Report on Government Services 2003

Volume 2:
Health, Community Services, Housing

Steering Committee for the Review of Commonwealth/State Service Provision

ISSN 1328 181X
ISBN 1 74037 110 0

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Suggestions:

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An appropriate citation for this publication is:

SCRCSSP (Steering Committee for the Review of Commonwealth/State Service Provision) 2003, *Report on Government Services 2003*, Productivity Commission, Canberra.

Contents

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

Volume 1

Volume 2

Acronyms and abbreviations

ABS	Australian Bureau of Statistics
ACAP	Aged Care Assessment Program
ACAT	Aged Care Assessment Team
ACC	Australian Crime Commission
ACCHS	Aboriginal Community Controlled Health Services
ACER	Australian Council for Educational Research
ACHS	Australian Council on Healthcare Standards
ACIR	Australian Childhood Immunisation Register
ACPR	Australian Centre for Policing Research
ACSQHC	Australian Council for Safety and Quality in Health Care
ACT	Australian Capital Territory
AFAC	Australasian Fire Authorities Council
AGPAL	Australian General Practice Accreditation Limited
AGPS	Australian Government Publishing Service
AHA	Aboriginal Housing Authority (SA)
AHCA	Australian Health Care Agreements
AHMAC	Australian Health Ministers' Advisory Council
AIC	Australian Institute of Criminology
AIHW	Australian Institute of Health and Welfare
AIMS	Australian Incident Monitoring System
AJJA	Australasian Juvenile Justice Administrators
ANTA	Australian National Training Authority
ANTA MINCO	Australian National Training Authority Ministerial Council
AQF	Australian Qualifications Framework
AR-DRG	Australian revised diagnosis related group
ARHP	Aboriginal Rental Housing Program

ARIA	Accessibility and Remoteness Index for Australia
ATLAS	Audit Training, Learning and Support Program (NSW)
ATSIC	Aboriginal and Torres Strait Islander Commission
Aust	Australia
BEACH	Bettering the Evaluation and Care of Health
BRC	Belconnen Remand Centre (ACT)
CAA	Convention of Ambulance Authorities
CACP	Community Aged Care Package (Program)
CCCCS	Commonwealth Census of Child Care Services
CD-ROM	Compact Disc Read Only Memory
CFA	Country Fire Authority
CFU	Community Fire Unit (NSW)
CGC	Commonwealth Grants Commission
CHINS	Community Housing and Infrastructure Survey
CHOGM	Commonwealth Heads of Government Meeting
CIS	Complaints Information System
CMF	Command Management Framework
COAG	Council of Australian Governments
CRA	Commonwealth Rent Assistance
CRF	Common Reporting Framework
CRROH	Centre for Remote and Rural Oral Health (WA)
CSDA	Commonwealth–State Disability Agreement
CSHA	Commonwealth State Housing Agreement
CSTDA	Commonwealth–State–Territory Disability Agreement
DALE	Disability Adjusted Life Expectancy
DALY	Disability Adjusted Life Years
DCIS	Ductal carcinoma in situ
DCS	Department of Correctional Services (SA)
DEA	data envelopment analysis
DES	Department of Emergency Services (Qld)

DEST	Department of Education, Science and Training
DFaCS	Department of Family and Community Services
DHA	Department of Health and Ageing
DHAC	Department of Health and Aged Care
DHS	Department of Human Services (Vic)
DMMR	Domiciliary Medication Management Review
DNRE	Department of Natural Resources and Environment (Vic)
DoCS	Department of Community Services (NSW)
DoH	Department of Health (WA)
DRG	Diagnosis related group
DSQ	Disability Services Queensland
DVA	Department of Veterans' Affairs
EACH	Extended Aged Care at Home
ERP	estimated resident populations
ESL	Emergency Services Levy
FACS	Family and Community Services (NT)
FESA	Fire and Emergency Services Authority (WA)
FTE	full time equivalent
FWE	full time workload equivalent
GAP	Government Action Plan (NSW)
GDP	gross domestic product
GP	general practitioner
GPA	General Practice Australia
GPMoU	General Practice Memorandum of Understanding
GST	goods and services tax
HACC	Home and Community Care (program)
HRSCEET	House of Representatives Standing Committee on Employment, Education and Training
ICD	International classification of diseases
ICD-10-AM	international statistical classification of diseases and related health problems, 10th revision, Australian modification

ICMS	Integrated Court Management System
ICT	information and communication technology
IHANT	Indigenous Housing Authority of the NT
IMP	Information Management Plan
ITAB	Industry Training Advisory Bodies
KPI	Key Performance Indicators
LAC	local area command
LLEN	Local Learning and Employment Networks
LLISC	Learning Lessons Implementation Steering Committee
LSI	Likert Summation Index
MAP	Multilevel Assessment Program
MBS	Medicare Benefits Schedule
MCATSIA	Ministerial Council for Aboriginal and Torres Strait Islander Affairs
MCEETYA	Ministerial Council on Education, Employment, Training and Youth Affairs
MDS	minimum data set
NAC	National Advisory Committee to BreastScreen Australia
NACCHO	National Aboriginal Community Controlled Health Organisation
NAGATSIHID	National Advisory Group Aboriginal and Torres Strait Islander Health Information and Data
NATSEM	National Centre for Social and Economic Modelling
NBCC	National Breast Cancer Centre
NCA	National Crime Authority
NCIS	National Coroners Information System
NCJSF	National Crime and Justice Statistical Framework
NCPASS	National Child Protection and Support Services
NCSIMG	National Community Services Information Management Group
NCVER	National Centre for Vocational Education Research

NDCA	National Data Collection Agency
NESB	non-English speaking background
NGO	non-Government organisation
NHCDC	Commonwealth Department of Health and Aged Care, National Hospital Cost Data Collection
NHIMG	National Health Information Management Group
NHPC	National Health Performance Committee
NHPF	National Health Performance Framework
NIDP	National Information Development Plan
NMDS	national minimum data set
NMHS	National Mental Health Strategy
NPDDC	National Perinatal Data Development Committee
NPS	National Prescribing Service
NRCP	National Respite for Carers Program
NSCSP	National Survey of Community Satisfaction with Policing
NSMHS	National Survey of Mental Health Services
NSW	New South Wales
NT	Northern Territory
NTDAB	NT Disability Advisory Board
NTFRS	NT Fire and Rescue Service
NTPFES	Northern Territory Police, Fire and Emergency Services
OCR	Operations and Crime Review (NSW)
OECD	Organisation for Economic Cooperation and Development
OHCWA	Oral Health Centre of Western Australia
OMP	Other Medical Practitioner
PACT	Police Accountability Community Team (NSW)
PBS	Pharmaceutical Benefits Scheme
PIP	Practice Incentives Program
PIPS	Performance Indicators for Primary Schools
PISA	Program for International Student Assessment

PMRT	Performance Measurement and Reporting Taskforce
PSM	Population Survey Monitor
QIAS	Quality Improvement and Accreditation System
Qld	Queensland
RACGP	Royal Australian College of General Practitioners
RCS	Resident Classification Scale
Review	Review of Commonwealth/State Service Provision
RRMA	Rural, Remote and Metropolitan Area Classification System
SA	South Australia
SAAP	Supported Accommodation Assistance Program
SAAS	SA Ambulance Service
SACHA	South Australian Community Housing Authority
SAHT	South Australian Housing Trust
SAPOL	South Australia Police
SCRCSSP	Steering Committee for the Review of Commonwealth/State Service Provision
SDA	service delivery area
SES/TES	State Emergency Service/Territory Emergency Service
SHMT	State Health Management Team (WA)
SLA	statistical local area
SMART	SAAP Management and Reporting Tool
SRCSSP	Secretariat for the Review of Commonwealth/State Service Provision
STRC	Symonston Temporary Remand Centre (ACT)
SWPE	standardised whole patient equivalent
TAFE	technical and further education
Tas	Tasmania
TCP	Transitional Care Program (WA)
TFS	Tasmania Fire Services
VCAL	Victorian Certificate of Learning
VCE	Victorian Certificate of Education

VET	vocational education and training
VHC	Veterans' Home Care (program)
VHS	Victorian Homelessness Strategy
Vic	Victoria
WA	Western Australia
WHO	World Health Organisation
YLD	years of life lost due to disability
YLL	years of life lost due to premature mortality

Glossary

Constant prices	See ‘real dollars’.
Current prices	See ‘nominal dollars’.
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.
Nominal dollars	Refers to financial data expressed ‘in the price of the day’ and which is **not** adjusted to remove the effects of inflation. Nominal dollars do not allow for inter-year comparisons because reported changes may reflect changes to financial levels (prices and/or expenditure) and adjustments to maintain purchasing power due to inflation.
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.
Real dollars	Refers to financial data measured in prices from a constant base year to adjust for the effects of inflation. Real dollars allow the inter-year comparison of financial levels (prices and/or expenditure) by holding the purchasing power constant.

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

E 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 of health issues, thereby reducing the risk and onset of illness and injury (box E.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 primarily concentrates on the performance of public hospitals (chapter 9) and general practitioners (GPs) (chapter 10) because these services represent a significant component of government recurrent expenditure on health care. Australian governments expended $21.6 billion (1999-2000 dollars[1]) on public hospitals and medical services (which includes payments to GPs and other specialist practitioners) in 2000-01 — 56.7 per cent of government recurrent health expenditure (table EA.2). The Report also examines the interactions between different service mechanisms for dealing with two health management issues: mental health and breast cancer (chapter 11). While there are no specific estimates of government expenditure for the detection and management of breast cancer, government expenditure on specialist mental health services was estimated to be $2.6 billion in 2000-01. Some of this expenditure was on psychiatric care provided by public (non-psychiatric) hospitals.

Estimates of government expenditure on health care provision commonly include (by definition) high level residential aged care services. These services are not covered in the health chapters in this Report but are reported separately in chapter 12 (Aged care services). Patient transport services are also included in estimates of government health expenditure. Ambulance services (defined as pre-hospital care, treatment and transport services) are reported in chapter 8 (Emergency management).

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

[1] In real dollars (1999-2000). The published source data from the Australian Institute of Health and Welfare (AIHW) use this base year and the same base year is used here for consistency.

- government support for pharmaceuticals;
- community health services (although reporting on community health services for patients with mental disorders is increasing);
- public health programs, other than those for breast cancer and mental health; and
- funding for specialist medical practitioners.

A range of government services, such as education, public housing, sanitation and water supply also influence health outcomes. These are not formally part of Australia's health system and are not the subject of the health chapters. Education (chapters 3 and 4) and public housing (chapter 16) are, however, included in other chapters of the Report. A range of other factors, such as Indigenous status, socioeconomic status and residential location are also potential influences on health outcomes. It is a priority of the Review to improve the reporting of data on delivery of health care services for Indigenous people and residents in nonmetropolitan regions of Australia.

The remainder of this preface is a summary of the nature of Australia's health care system and health outcomes. It also foreshadows future directions in reporting.

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\2003\AttachEA.xls or in Adobe PDF format at \Publications\Reports\2003\AttachEA.pdf.

Supporting tables are identified in references throughout this chapter by an 'A' suffix (for example, table EA.3 is table 3 in the electronic files). 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 these tables (see details on the inside front cover of the Report).

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

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

General practitioners: medical practitioners who, for the purposes of Medicare, are vocationally registered under 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 [MBS]). Some people use the term to include other forms of Commonwealth Government funding — for example, funding of selected pharmaceuticals (Pharmaceutical Benefits Scheme [PBS]) and public hospital funding (Australian Health Care Agreements [AHCA]) — 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 people who elect to be treated as public patients. It also provides free services to eligible non-admitted patients and may provide (and charge for) treatment and accommodation services to private patients. However, charges to non-admitted patients and admitted patients on discharge may be levied in accordance with the AHCA (for example, charges for aids and appliances).

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

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;
- funding the PBS;
- funding high level residential aged care 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 (such as health promotion programs and disease prevention);
- mental health programs;
- patient transport; 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), private hospitals and high level residential aged care 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 MBS, 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 AHCA.

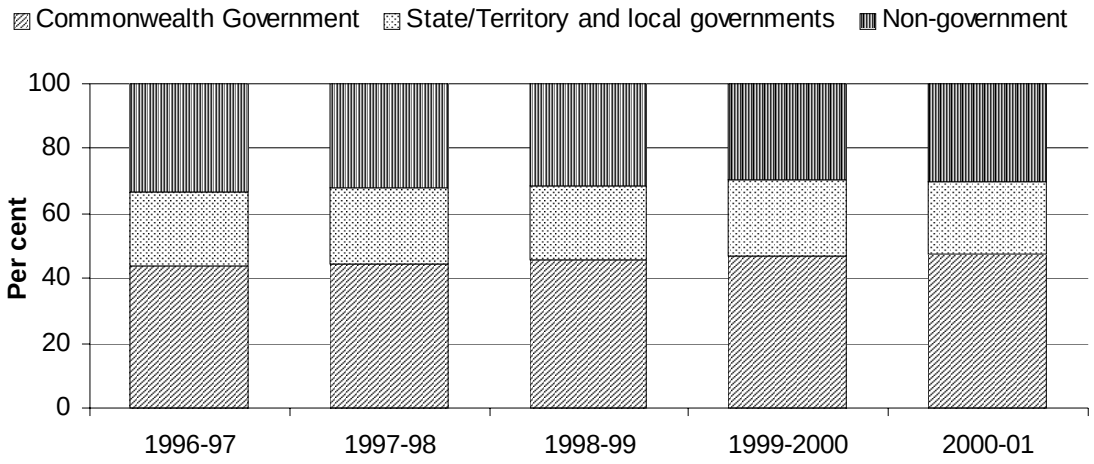
State and Territory governments, through income raised by taxes and from both general and specific-purpose grants received from the Commonwealth, contribute funds to community health services and public hospitals (through casemix and other payments), which in turn fund specialists (through limited fee-for-service 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 $42.5 billion (70.0 per cent) of total health expenditure in 2000-01, with the remainder coming from individuals, health insurance funds, and workers compensation and compulsory motor vehicle third party insurance providers (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 — $28.8 billion or 47.5 per cent in 2000-01 (figure E.1). State, Territory and local governments contributed $13.7 billion or 22.5 per cent of total health care expenditure.

Size and scope of sector

Total expenditure (recurrent and capital) on health care services in Australia was estimated to be $60.8 billion in 2000-01. This was equivalent to 9.0 per cent of gross domestic product, up from 7.9 per cent in 1990-91 (AIHW 2002a). This implies that health care expenditure grew faster than the economy over the last decade.

Figure E.1 **Total health expenditure by source, 1996-97 to 2000-01**[a, b, c, d, e]



[a] Includes recurrent and capital expenditure. [b] Includes expenditure on high level residential aged care which is reported in chapter 12. [c] Expenditure by the Commonwealth Government and the non-government sector has been adjusted for tax expenditures. [d] 'Non-government' includes expenditure by individuals, health insurance funds, workers compensation and compulsory motor vehicle third party insurers. [e] Expenditure for 2000-01 based on preliminary estimates by the AIHW and the Australian Bureau of Statistics (ABS).

Source: AIHW (2002a); table EA.1.

The growth of total health 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

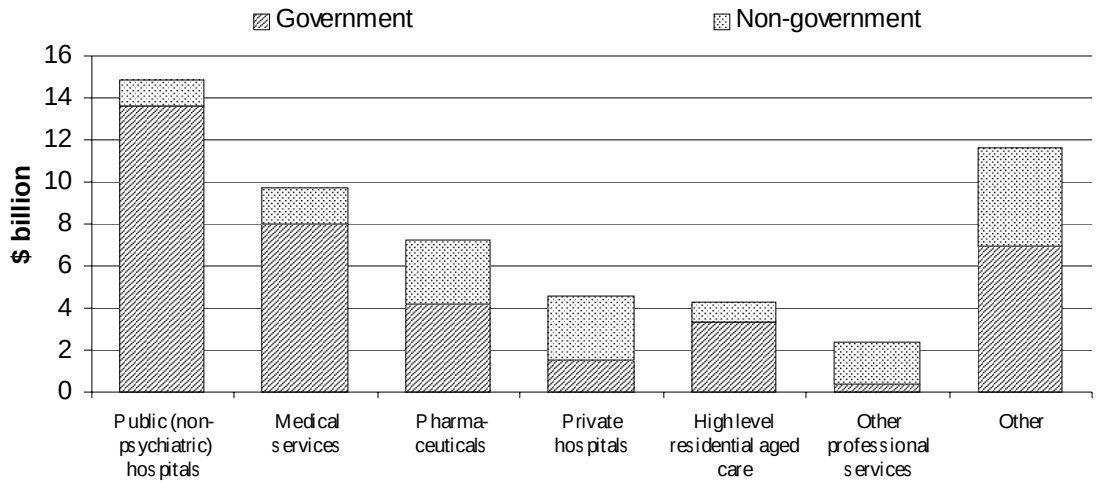
governments and non-government sources. Between 1990-91 and 2000-01 the real average annual rate of growth in expenditure was 5.7 per cent for the Commonwealth Government, 3.2 per cent for State, Territory and local governments and 3.5 per cent for non-government sources (AIHW 2002a). A significant factor in the latter part of the decade 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 was $1.6 billion for 1999-2000 and increased to $2.1 billion for 2000-01 (AIHW 2002a).

The single largest item of recurrent health care expenditure by government and non-government sources in 2000-01 was public (non-psychiatric) hospitals. Total expenditure on these services was $14.8 billion, of which governments contributed $13.6 billion (1999-2000 dollars[2]) (tables EA.2 and EA.3). Public (non-psychiatric) hospitals accounted for 35.7 per cent of government recurrent expenditure on health care services in 2000-01. Medical services accounted for $8.0 billion of government expenditure (21.0 per cent) and pharmaceutical services accounted for $4.2 billion (11.0 per cent) (figure E.2). More information on health expenditure by area of expenditure and source of funds is included in table EA.14.

[2] In real dollars (1999-2000). The published source data from the AIHW use this base year and the same base year is used here for consistency.

Figure E.2 **Total health services recurrent expenditure, 2000-01 (1999-2000 dollars)[a, b, c, d]**

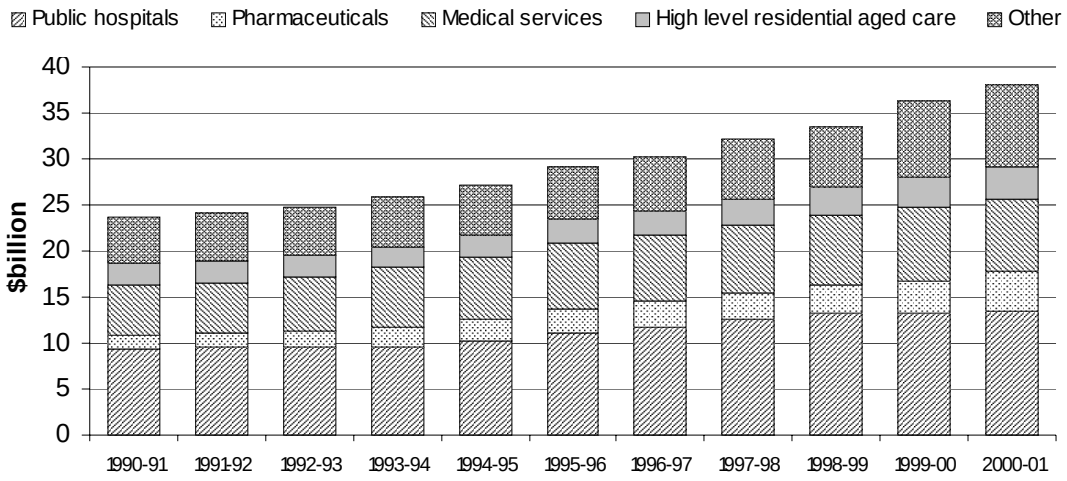


a Almost all expenditure on 'medical services' relates to services provided by practitioners on a fee-for-service basis, including those provided to private patients in hospitals. Excluded are the medical component of hospital care provided to public hospital inpatients and outpatient medical services provided at public hospitals. **b** 'Pharmaceutical services' include (but are not limited to) those provided under the PBS. **c** High level residential aged care services cover services to those residents requiring and receiving a level of care that falls within one of the four highest levels of care in residential aged care services. These services are commonly classified as health services expenditure, but are included in the Report in chapter 12 (Aged care services). **d** 'Other' includes community and public health services, dental services, funding for aids and appliances, administration, ambulance services (reported in chapter 8 [Emergency management]), research and public psychiatric hospitals.

Source: AIHW (2002a); tables EA.2 and EA.3.

The relative share of government recurrent health expenditure allocated to public hospitals has fallen since 1990-91 when it was 39.6 per cent. This decline reflects the more rapid growth over the decade of expenditure on medical and pharmaceutical services (figure E.3). The real average annual growth rate of government recurrent expenditure on medical services was 4.2 per cent between 1990-91 and 2000-01 and on pharmaceuticals was 10.8 per cent, compared with 3.7 per cent for public hospitals (AIHW 2002a). The most rapid areas of growth in government expenditure were private hospitals and other professional services, which grew 30.7 per cent and 9.0 per cent, respectively (AIHW 2002a). Several policy measures introduced to restrain growth in health expenditure over the decade include the restriction of Medicare provider numbers, initiatives to encourage the use of generic pharmaceutical brands and increases in co-payments for pharmaceuticals.

Figure E.3 **Government real recurrent health expenditure (1999-2000 dollars)[a, b, c, d]**



a 'Pharmaceutical services' include (but are not limited to) those provided under the PBS. **b** Almost all expenditure on 'medical services' relates to services provided by practitioners on a fee-for-service basis, including those provided to private patients in hospitals. Excluded are the medical component of hospital care provided to public hospital inpatients and outpatient medical services provided at public hospitals. **c** High level residential aged care is included by definition in health expenditure, but is reported along with other aged care services in chapter 12 (Aged care services). **d** 'Other' includes community and public health services, funding for aids and appliances, administration, private hospitals, ambulance services (reported in chapter 8 [Emergency management]), research, dental services and public psychiatric hospitals.

Source: AIHW (2002a); table EA.2.

The rapid growth of expenditure on pharmaceutical services and private hospitals meant that their proportion of government health care expenditure rose over the period 1990-91 to 2000-01. Expenditure on pharmaceutical services increased from 6.4 per cent of government expenditure in 1990-91 to 11.0 per cent in 2000-01. Expenditure on private hospitals increased from 0.5 per cent in 1990-91 to 4.1 per cent in 2000-01 (table EA.2).

Health expenditure per person

Health expenditure in each State and territory is affected by different policy initiatives and differences in socioeconomic and demographic characteristics. Total health expenditure (recurrent and capital) per person in 2000-01 was $3153, rising by 14.9 per cent in the two years since 1998-99 (when it was $2743). In 2000-01, it was highest in the ACT ($3499) and lowest in WA ($3092) (table EA.13).

The most recent data for recurrent expenditure by State and Territory are for 1999-2000. Recurrent expenditure on health care services rose from $2616 per person in 1998-99 to $2726 per person in 1999-2000 (in 1999-2000

dollars) (table EA.11).[3] Recurrent spending per person in 1999-2000 was highest in the NT ($3020) and lowest in Queensland ($2609).

Government recurrent spending rose from $1776 per person in 1998-99 to $1898 in 1999-2000 (1999-2000 dollars) (table EA.11).[4] Government expenditure in 1999-2000 was highest in the NT ($2393 per person) and lowest in Victoria ($1795 per person) (figure E.4).

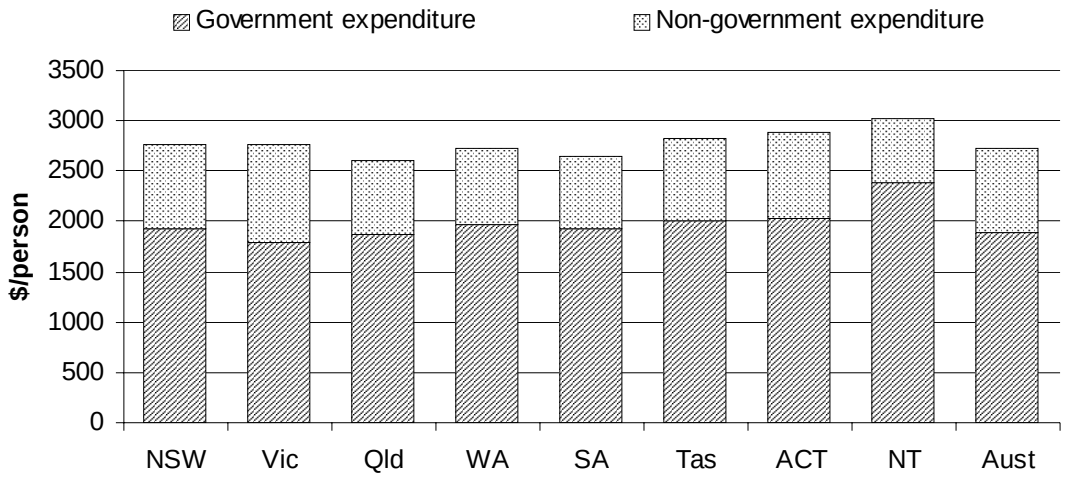
Non-government recurrent spending per person declined between 1998-99 and 1999-2000 (from $840 to $827 in 1999-2000 dollars).[5] Non-government expenditure was highest in Victoria ($974 per person) and lowest in the NT ($628 per person) in 1999-2000 (figure E.4).

[3] For the purposes of separating health expenditure from spending on aged care covered in chapter 12, recurrent spending per person on health care services can also be calculated excluding expenditure on high level residential aged care. If spending on high level residential aged care is removed, total recurrent expenditure on health care services rose from $2415 per person in 1998-99 to $2513 per person in 1999-2000 (in 1999-2000 dollars) (table EA.12). In 1999-2000, total expenditure per person on health excluding spending on high level residential aged care was highest in the NT ($2959) and lowest in SA ($2387).

[4] If spending on high level residential aged care is removed, government recurrent expenditure on health care services rose from $1619 per person in 1998-99 to $1733 per person in 1999-2000 (in 1999-2000 dollars) (table EA.12). In 1999-2000, government expenditure on health excluding spending on high level residential aged care ranged from $2347 in the NT to $1641 in Victoria.

[5] If spending on high level residential aged care is removed, non-government recurrent expenditure on health care services dropped from $796 per person in 1998-99 to $780 per person in 1999-2000 (in 1999-2000 dollars) (table EA.12). In 1999-2000, non-government expenditure on health excluding spending on high level residential aged care ranged from $930 per person in Victoria to $612 per person in the NT.

Figure E.4 **Total recurrent expenditure per person, 1999-2000**



Source: AIHW (2002a); table EA.11.

Expenditures on health services for Indigenous people

The Steering Committee has allocated a high priority to reporting on Indigenous people. There are limited data available on Indigenous health and the data are of poor quality. Some of the problems associated with Indigenous health data are outlined in ABS/AIHW (2001) and Australian Indigenous Health Infonet (2002). In summary:

- estimating the Indigenous population is difficult because the propensity for people to identify as Indigenous varies;
- Indigenous people are not always accurately identified in administrative collections, such as hospital records and birth and death registrations, due to variations in definitions, different data collection methods and failure to record Indigenous status; and
- sampling for national household surveys is usually designed to provide aggregate information about the total Australian population, often does not include remote areas, and is usually insufficient to enable separate results to be published for Indigenous people.

Estimating health services expenditure for Indigenous people is difficult. Department of Veterans' Affairs' records do not identify Indigenous status. In other data sets, while Indigenous status is recorded, the identification of Indigenous people remains incomplete. Indigenous people have been able to voluntarily identify as Indigenous for the Medicare and PBS databases since late 2002.

Two sets of estimates of health services expenditure for Aboriginal and Torres Strait Islander people have now been released; the most recent for 1998-99 (AIHW 2001a). Expenditure on primary care (including Medicare and the PBS) was approximated based on survey data, with identification of Indigenous status acknowledged as being incomplete. A full account of the most recent estimates was provided in the 2002 Report. The key issues are repeated here.

Total recurrent expenditure on health services for Indigenous people was around $1.2 billion in 1998-99.[6] This was equivalent to $3065 per Indigenous person compared with $2518 per non-Indigenous person; a ratio of 1.22:1 (table E.1).[7]

The study (AIHW 2001a) found that 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 was taken into account. Indigenous people were on average much higher users of publicly provided health services, but used fewer privately provided services (such as doctors in private practice). 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 in 1998-99. 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 E.1).

The vast majority of Indigenous health expenditure was allocated through mainstream health programs — admitted and non-admitted patient services, community health services, medical and pharmaceutical health services and public health services. A small proportion of health expenditure was allocated through programs directly targeting Indigenous people, the most significant being the Aboriginal Community Controlled Health Services (ACCHSs).

6 The Report examines recurrent expenditure only. Capital costs are not included in expenditure estimates.

7 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 E.1 **Estimated recurrent expenditure by source of funds and by Indigenous status, 1998-99 (per person)[a]**

Source of funds	*Indigenous*		*Non-Indigenous*		*Indigenous/ other*
	$/person	%	$/person	%	Ratio
State government funding of State government programs	*1 376*	*44.9*	*484*	*19.2*	*2.84*
Commonwealth Government funding	*1 393*	*45.5*	*1 206*	*47.9*	*1.15*
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
Local government funding	*15*	*0.5*	*9*	*0.4*	*1.67*
Total government	**2 783**	**90.8**	**1 700**	**67.5**	**1.64**
Total private[b]	**281**	**9.2**	**819**	**32.5**	**0.34**
Total health expenditure	**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. – Nil or rounded to zero. .. Not applicable.

Source: AIHW (2001a).

While the Commonwealth was the major *source* of funding in 1998-99 (table E.1), the majority of health services provided to Indigenous people were *administered* by State and Territory governments (around 72.0 per cent). State and Territory government services may be funded by the States and Territories, by the Commonwealth or from private sources. 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 (AIHW 2001a). Commonwealth Government programs may be funded by the Commonwealth or from private sources.

Indigenous Australians are currently using secondary/tertiary care at a higher rate than primary health care. Patterns of government expenditure per person in 1998-99 for Indigenous people reflected their relatively higher use of hospital services (both admitted and non-admitted) compared with non-Indigenous Australians. Expenditure on Indigenous people in public hospitals was twice as much per person, and in community and public health services more than five times as much per person, as expenditure for non-Indigenous people (see table E.2). On the other hand, expenditure per person on Medicare and the PBS was much lower for Indigenous people — around 39 per cent of that for non-Indigenous people (AIHW 2001a) (table E.1). Indigenous per person expenditure on private sector services was only 23 per cent of non-Indigenous expenditure per person (table E.2).

Table E.2 **Estimated recurrent expenditure by program and by Indigenous status, 1998-99[a]**

	Indigenous $/person	*non-Indigenous $/person*	*Ratio Indigenous/ non-Indigenous*
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
Public hospitals	*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[c]	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 health expenditure	**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, and includes MBS payments through patient co-payments, and MBS payments through the Department of Veterans' Affairs. **c** Includes PBS payments through patient co-payments and PBS payments through the Department of Veterans' Affairs.

Source: AIHW (2001a).

International experience has shown that a comprehensive approach to primary health care can contribute to significant improvements in health in developing countries and among Indigenous populations in developed countries comparable to Australia (DHA 2001).

In its 1999-2000 budget, the Commonwealth Government announced the Primary Health Care Access Program, a local health services development program to increase the availability of appropriate primary health care services for Indigenous Australians where services are inadequate. The program will establish a framework for the expansion of comprehensive primary health care services, including clinical care, illness prevention and early intervention activities and management and support system, in a planned and coordinated manner in line with regional planning.

Framework for measuring the performance of the health system

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

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

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

- preventing or detecting illness through the provision of services that can achieve improved health outcomes at relatively low cost;
- caring for ill people through the use of appropriate health and medical intervention services;
- providing appropriate health care services 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 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), play an important role in determining outcomes. Factors external to the health system, such as socioeconomic and demographic characteristics of the population, and infrastructure and the environment, are also relevant.

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 taken a two-pronged approach. First, there are performance indicator

frameworks for significant providers (hospitals and GPs). Second, there are separate frameworks that aim to examine the appropriate mix of services, including the prevention of illness and injury, medical treatment and the appropriate mix of service delivery mechanisms. The latter are measured by focusing on health management issues — breast cancer and mental health.

Individual performance indicator frameworks are discussed in more detail in chapters 9, 10 and 11. 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 National Health Performance Committee framework for measuring the performance of the health system

The 2002 Report noted the development, in 2001, of the National Health Performance Framework (NHPF) by the National Health Performance Committee (NHPC). The framework consists of three tiers:

- 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
- performance of health systems (grouped into nine dimensions comprising effectiveness, appropriateness, efficiency, responsiveness, accessibility, safety, continuity, capability and sustainability).

Equity is incorporated across all tiers of the framework using the question: 'Is it the same for everyone?'

A number of other groups involved in health performance indicator development have adopted this framework, adapting it for use within specific project areas. These groups include, for example, the National Health Priority Performance Advisory Group, the National Public Health Partnership, the Australian Council for Safety and Quality in Health Care, the National Mental Health Working Group and the Australian Council on Healthcare Standards.

Alignment of the Review and NHPC frameworks

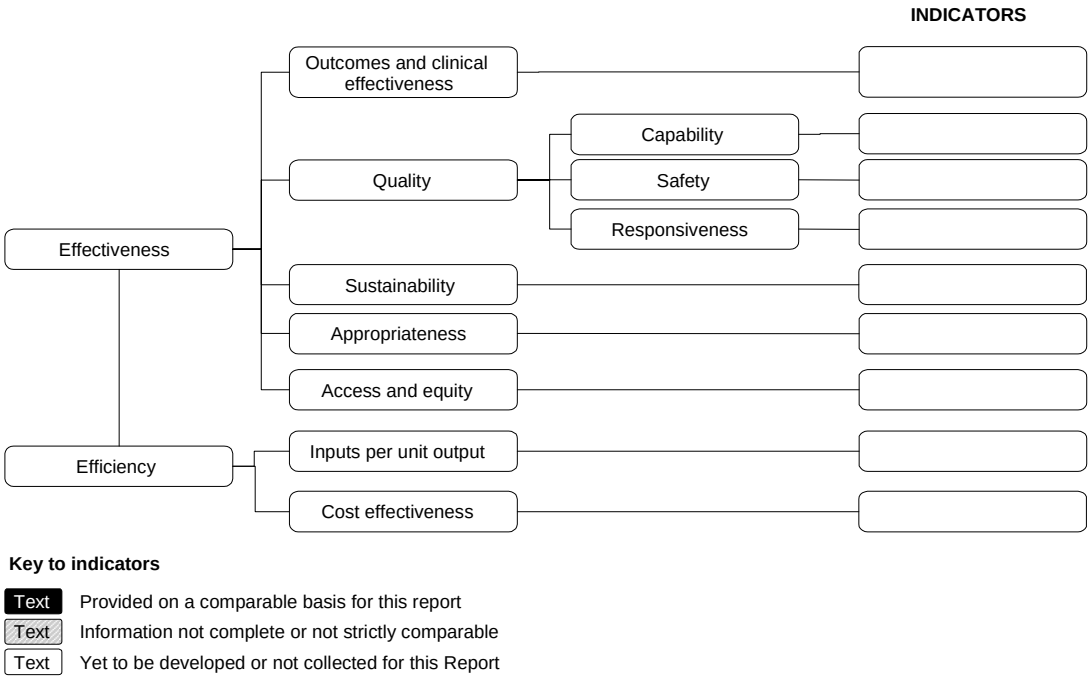
The development of the NHPF is a significant achievement and is likely to drive reporting in the health sector in future. The Steering Committee therefore considers

alignment of the Review framework and the NHPF desirable wherever possible. There are obvious similarities between the frameworks used for the health chapters of the Report and the framework used by the NHPC, however, it should be noted that the frameworks cannot be completely aligned as the aims and terms of reference of the Review and the NHPC differ.

- The Review focuses on comparisons across State and Territory governments, while the NHPC does not necessarily report by jurisdiction.
- The NHPC may not always present ongoing comparisons of the same indicators, with the intention of taking a theme based approach, whereas the terms of reference for the Review require that it present a consistent set of data and indicators to allow for evaluation over time.
- The Review framework is used to compare the efficiency and effectiveness of government service provision (tier three of the NHPC framework), while the NHPC framework is designed to allow benchmarking of the whole health system, including the performance of the non-government sector and external influences.

A new Review framework more closely aligned to the NHPC framework is presented in figure E.5. It includes dimensions from the third tier of the NHPC framework (sustainability, responsiveness, capability and safety). Reporting against this framework will commence in the 2004 Report.

Figure E.5 **Future performance indicator framework for the health chapters of the *Report on Government Services 2004***



Selected indicators of health outcomes

It is difficult to isolate the effect of health care services on the general health of the population. Socioeconomic factors (such as ethnicity, residential location, income levels and employment rates) and the provision of nonhealth care government services (such as clean water, sewerage, nutrition, education and public housing) each contribute to overall health outcomes. Data on health outcomes presented in this Report include life expectancy, mortality rates (for infants and all people), leading causes of death, and the birthweight of babies.

As discussed elsewhere, reporting data for Indigenous people is a priority for the Review. Where possible, data are presented for Indigenous people as well as the Australian population as a whole.

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. It is important to remember the limits of the data presented, due to the effects of other nonhealth related factors.

Prevalence of illness and injury

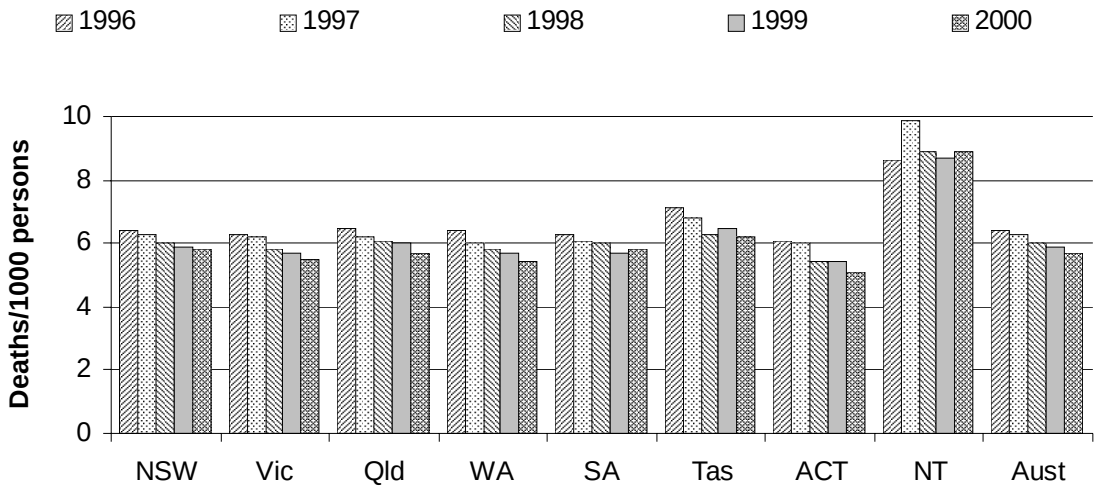
One method for measuring overall health outcomes is to use data outlining the prevalence and incidence of illness and injury. The Australian Bureau of Statistics (ABS) published data on the prevalence of illness and injury in 1997 based on the 1995 National Health Survey (table EA.4). These data have been discussed in previous editions of the Report. Data from the 2001 National Health Survey will be included in the 2004 Report.

Mortality rates

Another method for measuring overall health outcomes is to use mortality rates among all people and infants. There were 128 291 deaths in Australia in 2000 (ABS 2001a) which translated into an age-standardised mortality rate of 5.7 per 1000 people (figure E.6). Across jurisdictions, mortality rates in 2000 were highest in the NT (8.9 per 1000) and lowest in the ACT (5.1 per 1000).

Data on Indigenous mortality are collected through State and Territory death registrations. Although these data collections have good data for the total Australian population, the accuracy of the identification of Indigenous Australians varies significantly between States and Territories. The term 'coverage' refers to the number of Indigenous deaths registered, expressed as a percentage of the number of deaths expected based on Census-based population data. The NT, SA, WA and, more recently, Queensland are generally considered to have the best coverage of death registrations for Indigenous people. In 2000, the estimated coverage ranged from 92 per cent in the NT to six per cent in Tasmania, with 59 per cent coverage Australia-wide (based on 1996 low series population projections). There are also limitations to identification in the Census and births data which affect the reliability of Indigenous mortality data. There can be underestimation of the number of Indigenous deaths (or births) and, by extension, an underestimation of the mortality (or birth) rate of Indigenous people (ABS 2001a). 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 2000). With these caveats in mind the Indigenous mortality rate in 2000 in the NT, SA and WA combined was 21 deaths per 1000, a rate over three times the national rate for all people (six per 1000) (ABS 2001a). Of these three jurisdictions, the Indigenous mortality rate in 2000 was highest in the NT (24.0 per 1000) and lowest in SA (18.1 per 1000) (table E.3).

Figure E.6 **Mortality rate per 1000 people, age standardised**



Source: ABS (2001 and unpublished); table EA.5.

Table E.3 **Mortality rates, age standardised for all causes, 2000 (per 1000 people)**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*[a]
All Australians	5.8	5.5	5.7	5.4	5.8	6.2	5.1	8.9	5.7
Indigenous[b]	12.0	12.1	14.0	19.8	18.1	**na**	**na**	24.0	15.2

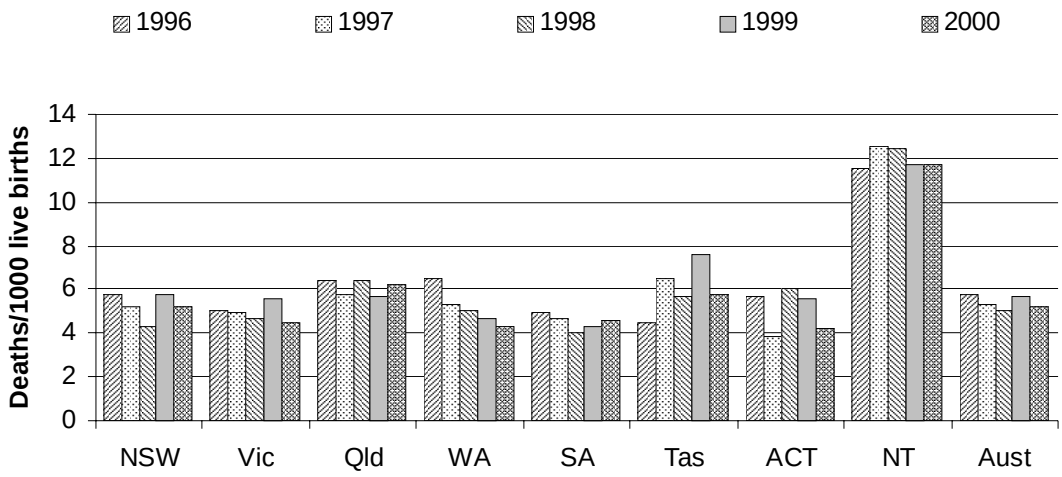
a Figures for Australia include 'Other Territories'. **b** Indigenous death rates for 2000 are based on indirect age standardisation according to the ABS *Experimental Projections for the Indigenous Population: 1996 to 2006.* **na** Not available.

Source: ABS (2001a); table EA.5.

Infant mortality rates[8] in Australia declined between 1991 and 1998 — from 7.1 to 5.0 per 1000 live births (table EA.6). Between 1998 and 1999, the national infant mortality rate increased from 5.0 to 5.7, however, between 1999 and 2000 infant mortality rates decreased in NSW, Victoria, WA, Tasmania and the ACT. These decreases are reflected in a lower national infant mortality rate — 5.2 in 2000 (figure E.7). Across jurisdictions, infant mortality rates in 2000 were highest in the NT (11.7 per 1000 live births) and lowest in the ACT (4.2 per 1000 live births).

8 The number of deaths of children under one year of age in a calendar year per 1000 live births in the same calendar year.

Figure E.7 **Infant mortality rate**



Source: ABS (2001 and unpublished); table EA.6.

Infant mortality rates for Indigenous Australians are reported for NSW, Queensland, WA and the NT in this year's Report. The accuracy of Indigenous mortality data is variable due to varying rates of coverage across jurisdictions and over time, and changes in the estimated Indigenous population caused by changing rates of identification in the Census and births data. The Indigenous infant mortality rate was between 22.9 per 1000 live births in the NT and 10.7 per 1000 live births in Queensland (between 4.4 times (NT) and 2.1 times (Queensland) the national average for all Australians in 2000) (table EA.6).

Principal causes of death

The main causes of death among Australians in 2000, 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 83.5 per cent of all deaths among males and 80.2 per cent of all deaths among females (table EA.7).

Table E.4 summarises the most significant individual causes of mortality among Australian males and females. Ischaemic heart disease, acute myocardial infarction and stroke are the most common causes for both men and women.

Table E.4 **Principal causes of deaths, 2000 (per cent)**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Male									
Heart disease[a]	21.5	20.2	21.6	19.8	22.2	20.4	19.2	15.8	21.0
Acute myocardial infarction[c]	11.2	11.0	11.7	11.2	12.9	11.4	9.7	7.2	11.4
Stroke[b]	8.1	6.8	7.2	6.6	7.0	8.0	6.5	3.5	7.4
Lung cancer[d]	6.7	6.7	7.3	7.3	7.1	7.0	5.0	6.0	6.9
Prostate cancer	3.8	4.2	4.3	3.7	4.1	4.4	3.7	1.1	4.0
Suicide	2.5	2.3	3.5	3.6	2.6	2.1	3.9	6.5	2.8
Diabetes mellitus	1.9	3.0	2.6	2.5	2.1	2.1	1.6	3.2	2.4
Female									
Heart disease[a]	20.5	18.7	23.2	20.8	18.6	19.2	9.8	20.2	20.3
Stroke[b]	12.8	11.1	12.4	12.0	11.0	11.3	5.6	12.9	12.0
Acute myocardial infarction[c]	10.8	11.0	13.4	13.0	10.4	10.5	4.4	11.9	11.4
Breast cancer	3.8	4.5	3.8	3.9	4.1	4.4	4.4	6.7	4.1
Lung cancer[d]	3.6	3.8	3.5	3.4	4.7	4.2	3.8	4.7	3.7
Suicide	0.6	0.8	1.2	0.7	1.1	0.6	1.5	0.6	0.8
Diabetes mellitus	1.8	2.8	2.4	2.7	2.5	1.3	5.0	1.7	2.3

a Ischaemic heart disease. **b** Cerebrovascular disease. **c** Heart attack. **d** Cancer of the trachea, bronchus and lung.

Source: ABS (2001a); table EA.7.

The leading causes of death for Indigenous people in 2000 are presented in table E.5. External causes[9] of death made up a higher proportion of deaths for Indigenous people (19.2 per cent for males and 10.3 per cent for females) than for all Australians (8.3 per cent for males and 4.2 per cent for females). Similarly, diabetes mellitus contributed to 5.6 per cent (males) and 11.3 per cent (females) of Indigenous deaths compared to 2.3 per cent (females) and 2.4 per cent (males) of total deaths (table E.5). Malignant neoplasms (cancers) accounted for a smaller proportion of Indigenous deaths (15.7 per cent for males and 15.8 per cent for females) than for all Australians (30.2 per cent for males and 25.2 per cent for females) (tables EA.7 and EA.8).

9 'External causes' includes transport accidents, suicide, assault and all other external causes of mortality.

Table E.5 **Principal causes of deaths for Indigenous people, 2000 (per cent)[a]**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Male									
External causes[b]	15.4	15.8	19.2	24.5	17.7	**na**	**na**	19.1	19.2
Suicide	4.2	5.3	6.9	8.4	3.8	**na**	**na**	5.3	6.0
Transport accidents	4.2	1.8	3.8	5.1	5.1	**na**	**na**	6.1	4.6
Assault	2.7	–	1.7	2.1	1.3	**na**	**na**	4.1	2.4
Heart disease[c]	24.7	22.8	18.2	13.1	15.2	**na**	**na**	15.9	18.1
Diabetes mellitus	4.2	3.5	7.2	6.3	6.3	**na**	**na**	4.9	5.6
Female									
External causes[b]	9.8	11.8	8.6	15.3	15.4	**na**	**na**	6.9	10.3
Suicide	1.9	3.9	1.6	1.8	3.1	**na**	**na**	0.5	1.7
Transport accidents	3.3	3.9	2.0	2.9	4.6	**na**	**na**	2.0	2.7
Assault	2.3	–	2.0	4.1	–	**na**	**na**	2.5	2.3
Heart disease[c]	18.7	5.9	17.6	17.1	18.5	**na**	**na**	9.8	15.4
Diabetes mellitus	6.1	11.8	16.0	14.1	20.0	**na**	**na**	6.4	11.3

a The NT, SA, WA and, more recently, Queensland are generally considered to have the best coverage of death registrations for Aboriginal and Torres Strait Islander Australians. Numbers of Indigenous deaths for some causes in some jurisdictions are very small and a small change in the number of deaths for one of those causes may result in a large change in percentage terms. **b** Includes transport accidents, intentional self harm, assault and all other external causes of mortality. **c** Ischaemic heart disease. **na** Not available.

Source: ABS (2001b); table EA.8.

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 E.3). 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 E.3 **Disability- adjusted life expectancy and adjusted life years**

Both Disability-Adjusted Life Expectancy (DALE) and 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 is often used in common language.

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).

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 82.0 for females and 76.6 years for males in 1998–2000 (table EA.9).

Life expectancy at birth varies across jurisdictions. Average life expectancy for males at birth was 78.3 years in the ACT in 2000, compared with 70.3 years in the NT (table E.6). The average for females in WA was 82.6 years, which was more than seven years longer than that for females in the NT (75.2 years). These differences reflect the large Indigenous proportion of the NT population (compared with other jurisdictions) and the shorter life expectancy of Indigenous people generally (table EA.9).

Table E.6 **Average life expectancy at birth (years)**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
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
1998–2000	76.4	77.1	76.4	76.9	76.6	75.7	78.3	70.3	76.6
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
1998–2000	81.9	82.3	81.9	82.6	82.3	81.2	82.3	75.2	82.0

Source: ABS (2001a); table EA.9.

Indigenous Australians had considerably lower life expectancies than non-Indigenous Australians for all years reported. The ABS has published experimental estimates of life expectancy for Indigenous Australians for 1998–2000. Based on these estimates, the life expectancies at birth of Indigenous Australians were 56.0 for males and 62.7 for females. Indigenous life expectancies are 19.3 years less for females and 20.6 years less for males than the average life expectancies for all Australians (table EA.9). 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 2001a). An alternative measure of longevity is the median age at death, although this does not indicate the current health status of living people. In 2000, the median age at death for all Australians was 75.3 years for males and 81.7 years for females. In contrast, the median age at death for Indigenous Australians was 50.8 years for males and 57.4 years for females (table EA.10).

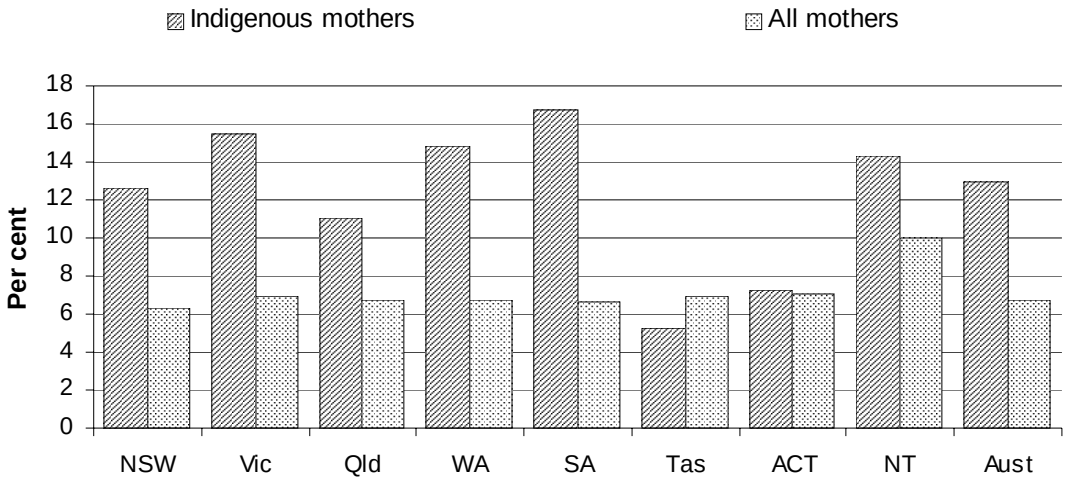
The median age at death for Indigenous Australians was highest among females in Queensland (61.3 years) and lowest among males in the NT (46.2 years). For all Australians, the highest median age at death was for females in SA (82.2 years) and the lowest was for males in the NT (55.7 years) (table EA.10).

Birthweight of babies

For the first time this year, the Report contains information on the birthweights of babies born to all mothers and to Indigenous mothers. It is reported as part of the Steering Committee's focus on improving reporting on the Indigenous population, and this indicator is a key signal of the health and life expectancy of Indigenous people compared with the population generally.

The birthweight of a baby is an important indicator of its health status and future wellbeing. The mean birthweight of babies born to Indigenous mothers nationally was 3149 grams in 1999, compared to 3360 grams for babies born to all mothers (tables EA.15 and EA.16). The percentage of babies weighing less than 2500 grams born to Indigenous mothers nationally was 13.0 per cent in 1999, compared with 6.7 per cent for babies born to all mothers. The percentage of babies weighing less than 2500 grams born to Indigenous mothers ranged from 16.7 per cent in SA to 5.3 per cent in Tasmania. The percentage of babies weighing less than 2500 grams born to all mothers ranged from 10.0 per cent in the NT to 6.3 per cent in NSW (figure E.8). The data are only for babies born to Indigenous mothers and do not include babies with Indigenous fathers and non-Indigenous mothers.

Figure E.8 **Proportion of babies with birthweights under 2500 grams, 1999[a, b]**



a Data are for babies born to Indigenous mothers only. Babies with Indigenous fathers and non-Indigenous mothers are not included. **b** Data for 1999 for Tasmania unavailable. Data for 1998 used as estimates.

Source: AIHW (2001b), tables EA.15 and EA.16.

Future directions

The Steering Committee has agreed to focus on developing reporting of health services across four broad areas:

- Indigenous health;
- primary health and community care;
- interactions between services; and
- regional, rural and remote health.

Indigenous health

Performance indicators for use of health services by Indigenous Australians were first published in the 2000 Report. Since then improvements have been made where possible. The 2003 Report's Health preface includes data on expenditure on health services to Indigenous people and Indigenous mortality, causes of death and life expectancy. The Public hospitals chapter (chapter 9) in the 2003 Report includes several indicators for use of public hospital services by Indigenous people.

During 2002, the Review considered how best to expand its reporting of Indigenous health. The Review has considered the work done by other bodies in identifying

priorities, for example, the Commonwealth Grants Commission (CGC) (box E.4), the National Aboriginal and Torres Strait Islander Health Council, and the Australian Health Ministers Advisory Council (AHMAC) (box E.5). Governments have tested health reforms to improve Indigenous health through the Aboriginal and Torres Strait Islander Coordinated Care Trials (box E.6).

Box E.4 **Commonwealth Grants Commission *Report on Indigenous Funding 2001***

The CGC *Report on Indigenous Funding 2001* suggested the following priorities for Indigenous health:

- Increased resources allocated to Indigenous health — particularly in rural and remote areas — justified by the poor health status of Indigenous people and their reliance on the public health system. (The Commonwealth Government in its response to the CGC report said that data limitations mean it is difficult to draw conclusions about whether Indigenous people in remote areas have poorer health than those in urban areas [Commonwealth Government 2002]);
- Equitable access to mainstream services: access to renal dialysis and 'improved support services such as patient transport and liaison officers' in acute care settings, and increasing Indigenous people's access to Medicare and the PBS;
- Improving the effectiveness of primary care services and increasing their use through:
  - partnership arrangements/community control;
  - improving access to mainstream services;
  - expansion of community controlled health services in accordance with regional health plans;
  - focusing on environmental issues; and
  - focusing on workforce issues;
- Emphasising community-based care to assist elders to remain in communities.

Source: CGC (2001)

Box E.5 National performance indicators for Aboriginal and Torres Strait Islander health

For several years there has been a collaborative effort between statistical agencies, health departments and Indigenous organisations to improve the quality of data and reporting on Indigenous health status and health services. A key initiative has been the development of an indicator set for annual reporting by all jurisdictions. An interim set of national health performance indicators was endorsed by AHMAC in 1997, and a refined set was endorsed in 2000.

The interim set covered performance within a framework of health status, risk factors and service delivery and has been reported against by jurisdictions for 1998 and 1999. For many jurisdictions, the data required to report on the indicators were unavailable, of poor quality, or in need of substantial development in order to be reported (NHIMG 2001).

At present, the refined set includes over 50 indicators covering mortality, morbidity, access to health services, health services impacts, workforce developments, risk factors, intersectoral issues, community development and quality of service provision. The technical specifications for the refined set include recommendations for improved definitions and methods of collection for many of the indicators. In August 2002, the AHMAC Standing Committee on Aboriginal and Torres Strait Islander Health established a sub-committee to prioritise a subset of core indicators for jurisdictions to develop and improve data. The sub-committee will choose the indicators for their usefulness rather than the ability of jurisdictions to report on them. As the quality of reporting improves for the core indicators, the sub-committee will choose another group of the refined indicators for developing data with the eventual aim of improving data quality for all of the indicators.

Box E.6 The Aboriginal and Torres Strait Islander Coordinated Care Trials

A first round of Aboriginal and Torres Strait Islander Coordinated Care Trials, comprising four trials in the NT, NSW and WA, ran from 1997 to 1999. They were evaluated in 2000. The Aboriginal and Torres Strait Islander trials ran concurrently with a first round of general trials. The trials were implemented by Aboriginal community health organisations with pooling of Commonwealth, State and Territory funds for health services in the participating communities. Their overall objective was to improve the health status of targeted Indigenous communities through a more coordinated approach to delivery of health care. The approach was to improve accessibility and appropriateness of health care services and establish or improve local organisational capacity and make financial and administrative arrangements more flexible. The process was to be driven by clients and their communities to create empowerment.

(Continued on next page)

Box E.6 **(Continued)**

The evaluation found that the trials made considerable progress in all aspects of the intended program of reforms. The reported outcomes included 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 could be made and sustained into the future.

Financial reform and enhanced community capacity — that is, the combination of 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.

A second round of Coordinated Care Trials includes three trials specifically targeting Aboriginal and Torres Strait Islander people. The second round of Aboriginal and Torres Strait Islander Coordinated Care Trials will run for three years and include a focus on reforming local health care systems, building the capacity of communities, organisations and services to identify and address local health care needs, and ways to enhance access to medical services for Indigenous people.

Source: DHAC (2001).

Future priorities for Indigenous health reporting by the Review are likely to include:

- social equity/access/disadvantage;
- mental health;
- substance abuse;
- primary and community health;
- funding for Indigenous health; and
- information on Indigenous health trends over time.

These issues have been selected as priorities because they have been identified by governments as key policy and program priorities in Indigenous health or because they represent areas where there is currently a dearth of information or where the availability of reliable and comparable data is limited but where the Review can potentially be a positive influence in improving data sets.

The availability of data is gradually improving. During 2001-02, key statistics on the services provided by Commonwealth funded Aboriginal primary health care services were collected and are being used for policy development and planning by the services, the sector, the National Aboriginal Community Controlled Health Organisation (NACCHO) and government. These statistics are collected through the annual Service Activity Reporting Questionnaire, a joint Office of Aboriginal and

Torres Strait Islander Health and NACCHO initiative. The questionnaire collects service level data on health care and health-related activities over a 12-month period from over 100 Commonwealth funded Aboriginal primary health care services.

Comprehensive data have been published for the first time on the activities of Commonwealth funded stand-alone Aboriginal and Torres Strait Islander substance use services. The annual Drug and Alcohol Service Report questionnaire collects detailed service level information about episodes of care provided, staffing profiles, and the broad range of activities undertaken to prevent and treat substance use. This important information can be used by the government and the sector in formulating policy, in planning, and to profile the work of substance use services for Indigenous people.

Data development in the area of primary health care has been recognised as a priority by the National Advisory Group Aboriginal and Torres Strait Islander Health Information and Data (NAGATSIHID). A NAGATSIHID working group is being formed to consider issues such as the development of a minimum data set to standardise primary health care information across the health sector with an emphasis on improving service delivery.

Primary health and community care

There is already relatively good coverage of performance indicators in some areas where the processes of data specification and capture have been refined over a number of years, particularly in hospital care. Major gaps remain in reporting on other areas of the health system, such as primary health and community care. In order to achieve more comprehensive reporting on whether 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.

The primary health and community care sector is responsible for approximately one third of all health expenditure in Australia. It is the most visible and commonly used part of the health system with nine out of every 10 Australians accessing services in any given year (DHAC 2000).

In general terms, the sector encompasses services which are a person's first point of contact with the health system, such as general practice, hospital emergency departments and pharmacies, community-based care to support people within their

own homes, and services with an emphasis on illness and injury prevention and early detection, such as maternal and child health programs.

The effectiveness and efficiency of services provided in the primary health and community care sector affect the use of the health system as a whole. Appropriate, easily accessed, well integrated community-based services, for example, can reduce the overall reliance of the health system on the provision of more acute care services. Understanding the relative investment in these services and their impact is critical for governments that need to make decisions about future investment in health services.

To better understand these issues, the Review will increase its focus on the primary health and community care sector by expanding reporting in this area. Currently, the Report covers general practice (in the General practice chapter), mental health and breast cancer (within the Health management issues chapter), hospital emergency department services (within the Public hospitals chapter) and community care (within the Aged care services chapter), but does not specifically focus on primary health and community care. In future, the Report may include State and Territory funded community services, including community nursing, community dental services, podiatry, Aboriginal Medical Services, community pharmacy and other allied health services that are key components of the primary health and community care sector. In addition to broadening reporting, the existing performance indicators for services such as general practice and preventable hospital admissions will be refined.

The pace of new reporting will reflect developments in data collection. Information on primary and community care is currently limited because of the nature of the sector, which comprises a large number of public and private service providers funded by Commonwealth, State and Territory governments and private contributions.

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:

- refining existing performance indicators and/or developing new indicators in areas such as community health and population health (box E.7);
- improving reporting of the effectiveness of service delivery to specific client groups, including Indigenous people and people in regional, rural and remote areas; and
- working to improve understanding of the interface between services.

Box E.7 **Possible indicators of performance of community and population health services**

Future editions of the Report may include the following indicators of community health and population health services:

1. Measure of effectiveness and accessibility — influenza prevention:
   - influenza immunisations provided to people with chronic health conditions;
   - hospital separations for conditions associated with influenza for people aged 65 years and older; and
2. Measure of effectiveness — health assessments:
   - annual voluntary health assessments provided to people within the target population.

Interactions between services

Many people have complex care needs and require a number of services. These services are typically provided by a range of service providers and are funded or provided by both government and non-government organisations within each jurisdiction, and across tiers of government. This means clients usually have contact with, and receive services from, a number of care providers.

An important issue for government is to determine how to meet complex care needs in a coordinated fashion and to assess performance in meeting those needs across agencies.

There are links between health services and other government services. The performance of health services may influence outcomes for clients of education, aged care, disability, ambulance and justice sector services, while these other

service areas, in turn, affect outcomes for clients of health services. A broader discussion of these links is contained in chapter 1.

Work has commenced on a long term strategy to enhance the capacity of the Review's reporting frameworks to reflect interrelationships between services. In the first instance, this analysis is focusing on the nexus between general practice and aged care. Work on this issue is also being undertaken for the health sector more generally by the AHCA Reference Group on the Interface between Aged and Acute Care.

Regional, rural and remote health

In Australia, approximately two thirds of all people live in major cities. The remaining third live in regional, rural, and remote areas, and have many health disadvantages their urban counterparts do not experience. These include shortages of health care providers and services, difficulties in accessing health care, a higher disease burden in relation to chronic conditions such as diabetes, asthma and cardiovascular disease, and greater exposure to injury. The much poorer health of the Indigenous population is a significant aspect of rural and remote health.

Governments have recognised the need for improved health services in rural Australia. The Commonwealth Government has introduced a range of programs in recent years that aim to improve access to health services and health workers for rural communities. The Regional Health Strategy is summarised in box E.8. Improved data and reporting will be important as these programs are reviewed and further improvements made.

The number of new Commonwealth health services supported in rural areas has grown from 60 in 1996-97 to over 350 in 2002-03.

Commonwealth initiatives to improve access to health services in rural communities include:

- the Multipurpose Services Program — which is jointly funded by the Commonwealth, State and Territory governments, provides aged care and health services to small rural communities. In 2001-02 there were 63 Multipurpose Services operating across all States and Territories;
- the Regional Health Services Program — which involves the planning and delivery of primary health care services at the local level. Many of the Regional Health Services funded by the Commonwealth are delivered by State and Territory Governments. In 2001-02 there were 106 Regional Health Services in operation across all States and Territories;

- more medical specialists and allied health professionals visiting rural Australia;
- improved access to pharmacies, pathology and imaging services and to Medicare claiming facilities;
- the establishment of ten university departments of rural health and nine clinical schools in regional locations to enable students in rural areas the opportunity to study to be rural health professionals in, or near, their home towns;
- the expansion of Commonwealth scholarship schemes for people seeking to enter rural health practice — medical, nursing and allied health professions. At the end of 2001-02 there were over 1750 students accessing Commonwealth funded rural health scholarships;
- financial incentives for encouraging long serving rural doctors to stay in country communities. To the end of 2001-02, over 2100 rural doctors have received rural retention payments totalling in excess of $32.6 million; and
- additional workforce support to the general practice workforce in rural and remote areas.

Box E.8 **Regional Health Strategy**

A consolidated set of programs is now in place at the Commonwealth level, collectively known as the Regional Health Strategy, which seeks to redress the imbalance of rural health service delivery by:

- increasing and improving access to health and aged care services in rural areas; and
- strengthening the rural health workforce.

Overall, annual Commonwealth expenditure for specifically targeted programs in rural and remote areas has increased from approximately $190 million in 1996-97 to $610 million in 2001-02 (refer to figure E.9 below).

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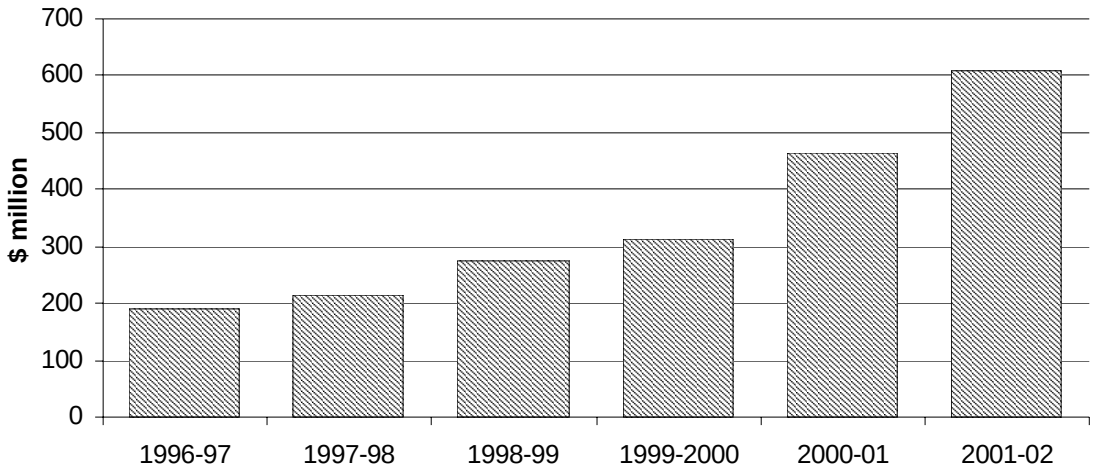
Box E.8 **(Continued)**

Figure E.9 **Real Commonwealth expenditure — approximate consolidation — for targeted rural health initiatives ($million)[a]**



a Excluding MBS, PBS, ACHA and aged care funding.

Source: DHA (unpublished)

Future directions in performance reporting on regional, rural and remote health

The limited information currently available about regional, rural and remote health is partly due to the extreme diversity amongst rural populations and the limitations of the service delivery mechanisms. Reviews of the early impact of some of the rural programs are being conducted with a view to determining progress, including identifying barriers to the provision of new services in rural areas. In addition, the Australian Institute of Health and Welfare has been engaged to provide a series of reports on rural health performance indicators and selected rural health issues. The series includes a Framework for Rural Health Information (based on the NHPF) and a first report against the indicators in the framework.

Healthy Horizons: A Framework for Improving the Health of Rural, Regional and Remote Australians 1999–2003

The Commonwealth, State and Territory Governments and the National Rural Health Alliance developed a framework to guide the provision of rural health programs and services, and agreed to implement actions and programs in their own

jurisdictions which are based on a primary health care approach. The Healthy Horizons Framework was endorsed by the Australian Health Ministers Conference in 1999.

The first national report of progress against the Healthy Horizons framework is due to be launched early in 2003. It will include a snapshot of what jurisdictions have been doing to improve health conditions and services for people living in rural and remote areas to the end of 2001. The Review will be able to draw on the information in this report to further expand reporting on health services performance in nonmetropolitan areas.

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9 Public hospitals

Public hospitals are important providers of government funded health care services in Australia. This chapter reports on the performance of State and Territory 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 9.1. A framework of performance indicators and the key performance indicator results for public hospitals are outlined in section 9.2. The performance indicator framework and key results for maternity services provided by public hospitals are discussed in section 9.3. Future directions in reporting are discussed in section 9.4. Terms and definitions are summarised in section 9.5.

This year, changes have been made to the reporting of waiting times for elective surgery. An additional method of reporting is based on times waited for admission for elective surgery for all patients, regardless of the clinical urgency category assigned to them. Reporting on hospital accreditation has improved with data being presented for the first time for all hospitals accredited by recognised accreditation programs. Reporting of the relative stay index has also been improved.

Reporting on maternity services has been expanded for this year's Report, with data reported in the health preface on the birthweights of babies born to Indigenous mothers and to all mothers. The inclusion of these data is also in line with the Review's focus on improved reporting for Indigenous people. An indicator of quality is being reported for maternity services for the first time, with the inclusion of the 'perineal status after delivery' indicator.

Supporting tables

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\2003\Attach9A.xls and in Adobe PDF format as \Publications\Reports\2003\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). 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 these tables (see details on the inside front cover of the Report).

9.1 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 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

[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 Australian Institute of Health and Welfare (2001a).

examined more closely in the health management chapter (chapter 11). Some common health terms relating to hospitals are defined in box 9.1.

Box 9.1 **Some common terms relating to hospitals**

Patients

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

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

Types of care

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

Acute care: clinical services provided to 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.

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

(Continued on next page)

Box 9.1 **(Continued)**

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 (the Australian Modification (AM) of the International Standard Classification of Diseases and Related Health Problems): a classification of diseases and injuries; replaces the earlier ICD-9-CM (Australian Version of the International Classification of Diseases, Revision 9, Clinical Modification).

Source: AIHW (2001a); Department of Health and Aged Care (1998) and National Centre for Classification in Health (1998).

Funding

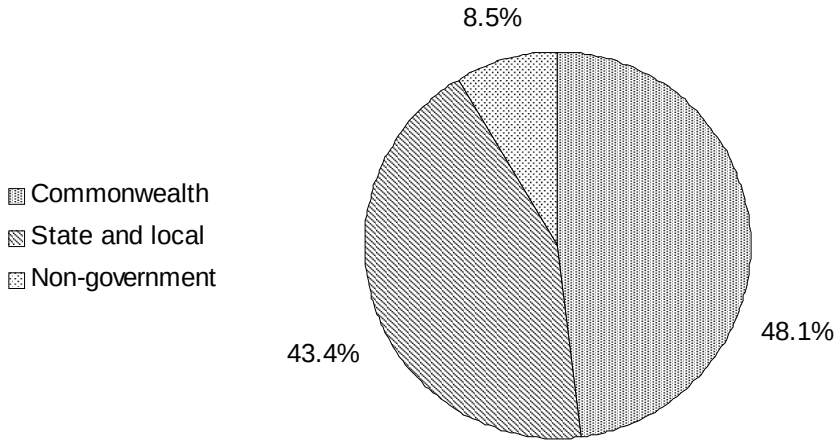
Total recurrent expenditure on public hospitals (excluding depreciation) was $15.5 billion in 2000-01 (table 9A.1).[2] Data provided by NSW for 2000-01 contain for the first time since 1995-96 expenditure through community health programs administered by hospitals, and therefore are not comparable with data for previous years. Based on preliminary revised data provided by NSW for 1999-2000, expenditure increased nationally in constant price terms by 2.7 per cent in 2000-01 (in 1999-2000 dollars) (AIHW 2002a).

Financing for public hospitals comes from a number of sources. 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. Based on preliminary data, governments contributed about 91.5 per cent of funding for public (non-psychiatric) hospitals in

[2] This figure includes spending on patient transport.

2000-01 (figure 9.1).[3] Public (non-psychiatric) hospitals accounted for 35.7 per cent of government recurrent expenditure on health services in 2000-01 (AIHW 2002b).

Figure 9.1 **Recurrent expenditure on public (non-psychiatric) hospitals, by source of funds, 2000-01 (per cent)[a]**



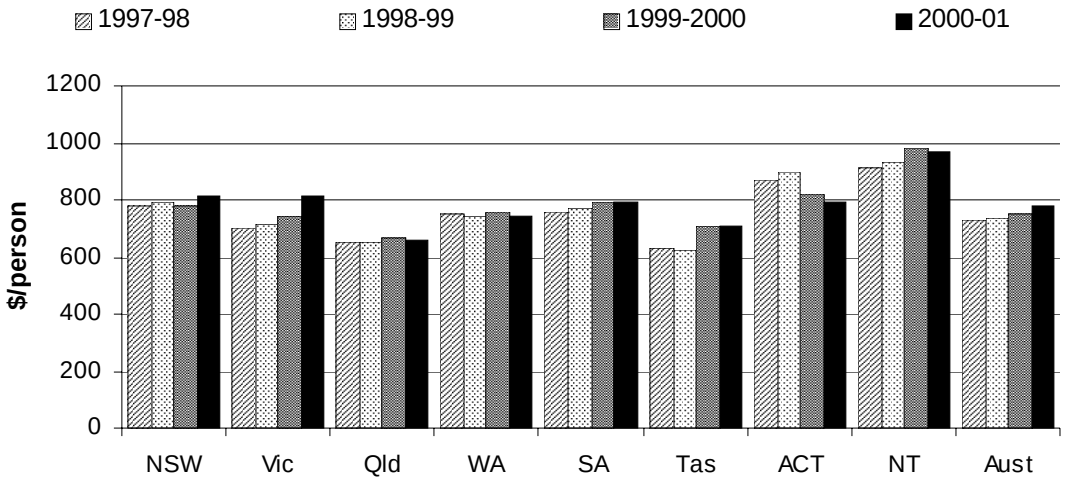
a Based on preliminary AIHW and Australian Bureau of Statistics (ABS) estimates.

Source: AIHW (2002b).

For selected public hospitals, expenditure on admitted patients (based on the inpatient fraction) ranged from 68 to 81 per cent of total recurrent expenditure across jurisdictions in 2000-01 (table 9A.25). In 2000-01, per person government recurrent expenditure on public hospitals was $776 for Australia, ranging from $969 in the NT to $660 in Queensland (1999-2000 dollars). Real expenditure per head across Australia increased over time, from $733 to $776 between 1997-98 and 2000-01 (1999-2000 dollars) (figure 9.2). Not all jurisdictions followed this trend.

[3] These expenditure data (figure 9.1) are from the AIHW's *Health Expenditure Australia* and are not directly comparable with the expenditure data drawn from the AIHW's *Australian Hospital Statistics*. The *Health Expenditure Australia* 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 2001a).

Figure 9.2 **Recurrent expenditure per person, public hospitals (including psychiatric) (1999-2000 dollars)[a, b, c, d e, f]**

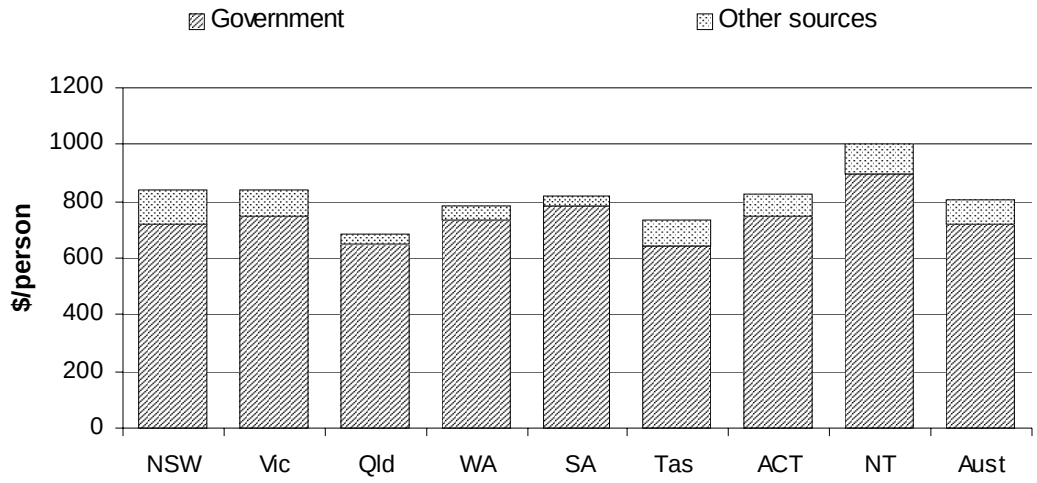


a Expenditure data exclude depreciation and interest payments. Data include patient transport which was excluded in previous reports. **b** Hospital expenditure recorded against special purposes and trust funds and population and primary care programs is excluded. Other personal care staff are not reported separately. **c** Queensland Pathology services are purchased from a Statewide pathology service rather than being provided by each hospital's employees. **d** SA interest payments are included in administrative expenses. Most trainee/pupil nurses are enrolled in tertiary institutions. **e** Tasmanian hospitals pay payroll tax, with most being included in administrative expenses and the remainder in other recurrent expenditure. Except for medical officers, salaries for staff categories are not reported separately. For 2000-01, data for six small Tasmanian hospitals are incomplete. **f** Prior to 2000-01, superannuation for four of the five NT hospitals is included. For 2000-01, superannuation for all NT hospitals is included. Interest payments are not reported.

Source: AIHW (2002a, 2002b); table 9A.2.

In 2000-01, public hospitals (including psychiatric hospitals) received almost $1.6 billion revenue from non-government sources, which accounted for 10.2 per cent of all recurrent expenditure (excluding depreciation). 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 per person funded from non-government sources varies across jurisdictions (figure 9.3).

Figure 9.3 **Source of funds per person, public hospitals, 2000-01 (current prices)[a]**



a Data include psychiatric hospitals.

Source: AIHW (2002a); tables 9A.1 and 9A.26.

Size and scope of sector

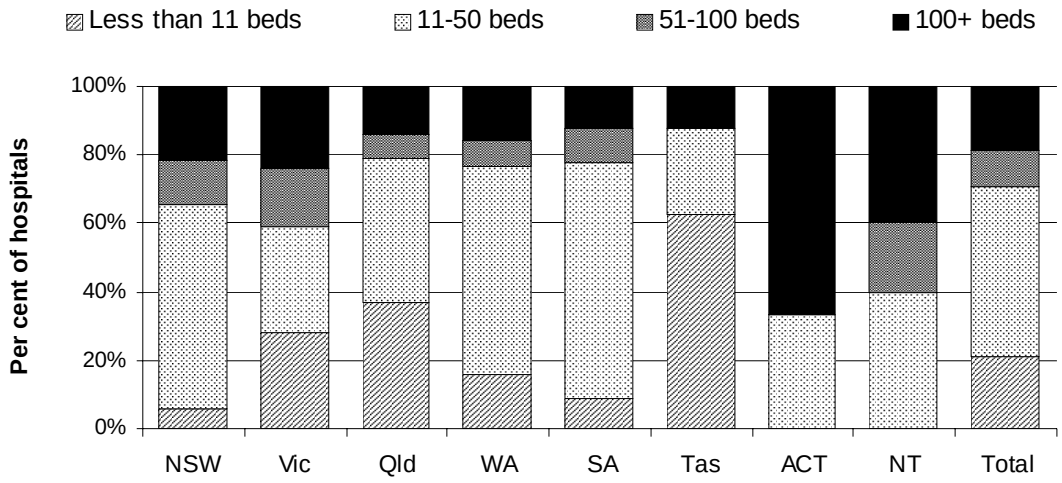
Hospitals

In 2000-01, Australia had 749 public hospitals (including 23 psychiatric hospitals) with 52 591 beds. There were 75 fewer beds in public (non-psychiatric) hospitals in 2000-01 than in 1999-2000, and 281 fewer beds in public psychiatric hospitals (AIHW 2002a). Although 70.6 per cent of hospitals had fewer than 50 beds, these smaller hospitals represented only 19.3 per cent of total available beds (figure 9.4).

Beds

On average, there were 2.7 beds per 1000 people in 2000-01 (figure 9.5). 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, although 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 (information in appendix A) and morbidity and mortality of the population in each jurisdiction.

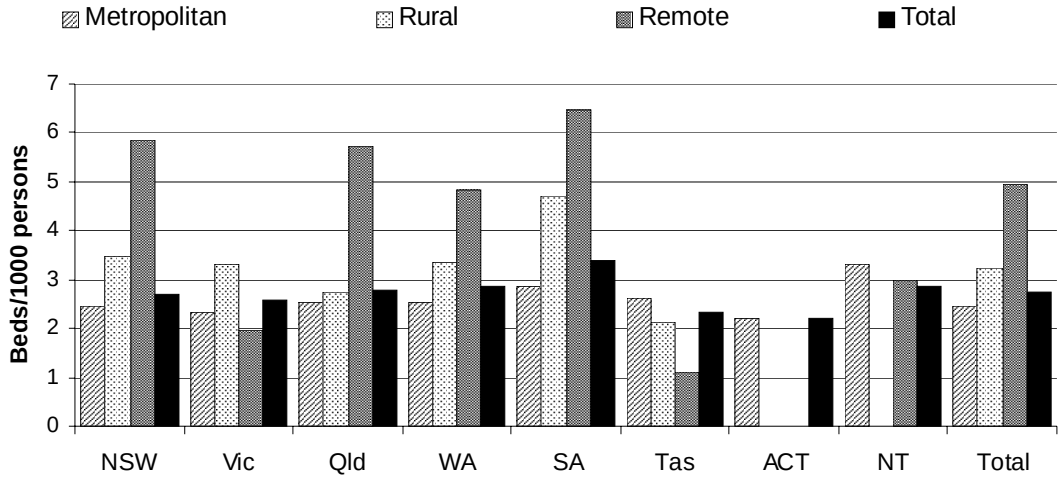
Figure 9.4 **Public hospitals by size, 2000-01[a, b, c]**



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 report data separately to the National Hospital Morbidity Database.

Source: AIHW (2002a); table 9A.3.

Figure 9.5 **Number of available beds by region, public hospitals, 2000-01[a, b]**



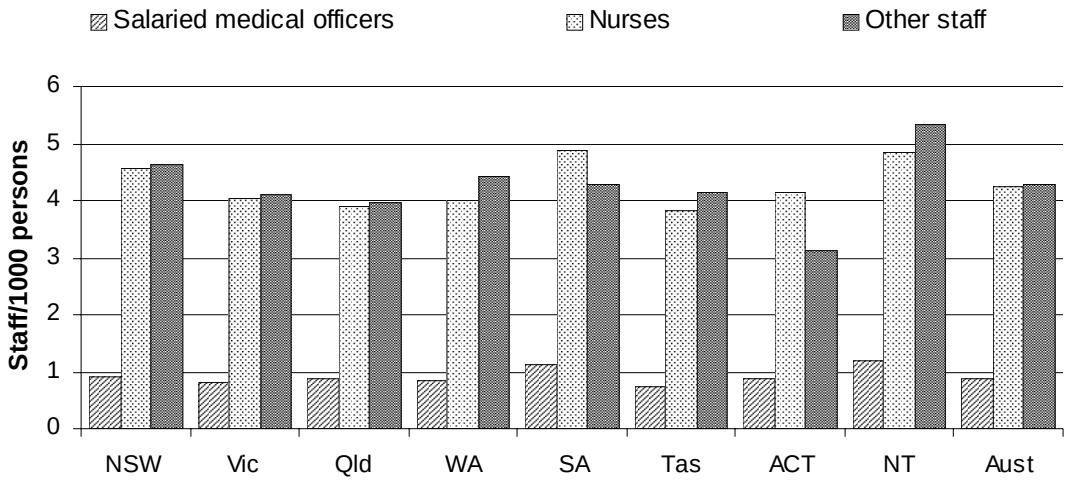
a An 'available bed' is one that is immediately available to be used by an admitted patient. A bed is immediately available if located in a suitable place for care, with nursing and auxiliary staff available within a reasonable period. Surgical tables, recovery trolleys, delivery beds, cots for normal neonates, emergency stretchers/beds not normally authorised or funded, and beds designated for same day non-admitted patient care are excluded. Beds in wards which were closed for any reason (except weekend closures/wards staffed and available on weekends only) are also excluded (AIHW 2001a). **b** Data should be viewed in the context of the age and sex structure and morbidity and mortality of the population in each jurisdiction. This information is included in the statistical appendix to the Report.

Source: AIHW 2002a; table 9A.4.

Staff

There were 182 995 full time equivalent (FTE) staff employed in Australian public hospitals in 2000-01 (based on the average number of staff available for the year). 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 2002a). The NT had the most FTE staff per 1000 people (11.4) while the ACT had the least (8.2) (figure 9.6). 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 the apparent decline in FTE staff in some staffing categories and also the differences between the jurisdictions (AIHW 2000a).

Figure 9.6 **Average FTE staff, public hospitals, 2000-01[a, b, c, d]**



a Where average FTE staff numbers were not available, staff numbers at 30 June 2000 were used. Staff contracted to provide products (rather than labour) are not included. **b** For Victoria, FTEs may be slightly understated. **c** For Queensland, pathology services are provided by staff employed by the State pathology service and are not reported here. **d** Data for three small Tasmanian hospitals not supplied.

Source: AIHW (2002a); table 9A.5.

Activity

Admitted patient care

There were around 3.9 million acute, sub-acute and non-acute separations in public hospitals in 2000-01 (table 9A.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 9A.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, 46.4 per cent were for same day patients (table 9A.6).

Table 9.1 shows the 10 AR-DRGs with the highest number of overnight acute separations in public hospitals for 2000-01. These 10 AR-DRGs accounted for 16.4 per cent of all acute separations nationally. In the NT, which reported the highest jurisdictional percentage, these 10 AR-DRGs accounted for around 19.9 per cent of all acute separations. If same day separations were included, renal dialysis and chemotherapy would form a large proportion (16.0 per cent) of the total national number of separations. In 2000-01, 1.8 million same day separations occurred in Australia. Renal dialysis accounted for 27.7 per cent of these and chemotherapy 6.4 per cent (AIHW 2002a). There may be differences across jurisdictions in the way renal dialysis and chemotherapy patients are treated, with some patients treated as same day admissions and others as outpatients.

Table 9.1 **Ten AR-DRGs with the highest number of overnight acute separations, public hospitals, 2000-01 (per cent)[a, b, c, d]**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Vaginal delivery W/O CD	5.1	5.2	5.6	4.3	3.9	4.9	6.2	5.6	5.1
Chest pain	1.6	1.5	1.9	1.2	1.6	0.8	1.2	1.7	1.6
Oesophagitis, gastroenteritis and miscellaneous digestive system disorders Age>9 W/O Cat/Sev CC	1.6	1.4	1.7	1.6	1.5	1.2	0.8	0.9	1.6
Bronchitis and asthma aged<50 W/O CC	1.5	1.3	1.3	1.7	1.9	0.8	1.3	1.2	1.5
Cellulitis aged>59 W/O Cat/Sev CC	1.2	1.1	1.5	1.5	0.9	0.9	1.0	4.2	1.3
Caesarean delivery W/O CD	1.1	1.2	1.4	1.1	1.0	1.2	1.4	1.2	1.2
Unstable angina W/O Cat/Sev CC	1.1	1.1	1.4	0.7	0.8	1.3	0.9	0.9	1.0
Respiratory infections/inflamations W/O CC	1.2	1.0	1.1	1.2	0.9	0.9	1.2	2.6	1.1
Heart failure and shock W/O Cat CC	1.2	1.1	1.0	1.0	1.1	1.1	0.8	0.8	1.1
Abdominal pain or Mesenteric adenitis W/O CC	1.1	1.1	1.1	1.1	0.9	0.9	0.8	0.6	1.1
Per cent of acute separations accounted for by 10 AR-DRGs with most acute separations	16.8	16.0	18.0	15.4	14.5	13.8	15.6	19.9	16.4
Total acute separations ('000)	**700**	**474**	**357**	**185**	**177**	**39**	**28**	**28**	**1 988**

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. **d** Excludes same day separations.

Source: AIHW (2002a); table 9A.9.

Table 9.2 lists the 10 AR-DRGs that accounted for the largest number of patient days for overnight stays in 2000-01. These account for 17.5 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 9.2 **Ten AR-DRGs with the most patient days, excluding same day separations, public hospitals, 2000-01(per cent)[a, b]**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Vaginal delivery W/O CD	2.8	2.8	3.0	2.6	2.1	2.9	3.0	3.7	2.8
Schizophrenic disorders W/O legal status	2.3	3.2	3.6	3.2	2.5	0.3	1.3	**na**	2.7
Major affective disorder aged<70 W/O Cat/Sev CC	1.9	2.1	2.3	3.0	3.1	1.8	3.1	1.1	2.2
Tracheostomy, any age, any condition	2.1	2.3	1.8	1.6	2.3	2.1	2.5	2.1	2.1
Chronic obstruction airway Disorder W Cat/Sev CC	1.5	1.4	1.5	1.4	1.3	1.5	0.9	1.4	1.5
Schizophrenia disorders W legal status	1.2	1.5	1.2	1.7	1.2	5.1	1.4	1.5	1.4
Stroke with Sev CD/proc	1.3	1.4	1.0	1.6	1.5	1.2	1.1	0.7	1.3
Dementia and chronic disturb Crbrl Fn	1.0	1.5	0.8	1.4	2.4	2.5	0.4	0.3	1.3
Heart failure and shock W/O Cat CC	1.4	1.1	1.2	1.1	1.2	1.3	0.9	0.8	1.2
Chronic obstruction airway disorder W/O Cat/Sev CC	1.2	0.8	1.1	0.9	0.8	1.2	0.7	1.0	1.0
Total patient days accounted for by top 10 AR-DRGs (%)	16.6	18.2	17.6	18.5	18.4	19.9	15.3	12.6	17.5
Total days (excluding same day separations) ('000)	**3 899**	**2 625**	**1 746**	**1 003**	**997**	**252**	**166**	**154**	**10 843**

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 9A.27.

Non-admitted patient services

There is no agreed classification system for services to non-admitted patients, so activity is difficult to measure and cannot be compared across jurisdictions. As well as differences in the way data are collected, differing admission practices 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 to 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, a simple urine glucose test is treated equally with complete biochemical analysis of all body fluids) (AIHW 2001a). Table 9.3 presents data from the Australian Institute of Health and Welfare (AIHW)

Australian Hospital Statistics publication and can be considered a 'best available estimate' of activity in this area.

A total of 40.1 million occasions of service were provided to individual non-admitted patients in public hospitals in 2000-01. In addition to services provided to individuals, 594 323 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) (table 9A.10). In public hospitals in 2000-01, accident and emergency services comprised 13.5 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 9.3).

Table 9.3 **Ten most common types of non-admitted patient care, public hospitals, 2000-01 (per cent)[a, b]**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Accident and emergency [c]	10.6	16.4	13.7	13.7	20.8	12.3	23.7	28.6	13.5
Outpatient services									
Other medical/ surgical/ obstetric [d]	36.4	19.9	26.0	12.0	38.4	27.1	45.0	24.5	28.7
Pathology	11.7	10.0	25.8	13.1	..	24.7	7.8	19.3	14.1
Allied health [e]	..	14.3	7.2	20.7	11.2	13.4	2.3	3.4	7.1
Radiology and organ imaging	5.0	7.2	8.0	7.7	10.2	8.8	15.8	22.3	6.9
Pharmacy	4.0	4.9	8.8	4.3	..	9.2	0.1	1.8	5.0
Mental health	5.6	11.8	1.0	3.3	0.7	0.2	1.4	..	5.0
Dental	2.6	2.5	4.9	0.2	0.4	0.2	..	..	2.6
Alcohol and drug	5.5	0.6	0.4	..	..	..	..	..	2.5
Other non-admitted									
Community health [f]	11.5	7.4	2.1	19.0	..	..	..	..	8.5
10 most common as a per cent of total (%)	92.8	95.1	97.8	94.1	81.6	95.9	96.0	100.0	93.9
Total occasions of service ('000)	**16 710**	**6 965**	**8 538**	**4 121**	**2 286**	**749**	**392**	**339**	**40 099**

[a] The reliability of non-admitted patient occasions of service data is not good. In addition, signficant differences occur between States and Territories due to different counting methods, rendering the overall comparability of the data poor. [b] For public psychiatric hospitals, national totals include only those States and Territories for which data are available. [c] Includes accident and emergency patients that are subsequently admitted in Victoria, Queensland, SA, Tasmania, the ACT and the NT. [d] 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). [e] 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 and so on. [f] 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.

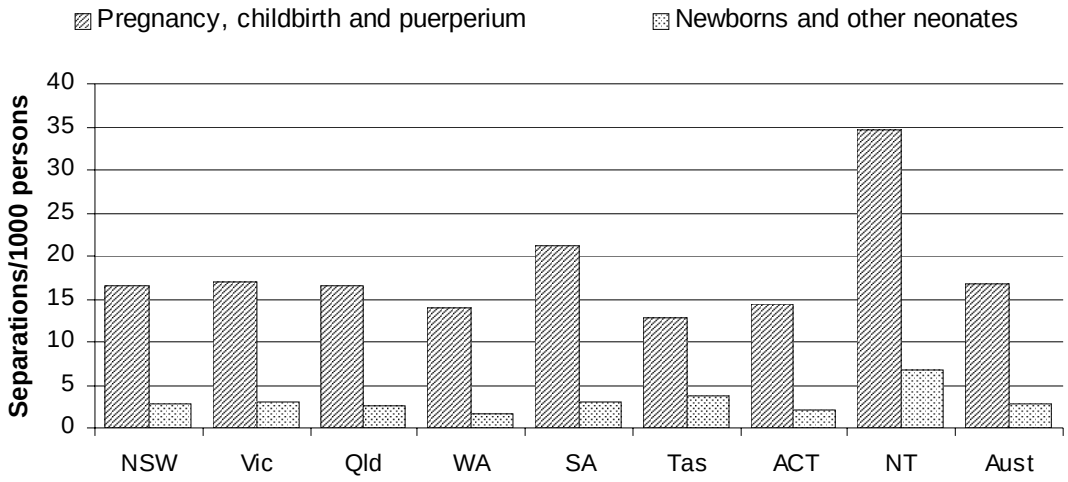
Source: AIHW (2002a); table 9A.10.

Maternity services

Maternity services (defined as AR-DRGs relating to pregnancy, childbirth and the puerperium, and newborns and other neonates) accounted for the third highest number of separations in public hospitals in Australia in 2000-01 after diseases and disorders of the kidney and urinary tract, and diseases and disorders of the digestive system (AIHW 2002a). Maternity services separations accounted for 10.1 per cent of total acute separations in public hospitals (table 9A.33) and contributed around

10.8 per cent to the total cost of all acute separations in public hospitals in 2000-01 (table 9A.32). Figure 9.7 shows that the NT had the highest number of acute separations per 1000 people for maternity services (41.5) in 2000-01 and WA had the lowest (15.7).

Figure 9.7 **Separation rates for maternity services in public hospitals, 2000-01[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 (2002a); table 9A.33.

Vaginal deliveries without complicating diagnosis accounted for a substantial proportion of the separations for pregnancy, childbirth and the puerperium (32.3 per cent) in 2000-01. Excluding same day separations, vaginal deliveries without complicating diagnosis accounted for the largest number of acute separations and patient days in public hospitals (tables 9.1 and 9.2) and the second highest cost in 2000-01 ($246.3 million) (table 9A.34) (AIHW 2002a).

The complexity of cases across jurisdictions for maternity services is in part related to the mother's age at the time of giving birth. Data on the mean age of giving birth across jurisdictions for 2000 and 2001 are shown in table 9.4.

Table 9.4 **Mean age of mothers at time of first, second and third births in public hospitals (years)**

	NSW	*Vic*[a]	*Qld*[b]	*WA*	*SA*[c]	*Tas*	*ACT*[d]	*NT*
Mean age of mothers at the following:								
2000								
First birth	27.3	27.1	25.2	25.8	26.2	27.0	27.1	**na**
Second birth	29.5	29.4	27.7	28.2	28.7	29.0	29.3	**na**
Third birth	30.9	31.0	30.9	29.8	30.2	31.0	30.7	**na**
All confinements	29.2	29.9	27.5	27.9	28.3	29.0	28.9	**na**
2001								
First birth	27.2	27.0	**na**	25.6	26.0	**na**	**na**	**na**
Second birth	29.5	29.4	**na**	28.1	28.6	**na**	**na**	**na**
Third birth	30.9	30.9	**na**	29.5	30.2	**na**	**na**	**na**
All confinements	29.1	30.0	**na**	27.7	28.2	**na**	**na**	**na**

a Total births of 62 562 in 2000 and of 62 143 in 2001. **b** Data for 2000 are preliminary and subject to change. **c** Data for 2001 are provisional. **d** Previously, both public and private hospital data were requested. The average age for women giving birth in ACT private hospitals is higher than for public hospitals. **na** Not available.

Source: State and Territory governments (unpublished).

9.2 Public hospitals

Framework of performance indicators

The performance indicator framework is based on the shared government objectives for public hospitals (box 9.2).

Box 9.2 **Objectives for public hospitals**

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

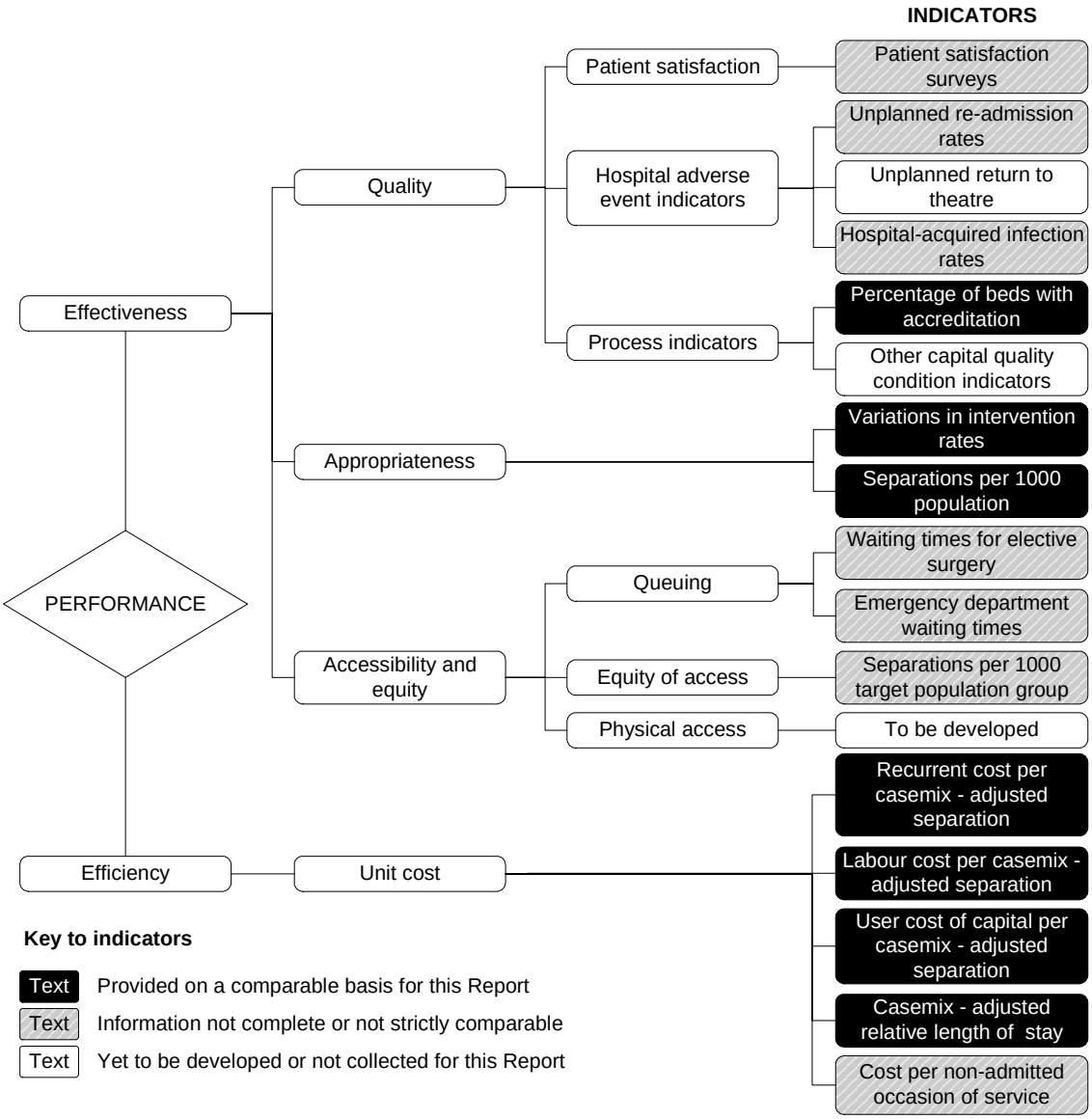
- safe and of high quality;
- responsive to individual needs;
- accessible and equitable; and
- efficiently delivered.

The framework captures general aspects of the performance of public hospitals in providing health care services (figure 9.8). 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 9.4.

The performance indicator framework shows which data are comparable in the 2003 Report (figure 9.8). For data that are not considered strictly comparable, the text includes relevant caveats and supporting commentary. Chapter 1 discusses data comparability from a Report-wide perspective (see section 1.6).

Figure 9.8 **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 9.1, 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 clinical indicators including unplanned re-admission rates and hospital-acquired infection rates.

The Australian Council for Safety and Quality in Health Care (ACSQHC) recently identified a reduction in health care associated infections as a high priority area, recognising that infections can result in serious consequences for individual patients and place a significant burden on the health system. Other priorities identified were reducing patient harm from medication use and monitoring serious adverse events. Prevention of patient falls in health care facilities was also identified as a key area for action.

The ACSQHC noted accreditation of health care facilities has contributed significantly to quality practices and system wide awareness of quality issues, while noting accreditation processes could be improved. The Council recognised any national effort to improve accreditation processes must lead to sustainable and demonstrable improvements in patient safety (ACSQHC 2002).

Accreditation

Public hospitals may seek accreditation through the Australian Council on Healthcare Standards (ACHS) Evaluation and Quality Improvement Program, the Australian Quality Council, the Quality Improvement Council, the 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. Previously, data presented in the Report reflected accreditation only by the ACHS. This year, for the first time, data are presented for all hospitals accredited by recognised accreditation programs. This is a significant improvement.

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 only dental or mothercraft services). The costs of preparing a hospital for accreditation are significant, so a low level of accreditation may reflect cost constraints rather than 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 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. Comparable data on proportions of hospital beds with accreditation are one of the few nationally available indicators of hospital quality.

Ninety-one per cent of public hospital beds were in accredited hospitals at 30 June 2001. Across jurisdictions, the proportion ranged from 100 per cent in the ACT to 53 per cent in the NT (table 9.5).

Table 9.5 **Proportion of accredited beds in public hospitals (per cent)[a, b, c]**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Beds accredited by ACHS									
1999	77	88	66	63	78	76	100	52	76
2000	80	94	71	62	75	76	99	47	79
2001	81	95	83	76	89	82	97	53	85
Total beds accredited by ACHS or other agency[d]									
2001	92	96	92	76	97	82	100	53	91

[a] Accreditation status at 30 June. [b] Does not indicate that hospitals without accreditation are of lesser quality. Accreditation is voluntary (except in Victoria where it is now mandatory for most public hospitals). The costs of accreditation are significant so a low level of accreditation may reflect cost constraints rather than poor quality. Accreditation costs may not rise proportionally with hospital size, so larger hospitals may find it relatively less costly to obtain accreditation. [c] Data includes psychiatric hospitals. [d] Data for 30 June 2001 include all hospitals accredited by recognised accreditation programs. These data are not comparable with previous years as in previous years only hospitals accredited by the ACHS were counted.

Source: AIHW (2002a); table 9A.11.

Patient survey results

Patient satisfaction 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 9.6 reflects the editions of the *Report on Government Services* for which patient satisfaction data have been provided by jurisdictions.

Table 9.6 **Patient satisfaction data provided by jurisdictions for each edition of the *Report on Government Services***

Report edition	*NSW*	*Vic*	*Qld*	*WA*	*SA*[a]	*Tas*	*ACT*	*NT*
1995	✓	✓	✓	✓	✗	✗	✓	✗
1999	✗	✓	✗	✓	✗	✓	✓	✓
2000	✓	✓	✓	✓	✗	✓	✓	✗
2001	✓	✗	✗	✓	✗	✓	✓	✗
2002	✗	✓	✗	✓	✓	✓	✓	✗
2003	✓	✗	✓	✓	✗	✓	✓	✗

[a] SA has conducted a patient satisfaction survey for 2002 although data were not available in time for inclusion in the 2003 Report.

Source: SCRSCCP (1995, 1999, 2000, 2001a and 2002).

Jurisdictions reported the following developments this year.

- NSW conducted a patient survey between January and August 2002, sampling over 9000 patients from across the 17 area health services. The survey received a 70 per cent response rate. Of those patients surveyed following an overnight hospital stay, 73.1 per cent rated the service received as 'very good' or 'excellent'. The results are outlined in table 9A.59.
- Queensland Health conducted a mailout patient satisfaction survey in 2001 with patients who spent at least one night in one of Queensland's 55 largest hospitals. Based on 27 questions about specific aspects of hospital care, the State achieved an average score of 65 on a scale of 0 to 100. This result indicates that patients on average rated the service as either very good or good. Survey results are detailed in table 9A.70.
- WA conducted a patient survey between February and June 2002 covering sameday, outpatients and emergency patients. Patients were asked to assess the outcome of their hospital stay and results are presented as scale scores out of 100. The results are outlined in table 9A.71.

- Tasmania conducted a mailout survey of 1659 hospital patients during 2002. The response rate for the mailout was 35 per cent. Overall, 94.8 per cent of hospital patients rated their overall care as 'good' or 'very good' (table 9A.83).
- The ACT surveyed its inpatients, emergency and day surgery patients using mailout surveys in 2000-01. The response rate for the survey was 57 per cent for inpatients, 48 per cent for emergency patients, and 64 per cent rate for day surgery patients. Inpatients reported an overall satisfaction rate of 88 per cent, emergency patients an overall satisfaction rate of 76 per cent and day surgery patients an 89 per cent overall satisfaction rate (table 9A.87).
- No Territory-wide patient satisfaction data for the NT have been collected in recent years. Hospitals conduct their own hospital-specific patient satisfaction surveys. Development of a Territory-wide survey is planned for 2003.

Clinical indicators

Selected clinical indicators, including re-admissions and infection rates, were evaluated in a research project undertaken in 1998 (box 9.3). The Steering Committee acknowledges the limitations of the current indicators 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 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 clinical indicators presented here are also reported elsewhere, including in the annual reports of the WA, Tasmanian and ACT health departments. The WA and ACT health departments report on unplanned re-admissions, while the Tasmanian health department reports on unplanned re-admissions and rates of hospital acquired bacteraemia (Health Department of WA 2001; Tasmanian Department of Health and Human Services 2001; ACT Department of Health and Community Care 2002). The ACT Department of Health and Community Care has included a range of clinical indicators in its purchase agreements with its major public hospitals.

Box 9.3 **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-admissions within 28 days of separation;
- the rate of hospital-acquired bacteraemia;
- the rate of post-operative wound infections following clean and contaminated surgery; and
- the rate of unplanned returns to an operating room.

The last indicator could not be easily extracted from available databases, so was not included in the project's more detailed analysis.

The project set a high standard for each indicator, requiring it to accurately reflect hospital-wide medical care. 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 as such the indicators were unsuited as national performance measures of hospital quality. As a result, 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).

The presentation of data for the clinical indicators reported here has changed significantly for the 2003 Report, to better reflect the purpose for which the data are collected. The data for these indicators are sourced from the ACHS Comparative Report Service (Clinical Indicators). The data are collected for the purposes of internal clinical review by individual hospitals. The ACHS data are predominantly used to demonstrate the potential for improvement across Australian hospitals if all hospitals could achieve the same outcomes as those hospitals achieving the best outcomes for patients. When interpreting results of these indicators therefore emphasis should be given to the potential for improvement. Statewide conclusions cannot be drawn from the data as participation in the Comparative Report Service (Clinical Indicators) is voluntary and the data are therefore not necessarily drawn from representative samples.

An explanation of the reporting of clinical indicators sourced from the ACHS is contained in box 9.4.

Box 9.4 **Reporting of ACHS clinical indicators**

The data for the unplanned re-admissions and infection rate indicators are sourced from the ACHS. This year, the presentation of data for these indicators has changed significantly to better reflect the purpose for which the data are collected.

The methodology used by the ACHS for reporting of clinical indicators is explained in its publication, *Determining the Potential to Improve the Quality of Care in Australian Health Care Organisations* (ACHS 2001). The ACHS reports the average (that is, mean) rate of occurrence of an event and the performance of hospitals at the 20th and 80th centile (that is, the rate at (or below) which the top 20 per cent and 80 per cent of hospitals are performing). This is designed to allow hospitals to determine whether their performance against an indicator is above or below average, and what scope may exist for improvement.

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

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

(Continued on next page)

Box 9.4 **(Continued)**

(Shrunken rates are used rather than actual rates as actual rates of 0 per cent and 100 per cent may be obtained for individual hospitals based on random variation where there are low denominators. Shrinkage estimators adjust each hospital's observed rate using the hospital's numerator and denominator together with the mean and standard deviations of other hospitals to obtained corrected rates. The smaller the denominator for an individual hospital, the larger the shift to the overall mean.)

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

Finally, using the shrunken rates for individual hospitals, the observed occurrence of the event measured is compared to the expected occurrence of the event to provide a measure of difference from the mean. To avoid responding to random variation, three-sigma limits are plotted and values outside the three-sigma limits are assumed to be systematically different to the average rate. The potential gains from shifting the performance of these 'outliers' to the performance of 'mean' hospitals are calculated (ACHS 2001).

Source: ACHS (unpublished).

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). (There is a more detailed definition of this indicator in table 9.32.)

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 2000). 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 9.3 outlines some limitations to this indicator. These estimates should also be viewed in context of the statistical (standard) errors. High standard errors signal that data are particularly unreliable.

New South Wales

Among those NSW public hospitals participating in the ACHS Service in 2001 the mean rate of unplanned re-admissions was 2.3 per 100 admissions (subject to a standard error of 0.7). The ACHS estimates that if the performance of all NSW public hospitals matched the performance of the top 20 per cent of public hospitals nationally, there would be 1.1 per cent fewer re-admissions to NSW public hospitals (table 9.7). The terms in table 9.7 are defined in box 9.5.

Box 9.5 **Definitions of terms for clinical indicators**

Centile: value separating one hundredth parts of a distribution in order of size. The 20th centile of hospitals for the unplanned re-admissions indicator would represent the best performing 20 per cent of hospitals (with the lowest number of re-admissions); the 20th centile of hospitals for the infections indicators would represent the best performing 20 per cent of hospitals (with the lowest number of infections).

Centile gains: the potential gains from shifting 'mean' hospitals to the performance at the 20th centile, obtained by calculating the change in the occurrence of an event were the mean equal to performance at the 20th centile.

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

Rate (mean): the sum of a set of numbers divided by the amount of numbers in the set; often referred to as an average.

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

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

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

Stratum rate: mean rates for a particular jurisdiction.

Source: ACHS (2001).

Table 9.7 **Unplanned re-admissions per 100 admissions, public hospitals, NSW, 2001[a]**

No. hospitals	*No. reports*	*Numerator (readmissions)*	*Denominator (separations)*	*Rate*	*Standard error* (±)
61	92	7 124	308 698	2.31	0.65
National performance at 80th centile (rate)	*National performance at 20th centile (rate)*	*Potential centile gains (no. readmissions)*	*% change represented by potential gains*	*Potential outlier gains (no. readmissions)*	*Potential stratum gains (no. readmissions)*
4.61	1.17	3 512	1.14	1 179	2 213

a Health organisations contribute data voluntarily to the ACHS and therefore the samples are not necessarily representative of all hospitals in each jurisdiction.

Source: ACHS (unpublished); table 9A.56.

Victoria

Among those Victorian public hospitals participating in the ACHS Service in 2001, the mean rate of unplanned re-admissions was 2.7 per 100 admissions (subject to a standard error of 0.3). The ACHS estimates that if the performance of all Victorian public hospitals matched the performance of the top 20 per cent of public hospitals nationally, there would be 1.5 per cent fewer re-admissions to Victorian public hospitals (table 9.8). See box 9.5 for definitions of terms used.

Table 9.8 **Unplanned re-admissions per 100 admissions, public hospitals, Victoria, 2001[a]**

No. hospitals	*No. reports*	*Numerator (readmissions)*	*Denominator (separations)*	*Rate*	*Standard error* (±)
44	77	8 847	334 312	2.65	0.31
National performance at 80th centile (rate)	*National performance at 20th centile (rate)*	*Potential centile gains (no. readmissions)*	*% change represented by potential gains*	*Potential outlier gains (no. readmissions)*	*Potential stratum gains (no. readmissions)*
4.61	1.17	4 936	1.48	2 894	3 529

a Health organisations contribute data voluntarily to the ACHS and therefore the samples are not necessarily representative of all hospitals in each jurisdiction.

Source: ACHS (unpublished); table 9A.62.

Queensland

Among those Queensland public hospitals participating in the ACHS Service in 2001, the mean rate of unplanned re-admissions was 2.7 per 100 admissions (subject to a standard error of 0.7). The ACHS estimates that if the performance of

all Queensland public hospitals matched the performance of the top 20 per cent of public hospitals nationally, there would be 1.5 per cent fewer re-admissions to Queensland public hospitals (table 9.9). See box 9.5 for definitions of terms used.

Table 9.9 **Unplanned re-admissions per 100 admissions, public hospitals, Queensland, 2001[a]**

No. hospitals	*No. reports*	*Numerator (readmissions)*	*Denominator (separations)*	*Rate*	*Standard error* (±)
12	17	2 182	81 047	2.69	0.66
National performance at 80th centile (rate)	*National performance at 20th centile (rate)*	*Potential centile gains (no. readmissions)*	*% change represented by potential gains*	*Potential outlier gains (no. readmissions)*	*Potential stratum gains (no. readmissions)*
4.61	1.17	1 234	1.52	528	893

a Health organisations contribute data voluntarily to the ACHS and therefore the samples are not necessarily representative of all hospitals in each jurisdiction.

Source: ACHS (unpublished); table 9A.68.

Western Australia

Among those WA public hospitals participating in the ACHS Service in 2001, the mean rate of unplanned re-admissions was 1.9 per 100 admissions (subject to a standard error of 0.4). The ACHS estimates that if the performance of all WA public hospitals matched the performance of the top 20 per cent of public hospitals nationally, there would be 0.7 per cent fewer re-admissions to WA public hospitals (table 9.10). See box 9.5 for definitions of terms used.

Table 9.10 **Unplanned re-admissions per 100 admissions, public hospitals, WA, 2001[a]**

No. hospitals	*No. reports*	*Numerator (readmissions)*	*Denominator (separations)*	*Rate*	*Standard error* (±)
10	14	847	45 692	1.85	0.37
National performance at 80th centile (rate)	*National performance at 20th centile (rate)*	*Potential centile gains (no. readmissions)*	*% change represented by potential gains*	*Potential outlier gains (no. readmissions)*	*Potential stratum gains (no. readmissions)*
4.61	1.17	312	0.68	102	120

a Health organisations contribute data voluntarily to the ACHS and therefore the samples are not necessarily representative of all hospitals in each jurisdiction.

Source: ACHS (unpublished); table 9A.74.

South Australia

Among those SA public hospitals participating in the ACHS Service in 2001, the mean rate of unplanned re-admissions was 3.3 per 100 admissions (subject to a standard error of 0.8). The ACHS estimates that if the performance of all SA public hospitals matched the performance of the top 20 per cent of public hospitals nationally, there would be 2.1 per cent fewer re-admissions to SA public hospitals (table 9.11). See box 9.5 for definitions of terms used.

Table 9.11 **Unplanned re-admissions per 100 admissions, public hospitals, SA, 2001[a]**

No. hospitals	*No. reports*	*Numerator (readmissions)*	*Denominator (separations)*	*Rate*	*Standard error* (±)
13	23	2 630	80 370	3.27	0.83
National performance at 80th centile (rate)	*National performance at 20th centile (rate)*	*Potential centile gains (no. readmissions)*	*% change represented by potential gains*	*Potential outlier gains (no. readmissions)*	*Potential stratum gains (no. readmissions)*
4.61	1.17	1 690	2.10	813	1 352

a Health organisations contribute data voluntarily to the ACHS and therefore the samples are not necessarily representative of all hospitals in each jurisdiction.

Source: ACHS (unpublished); table 9A.79.

Data for Tasmania, the ACT and the NT were not provided by the ACHS because of the small number of hospitals in those jurisdictions. Nationally, among those public hospitals participating in the ACHS Service in 2001, the mean rate of unplanned re-admissions was 2.5 per 100 admissions. The ACHS estimates that if the performance of all Australian public hospitals matched the performance of the top 20 per cent of public hospitals nationally, there would be 1.3 per cent (or 12 619) fewer re-admissions to Australian public hospitals.

Hospital-acquired infection rates

The ACSQHC views reducing health care associated infections as a high priority area, recognising that infections can result in serious consequences for individual patients and place a significant burden on the health system (ACSQHC 2002). 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 9.32.) 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 and are collected for the purposes of internal clinical review by individual hospitals. Statewide 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. As with the unplanned re-admissions data, reporting of this indicator has been changed this year to better reflect the purpose for which the data are collected.

It should be noted that the data are not adjusted for differences in the risk of infection across cases or differences in casemix across hospitals. Higher rates for bacteraemia are to be expected in those hospitals treating conditions where bacteraemia infections were more likely. Box 9.3 outlines limitations associated with this indicator. Estimates shown should be viewed in the context of the statistical (standard) errors. High standard errors signal that the data may be particularly unreliable.

This is the final year for which these indicators are to be reported. Changes made by the ACHS to reporting on hospital-acquired infections taking place from calendar year 2002 should significantly assist in addressing concerns over the absence of casemix or risk adjustment. Recording by the ACHS of surgical site infection rates will become surgical procedure-specific, while indicators of central line-associated blood stream infections will relate to particular clinical units of hospitals. More detail on these changes is contained in section 9.4.

New South Wales

Among those NSW public hospitals participating in the ACHS Service in 2001, the mean rate of post-operative infections following clean surgery was 1.9 per 100 separations (subject to a standard error of 0.7). The ACHS estimates that if the performance of all NSW public hospitals matched the performance of the top 20 per cent of public hospitals nationally, there would be 0.7 per cent fewer post-operative infections following clean surgery in NSW public hospitals (table 9.12).

The mean rate of post-operative infections following contaminated surgery was 1.8 per 100 separations (subject to a standard error of 1.0). The ACHS estimates that if the performance of all NSW public hospitals matched the performance of the top 20 per cent of public hospitals nationally, there would be 0.2 per cent fewer post-operative infections following contaminated surgery in NSW public hospitals (table 9.12).

The mean rate of hospital-acquired bacteraemia was 0.4 per 100 separations (subject to a standard error of 0.04). The ACHS estimates that if the performance of all NSW public hospitals matched the performance of the top 20 per cent of public hospitals nationally, there would be 0.3 per cent fewer cases of hospital-acquired bacteraemia in NSW public hospitals (table 9.12). See box 9.5 for definitions of terms used.

Table 9.12 **Hospital-acquired infections per 100 separations, public hospitals, NSW, 2001[a]**

	Post-operative infection following clean surgery	*Post-operative infection following contaminated surgery*	*Hospital-acquired bacteraemia*
No. hospitals	24	23	47
Rate	1.88	1.76	0.40
Standard error (±)	0.71	0.98	0.04
National performance at 80th centile (rate)	2.27	3.40	0.44
National performance at 20th centile (rate)	1.20	1.56	0.11
Potential centile gains (no. infections)	43	10	603
% change represented by potential gains	0.68	0.20	0.29
Potential outlier gains (no. infections)	8	5	228
Potential stratum gains (no. infections)	51	28	571

a Health organisations contribute data voluntarily to the ACHS and therefore the samples are not necessarily representative of all hospitals in each jurisdiction.

Source: ACHS (unpublished); table 9A.57.

Victoria

Among those Victorian public hospitals participating in the ACHS Service in 2001, the mean rate of post-operative infections following clean surgery was 1.9 per 100 separations (subject to a standard error of 1.6). The ACHS estimates that if the performance of all Victorian public hospitals matched the performance of the top 20 per cent of public hospitals nationally, there would be 0.7 per cent fewer

post-operative infections following clean surgery in Victorian public hospitals (table 9.13).

The mean rate of post-operative infections following contaminated surgery was 2.8 per 100 separations (although subject to a very high standard error of 4.5). The ACHS estimates that if the performance of all Victorian public hospitals matched the performance of the top 20 per cent of public hospitals nationally, there would be 1.2 per cent fewer post-operative infections following contaminated surgery in Victorian public hospitals (table 9.13).

The mean rate of hospital-acquired bacteraemia was 0.6 per 100 separations (subject to a standard error of 0.1). The ACHS estimates that if the performance of all Victorian public hospitals matched the performance of the top 20 per cent of public hospitals nationally, there would be 0.4 per cent fewer cases of hospital-acquired bacteraemia in Victorian public hospitals (table 9.13). See box 9.5 for definitions of terms used.

Table 9.13 **Hospital-acquired infections per 100 separations, public hospitals, Victoria, 2001[a]**

	Post-operative infection following clean surgery	*Post-operative infection following contaminated surgery*	*Hospital-acquired bacteraemia*
No. hospitals	15	14	28
Rate	1.93	2.80	0.55
Standard error (±)	1.59	4.47	0.13
National performance at 80th centile (rate)	2.27	3.40	0.44
National performance at 20th centile (rate)	1.20	1.56	0.11
Potential centile gains (no. infections)	19	24	427
% change represented by potential gains	0.73	1.24	0.44
Potential outlier gains (no. infections)	0	3	253
Potential stratum gains (no. infections)	22	31	412

a Health organisations contribute data voluntarily to the ACHS and therefore the samples are not necessarily representative of all hospitals in each jurisdiction.

Source: ACHS (unpublished); table 9A.63.

Queensland

Among those Queensland public hospitals participating in the ACHS Service in 2001, the mean rate of post-operative infections following clean surgery was

1.1 per 100 separations (subject to a standard error of 0.6). The mean rate of post-operative infections following clean surgery was lower in Queensland than the rate of the best performing 20 per cent of participating hospitals nationally (table 9.14).

The mean rate of post-operative infections following contaminated surgery was 1.2 per 100 separations (subject to a standard error of 1.1). The mean rate of post-operative infections following contaminated surgery was lower in Queensland than the rate of the best performing 20 per cent of participating hospitals nationally (table 9.14).

The mean rate of hospital-acquired bacteraemia was 0.2 per 100 separations (subject to a standard error of 0.03). The ACHS estimates that if the performance of all Queensland public hospitals matched the performance of the top 20 per cent of public hospitals nationally, there would be 0.1 per cent fewer cases of hospital-acquired bacteraemia in Queensland public hospitals (table 9.14). See box 9.5 for definitions of terms used.

Table 9.14 **Hospital-acquired infections per 100 separations, public hospitals, Queensland, 2001[a]**

	Post-operative infection following clean surgery	*Post-operative infection following contaminated surgery*	*Hospital-acquired bacteraemia*
No. hospitals	7	5	15
Rate	1.08	1.22	0.20
Standard error (±)	0.56	1.05	0.03
National performance at 80th centile (rate)	2.27	3.40	0.44
National performance at 20th centile (rate)	1.20	1.56	0.11
Potential centile gains (no. infections)	-6	-7	129
% change represented by potential gains	-0.12	-0.34	0.09
Potential outlier gains (no. infections)	0	0	0
Potential stratum gains (no. infections)	0	0	108

a Health organisations contribute data voluntarily to the ACHS and therefore the samples are not necessarily representative of all hospitals in each jurisdiction.

Source: ACHS (unpublished); table 9A.69.

Western Australia

Among those WA public hospitals participating in the ACHS Service in 2001, the mean rate of post-operative infections following clean surgery was 1.3 per 100 separations (subject to a standard error of 1.3). The ACHS estimates that if the performance of all WA public hospitals matched the performance of the top 20 per cent of public hospitals nationally, there would be 0.1 per cent fewer post-operative infections following contaminated surgery in WA public hospitals (table 9.15).

The mean rate of post-operative infections following contaminated surgery was 6.2 per 100 separations (subject to a relatively high standard error of 2.8). The ACHS estimates that if the performance of all WA public hospitals matched the performance of the top 20 per cent of public hospitals nationally, there would be 4.7 per cent fewer post-operative infections following contaminated surgery in WA public hospitals (table 9.15).

The mean rate of hospital-acquired bacteraemia was 0.1 per 100 separations (subject to a standard error of 0.05). The ACHS estimates that if the performance of all WA public hospitals matched the performance of the top 20 per cent of public hospitals nationally, there would be 0.02 per cent fewer cases of hospital-acquired bacteraemia in WA public hospitals (table 9.15). See box 9.5 for definitions of terms used.

Table 9.15 **Hospital-acquired infections per 100 separations, public hospitals, WA, 2001[a]**

	Post-operative infection following clean surgery	*Post-operative infection following contaminated surgery*	*Hospital-acquired bacteraemia*
No. hospitals	5	5	6
Rate	1.29	6.22	0.13
Standard error (±)	1.25	2.80	0.05
National performance at 80th centile (rate)	2.27	3.40	0.44
National performance at 20th centile (rate)	1.20	1.56	0.11
Potential centile gains (no. infections)	0	11	1
% change represented by potential gains	0.09	4.66	0.02
Potential outlier gains (no. infections)	0	4	0
Potential stratum gains (no. infections)	1	12	0

a Health organisations contribute data voluntarily to the ACHS and therefore the samples are not necessarily representative of all hospitals in each jurisdiction.

Source: ACHS (unpublished); table 9A.75.

South Australia

Among those SA public hospitals participating in the ACHS Service in 2001, the mean rate of post-operative infections following clean surgery was 2.0 per 100 separations (subject to a standard error of 0.5). The ACHS estimates that if the performance of all SA public hospitals matched the performance of the top 20 per cent of public hospitals nationally, there would be 0.8 per cent fewer post-operative infections following clean surgery in SA public hospitals (table 9.16).

The mean rate of post-operative infections following contaminated surgery was 3.3 per 100 separations (subject to a relatively high standard error of 2.8). The ACHS estimates that if the performance of all SA public hospitals matched the performance of the top 20 per cent of public hospitals nationally, there would be 1.7 per cent fewer post-operative infections following contaminated surgery in SA public hospitals (table 9.16).

The mean rate of hospital-acquired bacteraemia was 0.4 per 100 separations (subject to a standard error of 0.08). The ACHS estimates that if the performance of all SA public hospitals matched the performance of the top 20 per cent of public hospitals nationally, there would be 0.3 per cent fewer cases of hospital-acquired

bacteraemia in SA public hospitals (table 9.16). See box 9.5 for definitions of terms used.

Table 9.16 **Hospital-acquired infections per 100 separations, public hospitals, SA, 2001[a]**

	Post-operative infection following clean surgery	*Post-operative infection following contaminated surgery*	*Hospital-acquired bacteraemia*
No. hospitals	7	5	9
Rate	2.01	3.29	0.43
Standard error (±)	0.45	2.76	0.08
National performance at 80th centile (rate)	2.27	3.40	0.44
National performance at 20th centile (rate)	1.20	1.56	0.11
Potential centile gains (no. infections)	6	8	131
% change represented by potential gains	0.81	1.73	0.32
Potential outlier gains (no. infections)	0	5	82
Potential stratum gains (no. infections)	7	10	125

a Health organisations contribute data voluntarily to the ACHS and therefore the samples are not necessarily representative of all hospitals in each jurisdiction.

Source: ACHS (unpublished); table 9A.80.

Data for Tasmania, the ACT and the NT were not provided by the ACHS because of the small number of hospitals in those jurisdictions. Nationally, among those public hospitals participating in the ACHS Service in 2001 the mean rate of post-operative infections following clean surgery was 1.7 per 100 separations. The ACHS estimates that if the performance of all Australian public hospitals matched the performance of the top 20 per cent of public hospitals, there would be 0.5 per cent (or 70) fewer post-operative infections following clean surgery in Australian public hospitals.

The mean rate of post-operative infections following contaminated surgery was 2.2 per 100 separations nationally. The ACHS estimates that if the performance of all Australian public hospitals matched the performance of the top 20 per cent of public hospitals, there would be 0.6 per cent (or 64) fewer post-operative infections following contaminated surgery in Australian public hospitals.

The mean rate of hospital-acquired bacteraemia was 0.4 per 100 separations nationally. The ACHS estimates that if the performance of all Australian public hospitals matched the performance of the top 20 per cent of public hospitals, there

would be 0.3 per cent (or 1398) fewer cases of hospital-acquired bacteraemia in Australian public hospitals.

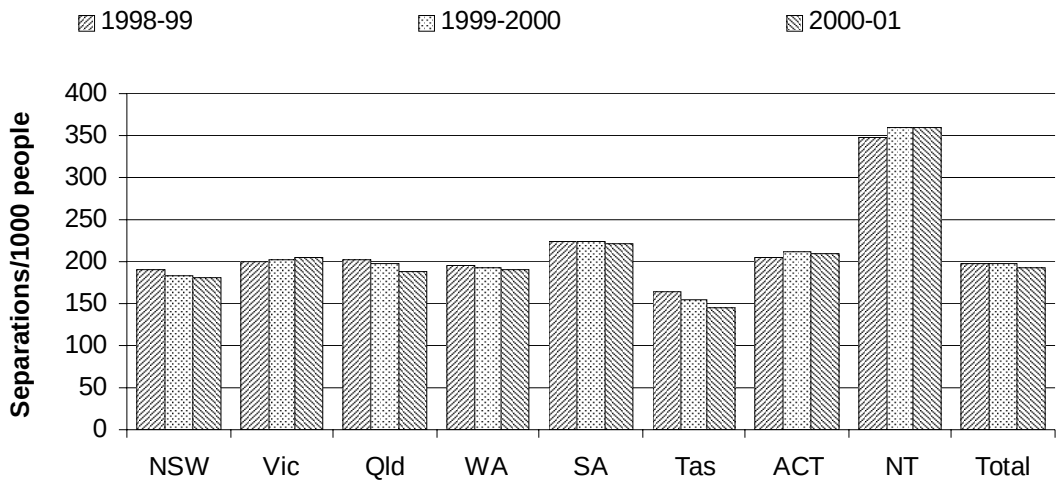
Appropriateness

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 (non-psychiatric) hospitals in 2000-01 (table 9A.7). Nationally, this translates into 193.0 separations per 1000 people, ranging from 360.3 per 1000 in the NT to 144.9 per 1000 in Tasmania (figure 9.9).

Figure 9.9 **Separation rates in public (non-psychiatric) hospitals[a]**



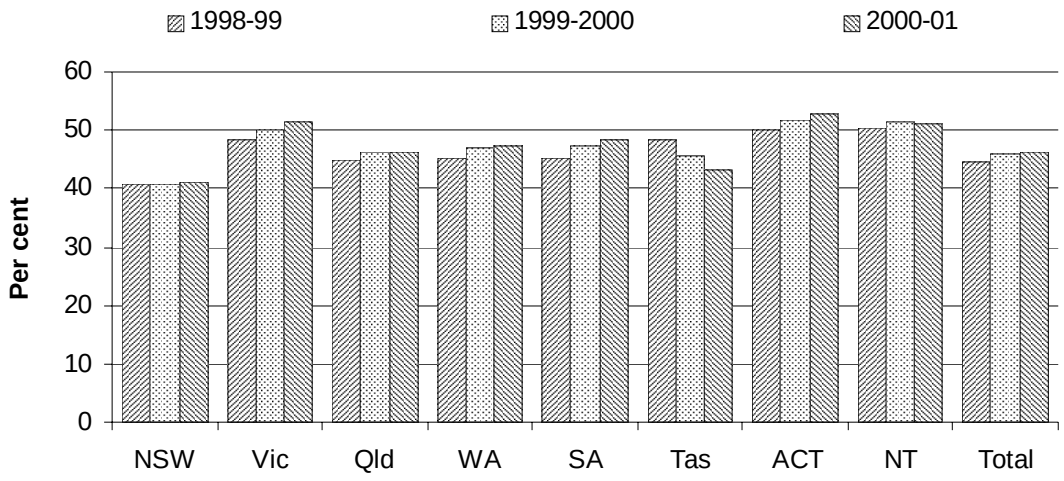
a Figures are directly age-standardised to the Australian population at 30 June 1991.

Source: AIHW (2002a); table 9A.7.

Nationally, in public (non-psychiatric) hospitals, 46.4 per cent of separations were same day separations in 2000-01. The ACT reported the highest percentage rate of same day separations (52.7) and NSW reported the lowest (41.0) (figure 9.10). 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. NSW 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.

Same day separations in public (non-psychiatric) hospitals increased 1.2 per cent between 1999-2000 and 2000-01 and the proportion of separations that were same day increased from 45.8 per cent to 46.4 per cent. In contrast, overnight separations in public (non-psychiatric) hospitals decreased 2.0 per cent between 1999-2000 and 2000-01 (calculated from table 9A.7).

Figure 9.10 **Proportion of separations that were same day, public (non-psychiatric) hospitals[a]**



a Figures are directly age-standardised to the Australian population at 30 June 1991.

Source: AIHW (2002a); table 9A.7.

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 9.17). The list of procedures has changed this year. Revision of hip replacement has been included for the first time as rates for this procedure may provide information on the performance of the original hip replacements. Separation rates for asthma and Type 2 diabetes (as principal diagnoses) have been included as indicators of care for the primary care sector. Separation rates for Type 2 diabetes as any diagnosis (principal or additional) have also been included, as 89.3 per cent of separations with diagnosis of diabetes have the diagnosis recorded as an additional diagnosis, rather than as the principal diagnosis.

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. Some are indicators of

the performance of primary care rather than hospitals. Some of the selected procedures, such as angioplasty and coronary artery bypass graft, are alternative treatment options for people diagnosed with similar conditions.

The data reported include all hospitals, so are reflective of the activities of both public and private health systems.[4] The most common procedures in 2000-01 were endoscopies, Type 2 diabetes (principal or additional diagnosis), lens insertions and arthroscopic procedures (table 9.17). Separation rates for all procedures varied across jurisdictions. The NT had significantly higher separation rates for Type 2 diabetes (principal diagnosis) and Type 2 diabetes (principal or additional diagnosis). Table 9A.12 outlines which State or Territory separation rates are statistically significantly different to the collective separation rate for all other jurisdictions. Statistically significant and material differences in the separation rates for these procedures may highlight variations in treatment methods across jurisdictions.

[4] 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 2002a).

Table 9.17 **Separations per 1000 people, public and private hospitals by selected procedure or diagnosis, 2000-01[a, b, c]**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Total*[d]
Appendicectomy	1.32	1.45	1.52	1.73	1.37	1.62	1.40	1.08	1.44
Coronary artery bypass	0.87	0.80	0.83	0.56	0.69	0.71	0.48	0.65	0.79
Angioplasty	1.03	1.19	0.84	1.05	1.01	1.12	1.22	0.73	1.04
Caesarean section separation rate	3.15	3.13	3.86	3.63	3.41	3.40	2.71	2.72	3.34
Caesarean section separations per 100 in-hospital births	22.8	24.3	26.4	26.8	26.1	22.7	20.1	21.3	24.4
Cholecystectomy	2.19	2.24	2.43	2.21	2.38	2.26	2.00	1.23	2.25
Diagnostic gastrointestinal endoscopy	24.88	27.71	30.28	27.02	23.63	20.40	12.05	12.09	26.29
Hip replacement	1.03	1.15	0.90	1.23	1.21	1.35	1.35	0.67	1.08
Revision of hip replacement	0.13	0.15	0.12	0.15	0.14	0.20	0.23	0.09	0.14
Hysterectomy	1.50	1.54	1.66	1.94	1.87	2.06	1.88	0.62	1.62
Lens insertion	6.07	5.62	6.59	6.49	5.32	5.91	4.07	5.59	5.99
Tonsillectomy	1.54	1.77	1.73	1.88	2.18	1.19	1.15	0.43	1.69
Myringotomy	1.48	2.28	1.67	2.32	3.36	1.20	1.49	0.63	1.92
Knee replacement	1.13	0.79	0.93	1.09	1.13	0.86	1.09	0.63	1.00
Prostatectomy	1.06	1.32	0.98	0.97	1.16	1.31	1.09	0.68	1.12
Arthroscopic procedures (includes arthroscopies)	4.74	5.96	4.42	7.20	8.18	4.95	4.78	3.71	5.49
Asthma (principal diagnosis)	2.73	2.38	2.49	2.71	3.98	1.39	1.80	2.33	2.64
Type 2 diabetes (principal diagnosis)	1.06	1.79	1.21	1.98	1.92	1.47	1.22	5.14	1.46
Type 2 diabetes (principal or additional diagnosis)	11.96	14.58	14.19	15.76	14.56	12.62	9.46	27.03	13.70

a The procedures and diagnoses 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 using December 2000 population estimates as divisors. **d** Excludes non-residents and unknown State of residence.

Source: AIHW (2002a); table 9A.12.

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 patients presenting to public hospital emergency departments in 2000-01 are presented in table 9.18. All patients of public hospital emergency departments are public patients. Data may vary across jurisdictions as a result of differences in clinical practices (for example, the allocation of cases to urgency categories). The proportion of patients in each triage category that were subsequently admitted, which is included for the first time in this year's Report, may provide an indication of the comparability of triage categorisations across jurisdictions, and thus comparability of the waiting times data.

The nationally agreed definition for measurement of waiting times is to subtract the time at which the patient presents at the emergency department (that is, the time at which the patient is clerically registered or at which they are triaged, whichever occurs earlier) from the time of commencement of service by a treating medical officer or nurse. Patients who subsequently do not wait for care after being triaged or clerically registered are excluded from the data. Victoria, Queensland, WA and the ACT use the national definition, while NSW, SA, Tasmania and the NT use the time of triage. In SA, patients are always triaged before being clerically registered (AIHW 2002a).

Other data issues 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. While the national standard allows being seen by either a nurse or a doctor to be used in this measure, Queensland has reported for 2000-01 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. There are also differences across jurisdictions in data coverage, with the estimated proportion of emergency visits covered ranging across jurisdictions in 2000-01 from 100 per cent in Tasmania, the ACT and the NT, to 54 per cent in Victoria (table 9.18).

In 2000-01, NSW, Victoria and the NT had the highest proportion of patients seen within the triage timeframe for category 1 (100 per cent) and Tasmania had the lowest proportion (89 per cent). For triage category 2, the ACT had the highest proportion of patients seen within the relevant timeframe (85 per cent) and Tasmania had the lowest (55 per cent). NSW and WA generally had a higher than average proportion of patients who were subsequently admitted in all triage categories (table 9.18).

Waiting times for elective surgery

Elective surgery waiting times are difficult to measure objectively, and the data can be complex to interpret. The 2002 Report noted that variation in performance between jurisdictions was likely to be caused by differences across jurisdictions in the way clinicians allocated patients to urgency categories. Due to uncertainties regarding the consistency with which clinical urgency categories are assigned across jurisdictions, two methods of reporting on waiting times for elective surgery are included in this year's Report.

A new indicator — times waited for admission for elective surgery (regardless of clinical urgency category) — is reported for the first time this year. This is a new national indicator developed by the health sector after a decision by the Australian Health Ministers' Advisory Council (AHMAC) in late 2001 not to report by urgency category. In its decision to develop the new indicator, AHMAC acknowledged that the data by urgency category are not comparable across jurisdictions. Data for the new indicator (included in this year's Report) are comparable.

Table 9.18 **Emergency department waiting time to service delivery, public hospitals 2000-01[a]**

Triage category	*NSW*	*Vic*	*Qld*	*WA*[b]	*SA*	*Tas*[c]	*ACT*	*NT*	*Aust*
Waiting times (per cent of patients seen within triage category)									
1 – Resuscitation	100	100	98	98	94	89	98	100	98
2 – Emergency	74	78	70	78	64	55	85	69	73
3 – Urgent	59	69	59	64	51	57	82	71	61
4 – Semi-urgent	63	56	65	59	46	64	71	64	60
5 – Non-urgent	87	82	86	75	51	90	83	88	83
Total	**67**	**65**	**66**	**65**	**49**	**65**	**78**	**68**	**65**
Estimated proportion of patients who were subsequently admitted (per cent)[d]									
1 – Resuscitation	86	65	83	82	79	83	74	63	79
2 – Emergency	71	47	68	63	63	61	51	60	63
3 – Urgent	50	34	38	49	42	33	37	39	43
4 – Semi-urgent	22	16	14	26	14	14	16	14	18
5 – Non-urgent	7	6	4	8	4	4	4	3	6
Total	**32**	**24**	**24**	**36**	**25**	**24**	**18**	**24**	**28**
Data coverage									
Estimated proportion of emergency visits (per cent)	80	54	80	82	77	100	100	100	..
Hospitals (number)	52	12	20	6	13	4	2	2	111

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. **b** Estimated proportion of patients who were admitted is based on four hospitals. **c** Estimated proportion of patients who were admitted is based on three hospitals. **d** This may provide an indication of the comparability of triage categorisations across jurisdictions. .. Not applicable.

Source: AIHW (2002a); table 9A.13.

Note: SA country hospitals reported incomplete waiting times data. Percentages for patients seen within triage categories excluding country hospitals are shown in the SA jurisdiction comments on page 11.77.

As in previous reports, data are also presented on waiting times for patients by clinical urgency category. To reflect the importance of treating patients according to the urgency of their condition, the Steering Committee has decided to continue to report the old indicator. It is, however, acknowledged that systematic differences across jurisdictions in the judgements applied by clinicians about the urgency of particular cases — as well as in the performance of hospital systems — are likely to

affect reported results. The Steering Committee considers that standardisation of the data for this indicator should be a priority.

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).

The new indicator is based on admissions (or throughput) data. Reporting based on the 'old' method shows both the time waited for surgery by patients on waiting lists at particular census dates, as well as for admitted patients.

For admissions data, waiting times are calculated from the time a patient is first included on the waiting list to the time the patient is admitted. Admissions data exclude patients who were on waiting lists although not subsequently admitted for surgery. It is estimated that between 10 and 20 per cent of patients are removed from waiting lists for reasons other than admission, including admission as an emergency patient for the relevant procedure, death of the patient, treatment at another location, the patient declining the surgery or inability to contact the patient (AIHW 2002c).

Census data reflect the proportion of patients waiting on the date of the census who have been waiting an extended period. Census data do not represent the completed waiting time of patients.

Both indicators will be affected by variations across jurisdictions in the approach to patients who changed clinical urgency category while they were on the waiting list or patients who are transferred from a waiting list managed by one hospital to a waiting list managed by a different hospital (AIHW 2002a). Where patients experience a change in their clinical condition leading to a review of their urgency category, the national definition specifies that waiting times are recorded as the period in the most recent urgency category and in any previous more urgent categories. For 1999-2000, Victoria, Queensland, WA and SA recorded waiting times in the most recent urgency category only, while the NT recorded total waiting time in all categories (AIHW 2002c, Queensland Government). For 2000-01, Victoria recorded waiting times in the most recent urgency category only, while SA and the NT recorded total waiting time in all categories (AIHW 2002a).

Where patients were transferred between waiting lists managed by different hospitals, generally only the time spent on the final list would be included in the waiting time reported. Victoria and WA reported based on the total time waited on all waiting lists. SA has stated that it is uncommon for patients to switch between waiting lists managed by different hospitals in that jurisdiction (AIHW 2002a).

Table 9.19 presents data for the new indicator — the number of days at which 50 per cent (that is, the 50th percentile) and 90 per cent (the 90th percentile) of patients were admitted, based on the time between when a patient was first included on a waiting list to when the patient was admitted. In 2000-01, the days waited at the 50th percentile ranged from 44 days in the ACT to 22 days in Queensland. The days waited at the 90th percentile ranged from 294 in Tasmania to 132 in Queensland. The proportion of patients waiting more than 365 days varied from 7.6 per cent in Tasmania, to 2.3 per cent in the NT (table 9.19).

Table 9.19 **Elective surgery waiting times, public hospitals**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
1999-2000									
Days waited at 50th percentile	26	28	22	31	30	36	**np**	23	27
Days waited at 90th percentile	168	187	134	242	157	292	**np**	149	175
% waited more than 365 days	2.4	3.6	3.0	5.7	2.2	6.7	**np**	1.6	3.1
Estimated coverage of surgical separations (%)**a**	100	71	95	75	67	99	**np**	100	85
2000-01									
Days waited at 50th percentile	28	28	22	27	34	37	44	23	27
Days waited at 90th percentile	229	205	132	215	199	294	266	198	202
% waited more than 365 days	5.2	4.0	3.3	4.0	3.6	7.6	5.3	2.3	4.4
Estimated coverage of surgical separations (%)**a**	100	70	94	75	67	100	100	100	85

a The number of separations with a surgical procedure for hospitals reporting to the National Elective Surgery Waiting Times Data Collection as a proportion of the number of separations with a surgical procedure for all public hospitals. **np** Not published.

Source: AIHW (2002a), (2002c); table 9A.14.

More information on elective surgery waiting times based on the new method of reporting is included in the attachment. Data on elective surgery waiting times by

hospital peer group, specialty of surgeon and indicator procedure, are contained in tables 9A.14, 9A.15 and 9A.16 respectively.

Data for the 'old indicator' reflect waiting times based on the urgency of the patient's condition. 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.

There is no specified or agreed desirable wait for category three patients, so the term 'extended wait' is used for patients waiting longer than 12 months for elective surgery.

As stated earlier, these data are not comparable across jurisdictions because of systematic differences in clinicians' approach to categorisation by urgency. Figures 5.12 and 5.13 of the 2002 Report illustrate differences across jurisdictions in the classification of patients to urgency categories for 1999. States and Territories with large proportions of patients in category 1 were also the States and Territories that had relatively large proportions of patients 'not seen on time'. Thus, the apparent variation in performance is likely to be significantly a result of variation in the classification practices employed (SCRSCCP 2002). Data on classification of patients to urgency categories for 2000-01 are available only for SA, Tasmania and the ACT.

- Of patients on waiting lists in SA at 30 June 2001, 4.8 per cent were in category one, 12.6 per cent were in category two and 82.6 per cent were in category three. Of patients admitted from waiting lists during 2000-01, in SA 25.9 per cent of patients were in category one, 20.0 per cent of patients were in category two and 54.1 per cent were in category three.
- Of those patients on waiting lists in Tasmania at 30 June 2001, 7.8 per cent were in category one, 40.2 per cent were in category two and 52.0 per cent were in category three. Of patients admitted from waiting lists during 2000-01, in Tasmania 44.4 per cent of admitted patients were in category one, 34.2 per cent were in category two and 21.4 per cent were in category three.
- Of those patients on waiting lists in the ACT at 30 June 2001, 4.0 per cent were in category one, 39.7 per cent were in category two and 56.3 per cent were in category three. Of patients admitted from waiting lists during 2000-01 in the ACT, 30.7 per cent were in category one, 45.3 per cent in category two and 24.0 per cent were in category three (State and Territory governments unpublished).

Data for the 'old indicator' have been supplied for this year's Report by Queensland, SA, Tasmania and the ACT. NSW, Victoria, WA and the NT did not provide data for this indicator.

For those jurisdictions that provided data:

- Census data for Queensland suggest that 4.5 per cent of category one patients on the waiting list at 30 June 2001 were subject to extended waits, 14.1 per cent of category two patients on the waiting list were subject to extended waits, 38.3 per cent of category three patients were subject to extended waits and 29.7 per cent of all patients on the waiting list at 30 June 2001 were subject to extended waits. Of patients admitted from waiting lists in 2000-01, 6.8 per cent of patients were subject to extended waits, 10.3 per cent of category two patients were subject to extended waits, 17.5 per cent of category three patients were subject to extended waits and 11.0 per cent of patients overall were subject to extended waits (table 9A.66).
- Census data for SA suggest that 20.3 per cent of category one patients on the waiting list at 30 June 2001 were subject to extended waits, 21.6 per cent of category two patients on the waiting list were subject to extended waits, 17.4 per cent of category three patients were subject to extended waits and 18.1 per cent of all patients on the waiting list at 30 June 2001 were subject to extended waits. Of patients admitted from waiting lists in 2000-01, 13.3 per cent of patients were subject to extended waits, 15.0 per cent of category two patients were subject to extended waits, 5.8 per cent of category three patients were subject to extended waits and 9.6 per cent of patients overall were subject to extended waits (table 9A.77).
- Census data for Tasmania suggest that 50.0 per cent of category one patients on the waiting list at 30 June 2001 were subject to extended waits, 66.0 per cent of category two patients on the waiting list were subject to extended waits, 41.0 per cent of category three patients were subject to extended waits and 52.0 per cent of all patients on the waiting list at 30 June 2001 were subject to extended waits. Of patients admitted from waiting lists in 2000-01, 34.0 per cent of patients were subject to extended waits, 50.0 per cent of category two patients were subject to extended waits, 31.0 per cent of category three patients were subject to extended waits and 36.0 per cent of patients overall were subject to extended waits (table 9A.85).
- Census data for the ACT suggest that 0.2 per cent of category one patients on the waiting list at 30 June 2001 were subject to extended waits, 54.4 per cent of category two patients on the waiting list were subject to extended waits, 45.4 per cent of category three patients were subject to extended waits and 25.3 per cent of all patients on the waiting list at 30 June 2001 were subject to

extended waits. Of patients admitted from waiting lists in 2000-01, 14.2 per cent of patients were subject to extended waits, 66.8 per cent of category two patients were subject to extended waits, 18.9 per cent of category three patients were subject to extended waits and 22.8 per cent of patients overall were subject to extended waits (table 9A.88).

Queensland , SA and Tasmania provided data on patients on waiting lists by clinical speciality for 2000-01 (tables 9A.67, 9A.78 and 9A.86) and SA and Tasmania provided data on elective surgery waiting lists at time of admission by clinical speciality for this period (tables 9A.78 and 9A.86).

Data are available for 1999-2000 for Victoria, WA and the NT on patients on waiting lists by clinical speciality and data on elective surgery waiting lists at time of admission by clinical speciality (tables 9A.61, 9A.73 and 9A.91).

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) (2000) 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 2000). 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 2000, 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 2000-01 are provided in table 9.20. Indigenous separations accounted for around 3 per cent of total separations in 2000-01 (and around 4.5 per cent of separations in public hospitals), although Indigenous people represented around 2 per cent of the total population in 1998 (AIHW 2002a). Most Indigenous separations occurred in public hospitals (98 per cent). The low proportion of private hospital separations for Indigenous people may be due partly to a lower proportion of Indigenous patients

being correctly identified in private hospitals and partly to a lower use of private hospitals (ABS 2000). Data in table 9.20 need to be interpreted with care. The AIHW advise that only data from SA and the NT are considered to be of acceptable quality (AIHW 2002a).

Table 9.20 **Separations by Indigenous status, 2000-01[a]**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT* [b]	*NT* [c]	*Aust*
Number of public hospital separations ('000)									
Indigenous	33.0	7.4	48.6	34.7	12.1	1.0	1.1	35.0	173.0
Non-Indigenous	1 203.2	1 021.2	621.6	327.9	335.9	66.6	58.6	23.8	3 658.8
Not reported	2.3	0.0	18.4	0.0	9.1	4.2	1.6	0.2	35.8
Total	**1 238.4**	**1 028.6**	**688.6**	**362.6**	**357.1**	**71.9**	**61.3**	**59.0**	**3 867.6**
Number of private hospital separations ('000)									
Indigenous	0.4	0.3	1.4	1.9	0.2	0.1	0.1	**na**	4.4
Non-Indigenous	638.0	580.2	417.7	248.2	177.1	25.1	24.3	**na**	2 110.6
Not reported	1.4	0.0	107.2	0.0	7.0	40.0	0.3	**na**	155.8
Total	**639.8**	**580.4**	**526.3**	**250.1**	**184.3**	**65.3**	**24.6**	**na**	**2 270.8**
Separations in public hospitals as a proportion of separations in all hospitals (%)									
Indigenous	99	97	97	95	98	79	95	**na**	98
Non-Indigenous	65	64	60	57	65	73	71	**na**	63

a Identification of Indigenous patients is not considered 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** Data for the private hospital in the NT not available. **na** Not available.

Source: AIHW (2002a); table 9A.17.

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 9.21. Data regarding private hospital separation rates are contained in table 9A.18.

In 2000-01, on an age-standardised basis, 520 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 195 per 1000. Indigenous separation rates for public hospitals were highest in the NT (875 separations per 1000 Indigenous people) and lowest in Tasmania (91) (table 9.21). It should be noted that the AIHW advise that only data from SA and the NT are considered to be of acceptable quality (AIHW 2002a). Incomplete identification of Indigenous people limits the validity of comparisons over time.

Table 9.21 **Estimates of separations per 1000 people by reported Indigenous status, public hospitals[a, b]**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*[c]	*NT*	*Aust*
1997-98									
Indigenous people	316	339	503	715	603	152	368	827	504
Total population	195	191	192	192	213	161	204	326	195
1998-99									
Indigenous people	336	331	590	805	673	23	33	887	550
Total population	194	201	205	198	224	165	208	352	201
1999-2000									
Indigenous people	344	380	631	800	771	132	1815	963	592
Total population	187	205	201	196	227	156	215	365	199
2000-01									
Indigenous people	320	356	558	702	646	91	670	875	520
Total population	181	206	191	193	222	145	207	356	195

[a] The rates are directly age-standardised to the Australian population at 30 June 1991. The rates for the years 1997-98 to 1999-2000 are calculated using population estimates based on the 1996 Census. The rates for 2000-01 are calculated using the actual census population counts. [b] Identification of Aboriginal and Torres Strait Islander patients is not considered complete and completeness varies across jurisdictions. [c] 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 9A.18.

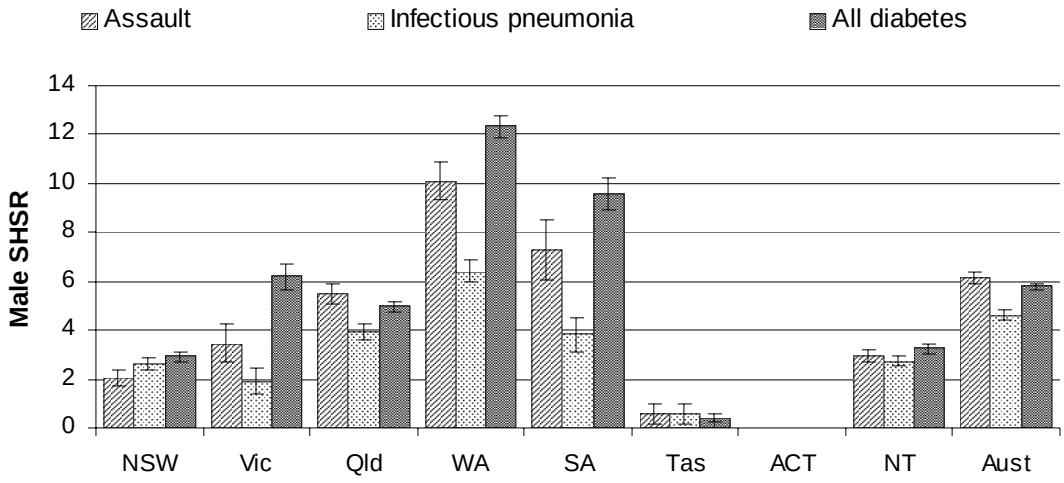
Data on Indigenous separations for selected conditions are presented for one of the refined national health performance indicators for Aboriginal and Torres Strait Islanders endorsed by AHMAC in 2000 — Standardised Hospital Separation Ratios. It should be noted, however, that the ratios are included 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 rates 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 9A.19 and 9A.20).

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 2000-01, 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 6.2 times higher than for all Australians), all diabetes[5] (Indigenous separation rates were 5.8 times higher than for all Australians), and infectious pneumonia (Indigenous separation rates were 4.6 times higher than for all Australians) (figure 9.11). (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 9A.19].)

Figure 9.11 **Indigenous males: standardised hospital separation ratios for selected conditions, 2000-01[a, b, c]**



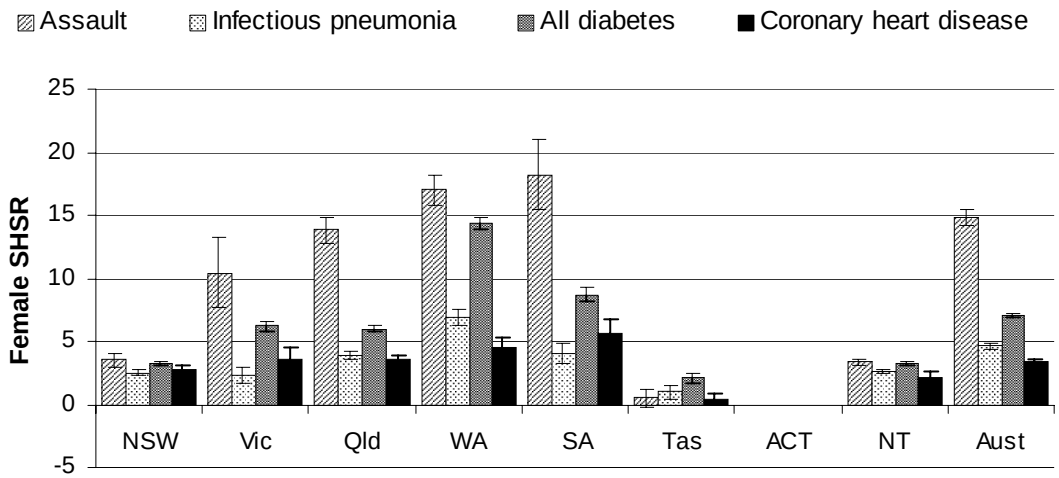
a The ratios are indirectly age-standardised to the Australian population aged 0–74 years at 30 June 1999. **b** The ACT data are not considered reliable due to the small size of the Indigenous population in that jurisdiction. **c** It should be noted that these data do not signal the performance of 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. Information on the Indigenous population in each jurisdiction is contained in the statistical appendix.

Source: AIHW (unpublished); table 9A.19.

5 'All diabetes' refers to separations with either a principal or additional diagnosis of diabetes.

Indigenous females' separation rates were markedly higher than those for all females for assault (the rate for Indigenous females was 14.9 times the rate for all females), all diabetes (the rate for Indigenous females was 7.1 times the rate for all females), infectious pneumonia (the rate for Indigenous females was 4.6 times the rate for all females) and coronary heart disease (the rate for Indigenous females was 3.4 times the rate for all females) (figure 9.12). (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 9A.20].)

Figure 9.12 **Indigenous females: standardised hospital separation ratios for selected conditions, 2000-01[a, b, c]**



a The ratios are indirectly age-standardised to the Australian population aged 0–74 years at 30 June 1999. **b** The ACT data are not considered reliable due to the small size of the Indigenous population in that jurisdiction. **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. Information on the Indigenous population in each jurisdiction is contained in the statistical appendix.

Source: AIHW (unpublished); table 9A.20.

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 accurately measured, 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 9.6). This may also influence unit cost outcomes.

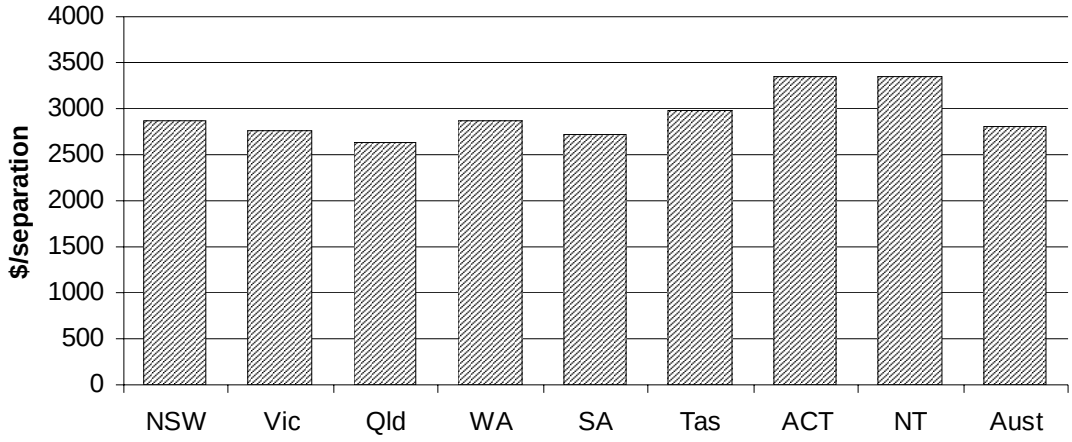
The data exclude spending on non-admitted patient care, the user cost of capital and depreciation, research costs and payroll tax. Overnight stays, same day separations, private patient separations in public hospitals and private patient recurrent costs are included.

The scope is hospitals that mainly provide acute care — that is, principal referral and specialist women's and children's hospitals, large hospitals, medium hospitals and small acute hospitals. Excluded are psychiatric hospitals, drug and alcohol services, mothercraft hospitals, unpeered and other hospitals, hospices, rehabilitation facilities, small non-acute and multi purpose services. Also excluded are hospitals that cannot be classified due to atypical events such as being opened or closed mid-year. Separations in the excluded hospitals comprised 4.4 per cent of separations (on average) in 2000-01 — although the proportion of separations excluded varies across jurisdictions (table 9A.25).

Recurrent cost per casemix-adjusted separation for each jurisdiction in 2000-01 is presented in figure 9.13. It should be noted that these data are based on 2000-01 cost weights and therefore differ from data in the AIHW's *Australian Hospital Statistics 2000-01*, which were based on 1999-2000 cost weights.

