, 2000-01^{a, b}

	Number	Rate per 100 encounters ^c	95% LCL ^d	95% UCL ^d
GPs participating in the BEACH study	998	..	..	..
Total encounters for which BEACH data were recorded	99 307	98.1	97.8	98.4
Encounters with missing data	12 512	..	..	..
Direct consultations ^e	85 148			
No charge	554	0.6	–	1.5
Medicare paid ^f	82 113	94.6	94.2	95.0
Workers' compensation	1 808	2.1	1.8	2.4
Other paid (hospital, State, etc.)	677	0.8	–	1.6
Indirect consultations ^g	1 647	1.9	1.2	2.6

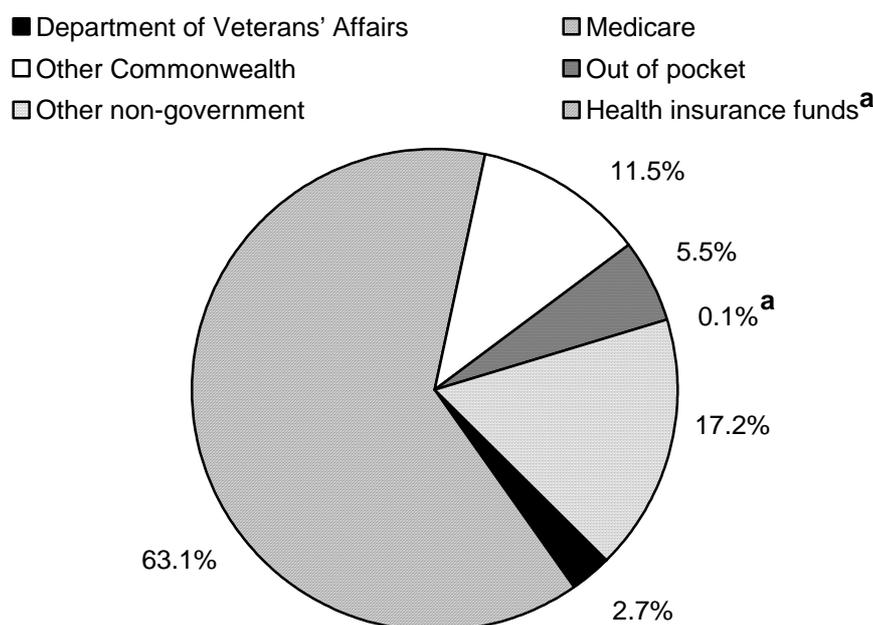
^a April 2000 to March 2001. ^b Britt *et al.* (2000) define an 'encounter' as any professional interchange between a patient and a GP. ^c Missing data for 12 512 encounters removed. Percentage base (N = 86 795). ^d UCL = upper confidence level; LCL = lower confidence level. ^e Categories do not add up to total direct consultations because there is overlap in some cases. ^f Includes Commonwealth payments made through DVA. ^g Indirect consultations are those at which the patient is not seen by the GP but which generate a prescription, a referral, a certificate or other service. They are usually the result of a phone call by a patient. .. Not applicable. – Zero or close to zero.

Source: Britt *et al.* (2001); table 6A.1.

Medicare fee-for-service payments comprised 81.7 per cent of Commonwealth expenditure on GPs in 1998-99 (and 63.1 per cent of total expenditure on GPs)

(figure 6.1). The Commonwealth also provided payments for GPs through the DVA local medical officer arrangements,² the Divisions of General Practice Program, the Practice Incentive Program (PIP) and the GP Immunisation Incentive Scheme (DHAC 2000a). Non-government sources contributed 22.7 per cent of total expenditure on GPs in 1998-99, comprising payments by health insurance schemes (including workers' compensation and third party insurance) and by private individuals.

Figure 6.1 Sources of funding for GPs, 1998-99



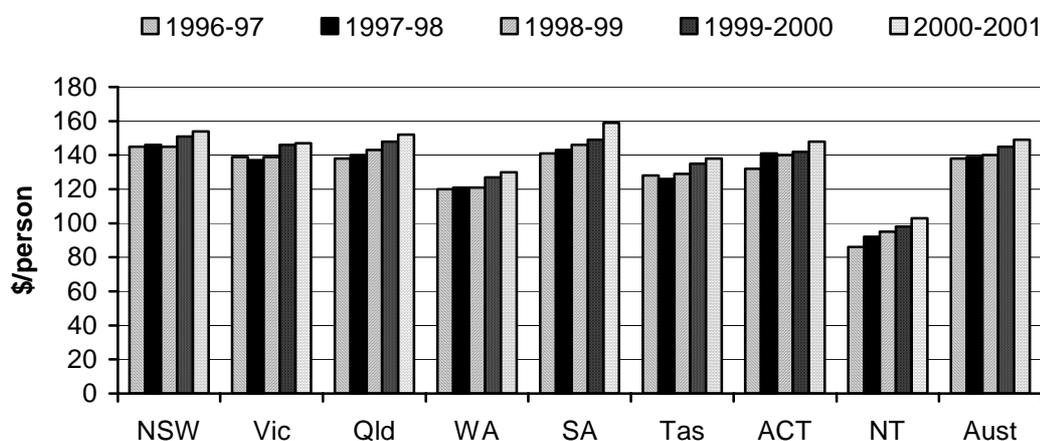
^a Health insurance funds accounted for \$5 million or just over 0.1 per cent of total GP funding in 1998-99.

Source: Britt et al. (2000), AIHW (unpublished); table 6A.2.

The cost to the Commonwealth Government of general practice was approximately \$2.9 billion in 2000-01 including non-Medicare funding and expenditure by DVA. This was equivalent to expenditure of \$149 per person in 2000-01 (figure 6.2). These data are not comparable with data in the 2001 Report due to the inclusion of non-Medicare funding and expenditure by DVA.

² Local medical officers are GPs who are registered with the DVA to provide services to veterans and other DVA beneficiaries.

Figure 6.2 Commonwealth Government real expenditure per person on general practice (2000-01 dollars)



Source: DHAC (unpublished); table 6A.3.

State and Territory governments also provide funding for general practice in a number of areas. Generally, this funding is provided indirectly through mechanisms such as support services for GPs. Expenditure on rural programs for general practice is one of the main areas funded by States and Territories — examples include assistance with housing and relocation, education programs and assistance with employment for spouses and family members of doctors in rural areas. Other types of expenditure are directed towards providing education and support services in areas such as diabetes management, smoking cessation, sexual health, and mental health and counselling. Funding in these areas is often provided through grants to bodies such as secretariats that help coordinate and deliver these support services to GPs and the community.

Some examples of State and Territory programs include:³

- the ACT Government funds a GP senior lecturer position for the Clinical School (\$150 000);
- the Tasmanian Government provides incentives for GP recruitment and retention to local government (\$80 000);
- the Queensland Government provides funding to the Divisions of General Practice to enable access to emergency Home and Community Care services;

³ Estimates of funding are included for some programs. These estimates are not comparable across jurisdictions.

-
- the Victorian Government assists with recruiting overseas doctors for rural hospitals and paying costs associated with immigration, registration with medical boards and retraining;
 - the WA Government funds initiatives to enhance communication, including supporting positions for the Secretariat to WA GP Advisory Council, and provision by the State Development Coordinator of information and education on communicable disease and sexual health; and
 - the SA Government funds initiatives to develop systems in hospitals to ensure that smoking cessation becomes an integral part of practice and that all interventions are linked to GPs and other health care providers (\$162 000).

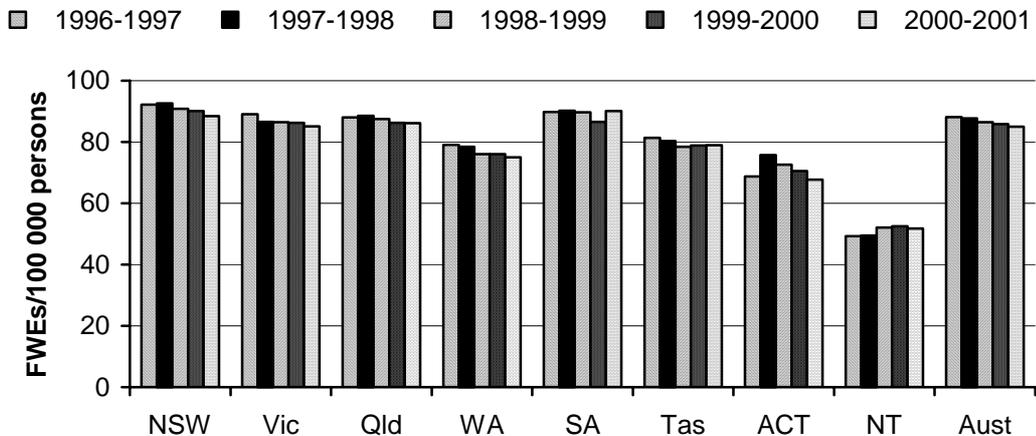
Size and scope of sector

In 2000-01, there were 24 249 GPs and OMPs billing Medicare in Australia (125.1 per 100 000 people), a decline from 132.4 per 100 000 in 1996-97 (table 6A.4). Care needs to be taken in interpreting these head counts of doctors billing Medicare as not all OMPs are GPs. In addition, some GPs provide only small numbers of services attracting Medicare benefits and there are substantial numbers of doctors working in medicine part time.

Figure 6.3 presents the distribution of full time workload equivalent (FWE) GPs across jurisdictions. An FWE is calculated for each doctor by dividing the doctor's Medicare billing (schedule fee value of claims processed by the Health Insurance Commission during the reference period) by the mean billing of full time doctors. The data exclude services provided by medical practitioners working with the Royal Flying Doctor Service, some doctors working in Aboriginal Medical Services, and salaried doctors working in public hospitals without the right of private practice. In addition, the data are based on doctors' Medicare claims, which for some doctors, particularly in rural areas, represent only part of their workload. GPs in rural or remote areas spend more of their time working in local hospitals than those in metropolitan centres.

Australia-wide in 2000-01, there were 85.0 full time workload equivalent GPs per 100 000 people. The highest number per 100 000 was in SA (90.1) and the lowest was in the NT (51.8) (figure 6.3).

Figure 6.3 **GPs (full time workload equivalent) per 100 000 persons**



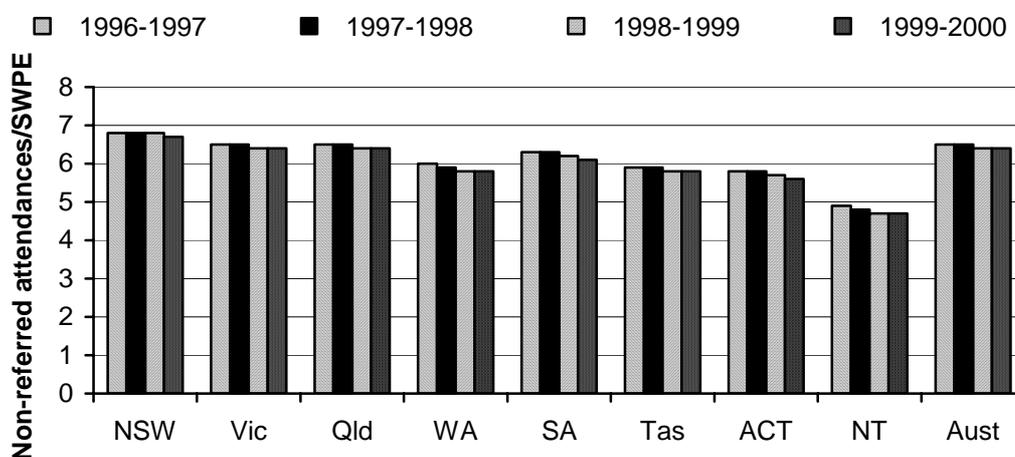
Source: DHAC (unpublished); table 6A.4.

Consulting a GP was the second most common health related action of Australians in 1995 (the last year for which data are available), after use of medications (ABS 1997). Consultations per standardised whole patient equivalent (SWPE)⁴ in 1999-2000 were highest in NSW (6.7) and lowest in the NT (4.7) (figure 6.4), and were generally highest in capital cities and lowest in remote areas — declining with population density (table 6A.6).

The most common reasons given by patients for visiting a GP in 2000-01 are outlined in table 6.2. In the BEACH study, participating GPs were asked to record at least one, and up to three, patient reasons for the encounter (Britt *et al.* 2001). Reasons for encounter reflect the patient's demand for care and can indicate service use patterns.

⁴ 'Standardised whole patient equivalent' is an indicator of practice workload based on the number of patients seen. The SWPE value for a jurisdiction is the sum of the fractions of care provided by doctors in that jurisdiction to their patients, weighted for the age and sex of each patient in accordance with national ratios.

Figure 6.4 **Non-referred attendances, per standardised whole patient equivalent^a**



^a 'Standardised whole patient equivalent' (SWPE) is an indicator of practice workload based on the number of patients seen. The SWPE value for a jurisdiction is the sum of the fractions of care provided by doctors in that jurisdiction to their patients, weighted for the age and sex of each patient in accordance with national ratios.

Source: DHAC (unpublished); table 6A.5.

Table 6.2 **Most frequent patient reasons for encounter, 2000-01^a**

Patient reason for encounter	No. of encounters	% of total reasons for encounter	Rate per 100 encounters ^b	95% LCL ^c	95% UCL ^c
Check-up (all) ^d	13 121	8.8	13.2	12.5	13.9
Prescription (all) ^d	9 161	6.1	9.2	8.7	9.8
Cough	6 900	4.6	7.0	6.5	7.4
Immunisation/ vaccination (all) ^d	4 369	2.9	4.4	4.0	4.8
Throat symptom/complaint	4 007	2.7	4.0	3.7	4.4
Back complaint ^d	3 726	2.5	3.8	3.5	4.0
Test results ^d	4 219	2.8	4.3	3.9	4.6
URTI	2 593	1.7	2.6	2.2	3.0
Rash ^d	2 896	1.9	2.9	2.8	3.1
Fever	2 241	1.5	2.3	1.9	2.6
Subtotal	53 231	35.5	–	–	–
Total reasons for encounters	149 962	100.0	151.0	149.2	152.8

^a An encounter is any professional interchange between a patient and a GP. ^b Figures do not total 100 as more than one reason for the encounter can be recorded at each encounter. ^c UCL = upper confidence level; LCL = lower confidence level. ^d Multiple primary care classification codes. – Zero or close to zero.

Source: Britt et al. (2001); table 6A.7.

More than one problem is often managed by a GP at a single encounter. Problems managed reflect the GP's understanding of the health problem presented by the

patient. The top 10 health problems managed by GPs are listed in table 6.3. Hypertension was the most common problem managed in 2000-01, followed by upper respiratory tract infection (a cold) (Britt *et al.* 2001).

Table 6.3 Top 10 health problems managed, 2000-01^a

<i>Problem managed</i>	<i>No. of problems</i>	<i>% of total problems</i>	<i>Rate per 100 encounters^b</i>	<i>95% LCL^c</i>	<i>95% UCL^c</i>
Hypertension ^d	8 560	6.0	8.6	8.2	9.1
Upper respiratory tract infection, acute	6 861	4.8	6.9	6.5	7.4
Immunisation/vaccination (all) ^d	4 543	3.2	4.6	4.2	5.0
Depression ^d	3 624	2.5	3.7	3.4	3.9
Lipid disorder	2 889	2.0	2.9	2.7	3.1
Asthma	2 821	2.0	2.8	2.7	3.0
Diabetes ^d	2 785	1.9	2.8	2.6	3.0
Acute bronchitis/bronchiolitis	2 724	1.9	2.7	2.5	3.0
Back complaint ^d	2 568	1.8	2.6	2.4	2.8
Osteoarthritis ^d	2 499	1.7	2.5	2.3	2.7
Subtotal	39 874	27.8	..	..	..
Total problems	143 528	100.0	144.5	142.8	146.3

^a Problems managed reflect the GP's understanding of the health problem presented by the patient. ^b Figures do not total 100 per cent as more than one problem can be managed at each encounter. ^c UCL= upper confidence level; LCL= lower confidence level. ^d Multiple primary care classification codes. .. Not applicable.

Source: Britt *et al.* (2001); table 6A.8.

The most common form of patient management undertaken by GPs in 2000-01 was prescription, supply and advice on medications (108.2 per 100 encounters). Clinical and procedural treatments were also significant (49.4 per 100 encounters) while referrals to specialists only accounted for 7.4 patient management activities per 100 encounters (table 6.4).

Table 6.4 Summary of patient management activities, 2000-01^a

<i>Management type</i>	<i>Number</i>	<i>Rate per 100 encounters</i>	<i>95% LCL^b</i>	<i>95% UCL^b</i>
Medications	107 400	108.2	105.7	110.6
Prescribed	91 647	92.3	89.9	94.7
Advised over the counter	8 906	9.0	8.1	9.8
GP supplied	6 847	6.9	5.7	8.1
Other treatments	49 072	49.4	47.1	51.7
Clinical	36 978	37.2	35.1	39.3
Procedural	12 094	12.2	11.6	12.8
Referrals	10 366	10.4	10.0	10.8
Emergency department	92	0.1	0.0	0.4
Hospital	499	0.5	0.3	0.7
Specialist	7 326	7.4	7.1	7.7
Allied health	2 313	2.3	2.1	2.5
Referral NOS ^c	137	0.1	0	0.6
Pathology	29 225	29.4	28.2	30.7
Imaging	8 227	8.3	7.9	8.7
Total management activities	204 290	205.7	..	..

^a An encounter is any professional interchange between a patient and a GP. ^b UCL = upper confidence level; LCL = lower confidence level. ^c Not elsewhere specified. .. Not applicable.

Source: Britt et al (2001); table 6A.9.

6.2 Policy developments

General Practice Memorandum of Understanding

A General Practice Memorandum of Understanding (GPMoU) exists between the Commonwealth Government and the RACGP, the Rural Doctors Association of Australia and the Australian Divisions of General Practice. The GPMoU provides an agreement regarding increased Commonwealth Government funding for general practice and provides the mechanism for joint management of funding between the Government and the profession. This allows for the development of good clinical practice. The GPMoU runs from 1 July 1999 until 30 June 2002 and guarantees government outlays on general practice will increase by over 4 per cent a year in nominal terms over the life of the GPMoU. This increase is expected to improve the remuneration of GPs, which has fallen relative to other areas of the profession, and to allow a focus on increased payments for improved outcomes of care.

The 2001-02 Budget included measures to increase funding for general practice by around \$750 million over the next four years. This includes additional funding for Medicare and the PIP to reward GPs for spending more time with their patients and improve health outcomes in mental health, cervical cancer, diabetes and asthma. Funding was also included to assist practices in employing nurses in areas of workforce shortage. Most of these measures are being implemented in 2001-02 (the final year of the agreement) and will result in additional money being spent under the umbrella of the GPMoU.

Workforce

Limits on the numbers of doctors training for general practice and those trained overseas have resulted in the GP workforce remaining relatively static over recent years. Different programs in each jurisdiction are addressing the rural doctor shortage and a new system to deliver general practice vocational training through regional programs has been established.

New training opportunities have been introduced to support non-vocationally registered rural doctors to achieve registration which will increase the level of patient fee rebates. This is expected to improve the financial viability of rural practice. Specific programs are addressing access issues to female rural GPs by encouraging short term rural placements. An additional program of workforce support for rural GPs is being delivered by rural Divisions of General Practice.

Quality

Diabetes and asthma are health priority areas where new chronic disease initiatives encourage the use of a more systematic approach to illness care through computerised general practice disease registers, recall and reminder systems, links with other providers, and use of audit and feedback linked to regional quality improvement programs. Preliminary work done through the National Divisions Diabetes Program has provided a base for models of care.

There are also a number of Quality Use of Medicines initiatives that focus on improving patient health outcomes, while reducing growth in the Pharmaceutical Benefits Scheme (PBS), in particular the educational activities of the National Prescribing Service (NPS) and the Enhanced Divisional Quality Use of Medicines Program.

The NPS uses evidence based strategies to educate and inform prescribers about high quality and appropriate prescribing. It focuses on providing independent information about medicines to prescribers. Coverage of NPS is being expanded so

that it can extend its support to all Divisions of General Practice and work more systematically with specialists, pharmacists and hospital doctors.

The aim of the Enhanced Divisional Quality Use of Medicines Program is to enhance current Quality Use of Medicines activity at the General Practice Divisional level to maintain or improve standards of patient care, while reducing the rate of growth of prescribing costs in specified areas. The three drug groups targeted under the program are antibiotics, peptic ulcer drugs and cardiovascular drugs. The program is delivered through Divisions of General Practice in partnership with the NPS whose activities it complements.

Practice Incentives Program

The PIP directly rewards general practices for parts of their service that are important to providing quality care, but which are not covered by fee-for-service arrangements. The PIP targets information management/information technology, after hours care, rural and remote practice, teaching of medical students, and also includes incentives for quality prescribing and for providing care plans and case conferences.

Practices joining the PIP after 1 January 2001 are required to register for accreditation against the RACGP's Standards for General Practice and to be fully accredited within 12 months of joining. Practices participating in the PIP prior to 1 January 2001 will need to be fully accredited by 1 January 2002.

6.3 Framework of performance indicators

The performance indicator framework is based on the shared government objectives for general practice, which reflect the primary care role of GPs (box 6.1).

Box 6.1 Objectives for general practice

General practice aims to promote the health of Australians by:

- acting as a main point of entry to the health care system;
- providing health care which promotes changes in lifestyle behaviour and prevents possible illness;
- coordinating and integrating health care services on behalf of clients; and
- providing continuity of care

in an equitable and efficient manner.

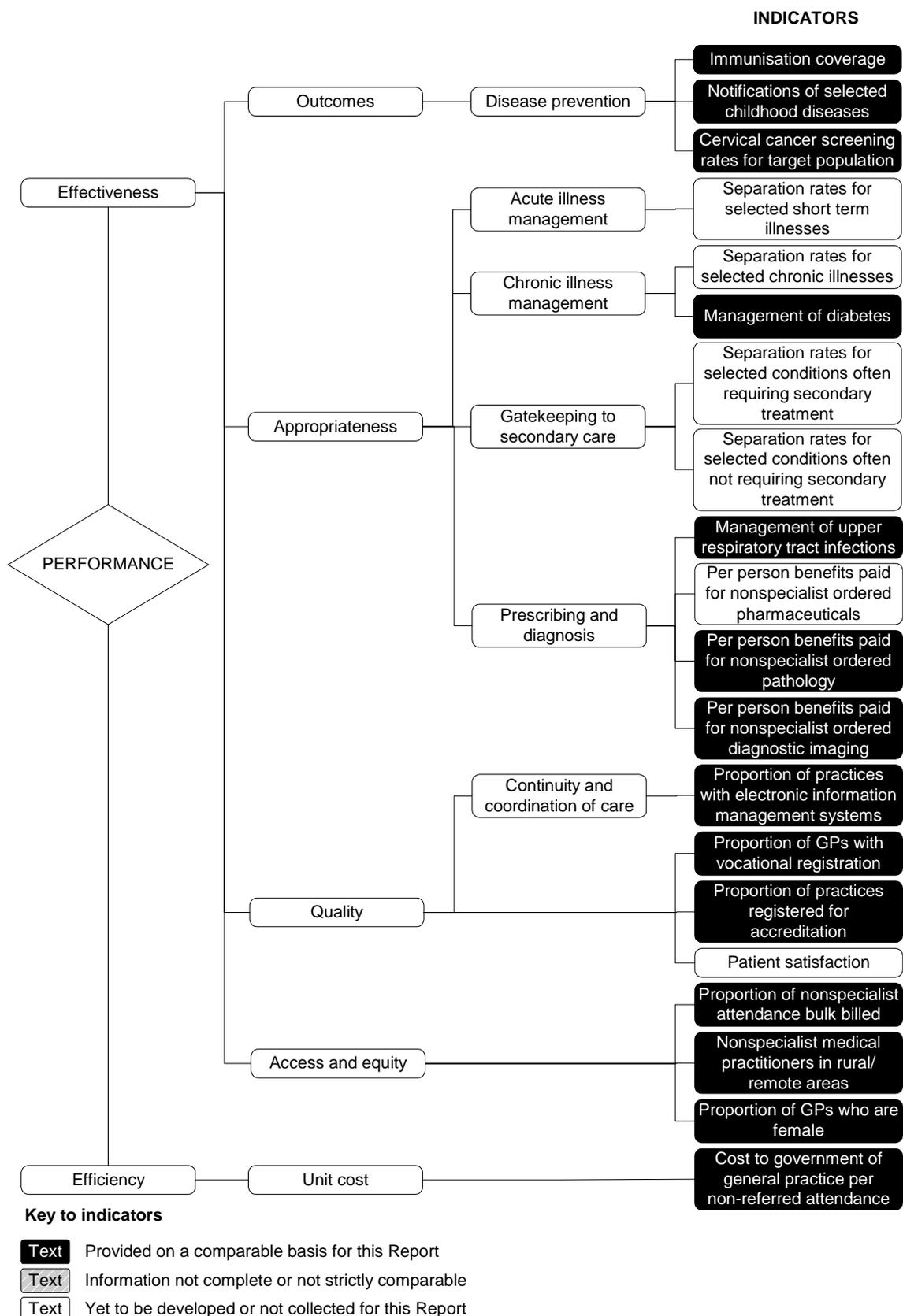
The performance indicator framework aims to inform analysis of the effectiveness and efficiency of policies targeted at general practice services (figure 6.5). The framework is evolving over time as better indicators are developed and as the focus and objectives for general practice change.

Significant changes have been made to the performance indicator framework this year. The Review has commenced reporting two new appropriateness indicators which examine prescription rates of oral antibiotics for upper respiratory tract infections and management of diabetes by GPs. The new indicators are discussed in more detail in section 6.4.

The Review has ceased reporting prescribing rates for anxiolytics and antidepressants. It is not clear whether recent increases in prescribing rates represent an over-reliance on the use of prescription drugs — a benchmark has yet to be defined — or whether awareness by GPs of the availability of a range of prescription pharmaceuticals has increased, allowing a range of conditions to be treated. While it appears that mental illness is under-diagnosed, evidence suggests that some GPs write out prescriptions prematurely for patients presenting with symptoms of mental illness, without first working through other possibilities set out in clinical good practice guidelines. It is therefore not possible to anticipate the direction in which prescribing rates for antidepressants and anxiolytics would head under optimal adherence to consensus guidelines if mental illness was better diagnosed.

The Review has also ceased reporting separation rates for myringotomy and tonsillectomy as an indicator of GP gatekeeping to secondary care. Decisions about these procedures are generally governed by specialists and can depend on socioeconomic characteristics of particular areas. There is no evidence that separation rates would alter significantly if GPs in Australia changed their current practices. Separation rates for these procedures are reported in chapter 5 (Public hospitals) as indicators of appropriateness because of their frequency and elective nature.

Figure 6.5 Performance indicators for general practice



6.4 Key performance indicator results

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

Outcomes

Disease prevention — immunisation

The level of immunisation coverage has been included in the framework because GPs are encouraged to achieve high immunisation coverage levels under the General Practice Immunisation Incentives Scheme. The Scheme provides incentives for the immunisation of children in the 0–6 age group. General Practitioners see 93 per cent of children in this age group seven times a year on average (DHAC 1999). The aim is to have full immunisation of 90 per cent of all children attending 90 per cent of all general practices (DHAC 1999). The introduction of the Scheme, however, has had different impacts in different States and Territories depending on the structure of service provision (table 6.5).

Child immunisation services are delivered by many providers. The Australian Childhood Immunisation Register (ACIR) records suggest that since data were first collected in 1996, GPs have played a major role in immunising children under seven years of age in NSW, Queensland, WA, SA and Tasmania. In Victoria, local governments share the main immunisation provider role with GPs. Territory governments are the main providers in the ACT and in the NT through community health centres (table 6.5).⁵

Around 91.5 per cent of Australian children turning 12 months of age by 31 March 2001 were assessed as fully immunised⁶ (figure 6.6). Tasmania had the highest proportion (93.8 per cent) and the NT had the lowest (88.7 per cent). The NT Childhood Immunisation Database estimate of vaccination coverage for children aged 12 months on 31 March 2000 was 89 per cent. The Medicare-generated ACIR

⁵ Approximately 40 per cent of children aged 0–6 years in the NT are Indigenous, living in remote communities that are not serviced by a GP. Since GPs provide immunisation services to only a small proportion of children in the NT, immunisation coverage rates are a weak indicator of GP performance in the NT.

⁶ Full immunisation at 12 months includes immunisation against diphtheria, tetanus, whooping cough, polio and *Haemophilus influenzae* type b.

records of immunisation for children in the NT do not match NT immunisation records.

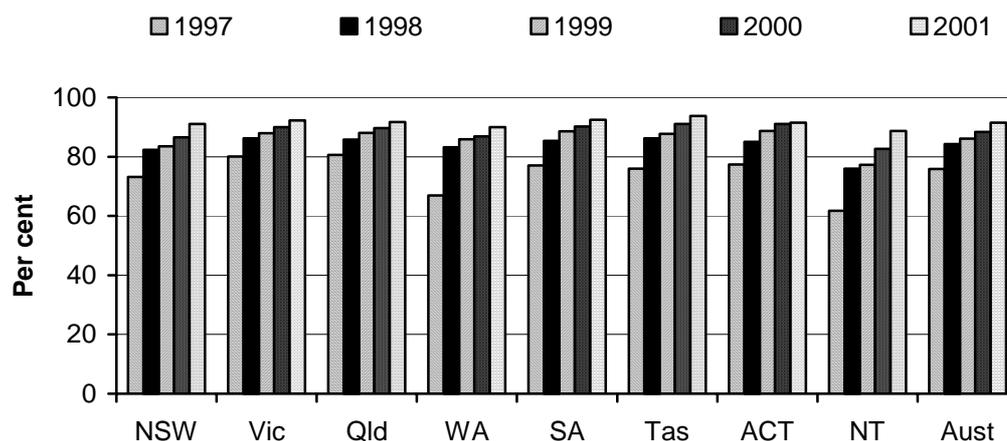
Table 6.5 Valid vaccinations supplied to children under seven years of age by the type and State/Territory of the immunising provider, 2001, (per cent)^a

<i>Provider</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
GPs	82.4	49.7	83.2	62.4	69.5	84.6	38.6	2.9	69.4
Council	7.0	49.3	8.0	8.5	18.1	14.8	–	–	18.9
State and Territory health department	–	–	–	5.2	0.1	0.2	46.6	–	1.3
Flying doctor service	–	–	0.4	–	0.2	–	–	–	0.1
Public hospital	3.2	0.2	3.1	5.2	5.4	0.2	1.2	1.8	2.6
Private hospital	0.2	–	–	–	–	–	–	1.0	0.1
Aboriginal health service/worker	0.5	0.1	0.5	0.5	0.3	–	0.2	6.0	0.4
Aboriginal health worker	–	–	0.5	–	0.1	–	–	0.2	0.1
Community health centre	6.7	0.7	4.4	18.3	6.4	0.3	13.4	88.2	7.0
Community nurse	–	–	–	–	–	–	–	–	–
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

^a At 30 June 2001. Data collected since 1 January 1996. – Zero or close to zero.

Source: DHAC (unpublished); table 6A.10.

Figure 6.6 Proportion of children aged 12 to 15 months who were fully immunised (per cent)^{a, b, c}

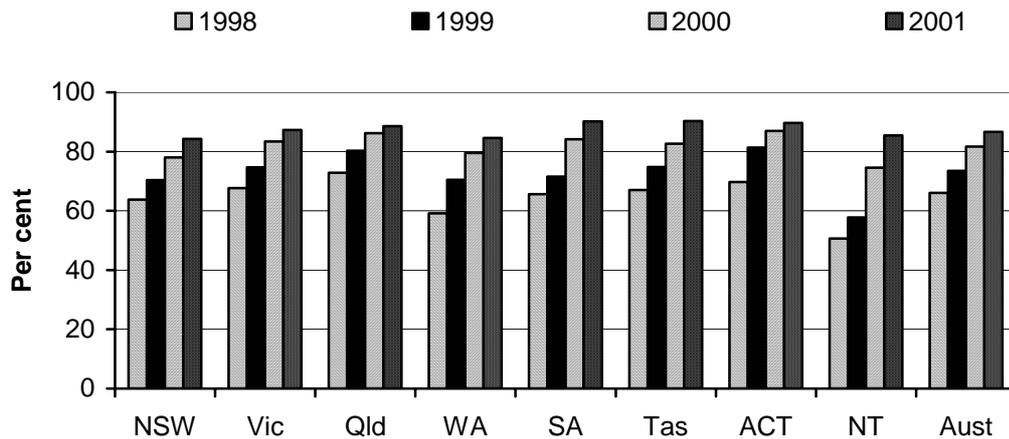


^a Coverage measured at 30 June for children turning 12 months of age by 31 March. ^b The Australian Childhood Immunisation Register (ACIR) includes all children under seven years of age who are registered with Medicare. By the age of 12 months, over 98 per cent of Australian children have been registered with Medicare (NCIRS 2000). ^c There may be some under-reporting by providers, and as a result, vaccine coverage estimates calculated using ACIR data should be considered minimum estimates (NCIRS 2000).

Source: DHAC (unpublished); table 6A.11.

Around 86.6 per cent of children turning 24 months of age by 31 March 2001 were assessed as being fully immunised⁷ (figure 6.7). Tasmania recorded the highest proportion (90.3 per cent), while NSW recorded the lowest (84.3 per cent).

Figure 6.7 **Proportion of children aged 24 to 27 months who were fully immunised (per cent)^{a, b, c}**



^aCoverage measured at 30 June. ^bThe Australian Childhood Immunisation Register includes all children under seven years of age who are registered with Medicare. By the age of 12 months, over 98 per cent of Australian children have been registered with Medicare (NCIRS 2000). ^cThere may be some under-reporting by providers, and as a result, vaccine coverage estimates calculated using ACIR data should be considered minimum estimates (NCIRS 2000).

Source: DHAC (unpublished); table 6A.12.

Disease prevention — notifications of selected childhood diseases

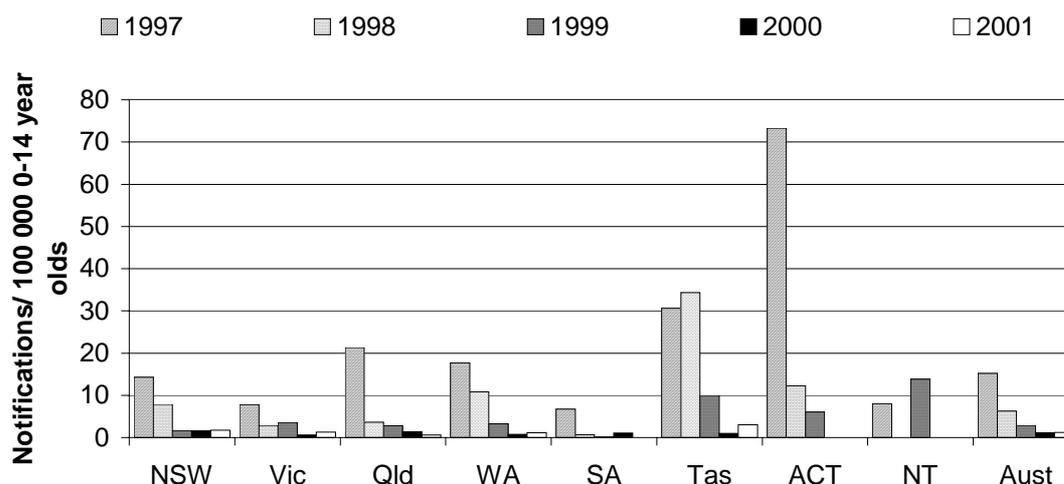
Notification rates for selected childhood vaccine preventable diseases (measles, pertussis [whooping cough] and *Haemophilus influenzae* type b) are used as an indicator because the activities of GPs can influence the rate of these diseases through immunisation. The debilitating effects of these diseases can be long term or even life threatening. The complications from measles, for example, can include pneumonia, which occurs in one in 25 cases. As part of the Immunise Australia Seven Point Plan, Australia has embarked on a strategy to eliminate measles. The indicator for the rate of notifications for selected childhood diseases reflects the number of notifications for 0–14 year olds per 1000 people in that age group.

The Immunise Australia Seven Point Plan, organised outside general practice and implemented by the immunisation sector, including GPs, has resulted in a large fall

⁷ Full immunisation at 24 months includes immunisation against diphtheria, tetanus, whooping cough, polio, *Haemophilus influenzae* type b and measles, mumps and rubella.

in the number of notifications of measles. In 2001, the notification rate for measles for 0–14 year olds was 1.2 per 100 000 children in that age group. This represents a large decline from the high levels of the early to mid-1990s (table 6A.14). In 2001, notification rates for 0–14 year olds for measles were highest in Tasmania (3.0) and lowest at zero in the NT, SA and the ACT (figure 6.8).

Figure 6.8 Notification rates for measles among persons aged 0–14 years^a

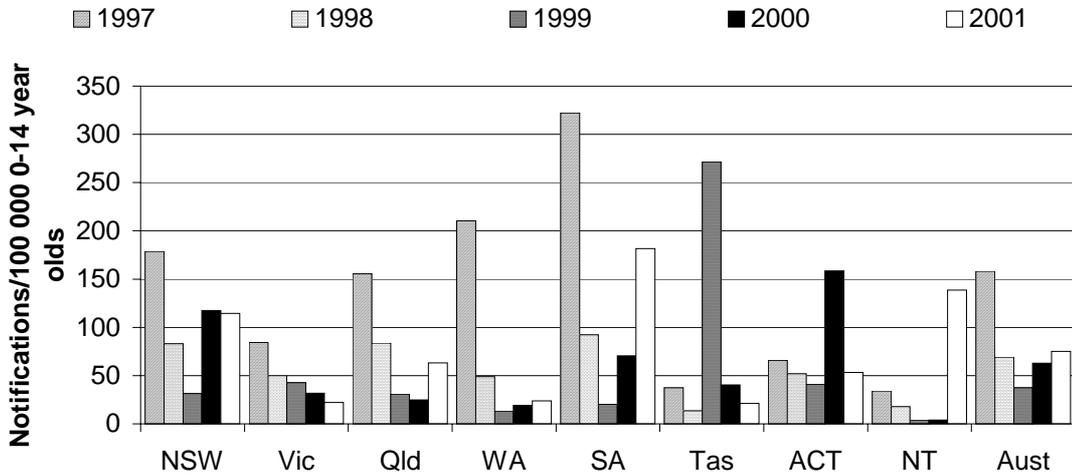


^a Notifications for 2001 are to August only and have been adjusted to annual rates for comparison.

Source: DHAC (unpublished); table 6A.14.

A severe outbreak of pertussis (whooping cough) occurred in 1997 (figure 6.9) within the identified pattern of pertussis epidemics in three-year cycles. The notification rate for Australia in that year was 158.0 notifications for 0–14 year olds per 100 000 persons aged 0–14 years. As a result of the increased incidence of pertussis, the then Commonwealth Department of Health and Family Services decided to encourage the immunisation of all children against the disease. In 1999, the notification rate for 0–14 year olds in Australia was 37.3, increasing to 75.2 in 2001 (figure 6.9). The highest rate in 2001 was in SA, with 181.7 notifications for 0–14 year olds per 100 000 children aged 0–14 years, and the lowest was in Tasmania, with a notification rate of 21.3.

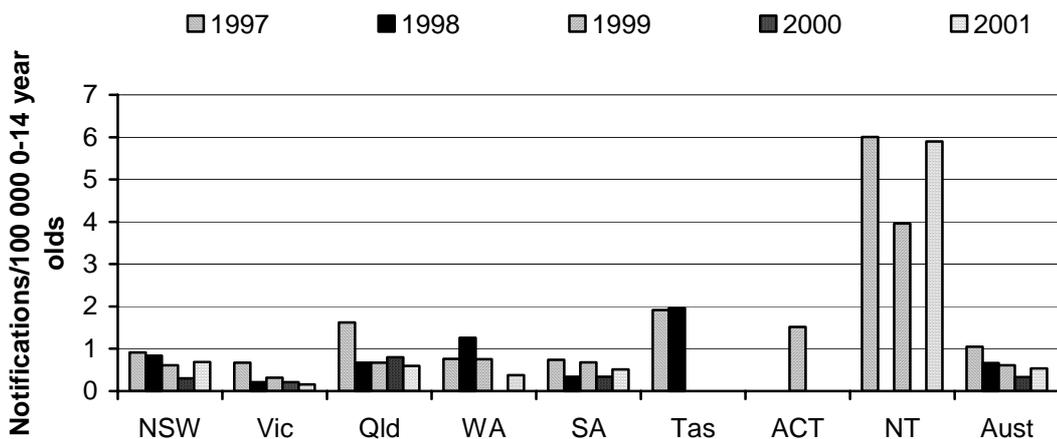
Figure 6.9 Notification rates for pertussis (whooping cough) among persons aged 0–14 years^a



^a Notifications for 2001 are to August only and have been adjusted to annual rates for comparison.
Source: DHAC (unpublished); table 6A.15.

In recent years, notification rates for *Haemophilus influenzae* type b have remained relatively low in all jurisdictions except the NT (figure 6.10). In 2001, the notification rate Australia-wide was 0.5 (per 100 000 children aged 0–14 years). The NT had 5.9 notifications, while Tasmania and the ACT had zero notifications.

Figure 6.10 Notification rates for *Haemophilus influenzae* type b among persons aged 0–14 years^a



^a Notifications for 2001 are to August only and have been adjusted to annual rates for comparison.
Source: DHAC (unpublished); table 6A.13.

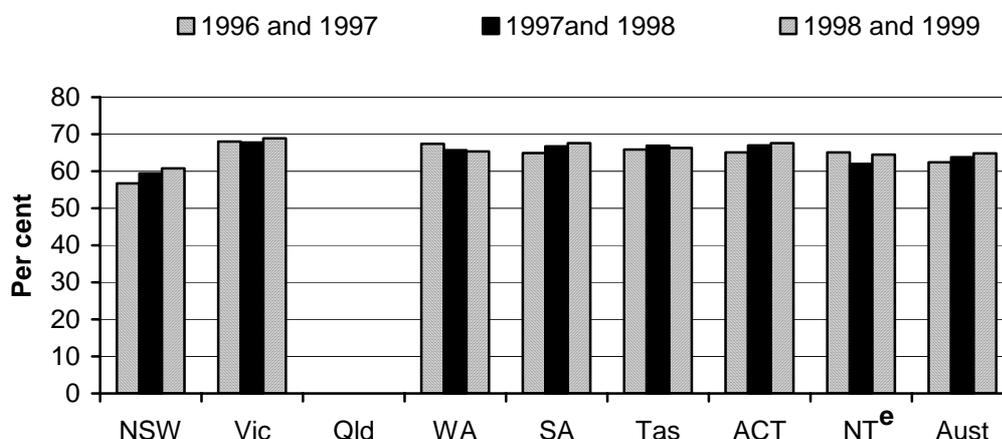
Disease prevention — cervical screening

The third outcome indicator for primary care services provided by GPs is the screening rate for cervical cancer. Like child immunisation, cervical cancer screening tests (that is, Pap smears) are offered by a range of health care providers under the National Cervical Cancer Screening Program — GPs, gynaecologists, family planning clinics and hospital outpatient clinics. Care needs to be taken in interpreting the results as the level of participation in the program reflects the activities of all health care providers — not only GPs.

General Practitioners play an important role in relation to cervical screening as they are often the first point of contact with the health system and are well placed to provide referrals and support where necessary. Medicare data indicates that around 80 per cent of smears are taken by GPs, however, the difficulty is reporting the exact number of smears taken by GPs in relation to other health professionals, such as gynaecologists or staff in women's health centres. Some smears are sent to public laboratories which do not provide data to the Health Insurance Commission and consequently, the number of smears taken by GPs may be underestimated in the short term. Where this is an issue, procedures are being put in place to ensure that data from public laboratories are aligned with Medicare data reporting requirements. It is anticipated that accurate data on the level of GP involvement in cervical screening may be available for future reports.

The National Cervical Cancer Screening Program is targeted at women aged 20–69 years. The screening interval is two years. Data for the 1999 and 2000 period will not be available until 2002. Figure 6.11 shows that in the 1998 and 1999 screening period, participation rates by women aged 20–69 years were highest in Victoria (68.9 per cent) and lowest in NSW (60.8 per cent). The Queensland Health Pap Smear Register did not start operating until February 1999, so no data are available for that State.

Figure 6.11 Participation rates of women aged 20–69 years in cervical screening programs (per cent)^{a, b, c, d}



^a Rates for Australia have been calculated excluding Queensland. ^b The Queensland Health Pap Smear Register did not start operating until February 1999. ^c The ACT register only records women with an ACT address. ^d All data are adjusted to remove women who have had a hysterectomy. ^e Participation rates differ from those published by the NT Pap Smear Register because the NT Register excludes Aboriginal women from the denominator, whereas all women are included in the denominator in this figure.

Source: AIHW analysis of State and Territory Cervical Cytology Registry data; table 6A.16.

Appropriateness

Chronic illness management — management of diabetes

General Practitioners can play a significant role in the management of diseases such as diabetes, by diagnosing their patients and enrolling them in structured care, and by following best practice condition management guidelines developed by the profession, including where early intervention is warranted. Over time, good management should start to noticeably affect patients' secondary care requirements.

Indicators for the management of diabetes are presented for the first time this year. Three new indicators are reported:

- the proportion of adults with diabetes who have been diagnosed and placed on a diabetes register;
- the proportion of registered people with diabetes who have had a glycaemic control assessment and the proportion who tested as seriously at risk of future complications; and

-
- hospital separations for Type 2 diabetes and complications associated with diabetes.

Proportion of adults with diabetes who have been diagnosed and placed on a diabetes register

Survey work conducted during the Australian Diabetes, Obesity and Lifestyle Study (AusDiab) (Dunstan *et al.* 2001) enables good estimates to be made of the prevalence of diabetes at a number of levels, including State and Territory and national.⁸ The level of diagnosis among adults with Type 2 diabetes and their formal placement within an appropriate management regime, is an indicator of the uptake of systematic efforts that have proved effective overseas.

The National Divisions Diabetes Program Data Collation Project was carried out in 1999 and had several components. One of these was to collate the quality of care and health outcomes data from Divisions of General Practice with a diabetes program that had a register operating for at least 12 months. Divisions participated on a voluntary basis: 15 of 38 in NSW; two of 31 in Victoria; two of 20 in Queensland; three of 14 in SA; three of 15 in WA; and one of 3 in Tasmania and the ACT. The duration of programs in Divisions (not necessarily registers) varied from one to eight years, averaging 3.7 years with a median of three years.

The proportion of adults with diabetes on a register in each jurisdiction is outlined in table 6.6. It should be noted that these data are based on a small and not necessarily representative number of Divisions of General Practice who voluntarily took part in a national data collection. Based on these data, Queensland had the highest proportion (7.5 per cent of adults with diabetes) and Victoria the lowest (2.3 per cent). The estimated number of people with diabetes in a Division has been calculated by applying 1999 Australian Bureau of Statistics population estimates in age groupings to the 1996 Census data by Division (to estimate the number of people in each age group in each Division) and then applying the AusDiab age-specific prevalence rates.

National evidence based guidelines are being prepared in Australia for the prevention, detection and management of Type 2 Diabetes. These are being developed by a consortium consisting of representatives from the Australian Diabetes Society, Australian Centre for Diabetes Strategies and Diabetes Australia. The guidelines are being developed in accordance with the National Health and Medical Research Council process.

⁸ This study was not representative of Aboriginal and Torres Strait Islander people.

Proportion of registered people with diabetes who have had a glycaemic control assessment in the previous six months and proportion of these who fell into the category of seriously at risk of future complications

Where a patient has been diagnosed with Type 2 diabetes, accepted clinical guidelines suggest that GPs should regularly monitor a number of important elements, including glycaemic control, blood pressure, weight, foot status, lipids, microalbumin level and eye status. The RACGP/Diabetes Australia guidelines recommend assessment every three to six months for insulin-treated patients (Type 1, sometimes referred to as juvenile diabetes because of peak onset much earlier in life) and every six to 12 months for non-insulin-treated patients (Type 2, sometimes referred to as mature age onset diabetes), and a target of glycated haemoglobin (HbA1c) within 1 per cent of the upper limit of normal. Where levels are more than 2 per cent above the upper limit of normal, early intensive intervention is important.

The proportion of registered adults with Type 2 diabetes who had a glycaemic control assessment in the previous six months is reported as a performance indicator for GPs (table 6.6). Based on the available data, Queensland had the highest proportion with 72.6 per cent of adults with Type 2 diabetes and Tasmania had the lowest proportion with 25.5 per cent.

The proportion of those tested whose measured levels were above the point at which there is cause for alarm (2 per cent above the upper limit of normal [ULN]) is also reported as a performance indicator for GPs (table 6.6). The percentage was highest in Queensland (36.2 per cent) and lowest in WA (4.1 per cent). While the proportion of adults with Type 2 diabetes with levels in this range may initially increase reflecting the impact of risk factors on changing population cohorts, over time regular testing and good management by GPs should result in a decline in the proportion of people with diabetes in the category most at risk of complications.

Table 6.6 Management of diabetes by participating Divisions of General Practice^{a, b, c}

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>Aust</i>
Estimated population aged 25 yrs and over with diabetes	no.	154 178	23 243	13 205	24 936	21 283	12 936	249 781
Percentage of estimated adult people with diabetes who are on a register (30 June 1999)	%	5.7	2.3	7.5	4.7	5.8	2.9	5.2
Percentage of registered patients having a glycaemic control test in 6 month period (1999)	%	45.0	54.7	72.6	43.3	57.7	25.5	48.0
Number of patients where result of HbA1c measurement known	no.	3 854	293	583	344	716	95	5 885
Percentage of patients with HbA1c measured with result >2% of ULN	%	21.7	22.2	36.2	4.1	17.5	7.4	21.4

^a To preserve confidentiality, the ACT results have been combined with those of NSW. ^b The results reported for glycaemic control are for the period 1 January 1999 to 30 June 1999. Glycated haemoglobin (HbA1c) levels are reported as being within a certain percentage from the upper limit of normal (ULN). The reagents and units of measurement used are different in different laboratories. The normal range is established by a set of standard samples which are tested by the lab using its particular reagents and equipment. For this reason, every laboratory reports a normal reference range when it reports an HbA1c result. Labs may also report whether a given result is within 1 per cent of the ULN range for their particular testing method or 'good', 'poor' etc. Evidence from the United Kingdom Prospective Diabetes Study has clearly demonstrated that keeping HbA1c within 1 per cent of normal (ie ULN) reduces the risk of developing complications of diabetes. Where levels are more than 2 per cent above the ULN, early intensive intervention is important. ^c Divisions participated on a voluntary basis: 15 of 38 in NSW; two of 31 in Victoria; two of 20 in Queensland; three of 14 in SA; three of 15 in WA; and one of 3 in Tasmania and the ACT. The duration of programs in Divisions (not necessarily registers) varied from one to eight years, averaging 3.7 years with a median of three years.

Source: DHAC (unpublished); table 6A.19.

Hospital separation rates where the principal diagnosis is Type 2 diabetes mellitus, by jurisdiction, standardised for age and sex

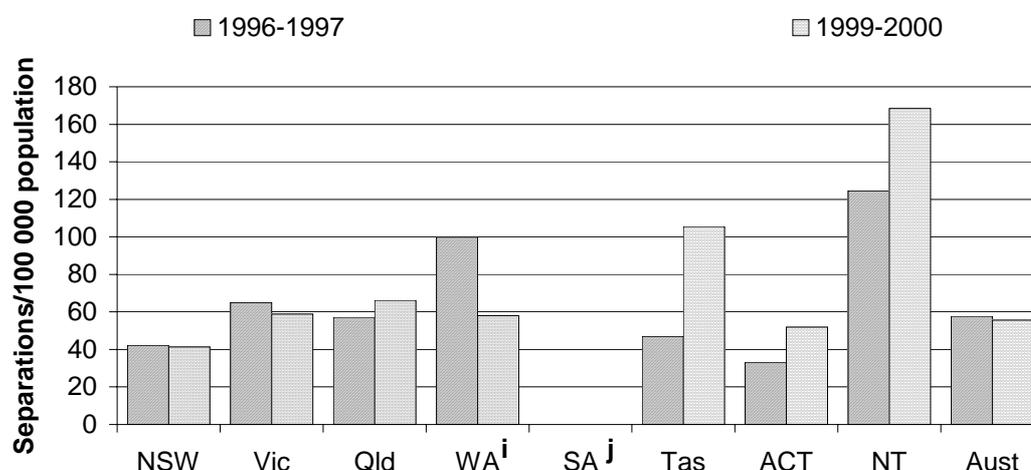
The United Kingdom Prospective Diabetes Study provides an evidence base for the management of raised blood pressure and hyperglycaemia to reduce the complications of Type 2 diabetes. Early detection of diabetes and effective management of blood pressure in particular have been shown to be effective in reducing the microvascular and macrovascular complications of diabetes. As primary care providers, GPs are well placed to both detect diabetes early and to provide care which can assist in the prevention or slowing of the development of the complications of diabetes.

The total hospital separation rates for admissions where Type 2 diabetes mellitus is the principal diagnosis are reported separately by jurisdiction after standardisation of populations for age and sex (figure 6.12). In 1999-2000, separation rates for Type 2 diabetes mellitus were highest in the NT (168.4 per 100 000 people) and lowest in NSW (41.3 per 100 000 people). South Australian data have not been published because there have been unexpected increases in hospital separation rates in SA for Type 2 diabetes and associated complications between 1996-1997 and 1999-2000 which are thought to be due to changes in clinical practice (however, this is still being investigated).

Separation rates for complications of diabetes are presented in figures 6.13 and 6.14. In 1999-2000, separation rates for renal complications were highest in the NT (9.9 per 100 000 people) and lowest in the ACT (1.3 per 100 000 people). Separation rates for ophthalmic complications were highest in Queensland (3.4 per 100 000 people) and lowest in Tasmania (0.8 per 100 000 people). South Australian data have not been published because there have been unexpected increases in hospital separation rates in SA for Type 2 diabetes and associated complications between 1996-1997 and 1999-2000 which are thought to be due to changes in clinical practice (however, this is still being investigated).

While hospital separation rates for conditions closely related to Type 2 diabetes may initially increase as a result of the ageing of the population and the effects of the presence of higher risk levels in recent decades, an extensive program of diagnosis and management by GPs may eventually lead to a gradual reversal of current trends and then continuing reductions in rates of hospitalisation with these specific diagnoses.

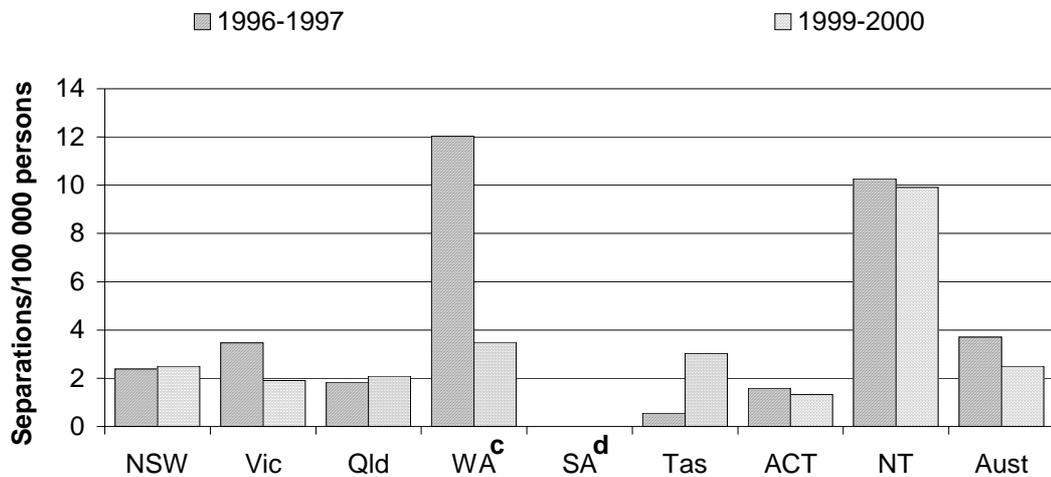
Figure 6.12 Separation rates for Type 2 diabetes^{a, b, c, d, e, f, g, h}



^a Separation rates are age-adjusted to the Australian national population at 30 June 1991 using direct standardisation. ^b Crude separation rates for each jurisdiction were calculated using ABS supplied age-sex specific resident populations within the jurisdiction in each year for the denominators. ^c Separation counts represent cases with a principal diagnosis of non-insulin-dependent diabetes mellitus (NIDDM) (ICD-9-CM v13 codes 250.x0 and 250.x2, x=0-9; ICD-10-AM 1st ed codes E11.00 to E11.91) on the 1996-97 and 1999-2000 National Morbidity Data Sets. The use of hospital separations means that there is not a true one-to-one correspondence between numerator and denominator units, as would normally apply in a standardisation exercise. Age-standardisation will tend to exaggerate the effect of multiple episodes for individual patients, particularly where they occur in small populations. In the NIDDM context, multiple admissions for one patient are typically associated with hyperbaric oxygen therapy and peritoneal/haemo dialysis. Although same-day admissions for dialysis are not normally coded with a principal diagnosis of NIDDM, the data contain a significant number in several jurisdictions. The results for small jurisdictions reflect both this type of distortion and unreliable results based on large relative changes arising from small numbers of separations. Results for specific complications of NIDDM should be interpreted with extreme caution. ^d Technically, standardised rates for renal and ophthalmic complications should be calculated using age-sex specific NIDDM populations, rather than total resident population. The age-standardisation performed does not account for increasing prevalence of NIDDM due to factors other than ageing of the population (for example lifestyle). ^e This analysis summarises only NIDDM-related cases treated as admitted patients, and coded with a principal diagnosis of NIDDM. These represent a small percentage of all separations coded with a diagnosis of NIDDM. ^f Treatment of NIDDM-related conditions is also provided in ambulatory settings. The availability of outpatient services may vary between jurisdictions, and over the time period of interest. ^g Morbidity data are coded under coding standards that may differ by time and jurisdiction. ^h ICD-9-CM codes for Type 2 diabetes mellitus (fourth digit 0/2) used in 1996-97 include diabetes mellitus unspecified as to NIDDM or insulin-dependent diabetes mellitus (IDDM). This could explain lower raw numbers of separations in that year compared to 1999-00. ⁱ 1996-97 WA separations contain 306 admissions coded with an incorrect diagnosis of 250.40 (renal complication) when the same patient was admitted for dialysis. ^j SA data have not been published because there have been unexpected increases in hospital separation rates in SA for Type 2 diabetes and associated complications between 1996-1997 and 1999-2000 which are thought to be due to changes in clinical practice (however, this is still being investigated).

Source: DHAC (unpublished); table 6A.18.

Figure 6.13 Separation rates for Type 2 diabetes – renal complications^{a, b}



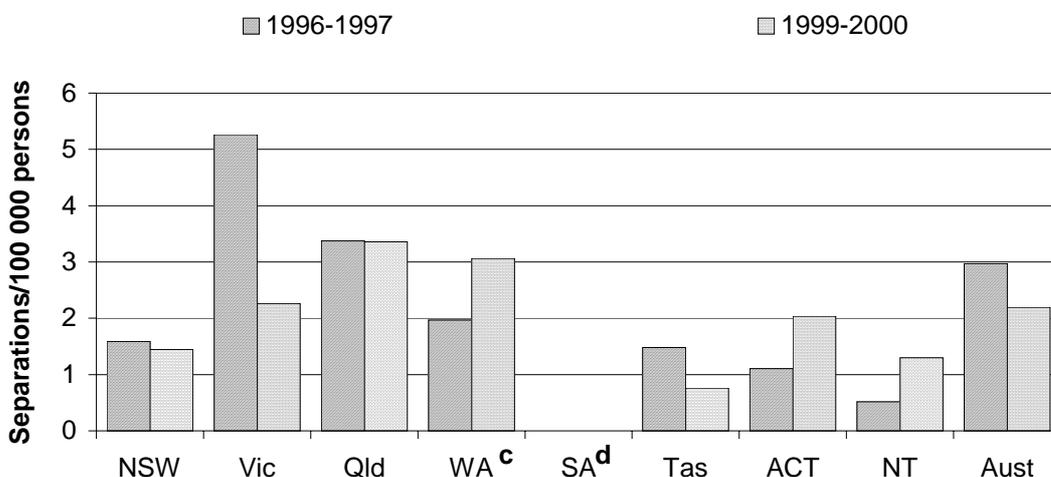
^a Separation rates are age-adjusted to the Australian national population at 30 June 1991 using direct standardisation. ^b ICD-9-CM codes for Type 2 diabetes mellitus (fourth digit 0/2) used in 1996-97 include diabetes mellitus unspecified as to NIDDM or IDDM. This could explain lower raw numbers of separations in that year compared to 1999-2000. ^c 1996-97 WA separations contain 306 admissions coded with an incorrect diagnosis of 250.40 (renal complication) when the same patient was admitted for dialysis. ^d SA data have not been published because there have been unexpected increases in hospital separation rates in SA for Type 2 diabetes and associated complications between 1996-1997 and 1999-2000 which are thought to be due to changes in clinical practice (however, this is still being investigated).

Source: DHAC (unpublished); table 6A.18.

Prescribing and diagnosis

Per person benefits paid by the Commonwealth Government for pathology tests and diagnostic imaging ordered by GPs are used as indicators of the appropriateness of prescribing and diagnosis. In addition, a new indicator of prescribing and diagnosis — prescription rates for oral antibiotics most commonly used in the treatment of upper respiratory tract infections — is reported for the first time in this Report.

Figure 6.14 Separation rates for Type 2 diabetes – ophthalmic complications^{a, b}



^a Separation rates are age-adjusted to the Australian national population at 30 June 1991 using direct standardisation. ^b ICD-9-CM codes for Type 2 diabetes mellitus (fourth digit 0/2) used in 1996-97 include diabetes mellitus unspecified as to NIDDM or IDDM. This could explain lower raw numbers of separations in that year compared to 1999-2000. ^c 1996-97 WA separations contain 306 admissions coded with an incorrect diagnosis of 250.40 (renal complication) when the same patient was admitted for dialysis. ^d SA data have not been published because there have been unexpected increases in hospital separation rates in SA for Type 2 diabetes and associated complications between 1996-1997 and 1999-2000 which are thought to be due to changes in clinical practice (however, this is still being investigated).

Source: DHAC (unpublished); table 6A.18.

Number of prescriptions for oral antibiotics most commonly used in the treatment of upper respiratory tract infections ordered by GPs, per 1000 persons with PBS concession cards

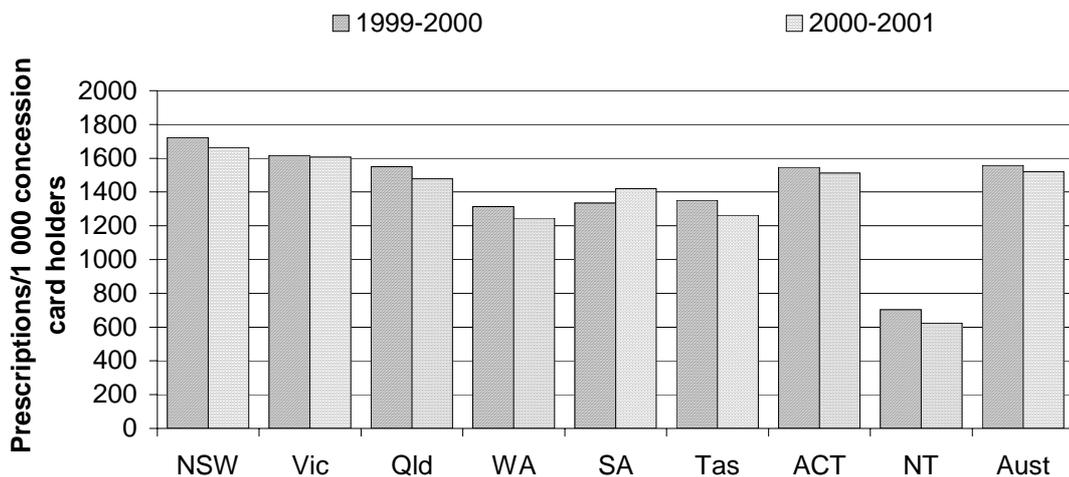
Antibiotics have no efficacy in the treatment of viral infections but are still frequently prescribed when they occur. Consequently, their prescription rates (overall, and particularly in relation to upper respiratory tract infections) are unambiguously too high. Reductions in the rate of prescription of those oral antibiotics most commonly used when patients present with upper respiratory tract infections are an indicator of more appropriate treatment being offered by GPs.

The cost at the pharmacy for most oral antibiotics used to treat upper respiratory tract infections is less than the maximum PBS co-payment. As there is therefore generally no Commonwealth subsidy for general patients, particulars of such patients obtaining prescriptions of this nature are not recorded by the Health Insurance Commission. With the data on oral antibiotics available for reporting essentially reflecting the requirements of concession cardholders, it is best to eliminate from the numerator any oral antibiotics supplied to general patients, and to use the total number of concession cardholders in the denominator.

Even though there are ongoing population ageing effects that may result in increases in the numbers of such beneficiaries and in the complexity of their pharmaceutical needs, if clinical guidelines for the treatment of upper respiratory tract infections were followed more closely by GPs, the trend for prescription of oral antibiotics should nevertheless be downwards.

Prescriptions per 1000 persons with PBS concession cards for 2000-01 were highest in NSW (1663.3) and lowest in the NT (623.2) (figure 6.15). The number of prescriptions decreased in all jurisdictions between 1999-2000 and 2000-01. Overall, prescriptions have fallen since 1996-97, when the rate was 1906.5 to 2000-01 when the rate was 1520.7 (table 6A.17).

Figure 6.15 Prescription rates for oral antibiotics for upper respiratory tract infections



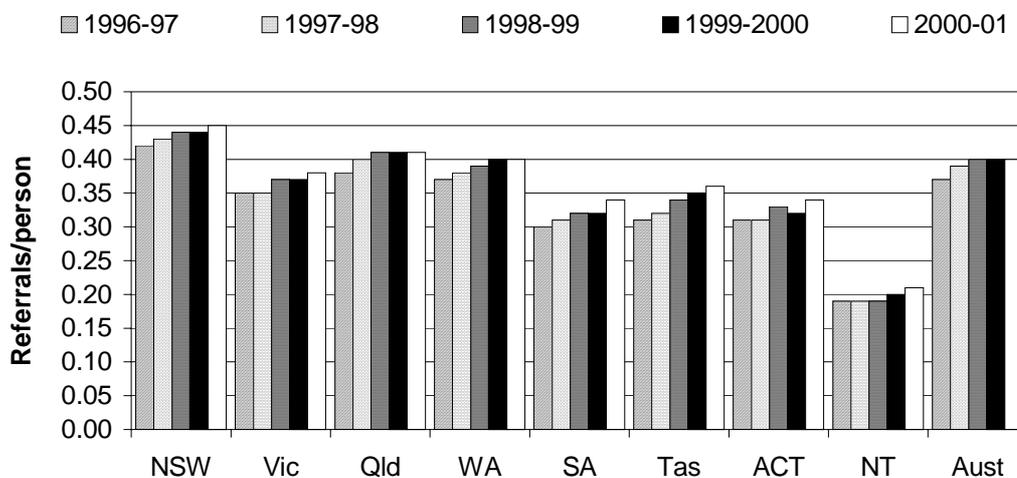
Source: DHAC (unpublished); table 6A.17.

Pathology and diagnostic imaging

Per person benefits paid for GP-ordered pathology tests and diagnostic imaging are used to report on the prescribing and diagnosis patterns of GPs. Differences across jurisdictions in the levels of benefits paid for pathology tests and diagnostic imaging ordered by GPs may indicate inappropriate use of these services in diagnosis and treatment. While high levels of benefits may indicate over-reliance on these methods of treatment by GPs, it is not possible to determine what the appropriate levels might be. Reporting these data contributes to discussion of such issues.

Figure 6.16 provides contextual information on referrals by GPs per person for diagnostic imaging. For diagnostic imaging in 2000-01, NSW had the highest number of referrals per person (0.45) and the NT the lowest (0.21).

Figure 6.16 Referrals per person for diagnostic imaging



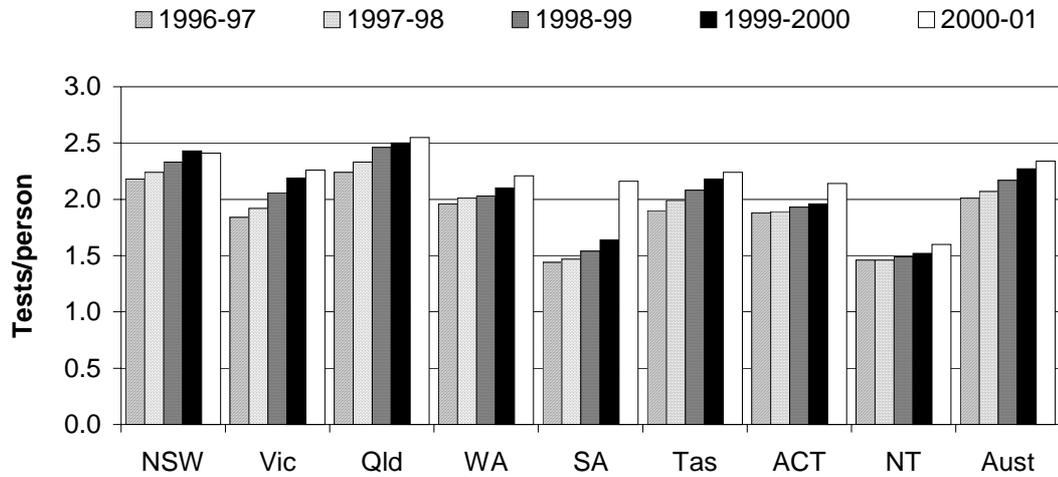
Source: DHAC (unpublished); table 6A.21.

Pathology data are presented for the number of tests ordered through Medicare rather than the number of referrals (figure 6.17).⁹ Pathology services for rural and remote areas in some States (especially in SA) are ordered through State managed, but Commonwealth funded, health program grants — hence, the data may underestimate orders in some jurisdictions, although the amounts are relatively insignificant. For testing ordered through Medicare in 2000-01, Queensland had the highest rate of pathology tests (2.6 per person) and the NT the lowest (1.6 per person).

Overall in 2000-01, Commonwealth expenditure under Medicare on pathology tests was \$40 per person and on imaging was \$33 per person. Figure 6.18 shows that benefits paid per person for pathology tests in 2000-01 were highest in Queensland (\$47 per person) and lowest in the NT (\$29). Benefits paid per person for diagnostic imaging were highest in NSW (\$37) and lowest in the NT (\$16).

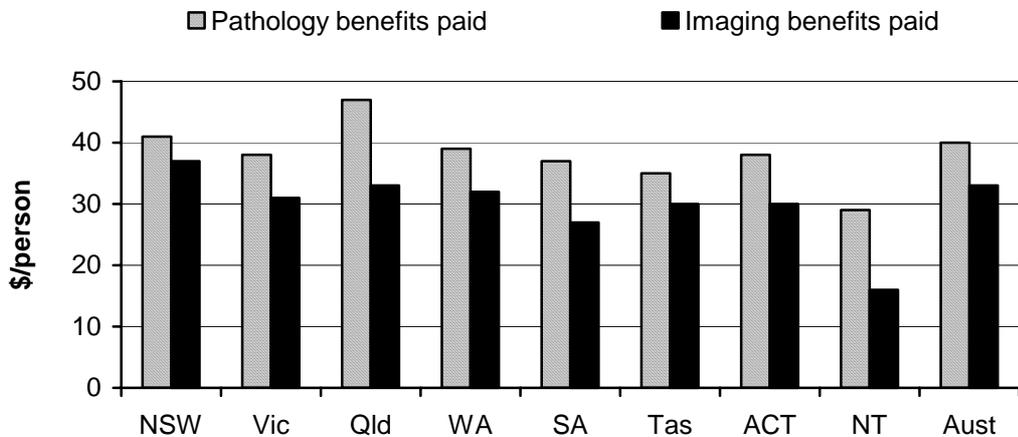
⁹ Up to three tests may be recorded following a pathology referral, whereas each imaging referral results in only one test.

Figure 6.17 Pathology tests per person



Source: DHAC (unpublished).

Figure 6.18 Benefits paid per person for pathology tests and diagnostic imaging, 2000-01



Source: DHAC (unpublished); tables 6A.20 and 6A.21.

Quality

Three indicators of the quality of health care delivered by GPs are: the proportion of practices with electronic information management systems; the proportion of full time workload equivalent GPs with vocational registration; and the proportion of practices that are registered for accreditation.

The proportion of practices with electronic information management systems

The proportion of practices with electronic information management systems is included as a quality indicator because information management/technology is recognised as a useful tool for helping GPs provide and maintain a high quality of care to patients. The use of clinical software and data interchange between GPs and organisations (such as Divisions of General Practice, pathology laboratories and hospitals) are examples (DHAC 2000b). Electronic information management systems also support directions and reforms in health care that focus on an integrated and evidence based health system. Under the PIP, a payment is made to those practices where the majority of GPs prescribe electronically and/or where the practice has either an Internet connection or an e-mail account.

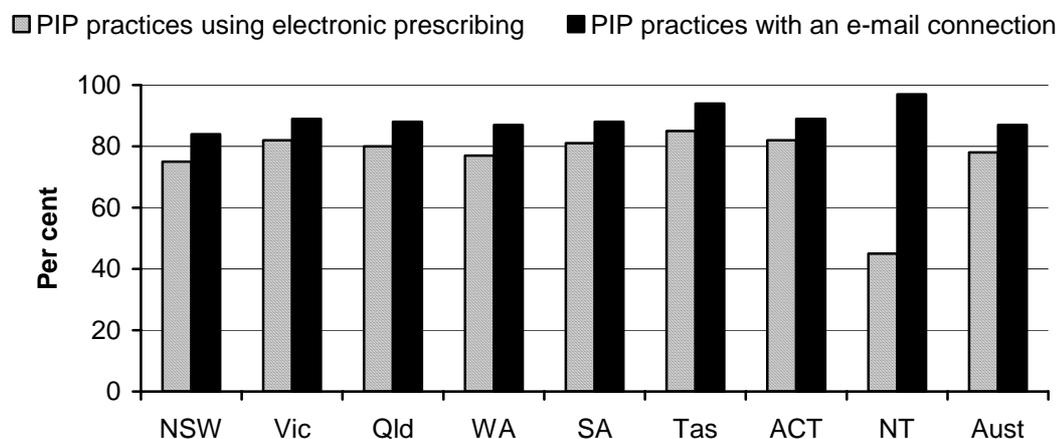
The proportion of practices with electronic information management systems is an indicator of quality which helps to identify the capacity for efficient handling of patient information, including management of screening and other preventive health activities, reminder systems, patient education, record management, data collection and analysis and practice business management (DHAC 2000a). Data on practices with electronic information management systems are available from the PIP.

The PIP structures payments to practices based on patients' ongoing health care needs rather than service volumes, promoting activities such as use of electronic information management systems (including prescribing software), after hours care and teaching medical students. While the PIP does not include all practices in Australia, PIP practices covered around 80 per cent of Australian patients (measured as SWPEs) in May 2001 (DHAC unpublished).

The data indicated that the proportion of PIP practices nationally that used electronic prescribing systems in May 2001 was 78 per cent (an increase from 73 per cent in August 2000) (table 6A.22). The proportion of PIP practices with an Internet connection or an e-mail account was 87 per cent in May 2001 (an increase from 84 per cent in August 2000) (table 6A.22).

At May 2001, PIP practices in Divisions of General Practice in the NT were most likely to have an e-mail connection and least likely to use electronic prescribing software (97 per cent and 45 per cent respectively). Practice Incentive Program practices in Divisions of General Practice in Tasmania were most likely to use electronic prescribing software (85 per cent) while NSW was the least likely to have an Internet connection (84 per cent) (figure 6.19).

Figure 6.19 Proportion of PIP practices using electronic prescribing software or with an e-mail connection, May 2001 (per cent)



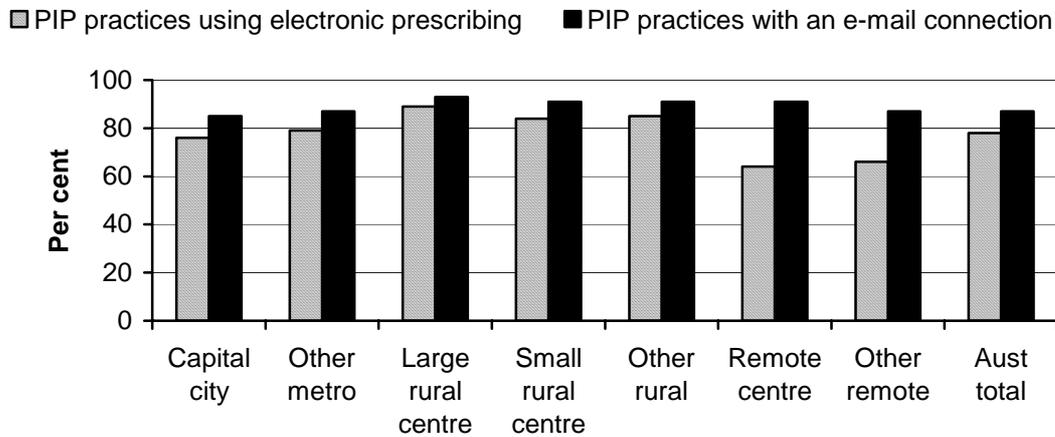
Source: DHAC (unpublished); table 6A.23.

In May 2001, PIP practices in large rural centres were more likely to use electronic prescribing and to be connected to the Internet than PIP practices in metropolitan areas or remote areas. PIP practices in remote areas were least likely to use electronic prescribing systems (figure 6.20). Remote practices in Indigenous communities in the NT have difficulty accessing the PIP, which affects coverage of these data.

Vocational registration

The proportion of full time workload equivalent GPs with vocational registration indicates the standard of appropriate training of GPs and their ability to deliver services of high quality. In 2000-01, the ACT had the highest proportion (96.5 per cent) and the NT had the lowest proportion (87.3 per cent) (figure 6.21). While this proportion has increased Australia-wide since 1996-97, this trend has not been experienced in all jurisdictions — most notably, in Tasmania. The proportion of GPs with vocational registration is lower in remote centres and other remote areas (table 6A.25).

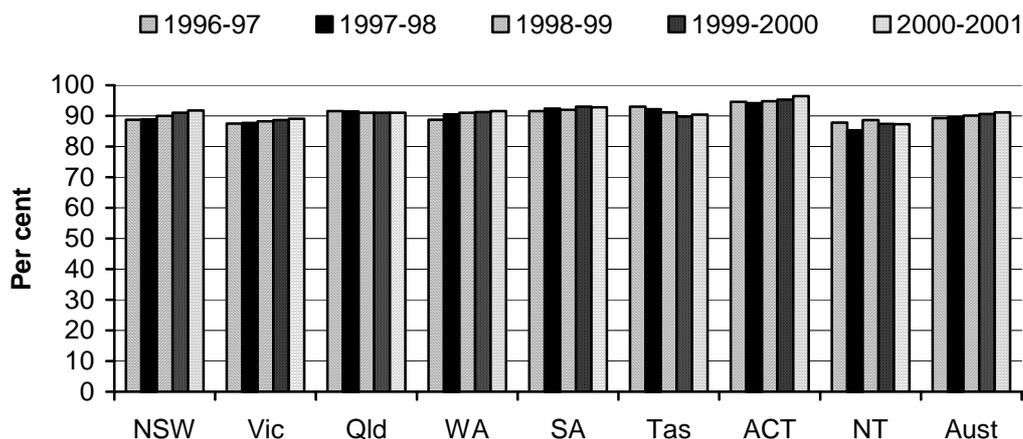
Figure 6.20 Proportion of PIP practices using electronic prescribing software or with an e-mail connection, May 2001 (per cent)^a



^a Capital city = State and Territory capital city statistical divisions; Other metropolitan centre = one or more statistical subdivisions that have an urban centre with a population of 100 000 or more; Large rural centre = Statistical Local Areas (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 5 000 or more; other remote area = all remaining SLAs in the remote zone.

Source: DHAC (unpublished); table 6A.22.

Figure 6.21 Proportion of GPs with vocational registration (full time workload equivalent)

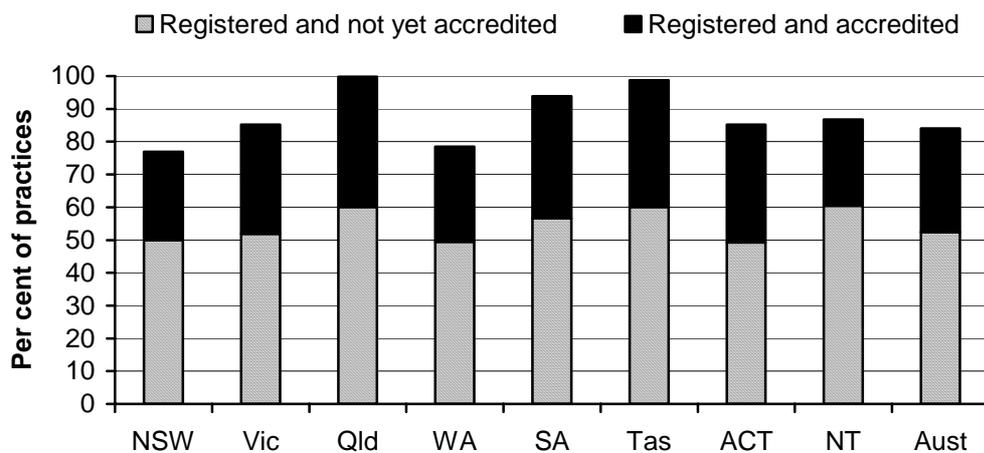


Source: DHAC (unpublished); table 6A.24.

Accreditation

Accreditation of practices is a systematic way to help identify quality in general practice and to provide GPs with a framework for improving their practices over time. There are two providers of general practice accreditation services: Australian General Practice Accreditation Limited (AGPAL), which oversees a peer review process to assess general practices against the RACGP Standards for General Practices and General Practice Australia. The latter is a for-profit private company and details of the scope of its activities are not available publicly. Australian General Practice Accreditation Limited data indicate that at 29 October 2001, 5003 practices throughout Australia (84 per cent of all practices) were registered for accreditation with AGPAL. This compares with nearly 65.2 per cent in August 2000 (table 6A.26). Queensland had the highest proportion of practices registered for accreditation (99.8 per cent) and NSW had the lowest (76.9 per cent) (figure 6.22).

Figure 6.22 **Proportion of practices registered for accreditation with AGPAL, October 2001 (per cent)**



Source: AGPAL (2001); table 6A.26.

Access and equity

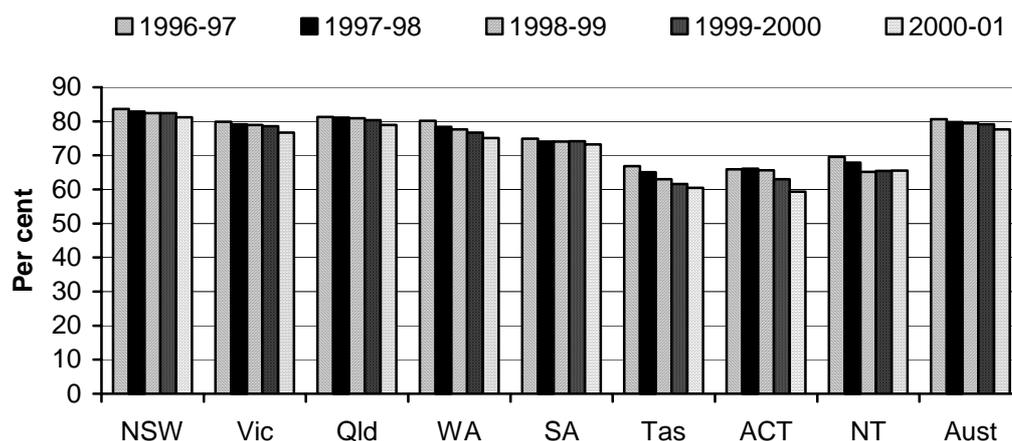
Three indicators are used to measure access and equity in GP service delivery: the proportion of total non-specialist non-referred attendances that are bulk billed; the number of full time workload equivalent GPs in rural/remote areas; and the proportion of full time workload equivalent GPs who are female.

Non-referred attendances that are bulk billed

The proportion of total non-referred attendances that are bulk billed indicates the affordability of GP services. In general practice, patients are either bulk billed for the medical services provided to them and make no out-of-pocket contribution because the practice bills Medicare direct and receives the schedule fee rebate as full payment for the service; pay for the medical service in full and submit their receipt to Medicare for reimbursement to the extent of the schedule fee rebate; or patients pay a patient contribution and sign an authorisation allowing the doctor to submit a claim for payment by cheque for the scheduled fee rebate amount. A high proportion of bulk billed services indicates a greater level of affordability.

Visits to GPs are classed as non-referred attendances under Medicare and these are further disaggregated into services provided by vocationally registered GPs and those provided by OMPs who are not vocationally registered. In 2000-01, NSW had the highest proportion of attendances that were bulk billed (81.2 per cent), while the ACT had the lowest (59.3 per cent). The proportion of attendances that were bulk billed has declined in all states since 1996-97. Australia-wide, it has declined from 80.6 per cent in 1996-97 to 77.6 per cent in 2000-01 (figure 6.23). Bulk billing rates are generally lower in rural and remote areas than in capital cities or other metropolitan centres (table 6A.28).

Figure 6.23 Non-referred attendances that were bulk billed as a proportion of all non-referred attendances (per cent)



Source: DHAC (unpublished); table 6A.27.

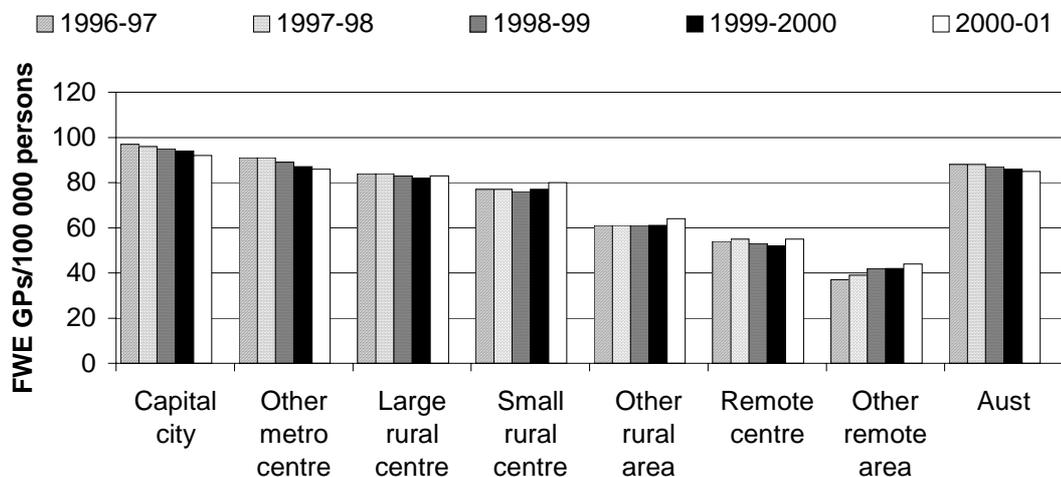
Full time workload equivalent GPs in rural/remote areas

Another important access issue is the ability of people in nonmetropolitan areas to access primary health care services provided by GPs. Commonwealth, State and Territory governments provide incentives for the recruitment and retention of GPs in rural and remote areas.

Many rural GPs provide a wide range of services in their own practices and in the public hospital system, including consultations, anaesthetics, obstetrics, psychiatric triage, emergency medicine, and relatively complex trauma procedures and operations. The comparatively low number of rural GPs per person means that they are often stretched in responding to their community's physical and mental health care needs (figure 6.24).

There were 85 FWE GPs per 100 000 people in Australia in 2000-01 — 92 per 100 000 in capital cities; 55 per 100 000 in remote centres; and 44 in other remote areas (figure 6.24).

Figure 6.24 Full time work load equivalent GPs per 100 000 people by region^a



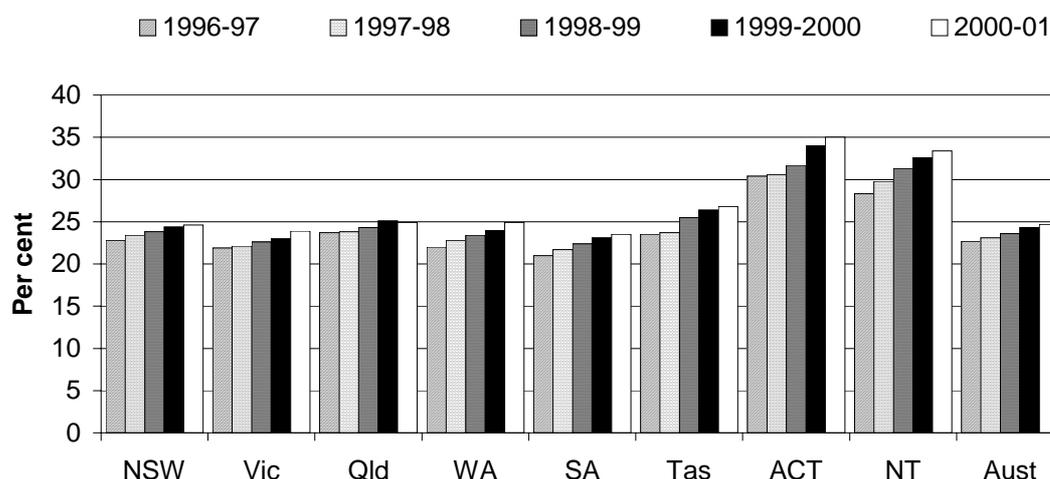
^a Capital city = State and Territory capital city statistical divisions; Other metropolitan centre = one or more statistical subdivisions that have an urban centre with a population of 100 000 or more; Large rural centre = Statistical Local Areas (SLAs) where most of the population resides in urban 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 5 000 or more; other remote area = all remaining SLAs in the remote zone.

Source: DHAC (unpublished); table 6A.29.

Full time workload equivalent GPs who are female

The final access indicator relates to female FWE GPs as a proportion of all FWE GPs. As a measure of access, this recognises that some female patients may be uncomfortable discussing health matters with a male GP. The proportion of female GPs in 2000-01 was highest in the ACT (35.0 per cent) and lowest in SA (23.5 per cent) (figure 6.25). In 2000-01, there were 21 female FWE GPs per 100 000 population compared with a total of 85 male and female FWE GPs per 100 000 population. There were 24 249 GPs in 2000-01, with 8 382 of these being female. Approximately one-third of total GPs are females, yet they represent approximately one-quarter of the FWEs (table 6A.4).