The recurrent cost per casemix-adjusted separation in 2000-01 was highest in the NT ($3355) and lowest in Queensland ($2636) (figure 9.13).

Figure 9.13 **Recurrent cost per casemix-adjusted separation (current prices)[a, b, c, d, e, f, g, h]**



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. **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 weights from the National Hospital Morbidity Database, based on acute and unspecified separations and newborn episodes of care with qualified days, using the 2000-01 AR-DRG v 4.1 cost weights (DHA, unpublished) applied to version 4.2 AR-DRGs. **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-public patients. **g** Queensland pathology services are now being purchased from the Statewide pathology service rather than being provided by each hospitals' employees. **h** These figures need to be interpreted in conjunction with the consideration of cost disabilities associated with hospital service delivery in the NT.

Source: AIHW (unpublished); table 9A.25.

Box 9.6 **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 AR-DRG cost weight for Indigenous patients is lower than for non-Indigenous patients due to their higher numbers of low cost AR-DRGs, such as dialysis, and lower numbers of high cost surgical AR-DRGs.
- The average length of hospital stay for Indigenous people tends to be longer than for non-Indigenous people within the same AR-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 5 per cent cost loading for Indigenous admitted patients to account for this effect.

Overall, after adjusting for length of stay and differences in hospital costs due to locational factors, costs per separation within AR-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, last year Victoria and NSW also reported recurrent cost per casemix-adjusted separation for acute patients only. These data are unavailable for the 2003 Report. It is anticipated that jurisdictions will be better able to isolate acute care costs in the near future.

Comparisons across jurisdictions are affected by differences in the mix of outputs (or admitted patient services) produced by hospitals in each jurisdiction. Hospitals

[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).

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 9A.28. The dominant peer classification is the principal referral and specialist women's and children's category. In 2000-01, these hospitals accounted for 67 per cent of public acute and psychiatric hospital expenditure and 65 per cent of separations (AIHW 2002a). The data for principal referral hospitals (excluding specialist women's and children's hospitals) are presented in table 9.22. Australia-wide, recurrent cost per casemix-adjusted separation for principal referral hospitals in 2000-01 was $2817. For those jurisdictions where publishable data were available, the recurrent cost per casemix-adjusted separation for principal referral hospitals was highest in NSW ($2935) and lowest in Queensland ($2714).

Table 9.22 **Recurrent cost per casemix-adjusted separation, principal referral hospitals (public), 2000-01[a, b, c]**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*[d]	*Aust*
No. of hospitals	20	14	12	3	3	2	1	1	56
Av. beds per hospital	392	585	402	598	474	382	504	297	458
Separations per hospital	34 261	51 680	34 488	58 221	55 117	29 175	49 712	31 187	41 105
Av. cost weight	1.12	1.00	1.05	1.01	1.08	1.12	0.95	0.83	1.05
Cost per casemix-adjusted separation ($)	**2 935**	**2 759**	**2 714**	**np**	**np**	**2 828**	**np**	**np**	**2 817**
Expenditure									
Principal referral hospitals ($m)	3 169	2 908	1 487	**np**	**np**	255	**np**	**np**	9 437
Total ($m)	**5 519**	**4 040**	**2 460**	**1 479**	**1 239**	**341**	**263**	**199**	**15 541**

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 a year. **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 2000-01 AR-DRG v 4.1 cost weights (DHAC, unpublished) applied to version 4.2 AR-DRGs. **np** Not published.

Source: AIHW (unpublished); table 9A.28.

Inclusion of capital costs

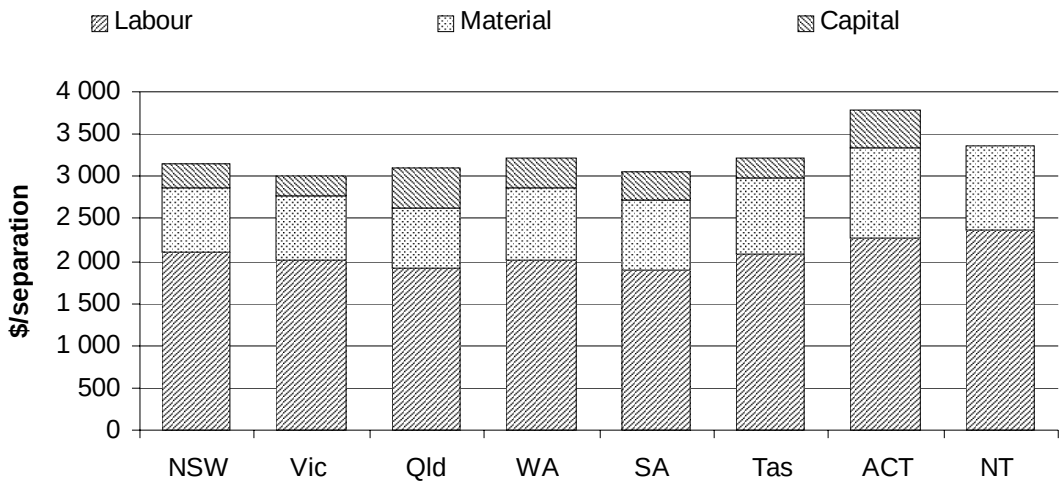
The estimated unit cost of admitted care services inclusive of capital costs is reported below. Total cost per casemix-adjusted separation is defined as the recurrent cost per casemix-adjusted separation plus the capital costs (depreciation

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 expenses were deducted directly from capital costs in all jurisdictions to avoid double counting.

Total costs per casemix-adjusted separation by jurisdiction (including capital costs) are presented in figure 9.14. These data exclude the user cost of capital associated with land. Excluding the user cost of capital for land, the total cost per casemix-adjusted separation ranged from $3785 in the ACT to $3007 in Victoria. The NT was unable to provide cost of capital or depreciation data.

Figure 9.14 **Total cost per casemix-adjusted separation, 2000-01**[a, b, c, d]



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 9A.21. **c** Variation across jurisdictions in the collection of capital-related data suggests that the data should be treated as indicative. **d** The NT did not provide cost of capital or depreciation data and therefore NT data reflect only recurrent costs.

Source: AIHW (2002a); State and Territory governments; table 9A.25 and table 9A.21.

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.

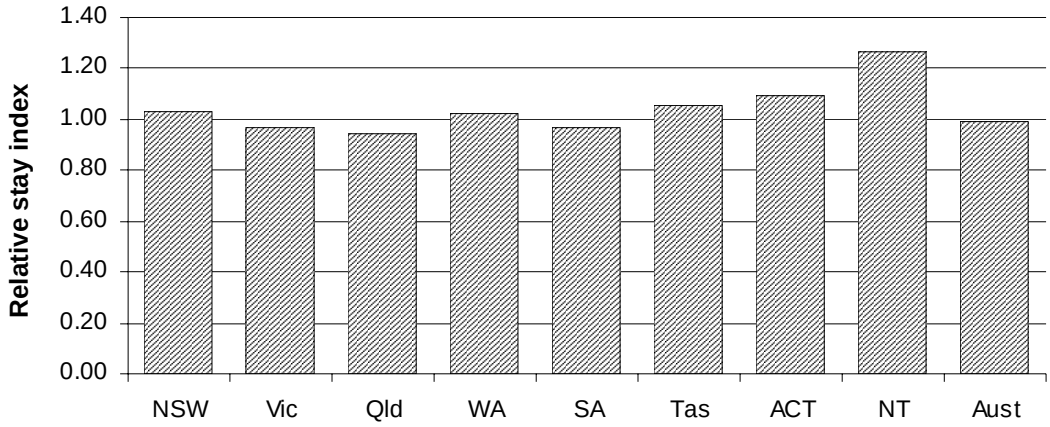
The relative length of stay for Australia for all hospitals is one. A relative stay index greater than one indicates that a patient's average length of stay is higher than would be expected given the jurisdiction's casemix distribution. A relative stay index of less than one indicates that the number 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 standardised relative stay index for acute patients in public hospitals in 2000-01 was highest in the NT (1.26) and lowest in Queensland (0.95) (figure 9.15).

Due to improvements in the way the index has been calculated, these data differ from those published in the AIHW's *Australian Hospital Statistics 2000-01*. The relative stay index compares groups of hospitals with the overall average. Where there are differences in the mix of AR-DRGs between groups it becomes less valid to compare their relative stay indexes. These issues are exacerbated where one group of hospitals has no separations for a particular AR-DRG. This can have a material effect on comparisons of performance. The alternative reported here attempts to standardise the relative stay index for the mix of AR-DRGs; for example to reflect the mix of AR-DRGs for Australian hospitals overall. Titulaer & Hargreaves (2002) compared the relative stay index and a standardised relative stay index between the public and private sectors. For medical, surgical and other groups, the differences between the relative stay index and a relative stay index standardised for the mix of AR-DRGs across Australia are minor. The difference between the relative stay index and a standardised relative stay index, however, is significant for the private sector as a whole. This is because the private sector has a lower proportion of medical separations, and when the distribution is standardised to the Australian total, the contribution of medical patients to the total is increased from 45 per cent of the expected bed days to 62 per cent, and the contribution of surgical and other patients scaled down accordingly, resulting in a difference in the totals that is higher than any of the differences in the components.

The problems encountered are analogous to the direct versus indirect age-standardisation dilemma. Direct age-standardisation is used where the

populations and their characteristics are stable and reasonably similar. Where either populations are sparse or the characteristics are rare indirect standardisation is typically used. The traditional relative stay index is analogous to indirect standardisation. The standardised relative stay index is similar to direct standardisation.

Figure 9.15 **Standardised relative stay index, acute patients in public hospitals, 2000-01[a, b]**



a Relative stay index based on all hospitals. **b** 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 9A.23.

The relative stay index by accommodation status and by medical, surgical and other AR-DRGs is reported in tables 9A.23 and 9A.24.

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 2000-01 data for this indicator reported the following results.

- In NSW, emergency department cost per occasion of service was $166 for 1.6 million occasions of service, outpatient cost per occasion of service was $117 for 5.2 million occasions of service, and overall, cost per occasion of service was $111 for 12.9 million occasions of service (table 9A.55).
- In WA in 2000-01, emergency department cost per occasion of service was $113 for 566 111 occasions of service, outpatient cost per occasion of service was $92 for 2.6 million occasions of service, and overall, cost per occasion of service was $88 for 4.2 million occasions of service (table 9A.76).
- In SA in 2000-01, emergency department cost per occasion of service was $189 for 208 136 occasions of service; outpatient cost per occasion of service was $140 for 1.0 million occasions of service; and overall, cost per occasion of service was $148 for 1.2 million occasions of service (table 9A.81).
- In Tasmania, emergency department cost per occasion of service was $237 for 91 843 occasions of service and outpatient cost per occasion of service was $140 for 233 578 occasions of service. Overall, cost per occasion of service was $167 for 325 421 occasions of service (table 9A.84).
- In the ACT, emergency department cost per occasion of service was $243 for 92 884 occasions of service; outpatient cost per occasion of service was $63 for 442 363 occasions of service. Overall, cost per occasion of service was $94 for 535 247 occasions of service (table 9A.89).

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, the average cost per encounter was $114 in 2000-01, compared with $109 in 1999-2000, $104 in 1998-99 (based on cost data from 13 major hospitals) and $105 in 1997-98 (based on cost data from nine major hospitals) (table 9A.64).

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 occasion of service for emergency departments (table 9.23) and cost per occasion of service for outpatients (table 9.24). 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 147 hospitals across Australia, whereas the outpatient (tier 1) data are based on figures provided by 25 hospitals. (Outpatient tier 0 data are included in the attachment and were contributed by 163 hospitals (attachment table 9A.30). These data suggest that cost per occasion of service for the public sector in 2000-01 was $120.) The NHCDC data are affected by differences in costing and admission practices across jurisdictions and hospitals.

Table 9.23 **Emergency department average cost per occasion of service by triage class, public sector, Australia, 2000-01**[a, b, c, d, e, f]

	Population estimated	*Actual*
Triage category	*Average cost per occasion of service ($)*	*Average cost per occasion of service ($)*
Admitted triage 1	609	608
Admitted triage 2	307	313
Admitted triage 3	304	314
Admitted triage 4	253	270
Admitted triage 5	189	226
Non-admitted triage 1	595	593
Non-admitted triage 2	343	346
Non-admitted triage 3	253	255
Non-admitted triage 4	172	176
Non-admitted triage 5	124	132
Did not wait[g]	57	58
Total	**206**	**219**

[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 147 public sector hospitals across Australia out of the 187 hospitals participating in the Round 5 collection. [c] Cost and activity emergency department data for Victoria were only captured for cost-modelled sites representing approximately 12 per cent of the available ED data for that State. [d] The NT did not submit emergency department data. [e] Costing and admission practices vary between jurisdictions and hospitals. [f] Depreciation costs are included. [g] 'Did not wait' means those presentations to an emergency department who were triaged but did not wait until the completion of their treatment, at which time they would have been either admitted to hospital or discharged home.

Source: Commonwealth Department of Health and Ageing, NHCDC, Round 5; table 9A.29.

Table 9.24 **Non-admitted clinic occasions of service for tier 1 clinics, actual results, public sector, 2000-01[a, b]**

Tier 1 clinic	*Occasions of service (no.)*	*Average cost per occasion of service ($)*
Allied health and/or clinical nurse spec.	640 708	54
Dental	11 043	133
Medical	616 048	217
Obstetrics and gynaecology	180 682	139
Paediatric	37 793	192
Psychiatric	47 191	239
Surgical	506 713	109
Total	**2 040 178**	**132**

a Depreciation costs are included. **b** Tier 1 results incorporate Tier 2 results rolled into Tier 1 clinic data. Data based on 25 public sector hospitals.

Source: Commonwealth Department of Health and Ageing, NHCDC, Round 5; table 9A.31.

9.3 Maternity services

Framework of performance indicators

The performance framework for maternity services is outlined in figure 9.16, 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.

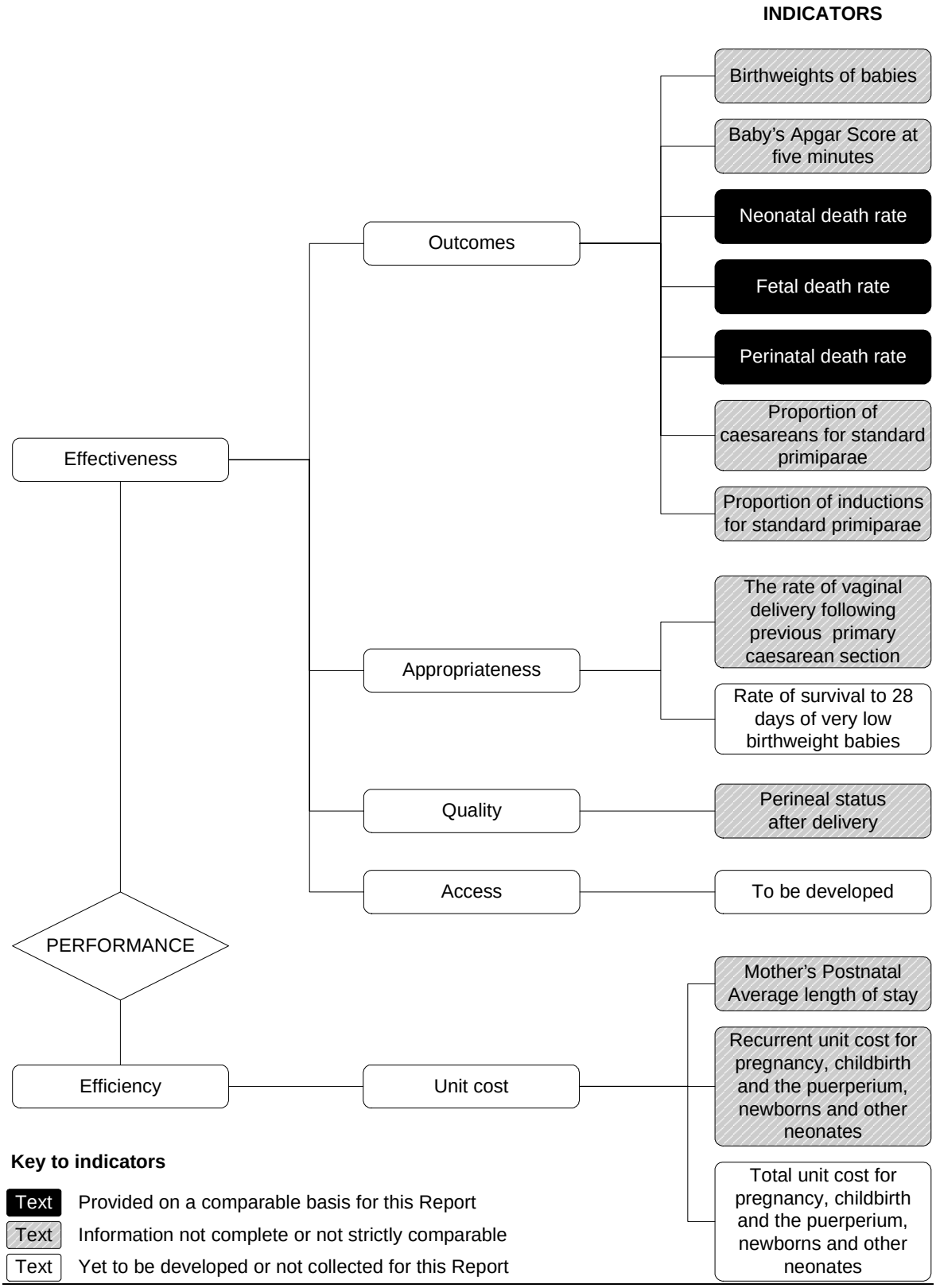
The performance indicator framework shows which data are comparable in the 2003 Report (figure 9.16). For data that are not considered strictly comparable, the text includes relevant caveats and supporting commentary. Chapter 1 discusses data comparability from a Report-wide perspective (see section 1.6).

Key performance indicator results

Outcomes

Seven maternity service outcome indicators are included in the Report this year: birthweights of babies born to all mothers and to Indigenous mothers, Apgar scores (which indicate a baby's wellbeing soon after birth); neonatal, fetal and perinatal death rates; and caesarean and induction rates for standard primiparae.

Figure 9.16 **Performance indicators for maternity services**



Birthweight of babies

For the first time this year, the Report contains information on the birthweights of babies born to all mothers and to Indigenous mothers. These data are included in the health preface. This indicator is not intended to indicate the performance of hospitals, with results influenced by the state of public health and pre-natal care generally. It is reported as part of the Steering Committee's focus on improving reporting on the Indigenous population, and is a key signal of the health and life expectancy of Indigenous people compared with the population generally.

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.

The reporting of this indicator has changed for this year's Report, with Apgar scores being reported only at five minutes after birth. Reporting of Apgar scores at one minute after birth has been discontinued as reporting at both one and five minutes was seen as unnecessary.

Table 9.25 illustrates the relationship between low birth weight and low Apgar score. In 2000, NSW had the highest proportion of babies weighing 0–1499 grams reporting an Apgar score of three or less five minutes after delivery (14.4 per cent), while WA reported the smallest proportion (8.9 per cent). For babies weighing 1500–1999 grams, Queensland reported the highest proportion of babies with Apgar scores of three or less (2.0 per cent) and Tasmania and the ACT reported the lowest (0.0 per cent). For other birthweights, Apgar scores of three or less were relatively rare and the proportion was fairly similar across jurisdictions. NSW, Victoria, WA and SA were also able to provide data for 2001, and these data are shown in table 9A.35.

Table 9.25 **Number of live births and proportion of babies with an Apgar score of three or less, five minutes post-delivery, public hospitals, 2000**

Birthweight (grams)	*Unit*	*NSW*	*Vic* [a]	*Qld* [b]	*WA*[c]	*SA*[d]	*Tas*	*ACT* [e]	*NT*
0–1499	No. live births	845	548	470	248	243	70	67	**na**
	%	14.4	13.3	13.6	8.9	11.5	11.5	10.5	**na**
1500–1999	No. live births	959	687	561	241	219	57	71	**na**
	%	0.7	0.9	2.0	1.2	0.9	0.0	0.0	**na**
2000–2499	No. live births	2 839	1 925	1 493	748	632	147	150	**na**
	%	0.5	0.3	0.5	0.5	0.2	0.0	0.7	**na**
2500 and over	No. live births	65 610	42 620	33 655	14 917	12 724	3 351	3 183	**na**
	%	0.2	0.1	0.2	0.1	0.1	0.3	0.3	**na**

a For Victoria, 2000 data for babies with birthweight 0–1499g, exclude six cases with unknown Apgar scores at five minutes. Data for babies with birthweight 1500–1999g exclude five cases with unknown Apgar scores at five minutes. Data for babies with birthweight 2000–2499g exclude three cases with unknown Apgar scores at five minutes. Data for babies with birthweight 2500g and over exclude 51 cases with unknown Apgar scores at five minutes. **b** Queensland data for 2000 are preliminary and subject to change. **c** For WA, 2000 data for babies with birthweight 0–1499g, exclude one case with an unknown Apgar score at five minutes. Data for babies with birthweight 1500–1999g exclude one case with an unknown Apgar score at five minutes. Data for babies with birthweight 2000–2499g exclude five cases with unknown Apgar scores at five minutes. Data for babies with birthweight 2500g and over exclude 18 cases with unknown Apgar scores at five minutes. **d** SA data exclude live births if Apgar scores are not recorded. **e** In previous years both the Apgar score at one minute and five minutes were requested. The differences between the two scores is an indication of those babies that required some form of resuscitation and the effectiveness of that resuscitation. Six records for the ACT in 2000 of the Apgar score at five minutes have been excluded from this analysis. **na** Not available.

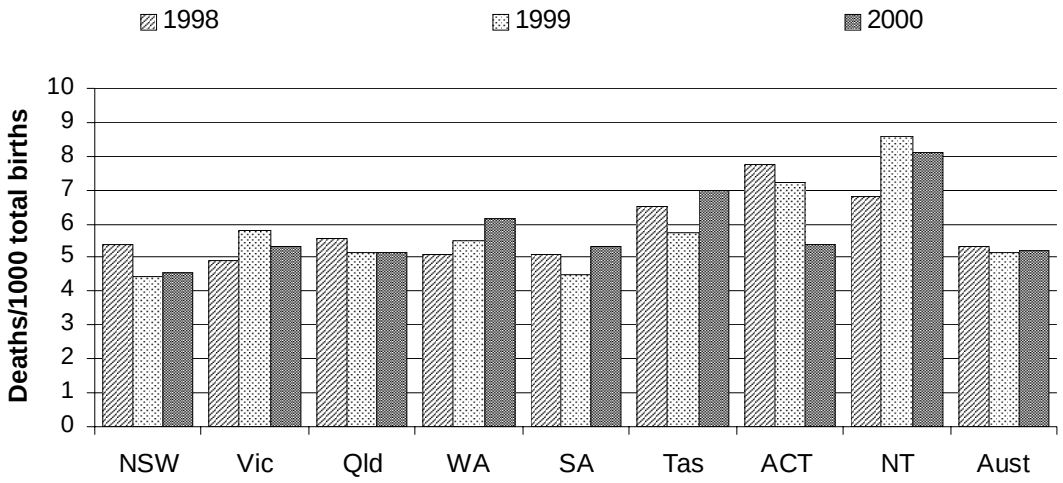
Source: State and Territory governments (unpublished); table 9A.35.

The following data for fetal, neonatal and perinatal death rates may fluctuate due to the low incidence of these events.

Fetal deaths

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 2000, the national rate was 5.2 per 1000 births. This rate was slightly higher than the 1999 rate (5.1) and slightly lower than the rate in 1998 (5.3). In 2000, the fetal death rate was highest in the NT (8.1 deaths per 1000 births) and lowest in NSW (4.6 deaths per 1000 births) (figure 9.17).

Figure 9.17 **Fetal death rate[a, b]**



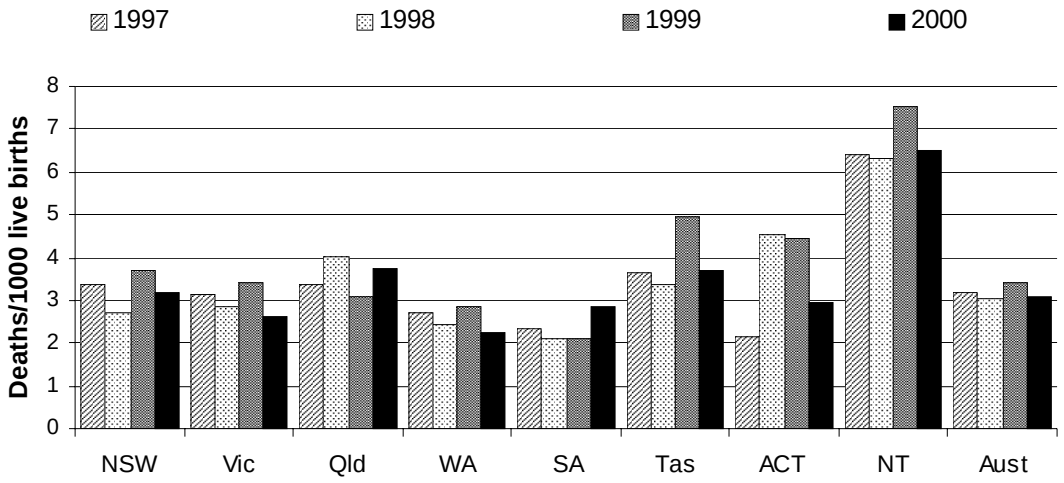
a Rate expressed as a proportion of total births in Australia. **b** Statistics relate to the number of deaths registered, not those which actually occurred, in the years shown. The ABS estimates that about 5 to 6 per cent of deaths occurring in one year are not registered until the following year or later.

Source: ABS (2001); table 9A.39.

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 2000, the national rate was 3.1 deaths per 1000 live births. This was lower than the 1999 rate (3.4) and the 1997 rate (3.2) and slightly higher than the 1998 rate (3.0). In 2000, the neonatal death rate was highest in the NT (6.5 deaths per 1000 live births) and lowest in WA (2.2 deaths per 1000 live births) (figure 9.18).

Figure 9.18 **Neonatal death rate[a, b]**



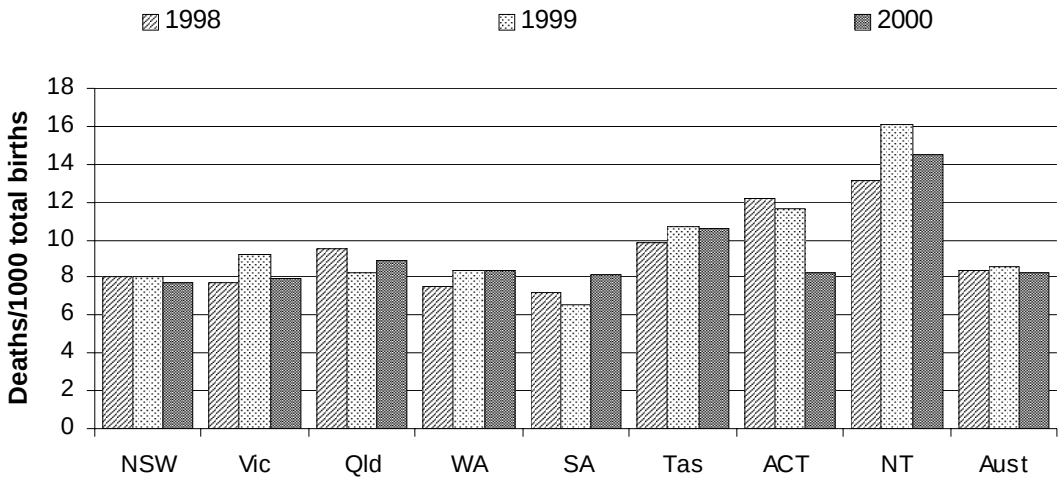
a Rate expressed as a proportion of live births in Australia. **b** Statistics relate to the number of deaths registered, not those which actually occurred, in the years shown. The ABS estimates that about 5 to 6 per cent of deaths occurring in one year are not registered until the following year or later.

Source: ABS (2001); table 9A.37.

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 2000, the perinatal death rate Australia-wide was 8.3 deaths per 1000 total births, down slightly from the 1999 rate (8.5) and equal to the 1998 rate. In 2000, the perinatal death rate was highest in the NT (14.5 deaths per 1000 total births) and lowest in NSW (7.7 deaths per 1000 total births) (figure 9.19).

Figure 9.19 **Perinatal death rate[a, b]**



a Rate expressed as a proportion of total births in Australia. **b** Statistics relate to the number of deaths registered, not those which actually occurred, in the years shown. The ABS estimates that about 5 to 6 per cent of deaths occurring in one year are not registered until the following year or later.

Source: ABS (2001); table 9A.38.

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 second time in this Report. 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 recent definition suggested by some members of the National Perinatal Data Development Committee (NPDDC) refers to standard primiparae as mothers aged 25–29 years, with a singleton pregnancy and with a vertex presentation. This definition, however, has not been applied across all 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 of standard primiparae are provided.

- NSW defined standard primiparae according to the suggested NPDDC definition. The 2001 rate of inductions for standard primiparae was

[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).

23.9 per cent. The 2001 rate of caesareans for standard primiparae was 15.5 per cent (table 9A.41).

- Victoria defined standard primiparae as a mother 20–34 years of age, with a baby not small for gestational age (birth weight greater than 10th percentile), singleton pregnancy, at term (37–41 weeks gestation), with a cephalic presentation and free of medical complications of pregnancy. Victoria's 2001 rate of inductions for standard primiparae was 23.6 per cent. The 2001 rate of caesareans for standard primiparae was 16.8 per cent (table 9A.42).
- Queensland defined standard primiparae according to the suggested NPDDC definition. The most recently available preliminary data are for 2000, with a rate of inductions for standard primiparae of 34.1 per cent. The 2000 rate of caesareans for standard primiparae was 22.7 per cent (table 9A.43).
- WA defined standard primiparae as involving maternal age between 20–34 years inclusive, primary issue, a singleton birth, estimated gestation between 37 and 41 weeks inclusive, a vertex presentation and no complications of pregnancy. The 2001 rate of inductions for standard primiparae was 24.2 per cent. The 2001 rate of caesareans for standard primiparae was 16.3 per cent (table 9A.44).
- Based on provisional data, the 2001 rate of inductions for standard primiparae for SA was 33.9 per cent. The 2001 rate of caesareans for standard primiparae was 21.6 per cent. SA defined standard primiparae as a mother aged 25–29 years, with a singleton pregnancy, vertex presentation and a gestation between 37 and 41 weeks (table 9A.45).
- Tasmania defined standard primiparae according to the suggested NPDDC definition. The most recently available data are for 1999, with a rate of inductions for standard primiparae of 37.4 per cent and a rate of caesareans for standard primiparae of 15.2 per cent (table 9A.46).
- The ACT provided data based on the suggested NPDDC definition while noting it did not support this definition as clinically meaningful. The 2000 rate of inductions for standard primiparae was 26.8 per cent. The 2001 rate of caesareans for standard primiparae was 14.2 per cent (table 9A.47).
- The NT defined a standard primipara as a mother 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 presentation is vertex, there are no medical complications, and where there are no indicators for intrauterine growth retardation. The most recently available data are for 1999. The 1999 rate of inductions for standard primiparae was 19.1. The 1999 rate of caesareans for standard primiparae was 12.4 (table 9A.48).

Appropriateness

One appropriateness indicator is reported this year: the rate of vaginal delivery following previous primary caesarean section. 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 2002).

In interpreting results of this indicator it should be noted that there is an ongoing debate about the relative risk to both mother and baby of a repeat caesarean section compared to a vaginal birth following a previous primary caesarean. The inclusion of this indicator reflects the current prevailing view that differences across jurisdictions in rates of vaginal birth following a previous primary caesarean may warrant investigation.

Consistent with reporting on unplanned re-admissions and hospitals infections, the presentation of data for this indicator has changed significantly for the 2003 Report to better reflect the purpose for which the data are collected. 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. The ACHS data are predominately used to demonstrate the potential for improvement across Australian hospitals if all hospitals could achieve the same outcomes as those hospitals with the best outcomes for patients. When interpreting this indicator, emphasis should be given to the potential for improvement. Statewide 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. Estimated rates should be viewed in the context of the statistical (standard) errors. High standard errors signal that data are particularly unreliable.

An explanation of the reporting of the clinical indicators sourced from the ACHS is contained in box 9.4.

New South Wales

Among those NSW public hospitals participating in the ACHS Service in 2001, the mean rate of vaginal delivery following a primary caesarean was 22.9 per 100 deliveries (subject to a standard error of 2.7). The ACHS estimates that if the performance of all NSW public hospitals matched the performance of those at the 80th centile nationally, the rate of vaginal delivery following a primary caesarean would be 5.5 per cent higher (table 9.26). See box 9.5 for definitions of terms used.

Table 9.26 **Rate of vaginal delivery following primary caesarean per 100 deliveries, public hospitals, NSW, 2001[a, b]**

No. hospitals	*No. reports*	*Numerator (no VBAC)*	*Denominator (no. deliveries)*	*Rate*	*Standard error* (±)
36	62	529	2 307	22.93	2.66
National performance at 80th centile (rate)	*National performance at 20th centile (rate)*	*Potential centile gains (no. VBAC)*	*% change represented by potential gains*	*Potential outlier gains (no. VBAC)*	*Potential stratum gains (no. VBAC)*
28.40	18.40	126	5.47	17	408

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** Health organisations contribute data voluntarily to the ACHS and therefore the samples are not necessarily representative of all hospitals in each jurisdiction. VBAC = Vaginal birth following primary caesarean.

Source: ACHS (unpublished); table 9A.49.

Victoria

Among those Victorian public hospitals participating in the ACHS Service in 2001, the mean rate of vaginal delivery following a primary caesarean was 20.5 per 100 deliveries (subject to a standard error of 6.8). The ACHS estimates that if the performance of all Victorian public hospitals matched the performance of those at the 80th centile nationally, the rate of vaginal delivery following a primary caesarean would be 7.9 per cent higher (table 9.27). See box 9.5 for definitions of terms used.

Table 9.27 **Rate of vaginal delivery following primary caesarean per 100 deliveries, public hospitals, Victoria, 2001[a, b]**

No. hospitals	*No. reports*	*Numerator (no VBAC)*	*Denominator (no. deliveries)*	*Rate*	*Standard error* (±)
18	28	222	1 085	20.46	6.80
National performance at 80th centile (rate)	*National performance at 20th centile (rate)*	*Potential centile gains (no. VBAC)*	*% change represented by potential gains*	*Potential outlier gains (no. VBAC)*	*Potential stratum gains (no. VBAC)*
28.4	18.4	86	7.94	0	219

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** Health organisations contribute data voluntarily to the ACHS and therefore the samples are not necessarily representative of all hospitals in each jurisdiction. VBAC = Vaginal birth following primary caesarean.

Source: ACHS (unpublished); table 9A.50.

Queensland

Among those Queensland public hospitals participating in the ACHS Service in 2001, the mean rate of vaginal delivery following a primary caesarean was 25.3 per 100 deliveries (subject to a standard error of 6.6 per cent). The ACHS estimates that if the performance of all Queensland public hospitals matched the performance of those at the 80th centile nationally, the rate of vaginal delivery following a primary caesarean would be 3.1 per cent higher (table 9.28). See box 9.5 for definitions of terms used.

Table 9.28 **Rate of vaginal delivery following primary caesarean per 100 deliveries, public hospitals, Queensland, 2001[a, b]**

No. hospitals	*No. reports*	*Numerator (no VBAC)*	*Denominator (no. deliveries)*	*Rate*	*Standard error* (±)
11	17	208	823	25.27	6.57
National performance at 80th centile (rate)	*National performance at 20th centile (rate)*	*Potential centile gains (no. VBAC)*	*% change represented by potential gains*	*Potential outlier gains (no. VBAC)*	*Potential stratum gains (no. VBAC)*
28.4	18.4	26	3.13	0	126

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** Health organisations contribute data voluntarily to the ACHS and therefore the samples are not necessarily representative of all hospitals in each jurisdiction. VBAC = Vaginal birth following primary caesarean.

Source: ACHS (unpublished); table 9A.51.

Western Australia

Among those WA public hospitals participating in the ACHS Service in 2001, the mean rate of vaginal delivery following a primary caesarean was 15.0 per 100 deliveries (subject to a standard error of 2.4 per cent). The ACHS estimates that if the performance of all WA public hospitals matched the performance of those at the 80th centile nationally, the rate of vaginal delivery following a primary caesarean would be 13.4 per cent higher (table 9.29). See box 9.5 for definitions of terms used.

Table 9.29 **Rate of vaginal delivery following primary caesarean per 100 deliveries, public hospitals, WA, 2001[a, b]**

No. hospitals	*No. reports*	*Numerator (no VBAC)*	*Denominator (no. deliveries)*	*Rate*	*Standard error* (±)
8	11	63	419	15.04	2.43

National performance at 80th centile (rate)	*National performance at 20th centile (rate)*	*Potential centile gains (no. VBAC)*	*% change represented by potential gains*	*Potential outlier gains (no. VBAC)*	*Potential stratum gains (no. VBAC)*
28.4	18.4	56	13.36	0	107

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** Health organisations contribute data voluntarily to the ACHS and therefore the samples are not necessarily representative of all hospitals in each jurisdiction. VBAC = Vaginal birth following primary caesarean.

Source: ACHS (unpublished); table 9A.52.

South Australia

Among those SA public hospitals participating in the ACHS Service in 2001, the mean rate of vaginal delivery following a primary caesarean was 30.6 per 100 deliveries (subject to a standard error of 2.6 per cent). The ACHS estimates that if the performance of all SA public hospitals matched the performance of those at the 80th centile nationally, the rate of vaginal delivery following a primary caesarean would be 2.2 per cent lower (table 9.30). See box 9.5 for definitions of terms used.

Table 9.30 **Rate of vaginal delivery following primary caesarean per 100 deliveries, public hospitals, SA, 2001[a, b]**

No. hospitals	*No. reports*	*Numerator (no VBAC)*	*Denominator (no. deliveries)*	*Rate*	*Standard error* (±)
8	13	203	663	30.62	2.62

National performance at 80th centile (rate)	*National performance at 20th centile (rate)*	*Potential centile gains (no. VBAC)*	*% change represented by potential gains*	*Potential outlier gains (no. VBAC)*	*Potential stratum gains (no. VBAC)*
28.4	18.4	-15	-2.22	0	66

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** Health organisations contribute data voluntarily to the ACHS and therefore the samples are not necessarily representative of all hospitals in each jurisdiction. VBAC = Vaginal birth following primary caesarean.

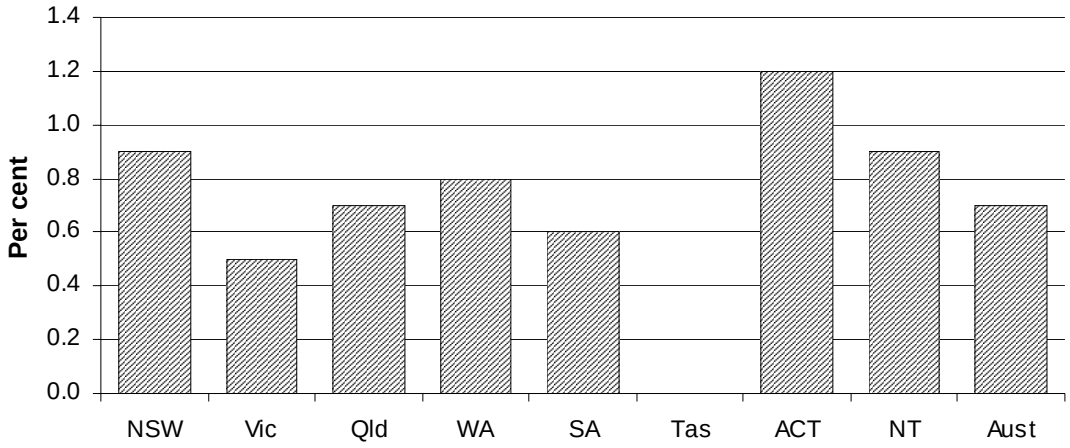
Source: ACHS (unpublished); table 9A.53.

Data for the ACT, the NT and Tasmania were not provided by the ACHS because of the small number of hospitals in those jurisdictions. Nationally, among those public hospitals participating in the ACHS Service in 2001, the mean rate of vaginal delivery following a primary caesarean was 23.3 per 100 deliveries. The ACHS estimates that if the performance of all Australian public hospitals matched the performance of the top 20 per cent of public hospitals, the rate of vaginal delivery following a primary caesarean would be 5.2 per cent higher.

Quality

An indicator of quality for maternity services is reported for the first time in the 2003 Report — perineal status after delivery. A third or fourth degree laceration (that is, a laceration extending to the anal sphincter) occurred in 0.7 per cent of mothers nationally, and in no more than 1.2 per cent of mothers in any single jurisdiction in 1999 (figure 9.20). More information on perineal status after delivery (including episiotomy rates, lesser degree lacerations and definitions) is contained in attachment table 9A.40.

Figure 9.20 **Perineal status after delivery: proportion of mothers with third or fourth degree lacerations, all hospitals 1999[a, b]**



a Data for Tasmania unavailable. In Tasmania, data included under first degree laceration do not identify higher degrees of laceration. **b** Data include all confinements, regardless of the method of birth.

Source: Nassar, N. and Sullivan, E.A. (2001); table 9A.40.

Efficiency

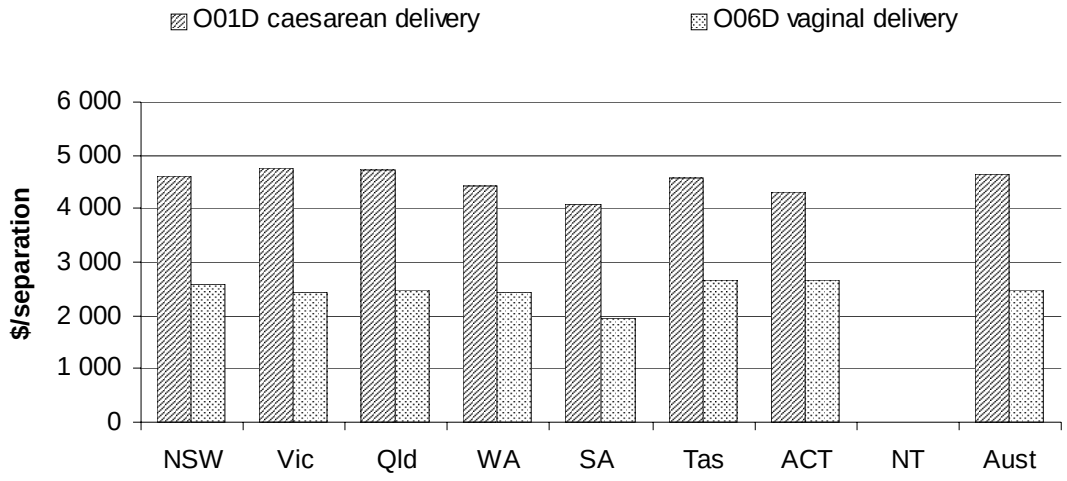
Two efficiency indicators are reported for maternity services — the cost per separation and the average length of stay. Figures 9.21 and 9.22 present data for the

two largest AR-DRGs that account for the largest number of maternity separations. Data for a number of other delivery-related AR-DRGs are shown in table 9A.54.

Data are sourced from the NHCDC and are based on the AR–DRG classification version 4.1. The NHCDC is a voluntary annual collection of hospital cost and activity data covering the financial year prior to the collection period. The NHCDC is coordinated by the Commonwealth Department of Health and Ageing and the results of the NHCDC are published as national and State and Territory cost weights and associated analytical tables in an annual cost report. Since participation in the NHCDC collection is voluntary, the samples are not necessarily representative of the set of hospitals in each jurisdiction, although this is improving over time. A population estimation process is undertaken to create national and State and Territory costing and activity estimates which are more representative of the total population.

The average cost per separation for caesarean delivery without complications in participating hospitals was $4635 for Australia in 2000-01 (figure 9.21). The highest average cost was in Victoria ($4779) and the lowest was in SA ($4090). The average cost per separation for a vaginal delivery without complications was $2491 for Australia. The highest average cost was in the ACT ($2678) and the lowest cost was in SA ($1952).

Figure 9.21 **Average cost per separation for selected AR-DRGs public hospitals, estimated results, 2000-01[a, b, c]**

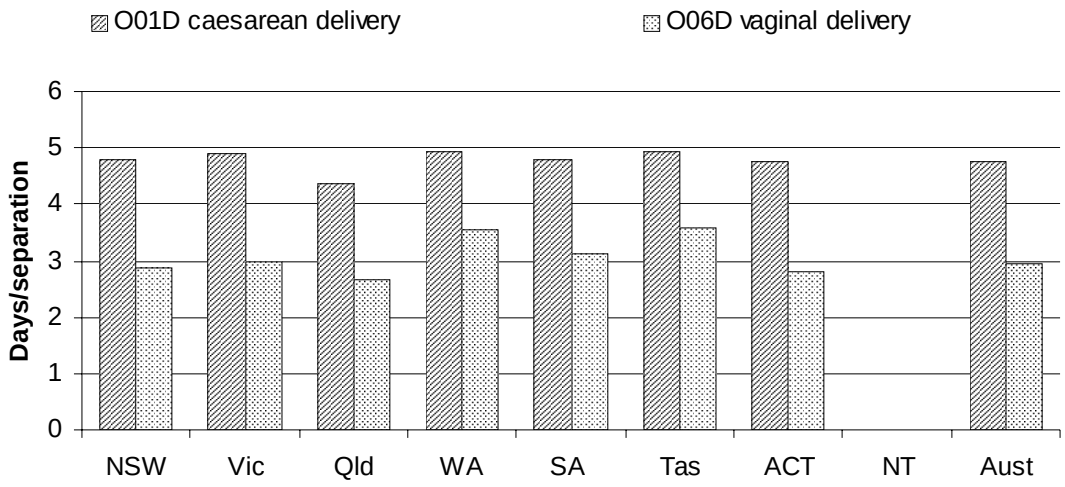


a Includes O01D caesarean delivery without complicating diagnosis and O060D vaginal delivery without complicating diagnosis. **b** The NT data were not included in Round 5 of the NHCDC. **c** Average cost is affected by a number of factors, some of which are admission practices, sample size, remoteness and the type of hospitals contributing to the collection.

Source: Commonwealth Department of Health and Ageing, NHCDC, Round 5; table 9A.54.

The average length of stay for caesarean delivery without complications was 4.74 days for Australia — the longest stay in Tasmania (4.94 days) and the shortest in Queensland (4.37 days). The average length of stay for vaginal delivery without complications was 2.94 days for Australia. The longest length of stay was in Tasmania (3.60) and the shortest in Queensland (2.66) (figure 9.22).

Figure 9.22 **Average length of stay per selected AR-DRG, public hospitals, 2000-01[a, b]**



a Includes O01D caesarean delivery without complicating diagnosis and O060D vaginal delivery without complicating diagnosis. **b** NT data were not included in Round 5 of the NHCDC.

Source: Commonwealth Department of Health and Ageing, NHCDC, Round 5; table 9A.54.

9.4 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 for public hospitals and maternity services where data are not complete or not strictly comparable;
- continue to improve reporting on hospital quality; and
- continue to improve the frameworks for reporting.

Quality

Australian governments and health care services place a high priority on improving the quality of care provided in hospitals. 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 ACSQHC in 2000, are likely to create scope for improved reporting in this area in the medium to long term.

Reporting of clinical indicators

As noted earlier in the chapter, presentation of reporting of clinical indicators obtained from the ACHS changed in the 2003 Report to better reflect the reason for which the data are collected. Until 2000, the ACHS had reported clinical indicator data simply as rates with mean averages and confidence intervals.

Reporting now focuses on the potential for improved performance if rates of individual organisations could be improved to the mean rate or to be equal to the performance of the top 20 percent of organisations who report. If all organisations work towards improving their rates to match this 20th centile, then care for consumers can be substantially improved.

Future reporting of ACHS clinical indicators will highlight those areas where there is the greatest potential to improve. It will also note where there is large variation around the mean averages. Research then needs to be done to determine the reasons for variation, minimising the variation and potentially resulting in improvements to quality of care. These developments in reporting by the ACHS have the potential to lead to improved reporting of quality by the Steering Committee.

Reporting on hospital infections

One of the concerns regarding the infections indicators in the Report has been that they are not casemix- or risk-adjusted. The changes to reporting on hospital-acquired infections taking place from calendar year 2002 should significantly assist in addressing these concerns. Recording by the ACHS of surgical site infection rates will become surgical procedure-specific, while indicators of central line associated blood stream infections will relate to particular clinical units of hospitals.

In 2002, data on surgical site infections will be collected by the ACHS for the following surgical procedures:

- hip prosthesis procedures;
- knee prosthesis procedures;
- coronary artery bypass graft procedures;

- elective resections for diverticular disease or cancer (where there is an anastomosis but no stoma formed) procedures;
- femoral-popliteal procedures;
- open abdominal aortic aneurysm procedures;
- lower segment caesarean section procedures; and
- abdominal hysterectomy procedures.

Data on central line associated blood stream infections will be collected separately for intensive care units, haematology units, oncology units and outpatient intravenous therapy units.

It is anticipated that these changes will lead to improved reporting of hospital infections in future reports. It is yet to be determined which, if any, of the new indicators will be included in the 2004 Report.

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, Davis *et al*. 2001). 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 has determined that routine hospital separations data in their current form cannot be used to reliably estimate the rate of adverse events that occur in hospitals nor the factors that contribute to their occurrence. The extent to which adverse events are recorded and identifiable in routinely collected hospital morbidity data and the validity and usefulness of the data nevertheless requires further investigation. The ACSQHC is funding a study to provide a description of the adverse events identifiable in routinely collected data, an assessment of the validity and coverage of the data and recommendations for changes to the data collections that would improve their value in monitoring adverse events (ACSQHC 2001b).

Estimates of hospital separations associated with an adverse event were produced by Hargreaves (2001) (table 9.31). The data are affected by changes in scope and

8 'Iatrogenic harm' refers to harm arising from health care, rather than from the patient's underlying disease or injury.

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 9.31 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.

Table 9.31 **Hospital separations with an adverse event, 1993-94 to 1997-98[a]**

Year	*Misadventures*	*Complications*	*Drug adverse events*	*Total[b]*	*Per cent of all separations*
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).

Reporting of sentinel events

Sentinel events are defined as those adverse events that cause serious harm to patients and that have the potential to seriously undermine public confidence in the health care system. The ACSQHC has consulted with jurisdictions about developing a more nationally consistent approach to serious and sentinel adverse events. The proposed national approach aims to improve the safety of patient care through better reporting and analysis of serious adverse events to understand their underlying causes. The intention is to focus on improvement that is based on a systemic understanding of the adverse event, not on punishment of the parties involved, and the implementation of effective change in response to any preventable system failures identified.

At the local level, this work will develop tools, processes and protocols to more effectively manage serious adverse events. At the national level, it will also involve

national aggregation of de-identified data about an agreed core set of sentinel events in order to:

- encourage greater consistency in methodologies used to investigate and analyse sentinel events;
- facilitate learning across Australia and disseminate successful preventive actions;
- analyse patterns and trends at a national level to identify further opportunities for improving patient safety;
- learn and disseminate lessons from analysis as well as from research, international collaboration and other sources of information; and
- facilitate effective change to prevent recurrence where possible and to reduce risks to patients in the future.

The national activity is not intended to capture all events that would be useful to report, but rather establish a manageable list of events that are of concern to consumers and providers, clearly identifiable, likely to indicate system breakdowns and which all States and Territories agree warrant robust investigation and analysis. A proposed national core set of sentinel events which has been broadly agreed by jurisdictions as potentially suitable for national aggregation and action is shown in box 9.7.

Box 9.7 **Proposed national core set of sentinel events**

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

Source: ACSQHC (2002).

Victoria has established a Statewide system for reporting sentinel events, defined as relatively infrequent clear-cut events that occur independently of a patient's condition, that commonly reflect hospital system and process deficiencies and that

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 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. The AIMS 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. An 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). Further analysis found 52.9 per cent of these incidents resulted in no harm, 10.8 per cent in minor harm not requiring treatment, 34.3 per cent in moderate harm requiring treatment and 0.8 per cent that caused significant harm (ACSQHC 2001b). Several examples of use of the data in studies to improve services have been published.

Reporting of patient falls

The ACSQHC has identified prevention of patient falls in health care facilities as a key area for action. In view of the priority hospitals place on avoiding patient falls and the potential for harm these falls may cause, the Steering Committee will

[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.

consider the feasibility of developing an indicator of patient falls to further enhance reporting on hospital quality.

Maternity services

Improving the quality and comparability across jurisdictions of maternity services data is a high priority for the Steering Committee. Two of the outcomes indicators for maternity services — 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. The NPDDC suggested a national definition for this year's Report, although the definition has not been agreed by all jurisdictions. It is an aim of the Review to continue to contribute to the development of a nationally consistent definition of standard primiparae in conjunction with the AIHW, the ACHS and Women's Hospitals Australia.

9.5 Definitions

Table 9.32 **Terms**

Term	*Definition*
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, and 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 (AR-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 AR-DRG, determined so that the average case weight for all AR-DRGs is 1.00.

(Continued on next page)

Table 9.32 **(Continued)**

Term	*Definition*
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 and so on. 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 admission or a designated census date.
Emergency department waiting times to service delivery	The time elapsed for each patient from presentation to the emergency department 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 (that is, live births registered and fetal deaths combined).
General practice	The organisational structure in which one or more general practioners 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 9.32 **(Continued)**

Term	*Definition*
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 *National Health Data Dictionary* version 10, 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 9.32 **(Continued)**

Term	*Definition*
Opportunity cost	The return forgone on the next best investment, calculated as 8 per cent of the 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	The ratio of beds accredited by recognised accreditation programs 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).
Perineal status after delivery	The state of the perineum following a birth.
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.
Relative stay index	The actual number of acute bed days divided by the expected number of acute bed days adjusted for casemix.
Same day patients	A patient whose admission date is the same as the separation date.
Sentinel events	Adverse events that cause serious harm to patients and that have the potential to seriously undermine public confidence in the health care system.
Sentinel procedures	Procedures that are the most common surgical operations, provided by acute care hospitals during a given period of time.

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Table 9.32 **(Continued)**

Term	*Definition*
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.
Standard primipara	The NPDDC has suggested defining this as mothers aged 25–29 years, with a singleton pregnancy and a vertex presentation.
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.

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10 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 10.1. Policy developments in general practice are discussed in section 10.2, a framework of performance indicators is presented in section 10.3 and key results are discussed in section 10.4. Future directions for reporting are covered in section 10.5 and relevant terms are defined at section 10.6.

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\2003\Attach10A.xls and in Adobe PDF format as \Publications\Reports\2003\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). 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 these tables (see details on the inside front cover of the Report).

10.1 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 in order to achieve vocational registration under the *Health Insurance Act 1973* (Cwlth). 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* (Cwlth), 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 10.6.

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 preventative 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). GPs may also be involved in teaching, research and activities related to other government services, such as those provided by Centrelink.

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 in some instances by patient contributions), they may also be employed by hospitals or other organisations in full time or part time capacities. 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 sometimes staff emergency departments, although this latter role is declining (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.

[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 noninstitutional settings.

Funding

Almost all of the services provided by private GPs are funded in part by the Commonwealth Government through Medicare and the Department of Veterans' Affairs (DVA). This is illustrated by the *Bettering the Evaluation and Care of Health* (BEACH) study of general practice activity in Australia. About 1000 GPs participate in the BEACH study each year, with each participant recording details of 100 consecutive patient encounters. The 2002 BEACH study involved 983 GPs who each recorded 100 patient encounters (98 300 encounters). After post-stratification weighting there were 96 973 encounters (table 10A.6). (Britt *et al*. (2000) define an 'encounter' as any professional interchange between a patient and a GP.) The BEACH study found that in 2001-02 93.9 per cent of all encounters with GPs were for services funded by Medicare or DVA (table 10.1).

Table 10.1 **Encounters by source of funding, 2001-02[a, b]**

	Number	*Rate per 100 encounters[c]*	*95% LCL[d]*	*95% UCL[d]*
GPs participating in the BEACH study	983	..	..	..
Total encounters for which BEACH data were recorded	96 973	..	..	..
Encounters with missing data	7 336	..	..	..
Direct consultations[e]	87 564	97.7	97.4	98.0
No charge	552	0.6	0.2	1.1
Medicare paid[f]	84 196	93.9	93.5	94.4
Workers compensation	1 799	2.0	1.8	2.3
Other paid (hospital, State, etc.)	1 019	1.1	0.2	2.0
Indirect consultations[g]	2 072	2.3	1.8	2.8

a April 2001 to March 2002. **b** Britt *et al.* (2000) define an 'encounter' as any professional interchange between a patient and a GP. **c** Missing data removed. Percentage base (N = 89 636). **d** UCL = upper confidence limit; LCL = lower confidence limit. **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.

Source: Britt *et al.* (2002b); table 10A.6.

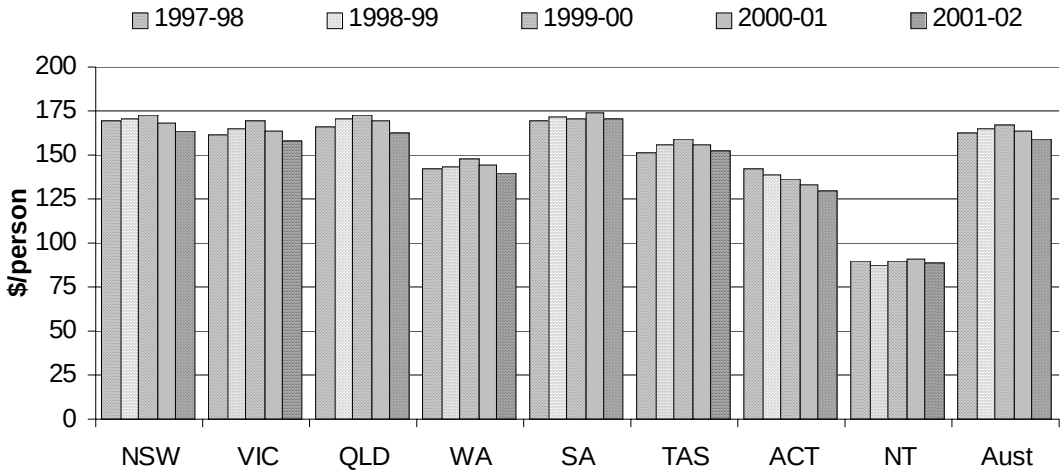
Medicare fee-for-service payments comprised 81.7 per cent of Commonwealth expenditure on GPs in 1998-99 (and 63.1 per cent of total expenditure on GPs from all sources) (table 10A.7). The Commonwealth also provided payments for GPs through the DVA local medical officer arrangements,[2] the Divisions of General Practice Program, the Practice Incentives Program (PIP) and the GP Immunisation

[2]Local medical officers are GPs who are registered with the DVA to provide services to veterans and other DVA beneficiaries.

Incentives Scheme (DHAC 2000a). Non-government sources contributed 22.8 per cent of total expenditure on GPs in 1998-99, comprising payments by insurance schemes (including private health insurance, workers compensation and third party insurance) and by private individuals (table 10A.7).

The cost to the Commonwealth Government of general practice was approximately $3.1 billion in 2001-02, including non-Medicare funding and expenditure by DVA. This was equivalent to expenditure of $159 per person in 2001-02 (figure 10.1). Some primary care services are provided by salaried GPs in community health settings particularly in rural and remote areas through accident and emergency departments and Aboriginal Community Controlled Health Services (ACCHSs). Consequently, expenditure reported through Medicare fee-for-service statistics will be understated in jurisdictions with larger proportions of rural and remote populations.

Figure 10.1 **Commonwealth Government real expenditure per person on general practice (2001-02 dollars)[a]**



a The data used include Medicare, PIP, DVA, Divisions and General Practice Immunisation Incentives Scheme data.

Source: Department of Health and Ageing (DHA) (unpublished); table 10A.8.

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.

Size and scope of sector

In 2001-02, there were 24 307 GPs and OMPs billing Medicare in Australia, which represents 123.3 per 100 000 people — a decline from 132.3 per 100 000 in 1996-97 (table 10A.9). Care needs to be taken in interpreting 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 clinical practice part time.

Figure 10.2 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. General practitioners in rural or remote areas spend more of their time working in local hospitals than those in metropolitan centres.

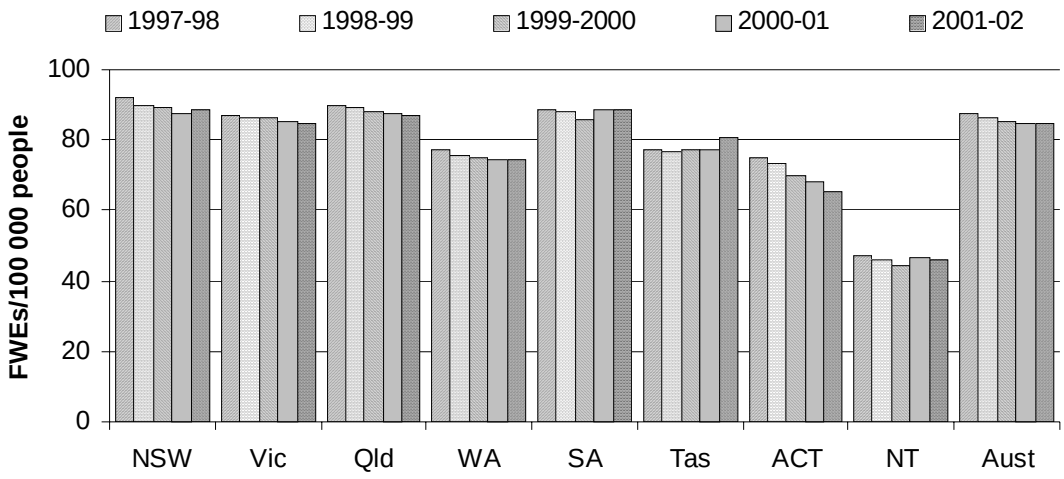
Australia-wide in 2001-02, there were 84.9 FWE GPs per 100 000 people. The highest number per 100 000 was in SA (88.8) and the lowest was in the NT (46.1) (figure 10.2).

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). The average consultation with a GP lasts just under 15 minutes (box 10.1).

Consultations per standardised whole patient equivalent (SWPE)[3] in 2000-01 were highest in NSW (6.6) and lowest in the NT (4.7) (figure 10.3), and were generally highest in capital cities and lowest in remote areas — declining with population density (table 10A.11).

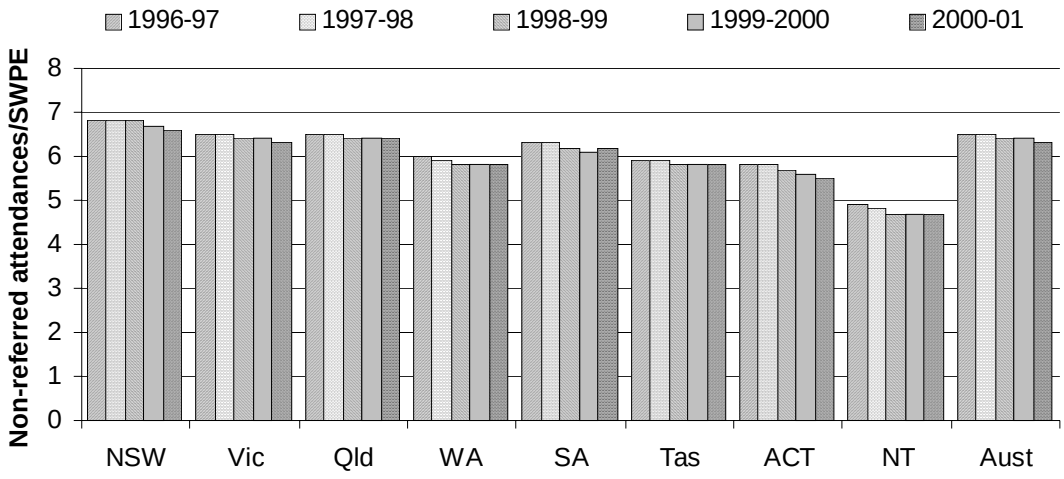
[3] 'Standardised whole patient equivalent' is an indicator of practice workload based on the number of patients seen. The SWPE value for a jurisdiction is the sum of the fractions of care provided by doctors in that jurisdiction to their patients, weighted for the age and sex of each patient in accordance with national ratios.

Figure 10.2 **GPs (full time workload equivalent) per 100 000 people**



Source: DHA (unpublished); table 10A.9.

Figure 10.3 **Non-referred attendances per standardised whole patient equivalent[a]**



a SWPE is an indicator of practice workload based on the number of patients seen. The SWPE value for a jurisdiction is the sum of the fractions of care provided by doctors in that jurisdiction to their patients, weighted for the age and sex of each patient in accordance with national ratios.

Source: DHA (unpublished); table 10A.10.

Box 10.1 **'Time for care'**

According to a study, the average GP consultation lasts just under 15 minutes. The study also shows that consultations with female GPs are longer on average (15.9 minutes) than those with male GPs (average 14.3 minutes). This finding was consistent with previous research that suggested female GPs deal with more psychological problems (such as depression) and more social problems. It was also found that younger male doctors (under 45 years) practising in metropolitan areas had the shortest average consultations at a little over 13 minutes. The GPs with the longest consultations, averaging 16.7 minutes, were rural female GPs aged 55 years and over.

The study was based on the timed length of 31 000 consultations for which a Medicare item number was claimed, from a random sample of 926 GPs. The study was undertaken between April 2000 and March 2001. The study shows that the average length of consultations varies greatly between different GPs, ranging from less than 10 minutes to more than 30 minutes. Consultations with a few GPs averaged less than 10 minutes, but the data show that the great majority of doctors are not in this category.

Source: Britt *et al.* (2002a).

Use of general practice services by Indigenous and non-Indigenous people

The Australian Institute of Health and Welfare (AIHW) and the (then) Department of Health and Aged Care report *Expenditures on health services for Aboriginal and Torres Strait Islander people, 1998-99* provides an analysis of data on the utilisation of general practice services collected in the BEACH survey. A series of adjustments were made to address under-identification and other methodological issues in the BEACH survey (AIHW 2001). These adjustments rest on a fundamental assumption that the characteristics of Indigenous people captured by the BEACH survey are identical to the people that were not covered in the survey. The adjusted data indicate that for every dollar expended on non-Indigenous people under the Medicare Benefits Schedule, 41 cents was spent on Aboriginal and Torres Strait Islander people. For Pharmaceutical Benefits Scheme (PBS) expenditure, 33 cents was spent on Indigenous Australians for every dollar expended for non-Indigenous people.

The BEACH study of general practice activity in Australia includes questions to identify encounters between Indigenous patients and participating GPs, however, the data should be treated with care. First, the sample frame has not been designed to produce statistically significant results for population sub-groups such as Indigenous Australians. Given that Indigenous Australians make up 2.4 per cent of

the Australian population, sample surveys such as BEACH generally do not identify sufficient Indigenous people to produce reliable results unless an additional sample has been specifically chosen to target Indigenous Australians. Therefore, the BEACH survey does not generally produce statistically reliable information for this population group.

Second, the identification of Indigenous Australians is not complete. In the BEACH survey there are more 'not stated' responses on the Indigenous question (10 per cent) than 'yes' responses. It can be assumed, therefore, that the survey consistently undercounts the number of Indigenous people visiting doctors. In addition, there is no information on whether the health characteristics of those who have been inaccurately 'not identified' are significantly different to those that have been identified. This affects the accuracy of the detailed results of the survey for Indigenous Australians.

There were 982 encounters between Indigenous patients and GPs in the 2001-02 BEACH study, which represented 1.0 per cent of encounters in the study — a lower proportion than the 2.4 per cent of the Australian population identified as Indigenous in June 2001 (tables A.1 and A.7 in the Statistical Appendix). Of the Indigenous encounters, 87.1 per cent stated they were Aboriginal, 9.7 per cent stated they were Torres Strait Islanders and 3.2 per cent said they were both.

The location of practices of the 272 GPs who saw Indigenous people was markedly different to that of the total GP sample. Only 54.6 per cent of GPs who saw Indigenous people practised in capital cities, compared with 69.3 per cent of the total sample. In contrast, 2.3 per cent of these GPs practiced in remote areas compared with 0.5 per cent of the total sample and approximately one quarter (24.6 per cent) practiced in small rural or other rural areas, compared with 15.4 per cent of the total sample (table 10A.1).

Indigenous people are more likely to live outside urban areas than non-Indigenous people, which may affect their access to and use of general practice services. In 1996, 26.1 per cent of Indigenous people lived in remote and very remote areas compared to only 2.0 per cent of non-Indigenous people (CGC 2001). Indigenous encounters by remoteness are shown in table 10A.2.

General practitioners treating Indigenous people tended to be younger — 13.6 per cent were aged 35 years or less, compared with 7.1 per cent of the total GP sample, and 31.5 per cent were aged 35 to 44 years, compared with 26.8 per cent of the total sample (Britt *et al* 2002b).

The age distribution of Indigenous patients differed markedly from that of the total sample of patients for all encounters. Overall, Indigenous patients were significantly

younger than the total sample of patients encountered. The proportion of Indigenous patients aged less than 44 years was 68.2 per cent compared with 48.6 per cent in the total data set. This difference was apparent in all the younger age groups. In contrast, the proportion of encounters with older Indigenous people was lower than that of the total data set. Only 8.9 per cent of Indigenous patients were over 65 years, compared with one in four in the total sample. The different age structure for Indigenous patients reflects the much younger age profile of the Indigenous population.

The ABS estimated residential population figures for 2001 show that 38.9 per cent of the Indigenous population was aged under 15 years, compared to 20.2 per cent of the non-Indigenous population. Only 2.8 per cent of the Indigenous population was aged over 65 years, compared with 12.4 per cent of the non-Indigenous population (tables A.1 and A.7 in the Statistical Appendix).

Most encounters (92.7 per cent) between GPs and Indigenous people in 2001-02 were paid for by the Commonwealth through Medicare, with standard surgery consultations accounting for 73.2 per cent of encounters (table 10.2).

Table 10.2 **Indigenous encounters by source of funding, 2001-02**

	Number[a]	*Rate per 100 encounters*	*95% LCL*[b]	*95% UCL*[b]
Direct consultations	916	97.6	96.5	98.6
No charge	12	1.3	–	21.3
MBS items of service	870	92.7	89.8	95.7
Standard surgery consultations	689	73.2	67.7	79.1
Workers compensation	12	1.3	–	25.9
Other paid (hospital, State, etc.)	22	2.3	–	17.7
Indirect consultations	23	2.4	–	5.5

[a] Missing data removed. [b] LCL = lower confidence limit; UCL = upper confidence limit. – Nil or rounded to zero.

Source: Britt *et al*. (2002b).

The most common reasons for encounters given by Indigenous patients are provided in table 10.3 with the comparative results from the total data set. The only significant difference between the more common reasons for encounters with Indigenous people and the total data set was the rate of requests for a checkup (either of a general nature or of a specific body system), which was significantly lower than the average at Indigenous encounters (5.2 per 100 Indigenous encounters compared with 13.4 per 100 total encounters).

Table 10.3 **Most frequent reasons for encounter, Indigenous patients and all patients, 2001-02**

	Indigenous encounters			*All encounters*		
Patient reasons for encounter	*Rate per 100 encounters (*n=982)	*95% LCL*[a]	*95% UCL*[a]	*Rate per 100 encounters (*n=*96 973)*	*95% LCL*[a]	*95% UCL*[a]
Prescription—all[b]	8.3	5.2	11.3	9.8	9.2	10.3
Cough	6.9	2.8	11.0	6.5	6.1	6.9
Check-up—all[b]	5.2	1.2	9.1	13.4	12.7	14.0
Back complaint[b]	4.4	–	9.2	3.8	3.6	4.1
Test results[b]	4.2	–	11.9	4.7	4.4	5.1
Immunisation all[b]	3.9	–	8.3	4.6	4.1	5.1
Fever	3.9	–	8.3	2.0	1.7	2.3
Abdominal pain[b]	2.9	–	6.1	2.1	2.0	2.3
Throat symptom/ complaint	2.7	–	6.5	3.8	3.4	4.1
Rash[b]	2.7	–	7.1	2.8	2.6	3.0
Diabetes (non-gestational)[b]	2.4	–	5.6	1.0	0.8	1.2
Total reasons for encounters	**149.5**	**143.6**	**155.5**	**149.2**	**147.4**	**150.9**

[a] LCL = lower confidence level; UCL = upper confidence level. [b] Includes multiple primary care classification codes. – Nil or rounded to zero.

Source: Britt *et al*. (2002b); table 10A.3.

The 10 most common problems managed at encounters with Indigenous and non-Indigenous people are presented in table 10.4. The wide confidence intervals generated by the small sample size rendered none of the differences statistically significant.

Table 10.4 **Indigenous and non-Indigenous health problems managed, 2001-02**

	Indigenous encounters			*All encounters*		
Problems managed	*Rate per 100 encounters* (n=982)	*95% LCL*[a]	*95% UCL*[a]	*Rate per 100 encounters* (n=96 973)	*95% LCL*[a]	*95% UCL*[a]
Hypertension[b]	6.6	3.1	10.2	9.0	8.6	9.5
Diabetes[b]	6.0	3.1	8.9	3.1	2.9	3.3
Asthma	5.0	–	10.5	2.8	2.6	3.0
Upper respiratory tract infection	4.9	1.0	8.8	6.2	5.8	6.6
Immunisation (all)[b]	4.6	–	12.2	4.7	4.2	5.1
Acute bronchitis/ bronchiolitis	3.9	0.3	7.5	2.7	2.5	3.0
Depression[b]	3.2	–	6.7	3.4	3.2	3.6
Back complaint[b]	3.1	–	8.5	2.6	2.4	2.8
Acute otitis media/ myringitis	3.0	–	6.1	1.3	1.2	1.5
Lipid disorder	2.3	–	5.7	2.9	2.7	3.1
General checkup[b]	2.2	–	6.0	1.8	1.6	2.0
Urinary tract infection[b]	2.1	–	5.8	1.6	1.5	1.7
Impetigo	2.1	–	11.0	0.2	–	0.5
Pregnancy[b]	2.0	–	5.0	0.9	0.7	1.1
Sub-total	501	35.2	..	29.9	..	..
Total problems	**144.7**	**136.8**	**152.7**	**143.4**	**141.7**	**145.2**

[a] LCL = lower confidence level; UCL = upper confidence level [b] Includes multiple primary care classification codes. – Nil or rounded to zero. .. Not applicable.

Source: Britt *et al.* (2002b); table 10A.4.

Table 10.5 summarises the major management activities associated with encounters with Indigenous people. The relative rate of problems managed at encounter were almost identical in the Indigenous encounters and in the total data set. There were no statistically significant differences in any of the other encounter variables due to wide confidence intervals generated by the small size of the Indigenous encounter sample.

Table 10.5 **Summary of management activities for Indigenous patients, 2001-02**

	Number	*Rate per 100 encounters (*n=*983)*	*95% LCL*[a]	*95% UCL*[a]
Problems managed	1422	144.7	136.8	152.7
New problems	606	61.7	52.9	70.5
Work-related	19	1.9	–	6.6
Medications	1176	119.7	105.5	134.0
Prescribed	1001	101.0	85.8	118.0
Advised OTC[b]	58	5.9	0.9	10.9
GP supplied	117	11.9	–	28.8
Other treatments	559	56.9	46.9	66.9
Clinical	427	43.5	35.2	51.8
Procedural	132	13.4	10.0	16.9
Referrals	106	11.9	7.6	16.2
Specialist	62	6.3	3.0	9.7
Allied health services	35	3.5	0.3	6.8
Pathology	375	38.1	22.6	53.7
Imaging	92	9.3	5.4	13.2
Total management activities	**1469**	**149.5**	**143.6**	**155.5**

[a] LCL = lower confidence limit, UCL = upper confidence limit. [b] OTC = over the counter.

Source: Britt *et al.* (2002b); table 10A.5.

10.2 Policy developments in general practice

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 under Medicare. This is expected to improve the financial viability of rural practice. Specific programs are addressing issues associated with accessing female GPs in rural areas by encouraging short term rural placements.

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 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 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. NPS coverage 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 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. In 2001-02, incentives were introduced through the PIP for improved management of asthma and diabetes, and for increasing cervical screening rates. Incentives were also introduced for practices in rural and other areas of need to employ a practice nurse or Aboriginal Health Worker.

Accreditation against the RACGP's Standards for General Practice is an entry requirement for participation in the PIP. From 1 January 2002, practices need to be

accredited or registered for accreditation to be eligible for PIP. Practices registered for accreditation need to attain full accreditation within 12 months.

Domiciliary Medication Management Review

Domiciliary Medication Management Review (DMMR) is a new service that encourages GPs and pharmacists to work collaboratively to review the medication management needs of patients in the community for whom quality use of medicines may be an issue. The service involves the patient, his or her GP and pharmacist, and other members of the health care team working together to ensure that the patient understands his or her medication and uses it optimally.

General practitioners claim for their involvement in DMMRs through a new item in the Medicare Schedule. Pharmacists are able to claim a fee for their involvement through funding under the Third Community Pharmacy Agreement.

The DMMR should result in improved patient satisfaction, as well as enhanced understanding of and concordance with medication regimens. It should also have positive clinical benefits for patients and lead to improved relationships between GPs, pharmacists and patients.

10.3 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 10.2).

Box 10.2 **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,

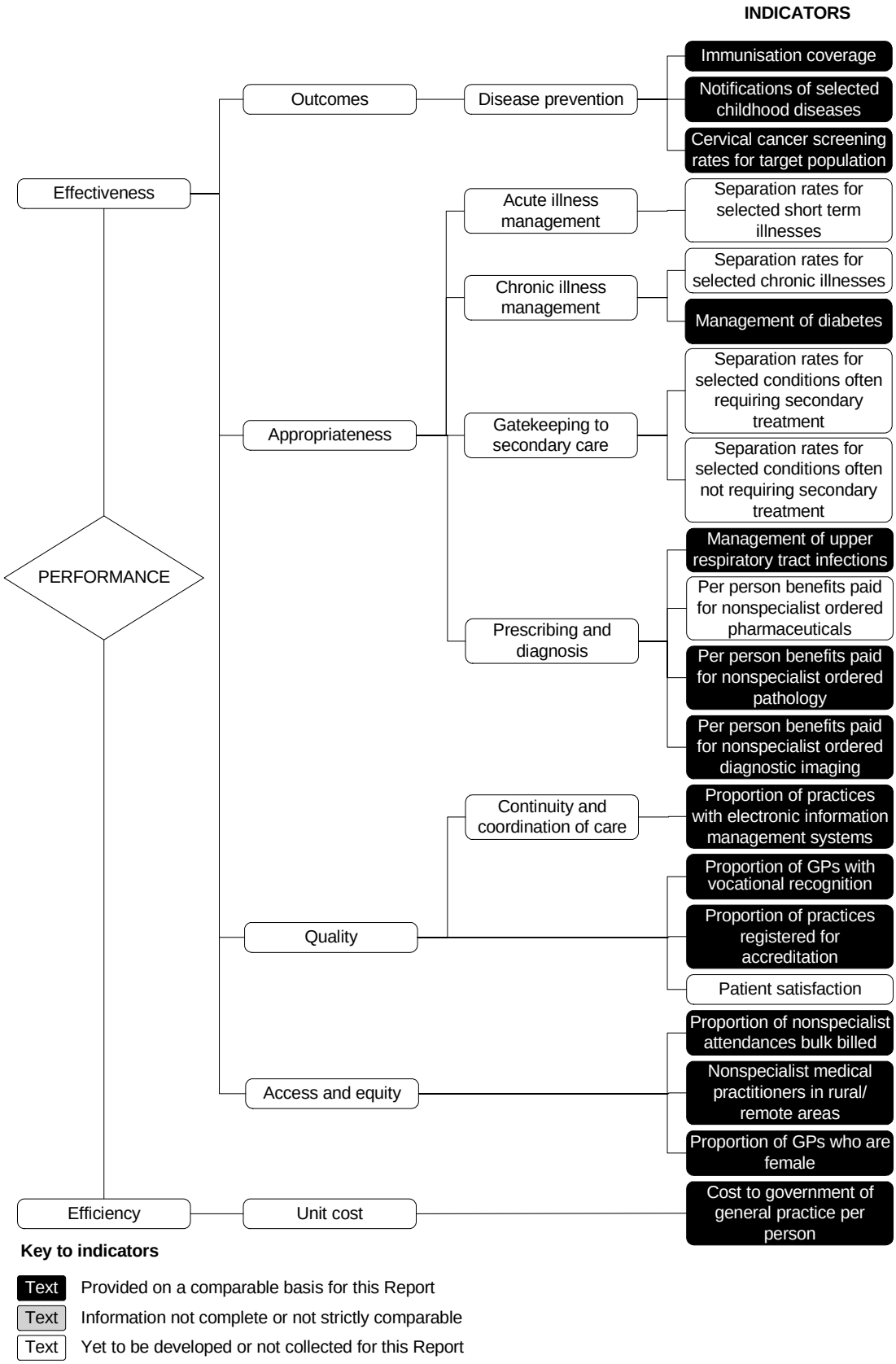
in an equitable and efficient manner.

The performance indicator framework aims to inform analysis of the effectiveness and efficiency of policies targeted at general practice services (figure 10.4). The

framework is evolving over time as better indicators are developed and as the focus and objectives for general practice change.

The performance indicator framework shows which data are comparable in the 2003 Report (figure 10.4). For data that are not considered strictly comparable, the text includes relevant caveats and supporting commentary. Chapter 1 discusses data comparability from a Report-wide perspective (see section 1.6).

Figure 10.4 **Performance indicators for general practice**



10.4 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 coverage

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 age group of 0–6 years. GPs 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 the 90 per cent of all children who attend 90 per cent of all general practices (DHAC 1999). The introduction of the Scheme, however, has had variable impacts in different States and Territories, depending on the structure of service provision.

Child immunisation services are delivered by many providers (table 10.6). 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 significant providers in the ACT and in the NT through community health centres (table 10.6).[4]

Around 90.2 per cent of Australian children aged 12 to 15 months at 30 June 2002 were assessed as fully immunised, down from 91.5 per cent at 30 June 2001 (figure 10.5).[5] Between 88.5 and 91.7 per cent of children in all jurisdictions were fully immunised (figure 10.5).

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4 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.

5 Full immunisation at 12 months includes immunisation against diptheria, tetanus, whooping cough, polio and Haemophilus influenzae type b.

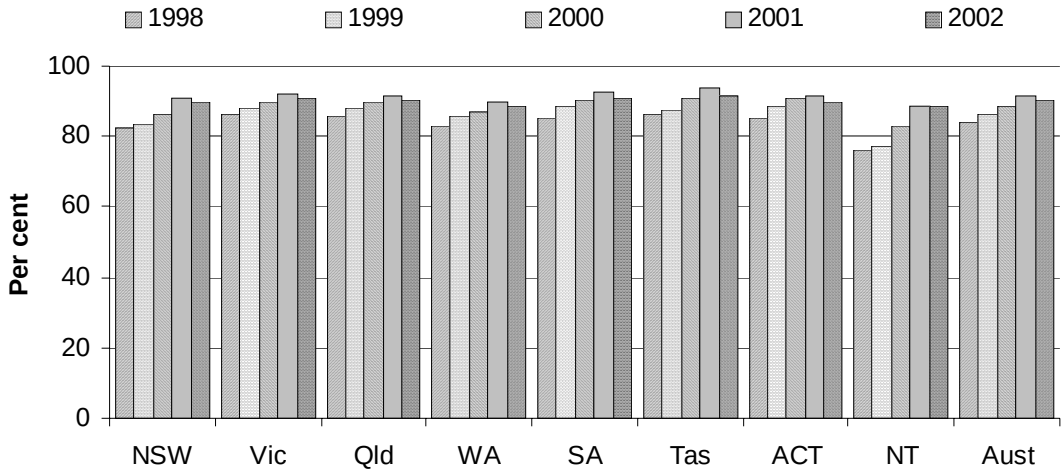
Table 10.6 **Valid vaccinations supplied to children under seven years of age by the type and State/Territory of the immunising provider, 2002 (per cent)[a]**

Provider	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
GPs	82.8	50.6	83.2	62.9	69.5	85.1	38.1	3.0	69.9
Council	6.8	48.3	7.8	8.1	17.5	14.3	–	–	18.4
State and Territory health department	–	–	–	5.1	0.1	0.1	40.2	–	1.2
Flying doctor service	–	–	0.4	–	0.2	–	–	–	0.1
Public hospital	2.9	0.2	3.1	5.4	4.8	0.2	1.1	1.8	2.5
Private hospital	0.2	–	–	–	–	–	–	1.0	0.1
Aboriginal health service/worker	0.5	0.1	0.5	0.5	0.3	–	0.2	6.5	0.5
Aboriginal health worker	–	–	0.5	–	0.1	–	–	0.2	0.1
Community health centre	6.8	0.8	4.5	18.0	7.6	0.4	20.4	87.5	7.3
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 2002. Data collected since 1 January 1996. – Nil or rounded to zero.

Source: DHA (unpublished); table 10A.15.

Figure 10.5 **Proportion of children aged 12 to 15 months who were fully immunised (per cent)[a, b, c]**



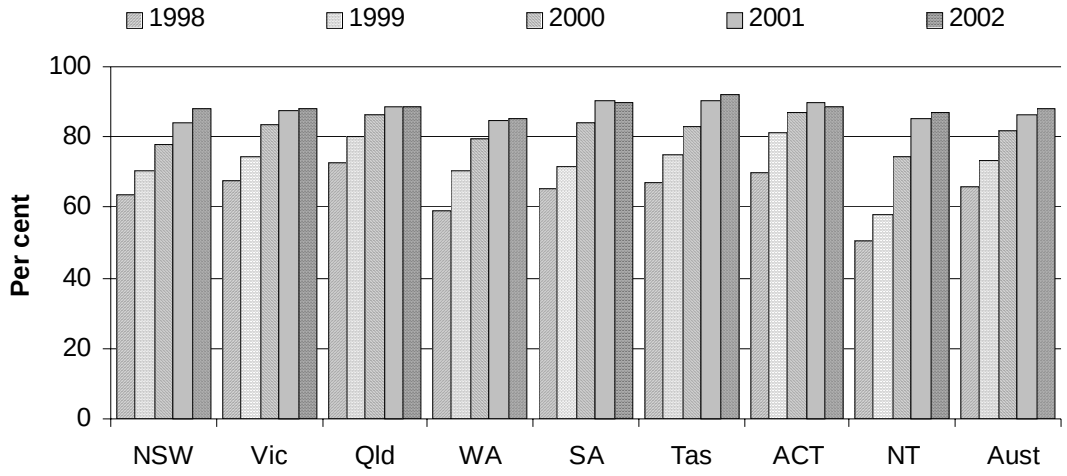
a Coverage measured at 30 June for children turning 12 months of age by 31 March. **b** The ACIR includes all children under seven years of age who are registered with Medicare. By the age of 12 months, over 98 per cent of Australian children have been registered with Medicare (NCIRS 2000). **c** There may be some underreporting by providers, and as a result, vaccine coverage estimates calculated using ACIR data should be considered minimum estimates (NCIRS 2000).

Source: DHA (unpublished); table 10A.16.

Nationally, 88.1 per cent of children aged 24 to 27 months at 30 June 2002 were assessed as being fully immunised, an increase from 86.6 per cent at 30 June 2001

(figure 10.6).[6] Tasmania recorded the highest proportion (91.8 per cent), while WA recorded the lowest (85.0 per cent).

Figure 10.6 **Proportion of children aged 24 to 27 months who were fully immunised (per cent)[a, b, c]**



[a] Coverage measured at 30 June. [b] The 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 underreporting by providers, and as a result, vaccine coverage estimates calculated using ACIR data should be considered minimum estimates (NCIRS 2000).

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

Disease prevention — notifications of selected childhood diseases

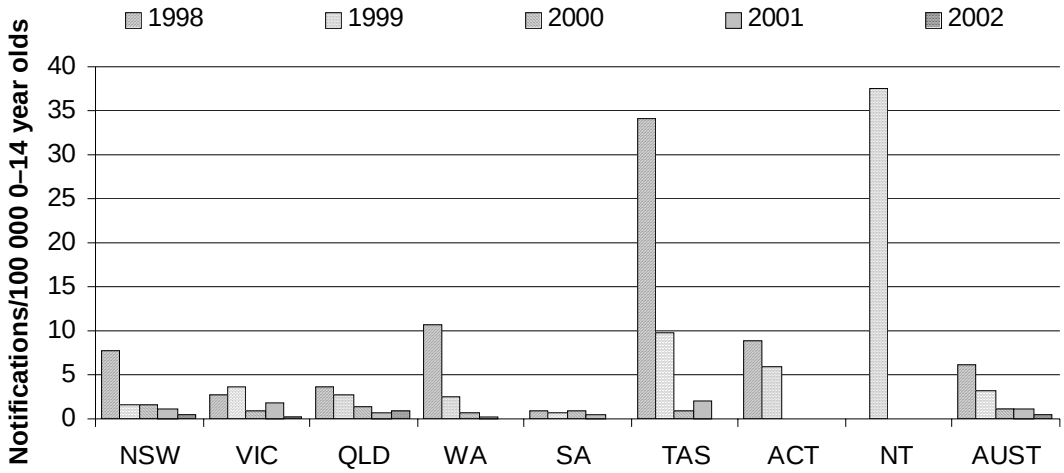
Notification rates for selected childhood vaccine-preventable diseases (measles, pertussis (whooping cough) and *Haemophilus influenzae* type b) are used as an indicator because the activities of GPs can influence the rate of these diseases through immunisation. The debilitating effects of these diseases 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 100 000 people in that age group.

In 2002, the notification rate for measles for 0–14 year olds was 0.4 per 100 000 people in that age group. This represents a large decline from the high levels of the early to mid-1990s (table 10A.19). In 2002, notification rates for 0–14 year olds for

[6] Full immunisation at 24 months includes immunisation against diptheria, tetanus, whooping cough, polio, Haemophilus influenzae type b and measles, mumps and rubella.

measles were zero in WA, SA, Tasmania, the ACT and the NT, with very low rates in all other jurisdictions (figure 10.7).

Figure 10.7 **Notification rates for measles among people aged 0–14 years (per 100 000 people aged 0–14 years)[a]**



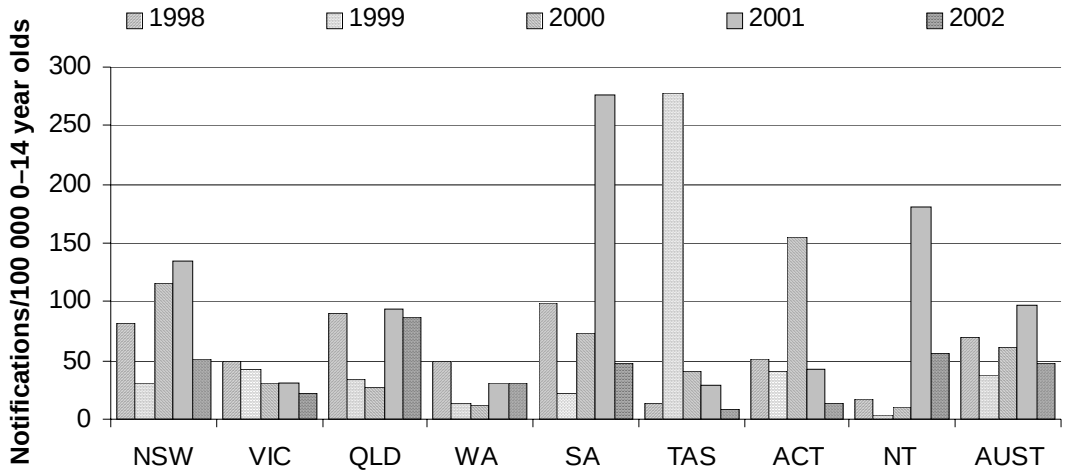
a Notifications for 2002 are to August only and have been adjusted to annual rates for comparison.

Source: DHA (unpublished); table 10A.19.

A severe outbreak of pertussis (whooping cough) occurred in 1997 (table 10A.20). The notification rate for Australia in that year was 156.5 notifications for 0–14 year olds per 100 000 people in that age group. As a result of the increased incidence of pertussis, the then Commonwealth Department of Health and Family Services decided to actively encourage the immunisation of all children against the disease. In 2002, the notification rate for 0–14 year olds in Australia was 47.4 (figure 10.8). The highest rate in 2002 was in Queensland, with 87.1 notifications per 100 000 children aged 0–14 years, and the lowest was in Tasmania, with a notification rate of 9.1.

In recent years, notification rates for *Haemophilus influenzae* type b have remained relatively low in all jurisdictions except the NT (figure 10.9). In 2002, the notification rate Australia-wide was 0.5 (per 100 000 children aged 0–14 years). The NT had a notification rate of 2.9 notifications per 100 000 children aged 0–14 years and WA had a notification rate of 1.9, while Tasmania and the ACT had zero notifications.

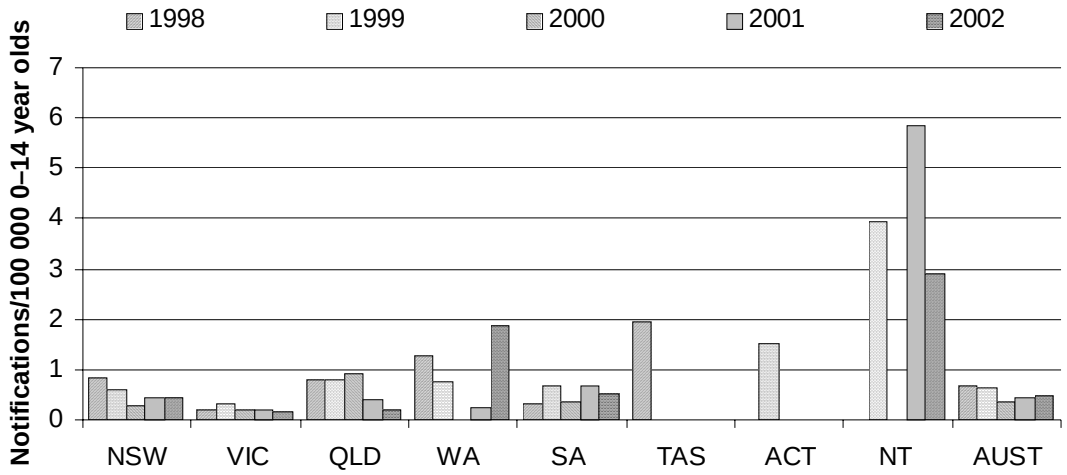
Figure 10.8 **Notification rates for pertussis (whooping cough) among people aged 0–14 years (per 100 000 people aged 0–14 years)[a]**



a Notifications for 2002 are to August only and have been adjusted to annual rates for comparison.

Source: DHA (unpublished); table 10A.20.

Figure 10.9 **Notification rates for *Haemophilus influenzae* type b among people aged 0–14 years (per 100 000 people aged 0–14 years)[a]**



a Notifications for 2002 are to August only and have been adjusted to annual rates for comparison.

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

Disease prevention — cervical screening

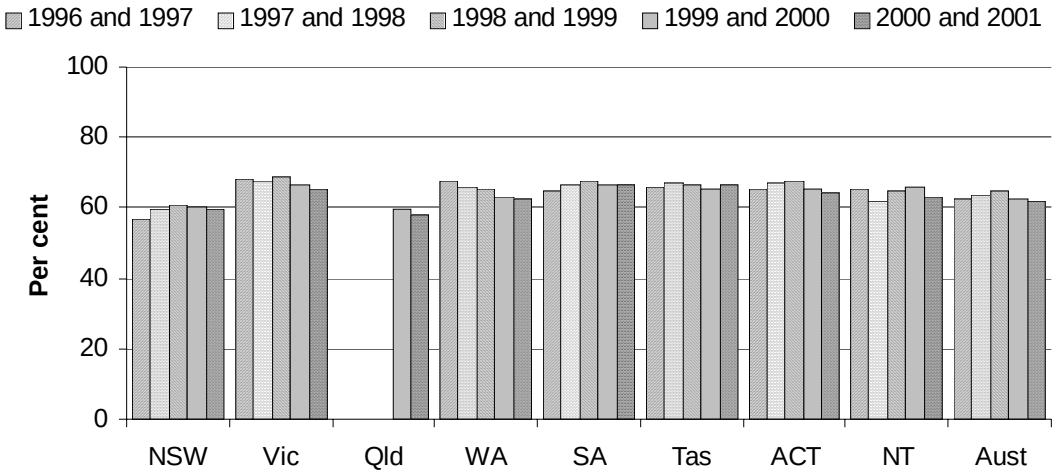
The third outcome indicator for primary care services provided by GPs is the cervical screening rate. Like child immunisation, cervical screening tests (that is, Pap smears) are offered by a range of health care providers under the National

Cervical 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, 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 is difficult. 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 Screening Program is targeted at women aged 20–69 years. The screening interval is two years. Figure 10.10 shows that in the 1999 and 2000 screening period, participation rates by women aged 20–69 years were highest in SA and Victoria (each 66.2 per cent) and lowest in Queensland (59.5 per cent) on an age-standardised basis. In the 2000 and 2001 screening period, participation rates were highest in Tasmania (66.6 per cent) and lowest in Queensland (58.2 per cent).

Figure 10.10 **Participation rates of women aged 20–69 years in cervical screening programs (per cent)[a, b, c, d, e]**



a Rates for Australia before 1999 and 2000 have been calculated excluding Queensland because the Queensland Health Pap Smear Register did not start operating until February 1999. **b** Rates for 1996 and 1997 are not age-standardised. **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** NSW Cervical Screening Program data indicate the participation rate for women aged 20–69 years up to 2001 is 75.1 per cent over 36 months and 84.2 per cent over 48 months.

Source: AIHW; State and Territory Cervical Cytology Registry data; table 10A.21.

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, preventing avoidable admissions to hospitals. While good GP management can limit the development of diabetic complications, patient compliance with measures to maintain blood glucose levels within the near-normal range such as medication, diet and physical activity, also plays an important part.

Three indicators for the management of diabetes are presented this year.

- Hospital separation rates for complications of Type 2 diabetes mellitus.
- Hospital separation rates for diseases of the circulatory system — diagnoses where Type 2 diabetes mellitus was an additional diagnosis.

- Hospital separations for lower limb amputations where Type 2 diabetes mellitus was a principal or additional condition.

There are no new data available for two indicators reported in the 2002 Report:

- the proportion of adults with diabetes who have been diagnosed and placed on a diabetes register; and
- 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.

These indicators were based on data from the National Divisions Diabetes Program Data Collation project carried out in 1999 and 2000. Data may be available for the 2004 Report.

Hospital separations for complications of Type 2 diabetes mellitus

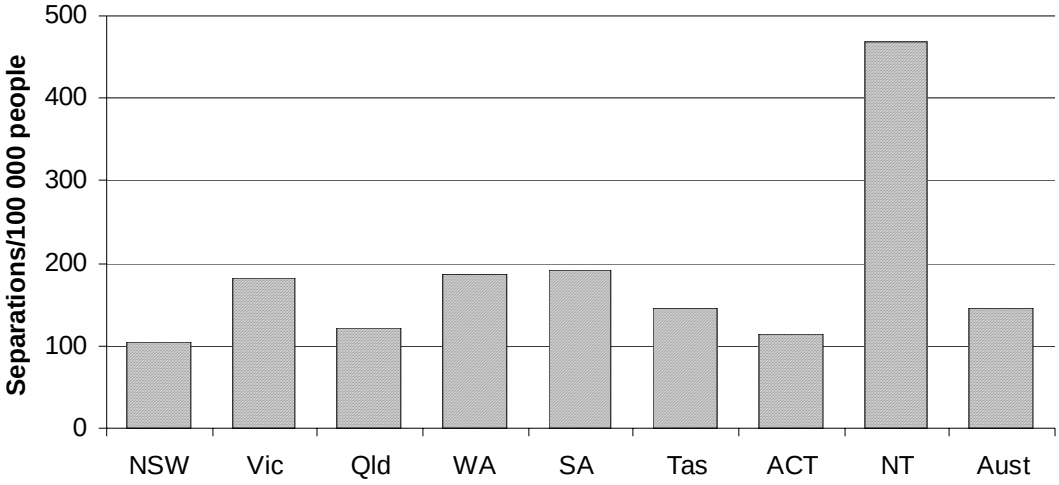
Poorly controlled diabetes mellitus results in the development of various associated conditions, the most common being renal, circulatory and ophthalmic complications which usually require admission to hospital. As primary care providers, GPs are well placed to both detect diabetes early and to provide care which can assist in the prevention or slowing of the development of the complications of diabetes.

Hospital separation rates for Type 2 diabetes and its complications may initially increase as a result of the ageing of the population, increasing longevity, and increasing risk factors, particularly excess weight in recent decades. An extensive program of early diagnosis and management in the primary care sector may eventually lead to a gradual reversal of current trends and continuing reductions in the rates of hospitalisation for diabetes and its complications.

It has been difficult to interpret time trends of hospital separation data in the context of diabetes management in the primary care sector, largely because diabetes coding guidelines and practice have been evolving in the past few years.

Age-standardised rates for hospital separations in all hospitals where the principal diagnosis was Type 2 diabetes mellitus are reported in figure 10.11. Separation rates were highest in the NT (469.6 separations per 100 000 people) and lowest in NSW (104.4 separations per 100 000 people).

Figure 10.11 **Hospital separation rates for Type 2 diabetes mellitus as principal diagnosis, all hospitals, 2000-01**[a, b, c, d, e, f, g, h, i, j, k, l]

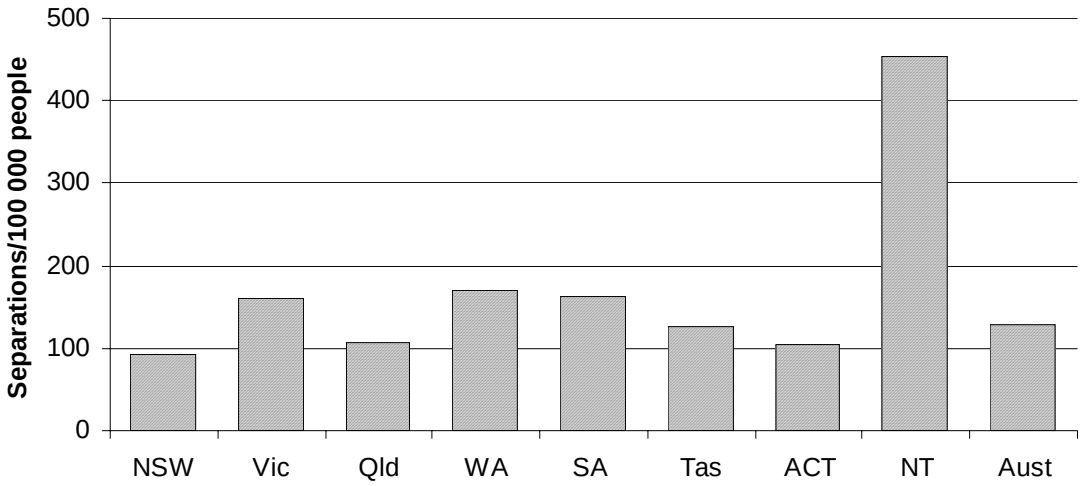


[a] Separation rates are age-standardised to the Australian national population at 30 June 1991 using direct standardisation. [b] Figures include unspecified diabetes. [c] Totals include separations for unspecified complications. [d] Crude rates for each jurisdiction were calculated using ABS estimated resident population by age group for the respective jurisdiction. [e] The figures are based on the ICD-10-AM classification. The codes are E11.x and E14.x, where x=2 renal complications, x=3 ophthalmic complications, x=5 peripheral circulatory complications, x=7 multiple complications, x=8 unspecified complications, x=9 without complications, and x=0,1,4,6 other specified complications. [f] The data are not person-based, but episode-based. A person who is admitted to hospital, say three times in the year, will be counted three times. [g] The principal diagnosis data are episode-based, but the secondary diagnosis data are diagnosis-based. A separation is represented three times in secondary diagnosis if given three different diabetes codes. [h] Age-standardisation tends to exaggerate the effect of multiple episodes for individual patients, particularly in small populations. [i] Although same day admission for dialysis are not normally coded with a principal diagnosis of Type 2 diabetes, the data could include miscoded separations in several jurisdictions. The results for small jurisdictions reflect both this type of distortion and unreliability arising from small numbers. [j] Results for individual complications may be affected by small numbers, particularly in the smaller jurisdictions, and need to be interpreted with care. [k] Treatment of Type 2 diabetes related conditions is also provided in ambulatory care settings. The availability of outpatient services may vary between jurisdictions and over time. [l] Morbidity data are coded under coding standards that may differ over time and across jurisdictions.

Source: DHA unpublished; table 10A.23.

The rate of separations per 100 000 people for Type 2 diabetes mellitus with complications as a principal diagnosis are shown in figure 10.12. At about three times the national rate, NT was much higher than any other jurisdiction.

Figure 10.12 **Hospital separation rates for Type 2 diabetes mellitus with complications as principal diagnosis, all hospitals, 2000-01[a, b, c, d, e, f, g, h, i, j, k, l]**

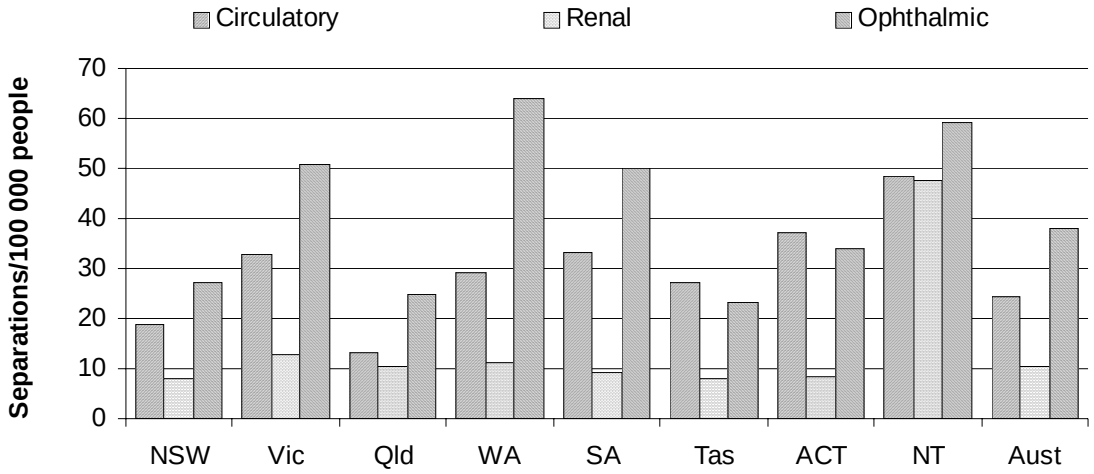


a Separation rates are age-standardised to the Australian national population at 30 June 1991 using direct standardisation. **b** Figures include unspecified diabetes. **c** Totals include separations for unspecified complications. **d** Crude rates for each jurisdiction were calculated using ABS estimated resident population by age group for the respective jurisdiction. **e** The figures are based on the ICD-10-AM classification. The codes are E11.x and E14.x, where x=2 renal complications, x=3 ophthalmic complications, x=5 peripheral circulatory complications, x=7 multiple complications, x=8 unspecified complications, x=9 without complications, and x=0,1,4,6 other specified complications. **f** The data are not person-based, but episode-based. A person who is admitted to hospital, say three times in the year, will be counted three times. **g** The principal diagnosis data are episode-based, but the secondary diagnosis data are diagnosis-based. A separation is represented three times in secondary diagnosis if given three different diabetes codes. **h** Age-standardisation tends to exaggerate the effect of multiple episodes for individual patients, particularly in small populations. **i** Although same day admission for dialysis are not normally coded with a principal diagnosis of Type 2 diabetes, the data could include miscoded separations in several jurisdictions. The results for small jurisdictions reflect both this type of distortion and unreliability arising from small numbers. **j** Results for individual complications may be affected by small numbers, particularly in the smaller jurisdictions, and need to be interpreted with care. **k** Treatment of Type 2 diabetes related conditions is also provided in ambulatory care settings. The availability of outpatient services may vary between jurisdictions and over time. **l** Morbidity data are coded under coding standards that may differ over time and across jurisdictions.

Source: DHA unpublished; table 10A.23.

Figure 10.13 shows the age-standardised separation rates for the three largest groups of Type 2 diabetes complications – circulatory, renal and ophthalmic. In all jurisdictions except Tasmania and the ACT, ophthalmic complications accounted for the highest separation rates. In both Tasmania and the ACT, rates for circulatory complications were highest, marginally above the rates for ophthalmic complications. In the NT, the rates for circulatory and renal complications were high and about the same.

Figure 10.13 **Hospital separation rates for Type 2 diabetes mellitus as principal diagnosis with complications, all hospitals, 2000-01[a, b, c, d, e, f, g, h, i, j, k, l]**

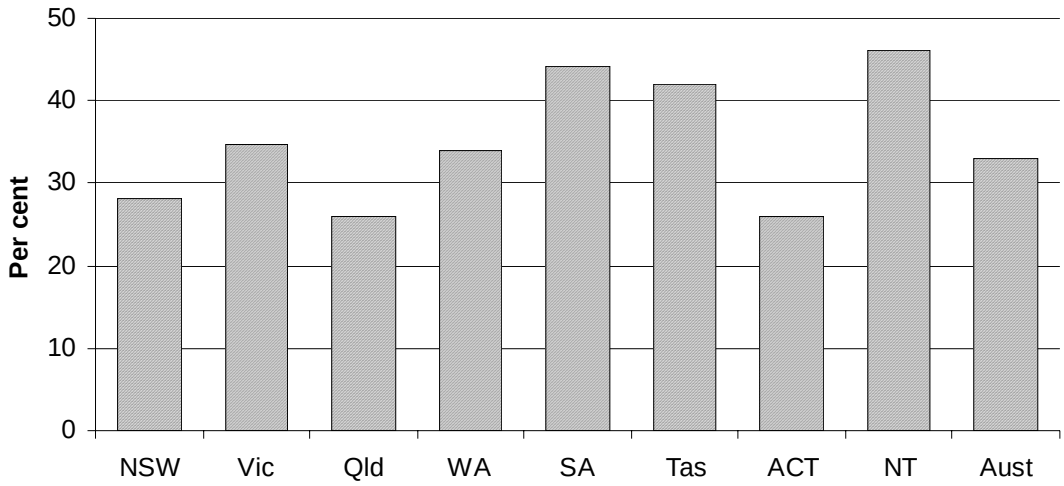


a Separation rates are age-standardised to the Australian national population at 30 June 1991 using direct standardisation. **b** Figures include unspecified diabetes. **c** Totals include separations for unspecified complications. **d** Crude rates for each jurisdiction were calculated using ABS estimated resident population by age group for the respective jurisdiction. **e** The figures are based on the ICD-10-AM classification. The codes are E11.x and E14.x, where x=2 renal complications, x=3 ophthalmic complications, x=5 peripheral circulatory complications, x=7 multiple complications, x=8 unspecified complications, x=9 without complications, and x=0,1,4,6 other specified complications. **f** The data are not person-based, but episode-based. A person who is admitted to hospital, say three times in the year, will be counted three times. **g** The principal diagnosis data are episode-based, but the secondary diagnosis data are diagnosis-based. A separation is represented three times in secondary diagnosis if given three different diabetes codes. **h** Age-standardisation tends to exaggerate the effect of multiple episodes for individual patients, particularly in small populations. **i** Although same day admission for dialysis are not normally coded with a principal diagnosis of Type 2 diabetes, the data could include miscoded separations in several jurisdictions. The results for small jurisdictions reflect both this type of distortion and unreliability arising from small numbers. **j** Results for individual complications may be affected by small numbers, particularly in the smaller jurisdictions, and need to be interpreted with care. **k** Treatment of Type 2 diabetes related conditions is also provided in ambulatory care settings. The availability of outpatient services may vary between jurisdictions and over time. **l** Morbidity data are coded under coding standards that may differ over time and across jurisdictions.

Source: DHA unpublished; table 10A.23.

Treatment for Type 2 diabetes and related conditions is also provided in ambulatory care settings. The number of people accessing ambulatory services is not included in the hospital separations data. Differences across jurisdictions in policy and practice relating to the admission of patients, availability of outpatient services and incentives to admit patients rather than treat them as outpatients will affect estimates of hospital separations. This is partially reflected in the substantial variation in the proportion of same day separations across jurisdictions (figure 10.14).

Figure 10.14 **Same day separations for principal diagnosis of Type 2 diabetes mellitus, all hospitals (per cent), 2000-01** [a, b, c, d, e, f, g, h, i, j, k, l]



[a] Separation rates are age-standardised to the Australian national population at 30 June 1991 using direct standardisation. [b] Figures include unspecified diabetes. [c] Totals include separations for unspecified complications. [d] Crude rates for each jurisdiction were calculated using ABS estimated resident population by age group for the respective jurisdiction. [e] The figures are based on the ICD-10-AM classification. The codes are E11.x and E14.x, where x=2 renal complications, x=3 ophthalmic complications, x=5 peripheral circulatory complications, x=7 multiple complications, x=8 unspecified complications, x=9 without complications, and x=0,1,4,6 other specified complications. [f] The data are not person-based, but episode-based. A person who is admitted to hospital, say three times in the year, will be counted three times. [g] The principal diagnosis data are episode-based, but the secondary diagnosis data are diagnosis-based. A separation is represented three times in secondary diagnosis if given three different diabetes codes. [h] Age-standardisation tends to exaggerate the effect of multiple episodes for individual patients, particularly in small populations. [i] Although same day admission for dialysis are not normally coded with a principal diagnosis of Type 2 diabetes, the data could include miscoded separations in several jurisdictions. The results for small jurisdictions reflect both this type of distortion and unreliability arising from small numbers. [j] Results for individual complications may be affected by small numbers, particularly in the smaller jurisdictions, and need to be interpreted with care. [k] Treatment of Type 2 diabetes related conditions is also provided in ambulatory care settings. The availability of outpatient services may vary between jurisdictions and over time. [l] Morbidity data are coded under coding standards that may differ over time and across jurisdictions.

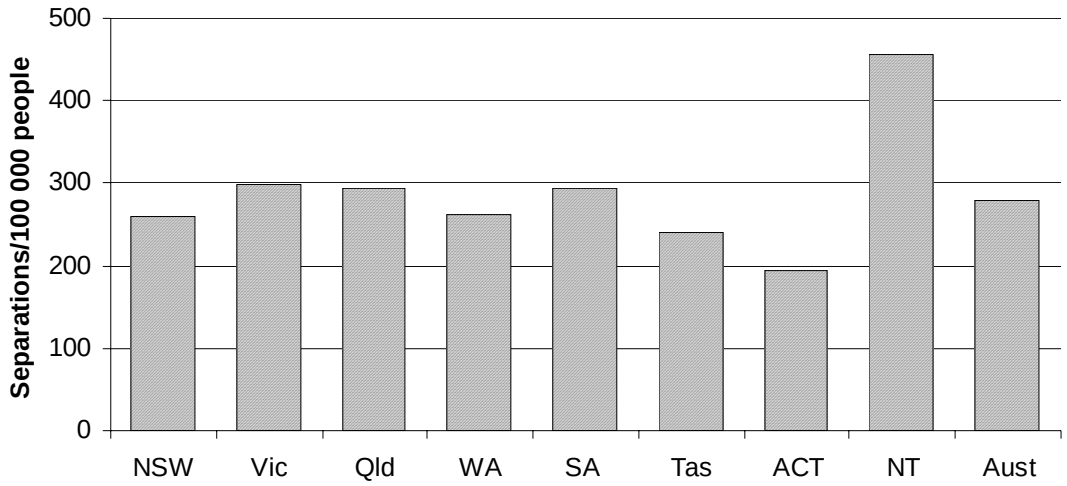
Source: DHA unpublished; table 10A.27.

Hospital separations for diseases of the circulatory system — diagnoses where Type 2 diabetes mellitus was an additional condition

There is a growing body of evidence implicating diabetes in the development of cardiovascular disease, the largest cause of death in Australia. Diabetes and diseases of the circulatory system share common risk factors and diabetes on its own is considered a risk factor for diseases of the circulatory system.

In the NT, hospital separation rates for diseases of the circulatory system where Type 2 diabetes mellitus was an additional diagnosis were over 60 per cent higher than the national average (figure 10.15). Coronary heart disease accounted for a large component of these separations in each jurisdiction (table 10A.24).

Figure 10.15 **Hospital separation rates for principal diagnosis of selected diseases of the circulatory system where Type 2 diabetes mellitus was an additional diagnosis, all hospitals, 2000-01[a, b]**



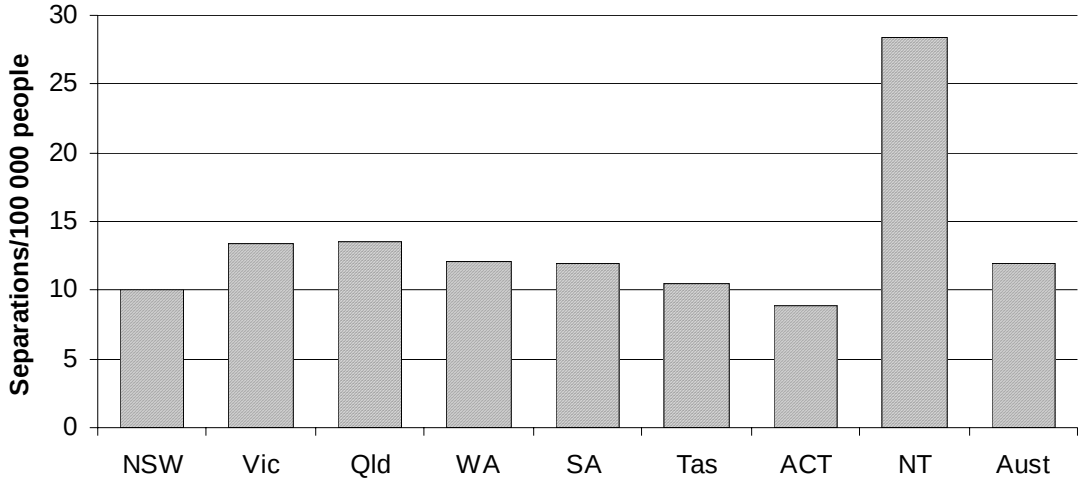
a Includes unspecified diabetes. Separation rates are age-standardised on the Australian total population at 30 June 1991 using direct standardisation. The figures are based on the ICD-10-AM classification. The codes used are E11.x and E14.x, where x= 0-9 for diabetes, and I00-I99 for diseases of the cardiovascular system. **b** The data are not person-based, but episode-based. A person who is admitted to hospital, say three times in the year, will be counted three times.

Source: DHA unpublished; table 10A.24.

Hospital separations for lower limb amputations where Type 2 diabetes mellitus was a principal or additional diagnosis

Amputation of a lower limb can be a serious outcome of diabetes-related complications. In 2000-01, there were 12.0 hospital separations per 100 000 people (age-standardised) for lower limb amputations where Type 2 diabetes mellitus was a principal or additional diagnosis (figure 10.16).

Figure 10.16 **Hospital separation rates for lower limb amputation with principal or additional diagnosis of Type 2 diabetes, all hospitals, 2000-01[a, b]**



a Includes unspecified diabetes. Separation rates are age-standardised on the Australian total population at 30 June 1991 using direct standardisation. The figures are based on the ICD-10-AM classification. The codes are E11.x and E14.x, where x=0-9 for diabetes, and Blocks 1533, 44367, 44370 and 44373 for amputations. **b** The data are not person-based, but episode-based. A person who is admitted to hospital, say three times in the year, will be counted three times.

Source: DHA unpublished; table 10A.26

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. Prescription rates for oral antibiotics most commonly used in the treatment of upper respiratory tract infections are also reported.

Number of prescriptions for oral antibiotics most commonly used in the treatment of upper respiratory tract infections ordered by GPs, per 1000 people with PBS concession cards

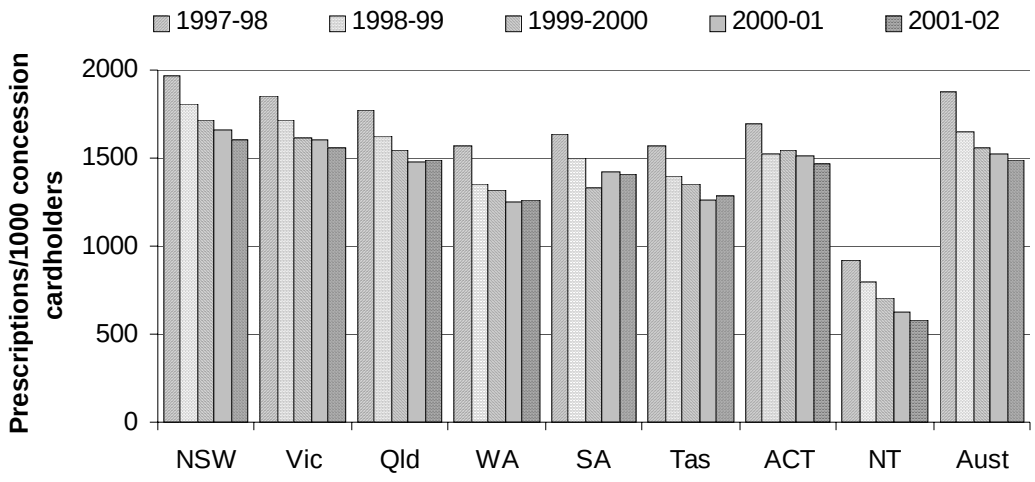
Antibiotics have no efficacy in the treatment of viral infections but are still frequently prescribed when they occur. Consequently, their prescription rates (overall, and particularly in relation to upper respiratory tract infections) are unambiguously too high. Reductions in the rate of prescription 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 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 people with PBS concession cards for 2001-02 were highest in NSW (1605.5) and lowest in the NT (575.4) (table 10A.22). Australia-wide, the number of prescriptions decreased between 1997-98 and 2001-02, although there were slight rises in some years in some jurisdictions (figure 10.17). Prescriptions rates fell from 1873.1 in 1997-98 to 1491.6 in 2001-02 (table 10A.22).

Figure 10.17 **Prescription rates for oral antibiotics for upper respiratory tract infections**



Source: DHA (unpublished); table 10A.22.

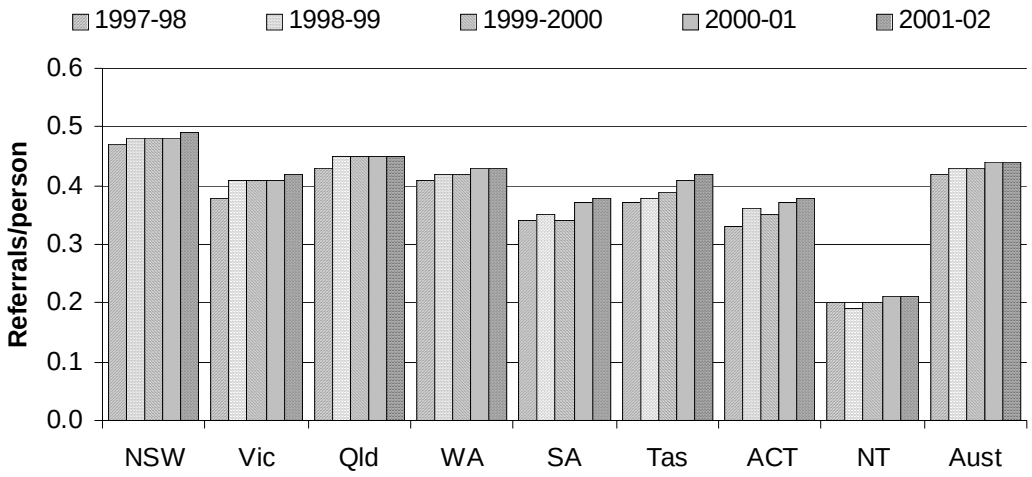
Pathology and diagnostic imaging

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 10.18 provides contextual information on referrals by GPs per person for diagnostic imaging. For diagnostic imaging in 2001-02, NSW had the highest number of referrals per person (0.49) and the NT the lowest (0.21).

Figure 10.18 **Referrals per person for diagnostic imaging**



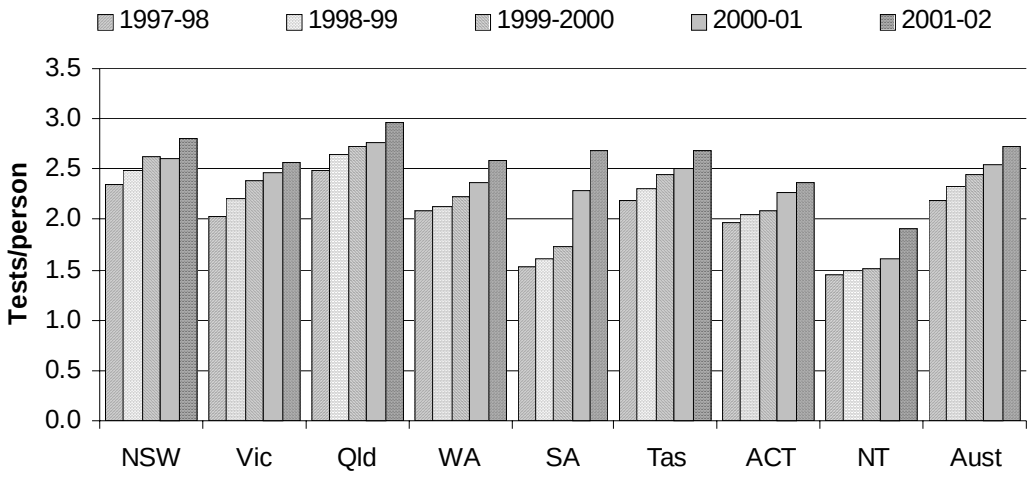
Source: DHA (unpublished); table 10A.29.

Pathology data are presented for the number of tests ordered through Medicare per person rather than the number of referrals (figure 10.19).[7] 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 2001-02, Queensland had the highest rate of pathology tests (3.0 per person) and the NT the lowest (1.9 per person). Between 1996-1997 and 2001-02 the national rate of pathology tests increased from 2.1 to 2.7 tests per person (table 10A.28).

Overall in 2001-02, Commonwealth expenditure under Medicare on pathology tests was $47 per person and on imaging was $38 per person. Figure 10.20 shows that benefits paid per person for pathology tests in 2001-02 were highest in Queensland ($54 per person) and lowest in the NT ($34). Benefits paid per person for diagnostic imaging were highest in NSW ($43) and lowest in the NT ($16).

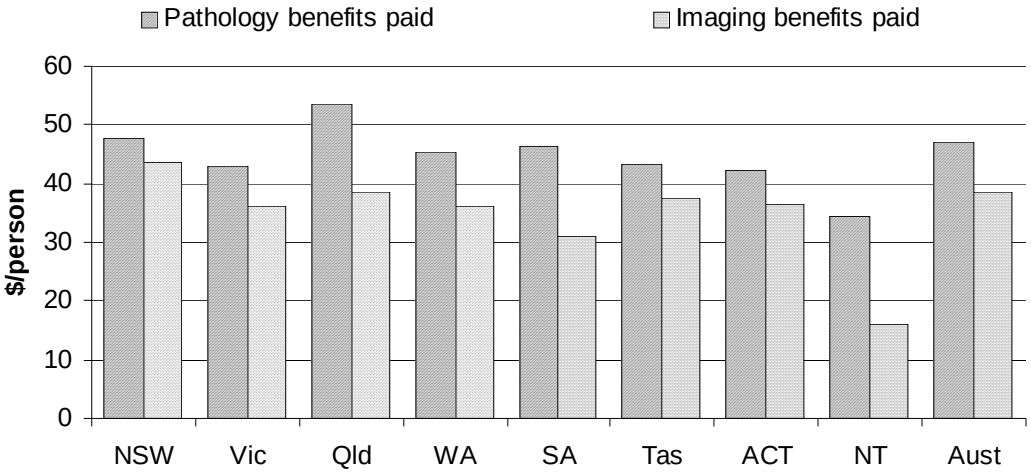
[7] Up to three tests may be recorded following a pathology referral, whereas each imaging referral results in only one test.

Figure 10.19 **Pathology tests per person**



Source: DHA (unpublished); table 10A.28.

Figure 10.20 **Benefits paid per person for pathology tests and diagnostic imaging, 2001-02**



Source: DHA (unpublished); tables 10A.28 and 10A.29.

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 FWE GPs with vocational recognition, 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 Information Management, Information Technology initiative, there are two incentives that encourage the computerisation of practices: the electronic prescribing incentive paid for use of bona fide electronic prescribing software to generate the majority of prescriptions, and an incentive paid for the use of computer systems to send and/or receive clinical information.

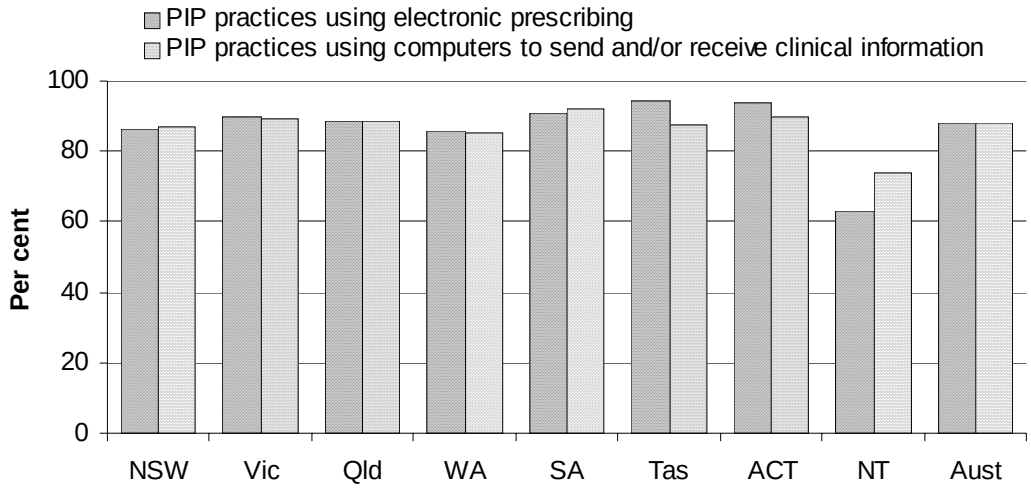
The proportion of practices with electronic information management systems is an indicator of quality which helps to identify the capacity for efficient handling of patient information, including management of screening and other preventive health activities, reminder systems, patient education, record 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 (DHA unpublished).

The data indicate that the proportion of PIP practices nationally that used electronic prescribing systems in May 2002 was 88.2 per cent (an increase from 78.3 per cent in May 2001) (table 10A.30). The proportion of PIP practices with the capacity to send and/or receive clinical information via use of computer technology was 88.1 per cent in May 2002 (an increase from 87.0 per cent in May 2001) (table 10A.30).

At May 2002, PIP practices in the NT were the least likely to send and/or receive clinical information electronically or to use electronic prescribing software (74.1 per cent and 63.0 per cent respectively) (figure 10.21). Participating PIP practices in Tasmania were most likely to use electronic prescribing software (94.5 per cent) while SA was the most likely to use computers to send and/or receive clinical information (91.9 per cent) (figure 10.21).

Figure 10.21 **Proportion of PIP practices using computers for clinical purposes, May 2002 (per cent)**



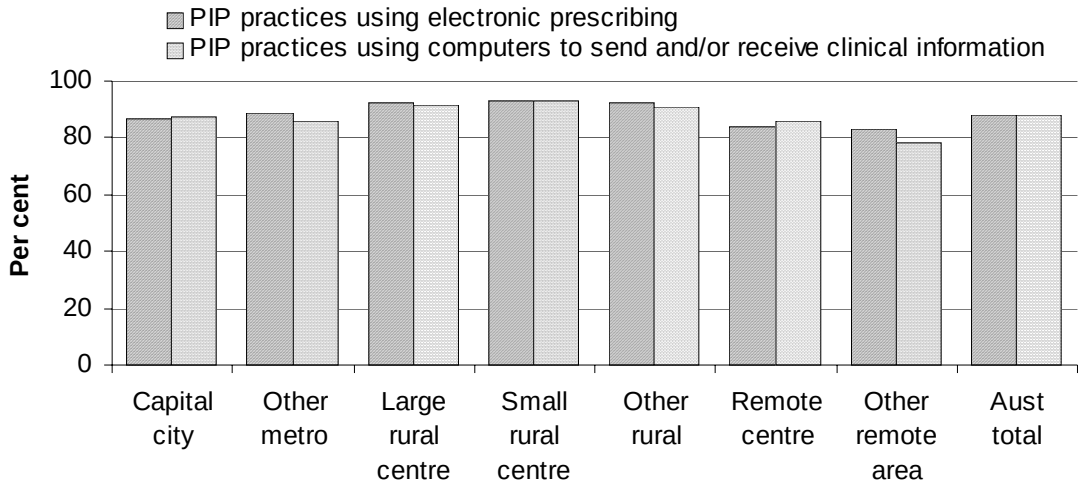
Source: DHA (unpublished); table 10A.31.

In May 2002, PIP practices in all rural areas were more likely to use electronic prescribing and to use computers to send and/or receive clinical information than PIP practices in metropolitan areas or remote areas. PIP practices in remote areas were least likely to use electronic prescribing systems (figure 10.22). Remote practices in Indigenous communities in the NT have difficulty accessing the PIP, which affects coverage of these data.

Vocational recognition

The proportion of full time workload equivalent GPs with vocational recognition indicates the standard of appropriate training of GPs and their ability to deliver services of high quality. In 2001-02, the ACT had the highest proportion (95.9 per cent) and the NT had the lowest proportion (86.3 per cent) (figure 10.23). While this proportion has increased Australia-wide since 1996-97, this trend has not been experienced in all jurisdictions — most notably in Queensland and Tasmania. The proportion of GPs with vocational recognition is lower in remote centres and other remote areas (table 10A.33).

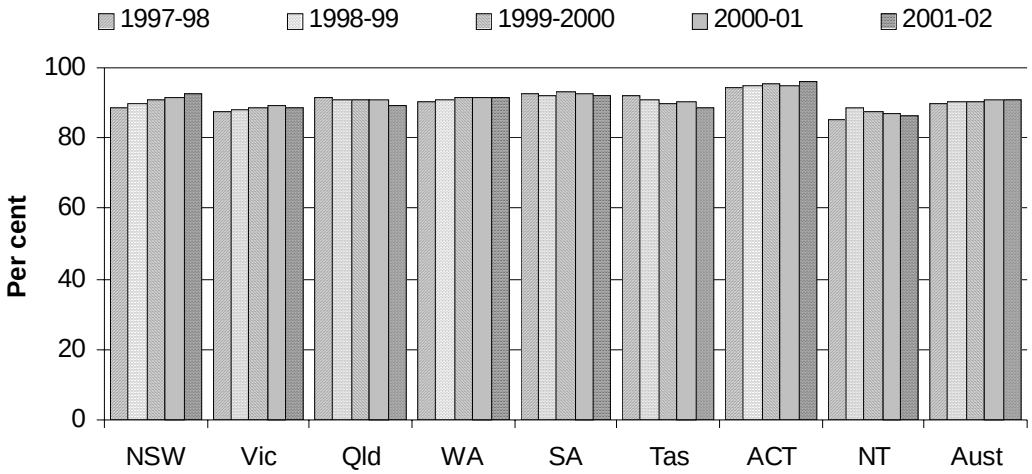
Figure 10.22 **Proportion of PIP practices using computers for clinical purposes, May 2002 (per cent)[a]**



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 5000 or more; Other remote area = all remaining SLAs in the remote zone.

Source: DHA (unpublished); table 10A.30.

Figure 10.23 **Proportion of GPs with vocational recognition (full time workload equivalent)**

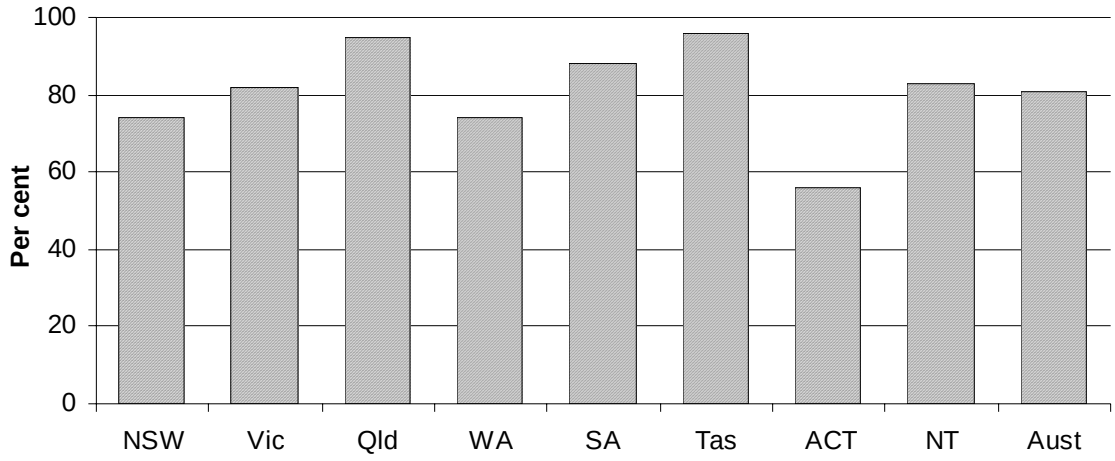


Source: DHA (unpublished); table 10A.32.

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) and General Practice Australia (GPA). These firms provide a peer review process to assess practices against the RACGP Standards for Social Practices. GPA is a for-profit private company and details of the scope of its activities are not publicly available. Accordingly, 4795 or 81 per cent of eligible practices were registered for accreditation with AGPAL on 3 October 2002. This compares with 65.2 per cent in August 2000 (table 10A.34). Tasmania had the highest proportion of practices registered for accreditation in October 2002 (96.1 per cent) and the ACT had the lowest (56.1 per cent) (figure 10.24).

Figure 10.24 **Proportion of practices registered for accreditation with AGPAL, October 2002 (per cent)**



Source: AGPAL (2002); table 10A.34.

Access and equity

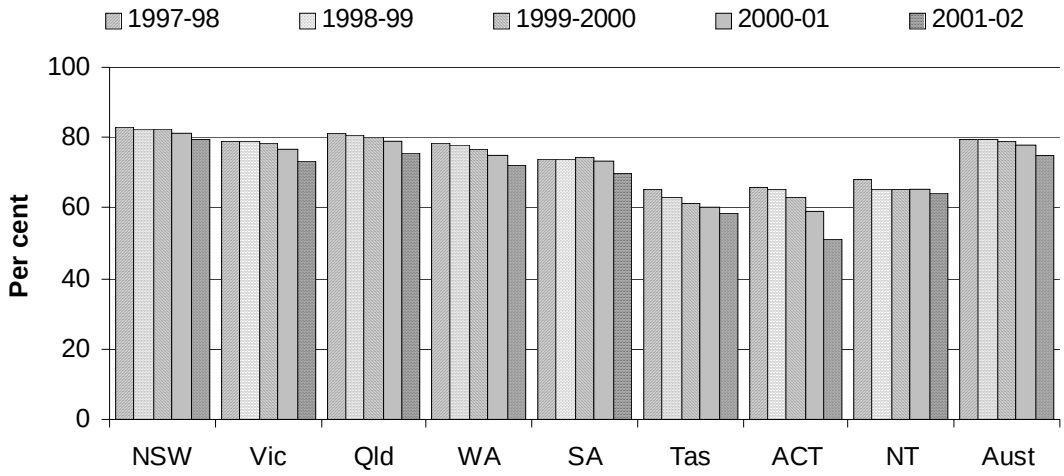
Three indicators are used to measure access and equity in GP service delivery: the proportion of total non-specialist non-referred attendances that are bulk billed, FWE GPs per 100 000 people in rural and remote areas, and the proportion of FWE GPs who are female.

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 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 rate of affordability.

Visits to GPs are classed as non-referred attendances under Medicare and these are further disaggregated into services provided by vocationally recognised GPs and those provided by OMPs who are not vocationally recognised. In 2001-02, NSW had the highest proportion of attendances that were bulk billed (79.8 per cent), while the ACT had the lowest (51.2 per cent) (figure 10.25). Australia-wide, the proportion of attendances that were bulk billed has declined from 80.6 per cent in 1996-97 to 74.9 per cent in 2001-02 (table 10A.35). Bulk billing rates are generally lower in rural and remote areas than in capital cities or other metropolitan centres. In 2001-02, bulk billing rates were 80.8 per cent in capital cities, 59.0 per cent in large rural centres and 58.9 per cent in remote centres (table 10A.36).

Figure 10.25 **Non-referred attendances that were bulk billed as a proportion of all non-referred attendances (per cent)**



Source: DHA (unpublished); table 10A.35.

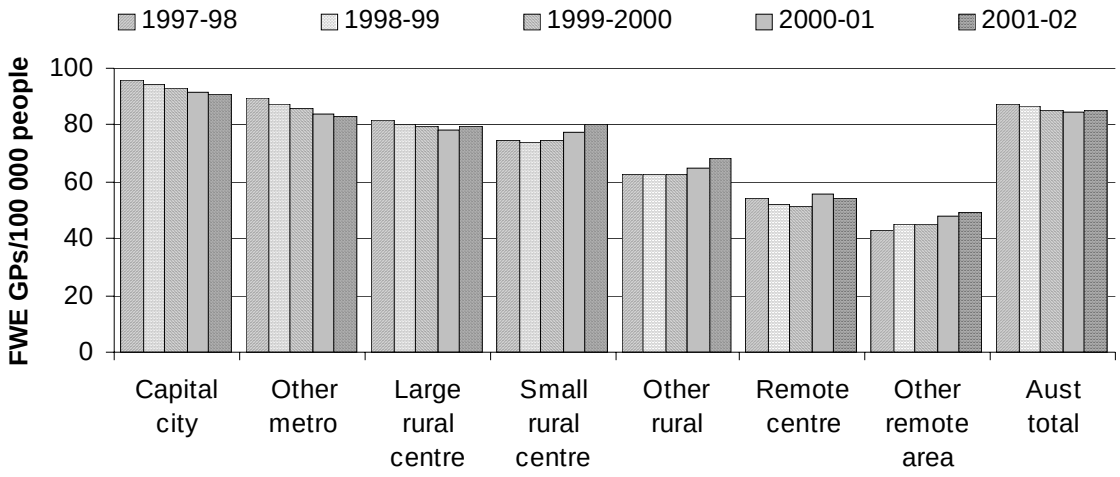
Full time workload equivalent GPs in rural and remote areas

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 10.26).

There were 84.9 FWE GPs per 100 000 people in Australia in 2001-02 — 90.8 per 100 000 in capital cities; 54.5 per 100 000 in remote centres; and 49.0 in other remote areas (figure 10.26).

Figure 10.26 **Full time work load equivalent GPs per 100 000 people by region[a]**



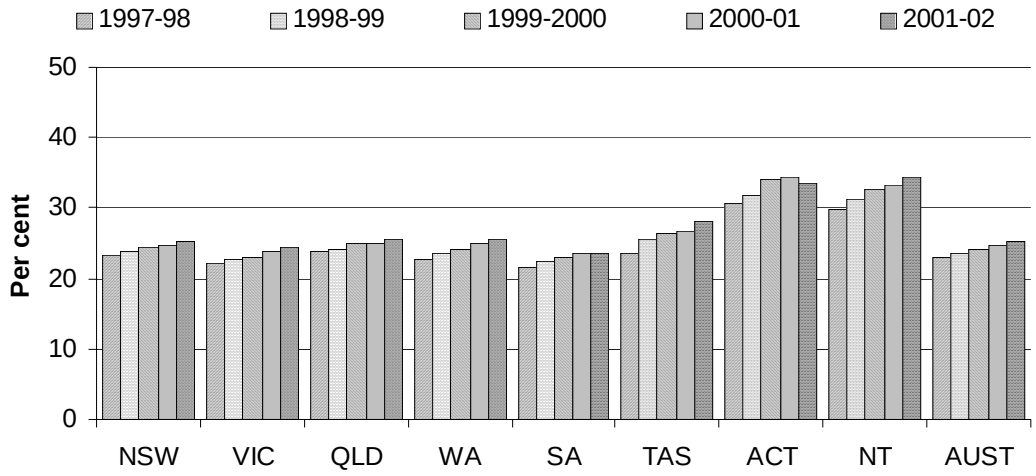
a Capital city = State and Territory capital city statistical divisions; Other metropolitan centre = one or more statistical subdivisions that have an urban centre with a population of 100 000 or more; Large rural centre = Statistical Local Areas (SLAs) where most of the population resides in urban centres 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 5000 or more; Other remote area = all remaining SLAs in the remote zone.

Source: DHA (unpublished); table 10A.37.

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. There were 24 307 GPs in 2001-02, with 8510 of these being female. Approximately one-third of total GPs are females, representing approximately one-quarter of FWE GPs (tables 10A.9 and 10A.38). The proportion of female FWE GPs in 2001-02 was highest in the NT (34.4 per cent) and lowest in SA (23.7 per cent) (figure 10.27). In 2001-02, there were 42.4 female FWE GPs per 100 000 female population compared with a total of 84.9 male and female FWE per 100 000 people (tables 10A.9 and 10A.38).

Figure 10.27 **Female full time workload equivalents as a proportion of all FWE GPs**



Source: DHA (unpublished); table 10A.38.

Efficiency

Unit cost

The cost to government of general practice per person is the only suggested efficiency indicator for GP services at this stage.[8] This indicator should be 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). As previously mentioned, some primary care services are provided by salaried GPs in community health

8 Includes non-Medicare funding and expenditure by the DVA.

settings, particularly in rural and remote areas through accident and emergency departments and ACCHSs. Consequently, expenditure reported through Medicare fee-for-service statistics will be understated in jurisdictions with larger proportions of rural and remote populations.

Nationally, the annual cost per person in 2001-02 was $159 (figure 10.1). Commonwealth expenditure in that year was highest in SA ($170 per person) and lowest in the NT ($89 per person) (table 10A.8).

10.5 Future directions in performance reporting

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, the Review is developing 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. 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, general 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 10.3). The Steering Committee is hopeful that progress will be made in both these areas to enable future reporting.

Box 10.3 **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.[9] A nonrandom 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 nonrandom 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).

9 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.

10.6 Definitions

Table 10.7 **Terms**

Term	*Definition*
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 person	Cost to the Commonwealth Government of total non-referred attendances by non-specialist medical practitioners per person.
Divisions of General Practice	Geographically based networks of GPs. Currently there are 121 Divisions of General Practice. The Divisions of General Practice Program (DGPP) evolved from the former Divisions and Projects Grants Program established in 1992. The aim of the DGPP is to improve health outcomes for patients by encouraging GPs to work together and link with other health professionals to upgrade the quality of health service delivery at the local level. 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 Diptheria, Tetanus, Pertussis 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 Diptheria, Tetanus, Pertussis vaccine, three doses of Oral Polio Vaccine, four doses of HbOC (HibTITER) (or three doses of PRP-OMP (PedvaxHIB)) and one dose of Measles, Mumps, 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 FTEs 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. Includes medical practitioners who work solely with one specific population, such as women's health and Indigenous health.

(Continued on next page)

Table 10.7 **(Continued)**

Term	*Definition*
General practitioner	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, 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	• Hospital separation rates for complications of Type 2 diabetes mellitus. • Hospital separation rates for diseases of the circulatory system — diagnoses where Type 2 diabetes mellitus was an additional diagnosis. • Hospital separations for lower limb amputations where Type 2 diabetes mellitus was a principal or additional condition.
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 1000 people 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 *Haemophilus influenzae* 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 10.7 **(Continued)**

Term	*Definition*
Other specialist	A medical practitioner not classified as a 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 which includes services that: • 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).
Preventative 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 recognition	Number of full time workload equivalent GPs who are vocationally recognised 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 Incentives 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 10.7 **(Continued)**

Term	*Definition*
Psychiatrist	A 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 recognition	Vocationally recognised GPs are registered separately for Medicare purposes, and receive higher Medicare benefits for services.

10.7 References

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11 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 and the health management performance measurement framework is provided in sections 11.1 and 11.2 respectively. Sections 11.3 and 11.4 report on the performance of breast cancer and mental health management respectively. Section 11.5 outlines the future directions for the chapter, and jurisdictions' comments relating to all the health chapters are summarised in section 11.6. Definitions are listed in section 11.7.

Improvements to reporting of breast cancer detection and management include:

- the reporting of descriptive information on cancer survival rates;
- replacement of the reporting of 'size and grade of screen-detected invasive breast cancers' by the reporting of size only. This is because the previous indicator was not easily interpreted. Further, the size of breast cancers at the time of detection is a better measure of the effectiveness of the screening program because women with smaller sized cancers generally have a better prognosis;
- changing the definition of a 'small invasive cancer' to achieve consistency with the BreastScreen Australia National Accreditation Standards and to enable comparison with international standards;
- reporting a new indicator reflecting the overall breast cancer detection rate; and
- replacing the indicator, 'ratio of benign to malignant diagnostic open biopsies' previously reported with a measure from the National Accreditation Standards relating to the effectiveness of pre-operative diagnosis.

Improvements to reporting of mental health management include:

- modifications to reporting recurrent spending and mental health patient days to improve comparability;
- changes to reporting separations and reporting of the number of beds;

- modifications to appropriateness indicators to reflect the objectives in the National Mental Health Strategy; and
- inclusion of an interim indicator reporting progress in the collection of client outcomes data.

Supporting tables

Supporting tables for chapter 11 are provided on the CD-ROM enclosed with the Report. The files are provided in Microsoft Excel 97 format as \Publications\Reports\2003\Attach11A.xls and in Adobe PDF format as \Publications\Reports\2003\Attach11A.pdf.

Supporting tables are identified in references throughout this chapter by an 'A' suffix (for example, table 11A.3 is table 3 in the electronic files). 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 these tables (see details on the inside front cover of the Report).

11.1 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, arthritis and musculoskeletal conditions. 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 subject of programs designed to improve public health (box 11.1). 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 9 and 10 respectively.)

Box 11.1 **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 cancer and cervical screening services); and
- provision of health services (for example, school dental services, and drug and alcohol treatment services).

Promotion, protection and prevention activities are 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 — general practitioners (GPs), public hospitals and community health services. GPs 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 (dieticians, community nurses, psychologists and so on). This multidisciplinary approach makes it difficult to attribute health outcomes to a particular service or provider.

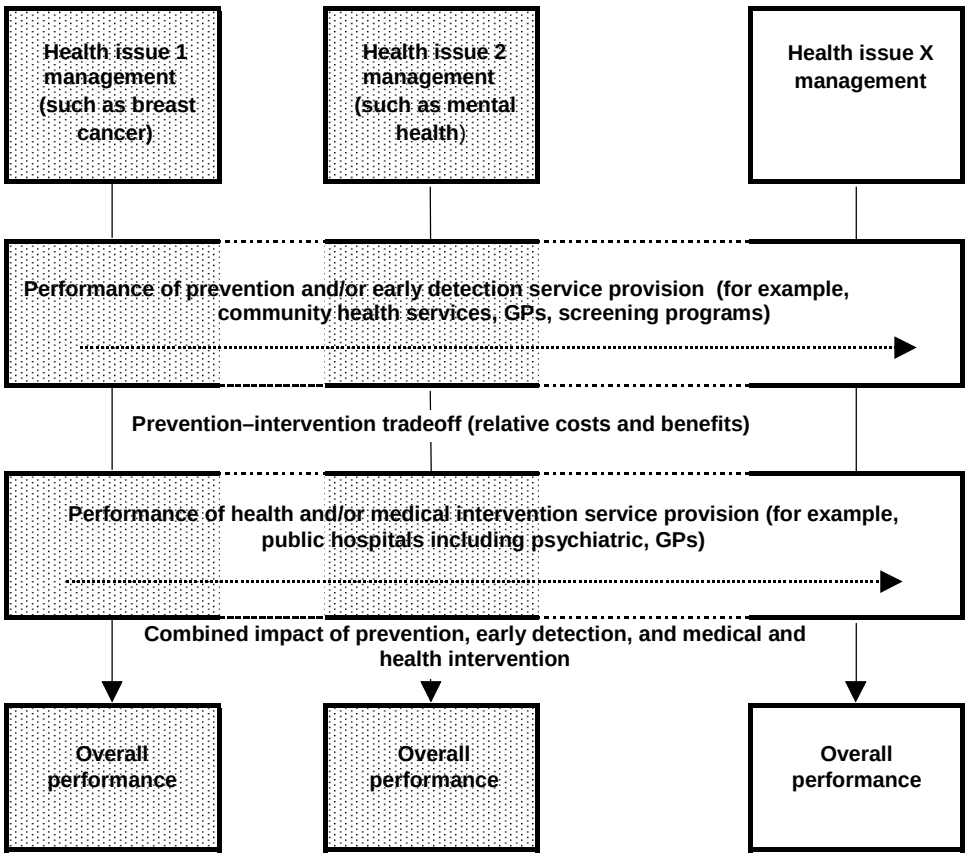
Source: Australian Institute of Health and Welfare (AIHW) (1998a); Fry (1994) and NPHP (1997).

11.2 Framework for measuring the performance of health management

The Health preface of this Report outlines the complexities of reporting on the performance of the overall health system in meeting its objectives. Frameworks for public hospitals and 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.

The measurement approach adopted in this chapter is represented diagrammatically (figure 11.1).

Figure 11.1 **Australian health system — measurement diagram**



The appropriate mix of services, including the prevention of illness and injury, 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 chapter 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.

11.3 Breast cancer

Profile

Breast cancer is a disease whereby uncontrolled or malignant cell division leads to the formation of a tumour or tumours in a woman's breast (box 11.2).[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 *ductal carcinoma in situ* (non-invasive tumours residing in the ducts of the breast).

[1] Breast cancer in males is very rare and is not examined in this Report.

Box 11.2 **Some common health terms used in breast cancer management**

Breast conserving surgery: an operation to remove the breast cancer but not the breast itself. Types of breast conserving surgery include lumpectomy (removal of the lump), quadrantectomy (removal of one quarter of the breast), and segmental mastectomy (removal of the cancer as well as some of the breast tissue around the tumour and the lining over the chest muscles below the tumour).

Ductal carcinoma in situ (DCIS): abnormal cells that involve only the lining of a duct. The cells have not spread outside the duct to other tissues in the breast. DCIS is also known as intraductal carcinoma.

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 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.

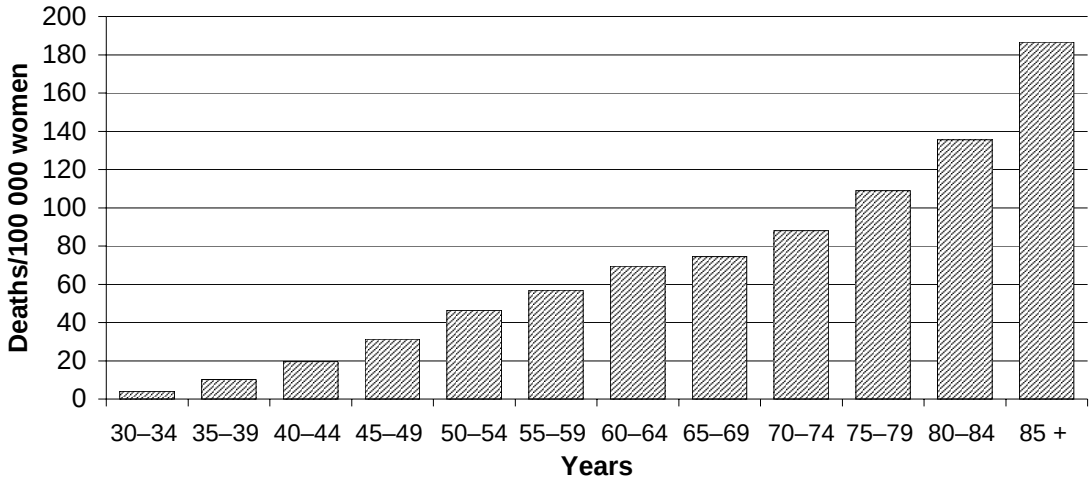
Screening round (first): a woman's first visit to a BreastScreen Australia mammography screening service.

Screening round (subsequent): a woman's visit to a BreastScreen Australia mammography screening service when she has attended such a service before.

Total mastectomy: removal of the breast. This is also known as simple mastectomy.

Breast cancer was responsible for 2505 female deaths in 1999 and 2511 female deaths in 2000, making it the most frequent cause of death from cancer for females (ABS 2000, 2001). The strong relationship between age and the mortality rate from breast cancer is shown for the period 1996–99 in figure 11.2. Whereas women aged 40–44 years have a mortality rate of 19.5 per 100 000 women, women aged 75–79 have a mortality rate of 108.9 per 100 000 women.

Figure 11.2 **Age-standardised mortality rates from breast cancer by age group, 1996–99[a]**

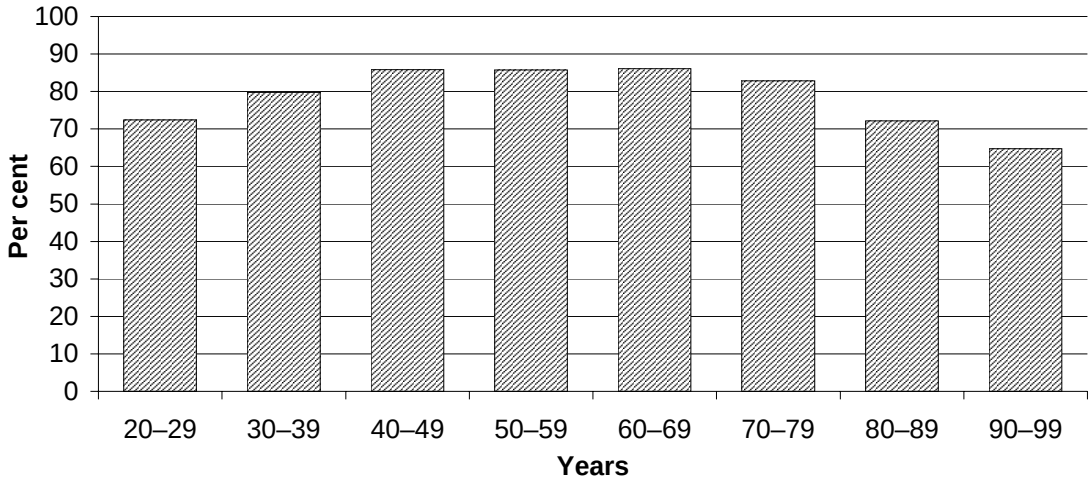


a Rates are expressed per 100 000 women and are age-standardised to the Australian population at 30 June 1991.

Source: AIHW (unpublished); table 11A.22.

Relative survival after diagnosis of breast cancer in females is good when compared with other cancers. Over the period 1992–1997, for women of all ages in Australia, relative survival one year after diagnosis was 96.4 per cent, and five years after diagnosis was 84.0 per cent. Relative survival 10 years after diagnosis was 68.3 per cent in the period 1987–1991 (AIHW and Australasian Association of Cancer Registries 2001). The five-year relative survival rate for breast cancer in Australia at diagnosis over the period 1992–97 increases with age from the age group 20–29 years (72.4 per cent) to a peak for the age groups 40–49 years (85.8 per cent), 50–59 years (85.7 per cent) and 60–69 years (86.1 per cent). The five-year relative survival rate declined with age for women over 70 years (figure 11.3).

Figure 11.3 **Breast cancer five-year relative survival rate in Australia at diagnosis 1992–97[a]**



a Five-year relative survival results for the 0–19 age group are not presented as interpretation is made difficult by statistical instability.

Source: AIHW *et al.* (2001)*;* table 11A.5.

Incidence and prevalence

Breast cancer is the most common cancer affecting Australian women. 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 increased from 7997 in 1992 to 10 702 in 1998 (table 11.1). 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).

Age-standardised incidence rates of breast cancer are presented in figure 11.4. (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, the latest year for which data are available for all jurisdictions (table 11A.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). Data for the ACT were not available in 1999, but across the other jurisdictions, incidence rates were highest in Queensland (103.6) and lowest in the NT (77.1).

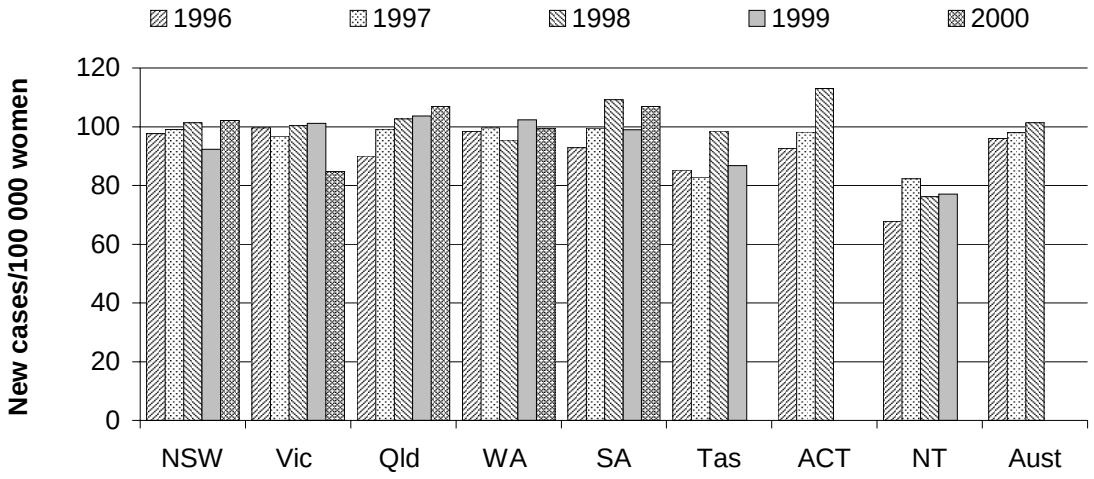
Table 11.1 **New cases of breast cancer diagnosed (number)**[a]

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
1992	2 683	2 123	1 345	748	763	203	100	32	7 997
1993	3 032	2 256	1 534	773	794	246	114	29	8 778
1994	3 318	2 657	1 587	847	822	287	140	45	9 703
1995	3 490	2 647	1 615	944	911	255	150	32	10 044
1996	3 401	2 612	1 582	878	825	227	134	46	9 705
1997	3 531	2 605	1 787	915	894	231	140	52	10 155
1998	3 703	2 719	1 887	924	983	272	171	43	10 702
1999	3 455	2 779	1 979	1 018	928	244	**na**	46	**na**
2000	3 842	2 839	2 100	1 009	996	**na**	**na**	**na**	**na**

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. **na** Not available.

Source: AIHW National Cancer Statistics Clearing House (for years 1992 to 1998); Australasian Association of Cancer Registries (unpublished) (for years 1999 and 2000); table 11A.1.

Figure 11.4 **Age-standardised incidence rates of breast cancer, women of all ages**[a, b, c]



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. **c** Data for 2000 were not available for Tasmania, the ACT and the NT. Data for 1999 were not available for the ACT. It is not possible to calculate Australian rates for these years. In absolute terms, small jurisdictions tend to have low incidence numbers that can result in large variations in rates from year to year, and for this reason data from 1999 and 2000 for the ACT have not been published.

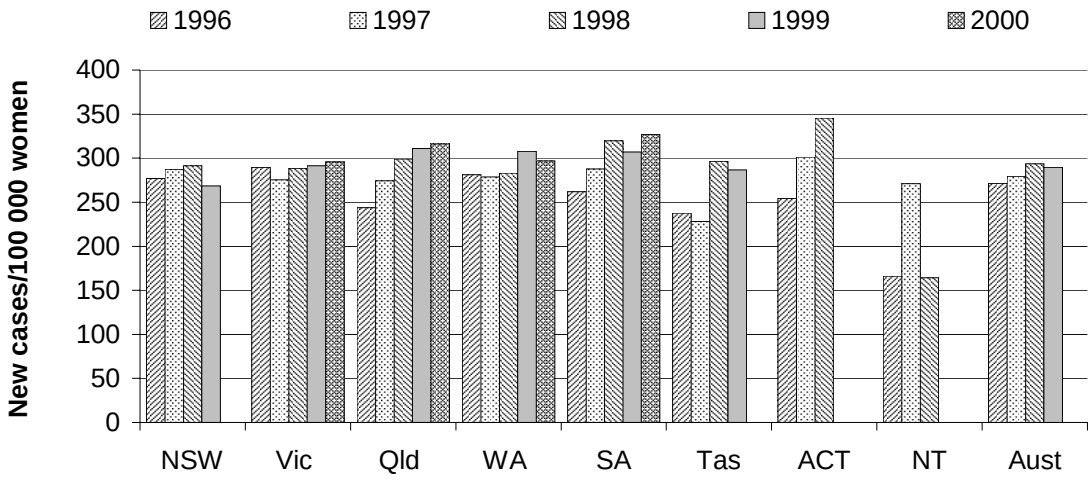
Source: AIHW National Cancer Statistics Clearing House (for years 1996 to 1998); Australasian Association of Cancer Registries (unpublished) (for years 1999 and 2000); table 11A.2.

Age-standardised incidence rates of breast cancer for women aged 50–69 years are shown in figure 11.5. Data for 2000 are not available for NSW, Tasmania, the ACT and the NT, although NSW provided crude rates (table 11A.4). For 2000, for jurisdictions where data are available, incidence rates were highest in SA (327.0 per

100 000 women) and lowest in WA (296.7 per 100 000 women) and Victoria (295.9 per 100 000 women). Data for 1999 are not available for the ACT and the NT. For the other jurisdictions, incidence rates were highest in Queensland (311.2 per 100 000 women) and lowest in NSW (268.6 per 100 000 women).

Incidence rates can vary significantly from year to year particularly for the smaller jurisdictions. In absolute terms, small jurisdictions tend to have low incidence numbers that can result in large variations from year to year. In future reports, incidence data will be presented averaged over a number of years to overcome this problem.

Figure 11.5 **Age-standardised incidence rates of breast cancer, women aged 50–69 years[a, b, c]**



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. **c** Data for 2000 were not available for NSW, Tasmania, the ACT and the NT, although NSW provided crude data for this year. It is not possible to calculate an Australian rate for this year. Data for 1999 were not available for the ACT and the NT. In absolute terms, small jurisdictions tend to have low incidence numbers that can result in large variations in rates from year to year, and for this reason data from 1999 and 2000 for the ACT have not been published.

Source: Australasian Association of Cancer Registries (unpublished); table 11A.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).

The focus of breast cancer control is on the use of screening mammography to enable early detection of breast cancer. There is evidence that population-based screening of women aged 50–69 can reduce deaths from breast cancer. According to the National Breast Cancer Centre (NBCC), 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 2002). It is generally argued that cancers detected early may be treated more conservatively and these women generally have a higher likelihood of survival.

A recent review of mammography screening research cast doubt on the evidence that screening for breast cancer reduces mortality, raising questions about the positive impact of screening on population health. It has also been suggested that screening may lead to more aggressive treatment that in some cases may be unnecessary (Olsen and Gotzsche 2001). There is also some morbidity associated with breast cancer screening, such as false positives, discomfort and anxiety. In addition, screening techniques have improved to the extent that very small growths can now be detected, however, the risk of such growths posing a future danger are uncertain (Gorman 2002).

In response to these doubts, a Working Group convened by the International Agency for Research on Cancer of the World Health Organisation evaluated the available research on breast cancer screening in March 2002. The group concluded that there is sufficient evidence of the efficacy of mammography screening for women aged between 50 and 69 years. The reduction in mortality from breast cancer among women who choose to participate in screening programs was estimated to be around 35 per cent. For women aged 40–49 years, there is only limited evidence of a reduction in mortality. When considering population screening models, the Working Group concluded that the effectiveness of national screening programs varies due to differences in coverage of the female population, quality of mammography, quality and appropriateness of treatment, and other factors. Organised screening programs are more effective in reducing death rates from breast cancer than sporadic screening of selected groups of women. The group also concluded that there is insufficient evidence that clinical breast examination or self examination reduces mortality from breast cancer (WHO 2002).

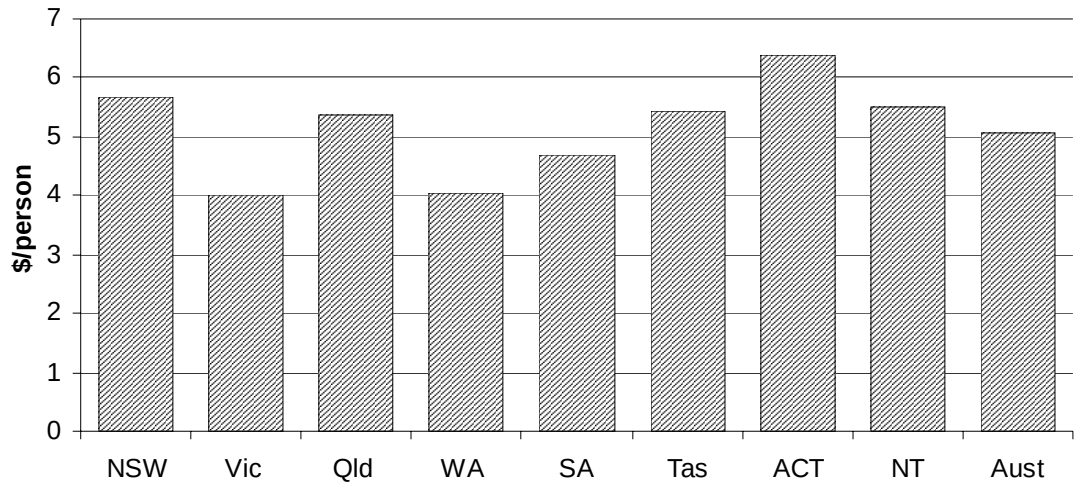
BreastScreen Australia, jointly funded by the Commonwealth, State and Territory governments, undertakes nationwide breast cancer screening. BreastScreen Australia targets women aged 50–69 years for screening once every two years. The program aims to have 70 per cent or more women aged between 50 and 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 include all screening and assessment services up to the point of diagnosis and referral for treatment. The program includes health promotion activities, information provision, counselling and data collection across the screening pathway. Each jurisdiction also manages a central Breastscreen Registry for quality assurance, monitoring and evaluation of the program. Some jurisdictions, however, do not include open biopsies in the funded program (table 11A.6).

Estimates of government expenditure on breast cancer screening by jurisdiction are presented in the attachment (table 11A.7) and estimates of expenditure on screening per person in each jurisdiction are presented in figure 11.6. The jurisdictional estimates include Commonwealth, State and Territory government expenditure.

Figure 11.6 **Public health expenditure on breast cancer screening, 1999-2000 financial year**[a, b, c, d, e, f, 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. **b** The data need to be viewed with care because of data deficiencies, differences across jurisdictions relating to the use of cash accounting and accrual methods, the treatment of corporate and central office costs, differences in methods used to collect expenditure figures and differences in the interpretation of public health expenditure definitions. **c** The Australian total includes Commonwealth direct project expenditure, database or registry and other program support, population health non-grant program costs and running costs. **d** Medicare funding for radiographic breast examinations is excluded as it is not public health expenditure. **e** Victorian data include depreciation. **f** Data for the ACT include expenditure on BreastScreen ACT and the Cancer Registry. **g** Data for the NT for direct expenditure include public health information systems, disease surveillance and epidemiological analysis, public health communication and advocacy, public health policy, program and legislation development, and public health workforce development.

Source: AIHW (2002c); table 11A.7.

Around $97.2 million was spent by governments on breast cancer screening in 1999-2000 (table 11A.7). Differences across jurisdictions will in part reflect variation in the proportion of women in the target age group for breast cancer screening, data deficiencies and collection methods, as well as the nature of the services and their relative efficiency. Some of the difference may also be due to the geography of a State or Territory and to the proportion of women living in rural and remote areas that need to be reached by BreastScreen Australia services. The data need to be viewed with care.

The number of women aged 40 years and over screened by BreastScreen Australia services provides an indication of the size of the BreastScreen Australia program. Around 836 000 women over 40 years of age were screened in 2001 (table 11.2).

Table 11.2 **Number of women screened by BreastScreen Australia[a]**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*
1999	273 995	171 366	153 931	59 993	64 194	19 382	12 256	**na**
2000	277 400	177 232	163 722	65 581	65 494	21 314	11 438	4 146
2001	297 372	188 677	171 308	71 431	69 774	20 703	12 144	4 409

a First and subsequent screening rounds, women aged 40 years and over. **na** Not available.

Source: State and Territory governments (unpublished); table 11A.8.

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 followup. Relevant clinical disciplines include surgery, plastic and reconstructive surgery, pathology, radiation and medical oncology, nursing, diagnostic radiology, 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 followup and palliative care services (DHS [Victoria] 1999).

Inpatient separations in public hospitals for selected breast cancer related diagnosis related groups (DRGs) in 1999-2000 are presented in table 11.3. 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.

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.

Table 11.3 **Separations for selected DRGs related to breast cancer, public hospitals (AR-DRG version 4.1) 1999-2000 ('000)**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
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.

Source: AIHW (2001b); table 11A.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

[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.

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 2002-03 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 have previously been reported by symptom status. For the 2002 and 2003 Reports, stratification of reporting by symptom status has been temporarily discontinued until symptom status can be more accurately defined.

Changes to the National Accreditation Standards have affected other indicators. The definition of 'small' for small invasive cancers has changed from 10 millimetres or less to 15 millimetres or less. The small invasive cancer detection rate is an indicator of the ability of the program to identify breast cancers at an early stage. The likelihood of mortality is reduced and breast conserving surgery is greatest when cancers are detected early. The change to the standard reflects that women with cancers of a diameter of 15 millimetres or less have a similarly positive prognosis to those with cancers of diameter 10 millimetres or less.

In addition, there are new National Accreditation Standards that relate to the detection of invasive breast cancers or DCIS without the need for diagnostic open biopsy through invasive surgery. These standards replace the standard measuring the benign to malignant ratio at diagnostic open biopsy due to more recent technical improvements in pre-operative diagnosis at the assessment stage. Accurate diagnoses are increasingly determined through less invasive core biopsies during the assessment of breast abnormalities and without the need for hospitalisation for more invasive diagnostic open biopsies. The change also reflects international standards and will allow for comparison of the effectiveness of breast cancer screening in Australia with that of other comparable programs overseas.

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 11.3).

Box 11.3 **Objective for breast cancer detection and management**

The objective for breast cancer detection and management is to reduce morbidity and mortality attributable to breast cancer and to improve the quality and duration of life of women with breast cancer in a manner that is equitable and efficient.

The performance indicator framework shows which data are comparable in the 2003 Report (figure 11.7). For data that are not considered strictly comparable, the text includes relevant caveats and supporting commentary. Chapter 1 discusses data comparability from a Report-wide perspective (see section 1.6).

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. A similar approach is adopted for Emergency management (chapter 8).

It should be noted that there are still insufficient data available on areas other than early detection through BreastScreen Australia. As a result, this chapter does not yet fully provide a balance of information on all aspects of breast cancer management.

Key performance indicator results

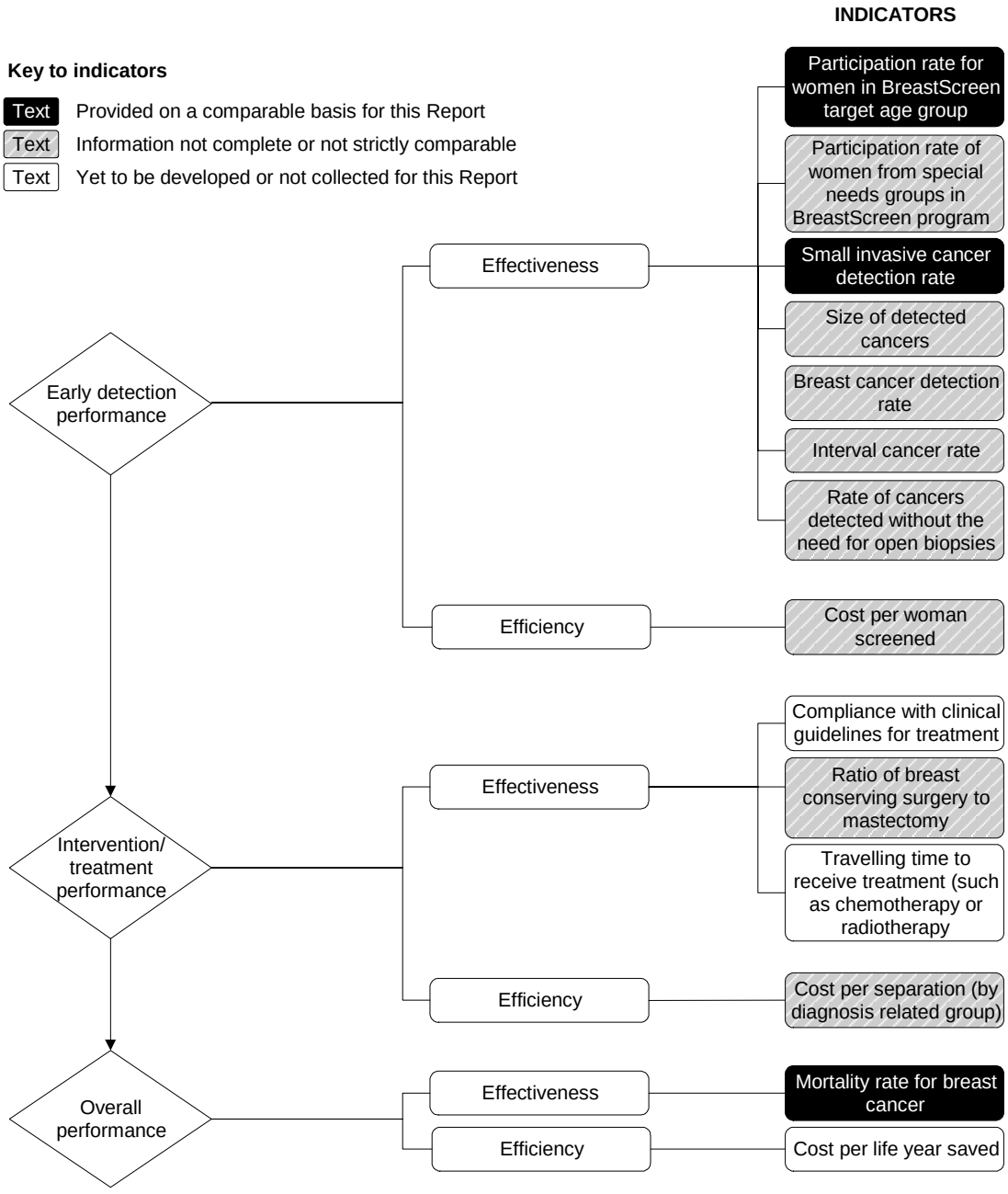
As mentioned, with significant amounts of data relating to breast cancer screening available, this is the focus of reporting. Data relating to the management and treatment of breast cancer are less readily available and it is a priority of the Review to extend reporting in this area in future.

Early detection

Participation rate of women in the target age group

The participation of women in the target age group in breast cancer screening is an indicator of the accessibility of the breast cancer screening programs. An objective of BreastScreen Australia is to achieve, after five years, a 70 per cent participation rate in the BreastScreen Australia Program by women in the target group (50–69 years) and access to the Program for women aged 40–49 years and 70–79 years (BreastScreen Australia 2002).

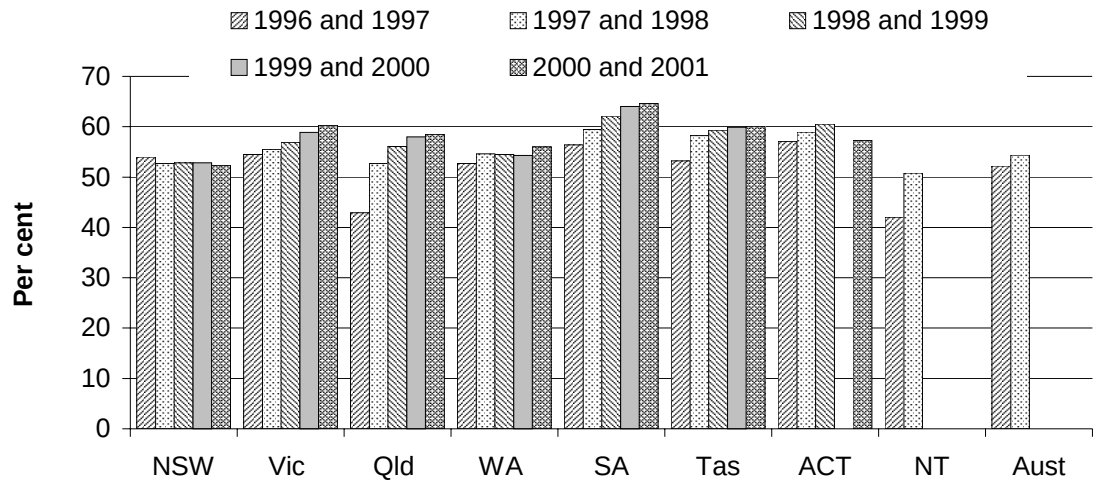
Figure 11.7 **Performance indicators for breast cancer detection and management**



Data for 2000-01 were not available for the NT. In the 24-month period 2000–2001, the participation rate for women aged 50–69 was highest in SA (64.6 per cent) and lowest in NSW (52.3 per cent) (figure 11.8). It should be noted that data for 1996–97, 1997–98 and 1998–99 were sourced from the Australian Institute of Health and Welfare (AIHW) and more recent data were sourced from State and Territory governments. There may be differences in method between the two sources which cause a break in the time series. Further, crude rates are presented because age-

standardised rates are not available for a number of jurisdictions for women aged 50–69 years.

Figure 11.8 **Participation rates of women aged 50–69 years in BreastScreen Australia screening programs (24-month period)[a, b, c, d]**



a The participation rate is the number of individual women resident in the catchment area of the jurisdiction screened during the 24-month period, divided by the number of women resident in the catchment area using ABS estimated resident populations (ERP). This value will represent the estimated population at the midpoint of the reference period. It will be an average of the two ERPs for the two calendar years (by adding both years and then dividing by two). 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 the population, accessibility and the location of other services. It is uniquely defined for each service based on postcode or Statistical Local Area (SLA). **b** Crude rates. **c** 2000–01 data were not available for the NT. 1999–2000 data for women aged 50–69 were not available for 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, 1997–98 and 1998–99 are sourced from the AIHW and data for 1999–2000 and 2000–01 are sourced from jurisdiction governments. There may be differences in method between the two sources which cause a break in the time series.

Source: State and Territory governments (unpublished); AIHW (1998a and 2000b); table 11A.10.

Participation rates of women from selected community groups in BreastScreen Australia programs

The participation rate of women from selected groups in the community (that is, Indigenous women, women from non-English speaking backgrounds (NESB), 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 11.4. Crude rates are reported because age-standardised rates are not available for a number of jurisdictions for women aged 50–69 years. Differences across jurisdictions in the

collection of Indigenous, NESB and rural and remote status make comparisons difficult. Care needs to be taken when comparing data across jurisdictions.

In most jurisdictions, participation rates for Indigenous women aged 50–69 years 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 nonmetropolitan areas are generally higher than the rates for women in metropolitan areas. The rates for women from NESB aged 50–69 years are higher than for the total female population aged 50–69 years in Victoria and Queensland and lower in other States for the 24-month periods 1999–2000 and 2000–2001.

Table 11.4 **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*
1998–1999 (24-month period)								
Indigenous[c]	35.1	**na**	54.4	42.7	43.0	42.5	52.0	**na**
NESB[d]	46.7	57.2	65.6	56.0	57.7	33.8	59.0	**na**
Metropolitan or capital city[e]	52.1	55.8	53.5	51.4	60.3	58.6	61.0	**na**
Rural and remote or rest of State[f]	57.3	63.7	59.8	63.8	68.2	58.6	**na**	**na**
Total 50–69 years	52.8	56.9	56.1	54.5	62.1	59.3	60.5	**na**
1999–2000 (24-month period)								
Indigenous[c]	29.1	49.0	47.1	35.6	41.9	59.1	48.0	**na**
NESB[d]	42.4	61.0	65.6	48.0	53.8	28.1	**na**	**na**
Metropolitan or capital city[e]	50.7	56.0	55.0	50.7	61.4	60.9	**na**	**na**
Rural and remote or rest of State[f]	56.6	66.0	61.0	60.9	64.2	59.9	..	**na**
Total 50–69 years	52.8	58.9	58.0	54.3	64.0	59.9	**na**	**na**
2000–2001 (24-month period)								
Indigenous[c]	32.6	51.0	48.8	35.4	43.6	66.2	36.0	**na**
NESB[d]	42.4	65.0	67.1	50.6	53.7	28.9	57.1	**na**
Metropolitan or capital city[e]	51.6	58.0	57.1	54.7	63.5	62.7	57.3	**na**
Rural and remote or rest of State[f]	59.4	66.0	62.4	58.5	67.7	62.8	..	**na**
Total 50–69 years	52.3	60.2	58.5	56.0	66.0	60.1	57.3	**na**

a First and subsequent rounds. **b** Crude rates. **c** 'Indigenous' is defined as women who have self identified as being of Aboriginal or Torres Strait Islander descent. **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' 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 11A.10 and 11A.11.

Breast cancer detection rate

The breast cancer detection rate is reported for the first time this year. It is an indicator of the effectiveness of screening services in identifying breast cancers at an early stage. Mammographic screening aims to reduce mortality from breast cancer by detecting cancers while they are still small and localised to the breast. The size of the breast cancer at diagnosis is an independent prognostic indicator of survival, as the smaller the size of the breast cancer diagnosed, the better the chance of effective treatment.

Figure 11.9 reports the number of invasive cancers detected per 10 000 women screened aged 50–69 years by screening round. Detection rates for DCIS per 10 000 women screened are reported in the attachment (table 11A.12). Definitions are presented in box 11.2 and section 11.7. Data are reported by round as it is anticipated that larger cancers will be found in the first round of screening. In subsequent rounds, cancers should be smaller if the program is achieving what it has set out to achieve — that is, early detection of small cancers through regular two-yearly screening.

In the first round in 2001, Tasmania had the highest detection rates (111.0 per 10 000 women aged 50–69 years) while WA had the lowest (41.4 per 10 000 women aged 50–69 years). In the subsequent round in 2001, SA and WA (46.9 per 10 000 women aged 50–69 years and 46.3 per 100 000 aged 50–69 years respectively), had the highest detection rates while Victoria (37.8 per 10 000 women aged 50–69 years) had the lowest. Data for the NT were not available for 2001 (figure 11.9).

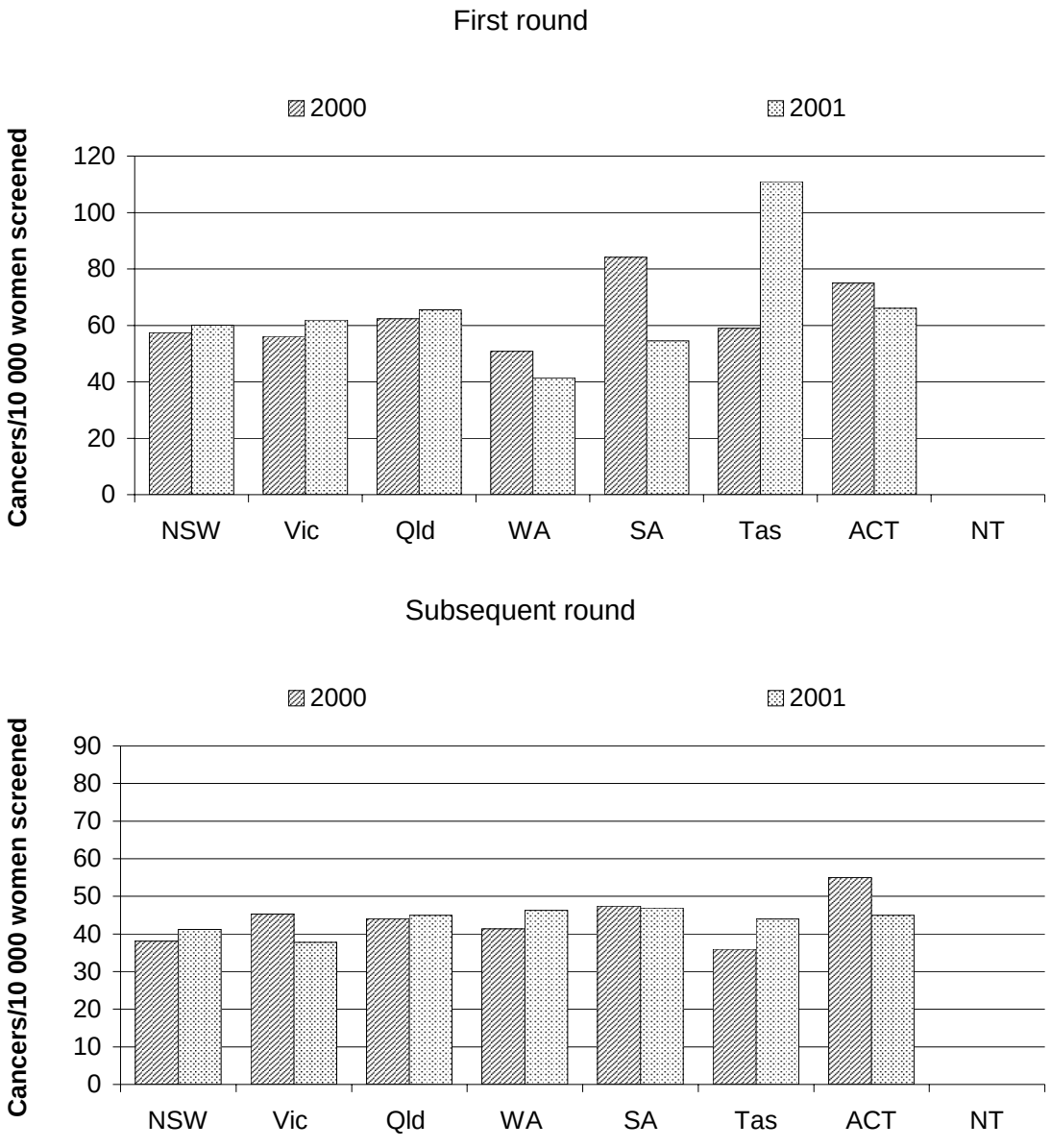
Crude rates are reported because age-standardised rates are not available for a number of jurisdictions for women aged 50–69 years. It should be noted that for the breast cancer detection rate, the reported crude rates differ quite substantially from the age-standardised rates. For example, in the first round in 2001, the ACT had an age-standardised rate of 92.5 per 10 000 women aged 50–69 years, compared to the crude rate of 66.0 per 10 000 women aged 50–69 years. In addition, in the first round in 2001, Queensland had an age-standardised rate of 73.5 per 10 000 women aged 50–69 years, compared to the crude rate of 65.5 per 10 000 women aged 50–69 years (table 11A.12).

The relevant BreastScreen Australia National Accreditation Standards are:

- greater than or equal to 50 per 10 000 women aged 50–69 years who attend for their first screen are diagnosed with invasive breast cancer;
- greater than or equal to 35 per 10 000 women aged 50–69 years who attend for their second or subsequent screen are diagnosed with invasive breast cancer;

- greater than or equal to 12 per 10 000 women aged 50–69 years who attend for their first screen are diagnosed with DCIS; and
- greater than or equal to seven per 10 000 women aged 50–69 years are diagnosed with DCIS (BreastScreen Australia 2002).

Figure 11.9 **Breast cancer detection rate, invasive cancers, for women aged 50–69 years[a, b]**



a Crude rates. **b** NT data not available.

Source: State and Territory governments (unpublished); table 11A.12.

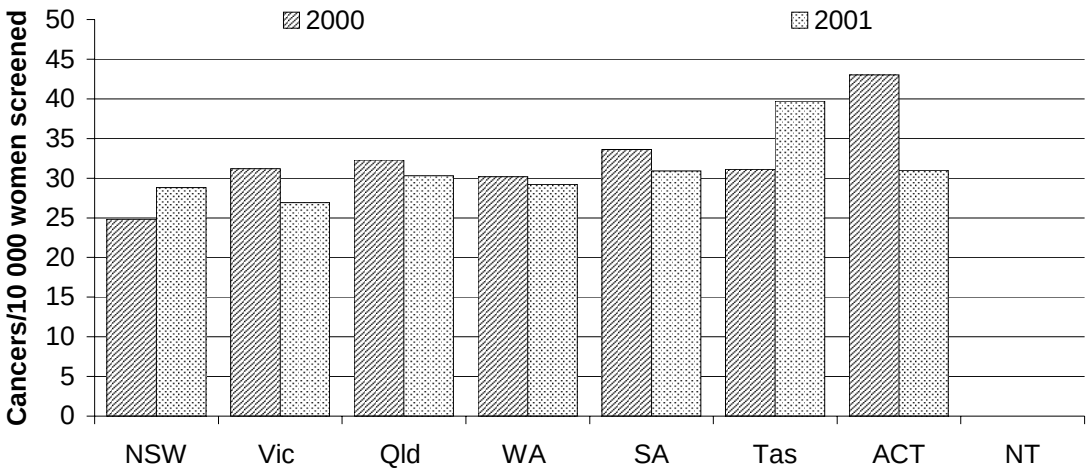
Small invasive cancer detection rate

The small invasive cancer detection rate is an important indicator of the effectiveness of breast cancer screening programs. Small cancers 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). To ensure consistency within the national accreditation standards, the definition of 'small' in the 'small invasive cancer detection rate' has changed this year from 10 millimetres or less, as reported in previous years, to 15 millimetres or less. The change reflects that women with cancers of a diameter of 15 millimetres or less have a similarly positive prognosis to women with cancers of diameter 10 millimetres or less.

The BreastScreen Australia National Accreditation Standard is that 25 or more per 10 000 women aged 50–69 years who attend screening are diagnosed with a small (15 millimetres or less) invasive breast cancer (BreastScreen Australia 2002). The previous national accreditation requirement was that more than eight per 10 000 screened women are diagnosed with an invasive cancer of diameter 10 millimetres or less. Data for the previous standard are reported in the attachment for the period 1996 to 2000 (table 11A.13).

Data for the revised standard are reported for 2000 and 2001 in table 11A.14 and figure 11.10. For women aged 50–69 years screened by BreastScreen Australia in 2000, the small invasive cancer detection rate (per 10 000 women screened) was highest in the ACT (43.0) and lowest in NSW (24.8). In 2001, the highest rate was in Tasmania (39.7) while the lowest was in Victoria (26.9). Data for 2000 and 2001 were not available for the NT. Crude rates are reported because age-standardised rates are not available for a number of jurisdictions for women aged 50–69 years (figure 11.10).

Figure 11.10 **Small diameter cancer detection rate, for women aged 50–69 years, all rounds of screening[a, b, c]**



a Crude rates. **b** Small diameter cancers were defined as invasive cancers up to and including 15 millimetres in diameter. **c** Data for the NT are not available.

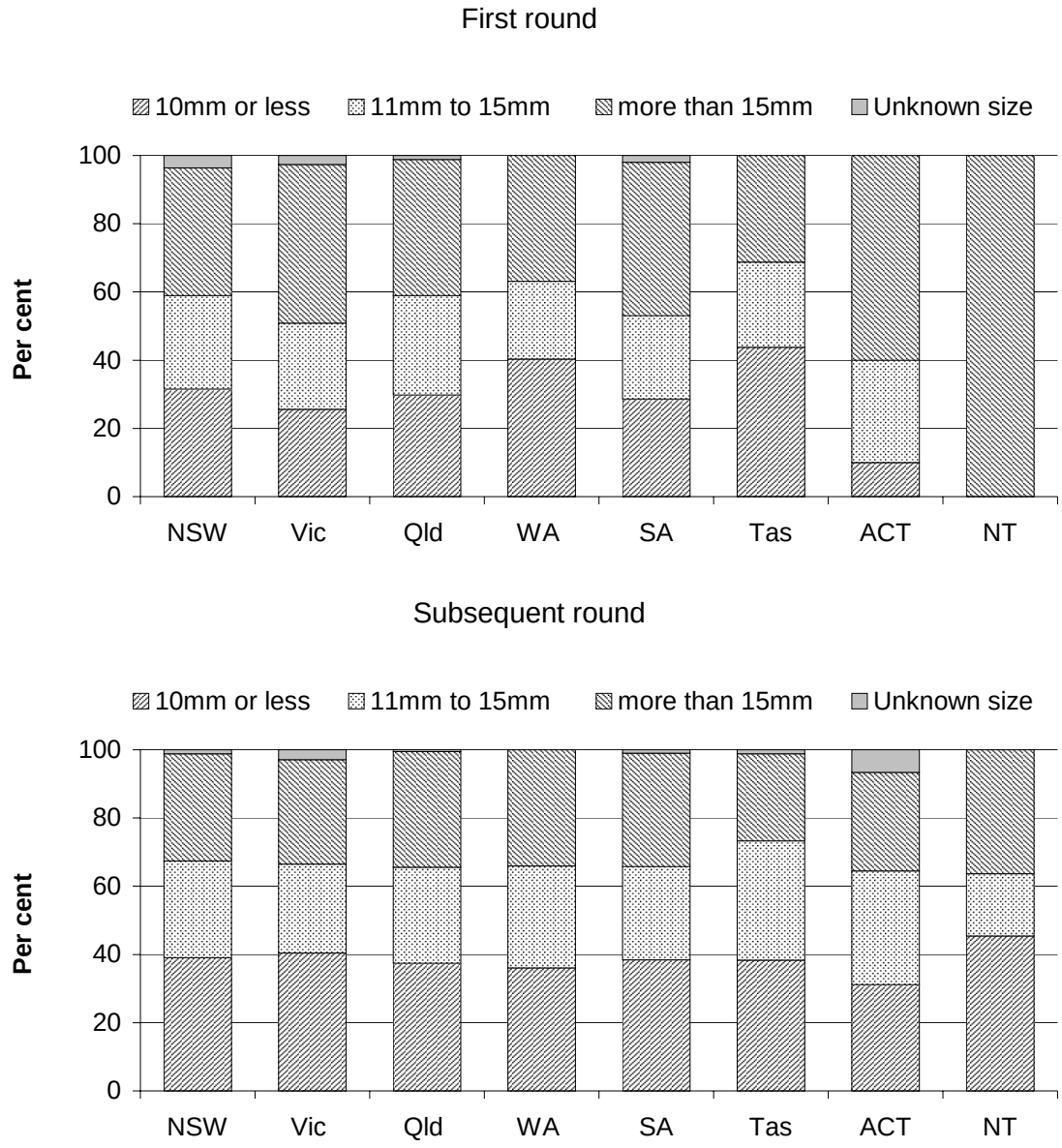
Source: State and Territory governments (unpublished); table 11A.14.

Size of detected cancers

The reporting of size and grade of detected invasive breast cancers has been replaced by the reporting of size by screening round (first and subsequent). Reporting by grade has been discontinued because the previous indicator was not easily interpreted.

Figure 11.11 presents the proportion of cancers by size by screening round for 2001. The source of the data is BreastScreen Australia and covers only clients of BreastScreen Australia. The data for 2001 reflect that larger cancers tend to be discovered in the first round, and smaller cancers detected in subsequent rounds.

Figure 11.11 **Detected invasive cancers by size as a proportion of total detected invasive cancers, women aged over 40 years, 2001[a, b]**



a Non-breast malignancies not counted. **b** The first round figure for the NT is based on one invasive cancer detected.

Source: State and Territory governments (unpublished); table 11A.15.

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 effectiveness and sensitivity

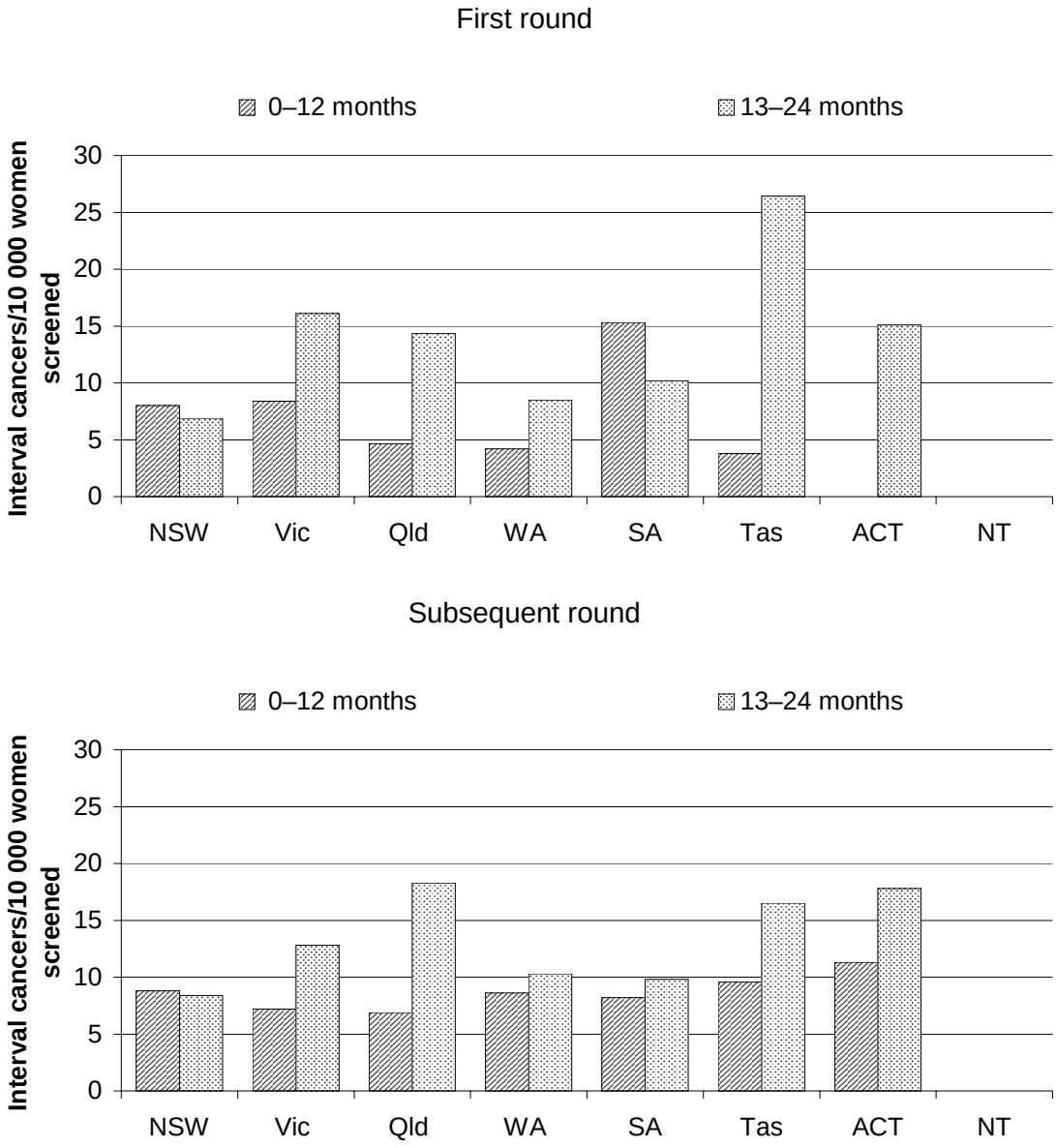
of breast cancer screening. The interval cancer rate should be interpreted in conjunction with the breast cancer detection indicators.

There is a time lag in obtaining data for this indicator due to the detection period falling between the last screening visit in the reference screening year and the next scheduled screening appointment. Following that period, a further lag time is required for the reporting of those cancers to the cancer registry before a process of data matching can occur between each jurisdiction's screening program and its cancer registry. As a result, the most recent data available for this Report are for women screened during 1998. As discussed in the policy developments section, data are not stratified by symptom status, and include both symptomatic and asymptomatic women.

Figure 11.12 presents the interval cancer rate by screening round for women aged 50–69 years. Differences in the rates across jurisdictions may be caused by differences in the policies of the BreastScreen services in each jurisdiction. Some jurisdictions, such as SA and some services in NSW, do not further investigate an abnormality of the breast, even when a symptom is reported, if the mammogram appears normal. These women are advised to visit their GP for a referral to a diagnostic service. This could have the effect of increasing the jurisdiction's interval cancer rate and reducing their cancer detection rate if an invasive breast cancer is subsequently diagnosed outside of the breast cancer screening program. Comparisons across jurisdictions therefore need to be made with care.

In 1998, for women aged 50–69 years in the first round of screening, the interval cancer rate 0–12 months following screening was highest in SA (15.3 per 10 000 women screened) and lowest in the ACT (zero per 10 000 women screened). In the subsequent screening round, the interval cancer rate 0–12 months following screening was highest in the ACT (11.3 per 10 000 women screened) and lowest in Queensland (6.9 per 10 000 women screened). Data for the NT were not available for the first or subsequent round. In the first round, the interval cancer rate 13–24 months following screening was highest in Tasmania (26.4 per 10 000 women screened) and lowest in NSW (6.9 per 10 000 women screened). In the subsequent screening round, the interval cancer rate 13–24 months following screening was highest in Queensland (18.3 per 10 000 women screened) and lowest in NSW (8.4 per 10 000 women screened).

Figure 11.12 **Interval cancer rate, asymptomatic and symptomatic, women aged 50–69 years, 1998**[a, b, c, d]



a Rates are expressed as the number of interval cancers per 10 000 women screened. **b** The numbers used to measure this indicator are small, resulting in large variations from year to year. It is reasonable to view this indicator over time rather than from one year to the next. **c** Rate for the first screening round for the ACT was zero. **d** Data for the NT were not available.

Source: State and Territory governments (unpublished); table 11A.16

Rate of cancers detected without the need for open biopsies

This is a new indicator, replacing the indicator 'ratio of benign to malignant diagnostic open biopsies'. The change reflects technical improvements in pre-operative diagnosis. Accurate diagnoses are increasingly determined through less invasive biopsies during assessment of breast abnormalities and without the need for hospitalisation for more invasive diagnostic open biopsies (surgery). Data for the old indicator — the ratio of benign to malignant diagnostic open biopsies — are reported for the calendar years 1996 to 2000 in table 11A.17.

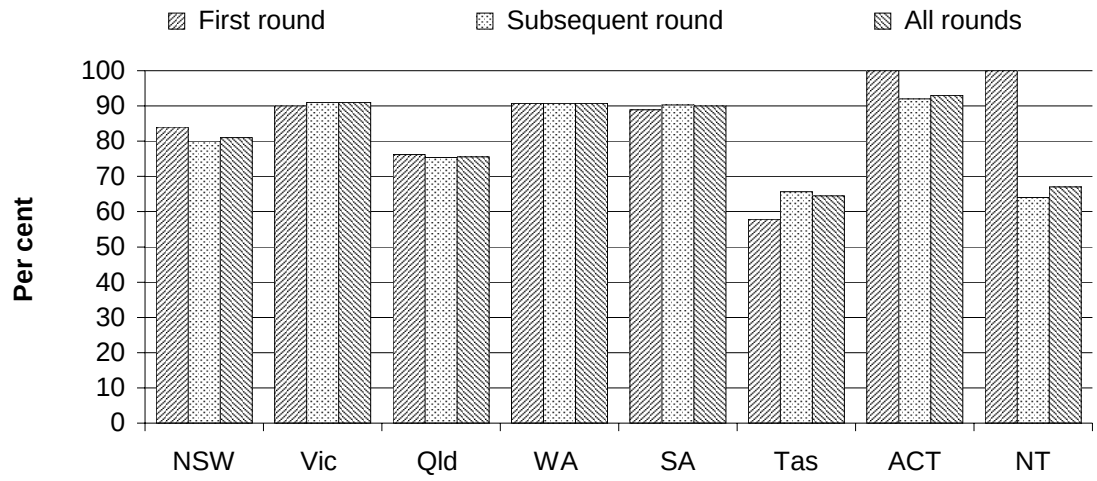
The new indicator reflects the proportion of women who were diagnosed with breast cancer without the need for a diagnostic open biopsy in relation to their screening visit during the reference year. The number of diagnoses without the need for a diagnostic open biopsy is divided by all breast cancers detected (invasive and DCIS). It is the measure of the effectiveness of the screening programs in diagnosing breast cancer without the need for a diagnostic open biopsy.

The BreastScreen Australia National Accreditation Standards state that 75 per cent or more of invasive cancers or DCIS should be diagnosed without the need for a diagnostic open biopsy. As the emphasis of breast cancer screening is on detecting small cancers, a high rate of cancers detected without the need for open biopsies indicates effectiveness in detecting malignancies while minimising the need for invasive procedures.[3]

In 2001, the rate of cancers detected without the need for open biopsies for women attending their first screening round was highest in the ACT and the NT (100 per cent in both jurisdictions) and lowest in Tasmania (58 per cent). In the subsequent round, the rate was highest in the ACT (92 per cent), Victoria and WA (91 per cent) and SA (90 per cent), and lowest in the NT (64 per cent) (figure 11.13).

[3] A breast biopsy is a procedure for obtaining a specimen of breast tissue for microscopic examination to establish a diagnosis.

Figure 11.13 **Rate of cancers detected without the need for open biopsies, all women, 2001**



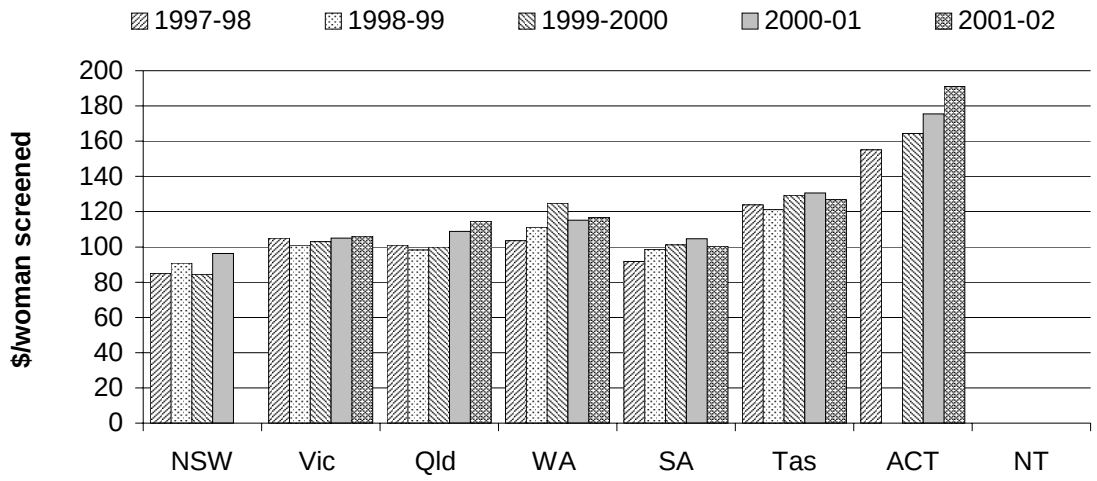
Source: State and Territory governments; table 11A.18.

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 program management.

Care needs to be taken when making comparisons across jurisdictions. There are potential differences in the items included in the measures of cost (particularly in the treatment of depreciation and capital asset charges, and inclusion of subsidies). There may also be differences across jurisdictions in the scope of activities being costed. Estimates of costs in each jurisdiction are presented in figure 11.14. NSW and the NT data were not available for the financial year 2001-02.

Figure 11.14 **Cost per woman screened, BreastScreen Australia services (financial year)[a, b, c, d]**



a Data for NSW do not include subsidies. **b** Data for Queensland includes depreciation and user cost of capital for 2000-01 and 2001-02 Both are excluded for 1997-98, 1998-99 and 1999-2000. **c** Data for SA calculated on accrual, not cash basis. **d** Data for the NT not available. Data for NSW not available for 2001-02.

Source: State and Territory governments; table 11A.19.

Intervention/treatment

Ratio of conserving surgery to mastectomy

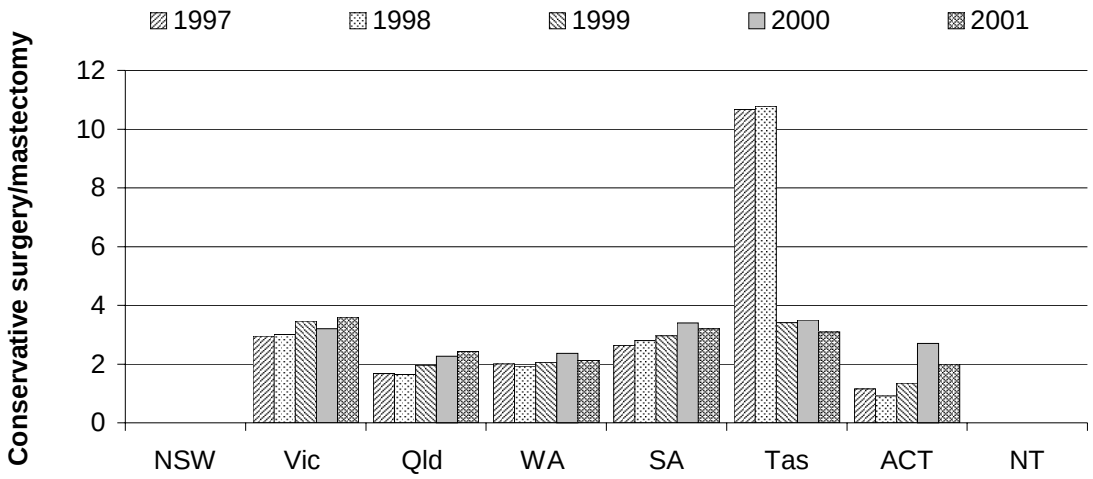
Breast conserving surgery removes the breast cancer but not the breast itself. Types of breast conserving surgery include lumpectomy (removal of the lump), quadrantectomy (removal of one quarter of the breast), and segmental mastectomy (removal of the cancer as well as some of the breast tissue around the tumour and the lining over the chest muscles below the tumour). Mastectomy involves removal of the breast. These terms are also defined in section 11.7 and box 11.2.

A high ratio of conserving 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 represent only a portion of the total possible treatment information available. Further, because BreastScreen Australia aims to diagnose small cancers that can be treated more effectively and with reduced morbidity for women, the data do not

necessarily provide a good indication of general clinical practice relating to breast cancer. Based on BreastScreen Australia data in 2001 the ratio was highest in Victoria (3.6:1) and lowest in the ACT (2.0:1) (figure 11.15). Data for NSW and the NT were not available.

Figure 11.15 **Ratio of conserving surgery to mastectomy[a]**



a Data for NSW and the NT were not available.

Source: State and Territory governments; table 11A.20.

Cost per separation by diagnosis related group

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 11.5 provides a summary of costs for selected breast cancer DRGs. The average cost of major procedures for malignant breast conditions across Australia was $4653 in the 2000-01 financial year. Minor procedures for malignant breast conditions cost on average $2696 in Australia. Table 11A.21 also summarises the average length of stay in public hospitals associated with each DRG. It needs to be noted that the data are derived from a sample of hospitals in each jurisdiction that is not necessarily representative and that in some cases comprises larger, rather than smaller, hospitals.

Table 11.5 **Average cost per DRG, selected breast cancer DRGs, public hospitals, population estimated 2000-01 (dollars per DRG)[a, b]**

DRGs	*NSW*[c]	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*[d]	*Aust*
J06A Major procedures for malignant breast conditions									
	4 851	5 395	4 138	4 273	3 582	4 565	3 086	**na**	4 653
J07A Minor procedures for malignant breast conditions									
	3 400	2 352	2 364	1 955	1 927	2 367	1 338	**na**	2 696
J62A Malignant breast disorders age>69 W CC[b]									
	4 462	3 725	6 183	5 007	5 093	7 158	3 765	**na**	4 434
J62B Malignant breast disorders (age<70 W CC) or (age>69 W/O CC)[d]									
	3 582	2 046	3 259	3 887	2 805	3 400	2 651	**na**	2 777
J62C Malignant breast disorders age<70 W/O CC[b]									
	1 461	789	893	831	655	2 324	1 036	**na**	953

a Samples are not necessarily representative of all hospitals in each jurisdiction, therefore, a population estimation process is undertaken to create estimated data which are representative of the total population. **b** W CC='with complications and comorbidities'. W/O CC='without complications and comorbidities' **c** Approximately 60 per cent of the separations in NSW are from tertiary referral hospitals, which have higher infrastructure and operational costs. **d** NT data were not included in Round 5 (2000-2001) of the National Hospital Cost Data Collection.

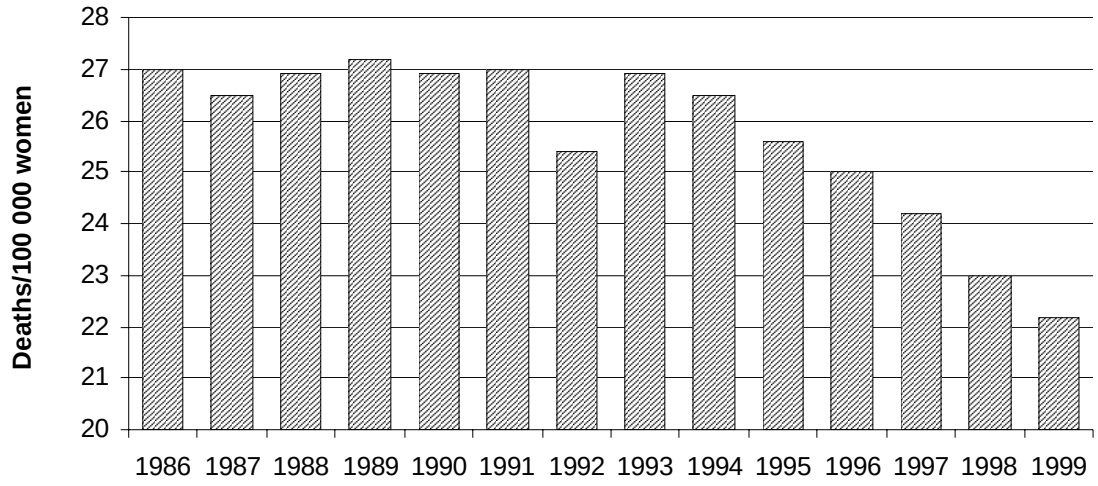
Source: Commonwealth Department of Health and Aged Care, National Hospital Cost Data Collection, Round 5; table 11A.21.

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 22.2 in 1999. The decline in mortality from breast cancer appears to have been strong and consistent from 1993 onwards (figure 11.16).

Figure 11.16 **Age-standardised mortality rate from breast cancer, all ages[a, b]**

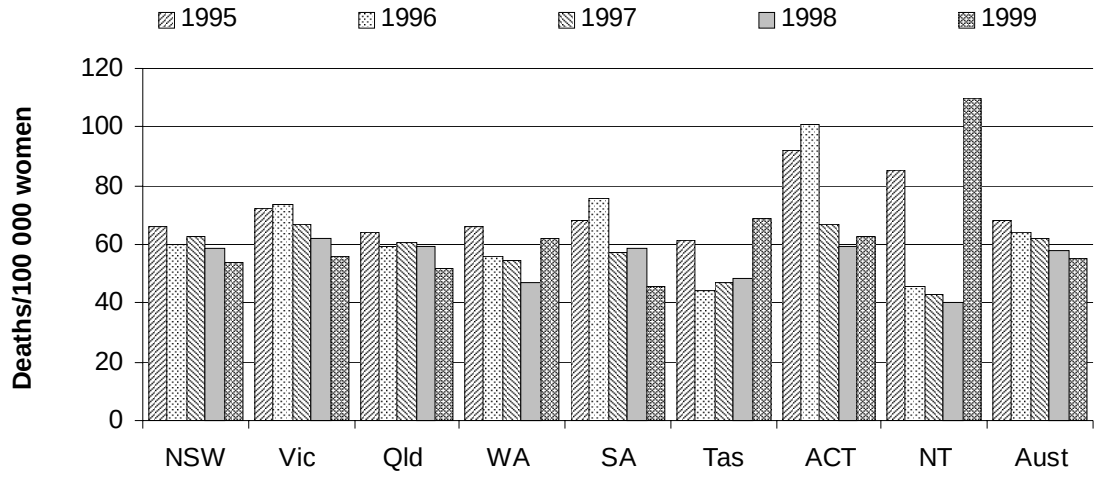


a Age-standardised to the Australian population at 30 June 1991. **b** Data for 1986 to 1998 are sourced from AIHW (2000b). 1999 is sourced from AIHW (unpublished).

Source: AIHW (2000b) and AIHW unpublished; table 11A.23.

The age-standardised mortality rate from breast cancer for Australian women aged 50–69 years between 1995 and 1999 was highest on average in the ACT and lowest on average in Tasmania (figure 11.17).

Figure 11.17 **Age-standardised mortality rate from breast cancer, women aged 50–69 years[a]**



a Age-standardised rates.

Source: AIHW (unpublished); table 11A.23.

11.4 Mental health

Profile

Mental health relates to an individual's ability to negotiate the daily challenges and social interactions of life without experiencing undue emotional or behavioural incapacity (DHAC *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 *et al.* 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).

Prevalence

There is little information currently available on the prevalence of mental disorders in Australia. Some data are available from the National Survey of Mental Health and Wellbeing initiated by the Commonwealth Department of Health and Family Services in 1995 which comprised:

- a survey of a nationally representative sample of 10 000 adults aged 18 years and over focusing on common mental disorders;
- a survey of mental disorders among children and adolescents aged 4–17 years; and
- a study of low prevalence disorders (people living with psychotic illness).

The survey of adults (undertaken in 1997) by the Australian Bureau of Statistics (ABS) suggested that almost one in five people suffered from one or more mental disorders during the 12 months before the survey was conducted (ABS 1998). People in institutions, such as nursing homes and psychiatric hospitals, and other accommodation arrangements, such as supported accommodation and boarding houses, were not included in the survey. The survey did not attempt to cover all

mental disorders. It focused on the relatively common disorders of anxiety, affective disorders and substance use disorders.[4]

The survey suggested that 10.6 per cent of adults aged 18–64 years, and 4.5 per cent of adults aged over 65 years suffered from anxiety disorders. It also suggested that 6.5 per cent of adults aged 18–64 years, and 1.7 per cent of adults aged over 65 years suffered from affective disorders. In terms of substance use disorders, 8.9 per cent of adults aged 18–64 years were sufferers while 1.1 per cent of adults over 65 years were sufferers (ABS 1998). Overall, the survey suggested that almost one in five people aged 18 years and over suffered from one or more mental disorders during the 12 months before the survey was conducted. Of the disorders that were covered, people were most likely to report anxiety disorders (54.6 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 11A.24).

The child and adolescent component of the National Survey of Mental Health and Wellbeing involved 4500 children aged 4–17 years in randomly selected households. 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. Data were collected between February and April 1998. Prevalence data from the survey were based on information derived from parents and from adolescents aged 13–17 years. The survey found that:

- 14.1 per cent of those aged 4–17 years had mental health problems; and
- Depressive disorders, conduct disorders and attention deficit/hyperactivity disorders were identified in 14.2 per cent of those aged 6–17 years. Importantly, there was substantial comorbidity between these disorders (Sawyer *et al.* 2000).[5]

[4] An anxiety disorder is represented by feelings of tension, distress or nervousness and 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. Survey participants in some cases reported more than one disorder, so percentages do not add to 100.

[5] Children with depressive disorders feel sad, lack interest in activities they previously enjoyed, criticise themselves and are pessimistic or hopeless about the future. They may contemplate suicide, or be irritable or aggressive. They may be indecisive and have problems concentrating and sleeping. Children with conduct disorder exhibit antisocial behaviour, such as aggression to people or animals, destruction of property, deceitfulness or theft and serious violations of rules. Attention deficit/hyperactivity disorder is persistent patterns of inattentive behaviour and or hyperactivity–impulsiveness that is more frequent and severe than typically observed in individuals of the same developmental level.

The University of Western Australia coordinated a epidemiological and clinical study of people aged 18–64 years living with psychotic illness. Psychotic disorders cover a diverse group of illnesses that are characterised by fundamental distortions in thinking, perception or emotional response and include schizophrenia, bipolar affective disorders, and delusional disorders. Participants in the survey were drawn from people who attended mental health services in Queensland and WA.

The study found that, in urban areas, four to seven adults per 1000 are in contact with mental health services during any given month because of symptoms of psychotic disorders. People with schizophrenia and schizoaffective disorders accounted for over 60 per cent of people with disorders covered by the study (Jablensky *et al.* 1999).

Services used

The ABS survey included only self reported service use by adults. It found that of those adults with the mental disorders covered, 38.0 per cent contacted a health service for their problem. GPs were the main mental health service providers, seeing 29.4 per cent of patients with a mental disorder. Less than 1 per cent of people with the types of mental disorder covered by the ABS survey were admitted to hospital (ABS 1998).

People of different ages have different service use characteristics. Of those adults aged 18–34 years with the mental disorders covered by the ABS survey, only 31.8 per cent contacted a health service for their problem. GPs were the main mental health service providers, seeing about 21.2 per cent of patients with a mental disorder in this age group (ABS 1998). Adults aged 35–64 years with a mental disorder were more likely to contact a health service for their problem (44.2 per cent of those with the mental disorders covered by the survey). Again, GPs were the main mental health service providers, seeing about 36.9 per cent of patients with a mental disorder in this age group (ABS 1998). Comparable figures for those aged over 65 were not published in the ABS survey. A substantial proportion of older people with a mental disorder are in nursing home care and were not therefore incorporated in the ABS survey (Commonwealth Department of Health and Family Services 1997).

The child and adolescent survey suggested that:

- of the 14.1 per cent of those aged 14–17 years with a mental health problem, 25 per cent attended one or more services in the six months prior to the survey. Most commonly, the services were provided by family doctors or school-based counselling. Few attended a specialist mental health service;

- of those aged 6–17 years with depression, conduct or attention deficit/hyperactivity disorder, 29 per cent attended at least one service in the six months prior to the survey. The services most frequently used were counselling in schools, family doctors and paediatricians. Around 3 per cent attended a mental health clinic, while only 2 per cent attended a hospital-based department of psychiatry (Sawyer *et al.* 2000).

Over half the participants in the survey of people living with psychotic illness had one or more inpatient admissions in the year prior to interview. On average, the length of an inpatient stay was six weeks, and 10 per cent had been in an inpatient facility for the whole of the year. Outpatient care was used by 60 per cent of survey participants, and 44 per cent used emergency services (mainly attending a general hospital department, or using the services of a psychiatric team). The term 'outpatient' is defined in box 11.4. In all, 81 per cent had been in contact with a GP, averaging 12 visits a year (Jablensky *et al.* 1999).

Substance use disorders, which were covered by the ABS survey of adults, are generally not treated by Australian mental health services except where they co-occur with a primary mental disorder. The ABS survey indicated that for all adults, there was low comorbidity of substance use and anxiety disorders (0.6 per cent) and substance use and affective disorders (0.2 per cent) (ABS 1998). For adults aged over 65 years comorbidity of both anxiety disorders and affective disorders with substance abuse was very low as substance use in this age group was negligible (ABS 1998). People with psychotic disorders on the other hand appear to have rates of alcohol abuse or dependence, and drug abuse or dependence, far in excess of the rates found in the general population. Diagnosis of comorbidity of a psychotic disorder and substance abuse was made in every fourth person in the sample of people living with a psychotic illness (Jablensky *et al.* 1999). In most jurisdictions, alcohol and drug problems are treated separately by specialist drug services.

The Report does not cover drug abuse services. This chapter covers specialist mental health care services which mostly treat low prevalence, but severe disorders. GPs are important service providers for people with a mental disorder (chapter 10). The Report does not, however, currently include performance information on services by GPs to those affected by mental illness.

Some common terms used in mental health management are outlined in box 11.4.

Box 11.4 **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: staffed residential units established in community settings that provide specialised treatment, rehabilitation or care for people affected by a mental illness or psychiatric disability. To be defined as community-based residences, the services must provide residential care to people with psychiatric illness or disability, be located in a community setting external to the campus of a general hospital or psychiatric institution, employ onsite staff for at least some part of the day, and be government funded.

Inpatient services: stand-alone psychiatric hospitals or specialist psychiatric units located within 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: diminished cognitive, emotional or social abilities, but not to the extent that the criteria for a mental disorder are met.

(Continued next page)

Box 11.4 **(Continued)**

Mental health promotion: activities designed to lead to improvement of the mental health functioning of persons through prevention, education and intervention activities and services.

Non-acute services: rehabilitation services that have a primary focus on intervention to reduce functional impairments that limit the independence of patients. Rehabilitation services are focused on disability and the promotion of personal recovery. They are also characterised by an expectation of substantial improvement over the short to mid term. Patients treated by rehabilitation services usually have a relatively stable pattern of clinical symptoms. Non-acute services also consist of extended care services that provide care over an indefinite period for patients who have a stable but severe level of functional impairment and inability to function independently without extensive care and support. Patients of extended care services usually show a relatively stable pattern of clinical symptoms, which may include high levels of severe unremitting symptoms of mental illness. Treatment effort is focused on preventing deterioration and reducing impairment. Improvement is only expected over a long time period.

Non-government organisations (NGO): private not-for-profit community-managed organisations that receive State and Territory government funding specifically for the purpose of providing community support services for people affected by a mental illness or psychiatric disability. Programs provided by the NGO sector may include supported accommodation services (including community-based crisis and respite beds), vocational rehabilitation programs, advocacy programs (including system advocacy), consumer self help services, and support services for families and primary carers.

Outpatient services, community-based: services primarily provided to non-admitted patients on an appointment basis and delivered from health centres located in community settings, physically separated within hospital sites. Services provided may also include outreach or domiciliary care as an adjunct to services provided from the centre base.

Outpatient services, hospital-based: services primarily provided to non-admitted patients on an appointment basis and delivered from clinics located within hospitals. Services provided may also include outreach or domiciliary care as an adjunct to services provided from the clinic base.

Prevalence: the number of cases of a disease present in a population at a given time (point prevalence) or during a given period (period prevalence).

Specialised care service: services whose primary function is specifically to provide treatment, rehabilitation or community support targeted to people affected by a mental disorder or psychiatric disability. This criterion is applicable regardless of the source of funds. Such activities are delivered from a service or facility which is readily identifiable as both specialised and serving a mental health function.

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 hospital emergency departments and outpatient departments, and public hospital general wards (as opposed to specialist psychiatric wards). Some people with a mental disorder are cared for in nursing homes. This chapter reports on specialist mental health care services only. The performance of non-specialist service providers is examined more closely in chapter 9 (Public hospitals), chapter 10 (General practice) and chapter 12 (Aged care services). Mental health patients often have complex needs and links exist with a number of other services covered in chapter 3 (School education), chapter 7 (Corrective services), chapter 8 (Emergency management) and chapter 13 (Services for people with a disability).

State and Territory governments are the primary sources of funding and service delivery for specialist public mental health services. The Commonwealth directly funds primary care health services for people with mental disorders through the Medicare Benefits Schedule and the Pharmaceutical Benefits Scheme. In addition, the Commonwealth has provided grants to State and Territory governments for mental health service reform under the Australian Health Care Agreements (AHCA). The Commonwealth also funds other services which people with mental disorders can access, such as emergency relief, employment, accommodation, income support, rehabilitation, nursing home care and other disability services. These latter services are not discussed in this chapter, but nursing homes are discussed in chapter 12 and disability services in chapter 13.[6]

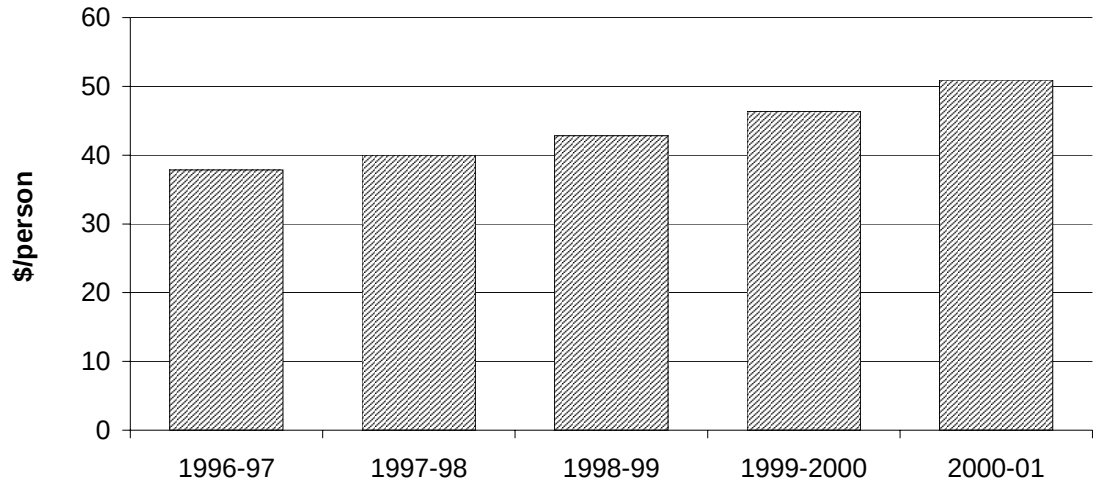
[6] In some jurisdictions, psychiatric disability support services provide specialist mental health care. Victoria advised for example that, while these services receive some Commonwealth funding under the Commonwealth-State Disability Agreement, the Victorian Government provides most of the funding for the Victorian services.

Funding

Public real recurrent spending of around $2.6 billion was allocated to mental health services in 2000-01 (tables 11A.26 and 11A.27).[7] State and Territory governments made the largest contribution ($1.6 billion or 62.5 per cent) although this includes some Commonwealth funds under the AHCA (table 11A.27). The Commonwealth Government spent $981.3 million. Real Commonwealth spending per person in 1999-2000 was $46, increasing to $51 in 2000-01 (figure 11.18).

Data in the Report relating to public mental health services are drawn from the National Survey of Mental Health Services (NSMHS). It should be noted that NSMHS data for 2000-01 are preliminary, as validation has not yet been completed. There are a number of anomalies yet to be resolved. For example, SA has found some anomalies with its staffing and expenditure data since the NSMHS data were included in this Report (see SA jurisdiction comments). Final validation is ongoing prior to publication in the *National Mental Health Report 2003*. Data for 2000-01 should therefore be treated with care.

Figure 11.18 **Commonwealth recurrent spending on mental health per person (1999-2000 dollars) [a, b, c]**



a 2000-01 data are preliminary only; final validation is ongoing prior to publication in the *National Mental Health Report 2003*. **b** Data for years prior to 2000-01 are as published in the *National Mental Health Report 2002*. Some historical adjustments are likely to be made for *National Mental Health Report 2003*. **c** Constant price expenditure for all years, expressed in 1999-2000 prices, using Implicit Price Deflator for Non-Farm GDP provided in table 11A.74.

Source: Department of Health and Ageing (DHA) (unpublished); table 11A.30.

[7] The data include revenue from other sources (including patient fees and reimbursement by third party compensation insurers) and 'other Commonwealth funds.'

The largest component of Commonwealth expenditure on mental health services in 2000-01 was expenditure under the Pharmaceutical Benefits Schedule for psychiatric medication (40.9 per cent). Medicare Benefits Schedule payments for consultant psychiatrists accounted for a further 19.2 per cent of Commonwealth expenditure on mental health services, followed by expenditure for mental health care by GPs (15.3 per cent). The Department of Veterans' Affairs (DVA) (12.5 per cent), the National Mental Health Strategy (NMHS) (7.0 per cent), private hospital insurance premium rebates, research and other time-limited program and project support accounted for the residual (table 11A.26).

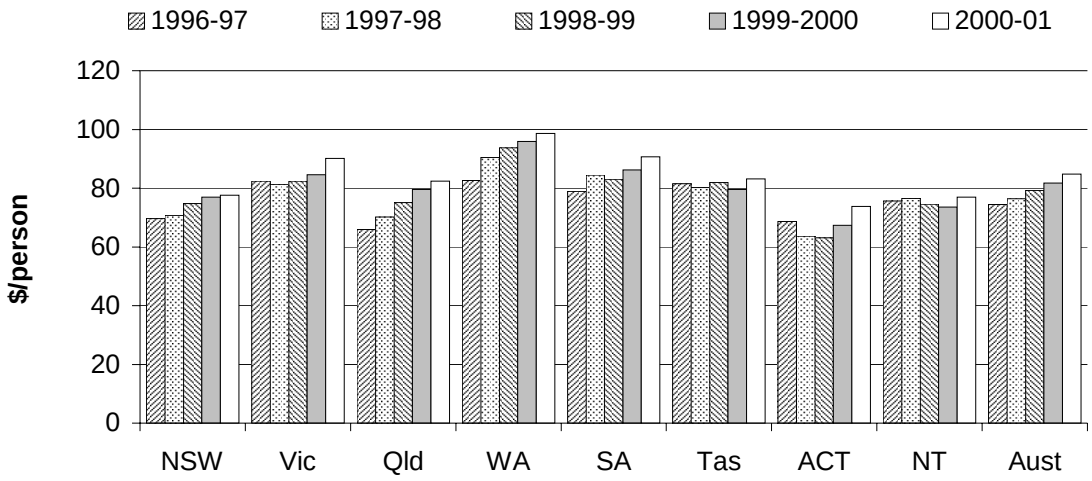
Data for State and Territory government expenditure include Commonwealth funds provided as part of the AHCA for mental health reform. This funding is referred to as expenditure 'at State and Territory discretion.' Real spending per person at State and Territory discretion has increased over time (figure 11.19).

In 2000-01, WA spent the most ($99 per person) and the ACT spent the least ($74). Commonwealth funding provided under the NMHS and through the DVA has been excluded from the estimates presented in figure 11.19. State and Territory government expenditure estimates, excluding revenue from other sources and other Commonwealth funds, are presented in the attachment (table 11A.28). 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.

In figure 11.19, expenditure at the discretion of State and Territory governments has been converted to 1999-2000 dollars using State and Territory deflators for government final consumption expenditure on hospital and clinical services. These deflators are reported in table 11A.74. The type of deflator used can affect estimates of expenditure in constant prices. Expenditure data deflated using a national deflator — rather than a State and Territory deflator — are presented in tables 11A.61 and 11A.62. The national deflator is reported in table 11A.75.

The data in figure 11.19 exclude depreciation. Estimates of depreciation are presented in the attachment (table 11A.29).

Figure 11.19 **Real recurrent expenditure at the discretion of State and Territory governments (1999-2000 dollars)[a, b, c, d, e]**

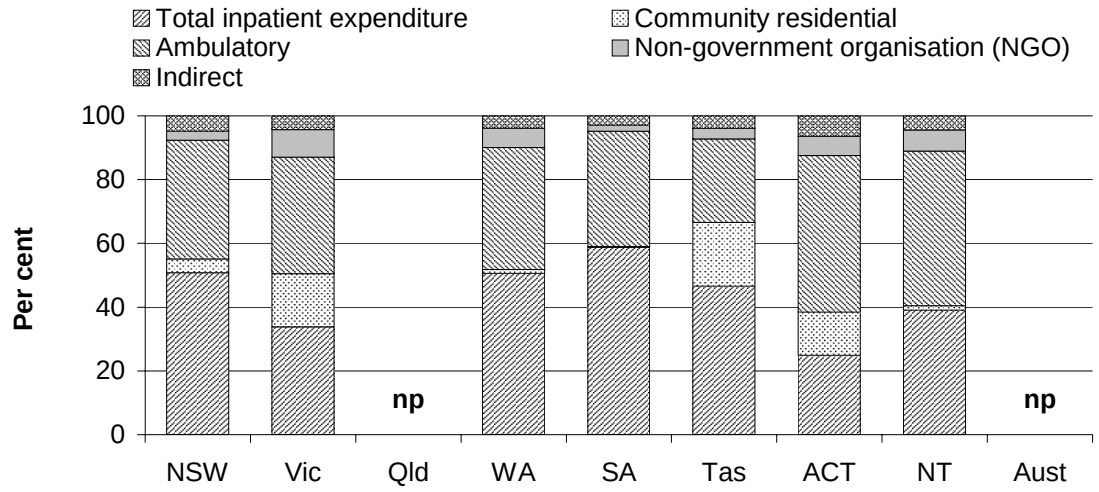


a 2000-01 data are preliminary only; final validation is ongoing prior to publication in the *National Mental Health Report 2003*. **b** Constant price expenditure expressed in 1999-2000 prices, using Government Final Consumption Expenditure on Hospital and Clinical Services as deflator. Deflator is reported in table 11A.74. **c** Estimates of State and Territory government spending include revenue from other sources (including patient fees and reimbursement by third party compensation insurers), and 'other Commonwealth funds' but exclude Commonwealth funding provided under the NMHS Funds and through the DVA. **d** Depreciation excluded for all years. Depreciation estimates reported in table 11A.29. **e** Funding is a mix of Commonwealth funds provided under the AHCA as well as funds provided by State and Territory governments.

Source: DHA NSMHS database (unpublished); table 11A.27.

Figure 11.20 shows how Commonwealth, State and Territory government spending was distributed across the range of mental health services in 2000-01. Recurrent expenditure allocated to hospital-based services (including both psychiatric hospitals and psychiatric units in public [non-psychiatric] hospitals) was highest in SA (58.7 per cent) and lowest in the ACT (24.9 per cent). (The ACT does not have a public psychiatric hospital.) Recurrent expenditure allocated to ambulatory services was highest in the ACT (49.1 per cent) and the NT (48.5 per cent) and lowest in Tasmania (26.2 per cent).

Figure 11.20 **Recurrent expenditure by service category, 2000-01**[a, b, c, d, e, f]



[a] 2000-01 data are preliminary only; final validation is ongoing prior to publication in the *National Mental Health Report 2003*. [b] Includes all spending regardless of source of funds. [c] Depreciation excluded. Depreciation estimates are reported in table 11A.29. [d] Community residential is defined as all staffed community-based units (external to the campus of a general hospital or psychiatric institution) regardless of the number of hours that staff are present. [e] The differential reporting of clinical service providers and NGO artificially segregates the mental health data. As the role of NGOs varies across jurisdictions, the level of NGO resourcing does not accurately reflect the level of community support services available. [f] WA advised that the two community residential facilities in WA are not representative of the development of current state mental health policy and are currently under review. WA has been increasing funding to the NGO sector to provide services to people in their own homes rather than to provide publicly funded community residential services. **np** Not published.

Source: DHA NSMHS database (unpublished); table 11A.31.

Size and scope of sector

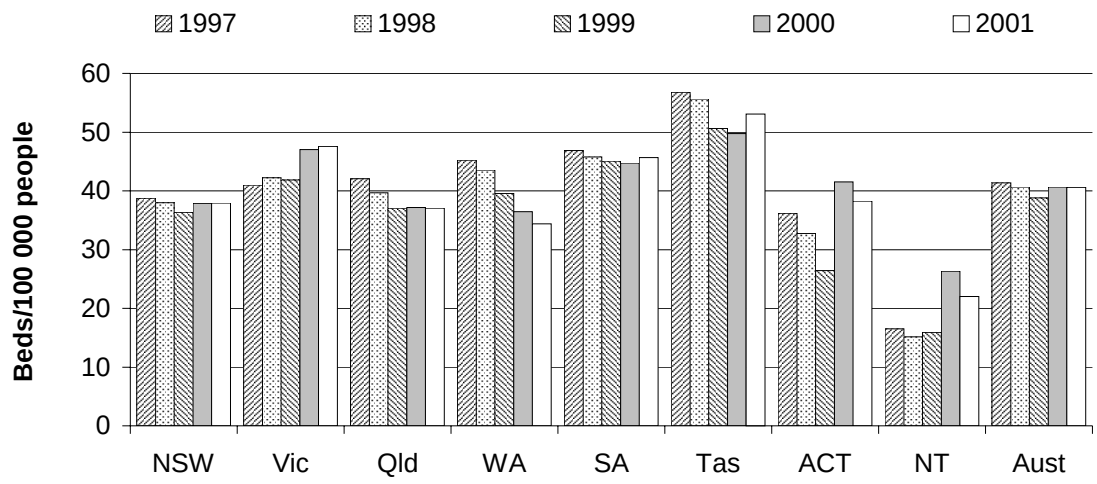
The number of beds

Beds are counted as those immediately available for use at 30 June by admitted patients if required. They are immediately available for use if located in a suitable place for care with nursing or other auxiliary staff available, or available within a reasonable period of time. Further, beds that were in wards that are temporarily closed due to factors such as renovations or strikes but that would normally be open are included.

The number of beds per 100 000 people for public hospitals and community residential facilities combined are presented in figure 11.21. It needs to be noted that there was a definitional change for community residential facilities in 1999-2000 which caused a break in the series. 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. In 2001, Tasmania had the highest number of beds per 100 000 people (53.1) and the NT had the lowest (22.0).

Figure 11.21 **The number of beds at 30 June**[a, b, c, d]



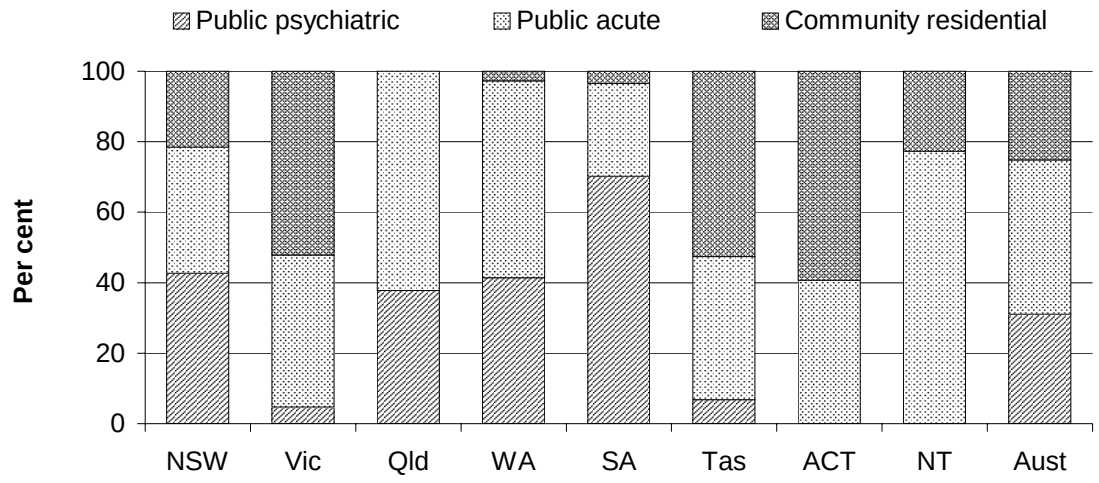
a 2001 data are preliminary only; final validation is ongoing prior to publication in the *National Mental Health Report 2003*. **b** Includes beds in public hospitals and publicly funded community residential units. **c** Prior to 1999-2000, community residential was defined as 24-hour staffed residential 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. **d** The apparent 18 per cent reduction for Queensland in inpatient bed numbers since 1993 is a temporary artifact of the process of decentralisation and delays in the completion of capital works for new extended treatment facilities.

Source: DHA NSMHS database (unpublished); table 11A.32.

The number of beds by service category are presented for 2001 in figure 11.22. These data show the differences in service mix across States and Territories. SA had the highest proportion of beds in public psychiatric hospitals (70.2 per cent) and Victoria the lowest (4.7 per cent). The ACT and the NT do not have public psychiatric hospitals. The ACT (59.4 per cent) had the highest proportion of beds in community residential services while WA had the lowest (2.7 per cent).

The apparent absence of community residential beds in 2001 in Queensland reflects Queensland's preference to describe such facilities as 'extended inpatient care'. Queensland has adopted a range of extended treatment services to replace the beds previously provided by psychiatric hospitals. New facilities include both campus-based and non-campus-based extended treatment and rehabilitation facilities for the adult and aged populations. Queensland does not consider these facilities to be 'community residential services'. This is not consistent with the definition of such services used by the NSMHS. Data prior to 2000-01 reflect the NSMHS definition.

Figure 11.22 **The number of beds at 30 June by service category, 2001**[a, b, c, d]



[a] 2001 data are preliminary only; final validation is ongoing prior to publication in the *National Mental Health Report 2003*. [b] The apparent absence of community residential beds in 2001 in Queensland reflects Queensland's preference to describe such facilities as 'extended inpatient care'. This is not consistent with the definition of such services used for the NSMHS. [c] WA advised that the two community residential facilities in WA are not representative of the development of current State mental health policy and are currently under review. WA has been increasing funding to the NGO sector to provide services to people in their own homes rather than provide publicly funded community residential services. [d] Tasmania advised that beds reported under 'public psychiatric hospitals' are located in a community-based mental health inpatient (non-residential) facility. The facility is not regarded by Tasmania as a hospital.

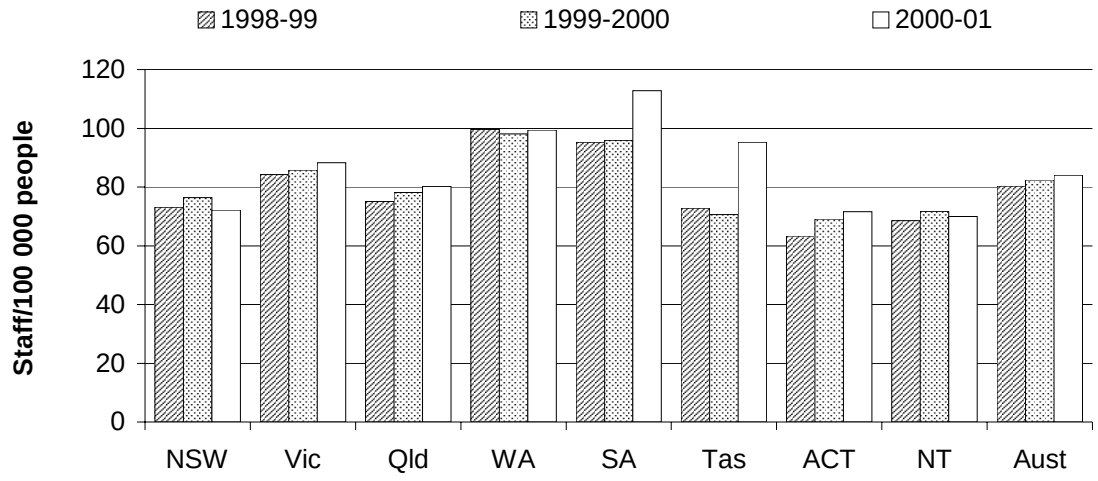
Source: DHA NSMHS database (unpublished); table 11A.32.

Staff

Figure 11.23 reports full time equivalent (FTE) direct care staff per 100 000 people and includes only staff within the health professional categories of 'medical', 'nursing' and 'allied health'. 'Other personal care' direct care staff are excluded. Medical staff consist of consultant psychiatrists, psychiatry registrars and officers who are neither registered as psychiatrists within the State or Territory, or are formal trainees of the Royal Australian and New Zealand College of Psychiatrists' Postgraduate Training Program. Nursing consists of registered and nonregistered nurses. Allied health consists of occupational therapists, social workers, psychologists and other allied health staff. Other personal care staff include attendants, assistants, home companions, family aides, ward helpers, wardsmen, orderlies, ward assistants and nursing assistants engaged primarily in the provision of personal care to patients or residents, who are not formally qualified or undergoing training in nursing or allied health professions. Definitions for staffing categories are provided in more detail in section 11.7.

In 2000-01, SA had the most FTE direct care staff per 100 000 people in specialist mental health services (112.8) and the NT had the least (70.0). It should be noted, however, that validation of the 2000-01 data is ongoing prior to the publication of the *National Mental Health Report 2003.* For example, SA has identified a number of anomalies with its staffing data since the NSMHS data were included in this Report. In addition, there was a definitional change for community residential facilities in 1999-2000 which caused a break in the time series.

Figure 11.23 **FTE health professional direct care staff per 100 000 people[a, b, c, d, e]**



a 2000-01 data are preliminary only; final validation is ongoing prior to publication in the *National Mental Health Report 2003*. **b** Includes health professional occupational categories only. **c** Prior to 1999-2000, community residential was defined as 24-hour staffed residential units in community settings (external to the campus of a general hospital or psychiatric institution) and funded by government. From 1999-2000, the definition was broadened to incorporate all staffed community-based units, regardless of the number of hours that staff are present. **d** NSW noted that its total staff numbers rose between 1999-2000 and 2000-01. The data reported in this chart reflect only health professionals, and do not incorporate non-professional staff. The discrepancy may be addressed when validation has been completed. **e** Tasmania has suggested that, in previous years, some direct care staff were not counted as they were incorrectly attached to administrative cost centres.

Source: DHA NSMHS database (unpublished); table 11A.34.

Nursing staff comprise the largest FTE component of health care professionals employed in mental health services. Across Australia in 2000-01, there were 55.0 nurses per 100 000 people working in specialised mental health services, compared with 19.6 allied health care staff (occupational therapists, social workers, psychologists and other allied health staff) and 9.4 medical staff (psychiatrists and other medical officers) (table 11A.34).

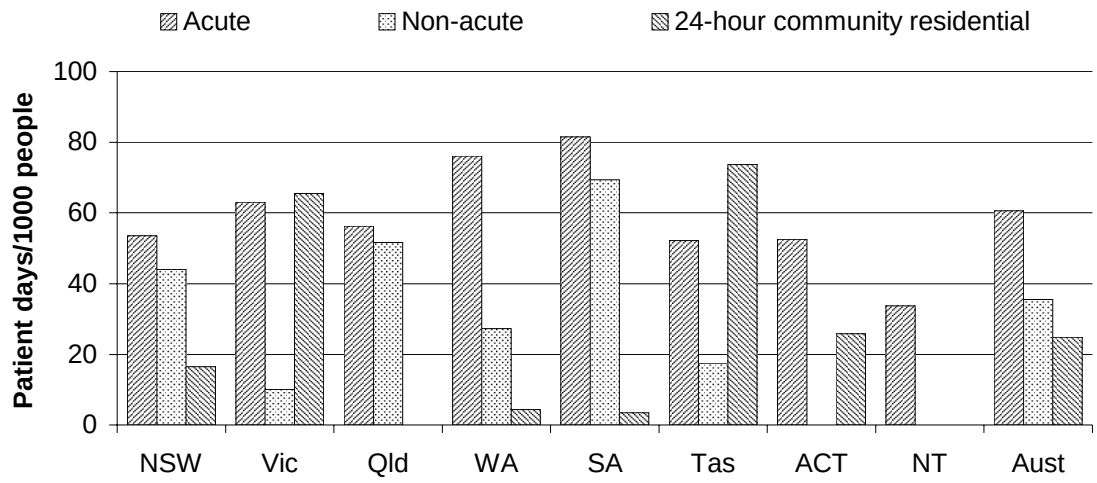
Services provided

Estimating activity across the specialised mental health services sector is problematic. Data for 'patient days' are provided in (figure 11.24) by acute, non-acute and 24-hour staffed residential care (definitions are in box 11.4) but show only part of the picture.[8] Hospital inpatient days and community residential patient days are included in figure 11.24, 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.

In 2000-01, patient days per 1000 people in acute units were highest in SA (81.6) and lowest in the NT (33.7). In non-acute units, patient days per 1000 people were highest in SA (69.4) and lowest in Victoria (10.0). The ACT and the NT did not provide mental health care in non-acute units in 2000-01. Tasmania had the highest patient days per 1000 people in 24-hour community residential facilities (73.7) and SA had the least (3.5) (figure 11.24). The NT did not provide mental health care in 24-hour community residential facilities in 2000-01. The previously discussed caveat for the apparent absence of community residential beds in Queensland also applies to the data in figure 11.24.

[8] Under the NSMHS, 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.

Figure 11.24 **Mental health patient days, 2000-01**[a, b, c, d, e]



[a] 2000-01 data are preliminary only; final validation is ongoing prior to publication in the *National Mental Health Report 2003*. [b] The apparent absence of community residential beds in 2001 in Queensland reflects Queensland's preference to describe such facilities as 'extended inpatient care'. This is not consistent with the definition of such services used for the NSMHS. [c] The two community residential facilities in WA are not representative of the development of current State mental health policy and are currently under review. WA has been increasing funding to the NGO sector to provide services to people in their own homes rather than provide publicly funded community residential services. [d] The ACT and the NT did not provide mental health care in non-acute units. [e] The NT did not provide mental health care in 24-hour community residential facilities.

Source: DHA NSMHS database (unpublished); table 11A.35.

In public psychiatric hospitals in 1999-2000, there were 15 568 overnight separations with specialised psychiatric care and 2379 same day separations (AIHW 2002b). In public acute hospitals in that year, there were 63 635 overnight separations with specialised psychiatric care and 24 316 same day separations. Schizophrenia accounted for a large proportion of overnight separations related to mental disorders in public hospitals (22.6 per cent of overnight separations related to mental disorders in public acute hospitals and 24.6 per cent in public psychiatric hospitals in 1999-2000) (table 11A.36).

The high level of same day separations reflects varying admission practices rather than genuine admissions to hospital. Unlike the general acute hospital sector, mental health has few procedural same day admissions, these being mainly related to electroconvulsive therapy treatment of people living in the community which represent only 6–10 per cent of all same day separations. Available evidence (for example, see *Mental Health Classification and Service Costs Report*, vol 1, p. 141) suggests that the majority of same day hospitalisations are in fact better described as ambulatory care, and involve the attendance by consumers at a variety of day and group-based programs that could otherwise be provided in community settings.

There are limited data available relating to care by GPs of mental health patients. The following data are collected from a sample of 1000 GPs. In 1999-2000, the most frequently reported mental health-related patient reason for an encounter with a GP was depression (1.7 per 100 encounters).[9] Sleep disturbance was the next most common reason (1.2 per 100 encounters), followed by anxiety (1.0 per 100 encounters) and acute stress reaction (0.6 per 100 encounters). In total there were 7.2 per 100 encounters involving mental health problems reported by patients as a reason for an encounter with a GP (AIHW 2002b).

In 2001-02, depression was the fourth most frequently managed problem by a GP (Britt, *et al.* 2002).[10] In 1999-2000, the most frequently reported mental health-related problem managed by a GP was depression (3.4 per 100 encounters). Anxiety was the next most common problem managed (1.7 per 100 encounters), followed by sleep disturbance (1.5 per 100 encounters) and drug abuse (0.6 per 100 encounters). In total there were 10.5 per 100 encounters involving mental health problems managed by a GP in 1999-2000 (AIHW 2002b).

There are very limited 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. The data 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 disorders. Indigenous Australians were nearly twice as likely to be admitted for overnight psychiatric care compared with the rest of the population. The average length of stay for Indigenous people was, however, similar to that for the rest of the population (table 11.6).

[9] In the Bettering the Evaluation and Care of Health 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.

[10] 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.

Table 11.6 **Specialised psychiatric care by Indigenous status, Australia 1999-2000[a, b]**

	Same day separations	Overnight separations	Total separations	Total patient days	Total psychiatric care days	Average length of stay (overnight)	Psychiatric care days per overnight separation
No.							
Indigenous	503	3 204	3 707	76 531	76 053	23.7	23.6
Total pop.	72 219	99 329	171 548	2 494 675	2 440 474	24.4	23.8
Per 1000 population							
Indigenous[c]	1.5	9.2	10.7	255.8	255.1	..	..
Total pop.	3.8	5.2	9.1	131.7	128.9	..	..

a The completeness of data on Indigenous status varies; hence these, data need to be used with care. **b** Specialised psychiatric care refers to separations in which at least one day of specialised psychiatric care was received. **c** Separations per 1000 population are indirectly age-standardised rates based on the projected Aboriginal and Torres Strait Islander population for 30 June 1999 and the estimated resident population for 30 June 1999. **..** Not applicable.

Source: AIHW (2002b); table 11A.37.

Schizophrenia disorders accounted for a large proportion of overnight specialised psychiatric care separations reported for Indigenous patients in Australia in 1999-2000 (22.3 per cent). Schizophrenia disorders also accounted for around 40.1 per cent of patient days for Indigenous patients, and a similar percentage of psychiatric care days (40.3 per cent) in 1999-2000 (table 11A.38).

Policy developments

The NMHS — agreed by Commonwealth, State and Territory Health Ministers in 1992 — places the focus of care in the community, advocating a fundamental shift in the service balance away from the historical reliance on separate psychiatric hospitals and on 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 NMHS 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 AHCAs. 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 (1992–1998) outlined agreed strategies for implementing the Policy. The Second Plan (1998–2003) 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 11.5).

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 as well as emphasising early intervention. The mental illness indicators in this Report focus on reforms to service delivery that commenced under the first National Mental Health Plan and were extended under the second National Mental Health Plan. However, the Second Plan also emphasises 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. Details of national initiatives in the field on mental health promotion and prevention are described in chapter 7 of the *National Mental Health Report 2002* (DHA 2002). 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 11.5) 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. It covers a number of service delivery types (institutional and community-based services) and indicators of systemwide performance. Improving the framework is a priority for the Review and the Australian Health Ministers' Advisory Council National Mental Health Working Group.

Box 11.5 **Objectives for mental health service delivery**

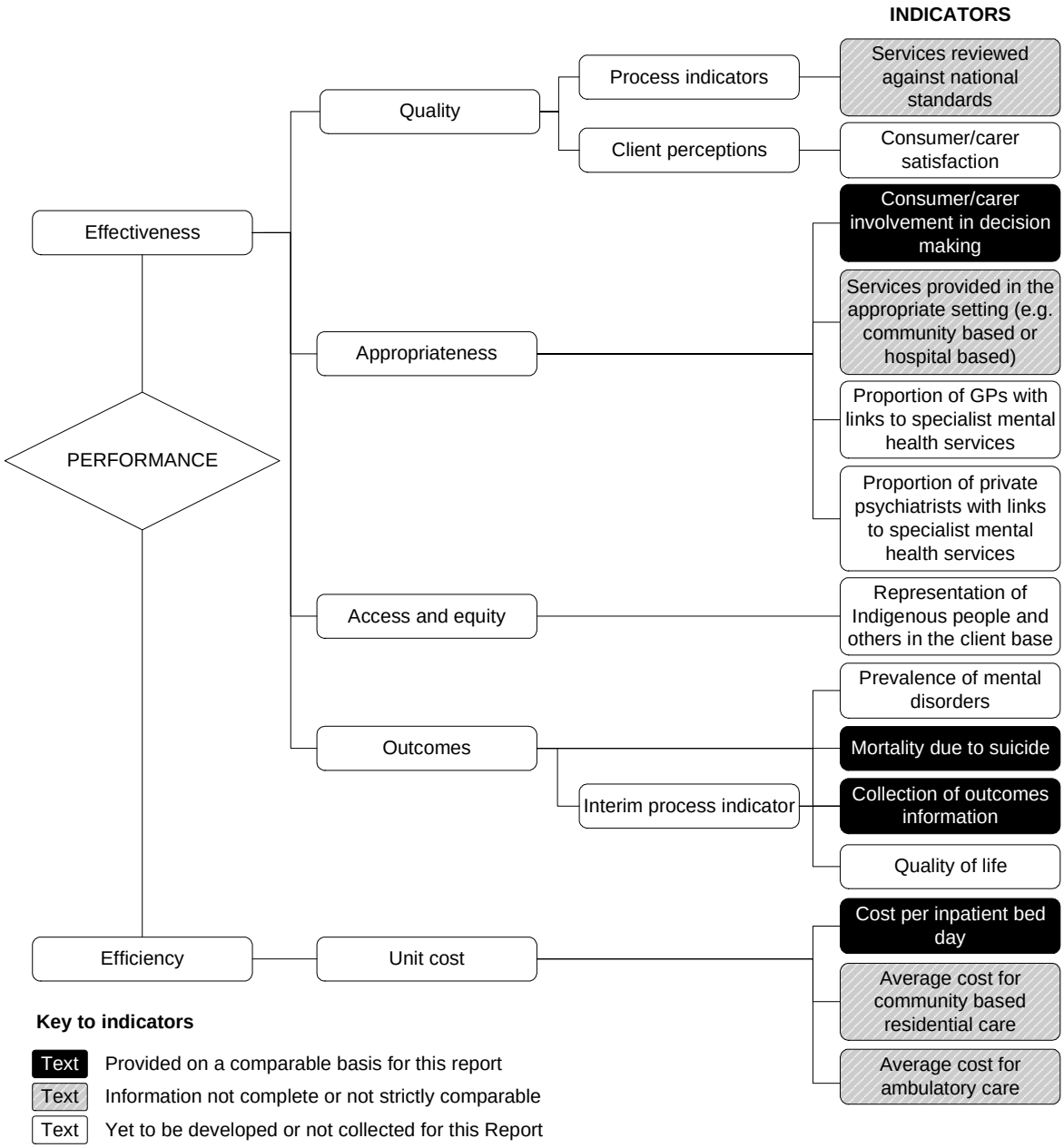
Key objectives include to:

- 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 performance indicator framework shows which data are comparable in the 2003 Report (figure 11.25). For data that are not considered strictly comparable, or that have not been completely validated, the text includes relevant caveats and supporting commentary. Chapter 1 discusses data comparability from a Report-wide perspective (see section 1.6).

Figure 11.25 **Performance indicators for mental health management**



Key performance indicator results

Quality

Per cent of specialised public mental health services reviewed against the National Standards for Mental Health Services

The percentage of specialised public mental health services reviewed by an external accreditation agency against the National Standards for Mental Health Services is used as a process indicator of quality. It reflects accreditation against the National Standards. 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 yet to undergo review are necessarily of poorer quality. The National Standards for Mental Health Services are summarised in box 11.6.

Box 11.6 **The National Standards for Mental Health Services**

The National Standards for Mental Health Services were developed under the First National Mental Health Plan for use in assessing service quality and as a guide for continuous quality improvement in all Australian mental health services. They comprise 11 major criteria as follows:

- Consumer rights;
- Safety;
- Consumer and carer participation;
- Promoting community acceptance;
- Privacy and confidentiality;
- Prevention and mental health promotion;
- Cultural awareness;
- Integration;
- Service development;
- Documentation; and
- Delivery of care.

Source: DHA (2002).

It should be noted that 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. Therefore, accreditation of a parent organisation does not currently require a mental health service to be separately assessed against the national standards. Accreditation *per se* does not assess or provide information on implementation of the National Standards for Mental Health Services. Assessment of a service against the national standards must be specifically requested and involves a separate review process. Data in table 11.7 relate to the percentage of specialised public mental health services that have participated in or are currently participating in an in-depth review, by an external accreditation agency, against the National Standards for Mental Health Services. Such reviews may take place in conjunction with, or separately to, overall accreditation of a parent organisation. Review against the national standards will, in some cases and in some jurisdictions, be delayed until an appropriate point is reached within the overarching accreditation cycle (for example, mid-term review).

The extent to which reviews were completed varied across jurisdictions at June 2002. At June 2002, reviews were completed in all the ACT specialist mental health organisations and no reviews were completed in the NT (table 11.7).

Table 11.7 **Specialised public mental health services reviewed against the National Standards for Mental Health Services (per cent)[a]**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
December 2000									
Review commenced	38.6	28.0	100.0	–	14.9	–	100.0	–	39.7
Review completed	9.9	28.0	4.2	–	–	–	100.0	–	12.3
June 2001									
Review commenced	65.7	28.0	100.0	–	14.9	–	100.0	–	49.0
Review completed	15.9	28.0	7.6	–	–	–	100.0	–	15.0
June 2002									
Review commenced	79.5	42.9	100.0	59.4	14.9	11.1	100.0	100.0	65.0
Review completed	18.8	38.5	85.6	15.6	14.9	2.8	100.0	–	35.0

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: DHA (unpublished), based on State and Territory progress reports submitted under the reporting requirements of Information Development Agreements; table 11A.39.

Appropriateness

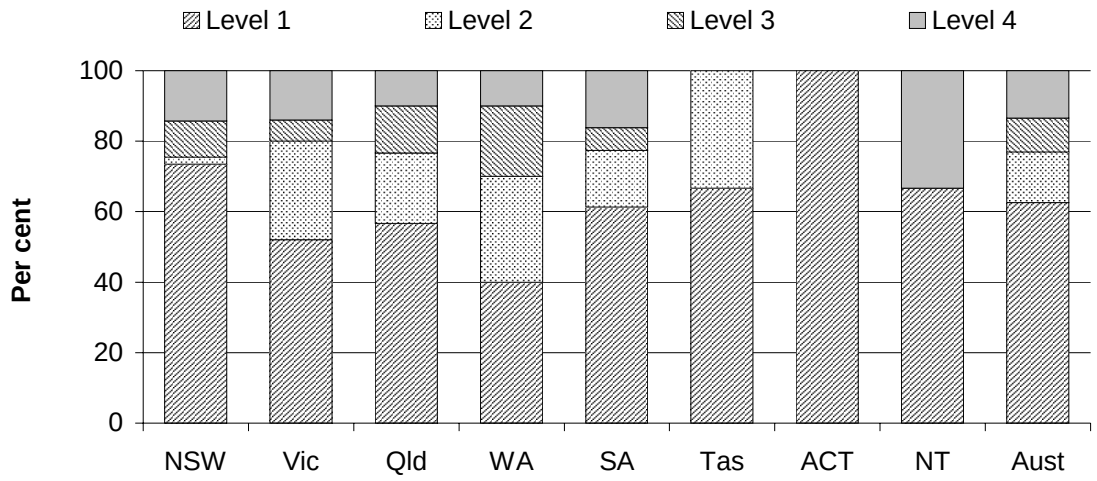
Consumer and carer participation in decision making

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 2001, the ACT had the highest proportion of organisations with a level 1 rating (100 per cent). (The ACT data are for three organisations.) WA had the lowest (40 per cent). The NT had the highest proportion of organisations reporting no consumer and carer involvement in decision making (level 4) (33 per cent of three organisations), although the proportion of organisations in the NT with a level 1 rating (67 per cent), was higher than that for Australia as a whole (63 per cent) (figure 11.26).

Figure 11.26 **Organisations with consumer and carer participation in decision making, 2001[a, b, c, d]**



a 2001 data are preliminary only; final validation is ongoing prior to publication in the *National Mental Health Report 2003*. **b** NSW advised that the government has no authority to require consumer participation in services delivered through the primary care program. **c** Victoria advised its model of consumer consultants fits poorly with the AHCA categories. Victoria has paid consumer consultants working in mental health services. Many agencies report this in the 'other' category, which has a low ranking and according to Victoria, does not reflect the active role played by consumer consultants in service operation. **d** WA advised that NSMHS does not accurately represent consumer and carer participation strategies used in WA. At the State and regional levels, the Office of Mental Health gives high priority to the involvement of consumers and carers in developing a responsive mental health service. Several key consumer and carer advisory groups are supported and provided with financial assistance by the Office of Mental Health. Collectively, these groups provide advice and representation on consumer and carer issues.

Source: DHA NSMHS database (unpublished); table 11A.40.

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.

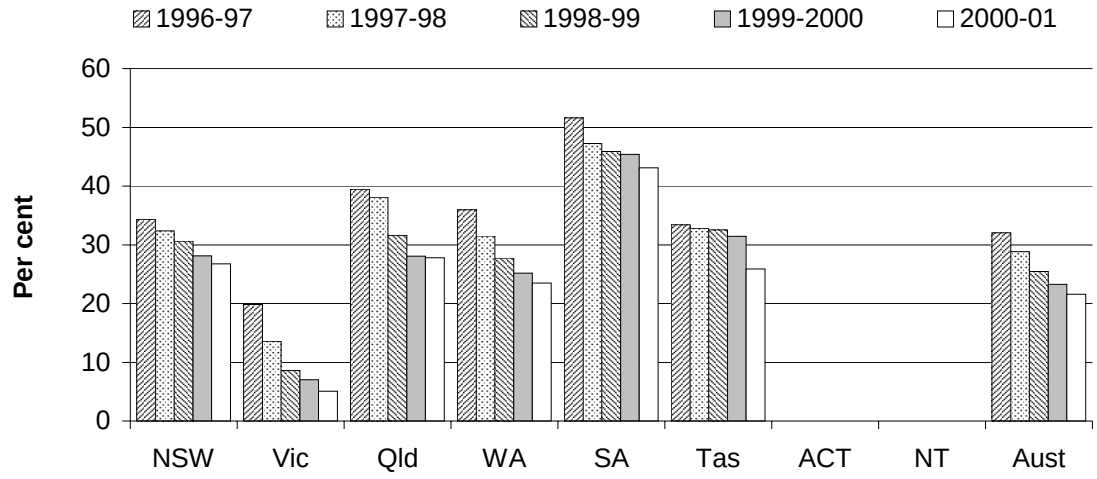
By encouraging treatment of patients in community settings and public (non-psychiatric) hospitals rather than in stand-alone psychiatric hospitals — that is, to

substitute the service settings — more appropriate treatment options can be provided.

As mentioned earlier, data in the Report relating to public mental health services are drawn from the NSMHS. It should be noted that NSMHS data for 2000-01 are preliminary, as validation has not yet been completed. There are a number of anomalies yet to be resolved. For example, SA has found some anomalies with its staffing and expenditure data since the NSMHS data were included in this Report. Final validation is ongoing prior to publication in the *National Mental Health Report 2003*. Data for 2000-01 should, therefore, be treated with care.

Figure 11.27 shows recurrent expenditure on stand-alone psychiatric hospitals as a proportion of total spending on mental health services. This indicator has changed from previous years, where recurrent expenditure on psychiatric hospitals was expressed as a proportion of recurrent spending on inpatient services. The new indicator is a broad measure of progress towards establishing an 'appropriate service mix' and provides a better basis for comparisons between jurisdictions. In 2000-01, the proportion was highest in SA (43.1 per cent) and lowest in Victoria (5.1 per cent). (As noted earlier, the ACT and the NT have no psychiatric hospitals.)

Figure 11.27 **Recurrent expenditure on stand-alone psychiatric hospitals as a proportion of total spending on mental health services[a, b]**



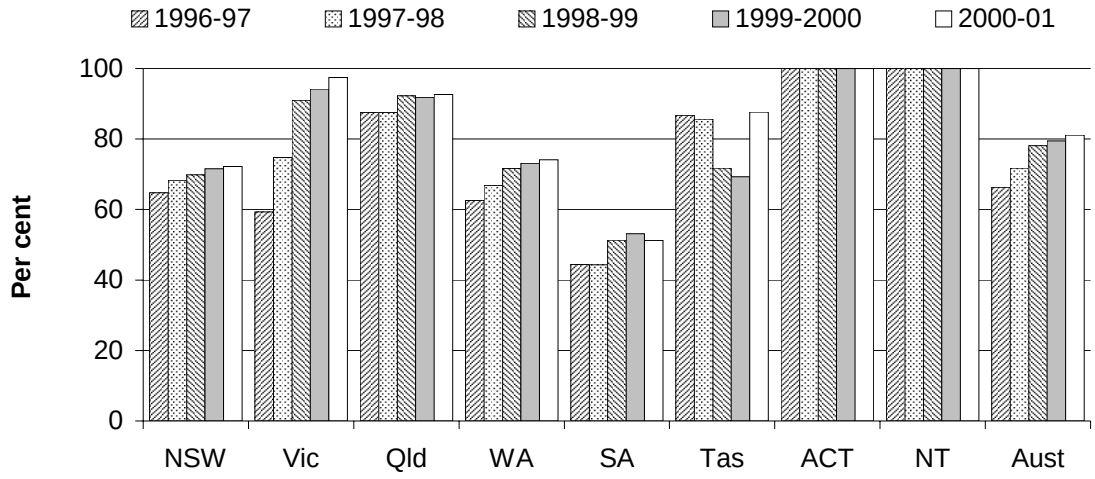
a 2000-01 data are preliminary only; final validation is ongoing prior to publication in the *National Mental Health Report 2003*. **b** The ACT and the NT do not have public psychiatric hospitals.

Source: DHA NSMHS database (unpublished); table 11A.41.

Figure 11.28 shows acute patient days in public acute hospitals as a proportion of total acute inpatient bed days in public acute and psychiatric hospitals. This indicator has changed from previous years. Previously, patient days in public (non-

psychiatric) hospitals were divided by total inpatient bed days. The change reflects the objectives of the NMHS to mainstream acute inpatient services. Again, it needs to be noted that the ACT and the NT do not have psychiatric hospitals. In 2000-01, aside from the Territories, the highest proportion of acute patient days in public acute hospitals was in Victoria (97.4 per cent) and the lowest in SA (51.2 per cent).

Figure 11.28 **Acute patient days in public acute hospitals as a proportion of total acute inpatient bed days in public acute and psychiatric hospitals[a]**



a 2000-01 data are preliminary only; final validation is ongoing prior to publication in the *National Mental Health Report 2003*.

Source: DHA NSMHS database (unpublished); table 11A.41.

Outcomes

Mortality due to suicide

Evidence indicates that people with a mental disorder are at a higher risk of suicide than the general population (although it is worth noting that they are also at a higher risk of death from other causes, such as cardiovascular disease).

While the performance of mental health services is important in reducing suicide, other government services also play a significant role. Public mental health programs are primarily concerned with providing treatment and support services for individual clients affected by serious mental illness, some of whom have either attempted or indicated the intention to commit suicide. Suicide prevention targeted at the wider population is also addressed through the initiatives of a range of other government departments and NGOs and other special interest groups. Therefore,

any impact on suicide will be as a result of a coordinated response across a range of collaborating agencies, including police, education, housing, justice, and community services.

In addition, there are many factors outside the control of mental health services that may influence a person's decision to commit suicide. These include environmental, sociocultural and economic risk factors. For example, adverse childhood experiences, such as sexual abuse, can increase the risk of suicide, particularly in adolescents and young adults. Alcohol and other drugs are also often associated with increased risk of suicidal behaviour. Other factors can also influence suicide rates, such as economic growth rates that affect unemployment rates and social disadvantage. Often the risk of suicidal behaviour can be increased by a combination of these factors.

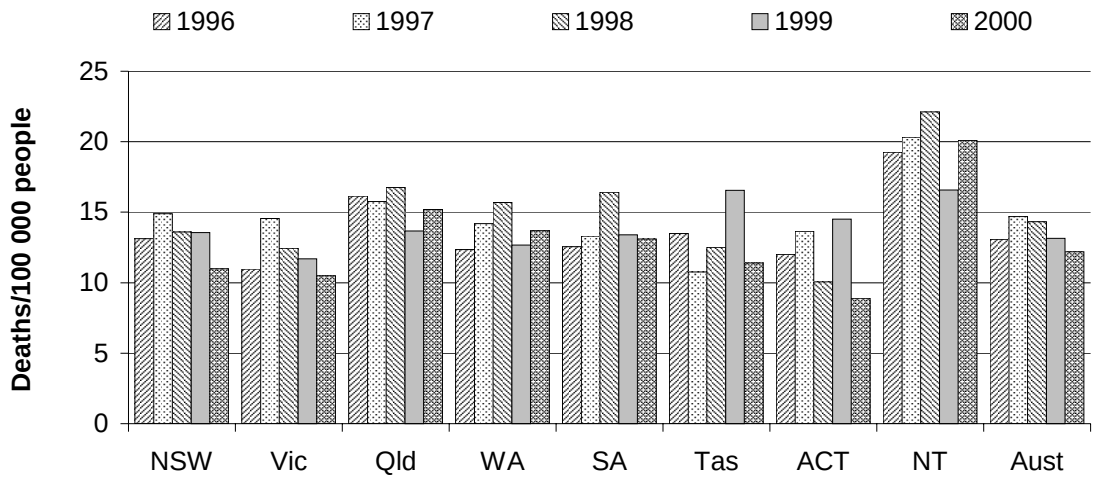
It needs to be noted that not all of those who commit suicide are patients of mental health services. An improved indicator would be restricted to suicide by patients of mental health services.

In 2000, 2363 deaths by suicide were recorded in Australia — equivalent to 12.2 deaths per 100 000 people. The national rate has fallen each year since 1997. The rate for males was around four times that for females in 2000 — a ratio that was constant over the 10 years to 2000 (table 11A.42). The NT had the highest suicide rate in 2000 (20.1 suicides per 100 000 people). The ACT had the lowest rate (8.9) (figure 11.29).

In 1999 and 2000, suicide was the second leading cause of death for people aged 15–24 years after transport accidents (ABS 2001) — 338 people in this age group died as a result of suicide. This represented 20.3 per cent of deaths in this age group — equivalent to a rate of 12.5 deaths per 100 000 people aged 15–24 years. The NT recorded the highest suicide rate (22.3 deaths per 100 000 people aged 15–24 years), while both Victoria and the ACT recorded the lowest (9.7 deaths) (table 11A.44). Suicide was the leading cause of death for 25–34 year olds in 1999 and 2000 (22.8 per cent of deaths in this age group resulted from suicide) (ABS 2001).

The suicide rate per 100 000 people in 2000 was generally higher in rural areas than in capital cities or other urban areas (table 11A.45). In 2000, Australia-wide, there were 15.4 suicides per 100 000 people in rural areas compared with 10.8 suicides in capital cities and 13.8 in other urban centres (figure 11.30).

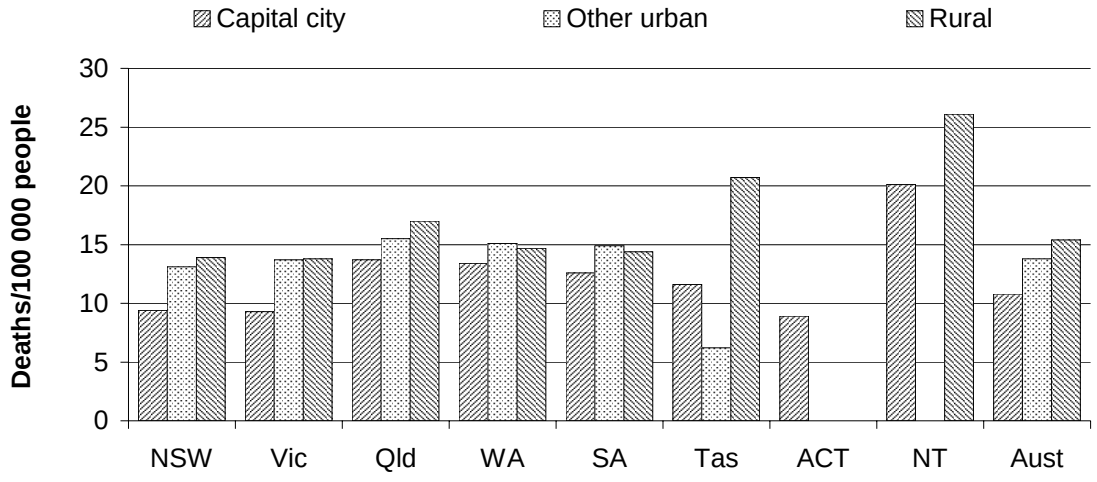
Figure 11.29 **Suicide deaths per 100 000 people**[a, b, c]



a By year of registration. Year-to-year variation can be influenced by coronial workloads. **b** Age-standardised death rate to the mid-year 1991 population. **c** Low populations can result in small variations in the number of suicides appearing as large changes in rates (which are not statistically significant).

Source: ABS (2001); table 11A.43.

Figure 11.30 **Suicide deaths by area per 100 000 people, 1999**[a, b, c, d, e]



a Other urban = centres with more than 20 000 population. **b** Age-standardised death rate to the mid-year 1991 population. **c** By year of registration. Year-to-year variation can be influenced by coronial workloads. **d** Tasmania advised that the three criteria for these data tend to distort the Tasmanian picture due to the low level of urbanisation. **e** The ACT rates for rural were zero. The ACT did not have any 'other urban areas'. The NT rate for other urban was zero.

Source: ABS (2001); table 11A.45.

In 2000, 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.[11] Estimating the Indigenous population is difficult because the propensity for people to identify as Indigenous varies across jurisdictions and over time. In addition, Indigenous people are not always accurately identified in administrative collections, such as hospital records and birth and death registrations, due to variations in definitions, different data collection methods and failure to record Indigenous status. See the Health preface for a discussion of the quality of Indigenous mortality data collected by the ABS.

The 2000 Indigenous suicide rate in WA was 41.4 per 100 000 Indigenous people compared with around 13.7 per 100 000 for the total WA population. In the NT in 2000, the Indigenous suicide rate was 23.3 per 100 000 Indigenous people compared with 20.1 per 100 000 people for the total population (tables 11A.46 and 11A.43).

Progress towards the introduction of routine consumer outcomes assessment by services

This indicator is reported for the first time this year. There is currently no information on consumer outcomes, but jurisdictions are introducing a collection which will enable reporting in future (section 11.5). As a result, this is an interim indicator. The consumer outcomes measurement implementation strategy is summarised in box 11.7. The percentages of specialised mental health services that have introduced routine consumer outcome measurement are shown in table 11.8.

Box 11.7 **Summary of the consumer outcomes measurement implementation strategy**

States and Territories have taken the following approach to introducing consumer outcome measurement as part of day to day service delivery.

- Measures to include ratings by clinicians and self ratings by consumers.
- All clinical staff to have undergone training.
- Processes established to ensure uniformity in collection.
- Funding for information systems to store, analyse and report on the data.
- National approach to data analysis, reporting and benchmarking.

Source: DHA (2002).

11 While the ABS considered data for Queensland, WA, SA and the NT to be of publishable standard, the trend figures for Indigenous suicides should still be interpreted with care because of the low number of suicides among Aboriginal people and uncertainty about the accuracy of Aboriginal population estimates.

Table 11.8 **Specialised mental health services that have introduced routine consumer outcome measurement (per cent)[a]**

	NSW	*Vic*	*Qld*[b]	*WA*[c]	*SA*[d]	*Tas*	*ACT*	*NT*	*Aust*
December 2000	–	–	–	–	–	–	–	–	–
June 2001	25.1	16.9	–	–	–	19.4	–	–	18.3
June 2002	88.3	16.9	–	–	–	16.7	–	–	34.0

a Data are based on reports from jurisdictions. Jurisdictions report at varying levels, reflecting differences in service structure; for example, data may be reported at area health service level or at hospital level, with each level containing a number of specialist mental health services. Data are therefore aggregated. National averages are weighted by the relative share of total mental health expenditure. See *National Mental Health Report 2002* for further details. **b** Queensland has renegotiated its National Mental Health Information Development Funding Agreement to more accurately reflect its capacity to report. Substantial technical and planning work is underway to introduce information system enhancements and design a workforce training strategy to implement routine outcomes measurement. Queensland should be able to report a small number of sites by June 2003. **c** The three major components of the WA Mental Health Information Development Plan (including the development and rollout of the new Mental Health Clinical Information System, the Clinical Training Program and the Business Process Re-engineering) are on target as per agreement with the Commonwealth Department of Health and Ageing. The development of the new information system is on schedule. The system will be rolled-out to all public mental health services in WA between January and June 2003. The Clinical Training Program commenced in October 2002 and will continue until September 2003. The training focuses on the integration of consumer outcome assessment using the nationally agreed tools in day to day clinical practice. The Business Process Engineering is concerned with changes to mental health services at a local level to ensure that benefits of the implementation of routine assessment of consumer outcomes are fully realised. **d** SA has not yet started collecting these data. – Nil or rounded to zero.

Source: DHA (unpublished), based on State and Territory progress reports submitted under the reporting requirements of Information Development Agreements; table 11A.48.

Efficiency

Data in the Report relating to public mental health services are drawn from the NSMHS. As previously mentioned, NSMHS data for 2000-01 are preliminary, as validation has not yet been completed and there are a number of anomalies yet to be resolved. Final validation is ongoing prior to publication in the *National Mental Health Report 2003*. Data for 2000-01 should therefore be treated with care.

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 9). The current method for adjusting inpatient separations (AR-DRGs), however, does not account for the full range or complexity 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. These data needs to be used with care when making comparisons.

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 across all service settings. Through this process, it is expected that casemix-adjusted comparisons between jurisdictions will be possible in future years.

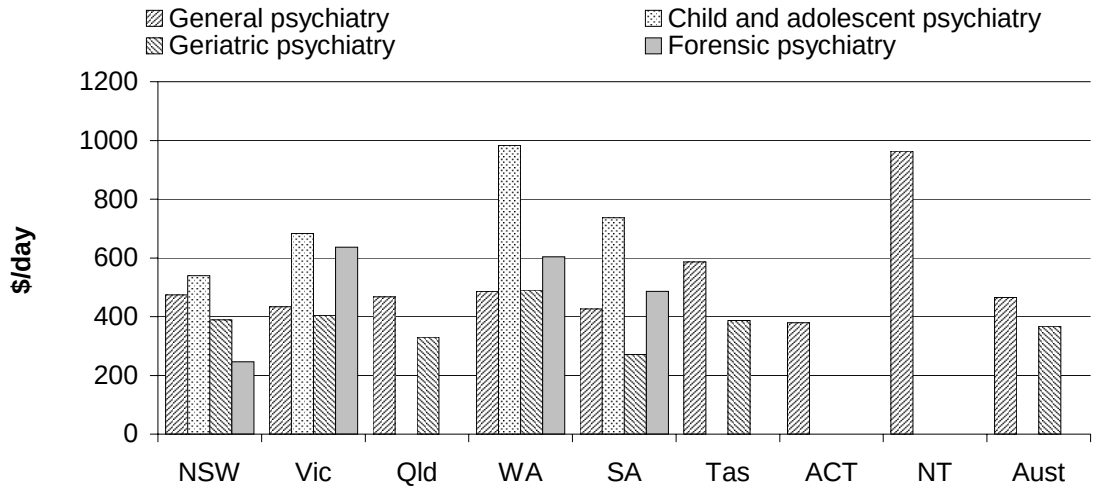
The cost per inpatient bed day is affected by factors such as differences in the client mix and average length of stay. The client mix in inpatient settings may differ — for example, some jurisdictions treat a higher proportion of less complex patients in inpatient settings rather than in the community. 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.

This year, real inpatient costs per day are reported disaggregated by inpatient program type (general psychiatry, child and adolescent psychiatry, geriatric psychiatry, and forensic psychiatry) and hospital type (psychiatric hospitals [acute units], psychiatric hospitals [non-acute units], and general hospitals). Disaggregating these data improves comparability across jurisdictions. Real inpatient costs per day are presented in figures 11.31 and 11.32. Changes over time reflect in part institutional change in accordance with the NMHS.

In terms of inpatient program type in 2000-01, average general psychiatry patient day costs were highest in the NT ($964) and lowest in the ACT ($380). Average patient day child and adolescent psychiatry costs were highest in WA ($983) and lowest in NSW ($539). Geriatric psychiatry costs were highest in WA ($490) and lowest in SA ($272). Forensic psychiatry costs were highest in Victoria ($636) and lowest in NSW ($246) (figure 11.31).

Average recurrent cost per inpatient bed day by inpatient program type has been converted to 1999-2000 dollars using State and Territory deflators for government final consumption expenditure on hospital and clinical services. Average costs converted to 1999-2000 dollars using a national deflator for final consumption expenditure by governments on hospital/nursing home care are reported in table 11A.63. The deflators are included in tables 11A.74 and 11A.75.

Figure 11.31 **Average cost (recurrent) per inpatient bed day, public hospitals, by inpatient program type, 2000-01 (1999-2000 dollars)**[a, b, c, d, e, f]



[a] 2000-01 data are preliminary only; final validation is ongoing prior to publication in the *National Mental Health Report 2003*. [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] Constant price expenditure expressed in 1999-2000 prices, using Government Final Consumption Expenditure on Hospital and Clinical Services as deflator. Deflator is reported in table 11A.74. [e] In 2000-01, child and adolescent psychiatry and forensic psychiatry programs were not available, or could not be separately identified, in Tasmania, the ACT and the NT. Geriatric psychiatry programs were not available, or could not be separately identified, in the ACT and the NT. Tasmanian figures include child and adolescent psychiatry and forensic psychiatry within the general psychiatry category. [f] Queensland data for forensic psychiatry along with child and adolescent psychiatry not provided.

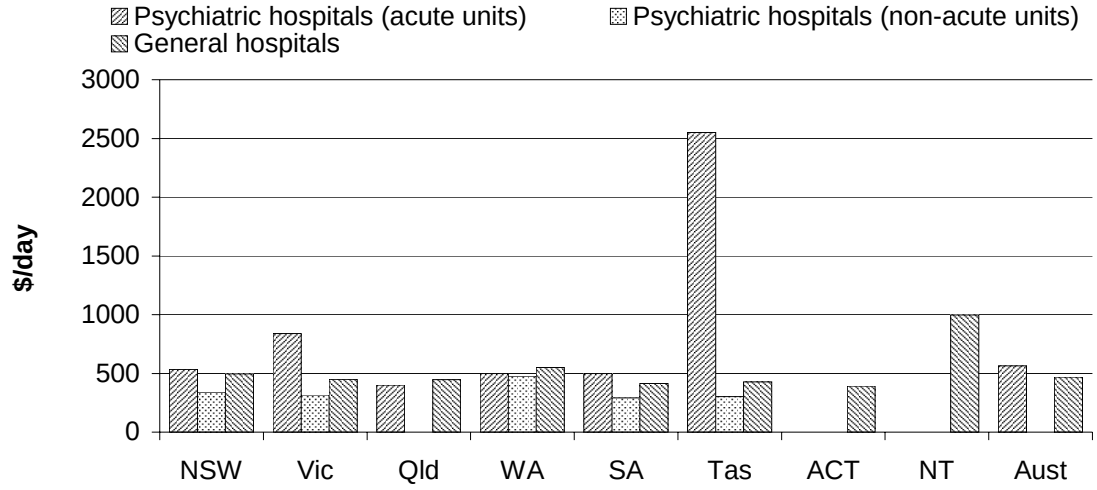
Source: DHA NSMHS database (unpublished); table 11A.49.

In terms of hospital type in 2000-01, average patient day costs in psychiatric hospitals (acute units) were highest in Tasmania ($2550) and lowest in Queensland ($402). Average costs in psychiatric hospitals (non-acute units) were highest in WA ($476) and lowest in SA ($292). The ACT and the NT do not have psychiatric hospitals. Average costs in general hospitals were highest in the NT ($997) and lowest in the ACT ($392) (figure 11.32).

Institutional downsizing and structural reform are important considerations when interpreting interjurisdictional differences. For example, Tasmania's high unit costs for public psychiatric hospitals are a direct effect of the downsizing and eventual closure of the jurisdiction's only stand-alone psychiatric hospital.

Average recurrent cost per inpatient bed day by hospital type has been converted to 1999-2000 dollars using State and Territory deflators for government final consumption expenditure on hospital and clinical services. Average costs converted to 1999-2000 dollars using a national deflator for final consumption expenditure by governments on hospital/nursing home care are reported in table 11A.64.

Figure 11.32 **Average cost (recurrent) per inpatient bed day, public hospitals, by hospital type, 2000-01 (1999-2000 dollars)[a, b, c, d, e, f, g, h]**



a 2000-01 data are preliminary only; final validation is ongoing prior to publication in the *National Mental Health Report 2003*. **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** Constant price expenditure expressed in 1999-2000 prices, using Government Final Consumption Expenditure on Hospital and Clinical Services as deflator. Deflator is reported in table 11A.74. **e** Mainstreaming has occurred at different rates in different jurisdictions. Victoria advised that the data for psychiatric hospitals comprises mainly forensic services, since nearly all general psychiatric treatment occurs in mainstreamed units in general acute hospitals. This means that the client profile and service costs are very different from those of a jurisdiction where general psychiatric treatment still occurs mostly in psychiatric hospitals. **f** The ACT and the NT do not have psychiatric hospitals. **g** Tasmania advised that the last stages of the closure of the Royal Derwent Hospital resulted in anomalous data; that is, infrastructure expenditure spread over very few beds. **h** Queensland data for psychiatric hospitals (non acute units) not provided.

Source: DHA NSMHS database (unpublished); table 11A.50.

Average costs for community residential patient care

The average cost to government (recurrent) per patient day for community residential services is presented in table 11.9. 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 11.9. 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.

This year average cost to government (recurrent) per patient day for community residential services are reported for both care of adults and care of older people. The distinction is made to reflect the differing unit costs of treating the two groups.

The estimates in table 11.9 suggest that for general adult units in 2000-01, the average cost to government per patient day for 24-hour staffed community residential services Australia-wide was $221 — highest in Tasmania ($349) and lowest in SA ($86). Within the NT, 24-hour staffed residential services were not available in 2000-01. For non 24-hour staffed community residential units, the average cost to government per patient day Australia-wide was $86 — highest in Victoria ($127) and lowest in the ACT ($46). Non 24-hour staffed residential services were not available within WA, SA and Tasmania in 2000-01. The previous caveat for the apparent absence of community residential beds in Queensland also applies to the data in table 11.9, in particular data prior to 2000-01 reflects the NSMHS definition.

In 2000-01, for jurisdictions that had community-based aged care units, the average cost to government per patient day for 24-hour staffed community residential services Australia-wide was $211. For non 24-hour staffed community residential units, the average cost to government per patient day Australia-wide was $132.

Average cost to government (recurrent) per patient day for community residential services has been converted to 1999-2000 dollars using State and Territory deflators for government final consumption expenditure on hospital and clinical services. Average costs converted to 1999-2000 dollars using a national deflator for final consumption expenditure by governments on hospital/nursing home care are reported in table 11A.65.

Average costs for ambulatory (non-admitted) services

Estimates of average costs for non-admitted patients are presented as an indicator of efficiency. 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. Unit costs (dollars per treated patient in the community) for 2000-01 are presented for all States and Territories in the points below.

Table 11.9 **Average cost to government (recurrent) per patient day for community residential services (1999-2000 dollars)[a, b, c, d]**

	NSW	*Vic*	*Qld* [e, f]	*WA*	*SA*[g]	*Tas*[h]	*ACT*	*NT* [e]	*Aust*
General adult units									
1998-99									
24-hour staffed units	252.86	230.42	..	209.67	93.39	244.80	226.58	..	230.48
1999-2000									
24-hour staffed units	199.28	228.53	774.36	265.62	96.67	233.56	218.27	..	220.62
Non 24-hour staffed units	61.14	123.19	..	..	..	..	47.77	62.83	85.87
2000-01									
24-hour staffed units	155.33	250.36	..	279.61	86.18	349.06	305.15	..	220.58
Non 24-hour staffed units	52.89	127.26	..	..	..	..	46.46	73.93	86.45
Aged care units									
1998-99									
24-hour staffed units	199.69	198.02	..	..	..	282.94	..	..	201.98
1999-2000									
24-hour staffed units	237.75	186.29	..	..	..	277.12	..	..	199.16
Non 24-hour staffed units	110.14	..	..	..	..	..	..	..	110.14
2000-01									
24-hour staffed units	234.60	206.56	..	..	..	213.57	..	..	210.91
Non 24-hour staffed units	118.60	138.36	..	..	..	..	..	..	131.57

a 2000-01 data are preliminary only; final validation is ongoing prior to publication in the *National Mental Health Report 2003*. **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** Constant price expenditure expressed in 1999-2000 prices, using Government Final Consumption Expenditure on Hospital and Clinical Services as deflator. Deflator is reported in table 11A.74. **e** 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. **f** According to the NSMHS, 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** SA does not have any community residential services which are aged care units. **h** Tasmanian services include both acute and rehabilitation units which have higher unit costs than extended care units. In 2001 additional new units were established with establishment costs included in recurrent expenditure for that year. **..** Not applicable.

Source: DHA NSMHS database (unpublished); table 11A.51.

The data currently reported for this indicator are unreliable and comparisons across jurisdictions are not possible for several reasons. First, a marked proportion of

services did not report. Second, the absence of unique patient identifiers in many jurisdictions means that clients who happen to attend mental health services other than their usual service may be counted twice. This double counting may artificially reduce average costs in some States or Territories. Victoria, WA and the NT have Statewide systems of unique identifiers, so the extent of overcounting of patients in these States is relatively low compared with other jurisdictions. Third, differences across jurisdictions in the complexity of cases treated, the service options available for treatment and admission practices also reduce comparability of data between States and Territories. Lastly, cost components such as depreciation are not measured consistently across jurisdictions.

- NSW reported unit costs for ambulatory care of $850, with 26.7 per cent of services not reporting (table 11A.52).
- Victoria reported unit costs for ambulatory care of $2125, with 1.6 per cent of services not reporting (table 11A.53).
- Queensland reported unit costs for ambulatory care of $1177, with all services reporting (table 11A.54).
- WA reported unit costs for ambulatory care of $1358, with 2.3 per cent of services not reporting (table 11A.55).
- SA reported unit costs for ambulatory care of $988, with 25.3 per cent of services not reporting (table 11A.56).
- Tasmania reported unit costs for ambulatory care of $1611, with all services reporting (table 11A.57).
- The ACT reported unit costs for ambulatory care of $1011, with 14.3 per cent of services not reporting (table 11A.58).
- The NT reported unit costs for ambulatory care of $1236, with all services reporting (table 11A.59).

Average costs for ambulatory (non-admitted) services have been converted to 1999-2000 dollars using State and Territory deflators for government final consumption expenditure on hospital and clinical services. Average costs converted to 1999-2000 dollars using a national deflator for final consumption expenditure by governments on hospital/nursing home care are reported in tables 11A.66 to 11A.73.

11.5 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 to include management of breast cancer;
- 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.

The possibility of matching data from hospital registers with BreastScreen Australia data will be investigated. This could broaden the emphasis of the chapter from breast screening towards overall breast cancer management. The indicator 'ratio of conservative surgery to mastectomy' is an example of a currently reported indicator where data matching could occur to improve the accuracy and completeness of reporting.

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 not anticipated to commence until at least the end of 2003.

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

Victoria is developing a set of clinical performance indicators for breast cancer management as part of a comprehensive approach to quality improvement through performance monitoring and reporting. The work involves the development of indicators, a minimum dataset, and an appropriate framework for reporting to hospitals, government and the public. The project has been commissioned by BreastCare Victoria (Department of Human Services), and is being undertaken by a team from BreastScreen Victoria Inc. A strongly collaborative approach is being adopted in the development and field testing of the indicators, in order to maximise participation and ownership of the project among key stakeholders. Involvement of consumers is also a key feature of the method.

BreastScreen Victoria has conducted a comprehensive review of the national and international literature in this area, and the performance indicators being developed are based on a combination of internationally accepted best practice and consensus among stakeholders. Working groups have been convened to consider indicators across the clinical pathway, and potential indicators have been ranked according to agreed criteria, such as evidence base, burden of disease, content validity, data value, reliability and responsiveness. A draft set of indicators for field testing is being refined and the pilot sites recruited. A final recommended set of indicators should be available by August 2003.

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.

The Australian Council for Safety and Quality in Healthcare has recently been formed to establish a safety and quality agenda across health care in Australia. It is proposed that patient safety in mental health be addressed by strengthening the focus on safety and quality issues on the national mental health agenda. It is also proposed that specific indicators be developed to measure use of seclusion in acute psychiatric inpatient units, adverse drug events and suicide/attempted suicide.

The *Mental Health Information Development Plan: National Information Priorities and Strategies under the Second Mental Health Plan 1998-2003* was released in September 1999 and includes the introduction of routine consumer outcome measurement in mental health services. The Plan puts forward a number of information development strategies to strengthen the focus on consumer outcomes. These include developing agreed measurement standards, developing national reporting guidelines, establishing a national network of accredited organisations to provide clinician training in the use of outcome measures, broad adoption by service organisations of outcome measurement as an integral part of service delivery, and regular reporting by agencies of core measures.

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 AHCAs. 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.

11.6 Jurisdictions' comments

This section provides comments from each jurisdiction on the services covered in this chapter. Appendix A contains data which may assist in interpreting the performance indicators presented in this chapter. These data cover a range of demographic and geographic characteristics, including age profile, geographic distribution of the population, income levels, education levels, tenure of dwellings and cultural heritage (such as Indigenous and ethnic status).

New South Wales Government comments

“ The 2003 Report on Government Services continues to be a valuable source of data and comparisons on key areas of interest in publicly provided services. Many improvements have been made to the Report over time, but there are still areas requiring closer attention in future publications.

Comparability of data across jurisdictions remains a significant challenge. An increasing number of measures are drawn from a single source, such as the ABS and AIHW. However, there are still variable practices in the collection of data that make up these measures within and between jurisdictions. Whilst the Report aims to provide comparable data which reflect genuine issues of performance and/or gaps in services, many of the differences observed are due to data issues rather than service delivery variation. The Steering Committee for the Report maintains the principle that imperfect data should be reported, so as to draw attention to the issues to motivate data improvements. Whilst this has led to better standardisation in some areas, there are other areas where the progress has been limited. For example, the current Report includes an expanded set of measures that overcome the problems of the inconsistent assignment of patients to urgency category in this data. This expanded set reflects work undertaken by jurisdictions and the AIHW to develop more robust measures of performance for elective surgery waiting times. However, data by urgency category continue to be sought and published in the Report. Similar problems are encountered with measuring Emergency Department waiting times, given inconsistencies between clinicians, hospitals and jurisdictions in assignment of patients to triage categories, and further efforts are required to address this issue.

Where data collection is not routine, reported measures may be unrepresentative. In addition with indicators based on small numbers of events, random fluctuations may mean difference between jurisdictions lack statistical significance. Examples where these issues are of particular concern are hospital acquired infections and maternal and perinatal health. A further challenge for the report relates to changing models of care. In hospital services, concerted attempts are now being made is some States to move to treatment of patients on an outpatient basis rather than admitted patient basis. These trends have perverse impacts on a number of indicators.

Variations in how programs are organised pose other issues for comparability. For example, jurisdictions take a varied approach to whether certain services are classified under mental health programs, such as some drug and alcohol services, early intervention services for children, programs for people with brain injury, psycho-geriatric services, and community based psycho-social services. These variations impact on several measures presented in the Report. ”

Victorian Government comments

“ Victoria continues to strongly support comparisons of overall performance and key performance indicators between jurisdictions and with the best practitioners worldwide. 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 is particularly welcome. 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. 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.

A recent initiative to improve performance reporting at the State level is the development of a suite of indicators on ambulatory care sensitive conditions for which hospital admission rates may provide an indicator of the effectiveness of primary care. These indicators are based on a Victorian research study and are considered to be useful surveillance measures for commenting on aspects of accessibility to primary care prevention programs, as well as providing indicators of performance in relation to effectiveness of primary care programs in dealing with these conditions.

Encouragement is also given for individual service providers to benchmark at a much greater level of detail, and to achieve improvements at the organisational level. A current Victorian benchmarking project is seeking to bring about a commonality of financial information systems across public hospitals through the introduction of a common chart of accounts, a consistently applied financial methodology and consistency of cost allocations. This commonality will enable effective centralised monitoring of systemic cost movements and other key performance indicators (KPIs) across the industry. The system will provide hospitals with the ability to benchmark KPIs (financial/human resource/product cost) against each other. ”

Queensland Government comments

Queensland Government continues its support of performance measurement and continuous improvement in public sector service delivery through its Managing for Outcomes Performance Management Framework. The Framework provides for the regular reporting of performance to the community, culminating in the annual Priorities in Progress whole-of-government report. The Charter of Social and Fiscal Responsibility requires that the Government reports progress against the stated Outcomes on an annual basis, also incorporating a summary of Outcome evaluations undertaken during the preceding year. In addition, agencies are required to prepare Ministerial Portfolio Statements, which summarise the achievements of the agency in the preceding year against agreed performance measures and strategic directions of the forthcoming year. Queensland Health's *Quality Improvement and Enhancement Program 1999-2004,* continues its implementation to guide improvements in the safety and quality of health care, with a particular emphasis on hospital-based care. A *Patient Satisfaction Survey* was conducted to investigate patient perceptions of the care and treatment provided by the 55 largest acute care public hospitals of Queensland. Patients included in the survey were those who had spent at least one night in a participating hospital. The patients surveyed reflected a satisfaction rate of 89%. The high proportion of patients that report being satisfied with their hospital stay is reassuring and indicates that hospitals are providing high quality care and treatment. A range of health outcomes plans have been implemented in the areas of coronary heart disease, injury, diabetes mellitus and asthma, while strong support for cancer research has continued. Future plans will target cancer and stroke. Queensland Health supports improved reporting of Indigenous health indicators by the Review of Commonwealth/State Service Provision and continues an active role in assisting with this task. Queensland Health is committed to improving health outcomes for Indigenous Queenslanders through partnerships with Aboriginal and Torres Strait Islander communities. The *Aboriginal and Torres Strait Islander Primary Care Initiative* is enhancing the Government's capacity to improve health outcomes focusing on child health, nutrition and chronic disease prevention. The appointment of additional Indigenous health and nutrition workers will further assist communities develop culturally appropriate health programs and implement strategies to address alcohol-related crime and violence, cancer screening, childhood growth and nutrition in mothers and children. Queensland Health is currently developing the *Strategic Policy Framework for Aboriginal and Torres Strait Islander People's Health 2002-2007.* The Queensland Health *Framework* is underpinned by the principles of the 1994 policy as well as the key action areas identified *National Strategic Policy Framework for Aboriginal and Torres Strait Islander Health: Framework for Action by Governments (June 2002).* The *Framework* is also aligned with other key Queensland Health population based frameworks and will clarify for users the suggested action based on current and emerging strategic priorities.

Western Australian Government comments

“In 2002, the unified State public health system in WA consolidated the oversight of health into the care of the State Health Management Team (SHMT). In this model, the more traditional governance functions of a State health authority have become the responsibility of SHMT, an executive made up of the funder, the purchaser and the providers of public health services.

Population health objectives remain a significant focus of much activity in WA health. Initiatives for the maintenance of good health and the prevention of illness received attention through a number of programs that encouraged the community to pursue good lifestyle habits. Prominent among these were the *Go for 2 & 5* and the *Take Thirty* campaigns that respectively promoted the virtues of healthy eating and regular exercise.

The State held a Diabetes Symposium in May 2002 which introduced a 3-level care continuum framework to support diabetes sufferers. The Symposium brought together for the first time, all stakeholders in the care of people with diabetes.

The Oral Health Centre of Western Australia (OHCWA) and the Centre for Remote and Rural Oral health (CRROH) commenced operations in 2002. OHCWA combines tertiary training for the oral health workforce with the provision of dental health services to the eligible community. CRROH encourages dental health workers to take-up rural and remote service, through apprenticeship and rostering techniques. Both OHCWA and CRROH are jointly auspiced by the Department of Health (DoH) and the University of Western Australia.

A number of initiatives in the Mental Health sector focused on the improvement and expansion of care and support to sufferers and families of people with psychiatric illness. For example, a number of policies were released to guide the delivery of mental health services to different age groups and to people from culturally and linguistically diverse backgrounds

A major inquiry (Douglas Inquiry) into obstetric and gynaecological services at King Edward Memorial Hospital 1990-2000 was completed in 2002. A number of the Inquiry report’s recommendations are already being implemented.

The Western Australian Council of Safety and Quality of Health Care was established in 2002 to provide high level strategic advice to the Minister and the Director General. Specifically the Council is to advise the DoH on:

- monitoring and evaluating the standard of safety and quality of services;
- providing strategic direction for quality improvement in health; and
- providing an expert forum for safety and quality development in WA.

The tragedy of Bali has demonstrated the readiness of the health system to respond to immediate and unforeseen demands for complex health care. However, meeting these demands has had flow-on effects on capacity, particularly for undertaking elective care in the State’s hospitals.”

South Australian Government comments

“ 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.

The SA Government has commissioned a comprehensive review of South Australia's health system including its interface with the private and non-government sectors. The aim of the Generational Health Review is to deliver a plan that provides effective strategies for health system reform, which ensures that all South Australians enjoy the best possible health and have access to high standards of health care.

Constraints within the human services operational environment include a steadily increasing demand for human services, 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.

Due to the inclusion in this report of unvalidated data from the National Survey of Mental Health Services, total recurrent expenditure for SA on specialist mental health services is overstated for 2000-01 by about $7 million. Also full time equivalent health professional direct care staff numbers in specialist mental health services are significantly overstated. There is a trend for these staff numbers to decrease.

Table 9.18 reports Emergency Department waiting times by triage category. For the first time South Australia included data from major country hospitals (previously the scope was limited to major metropolitan hospitals). Country hospitals incorrectly reported some data, resulting in lower than expected percentages for patients seen within triage category. The percentages for SA, excluding country hospitals, are:

1- Resuscitation: 99

2- Emergency: 68

3- Urgent: 57

4- Semi-urgent: 56

5- Non-urgent: 87

Total 49 ”

Tasmanian Government comments

“Tasmania continues to support comparisons of performance against key indicators between jurisdictions. The Department of Health and Human Services acknowledges the value of the Report on Government Services and uses information from the Report in monitoring its overall performance under a framework based on that adopted by the National Health Performance Committee (NHPC). As with the frameworks used in this report and the NHPC framework, the development of meaningful and measurable indicators of performance is a continuous process of improvement over time.

During 2002 The Department has continued to embed the community benchmarks set by Tasmania *Together* into its performance monitoring system. Tasmania *Together* is a twenty-year social, environmental and economic plan for Tasmania developed through extensive community consultation. Under the plan Government Agencies are required to report annually to an independent body, the Tasmania *Together* Progress Board, on performance against a range of outcome targets.

As with other jurisdictions, Tasmania continues to face the challenges associated with increasing cost and demand pressures. The cost of maintaining and replacing essential technology and equipment together with difficulties in recruiting, training and retaining an appropriate workforce have a continuing impact on the capacity of the Department to deliver services to clients. Additionally, and as with other jurisdictions, growth in demand associated with an ageing population and increases in the prevalence of chronic disease and social conditions place a growing strain on the health and human services system. In particular, the burden of maintaining and supporting patients with chronic conditions through regular high cost intervention needs to be balanced against a greater investment and focus on lower cost preventative strategies.

Notwithstanding Tasmania’s support for the objectives of this Report, it should be noted that there are significant issues affecting jurisdictional comparability under some indicators. Jurisdictional differences in funding arrangements, administration and clinical practice can reduce comparability of data. It is hoped that further planned work undertaken around indicators, such as those relating to elective surgery, will increase the relevance of inter-jurisdictional comparisons over time.”

Australian Capital Territory Government comments

“The ACT provides a comprehensive range of health services to its residents, as well as to those living in surrounding regions of New South Wales. The ACT continues to support the comparative reporting of data across jurisdictions as a tool for supporting attempts to improve the health of its population and the cost efficiency of ACT Health Services. As in previous reports, however, readers should take care when comparing results for the ACT with those from other jurisdictions.

The ACT has a relatively small population, and comparisons of participation rates for selected services, especially for minority groups, are subject to substantial variation across time due to small numbers. A similar situation applies when comparing incidence, prevalence and mortality rates for selected conditions across jurisdictions.

Comparisons of costs for particular services across jurisdictions should also be read with caution. Accounting methods for costing services are subject to substantial variation. For example, the attribution of oncosts to services operating within a centralised administrative network can be difficult. This issue applies with public hospital costing, and may affect estimated costs for other services.

Regardless of accounting issues, readers of cost comparisons across jurisdictions should also be aware of cost drivers that may apply differentially across jurisdictions. Issues of note include: differences in the way jurisdictions structure their health systems; the presence of economies and diseconomies of scale; and, relative ability to attract qualified health workers.

The ACT Department of Health and Community Services has recently undergone a review. Along with some restructures, outcomes of this review include a move to step away from the use of a Purchaser-Provider model for hospital funding, and a more collegiate approach between the Department and health care providers. In the medium term, this may have impacts on key indicators for some ACT health services.”

Northern Territory Government comments

“The Department of Health and Community Services operates five public hospitals located in the major population centres with a combined total of 569 beds. The hospitals form a network of general and specialist medical services providing primary screening, prevention, acute and chronic care services. A network of 98 community health centres and more than 100 GP practices support the hospitals. Almost 30 per cent of the populace is Indigenous persons many living in remote localities which create challenges to ensuring access to health services.

Demands on the public hospital system in the Territory differ markedly from most other parts of Australia due to a combination of factors, including remoteness, small and scattered population and the absence of alternative health care providers. Another demand on health services is the large number of tourists who use Territory health care while in the area

As a result, public hospitals in the Territory provide a range of acute and non acute services that would not usually be provided in other states. In addition, where specialised treatments and services are not available locally, referrals are arranged for patients between NT based hospitals or to interstate hospitals. These factors, as well as relatively higher costs for transport, fuel, labour and consumables add to the cost of providing hospital services when compared to those accessed by other Australians.”

11.7 Definitions

Table 11.10 **Terms**

Term	*Definition*
General	
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.
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.
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.
Health management	The ongoing process beginning with initial client contact and including all actions relating to the client. Includes assessment/evaluation; education of the person, family or carer(s); 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).
Separation	Separation is defined as the process whereby an admitted patient completes an episode of care.
Breast cancer	
Adjuvant therapy	Treatment given after the primary treatment to increase the chances of a cure. Adjuvant therapy may include chemotherapy, radiation therapy, or hormone therapy.
Breast conserving surgery	An operation to remove the breast cancer but not the breast itself. Types of breast conserving surgery include lumpectomy (removal of the lump), quadrantectomy (removal of one quarter of the breast), and segmental mastectomy (removal of the cancer as well as some of the breast tissue around the tumour and the lining over the chest muscles below the tumour).
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.
Detection rate for small cancers	The rate of small (<= 15 mm) invasive breast cancers detected per 10 000 women screened.
Ductal carcinoma in situ (DCIS)	Abnormal cells that involve only the lining of a duct. The cells have not spread outside the duct to other tissues in the breast. DCIS is also known as intraductal carcinoma.
Invasive cancer	A tumour whose cells invade healthy or normal tissue.

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Table 11.10 **(Continued)**

Term	*Definition*
Modified radical mastectomy	Surgery for breast cancer in which the breast, some of the lymph nodes under the arm, the lining over the chest muscles, and sometimes part of the chest wall muscles are removed.
Mortality rate from breast cancer	The age-specific and age-standardised mortality rates of women who died as a result of breast cancer, expressed per 100 000 women in the population.
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.
Radiation therapy	The use of high-energy radiation from X-rays, gamma rays, neutrons, and other sources to kill cancer cells and shrink tumours. Radiation may come from a machine outside the body (external-beam radiation therapy), or from materials called radioisotopes. Radioisotopes produce radiation and can be placed in or near the tumour or in the area near cancer cells. This type of radiation treatment is called internal radiation therapy, implant radiation, interstitial radiation, or brachytherapy. Systemic radiation therapy uses a radioactive substance, such as a radiolabeled monoclonal antibody, that circulates throughout the body.
Screening	The performance of tests on apparently well people to detect a medical condition at an earlier stage than would otherwise be the case.
Screening round (first)	A woman's first visit to a BreastScreen Australia mammography screening service.
Screening round (subsequent)	A woman's visit to a BreastScreen Australia mammography screening service when she has attended such a service before.
Size of detected cancers	The percentage of invasive cancers detected classified according to tumour size.
Total mastectomy	Removal of the breast. This is also known as simple mastectomy.
Mental health	
Acute services	These services provide 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 the treatment effort is focused on symptom reduction with a reasonable expectation of substantial improvement. In general, acute psychiatric services provide relatively 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; and • targeted at the general population, or be specialist in nature, targeted at specific clinical populations. The latter group include psychogeriatric, child and adolescent, and forensic psychiatry services.

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Table 11.10 **(Continued)**

Term	*Definition*
Affective disorders	A mood disturbance, including 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 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.
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.
Available beds	Refers to the number of available beds at 30 June. Available beds are those immediately available for use by admitted patients if required. They are immediately available for use if located in a suitable place of care with nursing or other auxiliary staff available within a reasonable period. Beds in wards which were temporarily closed due to factors such as renovations or strikes but which would normally be open and therefore available for admission of patients are generally included. In many cases, available beds will be less than the number of approved beds, with the former controlled by utilisation factors and resourcing levels, while the latter refers to the maximum capacity allowed for the hospital, given sufficient resources and community demand.
Bipolar disorder	A mood disorder characterised by a history of manic (or hypomanic) episodes usually alternated with depressive episodes.
Child and adolescent psychiatry services	Services principally targeted at children and young people up to the age of 18 years. Classification of services in this category requires a recognition by the regional or central funding authority of the special focus of the inpatient service on children or adolescents.
Co-located services	Psychiatric inpatient services established physically and organisationally as part of a general hospital.
Community based residential services	Staffed residential units established in community settings that provide specialised treatment, rehabilitation or care for people affected by a mental illness or psychiatric disability. To be defined as community-based residences, the services must: provide residential care to people with psychiatric illness or disability; be located in a community setting, external to the campus of a general hospital or psychiatric institution; employ onsite staff for at least some part of the day; and be government funded.
Comorbidity	The simultaneous occurrence of two or more disorders such as depressive disorder with anxiety disorder, or depressive disorder with anorexia.

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Table 11.10 **(Continued)**

Term	*Definition*
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.
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.
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.
Forensic psychiatry services	Services principally providing assessment, treatment and care of mentally disordered individuals whose behaviour has led them to commit criminal offences or makes it likely that they will offend in the future if not adequately treated and contained.
General psychiatry services	Services principally targeting the general adult population (18–65 year range) but which may provide services to children, adolescents or the aged. General Psychiatry services therefore are those services that cannot be described as specialist child and adolescent, geriatric or forensic services. General psychiatry inpatient services include hospital units in which the principal function is the provision of some form of specialised service to the general adult population (for example, inpatient psychotherapy) or which focus on specific clinical disorders within the adult population (for example, post-natal depression, anxiety disorders).
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.
Geriatric psychiatry services	Services principally targeting people in the age group 65 years and over. Classification of services in this category requires a recognition by the regional or central funding authority of the special focus of the inpatient service on aged persons. This category does not include general psychiatry services that may treat older people as part of a more general service.
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, overfamiliarity and a decreased need for sleep are often present, but not to the extent that they lead to severe disruption.
Inpatient services	Stand-alone psychiatric hospitals or specialist psychiatric units located within general hospitals.
Mental disorder	A diagnosable illness that significantly interferes with an individual's cognitive, emotional or social abilities.

(Continued on next page)

Table 11.10 **(Continued)**

Term	*Definition*
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 health problems	Diminished cognitive, emotional or social abilities but not to the extent that the criteria for a mental disorder are met.
Mental illness prevention	Interventions that occur before the initial onset of a disorder.
Mental health promotion	Activities designed to lead to improvement of the mental health functioning of persons through prevention, education and intervention activities and services.
Mortality rate from suicide	The percentage of the population who died as a result of suicide.
Non acute services	Rehabilitation services that have a primary focus on intervention to reduce functional impairments that limit the independence of patients. Rehabilitation services are focused on disability and the promotion of personal recovery. They are also characterised by an expectation of substantial improvement over the short to mid term. Patients treated by rehabilitation services usually have a relatively stable pattern of clinical symptoms. Non-acute services also consist of extended care services that provide care over an indefinite period for patients who have a stable but severe level of functional impairment and inability to function independently without extensive care and support. Patients of extended care services usually show a relatively stable pattern of clinical symptoms, which may include high levels of severe unremitting symptoms of mental illness. Treatment effort is focused on preventing deterioration and reducing impairment. Improvement is only expected over a long time period.
Non-government organisations (NGOs)	Private not-for-profit community managed organisations that receive State and Territory government funding specifically for the purpose of providing community support services for people affected by a mental illness or psychiatric disability. Programs provided by the NGO sector may include: supported accommodation services, (including community-based crisis and respite beds); vocational rehabilitation programs; advocacy programs (including system advocacy); consumer self help services; and support services for families and primary carers.
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.
Outpatient services, —community-based	Services primarily provided to non-admitted patients on an appointment basis and delivered from health centres located in community settings, physically separated within hospital sites. Services provided may also include outreach or domiciliary care as an adjunct to services provided from the centre base.

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Table 11.10 **(Continued)**

Term	*Definition*
Outpatient services, —hospital-based	Services primarily provided to non-admitted patients on an appointment basis and delivered from clinics located within hospitals. Services provided may also include outreach or domiciliary care as an adjunct to services provided from the clinic base.
Panic disorder	Panic (anxiety) attacks that occurs suddenly and unpredictably. A panic attack is a discrete episode of intense fear or discomfort.
Patient days (occupied bed days)	Records all days or part days that each patient was in hospital during the reporting year (1 July to 30 June), regardless of the original data of admission or discharge. Key definitional rules include: • for a patient admitted and discharged on different days, only the day of admission is counted as a patient day; • admission and discharge on the same day is equal to one patient day; • leave days are not included when they involve an overnight absence; and • a patient day is recorded on the day of return from leave.
Percentage of facilities accredited	The percentage of facilities providing mental health services that are accredited according to the National Standards for Mental Health Services.
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 number of cases of a disease present in a population at a given time (point prevalence) or during a given period (period prevalence).
Preventive interventions	Programs designed to decrease the incidence, prevalence and negative outcomes of disorders.
Psychiatrist	A medical practitioner with specialist training in psychiatry.
Public health	The organised, social response to protect and promote health and to prevent illness, injury and disability. The starting point for identifying public health issues, problems and priorities, and for designing and implementing interventions, is the population as a whole or population subgroups. Public health is characterised by a focus on the health of the population (and particular at-risk groups) and complements clinical provision of health care services.
Public (non-psychiatric) hospital	A hospital that provides at least minimum medical, surgical or obstetric services for inpatient treatment and/or care, and around-the-clock, comprehensive, qualified nursing services as well as other necessary professional services.
Schizophrenia	A combination of signs and symptoms which may include delusions, hallucinations, disorganised speech or behaviour, a flattening in emotions and a restriction in thought, speech and goal-directed behaviour.
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.