Figure 6.25 Female full time workload equivalents as a proportion of all FWE GPs



Source: DHAC (unpublished); table 6A.30.

Efficiency

Unit cost

It is an objective of the Review to report comparable estimates of costs. Comparability is maximised when the full range of costs to government is counted on a comparable basis. Where the full costs cannot be counted, comparability is achieved by estimating costs on a consistent basis.

The cost to government of general practice per person is the only suggested efficiency indicator for GP services at this stage.¹⁰ This indicator should be

¹⁰ Includes non-Medicare funding and expenditure by DVA.

interpreted with care, however, as a higher cost per person may reflect service substitution between primary care and hospital services or specialist services (the latter both potentially higher cost than primary care). Nationally, the annual cost per person in 2000-01 was \$149 (figure 6.2). Commonwealth expenditure in that year was highest in SA (\$159 per person) and lowest in the NT (\$103 per person).

6.5 Future directions

The key challenge for the Steering Committee in future years is to improve the reporting of general practice services delivered to special needs groups, especially Indigenous people. In addition, as mentioned in the Health preface, it is a long term aim of the Review to develop a performance reporting framework that reflects choices about the combination of health services provided across the health service spectrum (primary, secondary and tertiary). The Coordinated Care Trials are an example of experiments in this area (box C.5). With a view to exploring this issue, the Review is undertaking work on primary, public and community health and on the interaction between health and other services, such as aged care.

Quality

No routinely collected data relating to patient satisfaction as an indicator of the quality of GP services are available at present. Definitional problems surrounding this indicator still exist. Nevertheless, patients' views of, or complaints about, medical practice could be used as a proxy measure of dissatisfaction.

Patient safety is another potentially important source of quality data for general practice. There are no Australia-wide data available on the prevalence of harmful incidents in general practice, although some work has been done on the types of incidents occurring (box 6.2). The Steering Committee is hopeful that progress will be made in both these areas to enable future reporting.

Chronic illness management

In February 2002, the PIP Care Planning Incentive, an annual payment, will be paid for the first time. This incentive is designed to encourage practices to provide care plans and case conferences for their patients with chronic and complex conditions. Future policy directions will reflect the May 2001 Commonwealth Budget announcements, which include incentives for better management of diabetes, mental health, asthma and cervical screening, as well as incentives for employing practice nurses in general practice.

Box 6.2 Analysing potential harm in Australian general practice: an incident monitoring study

Between October 1993 and June 1995, a study was conducted in Australia to collect data on incidents of potential or actual harm to general practice patients and to evaluate the possible causes of these incidents.¹¹ A non-random sample of 324 GPs participated in the study and submitted 805 incident reports.

According to the results, 76 per cent of the incidents reported were considered preventable and 27 per cent had potential for severe harm. Major immediate consequences were reported in 17 per cent of incidents and 4 per cent resulted in the patient's death.

Incidents were grouped into pharmacological, non-pharmacological, diagnostic and equipment. Pharmacological incidents (such as use of inappropriate drugs, prescription error or administering error) were the most frequent and largely preventable (51 per 100 incidents). In contrast, diagnostic events (such as missed or delayed diagnosis) were less preventable and potentially more harmful (34 per 100 incidents). Of the 38 deaths reported, 30 involved a diagnostic incident.

Ineffective communication was a frequent contributing factor, with patients with mental health problems or poor or no English language skills particularly at risk.

While the study does not indicate the prevalence of incidents of potential or actual harm to general practice patients, it demonstrates some of the types of incidents occurring in Australian general practice. Limitations to the validity of the data include the non-random sample, limited recognition of incidents, selectivity in reporting incidents and the lack of an alternative perspective (such as the patient's view).

Source: Bhasale et al. (1998).

¹¹ An incident was broadly defined as 'an unintended event, no matter how seemingly trivial or commonplace, that could have harmed or did harm a patient'. This criterion included near misses where the harm may have been averted but the potential for harm existed.

6.6 Definitions

Table 6.7 Terms

<i>Term</i>	<i>Definition</i>
Age standardised	Removing the effect of different age distributions (across jurisdictions or over time) when making comparisons, calculated by weighting the age-specific rates for each jurisdiction by the national age distribution.
Ambulatory services	Services provided by an acute care hospital to non-admitted patients.
Casemix adjustment	Adjustment of data on cases treated to account for the number and type of cases. Cases are sorted into diagnosis related groups that represent a class of patients with similar clinical conditions requiring similar hospital services.
Cervical screening rates for target population	Proportion of women screened against cervical cancer in the age group 20–69 years.
Community health services	Health services for individuals and groups delivered in a community setting, rather than in hospitals or private facilities.
Consultations	The different types of services provided by GPs.
Cost to government of general practice per non-referred attendance	Cost to the Commonwealth Government of total non-referred attendances by non-specialist medical practitioners per 1000 population.
Divisions of general practice	Geographically based networks of GPs who provide peer support and promote links with the local community and other health professionals. In 1998, there were 123 Divisions in Australia. The Divisions of General Practice Program (DGPP) evolved from the former Divisions and Projects Grants Program established in 1992. Priorities include providing infrastructure to link GPs with government and other health service providers and the recruitment and the retention of GPs in rural areas. Around \$72 million was provided by the Commonwealth in 2000-01 under the DGPP.
Fully immunised at 12 months	A child that has completed three doses of Diphtheria, Tetanus, Pertussis containing vaccine, three doses of Oral Polio Vaccine, three doses of HbOC (HibTITER) (or two doses of PRP-OMP (PedvaxHIB)) and one dose of measles, Mumps, Rubella.
Fully immunised at 24 months	A child that has received four doses of Diphtheria, Tetanus, Pertussis containing vaccine, three doses of Oral Polio Vaccine, four doses of HbOC (HibTITER) (or three doses of PRP-OMP (PedvaxHIB)) and one dose of Measles, Mumps, Rubella.
Full time workload equivalents	A measure of medical practitioner supply based on claims processed by Medicare in a given period. The calculation is made by dividing the practitioner's Medicare billing by the mean billing of full time practitioners for that period. Full time equivalents (FTEs) are calculated in the same way as full time workload equivalents, however FTE's are capped at one for each practitioner.
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 and Indigenous health.

(Continued on next page)

Table 6.7 (Continued)

<i>Term</i>	<i>Definition</i>
General practitioner	Medical practitioners who, for the purposes of Medicare, are vocationally registered under section 3F of the <i>Health Insurance Act 1973</i> (Cwlth), hold fellowship of the Royal Australian College of General Practitioners or equivalent, hold a recognised training placement or are otherwise entitled to bill Group A1 Medicare Benefits Schedule items. Or other medical practitioners who have at least half of the schedule fee value of their Medicare billing from non-referred attendances, consisting solely or predominantly of Group A2 items.
Health management	An ongoing process beginning with initial client contact and including all actions relating to a client. Includes assessment/evaluation; education of the person, family or carer(s); diagnosis and treatment; and problems associated with adherence to treatment; and liaison with or referral to other agencies.
Immunisation coverage	A generic term indicating the proportion of a target population that is fully immunised with a particular vaccine or the specified vaccines from the Australian Standard Vaccination Schedule for that age group.
Management of diabetes	Proportion of adults with diabetes who have been diagnosed and placed on a register, proportion of adults with diabetes who have had a glycaemic control assessment in the previous six months and separation rates where the principal diagnosis is Type 2 diabetes.
Management of upper respiratory tract infections	Number of prescriptions for oral antibiotics most commonly used in the treatment of upper respiratory tract infections ordered by GPs, per 1 000 persons with Pharmaceutical Benefits Scheme concession cards.
Non-referred attendances	GP services, emergency attendances after hours, other prolonged attendances, group therapy and acupuncture. All attendances for specialist services are excluded as these must be 'referred' to receive Medicare reimbursement.
Non-specialist attendances that are bulk billed	Number of non-referred attendances that are bulk billed and provided by non-specialist medical practitioners divided by the total number of non-referred attendances.
Non-specialist medical practitioners by region	Number of full time workload equivalent non-specialist medical practitioners practising in capital cities, other metropolitan centres and rural/remote areas, divided by the total number of FWE non-specialists.
Notifications of selected childhood diseases	Number of cases of measles, pertussis and <i>Haemophilus influenzae</i> type b notified by State and Territory health authorities.
Other medical practitioner	A medical practitioner other than a recognised general practitioner who has at least half of the schedule fee value of his/her Medicare billing from non-referred attendance items consisting solely or predominantly of Group A2 items.

(Continued on next page)

Table 6.7 (Continued)

<i>Term</i>	<i>Definition</i>
Other specialist	A medical practitioner not classified as general practitioner, other medical practitioner or recognised specialist who undertakes a majority of specialist work, but who is not formally recognised as a specialist by Medicare. Also includes specialists with recognition in one field but working in an unrelated field.
Pap smear	A procedure for the detection of cancer and pre-cancerous conditions of the female genital tract.
Per person benefits paid for GP-ordered pathology	Total benefits paid for pathology tests ordered by GPs divided by the population.
Per person benefits paid for GP-ordered diagnostic imaging	Total benefits paid for diagnostic imaging tests ordered by GPs divided by the population.
Primary care	The primary health and community care sector includes services which: <ul style="list-style-type: none"> • are the first point of contact for people; • have a particular focus on prevention of illness or early intervention; and/or • are intended to maintain people's independence and maximise their quality of life through care and support at home or in local community settings.
Prevalence	The proportion of the population suffering from a disorder at a given point in time (point prevalence) or during a given period (period prevalence).
Preventive interventions	Programs designed to decrease the incidence, prevalence and negative outcomes of disorders.
Proportion of GPs who are female	Number of all full time workload equivalent GPs who are female divided by the total number of full time workload equivalent GPs.
Proportion of GPs with vocational registration	Number of full time workload equivalent GPs who are vocationally registered divided by the total number of full time workload equivalent GPs.
Proportion of practices registered for accreditation	Number of practices that have registered for accreditation through Australian General Practice Accreditation Limited divided by the total number of practices in the Divisions of General Practice.
Proportion of practices with electronic information management systems	Number of practices with electronic prescribing and/or electronic connectivity, registered under the Practice Incentive Program, divided by the total number of practices registered.
Public health	The organised, social response to protect and promote health and to prevent illness, injury and disability. The starting point for identifying public health issues, problems and priorities, and for designing and implementing interventions, is the population as a whole or population subgroups. Public health is characterised by a focus on the health of the population (and particular at-risk groups) and complements clinical provision of health care services.

(Continued on next page)

Table 6.7 (Continued)

<i>Term</i>	<i>Definition</i>
Psychiatrist	Medical practitioner with specialist training in psychiatry.
Reasons for encounter	The expressed demand of the patient for care as perceived and recorded by the GP.
Recognised general practitioner	A vocationally registered general practitioner, a Fellow of the Royal Australian College of General Practitioners or equivalent, or a general practice registrar in a training placement.
Recognised immunisation provider	A provider recognised by the Health Insurance Commission as a provider of immunisation to children.
Recognised specialist	A medical practitioner classified as a specialist on the Medicare database earning at least half of his/her income from relevant specialist items in the schedule, having regard to the practitioner's field of specialist recognition.
Screening	The performance of tests on apparently well people to detect a medical condition at an earlier stage than would otherwise be possible without the test.
Standardised separation rates for selected conditions often requiring secondary treatment	Age and sex standardised hospital separation rates for hip replacements, lens insertion and angioplasty.
Vocational registration	A formal training program that promotes quality in general practice. Vocationally registered GPs are registered separately from other non-specialist practitioners for Medicare purposes, and receive higher Medicare benefits for services.

7 Health management issues

Health management is concerned with the management of diseases, illnesses and injuries using a range of services (promotion, prevention/early detection and intervention) in a variety of settings (for example, public hospitals, community health centres and general practice). This chapter reports on the management of breast cancer and mental health, and represents only some of the activities of Commonwealth, State and Territory governments in health management.

An overview of health management is provided in section 7.1. Sections 7.2 and 7.3 report on the performance of breast cancer and mental health management respectively. Section 7.4 outlines the future directions for the chapter and jurisdictions' comments relating to all the health chapters are summarised in section 7.5. Definitions are listed in section 7.6.

Improvements to reporting of breast cancer detection and management include refining the reporting of participation rates for special needs groups in screening and cost per woman screened and presenting information on government funding of BreastScreen Australia.

Improvements to reporting of mental health management include:

- reporting estimates of State and Territory government expenditure on specialised mental health services that have been refined to exclude all components of Commonwealth Government spending;
- improved reporting of quality of care to reflect review against National Standards for Mental Health Services with such reviews being included in the accreditation processes for health facilities; and
- presentation of unit cost data for community based care.

Supporting tables

Supporting tables for chapter 7 are provided on the CD-ROM enclosed with the Report. The files are provided in Microsoft Excel 97 format as \Publications\Reports\2002\Attach7A.xls and in Adobe PDF format as \Publications\Reports\2002\Attach7A.pdf.

Supporting tables are identified in references throughout this chapter by an 'A' suffix (for example, table 7A.3 is table 3 in the electronic files). They may be subject to revision. The most up-to-date versions of these files can be found on the Review's web page (www.pc.gov.au/gsp/). Users without Internet access can contact the Secretariat to obtain up-to-date versions of these tables (see details on the inside front cover of the Report).

7.1 Overview of health management

Some fundamental changes have taken place in the Australian health care system in recent years. Policy makers are seeking alternative service delivery settings and a more coordinated approach to managing health problems. The ability of governments to improve particular health outcomes is maximised when health care providers integrate their promotion, prevention, early detection and treatment services. Measuring the management of a health problem involves measuring the performance of service providers and the management of prevention/early detection and intervention programs.

Breast cancer and mental illness are significant causes of morbidity and mortality in Australia. Cancer control and mental health are identified by governments as National Health Priority Areas, along with diabetes mellitus, cardiovascular health, injury prevention and the control of asthma. These areas represent a significant proportion of the burden of illness in Australia and their management offers considerable scope for reducing this burden (AIHW 1998a).

Appropriate management of breast cancer and mental health will have a large effect on the health and wellbeing of many Australians. Both are the subjects of public health programs designed to reduce the impact of the health problem (box 7.1). Public health programs require the participation of public hospital services, community health services and general practice services. (The public hospital and general practice components of the health care system are discussed in chapters 5 and 6 respectively.)

The Health preface of this Report outlines the complexities of reporting on the performance of the overall health system in meeting its objectives. This Report breaks the health system into smaller components and reports on their performance (see figure C.4 of the Health preface). Frameworks for public hospitals and general practitioners (GPs) report the performance of particular service delivery mechanisms. The appropriateness of the mix of services (prevention versus intervention) and the appropriateness of the mix of delivery mechanisms (hospital based versus community based) are the focus of reporting in this chapter.

A longer term goal of the Review is to extend the health management framework to other health issues, such as the remaining National Health Priority Areas. The Commonwealth, State and Territory governments report a limited number of priority indicators encompassing the continuum of care (from prevention through to treatment, rehabilitation and palliation) for each area on a regular basis (AIHW 2000a). The first report on injury prevention and control was released in 1998, and reports for cardiovascular health, diabetes mellitus and mental health were released in 1999. National reports for the Cervical Screening Program and BreastScreen Australia were published in 1998, 1999 and 2000.

Box 7.1 Public and community health

Public health is defined as 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. All jurisdictions perform public health services or undertake programs to enhance the health of the population. Activities provided and classified as 'public health' are grouped under four headings:

- promotion of health (for example, public campaigns designed to improve nutrition);
- protection against hazards (for example, surveillance of food premises and control of water and air quality through legislation or regulation);
- prevention and early detection of illness (for example, child immunisation and breast and cervical cancer screening services); and
- provision of health services (for example, school dental services and drug and alcohol treatment services).

Promotion and protection activities are often referred to as 'population public health' activities because they are delivered to populations rather than to individuals. Prevention and provision activities are termed 'public health personal clinical activities'.

This Report focuses on public health activities related to promotion, prevention and provision activities. (Most protection activities are not the responsibility of health care providers and therefore are not included in the analysis.) Public health efforts currently target areas such as communicable diseases (for example HIV/AIDS and tuberculosis), childhood immunisation and the National Health Priority Areas.

Many public health activities are delivered by a range of health care providers — GPs, public hospitals and community health services. General practitioners and public hospitals provide a range of services in addition to these public health services, whereas community health services concentrate on health promotion, early detection of health problems and the assessment and care of health problems. Community health care services are diverse by nature, incorporating a range of service providers

(Continued on next page)

Box 7.1 (Continued)

(dietitians, community nurses, psychologists and so on). This multidisciplinary approach makes it difficult to attribute health outcomes to a particular service or provider.

Source: AIHW (1998a); Fry (1994) and NPHP (1997).

7.2 Breast cancer

Profile

Breast cancer is a disease whereby uncontrolled or malignant cell division leads to the formation of a tumour or tumours in a woman's breast (box 7.2).¹ Tumours may expand locally by invading surrounding tissue or may spread via the lymphatic or vascular systems to the rest of the body. If left untreated, most malignant tumours eventually result in the death of the affected person (AIHW 2000b). The focus of this Report is on invasive cancers, although some data are reported on the size and grade of *ductal carcinoma in situ* (non-invasive tumours residing in the ducts of the breast).

Box 7.2 Some common health terms used in breast cancer management

health management: the ongoing process beginning with initial client contact and including all actions relating to the client. Included are 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.

incidence rate: the proportion of the population suffering from a disorder or illness for the first time during a given period (often expressed as per 100 000 persons).

invasive cancer: a tumour whose cells invade healthy or normal tissue.

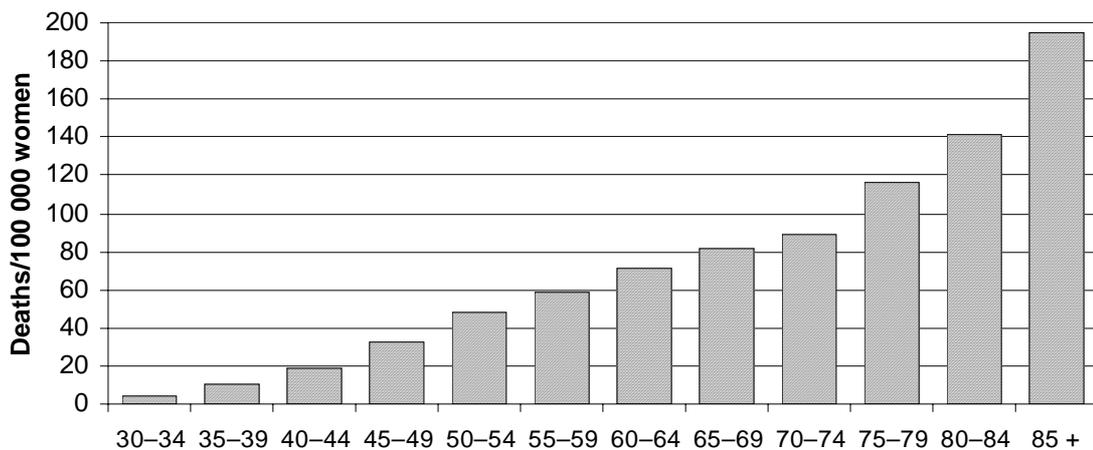
prevalence: the number of cases of a disease present in a population at a given time (point prevalence) or during a given period (period prevalence).

screening: the performance of tests on apparently well people to detect disease at an earlier stage than would otherwise be the case.

¹ Breast cancer in males is very rare and is not examined in this Report.

Breast cancer was responsible for 2542 female deaths in 1998 and 2505 female deaths in 1999, making it the most frequent cause of death from cancer for females (ABS 2000). The strong relationship between age and the mortality rate from breast cancer is shown for the period 1995–98 in figure 7.1. Whereas women aged 40–44 years have a mortality rate of 19.1 per 100 000 women, women aged 75–79 have a mortality rate of 115.7 per 100 000 women.

Figure 7.1 **Mortality rates from breast cancer by age group, 1995–98**



Source: AIHW 2000b; table 7A.19.

Incidence and prevalence

Breast cancer was the most common cancer affecting Australian women, with 10 665 new cases diagnosed in 1998 (AIHW 2000b). For the period 1992–96, the risk of a woman in Australia developing breast cancer before the age of 75 years was one in 12 (AIHW *et al.* 1999).

The number of new cases of breast cancer diagnosed in Australian women each year increased between 1992 and 1998 from 7976 to 10 665 (table 7.1). The increase in the number of cases detected reflects both an increase in the underlying rate of breast cancer as well as the detection of cancers that would have previously not been discovered for some years (AIHW 2000b).

Table 7.1 New cases of breast cancer diagnosed (number)^a

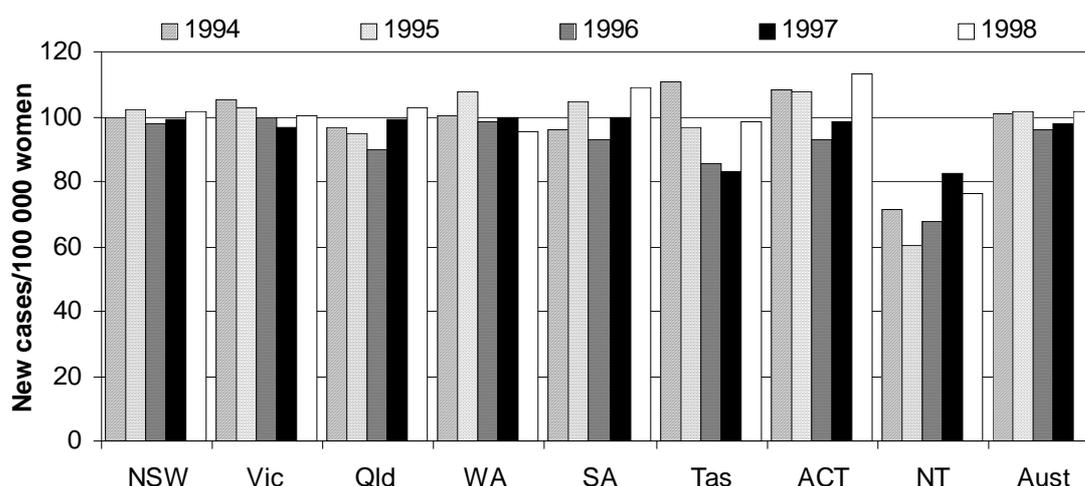
	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
1992	2 712	2 054	1 357	751	765	204	100	33	7 976
1993	3 053	2 173	1 544	779	794	244	115	29	8 731
1994	3 338	2 605	1 593	846	821	288	141	45	9 677
1995	3 489	2 595	1 621	942	909	255	150	32	9 993
1996	3 417	2 565	1 586	886	823	228	133	46	9 684
1997	3 530	2 560	1 787	923	893	230	141	53	10 117
1998	3 690	2 694	1 903	909	984	271	170	44	10 665

^a A new case is defined as a person who has a new cancer diagnosed for the first time. One person may have more than one cancer and therefore may be counted twice in incidence statistics if it is decided that the two cancers are not of the same origin.

Source: AIHW unpublished data; table 7A.1.

Age standardised incidence rates of breast cancer are presented in figure 7.2. (Age standardisation eliminates differences in population age distributions among jurisdictions to allow valid comparisons of similar age cohorts across jurisdictions.) The Australian incidence rate increased from 69.9 per 100 000 women in 1982 to 101.3 in 1998 (table 7A.2). In 1998, the incidence rate for women of all ages was highest in the ACT (113.1 per 100 000 women) and lowest in the NT (76.2 per 100 000 women).

Figure 7.2 Age standardised incidence rates of breast cancer, women of all ages^{a, b}

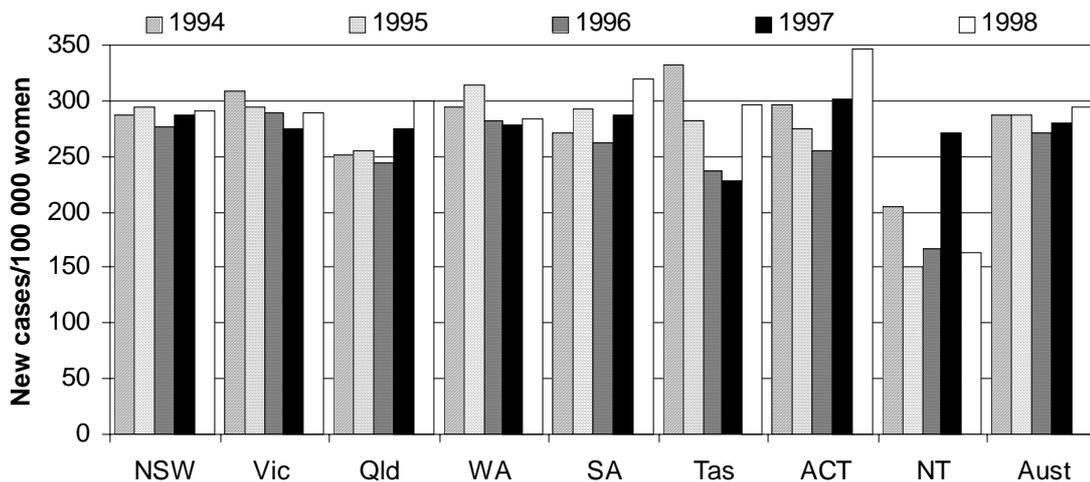


^a Incidence refers to the number of new cases of breast cancer expressed per 100 000 women. ^b Rates are age standardised to the Australian 1991 population standard.

Source: AIHW (unpublished 1998; 1999 and 2000); table 7A.2.

Incidence rates of breast cancer for women aged 50–69 years are shown in figure 7.3. In 1998, incidence rates were highest in the ACT (345.5 per 100 000 women) and lowest in the NT (164.1 per 100 000 women).

Figure 7.3 Incidence rates of breast cancer, women aged 50–69 years^{a, b}



^a Incidence refers to the number of new cases of breast cancer, expressed per 100 000 women. ^b Rates are age standardised to the Australian 1991 population standard.

Source: AIHW (unpublished); table 7A.4.

Size and scope of breast cancer detection and management services

Breast cancer detection and management services comprise a number of major components: primary care and community based services, including GP services and community based women's health services; screening services; acute services based in hospitals, including both inpatient and outpatient services; private consultations for a range of disciplines; and post-acute services, including home based and palliative care (DHS (Victoria) 1999).

Most of the data relating to breast cancer detection and management in this Report are provided by BreastScreen Australia. At present, data for services other than breast cancer screening are limited.

The focus of breast cancer control is on screening to enable early detection and intervention as this increases the probability of survival. If breast cancer is detected early, while still localised in the breast, chances of five-year survival are around 90 per cent. The survival rate drops to 18 per cent if the tumour has spread to other parts of the body (NBCC 1999). Cancers detected early may be treated more conservatively and these women generally have a higher likelihood of survival.

BreastScreen Australia, a joint Commonwealth–State program, undertakes nationwide breast cancer screening. BreastScreen Australia targets women aged 50–69 years. Some international evidence would suggest that for this age group, organised systematic population based mammographic screening every two years can reduce deaths from breast cancer. The program aims to have 70 per cent or more women aged between 50 and 69 participating in screening over a 24 month period. All recruitment activities undertaken by BreastScreen Australia specifically target women in this age group, although women aged 40–49 years and those over 70 years may also use the service.

Services provided by BreastScreen Australia in each State and Territory generally encompass x-ray screening and assessment services up to the point of diagnosis and referral for treatment. Some jurisdictions, however, do not offer open biopsies (table 7A.5).

Estimates of government expenditure on breast cancer screening by jurisdiction are presented in the attachment (table 7A.6) and estimates of expenditure on screening per person in each jurisdiction are presented in figure 7.4. The jurisdictional estimates include Commonwealth, State and Territory government expenditure.

According to the Australian Institute of Health and Welfare (AIHW 2001c), \$90.8 million was spent by governments on breast cancer screening in 1998–99. Differences across jurisdictions will in part reflect variation in the proportion of women in the target age group for breast cancer screening. Differences across jurisdictions may also, however, reflect data deficiencies and collection methods, as well as the nature of the services and their relative efficiency. The data should therefore be viewed with care.

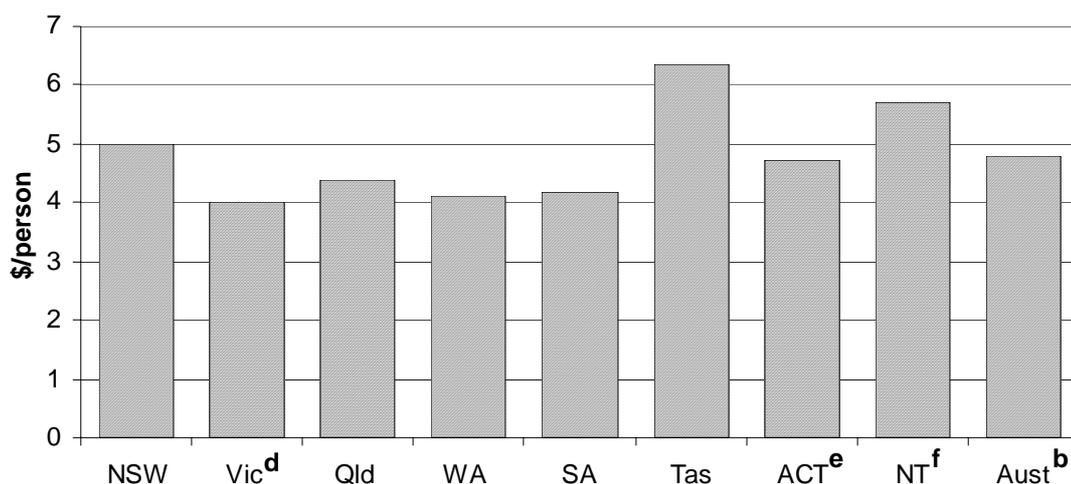
The number of women aged 40 years and over screened by BreastScreen Australia services between 1996 and 2000 and the number of screens performed over the same time period provides an indication of the size of the BreastScreen Australia program (table 7.2).

A number of services assist in the management of breast cancer once diagnosed. Hospitals provide initial treatment for breast cancer and assist in the management of ongoing care and follow-up. Relevant clinical disciplines include surgery, plastic and reconstructive surgery, pathology, radiation and medical oncology, nursing, diagnostic radiology, radiography, physiotherapy, allied health and psychological and psychiatric services. Post-acute services include a range of further treatments, such as radiotherapy and chemotherapy (most of which take place on a same day or outpatient basis) and a range of follow-up and palliative care services (DHS 1999).

Inpatient separations in public hospitals for selected breast cancer related diagnosis related groups (DRGs) in 1999–2000 are presented in table 7.3. Chemotherapy and radiotherapy data include procedures unrelated to breast cancer management and

therefore overestimate services related to breast cancer. Currently, no disaggregated data are available in relation to these post-acute services.

Figure 7.4 Public health expenditure on breast cancer screening, 1998-99^{a, c, g}



^a In every jurisdiction, BreastScreen Australia is a joint initiative funded by both the jurisdiction government and the Commonwealth under the Public Health Outcome Funding Agreements (PHOFA). ^b The Australian total includes Commonwealth direct project expenditure, statistical and other program support, population health non-grant program costs and running costs. ^c Medicare funding for radiographic breast examinations is excluded as it is not considered public health expenditure. ^d Victorian data include depreciation. ^e ACT data include expenditure on BreastScreen ACT and the Cancer Registry. ^f NT data for direct expenditure include public health information systems, disease surveillance and epidemiological analysis, public health communication and advocacy, public health policy, program and legislation development and public health workforce development. ^g The data should be viewed with care because of data deficiencies and differences across jurisdictions relating to the use of cash accounting and accrual methods, the treatment of corporate and central office costs, differences in methods used to collect expenditure figures and differences in the interpretation of public health expenditure definitions.

Source: AIHW (2001c); table 7A.6.

Table 7.2 Number of women screened and number of screens performed by BreastScreen Australia^a

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT
1999								
Women	273 995	171 366	na	59 993	64 194	19 382	12 256	na
Screens	274 289	171 390	153 931	60 015	64 199	19 381	12 256	na
2000								
Women	277 400	177 232	na	65 581	65 494	na	11 438	na
Screens	277 597	177 237	na	65 630	65 497	21 341	11 439	na

^a First and subsequent screening rounds, women aged 40 years and over. **na** Not available.

Source: BreastScreen Australia; table 7A.7 and table 7A.8.

Table 7.3 Separations for selected DRGs related to breast cancer, public hospitals, 1999-2000 ('000)

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
Major procedures for malignant breast conditions	1.98	1.62	1.13	0.63	0.58	0.12	0.11	0.03	6.19
Minor procedures for malignant breast conditions	0.96	0.61	0.40	0.15	0.28	0.07	0.07	0.01	2.56
Skin, subcutaneous tissue and plastic breast procedures	2.00	1.53	1.47	0.68	0.83	0.13	0.09	0.04	6.77
Other skin, subcutaneous tissue and breast procedures	9.75	7.68	10.04	3.43	4.99	0.82	0.50	0.24	37.44
Malignant breast ^b disorders (age>69 W CC)	0.13	0.13	0.06	0.03	0.06	0.01	—	—	0.40
Malignant breast ^{a,b} disorders (age<70 W CC) or (age>69 W/O CC)	0.36	0.60	0.27	0.08	0.12	0.07	0.08	0.01	1.59
Malignant breast ^a disorders (Age<70 W/O CC)	0.11	0.40	0.11	0.14	0.06	0.04	0.03	—	0.88
Chemotherapy	18.15	40.59	26.69	12.76	12.58	1.73	3.69	0.48	116.66
Radiotherapy	0.23	0.04	0.01	0.02	0.01	—	—	—	0.31
Total separations in public hospitals	1 245.81	1 003.61	707.91	360.39	360.02	75.95	60.66	57.84	3 872.20

^a W/O CC = 'without complications and comorbidities'. ^b W CC = 'with complications and comorbidities'. — Nil or close to zero. AR-DRG version 4.1.

Source: AIHW (2001b); table 7A.9.

Policy developments

BreastScreen Australia's policy on symptomatic women was reviewed in 2000-01. BreastScreen Australia is a population based mammographic screening program for

women without symptoms. Current BreastScreen Australia policy states that it is preferable for women with symptoms, such as breast lumps or nipple discharge, to be referred by their medical practitioner to a diagnostic service.

The National Advisory Committee (NAC) to BreastScreen Australia considered the outcomes of the policy review in July 2001.² The Committee has agreed that further work is required to implement a flexible policy framework responsive to the needs of women with symptoms presenting to BreastScreen Australia services. The Committee has also determined that standardised definitions of symptoms are critical for the local monitoring of symptomatic women in the program and for consistent national monitoring and reporting. Projects will be undertaken in 2001-02 to establish clear and nationally consistent definitions of symptoms, principles of duty of care and protocols to support decision making within a flexible policy framework at the State and Territory level.

Interval cancer rates were previously reported by symptom status. In the 2002 Report, stratification of reporting by symptom status has been temporarily discontinued until symptom status can be more accurately defined.

Framework of performance indicators

The indicators developed to report on the performance of breast cancer detection and management are based on the shared government objective for managing the disease (box 7.3).

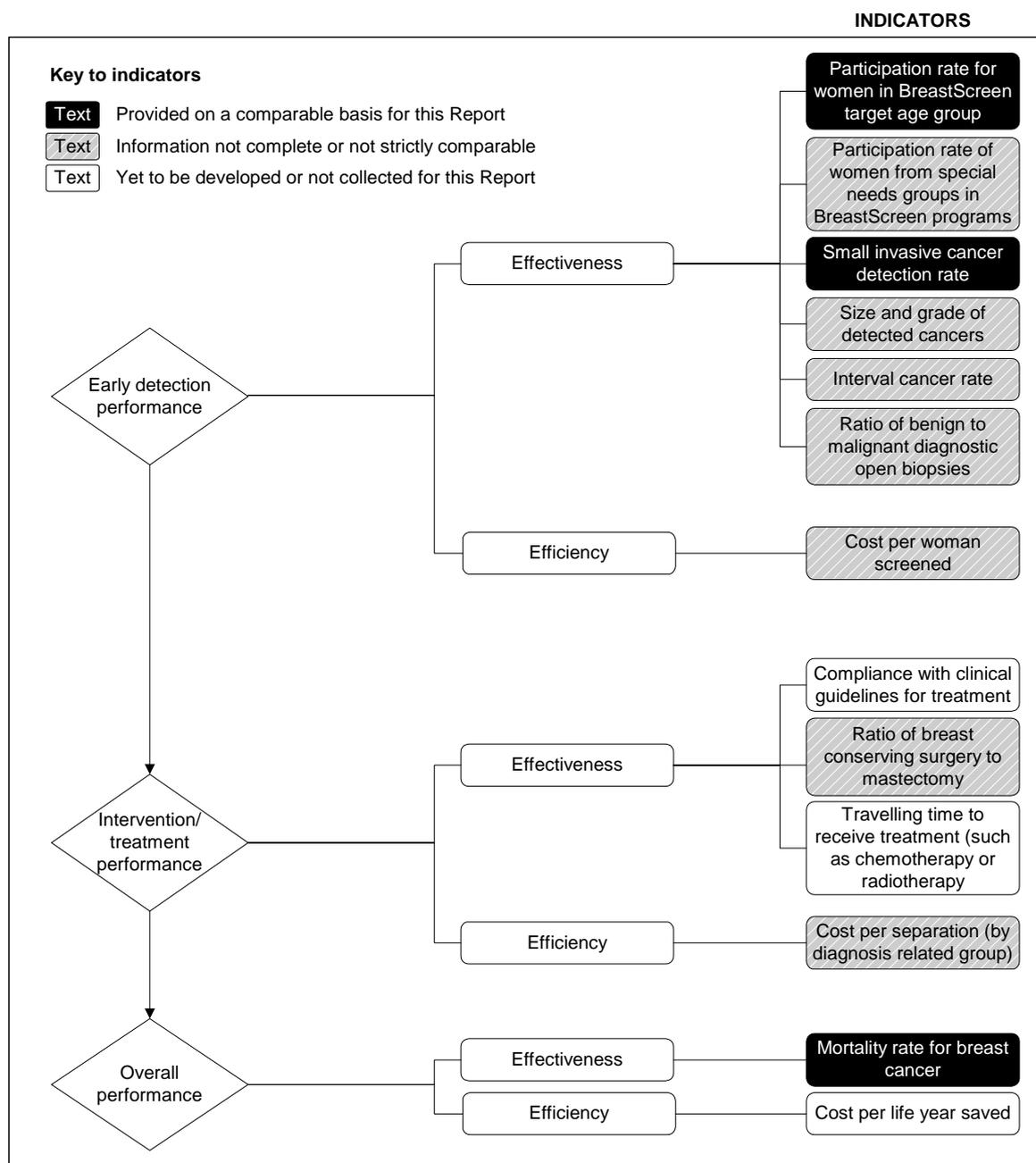
Box 7.3 Objective for breast cancer detection and management

The objective for breast cancer management is to reduce incidence of, and mortality from, breast cancer and to improve the quality and duration of life of women with breast cancer or at heightened risk of breast cancer in a manner that is equitable and efficient (Commonwealth Department of Human Services and Health 1994).

The framework for breast cancer detection and management focuses on achieving a balance between early detection of the disease and treatment. It has a tripartite structure. The performance indicators presented relate to early detection, intervention and overall performance (figure 7.5). A similar approach is adopted for emergency management services (see chapter 11).

² The NAC to BreastScreen Australia provides advice to all Australian governments on specific policy, quality, data management and clinical and administrative issues arising out of the management of the BreastScreen Australia Program.

Figure 7.5 Performance indicators for breast cancer detection and management



Key performance indicator results

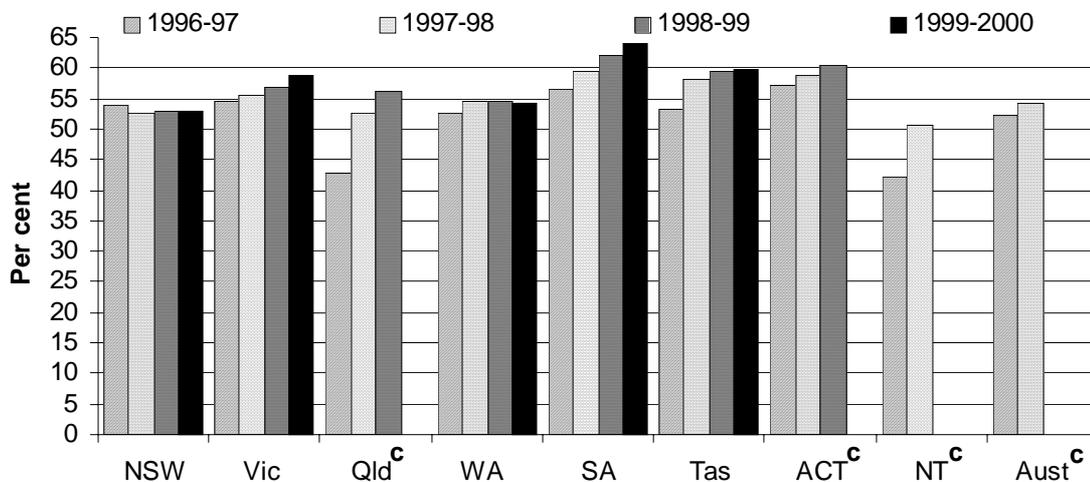
As mentioned, as there are significant amounts of data relating to breast cancer screening, this is the focus of reporting. Data relating to the management and treatment of breast cancer are less readily available and it is a priority of the Review to extend reporting in this area.

Early detection

Participation rate of women in the target age group

The aim of BreastScreen Australia is to screen 70 per cent of women aged 50–69 years at regular two-year intervals, where screening services have been established for five years or more. The participation of women in the target age group in breast cancer screening is an indicator of the effectiveness of breast cancer screening programs. Data for 1999–2000 are not available for the ACT, the NT and Queensland (figure 7.6). In 1999–2000, the participation rate for women aged 50–69 was highest in SA (64.0 per cent) and lowest in NSW (52.8 per cent). It should be noted that data for 1996–97 and 1997–98 were sourced from the AIHW and more recent data were sourced from jurisdiction governments. There may be differences in methodology between the two different sources that cause a break in the time series.

Figure 7.6 Participation rates of women aged 50–69 years in BreastScreen Australia screening programs^{a, b, d}



^a The participation rate is the number of women resident in the catchment area screened during the reference period, divided by the number of women resident in the catchment area during the reference period based on ABS ERP data. Where service boundaries cross State localised areas, calculation of resident women is made on a proportional basis. If a woman is screened more than once during the reference period then only the first screen is counted. Catchment area is a geographic region based on service size in relation to population, accessibility and the location of other services. It is uniquely defined for each service based on postcode or statistical local area (SLA). Reference period is 24 months. ^b Crude rates. ^c 1999–2000 data were not available for Queensland, the ACT and the NT. 1998–99 data were not available for the NT. It is not possible to calculate Australian rates for these years. ^d Data for 1996–97 and 1997–98 are sourced from the AIHW and data for 1998–99 and 1999–2000 are sourced from jurisdiction governments. There may be differences in methodology between the two sources that cause a break in the time series.

Sources: State and Territory governments (unpublished); AIHW (1998a and 2000b); table 7A.10.

Under the national accreditation requirements of the BreastScreen Australia program, at least 60 per cent of the women screened need to be in the target age group (50–69 years). According to BreastScreen Australia, this target was achieved in all jurisdictions in 1997-98, with approximately two thirds of women screened in the target age group. The remaining third comprised 20 per cent aged 40–49 years and 10 per cent aged 70 years or more (AIHW 2000b). This target was also achieved by all jurisdictions in 1999 (except the NT where data were not available) (table 7A.7).

Participation rates of women from special needs groups in BreastScreen Australia programs

The participation rate of women from special needs groups (that is, Indigenous women, women from non-English speaking backgrounds and women living in rural and remote areas) in breast cancer screening is another indicator of the effectiveness (in terms of access and equity) of the breast cancer screening program. Data for this indicator are presented in table 7.4. The data are not age standardised. Differences across jurisdictions in the collection of Indigenous, non-English speaking background and rural/remote status make comparisons difficult. Care needs to be taken in comparing data across jurisdictions.

In most jurisdictions, it appears that participation rates for Indigenous women aged 50–69 are lower than for all females in that age group, however this may be influenced by problems with identification of Indigenous status. Participation rates of women in non-metropolitan areas appear higher (in general) than the rates for women in metropolitan areas. The rates for women from non-English speaking backgrounds aged 50–69 are higher than for the total female population aged 50–69 in Victoria, Queensland, and WA and lower in other States.

Table 7.4 Participation rates of women aged 50–69 years from selected communities in BreastScreen Australia screening programs (per cent)^{a, b}

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT
Indigenous ^c								
1998-99	35.1	na	54.4	42.7	43.0	42.5	52.0	na
1999-2000	37.8	na	na	43.5	48.0	43.6	49.0	na
NESB ^d								
1998-99	46.7	57.2	65.6	56.0	57.7	33.8	59.0	na
1999-2000	47.7	60.9	na	58.3	60.3	32.1	59.0	na
Metropolitan or capital city ^e								
1998-99	52.1	55.8	53.5	51.4	60.3	58.6	61.0	na
1999-2000	51.3	56.4	na	51.5	62.8	60.7	60.0	na
Rural and remote or rest of state ^f								
1998-99	57.3	63.7	59.8	63.8	68.2	58.6	..	na
1999-2000	57.0	65.6	na	62.5	67.5	60.3	..	na
Total aged 50–69								
1998-99	52.8	56.9	56.1	54.5	62.1	59.3	60.5	na
1999-2000	52.8	58.9	na	54.3	64.0	59.9	na	na

^a First and subsequent rounds ^b Crude rates. ^c Indigenous is defined as women who have self identified as being Aboriginal or Torres Strait Islander. ^d NESB is defined as persons who speak a language other than English at home. ^e 'Metropolitan' includes 'capital city' (State and Territory capital city statistical divisions) and 'other metropolitan centre' (one or more statistical subdivisions that have an urban centre with a population of 100 000 or more). ^f 'Rural and remote' includes 'large rural centre' (statistical local areas (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) and 'other remote area' (all remaining SLAs in the remote zone). **na** Not available .. Not applicable.

Source: State and Territory governments (unpublished); tables 7A.10 and 7A.11.

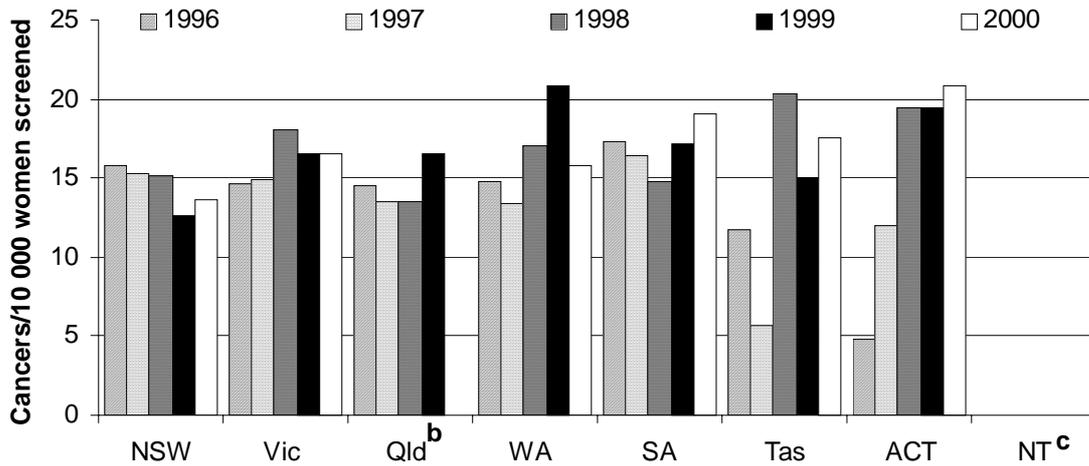
Small invasive cancer detection rate

The small invasive cancer detection rate is an important indicator of the effectiveness of breast cancer screening programs. The BreastScreen Australia National Accreditation Requirements Standard is that more than eight invasive cancers per 10 000 women screened have a diameter of 10 millimetres or less. Small cancers (those with a diameter less than or equal to 10 millimetres) are generally associated with increased survival rates and reduced morbidity and mortality, with some cost savings to the health care system and to women. Women with small cancers are less likely to require a mastectomy than women with larger tumours (AIHW *et al.* 1998).

For women aged 50–69 years screened by BreastScreen Australia in 1999, the small invasive cancer detection rate (per 10 000 women screened) was highest in WA (20.8) and lowest in NSW (12.6). In 2000, the highest rate was in the ACT (20.8)

and the lowest in NSW (13.6). Data for 2000 were not available for Queensland (figure 7.7).

Figure 7.7 Small diameter cancer detection rate, for women aged 50–69 years, all rounds of screening^a



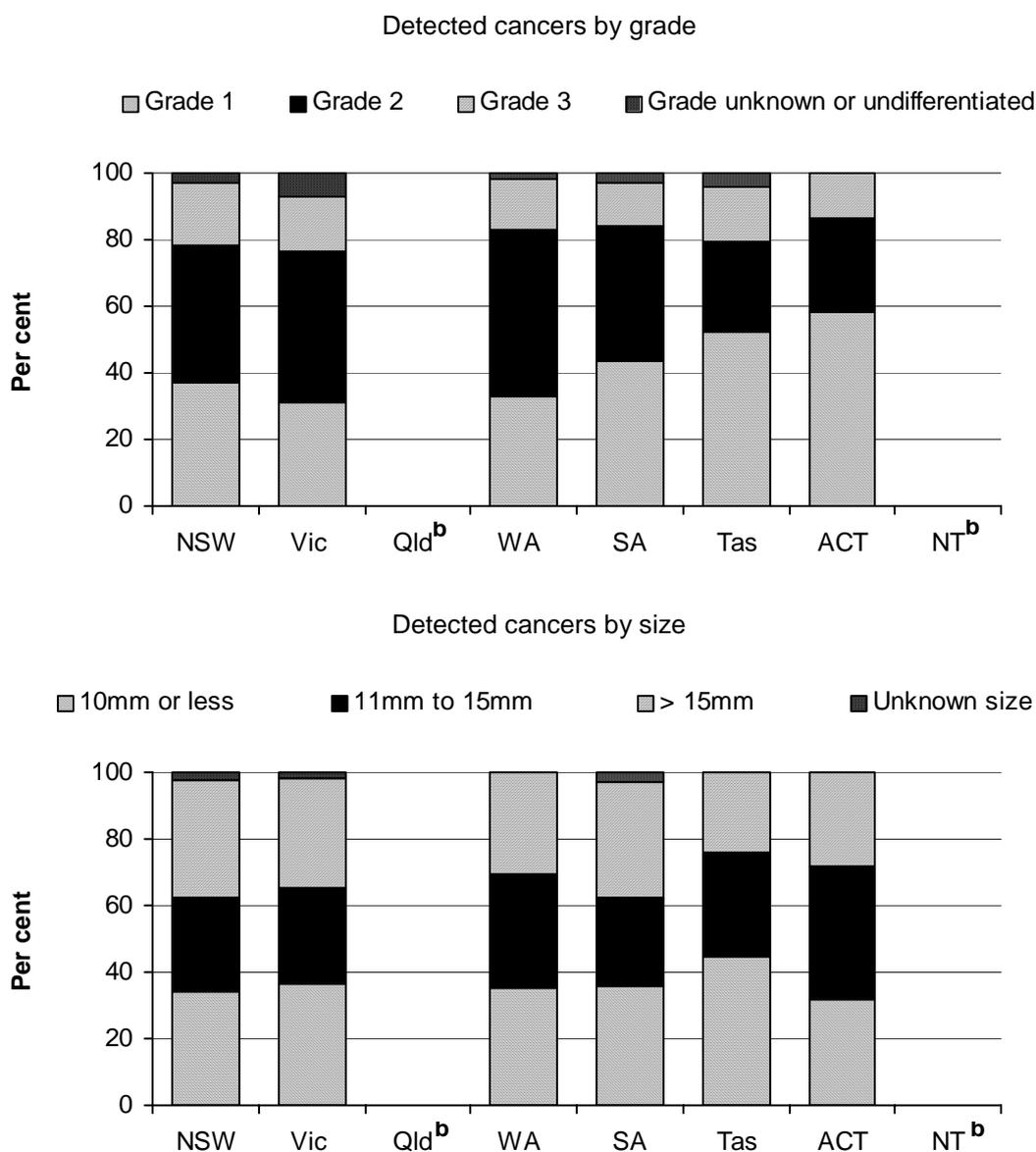
^a Crude rates. ^b Queensland data for 2000 not available. ^c NT data not available.

Source: State and Territory governments (unpublished); table 7A.12.

Size and grade of detected cancers

The size and grade of detected invasive cancers are also indicators of the effectiveness of the breast cancer screening program. The tumour grade describes the degree of similarity of cancer cells to normal cells. The degree of differentiation of the cancer determines the disease prognosis. Women with low grade (grade 1, well differentiated) cancers have a better prognosis than those with high grade cancers. Figure 7.8 presents the proportion of cancers by size and grade for 2000. The source of data is BreastScreen Australia and covers only clients of BreastScreen Australia. Not all invasive cancers are included.

Figure 7.8 Detected invasive cancers by grade and size as a proportion of total detected invasive cancers^a



^a Non-breast malignancies not counted. ^b NT and Queensland data not available.

Source: State and Territory governments (unpublished); table 7A.13.

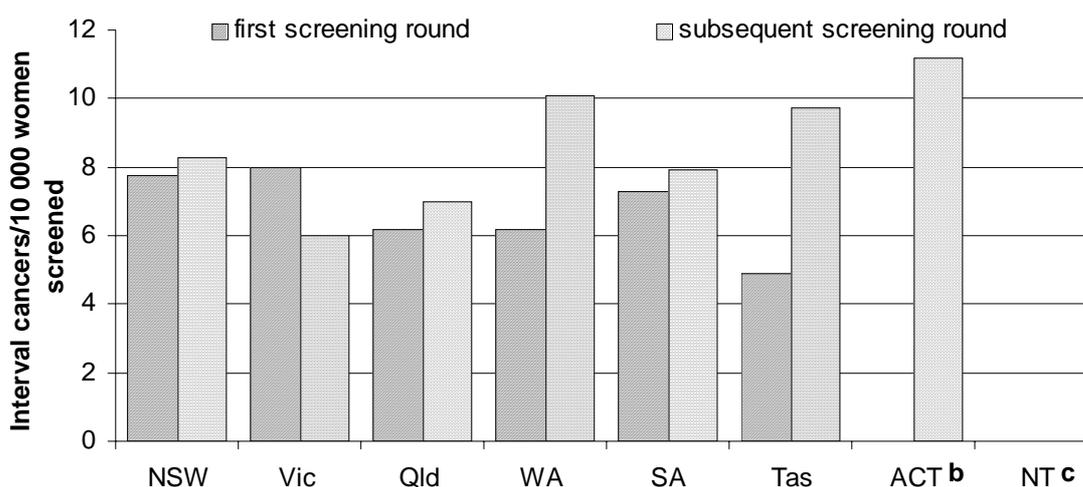
Interval cancer rate

An interval cancer is an invasive breast cancer diagnosed in the interval between a negative screening result and the next scheduled screening examination. The interval cancer rate provides an indication of both the sensitivity and the efficiency of breast cancer screening. A high rate may indicate that not all breast cancers were detected during screening.

There is a time lag in obtaining data for this indicator as BreastScreen Australia data must be matched with that of Cancer Registries. Hence, the latest data available are for 1997. More recent data are included in the attachment but are preliminary only (table 7A.15). As discussed in the Policy developments section, data this year are not stratified by symptom status and include both symptomatic and asymptomatic women.

In 1997 for women aged 50–69 years, during the 12 month period after the first screening round, interval cancer rates were highest in Victoria (8.0 per 10 000 women screened) and lowest in the ACT (zero per 10 000 women screened). During the 12 month period after the subsequent screening round, interval cancer rates were highest in the ACT (11.2) and lowest in Victoria (6.0) (figure 7.9).

Figure 7.9 Interval cancer rate, asymptomatic and symptomatic, women aged 50–69 years, 1997^a



^a Rates are expressed as number of invasive cancers per 10 000 women screened. ^b Rate for the first screening round for the ACT was zero. ^c NT data not available.

Source: State and Territory governments (unpublished); table 7A.14

Ratio of benign to malignant diagnostic open biopsies

As the emphasis of breast cancer screening is on detecting small malignant cancers, a low ratio of benign to malignant diagnostic open biopsies indicates effectiveness in detecting malignant cancers while minimising the need for invasive procedures.³ The ratio summarises the results for all women who underwent an open surgical procedure (biopsy) relating to their screening visit in the reference year. The benign

³ A breast biopsy is a procedure for obtaining a specimen of breast tissue for microscopic examination, to establish a diagnosis.

to malignant diagnostic open biopsy ratio expresses the number of benign open biopsies compared to all malignancies detected. The intent is to measure the ratio of women who had unnecessary surgery because a diagnosis was not obtained during the assessment process. It is a measure of the effectiveness of the assessment process in obtaining a diagnosis. The BreastScreen Australia National Accreditation Requirements stipulate a benign to malignant open surgical procedure ratio of less than 2:1 for first round screening and of 1:1 for subsequent screening rounds.

In 2000, the ratio of benign to malignant diagnostic open biopsies for women aged 50–69 years in:

- NSW for the first screening round was 0.68 and the subsequent round was 0.44;
- WA for the first screening round was 0.28 and the subsequent round was 0.17;
- SA for the first screening round was 0.19 and the subsequent round was 0.04;
- Tasmania for the first screening round was 0.80 and the subsequent round was 0.30; and
- the ACT for the first screening round was zero and the subsequent round was 0.50 (table 7A.15).

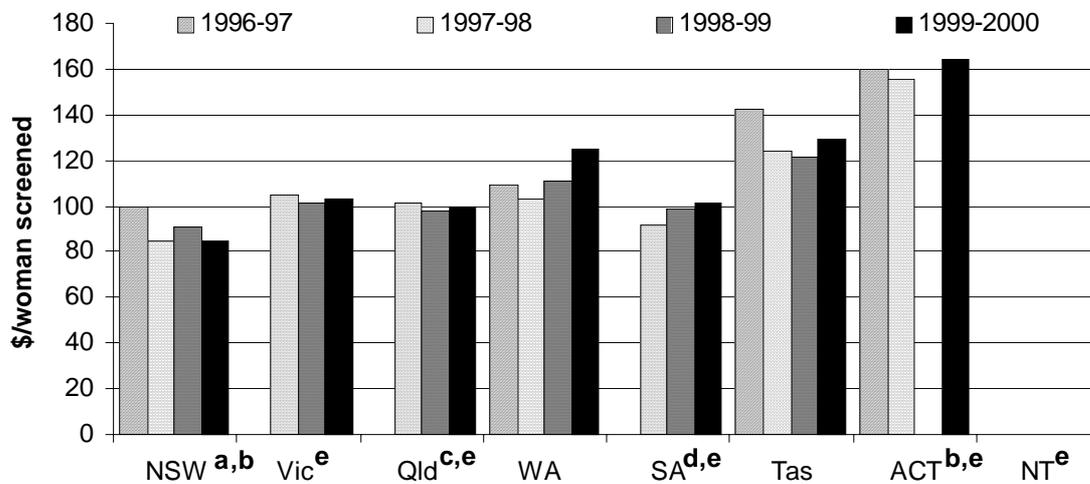
Data for 2000 were not available for Victoria, Queensland or the NT.

Cost per woman screened

The cost per woman screened is an efficiency indicator for the breast cancer screening program. It measures the total cost per woman of providing services including screening, assessment and management.

There are potential differences in the items included in the measures of cost (particularly in the treatment of depreciation and capital asset charges, and inclusion of subsidies). There may also be differences across jurisdictions in the scope of activities being costed. Care needs to be taken when making comparisons across jurisdictions. Estimates of costs in each jurisdiction are presented in figure 7.10. In 1999-2000, unit costs appeared to be highest in the ACT and lowest in NSW.

Figure 7.10 Cost per woman screened, BreastScreen Australia services



^a NSW data do not include subsidies. ^b NSW and the ACT were the only states to include a user cost of capital. ^c Qld data do not include depreciation. ^d SA data calculated on accrual not cash basis. ^e NT data not available. ACT data not available for 1998-99. Victorian, Queensland and SA data not available for 1996-97.

Source: State and Territory governments; table 7A.16

Intervention/treatment

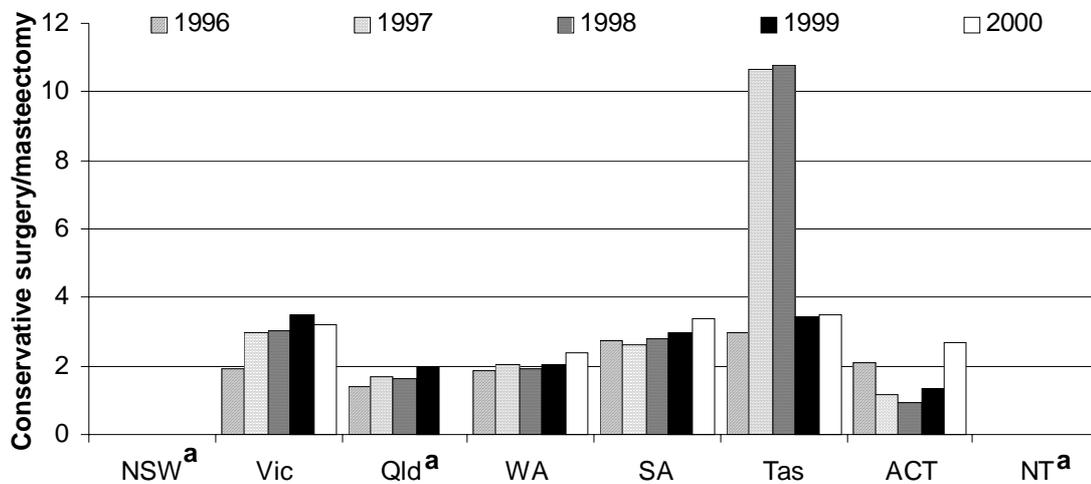
Ratio of conservative surgery to mastectomy

A high ratio of conservative surgery to mastectomy may reflect the early detection of breast cancer, as breast conserving surgery is more likely to be able to be carried out when cancers are detected at an early stage. Other factors, however, such as the judgment of surgeons as to the best treatment for the patient can also affect the type of surgery undertaken.

Data for this indicator are currently derived from BreastScreen Australia and hence represent only a portion of the total possible treatment information available. Further, BreastScreen Australia mainly diagnoses small cancers that can be treated conservatively, so at present, the data do not provide a good indication of general clinical practice relating to breast cancer. It is a priority for the Review to improve the data for this indicator in future.

Based on BreastScreen Australia data, in 2000, the ratio was highest in Tasmania (3.50:1) (figure 7.11). Data for 2000 for NSW, Qld and the NT were not available.

Figure 7.11 Ratio of conservative surgery to mastectomy



^a Data for NSW and NT, and for Queensland for 2000 not available.

Source: State and Territory governments; table 7A.17

Cost per separation by diagnosis related group (DRG)

The average cost per DRG is used as an indicator of efficiency. It describes the cost of care for admitted patients in public hospitals with selected breast cancer related conditions. Not all intervention strategies are reported and some of those reported cover treatment of a range of conditions, not all of which are related to breast cancer (for example, chemotherapy).

Table 7.5 provides a summary of costs for selected breast cancer DRGs. The average cost of major procedures for malignant breast conditions across Australia was \$4166 in 1999-2000. Minor procedures for malignant breast conditions cost on average \$2099 in Australia. Table 7A.18 also summarises the average length of stay in public hospitals associated with each DRG. It should be noted that the data are derived from a sample of hospitals in each jurisdiction that is not necessarily representative and that often comprises larger rather than smaller hospitals.

Table 7.5 Selected breast and other cancer AR-DRGs, public sector, population estimated, 1999-00 (dollars)^{a, b, c, d, e}

AR-DRGs	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust
J06A Major procedures for malignant breast conditions	4 098	4 538	3 990	4 428	3 446	3 604	3 805	5 868	4 166
J07A Minor procedures for malignant breast conditions	2 122	2 033	2 245	1 992	2 014	2 347	1 635	*	2 099
J10Z Skin, subcutaneous tissue and plastic breast procedures	1 811	1 616	1 391	2 021	1 793	1 755	1 994	2 696	1 690
J11Z Other skin, subcutaneous tissue and breast procedures	1 487	1 297	900	1 804	1 085	1 534	1 847	2 019	1 259
J62A Malignant breast disorders age>69 W CC	4 390	2 849	5 166	3 241	3 980	7 689	*	–	3 932
J62B Malignant breast disorders (age<70 W CC) or (age>69 W/O CC)	3 060	1 304	1 389	2 855	1 809	2 286	944	*	1 895
J62C Malignant breast disorders age<70 W/O CC	1 015	650	793	976	1 390	1 539	420	*	869
R63Z Chemotherapy	604	482	515	527	547	1 179	383	546	532

^a Average cost is affected by a number of factors, some of which are admission practices, sample size, remoteness and the type of hospitals contributing to the collection. Approximately 60 per cent of the separations in NSW are from tertiary referral hospitals, which have higher infrastructure and operational costs. For example, the large disparity between NSW and Victoria for J62B indicate practice differences or episode definition differences and not necessarily differences in efficiency. ^b Population estimates derived by National Hospital Cost Data Collection (NHDCDC) from NHDCDC sample data. Samples are not necessarily representative of all hospitals in each jurisdiction. ^c *=Asterisks have been included in the case of small numbers to protect confidentiality ^d W/O CC='without complications and comorbidities'. ^e W CC='with complications and comorbidities'.

– Nil or rounded to zero.

Source: DHAC, National Hospital Cost Data Collection, Round 4; table 7A.18.

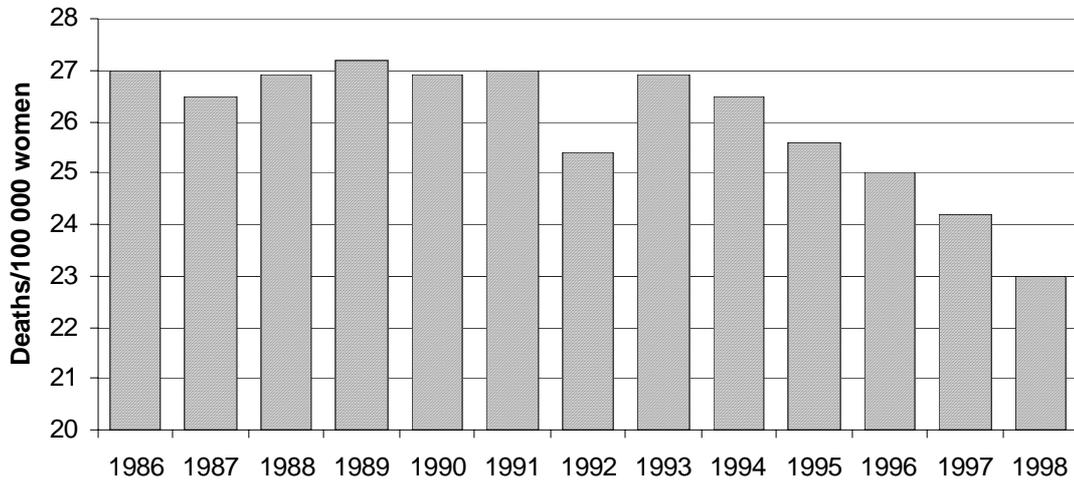
Overall performance

Mortality

Mortality rates indicate the effectiveness of both early detection and treatment services for breast cancer. Age standardised mortality rates are the most appropriate measure for looking at changes in mortality rates. The age standardised mortality rate has declined from a peak of 27.2 per 100 000 women in 1989 to 23.0 in 1998.

The decline appears to have been strong and consistent from 1994 onwards (figure 7.12).

Figure 7.12 Age standardised mortality rate, all ages^a

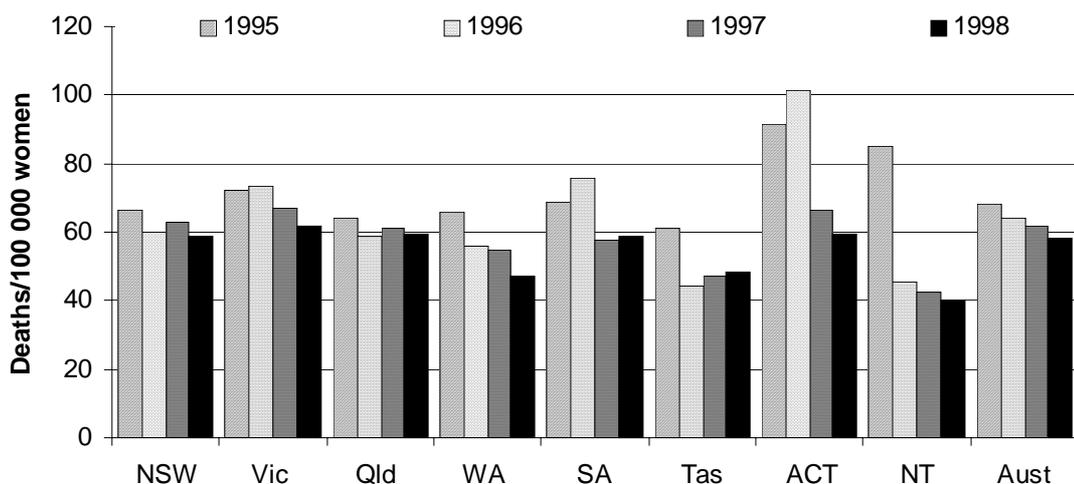


^a Age standardised to the Australian population at 30 June 1991.

Source: AIHW (2000b).

The mortality rate for Australian women aged 50–69 years between 1995 and 1998 was highest on average in the ACT and lowest on average in Tasmania (figure 7.13).

Figure 7.13 Mortality rate from breast cancer, women aged 50–69 years



Source: AIHW unpublished data; table 7A.20.

7.3 Mental health

Profile

Mental health relates to an individual's ability to negotiate the daily challenges and social interactions of life without experiencing undue emotional or behavioural incapacity (DHAC *et al.* 1999). Problems and disorders that interfere with this ability and diminish quality of life and productivity cover cognitive, emotional and behavioural disorders. Some of the major mental disorders perceived to be public health problems are schizophrenia, depression, anxiety disorders, dementia and substance use disorders (DHAC *et al.* 1999). Each of these disorders is unique in terms of its incidence across the lifespan, causal factors and treatments.

Mental disorders are a major cause of chronic disability. In 1996, mental disorders accounted for 1 per cent of years of life lost as a result of mortality, but were the leading cause of years of healthy life lost as a result of disability (nearly 30 per cent of the non-fatal burden of disease) (Mathers, Vos and Stevenson 1999). Most of this burden has been attributed to affective disorders (35 per cent of the calculated burden), anxiety disorders (24 per cent) and substance use disorders (20 per cent).

In 1995, the Commonwealth Department of Health and Family Services initiated the National Survey of Mental Health and Wellbeing, comprising:

- a survey of a nationally representative sample of 10 000 adults aged 18 and over focussing on common mental disorders;
- a survey of mental disorders among children and adolescents aged 4–17 years; and
- a study of low prevalence disorders.

The survey of adults (undertaken in 1997 by the Australian Bureau of Statistics (ABS)) suggested that almost one in five suffered from one or more mental disorders during the 12 months before the survey was conducted (ABS 1998). The Survey did not attempt to cover all mental disorders. Of the disorders that were covered, people were most likely to report anxiety disorders (54.5 per cent of those reporting symptoms of a mental disorder) followed by substance use disorders (43.7 per cent), and affective disorders (32.7 per cent) (table 7A.21).⁴ Females most

⁴ An anxiety disorder is represented by feelings of tension, distress or nervousness. Includes agoraphobia, social phobia, panic disorder, generalised anxiety disorder, obsessive-compulsive disorder and post traumatic stress disorder; an affective disorder is a mood disturbance that includes mania, hypomania and depression; substance use disorders are harmful use and or dependence on drugs (including sedatives, stimulants, marijuana and opioids) and or alcohol.

commonly experienced anxiety disorders. By contrast, males most commonly experienced substance abuse.

The survey found that — of those adults with the mental disorders covered — 38.0 per cent contacted a health service for their problem. General practitioners were the main mental health service providers, seeing 29.4 per cent of patients with a mental disorder (table 7A.22). Less than 1 per cent of people with the types of mental disorder covered by the ABS survey were admitted to hospital (ABS 1998). It should be noted, however, that most government services provide care for disorders other than those included in the ABS survey. In particular, substance use disorders are generally not treated by Australian mental health services except where they co-occur with a primary mental disorder. In most jurisdictions, alcohol and drug problems are treated separately.

Results from the child and adolescent component of the National Survey of Mental Health and Wellbeing were released in October 2000. The survey was undertaken by the University of Adelaide in consultation with the National Collaborating Centres for the Survey of Mental Health of Young People. It found that 14 per cent of Australian children and adolescents have mental health problems. This is similar to rates identified in earlier adult surveys and in international surveys. The survey also found that young people with mental health problems are most likely to seek help from family doctors, school based counsellors and paediatricians, with only one out of every four accessing specialist services.

The University of Western Australia coordinated the epidemiological and clinical study of low-prevalence disorders (such as schizophrenia and mood disorders with psychotic features). The study found that, in urban areas in Australia, four to seven adults per 1000 have psychotic disorders — depending on the catchment area. People with schizophrenia and schizoaffective disorders accounted for over 60 per cent of people with disorders covered by the study.

Some common terms used in mental health management are outlined in box 7.4.

Survey participants in some cases reported more than one disorder, so percentages do not add to 100.

Box 7.4 **Some common terms relating to mental health**

acute services: specialist psychiatric care for people who present 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 this treatment effort is focused on symptom reduction with a reasonable expectation of substantial improvement. In general, acute psychiatric services provide short term treatment. Acute services may be focused on assisting people who have had no prior contact or previous psychiatric history, or individuals with a continuing psychiatric disorder for whom there has been an acute exacerbation of symptoms.

ambulatory care services: mental health services dedicated to the assessment, treatment, rehabilitation or care of non-admitted inpatients, 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.

community residential services: services that provide beds in the community, staffed by mental health professionals. These services are designed for people with significant disability and dependency needs and are aimed at replacing many of the functions traditionally performed by long stay psychiatric hospitals. They include residential services established as specialised psychogeriatric nursing homes for older people with mental illness, or dementia with severe behavioural disturbance, as well as community care units and hostels.⁵

inpatient services: psychiatric hospitals or specialist psychiatric units located within public (non-psychiatric) hospitals.

mental disorder: a diagnosable illness that significantly interferes with an individual's cognitive, emotional 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, optimal development and use of mental abilities (cognitive, affective and relational) and the achievement of individual and collective goals consistent with justice.

mental illness prevention: interventions that occur before the initial onset of a disorder.

mental health problem: a disruption in the interactions between the individual, the group and the environment, producing a diminished state of mental health.

(Continued next page)

⁵ Note that this definition has changed from last year's Report. Data for community residential services in the 2001 *Report on Government Services* included only those services staffed on a 24 hour basis. For this Report, the definition includes residential services employing on-site staff for at least some part of the day.

Box 7.4 (Continued)

mental health promotion: focuses on improving environments (social, physical, economic) that affect mental health and on enhancing the coping capacity of communities as well as individuals.

non-government organisations: not-for-profit services funded by governments to provide support services for people with a psychiatric disability arising from a mental illness. These services include a wide range of accommodation, rehabilitation, recreational, social support and advocacy programs.

prevalence: the number of cases of a disease present in a population at a given time (point prevalence) or during a given period (period prevalence).

specialised care service: A facility or unit dedicated to the treatment, rehabilitation or community support of people with a mental disorder or psychiatric illness or disability.

Roles and responsibilities

Specialist mental health care providers include a range of government and non-government service providers offering promotion, prevention, treatment and management, and rehabilitation services. Community mental health facilities, psychiatrists, clinical psychologists, psychotherapists, mental health clinicians in private practice, counsellors, public hospitals with specialist psychiatric units and stand-alone psychiatric hospitals all provide specialist mental health care.

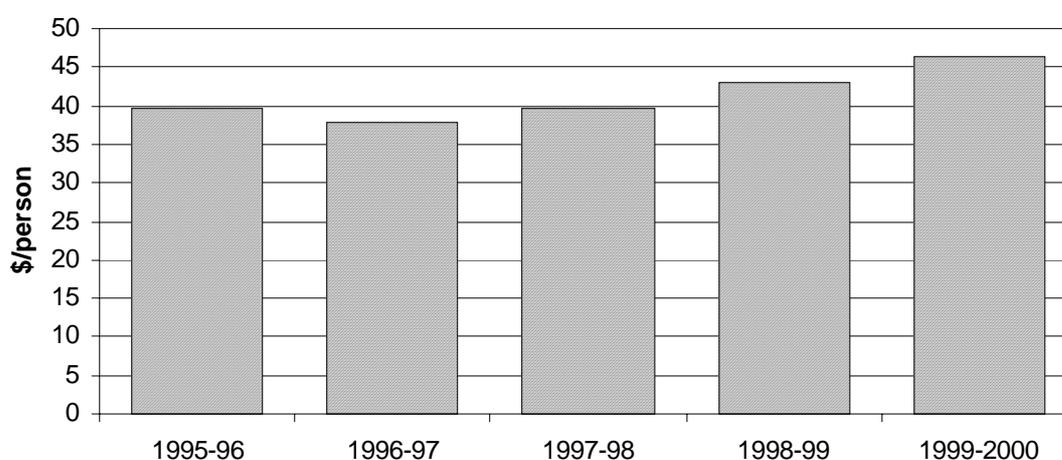
In addition, a number of health services provide care to mental health patients in a ‘non-specialist’ health setting — for example, GPs, public hospitals’ emergency departments and outpatients, public hospitals’ general wards (as opposed to specialist psychiatric wards) and nursing homes. The performance of these non-specialist service providers is examined more closely in chapter 5 (Public hospitals), chapter 6 (General practice) and chapter 12 (Aged care services).

State and Territory governments are the primary sources of both funding and service delivery for mental health services. The Commonwealth directly funds some health services for people with mental disorders through the Medicare Benefits Schedule, Pharmaceutical Benefits Scheme and the Department of Veterans’ Affairs programs. In addition, the Commonwealth has provided grants to State and Territory governments for mental health service reform under the Australian Health Care Agreements. The Commonwealth also funds other services for people with mental disorders, such as emergency relief, employment, accommodation, income support, rehabilitation and other disability services. These latter services are not discussed in this Report.

Funding

Public real recurrent spending of around \$2.3 billion was allocated to mental health services in 1998-99.⁶ State and Territory governments made the largest contribution — \$1.5 billion or 65.2 per cent. The Commonwealth Government spent \$809 million. Real Commonwealth spending per person in 1998-1999 was \$43, increasing to \$46 in 1999-2000 (figure 7.14).

Figure 7.14 **Commonwealth recurrent spending per person, (1999-2000 dollars)^a**



^a Preliminary data, final validation ongoing prior to publication in National Mental Health Report 2001.

Source: DHAC (unpublished); table 7A.23.

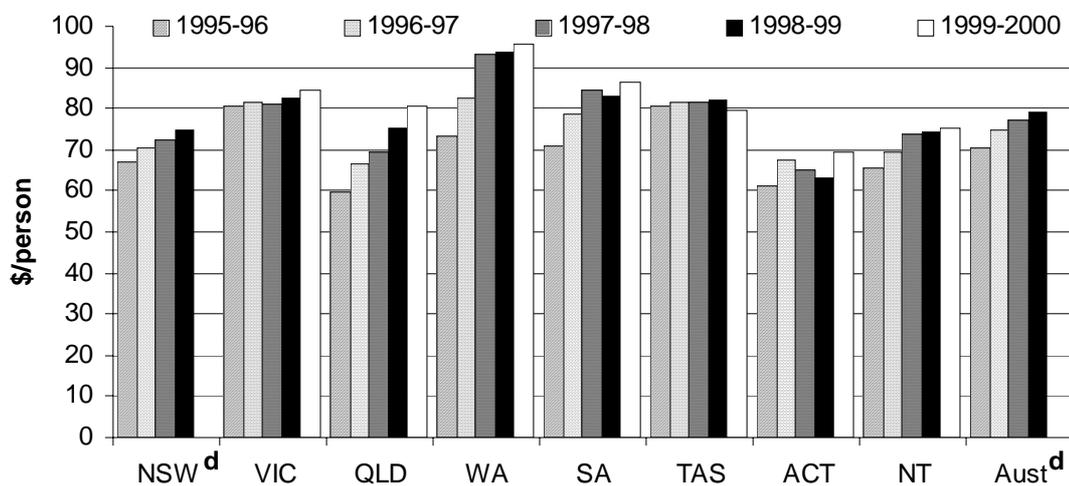
The largest component of Commonwealth expenditure on mental health services in 1999-2000 was expenditure under the Pharmaceutical Benefits Schedule for psychiatric medication (39.5 per cent). Medicare Benefits Schedule payments for consultant psychiatrists accounted for a further 21.8 per cent of Commonwealth expenditure on mental health services, followed by expenditure for mental health care by GPs (16.9 per cent). The Department of Veterans' Affairs (9.7 per cent), the National Mental Health Strategy (NMHS) (7.1 per cent), private hospital insurance premium rebates, research and other time limited program and project support accounted for the residual (table 7A.23).

Real State and Territory government spending per person has increased over time (figure 7.15). In 1999-2000, WA spent the most (\$96 per person) and the ACT spent the least (\$69). Data for 1999-2000 for NSW were not available for this Report. It

⁶ Real 1998-99 data are reported (1999-2000 prices) as NSW data for 1999-2000 were not available for this Report. A total for 1999-2000 is therefore not available.

should be noted that, while Commonwealth funding provided under the NMHS and through the Department of Veterans' Affairs has been excluded from the estimates presented in figure 7.15, revenue from other sources (including patient fees and reimbursement by third party compensation insurers) and 'other Commonwealth funds' are included. State and Territory government expenditure estimates excluding revenue from other sources and other Commonwealth funds are presented in the attachment (table 7A.24). They are not presented here as the revenue categories are subject to minimal validation and may be inconsistently treated across jurisdictions. In addition, it is not possible to extract these amounts uniformly across time.

Figure 7.15 **State and Territory government recurrent spending per person (1999-2000 dollars)^{a, b, c}**

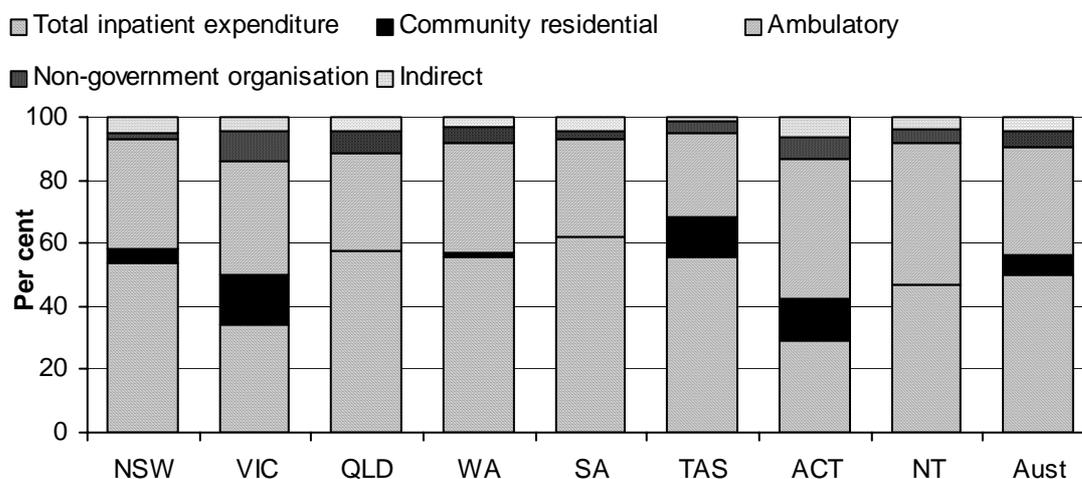


^a Preliminary data, final validation ongoing prior to publication in National Mental Health Report 2001.
^b Estimates of State and Territory government spending include revenue from other sources (including patient fees and reimbursement by third party compensation insurers), and 'other Commonwealth funds' but exclude Commonwealth funding provided under the NMHS Funds and through the Department of Veterans' Affairs.
^c Depreciation excluded for all years. ^d Data for 1999-2000 for NSW (and therefore Australia) were not available for this Report.

Source: DHAC, National Survey of Mental Health Services Database, (unpublished); table 7A.24.

Figure 7.16 shows how Commonwealth, State and Territory government spending was distributed across the range of mental health services in 1998-1999. Data for 1999-2000 for NSW were not available for this Report. Across Australia, 50.1 per cent of recurrent expenditure was allocated to hospital based services (including both psychiatric hospitals and psychiatric units in public (non-psychiatric) hospitals) — highest in SA (61.9 per cent) and lowest in the ACT (29.2 per cent). Ambulatory services comprised 34.1 per cent of recurrent expenditure on mental health services overall — highest in the NT (45.0 per cent) and lowest in Tasmania (27.0 per cent).

Figure 7.16 Recurrent expenditure by service category, 1998-1999^{a, b, c}



^a Preliminary data, final validation ongoing prior to publication in National Mental Health Report 2001.

^b Includes all spending regardless of source of funds. ^c Depreciation excluded.

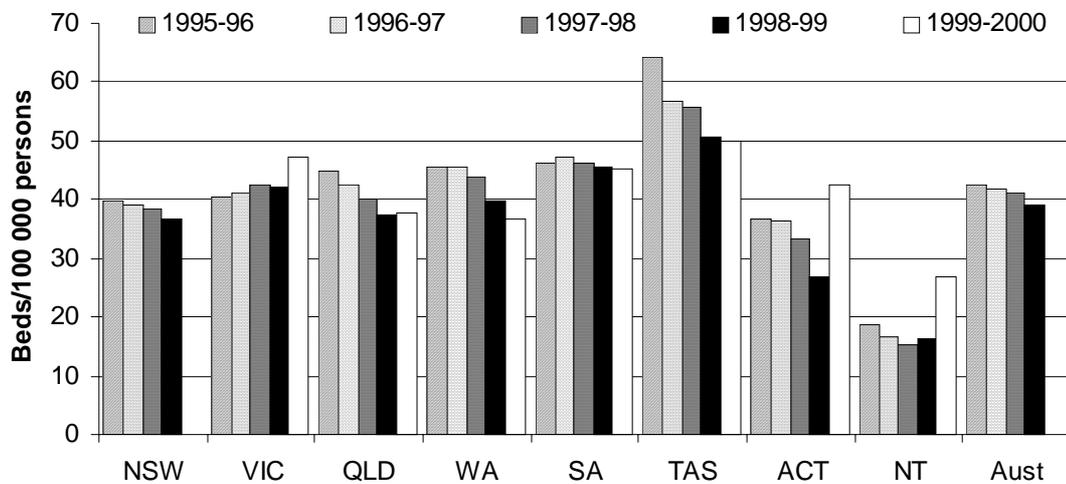
Source: DHAC, National Survey of Mental Health Services Database, (unpublished); table 7A.26.

Size and scope of sector

Available beds

Available beds are those that are immediately available for use by patients as required. Available beds per 100 000 people for public hospitals and community residential facilities combined are presented in figure 7.17. It should be noted that there was a definitional change for community residential facilities in 1999-2000 causing a break in the series. In 1998-99, Tasmania had the highest number of beds per 100 000 people (50.7) and the NT had the lowest (16.2). Between 1996-97 and 1998-99, the number of available beds per 100 000 people across psychiatric hospitals, public (non-psychiatric) hospitals and community residential facilities has fallen. In 1999-2000, the number of available beds per 100 000 people was highest in Tasmania (50.0) and lowest in the NT (26.8). Data for 1999-2000 for NSW were not available for this Report.

Figure 7.17 Available mental health beds^{a, b, c, d}



a Preliminary data, final validation ongoing prior to publication in National Mental Health Report 2001. **b** Available beds as at 30 June. **c** Includes beds in public hospitals and publicly funded 24 hour staffed community residential units. **d** Prior to 1999-2000, community residential was defined as 24 hour staffed residential units in community settings (external to the campus of a public hospital or psychiatric institution) and funded by government. From 1999-2000, the definition has been broadened to incorporate all staffed community-based units, regardless of the number of hours that staff are present.

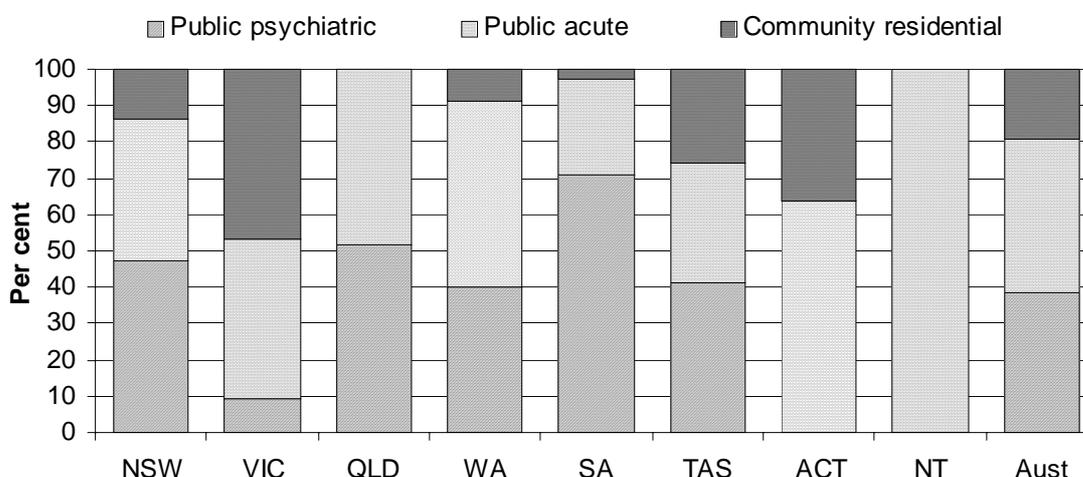
Source: DHAC, National Survey of Mental Health Services Database, (unpublished); table 7A.27.