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Table 11.10 **(Continued)**

Term	*Definition*
Specialised mental health services	Services defined as those in which: • the primary function is specifically to provide treatment, rehabilitation or community support targeted towards people affected by a mental disorder or psychiatric disability, this criterion being applicable regardless of the source of funds; and • such activities are delivered from a service or facility which is readily identifiable as both specialised and serving a mental health function.
Specialised residential services	Services provided in the community that are staffed by mental health professionals on a 24-hour basis.
Staffing categories (mental health)	*Medical officers:* All medical officers employed or engaged by the organisation on a full time or part time basis. Includes visiting medical officers who are engaged on an hourly, sessional or fee for service basis. *Other medical officers:* Medical officers employed or engaged by the organisation who are neither registered as psychiatrists within the State or Territory nor formal trainees within the Royal Australian and New Zealand College of Psychiatrists' Postgraduate Training Program. *Psychiatrists and consultant psychiatrists:* Medical officers who are registered to practice psychiatry under the relevant State or Territory Medical Registration Board. *Psychiatry registrars and trainees:* Medical officers who are formal trainees within the Royal Australian and New Zealand College of Psychiatrists' Postgraduate Training Program. *Nursing staff:* All categories of registered nurses, enrolled nurses, student nurses or trainee/pupil nurses employed or engaged by the organisation. *Registered nurses:* Persons with at least a three-year training certificate or tertiary qualification and certified as a registered nurse with the State or Territory registration board. This is a comprehensive category and includes general and specialist categories of registered nurses. *Non registered nurses:* Enrolled nurses and student nurses not included in the previous category. *Diagnostic and health professionals:* Qualified staff (other than qualified medical or nursing staff) engaged in duties of a diagnostic, professional or technical nature. This category covers all allied health professionals, such as social workers, psychologists, occupational therapists, physiotherapists, pharmacists, speech pathologists, and dietitians. *Social workers:* Persons who have completed a course of recognised training and are eligible for membership of the Australian Association of Social Workers. *Psychologists:* Persons who are registered as psychologists with the relevant State or Territory registration board. *Occupational therapists*: Persons who have completed a course of recognised training and who are eligible for membership of the Australian Association of Occupational Therapists. *Other personal care staff:* Attendants, assistants, home companions, family aides, ward helpers, wardsmen, orderlies, ward assistants and nursing assistants engaged primarily in the provision of personal care to patients or residents, who are not formally qualified or undergoing training in nursing or allied health professions.

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Table 11.10 **(Continued)**

Term	*Definition*
Staffing categories (mental health) (Continued)	*Administrative and clerical staff:* Staff engaged in administrative and clerical duties. Medical, nursing, diagnostic and health professional and domestic staff wholly or partly involved in administrative and clerical duties are excluded, and should be counted under their appropriate occupational categories.
	Domestic and other staff: Staff involved in the provision of food and cleaning services. This category also includes all staff not elsewhere included (for example, maintenance staff, tradespersons, gardening staff).
Stand-alone hospitals	Beds within health establishments primarily devoted to the treatment and care of inpatients with psychiatric, mental or behavioural disorders, which are situated at physically separate locations from a general hospital. Stand-alone hospitals may or may not be managed by the mainstream health system. Psychiatric hospitals situated at physically separate locations from a general hospital are included within the 'stand alone' category regardless of whether they are under the management control of a general hospital.
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.

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F Community services preface

Families are the principal providers of care for children, older people and people with a disability. Community services can help families to undertake this role and can fulfil this role where families are not in a position to provide care. Community services covered by this Report encompass aged care services, services for people with a disability, children's services, and protection and support services (child protection, supported placements, and supported accommodation and assistance).

Community service activities (box F.1) typically include those activities 'which assist or support members of the community in personal functioning as individuals or as members of the wider community' (ABS 2001). They may include financial assistance and relief to people in crisis, and housing assistance of a short term or transitional nature, but exclude acute health care services (see chapters 9–11), long term housing assistance (see chapter 16) and income support (such as social security pensions and allowances).

The definition of community service activities contained in this preface is based on the National Classification of Community Services, developed by the Australian Institute of Health and Welfare (AIHW 1997) (box F.1). Data for this preface were derived from the expenditure data collated for the chapters on:

- aged care services (chapter 12);
- services for people with a disability (chapter 13);
- children's services (chapter 14) and
- protection and support services (chapter 15).

The preface also includes descriptive data obtained from the Australian Institute of Criminology (AIC) on the number and detention rates of, juveniles in correctional facilities. It is anticipated that the Report will contain performance reporting on juvenile justice in future years.

Performance information on community services as a whole is not currently reported. While there are many interactions among the various community services, the services and their systems are too varied to enable aggregate community services reporting.

Box F.1 **Community service activities**

Child care — the provision of care, by persons other than the child's parents, under the supervision of a paid coordinator in a group setting or in another home.

Training and employment for people with disabilities — services that assist people with a disability in the labour market by providing training, job search skills, help in finding work, placement and support in open employment and, where appropriate, supported employment.

Financial and material assistance — provision of financial aid and goods (such as equipment, clothing and household items, food and vouchers) on a temporary emergency basis, to meet particular needs in times of crisis or disaster.

Residential care — services that help people who are disadvantaged (in terms of their capacity for independent living) to access suitable community housing arrangements and other appropriate community resources.

Foster care placement — placement of a child or young adult who lives apart from natural or adoptive parents in a private household with one or more adults who act as substitute parents.

Accommodation placement and support — services that assist disadvantaged people gain access to, and help maintain them in, suitable community housing arrangements (for example, State or Territory housing agency accommodation). These services include placement/outreach services for those leaving refuges.

Statutory protection and placement — services that include daily care, protective investigation, post-investigation intervention, removal to alternative care, statutory case management of out-of-home placements and/or application for a child protection order to the Children's Court and adoption placement.

Juvenile and disability corrective services — services that provide correctional and rehabilitative supervision and protection of public safety through corrective arrangements (for example, supervision of community-based orders and management of juvenile justice detention centres) and advice to courts and parole boards on juvenile offenders or offenders with intellectual or psychiatric disabilities. (Corrective activities for adults other than those with an intellectual or psychiatric disability are excluded.)

Other direct community service activities — other direct community service activities, such as preschool activities, recreation/leisure activities, community nursing services and other personal and social support.

Community service related activities — policy, community and service development and support, government administration of funding and monitoring of the licensing and regulating of service providers, retirement village self care units, and other community service related activities.

Source: Australian Bureau of Statistics (ABS) (2001).

Profile of community services

Roles and responsibilities

Government involvement in community services includes:

- funding non-government community service organisations (which then provide community services to clients);
- providing services to clients directly;
- regulating non-government providers; and
- undertaking policy development and administration.

The relative contribution of government to the direct provision of services varies across community service activities. Statutory protection and placement, and corrective services are provided primarily by government, while residential care and accommodation support, and other community services activities are provided primarily by non-government organisations.

Expenditure

In previous reports, expenditure has been estimated using data derived from the AIHW *Welfare Services Expenditure Bulletin no. 6*, the AIHW *Health Expenditure Bulletin no. 17* and the Australian Bureau of Statistics (ABS) Community Services Survey. These data were unavailable for this report, so, total expenditure has been calculated based on the 2001-02 expenditure totals for aged care services (see chapter 12), services for people with a disability (see chapter 13), children's services (see chapter 14) and protection and support services (see chapter 15). Community services expenditure in this preface, therefore, relates to only the activities as defined under these individual chapters.

Total expenditure on community services covered by this report was estimated to be $11.5 billion in 2001-02. Total community services expenditure was equivalent to 1.7 per cent of gross domestic product in that year, with government community services expenditure equivalent to 7.0 per cent of total government outlays (ABS 2002).

Given the move in government financial statistics from a cash accounting system to an accrual accounting system, data for 1998-99 onwards are not comparable to data for earlier years. Between 1998-99 and 2001-02, community services expenditure increased by $2.2 billion, or 23.5 per cent in real terms (table F.1). The biggest increase was in children's services, for which expenditure rose by 43.4 per cent

between 1998-99 and 2001-02; the smallest increase was in aged care services, for which expenditure rose 16.8 per cent over the period.

Table F.1 **Real recurrent expenditure on community services (2001-02 dollars) ($ million)**

	Aged care services	*Disability services*	*Children's services*	*Protection and support services*	***Total***
1998-99	4 703	2 262	1 507	856	**9 328**
1999-200	4 897	2 415	1 598	953	**9 863**
2000-01	4 982	2 545	1 863	1 025	**10 415**
2001-02	5 492	2 746	2 161	1 120	**11 519**

Source: Commonwealth, State and Territory governments (unpublished); tables 12A.45–51, 13A.22, 14.A4, 15A.1 and 15A.155.

In 2001-02, 47.7 per cent of community services expenditure related to aged care services, 23.8 per cent related to disability services, 18.8 per cent related to services for children's services, and 9.7 per cent related to protection and support services (table F.2).

Table F.2 **Government recurrent expenditure on community services covered in the Report, 2001-02**

Category	*Expenditure*	*Share*
	$m	%
Aged care service	5 492	47.7
Disability services	2 746	23.8
Children's services	2 161	18.8
Protection and support services	1 120	9.7
Total	**11 519**	**100.0**

Source: Commonwealth, State and Territory governments (unpublished); tables 12A.45–51, 13A.22, 14A.4, 15A.1 and 15A.155.

Size and scope

Almost 9300 organisations were providing community services, covering the not-for-profit, government, and for-profit sectors, at 30 June 2000. The number of organisations increased by 15.3 per cent from the previous ABS Community Services Survey in 1995-96. The number of government organisations remained virtually unchanged over this period, while the number of for-profit and not-for-profit organisations increased by 32.4 per cent and 9.9 per cent respectively (ABS 2001).

Across the three sectors at June 2000, these organisations employed 341 400 people (up 7.0 per cent from 1995-96), including 277 300 employed in direct service

provision (up 24.2 per cent). A further 299 400 volunteers assisted in community service activities, representing a 25.4 per cent increase from the number of volunteers in 1995-96 (ABS 2001). Government organisations employed 59 200 people in providing community services (down 13.0 per cent from the number in 1995-96), who were assisted by almost 18 000 volunteers (down 18.5 per cent) (ABS 2001).

Table F.3 **Output measures for direct community services activities, 1999-2000[a]**

Direct community service activity	*Unit*	*Number ('000)*
Personal and social support		
Information, advice and referral	Contacts/year	7 612.1
Individual and family support	Cases/year	3 663.2
Independent and community living support	Cases/year	1 871.1
Support in the home	Clients/year	1 965.0
Child care		
Centre based long day care	children/day	140.0
Family day care	children/day	11.1
Occasional care	children/day	7.2
Before and after school hours care	children/day	35.8
Vacation care	children/day	23.2
Other child care	children/day	4.2
Training and employment for people with disabilities		
Pre-vocational/vocational training	trainees/year	9.6
Employment, job placement and support	clients/year	44.0
Supported employment/business services	employees/day	17.4
Financial and material assistance	Cases/year	1 749.1
Residential care		
Transitional accommodation	bed nights/year	2 587.2
Crisis accommodation	bed nights/year	2 796.5
Intensive residential care	residents/day	72.6
Hostel care	residents/day	66.8
Residential respite care	occupants/day	6.5
Residential rehabilitation	residents/day	2.4
Other residential care	residents/day	22.6
Foster care placement	placements/year	57.8
Statutory protection and placement	cases/year	139.8
Juvenile and disability corrective services	cases/year	37.0

a See definitions in box F.1. **na** Not available.

Source: ABS (2001).

The numbers and types of service provided in 1999-2000 varied across community service activities (table F.3).

- In personal and social support, 7.6 million contacts for information, advice and referral were made.

- In child care, around 140 000 children each day were in centre-based long day care.
- An average of 72 600 residents per day were in intensive residential care (such as nursing homes and residential support institutions for the aged or people with a disability).
- A total of 2.8 million bed nights of crisis accommodation were provided, in addition to 2.6 million bed nights of transitional accommodation.

An important issue for government is to determine how to assist community service clients in meeting their complex needs and how to assess performance in meeting these needs. Governments have introduced case management and policy coordination at a more central level to improve the delivery of services.

There are also links between community services and other government services. The performance of community services may influence outcomes for clients of education, health, housing and justice sector services; in turn, these other service areas, affect outcomes for clients of community services. A broader discussion of these links is contained in chapter 1.

Juvenile justice

It is anticipated that the Report will contain performance reporting on a range of juvenile justice services in future years. The AIHW is developing a National Minimum Data Set (NMDS) for juvenile justice. This is being developed on behalf of the Australasian Juvenile Justice Administrators (AJJA) and the National Community Services Information Management Group. The NMDS is currently in the pilot test stage and will be completed in 2003. Following the pilot, the AJJA will decide about proceeding to an ongoing national collection.

Initial work has begun on the development of performance indicators. The indicators that are developed will need to be agreed to nationally and fully tested before any decision to report against them. Comparable data sources also need to be developed.

This report as it relates to juvenile justice focuses only on detention centre data. Jurisdictions have different definitions of a juvenile, however, which may have an impact on the number and rates reported for people aged 10–17 years.

The 2003 Report includes descriptive data on the number of, and detention rates of, juveniles in correctional facilities. The AIC has published these data, having obtained the data from juvenile corrections agencies in each jurisdiction (AIC 2002). The following data relates to juvenile custodial services only and does

not describe the operation of community-based services, which supervise the majority of juvenile offenders. Community-based services have an emphasis on diversion and include a range of specific diversionary mechanisms (both cautioning and conferencing), community-based remand options and community-based sentences, either unsupervised or supervised by the juvenile justice departments.

The AIC detention data are available for all years between 1981 and 2001, although only data from 1996-97 to 2000-01 are shown here. The number of juveniles in the tables includes those on remand as well as those sentenced. In some jurisdictions, (for example, WA) juveniles that have been arrested and have not yet appeared before a court are also held in a detention centre.

For its Indigenous population figures, the AIC has used high-level estimates, June 1996 to June 2006 (ABS 1998).

Nationally, the average daily number of people aged 10–17 years detained in juvenile corrective institutions fell from 786 to 611 between 1996-97 and 2000-01 (table F.4).

Table F.4 **Average daily population of people aged 10–17 years in juvenile corrective institutions (number)[a]**

Year	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*[b, c]	*ACT*	*NT*	*Aust*
1996-97	347	76	126	102	83	20	17	16	786
1997-98	303	74	144	122	57	19	11	21	751
1998-99	285	72	133	125	42	29	9	23	716
1999-2000	251	63	112	116	47	31	11	15	647
2000-01	223	62	87	103	59	43	17	17	611

a Average based on population of juvenile corrective institutions on the last day of each quarter of the financial year. **b** A review of data provided by Tasmania indicates that discrepancies in the number of young people reported in the data may result in higher numbers reported than the actual numbers in the detention centre. **c** The proclamation of the *Tasmanian Youth Justice Act 1997* in February 2000 extended the upper range of the target group, resulting in an increased number of young people in detention.

Source: AIC (2002).

Australia-wide, the rate of detention of people aged 10–17 years in juvenile corrective institutions fell by around one quarter between 1996-97 and 2000-01, although there were substantial differences across jurisdictions (table F.5).

The proportion of females detained as a proportion of the total population of juveniles in juvenile corrective institutions fluctuated between 6.3 per cent and 10.4 per cent nationally over the five-year period to 2000-01, and was 10.4 per cent at 30 June 2001 (table F.6).

Table F.5 **Average annual rate of detention per 100 000 people aged 10–17 years in juvenile corrective institutions (number)[a]**

Year	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*[b, c]	*ACT*	*NT*	*Aust*
1996-97	50.2	15.1	31.6	48.1	51.6	34.5	46.1	66.9	37.8
1997-98	43.5	14.7	35.9	56.4	35.5	33.4	30.9	86.6	35.8
1998-99	40.6	14.2	32.7	57.3	25.7	51.4	25.0	92.8	33.9
1999-2000	35.7	12.4	27.3	52.7	29.2	55.9	30.9	61.2	30.8
2000-01	31.5	12.0	21.0	46.4	36.6	78.0	47.9	68.4	28.6

a Detention rates based on average population of juvenile corrective institutions on the last day of each quarter of the financial year. **b** A review of data provided by Tasmania indicates that discrepancies in the number of young people reported in the data may result in higher numbers reported than the actual numbers in the detention centre. **c** The proclamation of the Tasmanian *Youth Justice Act 1997* in February 2000 extended the upper range of the target group, resulting in an increased number of young people in detention.

Source: AIC (2002).

Table F.6 **Males and females aged 10–17 years in juvenile corrective institutions at 30 June as a proportion of total population aged 10–17 years in juvenile corrective institutions (per cent)**

Year	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*[a, b]	*ACT*	*NT*	*Aust*
Males									
1996-97	92.7	90.1	89.0	90.1	92.2	87.0	87.5	100.0	91.5
1997-98	95.5	92.5	92.6	90.4	92.0	94.7	90.9	100.0	93.7
1998-99	91.0	95.0	92.7	89.6	85.3	96.8	75.0	85.7	90.9
1999-2000	91.6	82.7	91.3	89.6	83.1	91.9	93.3	100.0	90.0
2000-01	90.5	89.4	91.8	83.5	87.5	97.3	88.0	100.0	89.6
Female									
1996-97	7.3	9.9	11.0	9.9	7.8	13.0	12.5	–	8.5
1997-98	4.5	7.5	7.4	9.6	8.0	5.3	9.1	–	6.3
1998-99	9.0	5.0	7.3	10.4	14.7	3.2	25.0	14.3	9.1
1999-2000	8.4	17.3	8.7	10.4	16.9	8.1	6.7	–	10.0
2000-01	9.5	10.6	8.2	16.5	12.5	2.7	12.0	–	10.4

a A review of data provided by Tasmania indicates that discrepancies in the number of young people reported in the data may result in higher numbers reported than the actual numbers in the detention centre. **b** The proclamation of the *Tasmanian Youth Justice Act 1997* in February 2000 extended the upper range of the target group, resulting in an increased number of young people in detention. – Nil or rounded to zero.

Source: AIC (2002).

Data disaggregated by Indigenous status were available from 1993, although only data for selected years are shown here. The daily average number of Indigenous people aged 10–17 years detained in juvenile corrective institutions fluctuated between 1996-97 and 2000-01, from a high of 321 in 1997-98 to a low of 255 in 2000-01 (table F.7).

Table F.7 **Average daily population of Indigenous people aged 10–17 years in juvenile corrective institutions (number)[a, b]**

Year	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas[c, d]*	*ACT*	*NT*	*Aust[e]*
1996-97	115	12	72	59	21	5	3	13	299
1997-98	110	12	80	77	16	6	3	18	321
1998-99	96	9	77	80	14	6	2	17	301
1999-2000	91	8	60	77	13	8	2	10	269
2000-01	86	7	53	71	13	9	4	12	255

a Average based on population of juvenile corrective institutions on the last day of each quarter of the financial year. **b** Jurisdictional comparisons need to be treated with caution, especially for those States and Territories with low Indigenous populations, where small number effects can introduce statistical variations that do not accurately represent trends over time or consistent differences from other jurisdictions. **c** A review of data provided by Tasmania indicates that discrepancies in the number of young people reported in the data may result in higher numbers reported than the actual numbers in the detention centre. **d** The proclamation of the *Tasmanian Youth Justice Act 1997* in February 2000 extended the upper range of the target group, resulting in an increased number of young people in detention. **e** The 2000-01 figure includes one Indigenous male held in detention for other reasons.

Source: AIC (2002).

Nationally, the detention rate for Indigenous people aged 10–17 years in 2000-01 was 276.2 per 100 000 (table F.8). This compares with a detention rate of 17.4 per 100 000 for the non-Indigenous population aged 10–17 years (figure F.1).

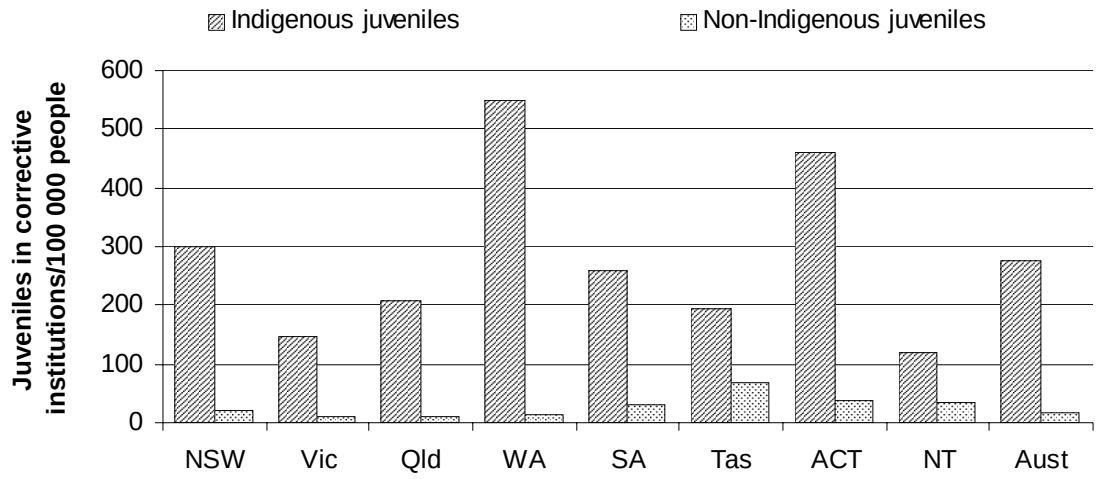
Table F.8 **Rate of detention per 100 000 Indigenous people aged 10–17 years in juvenile corrective institutions (number)[a, b]**

Year	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas[c, d]*	*ACT*	*NT*	*Aust[e]*
1996-97	553.9	310.4	364.3	561.0	518.9	156.3	457.7	134.5	413.7
1997-98	490.0	283.6	383.3	690.1	367.0	166.1	397.4	189.3	418.1
1998-99	393.9	201.8	347.1	677.6	314.7	157.2	236.1	173.5	368.1
1999-2000	343.5	181.9	251.8	624.1	266.2	182.6	284.1	97.6	309.1
2000-01	300.8	146.0	209.0	548.4	259.0	194.1	460.3	119.6	276.2

a Average based on population of juvenile corrective institutions on the last day of each quarter of the financial year. **b** Jurisdictional comparisons need to be treated with caution, especially for those States and Territories with low Indigenous populations, where small number effects can introduce statistical variations that do not accurately represent trends over time or consistent differences from other jurisdictions. **c** A review of data provided by Tasmania indicates that discrepancies in the number of young people reported in the data may result in higher numbers reported than the actual numbers in the detention centre. **d** The proclamation of the *Tasmanian Youth Justice Act 1997* in February 2000 extended the upper range of the target group, resulting in an increased number of young people in detention. **e** The 2000-01 figure includes one Indigenous male held in detention for other reasons.

Source: AIC (2002).

Figure F.1 **Indigenous and non-Indigenous detention rates, 2000-01[a, b, c, d]**



a Jurisdictional comparisons need to be treated with caution, especially for those States and Territories with low Indigenous populations, where small number effects can introduce statistical variations that do not accurately represent trends over time or consistent differences from other jurisdictions. **b** Detention rate is based on the average population of juvenile corrective institutions on the last day of each quarter of the financial year. **c** A review of data provided by Tasmania indicates that discrepancies in the number of young people reported in the data may result in higher numbers reported than the actual numbers in the detention centre. **d** The proclamation of the *Tasmanian Youth Justice Act 1997* in February 2000 extended the upper range of the target group, resulting in an increased number of young people in detention.

Source: AIC (2002).

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ABS (Australian Bureau of Statistics) 2001, *Community Services, 1999-2000*, cat. no. 8696.0, Canberra.

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AIC (Australian Institute of Criminology) 2002, *Statistics on Juvenile Detention in Australia: 1981–2001*, Technical and Background Series, no.1,Canberra.

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12 Aged care services

The aged care system comprises all services specifically designed to meet the needs of Australia's frail older people for care and support. This chapter focuses on government funded residential and community based services for older people, particularly:

- residential services, which include high care services, low care services, services providing a mixture of high and low care, and residential respite services (box 12.1);
- community care services, which include Home and Community Care (HACC) program services, the Community Aged Care Package (CACP) program, the Extended Aged Care at Home (EACH) program and Veterans' Home Care (VHC);[1]
- respite services, which include HACC respite and centre-based day care and the National Respite for Carers Program (NRCP); and
- assessment services, which are provided by Aged Care Assessment Teams (ACATs).

A profile of aged care services appears in section 12.1, followed by a brief discussion of recent policy developments in section 12.2. Together, these provide a context for assessing the performance indicators presented later in the chapter. This chapter reports data on the effectiveness and efficiency of publicly funded aged care services. Effectiveness is indicated by service quality, accessibility and equity, while efficiency is indicated by expenditure per head of target population. A framework of performance indicators is outlined in section 12.3 and data are discussed in section 12.4. Future directions in performance reporting are discussed in section 12.5. Jurisdictions' comments are reported in section 12.6. Definitions for data and indicators are provided in section 12.7.

A number of additions and improvements have been made to the chapter this year. These include the reporting of expenditure for a number of community care programs and preliminary data from the HACC Minimum Data Set (MDS). The

[1] Unless otherwise stated, HACC expenditure excludes the Department of Veterans' Affairs expenditure on Veterans' Home Care.

indicator ‘waiting times for community care’ is also reported for the first time using CACP data.

Box 12.1 **Interpreting residential care data**

This chapter describes the characteristics and performance of residential aged care in terms of residential services, clients, places and locality.

- *Residential services data*. This Report groups residential services for reporting purposes based on the eight level Resident Classification Scale (RCS) profile of their clients. Services are classified as:
  - high care services: similar to nursing homes in the pre-1997 regime, these services cater primarily to the needs of high care residents. These services have 80 per cent or more residents classified as RCS levels 1–4; or
  - low care services: similar to hostels in the pre-1997 regime, these services cater primarily to the needs of low care residents. These services have 80 per cent or more residents classified as RCS levels 5–8; or
  - services with a mixture of high and low care: these services meet the needs of both high care and low care residents. They have less than 80 per cent residents classified as RCS levels 1–4 and more than 20 per cent of residents classified as RCS levels 5–8.

  These categories have been used for descriptive purposes and do not have any legal foundation in the *Aged Care Act 1997* (Cwlth). Similarly, the choice of 80 per cent as a cut-off is subjective but considered appropriate for descriptive purposes.
- *Resident data*. This Report classifies clients as high care or low care based on their RCS assessment. High care residents have been assessed as RCS levels 1–4. Low care residents have been assessed as RCS levels 5–8.
- *Place data*. Part 2.2 of the Aged Care Act details the processes for the planning and allocation of subsidised services to meet residential aged care needs and community care needs. Planning is done on the basis of high care and low care need. High care places are planned to meet the needs of residents with care needs equivalent to RCS levels 1–4. Low care places are planned to meet the needs of residents with care needs equivalent to RCS levels 5–8.

  Although there must be a needs match between residents entering vacant places (that is, in general vacant low care places must be filled by low care residents), this can change over time with ‘ageing in place’ which allows a low care resident who becomes high care within the same service to occupy a low care place until they are discharged.
- *Locality data*. Geographical data areas are based on the Rural, Remote and Metropolitan Area (RRMA) classification (DPIE and DHSH 1994). Data are classified according to an index of remoteness which rates each Statistical Local Area (SLA) based on the number and size of towns, the distance to major towns and urban centres, and population densities.

(Continued on next page)

Box 12.1 **(Continued)**

Areas are classified into three groups:

- metropolitan areas: comprising State and Territory capital cities, based on the Australian Bureau of Statistics (ABS) capital city Statistical Division, and urban centres with 100 000 people or more, such as Geelong, Gold Coast, Townsville, Newcastle and Wollongong;
- rural areas: having several large towns with between 10 000 and 99 999 people; and
- remote areas: having few large towns with more than 5000 people and where there are great distances between centres and other SLAs.

Older Australians also use many other mainstream health and community services. Other chapters cover outcomes for older people in some of these services — namely, acute health care services for older people in chapter 9 and housing services in chapter 16. There are interactions between these service areas; for example, the number of residential places may affect demand for public hospital beds and changes in service delivery in the acute care sector may affect demand for residential aged care.

Supporting tables

Supporting tables for chapter 12 are provided on the CD-ROM enclosed with the Report. The files are provided in Microsoft Excel 97 format as \Publications\Reports\2003\Attach12A.xls and in Adobe PDF format as \Publications\Reports\2003\Attach12A.pdf.

Supporting tables are identified in references throughout this chapter by an 'A' suffix (for example, table 12A.3 is table 3 in the electronic files). 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 these tables (see details on the inside front cover of the Report).

12.1 Profile of aged care services

Service overview

This chapter focuses on residential care, community care and assessment services for older people. Services designed for the carers of older people are also within the scope of this chapter.

Services for older people are provided on the basis of the frailty or functional disability of the recipients rather than specific age criteria. Nevertheless, in the absence of more specific information, people aged 70 years and over are used as a proxy for the likelihood of a person in the general population requiring these services. Certain groups (notably Indigenous people) may require various services at a younger age. For Indigenous people, those aged 50 years and over are used as a proxy for the likelihood of requiring aged care services. The Commonwealth Government also uses these age proxies for planning the allocation of residential care and CACPs.

Government funded aged care services covered in this chapter relate to the three levels of government (Commonwealth, State and Territory, and some local) involved in service funding and delivery. The formal publicly funded services covered in this chapter represent a small proportion of total assistance provided to frail older people. Extended family and partners are the largest source of emotional, practical and financial support for older people. More than 90 per cent of older people living in the community in 1998 who required help with self care, mobility or communications received assistance from the informal care network of family, friends and neighbours (ABS 1999). Many people also receive assistance from both formal aged care services and informal sources.

A range of privately funded services also provide support for older Australians. These services do not receive government support and are not within the scope of reporting in the chapter.

Roles and responsibilities

Assessment services

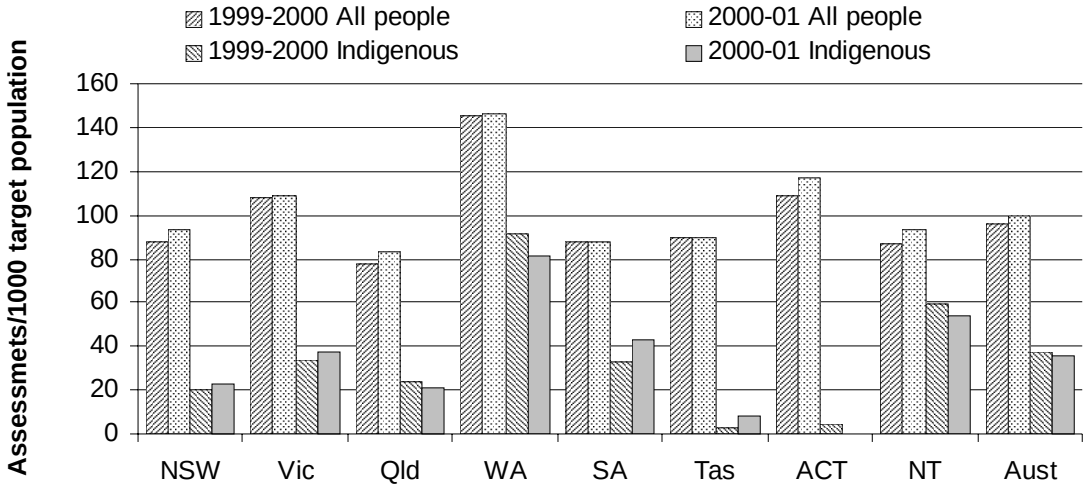
The Commonwealth established the Aged Care Assessment Program in 1984 based on the assessment processes used by State and Territory Area Health Services to determine eligibility for admission into residential care and the level of care required (and thus the subsidy paid to such services). The core objective of ACATs is to assess the needs of frail older people and recommend appropriate services. Assessment and recommendation by ACATs is mandatory for admission to residential care or receipt of a CACP. People may also be referred by ACATs to other services, such as those funded by the HACC program. An ACAT referral is not mandatory for receipt of a HACC service.

State and Territory governments are responsible for the day-to-day operation and administration of ACATs and provide the necessary accommodation and support

services. The role of the teams differs across jurisdictions and within a jurisdiction, partly reflecting the service location (for example, whether the team is attached to a residential service, a hospital or a community service).

The number of assessments per 1000 target population varied across jurisdictions in 2000-01. Western Australia had the highest assessments of people aged 70 years and over per 1000 people aged 70 years and over (146.1) and the highest rate for Indigenous assessments per 1000 Indigenous people aged 50 years and over (81.8).[2] The lowest rate of assessment for all people during 2000-01 was in Queensland (83.4) while the ACT had no Indigenous assessments during the same period (figure 12.1).

Figure 12.1 **Assessments per 1000 target population[a, b]**



a 'All people' includes all assessments of people aged 70 and over per 1000 people aged 70 and over. **b** 'Indigenous' includes all Indigenous assessments per 1000 Indigenous people aged 50 and over.

Source: Lincoln Gerontology Centre (2001, 2002); table 12A.39.

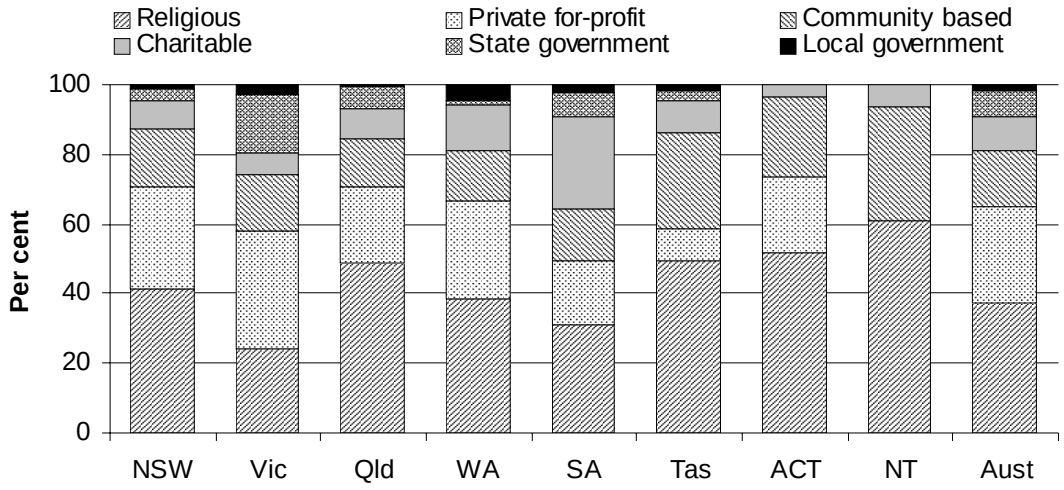
Residential care services

Residential care services are run mainly by private for-profit, religious, charitable and community based organisations. Some State, Territory and local governments also operate some residential services (figure 12.2). The largest providers of places at June 2002 were religious and private for-profit services (37.5 per cent and 27.4 per cent respectively). The private sector is mostly involved in high care services, managing about 46 per cent of places in these services

[2] Remote areas of WA often do not have other agencies and services in a position to perform 'comprehensive assessments' for many groups, and therefore a higher rate of referral to ACATs than in metropolitan areas may occur.

(DHA unpublished). The proportion of aged care services provided by government, private enterprise and charitable organisations varied markedly across jurisdictions in June 2002.

Figure 12.2 **Ownership of residential places, June 2002[a, b]**



a 'Community based' residential services provide a service for an identifiable community based on locality or ethnicity, not for individual financial gain. **b** 'Charitable' residential services provide a service for the general community or an appreciable section of the public, not for individual financial gain.

Source: Department of Health and Ageing (unpublished); table 12A.4

The Commonwealth Government is responsible for most of the regulation of residential aged care services, including accreditation. State, Territory and local governments also have a regulatory role in areas such as determining staffing and industrial awards, and monitoring compliance with building and fire safety regulations (box 12.2).

Community care services

The main community care programs reported in this chapter — the HACC, CACP and VHC programs — fund services that aim to provide practical assistance to enable frail older people (HACC and CACP), people with a disability (HACC) and veterans (VHC) to continue living in the community. These services also provide assistance to carers of older people. The services are usually provided by State, Territory and local government organisations, charitable bodies, community organisations and commercial providers.

Box 12.2 **Examples of regulatory arrangements for residential services**

The Commonwealth Government controls the number of subsidised bed places, with a target of 40 high care places, 50 low care places and 10 community aged care packages for each 1000 people in the population aged 70 years and over. In addition:

- services are expected to meet regional targets for places for concessional residents, ranging from 16 per cent to 40 per cent of places, to ensure residents who cannot afford to pay an accommodation bond or charge have equal access to care (with criteria for being deemed a concessional resident being based on home ownership and occupancy, receipt of income support and the level of assets held at entry); and
- extra service places (where residents pay for a higher standard of accommodation, food and services) are restricted.

Various Commonwealth, State and Territory laws govern regulatory arrangements for residential care. State and Territory legislation may prescribe matters such as staffing, the dispensing of medication and/or certain medical procedures, occupational health and safety, workers' compensation requirements, building standards, and fire prevention and firefighting measures. Staff wages and conditions are generally set by jurisdictional based awards. Local government by-laws may also apply (for example, waste disposal rules).

Source: Productivity Commission (1999).

Indigenous specific and flexibly funded services

Flexible models of care are provided under the Aboriginal and Torres Strait Islander Aged Care Strategy. Services delivered under the Strategy are outside the Aged Care Act (DHA 2002). About 70 per cent of Indigenous Australians receiving residential aged care services have their needs met through the mainstream services covered by this chapter (DHA unpublished). A number of aged care residential services are targeted to Indigenous people and these services are funded under the Aged Care Act. The DHA also actively targets CACPs to Indigenous communities and contracts Aboriginal Hostels Limited to provide ongoing assistance to ensure that services in rural and remote areas remain viable (DHA 2002).

Funding

Assessment services

Under a cooperative arrangement, the Commonwealth provides grants to State and Territory governments to operate 123 ACATs and Evaluation Units. In 2001-02, the Commonwealth provided funding of $39.9 million nationally for aged care

assessment (table 12A.49). Expenditure per person aged 70 years and over plus Indigenous persons aged 50–69 years was highest in the NT ($71.4) during 2001-02 (table 12A.50).

Residential care services

The aged care reforms introduced in October 1997 resulted in a government funding system that does not differentiate between high care and low care services and incorporates high and low care services into a single funding system. One aim of this funding system is to promote 'ageing in place' — that is, enabling residents to remain in one aged care facility irrespective of their dependency level. Access to 'ageing in place' is subject to the decision of service providers to offer this option.

The Commonwealth Government provides the majority of annual funding for residential aged care services — $4.0 billion in 2001-02, or approximately 71 per cent of the cost of care (DHA unpublished). State and Territory governments also provide some funding for public sector beds. Residents provide most of the remainder of service revenue, with some income derived from charitable sources and donations.

Commonwealth Government funding of approximately $5.6 million in 2001-02 was also provided through the Residential Care Development Scheme run by the Department of Veterans' Affairs (DVA). The scheme aimed to help ex-service and community-based organisations to provide high quality residential aged care services and community care packages to the veteran community (table 12A.47).

The Commonwealth Government annual RCS subsidy for each occupied place varies according to the client's level of dependency. A high level of care is classified as RCS levels 1–4 and low level care is classified as RCS levels 5–8. The average Commonwealth annual RCS subsidy per residential place at June 2002 varied across jurisdictions, ranging from $29 187 in the NT to $23 998 in WA. Variations in average annual subsidies reflect differences in subsidy rates as well as differences in the dependency of residents (table 12.1). Low care subsidy rates (RCS levels 5–8) are the same across all States and Territories, while high care subsidy rates (RCS levels 1–4) are being adjusted towards a uniform national rate by July 2006 under the Commonwealth Government's Funding Equalisation and Assistance Package, totalling $148 million over six years. The NT had the highest proportion of high care residents at June 2002 (table 12.1).

Table 12.1 **Average annual Commonwealth RCS subsidy per occupied place and the dependency level of aged care residents, June 2002**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Average annual Commonwealth RCS subsidy per residential place[a]										
All RCS levels	$	26 342	25 494	24 286	23 998	25 669	27 932	25 182	29 187	25 534
Proportion of high care residents[b]										
RCS 1	%	18.5	20.7	16.2	21.5	18.5	15.8	24.9	7.8	18.9
RCS 2	%	26.9	23.8	24.8	21.0	26.3	26.8	19.5	33.1	25.1
RCS 3	%	15.7	12.1	16.8	11.1	15.2	20.8	12.8	26.9	14.7
RCS 4	%	4.3	3.9	6.0	4.4	4.3	6.0	4.3	7.2	4.6
Proportion of low care residents										
RCS 5	%	9.5	11.8	9.8	12.6	9.9	10.6	11.0	6.6	10.5
RCS 6	%	9.9	11.8	10.3	13.8	10.4	8.2	12.0	9.9	10.8
RCS 7	%	13.4	14.4	14.2	14.3	14.2	10.9	13.4	8.4	13.8
RCS 8	%	1.9	1.5	1.9	1.2	1.1	0.8	2.1	0.3	1.6

a Includes only RCS funding; pensioner supplement and other supplements add around $4100 a year for residents. On average, residents contribute $11 400 per year to their care. **b** Differences in average annual subsidies reflect differences in subsidy rates as well as differences in the dependency of residents.

Source: DHA (unpublished); table 12A.5.

State and Territory governments contribute financially to the services they operate, and these services generally receive lower Commonwealth subsidies than those received by other services. Some States and Territories have made arrangements to continue supplementing former government services following the transfer of those services to the private sector. The NT Government also provides some funding to some private not-for-profit residential care services.

The combined number of operational high care and low care places per 1000 people aged 70 years and over at June 2002 ranged from 112.5 in the NT to 79.0 in Victoria. The ACT had proportionally more low care places (58.4 per cent) than those in other jurisdictions. There were proportionally more high care places in the NT (59.6 per cent) (table 12.2). The proportion of low care places relative to high care places rose between 1990 and 2002 (table 12A.10).

Table 12.2 **Operational high care and low care residential places, 30 June 2002[a]**

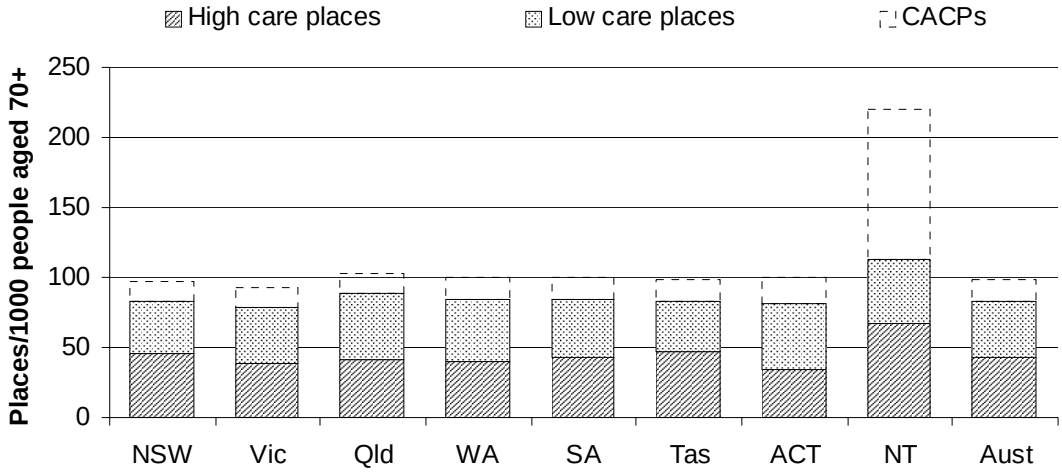
	Unit	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust
Number of places per 1000 people aged 70 years and over										
High care places	no.	46.2	38.2	41.5	39.7	43.5	47.0	33.6	67.1	42.4
Low care places	no.	36.3	40.8	46.5	44.9	41.1	36.4	47.2	45.4	40.5
Total places	**no.**	**82.5**	**79.0**	**88.0**	**84.6**	**84.6**	**83.4**	**80.8**	**112.5**	**82.9**
Proportion of places										
High care places	%	56.0	48.4	47.2	46.9	51.4	56.4	41.6	59.6	51.1
Low care places	%	44.0	51.6	52.8	53.1	48.6	43.6	58.4	40.4	48.9

a Excludes places that have been 'approved' but are not yet operational.

Source: DHA (unpublished); table 12A.10.

Figure 12.3 shows the combined number of high care residential places, low care residential places and CACPs. Box 12.2 sets out the Commonwealth targets for the provision of residential places and CACPs.

Figure 12.3 **Operational residential places and CACPs per 1000 people aged 70 years and over, June 2002[a, b, c, d]**



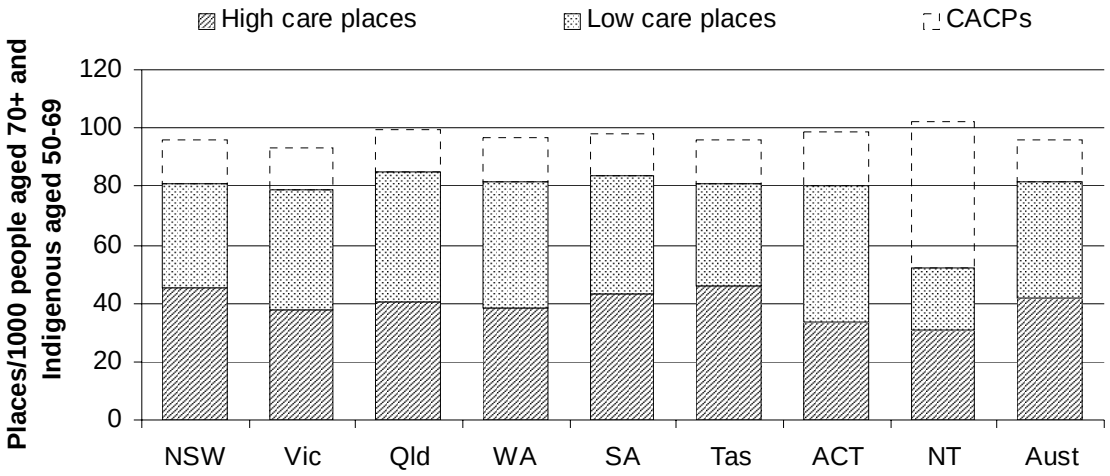
a Excludes places that have been 'approved' but are not yet operational. **b** 'Ageing in place' may result in some low care places being filled by high care residents. **c** Government planning targets are based on providing 100 places per 1000 people aged 70 years and over. However, in recognition of poorer health among Indigenous communities, planning in some cases also takes account of the Indigenous population aged 50–69 years. This means that the provision ratio based on the population aged 70 years and over will appear high in areas with a high Indigenous population (such as the NT). **d** CACPs are not residential services but are included in the Commonwealth planning targets of 100 places per 1000 people in the target population. See boxes 12.1 and 12.2 for interpretation of residential care data.

Source: DHA (unpublished); table 12A.10.

The number of operational places can also be shown using a target population that incorporates Indigenous 50–69 year olds (figure 12.4). Using this 'adjusted' target

population has a noticeable effect on smaller jurisdictions with a large proportion of Indigenous people.

Figure 12.4 **Operational residential places and CACPs per 1000 people aged 70 years and over plus Indigenous people aged 50–69 years, June 2002[a, b, c]**



a Places do not include those that have been 'approved' but are not yet operational. **b** 'Ageing in place' may result in some low care places being filled by high care residents. **c** CACPs are not residential services but are included in the Commonwealth planning targets of 100 places per 1000 people in the target population. See boxes 12.1 and 12.2 for interpretation of residential care data.

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

Community care services

Total national expenditure on HACC was just over $1 billion in 2001-02, which consisted of $615.6 million from the Commonwealth Government and $396.8 million from the State and Territory governments. This is equivalent to the Commonwealth Government contributing approximately 60.8 per cent and State and Territory governments funding the remainder (table 12A.46).

The NRCP provides community care services and is funded by the Commonwealth. Expenditure on this program was $72.9 million in 2001-02 (table 12A.49). Expenditure for in-home respite care from the DVA, including emergency home care, was $9.4 million in 2000-01 (DVA unpublished). The DVA also provided $61.6 million for the VHC program during 2001-02 (table 12A.48). This figure includes expenditure for in-home respite and emergency home care.

The CACP program is funded by the Commonwealth Government, which expended $246.0 million on the program in 2001-02 (table 12A.49). CACPs are also part funded by client contributions.

Expenditure data on a range of other community care programs targeting aged people are contained in tables 12A.49 and 12A.50.

Size and scope of sector

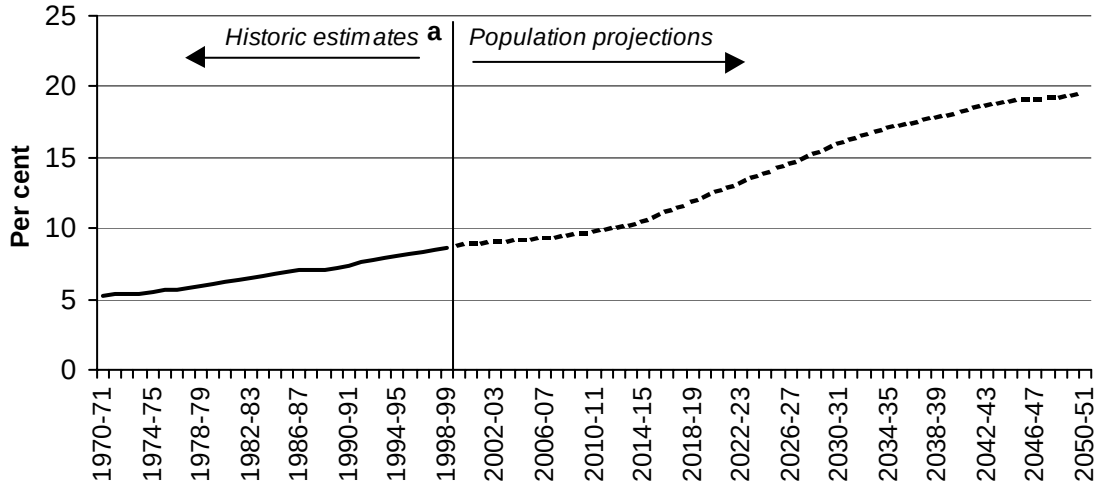
Size and growth of the older population

The Australian population is ageing as indicated by an increase in the proportion of people aged 70 years and over in the total population. This trend is expected to continue and the proportion of older people is expected to increase dramatically in the twenty-first century (figure 12.5).

The distribution of older people varied across jurisdictions at June 2002, with relatively more older people in SA and relatively fewer in the NT (figure 12.6). Higher life expectancy for females is reflected in there being a higher proportion of older females than older males in all jurisdictions.

Demographic profiles affect the demand for aged care services because females use aged care services, particularly residential services, more than males do; for example, 72.4 per cent of aged care residents at June 2001 were female (DHA unpublished). Females are more likely to use residential services partly because they tend to live longer (that is, there are more women than men in the older population) and are less likely to have a partner to provide care. There are also greater incidences of incontinence, hip fractures and financial disadvantage among older women.

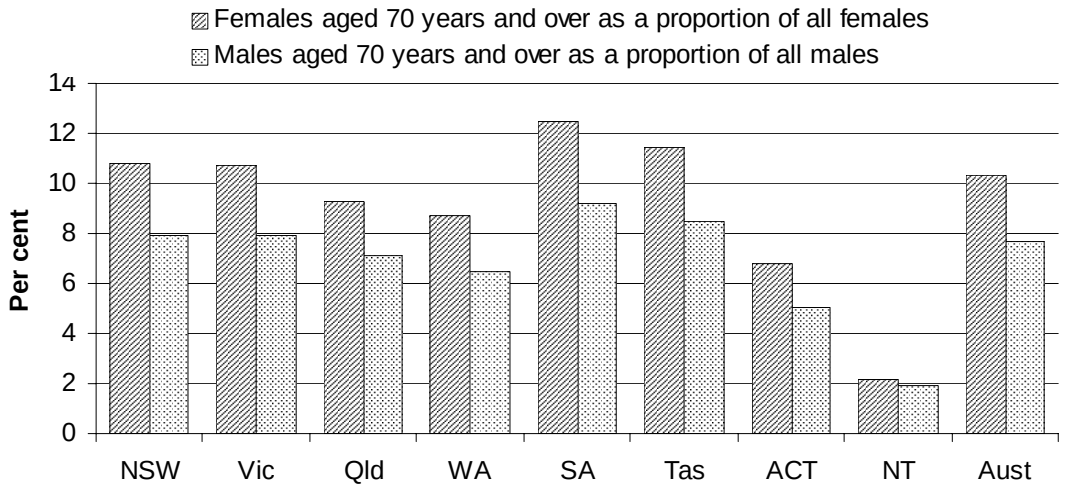
Figure 12.5 **Persons aged 70 years and over as a proportion of the total population — time series**



a Historic estimates are based on the population census that is held at five-year intervals.

Source: ABS (2000).

Figure 12.6 **People aged 70 years and over as a proportion of males and females in the total population, by sex, June 2002 (estimated)**



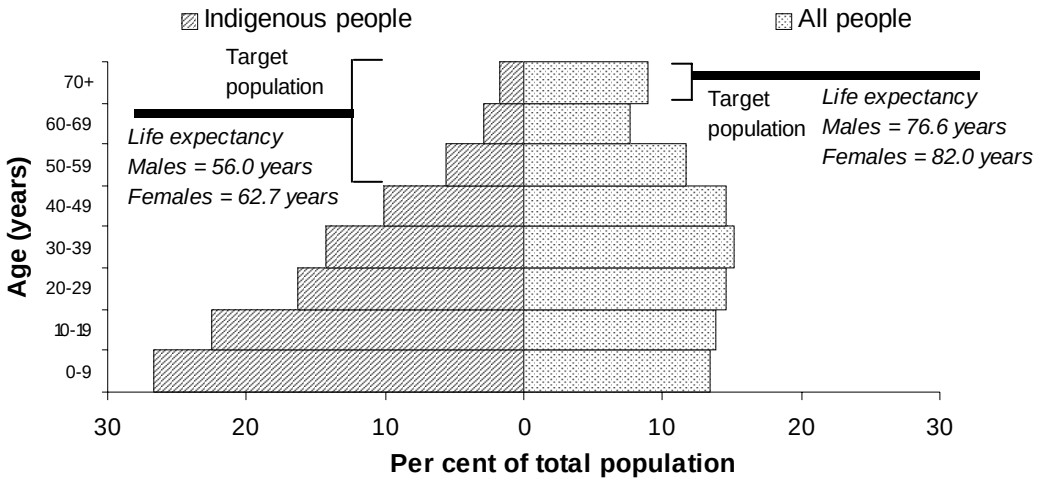
Source: DHA (unpublished); table 12A.1.

Characteristics of older Indigenous people

The ABS estimated that about 41 700 Indigenous people were aged 50 years or more in Australia at 30 June 2002. The majority were located in NSW (29.7 per cent), Queensland (26.6 per cent), WA (13.9 per cent) and the NT (13.7 per cent) (table 12A.2).

Although the Indigenous population is also ageing, there are significant differences in the age profile and life expectancy of Indigenous Australians compared with the non-Indigenous population. The life expectancy of Indigenous males (56.0 years) and females (62.7 years) at June 2001 was nearly 20 years below that recorded for the total Australian population (figure 12.7). As a result, Indigenous people are likely to need aged care services earlier in life, compared with the general population.

Figure 12.7 **Age profiles, target populations and life expectancy differences between Indigenous and other Australians, June 2001**



Source: ABS (2001 and unpublished).

Residential care services

The size and location of residential services — which may influence the costs of service delivery — vary across jurisdictions. Nationally, there were approximately 144 139 operational places (permanent and respite) in residential care services (71 570 in predominantly high care services, 28 596 in predominantly low care services and 43 973 in services with a mixture of high care and low care residents) at June 2002 (tables 12A.6, 12A.7, 12A.8 and 12A.9).

As the trend towards 'ageing in place' (box 12.3) increases, there has been a steady increase in the number of services categorised as services providing a mixture of high care and low care places. In June 2000, 15.7 per cent of all places were located in services offering high care and low care places; this proportion rose to 25.5 per cent of all places in June 2001 and accounted for 30.5 per cent of places in June 2002 (tables 12A.6 and 12A.9; SCRCSSP 2001, 2002).

Box 12.3 **Ageing in place**

In its Objects, the *Aged Care Act 1997* (Cwlth) aims to:

> *... encourage diverse, flexible and responsive aged care services that:*
>
> *(i) are appropriate to meet the needs of the recipients of those services and the carers of those recipients; and*
>
> *(ii) facilitate the independence of, and choice available to, those recipients and carers.*

Further, the Aged Care Act aims explicitly to encourage and facilitate 'ageing in place'. It does not define 'ageing in place' but one useful definition is 'the provision of a responsive and flexible care service in line with the person's changing needs in a familiar environment'. In effect, ageing in place refers to a resident remaining in the same residential aged care service as their care needs increase from low level to high level care. Over time, this may change the profile of people in services.

The Aged Care Act does not require any residential aged care service to offer ageing in place; neither does it establish any 'program'. Rather, it creates the opportunity for providers to choose to provide the full continuum of care, by removing the legislative and administrative barriers that prevented this outcome in the past.

The concept of 'ageing in place' is linked to the outcomes of increasing choice and flexibility in residential aged care service provision. These are difficult outcomes to measure.

One possible proxy for measuring 'ageing in place' is the proportion of residential aged care service providers who are caring for residents whose care needs range across high care and low care. As noted there has been a steady increase in the number of services categorised as services providing a mixture of high and low care places.

Another possible measure is the proportion of residents who remain in the same home as their care needs increase (table 12.3). The main difficulty with measuring this is determining whether decreasing mobility between hostels and nursing homes reflects negatively or positively on the choice and flexibility of residential care available to residents.

Source: DHA (unpublished).

The client profile of services that had predominantly low care residents in 2000 has changed, with low care residents staying in their current service as their dependency levels rise over time, and with aged care services expanding. Low care services were generally smaller (as measured by number of places) than high care services at June 2002. Nationally, 84.4 per cent of low care services had 60 or fewer places (table 12A.8), compared with 73.8 per cent of high care services (table 12A.7).

The proportion of residents who remained in the same service as their care needs increased is illustrated in table 12.3. The 'ageing in place' policy has a clear

influence on the population of residential care facilities. While the planning ratio for residential aged care is 40 high care beds and 50 low care beds per 1000 people aged over 70 years, on average, over 60 per cent of the population of residents are high care residents (table 12.1).

Table 12.3 **'Ageing in Place' - resident movements for admissions during 1999-2000 after admission to permanent care**

Months after admission		*6 months*	*12 months*	*18 months*
Discharged or died	%	24.7	35.3	43.3
Remain high care	%	34.5	28.1	23.6
From high care to low care	%	0.5	0.6	0.7
From low care to high care	%	4.7	6.8	9.2
Remain low care	%	35.6	29.1	23.1
Total	**%**	**100**	**100**	**100**
Total admissions	no.	40 108	40 108	40 108

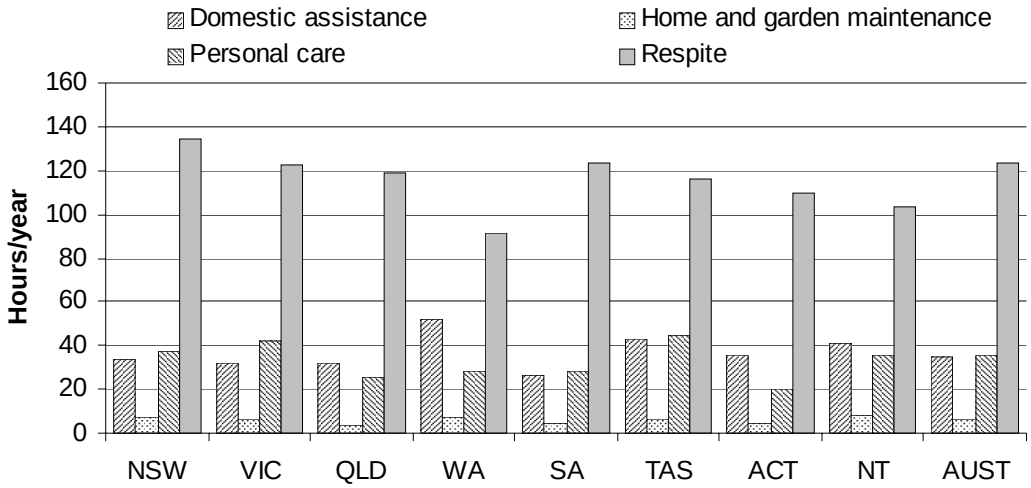
Source: DHA (unpublished); table 12A.56.

Community care services

A range of services are provided by HACC, such as domestic assistance and home maintenance, personal care, food services, respite care, transport, allied health care and community nursing. The target population is defined as people living in the community who are at risk, in the absence of basic maintenance and support services, of premature or inappropriate long term residential care. The target population comprises both frail aged people and younger people with a disability, and their carers. Approximately 70 per cent of the program's recipients are aged 70 years and over, but the program is also an important source of community care for younger people with a disability and their carers (DHA unpublished). (Chapter 13 covers younger people with a disability.)

The services of the VHC program target veterans and war widows/widowers with low care needs. There were 56 073 VHC recipients in 2001-02 (table 12A.48). The program offers veterans and war widows/widowers home support services, including domestic assistance, personal care, home and garden maintenance, and respite care. Other services, such as community transport, social support and delivered meals, are also available under the DVA's arrangements with State and Territory governments. Eligibility for VHC services is not automatic, but based on assessed need. Figure 12.8 shows the average number of hours approved per year for veterans who were approved to receive home care services between 1 July 2001 and 30 June 2002.

Figure 12.8 **Average number of hours approved for Veterans' Home Care, 2001-2002**



Source: DVA (unpublished); table 12A.48.

Community Aged Care Packages provide an alternative home-based service for older people who ACATs assess as eligible for care equivalent to low level residential care (RCS levels 5-8). The main distinctions between the HACC and CACP programs are summarised in table 12.4. Community care is likely to continue to play an increasing role in aged care services, given the longer term policy objective of improving the capacity of aged care services to support people at home, which reflects a strong consumer preference.

Table 12.4 **Distinctions between the HACC and CACP programs**

	HACC	*CACPs*
Range of services[a]	Wider range of services available	Narrower range of services available
Relationship to residential care	Prevents premature or inappropriate admission	Substitutes for a bed
Eligibility	ACAT assessment not mandatory	ACAT assessment mandatory
Funding	Cost shared by Commonwealth, State and Territory governments and client contributions	Funded by the Commonwealth and client contributions
Target client groups[b]	Available to people with a greater range of care needs	Targets people with care needs similar to low level residential care
Size of program	$1 billion funding in 2001-02	$246 million funding in 2001-02
	About 583 000 clients for the year 2001-02	About 26 400 places for the year 2001-02

[a] HACC services such as community nursing, which are not available under CACPs, can be supplied to someone receiving a CACP. [b] Most HACC recipients at the lower end of the scale would not be assessed as eligible for residential care; for example, an individual may receive only an hour of home care a fortnight. At the higher end, some people have levels of need that would exceed the level available under CACPs.

Source: DHA (unpublished); tables 12A.30, 12A.45 and 12A.46.

Changing government policies over the past decade — shifting the balance of care away from the more intensive types of residential care towards home-based care — have meant that the HACC, EACH and CACP programs have become increasingly important components of the aged care system. During 2001-02, the HACC program delivered approximately 9023 hours per 1000 people aged 70 years and over plus Indigenous people aged 50–69 years (table 12A.20). The total number of CACP places per person aged 70 years and over plus Indigenous people aged 50–69 years increased by 5.0 per cent between June 2001 and June 2002, from 14.0 to 14.7 (table 12A.11).

12.2 Policy developments in aged care services

The Extended Aged Care at Home Program

The EACH program is a small program funded by the Commonwealth Government to provide a community alternative to high level residential aged care services. The program provides individually planned and coordinated packages of care, designed to meet older people's daily care needs in the community. The EACH program differs from the CACP program in that it targets frail older people who would otherwise be eligible for high level residential aged care. An EACH package typically provides between 15 and 20 hours of direct assistance each week.

Packages are flexible in content; the expectation, however, is that a package would include qualified nursing input, particularly in the design and ongoing management of the package and also where there are complex and technical nursing care needs.

The EACH program was introduced in 1993 at a single trial site in SA. The 1995 Commonwealth Budget expanded the program, which at that stage was called the Nursing Home Care Package pilot. By 1998, the trial had expanded to 10 pilot sites with 290 packages and had been renamed the EACH program. The pilot program was comprehensively evaluated over the three years from 1998 to 2001. This evaluation has been published by the DHA as a series of Aged and Community Care Service Development and Evaluation Reports: *Evaluation of the Extended Aged Care at Home (EACH) Pilot Program.*

In May 2002, the Minister for Ageing announced a further program expansion (160 new places). By early 2003, approximately 450 EACH packages are expected to be in place nationally. Work is being undertaken concurrently to move the program from its initial pilot status to a program consolidation stage which will focus on the development of a quality assurance and accountability framework. Expenditure data for the EACH program during 2001-02 are contained in table 12A.49.

Innovative Pool of aged care places

The national pool of flexible care places available for allocation to innovative services outside of the Aged Care Approvals Round was established in 2001-02. The 2002-03 Level 1 release of aged care places includes 550 flexible care places available to be allocated to innovative services. The national Innovative Pool allows for the development of pilots for innovative service provision, in partnership with other stakeholders (including State and Territory governments and approved providers).

The flexible care places through the Innovative Pool can be used to develop projects that will allow the Commonwealth to conduct an evidence-based test of alternative service models to address the Commonwealth's policy priorities. Evaluation will be an integral element of all projects involving alternative service models.

There are 550 places in the 2002-03 Innovative Pool, targeted at the following types of proposals:

- Innovative Care Rehabilitation Services Pilots, which combine personal and nursing care and rehabilitation (Commonwealth, State and Territory funded); and
- High Need and Specific Need proposals seeking residential, community or flexible care places for high need areas, alternative dementia care provision and projects addressing issues at the interface between disability and aged care services.

An example of a pilot under the Innovative Pool is discussed in box 12.4.

Box 12.4 **The Home Rehabilitation and Support Service (HRSS) in SA**

A State funded Transition Care Project, which was the forerunner to the HRSS, ran successfully from January to December 2001. The Commonwealth Government agreed to contribute towards a similar but distinct joint project, with matching State and Commonwealth funding contributions. The Commonwealth contributes 50 Flexible Care Places from the Innovative Pool to the project (approximate value of $525 000 a year) with the State also contributing $525 000 a year. The Aged Care and Housing Group manages the project, which will run for an initial two year period.

The HRSS formally commenced on 21 December 2001. Thirteen residential and community care providers form the Acute Transition Care Alliance, which provides residential places for the purpose of the service, as well as home-based and community-based services. The target group for the project is older people who have either had an unnecessarily long stay or are at risk of an extended stay in the acute hospital system and who are also at risk of premature admission to a residential aged care facility. The Service provides short term rehabilitation and support services, including short term residential care, physiotherapy, occupational therapy, nursing and personal care and community based support services.

To 9 October 2002, 230 referrals had been received, of which 147 (about 64 per cent) were appropriate for the HRSS. Of these, 101 have made a transition from the program, with 18 per cent of clients going to residential care, 58 per cent of clients going home (receiving levels of support ranging from CACPs to family support, or refusing services) and 24 per cent being re-admitted to hospital.

Source: DHA and SA Government (unpublished).

12.3 Framework of performance indicators

The aim of the indicators is to provide information on the efficiency and effectiveness of publicly funded aged care services. Effectiveness indicators focus

on access to services and the appropriateness and quality of services. Efficiency indicators focus on the unit costs of providing services. These indicators relate to government objectives in the aged care sector (box 12.5).

Box 12.5 **Objectives for aged care services**

The aged care system aims to promote the health, wellbeing and independence of frail older people and their carers through the funding and delivery of care services that are:

- accessible;
- appropriate to needs;
- high quality; and
- efficient.

The performance indicator framework shows which data are comparable in the 2003 Report (figure 12.9). For data that are not considered strictly comparable, the text includes relevant caveats and supporting commentary. Chapter 1 discusses data comparability from a Report wide perspective (see section 1.6).

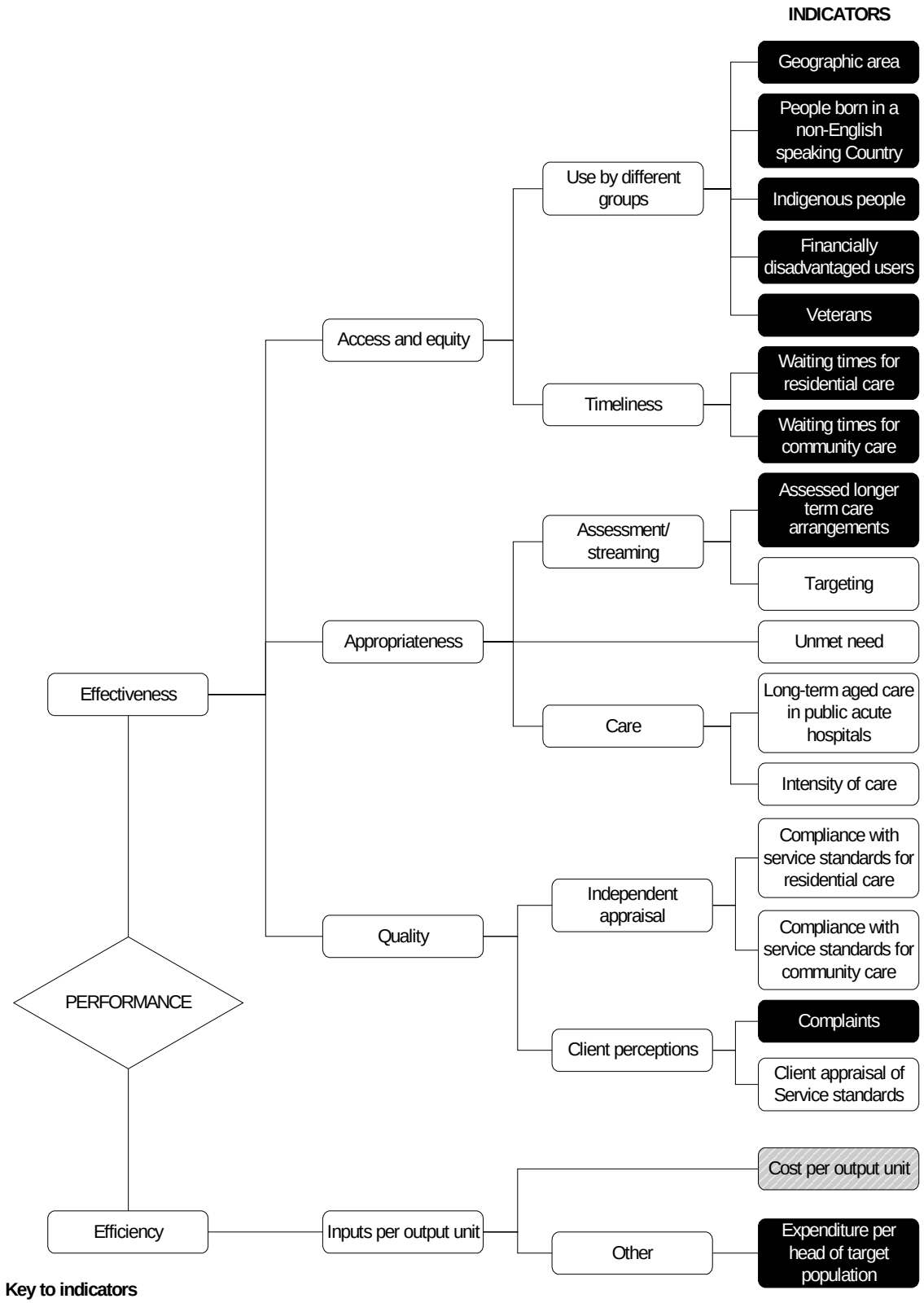
New and refined indicators

The performance indicator framework has been further refined for the 2003 Report. The indicator 'waiting times for community care' is reported for the first time using CACP data. Ongoing work to provide a more comprehensive set of performance indicators and to improve existing indicators and data is discussed in section 12.5.

12.4 Key performance indicator results

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

Figure 12.9 **Performance indicators for aged care services**



Access and equity — use by different groups

Residential services

Special needs groups identified by the Aged Care Act are people from Indigenous communities, people from non-English speaking countries, people who live in rural or remote areas, people who are financially or socially disadvantaged, and veterans. A key national objective of the aged care system is to provide equitable access to residential services for all people who require these services. Indigenous people tend to require aged care services at a younger age than the general population. Participation is therefore based on Indigenous people aged 50 years and over.

One way of measuring accessibility is to compare the proportion of residents from a special needs group with their representation in the target population (which is all people aged 70 years and over, plus Indigenous people aged 50–69 years). However, factors such as cultural differences — which may influence the extent to which various special need groups use residential care services — need to be considered in the interpretation of such results.

In all jurisdictions, on average, Indigenous people and people from mainly non-English speaking countries have lower rates of use of aged care residential services, compared with the rest of the population, at June 2002 (figure 12.10).

Figure 12.10 **Residents per 1000 target population, June 2002**[a, b, c]

[a] All residents data are per 1000 people aged 70 years and over plus Indigenous people aged 50–69 years. [b] Indigenous residents data are per 1000 Indigenous people aged 50 years and over. [c] Residents from a non-English speaking country data are per 1000 people from non-English speaking countries aged 70 years and over.

Source: DHA (unpublished); tables 12A.12, 12A.14 and 12A.16.

Commonwealth planning guidelines require that services allocate a minimum proportion of places for concessional residents. These targets range from 16 per cent of new places to 40 per cent, depending on the service's region. Most services exceed the minimum amount. All jurisdictions exceeded the minimum amount at 30 June 2002, with the NT reporting the highest proportion of concessional residents (79.1 per cent) (table 12.5).

Table 12.5 **New residents classified as concessional or assisted residents, 30 June 2002 (per cent)[a, b]**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
High care residents	49.3	53.0	49.5	53.7	50.1	50.6	48.1	78.3	50.7
Low care residents	44.1	41.8	46.3	48.6	44.1	41.9	39.6	81.2	44.3
All residents	47.4	48.2	48.3	51.5	47.9	47.9	44.7	79.1	48.2

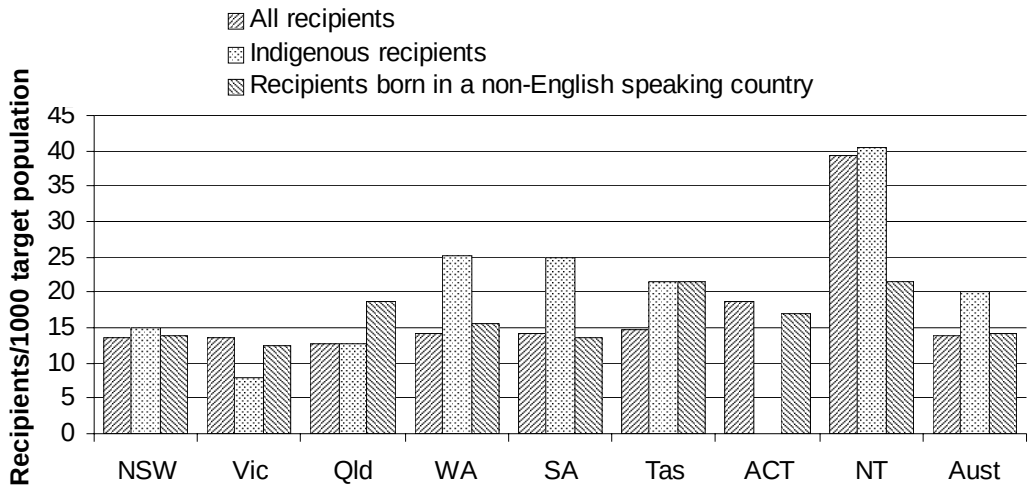
a Only new residents entering residential care post-October 1997 are eligible for either a concessional or assisted resident supplement. **b** Concessional residents are those who on entry to care were in receipt of an income support payment, who had not owned a home in the previous two years or whose home was occupied by a spouse or carer, and who had assets of less than $26 500. For married residents, half the couple's combined assets are counted. Assets include interest-free loans. Assisted residents are those meeting the above criteria with asset levels between $26 500 and $42 000. The asset levels are at 30 June 2002.

Source: DHA (unpublished); table 12A.19.

Community Aged Care Packages

The number of CACP recipients per 1000 people aged 70 years and over plus Indigenous people aged 50–69 years has grown in recent years but at June 2002 was small relative to the total number of recipients of residential care (13.8 compared with 78.5 recipients respectively per 1000 people aged 70 years and over plus Indigenous people aged 50–69 years) (table 12A.12). The jurisdictions with smaller populations had the highest proportion of CACP recipients per 1000 people aged 70 years and over plus Indigenous people aged 50–69 years at June 2002. The NT had the highest proportion of CACP recipients per 1000 Indigenous people aged 50 years and over (40.4) (table 12A.16). Tasmania and the NT had the highest proportion of CACP recipients from non-English speaking countries per 1000 people aged 70 years and over (figure 12.11). The Commonwealth's allocation of CACPs in every jurisdiction at June 2002 exceeded its target of ten CACPs per 1000 target population.

Figure 12.11 **CACP recipients per 1000 target population, June 2002[a, b, c, d]**



a All recipients data are per 1000 people aged 70 years and over plus Indigenous people aged 50–69 years. **b** Indigenous recipients per 1000 Indigenous people aged 50 and over. **c** Recipients from non-English speaking countries per 1000 people from non-English speaking countries aged 70 years and over. **d** The ACT has a very small Indigenous population aged over 50 years and a small number of packages will result in a very high provision ratio. Consequently, the ACT Indigenous CACP figures are not considered to be reliable and have not been reported.

Source: DHA (unpublished); tables 12A.12, 12A.14 and 12A.16.

Home and Community Care program

The services of the HACC program are provided in the client's home or community to frail older people with a severe, profound or moderate disability and to their carers. Around 69.8 per cent of HACC recipients are estimated to be aged 70 years and over (table 12A.30).

The HACC MDS will facilitate separate reporting of the three client groups (frail older people, young people with a disability and their carers), which previously has not been possible. Data from the MDS are reported for the first time this year and need to be interpreted with extreme caution. The items reported are broadly similar to estimated HACC data in previous editions of the Report, but they are not directly comparable. It should also be noted that the proportion of HACC funded agencies that submitted MDS data for 2001-02 differed across jurisdictions, and ranged from 94 per cent to 56 per cent (table 12.6). Consequently, actual service levels will be higher than those reported. Future data from the HACC MDS are expected to have wider coverage.

Table 12.6 **HACC services received, 2001-02 (per 1000 people aged 70 years and over, plus Indigenous people aged 50–69 years)[a]**

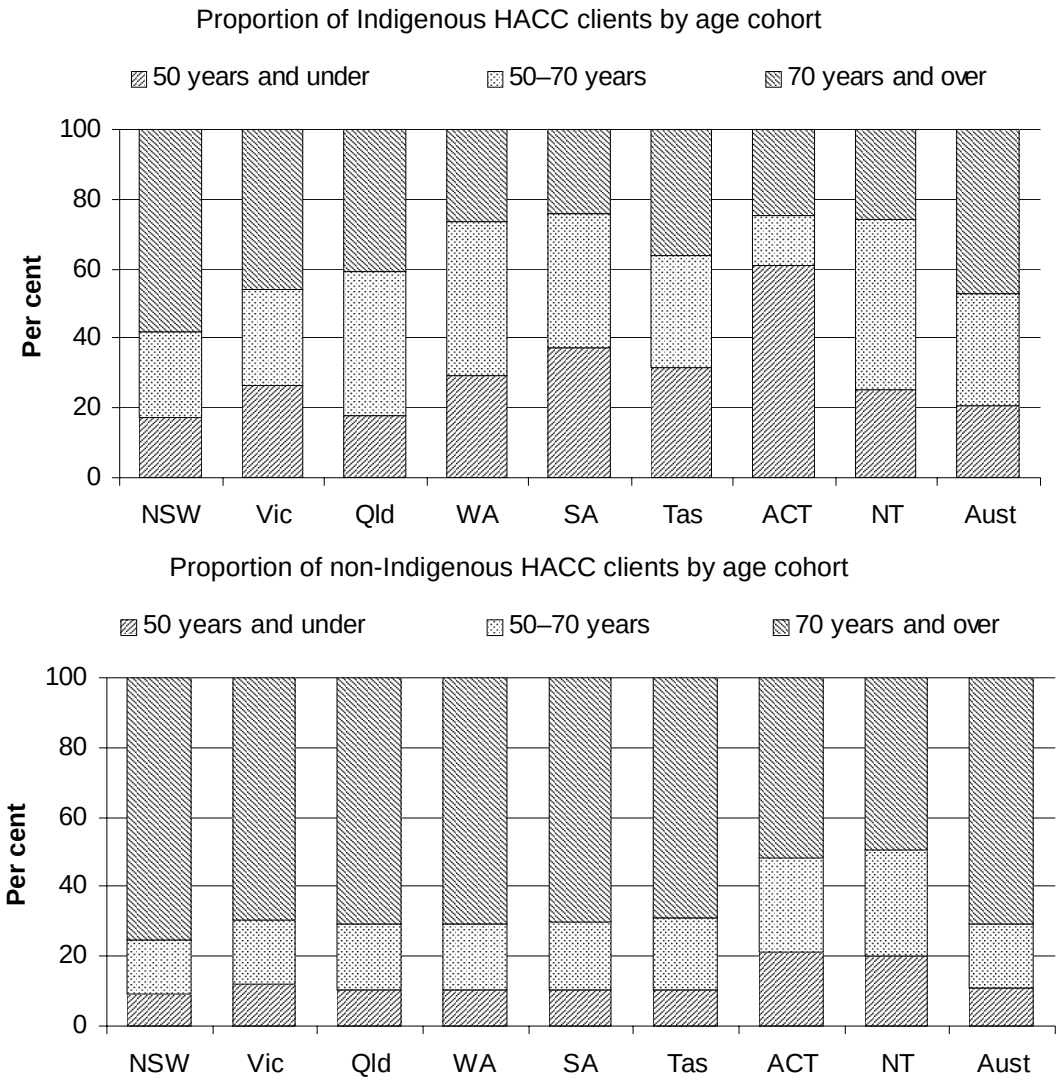
	NSW[b]	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*[c]	*NT*	*Aust*
Percentage of agencies who reported MDS data	66	70	85	94	78	73	89	56	74
Total hours[d]									
Capital city	4 909	8 816	11 000	13 112	9 681	5 604	11 263	7 314	8 311
Other major urban areas	6 022	9 107	8 039	–	–	–	–	–	6 985
Rural areas	5 629	11 900	10 102	12 061	9 181	8 039	–	20 401	8 964
Remote areas	9 118	12 797	15 224	16 979	9 428	15 339	–	11 698	13 889
All areas	**5 301**	**9 670**	**10 411**	**13 151**	**9 552**	**7 085**	**11 280**	**10 678**	**9 023**
Total meals[e]									
Capital city	2 931	3 961	7 583	5 401	846	4 723	5 274	4 716	3 907
Other major urban areas	3 837	3 645	4 736	–	–	–	–	–	4 092
Rural areas	4 706	4 381	6 789	7 317	1 109	6 800	–	17 690	5 079
Remote areas	4 498	1 342	8 258	13 649	3 523	6 497	–	19 994	10 244
All areas	**3 558**	**4 053**	**6 888**	**6 295**	**946**	**5 945**	**5 283**	**14 942**	**4 465**

a The proportion of HACC funded agencies that submitted MDS data for 2001-02 differed across jurisdictions, and ranged from 94 per cent to 56 per cent. Consequently, actual service levels will be higher than those reported here. **b** NSW advise that NSW data does not include a significant proportion of allied health and home nursing service data. **c** The ACT advise that nursing hours are significantly overstated. **d** See table 12A.20 for a full list of categories. **e** Includes home meals and centre meals. – Nil or rounded to zero.

Source: DHA (unpublished); tables 12A.20–12A.24.

Use of HACC services reported for all people compared with Indigenous people across all age groupings shows a substantial difference in the age profile for the two groups. This reflects the substantial difference in morbidity and mortality trends between Indigenous people and the general population (figure 12.12).

Figure 12.12 **HACC service by recipient age and Indigenous status, 2001-02**



Source: DHA (unpublished); table 12A.32.

Access and equity — timeliness

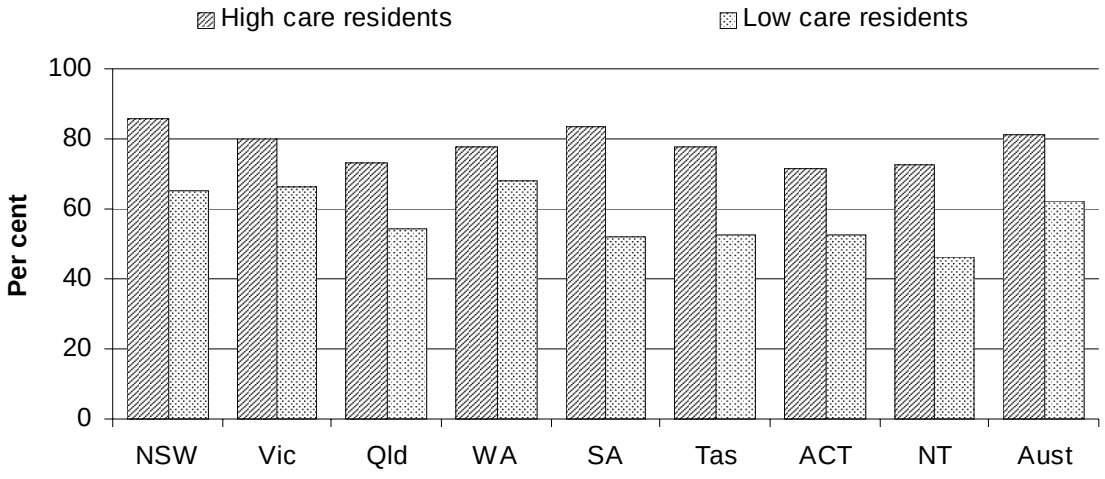
Elapsed time between ACAT assessment and entry into residential care service

The elapsed time between an ACAT assessment and entry into residential care partly reflects the extent to which aged care services meet the demand for residential services, but may also reflect applicants' willingness to wait for particular residential services or to defer entry. These data should therefore be viewed with care (boxes 12.6 and 12.7). The Steering Committee acknowledges the limitations of the current indicators and supports the need to improve them. Until improved data are available, the current indicators will continue to be reported.

On average, 72.1 per cent of all people entering residential care during 2001-02 did so within three months of being assessed by an ACAT, and almost half (44.1 per cent) entered within one month of their ACAT assessment. Across jurisdictions, the proportion of people who entered care within three months of assessment ranged from 77.1 per cent in NSW to 61.9 per cent in the ACT (table 12A.37).

Nationally, a greater proportion of people entering high care residential services entered within three months of assessment (81.1 per cent) compared with the population entering low care residential services within that time (62.3 per cent) (table 12A.37). Across jurisdictions, the proportion of people entering high care residential services within three months of being assessed ranged from 85.6 per cent in NSW to 71.6 per cent in the ACT. The proportion of people entering low care residential services within three months of being assessed ranged from 68.2 per cent in WA to 46.2 per cent in the NT (figure 12.13).

Figure 12.13 **People entering residential care in 2001-02 within three months of their ACAT assessment**



Source: DHA (unpublished); table 12A.37.

Box 12.6 **Interpretation of the elapsed time between ACAT approval and entry into residential care service indicator**

Broadly, the indicator 'elapsed time between ACAT approval and entry into residential care service' measures the time between the assessment of eligibility and admission to a service. The definitions used in this chapter are:

- ACAT approval — that is, the approval date of an ACAT assessment; and
- entry into a residential care service — that is, the date of admission to a residential care service.

This indicator needs to be interpreted with care, because a range of factors may influence jurisdictional variations, such as:

- the classification of residential placement offers that are not accepted;
- the availability of alternative community care and respite services;
- hospital discharge policies and practices;
- the availability and distribution of operational residential care services;
- building quality and perceptions about quality of care, which influence client choice of preferred service;
- delays between the date of ACAT assessments and approval of assessments; and
- priority allocations.

Box 12.7 **Entry Period for Residential Care**

In 2002, the Australian Institute of Health Welfare (AIHW) released the report *Entry Period for Residential Care* (AIHW 2002*)*. The AIHW found that the 'entry period' for residential care, which is a measure often used as a performance indicator of timeliness of access for the residential aged care system, is often unrelated to actual waiting times for residential care.

The 'entry period' is the time between ACAT assessment of a person as being eligible for residential aged care, and that person's entry into a residential aged care service. In 1999-2000, the median entry period was 34 days, but it varied substantially between people admitted for low care (55 days) and those admitted for high care (24 days).

In recent years the entry period has been increasing, and concerns have been raised that this reflects decreasing accessibility of aged care in Australia, however, the AIHW found that the supply of services in any particular region has a negligible effect on the entry period.

One of the main determinants of a short entry period was whether the resident had an ACAT assessment performed while they were in hospital rather than when they were living at home. A longer entry period was also strongly related to whether the resident had used a community aged care package or residential respite care prior to admission.

Many people assessed by an ACAT and recommended for residential aged care never enter a residential service. Others receive recommendations for both residential aged care and a community aged care package, and take up the latter. Recommendations for residential care remain active for 12 months; consequently, people often do not act on the recommendation immediately. They may believe they are quite capable of continuing to manage at home and that they do not need admission.

Some people may want to enter a particular service and are prepared to wait a lengthy period for that opportunity. For others, personal circumstances may change, for the better or the worse, affecting the timing of their decision. The AIHW found that many factors affect the entry period, but are not linked to the performance of the aged care system. The AIHW recommended that the entry period for residential care not be used as a performance indicator.

The AIHW concluded that the 'waiting time' for residential aged care, as opposed to the entry period, is an important piece of information that is not currently collected. Before data can be collected, a definition of 'waiting time' needs to be agreed. The AIHW suggested that a starting point would be to define it as the time between a person actively seeking residential aged care and their actual entry to aged care.

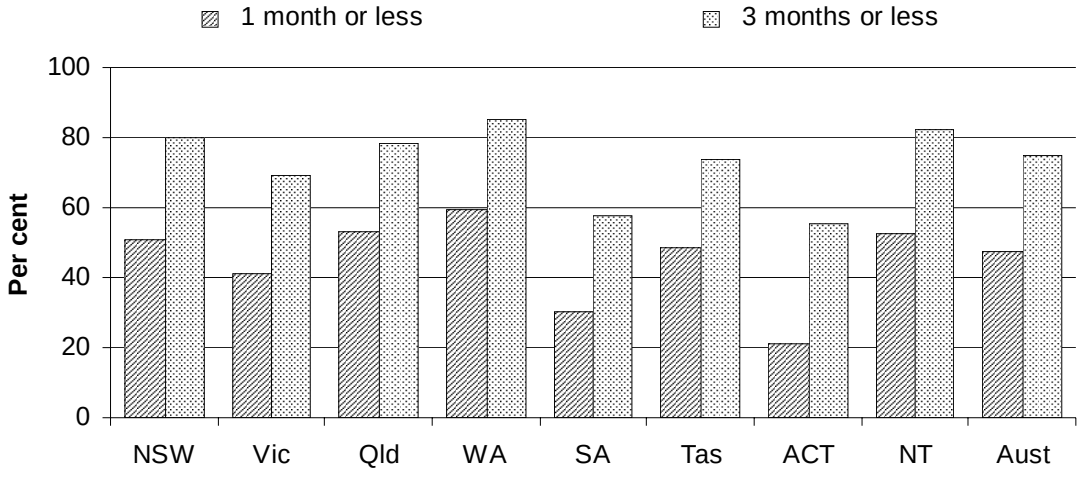
Source: AIHW (2002).

Elapsed time between ACAT assessment and the receipt of a CACP

The elapsed time between an ACAT assessment and the receipt of a community care service partly reflects the extent to which aged care services meet the demand for community care services. This indicator is reported using CACP data.

On average, 75.0 per cent of all people receiving a CACP during 2001-02 had received it within three months of being assessed by an ACAT, and 47.3 per cent had started receiving a CACP within one month of their ACAT assessment (table 12A.37). Across jurisdictions, the proportion of people who received a CACP within three months of assessment ranged from 85.3 per cent in WA to 55.2 per cent in the ACT (figure 12.14).

Figure 12.14 **Elapsed time between ACAT approval and the receipt of a CACP service, 2001-02**



Source: DHA (unpublished); table 12A.37.

Appropriateness — assessment/streaming

ACAT recommendations of longer term living arrangements

Data on the recommended longer term living arrangements of people referred by ACATs to residential and community care provide information on the patterns and levels of use of aged care services, even though there is no 'correct' mix. ACAT data provide information on referrals to aged care services, not necessarily on their use. Some people may choose not to take up a referral at that time for various reasons, or the local service provider may choose not to admit them or be unable to

do so at the time of application. (Service providers decide which eligible people are admitted to their service.)

The differences in recommendations may reflect external factors such as geographic dispersion of clients and services availability, but also client preferences and views on the types of client best served by community-based services. ACAT approvals are required for entry into residential care and for CACPs, so the client mix is likely to be weighted towards those who have higher levels of dependency.

Table 12.7 provides information on the proportion of assessed people referred to community or residential care. Queensland had the highest proportion of ACAT clients referred to residential care in 2000-01 (62.0 per cent), while the ACT had the highest proportion of clients referred to community care (63.8 per cent).

Table 12.7 **Recommended longer term care arrangements of ACAT clients, 2000-01[a]**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Community	%	51.9	53.0	36.5	58.5	34.0	36.2	63.8	52.5	49.2
Residential	%	37.7	39.0	62.0	36.7	52.6	61.0	29.4	28.2	43.0
Other	%	2.4	2.8	1.2	1.2	5.9	0.8	1.4	0.5	2.4
No long term plan made										
Died	%	0.6	0.7	0.1	1.0	1.8	0.2	0.1	1.6	0.7
Cancelled	%	2.0	1.0	0.2	–	4.6	1.4	0.3	0.5	1.4
Transferred	%	1.3	2.6	–	2.6	1.2	0.3	0.1	1.0	1.6
Unknown	%	4.1	0.9	–	–	–	–	4.9	15.8	1.8
Total	**no.**	**65 355**	**54 099**	**27 676**	**23 831**	**15 438**	**4 473**	**2 430**	**628**	**193 930**

a Includes deaths, cancellations and transfers. – Nil or rounded to zero.

Source: Lincoln Gerontology Centre (2002); table 12A.38.

The distribution of ACAT living arrangement recommendations will be influenced by the degree to which any pre-selection process refers a higher proportion of people requiring residential care to ACATs for assessment. Access to residential care requires an ACAT assessment, and jurisdictions with lower overall assessment rates may operate a filtering process to focus assessments on individuals who are more likely to require this level of care. In Queensland, for example, the high proportion of residential care assessments may partly reflect its low rate of use of ACATs other than for primarily residential assessments (table 12.7).

Appropriateness — unmet need

Defining and determining the level of need at an individual level, let alone at a population level, are complex tasks. The perceptions of need and unmet need are often subjective. Previous reports included discussion of unmet need from a

recipient's perspective based on the 1998 ABS Survey of Disability, Ageing and Carers concerning older people requiring assistance with daily activities (ABS 1999 and table 12A.40). Updated ABS data from the 2003 Survey of Disability, Ageing and Carers will be released during 2004 and will be included in the 2005 Report.

Quality — independent appraisal

Compliance with service standards for residential care

Data showing compliance with standards for residential care were not available for this year's Report. Accreditation aims to promote the quality of life and quality of care of residents of government funded aged care services. Services are assessed against 44 'Expected Outcomes' under four main standards (management systems, staffing and organisational development; health and personal care; resident lifestyle; and physical environment and safe systems) to ensure they have internal processes conducive to quality outcomes and continuous improvement.

The accreditation process comprises a series of activities, including a self-assessment undertaken by the service and site audits. It results in a decision by the Aged Care Standards and Accreditation Agency (the Agency) on the period of accreditation to be granted. On the introduction of the accreditation process in 1999, services were rated on a four-level scale (commendable, satisfactory, unacceptable or critical) against each of the 'Expected Outcomes'. Following the completion of the first round of accreditation, the Agency revised the ratings scale and since December 2001 services are now assessed as either 'compliant' or 'non-compliant' against each 'Expected Outcome'. In cases where a serious risk is identified for an 'Expected Outcome' a rating of 'non-compliant with serious risk' is given.

The decision the Agency makes on a service's period of accreditation is based on desk and site audits and any other relevant information (box 12.8). Each decision is based on individual merits but services that are compliant with all 44 'Expected Outcomes' and that have demonstrated continuous improvement are generally awarded three-year accreditation. Services that are truly exceptional may be considered for a period of up to four years accreditation.

Services can seek reconsideration and review of decisions on accreditation, and are advised of any necessary improvements. Ongoing compliance is monitored through support contacts, and review audits may be conducted. Commencing services are assessed on the basis of a written application and, by law, can receive a maximum of only 12 months accreditation.

Accreditation decisions and other information relating to the Accreditation Standards and the Aged Care Standards and Accreditation Agency are publicly available via the Agency's web site (www.accreditation.aust.com).

Box 12.8 **Accreditation**

The Aged Care Standards and Accreditation Agency takes into account the following factors, as required by the *Accreditation Grant Principles 1999*:

- the desk audit report;
- the site audit report;
- information received from the Secretary of the DHA about matters that must be considered under division 38 of the Aged Care Act for certification of the service;
- other information received from the Secretary;
- information received from the applicant in response to the statement of major findings presented to the applicant at the conclusion of the site audit (note that the site audit report may take into account this information from the applicant); and
- whether the agency is satisfied that the residential care service will undertake continuous improvement, measured against the Accreditation Standards, if it is accredited.

The following levels of accreditation are awarded on the basis of assessment standards.

Accreditation	*Criteria*
Three-year accreditation	Service is rated 'satisfactory' or 'commendable' on all four standards.
One-year accreditation	Service is: • rated 'unacceptable' on one or more standards but has an acceptable plan of address in place; and • rated 'satisfactory' or 'commendable' on the remaining standards.
Not accredited	Service is either: • rated 'critical' on any of the four standards; or • rated 'unacceptable' on one or more standards and does not have an acceptable plan of address in place.

Source: Aged Care Standards and Accreditation Agency (1998).

Certification aims to improve the physical quality of residential aged care services. The certification framework is underpinned by Part 2.6 of the Aged Care Act and by the Certification Principles. Certified services gain access to accommodation payments and are eligible for Commonwealth funding supplements for concessional and assisted residents.

The certification program has established minimum standards of building quality, which are to be achieved progressively by the industry. To achieve certification, services are assessed against seven aspects of building quality. All services were assessed for certification in 1997 and are now working to achieve continuous improvement targets, which were introduced in 1999 as part of a 10 year plan to improve building quality. Services are to achieve a safety score of 19 out of 25 and an overall score of 60 out of 100 by 2003, and to achieve privacy and space targets for residents by 2008. Timeframes for achievement of targets vary depending on whether the service is existing or new.

All services were required to be accredited by 1 January 2001. To achieve the second accreditation, all services must make a further application for accreditation approximately six months before their present period of accreditation expires. The process of desk audits and site audits is then repeated.

While data on accreditation decisions on residential care services were not available this year, data on safety scores and residents per room were provided. The average number of residents per room at July 2002 varied from 1.66 in NSW to 1.16 in Tasmania. Average safety scores ranged from 21.4 in SA to 17.4 in Tasmania (table 12.8).

Table 12.8 **Average certification safety score and residents per room, July 2002**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Fire score[a]	19.6	18.5	19.7	18.9	21.4	17.4	19.9	20.2	19.4
Residents per room	1.66	1.47	1.41	1.31	1.37	1.16	1.19	1.19	1.48

[a] Maximum score is 25; a score of 19 is to be achieved by 2003.

Source: DHA (unpublished); tables 12A.42 and 12A.43.

Quality — client perceptions

Complaints

The Aged Care Complaints Resolution Scheme was established in October 1997 under the Aged Care Principles. The Scheme is a free and accessible complaints system run by the DHA.

The Scheme is available to anyone who wishes to make a complaint about a Commonwealth funded aged care service. This can include residents of aged care facilities and their families, staff, and people receiving CACPs. Complaints can be

made verbally or in writing, and on a confidential or anonymous basis if necessary. All aged care services are required to have an internal complaints system and in many cases complaints may be resolved without the need to involve the Scheme.

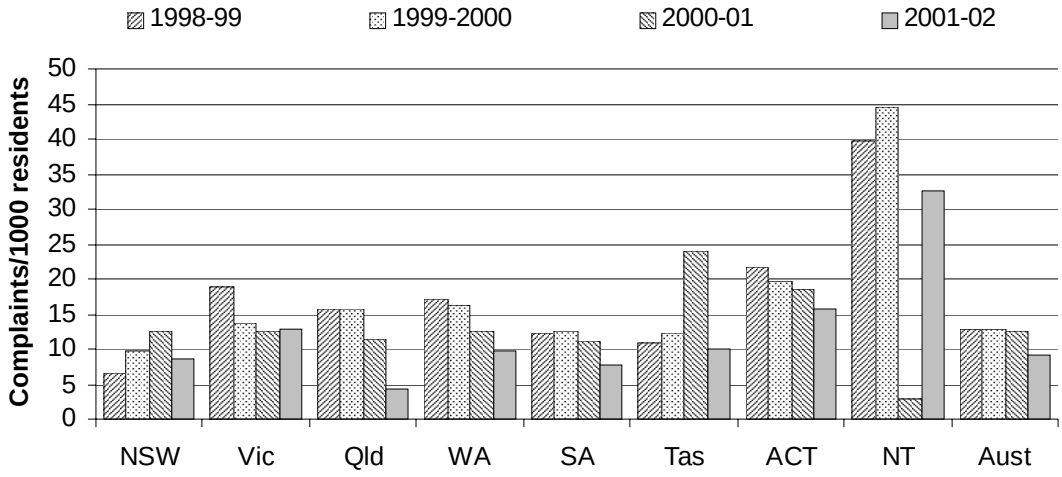
The Scheme is based on the intent that most complaints will be dealt with to the satisfaction of all parties through a resolution process. While approximately 90 per cent of cases have been resolved in this way since 1997, achieving this outcome can be resource intensive depending on the nature of the complaint and the attitudes of the parties.

Since the Scheme was introduced, it has handled over 7000 complaints. More than 95 per cent of these complaints have been dealt with through negotiation and mediation; only 1–2 per cent of cases proceeded to Committee for determination.

Many complaints are complex, raising one or more issues. Of the more than 7000 complaints dealt with, over 12 000 issues have been involved. The issues raised include care needs, financial matters, staff, catering, safety, environment, choice, continence, hygiene and security.

The number of complaints registered per 1000 residents in 2001-02 ranged from 13.0 in Victoria to 4.4 in Queensland (excluding Tasmania, the ACT and the NT, which are not directly comparable because the small number of residents in these jurisdictions exaggerates the number of complaints per 1000 residents) (figure 12.15).

Figure 12.15 **Aged Care Complaints Resolution Scheme complaints per 1000 residents**



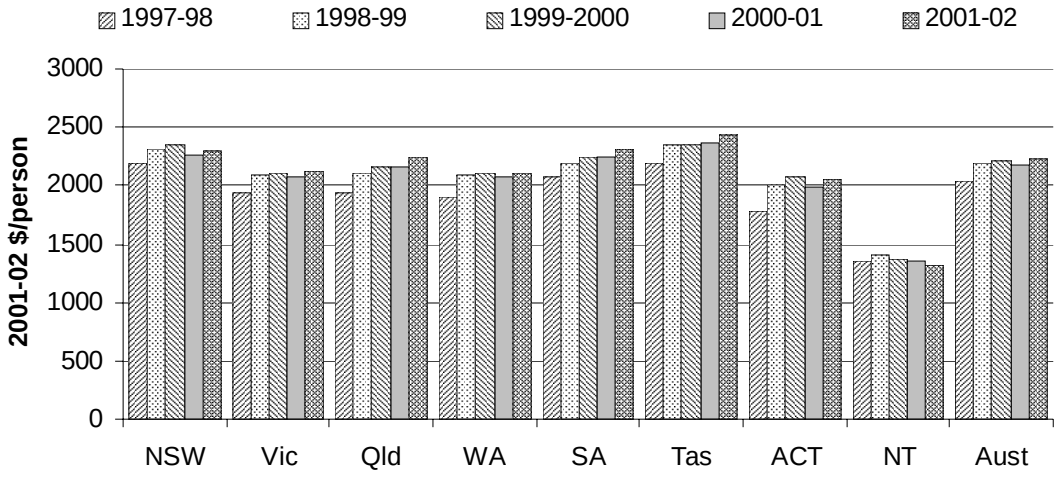
Source: DHA (unpublished); table 12A.44.

Efficiency

This section provides information on expenditure per person on the main types of aged care services. A proxy indicator of efficiency is cost per person in the target population — that is, government inputs (expenditure) per person aged 70 years and over plus Indigenous people aged 50–69 years. Unit cost data for aged care services delivered by government do not contain capital costs.

Commonwealth Government expenditure (including expenditure by the DVA) on residential care services per person aged 70 years and over plus Indigenous people aged 50–69 years varied across jurisdictions in 2001-02, ranging from $2428 in Tasmania to $1324 in the NT (figure 12.16).

Figure 12.16 **Commonwealth real expenditure on residential services — expenditure per person aged 70 years and over plus Indigenous people aged 50–69 years (2001-02 dollars)[a]**

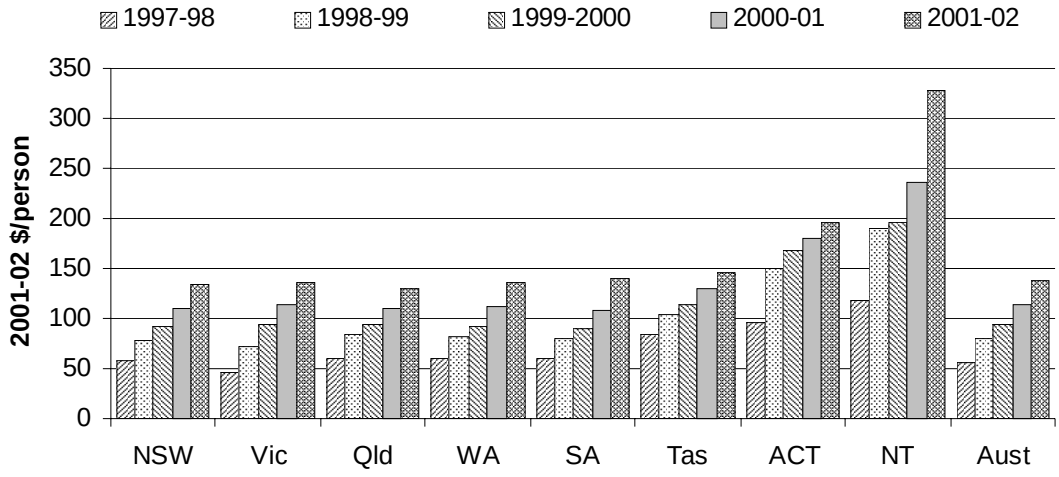


a Includes expenditure on nursing home benefits, hostel subsidies and residential respite. Includes the DVA's contribution (table 12A.47).

Source: DHA (unpublished); DVA (unpublished); table 12A.52.

Expenditure on CACPs per person aged 70 years and over plus Indigenous people aged 50–69 years varied across jurisdictions in 2001-02, and was highest in the NT ($328) and lowest in Queensland ($130) (figure 12.17).

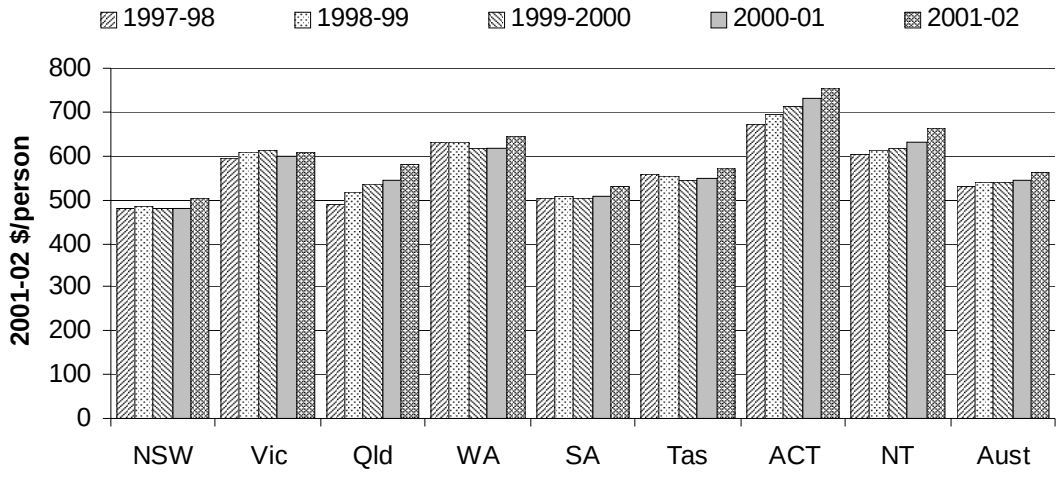
Figure 12.17 **Commonwealth real expenditure on CACP services — expenditure per person aged 70 years and over plus Indigenous people aged 50–69 years (2001-02 dollars)**



Source: DHA (unpublished); table 12A.55.

Commonwealth, State and Territory expenditure on HACC services per person aged 70 years and over plus Indigenous people aged 50–69 years was highest in the ACT ($756) and lowest in NSW ($504) (figure 12.18).

Figure 12.18 **Commonwealth and State Government real expenditure on HACC services — expenditure per person aged 70 years and over plus Indigenous people aged 50–69 years (2001-02 dollars)**



Source: DHA (unpublished); table 12A.54

Many government services have moved towards better measurement of unit costs as part of a strategy to promote efficiency improvements. It is difficult to measure the

overall efficiency of community care services, given their heterogeneity, but components can be identified and unit costs can be measured. Where services are viewed as substitutes, cost comparisons may be affected.

One approach is to identify service types so a classification system can be developed with corresponding unit costs. The development of a community care classification system remains a challenge, including the question of how to define a meaningful episode of care and show how client outcomes are related to the level and mix of resource inputs.

12.5 Future directions in performance reporting

There are several aspects of aged care services for which indicators are not fully developed and for which there is little performance reporting. Further development work is required to establish a full set of indicators. Developments that are relevant to all service areas are discussed in chapter 2. Box 12.9 outlines the Retirement Villages Care Pilot.

Box 12.9 **Retirement Villages Care Pilot**

In the 2002-03 Budget, the Commonwealth Government provided $14.9 million over four years to pilot the provision of community care into retirement villages. The Retirement Villages Care Pilot initiative focuses on residents of retirement villages as a subgroup of those older Australians who require additional services to assist in their choice to stay at home for as long as possible.

The initiative will supplement the care already available in many villages. It should facilitate self provision of future care needs by supporting those who move to a retirement village — a choice that is becoming more common for older Australians.

Two hundred places are available for this initiative in 2002-03, comprising a mix of high care and low care equivalent places. Allocation will be on the basis of an expression of interest and the development of final proposals.

Source: DHA (unpublished).

Developing indicators and data

The AIHW has examined methods for including consumer views in the assessment of HACC service quality. The project developed a Consumer Survey Instrument (CSI), of which a number of versions have been produced to suit particular HACC service types, consumer groups and different ways of gathering consumer feedback. All States and Territories are committed to using the CSI and have agreed to

investigate methods of incorporating it into the National Service Standards Instrument.[3]

Further work is required to improve the definitions of the appropriateness indicators (adequacy of assessment, intensity and appropriateness of care). A lack of data has also prevented progress in this area. The HACC National Service Standards Instrument may provide useful data for these indicators in the future. Further work is also required to refine the timeliness indicators.

12.6 Jurisdictions' comments

This section provides comments from each jurisdiction on the services covered in this chapter. Appendix A contains data which may assist in interpreting the performance indicators presented in this chapter. These data cover a range of demographic and geographic characteristics including age profile, geographic distribution of the population, income levels, education levels, tenure of dwellings and cultural heritage (including Indigenous and ethnic status).

[3] The HACC National Service Standards instrument measures the extent to which agencies comply with national service standards. Developed in 1996-97, the instrument is the basis for monitoring, evaluating and reporting on the quality of HACC services.

Commonwealth Government comments

“ The Commonwealth’s emphasis on community care continued over the last year with increased funding for carers and respite services and increasing availability of Community Aged Care Packages. By the end of this financial year almost 28 000 care packages will be in operation.

Commonwealth expenditure on aged and community care programs increased substantially between 1995-96 and 2001-02. Expenditure on:

- Community Aged Care Package increased sevenfold, from $33 million to $246 million;
- Home and Community Care (HACC) increased from $423 million to $616 million, an increase of 45 per cent;
- the National Respite for Carer’s Program increased from $15 million to $73 million, an increase of 402 per cent; and
- residential aged care increased from $2.4 billion to $4.0 billion, an increase of $1.6 billion.

In the last four years the Government has allocated more than 38 000 new places. In May, the Commonwealth Minister for Ageing announced the release of more than 8231 new aged care places for Aged Care, including 5737 residential care beds, 1150 Community Aged Care Packages and 1344 flexible care places.

The Australian Institute of Health and Welfare (AIHW) was commissioned to undertake a multivariate statistical analysis of entry periods to residential care. The AIHW’s Report confirms that people with the greatest health or social support needs enter care quickly, while people in receipt of other community care programs wait longer to enter residential care as they are receiving support services in the community in the interim. Significantly, the AIHW Report concludes that the supply of residential aged care places has marginal or no discernible effect on entry periods: for high care residents, a decrease in the provision ratio of 10 places per 1000 people aged 70 years and over was associated with only a two-day increase in entry period. The AIHW has now been asked to report on entry periods for Community Aged Care Packages.

The HACC Minimum Data Set (MDS) is being reported for the first time in this year's Report. Work is ongoing to improve reporting from the MDS and its accuracy. For 2001-02 it is estimated that approximately 74 per cent of HACC-funded agencies successfully submitted MDS data, ranging from 56 per cent in the Northern Territory and 66 per cent in New South Wales to 89 per cent in the ACT and 94 per cent in Western Australia. The Commonwealth will engage a consultant to undertake a comprehensive evaluation of the HACC MDS. It is expected that the Final Report of the consultancy will provide significant strategic direction for improving HACC MDS data quality for subsequent collections. Another community care data collection, the Carer Respite MDS, will be collected from January 2003. ”

New South Wales Government comments

“ The NSW Government is committed to providing services to older people and their carers to maximise their independence and participation in community life, to promote their health and wellbeing and to provide accurate and timely information to enable them to choose and access appropriate services as they need them.

The NSW Government established the Office for Ageing in March 2002 to enhance the quality of life of those in NSW who are ageing and to promote opportunities for older people who are active, healthy and contribute to their community. The Office has already progressed a number of strategies, such as Seniors On-Line, Future Directions for Dementia Care and Support (2001-2006) and the Seniors Information Service.

Additional funding for the Home and Community Care (HACC) program was more than $26.4 million in 2001-02, and significant additional funding was allocated to expansion in basic maintenance and support services, particularly domestic assistance, home maintenance, transport, and allied health. Improved service delivery to special needs groups was also a focus for HACC in 2001-02. In particular, resources were directed to services for Aboriginal and Torres Strait Islander people, people with dementia and their carers and people from non-English speaking backgrounds.

It should be noted that HACC data comparability across jurisdictions is complex, given the different data return rates from HACC providers in each jurisdiction, historically different service provision patterns, as well as the range and diversity of organisations funded. NSW makes a substantial investment in personal care services, one of the most significant services in preventing premature admission to institutional care. Improvements in data collection, together with the National HACC Equalisation Strategy that will ensure all jurisdictions receive a share of total HACC funding consistent with its share of the HACC target population, will mean that data comparability across jurisdictions will be improved.

Under the Government Action Plan (GAP) for Health, the NSW Minister for Health has established the Working Group on the Care of Older People in the NSW Health Care System to develop policy options for improving the interface between the acute, community and residential aged care sectors. An initial outcome of this work has been the allocation of an additional $5.5 million per annum for 34 multidisciplinary Aged care Services Emergency Teams across NSW to improve the care of older people who present to Emergency Departments. Other relevant GAP initiatives include improved discharge planning and the introduction of a personal health care record for people with chronic and complex care needs.

NSW is also continuing its planned and comprehensive response to the rapid increase in the number of people living with dementia through the allocation of an additional $11.043 million over four years for a range of dementia strategies. ”

Victorian Government comments

“Victoria is committed to enhancing the quality of life of seniors and to encouraging the community to plan for an ageing population through the establishment of the Office of Senior Victorians. The Office coordinates policy and action across the whole of Government to promote the wellbeing and social participation of older Victorians.

Over the past year, Victoria has faced increasing pressure on the health and community care system generally, and the HACC program in particular, to respond to a growing demand for aged care services.

In 2001-2002, Victoria has focused on the need to improve the interface between acute/sub-acute, residential aged care and the community-based sector. Initiatives included a HACC Workforce Development Strategy, recognising that quality service provision is critically dependent on quality staff. Development within the Primary Care Partnership Strategy, provides a common basis for HACC agencies to work together to ensure effective service delivery.

Victoria has continued to provide additional funds for HACC and HACC-like services over and above the requirements of the Commonwealth/State matched funding.

State funded programs provide additional services that assist Victorians to continue to live in their own homes. Further funds were made available for Personal Alert Victoria, which funded 14 915 personal alarm units across the State at June 2002. The Carers’ program also received new funds of $0.675m. and totalled $8.8m for 2001/02.

Victoria has made a strong commitment to improving access to services for, and better meeting the needs of, special needs groups in the community. The Ethnic Communities Council was funded to develop a range of strategies to assist small rural communities and emerging ethnic communities to understand the HACC service system. This initiative builds on Victoria’s high level of HACC service delivery for people living in rural and remote areas.

Victoria has a high proportion of state-owned residential aged care facilities. During the year 110 aged care beds were reopened in areas of high hospital demand and 60 aged care beds and 83 community aged care packages were reallocated to areas of need across the State. Capital works projects were completed at nine residential aged care facilities, contributing to quality accommodation for aged residents.”

Queensland Government comments

“In June 2002, the Queensland Government announced a new portfolio for Seniors. The Minister for Seniors has lead agency responsibility for issues relating to older people in Queensland. The Department of Families completed two suicide prevention projects targeting older people, both of which were evaluated as successful. These included a community awareness raising project and implementation of strategies to reduce social isolation of older people.

In 2002-2003, additional funding has been provided to support the Future Directions initiatives of the Department of Families. This includes the development of the “A Society for All Ages: Our Shared Future - 2020” framework, a long-range planning agenda to address the policy issues of the ageing population and the interconnected needs of other generations. Other Future Directions initiatives for older people include bridging the generation gap in multicultural communities, improving access to information technology for older people and elder abuse prevention.

The Queensland Government is committed to improving aged care. In 2002 Queensland Health’s draft Aged Care Strategy was released for public consultation. The Strategy outlined new directions in services for older people in inpatient services, mental health services (community and residential), State run residential aged care, dementia care and community services. The Government will consider the outcomes of the consultation in early 2003.

Queensland Health manages the Home and Community Care Program, Aged Care Assessment Program, State Government residential aged care facilities and a range of other services providing long term care for older people. The 2002/03 State Budget provided for the commencement of a major five year $120 million capital program to redevelop Queensland Health’s residential aged care facilities.

Queensland Health continues to address issues identified with the collocation of older mental health consumers in residential aged care facilities. These issue include accreditation, workforce and partnership arrangements between the mental health and aged care systems. Two memory clinics are now in operation.

A major priority for HACC in 2002/03 is to improve access to basic support services including personal care, domestic assistance and social support and home maintenance services. Other HACC priorities include extending access to Indigenous services; building on existing initiatives in continence management, and workforce training to better service the needs of clients suffering from dementia.

New approaches to assessment and client referral mechanisms are being trialled and evaluated. The aim is to reduce the burden of multiple comprehensive assessments for clients with complex needs, to promote consistency and ensure older people are able to access the most appropriate services based on their assessed need.”

Western Australian Government comments

“The Western Australian government’s commitment to aged care was reinforced early in 2002 with the formation of the WA Aged Care Advisory Council to oversee a whole-of-sector approach to the planning and provision of the State’s health and related aged care programs. The Advisory Council is taking a person-centred approach, considering the needs and preferences of individuals while building on the strengths of the existing system and the experience and expertise of service providers.

The principle of supporting people in their own homes, and recommending for residential care only when other support systems are not appropriate to meet specific needs, continues to inform the operations of the Aged Care Assessment Program (ACAP). Data derived from the ACAP Minimum Data Set (MDS) client-based data collection relating to recommended care plans resulting from an individual’s assessment, showed that, for 2001, 60.5 per cent of all ACAT assessments recommended that the person assessed returned to their home with or without community support services. Residential care was the recommended outcome for 35 per cent of all assessments. Remote ACATs recorded the greatest percentage of recommendations for returning home with or without support (71 per cent).

The Home and Community Care (HACC) program continues to expand in line with the commitment to improve the capacity of services to assist people to stay in their own homes. Planning for HACC services has been greatly enhanced by the availability of consistent and reliable data from the HACC MDS initiative. The State had close to 100 per cent compliance, well above the national average of 74 per cent, in the reporting of HACC services received in 2001-02.

The Care Awaiting Placement program encompasses the provision of 108 interim residential beds across the Perth metropolitan area to accommodate, in an appropriate environment, frail older people waiting for residential care. In the 12 months to June 2002, the number of older people waiting for residential care in an acute hospital setting decreased by 25 per cent.

Western Australia continues to implement a range of flexible care options for the frail elderly, including the provision of post-hospitalisation nursing and allied health support and home care services, to assist people to continue living in their own home. The Transitional Care Pilot (TCP), a collaborative State and Commonwealth project, is designed to provide rehabilitation for frail older people who have been hospitalised, to enable them to return home with appropriate support. The TCP, with an additional 50 places made available under the Commonwealth Innovations Pool, will be piloted for two years to determine whether it is a cost-effective and appropriate model of care for frail older people.

Western Australia is committed to further refinement of its range of programs and services in accordance with demographic changes, the geographic spread and diversity of the population, and the needs and preferences of older people.”

South Australian Government comments

“The 2001 ABS Census indicates that 10.8 per cent of South Australians were estimated to be aged 70 years and over in June 2002 compared with the national figure of 9.0 per cent. This continues to challenge the State in the provision of care and support, yet untapped opportunities remain to realise the contribution that senior residents can and do offer.

The Government which came into office in February 2002 has appointed a new Ministerial Advisory Board on Ageing. The Minister intends for the Board to oversight the development of a new State Plan on Ageing which builds on *Ageing – A Ten Year Plan* and *the National Strategy for an Ageing Australia.* Key considerations for the Board will be on working across Government and across generations.

Timely access to residential care remains an issue in South Australia. One issue has been the availability of funds to build newly allocated places. The Government is providing capital works funding and a loan facility to State health units which provide aged care. In addition, HomeStart has a loan facility for not-for-profit providers to access in establishing new beds, or moving places from areas of high to low supply.

A State funded Transition Care Project, which was the forerunner to the Home Rehabilitation and Support Service, ran successfully from January to December 2001. The Commonwealth Government agreed to contribute towards a similar but distinct joint project, with matching State and Commonwealth funding contributions. The target group is older people who have either had an unnecessarily long stay or are at risk of an extended stay in the acute hospital system, and who are assessed as eligible for residential care. The Service provides short-term rehabilitation and support services, including short-term residential care, therapy, nursing and personal care, and community based support. The project facilitated residential placement for 18 per cent of people completing their transition, and resulted in a return home for 58 per cent with varying levels of support. The outcomes of the project have challenged the thinking of aged care providers and program administrators in determining the appropriate balance between short-term or episodic support options compared with permanent placement.

The DHS has now released the document *Strategic Directions for Older People from Culturally and Linguistically Diverse Backgrounds*. This will influence priorities in many areas of work, including growth in the HACC Program. Services for Aboriginal people remain a priority. South Australia is actively contributing to the national HACC Best Practice Project in diverse areas across the State.”

Tasmanian Government comments

“ The Tasmanian Government is committed to promoting healthy ageing and providing a care system that has an appropriate focus on the health and care needs of older Tasmanians with adequate infrastructure to meet these needs.

Tasmania’s ageing population, along with the rurality of a small-dispersed population and its low socio-economic status, is increasingly becoming one of the major dominant influences on the planning and development of health services.

The State currently has a higher proportion of people aged 70 years or over, than the national average. It is rapidly moving towards a community where one third of its population will be aged 65 years or more, of which a significant proportion will be aged 85 years or more. In fact, the most rapid growth is predicted to be in the aged group of 85 years plus, which by 2050 will increase from 1.5 per cent to 6.8 per cent of the total population.

Tasmania continues to experience increasing numbers of people waiting for placement into residential aged care. Consequently, this significantly impacts upon the State’s community health and hospital services. Not only has the number of people waiting increased, but the percentage of these people needing to wait in hospital has more than doubled over the past 5 years.

In response to these challenges, the Government has relocated the Seniors Bureau to the Department of Premier and Cabinet to provide a stronger, more integrated and coordinated approach across the whole of government.

The Department of Health and Human Services is undertaking reviews of the Aged Care Assessment Program, Home Help & Home Maintenance Service and Community Transport systems and is developing a Community Nursing Strategic Plan. It is implementing reforms to statewide rehabilitation services. In addition, a new 25-bed unit under the Commonwealth’s Innovative Care Rehabilitation Service Pilots has been opened. Packages of care are being provided for people with complex care needs and efforts are being made to improve data collection and management information systems.

In order to address longer term needs, the Tasmanian Government is giving priority to developing a strategic plan that will provide a comprehensive understanding of the full extent of cost and demand pressures on health and human services created by an ageing population. This will also give strategic direction for the future development of health and community services.

Tasmania’s Department of Health and Human Services has identified the need to ensure that the services it provides are responsive to the needs of an ageing population and it recognises that the opportunity exists, in partnership with others, to undertake research and pilot new policies and models of service delivery to enable health services to meet the care needs of an ageing population. ”

Australian Capital Territory Government comments

“The ACT Government is committed to ensuring that older people in the ACT have access to timely and appropriate care services. The Government has developed a Health Action Plan that sets the directions for public health services in the ACT for the next three to five years. The Plan articulates an approach to older persons that is founded on the principles of independence, participation, care, self-fulfilment and dignity.

The ACT Government has undertaken a number of initiatives to improve the interface between acute care and aged care services. These include a joint initiative with the Commonwealth Government to fund 11 transitional care beds within a residential facility to assist elderly people to return home safely following a hospital stay. Other ACT Government funded services include transitional care packages in the community, and a convalescent service to assist people to restore function following discharge from hospital.

The ACT Government continues to work with the community sector and the Commonwealth Government to enhance services for elderly people. A priority for 2001-02 has been the commencement of a collaborative partnership between the Aboriginal community, the Commonwealth and the ACT Government to assess the aged care needs of Aboriginal people in the ACT. For the first time in 2001-02 an Aboriginal service provider was funded through the Home and Community Care (HACC) Program.

Steps are being taken to address the respite needs in the ACT in recognition of the vital role that carers play in supporting family members, friends and neighbours. The ACT Government is assessing the extent of met and unmet need for various client groups and individuals and plan for future respite services to ensure that carers and individuals are adequately supported.

Mental Health ACT has provided additional funds over the next three years to address the gap in services for people with dementia-related challenging behaviours. Negotiations have begun with a residential care provider and the Commonwealth regarding the provision of specialist psycho-geriatric residential beds. Negotiations also continue with the Commonwealth with regards to accessing funding for a Psycho-Geriatric Unit.

In the past twelve months the ACT Government has placed a strong emphasis on participating in and facilitating consultation in order to develop clear direction for the HACC Program in 2002-2003. Planning processes have included sector network meetings, planning sessions, reports and evaluations from services, consultation with relevant agencies and individuals. This has included consultation with consumers and regular contact with service providers. Particular emphasis has been given to listening and responding to consumers with a commitment to develop a consumer participation plan in 2002-2003.

The agreed vision for clients of HACC services includes the right to pursue lives of dignity and self-esteem, self-worth, independence and meaning, and a right to accurate information, and involvement in decision making.”

Northern Territory Government comments

“ The Northern Territory Government faces the challenge of providing services to an aged care target group that does not match the national norm. For instance, the NT currently has the smallest proportion of people aged 70 years and over, but it also has the fastest growing population in the target group. Additionally, over half of the target group for aged care services in the NT is Indigenous, in marked contrast with all other states/territories.

In the Territory, we are servicing a client group with higher support needs than the national average, and one that generally needs and accesses services at a much younger age than the national average. The aged care target group also includes many more indigenous, remote and non-English speaking background clients in all programs than any other jurisdiction in Australia; and has less capacity to share the cost of service delivery through co-payment systems such as residential aged care bonds.

Further, the diverse cultural mix of the Northern Territory population, remotely located communities, issues with recruitment, retention and training of staff, along with the harsh climatic conditions are all factors which challenge and encourage innovative approaches.

With this in mind, the Northern Territory has already developed a range of new responses to its unique client profile. Principally this is achieved through providing services to people in the community where they reside. Consequently, the NT has a higher number of very small, remote aged care services than any other jurisdiction. These services include CACP, HACC and indigenous pilots as well as a focus on integrating aged care with existing health and other community services.

Integration of HACC and ACAT assessment will be trialled in the Katherine district, as well as establishing links with other coordinated care and allied health trials under way in Katherine.

Current national projects which focus on the unique circumstances of remote indigenous service delivery include the documentation of good practice in remote HACC service delivery, and the development of an Indigenous HACC dependency tool.

These different types of services will ultimately ensure that ageing Territorians will be able to access service within their own communities. ”

12.7 Definitions

Table 12.9 **Terms**

Term	*Definition*
Aged care	Formal services funded and/or provided by governments, that respond to the functional and social needs of frail older people, and the needs of their carers. Community aged care services are aimed to optimise independence and to assist frail older people to stay in their own homes. Residential care services provide accommodation and care for those who can no longer be assisted to stay at home. The majority of aged care services assist in activities of daily living such as personal care (eg. bathing and dressing), housekeeping and meal provision, and are delivered by trained aged care workers. However, aged care services may also be delivered by health professionals such as nurses and occupational therapists. These services are generally aimed to maintain function rather than treat illness or to rehabilitate, and are distinguished from the health services described in Part E of this report. Assessment of care needs is also an important component of aged care. Aged care services may be funded through programs specifically or mainly directed to older people, or through programs that address the needs of people of different ages. Generally, the target groups of aged care services are people over the age of 70 years and Indigenous people aged over 50 years.
Ageing in place	An approach that aims to provide residents with appropriate care and increased choice by allowing them to remain in the same facility regardless of their levels of care needs. It also allows couples with different levels of care needs to be cared for in the same facility. The main facet of 'ageing in place' is that funding is tied to the assessed care needs of the client rather than to the services provided by the facility. One of the objectives of Commonwealth aged care legislation is ' to promote ageing in place through the linking of care and support services to the places where older people prefer to live' (*Aged Care Act 1997* (Cwlth), s.2-1 [1j]).
Centre day care	Respite care provided from a facility such as a day care or health centre. Respite care is usually combined with social support services to maintain the functional capabilities of the person receiving care.
Complaint	The affected care recipient or his or her representative, or anyone else, may make a complaint to the Secretary about anything that: (a) may be a breach of the relevant approved provider's responsibilities under the *Aged Care Act 1997* or the Aged Care Principles; and (b) the complainant thinks is unfair or makes the affected care recipient dissatisfied with the service.
Disability	A limitation, restriction or impairment which has lasted, or is likely to last, for at least six months and restricts everyday activities.
Elapsed time between ACAT approval and entry into a residential care service	The measure of the elapsed time between ACAT approval and entry into a residential care service. It has been used in past years as an indicator of access to residential care.

(Continued on next page)

Table 12.9 **(Continued)**

Term	*Definition*
High/low care recipient	Recipient of a high level of residential care (that is, a level of residential care corresponding to RCS levels 1–4) or a recipient of a low level of residential care (that is, a level of residential care corresponding to RCS levels 5–8). If the person is approved as a recipient of a high level of care, that person can receive care at any care classification level (*Approval of Care Recipients Principles 1997*, s.5-9). A person approved as a recipient of a low level of care can be classified only as RCS 5–8. (*Classification Principles 1997*, s.9-19).
In-home respite	A short term alternative for usual care
People from non-English speaking countries	People who were born in non-English speaking countries. English-speaking countries are defined as Australia, New Zealand, the United Kingdom, Ireland, the United States, Canada and South Africa.
People with a moderate disability	Where a person does not need assistance, but has difficulty with self care, mobility or communication.
People with a profound disability	Where a person is unable to perform self care, mobility and/or communication tasks, or always needs assistance.
People with a severe disability	Where a person sometimes needs assistance with self care, mobility or communication.
Personal care	Assistance in undertaking personal tasks (for example, bathing).
Places	A capacity within an aged care service for the provision of residential care, community care or flexible care in the residential care context to an individual (*Aged Care Act 1997* (Cwlth)); also refers to 'beds' (*Aged Care (Consequential Provisions) Act 1997* (Cwlth), s.16).
Real expenditure	Actual expenditure adjusted for changes in prices, using the GDP(E) price deflator and expressed in terms of final year prices.
Resident	For the purposes of the *Aged Care Act 1997*, a person who is being provided with residential care through an aged care service conducted by an approved provider under the Act.
Respite care	Alternative care arrangements for dependent people living in the community, with the primary purpose of giving their carer a short term break from their usual caring commitments.
Special needs groups	Section 11-3 of the *Aged Care Act 1997* specifies the following people as people with special needs: people from Aboriginal and Torres Strait Islander communities; people from non-English speaking countries; people who live in rural or remote areas; people who are financially or socially disadvantaged; and veterans.
Veterans	Veterans and war widow(er)s who are entitled to treatment through the Department of Veterans' Affairs under the provisions of the *Veterans' Entitlements Act 1986*.

12.8 References

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—— 2000, *Estimated Residential Population, by Age and Sex* cat no. 3201.0, Canberra.

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13 Services for people with a disability

Commonwealth, State and Territory governments aim to maximise opportunities for people with a disability to participate actively in the community, by providing services and supports for people with a disability and their carers. The Commonwealth–State Disability Agreement (CSDA) provides a framework for the provision of specialist disability services to those with a disability who require ongoing or long term episodic support.

This chapter focuses on the performance of the Commonwealth, State and Territory governments in providing services and supports for people with a severe or profound disability aged less than 65 years under the CSDA. Services to people with severe psychiatric conditions are excluded from State government data. A definition of disability is provided in box 13.1.

Services to people with a disability can be grouped into income support, disability support services, and relevant generic services provided to the community as a whole as well as to people with a disability. The Review generally does not report information on income support. Disability support services are largely provided under programs such as Home and Community Care (HACC), rehabilitation and the CSDA.

The recipients of HACC services are people living in the community who are, in the absence of basic maintenance and support services, at risk of premature or inappropriate admission to long term residential care. Funding through HACC applies to both frail aged people (estimated at 69.8 per cent of HACC clients) and younger people with a disability (estimated at 30.2 per cent of HACC clients) (table 12A.30). Performance information on the HACC program is provided in the aged care services chapter (chapter 12). Performance information is not provided in the Report for rehabilitation services for people with a disability.

Some mainstream services provided to the community as a whole as well as to people with a disability (for example, vocational education and training, school education, public hospital care, mental health services and housing) are covered elsewhere in this Report (box 13.2). Other mainstream services provided to people with a disability — such as transport and utility services at concessional rates — are outside the scope of this Report.

Box 13.1 **Definition of disability**

Disability is conceptualised as being a multidimensional experience for the person involved, relating to body functions and structures, the activities people do, and the life areas in which they participate (WHO 2001). The International Classification of Functioning, Disability and Health also recognises the role of physical and social environmental factors in affecting disability.

The Australian Bureau of Statistics (ABS) Survey of Disability, Ageing and Carers was conducted in 1981, 1988, 1993 and 1998, and was based on the International Classification of Functioning, Disability and Health and its predecessor. The 1998 survey defined disability as any person with a limitation, restriction or impairment that has lasted, or is likely to last, for at least six months and restricts everyday activities.

Self care, mobility and communication are defined as core activities. The ABS defines levels of core activity restriction as follows:

- *mild* — where a person has no difficulty with self care, mobility or communication, but uses aids or equipment;
- *moderate* — where a person does not need assistance, but has difficulty with self care, mobility or communication;
- *severe* — where a person sometimes needs assistance with self care, mobility or communication; and
- *profound* — where a person is unable to perform self care, mobility and/or communication tasks, or always needs assistance.

Source: ABS (1999); World Health Organisation (2001).

Comparability is improved this year for accommodation activity/financial data (through revised definitions and counting rules) and expenditure data overall (due to accounting for differences in payroll tax). The scope of reporting this year has also increased.

Data from several jurisdictions' collections on quality assurance processes for providers of disability services, consistent with the existing indicators, are included for the first time in this Report. Data for geographic indicators of access to employment services are included for the first time in this Report. No new data for social participation were available from the ABS Survey of Disability Ageing and Carers. Alternate data for social participation are included from collections in several jurisdictions for the first time in this Report.

A profile of services for people with a disability to be provided under the CSDA appears in section 13.1. Policy developments in services for people with a disability are presented in section 13.2. Under the Review and the CSDA, all jurisdictions have developed and agreed to report against comparable performance indicators. A

framework of performance indicators is outlined in section 13.3. The performance of jurisdictions is discussed in section 13.4 and future directions for performance reporting are discussed in section 13.5. The chapter concludes with jurisdictions' comments in section 13.6 and definitions of the data descriptors and indicators in section 13.7.

Box 13.2 **Other disability reporting in the 2003 Report**

School education (chapter 3) reports data on students with a disability in the student body mix.

Vocational education and training (VET) (chapter 4) reports data on the pass rates and participation rates of people with a disability in VET courses.

Health preface reports information on Disability Adjusted Life Expectancy, Disability Adjusted Life Years and provides a broad definition of disability.

Health management issues (chapter 11) reports data on mental health, the prevalence of mental disorder and expenditure on services for people with mental disorders, including those with long term psychiatric disorders.

Community services preface reports data on recurrent expenditure on services for people with a disability.

Aged care services (chapter 12) reports data on the level of HACC services received by people with a profound, severe or moderate core activity restriction, disaggregated by jurisdiction and geographic location.

Children's services (chapter 14) reports data on the representation of children with a disability in Commonwealth approved child care.

Protection and support services (chapter 15) reports data on potential consumers who are not able to be supported because facilities to meet disability needs are not available.

Housing (chapter 16) reports data on access to public housing assistance (affordability with/without rent assistance including disability support pensioners in public housing) — special needs households as a proportion of all new households; the proportion of new tenancies allocated to households with special needs; households that pay less than market rent or that are special needs households paying market rent as a proportion of all households — where special needs groups include applicants with a disability in the household. Also reported are disability support pension recipients by the proportion of their income spent on rent with and without Commonwealth Rent Assistance.

Supporting tables

Supporting tables for chapter 13 are provided on the CD-ROM enclosed with the Report. The files are provided in Microsoft Excel 97 format as

\Publications\Reports\2003\Attach13A.xls and in Adobe PDF format as \Publications\Reports\2003\Attach13A.pdf.

Supporting tables are identified in references throughout this chapter by an 'A' suffix (for example, table 13A.3 is table 3 in the electronic files). 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 these tables (see details on the inside front cover of the Report).

Data on employment services in 2002 were not available in time for publication. These data will be available in Attach13A on the Review web page.

13.1 Profile of services for people with a disability

Service overview

Under the CSDA, governments fund both government and non-government providers of services for people with a disability. The funding and delivery of CSDA services differ across jurisdictions as a result of policy differences and a range of other factors described in appendix A.

In recent years, governments have increased funding for community-based services, partly as a substitute for government and non-government operated intensive, institutionalised care. To increase the overall level and range of services available for people staying in the community, programs have been developed that provide funding directly to consumers. These programs allow consumers to choose a customised package of services, which better reflects their needs (SCRCSSP 1998).

The National Disability Administrators commissioned the Australian Institute of Health and Welfare (AIHW) to conduct a study with two objectives, namely to:

- assess the effectiveness of the unmet need funding in reducing unmet need for disability services; and
- identify the remaining unmet need to obtain an understanding of current shortfalls in services (AIHW 2002d).

The report found that additional Commonwealth and State/Territory funding for unmet need in disability services totalling $519 million was effective in providing additional services. On a snapshot day in 2001 an additional 920 people were receiving accommodation support services, an additional 2350 were receiving

community support services and 2425 additional people were receiving community access services. The resulting estimates of remaining unmet need in 2001 are:

- 12 500 people needing accommodation and respite services;
- 8200 places needed for community access services; and
- 5400 people needing employment support.

These estimates are made on a conservative basis. Community support services are not included in the estimates (AIHW 2002d).

Roles and responsibilities

The CSDA defines the roles and responsibilities of the Commonwealth, State and Territory governments in the provision of certain services to people with a disability. Its broad aims are to:

- establish a national framework to underpin the provision of specialist disability services across Australia;
- outline the respective and collective roles of specialist disability services, along with their funding, policy setting, planning and management; and
- provide for the Commonwealth, States and Territories to contribute funds under the agreement, and identify factors affecting the need for funds now and in future years (CSDA 1998).

A number of services are provided under the CSDA (box 13.3).

Family and friends meet most needs of people with a disability. In 1998, 450 900 primary carers provided the majority of help with self care, mobility and verbal communication for persons with a disability (ABS 1999). Recognising the cost of providing such informal support, the Commonwealth Government provides income support in the form of the Carer Payment and other financial assistance through the Carer Allowance to families and carers of people with a disability. This financial assistance is not included under the CSDA funding arrangements (box 13.4).

Box 13.3 Services provided under the Commonwealth–State Disability Agreement

The second CSDA was signed in 1998 by Commonwealth, State and Territory governments and covers the provision of specialist disability services by those jurisdictions for the five-year period ending 30 June 2002. The CSDA was due to expire on 30 June 2002 and has been extended until the Commonwealth–State–Territory Disability Agreement (CSTDA), which is under negotiation, is finalised. Specialist disability services are defined under the agreement as services that are specially designed from time to time to meet the needs of people with a disability.

The Commonwealth Government administers the following services:

- Open employment services provide employment assistance to people with a disability in obtaining and/or retaining paid employment in the open market.
- Supported employment services support or employ people with a disability within the same organisation.
- Open and supported employment services provide both open and supported employment assistance.

The State and Territory governments administer the following services:

- Accommodation support services provide people with a disability with accommodation (group homes, hostels and institutions) and support to maintain accommodation (attendant care and in-home support).
- Community access services help people with a disability to develop or maintain the personal skills and self confidence necessary to enhance their independence and self reliance in the community. It includes learning and life skills development and recreation/holiday program.
- Respite care services relieve or support (for limited periods) people with a disability living in the community and their families and carers.
- Community support helps people with a disability to integrate and participate in the community. It includes case management, counselling, early intervention therapy and other therapy services.
- Advocacy, information and print disability services (in part), which enable people with a disability to increase their control over their lives by representing their interests and views in the community. State/Territory only responsibility includes mutual support/self help groups.

(Continued on next page)

Box 13.3 **(Continued)**

Services for which administration is shared are:

- Advocacy, information and print disability services (in part), which enable people with a disability to increase their control over their lives by representing their interests and views in the community. Shared Commonwealth–State/Territory responsibility includes advocacy, information/referral, combined information/advocacy, and print disability/alternative formats of communication services.
- Research and development.

The CSDA does not apply to the provision of:

- disability services and activities provided under the *Veteran's Entitlements Act 1986* (Commonwealth); or
- services with a specialist clinical focus, regardless of whether those services are provided to people eligible to receive other services under the CSDA.

Source: CSDA (1998).

Box 13.4 **Commonwealth supplementary and income support arrangements**

The Commonwealth Government funds payments for people with a disability, those caring for people with a disability and those temporarily incapacitated from work as a result of illness. These income support arrangements do not constitute a CSDA service. These payments include the Disability Support Pension, the Carer Payment, the Carer Allowance, the Sickness Allowance and the Mobility Allowance. Commonwealth outlays on payments to people with a disability in 2001-02 (on an accrual basis) amounted to $6.4 billion for the Disability Support Pension, $595.8 million for the Carer Payment, $645.7 million for the Carer Allowance, $93.7 million for the Sickness Allowance and $67.8 million for the Mobility Allowance (DFaCS unpublished).

At 30 June 2002 there were 658 900 recipients of the Disability Support Pension, 67 300 recipients of the Carer Payment, 283 800 recipients of the Carer Allowance, and 41 500 recipients of the Mobility Allowance (table 13A.29). There were also 9500 recipients of the Sickness Allowance (DFaCS unpublished).

Source: DFaCS (unpublished); table 13A.29.

Accommodation, respite, and community access and support services provided under the CSDA on the snapshot day in 2002 were used by 47 915 consumers (table 13A.3). There were 17 730 consumers of employment services provided under the CSDA on the snapshot day in 2001 (table 13A.3). Data for

Commonwealth employment services in 2002 were not available in time for publication. These data will be available on the Review web page.

The proportion of consumers serviced by non-government organisations on the snapshot day in 2002 varied across jurisdictions ranging from 81.8 per cent in Victoria to 55.1 per cent in SA, with the national average at 71.8 per cent (table 13A.3). More information on users of CSDA services can be found in the attachment (table 13A.3).

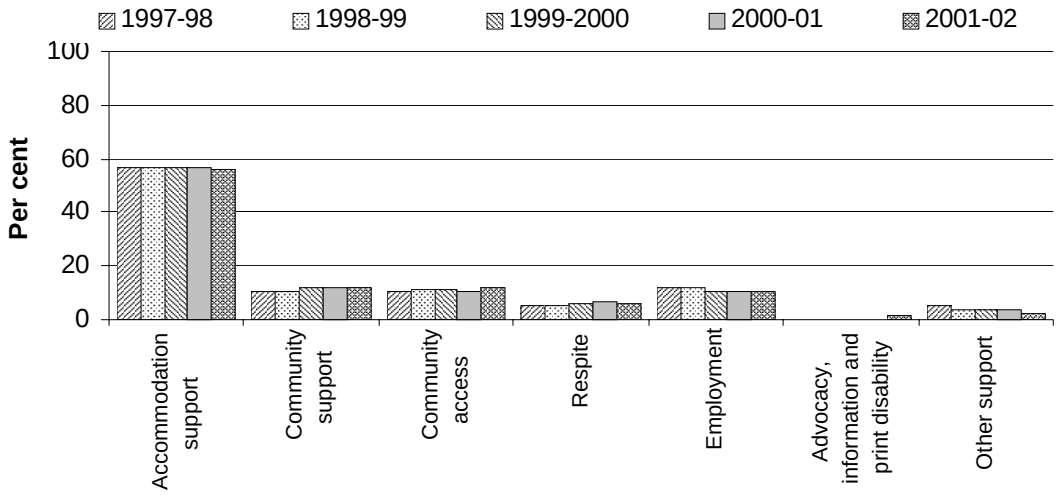
Funding

Governments fund both government and non-government service providers of services for people with a disability under the CSDA and HACC programs, and through the provision of rehabilitation services. Total government expenditure on CSDA services was $2.7 billion in 2001-02 — a real increase of 7.9 per cent from the level of expenditure in 2000-01 (table 13A.21).

State and Territory government expenditure accounted for the majority (70.3 per cent, or $1.9 billion) of total CSDA expenditure in 2001-02. The Commonwealth Government funded the remainder (29.7 per cent, or $816.2 million), which included $503.1 million in transfer payments to States and Territories (table 13A.21). The State and Territory governments spent $1.4 billion on accommodation support, $299.1 million on community support and $218.6 million on other services for people with a disability. The Commonwealth spent $313.1 million on employment assistance and other services, including $261.2 million on employment services for people with a disability (table 13A.21).

The distribution of expenditure across CSDA services varied across jurisdictions. The main areas of State and Territory government expenditure in 2001-02 were accommodation support services (55.9 per cent of total direct service delivery expenditure) and community support (11.8 per cent). Employment services was the main area of Commonwealth Government expenditure in 2001-02 (10.3 per cent) (figure 13.1). Non-government service providers receive funds from the private sector and the general public, in addition to government grants and input tax concessions from governments (such as payroll tax exemptions).

Figure 13.1 **Distribution of expenditure, by disability service type[a]**



a See table 13A.21 for detailed notes accompanying expenditure data.

Source: Commonwealth, State and Territory governments (unpublished); table 13A.21.

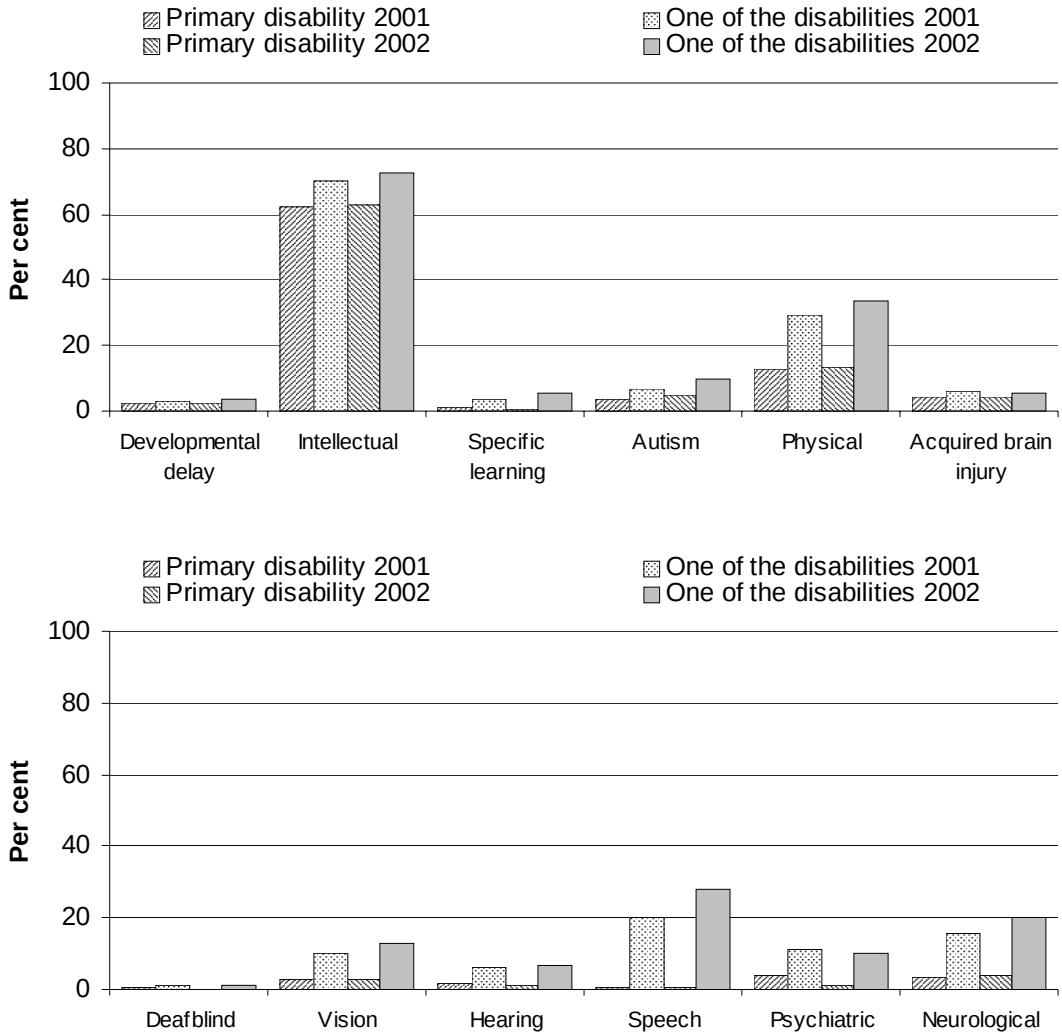
Size and scope

The performance indicators in this chapter mainly focus on accommodation support and employment services (which accounted for 60.9 per cent of total government expenditure on services provided under the CSDA in 2001-02). There is also some reporting on community access and other services (table 13A.21).

The ABS conducts a Survey of Disability, Ageing and Carers once every six years. The last survey was conducted in 1998. People with a core activity, schooling or employment restriction accounted for 13.4 per cent of the total Australian population aged 5–64 years in 1998 (ABS 1999). Detailed survey results provide contextual information about disability-related matters (table 13A.1).

Intellectual disability was identified as the primary disability for 63.1 per cent of all people with a disability who received services on the snapshot day in 2002 (figure 13.2).

Figure 13.2 **Consumers' nominated disability type(s), State and Territory governments, by disability group[a, b, c]**



a Consumer data are estimates after use of a statistical linkage key to account for individuals who have received more than one service on the snapshot day. Where primary disability group was inconsistently recorded for the same consumer, the person was allocated a primary disability group according to a standard method (see AIHW 2002a). Row totals may not be the sum of the components since individuals may access services from more than one jurisdiction on the snapshot day. **b** Data for consumers of CSDA services funded by the States and Territories exclude psychiatric services specifically identified by the jurisdiction. **c** Excludes Commonwealth employment data so the number of consumers used in the calculation of data is lower than in the 2001 and previous reports, where Commonwealth employment data were included.

Source: AIHW (2001a, 2002a); tables 13A.4 and 13A.5.

13.2 Policy developments in services for people with a disability

New policy priorities will continue the work on the policy areas outlined in the 2002 Report. These policy areas were community inclusion, demand management, individualised approaches, transitions, early intervention and prevention, and better assessment.

The following five policy priorities complement the key directions for the management, planning and delivery of specialist disability services for people with a disability, their families and carers. These policy priorities have been endorsed by disability services Ministers as part of the negotiation process for the CSTDA. Until the CSTDA is finalised, the CSDA (which was due to expire as at 30 June 2002) funding arrangements will continue to operate. Once the CSTDA is finalised, all jurisdictions will work collaboratively and independently to progressively implement the policy priorities over the life of the CSTDA, and will regularly report progress against achievements.

The five policy priorities under the CSTDA are described below.

- *Strengthening access to generic services* enables people with a disability to participate further in their community — both economically and socially — and recognises that generic services complement specialist disability services. Initiatives to strengthen access to generic services include promoting the responsiveness and accessibility of general community services and facilities through legislation, partnerships, education and awareness, and access and inclusion initiatives. Initiatives also include promoting the planning and implementation of action plans or similar mechanisms across government agencies and between government programs, and promoting a better understanding of the *Disability Discrimination Act 1992* and other relevant legislative requirements relating to people with a disability.

- *Strengthening across-government linkages* involves influencing the service system to enable people with a disability to have appropriate access to a range of services. It also involves improving collaboration and coordination between, and transition across, programs and Governments to ensure that people with a disability have opportunities to access and move to services at all stages of their lives.

- *Strengthening individuals, families and carers* enhances their wellbeing, contribution, capacity and inclusion. Initiatives to strengthen individuals, families, and carers involve developing supports and services based on individual needs and outcomes, and increasing the opportunity of people with a

disability, their families and carers to influence the development and implementation of supports and services at all levels.

- *Responding to, and managing demand for, specialist disability services* means that as the demand for specialist disability services continues to grow, all jurisdictions need to improve long term strategies to respond to and manage this increasing demand. This involves developing approaches that enhance prevention and early intervention outcomes, effective coordination across service systems, and clear and transparent decision making.

- *Improving accountability, performance reporting and quality*, as well as the transparency of specialist disability services, involves ensuring that performance information is provided within a nationally consistent, output/outcome based framework. This includes implementing consistent data collection items and coherent data systems linked to a national performance reporting framework.

13.3 Framework of performance indicators

The framework of performance indicators is based on shared government objectives of services for people with a disability (box 13.5). The framework provides information on the efficiency and effectiveness of government services for people with a disability.

Proxy efficiency indicators focus on unit cost and administrative costs. Effectiveness indicators focus on outcomes, service quality and access to services (figure 13.3).

Box 13.5 **Objectives of government services for people with a disability**

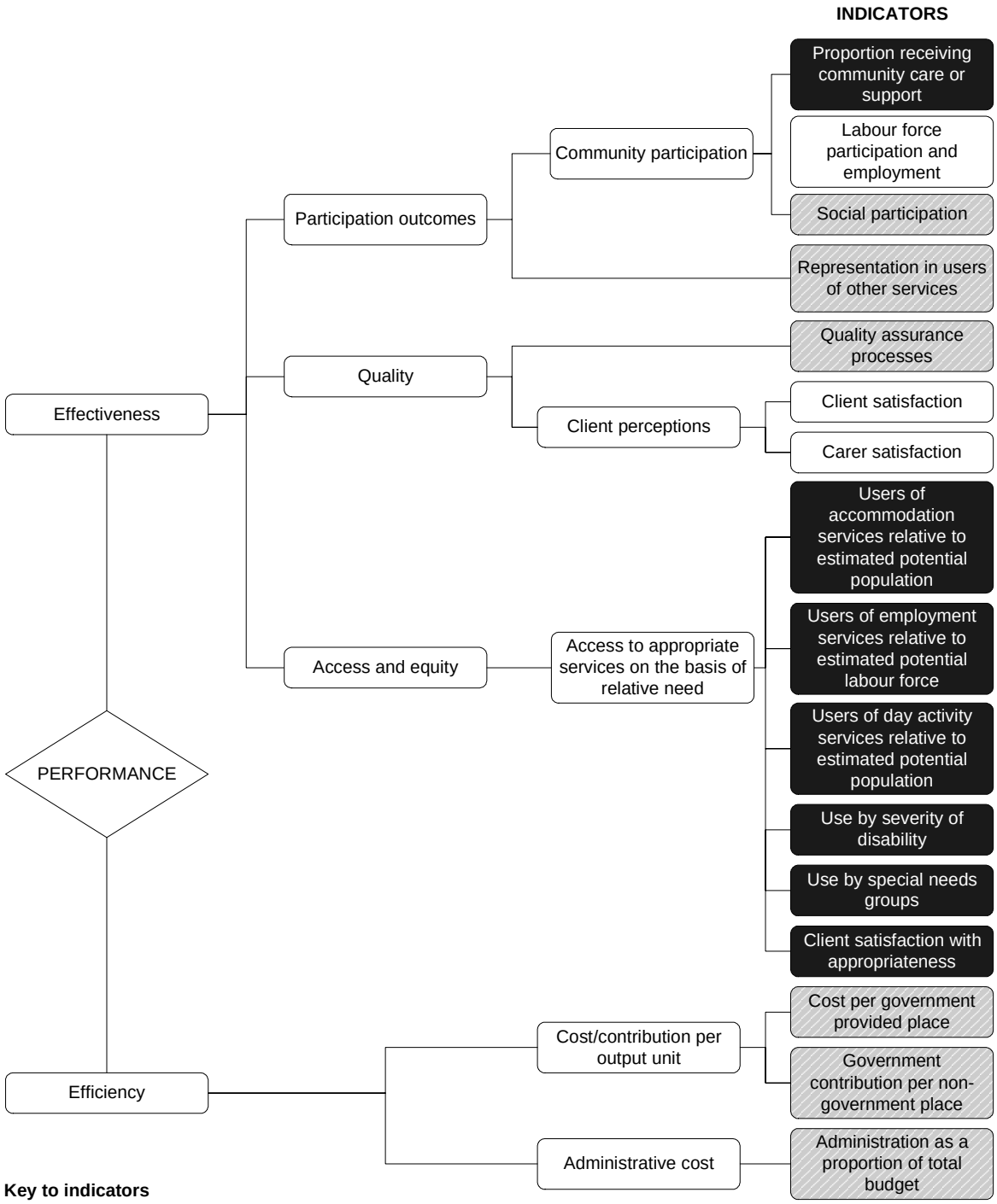
Under the second CSDA, governments strive to enhance the quality of life experienced by people with a disability by assisting them to live as valued and participating members of the community. In working towards the above objectives, governments aim to:

- provide access to specialist government funded or provided disability services on the basis of relative need and available resources;
- promote access to general community services and facilities;
- fund or provide quality services in an efficient and effective way, and be accountable to those using the services;
- ensure consumers and carers are consulted about the types and mix of services made available to meet their individual needs and goals; and
- promote the rights of people with a disability as members of the community and empower them to exercise these rights.

Source: CSDA (1998).

The performance indicator framework shows which data are comparable in the 2003 Report (figure 13.3). For data that are not considered strictly comparable, the text includes relevant caveats and supporting commentary. Chapter 1 discusses data comparability from a Report-wide perspective (see section 1.6).

Figure 13.3 **Performance indicators for disability services**



13.4 Key performance indicator results

Different delivery contexts, locations and client characteristics may affect the effectiveness and efficiency of disability services. Appendix A contains data that may assist in interpreting the performance indicators presented in this chapter.

The main sources of performance data for 2002 indicators were the CSDA Minimum Data Set (MDS) snapshot day collection and the Commonwealth, State and Territory governments. The performance indicator results reported in this chapter relate to CSDA services only. The CSDA MDS collection commenced in 1995 and has been conducted each year until 2002. Data for 2002 have been collected using the 2002 CSDA MDS revised service type definitions, which are a refinement on the 2001 CSDA MDS items, in preparation for the CSTDA National Minimum Data Set (NMDS) (box 13.6). The main changes to the 2002 definitions have improved the comparability of data collected across jurisdictions, and include:

- the further disaggregation of accommodation support categories, which allows hostels and institutional/small residential accommodation to be reported separately;
- the addition of a category for advocacy, information and print disability; and
- the reduction of several items that were previously part of community support.

These changes mean that data for previous years collected under the CSDA MDS are not fully comparable to the 2002 data collected under the CSDA MDS. Further, refinements to the agreed definitions for the chapter for this year have an impact on data comparability over time. Cost per accommodation place data, for example, were provided for six categories this year, representing a disaggregation from the four categories reported in previous years. To assist comparability to preceding years data, these data have also been presented in aggregate. National data were collected on all services received by CSDA consumers on a snapshot day, which was in May/June in 2002. A single consumer may receive more than one service on the snapshot day, so the number of consumers on the snapshot day is less than the number of services received on the day.

Box 13.6 **CSTDA NMDS development**

The second CSDA reflected significant changes in the nature of services and delivery methods, information needs and capabilities, suggesting a need for redeveloping the CSDA MDS collection. Accordingly, the National Disability Administrators and the AIHW have developed the CSTDA NMDS collection.

It is anticipated that the CSTDA NMDS, in specifying revised core data items for ongoing collection by all service providers funded under the CSTDA, will:

- better meet critical data needs across the disability field, and be consistent with other major data developments such as the HACC MDS;
- integrate data collation with the operations of agencies and funding departments; and
- use statistical linkage keys to enable data from various sources to be related and collated without duplication of effort.

Consistent with the CSDA MDS, the CSTDA NMDS has an agreed set of nationally significant data items, and an agreed framework for collection and national collation. Data items relate to the accessibility, appropriateness, efficiency and effectiveness of services, with data to be collected on an ongoing basis from 2002-03, replacing the current snapshot day census collection.

Due to a revised commencement date for the CSTDA NMDS, a snapshot day census was again conducted in May/June in 2002. The CSTDA NMDS ongoing collection was operational for the Commonwealth and WA from June 2002 and was nationally operational as of 1 October 2002 (revised from July 2002), replacing the snapshot day census collection for all other jurisdictions.

Source: AIHW (2001b, 2001c, 2001d, 2001e, 2002a, 2002b, 2002c).

Data sourced from the CSDA MDS on the number of consumers or places provided in each jurisdiction may differ from information reported elsewhere (such as in departmental annual reports) because the CSDA MDS collection for 2002 relates to services delivered on a single snapshot day. Expenditure data sourced from jurisdictions' collections may also differ from information reported elsewhere because, for example, expenditure on psychiatric services is excluded here. The number of consumers receiving accommodation services on the snapshot day for 1999–2002 has been estimated from the number of occasions on which a service was received, using a statistical linkage key to remove double counting. This is possible because the statistical linkage key enables, with a small degree of error, the identification of multiple data records belonging to the same individual, but without identifying the individual.

The number of consumers on the snapshot day will be less than the number for the whole year because some consumers will not receive services on that day. The

difference between the two will be greater for employment services and community access services than for accommodation services, given differences in the nature of these services.

Effectiveness

Participation outcomes

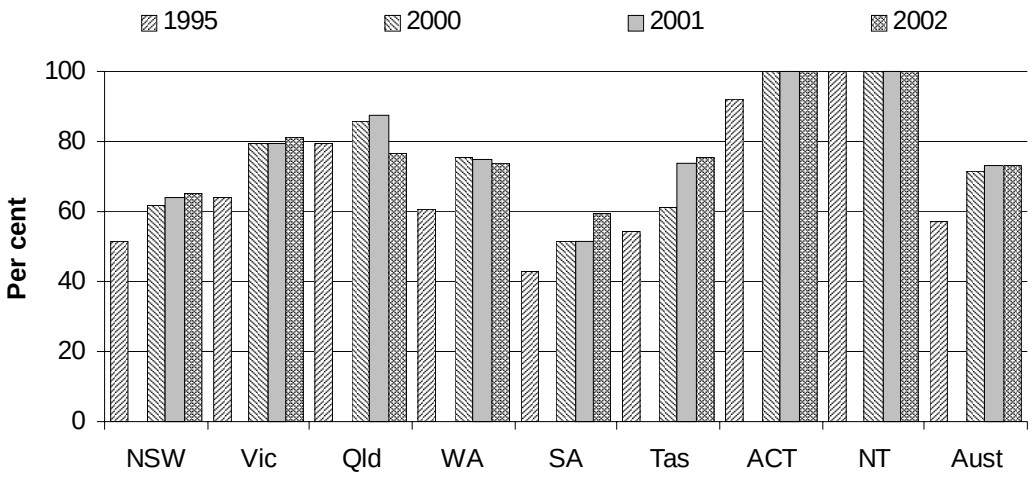
Four indicators of participation are outlined in the framework: the proportion of accommodation consumers receiving community-based accommodation support or care; labour force participation and the employment status of people with a disability; the level of social participation of people with a disability; and the representation of users of disability services in other services.

Proportion of accommodation consumers receiving community-based care or support

State and Territory governments have generally sought to increase the provision of accommodation support services outside institutional settings for people with a disability. This process is aimed at meeting the government objective of assisting people with a disability to live as both valued and participating members of the community. Community-based accommodation support and care are considered to provide better opportunities for people with a disability.

Nationally, 72.9 per cent of accommodation consumers had community-based accommodation or 'in-home' support on the snapshot day in 2002, rising from 66.0 per cent in 1998 (table 13A.6). The ACT and the NT had the highest proportion of accommodation consumers receiving community-based care or support (both 100 per cent) on the snapshot day in 2002 and SA had the lowest (59.5 per cent) (figure 13.4). The upward trend in consumers of CSDA community-based or 'in-home' accommodation support services reflects de-institutionalisation nationally over the period 1995 (57.4 per cent) to 2002 (72.9 per cent) (figure 13.4).

Figure 13.4 **Consumers of community-based or 'in-home' accommodation support services as a proportion of all accommodation consumers[a, b, c, d]**



a Consumer data are estimates after use of a statistical linkage key to account for individuals who have received more than one service on the snapshot day. Where the accommodation service type was inconsistently recorded for the same consumer, the consumer was counted as receiving an 'institutional/residential or hostel' accommodation support service. Totals may not be the sum of the components because individuals may access services from more than one jurisdiction on the snapshot day. **b** Community-based or 'in-home' accommodation support services include group homes, attendant care, outreach/other 'in-home'/drop-in support, alternative family placement and other accommodation support for data prior to 2002. Community-based or 'in-home' accommodation support services include group homes, attendant care/personal care, 'in-home' accommodation support, alternative family placement and other accommodation support for 2002 data. **c** Data for consumers of CSDA funded accommodation support services exclude psychiatric services specifically identified by the jurisdiction. **d** Data for 1995 were based on services received (recipients, not consumers). The 2000–02 data are consumer data.

Source: AIHW (2000, 2001a, 2002a); Madden et al. (1997); table 13A.6.

Labour force participation of people with a disability

The ABS 1998 Survey of Disability, Ageing and Carers provides data for labour force participation and employment rates for people aged 15–64 years with a profound or severe core activity restriction. The participation rate for people with a profound or severe core activity restriction in 1998 was 34.7 per cent, which equates to 28.6 percentage points below the participation rate for the general population in all jurisdictions (63.3 per cent). The employment rate for people with a profound or severe core activity restriction was 89.0 per cent — 3.1 percentage points below the rate for the general population (92.1 per cent) (table 13A.7).

Social participation of people with a disability

A primary objective of government services for people with a disability is to enhance consumers' quality of life. Governments seek to advance the rights and wellbeing of people with a disability by helping them to live as valued and participating members of the community.

It was agreed in the recent CSTDA NMDS development process that social participation data would not be collected as part of the NMDS. Nevertheless, Victoria and WA have independently developed indicators and data on social participation for people with a disability, and these are reported for the first time in this Report.

Data reported are from different collection instruments in Victoria and WA. In Victoria, annual data have been collected by adding questions onto the CSDA MDS census instrument in 2001. Victoria expects to collect social participation data on an ongoing basis from 2003. In WA, a consumer satisfaction survey was applied in 2002 for the collection of social participation data for the second time and the data are expected to be collected on a regular, but less than annual, basis. Notwithstanding these differences, there is some synergy between the Victorian data items 'maintaining relationships with family', 'maintaining social relationships' and 'participation and recreation' and the WA data items 'social relationships' and 'recreation/entertainment' (box 13.7).

Representation of users in other services

Indicators for participation in other services by people with a disability are included in the performance indicator frameworks for those service areas. Participation is reported for vocational education and training (chapter 4), children's services (chapter 14) and housing (attachment 16A).

Quality

The 2000 Report provided survey data on the quality of services provided to people with a disability (SCRCSSP 2000). These data have not been updated.

Box 13.7 **Social participation of people with a disability**

Victoria

In May 2001, Victoria collected census data through the CSDA MDS on the Disability Services Program Day Program and Shared Accommodation Clients' ability to participate fully, partially or not at all. Reported results of consumer perceptions are:

- for all people with a disability, 37 per cent of consumers were able to fully participate in maintaining relationships with family, 43 per cent reported that they partially participated, 12 per cent reported that they did not participate at all, and 8 per cent were reported as unknown;
- for all people with a disability, 20 per cent of consumers were able to fully participate in maintaining social relationships, 54 per cent reported that they partially participated, 19 per cent reported that they did not participate at all, and 7 per cent were reported as unknown; and
- for all people with a disability, 25 per cent of consumers were able to fully participate in recreation or leisure activities, 63 per cent reported that they partially participated, 10 per cent reported that they did not participate at all, and 3 per cent were reported as unknown.

Data were disaggregated by severity of disability. Between 11 and 41 per cent of those in the profound and severe disability severity groups reported that they participate fully for all three of the above indicators.

WA

In 2002, 450 randomly selected disability services consumers were surveyed on a variety of social participation items. Reported results of consumer perceptions indicate:

- for all people with a disability, 37 per cent of consumers reported that they had friend(s) that they could talk or do things with, besides staff or family members;
- for all people with a disability 41 per cent reported that they had a friend(s) that they could talk or do things with who is staff and 54 per cent reported that they had a friend(s) that they could talk or do things with who is family;
- for all people with a disability, 51 per cent of consumers reported that they were able to participate in entertainment activities (for example, movies and concerts) as often as he/she would like to; and
- for all people with a disability, 48 per cent of consumers reported that they were able to participate in exercise or play sports (for example, walking, swimming cycling) as often as he/she would like to.

Source: Department of Human Services (2002); WA Government (unpublished).

Quality assurance processes

Quality assurance monitoring of service providers data for 2002 are reported for the first time for the Commonwealth, WA and Tasmania (box 13.8). Data reported are from newly implemented collections and relate to a sample of service providers from all disability service types provided under the CSDA. It is anticipated that those jurisdictions implementing quality assurance monitoring will review all service providers in a rolling process over several years.

Box 13.8 **Quality assurance for disability services**

The quality assurance data reported below relate to CSDA funded services. Data are from jurisdictions' collections as at 27 September 2002.

Commonwealth

The proportion of assessed disability employment support service organisations that have been certified against all standards and key performance indicators by independent accredited certification bodies is 3 per cent (13 of 414) of all organisations and 100 per cent (13 of 13) of assessed organisations. All 414 disability employment service organisations have registered their intention to be certified by December 2004 against the revised Disability Service Standards and new Key Performance Indicators which were implemented on 1 July 2002. Only certified organisations will receive Commonwealth funding from 2005.

WA and Tasmania

Different quality assurance monitoring systems are in place in WA and Tasmania, but these jurisdictions collect data on similar indicators. Disability services providers refer to providers of accommodation support; community support; community access; respite services; advocacy, information and print disability; and other support services. For Tasmania, the following relates to non-government disability service outlets only.

The number of total disability service outlets independently monitored (comprehensive and abridged) for WA or self assessed (or another form of assessment) for Tasmania against the service standards as a proportion of total disability service outlets is 20 per cent in WA and 61 per cent in Tasmania. In WA, 135 of 688 total service outlets have been assessed. In Tasmania, 97 of 159 total service outlets have been assessed.

The number of disability service outlets that are quality assured against all assessed service standards as a proportion of total number of assessed disability service outlets is 83 per cent in WA and 100 per cent in Tasmania. In WA, 112 service outlets of the 135 that have been assessed, have been quality assured against all assessed service standards. In Tasmania, all 97 service outlets of the 97 that have been assessed, have been quality assured (through self assessment) against all assessed service standards.

Source: Commonwealth, WA and Tasmanian governments (unpublished).

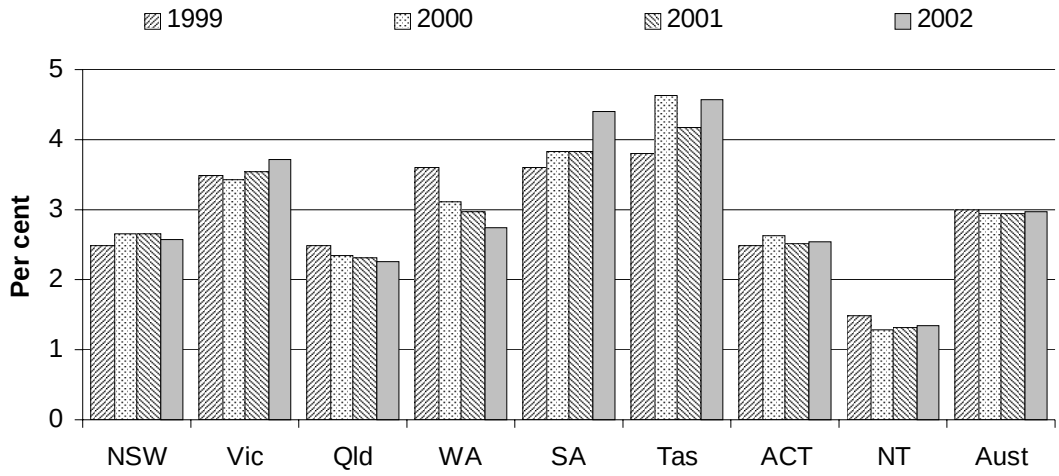
Access to services

Access data are reported for accommodation support, employment services and community support day activities. One indicator of access is the proportion of the potential population using the service. The potential populations for accommodation and employment services are defined in table 13.2. Data are also reported on access to employment and accommodation services by severity of disability.

Accommodation support

Nationally, 3.0 per cent of the estimated potential population were using accommodation support services on the snapshot day in 2002. Across jurisdictions, this proportion was highest in Tasmania (4.6 per cent) and lowest in the NT (1.3 per cent) (figure 13.5).

Figure 13.5 **Consumers of accommodation support services as a proportion of the total potential population for accommodation support services[a, b, c, d, e]**



a Consumer data are estimates after use of a statistical linkage key to account for individuals who have received more than one service on the snapshot day. Totals may not be the sum of the components because individuals may access services from more than one jurisdiction on the snapshot day. Totals may not be the sum of the components because individuals might have accessed services from more than one jurisdiction on the snapshot day. **b** Data are estimates. Population estimates of 9000 or less have a relative standard error of 25 per cent or more. **c** The potential population for accommodation services is the number of people aged less than 65 years, with profound and/or severe core activity restriction, adjusted for the Indigenous factor for that jurisdiction. **d** Data for 2000 are revised and therefore differ from those in previous reports. **e** WA consumer data for 1999 to 2001 are inflated by between 123 and 466 consumers due to incorrect coding by two providers over this time period. This error has been corrected for 2002 data.

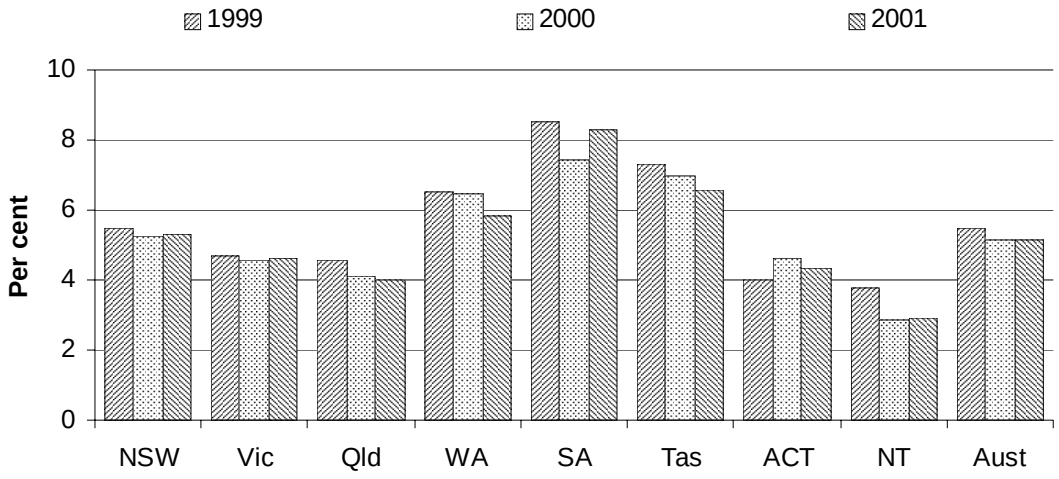
Source: AIHW (1999, 2000, 2001a, 2002a); table 13A.8.

Employment services

The Commonwealth has responsibility for employment services under the CSDA and purchases most services from non-government providers. Data for employment services for 2002 were not available in time for publication. This information can be found, however, on the Review web page (see supporting tables section, p. 13.3).

Nationally, 5.1 per cent of consumers of the estimated potential population were using employment services on the snapshot day in 2001. Across jurisdictions, the proportion was highest in SA (8.3 per cent) and lowest in the NT (2.9 per cent) (figure 13.6).

Figure 13.6 **Consumers of employment services as a proportion of the total potential population for employment services[a, b, c]**



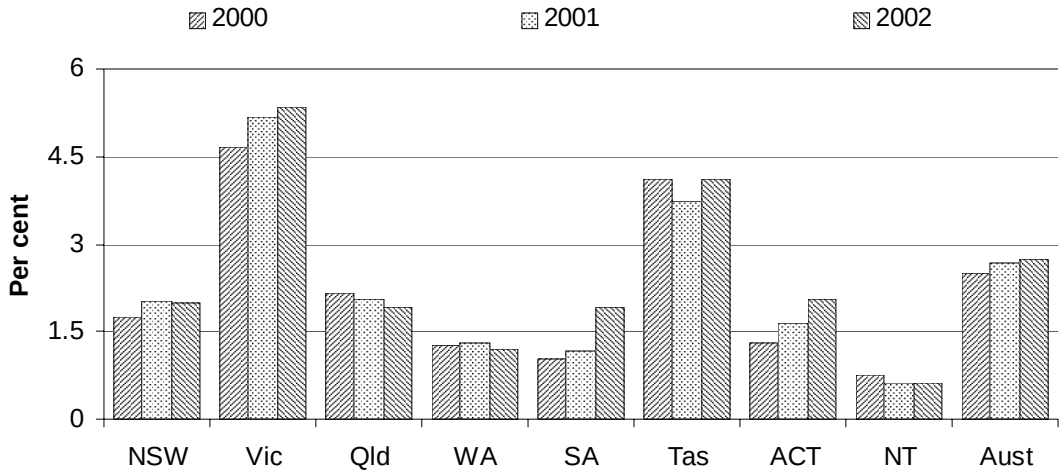
a Consumer data are estimates after use of a statistical linkage key to account for individuals who have received more than one service on the snapshot day. The population data are estimates. **b** The potential population for employment services is the number of people aged 15–64 years with a severe or profound core activity restriction, multiplied by both the Indigenous factor and the labour force participation rate for that jurisdiction. Due to this adjustment the sum of the potential populations of the jurisdictions is not necessarily equal to the national total. **c** Data for 2000 are revised and therefore differ from those in previous reports.

Source: AIHW (1999, 2000, 2001a); table 13A.9.

Use of day activity services

Nationally, 2.7 per cent of consumers of the potential labour force received a day activity service on the snapshot day in 2002. Across jurisdictions, Victoria had the highest proportion of consumers (5.4 per cent) and the NT had the lowest (0.6 per cent) (figure 13.7).

Figure 13.7 **Consumers of day activity services as a proportion of the total potential population for day activity services[a, b, c, d, e, f]**



a Data are estimates. Population estimates of 9000 or less have a relative standard error of 25 per cent or more. **b** The potential population for day activity services is the number of people aged 15–64 years, with a severe or profound core activity restriction, multiplied by the Indigenous factor for that jurisdiction. **c** Consumer data are estimates after use of a statistical linkage key to account for individuals who have received more than one service on the snapshot day. Totals may not be the sum of the components because individuals may access services from more than one jurisdiction on the snapshot day. **d** Day activity services in 2001 include consumers using community access service types 'continuing education/independent living training/adult training centre', 'post-school options/social and community support/community access' and 'other community access and day programs'. Day activity services in 2002 include consumers using community access service types 'learning and life skills development' and 'other community access', but not 'recreation/holiday programs'. **e** Data for consumers of CSDA funded day activity services exclude psychiatric services specifically identified by the jurisdiction. **f** Data may have different inclusions for different jurisdictions which may explain the variability across jurisdictions. Data are, therefore, not strictly comparable.

Source: AIHW (2000, 2001a, 2002a); table 13A.10.

Service use by disability status

Services provided under the CSDA are allocated to consumers on the basis of relative need. This depends on the level of support need (including status of disability) and access to other formal and informal help. An indicator of access to services is the level of service use by severity of disability. Consumers of accommodation support services, by severity of core activity restriction data for 2002, are not strictly comparable to data for previous years, because of refinements to questions on self-care, mobility and communication. These changes were made to achieve greater consistency with the ABS data collection items.

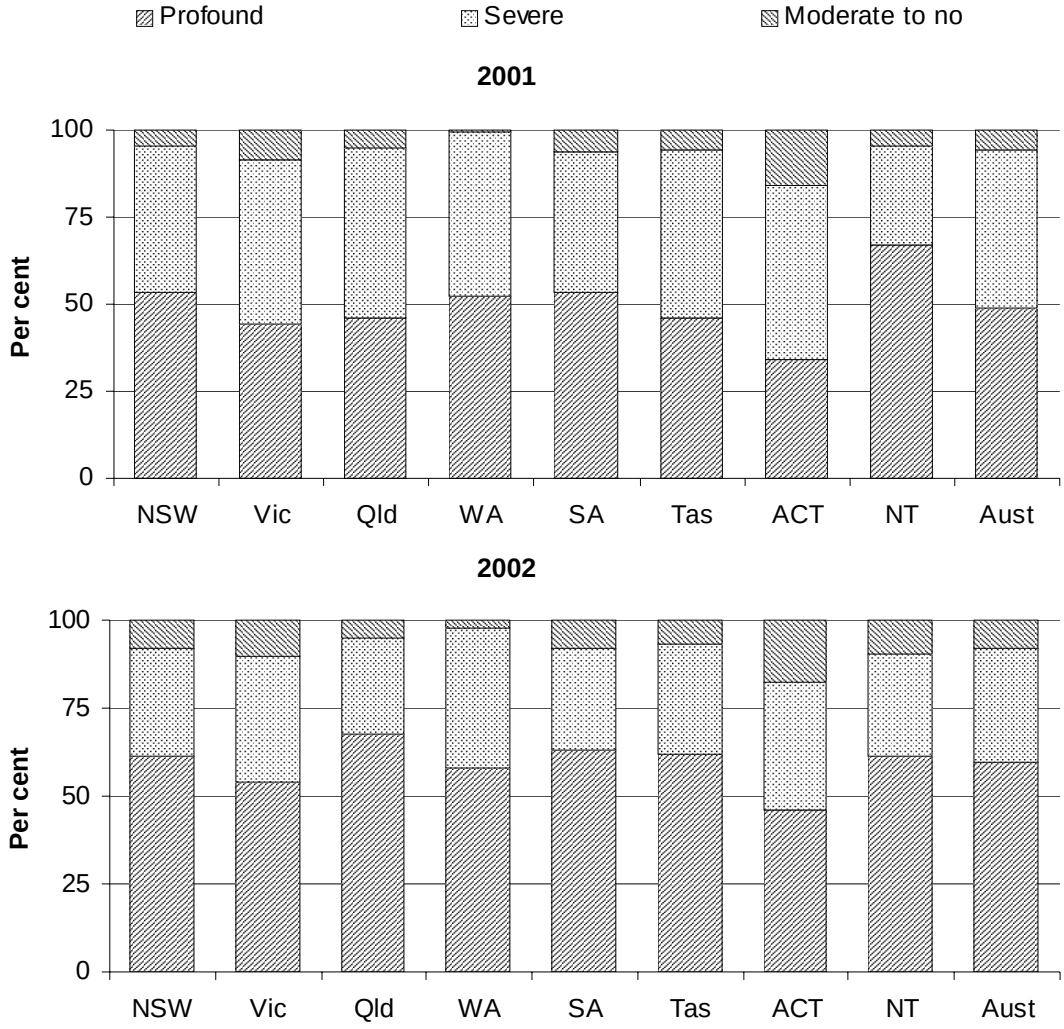
Nationally, 7.7 per cent of consumers of accommodation services had a moderate to no core activity restriction on the snapshot day in 2002, 32.6 per cent had a severe core activity restriction and 59.7 per cent had a profound core activity restriction. Across jurisdictions, the ACT had the highest proportion of consumers with a

moderate to no core activity restriction (17.5 per cent) and WA had the lowest (2.2 per cent). The highest proportion of consumers with a severe core activity restriction was in WA (39.6 per cent) and the lowest was in Queensland (27.5 per cent). The highest proportion of consumers with a profound core activity restriction (that is, people who always require help or supervision) was in Queensland (67.4 per cent) and the lowest was in the ACT (46.1 per cent) (figure 13.8).

Information on the use of employment services by severity of disability for 2002 were not available in time for publication. This information can be found on the Review web page (see supporting tables section p. 13.3).

Nationally, 21.8 per cent of consumers of employment services had a moderate to no core activity restriction on the snapshot day in 2001, 65.1 per cent had a severe core activity restriction and 13.1 per cent had a profound core activity restriction. Across jurisdictions, Queensland had the highest proportion of consumers with a moderate to no core activity restriction (25.0 per cent) and the NT had the lowest (16.5 per cent). The highest proportion of consumers with a severe core activity restriction was in the ACT (67.9 per cent) and the lowest was in Tasmania (61.5 per cent). The highest proportion of consumers with a profound core activity restriction was in the NT (19.4 per cent) and the lowest was in Queensland (8.3 per cent) (figure 13.9).

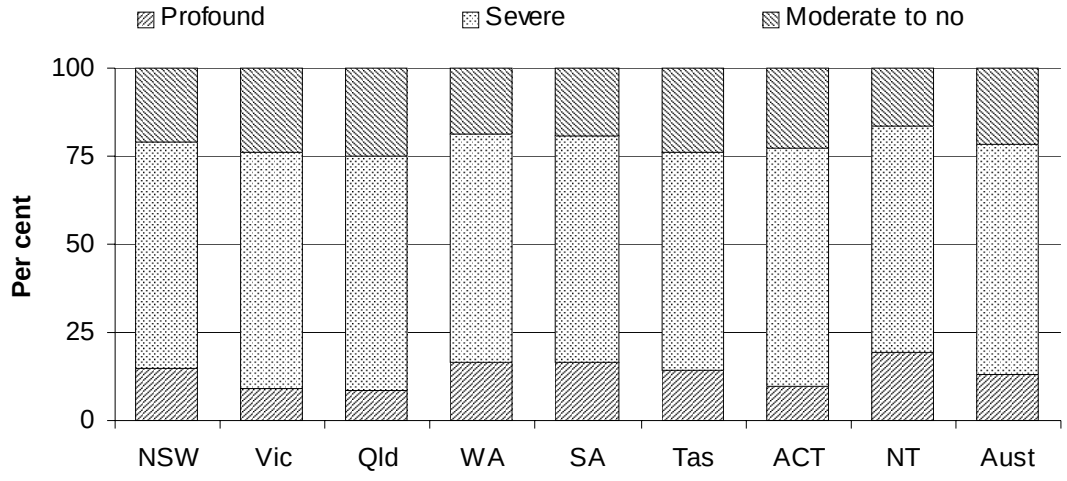
Figure 13.8 **Consumers of accommodation support services, by severity of core activity restriction[a, b, c, d]**



a Severity of core activity restriction is derived using data on level of support needed in one or more of the support areas: self care, mobility and communication. Consumers with profound core activity restriction reported always needing support in one or more of these areas. Consumers with severe core activity restriction reported sometimes needing support in one or more of these areas. Consumers with moderate or no core activity restriction reported needing no support in all of these areas. **b** Consumer data are estimates after use of a statistical linkage key to account for individuals who received more than one service on the snapshot day. Where the level of support need was inconsistently recorded for the same consumer, the person was allocated a level of support according to a standard method. Row totals may not be the sum of the components because individuals may access services from more than one jurisdiction on the snapshot day. **c** Data exclude 293 consumers in 2001 and 246 consumers in 2002 who did not report on a need for support with self care, mobility or communication. Consumer totals do not, therefore, necessarily match those in table 13A.3. **d** Data for consumers of CSDA funded accommodation support services exclude psychiatric services specifically identified by the jurisdiction.

Source: AIHW (2001a, 2002a); table 13A.11.

Figure 13.9 **Consumers of employment services, by severity of core activity restriction, 2001[a, b, c, d]**



a Consumer data are estimates after use of a statistical linkage key to account for individuals who received more than one service on the snapshot day. **b** Data exclude 342 consumers who did not report a need for support with one or more of these areas: self care, mobility or communication. Consumer totals do not therefore necessarily match those in table 13A.3. **c** Severity of core activity restriction was derived using data on the level of support needed in one or more of the following support areas: self care, mobility and communication. Consumers with a profound core activity restriction reported a continual need for support in one or more of these areas. Consumers with a severe core activity restriction reported occasional or frequent need for support in one or more of these areas. Consumers with moderate or no core activity restriction reported needing no support in one or more of these areas. **d** Where the level of support need was inconsistently recorded for the same consumer, the person was allocated a level of support according to a standard method.

Source: AIHW (2001a); table 13A.12.

Service use by special needs groups

An important indicator of access is the comparison between the representation of all people with a disability who access services and the representation of people with a disability from rural and remote locations, Indigenous or non-English speaking origin who access services. This information is provided for accommodation support, employment and community access services.

Data are presented by disability service type, as the representation of each special needs group in the total population of people with special needs, per 1000 people; compared to the representation of all disability services consumers in the total Australian population, per 1000 people.

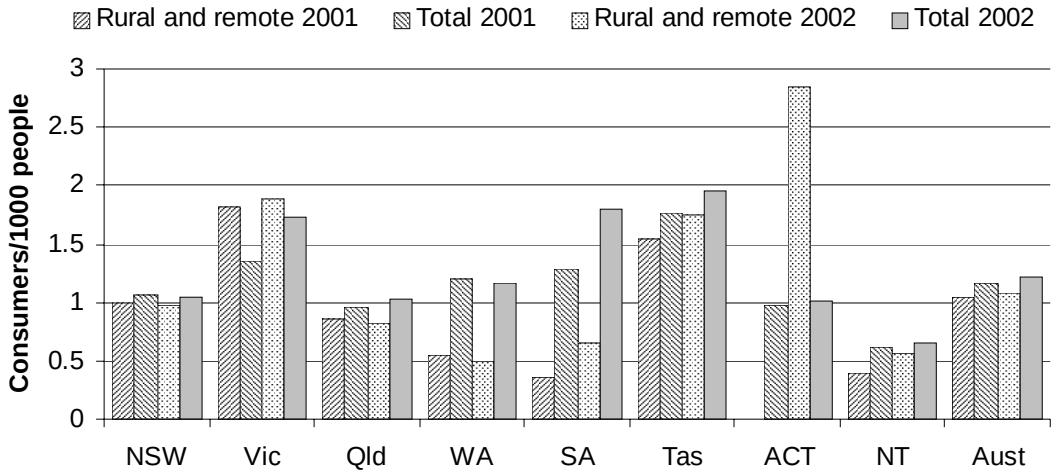
Rural and remote representation per 1000 people

Nationally, the representation of rural and remote consumers in accommodation support services was lower than the community representation in all consumers of

accommodation support services (1.08 rural and remote consumers per 1000 people and 1.22 consumers per 1000 people, respectively) on the snapshot day in 2002. Notwithstanding this national result, a higher representation of the rural and remote population than of the total population used accommodation support services in Victoria and the ACT. It should be noted throughout this section that the rural and remote data category reported, in relation to the ACT, includes rural data only because the ACT has no remote areas (table A.6). The data category, however, is an aggregate of rural and remote data. A lower representation of the rural and remote population than of the total population used accommodation support services in all other jurisdictions. The highest representation of rural and remote consumers accessing accommodation support services was in the ACT (2.84 rural and remote consumers per 1000 people) and the lowest was in WA (0.5 rural and remote consumers per 1000 people) (figure 13.10).

Interpretation of these data should consider that the ACT is an urban regional centre and the majority of the population lives in areas classified as urban. Raw data indicate that the servicing of one cross-border client has skewed the rural and remote representation of consumers accessing accommodation support services to an erroneous level. Results of rural and remote users of accommodation support services need to be considered with care, generally, because it is difficult to measure accommodation services in rural and remote areas, and compare them to those in urban areas. Specifically, accommodation support services in rural areas are largely provided informally, making use of local area coordinators and local community resources, compared with greater levels of institutional care in urban areas. Formal services such as group homes, however, are also widely used in rural areas. The variation in accommodation types may explain the dispersion of jurisdictions' data.

Figure 13.10 **Consumers of accommodation support services per 1000 people, by geographic location[a, b, c, d, e, f]**

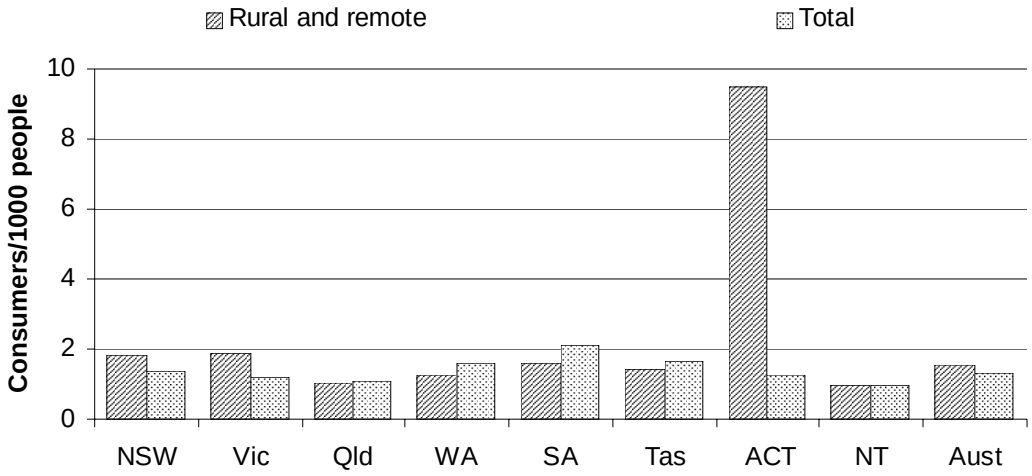


a The State and Territory data on the rural and remote population are derived by the AIHW from ABS statistical local area population estimates for June 2000 and 2001. **b** Data for rural and remote consumers were based on the residential postcode of the consumer except for SA, the ACT and the NT in 2001, which were based on the postcode of the service outlet. A postcode is classified as rural or remote if more than 50 per cent of the population in the postcode area are so classified. **c** Data for rural and remote consumers (per 1000) are per rural and remote people. That is, the rural and remote consumer data divided by the rural and remote Australians data multiplied by 1000. The rural and remote data category in relation to the ACT includes rural only, because the ACT has no remote areas (table A.6). **d** Consumer data are estimates after use of a statistical linkage key to account for individuals who received more than one service on the snapshot day. **e** Data for all consumers exclude 626 consumers in 2001 and 214 consumers in 2002 whose postcode was not known, thus totals may differ from other tables. **f** Data for consumers of CSDA accommodation support services exclude psychiatric services specifically identified by the jurisdiction.

Source: AIHW (2001a, 2002a); table 13A.18.

Nationally, the representation of rural and remote consumers in employment support services was higher than the community representation of all consumers in employment support services (1.52 rural and remote consumers per 1000 people and 1.33 consumers per 1000 people, respectively) on the snapshot day in 2001. A higher representation of the rural and remote population than of the total population used employment support services in NSW, Victoria and the ACT. A lower representation of the rural and remote population than of the total population used employment support services in all other jurisdictions. The highest representation of rural and remote consumers accessing employment support services was in the ACT (9.48 rural and remote consumers per 1000 people) and the lowest was in the NT (0.95 rural and remote consumers per 1000 people) (figure 13.11). The large variation in the ACT data may be due to the relatively small proportion of the rural population to the general population (table A.6) (and, as noted, the ACT has no remote population).

Figure 13.11 **Consumers of employment support services per 1000 people, by geographic location, 2001**[a, b, c, d, e]



a The State and Territory data on the rural and remote population are derived by the AIHW from ABS statistical local area population estimates for June 2000. **b** A postcode is classified as rural or remote if more than 50 per cent of the population in the postcode area are so classified. **c** Data for rural and remote consumers (per 1000) are per rural and remote people. That is, the rural and remote consumer data divided by the rural and remote Australians data multiplied by 1000. The rural and remote data category in relation to the ACT includes rural only, because the ACT has no remote areas (table A.6). **d** Consumer data are estimates after use of a statistical linkage key to account for individuals who received more than one service on the snapshot day. Where postcode was inconsistently recorded for the same consumer, the consumer was counted as rural/remote on the basis of a least one postcode being so classified. Totals may not be the sum of the components because individuals may access services from more than one jurisdiction on the snapshot day. **e** Data for all consumers exclude 292 consumers in 2001 whose postcode was not known, thus totals may differ from other tables.

Source: AIHW (2001a); table 13A.19.

Indigenous representation per 1000 people

Nationally, the representation of Indigenous consumers in accommodation support services was similar to the community representation of all consumers in accommodation support services (1.10 Indigenous consumers per 1000 people and 1.17 consumers per 1000 people, respectively) on the snapshot day in 2002. Notwithstanding this national result, a higher representation of the Indigenous population than of the total population used accommodation support services in NSW, Victoria, SA and the NT. A lower representation of the Indigenous population than of the total population used accommodation support services in all other jurisdictions. The highest representation of Indigenous consumers accessing accommodation support services was in SA (1.91 Indigenous consumers per 1000 people) and the lowest was in the ACT (0.52 Indigenous consumers per 1000 people) (figure 13.12).

Figure 13.12 **Consumers of accommodation support services per 1000 people, by Indigenous status[a, b, c, d, e]**

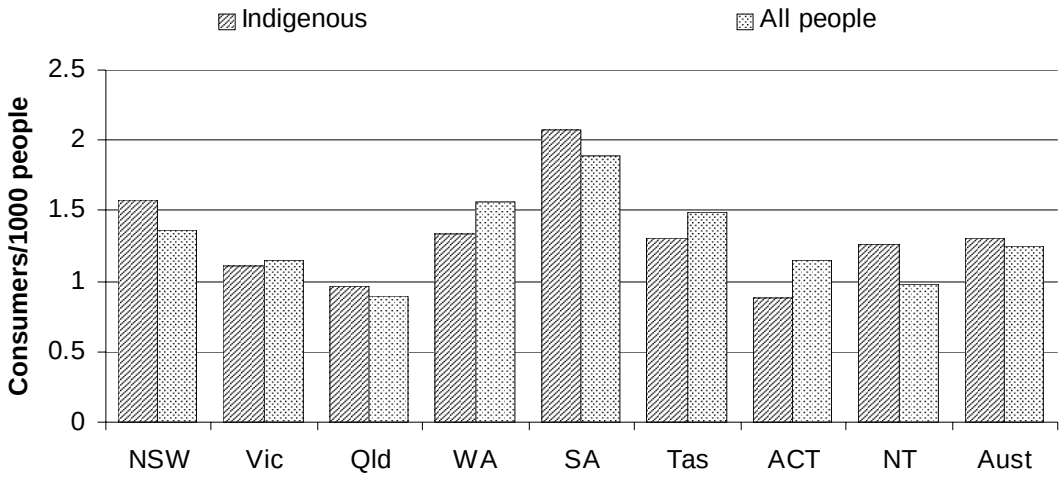
a Consumer data are estimates after use of a statistical linkage key to account for individuals who received more than one service on the snapshot day. Where Indigenous status was inconsistently recorded for the same consumer, the consumer was counted as an Indigenous Australian. Totals may not be the sum of the components because individuals may access services from more than one jurisdiction on the snapshot day. **b** Data for Indigenous consumers (per 1000) are per 1000 Indigenous people. That is, the Indigenous consumer data are divided by the Indigenous Australians data, multiplied by 1000. **c** Data for all consumers exclude 626 consumers in 2001 and 943 consumers in 2002 whose Indigenous origin was 'not known' or 'not stated'; therefore, totals may differ from other tables. **d** ABS Indigenous population projections were used for 2001. Indigenous population projections for 2002 were obtained by multiplying percentages of Indigenous people in each State or Territory based on the most recently available 2001 ABS Census data on the Indigenous population, and applying these percentages to June 2002 ABS projected population data. **e** Data for consumers of CSDA accommodation support services exclude psychiatric services specifically identified by the jurisdiction.

Source: AIHW (2001a, 2002a); table 13A.13.

Information on the use of employment services by consumers by Indigenous status for 2002 were not available in time for publication. This information can be found on the Review web page (see supporting tables section p. 13.3).

Nationally, the representation of Indigenous consumers in employment support services was similar to the community representation of all consumers in employment support services (1.31 Indigenous consumers per 1000 people and 1.25 consumers per 1000 people, respectively) on the snapshot day in 2001. A higher representation of the Indigenous population than of the total population used employment support services in NSW, Queensland, SA and the NT. A lower representation of the Indigenous population than of the total population used employment support services in all other jurisdictions. The highest representation of Indigenous consumers accessing employment support services was in SA (2.08 Indigenous consumers per 1000 people) and the lowest was in the ACT (0.88 Indigenous consumers per 1000 people) (figure 13.13).

Figure 13.13 **Consumers of employment support services per 1000 people, by Indigenous status, 2001[a, b, c, d]**

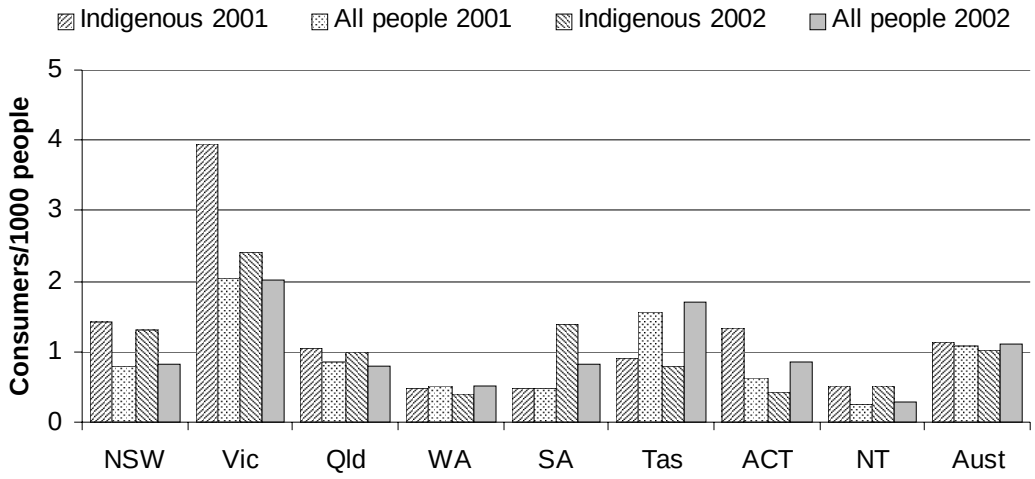


a Consumer data are estimates after use of a statistical linkage key to account for individuals who received more than one service on the snapshot day. **b** Where Indigenous status was inconsistently recorded for the same consumer, the consumer was counted as an Indigenous Australian. **c** Data for Indigenous consumers (per 1000) are per 1000 Indigenous people. That is, the Indigenous consumer data divided by the Indigenous Australians data, multiplied by 1000. **d** Data exclude 973 consumers in 2001 of employment services whose Indigenous origin was 'not known' or 'not stated'.

Source: AIHW (2002a); table 13A.14.

Nationally, the representation of Indigenous consumers in day activity services was similar to the community representation of all consumers in day activity services (1.03 Indigenous consumers per 1000 people and 1.10 consumers per 1000 people, respectively) on the snapshot day in 2002. Across jurisdictions, a higher representation of the Indigenous population than of the total population used day activity services in all jurisdictions except WA, Tasmania and the ACT. The highest representation of Indigenous consumers accessing day activity services was in Victoria (2.41 Indigenous consumers per 1000 people) and the lowest was in WA (0.40 Indigenous consumers per 1000 people) (figure 13.14).

Figure 13.14 **Consumers of day activity services per 1000 people, by Indigenous status[a, b, c, d, e, f, g]**



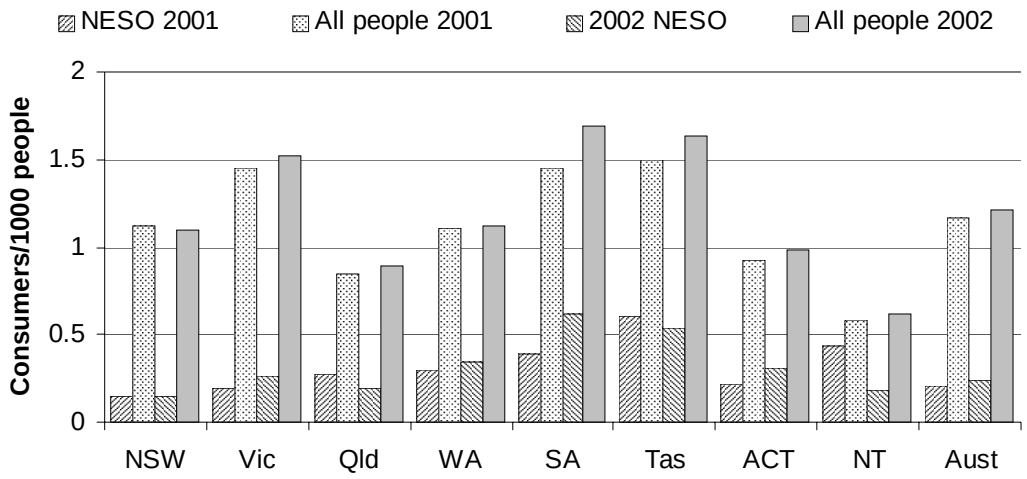
a Consumer data are estimates after use of a statistical linkage key to account for individuals who received more than one service on the snapshot day. Where Indigenous status was inconsistently recorded for the same consumer, the consumer was counted as an Indigenous Australian. Totals may not be the sum of the components because individuals may access services from more than one jurisdiction on the snapshot day. **b** Data for Indigenous consumers (per 1000) are per 1000 Indigenous people. That is, the Indigenous consumer data divided by the Indigenous Australians data multiplied by 1000. **c** Indigenous population projections were obtained by multiplying percentages of Indigenous people in each State or Territory based on the most recently available 2001 ABS Census data on the Indigenous population, and applying these percentages to June 2002 ABS projected population data. **d** Day activity services in 2001 include consumers using the community access service types 'continuing education/independent living training/adult training centre', 'post-school options/social and community support/community access' and 'other community access and day programs'. Day activity services in 2002 include consumers using the community access service types 'learning and life skills development' and 'other community access', but not 'recreation/holiday programs'. **e** Data for all consumers exclude 372 consumers in 2001 and 737 consumers in 2002 whose Indigenous origin was 'not known' or 'not stated'; therefore, totals may differ from other tables. **f** Data for consumers of CSDA community access services exclude psychiatric services specifically identified by the jurisdiction. **g** Data may have different inclusions for different jurisdictions, which may explain variability across jurisdictions. Data are therefore not strictly comparable.

Source: AIHW (2001a, 2002a); table 13A.15.

Non-English speaking origin representation per 1000 people

Nationally, the representation of non-English speaking origin consumers in accommodation support services was lower than the community representation of all consumers in accommodation support services (0.24 non-English speaking origin consumers per 1000 people and 1.21 consumers per 1000 people, respectively) on the snapshot day in 2002. This was the case for all jurisdictions. The highest representation of non-English speaking origin consumers accessing accommodation support services was in SA (0.61 non-English speaking origin consumers per 1000 people) and the lowest was in NSW (0.15 non-English speaking origin consumers per 1000 people) (figure 13.15).

Figure 13.15 **Consumers of accommodation support services per 1000 people, by non-English speaking origin**[a, b, c, d, e, f, g]



a Consumer data are estimates after use of a statistical linkage key to account for individuals who received more than one service on the snapshot day. Where country of birth was inconsistently recorded for the same consumer, the consumer was counted as having a non-English speaking origin. **b** Data for consumers of non-English speaking origin were based on consumer responses for country of birth other than Australia, New Zealand, Canada, United Kingdom, South Africa, Ireland or the United States of America. **c** Data for consumers of non-English speaking origin (per 1000) are per 1000 people of non-English speaking origin. That is, the non-English speaking origin consumer data divided by the non-English speaking origin Australians data, multiplied by 1000. **d** The State and Territory data on the non-English speaking origin population are derived from the corresponding 1996 Australian Census proportional distribution of population of States and Territories applied to the ABS national estimate of 2000 country of birth data, adjusted for expected 2001 increases in total and non-English speaking background populations. Estimates exclude people whose non-English speaking origin was not stated or who were visitors to Australia from overseas. **e** Data for all Australians exclude people whose birthplace was not stated or who were visitors to Australia from overseas. **f** Data for all consumers exclude 754 consumers for 2001 and 353 consumers for 2002 whose non-English speaking origin was 'not known' or 'not stated'; therefore, totals may differ from other sections of this Report. **g** Data for consumers of CSDA funded accommodation support services exclude psychiatric services specifically identified by the jurisdiction.

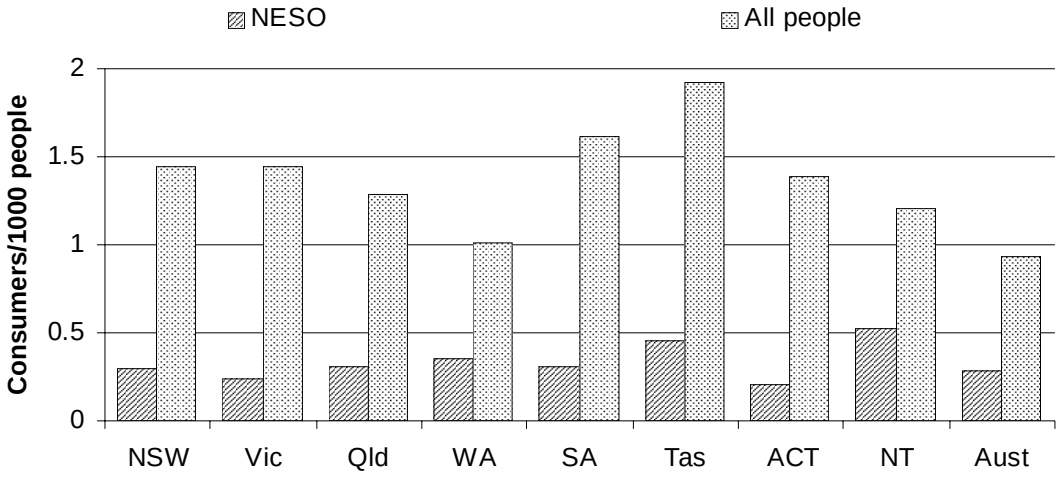
Source: AIHW (2001a, 2002a); table 13A.16.

Information on the use of employment services by consumers by non-English speaking origin status for 2002 were not available in time for publication. This information can be found on the Review web page (see supporting tables section, p. 13.3).

Nationally, the representation of non-English speaking origin consumers in employment support services was lower than the community representation of all consumers in employment support services (0.28 non-English speaking origin consumers per 1000 people and 1.37 consumers per 1000 people, respectively) in 2001. This was the case for all jurisdictions. The highest representation of non-English speaking origin consumers accessing employment support services was in the NT (0.53 non-English speaking origin consumers per 1000 people) and the

lowest was in the ACT (0.21 non-English speaking origin consumers per 1000 people) (figure 13.16).

Figure 13.16 **Consumers of employment services per 1000 people, by non-English speaking origin, 2001**[a, b, c, d, e, f, g]



a Consumer data are estimates after use of a statistical linkage key to account for individuals who may have received more than one service on the snapshot day. Where non-English speaking origin was inconsistently recorded for the same consumer, the consumer was counted as a non-English speaking origin consumer. **b** Data for consumers of non-English speaking origin were based on consumer responses for country of birth other than Australia, New Zealand, Canada, United Kingdom, South Africa, Ireland or the United States. **c** Data for consumers of non-English speaking origin (per 1000) are per 1000 people of non-English speaking origin, that is, the consumers of non-English speaking origin divided by the non-English speaking origin Australians data, multiplied by 1000. **d** The State and Territory data on the non-English speaking origin population are derived from the corresponding 1996 Australian Census proportional distribution applied to the ABS national estimate of 1999 country of birth data. They exclude people whose non-English speaking origin was not stated or who were visitors to Australia from overseas. **e** Data for all Australians exclude people whose birthplace was not stated or who were visitors to Australia from overseas. **f** Data exclude 248 consumers of employment services whose non-English speaking origin was 'not known' or 'not stated'. **g** Commonwealth data are preliminary and cover 99 per cent of Commonwealth-funded services.

Source: AIHW (2001a); table 13A.17.

Efficiency

An indicator of efficiency is the level of government inputs per place (unit cost). Indicators include:

- the cost to government of providing institutional/residential and community accommodation places;
- the level of government funding of non-government delivered institutional/residential and community accommodation places;
- the level of government funding of non-government delivered open, supported, and open and supported employment services; and

- the proportion of total expenditure on disability services spent on administration expenditure.

Unit cost data for government delivered services for people with a disability does not yet include the user cost of capital.

Institutional residential accommodation support includes both institutions and hostels. Community accommodation support includes group homes, attendant care/personal care, in-home accommodation support, alternative family placement, and other accommodation support. In recent years, there has been an ongoing process across States and Territories of de-institutionalisation of services for people with a disability. As a result, total government expenditure on institutional/residential accommodation places has decreased, with a corresponding increase in expenditure on non-institutional accommodation and care.

It is an objective of the Review to report comparable estimates of costs. Ideally, such comparisons would include the full range of costs to government. Where the full costs cannot be counted, costs are best estimated on a consistent basis.

Considerable effort has been made to document any differences in calculating the reported efficiency indicators. Some concerns remain over the comparability of the results, however, because jurisdictions use somewhat different methods of data collection (table 13.1). Expenditure estimates for all jurisdictions except SA and the NT are generally comparable because the estimates for all items are based on accrual accounting and include all major items in a consistent way. The expenditure data from SA and the NT are not strictly comparable and may understate the full accrued cost. Further, as noted, accommodation data for 2001-02 are not strictly comparable to data on previous years, due to the refinement of definitions.

Table 13.1 **Comparability of expenditure estimates for government delivered disability services, by items included, 2001-02[a, b]**

Expenditure	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*
Superannuation included	✔	✔	✔	✔	✘	✔	✔	✔
Basis of estimate	Accrual	Accrual	Accrual	Accrual	..	Accrual	Accrual	Cash
Workers' compensation included	✔	✔	✔	✔	✔	✔	✔	✔
Payroll tax included								
Actual	✔	✔	✔			✔	✘	✔
Imputed		✔		✔	✔		✘	
Apportioned umbrella department costs included	✔	✔	✔	..	✔	✔	✔	✔
Basis of apportioning								
Departmental formula	✔	✔	✘	..	✔	✘	✘	✘
% of FTE employees	✘	✘	✔	..	✘	✔	✔	✔
Long service leave								
Entitlements	✔	✔	✔	✔	✘	✔	✔	✔
Basis of estimate	Accrual	Accrual	Accrual	Accrual	..	..	Accrual	Cash
Depreciation	✔	✔	✔	✔	✘	✘	✘	✘

a Actual amounts only are included in cost per place data for NSW, Victoria, Queensland, Tasmania and the NT because actual and imputed amounts are not separately identified at the service delivery area level. **b** Actual and imputed amounts are included in total CSDA expenditure proportional to administrative costs and total CSDA expenditure per consumer. FTE Full time equivalent. .. Not applicable.

Source: State and Territory governments (unpublished).

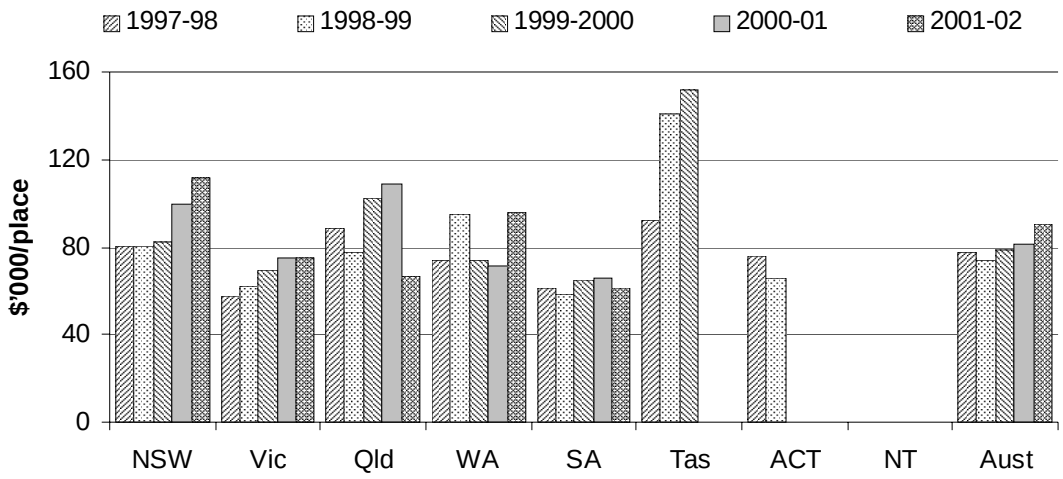
Cost to government of government provided services

Data reported in this section are from individual jurisdictions' collections and may differ from cost per place data reported elsewhere.

Cost per government provided institutional residential place

The average cost to government of providing institutional residential accommodation was $90 609 per place in 2001-02. Across jurisdictions, the highest expenditure per place was in NSW ($111 834) and the lowest was in SA ($60 803). The Tasmanian, ACT and NT governments did not provide institutional residential accommodation in 2001-02 (figure 13.17).

Figure 13.17 **Real cost per government provided institutional residential place, (2001-02 dollars)[a, b, c, d, e, f]**



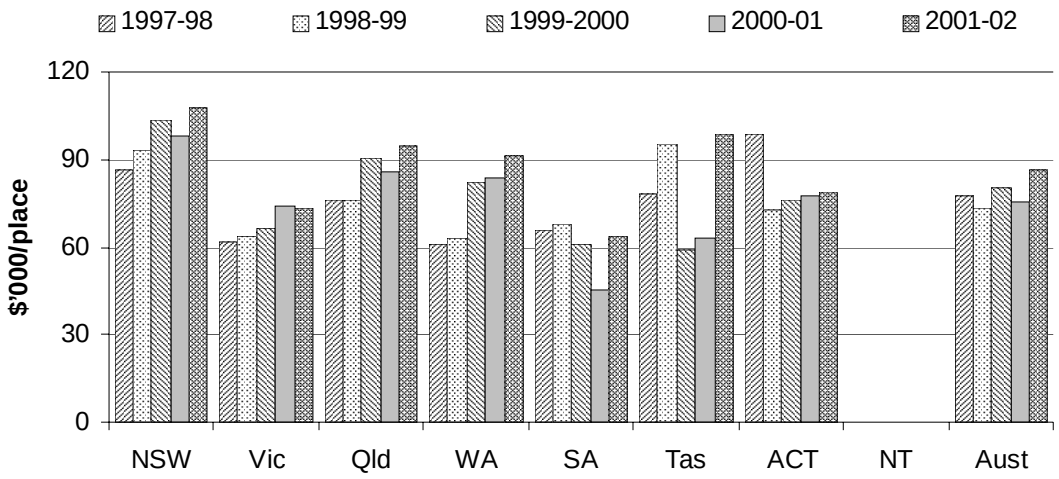
a Based on total expenditure divided by the number of places on a snapshot day (rather than average number of places during the year). The change from 1998-99 reflects the refinement of the process (based on accrual accounting) used to allocate expenditure between institutions and community accommodation. **b** Increased costs in NSW in 2000-01 and 2001-02 reflect devolution expenditure on transitional accommodation and crisis support to people residing in institutions and being relocated. This will reduce as the relocation program accelerates. **c** Data for Victoria prior to 2001-02 are not comparable with previous reports, which used data from departmental administrative collections. **d** The decrease in Queensland government expenditure per government provided institutional residential place is due to transitional changes in models of accommodation support provided. **e** An improved cost allocation and payments database has been used for WA data in 2001-02. This has resulted in a refinement and in some cases a major re-alignment of costs previously reported. Accommodation support also reflects growth, indexation and parity funding provided for wage increases. **f** There was no government provided institutional residential accommodation support in Tasmania (in 2000-02), the ACT (in 1999-2002) or the NT.

Source: State and Territory governments (unpublished); table 13A.23.

Cost per government provided community accommodation and care place

Nationally, the cost per government provided community accommodation and care place was $86 360 in 2001-02. Across jurisdictions, the cost per place was highest in NSW ($107 434) and lowest in SA ($63 507). The NT did not provide government provided community accommodation and care places (figure 13.18).

Figure 13.18 **Real cost per government provided community accommodation and care place, (2001-02 dollars)[a, b, c, d]**



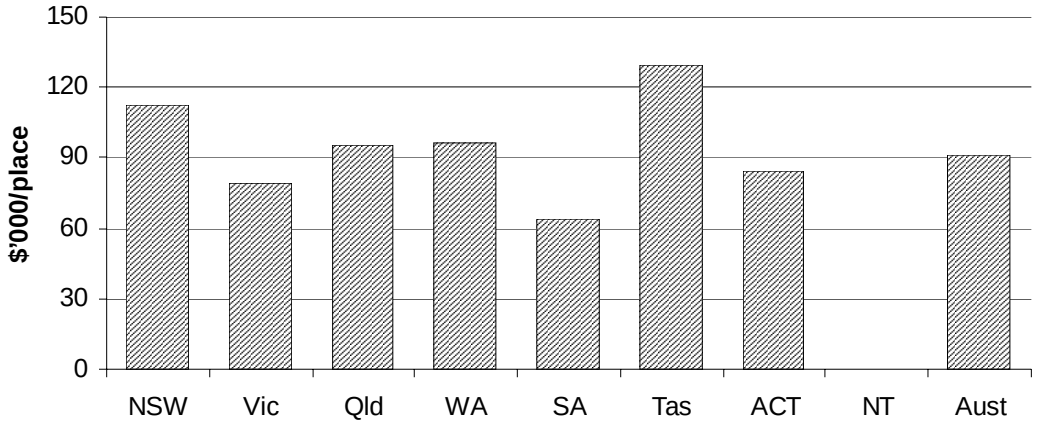
a Based on total expenditure divided by the number of places on a snapshot day (rather than average number of places during the year). The change from 1998-99 reflects the refinement of the process, based on accrual accounting, used to allocate expenditure between institutions and community accommodation. **b** Due to refinements made to the counting rules for accommodation data, the 2001-02 data are not strictly comparable with data for previous years. **c** Data for Victoria prior to 2001-02 are not comparable with previous reports, which used data from departmental administrative collections. **d** There was no government provided community accommodation support in the NT.

Source: State and Territory governments (unpublished); table 13A.23.

Cost per government provided community accommodation and care place — group homes

Nationally, the cost per government provided community accommodation and care place — group homes — was $91 463 in 2001-02. Across jurisdictions, the cost per place was highest in Tasmania ($129 709) and lowest in SA ($63 507). The NT did not provide government provided community accommodation and care places — group homes (figure 13.19).

Figure 13.19 **Real cost per government provided community accommodation and care place — group homes, 2001-02 (2001-02 dollars)[a, b]**



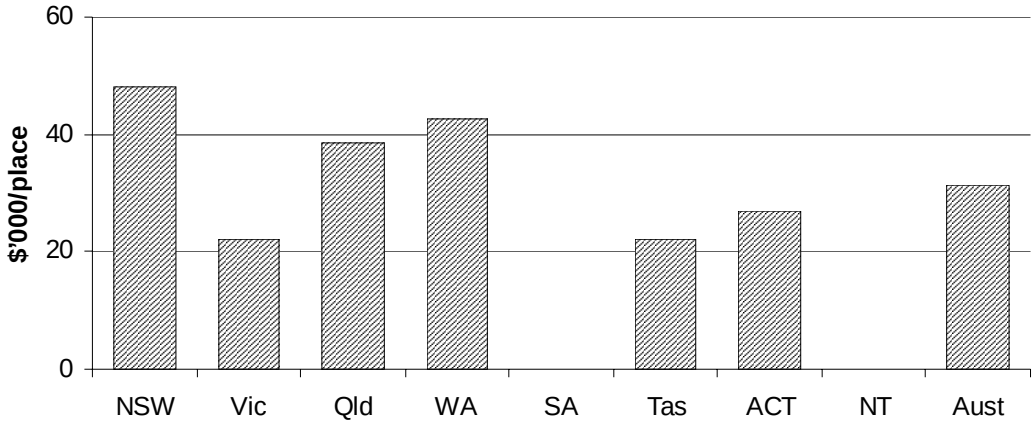
a Based on total expenditure divided by the number of places on a snapshot day (rather than average number of places during the year). The change from 1998-99 reflects the refinement of the process (based on accrual accounting) used to allocate expenditure between institutions and community accommodation. **b** There was no government provided community accommodation support — group homes — in the NT.

Source: State and Territory governments (unpublished); table 13A.23.

Cost per government provided community accommodation and care place — other

Nationally, the cost per government provided community accommodation and care place — other — was $31 270 in 2001-02. Across jurisdictions, the cost per place was highest in NSW ($47 991) and lowest in Victoria ($22 246). Both SA and the NT did not provide government provided community accommodation and care places — other (figure 13.20).

Figure 13.20 **Real cost per government provided community accommodation and care place — other, 2001-02 (2001-02 dollars)[a, b]**



a Based on total expenditure divided by the number of places on a snapshot day (rather than average number of places during the year). The change from 1998-99 reflects the refinement of the process (based on accrual accounting) used to allocate expenditure between institutions and community accommodation. **b** There was no government provided community accommodation support — other — in SA or the NT.

Source: State and Territory governments (unpublished); table 13A.23.

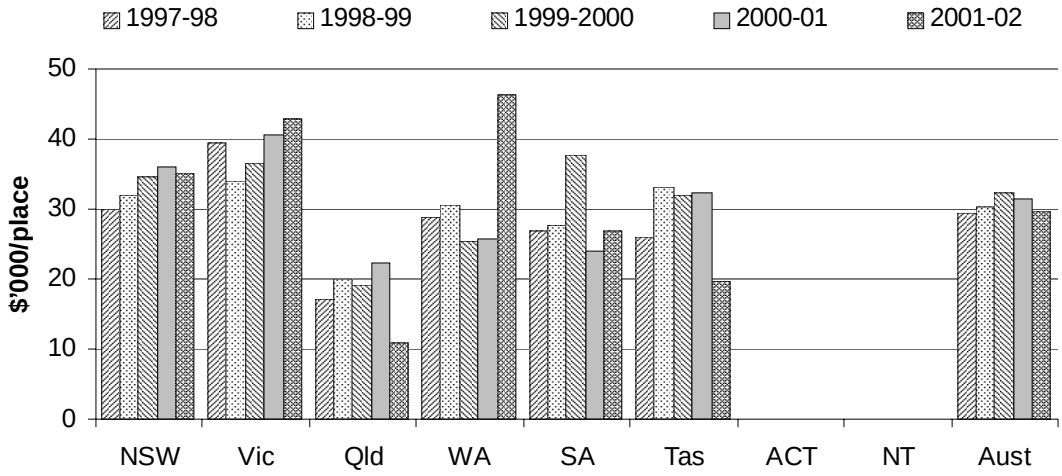
Government funding of non-government service providers

Governments do not always provide accommodation services; rather, governments may fund non-government service providers to deliver this service.

Government funding per non-government provided institutional residential place

Nationally, government funding per non-government delivered institutional residential accommodation place was $29 649 in 2001-02. Across jurisdictions, government funding per place was highest in WA ($46 161) and lowest in Queensland ($10 908). There were no non-government or government providers of institutional residential accommodation in the ACT or the NT (figure 13.21).

Figure 13.21 **Real government funding per non-government provided institutional residential place, (2001-02 dollars)[a, b, c, d, e]**



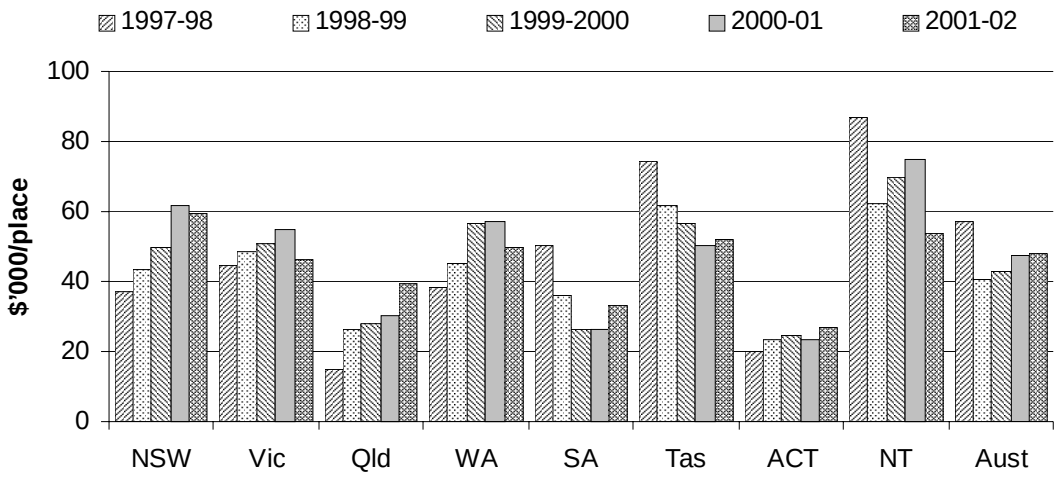
a Based on total expenditure divided by the number of places on a snapshot day (rather than average number of places during the year). The change from 1998-99 reflects the refinement of the process (based on accrual accounting) used to allocate expenditure between institutions and community accommodation. Data for non-government provided places reflect cost to government and not full cost of providing accommodation places. Government makes a contribution towards non-government provided places. **b** Data for Victoria prior to 2001-02 are not comparable with previous reports, which used data from departmental administrative collections. **c** The decrease in Queensland's 2001-02 data is due to changes in service-type definitions. **d** An improved cost allocation and payments database has been used for WA data in 2001-02. This has resulted in a refinement and in some cases a major re-alignment of costs previously reported. Accommodation support also reflects growth, indexation and parity funding provided for wage increases. **e** There was no non-government provided institutional residential accommodation support in the ACT or the NT.

Source: State and Territory governments (unpublished); table 13A.23.

Government funding per non-government provided community accommodation and care place

Nationally, government funding per non-government provided community accommodation and care place was $48 139 in 2001-02. Across jurisdictions, it ranged from $59 178 per place in NSW to $26 766 per place in the ACT (figure 13.22).

Figure 13.22 **Real government funding per non-government provided community accommodation and care place, (2001-02 dollars)[a, b, c, d]**



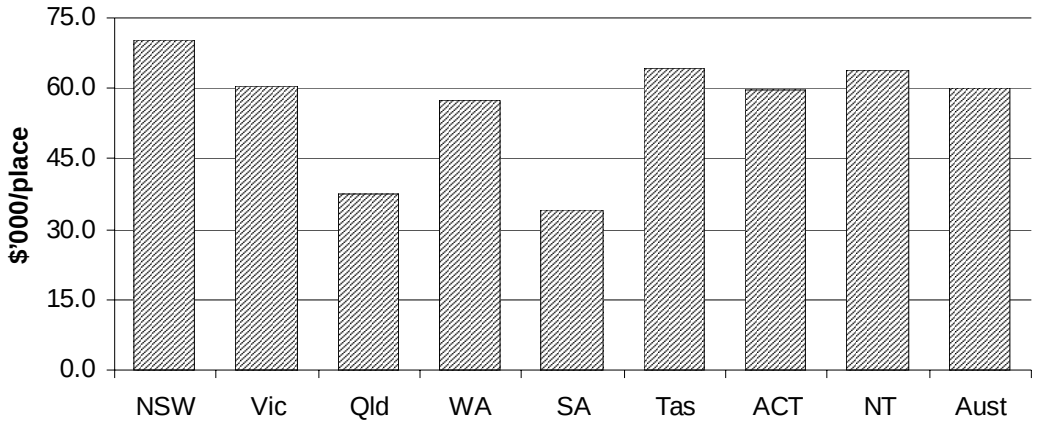
a Based on total expenditure divided by the number of places on a snapshot day (rather than average number of places during the year). The change from 1998-99 reflects the refinement of the process (based on accrual accounting) used to allocate expenditure between institutions and community accommodation. Data for non-government provided places reflect cost to government and not full cost of providing accommodation places. Government makes a contribution towards non-government provided places. **b** Due to refinements made to the counting rules for accommodation data, the 2001-02 data are not strictly comparable with data for previous years. **c** Data for Victoria prior to 2001-02 are not comparable with previous reports, which used data from departmental administrative collections. **d** Expenditure variations in 2001-02 for the disability service types reflect changes in service provision under an individual funding model. Payments under the model are categorised as community support (as per CSTDA NMDS definitions) and are not included specifically in the service type purchased (for example, supported accommodation. In the NT, some non-government organisations received three quarterly payments in 2001-02. One quarterly payment was paid in advance in 2000-01. These factors affect the ability to make meaningful comparisons to previous financial years.

Source: State and Territory governments (unpublished); table 13A.23.

Government funding per non-government provided community accommodation and care place — group homes

Nationally, government funding per non-government provided community accommodation and care place — group homes — was $60 068 in 2001-02. Across jurisdictions, it ranged from $70 272 per place in NSW to $34 059 per place in SA (figure 13.23).

Figure 13.23 **Real government funding per non-government provided community accommodation and care place — group homes, (2001-02 dollars)[a]**



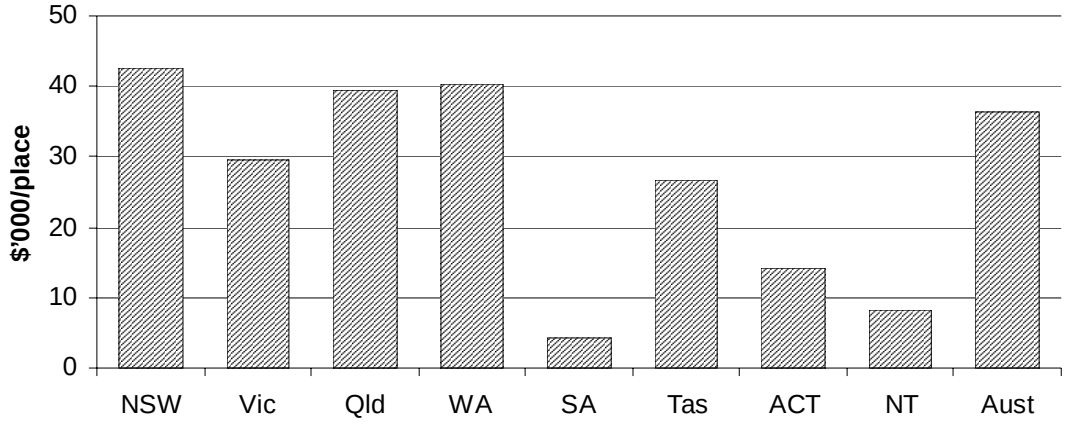
a Based on total expenditure divided by the number of places on a snapshot day (rather than average number of places during the year). Data for non-government provided places reflect cost to government and not full cost of providing accommodation places. Government makes a contribution towards non-government provided places.

Source: State and Territory governments (unpublished); table 13A.23.

Government funding per non-government provided community accommodation and care place — other

Nationally, government funding per non-government provided community accommodation and care place — other — was $36 288 in 2001-02. Across jurisdictions, it ranged from $42 713 per place in NSW to $4307 per place in SA (figure 13.24).

Figure 13.24 **Real government funding per non-government provided community accommodation and care place — other, (2001-02 dollars)[a, b, c]**



a Based on total expenditure divided by the number of places on a snapshot day (rather than average number of places during the year). **b** Data for non-government provided places reflect cost to government and not full cost of providing accommodation places. Government makes a contribution towards non-government provided places. **c** Data for 2001-02 on non-government provided community accommodation, other, include the In Home Accommodation Support program not previously reported.

Source: State and Territory governments (unpublished); table 13A.23.

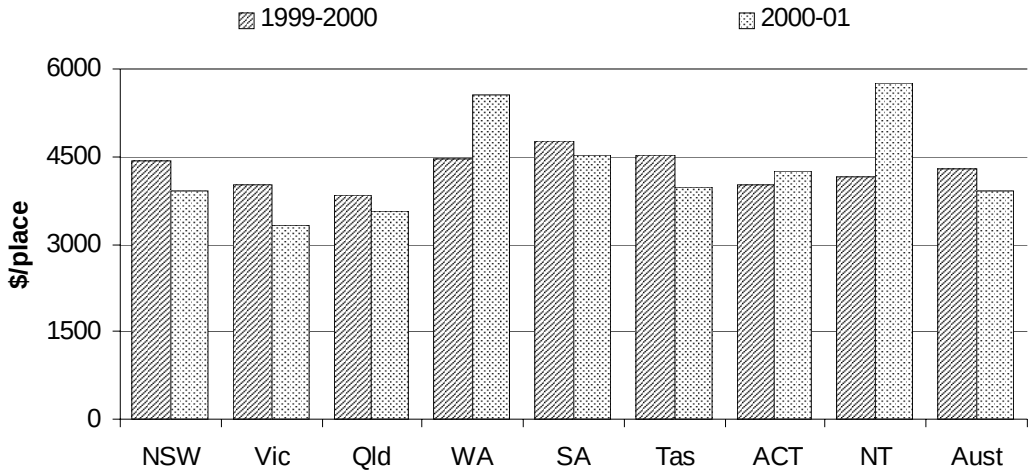
Government expenditure on employment services

Assistance with employment for people with a disability is the responsibility of the Commonwealth Government under the CSDA. Cost per place data disaggregated by jurisdiction for employment services are reported here for 1999–2001. Number of places data for employment services in 2002 were not available in time for publication. This information can be found, however, on the Review web page (see supporting tables section, p. 13.3).

Nationally, real cost per place for all employment service types was $3086 (open program) $5877 (supported program) and $3370 (open and supported program) in 2000-01 (table 13A.25). This represents a real decrease in cost per place for open program, supported program, and open and supported program employment services ($3178, $6156 and $4661 respectively, in 1999-2000) nationally (table 13A.25).

Nationally, real cost per place for all employment service types decreased from $4275 in 1999-2000 to $3907 in 2000-01. There was a decrease in cost per place for all jurisdictions except WA, the ACT and the NT from 1999-2000 to 2000-01. Across jurisdictions, cost per place for all employment service types in 2000-01 was highest in the NT ($5749) and lowest in Victoria ($3322) (figure 13.25).

Figure 13.25 **Real Commonwealth expenditure per employment place, by jurisdiction (2001-02 dollars)[a, b]**



a Based on the number of places during the whole year. **b** Expenditure data represent payments made directly to services for the provision of disability employment assistance in 2000-01. These do not include other elements of the Commonwealth Employment Assistance program such as consumer training and support, supported wages system and wage subsidies.

Source: DFaCS (unpublished); table 13A.26.

Administrative efficiency

The proportion of total expenditure on administration is not yet comparable across jurisdictions because different methods are used to apportion administration costs. Administration cost data are useful, however, for indicating trends within jurisdictions over time.

The national average administrative expenditure as a proportion of total government expenditure on disability services remained relatively constant from 7.9 per cent in 2000-01 to 8.0 per cent in 2001-02, where actual payroll tax is included in total CSDA expenditure for NSW, Victoria (in part), Queensland, Tasmania and the NT. Across jurisdictions, the proportion increased between 2000-01 and 2001-02 for NSW, WA, SA and the NT, and decreased for all other jurisdictions. The highest administrative expenditure as a proportion of total expenditure was in the ACT (11.5 per cent) and the lowest was in WA (4.4 per cent) (figure 13.26).

Data that account for differences in payroll tax regimes across jurisdictions are included for the first time this year to improve the comparability of reported costs. Payroll tax data need to be interpreted with caution, however, because some jurisdictions have provided payroll/payroll tax data on the basis of direct service delivery expenditure for government provided services (NSW, Queensland, the

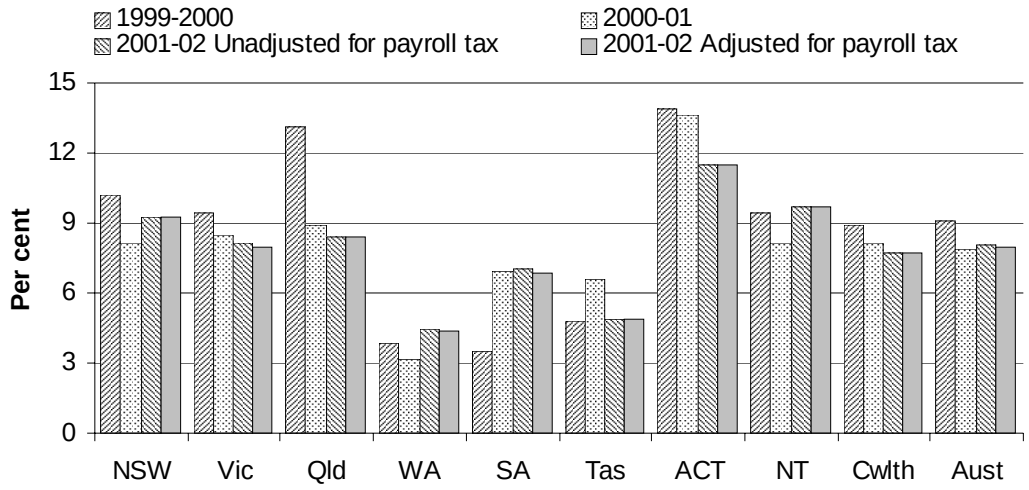
ACT and the NT) and others have provided the data on the basis of total expenditure for government provided services (Victoria, WA, SA and Tasmania). Specifically, total CSDA expenditure is reported, excluding both actual and imputed payroll tax amounts and including both actual and imputed payroll tax amounts, respectively (table 13A.21). Nationally, where payroll tax is excluded, average administrative expenditure as a proportion of total CSDA expenditure was 8.1 per cent in 2001-02. Nationally, where actual and imputed payroll tax is included, average administrative expenditure as a proportion of total CSDA expenditure was 8.0 per cent in 2001-02 (figure 13.26).

Expenditure per consumer

Expenditure per consumer is reported for the first time this year and accounts for payroll tax. Expenditure per consumer is reported both net of payroll tax and including actual and imputed payroll tax. Nationally, expenditure per consumer was $57 131 excluding payroll tax and $57 749 including actual and imputed payroll tax (figure 13.27).

Across jurisdictions, the NT had the highest dollars per consumer both where payroll tax was included ($71 512) and excluded ($70 834). SA had the lowest dollars per consumer both where payroll tax was included ($35 600) and excluded ($34 690) (figure 13.27).

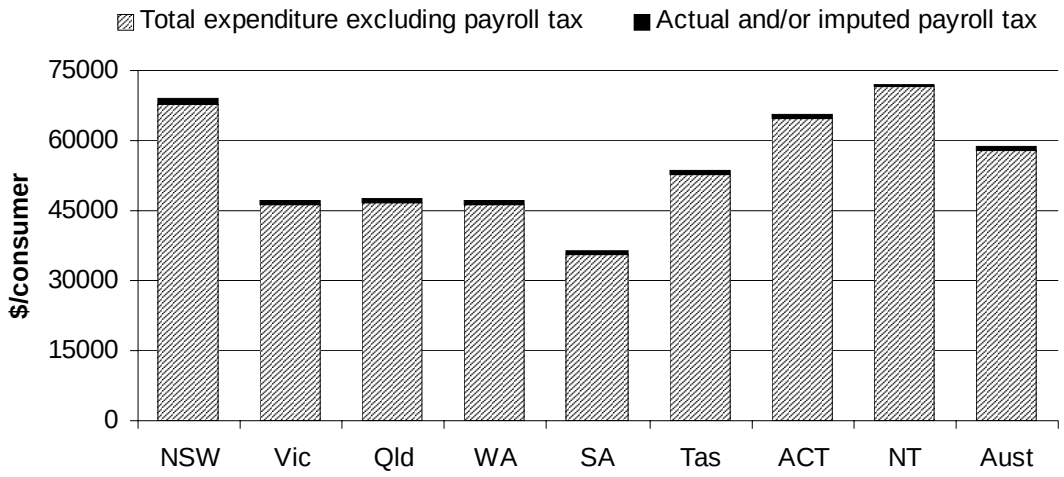
Figure 13.26 **Administrative expenditure as a proportion of total expenditure on services[a, b, c, d, e, f, g, h]**



a See table 13.1 for an explanation of different methods of apportioning departmental costs. **b** Payroll tax is applicable in all jurisdictions. In some jurisdictions the payroll tax is paid directly by the service (NSW, Victoria in part, Queensland, Tasmania and the NT) and in other jurisdictions (Victoria in part, WA, SA and the ACT) payroll tax is not paid directly by the service. Data for 2001-02 adjusted for payroll tax exclude actual payroll tax amounts for all jurisdictions. Data for 2001-02 unadjusted for payroll tax include actual payroll tax amounts for NSW, Victoria (in part), Queensland, Tasmania and the NT. **c** The method of apportioning government administration expenditure in Queensland changed in 2000-01 as a result of improved financial reporting systems and with the establishment of Disability Services Queensland. Payroll tax data for Queensland include payroll tax, accrued payroll tax and long service leave on-costs recovered payroll tax. **d** The decrease in WA 2000-01 administration expenditure reflects a reduction in corporate services costs and the elimination of costs associated with the implementation of the GST in 1999-2000. The increase in WA 2001-02 administration expenditure mainly reflects the realignment of policy costs previously allocated across all outputs. **e** Data for SA include administration expenses (indirect service delivery costs) relating to all Government agencies receiving funding from the department. Reports in previous years included only the Central Office and Intellectual Disability Services Council administrative costs. Improved allocation of corporate overheads occurred again in 2000-01 within the government sector. **f** The ACT incurred additional one-off overhead costs in 2000-01 due to the Inquiry into Disability Services in the ACT. **g** The NT administrative expenditure prior to 2001-02 is estimated only and is based on average staffing levels. There was improved financial reporting in the NT in 2001-02 due to operation within a funder/purchaser/provider framework. Payroll tax relates to NT Government service provision and does not include expenditure for program management and administration. **h** Commonwealth administrative expenditure is an estimate only and is based on average staffing levels.

Source: State and Territory governments (unpublished); table 13A.27.

Figure 13.27 **Total expenditure per consumer, 2001-02[a, b, c]**



[a] Payroll tax is applicable in all jurisdictions. In some jurisdictions the payroll tax is paid directly by the service (NSW, Victoria in part, Queensland, Tasmania and the NT) and in other jurisdictions (Victoria in part, WA, SA and the ACT) payroll tax is not paid directly by the service. [b] Payroll tax data for Queensland includes payroll tax, accrued payroll tax and long service leave on-costs recovered payroll tax. [c] Payroll tax relates to NT Government service provision and does not include expenditure for program management and administration.

Source: AIHW (2002a); State and Territory governments (unpublished); table 13A.28.

13.5 Future directions in performance reporting

A new NMDS has been established in anticipation of the CSTDA (see performance indicators section, p. 13.12). Significant development and further refinement of reporting against performance indicators are planned for subsequent reports, largely arising from improved, ongoing data expected to be available from the CSTDA NMDS collection from 2002-03. It is unknown, due to the revised implementation timetable, whether the 2004 Report will include part-year data for 2002-03 captured through the CSTDA NMDS collection. The 2003 Report includes 2001-02 snapshot day data consistent with the approach in previous years.

Notwithstanding the improvements in reporting made in the 2003 Report, limitations remain in reporting against the current framework:

- There are gaps in reporting service quality (for example, client and carer satisfaction).
- The availability of snapshot day data only, rather than whole-of-year data, has an impact on the reliability of performance indicators.
- The scope of reporting is restricted to CSDA services.

The Review intends to address these limitations by:

- expanding reporting to cover non-CSDA services used by people with a disability;
- reporting more complete, current, ongoing social participation data; and
- reporting more complete, current, ongoing quality assurance data.

Reporting on social participation and quality assurance processes is expected to become more complete and comparable over time, with refinements to performance indicators and data collections. In Tasmania, for example, self assessment quality data were collected for 2001-02, but for 2002-03 data will be collected from a new evaluation process. In Victoria, a program of independent review has commenced, and it is expected that 10 per cent of service outlets in 2002-03 will be evaluated.

Additional reporting of rural and remote data — for CSDA services other than accommodation and employment — may be achievable in future reports.

13.6 Jurisdictions' comments

This section provides comments from each jurisdiction on the services covered in this chapter. Appendix A contains data that may assist in interpreting the performance indicators presented in this chapter. These data cover a range of demographic and geographic characteristics, including age profile, geographic distribution of the population, income levels, education levels, tenure of dwellings and cultural heritage (including Indigenous and ethnic status).

Commonwealth Government comments

“ In the spirit of improving performance measurement and accountability, both key policy priorities for the third CSTDA, the Commonwealth supports the continuing reporting of achievements and policy progress of all jurisdictions in the delivery of specialist support services for people with disabilities within this report. The redevelopment of the MDS, the move towards reporting whole-of-year data by all jurisdictions and the annual CSTDA Performance Report on the progress of implementing policy priorities under the third agreement will also help provide better information for the disability sector.

Consistent, accurate and comparable data are a key objective of the Commonwealth as reflected by our annual Disability Services Census, which provides the data for the Report.

The Disability Services Census captures data for the full financial year, rather than just snapshot day data, which most other jurisdictions have been collecting up to now. Data are collected for outcomes measurement and statistical information for the full financial year of operations of each employment service. Therefore, the Commonwealth collection of data cannot commence until the end of the financial year.

The Commonwealth goes to a great deal of effort to ensure the data collected from service providers are fully cleaned through rigorous data consistency and error checking prior to being made publicly available. This process takes time and cannot conclude until the returns from service providers are received. Therefore, Commonwealth data were not available at the time that performance indicators are prepared for this report. However, the data were finalised in November 2002 and can also be accessed on the Productivity Commission Review web site.

The Commonwealth has some concerns over the reliability of snapshot data in representing the level of service provision. ‘Whole of year’ data, which is a count of all registered consumers who have been assisted by the service throughout the year provides a more complete picture of employment services activity. To illustrate this, the number of consumers receiving employment services on snapshot day was 18 381 in 2001-02 compared with the more representative figure of 64 595 consumers reported on whole-of-year data for 2001-02. Between 1999-2000 and 2001-02 there was an increase of 11 168 consumers of employment services recorded for the full financial year. This and future increases in consumer numbers can be attributed to increased Commonwealth funding for disability employment services of $200 million announced in the last two Federal Budgets.

To obtain a comprehensive picture of Commonwealth funded services for people with disabilities we recommend looking at the whole of year disability census data available on the FaCS website http://www.facs.gov.au/internet/facsinternet.nsf/aboutfacs/programs/disability-dscensus_nav.htm). ”

New South Wales Government comments

“ The NSW Government is committed to providing services to people with a disability and their carers to maximise their independence and participation in community life.

The proportion of people in NSW who have a disability is increasing at a faster rate than for the general population, and this is having a major impact on the demand for services. Efforts in NSW are being directed towards policy leadership in disability issues, strengthening the availability and responsiveness of generalist services, and targeted growth in specialist disability services. This balance of approaches will allow us to provide a greater range of opportunities for people with a disability and their carers in the future.

Expenditure on disability services in NSW increased by more than $100 million from 2000-01 to 2001-02 — an increase of approximately 14 per cent. This resulted in significant additional resources being directed towards respite services, community access and day programs, case management and brokerage, accommodation outreach, in-home support and early childhood intervention.

Two significant areas of disability services reform in NSW include the devolution program and reform of the Adult Training, Learning and Support (ATLAS) Program.

Under the devolution program, the NSW Government has made a commitment to providing alternate accommodation for people with a disability living in large institutions. This process has begun.

The ATLAS Review and Reform process continues and includes Post School Options and Day Program Services. The reform aims to build more effective pathways between school, work, other day and lifelong learning activities. A critical ingredient is ongoing negotiation with the Commonwealth about enhancing pathways between employment, education and community support for people with a disability.

Disability output data contained in future reports, and the comparability of data across jurisdictions, will be vastly improved with the implementation of the new CSTDA NMDS. The new NMDS has progressed from a one-day snapshot to a routine, ongoing collection from 1 October 2002. ”

Victorian Government comments

“ Victoria has continued to build on previous improvements in the collection and provision of data that are comparable on a national basis. Additional Victorian data related to social participation have been collected and included for the first time in the 2003 Report.

The information in this report on social participation reflects current policy directions and provides feedback on the level of community participation for people with a disability across a range of activities. This is very much in keeping with the Victorian State Disability Plan 2002-2012, launched in September 2002, which includes strategies that seek to improve the lifestyles of people with a disability including greater participation in the full range of community activities.

The MDS continues to be an important source of information for a range of planning and policy development purposes. The implementation of the redeveloped MDS for disability services from October 2002 is an exciting development that holds out the promise of better national data with an enhanced focus on client outcomes and effectiveness. The bedding down of a new data collection system in Victoria will lead to improved reporting from 2003.

Victoria, along with other jurisdictions, is particularly interested in collecting data that highlight service outcomes on an ongoing basis and using this information, in partnership with non-government organisations and other governments, to enhance service delivery.

Notwithstanding improvements in nationally comparable information, like all reports of this kind, some cautionary notes regarding the interpretation of data are necessary. Victoria recognises that problems with data consistency and comparability still exist and that more work is required in some areas. A notable case in point relates to the apportionment of costs to service outputs and resulting efficiency measures. For example, the proportion of total expenditure spent on administration is not comparable across jurisdictions due to the different methods used to apportion administration costs in each jurisdiction. Readers should keep such differences in mind when interpreting data reported here. ”

Queensland Government comments

“During 2001-2002 Disability Services Queensland (DSQ) has actively supported the redevelopment of the CSTDA NMDS collection. The collection of the full year data will provide the basis for improved planning, reporting and comparison across the jurisdiction, and with other jurisdictions. However care in interpretation of the data in this report is cautioned as data consistency and comparability issues still remain.

Over the past 12 months, DSQ has continued the Funding Reform project which aims to :

- identify and analyse demand for disability services in Queensland, including the development of a predictive model for demand;
- review current service responses under the existing DSQ Program Framework; and
- review viability issues confronting non-government service providers.

An extensive consultation process was undertaken to seek the views of the disability sector on future funding directions. Government will consider the recommendations from the Funding Reform Project during 2003.

Over the same period of time, a Legislative Reform Project has been addressing two key streams of work. The first of these is a review of the Queensland *Disability Services Act 1992*. This review will provide people with a disability, their families, Government and non-government service providers across Queensland with an improved legislative platform for disability policy and contemporary disability practice. The second is to recognise carers' needs and concerns as well as their role in service delivery. Whilst a number of departments deal with carer issues, DSQ will lead the whole-of-Government commitment to develop a Queensland Carer Policy and to identify issues which may require a legislative response.

A project to develop models of innovative and supportive housing to increase the capacity of the Queensland disability sector to respond to the support needs of people with a disability who display complex and seriously harmful behaviours has been established. These models are to improve outcomes for individuals who are part of this target group.

The joint Commonwealth and State funding for unmet need has enabled DSQ to provide support for a significant number of Queenslanders with a disability and their carers, in addition to funding the development of additional service infrastructure and community initiatives.

The 2002-03 Queensland State Government Budget provided additional recurrent funding of $22.6 million to help address demand within the disability sector in Queensland. A significant amount of DSQ's budget is allocated to people with psychiatric disability, data on whom are not included in this Report.”

Western Australian Government comments

“WA welcomes the improvements to this year’s report on disability services, which reflect the ongoing commitment by all jurisdictions to improved performance reporting and accountability under the CSDA. In particular, WA welcomes the inclusion for the first time of data on quality assurance processes, the further development of social participation data, and the improved comparability of accommodation financial data. More accurate consumer data for 2001-02 also means that where consumer data were previously inflated, unit costs were deflated. This year’s accommodation financial data reflects more accurate consumer data, as well as more accurate cost allocation.

Good progress has been made on the redevelopment of the NMDS, which once complete will lead to a much improved national data collection to allow better benchmarking and the collection of comparable whole-of-year performance data.

These developments will provide more comparable data both within and across jurisdictions in future years. Caveats remain however with regard to data interpretation and comparison with earlier years, where data trends reflect changes and improvements in data collection, as well as changes in service delivery. For example, the Report suggests a decline in the number of WA consumers receiving accommodation support. A recent review of individual provider data returns revealed that this reflects the earlier reporting by two providers of data in the wrong categories, leading to an inflated figure for accommodation support over the years 1998–2001. When corrected for earlier years, an increase in snapshot day data over the past three years is revealed. This reflects more accurately the sustained growth in accommodation support funding under the Disability Services Commission’s Business Plan, which provided additional accommodation funding for 185 people with disabilities over the past two years.

WA supports the need for further development with regard to service quality. This year, the Disability Services Commission undertook its second telephone survey of consumer satisfaction. For the first time, the survey included both provided and funded services. A total of 450 consumers and 300 carers responded. More than 80 per cent of consumers are satisfied with the provision of accommodation support, community support (service coordination), and community access services. A major focus of the survey was Local Area Coordination, which is now available Statewide. At least three quarters of all consumers and carers believed that their local area coordinator (LAC) understood their disability needs; just over half indicated that their LAC had helped them in their decision making and half reported that their local area coordinator had helped increase the number of services/supports they could access.”

South Australian Government comments

SA supports the continuing improvements made to the national reporting of disability services data through redevelopment of the MDS reporting arrangement, particularly the move to 'whole-of-year' data reporting.

Together with improved data reporting under the HACC MDS, this will mean that disability services planning will be better informed by accurate and meaningful data. Some changes have been made in the ways in which the categories of community support are conceptualised, which means agencies in the State categorise service types in a standardised way.

In SA there is close coordination between CSDA funding and HACC funding, to ensure that they operate in complementary ways.

In SA the Options Coordination Agencies are, in effect, 'lead agencies' that work with clients around their individual needs, both referring clients to service provider agencies and also purchasing assistance in a variety of flexible ways.

The Disability Services Planning and Funding Framework for the period up until 2003 identifies the distribution of disability services in SA. There was considerable community consultation on the content of the framework document and there is broad agreement around the more important themes, including:

- agencies working together to solve problems for people with complex needs;
- the creation of community options for people currently residing in institutions;
- the development of common assessment tools to ensure benchmarking of support services for people in accommodation and day options;
- working closely with the aged care sector to develop appropriate service models for people with disabilities who are ageing; and
- clarifying the roles of the Department of Human Services as funder, and the Options Coordination Agencies as lead agencies working closely with individuals around their needs.

The 'unmet needs' funding received from the Commonwealth and State Government has allowed the Department of Human Services to address considerable demand for services.

An additional recurrent $3.15 million for new services was allocated in 2002-03 by the SA Government to address demand for accommodation and day-time support services.

Tasmanian Government Comments

“Through the improved availability of data that the redevelopment of the CSTDA NMDS collection will enable, Tasmania is looking forward to more concise and accurate information across the sector. The redeveloped data collection will also be enhanced in the State by clearer links for funded organisations within their individual Service Agreements.

The availability of qualitative data around service provision also enhances the Report. This year Tasmania has seen the introduction of a new Evaluation Process that assesses both the management structure of service outlets and the personal outcomes of service users. Data related to the new evaluation process will be available for the 2004 Report.

This year also saw the appointment of Tasmania’s first Ministerial Advisory Council. The Council’s terms of reference includes providing advice on disability policy and planning issues to the State Minister; advising on research initiatives and quality assurance matters and to facilitate consultation processes to enable community input to major policy initiatives affecting people with disabilities.

The new evaluation process and the Ministerial Advisory Council both stem from the Sector Reform process. Nearing the completion of the reform’s second phase, review of funding equalisation initiatives are still being continued, as is the development of service protocols with other key programs and agencies.

Utilisation of and demand for individually funded packages has grown steadily across the year. In 2001-02 the Individual Options Program supported 126 individuals with recurrent support (predominantly respite and personal support) and has supported 207 individuals through the provision of equipment and one off support funding allocations. The Personal Support Program assisted 61 individuals at an average allocation of 20 hours per week.

The Post School Options program has assisted 58 people in the three years of the program. An extensive review of the program was carried out providing opportunity for feedback from service users, families, service providers and other key stakeholders across the sector. The review highlighted the importance of access to learning and life skills development programs particularly for school leavers.”

Australian Capital Territory Government Comments

“On the 20 June 2002 a new Department of Disability, Housing and Community Services was announced in the ACT and came into operation on 1 July 2002.

The new Department brings together the Office of Disability, the Disability Program, Housing some parts of Child Health and Development Service and some parts of Community Services.

The Office of Disability and the Disability Program have become Disability ACT as one section of the new Department. The Disability Program is no longer a service provided by ACT Community Care but an operational arm of Disability ACT. The other functions of Disability ACT are policy, planning and partnership. It is anticipated that these arrangements will result in a more coordinated disability service sector.

The Government and the Disability Reform Group provided responses to the recommendations of the Board of Inquiry into Disability Services in the ACT in September 2002. The Government response outlined a framework for disability reform in the ACT over the period 2002–05.

The ACT Government reaffirmed its commitment to reforming the disability service and support environment, and acknowledged that reform involves changing cultures and practices through gaining knowledge about the ‘state of the art’ in the disability field.

The ACT has actively participated in the redevelopment and implementation of the CSTDA NMDS and look forward to maximising the benefits of this national data collection and continues to support the development of data which are nationally comparable.

The ACT has continued to decrease the administrative overheads for the jurisdiction over the previous year.”

Northern Territory Government comments

“ The NT welcomes the eighth report on Government services and the opportunity to comment on policy and service development initiatives in the delivery of specialist support services for people with a disability.

The NT government is committed to working collaboratively with the disability community to improve outcomes for people with a disability. In October–November 2001 the NT Government convened two key Disability Community Consultation Forums in Darwin and Alice Springs with a focus on prioritising areas of unmet need funding.

Forums were attended by people with disabilities, family members, carers, service providers, peak bodies, advocates, government representatives and members of the NT Disability Advisory Board (NTDAB).

The forums identified a number of broad areas as priorities including: Early Childhood Intervention, Post School Options, Remote Area Services, Respite, People with High Support needs, School Therapy Services and Accommodation services which will be progressively implemented over the life of the third CSTDA.

In late 2001 the NTDAB commenced the development of a whole-of-Government approach to disability services through extensive consultation with a number of departments. In partnership with government, Disability Action Plans will be finalised in 2003 which will broaden access for people with disabilities to a range of Government services across the Territory.

In particular, the needs of Indigenous people with a disability require further investigation. With this in mind the CSTDA NMDS is an essential tool for improved data on service user characteristics which will be the basis for the future planning of innovative and flexible service options.

Finally, it should be noted that when interpreting data, there are difficulties with data consistency and comparability across jurisdictions, for example, the representation of payroll tax. In addition, the development of individualised funding has led to some obscuring of boundaries between different categories of service as individualised funding brokered services are categorised as Community Support in lieu of the specific service type purchased. ”

13.7 Definitions

Table 13.2 **Terms and indicators**

Term or indicator	*Definition*
Accommodation consumers receiving community-based accommodation and care — group homes	People using CSTDA NMDS service type 1.04 as a proportion of all people using CSTDA accommodation services (excluding services provided to people with a psychiatric disability).
Accommodation consumers receiving community-based accommodation and care — other	People using CSTDA NMDS service types 1.05–1.08 as a proportion of all people using CSTDA accommodation services (excluding services provided to people with a psychiatric disability).
Accommodation consumers receiving institutional (or residential) accommodation	People using CSTDA NMDS service types 1.01–1.03 as a proportion of all people using CSTDA accommodation services (excluding services provided to people with a psychiatric disability).
Administration expenditure as a proportion of total expenditure	The numerator — expenditure (accrual) by jurisdictions on administering the system as a whole (including the regional disability program administration, regional administration, the central program policy branch administration, the disability program administration and the disability program share of corporate administration costs under the umbrella department, but excluding administration expenditure on individual services) — divided by the denominator — total government expenditure on providing and funding services for people with a disability (including expenditure on both programs and administration, direct expenditures and grants to government service providers, and government grants to non-government service providers).
Core activities as per the ABS' Survey of Disability, Ageing and Carers	Self care — bathing or showering, dressing, eating, using the toilet, and managing incontinence; mobility — moving around at home and away from home, getting into or out of a bed or chair and using public transport; and communication — understanding and being understood by strangers, family and friends in own native language or most effective method of communication.
Cost per consumer of employment service	The numerator — Commonwealth grant and case based funding expenditure (accrual) on specialist disability employment services as defined by CSTDA NMDS service types 5.01 open, 5.02 supported, 5.03 combined open and supported — divided by the denominator — number of customers who received assistance during the financial year.
Cost per government provided community-based accommodation and care place — group homes	The numerator — government expenditure (accrual) on government delivered community accommodation and care as defined by CSTDA NMDS service type 1.04 and where the service usually has six or fewer consumers — divided by the denominator — the number of places of this type on the snapshot day.
Cost per government provided community-based accommodation and care place — other	The numerator — government expenditure (accrual) on government delivered community accommodation and care as defined by CSTDA NMDS service types 1.05–1.08 divided by the denominator — the number of places of this type on the snapshot day.

(Continued on next page)

Table 13.2 **(Continued)**

Term or indicator	*Definition*
Cost per government provided institutional (residential) place	The numerator — government expenditure (accrual) on government delivered institutional (residential) accommodation, as defined by CSTDA NMDS service types 1.01, 1.02 and 1.03 — divided by the denominator — the number of places of this type on the snapshot day.
Disability	A multidimensional experience that may involve effects on organs or body parts, and effects on a person's participation in areas of life. Correspondingly, three dimensions of disability are recognised in the International Classification of Functioning, Disability and Health final draft classification: body structure and function (and impairment thereof), activity (and activity restrictions) and participation (and participation restriction) (WHO 2001). The classification also recognises the role of physical and social environmental factors in affecting disability outcomes. The 1998 ABS Survey of Disability, Ageing and Carers defined 'disability' as the presence of one or more of 17 limitations, restrictions or impairments: restrictions or impairments that have lasted, or are likely to last, for a period of six months or more: loss of sight (even when wearing glasses or contact lenses); loss of hearing; speech difficulties in native languages; blackouts, fits or loss of consciousness; slowness at learning or understanding; incomplete use of arms or fingers; difficulty gripping or holding small objects; incomplete use of feet or legs; treatment of nerves or an emotional condition; restriction in physical activities or in doing physical work; disfigurement or deformity; long term effects of head injury, stroke or any other brain damage; a mental illness requiring help or supervision; treatment or medication for a long term condition or ailment that still results in a restriction; and any other long term condition resulting in a restriction.
Employment	Employment in relation to the labour force participation rate and the employment rate is defined as persons aged 15 years and over who during the reference week: • worked for one hour or more for pay, profit, commission or payment in kind in a job or business, or on a farm; or • worked for one hour or more without pay in a family business or on a farm (ABS 1999).
Government funding per non-government provided community-based accommodation and care place — group homes	The numerator — government expenditure (accrual) on government delivered community-based accommodation and care as defined by CSTDA NMDS service type 1.04 and where the service usually has six or fewer consumers (government contributions to non-government providers per place represents only a proportion of the total cost of providing a place, with this proportion varying among jurisdictions) — divided by the denominator — the number of places of this type on the snapshot day.
Government funding per non-government provided community-based accommodation and care place — other	The numerator — government expenditure (accrual) on government delivered community-based accommodation and care as defined by CSTDA NMDS service types 1.05–1.08 (government contributions to non-government providers per place represents only a proportion of the total cost of providing a place, with this proportion varying among jurisdictions) — divided by the denominator — the number of places of this type on the snapshot day.

(Continued on next page)

Table 13.2 **(Continued)**

Term or indicator	*Definition*
Government funding per non-government provided institutional (residential) place	The numerator — government funding (accrual) to non-government delivered institutional (residential) accommodation and care, as defined by CSTDA NMDS service types 1.01, 1.02 and 1.03 (government per place contributions to non-government providers represent only a proportion of the total cost of providing a place, with this proportion varying among jurisdictions) — divided by the denominator — the number of places of this type on the snapshot day.
Labour force participation rate for people with a disability	The total number of people with a disability in the labour force (where the labour force includes employed and unemployed), divided by the total number of people with a disability aged 15 years and over and multiplied by 100. An *employed person* is a person aged 15 years or more, who in their main job during the remuneration period (reference week): • worked one hour or more for pay, profit, commission or payment in kind in a job or business, or on a farm (including employees, employers and self-employed persons); • worked one hour or more without pay in a family business, or on a farm (excluding persons undertaking other unpaid voluntary work); or • was an employer, employee or self employed person or unpaid family helper who had a job, business or farm, but was not at work. An *unemployed person* is a person aged 15 years or more who was not employed during the remuneration period, but was looking for work.
Labour force participation rate for the total population	Total number of people aged 15 years or more in the labour force (where the labour force includes both employed and unemployed people) divided by the total number of people aged 15 years and over and multiplied by 100.
Mild core activity restriction (as per the 1998 ABS Survey of Disability, Ageing and Carers)	Having no difficulty performing a core activity, but using aids or equipment as a result of a disability.
Moderate core activity restriction (as per the 1998 ABS Survey of Disability, Ageing and Carers)	Not needing assistance but having difficulty performing a core activity.
Non-English speaking origin	People with a country of birth other than Australia, New Zealand, Canada, United Kingdom, South Africa, Ireland or the United States.
People using CSTDA accommodation support services	People using one or more services corresponding to the following CSTDA NMDS service types on the snapshot day: 1.01 large residentials/institutions (more than 20 people); 1.02 small residentials/institutions (7–20 people); 1.03 hostels; 1.04 group homes (less than 7 people); 1.05 attendant care/personal care; 1.06 in-home accommodation support; 1.07 alternative family placement; and 1.08 other accommodation support.
People using CSTDA community access services	People on the snapshot day using one or more services corresponding to the following CSTDA NMDS service types: 3.01 learning and life skills development; 3.02 recreation/holiday programs; and 3.03 other community access.

(Continued on next page)

Table 13.2 **(Continued)**

Term or indicator	*Definition*
People using CSTDA community support services	People on the snapshot day using one or more services corresponding to the following CSTDA NMDS service types: 2.01 therapy support for individuals; 2.02 early childhood intervention; 2.03 behaviour/specialist intervention; 2.04 counselling; 2.05 regional resource and support teams; 2.06 case management, local coordination and development; and 2.07 other community support.
People using CSTDA employment services	People on the snapshot day using one or more services corresponding to the following CSTDA NMDS service types: 5.01 open employment; 5.02 supported employment; and 5.03 combined open and supported employment.
People using CSTDA respite services	People on the snapshot day using one or more services corresponding to the following CSTDA NMDS service types: 4.01 own home respite; 4.02 centre based respite/respite homes; 4.03 host family respite/peer support respite; 4.04 flexible/combination respite; and 4.05 other respite.
Potential labour force	The population with the potential to require disability employment services. This is estimated as the 'potential population' (see following) aged 15–64 years with a severe or profound core activity restriction. Jurisdiction-specific potential labour force estimates include adjustment for labour force participation rates and the Indigenous population. Some performance indicators use these estimates as denominators.
Potential population	The population with the potential to require disability support services. The ABS' concept of 'severe or profound' core activity restriction, relating as it does to the need for assistance with everyday activities of self care, mobility and verbal communication, was argued to be the most relevant population figure for disability services. The relatively high standard errors in the prevalence rates for smaller jurisdictions, as well as the need to adjust for the Indigenous population, necessitated, however, the preparation of special estimates of the 'potential population' for disability services. These estimates, prepared by the AIHW, were used in the performance indicators when population data were needed in the denominator. Briefly, the 1998 national age and sex specific rates of severe and profound core activity restriction for people aged under 65 years were applied to the current year age and sex structure of each jurisdiction in the current year to give an 'expected current estimate' of people with a severe or profound core activity restriction who were aged under 65 years in that jurisdiction. People of Indigenous status were given a weighting of 2 in these estimates, in recognition of their greater prevalence rates of disability and their relatively greater representation in CSTDA services (AIHW 2000a).
Primary carer	A person of any age who provides the most informal assistance, in terms of help or supervision, to a person with one or more disabilities. The assistance has to be ongoing, or likely to be ongoing, for at least six months and be in one or more of the areas of self care, mobility and/or communication (ABS 1998).

(Continued on next page)

Table 13.2 **(Continued)**

Term or indicator	*Definition*
Profound core activity restriction (as per the 1998 ABS Survey of Disability, Ageing and Carers)	Being unable to perform a core activity or always needing assistance.
Proportion of people with a disability employed	Total number of people with a disability aged 15 years or more who are employed, divided by the total number of people with a disability aged 15 years or more in the labour force and multiplied by 100.
Proportion of people with a disability unemployed	Total number of people with a disability aged 15 years or more who are unemployed, divided by the total number of people with a disability aged 15 years or more in the labour force and multiplied by 100.
Proportion of the total population employed	Total number of people aged 15–64 years who are in the labour force and employed, divided by the total number of people aged 15–64 years in the labour force.
Proportion of the total population unemployed	Total number of people aged 15–64 years who are in the labour force but unemployed, divided by the total number of people aged 15–64 years in the labour force.
Real expenditure	Actual expenditure (accrual) adjusted for changes in prices, using the GDP(E) price deflator, and expressed in terms of the base year (2001-02) dollars.
Schooling or employment restriction	*Schooling restriction*: as a result of disability, being unable to attend school; having to attend a special school; having to attend special classes at an ordinary school; needing at least one day a week off school on average; and/or having difficulty at school. *Employment restriction*: as a result of disability, being permanently unable to work; being restricted in the type of work they can do; needing at least one day a week off work on average; being restricted in the number of hours they can work; requiring an employer to provide special equipment, modify the work environment or make special arrangements; needing to be given ongoing assistance or supervision; and/or finding it difficult to change jobs or to get a better job.
Severe core activity restriction (as per the 1998 ABS Survey of Disability, Ageing and Carers)	Sometimes needing assistance to perform a core activity.
Specific restrictions (as per the 1998 ABS Survey of Disability, Ageing and Carers)	Core activity restrictions and/or schooling or employment restrictions.

13.8 References

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14 Children's services

Children's services aim to meet the care, education and development needs of children, although the emphasis on these broad objectives may differ across the services. Child care is provided to children aged 12 years and younger, by someone other than the child's parents or guardian. Preschool services are provided to children mainly in the year or two before those children commence full time schooling.

This chapter presents performance and descriptive information for government funded and/or delivered child care and preschool services. Unless otherwise stated, the data presented in this chapter relate to services that are provided for children aged 12 years and younger and that are supported by the Commonwealth, State and Territory governments. Local governments also plan, fund and deliver children's services; given data limitations, however, this chapter records data on local government activities only where Commonwealth, State and Territory funding and licensing are involved. The chapter does not include services that do not receive government funding (unless otherwise noted).

A profile of children's services is presented in section 14.1. This provides a context for assessing the performance indicators presented later in the chapter. All jurisdictions have agreed to develop, and aim to report, comparable indicators, and a framework of performance indicators is outlined in section 14.2. The data are discussed in section 14.3 and future directions for performance reporting are discussed in section 14.4. The chapter concludes with jurisdictions' comments in section 14.5. Definitions of terms specific to children's services are found in section 14.6.

Supporting tables

Supporting tables for chapter 14 are provided on the CD-ROM enclosed with the Report. The files are provided in Microsoft Excel 97 format as \Publications\Reports\2003\Attach14A.xls and in Adobe PDF format as \Publications\Reports\2003\Attach14A.pdf.

Supporting tables are identified in references throughout this chapter by an 'A' suffix (for example, table 14A.3 is table 3 in the electronic files). These files can be found on the Review web page (http://www.pc.gov.au/gsp/2003/index.html). Users without Internet access can contact the Secretariat to obtain these tables (see details on the inside front cover of the Report).

14.1 Profile of children's services

Service overview

Children's services include:

- *centre based long day care* — services aimed primarily at 0–5 year olds provided in a centre usually by a mix of qualified and other staff. Educational and recreational programs are provided based on the developmental needs, interests and experience of each child. Centres typically operate for at least eight hours a day on normal working days for a minimum of 48 weeks per year;
- *family day care* — services provided in the carer's own home. The care is largely aimed at 0–5 year olds, but primary school children may also receive care before and after school, and during school vacations. Central coordination units in all States and Territories organise and support a network of carers, often with the help of local governments;[1]
- *occasional care* — services usually provided at a centre on an hourly or sessional basis for short periods of time or at irregular intervals specifically for parents who need time to attend appointments, take care of personal matters, undertake casual and part time employment, study or have temporary respite from full time parenting. These services provide developmental activities for children and are aimed primarily at 0–5 year olds. Centres providing these services usually employ qualified staff;
- *preschool* — services usually provided by a qualified teacher on a sessional basis in dedicated preschools. Preschool programs or curriculum may also be provided in long day care centres and other settings. These services are primarily aimed at children in the year before they commence full time schooling (that is, when children are four years old in all jurisdictions except WA where children

[1] In WA, all carers providing care in their own home are licensed and supported by the Department for Community Development, but data on those who are not supported by the department's coordination units are not included in this chapter. NSW and Tasmania license home-based carers who are not part of a family day care scheme, but data on these carers are not included in this chapter.

are five years old), although younger children may also attend in NSW, Queensland, WA, SA and the ACT;

- *outside school hours care* — services provided for school aged children (5–12 year olds) outside school hours during term and vacations. Care may be provided on student free days and when school finishes early; and
- *other services* — government funded services to support children with additional needs or in particular situations (including children from an Indigenous background, children from non-English speaking backgrounds, children with a disability or of parents with a disability, and children living in remote and rural areas).

Roles and responsibilities

The Commonwealth, State and Territory governments have different but complementary roles in supporting children's services. Both levels of government help fund services, provide information and advice to parents and service providers, and help plan, set and maintain operating standards.

The Commonwealth Government's roles and responsibilities for child care include:

- assisting families to participate in the social and economic life of the community through the provision of child care services and payments (such as Child Care Benefit);
- developing a quality assurance system for outside school hours care;
- planning the location of services in conjunction with other levels of government;
- providing information and advice to parents and providers about the availability of Commonwealth funded services and some State and Territory funded services;
- helping to enhance the quality of child care by funding the National Childcare Accreditation Council to administer the Quality Improvement and Accreditation System (QIAS) for long day care centres and Family Day Care Quality Assurance for family day care schemes. These quality systems are mandatory for services eligible for government funding;
- providing information, support and training to service providers through funding to organisations; and
- providing operational and capital funding to some providers.

State and Territory governments' roles and responsibilities vary across jurisdictions and may include:

- providing operational and capital funding to non-government service providers;
- delivering some services directly (especially preschool services);
- developing new child care and preschool services;
- licensing and setting standards for children's services providers;
- monitoring and resourcing licensed and/or funded children's services providers;
- providing information, support, training and development opportunities for providers;
- assisting services in enhancing quality by providing curriculum and policy support and advice, as well as training and development for management and staff;
- planning to ensure the appropriate mix of services is available to meet the needs of the community;
- providing information and advice to parents and others about operating standards and the availability of services; and
- providing dispute resolution and complaints management processes.

The major differences in the roles of the different levels of government relate to each level's objectives for children's services. The primary focus of the Commonwealth Government is support for families through payments such as Child Care Benefit, which is payable to families using approved child care services or registered informal carers. State and Territory governments place a greater emphasis on providing educational and developmental opportunities for children, such as preschool services.

Quality of care

Both levels of government are active in maintaining the quality of care provided by children's services. The mechanisms used to maintain quality are accreditation, licensing, and performance standards and outcomes linked to funding. These are used in addition to the provision of curriculum and policy support and advice, and the training and development of management and staff.

Licensing

State and Territory licensing requirements establish the foundations for quality of care by stipulating enforceable standards to support the health, safety, welfare and developmental needs of children in formal child care settings. Accreditation of services is built on this platform.

State and Territory governments are responsible for licensing children's services in their jurisdiction. This responsibility involves setting regulatory requirements and monitoring adherence to these standards. State and Territory governments also undertake activities aimed at quality promotion, such as, publishing curriculum materials and other resources, and undertaking consumer education. The types of service covered by legislation vary across States and Territories, as do the standards that apply.

Licensed children's services may include centre based long day care, occasional care, preschools, family day care and outside school hours care. Commonwealth, State and Territory governments have developed national standards for centre based long day care, family day care and outside school hours care. Jurisdictions refer to these standards when writing regulations. The extent of implementation of these standards varies across Australia.

Accreditation

In 1994, the Commonwealth Government introduced the QIAS to improve the quality of Commonwealth funded centre based long day care services. Centre based long day care centres are required to participate in the system to remain as eligible centres for Child Care Benefit purposes (and previously for Child Care Assistance). The Commonwealth introduced a quality assurance scheme for family day care from 1 July 2001. It is also developing quality assurance mechanisms for outside school hours care. In addition, SA and Victoria have implemented quality assurance or improvement systems for preschools, while some other jurisdictions are developing such systems.

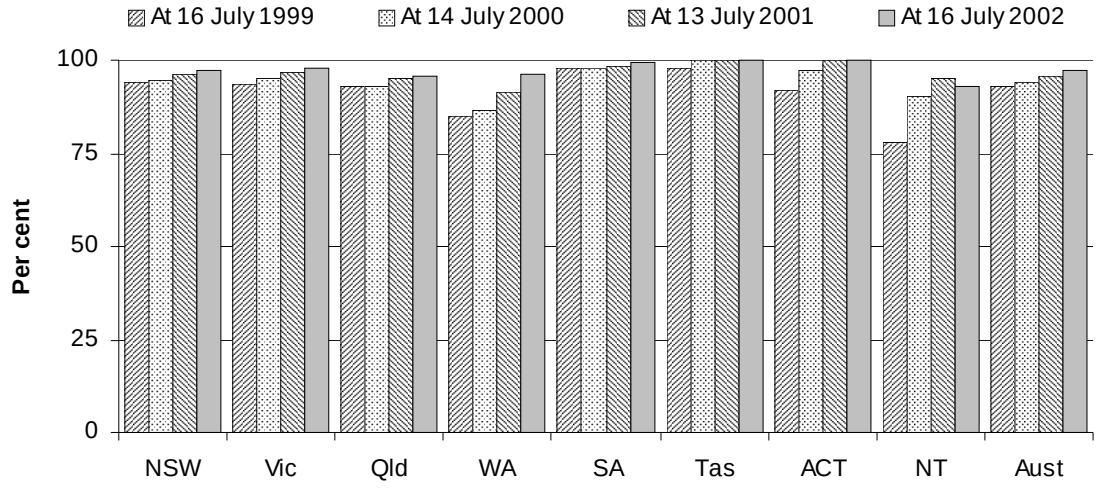
The QIAS system was modified as of 1 January 2002. Revised standards and processes were implemented, and the previous three-tier accreditation review process (whereby centres were accredited for periods of three years, two years or one year) was replaced with a single accreditation period of two and a half years. All centres achieving accreditation under the previous system were transferred to the new single accreditation period.

There were 4136 centres participating in the accreditation process in July 2002: 3774 centres that were fully accredited; 256 centres that were in self study, review or moderation, or awaiting an accreditation decision; and 106 centres that were not accredited (table 14A.2). These centres collectively represent all centre based long day care services receiving Child Care Benefit and the majority of all centre based long day care services operating in Australia.

Nationally, 91.2 per cent of all centres were accredited at 16 July 2002. A further 6.2 per cent of all centres were in the process of self study, review or moderation, or awaiting an accreditation decision and 2.6 per cent were not accredited (derived from table 14A.2). Centres that do not have accreditation must work towards gaining accreditation to retain their eligibility for Child Care Benefit. The Commonwealth Government funds resource and advisory services across the country to assist centres participating in quality assurance systems.

Of those centres that had completed the accreditation process at 16 July 2002, 97.3 per cent were successful. This proportion varied from 100 per cent in Tasmania and the ACT to 92.9 per cent in the NT, and has increased over time in all jurisdictions (except the NT, which had a decrease last year) participating in the process (figure 14.1).

Figure 14.1 **Accredited centres as a proportion of centres fully assessed under QIAS[a, b]**



a Figures may change daily and are updated every six weeks following a National Childcare Accreditation Council meeting. **b** Results for Tasmania, the ACT and the NT may be unduly influenced by the relatively small number of services (57, 81 and 45 respectively, at 16 July 2002) participating in the process.

Source: National Childcare Accreditation Council. (unpublished); table 14A.2.

Funding performance standards and outcomes

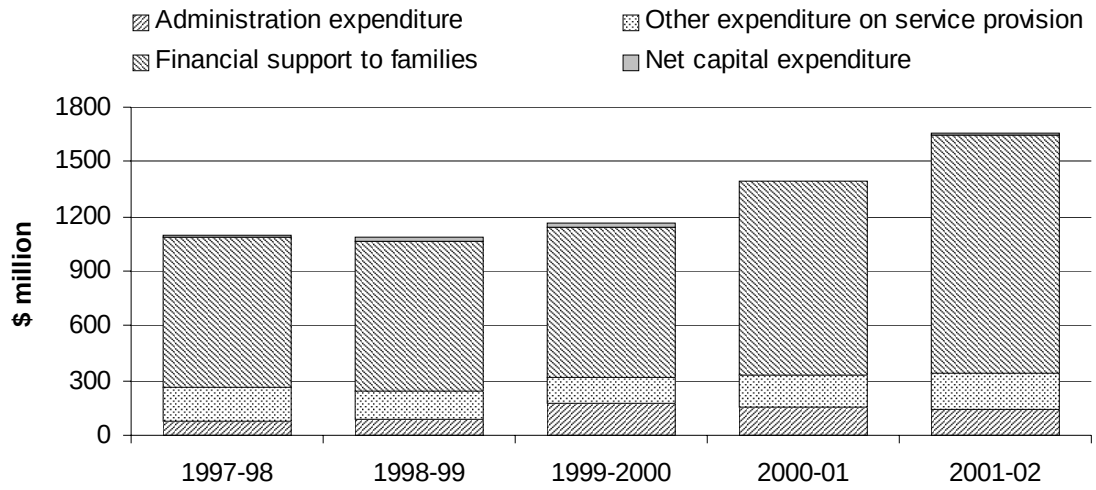
State and Territory governments impose varying requirements for funding children's services. These requirements may include: the employment of higher qualified staff than required by licensing or minimum standards; self assessment of quality; and a demonstration of the delivery of quality educational and recreational programs.

Funding

Commonwealth, State and Territory government expenditure on children's services amounted to approximately $2.2 billion in 2001-02 (compared with $1.8 billion in real terms in 1999-2000 and $2.0 billion in 2000-01) (table 14A.4).

Commonwealth Government expenditure in 2001-02 accounted for approximately $1.7 billion. The major component of this expenditure was financial support to families through assistance with fees, which accounted for 79.4 per cent ($1.3 billion). Administration expenditure for national, State and Territory offices accounted for a further 8.7 per cent ($144 million). Other expenditure on service provision and net capital expenditure accounted for the remaining 11.8 per cent ($194 million) and 0.2 per cent ($3 million) respectively (figure 14.2).

Figure 14.2 **Commonwealth Government real expenditure on children's services (2001-02 dollars)**



Source: Department of Family and Community Services (unpublished); table 14A.4.

State and Territory government expenditure accounted for approximately $537 million of total government expenditure on children's services in 2001-02. Recurrent expenditure on service provision comprised around 47.5 per cent ($255.2 million) of State and Territory government expenditure. Administration, financial support to families and net capital expenditure accounted for 39.3 per cent ($211.0 million), 8.3 per cent ($44.8 million) and 4.9 per cent ($26.3 million) respectively (table 14A.4). In the distribution of total State and Territory government expenditure across all children's service types, the provision of preschool services accounted for the largest proportion (around 77.7 per cent, or $417.7 million, for those jurisdictions for which data are available) (tables 14A.19, 14A.28, 14A.37, 14A.46, 14A.55, 14A.64, 14A.73 and 14A.82).

The Commonwealth Government provides a small amount of funding to Queensland and WA directly for the preschool year (for more information, see AIHW 1997). The Commonwealth also provides supplementary funding for the preschool education of children from Indigenous backgrounds.

Size and scope

Child care services

The Commonwealth Government supported approximately 500 000 child care places in 2001-02, providing care for 14.6 per cent of children aged 12 years and younger (tables 14A.1 and 14A.7) — an increase of just over 42 000 places over 2000-01. The majority of Commonwealth child care places were outside school hours care places (46.1 per cent), followed by centre based long day care places (38.8 per cent), family day care places (14.2 per cent), occasional care places (0.6 per cent) and other care places (0.4 per cent) (table 14A.7). State and Territory governments supported at least 207 000 preschool places in 2001-02 (tables 14A.20, 14A.29, 14A.38, 14A.47, 14A.56, 14A.65 14A.74 and 14A.83).

Approximately 850 000 children (24.9 per cent of children aged 12 years and younger) used Commonwealth, State and Territory government funded and/or provided child care in 2001-02 (tables 14.1, 14A.1, 14A.9, 14A.21, 14A.30, 14A39, 14A.48, 14A.57, 14A.66, 14A.75 and 14A.84). Of these children, at least 575 000 were aged five years and younger. Changes to approaches to data collection and the exclusion of certain services funded by some jurisdictions reduce the comparability of these data across jurisdictions.

Table 14.1 **Proportion of children in the population attending Commonwealth, State and Territory government funded and/or provided child care, 2001-02 (per cent)**

Age	*NSW*	*Vic*	*Qld*	*WA* [a]	*SA*	*Tas*	*ACT*	*NT*	*Aust*
0–5 years	49.1	27.7	40.5	23.7	31.5	35.5	42.7	20.6	37.6
0–12 years	29.7	19.8	27.5	15.3	25.9	22.8	31.2	17.4	24.9

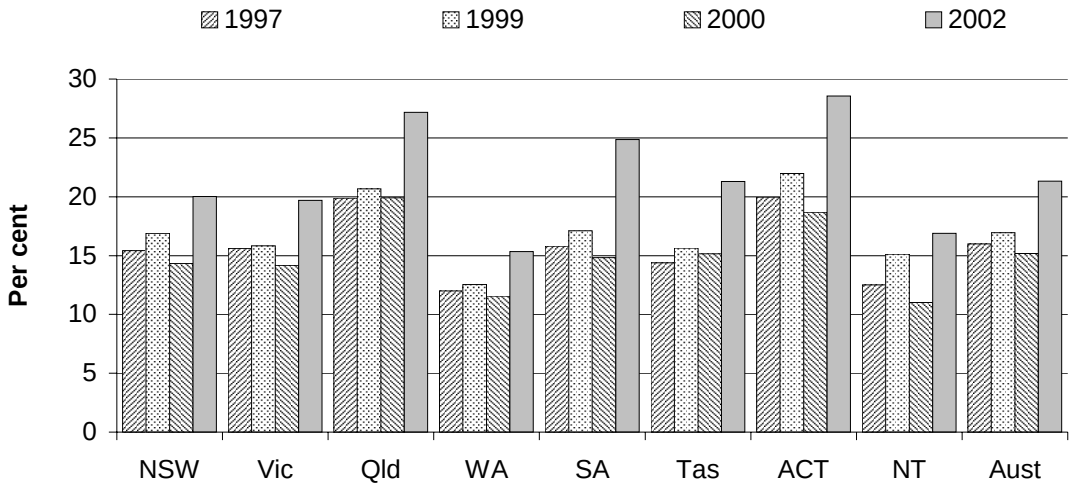
[a] Data for WA do not include children attending kindergartens for four year olds provided by the Department of Education who would otherwise be in child care.

Source: Australian Bureau of Statistics (ABS) (unpublished), *Population by Age and Sex, Australian States and Territories*, Cat. no. 3201.0; ABS (unpublished), *Population Projections 1997 to 2051*, Cat. no. 3222.0; Commonwealth Census of Child Care Services (CCCCS), May 2002 (unpublished), State and Territory governments (unpublished); tables 14A.1, 14A.9, 14A.21, 14A.30, 14A.39, 14A.48, 14A.57, 14A.66, 14A.75 and 14A.84.

Approximately 728 500 Child Care Benefit-eligible children aged 12 years and younger (21.0 per cent of all children in this age group) attended Commonwealth Government approved child care in May 2002. Across jurisdictions, the proportion ranged from 28.6 per cent in the ACT to 15.3 per cent in WA (figure 14.3). The majority (475 505 nationally, or 65.3 per cent) of those children were aged five years and younger. In May 2002, 31.1 per cent of children aged five years and younger attended Commonwealth funded and/or provided child care services (tables 14.A1 and 14A.9).

The average hours of attendance for Child Care Benefit-eligible children in Child Care Benefit-eligible services in May 2002 varied considerably across jurisdictions, for all service types. The average attendance per child at centre based long day care centres in 2002 ranged from 28.4 hours a week in the NT to 14.5 hours a week in Tasmania, while the average attendance per child at occasional care services ranged from 10.2 hours a week in Queensland to 7.5 hours a week in Victoria. The average attendance per child at vacation care ranged from 3.9 days a week in the NT to 2.5 days a week in Tasmania (table 14A.8).

Figure 14.3 **Proportion of children aged 0–12 years using Commonwealth approved child care services**[a, b, c, d, e]



a Children are defined as persons aged 12 years and younger. **b** Excludes children cared for in neighbourhood model services. **c** Australian total includes children in other Territories. **d** Note that data for 1997, 1999 and 2002 are drawn from the respective CCCCS, while data for 2000 are drawn from Centrelink administrative data. The CCCCS and Centrelink data are not fully comparable and such comparisons need to be treated with care. **e** Data for WA exclude children attending kindergartens for four year olds, provided by the Department of Education, who would otherwise be in childcare.

Source: ABS (unpublished), *Population by Age and Sex, Australian States and Territories*, Cat. no. 3201.0; ABS (unpublished), *Population Projections 1997 to 2051*, Cat. no. 3222.0; CCCCS, May 2002 (unpublished); Centrelink administrative data, August 2000 (unpublished); table 14A.9.

Preschool services

Preschools provide a range of educational and developmental programs (generally on a sessional basis) to children in the year immediately before they commence full time schooling and also, in some jurisdictions, to children aged three years or under (children aged four years or under in WA). The age from which children may attend preschools varies across jurisdictions. Children in Victoria, Tasmania, the ACT and the NT are usually funded by government to attend preschool in the year before they commence schooling. Younger children in NSW, Queensland, WA, SA, Tasmania and the ACT may also access government funded preschool services. In Tasmania, the flexibility to enrol children of pre-kindergarten age is permitted only under limited circumstances (such as for gifted children or children previously enrolled in another State or Territory but who now reside in Tasmania).

Younger Indigenous children living in remote areas also may attend preschools in the NT and Queensland. In SA, a pre-entry program provides one session of preschool a week for ten weeks in the term before preschool, and children from Indigenous backgrounds may attend preschool at three years of age. In the ACT, children from Indigenous backgrounds, children with English as a second language, and children with a hearing impairment and/or whose parents have a hearing impairment may be eligible for early entry into preschool (for 5.25 hours a week) at three years of age.

This disparity in the age from which children may access preschool services has reduced the comparability of preschool data across jurisdictions. Preschool data are presented for two categories to improve comparability:

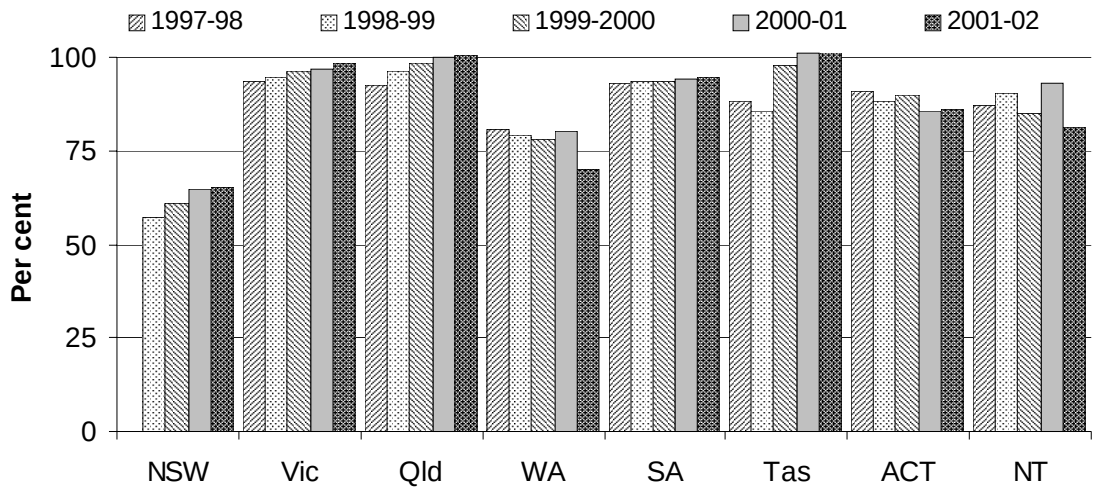
- children attending preschool in the year immediately before they commence full time schooling (data that are largely presented on a comparable basis for all jurisdictions); and
- younger children attending preschool services.

At least 240 000 children attended State and Territory funded and/or provided preschool services in 2001-02. The majority (89.1 per cent, or approximately 214 000 children) were to begin full time schooling the following year (tables 14A.21, 14A.30, 14A.39, 14A48, 14A.57, 14A.66, 14A.75, 14A.84).

Some jurisdictions differ in their age criterion for access to preschool services; as a result, the following data need to be interpreted with caution. Approximately 84.1 per cent of children of four years of age in 2000-01 attended preschool in the year immediately before they commenced school. Across jurisdictions for which 2001-02 data were available, this proportion ranged from about 100 per cent in Queensland and Tasmania to 65.4 per cent in NSW. There is some double counting

in several jurisdictions, as well as synchronisation issues leading to overestimation of the attendance rates being reported (figure 14.4).

Figure 14.4 **Proportion of children in the population who attended State and Territory government funded and/or provided preschool services immediately before the commencement of full time schooling[a, b, c, d, e, f]**



a The denominator — the population of preschool aged children — is defined as persons aged four years in all States and Territories. **b** Data for 1997-98 were for the calendar year ending 1997; data for 1998-99 were for the calendar year ending 1998. There is some double counting of children in all jurisdictions (except SA, Tasmania and the ACT) because they moved in and out of the preschool system throughout the year; as a result, the number of children in preschool exceeds the number of children in the target population. There is no double counting for SA, Tasmania and the ACT because a snapshot is used for each year's data collection (so children appear in only one preschool centre in one year at the time of the snapshot). **c** NSW used a revised method of calculating the number of children receiving child care and preschool services. This new method of calculation will provide clear trend data for each age group for child care and preschool. The data include estimates based on the rate of survey return for each year. NSW data are not comparable with data for other States and Territories. Data for 1997-98 are not comparable with data for future years. **d** Victorian data include some children attending preschool services conducted in a centre based long day care centre. **e** Queensland data include non-government preschool data for the first time in 1997-98. **f** WA data exclude children attending non-government preschools. 2001-02 data are affected by WA's alteration of entry age from five to four years.

Source: ABS (unpublished), *Population by Age and Sex, Australian States and Territories*, Cat. no. 3201.0; ABS (unpublished), *Population Projections 1997 to 2051*, Cat. no. 3222.0; State and Territory governments (unpublished); tables 14A.1, 14A.21, 14A.30, 14A.39, 14A.48, 14A.57, 14A.66, 14A.75 and 14A.84.

Younger children in NSW, Queensland, SA and the ACT were able to attend funded preschool services in 2001-02. Approximately 26 100 younger children attended preschool services in that year — around 16.3 per cent of children of three years of age. The participation rate differed across jurisdictions, reflecting variation in policies on access to funded preschool services. The proportion of children of three years of age attending preschool services in 2001-02 was 12.7 per cent in NSW, 21.1 per cent in Queensland, 25.4 per cent in SA (where younger children may attend a pre-entry program for one term in the year before preschool) and 3.1 per

cent in the ACT (tables 14A.1, 14A.21, 14A.30, 14A.39, 14A.48, 14A.57, 14A.66, 14A.75 and 14A.84).

All jurisdictions except NSW and Victoria supplied data on the average hours of attendance for government funded and/or provided preschool services in 2001-02. The average attendance of children in the year immediately before they commenced full time schooling ranged from 12.9 hours a week in Queensland to 10.4 hours a week in Tasmania (tables 14A.20, 14A.29, 14A.38, 14A.47, 14A.56, 14A.65, 14A.74 and 14A.83).

Employment status of parents

Access to children's services differs according to the service type. The workforce status of parents is one factor that may influence children's access to services. Those services that were eligible for Child Care Benefit, for example, gave a high priority to children at risk and children of parents with work-related child care needs. Occasional care gives priority to parents requiring care to meet other requirements (such as to attend appointments, to take care of personal matters or to have temporary respite from full time parenting).

Details of the labour force status of parents whose children using services are shown in table 14A.12. The data were drawn from The Australian Bureau of Statistics (ABS) Child Care Surveys conducted in 1996 (ABS 1996) and 1999 (ABS 2000) and reported in the 2002 Report.

Services by management type

Children's services are managed by the government (State, Territory and local), community and private sectors. The management structure of services indicates the involvement of these various sectors in the direct delivery of children's services.

The data on the management type of child care, which are limited, need to be interpreted with care because the scope of the data collection varies across jurisdictions. Available data on the management type of preschool services in 2000-01, although more complete, also indicate considerable variation across jurisdictions (table 14.2).

Table 14.2 **Proportion of State and Territory licensed and/or registered children's services, by management type, 2001-02 (per cent)[a]**

	NSW	*Vic*[b]	*Qld*	*WA*	*SA*	*Tas*[c]	*ACT*	*NT*[d]
Child care								
Community managed[e]	30.4	95.8	36.5	59.9	43.4	53.6	86.1	100.0
Private[f]	69.6	0.9	63.5	36.0	29.2	20.3	13.9	–
Employer sponsored	–	**na**	**na**	–	–	–	–	–
Government managed	–	3.3	**na**	4.1	27.4	26.1	–	–
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**
Preschool								
Community managed[e]	90.3	63.8	24.0	9.4	4.8	..	8.0	–
Private[f]	9.7	21.7	17.9	**na**	–	22.0	–	–
Employer sponsored	–	**na**	**na**	–	–	..	–	–
Government managed	–	14.5	58.1	90.6	95.2	78.0	92.0	100.0
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**

a Excludes Commonwealth supported services. **b** All government managed preschools in Victoria are managed by local government. **c** Preschools include funded non-government preschools. **d** Preschool services are provided by the Department of Education directly, but a range of management functions are devolved to school councils and parent management committees. **e** Community managed services include not-for-profit services provided or managed by parents, churches, or co-operatives **f** Private for-profit services provided or managed by a company, private individual or a non-government school. **na** Not available. **..** Not applicable. **–** Nil or rounded to zero.

Source: State and Territory governments (unpublished); tables 14A.24, 14A.33, 14A.42, 14A.51, 14A.60, 14A.69, 14A.78 and 14A.87.

14.2 Framework of performance indicators

The framework of performance indicators is based on common objectives for children's services across Australia (box 14.1). The relative emphasis placed on each objective varies across jurisdictions.

Box 14.1 **Objectives for children's services**

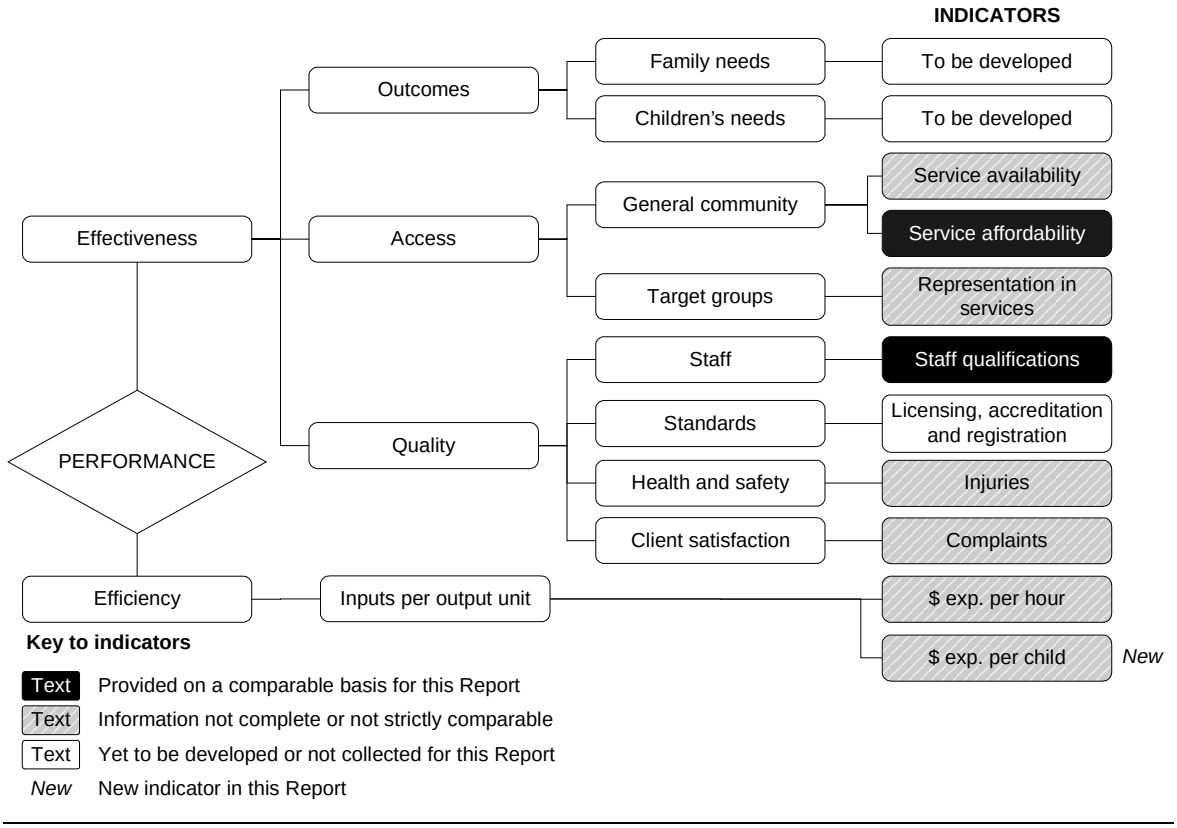
Children's services aim to:

- meet the care, education and development needs of children in a safe and nurturing environment;
- provide support for families in caring for their children; and
- provide these services in an equitable and efficient manner.

A performance indicator framework consistent with these objectives is summarised in figure 14.5. The framework shows which data are comparable in the 2003 Report. For data that are not considered strictly comparable, the text includes

relevant caveats and supporting commentary. Chapter 1 discusses data comparability from a Report wide perspective (see section 1.6).

Figure 14.5 **Performance indicators for children's services**



New and refined indicators

The performance indicator framework has been improved for the 2003 Report to ensure it remains consistent with the agreed objectives for children's services. It includes two new indicators for the first time:

- a quality indicator for staff qualifications; and
- a proxy efficiency indicator for State and Territory expenditure per child.

Among other work on improvements to the framework, the Working Group is developing a quality indicator for licensing, accreditation and registration, and additional efficiency indicators. Refinement of the financial and nonfinancial data counting rules and the collection process is expected to contribute to improved comparability of data across jurisdictions in future reports.

In conjunction with the introduction of the proxy efficiency indicator for State and Territory expenditure (figure 14.15) and the development of further efficiency measures, the Steering Committee agreed to delete the indicator of administrative efficiency for the States and Territories for the 2003 Report.

14.3 Key performance indicator results

Different delivery contexts, locations and types of client may affect the effectiveness and efficiency of children's services. Most of the data available for reporting in this chapter are not comparable across jurisdictions. Appendix A contains contextual information, which may assist in interpreting the performance indicators presented in this chapter.

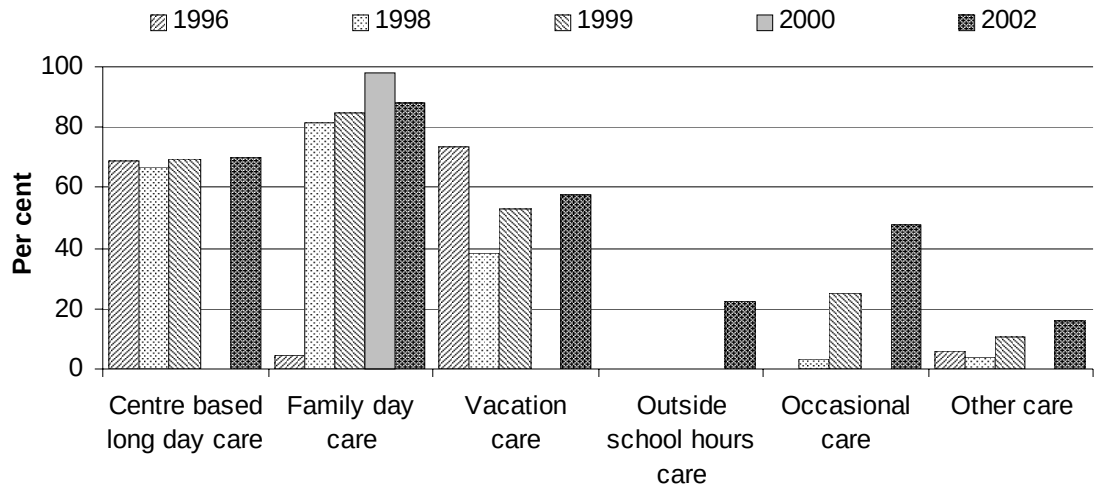
Effectiveness

Access of general community — service availability

An indicator of community access to children's services is the proportion of services offering nonstandard hours of care. What constitutes nonstandard hours varies across service types, and a full explanation can be found in the definitions section in table 14.5.

The 2002 Commonwealth Census of Child Care Services (CCCCS) found that 87.8 per cent of family day care services nationally provided non-standard hours of care in May 2002 (table 14A.13). Centre based long day care had the next highest proportion (70.5 per cent), followed by vacation care (57.7 per cent), occasional care (47.7 per cent), outside school hours care (22.5 per cent) and other care (16.1 per cent) (figure 14.6).

Figure 14.6 **Proportion of Commonwealth approved child care services providing nonstandard hours of care, by service type[a, b]**



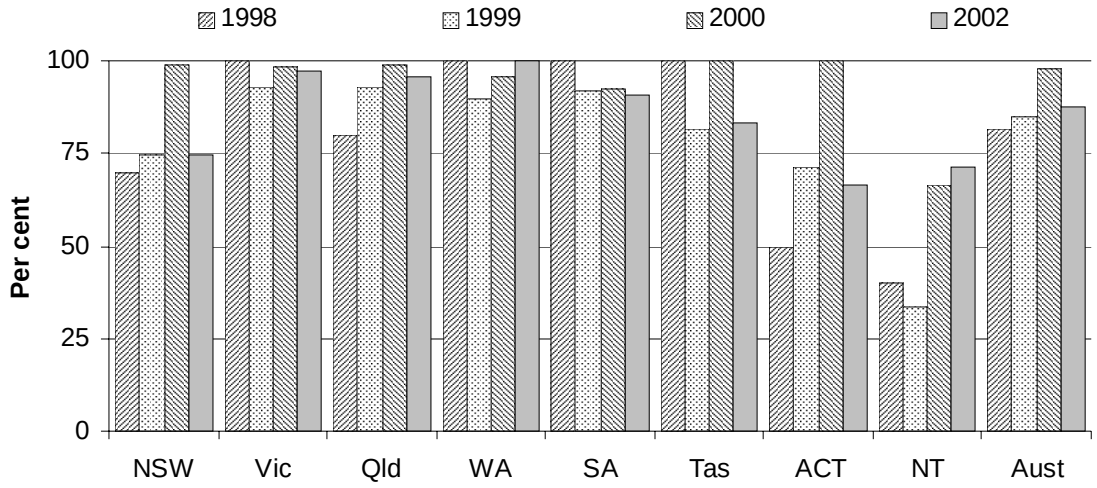
a Only family day care can be reported for 2000-01. **b** Comparison between 2002 data and data for other years is not possible due to different data collection methods and time frames.

Source: CCCCS, August 1997, May 1999 and May 2002 (unpublished); Centrelink administrative data, August 2000 (unpublished); table 14A.13.

In Victoria, Queensland, WA and SA, more than 90 per cent of family day care schemes offered nonstandard hours in May 2002. In NSW, Tasmania, the ACT and the NT less than 90 per cent of these schemes offered nonstandard hours of care (figure 14.7).

Limited data were available on the proportion of services not included in the CCCCS that were offering nonstandard hours of care. Three jurisdictions were able to provide data on nonstandard hours of preschool for 2001-02: 69.4 per cent of preschools in NSW (table 14A.25) and 66.3 per cent of preschools in SA (table 14A.61). In SA, preschools are encouraged to offer back-to-back preschool services to assist parents, particularly in country regions where the need to travel long distances would make it impractical for children to attend preschool more frequently (see footnotes to table 14A.61).

Figure 14.7 **Proportion of Commonwealth approved family day care services providing nonstandard hours of care[a]**



a Comparison between 2002 and other years is not possible due to different data collection methods and time frames.

Source: CCCCS, August 1997, May 1999 and May 2002 (unpublished); Centrelink administrative data, August 2000 (unpublished); table 14A.13.

Access of general community — service affordability

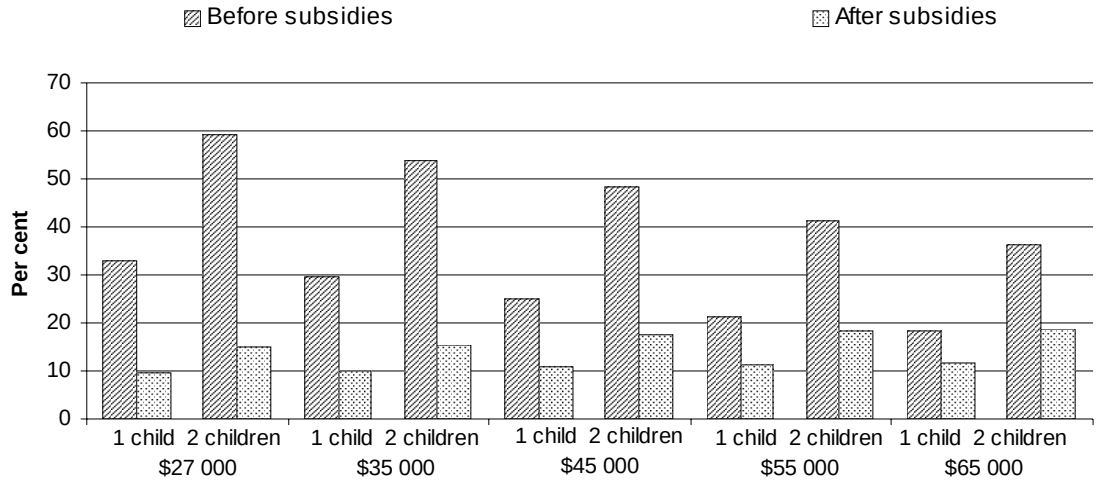
This indicator measures out-of-pocket child care costs as a proportion of weekly disposable income at July 2002 before and after the payment of child care subsidies. Care needs to be exercised when interpreting results because a variety of factors may influence fees.

Out-of-pocket costs are estimated for families with one child in care and families with two children in care, for five indicative levels of gross annual family income. Only data for centre based long day care and family day care services are available, with data for other service types expected to become available over time. The calculation is based on children attending full time care (equal to 50 hours per child per week) in centre based long day care and family day care at May 2002.

After the payment of child care subsidies, out-of-pocket costs as a proportion of weekly family income increase with gross annual family income. Nationally, families with one child in full time centre based long day care at May 2002 and an annual gross family income of $27 000 spent 9.5 per cent of their weekly disposable income on child care (compared with 33.0 per cent before payment of child care subsidies). By contrast, families with one child in care and an annual gross family income of $65 000 spent 11.8 per cent of their weekly disposable income on child

care (compared with 18.4 per cent before payment of child care subsidies) (figure 14.8).

Figure 14.8 **Out-of-pocket costs of child care for families with children in full time centre based long day care, as a proportion of weekly disposable income, by gross annual family income, 2002[a, b]**



a Disposable income calculations are based on 1 July 2002 tax and payment parameters. Calculations are modelled on dual-income couple families (60:40 income split) with one or two dependent children aged under five years. **b** Out-of-pocket cost calculations are based on May 2002 average fees.

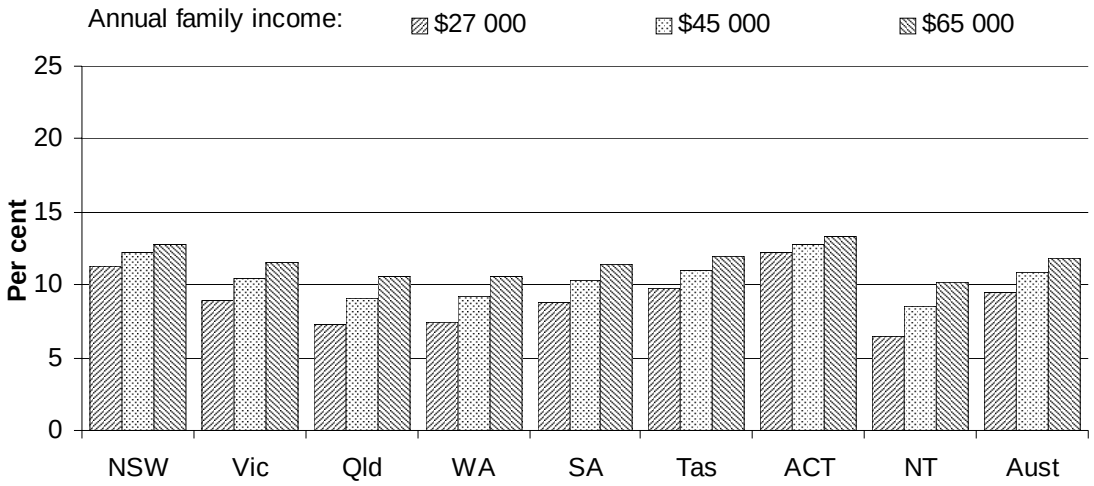
Source: CCCCS, May 2002 (unpublished); table 14A.14.

For families with two children in full time centre based long day care, the proportion of weekly disposable income spent on child care ranged from 18.8 per cent for those on annual incomes of $65 000 (compared with 36.1 per cent before child care subsidies) to 15.2 per cent for those on annual incomes of $27 000 (compared with 59.1 per cent before child care subsidies) (figure 14.8).

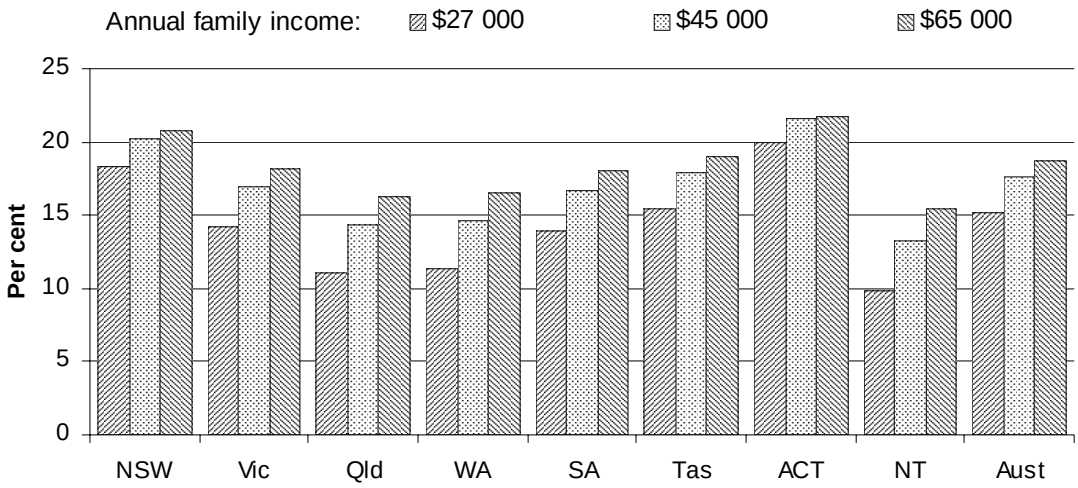
Across jurisdictions, out-of-pocket costs after subsidies for centre based long day care for families with gross annual incomes of $27 000 and one child in care ranged from 12.2 per cent of weekly disposable income in the ACT to 6.5 per cent in the NT. Out-of-pocket costs after subsidies for families with gross annual incomes of $65 000 and one child in care ranged from 13.3 per cent of weekly disposable income in the ACT to 10.1 per cent in the NT (figure 14.9a).

Figure 14.9 **Out-of-pocket costs for centre based long day care (net of subsidies), as a proportion of weekly disposable income, by gross annual family income, 2002[a, b]**

(a) Families with one child



(b) Families with two children

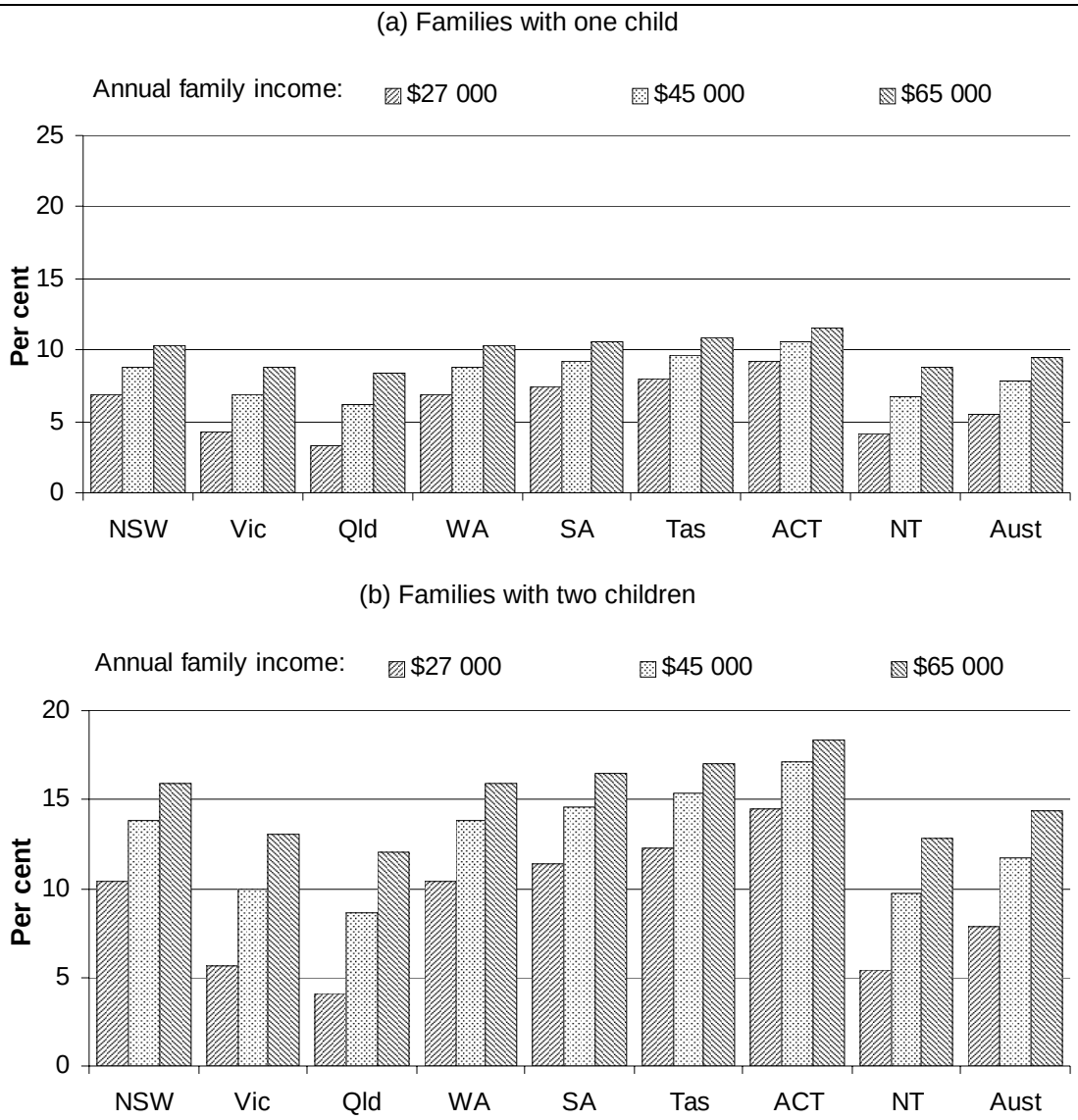


a Disposable income calculations are based on 1 July 2002 tax and payment parameters. Calculations are modelled on dual-income couple families (60:40 income split) with one or two dependent children aged under five years. **b** Out-of-pocket cost calculations are based on May 2002 average fees.