Available beds by service category are presented for 1998-99 in figure 7.18 as NSW data for 1999-2000 were not available for this Report. These data show the differences in service mix across States and Territories. South Australia had the highest proportion of beds in public psychiatric hospitals (71.0 per cent) and Victoria the lowest (9.6 per cent). The ACT and the NT do not have public psychiatric hospitals. Victoria had the highest proportion of beds in community residential services staffed on a 24 hour basis (46.5 per cent) and SA the lowest (3.0 per cent). Queensland and the NT did not have these types of community residential services in 1999 (although in Queensland's case this is subject to discussion of definitions – see table 7.8).

Staff

In 2000, WA had the most full time equivalent staff per 100 000 people in specialist mental health services (126.7) and the NT had the least staff per 100 000 people (85.1) (figure 7.19). Data for 1999-2000 for NSW were not available for this Report.

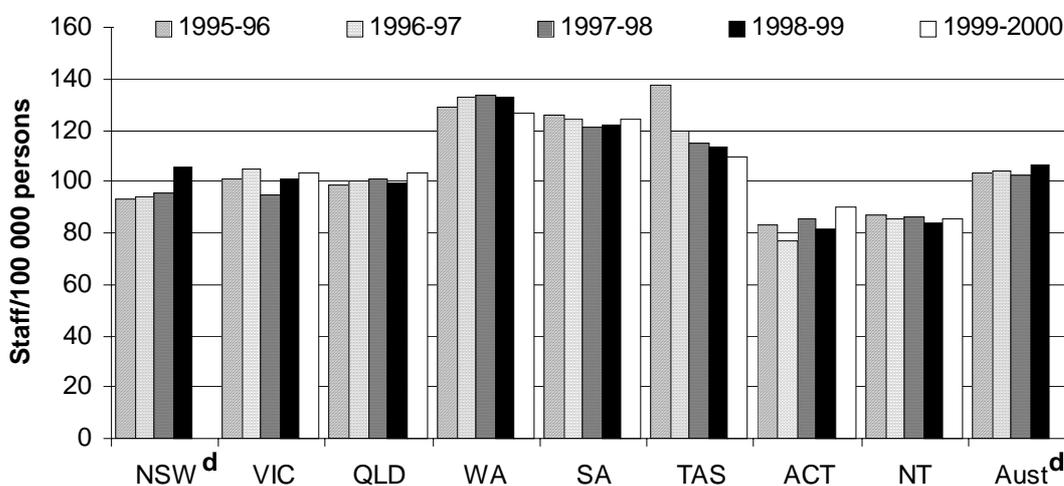
Figure 7.18 Available mental health beds by service category, 1998-99^{a, b, c}



^a Preliminary data, final validation ongoing prior to publication in National Mental Health Report 2001. ^b Available beds as at 30 June 1999. ^c Community residential are 24 hour staffed units funded by governments.

Source: DHAC, National Survey of Mental Health Services Database, (unpublished); table 7A.27.

Figure 7.19 Full time equivalent staff per 100 000 persons^{a, b, c}



^a Preliminary data, final validation ongoing prior to publication in National Mental Health Report 2001. ^b Full time equivalent includes all health professional and non direct-care occupational categories. ^c Prior to 1999-2000, community residential was defined as 24 hour staffed residential units in community settings (external to the campus of a public hospital or psychiatric institution) and funded by government. From 1999-2000, the definition has been broadened to incorporate all staffed community-based units, regardless of the number of hours that staff are present. The impact of this is to transfer a significant number of staff previously included but not enumerated under the NGO category. ^d Data for 1999-2000 for NSW (and therefore Australia) were not available for this Report.

Source: DHAC, National Survey of Mental Health Services Database, (unpublished); table 7A.28.

Nursing staff comprise the largest full time equivalent component of health care professionals employed in mental health services. Across Australia in 1998-99, there were 53.7 nurses per 100 000 people working in specialised mental health services, compared with 17.8 allied health care staff per 100 000 persons (occupational therapists, social workers, psychologists and other allied health staff) and 8.9 medical staff per 100 000 persons (psychiatrists and other medical officers) (table 7A.29).

Services provided

Estimating activity across the specialised mental health services sector is problematic. Data for 'patient days' are provided here (figure 7.20) but show only part of the picture.⁷ Hospital inpatient days and community residential patient days are included in figure 7.20, but other types of community services are not covered. Data outlining community mental health care patient contacts are limited, although collection of these data commenced in July 2000 as part of the National Minimum Data Set (NMDS). While data are presented to 1999-2000, it is important to note that there was a definitional change for community residential facilities in 1999-2000 causing a break in the time series. In 1999-2000, patient days per 1000 people were highest in Tasmania (149.5) and lowest in the NT (79.7). Data for 1999-2000 for NSW were not available for this Report.

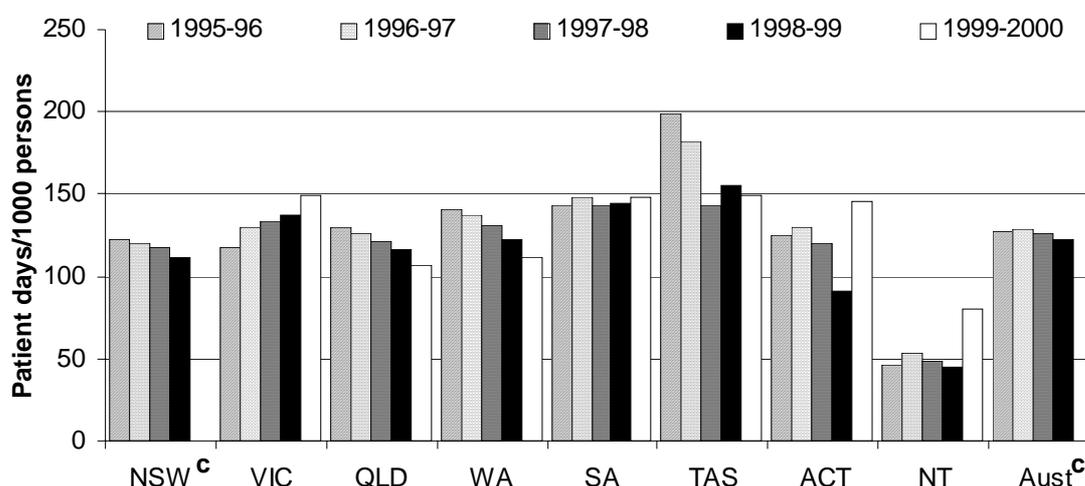
In public psychiatric hospitals in 1998-99, there were 19 326 acute separations with specialised psychiatric care and 1 259 511 patient days (AIHW 2001a). In public (non-psychiatric) hospitals in that year, there were 85 055 acute separations with specialised psychiatric care and 924 586 patient days related to mental disorders. Schizophrenia disorders accounted for a marked proportion of patient days related to mental disorders in public hospitals (49.9 per cent of patient days related to mental disorders in public psychiatric hospitals and 36.6 per cent in public [non-psychiatric] hospitals and in 1998-99) (table 7A.31).

There is a very limited amount of data available on specialised psychiatric care provided by hospitals to Indigenous patients. Comparisons are difficult because data on Indigenous status are incomplete and there may be differences in the use of hospital services relative to other health services by Indigenous status. In 1998-99, however, separations involving at least one day of specialised psychiatric care per 1000 people for Indigenous patients were relatively similar to the rates for the total

⁷ Under the National Survey of Mental health Services, patient days refer to all days or part days that the patient was in hospital during the period, regardless of the original date of admission or discharge.

population, although patient days per 1000 Indigenous people and psychiatric care days per 1000 Indigenous people appeared markedly higher (table 7.6).

Figure 7.20 Mental health patient days^{a, b}



^a Preliminary data, final validation ongoing prior to publication in National Mental Health Report 2001. ^b Patient days included for public psychiatric hospitals, public (non-psychiatric) hospitals and 24 hour staffed community residential care. ^c Data for 1999-2000 for NSW (and therefore Australia) were not available for this Report.

Source: DHAC, National Survey of Mental Health Services Database, (unpublished); table 7A.30.

Table 7.6 Specialised psychiatric care by Indigenous status, Australia 1998-99^{a, b}

	Separations per 1000 ^c	Patient days per 1 000 people ^d	Psychiatric care days per 1000 people ^c	Average length of stay (overnight)	Psychiatric care days per overnight separation
Indigenous people	9.0	221.2	210.7	24.3	23.1
Total population	8.9	136.5	115.4	25.8	21.7

^a The completeness of data on Indigenous status varies, hence these data should be used with care. ^b Specialised psychiatric care refers to separations in which at least one day of specialised psychiatric care was received. ^c Rates are indirectly age-standardised based on December 1998 Estimated Resident Population and the December 1998 Indigenous population projections. ^d Does not include psychiatric care days from WA public (non-psychiatric) or private hospitals. The total is therefore an underestimate of total psychiatric care days.

Source: Australian Institute of Health and Welfare 2001a; table 7A.32.

Policy developments

The NMHS (1993–2003) — agreed by Commonwealth, State and Territory health ministers — places the locus of care in the community, advocating a fundamental shift in the service balance away from the historical reliance on separate psychiatric hospitals to the development of local, comprehensive mental health service systems. The aim is to provide integrated services that emphasise continuity of care, both over time and across service boundaries, mainstreamed with the health system as a whole. While the Strategy calls for a change in the balance of services, it does not prescribe a specific service mix. Instead, each State and Territory (and area/region where required) is to develop a plan covering the range of mental health services to be made available. Hence, while community based care has been expanding (only a small proportion of people with mental disorders now spend extended periods in psychiatric hospitals; most are cared for in the community), differences exist across States and Territories in the balance of inpatient services and of community care across ambulatory, residential and non-government services.

The NMHS consists of several components: the *National Mental Health Statement of Rights and Responsibilities*, the *National Mental Health Policy*, two national mental health plans, and the Medicare Agreements (subsequently the Australian Health Care Agreements). The aims of the Policy are to:

- promote the mental health of the Australian community and, where possible, prevent the development of mental health problems and mental disorders;
- reduce the impact of mental disorders on individuals, families and the community; and
- assure the rights of people with mental disorders.

The First Plan (1992 to 1998) outlined agreed strategies for implementing the Policy. The Second Plan (1998 to 2003) maintains the same policy objectives and targets three additional themes: quality and effectiveness, promotion and prevention, and partnerships in service reform and delivery. Governments have agreed to develop performance indicators and targets around these themes and to improve information structures to support data collection to assist reporting.

While some data in this Report flow from these new information structures, other data developments are likely to impact on future reports and are outlined in the Future directions section (section 7.4).

Framework of performance indicators

The distinction between prevention and intervention is more difficult in the case of mental illness. Preventing the onset of mental illness is challenging, primarily because individual disorders have many origins. Most efforts have been directed at treating mental illness when it occurs and, in particular, at determining the most appropriate setting for providing treatment. The mental illness indicators in this Report focus on reforms to service delivery introduced under the first National Mental Health Plan. However, the Second Plan places emphasis on promoting mental health and preventing mental illness. The Mental Health Promotion and Prevention National Action Plan has been drawn up specifically to meet the prevention and promotion priorities and outcomes outlined in the second plan. The performance indicator framework will be redeveloped to reflect these components of mental illness management in future reports.

The framework of performance indicators for mental health services builds on government objectives for mental health service delivery (box 7.5) as encompassed in the NMHS. The framework reports on the effectiveness (in terms of quality, appropriateness, access and outcomes) and efficiency (in terms of unit cost) of mental health services (figure 7.21). It covers a number of service delivery types (institutional and community based services) and indicators of system-wide performance. Improving the framework is a priority for the Review and the Australian Health Ministers' Advisory Council National Mental Health Working Group.

The prevalence of mental disorders in the general population and the mortality rate from suicide (both indicators of outcomes of mental health services) reflect two goals of the NMHS — to promote the mental health of the Australian community, and where possible, to prevent the development of mental health problems. The quality of life indicator, which has still to be developed, provides some information on the ability of mental health services to reduce the effect of mental illness on individuals, families and the community. It is important to note that these outcome indicators may be influenced by a range of factors in addition to mental health care services; for example, social and disability support, education and employment are all likely to have an effect on the prevalence of mental illness and the number of deaths from suicide.

Box 7.5 Objectives for mental health service delivery

Key objectives include to:

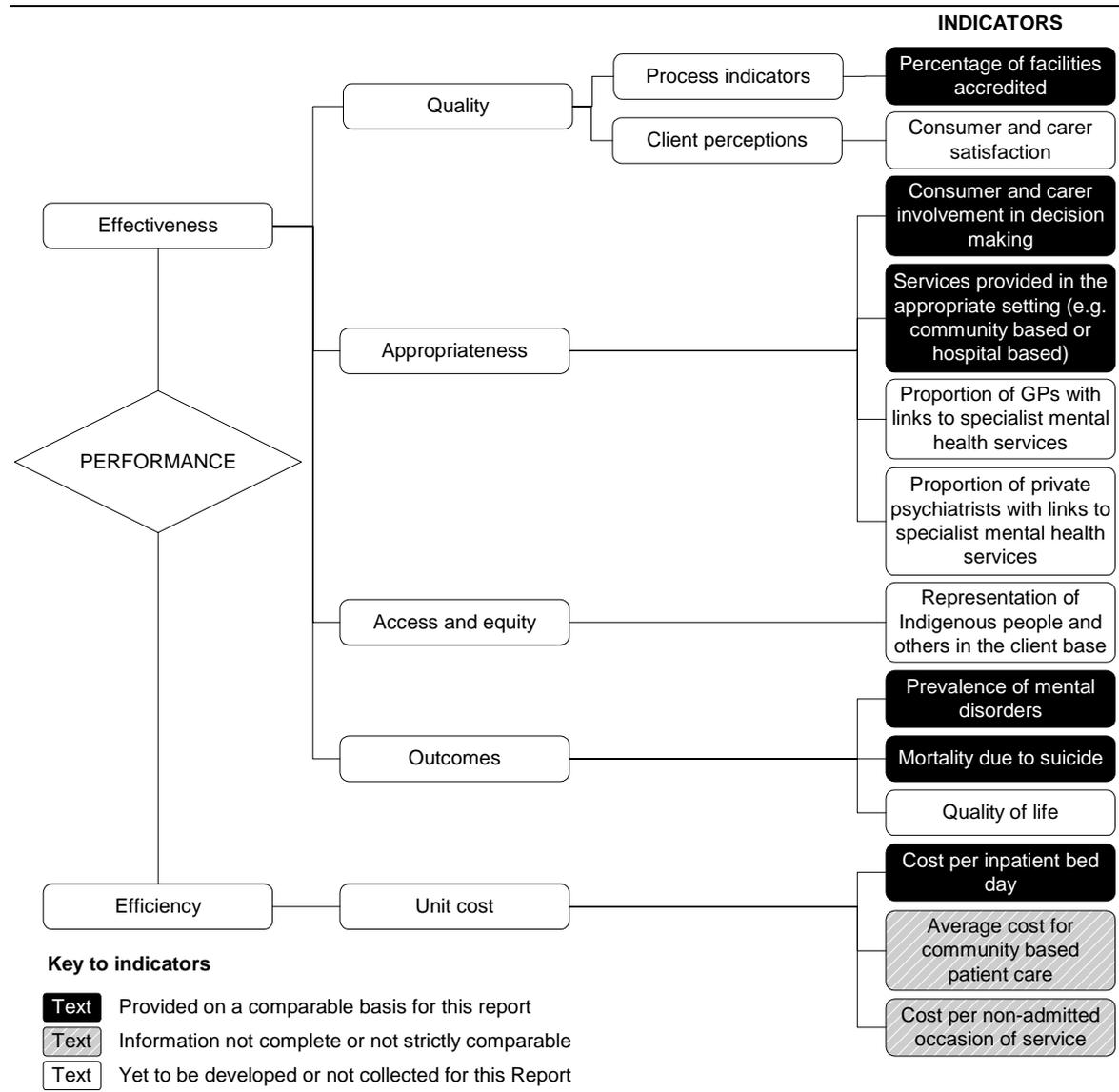
- improve the effectiveness and quality of service delivery and outcomes;
- promote, where appropriate, community awareness of mental health problems;
- prevent, where possible, the development of mental health problems and mental disorders;
- undertake, where appropriate, early intervention of mental health problems and mental disorders;
- reduce, where possible, the impact of mental disorders on individuals, families and the community;
- assure the rights of persons with mental disorders; and
- encourage partnerships among service providers and between service providers and the community.

Governments also aim to provide services in an equitable and efficient manner.

The proportion of facilities delivering mental health services to people with a mental health problem that are accredited is used as a process indicator of quality. Consumer and carer involvement in decision making is an appropriateness indicator that reflects the NMHS's aim to assure the rights of people with mental disorders, and to focus on improving the outcomes for consumers.

A number of other effectiveness indicators are included in the framework. For example, the extent to which mental health services are offered as part of mainstream health care services, consumer and carer satisfaction and access and equity (the representation in the client base of special needs groups, such as Indigenous people and those from culturally and linguistically diverse backgrounds, and people in rural and remote areas). The efficiency of mental health services is indicated by the cost per bed day for inpatient services and the cost per non-admitted occasion of service for outpatient and community based services.

Figure 7.21 Performance indicators for mental health management



Key performance indicator results

Quality

Percentage of facilities accredited

The percentage of facilities that have been accredited is used as a process indicator of quality. Reporting for this indicator is significantly improved this year and reflects accreditation against the National Standards for Mental Health Services. All jurisdictions have indicated an intent to formally commence external review against the National Standards for Mental Health Services in all specialist public mental

health services by June 2003. At this point in time, therefore, it cannot be concluded that services not yet accredited are necessarily of poorer quality.

External accreditation agencies, such as the Australian Council on Healthcare Standards, undertake accreditation processes in relation to a parent health organisation (for example, a hospital) which may cover a number of specialist services, including mental health services. Accreditation of a parent organisation does not currently require a mental health service to be separately assessed against the National Standards for Mental Health Services. Assessment against the Mental Health Standards must be requested and involves a separate review process. Data reported this year reflect the percentage of specialised public mental health services that have participated in or are currently participating in an external review by an external accreditation agency, against the Mental Health Standards. Reviews may take place in conjunction with, or separately to, overall accreditation of a parent organisation. Review against the Mental Health Standards will, in some cases and in some jurisdictions, be delayed until an appropriate point is reached within the overarching accreditation cycle (for example, midterm review). An accreditation model is yet to be developed for non-government organisations.

In 2001, reviews were completed in all ACT specialist mental health organisations, and no reviews were completed in Victoria (table 7.7).

Table 7.7 Specialised public mental health services reviewed against the National Standards for Mental Health Services (per cent)^a

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
2000									
Review commenced	29	–	96	–	30	39	100	–	33
Review completed	9	–	25	–	–	3	81	–	9
2001									
Review commenced	55	–	100	11	99	52	100	100	49
Review completed	15	–	39	–	16	3	100	–	16

^a "Review commenced" means the percentage of specialised public mental health services that have formally registered for review against the National Standards for Mental Health Services by an external accreditation agency; "Review completed" means the percentage of specialised public mental health services that have formally completed review against the National Standards for Mental Health Services by an external accreditation agency. – Nil or rounded to zero.

Source: DHAC (unpublished); table 7A.33.

Appropriateness

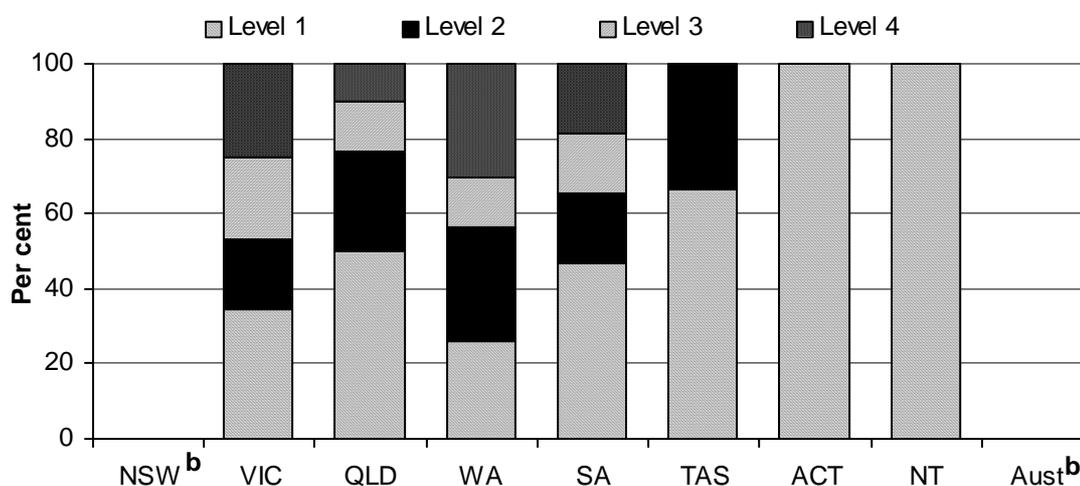
Consumer and carer participation in decision making

An indicator of appropriateness is consumer and carer participation in decision making. Public sector mental health service organisations are asked each year to describe the arrangements provided to allow consumers and carers to contribute to local service planning and delivery. Responses are grouped into four categories:

- level 1 — appointment of a person to represent the interests of consumers and carers on the organisation management committee or a specific consumer and carer advisory group to advise on all aspects of service delivery;
- level 2 — a specific consumer and carer advisory group to advise on some aspects of service delivery;
- level 3 — participation of consumers and carers in broadly based committees; and
- level 4 — other/no arrangements.

In 1999–2000, the ACT and the NT had the highest proportion of organisations with a level 1 rating (100 per cent) (figure 7.22). (The ACT data are for three organisations and the NT are for seven.) Western Australia had the highest proportion of organisations reporting no consumer and carer involvement in decision making (level 4) (30 per cent of 23 organisations). Data for 1999–2000 for NSW were not available for this Report.

Figure 7.22 Organisations with consumer and carer participation in decision making, 2000^a



^a Preliminary data, final validation ongoing prior to publication in National Mental Health Report 2001. ^b Data for 1999-2000 for NSW (and therefore Australia) were not available for this Report.

Source: DHAC, National Survey of Mental Health Services Database, (unpublished); table 7A.34.

Services provided in the appropriate setting

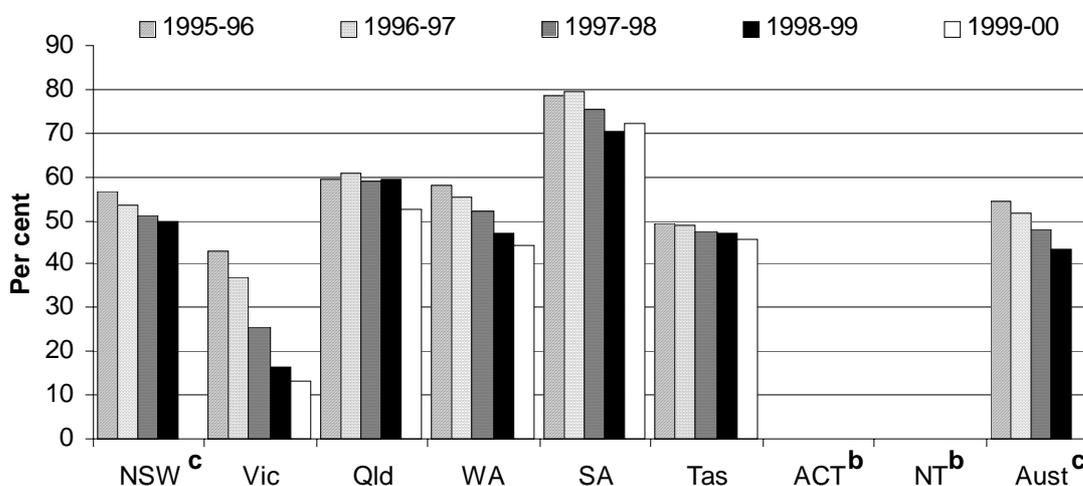
The NMHS advocates the development of local, comprehensive mental health service systems. The services must be capable of responding to the individual needs of people with mental disorders and of providing continuity of care, so that consumers can move between services as their needs change. Under the directions set by the Strategy, structural reform of mental health services has resulted in:

- reduced reliance on stand-alone psychiatric hospitals;
- expanded delivery of community based care integrated with inpatient care; and
- mental health services being mainstreamed with other components of health care.

By encouraging treatment of patients in community settings and public (non-psychiatric) hospitals rather than in stand-alone psychiatric hospitals — that is, to substitute the service settings — more appropriate treatment options can be provided.

Figure 7.23 shows the proportion of recurrent expenditure on psychiatric hospitals, as a proportion of spending on inpatient services. (As noted earlier, the ACT and the NT have no psychiatric hospitals.) In 1999-2000, the proportion was highest in SA (72.0 per cent) and lowest in Victoria (13.3 per cent). Data for 1999-2000 for NSW were not available for this Report.

Figure 7.23 Recurrent expenditure on psychiatric hospitals as a proportion of recurrent spending on inpatient services^a



^a Preliminary data, final validation ongoing prior to publication in National Mental Health Report 2001. ^b The ACT and the NT do not have public psychiatric hospitals. ^c Data for 1999-2000 for NSW (and therefore Australia) were not available for this Report.

Source: DHAC, National Survey of Mental Health Services Database, (unpublished); table 7A.35.

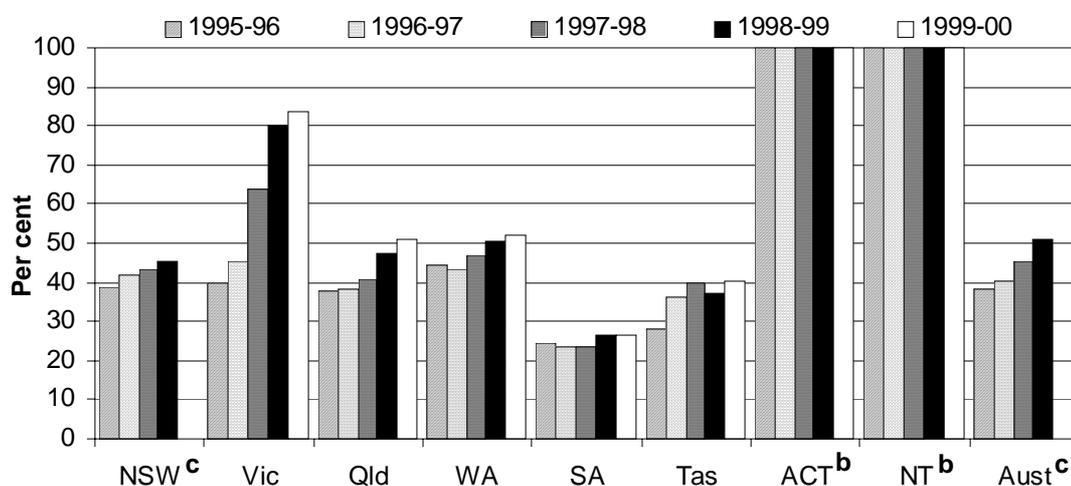
Similarly, figure 7.24 shows that Australia-wide, mental health bed days in general public hospitals as a proportion of all inpatient bed days has increased. Again, it should be noted that the ACT and the NT do not have psychiatric hospitals. In 1999-2000, aside from the Territories, the highest proportion of bed days in public (non-psychiatric) hospitals was in Victoria (83.9 per cent) and the lowest in SA (26.7 per cent). Data for 1999-2000 for NSW were not available for this Report.

Outcomes

Prevalence of mental disorders

Outcome indicators for mental health management include the prevalence of mental illness in the community and deaths from suicide among adults. The most recent national data on prevalence of mental disorders among adults is provided by the ABS (1998) Mental Health and Wellbeing Survey discussed earlier and in the 2001 Report. Data from this Survey are presented by jurisdiction in the attachment table 7A.36 and by age and geographic location at tables 7A.37 and 7A.38. As noted previously, the Survey did not cover all mental disorders.

Figure 7.24 Patient days in public (non-psychiatric) hospitals as a proportion of total inpatient bed days^a



^a Preliminary data, final validation ongoing prior to publication in National Mental Health Report 2001. ^b The ACT and the NT do not have public psychiatric hospitals. ^c Data for 1999-2000 for NSW and therefore Australia were not available for this Report.

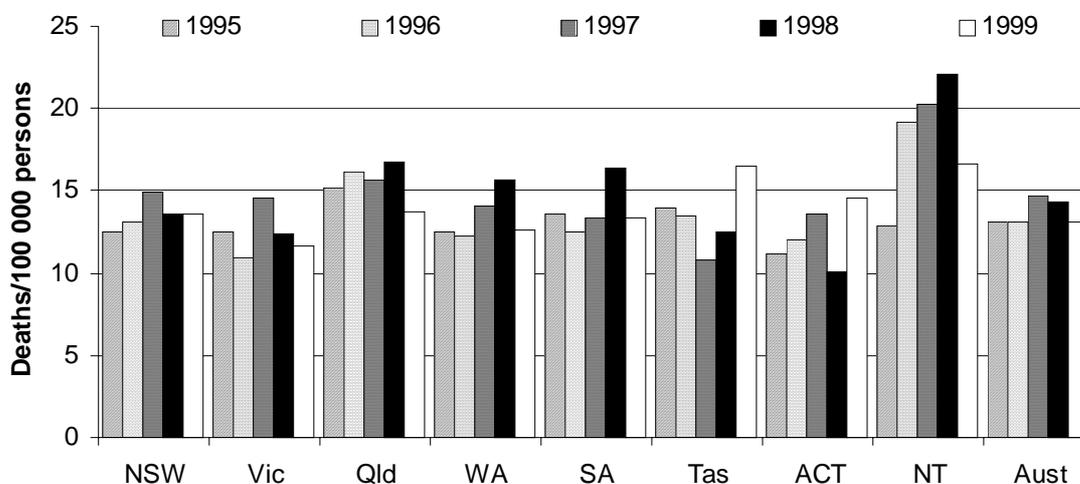
Source: DHAC, National Survey of Mental Health Services Database, (unpublished); table 7A.35.

There are no government plans at this point to undertake another stand-alone mental health survey estimating the prevalence of mental disorders. A mental health component, however, will be included in the periodic general health surveys conducted by the ABS. Separate data for NSW (1996) and SA (1997) are available in the attachment (tables 7A.50 and 7A.51). The NSW data are broader than the ABS data, but are no more recent.

Mortality due to suicide

Evidence indicates that people with a mental disorder are at a higher risk of suicide than the general population. Nearly 2500 deaths from suicide were recorded in Australia in 1999 — equivalent to 13.1 deaths for every 100 000 people. The rate for males was around four times that for females in 1999 — a trend that was consistent over the 10 years to 1999 (table 7A.39). The NT and Tasmania had the highest suicide rate in 1999 (16.6). Victoria had the lowest rate (11.7) (figure 7.25).

Figure 7.25 Suicide deaths per 100 000 people



Source: ABS 2000; table 7A.40.

In 1999, suicide was the second leading cause of death for people aged 15–24 years after transport accidents (ABS 2000) — 380 people in this age group died as a result of suicide. In 1999, 20.3 per cent of deaths in this age group resulted from suicide — equivalent to a rate of 14.1 deaths per 100 000 people aged 15–24 years. This is the lowest rate since 1990. In 1999, the NT recorded the highest suicide rate in this age group (41.4 deaths per 100 000 people aged 15–24 years), while SA recorded the lowest (11.0 deaths per 100 000 people aged 15–24 years) (table 7A.41). Suicide was the leading cause of death for 25–34 year olds in 1999 (22.9 per cent of deaths in this age group resulted from suicide) (ABS 2000).

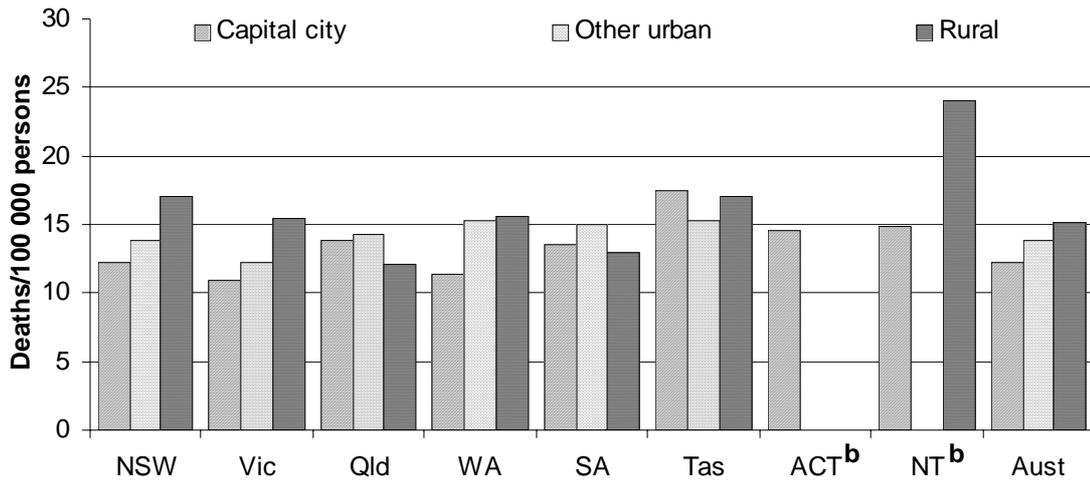
The suicide rate per 100 000 people in 1999 was higher in rural areas than in capital cities or other urban areas in all States except Queensland, South Australia and Tasmania (table 7A.42). In 1999, Australia-wide, there were 15.1 suicides per 100 000 people in rural areas compared with 12.3 suicides in capital cities and 13.8 in other urban centres (figure 7.26).

In 1999, the suicide rate for Indigenous people was considerably higher than the rate for the total population. Care needs to be taken when interpreting these data because data for Indigenous people are incomplete and data for some States are not considered of publishable standard.⁸ In the NT in 1999, the Indigenous suicide rate was 30.8 per 100 000 Indigenous people compared with 16.6 per 100 000 people for the total population. In Queensland, the Indigenous suicide rate was 22.9 suicides

⁸ See the 'Health preface' for a discussion of the quality of Indigenous mortality data collected by the ABS. The ABS considered 1998 data for Queensland, WA, SA and the NT to be of publishable standard.

per 100 000 Indigenous people compared with around 13.7 suicides per 100 000 for the total population. In WA, the 1999 Indigenous suicide rate was 21.4 per 100 000 Indigenous people compared with around 12.7 per 100 000 for the total WA population (tables 7A.43 and 7A.40).

Figure 7.26 **Suicide deaths by area per 100 000 people, 1999^a**



^a Other Urban = centres with more than 20 000 population. ^b ACT rates for other urban and rural were zero. NT rate for other urban was zero.

Source: ABS 2000; table 7A.42.

Efficiency

Cost per inpatient bed day

A proxy indicator of efficiency is the level of government inputs per unit of output (unit cost). The most suitable indicator for mental health services would be to adjust the number of separations by the type and complexity of cases to develop a cost per casemix adjusted separation similar to that presented for public hospitals (chapter 5). The current method for adjusting inpatient separations (AR-DRGs), however, does not account for the full range of mental health services provided. Until an appropriate casemix classification has been developed and introduced, average inpatient day costs will be used as an indicator of efficiency. However, these data should be used cautiously in any comparative assessment.

All States and Territories have committed to collecting and reporting casemix related data based on the Mental Health Classification and Service Costs model and intend to refine the classification for routine adoption. Through this process, it is

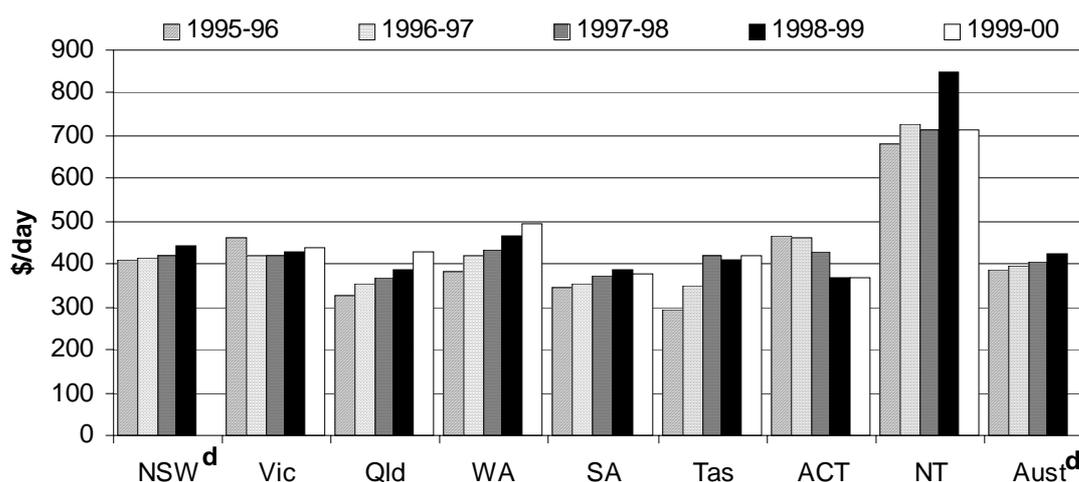
expected that casemix adjusted comparisons between jurisdictions will be possible in future years.

Comparability of costs is maximised when the full range of costs to government are counted for all jurisdictions. Where the full costs cannot be counted, comparability is achieved by estimating costs on a consistent basis.

The cost per inpatient bed day is affected by factors such as differences in the client mix and average length of stay. The client mix in inpatient settings may differ — for example, some jurisdictions treat a higher proportion of less complex patients in inpatient settings rather than in the community. Longer lengths of stay may also be associated with lower average inpatient day costs, because the cost of admission and discharge and more intensive treatment early in a stay is spread over more days of care. Average length of stay varied across jurisdictions and hospital types (tables 7A.45 and 7A.46).

Real inpatient costs per day are presented in figure 7.27. Changes over time reflect in part institutional change in accordance with the NMHS. In 1999-2000, unit costs were highest in the NT (\$714 per day) and lowest in the ACT (\$371 per day). Data for 1999-2000 for NSW were not available for this Report. In 1998-99, unit costs Australia-wide were \$425 — again highest in the NT (\$847 per day) and lowest in the ACT (\$368 per day).

Figure 7.27 **Average cost (recurrent) per inpatient bed day, public hospitals, (1999-2000 dollars)^{a, b, c}**



^a Preliminary data, final validation ongoing prior to publication in National Mental Health Report 2001.

^b Depreciation excluded. ^c Costs are not adjusted for differences in the complexity of cases across jurisdictions and may reflect differences in the rate of institutional change (that is, the mainstreaming of mental health services). ^d Data for 1999-2000 for NSW (and therefore Australia) were not available for this Report.

Source: DHAC, National Survey of Mental Health Services Database, (unpublished); table 7A.47.

Average costs for community based patient care

The average cost to government (recurrent) per patient day for community residential services is presented in table 7.8. It is likely that these data are also affected by institutional changes occurring as a result of the NMHS. In addition, differences across jurisdictions in the types of patients admitted to community residential care will affect average costs in these facilities. The definition of community residential services changed between 1998-99 and 1999-2000 and this is reflected in table 7.8. Prior to 1999-2000, community residential was defined as 24 hour staffed residential units in community settings (external to the campus of a public hospital or psychiatric institution) and funded by government. From 1999-2000, the definition has been broadened to incorporate all staffed community based units, regardless of the number of hours that staff are present.

The estimates in table 7.8 suggest that in 1998-99, the average cost to government per patient day for community residential services Australia-wide was \$209 — highest in Tasmania (\$264) and lowest in SA (\$91). In 1999-2000, according to the National Survey of Mental Health Services, Queensland data were affected by the establishment of a single, new unit late in the year — however, there is some inconsistency with the classification of this service type and at this point reporting against residential community care is not supported by Queensland Health. Further work needs to be undertaken to clarify reporting of these data in the future. Across the other jurisdictions, the highest cost per patient day was in WA (\$266) and the lowest in SA (\$97). Data for 1999-2000 for NSW were not available for this Report.

Table 7.8 Average cost to government (recurrent) per patient day for community residential services (current prices)^{a, b, c, d}

	NSW ^g	Vic	Qld ^{e, f}	WA	SA	Tas	ACT	NT ^e	Aust ^g
1998-99									
24 hour staffed units	\$217	\$204	..	\$207	\$91	\$264	\$222	..	\$209
1999-2000									
24 hour staffed units	na	\$201	\$779	\$266	\$97	\$263	\$218	..	na
Non 24 hour staffed units	na	\$123	..	..	..	..	\$48	\$63	na

^a Preliminary data, final validation ongoing prior to publication in National Mental Health Report 2001.

^b Depreciation included, variably handled by jurisdictions. ^c Costs are not adjusted for differences in the complexity of cases across jurisdictions and may reflect differences in the rate of institutional change (that is, the mainstreaming of mental health services). ^d Prior to 1999-2000, community residential was defined as 24 hour staffed residential units in community settings (external to the campus of a public hospital or psychiatric institution) and funded by government. From 1999-2000, the definition has been broadened to incorporate all staffed community based units, regardless of the number of hours that staff are present. ^e 24 hour residential services not available in 1998-99 within NT and Queensland. ^f According to the National Survey of Mental Health Services, Queensland data for 1999-2000 were affected by the establishment of a single, new unit late in the year, however, there is some inconsistency with the classification of this service type and at this point reporting against residential community care is not supported by Queensland Health. Further work needs to be undertaken to clarify reporting of these data in the future. ^g Data for 1999-2000 for NSW (and therefore Australia) were not available for this Report. **na** Not available .. Not applicable.

Source: DHAC, National Survey of Mental Health Services Database, (unpublished); table 7A.48.

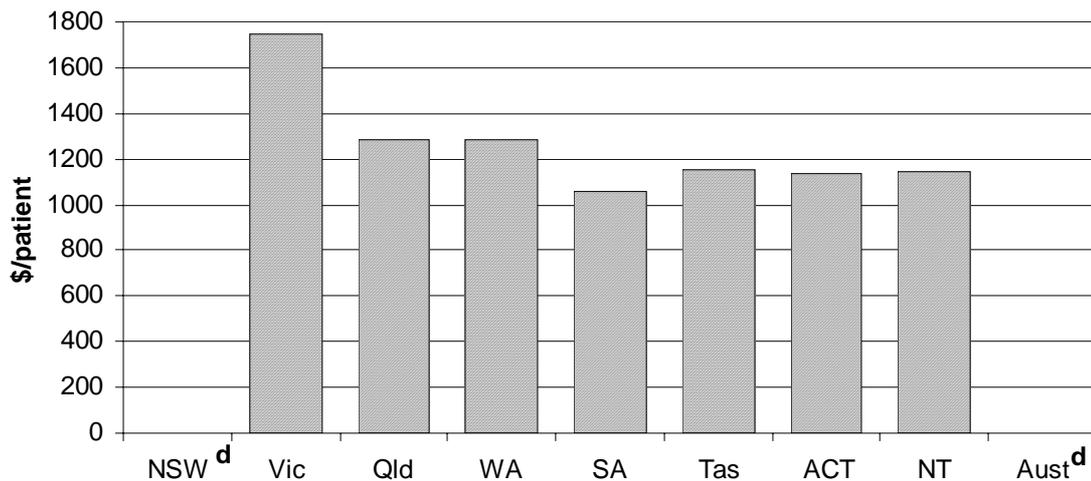
Average costs for ambulatory (non-admitted) services

Estimates of average costs for non-admitted patients are reported for the first time this year. These data should be treated with care as a marked proportion of patient data were missing (table 7A.49). In addition, the absence of unique patient identifiers in many jurisdictions creates overcounting of the number of patients treated, as clients who happen to attend mental health services other than their usual service may be counted twice. This may artificially reduce average costs. Victoria and WA have state-wide systems of unique identifiers, so the extent of overcounting in these states is relatively lower than in other jurisdictions. Further, differences in the complexity of cases treated, the service options available for treatment and admission practices across jurisdictions are not taken into account. Nevertheless, the provision of ambulatory treatment, rehabilitation and support to non-inpatients and post-acute care is an important component of service provision and it is a priority for the Review to continue improving reporting in this area.

The data in figure 7.28 suggest that cost per treated patient in the community in 1999-2000 ranged from \$1747 in Victoria to \$1057 in SA. These costs should be viewed in the context of the proportion of missing data outlined in table 7A.49. The

apparent higher unit costs in Victoria may reflect the lower probability of overcounting of patients in that state compared with jurisdictions (other than WA) that do not have unique patient identifiers. Data for 1999-2000 for NSW were not available for this Report.

Figure 7.28 **Average cost to government (recurrent) per treated patient in the community, 1999-2000^{a, b, c}**



^a Preliminary data, final validation ongoing prior to publication in National Mental Health Report 2001.
^b Reporting of number of patients treated has a variable level of missing data across jurisdictions. In some jurisdictions, it is not possible to calculate the exact number of patients treated, so a best estimate is used. Additionally, the absence of unique patient identifiers in most jurisdictions creates overcounting of the number of patients treated, artificially reducing average costs. Victoria and WA have unique state-wide client identifier systems which limit double counting of clients who happen to attend mental health services other than their usual service. This may create the impression that unit costs in these states are apparently higher than those of other jurisdictions without unique patient identifiers. It should also be noted that differences in the complexity of cases treated, the service options available for treatment and admission practices across jurisdictions are not taken into account in these data. ^c Depreciation included, handled variably across jurisdictions. ^d Data for 1999-2000 for NSW (and therefore Australia) were not available for this Report.

Source: DHAC, National Survey of Mental Health Services Database, (unpublished); table 7A.49.

7.4 Future directions in performance reporting

Breast cancer

Key challenges for improving reporting of health management performance of breast cancer include:

- expanding the scope of reporting;
- further developing indicators of outcomes; and
- improving data and the measurement of existing indicators.

Expanding the scope of reporting

Existing performance data for breast cancer management places relatively more emphasis on the performance of State and Territory BreastScreen Australia programs than on the treatment and ongoing management of breast cancer. This is in large part due to the relative availability of breast cancer screening data across jurisdictions. It is the aim of the Review to expand reporting in future to incorporate treatment and clinical outcomes data.

Developing indicators of outcomes

A number of international studies have found evidence that screening has been associated with a reduction in breast cancer mortality (for example, Alexander *et al.* (1999) and Moss *et al.* (1999) for the UK), although there is some doubt about breast self examination (Moss *et al.* 1999). Neither of these particular studies, however, used economic evaluation tools. At present, there are no Australian studies of this nature, however, a study for BreastScreen Australia estimating the cost per life year saved of breast screening is being designed and is anticipated to commence in late 2002.

The NAC Monitoring and Evaluation Working Group has developed an Evaluation Plan and Monitoring Plan that will facilitate reporting of outcomes in future.

Improving data and the measurement of existing indicators

During 2000-01, the NAC completed a number of projects that affect the monitoring and evaluation of the BreastScreen Australia Program into the future. Key projects undertaken during this period include the development of the BreastScreen Australia Data Dictionary, and completion of the review of the BreastScreen Australia National Accreditation Requirements.

The BreastScreen Australia Data Dictionary has established definitions for each of the items contained in the BreastScreen Australia agreed Minimum Data Set (MDS) in a form consistent with the National Health Data Dictionary. Services collect and record data against each of the items in the MDS. The Data Dictionary, which was endorsed by the NAC in July 2001, will provide a rich source of data for monitoring the performance of BreastScreen Australia, improving comparability across jurisdictions in future reports.

The review of the National Accreditation Requirements, the current quality assurance standards for BreastScreen Australia screening and assessment services, was finalised in 2000 and the NAC endorsed the new National Accreditation

Standards in July 2001. The Standards establish a set of benchmarks against which performance can be measured and will become operational in July 2002, with implications for the 2003 Report.

Mental health

Key challenges for improving the reporting of mental health management are similar to those of last year:

- improving reporting of effectiveness and efficiency indicators for Indigenous, rural/remote and other special needs groups;
- revising the performance indicator framework to take account of the Second National Mental Health Plan to ensure that reporting remains consistent with government policy objectives for mental health; and
- improving reporting of effectiveness/efficiency indicators for community based mental health care.

As mentioned in the Policy developments section, information structures are being developed under the NMHS that will enable improved performance reporting in future. At present, while community based mental health care is expanding in accordance with the NMHS, performance reporting in this area is limited by the paucity of data.

An NMDS covering inpatient and community services has been developed. Some data from the NMDS on admitted patient mental health care and community mental health care establishments are already available. Collection of patient level data for community mental health care services commenced 1 July 2000. These data are scheduled for publication in 2002.

In addition, all jurisdictions have undertaken to begin collecting unit record consumer outcomes data, to further develop the mental health casemix classification system, and to collect data on the implementation of standards. Delays in the adoption of a consistent mental health casemix classification system are a particular constraint on comparable performance reporting. Data on consumer outcomes and standards will be reported nationally to the Commonwealth progressively from 2001, although comprehensive coverage is not expected until 2003.

Commonwealth, State and Territory governments are also required to agree on indicators and performance targets under the Australian Health Care Agreements. Work by the Australian Health Ministers' Advisory Council National Mental Health Working Group will contribute to performance reporting in the medium to longer term.

All of these initiatives will facilitate improvements in both the performance framework and data used by the Review to report on mental health care in future.

7.5 Jurisdictions' comments

This section provides comments from each jurisdiction on the services covered in the health chapters and attachments 5A to 7A in the CD-ROM. Appendix A contains detailed statistics and short profiles on each State and Territory, which may assist in interpreting the performance indicators presented in the health chapters. The information covers aspects such as age profile, geographic distribution of the population, income levels, education levels, tenure of dwellings and cultural heritage (such as Indigenous status and ethnicity).

New South Wales Government comments

“ Health is a significant area of expenditure for government. Public scrutiny of health system performance, through mechanisms such as the Report on Government Services, has an important role in stimulating improvements in cost effectiveness.

One of the approaches adopted in preparing the Report is to include data if it is available, with appropriate qualification, even where the data are imperfect. The rationale behind this approach is to establish a basis for further work on improving the comparability of the data. This year this approach has led to closer scrutiny of the quality and comparability of data across jurisdictions in the areas of waiting times for elective surgery and for emergency department services. These are two areas where the data continue to be incomparable, even after several years of publication in the Report. This is evident in the differences in the proportions of patients reported in each of the urgency categories in both indicators. NSW and other States have raised this issue with key national groups such as the Australian Health Ministers' Advisory Council (AHMAC) and national work on improving comparability in these areas is now progressing.

Problems of comparability persist in a number of other areas. One underlying problem is that there is systematic variation across jurisdictions in relation to the classification of non-surgical same day admissions. Some States tend to classify these patients as “admitted” patients whilst others tend to classify them as outpatients. This variation distorts a number of performance indicators. For example separation per capita is used as an indicator of “appropriateness”. It is clear from this indicator that some jurisdictions apply lower thresholds for treating some patients as admitted patients, which will show a higher per capita separation rate for these jurisdictions. This is particularly the case for same day non-surgical cases. Whilst there have been attempts to address this issue nationally, it appears from the results reported in this publication that national uniformity has not been achieved in the rules for admission. Further work is required in this area.

There are two important factors that impact on the comparability of figures presented in this Report. The first is that each State/Territory must first and foremost respond to local issues, and in this way, jurisdictions are likely to differ. However, the source of variation is a legitimate one. In this instance we should concentrate on describing the reasons for the differences. The second is that there are some areas where States/Territories should be similar, but the data are showing a different picture. One reason for this is that jurisdictions are genuinely different, in which case efforts should be focussed on discovering the reasons behind the variation and use this as an opportunity for improvement. A second reason is that the data collection process and application of definitions is not uniform. The latter is the type variation that we should endeavour to reduce over time.

NSW supports the approach of the Report, and welcomes the opportunity to do further work to improve the comparability of the indicators presented. ”

Victorian Government comments

“

Victoria continues to strongly support comparisons of overall performance and key performance indicators between jurisdictions and with the best practitioners worldwide. In this context the establishment of the National Health Performance Committee is particularly welcome. The Committee has recently published a national performance measurement framework for the health system as a whole and this has provided a basis for a quality framework to be used by all Victorian public hospitals in reporting on the quality and safety of the services which they provide.

The Committee has also moved to establish a working relationship both with this Review and with other key bodies involved in national performance measurement such as the Australian Council for Safety and Quality in Health Care and the National Health Information Management Group.

The increased and broader emphasis on health care services in recent editions of this report is also welcome and reflects the level of government expenditure on these services. In particular, the development of a performance measurement framework for general practice, including indicators of quality, safety and evidence of best practice, is important in a funding environment where outcomes are rewarded and emphasis is placed on quality.

Victoria also welcomes the current work of the Review towards the enhancement of its reporting frameworks to reflect inter-relationships between services such as public hospitals, general practice and aged care. Many of the chronic conditions of ageing make it likely that an older person will come into contact with a succession of services. The use of 'discrete' frameworks and key performance indicators for general practice, acute health and aged care does not permit analysis of the extent to which people are receiving the most effective, least cost intervention at the right time.

It is acknowledged that many of the indicators in the health chapters of this report need further development as they often highlight differences in state administrations, funding mechanisms and service provision rather than performance. However, they do provide a useful starting point for further analysis. The recognition of the need for separate unit cost measures for acute, psychiatric and sub-acute admitted patient services provides an example of this and highlights the need for continual development of even the most conceptually simple indicators. For this reason the Review's iterative approach to reporting, publishing imperfect data with caveats and then working to improve quality and comparability, is strongly supported.

Encouragement should also be given for individual service providers to benchmark at a much greater level of detail, and to achieve improvements at the organisational level. Consideration could also be given to showing the distribution of key results (for example, quartiles) rather than only means to provide more discriminating benchmarking between jurisdictions.

”

Queensland Government comments



Queensland Health supports performance measurement and the continuous improvement in the delivery of health services. This commitment is demonstrated by achievements in a range of projects commenced under the Quality Improvement and Enhancement (QIEP) Program. These projects aim to improve service delivery through streamlining and standardising systems and improved use of information. Projects include a risk management project to standardise incident monitoring policy and systems, implementation of a state-wide patient satisfaction survey and a state-wide approach to clinical pathway development. A Measured Quality Program aims to report on hospital performance indicators in the areas of internal business, efficiency, patient satisfaction and system integration and change. Clinical indicators for a range of conditions and procedures are being developed in consultation with a network of clinicians.

Queensland Health's five year Information Management Strategic Plan sets the direction for continuous improvement and the effective and innovative use of information to ensure access to timely and high quality information required to support evidence based health services. Clinicians across Queensland Health facilities have 24 hour access to clinical information through the Clinicians Knowledge Network. The Clinical Benchmarking Project enables analysis and reporting of hospital cost, casemix data and other management information across major hospitals.

Queensland Health supports improved reporting of Indigenous health indicators by the Review of Commonwealth/State Service Provision and has taken an active role in assisting with this task. A strategic priority for Queensland Health is the provision of appropriate health services to Indigenous people and a range of activities are being undertaken in partnership with local communities to enhance the health of Indigenous communities. For example, strategies to address alcohol and drug issues, tobacco use, access to healthy foods in rural and remote areas, and access to Indigenous women's cervical screening services are well advanced. All Queensland Health employees are required to attend cultural awareness training and encouraged to participate in reconciliation learning circles to ensure the delivery of culturally appropriate and sensitive Indigenous health services.

Significant work is being undertaken to reduce elective surgery and emergency department waiting lists. The implementation of clinical best practice development projects across Queensland hospital emergency departments and a statewide emergency department benchmarking process aim to reduce waiting times and improve services in Queensland emergency departments.



Western Australian Government comments

“ The year 2001 has seen a shift in the focus of health initiatives to reflect a growing appreciation of population health issues resulting in an increase in the overall sum of resources going to population health programs.

A number of special projects were completed and others commenced in the State. The Western Australian Aboriginal Coordinated Care trials concluded its first full year of operation with another round being considered by the national Coordinated Care Trials organisers. The renal program for 2002 saw the launch of dialysing facilities ('satellite' units) in two shopping centres in metropolitan Perth, the finalisation of plans for a satellite unit to be located in an Aboriginal Medical Service (AMS) establishment in the State's Northwest and general recognition of the renal dialysis innovations with commendations to the program for Innovation and Management Improvement at this years WA Premier's awards.

The Central Wait List Bureau (CWLB) presided over a process which brought the State's elective surgery waiting list numbers to its lowest levels since 1996. This result was assisted by a review of the lists, undertaken in collaboration with the General Practice Division of WA (GPDWA), who with their members, examined the continued validity of the waiting lists and related specialist referrals. The scope of the waiting list management program was extended to include patients awaiting appointments at hospital outpatient clinics, particularly, allied health type scheduled services.

In response to identified need and the changed focus of care, a number of service areas have received a funding boost this year. Rural specialist services, the patients assisted travel scheme (PATS), orthodontic treatment, care awaiting placement and step down facilities and strategies to manage elective services have all been provided extra funds. A number of capital works initiatives including major upgrades to a metropolitan peripheral hospital and a regional country facility, have also been confirmed in their bid for funding support.

Western Australia has undertaken extensive work using linked health record information for both epidemiological and economic analyses. The patterns of care utilisation by the elderly and by indigenous people, the recurrence of care for individuals over time and across hospital campuses, and, the iatrogenic patterns of disease re-occurrence among patients in certain diagnosis/treatment groups, are among the investigations that have been undertaken. In addition, budget deliberations have been informed by intensive analyses of health service activity and related financial information.

Western Australia's costs, particularly, recurrent cost per casemix adjusted separation, have been the subject of discussion and a preliminary set of revised figures are published in this report. There were errors identified in the figures initially submitted to the Australian Institute of Health and Welfare for use in their Australian Hospital Statistics Report 1999-2000 publication. Final revisions to these statistics are in progress and the results will be published on the Report's web page at about the same time as the release of this 2002 document.”

South Australian Government comments

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The Department of Human Services continues to provide a quality health service for the South Australian community. The Department maintains its efforts to ensure that appropriate health care is provided to all who need it and is actively undertaking further development of integrated and coordinated service provision across all three portfolio areas of health, housing and community services.

Constraints within the human services operational environment include an increasing demand for human services outstripping available resources, ageing capital infrastructure, and new technologies setting higher expectations of medical science. Despite these pressures, the SA public hospital system is still one of the most technically efficient (as measured by the cost per casemix-adjusted separation). SA has successfully implemented population based breast and cervix screening programs, and immunisation programs as well as exploring innovative methods of case management, continuity of care and chronic illness management for target population groups and alternative models for service delivery. These alternative models of service delivery include rehabilitation in the home, hospital in the home, same day of admission surgery, telehealth linkages for renal review and the off-site location of clinics closer to their target populations.

Changing population demographics are a continuing challenge. The latter includes the challenge of influencing the continued lower life expectancy for indigenous people, high rates of poverty and associated high rates of ill health, especially for single parents, younger single people and families with children. Other challenges are to ensure that services are able to respond appropriately to an ageing population.

Health is central to the key outcomes the Human Services portfolio aims to achieve. These aims are to:

- enhance the quality of life for South Australians through government and community partnerships promoting health and wellbeing, the development of a sustainable community and quality living standards; and
- provide the care and support necessary for people to maintain and improve their health and wellbeing at a cost the community is willing to bear.

The Department strongly supports directions to improve reporting of GP services to population groups, especially indigenous people, and to improve reporting of effectiveness and efficiency indicators for indigenous, rural/remote and other population groups.

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Tasmanian Government comments

“ The Tasmanian Government is committed to improving the health and wellbeing outcomes for individuals, families and communities. It acknowledges the value provided by the Report on Government Services in offering standards of comparison nationally and between jurisdictions. The information in the report is used by the Department of Health and Human Services in its own review of performance. As with other jurisdictions, a significant task for Tasmania is the ongoing development of information systems to ensure that reliable and meaningful data is collectable, accessible and appropriately maintained. Expanding data requirements for purposes such as this review are addressed by the Department the development of its information management capability.

In some areas of performance demographic and population differences together with data quality and definition issues make comparison with other jurisdictions of doubtful value. For example, the consistency and reliability of Indigenous population and service usage data varies considerably in Tasmania. Tasmania also has a larger private hospital sector than most other jurisdictions, meaning that some population-based data relating to activity in public hospitals appears disproportionately low. The effect of a comparatively large and growing aged population in Tasmania also translates into differences between it and most other jurisdictions in demand across a wide range of health and human services.

The Department has continued to develop and implement a performance framework based on the multi-dimensional model adopted by the National Health Performance Committee. As with the national framework, the development of meaningful and measurable indicators of performance will be an iterative process with improvement over time.

During the latter part of 2001 the Department worked on incorporating the community benchmarks set by Tasmania Together into the Framework. Tasmania Together is a twenty-year social, environmental and economic plan developed through extensive community consultation and with support from, but not influenced by, Government. Under the plan Government Agencies will be required to report annually to an independent body on performance against a range of outcome targets.

A range of initiatives have been developed and implemented over the year aimed at improving particular dimensions of health and human services system performance in Tasmania. For example the establishment of an internet-based community consultation mechanism, Interact, has improved ‘access’ by targeted groups and the wider community in providing comment on policy and service initiatives.”

Australian Capital Territory Government comments



The ACT purchases hospital services on the basis of price, volume and quality and these are defined in service agreements between the Department of Health, Housing and Community Care and the two public hospitals.

Most national benchmarking studies examining the factors contributing to the costs of the public hospital system show that the ACT has a high cost system. There are a number of features specific to the ACT health care system that confound inter-jurisdictional comparisons.

The ACT public hospital system provides a near-comprehensive range of services. As a small jurisdiction the ACT is unable to exploit economies of scale, especially in costly specialist service areas. The system is dominated by a major tertiary referral hospital and both ACT sites are teaching hospitals. The cost structure of the ACT differs from jurisdictions with many hospitals of varying size and function.

The role of hospitals in the service continuum for a small jurisdiction may differ from that of large jurisdictions, with associated cost implications. In large jurisdictions the roles of acute hospitals and non-acute and/or community based services are clearly delineated. Such boundaries can blur in small systems and comparisons of cost of service provision limited to one sector of the service continuum disadvantages them.

The ACT services a region with limited options for down-transferring complex patients to other hospitals. Such episodes tend to be longer. The ACT cost of service delivery may be spread over fewer episodes than those in larger jurisdictions with effective hospital networks

The ACT has a comparatively stable workforce and staff may be on relatively high salary increments. ACT sites may also carry high superannuation costs as a carry-over from the period where many staff were members of the Commonwealth Public Service. Such costs are, in the short to medium term, difficult to influence.

ACT hospitals carry all costs for administration, insurance and workers compensation on site. This foregoes economies of scale which may occur in those jurisdictions where such services are centralised. The extent to which these costs in other jurisdictions are effectively attributed back to individual sites is unclear.

The ACT continues to support the comparative reporting of data across jurisdictions where it can provide meaningful indicators of the performance of the public hospital system. Care needs to be exercised in the interpretation of the comparative data because of factors such as the differences in state administration, funding models and service provision.



Northern Territory Government comments

“ The Northern Territory Government provides and purchases a cluster of interdependent health and community services including: hospitals (acute care); community services (mental health, aged care, disability and family and children services); primary (community health); and public health (health development).

Health and community services accounted for 13 per cent of NT Government expenditure during 2000/2001.

There are five public hospitals in the NT. They are located in Darwin, Nhulunbuy, Katherine, Tennant Creek and Alice Springs with a combined total of 570 beds. One private hospital operates in Darwin. Hospitals are supported by a network of 98 community health centres throughout the Territory and close to 100 GP practices. The NT population is 190 000 scattered over the wide expanses of the Territory with almost 30 per cent of the populace Indigenous persons. Many more people travel through the Territory as tourists and use the health care system while in the area.

A small population, remote communities and the special health needs of a youthful and Indigenous populace present challenges in providing equivalent health services in the NT that are on offer in other jurisdictions. Higher costs and access difficulties confront service providers. Illustrative of this was the movement of 16 000 people intrastate and 2000 interstate for medical treatment. Services must be culturally appropriate requiring special training and interpreting assistance. With only one private hospital, demand on the public hospital system continues to rise.

Remoteness, special needs, diseconomies of scale, an environment ranging from desert to tropical require unique ways of providing health and community services. Successful coordinated trials have been the forerunner to the establishment of health zones. Features of these are: an emphasis on prevention and primary health care; involvement of local people in administering the zones; and increased resources by addressing access issues to Commonwealth Pharmaceutical and Medical Benefit Schemes due to limited numbers of GPs in remote communities.

The NT Government endorsed the Preventable Chronic Disease Strategy as an approach to healthier Territorians. The Strategy targets diabetes, high blood pressure, obstructive airways disease, heart disease and kidney disease as major diseases causing illness and disability. Breast screening, mental health programs, cooperative arrangements with GPs and maternal health feature prominently in this Strategy. In subsequent reports, NT data will reflect the best service buys and delivery of them through our health zones to reduce illness and disability.”

7.6 Definitions

Table 7.9 Terms

<i>Term</i>	<i>Definition</i>
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.
Affective disorders	A mood disturbance, includes mania, hypomania, bipolar affective disorder, depression and dysthymia.
Agoraphobia	Fear of being in public places from which it may be difficult to escape. A compelling desire to avoid the phobic situation is often prominent.
Ambulatory services	Services provided by hospitals to non-admitted patients.
Antidepressant	A drug that alleviates depression, usually by energising the person and thus elevating mood.
Anxiolytics	Tranquillisers; drugs that reduce anxiety.
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.
Bipolar disorder	A mood disorder characterised by a history of manic (or hypomanic) episodes usually alternated with depressive episodes.
Casemix-adjustment	Adjustment of data on cases treated to account for the number and type of cases. Cases are sorted into diagnosis related groups (DRGs) which represented a class of patients with similar clinical conditions requiring similar hospital services.
Co-located units	Psychiatric units in public (non-psychiatric) hospitals. Includes ambulatory services and specialised residential services.
Community health services	Health services for individuals and groups delivered in a community setting, rather than in hospitals or in private facilities.
Comorbidity	The simultaneous occurrence of two or more disorders such as depressive disorder with anxiety disorder, or depressive disorder with anorexia.
Consumer and carer involvement in decision making	Consumer and carer 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
Cost per woman screened	The total cost of provision of breast screening services divided by the number of women screened. The total cost of provision of breast screening services should include the cost of providing the BreastScreen Australia Program in each jurisdiction, in addition to the cost of providing the program to women
Depression	A state of gloom, despondency or sadness lasting at least two weeks. The person usually suffers from low mood, loss of interest and enjoyment, and reduced energy. Sleep, appetite and concentration may be affected.
Detection rate for small cancers	The rate of small (≤ 10 mm) invasive breast cancers detected per 10 000 women screened

(Continued on next page)

Table 7.9 (Continued)

<i>Term</i>	<i>Definition</i>
Dysthymia	Constant or constantly recurring chronic depression of mood, lasting at least two years, which is not sufficiently severe, or whose episodes are not sufficiently prolonged, to qualify as recurrent depressive disorder. The person feels tired and depressed, sleeps badly and feels inadequate, but is usually able to cope with the basic demands of everyday life.
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 and Indigenous health.
Generalised anxiety disorder	Unrealistic or excessive anxiety and worry about two or more life circumstances for six months or more, during which the person had these concerns more days than not.
Hypomania	A lesser degree of mania characterised by a persistent, mild elevation of mood and increased activity lasting for at least four days. Increased sociability, over-familiarity and a decreased need for sleep were often present, but not to the extent that they led to severe disruption.
Invasive cancer	A tumour whose cells invade healthy or normal tissue.
Mental disorder	A diagnosable illness that significantly interferes with an individual's cognitive, emotional or social abilities.
Mental health problems	Diminished cognitive, emotional or social abilities but not to the extent that the criteria for a mental disorder are met.
Mental health promotion	Action to maximise mental health and wellbeing among populations and individuals.
Mortality rate from breast cancer	The age-specific and age-standardised mortality rates, expressed per 100 000 women in the population, who died as a result of breast cancer
Mortality rate from suicide	The percentage of the population who died as a result of suicide
Obsessive-compulsive disorder	Obsessions: recurrent, persistent ideas, thoughts, images or impulses that intrude into the person's consciousness against his/her will. The person experiences these as being senseless or repugnant, but is unable to ignore or suppress them. Compulsions: recurrent, stereotyped behaviours performed according to certain rules. The person often views them as preventing some unlikely event, often involving harm to, or caused by, themselves. The person generally recognises the senselessness of the behaviour, attempts to resist it and does not derive any pleasure from carrying out the activity.
Panic disorder	Panic (anxiety) attacks that occurs suddenly and unpredictably. A panic attack is a discrete episode of intense fear or discomfort.
Participation rate	the number of women resident in the catchment area screened divided by the number of women resident in the catchment area. If a woman is screened is more than once during the reference period, then only the first screen is counted. Expressed as a per cent. Catchment Area is a geographic region based on service size in relation to the population, accessibility and the location of other services. It is uniquely defined for each service based on post code or SLA.

(Continued on next page)

Table 7.9 (Continued)

<i>Term</i>	<i>Definition</i>
Percentage of facilities accredited	The percentage of facilities providing mental health services that are accredited according to the National Standards for Mental Health Services.
Post traumatic stress disorder	A delayed and/or protracted response to a psychologically distressing event that is outside the range of usual human experience.
Prevalence	The percentage of the population suffering from a disorder at a given point in time (point prevalence) or during a given period (period prevalence).
Preventive interventions	Programs designed to decrease the incidence, prevalence and negative outcomes of disorders.
Psychiatrist	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.
Schizophrenia	A combination of signs and symptoms which may include delusions, hallucinations, disorganised speech or behaviour, a flattening in emotions and a restriction in thought, speech and goal-directed behaviour.
Screening	The performance of tests on apparently well people to detect a medical condition at an earlier stage than would otherwise be the case.
Size and grade of detected cancers	The percentage of invasive cancers detected classified according to tumour size and grade
Social phobia	A persistent, irrational fear of being the focus of attention, or fear of behaving in a way that would be embarrassing or humiliating.
Specialised residential services	Services provided in the community that are staffed by mental health professionals on a 24-hour basis.
Stand-alone hospitals	Psychiatric hospitals that are separated from the general health care system.
Substance use disorders	Disorders in which drugs or alcohol are used to such an extent that behaviour becomes maladaptive; social and occupational functioning is impaired, and control or abstinence becomes impossible. Reliance on the drug may be psychological as in substance misuse, or physiological as in substance dependence.

D Justice preface

Justice services are concerned with ensuring a safe society by enhancing public order and security and upholding the rule of law. This involves crime prevention, detection and investigation, judicial processes and dispute resolution, prisoner and offender management, and rehabilitation services.

The focus of this Report is on the justice services of police, court administration and adult corrective services. Other government services not included in this Report also contribute to civil and criminal justice outcomes, for example:

- legal aid services, which provide access to both criminal and civil aspects of the justice system;
- alternative dispute resolution services, such as conciliation and mediation;
- offices of fair trading or consumer affairs, which operate to minimise the incidence of unlawful trade practices;
- crimes compensation services and victim support services, which assist victims' recovery from crime;
- prosecution services, which bring actions on behalf of the community in criminal actions; and
- various social services and community organisations in combination, which help prisoners released from prison re-integrate into society, support families of prisoners during the prisoner's incarceration, and assist people who have contact with the criminal justice system.

In addition, some smaller elements of justice services are excluded from this Report. The police services chapter, for example, does not cover the National Crime Authority or the federal functions of the Australian Federal Police. The courts administration chapter does not cover the operations of tribunals and registries (except for probate and court registries). The corrective services chapter does not cover juvenile corrective services (information on juvenile justice can be found in the Community services preface).

Profile of the justice system

Total recurrent expenditure for that part of the justice system covered in this Report was nearly \$6.8 billion in 2000-01 (table D.1). This represents approximately 11 per cent of all expenditure on services covered in the Report. Police services accounted for approximately \$4.4 billion in 2000-01, corrective services accounted for around \$1.5 billion and criminal courts administration accounted for \$456 million. Expenditure on civil justice (including the Federal Court and family courts) was approximately \$476 million (table D.1).

Expenditure between 1996-97 and 2000-01 grew fastest in real terms for criminal courts administration (at an annual average of 6.5 per cent) and slowest for civil courts administration (at an annual average of 2.0 per cent) (table D.1).

Table D.1 Real expenditure on justice by all Australian governments (2000-01 dollars)^{a, b, c}

	1996-97	1997-98	1998-99	1999-2000	2000-01	Annual average growth
	\$m	\$m	\$m	\$m	\$m	%
Police services	3 839	3 879	4 240	4 408	4 383	3.4
Court admin. – criminal ^d	355	381	409	406	456	6.5
Court admin. – civil ^{e, f}	440	441	479	502	476	2.0
Corrective services ^g	1 154	1 141	1 254	1 409	1 461	6.1
Total justice system	5 789	5 843	6 382	6 725	6 776	4.0
	%	%	%	%	%	
Police services	66.3	66.4	66.4	65.5	64.7	..
Court admin. – criminal	6.1	6.5	6.4	6.0	6.7	..
Court admin. – civil	7.6	7.6	7.5	7.5	7.0	..
Corrective services	19.9	19.5	19.6	21.0	21.6	..
Total justice system	100.0	100.0	100.0	100.0	100.0	..

^a Expenditure figures from 1996-97 to 1999-2000 have been amended to take account of inflation. Totals may not sum as a result of rounding. ^b Defined as recurrent expenditure plus depreciation less revenue from own sources. Excludes capital expenditure and estimates of the user cost of capital in police and courts, but includes capital asset charge and debt servicing fees in corrective services. ^c Payroll tax has not been included for WA and the ACT as they are exempt. For all other jurisdictions, it has been included. ^d Includes the cost of coroners' courts. ^e Excludes the cost of probate hearings. ^f Includes the cost of the Family Court and Federal Court of Australia. ^g Excludes WA community corrections expenditure during 1996-97. The NT prison and community corrections did not deduct revenue from own sources in 1996-97. .. Not applicable.

Sources: State and Territory governments (unpublished); ABS (2001).

Expenditure per person on civil and criminal justice in 2000-01 was highest in the NT (\$802) and lowest in Victoria (\$282). Expenditure per person was highest for police services in the NT (\$483) and equally lowest in Victoria, Queensland and Tasmania (\$212). In criminal courts administration, the highest expenditure per

person was in the NT (\$64) and the lowest was in Victoria (\$15). In civil court administration, the highest expenditure per person was in the NT (\$48) and the lowest was in Tasmania (\$8). The NT also had the highest expenditure per person on corrective services (\$207) and Victoria the lowest (\$45) (table D.2).

Table D.2 Government expenditure on justice, per person (2000-01 dollars)^{a, b, c, d}

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
	\$	\$	\$	\$	\$	\$	\$	\$	\$
Police services	235	212	212	232	221	212	230	483	225
Court admin. – criminal	24	15	24	31	29	19	42	64	23
Court admin. – civil ^{e, f}	16	11	10	22	17	8	25	48	24
Corrective services	83	45	73	118	81	63	64	207	75
Total justice system	358	282	320	403	348	302	360	802	348
	%	%	%	%	%	%	%	%	%
Police services	65.7	74.9	66.4	57.6	63.6	70.1	63.8	60.3	64.7
Court admin. – criminal	6.6	5.3	7.7	7.8	8.4	6.4	11.5	8.0	6.7
Court admin. – civil ^f	4.5	4.0	3.2	5.5	4.8	2.5	7.0	5.9	7.0
Corrective services	23.1	15.8	22.8	29.2	23.2	20.9	17.7	25.8	21.6
Total justice system	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

^a Defined as recurrent expenditure plus depreciation less revenue from own sources. Excludes capital expenditure and estimates of the user cost of capital in police and courts, but includes capital asset charge and debt servicing fees in corrective services. ^b Payroll tax has not been included for WA and the ACT as they are exempt. For all other jurisdictions, it has been included. ^c Population estimated at 30 June 2001. ^d Totals may not sum as a result of rounding. ^e Australian total includes expenditure on the Family Court of Australia and the Federal Court, which are not attributed to jurisdiction expenditure. ^f Excludes cost of probate hearings.

Sources: State and Territory governments (unpublished); ABS (2001).

A number of factors contribute to the marked differences in expenditure across jurisdictions. This includes factors beyond the control of jurisdictions (such as geographic dispersion, economies of scale and socioeconomic factors). As well, differences in justice policies and/or the scope of services that are delivered by justice agencies may help to explain the differences in expenditure. For example, police agencies in some jurisdictions provide event management and emergency response services, while others do not.

Policy developments in the criminal justice system

The provision of services is continually evolving. Recent policy initiatives within the areas of courts, police and corrective services are contained in chapters 8–10 respectively. In addition to these developments, there are also a number of initiatives occurring across police, courts and corrective services that have implications for the system as a whole. These are outlined as follows.

Crime prevention

All jurisdictions have endeavoured, where practical, to develop mechanisms aimed at crime prevention. A common theme has been the involvement of police in the community. The following outlines some of the initiatives undertaken by jurisdictions.

Victoria has established a new agency – Crime Prevention Victoria – to develop effective strategies for reducing crime and violence. As well, Victoria Police is actively involved in a number of community safety and crime prevention strategies targeted at different sections of the community, including:

- the development of a project to trial the effectiveness of providing safety forums and safety audits to women who have been victims of certain crimes;
- the provision of practical advice on safety and security to Victorians aged 55 and over through the ‘Confident Living for Older Victorians Program’;
- the establishment of multicultural liaison units to work closely with other government and non-government service providers to focus on pro-active community awareness initiatives; and
- the involvement in a number of programs aimed at broadening the experiences of young people in the community to foster mutual respect and understanding.

The Queensland Government has committed more than \$80 million over the past three years (1998–2001) to fund new and expanded crime prevention programs through the Safer Communities Strategy. The strategy involves being tough on crime and its causes. The vast majority of the \$80 million has been directed toward crime prevention initiatives that address the underlying causes of crime rather than relying on traditional law and order responses.

Under the SA Crime Prevention Strategy, community based programs and crime prevention build on partnerships between government agencies, community organisations, businesses and all South Australians. The Premier’s Police Taskforce has resulted in additional police positions, some of which have been provided specifically to bolster community policing. Initiatives to improve public safety, prevent crime and minimise the effects of crime include:

- a Safe City Working Group that meets regularly to improve city safety, and the trial of a city wide alcohol-free zone, with extra support provided for homeless people and those misusing alcohol and other drugs;
- pilot ‘No Domestic Violence’ projects, aimed at reducing repeat victimisation of domestic violence and improving the coordination of victim support;

-
- the Police Youth Policy, *Police and Young People: Sharing the State's Future*, through which police have embraced the issues raised in the Youth Crime Prevention forum held in December 2000; and
 - an interagency code of practice which has been put in place for interviewing children and caregivers when it is suspected that the child is a victim of abuse or neglect.

The NT Government has established an Office of Crime Prevention in the newly formed Department of Justice. The Office will:

- develop and coordinate the implementation of a whole-of-government crime prevention strategy with wide community involvement;
- evaluate the success or failures of crime prevention strategies;
- provide policy advice about crime reduction initiatives; and
- independently collect, analyse and publish crime statistics.

The Office also includes *NTsafe*, a whole-of-government crime prevention office with oversight by a Committee of Government and community representatives.

The Tasmanian Government is working with local government to develop partnerships with a community safety focus. The whole-of-government/community based 'Crime Prevention and Community Safety Council' is sponsoring a range of crime prevention initiatives. As well, in keeping with a goal of 'having a community where people feel safe and are safe in all aspects of their lives', whole-of-government programs will be developed with five year targets for a range of performance indicators.

The WA Government's strategic direction statement, 'Making Our Community Safer' outlines the Government's policy commitments to crime prevention. The focus is on the development of a whole-of-government crime prevention strategy, which requires closer partnerships between agencies, local governments and communities. A key element of the strategy is the establishment of an Office of Crime Prevention directly responsible to the Premier.

The ACT has had a particular focus on prevention of property crime. Initiatives have included public education about how best to protect property and a law enforcement and corrections focus on recidivist and high risk offenders. A whole-of-government focus has also been placed on targeting high risk children and families with the introduction of early intervention programs, particularly in the corrections, education, family services and health portfolios.

Drug courts

The purpose of drug courts is to deal with individuals who would ordinarily face a prison sentence and present them with an option for long term treatment and rehabilitation within the community, under the close supervision of the court. A number of jurisdictions are trialing or operating drug courts throughout Australia.

In 2000-01, NSW introduced a youth drug court to supervise young offenders undertaking rehabilitation. The youth drug court program commenced in July 2000, with the first participant graduating in February 2001.

In February 1999, a drug court program for adult offenders was introduced in NSW. Funding to continue current drug court operations through the 2001-02 financial year has been approved and an interdepartmental working party has been established to develop recommendations for the future of the drug court program.

Drug courts are another Queensland Government funded initiative aimed at reducing the social and economic impact of crime and the poor health of drug dependent offenders. The drug court program is aimed at drug addicted offenders who have a long criminal history and who are facing a jail sentence. If admitted to the program, the offender is required to undertake a prescribed program of treatment. Drug courts were initially held in three areas of the State and the initiative is expanding into other locations.

The Queensland drug courts complement the Court Diversion Program for minor drug offenders charged with possession of a small amount of illicit drugs other than cannabis, and the Police Diversion Program targeting minor offenders for possession of cannabis. These programs focus on early intervention in drug use.

Western Australia is midway through a two-year drug court pilot that extends across the Perth Children's, Magistrates' and District Courts. The path adopted by the Department of Justice in conjunction with the WA Drug Abuse Strategy has been to develop a model that tailors the criminal justice response to both the offender's level of substance abuse and to the level of offending. The approach is multifaceted as it combines a number of sentencing options with a number of treatment interventions. The WA Drug Court does not utilise prison bed spaces, but instead relies on a process of behavioural sanctions.

The SA Drug Strategic Framework outlines how South Australians can work together to prevent alcohol abuse and other drug problems. Through the Police Drug Diversion Initiative, which aims to reduce crime and harm within the community by addressing underlying drug dependence problems, drug offenders will be diverted to

assessment, education, treatment and post-treatment support and will be given early opportunity to address their drug use problem.

Not all jurisdictions currently operate drug courts. For instance, in Tasmania, an interdepartmental working group is examining the options and opportunities associated with the introduction of drug courts, and Victoria is preparing to trial a pilot drug courts program in early 2002.

Alternative sentencing mechanisms

While there has been a sustained growth in prisoner populations over recent years, jurisdictions have also considered, and in some cases implemented, various alternative sentencing mechanisms. This stems from both the rise in prisoner populations and methods to improve rehabilitation of offenders. It is likely that alternative sentencing orders, such as intensive supervision orders, home detention and electronic surveillance will continue to be considered in the future as access to technology increases. The following outlines some of the alternative sentencing mechanisms being implemented, or considered, by jurisdictions.

During 2000-01, NSW developed a model to conduct a 'trial of circle sentencing', in order to improve the effectiveness of sentencing for Indigenous people and their communities. The initiation of a series of community forums helped to improve recognition of Indigenous customary law. As well, NSW and the ACT are the only jurisdictions that operate periodic detention (an order of confinement requiring that a person be held in a prison or periodic detention facility for two consecutive days within a one-week period).

The WA Government is committed to the notion that reducing re-offending is more effectively carried out in the community, reserving imprisonment for those offenders from whom the community requires most protection. To support this, the Government is developing a range of legislative reforms which include:

- proscription on sentences of six months and less;
- providing for a full range of sentencing options for traffic offences; and
- providing courts with the capacity to impose conditions on suspended imprisonment.

A major review of sentencing is well underway in Victoria which may lead to further refinement of the sentencing options available in that jurisdiction.

Framework of the criminal justice system

The criminal justice system is broad and complex, and has many interrelated objectives. An overarching objective is to encourage community access to a fair system of justice that protects the rights of individuals and is responsive to community needs (box D.1).

Box D.1 Objectives for the criminal justice system

The goal of the criminal justice system is to provide protection for the rights and freedoms of all people through:

- the operation of police services that enhance community safety by preventing, detecting and investigating crime;
- the administration of criminal justice that determines guilt and applies appropriate, consistent and fair sanctions to offenders; and
- the provision of a safe, secure and humane adult correctional system that incorporates the elements of safe custody and rehabilitation of offenders, and restorative justice to the community.

These objectives are pursued in a manner that is accessible, equitable, timely and efficient.

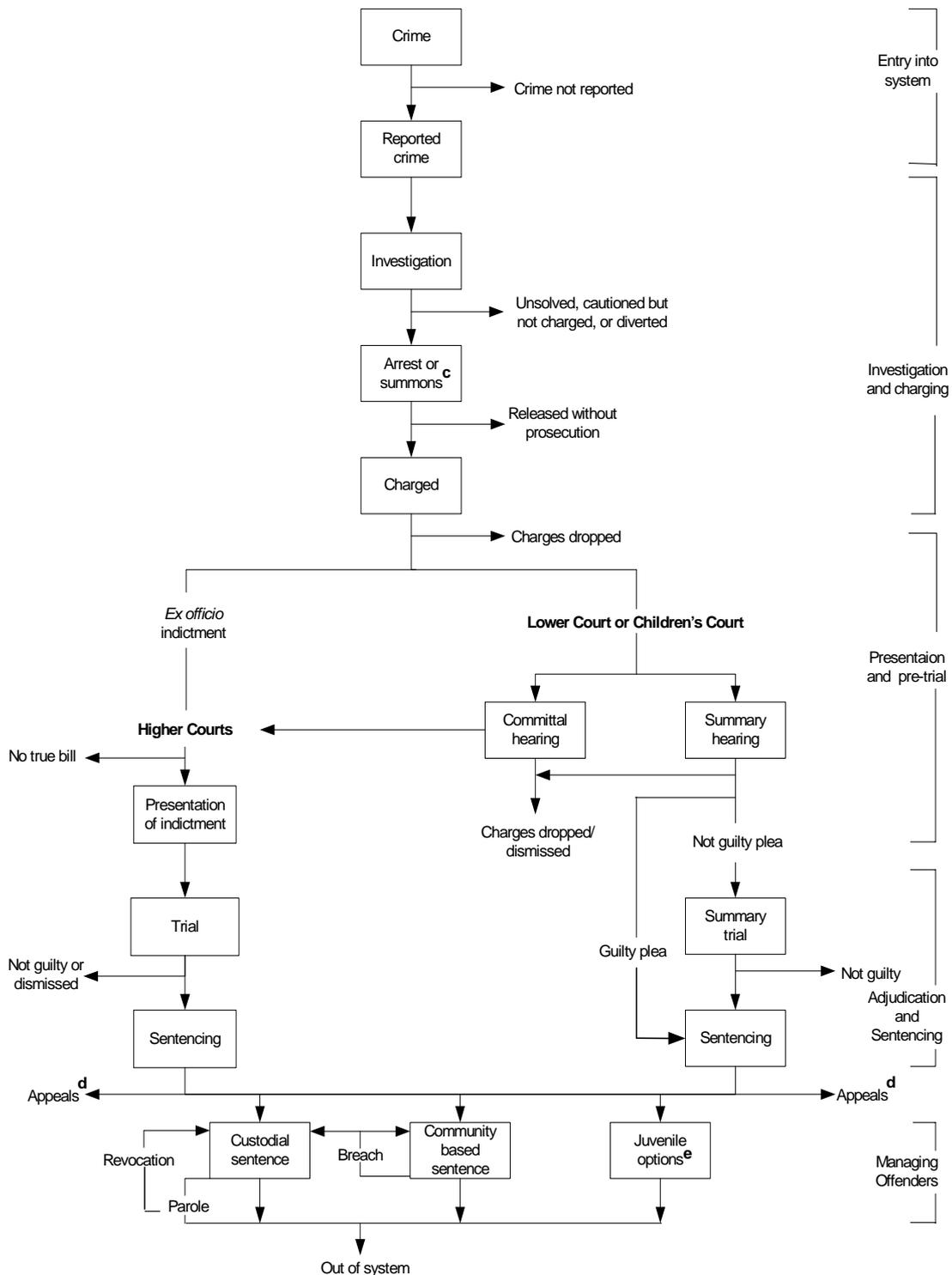
A model of the criminal justice system

The performance of the criminal justice system is measured against the stated policy objectives of effectiveness (the ability of agencies to meet the outcomes of access, equity and timeliness) and efficiency (the measurement of how well inputs are used to deliver a range of outputs). As individuals move through the criminal justice system, they interact with police, courts and corrections. Examples of this are:

- the police service's direct influence on the judicial system, through policing strategies such as police cautions and other diversionary strategies;
- the judicial system's direct influence on the correctional system, through changes in sentencing practices; and
- the correctional system's direct influence on the police service, through offences in prison and input to the judicial system by advisory services provided to courts.

Figure D.1 illustrates the possible stages involved in the processing of cases as they move through the criminal justice system, and shows some of the links between police, courts and corrective services. This depiction is broadly indicative and, for purposes of brevity, does not seek to capture all the complexities of the criminal justice system.

Figure D.1 Flows through the criminal justice system^{a, b}



^a Does not account for all variations across jurisdictions. ^b The flow diagram is indicative and does not seek to include all the complexities of the justice system. The diagram will continue to be refined. ^c Includes voluntary agreement to attend court in some jurisdictions. ^d Appeals are referred to higher courts. Lower court sentencing is upheld for unsuccessful appeals. ^e Juvenile justice is covered in the Community services preface.

Source: Adapted from Criminal Justice Commission (1991).

Key results of the criminal justice system

The following discussion matches the stated policy objectives of the criminal justice system (box D.1), while accounting for the process by which the criminal justice system operates (figure D.1). The discussion illustrates the set of performance indicators used in this Report. It also identifies other areas that are not covered in this analysis, but which may also be relevant in providing a more complete picture of the operations of, and options available to, police, courts and corrective services agencies.

Crime prevention and detection

Effectiveness

The Report includes measures of community perceptions of safety as well as rates of reported crime and victimisation. Measures of public perceptions of safety indicate the success of the system in ensuring the public feels safe both personally and in regard to their property. Public perceptions of safety are reported in detail in chapter 8 and include measures of perceptions of safety in the home, in public places and on public transport.

An indicator of the success of crime prevention and law enforcement is the recorded rate of crime. Given that a number of factors can influence recorded rates of crime, including the general willingness of the public to report crimes to police, additional information is also required. A survey of the community's experience with crime, such as the Australian Bureau of Statistics' (ABS) Crime and Safety Survey, helps to clarify the relationship between reported and unreported crimes. Recorded rates of crime and information from crime victimisation surveys are reported in chapter 8.

Efficiency

The cost per person of the service delivery area 'community safety and support' is used as a proxy for the efficiency of delivering these services. This is contained in chapter 8.

Crime investigation

Effectiveness

Information on the outcomes of criminal investigations indicates the success of the police in responding to criminal incidents. Chapter 8 reports on outcomes of investigations. The data includes: the total number of investigations for a range of crimes; the investigations finalised as a proportion of total investigations; and the investigations in which the offender was proceeded against as a proportion of investigations finalised.