Source: CCCCS, May 2002 (unpublished); table 14A.14.

For families with two children and a gross annual income of $27 000, the out-of-pocket costs for centre based long day care ranged from 19.9 per cent of weekly disposable income in the ACT to 9.8 per cent in the NT. For families with two children in care and a gross annual income of $65 000, the proportion of weekly disposable income spent on child care ranged from 21.7 per cent in the ACT to 15.5 per cent in the NT (figure 14.9b).

Figure 14.10 **Out-of-pocket costs for family day care (net of subsidies), as a proportion of weekly disposable income, by gross annual family income, 2002[a, b]**



a Disposable income calculations are based on 1 July 2002 tax and payment parameters. Calculations are modelled on dual-income couple families (60:40 income split) with one or two dependent children aged under five years. **b** Out-of-pocket cost calculations are based on May 2002 average fees.

Source: CCCCS, May 2002 (unpublished); table 14A.15.

The out-of-pocket costs for family day care (net of subsidies) as a proportion of weekly disposable income for a family with a gross annual income of $27 000 and one child in full time care in May 2002 ranged from 9.2 per cent in the ACT to 3.3 per cent in Queensland (figure 14.10a). The corresponding proportion for families with two children in care ranged from 14.5 per cent in the ACT to 4.1 per cent in Queensland (figure 14.10b).

The proportion of weekly disposable income spent on child care for a family with a gross annual income of $65 000 and one child in full time family day care ranged from 11.6 per cent in the ACT to 8.3 per cent in Queensland, while the corresponding proportion for a family with the same income and two children in full time family day care ranged from 18.4 per cent in the ACT to 12.0 per cent in Queensland (figure 14.10b).

Access of target groups — representation in services

Data on the representation of children from some special needs groups in Commonwealth approved child care services are available for 1997, 1999 and 2002 from the CCCCS, and for August 2000 from Centrelink administrative data. These two data sources are not directly comparable because there are differences in their collection methods.[2] The variations are particularly distorting for data on children from Indigenous backgrounds, and for NT data.

The available data indicate that the proportion of children in special needs groups in Commonwealth supported child care is sometimes substantially different across jurisdictions. This variation largely reflects jurisdictional differences in the representation of children from the special needs groups in the community (table 14.3).

The proportion of child care attendees from a non-English speaking background ranged from 16.6 per cent in NSW (where representation of children from a non-English speaking background in the population was 20.4 per cent) to 2.4 per cent in Tasmania (where the representation in the population was 2.6 per cent). Of note for the data on children from a non-English speaking background is the large difference between their representation in the population of the NT (29.4 per cent) and their representation in child care (8.1 per cent) — a difference that may be correlated with the representation of Indigenous attendees and children in the population (table 14.3).

The proportion of child care attendees from an Indigenous background in May 2002 ranged from 9.9 per cent in the NT (where the representation of Indigenous children in the population was 41.6 per cent) to 0.5 per cent in Victoria (where the

[2] The CCCCS data are collected from Commonwealth approved child care services based on enumeration from services. The CCCCS includes all children attending Commonwealth Government supported services, and there will be double counting where a child attends more than one service. Centrelink administrative data are collected from customers when they claim Child Care Benefit. As such, the data collection is restricted to customers who are eligible for Child Care Benefit. There is no double counting where children attend more than one service because Centrelink assigns each child a unique reference number.

representation in the population was 1.1 per cent). Nationally, the representation of children from Indigenous background among children accessing child care services was lower than this group's overall representation in the community (table 14.3).

Table 14.3 **Proportion of children from special needs groups attending Commonwealth approved child care services, 2002 (per cent)**

									Australia	
Representation	*NSW*	*Vic*	*Qld*	*WA*[a]	*SA*	*Tas*	*ACT*[b]	*NT*[b]	*2001*	*2002*
Children from non-English speaking backgrounds										
In child care services	16.6	12.3	6.0	7.4	6.3	2.4	11.1	8.1	**na**	10.9
In the community[c]	20.4	19.9	7.1	11.0	11.2	2.6	13.1	29.4	15.6	**na**
Children from Indigenous backgrounds										
In child care services	1.5	0.5	2.5	1.7	1.3	1.2	0.7	9.9	**na**	1.6
In the community[c]	4.1	1.1	6.6	6.5	3.4	7.1	2.3	41.6	4.6	**na**
Children from a single parent family										
In child care services[d]	16.8	17.6	20.6	20.6	21.1	18.5	14.6	17.0	**na**	18.6
In the community[c]	17.5	16.3	19.9	18.1	19.5	20.9	16.5	20.5	18.0	**na**
Children with a disability										
In child care services	2.4	2.3	2.1	1.6	3.4	2.3	2.1	2.3	**na**	2.3
In the community[e]	6.6	6.6	8.3	10.3	9.6	7.1	**na**	**na**	7.6	**na**
Children from rural and remote areas										
In child care services	22.6	22.9	23.1	22.5	19.5	47.2	–	51.7	**na**	22.9
In the community[f]	29.0	28.0	36.9	30.6	30.2	39.9	0.2	59.8	30.7	**na**

[a] WA data do not include those children who attend kindergartens for four year olds provided by the Department of Education. [b] Data on children with a disability in the community were not available for publication. [c] Data relate to children aged 0–14 years and were obtained from the ABS 2001 Census of Population and Housing. [d] No information on the number of children from single parent families was available for mobile and toy libraries, occasional care neighbourhood models, occasional care, Aboriginal playgroups and vacation care. [e] Data relate to children aged 0–14 years at June 1998 and were obtained from the ABS 1998 Survey of Disability, Ageing and Carers. [f] Data relate to children aged 0–14 years at June 1996, and were obtained from the ABS 1996 Census of Population and Housing. **na** Not available. **–** Nil or rounded to zero.

Source: ABS 1997 and 2002, *Census of Population and Housing* (unpublished); ABS (*Disability, Ageing and Carers: Summary Tables, Australia, 1998*, Cat. no. 4430.1.40.001; *Disability, Ageing and Carers: Summary Tables, New South Wales, 1998*, Cat. no. 4430.2.40.001; *Disability, Ageing and Carers: Summary Tables, Victoria, 1998*, Cat. no. 4430.3.40.001; *Disability, Ageing and Carers: Summary Tables, Queensland, 1998*, Cat. no. 4430.4.40.001; *Disability, Ageing and Carers: Summary Tables, South Australia, 1998*, Cat. no. 4430.5.40.001; *Disability, Ageing and Carers: Summary Tables, Western Australia, 1998*, Cat. no. 4430.6.40.001; *Disability, Ageing and Carers: Summary Tables, Tasmania, 1998*, Cat. no. 4430.7.40.001; *Disability, Ageing and Carers: Summary Tables, Australian Capital Territory, 1998*, Cat. no. 4430.8.40.001*; Disability, Ageing and Carers: Summary Tables, Northern Territory, 1998*, Cat. no. 4430.9.40.001) CCCCS, May 2002 (unpublished); table 14A.16.

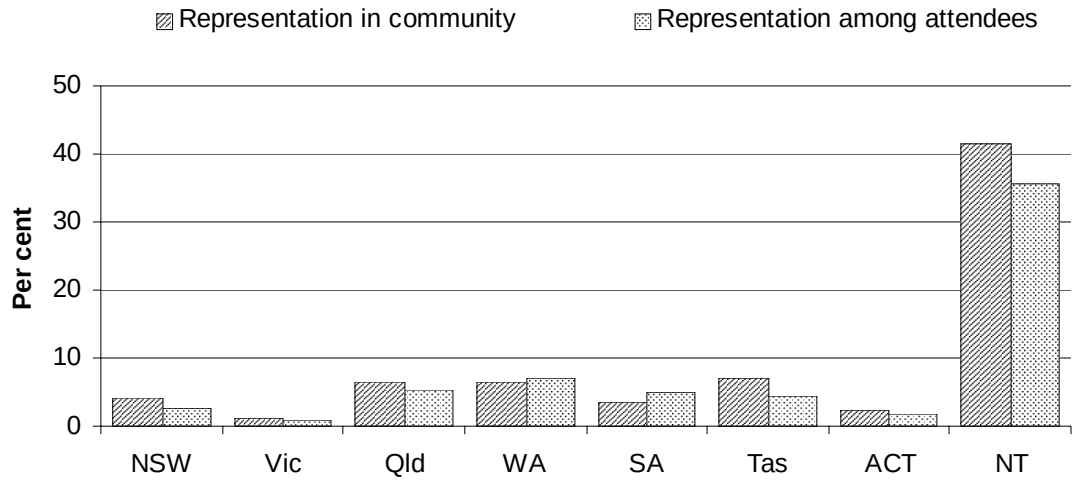
The representation of children from single parent families among attendees of Commonwealth supported child care in May 2002 ranged from 21.1 per cent in SA (where their representation in the population was 19.5 per cent) to 14.6 per cent in the ACT (where their representation in the population was 16.5 per cent) (table 14.3).

The proportion of child care attendees with a disability varied from 3.4 per cent in SA (9.6 per cent in the community) to 1.6 per cent in WA (10.3 per cent in the community) (table 14.3).

The proportion of child care attendees from rural and remote areas in May 2002 ranged from 51.7 per cent in the NT (where their representation in the population was 59.8 per cent) to 19.5 per cent in SA (where their representation in the population was 30.2 per cent). The ACT does not have child care attendees from rural areas (the ACT does not contain any areas classified as remote). Across all jurisdictions, except Tasmania, the representation of children from rural and remote areas among children accessing child care was lower than their overall representation in the community (table 14.3).

Data on the proportion of preschool attendees from the specified special needs groups are less extensive for all jurisdictions. All jurisdictions could provide data on Indigenous children attending preschools in 2001-02. Across jurisdictions, the proportion of Indigenous children attending preschools in 2001-02 was broadly similar to their representation in the community. The proportion ranged from 35.4 per cent in the NT (where the representation of Indigenous children in the community was 41.6 per cent) to 0.8 per cent in Victoria (where their representation in the community was 1.1 per cent) (figure 14.11). The proportion of preschool attendees from Indigenous backgrounds varied across jurisdictions, but has been relatively constant over time within jurisdictions (figure 14.12).

Figure 14.11 **Proportion of preschool attendees from Indigenous backgrounds, 2001-02[a, b]**



Representation	*Unit*	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*
In community	%	4.1	1.1	6.6	6.5	3.4	7.1	2.3	41.6
Among attendees	%	2.7	0.8	5.3	7.2	5.0	4.3	1.8	35.4

a Comparisons between the representation of Indigenous children among preschool attendees and their representation in the community need to be treated with caution because there are definitional differences and differences in the base population. **b** Excludes younger children attending preschool and all children attending non-government preschools.

Source: ABS 2002, *Census of Population and Housing* (unpublished); State and Territory governments (unpublished); tables 14A.25, 14A.34, 14A.43, 14A.52, 14A.61, 14A.70, 14A.79 and 14A.88.

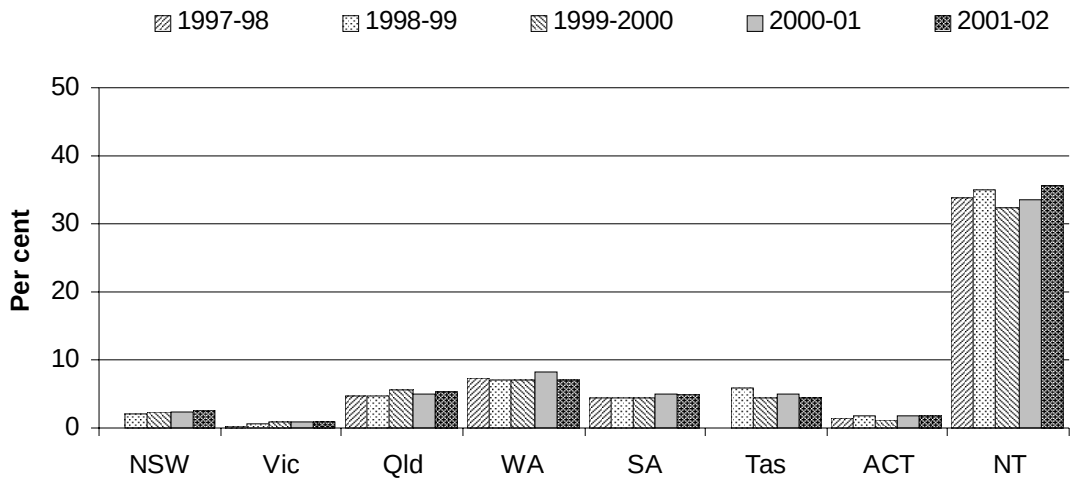
Data on the representation of other special needs groups among government funded preschool attendees are limited for 2001-02.

- Children from non-English speaking backgrounds represented 12.0 per cent of children attending preschool in Victoria, 8.8 per cent in SA, 8.4 per cent in the ACT, 6.6 per cent in NSW and 0.7 per cent in Queensland (tables 14A.25, 14A.34, 14A.43, 14A.61 and 14A.79).
- The proportion of preschool attendees from single parent families was 14.4 per cent in SA, 11.6 per cent in Victoria, 8.8 per cent in NSW and 1.0 per cent in Queensland (tables 14A.25, 14A.34, 14A.43 and 14A.61).
- Children with a disability represented 14.7 per cent of preschool attendees in SA, 10.2 per cent in NSW, 4.6 per cent in the ACT, 3.9 per cent in Victoria and 0.9 per cent in Queensland (tables 14A.25, 14A.34, 14A.43, 14A.61, and 14A.79).
- The proportion of preschool attendees from rural and remote areas was 61.4 per cent in Tasmania, 43.3 per cent in the NT, 33.9 per cent in WA, 33.2 per cent in

both SA and NSW, 27.5 per cent in Queensland and 0.7 per cent in the ACT (tables 14A.25, 14A.34, 14A.43, 14A.52, 14A.61, 14A.70, and 14A.79).

The representation of these special target groups in the general community is provided in table 14.3.

Figure 14.12 **Proportion of preschool attendees from Indigenous backgrounds[a]**



Year	*Unit*	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*
1997–98	%	**na**	0.4	4.7	7.3	4.3	**na**	1.4	33.7
1998–99	%	2.0	0.5	4.8	7.1	4.5	5.8	1.7	34.9
1999–2000	%	2.3	0.8	5.6	6.9	4.5	4.4	1.1	32.2
2000–01	%	2.3	0.8	5.1	8.1	5.0	4.9	1.9	33.6
2001–02	%	2.7	0.8	5.3	7.2	5.0	4.3	1.8	35.4

a Excludes younger children attending preschool and children attending non-government preschools. **na** Not available.

Source: State and Territory governments (unpublished); tables 14A.25, 14A.34, 14A.43, 14A.52, 14A.61, 14A.70, 14A.79 and 14A.88.

Quality

An important focus of Commonwealth, State and Territory governments is to set and maintain appropriate quality standards in child care and preschool services. Indicators of the quality of children's services are staff qualifications, the number of serious injuries, and the number of substantiated complaints per registered or licensed service, by service type. These data need to be treated with caution because there are differences in reporting among jurisdictions.

Staff — staff qualifications

Nationally, the proportion of staff with formal qualifications (including those studying for qualifications) in Commonwealth approved child care was 54.8 per cent in 2002. A further 17.0 per cent had no formal qualifications but three or more years of relevant experience. The remaining 28.3 per cent had no formal qualifications and less than three years experience. The proportion of staff with formal qualifications varied across jurisdictions, ranging from 58.4 per cent in Victoria to 41.1 per cent in the NT (figure 14.13). In all jurisdictions except SA, the number of staff with formal qualifications increased between 1997 and 2002 (table 14A.11).

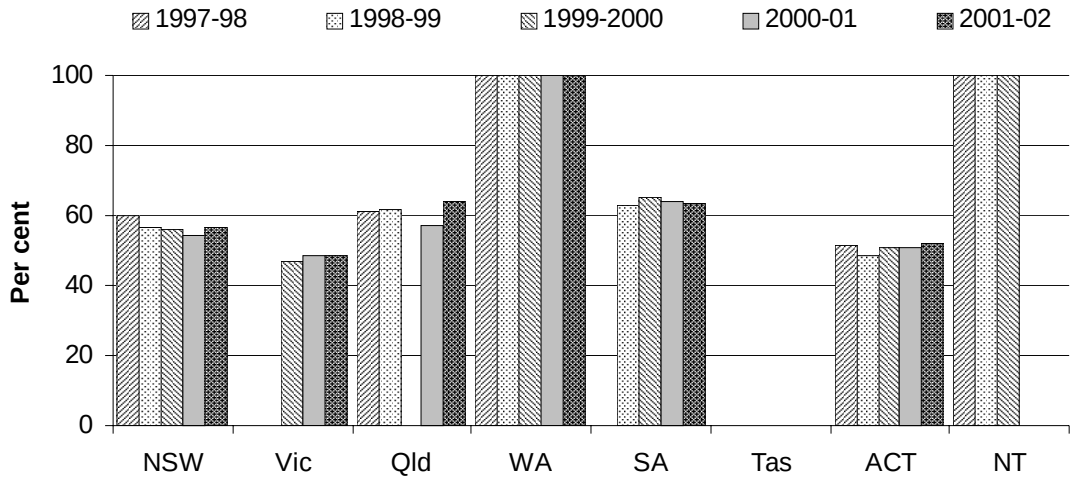
Figure 14.13 **Paid primary contact staff employed by Commonwealth approved child care services, by qualification, May 2002[a, b, c]**

a Excludes Aboriginal play groups, mobile and toy libraries and the occasional care neighbourhood model. **b** 'Three years or more relevant experience' category does not include staff with a relevant formal qualification. **c** 'Fewer than three years relevant experience' category does not include staff with a relevant formal qualification (but does include staff training for a qualification).

Source: CCCCS, May 2002 (unpublished); table 14A.11.

Some data are available for preschool services receiving funding from State and Territory governments only. The comparability of these data is limited by the different licensing and funding arrangements across jurisdictions. Across those jurisdictions for which 2001-02 data are available, the proportion of staff in preschool services with relevant formal qualifications ranged from 100.0 per cent in WA (where all contact staff must be qualified) to 48.7 per cent in Victoria (where only one of the two staff must be qualified) (figure 14.14).

Figure 14.14 **Proportion of paid primary contact staff employed by State/Territory funded and/or managed preschool service providers with a relevant formal qualification[a]**



a All funded preschool services in Victoria and Queensland must have at least two staff, one of whom must have a relevant formal qualification. All primary contact staff for preschools in WA must be qualified.

Source: State and Territory governments (unpublished); tables 14A.23, 14A.32, 14A.41, 14A.50, 14A.59, 14A.68, 14A.77 and 14A.86.

Health and safety — injuries

Data on the number of serious injuries and the number of serious injuries per registered or licensed service provider were limited for 2001-02. Although most jurisdictions were able to provide some information, the small numbers of incidents involved and differences in the data collection approaches by jurisdictions mean direct comparisons are problematic. Tables 14A.26, 14A.35, 14A.44, 14A.53, 14A.62, 14A.71, 14A.80 and 14A.89 provide a breakdown of the available information for each jurisdiction.

Client satisfaction — complaints

All jurisdictions except NSW[3] provided data on the number of substantiated complaints and alleged breaches of regulations made to the State and Territory government regulatory bodies for 2001-02 (tables 14A.27, 14A.36, 14A.45, 14A.54, 14A.63, 14A.72, 14A.81 and 14A.90).

3 NSW is developing a new information system in line with its new legislation. Data on substantiated complaints are expected to be available for future reports.

The results for the substantiated complaints indicator need to be interpreted with caution. The limitations of this indicator include:

- the priority that some jurisdictions give to developing well-informed client groups as part of improving their service delivery (a limitation in that well-informed clients may be more likely to make a complaint than clients without access to this information);
- differences in the number of approved care providers or parent users per service in each service across States and Territories; and
- variation in complaints management systems across jurisdictions. In SA, for example, the department is the sole sponsor of family day care and deals with all complaints that otherwise may be managed at a scheme level in other States and Territories and, as such, may not be reported.

Efficiency

Differences in the indicator results across jurisdictions may reflect differences in counting and reporting rules for financial data and in reported expenditure, which are partly due to different treatments of various expenditure items. Some information on the extent of the comparability of the expenditure is shown in table 14A.5.

Cost per output unit

The levels of government input per unit of output(s) (unit costs) are proxy indicators of efficiency. The indicators used here are:

- Commonwealth government recurrent expenditure per hour of service; and
- State and Territory real total expenditure on children's services per child (0–12 years).

Data were sought from all governments on their expenditures by service type. Incomplete data and changes in collection method, however, make it difficult to compare expenditure across jurisdictions and over time. Unit cost data for children's services do not yet contain an estimate of user cost of capital.

Commonwealth Government recurrent expenditure per hour for centre based long day care services in 2001-02 ranged from $3.44 an hour in Queensland to $1.47 an hour in the ACT. For both centre based long day care and family day care, such expenditure was higher in all jurisdictions compared with 1997-98 levels. Funding

per hour of outside school hours care in 2001-02 was equal to or higher than that in 1997-98 in all jurisdictions except the NT (table 14.4).

Table 14.4 **Commonwealth Government real recurrent expenditure per hour of service (2001-02 dollars) ($/hour)[a]**

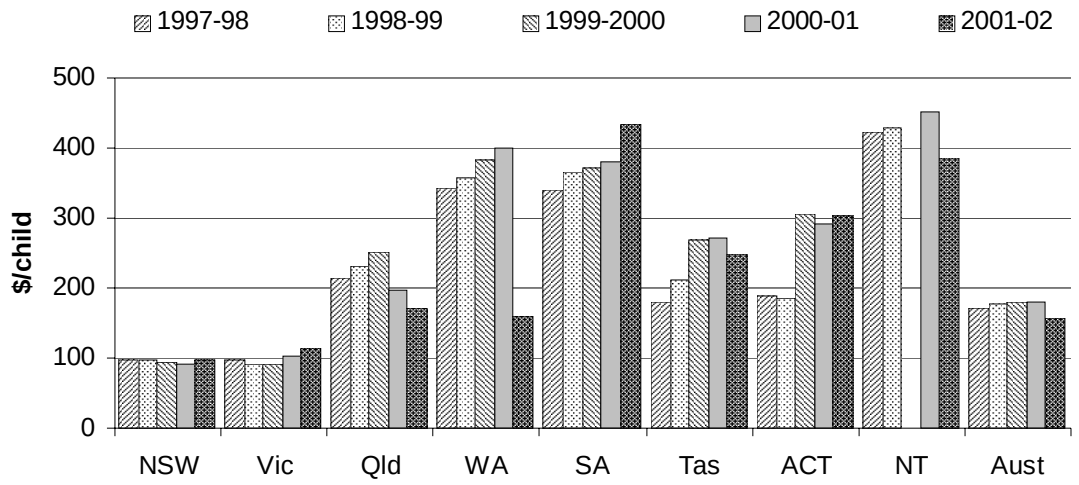
	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*
Centre based long day care								
1997-98	1.96	1.97	2.29	2.05	2.14	1.99	1.45	1.99
1999-2000	1.83	2.04	2.31	2.14	2.05	1.89	1.34	1.84
2001-02[b]	2.68	2.81	3.44	3.04	3.01	2.92	1.47	2.80
Family day care								
1997-98	2.41	2.61	2.63	2.91	3.06	2.79	2.45	2.43
1999-2000	2.63	2.86	2.86	3.20	3.99	3.01	2.55	1.86
2001-02[b]	3.73	4.18	3.82	4.73	3.87	4.34	3.70	4.80
Outside school hours care[c]								
1997-98	1.88	1.52	1.72	1.92	1.67	2.16	1.73	1.72
1999-2000	1.07	1.25	1.45	1.40	1.33	1.45	0.98	1.29
2001-02[b]	3.05	2.91	2.88	3.25	3.67	3.24	1.92	1.66
Occasional care								
1997-98	4.02	1.61	2.31	3.94	4.42	2.34	2.15	11.28
1999-2000	**na**	**na**	**na**	**na**	**na**	**na**	**na**	**na**
2001-02[b]	3.11	3.08	2.48	3.05	3.61	4.65	2.28	**na**

a Excludes administration expenditure. **b** Estimated from preliminary data from May 2002 CCCCS and, as such, is subject to change **c** Data for 1999-2000 include vacation care. For 1997-98, data have been revised to provide a consistent series and, therefore, are not comparable with figures reported in the 2000 Report. **na** Not available.

Source: CCCCS, August 1997, May 1999 and May 2002 (unpublished); table 14A.17.

The indicator for State and Territory total expenditure per child (0–12 years) in the jurisdiction is a new indicator for the 2003 Report, and the data are presented in figure 14.15. Expenditure for 2001-02 ranged from $433.60 per child for SA to $96.50 per child in NSW (table 14A.18).

Figure 14.15 **Total State/Territory real expenditure on children's services per child (0–12 years) in the jurisdiction (2001–02 dollars)[a, b]**



a Includes administration expenditure, other expenditure on service provision, financial support to families and net capital expenditure on child care and preschool services. **b** The drop in WA expenditure for 2001-02 is in response to the changes in the school entry age and the associated move to full time schooling for pre year one children.

Source: State and Territory governments (unpublished); table 14A.18.

Administrative efficiency

Another measure of efficiency is administration and regulation expenditure as a proportion of total expenditure. As noted earlier, the Steering Committee agreed to discontinue reporting of administrative efficiency for State and Territory governments, given the differences in licensing arrangements and the varying extent to which different jurisdictions could include the costs of other activities (such as planning, policy development, resource management, quality assurance and regulation) in the reported data. For the Commonwealth Government, however, estimated administration costs accounted for 8.7 per cent of its expenditure on children's services in 2001-02 (derived from table 14A.3).

14.4 Future directions in performance reporting

The Steering Committee is committed to ongoing improvement in the comparability, completeness and overall quality of reported data for all indicators included within the performance indicator framework.

Future indicator development

The Children's Services Working Group will continue to improve the appropriateness and completeness of the performance indicator framework. Future work on indicators will focus on:

- indicators to measure the extent to which children's services meet family needs;
- the development of indicators to measure the extent to which children's services meet children's needs;
- the development of a more appropriate indicator of service affordability;
- the completion of a quality indicator for licensing, accreditation and registration; and
- a rolling revision of all indictors within the framework.

Options for reporting on service appropriateness in future reports will also be investigated. While these areas have been identified as requiring further work, the improvements to the chapter and progress on performance reporting will not be limited to these indicators.

Improving reporting of existing indicators

Processes for refining definitions, estimating methods and counting rules are continuing. Further work is planned to improve the consistency and comparability of performance information across jurisdictions. Changes in the children's services industry have required jurisdictions to revise collection methods, and these revisions reduce data comparability across years and across jurisdictions. It will take some time before all improvements are reflected in the chapter. The Children's Services Working Group will also continue to explore options for reporting against the two quality indicators introduced in the 2003 Report.

Improving the completeness and comparability of data

National minimum data set

The National Community Services Information Management Group's (NCSIMG) Children's Services Data Working Group, under the auspices of the Community Services Ministers' Council, is developing a national minimum data set for children's services. When completed, this will provide a framework for the collection of a minimum set of nationally comparable data and assist the development of measurable performance indicators and descriptors.

The first stage of the national minimum data set is well advanced. The national minimum data set manual was submitted to the NCSIMG for information in November 2001. Pilot testing of the framework was carried out in all States and Territories in August and September 2002, addressing issues related to the collection, comprehensiveness and comparability of the proposed data items.

Data collection

Consistency in the data collected by State and Territory governments is an important goal in terms of data comparability. One way of improving comparability is to collect data in a (preferably common) sample week that is representative of a typical standard week (and that does not include any public holidays) in each State and Territory. There is still room for improvement in the data collection process.

Data availability

The CCCCS is the most complete national data set on child care and, as such, indicates the relative participation in child care across jurisdictions. The CCCCS is conducted biennially by the Commonwealth Department of Family and Community Services to collect information on the characteristics of users and providers of Commonwealth funded child care services. State and Territory governments may also support many of these services.

Prior to 2001 the CCCCS collected information on all Commonwealth funded services. The 2001 CCCCS, however, was limited to a survey of family day care services and did not cover centre based long day care, outside school hours care, vacation care and occasional care services. Some 2001 data for these other services were sourced from Centrelink administrative data for the 2002 Report. The return to a full CCCCS census for 2002 means all services are again reported from the same source in the 2003 Report. Comparison of 2001 data with other years is constrained by the relative quality and compatibility of the data from the different sources.

14.5 Jurisdictions' comments

This section provides comments from each jurisdiction on the services covered in this chapter. Appendix A contains data that may assist in interpreting the performance indicators presented in this chapter. These data cover a range of demographic and geographic characteristics, including age profile, geographic distribution of the population, income levels, education levels, tenure of dwellings and cultural heritage (including Indigenous and ethnic status).

Commonwealth Government comments

“

In recognition of the importance of high quality data on child care across jurisdictions, the Commonwealth ensured that preliminary data from the May 2002 CCCCS were available in time for this year’s Report. The Commonwealth also continued to work with all jurisdictions on developing a national minimum data set to collect consistent and comparable national data on children using government funded and/or licensed child care and preschool services.

Pilot testing of the proposed data elements for inclusion in the first stage of the data set was conducted in all States and Territories from August 2002. The aim of pilot testing was to test the data items in the widest range of service delivery settings possible to ascertain their potential to produce nationally consistent, comparable and comprehensive data. The pilot test report is currently being drafted. Future work will be directed towards the development of stage two data items, and the model and timing for data collection.

Ensuring that child care is flexible and responsive to the needs of Australian families is a priority for the Commonwealth Government.

Under the Government’s Stronger Families and Communities Strategy, a number of child care measures were recently introduced to help families find the right mix between their work, community and parenting roles, including:

- incentives to encourage private operators to establish child care centres in rural and remote locations;
- expanding in-home child care, where care is provided in the child’s home;
- enabling other providers, including private operators to run Commonwealth funded outside school hours care and family day care services; and
- the implementation of a quality assurance system for family day care and the development of a quality assurance system for outside school hours care. These complement the existing quality assurance system in place for long day care.

The redevelopment of the Child Care Broadband, which funds a number of programs for child care services, and support for service provision, also commenced in 2002. The redevelopment will ensure the best use of the funds that are available and make it possible to maximise opportunities to respond to priorities in child care. The re-development will be achieved through extensive consultations with the children’s services sector and will focus on improving flexibility and support, balancing viability and flexibility, as well as ensuring a better deal for children and families with specific needs.

”

New South Wales Government comments

“ The structure of the children’s services chapter poses difficulties in comparing the performance of NSW with that of other jurisdictions and in accurately reporting NSW data. The chapter is based on service type classifications of pre-school and child care, which suits the way children’s services are structured in most jurisdictions but not in NSW.

All licensed early childhood centres are required by regulation to provide an education program tailored to each child’s intellectual, physical, social and emotional development and to employ appropriately qualified teaching staff. In this environment all licensed centres provide a pre-school program. This is very different from the situation in other States.

While data have been provided to meet the requirements of the chapter, NSW urges caution in any use or interpretation of these data in relation to the numbers of children that access a preschool program.

NSW has recently launched the State Curriculum Framework, which provides a contemporary evidence based practice tool for early childhood professionals in support of best outcomes for children.

In 2002, NSW also commenced implementation of more flexible funding arrangements to support some 9000 children with additional needs to attend prior to school services. A web site (www.parenting.nsw.gov.au) was also established to provide expert advice and information on parenting topics. ”

Victorian Government comments

“Of the 2722 licensed children’s services, approximately 2032 locations receive State Government funding to provide children’s services, including preschool, occasional care and TAFE long day care services. New initiatives have been introduced in 2001-02 to enhance children’s services.

The “Best Start” initiative is a prevention and early intervention project that aims to improve the health, development, learning and wellbeing of all Victorian children from pregnancy through transition to school (usually taken to be eight years of age). This will be achieved by supporting communities, parents and service providers to improve universal local early years services so that they are more responsive to local need.

In response to the 2001 Review of the Issues that Impact on the Delivery of Preschool Services to Children and Their Families, the introduction of a Group Employer Models of management, which will group individual preschool services together under a single employer, has commenced.

As part of a $10.25 million initiative over three years, $5.5 million has been paid to community based, non-profit preschools, long day care and occasional care services for capital works to meet the premises requirements of the transitional provisions of the *Children’s Services Act 1996* and the Children’s Services Regulations 1998 (the Regulations).

$2 million has been paid in community equipment and maintenance grants to community based, non-profit long day care and out of school hours care services to maintain existing facilities, purchase new equipment and provide staff training. This is part of a $6.25 million initiative over three years.

A study grants scheme has been established to assist child care staff in Neighbourhood Houses obtain a qualification recognised under the Regulations. $100 000 has been allocated each year for two years to fund this initiative.”

Queensland Government comments

“The Queensland Government continues to work towards a child care system for Queensland children and families that is responsive, sustainable and of a high quality through implementation of the Queensland Child Care Strategic Plan 2000–05.

A key step in implementing the Strategic Plan has been the development of a new regulatory framework. In 2001–02, the Department of Families undertook a statewide consultation strategy on an exposure draft of the proposed new legislation. Feedback from this process assisted in finalising the Bill which was unanimously passed by the Parliament on 24 October 2002. The *Queensland Child Care Act 2002* represents a strengthened regulatory framework for the provision of child care services in Queensland, increasing qualification requirements for child care workers and including the licensing of school-age care services for the first time.

The Queensland Child Care Industry Plan 2002–05, launched in March 2002, represents an important milestone in the development of effective partnerships between key stakeholders of the child care industry. It aims to strengthen the sector, improve service delivery and promote a positive image of both child care services and workers by focusing on the three critical areas of human resources and training, research and information technology.

In implementing the Industry Plan the Department of Families funded the National Centre for Vocational Education Research to conduct research into the training and employment patterns and trends in the Queensland child care industry. The research will explore issues related to employment trends within the industry, the availability and suitability of training and the retention of qualified staff. Factors and strategies that support the retention of qualified staff will be identified as part of the final report, expected in December 2002.

Implementation of the Child Care and Family Support Hub Strategy continued in 2001–02, bringing the total number of funded hubs to 24 across the State. This funding assists services to deliver integrated child care and family support services in their communities and enhance access to existing and new services for families. Included are two hubs, established in the Indigenous communities of Doomadgee and Aurukun, that offer a range of child care and family support services such as playgroup, parent education and health and other specialist services.

Under the Child Care Statewide Training Strategy, child care workers in Queensland have access to subsidised training to improve their skill levels and gain qualifications. Since inception in November 2001 over 3,000 child care workers have taken up this opportunity. In addition, Education Queensland conducted consultations on the implementation of a preparatory year of schooling. Trials for the preparatory year will commence in 2003.”

Western Australian Government comments

“The new structure for the Department for Community Development is currently being implemented. In addition to an increased focus on community development and strengthening families the Department is placing increased emphasis on the early years and developing closer collaborative relationships with other government departments, the not-for-profit sector, communities and business.

As part of this process the Department is aligning its licensing and support functions. The new structure for licensing is based on a risk management framework and will be implemented early in 2003.

The new Community Services (Outside School Hours Care) Regulations 2002 were gazetted on 28 August 2002. The Department for Community Development is currently providing centres catering for school aged children with information and training to assist them meet the new standards when they come into effect in August 2003. Financial support to upgrade premises and purchase equipment is being provided to not-for-profit services. The regulations address key elements of operation and set minimum standards to ensure the health, safety and developmental wellbeing of children in services.

The Department is currently developing new legislation and a single Act will replace three of the four Acts under which the Department for Community Development now operates. This has created the opportunity to redraft the Children's Services Part of the *Community Services Act 1972* to reflect the changes that have occurred in the child care industry since the child care licensing provisions were legislated in 1987.

At the same time any discrepancy in the standards in the care and education systems has been addressed with the ministers for education and community development reaching an agreement on similar standards for children aged 3–6 years in care and education environments.

The introduction of the new school entry age, four half day sessions for kindergarten children and five full days for pre-primary has had an impact on long day care services. The industry reports an increased demand for places for babies, toddlers and the younger four year olds who would previously have had a place in a kindergarten program.”

South Australian Government comments

“A new Education and Children’s Services department was formed following a State election in March 2002. At this time the incoming government made a commitment to making education a top priority for South Australia. This commitment was reflected in immediate budget allocations for education and children’s services. Over the next four years the increase in funds will be used to provide a raft of new and ongoing initiatives.

These new commitments underscore the new Government’s understanding of the importance of the early years and its previous history of support for children’s services while in government. The development of new ways to support young children who are at greatest risk of disengagement from early childhood care and education is a key priority. Children from birth to three years of age are the focus of the new Learning Together program that is now unfolding in five locations across South Australia. These new projects will explore new and improved ways for children’s services, schools and family support organisations to link with and support families with very young children. Links with other levels of government and with other agencies such as child health providers are key features of these projects.

These new projects complement ongoing work on integrating children’s services and the first years of school through new leadership and governance models. Access to child care in small rural communities will improve as further new rural child care services are developed in partnership with the Commonwealth.

Per capita expenditure by the State government in South Australia remains at a high level. However the children’s services sector is under increasing pressure, as demand for care continues to outstrip supply and as children’s services providers in child care centres and out of school hours programs face increasing difficulty in training and recruiting qualified staff. The shortage of subsidised child care places is a Commonwealth responsibility, but the State is interested in pursuing improved planning and coordination of children’s services and in supporting workforce planning initiatives that will address the chronic shortage of trained staff in parts of the children’s services sector.

The South Australian government has continued its commitment to quality in the children’s services sector. Implementation of the new birth to 18 Curriculum Standards and Accountability Framework has included child care centre staff through Statewide professional development tailored to the needs of that sector and through the participation of child care staff in district professional development networks. This work will be adapted and extended to family day care providers and out of school hours services.”

Tasmanian Government comments

“The Department of Education continues to support the early years through its commitment to child care and education and in ensuring that families have access to high quality, affordable services. The department directly provides all government preschools/kindergartens across the State and provides funding for some non-government kindergartens. It is also responsible for licensing, monitoring, coordinating, funding and resourcing child care services and related programs.

The relationship between child care and education has continued to strengthen, as professionals from both sectors have worked together on the new curriculum framework for 0–8 year olds and on a number of specific projects. New budget initiatives in relation to strengthening families have also resulted in the consideration of using child care buildings as a base for other family support organisations. The number of government and non-government schools with licensed child care services has also increased. This is partly due to the increased facilitation of linkages between the areas, but also the impact of the change to the starting age for both government and non government schools.

In light of the imminent proclamation of the *Child Care Act 2001*, work has been continuing on the revision of child care standards for services currently licensed and the development of new standards for service types which will be licensed for the first time under the new legislation. A licensing review is being undertaken to account for the additional workload under the new *Child Care Act 2001* and to ensure that the process of licensing is as effective as possible and in line with recommended practices.

Like many other States, Tasmanian child care services have had difficulty due to the significant shortage of available qualified carers. Previous initiatives such as the mentorship and scholarship programs are continuing and a new initiative providing funds to support unqualified carers undertaking the recognition process is being implemented. There has also been considerable consultation with the industry about this issue which has resulted in the development of a policy that provides more flexibility for services. Defined parameters are in place so that the qualification requirements are not undermined.

In 2000-03, the focus will be on the implementation of the *Child Care Act 2001* and the related licensing standards, and the development of a Tasmanian child care policy which will provide a solid foundation for future strategic planning.”

Australian Capital Territory Government comments

“The provision of quality children’s services is an investment in the future, providing the foundation for children’s learning and development. The ACT Government, through the Department of Education, Youth and Family Services, supports children’s services to deliver quality programs that give children every chance to realise their full potential.

The Department of Education, Youth and Family Services, in partnership with parent communities, is responsible for providing preschool services for all eligible children in the year immediately before their entry to school. The department is also responsible for licensing and monitoring children’s services in the ACT to ensure that they meet the requirements of the *Children and Young People Act 1999*. These services include centre based children’s services, school age care, family day care, independent preschools and play schools. Funding is also provided to assist with the provision of a range of children’s services programs.

This year has also seen the implementation of Professional Pathways for all permanent teachers in ACT Government preschools. Professional Pathways is a confidential professional appraisal and planning process aimed at providing teachers with meaningful feedback, support and advice. In the Professional Pathways cycle, teachers develop a set of priorities informed by the ACT Government Schools Plan, and the ACT Government Preschools Strategic Plan. Teachers work on these priorities throughout the year with their mentor and peers. Outcomes of the program are very positive. Teachers have highlighted the sense of purpose gained from the program and the benefit of working in small professional groups.

The collaborative work occurring across early childhood services in the ACT, culminated in the inaugural Children’s Services Early Childhood Conference, ‘Making Connections — Children and Change’, which was held in October 2002 during Children’s Week. The focus of the conference was strengthening resilience in children and supporting them through transitions of various kinds. Representatives from the range of early childhood services attended the conference.”

Northern Territory Government comments

Children's services in the Northern Territory aim to support families in caring for their young children, as a fundamental component in the range of activities and services that enhance the capacity of individuals, families and communities to improve their wellbeing.

The Territory has a small (195 500) and young population dispersed across one-sixth of the national landmass. About 36 per cent of the 0-12 population are Indigenous children, some 75 per cent of whom live in small remote communities and townships. Diseconomies of scale, an environment ranging from desert to tropical climates, and the particular interests and needs of the population have resulted in unique approaches to providing children's services in the Northern Territory. Due to this, comparability for reporting purposes continues to be difficult. For example, this Report indicates a considerably lower participation level of Indigenous children in child care services; however, the data does not include participation in other services and activities such as innovative child care centres, play groups and informal care services, preferred service models in a number of communities.

The NT continues to sustain relative affordability for centre based child care services across all income brackets. The NT has the longest average hours of attendance at child care centre and vacation care services, due in part to high full time employment levels in the NT relative to other jurisdictions. A low proportion of services offering nonstandard hours of operation may be due to reduced travel to work times in the major urban areas.

In 2001-02, the focus of the program was on tailoring and diversifying services to better meet family needs. Program development activities included improving the supply of appropriately qualified staff, and strengthening collaboration and service delivery coordination among children's education, health, disability and care services.

14.6 Definitions

Table 14.5 **Terms**

Term	*Definition*
Administration expenditure	All expenditure by the departments responsible for the provision of 'licensing', 'advice', 'policy development', 'grants administration' and 'training' services. Responsible departments include those departments that are responsible for administering policy, funding and licensing/accreditation of child care and preschool services in each jurisdiction.
Approved preschool care	Preschool care that meets State and Territory government licensing requirements (where such requirements exist).
Centre based long day care	Care for children (usually aged 0–5 years) in a licensed child care centre that is open for a minimum of eight hours per day, five days per week, 48 weeks per year. These centres provide quality all day or part-time care for working families and the general community. Some centres provide care for limited numbers of primary school children before and after school, and during school holidays.
Child care	The meeting of a child's care, education and developmental needs by a person other than the child's parent or guardian. The main types of service are centre based long day care, family day care, outside school hour care (vacation, before/after school hours and 'pupil free days' care), occasional care and other care.
Children	All resident male and female Australians aged 12 years and younger as at 30 June of each year.
Children from Indigenous backgrounds	Children of Indigenous descent who identify as being Indigenous and are accepted as such by the community in which he or she lives.
Children from non-English speaking backgrounds	Children living in situations where the main language spoken is not English.
Children from single parent families	Dependent children who are resident in households of lone parent (either father or mother) families.
Children's services	All government funded and/or provided child care and preschool services (unless otherwise stated).
Counting rules	Prescribed standards, definitions and mathematical methods for determining descriptors and performance indicators for monitoring government services.
Expenditure on assets	Expenditure on the acquisition or enhancement of fixed assets, less trade-in values and/or receipts from the sale of replaced or otherwise disposed of items.
Disability related care	Care of children who have a developmental delay or disability (including intellectual, sensory or physical impairment), or parent(s) with a disability.

(Continued on next page)

Table 14.5 **(Continued)**

Term	*Definition*
Family day care	A network of experienced carers who provide care and developmental activities in their own homes for other people's children. A coordinating unit oversees each family day care scheme, which covers a number of carers in an area. The unit provides support and resources to the carers. Care is flexible and can be tailored to suit each family's needs, including care outside normal working hours and, if needed, overnight care. The number of children per carer is restricted in some States by State licensing requirements.
Financial support to families	Any form of fee relief paid by governments to the users of children's services (for example, the Child Care Benefit).
Formal child care	Organised care provided by a person other than the child's parent or guardian, usually outside of the child's home — for example, centre based long day care, family day care, outside school hours care, vacation care and occasional care (excluding babysitting).
Formal qualifications	Early childhood related teaching degree (three or four years), a child care certificate or associate diploma (two years) and/or other relevant qualifications (for example, a diploma or degree in child care [three years or more], primary teaching, other teaching, nursing [including mothercraft nursing], psychology and social work). Some jurisdictions do not recognise one-year certificates.
Full time equivalent staff numbers	A measure of the total level of staff resources used. A full time staff member is employed full time and engaged solely in activities that fall within the scope of children's services covered in the chapter. The full time equivalent of part time staff is calculated on the basis of the proportion of time spent on activities within the scope of the data collection compared with that spent by a full time staff member solely occupied by the same activities.
Government funded or/and provided	All government financed services — that is, services that receive government contributions towards providing a specified service (including private services eligible for the Child Care Benefit) and/or services for which the government has primary responsibility for delivery.
Informal child care	Child care arrangements provided privately (for example, by friends, relatives, nannies) for which no government assistance (other than the Child Care Benefit) is provided. Such care is unregulated in most States and Territories.
Licensed services	Those services that comply with the relevant State or Territory licensing regulations. These regulations cover matters such as the number of children whom the service can care for, safety requirements and the required qualifications of carers.
Metropolitan areas	Defined as per the publication *Rural, Remote and Metropolitan Areas Classification 1991 Census Edition* (DPIE and DHSH 1994). In this publication, metropolitan areas are defined as areas that have an urban centre of 100 000 people or more. Jurisdictions were provided with a table indicating the classification assigned to 1996 statistical local areas. Jurisdictions used this table to establish the total number of rural and remote places receiving government funding.

(Continued on next page)

Table 14.5 **(Continued)**

Term	*Definition*
Nonstandard hours of care	Nonstandard hours of care by service type are defined as: • centre based long day care — services providing service for more than 10 hours a day on Monday to Friday and/or providing service on weekends; • preschool — services providing service for more than six hours a day; • family day care — services providing service for more than 50 hours a week and/or providing service overnight and/or on weekends; • vacation care — services providing service for more than 10 hours a day; • before school hours care — services providing service for more than two hours before school; • after school care — services providing service for more than three hours after school; • occasional care — services providing service for more than eight hours a day; and • other — services providing service for more than 10 hours a day.
Occasional care	Services for parents who need short periods of care for children under school age. They can be used regularly or irregularly while parents shop or attend appointments, for respite from full time parenting, and to provide developmental opportunities for children. Some occasional care services also provide for casual or part time workers.
Operational place	A licensed place (where a licensing system exists, or in receipt of government funding where not licensed) able to accept children at 30 June each year.
Other care	Child care designed to meet the needs of children in particular situations (including children from an Indigenous background, children from non-English speaking backgrounds, children with a disability or whose parents have a disability, and children living in remote and rural areas). These services include multifunctional services, multifunctional Aboriginal and Torres Strait Islander children's services, mobiles, and toy libraries.
Other expenditure on service provision	All recurrent expenditure on government funded and/or provided child care and preschool services. It also includes one-off, non-capital payments to peak agencies who support child care and preschool service providers.
Outside school hours care	Outside school hours care provides care for primary school children before and/or after school and, in some services, on 'pupil free days' during the school term. Some outside school hours care services also provide school holiday care or are linked to vacation care services, and provide for primary school children all year. These services are generally located on or near primary schools and offer recreational programs and activities along with time for rest and homework.
Preschools	Educational and developmental programs for children in the year or two before they begin full time school. Traditional preschool services are generally provided on a sessional basis (two to five sessions of 2.5–3 hours in length per week) in dedicated preschools during school terms only. Preschool programs can also be provided in a long day care centre by a qualified early childhood teacher.

(Continued on next page)

Table 14.5 **(Continued)**

Term	*Definition*
Primary contact staff	Staff whose primary function is to provide care and/or preschool services to children.
Program support activities	Administration expenditure associated with the licensing of services that do not receive government funding.
Real expenditure	Actual expenditure adjusted for changes in prices. Adjustments were made using the GDP (E) price deflator, and expressed in terms of final year prices.
Recurrent expenditure	Expenditure that does not result in the creation or acquisition of fixed assets (new or secondhand). It consists mainly of expenditure on wages, salaries and supplements, purchases of goods and services, and the consumption of fixed capital (depreciation).
Rural and remote areas	Areas defined as per the *publication Rural, Remote and Metropolitan Areas Classification 1991 Census Edition* (DPIE and DHSH 1994). This publication assigned a measure of remoteness to each statistical local area in Australia. Jurisdictions were provided with a table showing the classification assigned to each statistical local area. Jurisdictions used this table to establish the total number of rural and remote places receiving government funding.
Serious injury	Injury requiring a visit to (or by) a doctor or hospitalisation.
Service	The type of service provided. Preschool service, for example, is a package of educational and developmental services received by a child in the year or two before full time schooling. Preschool services may be provided by either a preschool service provider or a child care service provider.
Service type	The categories for which data were collected, namely: • long day care; • family day care; • vacation care; • before/after school care (outside school hours care); • occasional care; • 'other' care; and • preschool services.
Substantiated complaint	An expression of concern about a child care or preschool service, made orally, in writing or in person, which constitutes a failure by the service to abide by the State or Territory legislation, regulations or conditions. This concern is investigated and subsequently considered to have substance by the regulatory body.
Vacation care	Care and developmental activities provided for school age children during school vacation periods.

Table 14.6 **Indicators**

Indicator	*Definition*
Proportion of services providing nonstandard hours of care	The number of services providing nonstandard hours of care divided by the total number of services, by service type.

(Continued on next page)

Table 14.6 **(Continued)**

Indicator	*Definition*
Proportion of special needs groups using services relative to their population proportions	The number of children from special needs groups using children's services divided by the total number of children using children's services. Results are presented separately for child care and preschool services, with special needs groups divided into children from a non-English speaking background, children from an Aboriginal or Torres Strait Islander background, children from single parent families, children with a disability, and children from remote or rural areas. These results were compared with these groups' representation in the community.
Serious injuries sustained per registered or licensed service	The total number of serious injuries sustained by children divided by the total number of registered or licensed services.
Substantiated complaints per registered or licensed service	The number of substantiated complaints divided by the total number of registered or licensed services. Results are presented separately by service type. The proportion of substantiated complaints against which action was taken is also reported.
Out-of-pocket costs relative to family income for children's services	Modelling undertaken by the Department of Family and Community Services for families with one child and two children respectively in full time care (defined as 50 hours per week for each child) for a range of indicative annual incomes. Out-of-pocket costs are based on the average weekly fee for one child and two children in full time care, and are calculated as a proportion of weekly disposable income, after the payment of child care subsidies. The annual income levels used are: $27 000, $35 000, $45 000, $55 000 and $65 000.
Government recurrent expenditure per hour of service	Total government recurrent funding on children's services divided by the total hours of care provided by services receiving government funding.
Administrative expenditure as a proportion of total government expenditure	Total government administrative expenditure divided by total government expenditure.

14.7 References

ABS (Australian Bureau of Statistics) 1996, *Child Care Survey 1996*, ABS, Canberra.

—— 2000, *Child Care Survey 1999*, ABS, Canberra.

AIHW (Australian Institute of Health and Welfare) 1997, *Children's Services in Australia, 1996: Services for children under school age,* AIHW, Canberra.

DPIE (Department of Primary Industries and Energy) 1994 and DHSH (Department of Human Services and Health), *Rural, Remote and Metropolitan Areas Classification 1991 Census Edition*, AGPS, Canberra.

15 Protection and support services

Protection and support services aim to assist individuals and families who are in crisis or experiencing difficulties that hinder personal or family functioning. They do this by alleviating the difficulties and reducing the potential for their recurrence.

This chapter reports on:

- *child protection services*: the functions of government that receive and assess allegations of child abuse and neglect, and/or harm to children and young people, that provide and refer clients to family support and other relevant services, and that intervene to protect children;
- *out-of-home care services*: care for children placed away from their parents for protective or other family welfare reasons; and
- *supported accommodation and assistance services:* services to assist young people, adults and families who are homeless or at imminent risk of becoming homeless.

A profile of child protection and out-of-home care services appears in section 15.1, followed by a brief discussion of recent policy developments in section 15.2. A framework of performance indicators is outlined in section 15.3 and data are discussed in section 15.4. Future directions in performance reporting are outlined in section 15.5.

A profile of accommodation and assistance services funded under the Supported Accommodation and Assistance Program (SAAP) appears in section 15.6, followed by a brief discussion of recent policy developments in section 15.7. A framework of performance indicators for these services is outlined in section 15.8 and data are discussed in section 15.9. Future directions in performance reporting are discussed in section 15.10.

Jurisdictions' comments on both child protection and out-of-home care services, and supported accommodation and assistance services are reported in section 15.11. Definitions of data descriptors and indicators are provided in section 15.12.

Supporting tables

Supporting tables for chapter 15 are provided on the CD-ROM enclosed with the Report. The files are provided in Microsoft Excel 97 format as \Publications\Reports\2003\Attach15A.xls and in Adobe PDF format as \Publications\Reports\2003\Attach15A.pdf.

Supporting tables are identified in references throughout this chapter by an 'A' suffix (for example, table 15A.3 is table 5 in the electronic files). These files can be found on the Review web page (www.pc.gov.au/service/gsp). Users without Internet access can contact the Secretariat to obtain these tables (see details on the inside front cover of the Report).

15.1 Profile of child protection and out-of-home care services

Service overview

Child protection services

Child protection services are provided to protect children and/or young people aged 0–17 years who are at risk of harm within their families, or whose families do not have the capacity to protect them. These services include:

- receiving and responding to reports of concern about children or young people, including investigation and assessment where appropriate;
- providing support services (directly or through referral) where harm or a risk of significant harm is identified, to strengthen the capacity of families to care safely for children;
- initiating intervention where necessary, including applying for a care and protection order through a court and, in some situations, placing children or young people in out-of-home care to secure their safety;
- ensuring the ongoing safety of children and young people by working with families to resolve protective concerns;
- working with families to reunite children (who were removed for safety reasons) with their parents as soon as possible; and
- securing permanent alternative care when it is determined that a child is unable to be returned to the care of their parents, and working with young people to

identify alternative supported living arrangements where family reunification is not possible. (In NSW, restoration may occur in voluntary placements as well.)

Certain social and demographic factors are associated with involvement in the child protection system (box 15.1).

Box 15.1 **Current research in child protection**

During 2001-02, the Department of Human Services in Victoria undertook detailed research and analysis of its child protection system as outlined in the report *An Integrated Strategy for Child Protection and Placement Services* (DHS 2002). This analysis was undertaken partly as a response to rising rates of both notifications and renotifications of child abuse and neglect.

The report looked at the characteristics of children and families involved in the child protection system. Some of the findings were that:

- more than 75 per cent of families investigated for suspected child abuse were on pensions, benefits or low incomes, and 45 per cent were sole parent families;
- around one-third of parents had problems with alcohol abuse, one-third had substance abuse problems, 19 per cent had a psychiatric disability and more than half had experienced family violence. All of these factors, including the presence of more than one of these factors, have increased over the past five years;
- the proportion of renotifications of child abuse and neglect rose from 36 per cent of all notifications in 1993-94 to 61 per cent of notifications in 2000-01;
- there was evidence of an increase in the incidence of child abuse and neglect in the Indigenous community, with the number of substantiations for Indigenous children increasing by 88 per cent between 1995-96 and 2000-01; and
- a number of families were offered only limited assistance by child protection, and many families had chronic problems that were not addressed through their involvement in the child protection system.

The report concluded that demand for child protection and placement services in Victoria could be more effectively managed and, in the longer term reduced. The report sought to identify better responses to the often complex and chronic problems experienced by some families and to allow intervention earlier to prevent child abuse and neglect occurring. It proposed an integrated strategy to improve child protection practice in Victoria.

Source: Department of Human Services (DHS) (2002).

Out-of-home care services

Out-of-home care services provide care for children and young people aged 0–17 years who are placed away from their parents or family home for reasons of

safety or family crisis. These reasons include abuse, neglect or harm, illness of a parent and the inability of parents to provide adequate care. The placements may be voluntary or in conjunction with care and protection orders.

Box 15.2 **Intensive family support services**

Intensive family support services are specialist services established in each jurisdiction that aim to:

- prevent the imminent separation of children from their primary caregivers as a result of child protection concerns; or
- reunify families where separation has already occurred.

In 2001-02, at least 56 intensive family support programs and sub programs were operating across Australia (two in NSW, 36 in Victoria, three in Queensland, three in WA, nine in SA, one in Tasmania and two in the ACT). The NT do not fund any intensive family support services.

Intensive family support services differ from other types of child protection and family support services referred to in this chapter, in that they:

- are funded or established explicitly to prevent the separation of, or to reunify, families;
- provide a range of services as part of an integrated strategy focusing on improving family functioning and skills, rather than providing a single type of service;
- are intensive in nature, averaging at least four hours of service provision per week for a specified short term period (usually less than six months); and
- generally receive referrals from a child protection service.

Intensive family support services may use some or all of the following strategies: assessment and case planning; parent education and skill development; individual and family counselling; anger management; respite and emergency care; practical and financial support; mediation, brokerage and referral services; and problem solving training.

Expenditure data indicate that recurrent expenditure on intensive family support services across all jurisdictions in 2001-02 was at least $46.2 million (table 15A.1). Table 15A.21 provides additional information about families and children who were involved with family preservation services during 2001-02.

Source: Australian Institute of Health and Welfare (AIHW) (unpublished).

Out-of-home care services are either home-based care (such as foster care, care with the child's extended family and other home-based arrangements), facility-based care (such as family group homes and community residential care), or independent living (which is often intensively supported) as a transition to full independence or supported placements. Across jurisdictions, there has been a shift away from the use

of facility-based (or residential) care towards foster care and other forms of home-based care, including relative/kinship care. Intensive family support services are increasingly seen as an alternative to the removal of the child from their home for child protection reasons (box 15.2).

Roles and responsibilities

State and Territory governments fund child protection, out-of-home care, family preservation and other relevant services that may be delivered by the government or the non-government sector. State and Territory community services departments are responsible for investigating and assessing reports to the department, referring families to support services and intervening where necessary (including making court applications when an order is required to protect a child and placing children in out-of-home care). The non-government sector plays a significant role in the delivery of family support services in all jurisdictions.

Other areas of government also have a role in child protection and provide services for children who have come into contact with community services departments for protective reasons. Examples include:

- police services, which investigate serious allegations of child abuse and neglect, particularly criminal matters;
- courts, which decide whether a child will be placed on an order;
- education and child care services, which provide services for these children and also conduct mandatory reporting and protective behaviours education in some jurisdictions; and
- health services, which support the assessment of child protection matters and deliver therapeutic, counselling and other services.

Size and scope

The child protection system

Child protection legislation, policies and practices vary among jurisdictions, but the broad processes in the child protection system are similar (figure 15.1).[1] State and

[1] Child protection services, care and protection orders and out-of-home care relate to children aged 0–17 years. Rates of children in notifications, investigations and substantiations, however, are calculated for children aged 0–16 years, given differences in jurisdictions' legislation, policies and practices regarding children aged 17 years.

Territory community services departments are advised of concerns about the wellbeing of children through reports to the department. Reports may be made by people mandated to report (such as medical practitioners, police services, and school teachers and principals) or by other members of the community. These reports are then assessed and classified as child protection notifications, child concern reports or matters requiring some other kind of response. The most common sources of notification for finalised investigations in 2001-02 were school personnel (17 per cent), police (17 per cent), parents and guardians (12 per cent), and friends and neighbours (10 per cent) (AIHW 2002).

Jurisdictions count notifications at different points in the response to a report, ranging from the point of initial contact with the source of the report to the end of a screening and decision making process. This means the number of notifications is not strictly comparable across jurisdictions.

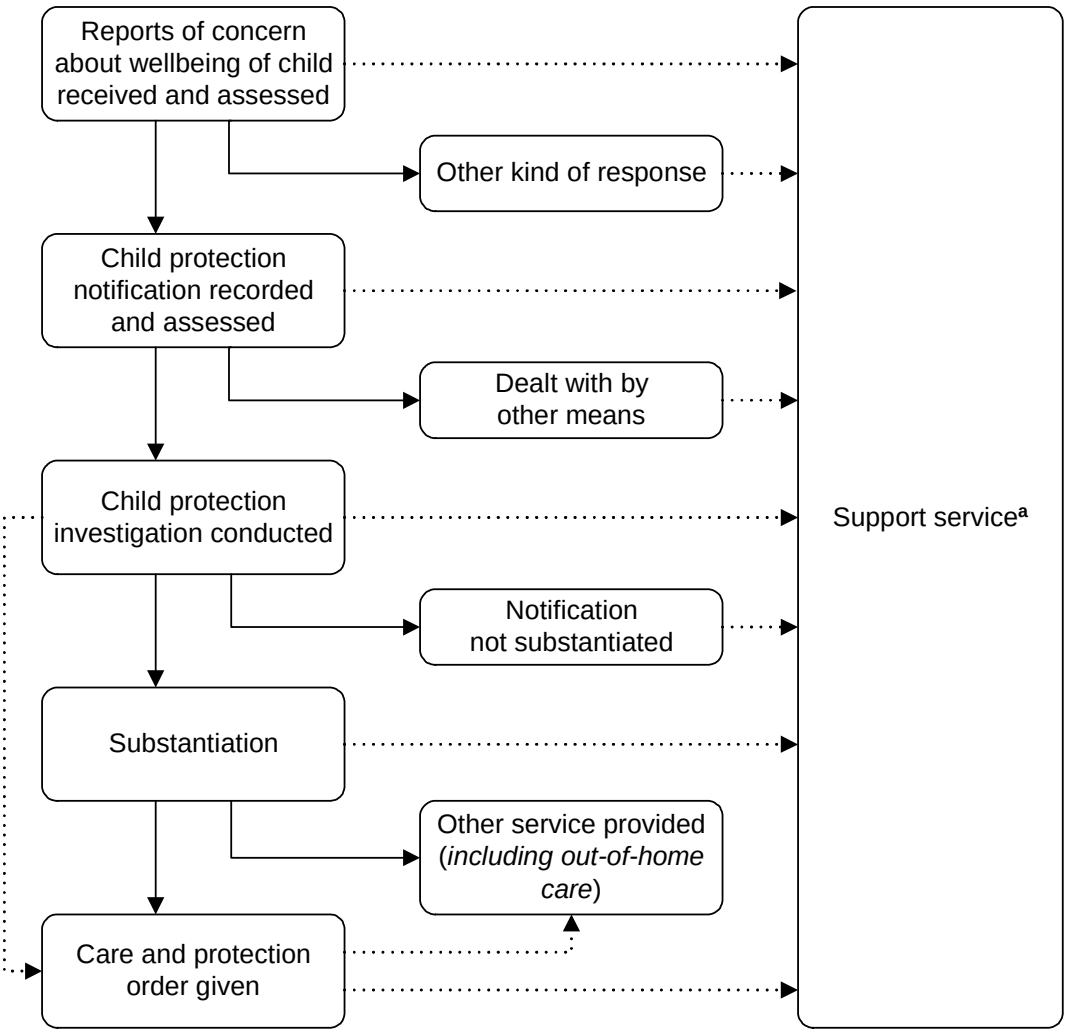
Notification

All jurisdictions, apart from Victoria and the NT, screen each incoming report before deciding whether it will be designated and counted as a notification, thus reducing the proportion of reports that become notifications. WA and Tasmania undertake a further screening process, designed to differentiate between concerns relating to child protection and family support/other matters, which further reduces the number of notifications. For WA and Tasmania therefore, only 'child harm/maltreatment' notifications are the subject of this Report.

In all jurisdictions, notifications are investigated when deemed appropriate, based on the policies and practices in that jurisdiction. Once it has been decided that an investigation is required, the investigation process is similar across jurisdictions. The community services department obtains further information about the child and their family by checking information systems for any previous history, undertaking discussion/case planning with agencies and individuals, interviewing/sighting the child and/or interviewing the caregivers/parents. At a minimum, the child is sighted whenever practicable, and the child's circumstances and needs are assessed. This investigation process will determine whether the notification is substantiated or not substantiated (figure 15.1).

Although notifications are defined differently across jurisdictions, around 99 524 children were the subject of child protection notifications in 2001-02. Nationally in 2001-02, the rate of notifications per 1000 children in the population aged 0–16 years was 22.3. Across jurisdictions, the rate was highest in Victoria (25.9) and lowest in Tasmania (4.0) (table 15A.8).

Figure 15.1 **Child protection system**



Note: Dashed lines indicate that clients may or may not receive these services, depending on need.

[a] Support services include family support or family preservation services provided by community service departments and referrals to other agencies.

Indigenous children

Nationally, 9421 Indigenous children and 90 103 non-Indigenous children were the subject of child protection notifications in 2001-02. The rate of notifications per 1000 children in the population aged 0–16 years was 51.6 for Indigenous children and 21.1 for non-Indigenous children (table 15A.8).

Substantiation

The criteria for substantiation vary across jurisdictions. In some jurisdictions, a notification is substantiated when an incident of abuse or neglect has occurred or is likely to occur; in others, it is substantiated when the child has been harmed or is likely to be harmed, or when there is a combination of action and harm.[2]

If an investigation results in substantiation, then intervention by the relevant community services department may be needed to protect the child. This intervention can take a number of forms, including referral to other services, supervision, counselling or recourse to the court, or placement in out-of-home care.

Across Australia in 2001-02, 25 313 children were the subject of a substantiation. The rate of children who were the subject of a substantiation per 1000 children in the population aged 0–16 years was 5.7. Across jurisdictions, this ranged from 8.3 per 1000 in Queensland to 1.4 per 1000 in Tasmania (table 15A.8).

Indigenous children

Nationally in 2001-02, 3254 Indigenous children and 22 059 non-Indigenous children were the subject of a substantiation. The rate of children who were the subject of a substantiation per 1000 children in the population aged 0–16 years was 17.8 for Indigenous children and 5.2 for non-Indigenous children (table 15A.8).

Care and protection orders

Although child protection substantiations are often resolved without the need for a court order (which is usually a last resort), recourse to the court may take place at any point in the child protection investigation process (figure 15.1). The types of order available vary across jurisdictions.

Across Australia, 20 557 children were on care and protection orders at 30 June 2002. The rate of children on care and protection orders per 1000 children in the population aged 0–17 years was 4.3. Across jurisdictions, this ranged from 5.1 per 1000 in NSW to 2.8 per 1000 in WA (table 15A.8).

[2] In the past child protection legislation and policy focused on the identification and investigation of narrowly defined incidents that were broadly grouped as types of abuse or neglect. Across all jurisdictions, the focus is shifting away from the actions of parents and guardians, towards the outcomes for the child, and the identification and investigation of actual harm to the child and the child's needs.

Indigenous children

Nationally, 4264 Indigenous children and 16 293 non-Indigenous children were on care and protection orders at 30 June 2002. The rate of children on care and protection orders per 1000 children in the population aged 0–17 years was 22.1 for Indigenous children and 3.6 for non-Indigenous children (table 15A.8).

Out-of-home care

Out-of-home care is one of a range of services provided to families and children where there is a need to provide safe care for a child. The current emphasis in policy and practice is to maintain the child within the family if at all possible, and to place a child in out-of-home care only if this will improve the outcome for the child. If it is necessary to remove the child from their home, then placement with the wider family or community is sought where possible, particularly in the case of Indigenous children (AIHW 1999). Continued emphasis is being placed on improving case planning and case management processes, to facilitate the safe return home of children in out-of-home care and to maximise case workers' contact time with children and families.

Across Australia, 18 880 children were in out-of-home care at 30 June 2002. The rate of children in out-of-home care per 1000 children in the population aged 0–17 years was 4.0. Across jurisdictions, this ranged from 5.0 per 1000 in NSW to 2.7 per 1000 in the NT (table 15A.11).

Indigenous children

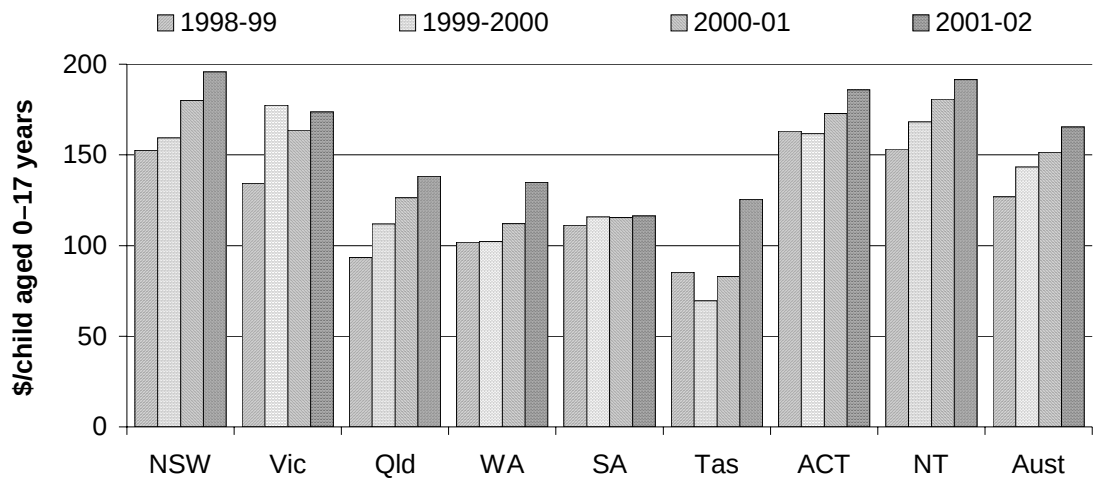
Nationally, 4199 Indigenous children and 14 681 non-Indigenous children were in out-of-home care at 30 June 2002. The rate of children in out-of-home care per 1000 children in the population aged 0–17 years was 21.7 for Indigenous children and 3.2 for non-Indigenous children (table 15A.11).

Funding

Recurrent expenditure on child protection and out-of-home care services was at least $796.6 million across Australia in 2001-02 — a real increase of $80.1 million (or 11.2 per cent) from the 2000-01 expenditure. Nationally, out-of-home care services accounted for the majority (60.2 per cent, or $479.4 million) of this expenditure. Some jurisdictions, however, have difficulty in separating expenditure on child protection from expenditure on out-of-home care services (table 15A.1).

Nationally, real recurrent expenditure per child aged 0–17 years was about $165 in 2001-02. This varied across jurisdictions, from $196 in NSW to $116 in SA (figure 15.2). Real recurrent expenditure on child protection and out-of-home care services per child aged 0–17 years increased in all jurisdictions between 2000-01 and 2001-02.

Figure 15.2 **Real recurrent expenditure on child protection and out-of-home care services (2001-02 dollars)**



Source: State and Territory governments (unpublished); table 15A.1.

It is an objective of the Review to report comparable estimates of costs. Ideally, the full range of costs to government would be determined on a comparable basis across jurisdictions. Where the full costs cannot be counted, costs should be estimated on a consistent basis across jurisdictions. In the area of child protection, however, there are differences across jurisdictions in the costs reported. (Table 15A.4 identifies the level of consistency across jurisdictions for a number of expenditure items.) The scope of child protection systems also varies across jurisdictions, and expenditure on some services may be included for some jurisdictions and not for others (see page 15.6 for a discussion of the child protection system).

15.2 Policy developments in child protection and out-of-home care services

Most jurisdictions are implementing child protection reforms — including the introduction of new legislation — to enhance the safety of children and ensure children and families receive the types of service most likely to meet their needs.

In NSW, legislation that was partially proclaimed in December 2000 provides staff with greater flexibility in responding to a report of child abuse. It also shifts the focus to the children and young people most at risk, and emphasises a search for early solutions through cooperation between the Government and community agencies. The remaining sections of the NSW legislation are yet to be proclaimed.

During 2001-02, Victoria completed a wide-ranging examination of child protection and support services which resulted in the report *An Integrated Strategy for Child Protection and Placement Services.* The report recommended approaches to highlight strengthened prevention and early intervention services, as well as a range of improved service responses for children and young people who are more deeply involved in the protection and placement system. Further details, and other significant policy initiatives for 2001-02 are outlined on Victoria's jurisdictional page.

Queensland's reform of child protection service delivery — commencing in 2000 with the proclamation of the *Child Protection Act 1999* and the implementation of responses to the Forde Inquiry recommendations — has continued. Further policy development and implementation has involved: licensing of care services to ensure the quality of care provided to children and young people in care meets legislated standards; addressing standard of care issues by training staff and community stakeholders involved in assessing such issues, and establishing a formal client complaint mechanism to respond and monitor complaints about services delivered directly to departmental clients.

In WA, the Department for Community Development was established in 2001-02, with the objective of engaging all Western Australians in strengthening and developing their communities. The key principles of inclusiveness, engagement, capacity building and coordination will be applied to build partnerships between service providers and communities, to enhance the delivery of child protection and out-of-home care services.

In SA, a major review on the provision of alternative care services has been completed, and a steering group representing alternative care peak bodies, government and non-government organisations has been appointed to implement recommendations.

In Tasmania, the implementation of the *Children, Young Persons and their Families Act 1997* has resulted in greater emphasis on child and family services. The emphasis is on holistic services that aim to support families to keep children and young people safe within their families. Where this aim is not possible to achieve, the objective is to support the community to promote the best possible future for children and young people in out-of-home care services.

The ACT has had a policy shift — in line with its *Children and Young People Act 1999* — away from substantiating an event or occurrence in a child's life and towards substantiating significant harm to the child. This means that while harm might have occurred, it is necessary before substantiation to establish that the harm has had or will have a significant impact on the development or wellbeing of the child. This may also lead to lower numbers of investigations being substantiated. The Act is being reviewed. Policies and service delivery models are also under review.

15.3 Framework of child protection and out-of-home care services performance indicators

The framework of performance indicators for child protection and out-of-home care services is based on shared government objectives (box 15.3).

Box 15.3 **Objectives for child protection and out-of-home care services**

The aims of child protection services are to:

- protect children and young people at risk of harm within their family or in circumstances in which the family of the child or young person does not have the capacity to protect them; and
- assist families to protect children and young people.

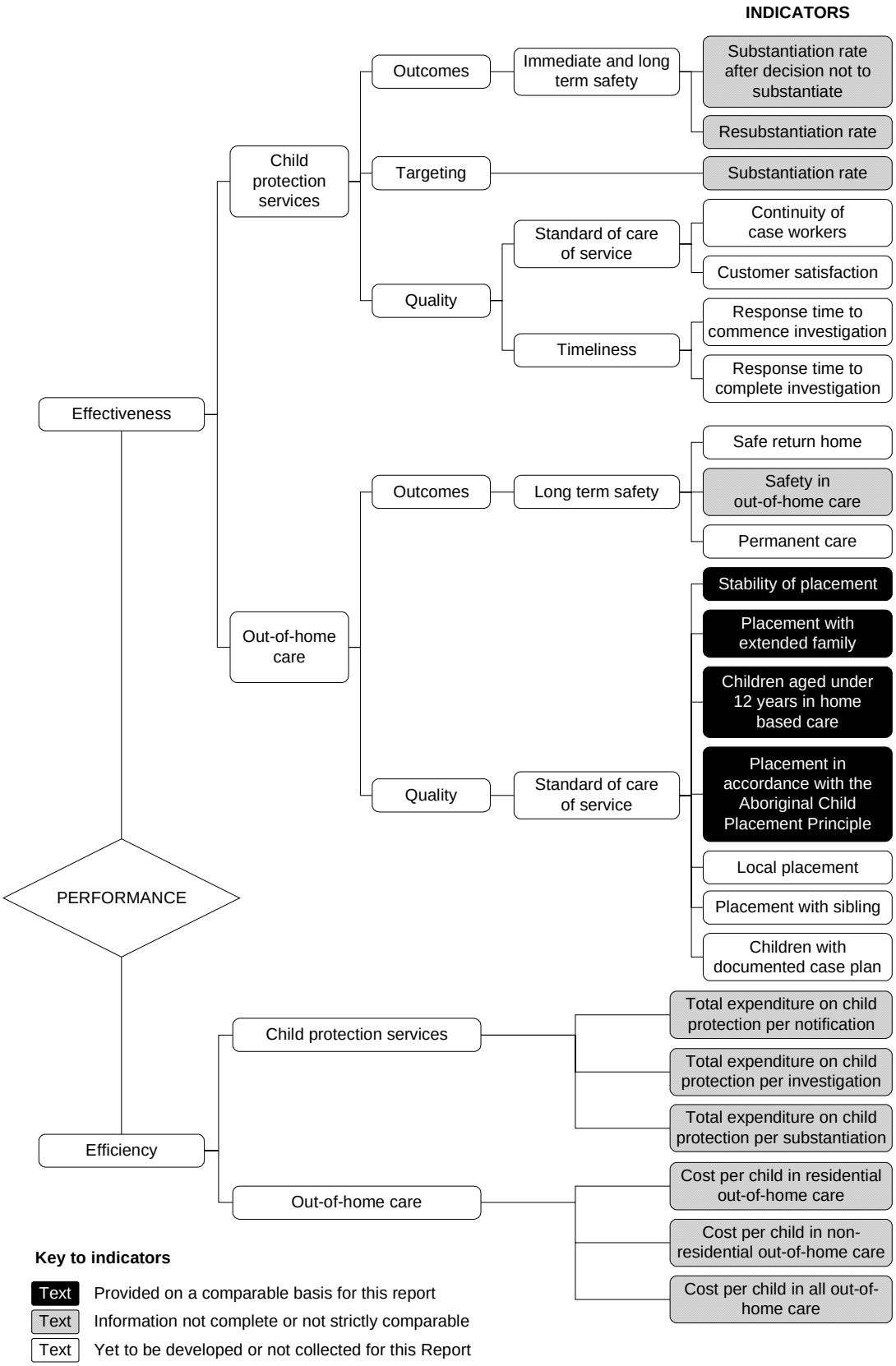
The aim of out-of-home care services is to provide quality care for children and young people aged 17 years and under who cannot live with their parents for reasons of safety or family crisis.

Child protection and out-of-home care services should be provided in an efficient and effective manner.

The goal of child protection is to maintain the child within the family wherever this can be safely achieved. In some situations, however, it may be necessary to place the child in out-of-home care. The framework identifies key result areas that indicate the extent to which these broad objectives are met (figure 15.3).

The performance indicator framework, and those indicators that are comparable in the 2003 Report, are shown in figure 15.3. For data that are not considered strictly comparable, the text includes relevant caveats and supporting commentary. Chapter 1 discusses data comparability from a Report-wide perspective (see section 1.6).

Figure 15.3 **Performance indicators for child protection and out-of-home care services**



15.4 Key child protection and out-of-home care services performance indicator results

Different delivery contexts, locations and types of client may affect the effectiveness and efficiency of child protection services. Appendix A contains detailed statistics which may assist in interpreting the performance indicators.

Effectiveness: child protection services

Outcomes — resubstantiation rate

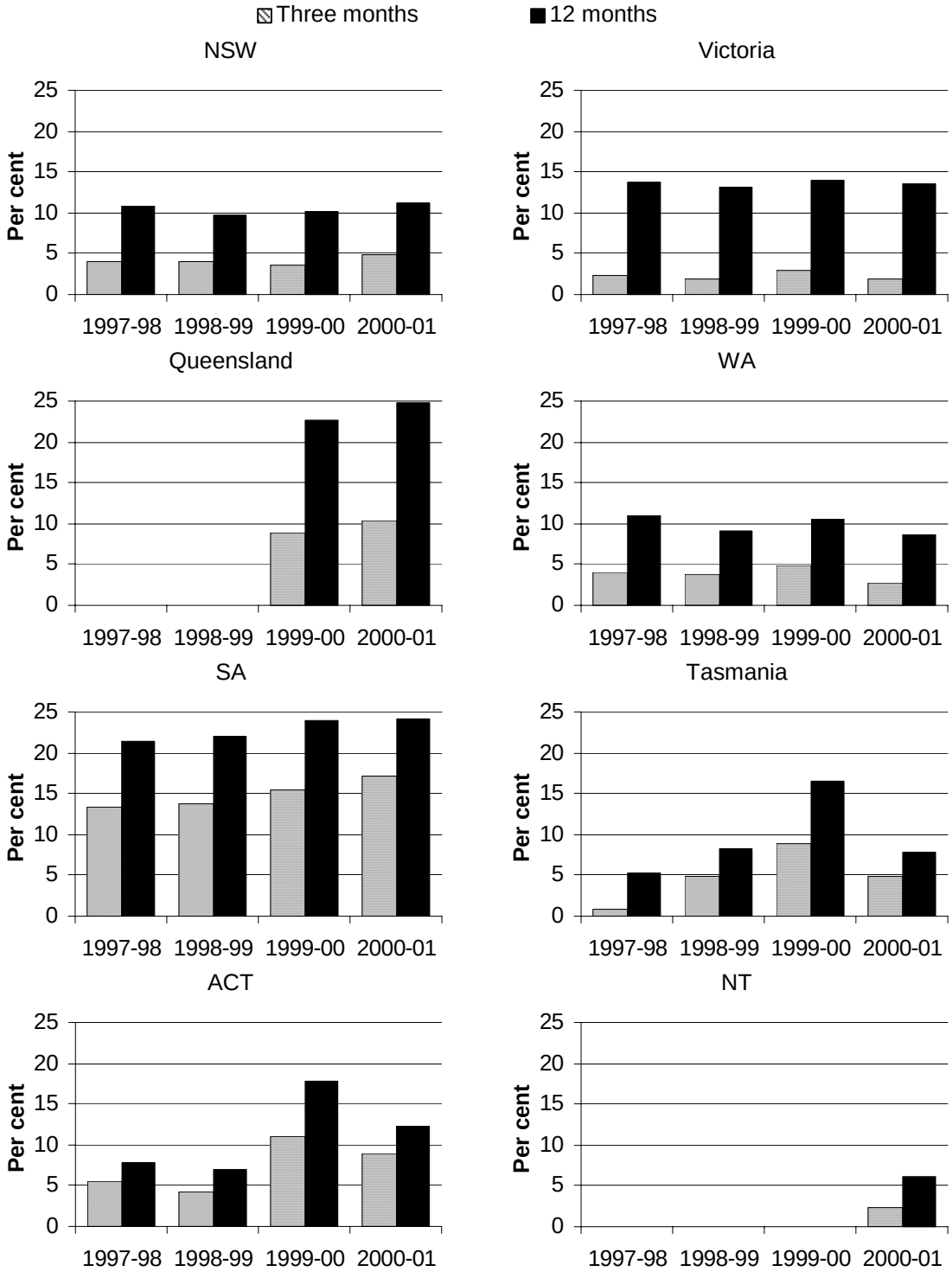
Child protection services aim to prevent the recurrence of abuse and neglect or harm to children. One way of observing whether this is achieved is to measure the number of children who were the subject of a resubstantiation. This indicator of service outcomes is important because it partly reveals the extent to which intervention by child protection services has succeeded in preventing further harm. Reported results, however, may be affected by factors that are beyond the control of child protection services, such as changes in the family situation (for example, illness, unemployment, a new partner).

Resubstantiation is measured by counting the proportion of children who were the subject of a substantiation in the previous financial year (2000-01 for this Report) and who were subsequently the subject of a further substantiation within the following three and/or 12 months.

Data that are comparable across jurisdictions were not available for this Report, but data are comparable within each jurisdiction over time (figure 15.4).

- In NSW, the proportion of children who were the subject of a resubstantiation within three months after an initial substantiation in 2000-01 was 4.9 per cent (an increase of 1.3 percentage points from 1999-2000). The proportion who were the subject of a resubstantiation within 12 months was 11.1 per cent (an increase of 0.9 percentage points from 1999-2000) (table 15A.29).
- In Victoria, the proportion of children who were the subject of a resubstantiation within three months after an initial substantiation in 2000-01 was 1.9 per cent (a decline of 1.0 percentage point from 1999-2000). The proportion who were the subject of a resubstantiation within 12 months was 13.7 per cent (a decline of 0.3 percentage points from 1999-2000) (table 15A.45).

Figure 15.4 **Proportion of children who were the subject of a substantiation during the previous year, who were the subject of a subsequent substantiation within three and 12 months[a]**



a Data are not comparable across jurisdictions because definitions of substantiation vary significantly. Consequently, rates should not be compared across jurisdictions.

Source: AIHW *Child protection notifications, investigations and substantiations, Australia* data collection (unpublished); tables 15A.29, 15A.45, 15A.61, 15A.77, 15A.93, 15A.109, 15A.125 and 15A.141.

- In Queensland, the proportion of children who were the subject of a resubstantiation within three months after an initial substantiation in 2000-01 was 10.4 per cent (an increase of 1.4 percentage point from 1999-2000). The proportion who were the subject of a resubstantiation within 12 months was 24.8 per cent (an increase of 2.2 percentage points from 1999-2000) (table 15A.61).
- In WA, the proportion of children who were the subject of a resubstantiation within three months after an initial substantiation in 2000-01 was 2.8 per cent (a decline of 2.1 percentage points from 1999-2000). The proportion who were the subject of a resubstantiation within 12 months was 8.7 per cent (a decline of 1.8 percentage points from 1999-2000) (table 15A.77).
- In SA, the proportion of children who were the subject of a resubstantiation within three months after an initial substantiation in 2000-01 was 17.2 per cent (an increase of 1.8 percentage points from 1999-2000). The proportion who were the subject of a resubstantiation within 12 months was 24.2 per cent (an increase of 0.3 percentage points from 1999-2000) (table 15A.93).
- In Tasmania, the proportion of children who were the subject of a resubstantiation within three months after an initial substantiation in 2000-01 was 5.0 per cent (a decline of 3.9 percentage points from 1999-2000). The proportion who were the subject of a resubstantiation within 12 months was 7.9 per cent (a decline of 8.6 percentage points from 1999-2000) (table 15A.109).
- In the ACT, the proportion of children who were the subject of a resubstantiation within three months after an initial substantiation in 2000-01 was 8.9 per cent (a decline of 2.2 percentage points from 1999-2000). The proportion who were the subject of a resubstantiation within 12 months was 12.3 per cent (a decline of 5.6 percentage points from 1999-2000) (table 15A.125).
- In the NT, the proportion of children who were the subject of a resubstantiation within three months after an initial substantiation in 2000-01 was 2.4, while the proportion who were the subject of a resubstantiation within 12 months was 6.0 (table 15A.141). The NT was unable to provide data for previous years.

Outcomes — substantiation rate after a decision not to substantiate

This indicator measures the proportion of children who were the subject of an investigation in the previous financial year which led to a decision not to substantiate, who were subsequently the subject of a substantiation within three and 12 months of the initial decision not to substantiate. This indicator is important because it partly reveals the extent to which an investigation has not succeeded in identifying the risk of harm to a child who is subsequently the subject of

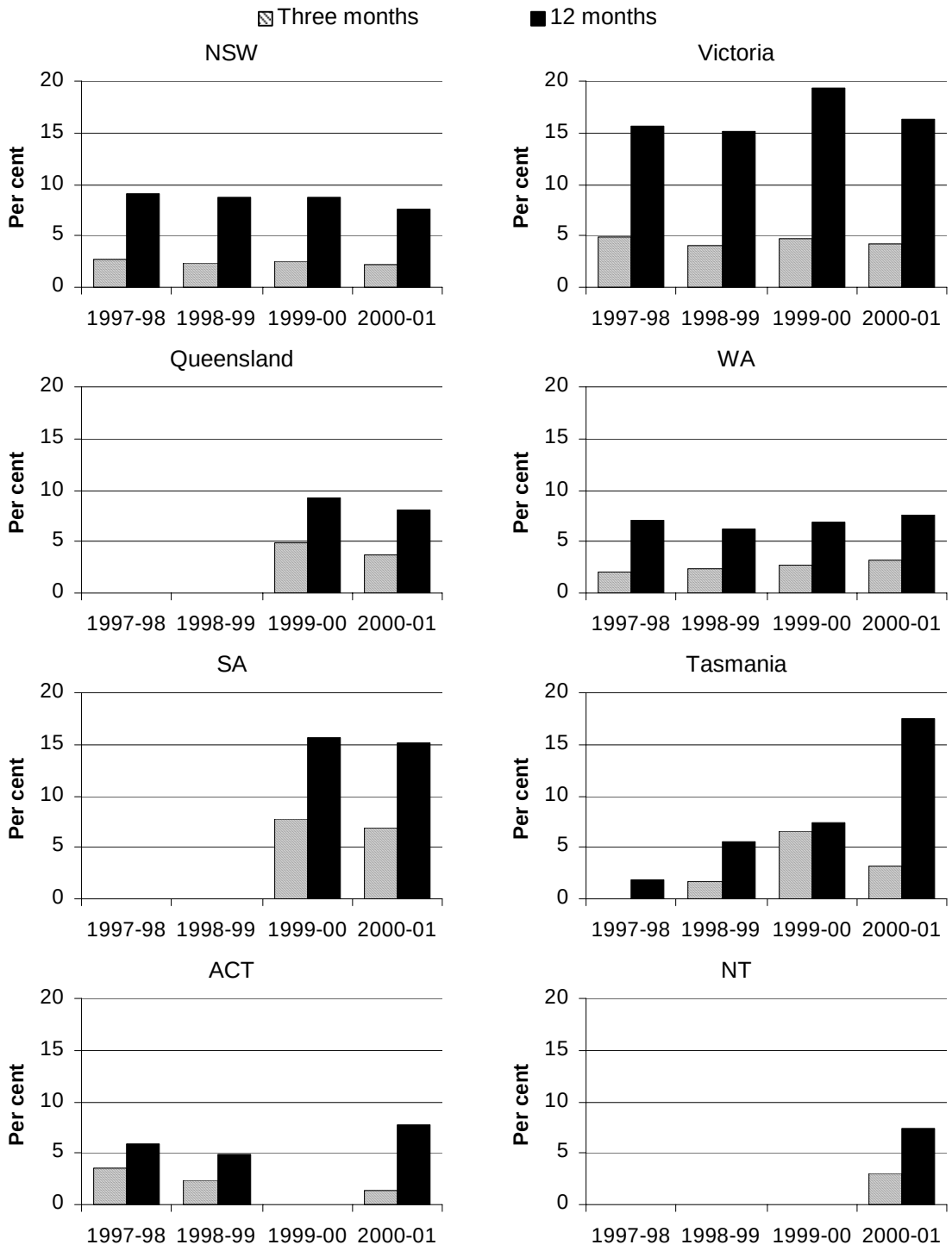
substantiated harm. It should be noted, however, that a demonstrable risk of harm might not have existed in the first instance. As such, reported results may be affected by factors that are beyond the control of child protection services.

Data that are comparable across jurisdictions were not available for this Report, but data are comparable within each jurisdiction over time (figure 15.5).

- In NSW, the proportion of children who were the subject of a decision not to substantiate in 2000-01 and then the subject of a substantiation within three months was 2.1 per cent (a decline of 0.4 percentage points from 1999-2000). The proportion who were the subject of a decision not to substantiate in 2000-01 and then the subject of a substantiation within 12 months was 7.6 per cent (a decline of 1.1 percentage points from 1999-2000) (table 15A.28).
- In Victoria, the proportion of children who were the subject of a decision not to substantiate in 2000-01 and then the subject of a substantiation within three months was 4.2 per cent (a decline of 1.5 percentage points from 1999-2000). The proportion who were the subject of a decision not to substantiate in 2000-01 and then the subject of a substantiation within 12 months was 16.3 per cent (a decline of 3.0 percentage points from 1999-2000) (table 15A.44).

  In Queensland, the proportion of children who were the subject of a decision not to substantiate in 2000-01 and then the subject of a substantiation within three months was 3.8 per cent (a decline of 1.1 percentage points from 1999-2000). The proportion who were the subject of a decision not to substantiate in 2000-01 and then the subject of a substantiation within 12 months was 8.0 per cent (a decline of 1.2 percentage points from 1999-2000) (table 15A.60).
- In WA, the proportion of children who were the subject of a decision not to substantiate in 2000-01 and then the subject of a substantiation within three months was 3.2 per cent (an increase of 0.5 percentage points from 1999-2000). The proportion who were the subject of a decision not to substantiate in 2000-01 and then the subject of a substantiation within 12 months was 7.5 per cent (an increase of 0.6 percentage points from 1999-2000) (table 15A.76).
- In SA, the proportion of children who were the subject of a decision not to substantiate in 2000-01 and then the subject of a substantiation within three months was 6.9 per cent (a decline of 0.8 percentage points from 1999-2000). The proportion who were the subject a decision not to substantiate 2000-01 and then the subject of a substantiation within 12 months was 15.1 per cent (a decline of 0.6 percentage points from 1999-2000) (table 15A.92).

Figure 15.5 **Proportion of children who were the subject of an investigation and decision not to substantiate in the previous year, who were the subject of a subsequent substantiation within three and/or 12 months[a]**



a Data are not comparable across jurisdictions because definitions of substantiation vary significantly. Consequently, rates should not be compared across jurisdictions.

Source: AIHW *Child protection notifications, investigations and substantiations, Australia* data collection (unpublished); tables 15A.28, 15A.44, 15A.60, 15A.76, 15A.92, 15A.108, 15A.124 and 15A.140.

- In Tasmania, the proportion of children who were the subject of a decision not to substantiate in 2000-01 and then the subject of a substantiation within three months was 3.2 per cent (a decline of 3.4 percentage points from 1999-2000). The proportion who were the subject of a decision not to substantiate in 2000-01 and then the subject of a substantiation within 12 months was 17.5 per cent (an increase of 10.1 percentage points from 1999-2000) (table 15A.108).
- In the ACT, the proportion of children who were the subject of a decision not to substantiate in 2000-01 and then the subject of a substantiation within three months was 1.3 per cent. The proportion who were the subject of a decision not to substantiate in 2000-01 and then the subject of a substantiation within 12 months was 7.7 per cent (table 15A.124). Data for 1999-2000 were not available for comparison.
- In the NT, the proportion of children who were the subject of a decision not to substantiate in 2000-01 and then the subject of a substantiation within three months was 3.0 per cent. The proportion who were the subject of a decision not to substantiate in 2000-01 and then the subject of a substantiation within 12 months was 7.4 per cent (table 15A.140). The NT was unable to provide data for previous years.

Targeting — substantiation rate

Targeting is conceptually difficult to measure. The substantiation rate (the proportion of finalised investigations that result in substantiation) attempts to measure the effectiveness of targeting of investigations, in terms of the human and financial cost of investigation where no harm has occurred. Decisions on targeting must weigh up the investigation costs against the cost of failing to investigate a case where harm has occurred. The substantiation rate provides information on only one aspect of targeting — that is, the proportion of investigations that substantiated harm. It provides no information on cases that were not investigated but for which an investigation would have substantiated harm.

An increase in the substantiation rate may reflect changes in targeting strategies (that is, the same number of investigations with increased targeting of cases where harm has occurred). For example, more narrow targeting (that is, fewer investigations targeted at the highest priority cases). In the case of narrower targeting, the benefits (both human and financial) from fewer investigations need to be weighed against the costs of harm having occurred in the 'lower risk' cases (as determined by the assessment process) that were not investigated.

Differences in the substantiation rate across jurisdictions (when comparable data are available) and changes over time within jurisdictions are best used, therefore, to

prompt further analysis, rather than to be considered as definitive performance information.

Data that are comparable across jurisdictions were not available for this Report because definitions of substantiation vary across jurisdictions, but data are comparable within each jurisdiction over time unless otherwise stated (figure 15.6).

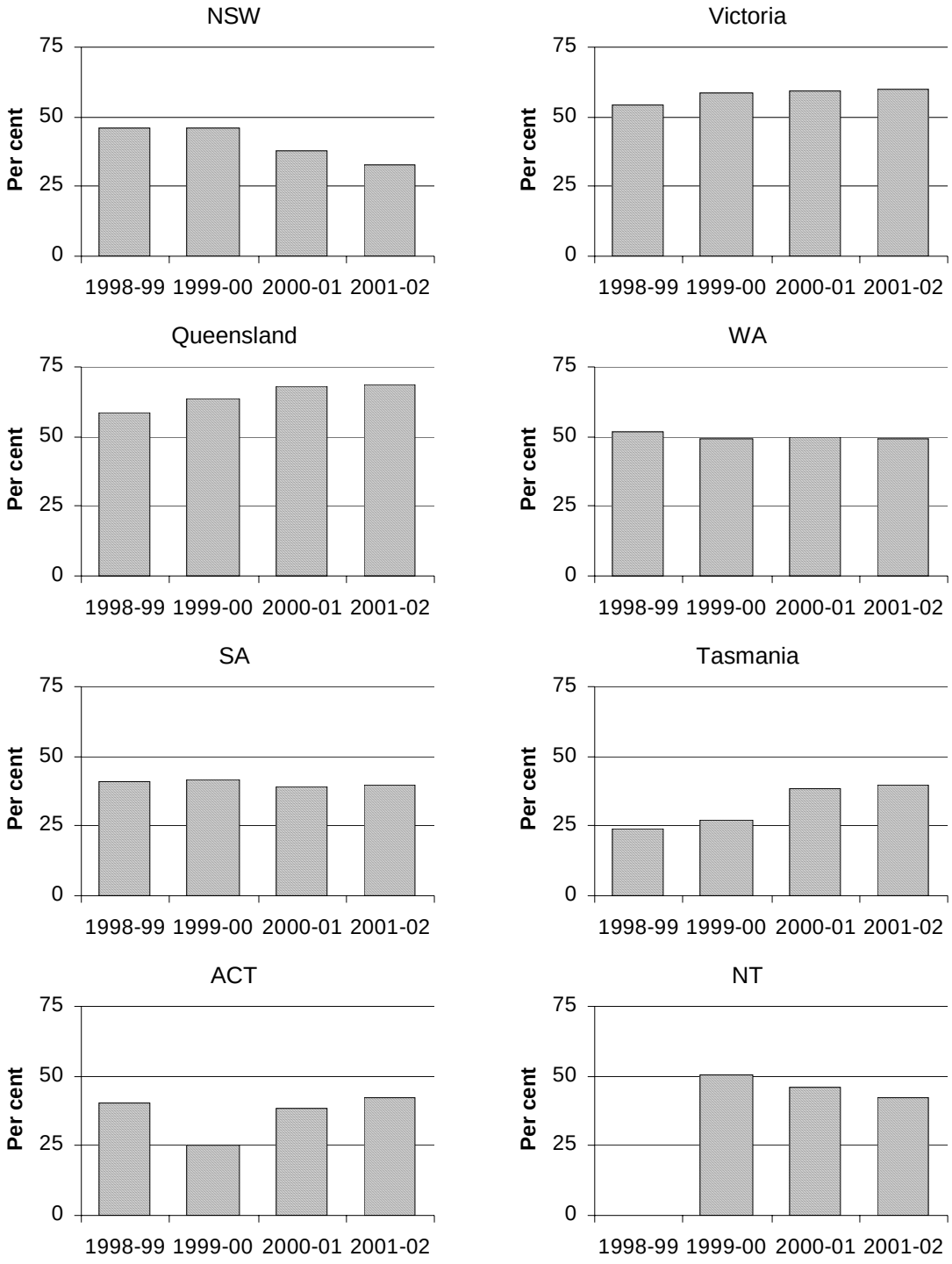
- In NSW, the substantiation rate was 32.8 per cent in 2001-02 — a decline of 4.9 percentage points from 2000-01 (table 15A.24).
- In Victoria, the substantiation rate was 59.7 per cent in 2001-02 — an increase of 0.8 percentage points from 2000-01 (table 15A.40).
- In Queensland, the substantiation rate was 68.6 per cent in 2001-02 — an increase of 0.6 percentage points from 2000-01 (table 15A.56).
- In WA, the substantiation rate was 48.9 per cent in 2001-02 — a decline of 0.9 percentage points from 2000-01 (table 15A.72).
- In SA, the substantiation rate was 39.7 per cent in 2001-02 — an increase of 0.7 percentage points from 2000-01 (table 15A.88).
- In Tasmania, the substantiation rate was 39.9 per cent in 2001-02 — an increase of 1.5 percentage points from 2000-01 (table 15A.104).
- In the ACT, the substantiation rate was 42.1 per cent in 2001-02 — an increase of 3.7 percentage points from 2000-01 (table 15A.120).
- In the NT, the substantiation rate was 42.4 per cent in 2001-02 — a decline of 3.9 percentage points from 2000-01 (table 15A.136).

Effectiveness: out-of-home care services

Client outcomes — safety in out-of-home care

One indicator of the effectiveness of out-of-home care is the safety of clients in care situations. Only Victoria, Queensland, WA, Tasmania and the ACT were able to provide data on the incidence of child protection substantiations in 2001-02 where the person believed responsible was either the carer or another person living in the household. In less than 1 per cent of cases in all jurisdictions that provided data, except Queensland (3.8 per cent), children in out of home care were subject to a substantiation and the person believed responsible was living in the household (table 15A.20). Data are not comparable across jurisdictions, as a result of differences in policy and recording.

Figure 15.6 **Proportion of finalised child protection investigations that were substantiated[a]**



a Data are not comparable across jurisdictions because definitions of substantiation vary significantly. Consequently, rates should not be compared across jurisdictions.

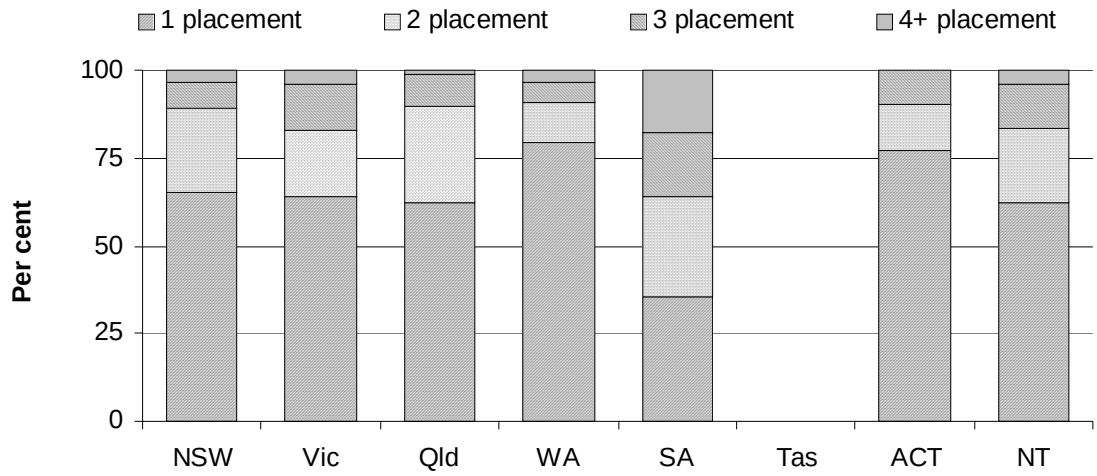
Sources: AIHW *Child protection notifications, investigations and substantiations, Australia* data collection (unpublished); tables 15A.24, 15A.40, 15A.56, 15A.72, 15A.88, 15A.104, 15A.120 and 15A.136.

Service quality — stability of placement

Stability of placement for children placed away from their family for protective reasons is an important indicator of service quality, particularly for those children who require long term placements. Many children will have more than one placement for good reasons (for example, an initial placement followed by a longer term placement).

Data were collected on the number of different placements for children on a care and protection order who had exited out-of-home care in 2001-02. Data were grouped according to the length of time in care (less than 12 months and 12 months or more). For the jurisdictions able to provide data (apart from SA), more than half the children on a care and protection order who exited care in 2001-02 after less than 12 months had had only one placement. The proportion of children who had only one placement ranged from 79.6 per cent in WA to 35.7 per cent in SA (figure 15.7).

Figure 15.7 **Children on a care and protection order and exiting care after less than 12 months, by number of different placements, 2001-02[a, b]**

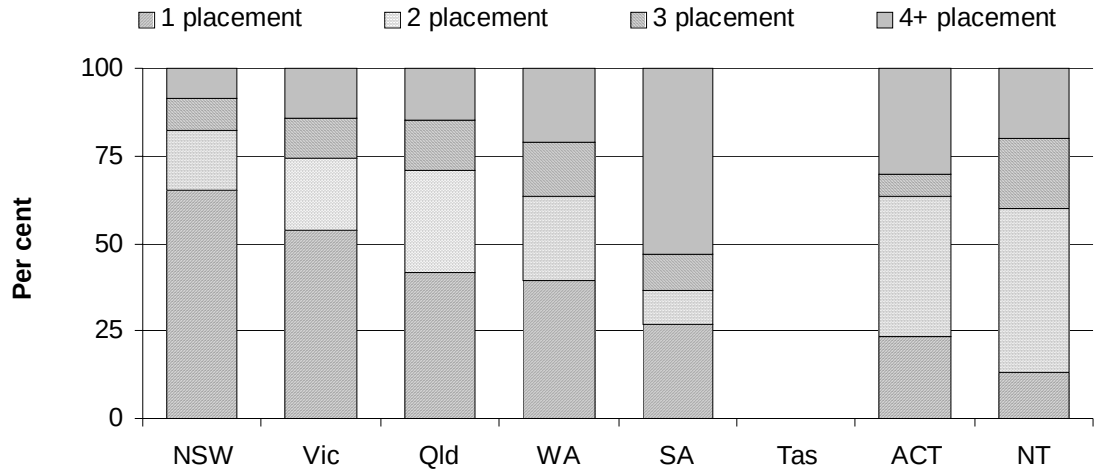


a Data refer to children exiting care in 2001-02. **b** Out-of-home care data are not the same for each State and Territory. Refer to footnotes in the source table for information about what each jurisdiction's data include.

Source: AIHW *Children in out-of-home care, Australia data collection* (unpublished); table 15A.19.

For the jurisdictions able to provide data, children who had been in out-of-home care longer tended to have had more placements. The proportion of children exiting care in 2001-02 after 12 months or more who had experienced one placement ranged from 65.1 per cent for NSW to 13.3 per cent in the NT (figure 15.8).

Figure 15.8 **Children on a care and protection order and exiting care after 12 months or more, by number of different care placements, 2001-02[a, b]**



a Data refer to children exiting care in 2001-02. **b** Out-of-home care data are not the same for each State and Territory. Refer to footnotes in the source table for information about what each jurisdiction's data include.

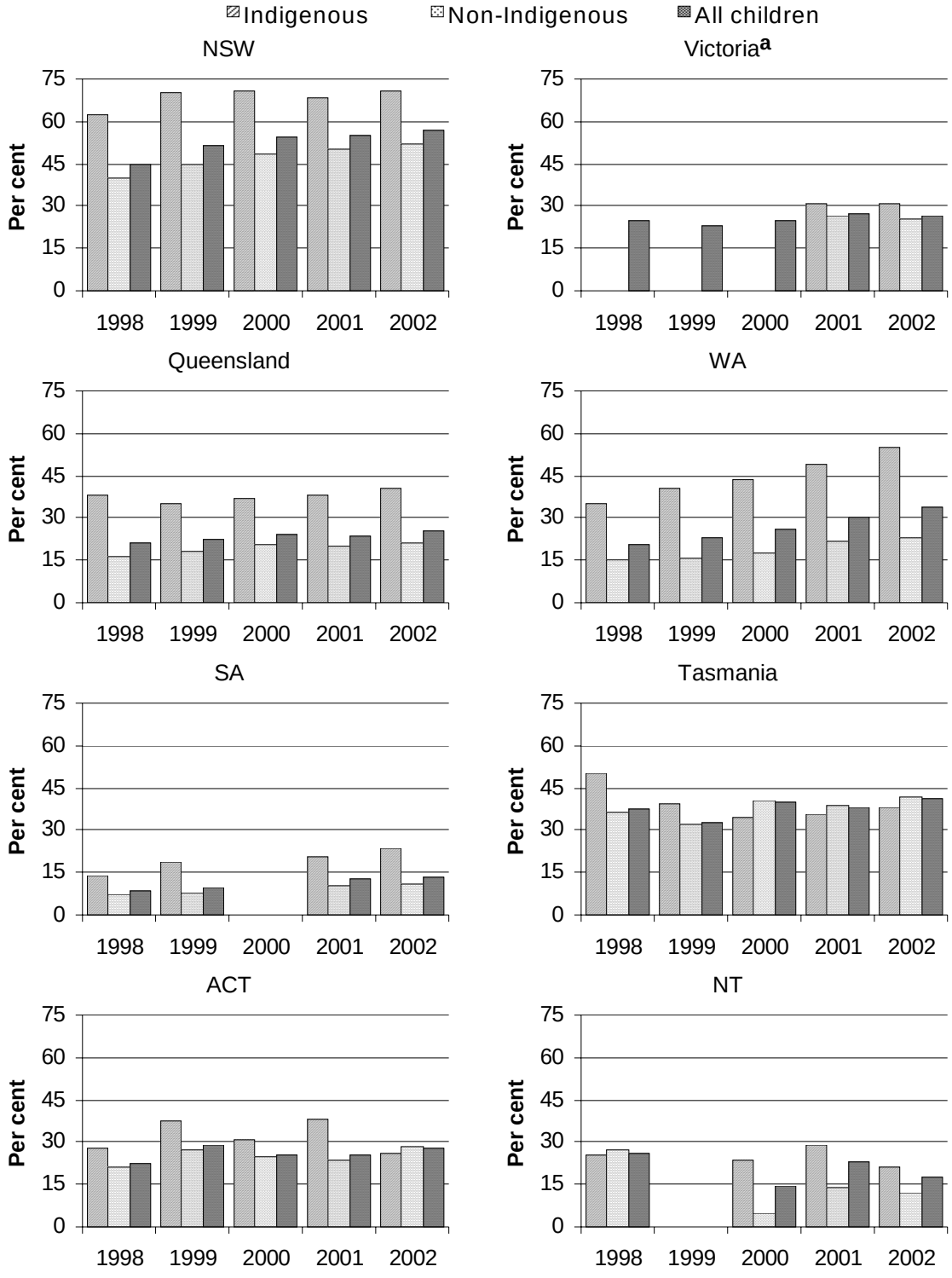
Source: AIHW *Children in out-of-home care, Australia data collection* (unpublished); table 15A.19.

Service quality — placement with extended family or in home- based care

The type of placement is another indicator of the quality of child placement. Placing children with their relatives or kin is generally preferred for children in out-of-home care. The proportion of children placed with relatives or kin at 30 June 2002 ranged from 56.9 per cent in NSW to 13.3 per cent in SA. The proportion of children placed with relatives or kin was greater for Indigenous children than for non-Indigenous children in all jurisdictions except Tasmania and the ACT (figure 15.9).

Placing children in home-based care is generally considered to be in their best interests, particularly for younger children. The proportion of children aged under 12 years who were placed in home-based care at 30 June 2002 ranged from 99.1 per cent in SA to 86.0 per cent in Tasmania. In all jurisdictions except NSW and SA, the proportion of Indigenous children aged under 12 years placed in home-based care was smaller than the proportion of non-Indigenous children (figure 15.10).

Figure 15.9 **Proportion of children in out-of-home care placed with relatives/kin, by Indigenous status, 30 June**

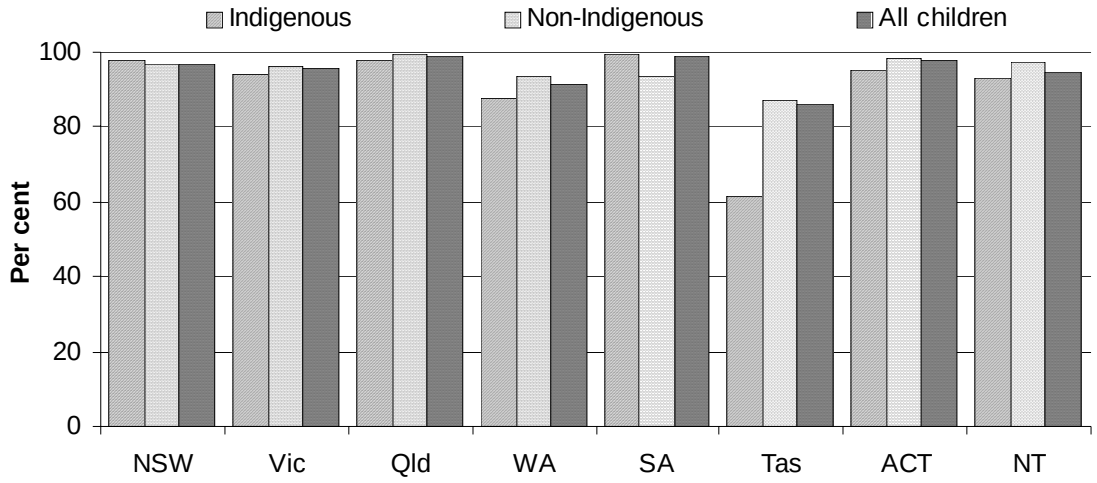


a Prior to 2001, Victoria was unable to provide data by Indigenous status.

Sources: AIHW *Children in out-of-home care, Australia data collection* (unpublished); tables 15A.35, 15A.51, 15A.67, 15A.83, 15A.99, 15A.115, 15A.131 and 15A.147.

It is also desirable to place children locally, so some elements of their life remain unchanged (for example, enabling the child to continue attendance at the same school). Data are not yet available for this indicator.

Figure 15.10 **Proportion of children aged under 12 years in out-of-home care placed in home-based care, by Indigenous status, 30 June 2002**



Source: AIHW *Children in out-of-home care, Australia data collection* (unpublished); table 15A.18.

Service quality — placement in accordance with the Aboriginal Child Placement Principle

According to the Aboriginal Child Placement Principle, the following hierarchy or placement preference should be pursued for Indigenous children:

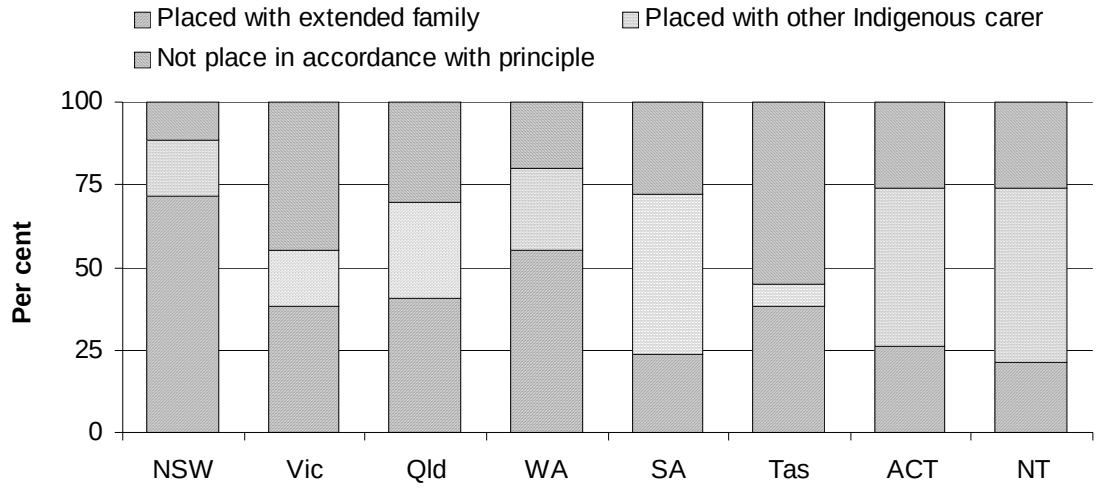
- placement with the child's extended family (which includes Indigenous and non-Indigenous relatives/kin);
- placement within the child's Indigenous community; or
- placement with other Indigenous people (NLRC 1997).

All jurisdictions have adopted this principle either in legislation or policy. The proportion of Indigenous children in out-of-home care at 30 June 2002 placed in accordance with the principle ranged from 88.3 per cent in NSW to 44.8 per cent in Tasmania (figure 15.11).

The preferred placement option outlined under the Aboriginal Child Placement Principle is placement with the child's extended family. The proportion of Indigenous children in out-of-home care placed with extended family at 30 June 2002 ranged from 71.6 per cent in NSW to 21.4 per cent in the NT. Placement with other Indigenous care providers (the child's Indigenous community or other

Indigenous people) also complies with the principle. The proportion, at 30 June 2002, placed with other Indigenous care providers ranged from 52.4 per cent in the NT to 16.3 per cent in NSW (table 15A.17).

Figure 15.11 **Placement of Indigenous children in out-of-home care, 30 June 2002[a, b, c]**



a Excludes Indigenous children living independently and those whose living arrangements were unknown. **b** 'Placed with another Indigenous carer' includes those living in Indigenous residential care.**c** Note that data for Tasmania and the ACT relate to a small number of Indigenous children (29 and 27 respectively) in care at 30 June 2002.

Source: AIHW *Children in out-of-home care, Australia data collection* (unpublished); table 15A.17.

Customer satisfaction

Client views can be used to report on service delivery and to learn important information about how to improve services. Although the use of client surveys in child protection services is not yet common, the Victorian Department of Human Services (DHS) and the Queensland Department of Families have completed exploratory work in this area.

Victorian child protection client and family survey

The DHS commissioned a survey in 2001 of clients and family members who had reached the substantiation stage in their engagement with the Victorian child protection system. Survey respondents included 457 young people aged 11–18 years old and 472 parents and family members. The survey was designed to assess the child protection service by focusing on the following for clients and families:

- *their experience during initial involvement*, with a focus on whether the respondents understood the reason for Child Protection's involvement and actions, were given the opportunity to state their views and were provided with accessible information on what needed to be done and their options, and whether they accepted Child Protection's involvement as reasonable;
- *their perceptions of child protection workers*, with a focus on the child protection workers' responsiveness, issues associated with continuity and general understanding of the respondents' circumstances;
- *their involvement in decisions*, with a focus on whether the respondents' views were acknowledged and their support for progress and processes for dealing with disagreements about decisions;
- *their experience with links to other services*, with a focus on the availability of information and support to access other services, and whether these services were beneficial to the respondents;
- *their overall perceptions of child protection services*, with a focus on perceptions of the child care workers (whether they were fair, helpful and inclusive), whether the services were beneficial (by improving the clients sense of safety, helping the client access needed help, making the client's overall circumstances better), and the respondents' general level of satisfaction with the service; and
- *out-of-home placement experiences*, with a focus on whether the respondents were informed of the reason for placement and whether there was active encouragement to maintain contact with the family.

The survey revealed a number of specific strengths along with areas for improvement. The strengths in child protection practice included:

- that child protection intervention improved the safety (69 per cent) and life circumstances (75 per cent) of young people who were clients;
- that the majority of parents and families reported that they understood the reason for child protection involvement (62 per cent), were provided with information about other services (62 per cent) and were given reasons for actions (68 per cent); and
- that where young people were placed in out-of-home care, child protection intervention outcomes were better for clients living with relatives.

The survey also identified the following areas for improvement:

- the extent of, and arrangements for, worker changeover;
- the level of contact from workers, including telephone contact and visits;
- the lack of opportunity for decisions to be reviewed and the minimal involvement of families in decision making;

- poor satisfaction of parents of adolescent clients with child protection;
- clients' understanding of information and the linking of families with appropriate services; and
- the level of support and encouragement provided to family members in their contact with young people placed in out-of-home care.

Queensland Client and Carer Survey

The Queensland Department of Families commissioned Colmar Brunton Social Research to plan, implement and analyse the Client and Carer Survey (CBSR 2001). The survey objectives included the establishment of baseline data to inform appropriate benchmarks of client and carer satisfaction, and to provide data on which service areas need to be improved. The survey — which commenced in July 2000 and was finalised in October 2001 — canvassed 216 young people in the guardianship of the department, 150 parents of children or young people who were subject to case work intervention, and 477 foster carers.

The key findings were that approximately 50 per cent of young people surveyed, nearly half of the carers surveyed and approximately 30 per cent of parents surveyed were satisfied with the services received over the previous 12 months (table 15.1).

Table 15.1 **Proportion of respondents to the Queensland Client and Carer Survey who were 'satisfied' with the service they had received, 2000 (per cent)[a]**

	Young people	*Parents*	*Carers*
Overall satisfaction with service received over previous 12 months	50.5	29.3	48.2
Overall satisfaction with amount of contact with family services officer	46.8	34.7	51.3
Overall satisfaction with number of family services officer over previous 12 months	55.1	38.3	**na**
Overall satisfaction with number of placements	71.8	41.4	**na**
Overall satisfaction with the care received	83.8	50.7	**na**

a In the survey, levels of satisfaction with services overall and with a number of service aspects, were measured using a 10-point scale. Respondents were able to choose any number from 1 (extremely dissatisfied) to 10 (extremely satisfied). To assist in analysis, scores towards the lower end of the scale (1–4) were summed and categorised as 'dissatisfied' and higher scores (7–10) were summed and categorised as 'satisfied'. **na** Not available.

Source: Colmar Brunton Social Research (CBSR) (2001).

Efficiency

Understanding the efficiency of the child protection systems that they administer helps State and Territory governments to identify the key cost drivers of their systems and to weigh the efficacy of options for addressing child protection issues.

Challenges in reporting efficiency for child protection systems

Although the Review is committed to reporting comparable efficiency data, identifying and measuring comparable and meaningful unit cost indicators for child protection is problematic. As outlined in section 15.1, the child protection systems in Australia have evolved under the auspices of State and Territory governments so the emphasis of the systems and processes varies across jurisdictions. Further, across most jurisdictions, there is an increasing but variable emphasis on tailoring services to meet the individual client's needs, including a greater focus on diversionary options (box 15.1). In addition, in many jurisdictions, there is not an easy separation between the delivery of child protection services, out-of-home care services and other support services for families. It is difficult, therefore, to apportion costs consistently across these services. Finally, the State and Territory agencies responsible for child protection issues are typically encompassed within larger community services departments, and it can be difficult to identify discretely many of the costs associated with child protection. (Table 15A.4 identifies the level of consistency in expenditure data across jurisdictions.)

The pathways project

In April 2002, the Protection and Support Working Group initiated a project to develop a method for annual reporting of efficiency data for a national framework of protection and support pathways. This project was completed in January 2003. The model proposed in the final consultancy report is expected to influence efficiency reporting for protection and support services for future Reports.

Limitations of reported indicators

This Report includes proxy efficiency indicators for child protection and out-of-home care.

Issues with child protection efficiency indicators

Three different indicators of child protection costs are provided. These indicators were calculated by dividing total expenditure on child protection by the numbers of

notifications, investigations and substantiations. They do not indicate the cost per notification, cost per investigation and cost per substantiation so need to be interpreted with care. The three different indicators are:

- **total expenditure on child protection** per notification;
- **total expenditure on child protection** per investigation; and
- **total expenditure on child protection** per substantiation.

While these indicators may provide some insight into the cost of providing child protection services, they should not be added together**.**

Issues with out-of-home care efficiency indicators

The out-of-home care proxy efficiency indicators look at the cost of placements in residential care, non-residential care and all residential care (the sum of the previous two). Some jurisdictions are unable to disaggregate their expenditure into residential and non-residential care. The number of children in each type of care is available for a snapshot day on 30 June each year. This allows for the following three proxy efficiency indicators for out-of-home care:

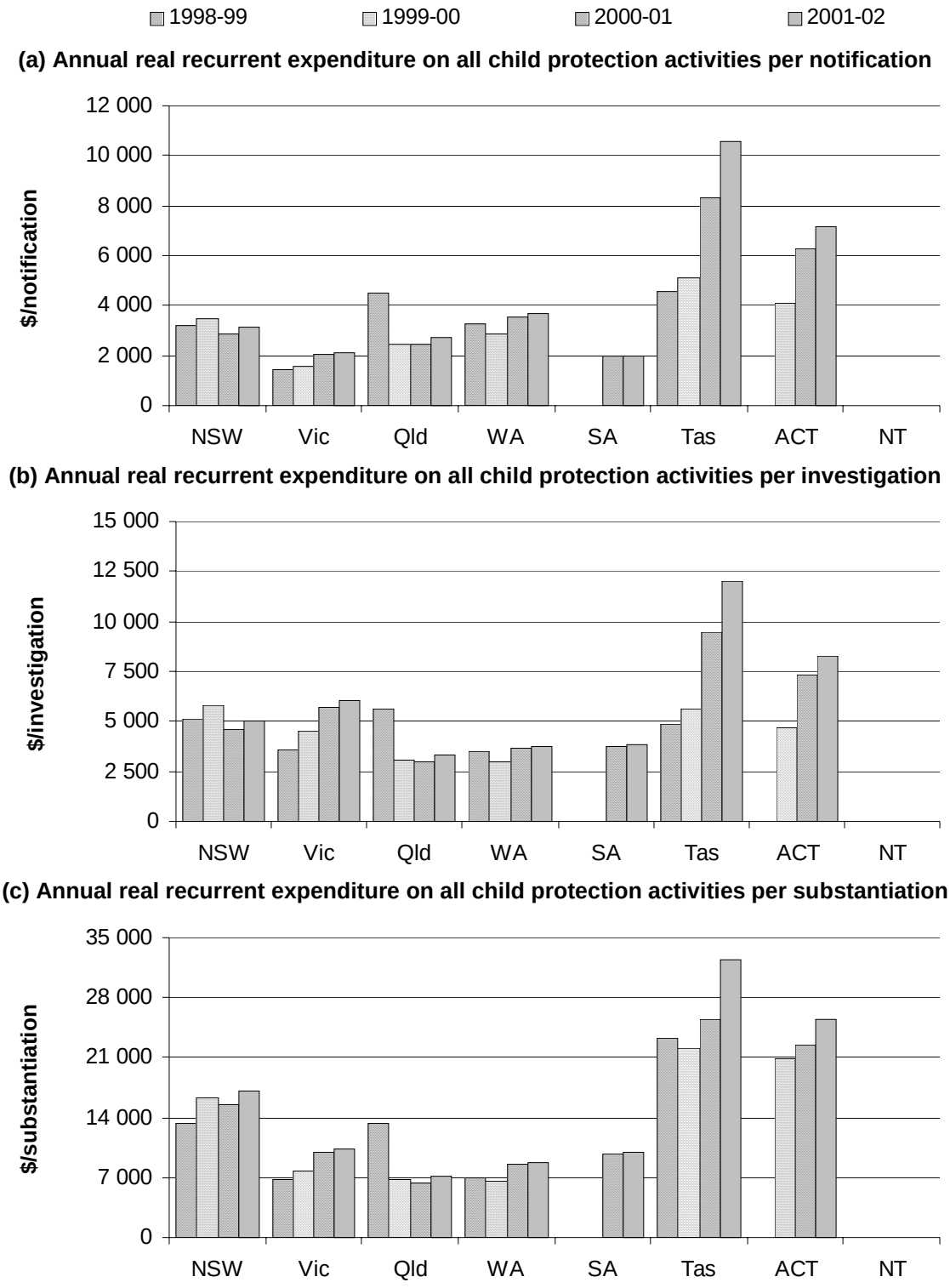
- annual expenditure on residential out-of-home care per child in residential care at 30 June;
- annual expenditure on non-residential out-of-home care per child in non-residential care at 30 June; and
- annual expenditure on all out-of-home care per child in all types of out-of-home care at 30 June.

Although more robust than the child protection indicators, these indicators still need to be treated with caution. Specifically, they do not represent the cost of providing out-of-home care to an individual child. Basing expenditure per child on the number of children in care at 30 June overstates the cost per child, because significantly more children are in care during a year than at a point in time. In addition, some children may have longer periods in care than others have, which may lead the actual cost of providing out-of-home care to an individual child to be significantly overstated.

Child protection efficiency indicator results

Total expenditure on child protection per notification in 2001-02 ranged from $3653 in WA to $1984 in SA (excluding Tasmania and the ACT) (figure 15.12a). Total expenditure on child protection per investigation in 2001-02 ranged from $6010 in

Figure 15.12 **Child protection efficiency indicators (2001-02 dollars)[a, b]**



a Real expenditure based on ABS GDP price deflator 2001-02 = 100 (table A.26). **b** These data should not be interpreted as the 'cost per notification', 'cost per investigation' or 'cost per substantiation' because each is based on the total cost of all child protection activities. Differences across jurisdictions reflect the quantity of the three activities rather than a difference in unit costs.

Source: State and Territory governments (unpublished); table 15A.2.

Victoria to $3285 in Queensland (excluding Tasmania and the ACT) (figure 15.12b). Total expenditure on child protection per substantiation in 2001-02 ranged from $17 011 in NSW to $7092 in Queensland (excluding Tasmania and the ACT) (figure 15.12c).

Tasmania's relatively high expenditure may be attributed to the fact that the number of notifications, investigations and substantiations counted for this Report represent child harm/maltreatment activity data, which is only one component of child protection activity that is occurring.

The ACT's relatively high expenditure may relate to the fixed costs associated with maintaining a child protection system and the economies of scale available to other jurisdictions.

Out-of-home care efficiency indicator results

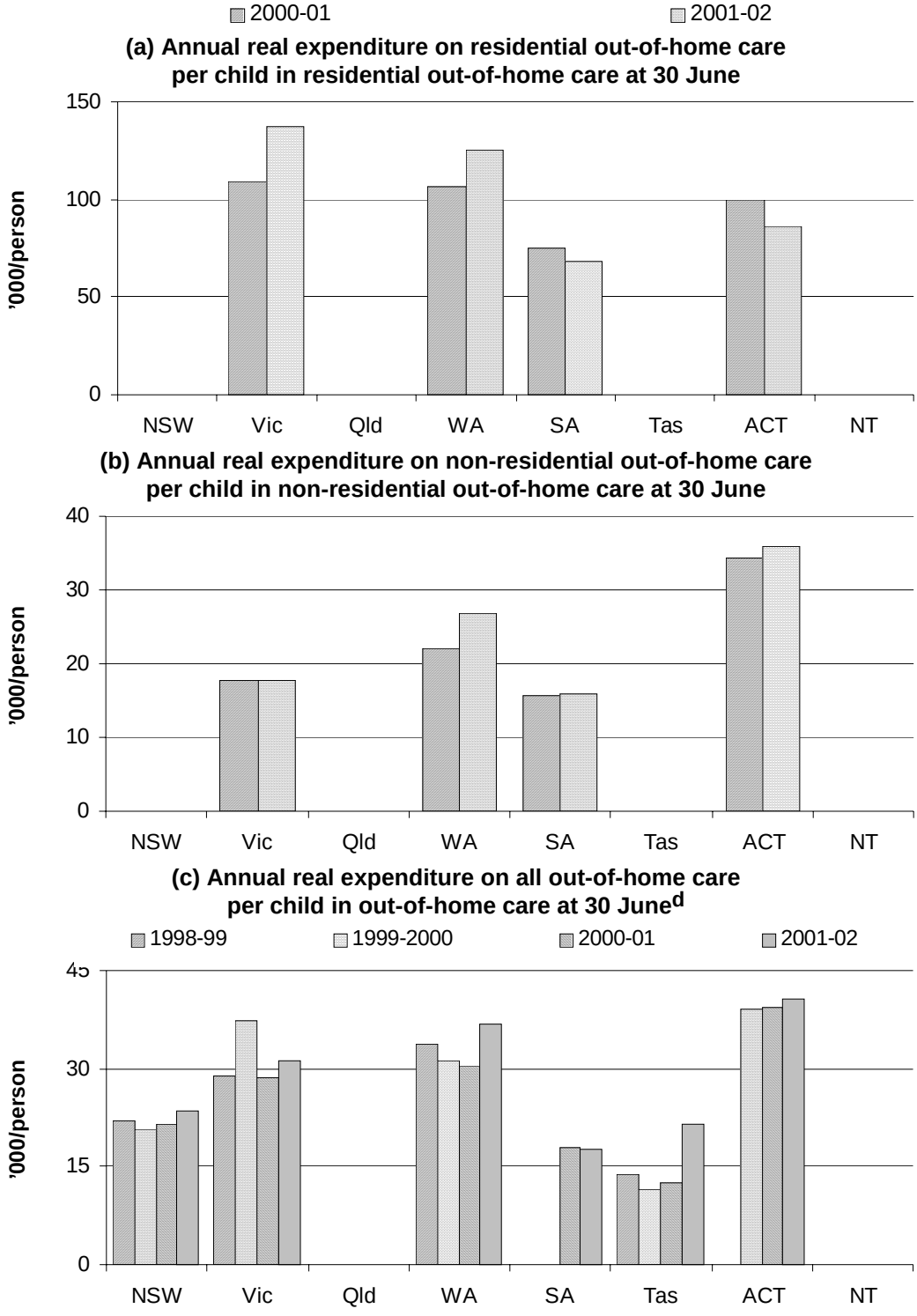
All jurisdictions except NSW, Tasmania and the NT were able to separate expenditure on out-of-home care into expenditure on residential care and expenditure on non-residential care. For those jurisdictions that provided data, expenditure on residential care ranged from about $137 218 per child in residential care at 30 June 2002 in Victoria to about $68 205 in SA (figure 15.13a). (WA expenditure may be overstated because it includes corporate and policy costs and funding to the non-government agencies). For those jurisdictions that provided data on non-residential care, expenditure ranged from about $35 990 per child in non-residential care at 30 June 2002 in the ACT to $15 840 in SA (figure 15.13b). For those jurisdictions that provided data, total expenditure on residential care per child in care at 30 June 2002 ranged from $40 647 in the ACT to $17 767 in SA (figure 15.13c).

15.5 Future directions in child protection and out-of-home care services performance reporting

Improving the national child protection data

Between 2000 and 2002 the National Child Protection and Support Services data working group undertook a review of the reporting framework used to collect the national child protection data. The National Community Services Information Management Group, sponsored this review, which aimed to

Figure 15.13 **Out-of-home care efficiency indicators (2001-02 dollars)[a, b, c]**



a Real expenditure based on ABS GDP price deflator 2001-02 = 100 (table A.26). **b** Queensland data for residential and non-residential out-of-home care are an estimated breakdown only. **c** Using the number of children in care at 30 June rather than the total number of children in care during the year leads to a significant overestimation of costs for WA . **d** ACT data are affected by the higher subsidy levels for carers, higher SACS award costs in the ACT due to a more recently negotiated agreement, and the effect of a small number of children in care with special high support needs.

Source: State and Territory governments (unpublished); table 15A.3.

establish the feasibility of updating the national reporting framework so the national data:

- more accurately reflect the current responses of States and Territories to child protection and child concern reports;
- present a more comprehensive data set; and
- increase the consistency and comparability of the data reported upon.

The review resulted in the development of a broader framework to count responses to calls received by community services departments in relation to the safety and wellbeing of children. The responses include those that occur outside the formal child protection system. The new framework incorporates data elements such as the provision of advice and information, the assessment of needs, and general and intensive family support services. Subject to data availability and jurisdictional sign-off, national reporting will be aligned to this framework over the next few years. As part of this process, the current scope of the intensive family support services data collection (described in box 15.2) will be reviewed.

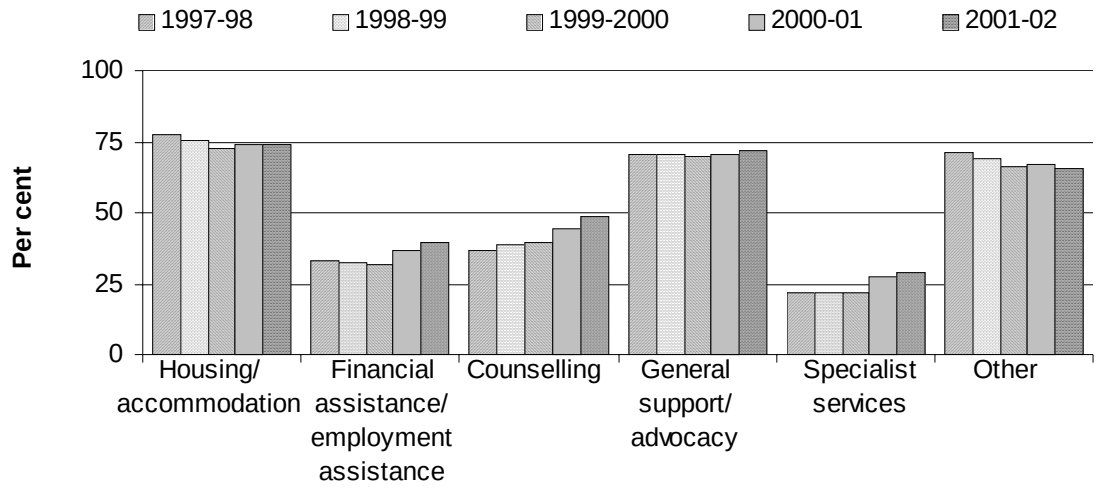
15.6 Profile of supported accommodation and assistance

Service overview

Supported accommodation and assistance services aim to assist people who are homeless or at imminent risk of becoming homeless as a result of a crisis, including women and children escaping domestic violence. Sections 15.6–15.10 report on services provided under the Supported Accommodation Assistance Program (SAAP).

The primary focus of SAAP is to use a case management approach to support homeless people and women and children escaping domestic violence. Through this process, clients are offered a range of services, including supported accommodation; counselling; advocacy; links to housing, health, education and employment services; outreach support; brokerage; and meals services. Housing and accommodation services were provided in 74.0 per cent of support periods in 2001-02. General support and advocacy (provided in 71.9 per cent of support periods), counselling (48.3 per cent), financial and employment assistance (39.3 per cent) and specialist services (29.2 per cent) were also commonly provided (figure 15.14).

Figure 15.14 **SAAP support periods, by type of service received[a]**



a Agencies may provide more than one type of service as a part of a single support period, so services provided do not sum to 100 per cent.

Source: SAAP National Data Collection Agency (NDCA) Administrative Data and Client Collections (unpublished); table 15A.152.

Size and scope

Support services funded by SAAP are provided by agencies to a range of groups, such as homeless families, single men, single women, young people, and women and children escaping domestic violence. At least 1286 agencies are funded under the SAAP program and most target principally one client group. Services were delivered in 2001-02 by agencies targeting:

- young people (37.0 per cent of agencies);
- women escaping domestic violence (22.5 per cent);
- single men (7.5 per cent);
- families (9.4 per cent); and
- single women (3.6 per cent).

Agencies targeting multiple client groups or providing general support accounted for 20.0 per cent of service providers in 2001-02 (table 15A.153).

Agencies also vary in their service delivery model. The most common models in 2001-02 were the provision of medium to long term supported accommodation (37.6 per cent of agencies) and the provision of crisis or short term supported accommodation (34.1 per cent). Agencies also provided services other than accommodation, such as outreach support (5.4 per cent of agencies), day support

(1.9 per cent) and telephone information and referral (1.3 per cent). A further 13.1 per cent of agencies provided multiple services and 1.8 per cent provide agency support (table 15A.154).

Roles and responsibilities

Primarily non-government agencies, with some local government participation, deliver SAAP services. The Commonwealth, State and Territory governments jointly fund SAAP, which was established in 1985 to consolidate a number of existing programs. The State and Territory governments have responsibility for the day-to-day management of SAAP, including distributing funding to SAAP funded agencies. Research, strategy, and other planning and development activities are coordinated at the national level by the SAAP National Coordination and Development Committee (which includes representatives of the Commonwealth Government and each State and Territory government).

Funding

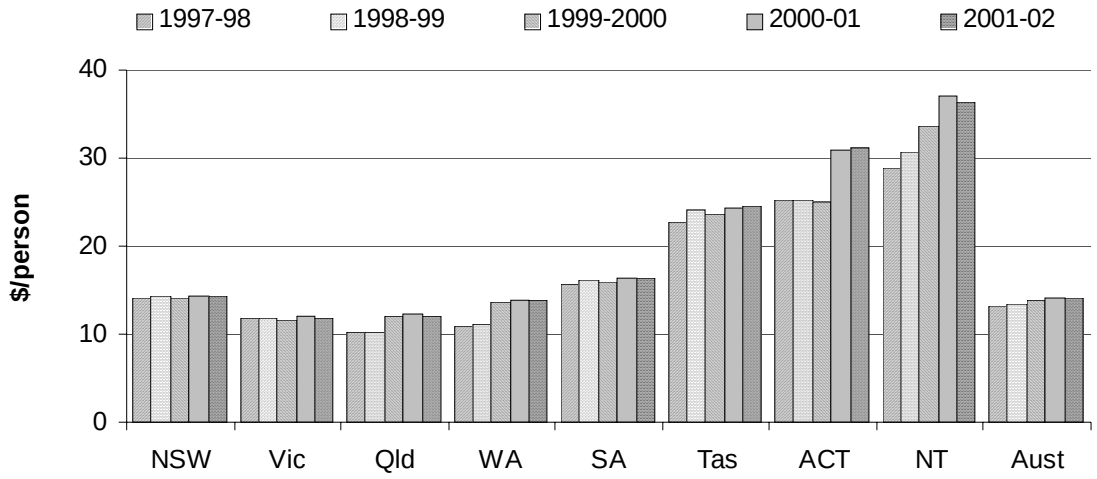
Recurrent funding of SAAP services was $277.2 million in 2001-02, of which the Commonwealth Government contributed 58.5 per cent and the States and Territories contributed 41.4 per cent (table 15A.155). Combined Commonwealth, State and Territory government funding for the period 1997-98 to 2001-02 increased (in real terms) in all jurisdictions, with the largest increases experienced in the NT (from $28.95 per person to $36.35 per person), the ACT (from $25.20 to $31.09) and WA (from $10.91 to $13.77) over the period (table 15A.157). Recurrent SAAP funding per person in the total population was $14.09 nationally in 2001-02. It ranged from $36.35 in the NT to $11.81 in Victoria (figure 15.15).

15.7 Policy developments in supported accommodation and assistance

The SAAP IV Agreement between the Commonwealth, States and Territories commenced on 1 July 2000 and will conclude on 30 June 2005. The agreement is underpinned by:

- the *Supported Accommodation Assistance Act 1994*;
- a Memorandum of Understanding, which sets out high level principles, strategic themes, a commitment to develop outcomes and measures of outcomes, roles and responsibilities, and arrangements for implementation. All signatories endorsed this memorandum on 8 April 1999; and

Figure 15.15 **Real recurrent SAAP funding per person in the residential population (2001-02 dollars)[a, b, c, d]**



a Includes total recurrent allocations (including State and Territory level allocations for program administration). **b** The total population figure is not indicative of the demand for these services. **c** In the NT, funding has increased as a result of the provision of additional award-related funding **d** Real expenditure based on the ABS GDP price deflator 2001-02 = 100 (table A.26).

Source: Commonwealth Department of Family and Community Services (unpublished); table 15A.157; table A.26.

- bilateral agreements between the Commonwealth Government and each State and Territory government. These bilateral agreements establish State and Territory priorities within a multilateral policy and administrative framework, and establish outcomes for funding. All jurisdictions have signed bilateral agreements with the Commonwealth Government.

A National Strategic Plan for SAAP IV has been developed, approved and widely distributed. This plan is based on the Memorandum of Understanding and the bilateral agreements, and represents the basis for national reporting on SAAP IV (box 15.4). The plan will be reflected in State and Territory planning, which will also respond to the needs and priorities of individual jurisdictions.

Box 15.4 **Evaluation and reporting under SAAP IV**

The Memorandum of Understanding requires the development of a National Strategic Plan which identifies the key principles, priorities, strategies, data, research and other project commitments of SAAP IV. The plan sets out a national evaluation and reporting framework that will comprise:

- an annual national program report that provides:
  - an analysis of achievements, including analysis against program outcomes and performance indicators; and
  - a commentary on, and identification of, areas for further development and attention in subsequent years;
- a mid-term review; and
- a final evaluation report to be completed 12 months before the end of the SAAP IV Agreement.

Outcomes and performance indicators form the accountability framework in bilateral agreements and are the basis for review, evaluation and national annual reporting.

An evaluation framework has been cooperatively developed as part of the National Strategic Plan and focuses on:

- client outcomes, particularly the extent to which SAAP demonstrates capacity to:
  - resolve crises;
  - re-establish family links where appropriate; and
  - re-establish a capacity of clients to live independently of SAAP;
- client satisfaction with aspects of service delivery, including quality, accessibility, appropriateness and achievement of outcomes;
- the extent to which the strategic themes, directions and administrative framework for SAAP IV are addressed and implemented; and
- measures of performance in relation to appropriateness, efficiency and effectiveness.

Source: SAAP IV Memorandum of Understanding.

15.8 Framework of supported accommodation and assistance performance indicators

Framework of performance indicators

The framework of performance indicators is based on SAAP objectives (box 15.5).

Box 15.5 **Objectives for SAAP services**

The overall aim of SAAP is to provide transitional supported accommodation and a range of related support services, so as to help people who are homeless or at imminent risk of homelessness to achieve the maximum possible degree of self-reliance and independence. Within this aim, the goals are to:

- resolve crises;
- re-establish family links where appropriate; and
- re-establish the capacity of clients to live independently of SAAP.

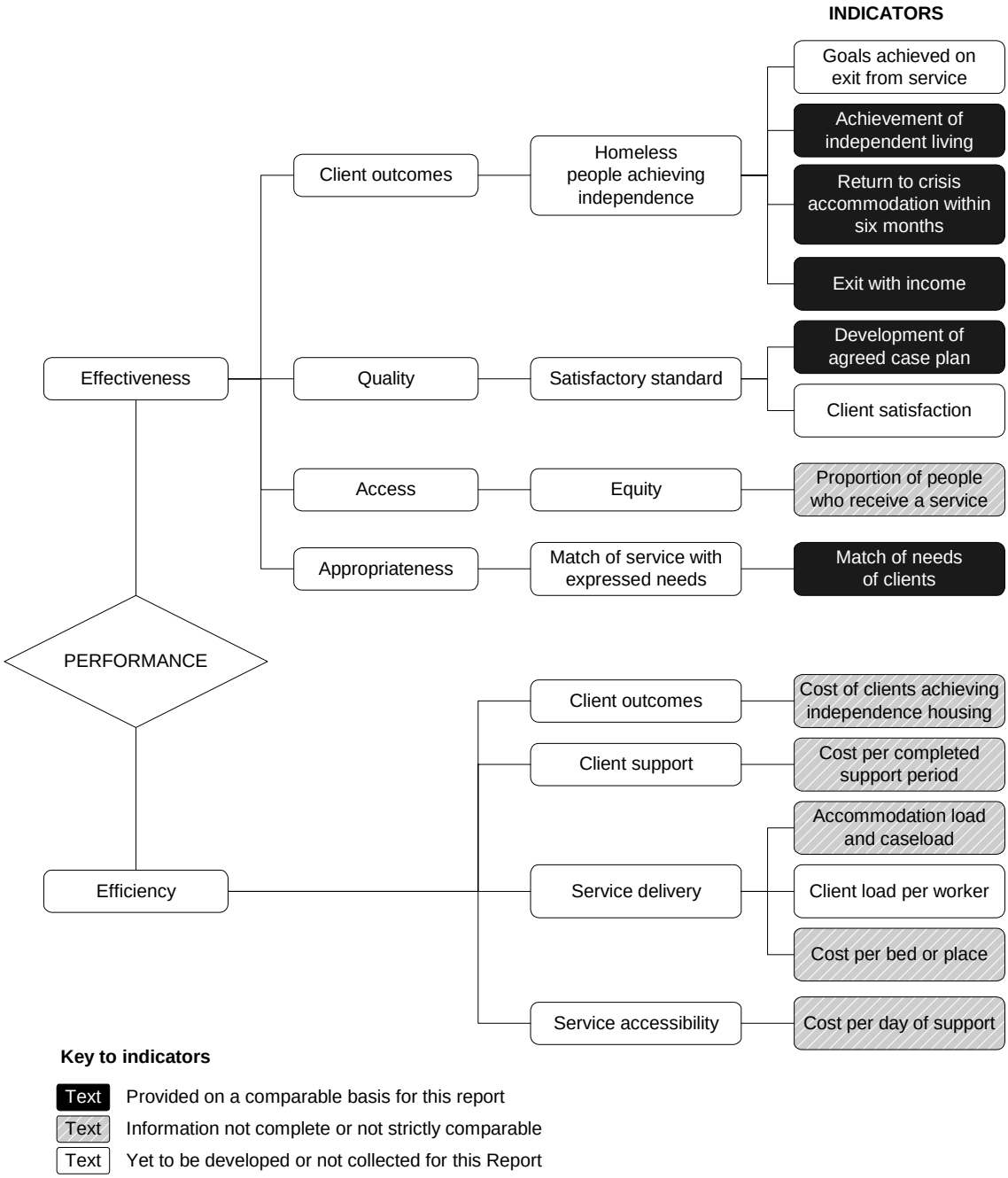
These services should be provided in an equitable and efficient manner.

The performance indicator reporting framework for SAAP is shown in figure 15.16. (Ongoing work to provide a more comprehensive set of performance indicators and to improve existing indicators and the data is discussed in section 15.10.) The framework shows which data are comparable in the 2003 Report. For data that are not considered strictly comparable, the text includes relevant caveats and supporting commentary. Chapter 1 discusses data comparability from a Report-wide perspective (see section 1.6).

New and refined indicators

The 2003 Report for the first time includes data relating to Indigenous clients in the areas of income, housing, labour force status and SAAP support periods.

Figure 15.16 **Performance indicators for SAAP services**



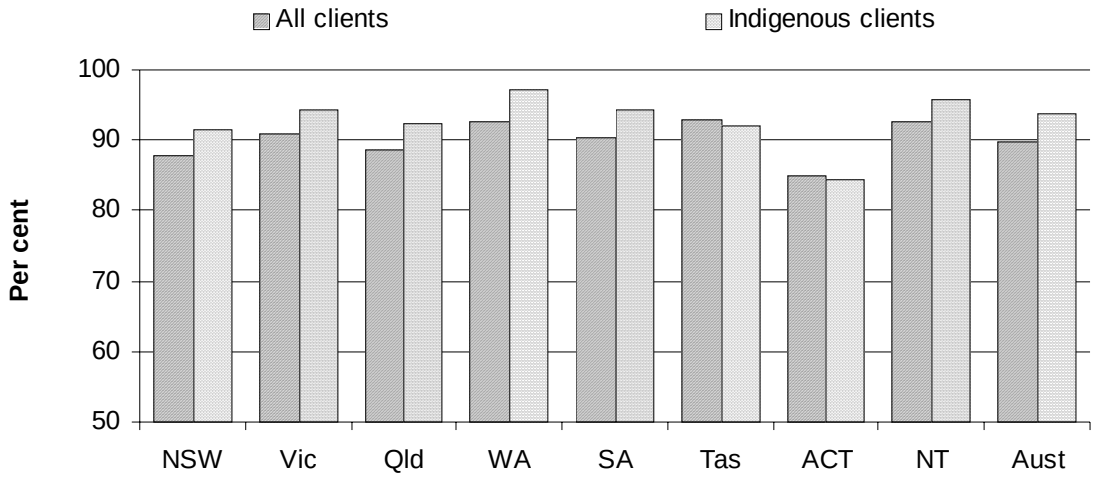
15.9 Key supported accommodation and assistance performance indicator results

Client outcomes — achievement of independent living

An important outcome is clients' achievement of self reliance and independence. Characteristics that may indicate whether clients can live independently include their income, housing status and workforce status. These characteristics of clients are recorded at the end of their support period.

In all jurisdictions in 2001-02, most clients had no substantive change in income source between entering and exiting the program (figure 15.17). The majority of clients entering SAAP were receiving government benefits, and they were still receiving them when they exited SAAP support.

Figure 15.17 **Proportion of clients who had no substantive change in income source after SAAP support, by Indigenous status, 2001-02[a]**



a Excludes clients of high volume agencies (those accommodating 50 or more clients per night, telephone referral agencies, day centres, and information and referral centres) because data on income source after support were not collected.

Source: SAAP NDCA Administrative Data and Client Collections (unpublished); tables 15A.158 and 15A.159.

Client independence is enhanced when the client moves from having no income before entering SAAP services to obtaining some income (including wages and/or benefits) on exit from SAAP services. The proportion of all clients in 2001-02 who had no substantive change in income source ranged from about 93.0 per cent in Tasmania to 84.9 per cent in the ACT.

The proportion of clients in 2001-02 who moved from having no income support to obtaining some income ranged from 3.5 per cent in the ACT to 2.1 per cent in Queensland, WA and the NT. The proportion of clients who obtained their own benefit or a wage ranged from 2.0 per cent in SA to 0.8 per cent in Tasmania. The proportion who had no income before or after support ranged from 9.9 per cent in the ACT to 2.9 per cent in the NT. Nationally, 0.9 per cent of clients exiting the program moved from having a wage to receiving a government payment, or from having some income to having no income (table 15A.158).

The proportion of Indigenous clients in 2001-02 who had no substantive change in income source ranged from about 97.1 per cent in WA to 84.5 per cent in the ACT. The proportion who moved from having no income support to obtaining some income ranged from 2.2 per cent in NSW to 0.5 per cent in WA. The proportion who obtained their own benefit or a wage ranged from 1.2 per cent in Victoria to 0.2 per cent in WA. The proportion of Indigenous clients in 2001-02 who had no income before or after support ranged from 12.6 per cent in the ACT to 1.9 per cent in WA. Nationally, 0.4 per cent of clients exiting the program moved from having a wage to receiving a government payment, or from having some income to having no income (table 15A.159).

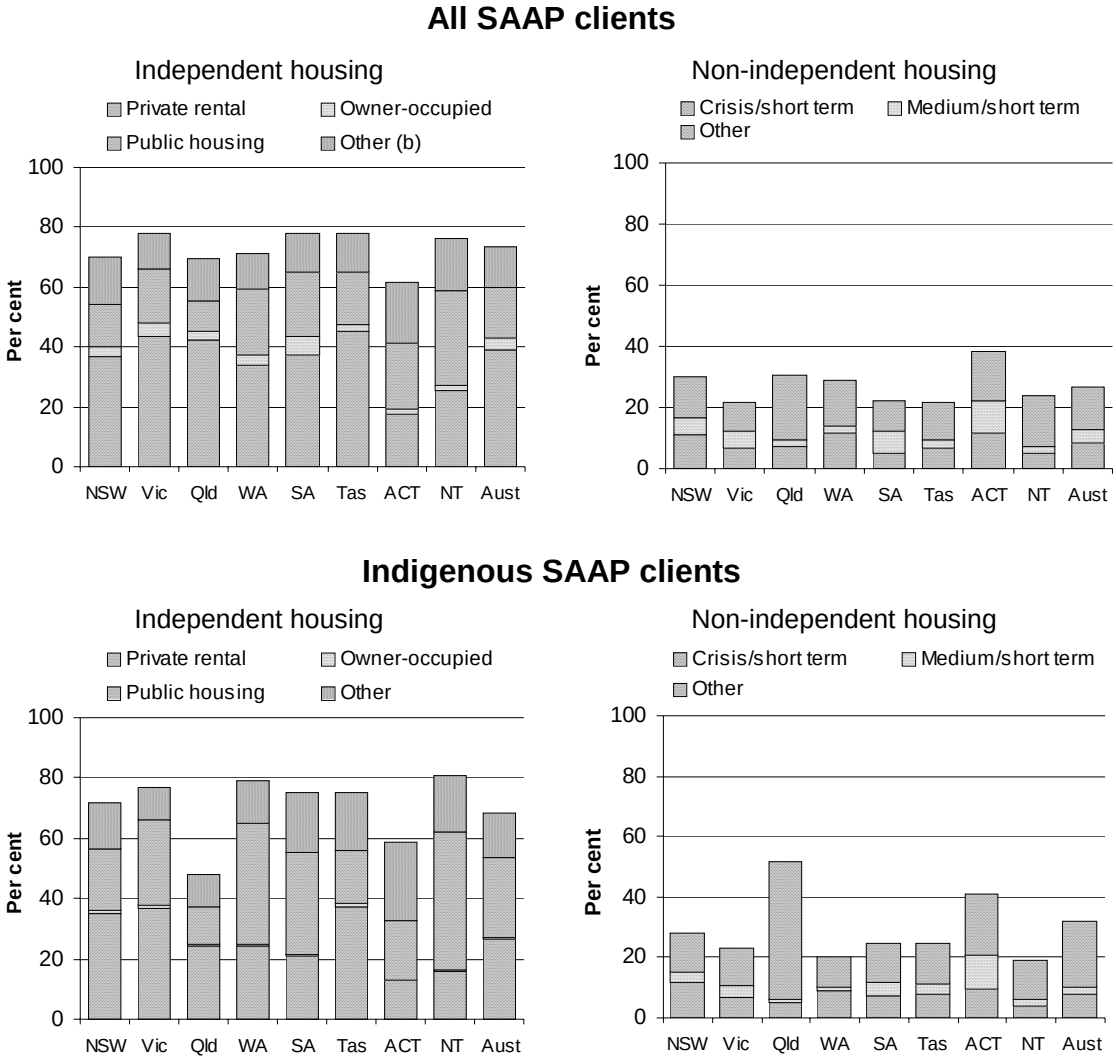
The proportion of clients achieving independent living at the end of a support period indicates the independence of clients after program support. Nationally, 73.5 per cent of clients achieved independent housing at the end of a support period in 2001-02 (figure 15.19). Across jurisdictions, the proportion ranged from 78.2 per cent in Victoria and Tasmania to 61.8 per cent in the ACT. Data are available for only one third of completed support periods, so may not be representative of the total SAAP population. Nationally, the proportion of Indigenous clients achieving independent housing at the end of a support period was 68.1 per cent in 2001-02 (figure 15.18).

By type of independent housing on exiting from SAAP, 39.2 per cent of all clients in 2001-02 moved to private rental housing (26.6 per cent of Indigenous clients), 17.0 per cent entered public housing (26.6 per cent of Indigenous clients) and 3.6 per cent moved to owner-occupied housing (0.6 per cent of Indigenous clients). The proportion of clients moving to private rental housing was highest in Tasmania (45.3 per cent) and lowest in the ACT (17.5 per cent). The proportion moving to public housing ranged from 31.5 per cent in the NT to 10.3 per cent in Queensland (figure 15.18).

By type of non-independent housing, 12.9 per cent of all clients in 2001-02 continued to live in SAAP accommodation (9.9 per cent of Indigenous clients): 8.3 per cent in crisis or short term accommodation (7.6 per cent of Indigenous clients) and 4.6 per cent in medium to long term accommodation (2.3 per cent of

Indigenous clients). The proportion of clients remaining in SAAP accommodation was highest in the ACT (22.5 per cent) and lowest in the NT (7.3 per cent) (figure 15.18).

Figure 15.18 **Accommodation type on exit from SAAP support, 2001-02[a, b]**



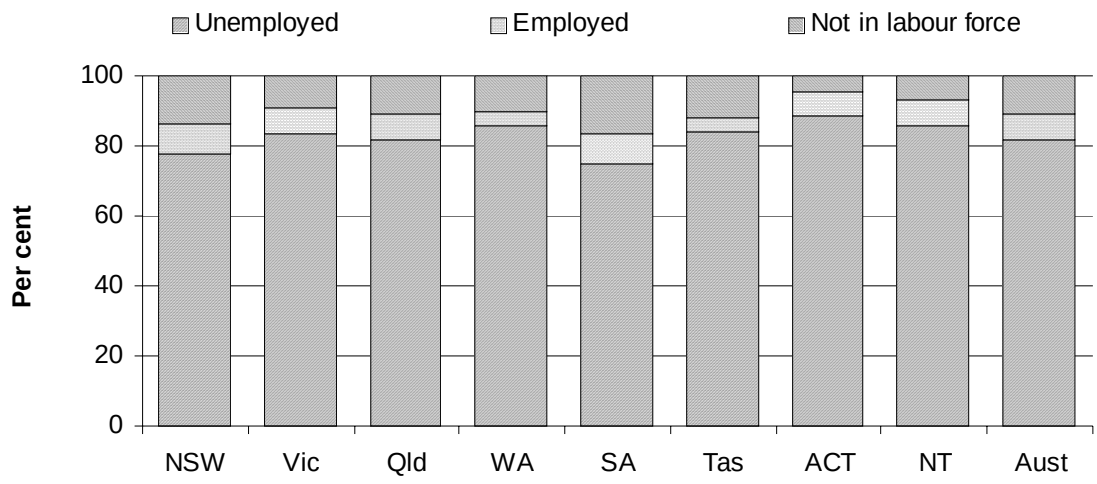
a Excludes high volume records because not all items are included in high volume forms. **b** 'Other' independent housing may include living rent free in a house or flat. 'Other' non-independent housing may include: SAAP funded accommodation at hostels, hotels or community placements; non-SAAP emergency accommodation; car, tent or squat; and an institutional setting.

Source: SAAP NDCA Administrative Data and Client Collections (unpublished); table 15A.160.

Employment is another indicator of clients' achievement of self reliance and independence. Nationally, 8.8 per cent of support periods in 2001-02 involved clients who were employed before support, while 33.3 per cent of support periods involved clients who were previously unemployed (table 15A.162). Of the clients who were unemployed when entering the program, about 7.3 per cent were employed at the end of the support period (2.6 per cent full time, 1.5 per cent part

time and 3.2 per cent on a casual basis), 81.6 per cent remained unemployed and 11.1 per cent were not in the labour force (figure 15.19). Across jurisdictions, the proportion of clients who achieved employment at the end of the support period ranged from 8.8 per cent in NSW to 3.7 per cent in Tasmania (Table 5A.163).

Figure 15.19 **Change in the labour force status of clients after SAAP support, 2001-02[a, b]**



a Data are for people who were unemployed when entering SAAP services. **b** Excludes high volume records because not all items are included on high volume forms.

Source: SAAP NDCA Administrative Data and Client Collections (unpublished); table 15A.163.