Areas that are not covered in chapter 8, but which may also be relevant, are the proportion of investigations that resulted in the offender being cautioned or diverted from the criminal justice system, as well as the proportion of investigations that are not resolved.

Efficiency

The efficiency measure of crime investigation is the cost per person of delivery of the service to the community. This is contained in chapter 8.

Presentation and pre-trial

Effectiveness

Measures relating to the proportion of lower court cases resulting in a guilty plea indicate the work undertaken by police and prosecuting services. Chapter 8 provides data for police in this area. The timeliness with which criminal committal matters are finalised is included in chapter 9. Data on the timeliness of hearings provide important information on the ability of the justice system to meet community demands for accused persons to be dealt with in a timely manner, and on the courts' ability to effectively manage caseload.

Efficiency

The cost per person of the service delivery area, 'services to the judicial process' is used as a proxy for the efficiency of delivering police prosecution services. This is contained in chapter 8. The cost per case in lower criminal courts is used to measure the efficiency of case management by court administrators. This is contained in chapter 9.

Adjudication and sentencing

Effectiveness

Measures relating to the proportion of higher court cases resulting in a guilty finding are contained in chapter 8. Case completion times and adjournment rates are included in chapter 9. Data on the timeliness of hearings provide important information on the ability of the justice system to meet community demands for accused persons to be dealt with in a timely manner, and on the courts' ability to effectively manage caseload.

Offender custody

Effectiveness

The key effectiveness measures of custody are prisoner assault, death and escape rates. Descriptive indicators, such as imprisonment rates, are disaggregated by gender and Indigenous status. Chapter 10 reports on these data.

Efficiency

There are no data that report the cost of custody. Costs associated with 'total resource management' and 'government operations resource management' provide some indicators of the cost of corrective services, but these costs also include components such as rehabilitation, reparation, and prisoner custody and transport (chapter 10).

Community corrections

Effectiveness

In community corrections, the key effectiveness measure is the proportion of orders successfully completed. Descriptive indicators, such as offender rates, are disaggregated by gender and Indigenous status. Chapter 10 reports on these data.

Efficiency

The cost per offender per day is used as a proxy for the efficiency of providing community corrections. These data are included in chapter 10.

Offender programs and reparation

Effectiveness

Information on the number of prisoners and offenders undertaking approved education and training courses, as well as personal development courses, provides an indication of the role of corrective services in providing program opportunities for offenders. These types of programs are reported on in chapter 10.

Reparation may include prisoners undertaking work in the community on environmental and other work projects. Offenders in community corrections provide reparation by serving court orders with unpaid community work components. The level and distribution of this reparation is detailed in chapter 10.

An area that is not covered in this Report, but which may also be relevant as part of rehabilitation, is the number of offence related programs offered (for example, intensive sex offender treatment programs and anger management programs).

Efficiency

Another area that is not reported, but which may be relevant, is the cost associated with rehabilitation and reparation programs. Currently, these data are incorporated into the total cost of corrective services (chapter 10).

Overall performance

Effectiveness

Recidivism — the extent to which persons convicted by the criminal justice system re-offend — is a partial measure of the performance of the system as a whole in improving public safety by reducing the incidence of crime. The only indicator of recidivism presented in this Report relates to the return to corrective services of persons released from custody or community correction orders. This measure does not fully reflect the extent of recidivism because it:

- does not include arrests that do not proceed to court (for example, restitution or police caution);
- does not include convictions for re-offending that lead to outcomes that are not administered by corrective services (for example, fines);
- does not include a corrections sanction for a repeat offender who has previously been sentenced to only non-corrections sanctions, such as fines; and

- is not weighted in any way to account for the nature of the re-offence (for example, a return to prison for a traffic offence is counted in the same manner as a return for a more serious offence, such as armed robbery).

The original indicator of recidivism assessed within the corrective services sector was limited to the percentage of prisoners returning to prison within two years of release. A second indicator of return to corrective services (either prisons or community corrections) was introduced in 1997-98. Both indicators are based on the outcomes for prisoners released from custody during the two years before the year in which the indicator is reported; thus data for 2000-01 relate to prisoners released during the 1998-99 period.

Recidivism among offenders under community correction orders is also assessed by two indicators — a return to community corrections and a return to corrective services (either prisons or community corrections). Return to corrective services is the preferred indicator in both cases.

In 2000-01, NSW reported the highest rate of prisoners returning to corrective services within two years (51.5 per cent) and SA the lowest (31.7 per cent). Western Australia was not able to provide data. For prisoners returning to prison within two years, the highest rate was exhibited by WA (45.1 per cent) and the lowest rate by SA (14.2 per cent) (table [Error! Not a valid link.](#)).

The NT reported the highest rate of offenders returning to corrective services within two years (35.2 per cent) and Queensland the lowest (18.0 per cent). Two jurisdictions, NSW and WA, did not report on this indicator. For offenders returning to community corrections, the highest rate of return within two years was reported by WA (26.6 per cent) and the lowest by Queensland (9.2 per cent). No data were provided by NSW (table D.3).

Table D.3 Proportion of prisoners and offenders released or completing order in 1998-99, returning with a correctional sanction within two years (per cent)

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
Prisoners returning									
– to corrective services	51.5	44.3	51.0	na	31.7	48.0	..	45.2	47.6
– to prison	41.4	34.1	30.2	45.1	14.2	33.5	..	29.5	35.5
Offenders returning									
– to corrective services	na	23.1	18.0	na	18.1	29.9	20.0	35.2	22.1
– to community corrections	na	19.6	9.2	26.6	12.6	19.7	15.3	18.3	17.6

na Not available. .. Not applicable.

Source: State and Territory governments (unpublished).

Efficiency

The efficiency of the criminal justice system is reflected in the level of resources used to deliver justice services. Unit cost indicators for individual justice services are presented in the relevant chapters, but some system outcomes result from interactions between the individual services. One indicator of efficiency is annual government expenditure on the criminal justice system per person (table D.4). However, comparisons of unit costs need to account for conflicting objectives and tradeoffs between cost, quality and timeliness, and need to be viewed in the context of the suite of effectiveness indicators in each chapter.

Real expenditure per person on criminal justice in Australia grew at an average annual rate of 2.9 per cent between 1996-97 and 2000-01. The highest rate of annual growth was experienced in the ACT (9.2 per cent) (table [Error! Not a valid link.](#)), although a proxy amount of payroll tax has been included in the 1999-2000 and 2000-01 years. The only jurisdiction to experience a decrease in growth was Victoria (a fall of 0.8 per cent) (table D.4).

Table D.4 **Real government expenditure on criminal justice system per person (2000-01 dollars)^{a, b, c}**

	1996-97	1997-98	1998-99	1999-2000 ^d	2000-01 ^d	Real annual growth rate
	\$	\$	\$	\$	\$	%
NSW	292	307	330	333	341	4.0
Victoria	280	270	285	290	271	-0.8
Queensland	251	258	282	310	309	5.4
WA ^e	328	341	364	388	394	4.7
SA	310	292	305	319	331	1.6
Tasmania	259	270	285	285	294	3.2
ACT	245	265	294	316	349	9.2
NT ^f	733	769	833	754	754	0.7
Australia	289	294	315	324	324	2.9

^a Defined as recurrent expenditure plus depreciation less revenue from own sources. Excludes capital expenditure and estimates of the user cost of capital in police and courts, but includes capital asset charge and debt servicing fees in corrective services. ^b Population estimated at 30 June. ^c Excludes costs of civil and probate hearings. ^d Includes adjustments for WA and the ACT to include a proxy amount for payroll tax (\$13 and \$14 per head of population respectively in 2000-01). Data from 1996-97 to 1998-99 exclude any adjustments for differences in payroll tax. Consequently, rates of growth for these two jurisdictions may be misleading. All other jurisdictions have payroll tax included. ^e Excludes WA community corrections expenditure during 1996-97. ^f Prison and community corrections revenue from own sources not deducted in 1996-97.

Sources: State and Territory governments (unpublished); ABS (2001).

Future directions in performance reporting

Each chapter (police, courts and corrective services) contains its own service-specific future directions. The aim of this section is to provide an insight into directions in performance reporting that covers the whole justice sector.

Juvenile justice

Information on juvenile justice is contained in the Community services preface. The Community services preface contains descriptive data on the number and detention rates of juveniles (including Indigenous juveniles) in correctional facilities. It is anticipated that the Report will contain performance reporting on juvenile justice in future years.

Crime and justice statistical framework

In July 2001, the ABS released the 'National Criminal Justice Statistical Framework' (NCJSF). The development of the framework arose from the need to develop comprehensive and integrated national criminal justice data. The NCJSF discusses the various connections across the main sectors of the criminal justice system and identifies some of the key counting units (such as 'person' and 'criminal incident') and data variables that characterise its main aspects.

The strategic objectives of the NCJSF include integrating criminal justice data between the different interconnecting sectors of the criminal justice system, as well as across the States and Territories. It achieves this by promoting comparability of data both within and across jurisdictions by using common definitions and standards across services areas and jurisdictions. A common language is created that facilitates a shared understanding of the criminal justice system and the populations that flow through it.

The NCJSF's promotion of a common language based on the person ensures consistent reporting across jurisdictions and criminal justice agencies, and allows for an examination of the flow of aggregate populations of offenders through the criminal justice system. The ABS currently reports both person (for example, demographic information on defendants and on prisoners) and non-person based data (for example, the number of cases handled by the courts) and is working to expand its police statistics collection to include information on alleged offenders.

Indigenous issues

The information available on contact by Indigenous people with parts of the criminal justice system is of varying quality. The most important reason for the poor quality of Indigenous data is the reluctance of justice agencies to explicitly ask for the person's Indigenous status. Self identification is the ABS' preferred method of identifying Indigenous clients. However, self identification can be difficult to implement, given that identifying Indigenous status may be perceived as discriminatory or prejudicial at certain stages of the prosecution process.

The data on the deaths of Indigenous people in police custody and custody related operations (chapter 8), Indigenous representation in prisons and community corrections (chapter 10), and Indigenous deaths in prison custody (chapter 10) are of a high quality and are published in the Report.

Another source of Indigenous data is the Australian Institute of Criminology, which produces a number of statistical and analytical reports on the involvement of Indigenous people within the criminal justice system, particularly in relation to deaths in police and corrective services custody.

8 Police services

This chapter reports on the performance of police services. These comprise the operations of the police agencies of each State and Territory government and the ACT community policing function performed by the Australian Federal Police under the 'Policing arrangement between the ACT and Commonwealth governments'. The national policing function of the Australian Federal Police and other national non-police law enforcement bodies, such as the National Crime Authority, are not included in the Report.

A profile of the police sector appears in section 8.1, followed by a brief discussion of recent policy developments in section 8.2. The general approach to performance measurement for police services is outlined in section 8.3. The overarching indicators of police performance are contained in section 8.4, and the specific performance measurement frameworks and data for each service delivery area are discussed in sections 8.5–8.9. Section 8.10 contains information on capital costs in police services and section 8.11 covers the future directions in performance reporting. The chapter concludes with information on sample data (section 8.12), jurisdictions' comments (section 8.13) and definitions (section 8.14).

Supporting tables for chapter 8 are provided on the CD-ROM enclosed with the Report. The files are provided in Microsoft Excel 97 format as `\Publications\Reports\2002\Attach8A.xls` and in Adobe PDF format as `\Publications\Reports\2002\Attach8A.pdf`.

Supporting tables are identified in references throughout this chapter by an 'A' suffix (for example, table 8A.3 is table three in the electronic files). They may be subject to revision. The most up-to-date versions of these files can be found on the Review's web page (www.pc.gov.au/gsp). Users without Internet access can contact the Secretariat to obtain up-to-date versions of these tables (see details on the inside front cover of the Report).

8.1 Profile of police services

Service overview

The police services are the principal means through which State and Territory governments pursue the achievement of a safe and secure environment for the community; the investigation of offences and provision of services to the judicial process; and the provision of road safety and traffic management.

Police are involved in a diverse range of activities aimed at reducing the incidence and effect of criminal activity. Police also respond to more general needs in the community — for example, assisting emergency services, mediating family and neighbourhood disputes, delivering messages regarding death or serious illness and advising on general policing and crime issues (Criminal Justice Commission 1996).

Roles and responsibilities

Policing services are predominantly the responsibility of State and Territory government police agencies. The Australian Federal Police provides a community policing service in the ACT through a strategic partnership underpinned by a detailed purchaser/provider agreement. The Commonwealth Government is responsible for the Australian Federal Police.

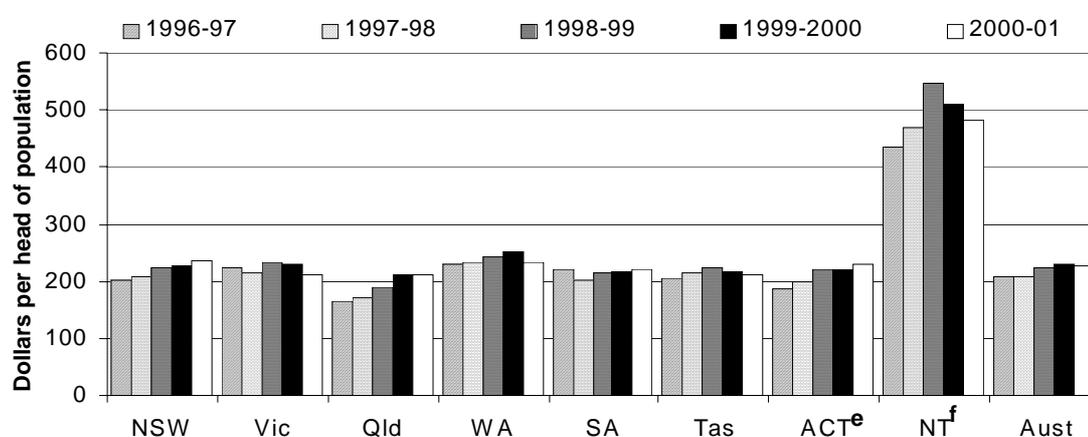
While each jurisdiction's police service is autonomous, there is significant cooperation across jurisdictions under the auspices of the Australasian Police Ministers' Council (APMC). There are also bilateral arrangements and common national police services, such as the National Institute of Forensic Sciences and the Australasian Centre for Policing Research.

Expenditure

Funding for police services comes almost exclusively from State and Territory government budgets, with some specific-purpose Commonwealth grants. Real recurrent expenditure (less revenue from own sources) on police services across Australia was approximately \$4 billion (or \$225 per head of population) in 2000-01. Across jurisdictions, it varied from \$483 per head of population in the NT to \$212 per head of population in Victoria, Queensland and Tasmania (figure 8.1). The average annual change in real recurrent expenditure (less revenue from own sources) between 1996-97 and 2000-01 ranged from an increase of 6.7 per cent in Queensland to a reduction of 1.5 per cent in Victoria (table 8A.11).

Variations in policies, socioeconomic factors and geographic/demographic characteristics may impact on expenditure for police services in each jurisdiction. To this end, some preliminary work has been undertaken to assess the degree to which remoteness affects the level of police expenditure within jurisdictions (box 8.1). As well, the scope of activities undertaken by police services will vary across jurisdictions. Tables 8A.1–8A.8 contain a breakdown of the expenditure and revenue from own sources (as well as staffing levels and asset values) of each jurisdiction’s police service for 1996-97 to 2000-01.

Figure 8.1 Real recurrent expenditure (less revenue from own sources) on police services^{a, b, c, d}



^a Revenue from own sources includes user charges and other types of revenue (for example, revenue from sale of stores and plant). It excludes fine revenue, money received as a result of warrant execution, and revenue from the issuing of firearm licences. ^b Excludes the user cost of capital. ^c Includes payroll tax for all jurisdictions, except WA and the ACT (which are exempt from payroll tax). If WA and the ACT were liable for paying payroll tax, then real recurrent expenditure (less revenue from own sources) in 2000-01 would have increased by \$10 per head of population in WA and \$12 in the ACT. ^d Population based on ABS estimates for June 2001. ^e In 2000-01, as a result of a comprehensive review of enabling costs applicable to ACT Policing, the formula previously applied to the calculation of staffing and expenditure data has been significantly revised. This methodological shift means that material in this Report is not directly comparable with that for previous years. ^f The inclusion of superannuation costs for the first time in 1998-99 accounted for two thirds of the increase in expenditure data from 1997-98 to 1998-99.

Source: table 8A.11.

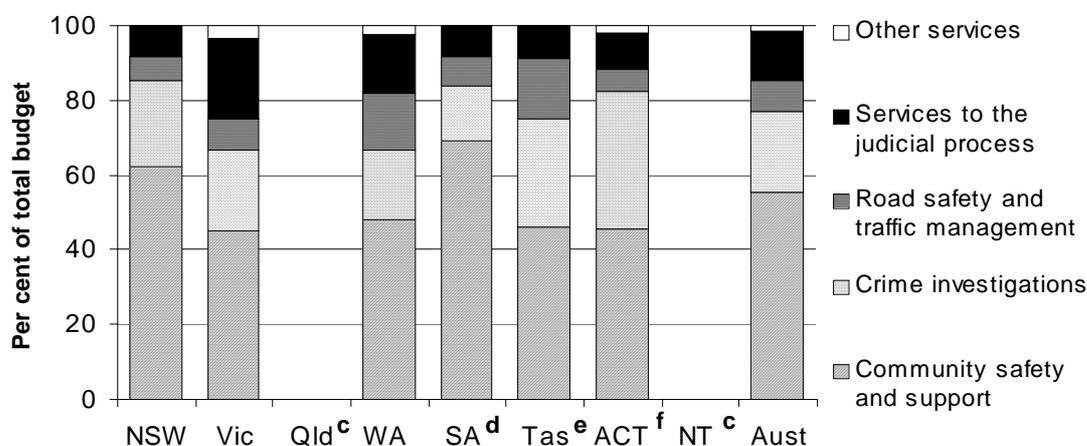
Expenditure breakdown by key service delivery area

The chapter breaks police outputs/programs into four service delivery areas (SDAs). A fifth area (‘other services’) has been identified to account for expenditure by jurisdictions on unique functions that are not included in the SDAs. Expenditure data on each SDA are not strictly comparable. (Further information is included in section 8.3 and the outputs/programs undertaken within each SDA, by jurisdiction, are listed in table 8A.10).

Differences in counting rules exist across jurisdictions as a result of the differing mixes of activities undertaken within each of the common SDAs. As well, the activity survey data which provides the relative breakdown of expenditure, is reliant on snapshot data for most jurisdictions and may not be truly reflective of peaks and troughs in expenditure throughout the year. The reliability and representativeness of survey data will continue to improve as more surveys are conducted. In the meantime, caution should be taken when comparing results across jurisdictions.

The NT cannot produce activity based results as it does not collect the necessary data, and Queensland did not provide a breakdown by SDA because of concerns about the comparability of data. As a proportion of each jurisdiction's total budget, SA spent the most on community safety and support (69.1 per cent) in 2000-01, while the ACT spent the most on crime investigation (36.8 per cent). Expenditure on road safety and traffic management (as a proportion of total budget) was highest in Tasmania (16.0 per cent), while Victoria spent the most on providing services to the judicial process (21.8 per cent) (figure 8.2). Expenditure is broken down by SDA for 2000-01 in figure 8.2 and for 1999-2000 in table 8A.13.

Figure 8.2 Recurrent expenditure (less revenue from own sources) on police services, by service delivery area, 2000-01^{a, b}



^a Data have not been subject to extensive tests to determine comparability. Further, some differences in counting rules may exist across jurisdictions as a result of the differing mixes of activities undertaken within each of the common SDAs. ^b Overheads (for example, infrastructure costs, such as rent on buildings and vehicle and equipment costs) have been apportioned to these SDAs on a *pro rata* basis. ^c Data are only available for all key SDAs combined. ^d The allocation of resources in 2000-01 was based on both work activity surveys from a representative sample of four major local service areas in February 2001 and data provided by service areas. The crime investigation activities exclude a wide range of crime prevention, reduction and response activities which is the same methodology applied in 1999-2000. ^e The data exclude expenditure associated with emergency management and the protection of primary industries and fisheries resources. Costs associated with a new section, Forensic Science Service, in July 2000 have also been excluded. ^f Costs are apportioned across SDAs through use of direct and indirect cost attribution. In situations where no direct relationship can be identified, or where expenditure is attributable to numerous SDAs, indirect costing systems (based on activity survey data) are used.

Source: table 8A.12.

Box 8.1 Police analysis of rural/remote issues

The Police Working Group has tried to measure the extent to which remoteness affects the level of police expenditure in jurisdictions.

A preliminary study was conducted in NSW to evaluate the usefulness of the Accessibility and Remoteness Index for Australia (ARIA) in defining areas for analysis on the basis of their apparent remoteness. The study used the 12-point ARIA scores for Census collector districts to derive an average ARIA score for police administrative areas — Local Area Commands (LACs). The LACs were then categorised into highly accessible; moderately accessible; accessible; remote; and very remote.

The total costs of policing for each category were calculated after apportioning costs absorbed at higher administrative units (for example, region and headquarters). Finally, the average cost per head of population (using 1996 Census data) was calculated for each category.

The cost of policing per head of population was least in highly accessible areas and increased for each subsequent category of remoteness. The average cost in the most remote areas of NSW was almost equivalent to the average cost in the NT as a whole (that is, over \$500 per head of population). Similarly, the average cost in the ACT was about the same as that for highly accessible areas of NSW.

Although the study shows average costs increase in line with remoteness, the Police Working Group has some outstanding issues associated with the use of ARIA. The ARIA scores are derived by determining the distance by road from centres of various sizes. As such, ARIA provides a measure of relative remoteness but does not address the fundamental issue of accessibility, for which additional information (for example, road condition or alternative means of access) are required. Further, the treatment of islands, which receive a score of 2 plus the value of the nearest mainland point, is considered arbitrary, as it does not take account of means of access and affordability.

While the study undertaken by NSW is preliminary, it does nonetheless provide some insights. Should the Working Group agree on an appropriate rural/remoteness framework, there may be the potential for more in-depth reporting in this area for future Reports.

Source: NSW Police (unpublished).

Size and scope of sector

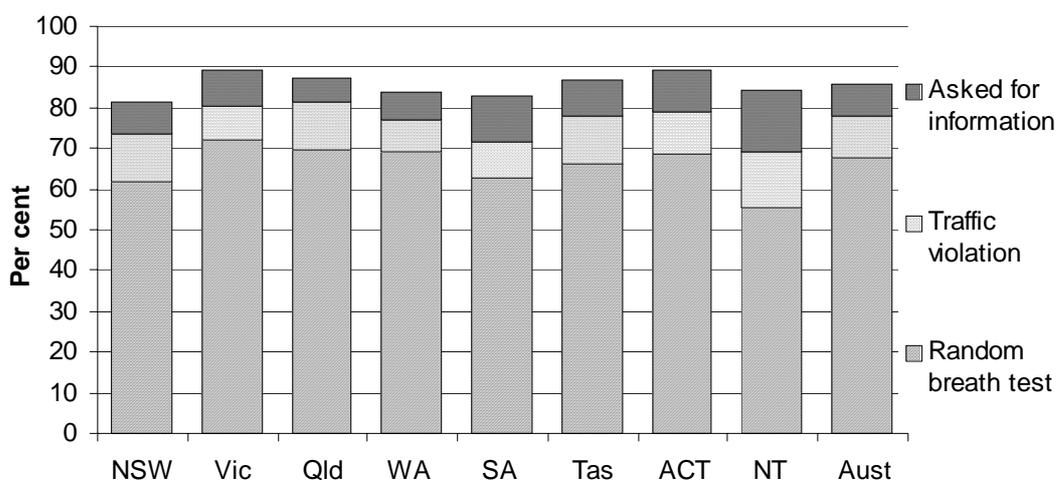
Client groups

Broadly, the whole community is a 'client' of the police. All individuals are provided with protection, help and reassurance, and everyone is required to comply with the law. Some members of the community have more direct dealings with the police and can be considered a specific client group, for example:

- victims of crime;
- those suspected of committing offences;
- those reporting criminal incidents;
- those involved in traffic related incidents;
- third parties (such as witnesses to crime and people reporting accidents); and
- those requiring police services for non-crime related matters.

Of all people in Australia aged 18 years and over, approximately 49.4 per cent had some form of contact with police in 2000 (table 8A.36). Police initiated the most recent contact in 58.8 per cent of these cases (table 8A.38), mainly to undertake random breath testing (67.6 per cent of cases), pursue traffic violations (10.1 per cent) and ask for information (8.1 per cent). The three main reasons for police contact are outlined by jurisdiction in figure 8.3.

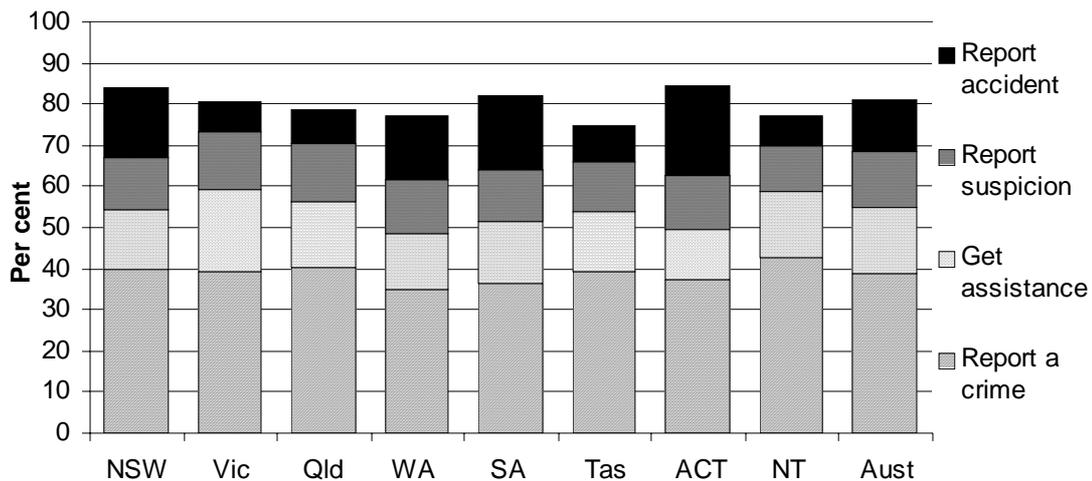
Figure 8.3 The three most frequent reasons for police contacting respondent in most recent contact, 2000 (per cent)



Sources: ABS, Population Survey Monitor, 2000; table 8A.40.

Nationally, the respondents to the survey initiated the contact with police in 41.2 per cent of cases (table 8A.38), mainly to report a crime (38.8 per cent), receive assistance (16.2 per cent) or report a suspicion (13.3 per cent). The four main reasons are outlined by jurisdiction in figure 8.4.

Figure 8.4 The four most frequent reasons for respondent contacting police in most recent contact, 2000 (per cent)



Sources: ABS, Population Survey Monitor, 2000; table 8A.39.

Recorded crime in Australia

The Australian Bureau of Statistics (ABS) compiles comparable data on recorded victims of crime for selected offences. These statistics relate to those crimes against the person and crimes against property that are common across jurisdictions, but do not reflect all recorded crimes (box 8.2).

Therefore, the data reported in the chapter on crimes against the person and crimes against property understate the true level of crime in Australia because not all offences are reported to, or become known by, police. In addition, the offences include only selected offences and exclude certain offences for which it is more difficult to develop comparable data (for example, fraud offences). Section 8.5 contains further information on crime rates and victims of specific offences.

Crimes against the person include murder; attempted murder; manslaughter; assault; sexual assault; kidnapping/abduction; robbery; and blackmail/extortion. Crimes against property include unlawful entry with intent; motor vehicle theft; and other theft.

Box 8.2 Victims of crime

Recorded crime statistics

Since 1993, the ABS has produced a series of publications providing crime statistics on victims of crime for a selected group of offence types, recorded by State and Territory police services in Australia. Victims can be people, organisations, premises or motor vehicles, depending on the type of offence. Included are victims of attempted offences (ie. attempted assault is counted as part of assault), but attempted motor vehicle theft is excluded. *Recorded Crime, Australia, 2000* is the latest publication in this series.

Comparing recorded crime statistics across jurisdictions

The compilation of recorded crime statistics uses national standards and classifications, but caution should be exercised when directly comparing these statistics across States and Territories because:

- data are based on recorded crimes only; and
- reporting procedures, crime recording systems and legislation differ across States and Territories.

Comparing recorded crime statistics with jurisdiction-specific data

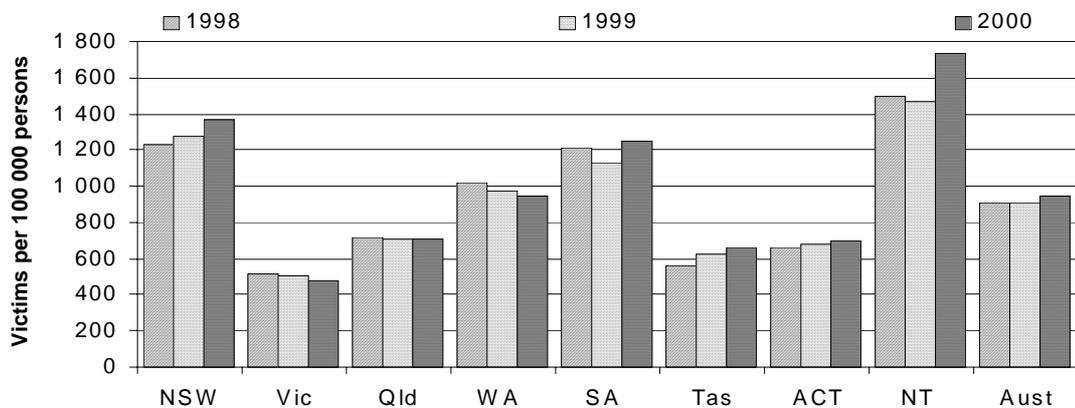
Care should also be taken if attempting to compare the ABS' recorded crime statistics with data reported by some jurisdictions. The former are *victim based* (that is, based on the number of victims per selected offence category), whereas data for each State and Territory are commonly *offence or incident based* (that is, based on the total number of offences or incidents recorded). To illustrate the difference, multiple offences of the same national offence category committed against the same victim are included as only one count in the national crime statistics, but the information systems in each jurisdiction may separately count each offence committed against the same victim.

Crime and safety statistics

Another valuable measure of crime is the Crime and Safety Survey Australia, conducted by the ABS. The latest national survey was conducted in April 1998, and data from this survey were released in August 1999. This survey provides information on the levels of both reported and unreported victimisation in the Australian community for selected offences. In addition, the ABS undertook to repeat the survey in NSW, WA and SA in 2000. The next national survey will be conducted in April 2002.

In Australia during 2000, there were 181 747 victims of crime against the person recorded by police (table 8A.14). This figure includes 4610 victims (such as organisations) of armed/unarmed robbery and blackmail/extortion. Expressed as a proportion, there were 949 victims of crime against the person, per 100 000 persons. The number of crimes per 100 000 persons in 2000 varied across jurisdictions, from 1737 in the NT to 475 in Victoria. Rates from 1998 to 2000 for each jurisdiction are outlined in figure 8.5.

Figure 8.5 Victims of recorded crimes against the person, 1998 to 2000^{a, b}

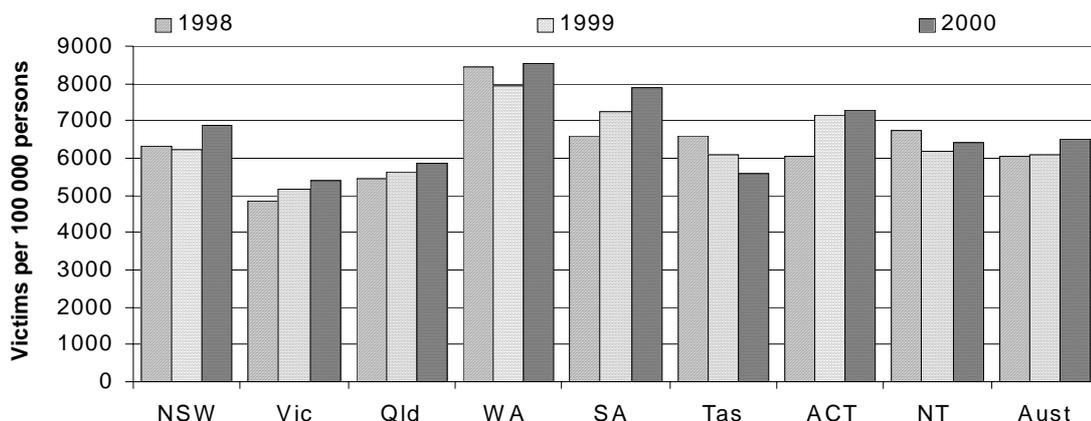


^a Excludes offences against Commonwealth laws processed under Commonwealth jurisdiction; conspiracy offences; aiding, abetting and accessory offences; and other offence types, such as drug and prostitution offences. ^b Includes murder; attempted murder; manslaughter; assault; sexual assault; kidnapping/abduction; armed robbery; unarmed robbery; and blackmail/extortion. Data are based on crimes reported to police. Includes a small proportion of non-person victims (such as organisations) of armed/unarmed robbery and blackmail/extortion. For person offences, the victim may be the victim of multiple person offences within a single criminal incident.

Sources: ABS 2001c; table 8A.14.

In 2000, there were 1 250 772 victims of crimes against property (or 6530 per 100 000 persons) in Australia. Across jurisdictions, the number per 100 000 persons ranged from 8547 in WA to 5384 in Victoria. The number of crimes against property, per 100 000 persons, between 1998 and 2000 is outlined for each jurisdiction in figure 8.6.

Figure 8.6 Victims of recorded crimes against property, 1998 to 2000^{a, b}



^a Excludes offences against Commonwealth laws processed under Commonwealth jurisdiction; conspiracy offences; aiding, abetting and accessory offences; and other offence types, such as drug and prostitution offences. ^b Includes unlawful entry with intent; motor vehicle theft; and other theft. Data are based on crimes reported to police. Includes a small proportion of person victims of other theft.

Sources: ABS 2001c; table 8A.14.

Staffing

Most people directly involved in delivering police services are sworn police officers. These officers exercise police powers, including the power to arrest, summons, caution, detain, fingerprint and search. A trend has developed in recent years to increase the participation of non-sworn officers (or contracted external providers) in some activities. 'Civilianisation' of police services has three key objectives:

- to reduce costs;
- to account for the increasing need for specialist skills; and
- to reduce the involvement of sworn staff in duties that do not require police powers (eg. administrative work, crime scene analysis and intelligence analysis).

Total police staffing in Australia was 53 912 (or 277 staff per 100 000 persons) in 2000-01, which is around the same number of staff per 100 000 persons recorded in 1996-97 (278 staff per 100 000 population), and is higher than the 274 staff per 100 000 population recorded in 1998-99 (table 8A.15).

Nationally, staffing comprised 215 sworn police officers and 62 unsworn employees per 100 000 persons in 2000-01. Across jurisdictions, total staffing ranged from 561 staff per 100 000 persons in the NT to 243 staff per 100 000 persons in Victoria. Over the period of 1996-97 to 2000-01, the national level of sworn police staff fell by two staff members per 100 000 population while the level of unsworn police staff increased by one staff member per 100 000 population (table 8.1).

Table 8.1 **Police staff by sworn/unsworn status (staff members per 100 000 population)^a**

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas^b</i>	<i>ACT^c</i>	<i>NT^d</i>	<i>Aust</i>
Sworn police staff									
1996-97	207	219	193	264	229	218	210	438	217
1998-99	208	203	199	251	231	227	214	454	214
2000-01	207	196	213	247	238	230	187	475	215
Unsworn police staff									
1996-97	64	46	69	79	43	86	25	117	61
1998-99	57	43	79	74	57	73	21	93	60
2000-01	59	47	86	63	65	72	58	86	62

^a Comprises all full time equivalent staff. ^b Additional unsworn staff were employed in 1996-97 to manage the firearms buy-back scheme. ^c Civilianisation of support functions has occurred throughout 2000-01 with the 'communications centre' now being substantially staffed by non-sworn staff. As well, as a result of a comprehensive review of enabling costs applicable to ACT policing, the formula previously applied to the calculation of staffing and expenditure data has been significantly revised. This methodological shift means that material in this Report is not directly comparable with that for previous years. ^d Sworn police officers include police auxiliaries and Aboriginal community police officers.

Source: table 8A.15.

The changes in composition, however, varied depending on the jurisdiction; for example, the NT increased its level of sworn police staff per 100 000 persons from 438 to 475, but decreased its unsworn staff from 117 to 86 over this period. In contrast, over the same 1996-97 to 2000-01 period, Victoria's sworn police staff (per 100 000 persons) decreased from 219 to 196, while its unsworn staff increased from 46 to 47 persons (table 8.1).

Police staff can also be categorised according to their operational status. An operational staff member is any person (sworn or unsworn) who delivers a police or police related service to an external customer directly (where an external customer refers to members of the public, other government departments, courts and the government) and includes:

- operational staff (general duties officers, detectives, traffic officers, community policing and station counter staff); and
- operational support staff (any person directly supporting the operational provider, including technical staff and intelligence staff).

A non-operational staff member is any person who does not satisfy the operational staff criteria, including functional support staff, such as finance staff and personnel services staff. Approximately 80.6 per cent of staff were operational in Australia in 2000-01. Across jurisdictions, the proportion ranged from 91.4 per cent in WA to 65.5 per cent in Queensland (table 8.2). However, the definition of operational status used by Queensland did not align with the national data dictionary. Care, therefore, needs to be taken when comparing Queensland with other jurisdictions.

Table 8A.16 in the attachment shows data on operational status for each jurisdiction from 1998-99 to 2000-01. Caution should be used when interpreting these results within and between jurisdictions, as the data for earlier years may not be strictly comparable due to changes in definitions or methods used to compile the data.

Table 8.2 Police staff by operational status (per cent)^{a, b}

	<i>NSW</i>	<i>Vic</i>	<i>Qld^c</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT^d</i>	<i>NT</i>	<i>Aust</i>
Operational staff									
2000-01	82.4	81.3	65.5	91.4	91.0	83.3	86.9	83.8	80.6
Non-operational staff									
2000-01	17.6	18.7	34.5	8.6	9.0	16.7	13.1	16.2	19.4

^a Comprises all full time equivalent staff. ^b The definition of operational status is quite broad and may be interpreted differently across jurisdictions. ^c The definitions of operational and non-operational status does not align with the national data dictionary, therefore, care should be taken when comparing Queensland with other jurisdictions. ^d This year, as a result of a comprehensive review of enabling costs applicable to ACT Policing, the formula previously applied to the calculation of staffing and expenditure data has been significantly revised. This methodological shift means that material in this Report is not directly comparable with that for previous years.

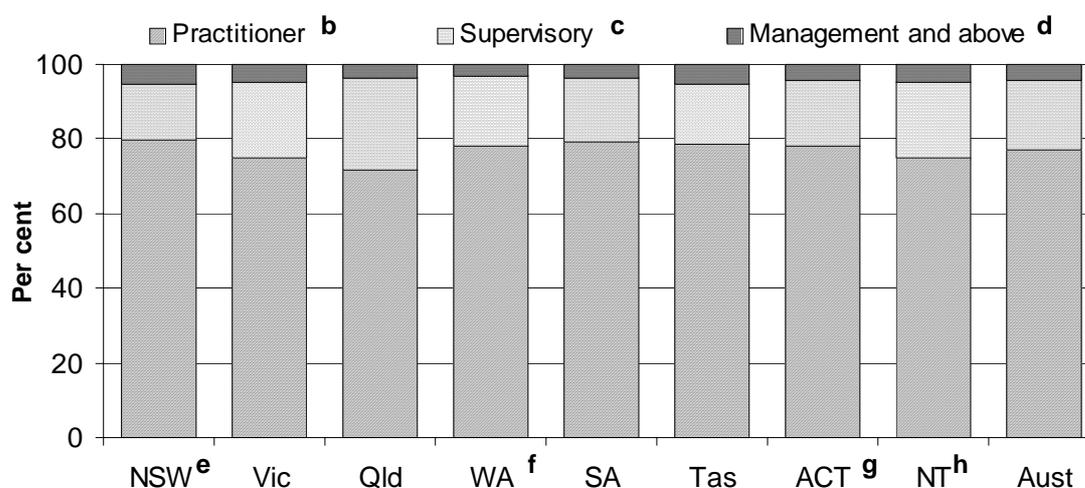
Source: table 8A.16.

Police staff can also be categorised according to their classification level. Nationally, in 2000-01, the majority of police staff (76.8 per cent) were concentrated at the practitioner level (comprising civilian administration staff and sworn staff from constable to senior constable). While there was little difference between jurisdictions, NSW had the highest proportion of its staff at the practitioner level (79.9 per cent).

More staff were at a supervisory level in Queensland (24.1 per cent) than anywhere else. New South Wales and Tasmania had the highest proportion (5.5 per cent) of staff at management level or above (including executive or senior executive level staff). The lowest proportion of staff at management level or above was in WA (2.9 per cent) (figure 8.7).

This is the third year in which these data have been published in the Report, and the results do not differ significantly from the classifications data published previously (tables 8A.18-8A.19).

Figure 8.7 Police staff by classification, 2000-01^a



^a Comprises all full time equivalent staff. ^b Comprises civilian administration staff and sworn staff (from constable to senior constable). ^c Comprises civilian team leaders and sworn staff (from sergeant to senior sergeant). ^d Comprises management level staff (civilian managers and sworn staff from inspectors to superintendents), executive level staff (civilian senior executive service and sworn staff from chief superintendent to assistant commissioner) and senior executive level staff (civilian top senior executive service and sworn staff, including commissioner, deputy commissioner and equivalent executives). ^e Students at Charles Sturt University are not included in the practitioner category. ^f Excludes recruits in training. ^g As a result of a comprehensive review of enabling costs applicable to ACT Policing, the formula previously applied to the calculation of staffing and expenditure data has been significantly revised. This methodological shift means that material in this Report is not directly comparable with that for previous years. ^h Small units and remote stations are staffed at sergeant level.

Source: table 8A.17.

8.2 Policy developments in policing

At its meeting on 13 December 2000, the APMC resolved that its top three agenda priorities for 2001 should be CrimTrac, e-crime and drug issues.

CrimTrac

Australian police agencies have a long established commitment to the exchange of national policing information. In May 1990, the APMC formally established the National Exchange of Police Information (NEPI) to combine the resources of jurisdictions and to maximise the exchange of operational information. Established on 1 July 2000, CrimTrac is designed to build on the NEPI initiative by capitalising on advances in technology. It will allow Australian police agencies to take advantage of the dramatic opportunities opened up by recent advances in forensic science, information technology and communications. CrimTrac deliverables include: the National Automated Fingerprint Identification System; the National Criminal Intelligence DNA Database; and the National Child Sex Offenders Database. CrimTrac will allow for integrated access to policing information.

E-crime

The issue of e-crime is particularly complex and challenging. The APMC has given its support to the Australasian Police Commissioners' E-crime Strategy, which will complement and build on various international initiatives. It will also complement the important work already undertaken by the Australasian Centre for Policing Research's Australasian Computer Crime Program; the Action Group into the law enforcement implications of electronic commerce; and initiatives directed at the protection of Australia's National Information Infrastructure.

The E-crime Strategy will position police to enable an effective response to a wide range of local and global crimes that use or target the Internet and information technology. Flowing from the Strategy, workplans have been developed addressing a number of critical activities. At their meeting in March 2001, the Police Commissioners identified a number of high priority issues including the development of broad based multi-level training strategies; an examination of current and emerging legislation; an examination of the role of law enforcement in this area; and options for the establishment of a National Centre for Cybercrime.

Drugs issues

Illicit drug use in Australia is associated with a range of social, economic and health problems. Australian police have instituted a range of measures in recognition of the need for vigorous law enforcement involvement to prevent and address these problems. In recognition of the lead role taken by the law enforcement sector in the area of illicit drug supply reduction, the APMC asked its Senior Officers' Group to develop a supply reduction strategy for heroin, which at the request of the Ministerial Council on Drug Strategy, was later broadened to include other illicit drugs. Since its inception, this strategy has undergone regular revisions and more recently has been completely rewritten to ensure that it continues to provide a relevant framework to guide drug law enforcement activities carried out by Australian agencies.

In addition, the May 1999 Police Commissioners' Conference resolved to establish a Drug Policy Subcommittee (DPS). The Subcommittee was established to provide a mechanism for the Police Commissioners to more clearly and strategically focus on illicit drug issues. The DPS has a work plan that contains 32 distinct issues. The work plan is regularly revised to ensure that it continues to address issues of concern for drug law enforcement in Australia.

Law enforcement liaises closely with its partners and other key stakeholders in this area to ensure a coordinated and holistic response to the issue.

8.3 General approach to performance measurement for police services

Performance can be defined in terms of how well a service meets its objectives, given its operating environment. Performance indicators need to focus on outcomes and/or outputs aimed at meeting common, agreed objectives.

Four such objectives (and associated SDAs) have been identified for the purposes of this Report (box 8.3). The individual outputs/programs that are linked to the SDAs are contained in table 8A.10. For some jurisdictions, one output/program may be relevant for more than one SDA, and thus the jurisdiction may choose to disaggregate that output/program according to the data relevant to each SDA.

Box 8.3 Objectives for police services

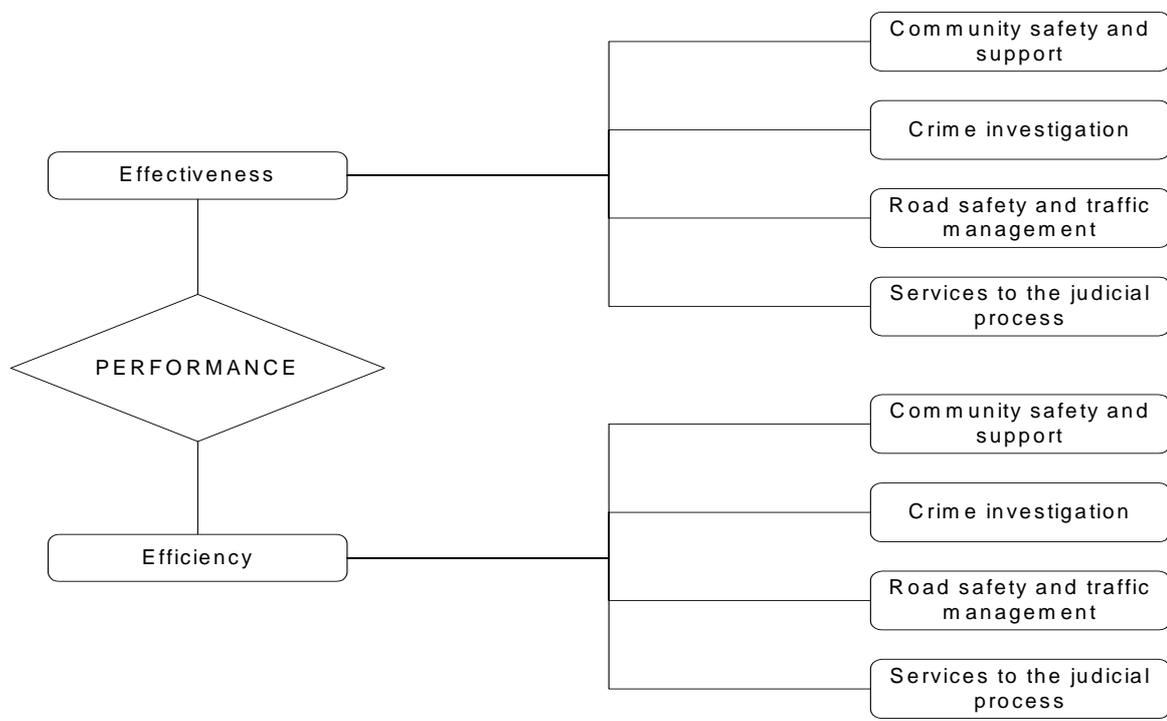
The key objectives for police services (and associated SDAs) are:

- to allow people to undertake their lawful pursuits confidently and safely (through activities associated with community safety and support);
- to bring to justice those persons responsible for committing an offence (through activities associated with crime investigation);
- to promote safer behaviour on roads (through activities associated with road safety and traffic management); and
- to support the judicial process to achieve efficient and effective court case management and judicial processing, while providing safe custody for alleged offenders, and ensuring fair and equitable treatment of both victims and alleged offenders (through activities associated with services to the judicial process).

These objectives are to be met through the provision of services in an equitable and efficient manner.

Figure 8.8 shows the framework of performance indicators. The reported results should be considered in conjunction with the data on demographic and geographic differences reported in appendix A, and with other available information on jurisdiction-specific characteristics.

Figure 8.8 General performance framework for the police services sector



Population Survey Monitor

As in past years, the ABS has undertaken a Community Perceptions of Police Services Survey. The ABS has conducted this survey quarterly using its Population Survey Monitor (PSM).

This survey provides a range of information, including the way in which the community perceives the police service, their own safety, and problems in the community and neighbourhood.

The combination of four quarters' results produces estimates for each year. (Selected results from the survey are presented in this chapter and in attachment 8A.) The timing of the quarterly survey in each jurisdiction may influence the survey data reported. Rare but significant adverse events in a jurisdiction (such as a mass murder or police corruption incident) may influence general satisfaction with police and perceptions of safety and crime levels.

The data obtained from the PSM may be different from the data that would have been obtained if the entire population was surveyed. Consequently, care needs to be taken when using survey results (box 8.4).

Box 8.4 **Sampling error and statistical significance**

The actual precision of survey estimates depends on the survey sample size, the representativeness of the sample and the sample estimate. Large sample sizes result in higher precision, as do large sample estimates; for example, if 90 per cent of surveyed respondents chose an answer, then there would be less uncertainty about the actual population's views than if 50 per cent of respondents had chosen it. Consequently, caution should be used when interpreting small differences in results and estimates that are small. (Section 8.12 discusses the sampling method, including sample size, and provides information for calculating confidence intervals).

Appendix A outlines a method that can be used to test whether the difference between two proportions is statistically significant. This test may be used to assess the significance of differences between the PSM estimates reported here.

General national trends from the PSM over the 1996 to 2000 period are available from box 8.5. Trends specific to certain jurisdictions are outlined throughout the chapter and in attachment 8A.

Box 8.5 **General national trends from the five years of PSM results**

General satisfaction with police services

Satisfaction with police services has been relatively consistent over the five year period of the survey. The variations have not been statistically significant, with general satisfaction declining from 70 per cent in 1996 to 67 per cent in 2000.

About 80 per cent of people were satisfied with their last contact with police throughout the five years of the survey. It is possible that people were more satisfied with their own contact with police officers, rather than the overall services supplied by police.

General satisfaction by age and sex

Over the past five years more women were satisfied with the services supplied by police (in 2000, 69 per cent of women compared with 66 per cent of men). For the 18-24 year age group, 62 per cent of women were satisfied with police services compared with 55 per cent of men (this particular result relates to a special series of PSM data). Satisfaction generally increased with age, while the gap in opinion between the genders narrowed. There was no significant difference between men and women for the 65 year and over age group in 2000, with about 79 per cent of people satisfied.

Attitudes towards police

In all cases, people's attitudes towards police improved over the five years of the survey (including perceptions on whether police were honest, performed their duties professionally, and treated people fairly and equally). In 1996, only 51 per cent of people thought that police treated people fairly and equally and 72 per cent thought that police performed their job professionally. By 2000, these figures were 62 per cent and 80 per cent respectively.

Feelings of safety

Over the past five years, people generally felt safe in all situations during the day. At night, the proportion of people feeling safe at home ranged from 79 per cent to 84 per cent. However, the proportion of people who felt safe walking/jogging in the neighbourhood at night ranged from 38 per cent to 43 per cent. The lowest feelings of safety at night were on public transport (ranging from 21 per cent to 25 per cent).

Perceptions of problems

People perceived a variety of anti-social behaviours as problems in the general community. Over the past three years, about 90 per cent of people perceived illegal drugs as a problem in the community. Anti-social behaviours involving violence (family violence, assault and sexual assault) were perceived as a problem in the community by 78 per cent to 85 per cent of people.

Over the past five years, other behaviours that people perceived as problems in their neighbourhoods were speeding cars/noisy driving (ranging from 69 per cent to 73 per cent), housebreaking (ranging between 62 per cent and 64 per cent) and motor vehicle theft (ranging between 49 per cent and 53 per cent).

Source: ABS, Population Survey Monitor, 1996–2000.

Discontinuation of the PSM data

As a result of a review of its Household Survey Program, the ABS decided to discontinue the PSM from November 2000. Consequently, it is not possible to generate survey data for the 2000-01 financial year in this year's Report.

In order to use the six months of PSM data that was not used last year (that is, August and November quarter 2000 PSM results), the chapter uses PSM calendar year results. Calendar year data from the PSM for the period 1996 to 2000 have been used throughout this year's Report.

To replace the PSM, the police jurisdictions, coordinated through the Australasian Centre for Policing Research, have chosen a new provider for the Survey of Community Satisfaction with Policing. It is anticipated that a first set of results will be available from the new provider in time for the 2003 Report. Care will need to be taken next year when comparing data from the new provider with the PSM results, as the timing, methodology, sample size and coverage of the two surveys will differ.

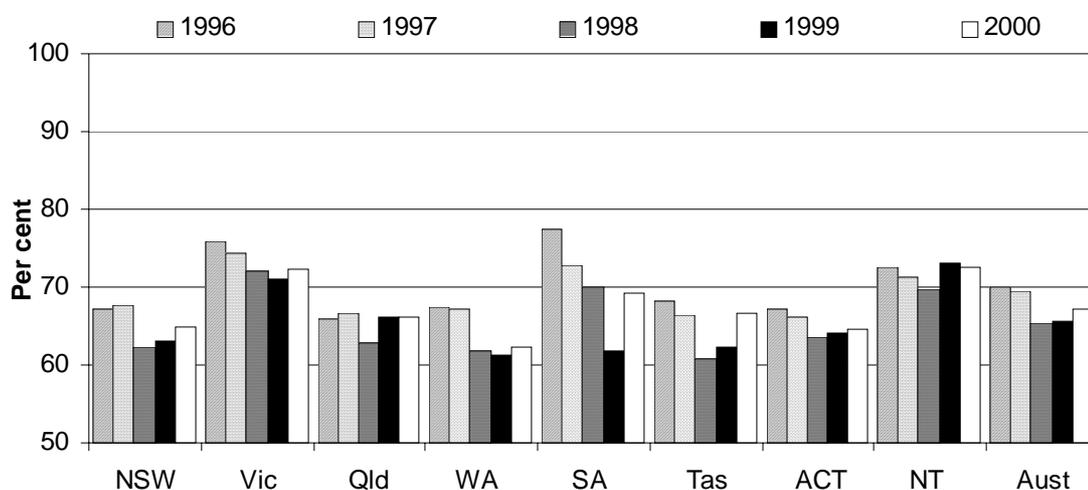
8.4 Indicators relevant to all service delivery areas

The four SDAs of the performance indicator framework identify the core areas of police work. Within this context, certain indicators of police performance are not specific to any one particular SDA but are relevant for all SDAs. These indicators may include satisfaction with police services, the integrity and professionalism with which police deliver their services, and access and equity considerations. This section provides information on these overarching indicators of police performance, while sections 8.5–8.9 examine each particular SDA.

Satisfaction with police services

The majority (67.2 per cent) of the surveyed adult population in 2000 was 'satisfied' or 'very satisfied' with services provided by police. Across jurisdictions, this proportion varied from 72.6 per cent in the NT to 62.3 per cent in WA. The national trend shows a slight decline in satisfaction levels from 1996 to 2000. The trends across jurisdictions vary, but in each case, the level of satisfaction with police services in 2000 is either around or less than that found in 1996. Over the last year, the largest increases in satisfaction occurred in SA and Tasmania (7.3 and 4.4 percentage points respectively) with little variation occurring in the other jurisdictions (figure 8.9).

Figure 8.9 Persons aged 18 years and over who were 'satisfied' or 'very satisfied' with police services^a



^a Caution should be used when comparing differences in results across jurisdictions and over time. The size of the sample may affect the accuracy of the results.

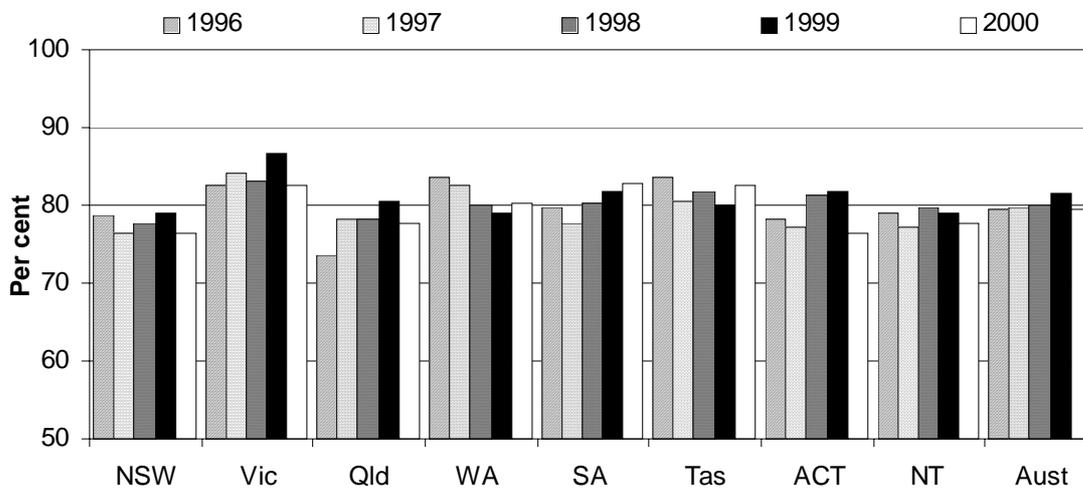
Sources: ABS, Population Survey Monitor, 1996–2000; table 8A.20.

General satisfaction with police categorised by sex, age and birthplace for the period 1996 to 2000, can be found in tables 8A.21–8A.35.

Nationally, 49.4 per cent of respondents had contact with police in 2000 (table 8A.36). The distribution in the number of contacts is contained in table 8A.37. Of those respondents who had contact with police in 2000, 79.5 per cent were 'satisfied' or 'very satisfied' with the service they received during their most recent contact. This proportion ranged from 82.9 per cent in SA to 76.4 per cent in NSW (figure 8.10). While there was some variation within jurisdictions over the five-year period, nationally, the level of satisfaction with police contact was relatively consistent throughout the period.

Of people aged 18 years and over who had contact with police in 2000, the most common reason for satisfaction with police services was that police were courteous (given by 46.2 per cent of the surveyed population who were satisfied). The prevalence of this reason ranged from 50.1 per cent in WA to 41.8 per cent in Tasmania. 'Approachable/friendly' treatment from police was the second most common reason for satisfaction (given by 42.1 per cent of the surveyed population who were satisfied). Across jurisdictions, this proportion ranged from 44.2 per cent in WA to 40.7 per cent in Queensland. Police acting in a 'professional/fair' manner was the third most common reason for satisfaction (given by 34.0 per cent of the surveyed population who were satisfied). Across jurisdictions, this proportion ranged from 43.8 per cent in the ACT to 28.9 per cent in Tasmania (table 8.3).

Figure 8.10 Persons aged 18 years and over who were 'satisfied' or 'very satisfied' with police in their most recent contact^a



^a Caution should be used when comparing differences in results across jurisdictions and over time. The size of the sample may have an affect on the accuracy of the results.

Sources: ABS, Population Survey Monitor, 1996–2000; table 8A.41.

Table 8.3 Persons aged 18 years and over who had contact, and were satisfied, with police in the past 12 months: reason for satisfaction with police services in most recent contact, 2000 (per cent)^{a, b}

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust
Courteous	44.5	45.3	49.0	50.1	44.5	41.8	48.5	45.4	46.2
Approachable/friendly	42.6	41.7	40.7	44.2	42.0	41.0	42.5	42.7	42.1
Professional/fair	35.5	34.2	35.6	29.2	29.7	28.9	43.8	36.6	34.0
Took appropriate action	25.2	24.9	27.0	30.3	28.0	29.3	31.3	35.9	26.5
Helpful	31.2	22.2	24.2	27.1	29.9	25.1	27.2	27.0	26.4
Handled matter well	25.8	23.8	23.0	25.3	27.8	23.4	24.8	32.0	24.8
Prompt service	23.4	27.3	22.7	21.8	28.6	23.8	24.5	27.8	24.7
Efficient	20.1	20.0	20.7	22.9	23.1	22.6	25.2	23.0	20.9
Communicated clearly	14.3	15.6	17.5	14.4	17.1	14.1	19.6	17.4	15.6
Respondent kept informed	8.0	5.9	7.2	6.8	9.6	6.7	8.1	9.7	7.2
Recovered property	2.0	3.7	2.7	2.0	2.5	2.8	2.2	3.5	2.7
Other	0.2	0.6	1.3	1.1	0.6	0.2	0.3	0.6	0.7
Don't know	–	–	0.2	0.2	–	–	–	–	0.1

^a The sum of the responses exceed 100 per cent for each jurisdiction because respondents could choose more than one reason. ^b Caution should be used when comparing differences in results across jurisdictions and over time. The size of the sample may have an affect on the accuracy of the results. – Nil or rounded to zero.

Sources: ABS, Population Survey Monitor, 2000; table 8A.42.

Nationally, the most common reason in 2000 for dissatisfaction with police services was that police ‘took no action’ (given by 34.0 per cent of the surveyed population who were dissatisfied). The prevalence of this reason ranged from 51.1 per cent in the NT to 32.6 per cent in Queensland. ‘No interest shown’ was the second most common reason for dissatisfaction, given by 28.8 per cent of dissatisfied persons nationally. Across jurisdictions, this proportion ranged from 33.9 per cent in WA to 20.5 per cent in SA. ‘Unfriendly/impolite’ was the third most common reason for dissatisfaction, given by 27.0 per cent of dissatisfied persons nationally. This ranged from 35.8 per cent in Victoria to 18.6 per cent in NSW (table 8.4).

Table 8.4 Persons aged 18 years and over who had contact, and were dissatisfied, with police in the past 12 months: reason for dissatisfaction with police services in most recent contact, 2000 (per cent)^{a, b}

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
Took no action	33.4	33.4	32.6	37.1	33.4	37.2	42.6	51.1	34.0
Showed no interest	28.1	27.1	31.4	33.9	20.5	24.8	32.5	32.3	28.8
Unfriendly/impolite	18.6	35.8	27.5	33.3	29.4	30.3	27.5	20.8	27.0
Unhelpful	27.7	22.8	23.9	20.7	23.2	24.7	28.4	39.7	24.9
Left waiting	25.6	22.4	23.7	18.2	15.3	16.6	23.8	30.2	23.0
Unprofessional/unfair	18.8	21.8	29.7	20.1	26.6	20.2	22.2	22.6	22.7
Not kept informed	22.3	21.3	20.3	17.2	17.5	22.2	24.4	37.6	21.0
Other	10.8	9.1	13.3	8.4	10.6	7.7	8.4	4.5	10.6
Made false accusation	8.7	9.8	7.9	6.0	16.0	12.5	7.6	3.4	9.0
Used complex language	3.5	0.8	3.2	3.7	–	2.1	1.7	4.7	2.6
Used unnecessary force	4.1	–	2.2	3.0	1.1	2.6	3.1	–	2.3
Don't know	–	–	–	–	–	–	–	–	–

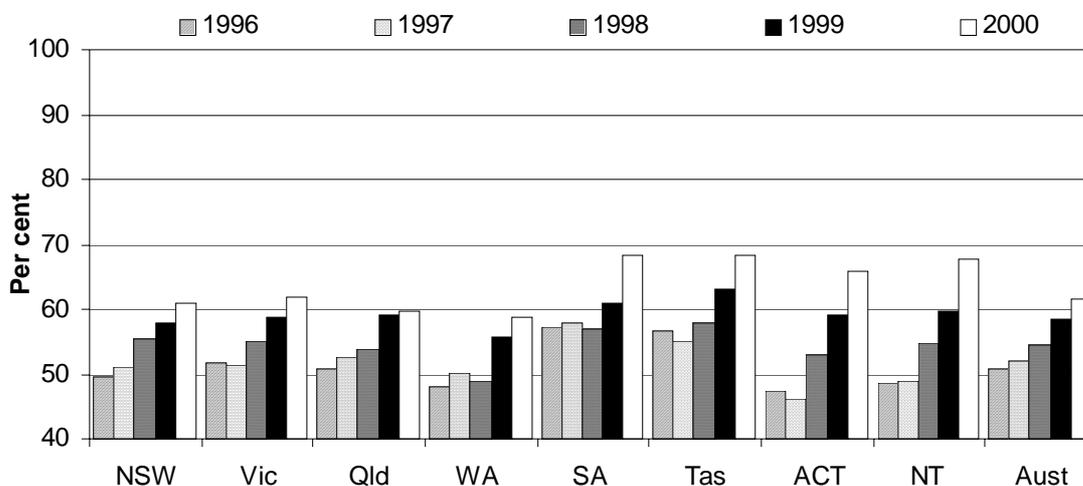
^a The sum of the responses exceed 100 per cent for each jurisdiction because respondents could choose more than one reason. ^b Caution should be used when comparing differences in results across jurisdictions and over time. The size of the sample may have an affect on the accuracy of the results. – Nil or rounded to zero.

Sources: ABS, Population Survey Monitor, 2000; table 8A.43.

Perceptions of police integrity

Important aspects of police services’ performance are: (a) the ability of various individuals and groups to access services; and (b) the service those individuals receive. Nationally, 61.6 per cent of persons aged 18 years and over in 2000 ‘agreed’ or ‘strongly agreed’ that police treat people ‘fairly and equally’. This ranged from 68.4 per cent in SA to 58.7 per cent in WA. Nationally, from 1996 to 2000, those people who ‘agreed’ or ‘strongly agreed’ that police treat people ‘fairly and equally’ increased by 10.7 percentage points. The proportion increased in every jurisdiction over this period (figure 8.11).

Figure 8.11 Persons aged 18 years and over who 'agreed' or 'strongly agreed' that police treat people fairly and equally^a

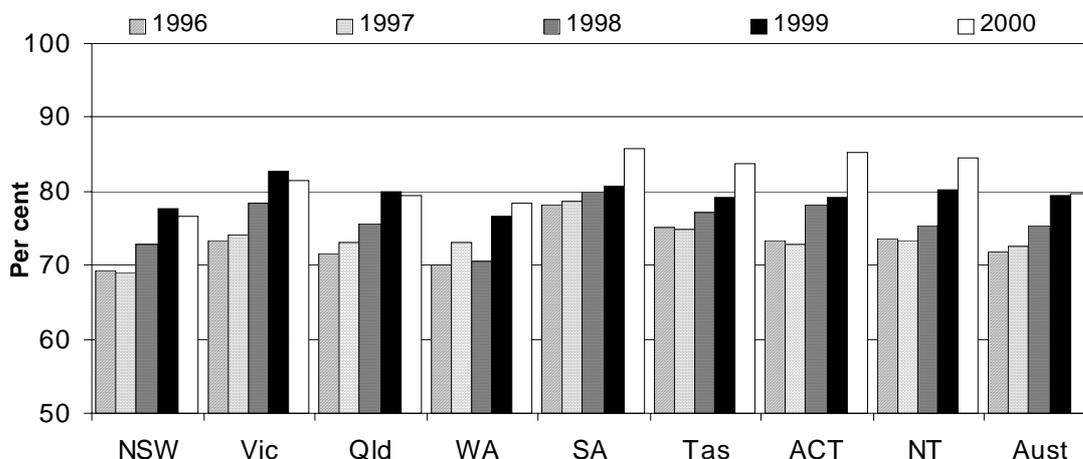


^a Caution should be used when comparing differences in results across jurisdictions and over time. The size of the sample may have an affect on the accuracy of the results.

Sources: ABS, Population Survey Monitor, 1996–2000; tables 8A.44–8A.48.

Nationally, 79.7 per cent of persons 'agreed' or 'strongly agreed' in 2000 that police perform the job 'professionally'. The proportion ranged from 85.8 per cent in SA to 76.7 per cent in NSW. Again, this proportion increased across all jurisdictions between 1996 and 2000, ranging from an increase of 12.0 percentage points in the ACT to 7.3 percentage points in NSW over this period (figure 8.12).

Figure 8.12 Persons aged 18 years and over who 'agreed' or 'strongly agreed' that police perform the job professionally^a

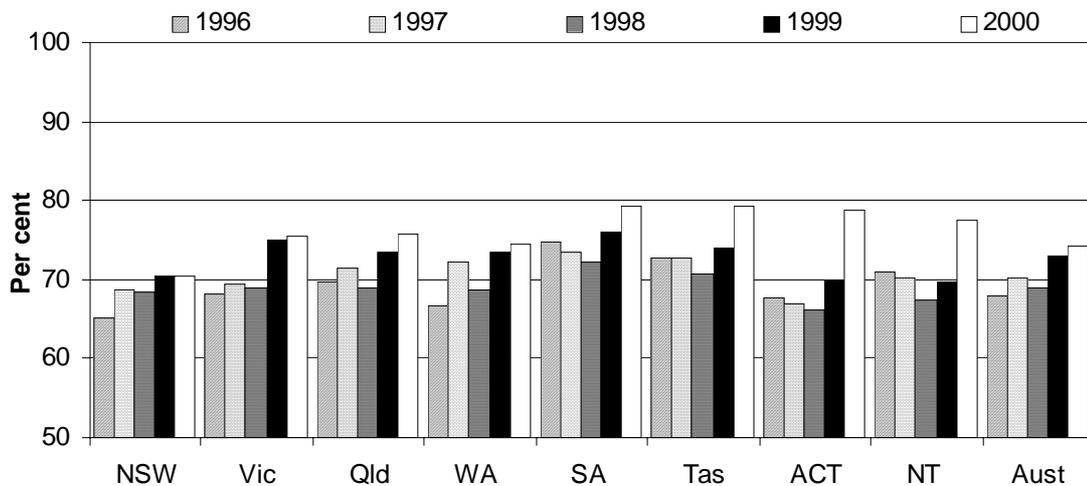


^a Caution should be used when comparing differences in results across jurisdictions and over time. The size of the sample may have an affect on the accuracy of the results.

Sources: ABS, Population Survey Monitor, 1996–2000; tables 8A.44–8A.48.

Police integrity is another important influence on police services' performance. This can be judged to some extent by the public perception of police honesty. The perception of police honesty in Australia increased between 1996 and 2000, with 74.3 per cent of persons 18 years and over nationally having 'agreed' or 'strongly agreed' in 2000 that most police are honest. Across jurisdictions, this proportion in 2000 ranged from 79.4 per cent in SA to 70.5 per cent in NSW (figure 8.13).

Figure 8.13 Persons aged 18 years and over who 'agreed' or 'strongly agreed' that police are honest^a



^a Caution should be used when comparing differences in results across jurisdictions and over time. The size of the sample may have an affect on the accuracy of the results.

Sources: ABS, Population Survey Monitor, 1996–2000; tables 8A.44–8A.48.

Complaints

Police services across Australia have moved to encourage codes of customer service that provide for openness and accountability. Complaints made against police increasingly reflect a range of issues relating to service delivery. Only a small percentage of complaints relate to serious misconduct. Complaints of a more serious nature are also overlooked by external review bodies, such as the Ombudsman, Director of Public Prosecutions or integrity boards.

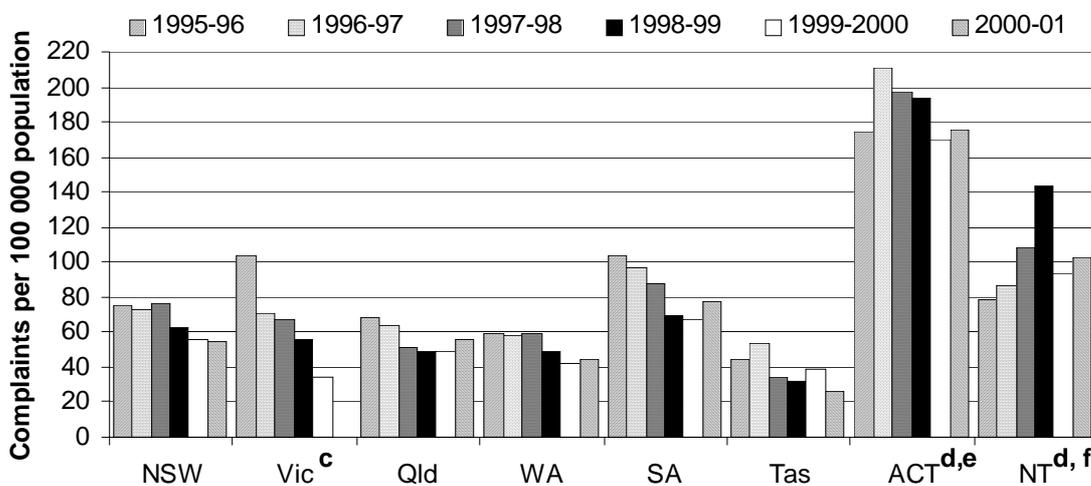
Complaint data represented in figures 8.14 and 8.15 provide an accurate picture of trends over time for each jurisdiction. The ratios, however, do not accurately reflect a comparison across jurisdictions because of the vastly different counting rules, particularly in the ACT.

While there have been fluctuations, the number of complaints against the police per 100 000 people was on a general downward trend in NSW, Queensland, WA, SA

and Tasmania over the period 1995-96 to 2000-01. Victoria has also exhibited a downward trend, although 2000-01 complaints data are not available due to Victoria Police work bans.

Over the past year, however, Queensland, WA, SA, the ACT and the NT all experienced increases in complaints per 100 000 population. The largest increase over the year occurred in SA and the NT (an increase of nine complaints per 100 000 population). The largest decrease over the past year occurred in Tasmania (a fall of 13 complaints per 100 000 population) (figure 8.14).

Figure 8.14 Complaints per 100 000 population^{a, b}

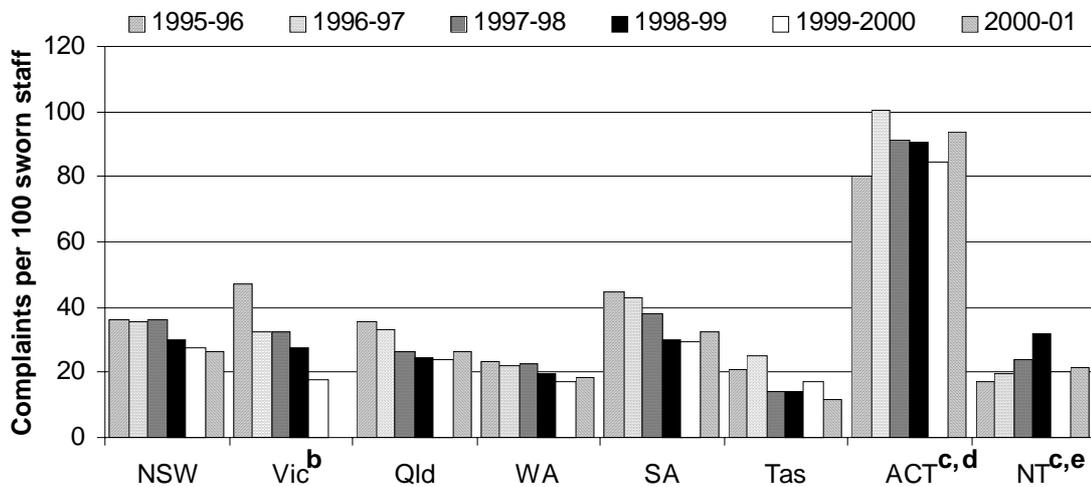


^a Data are not comparable across jurisdictions. Data should only be used to view trends over time within jurisdictions. ^b The impact of tourists (and any associated complaints) should be considered in the light of a complaints ratio based on population. ^c Data for 2000-01 were not available at the time of data collection due to Victoria Police work bans. ^d Data include verbal complaints in the NT and the ACT. ^e Complaints data from 1995-96 have been revised from previous years. The complaints data have been updated to remove reference to complaints against Federal Agents working in the ACT. ^f A significant proportion of complaints in 1998-99 arose from the Jabiluka Uranium Mine protests in Kakadu National Park.

Source: table 8A.49.

Another way of interpreting the complaints data is to consider the number of complaints per 100 sworn police officers in each jurisdiction. This alternative presentation is shown in figure 8.15. The general trends within jurisdictions are the same as discussed in ‘complaints per 100 000 population’.

Figure 8.15 Complaints per 100 sworn police staff^a



^a Data are not comparable across jurisdictions. Data should only be used to view trends over time within jurisdictions. ^b Data for 2000-01 not available at the time of data collection due to Victoria Police work bans. ^c Data include some verbal complaints in the NT and the ACT. ^d Complaints data from 1995-96 have been revised from previous years. The complaints data have been updated to remove reference to complaints against Federal Agents working in the ACT. ^e A significant proportion of complaints in 1998-99 arose from the Jabiluka Uranium Mine protests in Kakadu National Park.

Source: table 8A.49.

Access and equity — Indigenous staffing

This section focuses on the performance of mainstream services in relation to Indigenous Australians. The process of identifying Indigenous staff members poses challenges, particularly when relying on self identification.

If Indigenous people are required to identify themselves, then the accuracy of the data will partly depend on how they perceive the advantages (or disadvantages) of identification and whether these perceptions change over time. For the purposes of this chapter, an Indigenous person is one who self identifies as an Aborigine or Torres Strait Islander.

The data relate to those (sworn and unsworn) staff who self identify as being of Aboriginal or Torres Strait Islander descent. In 2000-01, of the jurisdictions that could provide data, the NT had the highest proportion of Indigenous police staff (5.4 per cent), while the ACT had the lowest proportion (0.7 per cent) (table 8.5).

In most jurisdictions, the proportion of Indigenous police staff generally reflected the Indigenous proportion of the population. The exception was the NT, where the relative discrepancy between the number of Indigenous police staff as a proportion

of total police staff (5.4 per cent) and the Indigenous population as a proportion of the total population (24.4 per cent) was greatest (table 8.5).

Table 8.5 Indigenous sworn and unsworn police staff (per cent)^a

	<i>NSW^b</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>
Indigenous staff as proportion of total staff								
1998-99	na	na	2.7	2.3	1.1	1.3	0.5	6.0
1999-2000	na	na	na	na	1.2	1.3	1.0	6.0
2000-01	0.9	na	2.4	1.7	1.2	1.7	0.7	5.4
Indigenous population as a proportion of total population (1996) ^c	1.7	0.5	2.9	3.0	1.4	3.0	1.0	24.4

^a Indigenous staff numbers relate to those staff who self identify as being of Aboriginal or Torres Strait Islander descent. ^b Information on Indigenous status is only collected at time of recruitment. ^c Population data based on the ABS *Census of Population and Housing: Community Profiles*. **na** Not available.

Sources: ABS 1996a; table 8A.50.

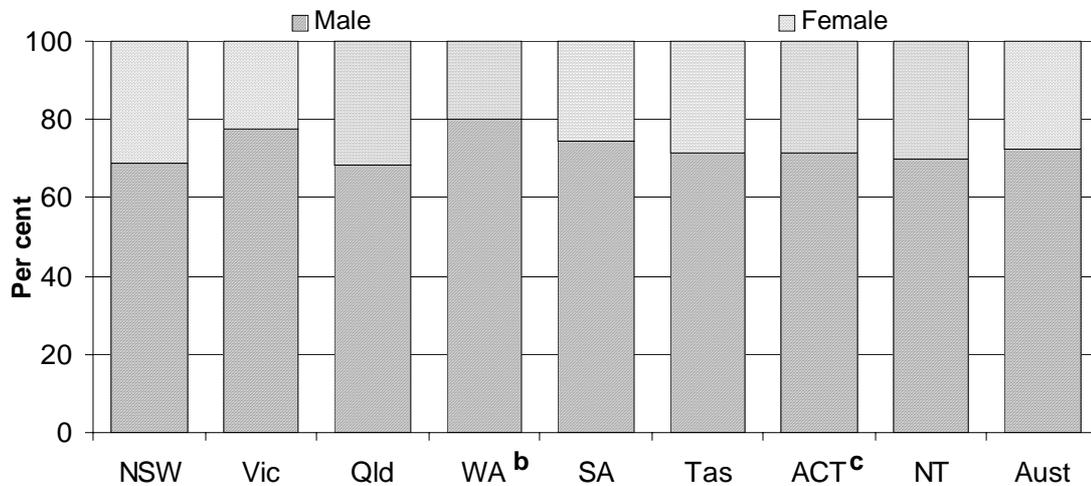
Access and equity — staffing by gender

Another measure of access and equity is the level of (sworn and unsworn) police staff by gender. Nationally, 72.5 per cent of police staff in all States and Territories in 2000-01 were male. This proportion ranged from 80.0 per cent in WA to 68.5 per cent in Queensland (figure 8.16).

Nationally, the proportion of female police staff has increased by 2.5 percentage points over the past two years (from 25.0 per cent to 27.5 per cent of staff). Nearly all jurisdictions increased their proportion of female police staff over the past two years. The greatest increase occurred in the ACT (from 23.4 to 28.6 females per 100 staff), followed by NSW (from 27.4 to 31.2 females per 100 staff) (table 8A.51). The change in the ACT should be viewed with some caution due to the introduction of a revised methodology which better identifies those personnel within the Australian Federal Police National involved in the provision of enabling services to ACT policing.

The only jurisdiction to show a decrease in the proportion of female staff over the past two years was WA (from 20.5 to 20.0 females per 100 staff). Previous year data on staffing by gender for 1998-99 and 1999-2000 are contained in table 8A.51.

Figure 8.16 Police staff (sworn and unsworn), by gender, 2000-01^a



^a Comprises all full time equivalent staff. ^b Excludes recruits in training. ^c As a result of a comprehensive review of enabling costs applicable to ACT policing, the formula previously applied to the calculation of staffing and expenditure data has been significantly revised. This methodological shift means that material in this Report is not directly comparable with that for previous years.

Source: table 8A.51.

8.5 Community safety and support

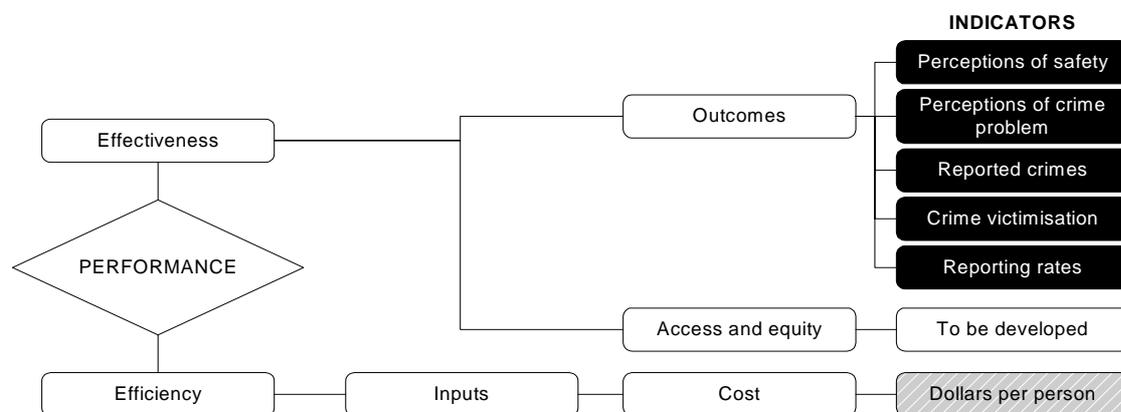
This SDA captures the role of police in preserving public order and promoting a safer community through a range of activities, including:

- responding to calls for assistance;
- responding to, managing and coordinating major incidents and emergencies; and
- undertaking crime prevention activities and community support programs.

Framework of performance indicators

The performance of the police in undertaking these activities is measured using a suite of indicators that incorporates information on recorded crime levels and community perceptions data (figure 8.17).

Figure 8.17 Performance indicators for community safety and support



Key to indicators

- Text** Provided on a comparable basis for this Report
- Text** Information not complete or not strictly comparable
- Text** Yet to be developed or not collected for this Report

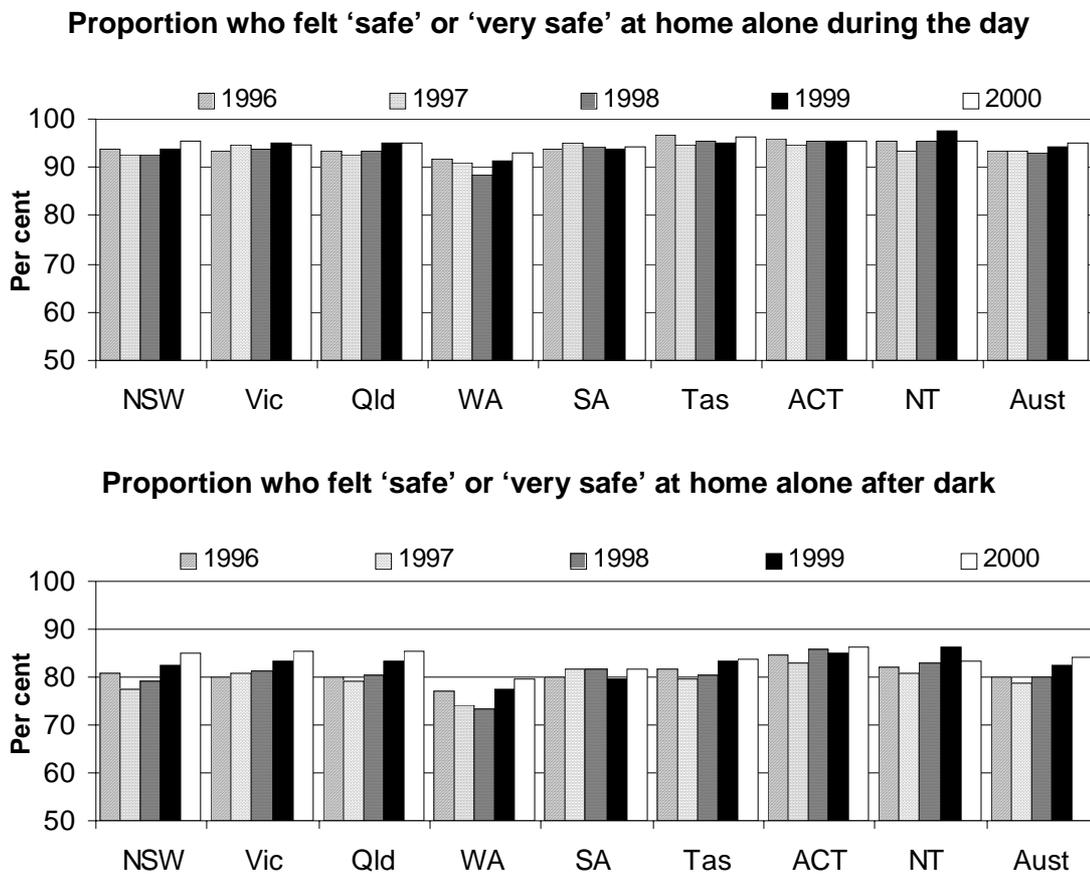
Perceptions of safety

An important objective of police services is to ‘reassure the public’ by ensuring that the community feels safe (within themselves and regarding their property) in public and private.

Perceptions of safety are reported here, although these perceptions may not reflect reported crime for many reasons — for example, reported crime may understate actual crime, under-reporting may vary across jurisdictions, and many factors (including media reporting) may affect public perceptions of crime levels and safety.

Nationally, 94.9 per cent of the surveyed adult population felt ‘safe’ or ‘very safe’ at home alone during the day. There was little difference across jurisdictions. Nationally, 84.3 per cent of persons felt ‘safe’ or ‘very safe’ at home alone after dark. This proportion ranged from 86.4 per cent in the ACT to 79.4 per cent in WA (figure 8.18).

Figure 8.18 Persons aged 18 years and over: perception of safety at home^a



^a Caution should be used when comparing differences in results across jurisdictions and over time. The size of the sample may affect the accuracy of the results.

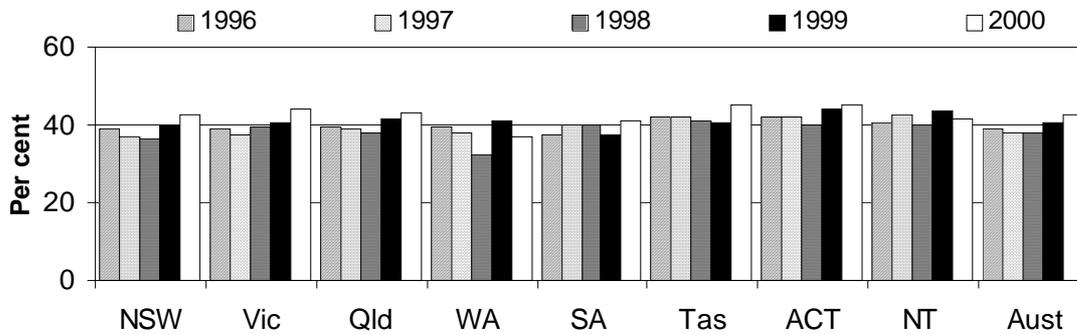
Sources: ABS, Population Survey Monitor, 1996–2000; tables 8A.52–8A.56.

Nationally, 42.5 per cent of persons aged 18 years and over felt 'safe' or 'very safe' when walking or jogging locally after dark. Across jurisdictions, the proportion ranged from 45.0 per cent in the ACT to 37.1 per cent in WA (figure 8.19).

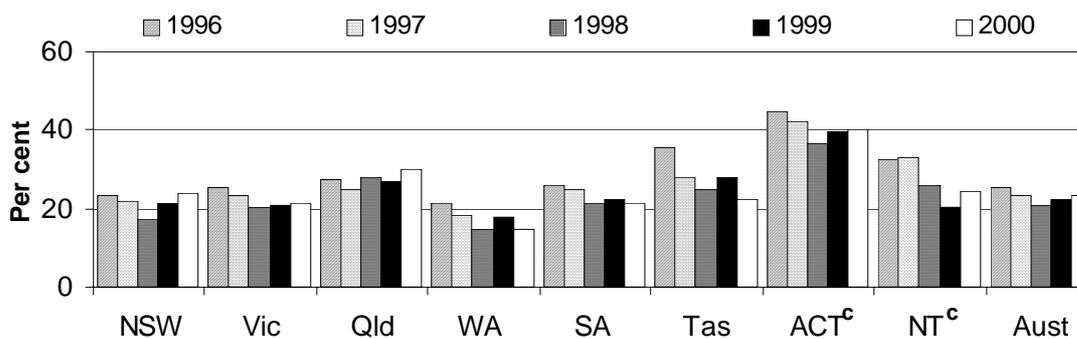
Nationally, 23.6 per cent of the surveyed adult population felt 'safe' or 'very safe' when travelling on public transport after dark. This perception of safety ranged from 40.0 per cent in the ACT to 14.9 per cent in WA (figure 8.19). The ACT and NT, however, do not operate a suburban train network, and the results will also be influenced by the mix (that is, trains, buses and trams) of public transport in each jurisdiction.