For Indigenous clients who were unemployed when entering the program in 2001-02, about 4.1 per cent were employed at the end of the support period (1.3 per cent full time, 1.0 per cent part time and 1.7 per cent on a casual basis), 83.4 per cent remained unemployed and 12.6 per cent were not in the labour force (table 15A.164).

The performance information above relates to relatively short term outcomes — that is, outcomes for clients immediately after their support period. Longer term outcomes are important, but there are challenges in collecting information on these outcomes. The data collection for SAAP allows for the measurement of the number of clients and the number and types of service provided to clients (box 15.6).

Box 15.6 **Issues when analysing SAAP data**

The following four important issues need to be considered when analysing SAAP data.

- Informed consent is an essential component of the integrity of the data. The principle of client/consumer rights (which underpins informed consent) recognises that clients do not receive services under a mandatory order. They have the right to accept or reject the services offered, as they have the right to provide or not provide information while receiving SAAP services.
- Comprehensive information cannot be collected for all clients, such as casual clients and clients of high volume agencies (those accommodating 50 or more clients per night, telephone referral agencies, day centres, and information and referral centres).
- Clients consented to provide personal details for the SAAP client collection for 85 per cent of support periods in 2001-02. A weighting system has been developed to adjust for agency non participation (95 per cent of agencies participated in the client collection) and non-consent.
- Caution should be taken when comparing 2001-02 client data with previous years data because 2001-02 data are based on estimated support periods per client rather than observed support periods per client as reported in previous years.

Source: AIHW (2002).

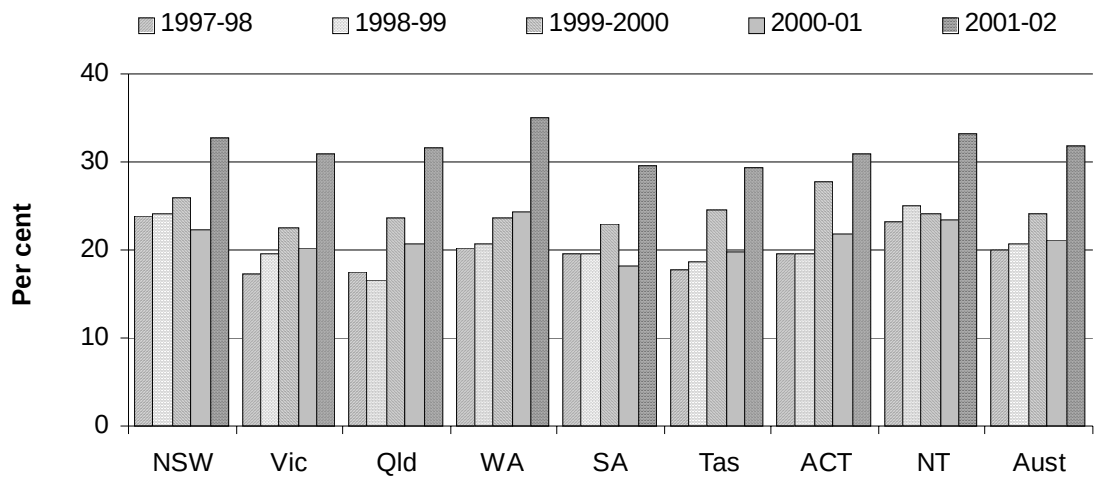
An important longer term indicator of whether clients are achieving self reliance and independence is whether a client has needed to return to SAAP services. If a client received two or more support periods over the year, then they must have returned to the program (but not necessarily to the same agency) for a period of support during the year.

Nationally, 31.8 per cent of clients returned to SAAP services in 2001-02 after having exited the program less than 12 months earlier. Across jurisdictions, the proportion ranged from 34.9 per cent in WA to 29.4 per cent in Tasmania (figure 15.20). It may be appropriate, however, for some clients to receive more than one support period (moving from crisis to medium term accommodation, for example). Of Indigenous clients, 35.0 per cent returned to SAAP services nationally in 2001-02 (table 15A.166). One group that makes multiple use of SAAP are women and children escaping domestic violence. A number of SAAP clients with long term problems also access SAAP services a number of times before being able to address their issues.

A further medium term indicator of the achievement of self reliance and independence is when the client exits to independent housing and does not return to SAAP within a specified period (in this case, six months). Given the data issues

discussed above, current estimates may not be representative of all clients; for example, only approximately 49.5 per cent of clients nationally in 2001-02 provided information on their accommodation after exiting at least one support period over the year (table 15.2).

Figure 15.20 **Clients who returned to a SAAP service in 2001-02 after having exited the program less than 12 months earlier[a]**



a 2001-02 data are based on estimated support periods per client rather than on observed support periods per client as reported in previous years.

Source: SAAP NDCA Administrative Data and Client Collections (unpublished); table 15A.165.

Table 15.2 **Indicative estimates of clients who exited SAAP to independent housing and did not return within six months, 2001-02[a, b]**

Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Clients who provided information on accommodation after exit from support									
no.	11 500	15 900	6 900	4 900	3 400	2 000	1 100	1 700	47 300
As a proportion of total clients[c]									
%	45.6	56.4	39.9	57.0	41.5	57.1	61.1	58.6	49.5
Clients recorded as exiting to independent accommodation and not returning within six months									
no.	4 200	6 600	2 800	2 400	1 400	800	400	800	19 300
Indicative estimates of clients exiting to independent housing and not returning within six months[d]									
%	36.5	41.5	40.6	49.0	41.2	40.0	36.4	47.1	40.8

a See notes to table 15A.167 for details of how the estimates were calculated. **b** Preliminary data. **c** Estimate based on estimated total number of clients for 2001-2002. **d** Clients recorded as exiting to independent accommodation and not returning within six months as a proportion of clients who provide information on accommodation on exit from support.

Source: SAAP NDCA Administrative Data and Client Collections (unpublished); table 15A.167.

It is possible to estimate the proportion of clients who exit to independent housing and do not return to SAAP within six months (based on the subset of clients who

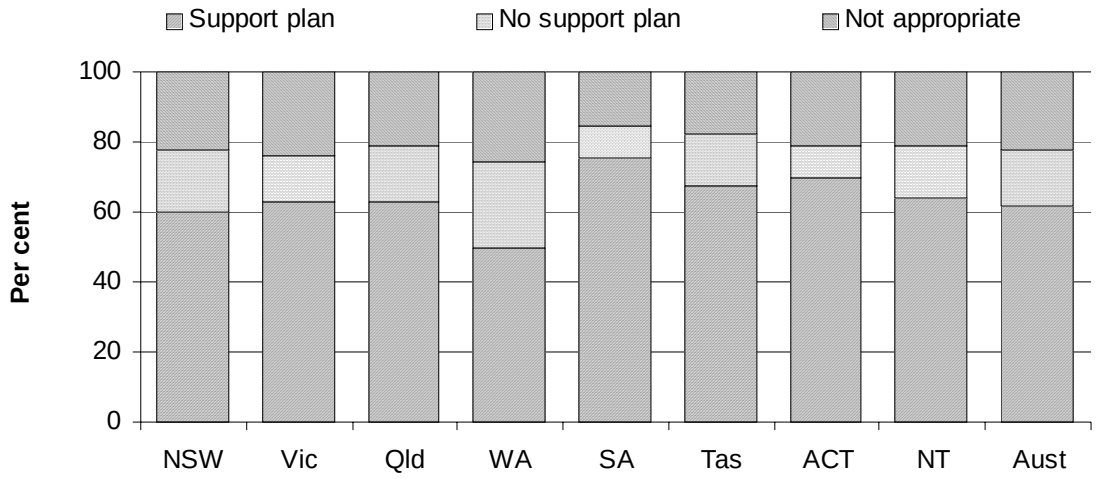
provide information on accommodation after exiting support). Given the potential for bias in the data, however, these estimates should not be used for definitive performance comparisons across jurisdictions. They may be used to prompt further analysis of the reasons for cross-jurisdictional differences.

It is important to have data that are representative of all SAAP clients. Strategies are being implemented to improve the data quality progressively, including improving client consent rates and the collection of exit information. It is hoped that the data will eventually be robust enough to allow comparative performance assessment.

Quality — development of an agreed support plan

The existence of an agreed support plan is an indicator of service quality and quality in service delivery, but it may be judged to be inappropriate for some support periods (such as when a support period is short term). Nationally, the case worker in 22.2 per cent of support periods in 2001-02 judged that a support plan was inappropriate. Across jurisdictions, this proportion ranged from 25.7 per cent in WA to 15.3 per cent in SA (table 15A.168).

Figure 15.21 **Support periods, by the existence of a support plan, 2001-02[a, b]**



a Excludes high volume records because not all items are included on high volume forms. **b** See notes to table 15A.168 for more detail.

Source: SAAP NDCA Administrative Data and Client Collections (unpublished); table 15A.168.

There was an agreed support plan for 61.9 per cent of support periods nationally in 2001-02. Across jurisdictions, the proportion ranged from 75.5 per cent in SA to 49.7 per cent in WA (figure 15.21). Nationally, 62.6 per cent of Indigenous clients had a support plan, 16.8 per cent had no support plan and the case worker in

20.6 per cent of support periods for Indigenous clients in 2001-02 considered a support plan was inappropriate (table 15A.169).

Access and equity — proportion of people who receive a service

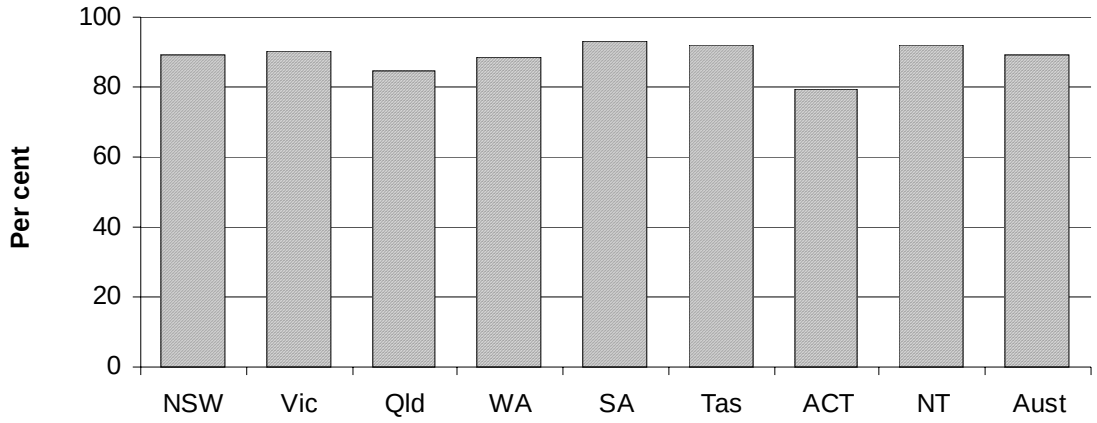
Supported Accommodation Assistance Program (SAAP) services target homeless people in general, but access by special needs groups (such as Indigenous people and people from non-English speaking backgrounds) is particularly important. Data for assessing access to SAAP services are available from the data collection on unmet demand. Data for 2001-02 were based on surveys conducted between 22–28 August 2001 and 8–14 May 2002.

Assessing the experience of target groups using data from the unmet demand collection is problematic. The client data and unmet demand data are not comparable. The client collection counts clients and each client's cultural status. The unmet demand collection is based on valid requests for services and records the cultural status of everyone in the group — making no distinction between adults and accompanying children. Also, the two-week sample period over which data were collected might not be representative of the eventual success of clients accessing SAAP services over the full year (see notes to tables 15A.170–15A.171).

Requests for SAAP services were not met for a number of reasons in 2001-02, including: lack of available accommodation (the main reason for 88.5 per cent of potential clients who were not provided with services), insufficient staff (2.4 per cent) and lack of facilities for special needs such as disability, culturally specific needs and other special needs (1.9 per cent) (table 15A.170).

The available data suggest that around 89.0 per cent of requests for SAAP services were provided with the assistance requested in the data collection period in 2001-02. The proportion of requests for services that were fulfilled ranged from 93.2 per cent in SA to 79.3 per cent in the ACT (figure 15.22).

Figure 15.22 **Proportion of requests for SAAP services that were provided with the requested support, 22–28 August 2001 and 8–14 May 2002[a, b]**



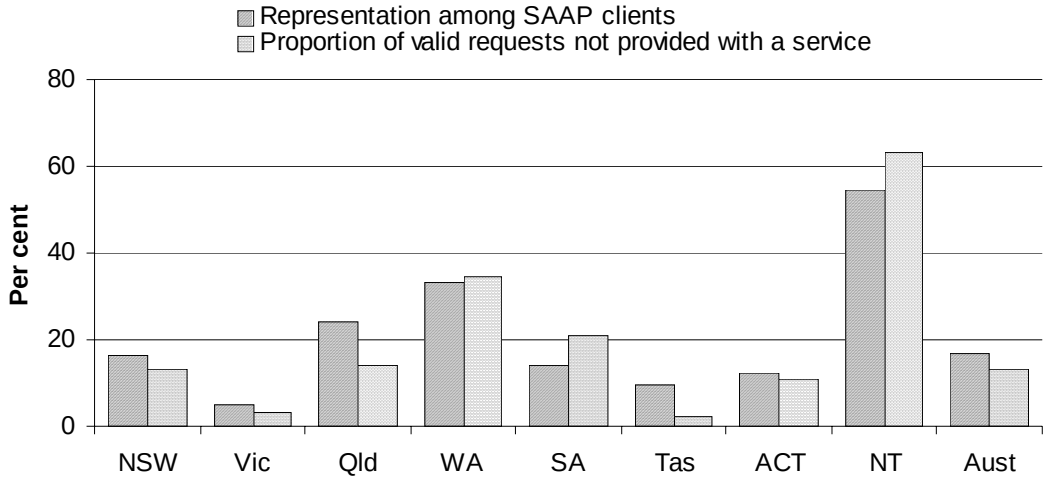
a See table 15A.171 for an explanation of how the number of SAAP clients was estimated and for the definition of unmet demand. **b** Data on unmet demand need to be interpreted with care for several reasons. First, a person can make a request on more than one occasion and to more than one SAAP agency. While double counting has been limited through the exclusion of those requests where the person had made a similar request to a SAAP agency within the collection period, this information might not always have been available to record; therefore, the total numbers do not represent actual people. Second, a number of people may receive ongoing support or accommodation from a SAAP agency at a later time, quite possibly soon after their initial request. As a result, this estimate may overstate the actual level of unmet demand. Third, a number of potential clients have their needs met by other means and do not return to a SAAP agency. Many factors influence the capacity of individual SAAP agencies to meet day-to-day demand for their services; it is not possible to identify a two-week period that is 'typical' for all SAAP agencies.

Source: SAAP NDCA Unmet Need and Client Collections (unpublished); table 15A.171.

Nationally, the proportion of requests for SAAP service from Indigenous people in the data collection period in 2001-02 that did not result in the assistance requested (13.3 per cent) was lower than the representation of Indigenous clients among SAAP clients (16.7 per cent). In all jurisdictions except the SA and the NT (and WA to a lesser extent), the proportion of requests from Indigenous people that did not result in the provision of a service was lower than the representation of Indigenous people among clients (figure 15.23).

On average, the proportion of requests for SAAP service from people of non-English speaking backgrounds that did not result in the assistance requested (6.8 per cent) was lower than the representation of clients from non-English speaking backgrounds among SAAP clients (10.4 per cent) (figure 15.24).

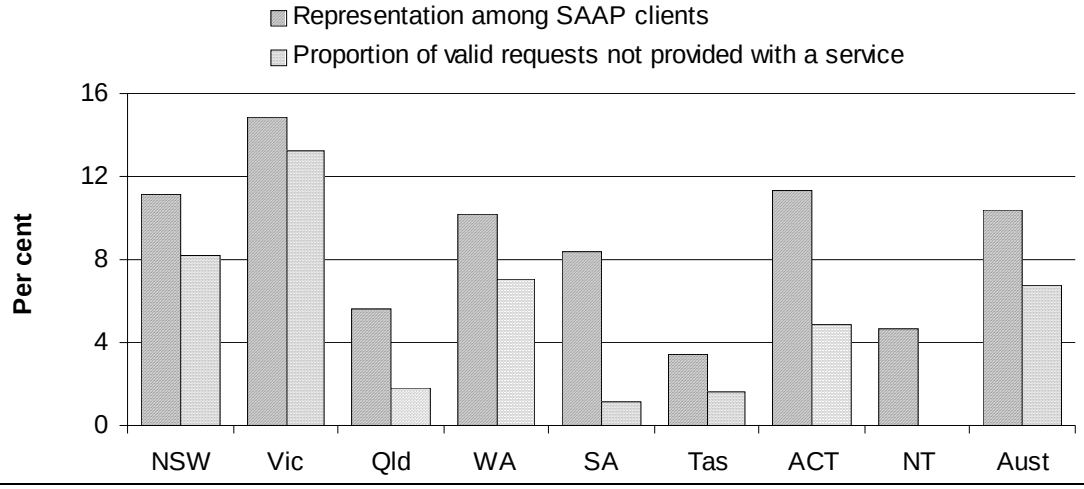
Figure 15.23 **Indigenous people among SAAP clients, and the proportion of requests for SAAP service from Indigenous people that did not result in the assistance requested, 2001-02[a, b]**



a The number of people unable to be provided with a SAAP service was the 'unmet demand'. See notes to table 15A.172 for more detail. **b** Excludes people who refused offered assistance; those who made a similar request at a SAAP funded agency within the collection period (to limit double counting); and those whose request was not met because either the referral was inappropriate (wrong target group) or the agency did not provide the type of service requested.

Source: SAAP NDCA Administrative Data and Client Collections (unpublished); table 15A.172.

Figure 15.24 **People from non-English speaking backgrounds among SAAP clients, and the proportion of requests for SAAP service from people from non-English speaking backgrounds that did not result in the assistance requested, 2001-02[a, b]**



a The number of people unable to be provided with a SAAP service was the 'unmet demand'. See notes to table 15A.173 for more detail. **b** Excludes people who refused offered assistance; those who made a similar request at a SAAP funded agency within the collection period (to limit double counting); and those whose request was not met because either the referral was inappropriate (wrong target group) or the agency did not provide the type of service requested.

Source: SAAP NDCA Administrative Data and Client Collections (unpublished); table 15A.173.

Appropriateness — matching of service with expressed needs

The proportion of clients receiving services that they need is an indicator of appropriateness. Data are collected on which services are needed by clients and whether these services are provided or the clients are referred to another agency. The range of needed services is broad (ranging from meals to laundry facilities to long term accommodation), so the effect of not providing these services varies.

Nationally, the proportion of clients who received needed services or were referred to another agency for needed services was 92.7 per cent in 2001-02. Across jurisdictions, the proportion ranged from 97.7 per cent in the NT to 88.3 per cent in Queensland (figure 15.25).

Figure 15.25 **SAAP clients, by met and unmet support needs, 2001-02**

Source: SAAP NDCA Administrative Data and Client Collections (unpublished); table 15A.174.

Nationally, 89.2 per cent of Indigenous clients in 2001-02 either received needed SAAP services or were referred to another agency for these services — 3.5 percentage points lower than the proportion for all clients. Across jurisdictions, the proportion ranged from 98.2 per cent in the NT to 83.5 per cent in Queensland (figure 15.26).

Nationally, 94.1 per cent of clients from a non-English speaking background in 2001-02 either received needed services or were referred to another agency. Across jurisdictions, the proportion ranged from 96.6 per cent in Queensland to 91.2 per cent in Victoria (figure 15.27).

Figure 15.26 **Indigenous clients, by met and unmet support needs, 2001-02**

Source: SAAP NDCA Administrative Data and Client Collections (unpublished); table 15A.175.

Figure 15.27 **Clients from non-English speaking backgrounds, by met and unmet support needs, 2001-02**

Source: SAAP NDCA Administrative Data and Client Collections (unpublished); table 15A.176.

Efficiency

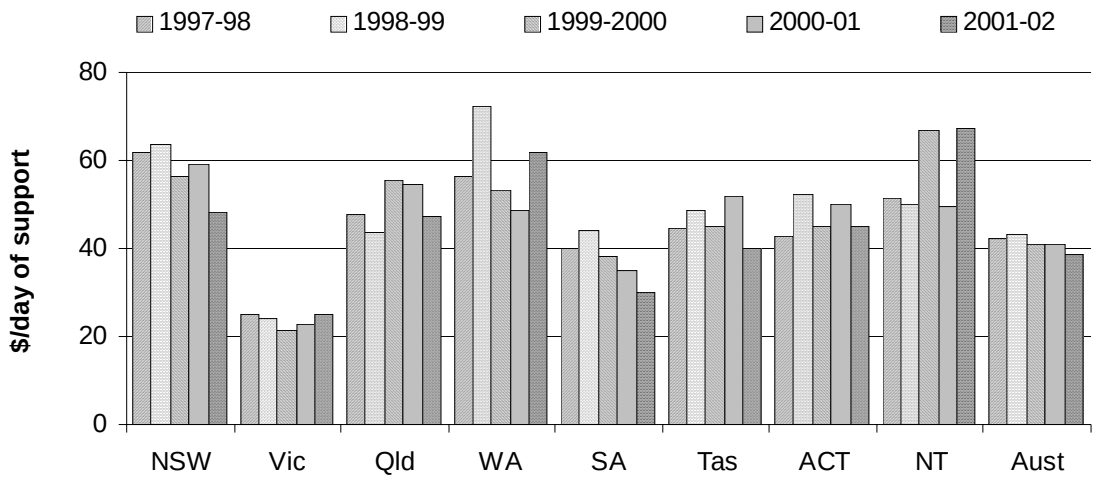
A proxy indicator of efficiency is the level of government inputs per unit of output (unit cost). Across jurisdictions, there are varying treatments of expenditure items (for example, superannuation) and different counting and reporting rules in generating financial data. Efficiency indicator results may reflect these differences.

The unit cost analysis includes only expenditure by service delivery providers. Conceptually, unit cost indicators should include some of the administration costs

borne by State and Territory departments in administering these services, but this is not yet possible. Unit cost data do not contain capital costs because capital funding for SAAP is provided under the Commonwealth State Housing Agreement through a special-purpose program (the Crisis Accommodation Program).

The real recurrent cost per day of support for SAAP clients receiving support and/or supported accommodation (excluding casual and potential clients, and accompanying children who receive services as clients in their own right) averaged $39 in 2001-02. Across jurisdictions, the cost ranged from $67 in the NT to $25 in Victoria (figure 15.28).

Figure 15.28 **Real recurrent cost per day of support for homeless clients (2001-02 dollars)[a]**

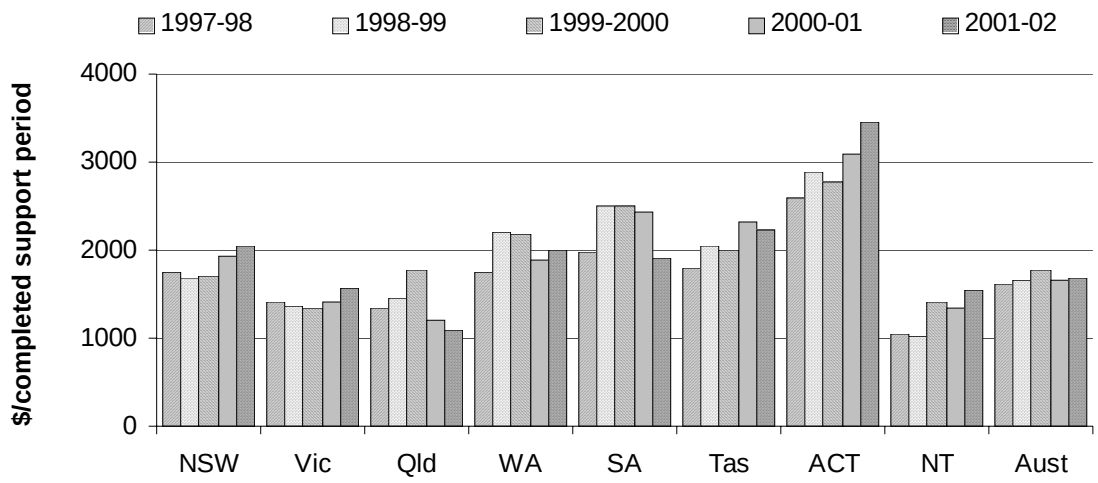


a See notes to table 15A.177 for a description of the analysis.

Source: SAAP NDCA Administrative Data and Client Collections (unpublished); table 15A.177.

The recurrent cost per completed support period (excluding casual and potential clients, and accompanying children who received services as clients in their own right) averaged $1690 in 2001-02. Across jurisdictions, it ranged from $3450 in the ACT to $1110 in Queensland (figure 15.29).

Figure 15.29 **Real recurrent cost per completed support period (2001-02 dollars)[a]**

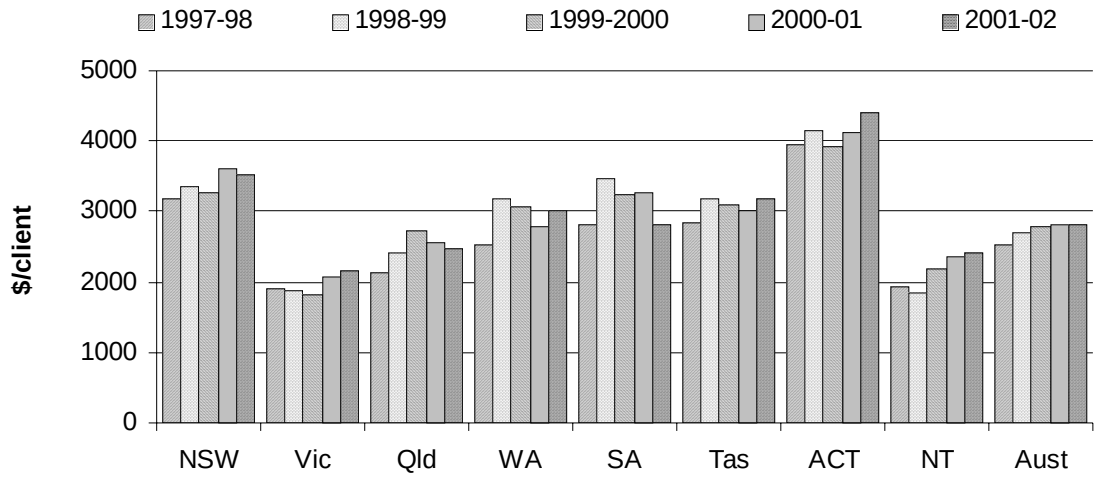


a See notes to table 15A.178 for a description of the analysis.

Source: SAAP NDCA Administrative Data and Client Collections (unpublished); table 15A.178.

Nationally, the recurrent cost per client accessing SAAP services was $2800 in 2001-02. This figure varied across jurisdictions, from $4410 in the ACT to $2170 in Victoria (figure 15.30).

Figure 15.30 **Real recurrent cost per client accessing services (2001-02 dollars)[a]**

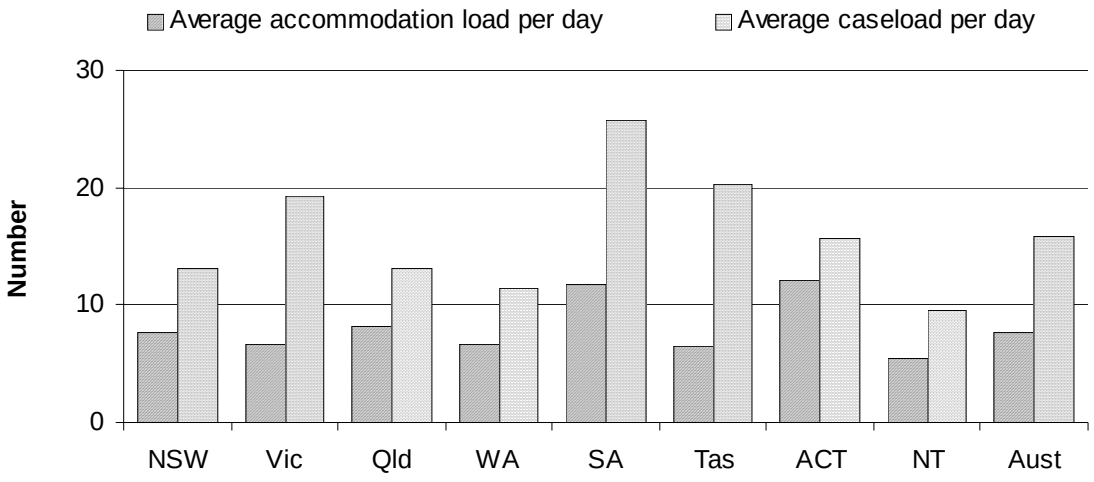


a See notes to table 15A.179 for a description of the analysis.

Source: SAAP NDCA Administrative Data and Client Collections (unpublished); table 15A.179.

The average accommodation load is an indicator of the average number of people accommodated per day per agency. The average accommodation load in 2001-02 was 7.6 nationally. Across jurisdictions it ranged from 12.1 in the ACT to 5.4 in the NT. The average caseload is an indicator of the average number of people being supported per day per agency. The average caseload in 2001-02 was 15.8 nationally and ranged from 25.7 in SA to 9.5 in the NT (figure 15.31). Differences in the average accommodation load and caseload may reflect differences in the average size of agencies across jurisdictions.

Figure 15.31 **Average accommodation load and caseload per day, 2001-02[a]**



a See notes to table 15A.180 for a description of how accommodation and caseload were estimated.

Source: table SAAP NDCA Administrative Data and Client Collections (unpublished); 15A.180.

15.10 Future directions in supported accommodation and assistance performance reporting

Measuring client satisfaction, client outcomes and clients with high and complex needs

Client satisfaction is an important indicator of quality. Work on developing measures of client satisfaction within the SAAP population is being undertaken through a two-stage consultancy which commenced in September 2001. The consultancy has involved widespread consultations and developmental work supported by limited trials of measures that are considered to be appropriate for SAAP clients. The report on the first stage of this work was received in July 2002

and the second stage (designed to trial the client satisfaction measures within a much larger group of agencies) is underway.

Projects on the measurement of client outcomes and on clients with high and complex needs are also underway. These projects are developing and testing client outcome measures and developing a method for collecting meaningful information on clients with high and complex needs. Both projects are expected to report in the first half of 2003.

Improving data and information collection

An Information Management Plan (IMP) for SAAP IV was adopted in 2001 by the SAAP National Coordination and Development Committee. The committee has approved the guiding principles of the IMP and work is underway. The first stage of the implementation process involves defining the information needs of all stakeholders more precisely and then determining the best way in which to collect and use this information. This work is likely to lead to changes in the scope and nature of the SAAP national data collection. The movement to an information management paradigm, from one more focussed on data collection from SAAP services, will require changes at all levels and will involve progressive implementation over a number of years.

The implementation of the IMP will:

- place increased emphasis on electronic data capture;
- require increased support processes for SAAP agencies (including training, and a help line) to increase data quality and maximise use of the data.

Electronic data capture within SAAP agencies currently occurs through the use of specially developed software (SMART — SAAP Management and Reporting Tool) provided free to SAAP agencies and supported through specially developed training and documentation and the provision of a hot line. Agencies are encouraged to submit their data via SMART rather than via paper forms.

The number of SAAP agencies using SMART has steadily increased over the years. The increased take-up is probably due to the provision of additional training, increased publicity and information about the benefits of SMART, and to a broader understanding that the automatic encryption process incorporated into SMART provides significantly better security than that of paper forms. A further benefit in using SMART is that data quality is enhanced because the software's prompts and processes aid the user.

During the implementation of the IMP process, SMART will be maintained, enhanced and supported with increased training. The progressive move to an information management paradigm within SAAP may require new data capture processes (including new software), which may eventually involve the electronic transfer of information.

15.11 Jurisdictions' comments

This section provides comments from each jurisdiction on the services covered in this chapter. Appendix A contains data that may assist in interpreting the performance indicators presented in this chapter. These data cover a range of demographic and geographic characteristics, including age profile, geographic distribution of the population, income levels, education levels, tenure of dwellings and cultural heritage (including Indigenous and ethnic status).

Commonwealth Government comments

“ 2001-02 was the second year of the five-year Supported Accommodation Assistance Program (SAAP) Agreement between the Commonwealth and the States and Territories. This is the fourth set of SAAP Agreements (SAAP IV).

The Commonwealth is providing over $800 million for SAAP IV. This represents an increase of over $160 million or some 30 per cent over total Commonwealth funding for the SAAP III Agreements.

Work has progressed during the year on the implementation of an Information Management Plan for SAAP. The emphasis in the plan is on strengthening the capacity of SAAP funded agencies to collect and use information. A number of strategies have been employed to achieve this objective, including improved data training and support, improved communication (including an interactive web site) and work on streamlining the existing national data collection. A new research program was launched during the year to provide opportunities for SAAP agencies to obtain funding for local level research in collaboration with networks and research agencies or individuals. This activity will contribute to the knowledge base for SAAP and also assist agencies to build capacity. The first *SAAP National Performance Report* was published in early 2002.

The Commonwealth has a number of other programs and new initiatives, which provide valuable support to homeless people, people in crisis and those affected by domestic violence. An evaluation of the Job Placement, Employment and Training Program highlighted how it is providing positive training and employment outcomes for young people who are homeless or at risk of becoming homeless. The new Personal Support Program, which is designed to give special help to people with problems such as homelessness, drug and alcohol addiction, mental illness and domestic violence, was launched during the year. The program will fund 144 organisations to deliver support from 600 sites across Australia. The Reconnect Program, an early intervention program for young people at risk of homelessness and their families, was expanded during the year.

The National Homelessness Strategy is being progressed on a number of fronts. A key focus of the Strategy during 2002 has been the improvement of Centrelink service delivery to people who are homeless or at risk of homelessness. The Commonwealth Advisory Committee on Homelessness has revised its discussion paper *Working towards a National Homelessness Strategy* to incorporate feedback received during national consultations on the paper. In addition, innovative demonstration projects have been commissioned in a number of key priority areas. Results of the projects inform policy in areas relevant to homelessness. One of the projects funded under the National Homeless Strategy is a National Homelessness Conference to be held in April 2003. ”

New South Wales Government comments

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Child protection and out-of- home care

Since the proclamation of the new legislation and the opening of the HelpLine there has been a substantial increase in workload and complexity of cases for the Department of Community Services (DoCS). Additional caseworkers were engaged at the HelpLine, and the ‘Kibble Committee’ — a joint DoCS, Central Agency and NSW PSA working party — reviewed the impact of this increase in demand for DoCS services and brought forward an interim report in June 2002. Its work on demand management is continuing.

NSW established the Aboriginal Children and Family Services State Secretariat, which is a peak group bringing together Aboriginal out-of-home care service providers to develop and manage service delivery across the State.

Leaving care and after care services were expanded to support young people in their transition to independence from out of home care.

The Shared Stories/Shared Lives Project brought Government and non-government providers together for joint training to improve foster care services.

A Children’s Court Clinic was established to provide independent assessments of children, young people and their families to the Children’s Court. A panel of psychiatrists, psychologists and social workers is available to undertake assessments throughout the State.

Legislation on permanency planning passed through the NSW Parliament in November 2001. The changes focus on restoration of the child/young person to their family wherever possible, and an early decision on permanent placement.

Supported Accommodation Assistance Program (SAAP)

NSW has been pleased with its improvement in a number of the efficiency indicators in 2001-02, including its 19 per cent reduction on costs per day of support. These are positive indicators of the efforts being made in NSW by both Government and non-government stakeholders (including workers) to improve the performance of SAAP in NSW.

However, NSW was hampered in achieving maximum progress on SAAP IV reforms during the 2001-02 financial year as a result of the protracted work associated with the implementation of a new state industrial award (Social and Community Services Employees (State) Award) in November 2001, particularly the failure of the Commonwealth to pay its share of the award increase. Following the decision by the NSW Government to fund both the NSW and Commonwealth governments’ share of the new award costs and protect the SAAP IV Reform funding, NSW is now able to renew its effort with the implementation of SAAP IV reforms. Progress is now well in train to expedite the implementation of area plans developed through the system’s review and to bring the negotiation of new performance agreements back to the pre-award schedule.

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Victorian Government comments

“ *Child protection and supported placements*

During 2001-02 Victoria has completed a wide-ranging examination of child protection and support services which resulted in the report *An Integrated Strategy for Child Protection and Placement Services.* The report has recommended approaches to highlight strengthened prevention and early intervention services, as well as a range of improved service responses for children and young people who are more deeply involved in the protection and placement system.

In response, a series of innovation projects have been established to provide a new and improved focus on prevention and early intervention. These include service enhancements to family support services in eight local government areas. They are specifically designed to reduce re-notifications to child protection though both provision of support and assistance to vulnerable families. Intensive therapeutic services are being established for children and young people who have been abused. Related initiatives include the implementation of the new Aboriginal Protocol and the Looking after Children framework.

Other significant initiatives, which have been successfully completed during 2001-02, include the Child Protection Client and Family Survey. This survey was designed to identify client and family experiences of child protection. It has been complemented by the audit of the provision of home-based care services. Both projects are being used to inform and improve child protection and out-of-home care services. Work has also commenced on the development of new service standards and outcome objectives for residential care and the development of a Statewide approach for pre-service training for home based carers.

Supported Accommodation and Assistance Program (SAAP)

Development of the Victorian Homelessness Strategy (VHS) has been completed and was released in February 2002. It was undertaken over a two-year period and involved extensive sector and consumer consultations. The final report, *Directions for Change*, provides the framework for ongoing development and enhancement of services for Victorian homeless people.

Directions for Change has identified 15 actions and 16 strategies that will improve the sector’s capacity to respond to homelessness and are designed to help stem the flow into crisis accommodation. A key emphasis has been to build stronger collaborative partnerships between homelessness services and other areas of government, including health, education and employment.

A number of innovative cross-portfolio initiatives have already been commenced. They are focused on intervening earlier with groups who have a high propensity to remain homeless. Initiatives include targeted services for those leaving correctional and juvenile justice facilities. Other VHS funded pilots include working with public housing tenants at risk of eviction, working with older persons in tenuous private rental, and increasing housing options for women escaping domestic violence. ”

Queensland Government comments

“ Queensland continued to implement responses to the recommendations of the Commission of Inquiry into Abuse of Children in Queensland Institutions (Forde Inquiry). The third instalment of $10 million was applied to a range of ongoing initiatives including new service delivery positions and the strengthening of responses to former residents. Further reform continued following the proclamation of the *Child Protection Act 1999* in March 2000 and included:

- an increase in the allowance to foster carers;
- the trialling of new intake and assessment tools for responding to child protection notifications and assessing the needs of children in care;
- the licensing of care services to ensure the quality of care provided to children and young people meets legislated standards;
- the progression of the recommendations of Project Axis through cross-agency responses to child sexual abuse;
- the implementation of departmental policy and training around standard of care issues; and
- the establishment of a Child Death Review register to ensure the effective and timely identification of suitable persons to lead child death reviews and to ensure accountable and transparent review processes.

Supported Accommodation Assistance Program (SAAP)

Reform efforts in SAAP in 2001-02 focused on enhancing the integration of SAAP services with each other and with the broader service system to improve outcomes for a diverse client group. A planning strategy was undertaken in each departmental region to reform service delivery to women and children escaping domestic and family violence, with a view to enhancing the diversity of service models and addressing inconsistent practices. Sub regional service integration strategies were completed in four regions to review the mix of service types in each location and encourage consistent assessment and case management practices and policies. A further project established links between SAAP agencies and services targeting people from diverse cultural and linguistic backgrounds, and promoted the adoption of access and equity policies by SAAP services.

The Queensland Government also established forums to enhance coordination between State Government departments to improve responses to homeless people. In particular, issues related to homelessness among Aboriginal and Torres Strait Islander people are the subject of a whole-of-Government strategy due to be completed in 2003. ”

Western Australian Government comments

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Child protection

In 2002, the Gordon Inquiry report, *Putting the Picture Together,* reported on responses by Government agencies to complaints of family violence and child abuse in Aboriginal communities, and the Harries Report, *Mandatory Reporting of Child Abuse: Evidence and Options*, reported on the merits of introducing mandatory reporting of child maltreatment in WA. The findings of these reports are being taken into account in the development of the new Department for Community Development and in building mechanisms to improve collaboration and coordination across Government and with non-government service providers in the provision of services to families and children in need.

Supported placements

The department developed a strategic framework to achieve positive results for children and young people in care in partnership with the not for profit sector and the community. Development of the framework, which will guide the department in its work in this area to 2005, involved consultations with key stakeholders.

The Department for Community Development commenced working with other Government departments to develop protocols to implement an Interagency Policy for Working with Young People in State Care in recognition that across-Government strategies are required to improve outcomes for children and young people in care.

The Looking After Children case management system was implemented Statewide, which involved training for departmental staff, the not-for-profit sector and departmental foster carers. The pilot Foster Care Recruitment Service was reviewed, and its continuation was recommended and endorsed.

Supported Accommodation Assistance Program (SAAP)

The Government established the State Homelessness Taskforce in July 2001. In May 2002, the Government responded to the State Homelessness Taskforce report with a range of initiatives and $32 million over four years to improve services under three themes: better options for housing; vulnerability and transition; and stability in housing. An across-Government monitoring committee was established to oversee the implementation of the strategy.

Revised SAAP Service Standards were distributed to SAAP services during the year. The revised standards provide services with a guideline for best practice in SAAP. Protocols were completed with the department’s service delivery offices and in relation to immigration and multicultural affairs. Work commenced on protocols with the Department of Education and the Western Australian Police Service. Implementation workshops were held in the metropolitan area with SAAP services, mental health services and community drug service teams.

Through the joint Commonwealth/State Partnerships Against Domestic Violence initiative, four new services to address family violence were established in remote Aboriginal communities in the Kimberley.

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South Australian Government comments

Child protection

South Australia continues to receive increasing numbers of reports of suspected child abuse. Strengths in the system include the centralised intake process — increasing the consistency in intake, with the Aboriginal team providing culturally sensitive assessments — and the differential response system, which provides for both investigatory and non-investigatory responses according to the particular circumstances of the family or child. Interagency collaboration concerning children assessed to be in danger has been improved through joint training of Family and Youth Services, Police and Child Protection Services personnel. Further family intervention is offered to those families where there is an assessed likelihood of further harm to children. Renotification and resubstantiation rates are a matter of concern, however, and a Review into Child Protection legislation, policies and practices across the government and non-government sector is underway, with recommendations due to be provided to Government in December 2002.

Out-of-home care

Supported placement provision in SA is designed to ensure a continuum of placement outcomes from providing primary support to families (family preservation and reunification services), to supplementing the care provided by birth families (respite and short term care provision), to providing care outside of the family for children and young people who can no longer remain with their birth family (long-term placements: foster, relative or congregate care). Implementation of the recommendations of the major Alternative Care Review is proceeding.

Supported Assistance and Accommodation Program

The SA Government has a commitment to reducing homelessness, which will be actioned through the newly formed Social Inclusion Unit. This unit will work closely with the Department of Human Services at a strategic level to implement the SA Homelessness Plan, of which SAAP is an integral part. There is a continued strategic focus on vulnerable adults in the inner city, young people in rural areas, and the development of a single telephone referral and assessment point for SAAP clients. A research study exploring homelessness among Aboriginal young people has been completed and provides valuable insight into pathways to homelessness for this group. Evaluation has identified successful outcomes for three pilot early intervention projects aimed at preventing family homelessness. These will inform the development of new models of service.

Tasmanian Government comments

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Protection and support services

Care and protection services have achieved greater integration with complementary services, with the creation of a new Children and Families Division, which brings pre and post-natal support services, child health nurses, child development units, youth health services and parenting centres under the same management structure as the statutory care and protection service. The establishment of the Our Kids Bureau aims for earlier intervention, improved integration of services and support to children from conception to 11 years. Projects that promote the strategic policy objectives of the Our Kids Bureau include the centralisation of the intake service for reports on child abuse or neglect and the establishment of a 24-hour information line for parents. The Government has also committed to a new initiative called ‘Kids in Mind’, to be implemented from 2003-04, that supports children of parents with mental health and/or alcohol and drug problems.

Out-of-home-care services

Work commenced on the research and analysis of the cost of care and protection services. This should promote equity and transparency both in relation to reimbursement for carers and case management services.

There has also been agreement between the Commonwealth, States and Territories to develop a national foster carers plan that should identify joint work that will improve the outcomes for children in care, and also enhance the support to carers.

Supported Accommodation Assistance Program (SAAP) services

Tasmania implemented a major reform of the SAAP service system and a number of improvements in program management. Features of the new service system include increased emphasis on early intervention and an improved match between the clients’ needs and the services provided through increasing the proportion of funds allocated to flexible support services (including the establishment of a brokerage fund). Also, it includes increased emphasis on assessment, including the development and implementation of a common assessment tool, improved access to services through the redistribution of services on a population basis, the establishment of a 24-hour toll free telephone assistance service, and an enhanced range of accommodation options (including the provision of additional community tenancies).

Over the next 12 months, priority will be placed on the development of a Quality Assurance Framework and a Statewide Reporting Framework. Priority will also be placed on the redevelopment of the policy framework for the provision of services to those who are homeless or at risk of homelessness. This will be achieved through the establishment of a round table on homelessness.

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Australian Capital Territory Government comments

Child protection and supported placements

This year has been characterised by a period of learning and development within the organisation. Stemming from the implementation of new legislation in May 2000, a review of the *Children and Young People Act 1999* has commenced in line with section 418 of this Act. It is also timely to review and evaluate the implementation of various aspects of policy and practice that were introduced with the new legislation. The ACT is seeking to refocus service delivery to create and consolidate a service of excellence in the area of child protection. This goal is underpinned by two central concerns, a commitment to continuous learning and improvement, and supporting staff. The strategy is being driven by a commitment to improved service delivery based on best practice standards nationally and internationally.

Another important achievement for 2002 was the launch of a Foster Carer Recruitment Campaign on 30 May 2002 by Minister Corbell. Recurrent funding has been made available by the Government specifically for this purpose. As part of the campaign, a range of materials have been produced, including a television commercial, a radio commercial, an information booklet and a poster. Recruitment and retention of foster carers is crucial to the work of child protection and family support. Research also suggests that the needs of children coming into care are increasingly complex. The campaign is an excellent example of Government working in partnership with non-government foster care agencies and other key stakeholders.

The relatively high cost of SAAP in the ACT reflects a relatively low proportion of clients achieving independent living following SAAP support periods, due to: the low vacancy rate in the private rental market and availability of public housing stock, and the high percentage of SAAP clients arriving with no income. A number of projects have commenced through the year to facilitate sustainable responses to homeless including:

- The *Affordable Housing Taskforce Report*, proposes a whole of government and community response to housing affordability issues.
- A reform process of SAAP services includes the expansion of a Complex Needs project, which will focus on working with service providers to respond to risk factors experienced by Indigenous people.
- A review of the Territory's largest SAAP funded service (200 places) was completed in May 2002. The Government is working to re-develop this facility as a community housing site, with accessible support options (including SAAP services). This will improve the outcomes for residents of the service and enhance the efficiency of the overall Program.
- A *Needs Assessment of Homelessness in the ACT* was undertaken to inform future SAAP development. An ACT Homelessness Advisory Group was established in June 2002 to develop an ACT Homelessness Strategy.

Northern Territory Government comments

“ The Family and Children’s Services (FACS) Program of the Department of Health and Community Services is responsible for child protection and out-of-home care services, and the administration of the Supported Accommodation Assistance Program (SAAP).

Aboriginal and Islander Community Worker Career Pathway Strategy

During the year, an Indigenous employment strategy was introduced to increase the number of Indigenous employees in FACS, improve their access to outcome-based training, and enhance mobility and career prospects.

Until recently, promotion prospects for indigenous staff were limited by a requirement for a degree in social work or psychology. This barrier has now been removed, and a competency-based qualifications system has been introduced for Indigenous staff.

A target of 36 per cent has been set for the FACS Indigenous workforce, in line with the proportion of children in the Territory who are Indigenous. Currently, approximately 15 per cent of FACS staff are Indigenous.

The strategy aims to enhance the career prospects of Indigenous staff by creating a career pathway that is aligned with the Australian National Training Authority’s Community Services Training Package.

The first nationally accredited courses were offered on the job by the Northern Territory University and Family and Community Services. So far, 16 Aboriginal Community Workers have graduated from the Northern Territory University in Certificate IV in Community Services (Community Work).

The Minister for Health and Community Services also announced an additional $500 000 in the 2002-03 Budget for the employment of eight new FACS staff across the NT, with half of these positions designated for Indigenous staff. This funding was allocated in recognition of the increasing demands on the FACS Program and a demonstration of the department’s commitment to implementation of the strategy. ”

15.12 Definitions

Child protection services

Table 15.3 **Terms**

Term	*Definition*
Care and protection orders	Legal orders or administrative/voluntary arrangements involving the community services department, issued in respect of an individual child who is deemed to be in need of care and/or protection. Community services department involvement may include: • total responsibility for the welfare of the child (for example, guardianship); • responsibility to oversee the actions of the person or authority caring for the child; and • responsibility to provide or arrange accommodation, or to report or give consideration to the child's welfare. The order may have been from a court, children's panel, minister of the Crown, authorised community services department officer or similar tribunal or officer. Care and protection orders are categorised as: • finalised guardianship and finalised custody orders sought through a court; • finalised supervision and other finalised court orders that give the department some responsibility for the child's welfare (excluding interim orders); • interim and temporary orders (including orders that are not finalised); and • administrative or voluntary arrangements with the community services department, for the purpose of child protection. Children are counted only once, even if they are on more than one care and protection order.
Child	A person aged 0–17 years.
Child at risk	A child for whom no abuse or neglect can be substantiated but where there are reasonable grounds to suspect the possibility of prior or future abuse or neglect, and for whom it is considered that continued departmental involvement is warranted.
Child concern reports	Reports to community services departments regarding concerns about a child, as distinct from notifications of child abuse and neglect. The distinction between the two differs across and within jurisdictions.
Indigenous person	Person of Aboriginal and/or Torres Strait Islander descent, who identifies as an Aboriginal and/or Torres Strait Islander and is accepted as such by the community with which they are associated.
Investigation	An investigation of child abuse and neglect that involves identifying harm or risk of harm to the child, determining an outcome and assessing protective needs. It includes the interviewing or sighting of the subject child where it is practicable to do so.

(Continued on next page)

Table 15.3 **(Continued)**

Term	*Definition*
Investigation finalised	Where an investigation is completed and an outcome is recorded by 31 August.
Investigation not finalised	Where an investigation is commenced but an outcome is not recorded by 31 August.
Notification	Contact with an authorised department by persons or other bodies making allegations of child abuse or neglect or harm to a child.
Substantiation	Notification for which an investigation concludes that there is reasonable cause to believe that the child had been, was being, or is likely to be abused, neglected or otherwise harmed. It does not necessarily require sufficient evidence for a successful prosecution and does not imply that treatment or case management is, or is to be, provided.

Out-of-home care

Table 15.4 **Terms**

Term	*Definition*
Child	A person aged 0–17 years.
Exited out-of-home care	Where a child does not return to care within two months.
Family based care	Home-based care (*see* placement types).
Family group homes	Residential child care single dwelling establishments that have as their main purpose the provision of substitute care to children. They are typically run like family homes, with a limited number of children who eat together as a family group and are cared for around-the-clock by resident substitute parents.
Foster care	Care of a child who is living apart from their natural or adoptive parents in a private household, by one or more adults who act as 'foster parents' and are paid a regular allowance for the child's support by a government authority or non-government organisation. The authorised department or non-government organisation provides continuing supervision or support while the child remains in the care of 'foster parents'.
Foster parent	Any person who is being paid a foster allowance (or such a person's spouse) by a government or non-government organisation for the care of a child (excluding children in family group homes).
Guardian	Any person who has the legal and ongoing care and responsibility for the protection of a child.
Indigenous person	Person of Aboriginal or Torres Strait Islander descent, who identifies as being an Aboriginal or Torres Strait Islander and is accepted as such by the community with which they are associated. If Indigenous status is unknown, then a person is considered to be non-Indigenous.

(Continued on next page)

Table 15.4 **(Continued)**

Term	*Definition*
Non-respite care	Out-of-home care for children for child protection reasons.
Other relative	Grandparent, aunt, uncle or cousin, whether the relationship is half, full, step or through adoption and can be traced through or to a person whose parents were not married to each other at the time of the child's birth. This category includes members of Aboriginal communities who are accepted by that community as being related to the child.
Out-of-home care	Overnight care, including placement with relatives (other than parents) where the government makes a financial payment. Includes care of children in legal and voluntary placements (that is, children on and not on a legal order) but excludes placements made in disability services, psychiatric services, juvenile justice facilities or overnight child care services.
Placement types	Four main categories: • facility-based care (placement in a residential building where the purpose is to provide placement for children and where there are paid staff, including placements in family group homes); • home-based care (placement in the home of a carer who is reimbursed for expenses for the care of the child). The three subcategories of home-based care are foster care/community care, relative/kinship care and other; • independent living (including private board); and • other (including unknown).
Relatives/kin	Family members other than parents, or a person well known to the child and/or family (based on an existing relationship).
Respite care	Out-of-home care on a temporary basis for reasons other than child protection — for example, when parents are ill. Excludes emergency care provided to children who are removed from their homes for protective reasons.

Table 15.5 **Descriptors**

Descriptor	*Definition*
Children in out-of-home care during the year	The total number of children who are in at least one out-of-home care placement at any time during the year. A child who is in more than one placement is counted only once.
Length of time in continuous out-of-home care	The length of time for which a child is in out-of-home care on a continuous basis. A return home of less than seven days is not considered to break the continuity of placement.
Safety in out-of-home care	The proportion of children in out-of-home care who are the subject of a child protection substantiation and the person believed responsible is living in the household (or was a worker in a residential care facility).

Table 15.6 **Out-of-home care effectiveness indicators**

Indicator	*Definition*
Stability of placement	Number of placements for children who have exited out-of-home care and do not return within two months. Placements do not include respite or temporary placements lasting less than seven days. Placements are counted separately where there is: • a change in the placement type — for example, from a home-based to a facility-based placement; or • within placement type, a change in venue, or a change from one home-based placement to a different home-based placement. A particular placement is counted only once, so a return to a previous placement is another placement.

Supported accommodation and assistance

Table 15.7 **Terms**

Term	*Definition*
Accommodation	Crisis or short term accommodation, medium to long term accommodation, and other SAAP funded accommodation (which comprises accommodation at hostels, motels and hotels, accommodation in caravans, community placements and other SAAP funded arrangements).
Agency	The body or establishment with which the State or Territory government or its representative agrees to provide a SAAP service. The legal entity has to be incorporated. Funding from the State or Territory government could be allocated directly (that is, from the government department) or indirectly (that is, from the auspice of the agency). The SAAP service could be provided at the agency's location or through an outlet at a different location.
Casual client	A person who is in contact with a SAAP agency and receives one-off assistance for a period of generally not more than one hour, and who does not establish an ongoing relationship with an agency.
Client	A person who receives supported accommodation or support
Crisis or short term supported accommodation	Supported accommodation for periods of generally not more than three months (short term) and for persons needing immediate short term accommodation (crisis).
Cross-target/multiple/ general services	SAAP services targeted at more than one primary client group category — for example, SAAP services for single persons regardless of their gender.
Day support	Support only on a walk-in basis — for example, an agency that provides a drop-in centre, showering facilities and a meals service at the location of the SAAP agency.

(Continued on next page)

Table 15.7 **(Continued)**

Term	*Definition*
Homeless person	A person who does not have access to safe, secure and adequate housing. A person is considered to not have access to such housing if the only housing to which the person has access: • is damaged, or is likely to damage, the person's health; or • threatens the person's safety; or • marginalises the person through failing to provide access to adequate personal amenities or the economic and social supports that a home normally affords; or • places the person in circumstances that threaten or adversely affect the adequacy, safety, security and affordability of that housing; or • is of unsecured tenure. A person is also considered homeless if they are living in accommodation provided by a SAAP agency or some other form of emergency accommodation.
Indigenous person	Person who is of Aboriginal and/or Torres Strait Island descent, who identifies as being an Aboriginal and/or Torres Strait Islander, and who is accepted as such by the community with which they are associated.
Medium to long term supported accommodation	Supported accommodation for periods over three months. Medium term is around three to six months and long term is longer than six months.
Multiple service delivery model	SAAP agencies that use more than one service delivery model to provide SAAP services — for example, crisis or short term accommodation and support, as well as day support (that is, the provision of meals).
Non-english speaking background services	Services that are targeted at persons whose first language is not English.
Non-recurrent funds	SAAP funds received for non recurrent purposes, such as funds for research, a special one-off project or replacement of capital items (for example, furniture and motor vehicles).
Non-saap accommodation places	Accommodation places in the form of permanent beds (owned or managed by the agency) that use funds other than SAAP funds.
One-off assistance	Assistance provided to a person who is not a client, such as the provision of a meal, a shower, transport, money, clothing, telephone advice, information or a referral.
Ongoing support period	A support period for which, at the end of the reporting period, no support end-date and no after-support information are provided.
Other special characteristics	Primary or secondary characteristics that are not included in those of a service's primary client or group or in other categories of the secondary client group — for example, a service specifically targeted at homeless persons with a disability.
Outlet	A premise owned/managed/leased by an agency at which SAAP services are delivered. Excludes accommodation purchased using SAAP funds (for example, at a motel).

(Continued on next page)

Table 15.7 **(Continued)**

Term	*Definition*
Outreach support services	Services that exist to provide support and other related assistance specifically to homeless people. These clients may be isolated and able to receive services and support from a range of options that enhance their flexibility (for example, advocacy, life skills and counselling). Generalist support and accommodation services may also provide outreach support in the form of follow-up to clients where they are housed. In this context, support is provided 'off site'.
Providers	Agencies that supply support and accommodation services
Real expenditure	Actual expenditure adjusted for changes in prices. Adjustments are made using the GDP(E) price deflator and expressed in terms of final year prices.
Recurrent funding	Funding provided by the Commonwealth and State and Territory governments to cover operating costs, salaries and rent.
Referral	When a SAAP agency contacts another agency and that agency accepts the person concerned for an appointment or interview. A referral is not provided if the person is not accepted for an appointment or interview.
SAAP service	Supported accommodation, support or one-off assistance that is provided by a SAAP agency and intended to be used by homeless persons.
Service delivery model	The mode or manner in which a service is provided through an agency. The modes of service delivery could be described as crisis or short term accommodation and support; medium to long term accommodation and support; day support; outreach support; telephone information; and referral or agency support. An agency may deliver its services through one or more of these means of delivery.
Service provider	Worker or volunteer employed and/or engaged by a SAAP agency, who either directly provides a SAAP service or in some way contributes to the provision of a SAAP service. Includes persons such as administrative staff of an agency, whether paid or not paid.
Single men services	Services provided for males who present to the SAAP agency without a partner or children.
Single women services	Services provided for females who present to the SAAP agency without a partner or children.
Support	SAAP services, other than supported accommodation, that are provided to assist homeless people or persons at imminent risk of becoming homeless to achieve the maximum possible degree of self reliance and independence. Support is ongoing and provided as part of a client relationship between the SAAP agency and the homeless person.
Support period	The period that commences when a SAAP client establishes or re-establishes (after the cessation of a previous support period) an ongoing relationship with a SAAP agency. The support period ends when: • support ceases because the SAAP client terminates the relationship with the SAAP agency; or • support ceases because the SAAP agency terminates the relationship with the SAAP client; or

(Continued on next page)

Table 15.7 **(Continued)**

Term	*Definition*
	• no support is provided to the SAAP client for a period of three months. A support period is relevant to the provision of supported accommodation or support, not the provision of one-off assistance.
Supported accommodation	Accommodation provided by a SAAP agency in conjunction with support. The accommodation component of supported accommodation is provided in the form of beds in particular locations or accommodation purchased using SAAP funds (for example, at a motel). Agencies that provide accommodation without providing support are considered to provide supported accommodation.
Telephone information and referral	Support delivered via telephone without face-to-face contact. Support provided may include information and/or referral.
Total funding	Funding for allocation to agencies (not available at the individual client group level) for training, equipment and other administration costs.
Unmet demand	A homeless person who seeks supported accommodation or support, but is not provided with that supported accommodation or support. The person may receive one-off assistance.
Women escaping domestic violence services	Services specifically designed to assist women and women accompanied by their children, who are homeless or at imminent risk of becoming homeless as a result of violence and/or abuse.
Youth/young people services	Services provided for persons who are independent, and above the school-leaving age for the State or Territory concerned, and who present to the SAAP agency unaccompanied by a parent/guardian.

Table 15.8 **Indicators**

Indicator	*Definition*
Accommodation load (of agencies)	The number of accommodation days divided by the number of days for which the agency is operational during the reporting period, where the number of accommodation days equals the sum of accommodation days for all clients of an agency who are supported during the reporting period. The average accommodation load is the mean value of all agencies' accommodation loads. Support periods without valid accommodation dates are assigned the inter quartile modal duration of accommodation for agencies of the same service delivery model in the same jurisdiction.
Caseload (of agencies)	The number of support days divided by the number of days for which the agency is operational during the reporting period, where the number of support days equals the sum of support days for all clients of the agency who are supported during the reporting period. The average caseload is the mean value of all agencies' caseloads. Support periods without valid support dates are assigned the inter quartile modal duration of support for agencies of the same service delivery model in the same jurisdiction.

15.13 References

AIHW (Australian Institute of Health and Welfare) 1999, *Child Protection Australia, 1997-98*, cat. no. CWS 8, Canberra.

—— 2002, *Child Protection Australia, 2000-01*, cat. no. CWS 16, Canberra.

CBSR (Colmar Brunton Social Research) 2001, *Client and Carer Survey*, mimeo, Melbourne.

DHS (Department of Human Services) 2002, *An Integrated Strategy for Child Protection and Placement Services*, Melbourne.

NLRC (NSW Law Reform Commission) 1997, *The Aboriginal Child Placement Principle*, Research Report no. 7, Sydney.

16 Housing

Government plays a significant role in the Australian housing market, directly through housing assistance and indirectly through policies associated with land planning and taxation. Commonwealth, State and Territory governments share responsibility for housing assistance. Direct assistance includes public and community housing, home purchase and home ownership assistance, Indigenous housing, State and Territory rental assistance (such as State and Territory provided bond loans, assistance with rent payments and advance rent payments, relocation expenses and other one-off grants) and Commonwealth Rent Assistance (CRA).

This chapter focuses on the performance of governments in providing public, Indigenous and community housing under the Commonwealth State Housing Agreement (CSHA) (box 16.1) and CRA.

Close links exist between public and community housing services and other government programs and support services discussed elsewhere in the Report. These include:

- the Supported Accommodation Assistance Program (SAAP), which provides accommodation and other services for homeless people or those at imminent risk of becoming homeless (chapter 15); and
- health services delivered by Commonwealth, State and Territory governments and community organisations to promote independent living, including disability services (chapter 13), mental health services (chapter 11) and aged care services, for example, the Home and Community Care Program (chapter 12).

A negotiated four-year CSHA came into effect on 1 July 1999. At this time a new performance framework for reporting under the CSHA was developed to reflect the national objectives of the agreement, to improve the quality of national performance information and to recognise the need for balanced reporting at the national and bilateral levels. Performance reporting in this chapter for public, community and State and Territory owned and managed Indigenous housing is based on this framework.

Box 16.1 **Commonwealth State Housing Agreement**

The CSHA is an agreement made under the *Housing Assistance Act 1996* (Cwlth) between the Commonwealth, State and Territory governments to provide strategic direction and funding certainty for the provision of housing assistance. The aim of this agreement is to provide appropriate, affordable and secure housing assistance for those who most need it, for the duration of their need.

A new four-year agreement came into effect on 1 July 1999 and includes, for the first time, bilateral agreements between the Commonwealth and each State and Territory government, as well as an overarching multilateral agreement. Bilateral agreements are intended to provide greater flexibility for States and Territories to respond to their particular housing needs.

Funding arrangements

The majority of funding under this agreement is provided by the Commonwealth Government and takes the form of general assistance funding (public housing, home purchase assistance and private rental assistance) and specified funding for identified programs — the Aboriginal Rental Housing Program (ARHP), the Crisis Accommodation Program and the Community Housing Program. The majority of CSHA funding is distributed to State and Territory governments on a modified per capita basis, with the State and Territory governments contributing additional funding from their own resources to partly 'match' Commonwealth funding allocations.

Roles and responsibilities

Under the CSHA, the Commonwealth Government has responsibility for:

- ensuring the outcomes pursued through the agreement are consistent with broader national objectives, particularly in relation to support for individuals and communities;
- advising State and Territory governments of Commonwealth objectives to be achieved under the agreement; and
- reporting to the Commonwealth Parliament on performance against agreed outcomes and targets of housing assistance provided under the agreement.

State and Territory governments have responsibility for:

- developing housing assistance strategies that are consistent with Commonwealth, State and Territory objectives and that best meet the circumstances of the State or Territory;
- developing, implementing and managing services and programs to deliver agreed outcomes; and
- reporting on a basis that enables performance assessment by the Commonwealth, State or Territory, based on agreed performance indicators.

Source: CSHA (1999).

A profile of housing and housing assistance is presented in section 16.1, followed by a brief discussion of recent policy developments in section 16.2. Together, these provide the context for assessing the performance indicators presented later in the chapter. All jurisdictions have agreed to develop and report comparable indicators, and a framework of performance indicators is outlined in section 16.3. The data are discussed in section 16.4 and future directions for performance reporting are discussed in 16.5. The chapter concludes with jurisdictions' comments in section 16.6 and definitions in section 16.7.

The 2002 Report included for the first time performance reporting on State and Territory owned and managed Indigenous housing based on the new national framework. This program provides government owned housing to Indigenous Australians. This year's Report also contains selected information relating to the community Indigenous housing sector from the Aboriginal and Torres Strait Islander Commission (ATSIC)/ Australian Bureau of Statistics (ABS) 2001 Community Housing and Infrastructure Needs Survey (CHINS).

Reporting on CRA has been improved this year, with a new performance indicator framework, providing more information on satisfaction with housing, and accessibility and affordability outcomes for special needs groups. Where appropriate, time series data are also presented for public, community and State and Territory owned and managed Indigenous housing.

Public, community and State and Territory owned and managed Indigenous housing information has been obtained from Commonwealth, State and Territory governments except where otherwise indicated. The Australian Institute of Health and Welfare (AIHW) collects and collates these data and produces annual data collection manuals. The data manuals and data reports are available from the AIHW and can be accessed via the Institute's web site at www.aihw.gov.au (AIHW 2002a, 2002b and 2002c).

Housing services not covered

The chapter does not cover a number of government funded and provided housing services, including:

- the Crisis Accommodation Program under the CSHA, which provides capital funding for accommodation for homeless people;
- home purchase assistance and private rental assistance provided under the CSHA;
- the ATSIC/Army Community Assistance Program, which provides new housing and improved infrastructure to Indigenous communities;

- non-CSHA programs, including those provided by the Department of Veterans' Affairs (DVA) and ATSIC;
- CRA paid by the DVA or the Department of Education, Science and Training (DEST);
- The First Home Owners Grant, provided by Commonwealth Treasury and delivered through State and Territory governments;
- some Indigenous housing and infrastructure assistance provided by ATSIC, State and Territory governments, land councils and Indigenous community organisations; and
- non-Indigenous community housing not funded under the CSHA.

Supporting tables

Supporting tables for chapter 16 are provided on the CD-ROM enclosed with the Report. The files are provided in Microsoft Excel 97 format as \Publications\Reports\2003\Attach16A.xls and in Adobe PDF format as \Publications\Reports\2003\Attach16A.pdf.

Supporting tables are identified in references throughout this chapter by an 'A' suffix (for example, table 16A.3 is table 3 in the electronic files). 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 these tables (see details on the inside front cover of the Report).

16.1 Profile of housing and housing assistance

Service overview

The 2001 ABS Population Census identified just under 7.1 million households in Australia, where 'household' is classified as a person living alone or as a group of related or unrelated people who usually reside and eat together. Of these households, 66.2 per cent owned or were purchasing their own home, 21.8 per cent rented in the private sector, 4.5 per cent were in public rental accommodation, with 2.8 per cent residing in other tenure types (table 16A.67). Due to nonresponse, Census data are likely to underestimate the number of tenants in public housing.[1] Approximately 0.4 per cent of Australian households live in community housing.[2]

[1] Public housing tenants appear to be undercounted in the 2001 Census (and in previous Censuses). For NSW, the 2001 Census reported 114 130 public housing households out of a total of

The composition of Australian households is changing. There is an increasing number of smaller households, including a rising number of single person households. The average Australian household size fell from 3.3 people to 2.6 people between 1971 and 2001, while the proportion of lone person households increased from 18.1 per cent to 22.9 per cent over this period (ABS 2002a).

The average Indigenous household is larger than the average non-Indigenous household. In 1996, the average non-Indigenous Australian household size was 2.7 people, whereas the average Aboriginal household was 3.7 people, and the average Torres Strait Islander household was 4.7 people in the Torres Strait and 3.4 people outside the Torres Strait (ABS and AIHW 2001).

The Indigenous population is a younger population than the non-Indigenous population. The 2001 ABS Population Census showed that 38.9 per cent of the Indigenous population was aged under 15 years but only 20.2 per cent of the non-Indigenous population was aged under 15 years. Only 2.8 per cent of the Indigenous population was aged over 65 years compared with 12.4 per cent of the non-Indigenous population (ABS 2002a and tables A.1 and A.7).

Why government provides housing assistance

Australia's private housing stock houses the majority of the population. Most Australian households are able to access accommodation either through owner occupation or by renting from a private landlord. Many households, however, face problems in acquiring or accessing suitable private accommodation for reasons of cost, discrimination, availability or adequacy. The price of rental dwellings can be prohibitive for lower income families. Further, stock may not be available in the private rental market for households with special accommodation needs. Housing assistance from Commonwealth, State and Territory governments can help these households.

2 343 667 (or 4.9 per cent), while NSW reports there are more than 125 000 public housing households in the state (representing around 5.3 per cent of households). Across Australia, the Census reports there were 317 000 households in public housing, but the 2001-02 public housing data collection indicates there were just under 343 000 such households.

2 This estimate is based on data received from jurisdictions regarding the number of community housing dwellings in each jurisdiction combined with data from the 2001 ABS Population Census on the total number of dwellings in each jurisdiction.

Roles and responsibilities

Various levels of government have different roles and responsibilities in housing and housing assistance:

- the Commonwealth Government provides CRA and shares responsibility with State and Territory governments for housing assistance provided under the CSHA (box 16.1). The Commonwealth also influences the housing market through other direct and indirect means, including taxation and home purchase assistance;
- State and Territory governments provide housing assistance under the CSHA, such as public housing, community housing, Indigenous rental housing (both State and community managed), private rental assistance and home purchase assistance. Some State and Territory governments also contribute to the delivery of housing assistance through mechanisms such as home lending programs and joint ventures with the private sector. State and Territory governments are also responsible for land taxes, stamp duties and residential tenancy legislation; and
- local governments implement planning regulations and are sometimes involved in providing community housing.

Funding

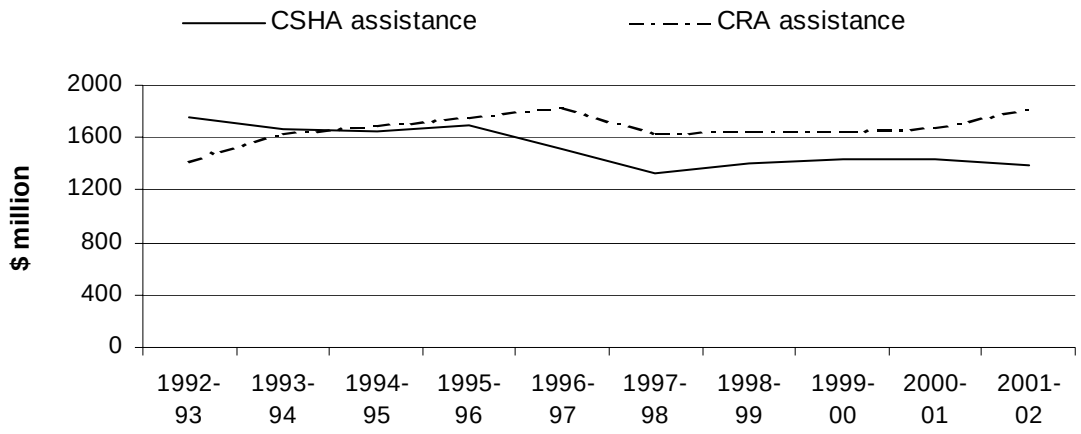
The Commonwealth Government provided over $1.8 billion for CRA in 2001-02. The Commonwealth, State and Territory governments also provided just under $1.4 billion (contributing about 74 per cent and 26 per cent respectively) for housing programs under the CSHA in 2001-02. Public and community housing accounted for the majority of CSHA funding in 2001-02 (CSHA 1999).

Expenditure on CRA increased by approximately 27.9 per cent in real terms between 1992-93 and 2001-02, while expenditure on CSHA assistance declined by approximately 20.8 per cent over the same period (figure 16.1). Included in CSHA expenditure in 2001-02 was $89.7 million of GST compensation paid to State and Territory governments (table 16A.74).

Public housing is the largest program under the CSHA. Given the capital-intensive nature of public housing, in addition to annual funding, assistance is provided through the use of approximately $40 billion of housing stock owned by housing authorities (2000-01 State and Territory financial statements). Reduced funding in any given year may not necessarily result in a decline in the level of housing stock provided for that year, although it may affect levels of maintenance and the ability to reconfigure stock, and may eventually result in fewer dwelling constructions or acquisitions.

Nationally, total government recurrent expenditure on public housing per person in the population in 2001-02 was approximately $75. State and Territory recurrent expenditure on public housing per person in the population ranged from $220 in the NT to $40 in Victoria in 2001-02. Including capital costs, total government expenditure on public housing per person in the population ranged from $693 in the ACT to $176 in Queensland. Average national total government expenditure on public housing per person in the population in 2001-02 was $247 (table 16A.82). It is important to note the diversity of housing assistance operations across jurisdictions when discussing expenditure per person on public housing.

Figure 16.1 **Real government expenditure on CSHA assistance and CRA (2001-02 dollars)[a, b, c]**



a Care needs to be taken in interpreting data because CRA is a demand-driven recurrent expenditure program, whereas CSHA expenditure includes a component for capital investment that has resulted in around $40 billion of public housing assets that are continually used for housing assistance. **b** CSHA data are not comparable to data published before the 2001 Report. The data for 1992-93 to 1995-96 have been adjusted to enable comparability (see the 2002 Report for further explanation). Commonwealth CSHA expenditure differed from Commonwealth budgetary allocations for the three years from 1996-97 to 1998-99 as some States and Territories chose CSHA funds as the source to offset their State Fiscal Contributions to the Commonwealth's debt reduction program, which was agreed at the 1996 Premiers' Conference. **c** CSHA expenditure in 2000-01 and 2001-02 contained $89.7 million of Goods and Services Tax (GST) compensation paid to State and Territory governments.

Source: CSHA (1999), Commonwealth Department of Family and Community Services (1999, 2000a, 2000b, 2001) and table 16A.74.

Size and scope

Housing assistance is provided in various forms and models for delivering assistance can vary both within and between jurisdictions. The main forms of assistance are outlined in box 16.2.

Box 16.2 **Forms of housing assistance**

Forms of CSHA housing assistance include:

- *public housing*: dwellings owned (or leased) and managed by State and Territory housing authorities to provide affordable rental accommodation. The CSHA is the main source of funding for public housing;
- *community housing*: rental housing provided for low to moderate income or special needs households managed by community-based organisations which are at least partly subsidised by government. Community housing models vary across jurisdictions;
- *Indigenous housing*: includes public rental housing targeted at Indigenous households and houses which are owned and managed by Indigenous community housing organisations and community councils in urban, rural and remote areas;
- *crisis accommodation*: accommodation services to help people who are homeless or in crisis. Services are generally provided by non-government organisations and many are linked to support services funded through the SAAP. Sources of government funding include the Crisis Accommodation Program of the CSHA, which provides funding for accommodation, and SAAP funding for live-in staff, counselling and other support services;
- *home purchase assistance*: assistance provided by State and Territory governments to low to moderate income households to help with first home purchases or mortgage repayments; and
- *private rental assistance*: assistance funded by State and Territory governments to low income households experiencing difficulty in securing or maintaining private rental accommodation. This assistance may include ongoing or one-off payments to help households meet rent payments, one-off payments for relocation costs, guarantees or loans to cover the cost of bonds, and housing assistance advice and information services. Assistance may be provided by community-based organisations funded by government.

The chapter also reports on:

CRA: a non-taxable income support supplement paid by the Commonwealth Government to income support recipients or people who receive more than the base rate of Family Tax Benefit Part A who rent in the private rental market; and

Indigenous community housing: in addition to funding under the CSHA, Indigenous housing and housing-related infrastructure is funded through the Community Housing Infrastructure Program administered by ATSIC. State and Territory governments also provide funding from their own resources.

Source: Department of Social Security (1998) and CSHA (1999).

This chapter focuses on four forms of assistance: public housing, community housing, State and Territory owned and managed Indigenous housing, and CRA.

CRA is available only to people receiving income support payments or more than the base rate of Family Tax Benefit Part A and is paid as a supplement to their other payments. Eligibility and assistance levels differ for each form of assistance. Eligibility for public and community housing tends to be reasonably consistent across jurisdictions. Eligibility for public and community housing is income tested but, unlike CRA, not limited to those receiving an income support payment or more than the base rate of Family Tax Benefit Part A. Access to public and community housing is restricted by the amount of housing stock available.

The level of assistance provided in public and community housing depends on the income of the household and the rental value of the property. Rent rebates are set to achieve an affordability outcome for low income tenants where tenants pay the lower of market rent or a maximum 25 per cent of their assessable income in rent. CRA payments are based on the amount of rent paid for a private rental dwelling. Income supplements paid under CRA are set subject to a minimum rent threshold and cannot exceed a maximum rate, with both the minimum rent threshold and maximum rate varying according to family structure. Unlike public and community housing, affordability outcomes for households receiving CRA will vary with the rental value of the property and with the amount of private income and benefits the households receive.

Public housing

Public housing comprises those dwellings owned (or leased) and managed by State and Territory housing authorities. The CSHA is the main source of funding for public housing. A total of 342 819 public housing dwellings were occupied at 30 June 2002.

Public housing is available to people on low incomes and those with special needs. Although people with a disability represented 17 per cent of the total population aged between 15–64 years in 1998, 39 per cent of public housing tenants of this age group in 1998 were people with a disability (ABS 1999a, AIHW 1999b).[3]

Commonwealth Government pensions and allowances are the main source of income for the majority of households in public housing. The ABS estimated that approximately 80 per cent of households renting from a State or Territory housing authority in 1997-98 relied on pensions and allowances as their principal source of income (ABS 1999a).

[3] Disability is defined as any restriction or lack of ability (resulting from an impairment) to perform an action in the manner or within the range considered normal for a human being.

Public housing rents are generally set at market levels and rebates are granted to low income earners (so tenants should pay no more than 25 per cent of their assessable income in rent), in order to provide affordable housing to people on low incomes. The proportion of total households residing in public housing ranged from 8.6 per cent in the ACT to 3.2 per cent in Victoria in 2001 (table 16A.70). Information on the proportion of income paid in rent by public housing tenants is contained in table 16A.75.

Community housing

Community housing is generally managed by not-for-profit organisations or local government, which perform asset and tenancy management functions. A major objective of community housing is to increase social capital by encouraging local communities to take a more active role in planning and managing appropriate and affordable transitional and long term rental accommodation. Community housing also aims to provide a choice of housing location, physical type and management arrangements. Some forms of community housing also allow tenants to participate in the management of their housing.

The community housing program aims to achieve links between housing and services that are best managed at the community level, including disability services and home and community care. Notwithstanding their common objectives, community housing programs vary within and across jurisdictions in their administration and types of accommodation (box 16.3).

Funding for community housing is typically either fully or partly provided by governments to not-for-profit organisations or local government. Commonwealth funding for community housing amounted to 6.2 per cent (or $64.0 million) of total CSHA funding provided by the Commonwealth in 2001-02. There were 29 114 CSHA community housing dwellings in Australia at June 2002[4], or about 7.8 per cent of the total public and community housing stock supported under the CSHA (table 16A.15).

Reporting of community housing in this chapter focuses on community housing stock that is funded wholly or partly through the CSHA. A 1998 mapping study estimated that approximately 15 000 community housing dwellings (or 38 per cent of total community housing dwellings) across Australia at 30 June 1998 were funded and delivered through other means (AIHW 1999a). There is also likely to be additional community housing stock not identified through the study.

4 Data are based on survey results except for Victoria and the NT. Results are therefore affected by survey nonresponse.

Box 16.3 **Models of community housing**

Community housing models vary across jurisdictions in terms of their scale, organisational structure, financing arrangements and the extent to which the community or government has management responsibility and ownership of the housing stock. Table 16A.71 lists the relevant community housing programs in each jurisdiction.

Some community housing models are:

- *regional or local housing associations*: the associations provide property and tenancy management services and community groups provide support services to tenants;
- *headleasing*: housing authorities or private landlords own the housing stock, which is managed by community groups;
- *joint ventures and housing partnerships*: a range of church, welfare, local government agencies and other organisations provide resources in cooperation with State and Territory government organisations;
- *housing cooperatives*: the cooperatives are responsible for tenant management and maintenance, while government, a central finance company or individual cooperatives own the housing stock;
- *community management and ownership*: not-for-profit or community housing associations both own and manage housing;
- *local government housing associations*: the associations provide low cost housing within a particular municipality, are closely involved in policy, planning, funding and/or monitoring roles and may directly manage the housing stock; and
- *equity share rental housing*: housing cooperatives wholly own the housing stock and lease it to tenants (who are shareholders in the cooperative and therefore have the rights and responsibilities of cooperative management).

Source: State and Territory governments (unpublished).

Indigenous housing

Government funded Indigenous housing includes both State managed and community managed housing. The State managed component is generally funded by the ARHP and may be supplemented by untied CSHA funds and State matching funds. Community managed Indigenous housing may be funded from ARHP funds, supplementary State funds, untied CSHA funds, ATSIC funds and funds from a range of other sources.

State and Territory owned and managed Indigenous housing

Reporting on State and Territory owned and managed Indigenous housing was included for the first time in the 2002 Report. In the 2002 Report, this was referred to as the ARHP.[5] The title has changed for this Report to reflect that while the ARHP data collection referred only to State and Territory owned and managed Indigenous housing, ARHP funds are also used to provide other forms of Indigenous housing, particularly Indigenous community housing. State and Territory owned and managed Indigenous housing refers to rental housing owned and managed by the State or Territory government and allocated to Indigenous households only. This includes dwellings managed by government Indigenous housing agencies for allocation to Indigenous tenants. The framework for reporting on State and Territory owned and managed Indigenous housing is based on that used for public and community housing.

State and Territory owned and managed Indigenous housing is only one of a number of programs designed to provide housing assistance to Indigenous people. Indigenous Australians may also be eligible for assistance under Indigenous community managed housing (where tenancy management functions are carried out by community agencies), the mainstream public and community housing programs, CRA, and other government housing programs (both Indigenous-specific and mainstream). Some mainstream community housing providers specifically target Indigenous Australians for the allocation of housing. In the 2001-02 CSHA community housing data collection, 30 mainstream community housing organisations nominated Indigenous Australians as their primary target group for the allocation of housing.[6]

The ACT does not receive funding for or administer any Territory owned and managed Indigenous housing programs, while in the NT, ARHP funding is directed to community managed Indigenous housing. The NT government is unable to differentiate between the various funding sources because of its commitment under the CSHA Indigenous Agreement to specifically 'pool' all funds earmarked for

[5] While the term State and Territory owned and managed Indigenous housing is used, the ACT and the NT are not included in the data collection for this program.

[6] In the 2001-02 mainstream community housing data collection for NSW, Queensland and Tasmania the data for this item were collected by survey. Survey non-response rates influence the figure reported (survey response rates were 86 per cent in NSW, 60 per cent in Queensland and 46 per cent in Tasmania). In NSW, there might be variation in the way providers who target groups with multiple characteristics (for example, Indigenous people with disabilities) responded. The reported number of targeted providers for any particular group may be understated. In the Community Housing Mapping Project conducted in 1999, 39 mainstream CSHA funded community housing organisations were identified as targeting assistance to Indigenous Australians.

Indigenous housing and associated infrastructure in the NT. The ACT and the NT are not included in the State and Territory owned and managed Indigenous housing data collection.

Indigenous community housing

Performance reporting on State and Territory owned and managed Indigenous housing is complemented in this year's Report by the inclusion of selected information on the Indigenous community housing sector from the 2001 ATSIC/ABS CHINS.

For community managed Indigenous housing, it is not possible to report against a performance indicator framework, but CHINS data provide a snapshot of the sector. The CHINS data provide information on housing managed by Indigenous community housing organisations, including discrete community councils. Readers should not make comparisons between CHINS and State and Territory owned and managed Indigenous housing data. The former is a survey, while reporting for State and Territory owned and managed Indigenous housing is based on administrative data.

The CHINS was conducted between March and June 2001 to collect information about all discrete Indigenous communities and Indigenous organisations that provide housing to Indigenous people in urban, rural and remote locations in all States and Territories. The response rate was 98.1 per cent for discrete Indigenous communities and 98.6 per cent for Indigenous housing organisations. Information was collected by trained ABS officers in personal interviews with key community and Indigenous housing organisation representatives.

There were 12 579 dwellings identified in the 2001-02 State and Territory owned and managed Indigenous housing collection (table 16A.27). In the 2001 ATSIC/ABS CHINS, 21 287 permanent Indigenous community housing dwellings were identified (table 16A.38) of which 7.8 per cent were unoccupied (table 16A.39). Cultural factors may influence the time taken to re-occupy Indigenous dwellings. Following the death of a significant person, for example, a dwelling may need to be vacant for a longer period of time (Morel and Ross 1993). In some cases, the dwelling may be so sub-standard as to be uninhabitable. The higher proportion of dwellings in rural and remote areas may also contribute to delays in completing administrative tasks and maintenance before dwellings can be re-tenanted. Due to the diversity of funding arrangements between programs and jurisdictions, problems may occur with program boundaries (especially where management of government owned stock has transferred to the Indigenous community sector) and, therefore, there is potential for some government owned

dwellings to be reported in the CHINS results. In addition to the number of permanent dwellings mentioned above, the CHINS also identified 5600 people living in temporary dwellings.

Of the 616 Indigenous housing organisations included in the CHINS, 47.2 per cent managed one to 19 dwellings, 33.6 per cent managed 20 to 49 dwellings and 18.8 per cent managed 50 or more dwellings. The majority (56.7 per cent) of Indigenous housing organisations were in discrete Indigenous communities and the remainder in urban areas. Most (93.7 per cent) discrete Indigenous communities were in remote and very remote parts of Australia. The total population of discrete Indigenous communities was reported as 108 000, of whom 85.9 per cent lived in remote and very remote communities.

Housing grants were received by 57.9 per cent of Indigenous housing organisations during the financial year prior to the 2001 CHINS. Indigenous housing organisations in discrete communities were more likely to receive grants (68.8 per cent) than urban Indigenous housing organisations (43.8 per cent). The main providers of grants were ATSIC (28.4 per cent of organisations) and the State and Territory governments (19.6 per cent of organisations), with joint State or Territory and Commonwealth funding reported for 16.6 per cent of organisations. No grants were received by 41.9 per cent of organisations.

In the 2001 CHINS, 70.4 per cent of permanent Indigenous community housing dwellings were classified as needing minor or no repair, 18.9 per cent were in need of major repair and 8.4 per cent were classified as needing replacement (table 16A.40).

Average annual maintenance expenditure per permanent Indigenous community housing dwelling in 2001 was $1870 a year, while the average weekly rent paid by Indigenous community households was $38 (table 16A.41) (ABS 2002b).

CRA

Commonwealth Rent Assistance is a non-taxable supplementary payment to help with the additional cost of private rental housing. It is available to recipients of income support payments, including those who receive more than the base rate of Family Tax Benefit Part A and who pay private rent above minimum thresholds. Private rent includes rent paid under both formal tenancy agreements and informal arrangements, such as board and lodgings paid to a family member. It also includes mooring and site fees (for boats and caravans) and payments for retirement village services. Community housing tenants may also be eligible for CRA.

The rate at which CRA is paid is 75 cents for every dollar above the threshold until a maximum rate is reached. The maximum rates and thresholds vary according to a client's family situation and to their number of children (table 16.1). For single people without children, the maximum rate also varies according to whether accommodation is shared with others. Rent thresholds and maximum rates are indexed twice a year (March and September) to reflect changes in the consumer price index.

Table 16.1 **Eligibility and payment scales for CRA[a]**

Personal circumstances	*Minimum rent to be eligible for CRA ($/fortnight)*	*Minimum rent to be eligible for maximum CRA ($/fortnight)*	*Maximum CRA ($/fortnight)*	*Average CRA paid ($/fortnight)*[b]
Single, no children	80.40	201.20	90.60	70.58
Single, no children, sharer	80.40	160.93	60.40	51.12
Couple, no dependant children	131.00	244.87	85.40	69.01
Single, 1 or 2 dependant children	105.84	247.52	106.26	80.83
Single, 3 or more dependant children	105.84	266.00	120.12	94.36
Partnered, 1 or 2 children	156.66	298.34	106.26	79.82
Partnered, 3 or more children	156.66	316.82	120.12	89.57
Partnered, illness separated, no children	80.40	201.20	90.60	87.00
Partnered, temporarily separated, no children	80.40	194.27	85.40	84.94

a Maximum rates and thresholds payable at 30 June 2002. **b** At June 2002.

Source: DFaCS (unpublished).

As CRA is a national payment, the Department of Family and Community Services (DFaCS) seeks to ensure CRA clients who have the same household characteristics and who pay the same amount of rent receive the same amount of assistance wherever they live. The maximum rate of assistance is received by 56.9 per cent of CRA recipients. This outcome and the national payment objective of CRA result in little variation in the average level of assistance across locations (table 16A.56) even though rents vary considerably by location. At 30 June 2002, the average payment across Australia was $72 per fortnight (or approximately $1874 a year). On a capital city/rest of State or Territory basis, Sydney had the highest average CRA payment ($75 a fortnight). Excluding other Australian Territories,[7] the lowest average CRA payment ($66 a fortnight) was in non-capital city Tasmania (table 16A.56).

7 'Other Australian Territories' comprises Jervis Bay, Christmas Island and Cocos (Keeling) Island.

There were 943 877 income units — where an income unit is defined as either a single person or a couple with or without dependents[8] — receiving CRA at 30 June 2002 (table 16.15).

The mix of clients by payment type reflects the fact that the proportion of social security recipients receiving CRA decreases with age. Approximately 44 per cent of income units aged 25–27 years received CRA on 30 November 2001 (the most recent year for which data are available), but this proportion decreased to 36 per cent at age 34 years, 28 per cent at age 48 years, 20 per cent at age 59 years and less than 14 per cent at age 65 years or more. The proportion of clients receiving CRA also decreases for those aged under 25 years due to the home rules for recipients of Youth Allowances. In most cases this means they have to live away from home for study or training. The likelihood of this increases with age. The type of property rented may also affect CRA eligibility.

Diversity of State and Territory housing assistance operations

State and Territory governments have similar broad objectives for providing housing assistance. Individual jurisdictions, however, emphasise different objectives depending on their historical precedents and ways of interacting with community sector providers. These differences lead to a variety of policy responses and associated assistance products. It is important to be aware of all the housing assistance operations in each State and Territory when analysing performance information.

Appendix A contains information on each State and Territory that may help in interpreting the performance indicators presented in this chapter. State and Territory governments have provided some additional information on the key operating parameters characterising housing assistance provision in their jurisdictions.

Public housing

- *Eligibility criteria for access to public housing.* Definitions of income and assets, and income and asset limits for access to public housing, vary across jurisdictions. At June 2002, income limits for a single person ranged from $540 a week in SA to $323 a week in Victoria and Tasmania. In most cases, jurisdictions require that applicants must be Australian citizens or permanent residents and do not own or part own residential property. 'Other' asset limits for a single person household ranged from $249 750 in SA (with the same definition as the Centrelink asset test threshold at 30 June 2002 for a single person who

[8] Children over 16 years of age are not regarded as dependent unless they are full time secondary students aged under 18 years and do not receive social security payments.

does not own their own home) to $25 460 in Tasmania (for people under 55 years of age). There are no 'other' asset limits in NSW and Queensland, although NSW assesses liquid assets as part of a household's weekly income when determining eligibility. The minimum age for eligibility also differs — 18 years in Queensland and WA; 16 years in Tasmania and the ACT; 15 years in Victoria; and no set minimum age in NSW, SA and the NT. Applicants under the age of 18 in NSW, however, must demonstrate living skills to be eligible for housing. All jurisdictions require eligible applicants to be resident in the respective State or Territory.

- *Management of the waiting list.* All State and Territory governments have at least a two-segment waiting list (generally 'priority' and 'wait turn'). NSW, Victoria, SA and the ACT have implemented more complex segmented waiting lists to categorise levels of priority, while Tasmania seeks to categorise levels of need. Segments are defined differently across jurisdictions, but generally reflect urgent need/homelessness and inability to access appropriate private market accommodation.
- *Term of tenure.* Most jurisdictions provide security of tenure after an initial probationary period. In Victoria, new tenants after November 1997 are subject to ongoing eligibility review. Tenants aged 65 years and over have lifetime tenure. In SA, tenants who applied after February 1998 and were housed after September 1999, who exceed set income limits over three consecutive years and who do not meet a needs test, have their tenure reviewed and may have a tenure premium applied. The ACT has introduced limited tenure with three- to five-year reviews for tenancies commenced after 1 January 2001. This is currently under review. In the NT, tenants are offered an initial three- or six-month probationary lease (depending on the circumstances). Those successfully completing a six-month lease are then offered a two-year lease, followed by a five-year lease. At the end of each lease period, ineligible tenants are required to find alternative housing.
- *Rebated rent setting.* Rebated rents in all jurisdictions are based on the majority of households paying no more than 25 per cent of their assessable income in rent (the income-to-rent ratio). In recent years, NSW, Victoria, Queensland, WA and the ACT have introduced an income-to-rent ratio of 25 per cent for new tenants and the NT has introduced a ratio of 23 per cent (or 18 per cent for aged pension recipients). In SA, the income-to-rent ratio ranges from 19.5 per cent (18.5 per cent in country regions) up to 25 per cent. In 2001-02, the income-to-rent ratio for tenants receiving a Centrelink Family Allowance was lower in most jurisdictions (ranging from 15 per cent to 10 per cent). Definitions of assessable income vary across jurisdictions.

- *Rebated tenants.* The proportion of public housing tenants in receipt of a rebated rent at 30 June 2002 was 89.5 per cent in NSW, 88.7 per cent in Victoria, 89.6 per cent in Queensland, 86.7 per cent in WA, 84.9 per cent in SA, 88.6 per cent in Tasmania, 79.2 per cent in the ACT and 89.6 per cent in the NT. Nationally, 88.3 per cent of public housing tenants received a rebate.
- *Priority access.* The proportion of public rental allocations made on the basis of greatest need is reported in section 16.4.
- *Remote area concentrations.* The proportion of public housing in remote areas, based on the Rural Remote Classification System (known as RRMA), was below 2.0 per cent in NSW, Victoria, SA and Tasmania and was 3.7 per cent in Queensland, 12.3 per cent in WA and 31.2 per cent in the NT. There are no remote areas in the ACT (table 16A.1). The proportions calculated exclude properties where details of the location are unavailable.
- *Rural area concentrations.* The proportion of public housing in rural (as distinct from remote) areas, based on RRMA classifications, was 17.7 per cent in NSW, 27.4 per cent in Victoria, 26.1 per cent in Queensland, 16.4 per cent in WA, 23.1 per cent in SA, 51.2 per cent in Tasmania, 0.1 per cent in the ACT and 1.3 per cent in the NT. Nationally, 21.7 per cent of public housing was located in rural (as distinct from remote) areas (table 16A.1). The proportions calculated exclude properties where details of the location are unavailable.

Community housing

- *Eligibility.* Eligibility for community housing is generally consistent with eligibility requirements for public housing in each jurisdiction.
- *Waiting list management.* In most jurisdictions there is no requirement for community housing organisations to segment waiting lists. In March 2000, SA introduced a segmented waiting list for community housing consistent with the segmented waiting list in place for public housing.
- *Proportion of community housing dwellings.* The proportion of community housing dwellings to total public and community housing dwellings at June 2002 was approximately 6.7 per cent in NSW (excluding Crisis Accommodation Program dwellings), 10.7 per cent in Victoria, 7.3 per cent in Queensland, 10.1 per cent in WA, 7.2 per cent in SA, 1.8 per cent in Tasmania[9], 3.7 per cent in the ACT and 2.0 per cent in the NT (based on administrative data). Nationally, community housing dwellings represented approximately

9 Tasmania advises that based on administrative data, the proportion of community housing dwellings to total public and community housing dwellings in Tasmania at June 2002 was 2.4 per cent.

7.8 per cent of total public and community housing dwellings. Where based on survey data, these results are affected by survey nonresponse.

- *Remote area concentrations.* The proportion of community housing in remote areas was none (or negligible, at less than 2 per cent) in NSW, Victoria, SA and Tasmania, 13.0 per cent in Queensland, 16.0 per cent in WA and 34.4 per cent in the NT. There are no remote areas in the ACT. Nationally, 5.0 per cent of community housing was located in remote areas. These results may be affected by survey nonresponse (table 16A.15). The proportions calculated exclude properties where details of the location are unavailable.
- *Rural area concentrations.* The proportion of community housing in rural (as distinct from remote) areas was 27.0 per cent in NSW, 22.6 per cent in Victoria, 44.7 per cent in Queensland, 22.5 per cent in WA, 12.0 per cent in SA, 43.2 per cent in Tasmania and 4.1 per cent in the NT. There was no community housing located in rural areas in the ACT. Nationally, 25.8 per cent of community housing was located in rural (as distinct from remote) areas (table 16A.15). These results may be affected by survey nonresponse.

State and Territory owned and managed Indigenous housing

State and Territory owned and managed Indigenous housing dwellings are defined as those rental housing dwellings owned and managed by government and allocated only to Indigenous Australians (AIHW 2002c). The ACT and the NT are not included in the data collection reported in this chapter. The ACT does not receive funding for or administer any Territory owned and managed Indigenous housing programs. In the ACT, Indigenous people are housed predominantly in mainstream public and community housing.

In the NT, funding under the ARHP is directed at community managed Indigenous housing. The NT Government is unable to differentiate between the various funding sources as a result of its commitment under the CSHA Indigenous Agreement to specifically 'pool' all funds earmarked for Indigenous housing and associated infrastructure in the NT. All Indigenous housing programs in the NT are community managed and administered, and specific management issues, such as eligibility and waiting lists, are the responsibility of approximately 130 Indigenous housing organisations which, on 30 June 2002, were managing 6100 permanent dwellings for 46 128 people in 700 discrete Indigenous communities. The approaches of these organisations may differ significantly depending on the size of the organisations, the socioeconomic circumstances of particular communities and cultural considerations. The Indigenous Housing Authority of the NT (IHANT) allocates funds to the seven ATSIC regional councils in the NT, which in turn allocate funds to those communities most in need. During 2001-02, the IHANT oversaw the

construction (or major refurbishment) of 241 houses, which provided better housing for 1928 people.

Some other jurisdictions are increasingly pooling funding but currently report State and Territory owned and managed Indigenous housing data separately. Queensland administers a separate Aboriginal and Torres Strait Islander Housing Program, which includes ARHP funds, untied CSHA funds and State funds, and does not report separately against the ARHP component of the program funds, which forms more than one third of total expenditure.

- *Eligibility criteria for access to State and Territory owned and managed Indigenous housing.* In NSW, Victoria, SA and Tasmania, once an applicant is confirmed as being Indigenous, eligibility for State owned and managed Indigenous housing is consistent with eligibility requirements for public housing, although in Tasmania applications outside the guidelines may be considered where there are extenuating circumstances in relation to income, asset and age criteria. In Queensland, there are no income or age eligibility limits on State owned and managed Indigenous housing as the program is aimed at addressing discrimination and a history of social disadvantage, and discrimination can occur regardless of income or age. Provided other eligibility criteria are met, the Queensland Department of Housing will accept applications from people living interstate and newly arrived interstate applicants, with waiting times commencing from the date applications are received. Applicants who previously have had debts to the department are eligible to be placed on waiting lists for housing, although housing is not generally allocated until the debt is repaid, except in extenuating circumstances or where more than 75 per cent of the debt has been paid under agreed terms.
- *Management of the waiting list.* Management of waiting lists varies across jurisdictions for State and Territory owned and managed Indigenous housing. In Victoria, there is one waiting list for both State owned and managed Indigenous housing and public housing. Indigenous applicants are placed on the waiting list and provided housing under the first available program. In Queensland, State owned and managed Indigenous housing is provided on a 'wait turn' basis, with provision for a small number of applicants to be housed ahead of turn in very urgent circumstances. No more than 10 per cent of annual allocations are to be based on priority. SA has divided the State owned and managed Indigenous housing waiting list into four categories, with 'category one' reflecting those in most urgent need of housing and 'category four' reflecting the least urgent housing need. In Tasmania, although the Housing Assessment System developed for public rental housing may be used as a guide, applications for State owned and managed Indigenous housing are not subject to the allocation of points to determine overall housing need or relative priority. Assessments are undertaken

by Aboriginal Customer Service Officers who consider an applicant's claim against criteria such as ill health, medical requirements, and the affordability and adequacy of current housing. Priority may be given to applicants with children and applicants who may have their educational or employment opportunities enhanced by the provision of housing. Regional Aboriginal housing committees determine priority and allocate properties.

- *Term of tenure*. In NSW, Victoria and SA, security of tenure is the same as that for public housing. In Queensland, security of tenure is dependent on State owned and managed Indigenous housing tenants meeting their responsibilities under the *Residential Tenancies Act* (Qld) (which involves paying their rent, maintaining the property and keeping the peace of the neighbourhood). In Tasmania, tenants are signed either to a fixed-term lease or to a lease of no fixed term, depending on their previous housing history. Tenure arrangements may be reviewed if, following family breakdown or death, a non-Indigenous person is the remaining tenant in a State owned and managed Indigenous housing dwelling.
- *Remote area concentrations*. State and Territory owned and managed Indigenous housing dwellings are more likely to be located in rural or remote areas than public or community housing dwellings. The proportion of the State owned and managed Indigenous housing dwellings located in remote areas was 6.5 per cent in NSW, 3.0 per cent in Victoria, 31.4 per cent in Queensland, 48.8 per cent in WA and 7.9 per cent in SA. No State owned and managed Indigenous housing was located in remote areas of Tasmania. Nationally, 20.1 per cent of State and Territory owned and managed Indigenous housing dwellings were located in remote areas (table 16A.27). The proportions calculated exclude properties where details of the location are unavailable. No data on State and Territory owned and managed Indigenous housing are available for the NT.
- *Rural area concentrations*. Across jurisdictions, the proportion of State owned and managed Indigenous housing dwellings located in rural (as distinct from remote) areas was 51.9 per cent in NSW, 58.8 per cent in Victoria, 42.1 per cent in Queensland, 21.6 per cent in WA, 31.4 per cent in SA and 60.6 per cent in Tasmania. Nationally, 41.5 per cent of the State and Territory owned and managed Indigenous housing dwellings were located in rural (as distinct from remote) areas (table 16A.27). The proportions calculated exclude properties where details of the location are unavailable. No data on State and Territory owned and managed Indigenous housing are available for the NT.

Private rental markets

- *Capital city vacancy rates*. Vacancy rates in the private rental market at June 2002 ranged from 9.6 per cent in Darwin to 2.0 per cent in Hobart. Tight

private rental markets (vacancy rates below 3.0 per cent) were evident in Hobart and Canberra (table 16A.68).

- *Capital city median rents*. Median rents for three-bedroom houses at June 2002 were highest in Canberra at $250 a week and lowest in Perth at $172 a week. For two-bedroom flats or units, median rents ranged from $265 a week in Sydney to $139 a week in Perth (table 16A.69).

16.2 Policy developments in housing assistance

Renegotiation of the CSHA

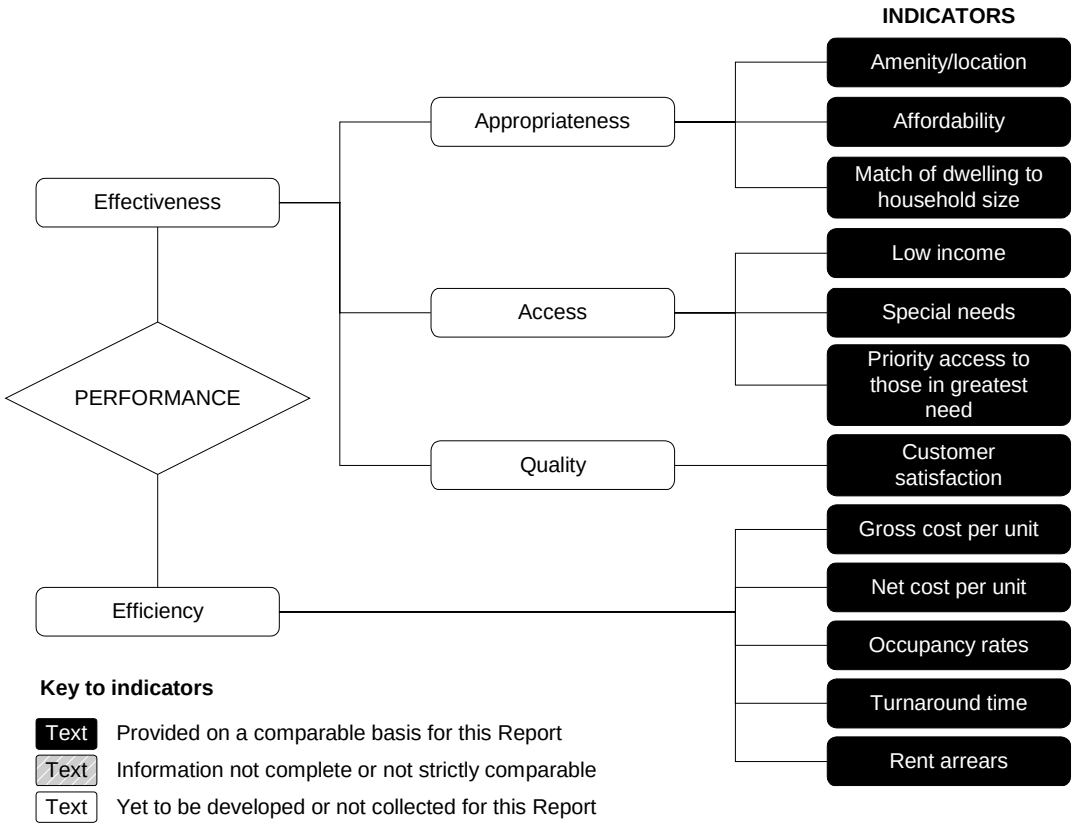
The current CSHA is due to expire in 2003 and funding arrangements for housing assistance beyond this time are being negotiated. The outcome of these negotiations may affect reporting in future years.

16.3 Framework of performance indicators

The framework of performance indicators for public, community and State and Territory owned and managed Indigenous housing in this chapter is based on the performance indicator framework developed for the 1999 CSHA (figures 16.2, 16.3 and 16.4). The CSHA framework reflects the national objectives of the Agreement as outlined in a number of guiding principles (CSHA 1999).

The performance indicator framework shows which data are comparable in the 2003 Report (figures 16.2, 16.3 and 16.4). For data that are not considered strictly comparable, the text includes relevant caveats and supporting commentary. Chapter 1 discusses data comparability from a Report-wide perspective (see section 1.6).

Figure 16.2 **Performance indicators for public housing**



The objectives for public and community housing services are similar (box 16.4). Both services aim to help eligible people obtain housing that is affordable, secure and appropriate to their needs. The delivery method for community housing differs from that for public housing however — community organisations and sometimes local government deliver community housing, while State and Territory governments deliver public housing.

Box 16.4 **Objectives for public and community housing under the 1999 CSHA**

The aim of the 1999 CSHA is to provide housing assistance that is:

- affordable — after accounting for housing assistance, housing costs for a household do not exceed agreed benchmarks relating to income; and
- appropriate — housing assistance is provided in a range of forms to meet different needs of different households, so assistance is appropriate to household size, household type, special needs and cultural needs.

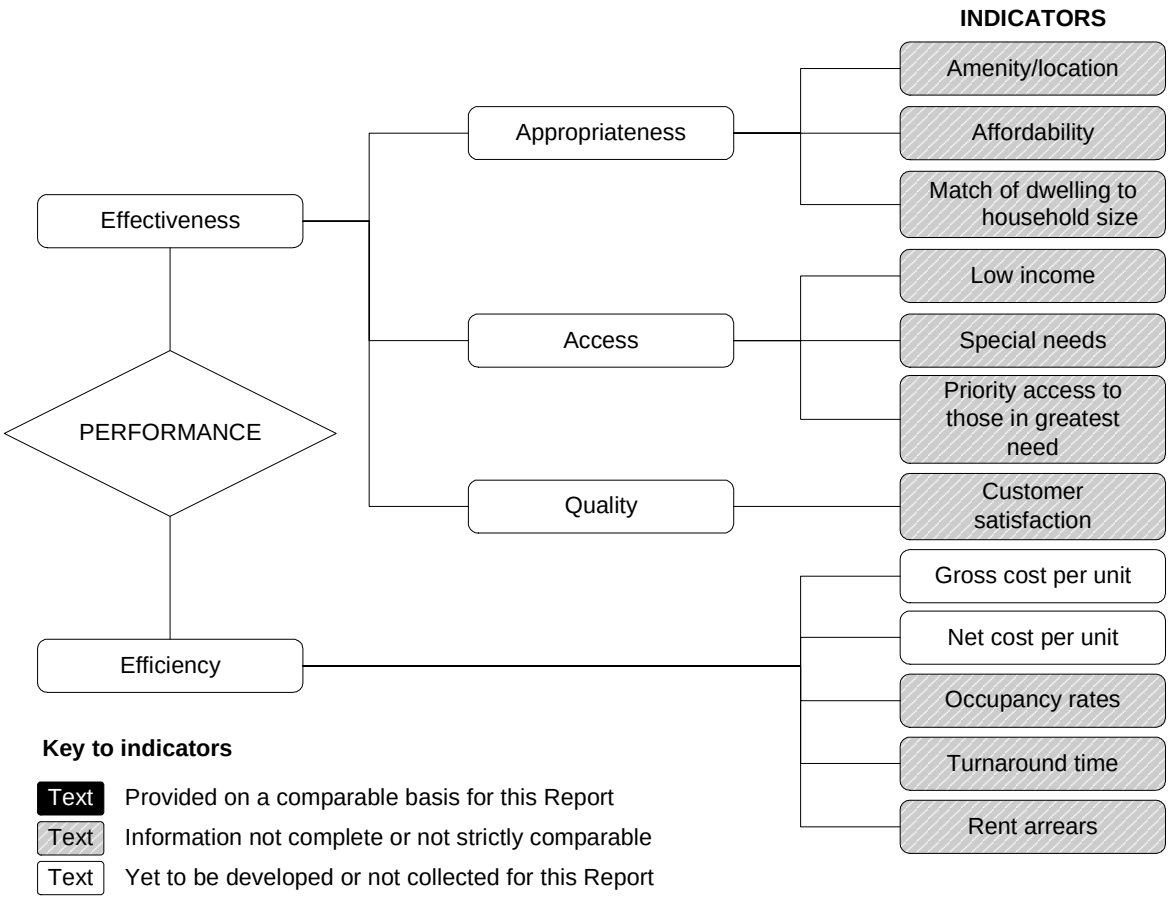
The guiding principles of the 1999 CSHA are to:

- assist those whose needs for appropriate housing cannot be met by the private market;
- provide assistance for the duration of the need;
- promote alternative methods of housing provision;
- ensure that the costs of assistance are transparent; and
- provide assistance in a way that minimises workforce disincentives.

Source: DFaCS (2002).

Performance indicator data are reported against the current public housing and community housing frameworks for the third consecutive year. Some additional information on affordability, and moderate overcrowding and underuse can be found in tables 16A.75, 16A.76 and 16A.77, and 16A.78, 16A.79 and 16A.80.

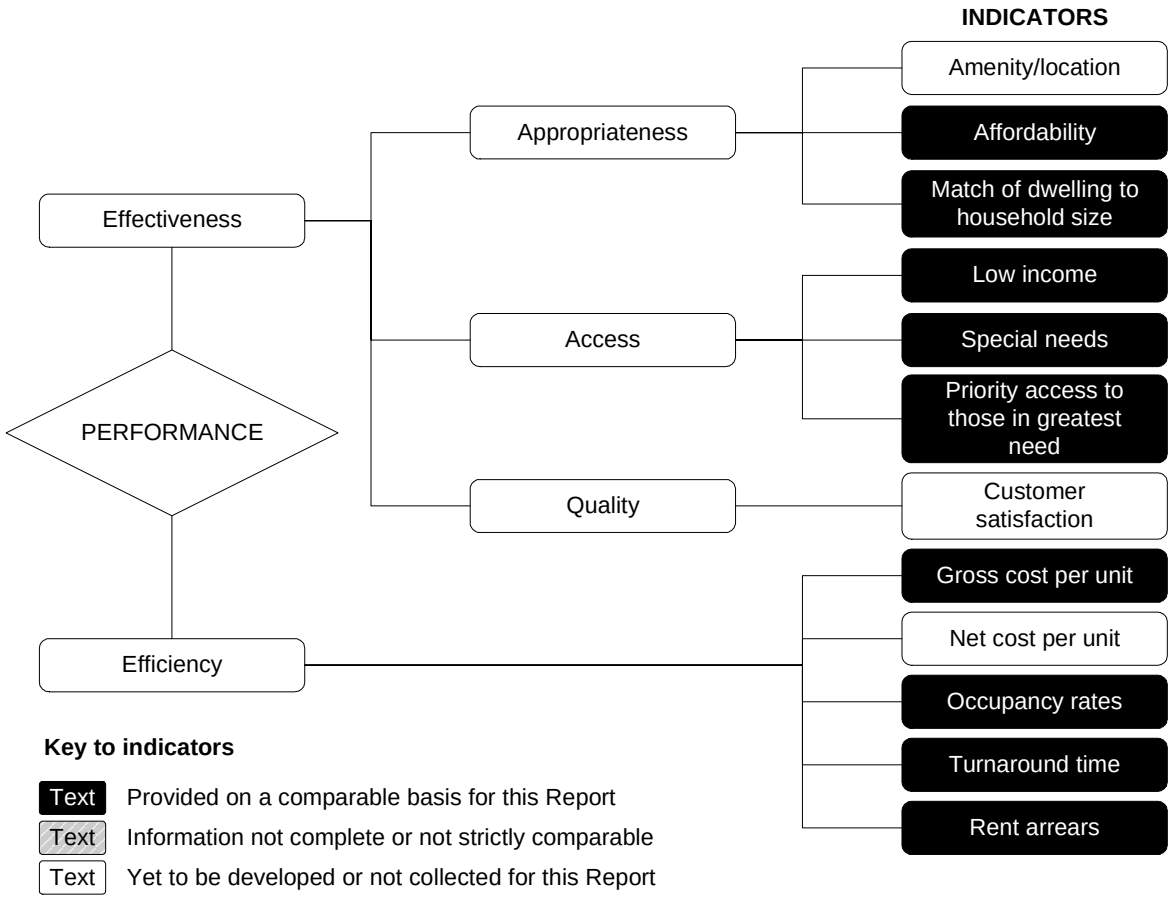
Figure 16.3 **Performance indicators for community housing**



As for other services, performance reporting this year is assessed in terms of effectiveness and efficiency. Comparable public housing data are presented for the full range of effectiveness and efficiency indicators in the performance measurement framework (figure 16.2).

It has not been possible to obtain nationally comparable performance information for community housing (figure 16.3) because current data standards and data collection capacity do not allow nationally comparable performance information to be reported in the community housing sector. Jurisdictions operate a variety of funding and asset management models (box 16.3) and they are not always managed by State or Territory housing authorities.

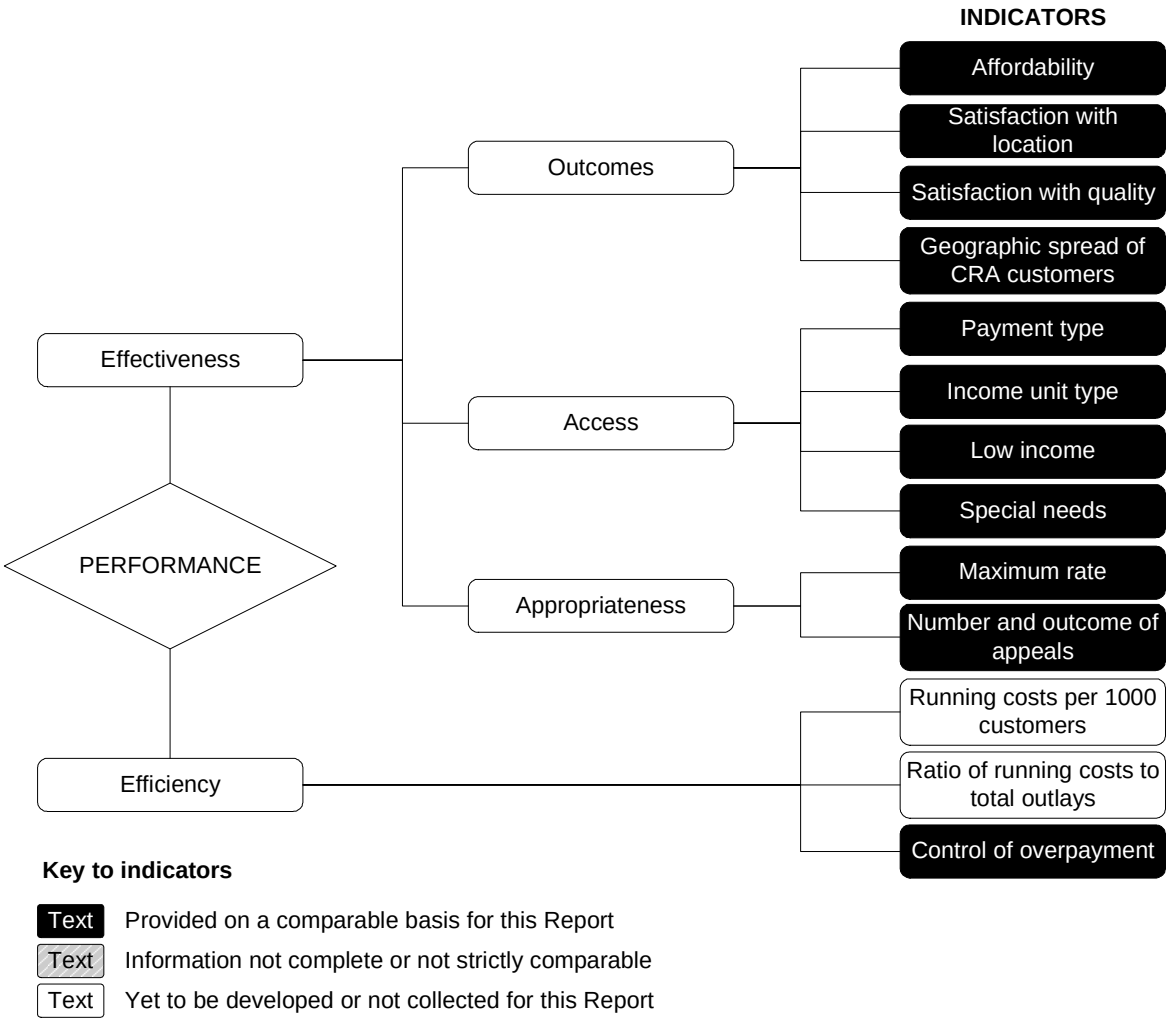
Figure 16.4 **Performance indicators for State and Territory owned and managed Indigenous housing**



Performance reporting on State and Territory owned and managed Indigenous housing was included for the first time in the 2002 Report. While the performance indicator framework for State and Territory owned and managed Indigenous housing is the same as that for public and community housing (figure 16.4), it is not appropriate to make direct comparisons between the performance of public housing and State and Territory owned and managed Indigenous housing as several definitions differ. The special needs indicator for public housing, for example, includes Indigenous households in the definition of 'special needs' households. Using this definition for State and Territory owned and managed Indigenous housing would result in 100 per cent of State and Territory owned and managed Indigenous housing households being regarded as having 'special needs'. State and Territory owned and managed Indigenous housing uses a more appropriate definition of 'special need'. More information on the differences between public housing and State and Territory owned and managed Indigenous housing is given in section 16.4.

The performance indicators for CRA differ from those for public, community and State and Territory owned and managed Indigenous housing because they have different objectives and delivery methods. Reporting for CRA this year uses a new performance indicator framework (figure 16.5), based on the objective outlined in box 16.5. Definitions for all indicators are provided in tables 16.21 and 16.22.

Figure 16.5 **Performance indicators for CRA**



Box 16.5 **Objective of CRA**

The objective of CRA is to provide income support recipients and low income families in the private rental market with additional financial assistance in recognition of the housing costs they face (Newman 1998). This assistance should be provided in an equitable and efficient manner. In addition to this objective, CRA is also governed by other objectives relating to the primary income support payment.

Data are for CRA recipients who are clients of DFaCS only. Data exclude those paid rental assistance by, or on behalf of, the DVA or DEST. Comparable data are presented for all effectiveness indicators within the performance measurement framework. It is not possible to report on two of the efficiency indicators as data are unavailable.

16.4 Key performance indicator results

Public housing

Different delivery contexts, locations and types of client may affect the performance of public housing reported in this chapter. Care needs to be taken in interpreting performance indicator results and the qualifications presented with the data need to be considered. Some descriptive information on public housing can be found in table 16A.1.

Effectiveness

Appropriateness

This chapter reports three measures of appropriateness. The first is the match of rental dwellings to household size. Data are provided on the match of households to different size dwellings using a proxy occupancy standard based on the size of the dwelling and household structure (table 16.2).

Table 16.2 **Proxy occupancy standard for appropriate sized dwelling by household structure**

Household structure	*Bedrooms required*
Single adult only	1
Couple with no children	2
Sole parent or couple with 1 child	2
Sole parent or couple with 2 or 3 children	3
Sole parent or couple with 4+ children	4

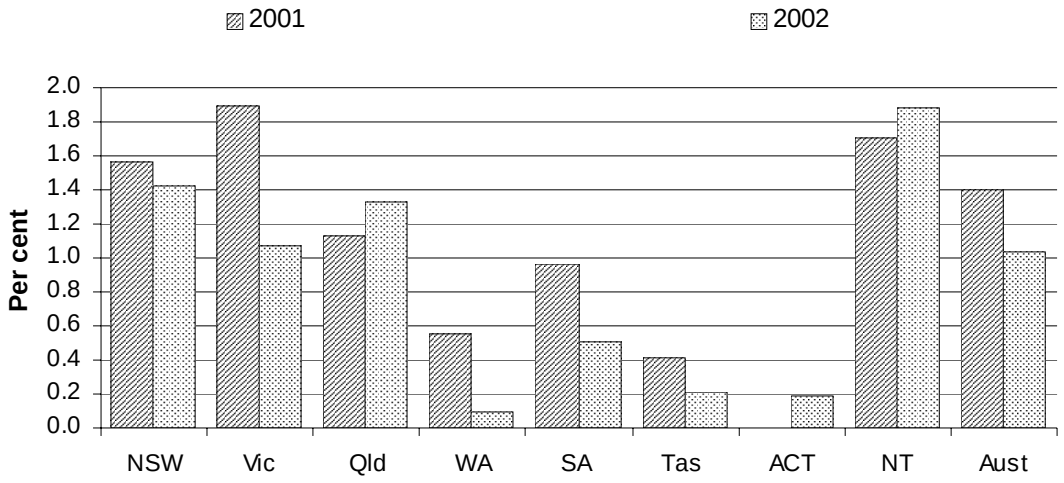
Source: AIHW (2002a).

Overcrowding is deemed to have occurred where two or more additional bedrooms are required to satisfy the proxy occupancy standard. The occupancy standards in table 16.2 may differ from the specific criteria used by State and Territory housing

authorities to match households to dwelling types, affecting interpretation of this indicator.

The NT had the highest proportion of overcrowded dwellings at June 2002 (1.9 per cent), while WA had the lowest proportion (0.1 per cent). Overcrowded dwellings represented 1.0 per cent of public housing dwellings nationally (figure 16.6). More information on overcrowding and underuse can be found in table 16A.80.

Figure 16.6 **Proportion of households in public housing with overcrowding at 30 June[a, b, c, d, e, f, g]**



a Includes rebated and non-rebated tenants where household composition is known. Changes in data collection methods between years may affect results for some jurisdictions. **b** In NSW excludes all non-rebated tenants and those rebated tenants with missing household composition details. **c** For Victoria for 2002, data exclude 6446 households paying market rent (representing 10.4 per cent of households) that were included in 2000-01, influencing the change in results. **d** For WA for 2002 data exclude 2051 multiple family households (representing 6.7 per cent of households) that were included in 2001, influencing the change in results. **e** For SA for 2002, data exclude 2340 multiple family households (representing 5.2 per cent of households) that were included in 2000-01, influencing the change in results. **f** For the ACT in 2001, data exclude households where the relationship of household members was unknown (for example, a three-tenant household where it is not known if the household consists of a couple and a single person, or three single people). For 2002, data exclude 2285 non-rebated or multiple family households (representing 20.8 per cent of households). **g** For the NT, data for 2001 exclude 189 multiple family households (representing 3.3 per cent of households). Data for 2002 data exclude 160 multiple family households (representing 2.8 per cent of households).

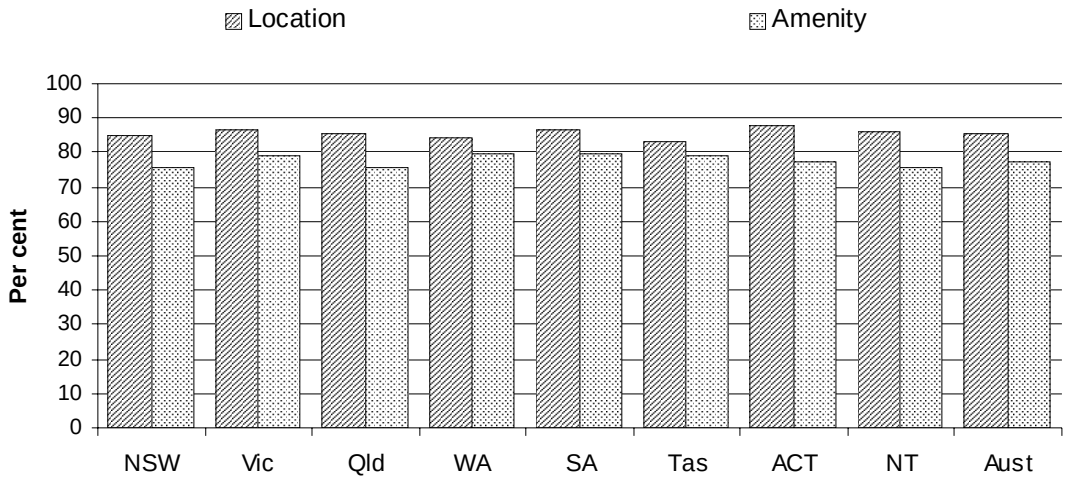
Source: State and Territory governments (unpublished); table 16A.2.

The second measure of the appropriateness of public housing assistance is obtained by surveying tenants about the amenity and location of their dwellings. The precision of survey estimates will depend on the survey sample size and the sample estimate. Larger sample sizes result in higher precision, as do larger sample estimates (for example, if 90 per cent of surveyed respondents chose an answer, there would be less uncertainty about the actual population's views than if

50 per cent of respondents chose it). Care needs to be taken in interpreting small differences in results. Further information on the sample size is provided in tables 16A.3 and 16A.4.

There was little difference across jurisdictions in the proportion of tenants satisfied with the location or amenity of their dwelling in 2001. Satisfaction with the location of dwellings was above the national average in Victoria, Queensland, SA, the ACT and the NT. Satisfaction with the amenity of dwellings was above the national average in Victoria, WA, SA, Tasmania and the ACT (figure 16.7).

Figure 16.7 **Proportion of tenants satisfied with location or amenity aspects of their dwelling, July-August 2001[a]**



a Care needs to be taken in interpreting small differences in the results that are affected by sample and estimate size.

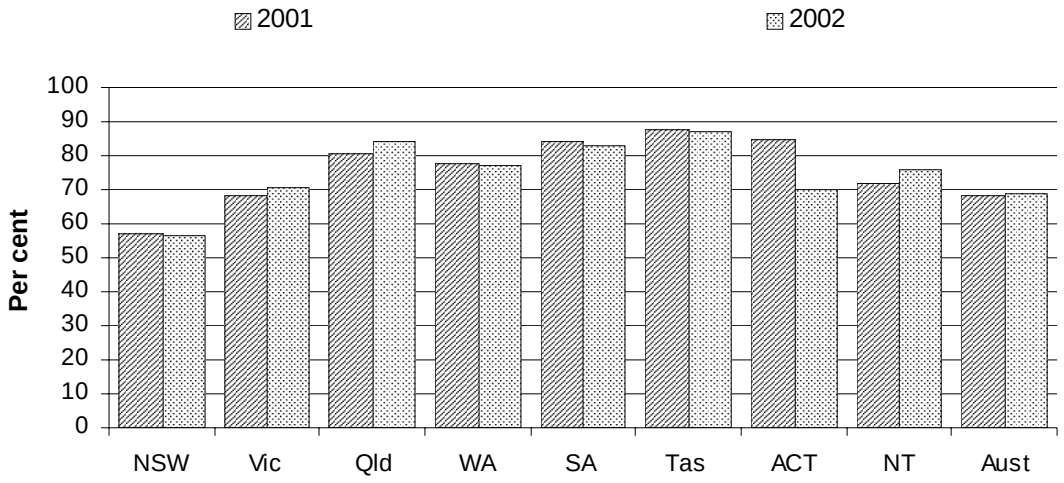
Source: NFO Donovan Research (2001b); tables 16A.3 and 16A.4.

These overall satisfaction results were obtained by surveying tenants about a number of aspects regarding the location and amenity of their dwellings. Tenants were asked whether particular aspects were important to them and, if so, whether they felt their needs were met. More information on this indicator can be found in tables 16A.3 and 16A.4. Information from 2001 on tenant assessments of the condition of public housing stock can be found in table 16A.81.

The third measure of appropriateness is affordability, which measures the rent charged to tenants as a proportion of the market rent for each dwelling, adjusted for CRA. The rent charged in 2001-02 as a proportion of the market rate for each dwelling (adjusted for CRA) ranged from 87.0 per cent in Tasmania to 56.5 per cent in NSW (figure 16.8).

More information on affordability, measured as the proportion of household income spent on housing costs, can be found at table 16A.75.

Figure 16.8 **Rent charged as a proportion of market rent, adjusted for CRA, at 30 June**[a, b, c, d, e, f, g, h]



a The methodology used for calculations has changed and now uses more complex modelling developed in CRA modelling for CSHA re-negotiations. Caution should therefore be used comparing results between 2001 and 2002. **b** In NSW market rents are the valuations applied to each property. The market rents for 2001 and 2002 are the same and refer to the 2001 valuation. The method of adjusting for CRA entitlements differs between years, making comparisons between the years difficult. **c** In Queensland, market rents for dwellings have not been globally adjusted to reflect the current market for a number of years, leading to a gradual reduction in the proportion of households paying less than market rent and a corresponding increase in the proportion of those paying market rent due to consumer price index rent rises. The overall market rent value as listed here would therefore be somewhat less than the true value. For 2002, complex derivation of household entitlement results in an estimate below the simple sum of rents for all households. As calculations are used in a ratio to calculate public/private affordability, this discrepancy has no effect. **d** For WA data for 2001 exclude 1834 multiple family households (representing 6 per cent of households). For 2002, data exclude 2051 multiple family households (representing 6.7 per cent of households) that were included in 2001, influencing the change in results. **e** For SA data for 2001 exclude 3113 multiple family households (representing 6.5 per cent of households). Data for 2002 exclude 2340 multiple family households (representing 5.2 per cent of households). **f** Data for 2001 in Tasmania exclude 1261 multiple family households (representing 10 per cent of households). **g** Market rents in the ACT were increased after 30 June 2001, resulting in rebated rents charged decreasing as a proportion of market rent. For 2001, data exclude households where the relationship of household members was unknown (for example, a three tenant household where it is not known if the household consists of a couple and a single person, or three single people). For 2002, for multiple family households it was assumed that each adult would pay an equal share of the market rent for the dwelling. Data exclude 2285 non-rebated or multiple family households (representing 20.8 per cent of households). **h** For the NT for 2001, data exclude 189 multiple family households (representing 3.3 per cent of households). For 2002, data exclude 160 multiple family households (representing 2.8 per cent of households).

Source: State and Territory governments (unpublished); table 16A.5.

Access

Three performance indicators measure access to public housing assistance for those in need. The first measures the 'low income' and 'special needs (but not low income)' status of households receiving public housing assistance (table 16.3). There are two household income measures for the purpose of this indicator:

- 'low income A' households — those in public housing where all members of the household have incomes at or below the maximum pension rate (pension rates have been selected for calculating this indicator because they are higher than allowance rates); and
- 'low income B' households — those in public housing that have incomes that would enable them to receive government income support benefits below the maximum pensioner rate.

Households with incomes below these levels are included in the measure, although they may not necessarily receive income support benefits.

The proportion of new tenancies allocated to 'low income A' households in 2002 ranged from 94.6 per cent in NSW to 83.8 per cent in WA. The proportion of new tenancies allocated to 'low income A' or 'special needs (not low income)' households varied from 97.4 per cent in NSW to 89.5 per cent in WA (table 16.3).

More information on 'low income B' households is contained in table 16A.6.

The second access indicator measures the proportion of new tenancies allocated to households with special needs. Special needs households are those that have either a household member with a disability, a principal tenant aged either 24 years or under or 75 years or more, or a household defined as being Indigenous.

The proportion of new tenancies allocated to 'special needs' households in 2001-02 ranged from 73.5 per cent in SA to 31.4 per cent in the ACT (figure 16.9).

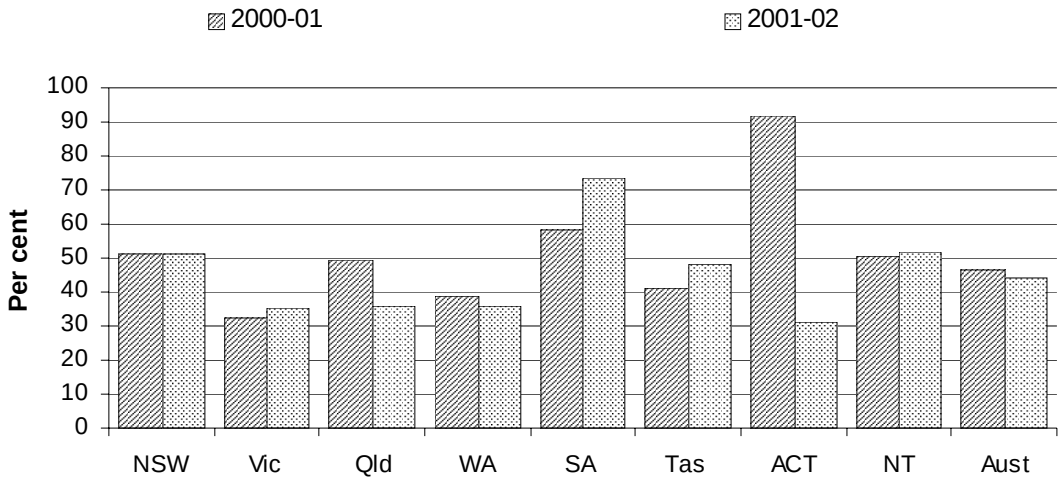
Table 16.3 **Low income and special needs households as a proportion of all new households at 30 June (per cent)[a]**

NSW[b]	*Vic*[c]	*Qld*[d]	*WA*[e]	*SA*[f]	*Tas*[g]	*ACT*[h]	*NT*[i]	*Aust*[j]
2001								
New 'low income A' households as proportion of all new households								
94.1	90.8	90.0	85.8	89.3	84.6	**nr**	83.6	89.5
New 'low income A' households or special needs (not low income households) as proportion of all new households[k]								
97.3	93.8	93.4	89.7	94.6	85.9	**nr**	**nr**	93.3
2002								
New 'low income A' households as proportion of all new households								
94.6	93.0	90.4	83.8	89.7	93.1	92.0	87.0	91.4
New 'low income A' households or special needs (not low income households) as proportion of all new households[l]								
97.4	95.6	93.7	89.5	94.2	96.2	94.3	93.4	94.9

a In 2001, the introduction of a national 'special needs' definition influenced changes in jurisdiction results. The counting rules for distinguishing between 'low income A' and 'low income B' households were clarified for the 2001-02 data collection to ensure a household was not counted in both low income categories. It appears that these counting rules were followed in the 2000 and 2001 data collections, however, and this clarification should not therefore affect the data reported. Households are excluded as a result of missing or zero household income, missing person information, and multiple family households resulting in an unknown household composition. **b** Special need information is only available for households housed after November 1999. **c** For 2001 data only include single family households. Households with zero or missing income are also excluded. **d** For 2002, disability is calculated from a flag used for assessment of new tenancies and may underestimate the count for ongoing households. **e** The change in results in 2001 is influenced by the use of gross household income and not assessable income. Includes only single family households, representing 94 per cent of households. There were 1934 multiple family households excluded. For 2002, 2051 multiple households were excluded (representing 6.7 per cent of households) that were included in 2000-01, influencing the change in results. Changes in the way data were compiled between years has influenced the change in reported results. **f** Excludes new allocations for 2000-01 who left public housing prior to 30 June 2001. Data for 2001 include only single family households which represent 93.5 per cent of households. There were 3113 multiple family households excluded. For 2002, data exclude 926 households within the special needs program (for example, student housing, migrant housing). Excludes 2340 multiple family households (representing 5.2 per cent of households). **g** For 2001, income and household composition are calculated at tenancy start date. Income source is not taken into account and based on gross income only. Reported via spreadsheet return for about 100 per cent of new households. Results for 2002 differ as data repository records did not contain income and household composition details for new households who were no longer tenants at 30 June 2002. **h** For 2001, data were available for only 4.3 per cent of households allocated housing and were therefore not reported (94.1 per cent and 100.0 per cent respectively were calculated for the indicators). **i** For 2001 data exclude multiple family households. For 2002, data exclude 160 multiple family households (representing 2.8 per cent of households). **j** While the ACT provided a complete data set in 2001, they were excluded from the national average due to data problems. In 2002, data for the ACT excludes 77 new non-rebated or multiple family households (representing 6.5 per cent of households). **k** Data for the NT were not reported due to data problems (180 per cent was calculated for the indicator). This result is excluded from the national average. **l** Figure for the ACT may be understated due to a relatively high proportion of missing special need data. **nr** Not reported.

Source: State and Territory governments (unpublished); table 16A.6.

Figure 16.9 **Proportion of new tenancies allocated to households with special needs[a, b, c, d, e, f, g, h]**

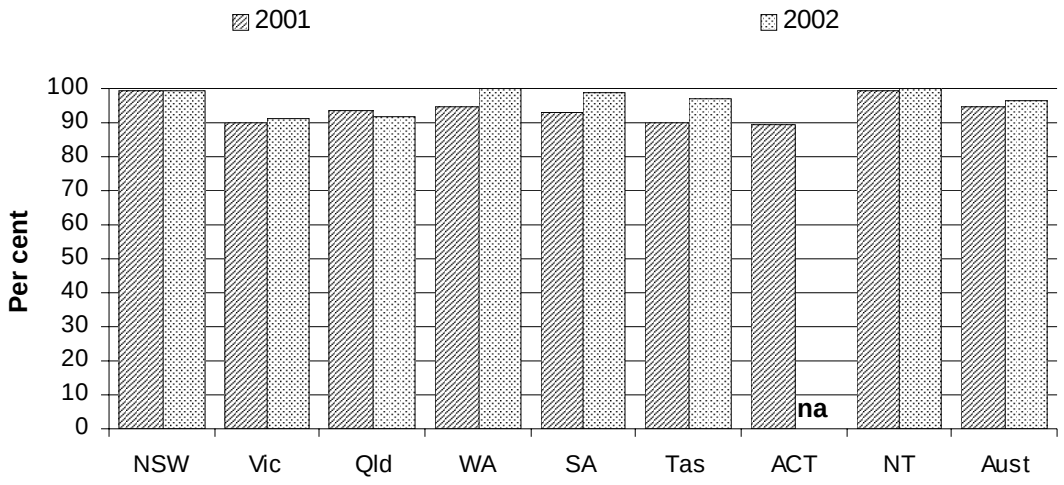


a The introduction of a national 'special needs' definition in 2000-01 influenced changes in jurisdiction results. **b** For NSW for 2000-01, there were 80 new households without 'special needs' information. In 2001-02, there were 56 new households without 'special needs' information. **c** For Queensland for 2000-01, the disability pension was the proxy for identifying households with a disability; in 2001-02 the disability identifier flag was the proxy, influencing changes in results reported. For 2001-02, household special need status was derived from the person file in the data repository. Where Indigenous or disability status was missing, it was assumed to be unknown and was excluded from the calculation. **d** Special needs details for WA are recorded only where they are known to exist. No record is kept if a household does not have special needs. All new households therefore are included so figure may represent an undercount. For 2000-01, data were reported about the special need status of 80 per cent of new households, influencing the change in results between years. For 2001-02, household special need status was derived from the person file in the data repository. Where Indigenous or disability status was missing, it was assumed to be unknown and was excluded from the calculation. **e** Special needs details for SA are recorded for the head tenant only. For 2001-02, data exclude 2340 multiple family households (representing 5.2 per cent of households). For 2001-02, household special need status was derived from the person file in the data repository. Where Indigenous or disability status was missing, it was assumed to be unknown and was excluded from the calculation. Data reports about 63 per cent of new allocations. For 2000-01 data are reported about the special need status of 83 per cent of new allocations, influencing the change in results. **f** For Tasmania data for 2001-02 reports about special need status of 90 per cent of new allocations. For 2000-01 data reports about the special need status of 100 per cent of new allocations, influencing the change in result. For 2001-02, household special need status was derived from the person file in the data repository. Where Indigenous or disability status was missing it was assumed to be unknown and were excluded from the calculation. **g** The ACT data for 2000-01 represent only 36 per cent of households allocated housing. Special needs information is unknown for the remainder of households. For 2001-02 some special needs are self identified. This can result in special needs being known for one household member, but not known for other household members in the dwelling. In these cases, unknown values are assumed to be a negative answer. Figure may be an undercount due to a relatively high proportion of missing special need data. For 2001-02, household special need status was derived from the person file in the data repository. Where Indigenous or disability status was missing, it was assumed to be unknown and was excluded from the calculation. **h** For the NT, special needs details are recorded only where they are known to exist. No record is kept if a household does not have special needs. All new households therefore are included so figure may represent an undercount. Excludes households with a disability because the NT does not include a disability identifier in their information management system. For 2000-01, 20 per cent of new households were excluded from the calculation, influencing the change in results.

Source: State and Territory governments (unpublished); table 16A.7.

The proportion of all households that pay less than market rent or that were special needs households paying market rent in 2001-02 ranged from 100.0 per cent in WA and the NT to 91.2 per cent in Victoria (figure 16.10).

Figure 16.10 **Households that pay less than market rent or that are special needs households paying market rent as a proportion of all public housing households at 30 June**[a, b, c, d, e, f, g, h, i]



a The introduction of a national 'special needs' definition in 2001 influenced changes in jurisdiction results. **b** For NSW, special need information is only available for households that were housed after November 1999. There is a small number of households with missing 'special needs information, which have been excluded from both years. **c** For 2001 for Victoria low income information includes only single family households. For 2001, households with zero or missing income were also excluded. **d** For 2002 for Queensland, disability is calculated from a flag used for assessment of new tenancies and may underestimate the count for ongoing households. **e** For WA, the change in results in 2001 is influenced by the use of gross household income and not assessable income. Includes only single family households, representing 94 per cent of households. There were 1834 multiple family households excluded (representing 6.0 per cent of households). For 2002 data exclude 2051 multiple family households (representing 6.7 per cent of households), influencing the change in results. **f** For SA data exclude new allocations for 2000-01 who left public housing prior to 30 June 2001. Data for 2000-01 include only single family households which represent 93.5 per cent of households. There were 3113 multiple family households excluded. For 2002, data exclude 926 households housed within the special needs program (for example, student housing, migrant housing). Data exclude 2340 multiple family households (representing 5.2 per cent of households). **g** For 2001 for Tasmania, income and household composition calculated as at tenancy start date. Income source not taken into account and based on gross income only. **h** For 2001 for the ACT, data for low income details were available for only 4.3 per cent of households. Data on 'special needs' represent only 36 per cent of all households allocated housing. Special needs information is unknown for the remainder of households. Data for 2002 unavailable as market rent data are outdated and unreliable. **i** For the NT, special needs details are only recorded where they are known to exist. No record is kept if a household does not have special needs. Inclusion of all new households in calculation (regardless of whether special needs status is known) means proportion could be understated. For both years, data exclude households with a disability as the NT data does not include a disability identifier in its information management system. For 2002, data exclude 160 multiple family households (representing 2.8 per cent of households). **na** Not available.

Source: State and Territory governments (unpublished); table 16A.8.

The third indicator of access measures the priority of access given to those in greatest need. 'Greatest need' households are defined as low income households

that at the time of allocation were either homeless, in housing inappropriate to their needs, in housing that was adversely affecting their health or placing their life and safety at risk, or that had very high rental housing costs.

Table 16.4 shows the proportion of all new allocations that are allocated to applicants with 'greatest need' for applicants spending various time periods on the waiting list. Data are provided for tenants waiting for periods from under three months to more than two years. These numbers are not cumulative. The proportion of new allocations to those in greatest need for the year ending 30 June 2002 varied from 84.5 per cent in the ACT to 4.9 per cent in Queensland (table 16.4).

Table 16.4 **Greatest need allocations as a proportion of all new allocations, 2001-02 (per cent)[a]**

	NSW[b]	*Vic*[c]	*Qld*	*WA*[d]	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Total for year ending 30 June 2002	**31.4**	**62.3**	**4.9**	**19.1**	**41.9**	**80.5**	**84.5**	**14.3**	**35.9**
Proportion of greatest need allocations to new allocations with time to allocation:									
< 3 months	61.6	74.0	10.9	22.0	58.5	87.3	94.6	29.5	58.7
3 —< 6 months	52.8	63.8	6.0	33.4	55.4	85.5	90.2	11.2	46.1
6 months — < 1 year	35.5	61.6	3.9	26.8	43.3	80.3	74.3	8.8	32.7
1 —< 2 years	18.1	42.6	2.5	17.8	13.7	81.8	50.6	8.6	16.0
2+ years	1.5	7.6	2.0	6.8	0.0	55.6	15.8	3.0	2.8

a The waiting list time was clarified for the 2000-01 collection to refer to the time the applicant was eligible for 'greatest need' assistance to the date on which assistance commenced. If an applicant transfers between waiting list categories, then only the time spent on the waiting list from when the applicant met the 'greatest need' definition is counted. The introduction of a national 'greatest need' definition in 2000-01 influenced changes in jurisdiction results. For 2001-02, the number of days in each of the time to allocation groups were adjusted such that a calendar month is equal to approximately 30 days. The determination of households in greatest need for 2001-02 was based on waiting list priority reason data codes for all jurisdictions except the NT rather than priority category on the waiting list. For 2000-01 most jurisdictions determined greatest need status from priority category on the waiting list, influencing changes in results reported. A number of priority wait list data codes have been excluded in the calculation this year. **b** For NSW for 2000-01, data exclude those households paying very high rental housing costs due to data availability. Records with missing waiting time information are included in the total but could not be assigned to a breakdown group. For 2001-02, waiting time is calculated as the time between the date of application registration and the date housed. In previous years the date of accepting the offer was used rather than the date housed, which is the standard in NSW. **c** In 2001-02, there was a policy change to Special Housing Circumstances eligibility criteria that resulted in a significant increase in the number of these applicants assisted. **d** In 2000-01 data for five priority levels were collected and reported from 8 January 2001 to 30 June 2001 only. In 2001-02 data for these priority levels were reported for the entire financial year, influencing increases in numbers reported.

Source: State and Territory governments (unpublished); table 16A.9.

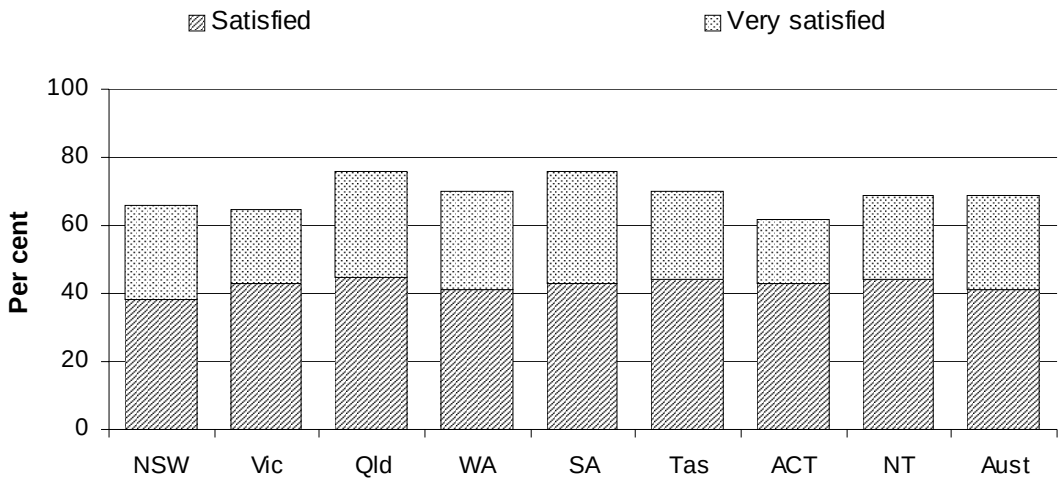
Quality

The quality of public housing is reported by surveying tenants about their overall satisfaction with housing provided. Satisfaction with the location and amenity aspects of public housing is reported under the appropriateness indicator

(figure 16.7). The satisfaction outcomes for location and amenity influence the general satisfaction of public housing tenants. A more comprehensive discussion of customer satisfaction results is provided in the *Report of the National Social Housing Survey with Public Housing* (NFO Donovan Research 2001b) which is available on the DFaCS website (www.facs.gov.au).

- Nationally, 69 per cent of tenants were either satisfied or very satisfied with the housing provided. This proportion varied from 76 per cent in Queensland and SA to 62 per cent in the ACT. This proportion increased in four jurisdictions between 2000 and 2001 and decreased in three. The largest change occurred in NSW, where the proportion of tenants who were satisfied or very satisfied with the housing provided decreased by 6 percentage points (table 16A.10).
- The proportion of public housing tenants surveyed who were very satisfied with the housing provided was the same as or above the national average in NSW, Queensland, WA, and SA in 2001 (figure 16.11).

Figure 16.11 **Tenant satisfaction, July-August 2001[a, b]**



a Care needs to be taken in interpreting small differences in the results that are affected by sample and estimate size (see table 16A.10 for details of the sample size). **b** Data for Australia calculated as simple numerical average due to a lack of raw data.

Source: NFO Donovan Research (2001b); table 16A.10.

Efficiency

Four performance indicators measure the efficiency of public housing provision.

Cost per unit of public housing

The first efficiency indicator is cost per unit of public housing. The costs incurred by jurisdictions in providing public housing include:

- administration costs (the cost of the administration offices of the property manager and tenancy manager);
- operating costs (the costs of maintaining the operation of the dwelling, including repairs and maintenance, rates, the costs of disposals, market rent paid and interest expenses);
- depreciation costs; and
- the user cost of capital (the cost of the funds tied up in the capital used to provide public housing).

Some cost data are either more complete or collected on a more consistent basis than other cost data. Consequently, care needs to be taken in interpreting the total cost of delivering public housing. Administration costs and operating costs, for example, may not capture all costs incurred by government, so could understate the total costs of public housing.

The user cost of capital for government services is the cost of having funds tied up in the capital used to deliver services (for example, houses and land in public housing). The user cost of capital makes explicit the opportunity cost of using the funds to deliver services rather than investing them elsewhere or using them to retire debt.

The user cost of capital is calculated by applying a jurisdictional cost of capital rate to the value of government assets (see chapter 2 for details of the determination of a cost of capital rate). The costs of capital for land and other assets are shown separately to allow users to consider any differences in land values among jurisdictions when assessing the results.

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
- 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).

The indicative user cost of capital for land per public housing dwelling was highest in the ACT ($8131) and lowest in Tasmania ($100) in 2001-02. The full indicative

cost of capital per dwelling ranged from $13 354 in the ACT to $4202 in Tasmania (table 16.5).

Cost per dwelling is broken down into gross cost to government (administration and operating costs plus capital costs) and the net cost to government (which nets out rents received from tenants). Interest payments have been subtracted from other capital costs (that is, depreciation and indicative user cost of capital) to obtain the total capital cost, and full gross and net cost to government, rendering these data not comparable with those published prior to the 2002 Report. Interest payments are included in recurrent costs and reported capital costs must be reduced by the amount of interest payments to avoid double counting of capital costs once the indicative user cost of capital is included. Previously, it has not been possible to avoid this double counting.

The net cost to government per dwelling in 2001-02 ranged from $15 348 in the ACT to $5772 in SA. Some jurisdictions had difficulty separating costs for public housing from those for other housing assistance activities, so care needs to be taken in interpreting these results (table 16.5).

Table 16.5 **Costs per dwelling, 2001-02 (dollars)[a]**

	NSW	*Vic*	*Qld*[b]	*WA*	*SA*[c]	*Tas*	*ACT*[d]	*NT*[e]	*Aust*
Total recurrent costs	4 034	3 027	4 150	4 260	4 248	6 788	6 231	7 252	4 140
Depreciation	1 510	1 450	2 052	1 231	814	846	1 004	1 931	1 421
Indicative user cost of capital									
– land	4 776	3 941	3 043	3 764	2 239	100	8 131	3 495	3 850
– other assets	5 380	5 601	3 990	4 374	2 933	4 102	5 224	4 587	4 727
– total assets	10 156	9 542	7 033	8 138	5 172	4 202	13 354	8 082	8 577
Interest payments[f]	401	–	370	639	926	954	547	2 226	474
Total capital costs	11 265	10 992	8 714	8 730	5 060	4 094	13 811	7 787	9 524
Full gross costs	**15 298**	**14 019**	**12 864**	**12 990**	**9 307**	**10 882**	**20 042**	**15 039**	**13 664**
Rent collected from tenants	3 654	3 693	3 521	3 378	3 535	3 181	4 694	4 154	3 625
Full net costs	**11 644**	**10 325**	**9 344**	**9 613**	**5 772**	**7 700**	**15 348**	**10 885**	**10 039**

a Issues surrounding the comparability of capital cost data are discussed in the Steering Committee research paper, *Asset Measurement in the Costing of Government* Services (SCRCSSP 2001b). **b** From the 2001-02 financial year, capital works in progress are excluded. **c** Excludes 990 dwellings under the special needs housing program (for example, student housing, migrant housing). **d** A high proportion of ACT Housing properties are in inner city areas. Land values have increased 80 per cent over the last three years. **e** Territory Housing only commenced depreciating public housing dwellings on 1 July 2000. The depreciation figure reported in the *Report on Government Services 2002* understated the actual depreciation amount included in the audited financial statements. **f** Interest payments are included in total recurrent costs, but they must be excluded from total capital costs and full gross and full net costs to avoid double counting of capital costs once the indicative user cost of capital is included. Prior to the 2002 Report, it had not been possible to avoid this double counting, and as a result, data are not comparable to those in earlier reports. – Nil or rounded to zero.

Source: State and Territory governments (unpublished); table 16A.11.

Care needs to be taken in comparing the full gross costs of public housing because there may be double counting for some jurisdictions. The user cost of capital is intended to capture all the costs of funding assets used to produce the services, but some of these costs (apart from interest payments) may already be included in reported operating costs.

The Steering Committee accepts that asset valuation data are imperfect. It also recognises that non-recognition of the cost of capital used by departments to deliver services can result in significant underestimation of costs for those services for which government capital is a major input. While the measurement of capital costs in this Report is not perfect, using an imperfect costing is preferable to not costing government capital.

In 2001, the Steering Committee completed a research project to assess the impact of asset measurement factors (such as depreciation and asset valuation methods) on the comparability of cost data in the Report. The results of this study are summarised in chapter 2. A brief summary of the results relating to housing is featured in box 16.6.

Box 16.6 **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 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 relative capital intensity associated with the provision of public housing increases the potential for differences in asset measurement techniques to have a material impact on total unit costs. The results of this study suggest, however, that the adoption under the CSHA of a uniform accounting framework has largely avoided this. The results are discussed in more detail in chapter 2.

Source: SCRCSSP (2001b).

Occupancy rates

The second indicator of efficiency measures the proportion of the housing stock occupied by households. The proportion of public rental stock occupied at

30 June 2002 ranged from 98.7 per cent in the ACT to 94.2 per cent in SA. The national average occupancy rate was 96.8 per cent (table 16.6).

Table 16.6 **Housing stock occupancy rates at 30 June (per cent)**

	NSW	*Vic*	*Qld* [a]	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Proportion of public housing dwellings occupied									
2001	98.2	96.2	96.6	95.6	94.4	94.3	95.7	95.2	96.6
2002	98.1	96.4	97.5	95.4	94.2	95.7	98.7	95.0	96.8

[a] For 2001, dwellings are defined as the 'unit of accommodation to which a rental agreement can be made' and dwelling numbers here will exceed figures based on discreet dwelling structures.

Source: State and Territory governments (unpublished); table 16A.12.

Turnaround time

The third indicator of efficiency — turnaround time — indicates the speed with which housing stock is reoccupied after it has been vacated, acquired or newly constructed. The length of time taken to rent untenanted stock affects allocations of public housing, waiting times, the length of waiting lists and rent forgone. All jurisdictions aim to minimise turnaround times.

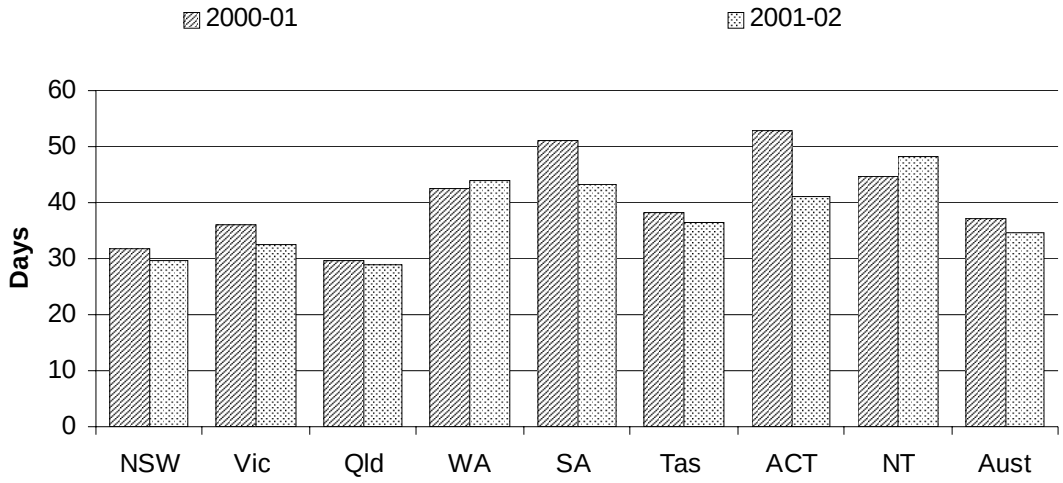
The average number of days for vacant stock to be allocated in 2001-02 varied from 48 days in the NT to 29 days in Queensland (figure 16.12). This indicator may be affected by changes in maintenance programs and some jurisdictions may have difficulty in excluding stock upgrades.

Rent collected as a proportion of the rent charged

The fourth efficiency indicator — total rent collected as a proportion of the rent charged — indicates the extent to which rent in arrears represents a financial burden to housing authorities. Differences in recognition policies, write-off practices, the treatment of disputed amounts and the treatment of payment arrangements may affect the comparability of this indicator's reported results.

Rent collected as a proportion of the rent charged in 2001-02 varied from 101.0 per cent in WA to 97.8 per cent in SA (table 16.7). Payment arrangements for rent in some jurisdictions mean that the rent collected over a 12-month period may be higher than rent charged over that period.

Figure 16.12 **Average turnaround times[a, b, c, d, e, f, g]**



a Excludes dwellings undergoing major redevelopment. For 2000-01, the indicator measures the number of times a dwelling was vacated and subsequently retenanted. Previously, the indicator measured the number of dwellings vacated and subsequently retenanted. Prior to the 2001-02 collection, the denominator used to calculate turnaround times was described as 'total number of dwellings that are vacated and subsequently tenanted for year ending 30 June'. The intention of this data item, however, was to count the number of vacancy episodes for all public housing dwellings. This clarification was made to the 2001-02 data manual, however, as this counting rule was implemented for the 2000-01 data collection, this clarification should not affect the data reported in 2001-02 relative to 2000-01. **b** For NSW for 2000-01, data exclude 938 properties with obvious date errors and 66 properties with a void status commencing prior to 30 June 1999 because the data are considered erroneous. For 2001-02, data exclude 753 properties with obvious date errors and 23 properties with a void status commencing prior to 30 June 2000 because the data are considered erroneous. **c** For Victoria, for 2001-02, reletting restriction days were excluded because properties were off-line during this period (for example, undergoing major upgrade or redevelopment). Excludes all properties where the vacancy start date was void and where there were erroneous dates. **d** For Queensland, the data source for this item changed in 2000-01 from 1999-2000. It is derived from tenancy information and does not distinguish between the different types of vacancy, nor does it contain information about the lead time for new dwellings to be occupied. Calculations using alternative data sources indicate that data limitations have only a minimal impact on the performance indicator. **e** For WA includes time vacant due to redevelopment. **f** For SA, redevelopments were excluded from calculations in 2001-02, but were included in 2000-01, resulting in a reduction in the figure reported. **g** The change in the NT figure reported in 2000-01 is due to incorrect reporting of this data item in 1999-2000.

Source: State and Territory governments (unpublished); table 16A.13.

Table 16.7 **Total rent collected as a proportion of total rent charged (per cent)[a]**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*[b]	*ACT*	*NT*	*Aust*
2000-01	100.0	99.6	99.4	101.4	98.6	101.4	98.2	97.4	99.7
2001-02	99.2	99.8	98.8	101.0	97.8	100.7	100.0	97.9	99.3

a Payment arrangements for rent in some jurisdictions mean that rent collected over a 12-month period may be higher than rent charged over that period. **b** Data for 2000-01 exclude the Aboriginal Rental Housing Program. These data were included in 1999-2000.

Source: State and Territory governments (unpublished); table 16A.14.

Community housing

Community housing data have three sources:

- administration data, collected by the State or Territory government body with responsibility for administering the community housing program in the jurisdiction;
- survey data, collected from the community organisations (providers) that manage the service delivery; and
- survey data, collected via the national social housing survey.

This chapter provides data on 10 of the 11 performance indicators in the community housing framework. Satisfactory data are unavailable for reporting against the direct cost per unit indicator. Community housing data are generally obtained by surveying community providers and the reliability of the data can be influenced by survey response rates. Comparisons over time using community housing data should therefore be made with care. Table 16.8 outlines the survey response rates and associated information for each jurisdiction for 2000-01 and 2001-02.

Some descriptive data on community housing are contained in table 16A.15. A list of State and Territory programs included in the community housing data collected is contained in table 16A.71.

Table 16.8 Community housing survey response rates and associated information

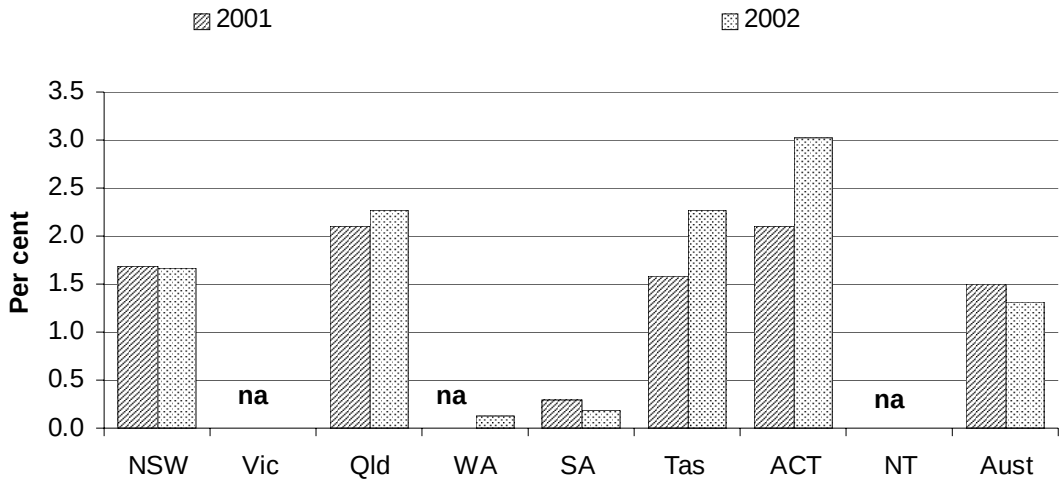
Jurisdiction	*Survey response rates/other details*
NSW	2000-01: Based on survey of 196 providers with 89 per cent response rate; 2001-02: Based on survey of 192 providers with 86 per cent response rate; Non-response was skewed to organisations managing a small number of dwellings.
Vic	2000-01: No survey; 2001-02: Survey data from 64 providers out of a total of 215 providers. The survey was not distributed to 19 agencies that manage 3151 properties under the Transitional Housing Management Program targeting homeless households. The survey instrument was tailored for each community program according to funding and service agreements. Some organisations completed two surveys as they manage stock under different agreements. Properties under joint venture arrangements where the state housing authority contributes a portion of capital funding to a property are excluded. No recurrent funding is provided. These agencies are not required to report on client or financial information and the only information retained internally relates to stock. The company reporting on Common Equity Housing Cooperative properties did not provide post codes for 2002. There has been no growth in the program, although a few properties may have been sold and replaced. Postcode information would be similar to 2001.
Qld	2000-01: Based on survey of 332 providers with 60 per cent response rate; 2001-02: Based on survey of 336 providers with 60 per cent response rate. Some organisations completed up to three surveys as they manage stock under different arrangements. As non-response was skewed to organisations managing a small number of dwellings, approximately 81 per cent of dwellings were included.
WA	2000-01: No survey; 2001-02: Based on survey of 239 providers with a 56 per cent response rate. Data include 394 Crisis Accommodation Program dwellings that are out of the scope of this collection.
SA	2000-01: Based on survey of 135 providers. Two surveys were mailed out with 94 per cent of household level surveys and 87 per cent of waiting list surveys returned; 2001-02: Based on survey of 134 providers. Two surveys were mailed out with 88 per cent of household level surveys and 58 per cent of waiting list surveys returned
Tas	2000-01: Based on survey of 73 providers with a 16 per cent response rate representing 104 households. The administrative data figure for number of dwellings is 260; 2001-02: Based on survey of 46 providers with a 46 per cent response rate.
ACT	2000-01: Data represent 87 per cent of community housing in the ACT. Data exclude 49 dwellings managed by 12 community housing providers including three targeted providers; 2001-02: Data from survey of 11 providers (out of a total of 20) managing 85 per cent of community housing in the ACT.
NT	2000-01 and 2001-02: No survey.

Effectiveness

Appropriateness

This chapter reports three measures of appropriateness for community housing. As with public housing, the first is indicated by the match of rental dwellings to household size. For those jurisdictions able to provide data, the ACT had the highest proportion of overcrowded dwellings (3.0 per cent) at 30 June 2002, while WA had the lowest (0.1 per cent) (figure 16.13). More information on overcrowding for community housing can be found in table 16A.78.

Figure 16.13 **Overcrowding in community housing dwellings at 30 June[a, b]**



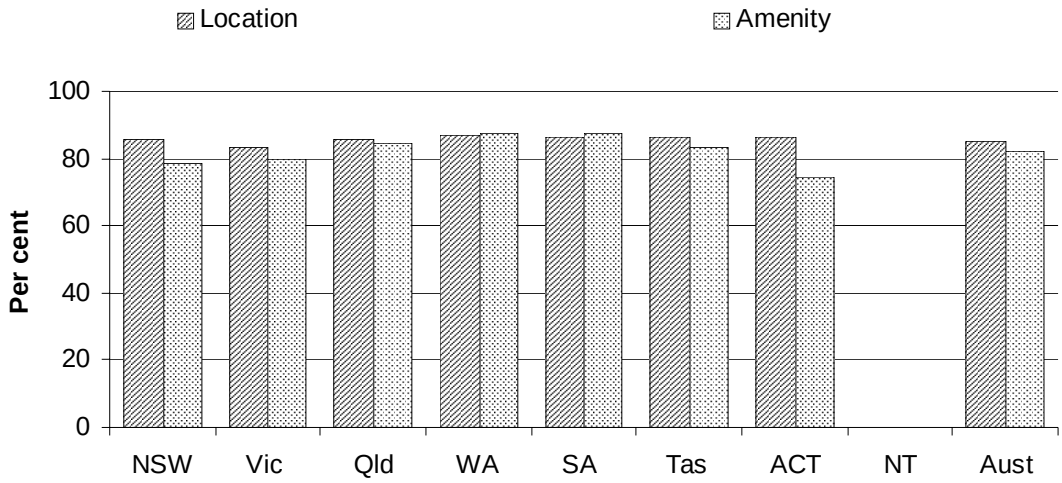
a For NSW, Queensland, WA, SA, Tasmania and the ACT data are based on surveys. See table 16.8 for response rates and other relevant information. **b** The ACT notes that the small numbers of community housing dwellings in the Territory means four households can make a one per cent difference to the figures. **na** Not available.

Source: State and Territory governments (unpublished); table 16A.16.

The second measure of the appropriateness of community housing assistance is provided by surveying tenants about the amenity and location of their dwellings (figure 16.14). As with public housing, the precision of survey estimates will depend on the survey sample size and the sample estimate. Larger sample sizes result in higher precision, as do larger sample estimates; for example if 90 per cent of surveyed respondents chose an answer, there would be less uncertainty about the actual population's views than if 50 per cent of respondents chose it. Care needs to be taken in interpreting small differences in results that are affected by sample and estimate size. More information on the sample size is provided in tables 16A.17 and 16A.18.

The proportion of tenants satisfied with the location of their dwelling in 2002 ranged from 87.1 per cent in WA to 83.1 per cent in Victoria. Satisfaction levels were above average in NSW, WA, SA, Tasmania and the ACT. The proportion of tenants satisfied with the amenity of their dwelling ranged from 87.3 per cent in WA and SA to 74.2 per cent in the ACT. Satisfaction levels were above average in Queensland, WA, SA and Tasmania (figure 16.14).

Figure 16.14 **Proportion of tenants satisfied with location or amenity aspects of their dwelling, February 2002[a, b, c]**



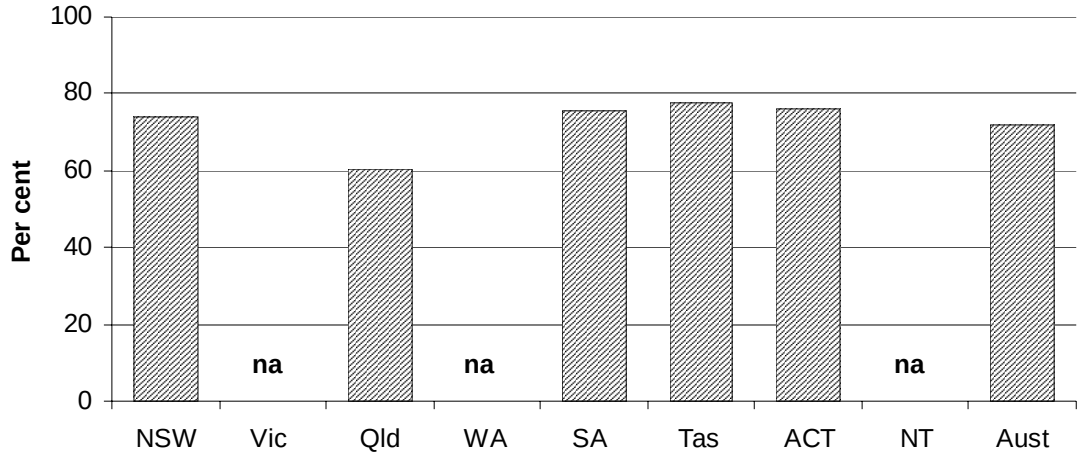
a Care needs to be taken in interpreting small differences in the results that are affected by sample and estimate size (see attachment 16A for details of the sample size). **b** Not applicable for the NT as it chose not to participate in the survey due to its small community housing tenant population. **c** National total is an unweighted average.

Source: NFO Donovan Research (2001a); table 16A.17 and 16A.18.

These overall satisfaction results were obtained by surveying tenants about a number of aspects of the location and amenity of their dwellings. Tenants were asked whether particular aspects were important to them and if so, whether they felt their needs were met. More information on this indicator can be found in tables 16A.17 and 16A.18.

The third measure of appropriateness for community housing is affordability, measured as the proportion of household income remaining after paying rent. For those jurisdictions able to provide data, this proportion ranged from 77.7 per cent in Tasmania to 60.6 per cent in Queensland (figure 16.15).

Figure 16.15 **Proportion of household income left after paying rent 2001-02[a, b]**



a For NSW, Queensland, WA, SA, Tasmania and the ACT data are based on surveys. See table 16.8 for response rates and other relevant information. **b** For Queensland, only includes figures for the 103 organisations that responded to all four data items and may not be representative of the community housing sector. **na** Not available.

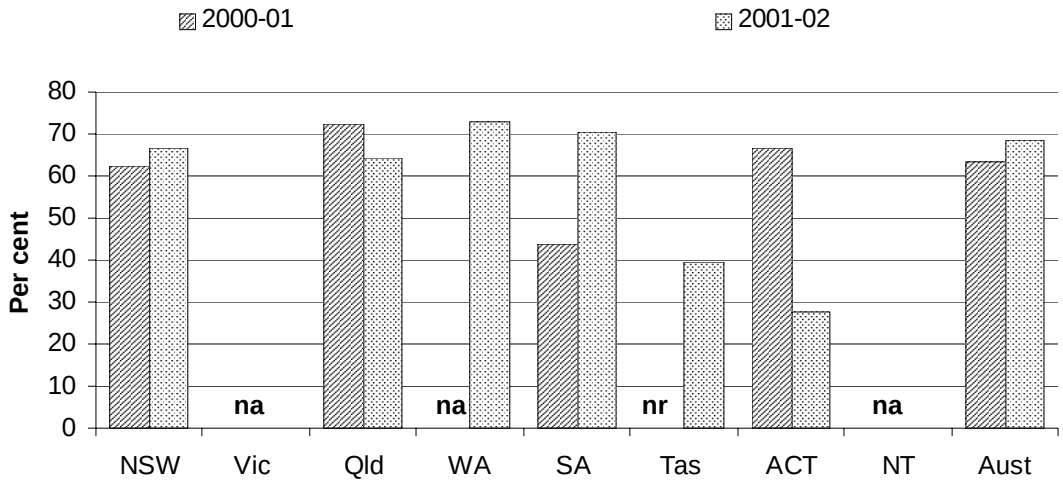
Source: State and Territory governments (unpublished); table 16A.25.

Access

This chapter reports three measures of access to community housing assistance for those in need. The first of these is the proportion of new tenancies allocated to households with special needs. Special needs households are those that have either a household member with a disability, a principal tenant aged either 24 years or under or 75 years or more, or a household defined as being Indigenous.

The proportion of new tenancies allocated to 'special needs' households in 2001-02 varies for those jurisdictions able to provide data, from 72.8 per cent in WA to 27.5 per cent in the ACT (figure 16.16).

Figure 16.16 **Proportion of new tenancies allocated to households with special needs[a, b, c, d]**

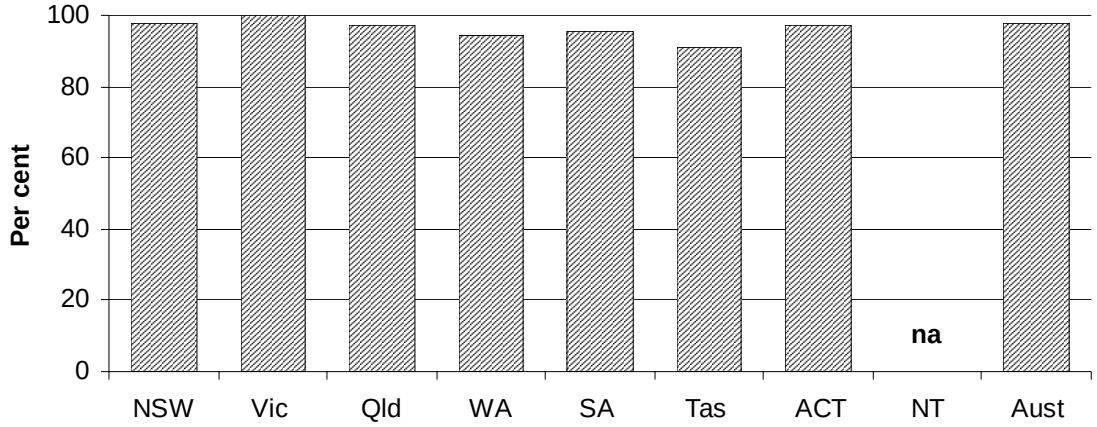


a For NSW, Queensland, WA, SA, Tasmania and the ACT data are based on surveys. See table 16.8 for response rates and other relevant information. **b** For NSW, for 2000-01 special needs categories include Indigenous households, households with a disability, households with older or young principal tenants, non-English speaking background households, households with support needs and other categories nominated by providers. **b** For Queensland, in 2000-01 data based on 74 per cent of allocations compared to 95 per cent in 2001-02, influencing variation in results. **c** For SA, in 2000-01 data based on 100 per cent of allocations compared to 85 per cent in 2001-02, influencing variation in results. **d** For the ACT in 2000-01 data based on 32 per cent of allocations compared to 96 per cent in 2001-02, influencing variation in results. Data may be unreliable because some organisations provided incorrect data about special need allocations. **na** Not available. **nr** Not reported.

Source: State and Territory governments (unpublished); table 16A.19.

The proportion of all households that pay less than market rent or that were special needs households paying market rent in 2001-02, for those jurisdictions able to provide data, ranged from 100.0 per cent in Victoria to 91.2 per cent in Tasmania (figure 16.17).

Figure 16.17 **Households paying less than market rent, or special needs households paying market rent at 30 June 2002, as a proportion of all households[a, b, c]**

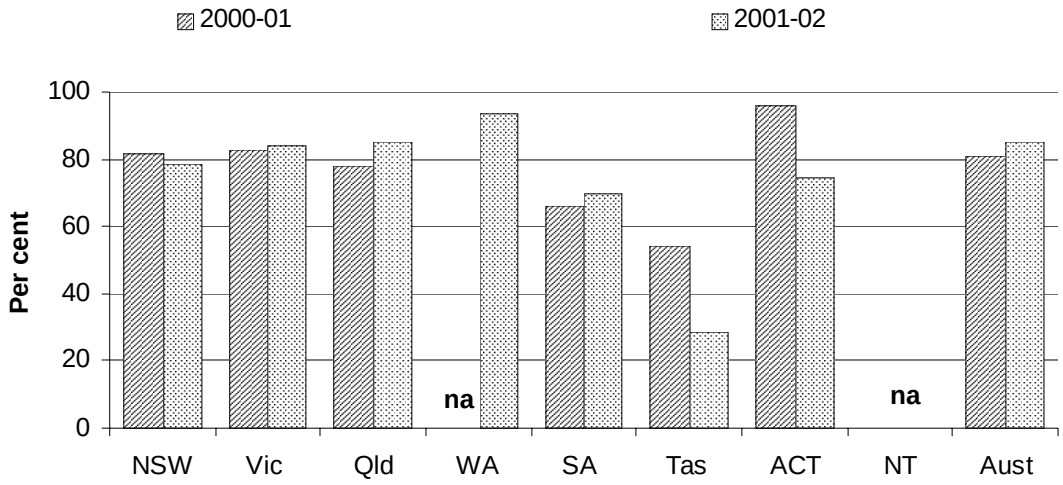


a For NSW, Queensland, WA, SA, Tasmania and the ACT data are based on surveys. See table 16.8 for response rates and other relevant information. **b** Data items are consistent with those for the equivalent indicator in the public housing collection. The proxy for identifying low income households is households paying a rent which is less than the market value of the dwelling. **c** For SA, the South Australian Community Housing Authority uses its own scales of 'ceiling rent', as opposed to market rent. Generally, the ceiling rent amount is below the market rent amount. Ceiling rent is worked out as follows: For properties worth up to $94 000, annual ceiling rent is the capital value of the property multiplied by 7.53 per cent (the weekly amount is this figure divided by 52). For properties valued between $94 001 and $101 500, the rate is fixed at $136.20 per week. For properties worth more than $101 500, the annual rent payable is 7 per cent of capital value (the weekly amount is this figure divided by 52). Special needs figure includes five Indigenous tenants, 115 non-English speaking background tenants (including 13 with disabilities), 104 others with disabilities, 52 aged people and 26 young people. There are 27 properties for which it is not known if the tenant is paying ceiling rent or not. **na** Not available.

Source: State and Territory governments (unpublished); table 16A.24.

The second indicator of access measures the proportion of new dwellings allocated to those in greatest need. 'Greatest need' households are defined as low income households whose members at the time of allocation were either homeless, in housing inappropriate to their needs, in housing that was adversely affecting their health or placing their life and safety at risk, or those with very high rental housing costs. For those jurisdictions able to supply data, this proportion varied from 93.5 per cent in WA to 28.7 per cent in Tasmania (figure 16.18).

Figure 16.18 **Greatest need allocations as a proportion of all new allocations[a]**



a For NSW, Queensland, WA, SA, Tasmania and the ACT data are based on surveys. See table 16.8 for response rates and other relevant information. **na** Not available.

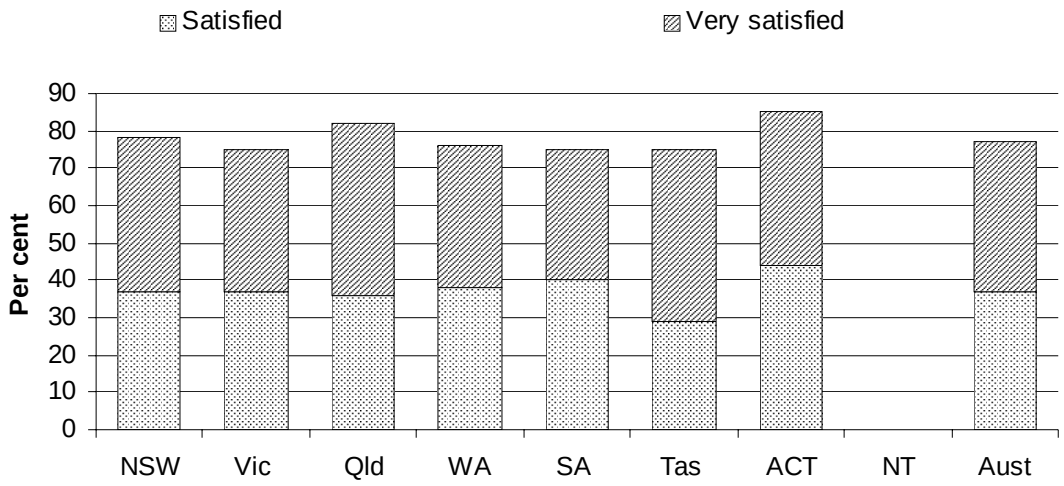
Source: State and Territory governments (unpublished); table 16A.20.

Quality

The quality of community housing is reported by surveying tenants about their overall satisfaction with their housing. Satisfaction with the location and amenity aspects of community housing is reported under the appropriateness indicator (figure 16.14). The satisfaction outcomes for these areas influence the general satisfaction of community housing tenants.

Nationally in 2002, 77 per cent of tenants were satisfied or very satisfied with their community housing dwellings and the services provided by their community housing organisation (including benefits derived from living in community housing and involvement in the organisation). For jurisdictions for which robust survey data were available, this proportion ranged from 85 per cent in the ACT to 75 per cent in Victoria, SA and Tasmania. The proportion of community tenants who were satisfied or very satisfied was above the national average in NSW, Queensland and the ACT (figure 16.19). The proportion of community housing tenants who were very satisfied was above the national average in NSW, Queensland, Tasmania and the ACT (table 16A.21). These results are obtained from the 2002 National Social Housing Survey for community housing.

Figure 16.19 **Tenant satisfaction, February 2002[a, b, c, d]**



a Care needs to be undertaken in interpreting small differences in the results that are affected by sample and estimate size (see attachment 16A for details of the sample size). **b** Categories do not add to 100 per cent because nonresponses and neutral responses are not included. **c** Comparisons may be influenced by a range of factors beyond quality of service, such as age profile of tenants. **d** Not applicable for NT as it chose not to participate in the survey due to its small community housing tenant population.

Source: NFO Donovan Research (2001a); table 16A.21.

Efficiency

This chapter reports three measures of efficiency for community housing. The first is the proportion of community housing occupied, which, at 30 June 2002 for those jurisdictions able to provide data, ranged from 100.0 per cent in Tasmania and the NT to 94.7 per cent in the ACT (table 16.9).

Table 16.9 **Community housing occupancy rates at 30 June (per cent)**

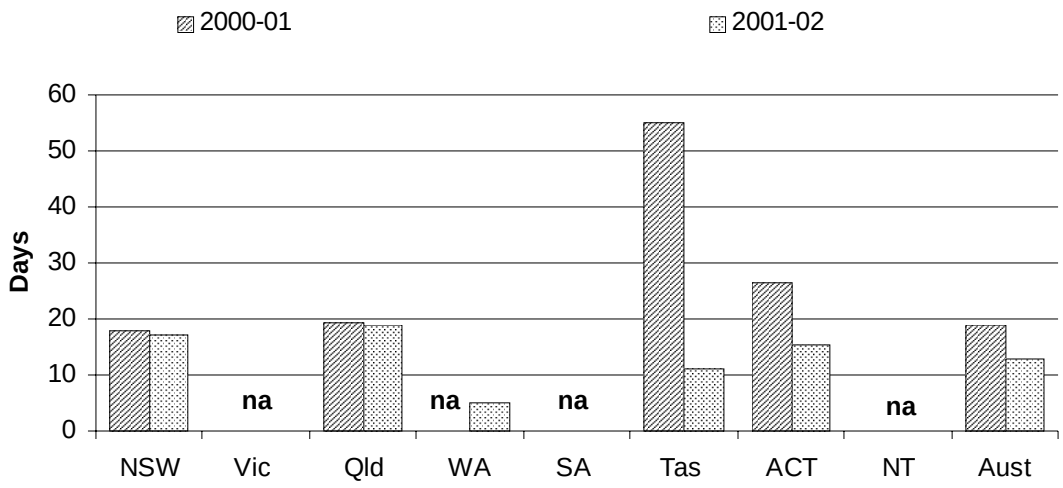
	NSW [a]	*Vic* [b]	*Qld* [c]	*WA*	*SA*	*Tas*	*ACT* [d]	*NT* [e]	*Aust*
2001	97.9	94.6	95.8	**na**	94.7	90.4	94.3	100.0	95.9
2002	98.2	95.6	94.8	97.2	95.8	100.0	94.7	100.0	96.5

a For NSW, Queensland, WA, SA, Tasmania and the ACT data are based on surveys. See table 16.8 for response rates and other relevant information. **b** For Victoria, data are an estimate only. **c** For Queensland data for 2001-02 are based on administrative data on Boarding House Program and Long Term Community Housing Program dwellings at 8 July 2002 and Community Rent Scheme dwellings (including private leases) at 30 June 2002. **d** For the ACT, as at 30 June 2002, data include properties funded under the Community Housing Program (43), Community Organisations Rental Housing Assistance Program properties used for community housing (36), Havelock House (98), Abbeyfield Society (2), properties transferred to Community Housing Canberra (209) and 80 properties head-leased on the private market. **e** In the NT, it is estimated that dwellings are fully occupied as a majority of organisations turn away people seeking accommodation. **na** Not available.

Source: State and Territory governments (unpublished); table 16A.23.

The second efficiency measure is turnaround time, or the speed with which housing stock is reoccupied after it has been vacated or acquired. The average number of days for vacant stock to be allocated in 2001-02 varied for those jurisdictions able to provide data from 19 days in Queensland to five days in WA (figure 16.20). This indicator may be affected by changes in maintenance programs and some jurisdictions may have difficulty excluding stock upgrades.

Figure 16.20 **Average turnaround times**[a, b, c]



a For NSW, Queensland, WA, SA, Tasmania and the ACT data are based on surveys. See table 16.8 for response rates and other relevant information. **b** Excludes dwellings undergoing major redevelopment. **c** For NSW, for 2001-02 providers reported on the number of dwellings occupied at 30 June 2002 which were vacant during the year. **na** Not available.

Source: State and Territory governments (unpublished); table 16A.26.

The third measure of efficiency for community housing is the proportion of rent in arrears indicator. For community housing, data are reported with a one-year lag to allow community providers an extra year to collate financial data. Rent collected as a proportion of rent charged varied from 99.2 per cent in WA to 92.5 per cent in NSW at 30 June 2001 (table 16.10). As with public housing, payment arrangements for rent in some jurisdictions means that the rent collected over a 12-month period may be higher than rent charged over that period.

Table 16.10 **Total rent collected as a proportion of total rent charged (per cent)[a]**

	NSW [b]	*Vic*	*Qld*	*WA*[c]	*SA*	*Tas*	*ACT*	*NT*	*Aust*
2000-01	92.5	**na**	98.6	99.2	97.8	**na**	97.6	**na**	95.5

[a] For NSW, Queensland, WA, SA, Tasmania and the ACT data are based on surveys. See table 16.8 for response rates and other relevant information. [b] Payment arrangements for rent in some jurisdictions mean that rent collected over a 12-month period may be higher than rent charged over that period. Data for the 2000-01 financial year are reported to provide additional time to collate financial data. [c] Only 120 providers responded to these questions. **na** Not available.

Source: State and Territory governments (unpublished); table 16A.22.

State and Territory owned and managed Indigenous housing

Different delivery contexts, locations and types of client may affect the performance reported in this section. Care needs to be taken in interpreting performance indicator results and the qualifications presented with the data need to be considered. There may also have been some difficulties in separating Indigenous housing data from public housing data. Variations in the funding and administration of State and Territory owned and managed Indigenous housing across jurisdictions may influence the comparability of data. Some descriptive data on State and Territory owned and managed Indigenous housing are included in table 16A.27.

The ACT and the NT are not included in the Territory owned and managed Indigenous housing data collection. As stated earlier, the ACT does not receive funding for or administer any Territory owned and managed Indigenous housing programs, while in the NT, funding under the ARHP is directed at community managed Indigenous housing. The NT Government is unable to differentiate between the various funding sources as a result of its commitment under the CSHA Indigenous Agreement to specifically 'pool' all funds earmarked for Indigenous housing and associated infrastructure in the NT. Some other jurisdictions are increasingly pooling funding, although they can report State owned and managed Indigenous housing data separately. While Queensland administers a separate Aboriginal and Torres Strait Islander Housing Program, it includes ARHP funds, untied CSHA funds and State funds, and there is no separate reporting against the ARHP component of the programs funds, which forms more than one third of expenditure.

As discussed in section 16.1, State and Territory owned and managed Indigenous housing dwellings are more likely to be located in rural or remote areas than public or community housing dwellings. Nationally, 20.1 per cent of State and Territory owned and managed Indigenous housing dwellings were located in remote areas

and 41.5 per cent of State and Territory owned and managed Indigenous housing dwellings were located in rural (as distinct from remote) areas (table 16A.27).

Effectiveness

Appropriateness

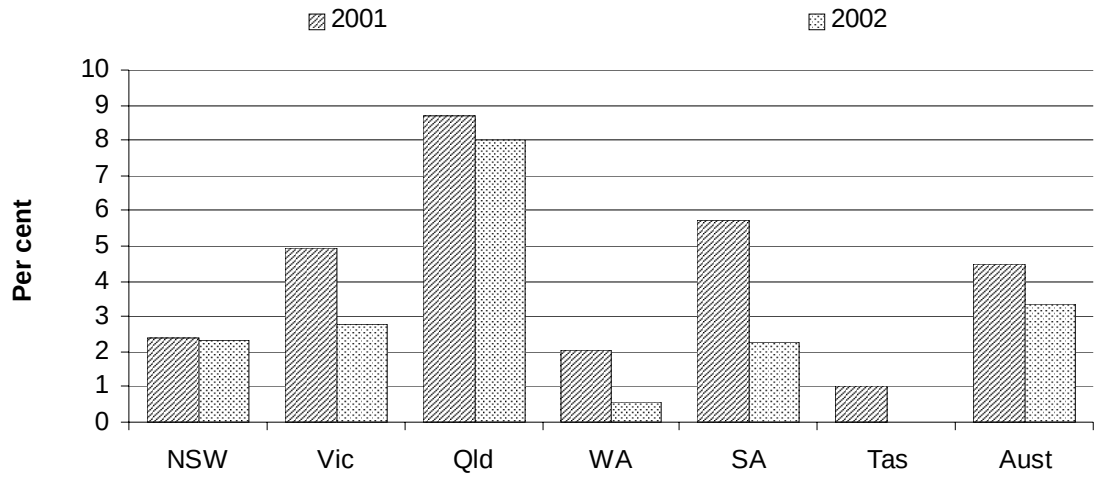
This chapter reports two measures of appropriateness for State and Territory owned and managed Indigenous housing. As with public and community housing, the first is indicated by the match of rental dwellings to household size. Queensland had the highest proportion of overcrowded dwellings at June 2002 (8.0 per cent), while Tasmania had the lowest (0.0 per cent) (figure 16.21).

Care needs to be taken in comparing performance in relation to overcrowding between public housing and State and Territory owned and managed Indigenous housing. There are two major factors that potentially result in a higher incidence of overcrowding in State and Territory owned and managed Indigenous housing dwellings relative to public housing dwellings:

- differences in Indigenous housing arrangements (for example, several generations living in one house or the possibility of visitors having 'right of access' in some circumstances) (Pholeros, Rainow and Torzillo 1993); and
- the influence of climate and culture (in rural areas people may live outside houses rather than inside and the proxy occupancy standard does not allow for verandahs or larger shared living spaces) (Pholeros *et al*. 1993).

More information on overcrowding and underuse for State owned and managed Indigenous housing can be found in table 16A.79.

Figure 16.21 **Proportion of State owned and managed Indigenous housing households with overcrowding**[a, b, c, d, e]



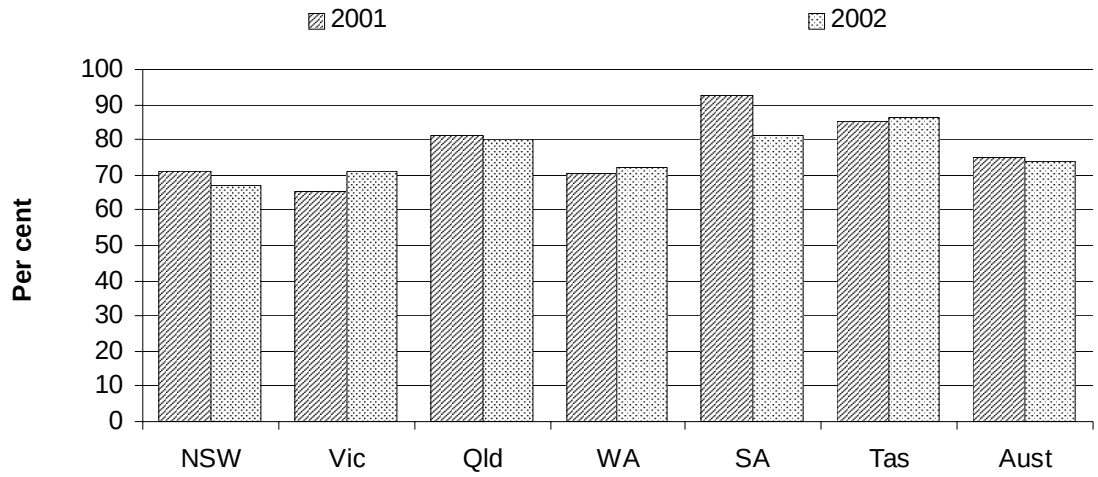
[a] At 30 June. [b] NSW data for 2002 exclude 475 non-rebated households (representing 12.3 per cent of households). [c] Victorian internal data showed an increase of 0.1 per cent from 1999-2000 to 2000-01 using consistent methodology. For 2001, Victoria had serious concerns about the credibility and validity of this data item and performance indicator. For 2002, Victorian data exclude 119 households paying market rent (10.7 per cent of households) that were included in 2000-01, influencing changes in results. [d] WA data for 2002 exclude 311 multiple family households (representing 23.8 per cent of households) that were included in 2000-01, influencing changes in results. [e] SA data for 2002 exclude 332 multiple family households (representing 20.3 per cent of households) that were included in 2000-01, influencing changes in results.

Source: State and Territory governments (unpublished); table 16A.28.

The second measure of appropriateness is affordability, which measures the rent charged to tenants as a proportion of the market rent for each dwelling, adjusted for CRA. Variations in the definition of market rent will influence the results for this indicator.

The rent charged in June 2002 as a proportion of the market rent for each dwelling (adjusted for CRA) for those jurisdictions able to provide data ranged from 86.6 per cent in Tasmania to 67.0 per cent in NSW (figure 16.22). More information on the proportion of income paid in rent by State owned and managed Indigenous housing tenants can be found in table 16A.77.

Figure 16.22 **Rent charged for State owned and managed Indigenous housing dwellings as a proportion of market rent, adjusted for CRA**[a, b, c, d, e, f, g]



[a] At 30 June. [b] Calculation of CRA entitlements for 2001 are based on an estimate of the actual entitlements that a low income household would receive if they were in the private rental sector. The 2000 calculation is based on an estimate of the average CRA payment for each State and Territory. The methodology for calculations has changed for 2002 and uses more complex modelling developed in CRA modelling for CSHA renegotiations. Caution should therefore be exercised in comparing results across the years. [c] In NSW market rents are the valuations applied to each property. The market rents for 2001 and 2002 are the same, and refer to the 2001 valuation. The method of adjusting for CRA entitlements differs between the years, making comparisons between the years difficult. [d] For Queensland, market rents for dwellings have not been globally adjusted to reflect the current market for a number of years. This has led to a gradual reduction in the proportion of households paying less than market rent, and a corresponding increase in the proportion paying market rent as a result of income increases. Consequently, the overall market rent value would also be somewhat less than the true value. Complex derivation of household entitlement resulted in an estimate below the simple sum of rents for all households in 2002. These figures are used in a ratio to calculate relative public/private affordability so this discrepancy has no effect. [e] For WA, data include only single family households, representing 89.7 per cent (2001) and 86.2 per cent (2002) of households. Data for 2001 exclude 237 multiple family households. Data for 2002 exclude 311 multiple family households (representing 13.8 per cent of households) that were included in 2000-01, influencing changes in results. WA data for 2001 have been revised since the 2002 Report. [f] SA data for 2002 exclude 332 multiple family households (representing 20.3 per cent of households) that were included in 2000-01, influencing changes in results. [g] National total for 2001 was revised from that in the 2002 Report as a result of revision of WA data for 2001.

Source: State and Territory governments (unpublished); table 16A.29.

Access

Three performance indicators measure access to State and Territory owned and managed Indigenous housing assistance for those in need. The first measures the low income and special needs (but not low income) status of households receiving State and Territory owned and managed Indigenous housing assistance (table 16.11).

As with public housing, there are two household income measures for the purpose of this indicator:

- 'low income A' households — those in State and Territory owned and managed Indigenous housing where all members of the household have incomes at or below the maximum pension rate (pension rates have been selected for calculating this indicator because they are higher than allowance rates); and
- 'low income B' households — those in State and Territory owned and managed Indigenous housing that have incomes that would enable them to receive government income support benefits below the maximum pensioner rate.

Households with incomes below these levels are included in the measure, although they may not necessarily receive income support benefits.

The proportion of new tenancies allocated to 'low income A' households varied in 2001-02 from 95.5 per cent in Tasmania to 81.3 per cent in WA. The proportion of new tenancies allocated to 'low income A' or 'special needs (not low income)' households varied from 97.0 per cent in Tasmania to 84.4 per cent in WA (table 16.11).

Table 16.11 **Low income and special needs households as a proportion of all new State owned and managed Indigenous housing households (per cent)[a]**

	NSW[b]	*Vic*	*Qld*[c]	*WA*[d]	*SA*[e]	*Tas*	*Aust*[f]
New 'low income A' households as proportion of all new households							
2000-01	91.3	80.0	81.4	89.3	88.9	76.8	86.5
2001-02	89.6	88.1	83.1	81.3	87.3	95.5	85.8
New 'low income A' households or special needs (not low income) households as proportion of all new households							
2000-01	96.9	83.3	87.0	92.0	97.9	81.7	91.4
2001-02	92.6	91.7	89.5	84.4	90.1	97.0	89.6

a The counting rules for distinguishing between 'low income A' and 'low income B' households have been clarified for the 2001-02 data collection to ensure a household is not counted in both low income categories. As it appears that these counting rules were implemented in the 1999-2000 and 2000-01 data collections, this clarification should not affect the data reported for this indicator. Households are excluded for having missing or zero household income, missing person information or for being multiple households with an unknown household composition. **b** Special needs information is only available for households that were housed after November 1999. **c** Disability is calculated from a flag used for assessment of new tenancies rather than ongoing disability, and will underestimate count for all households. **d** WA data for 2000-01 have been revised since the 2002 Report. Data only include single family households. For 2000-01, data exclude 237 multiple family households (or 51.9 per cent of households allocated housing). For 2001-02, data exclude 311 multiple family households (13.8 per cent of households) that were included in 2000-01, influencing changes in results. The change in results is also influenced by a change in the way market renter households are identified this year. **e** Data exclude new 2000-01 allocations that left State owned and managed Indigenous housing prior to 30 June 2001. For 2001-02, data exclude 332 multiple family households (representing 20.3 per cent of households) that were included in 2000-01, influencing changes in results. **f** National totals for 2001 have been revised from those in the 2002 Report as a result of a revision of WA figures.

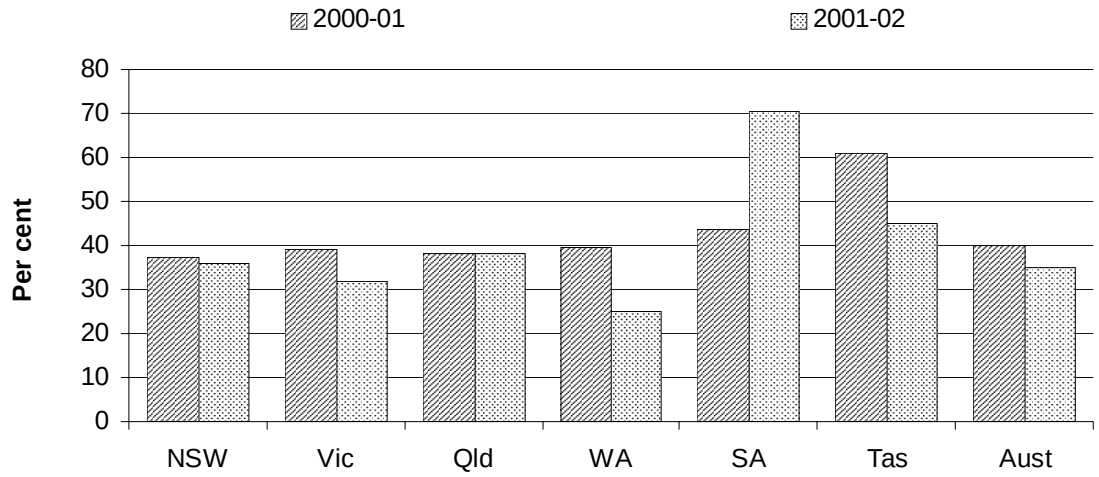
Source: State and Territory governments (unpublished); table 16A.30.

Table 16.11 only shows information on 'low income A' households. Information on both 'low income A' households and 'low income B' households is in table 16A.30.

The second indicator of access measures the proportion of new tenancies allocated to households with special needs. Special needs households are those that either have a household member with a disability or a principal tenant aged either 24 years or under or 50 years or more. The proportion of new tenancies allocated to 'special needs' households in 2001-02 varied from 70.5 per cent in SA to 25.2 per cent in WA (figure 16.23).

It is not appropriate to use this indicator to make comparisons between the performance of public housing and State and Territory owned and managed Indigenous housing. The special needs indicator for public housing includes Indigenous households in the definition of 'special needs' households. Using this definition for State and Territory owned and managed Indigenous housing would result in 100 per cent of State and Territory owned and managed Indigenous housing households being regarded as having 'special needs'. State and Territory owned and managed Indigenous housing uses a definition of 'special needs' more appropriate to the program. The definition of 'special needs' households also differs for 'aged' households: households with a principal tenant aged 50 years or more considered as 'special needs' households for State and Territory owned and managed Indigenous housing, while for mainstream public and community housing, households with a principal tenant aged 75 years or more are considered 'special needs' households. This difference reflects the lower life expectancy and the higher burden of illness among Indigenous Australians.

Figure 16.23 **Proportion of new State owned and managed Indigenous housing tenancies allocated to households with special needs, a, b, c, d, e**

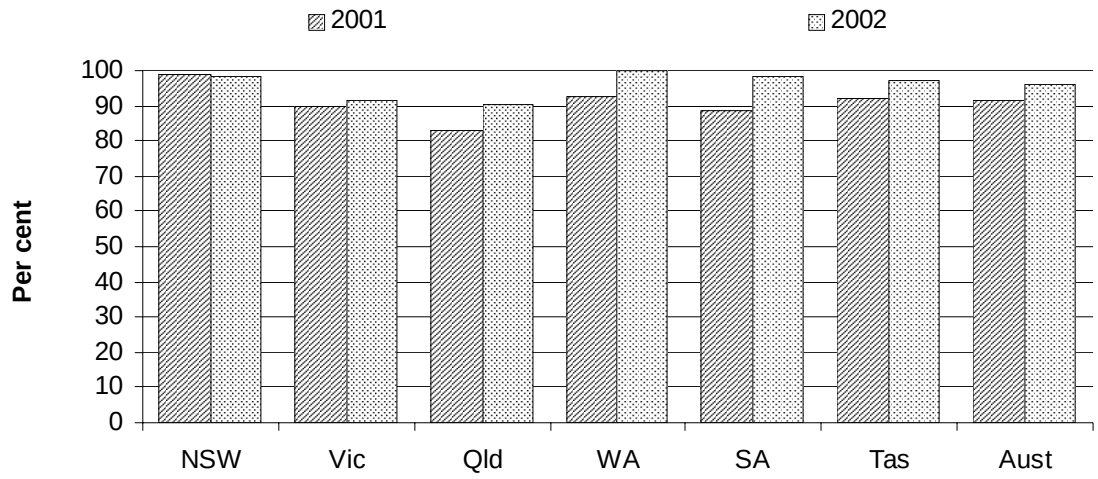


a For NSW, there were 25 new households without special needs information in 2000-01 and seven new households without special needs information in 2001-02. **b** For Queensland in 2000-01, the introduction of the special need national standard resulted in a reduction in the number of special needs households. Disability is calculated from a flag used for assessment of new tenancies rather than ongoing disability, and will underestimate current need. **c** For WA, special needs details are only recorded where they are known to exist – no record is kept if a household does not have special needs. All new households are included in the count and the figure may therefore represent an undercount. In 2000-01 data were reported about the special need status of 85 per cent of new households, influencing the change in results. **d** For SA, special needs details are recorded for the head tenant only. For 2001-02, the SA data exclude 124 new households (representing 58 per cent of new households). Results based on the special need status of 42 per cent of new allocations. In 2000-01, reported about the special need status of 100 per cent of new allocations, influencing the change in results. **e** For Tasmania, results for 2001-02 are based on the special need status of 92 per cent of new allocations. For 2000-01, data reported about the special need status of 100 per cent of new allocations, influencing the change in results.

Source: State and Territory governments (unpublished); table 16A.31.

The proportion of all households that pay less than market rent or that are special needs households paying market rent in 2001-02 ranged from 99.9 per cent in WA to 90.5 per cent in Queensland (figure 16.24).

Figure 16.24 **Households that pay less than market rent or that are special needs households paying market rent as a proportion of all State owned and managed Indigenous housing households**[a, b, c, d, e, f]



a At 30 June. **b** For NSW, there are seven new households without special needs information. Special needs information is only available for households that were housed after November 1999. **c** Market rents in Queensland have not been globally adjusted to reflect the current market for a number of years, leading to a reduced proportion of households paying less than market rent and a corresponding increase in the proportion of those paying market rent as a result of consumer price index rent rises. Consequently, the overall market rent value as listed here would be somewhat less than the true value. Disability is calculated from a flag used for assessment of new tenancies rather than ongoing disability, and will underestimate the count for all households. **d** WA data for 2001 has been revised since the 2002 Report. Data only include single family households. In 2001 excludes 237 multiple family households (or 51.9 per cent of households allocated housing). Data for 2002 excludes 311 multiple family households (representing 13.8 per cent of households) that were included in 2000-01, influencing changes in results. **e** For SA, data exclude 332 multiple family households in 2002 (representing 20.3 per cent of households). **f** National average for 2001 has been revised since 2002 Report as a result of a revision of WA data.

Source: State and Territory governments (unpublished); table 16A.32.

The third indicator of access measures the priority of access given to those in greatest need. 'Greatest need' households are defined as low income households that at the time of allocation were either homeless, in housing inappropriate to their needs, in housing that was adversely affecting their health or placing their life and safety at risk, or that had very high rental housing costs.

The proportion of new allocations to those in greatest need varied for the year ending 30 June 2002, from 54.7 per cent in SA to 14.8 in Victoria (table 16.12). The relatively low level of priority allocations in Victoria is partly because Indigenous tenants in greatest need are likely to be housed under the general public housing program. Table 16.12 shows the proportion of new allocations to applicants with greatest need for applicants spending various time periods on the waiting list. Data are provided for tenants waiting for periods from under three months to more than two years. These numbers are not cumulative.

It may not be appropriate to compare performance of public housing and State and Territory owned and managed Indigenous housing in relation to priority access to those in greatest need. In some jurisdictions, different priority allocation guidelines may be used to allocate targeted housing. Further, where allocation is made at the community level, reasons for allocation may not be recorded in information management systems.

Table 16.12 **Greatest need allocations as a proportion of all new State owned and managed Indigenous housing allocations[a]**

	NSW[b]	*Vic*[c]	*Qld*[d]	*WA*[e]	*SA*	*Tas*[f]	*Aust*
Total for year ending 30 June 2002	**17.3**	**14.8**	**na**	**20.7**	**54.7**	**na**	**24.1**
Proportion of greatest need allocations to new allocations with time to allocation[g]:							
< 3 months	36.0	18.9	**na**	21.6	69.6	**na**	**35.0**
3 —< 6 months	21.0	27.6	**na**	30.4	68.8	**na**	**33.7**
6 months — < 1 year	9.3	13.8	**na**	29.9	36.8	**na**	**21.8**
1 —< 2 years	4.7	5.3	**na**	11.8	14.3	**na**	**8.5**
2+ years	–	–	**na**	12.7	7.7	**na**	**4.5**

a Includes all greatest need allocations, regardless of whether they have missing application dates. **b** For NSW, eight records with missing waiting time information are included in the total but could not be assigned into a breakdown group. **c** For Victoria State owned and managed Indigenous housing shares a waiting list with public housing, and therefore the relatively low level of priority allocations in Victoria is partly because Indigenous tenants in greatest need are likely to be housed under the general public housing program. **d** The public housing priority waiting list is not administered in State owned and managed Indigenous housing. **e** For WA 2000-01 data for five priority levels were collected and reported from 8 January 2001 to 30 June 2001 only. In 2001-02, data for these priority levels are reported for the entire financial year, influencing increases in numbers reported this year. **f** There is no determination of 'greatest need' in the allocation of State owned and managed Indigenous housing properties and therefore no data are available. **g** For 2001-02, the number of days in each of the time allocation groups was adjusted such that a calendar month was equal to approximately 30 days. The determination of households in greatest need for all jurisdictions was based on waiting list priority reason data codes rather than priority category on the waiting list. This may influence the results for those jurisdictions that may have used priority category on the waiting list or other data sources to determine households in greatest need for the 2000-01 collection. A number of data codes were excluded for the collection for 2001-02 which may have influenced results for some jurisdictions (except the NT). **na** Not available. – Nil or rounded to zero.

Source: State and Territory governments (unpublished); table 16A.33.

Quality

The quality of housing provided under State and Territory owned and managed Indigenous housing is measured by surveying tenants about their overall satisfaction with housing provided. Survey data for State and Territory owned and managed Indigenous housing are not available for this year's Report, although surveys were undertaken by Queensland, WA, SA and Tasmania.

Efficiency

Four performance indicators measure the efficiency of the provision of housing under State and Territory owned and managed Indigenous housing. The first is cost per dwelling. The costs incurred by jurisdictions in providing housing include:

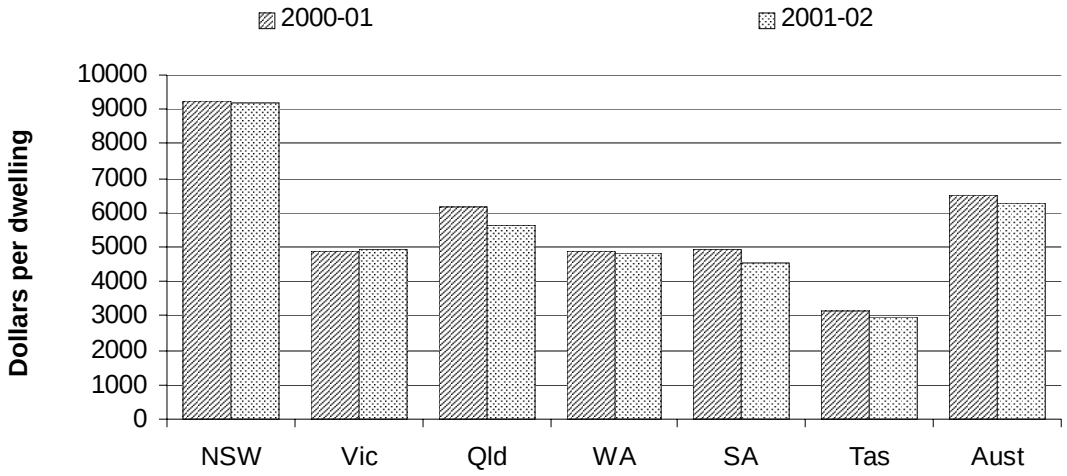
- administration costs (the cost of the administration offices of the property manager and tenancy manager);
- operating costs (the costs of maintaining the operation of the dwelling, including repairs and maintenance, rates, the costs of disposals, market rent paid and interest expenses);
- depreciation costs; and
- the user cost of capital (the cost of the funds tied up in the capital used to provide public housing).

Depreciation costs and the user cost of capital (capital costs) were not available for reporting on State owned and managed Indigenous housing. The cost per dwelling shown in figure 16.25 represents gross recurrent expenditure (that is, administration and operating costs) per dwelling. Rent received from tenants has not been deducted.

The gross cost per dwelling (excluding capital costs) for those jurisdictions able to provide data, ranged from $9192 in NSW to $2958 in Tasmania (figure 16.25).

As with other indicators, it is not appropriate to compare the gross cost per State and Territory owned and managed Indigenous housing dwelling with the recurrent cost per dwelling for public housing (which would be the public housing equivalent of this indicator). There is greater scope for economies of scale in relation to administration costs with public housing as the overall program is much larger. State and Territory owned and managed Indigenous housing dwellings are also more highly concentrated in rural and remote areas and the cost of providing housing assistance is potentially greater in these areas. The need to construct culturally appropriate housing (possibly requiring a higher standard of amenities, such as communal cooking, laundry and toilet facilities) may also affect the cost per dwelling. Finally, different cost structures may apply to the programs. Construction of dwellings, for example, under State and Territory owned and managed Indigenous housing may involve a skills development element to allow for training of apprentices in rural areas.

Figure 16.25 **Real gross cost per State owned and managed Indigenous housing dwelling, excluding capital costs (2001-02 dollars)[a, b, c]**



a The calculation for NSW for 2001-02 includes $22.285m 'capital upgrade' expenditure. This is one-off expenditure resulting from maintenance liabilities incurred before the Aboriginal Housing Office took possession of the stock. A total of 61 per cent of the direct cost per dwelling is attributable to capital upgrading. Excluding expenditure on upgrading, the direct cost per dwelling is $3567. **b** Expenditure on maintenance by Queensland influenced the reduction in direct costs reported this year. Overexpenditure in the maintenance budget in 2000-01 resulted in a cut-back to the maintenance budget in 2001-02. **c** The increase in costs in WA in 2000-01 over the previous year results from a rise in general rental costs, implementation of a tenant support initiative and more accurate apportionment of administrative costs between public housing and State owned and managed Indigenous housing.

Source: State and Territory governments (unpublished); table 16A.34.

Care needs to be taken in interpreting the total cost of delivering housing. Administration costs and operating costs, for example, may not capture all costs incurred by government, so could understate the total costs of housing provision.

The second indicator of efficiency measures the proportion of the housing stock (including untenantable dwellings) occupied by households. There was little variation across jurisdictions in the proportion of State owned and managed Indigenous housing stock occupied at 30 June 2002, which averaged 95.4 per cent nationally (table 16.13).

Table 16.13 **State owned and managed Indigenous housing stock occupancy rates[a]**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*Aust*
2001	98.0	95.4	94.0	96.0	94.3	93.1	95.8
2002	97.9	96.6	94.6	95.2	91.2	92.7	95.4

a At 30 June.

Source: State and Territory governments (unpublished); table 16A.35.

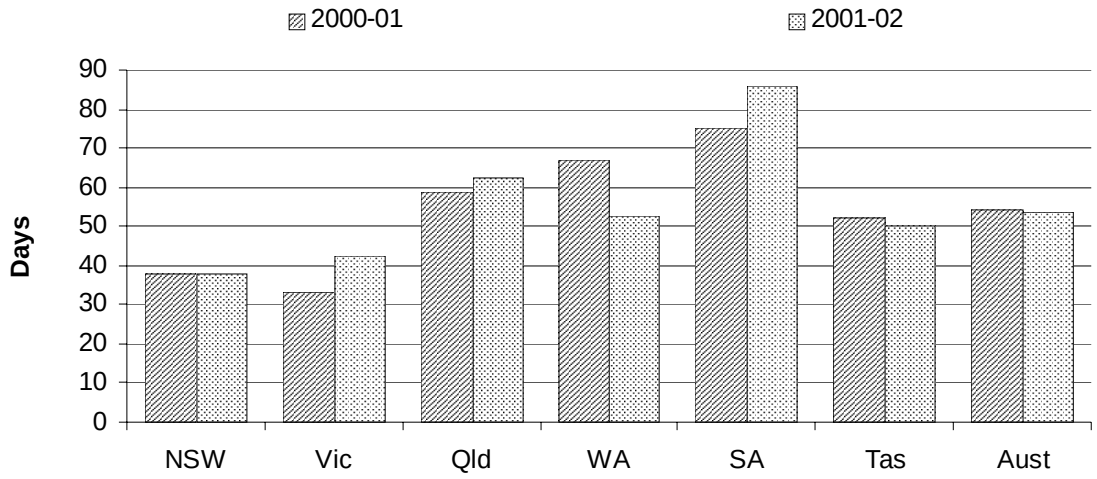
The third indicator — turnaround time — indicates the speed with which housing stock is reoccupied after it has been vacated or acquired. The length of time taken to rent untenanted stock affects allocations of State and Territory owned and managed Indigenous housing, waiting times, the length of waiting lists and rent forgone. All jurisdictions aim to minimise turnaround times.

The average number of days for vacant stock to be allocated in 2001-02 varied from 86 days in SA to 38 days in NSW (figure 16.26). This indicator may be affected by changes in maintenance programs and some jurisdictions may have difficulty excluding stock upgrades. Cultural factors may influence the turnaround time for State and Territory owned and managed Indigenous housing dwellings relative to public housing dwellings. Following the death of a significant person, for example, a dwelling may need to be vacant for a longer period of time (Morel and Ross 1993). The higher proportion of dwellings in rural and remote areas may also contribute to delays in completing administrative tasks and maintenance before dwellings can be re-tenanted.

The fourth efficiency indicator — total rent collected as a proportion of the rent charged — measures whether unpaid rent represents a financial burden to housing authorities. Differences in recognition policies, write-off practices, the treatment of disputed amounts and the treatment of payment arrangements may affect the comparability of this indicator's reported results.

Rent collected as a proportion of the rent charged in 2001-02 varied from 103.0 per cent in WA to 92.6 per cent in SA (table 16.14). Payment arrangements for rent in some jurisdictions mean that the rent collected over a 12-month period may be higher than rent charged over that period.

Figure 16.26 **Average State owned and managed Indigenous housing turnaround times[a, b, c, d, e, f]**



a Excludes dwellings undergoing major redevelopment. Before 2001-02, the denominator in the calculation of turnaround time was described as 'total number of dwellings that are vacated and subsequently tenanted for the year ending 30 June'. The intention of this data item was to count the number of vacancy episodes for all public housing dwellings. This clarification has been made to the 2001-02 data manual, however, as this counting rule was implemented in the 2000-01 data collection, this clarification should not affect data reported for turnaround time in the 2001-02 collection. For 2000-01, the indicator measured the number of times a dwelling was vacated and subsequently retenanted. For 1999-2000, the indicator measured the number of dwellings vacated and subsequently retenanted. **b** For NSW, 2000-01 data exclude 50 void properties with obvious date errors and 2001-02, data exclude 62 void properties with obvious date errors. **c** For Victoria, improved asset management influenced the result for 2000-01 as the amount of time a dwelling remains off line was minimised. **d** For Queensland for 2000-01, this was calculated according to the definition. The data item for 2000-01 was derived from tenancy information and did not distinguish between different vacancy types or contain information about the lead time of new dwellings to be occupied. Calculations using alternative data sources indicated that data limitations had only a minimal impact on the performance indicator. **e** This includes time vacant due to redevelopment in WA in 2001-02 that was excluded in 2000-01, influencing changes in results. **f** Some properties in SA undergoing redevelopment are included due to data coding errors.

Source: State and Territory governments (unpublished); table 16A.36.

Table 16.14 **Total rent collected for State and Territory owned and managed Indigenous housing dwellings as a proportion of total rent charged (per cent)[a]**

	NSW	*Vic*	*Qld*	*WA*[b]	*SA*	*Tas*	*Aust*
2000-01	99.3	99.5	99.1	101.1	95.0	94.8	98.8
2001-02	99.9	98.8	97.3	103.0	92.6	99.1	98.5

a Payment arrangements for rent in some jurisdictions mean that rent collected over a 12-month period may be higher than rent charged over that period. **b** These figures increased in 2000-01 as water consumption costs were retrospectively deducted from rent paid during 1999-2000. This deduction covered more than one year. While this deduction occurred for 2000-01, it only related to the one year.

Source: State and Territory governments (unpublished); table 16A.37.

Commonwealth Rent Assistance

Performance reporting for CRA is based on a new performance indicator framework for the 2003 Report. Data for CRA recipients are for clients of DFaCS only and are for the year to 30 June 2002. Data exclude those recipients paid rental assistance by, or on behalf of, the DVA or DEST. Data are collected centrally by Centrelink and DFaCS.

Effectiveness

Access

Access to CRA is measured by number and proportion of eligible income support recipients receiving the payment. Data are available both by type of income unit and type of payment received. This indicator also provides information on Indigenous recipients.

Commonwealth Rent Assistance is automatically paid once eligibility has been established. Important eligibility requirements are the receipt of an income support payment or more than the base rate of Family Tax Benefit Part A, and liability to pay rent. The only eligible clients who are not paid are those affected by recording errors or program errors.

There were 943 877 income units (where income units are analogous to family units with the distinction that non-dependent children and other adults living in the same household are treated as separate income units) receiving CRA at 30 June 2002 across Australia. Of these, over 21 535 (or approximately 2.3 per cent) self identified as Indigenous. Single people with no children represented approximately 38.8 per cent of CRA recipients and 30.7 per cent of Indigenous CRA recipients (table 16.15).

Nationally, the proportion of income units receiving CRA who identified as Indigenous was virtually identical to Indigenous representation in the overall community. The NT had the highest proportion of self identified Indigenous people receiving the payment (16.7 per cent) in 2002. This compared with the Indigenous proportion of the NT population of 28.6 per cent. Victoria had the lowest proportion of self identifying Indigenous people receiving the payment (0.6 per cent) (table 16.16).

Table 16.15 **Income units receiving CRA by income unit type, 30 June 2002**[a, b]

Benefit type	*Income units*	*Proportion of CRA recipients*	*Indigenous income units*	*Proportion of Indigenous CRA recipients*
	no.	%	no.	%
Single, no children	365 800	38.8	6 612	30.7
Single, no children, sharer	146 626	15.5	2 286	10.6
Single, 1 or 2 children	181 102	19.2	5 869	27.3
Single, 3 or more children	34 715	3.7	1 914	8.9
Partnered, no children	74 547	7.9	844	3.9
Partnered, 1 or 2 children	95 687	10.1	2 254	10.5
Partnered, 3 or more children	40 655	4.3	1 582	7.3
Partnered, illness separated, no children	2 078	0.2	36	0.2
Partnered, temporarily separated, no children	149	–	7	–
Unknown income unit	2 518	0.3	131	0.6
Total	**943 877**	**100.0**	**21 535**	**100.0**

a Data are for CRA recipients who were clients of DFaCS only. Data exclude those paid rent assistance by, or on behalf of, the DVA or DEST. Components may not sum to 100 per cent as a result of rounding. **b** An income unit is the basic unit used to determine eligibility for social security payments. Income units are analogous to family units with the distinction that non-dependent children and other adults living in the same household are treated as separate income units. Children are regarded as dependent until 16 years of age. Children aged 16–18 years may also be regarded as dependent if they are full time students, wholly or substantially dependent on another person and not in receipt of an income support payment. – Nil or rounded to zero.

Source: DFaCS (unpublished); table 16A.43.

Table 16.16 **Income units receiving CRA by Indigenous status and geographic location, 30 June 2002**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*[a]
Non-Indigenous										
Individual recipients	no.	309 122	200 219	229 073	84 708	63 725	22 094	8 282	4 885	922 342
In capital city	no.	170 209	143 441	100 717	65 444	50 241	9 690	8 270	3 402	551 413
In rest of State	no.	138 913	56 778	128 356	19 264	13 484	12 404	12	1 483	370 929
Share of all recipients	%	97.7	99.4	96.6	97.4	98.7	97.3	98.9	83.3	97.7
Non-Indigenous population, as a proportion of total population[b]	%	98.1	99.5	96.7	96.7	98.4	96.4	98.9	71.4	97.8
Indigenous										
Individual recipients	no.	7 423	1 258	8 052	2 248	861	610	93	976	21 535
In capital city	no.	1 957	620	2 274	1 191	555	220	93	481	7 391
In rest of State	no.	5 466	638	5 778	1 057	306	390	0	495	14 144
Share of all recipients	%	2.3	0.6	3.4	2.6	1.3	2.7	1.1	16.7	2.3
Indigenous population, as a proportion of total population[b]	%	1.9	0.5	3.3	3.3	1.6	3.6	1.1	28.6	2.2
Total individual recipients	no.	**316 545**	**201 477**	**237 125**	**86 956**	**64 586**	**22 704**	**8 375**	**5 861**	**943 877**

[a] National total includes postcodes that could not be classified. [b] Based on low series population projections (ABS 1999b).

Source: DFaCS (unpublished); table 16A.48.

Data are also available based on the type of primary payment received by CRA recipients. The highest proportion of CRA recipients (21.9 per cent) are recipients of the Newstart Allowance, followed by the Parenting Payment (Single), representing 20.1 per cent of CRA recipients. These proportions are higher for Indigenous Australians (at 32.9 per cent and 32.1 per cent respectively). Only 2.8 per cent of Indigenous CRA recipients receive the age pension, compared with 16.0 per cent for all Australians (table 16.17).

Table 16.17 **Income units receiving CRA by benefit type, 30 June 2002**[a]

Benefit type	*Income units*[b]	*Proportion of CRA recipients*	*Indigenous income units*	*Proportion of Indigenous CRA recipients*
	no.	%	no.	%
Newstart	206 317	21.9	7 085	32.9
Parenting Payment, Single	189 782	20.1	6 908	32.1
Disability Support Pension	162 048	17.2	3 315	15.4
Age Pension	151 120	16.0	596	2.8
Youth Allowance	90 741	9.6	1 268	5.9
Family Tax Benefit	81 179	8.6	1 335	6.2
Parenting Payment, Partnered	26 160	2.8	558	2.6
Other qualifying payments	36 530	3.9	470	2.2
Total	**943 877**	**100.0**	**21 535**	**100.0**

a Data are for CRA recipients who were clients of DFaCS only. Data exclude those paid rental assistance by or on behalf of the DVA or DEST. Components may not sum to 100 per cent as a result of rounding. **b** An income unit is the basic unit used to determine eligibility for social security payments. Income units are analogous to family units with the distinction that non-dependent children and other adults living in the same household are treated as separate income units. Children are regarded as dependent until 16 years of age. Children aged 16–18 years may also be regarded as dependent if they are full time students, wholly or substantially dependent on another person and not in receipt of an income support payment.

Source: DFaCS (unpublished); table 16A.45.

This year's Report includes a new 'low income' indicator showing income units receiving CRA broken down by quintiles of family income received per week. Among all income unit types, the bottom 20 per cent of CRA recipients have family income of $185.20 or less a week, while the top 20 per cent have family income in excess of $498.31 a week (table 16.18).

Among those income units paying enough rent to receive maximum CRA payments, the bottom 20 per cent of CRA recipients have family income of $185.20 or less a week, while the top 20 per cent have family income in excess of $552.20 a week (table 16A.44). Data for income units receiving maximum CRA payments and those not paying enough rent to receive maximum CRA payments are shown in table 16A.44.

Table 16.18 **Income units receiving CRA by quintiles of income at 30 November 2001 (all income units)[a, b]**

Income unit	*Income quintile (weekly family income received $)*			
	20 % of recipients	*40 % of recipients*	*60 % of recipients*	*80 % of recipients*
Single, no children	145.05	182.30	185.20	214.67
Single, no children, sharer	182.30	208.15	209.53	235.05
Single, 1 or 2 children	332.83	346.88	385.65	456.34
Single, 3 or more children	451.94	506.16	560.22	656.78
Partnered, no children	326.39	375.46	433.13	577.67
Partnered, 1 or 2 children	428.58	530.48	670.28	814.95
Partnered, 3 or more children	565.36	683.98	821.86	984.07
Partnered, illness separated, no children	403.24	422.55	453.30	530.10
Partnered, temporarily separated, no children	316.69	340.15	346.88	368.88
All income unit types	185.20	213.53	335.28	498.31

a Data are for CRA recipients who were clients of DFaCS only. Data exclude those paid rental assistance by or on behalf of the DVA or DEST. **b** An income unit is the basic unit used to determine eligibility for social security payments. Income units are analogous to family units with the distinction that non-dependent children and other adults living in the same household are treated as separate income units. Children are regarded as dependent until 16 years of age. Children aged 16–18 years may also be regarded as dependent if they are full time students, wholly or substantially dependent on another person and not in receipt of an income support payment.

Source: DFaCS (unpublished); table 16A.44.

A new 'special needs' indicator has been included to measure both access of special needs groups to CRA and the extent to which CRA assists with housing affordability. Overall, approximately 70.0 per cent of CRA recipients were located in capital city and other metropolitan areas, 28.2 per cent were in rural (as distinct from remote) areas and 1.6 per cent were in remote areas (table 16A.46). Of Indigenous CRA recipients, approximately 43.1 per cent were located in metropolitan areas, 45.8 per cent in rural (as distinct from remote) areas and 10.7 per cent were in remote areas (table 16A.47).

Affordability

The affordability measure provides information on the proportion of recipients who spend more than 30 and 50 per cent of their income on rent with and without CRA, disaggregated by Indigenous and rural and remote status. Nationally, if CRA was not payable, 32.4 per cent of those income units currently receiving CRA would have spent less than 30 per cent of income on rent at 30 November 2001. Across jurisdictions, this proportion ranged from 39.8 per cent in Tasmania to 28.3 per cent in the NT. Accounting for CRA (thereby reducing the rent paid by the amount of the assistance), the national proportion of income units who spent less than 30 per cent of income on rent increased to 66.9 per cent at 30 November 2001. Across jurisdictions, this proportion ranged from 78.7 per cent in Tasmania to 58.9 per cent in the ACT (figure 16.27).

Figure 16.27 **Recipients by proportion of income spent on rent with and without CRA, 30 November 2001**

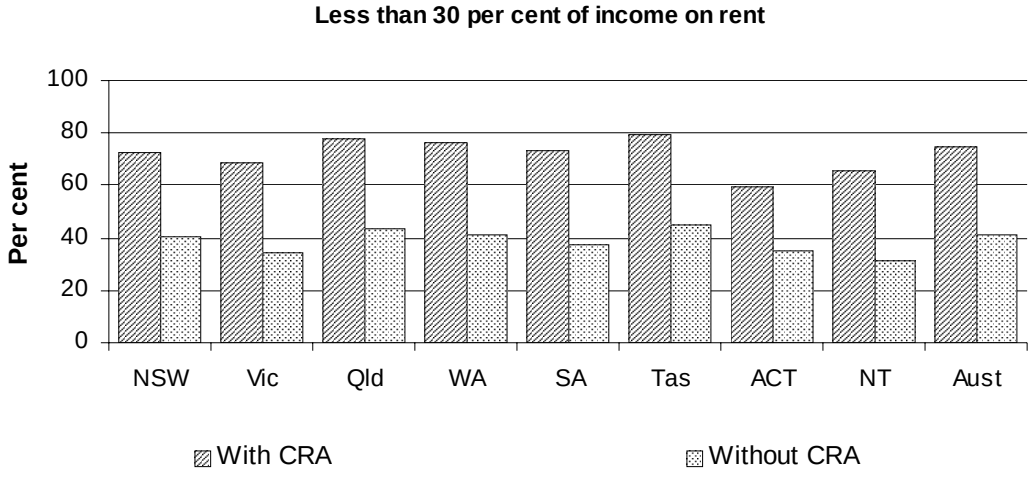
Source: DFaCS (unpublished); table 16A.49.

Similarly, if CRA was not payable, 73.8 per cent of income units across Australia would have spent less than 50 per cent of income on rent at 30 November 2001. Accounting for CRA payments, this proportion increases to 91.4 per cent (table 16A.49).

Data are also available on the proportion of income spent on rent with and without CRA by Indigenous Australians, Australians living in rural and remote areas, and disability support pension recipients. Nationally, if CRA was not payable, only

41.0 per cent of those Indigenous income units currently receiving CRA would have spent less than 30 per cent of income on rent at 30 November 2001. Across jurisdictions, this proportion ranged from 45.3 per cent in Tasmania to 31.3 per cent in the NT. Accounting for CRA payments (thereby reducing the rent paid by the amount of the assistance), the national proportion of Indigenous income units who spent less than 30 per cent of income on rent at 30 November 2001 increases to 74.7 per cent. Across jurisdictions, this proportion ranged from 79.5 per cent in Tasmania to 59.4 per cent in the ACT (figure 16.28).

Figure 16.28 **Indigenous recipients by proportion of income spent on rent with and without CRA, 30 November 2001**



Source: DFaCS (unpublished); table 16A.50.

Similarly, if CRA was not payable, 79.7 per cent of Indigenous income units across Australia would have spent less than 50 per cent of income on rent at 30 November 2001. Accounting for CRA payments, this increases to 94.5 per cent (table 16A.50).

If CRA was not payable, 24.8 per cent of disability support pension recipients across Australia would have spent less than 30 per cent of income on rent at 30 November 2001. Across jurisdictions, this proportion ranged from 32.3 per cent in Tasmania to 19.1 per cent in the NT. Accounting for CRA payments, the national proportion of disability support pension recipients spending less than 30 per cent of income on rent at 30 November 2001 increases to 71.3 per cent. Across jurisdictions this proportion ranges from 83.7 per cent in Tasmania to 62.9 per cent in the NT (figure 16.29).

Similarly, if CRA was not payable, 73.5 per cent of disability support pension recipients across Australia would have spent less than 50 per cent of income on rent

at 30 November 2001. Accounting for CRA payments, this increases to 94.0 per cent (table 16A.51).

Figure 16.29 **Disability support pension recipients by proportion of income spent on rent with and without CRA, 30 November 2001**

Source: DFaCS (unpublished); table 16A.51.

For the first time this year, the Report contains indicators of the satisfaction of CRA recipients with both the location and quality of their housing. Data are obtained from the most recent DFaCS customer survey conducted in 2000. Results are based on 477 responses from those individuals paying enough rent to qualify for CRA and receiving a relevant primary payment type.

Overall, 79 per cent of respondents described their location as 'good' or 'great', while only 5 per cent described the location as 'poor'. Regarding the quality of their housing, 75 per cent of respondents described their housing as 'good' or 'great' and only 4 per cent as 'poor' (table 16.19).

Table 16.19 **Satisfaction with location and quality of housing, 2000 (per cent)[a]**

Thinking about the location of the place you live in, would you say it is:			
Poor	Just OK	Good	Great
5	16	48	31
Thinking about the quality of the place you live in, would you say it is:			
Poor	Just OK	Good	Great
4	21	49	26

a Includes responses by individuals paying enough rent to qualify for CRA and receiving a relevant payment type. CRA may not be payable, or may be paid to a partner.

Source: DFaCS (unpublished); table 16A.57.

Reporting of the 'geographic spread of CRA customers' indicator has changed this year, with the indicator now relating to CRA recipients as a proportion of income units in each capital city receiving a social security income support benefit or more than the base rate of Family Tax Benefit. Results are shown in tables 16A.58 to 16A.66.

Information on the average CRA entitlement across locations is contained in table 16A.56.

Appropriateness

This chapter reports on two indicators of appropriateness:

- the proportion of CRA recipients receiving the maximum rate of CRA (by jurisdiction and payment type); and
- the number and outcome of appeals.

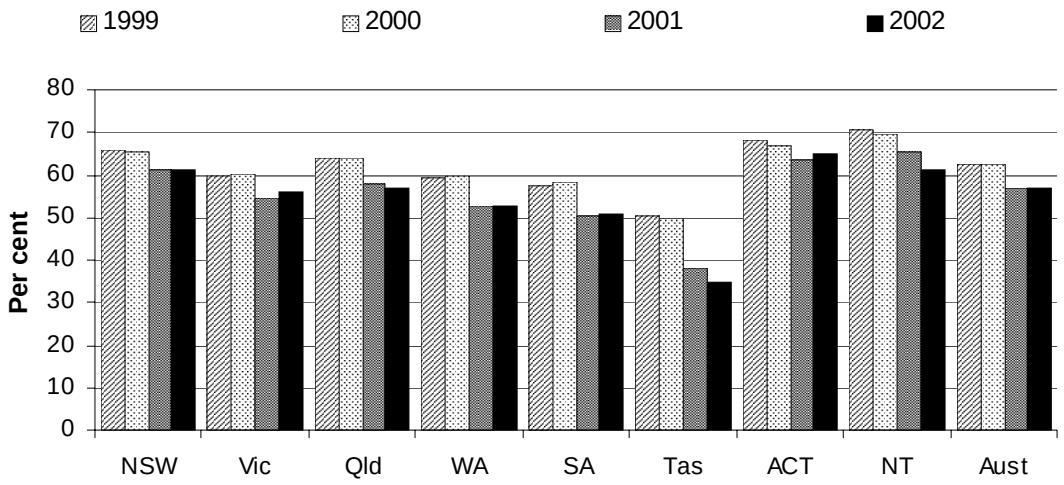
Maximum rate

One way of measuring the appropriateness of CRA provision is to consider the proportion of recipients receiving the maximum rate of CRA. A high proportion of recipients receiving maximum assistance may suggest that too much assistance goes to those paying moderate rents or that the maximum rate of assistance is too low.

At 30 June 2002, 56.9 per cent of CRA recipients across Australia qualified for the maximum rate of CRA payments. This varied from 65.1 per cent in the ACT to 34.9 per cent in Tasmania. The proportion of income units receiving the maximum rate of CRA has fallen over time. In June 1999, 62.7 per cent of CRA recipients qualified for the maximum rate of CRA payments (figure 16.30).

Data showing the proportion of CRA recipients qualifying for maximum CRA payments by the type of primary payment received are in table 16A.52.

Figure 16.30 **Proportion of income units receiving CRA paying enough rent to receive maximum assistance[a, b, c]**



a Data are for CRA recipients who were clients of DFaCS only. Data exclude those paid rental assistance by, or on behalf of, the DVA or DEST. **b** An income unit is the basic unit used to determine eligibility for social security payments. Income units are analogous to family units with the distinction that non-dependent children and other adults living in the same household are treated as separate income units. Children are regarded as dependent until 16 years of age. Children aged 16–18 years may also be regarded as dependent if they are full time students, wholly or substantially dependent on another person and not in receipt of an income support payment. **c** Proportion of income units with ongoing entitlement to CRA paying enough rent to receive maximum assistance.

Source: DFaCS (unpublished); table 16A.53.

Number and outcome of appeals

There is a formal review process for decisions related to the payment of CRA. Clients who are dissatisfied with a decision are encouraged to discuss the matter with the original decision maker before taking the matter further, although this is not a necessary step. Authorised review officers conduct a quick and informal internal review of the decision. Generally, customers who are dissatisfied with the authorised review officer's decision can appeal to the Social Security Appeals Tribunal. The Tribunal is an independent body with decision making powers. Either the customer or DFaCS can seek a further review of tribunal decisions by the Administrative Appeals Tribunal.

There were 267 finalised appeals to an authorised review officer in 2001-02, which represent approximately 0.03 per cent of people receiving CRA. Approximately 59.9 per cent of finalised appeals to an authorised review officer and 51.1 per cent of finalised appeals to the Social Security Appeals Tribunal led to the original decision being affirmed. In the case of the Administrative Appeals Tribunal, three finalised appeals led to the original decision being set aside (table 16.20).

Table 16.20 **Outcome of all CRA appeals finalised in 2001-02[a]**

Outcome	*Appeals to ARO*		*Appeals to SSAT*		*Appeals to AAT*	
	no.	%	no.	%	no.	%
Original decision affirmed	160	59.9	23	51.1	1	25.0
Original decision set aside	63	23.6	10	22.2	3	75.0
Original decision varied	42	15.7	4	8.9	0	0.0
Appeal withdrawn/dismissed	2	0.7	8	17.8	0	0.0
Total finalised	**267**	**100.0**	**45**	**100.0**	**4**	**100.0**

a ARO = Authorised Review Officer; SSAT = Social Security Appeals Tribunal; AAT = Administrative Appeals Tribunal. Totals may not add to 100 as a result of rounding.

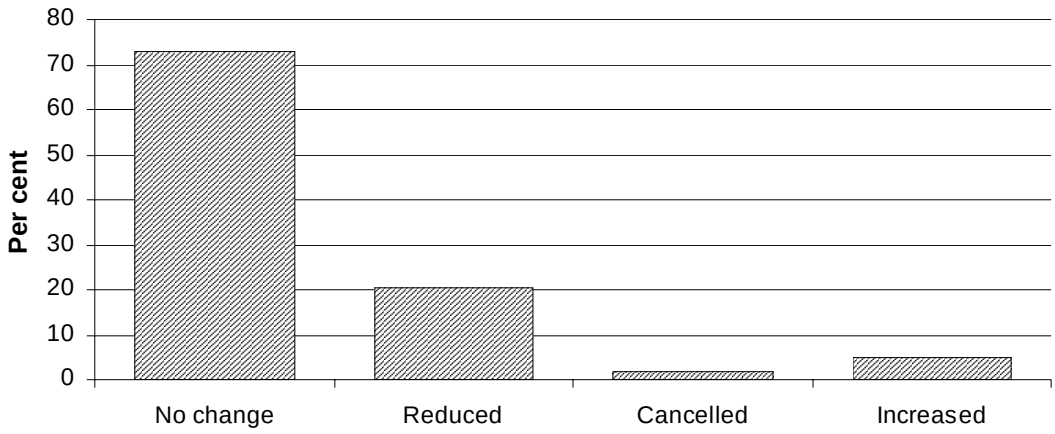
Source: DFaCS (unpublished); table 16A.54.

Efficiency

It has not been possible to report two of the three efficiency indicators for CRA (running costs per 1000 customers and ratio of running costs to total outlays) this year as data are not available. Data are available for the control of overpayment indicator.

Centrelink relies on risk-based review activities to control overpayment, some of which are targeted at CRA. In total, Centrelink conducted 104 648 risk-based reviews relating to CRA in 2001-02. In 1.6 per cent of cases, CRA was cancelled, in 20.4 per cent of cases it was reduced and in 5.1 per cent of cases it was increased. For the majority of cases (72.9 per cent), there was no change (figure 16.31).

Figure 16.31 **CRA payments adjustments resulting from a risk-based review, 2001-02**



Source: DFaCS (unpublished); table 16A.55.

16.5 Future directions in performance reporting

Further developing indicators and data

As the housing chapter data are already extensive, much of the work being undertaken is around filling the gaps in the data and improving reliability and comparability across jurisdictions. Work on improving the quality and comparability of data collected will continue, particularly for community housing. Improved financial reporting for the community housing sector is a high priority.

Improved reporting on housing provision to Indigenous Australians continues to be a priority, with work to be done over the next year to improve data availability on Indigenous Australians accessing public and community housing. Work will also be done to improve reporting on both State and Territory owned and managed Indigenous housing and the Indigenous community housing sector.

16.6 Jurisdictions' comments

This section provides comments from each jurisdiction on the services covered in this chapter. Appendix A contains data which may assist in interpreting the performance indicators presented in this chapter. These data cover a range of demographic and geographic characteristics, including age profile, geographic distribution of the population, income levels, education levels, tenure of dwellings and cultural heritage (including Indigenous and ethnic status).

Commonwealth Government comments

“ The Commonwealth negotiated a more comprehensive performance reporting framework with the States and Territories under the 1999 CSHA. The *Report on Government Services* covers the core of national performance information, but reporting under the CSHA goes beyond this and includes in-depth evaluation, much of it qualitative rather than quantitative, of specific initiatives at the jurisdiction level. The format of the *Housing Assistance Act Annual Report* has been modified to reflect this change in approach.

A new performance indicator framework for Rent Assistance has been introduced this year, which includes additional information relating to customer satisfaction with the standard and location of their housing, and low income/special needs customers. The geographic spread of Rent Assistance customers has also been refined and is provided in a mapped form.

Rent Assistance performance information is reported separately from public and community housing performance information. In addition, the indicators need to be interpreted with some caution as Rent Assistance is paid as a supplement to other income support payments, which have their own objectives.

Rent assistance is provided as a financial supplement and has the flexibility to cope with changing demand and to provide customers with more choice about where they live and the quality of their housing. This choice can involve a tradeoff with the consumer’s after-housing income. Therefore, it is important to recognise that the rent assistance program has no specific benchmark for affordability.

The adoption of an affordability benchmark would fail to recognise the element of choice exercised by customers who place a higher value on housing than others in comparable circumstances.

As ARHP funds of $91 million a year are used for State/Territory managed and Indigenous community managed housing, indicators that provide information on both sectors are needed. The Commonwealth provided an additional $75 million over four years for Indigenous housing and housing related infrastructure in the 2001-02 Budget. As part of the initiative, the Commonwealth requires improved accountability, focusing on outcomes, for all Commonwealth Indigenous-specific housing funds (ARHP and CHIP). ATSIC and FaCS, in consultation with State and Territory governments, have prepared a Common Reporting Framework (CRF) to assist in the development of State, Territory and ATSIC Indigenous housing strategic plans and performance reports. The CRF is based on *Building a Better Future: Indigenous Housing to 2010* and contains national Indigenous housing minimum data set items developed by the Standing Committee on Indigenous Housing. Common reporting will give a more complete, national picture of the progress being made to improve housing for Indigenous people. ”

New South Wales Government comments

“ Pressures on the availability of affordable housing for low to moderate income households in Sydney in particular have continued through 2001-02. Strong growth in housing prices in Sydney and coastal NSW has continued, along with a surge in new construction of both houses and flats. Rental vacancy rates have been relatively high in much of 2002. As a result, median rent levels for both houses and flats have stagnated or fallen for relatively higher-cost housing in the inner and middle rings of Sydney. In contrast, rents for both houses and flats in traditionally lower-cost areas of outer Sydney have continued to increase.

In this context, demand for housing assistance remains high. In 2001-02 the NSW Department of Housing introduced a number of new housing assistance products that will provide people with more options for meeting their housing needs, both in the private rental market and through home purchase. These products will be introduced progressively over the next three years.

The department has completed condition audits of all of its properties and has increased expenditure in 2001-02 on maintenance, upgrading and the Accelerated Improvement Program. This may have made some tenants more aware of some of the problems with their homes that the Department has not yet been able to address, contributing to a fall in customer satisfaction to 66 per cent in 2001. The department is continuing to give priority to asset strategies to improve client satisfaction with maintenance and condition of home. These asset strategies are being complemented by the implementation of the Estates Strategy and other community renewal work to strengthen public housing communities, including employment and training programs, trials of e-communities and internet café projects, and funding to community groups for tenant participation activities.

NSW has continued to achieve effective results in targeting assistance to those most in need. Of all new tenancies in 2001-02, 97 per cent were in the lowest income category or had special needs and 51 per cent were special needs households. NSW achieved an occupancy rate of 98.1 per cent at 30 June 2002, and the turnaround time for re-letting vacant stock was 30 days—a 7 per cent reduction from the previous year.

In 2001-2002, for the first time, the department has been able to provide an estimate, based on 2001 Census figures, of the number of Indigenous households in mainstream public housing — 8 700 (almost 7 per cent).

In community housing, overall tenant satisfaction is above the national average at 78 per cent, and tenant satisfaction with the amenity and location of their homes was even higher at 79 per cent and 85 per cent respectively. ”

Victorian Government comments

“ In Victoria the housing market has continued to experience increases in property prices and reduced availability of affordable housing. This has placed further pressure on low income households in the private rental sector, particularly in metropolitan areas of high demand. There has been a consequent decrease in the number of households exiting public housing, restricting the number of units available for new housing allocation.

The Victorian social housing sector expanded to 75 344 units at June 2002. This was despite property price increases and an environment of declining CSHA funds. This has been possible due to additional funds of $94.5 million over the three budget years to June 2003 and through equity contributions by non-government organisations in the provision of social housing.

In an environment of increasing demand and moderate housing growth, Victoria has responded to clients in greatest need of housing assistance, particularly homeless clients. This is reflected in the high proportion (60 per cent) of allocations to ‘greatest need’ clients and significant expansion of the transitional housing sector. Strategic leasing of stock in high demand areas has also been an important contributor to improved outcomes for clients.

Community building in areas of social and economic disadvantage continues to be a priority, in regional Victoria and inner city high rise estates. Many such areas have high concentrations of public housing, which are increasingly impacted by the housing of high need clients. Neighbourhood Renewal initiatives to tackle these issues include upgrading housing and the local environment, linked to employment and training programs, improved access to local and support services and increased community participation and decision making.

In order to maintain an aging public housing stock and support community renewal initiatives, Victoria has increased expenditure on property improvements and upgrades by 7 per cent to $162m in 2001-2002, resulting in major upgrades to 2 984 properties and significant fire and safety works. Additionally $25 million has been spent on redevelopment of existing stock, an increase of 34 per cent over the previous year.

Victoria has a positive performance against CSHA performance indicators and maintains its position as the State with the lowest recurrent operating cost per dwelling. Further development of performance indicators for the community housing sector has been undertaken in 2001-02. Victoria conducted for the first time the Community Housing Survey for long term community housing providers and expects coverage to expand to all agencies in 2002-2003. Development of integrated information systems to support a range of social housing providers is currently a major focus. ”

Queensland Government comments

“ The Queensland Department of Housing is committed to achieving the Government’s vision of equitable access to high standards of housing for all Queenslanders. The department is increasingly working in partnership with communities, other levels of government, other Queensland Government agencies and the private sector to deliver improved housing outcomes through integrated, client-focused programs.

Considerable effort has been devoted to addressing the challenges to the long term viability and effectiveness of traditional housing solutions. The Department continues to make a real difference to people’s lives through its assistance programs with:

- assistance to more than 58 000 households in public rental and Aboriginal and Torres Strait Islander housing; and
- funding to community organisations provided to assist over 120 000 households with accommodation, tenancy advice and minor home modifications.

As well as these traditional forms of assistance, innovative responses to the diverse housing needs of Queenslanders include the development of the Brisbane Housing Company, the continuing joint work with the Queensland University of Technology on the Kelvin Grove Urban Village and the completion of the Rockhampton Research House.

The Department’s efforts in collaborative work and community engagement over this past financial year have resulted in some significant achievements. In particular, the two bilateral agreements for mainland Queensland and the Torres Strait region and the implementation of the Thursday Island Redevelopment Project are practical examples of what strong working relationships can achieve.

The department also undertook significant work to prepare a new legislative framework that will recognise its role in delivering traditional forms of housing assistance but will also facilitate finding new ways to meet the housing needs of Queenslanders. In addition, the Government endorsed the preparation of a State Planning Policy for Affordable Housing and Residential Development after public consultations on the options available to promote affordable housing planning and delivery.

The department is well placed to pursue innovative, collaborative housing outcomes for Queenslanders. ”

Western Australian Government comments

“Since July 2001, the State Housing Commission has operated as part of the Department of Housing and Works, which was formed in accordance with the recommendations of the Machinery of Government Taskforce Review. During the year significant progress was made on the department’s housing and related programs such as ‘New Living’ estate redevelopment, the deinstitutionalisation strategy, the State Homelessness Strategy, provision of bond assistance for private renters, home ownership and the employment of Indigenous people.

The New Living program refurbished 623 dwellings, with 206 being retained as rental stock. The ‘New North’ project, which forms part of this program, won the UDIA WA 2001 Award for Excellence.

Under the deinstitutionalisation strategy, 56 purpose-built mobility homes were completed and 23 were purchased from the private sector. Bond assistance remains a popular option with customers and the real estate industry. A total of 15 254 bond assistance loans were approved during the year.

Homelessness remains a high priority and in May 2001 a Homeless Help Line, with a free call access point for homeless people, was made available. The high demand for the service has resulted in the facility being made permanently available. During the year, the Help Line received 2082 calls, resulting in 936 people in need being assisted through bond assistance, rental assistance in public housing, and via the Crisis Accommodation Program.

Home ownership continued to be a high priority and Government-backed loan schemes helped 3998 Western Australian households with home finance, providing 843 loans for building new homes and 3155 to buy existing homes. The effect of these loan approvals is an injection of $372.2 million into the State’s housing industry. They assist low-income people who would otherwise have difficulty obtaining a mortgage to achieve home ownership and reduce the call on limited low-price rental stock.

The housing procurement program for the year delivered:

- the completion of 943 dwellings for the rental program;
- an additional 99 dwellings for Aboriginal families;
- commencement of 88 dwellings for Community Housing, which included a major program to construct Women’s Refuges in the north of the State;
- refurbishment of 477 older properties; and,
- the conversion of bedsitter accommodation into 49 one-bedroom units.

In order to meet measures of fairness and equity, housing policies are continually reviewed. During the year changes were made to priority assistance, tenancy management and tenant liability policies. To enable customers to access up-to-date policy information and to keep abreast of changes, policies are available on the Department of Housing and Works Internet site. The address is www.dhw.wa.gov.au”

South Australian Government comments

“ SA has a significant investment in its social housing sector. According to Census 2001 public housing accounted for approximately 7.7 per cent of SA households, with community housing accounting for 0.7 per cent of households. The Indigenous housing sector is also strong with the Aboriginal Housing Authority managing 1798 properties at the end of June 2002.

During 2001-02, the three social rental housing agencies, the South Australian Housing Trust (SAHT), Aboriginal Housing Authority (AHA) and the South Australian Community Housing Authority (SACHA), joined with HomeStart Finance to form the Housing Management Council within the Human Services portfolio. These new administrative arrangements will ensure that housing issues are given prominent attention within the new portfolio structure.

While each of the social housing agencies continue to target housing resources to those in greatest need, the impacts of this policy on financial and organisational sustainability and community stability are becoming apparent.

During the year, the independent Triennial Review of the SAHT was undertaken in accordance with the SAHT Act. The review found that the SAHT was an effective and cost efficient housing provider. However, the review noted the pressures placed upon the SAHT as a result of ongoing reductions in funding through the Commonwealth State Housing Agreement, increasing rental rebates due to targeting to those in greatest need, increased costs associated with managing a more complex customer base and the high costs of managing and maintaining aged assets.

The AHA worked during the year to ensure that its programs are in line with the Australian Housing Ministers’ 10-year Statement of New Directions for Indigenous Housing — ‘Building a Better Future — Indigenous Housing to 2010’. The fundamental principles behind this approach are to work with Aboriginal communities in developing a sustainable and accountable Aboriginal housing sector that addresses housing need and empowers the Aboriginal community in South Australia. The range of housing programs managed by AHA include a statewide housing rental program, a community housing program in rural and remote areas and a home ownership program.

SACHA, through its funding and regulation of the community housing sector, continues to play an important role in supporting the provision of housing and supports for particularly vulnerable population groups, in partnership with a range of community housing organisations and service agencies. This assists the continuing de-institutionalisation of people with disabilities and older people, and is providing stable accommodation for people with long histories of homelessness. Joint ventures with local government and support agencies and fostering partnerships with key stakeholders are key to the success of these programs. ”

Tasmanian Government comments

“ Housing Tasmania continues to contribute to improved health and well-being outcomes for people on low incomes through a range of housing programs. These include public, community and Aboriginal housing, home ownership assistance, ongoing support for private renters on low incomes, and community capacity building initiatives in areas with high proportions of public housing. As the private rental sector in Tasmania has tightened, demand for public rental housing has steadily increased during the past year, reducing opportunities for low income renters to secure affordable housing.

In partnership with Mission Australia (Mission Employment), Housing Tasmania has implemented a key community development strategy which seeks to link employment opportunities with positive housing outcomes by providing traineeship opportunities for long term unemployed Tasmanians who live in, or in close proximity to, broadacre public housing areas. These projects proved extremely successful, with 60 percent of participants obtaining full-time employment at the conclusion of the program.

To support strategic decision making relative to Housing Tasmania’s asset portfolio, a comprehensive analytical tool has been developed to inform continued realignment of social housing stock. The Asset Decision Model was developed and reviewed during 2001-02, and provides the basis for consistency in asset retention / disposal decisions.

Tasmania has an ageing population, higher levels of unemployment and lower average household income, compared to other jurisdictions. The division is therefore developing strategies to improve the range of safe, adequate and affordable housing options for an increasingly diverse client group.

One initiative, GET*Smart* Homes aims to incorporate requirements for adaptable housing (housing suitable for people with disabilities), sustainable design principles, and affordable living as developed by the Australian Greenhouse Office. The GET*Smart* Homes program constructs homes that are well located, require low maintenance, are durable and energy efficient, and, most importantly, are suitable for a wide range of client groups — particularly the elderly and people with disabilities.

Development of an affordable housing strategy for the State will continue to build on existing links between all tiers of government and the community sector and private industry, ensuring a whole-of-system approach.

A highly decentralised stock with higher maintenance costs and other cost disadvantages, as well as locally based service delivery, contributes substantially to the administrative overheads per unit of public rental stock in Tasmania being one of the highest in the nation. In order to ameliorate these cost disadvantages, Housing Tasmania continues to review all areas of its business to ensure programs and services are delivered in the most efficient and effective manner possible. It is unlikely that the figure will ever conform closely to the national average. ”

Australian Capital Territory Government comments

“ The ACT has a relatively high proportion of public housing stock (10 per cent compared to the national average of around 5 per cent) and a relatively small proportion of affordable housing in the private rental market. The high total net cost per dwelling in part reflects the high cost of land in the ACT, the fact that there is a concentration of housing dwellings in the inner city and no cheaper, rural stock to bring the ACT average cost down. Much of the stock is also in poor condition, with many large flat complexes being over 40 years old.

An Affordable Housing Task Force has been convened to examine the issues and to recommend strategies across the Government, non-government and private sectors for the provision of affordable housing. The Task Force is due to report in December 2002.

The rejuvenation and restructuring of the ACT’s public housing stock has again been a high priority in 2001-02. The redevelopment and upgrading processes is partly funded from the proceeds of asset sales and, as a result, there will be a modest reduction in stock levels in the forward years. The requirement to use this source of funding is a consequence of the continued decline in funding under the 1999 CSHA, as well as of internalising the cost of rental rebates.

The ACT has housed, as a priority, those in greatest need. Of all new allocations, 84.5 per cent were to households in the greatest need category. The ACT focus on quality service provision is intended to support those households to obtain relevant support, connect with appropriate networks and to maintain their tenancies. Program initiatives such as the Housing Manager Specialists and the Community Linkages Program are tools to assist ACT households to sustain their tenancies.

The community housing sector is relatively small in the ACT, though it is expanding. The ACT Government has held extensive community consultations as the basis for the development of a framework for community housing. The process has involved the sector in discussions on standards, accreditation, regulatory frameworks and appeals mechanisms. The Government has funded a peak body for community housing organisations (Coalition of Community Housing Organisations of the ACT).

The ACT does not receive any ARHP funding. However the ACT Government is working with ATSIC and the Commonwealth Government to develop a Trilateral Agreement on Indigenous Housing for the provision of culturally appropriate housing for Indigenous people in the ACT. A viability study exploring Indigenous housing options is currently underway. ”

Northern Territory Government comments

“ The Northern Territory Government provides secure, affordable housing as a key component of a collective, cooperative response to the diverse range of housing needs of Territorians. In the third year of the Commonwealth State Housing Bilateral Agreement 1999–2003 many accomplishments have been achieved against the strategies and objectives, including:

- construction of a seniors' village specifically designed and constructed to meet the needs of senior Territorians;
- provision of funding to community organisations enabling them to pursue housing options to meet the needs of people with disabilities;
- the introduction of a Security Screening Policy, which will increase the safety and security of all public housing dwellings by raising standards to include security screening;
- provision of funding to implement a targeted project to address itinerancy in the Darwin area;
- provision of urban living skills programs designed to increase the success rate of indigenous tenants moving to urban areas from rural communities;
- further reduction of wait times in most areas for public housing tenants; and
- provision of consultative forums with the community, progressing work on key priorities.

The NT Government delivers housing assistance to Indigenous people through its partnership with the Indigenous Housing Authority of the Northern Territory (IHANT) and through improving access for Indigenous people to public housing in urban and rural centres (approximately a quarter of public housing tenants are Indigenous). Information in this Report does not include the NT Government's commitment to the provision of housing and related infrastructure to Indigenous communities, delivered by IHANT.

Under an agreement that pools available Indigenous housing funding to IHANT, ARHP contributed 47 percent of IHANT's funding in 2001-02. Using a needs model as a basis for allocations under its Construction Program, IHANT allocates funds to the seven ATSIC Regional Councils in the Territory, who in turn make allocations to those communities most in need. During 2001-02 the IHANT Construction Program oversaw the construction (and/or major refurbishment) of 241 houses, thereby providing better housing for 2 000 Indigenous people.

Other than Indigenous community-delivered housing, the community housing sector is extremely small in the NT. The NT's emphasis for community housing is to continue to encourage the development of flexible housing provider models, particularly targeting the provision of specific, unmet housing needs. ”

16.7 Definitions

Public, community and State and Territory owned and managed Indigenous housing

Table 16.21 **Terms**

Term	*Definition*
Administration costs	Those costs associated with the administration offices of the property manager and tenancy manager. They include the general accounting and personnel function costs relating to: • employee expenses (for example, superannuation, compensation, accrued leave, training); • supplies and services expenses (including stationery, postage, telephone, office equipment, information systems and vehicle expenses); • rent; • grants and subsidies (excluding rental subsidies); • expenditure incurred by other government agencies on behalf of the public housing agency; and • contracted public housing management services.
Affordability	The level of housing affordability within the public housing, community or State and Territory owned and managed housing sectors, measured as the rent charged as a proportion of the market rent for each dwelling (adjusted for CRA).
Amenity/location	The amenity of public, community or State and Territory owned and managed housing stock, measured as the percentage of tenants expressing different degrees of satisfaction in relation to the amenity and location of their dwelling.
Appropriate	The size of a dwelling, or the number of bedrooms a household is deemed to require based on the number of adults and children residing in it, as determined by the proxy occupancy standard (table 16.3).
Assessable income	The income used in the assessment of eligibility for housing assistance and to calculate the rental housing rebate that allows the household to pay a rent lower than the market rent. Actual definition may vary across jurisdictions.
Community housing rental dwelling	Includes properties covered by the Commonwealth State Housing Agreement. Excludes properties for which the tenancy management functions are undertaken and administered under the Public Rental Housing Program, the Aboriginal Rental Housing Program or transitional/emergency accommodation for people who are homeless and in crisis (Crisis Accommodation Program).
Customer satisfaction	The percentage of customers expressing different degrees of satisfaction in relation to various service aspects of their dwelling.
Depreciation costs (as per the Australian Accounting Standards 13–17)	Depreciation calculated on a straight-line basis at a rate that realistically represents the useful life of the asset.
Direct costs	Total administration costs and costs of maintaining the operation of dwellings.

(Continued on next page)

Table 16.21 **(Continued)**

Term	*Definition*
Disability (as per the ABS Survey of Disability Ageing and Carers)	Any restriction or lack of ability (resulting from an impairment) to perform an action in the manner or within the range considered normal for a human being.
Dwelling	For the purpose of the public, community and State and Territory owned and managed Indigenous housing collections, a dwelling equals a tenancy (rental) unit. A tenancy (rental) unit is defined as the unit of accommodation to which a tenancy agreement can be made. A tenancy (rental) unit is a way of counting the maximum number of distinct rentable units that a dwelling structure can contain. A dwelling structure can be a house, townhouse, duplex, flat or boarding/rooming house.
Greatest need	Low income households that at the time of allocation were subject to one or more of the following circumstances: • homelessness; • their life or safety was at risk in their accommodation; • their health condition was aggravated by their housing • their housing was inappropriate to their needs; or • they had very high rental housing costs.
Household	For the purpose of the public, community and State and Territory owned and managed Indigenous housing collections a household equals a tenancy agreement. Counting the number of tenancy agreements is the proxy for counting the number of households. A tenancy agreement is defined as a formal written agreement between a household (a person or group of people) and a housing provider specifying details of a tenancy for a particular dwelling.
Income unit	One person or a group of related people within a household who share command over income. The allowable relationships in the definition of income unit are restricted to marriage (registered or *de facto*) and parent and dependent child who usually reside in the same household. Operationally, an income unit is: • a married couple (registered or *de facto*) or sole parent, and dependent children only; or • married couple only (registered or *de facto*) with no dependent children present; or • a person in a private dwelling who is not related to any other household member either by marriage (registered or *de facto*) or by a parent/dependent child relationship. (Defined differently for CRA).
Indigenous household	A household with one or more members (including children) who identify as Aboriginal and/or Torres Strait Islanders.

(Continued on next page)

Table 16.21 **(Continued)**

Term	*Definition*
Low income household	A household whose members are assessed as having a low income according to the following definitions. Households are assigned an income status based on total household gross income and the composition of the household. • 'low income A' households are those in public housing for which all household members have incomes at or below the maximum pension rate. • 'low income B' households are those in public housing that have incomes that would enable them to receive government income support benefits below the maximum pensioner rate.
Maintenance costs	Costs incurred to maintain the value of the asset or to restore an asset to its original condition. The definition includes: day-to-day maintenance reflecting general wear and tear; cyclical maintenance, performed as part of a planned maintenance program; and other maintenance, such as repairs as a result of vandalism.
Market rent	Aggregate market rent that would be collected if the public rental housing properties were available in the private market.
Match of dwelling and household size	The percentage of households where dwelling size is inappropriate, calculated as the percentage of occupied public, community or State and Territory owned and managed Indigenous housing dwellings with overcrowding based on the following definition of *overcrowding:* two or more additional bedrooms are required to satisfy the proxy occupancy standard. To derive the number of households in this category, every household is assigned a proxy occupancy status based on the size of the dwelling — that is, the number of bedrooms; the number of adults; the number of children; and the family relationships of household members.
New household	Households who commenced receiving assistance for the financial year and were waitlist type 'new applicant/household.
Occupancy rate	The use of rental housing stock as measured by the occupancy rate of the stock, where 'occupied' is defined as tenantable dwellings occupied by tenants who have a public housing tenancy agreement with the relevant State housing authority.
Occupied dwelling	Any structure that people actually live in regardless of its intended purpose. The structure may or may not be tenantable.
Overcrowding	Where two or more additional bedrooms are required to meet the proxy occupancy standard.
Priority access to those in greatest need	Allocation processes to ensure those in greatest need have first access to housing. This is measured as the proportion of new allocations to those in greatest need in the following timeframes: • under three months; • three months to under six months; • six months to under one year; • one year to less than two years; • two years or more; and • total.

(Continued on next page)

Table 16.21 **(Continued)**

Term	*Definition*
Proportion of income paid in rent	A measure of housing affordability within the public, community or State and Territory owned and managed Indigenous housing sectors, calculated as the percentage of assessable household income spent on housing costs — that is, the number of rebated public rental households (or community housing households) paying X per cent of assessable income on rent at 30 June, divided by the total number of rebated public rental households (or community housing households) occupying public (or community) housing, multiplied by 100. 'X' is defined as: • 0–20 per cent; • 21–25 per cent; • 26–30 per cent; or • greater than or equal to 31 per cent. Previously reported as a performance indicator.
Proxy occupancy standard	The standard used to determine overcrowding/underuse. The standard used in the public and community housing collections is based on the Canadian model. (For further discussion on measuring household bedroom requirements, see Foard, *et al*. 1994).
Public rental dwelling	Includes only public rental properties covered by the Commonwealth–State Housing Agreement. Excludes properties administered under Community Rental Housing, the Aboriginal Rental Housing Program or transitional/emergency accommodation for people who are homeless and in crisis (Crisis Accommodation Program—CAP).
Relocated household	Households, either rebated or market renters, who relocate (transfer) from one public or community rental dwelling to another public or community rental dwelling.
Rent arrears	Total rent actually collected as a percentage of total rent charged.
Rent charged	The amount in dollars that households are charged based on the actual rents they are expected to pay. The rents charged to tenants may or may not have been received.
Rent collected	The actual rent received from tenants.
Special needs household	A household that has a member(s) with a disability, a principal tenant aged either 24 years or under or 75 years or more (50 years or more for State and Territory owned and managed Indigenous housing) or, except for State and Territory owned and managed Indigenous housing, a household defined as being Indigenous.
Special needs but not low income household	Where a household member(s) has a special need but the household income is assessed as not being 'low income' according to a household income cut-off value.
Tenantable dwelling	Dwellings where maintenance has been completed, whether occupied or unoccupied at 30 June. All occupied dwellings are tenantable.
Tenant or tenant household	The usual members of a household occupying a public, community or State and Territory owned and managed Indigenous housing dwelling where there is a tenancy agreement with the housing authority. A tenant household either receives rebated assistance or pays the market rent as determined by the agency.

(Continued on next page)

Table 16.21 **(Continued)**

Term	*Definition*
Total gross household income	The value of gross weekly income from all sources (before deductions for income tax, superannuation etc.) for all household members expressed as dollars per week. The main components of gross income are current usual wages and salary, income derived from self employment, government pensions, benefits and allowances, and other income comprising investments and other regular income.
Turnaround time	The time taken to use vacant stock.
Underutilisation	Where there are two or more bedrooms additional to the number required in the dwelling to satisfy the proxy occupancy standard.
Untenantable dwelling	Dwellings not currently occupied by a tenant where maintenance has been either deferred or not completed at 30 June.
Waiting list applicant	A household that has applied for public, community or State and Territory owned and managed Indigenous housing assistance and is deemed eligible but has not yet received the assistance. Includes current public housing tenants who are applicants for assistance other than that currently received (for example, transfer applicants).
Waiting list — total number of households on waiting list	The total number of applicants on the tenant manager/agency's waiting list at 30 June. The waiting list population refers to applicants who at 30 June are: • still residing in the State or Territory of application; • still eligible for public, community or State and Territory owned and managed Indigenous housing; and • still wish to pursue their application. Potential applicants still awaiting eligibility assessment at 30 June are excluded.

Source: AIHW (2002a, 2002b, 2002c).

Commonwealth Rent Assistance

Table 16.22 **Terms**

Term	*Definition*
ARO	Administrative review officer.
Control of overpayment	The number of reviews conducted targeted at CRA and their outcomes — that is, the number and value of any increases in assistance, decreases in assistance and overpayments detected. Although the reviews are targeted at CRA, they may also result in variations to the primary payment.
Customer and community satisfaction surveys	Surveys not specific to CRA that may be broadly indicative of the views of CRA recipients. This measure provides information about overall customer satisfaction with service delivery, customer service centre staff and call centre staff (the Centrelink telephone service).
Eligible income support clients	Clients in receipt of an income support payment or more than the minimum rate of family allowance. CRA is automatically paid once eligibility is established. The only eligible clients who are not paid are those affected by Centrelink errors in recording information or by program errors.

(Continued on next page)

Table 16.22 **(Continued)**

Term	*Definition*
Geographic spread of CRA customers	CRA customers as a proportion of all income units in each capital city receiving a social security support payment or more than the base rate of Family Tax Benefit.
Income units	The basic units used to determine eligibility for social security payments. Income units are analogous to family units with the distinction that non-dependent children and other adults living in the same household are treated as separate income units. Children are regarded as dependent until 16 years of age. Children aged 16–18 years may also be regarded as dependent if they are full time students, wholly or substantially dependent on another person and not in receipt of an income support payment. (Defined differently for public and community housing).
Low income	Income units receiving CRA broken down by quintiles of family income per week.
Maximum rate	Proportion of CRA recipients receiving the maximum rate of CRA by payment type.
Number and outcome of appeals	The number of customers who appealed to an authorised review officer as a proportion of the number of customers receiving CRA and the proportion of appeals where the decision was affirmed, set aside or varied, or the appeal withdrawn.
Number and proportion of CRA recipients by income unit type	A point in time indicator, showing the number of CRA recipients by income unit type, and the proportion of recipients within each income unit category. Includes data on Indigenous recipients.
Number and proportion of CRA recipients by payment type	A point in time indicator showing the number of CRA recipients by the type of primary payments received, and the proportion of recipients within each payment type category.
Proportion of income spent on rent with and without CRA	A point-in-time indicator, measuring the proportion of income units spending less than (a) 30 per cent, and (b) 50 per cent of their income on rent, both with and without CRA. The proportion of income spent on rent is calculated as follows: • with CRA: rent minus CRA/total income from all sources, excluding CRA; or • without CRA: rent/total income from all sources, excluding CRA.
Ratio of running costs to total outlays for the CRA program	Total running costs for the CRA program as a proportion of total outlays.
Rent	Amounts payable as a condition of occupancy of a person's home. Includes site fees for a caravan, mooring fees and payment for services provided in a retirement village. Rent encompasses not only a formal tenancy agreement, but also informal agreements between family members, including the payment of board or board and lodgings. Where a person pays board and lodgings and is unable to separately identify the amount paid for lodgings, two-thirds of the payment is deemed to be for rent. There is no requirement that rent be paid; a person whose rent is in arrears may remain eligible for assistance provided Centrelink is satisfied that the liability is genuine.
Running costs per 1000 CRA customers	Total running costs for the CRA program per 1000 CRA customers.

(Continued on next page)

Table 16.22 **(Continued)**

Term	*Definition*
Satisfaction with location of housing	Satisfaction with the location of housing as measured by the DFaCS General Customer Survey. Reports on individuals paid CRA the fortnight before interview.
Satisfaction with quality of housing	Satisfaction with the quality of housing as measured by the DFaCS General Customer Survey. Reports on individuals paid CRA the fortnight before interview.
Special needs	The proportion of income units spending less than(a) 30 per cent, and (b) 50 per cent of their income on rent, both with and without CRA, for Indigenous CRA recipients, those in rural and remote areas and disability support pension recipients.
Total income from all sources	Income received by the customer or partner, excluding income received by a dependent. Includes regular social security payments and any maintenance and other private income taken into account for income testing purposes. Excludes: • one-time payments; • arrears payments; • advances; • Employment or Education Entry Payments; • Mobility Allowance; • Maternity Allowance; and • Child Care Assistance Rebate. In most cases, private income reflects the person's current circumstances. Taxable income for a past financial year, or an estimate of taxable income for the current financial year, is used where the income unit receives more than the minimum rate of family allowance but no other income support payment.

Source: DFaCS (unpublished).

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A Statistical appendix

A.1 Introduction

This appendix contains contextual information that may aid in the interpretation of the performance indicators presented in the Report. Four key issues related to the interpretation of the performance data presented are addressed:

- *Australia's population*: section A.2 presents data on population characteristics, including size, age and sex, ethnicity, geographic location and a profile of Indigenous Australians;
- *family and household*: section A.3 provides an overview of the family and household environment within which Australians live;
- *income and employment*: section A.4 summarises the income and employment characteristics of Australians, including income, educational attainment, employment and participation; and
- *statistical concepts used in the Report*: section A.5 provides technical information on the key statistical methods used in the Report.

Supporting tables

Supporting tables for this appendix are provided on the CD-ROM enclosed with the Report. The files are provided in Microsoft Excel 97 format as \Publications\Reports\2003\Attach_stat_app.xls and in Adobe PDF format as \Publications\Reports\2003\ Attach_stat_app.pdf.

Supporting tables are identified in references throughout this chapter by an 'A' suffix (for example, table A.3 is table 3 in the electronic files). 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 these tables (see details on the inside front cover of the Report).

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Most of the service areas covered by the Report use the population data from table A.1 for descriptive information (such as expenditure per person in the population) or performance indicators (such as participation rates for vocational education and training). Financial data (which are expressed in real dollars in the chapters) for all services are deflated by the gross domestic product deflator data from table A.25 (except for health, and vocational education and training).

A.2 Population

The Australian people are the principal beneficiaries of the government funded and/or provided services covered by this Report. The size, trends and characteristics of the population can have a significant influence on the demand for government services and the cost of their delivery. This section provides a limited exposition of the Australian population to support the analysis of government services provided in other areas of the Report. A more detailed exposition is provided in the Australian Bureau of Statistics (ABS) annual *Australian Social Trends* publication (ABS 2002a).

Population size and trends

More than three-quarters of Australia's 19.3 million people lived in the eastern States in June 2001, with NSW, Victoria and Queensland accounting for 33.7 per cent, 24.9 per cent and 18.7 per cent respectively of the nation's population. Western Australia and SA accounted for a further 9.9 per cent and 7.7 per cent of the population respectively. Tasmania, the ACT and the NT accounted for the remaining 2.4 per cent, 1.6 per cent and one per cent respectively (table A.1).

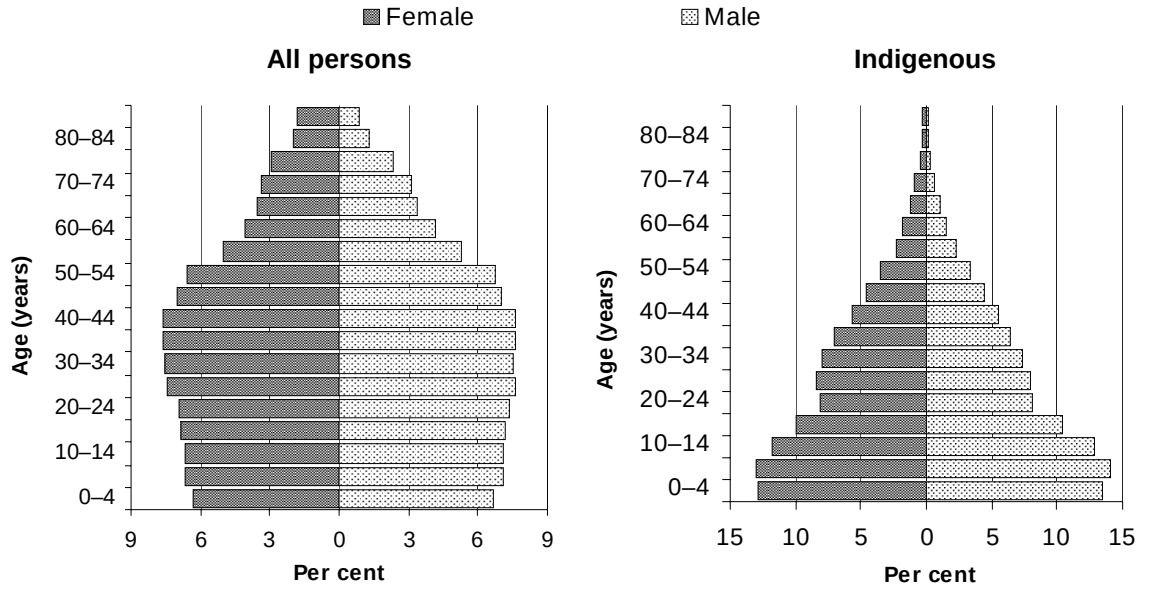
Nationally, the average annual growth rate of the population between 1997 and 2001 was approximately 1.3 per cent. The experience of individual jurisdictions ranged from an increase of 1.7 per cent in Queensland to zero growth (or a slight decline) in Tasmania (table A.2).

Population, by age and sex

In Australia — as in most other developed economies — greater life expectancy and declining fertility have contributed to an 'ageing' of Australia's population. The experiences of Indigenous people, however, are markedly different (figure A.1). At 30 June 2001, 8.9 per cent of Australia's population were aged 70 years or more.

Across jurisdictions, the proportion of people aged 70 years or more ranged from 10.7 per cent in SA to 2.2 per cent in the NT (table A.1).

Figure A.1 **Population distribution, by age and sex, June 2001**



Source: ABS (2002c); tables A.1 and A.7.

Approximately half (50.2 per cent) of the population at June 2001 was female. This distribution was similar across all jurisdictions except the NT, which had a relatively low representation of women in its population (47.2 per cent) (table A.1).

The proportion of women in the population varies noticeably by age. Nationally, approximately 48.7 per cent of people aged 14 years of age or less were female, compared with 57.8 per cent of people aged 70 years or more. These proportions were similar across all jurisdictions except the NT, which had relatively low representation of women in the group aged 70 years or more (49.9 per cent) (table A.1).

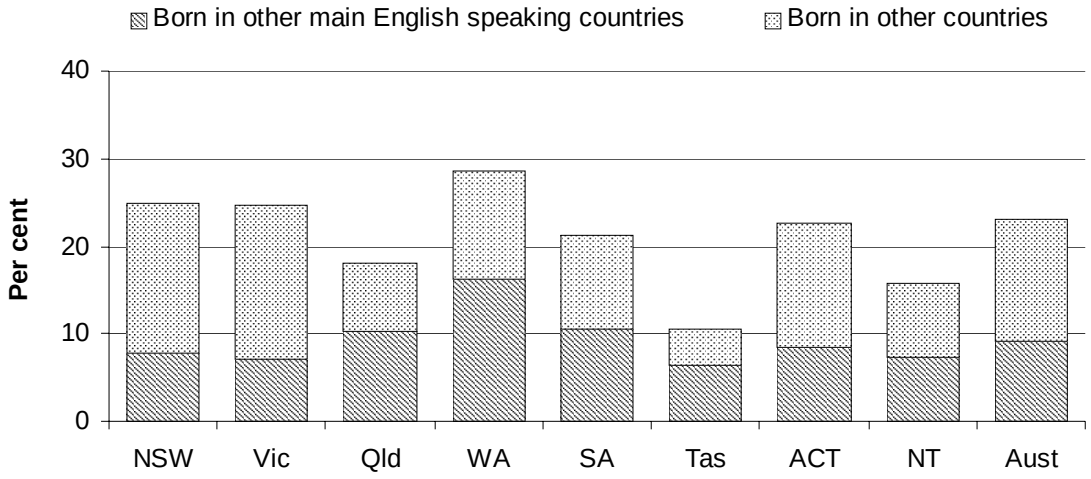
Population, by ethnicity

New Australians face specific problems when accessing government services. Language and culture can be formidable barriers for otherwise capable people. Cultural backgrounds can also have a significant influence on the support networks offered by extended families.

People born outside Australia accounted for 23.1 per cent of the population in August 2001 (9 per cent from the other main English speaking countries and

14.1 per cent from other countries).[1] Across jurisdictions, the proportion of people born outside Australia ranged from 28.5 per cent in WA to 10.5 per cent in Tasmania. The proportion from other countries ranged from 17.2 per cent in NSW to 4.1 per cent in Tasmania (figure A.2).

Figure A.2 **Proportion of people born outside Australia, by country of birth, August 2001[a, b]**



a Other main English speaking countries include the United Kingdom, Ireland, New Zealand, Canada, the United States and South Africa. **b** Excludes overseas visitors and 'not stated'.

Source: ABS (2002b); table A.4.

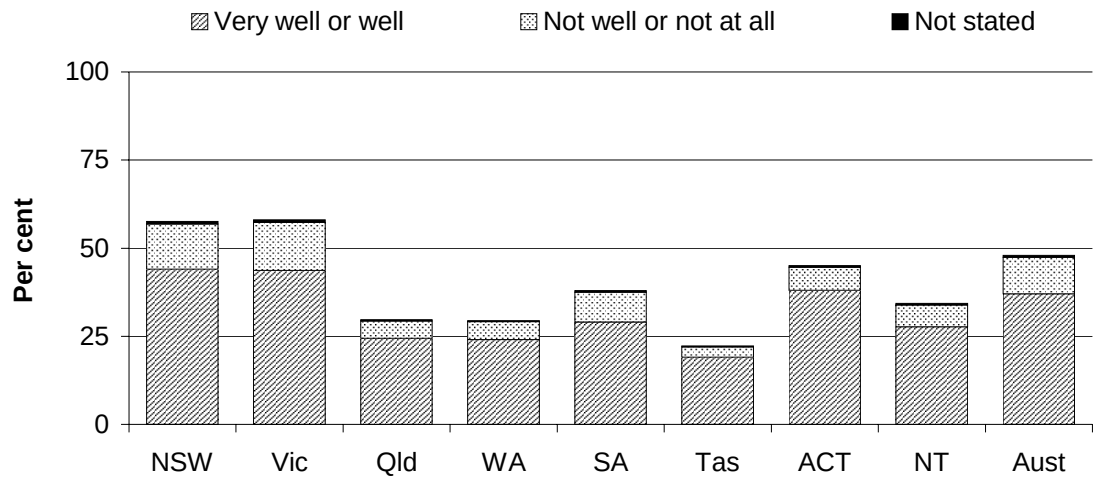
People who spoke a language other than English accounted for 48.4 per cent of the population born outside Australia in August 2001. Thirty-seven per cent felt they spoke English 'well' or 'very well'. A further 10.4 per cent did not speak English at all or did not speak English well. Across jurisdictions, the proportion of the population who were born outside Australia and who spoke a language other than English ranged from 58.0 per cent in NSW to 22.7 per cent in Tasmania. The proportion who were born outside Australia and who did not speak English at all or did not speak English well ranged from 13.6 per cent in Victoria to 2.9 per cent in Tasmania (figure A.3).

Approximately 15.2 per cent of Australians spoke a language other than English at home in August 2001. Across jurisdictions, this proportion ranged from 22.8 per cent in the NT to 3.1 per cent in Tasmania (table A.5). The most common languages spoken were Chinese, Italian and Greek, accounting for 16.1 per cent, 14.2 per cent and 10.6 per cent respectively of people who spoke a language other

[1] The ABS defines the main English speaking countries as the United Kingdom, Ireland, New Zealand, Canada, the United States and South Africa.

than English in their homes. The least common languages were Khmer, Sinhalese and South Slavic which each accounted for less than 1 per cent of people who spoke a language other than English in their homes.

Figure A.3 **Proficiency in spoken English of people born overseas who English and another language, August 2001[a, b, c]**



a Excludes overseas visitors and people who did not state their birthplace. **b** Australia total includes 'other territories'. **c** Not stated includes cases where language spoken at home was stated but proficiency in English was not stated.

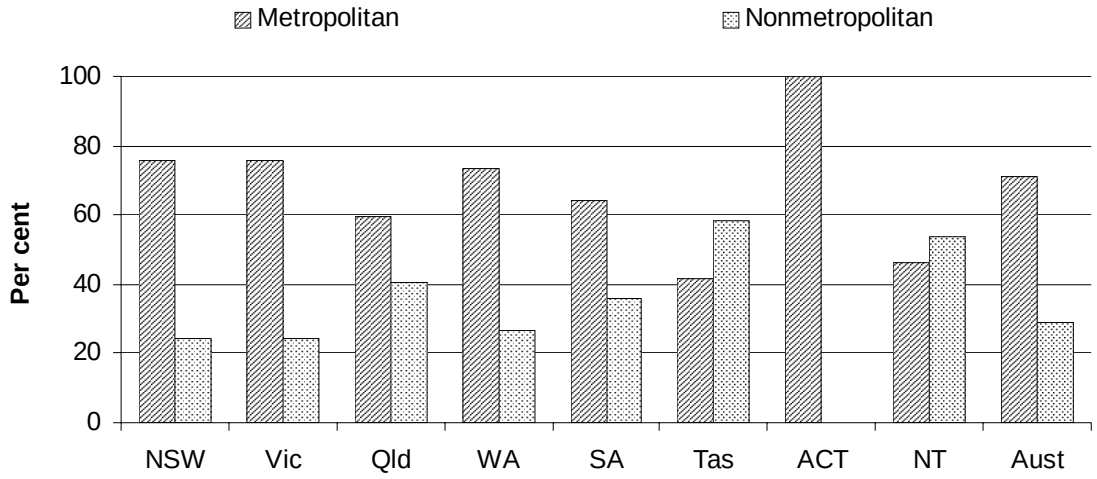
Source: ABS (2002b); table A.3.

The most and least common languages other than English in people's homes varied across jurisdictions in August 2001. The most extreme variation was in the NT, where 72.4 per cent of all people who spoke a language other than English in their homes spoke an Indigenous language (table A.5).

Population, by geographic location

The Australian population is highly urbanised, with 70.8 per cent of the population located in metropolitan areas in June 2001 (63 per cent in capital cities) (figure A.4). Across jurisdictions, the proportion of the population located in metropolitan areas in June 2001 ranged from 75.7 per cent in NSW and Victoria to 41.8 per cent in Tasmania (excluding the ACT, which has only a small proportion of its jurisdiction defined as nonmetropolitan) (table A.6).

Figure A.4 **Estimated residential, by geographic location[a]**



[a] Capital city areas are defined (DPIE and DHSH 1994) as State and Territory capital city statistical divisions. Other metropolitan areas are defined as other statistical subdivisions that include urban centres of population of 100 000 or more. Remote areas are defined in terms of low population density and long distances to associated large population centres. Rural areas include the remainder of nonmetropolitan statistical local areas.

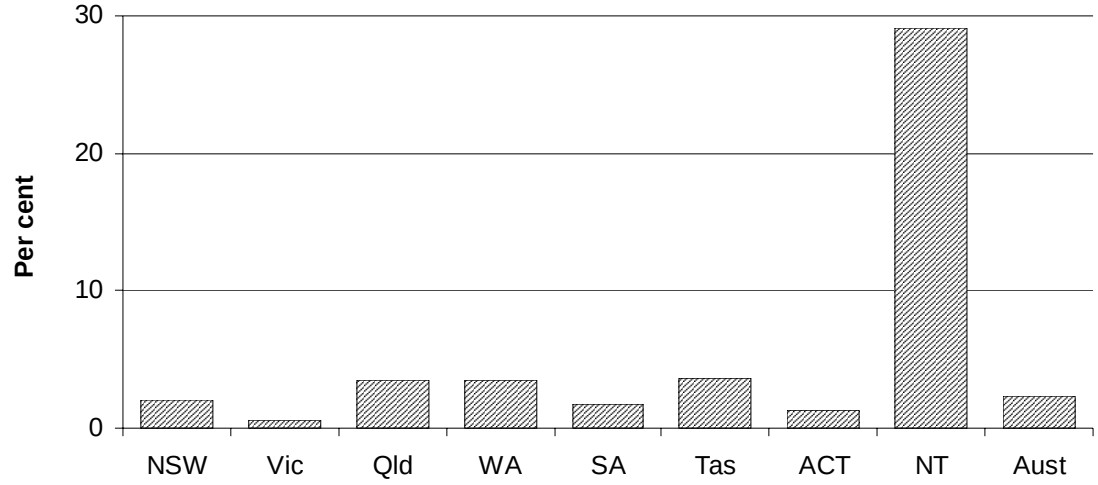
Source: ABS (2002d); Department of Primary Industries and Energy and Department of Human Services and Health (1994); table A.6.

Indigenous population profile

There were 460 376 (232 157 female and 228 219 male) Indigenous people in Australia in June 2001, accounting for approximately 2.4 per cent of the population (tables A.1 and A.7). The proportion of people who were Indigenous was significantly higher in the NT (29.4 per cent) than in any other jurisdiction. Across the other jurisdictions, the proportion ranged from 3.5 per cent in Queensland to 0.6 per cent in Victoria (figure A.5).

The majority of Indigenous people (79.8 per cent) at August 2001 spoke only English at home, 12.1 per cent spoke an Indigenous language and English, and 2.5 per cent spoke another language. At that time, 5.6 per cent did not state any specific language (table A.9).

Figure A.5 **Indigenous people as a proportion of the population, by State, 30 June 2001**



Source: ABS (2002c); tables A.1 and A.7.

A.3 Family and household

Family structure

There were 5.2 million families in Australia in 2001. The number of families ranged from 1.7 million in NSW to 37 000 in the NT. The average family size across Australia was 3.0 people (down from 3.1 in 2000) (table A.10). Across jurisdictions, average family size ranged from 3.1 people in NSW, Victoria and the NT, to 2.9 people in SA.

Sole parent families may have a greater need for government support and particular types of government service (such as child care for respite reasons). Nationally, sole parent families accounted for 17.1 per cent of all families (21.7 per cent of families with children aged under 15 years) in 2001. Across jurisdictions, the proportion ranged from 19.0 per cent in the ACT to 16.2 per cent in the NT (table A.10 and A.11).

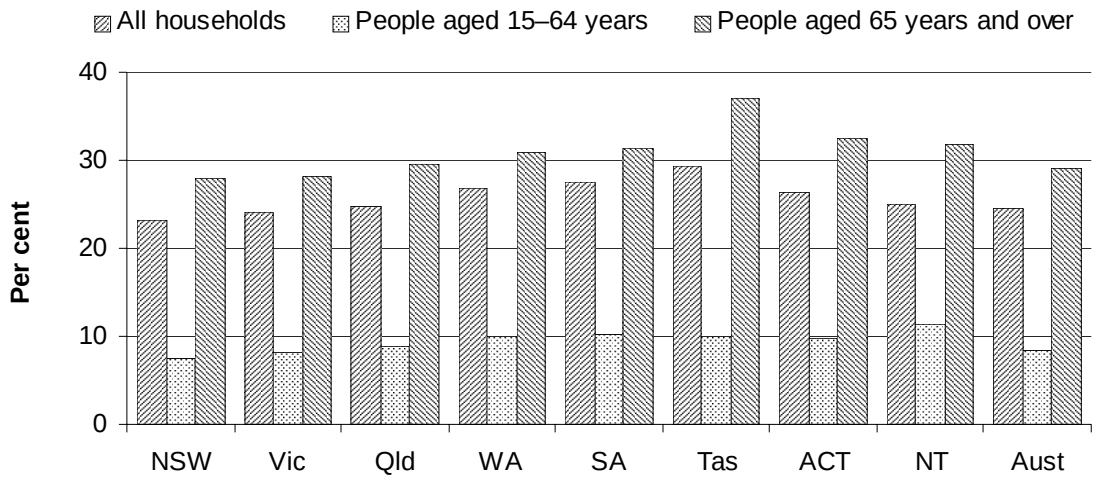
Employment status also has implications for the financial independence of families. Nationally, 17.9 per cent of children aged under 15 years in 2001 lived in families where no parent was employed. Across jurisdictions, the proportion ranged from 20.9 per cent in Tasmania to 11.7 per cent in the ACT (table A.12).

Household profile

There were 7.4 million households in Australia in 2001 (table A.14). Close to one-quarter (24.6 per cent) of these were lone person households. Across jurisdictions, the proportion of lone person households ranged from 29.3 per cent in Tasmania to 23.1 per cent in NSW. The proportion of people aged 65 years and over who lived in lone person households was considerably higher than that for people aged 15–64 years: nationally, 29.2 per cent compared with 8.5 per cent respectively. Across jurisdictions, the proportion of people aged 65 years and over who lived in lone person households ranged from 32.5 per cent in the ACT to 27.9 per cent in NSW (figure A.6).

Nationally, the majority of people (66.2 per cent, or 4.7 million people) in August 2001 lived in houses they owned or were purchasing. Home ownership was highest in Victoria (70.7 per cent) and lowest in the NT (43.0 per cent). Rented accommodation housed 26.3 per cent of Australia's population (4.5 per cent government rental, 21.5 per cent private rental, 0.3 per cent unknown) (table A.15). Across jurisdictions, the proportion of people in rental accommodation was highest in the NT (41.5 per cent) and lowest in Victoria (22.1 per cent) (figure A.7).

Figure A.6 **Proportion of households that are lone person households, by age, 2001**

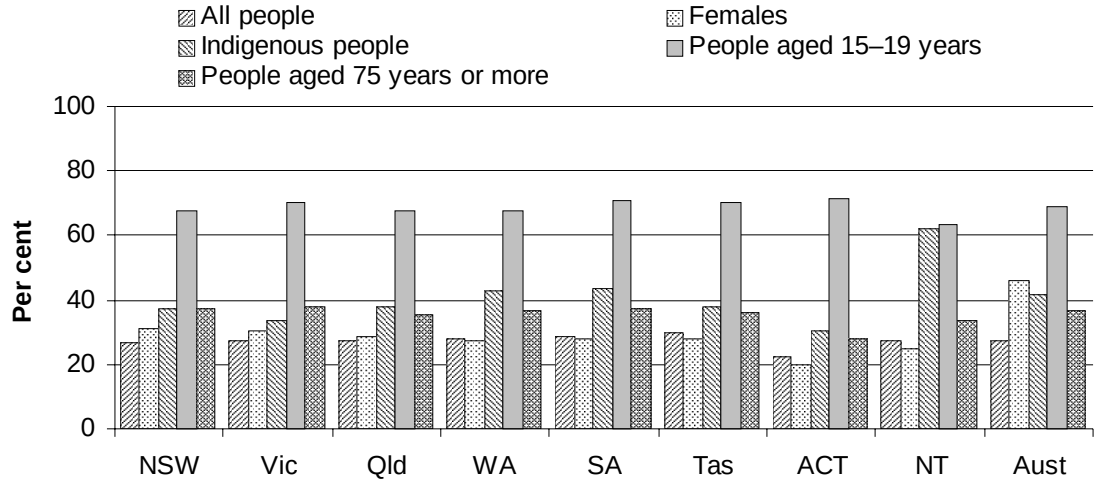


Source: ABS (2002a); table A.14.

Figure A.7 **Occupied private dwellings, by tenure type and landlord type, August 2001**

Source: ABS (2002b); table A.15.

Figure A.8 **Weekly individual income of less than $199, by sex, Indigenous status and age, August 2001**



Source: ABS (2002b); tables A.16–A.18.

A.4 Income and employment

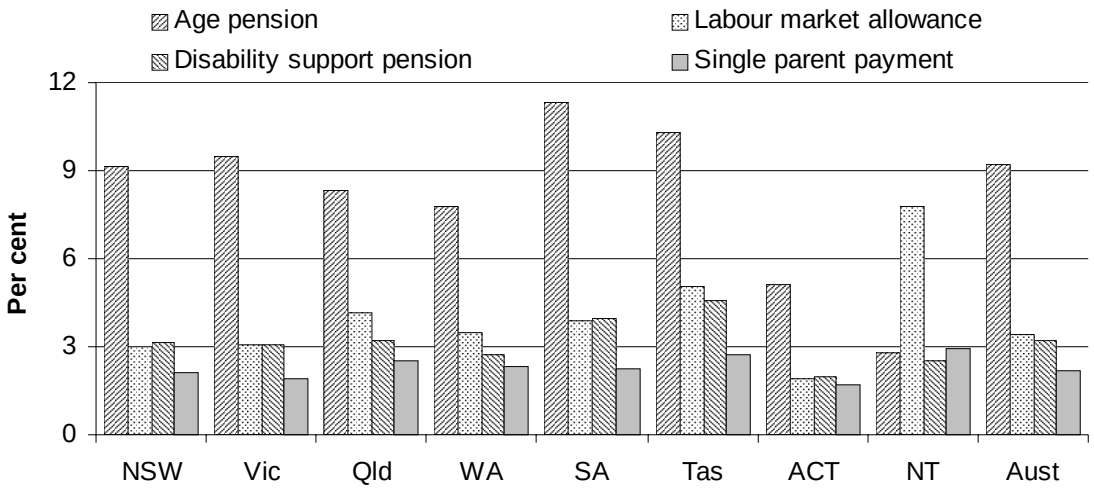
Income

Nationally, 27.1 per cent of people aged 15 years and over in August 2001 had a weekly individual income of less than $199. The proportion was considerably higher for females (46.3 per cent), Indigenous people (41.6 per cent), younger people (68.8 per cent for people aged 15–19 years) and older people (36.8 per cent for people aged 75 years or more) (figure A.8).

Nationally, 18 per cent of the population received some form of income support in 2001. The aged pension was received by 9.2 per cent, 3.4 per cent received some form of labour market allowance, 3.2 per cent received a disability support pension and 2.2 per cent received a single parent payment (figure A.9).

The proportion of people receiving the aged pension in 2001 ranged from 11.3 per cent in SA to 2.8 per cent in the NT. The proportion receiving a labour market allowance ranged from 7.8 per cent in the NT to 1.9 per cent in the ACT; the proportion on disability support pensions ranged from 4.6 per cent in Tasmania to 2.0 per cent in the ACT, and the proportion on a single parent payment, ranged from 2.9 per cent in the NT to 1.7 per cent in the ACT.

Figure A.9 **Proportion of total population on income support, 2001**



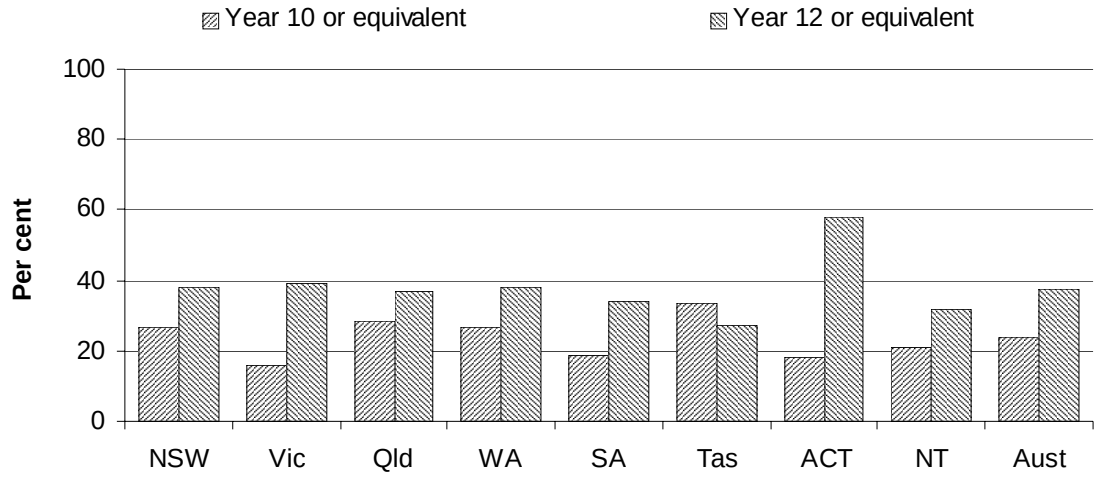
Source: ABS (2002a); tables A.19.

Educational attainment

Employment outcomes and income are closely linked to the education and skill levels of individuals. At August 2001, 37.7 per cent of people aged 15 years and over (approximately 5.6 million people) had completed year 12 or equivalent schooling. A further 23.8 per cent (3.5 million people) had completed year 10 or equivalent schooling. Across jurisdictions, the proportion of people aged 15 years and over who had completed year 12 or equivalent schooling ranged from 57.8 per cent in the ACT to 27.2 per cent in Tasmania (figure A.10).

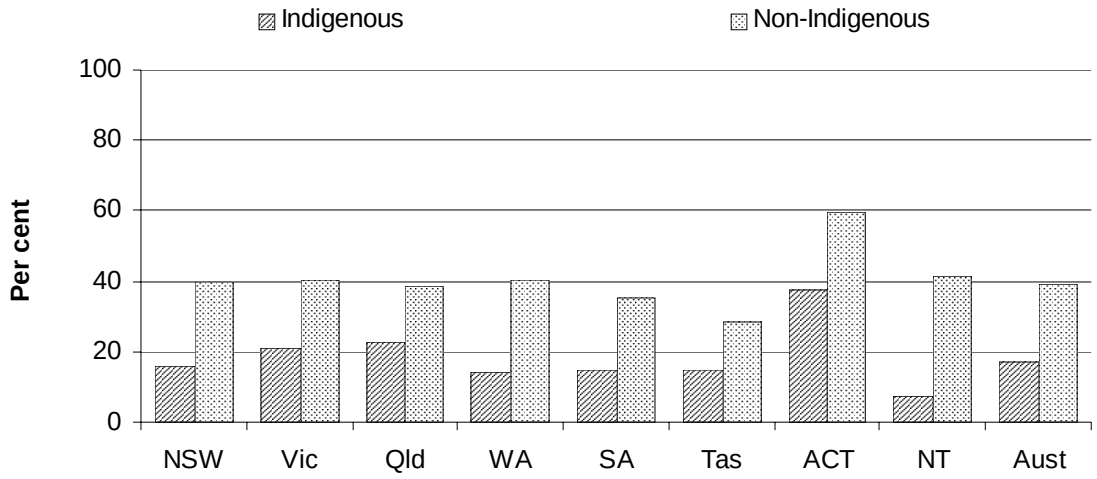
The proportion of Indigenous people aged 15 years and over who had completed year 12 or equivalent schooling was considerably lower than the proportion of non-Indigenous people (16.8 per cent and 39.5 per cent respectively) in August 2001. Across jurisdictions, the discrepancy between Indigenous and non-Indigenous proportions ranged from 34.3 percentage points in the NT to 13.3 percentage points in Tasmania (figure A.11).

Figure A.10 **Proportion of people aged 15 years and over, by highest level of schooling completed, August 2001**



Source: ABS (2002b); table A.20.

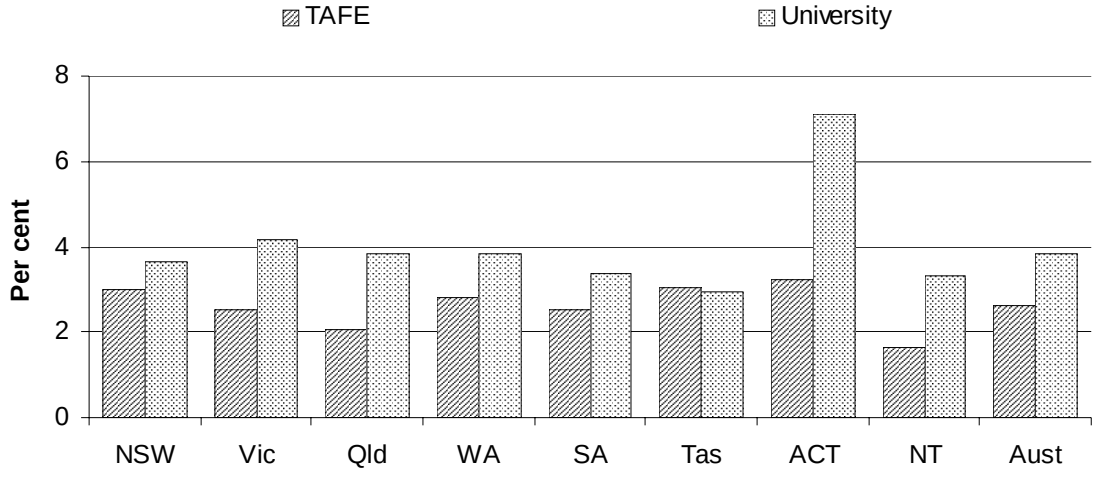
Figure A.11 **People aged 15 years and over that had completed year 12 or equivalent, by Indigenous status, August 2001**



Source: ABS (2002b); table A.20.

Tertiary education in Australia is principally provided by technical and further education (TAFE) and university institutions. Nationally, 6.5 per cent of the population were attending TAFE or university in August 2001 (2.6 per cent at TAFE and 3.8 per cent at university). Across jurisdictions, the proportion of people attending TAFE ranged from 3.2 per cent in the ACT to 1.6 per cent in the NT; the proportion attending university ranged from 7.1 per cent in the ACT to 3.3 per cent in the NT (figure A.12).

Figure A.12 **Proportion of population attending TAFE or university, August 2001[a, b, c]**

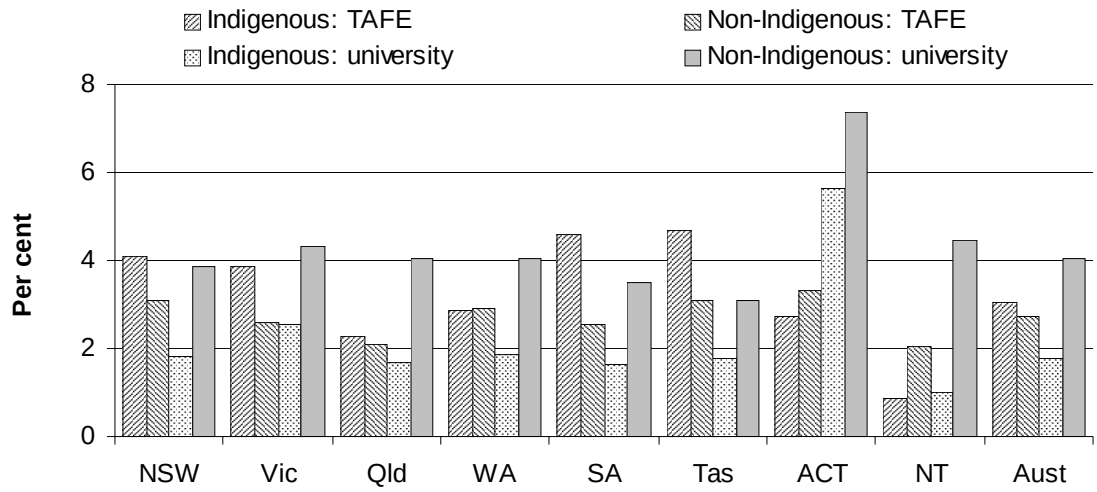


a Australian includes other territories. **b** TAFE refers to Technical and Further Educational Institutions **c** University includes other Tertiary Institutions.

Source: ABS (2002b); table A.21.

The proportion of the Indigenous population who were attending TAFE in August 2001 was greater than the proportion of the non-Indigenous population in all jurisdictions except WA, the ACT and the NT. Conversely, the proportion of the Indigenous population attending university was less than that of the non-Indigenous population in all jurisdictions except SA and Tasmania (figure A.13).

Figure A.13 **Proportion of population attending TAFE or university, by Indigenous status, August 2001[a, b, c]**



a Australian includes other territories. **b** TAFE refers to Technical and Further Educational Institutions **c** University includes other Tertiary Institutions.

Source: ABS (2002b); table A.21.

Employment and workforce participation

There were 9.3 million people aged 15 years or over employed in Australia in June 2002. The majority (70.8 per cent) were in full time employment. A further 624 000 were looking for either full time (76.7 per cent) or part time (23.3 per cent) work. Thus, 6.3 per cent of the participating labour force were unemployed (table A.22).

Across jurisdictions, the proportion of employed people in full time employment in June 2002 ranged from 73.9 per cent in NT to 66.8 per cent in Tasmania. The proportion of unemployed people looking for full time work ranged from 83.5 per cent in Tasmania to 61.0 per cent in the ACT. The unemployment rate ranged from 8.1 per cent in Tasmania to 4.6 per cent in the ACT and the NT (table A.22).

The proportion of males participating in the labour force was greater than the proportion of females in all jurisdictions across Australia (figure A.14a). A greater proportion of employed males had full time employment. The discrepancy ranged

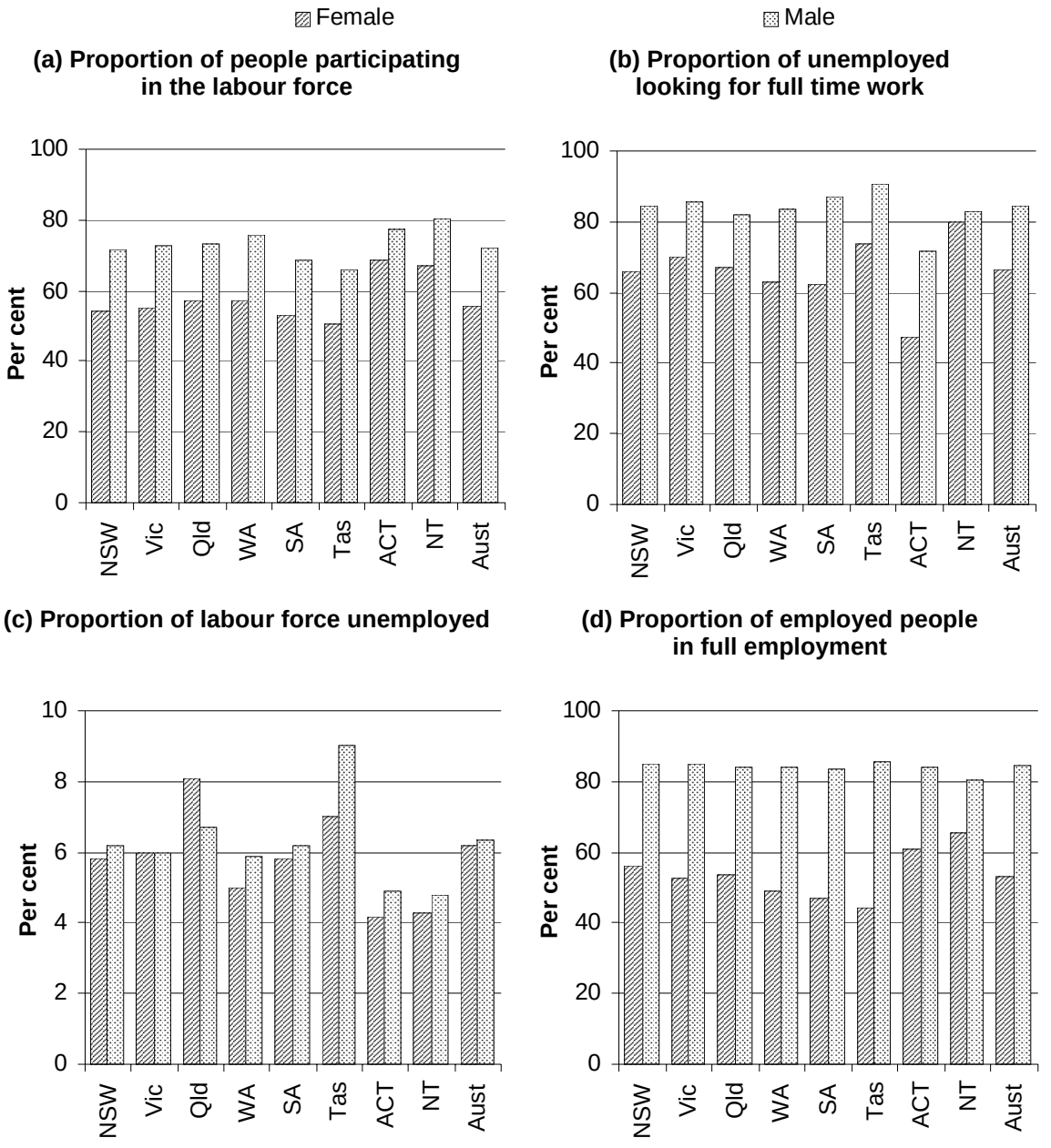
from 40.9 percentage points in Tasmania to 15.1 percentage points in the NT (figure A.14d). Fewer unemployed females, however, were looking for full time work. The discrepancy ranged from 24.7 percentage points in SA to 2.8 percentage points in the NT (figure A.14b).

The unemployment rate of females was equal to or lower than that of males in all jurisdictions except Victoria and Queensland. The discrepancy ranged from 2.0 percentage points in Tasmania to -1.4 percentage points in Queensland (figure A.14c). These rates should be interpreted within the context of labour force participation rates, which were considerably higher for males than for females in all jurisdictions. The discrepancy ranged from 18.5 percentage points in WA to 9.1 percentage points in the ACT (figure A.14d).

General economic indicators

The proportion of national real gross product varied widely across the States and Territories. For 2000-01, the real gross state product for NSW was 36.1 per cent, compared to 1.2 per cent for the ACT. Growth from the previous year's gross state product was highest for the ACT (4.5 per cent) and lowest for SA (-1.2 per cent). Across Australia, the gross state product per person was $33 281 (table A.25).

Figure A.14 **Labour force outcomes for people aged 15 year or over, by sex, June 2002**



Source: ABS (2002e); table A.22, A.23 and A.24.

A.5 Statistical concepts used in the Report

Reliability of estimates

Outcome and quality indicators are reported from client and community perception surveys for a number of services covered in this Report. Police services, for example, use the AC Nielsen survey to obtain an indication of the level of satisfaction within the community for the services that police agencies provide.

The presence of sampling error — that is, the error that occurs by chance because the data are obtained from only a sample and not the entire population — implies that the reported responses may not be indicative of the true responses.

Standard error

The standard error (SE) is one measure of the variability that occurs as a result of surveying a sample of the population. There are two chances in three (67 per cent) that a survey estimate is within one standard error of the figure that would have been obtained if the population had been included, and about 19 chances in 20 (95 per cent) that it is within approximately two standard errors. The true value of x lies within:

$$x - 1.96\ SE(x) \text{ and } x + 1.96\ SE(x)$$

where x is the estimate (for example, the number of persons responding either 'satisfied' or 'very satisfied'). The standard error of an estimate can be obtained from either (1) the tables reporting the estimates and relative standard errors or (2) the relative standard error tables produced at the end of each of the relevant attachments. Linear interpolation needs to be used to calculate the standard errors of estimates falling between the sizes of estimates listed in these tables.

Relative standard error

The standard error can be expressed as a proportion of the estimate — known as the relative standard error (RSE). The relative standard error is determined by dividing the standard error of the estimate $SE(x)$ by the estimate x and expressing it as a percentage. That is:

$$RSE(x) = \frac{SE(x)}{x}$$

If 4.3 million people in NSW were estimated to be satisfied with a service, and the standard error were approximately ±34,100 people, for example, then the *RSE*(*x*) would be equal to 0.0078, or 0.78 per cent. The relative standard error is a useful measure in that it provides an immediate indication of the percentage errors likely to have occurred as a result of sampling.

Proportions and percentages formed from the ratio of two estimates are also subject to sampling error, as when estimating the proportion of a population that is 'satisfied' or 'very satisfied' with a service. The size of the error depends on the accuracy of both the numerator (the estimated number of persons responding 'satisfied' or 'very satisfied') and the denominator (the estimated size of the population). The formula of a proportion is:

$$RSE(x_1/X) = \sqrt{[RSE(x_1)]^2 - [RSE(X)]^2}$$

where x_1 is estimated as the number of persons from jurisdiction x responding 'satisfied' or 'very satisfied' and X is the estimated population of jurisdiction x.

Testing for statistical differences

The chance that an estimate falls within a certain range of the true value is known as the *confidence* of the estimate. For any particular survey, there is a tradeoff between the confidence of the estimate and the range of error (in terms of standard errors) attached to the estimate. The appropriate level of reliability chosen depends on the purpose of obtaining the estimate. The lower the level of confidence required, the more precise the estimate will be.

Confidence intervals — the value ranges within which estimates are likely to fall — can be used to test whether the reported proportions between two jurisdictions are different. When comparing proportions, if the confidence intervals for the jurisdictions overlap, then there can be little confidence that the estimated proportions differ from each other.

If 60 per cent of NSW clients reported being 'satisfied' or 'very satisfied' with a service, and 58 per cent of Queensland clients reported being 'satisfied' or 'very satisfied', then the 95 per cent confidence interval for NSW would be estimated at ±3.2 per cent and that for Queensland would be estimated at ±1.5 per cent. These would imply a 56.8–62.3 per cent confidence interval for NSW clients and a 56.5–59.5 per cent confidence interval for Queensland clients. The two ranges overlap, so there would be little confidence (at the 95 per cent level) that the two differ.

Expressed mathematically, the estimated response is within the 95 per cent confidence interval:

$$\left(\frac{x_1}{X}-\frac{y_1}{Y}\right)-1.96\sqrt{RSE(x_1/X)\frac{x_1}{X}+RSE(y_1/Y)\frac{y_1}{Y}}$$

and

$$\left(\frac{x_1}{X}-\frac{y_1}{Y}\right)+1.96\sqrt{RSE(x_1/X)\frac{x_1}{X}+RSE(y_1/Y)\frac{y_1}{Y}}$$

where x_1, X, y_1 and Y represent the estimated number of respondents and estimated populations of jurisdictions x and y respectively. If none of the values in this interval is zero, then it is possible to conclude that the difference between jurisdiction x's response and jurisdiction y's response is statistically significant.

Growth rates

Average annual growth rates

Given that data in the Report cover different periods (for example, population growth, inflation and expenditure changes), compound annual averages have been used to facilitate more meaningful comparisons.

The formula for calculating a compound annual growth rate is:

$$\left(\left(\left(Pv/Po\right)^{\left(\frac{1}{n}\right)}\right)-1\right)\times 100$$

P_v = Present Value
P_o = Beginning Value
n = number of periods

Summing and taking averages of growth rates

Total growth rate

The formula for calculating a total growth rate from annual growth rates is:

$$r_T = \Pi_i\ (1+r)_i - 1$$

that is, the total growth over the period (r_T) is found by taking the product of each of the $(1+r)_i$'s and deducting 1.

If, for example, the sample ranges of growth rates are:

1995-96 to 1996-97	6 per cent
1996-97 to 1997-98	6 per cent
1997-98 to 1998-99	8 per cent

then the total growth over the period 1995-96 to 1998-99 can be calculated as:

$$\begin{aligned} r_T &= [\Pi\,(1+r)_i] \times 100 \\ &= [(1.06) \times (1.06) \times (1.08) - 1] \times 100 \\ &= [1.213488 - 1] \times 100 \\ &= 21.3 \text{ per cent.} \end{aligned}$$

Average growth rates

The formula for the average of growth rates is:

$$r_A = \{ [\Pi_i\ (1+r)_i]^{(1/t)} - 1 \} \times 100$$

This involves first finding the total growth over the period, then finding the average. Note that *t* is the count of growth rates that you are averaging, not the years. For example:

$$\begin{aligned} r_A &= \{ [(1.06 \times 1.06 \times 1.08)^{(1/3)} - 1] \times 100\} \\ &= \{ [(1.213488)^{(1/3)} - 1] \times 100\} \\ &= [(1.066625) - 1] \times 100 \\ &= 6.66 \text{ per cent.} \end{aligned}$$

GDP deflators

The table containing GDP deflators for the 1984–2002 period can be found in table A.18 on the CD-ROM. The general formula used to rebase GDP deflators is as follows:

New index for year *t* = 100× (current index for year *t*/current index for the year that will be the new base).

A.6 References

ABS (Australian Bureau of Statistics) 1998, *Experimental Projections of the Indigenous Population*, cat. no. 3231.0, Canberra.

—— 2002a, *Australian Social Trends 2002*, cat. no. 4102.0, Canberra.

—— 2002b, *Census of Population and Housing: Basic Community Profiles*, Australia, cat. no. 2002.0, DX Database (accessed 18 July 2002), unpublished.

—— 2002c, *Estimated Residential Population*, by Age, cat. no. 3201.0, DX Database (accessed 18 July 2002), unpublished.

—— 2002d, *Estimated Resident Population, by Age and Sex in Statistical Local Areas*, Australia, cat. no. 3227.0, DX Database (accessed 18 July 2002), unpublished.

—— 2002e, *Projected Population: Series 1*, cat. no. 3222.0, DX Database (accessed 18 July 2002), unpublished.

DPIE and DHSH (Department of Primary Industries and Energy and Department of Human Services and Health) 1994, *Rural, Remote and Metropolitan Classification*, 1991 Census Edition, AGPS, Canberra.