Figure 8.19 Persons aged 18 years and over: perception of safety in public places^a

Proportion who felt 'safe' or 'very safe' walking or jogging locally after dark



Proportion who felt 'safe' or 'very safe' travelling on public transport after dark^b



^a Caution should be used when comparing differences in results across jurisdictions and over time. The size of the sample may have an impact on the accuracy of the results. ^b For this survey question, the response 'not applicable' was very large and varied significantly across jurisdictions in line with the availability of public transport (see tables 8A.52–8A.56). ^c Unlike other jurisdictions, the ACT and the NT do not operate a suburban train network, relying on buses as the primary means of public transportation.

Sources: ABS, Population Survey Monitor, 1996–2000; tables 8A.52–8A.56.

Nationally, in 2000, 89.8 per cent of respondents felt 'safe' or 'very safe' when walking or jogging locally during the day and 65.9 per cent of respondents felt 'safe' or 'very safe' on public transport during the day. A jurisdiction breakdown of these results are available from table 8A.52.

Perceptions of crime problem

Nationally, in 2000, when people were asked about crime problems in the general community, the proportion of people who perceived the crime as a 'major problem' or 'somewhat of a problem' were: 90.3 per cent for illegal drugs; 83.1 per cent for physical assaults; 79.7 per cent for family violence; 78.1 per cent for sexual assault;

35.1 per cent for louts or gangs; and 32.7 per cent for drunken and disorderly behaviour. Data for each jurisdiction are presented in table 8A.57.

Nationally, 64.1 per cent of persons aged 18 years and over believed housebreaking to be a 'major problem' or 'somewhat a problem' in their neighbourhood in 2000. Across jurisdictions, the prevalence of this response ranged from 75.6 per cent in the ACT to 61.0 per cent in Queensland (figure 8.20).

The PSM results indicate that 52.5 per cent of the estimated population believed that motor vehicle theft was a 'major problem' or 'somewhat a problem' in their neighbourhood. The prevalence of this perception varied from 58.4 per cent in the ACT to 45.5 per cent in Queensland (figure 8.20).

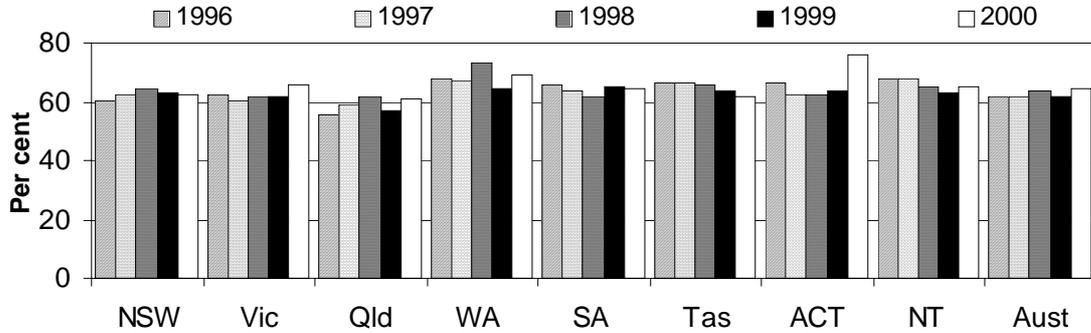
Nationally, 47.9 per cent of the estimated population believed graffiti and vandalism to be a 'major problem' or 'somewhat a problem' in their neighbourhood. Across jurisdictions, the prevalence of this response ranged from 54.6 per cent in SA to 35.3 per cent in Tasmania (figure 8.20).

Caution should be used when interpreting data on perceptions of crime. The perceptions of a problem and the actual incidence of these offences may differ significantly across jurisdictions. Reducing people's concerns about crime and reducing the actual level of crime are two separate but related challenges for police.

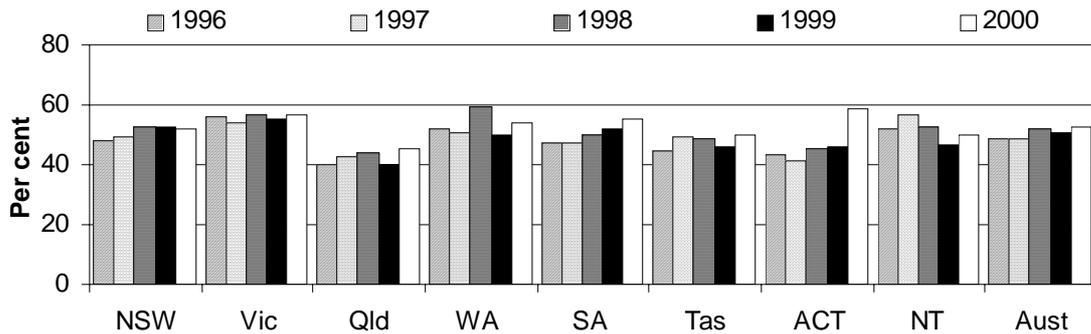
Comparisons between perceptions of crime problems and the level of crime raise questions about the factors that affect perceptions. More generally, such comparisons highlight the importance of considering the full suite of performance indicators rather than assessing performance on the basis of specific measures in isolation.

Figure 8.20 Persons aged 18 years and over: perception of problems in the neighbourhood^a

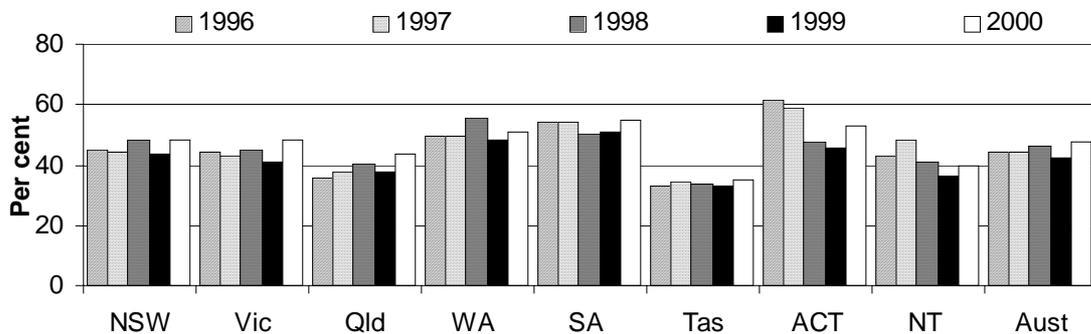
Proportion who felt that housebreaking was a 'major problem' or 'somewhat a problem'



Proportion who felt that motor vehicle theft was a 'major problem' or 'somewhat a problem'



Proportion who felt that graffiti or other vandalism was a 'major problem' or 'somewhat a problem'



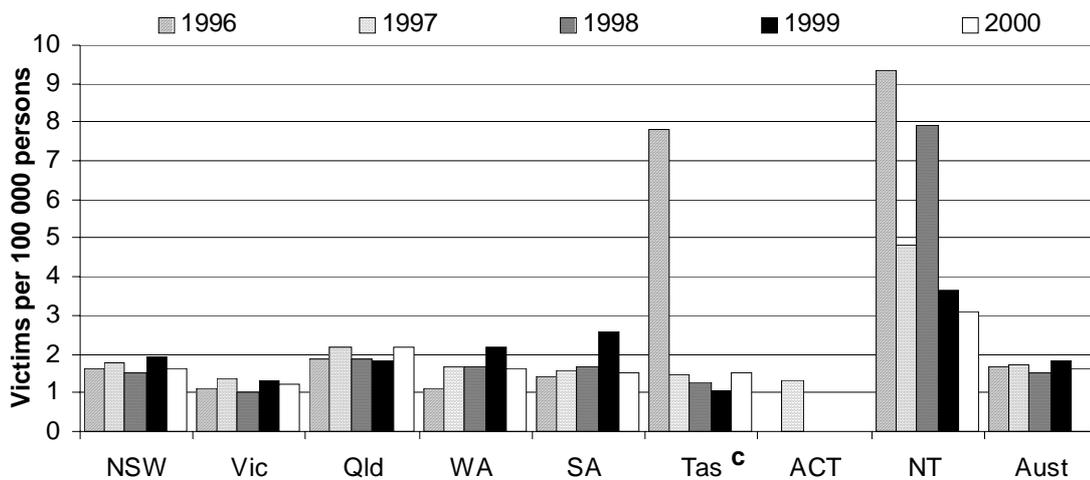
^a Caution should be used when comparing differences in results across jurisdictions and over time. The size of the sample may affect the accuracy of the results.

Sources: ABS, Population Survey Monitor, 1996–2000; tables 8A.57–8A.61.

Recorded crimes against the person

Nationally, there were 1.6 recorded victims of murder per 100 000 persons in 2000, which is similar to rates of previous years. The victimisation rate in 2000 ranged from 3.1 victims per 100 000 persons in the NT to a rate close to zero victims per 100 000 persons in the ACT (figure 8.21).

Figure 8.21 Recorded victims of murder^{a, b}

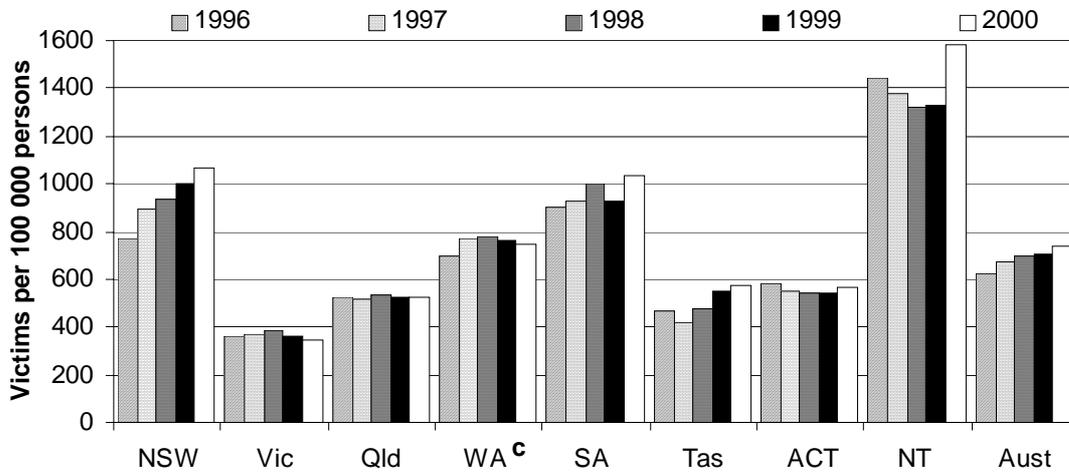


^a Data are based on crimes recorded by police. ^b For some jurisdictions, 1999 data have been revised from those published last year. ^c The higher rate of reported victims of murder in 1996 was the result of the multiple murder incident at Port Arthur.

Sources: ABS 2001c; table 8A.62.

Nationally, there were 737 victims of assault per 100 000 persons in 2000, ranging from 1580 victims per 100 000 persons in the NT to 347 victims per 100 000 persons in Victoria (figure 8.22). Between 1999 and 2000, the victimisation rate fell in Victoria and WA, remained steady in Queensland, and rose in NSW, SA, Tasmania, the ACT and the NT.

Figure 8.22 Recorded victims of assault^{a, b}

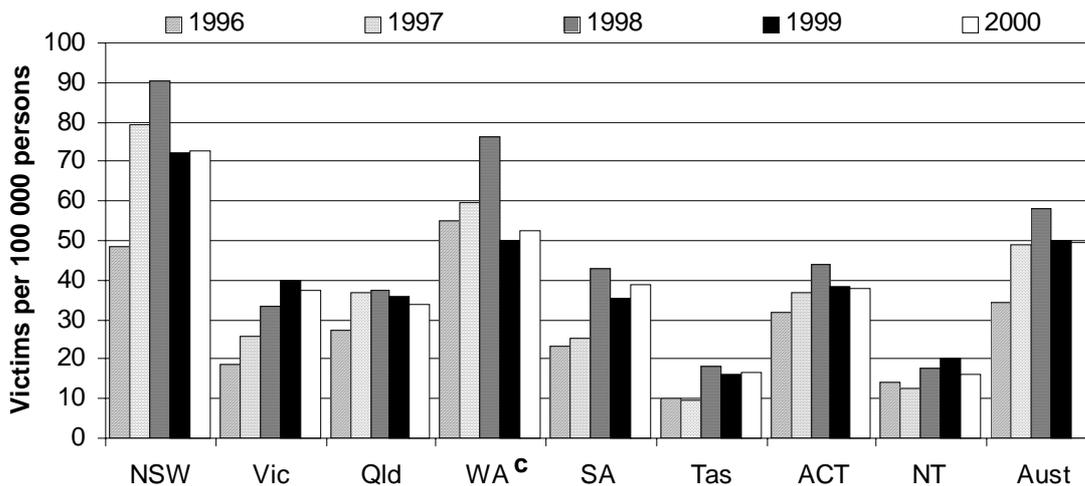


^a Data are based on crimes recorded by police. ^b For some jurisdictions, 1999 data have been revised from those published last year. ^c The recorded crime statistics for assault are not directly comparable with the results prior to 1998.

Sources: ABS 2001c; table 8A.62.

Nationally, there were 50 victims of armed robbery per 100 000 persons in 2000, ranging from 73 victims per 100 000 persons in NSW to 16 victims per 100 000 persons in the NT (figure 8.23).

Figure 8.23 Recorded victims of armed robbery^{a, b}



^a Data are based on crimes recorded by police. ^b Victims include persons and organisations. ^c The recorded crime statistics for armed robbery are not directly comparable with the results prior to 1998.

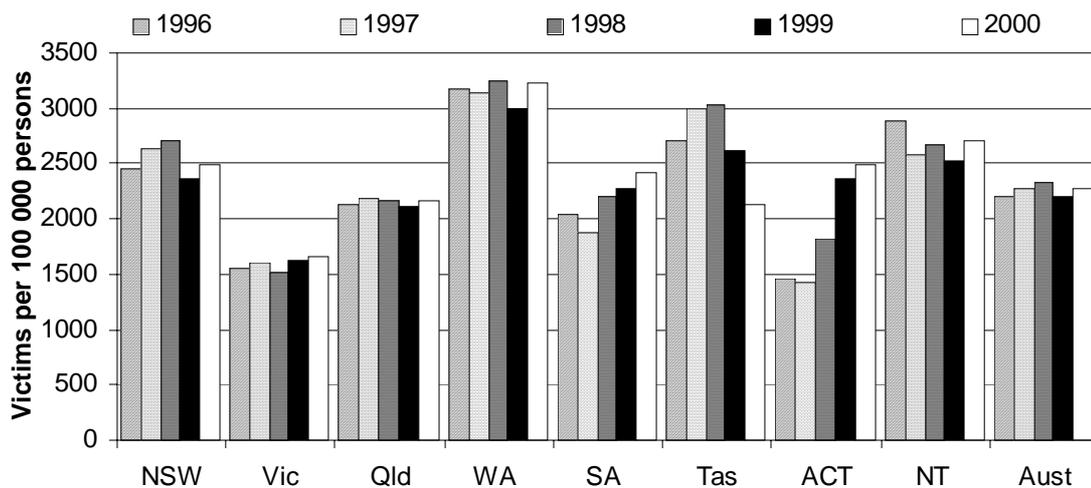
Sources: ABS 2001c; table 8A.62.

Nationally, per 100 000 persons, there were: 0.2 victims of manslaughter; 1.3 victims of blackmail/extortion; 1.3 victims of driving causing death; 2.0 victims of attempted murder; 3.6 victims of kidnapping/abduction; 72 victims of unarmed robbery; and 82 victims of sexual assault. Data on recorded crime for each of these offences are available across jurisdictions for the period 1996 to 2000 (table 8A.62).

Recorded crimes against property

Nationally, there were 2281 victims of unlawful entry with intent per 100 000 persons in 2000. The incidence varied from 3230 victims per 100 000 persons in WA to 1653 victims per 100 000 persons in Victoria. Victimization rates were higher in 2000 than in 1996 for all jurisdictions except Tasmania and the NT. Between 1996 and 2000, victims of unlawful entry with intent per 100 000 persons rose by 70.6 per cent in the ACT and fell by 21.1 per cent in Tasmania (figure 8.24).

Figure 8.24 Recorded victims of unlawful entry with intent^{a, b, c}



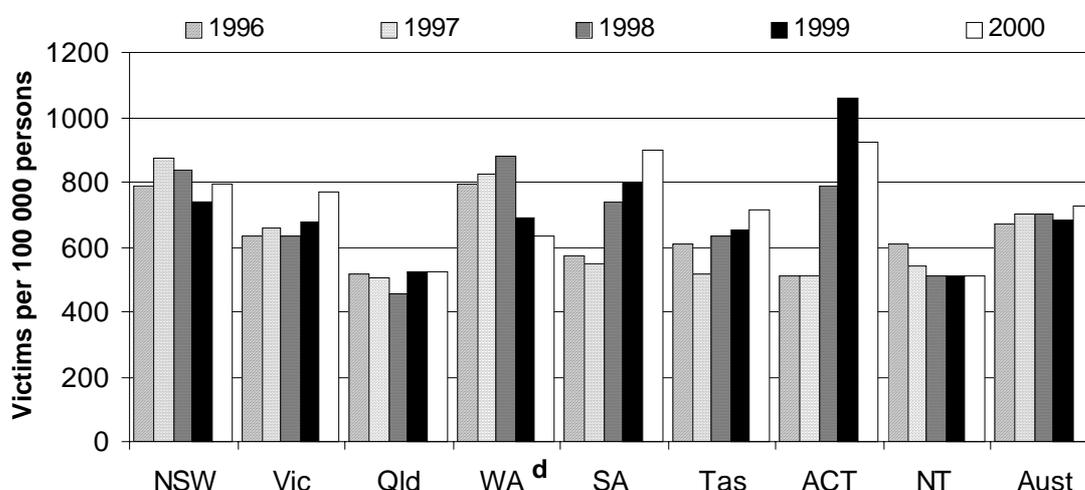
^a Data are based on crimes recorded by police. ^b Victims refers to places/premises. ^c For some jurisdictions, 1999 data have been revised from those published last year.

Sources: ABS 2001c; table 8A.63.

Nationally, there were 726 motor vehicles stolen per 100 000 persons in 2000. The victimisation rate ranged from 925 motor vehicles per 100 000 persons in the ACT to 511 motor vehicles per 100 000 persons in the NT (figure 8.25).

The largest increase in motor vehicles stolen per 100 000 persons between 1996 and 2000 was a 81.7 per cent increase in the ACT. The largest decrease in motor vehicles stolen per 100 000 persons over the same period was a 20.4 per cent fall in WA (figure 8.25).

Figure 8.25 Recorded victims of motor vehicle theft^{a, b, c}



^a Data are based on crimes recorded by police. ^b Victims are based on the number of motor vehicles. ^c For some jurisdictions, 1999 data have been revised from those published last year. ^d Counts of motor vehicle theft prior to 1997 are not directly comparable with other States and Territories.

Sources: ABS 2001c; table 8A.63.

Nationally, in 2000, there were 3523 victims of ‘other theft’ per 100 000 persons. This ranged from 4686 in WA to 2751 in Tasmania (table 8A.63).

The ABS also undertakes crime and safety surveys. As part of these surveys, reporting rates for selected major offences are contained in table 8A.64 and the estimated total victims of crime (both reported and unreported) for crimes against the person and property are included in tables 8A.65–8A.66.

Efficiency

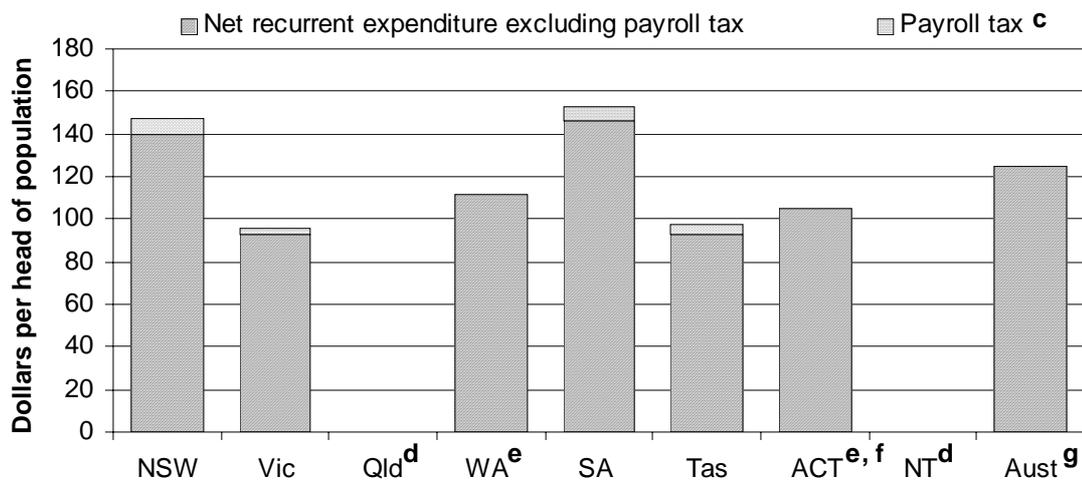
Expenditure on each police SDA is included in this Report for the third year. The comparability of data has been improved by accounting for differences in payroll tax liabilities across jurisdictions according to the approach recommended in *Payroll Tax in the Costing of Government Services* (SCRCSSP 1999). The separate identification of payroll tax liabilities facilitates comparisons of expenditure data (less payroll tax) across all jurisdictions.

The NT cannot produce activity based results as it does not collect the necessary data, and Queensland did not provide a breakdown by SDA because of concerns about the comparability of data.

Nationally, of the jurisdictions that were able to provide data in 2000-01, expenditure on community safety and support was \$125 per head of population. It

ranged from \$153 per head of population in SA to \$96 per head of population in Victoria (figure 8.26). Nationally, expenditure on community safety and support made up over half of all police expenditure (55.4 per cent). Expenditure on community safety and support, as a proportion of each jurisdiction's total police expenditure, ranged from 69.1 per cent in SA to 45.3 per cent in Victoria (table 8A.12).

Figure 8.26 Expenditure on community safety and support, 2000-01^{a, b}



^a Data have not been subjected to extensive tests to determine comparability. Further, some differences in counting rules may exist across jurisdictions as a result of the differing mixes of activities undertaken within each of the common SDAs. ^b Population based on ABS estimates for June 2001. ^c Calculated by multiplying the proportion of expenditure on salaries and payments for each SDA by the total payroll tax expenditure. ^d Data are only available for all key SDAs combined. ^e Exempt from payroll tax. ^f Includes major events and planning. Variation from last year is a result of the review of enabling costs associated with operational support services, which has led to significant improvements in the attribution of costs. ^g Includes payroll tax where applicable.

Source: table 8A.67.

While comparisons can be made with last year, caution should be used due to possible changes in the methods employed. The largest increase in real expenditure over the past year occurred in SA, where real expenditure on community safety and support rose by \$25 per head of population (from \$128 to \$153) (table 8.6).

The largest decrease in real expenditure over the past year occurred in Tasmania, where real expenditure fell by \$28 per head of population (down from \$125 to \$97). Nationally, real expenditure on community safety and support fell by \$4 per head of population over the last year (down from \$129 to \$125) (table 8.6).

Table 8.6 **Real expenditure on community safety and support (dollars per head of population)^{a, b}**

	NSW	Vic	Qld ^c	WA ^d	SA	Tas	ACT ^{d, e}	NT ^c	Aust ^f
Net recurrent expenditure excluding payroll tax									
1999-2000	137	108	na	117	122	119	128	na	129
2000-01	140	92	na	112	146	93	105	na	125
Payroll tax ^g									
1999-2000	6	4	na	..	6	6	..	na	..
2000-01	7	3	na	..	6	4	..	na	..
Total^h									
1999-2000	143	112	na	117	128	125	128	na	129
2000-01	147	96	na	112	153	97	105	na	125

^a Data have not been subjected to extensive tests to determine comparability. Further, some differences in counting rules may exist across jurisdictions as a result of the differing mixes of activities undertaken within each of the common SDAs. ^b Population based on ABS estimates for June 2001. ^c Data are only available for all key SDAs combined. ^d Exempt from payroll tax. ^e Includes major events and planning. In the ACT, variation from last year is a result of the review of enabling costs associated with operational support services, which has led to significant improvements in the attribution of costs. ^f Includes payroll tax where applicable. ^g Calculated by multiplying the proportion of expenditure on salaries and payments for each SDA by the total payroll tax expenditure. ^h May not add to sum of its components as a result of rounding. **na** Not available. **..** Not applicable.

Source: table 8A.67.

8.6 Crime investigation

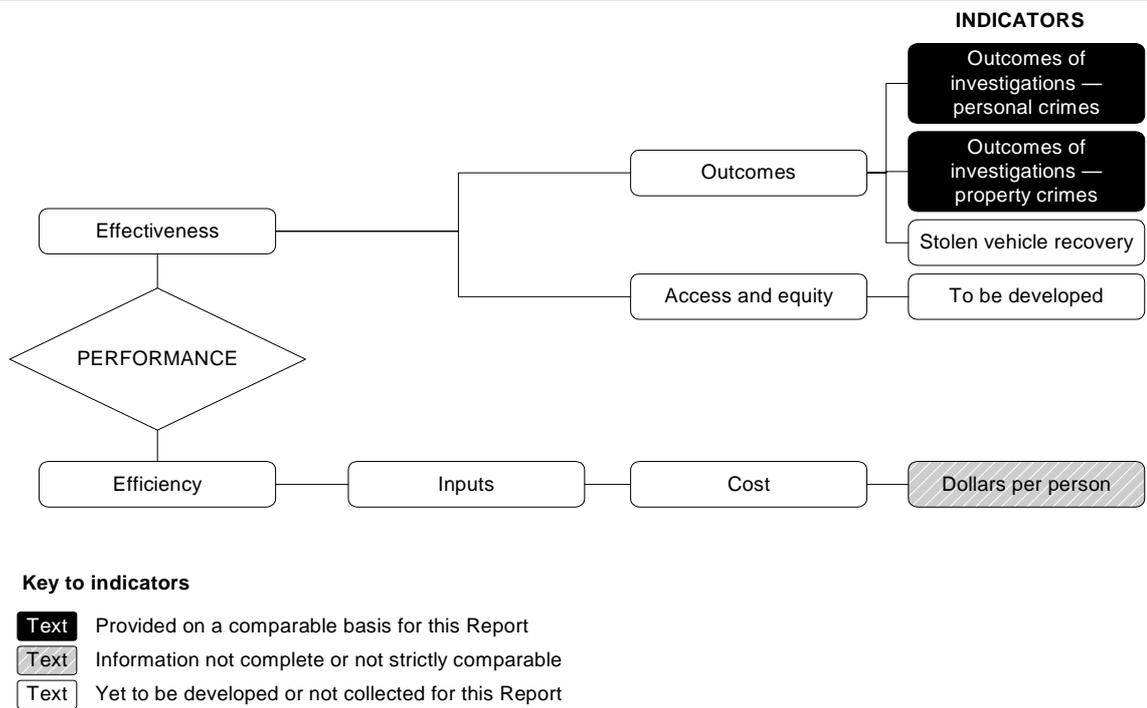
This SDA captures the role of police in investigating crime and identifying and apprehending suspects. Activities include:

- gathering intelligence on suspects and locations to assist with investigations; and
- collecting and securing evidence in relation to both the offence and the suspect.

Framework of performance indicators

The performance of the police in undertaking these activities is measured using a suite of indicators that includes outcomes of investigations (figure 8.27).

Figure 8.27 Performance indicators for crime investigation



Key performance indicator results

The ABS collects data on the 30-day status of investigations — that is, the stage that a police investigation has reached 30 days after the recording of the incident by police.

Outcomes of investigations — crimes against the person

Across jurisdictions, the proportion of investigations into reported murders which were finalised within 30 days of the offence becoming known to police, varied from 100.0 per cent in the ACT (based on two murder investigations) to 60.9 per cent in SA (based on 23 murder investigations) (table 8.7).

For all finalised murder investigations, proceedings against an alleged offender which had begun within 30 days ranged across jurisdiction from 100.0 per cent in Tasmania and the ACT to 87.8 per cent in Queensland (table 8.7).

Table 8.7 Victims of murder: outcomes of investigations, 30-day status, 1 January to 31 December 2000

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT^a</i>	<i>Aus</i>
Total	no.	101	55	77	31	23	7	2	6	302
Investigations finalised as a proportion of total investigations	%	66.3	61.8	63.6	64.5	60.9	85.7	100	na	na
Investigations in which offender is proceeded against as a proportion of investigations finalised	%	92.5	91.2	87.8	95.0	92.9	100	100	na	na

^a Due to data production problems in figures supplied by the NT to the ABS, the NT data have been withdrawn.

Sources: ABS 2001c; table 8A.68.

The proportion of investigations into reported assaults, that were finalised within 30 days, ranged from 65.2 per cent in SA to 47.3 per cent in the ACT. For all finalised assault investigations, the proportion of proceedings against an alleged offender which had begun within 30 days, ranged across jurisdictions from 86.8 per cent in Tasmania to 57.1 per cent in SA (table 8.8).

Table 8.8 Victims of assault: outcomes of investigations, 30-day status, 1 January to 31 December 2000

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT^a</i>	<i>Aust</i>
Total	'000	69	17	19	14	15	3	2	3	141
Investigations finalised as a proportion of total investigations	%	62.2	51.2	53.2	54.9	65.2	59.9	47.3	na	na
Investigations in which offender is proceeded against as a proportion of investigations finalised	%	82.5	82.5	83.8	64.6	57.1	86.8	82.1	na	na

^a Due to data production problems in figures supplied by the NT to the ABS, the NT data have been withdrawn.

Sources: ABS 2001c; table 8A.68.

The proportion of investigations into reported armed robbery, that were finalised within 30 days of the offence becoming known to police, ranged from 59.0 per cent in Tasmania to 17.4 per cent in NSW. For all finalised armed robbery investigations, the proportion of proceedings against an alleged offender which had begun within 30 days, ranged across jurisdictions from 95.7 per cent in Tasmania to 78.5 per cent in NSW (table 8.9).

Table 8.9 Victims of armed robbery: outcomes of investigations, 30-day status, 1 January to 31 December 2000

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT^a</i>	<i>Aust</i>
Total	no.	4 688	1 785	1 203	986	585	78	117	32	9 474
Investigations finalised as a proportion of total investigations	%	17.4	30.1	34.6	29.0	28.9	59.0	28.2	na	na
Investigations in which offender is proceeded against as a proportion of investigations finalised	%	78.5	84.2	89.7	87.8	92.3	95.7	84.8	na	na

^a Due to data production problems in figures supplied by the NT to the ABS, the NT data have been withdrawn.

Sources: ABS 2001c; table 8A.68.

Jurisdiction specific data on the outcomes of investigations into kidnapping/abduction, blackmail/extortion, sexual assault and unarmed robbery are contained in table 8A.68.

Outcomes of investigations — crimes against property

The proportion of investigations into reported unlawful entry with intent, that were finalised within 30 days of the offence becoming known to police, ranged from 9.3 per cent in Victoria to 4.1 per cent in the ACT. For all finalised unlawful entry with intent investigations, the proportion of proceedings against an alleged offender which had commenced within 30 days, ranged across jurisdictions from 97.5 per cent in the ACT to 71.1 per cent in NSW (table 8.10).

Table 8.10 Victims of unlawful entry with intent: outcomes of investigations, 30-day status, 1 January to 31 December 2000

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT^a</i>	<i>Aust</i>
Total	'000	161	79	77	61	36	10	8	5	437
Investigations finalised as a proportion of total investigations	%	6.3	9.3	8.8	6.7	6.4	8.5	4.1	na	na
Investigations in which offender is proceeded against as a proportion of investigations finalised	%	71.1	92.1	91.4	79.3	84.0	91.5	97.5	na	na

^a Due to data production problems in figures supplied by the NT to the ABS, the NT data have been withdrawn.

Sources: ABS 2001c; table 8A.69.

The proportion of investigations into reported motor vehicle theft, that were finalised within 30 days of the offence becoming known to police, ranged from

17.3 per cent in Queensland to 3.0 per cent in Tasmania. For all finalised motor vehicle theft investigations, the proportion of proceedings against an alleged offender which had begun within 30 days, ranged across jurisdictions from 83.9 per cent in the ACT to 57.1 per cent in WA (table 8.11).

Table 8.11 Victims of motor vehicle theft: outcomes of investigations, 30-day status, 1 January to 31 December 2000

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT^a</i>	<i>Aust</i>
Total	'000	51	37	19	12	13	3	3	1	139
Investigations finalised as a proportion of total investigations	%	6.6	9.7	17.3	13.9	9.8	3.0	4.8	na	na
Investigations in which offender is proceeded against as a proportion of investigations finalised	%	77.6	83.8	77.1	57.1	78.8	82.4	83.9	na	na

^a Due to data production problems in figures supplied by the NT to the ABS, the NT data have been withdrawn.

Sources: ABS 2001c; table 8A.69.

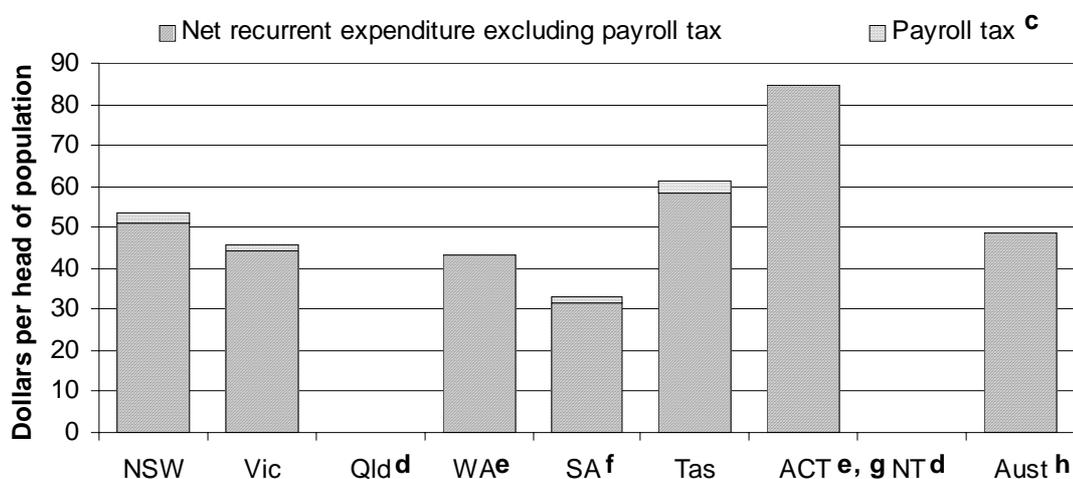
The proportion of investigations into reported 'other theft', that were finalised within 30 days of the offence becoming known to police, ranged from 17.2 per cent in Queensland to 9.3 per cent in the ACT. Data on 'other theft', for all jurisdictions, are contained in table 8A.69.

Efficiency

Nationally, of the jurisdictions that were able to provide data in 2000-01, expenditure on crime investigations was \$49 per head of population. It ranged from \$85 per head of population in the ACT to \$33 per head of population in SA (figure 8.28).

Nationally, expenditure on crime investigations as a proportion of total police expenditure, was 21.6 per cent. Expenditure on crime investigations as a proportion of each jurisdiction's total police expenditure, ranged from 36.8 per cent in the ACT to 14.9 per cent in SA (table 8A.12).

Figure 8.28 Expenditure on crime investigation, 2000-01^{a, b}



^a Data have not been subjected to extensive tests to determine comparability. Further, some differences in counting rules may exist across jurisdictions as a result of the differing mixes of activities undertaken within each of the common SDAs. ^b Population based on ABS estimates for June 2001. ^c Calculated by multiplying the proportion of expenditure on salaries and payments for each SDA by the total payroll tax expenditure. ^d Data are only available for all key SDAs combined. ^e Exempt from payroll tax. ^f The crime investigation activities exclude a wide range of crime prevention, reduction and response activities which is the same methodology applied in 1999-2000. ^g Variation from last year is a result of the review of enabling costs associated with operational support services, which has led to significant improvements in the attribution of costs. This, together with the fact that there has been a greatly increased focus on reversing escalating trends in burglary and motor vehicle theft offences over the reporting period, has meant that a much greater proportion of core ACT policing activity has been concentrated in the investigations area. ^h Includes payroll tax where applicable.

Source: table 8A.70.

While comparisons can be made with last year, caution should be used due to possible changes in the methods employed. The largest increase in real expenditure over the past year occurred in the ACT, where real expenditure on crime investigation rose by \$41 per head of population (up from \$44 to \$85) (table 8.12). In the ACT, the variation from last year is a result of the review of enabling costs associated with operational support services, which has led to significant improvements in the attribution of costs. This, together with the fact that there has been a greatly increased focus on reversing escalating trends in burglary and motor vehicle theft offences over the reporting period, has meant that a much greater proportion of core ACT policing activity has been concentrated in the crime investigations area.

The largest decrease in real expenditure over the past year occurred in Victoria, where real expenditure fell by \$4 per head of population (down from \$50 to \$46). Nationally, real expenditure on crime investigations increased by \$2 per head of population (up from \$47 to \$49) (table 8.12).

Table 8.12 **Real expenditure on crime investigation (dollars per head of population)^{a, b}**

	NSW	Vic	Qld ^c	WA ^d	SA ^e	Tas	ACT ^{d, f}	NT ^c	Aust ^g
Net recurrent expenditure excluding payroll tax									
1999-2000	48	48	na	44	33	46	44	na	47
2000-01	51	44	na	43	31	59	85	na	49
Estimated payroll tax ^h									
1999-2000	2	2	na	..	2	2	..	na	..
2000-01	2	2	na	..	2	3	..	na	..
Totalⁱ									
1999-2000	50	50	na	44	34	48	44	na	47
2000-01	53	46	na	43	33	61	85	na	49

^a Data have not been subjected to extensive tests to determine comparability. Further, some differences in counting rules may exist across jurisdictions as a result of the differing mixes of activities undertaken within each of the common SDAs. ^b Population based on ABS estimates for June 2001. ^c Data only available for key SDAs combined. ^d Exempt from payroll tax. ^e The crime investigation activities exclude a wide range of crime prevention, reduction and response activities which is the same methodology applied in 1999-2000. ^f Variation from last year is a result of the review of enabling costs associated with operational support services, which has led to significant improvements in the attribution of costs. This, together with the fact that there has been a greatly increased focus on reversing escalating trends in burglary and motor vehicle theft offences over the reporting period, has meant that a much greater proportion of core ACT policing activity has been concentrated in the investigations area. ^g Includes payroll tax where applicable. ^h Calculated by multiplying the proportion of expenditure on salaries and payments for each SDA by the total payroll tax expenditure. ⁱ May not add to sum of its components as a result of rounding. na Not available. .. Not applicable.

Source: table 8A.70.

8.7 Road safety and traffic management

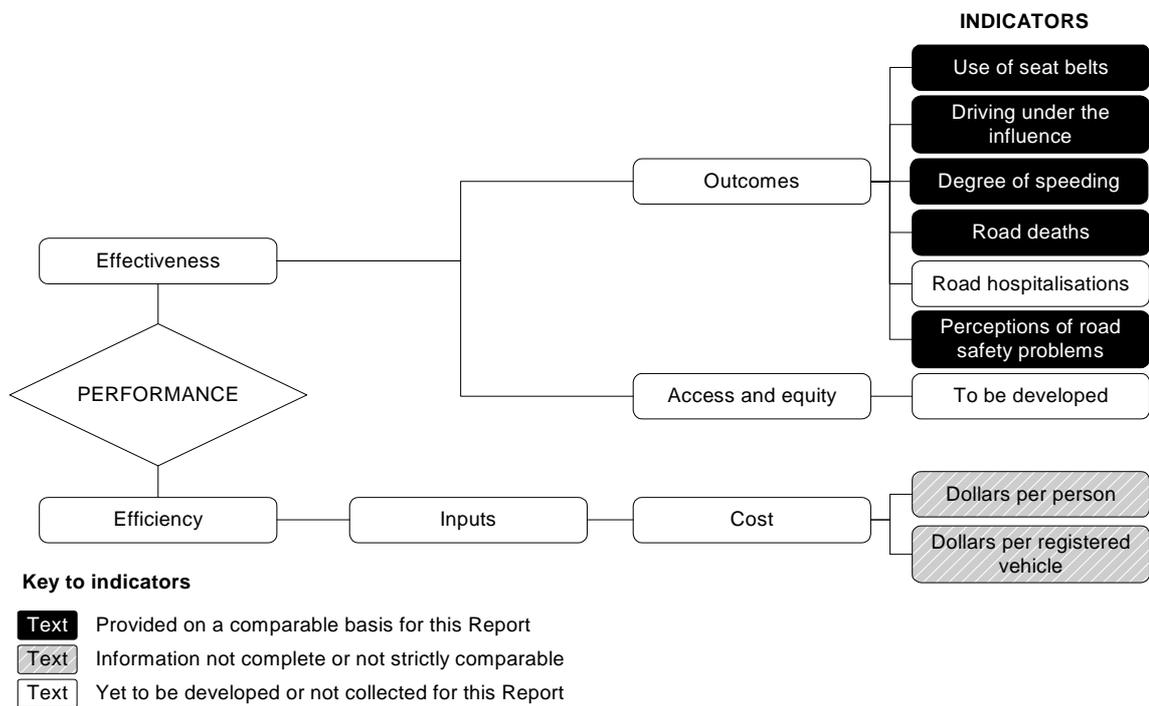
This SDA captures the role of police in maximising road safety through targeted operations to reduce the incidence of traffic offences and through attendance at, and investigation of, road traffic accidents and incidents. Activities typically include:

- monitoring road-user behaviour, including speed and alcohol related traffic operations;
- undertaking general traffic management functions;
- attending and investigating road traffic accidents and incidents; and
- improving public education and awareness of traffic and road safety issues.

Framework of performance indicators

The performance of the police in undertaking road safety and traffic management activities is measured using a suite of indicators that includes people's behaviour on the roads and the number of road hospitalisations and fatalities (figure 8.29).

Figure 8.29 Performance indicators for road safety and traffic management



Key performance indicator results

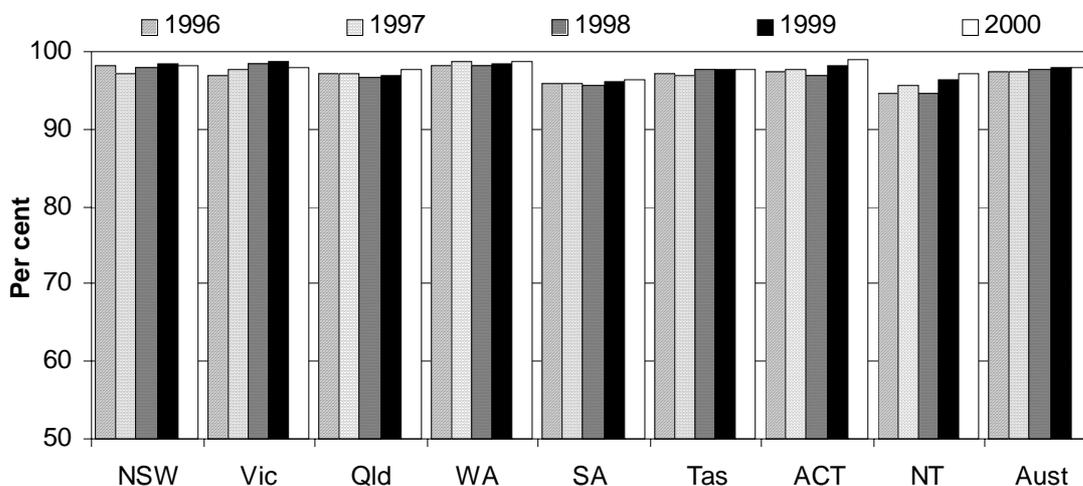
Comparable data on actual levels of seat belt use, speeding, and driving while under the influence are not available for reporting, so the performance indicators are based on survey responses from the PSM. For contextual purposes, 87.0 per cent of the respondents stated that they had driven a motor vehicle in the past 12 months (table 8A.71).

Use of seat belts

An aim of police road safety programs is to influence road users' behaviour, such as to increase the use of seat belts to reduce the risk of injury from road crashes. This involves promoting the use of seat belts, speed reduction and sober driving.

Nationally, in 2000, 98.0 per cent of persons aged 18 years and over said they wear a seat belt 'most of the time' or 'always'. There was little difference across jurisdictions or across years (figure 8.30).

Figure 8.30 Persons who wear a seat belt 'most of the time' or 'always,' for persons aged 18 years and over ^a



^a Caution should be used when comparing differences in results across jurisdictions and over time. The size of the sample may affect the accuracy of the results.

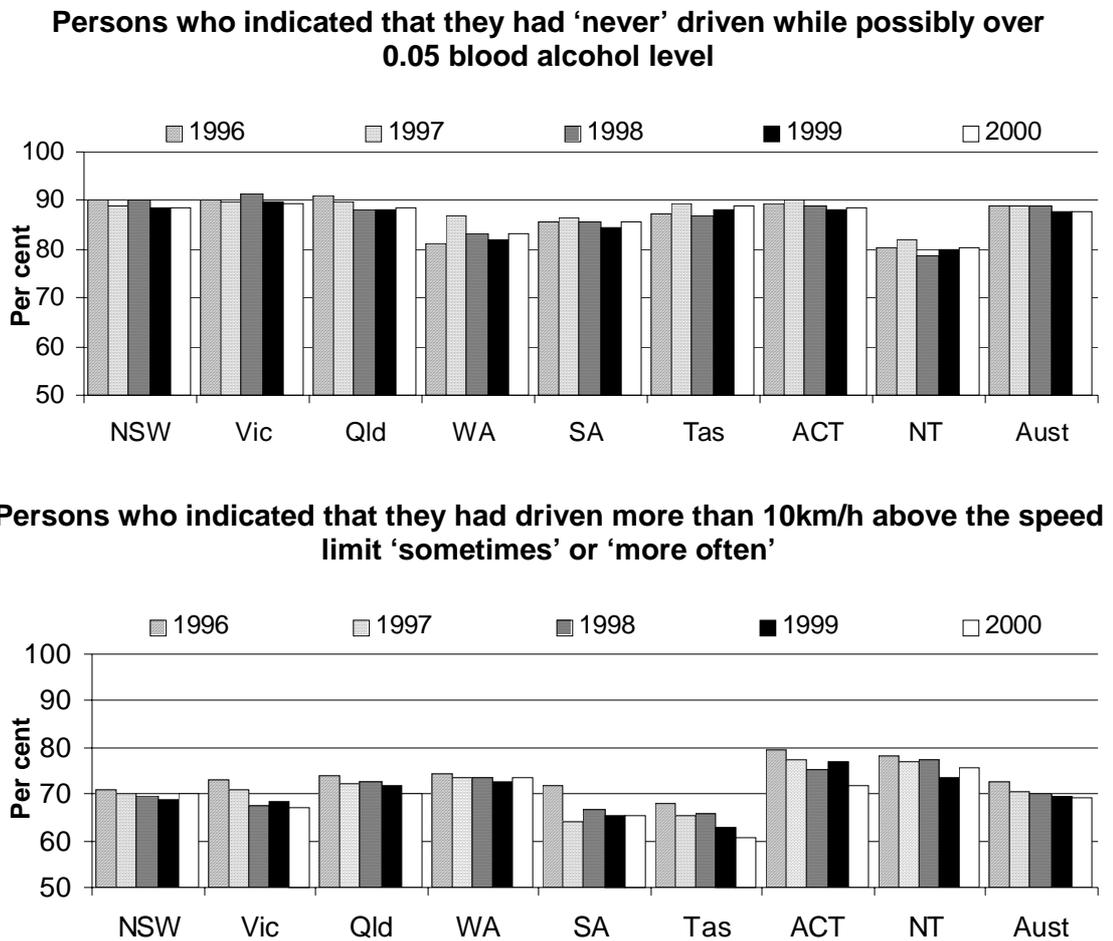
Sources: ABS, Population Survey Monitor, 1996–2000; table 8A.72.

Road safety behaviour — speed and alcohol

Nationally, in 2000, 87.8 per cent of persons who drive and are aged 18 years and over indicated that they had 'never' driven when possibly over the 0.05 blood alcohol limit. This proportion ranged from 89.3 per cent in Victoria to 80.3 per cent in the NT (figure 8.31).

Nationally, 69.1 per cent of persons who drive reported travelling more than 10 kilometres per hour above the speed limit 'sometimes' or 'more often'. Across jurisdictions, the proportion ranged from 75.7 per cent in the NT to 60.5 per cent in Tasmania (figure 8.31).

Figure 8.31 **Persons aged 18 years and over: acknowledged road safety behaviour as a proportion of those who drive^a**



^a Caution should be used when comparing differences in results across jurisdictions and over time. The size of the sample may affect the accuracy of the results.

Source: ABS, Population Survey Monitor, 1996–2000; tables 8A.73–8A.74.

Road fatalities

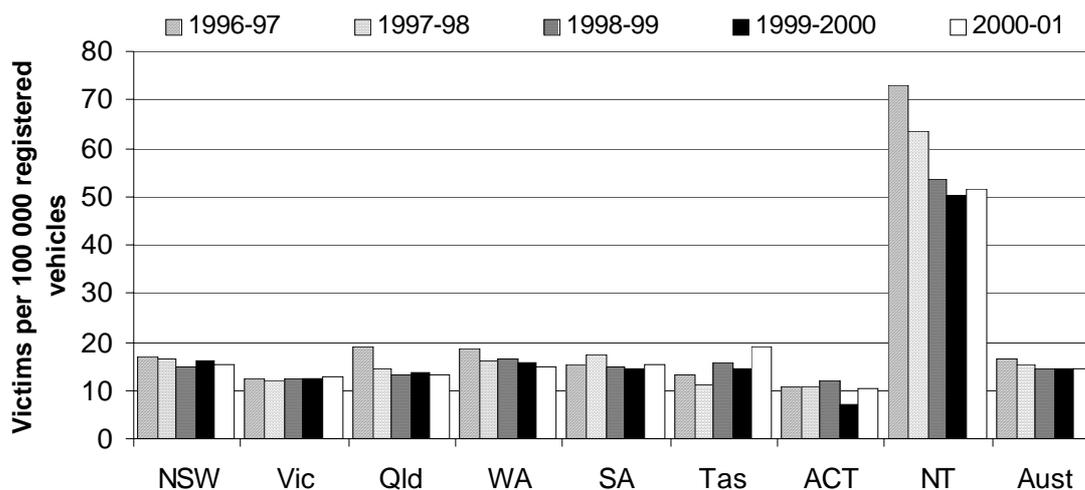
One aim of policing is to contribute to a reduction in road crashes and related road deaths and hospitalisations. The performance of the police in helping to minimise deaths and crashes that require a person to be admitted to hospital can affect the demand for many other government services (for example, hospital services).

Nationally, there were 1774 road deaths in 2000-01. Across jurisdictions, this number ranged from 556 in NSW to 20 in the ACT (table 8A.75).

There were 14 road deaths per 100 000 registered vehicles in Australia in 2000-01, ranging from 51 in the NT to 10 in the ACT. The largest fall in deaths per 100 000

registered vehicles over the period 1996-97 to 2000-01 occurred in the NT (down 22 deaths per 100 000 registered vehicles) followed by Queensland (down six deaths per 100 000 registered vehicles). The only increase in deaths per 100 000 registered vehicles over this period occurred in Tasmania (up six deaths per 100 000 registered vehicles) (figure 8.32).

Figure 8.32 Road fatalities^a



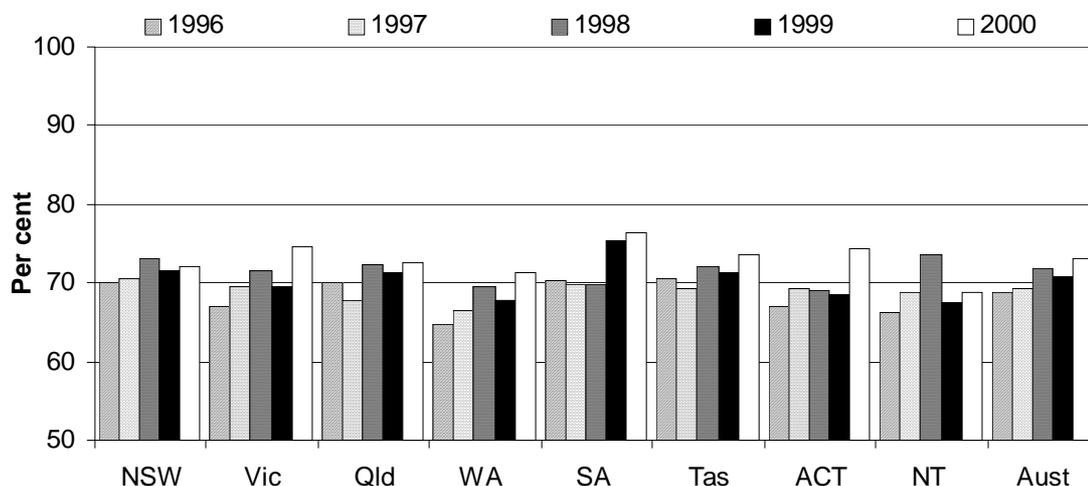
^a Road fatalities data provided by the Australian Transport Safety Bureau (ATSB) for each of the respective years.

Sources: ATSB various years; table 8A.75.

Perceptions of road safety problems

Nationally, in 2000, 73.2 per cent of persons aged 18 years and over believed speeding cars or dangerous, noisy driving to be a ‘major problem’ or ‘somewhat a problem’ within their neighbourhood. Across jurisdictions, this observation ranged from 76.5 per cent in SA to 68.7 per cent in the NT (figure 8.33).

Figure 8.33 **Persons aged 18 years and over: proportion who felt that speeding cars or dangerous, noisy driving was a 'major problem' or 'somewhat a problem' in their neighbourhood^a**



^a Caution should be used when comparing differences in results across jurisdictions and over time. The size of the sample may affect the accuracy of the results.

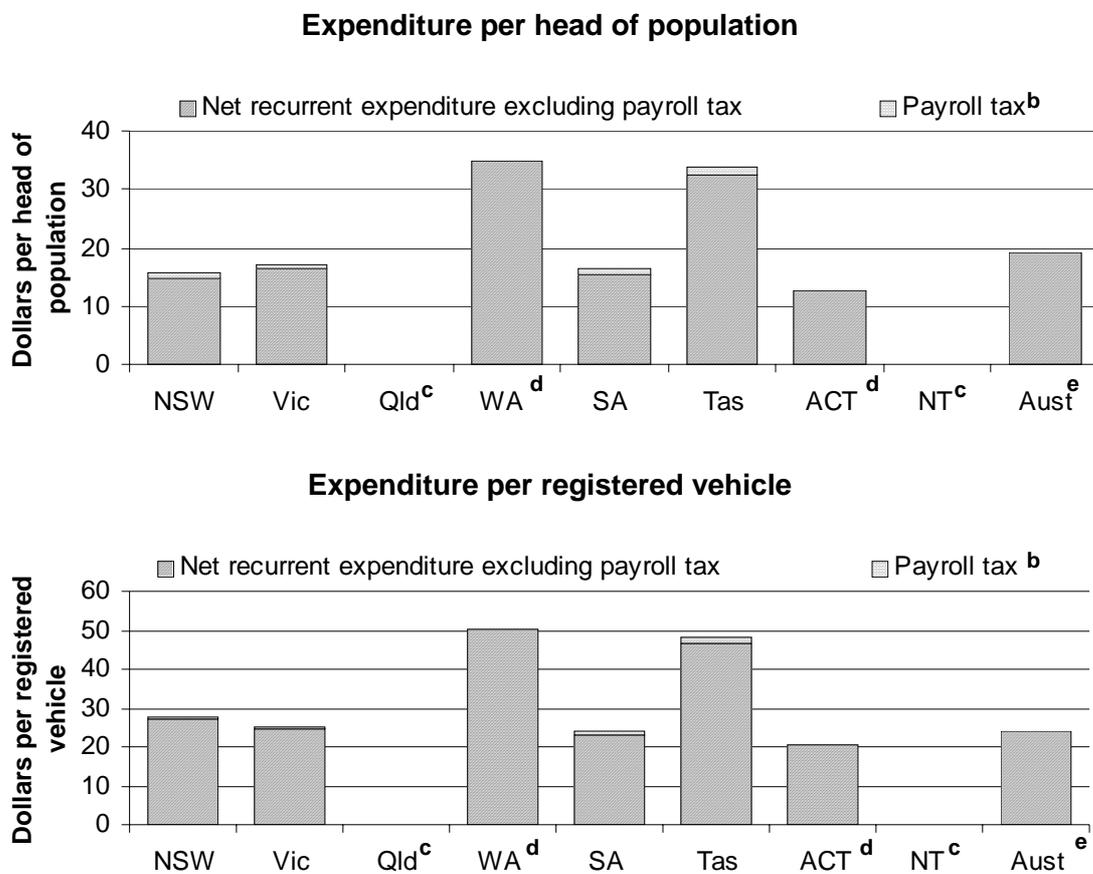
Sources: ABS, Population Survey Monitor, 1996–2000; table 8A.76.

Efficiency

Nationally, of the jurisdictions that were able to provide data in 2000-01, estimated expenditure on road safety and traffic management was \$19 per head of population. It ranged from \$35 per head of population in WA to \$13 per head of population in the ACT. Estimated expenditure on road safety and traffic management per registered vehicle also varied across jurisdictions, from \$50 in WA to \$20 in the ACT (figure 8.34).

Nationally, the expenditure on road safety and traffic management as a proportion of total police expenditure was 8.4 per cent. Expenditure on road safety and traffic management as a proportion of each jurisdiction's total police expenditure ranged from 16.0 per cent in Tasmania to 5.5 per cent in the ACT (table 8A.12).

Figure 8.34 Expenditure on road safety and traffic management, 2000-01^a



^a Data have not been subjected to extensive tests to determine comparability. Further, some differences in counting rules may exist across jurisdictions as a result of the differing mixes of activities undertaken within each of the common SDAs. ^b Calculated by multiplying the proportion of expenditure on salaries and payments for each SDA by the total payroll tax expenditure. ^c Data are available only for all key SDAs combined. ^d Exempt from payroll tax. ^e Includes payroll tax where applicable.

Source: table 8A.77.

While comparisons can be made with last year, caution should be used due to possible changes in the methods employed. The largest increase in real expenditure on road safety and traffic management over the past year occurred in Tasmania, which increased real expenditure by \$9 per head of population (from \$25 to \$34) (table 8.13).

The largest decrease in real expenditure from last year occurred in SA, where real expenditure decreased by \$11 per head of population (from \$28 to \$17). Nationally, real expenditure on road safety and traffic management decreased by \$2 per head of population (from \$21 to \$19) (table 8.13).

Table 8.13 Real expenditure on road safety and traffic management^a

	NSW	Vic	Qld ^b	WA ^c	SA	Tas	ACT ^c	NT ^b	Aust ^d
<i>Dollars per head of population</i>									
Net recurrent expenditure (excluding payroll tax)									
1999-2000	15	18	na	38	27	24	11	na	21
2000-01	15	17	na	35	15	32	13	na	19
Payroll tax ^e									
1999-2000	1	1	na	..	1	1	..	na	..
2000-01	1	1	na	..	1	2	..	na	..
Total^f									
1999-2000	15	19	na	38	28	25	11	na	21
2000-01	16	17	na	35	17	34	13	na	19
<i>Dollars per registered vehicle</i>									
Net recurrent expenditure (excluding payroll tax)									
1999-2000	26	27	na	54	39	35	18	na	26
2000-01	27	25	na	50	23	47	20	na	24
Payroll tax ^e									
1999-2000	1	1	na	..	1	1	..	na	..
2000-01	1	1	na	..	1	2	..	na	..
Total^f									
1999-2000	27	27	na	54	40	36	18	na	26
2000-01	28	25	na	50	24	48	20	na	24

^a Data have not been subjected to extensive tests to determine comparability. Further, some differences in counting rules may exist across jurisdictions as a result of the differing mixes of activities undertaken within each of the common SDAs. ^b Data are available only for all key SDAs combined. ^c Exempt from payroll tax. ^d Includes payroll tax where applicable. ^e Calculated by multiplying the proportion of expenditure on salaries and payments for each SDA by the total payroll tax expenditure. ^f May not add to sum of its components as a result of rounding. **na** Not available. **..** Not applicable.

Source: table 8A.77.

8.8 Services to the judicial process

This SDA captures the role of police in providing effective and efficient support to the judicial process, including the provision of safe custody for alleged offenders and fair and equitable treatment of both victims and alleged offenders.

Activities typically include:

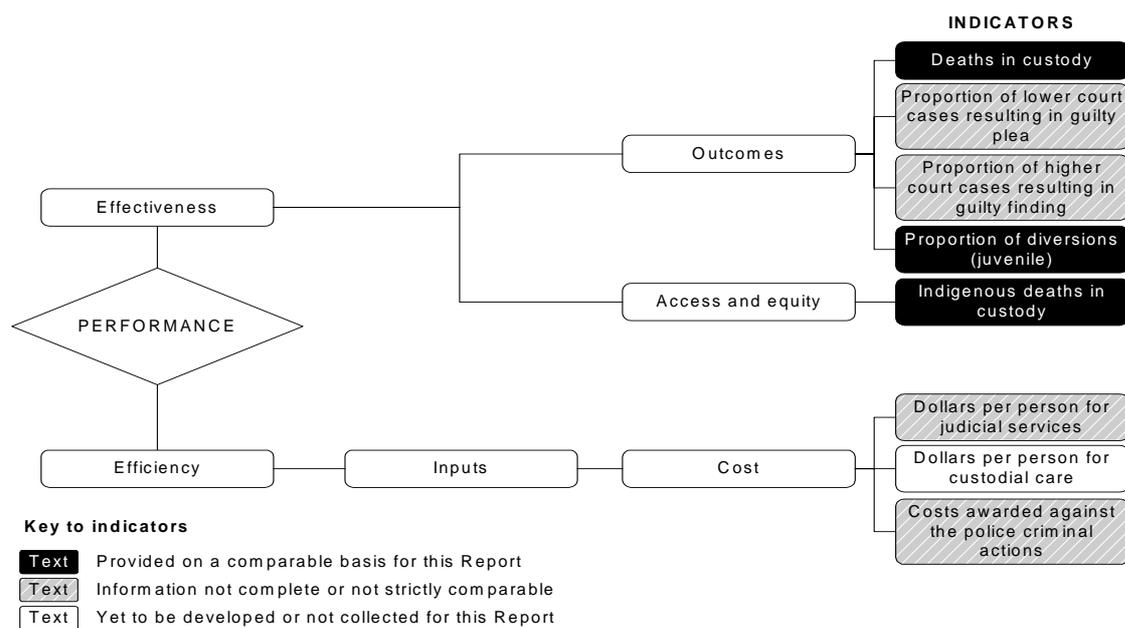
- preparing briefs;
- presenting evidence at court; and
- conducting court and prisoner security.

The role of police services in conducting court and prisoner security differs across jurisdictions.

Framework of performance indicators

The performance of the police in undertaking these activities is measured using a suite of indicators that includes the number of court cases resulting in guilty pleas or guilty findings, and the effectiveness of police in diverting offenders from the criminal justice system (figure 8.35).

Figure 8.35 Performance indicators for services to the judicial process



Key performance indicator results

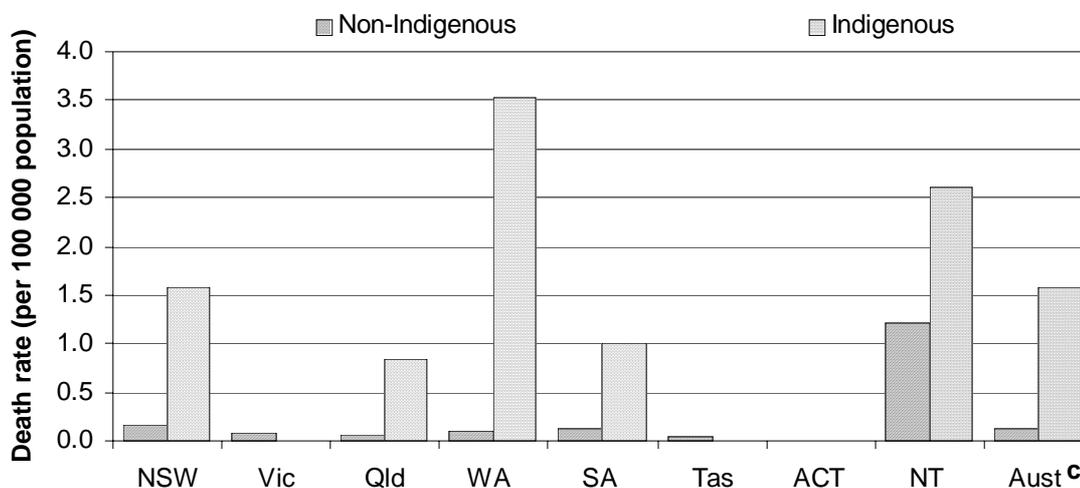
Deaths in police custody and custody related operations

Nationally, there were 25 deaths in police custody and custody related operations in 2000 (table 8A.78). Across jurisdictions, the average number of non-Indigenous deaths each year between 1996 and 2000 ranged from 1.2 deaths per 100 000 population in the NT to zero deaths in the ACT (figure 8.36).

Nationally, the average number of Indigenous deaths each year between 1996 and 2000 ranged from 3.5 Indigenous deaths per 100 000 Indigenous population in WA to zero in Victoria, Tasmania and the ACT (figure 8.36).

More detail on the number of deaths in police custody and custody related operations (including number of deaths and rates by jurisdiction), over the period 1996–2000, appears in table 8A.78.

Figure 8.36 Deaths in police custody and custody related operations, per 100 000 population^{a, b}



^a Calculated as the average number of deaths in custody between 1996 and 2000, divided by the population in each jurisdiction (1996 ABS Census) and multiplied by 100 000. ^b Deaths in police custody include: deaths in institutional settings (for example, police stations/lockups and police vehicles, or during transfer to or from such an institution, or in hospitals following transfer from an institution); and other deaths in police operations where officers were in close contact with the deceased (for example, most raids and shootings by police). Deaths in custody related operations cover situations where officers did not have such close contact with the person as to be able to significantly influence or control the person's behaviour (for example, most sieges and most cases where officers were attempting to detain a person, such as pursuits). ^c Includes one Australian Federal Police (national, not the ACT) death in custody in 1999.

Source: table 8A.78.

Outcomes of court cases

The police assist the judicial process in a variety of ways, including by collecting evidence and providing testimony in court. Police work in this area can be measured to some extent by the success of the police in achieving a guilty plea or conviction.

Victoria, Tasmania, the ACT and the NT were unable to provide any data this year on the outcome of court cases. The proportion of lower court cases resulting in a guilty plea ranged from 89.0 per cent in WA to 67.4 per cent in Queensland in 2000-01 (table 8.14).

The proportion of higher court cases resulting in a guilty finding ranged from 90.9 per cent in Queensland to 61.9 per cent in SA (table 8.14). All jurisdictions that provided data on the outcome of higher court cases included guilty findings and guilty pleas.

Table 8.14 Outcomes of court cases, 2000-01 (per cent)

	NSW	Vic ^b	Qld ^c	WA	SA	Tas	ACT	NT
Lower court cases resulting in guilty plea	78.0	na	67.4	89.0	79.4	na	na	na
Higher court cases resulting in guilty finding ^a	76.0	na	90.9	na	61.9	na	na	na

^a All jurisdictions' data include guilty findings and guilty pleas. ^b Data not available at the time of data collection due to Victoria Police work bans. ^c For lower court cases in Queensland, total matters (denominator) include those matters committed to a higher court, heard summarily, dismissed or withdrawn, and matters where a warrant has been issued. Results are based on individual charges. **na** Not available.

Source: table 8A.79.

Juvenile diversions

When police apprehend offenders, they have a variety of options available. The police can charge the offender, in which case criminal proceedings occur through the traditional court processes, or they can use their discretion to divert the offender away from this potentially costly, time consuming and stressful situation (for both the offender and victim).

Diversionsary mechanisms include cautions and attendances at community and family conferences. These options can be appealing because they allow the offender to be admonished, without the necessity of traditional court processes. They are particularly useful mechanisms for dealing with juvenile offenders.

A juvenile diversion is defined as juveniles who would otherwise be proceeded against (that is, taken to court) but who are diverted by police, as a proportion of all juvenile offenders formally dealt with by police. The term 'diverted' includes diversions of offenders away from the courts by way of community conference; diversionsary conference; formal cautioning by police; family conferences; and other diversionsary programs (for example, drug assessment/treatment). Offenders who would not normally be sent to court for the offence detected and who are treated by police in a less formal manner (for example, issued warnings or infringement notices) are excluded. This is the standard definition used by most jurisdictions in compiling their data.

Across jurisdictions, in 2000-01, the proportion of juveniles undergoing diversionsary programs ranged from 80.4 per cent in the NT to 43.2 per cent in Queensland (table 8.15). It should be noted, however, that there are variations across jurisdictions over what is determined to be a 'diversion' and hence variations from the standard definition. For instance, the large proportion of diversions in the

NT may be a result of the inclusion of verbal warnings which are not included in other jurisdictions.

The greatest increase in the use of juvenile diversions between 1997-98 and 2000-01 occurred in Tasmania, where the proportion of juveniles diverted rose from 26.0 per cent to 59.0 per cent. The only other variation of substance occurred in the ACT (an increase from 36.0 per cent to 48.3 per cent over the period) (table 8.15). Victoria and WA were unable to provide data on juvenile diversions for 2000-01.

Table 8.15 Juvenile diversions as a proportion of juvenile offenders (per cent)^a

	<i>NSW</i>	<i>Vic</i> ^b	<i>Qld</i> ^c	<i>WA</i> ^d	<i>SA</i> ^e	<i>Tas</i>	<i>ACT</i>	<i>NT</i> ^f
1997-98	na	33.0	43.0	40.0	54.0	26.0	36.0	na
1998-99	na	29.0	43.0	42.0	53.0	51.0	32.0	na
1999-2000	48.0	32.0	43.0	41.0	53.0	50.0	34.0	na
2000-01	51.0	na	43.2	na	53.0	59.0	48.3	80.4

^a 'Juvenile diversion' is defined in the accompanying text. ^b Data for 2000-01 not available at the time of data collection due to Victoria Police work bans. ^c Data also include cautions and community conferences. ^d Data are calendar year not financial year. Juvenile diversions include juvenile cautions and referrals to Juvenile Justice Teams. The proportion of juvenile diversions has been calculated on total recorded police contacts with juvenile offenders comprising juvenile cautions, referrals to Juvenile Justice Teams and charges pertaining to juveniles. ^e No valid data for 'other diversionary programs' in SA Police. ^f Data also include verbal warnings. The data are for a nine month period. **na** Not available.

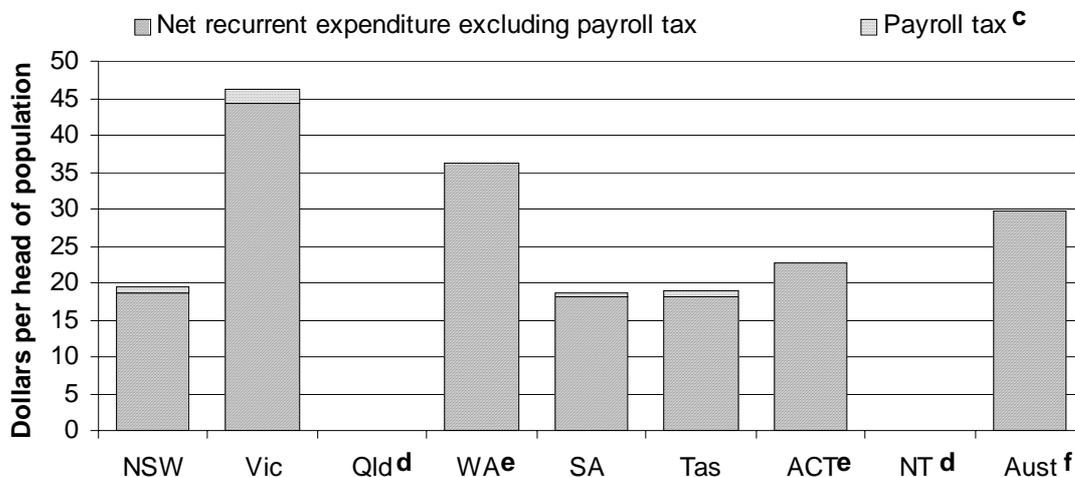
Source: table 8A.80.

Efficiency

Nationally, of the jurisdictions able to provide data in 2000-01, estimated expenditure on services to the judicial process was \$30 per head of population. It ranged from \$46 per head of population in Victoria to \$19 per head of population in NSW, SA and Tasmania (figure 8.37).

Nationally, expenditure on judicial processes as a proportion of total police expenditure, was 13.2 per cent. Expenditure on judicial processes as a proportion of each jurisdiction's total police expenditure, ranged from 21.8 per cent in Victoria to 8.3 per cent in NSW (table 8A.12).

Figure 8.37 Expenditure on services to the judicial process, 2000-01^{a, b}



^a Some data are preliminary and thus have not been subjected to extensive tests to determine comparability. Further, some differences in counting rules may exist across jurisdictions as a result of the differing mixes of activities undertaken within each of the common SDAs. ^b Population based on ABS estimates for June 2001. ^c Calculated by multiplying the proportion of expenditure on salaries and payments for each SDA by the total payroll tax expenditure. ^d Data are only available for all key SDAs combined. ^e Exempt from payroll tax. ^f Includes payroll tax where applicable.

Source: table 8A.81.

While comparisons can be made with last year, caution should be used due to possible changes in the methods employed. The only increase in real expenditure on services to the judicial process over the past year occurred in NSW, where real expenditure rose by \$1 per head of population (up from \$18 to \$19) (table 8.16).

The largest decrease in real expenditure was in the ACT, which fell by \$15 per head of population (down from \$38 to \$23). Nationally, real expenditure on services to the judicial process decreased by \$2 per head of population (down from \$32 to \$30) (table 8.16).

Another indicator of efficiency is the court costs awarded against the police in criminal actions. Court costs will generally be awarded when a criminal action against an offender has failed; in this respect, it represents at least some of the resources expended when a prosecution fails. In 2000-01, ACT had the highest cost awarded against the police per head of population (30 cents) and Tasmania had the lowest (1 cent). Victoria and the NT have not provided data for this year. Since 1998-99, each jurisdiction that has reported has shown a reduction in costs awarded against police (table 8.17).

Table 8.16 Real expenditure on services to the judicial process (dollars per head of population)^{a, b}

	<i>NSW</i>	<i>Vic</i>	<i>Qld^c</i>	<i>WA^d</i>	<i>SA</i>	<i>Tas</i>	<i>ACT^{d, e}</i>	<i>NT^c</i>	<i>Aust^f</i>
Net recurrent expenditure excluding payroll tax									
1999-2000	17	49	na	45	25	18	38	na	32
2000-01	19	44	na	36	18	18	23	na	30
Payroll tax ^g									
1999-2000	1	2	na	..	1	1	..	na	..
2000-01	1	2	na	..	1	1	..	na	..
Total^h									
1999-2000	18	50	na	45	26	19	38	na	32
2000-01	19	46	na	36	19	19	23	na	30

^a Some data are preliminary and thus have not been subjected to extensive tests to determine comparability. Further, some differences in counting rules may exist across jurisdictions as a result of the differing mixes of activities undertaken within each of the common SDAs. ^b Population based on ABS estimates for June 2001. ^c Data are available only for all key SDAs combined. ^d Exempt from payroll tax. ^e This variation in ACT expenditure should be viewed with caution as it is due, in part, to the revised methodology for the apportioning of direct costs to outcomes and the consequent increase in costs directly attributed to investigations. ^f Includes payroll tax where applicable. ^g Calculated by multiplying the proportion of expenditure on salaries and payments for each SDA by the total payroll tax expenditure. ^h May not add to sum of its components as a result of rounding. **na** Not available. **..** Not applicable.

Source: table 8A.81.

Table 8.17 Costs awarded against the police in criminal actions^a

	<i>NSW</i>	<i>Vic^b</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>
Total costs ('000 dollars)								
1998-99	na	1 544	178	862	349	35	na	na
1999-2000	na	1 296	192	388	366	22	177	na
2000-01	492	na	154	421	297	4	96	na
Total costs per head of population (dollars)								
1998-99	na	0.33	0.05	0.47	0.23	0.07	na	na
1999-2000	na	0.27	0.05	0.21	0.24	0.05	0.57	na
2000-01	0.07	na	0.04	0.22	0.20	0.01	0.30	na

^a Total costs awarded against the police resulting from summary offences and indictable offences tried summarily before a court of law. ^b Data for 2000-01 not available at the time of data collection due to Victoria Police work bans. **na** Not available.

Source: table 8A.82.

8.9 Other services provided by police

Where possible, all jurisdictions have tried to fit their police activities within the four SDAs identified within the chapter (community safety and support; crime investigation; road safety and traffic management; and services to the judicial process). It is acknowledged that in some instances, a clear cut breakdown of

activities into these four activities is not always possible, so a ‘best fit’ scenario applies.

In some instances, it is not possible for jurisdictions to allocate particular activities or costs to the four SDAs already reported in this chapter. Therefore, a fifth SDA has been developed, called ‘other services.’ This SDA can include (but is not limited to) such things as information and licensing services, regulatory services and ministerial support services (refer to table 8A.10 for activities included in ‘other services’). For this Report, Victoria, WA and the ACT have included expenditure under this category.

Victoria spent the most on ‘other services’ per head of population (\$7), followed by WA (\$6) and the ACT (\$5) (table 8.18). As a proportion of each jurisdiction’s total police expenditure, ‘other services’ represented 3.2 per cent of Victorian expenditure, 2.7 per cent of WA’s expenditure, and 2.1 per cent of the ACT’s expenditure (table 8A.12).

Table 8.18 **Real expenditure on ‘other services’ (dollars per head of population)^{a, b}**

	NSW	Vic	Qld ^c	WA ^d	SA	Tas	ACT ^{d, e}	NT ^c	Aust ^f
Net recurrent expenditure excluding payroll tax									
1999-2000	–	–	na	7	–	–	–	na	1
2000-01	–	7	na	6	–	–	5	na	3
Payroll tax ^g									
1999-2000	–	–	na	..	–	–	..	na	..
2000-01	–	–	na	..	–	–	..	na	..
Total									
1999-2000	–	–	na	7	–	–	–	na	1
2000-01	–	7	na	6	–	–	5	na	3

^a Some data are preliminary and thus have not been subjected to extensive tests to determine comparability. Further, some differences in counting rules may exist across jurisdictions as a result of the differing mixes of activities undertaken within each of the common SDAs. ^b Population based on ABS estimates for June 2001. ^c Data are available only for all key SDAs combined. ^d Exempt from payroll tax. ^e In the ACT, ‘other services’ consist of regulatory activities. ^f Includes payroll tax where applicable. ^g Calculated by multiplying the proportion of expenditure on salaries and payments for each SDA by the total payroll tax expenditure. **na** Not available. **..** Not applicable. **–** Nil or rounded to zero.

Source: table 8A.83.

8.10 Capital costs in the costing of police services

Capital costs (including depreciation and the user cost of capital) for each jurisdiction are contained in tables 8A1–8A.8. Costs associated with non-current physical assets (such as depreciation and the user cost of capital) are potentially important components of the total costs of many services delivered by government

agencies. Differences in the techniques for measuring non-current physical assets (such as valuation methods) may reduce the comparability of cost estimates across jurisdictions. In response to concerns regarding data comparability, the Steering Committee initiated a study: *Asset Measurement in the Costing of Government Services* (SCRCSSP 2001). The aim of the study was to examine the extent to which differences in asset measurement techniques applied by participating agencies affect the comparability of reported unit costs.

In police services, the results reported in the study indicate that different methods of asset measurement could lead to quite large variations in reported capital costs. Considered in the context of total unit costs, however, the differences created by these asset measurement effects were relatively small, as capital costs represent a relatively small proportion of total cost. A key message from the study was that the adoption of national uniform accounting standards across all service areas would be a desirable outcome from the perspective of the Review. The results are discussed in more detail in chapter 2.

8.11 Future directions in performance reporting

Agreed indicators for best practice that can be measured for both effectiveness and efficiency

Last year, the Police Working Group undertook to examine more robust and suitable ways to measure levels of efficiency in the range of services that police jurisdictions provide to the community. The Police Working Group has identified the areas of ‘community safety and support’ and ‘road safety and traffic management’ as areas where initial developmental work can be undertaken. It is possible that as a result of this work, the Report may include new indicators next year or in future years.

While the Report provides information on the costs of services for each SDA, it has proved difficult to develop efficiency indicators for each SDA and for policing in general. At present, the only efficiency indicators shown are the ‘total cost of service per head of population’ for each SDA. These are considered to be partial efficiency measures.

Policing services are often delivered contemporaneously, covering one SDA or even extending over several SDAs. For example, police response to a call for service will not only deal with the incident at hand, but may also increase police visibility and, therefore, provide public reassurance. Likewise, police road safety operations and crime investigations may also have crime prevention components.

As a result, police services are examining alternative methods for developing efficiency indicators. The approach is to identify issues/problems of prime importance and the activities required to redress the problems. Measures can then be made of the time/cost of activities and of the actions resulting from those activities.

Efficiency indicators would be defined in terms of the cost per unit of output, where output is defined as the sum of actions taken, weighted to reflect the importance of redressing the problem.

Community safety and support

For the 'community safety and support' SDA, three areas of prime concern to the community were identified from the community attitudes to policing survey. Further research reveals the main services that people seek from police in relation to each of these areas of concern:

- response capability: be contactable and attend as necessary;
- family (domestic) violence: attend in a timely manner, ensure safety of victim and follow-up; and
- street and public order: patrol designated 'hot spots', care for intoxicated persons, and manage street-level drug dealing.

Preliminary analysis suggests the following indicators may be considered as related efficiency indicators:

- cost of response service/calls received: a measure of efficiency of communications operations;
- cost of domestic violence/domestic violence victims: a measure of efficiency of police domestic violence services;
- cost of response service/(weighted) calls attended: a measure of efficiency in response capability; and
- cost of targeted street patrols/weighted actions: a measure of efficiency in public order.

For any efficiency indicator, however, it is necessary to derive costs actually associated with the units or actions, to form the denominator of the indicator. For example, if the total cost of 'community safety and support' was divided by the number of calls attended, the resultant partial efficiency indicator would not be readily interpretable. A jurisdiction placing more emphasis on crime prevention may increase the cost of the SDA overall, while reducing the cost of attending calls.

The partial measure of efficiency would suggest less efficient operations when the opposite may be true.

A challenge for police services, therefore, is the development of consistent methods for calculating the costs associated with specific activities.

Road safety and traffic management

The underlying objective for all police services in relation to road safety is to reduce the severity and incidence of road collisions through an improvement in road use behaviour. By definition, the efficiency of service delivery is directly related to its effectiveness in as much as resource use needs to be measured against the results achieved.

While the specific police activities that contribute to the achievement of the output are similar, road safety outputs vary across jurisdictions. In addition, it has proven difficult to separate the contribution of police-specific outputs from outputs of other agencies that lead to government outcomes. This is particularly relevant in those jurisdictions where an integrated approach to road safety encompasses a number of agencies.

Victoria is undertaking an output evaluation for road safety and traffic management. It is anticipated that the Working Group may be able to pick up on this work. The objectives of the work include examination of the extent to which government outcomes and objectives are being achieved, the impact of specific outputs in meeting those outcomes and objectives, the relevance and appropriateness of key performance indicators and the appropriateness of the output mix.

The objectives of the review are to determine the appropriateness of the price structure and the final price paid by government for each output and to consider the availability of alternative outputs or output providers that might more efficiently deliver required government outcomes.

It is anticipated that the outcomes of the Victorian output evaluation will assist the Working Group in focusing on those areas of police-specific activity where a clear link can be made between the level of results achieved and the resources deployed.

Appropriateness of service delivery

Public demands for greater efficiency and effectiveness within all government services, including policing, have led to an increased emphasis on the quality of service delivery. Historically, performance assessment has focused on how well a

police service has met its objectives (effectiveness) and also the costs associated with doing so (efficiency). Another relevant way of assessing performance in a service industry such as policing is to consider the appropriateness of the service being delivered. Typically, clients of a police service will come from many diverse groups, which will include: the government; the community of the State/Territory; victims of crime; people who call the police for a non-crime related service; and offenders.

Appropriateness indicators should go beyond simple measures of public satisfaction with services provided. They must address the more difficult issues of:

- assessing to what extent the agency identifies what its clients want; and
- assessing its response to meeting those needs and expectations.

To date, police services have addressed the issue of determining appropriateness of service delivery in different ways. The Queensland Police Service has set up a project team tasked with developing a 'Client Service Charter and Standards' for the Service. Operational police and senior executive officers were surveyed to establish their perceptions of what the public wanted from the police, in terms of the actual services provided and the characteristics of the services (for instance, timeliness, communication and courtesy).

The general public were also surveyed to establish what they wanted and what they thought of the quality of service provided. In addition, focus groups from the community were conducted around the State to determine specific issues relevant to participants (for example, women, rural communities, the unemployed and youth issues).

In developing its 2001–2006 Strategic Plan, the WA Police Service conducted an environmental scan, which included a survey of all 'Safer WA' Committees around the State. These committees were established as a forum where all parties involved in safety and security issues could come together to develop local solutions. The survey assessed their views on a range of safety and security issues, and was supplemented with interviews of chief executive officers from the relevant State agencies, including the ministries of justice and health.

The data from the survey and interviews were used to assist in mapping out and focusing the strategic direction of the agency over a five-year period. The agency's strategic plan provides a clear picture of its objectives for community safety and security, and is the basis for the development of an appropriate performance framework to measure the achievement of those objectives.

The Department of Police and Public Safety in Tasmania has demonstrated a commitment to develop strategic partnerships and networks with key stakeholders – a philosophy which underpins the *Tasmania Together* goal of ‘having a community where people feel safe in all aspects of their lives’. An extensive consultation process was undertaken in 2000 to achieve this and the plan represents a government-community partnership ‘driven by the community for the community’. The Premier of Tasmania began the process of consultation by meeting major community groups throughout Tasmania in February 1999. Subsequently, a 24 member Community Leaders’ Group was established to consult with the people of Tasmania and facilitate the development of the plan.

The State Government Partnership Agreements take into account consultative mechanisms at the local level and are aimed at encouraging local input to community and economic development and promoting shared responsibilities for better targeted service delivery. Tasmania Police are actively involved in the development of these partnerships.

The primary objective of the Victoria Police Local Priority Policing (LPP) initiative is to deliver effective policing services that satisfy local community needs and expectations. Full implementation of the initiative will ensure that the mix and nature of policing services delivered to individual communities are appropriate to the perceived needs of each community.

The first two phases of the LPP initiative involved structural and service delivery reforms. The final phase of LPP involves the delivery of the Community Consultation Model that focuses on developing strategic partnerships with communities and other community service agencies. It also ensures that community input into the determination of priorities and levels of service is formalised within the Victoria Police corporate planning framework.

New South Wales Police believe the question of appropriateness is best answered by looking at how services are determined and by appreciating that services should concentrate on things that are of most concern to the public (eg break and enter, motor vehicle theft etc). Effort is concentrated on preventing these crimes by focusing on things such as repeat offenders and licensing second hand dealers.

New South Wales Police efforts to monitor response to calls and the introduction of the ‘police assistance line’ provide further alternative methods of contact. This approach involves using surveys (such as the national attitudes survey and the NSW Police Service Crime and Safety Survey) to identify what the customer wants and then planning the police response to meet customer needs and expectations.

Northern Territory Police has adopted a whole-of-community approach to crime prevention. A 'NTsafe' Committee has been established, comprising membership across six key government agencies, and six community members to represent Aboriginal communities, ethnic communities, local government, the youth and business sectors. Between August and November 2000, 'NTsafe' conducted a series of 23 public meetings in urban and remote communities across the NT to identify the crime prevention and community safety issues of most importance or concern to Territorians. The meetings were also an opportunity for communities to identify potential solutions to problems being experienced.

The NT Police, in partnership with the 'NTsafe' Secretariat, has been actively involved in promoting the 'NTsafe' grant scheme and, in some cases, participating in projects with local community groups. The NT Police has also, in partnership with 'NTsafe', contracted an expert to consult with stakeholders in the Darwin and Palmerston areas about the legitimate use of public space.

Police services recognise that the diverse nature of client groups across jurisdictions will create inherent difficulties in making comparisons of appropriateness. Compounding this problem is the divergence in government policy, differing legislative requirements, relationships with other government departments and the unique socioeconomic conditions of the local community. While acknowledging these difficulties, the police services will continue to explore ways to measure and compare appropriateness of services delivered.

8.12 Information on sample data

Some of the results reported are estimates obtained by conducting surveys with samples of the group or population in question. Results are therefore subject to sampling error. The data obtained from a sample may be different from the 'true' data which would have been obtained from the entire group or population (not just a sample) using the same methods. Consequently, when using survey results, it is necessary to be cautious (see Appendix A).

The standard error is a measure of sampling error. It indicates the extent to which the estimate may differ by chance from the 'true value' because only a sample was taken. If the survey is performed repeatedly, the difference between the sample estimate and the population value will be less than one standard error about 68 per cent of the time. The difference will be less than two standard errors 95 per cent of the time. It will be less than three standard errors 99 per cent of the time. Another way of expressing this is to say that, in 68 (95, 99) of every one

hundred samples, the estimate obtained from a single survey will be within one (two, three) standard errors of the ‘true’ value.

The chance that an estimate falls within a certain range of the true value is known as ‘the confidence of the estimate’. For any particular survey, there is a tradeoff between the confidence of the estimate (68, 95 or 99 per cent) and the size of the survey. The appropriate level of confidence chosen depends on the purpose of obtaining the estimate.

The relative standard error is the standard error, expressed as a percentage, which should be attached to the estimate. It indicates the margin of error that should be attached to the estimate. The smaller the estimate, the higher the relative standard error.

In table 8.19, relative standard errors are presented for various estimates of the number of people. Some tables in this Report present the results as a percentage of the total population. To calculate a relative standard error for these cases, the percentage estimate must be converted back to an estimate of the number of people. Tables throughout the PSM show the estimated population sizes for the questions in the survey.

For example, if in NSW 60 per cent of males were ‘satisfied’ or ‘very satisfied’ with police services, and if the estimated population size for this question was 2 274 000, this would mean that 1 364 400 persons were satisfied. Table 8.19 shows that the associated relative standard error is approximately 2.5 per cent. There is a 68 per cent probability that the proportion of the population using the service is within one relative standard error of the estimated proportion. That is, we can be 68 per cent confident that the true value lies between 60 per cent plus or minus 2.5 per cent of 60 per cent — 58.5 to 61.5 per cent. (Note that is not equivalent to 60 per cent plus or minus 2.5 per cent.) We can be 95 per cent confident that the true value lies within two relative standard errors — that is, between 57.0 and 63.0 per cent.

Table 8.19 Relative standard error of estimates for the *Population Survey Monitor* by jurisdiction^a

<i>Estimate</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
'000	%	%	%	%	%	%	%	%	%
Three quarter survey questions									
5	70.4	67.0	55.4	40.4	46.2	23.1	18.5	19.6	56.6
10	49.8	47.4	39.2	28.6	32.7	16.3	13.1	13.9	40.0
20	33.9	31.8	27.8	19.6	21.2	9.8	8.6	9.4	28.2
50	20.1	18.8	16.2	11.4	12.7	5.4	5.4	5.1	17.5
100	13.5	12.5	10.6	7.4	8.3	3.3	3.7	3.3	12.0
200	8.8	8.2	7.1	4.8	5.4	1.9	2.5	2.1	8.0
500	5.0	4.6	4.0	2.7	3.0	0.9	..	..	4.7
800	3.7	3.4	2.9	1.9	2.2	..	..	..	3.5
1000	3.2	3.0	2.5	1.7	1.9	..	..	..	3.1
1500	2.5	2.3	2.0	1.3	1.5	..	..	..	2.3
2000	2.0	1.9	1.6	1.0	1.2	..	..	..	2.0
5000	1.1	1.0	0.9	..	..	..	..	..	1.1
Four quarter survey questions									
5	60.8	58.0	48.1	39.6	35.4	19.8	17.0	15.6	49.5
10	43.0	41.0	34.0	28.0	25.0	14.0	12.0	11.0	35.0
20	29.5	27.5	24.0	18.5	17.0	8.5	8.0	7.5	24.5
50	17.4	16.2	14.0	11.0	10.0	4.6	4.4	4.6	15.2
100	11.7	10.8	9.2	7.2	6.4	2.8	2.9	3.2	10.4
200	7.7	7.2	6.1	4.7	4.2	1.7	1.8	2.2	7.0
500	4.3	4.0	3.4	2.6	2.3	0.8	..	..	4.0
800	3.2	3.0	2.6	1.9	1.7	..	..	..	3.0
1000	2.8	2.6	2.2	1.7	1.5	..	..	..	2.7
1500	2.2	2.0	1.7	1.3	1.1	..	..	..	2.0
2000	1.8	1.6	1.4	1.1	0.9	..	..	..	1.7
5000	1.0	0.9	0.8	..	..	..	..	..	0.9

^a The ABS considers that only estimates with relative standard errors of 25 per cent or less are sufficiently reliable for most purposes. Estimates greater than 25 per cent are subject to sampling variability too high for most practical purposes and should be treated with caution and viewed as merely indicative of the magnitude involved. .. Not applicable.

Source: ABS, *Population Survey Monitor*, 1996–2000.

8.13 Jurisdictions' comments

This section provides comments from each jurisdiction on the services covered in this chapter. Appendix A contains short profiles on each State and Territory, which may assist in interpreting the performance indicators presented in this chapter. The information covers aspects such as age profile, geographic distribution of the population, income levels, education levels, tenure of dwellings and cultural heritage (such as Indigenous and ethnic status).

New South Wales comments

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The mission of the NSW Police Service is ‘to have police and community working together to establish a safer environment by reducing violence, crime and fear.’ The Service has adopted ethical cost-effective crime reduction and improved public safety as its primary objective. In particular, the Service has focused on the most traumatic personal crimes of assault and robbery, and the most voluminous property crimes of break & enter, motor vehicle theft and stealing. In redressing these crimes, the Service takes a whole of crime approach and with the cooperation of local communities, has put in place many problem-solving operations, designed to ensure all people can freely enjoy their lawful pursuits.

Key performance indicators (KPIs) used by the NSW Police Service include many of the performance indicators shown in this Report. Overall ‘success’ is measured in terms of general community satisfaction and confidence in police. Crime trends, alleged offenders proceeded against and road fatalities and injuries are also used as KPIs.

Accountability in the Service is assessed by internal benchmarking, both against past trends and by the comparison of Local Area Commands. Comparison with other States/Territories is considered less useful, as the information is not timely to be used operationally.

Service to the community is also assessed in terms of calls for assistance. During 2000-01, over 1 million calls were received at the ‘000’ emergency number. Police responded to over 1.5 million calls for assistance, of which about 106 000 required urgent attendance by police. Over 80 per cent of urgent calls were attended within 12 minutes and 80 per cent of non-urgent calls were attended within 43 minutes. This level of service is considered among the best in the world given the dispersed nature of this Statewide coverage.

In any given year, about 40 per cent of people aged 15 and over have contact with police, generating over 3 million contacts between police and community members in NSW. Less than 1 in 900 of these interactions resulted in a public complaint against police.

The NSW Police Service believes the level of achievement in delivering policing services to the NSW community is high and will further improve with increased emphasis on ethical crime investigation and intelligence-based crime prevention initiatives.

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Victorian comments

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This year in Victoria saw the roll-out of the final phase of the Local Priority Policing initiative – the Community Consultation Model – which is focused on developing partnerships with communities and community service agencies. A key element of the Model has been the establishment of a network of some 63 Local Safety Committees across Victoria and the development of Community Safety Plans which set out the strategies and initiatives proposed to address particular community safety issues. Victoria Police’s planning reporting and evaluation cycles have been aligned to ensure that local needs and priorities directly influence local police service delivery.

While the *Report on Government Services* shows that the Victorian community is generally satisfied with the services provided by police, there is always room to improve. Victoria Police will continue to focus on those broad areas identified as being of greatest concern to the community. Those areas are crime control, ensuring safer homes and public places and reducing violent crime.

Victoria remains a very safe place to live and work, but overall crime increased by some 3 per cent in the last year, with the most significant individual rises being in aggravated burglary, robbery, homicide and motor vehicle theft. In the current year, Victoria Police will focus on specific strategies to reduce violence against women, burglaries and motor vehicle theft. A police Commander will take a lead role in each of these areas to develop new strategies and a fresh approach to policing these areas of community concern.

Victoria Police is presently undertaking a critical examination of the systems and structures that underpin its delivery of policing services to the community. This examination is aimed at ensuring that the right systems are in place to support effective change and that those systems are properly resourced to allow them to deliver results.

In 2002 there will be a fundamental change in the way operational business is undertaken in Victoria Police, with an enhanced focus on customised crime reduction strategies at the state, regional and local levels. Those strategies will be based on the analysis and interpretation of crime data. Operational managers at each level will meet regularly to engage in critical reflection in determining operational and resource management, target setting, decision making, performance review and strategy validation.

Ensuring that the delivery of policing services is fully aligned with community concerns and expectations will remain a key focus for Victoria Police. An effective performance measurement and reporting framework is a fundamental requirement to ensuring that focus is maintained.

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Queensland comments

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The desire to work in partnership with the community and provide a range of responsive policing services that meet the needs of our clients is a central feature of our service orientation. The Queensland Police Service (QPS) remains committed to continually improving the quality and efficiency of policing service delivered to our clients throughout Queensland. During the year the QPS continued a Client Service Standards project to develop a Client Service Charter that will set the standard for the delivery of policing services in the future. The Volunteers in Policing program also continued to promote partnership between the police and community, to extend service delivery in the areas of community liaison, crime prevention, client support and victim and witness support.

A trial process called Operational Performance Review (OPR) was introduced to help ensure that we continue to provide a professional service to the community. OPRs seek to provide the opportunity for the Commissioner to hold regular, performance-focused meetings to review each District's activities with Regional and District Managers and other members of the senior executive. The OPR process has been developed to provide a constructive, supportive performance management process to improve the delivery of policing services.

Through the year the Service planned for, and managed, a number of significant events including activities associated with the Sydney 2000 Olympic Games, the Centenary of Federation and the 2001 Goodwill Games.

The Queensland Police Service's commitment to continual organisational improvement was also demonstrated through the evaluation of a number of initiatives. Significant reviews that were finalised, continued or commenced included: the implementation of Problem-Oriented and Partnership Policing; the Queensland Aboriginal and Torres Strait Island Police trial; and the Police Powers and Responsibilities Act. Project Lighthouse continued to deliver operational training in relation to the situational use of force, and this, combined with new equipment, provided police with a broader range of options for protecting themselves and the community.

The national CrimTrac system was formally launched in June 2001. The QPS played a significant role in the development of the integrated crime investigation system, which will facilitate the exchange of information between all police jurisdictions in Australia. The system will enhance the Service's capacity to deal with fingerprint identification, DNA profiling, paedophilia, domestic violence, firearms, vehicles of interest and criminal histories.

In June 2001 a Police Drug Diversion Program was also commenced, offering minor drug offenders the opportunity to avoid entering the criminal justice system, and instead access assessment, education, counselling and treatment programs at an early stage in their drug use.

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Western Australian comments

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The development of the Strategic Plan 2001-2006 in 2000-01 provides the WAPS with a long-term direction. In considering its future role, the conclusion was that the WAPS can achieve the outcomes it seeks only by continuing to work closely with others, across government and the community, and moving increasingly towards early intervention initiatives.

However, 2000-01 was generally a period of consolidation as the impact of the Strategic Plan on service delivery was determined. Priority was given to refining and building on the community policing and intelligence-led policing models commenced in the 1990s. This was achieved through encouraging local participation in the resolution of community safety and security, reducing the rate of fatal crashes where excessive speed or drink-driving were major contributing factors and the use of intelligence-led policing to reduce and clear offences.

A number of management initiatives were implemented to support these policing strategies. These initiatives focused on assisting frontline officers in delivering services. Their implementation recognised the need for more sophisticated and flexible work practices; a workforce that represents a diverse community; and the more effective use of technology and other resources to remain contemporary and be able to respond to the ever-changing environment in which it operates.

A Region and District Allocation of Resources (RADAR) Model was developed, based on considerable research and consultation. The RADAR model applies a number of variables in determining an equitable distribution of police officers to each police region or district. Whilst the RADAR model will be used as a guide, local conditions and management consultation will continue to be major factors in determining the final allocation of police officers in an area.

A review of district boundaries was completed, with metropolitan police boundaries being aligned with local government areas to assist service delivery and the establishment of key partnerships at the local level. The changes to the boundaries and renaming of the six metropolitan districts became effective on 1 July 2001.

These initiatives, along with the implementation of Strategic Plan, focus on positioning the WAPS to meet the challenges of the future, and involve implementing changes in the way it operates, to assure the safety and security of the community.

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South Australian comments

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SAPOL clearly understands community concerns about crime and disorder and the fear of crime. These concerns shape decision making throughout SAPOL's business planning process, which considers the wider environment that characterises operational policing in South Australia. Issues such as illicit drug use and alcohol abuse have long been significant problems for police and the community because of the social, economic and personal harm they create, and their connection with traditional crimes such as serious criminal trespass and robbery. SAPOL is also preparing for emerging crimes such as those involving outlaw motor cycle gangs, e-crime, and politically motivated violence. To keep abreast of these emerging issues and best practice responses, SAPOL successfully hosted the International Policing Conference *Global Directions: Local Solutions*, which attracted over 450 delegates from around Australia and the world.

There are two key elements to delivering quality services in complex environments. One is understanding and anticipating the community's needs and expectations. The other rests on SAPOL's ability to adapt its services to meet the specific needs of the diverse South Australian community. The results of the community satisfaction survey presented in this chapter will enable SAPOL to closely monitor the service delivery needs and expectations of a greater number of South Australians than in the past. This information is critical to measuring community perceptions of the outcomes of the services provided by SAPOL.

The primary vehicle through which service delivery is guided and monitored throughout SAPOL is the *Future Directions Strategy*. This Strategy is currently being revised and a new version will be released shortly. It will enable ASPOL to achieve its Mission by articulating a policing model for South Australia based on a Local Service Area structure, Core Strategies, a Crime Reduction Strategy and problem-solving principles. Underpinning operational service delivery to the community are eight Key Management Areas that collectively contribute to sound business practices. These are Service Orientation; Working Together; Problem-Solving; Ethics and Integrity; Valuing our People; Resource Management; Performance Management; and Continuous Improvement. SAPOL recognises that the community often access policing services in times of significant uncertainty, importance, or risk. Initiatives are in place to help overcome barriers that restrict access to essential services. For example, SAPOL's newly created call centre represents a major advance in service delivery and will improve community access to police services for non-emergency calls.

A national survey, conducted by the Morgan Research Centre during 2000, found that SAPOL was the most highly regarded amongst Australian police services for ethics and honesty; an increase of 11 per cent over the previous year. From this sound base of community confidence, SAPOL is positive about achieving its vision of being *held in the highest regard as a modern motivated, progressive and professional organisation responsive to the community's needs and expectations*.

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Tasmanian comments

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Tasmania Police continues to be at the forefront of strengthening community partnerships. Substantial progress has been made in formalising agreements between the State Government, local governments and community groups. Within the context of the Government's Tasmania *Together* initiative, Tasmania Police has a clear responsibility in responding to the community leaders' goal of '*having a community where people feel safe and are safe in all aspects of their lives*'. Many programs over the coming years will be focused specifically on achieving key performance targets to ensure that Tasmania maintains its position of having the lowest rate of crimes against people and property, and remains the safest state in Australia.

There has been significant progress in several aspects of the national CrimTrac program which is designed to streamline access to national policing information throughout Australia. Planning processes for the introduction of the national DNA database are well in hand. The new National Automated Fingerprint Identification System (NAFIS) was implemented, delivering a greatly improved capacity for fingerprint identification and matching. In support of this national approach, the *Forensic Procedure Act 2000* was enacted in January 2001 and a comprehensive training program was undertaken in preparation for the legislation.

National crime statistics for the calendar year 2000 indicate that Tasmania was below the national average in all offence categories for the first time. This is a significant achievement. Particularly noteworthy is the fact that our rate for the offence of Unlawful Entry with Intent was below the national rate for the first time since 1993. This offence decreased by 18 per cent in 2000 compared with the previous year, and contrasts with the national increase of 5 per cent.

The proportion of juvenile offenders diverted from the court system increased substantially. It is pleasing to note that Tasmania leads the way nationally in achieving the greatest increase in the use of diversionary processes for juveniles.

Within the Government's youth justice framework, Tasmania Police will continue with its policy of diverting youth offenders, where possible, from the criminal justice system. Early intervention programs are being developed, in partnership with other government and non-government organisations, in an effort to begin to break the cycle of intergenerational crime.

Tasmania was the only jurisdiction to experience a discernible reduction in the number of complaints against police. Complaints reached their lowest level since 1991 reflecting a growing level of professionalism.

Corporate priorities have been established for the year ahead which identify areas needing special attention. Although Tasmania was below the national average for all offence categories this year, three key areas - home burglary, motor vehicle theft and assault in public places will be vigorously addressed.

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Australian Capital Territory comments

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A number of key milestones have been achieved during the past 12 months to reduce crime levels in the ACT, enhance feelings of public safety and protect property against theft and damage.

The application of intelligence-led policing operations, the introduction of new legislation and significant increases in Government funding for the establishment of new crime prevention initiatives, have resulted in record reductions in property crime in the ACT.

Increased funding during the 2000-01 year enabled the appointment of 50 new police positions to intensify efforts in relation to burglary and motor vehicle theft offences. Intelligence-led operations were established, culminating in Operation Anchorage, which was launched in February 2001. As a result, Canberra recorded a 21 per cent reduction in burglary for the financial year 2000-01 while motor vehicle theft fell by 29 per cent. Other property related offences also fell during the reporting period including armed robbery by 12 per cent, fraud and misappropriation by nearly 60 per cent and vandalism and graffiti by 7 per cent. These reductions are remarkable when considered in the context of escalating trends in property crime in the ACT in recent years.

Policing services were delivered to the ACT community for the first time under a purchaser provider model in 2000-01. The Purchase Agreement covers all the purchaser interests of the ACT Government including the outcomes to be provided and the performance measures for the each outcome together with performance targets where appropriate. The agreement significantly enhances accountability to the ACT Government in terms of policing outcomes in the key areas of community safety, investigations, road safety and support to the judicial process.

As a consequence of this significant shift in business arrangements a detailed review of associated enabling costs was conducted during the year. This revision better quantifies the costs and nature of enabling services and formalises the segregation of services performed by ACT Policing in relation to Commonwealth and ACT outcomes.

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Northern Territory comments

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The Northern Territory accounts for 17.5 per cent of Australia's land mass, but has only 1 per cent of the country's population. The Territory is thus sparsely populated, and many of its people live in remote and isolated areas. The remoteness and isolation is compounded by a climate that frequently causes problems of access, and creates a regular need to evacuate people to less remote areas on a temporary basis.

This remoteness and isolation presents immense challenges in ensuring that all our citizens have access to the full range of services we provide. Remoteness and access impact on the costs of policing services, and we note the comments to this end elsewhere in this report. The Northern Territory Police Force is strongly supportive of attempts to build 'access' into indicators of remoteness.

There are three demographic trends that distinguish the Territory from other Australian jurisdictions. The proportion of Aboriginal and Torres Strait Islander people is significantly higher here than elsewhere. The Northern Territory Police are pleased to report that we have the highest absolute number of Aboriginals providing policing services to the community. However, we readily acknowledge that we must do more to increase the representation of Aboriginal people in the police and decrease their representation in our victims and offenders statistics.

The Territory also has a faster growing and younger population than other Australian jurisdictions. For example, the Territory's median age is 26.6, which is in the category of persons most likely to be both an offender and a victim of crime. This is possibly one contributory factor in explaining why the Territory's victimisation rates for crimes against the person, crimes against property and road accidents is so much higher than the national average.

To assist in tackling these unacceptably high rates, the Northern Territory Police have intensified their use of intelligence-led policing. Our data collection systems are being enhanced and strategic information is beginning to generate plans which target particular problem areas. We have also intensified our cooperation with other community groups.

Finally, we note that the Northern Territory Police have scored higher than the national average in terms of fairness, professionalism and honesty and that the Northern Territory community is generally either satisfied or very satisfied with the services we provide.

”

8.14 Definitions

Table 8.20 Terms

<i>Term</i>	<i>Definition</i>
Armed robbery	Robbery conducted with the use (actual or implied) of a weapon, where a weapon can include, but is not restricted to: <ul style="list-style-type: none"> • firearms — pistol, revolver, rifle, automatic/semi-automatic rifle, shotgun, military firearm, airgun, nail gun, cannon, imitation firearm and implied firearm; and • other weapons — knife, sharp instrument, blunt instrument, hammer, axe, club, iron bar, piece of wood, syringe/hypodermic needle, bow and arrow, crossbow, spear gun, blowgun, rope, wire, chemical, acid, explosive, vehicle, other dangerous article and imitation weapons.
Assault	The direct (and immediate/confrontational) infliction of force, injury or violence on a person(s) or the direct (and immediate/confrontational) threat of force, injury or violence where there is an apprehension that the threat could be enacted.
Available full time equivalent staff	Any full time equivalent category where the individual is on duty performing a function. To be measured using average staffing level for the whole reporting period.
Average non-police staff salaries	Salaries and payments in the nature of salary paid to civilian and other employees, divided by the total number of such employees.
Average police salaries	Salaries and payments in the nature of salary paid to sworn police officers, divided by the number of sworn officers.
Blackmail and extortion	The unlawful demanding with intent to gain money, property or any other benefit from, or with intent to cause detriment to, another person, accompanied by the use of coercive measures, to be carried out at some point in the future if the demand is not met. This may also include the use and/or threatened use of face-to-face force or violence, provided there is a threat of continued violence if the demand is not met.
Civilian staff	Unsworn staff, including specialists (civilian training and teaching medical and other specialists) and civilian administrative and management staff.
Complaints	Number of statements of complaint by members of the public regarding police conduct.
Crimes against property	Total reported crimes against property, including: <ul style="list-style-type: none"> • unlawful entry with intent; • motor vehicle theft; and • other theft.
Crimes against the person	Total reported crimes against person, including: <ul style="list-style-type: none"> • murder; • attempted murder; • manslaughter; • assault; • kidnapping/abduction; • armed robbery; • unarmed robbery;

(Continued on next page)

Table 8.20 (Continued)

<i>Term</i>	<i>Definition</i>
Deaths in police custody and custody related incidents	<ul style="list-style-type: none"> • sexual assault; and • blackmail/extortion. <p>At least one of the following deaths: death of a person who was in police custody; death caused or contributed to by traumatic injuries while in custody; death of a person who was fatally injured when police officers attempted to detain that person; and/or death of a person who was fatally injured when escaping or attempting to escape from police custody.</p>
Depreciation	Where possible, based on current asset valuation.
Driving causing death	The unlawful killing of another person, without intent to kill, as a result of culpable, dangerous, reckless or negligent driving.
Executive full time equivalent staff	Number of executive full time equivalent staff, including civilian senior executive service and sworn (chief superintendent to assistant commissioner) staff.
Full time equivalent (FTE)	The equivalent number of full time staff required to provide the same hours of work as performed by staff actually employed. A full time staff member is equivalent to a full time equivalent of one, while a part time staff member is greater than zero but less than one.
Indigenous full time equivalent staff	Number of full time equivalent staff who are identified as being of Aboriginal or Torres Strait Islander descent.
Management full time equivalent staff	Number of management full time equivalent staff, including civilian (managers) and sworn (inspector to superintendent) staff.
Motor vehicle theft	The taking of another person's motor vehicle illegally and without permission.
Murder	The wilful killing of a person either intentionally or with reckless indifference to life.
Non-Indigenous full time equivalent staff	Number of full time equivalent staff who do not satisfy the Indigenous staff criteria.
Non-operational full time equivalent staff	Any person who does not satisfy the operational staff criteria, including functional support staff only. Functional support full time equivalent staff includes any person (sworn or unsworn) not satisfying the <i>operational</i> or <i>operational support</i> staff criteria (for example, finance, policy, research, personnel services, building and property services, transport services, and management above the level of station and shift supervisors).
Operational full time equivalent staff	<p>Any person (sworn or unsworn) who delivers a police or police related service to an external customer directly (where an external customer refers to members of the public, other government departments, courts and the government). This category includes both operational staff and operational support staff serving in a unit:</p> <ul style="list-style-type: none"> • operational full time equivalent staff include patrols, beat officers, detectives, traffic, Special Operation Group, community policing and station counter staff. • operational support full time equivalent staff are any person (sworn or unsworn) directly supporting the operational provider (the internal customer), including technical staff, legal staff, unsworn staff supporting investigations, communications, records staff, intelligence staff, station and shift supervisors where these persons do not directly provide services to external customers.

(Continued on next page)

Table 8.20 (Continued)

<i>Term</i>	<i>Definition</i>
Other recurrent expenditure	Maintenance and working expenses; expenditure incurred by other departments on behalf of police; expenditure on contracted police services; and other recurrent costs not elsewhere classified. Expenditure is disaggregated by service delivery area.
Other staff	All unsworn, non-civilian staff, including all auxiliary police personnel who are neither sworn officers nor strictly civilians because they are authorised to exercise statutory powers normally restricted to sworn officers. This category includes police cadets, police aides and special constables.
Other theft	The taking of another person's property with the intention of depriving the owner of the property illegally and without permission, but without force, threat of force, use of coercive measures, deceit or having gained unlawful entry to any structure even if the intent was to commit theft.
Outcome of investigations	The stage reached by a police investigation after a period of 30 days has elapsed since the recording of the incident.
Practitioner full time equivalent staff	Number of practitioner full time equivalent staff, including civilian (administration) and sworn (constable to senior constable) staff.
Proportion of higher court cases resulting in guilty finding	Total number of higher court cases for which there was a finding of guilty or where the person pleads guilty, as a proportion of the total number of higher court cases. Higher court is either: <ul style="list-style-type: none"> • an intermediate court (known either as the district court or county court) that has legal powers that are intermediate between those of a court of summary jurisdiction (lower level courts) and a supreme court, and deals with the majority of cases involving serious criminal charges; or • a supreme court (a higher court level which deals with the most serious criminal charges and has the greatest legal powers of all the State and Territory court levels) (ABS cat. no. 4513.0). Guilty finding is an outcome of a trial in which a court determines that the criminal charge against a defendant has been proven (ABS cat. no. 4513.0).
Proportion of juvenile diversions	Total number of juvenile offenders who are diverted by police (for example, through the use of cautions, official warnings or other diversionary programs), away from the criminal justice system, as a proportion of the total number of juvenile offenders either diverted from or dealt with by the criminal justice system (that is, those who are either diverted or prosecuted), divided by the total number of juvenile offenders, or the total number of juvenile offenders diverted or dealt with by the criminal justice system.

(Continued on next page)

Table 8.20 (Continued)

<i>Term</i>	<i>Definition</i>
Proportion of lower court cases resulting in guilty plea	<p>Total number of cases (excluding committal hearings) heard before lower courts of law only, for which there was a plea of guilty, as a proportion of the total number of cases (excluding committal hearings) heard before lower courts of law only.</p> <p>Lower court: a court of summary jurisdiction, or lower court level (commonly referred to as magistrates' court, local court or court of petty sessions), deals with relatively less serious charges and has the most limited legal powers of all State and Territory court levels. Such courts are presided over by a magistrate and have jurisdiction to hear trial and sentence matters relating to summary offences. Under some circumstances, this court level may also deal with the less serious indictable offences known as 'minor indictable' or 'triable either way' offences (ABS cat. no. 4513.0).</p> <p>Plea: a guilty plea is the formal statement by a defendant admitting culpability in relation to a criminal charge. A not guilty plea is the formal statement by a defendant denying culpability in relation to a charge (ABS cat. no. 4513.0).</p> <p>For the purposes of this data collection, a plea of 'not guilty' should also include 'no plea', 'plea reserved' and 'other defended plea'</p> <p>Further, these definitions:</p> <ul style="list-style-type: none"> • exclude preliminary (committal) hearings for indictable offences dealt with by a lower court; and • count cases that involve multiple charges as a 'lower court case resulting in a plea of guilty' if a plea of guilty has resulted for at least one of those charges.
Real expenditure	Actual expenditure adjusted for changes in prices, using the GDP(E) price deflator, and expressed in terms of final year prices.
Recorded crime	Crimes reported to (or detected), and recorded by police.
Registered vehicles	Total registered motor vehicles, including motorcycles.
Reporting rate	The proportion of crime victims who told police about the last crime incident of which they were the victim, as measured through a crime victimisation survey.
Revenue from own sources	Revenue from activities undertaken by police, including revenue from the sale of stores, plant and vehicles; donations and industry contributions; user charges; and other revenue (excluding fine revenue and revenue from the issuing of firearm licenses). Revenue is disaggregated by service delivery area.
Road deaths	Fatal road injury accidents as defined by the Australian Transport Safety Bureau
Road hospitalisations	Hospitalisation as a result of a motor vehicle accident as defined by the Australian Institute of Health and Welfare.
Robbery	The unlawful taking of property from the immediate possession, control, custody or care of a person, with the intent to permanently deprive the owner of the property accompanied by the use, and/or threatened use of immediate force or violence.

(Continued on next page)

Table 8.20 (Continued)

<i>Term</i>	<i>Definition</i>
Salaries and payments in the nature of salary	<p>Includes:</p> <ul style="list-style-type: none"> • base salary package; • motor vehicle expenses that are part of employer fringe benefits; • superannuation, early retirement schemes and payments to pension schemes (employer contributions); • workers compensation (full cost) including premiums, levies, bills, legal fees; • higher duty allowances (actual amounts paid); • overtime (actual amounts paid); • actual termination and long service leave; • actual annual leave; • actual sick leave; • actual maternity/paternity leave; • fringe benefits tax paid; • fringe benefits provided (for example, school fee salary sacrifice at cost to the government, car parking, duress alarms, telephone account reimbursements, 'gold passes', other salary sacrifice benefits, frequent flier benefits, overtime meals provided, and any other components that are not part of a salary package); and • payroll tax. <p>These are disaggregated by service delivery area.</p>
Senior executive full time equivalent staff	Number of senior executive full time equivalent staff, including civilian (top senior executive service) and sworn (commissioner, deputy commissioner and equivalent civilian executives) staff.
Service delivery areas	<p>The core areas of police work. Four service delivery areas are identified for the purposes of this Report:</p> <ul style="list-style-type: none"> • community safety and support; • crime investigation; • road safety and traffic management; and • services to the judicial process. <p>A fifth service delivery area ('other' or 'other services') was identified to account for those unique functions of jurisdictions that were not directly associated with the aforementioned areas.</p> <p>While this is an attempt to identify common areas of core service delivery, their exact formats do not neatly fit with any jurisdiction or with how the jurisdictions measure or plan for performance.</p>
Sexual assault	Physical contact of a sexual nature directed toward another person where that person does not give consent, that person gives consent as a result of intimidation or fraud, or consent is proscribed (that is, the person is legally deemed incapable of giving consent as a result of youth, temporary/permanent (mental) incapacity or a familial relationship). Includes rape, attempted rape, indecent assault and assault with intent to commit sexual assault. Excludes sexual harassment not leading to assault.
Supervisory full time –equivalent staff	Number of supervisory full time equivalent staff, including civilian (team leaders) and sworn (sergeant to senior sergeant) staff.

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Table 8.20 (Continued)

<i>Term</i>	<i>Definition</i>
Sworn staff	Sworn police staff recognised under each jurisdiction's Police Act.
Total capital expenditure	Total expenditure on the purchase of new or second hand capital assets, and expenditure on significant repairs or additions to assets that add to the assets' service potential or service life.
Total expenditure	Total capital expenditure plus total recurrent expenditure (less revenue from own sources).
Total FTE staff	Operational staff and non-operational staff, including full time equivalent staff on paid leave or absence from duty (including secondment and training), as measured using absolute numbers for the whole reporting period.
Total number of staff	Full time equivalent staff directly employed on an annual basis (excluding labour contracted out).
Total recurrent expenditure	Includes: <ul style="list-style-type: none"> • salaries and payments in the nature of salary; • other recurrent expenditure; and • depreciation • less revenue from own sources.
Unarmed robbery	Robbery conducted without the use (actual or implied) of a weapon.
Unavailable full time equivalent staff	Any full time equivalent category where the individual is on paid leave or absent from duty (including secondment and training), as measured using the average staffing level for the whole reporting period.
Unlawful entry with intent — involving the taking of property	The unlawful entry of a structure with intent to commit an offence resulting in the taking of property from the structure, where the entry is either forced or unforced. Includes burglary and break and enter offences. Excludes trespass or lawful entry with intent.
Unlawful entry with intent — other	The unlawful entry of a structure with intent to commit an offence, but which does not result in the taking of property from the structure, where the entry is either forced or unforced. Excludes trespass or lawful entry with intent.
Value of physical assets — buildings and fittings	The value of buildings and fittings under direct control of police.
Value of physical assets — land	The value of land under direct control of police.
Value of physical assets — other	The value of motor vehicles, computer equipment, and general plant and equipment under the direct control of police.

Source: ABS 2001c (for those definitions related to recorded crime).

9 Court administration

This chapter covers the performance of court administration for State and Territory supreme, district/county, magistrates' (including electronic and children's) courts, coroner's courts and probate registries. The chapter also covers the performance of court administration for the Federal Court of Australia, the Federal Magistrates Service, the Family Court of Australia and the Family Court of Western Australia. The focus of this Report is on the administration of the courts, not the outcomes of the legal process.

A profile of court administration is presented in section 9.1 and policy developments are summarised in section 9.2. A framework of performance indicators is outlined in section 9.3 and data are discussed in section 9.4. While there have been no major changes to the framework, the scope of this year's data collection has increased through the disaggregation of magistrates' court data into electronic and children's court data, and through the inclusion of lodgment data for the Federal Magistrates Service (box 9.1). The aim is to provide progressively more meaningful data on each court level while continuing to improve data quality. Future directions for performance reporting are discussed in section 9.5. Jurisdictions' comments are provided in section 9.6 and the chapter concludes with definitions in section 9.7.

Supporting tables for chapter 9 are provided on the CD-ROM enclosed with the Report. The files are provided in Microsoft Excel 97 format as `\Publications\Reports\2002\Attach9A.xls` and in Adobe PDF format as `\Publications\Reports\2002\Attach9A.pdf`.

Supporting tables are identified in references throughout this chapter by an 'A' suffix (for example, table 9A.3 is table 3 in the electronic files). They may be subject to revision. The most up-to-date versions of these files can be found on the Review's web page (www.pc.gov.au/gsp). Users without Internet access can contact the Secretariat to obtain up-to-date versions of these tables (see details inside the front cover of the Report).

9.1 Profile of court administration services

Service overview

Court administration agencies throughout Australia provide a range of services integral to the effective performance of the judicial system. The primary functions of court administration agencies are to:

- manage court facilities and staff, including buildings, court security and ancillary services such as registries, libraries and transcription services;
- provide case management services, including client information, scheduling and case flow management; and
- enforce court orders through the sheriff's department or a similar mechanism.

Roles and responsibilities

Court structures

There is a hierarchy of courts at the State, Territory and Commonwealth levels. All courts handle a number of matters that appear in the court system for the first time (an originating jurisdiction). Higher courts hear disputes of greater seriousness than those heard in the lower courts. They also develop the law and operate as courts of judicial review or appeal (figure 9.1).

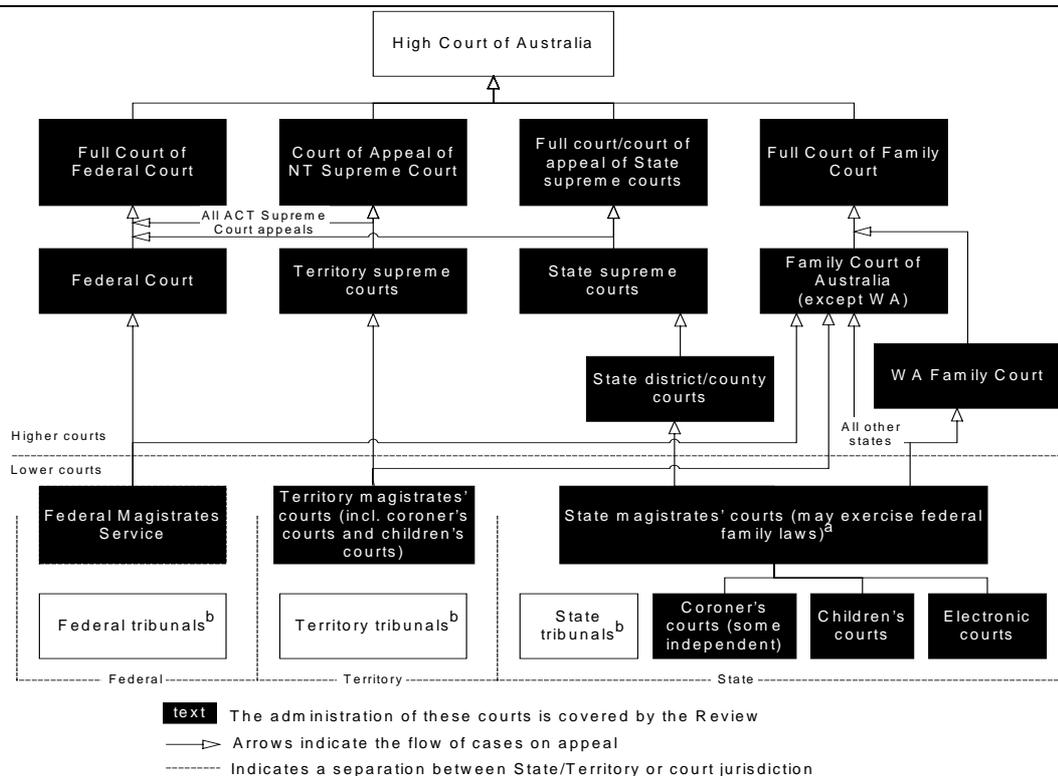
The structure of courts differs across States and Territories. Tasmania and the Territories do not have district/county courts and therefore operate two-tier systems. Only WA has a Family Court (that is, the Family Court of Australia has jurisdiction in all other States and Territories).

There are also differences in the jurisdictions of courts across States and Territories. In general, magistrates' courts have jurisdiction over summary criminal matters, traffic infringements and committal proceedings. District/county courts generally have jurisdiction over indictable criminal matters and appeals from magistrates' courts. Generally, supreme courts have jurisdiction over serious criminal matters. Differences in court jurisdictions can mean that the allocation of cases to courts varies across States and Territories. As a result, the seriousness and complexity of cases heard in each jurisdiction's equivalent court often vary. These factors need to be taken into account when comparing performance across States and Territories for specific indicators. Differences in the allocation of cases to courts are shown in table 9A.39. The allocation of responsibility between court administration and other

elements of the system (including the judiciary) also varies across the Commonwealth, State and Territory legal systems.

Most courts operate in both the civil and criminal jurisdictions. The essential difference between these jurisdictions is the source of the lodgment and the parties in dispute. Criminal matters are brought to the court by a government prosecuting agency, which is generally the Director of Public Prosecutions, but can also be the Attorney-General, the police, local councils and traffic camera branches.

Figure 9.1 Major relationships between courts in Australia



^a Appeals from lower courts in NSW go directly to the Court of Appeal in the NSW Supreme Court. ^b Appeals from Federal, State and Territory tribunals may go to any higher court in their jurisdiction.

Civil matters generally relate to claims for loss or damage and are lodged by individuals or organisations (the plaintiff or applicant) against another party (the defendant or respondent) who responds to the claim. Further, coroners' courts (which generally operate under the auspices of State and Territory magistrates' courts) inquire into the cause of sudden and unexpected deaths. Their findings can be the source of criminal prosecutions. Generally, suspicious fires are in the jurisdiction of the coroners' court (with the exception of WA, SA and the NT).

To improve understanding, this chapter presents magistrates' court data differently from previous years, and allows for the introduction of lodgment data relating to the Federal Magistrates Service (box 9.1).

Box 9.1 Changes to data representation for this Report

In previous reports, data were collected for the State and Territory supreme, district/county, magistrates', and coroners' courts and probate registries.

Data on magistrates' courts previously included children's and electronic court data which were not separately disaggregated in the collection.

This year, data on children's courts and electronic courts are reported separately from data on the magistrates' courts, allowing for differentiation between the courts and thus more meaningful comparisons across jurisdictions.

Not all jurisdictions operate electronic courts, and some States and Territories are currently unable to disaggregate their data to the children's court level, especially in the civil jurisdiction. Therefore, and for consistency with previous reports, the data have also been aggregated into a 'total magistrates' court'.

- *Magistrates' court (total)*: This is the sum of data collected for the magistrates' courts, children's courts and electronic courts.
- *Magistrates' court (only)*: Data were collected specifically in relation to the magistrates' courts.
- *Children's court*: Data were collected specifically in relation to the children's courts. (Some jurisdictions did not provide separate children's courts data).
- *Electronic court*: Data were collected on all electronic court infringement and expiated offence processing systems that have the status of a court or operate under the auspices of a court. The status of a court reflects the capacity of the system to produce an enforceable warrant for payment, arrest, attachment or garnishment of assets or incomes, without needing a judicial officer to ratify that warrant. As defined above, electronic courts included in the scope of this data collection are from Victoria, Queensland, WA and SA.

Past reports also covered the performance of court administration for the Federal Court of Australia and the family courts of Australia and WA. This year's report continues to do this, but also includes lodgment data on the Federal Magistrates Service for the first time. The first sittings of the Federal Magistrates Service were held on 3 July 2000.

The Federal Magistrates Service was established to provide a simpler and accessible service for litigants and to ease the workload of both the Family Court of Australia and the Federal Court of Australia. Its jurisdiction includes family law and child support, administrative law, bankruptcy, unlawful discrimination and consumer protection law.

The Federal Magistrates Service has only been able to provide lodgment data this year. Nonetheless, its introduction has implications for the financial and lodgment data of the Federal Court of Australia and the Family Court of Australia. It also affects any comparisons between the family courts of Australia and WA. Consideration may also need to be given to the 'free' allocation of resources by the Federal Court and Family Court of Australia to the Federal Magistrates Service.

Source: Federal Magistrates Service web site.

Administrative structures

Most courts use the same court infrastructure (such as court buildings and facilities) for civil and criminal case types. Given that separate information systems and case flow management practices have been established for each of the civil and criminal jurisdictions, the Steering Committee has sought to distinguish between them where possible.

Expenditure

Total expenditure less in-house revenue by Commonwealth, State and Territory court authorities (excluding the High Court) was approximately \$912.1 million in 2000-01. Nationally, court administration expenditure less in-house revenue was higher in the criminal jurisdiction (\$419.6 million) than in the civil jurisdiction (\$350.1 million). It was around \$115.3 million for family courts, \$24.8 million for coroner's courts and \$2.4 million for probate registries (table 9.1).

Real expenditure less in-house revenue (excluding payroll tax) on court administration from 1998-99 to 2000-01 for each Commonwealth, State and Territory court level is contained in attachment tables 9A.9–9A.11.

Table 9.1 **Court administration expenditure less in-house revenue, 2000-01 (\$ million)^{a, b, c}**

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Cwlth	Total
All civil courts ^{d, e}	102.8	52.1	35.9	40.6	23.9	3.5	7.2	9.2	74.9	350.1
All criminal courts	144.5	67.5	84.3	55.2	37.9	8.5	11.0	10.7	..	419.6
Family courts ^e	..	..	..	11.8	..	..	..	..	103.5	115.3
Coroners' courts ^f	6.6	4.6	2.2	5.3	3.3	0.4	0.7	1.7	..	24.8
Probate										
Supreme courts ^g	1.1	0.4	0.1	0.3	0.4	0.1	–	–	..	2.4
Total	254.9	124.5	122.5	113.2	65.5	12.5	18.8	21.7	178.4	912.1

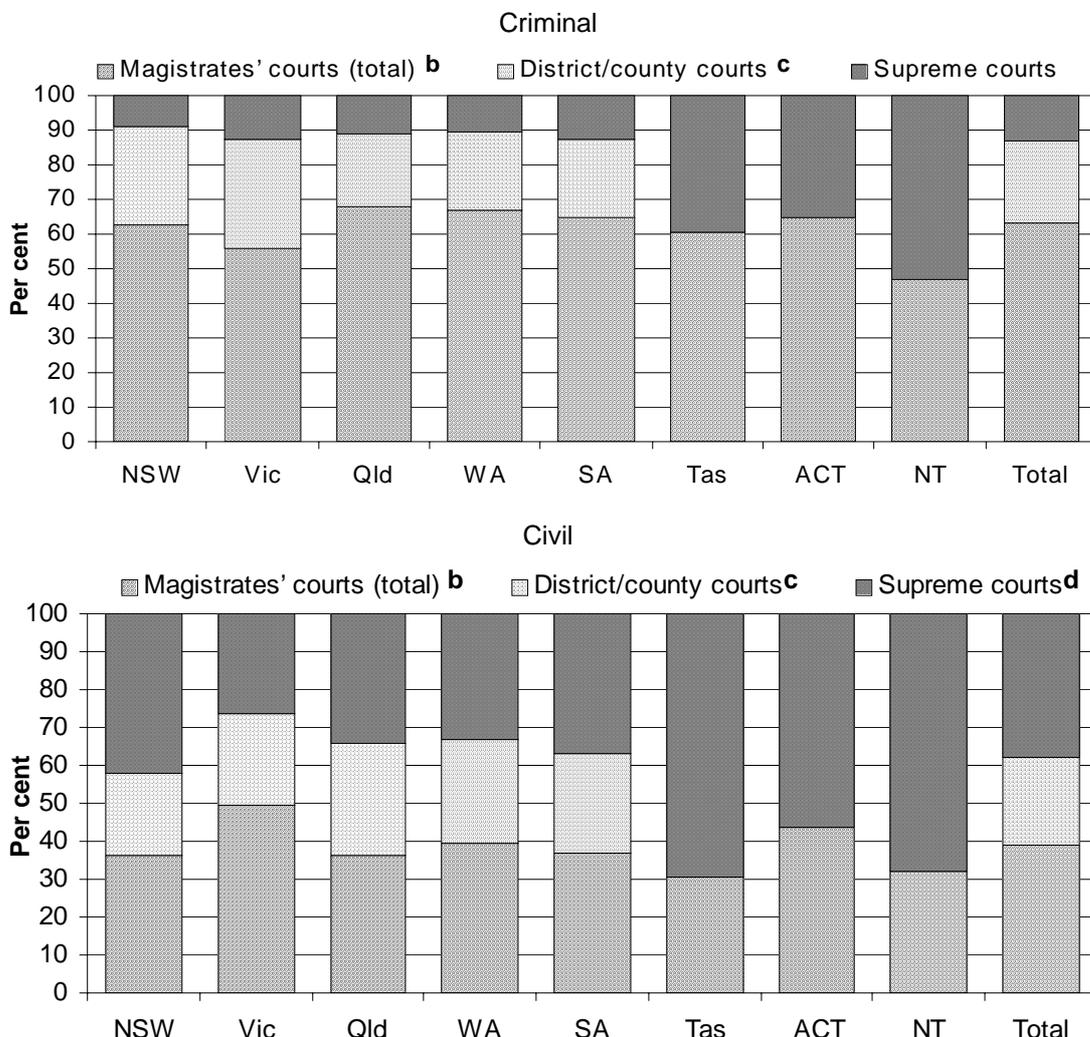
^a In-house revenue includes revenue earned by in-house providers of library, court reporting and civil bailiff services to external purchasers. ^b District/county courts do not operate in Tasmania, the ACT or the NT. The Commonwealth does not operate magistrates', district/county or supreme courts. ^c Payroll tax was excluded from reported expenditure. ^d Excludes family courts, but includes the Federal Court. No expenditure data were provided by the Federal Magistrates Service. ^e The introduction of the Federal Magistrates Service has implications for the expenditure of the Federal Court and Family Court of Australia. In addition, data for the Family Court of Australia excludes a preliminary estimate of the 'free' allocation of Family Court resources to the Federal Magistrates Service. Data for the Federal Court includes the cost of resources provided free of charge to the Federal Magistrates Service. ^f The cost of conducting autopsies is not included in the total cost for Queensland. ^g The full cost of probate may not be identified because costs such as rent or depreciation might have been included under general supreme court figures. It also was not possible to exclude payroll tax for probate registries. .. Not applicable. – Nil or rounded to zero.

Sources: tables 9A.9, 9A.10 and 9A.13.

Proportion of criminal and civil court administration expenditure in 2000-01

The proportion of criminal and civil court administration expenditure, less in-house revenue, in each of the magistrates', district/county and supreme courts varied across States and Territories. The proportions of court administration expenditure less in-house revenue in the supreme courts of Tasmania, the ACT and the NT (under the two-tier court system), for example, were larger than the proportions in the supreme courts in other jurisdictions (under the three-tier court system) (figure 9.2).

Figure 9.2 Proportion of court administration expenditure less in-house revenue, by court level, 2000-01^a



^a In-house revenue includes revenue earned by in-house providers of library, court reporting and civil bailiff services to external purchasers. ^b Includes expenditure on children's court for all jurisdictions and electronic courts for Victoria, Queensland, WA and SA. ^c There is no district/county court in Tasmania, the ACT or the NT. ^d Includes probate.

Sources: table 9A.9, 9A.10 and 9A.13.

Nationally, total magistrates' courts in the criminal jurisdiction (including children's and electronic courts) accounted for the highest proportion (62.9 per cent) of total expenditure less in-house revenue in 2000-01, followed by district/county courts (24.2 per cent), then supreme courts (12.9 per cent). Across States and Territories, the total magistrates' court share was highest in Queensland (68.0 per cent) and lowest in the NT (46.9 per cent); Victoria had the highest district/county court share (31.7 per cent) while Queensland had the lowest (21.1 per cent); and the NT had the highest supreme court share (53.1 per cent) while NSW had the lowest (9.2 per cent) (figure 9.2).

Nationally, total magistrates' courts in the civil jurisdiction (including children's courts) accounted for the highest proportion (39.2 per cent) of civil expenditure less in-house revenue in 2000-01, followed by supreme courts (37.9 per cent) and district/county courts (23.0 per cent). Across jurisdictions, the share of magistrates' courts varied from 49.3 per cent in Victoria to 30.4 per cent in Tasmania; the share of supreme courts ranged from 69.6 per cent in Tasmania to 26.6 per cent in Victoria; and the share of district/county courts ranged from 29.6 per cent in Queensland to 21.9 per cent in NSW (figure 9.2).

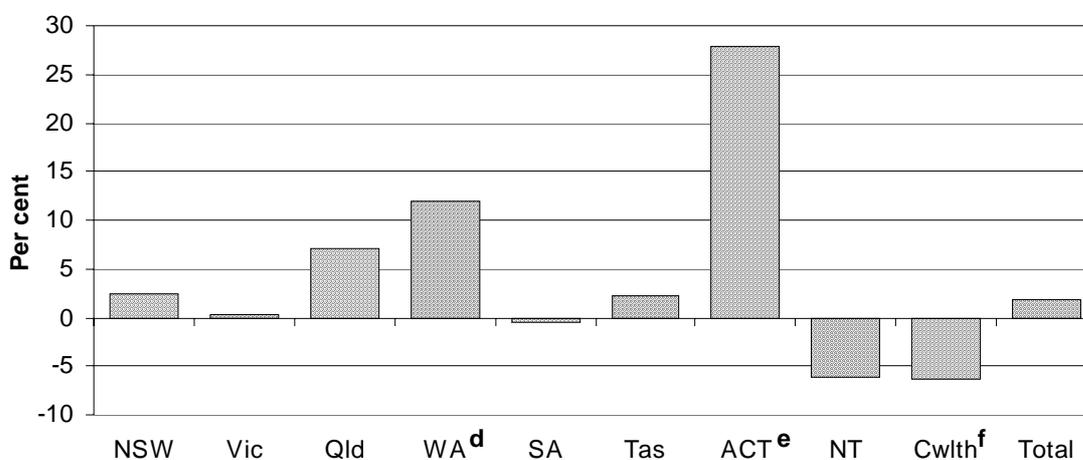
Change in court administration expenditure, less in-house revenue, over past year

Real expenditure less in-house revenue on court administration increased by 1.9 per cent between 1999-2000 and 2000-01 (including payroll tax where relevant). The trend in expenditure varied across the States and Territories (figure 9.3).

The ACT exhibited the largest increase (27.8 per cent) in expenditure less in-house revenue over the year. This change should be treated with caution as it has been caused by the ACT Magistrates' Court salary liabilities being formulated for the first time under the accrual accounting methodology (\$2.4 million), as well as reflecting a significant increase in Magistrates' Court cost overheads (\$1.6 million). As a result, comparability between 1999-2000 and 2000-01 ACT expenditure figures is unreliable (figure 9.3). The Federal Court and Family Court of Australia combined exhibited the largest decrease in expenditure less in-house revenue (6.3 per cent) (figure 9.3). This decrease over the past year may partly be attributed to the establishment of the Federal Magistrates Service.

Real criminal and civil expenditure less in-house revenue (including payroll tax) for each Commonwealth, State and Territory court level, from 1994-95 to 2000-01, is contained in tables 9A.12–9A.14. Real criminal and civil in-house revenue for each Commonwealth, State and Territory court level, from 1997-98 to 2000-01, is contained in table 9A.15.

Figure 9.3 Change in real expenditure less in-house revenue, 1999-2000 to 2000-01^{a, b, c}



^a In-house revenue includes revenue earned by in-house providers of library, court reporting and civil bailiff services to external purchasers. ^b Excludes coronial and probate expenditure. ^c Includes payroll tax payments for NSW, Victoria, Queensland, SA, Tasmania and the NT for both years. ^d Includes the WA Family Court. ^e This change should be treated with caution as it has been caused by ACT Magistrates' Court salary liabilities being formulated for the first time under the accrual accounting methodology (\$2.4 million), as well as reflecting a significant increase in Magistrates' Court cost overheads (\$1.6 million). As a result, comparability between 1999-2000 and 2000-01 expenditure figures is unreliable. ^f Includes the Federal Court and Family Court of Australia. The reduction in expenditure less in-house revenue may be a result of the introduction of the Federal Magistrates Service.

Sources: tables 9A.12–9A.14.

Size and scope of court activity

The numbers of lodgments, hearings and finalisations are reported as measures of court activity. The following sections outline the size and scope of each of these court activities.

Lodgments

Lodgments are matters initiated in the court system. The Report treats committals and appeals as separate lodgments. (Box 9.2 contains details of the different types of court lodgment).

Nationally, in 2000-01, there were approximately 3.0 million lodgments. In the criminal jurisdiction there were approximately 2.1 million lodgments; in the civil jurisdiction approximately 0.9 million (including family courts and the Federal Court); and coroners' courts accounted for 0.02 million lodgments.

Table 9.2 outlines the number of lodgments in 2000-01 by court level for the Commonwealth and each State and Territory.

Table 9.2 Court lodgments, by court level, 2000-01 ('000)^a

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Cwlth</i>	<i>Total</i>
Criminal courts										
Magistrates' (total) ^b	284	763	471	273	171	65	10	12	..	2050
<i>Magistrates' (only)</i>	265	92	191	77	55	63	<i>na</i>	12	..	755
<i>Children's^c</i>	19	8	13	9	4	2	<i>na</i>	1	..	57
<i>Electronic^d</i>	..	662	267	186	112	..	..	..	..	1228
District/county	8	4	8	3	1	..	..	..	..	25
Supreme	1.0	0.7	1.4	0.5	0.3	0.5	0.2	0.4	..	5
All criminal courts	294	768	480	276	173	66	11	13	..	2080
Coroners' courts	5.9	4.2	4.1	2.2	3.4	0.6	1.6	0.3	..	22
Civil courts										
Magistrates' (total) ^e	241	183	98	61	40	13	10	4	..	649
<i>Magistrates' (only)</i>	237	183	93	60	39	13	<i>na</i>	<i>na</i>	..	626
<i>Children's^f</i>	3.6	<i>na</i>	4.4	0.9	0.8	0.1	<i>na</i>	<i>na</i>	..	9.7
District/county	19	10	11	4	3	..	..	..	..	47
Supreme/Federal ^g	10.1	4.8	4.3	3.7	1.6	2.7	1.0	0.4	5.4	34
Federal Magistrates	..	..	..	..	..	..	..	..	36	36
All civil courts	270	198	113	68	45	16	11	4	41	767
Family courts ^g	..	..	..	15	..	..	..	..	90	104
Probate										
Supreme courts	20.4	14.9	3.4	4.5	4.8	2.0	0.4	0.1	..	51

^a Totals may not add as a result of rounding. ^b Tasmania estimated totals for criminal magistrates' and children's lodgments. Queensland lodgment data for the criminal magistrates' and children's court have been extrapolated using available data for the period January to June 2001. ^c The ACT was unable to provide separate criminal children's court lodgment data. ^d Electronic courts are fines enforcement registries that have the status of a court. As such, only Victoria, Queensland, WA and SA have electronic courts. In other jurisdictions, traffic infringements do not become court lodgments until the defendant elects to have the matter heard by a magistrate. ^e Victorian magistrates' court (total) data exclude civil children's court lodgments. All other jurisdictions data for magistrates' court (total) includes civil children's court lodgments. ^f The ACT and the NT have not provided separate data on civil children's court lodgments. ^g The introduction of the Federal Magistrates Service has implications for the number of lodgments in the Federal Court and Family Court of Australia. *na* Not available. *..* Not applicable.

Sources: tables 9A.1 and 9A.2.

Box 9.2 **Types of court lodgment**

Electronic court lodgments

Electronic court lodgments include unpaid minor traffic offences (including parking, speed, red light camera, driving behaviour and roadworthiness offences) processed by an electronic court. An electronic court is an infringement and expiated offence processing system that has the status of a court or operates under the auspices of a court. This type of court operates in Victoria, Queensland, WA and SA. The other jurisdictions' infringement processing systems do not operate under the status of a court.

Minor lodgments

A significant proportion of matters, particularly in the magistrates' courts, are largely routine or minor and are less costly to finalise. Minor lodgments include:

- minor traffic lodgments and other infringement notices (including appeals from electronic courts and fines enforcement registries); and
- undefended general civil lodgments and applications of an administrative nature (such as winding up applications, Criminal Injury Compensation applications, Australian Registered Judgments, intervention orders [excluding the prosecution of a breach of an order], residential tenancy disputes, joint applications for divorce and applications for debt recovery).

Primary lodgments

Primary lodgments are more significant criminal or civil matters, which may include:

- defended civil lodgments (for example, appeals or matters pertaining to personal injury); and
- criminal lodgments processed by magistrates' courts or higher courts (for example, offences against the person).

Probate lodgments

Probate lodgments are heard in supreme courts and encompass applications for the appointment of an executor or administrator to the estate of a deceased person. The two most common applications are where the executor nominated by a will applies to have the will proved and where the deceased died intestate (without a will) and a person entitled to administer the estate applies for letters of administration.

Coronial lodgments

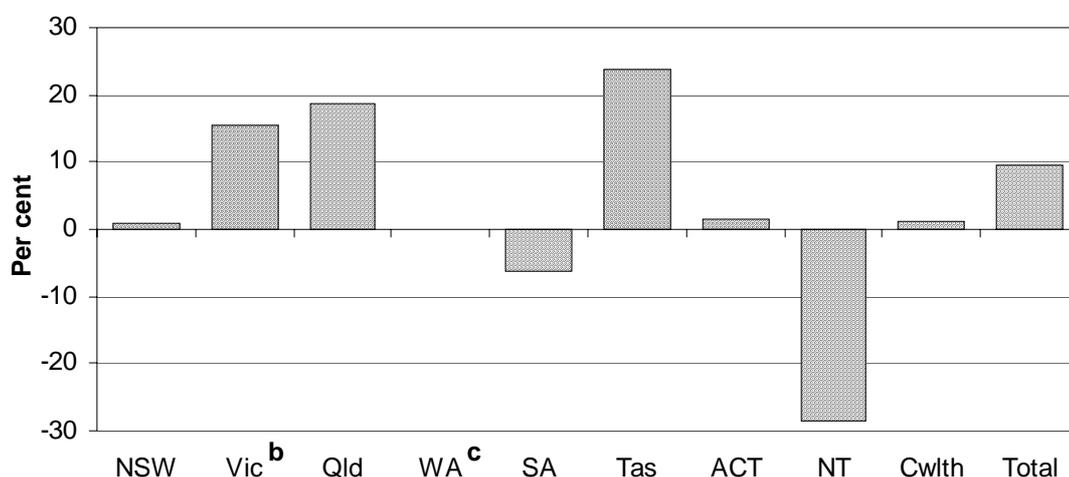
Coronial lodgments are heard in coroners' courts, which investigate the cause and circumstances of reportable deaths. The definition of a reportable death differs across States and Territories but generally includes deaths for which the cause is violent, suspicious or unknown. The coroner in some States and Territories has the power to commit for hearing, while the coroner in other jurisdictions is prohibited from making any finding of criminal or civil liability (that is, the matter may be referred to the Director of Public Prosecutions).

Change in court lodgments

The number of lodgments received by courts throughout Australia rose by 9.4 per cent over the past year (excluding WA lodgments for both years). The largest increase, from 1999-2000 to 2000-01, occurred in Tasmania (a rise of 23.7 per cent) while the largest decrease occurred in the NT (a fall of 28.6 per cent) (figure 9.4). There are no comparative figures for WA because the exclusion and inclusion of electronic court data over the respective years prevents meaningful comparisons.

Criminal and civil lodgments for each court level, from 1993-94 to 2000-01, are contained in tables 9A.1 and 9A.2.

Figure 9.4 **Change in court lodgments, 1999-2000 to 2000-01^a**



^a Excludes probate. Includes all minor and primary lodgments within each court, as well as coronial, electronic and family court lodgments (where relevant). ^b Excludes civil children's court lodgments in 2000-01. ^c There are no comparative figures for WA because the exclusion and inclusion of electronic court data over the respective years prevents meaningful comparisons.

Sources: tables 9A.1 and 9A.2.

Distribution of court lodgments

Nationally, the majority of criminal matters in 2000-01 were lodged in magistrates' courts (96.4 per cent), followed by the district/county courts (3.0 per cent) and supreme courts (0.6 per cent). Tasmania had the highest proportion of criminal cases lodged in the magistrates' courts (99.3 per cent); Victoria had the highest proportion of its criminal cases lodged in the district/county courts (4.2 per cent); and the NT had the highest proportion of cases lodged in the supreme courts (2.8 per cent) (table 9.3).

For civil matters, Victoria had the highest proportion of civil cases lodged in the magistrates' courts (92.5 per cent); Queensland had the highest proportion in the district/county courts (10.0 per cent); and Tasmania had the highest proportion of civil cases lodged in the supreme courts (17.0 per cent) (table 9.3).

In the Commonwealth jurisdiction, 68.4 per cent of civil cases were lodged in the Family Court of Australia; 27.5 per cent of cases were lodged in the Federal Magistrates Service; and 4.1 per cent in the Federal Court (table 9.3).

Table 9.3 Proportion of court lodgments (excluding electronic courts) by court level, 2000-01^a

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Cwlth</i>	<i>Total</i>
Criminal courts											
Magistrates' (total) ^b	%	96.8	95.1	95.6	96.0	97.4	99.3	98.0	97.2	..	96.4
District/county	%	2.9	4.2	3.8	3.5	2.1	..	..	..	..	3.0
Supreme	%	0.3	0.7	0.7	0.5	0.5	0.7	2.0	2.8	..	0.6
All courts	'000	294	106	213	90	61	66	11	13	..	852
Civil courts											
Magistrates' (total) ^c	%	89.2	92.5	86.2	73.3	89.5	83.0	91.2	90.2	..	74.6
District/county	%	7.1	5.0	10.0	4.7	6.9	..	..	..	..	5.4
Supreme/Federal	%	3.7	2.4	3.8	4.4	3.6	17.0	8.8	9.8	4.1	3.9
Federal Magistrates	%	..	..	..	..	..	..	..	..	27.5	4.1
Family courts	%	..	..	..	17.6	..	..	..	..	68.4	12.0
All courts	'000	270	198	113	83	45	16	11	4	131	871

^a Totals may not sum to 100 per cent as a result of rounding. ^b Excludes electronic court lodgments to provide a more meaningful comparison across jurisdictions. ^c Victorian data excludes civil children's court lodgments. .. Not applicable.

Sources: tables 9A.1 and 9A.2.

Minor lodgments

Minor lodgments (matters that are largely routine in nature) were most common in magistrates' courts in 2000-01. The type of lodgments that are regarded as minor are outlined in box 9.2. The data exclude minor traffic lodgments and other infringement notices processed in electronic courts and fines enforcement registries. Nationally, 28.9 per cent of criminal lodgments in magistrates' (including children's) courts were minor in 2000-01. Across jurisdictions, Tasmania had the highest proportion of minor criminal lodgments in magistrates' courts (67.1 per cent) and the ACT had the lowest (4.2 per cent). WA were unable to distinguish minor lodgments from primary lodgments. In the civil jurisdiction, 52.3 per cent of lodgments in magistrates' courts (including children's courts) across Australia were minor. Across jurisdictions, the proportion of minor civil lodgments that were

lodged in magistrates' courts ranged from 92.7 per cent in Tasmania to 0.5 per cent in NSW (table 9.4).

Nationally, 26.8 per cent of lodgments in district/county courts were minor in 2000-01. Across jurisdictions, this proportion ranged from 63.5 per cent in SA to 0.2 per cent in Victoria. Minor matters accounted for 22.7 per cent of the national total of civil lodgments in supreme/Federal courts. Across jurisdictions, the proportion of minor matters in supreme courts ranged from 54.5 per cent in Victoria to 1.0 per cent in Queensland (table 9.4). The proportion of court lodgments that were minor in the Federal Magistrates Service was 72.5 per cent; in the Family Court of Australia it was 25.5 per cent; in the WA Family Court it was 36.2 per cent; and the proportion in the Federal Court was zero per cent (table 9.4).

Table 9.4 Proportion of court lodgments that were minor within each court (excluding electronic courts), 2000-01 (per cent)^a

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Cwth	Total
Criminal courts										
Magistrates' (total) ^b	32.4	28.9	15.0	na	22.3	67.1	4.2	47.3	..	28.9
Civil courts										
Magistrates' (total) ^c	0.5	79.1	85.6	88.0	89.5	92.7	54.7	77.9	..	52.3
District/county	9.2	0.2	59.7	56.8	63.5	..	..	..	..	26.8
Supreme ^d /Federal	30.3	54.5	1.0	26.8	15.8	15.7	19.0	31.6	–	22.7
Federal Magistrates	..	..	..	..	..	..	..	..	72.5	72.5
Family ^e	..	..	..	36.2	..	..	..	..	25.5	27.0

^a The types of lodgment that are regarded as minor are outlined in box 9.2. ^b Includes minor lodgments with the children's courts but excludes minor traffic lodgments and other infringement notices processed in electronic courts and fines enforcement registries. WA are unable to distinguish minor and primary lodgments within their criminal courts. ^c Victorian data excludes civil children's court (both primary and minor) lodgments. ^d Excludes probate. ^e The introduction of the Federal Magistrates Service may affect the number of minor court lodgments progressing to the Family Court of Australia. This will also have an impact on any comparisons with the WA Family Court. **na** Not available. **..** Not applicable. **–** Nil or rounded to zero.

Source: table 9A.8.

Coronial and probate lodgments

Nationally, 22 250 coronial matters were lodged in 2000-01. Across jurisdictions, the largest number of coronial matters were lodged in NSW (5862 lodgments), while 304 coronial matters were lodged in the NT (table 9A.1).

Reporting rates for deaths reported to a coroner varied as a result of different reporting requirements; for example, deaths in institutions such as nursing homes of persons suffering intellectual impairment of any kind must be reported in SA, but not in other jurisdictions. The total number of deaths reported to a coroner was

approximately 19 500 across Australia in 2000-01. Across jurisdictions, the highest number of reported deaths was in NSW (5519) (table 9A.1). Deaths reported to the coroner as a proportion of total deaths across Australia were 15 per cent in 2000-01. Across jurisdictions, this proportion ranged from 37 per cent in the NT to 12 per cent in NSW. Table 9A.1 contains all jurisdiction data.

Reporting requirements also varied for fires; for example, fires may be reported and investigated at the discretion of the coroner in Victoria, but they are excluded from the coroner's jurisdiction in WA, SA and the NT. Nationally, 2751 fires were reported to a coroner in 2000-01 (incorporating results for NSW, Victoria, Queensland, Tasmania and the ACT) (table 9A.1).

There were 50 630 probate applications in 2000-01, with the largest number being lodged in NSW (20 428 applications) and the lowest number being lodged in the NT (108) (table 9A.2).

Hearings

A number of lodgments, particularly in the civil courts, will be settled or discontinued before the hearing stage. Hearings, particularly full court hearings and trials, are the primary cost driver for court administrations. Hearings encompass court trials, appeals and rehearings heard before a judicial officer for adjudication or determination. They do not include conferences or mediation and arbitration sessions. Most jurisdictions attempt to encourage pre-trial settlement of civil disputes through mediation and arbitration, to minimise the cost to the court and parties and to ensure only cases that require judicial determination proceed to a full hearing. Similarly, a guilty plea by the defendant generally reduces hearing length and cost in the criminal jurisdiction.

Not all jurisdictions compiled data on hearings for all courts in 2000-01: Tasmania did not provide data for any court levels (criminal or civil); Queensland did not provide data on criminal magistrates' court hearings or criminal supreme court hearings; Victoria did not provide data on criminal district/county court hearings; and SA did not provide data on coronial hearings. Given the amount of missing data, the following results should be viewed with some caution.

Approximately 903 409 court hearings (483 481 criminal, 314 062 civil, 104 999 family court and 867 coronial) were listed in 2000-01, of which the majority occurred in the magistrates' courts in their criminal jurisdiction (465 861 hearings) (tables 9A3 and 9A.4). District/county courts and supreme courts accounted for 15 363 hearings and 2257 hearings respectively, in the criminal jurisdiction (table 9A.3). In the civil jurisdiction, the largest number of hearings was in the

magistrates' courts (255 032 hearings). District/county courts accounted for 32 115 civil hearings, while supreme courts listed a further 26 915 civil hearings (table 9A.4). Criminal and civil hearings by court level and jurisdiction, from 1996-97 to 2000-01, are reported in tables 9A.3 and 9A.4. Care needs to be taken when interpreting these results because variations in reporting (and non-reporting) over the years have led to inconsistent results.

Finalisations

Finalisations represent the completion of matters in the court system. Each lodgment can only be finalised once. Like hearings, finalisations are an important measure of activity because they indicate where the majority of court administration costs are committed to court matters. Matters may be finalised by adjudication, transfer or other non-adjudicated method (such as withdrawal of a matter by the prosecution, issue of a bench warrant or settlement either by the court or by an external mediator).

Approximately 2.1 million matters were reported as finalised in 2000-01. In the criminal jurisdiction there were 1.7 million finalisations and in the civil jurisdiction (including family courts) there were 0.4 million finalisations (table 9.5). Finalisations data are not strictly comparable with lodgments data in the reported year because some lodgments from a previous year may be finalised in the current year. As well, care needs to be taken in comparing finalisation and lodgment data because not all lodgments that were subsequently settled out of court are reported to court administrators.

Table 9.5 outlines the number of finalisations in 2000-01 by court level for the Commonwealth and each State and Territory.

Table 9.5 Court finalisations, 2000-01 ('000)^{a, b, c}

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Cwlth	Total
Criminal courts^d										
Magistrates' (total)	133	765	358	183	171	59	14	13	..	1696
<i>Magistrates' (only)</i>	116	95	170	80	53	57	na	12	..	584
<i>Children's^e</i>	16	8	12	9	5	2	na	1	..	54
<i>Electronic^f</i>	..	662	175	94	113	..	..	..	..	1045
District/county	9	4	8	3	1	..	..	..	..	26
Supreme	1.1	0.5	1.2	0.4	0.2	0.4	0.3	0.4	..	4.5
All criminal courts	143	770	367	186	173	60	14	14	..	1727
Coroners' courts	5.6	3.7	3.0	2.1	3.0	0.3	0.3	0.2	..	18
Civil courts^g										
Magistrates' (total) ^h	35	181	38	21	38	2	7	2	..	324
<i>Magistrates' (only)</i>	32	181	na	21	38	2	na	na	..	273
<i>Children'sⁱ</i>	3.0	na	na	0.8	na	0.1	na	na	..	4
District/county	13	8	7	5	1	..	..	..	..	34
Supreme/Federal ^j	10.9	2.1	5.1	2.6	1.3	1.5	0.8	0.4	5.2	30
Federal Magistrates ^k	..	..	..	..	..	..	..	..	na	na
Family ^{j, l}	..	..	..	na	..	..	..	..	4	4
All civil courts	59	191	51	29	40	3	8	2	10	393

^a Finalisations are derived from timeliness data which may not reflect the total matters disposed by the courts in the reported period (as timeliness data may not allow for accurate extraction of the disposal of all matters).

^b Lodgments do not equal finalisations in any given year because matters lodged in one year may be finalised in the next. ^c Totals may not add as a result of rounding. ^d The expiration of cases after lodgment, such as following a bench warrant, may not be recorded as a finalisation in some jurisdictions. ^e The ACT did not provide separate data on criminal children's court finalisations. ^f Includes electronic court finalisations for Victoria, Queensland, SA and WA. ^g Cases withdrawn after initial lodgment may not be recorded as a finalisation in some jurisdictions. ^h Victorian and SA magistrates' court (total) data exclude civil children's court finalisations. ⁱ Civil children's court finalisations have not been provided separately in Victoria, Queensland, SA, the ACT and the NT. ^j The introduction of the Federal Magistrates Service has implications for the finalisations data of the Federal Court and Family Court of Australia. ^k Federal Magistrates Service data are not available for finalisations. ^l Family court data are not available for WA. **na** Not available. **..** Not applicable.

Sources: tables 9A.5 and 9A.6.

Method of finalisation

The method of finalisation describes how a charge leaves a particular court level. Finalisations data for criminal matters are presented by method of finalisation from the Australian Bureau of Statistics (ABS) *Higher Criminal Courts* (ABS 2001) collection for the reference period 1999-2000. Differences in the data collection methods and reference periods need to be considered when comparing these data with other finalisations data for criminal matters presented in the chapter.

In the supreme courts, in 1999-2000, 84.8 per cent of defendants in criminal matters were finalised by adjudication (that is, defendants were acquitted or proven guilty via a plea or finding). Nationally, a guilty plea was the most common method of

finalising adjudications in the supreme courts (67.8 per cent). Across jurisdictions, this proportion ranged from 76.4 per cent in Queensland to 35.7 per cent in SA. Nationally, 'withdrawn' was the most common means of non-adjudicated finalisations in the supreme courts (12.5 per cent). Across jurisdictions, the proportion of cases where finalisation occurred due to cases being 'withdrawn' ranged from 17.1 per cent in the SA Supreme Court to 4.3 per cent in the WA Supreme Court (table 9.6).

In the district/county courts, 85.6 per cent of criminal matters were finalised by adjudication (table 9.6).

Table 9.6 Defendants in criminal matters finalised, by method of finalisation, 1999-2000 (per cent)

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Total</i>
<i>District/county courts^a</i>									
Adjudicated									
Acquitted	10.6	9.4	5.6	8.0	6.8	..	..	..	7.8
Proven guilty									
Guilty verdict	9.7	7.7	4.9	12.7	9.3	..	..	..	8.0
Guilty plea	64.7	78.5	72.2	67.9	59.4	..	..	..	69.8
Total	84.9	95.6	82.7	88.6	75.5	..	..	..	85.6
Non-adjudicated									
Bench warrant issued ^b	3.6	0.5	na	3.4	5.5	..	..	..	1.8
Withdrawn	10.2	3.7	17.2	7.4	18.0	..	..	..	12.1
Other finalisation	1.2	0.1	0.1	0.6	1.1	..	..	..	0.5
Total^b	15.1	4.4	17.3	11.4	24.5	..	..	..	14.4
<i>Supreme courts</i>									
Adjudicated									
Acquitted	15.1	12.6	3.3	3.8	24.3	4.5	7.1	7.2	5.9
Proven guilty									
Guilty verdict	29.4	35.0	6.8	18.0	22.9	9.9	9.9	3.4	11.2
Guilty plea	48.4	46.6	76.4	69.2	35.7	67.4	59.9	70.9	67.8
Total	92.9	94.2	86.4	91.0	82.9	81.8	76.9	81.5	84.8
Non-adjudicated									
Bench warrant issued ^b	0.8	–	na	3.3	–	3.0	4.4	4.5	2.0
Withdrawn	5.6	5.8	13.6	4.3	17.1	13.8	16.5	14.0	12.5
Other finalisation	0.8	–	–	1.4	–	1.4	2.2	–	0.7
Total^b	7.1	5.8	13.6	9.0	17.1	18.2	23.1	18.5	15.2

^a There is no intermediate court in Tasmania, the ACT or the NT. ^b Excludes Queensland defendants finalised by a bench warrant being issued. **na** Not available. **..** Not applicable. **–** Nil or rounded to zero.

Sources: ABS (2001); table 9A.7.

9.2 Policy developments in court administration services

Technological access

The Australian community and the legal profession increasingly rely on the use of technology to obtain information, transact business and use on-line services. The court administration sector is responding to this demand by providing on-line court services that will increase the level of accessibility (particularly for regional areas), extend the range of services and enhance current 'over the counter' services.

Courts in a number of jurisdictions are developing a range of on-line services that are innovative in their approach, endeavouring to address the needs of court users and to provide for more streamlined processes for parties to court proceedings. Recent on-line and service developments include:

- the development of web interface to the High Court's case management system and integration with an electronic document system to support extensive hard copy records;
- an upgrade of the Family Court's web site and, in conjunction with the Commonwealth Attorney-General's department and the Federal Magistrates Service, the development of the Family Law On-line web site;
- the use of digital recording technology in the Federal Magistrates Service to assist judgment production, and the provision of example applications on the Federal Magistrates Service web site to assist self represented litigants;
- the development of a case management system for the Federal Court that integrates with its existing electronic filing service (which provides for the electronic servicing of documents and facilities for frequent users);
- the development of a number of e-business applications in Queensland, which include electronic court bookings, lodgment, information on courts, and electronic access to the civil information management system;
- the development in WA of a web enabled e-lodgment module for its integrated court management system and an 'e-Appeal' book to enable litigants to create their own e-appeal 'electronic books';
- the implementation in SA of an on-line fines and enquiries system and an e-lodgment system that interfaces with its case management system, and the set-up of an e-mail response centre;
- in the ACT the redevelopment of the courts' computer based information and management systems, which remains a priority, as does improved public access

to the law via an improved integrated web site and the development of e-business applications; and

- the development in the NT of a web interface to its Integrated Justice Information System, and the use of a fines and penalties system that enables on-line payments.

The NSW Attorney-General's department web site Lawlink NSW offers: electronic judgments for all NSW courts and tribunals available through Caselaw immediately after they are handed down; a one-stop help for victims of crime to find the support and information they need; fine payment at the State Debt Recovery Office; and downloadable forms from many courts and other justice agencies.

Other areas of technological access are also available in NSW, including: authenticated on-line lodgment of court documents, which was trialed in the Land and Environment Court during 2000-01; cooperation among justice agencies, which has been substantially improved through the Justice Agencies Data Exchange project; a video network covering 48 locations, which allows experts and other witnesses to give evidence to courts from remote and overseas locations; computer voice recognition for dictation, which is revolutionising the quality and efficiency of judicial work; and a major upgrade of court transcript services, which is underway with 16 district court rooms networked with remote video and audio recording equipment.

Jurisdictions within the Australian court system are examining ways in which information and evidentiary material can be exchanged between courts to improve the appeal processes and to reduce potential costs for litigants. One example is the first native title matter to be heard by the Federal Court in South Australia, where the court piloted an 'e-trial' whereby laptops and wireless technology were used to enable the court to conduct hearings in various remote localities. The technology also enabled the use of transcript and electronic evidentiary material taken at these remote localities to be accessible from a secure web site available to applicants and respondents on location.

Other policy developments include the use of an on-line 'virtual courtroom' by the NSW Land and Environment Court and the Federal Court for direction hearings. South Australia has a similar system for handling non-contentious matters.

9.3 Framework of performance indicators

The framework of performance indicators is based on a number of common objectives for court administration services across Australia (box 9.3). The emphasis placed on each objective varies across jurisdictions.

Box 9.3 Objectives for court administration

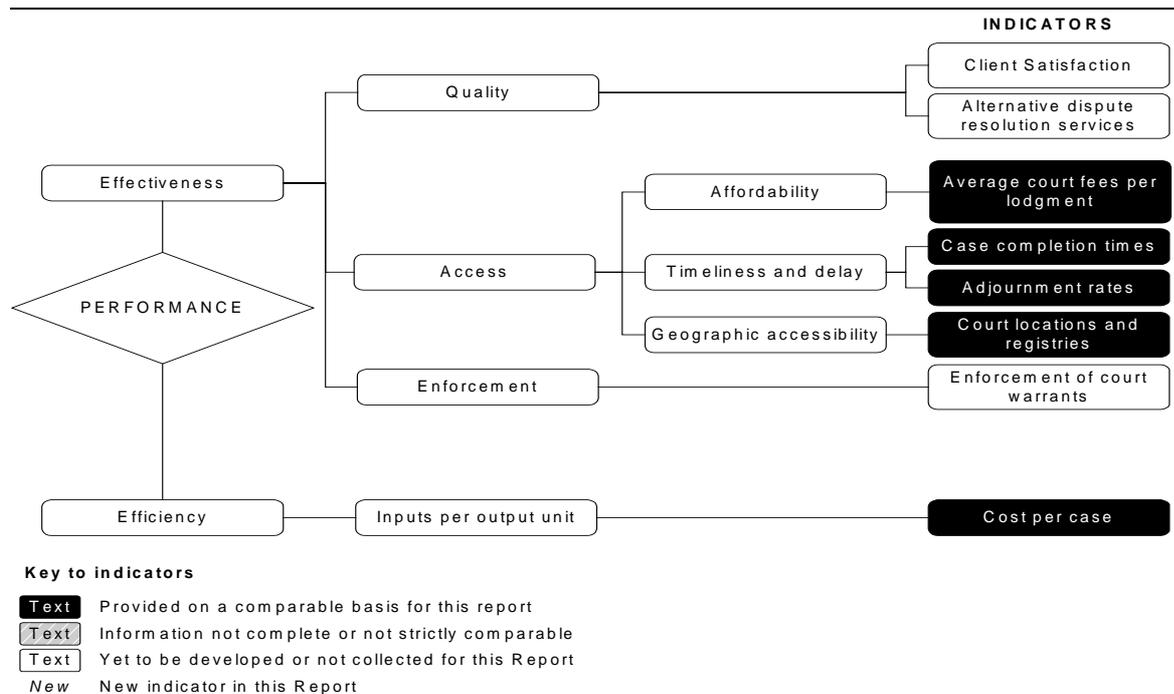
Objectives for court administration are:

- to be open and accessible;
- to process matters in an expeditious and timely manner;
- to provide due process and equal protection before the law; and
- to be independent yet publicly accountable for performance (Commission on Trial Court Performance Standards, 1989).

In addition, all governments aim to provide court administration services in an efficient manner.

The performance indicator framework for court administration services (figure 9.5) is under review, and changes may be included in next year's report. Processes to improve the comparability of existing data and the completeness of the performance indicators framework are discussed in section 9.5.

Figure 9.5 Performance indicators for court administration



9.4 Key performance indicator results

Different delivery contexts, locations and client types may affect the effectiveness and efficiency of court administration services. The allocation of cases to different courts also differs across jurisdictions (table 9A.39). These factors need to be taken into account in comparing performance across States and Territories for specific indicators. Appendix A contains detailed statistics and short profiles on each State and Territory, which may help in interpreting the performance indicators presented in this chapter.

Effectiveness indicators

Quality

Court administration authorities undertake surveys on court quality by obtaining court users' views on court administration services (such as court staff, facilities and available information). A number of surveys by different courts in individual jurisdictions have generated data on court users' views. These surveys generally used different methods and sample sizes, and took place in different courts. It is not possible, therefore, to publish comparable data across jurisdictions on the outcomes of client satisfaction surveys.

Affordability

Court filing fees largely relate to civil cases. While court fees are only part of the costs faced by litigants (with legal fees being more significant), they nonetheless can be considerable. Comparisons need to take into account that courts do not operate on a full cost recovery basis. The court may bear the cost of additional services provided to clients.

In 2000-01, average court fees collected per lodgment in higher courts were generally greater than those in intermediate and lower courts. New South Wales had the highest level of average civil fees collected per lodgment in the supreme court (\$1538) and in the district/county courts (\$682). For magistrates' courts (including children's courts), the NT had the highest level of average fees collected per lodgment (\$136) and the ACT had the lowest (\$48) (table 9.7). In the children's court, WA was the only jurisdiction that recorded average civil court fees per children's lodgment (\$6) (table 9A.18).

The average civil court fees collected were \$125 and \$60 for the Family Court of WA and the Family Court of Australia respectively in 2000-01. The average fees per lodgment in the Federal Court were \$906. The introduction of the Federal Magistrates Service has reduced fees received by the Family Court of Australia and

the Federal Court. Average probate fees collected per lodgment were highest in NSW (\$554 per probate lodgment) and lowest in Tasmania (\$98) (table 9.7).

Table 9.7 Average civil court fees collected per lodgment, 2000-01 (dollars)

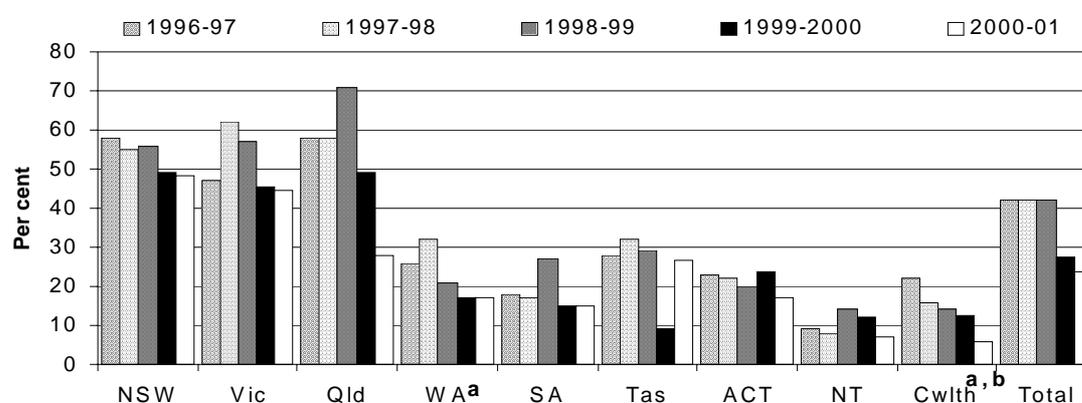
	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Cwlth	Total
Civil courts										
Magistrates' (total) ^a	94	70	59	77	58	52	48	136	..	77
<i>Magistrates' (only)</i>	96	70	62	78	59	53	na	na	..	78
District/county	682	531	230	384	198	..	..	..	..	486
Supreme/Federal ^b	1538	1260	444	261	475	97	786	323	906	921
Federal Magistrates ^c	..	..	..	..	..	..	..	..	na	na
Family ^b	..	..	..	125	..	..	..	..	60	70
Probate - Supreme	554	218	na	167	478	98	543	296	..	357

^a Victorian magistrates' court (total) figure excludes civil children's court lodgments. The ACT court fees rise with inflation and have traditionally been low, with no fees being charged for hearings in civil matters, and with fees only for lodgments and enforcements. ^b The introduction of the Federal Magistrates Service has reduced fees received for the Federal Court and Family Court of Australia. ^c No court fees data were provided by the Federal Magistrates Service. **na** Not available. **..** Not applicable.

Source: table 9A.18.

The level of revenue collected through court fees for the civil jurisdiction decreased on average between 1996-97 and 2000-01, with civil court fees collected representing 23.6 per cent of total expenditure in 2000-01 compared with 42.0 per cent in 1996-97. The proportion decreased from 1996-97 to 2000-01 in all jurisdictions (figure 9.6). Table 9A.17 contains data on civil court fees as a proportion of civil expenditure for separate court levels, from 1994-95 to 2000-01.

Figure 9.6 Civil court fees collected as a proportion of total civil expenditure, all courts



^a Includes respective family court. ^b Includes the Federal Court, but not the Federal Magistrates Service. The introduction of the Federal Magistrates Service has reduced the fees received by the Federal Court and Family Court of Australia in 2000-01.

Source: table 9A.17.

Timeliness – case completion times

Timeliness is currently measured by the time taken between the lodgment of a matter with the court and its finalisation. This measure can be affected by delays caused by parties other than those related to the workload of the court. Generally, lower courts complete a greater proportion of their workload in a shorter period of time because they hear less complex matters. Care needs to be taken when comparing results across the same court level, because caseloads and the complexity of cases may differ across jurisdictions. These differences will affect timeliness. Matters heard in electronic courts are excluded from timeliness data.

Timeliness – criminal (non-appeal matters finalised)

Tasmania, the ACT and the NT have a two-tier court system (that is, they do not have a district/county court) while the other jurisdictions have a three-tier court system. This difference needs to be taken into account when comparing timeliness performance across States and Territories. As well, in all jurisdictions, the complexity and distribution of cases may vary. For instance, second offences relating to drug matters automatically go to the Queensland Supreme Court whereas this does not occur (for example) in NSW.

The criminal jurisdiction of total magistrates' courts in all States and Territories finalised 87.9 per cent of cases within six months in 2000-01. This proportion ranged from 94.5 per cent of cases finalised within six months in WA to 74.5 per cent in the NT (table 9.8). Timeliness data for magistrates' courts (only) are contained in table 9A.19.

Nationally, children's courts finalised 84.3 per cent of cases within six months. Across jurisdictions, this proportion ranged from 92.3 per cent in Victoria to 46.0 per cent in the NT (table 9.8).

Nationally, district/county courts finalised 65.1 per cent of criminal cases within six months. Across jurisdictions, this proportion ranged from 73.5 per cent of cases finalised within six months in Queensland to 52.9 per cent in NSW (table 9.8).

In the supreme courts, a 12 month benchmark is used because the proceedings are generally more complex. Supreme courts in all States and Territories finalised 82.5 per cent of criminal cases within 12 months. Across jurisdictions, this proportion ranged from 96.2 per cent of cases finalised within 12 months in WA to 38.2 per cent in NSW (table 9.8).

Table 9.8 Non-appeal matters finalised, criminal, 2000-01 (per cent)^{a, b, c}

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Cwlth</i>	<i>Total</i>
Supreme										
<i>No. of cases</i>	144	113	920	238	88	394	213	349	..	2 459
<6 months	11.8	33.6	79.6	87.4	42.0	78.2	46.0	36.7	..	63.7
6–12 months	26.4	35.4	13.2	8.8	31.8	14.7	18.3	33.5	..	18.8
12–18 months	22.2	28.3	5.4	1.3	17.0	4.3	17.8	11.5	..	9.2
>18 months	39.6	2.7	1.8	2.5	9.1	2.8	17.8	18.3	..	8.3
District/county										
<i>No. of cases</i>	4 111	1 872	8 306	3 027	1 306	..	..	..	..	18 622
<6 months	52.9	61.4	73.5	61.5	63.0	..	..	..	..	65.1
6–12 months	23.9	19.7	16.8	13.7	26.0	..	..	..	..	18.8
12–18 months	10.5	9.8	7.7	16.7	8.0	..	..	..	..	10.0
>18 months	12.7	9.1	2.0	8.1	3.0	..	..	..	..	6.1
Magistrates' total^{d, e}										
<i>No. ('000)</i>	113	102	na	87	57	59	14	13	..	445
<6 months	93.7	89.2	na	94.5	80.7	77.5	75.7	74.5	..	87.9
6–12 months	5.2	8.1	na	3.8	10.9	13.8	13.9	12.0	..	7.9
12–18 months	0.7	1.4	na	0.9	2.7	4.9	3.7	5.3	..	2.0
>18 months	0.4	1.3	na	0.8	5.7	3.8	6.7	8.1	..	2.2
Children's^{d, f}										
<i>No. of cases</i>	na	8 445	na	8 586	5 051	2 124	na	973	..	25 179
<6 months	na	92.3	na	90.6	76.5	63.5	na	46.0	..	84.3
6–12 months	na	6.8	na	6.9	15.3	21.9	na	27.3	..	10.6
12–18 months	na	0.8	na	1.6	4.2	5.2	na	13.3	..	2.6
>18 months	na	0.1	na	1.0	4.1	9.4	na	13.4	..	2.5

^a Care should be taken when comparing timeliness data across jurisdictions as both the complexity and distribution of cases may vary. ^b Totals may not sum to 100 per cent as a result of rounding. ^c Timeliness data were not collected for electronic courts. ^d Queensland timeliness data for the criminal magistrates' and children's court are not available. There was a loss of continuity in the data sets transferred from the previous computerised and manual systems due to the implementation of the new Queensland Wide Interlinked Courts system. ^e NSW magistrates' (total) court figure excludes children's court criminal timeliness data. The NSW timeliness data for its magistrates' court were estimated via trend analysis based on the past three financial years. ^f NSW, Queensland and the ACT did not provide separate children's court timeliness data. **na** Not available. **..** Not applicable.

Source: table 9A.19.

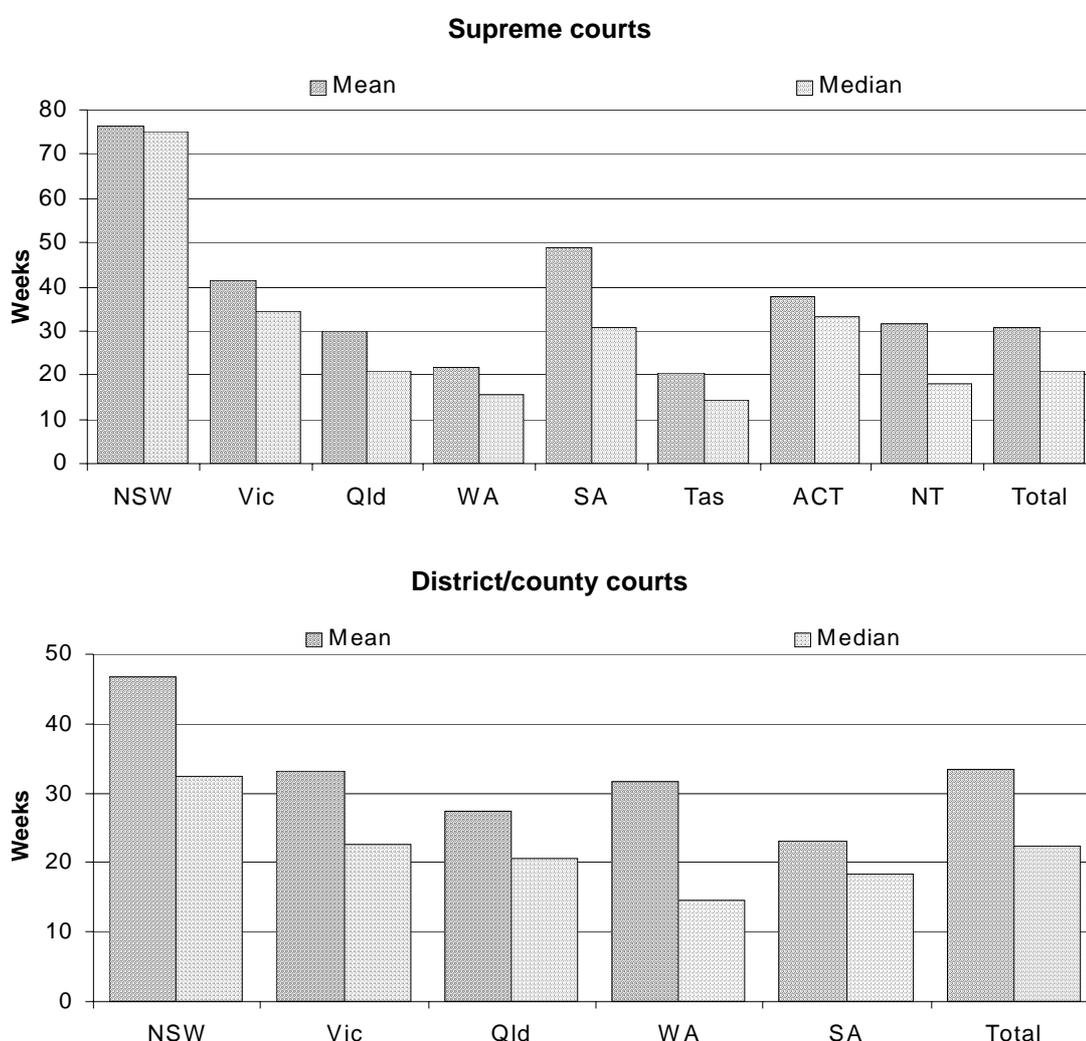
The ABS also publishes criminal higher court timeliness data. However, direct comparisons cannot be made with the results published in table 9.8 as the ABS uses different data collection methods and reference periods.

According to the ABS, in 1999-2000, the average period in supreme courts between lodgment and finalisation (duration) was 31 weeks (ABS 2001). Across jurisdictions, this average period ranged from 76 weeks in NSW to 21 weeks in Tasmania. For supreme courts, the median period (the point at which half the cases had been finalised) between lodgment and finalisation was 21 weeks. Across

jurisdictions, this median period ranged from 75 weeks in NSW to 14 weeks in Tasmania (figure 9.7).

Nationally, the mean period between lodgment and finalisation for district/county courts was 34 weeks. Across jurisdictions, this period ranged from 47 weeks in NSW to 23 weeks in SA. The median period of cases was 22 weeks across Australia, ranging from 32 weeks in NSW to 15 weeks in WA (figure 9.7). Tasmania, the ACT and the NT did not operate in the district/county court jurisdiction.

Figure 9.7 **Criminal matters duration, supreme and district/county courts, 1999-2000**



Sources: ABS (2001); table 9A.24.

Timeliness – civil (non-appeal matters finalised)

The civil timeliness data for the district/county court (presented in table 9.9) should not be used to compare performance across jurisdictions. Advice from jurisdictions indicate that there are differences in the way in which the district/county court timeliness data are provided (in terms of the types of matter counted and/or the date from which timeliness is measured). These differences prevent meaningful comparisons across jurisdictions for the district/county court. This issue will be addressed prior to publication of the 2003 Report.

As well, Tasmania, the ACT and the NT have a two-tier court system (that is, they do not have a district/county court) while the other jurisdictions have a three-tier court system. This difference needs to be taken into account when comparing timeliness performance across States and Territories. Further, in all jurisdictions, the complexity and distribution of cases may vary.

Nationally, the civil jurisdiction of total magistrates' courts finalised 88.5 per cent of cases within six months in 2000-01. Across jurisdictions, this proportion ranged from 98.1 per cent of cases finalised within six months in Victoria to 52.6 per cent in SA (table 9.9). It should be noted that the NSW, Victoria and SA total magistrates' court data exclude any data on civil children's court timeliness. Timeliness data on magistrates' court (only) are contained in table 9A.20. Longer case completion times in the civil jurisdiction reflected different case flow management practices and the priority given to criminal matters.

For children's courts, in the two jurisdictions that provided data, WA and Tasmania completed 83.7 per cent and 75.6 per cent of cases respectively within six months (table 9.9).

In the supreme courts, a 12 month benchmark is used because the proceedings are generally more complex. Supreme courts and the Federal Court finalised 69.3 per cent of civil cases within 12 months. Across jurisdictions, this proportion ranged from 83.9 per cent in the Supreme Court of Victoria to 42.9 per cent in the ACT Supreme Court (table 9.9). The ACT advise that the majority of proceedings are protracted personal injury matters which (under a three-tier system) would normally be heard in a district/county court.

The Federal Magistrates Service, the Family Court of WA and the Family Court of Australia did not provide data on timeliness for their finalised non-appeal matters (table 9.9).

Table 9.9 Non-appeal matters finalised, civil, 2000-01 (per cent)^a

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Cwlh</i>	<i>Total</i>
Supreme^b/Federal										
<i>No. of cases</i>	10 244	1 887	4 804	2 225	1 031	1 435	790	225	4 669	27 310
<6 months	52.7	78.2	60.9	38.6	66.4	43.7	25.3	36.9	61.5	55.4
6-12 months	13.7	5.7	7.9	21.3	14.1	13.5	17.6	14.7	19.8	13.9
12-18 months	10.5	14.3	6.2	12.1	5.9	8.9	15.2	4.9	7.8	9.5
>18 months	23.0	1.8	25.0	28.0	13.6	33.9	41.9	43.6	10.9	21.2
District/county ^{c, d}										
<i>No. of cases</i>	12 954	7 623	7 157	4 843	1 317	..	..	..	..	33 894
<6 months	16.2	26.7	30.3	22.3	31.4	..	..	..	..	23.0
6-12 months	37.0	31.1	17.6	14.8	24.6	..	..	..	..	27.9
12-18 months	27.8	27.0	13.7	26.6	15.8	..	..	..	..	24.0
>18 months	19.1	15.3	38.5	36.3	28.2	..	..	..	..	25.1
Magistrates' total^{e, f}										
<i>No. ('000)</i>	32	181	38	21	38	2	7	2	..	321
<6 months	85.4	98.1	86.2	86.8	52.6	89.8	70.3	75.6	..	88.5
6-12 months	9.2	1.5	9.0	7.2	11.8	9.7	20.1	10.2	..	5.2
12-18 months	2.8	0.3	2.4	2.4	29.9	0.2	3.9	5.6	..	4.5
>18 months	2.6	0.2	2.3	3.5	5.7	0.3	5.7	8.7	..	1.7
Children's ^g										
<i>No. of cases</i>	<i>na</i>	<i>na</i>	<i>na</i>	834	<i>na</i>	82	<i>na</i>	<i>na</i>	..	916
<6 months	<i>na</i>	<i>na</i>	<i>na</i>	83.7	<i>na</i>	75.6	<i>na</i>	<i>na</i>	..	83.0
6-12 months	<i>na</i>	<i>na</i>	<i>na</i>	11.5	<i>na</i>	12.2	<i>na</i>	<i>na</i>	..	11.6
12-18 months	<i>na</i>	<i>na</i>	<i>na</i>	2.9	<i>na</i>	4.9	<i>na</i>	<i>na</i>	..	3.1
>18 months	<i>na</i>	<i>na</i>	<i>na</i>	1.9	<i>na</i>	7.3	<i>na</i>	<i>na</i>	..	2.4
Family^h										
<i>No. of cases</i>	..	..	..	<i>na</i>	..	..	..	..	<i>na</i>	<i>na</i>
<6 months	..	..	..	<i>na</i>	..	..	..	..	<i>na</i>	<i>na</i>
6-12 months	..	..	..	<i>na</i>	..	..	..	..	<i>na</i>	<i>na</i>
12-18 months	..	..	..	<i>na</i>	..	..	..	..	<i>na</i>	<i>na</i>
>18 months	..	..	..	<i>na</i>	..	..	..	..	<i>na</i>	<i>na</i>
Federal Magistratesⁱ										
<i>No. of cases</i>	..	..	..	..	..	..	..	..	<i>na</i>	<i>na</i>
<6 months	..	..	..	..	..	..	..	..	<i>na</i>	<i>na</i>
6-12 months	..	..	..	..	..	..	..	..	<i>na</i>	<i>na</i>
12-18 months	..	..	..	..	..	..	..	..	<i>na</i>	<i>na</i>
>18 months	..	..	..	..	..	..	..	..	<i>na</i>	<i>na</i>

^a Care should be taken when comparing timeliness data across jurisdictions as both the complexity and distribution of cases may vary. ^b For the ACT, the majority of proceedings are personal injury matters which (under a three-tier system) would normally be heard in a district/county court. ^c The district/county court timeliness data should not be used to compare performance across jurisdictions, as advice from jurisdictions indicate that there are differences in the way in which the data are provided. ^d NSW data for district courts derived by estimation. ^e NSW, Victoria and SA data exclude civil children's court. All other jurisdictions data include civil children's court. ^f The ACT advise that a significant number of lengthy workers' compensation matters are dealt with in the magistrates' court rather than (under a three-tier system) in the district/county court. ^g Civil children's court data are not provided separately in NSW, Victoria, Queensland, SA, the ACT and the NT. ^h The Family Court of Australia case management system is not set up to allow extracts of time taken for all cases lodged. ⁱ Federal Magistrates Service did not provide data. *na* Not available. .. Not applicable.

Source: table 9A.20.

Timeliness – coroners' courts

Across Australia, 78.9 per cent of coronial cases were finalised within six months in 2000-01. South Australia had the largest proportion of coronial matters finalised within six months (93.3 per cent) and Tasmania had the smallest (52.5 per cent) (table 9.10).

Table 9.10 Coroners' court matters finalised, 2000-01 (per cent)^a

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Cwlth	Total
No. of cases	5 568	3 705	3 020	2 115	3 033	324	296	220	..	18 281
<6 months	82.0	72.9	71.2	73.6	93.3	52.5	91.6	83.6	..	78.9
6 -12 months	8.2	16.2	20.7	17.1	6.3	22.5	5.7	11.8	..	12.8
12 -18months	5.0	5.4	5.3	4.1	0.4	11.4	1.7	2.7	..	4.3
>18 months	4.8	5.5	2.7	5.2	–	13.6	1.0	1.8	..	3.9

^a Totals may not sum to 100 per cent as a result of rounding. .. Not applicable. – Nil or rounded to zero.

Source: table 9A.19.

Timeliness – committal proceedings

Committals are the first stage of hearing indictable (serious) matters in the criminal court system. A magistrate in a committal hearing assesses the sufficiency of evidence presented against the defendant and decides whether to commit the matter for trial in a superior court. Defendants are often held in custody pending a committal hearing and trial if ordered. The timely conduct of the committal hearing on the court's receipt of the charge sheet, therefore, is important for timely adjudication of the charges against the defendant.

Table 9.11 Committal (criminal) matters finalised, magistrates' courts, 2000-01 (per cent)^a

	NSW	Vic	Qld ^b	WA	SA	Tas ^c	ACT	NT	Cwlth	Total
No. of cases	3 484	1 674	na	1 522	988	na	186	300	..	8 154
<3 months	40.0	40.0	na	38.2	54.6	na	49.5	50.3	..	42.0
3 - 6 months	27.6	31.1	na	38.2	35.1	na	33.9	21.7	..	31.1
>6 -12 months	21.1	23.8	na	20.9	7.1	na	12.4	17.3	..	19.6
>12 months	11.3	5.1	na	2.7	3.2	na	4.3	10.7	..	7.3

^a Totals may not sum to 100 per cent as a result of rounding. ^b Queensland timeliness data are not available. There was a loss of continuity in the data sets transferred from the previous computerised and manual systems due to the implementation of the new Queensland Wide Interlinked Courts system. ^c Tasmania data not available. na Not available. .. Not applicable.

Source: table 9A.23.

Nationally, in 2000-01, 42.0 per cent of committal hearings were finalised within three months of the receipt of charges by the court. A further 31.1 per cent were

finalised in the subsequent three months. Committal hearings finalised within three months, across jurisdictions, ranged from 54.6 per cent in SA to 38.2 per cent in WA. Queensland and Tasmania did not provide data (table 9.11).

Timeliness – appeals

Appeals from lower courts are predominantly heard by the district courts and supreme courts of the States and Territories. The full bench of the Federal Court hears appeals from a single Justice of the Federal Court, the supreme courts of the ACT and Norfolk Island, and decisions of the Federal Magistrates Service. As well, the Federal Court hears certain decisions of State supreme courts exercising federal jurisdiction, and decisions of the Administrative Appeals Tribunal where a judicial member was involved.

Criminal appeals are generally shorter than civil ones. In the supreme courts, a 12 month benchmark is used because of the generally more complex nature of the proceedings. Within the supreme courts, 82.0 per cent of criminal appeals and 77.9 per cent of civil appeals were finalised within 12 months through the supreme and Federal courts (table 9.12).

Table 9.12 Appeal matters finalised, supreme courts and the Federal Court, 2000-01 (per cent)^{a, b}

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Cwlth</i>	<i>Total</i>
Criminal										
<i>No. of cases</i>	906	413	312	195	109	40	46	33	..	2 054
<6 months	31.8	46.7	83.0	45.6	89.9	40.0	67.4	48.5	..	48.2
6 -12 months	42.3	38.3	16.0	30.8	8.3	35.0	15.2	42.4	..	33.8
12 -18 months	16.6	10.4	–	15.4	–	15.0	6.5	–	..	11.3
>18 months	9.4	4.6	1.0	8.2	1.8	10.0	10.9	9.1	..	6.7
Civil										
<i>No. of cases</i>	658	241	275	367	265	34	46	166	574	2 626
<6 months	31.9	51.0	51.0	48.0	79.6	55.9	60.9	65.1	58.0	51.3
6 -12 months	29.6	14.9	40.0	25.1	20.0	32.4	21.7	25.9	25.8	26.6
12 -18 months	23.1	14.1	8.0	15.0	0.4	5.9	15.2	6.6	8.5	12.7
>18 months	15.3	19.9	1.0	12.0	–	5.9	2.2	2.4	7.7	9.4

^a Care should be taken when comparing timeliness data across jurisdictions as both the complexity and distribution of cases may vary. ^b Totals may not sum to 100 per cent as a result of rounding. .. Not applicable. – Nil or rounded to zero.

Source: table 9A.22.

The highest proportion of criminal appeals finalised within 12 months was in the Queensland Supreme Court (99.0 per cent). The lowest proportion was in the NSW Supreme Court (74.1 per cent of appeals). The SA Supreme Court finalised the

largest proportion of civil appeals within 12 months (99.6 per cent) while the NSW Supreme Court finalised the lowest proportion (61.5 per cent) (table 9.12). Care should be taken when comparing timeliness data across jurisdictions as both the complexity and distribution of cases may vary.

Timeliness – adjournment rates on the first day of hearing

The number of adjournments partly reflects the timeliness of courts. Adjournments at the request of the parties are generally considered to be outside the control of the court, and they may occur when the parties are not ready or a witness is not available. Adjournments may also be ordered by the court in instances such as overlisting (where court administrators expect a proportion of their case load not to proceed on any particular day and therefore list some standby matters to maximise the use of court proceedings). Court ordered adjournments can be used to approximate adjournments as a result of the unavailability of judicial time.

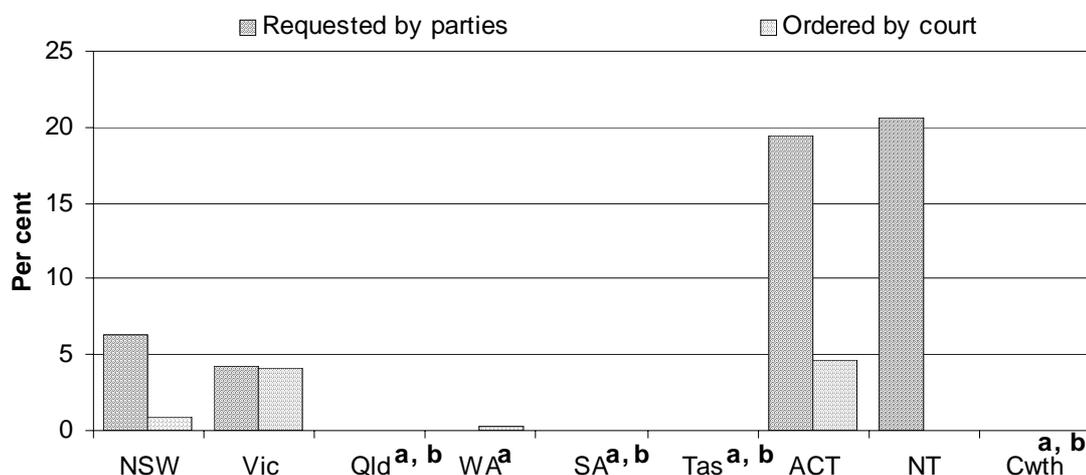
The following information is on court ordered (and party requested) adjournments on the first day of hearing, and as such does not encompass all of the possible adjournments that may occur during a hearing.

In 2000-01, court ordered adjournments on the first day of a hearing, as a proportion of all civil hearings initiated in the supreme court, varied from 4.6 per cent in the ACT to zero (or close to zero) per cent in WA and the NT. Adjournments on the first day of a hearing requested by the parties, as a proportion of all civil hearings initiated in the supreme courts, varied from 20.6 per cent in the NT to 4.3 per cent in Victoria (figure 9.8).

Queensland, SA, Tasmania and the Federal Court were unable to provide information on either hearings and/or court ordered adjournments. Queensland, WA, SA, Tasmania and the Federal Court were unable to provide information on either hearings and/or party requested adjournments.

Adjournment rates for criminal matters in the supreme courts and the Federal Court are contained in attachment 9A.25, as are the rates for the criminal and civil jurisdictions of other higher courts.

Figure 9.8 **Adjournments on the first day of hearing as a proportion of total civil hearings, supreme courts and the Federal Court, 2000-01**



^a Data for hearings and/or party requested adjournments are not available. ^b Data for hearings and/or court ordered adjournments are not available.

Source: table 9A.25.

Geographic accessibility – court locations and registries

Providing rural communities with access to judicial services can involve significant costs for court administration agencies. The services provided to improve the accessibility of courts to rural and remote communities include:

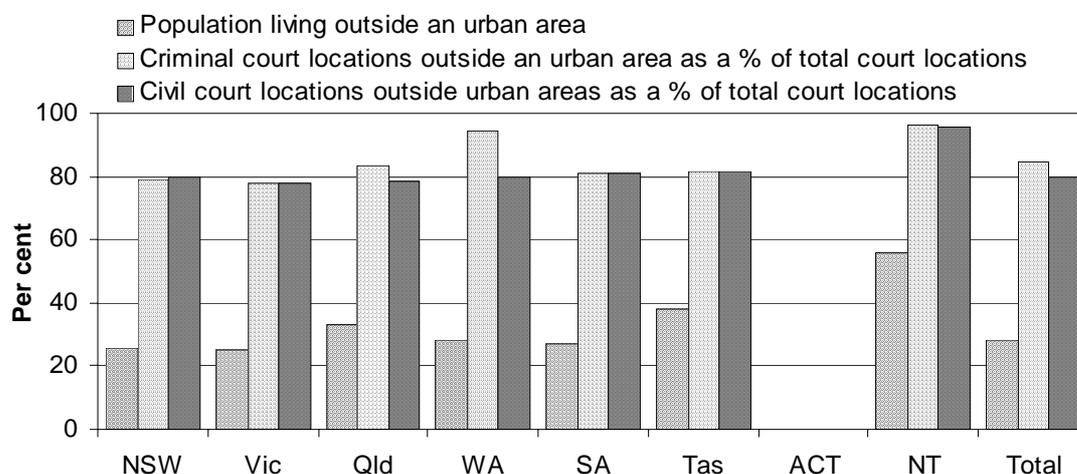
- judicial circuits where magistrates and judges tour rural courthouses to hear cases;
- the location of magistrates' courts in police stations, whereby police officers and Justices of the Peace staff the courts (when magistrates are not available);
- occasional caravan courts by superior courts in remote areas; and
- video conferencing facilities to link capital city courthouses to witnesses in remote locations.

One indicator of the accessibility of court services is the relationship between the proportion of magistrates' court locations in either urban or non-urban areas and the proportion of the population residing in either urban or non-urban areas of the State or Territory. In all States and Territories, the proportion of magistrates' court locations (in both the criminal and civil jurisdictions) in non-urban areas exceeded the proportion of population residing in non-urban areas in 2000-01 (figure 9.9).

Generally, States and Territories with relatively high proportions of their population in non-urban areas also had a higher proportion of magistrates' courts located in non-urban areas. In the criminal jurisdiction, the NT had the highest proportion (96.3 per cent) of magistrates' courts located outside an urban area, while the ACT had no magistrates' courts located outside an urban area (figure 9.9).

In the civil jurisdiction, again, the NT had the highest proportion of magistrates' courts located outside urban areas (95.7 per cent), while the ACT had the lowest share (zero per cent) (figure 9.9).

Figure 9.9 Criminal and civil magistrates' court locations outside an urban area, 2000-01 (per cent)^{a, b}



^a Court locations include permanent locations, temporary locations and registries without hearings. ^b Urban areas include State and Territory capital city statistical divisions and other urban areas (with populations of 100 000 or more). Non-urban areas include remote areas (defined in terms of low population density and long distances to large population centres) and rural areas (which include the remainder of non-urban statistical local areas).

Source: table 9A.26.

Efficiency indicators

Expenditure (including accommodation costs) less in-house revenue per lodgment for each court jurisdiction varied considerably among States and Territories in 2000-01, as well as over time. Expenditure data exclude payroll tax for NSW, Victoria, Queensland, SA, Tasmania and the NT (except where otherwise stated) to improve the comparability of efficiency indicators with the remaining jurisdictions that are exempt from payroll tax.

In instances where jurisdictions have not provided data, these jurisdictions are excluded from the calculation of the national or total figure.

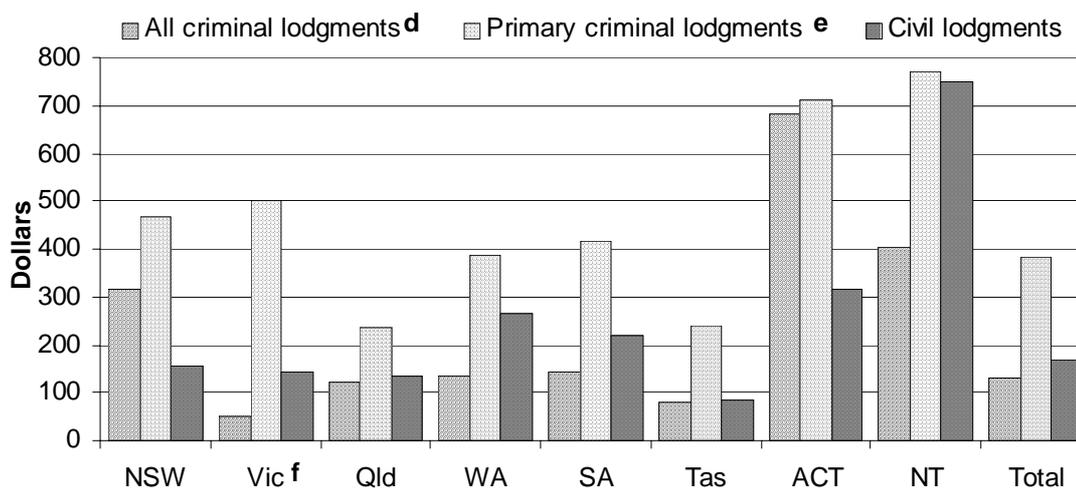
Expenditure less in-house revenue per lodgment for total magistrates' courts (including magistrates', electronic and children's courts)

In 2000-01, expenditure less in-house revenue per criminal lodgment for total magistrates' courts (including electronic and children's courts) was \$129 nationally. Across jurisdictions, it was highest in the ACT (\$681) and lowest in Victoria (\$49) (figure 9.10). However, comparisons of this nature should be viewed with caution as a number of jurisdictions (including the ACT) do not operate electronic courts. Consideration needs to be given, therefore, to the efficiency results that relate to expenditure less in-house revenue per primary lodgment (figure 9.10) and expenditure less in-house revenue for magistrates' courts only (figure 9.11), which exclude the impact of electronic courts.

Expenditure less in-house revenue per primary criminal lodgment (that is, excluding minor matters) for magistrates' courts was highest in the NT (\$771) and lowest in Queensland (\$234) (figure 9.10).

Nationally, expenditure less in-house revenue per lodgment in the civil jurisdiction of the magistrates' courts (including children's courts) was \$167. Across jurisdictions, it was highest in the NT (\$750 per lodgment) and lowest in Tasmania (\$84) (figure 9.10). The Commonwealth does not operate in this court jurisdiction.

Figure 9.10 Expenditure less in-house revenue per lodgment, total magistrates' courts, 2000-01^{a, b, c}



^a In-house revenue includes revenue earned by in-house providers of library, court reporting and civil bailiff services to external purchasers. ^b Excludes payroll tax for NSW, Victoria, Queensland, SA, Tasmania and the NT. ^c The Commonwealth does not operate in this court jurisdiction. ^d Includes electronic court lodgments in Victoria, Queensland, WA and SA which will have an impact on comparisons with other jurisdictions. ^e Excludes all minor lodgments and electronic court lodgments. ^f Victorian civil result includes civil children's expenditure, but excludes civil children's court lodgments as these were not provided.

Sources: tables 9A.27, 9A.28 and 9A.34.

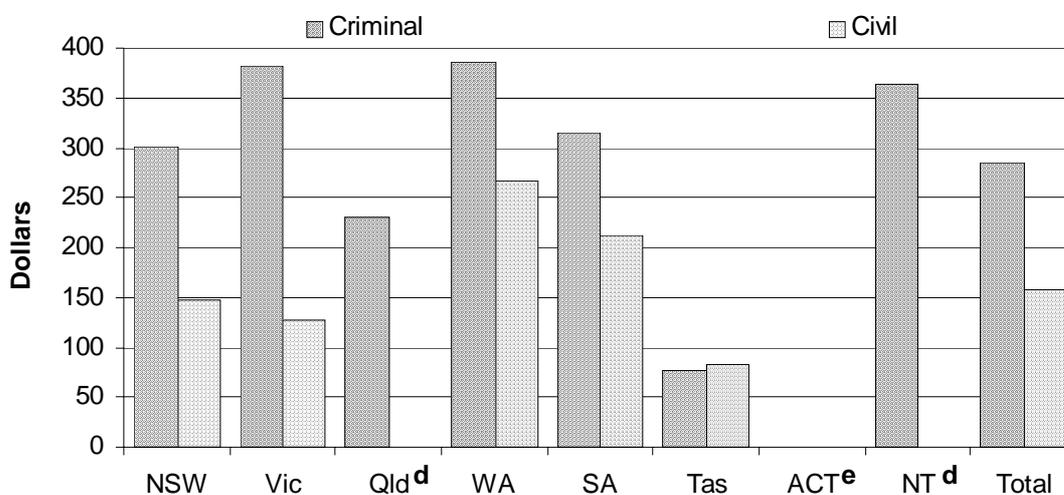
Expenditure less in-house revenue per lodgment for magistrates' courts only (excluding electronic and children's courts)

The ACT was unable to separate its criminal and civil magistrates' court data from its children's court data, and Queensland and the NT were unable to separate their civil magistrates' court data from their children's court data. Where relevant, the national figure excludes these jurisdictions.

Nationally, expenditure less in-house revenue per criminal lodgment in the magistrates' courts only (excluding electronic and children's courts) was \$286. Across jurisdictions, it was highest in WA (\$386) and lowest in Tasmania (\$77) (figure 9.11).

Nationally, expenditure less in-house revenue per civil lodgment in magistrates' courts only (excluding children's courts) was \$157. Across jurisdictions, it was highest in WA (\$266) and lowest in Tasmania (\$82) (figure 9.11). The Commonwealth does not operate in this court jurisdiction.

Figure 9.11 Expenditure less in-house revenue per lodgment, magistrates' court only, 2000-01^{a, b, c}



^a In-house revenue includes revenue earned by in-house providers of library, court reporting and civil bailiff services to external purchasers. ^b Excludes payroll tax for NSW, Victoria, Queensland, SA, Tasmania and the NT. ^c The Commonwealth does not operate in this court jurisdiction. ^d Queensland and the NT could not exclude their children's court data in the civil jurisdiction. ^e ACT could not exclude children's court data in the criminal or civil jurisdiction.

Sources: tables 9A.27 and 9A.28.

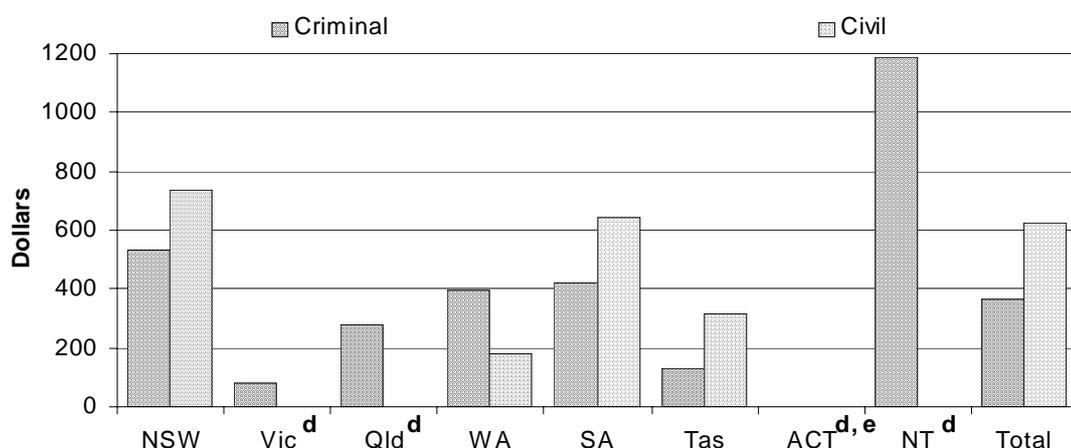
Expenditure less in-house revenue per lodgment for children's courts

The ACT could not separate its criminal or civil children's court data from its magistrates' court data, and Victoria, Queensland and the NT could not separate their civil children's court data from their magistrates' court data. Where relevant, the national figure excludes these jurisdictions.

In 2000-01, expenditure less in-house revenue per criminal lodgment for children's courts was \$368 nationally. Across jurisdictions, it was highest in the NT (\$1190) and lowest in Victoria (\$81) (figure 9.12).

Nationally, expenditure less in-house revenue per civil lodgment in the children's courts was \$627. Across jurisdictions, it was highest in NSW (\$738) and lowest in WA (\$182) (figure 9.12). The Commonwealth does not operate in this court jurisdiction.

Figure 9.12 Expenditure less in-house revenue per lodgment, children's courts, 2000-01^{a, b, c}



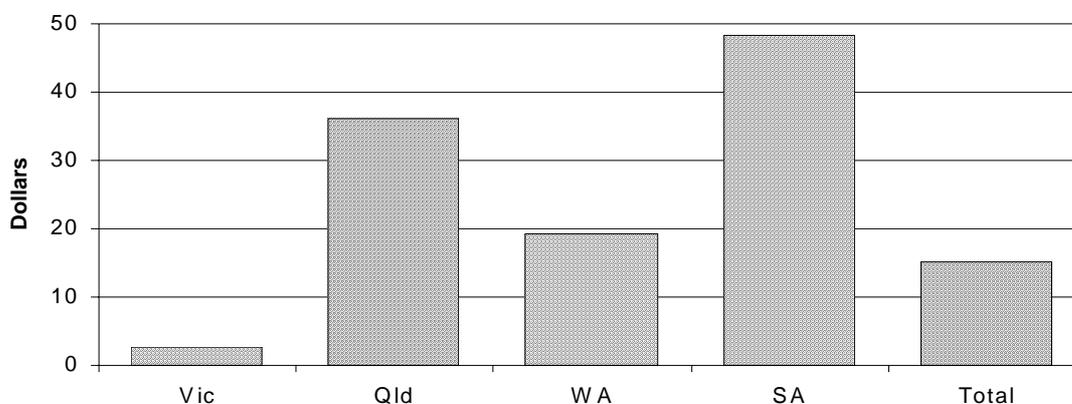
^a In-house revenue includes revenue earned by in-house providers of library, court reporting and civil bailiff services to external purchasers. ^b Excludes payroll tax for NSW, Victoria, Queensland, SA, Tasmania and the NT. ^c The Commonwealth does not operate in this court jurisdiction. ^d Civil lodgments in the children's courts were not provided. ^e The ACT did not provide separate expenditure or lodgment data for the criminal jurisdiction of its children's court.

Sources: tables 9A.27 and 9A.28.

Expenditure less in-house revenue per lodgment for electronic courts

In 2000-01, expenditure less in-house revenue per criminal lodgment for electronic courts was \$15 nationally (figure 9.13). Across jurisdictions, it was highest in SA (\$48) and lowest in Victoria (\$3) (figure 9.13). New South Wales, Tasmania, the ACT, the NT and the Commonwealth did not operate in this court jurisdiction.

Figure 9.13 Expenditure less in-house revenue per lodgment, electronic courts, 2000-01^{a, b, c}



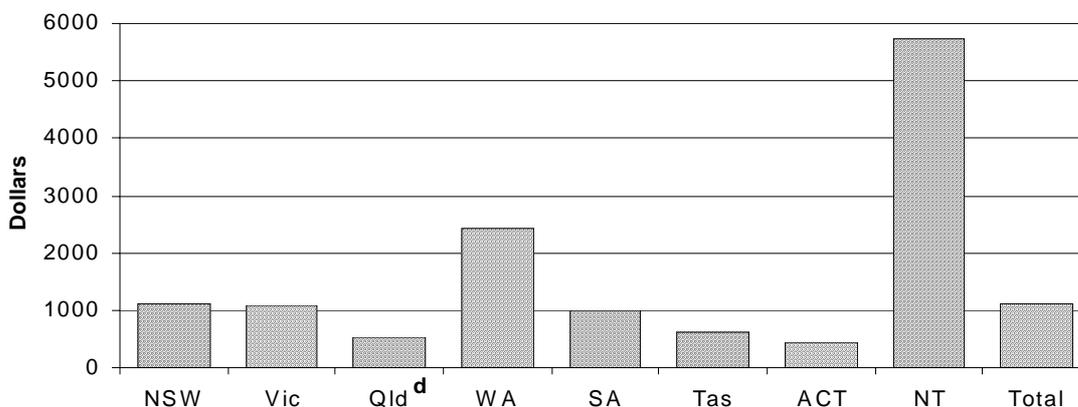
^a In-house revenue includes revenue earned by in-house providers of library, court reporting and civil bailiff services to external purchasers. ^b Excludes payroll tax for Victoria, Queensland and SA. ^c Electronic courts (infringement and expiated offence processing systems that have the status of a court) only operate in Victoria, Queensland, WA and SA.

Source: table 9A.27.

Expenditure less in-house revenue per reported death and fire for coroners' courts

Nationally, in 2000-01, the coroners' court expenditure per reported death and fire was \$1113, and was highest in the NT (\$5750) and lowest in the ACT (\$429) (figure 9.14). The Commonwealth does not operate in this court jurisdiction.

Figure 9.14 Expenditure less in-house revenue per lodgment, coroners' courts, 2000-01^{a, b, c}



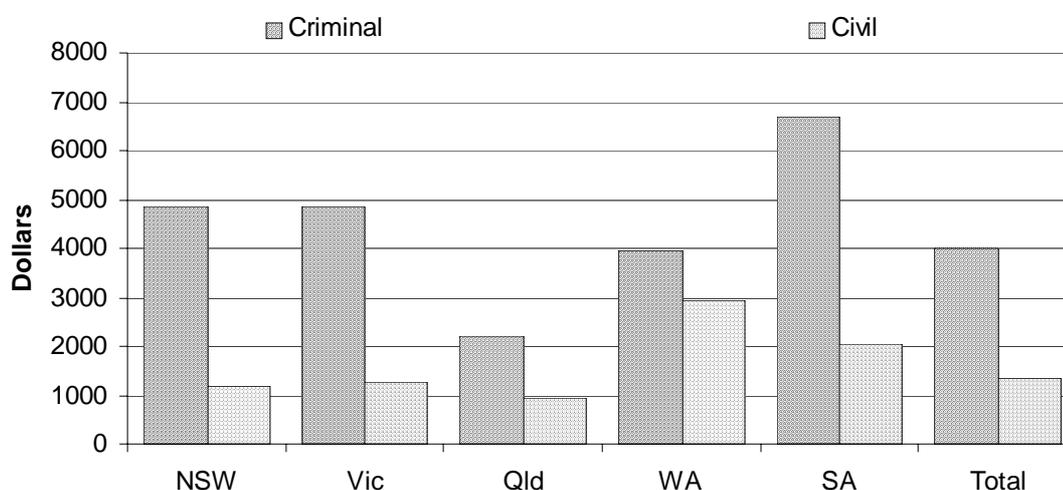
^a In-house revenue includes revenue earned by in-house providers of library, court reporting and civil bailiff services to external purchasers. ^b Excludes payroll tax for NSW, Victoria, Queensland, SA, Tasmania and the NT. ^c The Commonwealth does not operate in this court jurisdiction. ^d The cost of autopsies and forensic services is not included in the total cost provided by Queensland.

Source: table 9A.27.

Expenditure less in-house revenue per lodgment for district/county courts

Nationally, in 2000-01, expenditure less in-house revenue per criminal lodgment for district/county courts was \$3992. Across jurisdictions, it was highest in SA (\$6699) and lowest in Queensland (\$2201). Nationally, expenditure less in-house revenue per civil lodgment was \$1346 in district/county courts, and was highest in WA (\$2939) and lowest in Queensland (\$945) (figure 9.15). Tasmania, the ACT, the NT and the Commonwealth do not operate in this court jurisdiction.

Figure 9.15 Expenditure less in-house revenue per lodgment, district/county courts, 2000-01^{a, b, c}



^a In-house revenue includes revenue earned by in-house providers of library, court reporting and civil bailiff services to external purchasers. ^b Excludes payroll tax for NSW, Victoria, Queensland and SA. ^c District/county courts do not operate in Tasmania, the ACT, the NT or the Commonwealth.

Source: tables 9A.27 and 9A.28.

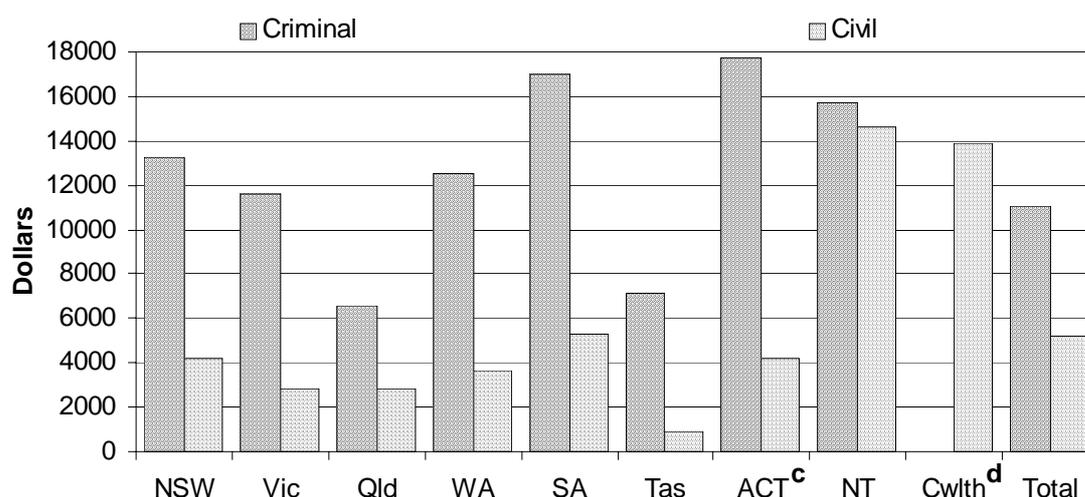
Expenditure less in-house revenue per lodgment for supreme courts and the Federal Court

Nationally, the expenditure less in-house revenue per criminal lodgment for the supreme courts was \$11 038. The ACT had the highest criminal supreme court expenditure less in-house revenue per lodgment (\$17 688) while Queensland had the lowest (\$6553) (figure 9.16). The Federal Court does not operate in the criminal jurisdiction.

Nationally, expenditure less in-house revenue per civil lodgment was \$5222. Across jurisdictions, it ranged from \$14 593 in the NT to \$892 in Tasmania (figure 9.16).

The Federal Court's expenditure less in-house revenue per civil lodgment was \$13 903 (figure 9.16). Data for the Federal Court include the cost of resources provided free of charge to the Federal Magistrates Service.

Figure 9.16 **Expenditure less in-house revenue per lodgment, supreme courts and the Federal Court, 2000-01^{a, b}**



^a In-house revenue includes revenue earned by in-house providers of library, court reporting and civil bailiff services to external purchasers. ^b Excludes payroll tax for NSW, Victoria, Queensland, SA, Tasmania and the NT. ^c The expenditure can be attributed to greater corporate overheads, including funding for the retirement of a Supreme Court judge and the (interstate) relocation of his replacement, the retirement of the Supreme Court Registrar and increased costing for information technology, the Russell Fox Library and the amalgamation of the Bailiffs and Sheriffs Units. ^d In the civil jurisdiction, the introduction of the Federal Magistrates Service has expenditure and lodgment implications for the Federal Court. As well, data for the Federal Court includes the cost of resources provided free of charge to the Federal Magistrates Service. The Federal Court does not operate in the criminal jurisdiction.

Sources: tables 9A.27 and 9A.28.

Expenditure less in-house revenue per lodgment for family courts

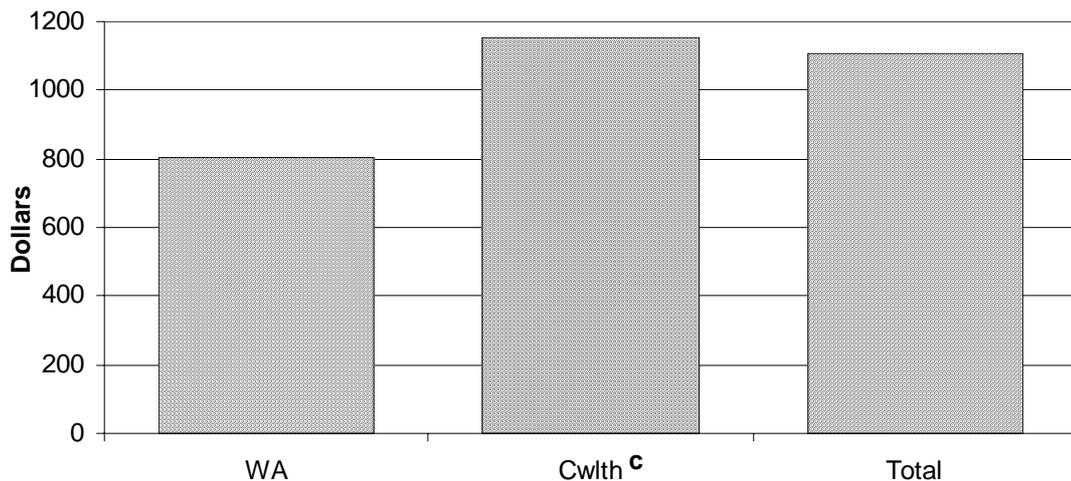
The establishment of the Federal Magistrates Service has implications for the number of lodgments and expenditure associated with the Family Court of Australia. The intention is for the Federal Magistrates Service to take on some of the workload previously managed by the Federal Court and Family Court of Australia.

In 2000-01, for the two family court services, expenditure less in-house revenue per lodgment was \$805 for the Family Court of WA and \$1156 for the Family Court of Australia (figure 9.17).

The data for the Family Court of Australia exclude a preliminary estimate of the 'free' allocations of the Family Court's resources to the Federal Magistrates

Service. As well, the introduction of the Federal Magistrates Service has implications for comparisons between the family courts of Australia and WA (figure 9.17). New South Wales, Victoria, Queensland, SA, Tasmania, the ACT and the NT do not operate in this court jurisdiction.

Figure 9.17 **Expenditure less in-house revenue per lodgment, family courts, 2000-01^{a, b}**



^a In-house revenue includes revenue earned by in-house providers of library, court reporting and civil bailiff services to external purchasers. ^b Expenditure data were not provided by the Federal Magistrates Service. ^c Data for the Family Court of Australia excludes a preliminary estimate of the 'free' allocation of the Family Court's resources to the Federal Magistrates Service. The introduction of the Federal Magistrates Service has expenditure and lodgment implications for the Family Court of Australia. This will also have an impact on any comparisons with the WA Family Court.

Source: table 9A.28.

Change in real expenditure less in-house revenue per lodgment, over the last year

Nationally, over the last year, real expenditure less in-house revenue per criminal lodgment decreased for the total magistrates' court (including children's and electronic courts) and district/county courts (by 11.2 per cent and 1.3 per cent respectively). Expenditure less in-house revenue per criminal lodgment rose for the supreme courts by 6.8 per cent between 1999-2000 and 2000-01 (table 9.13).

Nationally, over the last year, real expenditure less in-house revenue per civil lodgment for total magistrates' courts (including children's courts) increased by 4.4 per cent. Real expenditure less in-house revenue per civil lodgment fell for district/county courts (by 19.7 per cent) and the supreme/Federal courts (by 1.0 per cent) (table 9.13).

Tables 9A.27 and 9A.28 contain data on the real expenditure less in-house revenue per criminal and civil lodgment (excluding payroll tax) for each court level and jurisdiction from 1998-99 to 2000-01.

Table 9.13 Change in real expenditure less in-house revenue per lodgment, 1999-2000 to 2000-01 (per cent)^{a, b}

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Cwlth	Total
Criminal courts										
Magistrates' (total) ^{c, d}	5.2	-13.2	-7.4	-66.4	13.0	-18.6	115.0	38.1	..	-11.2
District/country	14.6	-12.7	-2.4	-17.1	-21.5	..	..	..	..	-1.3
Supreme	7.3	-21.0	1.7	8.2	41.5	54.5	10.2	-8.1	..	6.8
Civil courts										
Magistrates' (total) ^e	8.0	18.4	3.9	-5.4	-7.1	0.6	3.3	-25.6	..	4.4
District/country	-22.2	-31.8	-37.3	66.1	-5.7	..	..	..	..	-19.7
Supreme/Federal ^f	-9.9	-15.8	29.5	-27.2	-17.3	-14.0	28.0	25.4	20.3	-1.0
Family courts ^f	..	..	..	12.0	..	..	..	..	20.2	18.4

^a In-house revenue includes revenue earned by in-house providers of library, court reporting and civil bailiff services to external purchasers. ^b Includes payroll tax payments for NSW, Victoria, Queensland, SA, Tasmania and the NT for all years to maintain comparability over time. ^c Magistrates' (total) includes primary and minor lodgments in the magistrates' and children's courts, as well as electronic courts in Victoria, Queensland, WA and SA. ^d For WA, the large fall in expenditure per lodgment can partly be attributed to the inclusion of 186 364 electronic court lodgments that were not previously included. The increase in the ACT reflects newly accounted for liabilities (formulated for the first time under the accrual accounting methodology) and reflects increased salary liabilities of the magistrates' court. ^e For 2000-01, the Victorian civil result includes civil children's expenditure, but excludes civil children's court lodgments as these were not provided. This will make the change over the year appear greater than what it actually is. ^f The introduction of the Federal Magistrates Service has implications for the time series for the Family Court of Australia and the Federal Court. Data for the Family Court of Australia exclude a preliminary estimate of the 'free' allocation of its resources to the Federal Magistrates Service. Data for the Federal Court of Australia include the cost of resources provided free of charge to the Federal Magistrates Service. The inclusion of these costs might have resulted in the percentage increase being overstated. .. Not applicable.

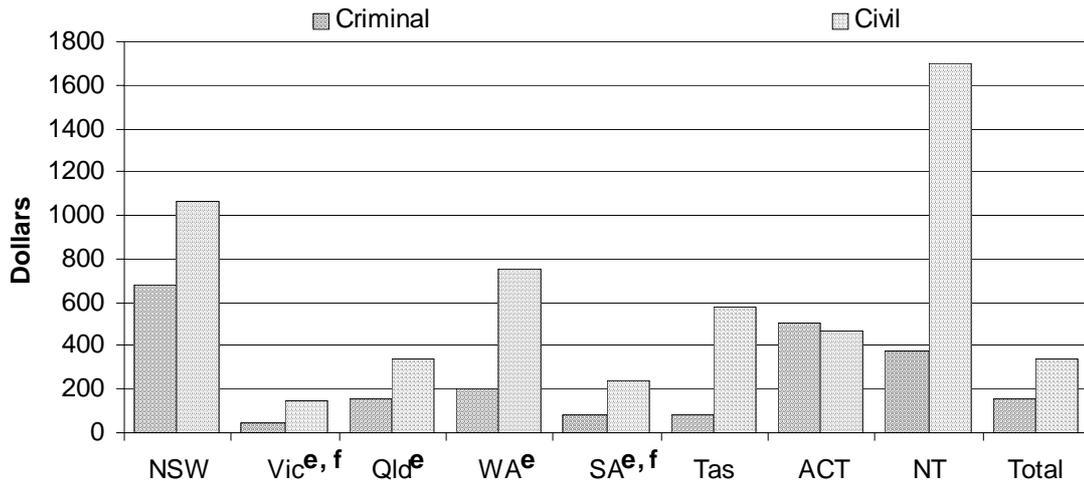
Source: table 9A.30.

Expenditure less in-house revenue per finalisation for total magistrates' courts (including magistrates', children's and electronic courts)

Nationally, expenditure less-in house revenue per criminal finalisation for total magistrates' courts (including children's and relevant electronic courts) was \$156. Across jurisdictions, it was highest in NSW (\$679) and lowest in Victoria (\$49) (figure 9.18). However, comparisons of this nature should be viewed with caution as a number of jurisdictions (including NSW) do not operate electronic courts. Consideration needs to be given, therefore, to the efficiency results that relate to expenditure less in-house revenue for magistrates' courts only (figure 9.19), which exclude the impact of electronic courts.

Nationally, expenditure less-in house revenue per civil finalisation for total magistrates' courts (including children's courts) was \$336. Across jurisdictions, it was highest in the NT (\$1698) and lowest in Victoria (\$143) (figure 9.18). The Commonwealth does not operate in this court jurisdiction.

Figure 9.18 Expenditure less in-house revenue per finalisation, total magistrates' courts, 2000-01^{a, b, c, d}



^a In-house revenue includes revenue earned by in-house providers of library, court reporting and civil bailiff services to external purchasers. ^b Finalisations are derived from timeliness data which may not reflect the total matters disposed by the courts in the reported period (as timeliness data may not allow for accurate extraction of the disposal of all matters). ^c Excludes payroll tax for NSW, Victoria, Queensland, SA, Tasmania and the NT. ^d The Commonwealth does not operate in this court jurisdiction. ^e Criminal finalisations include electronic court finalisations, which will impact on comparisons with other jurisdictions. ^f Victorian and SA civil result includes civil children's expenditure, but excludes civil children's court finalisations as these were not provided.

Sources: tables 9A.35 and 9A.36.

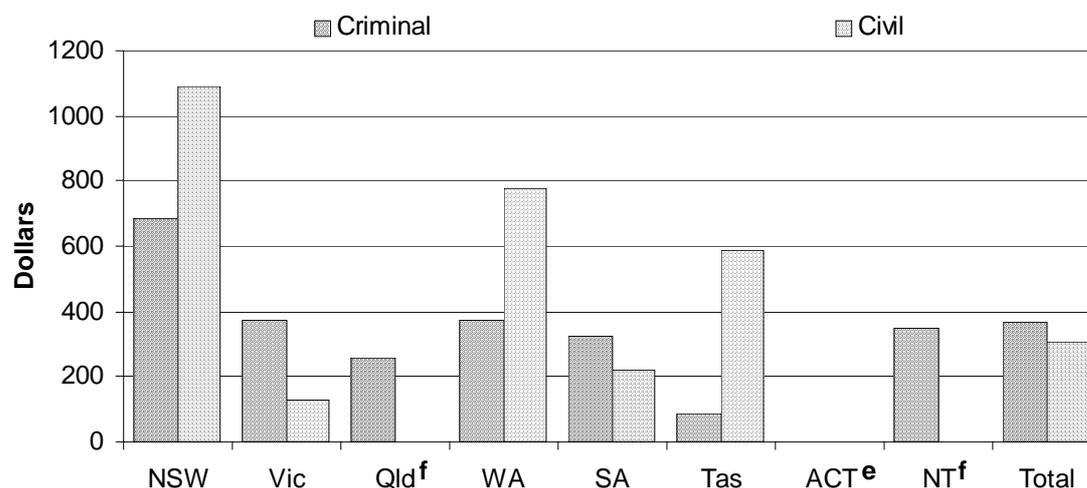
Expenditure less in-house revenue per finalisation for magistrates' courts only (excluding electronic and children's courts)

The ACT could not separate its criminal or civil magistrates' court data from its children's court data, and Queensland and the NT could not separate their civil magistrates' court data from their children's court data. Where relevant, the national figure excludes these jurisdictions. In 2000-01, expenditure less in-house revenue per criminal finalisation for magistrates' courts only (excluding electronic and children's courts) was \$369 nationally. Across jurisdictions, it was highest in NSW (\$688) and lowest in Tasmania (\$85) (figure 9.19).

Nationally, expenditure less in-house revenue per civil finalisation for the magistrates' courts only (excluding children's courts) was \$306. Across

jurisdictions, it was highest in NSW (\$1088) and lowest in Victoria (\$128) (figure 9.19). The Commonwealth does not operate in this court jurisdiction.

Figure 9.19 Expenditure less in-house revenue per finalisation, magistrates' courts only, 2000-01^{a, b, c, d}



^a In-house revenue includes revenue earned by in-house providers of library, court reporting and civil bailiff services to external purchasers. ^b Finalisations are derived from timeliness data which may not reflect the total matters disposed by the courts in the reported period (as timeliness data may not allow for accurate extraction of the disposal of all matters). ^c Excludes payroll tax for NSW, Victoria, Queensland, SA, Tasmania and the NT. ^d The Commonwealth does not operate in this court jurisdiction. ^e The ACT could not separate their criminal or civil magistrates' courts only data. ^f Queensland and the NT could not separate their civil magistrates' court data from their children's court data.

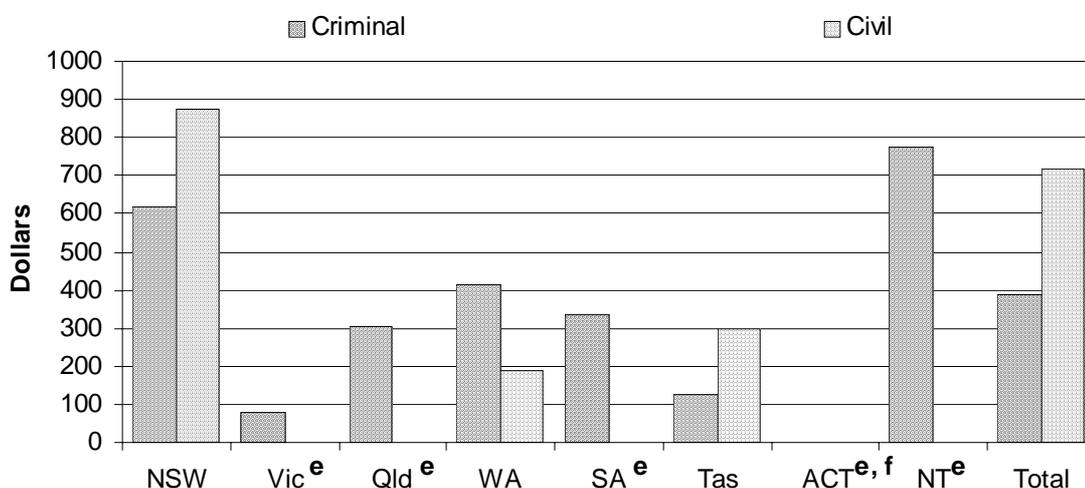
Sources: tables 9A.35 and 9A.36.

Expenditure less in-house revenue per finalisation for children's courts

The ACT could not separate its criminal or civil children's court data from its magistrates' court data, and Queensland, Victoria, SA and the NT could not separate their civil children's court data from their magistrates' court data. Where relevant, the national figure excludes these jurisdictions. In 2000-01, expenditure less in-house revenue per criminal finalisation for children's courts was \$387 nationally. Across jurisdictions, it was highest in the NT (\$772) and lowest in Victoria (\$81) (figure 9.20).

Nationally, expenditure less in-house revenue per civil finalisation for the children's courts was \$716. Across jurisdictions, it was highest in NSW (\$873) and lowest in WA (\$189) (figure 9.20). The Commonwealth does not operate in this court jurisdiction.

Figure 9.20 Expenditure less in-house revenue per finalisation, children's courts, 2000-01^{a, b, c, d}



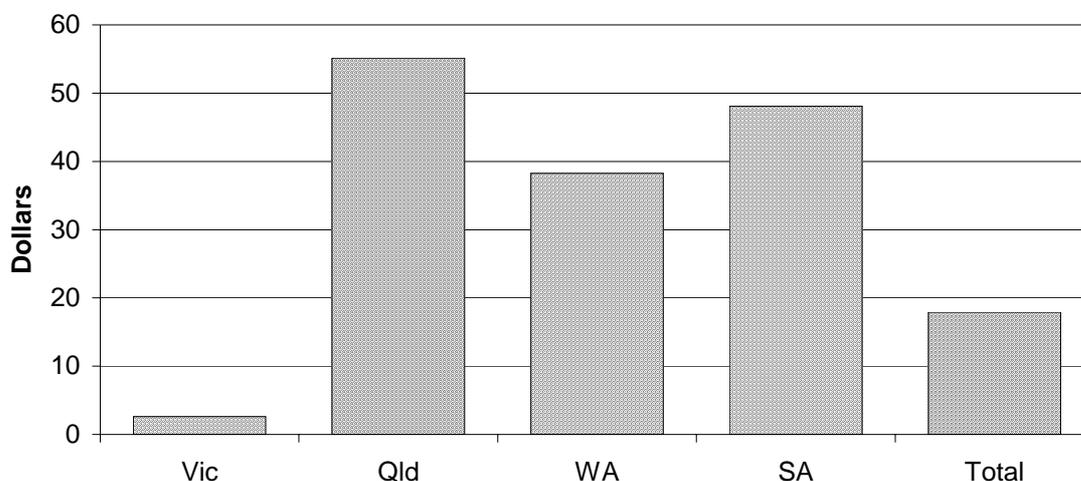
^a In-house revenue includes revenue earned by in-house providers of library, court reporting and civil bailiff services to external purchasers. ^b Finalisations are derived from timeliness data which may not reflect the total matters disposed by the courts in the reported period (as timeliness data may not allow for accurate extraction of the disposal of all matters). ^c Excludes payroll tax for NSW, Victoria, Queensland, SA, Tasmania and the NT. ^d The Commonwealth does not operate in this court jurisdiction. ^e Children's court civil finalisation data were not provided. ^f Children's criminal court finalisations data were not provided.

Sources: tables 9A.35 and 9A.36.

Expenditure less in-house revenue per finalisation for electronic courts

In 2000-01, expenditure less in-house revenue per finalisation for electronic courts was \$18 nationally. Across jurisdictions, it was highest in Queensland (\$55) and lowest in Victoria (\$3) (figure 9.21). New South Wales, Tasmania, the ACT, the NT and the Commonwealth do not operate in this court jurisdiction.

Figure 9.21 **Expenditure less in-house revenue per finalisation, electronic courts, 2000-01^{a, b, c, d}**



^a In-house revenue includes revenue earned by in-house providers of library, court reporting and civil bailiff services to external purchasers. ^b Finalisations are derived from timeliness data which may not reflect the total matters disposed by the courts in the reported period (as timeliness data may not allow for accurate extraction of the disposal of all matters). ^c Excludes payroll tax for Victoria, Queensland and SA. ^d Electronic courts (infringement and expiated offence processing systems that have the status of a court) only operate in Victoria, Queensland, WA and SA.

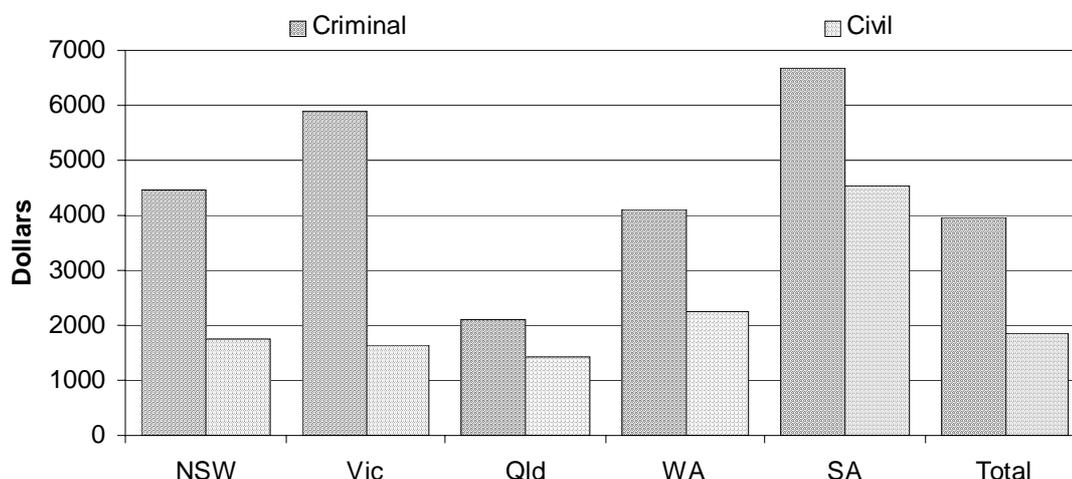
Source: table 9A.35.

Expenditure less in-house revenue per finalisation for district/county courts

Nationally, in 2000-01, expenditure less in-house revenue per criminal finalisation for district/county courts was \$3952. Across jurisdictions, it was highest in SA (\$6664) and lowest in Queensland (\$2103) (figure 9.22).

Nationally, expenditure less in-house revenue per civil finalisation for district/county courts was \$1847. Across jurisdictions, it was again highest in SA (\$4524) and lowest in Queensland (\$1428) (figure 9.22). Tasmania, the ACT, the NT and the Commonwealth do not operate in this court jurisdiction.

Figure 9.22 Expenditure less in-house revenue per finalisation, district/county courts, 2000-01^{a, b, c, d}



^a In-house revenue includes revenue earned by in-house providers of library, court reporting and civil bailiff services to external purchasers. ^b Finalisations are derived from timeliness data which may not reflect the total matters disposed by the courts in the reported period (as timeliness data may not allow for accurate extraction of the disposal of all matters). ^c Excludes payroll tax for NSW, Victoria, Queensland and SA. ^d District/county courts do not exist in Tasmania, the ACT, the NT or the Commonwealth.

Sources: tables 9A.35 and 9A.36.

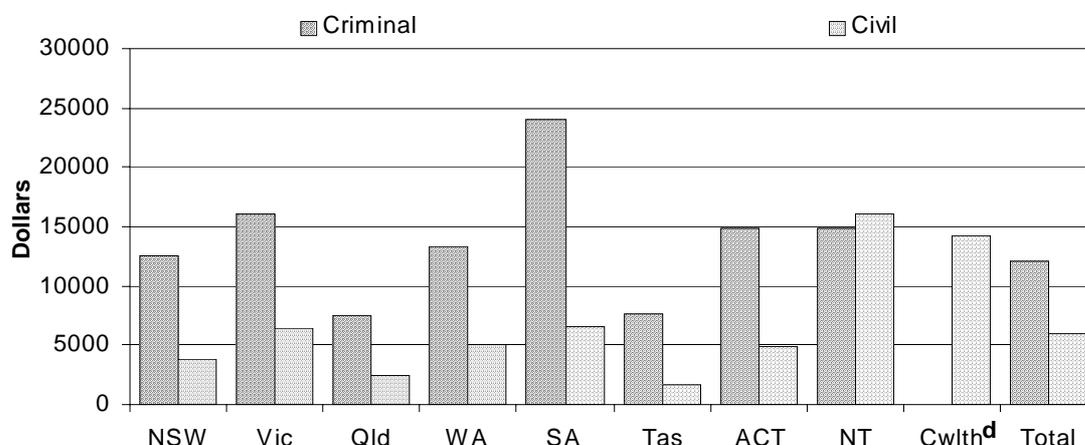
Expenditure less in-house revenue per finalisation for the supreme courts and the Federal Court

Nationally, expenditure less in-house revenue per criminal finalisation in the supreme courts was \$12 034. Across jurisdictions, it was highest in SA (\$24 029) and lowest in Queensland (\$7458) (figure 9.23). The Federal Court does not operate in the criminal jurisdiction.

Nationally, expenditure less in-house revenue per civil finalisation was \$5935. Across jurisdictions, it was highest in the NT (\$16 049) and lowest in Tasmania (\$1637) (figure 9.23).

The Federal Court expenditure less in-house revenue per finalisation was \$14 293 (figure 9.23). Data for the Federal Court includes the cost of resources provided free of charge to the Federal Magistrates Service.

Figure 9.23 Expenditure less in-house revenue per finalisation, supreme courts and Federal Court, 2000-01^{a, b, c}



^a In-house revenue includes revenue earned by in-house providers of library, court reporting and civil bailiff services to external purchasers. ^b Finalisations are derived from timeliness data which may not reflect the total matters disposed by the courts in the reported period (as timeliness data may not allow for accurate extraction of the disposal of all matters). ^c Excludes payroll tax for NSW, Victoria, Queensland, SA, Tasmania and the NT. ^d Data for the Federal Court includes the cost of resources provided free of charge to the Federal Magistrates Service. As well, the introduction of the Federal Magistrates Service has expenditure and lodgment implications for the Federal Court. The Federal Court does not operate in the criminal jurisdiction.

Sources: tables 9A.35 and 9A.36.

9.5 Future directions in performance reporting

Improving data quality

Differences in court jurisdictions and in the allocation of cases between courts across States and Territories affect the comparability of efficiency and effectiveness data. The different methods undertaken to collect the data can also have an impact on the data consistency and quality.

To address some of these disparities, the Commonwealth, States and Territories have all recently signed a Memorandum of Understanding with the ABS to improve the quality of statistical data within the court administration data collection, and to improve the standard of statistical comparability across jurisdictions. The ABS, as part of this process, will continue to provide advice and contribute to the development and refinement of the *Court Administration Data Manual* (SCRSSP 2001), including the ongoing development of civil and criminal data standards (for example, definitions, classifications, coding, and recording and reporting procedures).

Stage one of this project will address quality assurance issues associated with court lodgments across all court levels. Any changes or recommendations arising from this work are expected to be able to be implemented in time for the 2003 Report.

In recognition of the need to continue to refine the data collection and improve consistency across court jurisdictions, a Court Practitioners' Group has been established. It is anticipated that this group will also assist in recommending improvements to definitions and technical issues associated with the data collection process.

Court performance indicator framework

The Court Administration Working Group is proposing the development of a new performance indicator framework for possible inclusion in the 2003 Report. This work is still in its initial stages.

9.6 Jurisdictions' comments

This section provides comments from each jurisdiction on the services covered in this chapter and attachment 9A on the CD-ROM. Appendix A contains detailed statistics and short profiles on each State and Territory, which may assist in interpreting the performance indicators presented in this chapter. The information covers various aspects such as age profile, geographic distribution of the population, income levels, education levels, tenure of dwellings and cultural heritage (such as aboriginality and ethnic status).

Commonwealth Government comments

Federal Court

“ The Federal Court of Australia is a superior Court of record and a court of law and equity. It sits in all capital cities and elsewhere in Australia from time to time. During the year the Court continued to achieve its objective of promptly, courteously and effectively deciding disputes according to law so as to fulfil its role as a court exercising the judicial power of the Commonwealth under the Constitution.

Since the last *Report on Government Services*, the introduction of the Federal Magistrates Service has impacted on the Federal Court in two ways. Firstly, simple and quick cases (such as bankruptcy) can now be commenced in the Federal Magistrates Service. As a consequence the number of less complex applications lodged with the Court has dropped. Secondly, due to the reduction in applications being lodged with the Court, fees received are lower than in previous years.

It is important to be note that the work undertaken by the Federal Magistrates Service, in areas of concurrent jurisdiction, continues to be predominantly performed by Federal Court staff. The cost of these resources are provided free of charge to the Federal Magistrates Service and have been included in the Federal Court's costs shown in this chapter. This means that the results shown for the Federal Court throughout this chapter and associated appendices are overstating the Court's actual results.

Finalisation of lodgments within the 85 per cent benchmark target developed by the Court continues to show improvement from 85.1 per cent in 1996-97, 87.0 per cent in 1997-98, 90.5 per cent in 1998-99 to 90.9 per cent in 1999-2000 to 90.9 per cent in 2000-01. ”

New South Wales Government comments

“

A significant focus for NSW courts this year was the introduction of key performance indicators. Courts and tribunals now apply time standards and report on age of pending caseload and backlog against their time standards.

The Department expanded its electronic services. E-lodgements were successfully trialed in the Land and Environment Court, enabling online lodgement and payment of fees for court matters. Internet, bulletin board and tele-conferencing services for routine call-overs were also introduced in that Court. The District Court uses tele-conferencing for all directions hearings for matters outside Sydney and Parramatta in the Property Relations List. Through *CaseLaw NSW*, 4.3 million daily court lists were downloaded from *LawLink NSW*, servicing over 4000 subscribers. Video conferencing is now available in 62 court locations for taking evidence from vulnerable witnesses. In the District Court, 16 courtrooms were networked with remote video and audio recording equipment, allowing a single operator to monitor two court room proceedings remotely. Under the Justice Agencies Data Exchange (JADE) project, 56 of our Local Courts, representing about 80 per cent of finalisations, now electronically send court outcomes to NSW Police. Voice recognition software for judges and magistrates enables direct electronic dictation of notes, judgments and orders.

Other initiatives undertaken by courts include:

- the Supreme Court introduced time standards in all areas, except the civil caseload, and now reports against its time standards. The Supreme Court and District Court achieved a significant reduction in delay in 2000 and 2001, with median delay for criminal trial cases below 12 months for the first time in ten years. Contributing factors include the success of the centralised committals scheme (in the District Court), improved listing procedures and the target allocation of resources;
- a Flexible Service Delivery program, designed to improve service and responsiveness to clients with an intellectual or physical disability, was successfully trialed and State-wide roll-out commenced in June 2001; and
- Local Courts expanded its services to Indigenous people through its Aboriginal Client Service Specialists.

”

Victorian Government comments

“ The Victorian Courts continued their solid performance in 2000-2001 delivering high quality and timely court services. A range of reforms have focused on case management, legislative improvements and court infrastructure. Major achievements this year include:

- The Supreme Court has established an arbitration and mediation centre, conducted under the auspices of the Institute of Arbitrators and Mediators, to facilitate alternative dispute resolution at the earliest possible stage in civil proceedings.
- The Court of Appeal, with the cooperation of the Legal Aid Commission, introduced measures that have significantly ameliorated issues concerning unrepresented appellants.
- The County Court comprehensively reviewed the civil practice notes which culminated in the publication of two consolidated practice notes in April 2001.
- The Magistrates' Court has commenced a business process re-engineering process to review the operations of the court and identify improvement opportunities to processes and work.
- The Magistrates' Court undertook a range of initiatives to build effective links with Indigenous communities and to create a more culturally-sensitive system of justice for indigenous Victorians. These initiatives included the appointment of Aboriginal bail justices and participation in the Kick Start Program for youth.
- The Judicial College of Victoria is being established to enhance the independence, professionalism, stature and performance of the Judiciary. The College will assist in the professional development of judicial officers and provide continuing education and training for judicial officers.
- A number of legislative reforms have been introduced to improve the effectiveness and flexibility of the criminal justice system. These reforms include amendments to the committal process and changes to the jury system to make it more representative of the community.
- A new court complex will be developed in Morwell. In addition, the Moe Magistrates' Court will also be upgraded as part of this project.

A number of major initiatives are being implemented during 2001/02:

- The courts are developing a strategic directions framework that will culminate in the publication of an overarching Justice Statement. The Justice Statement will provide the blueprint for the future development of the Justice System.
 - Two additional County Court judges have been appointed to assist with the implementation of significant case management reforms in the criminal jurisdiction introduced by the Court in 2000/01.
- ”

Queensland Government comments

“

Queensland courts' performance in 2000-2001 maintained the high standards of effectiveness and efficiency demonstrated over the period since the first *Report on Government Services* in 1995. Of particular note is the cost effectiveness of all courts. In the criminal jurisdiction the Supreme and District Courts achieved the lowest cost per primary lodgment of any such court in Australia, with Magistrates Courts among the most efficient in this jurisdiction.

The introduction of the computerised criminal case management and financial system known as the Queensland Wide Interlinked Courts system (QWIC) during the year, was successful, despite the usual teething problems associated with such new systems.

Several tables in the chapter indicate that some of Queensland's data were not available at the time they were compiled. This has been rectified and in the interests of completeness the data are shown below.

Table 9.2. *Magistrates Court lodgments: 93 099, Children's Court lodgments: 4 449.*

Table 9.4. *Minor court lodgments: 15%.*

Table 9A.4 (attachments). *Supreme Court hearings: 474.*

Table 9.5. *Magistrates Court criminal finalisations (total): 357 618, Magistrates Court: 170 266, Children's Court: 12 172, Electronic Court: 175 180, All criminal courts: 170 266, Magistrates Court civil finalisations: 38 341.*

”

Western Australian Government comments

“ Western Australian courts have a commitment to implement strategic, process and structural reforms to improve community access and equity to justice in more effective and efficient ways. Major achievements in the 2000/01 year include:

- The commissioning of three new justice complexes, which incorporate state of the art facilities for stakeholders and customers. Each of the complexes has facilities to hold jury trials, and incorporate offices for Community Based Services operations and other support services.
- Continued development of the Integrated Courts Management System (ICMS), an IT system that will replace 14 existing case management systems in the State's courts, and provide for interactive capability with other justice agencies and e-business capacity.

Key initiatives for the next year include:

- Develop and implement plans for introduction of the 447 WA Law Reform Commission recommendations arising from the 1999 review of the State's criminal and civil justice system.
- Review fee structures and develop a cost recovery plan for presentation to the Government.
- Implement the first phase of the Integrated Courts Management System (ICMS).

The following comments are made in respect of this report:

- The increase in overall expenditure for court administration noted in this report is predominantly due to the implementation of a dedicated court security service. The new security service replaces a combination of arrangements that variously utilised police personnel, private security guards, prison staff and bailiffs as required across the State. The new service, which was let by tender, provides for “in-court” security and court custody services in to be delivered to all metropolitan and seven regional courts under contract by a private contractor.
 - As has been noted throughout the report, comparisons and analysis between the Family Court of Western Australia and the Family Court of Australia should be undertaken with caution for this reporting period. This comes about as a result of formation of the Federal Magistrates Courts jurisdiction and the subsequent transfer of specific types of work from the Family Court of Australia to that jurisdiction. No similar transfer of work occurred between the Family Court of Western Australia and the Federal Magistrates Court in this State. Note that the same level of caution should be exercised when comparing/analysing financial data.
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South Australian Government comments

“ The Courts Administration Authority implemented a number of initiatives during the year to improve the efficiency and effectiveness of services.

The Courts Consulting the Community initiative was undertaken in late 2000. The initiative included a conference at which the courts of South Australia gave representatives of the community the opportunity to express their views about matters affecting community confidence in the courts. About 100 people drawn from a wide range of interest groups attended the two-day conference. Strategies endorsed by the State Courts Administration Council have now been put in place to give effect to the recommendations from the Conference.

During the year an electronic lodgment scheme was launched in the Magistrates Court civil jurisdiction to facilitate easy lodgment of minor civil claims. Also in the Magistrates Court the Aboriginal Court Day was extended to Murray Bridge to meet the needs of the local Aboriginal community. Two Aboriginal Justice Officers were appointed to meet the needs of the Port Augusta area.

Additional security measures were put in place in city, metropolitan and some country courts to improve the safety of clients and staff. Information services expenditure includes the cost of the replacement of the CAA's ageing PC network. The full year impact of the new fines enforcement system was felt during the year with a substantial increase in amount of fines collected.

In relation to efficiency indicators changes in the number of lodgments continue to be a significant factor in any increase or decrease in cost per lodgement. Changes in performance indicators should be interpreted with care as results continue to vary due to statistical or reporting variations associated with the data collection exercise rather than as evidence of change in workload, activity or expenditure. The cost of the Youth Court Family Conference and Care and Protection teams is included for the first time this year.

Planning for the future includes:

- Expansion of the Aboriginal Court Day to Port Augusta;
 - Expansion of the Court Diversion Program;
 - Greater use of the Internet and video conferencing for conduct of routine business.
- ”

Tasmanian Government comments

“ Tasmania will embark on an ambitious information technology project in 2002 to deliver an integrated criminal justice information technology system. Called *CRIMES* this system will enable information to be shared by Tasmania Police, the Magistrates Court and Supreme Court. It will provide Tasmania with the ability to track the progress of offenders from date of offence to date of sentence. It is envisaged that further enhancements will be undertaken to provide outcome and sentencing data directly to relevant agencies such as prisons, probation services and licensing agencies.

The development of *CRIMES* will also open up new opportunities for the collection and analysis of statistics about both offenders and the criminal justice system. This will be reflected in future Reports. It will also provide Tasmania with its first opportunity to provide state-wide criminal data in the Magistrates Court. To date all Magistrates Court criminal data is estimated based on a 50 per cent sample size provided by the southern region.

The collection of data in civil areas continues to be limited by the lack of appropriate case management systems in both court levels. Whilst lodgment and finalisation data are readily available from existing systems, the more complex data sets such as hearings and reasons for adjournments cannot be collected. The courts will continue to work towards an appropriate solution to these issues.

Tasmanian courts are yet to adopt timeliness standards. This issue will be canvassed during 2001 - 2002.

Both court levels have again demonstrated during 2000 - 2001 that they provide accessible and efficient mechanisms for the resolution and adjudication of disputes. The statistics for cost per lodgment, time from disposal to finalisation and number of lodgments present a picture of well used, cost effective and efficient courts.

Tasmania continues to support the development of a new performance indicator framework for court administration. Whilst the information presented in this Report allows comparisons to be made between jurisdictions, the enormous differences between jurisdictions can undermine the usefulness of those comparisons. Further, critical areas of court activity such as diversionary strategies and mediation, are not reported on under the present framework. Tasmania welcomes the opportunity to work with the Court Administrators' Working Group, the Productivity Commission and Australian Bureau of Statistics towards a new performance indicator framework.”

Australian Capital Territory Government comments

“ During 2000-01 the following key areas were identified as and remain the focus of attention for the newly-introduced combined Courts Administration:

- Provide improved and/or upgraded Court facilities to the Judiciary, Court staff and Court users;
- Provide a harmonious and efficient joint administrative framework – wherein judicial officers, management and staff contribute to the performance and future planning and operations of the Court;
- Consultation and contact with the legal profession, other Agencies and justice systems locally, nationally and internationally to network and promote ideas for future improvements that will enhance the ACT Courts performance;
- Develop innovation in the Courts to increase efficiencies and disseminate information; and
- Increasing the Community’s access to, and understanding of, the operations of the ACT Law Courts and judicial system.

Legislative changes within the last two years are now being reflected in both Court’s data. The Supreme Court ceased to exercise its Criminal Injuries Compensation jurisdiction; the impact of that change is now reflected in a decrease in overall lodgements. Listings have decreased as a result of the introduction of Notices for Non Party Production. The Supreme Court’s web site has been expanded to include full transcripts of Judges’ sentencing remarks.

A new criminal listing system has been introduced in the Supreme Court which has reduced the number of trials waiting for dates. The number of pleas following committal have increased concomitantly. This system streamlines the process between committal and trial and involves the Supreme Court at an early date after committal. It is expected that there will be more certainty of a trial commencing on a fixed date and because of early disclosure of the crown case the length of trials will be shortened.

Magistrates Court salary liabilities were, for the first time, reported under accrual accounting methodology therefore the large increase in expenditure less in-house revenue is an aberration and should be treated with extreme caution.”

Northern Territory Government comments

“ The Office of Courts Administration (OCA) implemented a number of strategic initiatives during the year, which improved the efficiency and effectiveness of administrative services:

- Establishment of the Fines and Recovery Unit. This unit will, in effect be a ‘one-stop-shop’ for all aspects of the fine recovery process, from enforcement of orders, making time to pay arrangements to receiving payments. The Integrated Justice Information System was enhanced to facilitate the case management of fines and penalties, including bar coding and various electronic options for payment.
- The development of an Information and Information Technology Strategic Plan (I&IT Strategic Plan) designed to align the business direction and requirements of OCA with the rapid developments that are taking place, through the evolution of technology to support OCA in the delivery of its products and services to stakeholders.
- The development of the Northern Territory (NT) Supreme Court web site. A feature of this site is the publication of NT Supreme Court sentencing remarks.
- Acquisition of new ‘high tech’ video-conferencing systems in the Darwin Supreme Court and Magistrates Court. This has resulted in significant savings and improvements in both audio and videoconference capabilities.
- A preliminary assessment was initiated to investigate the business and technology effort involved in the introduction of electronic lodgment.
- Exploring and investigating the web-enablement tool of Visual Age Generator to convert the existing mainframe text based screen to a user friendly Graphic User Interface, running from a browser.”

9.7 Definitions

Table 9.14 Terms

<i>Terms</i>	<i>Definition</i>
Accommodation expenditure	<p>Depreciation, actual rent or imputed rent on court owned or occupied land and buildings as well as expenditure on electricity, gas, water, telecommunications, cleaning, gardening and maintenance.</p> <p>Where used, the imputed rent is calculated using the market lease value of the floor area of all properties occupied by the court. Imputed rent equals the square metres multiplied by the market price per square metre of similar grade office space in a similar location.</p>
Adjournment rate	The ratio between the number of court requested adjournments to court hearings or trials initiated. Hearings can be adjourned more than once, so adjournment rates can be greater than 100 per cent.
Adjudicated finalisation	Where a charge is considered complete and ceases to be active in any court, even if that charge was not adjudicated (for example, a bench warrant was issued or the charges was withdrawn by prosecution).
Average expenditure per case — excluding in-house revenue	Average expenditure per criminal or civil case (see below), excluding revenue from providing library court reporting and civil bailiff services.
Average expenditure per civil case	The total cost of the administrative services provided to civil matters divided by the total number of civil files handled. Total costs include salaries, sheriff expenses, juror costs, accommodation costs, library services, information technology, departmental overheads and court operating expenses.
Average expenditure per primary criminal case	The total cost of the administrative services divided by the total number of primary criminal matters handled. Total costs include salaries, sheriff expenses, juror costs, net court reporting costs, accommodation costs, the net cost of library services, information technology, departmental overheads and court operating expenses.
Cost recovery	The level of court fees divided by the level of court expenditure.
Court fees collected	Total court income from fees charged in the civil jurisdiction. It includes filing, sitting hearing and deposition fees, and excludes transcript fees.
Court locations	A single street address of a court. Where a location or facility provides services for both criminal and civil cases, or where superior courts sit in lower court facilities on circuit, these locations are counted separately for each jurisdiction. This category includes: locations that provide registry services on a permanent basis, at which a court hearing is listed for determination before a judicial officer; locations where hearings are listed for determination before a judicial officer in a facility that does not provide full time or part time registry services; and all permanent court locations providing full time or part time registry services, at which there are no matters listed before a judicial officer.
Court reporting expenditure	Salary expenditure on in-house court reporters, non-salary expenditure of in-house court reporting agencies, and contract fees paid to court reporting agencies less any revenue recovered from transcript fees by the in-house court reporting agency.

(Continued on next page)

Table 9.14 (Continued)

<i>Terms</i>	<i>Definition</i>
Court requested adjournments	A matter initiated but adjourned for more than one working day (such as an adjournment resulting from the unexpected unavailability of a judge, court room or other case related court resource). It includes matters adjourned as not reached and excludes matters adjourned as part heard.
Electronic court	A court with the capacity to produce enforceable orders against defendants (such as fines, licence cancellation and incarceration) and to process infringements, on-the-spot fines and summary offences.
Excluded courts and tribunals	Guardianship boards, environment resources and development courts, and administrative appeals tribunals.
Finalisation	The completion of a matter so it ceases to be an item of work to be dealt with by the court. Finalisations are derived from timeliness data which may not reflect the total matters disposed by the courts in the reported period.
Geographic accessibility	The number of metropolitan locations divided by the total number of court locations, expressed as a percentage.
Hearings	Any matter listed to be heard before a judicial or quasi-judicial officer, which either progresses towards finalisation or is finalised by determination or adjudication. It excludes pre-trial conferences, arraignment, mention hearings, status conferences, mediation and counselling.
In-house revenue	Revenue or income received by the court administration branch or division for the provision of court reporting, library or civil bailiff services.
Information technology expenditure	Non-salary and salary expenditure on information technology. It excludes capital expenditure on information technology infrastructure and includes licensing costs, computer leasing costs, the cost of consumables (such as data lines, paper, disks), training fees, access fees (for example, catalogue search and Internet access) and maintenance charges for software and hardware.
Inquests and inquiries held	Court hearings to determine the cause and circumstances of deaths reported to the coroner. They include all coronial inquests and inquiries in full court hearings.
Judicial and judicial support salaries	All salary expenditure and payments in the nature of salary paid to employees of court administration. They include base salaries, the employer-contributed component of superannuation, workers' compensation (full cost inclusive of any levies, bills and legal fees), higher duty allowances, overtime, actual and accruing terminal and long service leave, fringe benefits tax, and untaxed fringe benefits and payroll tax. (Judicial officers include judges, magistrates' masters, judicial registrars and other judicial officers where they fulfil a primarily judicial function. Judicial support staff include judicial secretaries, tipstaff and associates).
Library expenditure	Non-salary and salary expenditure on court operated libraries. Non-salary expenditure includes book purchases, journal subscriptions, fees for interlibrary loans, copyright charges, news clippings service fees and photocopying. Expenditure also includes current information technology costs and court administration contributions towards the running costs of non-government operated libraries. Any costs recovered through borrowing and photocopy fees by court operated libraries are subtracted from expenditure.

(Continued on next page)

Table 9.14 (Continued)

<i>Terms</i>	<i>Definition</i>
Lodgment	The initiation or commencement of a matter before the court. The date of commencement is counted as the date of registration of a court matter.
Matters	<p><i>Coronial matters:</i> Deaths and fires reported to the coroner in each jurisdiction, including all reported deaths and fires regardless of whether the coroner held an inquest or inquiry. Coronial jurisdictions could extend to manners of death of a person who was killed; was found drowned; died a sudden death of which the cause is unknown; died under suspicious or unusual circumstances; died during or following the administration of an operation of a medical, surgical, dental, diagnostic or like nature; died in a prison remand centre or lockup; or died under circumstances that (in the opinion of the Attorney-General) require that the cause of death be more clearly ascertained.</p> <p><i>Criminal matters:</i> Matters brought to the court by a government prosecuting agency, which is generally the Director of Public Prosecutions but could also be the Attorney-General, the police, local councils and traffic camera branches.</p> <p><i>Civil:</i> Matters brought before the court by individuals or organisations against another party, such as small claims and residential tenancies, as well as matters dealt with by the appeal court jurisdiction.</p> <p><i>Excluded matters:</i> Extraordinary driver's licence applications; any application on a pending dispute; applications for bail directions or judgment; secondary processes (for example, applications for default judgments); interlocutory matters; investigation/examination summonses; firearms appeals; escort agents' licensing appeals; pastoral lands appeals; local government tribunals; police promotions appeals; applications appealing the decisions of workers' compensation review officers.</p> <p><i>Minor criminal:</i> Minor traffic matters and other infringement matters.</p> <p><i>Minor civil:</i> Undefended general civil matters and applications of an administrative nature, such as winding up applications, criminal injury compensation applications, Australian registered judgments, residential tenancy disputes, joint applications for divorce and applications for debt recovery.</p> <p><i>Primary civil:</i> Defended matters, appeals from tribunals, justices' appeals, full court appeals, magistrates' appeals, assessment of damages requiring interlocutory applications (defended or not), injunctions and declarations.</p> <p><i>Primary criminal:</i> Those criminal matters that are not minor.</p> <p><i>Probate:</i> Matters such as applications for the appointment of an executor or administrator to the estate of a deceased person.</p>
Method of finalisation	The process that leads to the completion of a criminal charge within a higher court so it ceases to be an item of work in that court.
Method of initiation	How a criminal charge is introduced to a court level.
Non-adjudicated finalisation	A judgment or decision by the court as to whether the defendant is guilty of the charge laid against him or her. For example, whether the defendant pleaded guilty or was found guilty by the court or was acquitted.

(Continued on next page)

Table 9.14 (Continued)

<i>Terms</i>	<i>Definition</i>
Non-urban area	Remote areas (defined in terms of low population density and long distances to large population centres) and rural areas (which include the remainder of non-urban statistical local areas).
Other expenditure	Expenditure on consultants, expert witnesses, mediators, interpreters, motor vehicles, court registries, first line support staff, and overheads where incurred by the court administration agency.
Party requested adjournments	Matters adjourned on the first day of a hearing for more than one day on application by either the prosecution/plaintiff or the defendant for reasons such as: <ul style="list-style-type: none"> • the unavailability of a witness; • the failure of the accused to appear; • the granting of an application for more time; or • pleading on the day.
Probate registry expenditure	Salary expenditure of the probate registrar and probate clerks, along with non-salary expenditure directly attributable to probate registries.
Real expenditure	Actual expenditure adjusted for changes in prices using the GDP(E) price deflator and expressed in terms of final year prices.
Sheriff and bailiff expenditure	Expenditure on court orderlies, court security, jury management and witness payment administration. For the civil jurisdiction, it includes expenditure (by or on behalf of the court) on bailiffs to enforce court orders. In the coronial jurisdiction, it includes expenditure on police officers permanently attached to the coroner for the purpose of assisting in coronial investigations. It excludes witness payments, fines enforcement (criminal jurisdiction) and prisoner security.
Timeliness	<p>The percentage of <i>total criminal cases</i> completed that are completed within six months; six to 12 months; 12 to 18 months; and more than 18 months after lodgment. Cases are sorted according to the time taken to finalise after lodgment.</p> <p>The percentage of <i>total civil cases</i> completed that are completed within six months; six to 12 months; 12 to 18 months; and more than 18 months after lodgment. Cases are sorted according to the time taken to finalise after lodgment.</p> <p>The percentage of <i>defended civil cases</i> completed that are completed within six months; six to 12 months; 12 to 18 months; and more than 18 months after lodgment. Cases are sorted according to the time taken to finalise the defended cases after lodgment.</p> <p>The percentage of <i>civil trial cases</i> finalised through the initiation of a trial that are completed within six months; six to 12 months; 12 to 18 months; and more than 18 months after lodgement. Cases are sorted according to the time taken to finalise after lodgment.</p>
Umbrella department expenditure	Expenditure incurred by the umbrella department (the ministry or department of justice or Attorney-General). It includes expenditure on accounting, human resources functions, training, media liaison, research, policy, property management and administration).
Urban area	State and Territory capital city statistical divisions and other urban areas (which are urban centres of 100 000 people or more).
Withdrawn	The formal withdrawal of charges by the prosecution (that is, by police, the Director of Public Prosecutions or the Attorney-General).

10 Corrective services

Corrective services meet the overall objectives of the criminal justice system outlined in the Justice preface by providing a safe, secure and humane adult correctional system that incorporates the elements of protection, rehabilitation and reparation to the community.

In this Report, corrective services include prison custody (including periodic detention) and a range of community correctional orders and programs for adult offenders. Both public and privately operated facilities are included. The scope of this chapter does not, however, extend to:

- juvenile offenders (who are covered in the Community services preface);
- people held in institutions to receive psychiatric care (who are generally the responsibility of health departments);
- prisoners held in police facilities or custody (who are covered in the police services chapter); and
- people held in facilities such as immigration and military detention centres.

A profile of the corrective services sector is provided in section 10.1. Policy developments and how these may affect the collection, reporting and interpretation of data are briefly discussed in section 10.2. The framework of performance indicators is outlined in section 10.3 and the data collected are discussed in section 10.4. Future developments in performance reporting are broadly discussed in section 10.5. The chapter concludes with jurisdictions' comments in section 10.6 and definitions in section 10.7.

Supporting tables

Supporting tables for chapter 10 are provided on the CD-ROM enclosed with the Report. The files are provided in *Microsoft Excel 97* format as `\Publications\Reports\2002\Attach10A.xls` and in Adobe PDF format as `\Publications\Reports\2002\Attach10A.pdf`.

Supporting tables are identified in references throughout this chapter by an 'A' suffix (for example, table 10A.3 is table 3 in the electronic files). They may be subject to revision. The most up-to-date versions of these files can be found on the

Review's web page (www.pc.gov.au/gsp/). Users without Internet access can contact the Secretariat to obtain up-to-date versions of these tables (see the details inside the front cover of the Report).

10.1 Profile of corrective services

Service overview

As discussed in the Justice preface, the operation of corrective services is heavily influenced by, and in turn influences, the other two arms of the criminal justice system — police and courts. Corrective service functions in some jurisdictions include responsibilities that belong to different justice sector agencies in other jurisdictions — for example, prisoner escorts, the management of prisoners held in court cells, the management of prisoners in police cells, community correction supervision of juvenile offenders, juvenile detention and the prosecution of community correction order breaches.

Roles and responsibilities

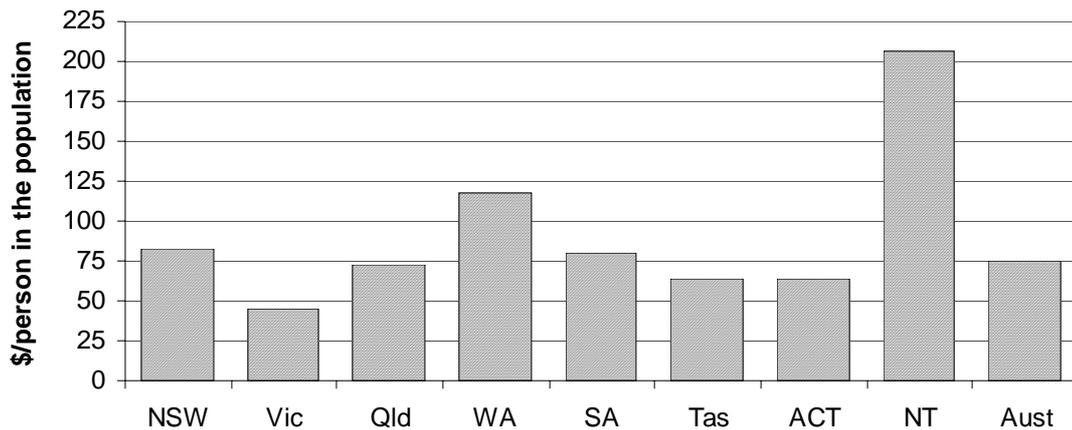
Corrective services are the responsibility of State and Territory governments which deliver services directly, purchase them through contractual arrangements, or operate a combination of both arrangements. All jurisdictions except the ACT maintained both open and secure custody prison facilities during the reporting period. The ACT maintained one remand prison and one periodic detention facility, with prisoners sentenced in the ACT being held in NSW prisons under contractual arrangements between the two jurisdictions. Four jurisdictions (NSW, Victoria, Queensland and SA) operated private prisons throughout 2000-01. A fifth jurisdiction (WA) commenced operation of its first private prison in early 2001. New South Wales and the ACT provided for periodic detention of prisoners — for example, weekend detention in prison, whereby prisoners are able to return home and maintain work commitments during the week.

Funding

Nationally, systemwide recurrent expenditure on corrective services (net of revenue derived from own sources) totalled \$1.5 billion in 2000-01 — \$1.3 billion (86.6 per cent) for prisons, \$148.6 million (10.2 per cent) for community

corrections and \$46.9 million (3.2 per cent) for transport and escort services¹. Recurrent expenditure per person ranged from \$206.7 in the NT to \$44.5 in Victoria. Nationally, recurrent expenditure was \$75.1 per person (figure 10.1).

Figure 10.1 Total recurrent expenditure per person, 2000-01^a



^a Total recurrent expenditure refers to the total expenditure for all corrections (prisons, transport and escort services, and community corrections) net of recurrent receipts (own source revenues) but including payroll tax, capital asset charges, and other associated expenses for jurisdictions reporting on these figures in 2000-01. Per person cost is calculated using total population (all ages) figures for 2000-01 (table A.2).

Source: table 10A.6.

Size and scope of sector

In 2000-01, there were 96 prisons (including 12 privately operated prisons, of which five are community custody centres), 11 periodic detention centres (located in NSW and the ACT) and twelve 24-hour court cell facilities under the responsibility of corrective services in NSW — totalling 119 facilities throughout Australia (table 10A.2).

On average, 21 138 people per day were held in Australian prisons during the year (excluding periodic detainees) — an increase of 1.9 per cent over average daily numbers in the previous year. Additionally, 1178 people on average were serving periodic detention orders in NSW and the ACT in 2000-01 — a decline of 11.7 per cent from 1999-2000. Excluding periodic detainees, 29.5 per cent of prisoners were held in open prisons (facilities containing prisoners classified as low security) in 2000-01 and 70.5 per cent were held in secure facilities. A daily average

¹ Transport and escort service expenditure is reported separately from overall prison expenditure by NSW, Victoria, WA, and the ACT.

of 3265 prisoners (or 15.4 per cent of the total Australian prisoner population, excluding periodic detainees) were held in privately operated facilities during the year. In 2000-01, the proportion of prisoners accommodated in private prisons in those jurisdictions operating private prisons ranged from 41.7 per cent in Victoria to under 0.2 per cent in WA, where the first private prison commenced taking prisoners in May 2001 (table 10A.1).

Nationally, the daily average number of prisoners (excluding periodic detainees) in 2000-01, comprised 19 787 males and 1351 females — 93.6 per cent and 6.4 per cent of the prison population respectively. The daily average number of Indigenous prisoners was 4091 — 19.4 per cent of prisoners nationally (table 10A.1).

The rate of imprisonment is the number of prisoners (excluding periodic detainees) per 100 000 of the general population aged 17 years and over in those jurisdictions where persons are remanded or sentenced to adult custody at 17 years of age (Victoria and Queensland) or per 100 000 of the general population aged 18 and over in all other jurisdictions, where the age for adult custody is 18 years for the reporting period. In previous reports up to the 1999 Report, imprisonment rates were calculated against a general population aged 17 years and over for every jurisdiction. Thus, rates prior to 1998-99 are not directly comparable with data published in this Report.

The national rate of imprisonment for all prisoners was 144.2 per 100 000 Australian adults in 2000-01. The national imprisonment rate for male prisoners was 273.6 per 100 000 adult males and 18.2 per 100 000 adult females for female prisoners. The national imprisonment rate per 100 000 Indigenous adults was 1727.4 in 2000-01 compared with a rate of 115.6 for non-Indigenous prisoners per 100 000 non-Indigenous adults (table 10A.4). The highest rate of Indigenous imprisonment per 100 000 adults was reported in WA (3018.1) and the lowest in Tasmania (456.7). The NT reported the highest non-Indigenous prisoner rate per 100 000 adults at 234.3 and the ACT reported the lowest rate at 80.0 in 2000-01 (figure 10.2).

Figure 10.2 Indigenous and non-Indigenous imprisonment rates, 2000-01^a



^a Imprisonment rates for all prisoners are based on the daily average prisoner population supplied by States and Territories, calculated against adult Indigenous and non-Indigenous population estimates (ABS figures supplied by the National Centre for Crime and Justice Statistics). Jurisdictional comparisons need to be interpreted with care, especially for those States and Territories with low Indigenous populations, where small number effects can introduce statistical variation that does not accurately represent real trends over time or consistent differences to other jurisdictions. The ACT data include prisoners held on remand in the ACT and ACT prisoners held in NSW prisons. Australian rates are calculated to exclude any double counting of ACT prisoners held in NSW prisons.

Source: table 10A.4.

In 2000-01, imprisonment rates were also calculated against the total population, regardless of age. The national per person imprisonment rate was 108.7 in 2000-01 and 109.4 in 1999-2000. The NT reported the highest per person imprisonment rate in 2000-01 at 331.7 and the ACT the lowest rate at 65.2 (table 10A.74).

All jurisdictions operate community corrections programs. Community corrections comprise a variety of non-custodial programs (listed for each jurisdiction in table 10A.17). These programs vary in the extent and nature of supervision, the conditions of the order (such as a community work component or personal development program attendance) and the restrictions on the person's freedom of movement in the community (as with home detention). There is no single objective or set of characteristics common to all community corrections programs, other than that they generally provide either a non-custodial sentencing alternative or a post-custodial mechanism for re-integrating prisoners into the community under continued supervision.

Community corrections include post-custodial programs under which prisoners released into the community continue to be subject to corrective supervision (as with parole, release on licence, pre-release orders and some forms of home detention). They also include orders imposed by the court as a sentencing sanction,

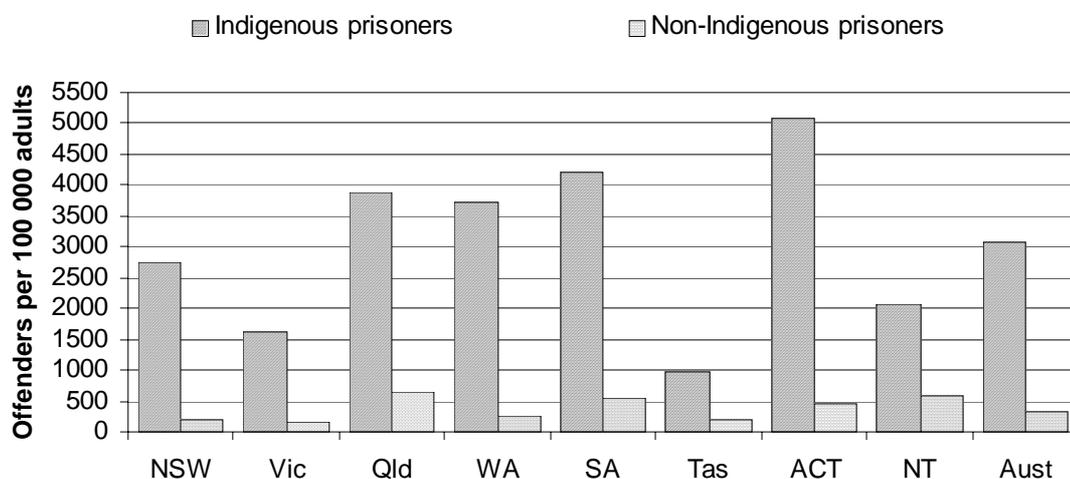
such as suspended sentences, court-imposed home detention, community service orders, probation, intensive supervision orders and recognisance. In most jurisdictions, fine default orders fall under community corrections, as does bail in some jurisdictions. Each jurisdiction has reparation and supervision orders, and restricted movement orders are available in all jurisdictions except Victoria, Tasmania and the ACT.

On average, 59 733 offenders per day were serving community corrections orders across Australia in 2000-01 — an increase of 1.3 per cent over the previous year. This daily average comprised 48 234 males (80.7 per cent) and 10 928 females (18.3 per cent), and 571 offenders whose gender was reported as not known. The daily average also comprised 7287 Indigenous offenders (12.2 per cent of the total community correction population) and 44 954 non-Indigenous offenders (75.3 per cent). The remaining offenders were reported as having Indigenous status ‘unknown’. In some jurisdictions, non-Indigenous offender data may also include some offenders whose Indigenous status was not known or not reported (table 10A.3).

The community corrections rate is the daily average number of offenders serving community corrections orders per 100 000 people in the general population aged either 17 or 18 years and over, depending on the relevant age of entry to the adult correctional system in each jurisdiction. Nationally, the rate was 407.4 per 100 000 adults in 2000-01. The national rate for female community correction offenders was 147.1 per 100 000 adults, compared with 667.0 for males. For Indigenous offenders, the national rate was 3077.0 per 100 000 Indigenous adults compared with 311.7 for non-Indigenous offenders (table 10A.4).

The ACT reported the highest rate of Indigenous offenders per 100 000 Indigenous adults in 2000-01 at 5075.8 and Tasmania the lowest at 978.7. Queensland reported the highest rate of non-Indigenous offender per 100 000 non-Indigenous adults at 639.9 and Victoria the lowest at 158.5 in 2000-01 (figure 10.3). These comparisons need to be interpreted with care, especially for States and Territories with low Indigenous populations, where small number effects can introduce statistical variation that does not accurately represent real trends over time or consistent differences from other jurisdictions.

Figure 10.3 **Indigenous and non-Indigenous community corrections rate, 2000-01^a**



^a Rates are based on the daily average offender population supplied by States and Territories, calculated against adult Indigenous and non-Indigenous population estimates (ABS figures supplied by the National Centre for Crime and Justice Statistics). Jurisdictional comparisons need to be interpreted with care, especially for those States and Territories with low Indigenous populations, where small number effects can introduce statistical variation that does not accurately represent real trends over time or consistent differences from other jurisdictions. Non-Indigenous offender rates may also include some offenders whose Indigenous status was not known or not reported.

Source: table 10A.4.

In 2000-01, community correction rates were also calculated against the total population, regardless of age. The national per person rate was 307.2 in 2000-01 compared with 311.0 in 1999-2000. The NT reported the highest per person community corrections rate at 666.3 and Victoria the lowest rate at 134.5 in 2000-01 (table 10A.74).

10.2 Policy developments in corrective services

Managing the specific needs of particular groups of prisoners and offenders introduces policy and resource challenges for corrective services. An example is that the number of female prisoners is increasing each year. In 1996-97, the daily average number of women held in Australian prisons was 939 compared with 1351 in 2000-01 — an increase of 43.9 per cent compared with a rise of 5.0 per cent in Australia's general population. However, women still comprise a relatively small proportion of the overall prison population at 6.4 per cent in 2000-01 (table 10A.1). Providing appropriate separate accommodation for women and meeting other specific needs, such as the provision of facilities and services that enable female

prisoners to continue to care for their babies and young children within the prison environment, has implications for resource efficiency.

Other prisoner and offender groups with specific management needs include those with a mental illness, intellectual disability, or substance dependency and elderly prisoners. Sentencing options operating or being introduced in many jurisdictions (such as drug courts, diversionary mechanisms, restorative justice, mediation and combinations of conditions of community correction orders that target specific offender needs and circumstances) require corrective services to develop a range of programs and facilities to appropriately address the conditions imposed. This poses policy, resourcing and management challenges for the corrective services sector that have implications for efficiency and effectiveness measures.

These policy challenges occur within a context of continuing increases in prisoner numbers. In 1996-97, the Australian daily average number of prisoners was 17 389 compared with 21 138 in 2000-01 — an increase of 21.6 per cent over the five-year period. This is being addressed directly by prison building programs in many States and Territories and indirectly by prison and post-release programs and initiatives directed at reducing the likelihood of return to prison. Nevertheless, prisoner numbers continue to exceed design capacity in several jurisdictions.

10.3 Framework of performance indicators

Corrective services performance is reported against seven key result areas based on the common objectives identified for the sector (box 10.1).

Box 10.1 Objectives for corrective services

Corrective services' *effectiveness* indicators relate to the objectives of:

- **custody:** to protect the community by the sound management of prisoners commensurate with the risks they pose to the community, and to ensure the environment in which prisoners are managed enables them to achieve an acceptable quality of life consistent with community norms;
- **community:** to protect the community by the sound management of offenders commensurate with the risks they pose to the community, and to ensure the environment in which offenders are managed enables them to achieve an acceptable quality of life consistent with community norms through referral to social support agencies;

(Continued on next page)

Box 10.1 (Continued)

- **reparation:** to ensure work undertaken by prisoners or offenders benefits the community either directly or indirectly (by reducing costs to the taxpayer);
- **offender programs:** to provide programs and opportunities that address the causes of offending, maximise the chances of successful re-integration into the community and reduce the risk of offending; and
- **advice to sentencing and releasing authorities:** to provide sentencing and releasing authorities with advice to assist the determination of the disposition of offenders, their release to parole, and necessary conditions for their supervision and post-release supervision.

These objectives are to be met through the provision of services in an equitable and efficient manner.

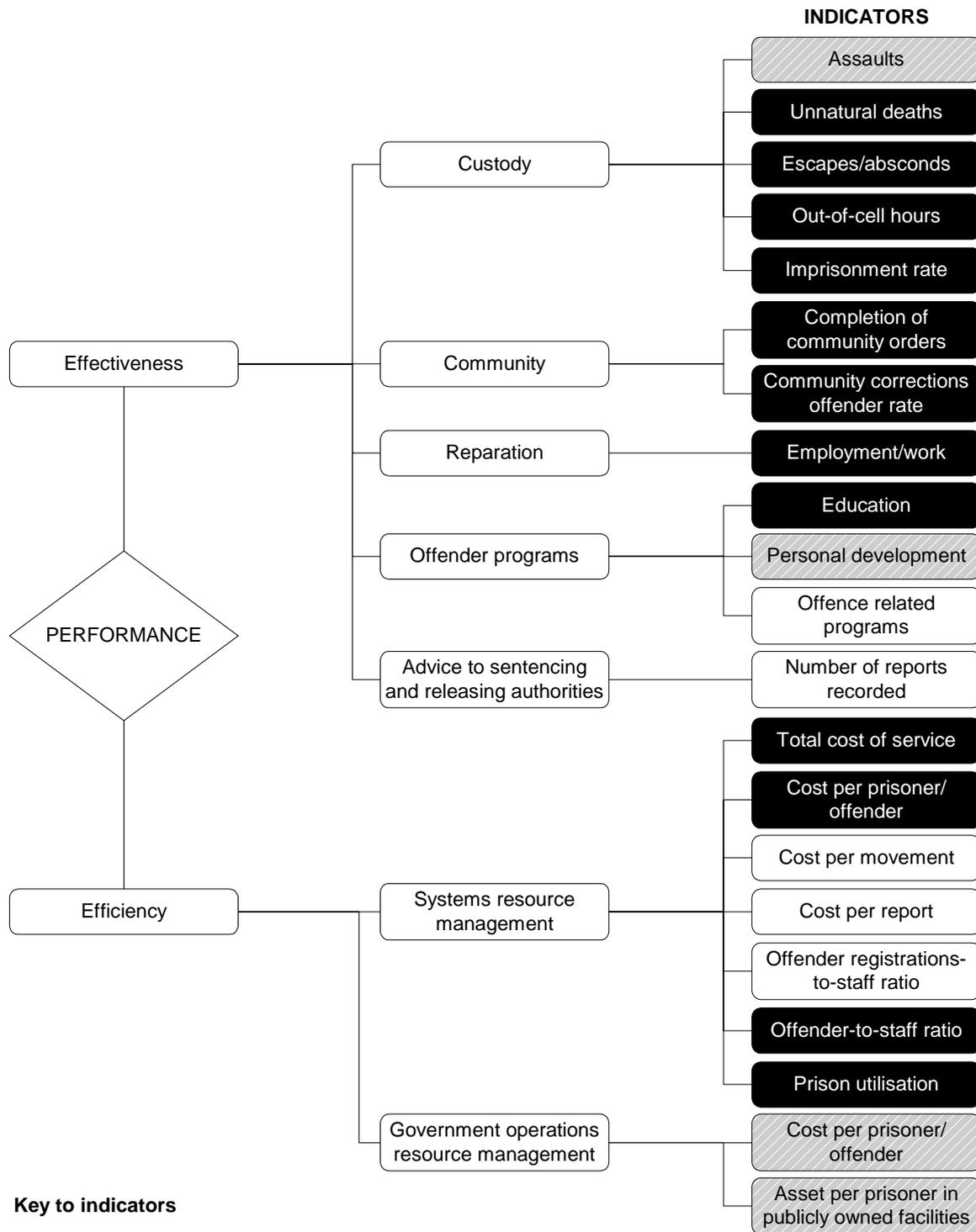
Corrective services' *efficiency* indicators relate to the objective of resource management — to manage resources so as to deliver correctional services efficiently.

Definitions and counting rules were refined during 2000-01 as part of the continuing effort to ensure jurisdictional comparability on all indicators. Data for previous years have been updated where possible, in accordance with refined counting rules and definitions. This Report presents some historical data that may be different from data published in the 2001 Report for a number of jurisdictions (and tables are footnoted accordingly). In other cases, it has not been possible to recalculate historical data, so any conclusions about changes within individual jurisdictions need to be considered in this context.

Figure 10.4 provides performance indicators for each of the objectives identified in box 10.1. Jurisdictions continue to investigate comparability issues each year through participation in the National Corrections Advisory Group and work to improve the counting rules for performance measures.

Relevant effectiveness indicators, such as assaults and escapes, are reported separately for periodic detainees. For relevant efficiency indicators, such as recurrent cost per prisoner, periodic detainees are counted as two-sevenths of a prisoner as they spend two days a week in prison. Given the ACT's unique circumstances of contracted service arrangements, the ACT indicators have been presented according to the most appropriate representation of effectiveness and cost — that is, either separately for remand prisoners and/or periodic detainees held in ACT centres, or as the total ACT prisoner population (whether held in NSW or ACT facilities).

Figure 10.4 Performance indicators for corrective services



Key to indicators

- Text** Provided on a comparable basis for this Report
- Text** Information not complete or not strictly comparable
- Text** Yet to be developed or not collected for this Report

10.4 Key performance indicator results

Performance is reported against the objectives for corrective services set out in box 10.1, using the indicator framework in figure 10.4. Differences in the settings for service delivery, geographic dispersal and prisoner/offender population profiles have an impact on the effectiveness and efficiency of correctional service systems. Appendix A contains detailed statistics and short profiles on each State and Territory, which may assist in interpreting the performance indicators presented in this chapter.

Effectiveness

Custody

Indicators of custody within prison are particularly vulnerable to the effects of small numbers, especially when expressed as a rate of total prisoner populations in jurisdictions with relatively small average daily prisoner populations. Given small absolute numbers in many cases, care needs to be taken when comparing effectiveness indicators across jurisdictions and over time within jurisdictions. A single incident in the smallest jurisdiction can double the rate of some indicators, but have little apparent effect in the larger jurisdictions. For example, a single death in an ACT prison in 2000-01 would calculate to a rate of 1.7 while a second death would increase the figure to 3.4. In NSW, one additional death during the year would change the rate from 0.15 to 0.16.

Assaults

Indicators reporting assaults were revised in 2000-01 to take account of differences in the level of severity of assaults reported. 'Serious assaults' refer to acts of physical violence resulting in actual bodily harm requiring medical treatment and assessment involving hospitalisation or extended periods of ongoing medical treatment, and includes all acts of sexual assault. 'Assaults' refer to acts of physical violence resulting in a physical injury that may or may not require short-term medical intervention but that do not involve hospitalisation.

In 2000-01, Victoria recorded the highest rate of 'serious assaults' by prisoners on other prisoners per 100 prisoners at 1.1 and SA the lowest at 0.3. New South Wales had the highest rate of 'assaults' by prisoners on other prisoners per 100 prisoners at 22.5 and SA was again the lowest at 0.9 (table 10.1).

The reported rate of ‘serious assaults’ by prisoners on officers per 100 prisoners ranged from 1.7 in the NT to zero in NSW, Victoria and Tasmania. The NT reported the highest rate of ‘assaults’ by prisoners on officers per 100 prisoners at 3.6 and Tasmania the lowest at 0.5 in 2000-01 (table 10.1). Queensland, WA and the ACT did not report on these indicators in 2000-01.

Table 10.1 Prison assault rates, 2000-01 (per 100 prisoners)

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>
<i>Prisoner on prisoner</i>								
Serious assault	0.9	1.1	na	na	0.3	0.8	na	0.8
Assault	22.5	8.3	na	na	0.9	7.6	na	10.0
<i>Prisoner on officer</i>								
Serious assault	–	–	na	na	0.4	–	na	1.7
Assault	2.2	0.9	na	na	0.7	0.5	na	3.6

na Not available. – Nil or rounded to zero.

Source: table 10A.7

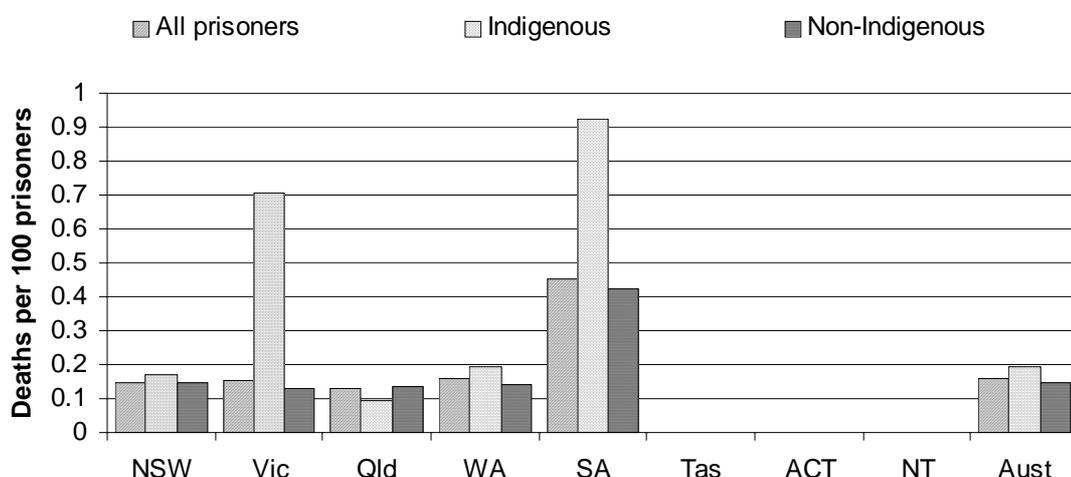
There were no incidents of ‘serious assault’ on periodic detainees by other periodic detainees or on staff by detainees reported in NSW in 2000-01. The rate of ‘assault’ on periodic detainees by other periodic detainees per 100 detainees was 2.8 and the rate of ‘assault’ on staff was 0.1 (table 10A.22). The ACT did not report on these indicators in 2000-01.

Unnatural deaths

Death rates per 100 prisoners from apparent unnatural causes for total prisoners in 2000-01 ranged from 0.5 (six deaths) in SA to zero in Tasmania, the ACT and the NT (figure 10.5). The highest number of deaths of Indigenous prisoners per 100 Indigenous prisoners from apparent unnatural causes was SA at 0.9 (two deaths) and zero for Tasmania, the ACT and the NT. The equivalent rate for non-Indigenous prisoners ranged from 0.4 in SA (four deaths) to zero in Tasmania, the ACT and the NT (figure 10.5).

Neither of the two jurisdictions operating periodic detention reported deaths of periodic detainees in 2000-01 (tables 10A.22 and 10A.60).

Figure 10.5 Prisoner death rates from apparent unnatural causes, 2000-01^a



^a Tasmania, the ACT and the NT had no deaths. Victoria had one Indigenous prisoner death and SA had two Indigenous prisoner deaths.

Source: table 10A.8.

Escapes/absconds

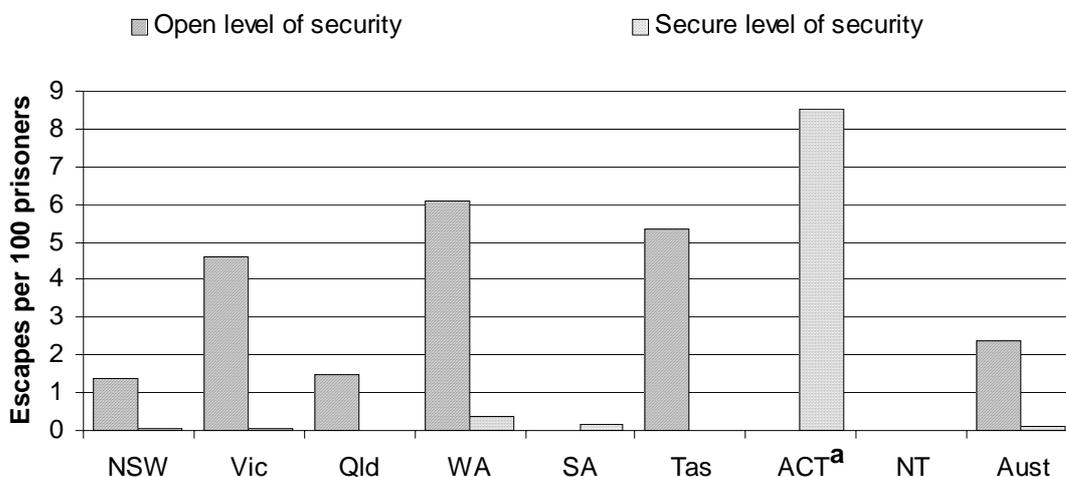
Western Australia reported the highest rate of escapes/absconds from open custody in 2000-01 with 6.1 per 100 prisoners and SA and the NT reported the lowest rate (zero). The rate of escapes/absconds for secure custody ranged from 8.5 in the ACT to zero in Queensland, Tasmania and the NT (figure 10.6).

The absconding rate among prisoners serving periodic detention was 0.3 per 100 prisoners for NSW in 2000-01 (table 10A.22). The ACT reported no absconds in 2000-01 (table 10A.60).

Out-of-cell hours

In 2000-01, Queensland and WA reported the highest average daily out-of-cell hours for all prisons combined (12.4 hours per day) and SA and the ACT reported the lowest (10.3 hours per day). The ACT figures relate only to prisoners held in the Belconnen Remand Centre and therefore open and secure custody breakdowns are not applicable for that jurisdiction. Out-of-cell hours for open custody ranged from 16.8 per day in Queensland to 12.6 hours per day in NSW. Out-of-cell hours for secure custody ranged from 11.9 hours per day in Victoria to 8.2 hours per day in the NT (figure 10.7).

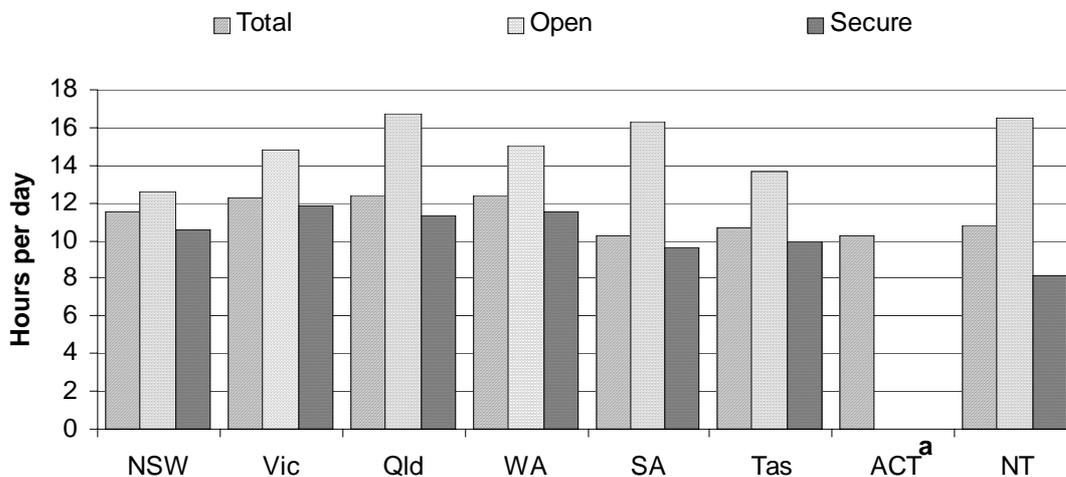
Figure 10.6 Prisoner escape/abscondment rate, 2000-01



^a The ACT does not operate open security prisons. The secure custody data comprise all escapes from the jurisdictions remand centre.

Source: table 10A.9.

Figure 10.7 Average out-of-cell hours, by type of prisoner, 2000-01



^a Open and secure custody breakdowns are not applicable to the ACT.

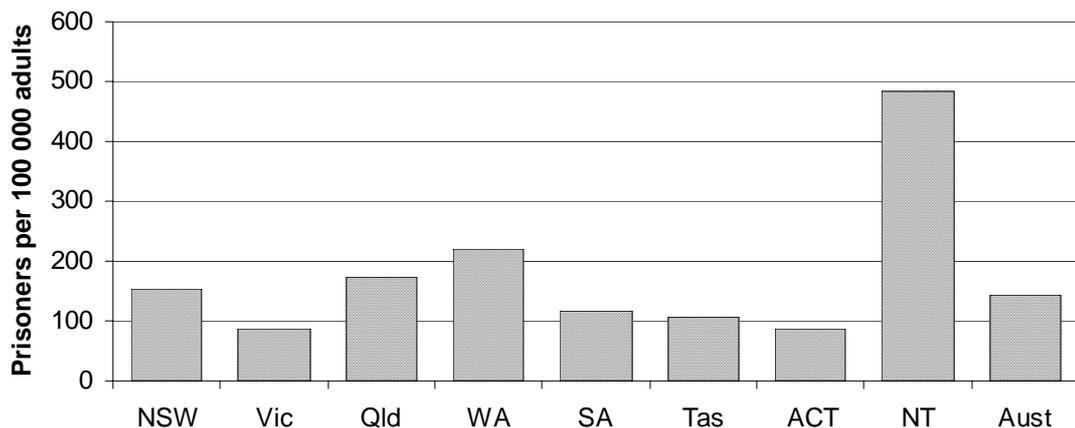
Source: table 10A.10.

Imprisonment rate

The rate of imprisonment per 100 000 adults (excluding periodic detainees) in 2000-01 ranged from 483.4 in the NT to 87.8 in the ACT (figure 10.8). Rates for Indigenous prisoners ranged from 3018.1 per 100 000 Indigenous adults in WA to

456.7 in Tasmania. The imprisonment rate per 100 000 adults for periodic detention was 22.6 in NSW and 29.2 in the ACT (table 10A.4).

Figure 10.8 **Imprisonment rates, 2000-01^a**



^a Imprisonment rates for all prisoners are based on the daily average prisoner population supplied by States and Territories, calculated against adult Indigenous and non-Indigenous population estimates (ABS figures supplied by the National Centre for Crime and Justice Statistics). The ACT data include prisoners held on remand in the ACT and ACT prisoners held in NSW prisons, and NSW rates include ACT prisoners held in NSW facilities. Australian rates are calculated to exclude any double counting of ACT prisoners held in NSW prisons.

Source: table 10A.4.

Community corrections

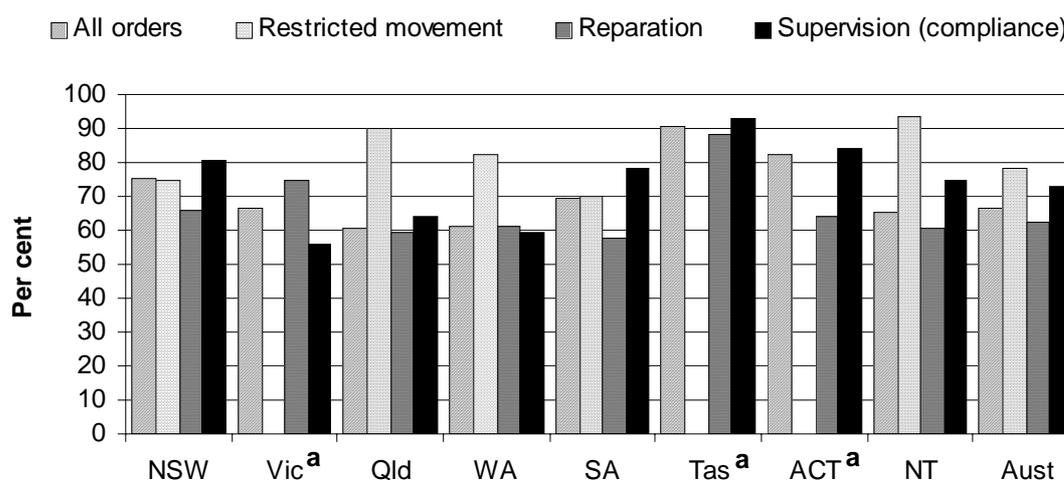
Completion of community orders

A key effectiveness indicator relevant to the management of offenders in the community is the successful completion of orders. Unsuccessful completion occurs when the offender breaches an order (failing to comply with the conditions of the order) or commits a further offence. Data needs to be interpreted with care because, for example, a 100 per cent order completion figure could mean either exceptionally high compliance or a failure to detect or act on breaches of compliance. Data are also affected by differences in the risk levels of offender populations and policy decisions that drive the determination of risk. High-risk offenders experiencing a higher level of surveillance have a greater likelihood of being detected and having their order breached. High breach rates, therefore, may be seen in some jurisdictions as a positive outcome reflecting tougher management of community based orders.

Tasmania reported the highest rates of successful completion for total orders at 90.3 per cent and Queensland the lowest at 60.4 per cent in 2000-01. Successful

completion of restricted movement orders (for those five jurisdictions operating this program) ranged from 93.5 per cent in the NT to 69.9 per cent in SA. Completion rates for reparation orders ranged from 88.3 per cent in Tasmania to 57.6 per cent in SA. Completion rates for supervision orders ranged from 93.2 per cent in Tasmania to 55.7 per cent in Victoria (figure 10.9).

Figure 10.9 Successful completion of community corrections orders, 2000-01



^a Victoria, Tasmania and the ACT did not have restricted movement orders in 2000-01.

Source: table 10A.11.

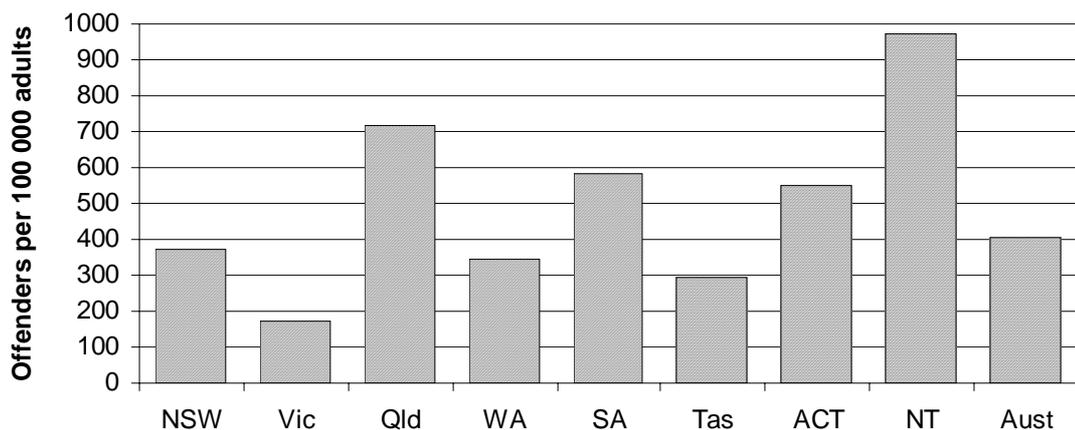
Community correction offender rate

In line with revised national counting rules, the average daily community correction population includes offenders on inactive orders — that is, offenders awaiting a breach or court hearing or interstate transfer, or those sentenced to a prison term that is shorter than the period still to serve on the order. The NT is the only jurisdiction in which offenders continue to be counted in the daily community correction population until the time that the breach is determined by a court, which can substantially exceed the term of the actual order. The inclusion in 2000-01 of offenders from the NT on inactive orders has effectively doubled the NT community correction offender rate compared to previous years.

The NT reported the highest community corrections rate for all offenders in 2000-01 (971.2 per 100 000 adults) and Victoria reported the lowest at 174.7 (figure 10.10). Rates for Indigenous offenders ranged from 5075.8 per 100 000 Indigenous adults in the ACT to 978.7 in Tasmania (table 10A.4). However, jurisdictional comparisons need to be interpreted with care, especially for those

States and Territories with low Indigenous populations where small number effects can introduce statistical variation that does not accurately represent real trends over time or consistent differences from other jurisdictions. This is particularly relevant for the ACT Indigenous offender rates reported here.

Figure 10.10 **Community corrections rate, 2000-01^a**



^a Rates are based on the daily average offender population supplied by States and Territories, calculated against a general population of either 17 or 18 years and over, depending on the age at which persons are received into adult custody.

Source: table 10A.4.

Reparation

Prisoner employment

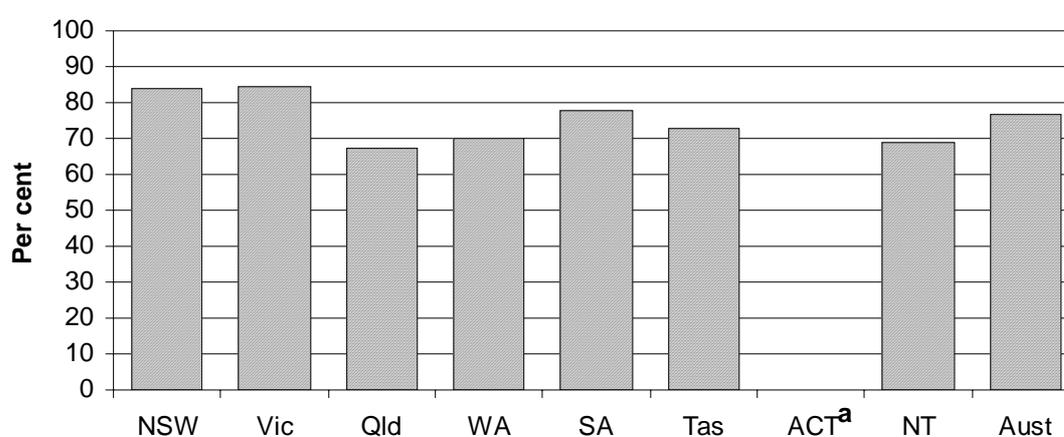
Prisoner work provides reparation by generating income from prison industries (industries that are run on a commercial basis and aimed at an external clientele) and by offsetting expenditure through work in prison services (work undertaken to service the prison) or unpaid community work by prisoners. All jurisdictions reported a significant number of prisoners employed in prison industries or services or, in a smaller number of cases, working in the community as part of a pre-release scheme whereby prisoners are employed under industrial award conditions. The ACT was not included in this analysis because it only accommodates remand prisoners.

Victoria reported the highest percentage of prisoners employed in 2000-01 (84.2 per cent of prisoners eligible to work) and Queensland reported the lowest percentage at 67.5 per cent (figure 10.11). These comparisons need to be interpreted

with care, because factors outside the control of corrective services (such as local economic conditions) affect their capacity to attract commercially viable prison industries, particularly where the prisons are remote from population centres.

The employment rate among periodic detainees in 2000-01 in the two jurisdictions operating periodic detention was 85.6 per cent in NSW (table 10A.22) and 45.5 per cent in the ACT (table 10A.60).

Figure 10.11 Proportion of eligible prisoners employed, 2000-01



^a Excludes the ACT as that jurisdiction's prison only accommodates remand prisoners.

Source: table 10A.12.

Community work by community corrections offenders

These indicators reflect corrective services' responses to court orders. Hours ordered to be worked depend on jurisdictional legislation, court sentencing practices and, in particular, government policy on dealing with fine defaulters.

The ACT reported the highest average number of community corrections hours ordered to be worked per offender (115.1 hours) and Queensland reported the lowest (41.8 hours) in 2000-01. As Queensland community work data include only hours to be worked on orders commenced during the year, they are not directly comparable with data from other jurisdictions, which include hours remaining to be worked on existing orders as well as new orders. New South Wales and Victoria did not report on this measure in 2000-01 (table 10A.12).

The ACT reported the highest number of hours actually worked per offender (63.3 hours) and Queensland reported the lowest (35.6 hours). New South Wales and Tasmania did not report on this indicator in 2000-01. South Australia reported

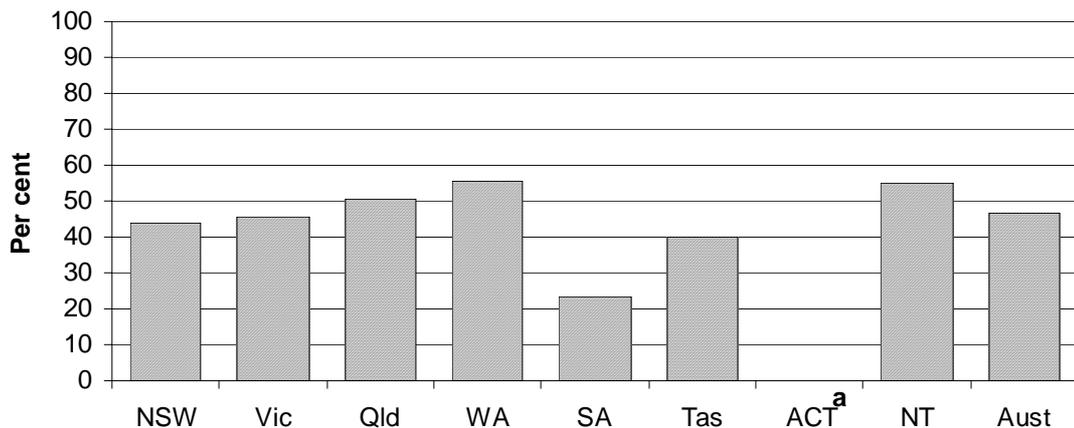
the largest ratio of hours ordered to hours worked at 2.8 and Queensland reported the smallest ratio at 1.2 (table 10A.12).

Offender programs

Education

Enhancing employment opportunities through education and training is important for successfully re-integrating prisoners into the community and reducing the risk of re-offending. The highest percentage of eligible prisoners undertaking education or training courses in 2000-01 was reported by WA (55.5 per cent) and the lowest was reported by SA (23.1 per cent) (figure 10.12).

Figure 10.12 **Proportion of prisoners enrolled in education and training, 2000-01**



^a Excludes the ACT as that jurisdiction's prison only accommodates remand prisoners. Prisoners eligible to participate in education are defined differently across jurisdictions (see single jurisdiction data in the supporting tables for details).

Source: table 10A.13.

The proportion of prisoners undertaking different types of education and training courses varied across jurisdictions, with the NT reporting the highest percentages in vocational education and training (53.2 per cent), NSW reporting the highest in secondary school sector courses (35.7 per cent), and Queensland reporting the highest in both higher education sector and pre-certificate level 1 courses² (4.9 per cent and 18.7 per cent respectively). Education indicators were not

² Refers to accredited education courses below the Certificate 1 level (eg learning to read, recognising numbers, etc).

applicable to the ACT because the jurisdiction only accommodates remand prisoners (table 10A.13).

Personal development

The relevant indicator for community corrections is the number of offenders undertaking personal development courses provided by, or on referral from, corrective services. Introduced for the first time in the 1998 Report, only two jurisdictions were able to report on this indicator for 2000-01 — WA (51.7 per cent) and the NT (28.4 per cent) (table 10A.13).

Offence related programs

This indicator is still under development, although some progress has been made in defining the indicator and developing counting rules. Appropriate information collection systems need to be developed and implemented before the indicator can be reported on a consistent basis in future reports.

Efficiency

System resource management

System resource management is the management of resources and the provision of services by:

- government owned and managed facilities; and
- government or privately owned facilities managed under contract by a private sector organisation.

If corrective facilities are owned and managed by government only, then system resource management indicators are also government operations resource management indicators.

Cost indicators are affected by factors other than differences in performance efficiency. These include the composition of the prisoner population (such as security classification, the number of female or special need prisoners, and the number of periodic detainees), the size and dispersion of the area serviced, and the scale of operations.

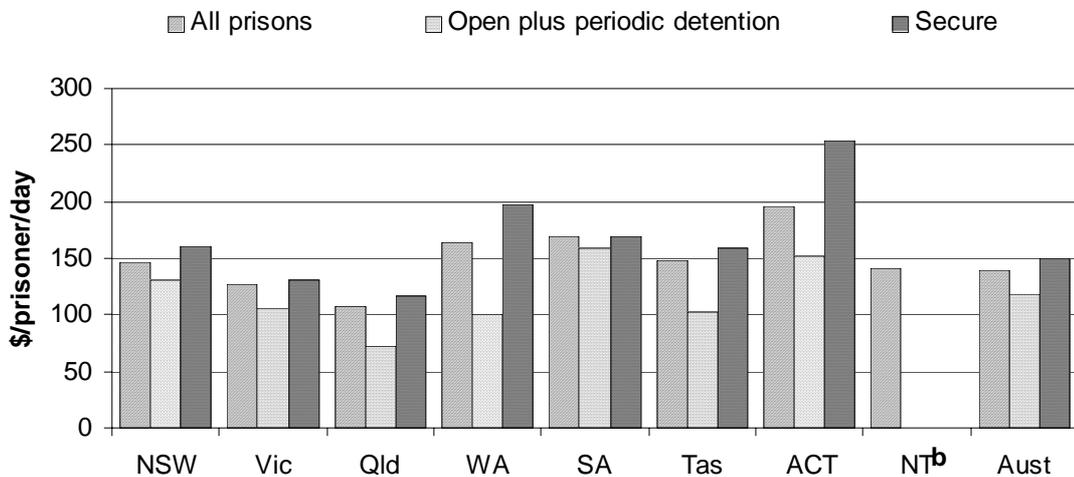
Total cost of service

This measure is an aggregate of all corrective service system costs (prisons, community corrections, and transport and escort services) per person in the population (all ages). Total recurrent expenditure per person ranged from \$206.7 in the NT to \$44.5 in Victoria (figure 10.1).

Cost per prisoner (all prisons)

A measure of the efficiency in systemwide resource management is the recurrent cost of prison services divided by the number of prisoner days (unit costs). Average recurrent cost per prisoner per day (for open and secure prisons combined) ranged from \$195.9 in the ACT to \$108.4 in Queensland in 2000-01. Calculating costs for open and secure custody separately, the ACT reported the highest unit cost for secure prisons at \$253.2 and Queensland maintained the lowest unit cost at \$116.5. South Australia reported the highest unit costs for prisoners in open custody (which includes periodic detention cost in NSW and the ACT) at \$159.5 and Queensland showed the lowest at \$72.3 (figure 10.13).

Figure 10.13 Cost of prisons, 2000-01^a



^a Net recurrent expenditure includes payroll tax, capital asset charges and other associated expenses (such as debt servicing fees, depreciation or accommodation fees) but is net of recurrent receipts (own source revenues). Unit costs are calculated against recurrent expenditure excluding all these items, in order to enhance comparability across jurisdictions. ^b The NT did not report on open and secure custody costs separately in 2000-01.

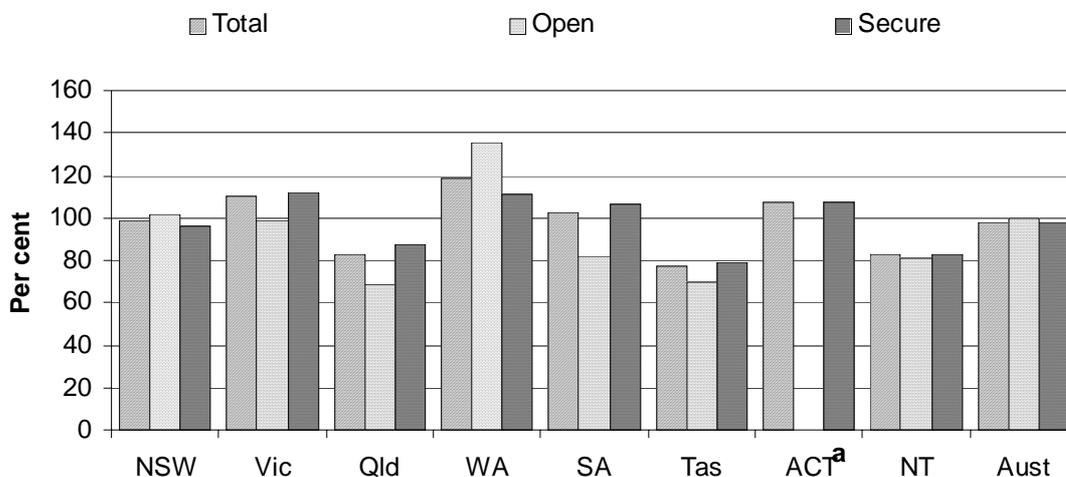
Source: table 10A.6.

Prison utilisation

A prison system's utilisation rate is considered to be an indicator of the efficiency with which private and publicly owned assets are employed. The optimum rate of prison utilisation lies in the range of 85 to 95 per cent because facilities need to accommodate the transfer of prisoners, provide special purpose accommodation such as hospital and protection units, provide separate facilities for males and females and for different security levels, and deal with short term fluctuations in prisoner numbers.

Prison utilisation for all prisons (open plus secure) in 2000-01 ranged from 118.5 per cent in WA to 76.8 per cent in Tasmania. Rates in Victoria, WA, SA and the ACT exceeded 100 per cent of current design capacity. (Rates exceed 100 per cent of design capacity when more prisoners are housed in a facility than allowed for in its design.) Victoria reported the highest secure prison utilisation rate at 111.6 per cent and Tasmania reported the lowest at 78.7 per cent. Western Australia had the highest open custody utilisation rate at 136.0 per cent and Queensland the lowest at 68.7 per cent in 2000-01 (figure 10.14).

Figure 10.14 **Prison capacity utilisation rates, 2000-01**



^a Open and secure custody breakdowns are not applicable to the ACT.

Source: table 10A.15.

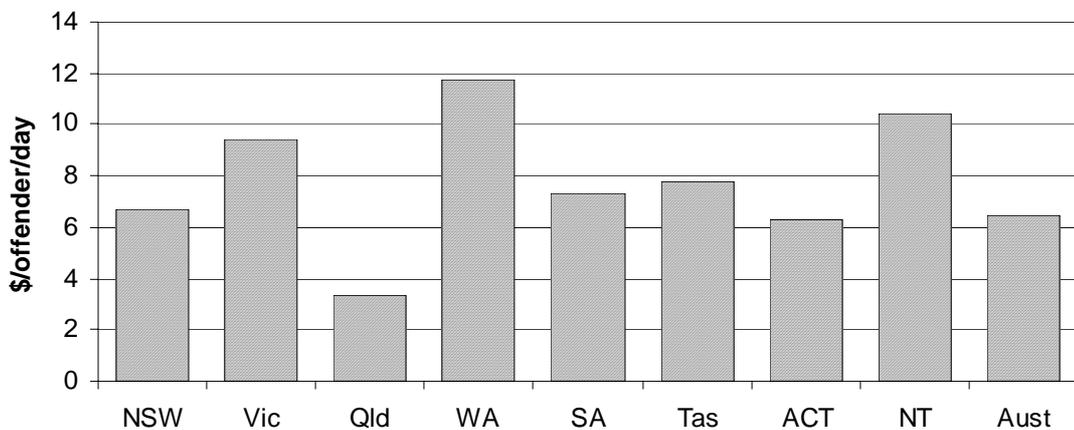
Cost per offender (community corrections)

A measure of the efficiency in system resource management is the total cost divided by the number of offenders per day (unit costs). The reported unit costs are also government-only unit costs for all jurisdictions. This indicator is affected by size

and dispersion factors, particularly in jurisdictions where offenders reside in remote communities. It can also be affected by differences in criminal justice system policies and practices — for example, in the availability and use of sentencing options that impose particular program or supervision requirements.

Cost per offender per day in community corrections ranged from \$11.7 in WA to \$3.3 in Queensland in 2000-01 (figure 10.15). The inclusion of NT offenders on inactive orders in 2000-01 has effectively halved the NT cost per offender from the previous year.

Figure 10.15 **Cost of community corrections, 2000-01^{a, b}**



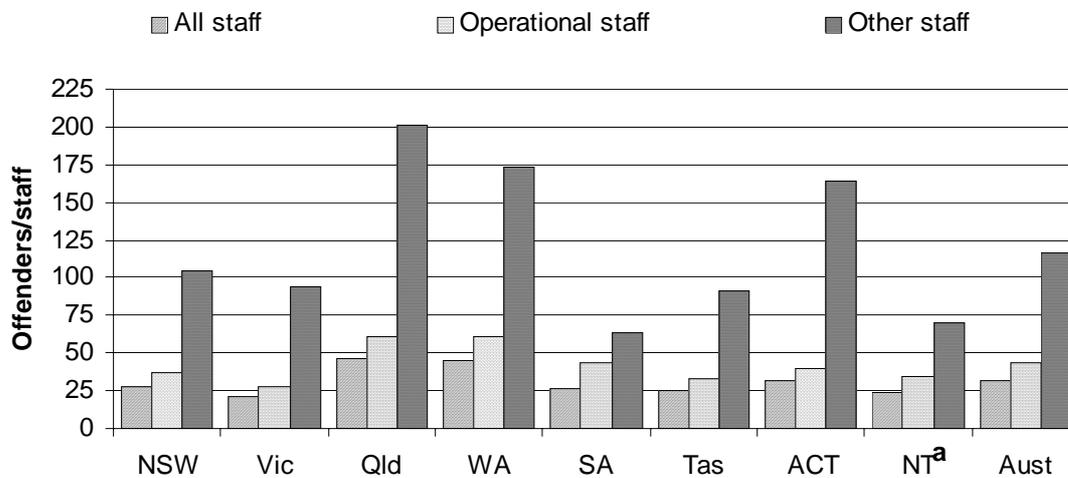
^a Unit cost is calculated using total recurrent expenditure less (where applicable to the jurisdiction) consolidated funds and receipts, payroll tax, capital asset charges and other associated expenses, such as debt servicing fees, depreciation or accommodation fees. ^b The NT unit costs do not take into account the impact of juvenile detainees supervised by community correction officers because these young offenders do not fall within the scope of the daily average offender population.

Source: table 10A.6.

Offender-to-staff ratio

Offender-to-staff ratios for community corrections ranged from 46.8 offenders per staff member in Queensland to 21.7 in Victoria in 2000-01. Western Australia reported the highest number of offenders to ‘operational staff’ at 61.4 and Victoria the lowest at 28.2. The equivalent figures for ‘other staff’ ranged from 200.7 in Queensland to 63.6 in SA (figure 10.16). The inclusion of NT offenders on inactive orders in 2000-01 has effectively doubled the ratio of offenders to staff in the NT from the previous year.

Figure 10.16 **Community corrections offender-to-staff ratios, 2000-01**



^a The NT ratios do not take into account the impact of juvenile detainees supervised by community corrections officers because these young offenders do not fall within the scope of the daily average offender population.

Source: table 10A.14.

Government operations resource management

Cost per prisoner

The framework of indicators also identifies the unit cost per prisoner day for government operated prisons as a preferred indicator of efficiency. None of the four jurisdictions that have private prisons (NSW, Victoria, Queensland and SA) provided data on the unit cost of government operations separately. Each jurisdiction, however, is committed to improving the reporting of this information for future years.

Assets per prisoner in publicly owned facilities

Value of assets per prisoner is an indicator of the capital inputs to corrective services. As an indicator of the use of government owned assets, it covers both government owned and operated prisons, and government owned assets in privately operated prisons, calculated against the relevant prisoner population. No jurisdiction provided data on this indicator for the 2002 Report.

User cost of capital

The user cost of capital for government services is the cost of the funds tied up in the capital used to deliver services (for example, the land and buildings used to

house prisoners). The user cost of capital makes explicit the opportunity cost of this capital (the return forgone by using the funds to deliver services rather than investing them elsewhere or using them to retire debt). Failing to account for a user cost of capital can lead to significant underestimating of costs for those services for which government capital is a major input.

No jurisdiction has provided data on asset values, which means that the user cost of capital cannot be calculated. It is anticipated that, given the findings of the Steering Committee's study into the comparability of asset values (box 10.2), data will be included for this indicator in future reports.

Box 10.2 Asset measurement in the costing of government services

Costs associated with non-current physical assets (such as depreciation and the user cost of capital) are potentially important components of the total costs of many services delivered by government agencies. Differences in the techniques for measuring non-current physical assets (such as valuation methods) may reduce the comparability of cost estimates across jurisdictions. In response to concerns regarding data comparability, the Steering Committee initiated a study: *Asset Measurement in the Costing of Government Services* (SCRCSSP 2001). The aim of the study was to examine the extent to which differences in asset measurement techniques applied by participating agencies affect the comparability of reported unit costs.

In corrective services, the results reported in the study indicate that different methods of asset measurement could lead to quite large variations in reported capital costs. Considered in the context of total unit costs, however, the differences created by these asset measurement effects were relatively small as capital costs represent a relatively small proportion of total cost. These differences may affect cost rankings between jurisdictions. A key message from the study was that the adoption of national uniform accounting standards across all service areas would be a desirable outcome from the perspective of the Review. The results are discussed in more detail in chapter 2.

Cost per offender

Cost per offender for each jurisdiction is shown in figure 10.15. These costs represent a systemwide and government-only measure of efficiency, because there are no non-government operated community corrections facilities.

10.5 Future directions in performance reporting

Jurisdictions will continue to refine definitions and counting rules to maximise comparability across States and Territories. A number of indicators are currently being trialed for inclusion in future reports. They relate to:

- number of reports recorded — that is, reports prepared by corrective services providing pre- or post-sentencing advice to sentencing or releasing authorities;
- cost per movement — that is, cost of transporting and escorting prisoners under the supervision of corrective services;
- cost per report; and
- offender registrations-to-staff ratio — that is, new offenders registered with community corrections during the counting period that do not have a current order as a ratio of community correction staff.

Other indicators are being developed to report on issues of policy relevance to corrective services, such as prisoner visits and indicators to assess illicit drug related incidents.

Time series data will be extended in future years as the base of comparable indicators expands over time.

10.6 Jurisdictions' comments

This section provides comments from each jurisdiction on the services covered in this chapter and attachment 10A on the CD-ROM. Appendix A contains detailed statistics and short profiles on each State and Territory, which may assist in interpreting the performance indicators presented in this chapter. The information covers aspects such as age profile, geographic distribution of the population, income levels, education levels, tenure of dwellings and cultural heritage (such as Indigenous and ethnic status).

New South Wales Government comments

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The NSW Department of Corrective Services is presented with the continual challenge of effectively managing individuals under its care and supervision. With an increase in the imprisonment rate (153.2 in 2000-01 compared with 150.3/100 000 adults in 1999-2000), a 9 per cent increase in prison population numbers since 1998-99 and a 3 per cent rise in numbers since last year, the strain on staff, facilities and budgets has been considerable.

To address the changing inmate populations, the Department has been reviewing existing systems and processes with the primary objective of implementing new programs and strategies targeted at reducing re-offending behaviour. Every new program, new process and new facility will be based on a 'throughcare' strategy which focuses on endeavouring to return the offender successfully back into the community by examining every aspect of the offender's contact with the Department.

In light of this increased demand, the Department has managed to improve its facilities, security, case management and classification processes, and staff training. In fact, the NSW escape/abscondment rate was relatively lower compared to other jurisdictions (2000-01 NSW: 1.37/100 prisoners; Australian average: 2.37/100 prisoners) and the 'apparent unnatural causes' death rate has declined considerably from previous years (0.33/100 prisoners in 1998-99 to 0.15/100 prisoners in 2000-01). Employment rates have also increased substantially from previous years to an eligible participation rate of 84 per cent.

Other correctional achievements occurring during 2000-01 have included the opening of the High Risk Management Unit (HRMU) at Goulburn Correctional Centre, as well as the redevelopment of existing institutions including Long Bay, Yetta Dhinnakkal Correctional Centre at Brewarrina and the Warakirri Correctional Centre at Ivanhoe. Other major developments include the opening of Stage 2 of the Emu Plains Correctional Centre for women, along with John Morony II Correctional Centre and the Metropolitan Periodic Detention Centre at Parklea.

During the 2000-01 financial year, many NSW Drug Summit recommendations were implemented to continue to help inmates to break the cycle of drug addiction. Some of these initiatives have included the establishment of ambulatory detoxification units throughout the state, including a new facility at Parklea Correctional Centre.

Overall, NSW has continued to perform consistently well across most indicators compared with other jurisdictions. NSW has also significantly improved its performance compared with results from previous years in assaults, deaths, time out of cells and employment.

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Victorian Government comments

“ The significant growth in prisoner numbers in Victoria over a number of years has resulted in a chronic shortage of permanent beds and overcrowding in our prisons. The Victorian Government regards imprisonment as a sanction of last resort, and is committed to providing effective sentencing alternatives to prison. The Victorian Government’s policy objectives for Correctional Services emphasise the concepts of community safety and reducing re-offending.

The Victorian Government has developed a Corrections Long Term Management Strategy plan which defines the framework for policy objectives for corrective services in Victoria over the next decade. The Strategy addresses the accommodation shortage through a prison building program and the establishment of a range of diversion and rehabilitation programs in both prisons and community corrections.

The major initiatives presented in the Corrections Long Term Management Strategy plan are:

- A prison infrastructure program — The program has three key components: a strategy to add temporary capacity to the system, expansion of the permanent accommodation in existing facilities, and construction of three new prisons. The net result of the building program will be over 1000 new prison places over the next four years. Accommodation in some existing prisons will also be upgraded. A review of prison cell design and associated prisoner safety issues was conducted during 2000-01 and established guidelines that will set the standard for future cell design and fire safety in Victoria's prisons.
- Redevelopment of Community Correctional Services — A major review of the Community Correctional Services in 2000-01 recommended that the services be reinforced and expanded. Community Correctional Services received a major funding boost in May 2001 to provide increased staffing levels, enhancement of the court advice services provided to magistrates, additional focus on services for high-risk offenders, improvement of the pre-release and parole program, additional assessment and counselling services and new programs aimed at reducing re-offending.
- Pre and Post-release Support — Improvement of transitional support for prisoners on release from custody is a key element of the Victorian Government's strategy of reducing re-offending. Significant funding has been allocated for a range of pilot programs aimed at assisting prisoners to make a successful transition from custody to the community.
- Rehabilitation and Reducing Offending Initiatives — Prisoners whose crimes have the greatest impact on their victims, violent and sex offenders, will be targeted for new intensive prison-based programs to improve their prospects for rehabilitation.
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Queensland Government comments

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Corrective Services in Queensland has continued to experience significant change during 2000-01 with the introduction of the *Corrective Services Act 2000* and the *Corrective Services Regulation 2001*. The new Act is designed to provide clearer, more comprehensive and equitable corrective services legislation for Queensland. It abolished remission for prisoners who have committed offences after commencement of the Act; provides for new orders, reforms release to work, home detention and parole as post-prison community based release orders, and provides statutory recognition for the Work Outreach Camp (WORC) and Women's Community Custody Programs.

The Department has continued to expand and modernise correctional centres throughout the State with the completion of the expansion of Woodford Correctional Centre to 1000 beds making it the largest correctional centre in Australia. The completion of this expansion combined with a 6.9% reduction in prisoner numbers from 1999-2000 assisted in the achievement of an improved utilisation rate of 83.2 per cent.

No escapes from secure custody have occurred in Queensland since 1997-98 and the rate of escapes from open custody of 1.51 continues below the Australian average of 2.37. The rate of unnatural deaths has continued to decline and at 0.13 remains below the Australian average of 0.16. A 37 per cent reduction in the rate of prisoner on prisoner assaults brought this rate down to 6.83, a level that has not been achieved since 1996-97. The rate of prisoner on staff assaults increased to 1.53 during 2000-01.

The overall rate of prisoner employment (commercial industries and prison services) at 67.5 per cent is an improvement from 1999-2000 but remains below the Australian average of 76.6 per cent. Queensland continues to record a high level of prisoner education and training at 50.6 per cent compared to the Australian average of 46.4 per cent.

The State Penalties Enforcement Register (SPER) was introduced in November 2000. The intent of SPER is to ensure that fines are satisfied through various payment options thereby reducing the number of fine defaulters in the custodial system. As part of the implementation of SPER, an amnesty on all warrants of commitment commenced in November 2000. As a consequence of this amnesty, the number of offenders subject to fine option orders has declined and this has had a subsequent effect on the total number of community orders under supervision.

Queensland continues to provide effective, low cost corrective services with the lowest cost per prisoner per day in each category of corrective services at \$116 in secure custody, \$72 in open custody and \$3 in community corrections.

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Western Australian Government comments

“ Western Australia has implemented a new custodial information management system which contributes to more systematic and integrated data collection, analysis and reporting. A new information management system for community corrections is being planned for development in 2002-03. In conjunction with the Integrated Courts Management Information system which is currently under development, these systems will further improve data quality, timeliness and value to management.

The 2002 Report shows improved comparability between jurisdictions on most indicators, however, geographic and demographic differences between jurisdictions can appear as differences in performance. This is particularly relevant to efficiency indicators for WA where cost can be greatly increased by providing services such as community corrections in areas that have vast distances between communities.

Western Australia's high rate of imprisonment is the target of the government's strategy to reduce imprisonment. It consists of legislative changes to restrict the availability of short sentences while increasing the range and effectiveness of community corrections sanctions and initiating a graduated range of responses to breaching offenders on parole or orders. It is anticipated that the rate of Indigenous imprisonment will be reduced as a consequence of this strategy.

The reducing imprisonment strategy is supported by detailed analysis of offender populations, long term demand projections and consultation with community people on the appropriate forms of service delivery. Services planning is currently focussed on the needs of women offenders and Indigenous offenders in regional areas. By engaging all sections of justice services in planning and establishing links between police, courts, custodial and community corrections, it is anticipated that better outcomes for the community and for offenders can be achieved.

During 2000-01, the new Hakea Assessment and Receiving Centre commenced operation which is an important contributor to the implementation of the Integrated Prison Regime. Based on a case management approach, there is a strong focus on addressing offending behaviours. The introduction of a cognitive skills program enhances the range of offence related programs that can be provided.

The pressure on the prison system arising from the high occupancy level in 2000-01 (118 per cent of design capacity) will decrease throughout 2001-02 with the commissioning in May 2001 of Acacia, the new privately operated prison. When fully operational in March 2002, it will hold 750 medium security prisoners.

This suite of strategies is part of the long-term vision for justice in WA that will result in more comprehensive and more effective management of offenders for the increased safety of the community.”

South Australian Government comments

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SA continues to support the development and collection of national performance indicators, which will ultimately assist in the identification of benchmarks or best practice in the corrections environment. This year, once again, SA has actively contributed to the work of the National Corrections Advisory Group in advancing the suite of nationally comparable performance indicators through the refinement of data definition and counting rules.

After three years of decline, the SA daily average prison population remained stable during 2000-01. The daily average was 1321 in 2000-01 compared with 1329 in 1999-2000. The imprisonment rate in SA has fallen to 115, well below the national average of 144.2. Additionally, the daily average community corrections population also stabilised at 6683 in 2000-01 from 6658 in 1999-2000. However, this is still well below the daily average of 1997-98 of 8366.

Despite the falling corrections population over the last few years, SA still has one of the highest “cost per prisoner” rates, because costs do not fall in direct proportion to prisoner numbers, particularly fixed costs which can only be significantly influenced by the full closure of a cellblock or prison.

SA’s performance in 2000-01 compared favourably with previous years.

- There was a substantial drop in secure and open perimeter escape rate.
- Further improvements in average daily time out of cells, compared with last year.
- SA prisoner employment rate remained above the national average.
- The overall rate of orders successfully completed in SA is higher than the national average for the first time.

Major developments during 2000-01 in SA corrections were:

- the continuation of security upgrades at two of the State’s major prisons, and the commencement of upgrades to fire and smoke detection systems;
- expansion of education facilities for all prisoners with discrete facilities for Aboriginal prisoners; and
- the commencement of the planning stages for *Corrections Towards 2020*. This project will endeavour to chart the department’s needs and direction over the next 20 years.

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Tasmanian Government comments

“ The Tasmanian prison population (remand and sentenced) has continued to increase, resulting in further pressure being placed on facilities and staff. Despite the opening of the Hobart Remand Centre in 1999, and the availability of the Launceston Remand Centre, additional remand accommodation is consistently required within the maximum security prison at Risdon.

The Tasmanian government has acknowledged the need for significant change in the physical prison environment. The Prisons Infrastructure Redevelopment Program was announced in 2001, with large-scale planning for new facilities and services currently underway. It is envisaged that, with the prison population continuing to increase, it may become necessary to incorporate additional accommodation into existing facilities to deal with short-term overcrowding.

Despite the demands on facilities and staff, Tasmania has recently experienced a significant decrease in escape rates, and is one of only three jurisdictions reporting zero deaths in custody due to unnatural causes in 2000-01.

Tasmania's recurrent expenditure figures were affected in 2000-01 by the fact that depreciation costs of most prisons were adjusted (increased) to reflect redevelopment plans for facility replacement.

A new information system implemented in Community Corrections has enabled data to be collected in a more coordinated fashion. A similar information system is planned for implementation within Prison Services — as a result, Tasmania will be in a strong position to continue to provide data for the *Report on Government Services*, both for existing indicators and those under development. ”

Australian Capital Territory Government comments

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The ACT has had a particular focus on prevention of property crime. Initiatives have included public education about how best to protect property and a law enforcement and corrections focus on recidivist and high risk offenders. A whole of government focus has also been placed on targeting high risk children and families with the introduction of early intervention programs, particularly in the corrections, education, family services and health portfolios.

In May 2001, the ACT Government decided to proceed with the establishment of an ACT prison to house remandees and sentenced prisoners. The Government also decided that the facility would be publicly owned and would have a capacity of 480 beds, including 50 beds for periodic detainees, and would house men and women prisoners of all security classifications. Following the decision, detailed work has proceeded on a functional brief and operating specifications, enabling legislation and project delivery methodology options. The project and the model developed so far are currently subject to consideration and possible review by the new ACT Government which came to office in October 2001.

High ACT prisoner per day costs are attributed to the small numbers of detainees that can be accommodated in the Remand Centre and Periodic Detention Centre. The opening of a prison in the ACT will provide an economy of scale because the majority of the ACT's prisoners will then be held in the Territory.

The 2000-01 statistics for the ACT reveal a continued increase in the imprisonment rate and the community correction rate. The increased remand population has highlighted a consistent demand on the existing remand facilities in the ACT. All sentenced prisoners are held in NSW facilities under an agreement between the two governments.

While low by Australian standards, the rate of imprisonment rose 9.75 per cent on the previous year's rate to 87.8 prisoners per 100 000 of the adult population. The average daily prisoner population rose from 186 in 1999-2000 to 206 in 2000-01. The increase in the offender rate, which refers to offenders managed by Community Corrections rose by 15 per cent compared to the previous period.

As stated in previous years, data for smaller jurisdictions can fluctuate dramatically from year to year due to a wide range of factors including small samples and populations. The ACT Government is keen to participate in the collection of data, and in the continued development of measures that constitute these national statistics.

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Northern Territory Government comments

“ The NT Government is confident of its continued support for the Report. The data collection is beneficial to the business of Correctional Services, and is important for comparative analysis and self improvement in the Territory where few valid comparisons can be made with other service providers or jurisdictions.

The NT has two 400 bed multi-classification prisons, each with its own open security facility, and located 1500 kilometres apart. Prisons, community corrections and juvenile justice (which is excluded from the data collection) are all administered by the one Agency in the Territory, which poses significant management issues due to the jurisdictions' large geographical size (over 1.3 million square kilometres), significant population dispersion with a relatively small mass (194 200 people), and a high Indigenous population of approximately 28.5 per cent (or 55 300 people).

The NT's daily average prisoner population for 2000-01 was 660, an increase of 45 over the previous year. This shows fairly static prisoner numbers for the past four years, and has given the NT a consistently low prison utilisation rate compared to design capacity for total secure and open custody (82.5 per cent).

While offender-to-staff ratios are low, Community Corrections' staff in the NT are unique in Australia, in that they all prepare statutory reports and manage caseloads (including home detention, supervision and reparation orders) with adult and juvenile clients, in the community and under custody or detention. With a total full time equivalent staff of around 58, Community Corrections had an average daily caseload of 971 community clients in 2000-01. This amount is more than double the previous year due to the inclusion of inactive (breach or in suspense) orders in this years' national count. The total caseload would be 497 if inactive orders were excluded from the data collection. Community Corrections figures do not adequately reflect management of day to day remote area operations in the Top End, Katherine, Tennant Creek and Alice Springs regions.

The NT's contribution to community safety has been extremely effective in terms of adult deaths in custody and prisoner escapes, with no deaths by apparent unnatural causes or escapes for the year in either category. This reflects well on current prisoner management and handling practices, and of all jurisdictions the NT has the lowest five-year ranking for total unnatural deaths and escapes.

One of the single biggest rehabilitation and reintegration measures available to inmates is participation in education, with the NT ranking second highest in total participation in education, as well as leading the country in the area of vocational education and training. As well, the continued high rankings and excellent performance of the home detention (restricted movement) program is a feature of our successful management of community corrections' orders.

The NT's continued high imprisonment rate is a product of its young, transient, predominantly male population, together with a large number of Foreign Nationals (illegal fishermen and people smugglers), currently 22.6 per cent of inmates.

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10.7 Definitions

Table 10.2 Terms

<i>Term</i>	<i>Definition</i>
24-hour court cells	24-hour court cells are a place of detention located in court and/or police complexes which are managed by correctional officers and which accommodate sentenced/unsentenced prisoners/offenders for short periods of time (not including holding cells).
Community corrections	Community based management of court-ordered sanctions, post-prison administrative arrangements and fine conversions for offenders, which principally involve the provision of one or more of the following activities: supervision, programs, or community work.
Home detention	A corrective services program requiring offenders to be subject to supervision and monitoring by an authorised corrective services officer, while confined to their place of residence or place other than a prison.
Indigenous	A person is regarded as Indigenous if they identify themselves as either an Aboriginal or Torres Strait Islander person and if they are accepted as such by an Aboriginal or Torres Strait Islander community. Counting was by self disclosure for the purposes of this data collection.
Offender	An adult person with a current community based corrections order (including bail supervision unless otherwise specified).
Open custody	A custodial facility where the regime for managing prisoners did not require them to be confined by a secure perimeter physical barrier irrespective of whether a physical barrier existed.
Periodic detainee	A person in respect of whom an order for periodic detention was in force.
Periodic detention	An order of confinement, imposed by a court of law, requiring that a person be held in a legally proclaimed prison or periodic detention facility for two consecutive days within a one-week period.
Prison	A legally proclaimed prison or remand centre which held adult offenders, excluding police prisons or juvenile detention facilities.
Prisoner	A person with a court-issued authority held in full time custody under the jurisdiction of an adult corrective service agency.
Private prison	A government or privately owned prison (see definition of prison) managed under contract by a private sector organisation.
Reparation (i)	A sub-category of community based corrections which refers to all offenders with a community service bond/order or fine option that requires them to undertake unpaid work.
Reparation (ii)	In the broader context of this data collection, refers to work undertaken by prisoners or offenders that benefits the community either directly or indirectly by reduction in cost to the taxpayer.
Restricted movement	A sub-category of community based corrections which refers to offenders who are subject to a system of restricted movement including supervision and/or electronic monitoring.
Secure custody	A custodial facility where the regime for managing prisoners required them to be confined by a secure perimeter physical barrier.
Supervision (compliance)	Sub-category of community based corrections which refers to all offenders (other than those categorised as restricted movement or reparation (i)).
Work order	A community service order or bond which imposed work upon an offender. (Note: in some jurisdictions, fine options and expiations also require an undertaking by the offender to pay off the fine through community work).

Source: NCAG (2001).

Table 10.3 Descriptors^a

<i>Descriptor</i>	<i>Definition</i>
Community corrections rate	The annual average number of offenders per 100 000 population aged 17 or over in those jurisdictions where persons are remanded or sentenced to adult custody at 17 years of age or 18 and over in those jurisdictions where the age for adult custody is 18.
Daily average prisoner/periodic detention/offender population	The average number of prisoners, periodic detainees and/or offenders during the counting period.
Imprisonment rate	The annual average number of prisoners per 100 000 population aged 17 or over in those jurisdictions where persons are remanded or sentenced to adult custody at 17 years of age or 18 and over in those jurisdictions where the age for adult custody is 18.
Number of prisons/periodic detention centres	A facility gazetted as a prison, remand centre or periodic detention centre for adult offenders, operated or administered by State/Territory correctional agencies.
Recurrent expenditure	Expenditure of an ongoing nature incurred in provision of government services or programs, including salaries, payroll tax, maintenance and working expenses, grants and subsidies, other services, expenditure incurred by other departments on behalf of corrective services, contracted management services, capital asset charges and associated expenses, other recurrent costs, and relevant expenditure by umbrella and other departments.

a In some instances there is a variation with the NCAG data manual classification of 'descriptors' and 'indicators'.

Source: NCAG (2001).

Table 10.4 Indicators^a

<i>Indicator</i>	<i>Definition</i>
Assault	An act of physical violence committed by a prisoner resulting in a physical injury that may or may not require short term medical intervention of a non-hospitalised nature. An assault is recorded where either (a) a charge is proved either by a jurisdictional correctional authority, a Governor's hearing or a court of law, or (b) there is evidence that an assault took place because <u>at least one</u> of the following circumstances apply: there is at least one apparently reliable witness to the assault, or the victim claims assault and there is no obvious reason to doubt this claim, or a visible injury has occurred and there is sufficient circumstantial or other evidence to make an assault the most likely cause of the injury on the basis of the balance of probabilities. The rate is expressed per 100 prisoner years, calculated by dividing the total number of assaults by the daily average prisoner population, multiplied by 100.
Serious assault	An act of physical violence committed by a prisoner against another prisoner or staff member resulting in actual bodily harm including: (i) requiring medical treatment and assessment by a medical officer resulting in overnight hospitalisation in a medical facility (for example, prison clinic, infirmary, hospital or a public hospital); (ii) requiring extended periods of ongoing medical treatment; or (iii) all acts of sexual assault. The same requirements of (a) and (b) (above) for assault apply.

(Continued on next page)

Table 10.4 (Continued)

<i>Indicator</i>	<i>Definition</i>
Assets per prisoner/offender	The value of government owned and operated assets as a function of the daily average number of prisoners (or daily average number of offenders) held in publicly owned facilities.
Average number of hours to be worked per offender	The balance of community work hours to be worked per offender with active work orders containing community hours on the first day of the counting period and/or imposed new community work hours ordered during the counting period.
Average number of hours actually worked per offender	The number of actual hours worked per offender with a work order.
Completion rate of community orders	The proportion of community orders successfully completed (by order type) within the counting period.
Cost per prisoner/offender	The daily cost of managing a prisoner/offender, calculated against recurrent expenditure net of consolidated funds and receipts (that is, own source revenue), payroll tax, capital asset charges and other associated expenses such as debt servicing fees, depreciation or accommodation fees.
Unnatural death rate	<p>The death wherever occurring (including hospital) of a person:</p> <ul style="list-style-type: none"> • who is in prison custody; • whose death is caused or contributed to by traumatic injuries sustained, or by lack of proper care, while in such custody; • who dies or is fatally injured in the process of prison officers attempting to detain that person; or • who dies or is fatally injured in the process of that person escaping or attempting to escape from prison custody. <p>And there is sufficient evidence to suggest, subject to a Coroner's finding, that the most likely cause of death is homicide, suicide, an accidental cause, or a drug overdose. The rate is expressed per 100 prisoner years, calculated by dividing the number of deaths by the daily average prisoner population, multiplied by 100.</p>
Education rate	<p>The number of prisoners actively participating in education as a proportion of those who are eligible for educational opportunities. Those excluded from the count include:</p> <ul style="list-style-type: none"> • remandees who choose not to participate; • hospital patients or aged prisoners who are unable to participate; • prisoners whose protection status prohibits access to participation; • fine defaulters (who are only incarcerated for a few days at a time); and <p>sub-groups of the above categories.</p>
Employment (prisoners and periodic detainees)	<p>The average number of prisoners or periodic detainees employed on the first day of each month as a proportion of those eligible to participate in employment. Prisoners excluded as ineligible for employment include prisoners undertaking full time education and prisoners whose situation may exclude their participation in work programs, for example:</p> <ul style="list-style-type: none"> • remandees who choose not to work; • hospital patients or aged prisoners who are unable to work; • prisoners whose protection status prohibits access to work; • fine defaulters (who are only incarcerated for a few days at a time); and <p>sub-groups of the above categories.</p>

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Table 10.4 (Continued)

<i>Indicator</i>	<i>Definition</i>
Employment (community corrections)	The number of community work hours worked per offender during the counting period.
Escape/abscond	A person who escaped from corrective services' custody (including under contract). The rate is expressed per 100 prisoner years, calculated by dividing the number of escapes/absconds by the daily average prison population, multiplied by 100.
Offender-to-staff ratio	The level of staff supervision based on the number of staff employed and the average number of offenders.
Out-of-cell hours	The time during which prisoners were not confined to cells, averaged over all days of the year.
Periodic detention utilisation rate	The extent to which periodic detention capacity is meeting demand for periodic detention accommodation, calculated as the total daily average periodic detention population attending a residential component of the order, divided by average usable periodic detention design capacity.
Personal development	The percentage of offenders taking personal development courses provided by, or on referral from, corrective services.
Prison design capacity utilisation rate	The extent to which prison design capacity was meeting demand for prison accommodation, calculated as the total daily average prisoner population divided by average useable prison design capacity.
Ratio of number of hours ordered to actual hours worked per offender	The ratio of number of hours ordered to be worked to number of hours actually worked during the counting period per offender with a work order.
Recidivism: return to corrections	<p><i>Prisoners</i></p> <p>The proportion of sentenced prisoners not subject to further supervision/contact with corrective services upon release who return to Corrective Services with a new correctional sanction within two years of completing a prison sentence.</p> <p><i>Community Corrections</i></p> <p>The proportion of offenders not subject to further supervision/contact with corrective services upon completion of an order who return to Corrective Services with a new correctional sanction, within two years of the last community order completion date.</p>
Recidivism: return to prison	The proportion of sentenced prisoners not subject to further supervision/contact with corrective services upon release who returned to prison with a new correctional sanction within two years of completing a prison sentence.
Recidivism: return to community corrections	The proportion of offenders completing a community order, not subject to further supervision/contact with corrective services upon completion, who returned to community corrections with a new correctional sanction, within two years of the last community order completion date.

^a In some instances there is a variation with the NCAG data manual classification of 'descriptors' and 'indicators'.

Source: NCAG (2001).

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